

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PRENATAL SUBSTANCE EXPOSURE:
STATE CHILD WELFARE LAWS
AND PROCEDURES**



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EXECUTIVE SUMMARY

PURPOSE

This report examines how specific prenatal substance exposure¹ provisions in State child welfare laws affect the handling of these cases.

BACKGROUND

An alcohol or drug exposed infant is born every 90 seconds in the United States. The recent increase in the number of substance exposed infants has focused attention on the problem of prenatal substance exposure.

States handle prenatal substance exposure in different ways. These include adding specific prenatal substance exposure provisions to child welfare laws, establishing testing and reporting requirements, and prosecuting women. The different approaches have affected State child welfare, medical, and legal systems to varying degrees.

The Office of Human Development Services, whose programs are now in the Administration for Children and Families, asked us to examine whether States with prenatal substance exposure provisions in their child welfare laws handle such cases differently than States without specific provisions. In this report, we refer to these States as "States with laws" and "States without laws."

METHODOLOGY

In 1990, we reviewed child welfare laws from all 50 States and the District of Columbia. We also gathered information on State prenatal substance exposure procedures through telephone discussions with a child welfare official in each State.

We selected 12 States for in-depth review. Six were States with laws (FL, IL, MA, MN, NV, OK) and six were States without laws (CA, KY, MI, NJ, NY, SC). We interviewed 229 respondents, including child welfare administrators and staff, hospital medical and social services staff, and attorneys.

FINDINGS

- ▶ Twelve States have child welfare laws addressing prenatal substance exposure.
- ▶ Such laws have little effect on hospital testing practices or the willingness of child welfare agencies to receive reports of prenatal substance exposure.

¹"Substance exposure" means exposure to illegal drugs, legal drugs, and alcohol.

- ▶ Child welfare agencies in States with such laws are more likely to investigate reports than child welfare agencies in States without these laws.
- ▶ Women have been prosecuted both in States with these laws and in States without them. The decision to prosecute rests with local prosecuting attorneys.
- ▶ While there is no agreement on what works best, most respondents believe that prosecution is not an effective deterrent.
- ▶ State legislative focus may be shifting from changing child welfare laws to providing prevention, education, and treatment services.

CONCLUSION

The only significant difference between States with child welfare laws addressing prenatal substance exposure and States without such laws is the way they investigate prenatal substance exposure cases. It appears that the major impact of these laws has been to lay the groundwork for developing special procedures and improving coordination.

There appears to be little agreement among States about whether prenatal substance exposure should be considered child abuse or neglect. States considering amending their child welfare laws to include prenatal substance exposure would be wise to review the expectations and experiences of States with such laws before deciding how to proceed.

In the last 2 years, most of the prenatal substance exposure legislation has involved prevention, treatment, and education initiatives rather than changes in child welfare laws. States may be emphasizing early intervention and education programs designed to prevent this problem from ever becoming a child welfare concern.

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INTRODUCTION

PURPOSE

This report examines how specific prenatal substance exposure provisions in State child welfare laws affects the handling of these cases.

BACKGROUND

An alcohol or drug exposed infant is born every 90 seconds in the United States.¹ However, prenatal exposure of infants to drugs and alcohol is not a new phenomenon. For decades, children have been born with medical complications caused by their mothers' use of harmful substances during pregnancy. Yet, recent dramatic increases in the number of substance exposed infants and their burden on child welfare systems have focused attention on this growing problem.

In 1990, the Office of Inspector General (OIG) issued a report on the impact of cocaine exposed infants on child welfare agencies ("Crack Babies" OEI 03-89-01540). The study revealed that States vary in the way they handle cases of prenatal substance exposure. It appeared that the child welfare statutes' definitions of child abuse and neglect determined the course of action taken in each State.

Little nationwide information is available. However, a 1990 report by the American Bar Association deals with coordinating the responses of the legal, medical, and protective services systems in handling cases of drug exposed infants and their families.²

This inspection was conducted in response to a request from the Office of Human Development Services, whose programs are now part of the Administration for Children and Families. In this report, we refer to States that explicitly mention substance exposed newborns in their child welfare statutes as "States with laws." States without specific references are referred to as "States without laws."

METHODOLOGY

During 1990, we reviewed current child welfare laws from all 50 States and the District of Columbia (hereafter referred to as a State) to determine if they made specific

¹Schipper, William, Testimony before the U.S. House of Representatives, Select Committee on Narcotics Abuse and Control, July 30, 1991.

²ABA Center on Children and the Law, ABA Young Lawyers Division, *Drug Exposed Infants and Their Families: Coordinating Responses of the Legal, Medical and Child Protection System* (Washington, DC: American Bar Association, 1990).

reference to prenatal substance exposure. We also gathered preliminary information concerning State policies and court procedures from current literature.

