

# **Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State**

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## EXECUTIVE SUMMARY

This document provides guidance to hospitals, health care providers and affiliated professionals about maternal drug screening, laboratory testing and reporting of drug-exposed newborns delivered in Washington State. We created this document in response to an increasing number of requests from hospital staff and attorneys seeking information on this complex topic. We want to promote consistent practice among health care providers. This work is a collaborative effort between the Washington State Department of Health and the Department of Social and Health Services.

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 law requires health care providers who deliver or care for such infants, to notify Child Protective Services.

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 develop a defined policy for identifying intrapartum women and newborns for substance use/abuse. Hospital risk management, nursing and social service, medical staff, and local Department of Social and Health Services Children’s Services should be involved. 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 care, 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 about maternal screening and testing and reporting drug-exposed newborns born in Washington State hospitals. This guidance also applies to newborns born elsewhere (home, clinic, or another hospital) and admitted to your hospital, and then determined to be drug exposed or affected.

**Screening** refers to methods used to identify risk of substance abuse during pregnancy and postpartum, including self-report, interview and observation. **Testing** is the process of laboratory testing to determine the presence of a substance in a specimen.

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 positive confirmed (as opposed to screen) drug toxicology; her newborn is presumed to be drug exposed. If a screen only positive toxicology (without confirmation testing), has been done on the mother, a newborn toxicology may be indicated.

### **Hospital Policy**

Each hospital should work with risk management attorneys, nursing, social service, and medical staff to develop a defined policy for identifying intrapartum and postpartum 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 pregnant women for treatment please refer to the *Substance Abuse During Pregnancy: Guidelines for Screening* best practice booklet located online at: <http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy>

Washington referral resource information can be found at the DSHS Behavioral Health and Service Integration Administration website: <https://www.dshs.wa.gov/bhsia/substance-use-treatment-services>

### **Table 1**

#### **Newborn Risk Indicators**

It is not necessary to test a newborn with signs of drug withdrawal whose mother has a positive confirmed 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 associated with maternal drug use may include: (American College Obstetricians and Gynecologists, 2005)

- 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 infant
- Signs of neonatal narcotic abstinence syndrome include: marked irritability, tremors, increased wakefulness, hyperactive deep tendon reflexes, exaggerated Moro reflex, seizures, high pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea, diaphoresis (American Academy of Pediatrics, 2012; see Appendix A):

*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. In a recent study, lower gestational age was associated with lower risk of withdrawal. The decrease in severity of signs in the preterm infant may relate to developmental immaturity of the CNS, differences in total drug exposure or lower fat deposits of the drug (AAP, 2012). Immature organ systems may also modify test results. In addition, scoring tools for withdrawal were developed in term or late preterm infants.

### **Table 2**

#### **Maternal Risk Indicators**

*Maternal characteristics that suggest a need for biochemical testing of the newborn include: (AAP, 2012)*

- No prenatal care
- Admitted history of drug use
- Previous unexplained fetal demise
- Precipitous labor
- Abruptio placentae
- Hypertensive episodes
- Severe mood swings

- Cerebrovascular accidents
- Myocardial infarction
- Repeated spontaneous abortions
- Cannabinoid hyperemesis syndrome (intractable nausea (unresponsive to treatment) relieved by frequent hot bathing/showers).

*Additional characteristics that suggest methamphetamine use:*  
(American College Obstetricians and Gynecologists, 2011)

- Gum or periodontal disease including broken teeth, severe decay, infections
- Significant weight loss, low BMI, malnutrition
- Psychiatric symptoms such as anxiety, panic, hallucinations and psychosis
- Skin conditions: abscesses, dry or itchy, acne type sores

### **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://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy>

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.

According to the June 2015 American College of Obstetricians and Gynecologists Committee Opinion, *Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetrics and Gynecologic Practice*, when a legal or medical obligation exists for obstetrician-gynecologists to test patients for substance use disorder, there is an ethical responsibility to notify patients of this test and make a reasonable effort to obtain informed consent.<sup>1</sup>

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 most useful when the history and clinical presentation strongly suggest neonatal withdrawal but the maternal urine screening is negative. (AAP, Pediatrics 2012). 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.
- **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. (Vinner, Therapeutic Drug Monitoring 2003) Hair has a high false positive rate because of passive exposure to minute quantities of illicit substances in the environment.

