

15. **Hospital Protocol for Evaluating and Reporting Cases
Involving Prenatal Drug/Alcohol Exposure**

Hospital Protocol for Evaluating and Reporting Cases Involving Prenatal Drug or Alcohol Exposure

The Los Angeles County Hospital Protocol is mandated for all hospital practitioners who provide services and treatment to newborns and their mothers.

The first of the documents included in this section is a letter dated April 27, 1998 addressed to all Los Angeles County hospital administrators from the Presiding Judge of Juvenile Court, Michael Nash. The letter explains the rationale behind the protocol. The following documents are the Hospital Protocol description, the Newborn Risk Assessment Form, and legal guidelines for the disclosure of medical records in child abuse reports.

Although the letter is included for historical interest, the other documents and materials remain current. The very few procedural and contact changes are as follows:

1. An electronic version of the Newborn Risk Assessment Form is now available to the hospital practitioners on the DCFS website www.dcfs.lacounty.gov in the Mandated Reporter Section of that website. This allows the reporter to print out the Newborn Risk Assessment Form at any time. Once it is filled out, it can be mailed or faxed to DCFS at the address or fax number provided by the Hotline intake evaluator at the time the call is made.
2. It is no longer necessary that the hospital practitioner forward a copy of the Newborn Risk Assessment to the Department of Health Services. It only needs to be submitted to DCFS.
3. Questions regarding the Hospital Protocol or other issues concerning infants at risk for drug or alcohol exposure may be directed to the ICAN main office at 626-455-4586.



JUVENILE DIVISION

The Superior Court

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CHAMBERS OF
MICHAEL NASH
PRESIDING JUDGE

April 27, 1998

TELEPHONE
(213) 526-6377

To: All Hospital Administrators and Staff
From: Michael Nash, Presiding Judge, Los Angeles County Juvenile Court
Re: Protocol for Births Involving Indications of Prenatal Substance Abuse

The Child Abuse and Neglect Reporting Act (CANRA) mandates that health practitioners report known or reasonably suspected child abuse to a child protective agency. Any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child. Senate Bill 2669 requires counties to establish protocols between county health departments, county welfare departments and all public and private hospitals to assess the needs of substance exposed infants. Accordingly, the "Hospital Protocol," "Newborn Risk Assessment Form," and outline of applicable law are attached to provide guidance for assessing suspected child abuse, recognizing indicators of maternal substance abuse, and disclosing confidential medical records.

If the assessment leads to a suspected child abuse report, the Suspected Child Abuse and Neglect Report Form (SS 8572), the Newborn Risk Assessment Form, and copies of relevant portions of the minor's medical records are to be provided to the investigating Children's Social Worker. Hospitals are requested to provide copies of the forms to the Department of Health Services Child Abuse Prevention Program: 241 N. Figueroa St., Room 306, Los Angeles, CA 90012, fax: (213) 482-3997.

The initiative to standardize and improve compliance with Senate Bill 2669 is the product of a cooperative effort by the Prenatally Alcohol and Drug Exposed Children (FADE) Committee of the Interagency Council on Child Abuse and Neglect (ICAN), the Department of Health Services and the Juvenile Court. Questions regarding the attached documents and Senate Bill 2669 may be directed to Penny Weiss, ICAN PADE Committee, (626) 455-4586, Elena Halpert Schilt, March of Dimes, (818) 953-3937, Sandra Guine, Department of Health Services Child Abuse Prevention Program, (213) 240-8146, or Randall Pacheco, Dependency Court Legal Services, (213)980-5709. Hospitals wishing to have further training on this issue should contact Penny Weiss, ICAN, (626) 455-4586.

Thank you for your compliance with the protocol.

Attachments: Hospital Protocol for SB 2669
Newborn Risk Assessment Form
Disclosure of Confidential Medical Records for the Purpose of Reporting
Suspected Child Abuse

**HOSPITAL PROTOCOL
FOR
EVALUATING AND REPORTING CASES INVOLVING PRENATAL
DRUG/ALCOHOL EXPOSURE**

This protocol is mandated for all public and private hospitals in the county of Los Angeles.

PURPOSE:

To specify the protocol for identifying potential child endangering drug/alcohol related situations involving perinatal patients, and to specify the steps for assessing and intervening in these situations.

