

Guidelines For Testing and Reporting Drug Exposed Newborns in Washington State

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Table of Contents

Executive Summary	1
Introduction	3
Indicators for Testing	3
Hospital Policy	3
Table 1: Newborn Risk Indicators	4
Table 2: Maternal Risk Indicators	4
Consent Issues for Testing	4
Table 3: Newborn Drug Testing	5
Table 4: Management of a Newborn with Positive Drug Toxicology	6
Reporting to Children’s Administration	6
Appendix A: References and Resources	7
Appendix B: Guidelines for Obtaining Consent from Parents for Infant Drug Testing	9
Appendix C: Sample Parent Letter: Information For Parents Whose Newborn Has Been Placed on Administrative Hold	11
Appendix D: Neonatal Abstinence Syndrome Scoring System	13
Appendix E: DSHS Children’s Administration Prenatal Substance Abuse	14

EXECUTIVE SUMMARY

The purpose of this document is to provide guidance to health care providers and affiliated professionals about maternal drug screening and laboratory testing and reporting of drug-exposed newborns delivered in Washington State. This document was written in response to an increasing number of requests from hospital staff and attorneys seeking information on this complex topic. This work is a collaborative effort between the Washington State Department of Health and the Department of Social and Health Services.

One impetus for this effort to promote consistent practice among health care providers is a recent change in federal law. In 2003, Congress enacted the Keeping Children and Family Safe Act which requires each state, as a condition of receiving federal funds under the Child Abuse Prevention and Treatment Act, to develop policies and procedures “to address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.” This includes a requirement that health care providers involved in the delivery or care of such infants notify Child Protective Services of the occurrence of such condition in infants. This differs from the existing legal duty to report suspected child abuse or neglect in that the federal law specifies that such reports of prenatal substance exposure shall not be construed to be child abuse or neglect and shall not require prosecution of the mother.

Department of Health and Department of Social and Health Services cannot provide legal counsel on this topic, but the following key points are included in this guidelines document:

- Each hospital with perinatal/neonatal services should work with hospital risk management, nursing services, social service, medical staff, and local Department of Social and Health Services Children’s Services to develop a defined policy for identifying intrapartum women and newborns for substance use/abuse. The hospital policy should be written in collaboration with local/regional Child Protective Services guidelines and include consent and reporting issues.
- Newborn testing should be performed only with evidence of newborn and/or maternal risk indicators.
- Newborn drug testing is done for the purpose of determining appropriate medical treatment.
- No uniform policy or state law exists regarding consent for newborn drug testing.
- Hospitals are encouraged to report all positive toxicology screens (mother or infant) to Child Protective Services. Reporting of this information, in and of itself, is not an allegation of abuse or neglect. The healthcare team acts as advocate for mother and newborn.
- Health care providers remain mandated reporters of child abuse and neglect under state law and are required to notify Child Protective Services when there is reasonable cause to believe a child has been abused or neglected. The presence of other risk factors or information combined with a positive toxicology screen may require that a report of child abuse or neglect be made to Child Protective Services in any given case.
- All women should be informed about planned medical testing, the nature and purpose of the test, and how results will guide management, including possible benefits and/or consequences of the test. Drug testing is based on specific criteria and medical indicators, not open-ended criteria such as “clinical suspicion” that invite discriminatory testing.

- If the woman refuses testing, maternal testing should not be performed. However, testing of the newborn may still occur if medically necessary or if newborn and/or maternal risk indicators are present. Department of Health strongly recommends that each institution develop, in collaboration with its attorneys, justification and process for newborn testing. The justification and process for newborn testing will be specific to the written policy of each institution.
- If there exists reasonable cause to believe leaving a newborn in the custody of the child's parent or parents would place the child in danger of imminent harm, a hospital may choose to place an administrative hold on the newborn and notify Child Protective Services per Revised Code of Washington (RCW).26.44.056. Department of Health recommends that each institution develop in collaboration with its attorneys the justification and process for placing administrative hold on a newborn. Child Protective Services may obtain custody of the newborn by court order or a law enforcement transfer of protective custody and may then give permission to test the newborn in order to safeguard the newborn's health.