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<sup>1</sup> American College of Obstetricians and Gynecologists. 2015, *Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice*, ACOG Committee Opinion, Number 633

- **Umbilical cord segments** reflect substance exposure during the second half of gestation. Drugs given to the mother during labor will appear in cord tissue toxicology. Recent testing of umbilical cord tissue by using drug class-specific immunoassays was shown to be in concordance with testing of paired meconium specimens for detection of amphetamines, opiates, cocaine and cannabinoids (AAP, 2012). Currently testing for buprenorphine (Subutex<sup>®</sup>), and designer stimulants (“bath salts”) is available. Detection of alcohol at high levels is also possible with cord tissue testing. The ease of collection and turn around time for results, make this confirmation test ideal for neonatal drug testing. Cost of analysis per specimen approximates the cost of meconium. More information is available at [www.usdtl.com](http://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 and umbilical cord tissue.
- 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.*

Legal substances such as alcohol and marijuana have strong potential to cause harm. Adverse effects due to maternal alcohol use are well known. Marijuana use by adults is now legal in Washington State. There are health risks to infants of mothers who use medical or recreational marijuana. The main psychoactive component in marijuana (THC) passes from mother to child during pregnancy and through breast milk. Emerging research also suggests there is an association between marijuana and decreased fetal growth, development and executive functioning and mood disorders in children. (Goodman) THC stays in the body of mothers and babies for a long time, babies can test positive for THC weeks after being exposed. (Garry) Babies exposed to THC can have problems with feeding. (Miller)

**Reporting to Children’s Administration**

Hospitals should contact their local Department of Social and Health Services Children’s Administration 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.

Parental substance use doesn't necessarily result in child harm or neglect.<sup>2</sup>If a mandated reporter has reasonable cause to believe that a child has suffered child abuse/neglect they are mandated to report. We also agreed to add the following language: If you believe that a parent's substance use/abuse is causing child abuse or neglect, consult CPS. This includes the use of marijuana and alcohol.

The DSHS guide for reporting allegations of child abuse and neglect can be found online at <http://www.dshs.wa.gov/pdf/publications/22-163.pdf>.

Child Protective Services: Guidance for Mandatory Reporters can be found online at <http://www.dshs.wa.gov/pdf/ca/MandatedReporterTraining.pdf>

You can find your local Children's Administration office by entering your zip code at the following website, <https://fortress.wa.gov/dshs/f2ws03apps/caofficespub/offices/general/OfficePick.asp> or by following this link, [Local Children's Administration Office locator](#).

#### **DSHS Substance Abuse during Pregnancy - Intake Screening**

Intake must take the following actions regarding reports of substance abuse during pregnancy.

- A. Document a pregnant woman's alleged abuse of substance(s) (not medically prescribed by the woman's medical practitioner) in an intake as "Information Only."
- B. Document available information on the following risk and protective factors:
  - 1. Current substance abuse (specific substance(s) used, frequency, intensity, duration and amount of use).
  - 2. History of substance abuse (e.g., periods of abstinence).
  - 3. History of or refusal to enter substance abuse treatment.
  - 4. Results of prior substance abuse treatment.
  - 5. Current prenatal care and name of physician or obstetric care provider.
  - 6. History or current presence of domestic violence.
  - 7. Previous history of serious mental health disorder and/or postpartum mood disorder.
  - 8. Environmental factors, including exposure to toxic chemicals (i.e. drug manufacturing).
  - 9. Support available to the pregnant woman.

Information from a-i above will be documented in the Narrative section - Caregiver Characteristics. This information may be used to assess safety of the child.

- C. On all "Screened Out" intakes on a pregnant woman allegedly abusing substances, intake staff will identify whether the woman is receiving Medicaid.
  - 1. If the woman is not on Medicaid, intake will email a copy of the intake to ESA at [CSDFirstSteps@dshs.wa.gov](mailto:CSDFirstSteps@dshs.wa.gov).

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<sup>2</sup> American College of Obstetricians and Gynecologists. 2015, *Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice*, ACOG Committee Opinion, Number 633

2. If the woman is on Medicaid, intake staff will send a copy of the intake by email, mail or fax to the First Steps provider whenever possible. If there are multiple First Steps providers serving one community, intake staff will send to ESA HQ at [CSDFirstSteps@dshs.wa.gov](mailto:CSDFirstSteps@dshs.wa.gov).
- D. When the referrer is an ESA HQ or First Steps provider, intake staff will not need to send an intake.
  - E. Upon receipt of an intake involving an Indian child, CA intake will send intakes to the Tribe for the Tribe's information. Refer to ICW Manual Section 05.05.
  - F. Follow the intake procedures (outlined in section 2220 Practices and Procedures Guide) when there is a pregnant woman who is parenting a child and there is an allegation of child abuse or neglect (CA/N).