POLICY:

California law (SB 2669, Chapter 1603, Statutes of 1990), mandates that any indication of maternal substance abuse shall lead to an assessment by a health care practitioner or medical social worker of the needed services of the mother and infant prior to discharge of the infant from the hospital. While a positive toxicology screen at the time of delivery is not, in and of itself, grounds for report to the Department of Children & Family Services (DCFS), a negative toxicology screen result does not preclude a suspected child abuse report if there are other risk factors present. The purpose of the assessment is to 1.) identify needed services for the mother and infant; 2.) determine the level of risk to the infant upon release home; 3.) determine the corresponding level of services and intervention necessary to protect the infant; and 4.) determine whether a referral to DCS is necessary.

RESPONSIBILITIES:

The responsibility for evaluating infants exposed to potentially harmful substances rests with all persons who are either required or permitted to report under Section 11165-11166 of the Penal Code which includes, but is not limited to physicians, nurses, and social workers.

PROCEDURES:

- I. During the Labor and Delivery Period:
 - A. Health care providers should be alert to the signs and symptoms of maternal drug/alcohol abuse:
 - Previous positive toxicology screen(s) in the prenatal period
 - Skin lesions such as abscesses or track marks consistent with I.V. drug abuse
 - Withdrawal symptoms
 - Current enrollment in a drug/alcohol treatment program
 - Presence of drug paraphernalia in the mother's belongings or hospital room

- Previous history of delivery of prenatally substance-exposed infant
- Altered mental status consistent with drug/alcohol intoxication

In addition, the presence of other factors may indicate substance abuse and should lead to further assessment:

- Inconsistent or inadequate prenatal care (less than 3 visits)
- Precipitous delivery
- Poor maternal weight gain
- Premature onset of delivery
- Unexplained changes in mental status
- Placental abruption in the absence of other identifiable causes
- Intrauterine growth retardation or oligohydramnios in the absence of other identifiable causes.
- Intrauterine fetal demise or stillbirth in absence of other identifiable causes
- Unexplained severe hypertension
- Sexually transmitted diseases
- Violence and substance abuse in the home
- History of incarcerations, probation, or parole

- B. The following steps should be taken for all patients presenting with a current history of drug/alcohol abuse, or signs/symptoms or other indicators of possible substance abuse:
1. Initiate the assessment described in the following policy statement.
 2. Chart the history of substance abuse in the patient's medical record.
 3. Chart any signs, symptoms or indicators of substance abuse in the patient's medical record.
 4. Order the appropriate toxicology screen to further assist in determining whether the patient is using drugs/alcohol and discuss the results with the patient.

II. During the Postnatal Period

- A. Signs/symptoms or other indicators of drug/alcohol abuse in the mother shall be documented in the mother's medical record and noted in the infant's medical record.

B. An assessment must be done in all situations in which an infant is born to a mother who has signs/symptoms or other indicators of substance abuse or if the infant has signs suggestive of prenatal drug/alcohol exposure. Prenatal exposure should be considered when a constellation of factors is present and in the absence of other medical causes:

- Positive toxicology screen for unprescribed medications or drugs
- Excessive tremulousness
- Poor feeding
- High-pitched cry
- Seizures
- Lethargy
- Vomiting
- Watery stools
- Small for gestational age
- Prematurity
- Diaphoresis
- Physical stigmata of fetal alcohol syndrome (refer to the latest edition of Smith's Recognizable Patterns of human Malformation by Kenneth Jones)
- Frantic sucking

C. The following steps shall be taken in these situations:

1. Signs of prenatal drug/alcohol exposure in the infant shall be documented in the infant's medical record.
2. A toxicology screen for the infant shall be ordered and the results discussed with the parent(s).
3. The required assessment shall minimally include the factors set forth in the attached "Newborn Risk Assessment" form. An explanatory comment must be noted for each risk factor. The assessment must be done prior to the infant's discharge from the hospital.

D. Child protective services shall be notified immediately when the assessment leads to suspicion of child endangerment due to the presence of or interaction of the particular infant, parent, and environmental risk factors.

1. The Suspected Child Abuse and Neglect Report form (11166PC) must be completed and submitted within 36 hours of the phone report.
 2. The Newborn Risk Assessment form, relevant portions of the infant's medical record, including but not limited to, the prenatal and labor and delivery record, and all other relevant documentation shall be provided to the Department of Children & Family Services (DCFS) worker investigating the report. (Information should be made available to Department of Children & Family Services promptly as a court hearing may be scheduled within seventy two [72] hours.)
 3. Document the outcome of the referral in the infant's medical record.
- E. The discharge plan shall:
1. Be developed in conjunction with child protective services, when notified.
 2. Identify services needed by the infant/parent/family/ and specify referrals.
 3. Include referral of the newborn for medical follow-up after discharge.

