PROTOCOL

for Making Reasonable Efforts to Preserve Families in Drug-Related Dependency Cases

National Council of Juvenile and Family Court Judges
Permanency Planning for Children Project
January 1992

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SECTION I

Introduction

This document was prepared in response to the urgent problems of drug-exposed infants and children, their mothers, fathers and families. It is designed to serve as a protocol for decision-makers confronted by these families and their problems. The information contained in these pages is based upon law, expert opinion and experience. The law mandates that families must be provided with services to safely prevent the placement of children in foster care or in other substitute placements. The expert opinion of child welfare specialists is that certain services can safely keep most families together. Experience has shown that services which strengthen families can actually save money, by reducing the need for costly, out-of-home placements, or by facilitating family reunification.

Model programs mentioned in the following pages are based on an ideal set of services. Some services may not be present in some communities, some may exist but remain underused, and other services may need to be developed. In all communities, however, dollars can be appropriately redirected toward safely strengthening families through effective services for drug-exposed infants, children, their mothers, fathers and families.

The number of infants born exposed to illicit drugs has grown dramatically. Researchers estimate that approximately 739,200 women may use one or more illegal substances during their pregnancies each year.[1] Many child welfare systems have been caught unprepared for this remarkable rise in the number of substance exposed infants. Some have removed newborn infants from their mothers without taking the time to determine whether such a removal is necessary or even in the infant's best interest.

The experience of leading experts throughout the United States is that removal of the infant in these cases is usually unnecessary and can even be harmful to the child. Decision-makers are encouraged to use this protocol when trying to identify what can be done to permit the infant to remain safely with the mother and family, and to help identify risk factors and unsafe situations in which the infant must be removed.

Congress took an important step to keep troubled families together when the Adoption Assistance and Child Welfare Act, P.L. 96-272, was passed in 1980. The law underscored three important principles: (1) the prevention of unnecessary foster care placement; (2) the reunification of children in foster care with their biological families, when feasible; and (3) the timely adoption of children unable to return home.

Among its major provisions, the Act requires judges to determine whether "reasonable efforts" have been made to enable children to remain safely at home instead of being placed in foster care. Judges must also ensure that "reasonable efforts" are made to reunite children with their biological parents, or to secure adoptive placements for children who cannot be reunited with their families.

As gatekeepers to the nation's foster care system, juvenile and family court judges have worked to implement the "reasonable efforts" requirement, to encourage services to protect children in their own home, and to prevent the unnecessary removal of children from families. Yet, continuing progress towards these goals is being hampered by a startling increase in substance abuse (alcohol and other drug abuse) among women of childbearing age that has overwhelmed the child protection, treatment, and other human service sectors nationwide.

Drug-exposed children are not born exclusively to poor and minority families. But poor and minority mothers face a much greater risk of having their children removed from their care when no other effective interventions are available. A 1989 study conducted in Pinellas County, Florida, found similar rates of drug abuse among pregnant white and black women of equal socioeconomic status. Yet only 1% of white abusers were reported to authorities, compared with nearly 11% of blacks.[2] The problem calls for a new cultural responsibility in decision-making about these children and their families. To ensure equity in decision-making among diverse cultural and racial groups, increased understanding is needed of the cultural and economic strengths and weaknesses of each family, regardless of class or color. Families are important to all children. Strengthening families is a goal second only to protecting children and every reasonable effort should be made to do both.

The problems of alcohol and other drug abuse pose many challenges to families trying to raise healthy children. Recent in-home work with drug affected families, however, has demonstrated that many parents can learn to decrease or eliminate their drug abuse and provide adequate nurturing for their children, and that individual family members can learn coping skills to deal with drug users. Long-term intellectual and emotional connectedness can affect children in many ways. Attachment can help the child to achieve his or her intellectual potential, cope with stress and frustration, and develop a conscience and future relationships. When families are in crisis, suffering from the painful effects of abuse, conflict, or violence, there are usually parallel family strengths which should be recognized and utilized.

Alternatives to strengthening families pose their own difficulties. Foster homes are increasingly difficult to find and

[1] Center for the Future of Children, *The Future of Children*, David and Lucille Packard Foundation, Spring 1991, Vol. 1, No. 1, p. 22.

[2] Ira J. Chasnoff, Harvey J. Landress, and Mark E. Barrett, "The Prevalence of Illicit Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida." *New England Journal of Medicine*, Vol. 322, Apr. 26, 1990, pp. 1202-06.

maintain. Children may experience many placements, never to find any real stability or continuity. In some counties, there are dozens to hundreds of newborn infants without parents or homes, who are being maintained in hospitals in rows of bassinets, with no plans for their future care. Costs of placement are enormous. In many cases, if comparable funds were spent strengthening families rather than separating them, more children would have a better chance at a stable childhood and a productive life.

Any decisions about children's welfare and living situations are complicated. Certainly some placements will always be necessary because the protection of the child is paramount. Yet, every year thousands of children are removed from their homes simply because few other options are available for helping their families deal with serious problems. In many cases these children continue to suffer. Children growing up in placement may feel rejected, inadequate and alone. They may envy siblings remaining at home. They miss out on significant portions of family history, making it difficult for them to have a sense of belonging and continuity. Often when they do return to their families, nothing has changed, and they still must cope with many of the problems that necessitated their removal. Once removed, they face many consequences: long separations from their families, potentially ineffective or damaging placements, and frequent moves and disruptions. The best interest of the child must remain the paramount consideration. In most instances, the child's best interest is served by remaining in the home with adequate services to ensure the child's safety and development.

Family-centered services can help families and social service systems avoid unnecessary out-of-home placement. These services can offer a promising first step to helping drug affected families and individuals help themselves. They also offer a cost-effective alternative to placement at a time when wise investment of social service dollars is a critical consideration.

Several groups of professionals play critical roles in the detection and resolution of substance abuse problems affecting children and families. These groups include individuals within the following professions: law enforcement, public health, medical, drug treatment, social service, and legal. Professionals have a dual role. They resolve problems by intervention and the delivery of services; and they provide information to fellow decision-makers such as juvenile and family court judges when these cases come before the courts. Each group has the responsibility to provide whatever is necessary to protect children and preserve families.

Law enforcement and social service workers have the responsibility to intervene to protect children and to coordinate with service providers so that children are not unnecessarily placed in shelter care. Professionals all have varied responsibilities in providing services to family members. All professionals must be prepared to accurately assess danger to infants and the capabilities of each mother and family to safely care for them. They must also be prepared to provide the necessary services and support to permit infants to remain with their mothers if at all possible.

Social service workers often are called upon to determine when a danger is so serious that the mother and family are unable, despite services provided, to safely care for an infant. When social service agency efforts to remove the risk of harm have not succeeded, it becomes necessary to take formal action in the juvenile or family court.

In these legal proceedings, the juvenile or family court has the responsibility to ensure that services have been provided to maintain the child within the family or to reunify the family if the child was removed. In addition to making the determination that "reasonable efforts" were provided to preserve the family, it is each judge's legal responsibility to examine the impact of substance abuse on poor and minority populations and to act to ensure racial and cultural equity, access to services, and the appropriateness of social service policies and practices.

Although the juvenile court cannot solve the problem of maternal drug use during pregnancy, a revitalized and reoriented juvenile court can play a positive and meaningful role.[3]

The current national trend in cases involving substance-exposed infants and children is to redefine "reasonable efforts" to address the special problems presented by these children and their families. Such a redefinition is necessary because our service system has not previously been constructed to deal with mothers and children with substance abuse problems. New and different types of family-focused services have been created that are both effective and economical. These promising, new, family-centered programs feature a multidisciplinary approach and early intervention with families. There is no doubt that treatment can work. Substance abuse can be ameliorated and children can safely remain with their families in many cases. The preservation of one family of one drug-exposed infant can help to ensure the health and safety of present and future siblings and, possibly, future generations. When this can be done for less cost than would otherwise be incurred for the unnecessary dissolution of the family, it makes a compelling case for expansion of such efforts.

Law enforcement, public health, medical, drug treatment service providers, social service workers, juvenile and family court judges and related professionals nationwide must prepare to face drug-related dependency cases in increasing

[3]Myers, John E. B., "A Limited Role for the Legal System in Responding to Maternal Substance Abuse During Pregnancy," *Notre Dame Journal of Law, Ethics & Public Policy*, Vol. 5, Issue No. 3, 1991.

numbers. In recognition of this problem, the National Council of Juvenile and Family Court Judges has developed the following *Protocol for Making Reasonable Efforts to Preserve Families in Drug-Related Dependency Cases.* The purpose of this protocol is to provide model questions to guide risk assessment and identify the family preservation service needs of drug-exposed families. The overriding principles which have governed the development of this protocol include:

- Juvenile and family court judges should play a leadership role in working with key people from all three branches of government, law enforcement, public health, medical, drug treatment service providers, social service workers, and the private sector to develop a comprehensive continuum of family-focused, multi-disciplinary drug treatment and family strengthening services.

- Effective treatment is linked to practical help for mothers, fathers, and families, such as transportation, housing, child care, nutrition, education, job training and health care. Drug and substance abuse treatment is a political and ideological issue. New attempts to understand and treat addiction should move beyond these constraints. New approaches should draw upon existing traditions, but should re-emphasize the importance of the family as a crucial unit of support and nurturance that cannot be effectively replaced by strangers or congregate care.

- Public health, medical and drug treatment service providers, social service workers, and juvenile and family court judges should work together to ensure substance abuse treatment upon demand. It would be counter-productive if any punitive consequences were attached to the provision of these services.

- All professionals must recognize that in most cases, the extended family can provide sufficient support to safely care for the child and enable the child to remain with family members in the community. Families demonstrate strength, potential, and commitment to caring for children which are often under-utilized.

- A child should be removed from the home only upon a showing that there is a substantial risk of harm to the child that cannot be ameliorated through family strengthening services. Decision-makers should balance the risk of harm to the child against the known harm inflicted upon children through removal from their families. Due consideration should be given to the potential for the active intervention of family strengthening services. These services should be designed to assess risk, and to restructure both family behavior and available caretaker resources to safely preserve families.

- Prevention of substance abuse by all family members is a goal of judges and other professionals who must respond to its effects on children and families. Yet pregnant women have special medical needs. Accordingly, comprehensive services, including preconceptual and prenatal substance abuse programs and all related medical services should be made available on demand to all women of child-bearing age. A complete continuum of care would include actual outreach efforts by service providers to ensure that women in need of services are reached.

- All professionals should recognize the relationship between substance abuse and the rising incidence of HIV exposure and other sexually transmitted diseases (especially hepatitis B and syphilis) and other infections (e.g., tuberculosis) and assist in ensuring an appropriate therapeutic response in each case.

- Law enforcement officials are a crucial, front line of contact with the community and often are the first to identify those with substance abuse problems, including substance-abusing parents. Police and other law enforcement agencies need adequate training on the dynamics of substance abuse as it affects women with children. They should encourage a more appropriate array of service responses and take better advantage of services that presently exist.

- Law enforcement leaders should coordinate and cooperate with social service, public health, and substance abuse treatment providers, and not preempt the provision of effective family strengthening services by the untimely and unnecessary removal of children from families. One essential ingredient is the awareness that intensive, home-based services, with or without juvenile and family court supervision, can provide for the safety of children and may best enable entry of parents into effective substance abuse treatment.

- Law enforcement contacts with a substance-abusing parent and even the arrest of the caretaking parent should not automatically result in the placement of children in shelter care.

- The existence of a continuum of services and intervention alternatives may make juvenile or family court proceedings unnecessary in many cases of substance-exposed infants. Juvenile and family courts should be involved, however, when these alternative services have been ineffective in supporting the family and protecting the child. Care should also be given to assure that when these children have been voluntarily placed, the court provides regular oversight either directly or through review boards.

- Prenatal substance abuse may create substantial harm, or risk of substantial harm, to a child. To make placement decisions requires good medical risk data on the mother and infant, as well as the assessment of parental capacity for responsible child rearing.

- In cases in which substitute placement of children is unavoidable, sensitive selection of placement and transition into care, as well as continued and regular contact between family members should be maintained and family reunification achieved as quickly as possible. Specialized foster parent training is recommended for these temporary caretakers of drug-exposed infants. For children unable to return home, permanent adoptive homes should be secured as quickly as feasible.

- The crucial nature of the developmental years of children and their need for stability in care and nurturance should encourage timely decision-making on termination of parental rights where indicated.

- The criminal prosecution of mothers for alcohol and other drug abuse during pregnancy may not be consistent with the goals of juvenile proceedings or the best interests of the child, and may even inhibit treatment or expose the child to unnecessary family disruption and attendant harm. A woman who uses drugs during pregnancy should not be subject to special criminal prosecution on the basis of allegations that her alleged drug use harms the fetus, except as a last resort. In the event of criminal court proceedings, they should be coordinated with proceedings in the juvenile and family court.

Following this introduction, the *Protocol for Making Reasonable Efforts to Preserve Families in Drug-Related Dependency Cases* includes seven additional sections: Roles and Responsibilities of Decision-Makers, a Court Proceedings Checklist, Recommended Service Delivery Systems for Strengthening Families, an Overview of Statutory and Case Law, Model Programs and Approaches, Acknowledgements, and a Court Proceedings Master Checklist which decision-makers are encouraged to tear out and use.

The National Council of Juvenile and Family Court Judges recommends this *Protocol for Making Reasonable Efforts to Preserve Families in Drug-Related Dependency Cases.* It is intended to help prevent the unnecessary removal of drug-exposed children from their families and is to be used by law enforcement, public health, medical, drug treatment, social service, and legal professionals. It will assist them in defining, providing and enforcing "reasonable efforts" towards enabling drug-exposed children to remain safely at home instead of being unnecessarily placed in foster care, or to rejoin their biological families as soon as possible.

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SECTION II

Roles and Responsibilities of Decision Makers

Several types of professionals witness the impact of substance abuse on children and families on a daily basis. Included among these professional groups are law enforcement, public health, medical and treatment service providers, social service workers, and juvenile and family court judges.

This section outlines the interfacing roles and responsibilities of several types of professionals involved in drug-related dependency case decision-making. The questions in this section are designed to guide risk assessment and identify the family preservation service needs of drug-exposed children and their mothers.

THE ROLE OF LAW ENFORCEMENT

Law enforcement regularly encounters the children of substance-abusing parents. Children may be left alone or be near when a parent is arrested for substance abuse, presenting problems for law enforcement. Unfortunately, these are common occurrences as police often find themselves with children in their care because of parental unavailability or substance abuse. Their response in these situations can be instrumental in family preservation and stability.

Law enforcement can be an effective front line for constructively resolving situations dangerous to children. Many law enforcement agencies have rediscovered the historic role of creative alternatives to conflict and potential harm in family situations. There are new and flexible concepts of community policing and alternative dispositions (similar to the development of diversion programs for youth) that should be applied to families in which the parent's substance abuse poses a risk to children. In this role, law enforcement provides safety to each child, but steps are taken to ensure that children do not necessarily suffer because of their parent's substance abuse.