**DSHS Intake numbers:**

Toll free number for region 3 (old regions 5 and 6) is **Toll Free Intake:** 1-888-713-6115.

Region 1 intake (old regions 1 and 2) is **Toll Free Intake:** 1-800-557-9671. Central intake covers new region 2 (old 4 and 5).

## Appendix A

### References and Resources:

American Academy of Pediatrics (AAP) Committee on Drugs and Committee on Fetus and Newborn. 2012. Neonatal Drug Withdrawal. *Pediatrics*; 129:e540-560.

American Academy of Pediatrics. Section on Breastfeeding. Breastfeeding and the use of Human Milk. 2012, *Pediatrics*, 129, e827-e841.

American College of Obstetricians and Gynecologists Committee Opinion. 2011. Substance Abuse Reporting and Pregnancy: the Role of the Obstetrician Gynecologist, Number 473.

American Society of Addiction Medicine. 2011. Public Policy statement on Women, Alcohol and other Drugs and Pregnancy. <http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/15/women-alcohol-and-other-drugs-and-pregnancy>

American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 2012 *Guidelines for Perinatal Care, Seventh Edition*. Elk Grove Village IL.

American Congress of Obstetricians and Gynecologists. 2014. Toolkit on State Legislation Pregnant Women and Prescription Drug Abuse, Dependence and Addiction. <http://www.acog.org/-/media/Departments/State-Legislative-Activities/2014SRTSAToolkit.pdf?dmc=1&ts=20150522T1547594846>

American College of Obstetricians and Gynecologists. 2015, *Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice*, ACOG Committee Opinion, Number 633. <http://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co633.pdf?dmc=1&ts=20150522T1540124212>

American College of Obstetricians and Gynecologists. 2015, *Marijuana use During Pregnancy and Lactation*, ACOG Committee Opinion, Number 637. <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Marijuana-Use-During-Pregnancy-and-Lactation>

American College of Obstetricians and Gynecologists, 2011. *Methamphetamine Abuse in Women of Reproductive Age*, ACOG Committee Opinion, Number 479.

American College of Obstetricians and Gynecologists Committee Opinion. 2012, Reaffirmed 2014. *Opioid Abuse, Dependence, and Addiction*. Number 524.

American College of Obstetricians and Gynecologists Committee Opinion. 2012. *Nonmedical Use of Prescription Drugs*. Number 538.

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.

Burns, E, Gray, R, Smith, L. Brief screening questionnaires to identify problem drinking during pregnancy: a systematic review. 2010. *Addiction*, 105, 601-614.

Chang, G, Orav, E, Jones, E, Buynitsky, T, Gonzalez, S, Wilkins-Haug, L. 2011. Self reported alcohol and drug use I pregnancy young women. *J Addiction Medicine* 5(3) 221-226.

Creanga, AA, et. (2011). Maternal Drug Use and its Impact on Neonates: population-based study in Washington State. *Obstetrics and Gynecology*, 119(5), 924-933.

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.

Garry, et al, (2009). Cannabis and breastfeeding. *Journal of Toxicology*. Doi:10.1155/2009/596149.

Goodman, DJ and Wolff KB. (2013). Screening for Substance Abuse in Women's Health: A Public health Imperative. *Journal of Midwifery and Women's Health*, 58, 278-287.

Hudak L, Tan RC and the Committee on Drugs and the Committee on Fetus and Newborn. (2012). Neonatal Drug Withdrawal. *Pediatrics*,129(2), e540-e560.

Humeniuk R, Babor T, Jones HE, Deppen K, Hudak ML, Leffert L, McClelland C, Sahin L, Starer J, Terplan M, Thorp JM. (2013). Clinical care for opioid- using pregnant women and postpartum women: the role of obstetric providers. *American Journal of Obstetrics and Gynecology*, 1-9.

Jansson L and Velez M. (2012). Neonatal abstinence syndrome. *Current Opinion Pediatrics*, 24(2), 252-258.

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>.

Martin CE, Longinaker N, Terpan M. (2014). Recent Trends in Treatment Admissions for Prescription Opioid Abuse During Pregnancy. *Journal of Substance Abuse Treatment*, article in press.