We interviewed a total of 229 respondents, including child welfare administrators and caseworkers, hospital medical and social services staff, and attorneys.

National Telephone Survey

We performed telephone interviews with State child welfare administrators in every State. Respondents were asked to describe State procedures for handling prenatal substance exposure cases and to assess the effectiveness of their State policies in identifying and protecting substance exposed infants.

In-depth State Review

We selected 12 States for more in-depth review. Child welfare laws in six of these States specifically addressed prenatal substance exposure (FL, IL, MA, MN, NV, OK). Laws in the remaining six States did not (CA,³ KY, MI, NJ, NY, SC). About half of all American children live in these 12 States.

We chose a targeted sample of States. Several States were included at the request of the Office of Human Development Services. The remaining States were selected depending on when their laws or policies were implemented, the comprehensiveness of their laws and policies, whether other States were using them as models, and whether localities in the State were prosecuting women for substance abusing behavior.

We selected two sites per State to minimize local biases and to review local differences in implementing State laws and policies. When possible, we chose one urban and one non-urban site. In seven States, the interviews were done on-site. For two States, we did a mix of on-site and telephone interviews; in the remaining three States we conducted telephone interviews.

In each of the 12 States, we interviewed child welfare agency staff, hospital medical and social services staff, and attorneys. In addition to the State child welfare administrators, we interviewed 61 child welfare agency workers in the 12 States. These respondents were most often selected based on suggestions from State and local child welfare administrators. Our review included 55 hospital respondents. Depending on the hospital administration practices, we spoke with either physicians or social service staff who were knowledgeable about the hospital's response to prenatal substance exposure cases. We interviewed 58 attorneys who had handled prenatal

³California's prenatal substance exposure law took effect January 1, 1991, after we finished data collection.

substance exposure cases. They included prosecuting and defense attorneys, legislators, and civil liberties advocates.

Legislative Follow-up

Our initial data collection was performed from June to December of 1990. In order to provide current information on legislative initiatives, we have also reviewed pending and enacted State legislation through January 1, 1992. The maternal and child health legislation was provided by the Intergovernmental Health Policy Project at George Washington University. The Project published a compendium of State substance abuse laws entitled 1991 State Substance Abuse Laws.

OVERVIEW OF CHILD WELFARE REPORTING PROCESS

Child welfare agencies differ in the way they handle allegations of prenatal substance exposure. The identification and acceptance of substance exposed infants into the child welfare system depends upon State child welfare laws and policies, health care practitioners' knowledge of prenatal substance exposure, and community awareness. Although prenatal substance exposure cases are handled differently throughout the nation, the States' child welfare processes contain similar components.

BASIS FOR REPORT OF PRENATAL SUBSTANCE EXPOSURE

Prenatal substance exposure cases are reported to child welfare agencies based on drug test results or suspicion of exposure. Reporters of prenatal substance exposure are most often health care practitioners, relatives, and neighbors. However, anyone may make a report.

Testing infants for drugs is the primary means of identifying prenatal substance exposure. Whether a test is performed depends mainly on the judgment of health care practitioners and hospital policies. Infants may be reported to child welfare agencies if the reporter suspects that prenatal substance exposure has occurred. Suspicion may be based on physical symptoms evident in mother or baby. Suspicion may also arise from a knowledge of the mother's behavior or lifestyle.

RECEIPT OF REPORT BY CHILD WELFARE AGENCY

Reports of prenatal substance exposure are received by either a central or a local agency. Some States have central registries which receive reports and forward them to local agencies. In other States, each locality receives allegations directly.

Once a report reaches the local agency, it is screened according to pre-established criteria. The criteria may vary from State to State, as each agency develops guidelines in accordance with State law and policy. Reports which meet these criteria are accepted and forwarded to the appropriate personnel.

Once a case is accepted it may be prioritized by the local agency. Prioritization allows the most dangerous cases to be swiftly investigated. Cases are prioritized according to the level of risk for the child. The cases are ranked from high priority to low priority and are investigated in this order. Therefore, the acceptance of an allegation does not always ensure that the case will be investigated timely. In areas with large numbers of reports, some cases are never investigated.

INVESTIGATION OF REPORT BY CHILD WELFARE AGENCY

If an allegation is accepted and the child is considered to be at risk of abuse, the case is assigned to a caseworker and investigated.

The caseworker talks with all parties involved. This may include family, health care practitioners, neighbors, friends, and other social service agencies. The caseworker also prepares a risk assessment for each case. Caseworkers use risk assessments as a tool to define the level of risk to the child.

The caseworker then reviews the case and determines the appropriateness and safety of the home environment. If the child is in an environment considered to be inappropriate, further steps are taken to ensure the safety of the child.

