



Annual Report

2017

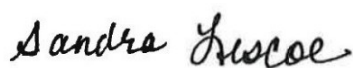
Letter from the CRP Coordinator:

On November 21, 2017, DCS Director Gregory McKay emailed a letter to the Arizona Citizen Review Panel members notifying them of the decision to not renew ASU's contract to coordinate the Arizona Citizen Review Panels, thanking members for their service, and encouraging them to continue their involvement as advisors to DCS.

As coordinators of the Arizona CRP, it has been a great honor to facilitate the panels for the last nine years. We extend our sincere gratitude to DCS for their partnership, and to each of the panel members for their commitment and dedication as volunteers carrying out the work of the panels.

Following the creation of the DCS, we embarked on a major transformation of the CRP. This transformation led to significant changes in the approach the panels took in fulfilling their CRP responsibilities. Most significantly, the panel members have taken the lead on identifying and understanding the issues faced in their communities. As a result, we believe the recommendations made by the panels have been better informed and more significant. This transformation also required the panels to define the mission, vision and values of the Arizona CRP, and to develop bylaws. Other achievements included the development of the Arizona CRP branding and logo; creation of a Google site for members to easily access documents, agendas and minutes; creation of an online orientation, manual, and clear member application and selection procedures. We look forward to sharing this information with DCS in the hope it will be helpful to them as they develop their work on citizen engagement.

The Arizona CRP has been a valued partner in the national CRP advisory and annual conference planning committees. An achievement we are particularly proud of was the 2016 National Citizen Review Panels conference, financed by the ASU Center for Child Well-Being and community sponsors. The conference was recognized as an outstanding event by the National CRP Coordinator and attendees. In closing, it has been our pleasure to facilitate this process of citizen participation in the governance of the state child welfare system.



Sandra Lescoe, MSW
Program Coordinator, Center for Child Well-Being

and



Judy Krysik, MSW, PhD
Director, Center for Child Well-Being

Overview of the Citizen Review Panel Program

The Arizona Citizen Review Panel Program provides opportunities for citizens to play an integral role in the Arizona public child welfare system. The federal government's motivation for mandating citizen involvement in the child welfare system was to, "provide new opportunities for citizens to play an integral role in ensuring that States are meeting their goals of protecting children from abuse and neglect." Congressional Record, House (September 25, 1996) 1149.

The Arizona Department of Child Safety (DCS) is the state administered government agency in Arizona responsible for the provision of child protection services. The Center for Child Well-Being (CCWB) at Arizona State University (ASU), through an interagency service agreement with DCS served as the coordinating center throughout 2017. CCWB provided administrative and technical support, and worked with DCS to meet all federal requirements specified in CAPTA regarding CRPs. Dr. Judy Krysik was the principal investigator, and Sandra Lescoe the program coordinator.

During 2017, Arizona had three regional CRPs (Central, Northern, and Southern) that represented all 15 counties. Each regional panel had a designated Chair or Co-Chairs who facilitated panel meetings and who performed other leadership responsibilities. The CRP members participated in quarterly three-hour meetings to engage in an array of review, evaluation, and educational activities. The Chairs and Co-Chairs participated in additional meetings and all panel members were invited to a statewide CRP meeting at the start of each calendar year.

The CRP members defined their program vision, mission, and values as follows:

Vision

The vision of the Arizona CRP is to be a catalyst for positive change in the Arizona child welfare system through citizen participation.

Mission

The mission of the Arizona CRP is to improve the child welfare system and outcomes for Arizona children and families through the:

- Provision of oversight
- Promotion of public awareness
- Advocacy and support for children and families currently involved in child welfare, and
- Partnering with members of the child welfare community

Values

The Arizona CRP's activities shall be guided by their established values and commitment to:

- Transparency
- Accountability
- Public awareness
- Public participation

Background and Purpose of Citizen Participation

Citizen participation in government is considered to be an important element of our democracy. CRPs are one of many mechanisms to promote meaningful public participation in the child protection system. CRPs allow citizens the opportunity to provide input about decisions that impact their community and advocate for community needs. Mandating citizen participation was also intended to:



- Promote transparency and accountability in the child welfare system;
- Impart new ideas into the child welfare system, especially child protection; and
- Foster community engagement involvement at the regional level, where people can conveniently participate and influence decisions in their community (Collins, 1998).

Establishment and Federal Requirements of CRPs

The following language is reproduced from the CAPTA Reauthorization Act of 2010 and outlines the requirements with regard to the Citizen Review Panels (<https://www.acf.hhs.gov/sites/default/files/cb/capta2010.pdf>).

ESTABLISHMENT

- **IN GENERAL** Except as provided in subparagraph (B), each State to which a grant is made under this section shall establish not less than 3 citizen review panels.
- **EXCEPTIONS**
 - **ESTABLISHMENT OF PANELS BY STATES RECEIVING MINIMUM ALLOTMENT.**—A State that receives the minimum allotment of \$175,000 under section 203(b)(1)(A) [42 U.S.C. 5116(b)(1)(A)] of this title for a fiscal year shall establish not less than 1 citizen review panel.
 - **DESIGNATION OF EXISTING ENTITIES.**—A State may designate as panels for purposes of this subsection one or more existing entities established under State or Federal law, such as child fatality panels or foster care review panels, if such entities have the capacity to satisfy the requirements of paragraph (4) and the State ensures that such entities will satisfy such requirements.

MEMBERSHIP Each panel established pursuant to paragraph (1) shall be composed of volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse and neglect, and may include adult former victims of child abuse or neglect.

MEETINGS Each panel established pursuant to paragraph (1) shall meet not less than once every 3 months.

FUNCTIONS

- **IN GENERAL**—Each panel established pursuant to paragraph (1) shall, by examining the policies, procedures, and practices of State and local agencies and where appropriate, specific cases, evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with—
 - the State plan under subsection (b) of this section;
 - the child protection standards set forth in subsection (b) of this section; and
 - any other criteria that the panel considers important to ensure the protection of children, including—
 - a review of the extent to which the State and local child protective services system is coordinated with the foster care and adoption programs established under part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.]; and
 - a review of child fatalities and near fatalities (as defined in subsection (b)(4) [of this section]).

CONFIDENTIALITY

- **IN GENERAL** The members and staff of a panel established under paragraph (1)—
 - shall not disclose to any person or government official any identifying information about any specific child protection case with respect to which the panel is provided information; and
 - shall not make public other information unless authorized by State statute.

PUBLIC OUTREACH Each panel shall provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations under subparagraph (A).

STATE ASSISTANCE Each State that establishes a panel pursuant to paragraph (1)—

- shall provide the panel access to information on cases that the panel desires to review if such information is necessary for the panel to carry out its functions under paragraph (4);
- shall provide the panel, upon its request, staff assistance for the performance of the duties of the panel.

REPORTS Each panel established under paragraph (1) shall prepare and make available to the State and the public, on an annual basis, a report containing a summary of the activities of the panel and recommendations to improve the child protection services system at the State and local levels. Not later than 6 months after the date on which a report is submitted by the panel to the State, the appropriate State agency shall submit a written response to State and local child protection systems and the citizen review panel that describes whether or how the State will incorporate the recommendations of such panel (where appropriate) to make measurable progress in improving the State and local child protection system.

