**Governor's Advisory Council for Exceptional Citizens (GACEC)**
**516 West Loockerman St., Dover, DE 19904**
**302-739-4553 (voice) 302-739-6126 (fax) http://www.gacec.delaware.gov**

# MEMORANDUM

**DATE:** **May 25, 2016**

**TO:** **The Honorable Members of the Delaware General Assembly**

**FROM:** **Robert D. Overmiller, Chairperson**
**GACEC**

**RE:** **House Bill No. 319 (Substance Exposed Infants)**

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed **House Bill No. 319**, which would require health care providers to report to the Division of Services for Children, Youth and their Families (DSCY&F) infants affected by either: 1) illegal substance abuse by the infant's mother; 2) withdrawal symptoms resulting from prenatal drug exposure (with exceptions); or 3) fetal alcohol spectrum disorder. Although reports of abuse or neglect can generally be made anonymously, this is not permitted for reports of substance exposed infants (lines 108-110). A "plan of safe care" would be developed for cases accepted by Division of Family Services (DFS) for investigation or family assessment (lines 44-60 and 136-137).

Approximately 3% of babies born in Delaware qualify for a diagnosis of neonatal abstinence syndrome (NAS) in which the infant undergoes opiate withdrawal. That percentage has been growing in recent years. DFS predicts that 600 babies will be born with NAS in Delaware in 2016. See April 28, 2016 News Journal article. DFS substantiates abuse in approximately 10% (44/448) of cases of suspected neglect or abuse reported to it among babies born with drugs or alcohol in their system. See March 7, 2016 News Journal article. Medical professionals prefer to place pregnant women with addictions on methadone resulting in only short-term effects on babies treated for withdrawal upon birth. See "Addicted babies", Delaware News Journal (November 20, 2015).

House Bill No. 268, which is similar to House Bill No. 319 was introduced in March, 2016 and stricken on April 14, 2016. The GACEC submitted the attached letter on that bill. House Bill No. 319 omits some of the provisions in House Bill No. 268 involving "medically fragile children"

which were highly disfavored by the Council. However, in some other respects, this legislation replicates several of the problematic provisions in the prior bill. Council would like to share the following observations on House Bill No. 319.

First, the legislation reinforces an autocratic model in which the State imposes requirements and offers only modest help to new mothers with substance abuse profiles. The bill (lines 44-60) contemplates unilateral development of the "plan of safe care" with zero input from the parent. This "top-down" plan is then shared with agencies but not the parent (lines 48-49 and 56-58). This approach is not a collaborative model which "engages" the new mother in a joint venture to benefit her infant. The "plan of safe care" section should preferably be amended to ensure parental input and collaboration in the development of the plan.

Second, the articles describe successful outcomes for parents receiving wrap-around services while highlighting the lack of resources available to many parents:

> Holly Rybinski, of Newport, said she had to go to jail in order to get the drug treatment she needed. That was almost two years ago. She had stayed clean for five years, but while she was pregnant with his child, her partner overdosed and died. Consumed with grief, Rybinski turned to heroin and cocaine during the last five months of her pregnancy. After she gave birth to her son James April 8, 2014, at Christiana Care's Wilmington Hospital, she was ready to be clean. She said the Division of Family Services told her that they had to take custody of him since James tested positive for drugs, she wasn't in a treatment program and Rybinski had a record. <u>They told her she had 90 days to find employment, treatment and stable housing and then they could discuss putting him back in her care.</u> That request was easier said than done. ..."I tried five different times to get into treatment," Rybinski said. "It was one obstacle after the other." As the number of pregnant and addicted mothers grows, the need for treatment is even more critical. Community members, families and those now in recovery, like Rybinski, have long lamented Delaware's lack of residential treatment options. Many people have to wait days and even weeks to get a bed. ...<u>Currently, there is one state-run treatment program for expectant or new mothers recovering from addiction in Delaware, but it is only for women who are incarcerated and it is in Newark.</u> ...<u>Brandywine Counseling ran a program for expecting moms wrestling with addiction, called Lighthouse, downstate in Ellendale, but it closed in September due to budget cuts and staffing shortages</u>. ...(I)t was extremely successful. Nearly 100 percent of women were able to give birth to babies free of drugs.

"More treatment key for addicted moms", Delaware News Journal (March 4, 2016).

It is difficult to assess whether the legislation will expand resources based on the incomplete fiscal note. Successful outcomes for both mothers and infants are highly dependent on the ready availability of a comprehensive, responsive system of supports.

Third, the "plan of care" section identifies a few types of support services (lines 51-56). It could be improved by adding "safe housing" as a support service. This section also contemplates the identification of family supports (line 50) without including which entity will assure provision of the supports. Merely identifying "available family supports" (lines 50-51) without clarification of the agency responsible for assuring provision of the supports will result in ambiguity and plan failure.

Fourth, the Judiciary Committee Report indicates that the bill was supported since "it provides essential support for families". In contrast, the text of the bill includes some relatively weak standards and expectations. For example, lines 123-124 recite that "(t)he system shall endeavor to coordinate community resources...". There is no definition of "the system" and the reference to "endeavor" (a/ka "try") establishes a weak expectation. The sentence could be improved by reciting that "(t)he Division shall coordinate community resources..." OR "(t)he Division shall ensure coordination of community resources...". Likewise, the plan of safe care contemplates simply a "referral" to substance disorder treatment programs and home visiting programs (lines 52 and 54). It would be preferable to include a more affirmative Division role in securing access to such supports than simply issuing a referral.

Fifth, lines 66-69 suggest that mothers prescribed Methadone (who would still have given birth to infants undergoing withdrawal) are exempt from the operative provisions in the bill. Their babies would not qualify under the definition of "substance exposed infant" (lines 61-63) since they are excluded from the definition of "withdrawal symptoms resulting from prenatal drug exposure" (lines 62 and 66-69). This approach is reinforced by lines 83-89. Reasonable persons might differ on the prudence of this approach since there would be no report to DSCY&F. Moreover, such infants would be categorically ineligible for a "plan of safe care" since such a plan is only available to a "substance exposed infant" (line 45).

Sixth, Council also notes that there may be unintended consequence of deterring expectant mothers with addictions from seeking treatment or having delivery at a hospital due to the reporting mechanism required by this legislation.

Thank you for your time and consideration of our observations and recommendations. Please feel free to contact me or Wendy Strauss should you have any questions.

Attachments