Law enforcement personnel should coordinate with social services in order to find the best plan for any such children. Social services can provide expertise in service delivery and extended family identification and investigation to avoid unnecessary shelter or foster care placement. The cooperative efforts between law enforcement and social services are a critical component for ensuring that children receive appropriate family services to avoid unnecessary placement.

Law enforcement must develop protocols with social service agencies to provide guidance to officers in the field and provide interdisciplinary training so that officers are familiar with the social services system. In this way, officers will avoid the apparently easy, but actually costly and destructive process of unnecessarily placing children in shelter care when it could be avoided by cooperation with social services and utilization of family preservation services.

Similarly, when parents on probation or parole, especially mothers with children in their care, are found to be using illegal substances in violation of conditions of their release or community sanction status, officers should be encouraged to use remedies that avoid removal of children whenever possible. Full knowledge of the effectiveness of alternative sanctions and the importance of avoiding significant, long-term harm to children by unnecessary foster care are crucial to changing case disposition priorities. Creative community sanctions include substance abuse treatment or recovery services, intensive, home-based services to protect the children, and other proven responses which may need to be expanded in many communities.

The following questions for police, probation and parole personnel, and other community law enforcement officials are designed to examine ways in which law enforcement authorities might assist in the process of preserving families affected by substance abuse:

Police and Other Law Enforcement Officials

- **Are there policies or procedures that currently preclude a focus on substance abuse treatment and family strengthening services as a preferred law enforcement response?**

- **Has training been provided to all personnel about substance abuse impact on the children of abusers, including the effects of placement, the potential for services to protect children in their own homes, and the need for mother and child-focused substance abuse treatment and recovery problems?**

- **Are there ways in which social services, mental health, public health or crisis-centered service providers can be immediately alerted so that they can assist in strengthening families and in preventing unnecessary detention out of the family?**

- **Has contact been made with potential caretakers in the household or extended family, including:**

    - **both maternal and paternal parents and extended families;**

    - **significant others that are not biologically related, but are within the family's definition of its kinship network?**

- **Is there a clear protocol describing alternatives to arrest and criminal prosecution (when appropriate as preferred course of action) except in cases of selling or dealing?**

- **Are there alternative routes provided so that children do not have to be removed automatically when a caregiver is arrested?**

- **Have police and social service agencies developed formal protocols which describe the ways in which families can be preserved and children can be placed with family when they come to the attention of law enforcement?**

Probation and Parole

- **Are authorities fully aware of alternatives to revocation or violation when relapse occurs in a substance-abusing client?**

- **Is there a protocol for assuring access to appropriate substance abuse treatment for mothers without separating the family?**

- **Have courts or departments established guidelines that encourage treatment and family preservation over prosecution and incarceration as a first resort except in cases of selling or dealing?**

- **Has appropriate training for all personnel been provided?**

- **Has a protocol been developed in conjunction with social services so that, in the event of an arrest, children will not be unnecessarily removed from their families?**

THE ROLE OF PUBLIC HEALTH, MEDICAL, AND DRUG TREATMENT SERVICE PROVIDERS

Public Health

Public health deals with the health and welfare of each community. It is a system of services which deals with prevention and health promotion. At the national level, the U.S. Public Health Service sets objectives for the nation to reduce preventable conditions that cause premature death or disability. At the state and local level, public health agencies provide direct services such as public health nurses and home visitors in a major effort to identify and assist the most needy families. Direct public health services include nutritional supplement programs for women, infants, and children; food supplement programs; infectious disease control, epidemiological consultation and data collection; and identification of disease trends. Public health decision-makers in cases involving drug-exposed children and their families need to know:

- **Do all in-state and local public health agencies maintain access to services, including public health nurses?**

- **Do all in-state and local public health agencies evaluate trends in drug usage during pregnancy, sexually transmitted diseases, and trends associated with alcohol and other drug usage?**

- **Do all in-state and local public health agencies acknowledge the importance of public health problems in their communities, including prenatal care, family planning services, infant mortality, and sexually transmitted diseases?**

- **Are judges able to identify gaps in services and enhance communication between social services and other public health care providers?**

Medical

Public health, medical, and drug treatment service providers are often the first professionals to encounter drug-exposed infants. One of the common ways in which infants are identified as having been exposed to drugs is the urine toxicology test. This test is performed either on the mother during pregnancy or immediately prior to delivery or on the infant immediately following birth. This test may become the basis of child abuse reports, child welfare investigations, and even removal of the child from the mother's custody. There is no question that some infants who are drug-exposed must be reported to child protective services, e.g., those who are abandoned by their parents or whose parents demonstrate an inability to care for them. However, mandatory reporting for positive toxicology cases and infants who are drug-exposed at birth, is an overly simplistic approach to a complex problem, and may actually harm rather than help children whom the policy is intended to protect.

Report of a drug exposed infant pursuant to a state's child abuse reporting law should be made only when it is necessary to protect the safety of the infant and when services available to the family fail to remove the risk of harm. All medical and other facilities which deliver babies should develop a protocol to assess risk and identify the family preservation service needs of drug-exposed infants and mothers. This protocol will assist public health, medical and treatment service providers in determining which cases must be reported to the social service agency.

The following questions are designed to assist professionals in identifying and understanding currently accepted risk factors for the infant of an illicit drug-using mother. It has been said that child neglect and abuse is a condition of parents that is manifest in the child. Licit and illicit drugs reach the fetus by crossing the placenta and can have direct toxic effects. Data support the fact that the infant can receive illicit

drugs, but there is a need for increased research to define the degree of permanent residual in these infants. The maternal history, including recognition of the signs and symptoms compatible with illicit drug use, is the key to suspecting the diagnosis. This diagnosis needs to be confirmed by appropriate screening and diagnostic toxicology on the mother and/or infant. It is important to keep an open mind about how to best manage the problems posed by drug-exposed infants. There is little research about what approaches are most effective in decreasing the use of illegal drugs during pregnancy. These questions address identification of the infant and the needs of drug-exposed infants and children.

- **Was the infant the product of a full-term, normal, spontaneous delivery with a normal birth weight?**
  Commentary:
  Infants who have normal, spontaneous deliveries and a normal birth weight and who have normal exams without congenital abnormalities and no signs of tremulousness, distress, or withdrawal symptoms, have a reduced chance of being positive on a toxicology screen.[4]

- **Was a toxicology screening test performed on the infant? Was a follow-up diagnostic toxicology done on the infant's urine?**
  Commentary:
  It is important to realize that infants can have the presence of illicit drugs and not manifest any medical problems at the time of birth. Withdrawal symptoms include vomiting, diarrhea, poor-sleep patterns, poor feeding, high-pitched cry, lethargy, seizures or tremulousness. Delayed withdrawal symptoms may occur as late as fourteen days after birth. Are there any later physical findings in infancy that are detected (e.g. cardiac defects, kidney defects, apneic spells, visual or hearing handicaps, etc.)?

- **What special health needs does the child have that would affect the level of care required for the child in the family or out of the family? Are there special problems in cuddling or bonding that need to be addressed?**
  Commentary:
  Specialized child care training for the natural parent(s) may be needed. Teaching the parent(s) both the need for and techniques of such special care handling of the infant should be the primary response. If foster care placement is needed, a specially trained foster parent(s) may be needed.

- **What is the nature and extent of drug exposure in the infant?**
  Commentary:
  What was the mother's history of drug use during pregnancy? Was treatment provided? Were there treatment failures?

- **Were there any complications at delivery? Especially abruptio placenta or infection of the placenta?**
  Commentary:
  A major complication which causes premature labor, is a premature separation of the placenta known as abruptio placenta. This may occur as a direct affect of constriction of blood vessels by cocaine but can also occur with alcohol and smoking. Infection of the placenta is another common complication.

- **What was the use of tobacco, alcohol and over-the-counter medicines during pregnancy?**
  Commentary:
  It is important to be aware that most polydrug use such as smoking or other drugs can have an addictive impact on the health of infants.

- **What illicit or licit drugs did the mother acknowledge use of during pregnancy?**
  Commentary:
  Studies indicate that polydrug use is the norm rather than a single drug.[5]

- **What was the extent and nature of the drugs during the pregnancy? Did the mother decrease drug use during pregnancy?**
  Commentary:
  It is known that mothers who become pregnant may have an aversion to alcohol but that cocaine and smoking are two of the strongest addictions to decrease or stop during pregnancy without adequate professional help.

- **When did the mother start receiving prenatal care and how many visits did she have?**
  Commentary:
  The access to quality care must be assessed. The average number of prenatal visits that enhance a positive outcome of pregnancy is eight. Visits should start either late in the first or the beginning of the second trimester.

[4] American Academy of Pediatrics, *PEDIATRICS*, Vol. 86, p. 4 (1990).
[5] Ibid.

- **What was the health status of the mother during her pregnancy?**
  Commentary:
  Special attention needs to be given to general physical and mental health, nutritional status, stress, other medical history, which may have a negative affect on the outcome of pregnancy.

- **Did the mother use any intravenous medications during pregnancy?**
  Commentary:
  It is well known that mothers using drugs intravenously are more susceptible to HIV and hepatitis B.

The physician or other health providers should be able to document objective evidence consistent with illicit drug use. This may include the presence of a positive toxicology screen and diagnostic confirmation in either the mother or the infant at the time of delivery. A secondary question is whether or not there has been any documented harm to the infant as manifested by withdrawal symptoms, seizures, slowed development or congenital malformation(s).

- **Interpreting the Toxicology Test to Determine Whether or Not Infants Have been Exposed to Illicit Drugs**

  The major test used in the United States at the present time is a collection of urine from the infant after birth. This test measures only a 48-hour time window of exposure. If a positive toxicology screen is obtained through a less sensitive test (immunophoresis), it must be confirmed with a reanalysis of the same urine specimen with a flame spectrometer which is diagnostic (e.g., less error). Screening tests are not diagnostic as the margin for error is great. Also, a mother can be taking drugs and the baby have a negative urinary screen at the time of birth. There is no known correlation between a positive toxicology screen in the baby and later serious impairment. Continuing education on technical and interpretive aspects for all disciplines is essential.

Drug Treatment Service Providers

Providers of alcohol and other drug services include professionals trained in the clinical, medical and peer-oriented treatment of chemical dependency in families. Alcohol and drug treatment and recovery services include: alcohol and drug education; counseling; and residential and outpatient services with a focus on integrating recovery with the acquisition of vital socialization skills. Treatment service providers involved with drug-exposed children and their families need to ask:

- **Has a comprehensive substance abuse assessment of the entire family and home environment been conducted? Has this substance abuse assessment been coordinated with public health and mental health assessments?**

- **Is family functioning impaired by substance abuse? If so, how?**

- **What is the comprehensive, inter-disciplinary alcohol and drug treatment plan?**

- **Does this plan include recommendations for appropriate treatment and recovery services for all family members?**

- **Have linkages been forged between all family members and the appropriate treatment and recovery services?**

- **Have family-centered services not traditionally utilized in the treatment of chemical dependency been included in the treatment plan where available and appropriate?**

- **What are the expected outcomes and how will treatment success be determined?**

THE ROLE OF SOCIAL SERVICE WORKERS

If the mother of a drug-exposed infant is prepared to accept voluntary services, the baby is healthy, and family support is available, formal intervention by a social service agency may be unnecessary. However, when formal social service agency involvement is initiated, the Adoption Assistance and Child Welfare Act of 1980, P.L. 96-272, requires agencies receiving federal foster care funds to make "reasonable efforts" to prevent the necessity for placing children in foster care, and whenever possible to reunify children in foster care with their biological families. The federal act makes clear that "reasonable efforts" to prevent placement or to reunify families must be made in each case for every child receiving federally funded foster care maintenance payments. The Act also requires that mandatory case plans for each child in federally-funded foster care specify the services that have been provided to prevent placement or facilitate reunification.

In addition, social service agencies are required to establish and maintain an adequate program of preventive and reunification services to qualify for increased funding for child welfare services. Establishing the required preventive and reunification service programs and making appropriate "reasonable efforts" in each case is the responsibility of the state social service agency and agency workers.

While developing a working definition of "reasonable efforts" in drug-related dependency cases, each state should bear in mind the underlying purpose of P.L. 96-272. The law was intended to ensure: (1) that no child be placed in foster care who can be protected in his or her own home; and (2) that when removal is necessary, reunification be considered a top priority before any other permanent arrangement is sought, unless it is not possible to reunify a family while protecting the child's safety.

Social service agencies must work with key people from all three branches of government, the public health, medical, drug treatment service community, and the private sector to develop a comprehensive continuum of family-focused, multidisciplinary drug-treatment and family strengthening services. These family strengthening services should enable the social service agency to respond to a drug-exposed child who is at imminent risk of removal from his or her home, by delivering services specifically designed to enable the child to remain safely at home. This will ensure that the social service agency is meeting its responsibility to make "reasonable efforts" in each case as required by federal law.

"Reasonable efforts" require the social service agency to look broadly at the family resources available to the child and to the parent(s). The family resources include the mother and natural/legal father and their extended families. In some instances, this may include unrelated persons who relate to the parents and child as if they are relatives. These potential resources may serve to stabilize the child's situation and increase the potential of the child to remain at home. The following are guidelines for determining whether social service agencies have made "reasonable efforts" to prevent placement in drug-related dependency cases.

- **Does the social service agency report include information on resources available to the family?**

- **Has there been adequate interagency or intra-agency coordination to ensure that *concrete* services have been made available in a timely manner so that the child is not removed as a result of delays in processing approval or beginning delivery of such services?**

- **How has the social service agency helped the substance abusing parent obtain treatment?**

- **Has there been a professional assessment by substance abuse professionals of the mother's substance abuse problems with recommendations for appropriate treatment?**

- **Has the agency identified appropriate programs that are experienced and qualified in treating women with the mother's particular addiction and problems with small children?**

- **Are the programs accessible to the mother financially as well as in other ways?**

- **Did the agency provide or help the mother obtain transportation and day care so that she could attend treatment?**

- **Have appropriate and frequent visitation opportunities been facilitated for all family members to promote reunification of those children who have been placed?**

- **Have appropriate, family-focused services been provided to promote reunification?**

- **Are active family strengthening services being continued after reunification has occurred?**

- **Has the availability/eligibility of the following service programs been examined:**

  - **family-centered drug treatment services**
  - **other family-centered services**
  - **intensive, family preservation services**
  - **counseling**
  - **emergency housing**
  - **in-home caretaker**
  - **out-of-home respite care**
  - **teaching and demonstrating homemakers**
  - **parent skills training**
  - **transportation**
  - **emergency cash assistance**
  - **government aid programs:**

    ***Women, Infants, Children food supplement program (WIC)**
    ***Food Stamps**
    ***Aid to Families with Dependent Children (AFDC)**
    ***Medicaid**
    ***SSI**
    ***Disability payments**
    ***Head Start or age-appropriate infant/child care program?**

When removal is necessary to protect a child's safety, reunification must be a top priority. Each family has a right to be immediately linked with an appropriate constellation of family-centered services directed toward reunification. These services should include, for example, frequent visitation by all family members before return and intensive family reunification services after return.