Arizona Operations and Infrastructure

- Each of the three CRPs met quarterly.
- All CRPs used a uniform meeting format, agenda and meeting minutes.
- Co-Chairs for each panel assisted in creating the meeting agendas and facilitating meetings.
- All members signed confidentiality agreements.
- Reports are available online through DCS and ASU and were submitted annually to:
 - U.S. Department of Health and Human Services (DHHS) (Children's Bureau, 2017)
 - Arizona State Legislators
 - Community Stakeholders



2017 Highlights

Statewide Annual Meeting - January 31, 2017



On January 31, 2017, the ASU Center for Child Well-Being hosted a CRP statewide meeting. Those invited to participate were the members of the three state panels (Northern, Central, Southern), and Department of Child Safety and Center for Child Well-Being staff. The purpose of the meeting was to acknowledge and thank participants for their contributions; examine shared purpose and understanding of various roles, responsibilities, and perspectives; seek opportunities to foster collaboration, communication, and cooperation and discuss how to enhance authentic partnerships among citizens, families, DCS, and the community.

A review of the Arizona CRP Program mandate was provided including the importance of citizen participation and engagement, alignment of the CRP and DCS vision, and CRP mission and values. CRP Co-Chairs provided an overview of their topics of focus:

- The Northern CRP was examining the screening and identification of Substance Exposed Newborns (SEN) and their mother/parents when calls come to the AZ DCS Hotline.
- The Central CRP was examining the screening and identification of medical neglect when calls come to the AZ DCS Hotline.
- The Southern CRP was focusing on parent/child visitation for children birth through 3 years of age placed in non-relative foster care and the impact on child well-being.

DCS representatives provided presentations on their roles and responsibilities, DCS organizational structure including the Policy Team, and the goal of the SAFE AZ Renovation.



An Ecological Framework for Fostering Collaborative Approaches to Enhancing Care for Vulnerable Children and Families in Arizona was presented and reviewed as a framework for oversight of the CRP work. Following the presentation, participants were divided into three work groups and each group was assigned one of the following topics for discussion – Expectations, Quality Improvement, and Oversight. Each topic had question prompts for consideration and discussion. Following the work session, each group was asked to provide recommendations for consideration.

1. Expectations

What are your expectations in terms of the roles and responsibilities of your own organization (DCS/CRP)? What do you want from your counterpart organization to help you fulfill your goals and objectives (i.e. what is mandate of DCS and CRP)? Discuss strategies for improving understanding and collaboration between the DCS and CRP.

The Expectations Group concluded that proactive planning between DCS and the CRPs would be the best strategy for moving forward in this collaborative effort. They proposed developing a Joint Planning team comprised of the co-chairs of CRP, and select senior leadership of DCS and CCWB staff working with the CRPs. It was recommended that this group meet early in the year to identify shared interests as well as what is needed from the other organization. The Joint Planning team did meet as intended throughout the year.

2. Quality Improvement (QI)

How does each organization (i.e. DCS, CRP) approach this subject in relation to one another's role? What are the expectations of your own organization and what do you believe you need from the other organization (i.e. DCS, CRP), including what is working well and what impedes the ability to perform effectively? The Quality Improvement group concluded:

- Leadership within each organization must make QI a priority as only then will it be valued and seen as important throughout the organization. This requires establishing a culture of commitment to QI goals.
- Need for collaboration and trust for the sake of the goals; and setting reasonable, attainable outcomes and timeframes.
- Partners need to have open communication, taking responsibility for providing feedback, considering it and supporting a "no blame" environment that increases understanding and improves work.
- It is important for partners to have regular attendance and have a decision maker present when needed. The consideration of best practices will help align partners' work and reduce duplication.



3. Oversight

What are the oversight mandates for each organization (DCS, CRP, CCWB)? What does each organization need/want from their counterpart? What are the limits of collaboration for each organization in this area? The Oversight group concluded that:

- The organizations and members have differing mandates, roles, priorities, expectations and agendas. Despite this, focusing on the mandates, mission and goals of the CRP requires that differing

- perspectives remain objective.
- Communication and dissemination of policy changes, directives, progress reports, plans and minutes provided in a timely fashion keeps the work progressing, promotes transparency and increases accountability.
- Each organization has limitations due to differing priorities, limited staffing, use of volunteers, workload, and requests for information and support.

Public Outreach

AZ CRP members presented at the National Citizen Review Panel Conference in Anchorage Alaska.



The ASU Center for Child Well-Being provided information on the CRP at the following events:

- AZ Child Abuse Prevention Conference
- AZ Indian Child Welfare Act Conference
- AZ Council of Human Service Providers Annual meeting
- AZ Cesar Chavez Conference

Partnering with Members of the Child Welfare Community

The CRP Coordinator attended the Arizona Council of Human Service Providers monthly meeting to receive information and feedback that would inform the CRP members.

The CRP Coordinator served as a member of the Maricopa County (MC) Safe Reduction Workgroup led by the Maricopa County Juvenile Court and DCS, and that focused on safely reducing the number of children and youth in out of home care in Maricopa County.



Provision of CRP Panel Oversight

In 2015, the three CRPs went through a facilitated strategic planning process that led to each panel selecting topics of local relevance that would be explored from 2015-2017. These topics were selected by the panel members to align with the DCS Strategic Plan. The CRPs chose a new framework to direct their work that included:

- Identifying and clearly establishing the topic and the purpose of pursuing the topic
- Posing questions that explore the topic
- Collecting information related to the topic on national, state and regional policies, procedures, current practices and data, as well as networking and presentations from experts, and interviews and focus groups with local stakeholders
- Reviewing the information collected and analyzing finding
- Making recommendations based on observations and conclusions

Northern Panel Project

	2015	2016	2017
Identify Topic	In 2015, the Northern CRP became interested in Substance Exposed Newborns (SEN) due to the high number of infants in foster care and the vulnerability of SENs. When these infants come to the attention of DCS, they require thorough child safety and risk assessments, and timely interventions to ensure their safety and well-being to prevent future maltreatment. The panel members determined that they would conduct a thorough review by examining how federal state/laws, policies, and procedures are applied to this population.		Substance Exposed Newborns (SEN) and their mother/parents who come to the attention of DCS require sufficient and timely identification, as they pose a higher risk of negative outcomes owing to their medical complexities and vulnerability. Due to the high number of infants in foster care, well documented opiate epidemic, and child fatalities highlighted by the media of children who were born drug exposed, the CRP began examining this complex issue at the initial stage of a child welfare case, i.e., the Hotline.
Goals and Desired Outcomes	Review current laws, policies, procedures, and practices or other known or best practices related to SEN.	Continue review and examination of SEN to enhance their understanding of current policies, procedures and practice that directly affect the safety, permanency and well-being of this population.	Examine the initial stage in the child protective service process of receiving and screening reports of abuse or neglect at the DCS Hotline when substance exposure of a newborn is suspected. Intake and screening includes gathering enough information to determine whether the report meets the legal definitions of abuse or neglect, whether it is a credible report that requires investigation, and whether it is so urgent that it requires immediate action.
Questions to be Explored	- Do child welfare policies and procedures address the needs of infants who are substance-exposed? - Do mandated health care providers identify these newborns and report an allegation to the Hotline?	Are DCS intake and screening policies, procedures and practices handled in a systematic method to adequately address the identification	What are the AZ policies, procedures, and protocols that currently govern the operations and practices of the DCS Centralized Hotline and how SENs are identified?