FINDINGS

TWELVE STATES HAVE CHILD WELFARE LAWS ADDRESSING PRENATAL SUBSTANCE EXPOSURE.

At the time of our data collection, child welfare laws which make specific reference to prenatal substance exposure had been implemented in Florida, Illinois, Indiana, Iowa, Massachusetts, Minnesota, Nevada, Oklahoma, and Utah. These laws vary in definitions used, toxicology testing criteria,⁴ and reporting requirements.

Three additional States (California, Missouri, Wisconsin) implemented laws involving prenatal substance exposure and child welfare issues after our initial data collection.

As shown below, seven State laws contain definitions of substance exposed infants, as abused, neglected, harmed, or in need of services. Three mention testing, and eight contain specific reporting provisions.

PRENATAL SUBSTANCE EXPOSURE PROVISIONS IN STATE CHILD WELFARE LAWS

STATE	DEFINITION	TESTING	REPORTING
CALIFORNIA			X
FLORIDA	X		X
ILLINOIS	X		X
INDIANA	X		
IOWA		X	X
MASSACHUSETTS			X
MINNESOTA	X	X	X
MISSOURI	X		
NEVADA	X		
OKLAHOMA	X		
UTAH			X
WISCONSIN		X	X

⁴A toxicology test is a blood or urine test for drugs and/or alcohol.

Definitions

Legal definitions vary. Illinois, for example, considers a child to be "neglected" if a toxicology test at birth is positive. Missouri law requires the social services department to "provide protective services" to a substance exposed infant referred to the health department by a physician; and Nevada defines a substance exposed newborn as a child "in need of protection."

Testing and Reporting

The three States that mention both testing and reporting in their laws have very different requirements.

- ▶ **Minnesota** law requires a physician who suspects prenatal substance exposure to do toxicology tests on infants and pregnant women. If test results are positive, the physician must report to a child welfare agency. Even if test results are negative, a physician who suspects substance abuse is expected to report.
- ▶ **Wisconsin** law allows a physician to perform a toxicology test on an infant with the consent of a parent or guardian. If the test is positive, the physician must make a report.
- ▶ **Iowa** physicians have much more leeway. The law leaves the testing decision to the judgment of the health care professional. If the physician decides to test and the results are positive, the physician must report to a child welfare agency unless the mother "has shown good faith in seeking appropriate care and treatment."

Laws in five other States, while silent on testing, require physicians to report prenatal substance exposure or fetal dependency cases to child welfare authorities. However, one State law dictates when not to report substance exposure cases.

- ▶ **California's** comprehensive perinatal services act includes a section directing that a positive toxicology screen is not in and of itself a sufficient basis for reporting child abuse and neglect.

See the appendix for the full text of pertinent sections of the 12 State laws.

STATE LAWS HAVE LITTLE EFFECT ON HOSPITAL TESTING PRACTICES OR THE WILLINGNESS OF CHILD WELFARE AGENCIES TO RECEIVE REPORTS OF PRENATAL SUBSTANCE EXPOSURE.

Hospital Testing

We found no overall consistency in hospital testing practices in the 12 States studied in

depth. This lack of consistency was true between States as well as within the same State, and regardless of whether or not a specific State law existed. The differing degrees of variation among the 43⁵ hospitals contacted in 1990 is illustrated below.

- ▶ **written protocols:** 16 hospitals had written protocols and 20 did not. Seven did not respond.
- ▶ **grounds for testing:** 30 of 42 responding hospitals tested if there were medical complications at birth, 26 if the mother had no prenatal care, and 24 if the mother had a history of substance abuse. One hospital tested all newborns.
- ▶ **who is tested:** 34 tested mother and baby, 8 tested the baby only, and 1 tested only the mother.
- ▶ **need for mother's informed consent:** 31 of 42 responding hospitals did not need the mother's consent to test herself or her baby; 3 others required her consent. Eight needed the mother's consent to test her, but not to test the baby.
- ▶ **substances included in the test:** 10 hospitals screened for all drugs, including alcohol; 9 others screened for all drugs except alcohol. Of the remaining 24, all screened for cocaine, 15 for amphetamines, and 8 for alcohol.

Even in Minnesota, where the law requires physicians who suspect prenatal substance exposure to test mother and infant, testing practices varied in four hospitals contacted.

Willingness of Child Welfare Agencies to Receive Reports

Child welfare agencies in 43 States accepted reports based solely on prenatal substance exposure during our 1990 data collection. This total included all 9 States which had laws at that time and 34 States without laws. Six of these 34 States left the decision to accept reports to each county's discretion.

States differed in the types of substances (illegal drugs, prescription drugs, and alcohol) they accepted for reporting. All 43 States that accepted reports took prenatal illegal drug exposure cases. Thirty-six of the 43 States also accepted alcohol reports and 20 accepted reports for prescription drug exposure.

