Trends in Investigative Practice

Information to keep you up to date with the most recent developments in the field of child protection

Florida Department of Children and Families
Office of Child Welfare

January 2018 No. 2

Substance Exposed Newborns

ISSUE: Investigations involving substance exposed newborns can be very challenging. The clinical presentation or onset of withdrawal symptoms may be severe, moderate, subtle or even delayed (by weeks, not days). The detection of controlled substances and their metabolites is also highly variable. Many drugs, especially Opioids, are quickly metabolized by the body *so regular or even heavy but intermittent use may go undetected.* The frequency and duration of the mother's use also explains the variability seen in the onset, type and severity of withdrawal symptoms exhibited in the newborn. When inconclusive medical findings related to withdrawal symptoms and/or drug tests are present, **CPIs must rely on the totality of the substance abuse information to accurately determine child safety and maltreatment findings**.

Practice Considerations

#1 "Rule Out" – When a woman is known to have used a prescribed medication during her pregnancy, the first issue a CPI must address is whether the presence of a controlled substance at birth reflects the mother's legal AND appropriate use of the prescribed drug. The AND qualifier is critical because legally prescribed drugs can be abused. Skipping scheduled doses in order to "double up" on the weekend is abusive use. Using alcohol to enhance (double or even triple) a prescribed drug's properties (especially painkillers and sedatives) is abusive use. An opioid prescription of 31 days or more increases an individual's chances of long-term opioid use to 30%.[1]

Essential information – (1) How clearly can collateral sources, especially family members, **describe improvement in the mother's overall functioning** since starting pain medication or Medication Assisted Treatment (MAT), such as methadone or buprenorphine? The before meds/after meds functioning should be substantially different. (2) For MAT, which dosage administration (e.g., daily clinic visits, weekend take-homes, one clinic visit per week) does the program require? Daily dosing for long-term MAT users is usually problematic because it typically indicates non-compliance with the prescribed treatment regimen.

#2 Drug Testing – An over-reliance on drug testing is a common assessment error. The duration of urinary excretion for many drugs is very short, so maternal and neonatal urinary screening routinely misses frequent users (i.e., "false negatives"). If a mother has abstained from use for several days prior to birth regular use may go undetected. Even the more reliable Meconium test, if negative, cannot be considered conclusive. **Drug test results are important, but should never be the singular determinant in assessing for the presence or severity of drug use.**

DETECTION PERIOD IN URINE[2] (in days)

Drug	Infrequent Use	Frequent Use
Marijuana	2 – 3	12 weeks
Cocaine	1 – 2	4 – 5
Opiates	1 – 2	2 – 4
Amphetamines	1 – 2	3 – 5

Contents

1 CDC Centers for Disease Control and Prevention March 17, 2017 66(10);265-269

2 https://www.csam-asam.org/sites/default/files/pdf/misc/CLARKDrugTesting.pdf

Substance Exposed Newborns

#3 Onset of Withdrawal Symptoms

While most newborns will typically exhibit signs of Neonatal Abstinence Syndrome (NAS) within 1 to 5 days after birth, some infants may take as long as up to four weeks to exhibit symptoms.[3] Hospitals will generally keep an infant under observation for 5 -7 days when one or two initial symptoms present.

Multiple factors account for differences in the onset and severity of withdrawal, including the amount and timing of the mother's most recent use, the baby's gestational age, the baby's exposure to prescribed medications while in the hospital setting, and the infant's in utero exposure to *polydrug* use (abuse of multiple substances) by the mother over the course of her pregnancy.

3 Kandall SR, Gartner LM. Late presentation of drug withdrawal symptoms in newborns. *Am J Dis Child.* 1974;127:58-61

#4 Potential Signs of NAS

In addition to the delayed onset of withdrawal symptoms, NAS identification is also more difficult when the initial presentation of withdrawal symptoms are compatible with other non-drug related medical conditions. This includes infectious or metabolic disorders such as hypoglycemia (jitteriness, seizures, poor feeding) and hypocalcemia (tremors, irritability, muscle twitches).

Infants with confirmed drug exposure who are asymptomatic or minimally symptomatic typically do not receive pharmacologic therapy. The multiplicity of factors affecting the onset and severity of withdrawal symptoms in infants means that child welfare professionals should regularly re-assess for symptoms post-hospital discharge.

The table below illustrates the most common clinical features observed when NAS is present.