	• Is there a consistent approach for SEN testing of newborns being utilized by hospitals? • Do DCS Hotline policies meet the Federal CAPTA criteria for SEN? • Does DCS have specific SEN policies, practices and procedures for decision making when an allegation is made?	of SEN? • How is quality assurance occurring regarding SEN Hotline calls? • How do other states' SEN policy and procedures compare to DCS; and do they capture SEN as a single data element or track additional data elements such as "Substance Affected Newborns?"	• How do Federal and State laws and rules regarding mandated reporting that govern the child welfare system's intake and screening processes and the receipt/identification of child maltreatment reports (specifically SEN) compare? • What are opportunities DCS can access to increase ongoing training for staff in the areas of early childhood development, assessment of child safety, and SEN, MAT and NAS as it relates to parental substance abuse? • What are other states' policies, procedures and definition of SEN? At the Hotline, are other states collecting SEN information? Are there benefits to classifying and capturing types of SEN as separate data? • Will the change of the statewide automated child welfare information system from CHILDS to GUARDIAN identify types of SEN?
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			• How has DCS implemented the new Safe Care Federal requirements? • What other organizations or groups are doing work related to the SEN population in AZ? Can efforts be shared and enhanced to increase benefits, reduce duplication and create systems of care for collective impact?
Literature, Presentations and Information Reviewed	See CRP Annual Report 2015	See CRP Annual Report 2016	See Appendix A for resources cited and materials examined
Observations and Conclusions	• Arizona has no statutory requirement to test all newborns for substance exposure. There is no single approach utilized by hospitals for mandatory testing of all newborns. • DCS policies indicated that when there is information that is received at the Hotline that meets the legal criteria for a SEN report, it is coded as high-risk neglect and dispositioned to the field for investigation. • Hotline questions, child safety and risk assessment questions and training need further development to reflect the assessment structure and needs of SEN. • The definition of what constitutes a plan of safe care for the infants born affected by illegal substance or withdrawal symptoms is unclear. • The Guidelines for Identifying Substance-Exposed Newborns (2008) do not reflect the practice advancements that have been made in maltreatment.	• The new Hotline decision-making tool improves the accuracy of report screening and prioritization. • DCS Hotline has dedicated audit staff who conduct quality assurance reviews which has increased consistency and interrater reliability to 80%. • A separate dedicated telephone line has been established for mandated reporters and has increased accessibility to immediate response. • The Hotline has established guidelines and questions that are asked regarding SEN and parent substance abuse that are consistent with federal and state statutes.	• Of the DCS Hotline reports that indicated neglect as one of the most serious allegations, the Morrison Institute researchers estimated that 9% involved substance-exposed newborns. (Morrison Institute, 2017) • In the Northern region, DCS received 4,864 reports for investigation in 2016. Of those, 410 were SEN (AZ DCS 2017 per Gina Magri) • Conducting SEN case reviews can provide information on how DCS responds to these reports. • SEN reports to the Hotline have a priority 1 allegation as

	• Neonatal Abstinence Syndrome (NAS) used as a reference in the DCS Policy Manual and staff training will provide guidance for the assessment of safety and risks • It remains unclear as to how SEN reports are categorized and what information exists on services. • Hotline staff SEN decision-making, an understanding of the role of removals based on active safety, staff training competencies and training application threats remain unclear.		neglect – (AZ DCS 2017 per Gina Magri) • The Hotline Decision Making Tool is used as a standardized guide to screen and identify reports of SEN. • It is unknown to the Panel how much information is collected at the Hotline on the type of SEN. • The following stakeholders are working on elements related to this topic area: ○ Arizona Department of Health Services ○ Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs ○ Arizona Substance Abuse Partnership ○ Arizona Prenatal Task force ○ Best for Babies ○ Child Abuse and Neglect Prevention Services ○ Department of Child Safety Sense Program ○ Healthy Families Arizona ○ Maricopa County specialized in-home Substance Exposed Newborn Safe
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			Environment (SENSE) program - o The Substance Abuse Epidemiology Work Group (Epi Work Group) • States vary in the definition of SEN. Some states have subtypes defined. See Appendix C for a comparison.
Panel Recommendations and DCS Response	1. The Northern CRP will examine potential changes to guide child safety and risk assessment, training, and supervision related to SEN. <i>The DCS agrees with this recommendation and looks forward to sharing our subject matter expertise with the CRP to examine potential changes to guide assessment, training and supervision related to SEN.</i> 2. The Northern CRP will explore sources of expert training on SEN. <i>The DCS agrees with this recommendation and looks forward to receiving the results of the CRP's exploration.</i>	1. The Northern CRP respectfully recommends that CRP and DCS collaborate to explore how other states are collecting information related to SEN and to review best practice research in order to develop strategies to address this issue. <i>The DCS agrees with this recommendation and will collaborate with the Northern Panel to gather information from other states to learn about SEN information collection and best practice research, to develop strategies that address the needs of substance exposed newborns.</i> 2. Northern Panel respectfully recommends DCS work with a national expert (for example, Children and Family	1. The Northern CRP recommends DCS establish procedures and protocols with the CRPs to gather and review issue specific information in order to gain understanding and determine how child protection laws, policies, procedures and practices are implemented and how they impact child welfare involved individuals in AZ. 2. The Northern CRP recommends DCS work collaboratively with other systems and stakeholders (as listed above under observations) working in the area of SEN to strengthen

	3. The Northern CRP will provide DCS information on existing practices of testing for substance exposure and yearly certification of assessment skills specific to SEN. <i>The DCS agrees with this recommendation and looks forward to receiving the information from the CRP on existing practices of testing for substance exposure and yearly certification of assessment skills specific to SEN.</i> 4. The Northern CRP respectfully recommends their recommendation from 2014 regarding training to ensure the workforce is educated in early childhood development, child safety and risk assessments, and medically assisted treatment (MAT) be considered. <i>The DCS respectfully recommends their recommendations from 2014 regarding training to ensure the workforce is educated in early childhood development, child safety and risk assessments and, MAT be considered.</i>	Futures that presented at the 2016 National CRP Conference to determine if there are better ways that they and system partners can identify children who have been impacted by prenatal substance use of the mother, assess the degree to which this exposure has or potentially affects the child's development, and pursue a collaborative approach for serving children and their caretakers). <i>The DCS agrees with this recommendation and has recently consulted with Child and Family Futures to develop resources and expand knowledge to determine if there are better ways to identify children who have been impacted by prenatal substance use of the mother, assess the degree to which this exposure has or potentially affects the child's development, and pursue a collaborative approach for serving children and their caretakers.</i> 3. The Northern Panel respectfully recommends that DCS give further consideration to their 2015 recommendation regarding ongoing training to ensure that the DCS workforce is well informed in early childhood development, assessment of child safety, and MAT, and is kept up to date in best practices related to substance abuse in child welfare. This should include ongoing	well-being of SEN infants and their families.
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		training and communication. <i>The DCS agrees that training is one of several key strategies to assure the DCS workforce is well informed in early childhood development, assessment of child safety, and MAT, and to keep up-to-date in best practices related to substance abuse in child welfare. The Department has recently launched a major renovation to the AZ SAFE Model which includes five days of training for DCS Investigation Specialists and two days of training for DCS Ongoing Specialists. All case carrying staff and their supervisors and Program Managers will be trained during the summer of 2017. Additional training of Ongoing Specialists will take place later in the year. Additionally, a significant overhaul of the DCS Core Training for new DCS Specialists is under development in collaboration with experts from ASU and other key stakeholders. Topics scheduled to be included in the new training include: Trauma and Child Development; interviewing and information gathering; and substance exposed newborns.</i>	
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2017 Meeting Dates: February 28, May 16, August 22, October 24, 2017