Ongoing assessment of progress toward reunification needs to occur to determine if additional services are needed or if an alternative plan for permanency is appropriate. Timeliness of assessment, services and final determination

of whether the child can be returned to the birth family is critical.

- **Has there been a full assessment of other members of the household, parents residing out of the home, extended family members and significant others, who may be vital resources in restructuring the capacity of the family to provide adequate protection for the children involved?**

- **Does the agency report reflect an offer of services, and appropriate contact made with these resources, such as intensive, home-based services, that are designed to improve the skills and capacity of the family to better protect children and monitor closely the circumstances that previously put children at risk?**

- **Has the father and his extended family been identified and contacted, and is he a placement option and/or resource for the child? Has the social service agency identified and actively pursued ex-tended family placement options?**

- **Has the agency been consistently active in the implementation of the case plans and assisting families in utilizing the resources needed to stablilize the family?**

- **Has there been an in-depth, holistic assessment of the family in context, including in-home evaluation of the family's environment, home, extended family and peers, including potential capacity as well as potential risks?**

- **Is there a process for individual tailoring of services and service packages for families?**

- **Have appropriate and frequent visitation opportunities been facilitated for all family members to promote reunification of children who have been placed?**

- **Have appropriate family-centered services been provided to families where a child has been placed to promote reunification?**

- **Are active family-centered services being continued after reunification has occurred?**

THE ROLE OF JUVENILE AND FAMILY COURT JUDGES

The delivery of comprehensive family preservation services by public health, medical and treatment service providers or social service workers can allow children to remain safely at home and make juvenile and family court proceedings unnecessary in many cases. When court referral becomes necessary, juvenile and family court judges are required by the Adoption Assistance and Child Welfare Act of 1980, P.L. 96-272, to ensure that "reasonable efforts" are made to prevent unnecessary foster care placement and to reunify the family if the child is removed.

To enforce this provision, juvenile and family court judges must determine in each case whether the agency has made "reasonable efforts." Judges must also assess the reasonableness of state plans which specify what services will be provided to prevent unnecessary foster care. A finding of "reasonable efforts" is necessary at shelter care, dispositional, and review hearings. In situations where there is significant risk attached to keeping the child at home, the Act specifies that the child be placed as close as possible to his or her family in order to facilitate continuing contact between family members, and in the least restrictive, most family-like setting.

Judges do not work in a vacuum. They learn of the situation facing children and their families from the legal proceedings, the report from the social service agencies and from the parties and their attorneys.

The quality of a judge's decision about children and their families is directly related to the quality of information the judge receives. Our legal system is built upon a process in which attorneys for the parties are given the duty to present evidence to the court and to test any evidence presented from other sources. From the different perspectives of the parties, the court is able to determine what happened and what should be done.

In the context of hearings related to the care, custody and control of a substance exposed infant, it is critical that the court have the benefit of independent views from the parents and the child. Trained attorneys and child advocates can provide these views.

The following questions are designed to help judges determine whether or not "reasonable efforts" have been made in drug-related dependency cases.

- **Have problems confronting the family or potential family strengths been identified in the following areas? When?**
  - **medical/health**
  - **psychological/social**
  - **environmental**
  - **educational**
  - **developmental**
  - **therapeutic family support**
  - **financial**
  - **housing**
  - **transportation**

- Have family-centered services been identified to address these problems or take full advantage of family strengths?

- Are the services appropriate? (If a drug treatment program is recommended, is the program qualified in treating women with the mother's particular addiction and with small children?)

- Is the social service agency ensuring the availability of these services? If not, why not? Is the social service agency providing financial assistance, transportation, health care, or other services?

- Did the family ask for additional or different services? Which ones? Are they appropriate? If they are, is the social service agency ensuring the availability of these services? If not, why?

- Did the services work? If not, Why? If not, what other services should be provided?

- If the child was removed, what alternatives were considered, e.g., (extended family, neighborhood or kinship support systems; non-abusing, non-custodial parent; least restrictive, most family-like setting)?

- What services are needed for family reunification? Were they provided? Were they successful? If not, why? If not, what else is needed?

- Are the attorneys representing all parties, especially the attorneys representing children, familiar with all aspects of the case and able to effectively present evidence to ensure that "reasonable efforts" are made to preserve families?

- Is a guardian ad litem or court appointed special advocate available? Has such an advocate been appointed? If not, why not?

PROTOCOL

SECTION III

Court Proceedings Checklist

Juvenile and family court proceedings are not necessary, and probably not desirable in most situations involving substance-exposed infants. Juvenile and family courts should be involved only when alternative services have not been offered or effective in providing support to the family and protection for the child. Where substantial risk of harm remains, the juvenile and family court has jurisdiction to assess the level of risk and determine what is in the best interest of drug-exposed children and mothers.

In cases which do proceed to court, all professionals must be prepared for a comprehensive judicial review of the facts. Courts must be satisfied that all professionals have made "reasonable efforts" to provide the family strengthening services necessary to keep the child safely at home, and children should be removed from home only upon a showing of substantial risk of harm. This checklist provides a comprehensive examination of factors designed to guide risk assessment and identify the family-centered service needs of drug-exposed children and their families at all stages of court proceedings.

I. SHELTER CARE/DETENTION HEARING

The shelter care hearing (sometimes called a detention hearing) is the first court proceeding in a juvenile dependency case. It occurs shortly (1-3 days) after the child has been removed from the parents. The court's primary concern at this critical juncture is whether "reasonable efforts" have been made to safely maintain the child at home and preserve the family by avoiding out-of-home placement. The shelter care hearing also addresses the following questions:

-have the parents been properly noticed of the proceedings?
-were preventive, family strengthening services considered or offered before the child was removed?
-what facts support a finding that the child is in imminent risk of danger?
-under what statutory authority was the child removed?
-have reunification services been provided after removal of the child?

This is an emergency hearing. The family is often in crisis. Great demands are placed upon the social service agency both to stabilize the situation and to provide services to permit the child to safely return home. Unfortunately, many social service agencies believe it is safer to remove the child as a preventive measure and return the child to the family only after a full investigation is completed. This perspective ignores the great risk of out-of-home placements, the loss of the child's family, and the expense. It also ignores the reality that safe caretaker situations can usually be found if adequate investigation is undertaken and services provided.

In many cases involving substance abuse, social service agencies often unnecessarily take custody of a baby shortly after birth while the baby is still in the hospital. Judges are then asked to detain the baby based solely upon the results of a positive toxicology screen and a confirmatory test which indicate the presence of drugs in the newborn baby.

A positive toxicology screen and confirmatory test are not sufficient basis for removal of a child. This testing can indicate only one exposure and does not prove chemical dependence. It also is but one factor indicating that the child may be at risk and does not mean that the mother and family cannot otherwise safely care for the child.

Judges must carefully review a recommendation to remove a child and social service efforts to prevent out-of-home placement. Comprehensive, careful judicial scrutiny of a drug-related dependency case at the shelter care stage includes consideration of the factors listed below. A failure to carefully examine alternatives to placement at this hearing puts the entire family at risk.

FACTORS TO CONSIDER:

Status of Infant/Child

- **Was the infant the product of a full-term, normal, spontaneous delivery with a normal birth weight?**
- **Has there been a positive result on a toxicology screen for either the infant or mother?**
- **What is the nature and extent of drug exposure in the infant?**
- **Has there been a diagnosis of fetal alcohol syndrome or fetal alcohol effect?**
- **A positive toxicology screen and confirmatory test are not sufficient basis for taking custody of a child.**
- **Does the child have special needs (e.g., clinical withdrawal, medical complications, immediate intensive medical care needs)?**

Status of Mother

- **What is the mother's history of drug abuse (including type of drug(s) used, length of use, period of last use)? What is the mother's or the custodial parent's recovery history?**

- Are there signs and symptoms of current drug use by the mother?
- What was the amount and quality of prenatal care?
- Has the mother made preparations for the baby at her place of residence?
- Is the mother willing and able to provide for her child's immediate medical needs and other specialized care? With help?
- What are the reports from the mother's collateral contacts, including the physician most familiar with the infant, current hospital staff observations, and current or past service providers?
- Is mental illness or retardation a major factor in the mother?
- Is there a willingness on the part of the mother or her partner to enter an appropriate drug rehabilitation program?
- Is language a barrier to social services for the mother or custodial parent?
- What strengths does the mother currently demonstrate? What strengths has she demonstrated in the past?
- What support systems, family or non-family, have been contacted to provide auxiliary support to the mother?

Status of Father or Non-Custodial Parent

- What is the legal status of the biological father or non-custodial parent?
- What is the relationship of the father or non-custodial parent to the child? What is the relationship of any other legal or biological parents to the child?
- What is the pattern of relationships among members of the non-custodial parent's extended families?
- If the whereabouts of the non-custodial parent are unknown, what efforts have been made to locate and contact the parents or the extended families?
- Has the father or non-custodial parent been notified of the hearing?
- Has the father or non-custodial parent acknowledged paternity?
- Is mental illness or retardation a major factor in the parent?
- Does the father or non-custodial parent want to plan for the child's future? Does the father or non-custodial parent want to participate in the child's future?
- Has the father or non-custodial parent ever had custodial care of the child?
- Does the father or non-custodial parent have an adequate home for the child?
- Can the father or non-custodial parent meet the special needs of a child?
- What is the relationship between the non-custodial parent and the custodial parent?
- What support systems, family or non-family, have been contacted to provide auxiliary support to this parent?
- Is the non-custodial parent's partner willing to assume care-giving support for the affected child?

Paternity Questions

- Will the putative father submit the paternity issue to the appropriate court for determination?
- Is the presumptive father the person listed on the child's birth certificate, court and agency documents?
- Is the child's paternity determined or disputed?

Home/Environment

- What is the quality of care received by other children in the home?
- What is the family's current and past involvement with social services (including past progress in compliance)?
- What type of support system is available through family, friends, professional caregivers or others?
- How visible will the infant be to persons other than the parents?

- **Does the mother have a home? Is there a current history of unstable residences? Has there been a home assessment?**

- **Does the baby have special needs not as immediate as those above, and what is the mother's ability to meet those needs?**

- **What is the partner's ability to assist the mother? Does the partner have any history of violent behavior or current pattern of drug use?**

Information the Court Needs from Social Service Agency

- **Previous involvement with social service agency(s).**

- **Mother's recent medical history and records.**

- **Child's recent medical history and records.**

- **Timely risk assessment and assessment of family strengths and capacity.**

- **Assessment of resources needed to ensure the safety of the child in the home.**

- **Drug use assessment of mother.**

- **Drug use assessment of partner.**

- **List of agency's "reasonable efforts" to avoid out-of-home placement of child.**

Examination of Social Service Agency Response

- **Has there been adequate intra-agency or interagency coordination to ensure that *concrete* services have been made available in a timely manner so that the child is not removed as a result of delays in processing approval or beginning delivery of such services?**

- **Have all relatives been contacted and their ability to care for the child been examined and assessed?**

- **How has the social service agency helped the substance abusing parent obtain treatment?**

- **Have referrals to treatment programs been appropriate?**

- **Have referrals been to programs experienced and qualified in treating women with the mother's particular addiction and problems with small children?**

- **Were the programs to which the mother was referred physically, financially, psychologically and culturally accessible?**

- **Did the agency provide or help the mother obtain transportation and child care so that she could attend treatment?**

- **Has the availability/eligibility of the following service programs been examined:**

  - **family-centered drug treatment services**
  - **other family-centered services**
  - **intensive family preservation services**
  - **counseling**
  - **emergency housing**
  - **in-home caretaker**
  - **out-of-home respite care**
  - **teaching and demonstrating homemakers**
  - **parent skills training**
  - **transportation**
  - **emergency cash assistance**
  - **government aid programs:**
    ***Women, Infants, Children food supplement program (WIC)**
    ***Food Stamps**
    ***Aid to Families with Dependent Children (AFDC)**
    ***Medicaid**
    ***SSI**
    ***Disability payments**
    ***Head Start or age-appropriate infant/child care program?**

- **Should the shelter care hearing be continued while additional information is gathered?**

- **Has a shelter care decision been continued before for reasons of inadequate information?**

Temporary Family Supervision/Interim Orders for the Social Service Agency

- **Contact relatives and obtain other leads from parents to consider as possible foster care placements.**

- **Contact all viable possibilities, arrange immediate drug-exposed-baby-caregiver training, and conduct timely risk assessment and assessment of family strengths and capacity.**

- **Finish all assessments already begun (as noted previously).**

- **If psychological/psychiatric evaluation ordered, set up appointment and ensure transportation for all parties.**

- **If no residence available, begin intensive search for at least temporary housing for mother and baby.**

- **Apply for financial aid for mother, if needed, with emphasis on coordinating intra-agency efforts.**

- **Evaluate the need for testing for hepatitis B, HIV (and any other sexually-transmitted diseases) for mother and baby.**

- **Ensure accessibility of the medical records of all parties.**

- **Immediately assess the safety of any siblings in the home.**

Temporary Family Supervision/Interim Orders for the Mother

- **Drug assessment.**

- **Immediate drug outpatient treatment.**

- **Immediate enrollment in Alcoholics Anonymous or Narcotics Anonymous program.**

- **Inpatient drug treatment if recommended by completed assessment.**

- **Daily visits with baby (this requirement can be decreased only if baby's medical condition warrants).**

- **Protective order if allegations of threat or abuse are present.**

Temporary Family Supervision/Interim Orders for the Partner

- **Same as above.**

- **Visits with baby at social service agency's discretion.**

II. ADJUDICATORY/DISPOSITIONAL HEARING

As the result of the shelter care hearing, a child may be placed in a shelter care or returned to the mother or other family members with supportive services. At the adjudicatory hearing, the court determines first whether the child comes within the jurisdiction of the court. That occurs usually by a reported admission by the parents or after a hearing on the petition is held and evidence is considered by the court.

During a dispositional hearing, the court must decide what is to happen to the child. To assist it in its decision, the court reviews a social report with recommendations prepared by investigating social workers as well as the evidence and comments that may be offered by the parents, attorneys and other interested parties. Much of the information will report on progress that the parents have made since the shelter care hearing, including the availability and utilization of services.

Placement of the child is the critical dispositional issue. The court must determine whether "reasonable efforts" have been made to preserve the child's family. A child should not be removed from parental custody and care unless there is a serious risk of harm if placed at home. Before making that decision, however, the court must determine:

1) Whether the utilization of services could permit a child to return safely to the family;

2) Whether the social services agency could provide these services.

The factors listed below are intended to assist the court and those appearing before the court to ask the questions necessary to make the important placement decision. In addition, whenever the child is placed, these factors will guide the court in determining what services must be available to the family and what the family is expected to do to maintain the child at home or to reunify.