INTRODUCTION

The purpose of this document is to provide consistent guidance to health care professionals and hospitals related to maternal screening* and testing** and reporting drug-exposed newborns born in Washington State hospitals.

This document is a collaborative effort between the Department of Health and Department of Social and Health Services, two separate agencies. The Washington State Department of Health is responsible for preserving public health, monitoring health care costs, maintaining minimal standards for quality health care delivery, and planning activities related to the health of Washington citizens. The Washington State Department of Social and Health Service is the state umbrella social service agency. Its mission is to improve the quality of life for individuals and families in need by helping people achieve safe and self-sufficient, healthy and secure lives.

Indicators for Testing

Maternal drug testing is based on specific criteria and medical indicators, not open-ended criteria such as “clinical suspicion” that invite discriminatory testing. Evidence-based risk indicators should also be used as a guide for performing drug toxicologies on newborns. Due to the limited time window for detection of drugs, difficulties in collecting specimens, as well as costs incurred for testing, all newborns with evidence of newborn risk indicators (Table 1) and/or maternal risk indicators (Table 2) should be tested for drug exposure, unless a different medical cause is identified. Laboratory testing of newborns should be done for the purpose of determining appropriate medical treatment. It is unnecessary to test a newborn whose mother has a positive drug toxicology; her newborn is presumed to be drug exposed.

Hospital Policy

Each hospital should work with risk management attorneys, nursing, social service, and medical staff to develop a defined policy for identifying intrapartum women and newborns for substance use/abuse. This policy should address specific evidence-based criteria for testing the woman and her newborn, timing of tests, test types, and consent issues. The justification and process for newborn testing will be specific to the written policy of each institution. All healthcare providers should be informed of the policy and educated in its use. Health care professionals may need additional education regarding how to approach and motivate women to make an informed choice regarding testing.

For in-depth guidance for screening, identifying, and referring women for treatment please refer to the *Substance Abuse During Pregnancy: Guidelines for Screening* best practice booklet located online at: <http://www.doh.wa.gov/cfh/mch/documents/ScreenGuideline.pdf> Another referral resource is the *Pregnant Women Chemical Dependency/Abuse Resource Guide/Matrix*. http://www.doh.wa.gov/cfh/mch/documents/DASA_CD_Preg_July2005.pdf

*Screening: methods used to identify risk of substance abuse during pregnancy and postpartum, including self-report, interview and observation.

**Testing: process of laboratory testing to determine the presence of a substance in a specimen.

Table 1

Newborn Risk Indicators

It is not necessary to test a newborn with signs of drug withdrawal whose mother has a positive drug test. This newborn may be presumed drug-exposed. This does not preclude doing a separate test of the child if medically indicated.

Newborn characteristics that may be associated with maternal drug use include: (American College Obstetricians and Gynecologists, 2008)

- Positive maternal toxicology screen
- Jittery with normal glucose level
- Marked irritability
- Preterm birth
- Unexplained seizures or apneic spells
- Unexplained intrauterine growth restriction
- Neurobehavioral abnormalities
- Congenital abnormalities
- Atypical vascular incidents
- Myocardial infarction
- Necrotizing enterocolitis in otherwise healthy term infants
- Signs of neonatal abstinence syndrome: marked irritability, high pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea, diaphoresis (Finnegan, 1986; see Appendix):
Note: Neonatal signs of fetal dependence may be delayed as long as 10-14 days, depending upon the half-life of the substance in question.

Preterm infants are less likely to overtly exhibit at-risk behaviors in spite of substance exposure. Immature organ systems may modify test results.

Table 2

Maternal Risk Indicators

Maternal characteristics that suggest a need for biochemical testing of the newborn include: (American College Obstetricians and Gynecologists, 2008)

- No prenatal care
- Previous unexplained fetal demise
- Precipitous labor
- Abruptio placentae
- Hypertensive episodes
- Severe mood swings
- Cerebrovascular accidents
- Myocardial infarction
- Repeated spontaneous abortions

Consent Issues for Testing

Controversies still exist regarding the extent to which maternal consent is required prior to toxicology testing of either the mother or the newborn. No uniform policy or state law exists regarding consent for newborn drug testing. This is a complex issue and hospitals, with advice from their risk management staff and legal counsel, should determine when it is necessary to obtain specific consent to test newborns and their mothers. A positive drug test is not in itself a diagnosis, nor does substance abuse by itself prove child neglect or inadequate parenting capacity (American College Obstetricians and Gynecologists, 2005).