CRP Chair: Becky Ruffner

Local CRP Members*: Elaine Grissom, Kim Chappellear, Trisha Riner, Laura Karnitschnig, Rebecca Prieto

DCS Members: Dani O’Connell, Northern Arizona University School of Social Work; Christie Kroger, Practice Improvement Administrator; Angie Trevino, Policy Specialist; Michael Messinese, Practice Improvement Specialist

ASU Staff: Sandra Lescoe, CRP Program Coordinator; Bob Cohen, CCWB Advisor

ASU MSW Intern: Tracy Smith

*As per CAPTA: MEMBERSHIP—Each panel established pursuant to paragraph (1) shall be composed of volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse and neglect, and may include adult former victims of child abuse or neglect.

Central Panel Project

	2015	2016	2017
Identify Topic	In 2015, the Central CRP focused their review on their topics of interest, medical neglect and medically complex children involved with DCS. Their interest was based on prior case reviews and panel member concerns which included inconsistencies in assessment of child safety and risk including contrasting professional opinions of what constitutes medical neglect and the identification of children who have medically complex issues.	In 2016, due to the high percentage of DCS reports that were categorized as neglect, the Central Panel chose to narrow their focus solely on medical neglect.	In 2017, the panel chose to gain a more comprehensive understanding of medical neglect by further examining the screening and identification when calls come to the AZ DCS Hotline. Complex medical issues can be misunderstood and if not adequately identified or responded to, may pose a threat of further maltreatment or death among children of all age groups. If screening of medical neglect reports is more accurate and consistent when it is defined, and if Hotline staff have access to medical professionals who know medical terminology, then there is a greater likelihood of a more accurate assessment.
Goals and Desired Outcomes	Review and examine relevant laws, policies, procedures, practice, training or other known or best practices to determine how medical neglect and medically complex children are identified at the Hotline.	Review and examine current AZ Hotline procedures and identify how medical neglect is identified compared to known and best practices.	Review and examine: • Changes to current DCS AZ Hotline intake and screening call script to determine whether the report meets the legal definitions of abuse or neglect to support report credibility for investigation and immediate action. • A national analysis of other state's definition and criteria of neglect to compare how medical neglect is handled at the Hotline. • To determine the prevalence of medical neglect by examining AZ data.
Questions to be Explored	• What are the number of medical neglect cases in AZ and how does DCS reflect these in the data? • Does DCS have Hotline policies and procedures in place to create consistency in the determination of	• What are the policies, procedures and practices of the Hotline when responding to calls related to medical neglect and medically complex children? • What are the benefits of classifying and capturing types of neglect as separate data elements starting at the Hotline?	• Do Hotline script and tools support the gathering of sufficient information to screen and identify medical neglect as a form of maltreatment whether or not there is an accompanying diagnosis? • What are the competencies that staff should have to assess reports involving allegations of medical neglect?

	medical neglect, medically complex and medically fragile children. How has the DCS Hotline used recommendations provided by independent consultants (e.g., Action for Child Protection 2010, Change and Innovations 2012-2013, the CARE Team) to change practices that support medical neglect and medically fragile children?	- What are other known, best practices and strategies that can best address this issue in AZ? - What other organizations or groups are doing work related to the medical neglect and medically complex population in AZ? Can efforts be shared and enhanced to increase benefits, reduce duplication and create systems of care for collective impact?	- How is medical expertise being accessed by Hotline staff in the determination of referrals? - How do other states define medical neglect and do they use similar criteria for a determination? - What are the benefits to classifying and capturing types of neglect as separate data? - Is the rate of medical neglect in Arizona different than in other states?
Sources of Information Reviewed	See CRP Annual Report 2015	See CRP Annual Report 2016	See Appendix A for cited resources and materials
Observations and Conclusions	- Neglect is broadly defined both nationally by other states and by AZ - There is no existing definition in the DCS policy manual which defines “medical neglect” or “medically fragile” - Medical personnel making referrals to the Hotline may be using terms that staff may not understand - DCS staff can request supervisory support to determine medical neglect, however there is no process or requirement that specifies how/when staff should or are required to seek medical expert consultation - The complexity of these cases, especially when domestic violence and substance abuse is involved, are difficult to assess	- Medical neglect is not tracked as a sub-type by the Hotline, therefore it is difficult to develop responsive policies, procedures and staff training - Inter-rater reliability completed by DCS at the Hotline is conducted by internal DCS staff and does not include any stakeholder input or outside review	- Of the DCS Hotline reports that indicated neglect as one of the most serious allegations, the Morrison Institute researchers estimated that 9% involved medical neglect (Morrison Institute, 2017). - The Hotline Decision Making Tool is used as a standardized guide to determine medical neglect. - DCS could more comprehensively collect data on type of medical neglect in AZ. - States vary in the definition of neglect. Some states have sub-types defined and the definition of medical neglect varies. See Appendix B for a comparison. - The Hotline training curriculum was received in October, 2017 and not reviewed in time for this report.