FACTORS TO CONSIDER:

For the Child

- **Is regular medical care needed for the child, including appropriate therapeutic interventions? (If so, mother should be notified and required to attend all such appointments with the child.)**

- **What are appropriate support services for child (e.g., physical therapy, counseling, health and education intervention)?**

If the Child is in the Home

- **Have all items noted in the shelter care hearing section been considered?**

- **Is there a specific deadline for completion of all assessments?**

- Should random drug testing be ordered (paid for by social services)? (Be very clear why you are ordering this. If no substantial reason, do not so order.)

- Is a drug rehabilitation program needed? (If residential treatment is needed but is not yet available, interim drug rehabilitation services should be instituted.)

- Are intensive family preservation services needed?

- Are Alcoholics Anonymous or Narcotics Anonymous or other self-help groups needed?

- Is drug-exposed-baby-caregiver training needed for mother and all other secondary caregivers?

- Is supportive/peer/therapeutic group support needed?

- Is respite care needed (at least once a week)?

- Is regular medical care needed for mother?

- Are efforts to stabilize housing needed?

- Should family members be designated for specific assistance?

- Should child care duties of partner be specified?

- Is assistance needed from a para-professional such as a home visitor, peer advocate, teaching and demonstrating homemaker, or a family service assistant?

- Are other kinds of parenting instruction needed?

- Is a public health nurse needed?

- Has screening for family violence and counseling been coordinated with recommendations in protective orders?

- Is psychological or educational therapy needed?

- Is job training needed?

If the Child is Out of the Home

- See all of the above.

- Do foster parents need any of the following services:
  - drug-exposed-baby-caregiver training?
  - respite care?
  - support groups?
  - ongoing training?
  - increased foster care payments related to special needs children?
  - at least weekly face-to-face contact with social service worker?

- Is a specific plan needed to avoid multiple placements? Is there a specific plan for re-placement of the child if re-placement becomes necessary?

- Visits:
  - Are visits regular and frequent? (A minimum of three times a week at two hours per visit, but optimally once a day unless medically contraindicated for the child.)
  - Are visits supervised or unsupervised?
  - If supervised, have specific findings to support this been stated?
  - Does supervision consist of a teaching or role model experience?
  - What is the frequency, time, duration and place of visitation?

- Has the social service agency shown cause why it cannot offer specific housing aid if lack of housing is a primary reason for continued foster care placement?

- Are intensive family reunification services available?

Possible Placement with Relatives

- Is alcohol or other drug abuse present?

- Is there any history of abuse, neglect or violence in the home?

- What are the relative's parenting skills, ability to understand the child's needs and ability to meet those needs (especially special care), access to medical care and other support services for the child? Could support services improve the relative's capacity to care for the child?

- Is the relative motivated and cooperative?

- Does the relative have a positive relationship with the parents? Is the relative also willing and able to set and enforce limits in the child's best interests?

- Is there a concomitant willingness and ability to protect the child?

- **Is the living environment adequate and safe for the child? Could housing assistance be made available to make the living environment adequate and safe?**

III. SUBSEQUENT JUDICIAL REVIEW HEARINGS

Once a dispositional order for substitute placement has been entered, the court must make a finding that "reasonable efforts" to rehabilitate and reunite children and family have been made at all subsequent review hearings.

In order for states to be in compliance with P.L. 96-272, review of these cases must be thorough, substantive and occur on a regular basis at least at six-month intervals following the adjudicatory/dispositional hearing. Unfortunately, in many jurisdictions, these hearings do not take place regularly and when they do they are perfunctory. Careful attention to the progress of the case is essential if the child and family are going to be well-served.

Reviews may be conducted by a citizen, administrative and/or judicial process. Regardless of who is conducting the review, progress on the family reunification/permanent plan and all of the factors previously noted in the shelter care and dispositional hearing sections should be considered. The following are additional factors to consider when deciding whether to return a child with a reunification plan in place:

FACTORS TO BE CONSIDERED:

- **Has the mother/partner complied with the reunification plan, especially made progress in drug rehabilitation?**
- **Has the mother/partner continued drug use or shown current signs and symptoms of drug usage? (It is unreasonable to expect perfection but look for a promising trend in spite of relapses as well as *involvement* in drug rehabilitation.)**
- **Does existing drug use affect the capacity of the mother/partner to protect and nurture the child? If so, how?**
- **Is the mother prepared for the child's homecoming? Is the living environment adequate and safe for this child?**
- **Does the child present any special needs? Will the mother be able to meet them?**
- **What are the recommendations and observations of the current professional support system, including the child's foster parents?**
- **Has the mother/partner acknowledged a drug problem, and what impact has this had on the child?**
- **What is the mother's/partner's present physical and emotional abilities?**
- **If certain needed services are still unavailable, what efforts have been undertaken to find appropriate substitute services?**
- **What is the frequency and quality of visits and level of bonding?**

PROTOCOL

SECTION IV

Recommended Service Delivery Systems for Strengthening Families

The use and abuse of alcohol and other drugs has been a recurrent theme throughout American history. However, over the past 20 years, alcohol and other drug abuse has become one of the most serious health and social problems facing the nation. Substance abuse crosses all societal barriers, affecting families at all socioeconomic levels. It impacts most grievously upon disadvantaged and minority populations which are least equipped to negotiate complex law enforcement, public health, medical, mental health, drug treatment, social service, and judicial systems.

Many practicing professionals within the substance abuse field believe that chemical dependency is a primary disease entity which is progressive and potentially fatal, although treatable through abstinence and recovery. Most substance abuse professionals generally view abstinence as the safest foundation for recovery because they believe that once individuals have become chemically dependent it is difficult and often impossible for them to engage in "controlled" alcohol and drug use without reverting to compulsive and thus dangerous abuse patterns. These professionals do accept, however, that establishing abstinence and recovery is a lifelong process and that relapse or brief periods when individuals resume using alcohol or other drugs, is a natural and expected part of that process. While recognizing that one or more relapses are normal in the course of treatment and recovery, in most instances, abstinence should remain the goal of treatment for parents abusing alcohol or other drugs.

A biopsychosocial approach to the treatment of drug abuse recognizes that some individuals may be physiologically predisposed to chemical dependency problems, and that substance abuse may lead to potentially fatal, physiologic effects on the body. In addition to physical factors, however, advocates of this treatment approach focus on the effects of learning, the environment, and social context for the development, maintenance and treatment of substance abuse. Primary to this approach is the belief that individuals are capable of lifestyle change and of learning new behavioral, psychological, and social skills to affect addictive or destructive habits and behaviors. The course of treatment is individually tailored to individual needs, preferences, and circumstances. Some clients choose abstinence, others are assisted in their efforts to reduce or control alcohol or drug use. A combination of cognitive-behavioral and ecological techniques are utilized. Counselors approach treatment as an educational process. Problems are viewed as skill deficits rather than personality traits, and programs tend to focus on necessary skill and behavioral acquisition.

A recent report of a study by a committee of the Institute of Medicine, Division of Mental Health and Behavioral Medicine, *Broadening the Base of Treatment of Alcohol Problems,* summarizes an emerging national position that is applicable to alcohol and other drug addiction and that proponents of both the disease and biopsychosocial approaches can endorse:

- **There is no likelihood that a single cause will be identified for all instances of alcohol problems.**
- **There is every likelihood that the range of causes that interact to produce alcohol problems in the population can be identified.**
- **Alcohol problems will prove to be the result of different interactions of different etiological factors in different individuals.**
- **While effective drug treatment will be served by a more precise knowledge of etiology, effective treatment is possible in the absence of such knowledge.**

Substance abusing women and families have many complex problems and require a variety of carefully integrated services. The most effective service delivery programs identify and provide for the extensive needs of substance abusing women and their families. These needs may include: treatment for mothers to stop the abuse of alcohol or other drugs; treatment for children to address developmental problems; and support services to restore the family to a safe and healthy lifestyle (e.g., income and medical assistance, housing, parent education, job training, child care, transportation).

Programs which take this approach are interdisciplinary. They use the resources of public and mental health, medical, social service, legal, educational, and other professionals. The programs are integrated, assuring access to all services the family requires to meet its needs. This approach to service delivery may be described generally in three categories: 1) multidisciplinary or interdisciplinary teams; 2) interdisciplinary case management; 3) specialized programs designed for women, infants, and children.

1. **Multidisciplinary or Interdisciplinary Teams**
   These teams may be used in the intervention process as well as during the recovery process. Since research demonstrates that during pregnancy and immediately after delivery women are highly motivated to seek alcohol and drug treatment, these teams should be available in a hospital setting.

   A multidisciplinary team should include but may not be limited to: a health professional, a social worker, a mental health professional, and a substance abuse professional. During intervention, team members educate the mother about the consequences of her continued drug use and offer a specific recovery plan which includes access to treatment and support services in her community.

2. **Interdisciplinary Case Management**
   At the point of intervention and throughout recovery, many women and their families have a bewildering

array of professionals assigned to them. In California, Minnesota, and other states, health, mental health, welfare, probation, and other professionals are beginning to develop collaborative case management systems so that chemically dependent women and their families receive timely, appropriate services.

Ideally, each woman is assigned to a single case manager. The case manager, in cooperation with a multidisciplinary team, conducts a comprehensive assessment and develops an individualized recovery plan for the woman and her family. The woman participates in the development of her own case plan, and the case manager remains in contact with the woman and her family throughout their involvement in various services or programs. This provides continuity and avoids gaps in service delivery.

3. Specialized Programs Designed for Women, Infants, and Children

These programs may be offered in a community and/or residential setting. Their most important feature is that they offer access to a full range of services within a single treatment setting to accommodate the needs of both women and children. They have been variously categorized as community-based, outpatient, intensive day treatment, and residential programs.

The significance of these specialized programs should not be underestimated since many women will not seek treatment in traditional settings because they fear the loss of their children. These programs are designed to meet the alcohol and other drug treatment needs of mothers, the health and developmental needs of children, and promote a healthy relationship between the mother and children. In order to have a truly effective program of this nature, elements of interdisciplinary case management must be present. The range of support services that make these programs effective are:

- **Specialized medical care and health services for both the mother and children**
- **Periodic home visits by a public health nurse**
- **Early childhood and parent education**
- **Peer group support and education**
- **Temporary and therapeutic foster care and specialized respite care**
- **Child care**
- **Employment and training services**
- **Transportation**
- **Income assistance**
- **Extended family support and counseling**

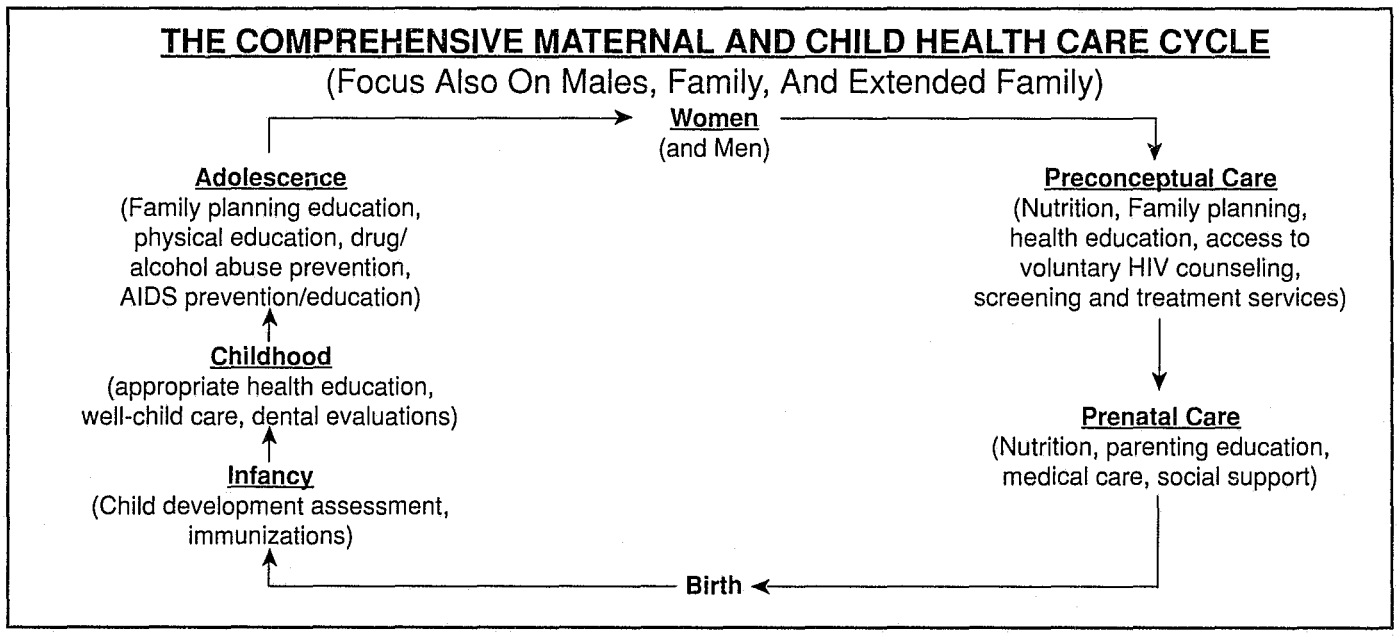
PERINATAL, PUBLIC HEALTH AND MEDICAL RESOURCES

Infants, children and families who are exposed to licit or illicit drugs need to have a comprehensive, continuous source of care. This source of care should be able to provide preventive health care services, monitor child development and health, and make suggestions regarding parental support. Pediatricians and family medicine physicians are two types of medical professionals who can provide these services. Family practice has the added advantage of dealing with the mother, family and children in a comprehensive fashion. Because of funding allocations, public health and maternal and child health services tend to be concentrated in communities with the greatest economic and social need. Community-based agencies offering comprehensive maternal and child health care services are often excellent resources. Many agencies are proving effective in opening access to treatment programs for children and families. Public health nurses are an excellent resource for home visits, assessing parenting capabilities, and providing guidance for infants who have been drug-exposed.

The term "perinatal" refers to the critical period from conception to six weeks post-partum. Perinatal care encompasses prenatal services, labor and delivery care, infant follow-up services for one month, and maternal follow-up services including a six-week check-up and family planning.

Maternal and Child Health Services are a part of the Social Security Act under which federal monies are allocated for perinatal care, special needs children and preventive services such as immunizations. Judges should be able to determine the availability of these services in their communities in cases involving drug-exposed children and order such services. Drug-exposed infants are considered children with "special needs," and they are eligible for a wide array of no-cost services.

A comprehensive Maternal and Child Health Care Cycle is provided in the following diagram.



Perinatal care is the most important part of this cycle of care, and is considered the keystone to prevention for healthy families and healthy children. Awareness of this comprehensive cycle can help all professionals assess the basic health care, social needs, and future support required by each mother, child and other family members. Mothers, children and families need support in every stage of this cycle. Prevention programs are needed throughout each stage, particularly during adolescence when involvement in early, school-sponsored drug and health education programs can help to prevent intrauterine drug exposure. Involvement of both mothers and their partners in preconceptual and perinatal care, and the establishment of strong public health services, including adequate nutrition and family planning services, are integral to good perinatal care.