Refer to *Substance Abuse During Pregnancy: Guidelines for Screening*, for a more detailed discussion of consent issues: <http://www.doh.wa.gov/cfh/mch/documents/ScreenGuideline.pdf>

The importance of clear and honest communication with the woman regarding drug testing cannot be overstated. The health care team should act as advocate for mother and newborn. This relationship is more difficult to establish if a woman is notified of testing after the fact. Therefore, all women should be informed about planned medical testing. Explain and document the nature and purpose of the test and how results will guide management, including possible benefits and/or consequences of the test.

The rationale for testing and the parental discussion should be documented in the medical record. If the woman refuses testing, this should be documented and maternal testing should not be performed. **In *Ferguson v Charleston, SC, 532 US 67 (2001)* the Supreme Court ruled that testing without maternal consent for the purposes of criminal investigation violated the mother's Fourth Amendment rights. (Lester, 2004)**

However, testing of the newborn may still occur if newborn and/or maternal risk indicators are present. Department of Health strongly recommends that each institution develop, in collaboration with its attorneys, justification and process for newborn testing. If there exists reasonable cause to believe leaving a newborn in the custody of the child's parent or parents would place the child in danger of imminent harm, a hospital may choose to place an administrative hold on the newborn and notify Child Protective Services per RCW.26.44.056. Department of Health recommends that each institution develop in collaboration with its attorneys the justification and process for placing administrative hold on a newborn. Child Protective Services may obtain custody of the newborn by court order or a law enforcement transfer of protective custody and may then give permission to test the newborn in order to safeguard the newborn's health.

See Table 3 for information about newborn drug testing. The procedure for obtaining samples for testing is institution-specific. See attached policy samples for guidance.

Comprehensive guidelines for hospital care of the drug-exposed newborn are beyond the scope of this document. See Table 4 for basic information about newborn management.

Table 3 Newborn Drug Testing

About Newborn Urine Toxicologies:

- Correlation between maternal and newborn test results is poor, depending upon the time interval between maternal use and birth, properties of placental transfer, and time elapsed between birth and neonatal urine collection.
- The earliest urine of the newborn will contain the highest concentration of substances.
- Failure to catch the first urine decreases the likelihood of a positive test.
- Threshold values (the point at which a drug is reported to be present) have not been established for the newborn.
- Fetal effects cannot be prevented by newborn testing.
- Newborn urine reflects exposure during the preceding one to three days.
- Cocaine metabolites may be present for four to five days.
- Marijuana may be detected in newborn urine for weeks, depending on maternal usage.
- Alcohol is nearly impossible to detect in newborn urine.

Other Methods of Newborn Drug Testing:

- **Meconium:** Meconium in term infants reflects substance exposure during the second half of gestation; preterm infants may not be good candidates for meconium testing. The high sensitivity of meconium analysis for opiate and cocaine and the ease of collection make this test ideal for perinatal drug testing. Meconium analysis is available for mass screening with an enzyme immunoassay kit or by radioimmunoassay. Cost of analysis per specimen approximates the cost of urine toxicology. (J Pediatrics 2001; 138:344-8)
- **Breast milk:** Breast milk is not a viable alternative for drug testing.
- **Hair:** Hair testing has high sensitivity for detecting perinatal use of cocaine and opiate but not for marijuana. Hair testing is restricted to a few commercial laboratories and the cost of testing is higher than for meconium. (J Pediatrics 2001; 138:344-8) Hair has a high false positive rate because of passive exposure to minute quantities of illicit substances in the environment. (ACOG, 2008)
- **Umbilical cord segments** may be a viable testing medium in the future, but is evolving technology at present. More information is available at www.usdtl.com

Table 4

Management of a Newborn with a Positive Drug Toxicology

- Confirm any positive test with gas chromatography/mass spectroscopy particularly if opiates are found.
- Consider the fact that intrapartum drugs prescribed to control labor pain can be detected in meconium.
- Notify newborn's provider for diagnostic work-up.
- Use the Neonatal Abstinence Scoring tool to document symptoms of narcotic withdrawal. See Appendix D for sample.
- Newborn assessment should include newborn health status, maternal drug use history and current family situation. Document assessment of family interaction (or lack of interaction). Include positive observations as well as areas of concern.
- Notify social worker or other designated staff member to coordinate comprehensive drug/alcohol assessment and outside referrals, including Child Protective Services. If designated staff member is not available, reporting to Child Protective Services is the responsibility of all health care providers. Child Protective Services after hours, weekends and holidays intake telephone number is: 1-800-562-5624.