	Qualifications and training of Hotline staff and utilization of temporary workers to fill vacant positions		The Hotline Decision Making Tool currently states “medical diagnosis of malnutrition/failure to thrive without previously diagnosed condition as a type of maltreatment.”
Panel Recommendations and DCS Response	- Continue in collaboration with DCS to assess how medical neglect and medically complex are defined and identified beginning at the Hotline, and to determine if there are changes warranted that would improve the identification and response to vulnerable children who otherwise might not be identified. <i>DCS agrees with this recommendation and looks forward to collaborating with the CRP to assess definitions and improve identification and response to medically neglected and medically complex children.</i> - DCS in collaboration with medical partners develop a means and process to cross train and provide ongoing training to staff on statutes, policies, and procedures in which they operate. <i>DCS agrees with this recommendation and looks forward to collaborating with the CRP to develop a means and</i>	- The first priority is to work with DCS to establish clear roles and responsibilities for each party in order to enhance the ability of the Panel to evaluate medical neglect and effectively collaborate with DCS. <i>DCS supports the Central Panel’s priority to establish clear roles and responsibilities for each party in 2017. DCS is communicating with all of the CRP Panels to support this priority.</i> - DCS consider involving its members when DCS is requesting stakeholder input on matters pertaining to medical neglect and complex medical needs. <i>DCS agrees with this recommendation and will involve Citizen Review Panel members when the DCS is seeking input on medical neglect and complex medical needs.</i> - The review of this subject continues in collaboration with DCS to assess how medical neglect and medically complex are defined and identified beginning at the Hotline, and to determine if there are changes warranted that would improve the	- Continue in collaboration with DCS to review the DCS Hotline Decision Making Tool and Practice Improvement tool and make changes warranted that would provide clarity regarding the types of maltreatment particular to neglect, malnutrition and failure to thrive. - Continue in collaboration with DCS to assess Hotline staff training to determine if changes are warranted that would increase staff competency to identify and determine medical neglect. - Continue in collaboration with DCS and medical experts to review the mandated reporter interview questions for relevance in regard to medical neglect and consider changes warranted that would improve disposition decisions. - Continue in collaboration with DCS to review the Hotline script to develop guidelines that are responsive to common types of medical neglect. - Continue in collaboration with DCS to review other state’s definitions of medical neglect, specifically sub-types that may improve identification and response.

process to cross train and provide ongoing training to staff.

3. DCS, with support from the CRP and ASU, develop a process for collecting and tracking medical-related reports that include allegations of domestic violence and substance abuse.

DCS agrees with this recommendation and looks forward to developing this process with support from CRP and ASU.

identification and response to vulnerable children who otherwise might not be identified.

DCS agrees with this recommendation and will continue to collaborate with the Central Panel to assess how medical neglect and medically complex are defined and identified at the Hotline, to determine if changes are warranted that would improve the identification and response to vulnerable children who otherwise might not be identified.

4. DCS in collaboration with medical partners develop a means and process to cross train and provide ongoing training to staff on statutes, policies, and procedures related to identification and response to children who have been medically neglected or have complex medical needs. The Panel can explore resource needs to realize this objective with DCS.

DCS agrees with this recommendation and will collaborate with the Central Panel and other partners to develop a process to cross train and provide ongoing training to staff on statutes, policies and procedures related to identification and response to children who have been medically neglected or have complex medical needs.

5. DCS, with support from the CRP and ASU, work on understanding the extent to which medical-related neglect reports are

		associated with allegations of domestic violence and substance abuse. <i>DCS agrees with this recommendation and will collaborate with the Citizen Review Panel and ASU to further understand the extent to which medical-related neglect reports are associated with allegations of domestic violence and substance abuse.</i>	
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2017 Meeting Dates: March 14, May 30, June 27, August 31

CRP Co-Chairs: Gary Brennan, Janet Cornell, Allison Thompson

Local CRP Members*: Dr. Monique Williams, Beth Rosenberg, Esther Kappas, Marcia Stanton, Joanne MacDonnell, Mary Jo Whitfield, Princess Lucas Wilson, Yvonne Fortier, Anika Robinson, Rhonda Baldwin, Teasi Colla, Tracy Sloat, Stephanie Zimmerman, Cynthia Elliott, Marcy Morales, and Anne Donahue

DCS Members: Christie Kroger, Practice Improvement Administrator; Angie Trevino, Policy Specialist; Bridget Corisdeo, Practice Improvement; Gina Magri, Hotline Practice Improvement

ASU Staff: Sandra Lescoe, CRP Program Coordinator; Bob Cohen, CCWB Advisor, Ann Carver, PhD Candidate

ASU MSW Interns: Tracy Smith, Claudia Robinson, Tiffany Claurer, Patience Pearson

*As per CAPTA: “MEMBERSHIP.—Each panel established pursuant to paragraph (1) shall be composed of volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse and neglect, and may include adult former victims of child abuse or neglect.”

Southern Panel Project

	2015	2016	2017
Identify Topic	In 2015, the Southern CRP became interested in the provision of timely and quality parent-child visitation for young children in out of home care. A critical component of child well-being is the promotion of parent-child attachment and separation as a result of foster care was concerning. They chose to focus on children ages birth to three who are placed in non-relative foster care and ascertain how quality visitation occurs.		
Goals and Desired Outcomes	- Gain a greater understanding of current parent-child visitation policies, procedures, practices, training, and systemic issues. - Determine if DCS visitation practices are achieving federal outcome-related goals and align with best practices.	- Provide input to DCS administrators and other child welfare decision makers to shape policies and develop procedures related to parent-child visitation. - Gain a greater understanding of DCS current Continuous Quality Improvement (CQI) to identify underlying systemic issues and barriers to improve the quality of parent-child visitation practices.	Examine DCS and local agencies' policies and procedures; and review specific cases to evaluate the extent to which DCS is effectively discharging their child protection responsibilities specific to parent-child visitation for children birth through three years of age who are placed in non-relative foster homes.
Exploration	- What are DCS policies, procedures, regulations and structure for the facilitation of parent-child visitation? - What documentation is required? - How does Team Decision Making (TDM) support decisions regarding parent-child and sibling visitation? - How do Court reports document the visitation schedule and plan?	- What are federal and state parent-child visitation statutes, policies, procedures and practice? - Does DCS meet the federal outcome measures for permanency? - What other organizations or groups are doing work related to the parent-child visitation population in AZ? Can efforts be shared and enhanced to increase	- Are the current DCS parent-child visitation policies and procedures clear and consistent with best practice? - How does the geographic area of the family and young child involved in the DCS system impact the frequency, duration and quality of the visitation?

	Nationally, what are other known or best practices and strategies that can best address this issue?	benefits, reduce duplication and create systems of care for collective impact? What are other known or best practices and strategies that can best address this issue in AZ?	- Do parent-child visitation service providers within each County implement visitation the same or differently? - What other known or best practice models are presently being implemented in the Southern region? - Do DCS staff who supervise and provide parent-child visitation have the qualifications and training that support competency? - Do service providers who supervise and provide parent-child visitation have the qualifications and training that support competency levels? - Is there any statistical information about citizen complaints about parent-child visitation that are made to the DCS Ombudsman Office?
Literature, Presentations and Information Reviewed	See CRP Annual Report 2015	See CRP Annual Report 2016	See Appendix A for resources cited and materials examined
Observations and Conclusions	- DCS clearly defines the definition, purpose, reason for visitation and requirements. - DCS policy includes frequency, duration, and location of contact and visitation as factors in determining visitation. - DCS Specialists would benefit from clearer and more concrete guidance for how the above factors should impact visitation-related decisions.	- There is a lack of engagement among key stakeholders who share the responsibility for system improvements. - The growing number of reports of maltreatment, number of children in foster care and backlog in pending investigations along with resource constraints and high caseload demands make it difficult for DCS	Conducting case reviews can provide information on how DCS policies and procedures are applied and how they impact clients.