The remaining eight States reported they did not accept prenatal substance exposure reports unless other suspected abuse and neglect issues were present. These included risk of physical harm and mother's inability to care for the child. Five of the eight

⁵For some categories, one hospital respondent was unable to definitively report the hospital's policy. Therefore, the total number of responding hospitals in those categories is 42.

States referred infants to local health departments for services. Services included visiting home nurses and high risk infant programs.

CHILD WELFARE AGENCIES IN STATES WITH SUCH LAWS ARE MORE LIKELY TO INVESTIGATE REPORTS THAN CHILD WELFARE AGENCIES IN STATES WITHOUT THESE LAWS.

Report acceptance by child welfare agencies does not necessarily lead to an investigation. While 43 States accepted prenatal substance exposure reports in 1990, only 30 investigated them based solely on prenatal substance exposure. This included all 9 States with laws at that time and 21 States without laws.

According to respondents, the remaining 13 States investigated only when other suspected abuse and neglect factors were present. As mentioned previously, these factors included risk of physical harm, mother's inability to care for the child, and also physical drug withdrawal symptoms in the infant.

The 30 States used several indicators as sufficient grounds to initiate an investigation involving prenatal substance exposure. As shown below, 30 States investigated reports based on a positive toxicology screen. Eighteen States also investigated based on suspicion of substance exposure. A mother's admission of substance abuse during pregnancy could trigger an investigation in 14 States.

INDICATIONS ACCEPTED TO INITIATE AN INVESTIGATION

	STATES WITH LAWS* N=9	STATES WITHOUT LAWS N=42	TOTAL N=51
INVESTIGATE REPORTS**	9	21	30
<i>Positive Toxicology</i>	9	21	30
<i>Suspicion</i>	6	12	18
<i>Self Admission</i>	5	9	14

* Three States implemented child welfare or testing laws after we finished data collection. In this chart, they are considered States without laws.

** States may accept more than one indicator as sufficient grounds to investigate.

Special Approaches for Handling Cases

States with laws were more likely than States without laws to have special procedures or approaches for handling prenatal substance exposure cases. Six of the 9 States with laws and about one-fifth of States without laws (8 of 42) had special procedures in 1990. We found two basic types of approaches in States with laws:

- ▶ Increased coordination among service agencies
 - In **Florida** and **Minnesota**, local agencies used multidisciplinary teams of child welfare workers, chemical dependency specialists, and public health nurses to handle prenatal substance exposure cases.
 - In **Illinois**, four Departments (Public Aid, Alcoholism and Substance Abuse, Children and Family Services, and Public Health) coordinated outreach and case management to provide drug treatment, health care, and social services.

- ▶ Special child welfare agency procedures
 - In **Massachusetts**, the child welfare agency had developed resources, clarified expectations for child welfare staff, and increased public awareness about what types of cases should be reported.
 - One **Nevada** county had developed an assessment and referral guide which covers investigation, case assessment, services, and court involvement.

Some respondents in States without laws expressed concern about the lack of specific, uniform guidelines for handling prenatal substance exposure cases. However, in **Oregon**, a State without a law, special guidelines have been developed for hospital identification, reporting, child protective assessment, and information for parents.

WOMEN HAVE BEEN PROSECUTED BOTH IN STATES WITH THESE LAWS AND IN STATES WITHOUT THEM. THE DECISION TO PROSECUTE RESTS WITH LOCAL PROSECUTING ATTORNEYS.

Women have been charged criminally in States with laws as well as in States without laws. Delivery of drugs to a minor is the most frequent charge. In our 12 State sample, 3 States with laws (FL, MA, and NV) and 2 States without laws (MI and SC) have used this charge when infants tested positive for controlled substances. The prosecuting attorneys reasoned that drugs were delivered to the infant through the umbilical cord during the brief period immediately after birth, before the umbilical cord was cut.

- ▶ In **Florida**, county prosecutors charged several women with delivering drugs to a minor. Florida county prosecutors worked directly with hospitals or police departments to identify women whose infants were born drug dependent.
- ▶ In **Massachusetts**, one woman was charged with distributing a controlled substance to a minor. The State's drug trafficking law for distributing cocaine to a minor carries a minimum 3-year State prison sentence.
- ▶ A county prosecutor in **Michigan** charged two women with delivering drugs in an amount less than 50 grams. These charges are normally associated with drug dealers. The crime is a felony in Michigan carrying sentences of 1 to 20 years.

Other criminal charges used include criminal neglect, drug possession, and involuntary manslaughter.

- ▶ At least 30 women in 2 **South Carolina** counties were charged with criminal neglect, distributing drugs to a minor, or drug possession. Their infants tested positive for substance exposure at birth.
- ▶ An **Illinois** woman was charged with involuntary manslaughter when her child died 2 days after birth. The infant's death was allegedly caused by the mother's cocaine use during pregnancy.