The earlier adequate health care education and therapeutic intervention occurs in the life cycle, the greater the chance to break the often intergenerational cycle of substance abuse. Pre-adolescence and adolescence are particularly critical times when alcohol, cocaine, and other drug use and sexuality issues need to be addressed by families, schools, religious institutions, and other support systems. Males as well as females must be educated to understand that the use of licit and illicit drugs, sexual intercourse and conception often occur together, and they must be made aware of the negative impact their actions may have upon a developing fetus.

- **Decision-makers confronted with cases involving drug-exposed parents and their children should become familiar with all medical and public health services available either publicly or privately in each community.**

- **Other community resources should be examined to reduce barriers to health care for drug-exposed infants, mothers and their families.**

- **Since drug-exposed infants are considered children with special needs, early intervention services should be made available in the community.**

FAMILY CENTERED SOCIAL SERVICES

Drug-affected families are entering all child and family service systems. Increasingly, traditional programs are being modified and new services are being developed to meet their needs. Clinical methods, duration of treatment, caseload size, the nature of concrete services provided, and other program components vary widely. Even wider variations exist in the vocabulary used to describe these programs. The most broadly descriptive category is that of "Family Focused" or "Family Centered" services, which generally are designed to strengthen and support families whose children may or may not be at imminent risk of placement outside the home. A more defined category of program provides "Home-Based Services" to families in their own homes and communities, involving varying degrees of intensity and problem severity.

These services may be used to prevent substance abuse, or to help families whose problems are less severe. Other services support and strengthen families in which the caregiver is returning from inpatient treatment. Many serve as a valuable supplement to substance abuse programs, providing specialized help in parenting, advocacy, or life skills training.

The most desirable programs increasingly tailor services to meet the needs of individual families and individual family members. They offer a holistic approach, involving the client's home, neighborhood and community, as well as skills training and drug treatment. These programs emphasize work with the extended family, as well as the primary caregiver(s). They work together, in concert with substance

abuse programs to help clients meet long-term as well as short-term goals. The most successful programs allow for flexibility in the length of sessions and number of sessions per week. They are respectful of diversity and client values. They utilize state of the art technology by emphasizing initial and ongoing staff training.

Many programs are reducing caseloads to 5-10 families per worker, and are serving families in their homes. Many use teams including a social worker and a paraprofessional to help families with concrete needs as well as help in resolving psychosocial problems that could lead to out-of-home placement.

A subset of these programs, called "Intensive Family Preservation and Reunification Services" (IFPS) was designed to serve as an alternative to out-of-home placement. Rather than relieving family pressure by removing a child, these programs are aimed at adding resources to strengthen families during crises, and provide skills training to empower families to prevent crisis recurrence. They serve only families in crisis for whom at least one child is at immediate risk of out-of-home placement. Their goals emphasize child safety and resolution of problems directly related to the potential need for out-of-home placement. In cases where the child has already been placed, IFPS programs facilitate reunification of families by providing intensive support and skills training during the re-entry period, in order to prevent re-placement of children.

The most widely replicated Intensive Family Preservation and Reunification Program is HOMEBUILDERS. This program, which began in Washington State in 1974, has now been replicated at over 250 sites in 30 states and several foreign countries.

IFPS programs feature short-term, intensive interventions in the family environment. Workers serve only two families at a time. They are on call 24 hours a day, seven days a week in order to monitor families' progress and assure children's safety. All work occurs in the home or natural environment. IFPS staff are able to engage previously reluctant families by meeting them on their own turf and their own terms. This service approach emphasizes teaching and modeling of skills to diminish stress and add resources. For four to six weeks, counselors meet with families in their homes and work with the parents and children to restore family functioning to allow family members to live together safely. These programs serve a variety of populations, including abused and neglected children, status offenders, delinquents, runaways, mentally ill children and adults, families affected by disrupted adoptions or family reunifications. Program costs are substantially less than placement.

Intensive Family-Based Services are not designed to stand alone, but rather as an alternative to placement in a continuum of care. Once crises have been resolved, most families are functioning well enough to allow them to take advantage of less intensive, ongoing family-centered and home-based services.

IFPS Program Characteristics

- **Client Population:** Families in crisis, all families with children at risk of imminent placement. Presenting problems include child abuse and neglect, runaway children, mental illness, developmental disabilities, delinquency, and substance abuse.
- **Preventing Unnecessary Placement:** A major goal of IFPS is to prevent unnecessary placement in foster, group, or institutional care.
- **Service Provided in the Natural Environment:** All IFPS services are delivered in client homes, schools, work settings, and neighborhoods, except on rare occasions when clients request otherwise.
- **Intensity of Services:** IFPS counselors average a minimum of 8-10 hours of face-to-face or telephone contact with each family per week. Hours are allocated according to family need rather than rigid guidelines.
- **Brevity:** The intervention is time-limited. In many programs, client families are seen for four to six weeks with an option for an extension if placement has not been averted at that time.
- **Low Caseload:** IFPS caseloads are usually two to four families per worker at any one time. Most counselors see a total of 18 to 24 families per year.
- **Same Day Intake:** Counselors are available to see families within 24 hours of referral.
- **24-hour Availability:** Counselors are accessible to clients 24 hours a day, seven days a week including holidays through their home phones or beepers.
- **Single Counselor with Team Backup:** A single counselor provides services to client families. Backup is available from supervisors and teammates in circumstances where little progress is occurring or counselor or client safety is jeopardized.
- **Flexibility of Services:** Services are tailored to individual family situations and to the needs of individual family members. Sessions are scheduled when and where the problems are occurring in order to have the most impact.

The IFPS Experience With Drug-Affected Families

During the 1970's and through the first half of the 1980's drug treatment was not a focus of family preservation programs. Certainly many families had substance abuse problems, but they were referred to traditional drug treatment programs. By the late 1980's, however, the increased use of crack cocaine, along with growing poverty, increased the number of families debilitated by substance abuse. IFPS workers could no longer find services that were appropriate for drug-affected families. Many addicted mothers would not enter inpatient programs because, in order to do so, they would have to place their children in foster care. Once in treatment, they would not stay, because they were unable to relate to programs that had originally been designed for white, middle class, male alcoholics. If they did complete a program, relapse was common upon re-entry to the community.

IFPS programs still refer to drug treatment programs where available and appropriate. But many programs are now incorporating drug treatment technology into their services, providing assessment, teaching employment skills, and helping clients learn new ways to prevent relapse. Drug treatment programs are beginning to incorporate family strengthening strategies into their models. Within the next five years, it is likely that many new models will integrate the strengths of both approaches.

SUBSTANCE ABUSE TREATMENT

Until very recently most alcohol and drug treatment programs were oriented almost exclusively toward serving individual men. The historical roots for this orientation can be found in Alcoholics Anonymous, the largest and best known self-help organization for alcoholics which has been expanded to address other addictive problems. The founders of Alcoholics Anonymous were two professional white middle-class men. Initially, women were not included in Alcoholic Anonymous meetings at all. After women did gain entry into the Anonymous fellowship, there was little recognition of their primary role as caretakers of children. Traditional residential alcohol and drug treatment programs do not accommodate children. This forces many women to choose between entering treatment and maintaining their children. Outpatient services, even where available, are often not accessible to women because of a lack of child care, transportation and income. The paucity of effective services for women and children still constitutes a national emergency. But there are currently a number of new and effective model programs for pregnant and parenting women which could be successfully replicated if the health of women and future generations of children and the integrity of families were to become a priority.

There is a key difference between the new, family oriented, women-specific programs and traditional alcohol and drug treatment programs. The key difference is that family oriented programs view women and children together as the unit for recovery, rather than the individual. Spouses are also included in these programs when there is no history of family violence or intimidation. Another unique characteristic of women-specific programs is that they provide age-appropriate services to infants and children. This is particularly crucial for drug-exposed infants who must receive developmentally appropriate services soon after birth or suffer a lifetime of damage.

Women-specific programs emphasize habilitation rather than rehabilitation. They recognize that recovery for many chemically dependent women means acquiring basic practical and social living skills for the first time rather than returning to pre-established norms of skill and behavior. To this end, women-specific programs do not isolate concrete supports, such as transportation, housing, income maintenance, job training, and literacy, from formal alcohol and drug treatment, but include them as a core part of the women's recovery program. Finally, these programs recognize that there is no "quick fix" for chemical dependency and that recovery is an ongoing process requiring a flexible, comprehensive continuum of services for women and their children over a significant period of time.

Drug Treatment and Recovery Services

Health and human service agencies in collaboration with drug dependency treatment providers are beginning to forge new integrated service systems. These family-focused programs are designed to address the woman, her infant, older children, and other key family members as the unit of recovery. Programs with this orientation include infants and children on-site whenever possible. The goal of these programs is to promote the recovery and overall health of the mother, infant, and older children; promote recovery for the family as a whole; and strengthen and preserve the family whenever possible.

- **Outpatient Alcohol and other Drug Counseling** (Often called outpatient "drug-free" counseling because it does not use methadone or other drugs in treatment and is generally oriented towards abstinence.)

  Many chemically dependent women do not want to enter residential treatment because it means loss of their children, job, or housing, or because they feel they do not need such intensive treatment. A recent survey estimates 25-40% of pregnant or parenting women require residential care to initiate sobriety.

  Outpatient programs offer women a range of services including individual, group, family, and multi-family alcohol and drug counseling; psycho-

logical counseling; parenting skills training; and alcohol, drug, and health information. Recently, typical outpatient services have been linked with other services under a new designation of "Intensive Day Treatment" that is also included here in the description of the continuum of care.

Some outpatient programs also offer age-appropriate counseling and therapy for children and adolescents who are either at risk of becoming chemically dependent due to their parent's drug use or are already involved in substance abuse.

Short-term, intensive, outpatient assessment groups can also be offered for substance-abusing women who are at risk of losing their children due to abuse or neglect. These groups offer basic assessment, alcohol and drug education, support, and help to motivate the mother to seek further treatment.

A new and effective type of program is offering Early Assessment and Development Intervention for drug-exposed infants; mother/child bonding and therapy assessments for the mother and child; alcohol and drug awareness education; and counseling, education and psychotherapy treatment for the mother all within one treatment setting.

In order to utilize outpatient services effectively, women must have available child care.

- **Women-Specific Residential Alcohol and Drug Treatment Programs**
  Some women require residential treatment in order to initiate recovery. Often, this is because they live in a home or community environment saturated by alcohol and other drugs. Sometimes it is due to the degree of chemical dependence they are experiencing. Women dependent on alcohol, barbiturates (sleeping pills), or benzodiazapenes (valium and librium) may require medical detoxification, although usually the need for medical supervision is of short duration. In such instances, hospitalization may be required and may be reimbursable under Medicaid in many states.

  The availability of alcohol and drug treatment specifically designed to meet the needs of women and children is tragically limited. This is particularly true with regard to residential treatment, which is the most expensive of all treatment modalities.

  Residential treatment falls into two broad categories: "Medical Model," treatment takes place in a hospital setting under medical supervision; and "Social Model," treatment takes place in a group home or therapeutic community where peer interaction with other recovering individuals and life skills building are the primary vehicles of recovery. Recently, the program content of both models has become quite similar, emphasizing peer supports, 12-step linkages, and group, individual, and family counseling. The major difference is that hospital-based treatment is generally short-term (28-45 days) and expensive (up to $30,000 per month), while social model treatment is longer term (28 days to 18 months) and is significantly less expensive ($2,500 to $8,000 per month).

  There are three types of women-specific residential programs. Most are offered primarily in social model settings, except when the health status of the mother or the infant is at high risk.

  1. **Specialized Pregnant, Postpartum Women and Infant Residential Programs**
     These programs have only begun to develop in any significant numbers over the last 2-5 years. They are designed to address the alcohol and drug treatment needs of mothers; the health and developmental needs of infants; and the development of an optimal mother/infant relationship. The federal Office for Substance Abuse Prevention (OSAP) is currently funding the implementation of these programs nationwide.

  2. **Specialized Mother/Child Residential Programs**
     These programs accept women and children of various ages. The major challenge faced by these programs is meeting the developmental needs of a range of children's age groups while fully addressing the needs of the mother.

  3. **Women-Only Programs**
     Women-only programs have been in existence since the 1970's and are appropriate for women who do not have custody of their children, or who need to focus on their recovery but have not yet been able to address parenting issues.

- **Intensive Day Treatment**
  In a recent informal client survey conducted in Solano County, California, women were asked which type of service they most needed and preferred. A majority answered that Intensive Day Treatment was their first preference.

Intensive Day Treatment programs offer women an integrated matrix of services in a centralized setting. These programs, also newly developed, serve as a central hub for case management, alcohol and drug counseling, parenting education, and access to the entire range of concrete services. Ideally, day treatment programs offer a safe, sober and nurturing environment open 4-7 days a week where women can pursue structured recovery-related activities. These centers provide basic child care. Some programs operate in conjunction with Head Start or other similar existing programs.

- **Sober Living Residences**
  Sober Living Residences, also called half-way houses, are designed to relieve the problems of homelessness and unsafe housing by providing a safe, nurturing environment for low-income women who are at a critical stage in their recovery. Women accepted into sober-living homes have completed alcohol and drug treatment and are expected to maintain sobriety, attend weekly Anonymous meetings (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous), and participate regularly in ongoing support groups as needed. Although most of these residences currently serve only women, some soon plan to accept women with children.

- **Therapeutic Foster Care and Specialized Respite Care**
  Some mothers must have short-term therapeutic foster care available to their children because they must enter residential treatment or for other reasons. Foster home parents who have been specifically trained in chemical dependency or who are recovering from alcohol and drug dependence themselves can offer invaluable support to both the children and their mother. Kinship placements can also be enhanced by the provision of chemical dependency education.

  Structured respite care is also an invaluable service in reducing the possibility of parental child abuse or neglect and further assisting the normal development of drug-exposed children. "Structured respite care" is a modification of traditional respite care services in which therapeutic child care is provided to recovering mothers while they participate in some pre-arranged activity or task off-site. Depending on the stage of maternal recovery, it is thought that unstructured free-time can pose a potential threat to the recovery process.

Regardless of the type of maternal drug-treatment, drug-exposed infants who remain in the custody or caregiving realm of their recovering mother/parents, should receive some therapeutic, early intervention services. This will help to ensure the infant's well-being by keeping the child visible in the larger community, and help ameliorate any adverse effects of perinatal drug exposure.

Culturally appropriate didactic parenting education and hands-on parent modeling are very important services for recovering mothers. In many instances, drug and alcohol-dependent women were themselves reared in dysfunctional families and are adult children of alcoholics or drug users. This situation has profound implications for a mother's own ability to parent and meet the dependency needs of her special care children. Because development of a routine, and consistent program attendance and participation in special activities, health care appointments, etc., is therapeutic for a recovering family, transportation services must be included as an integral part of service delivery.