	• DCS Specialists receive one-day of visitation training that includes an overview of child development. • Nationally, children who enter foster care are disproportionately toddlers and infants. Arizona has similar statistics. • Parental visitation is the primary intervention for maintaining the parent-child relationship with children who are removed and placed in out of home care. • Best Practice suggests: ○ Changing the terminology “visitation” to “family time”. ○ Timely first visits within 48 hours of initial removal reducing negative impact on the parent, child and siblings. ○ Consistent visitation is important for family preservation and developing and maintaining parent-child attachment. This is a key variable in determining reunification. ○ Frequent and consistent visitation increases the child’s feelings of security and the parent’s understanding and confidence in parenting skills. • A visit coach or supervisor can integrate visitation time with learning and modeling opportunities.	staff and contracted service providers to provide supervised parent-child visitation services, coaching and transportation. • The Best for Babies initiative has resulted in greater attention to the need for young children to have frequent visitation. • DCS has made efforts to reduce the length of stay for children in out of home care through targeted staffing, case reviews, TDMs, the development of family engagement tools and strategies, improving service delivery and practice guidelines for DCS Specialists on parent-child visitation.	• Once an understanding of the implementation of DCS policies and procedures is developed, a review of the DCS parent-child visitation Scope of Work (SOW) will provide expectations of implementation and service practice by providers (best practices).
Panel Recommendations and DCS Response	1. The CRP respectfully recommends the CRP in collaboration with DCS identify research and examples from other states to create a comprehensive parent child visitation guide that provides structure, continuity, and steps for decision making.	1. CRP respectfully recommends the CRP and Policy Administrator of DCS continue to work in partnership to establish a protocol that promotes consistent understanding and implementation of CRP and DCS roles/responsibilities in relation to the	

DCS agrees with this recommendation and looks forward to collaborating with the CRP to develop comprehensive parent-child visitation guidelines.

2. The CRP respectfully recommends DCS examine existing policies and procedures related to parent child visitation to enhance and ensure information is consistent, updated, and in alignment with DCS Specialist training, and specific guidance which includes how and where to document frequency, duration, location, and structure of contact and visitation.

DCS agrees with this recommendation. DCS recently reviewed best practice information recently related to the frequency, duration, location, and structure of parent-child contract and visitation. DCS will review policy and training to identify revisions that may be needed to ensure policy and procedures are consistent with the best practice information.

3. The CRP respectfully recommends DCS collaborate with the CRP and community partners in 2016 to examine best practices that could be considered for implementation and which would support quality parent child visitation (e.g. family time, parent coaching services).

DCS agrees with this recommendation and looks forward to collaborating with the CRP to examine best practices to support parent-child visitation.

CRPs, CRP federal responsibilities in relation to the CRPs, CRP federal statutory responsibilities, and sharing of information.

DCS agrees with this recommendation. The DCS Policy Administrator has been communicating with all of the CRP Panels to establish a protocol that promotes consistent understanding and implementation of CRP and DCS roles/responsibilities in relation to the CRP's, CRP federal statutory responsibilities, and sharing of information.

2. The Southern Panel respectfully recommends that CRP work with the Policy Administrator of DCS to identify and develop a plan to ensure that policies and procedures related to parent-child visitation reflect a single statewide standard that is consistent and provides a clear framework of parent-child visitation, including specificity for ages birth to three years (such as creating a comprehensive standardized parent child visitation guide).

DCS agrees with this recommendation and will work with the Southern Panel to evaluate and update existing Department policies and procedures, including recently published Practice Guidelines on Parenting

1. The Southern CRP recommends DCS establish procedures and protocols with the CRPs to gather and review issue specific information in order to gain understanding and determine how child protection laws, policies, procedures and practices are implemented and how they impact child welfare involved individuals in AZ.

Time, (parent-child visitation) so that they are consistent with best practice standards and provide a consistent framework for parenting time, including for children birth to three years.

3. The Southern Panel respectfully recommends DCS Administration and the Regional Managers seek strategies to strengthen (local/statewide) internal and external communication plans and consistency in the distribution of key initiatives, directives, and changes to statewide/local practice and policies so that:

- DCS Staff are informed about upcoming changes they need to know and understand (management to front line staff);
- There is continuity in messaging internally and to the public;
- DCS staff may be better prepared to respond when communicating with the public; and
- DCS promotes values of accountability and transparency.

DCS is working to improve regularity, quality, and consistency of communication for both internal and

external stakeholder groups. Key strategic initiatives such as the SAFE AZ Renovation, Safety Science and Guardian Mobile Solution all require a great deal of internal organizational change management as well as a shift in the public's understanding of how we practice both philosophically and technologically.

Internally, we will concentrate primarily on improved training delivery - taking the time required to prepare our front-line staff for change. Externally, we will increase visibility to our practice improvement work by delivering custom-tailored direct messages by audience (for example courts, CASAs, legislators, etc.) as well as issuing media releases when appropriate.

4. The Southern Panel respectfully recommends that the CRP, system partners, and DCS collaborate to determine whether parent-child visitation is being implemented and aligned with best practices within the Southern Panel's jurisdiction and identify barriers in providing parent-child visitation services that are aligned with best practices (i.e. through a review of protocols, contracts, etc.)

	<i>The DCS agrees with this recommendation and will collaborate with the Southern Panel and other system partners to evaluate and improve practices associated with parenting time (parent-child visitation) in the Southern Panel's jurisdiction.</i>	
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2017 Meeting Dates: March 7, May 18 and August 30, 2017 (The 4th meeting for 2017 was postponed until access to case files and the cooperative agreement was resolved.)

CRP Co-Chairs: Jessica Brisson and Kirk Short

Local CRP Members: Tiffany Clauer, Chet Ware, Terri Freed

DCS Members: Angie Trevino, Policy Specialist; Leslie Gross, Practice Improvement; Christie Kroger, Policy Improvement Administrator

ASU Staff: Sandra Lescoe, CRP Program Coordinator; Bob Cohen, CCWB Advisor

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Appendix A

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Appendix B

Intake Specialist Qualifications, Intake and Screening, and Medical Neglect Definitions

State	Intake Specialist Qualifications	Summary
Arizona	Requires Master's or Bachelor's Degree from an accredited college or university, OR Five (5) years of experience as a DCS Case Aide II in Arizona state service.	In general, most states reviewed required that their Hotline Intake Specialist have at least a Bachelor's Degree from an accredited college or university. In addition, it was preferred that the degree be in social work, human services, or a related field of study.
Colorado	High School diploma or GED, required language proficiency; bilingual a plus.	
Connecticut	Must be a social worker	
Florida	The minimum education requirement for all Hotline counselors is a Bachelor's degree from an accredited university. A number of Hotline counselors have obtained or are pursuing their Master's degrees.	
Iowa	No information found.	
Kentucky	Graduate of a college or university with a bachelor's degree in social work, sociology, psychology, marriage and family therapy or a related field.	
Michigan	Possession of a bachelor's or master's degree with a major in one of the following human services areas: social work, sociology, psychology, family ecology, community services, family studies, family and/or child development, guidance/school counseling, counseling psychology, criminal justice, or human services.	
Montana	Bachelor's degree in human service field and complete same training as CPS workers, and annual policy training.	
New York	A baccalaureate degree from an accredited school, including or supplemented by 24 semester credits in one or a combination of the following fields: social work, psychology, sociology, human services, criminal justice, education (including early childhood), nursing, or cultural anthropology, at least 12 of which must have been in one of these disciplines.	
Texas	Must have a 4-year degree from an accredited school in social work, psychology, sociology, or human services	