The goal of prosecution is to get women into treatment, according to some local prosecutors. The rise in substance exposure cases has led them to take action.

- ▶ One **Florida** county developed a diversionary program that allowed criminal delivery charges to be dropped if women successfully complete treatment.
- ▶ A **South Carolina** county required women who tested positive during pregnancy to enter drug treatment. A woman who failed to attend would be arrested.

WHILE THERE IS NO AGREEMENT ON WHAT WORKS BEST, MOST RESPONDENTS BELIEVE THAT PROSECUTION IS NOT AN EFFECTIVE DETERRENT.

Opinions were evenly divided on the effectiveness of the various approaches at the time of our 1990 data collection. Slightly more than half of respondents in States with laws (56 of 101) felt their laws were effective in addressing prenatal substance exposure. Slightly fewer than half (57 of 117) of respondents in States without laws judged their present approach effective.

Most respondents (165 of 222 who expressed an opinion) considered prosecution ineffective, unfair, or inappropriate. Child welfare administrators and staff

(43 of 55, 49 of 58) were strongly against prosecution followed by legal professionals (38 of 55) and hospital staff (35 of 54).

However, several prosecuting attorneys made a distinction between effectiveness and appropriateness. Although they believed that prosecution did not deter pregnant women from using drugs, they felt it was the appropriate response to a crime. One assistant district attorney related that he would never say he filed criminal petitions in these cases to rehabilitate; he did it strictly for punishment.

The greatest concern reported was that instead of helping to bring substance abusing women and their children into the child welfare and health care system, prosecution would frighten them away. According to some, fear of prosecution would not stop a pregnant woman from using drugs. Instead, it could cause her to have an abortion, go underground, not seek treatment, or not give birth in a hospital. One child welfare worker characterized it this way, "Prosecution doesn't impact substance abuse. It has potential to push them underground."

Even though three-quarters of the respondents did not favor prosecution, several indicated they could see its value if used to get women into treatment.

STATE LEGISLATIVE FOCUS MAY BE SHIFTING FROM CHANGING CHILD WELFARE LAWS TO PROVIDING PREVENTION, EDUCATION, AND TREATMENT SERVICES.

After our initial data collection, we performed a legislative follow-up to see if any additional legislation had been enacted or implemented in 1990 or 1991. We found that prenatal substance exposure is a topic of continuing concern at the State level.

Twenty-three States had enacted or implemented legislation concerning prenatal substance exposure. However, only three of them (California, Missouri, Wisconsin) implemented laws involving child welfare or testing.

The majority of new legislation targeted prevention, treatment, and education rather than child welfare as a way of addressing prenatal substance exposure. States seem to be focusing on a front-end proactive response to the issue.

State legislation ranged from specific funding bills to comprehensive laws covering a wide range of services. Half of the States (12) each implemented one law; the other half (11) each passed several laws. Some highlights:

- ▶ Six States enacted comprehensive programs including identification, intervention, and treatment services. For example, Louisiana enacted a plan to assure the availability of appropriate treatment, develop residential treatment programs specifically designed for substance abusing women and their children, increase public awareness, train providers, and encourage the medical community to identify and refer pregnant abusers to treatment programs.

- ▶ Thirteen States focused on treatment initiatives for pregnant substance abusers and addicted mothers with children. States created new treatment programs or provided priority access to existing treatment facilities.
- ▶ Ten States required State agencies, health care providers, and educators to disseminate information about the effects of substance abuse during pregnancy. One of these States, Missouri, enacted legislation requiring licensed physicians providing prenatal care to counsel patients on the perinatal effects of substance abuse. The law further requires that patients sign a written statement certifying that the counseling has been received.
- ▶ Seven States established programs to provide prenatal substance exposure training and information to health care, social services, and education providers.
- ▶ Seven State laws created task forces or special committees to collect data and provide recommendations on the prenatal substance exposure problem.
- ▶ Five States passed legislation requiring licensed alcoholic beverage vendors to post signs or provide information on the effects of alcohol and chemical dependency on pregnancy. Three States passed laws requiring this information to be distributed with marriage licenses.

CONCLUSION

The only significant difference between States with child welfare laws addressing prenatal substance exposure and States without such laws is the way they investigate prenatal substance exposure cases. It appears that the major impact of these laws has been to lay the groundwork for developing special procedures and improving coordination.

There appears to be little agreement among States about whether prenatal substance exposure should be considered child abuse or neglect. States considering amending their child welfare laws to include prenatal substance exposure would be wise to review the expectations and experiences of States with such laws before deciding how to proceed.