SJG:rs
Protocol: SB2669

NEWBORN RISK ASSESSMENT

(AS REQUIRED BY PENAL CODE SECTION 11165.13 AND HEALTH AND SAFETY CODE SECTION SECTION 10901, (SB2669), EFFECTIVE 7/1/91)

INFANTS NAME: _____ DOB: _____ DATE: _____
 MOTHERS NAME _____ RACE/ETHNICITY: _____ ZIP CODE OF MOTHER _____
 NAME OF HOSPITAL: _____ HOSPITAL RECORD # _____
 NAME OF INSURANCE CARRIER, HMO OR INDICATE MEDICAL _____
 NAME OF PERSON COMPLETING FORM: _____
 TELEPHONE # _____
 SIGNATURE: _____

LEVEL OF RISK: 1=Low Risk, 2= Intermediate, 3= High risk, 0= Unable to assess (refer to reverse of form for guidance)

RISK FACTOR	LEVEL OF RISK	EXPLANATION-MANDATORY FOR EACH FACTOR
1. INFANT WITHDRAWAL SYMPTOMS		
2. SPECIAL MEDICAL AND/OR PHYSICAL PROBLEMS		
3. SPECIAL CARE NEEDS OF CHILD		
4. DRUG/ALCOHOL USE		
5. DRUG/ALCOHOL TREATMENT HISTORY		
6. PRENATAL CARE		
7. EMOTIONAL AND INTELLECTUAL ABILITIES		
8. LEVEL OF COOPERATION		
9. AWARENESS OF IMPACT OF DRUG/ALCOHOL USE ON CHILD		
10. RESPONSIVENESS TO INFANT, BONDING, PARENTING SKILLS		
11. HISTORY OF FAMILY VIOLENCE		
OPTIONAL IF KNOWN		(INDICATE HOW INFORMATION WAS OBTAINED)
12. FATHER OR PARENT SUBSTITUTE IN HOME		
13. STRENGTH OF FAMILY SPPORT SYSTEMS		
14. DRUG/CRIMINAL ACTIVITY		
15. SIBLINGS IN HOME AT RISK		
16. KNOWN ENVIRONMENTAL RISK IN THE HOME		

Circle all that apply:

	<u>Tox screen done</u>	<u>Tox positive</u>	<u>Type of drug(s)</u>
Infant	yes no	yes no	results not available _____
Mother	yes no	yes no	results not available _____

Child Abuse Report Filed? yes no
 Child Abuse Report Accepted? yes no If yes, attach to copy of 1116 P.C. form given to DCFS

Service Plan Referrals (check all referrals given):

<input type="checkbox"/> AFDC/GR/Medi-Cal <input type="checkbox"/> Adoption <input type="checkbox"/> Alcohol/Drug Treatment <input type="checkbox"/> California Childrens Services <input type="checkbox"/> Domestic Violence Shelter <input type="checkbox"/> Other _____	<input type="checkbox"/> Family Planning Program <input type="checkbox"/> High Risk Infant Program <input type="checkbox"/> Hospital High Risk Follow Up <input type="checkbox"/> Mental Health/Counseling <input type="checkbox"/> Pediatric Follow Up care at: _____	<input type="checkbox"/> Parenting Program <input type="checkbox"/> PHN visit/Home Health Svcs <input type="checkbox"/> Regions Center <input type="checkbox"/> WIC Program
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Upon completion of form, retain original in medical file. If abuse report was filed, FAX this report and any additional comments to the Child Abuse Hotline at (213) 617-3574 immediately after making referral to the Hotline.