All 50 states, the District of Columbia, and the U.S. Territories have child abuse and neglect reporting laws that mandate certain professionals and institutions to refer suspected maltreatment to a child protective services (CPS) agency. Most CPS agencies use a two-step process to respond to allegations of child maltreatment: (1) screening and (2) investigation and alternative response. A CPS agency receives an initial notification—called a referral—alleging child maltreatment. A referral may involve more than one child. Agency Hotline or intake units conduct the screening response to determine whether a referral is appropriate for further action. State laws and policies also specify the required content of reports, criteria for screening reports, investigation procedures, timeframes for completing investigations, and classification of investigative findings. Many states also have special procedures for handling child fatalities and substance-exposed children.ⁱ

Hotline Intake and Screening of Child Abuse and Neglect– Initial screening script/questions, tools, and protocols

Arizona	Standardized interview questions and practice guide   Mandated Reporter Interview Questions.pdf Child Abuse Hotline Decision Making Tool Utilize guidelines that are like a script but it is intended to be used as a guide and to be adapted to the specific situation/call. There is specific content and information that needs to be gathered per state statute	Although all states recognized medical neglect and had similar definitions, only Iowa listed the questions that the intake specialist would ask if medical neglect was suspected or stated. One state specially mentioned that NOT providing immunizations or routine well care did not constitute medical neglect. All states recognized the denial of medical care was significant enough to be defined; however, not significant to be listed as its own indicator on a report. According to the Morrison Institute (2017), medical neglect is being recognized as a separate type of neglect; however, reports are still being combined “under the general term neglect” (Quintana, p. 4)¹.
Colorado	An enhanced screening guide was developed to provide call takers with a consistent and structured process for interviewing reporters https://sites.google.com/a/state.co.us/cdhs-dcw/home/programs/colorado-child-abuse-and-neglect-reporting-system	
Connecticut	LINK-generated tools including: CPS Report Protocol and Structured Decision Making (SDM) Screening Tool.	
Florida	Three Stages of Intake Assessment: introductory phase, exploration phase, closing phase	
Idaho	http://www.healthandwelfare.idaho.gov/Portals/0/Children/AdoptionFoster/PriorityGuidelines.pdf	
Illinois	https://www.illinois.gov/dcfs/safekids/reporting/Documents/cfs_1050-21_mandated_reporter_manual.pdf	

¹ <https://morrisoninstitute.asu.edu/sites/default/files/content/products/Neglect%20Analysis.pdf>

Iowa	Structured interview, Intake Screening Tool, Intake Sheet, and Desk Aid  SJA0003_Structured_Interview (2).pdf  Factoring Child Abuse Desk Aid v5.8.ç  Intake Screening Tool.pdf  Child Protection Intake Sheet.pdf Intake questions on medical neglect: - Does the child require immediate medical treatment? - Who, if anyone, has informed parents that child needs to seek medical treatment? - What the parental response was to this information? - What the child's current condition, i.e. displaying signs of injury or symptoms of medical ailment? - What has parent done up to this point to treat the medical need? - What are the medical consequences that put this child at risk if the child does not receive	
Indiana:	http://www.in.gov/dcs/files/3.1_Receiving_Calls_Overview.pdf	
Massachusetts	http://www.mass.gov/eohhs/docs/dcf/child-abuse-reporting-form.pdf	
Michigan	http://www.michigan.gov/documents/dhs/Pub-112_179456_7.pdf	
Mississippi	http://www.mdhs.state.ms.us/media/9600/sectionb.pdf	
Montana	Intake tree  CI Decision Tree 5.doc	
Nebraska	http://dhhs.ne.gov/children_family_services/Guidebooks/Intake%20Guidebook.pdf	
New York	Intake/Individual Report of Involvement (IRI) report. http://ocfs.ny.gov/main/cps/  NY Report of Suspected Child Abus	
South Carolina	https://dss.sc.gov/resource-library/manuals/hs_manuals/cpps_hs.pdf see chapter 7	
Washington	https://www.dshs.wa.gov/ca/2000-child-protective-services/2200-intake-process-and-response	
Wisconsin	https://dcf.wisconsin.gov/files/cwportal/policy/pdf/access-ia-standards.pdf	

Relevant Statute	Legal definition of neglect (medical neglect). https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/define/
Arizona AZ Rev. Stat. Title 8. Child Safety § 8-201	'Neglect' or 'neglected' means: The inability or unwillingness of a parent, guardian, or custodian of a child to provide that child with supervision, food, clothing, shelter, or medical care, if that inability or unwillingness causes unreasonable risk of harm to the child's health or welfare Exceptions Citation: Rev. Stat. § 8-201 A dependent child does not include a child who, in good faith, is being furnished Christian Science treatment by a duly accredited practitioner. A child is not considered neglected if a parent's inability to meet the needs of the child is due solely to the unavailability of reasonable services.
Alaska Alaska Stat. § 47.17.290	'Neglect' means the failure of the person responsible for the child's welfare to provide the child necessary food, care, clothing, shelter, or medical attention. Exceptions Citation: Alaska Stat. § 47.17.020(d) A religious healing practitioner is not required to report as neglect of a child the failure to provide medical attention to the child if the child is provided treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner of the church or denomination
Colorado Colo. Rev. Stat. Ann. §§ 19-1-103; 19-3-102	The term 'child abuse or neglect' includes any case in which a child is in need of services because the child's parent has failed to provide clothing, shelter, medical care, or supervision that a prudent parent would take. A child is 'neglected' or 'dependent' if the parent, guardian, or legal custodian fails or refuses to provide the child with proper or education, medical care, or any other necessary care. Medical neglect Failure to seek medical or dental treatment or to comply with medical advice for a health problem or condition that, if left untreated, enough to represent a danger to the child. Denial of health care: the failure to provide or to allow needed care as recommended by a competent health care physical injury, illness, medical condition, or impairment. Delay in health care: the failure to seek timely and appropriate medical care for a serious health problem that any would have recognized as needing professional medical attention. Examples of a delay in health care include not getting preventive medical or dental care for a child, not obtaining care for a sick child, or not following medical adequate mental health care also falls under this category. A lack or delay in health care may occur because the family health insurance.
Connecticut C.G.S.A § 46b-120	A child or youth may be found 'neglected' who, for reasons other than being impoverished: • Has been abandoned • Is being denied proper physical, educational, emotional, or moral care and attention • Is being permitted to live under conditions, circumstances, or associations injurious to the well-being of the child or youth • Has been abused A child or youth may be found 'uncared for' who is homeless; whose home cannot provide the specialized care that the physical, emotional, or mental condition of the child requires; or who has been identified as a victim of trafficking, as defined in § 46a-170. ⁱⁱ Exceptions Citation: Gen. Stat. § 46b-120 The treatment of any child by an accredited Christian Science practitioner, in lieu of treatment by a licensed practitioner of the healing arts, shall not of itself constitute neglect or maltreatment.