In the last 2 years, most of the prenatal substance exposure legislation has involved prevention, treatment, and education initiatives rather than changes in child welfare laws. States may be emphasizing early intervention and education programs designed to prevent this problem from ever becoming a child welfare concern.

APPENDIX

STATE CHILD WELFARE LAWS ADDRESSING PRENATAL SUBSTANCE EXPOSURE

CALIFORNIA

PERINATAL SUBSTANCE ABUSE SERVICES ACT

SECTION 1. (i) Urine testing to identify the presence of drugs in newborns and their mothers, which is used extensively as a tool for identifying and reporting suspected child abuse or neglect to child protective agencies, does not provide information that is adequate to determine either the level of risk to the newborn or the ability of the mother to provide adequate care for her child. This testing does not provide data which would be helpful for prevention and early intervention, nor does it identify exposure of infants to alcohol. The standard of accuracy of these tests is highly variable among different laboratories and technicians.

DIVISION 9.7

Chapter 1. General Provisions

SEC. 10901. (a) It is the intent of the Legislature, in enacting this division, to do all of the following:

(2) Encourage the development of a comprehensive delivery system of services to the mother, child, and family.

(b) It is further the intent of the Legislature, that the goals of that delivery system shall be to do all the following:

(1) Develop policies which recognize that the incidence of substance exposed infants and maternal substance abuse is fundamentally a health problem which is driven by addictive behavior, and that a substantially expanded substance abuse treatment, health care, public health nursing, and social services support system is required to deal with the problem effectively.

Chapter 2. Definitions

SEC. 10915. "Substance exposed infant" means any infant from birth to age three exposed, during the prenatal period through its mother's substance abuse or dependence.

Chapter 4. State Administration

SEC. 3. Section 11165.13 is added to the Penal Code, to read:

For purposes of this article, a positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child pursuant to Section 10922 of the Health and Safety Code. If other factors are present that indicate risk to a child, then a report shall be made. The report shall be made only to county welfare departments and not to law enforcement agencies.

FLORIDA

Definition of Abuse and Neglect: Reporting Law

FLA. STAT. ANN. s. 415.503

- (3) "Child abuse or neglect" means harm or threatened harm to a child's physical or mental health or welfare by the acts or omissions of the parent, adult household member, or other person responsible for the child's welfare, or, for purposes of reporting requirements, by any person.
- (9) "Harm" to a child's health or welfare can occur when the parent or other person responsible for the child's welfare:
 - (a) Inflicts, or allows to be inflicted, upon the child physical or mental injury. Such injury includes, but is not limited to:
 - (2) Physical dependency of a newborn infant upon any drug controlled in Schedule I of s. 893.03, upon any drug controlled in Schedule II of s. 893.03 with the exception of drugs administered in conjunction with a detoxification program as defined in s. 397.021, or upon drugs administered in conjunction with medically-approved treatment procedures; provided that no parent of such a newborn infant shall be subject to criminal investigation solely on the basis of such infant's drug dependency;
 - (g) Exposes a child from birth to 5 years of age to drugs. Exposure to drugs is established by a preponderance of evidence that the mother used a controlled substance during pregnancy or that the parent or parents demonstrate continued chronic and severe use of a controlled substance and as a result of such exposure the child exhibits any of the following:
 - 1. Abnormal growth.
 - 2. Abnormal neurological patterns.
 - 3. Abnormal behavior problems.
 - 4. Abnormal cognitive development.

For the purpose of this paragraph, "controlled substance" means any drug controlled in Schedule I or Schedule II of s. 893.03.

ILLINOIS

Definition of Abuse and Neglect: Reporting Law

ILL. ANN. STAT. ch. 23, s. 2053

"Neglected child" means any child

who is a newborn infant whose blood or urine contains any amount of a controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act or a metabolite thereof, with the exception of a controlled substance or metabolite thereof whose presence in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.

INDIANA

Definition of Abuse and Neglect: Court Code

IND. CODE ANN. s. 31-6-4-3.1

A child is a child in need of services if:

(1) the child is born with fetal alcohol syndrome or an addiction to a controlled substance or a legend drug;

or (2) the child:

(C) is at a substantial risk of a life threatening condition; that arises or is substantially aggravated because the child's mother was addicted to alcohol, a controlled substance, or a legend drug during pregnancy; and needs care, treatment, or rehabilitation that the child is not receiving, or that is unlikely to be provided or accepted without the coercive intervention of the court.

IOWA

Immunity From Liability

IOWA CODE ANN. s. 232.73

A person participating in good faith in the making of a report, or photographs, or X-rays, or in performance of a medically relevant test pursuant to this chapter, or aiding and assisting in an investigation of a child abuse report pursuant to section 232.71, shall have immunity from any liability, civil or criminal, which might otherwise be incurred or imposed. The person shall have the same immunity with respect to participation in good faith in any judicial proceeding resulting from the report or relating to the subject matter of the report.