Note: Child Protective Services may use a patient's chart as documentation in court. A release of information is not required.

Reporting to Children's Administration

Hospitals should contact their local Department of Social and Health Services Children's Services office and request an in-service on mandatory reporting and other Children's Protective Services processes. The hospital's risk management staff should attend the in-service. After the in-service, parties may have a better idea of points needing clarification. Starting at the local level is important for developing key relationships and ensuring smooth and consistent procedures. See Page 14 for Department of Social and Health Services Children's Administration Prenatal Substance Abuse Policy.

Appendix A

References and Resources:

American Academy of Pediatrics Committee on Drugs. 1998. Neonatal Drug Withdrawal. *Pediatrics*; 101:1079-1088.

American Academy of Pediatrics Committee on Substance Abuse. 1998. Tobacco, Alcohol and Other Drugs: The Role of the Pediatrician in Prevention and Management of Substance Abuse. *Pediatrics*; 101:125-128.

American Academy of Pediatrics Committee on Substance Abuse. 2001. Alcohol Use and Abuse: A Pediatric Concern. *Pediatrics*; 108: 185-189.

American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 2002. *Guidelines for Perinatal Care, Fifth Edition*. Elk Grove Village IL.

American College of Obstetricians and Gynecologists. 2008. *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice*, ACOG Committee Opinion, Number 422.

American College of Obstetricians and Gynecologists. 2005. Substance Use: Obstetric and Gynecologic Implications. In *Special Issues in Women's Health*. ACOG Committee on Health Care for Underserved Women.

Weiners and Finnegan LP (2002). Drug Withdrawal in the Neonate in Handbook of Neonatal Intensive Care, 5th Edition. Merenstein and Gardner, eds. CV Mosby: 163-178.

Finnegan LP. 1986. Neonatal abstinence syndrome: assessment and pharmacotherapy. In: Rubaltelli FF, Granati B, eds. *Neonatal therapy: an update*. New York: Excerpta Medica:122-46.

Lester BM, et al. 2004. Substance use during pregnancy: time for policy to catch up with research. *Harm Reduction Journal*; <http://www.harmreductionjournal.com/content/1/1/5>

Ostrea EM, et al. 2001. Estimates of illicit drug use during pregnancy by maternal interview, hair analysis, and meconium analysis. *Journal of Pediatrics*;138:344-8.

Washington State Department of Health. 2009. *Substance Abuse During Pregnancy: Guidelines for Screening*. <http://www.doh.wa.gov/cfh/mch/documents/ScreenGuideline.pdf>

Additional Resources

To order or download "The Parent's Guide to CPS" (mentioned in letter on Page 11):
http://www.dshs.wa.gov/ca/pubs/pubcats.asp?cat=Child_Abuse_and_Neglect

Swedish Medical Center, Seattle: Center for Perinatal and Pediatric Excellence (telephone: 206-215-2073)

Washington State Department of Health, Maternal and Infant Health Program (telephone: 360-236-3563)

Washington State Department of Social and Health Services Children's Administration website – video and materials for mandatory reporters: <http://www1.dshs.wa.gov/ca/general/index.asp>

Child Protective Services after hours, weekends and holidays intake telephone number: 1-800-562-5624.

Washington State Hospital Association (telephone: 206-216-2531)

Appendix B

Guidelines for Obtaining Consent from Parents For Infant Drug Testing

Set the Scene

The healthcare provider's attitudes and feelings about maternal substance use, as well as the environment in which this discussion takes place, often influences the success or failure of obtaining parental consent for infant drug testing. Often the way the subject is approached will be the major determinant in obtaining consent.