While early intervention services must be directed to drug-exposed babies, an appropriate focus on infants and toddlers need not exclude other high-risk older children in the family. Based on much of the current prevention literature, school age and early adolescent children of drug-abusing parents are at great risk, not only for being abused or neglected themselves if their parents do not receive services, but they are at risk of becoming our next generation of drug and alcohol users. By conducting family assessments, which include all family members, appropriate counseling, remedial, and prevention services can be provided for high-risk youth in these families.

OPPORTUNITIES FOR JUDICIAL LEADERSHIP

This protocol places great importance on the need for a continuum of services for substance-abusing parents and substance-exposed children. However, it is recognized that many services are limited or non-existent in many communities. This is especially true in rural America where clients may need to travel great distances to receive treatment. While there are many challenges to implementing the recommendations of this protocol, critical steps can be taken in the following areas:

Fiscal

The perception exists that there is not enough money to establish home-based services and that these types of services are more expensive than traditional services. These two misconceptions can easily be dispelled. Increased government funding may not be needed, but rather a reprioritization of needs. States and counties must re-examine priorities. Government leaders at all levels must be made aware of the high and escalating cost of foster care and other out-of-home placements. In some

instances, the search for innovative ways of handling substance abuse cases may be cost-driven. It is important that hard data be available for dissemination on the fiscal implications of pilot projects so that all concerned recognize that they are cost-effective in both the short- and long-term.

Professional Education

Although this publication provides professional checklists, it cannot prepare all professionals for the wide range of drug-involved families they will encounter. Education of all professionals involved in these cases is necessary so that all parties are aware of the ramifications of their recommendations. The result and implications of drug toxicology screens and relapses must be evaluated within the context of the disease. Professional, interdisciplinary training should examine such issues as the effectiveness of the "medical model" of residential treatment vs. the "social model," and the feasibility of controlled use vs. abstinence.

The "reasonable efforts" requirement provides attorneys for children and parents with a strong tool for enforcing their client's rights to services and to family integrity. It offers agency attorneys a way to determine that the agency is fulfilling its responsibilities, and that frivolous cases are not brought to court. Juvenile and family court judges should play a leadership role in ensuring that attorneys and volunteer guardians ad litem have substantial, initial, and ongoing training on issues related to child abuse neglect; the role of social service and law enforcement agencies; the court process; the developmental needs of children and their sense of time; the characteristics of drug-involved families; and the alternatives for services designed to preserve or reunify families or to achieve other appropriate permanent plans for the child.

Barriers to Interdisciplinary Communication and Cooperation

It is essential that the legal rights of all parties be recognized in proceedings before the court. Court orders may be used to improve professional and paraprofessional communications at all stages of treatment. Interdisciplinary treatment teams and interagency protocols must identify and mitigate any systemic barriers to communication.

When the court is addressing a mother's ability to care for high risk infants, information from mental health, medical and substance abuse professionals is critical. Detailed information must be made available from law enforcement agencies. This information should examine the risk of violence, history of illicit drug use by family members, criminal records and illegal activity in the home environment.

Socioeconomic Realities

The concrete services recommended in this protocol are based upon the fact that the vast majority of drug-exposed families and children coming before the court are poor and the head of the household is female. All of the pragmatic and logistical issues necessary to treat these families must be recognized: emergency housing; financial assistance; food stamps; nutrition services; transportation; medical care; day care; and all the other basics of family life.

Public Education/Media

It must be acknowledged that substance abusing parents are not typically viewed with sympathy by government leaders or the general public. Society's continued ignorance of substance problems can only be overcome through a major public relations initiative redefining the importance of the parent-child bond.

As communities initiate family strengthening strategies with these parents and children, thorough media groundwork needs to be laid. The concept of keeping at-risk children with drug-abusing parents may be a hard sell. Positive media coverage about family success stories can serve to broaden public awareness and support.

Longitudinal studies on the impact of substance exposure on infants and hard data from pilot initiatives is needed to educate and inform the public. There is already a significant body of data on the effects of fetal alcohol syndrome, but continued research is needed on the effects of multiple substance abuse at different stages of pregnancy. It should also be acknowledged that substance-abusing parents and their children are a relatively new population and a specialized field of endeavor for substance abuse professionals.

PROTOCOL

SECTION V

Overview of Statutory and Case Law

STATE STATUTES RELATED TO DRUG-EXPOSED CHILDREN AND THEIR FAMILIES

REPORTING LAW

California

West's Ann. Health and Safety Code §10900-11166, 1990, Division 9.7 Perinatal Substance Abuse Services Act

§10922 (a) Each county shall establish protocols between county health departments, county welfare departments and all public and private hospitals in the county, regarding the application and use of an assessment of the needs of and a referral for a substance-exposed infant to a county welfare department...

(c) The purpose of the assessment of the needs is to...identify needed services for mother, child or family...[including] services to assist maintaining children in their homes...

§11165.13...a positive toxicology screen at the time of delivery of an infant is not...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 child and mother... If other factors are present that indicate risk to a child then a report shall be made...

District of Columbia

D.C. Code §2-1352 (Supp. 1990)

(d) ...any health professional licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985...or a law enforcement officer, except an undercover officer whose identity or investigation might be jeopardized shall report immediately, in writing, to the Child Protective Services Division of the Department of Human Services, *that the law enforcement officer or health professional has reasonable cause to believe that a child is abused as a result of inadequate care, control, or subsistence in the home environment due to exposure to drug-related activity.*

Florida

Fla. Stat. Ann. §415.503 (Supp. 1988)

(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 or other person responsible for the child's welfare.

(7) "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 1 of §893.03, or upon any drug controlled in Schedule II of §893.03, with the exception of drugs administered in conjunction with a detoxification program as defined in §397.021, or 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.*

Hawaii

Hawaii Rev. Stat. §350-1(3) (1985)

"Harm" or "threatened with harm" means harm or threatened harm as defined in chapter 587 [incorporates definition in civil prosecution law, see § on Civil Prosecution Law]

Illinois

Ill. Ann. Stat. ch.23, §2053

[definition of neglected child tracks language in civil prosecution law, see § on Civil Prosecution Law]

Massachusetts

Mass. Gen. Laws Ann. ch.119, §51A (West Supp. 1988)

...have reasonable cause to believe that a child...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...*

Minnesota

Omnibus Crime Bill, Chapter No. 290, H.F. No. 59

Minnesota Statutes 1988 at 626.5561; and .5562

Section 5. (Reporting of Prenatal Exposure to Controlled Substances) [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.

Subdivision 2. *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 chapter 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.*

Section 6. (Toxicology Tests Required) [626.5562]

Subdivision 1. [test; report] *A physician shall administer a toxicology test to a pregnant woman under the physician's care 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 5. A negative result does not eliminate the obligation to report under section 5, if other evidence gives the physician reason to believe the patient has used a controlled substance for nonmedical purposes.*

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 a controlled substance for a nonmedical purpose prior to the birth. If the test results are positive, the physician shall report the results as neglect under section 626.556. A negative test 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.*

New York

N.Y. Soc. Serv. Law 412(9) (McKinney Supp. 1989)

Amended by 1988 N.Y. Laws Ch. 543, §1 and Ch. 634 §§1,2

9. "Neglected child in residential care" means a child whose custodian impairs, or places in imminent danger of becoming impaired, the child's physical, mental or emotional condition (a) *by intentionally administering to the child any prescription drug other than in accordance with a physician's or physician's assistant's prescription;*

Oklahoma

Okla. Stat. Ann. tit. 21, §846 (Supp. 1989)

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 dangerous substance shall promptly report the matter to the county in which such birth occurred.* Provided it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report any incident as provided above. If the report is not made in writing in the first instance, it shall be reduced to writing by the maker thereof as soon as may be after it is initially made by telephone or otherwise and shall contain the names and addresses of the child and his or her parents or other persons responsible for his injuries, including any evidence of previous injuries, *the nature and extent of the child's dependence on a controlled dangerous substance* and any other information that the maker of the report believes might be helpful in establishing the cause of the injuries and the identity of the person or persons responsible therefore if such information or any part thereof is known to the person making the report.

Rhode Island

R.I. Gen. Laws §40-11-2 (2), (3) (Supp. 1988)

(2) An "abused and-or neglected child" means a child whose physical or mental health or welfare is harmed or threatened with harm when his parent or other person responsible for his welfare:

(e) *Fails to provide the child with a minimum degree of care or proper supervision or guardianship because of his unwillingness or inability to do so by situations or conditions such as, but not limited to, social or psychiatric problems or disorders, mental incompetency, or the use of a drug, drugs, or alcohol to the extent that the parent or other person responsible for the child's welfare loses his ability or is unwilling to properly care for the child;...*

Utah

Utah Code Ann. §78-3b-8 (1), (6) (1987)

(1) *The division* [family services within the department of social services] *shall make a thorough investigation upon*

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

CIVIL PROSECUTION LAW

District of Columbia

D.C. Code §16-2301

(23) The term "abused" when used with reference to a child, means a child whose parent, guardian or custodian inflicts or fails to make reasonable efforts to prevent the infliction of physical or mental injury upon the child, including excessive corporal punishment, an act of sexual abuse, molestation, or exploitation, or *an injury that results from exposure to drug-related activity in the child's home environment.*

Hawaii

Hawaii Rev. Stat. §587-2 (1985)

"Harm" to a child's physical or psychological health or welfare occurs in:

(5) *Any case where the child is provided with dangerous, harmful, or detrimental drugs as defined by section 712-1240, however, this paragraph shall not apply to a child's family who provide such drugs to the child pursuant to the direction or prescription of a practitioner, as defined in section 712-1240.*

Illinois

Illinois Ann. Stat. ch.37, §802-3(1)

(1) Those who are neglected include

(c) *any 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, as now or hereafter amended, or a metabolite of a controlled substance, with the exception of controlled substances or metabolites of such substances, the presence of which in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.*

Indiana

Ind. Code Ann. §31-6-4-3.1 (Burns 1987)

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.*

Minnesota

Omnibus Crime Bill, Chapter No. 290, H.F. No. 59 Minnesota Statutes 1988 at 626.556 Section 4 Subdivision 2 (Definitions). *"Neglect" includes prenatal exposure to a controlled substance, as defined in section 5, 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 effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance.*

Nevada

Nev. Rev. Stat. §128.106 (1987)

In determining neglect by or unfitness of a parent, the court shall consider, without limitation, the following conditions which may diminish suitability as a parent...

3. *Excessive use of intoxicating liquors, controlled substances or dangerous drugs which renders the parent consistently unable to care for the child..*

New York

N.Y. Fam. Ct. Act §1012(e) (McKinney 1983 & Supp. 1989)

"Neglected child" means a child less than eighteen years of age (i) whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care...

(B) in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof,...

...by misusing a drug or drugs; or by misusing alcoholic beverages to the extent that he loses self-control of his action; or by any other acts of a similarly serious nature requiring the aid of the court; *provided, however, that where the respondent is voluntarily and regularly participating in a rehabilitative program, evidence that the respondent has repeatedly misused a drug or drugs or alcoholic beverages to the extent that he loses self-control of his actions shall not establish that the child is a neglected child in the absence of evidence that the child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as set forth in paragraph (i) of this subdivision.*

Oklahoma

Okla. Stat. Ann. tit. 10, §1101 (4) (Supp. 1989)

"Deprived child" means a child who is for any reason destitute, homeless, or abandoned or who does not have the proper parental care or guardianship or whose home is an unfit place for the child by reason of neglect, cruelty or depravity on the part of his parents, legal guardian, or other person in whose care the child may be, 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 to or willfully fails to provide said special care and treatment...*

CRIMINAL PROSECUTION LAW

Nevada

Nev. Rev. Stat. §201.090 (1987)

...a "neglected child," "delinquent child" or "child in need of supervision" means any person less than 18 years of age:

9. *Who habitually uses intoxicating liquors or who uses opium, cocaine, morphine, or other similar drug without the direction of a competent physician.*

Nev. Rev. Stat. §202.110

Any person who commits any act or omits the performance of any duty, which act or omission causes or tends to cause or encourage any person under the age of 18 to become a "neglected child," ...as defined in NRS 201.090...or which act or omission contributes thereto...shall be guilty of contributory neglect...

Oklahoma

Okla. Stat. Ann. tit. 21, §852 (Supp. 1989)

B. *It is the duty of any parent having legal custody of a child who is an alcohol-dependent person or a drug-dependent person as such terms are defined by Section 3-403 of Title 43A of the Oklahoma Statutes, to provide for the treatment, as such term is defined by Section 3-403 of Title 43A of the Oklahoma Statutes, of such child. Any parent having legal custody of a child who is an alcohol-dependent person or a drug-dependent person who without having made a reasonable effort fails or willfully omits to provide for the treatment of such child shall be guilty of a misdemeanor. For the purpose of this subsection, the duty to provide for such treatment shall mean that the parent having legal custody of a child must provide for the treatment in such a manner and on such occasions as an ordinarily prudent person, solicitous for the welfare of a child, would provide.*

WELFARE LAW

New York

N.Y. Soc. Serv. Law §371 (4-a) (McKinney 1983)

[incorporates language of the civil prosecution law quoted above]

CASE LAW RELATING TO DRUG-EXPOSED CHILDREN AND THEIR FAMILIES

PERINATAL DRUG ABUSE AS A FACTOR IN CIVIL NEGLECT

***In the Matter of Fathima Ashanti*, 558 N.Y.S.2d 447(Fam. Ct. 1990).**

The birth of a child with positive toxicology for cocaine, symptoms of drug withdrawal, and low birth weight to drug abusing parents established neglect, justifying judicial intervention for protection of child.

***In re Stephen W.*, 271 Cal. Rptr. 319(Cal. App. 3 Dist. 1990).**

The fact that newborn had positive toxicology for opiates and displayed symptoms of drug withdrawal after birth was sufficient to establish jurisdiction by dependency court.

***In re Troy D.*, 263 Cal. Rptr. 869(Cal. App. 4 Dist. 1989).**

An infant diagnosed as being born under the influence of drugs is sufficient to establish jurisdiction to declare infant a dependent child, even though mother's conduct of ingesting dangerous drugs occurred prior to infant's birth.

***Dept. of Soc. Serv. on behalf of Mark S. v. Felicia B.*, 543 N.Y.S.2d 637(Fam. Ct. 1989).**

Newborn had positive toxicology test results for cocaine. Court states that a fetus is owed a duty by those who come in contact with it, and that duty ripens into a cause of action if the child is injured, whether willfully or accidentally. The neglect petition against the mother could be based on prebirth conduct of ingesting cocaine.

***Cox v. Ct. of Common Pleas*, 537 N.E.2d 721(Ohio App. 1988).**

Juvenile court could not assert jurisdiction over pregnant mother for the benefit of the unborn child even though mother was known to use cocaine, because the statute does not give authority to regulate the life of an adult for the benefit of an unborn child.