As used in this section and section 232.77, "medically relevant test" means a test that produces reliable results of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs, or combinations or derivatives thereof, including a drug urine screen test.

Photographs, X-rays, and Medically Relevant Tests
IOWA CODE ANN. s. 232.77

- (2) If a health care practitioner discovers in a child under one year of age physical or behavioral symptoms of the effects of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs, or combinations of derivatives thereof, which were not prescribed by a health practitioner, or if the health practitioner has determined through examination of the natural mother of the child that the child was exposed in utero, the health practitioner may perform or cause to be performed a medically relevant test, as defined in section 232.73, on the child. The practitioner shall report any positive results of such a test on the child to the department, unless the natural mother has shown good faith in seeking appropriate care and treatment. The department shall begin an investigation pursuant to section 232.71 upon receipt of such a report. The positive result shall constitute a showing of probable cause under section 232.71, subsection 3, but shall not be used in any criminal prosecution of the natural mother of the child, and shall not represent grounds for a determination of child abuse.

MASSACHUSETTS

Definition of Abuse and Neglect: Reporting Law
MASS. GEN. LAWS ANN. ch. 119 s. 51A

Any physician, medical intern, hospital personnel engaged in the examination, care or treatment of persons, medical examiner, psychologist, emergency medical technician, dentist, nurse, chiropractor, podiatrist, osteopath, public or private school teacher, educational administrator, guidance or family counselor, day care worker or any person paid to care for or work with a child in any public or private facility, or home or program funded by the commonwealth or licensed pursuant to the provisions of chapter twenty-eight A. which provides day care or residential services to children or which provides the services of child care resource and referral agencies, voucher management agencies, family day care systems and child care food programs, probation officer, clerk/magistrate of the district courts, social worker, foster parent, firefighter or policemen, who, in his professional capacity shall have reasonable cause to believe that a child under the age of eighteen years is suffering serious physical or emotional injury resulting from abuse inflicted upon him including sexual abuse, or from neglect, including malnutrition, or who is determined to be physically dependent upon an addictive drug at birth, shall immediately report such condition to the department by oral communication and by making a written report within forty-eight hours after such oral communication; provided, however, that whenever such person

so required to report is a member of the staff of a medical or other public or private institution, school or facility, he shall immediately either notify the department or notify the person in charge of such institution, school or facility, or that person's designated agent, whereupon such person in charge or his said agent shall then become responsible to make the report in the manner required by this section.

MINNESOTA

Definition of Abuse and Neglect: Reporting Law

MINN. STAT. s. 626.556

Subdivision 2. Definitions

"Neglect" includes prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effect or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance.

MINN. STAT. s. 626.5561

Subdivision 1. Reports Required

A person mandated to report under section 626.556, subdivision 3, shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy. Any person may make a voluntary report if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy. An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required to report shall be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the local welfare agency. Any report shall be of sufficient content to identify the pregnant woman, the nature and extent of the use, if known, and the name and address of the reporter.

Subdivision 2. Local Welfare Agency

If the report alleges a pregnant woman's use of a controlled substance for a nonmedical purpose, the local welfare agency shall immediately conduct an appropriate assessment and offer services indicated under the circumstances. Services offered may include, but are not limited to, a referral for chemical dependency assessment, a referral for chemical dependency treatment if recommended, and a referral for prenatal care. The local welfare agency may also take any appropriate action under section 253B, including seeking an emergency admission under section 253B.05. The local welfare agency shall seek an emergency admission under section 253B.05 if the pregnant woman refuses recommended voluntary services or fails recommended treatment.

Subdivision 4. Controlled Substances

For purposes of this section and section 626.5562, "controlled substance" means a controlled substance listed in section 253B.02, subdivision 2.

MINN. STAT. s. 626.5562

Subdivision 1. Test: Report.

A physician shall administer a toxicology test to a pregnant woman under the physician's care or to a woman under the physician's care within eight hours after delivery to determine whether there is evidence that she has ingested a controlled substance, if the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose. If the test results are positive, the physician shall report the results under section 626.5561. A negative test result does not eliminate the obligation to report under section 626.5561, if other evidence gives the physician reason to believe the patient has used a controlled substance for a nonmedical purpose.

Subdivision 2. Newborns.

A physician shall administer to each newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance, if the physician has reason to believe, based on a medical assessment of the mother or the infant, that the mother used the controlled substance for a nonmedical purpose during the pregnancy. If the test results are positive, the physician shall report the results as neglect under section 626.556. A negative result does not eliminate the obligation to report under section 626.556 if other medical evidence of prenatal exposure to a controlled substance is present.

Subdivision 4. Immunity from Liability.