- Be aware of your own beliefs and values that may interfere with your ability to remain neutral and non-judgmental.
- Assess the environment for privacy and when possible, discuss the issue in a non-emergent setting.
- Attend to your non-verbal behavior including body stance, facial expression, eye contact, muscle tension, and arm and hand positioning.

Introduce the Topic

- Begin with open ended questions. Ask the mother how she is doing and what she needs.
- Reflect back to the mother what she has just stated and respond to any questions.
- Inform the mother that there is another topic you need to discuss.
- Give reasons /describe in a non-judgmental manner why you want to test her infant for evidence of maternal drug use during pregnancy (see script below).
- If the testing is requested by Child Protective Services, inform the mother of this and bring the focus back to the health of the mother and infant.
- Ask if she has any questions; if yes, answer them to the best of your ability.
- Ask permission for consent: "Do we have your permission to test the baby?" If yes, thank the mother for her cooperation and reinforce that she is working in the best interest of her child.
- Review what the testing process involves for the baby.

If the Parent is Angry, Resistant, Agitated and/or Defensive:

- Determine if the parent is intoxicated or has mental health issues that will interfere with her ability to comprehend.
- Stay calm.
- Do all of the steps described above: bring the focus back to the health of the infant, re-explain that her cooperation with this step shows that she is interested in the health of her baby.
- Allow more time for the parent to talk about what is happening and her concerns. Reassure as appropriate.
- Be matter of fact about the issue while remaining supportive and non-judgmental.
- Refer to your agency's policies regarding drug testing and Child Protective Services protocols.

Sample Scenario:

Hello Mary, how are you doing today? Do you have any questions or concerns you'd like to talk about?

(Patient responds and her questions concerns are addressed).

Those are good questions, Mary. Now I have something else to discuss with you that will help us provide the best care for your baby. This may be uncomfortable to discuss but it is very important.

(Give patient time to respond).

There is some concern about your drug use during this pregnancy and the impact it has had or may have on your baby. I know you want the best for your baby and wouldn't purposefully do anything to hurt her. When a woman uses drugs when she is pregnant or breastfeeding, there is a risk to the baby's health. We would like to get your permission to test your baby for drugs so we can give her the best medical care. Will you sign a consent form to test your baby?

If parent responds "Yes": I know this is scary but it's the best decision for your baby. Here is the consent form. Is there anything you'd like me to know or do you have any questions?

(Patient Response)

Okay, do you want to hear how this done and what you may be asked to do?

If parent responds "No": *(Use the same steps as above until the patient refuses.)*

I can't imagine how scary this sounds to you and I hope we can come to an agreement about you consenting but if we can't I am still required to do what I think is needed to make sure your baby is given appropriate medical care. Can we talk about this more?

(Client nonresponsive or says "No")

This facility and I are required to notify Child Protective Services when there is concern about the effect a parent's drug use has on the health of an infant. What happens now is staff here will contact Child Protective Services to let them know the situation. Your baby may then be placed on an administrative hold. When Child Protective Services gains custody, Child Protective Services can then give permission to test the baby. It would be great if we get consent and test now and begin any treatment your baby may need. What do you think?

(If the patient still refuses, follow the agency protocols and do what is necessary to keep the baby in the hospital and complete the testing after Child Protective Services has approved).

"OK, I hear you saying no to drug testing for your baby. I'll let the staff here know of that decision and we'll take it from here. It's important for you to know that your baby may still get tested for drugs. We would do that to protect your baby's health. We'll keep you informed about what will happen next."

Appendix C

Sample Parent Letter: Information for parents newborn has been placed on administrative hold

Hospital Letterhead

Dear Parent:

This letter tells about what is happening to you and your newborn. People who care for you and your baby have concerns about your drug and/or alcohol use and the impact it has on your baby. For this reason, your newborn has been placed on an administrative hold at the hospital. This means that you may not leave the hospital with your baby at this time.

The enclosed purple booklet “Parent’s Guide to Child Protective Services (CPS)” provides some important information that will help you through this time. Please take a few minutes to read it. You may ask your questions to the person from CPS who will come and speak with you at the hospital, or at your house if you have already left the hospital.