FACTOR	LOW RISK	INTERMEDIATE RISK	HIGH RISK
1. Infant's Withdrawal Symptoms	Withdrawal symptoms not apparent	Mild tremors, mild hypertonia, mild irritability, slight lethargy	Vomiting watery stools, fever, sleeps less than 2 hours after feeding, marked tremors, high pitched cry, seizures, lethargic, on medications for drug withdrawal
2. Special Medical &/Or Physical Problems	No apparent medical or physical Problems	Minor medical or physical problems which do not significantly affect infants vital life functions or physical & intellectual development, low birth weight, small for gestational age	Any pre-term infant (born at or before 36 weeks), physical or medical problem which significantly impacts vital life functions (e.g. apnea, seizure disorders, low APGAR, respiratory distress, congenital defects)
3. Special Care Needs	Routine pediatric visits, no special equipment or medication	Monthly pediatric care visits, no medicine or special equipment	Requires 2 or more monthly pediatric visits, special equipment or medications
4. Dug/Alcohol Use	Not current using any drugs/alcohol	Occasional use 1-2 times per week or weekend use	Use more than 2 rimes per week
5. Drug/Alcohol treatment History	Entered drug/alcohol tx early in the pregnancy, remains in program & considered compliant	Entered drug/alcohol tx early in the pregnancy, remains in program but attendance is sporadic; continues to use drugs	Not in drug/alcohol tx. Program or entered in third trimester
6. Prenatal Care	Sought early prenatal care and consistent with prenatal follow-up	Sought prenatal care in 2nd trimester or inconsistent with prenatal follow-up	Did not seek prenatal care until 3rd trimester, no prenatal care; noncompliance with medical treatment
7. Emotional And Intellectual Abilities	Appears to be competent in parental role with realistic expectations of the child	Exhibit mild intellectual limitations which would not significantly impact ability to care for child	Poor perception of reality; poor judgement, significant health problems, exhibits significant limitations in ability to care for the child
8. Level Of Cooperation	Willing to work to resolve any problems & protect child		Refuses to cooperate, disinterested or Evasive
9. Awareness Of Impact Of drug/Alcohol Use On Child	Receptive to professional advice		Demonstrates minimal awareness of drugs impact on child; denies symptoms
10. Responsiveness To Infant, Bonding, Parenting Skills	Parent is responsible to infant's needs & exhibits appropriate knowledge of infant care		Parent may provide appropriate physical care but is unresponsive to infant's needs (i.e. lack of response to crying of infant); poor eye contact; infrequent visits; inappropriate expectations and criticism of the child
11. History Of Family Violence	No known history of family Violence	Prior protective services provided to siblings with that episode resolved and case closed; history of prior domestic violence	Current Child Protective Services &/or domestic violence involvement; previous abuse/neglect of serious nature; prior court action; siblings in placement
12. Father Or Parent Substitute In Home	Is a supportive/stabilizing influence & available to assist with care giving	Assumes only minimal care giver responsibility for child, verbal threats of violence	Has poor impulse control, demonstrated violence in home, involved in criminal activity, drug use
13. Strength Of Family Support Systems	Family, neighbors or friends available & committed to help	Family is supportive but not in geographic area; limited support available	No appropriate relatives or friends available, social isolated; no phone; no transportation available; limited income
14. Drug/Criminal Activity	Household members not suspected to be involved in drug/criminal activity.		Any household member suspected to be involved in drug/criminal activity
15. Siblings In Home At Risk	Education, medical & environmental needs being met in home	Some but not all educational, medical & environmental needs being met in home	Few educational, medical & environmental needs being met for siblings in home, possible out-of-home placement
16. Known Environmental Risk In The Home	Home contains no apparent safety health hazards, utilities operable; parent report reparation for infants care	Home is relatively safe, but there are no reports or evidence of preparation for infant's care	Home unclean with safety or health hazards, lack of stove/refrigerator/heating system; no operable utilities, reports no evidence of preparation for infant's care; transiency, homelessness

**DISCLOSURE OF CONFIDENTIAL MEDICAL RECORDS FOR its PURPOSE
OF
REPORTING SUSPECTED CHILD ABUSE**

I. Child Abuse and Neglect Reporting Act (Penal Code § 11165 et seq)

A. Introduction

The Child Abuse and Neglect Reporting Act (CANRA) requires certain individuals, including health practitioners, to report suspected child abuse to a child protective agency. The Los Angeles County Department of Children and Family Services (DCFS) is a child protective agency as defined in Penal Code (PC) § 11165.9.

B. Definition of Health Practitioner (PC § 11165.8)

The definition of "health practitioner" includes, but is not limited to: physicians, surgeons, psychiatrists, psychologists, dentists, residents, interns, licensed nurses, emergency medical technicians, paramedics, persons who perform autopsies, and public health employees who treat minors.

C. Mandatory Reporting

1. Suspected Prenatal Substance Abuse (PC § 11165.13)

If there is any indication of maternal substance abuse, a health practitioner or a medical social worker must assess the needs of the child and mother pursuant to Health and Safety Code § 123605. A positive toxicology screen at the time of birth is not, by itself, a sufficient basis for reporting child abuse or neglect. However, if there are additional factors which indicate a risk to the child, then a child abuse report may be made to DCFS. A report based solely on a parent's inability to care for the child due to a substance abuse problem shall be made only to DCFS, and not to law enforcement agencies.