Any physician or other medical personnel administering a toxicology test to determine the presence of a controlled substance in a pregnant woman, in a woman eight hours after delivery, or in a child at birth or during the first month of life is immune from civil or criminal liability arising from administration of the test, if the physician ordering the test believes in good faith that the test is required under this section and the test is administered in accordance with an established protocol and reasonable medical practice.

Subdivision 5. Reliability of Tests.

A positive test result reported under this section must be obtained from a confirmatory test performed by a drug testing laboratory which meets the requirements of section 181.953, and must be performed according to the requirements for performance of confirmatory tests imposed by the licensing, accreditation, or certification program listed in section 181.953, subdivision 1, in which the laboratory participates.

MISSOURI

An Act Relating to the Protection of Certain Children 1991 Mo. SB 190

Section 7

1. Notwithstanding the physician-patient privilege, any physician or health care provider may refer to the department of health families in which children may have been exposed to a controlled substance listed in section 195.017, RSMo, schedules I, II, and III, or alcohol as evidenced by:

- (1) Medical documentation of signs and symptoms consistent with controlled substances or alcohol exposure in the child at birth; or
- (2) Results of a confirmed toxicology test for controlled substances performed at birth on the mother or the child; and
- (3) A written assessment made or approved by a physician, health care provider, or by the division of family services which documents the child as being at risk of abuse and neglect.

Section 8

1. The department of social services shall provide protective services for children that meet the criteria established in section 7 of this act. In addition the department of social services may provide preventive services for children that meet the criteria established in section 7 of this act.

NEVADA

Protective Services and Custody NEV. STAT. s. 432B.330

Circumstances under which a child may or may not be in need of protection.

- (1) A child is in need of protection if:
 - (b) He is suffering from congenital drug addiction or the fetal alcohol syndrome, because of the faults or habits of a person responsible for his welfare;

OKLAHOMA

Definition of Abuse and Neglect: Court Code

OKLA. STAT. ANN. tit. 10, s. 1101

- (4) "Deprived child" means a child who is for any reason destitute, homeless, or abandoned ... or who is a child in need of special care and treatment because of his physical or mental condition including a child born in a condition of dependence on a controlled dangerous substance, and his parents, legal guardian, or other custodian is unable or willfully fails to provide said special care and treatment ...

Reporting Law

OKLA. STAT. ANN. tit. 21, s. 846

- (A) ...Every physician or surgeon, including doctors of medicine, licensed osteopathic physicians, residents and interns, or any other health care professional attending the birth of a child who appears to be a child born in a condition of dependence on a controlled substance shall promptly report the matter to the county office of the Department of Human Services in the county in which such birth occurred.

UTAH

Reporting Law

UTAH STAT. s. 62A-4-504

Fetal alcohol syndrome and drug dependency - Reporting requirements.

When any person, including a licensee under the Medical Practice Act or the Nurse Practice Act, attends the birth of a child or cares for a child, and determines that the child, at the time of the birth, has fetal alcohol syndrome or fetal drug dependency, he shall report that determination to the division as soon as possible.

UTAH STAT. s. 62A-4-509

Investigation by division - Temporary protective custody.

The division shall make a thorough investigation upon receiving either an oral or written report of alleged abuse, neglect, fetal alcohol syndrome, or fetal drug dependency when there is reasonable cause to suspect a situation of abuse, neglect, fetal alcohol syndrome, or fetal drug dependency. The primary purpose of that investigation shall be protection of the child.

WISCONSIN

Testing Infants for Controlled Substances

WIS. STAT. s. 146.0255

(1) Definition. In this section, "controlled substance" has the meaning given in s. 161.01(4)

(2) Testing. Any hospital employee who provides health care, social worker or foster care intake worker may refer an infant to a physician for testing of the infant's bodily fluids for controlled substances if the hospital employee who provides health care, social worker or foster care intake worker suspects that the infant has controlled substances in the infant's bodily fluids because of the mother's ingestion of controlled substances while she was pregnant with the infant. The physician may test the infant to ascertain whether or not the infant has controlled substances in the infant's bodily fluids, if the parent or guardian consents to the testing and if the physician determines that there is a serious risk that there are controlled substances in the infant's bodily fluids because of the mother's ingestion of controlled substances while she was pregnant with the infant. If the results of the test indicate that the infant does have controlled substances in the infant's bodily fluids, the physician shall make a report under s. 46.238.

(3) Test results. The physician who performs a test under sub. 2 shall provide the infant's parents or guardians with all of the following information:

- (a) A statement of explanation concerning the test that was performed, the date of performance of the test and the test results.
- (b) A statement of explanation that the test results must be disclosed to a county department under s. 46.215, 46.22 or 46.23 in accordance with s. 46.238 if the test results are positive.