Each person’s situation is different, and the social worker from CPS will explain what will happen next. This social worker will talk with you and develop a plan for keeping your newborn safe. This person will give you information about services for you and your new baby. This may include dates and times of appointments or meetings that you need to attend.

We know this is a difficult time. Your nurses and hospital social worker want to help you in your efforts to ensure the health and safety of your baby. Please ask questions and let your nurses and social worker know your thoughts and feelings.

We believe the best place for a new baby is with the family. We hope you will work with CPS to make a safe and healthy home for your new baby.

Sincerely,

XXXXXX
Enclosure

Appendix D
Neonatal Abstinence Scoring System

		Dose																		
System	Signs and Symptoms	Score																		
Date/Time																				
Central Nervous System Disturbance	Crying: Excessive high pitched	2																		
	Crying: continuous high pitched	3																		
	Sleeps < 1 hour	3																		
	Sleeps < 2 hours after feeding	2																		
	Sleeps < 3 hours after feeding	1																		
	Hyperactive Moro reflex	2																		
	Markedly hyperactive Moro reflex	3																		
	Mild tremors: Undisturbed	3																		
	Moderate-severe tremors: Undisturbed	4																		
	Mild tremors: Disturbed	1																		
	Moderate-severe tremors: Disturbed	2																		
	Increased muscle tone	2																		
	Excoriation (specify area)	1																		
Myoclonic Jerks	3																			
Generalized convulsions	5																			
Metabolic, Vasomotor, and Respiratory Disturbances	Sweating	1																		
	Fever 37.2-38.3°C (99-101 F)	1																		
	Fever > 101 F (>38.4°C)	2																		
	Frequent yawning (>3)*	1																		
	Mottling	1																		
	Nasal Stuffiness	1																		
	Sneezing (>3) *	1																		
	Nasal flaring	2																		
Respiratory rate (>60/min.)	1																			
Respiratory rate (>60/min. with retractions)	2																			
Gastro-Intestinal Disturbances	Excessive sucking	1																		
	Poor feeding	2																		
	Regurgitation+	2																		
	Projectile vomiting+	3																		
	Loose stools	2																		
Watery stools	3																			
	Total Score																			
	Initials of Scorer																			

*As they have occurred in the entire scoring period (i.e. within the previous 2 or 4 hours, whatever the scoring interval).
 + More than or equal to 2 times during or after feeding.



Children's Administration

Prenatal Substance Abuse Policy

The Federal Child Abuse Prevention and Treatment Act (CAPTA) as amended by the Keeping Children and Families Safe Act of 2003 requires health care providers to notify Child Protection Services (CPS) of cases of newborns identified as being AFFECTED by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

Washington State statute does not authorize Children's Administration (CA) to accept referrals for CPS investigation or initiate court action on an unborn child.

In Washington State, health care providers are mandated reporters and required to notify CPS when there is reasonable cause to believe a child has been abused or neglected. If a newborn has been identified as substance exposed or affected this may indicate child abuse/neglect and should be reported. It is critical that mandated reporters provide as much information regarding concerning issues/behaviors, risk factors or positive supports that were observed during the interaction with the family.

HOW DO I MAKE A REPORT?

Children's Administration offices within local communities are responsible for receiving and investigating reports of suspected child abuse and neglect. Reports are received by CPS Intake staff either by phone, mail or in person and are assessed to determine if the report meets the legal definition of abuse or neglect and how dangerous the situation is.

Children's Administration offers several ways to report abuse:

Daytime: Contact local Children's Administration CPS office.

A local CPS office can be located on the following link:

<https://fortress.wa.gov/dshs/f2ws03apps/caofficespub/offices/general/OfficePick.asp>

Nights and Weekends: Call the Child Abuse and Neglect **Hotline** at **1-866-ENDHARM** (1-866-363-4276), which is Washington State's toll-free, 24 hour, 7 day-a-week hotline where you can report suspected child abuse or neglect.

Additional information about reporting abuse and neglect of children can be located at:

<http://www.dshs.wa.gov/ca/safety/abuseReport.asp?2>

AS A MANDATED REPORTER WHAT INFORMATION WILL I BE ASKED TO PROVIDE?