TABLE 1. Clinical Features of the Neonatal Narcotic Abstinence Syndrome[4]

Neurologic Excitability
- Tremors
- Irritability
- Increased wakefulness
- High-pitched crying
- Increased muscle tone
- Hyperactive deep tendon reflexes
- Exaggerated Moro reflex
- Seizures
- Frequent yawning and sneezing

Gastrointestinal Dysfunction
- Poor feeding
- Uncoordinated and constant sucking
- Vomiting
- Diarrhea
- Dehydration
- Poor weight gain

Autonomic Signs
- Increased sweating
- Nasal stuffiness
- Fever
- Mottling
- Temperature instability

4 Neonatal Drug Withdrawal; http://pediatrics.aappublications.org/content/pediatrics/101/6/1079.full.pdf

Learn more on page 3 about:
• Substance Abuse Indicators • CARA • Plans of Safe Care

Trends in Investigative Practice

Substance Exposed Newborns

#5 Substance Abuse Indicators - Drug tests and clinical documentation of maternal or infant withdrawal symptoms will likely identify women with severe substance use disorders. In many instances however, **CPIs must use the totality of information to show that substance use is extensive, abusive and chronic enough to qualify as impending danger.** These information and indicators include, but is not limited to:

1. Drug-related criminal history (mother or partner)
2. Verified prior child welfare reports are for substance misuse
3. Previous Termination of Parental Rights due to substance abuse
4. Family made arrangements (for older sibling) due to substance abuse
5. Impaired adult functioning on Family Functioning Assessment (FFA)
   - chaotic lifestyle (couch surfing, no structure to meals, bedtimes or child supervision)
   - "Parentified child"
   - Codependency dynamics
     - One high, one low functioning partner
     - Family enmeshment (typically grandparents)
     - Family "cut-offs" (family has discontinued all communication with parents due to drug-use

AND ESPECIALLY . . .

6. Unsuccessful discharge from last treatment program attended
7. No current participation in a drug treatment program
8. Substance Use Disorder diagnosis (Mild, Moderate or Severe)
9. Did not follow American Society of Addiction Medicine recommended level of care for preferred treatment modality
10. A history of crisis stabilization for drug overdose events (e.g., voluntary or Baker or Marchman Act filings)

#7 Plans of Safe Care

Points of Intervention

1. Universal **prenatal** maternal health screening
2. Universal infant risk screening **after delivery**
3. **CPI referrals to home visiting programs** such as Healthy Start and Healthy Families for "safe" children
4. Plan of Safe Care components discussed in **FFA-Ongoing or Progress Update by case manager**

#6 CARA Legislation - The **Comprehensive Addiction and Recovery Act of 2016** (CARA) mandates Plans of Safe Care shall be presented to parents of infants affected by the mother's pre-natal or parents' post-natal use of drugs (up to the infant's first birthday). It is incumbent on child protective investigators and case managers dealing with substance involved mothers to ask whether a Plan of Safe Care was developed by hospital personnel, behavioral health specialists, or prevention or family support services staff working with the mother prior to the child welfare professional's involvement.

If a Plan of Safe Care has been developed, the child welfare professional should check with the person or program monitoring the plan to make sure the mother remain sufficiently engaged with the program and that the plan is meeting the infant and mother's need for medical care, the mother's substance abuse and mental health needs, and any other family members' need that would support stabilizing the family.

Plan of Safe Care components are listed on the following page. CPIs should note that many components are compatible with essential elements of information gathering for their FFA-Investigation. Similarly for case managers, the plans should help identify both child needs and case/treatment planning considerations for the parents.

Plan of Safe Care Components

Infant's Medical Care

- ❑ Prenatal exposure history
- ❑ Hospital care (NICU, length of stay, diagnosis)
- ❑ Other medical or developmental concerns
- ❑ Pediatric care and follow-up
- ❑ Referral to early intervention and other services

Mother's Medical Care

- ❑ Prenatal care history
- ❑ Pregnancy history
- ❑ Other medical conditions
- ❑ Screening and education
- ❑ Follow-up care with OB-GYN
- ❑ Referral to other health care services

Mother's Substance Use and Mental Health

- ❑ Substance use history
- ❑ Mental health history
- ❑ Treatment history
- ❑ Medication-assisted treatment history
- ❑ Referrals for services

Family/Caregiver History and Needs

- ❑ Family history
- ❑ Living arrangements
- ❑ Parent-child relationships
- ❑ Prior involvement with Child Welfare
- ❑ Current services
- ❑ Other needed services
- ❑ Child safety and risk concerns