2. Suspected Child Abuse (PC § 11166(a))

A health practitioner must make a child abuse report to DCFS where: (1) in his or her professional capacity, or within the scope of his or her employment, (2) he or she has knowledge of or observes a child, (3) whom he or she knows, or reasonably suspects, has been the victim of child abuse. The health practitioner must report to DCFS by telephone immediately, or as soon as possible. Additionally, the health practitioner must send a written report within 36 hours of receiving the information concerning the suspected abuse.

D. Permissive Reporting (PC § 11166(b))

A health practitioner may make a child abuse report to DCFS where he or she has knowledge of or reasonably suspects, that a child has been inflicted with mental suffering or a child's well-being is endangered in any other way.

E. Immunity (PC § 11172(a))

A health practitioner is not civilly or criminally liable for any child abuse report which is made pursuant to mandatory or permissive reporting laws. Storch v. Silvetman (1986) [86 Cal.App.3d 671.

II. Physician/Psychotherapist Privilege (PC § 11171(b))

Neither the physician-patient nor psychotherapist-patient privilege applies to the information reported under CANRA. People v. Sttizinger (1983) 34 Cal.3d 505.

III. Mental Health Records

Although Welfare and Institutions Code § 5328 - requires that information provided by patients to their psychotherapists remain confidential, such information shall be disclosed for the purpose of reporting suspected child abuse pursuant to PC § 11165-11166. The duty to report child abuse prevails over the requirement to maintain confidentiality of communications between the patient and psychotherapist. 65 Op.Atty.Gen.Cal. 345, 6-1-82.

IV. Federal Law (42 USC 290dd-2)

Although federal law prohibits the release of a patient's records regarding substance abuse and mental health services, the law explicitly does not apply to the reporting of suspected child abuse to DCFS as required by California law.

V. Permissive Disclosure of Medical and Mental Health Information

A provider of health care may disclose any medical information to a county social worker, a probation officer, or any other person who is legally authorized to have custody or care of a minor for the purpose of coordinating health care services and medical treatment provided to the minor. This information shall not be further disclosed by the recipient unless the disclosure is for the purpose of coordinating health care services and medical treatment of the minor and the disclosure is authorized by law. Civil Code section 56.103 (a-d) Note that this disclosure is discretionary on the part of the health care provider in a situation where the medical information is not related to abuse investigation but is disclosed for the purpose of continuity of health care.

A provider of health care may disclose mental health information to a probation officer, a county social worker or any person who is legally authorized to have custody or care of a minor for the purpose of coordinating the minor's health care services and medical treatment, mental health services, or services for developmental disabilities. This information shall not be further disclosed by the recipient unless the disclosure is for the purpose of coordinating health care services and medical treatment of the minor and the disclosure is authorized by law. Welfare and Institutions Code section 5328.04 Note that this disclosure is discretionary on the part of the health care provider in a situation where the medical information is not related to abuse investigation but is disclosed for the purpose of continuity of health care. (Effective 1-1-09) This law extends the

ability of health care providers to discretionarily provide not only medical information as provided for in Civil Code section 56.103 (as referenced in the above preceding section), but also mental health information, related to children in custody and is disclosed for the purpose of continuity of care.

VI. Permissive Disclosure of Confidential Information in the Context of a Multidisciplinary Team

Members of a multidisciplinary personnel team engaged in the prevention, identification, and treatment of child abuse may disclose and exchange information and writings to and with one another relating to any incidents of child abuse that may also be a part of a juvenile court record or otherwise designated as confidential under state law. Welfare and Institutions Code section 830

"Multidisciplinary personnel" means any team of three or more persons who are trained in the prevention, identification, and treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse. The team may include but not be limited to: (1) Psychiatrists, psychologists, marriage and family therapists, or other trained counseling personnel. (2) Police officers or other law enforcement agents. (3) Medical personnel with sufficient training to provide health services. (4) Social workers with experience or training in child abuse prevention. (5) Any public or private school teacher, administrative officer, supervisor of child welfare and attendance, or certificated pupil personnel employee. Welfare and Institutions Code section 18951

“Child abuse” for the purposes of sharing information with a team means a situation in which a child suffers from any one or more of the following: (1) serious physical injury inflicted upon the child by other than accidental means; (2) harm by reason of intentional neglect or malnutrition or sexual abuse; (3) going without necessary and basic physical care;(4) willful mental injury, negligent treatment, or maltreatment of a child under the age of 18 years by a person who is responsible for the child’s welfare under circumstances that indicate that the child’s health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Director of Social Services; and, (5) any condition that results in the violation of the rights or physical, mental, or moral welfare of a child or jeopardizes the child’s present or future health, opportunity for normal development or capacity for independence. Welfare and Institutions Code section 18951 (e)(1-5)