Miller, Clinical Lactation, 2012, Vol. 3-3, 102-107.

O'Connor A, Alto W. (2013). The Outpatient Treatment Guide manual for Care of Opioid-Dependent Pregnant Women with Buprenorphine. Maine Dartmouth Family Medicine Residency, Dartmouth Medical School. [www.mainedartmouth.org/pdf/OConnorAltoOutpatientTreatmentManualOpioidDependentPregnant\\_V2.pdf](http://www.mainedartmouth.org/pdf/OConnorAltoOutpatientTreatmentManualOpioidDependentPregnant_V2.pdf)

Patrick SW, Schumacher RE, Benneyworth BD, Krans EE, Mcallister JM, Davis MM. (2012). Neonatal Abstinence Syndrome and Associated health Care Expenditures United States, 2000-2009. *Journal of American Medical Association*, published online April 30, 2012.

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.

Schmid, SM, Lapaire, O, Huang, DJ, Jürgens, FE, & Guth, U (2011) . Cannabinoid hyperemesis syndrome: an underreported entity causing nausea and vomiting of pregnancy. *Archives Gynecology and Obstetrics*, 284:1095-1097.

Vinner E, Vignau J, Thibault D, Codaccioni X, Brassart C, Humbert L, Lhermitte M. (2003). Neonatal Hair Analysis Contribution to Establishing a Gestational Drug Exposure profile and Predicting a Withdrawal Syndrome. *Therapeutic Drug Monitoring*; 25:421-432.

Washington State Department of Health. 2013. *Substance Abuse During Pregnancy: Guidelines for Screening*.

Weiner. S. M. & Finnegan, L.P. (2011). Drug withdrawal in the neonate. In S.L. Gardner, B.S. Carter, M. Enzman-Hines & J.A. Hernandez. (Eds.), *Merenstein and Gardner's Handbook of Neonatal Intensive Care*, (7<sup>th</sup> Edition. pp.201-222), St. Louis: Mosby Elsevier.

### **Additional Resources**

To order or download “The Parent’s Guide to CPS” (mentioned in letter on Page 11):  
<https://www.dshs.wa.gov/node/8330>

Washington State Department of Health, Access, Systems and Coordination Phone: 360-236-3582)

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 phone number: 1-800-562-5624.  
<http://www.dshs.wa.gov/ca/safety/abuseReport.asp?2>

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

Neonatal Advances – Enhancing the Care of Drug-Exposed Infants  
<http://neoadvances.com/>

Washington State Perinatal Collaborative Neonatal Abstinence Syndrome clinical pathway and sample hospital protocols -<http://waperinatal.org/neonatal-abstinence-syndrome/>

## **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."

**Sample Parent Letter:  
Information for parents of newborn 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**

**Morphine Sulfate**

System Date/Time	Signs and Symptoms	Dose Score														
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.)	Respiratory rate (>60/min. with retractions)	1														
		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.

Adapted from Finnegan, L.P. 1986. Neonatal abstinence syndrome: assessment and pharmacotherapy. In F.F., Rubatelli and B. Granadi (ed.) Neonatal therapy: an update. Exerpta Medica, NY.

## 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?**

Mandated reporters will be asked to provide as much of the following information as they are able:

1. The name, address and age of the child and parent(s) stepparents, guardians, or other persons having custody of the child.
2. The nature and extent of alleged
  - Injury or injuries
  - Neglect
  - Sexual Abuse
3. Any evidence of previous injuries.

4. Any other information that may be helpful in establishing the cause of the child's death, injury, or injuries and the identity of the alleged perpetrator(s).

It is important to provide as much information about why you have reasonable cause to believe there is child abuse or neglect. This information will assist DSHS at intake or during the course of a CPS investigation if the case screens in. Examples include:

- Issues, i.e., substance use, mental health that may impact a child's safety.
- Parents' resources and strengths that can help the parents' care for and protect the children.
- Parents' response to interventions, etc.
- Names of family members.
- Whether the child may be of Indian ancestry for Indian Child Welfare planning, if applicable.
- 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) resources and family strengths.
- Rational for toxicology testing.

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 a safety threat(s) 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.
- 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 safety threats and protective factors to determine if there is an allegation of child abuse or neglect or safety threat(s). If there are no allegations of child abuse or neglect or safety threats, 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.

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#### 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.



For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).