Reports to CPS or a law enforcement agency must contain the following information if known:

1. The name, address and age of the child and parent(s);
2. The nature and extent of the child abuse or neglect;
3. Any information about previous incidences of abuse or neglect;
4. Whether the family is of Indian ancestry

It is extremely important to provide information about risk and protective factors. This information will assist the intake worker in determining whether the situation meets the legal definition of child abuse or neglect or risk of imminent harm. Examples include:

- Parent(s) attitude about their newborn;
- Did the mother participate in prenatal care;
- Extended family and family strengths which can help the parent(s) to care for and protect children and their family;
- Parent(s) socioeconomic status;
- Parent(s) resources and family strengths;
- Rationale for toxicology testing;
- Previous history of mental health disorder and/or postpartum mood disorder;
- History of substance use;
- History of substance abuse treatment;
- Parent(s) response to interventions, etc.

If you are in doubt about what should be reported, it is better to make your concerns known and discuss the situation with your local CPS office or Child Abuse and Neglect Hotline.

If a crime has been committed law enforcement must be notified. The name of the person making the report is not a requirement of the law, however, mandated reporters must provide their name in order to satisfy their mandatory reporting requirement.

WHAT HAPPENS AFTER A REPORT IS MADE?

When a report of suspected child abuse or neglect is made, CA intake staff determines whether the situation described meets the legal definition of child abuse or neglect. In order for CPS to intervene in a family the report must meet the legal definition of child abuse or neglect or there is risk of imminent risk harm to the child.

Referrals which are determined to contain sufficient information may be assigned for investigation or other community response.

CPS investigations include the following:

- Determining the nature and extent of abuse and neglect;
- Evaluating the child's condition, including danger to the child, the need for medical attention, etc;
- Identifying the problems leading to or contributing to abuse or neglect;
- Evaluating parental or caretaker responses to the identified problems and the condition of the child and willingness to cooperate to protect the child;
- Taking appropriate action to protect the child, and;
- Assessing factors which greatly increase the likelihood of future abuse or neglect and the family strengths which serve to protect the child.

If a child is of Indian ancestry social services staff must follow requirements of the Federal Indian Child Welfare Act (ICWA), state laws, and the RCW.

WHAT SERVICES MAY BE PROVIDED?

Protective services are provided to abused/neglected children and their families without cost. Other rehabilitative services for prevention and treatment of child abuse are provided by the Department of Social and Health Services and other community resources (there may be a charge for these services) to children and the families such as:

- Home support specialist services
- Day care
- Foster family care
- Financial and employment assistance
- Parent aides
- Mental health services such as counseling of parents, children and families
- Psychological and psychiatric services
- Parenting and child management classes
- Self-help groups
- Family preservation services

WHAT HAPPENS IF A REPORT DOES NOT MEET THE DEFINITION OF CHILD ABUSE OR NEGLECT?

When CA receives information that does not meet the definition of child abuse or neglect and CA does not have the authority to investigate, intake staff documents this information in the systems database as an "Information Only" referral.

When CA receives information about a pregnant woman who is not parenting other children and is allegedly abusing substances, intake staff documents this information and available information about risk and protective factors in an "Information Only" referral. This referral is then forwarded to First Steps Services.

When CA receives information about a substance exposed but not substance-affected newborn, intake will ask about available information, including information about risk and protective factors to determine if there is an allegation of child abuse or neglect or imminent risk of harm. If there are no allegations of child abuse or neglect or imminent risk, CA does not have the authority to conduct a CPS investigation and the referral is documented as "Information Only."

If a decision is made not to respond, and you disagree, you may discuss your concerns with the Intake Supervisor. When a case is not appropriate for CPS, you may consult with the local Children's Administration office for suggestions or guidance in dealing with the family.

CA Practices and Procedures – Prenatal Substance Abuse Policy -- Definitions

A Substance-Exposed Newborn is one who tests positive for substance(s) at birth, or the mother tests positive for substance(s) at the time of delivery or the newborn is identified by a medical practitioner as having been prenatally exposed to substance(s).

A Substance-Affected Newborn is one who has withdrawal symptoms resulting from prenatal substance exposure and/or demonstrates physical or behavioral signs that **CAN BE** attributed to prenatal exposure to substances and is identified by a medical practitioner as affected.



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For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TYY 1-800-833-6388).