***Matter of Fletcher*, 141 Misc.2d 333, 533 N.Y.S.2d 241(Fam. Ct. 1988).**

Newborn had positive toxicology test results. Court dismissed petition for neglect because there was no allegation of misbehavior after the child's birth, or that mother was drug addicted or a regular drug user. Prenatal drug use could be a factor in neglect if petitioner could plead and prove drug addiction or a direct connection between use and child's safety.

***Dept. of Soc. Serv. v. Nash*, 419 N.W.2d 1(Mich. App. 1987).**

Child born with evidence of withdrawal symptoms, including tremors and poor feeding. Urine toxicology test showing presence of phenobarbital, dilatin and bezediazepine was enough to establish the probate court's dependency jurisdiction over the baby based on the mother's abuse of drugs during pregnancy.

***In re Ruiz*, 500 N.E.2d 935(Ohio Com. Pl. 1986).**

The fetus was a "child" who had the right to protection from abuse. Mother abused "child" by using heroin intravenously at least two weeks prior to child's delivery, which resulted in child being born addicted. This created a substantial risk to health or safety of child.

***Matter of Smith*, 128 Mich.2d 976, 492 N.Y.S.2d 331(Fam. Ct. 1985).**

Child whose mother had failed to seek prenatal medical care and who had misused alcoholic beverages during her pregnancy to such an extent as to create an imminent danger of impairment of the physical condition of the unborn child, including the possibility of fetal alcohol syndrome, was a neglected child.

***In the Matter of Baby X*, 293 N.W.2d 736(Mich. App. 1980).**

A newborn suffering narcotics withdrawal symptoms as a consequence of prenatal maternal drug addiction may properly be considered a neglected child within the jurisdiction of probate court. A child has the legal right to begin life with a sound mind and body, and it is within his best interest to examine all prenatal conduct bearing on that right.

***In the Matter of "Male" R*, 422 N.Y.S.2d 819(Kings Cty. Fam. Ct. 1979).**

Evidence established that child was born suffering from mild drug withdrawal symptoms, that mother was an abuser of barbiturates and had refused to enroll and remain in a drug program and that as a result of her abuse of barbiturates mother was unable to care for child. Child was a neglected child in that he was in imminent danger of

becoming impaired as a result of failure of mother to exercise a minimum degree of care providing proper supervision or guardianship.

In re Vanessa F., **351 N.Y.S.2d 337(1974).**

Newborn who has drug-withdrawal symptoms is prima facie a "neglected child."

TESTING AND REPORTING DRUG USE

A. Fourth Amendment and Privacy Issues

National Treasury Employees Union v. Yeutter, **733 F. Supp. 403(D.D.C. 1990).**

Government's interest in ensuring transportation safety justified random drug testing by urinalysis of motor vehicle operators employed by Department of Agriculture.

In re Noah M., **260 Cal. Rptr. 309(Cal. App. 4 Dist. 1989).**

Fourth Amendment applies only to governmental actions (including state, because California has a constitutional amendment relating to privacy). Performance of urine toxicology screens on mother and child was not state action because hospital was not required by law to perform screens and did not perform screen as agent of government. Mothers of newborns who tested positive for dangerous drugs had no reasonable expectation of privacy as to test results and release of information was justified by compelling state interest in protection of newborns from child abuse.

Skinner v. Railway Labor Executives Association, **109 S.Ct. 1402(1989).**

Federal Railway Act regulations authorizing tests are searches under the Fourth Amendment. The government has a compelling interest in safety that justifies these searches. Employees of a highly-regulated government agency have diminished expectations of privacy.

National Treasury Employees Union v. Von Raab, **489 U.S. 656, 103 L.Ed 2d 685, 109 S.Ct. 1384(1989).**

A warrant, probable cause, and individualized suspicion are not indispensable components of reasonableness in a Fourth Amendment drug test "search." Government had compelling interest to justify intrusion.

Feliciano v. City of Cleveland, **661 F. Supp. 578(N.D. Ohio 1987).**

Consent to voluntary relinquishment of constitutional right "must be proved by clear and positive testimony, and it must be unequivocal, specific and intelligently given, uncontaminated by any duress and coercion."

Jones v. McKenzie, **833 F.2d 335(D.C. Cir. 1987),** *modified Jenkins v. Jones*, **879 F.2d 1476(D.C. Cir. 1989).**

School district need not have probable cause for drug urinalysis of bus drivers where employees' duties make direct contact with school children and their physical safety, if testing is part of a routine, reasonably-required, employment-related medical examination, and there is a clear nexus between the test and the employer's legitimate safety concerns.

Blum v. Yaretsky, **457 U.S. 991, 73 L.Ed 2d 534, 102 S.Ct. 2777(1982).**

The acceptance of Medicaid benefits and the existence of extensive state regulations is not sufficient state involvement to subject a private nursing home to the requirements of the due process clause in the Fourteenth Amendment of the U.S. Constitution.

Rendell-Baker v. Kohn, **457 U.S. 830, 73 L.Ed 2d 418, 102 S.Ct. 2764(1982).**

The First Amendment of the U.S. Constitution does not apply to a private school through the Fourteenth Amendment, and action could not be considered state action solely on the basis of: (1) that nearly all of the tuition income comes from state public funds; (2) that the school is regulated by the state; (3) that the school performs a public function — education.

Schmerber v. Cal., **384 U.S. 757, 16 L.Ed 2d 908, 86 S.Ct. 1826(1966).**

Officer was not required to obtain a warrant before taking person who appeared to be drunk to a hospital where blood was drawn for alcohol test. This is because the time required to obtain a warrant threatened the destruction of

evidence. Thus, this is an emergency situation where officer, not neutral magistrate, was allowed to determine if man was drunk.

B. Accuracy of Test

***Nat. Federation of Fed. Employees v. Weinberger,* 640 F. Supp. 642(D.D.C. 1986).**

The Enzyme Multiplied Immunoassay Technique (EMIT) test consists of antibodies that attach themselves to drugs or drug metabolites (which are products resulting from the breakdown of drugs by the body) in an individual's urine sample. This test is 97% to 99% accurate, although the manufacturer conservatively estimates 95% accuracy. Positive results should be confirmed by gas chromatography/mass spectrometry.

C. Defenses to a "Positive" Test

***In re Fletcher,* 141 Misc.2d 333, 533 N.Y.S.2d 241 (Fam. Ct. 1988). [Described above under I. Perinatal Drug Abuse as Factor in Civil Neglect]**

Prenatal drug use alone is insufficient to establish an inference of neglect. Petitioner must prove a direct connection between the drug use and the child's safety.

DRUG TREATMENT

***In the Matters of Eunice, Mitchell and Antonia B.,* 535 N.Y.S.2d 25(A.D.2 Dept. 1988).**

Family Court has statutory authority to order drug abuse treatment for mother and counseling for children.

RELATIONS OF MATERNAL DRUG USE TO IMMINENT ENDANGERMENT

***In re Randall,* 96 Or. App. 672, 773 P.2d 1348(1989).**

Allegations of drug use alone are not sufficient to confer juvenile court jurisdiction over a child. The court cannot take judicial notice that all substance abusers are incapable of adequate parenting. Allegations must show that child over whom jurisdiction is to be asserted is threatened or affected by mother's substance abuse.

***In the Matter of Milland,* 548 N.Y.S.2d 995(Fam. Ct. 1989).**

Mother's prenatal conduct alone cannot be basis of finding of child neglect, nor is it enough to claim abuse without showing a specific detriment to newborn child; mother's prenatal conduct must be connected to a post birth risk of harm to child for finding of neglect based on prenatal conduct.

RIGHT OF MOTHER TO SELECT MEDICAL TREATMENT WITHOUT REGARD TO NEEDS OF FETUS

***Webster v. Reproductive Health Services,* 488 U.S. 1003, 102 L.Ed 2d 772, 109 S.Ct. 780(1989).**

The State of Missouri has an act which regulates abortions in the state. Its key provisions are a preamble that states that "the life of each human being begins at conception" and the "unborn children have protectable interests in life, health and well-being"; a provision that forbids the state government to allocate money for abortions; a provision that forbids public money to be used to counsel or encourage women to have abortions; and a provision that a physician must perform any necessary tests to determine the viability of a fetus at 20 weeks before performing an abortion.

The Supreme Court rules narrowly on these provisions. It does not consider the constitutionality of the preamble because there is no matter in controversy. It states that the prohibition of public funds for abortions puts no obstacle in the way of a woman seeking an abortion since she can go to a private physician or hospital. It states that the forbidding of public funds for counseling is a stricture on those who distribute funds, not on those who counsel. It states that a physician is to be guided by his judgment as to which tests are "necessary" to be performed at 20 weeks.

In re AC, **D.C. Ct. App., No. 87-609(June 16, 1987).**

In most cases the state is precluded from intervening in an adult's decision to refuse medical treatment. However, a child is not required to become a martyr to the parent. In some jurisdictions this is applicable to the fetus, where the state has a compelling interest. In this case, the mother's prognosis for surviving was poor (2 days of sedated life). The child, however, had a chance to survive, albeit in handicapped state. Therefore the State court ordered a caesarean, even though that would probably shorten the mother's life.

Rogers v. Com'r of Dept. of Mental Health, **458 N.E.2d 308(Mass. 1983).**

An involuntarily committed mental patient retains the right to make treatment decisions and doesn't lose that right until adjudicated incompetent.

Taft v. Taft, **446 N.E.2d 395(Mass. 1983).**

The state did not have any interest in forcing pregnant woman to have a "purse string" operation to keep from miscarriage when her religious convictions lead her to object.

Grodin v. Grodin, **301 N.W.2d 869(Mich. 1981).**

In action by son and father against mother for using tetracycline during pregnancy (which discolored child's teeth) Court of Appeals remanded to determine if mother acted "reasonably," in taking into consideration her own medical needs.

Jefferson v. Griffin Spalding Cty Hosp. Auth., **274 S.E.2d 457(Ga. 1981).**

Mother was forced to submit to caesarean to save life of child (fetus), despite mother's religious views. The state had an interest in the life of the unborn human being from meeting his death before being given the opportunity to live, which outweighed any intrusion into the life of the mother.

CONFIDENTIALITY OF MEDICAL RECORDS

Schuyler County DSS v. Schuyler Hosp., **543 N.Y.S.2d 872(Sup. 1989).**

Where reporting statute requires the release of medical information to investigating social worker about extent and kind of injuries to the child, the court determined that the medical records must be released, because actual records are far more reliable than just a brief synopsis.

In the Matter of O.L., **D.C. Superior Court, 116 (No. 251) Daily Wash. Rep. p.198, D.C.(Friday, Dec. 30, 1988).**

State has burden to overcome confidentiality provision. As such, waivers of confidentiality of parent's medical records prior to a fact finding hearing in a neglect case should not be automatic and inevitable.

People v. Strizinger, **194 Cal. Rptr. 431(Cal. 1983).**

Although the Child Abuse Reporting Act sets up a competing state interest, a waiver of patient's confidentiality privileges must be very narrowly drawn.

PROTECTION OF THE FETUS FROM HARM INFLICTED BY MOTHER OR THIRD PERSON

McKee v. McKee, **Gen. Sess. Court, Knoxville, Tn., Case No. 132(Dec. 1989).**

TRO granted to husband to restrain mother from drinking alcohol or taking drugs 5 months into her pregnancy.

Stallman v. Youngquist, **57 LW 2341(Dec. 13, 1988).**

In Ill. there is no cause of action by or on behalf of a fetus subsequently born alive, against its mother for negligent infliction of prenatal injuries.

Gloria C. v. William C., **476 N.Y.S.2d 991(Fam. Ct. 1984).**

The birth of a child is not a condition precedent to enforcement of an order of protection issued on behalf of the fetus.

Matter of Steven S., 178 Cal. Rptr. 525(Cal. App. 1981).

An unborn fetus cannot be adjudicated a dependent child for purposes of protection by the juvenile court.

Reyes v. Superior Ct., 141 Cal. Rptr. 912(Cal. App. 1977).

Mother's prenatal heroin use and lack of prenatal care was not sufficient to establish felony child endangerment since "child" did not include an unborn child or fetus.

Matter of Dietrich Infant, 263 N.W.2d 37(Mich. 1977).

Probate court does not have jurisdiction over custody of unborn child.

Raleigh Fitkin - Paul Morgan Mem. Hosp. v. Anderson, 201 A.2d 537(N.J. 1964).

Unborn child has right to protection of court so that blood transfusion can be forced on mother who has religious objection.

Hoener v. Bertinato, 67 N.J. Super. 517, 171 A.2d 140(Juv. Dom. Rel. Ct. 1961).

Parents who refused on religious grounds to consent to blood transfusion for baby at birth constituted neglect meriting protection of juvenile court.

LIABILITY OF HOSPITAL

Schloendorff v. Soc. of N.Y. Hosp., 105 N.E. 92(N.Y. 1914, Cardozo, J.).

Hospital, a charitable institution, not liable for errors in judgment of its physicians and health care workers.

UNTREATED DRUG ABUSE AS FACTOR IN TERMINATION OF PARENTAL RIGHTS

In the Interest of SC, 439 N.W.2d 500(Neb. 1989).
In re R.J., 436 N.W.2d 630(Iowa 1989).
State ex rel. Juv. Dept. v. Osequera, 773 P.2d 775(Or. App. 1989).
In re Interest of Q.R., 438 N.W.2d 146(Neb. 1989).
In re Marie G., 550 A.2d 1058(RI 1988).
In re Ashley G., 252 Cal. Rptr. 902(Cal. App. 5 Dist. 1988).
In the Matter of JLS and ADS, 761 P.2d 838(Mont. 1988).
In the Matter of RJP, 761 P.2d 1000(Wyo. 1988).
In the Matter of CEW (Appeal of USW), 541 A.2d 625(D.C. App. 1988).
In re Interest of Z.R., 415 N.W.2d 128(Neb. 1987).
In re Solomon L., 236 Cal. Rptr. 2(Cal. App. 4 Dist. 1987).

Where mother acknowledged she took drugs knowing them to be harmful to her child, and has been unable to successfully complete a treatment program, TPR justified as in the best interest of the child.

MY v. EY, 724 S.W.2d 647(Mo. App. 1986).
Matter of RJW, 642 P.2d 1072(Mont. 1982).

DRUG OR ALCOHOL ABUSE AS A FACTOR IN DIVORCE CUSTODY DISPUTES

Busch v. Busch, 1989 WL 103252(Mo. 1989).

Drug use by one parent, coupled with association with the drug culture, are relevant factors to consider in a divorce child custody dispute.

Burgel v. Burgel, 533 N.Y.S.2d 735(A.D.2 Dept. 1988).

Mother compelled to surrender her hair for Radioimmunoassay test (RIA) for analysis of cocaine usage. Mother had admitted to prior cocaine use but insisted that she had not used it for the past several months. Mother protested that testing procedure (gas chromatography/mass spectrometry) was unreliable. Court ruled that unreliability of test goes to admissibility of evidence and that purpose of discovery is to lead to other information.

CRIMINALIZING FETAL ABUSE

State v. Hardy, No. 128458 Slip op.(Mich. App. 1991).

Mother was criminally charged with second degree child abuse arising from the ingestion of crack cocaine

13 hours prior to giving birth. Court dismissed the charges because mother's conduct was not the type of conduct the legislature intended for prosecution under the delivery of cocaine statute.

***Commonwealth v. Pellegrini*, No. 87970(Mass. 1990).**

Mother was indicted for the crime of distributing cocaine to a person under 18 years on the ground that she ingested cocaine while pregnant. The indictment was dismissed because the statute was not designed to encompass the inutero transfer from a mother to her fetus.

***People v. Stewart*, No. M508097 Slip op.(San Diego County Ct., Feb. 23, 1987).**

Mother was criminally charged with "willful failure to provide medical attention to a minor child" on the grounds that she failed to follow medical direction during pregnancy. The charges were dismissed because the statute was intended to apply only to financial child support obligations.

***Reyes v. Superior Ct.*, 141 Cal. Rptr. 912(Cal. App. 1977).**

Mother charged with two counts of felony child endangerment. Court determined mother's prenatal heroin use and lack of prenatal care was not sufficient to establish felony child endangerment since "child" did not include an unborn child or fetus.

PROTOCOL

SECTION VI

Model Programs and Approaches

MODEL OUTPATIENT PROGRAMS FOR DRUG-EXPOSED MOTHERS AND CHILDREN

CARE (Chemical Addiction and Recovery Efforts) Clinic Center for the Vulnerable Child
Children's Hospital Oakland
747 52nd Street
Oakland, CA 94609
(510) 428-3783

EDEN Center
2115 North Wilmington Avenue
Compton, CA 90222
(213) 605-0650

Family Addiction Center for Education and Treatment
Bay Area Addiction Research and Treatment, Inc.
1040 Geary Street
San Francisco, CA 94102
(415) 563-9816

Healthy Infant Program
Highland Hospital
1411 East 31st Street
Oakland, CA 94602
(510) 437-4682

UCLA Infant and Family Services Program
Harbor-UCLA Medical Center
1000 Veteran Avenue, Suite 23-10
Los Angeles, CA 90024-1797
(213) 825-9527

The Perinatal Wellness Program
333 E. Superior, Suite 400
Chicago, IL 60611
(312) 908-0867

Pregnant Addicts and Addicted Mothers Program
Center for Comprehensive Health Practice
New York Medical College
1900 2nd Avenue, 12th floor
New York, NY 10029
(212) 360-7792

Project Star
1800 Columbus Avenue
Roxbury, MA 02119
(617) 442-7442

The Family Center
Thomas Jefferson Hospital
1201 Chestnut Street, 11th Floor
Philadelphia, PA 19107
(215) 955-8577

Operation PAR (Parental Awareness and Responsibility)
10901-C Roosevelt Blvd., Suite 1000
St. Petersburg, FL 33716
(813) 570-5095

Community University Health Care Center
2001 Bloomington Avenue South
Minneapolis, MN 55404
(612) 627-4774

Survival Skills Institute
1501 Xerxes Avenue North
Minneapolis, MN 55411
(612) 522-6654

Model Cities Health Center
430 North Dale Street
St. Paul, MN 55103
(612) 222-6029

Health Start
640 Jackson Street
St. Paul, MN 55101
(612) 221-3441

Eleonore Hutzel Recovery Center
301 E. Hancock Street
Detroit, MI 48201
(313) 745-7411

MODEL RESIDENTIAL TREATMENT PROGRAMS FOR DRUG-EXPOSED MOTHERS AND CHILDREN

Kiva
McAlister Institute
810 Arnele Avenue
El Cajon, CA 92020
(619) 442-0277

The Rectory
1901 Church Lane
San Pablo, CA 94806
(510) 263-3134

Via Avanta
11643 Glenoaks Blvd.
Pacoima, CA 91331
(818) 897-2609

Operation PAR (Parental Awareness & Responsibility)
10901-C Roosevelt Blvd., Suite 1000
St. Petersburg, FL 33716
(813) 570-5095

The Woman's Place
P.O. Box 745
Statesboro, GA 30458
(912) 764-3994

(CASPAR)-Cambridge and Somerville Program for Alcohol Rehabilitation
Womanplace/New Day
242 Highland Avenue
Somerville, MA 02143
(617) 628-8188

Odyssey House Family Center
666 Broadway, 10th Floor
New York, NY 10012
(212) 477-9493

EMO/ARA Women's and Children Recovery House
807 S.E. 28th Street
Portland, OR 97214
(503) 246-2440

Caton House/Genesis II
3945 Lancaster Avenue
Philadelphia, PA 19104
(215) 387-8808

Community House
521 W. Seventh Street
Erie, PA 16502
(814) 459-5853

Family House
901 DeKalb Street
Norriston, PA 19401
(215) 278-0700

Hutchinson House Diagnostic and Rehabilitation Center
3439 N. Hutchinson Street
Philadelphia, PA 19140
(215) 223-1005

Kindred House/Gaudenzia
1030 South Concord Road
West Chester, PA 19382
(215) 399-6929

New Image/Gaudenzia
Stenton & Tulpehocken Street
Philadelphia, PA 19138
(215) 924-6322

Vantage House/Gaudenzia
212-East King Street
Lancaster, PA 17602
(717) 291-1020

Turning Point Inc. Demand Program
1105-16th Avenue North
Minneapolis, MN 55411
(612) 588-0707

Eleonore Hutzel Recovery Center
301 E. Hancock Street
Detroit, MI 48201
(313) 745-7411

Hope, Unity & Growth, Inc. (HUG)
4875 Coplin Street
Detroit, MI 48215
(313) 822-8830

Hennepin County-Project Child
Hennepin County Community Services Department
Chemical Health Division
1800 Chicago Avenue
Minneapolis, MN 55404
(612) 879-3510

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627 Selby Avenue
St. Paul, MN 55104
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PROTOCOL

SECTION VII

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Hon. David B. Mitchell
Circuit Court of Baltimore County
Baltimore, Maryland

Hon. Gerald E. Rouse
21st Judicial District Court
Columbus, Nebraska

Hon. Raymond E. Shawcross
Rhode Island Family Court
Providence, Rhode Island

Hon. Merton B. Tice, Jr.
7th Judicial Circuit Court
Rapid City, South Dakota

Hon. Paul R. Wohlford
Juvenile Court
Bristol, Tennessee

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PROTOCOL

Court Proceedings Master Checklist

Tear-Out Section

MASTER CHECKLIST
SHELTER CARE/DETENTION HEARING
PAGE ONE

BASICS

- Were both parents properly noticed?
- Were family strengthening services considered or offered before the child was removed?
- Did these family strengthening services include visits from a public health nurse; the identification of a relative willing to provide ongoing support; temporary residential placement for the mother and child?
- What facts support a finding of imminent risk to the child?
- Under what statutory authority was the child removed?
- Is removal sought as a preventive measure until a full investigation is completed?
- Is a temporary, safe caretaker available as an alternative to removal?
- Is the baby being detained solely because of a positive toxicology screen?
- Have relatives been identified and consulted concerning support for the family?

FOCUS: CHILD

- Was there a full-term, normal, spontaneous delivery, with a normal birth weight?
- Has there been a positive toxicology screen for either infant or mother?
- What is the nature and extent of drug exposure in the infant?
- Has there been a diagnosis of fetal alcohol syndrome or fetal alcohol effect?
- Does the child have special needs, such as clinical withdrawal, medical complications?
- (A positive toxicology screen and confirmatory test are not sufficient basis for taking custody of a child.)

FOCUS: MOTHER

- What is the mother's history of drug abuse, and recovery history?
- Are there signs and symptoms of current drug use?
- What was the amount and quality of prenatal care?
- What preparations has the mother made for the child at her place of residence?
- Is the mother willing and able to meet the child's immediate medical and special needs?
- What assistance would allow the mother to provide for these needs?

SHELTER CARE/DETENTION HEARING
PAGE TWO

- What are the reports from collateral contacts (physician, hospital staff, service providers)?
- Is mental illness or retardation a major factor in the mother?
- Is there a willingness on the part of mother or her partner to begin drug rehabilitation?
- Is language a barrier to social services?
- What strengths does the mother have? What strengths did she demonstrate in the past?
- What support systems exist, family or non-family?

FOCUS: FATHER/NON-CUSTODIAL PARENT

- What is the legal status of the biological father or non-custodial parent?
- What is the relationship of the father or non-custodial parent to the child?
- What is the relationship of any other legal or biological parents to child?
- What efforts have been made to contact the non-custodial parent?
- What efforts have been made to contact the non-custodial parent's extended family?
- Was the non-custodial parent notified of hearing?
- Has the non-custodial parent acknowledged paternity?
- Is mental illness or retardation a major factor in the parent?
- Has non-custodial parent ever had custody of the child?
- Does the non-custodial parent have an adequate home for the child?
- Can the non-custodial parent meet any special needs of the child?
- What is the relationship between the non-custodial and custodial parent?
- What support systems, family or non-family, have been contacted?
- Is the non-custodial parent's partner willing to assume care for the child?

FOCUS: PATERNITY

- Will the putative father submit the paternity issue to the appropriate court?
- Is presumptive father listed on the child's birth certificate, court and agency documents?

FOCUS: HOME\ENVIRONMENT

- What is quality of care received by other children in the home?

SHELTER CARE/DETENTION HEARING
PAGE THREE

- What is family's current and past involvement with social services?
- What type of support systems are available through family/friends, professional caregivers?
- How visible will the infant be to persons other than the parents?
- Does the mother have a home?
- Is there a current history of unstable residences? Has a home assessment been done?
- Does the baby have special needs? What is the mother's ability to meet those needs?
- What is the partner's ability to assist the mother?
- Does partner have any history of violent behavior or current pattern of drug use?

FOCUS: SOCIAL SERVICE AGENCY

- Information which the social service agency should provide to the court:

  -record of previous involvement with social services;

  -mother's recent medical history and records;

  -child's recent medical history and records;

  -timely risk assessment and assessment of family strengths and capacity;

  -resources needed to ensure safety of the child in the home;

  -drug use assessment of mother;

  -drug use assessment of partner;

  -list of agency's "reasonable efforts" to avoid out-of-home placement of child;

  -list of *concrete* services made available in a timely manner in an effort to avoid placement;

  -list of all relatives contacted and assessed for care-giving potential.

- How has the social service agency helped the substance abusing parent obtain treatment?
- Have referrals to treatment programs been *appropriate*?
- Were the programs physically, financially, psychologically and culturally accessible?
- Was the mother provided with transportation and child care so that she could attend?
- Should the hearing be continued while additional information is gathered? Have there been previous continuances?

MASTER CHECKLIST
ADJUDICATORY/DISPOSITIONAL HEARING
PAGE ONE

BASICS

- Does the child come within the jurisdiction of the court?
- Has social service agency submitted a complete and comprehensive report?
- Does report include evidence and comments from parents, attorneys, other parties?
- Does report describe progress parents have made since the shelter care hearing?
- Could utilization of services permit the child to safely return to the family?
- Can the social service agency provide these services?

FOCUS: CHILD

- Is regular medical care needed?
- What are appropriate support services?
- Therapeutic interventions?
- Physical therapy/counseling/health and education intervention?
- Have all issues noted in shelter care hearing been considered?
- Is there a specific deadline for completion of all assessments?

FOCUS: PARENT

- Should random drug testing be ordered? Why?
- Is a drug rehabilitation program needed?
- Is residential treatment needed but not yet available?
- Are interim drug rehabilitation services being instituted?
- Are intensive family preservation services needed?
- Are Alcoholics Anonymous/Narcotics Anonymous or other self-help groups needed?
- Is drug-exposed-baby-caregiver training needed?
- Is supportive/peer/therapeutic group support needed?
- Is respite care needed?
- Is regular medical care needed for child or mother?

MASTER CHECKLIST
ADJUDICATORY/DISPOSITIONAL HEARING
PAGE TWO

- Are efforts to stabilize housing needed?
- Should family members be designated for specific assistance?
- Should child care duties of partner be specified?
- Is a home visitor, peer advocate, homemaker, or a family service assistant needed?
- Are other kinds of parenting instruction needed?
- Is a public health nurse needed?
- Has family violence screening been coordinated with protective orders?
- Is psychological or educational therapy needed?
- Is job training needed?

FOCUS: FOSTER CARE

- Do foster parents need:
  - drug-exposed-baby-caregiver training?
  - respite care?
  - support groups?
  - ongoing training?
  - increased foster care payments related to special needs children?
  - at least weekly face-to-face contact with social service worker?
- Is a specific plan needed to avoid multiple placements?
- Is there a specific plan for re-placement if necessary?
- Is lack of housing a primary reason for continued foster care placement?
- Has social service agency shown cause why it cannot offer specific housing aid?
- Are intensive family reunification services available?
- Are the foster parents willing to have the mother visit in their home?
- Are the foster parents willing to assist the mother to develop parenting skills?
- Visits:
  - regular and frequent?
  - visits supervised or unsupervised?

frequency, time, duration and place?

If supervised, why?

Is supervision based on teaching or role model experience?

- Possible Placement with Relatives

Alcohol or other drug abuse present?

History of abuse, neglect or violence in the home?

What are the relative's parenting skills?

What is the relative's access to medical care and other services for the child?

Could support services improve the relative's capacity to care for the child?

Is the relative motivated and cooperative?

Does the relative have a positive relationship with parents?

Is the living environment adequate and safe for the child?

Could housing assistance make the living environment adequate and safe?

MASTER CHECKLIST
SUBSEQUENT JUDICIAL REVIEW HEARINGS

BASICS

- Are judicial review hearings on each child in placement being conducted on a regular basis, at least at six-month intervals, beginning at at the time of the initial removal?
- Have all of the factors previously noted in the shelter care and dispositional hearing sections been considered?

ADDITIONAL FACTORS

- Has the mother/partner complied with the reunification plan, especially made progress in drug rehabilitation?
- Has the mother/partner continued drug use or shown current signs and symptoms of drug use? (It is unreasonable to expect perfection but look for a promising trend in spite of relapses as well as *involvement* in drug rehabilitation.)
- Does existing drug use affect the capacity of the mother/partner to protect and nurture the child? If so, how?
- Is the mother prepared for the child's homecoming? Is the living environment adequate and safe for this child?
- Does the child present any special needs? Will the mother be able to meet them?
- What are the recommendations and observations of the current professional support system, including the child's foster parents?
- Has the mother/partner acknowledged a drug problem, and what impact has this had on the child?
- What are the mother's/partner's present physical and emotional abilities?
- If certain needed services are still unavailable, what efforts have been undertaken to find appropriate substitute services?
- What is the frequency and quality of visits and level of bonding?

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