Florida Fla. Stat. Ann. § 39.01	'Neglect' occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment; or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired. Neglect of a child includes acts or omissions. 'Medical neglect' means the failure to provide or allow needed care as recommended by a health-care practitioner for a physical injury, illness, medical condition, or impairment; or the failure to seek timely and appropriate medical care for a serious health problem that a reasonable person would have recognized as requiring professional medical attention. Medical neglect does not occur if the parent or legal guardian of the child has made reasonable attempts to obtain necessary health-care services or the immediate health condition giving rise to the allegation of neglect is a known and expected complication of the child's diagnosis or treatment, and: • The recommended care offers limited net benefit to the child, and the morbidity or other side effects of the treatment may be considered to be greater than the anticipated benefit. • The parent or legal guardian received conflicting medical recommendations for treatment from multiple practitioners and did not follow all recommendations. Exceptions Citation: Ann. Stat. § 39.01 It shall not be considered neglect if failure to provide for the child is caused primarily by financial inability, unless actual services for relief have been offered to and rejected by the parent. A parent legitimately practicing religious beliefs in accordance with a recognized church or religious organization who does not provide specific medical treatment for a child may not, for that reason alone, be considered a negligent parent. This exception does not: • Eliminate the requirement that such a case be reported to the Department of Children and Family Services • Prevent the department from investigating such a case • Preclude a court from ordering, when the health of the child requires it, the provision of medical services by a physician or treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization
Iowa IA Code § 232.68	The terms 'child abuse' or 'abuse' include: • The failure on the part of a person responsible for the care of a child to provide adequate food, shelter, clothing, medical or mental health treatment, supervision, or other care necessary for the child's health and welfare when financially able to do so or when offered financial or other reasonable means to do so Exceptions Citation: Ann. Stat. § 232.68 A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child, for that reason alone, shall not be considered to be abusing the child. This provision shall not preclude a court from ordering that medical service be provided to the child when the child's health requires it.
Kentucky KY Rev. Stat. Acts Ch. § 600.020	The term 'abused or neglected child' includes a child whose health or welfare is harmed or threatened with harm when his or her parent, guardian, or other person exercising custodial control or supervision: Does not provide the child with adequate care, supervision, food, clothing, shelter, education, or medical care necessary for the child's well-being Exceptions Citation: Rev. Stat. § 600.020 A parent or other person exercising custodial control or supervision of the child who is legitimately practicing his or her religious beliefs shall not be considered a negligent parent solely because of failure to provide specified medical treatment for a child for that reason alone. This exception shall not preclude a court from ordering necessary medical services for a child.
Michigan M.C.L.A. § 722.622	'Child neglect' means harm or threatened harm to a child's health or welfare, by a parent, legal guardian, or any other person responsible for the child's health or welfare, that occurs through either of the following: • Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care

	Exceptions Citation: Comp. Laws § 722.634 A parent or guardian legitimately practicing his or her religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone shall not be considered a negligent parent or guardian. This section shall not preclude a court from ordering the provision of medical services or nonmedical remedial services recognized by State law to a child when the child's health requires it, nor does it abrogate the responsibility of a person required to report child abuse or neglect.
Mississippi Mississippi Code Title § 43-21-105	'Neglected child' means a child: • Whose parent, guardian, custodian, or any person responsible for his or her care or support neglects or, when able to do so, refuses to provide proper and necessary care or support; education as required by law; or medical, surgical, or other care necessary for his or her well-being • Who, for any reason, lacks the care necessary for his or her health, morals, or well-being Exceptions Citation: Ann. Code § 43-21-105 A parent who withholds medical treatment from any child who in good faith is under treatment by spiritual means alone through prayer, in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof, shall not, for that reason alone, be considered to be neglectful.
Montana Mont. Code. Ann. § 41-3-102	'Physical neglect' means: 'Withholding of medically indicated treatment' means failure to respond to an infant's life-threatening conditions by not providing treatment, including appropriate nutrition, hydration, and medication, that in the treating physician's or physicians' reasonable medical judgment is most likely to be effective in ameliorating or correcting the conditions. Exceptions Citation: Ann. Code § 41-3-102 This chapter may not be construed to require or justify a finding of child abuse or neglect for the sole reason that a parent or legal guardian, because of religious beliefs, does not provide adequate health care for a child. This chapter may not be construed to limit the administrative or judicial authority of the State to ensure that medical care is provided to the child when there is imminent substantial risk of serious harm to the child. The term 'withholding medically indicated treatment' does not include the failure to provide treatment, other than appropriate nutrition, hydration, or medication to an infant when, in the treating physician's or physicians' reasonable medical judgment: • The infant is chronically and irreversibly comatose. • The provision of treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life threatening conditions, or otherwise be futile in terms of the survival of the infant. • The provision of treatment would be virtually futile in terms of the survival of the infant, and the treatment itself under the circumstances would be inhumane.
New York NY Soc. Serv. L § 371	'Neglected child' means a child younger than age 18 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 or her parent or other person legally responsible for his or her care to exercise a minimum degree of care: In supplying the child with adequate food, clothing, shelter, education, or medical or surgical care, although financially able to do so In providing the child with proper supervision or guardianship
Texas Tex. Code Crim. Proc.	'Neglect' means the following acts or omissions by the person responsible for a child's care, custody, or welfare: Failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting a substantial risk of death, disfigurement, or bodily injury, or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child
Wisconsin Wis. Stat. Ann.	https://dcf.wisconsin.gov/files/cwportal/policy/pdf/access-ia-standards.pdf Have policy specific to Medical Neglect of Handicapped Infants

ⁱ <https://www.childwelfare.gov/pubPDFs/repproc.pdf#page=2&view=Reporting%20Substance-Exposed%20Infants>

ⁱⁱ <https://www.childwelfare.gov/pubPDFs/define.pdf#page=5&view=Summaries of State laws>

Appendix C

State Comparison Matrix- Substance Exposed Newborns

The Child Abuse Prevention and Treatment Act (CAPTA) requires States to have policies and procedures in place to notify child protective services (CPS) agencies of substance-exposed newborns (SEBs) and to establish a plan of safe care for newborns identified as being affected by illegal substance abuse or having withdrawal symptoms resulting from prenatal drug exposure. 42 U.S.C. § 5106a(b), as amended by the CAPTA Reauthorization Act of 2010 (P.L. 111-320).ⁱ

Suggested Citation: Child Welfare Information Gateway. (2016). *Parental drug use as child abuse*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Relevant Statutes	States who have incorporated specific reporting procedures for drug exposed infants.	States that include type of exposure in their definitions of child abuse or neglect.
Arizona A.R.S. § 13-3620(E)	A health-care professional who, after a routine newborn physical assessment of a newborn infant's health status or following notification of positive toxicology screens of a newborn infant, reasonably believes that the newborn infant may be affected by the presence of alcohol or a drug listed in § 13-3401 shall immediately report this information, or cause a report to be made, to the Department of Child Safety.	§ 8-201 'Neglect' or 'neglected' means: • Permitting a child to enter or remain in any structure or vehicle in which volatile, toxic or flammable chemicals are found or equipment is possessed by any person for the purposes of manufacturing a dangerous drug as defined in § 13-3401 • A determination by a health professional that a newborn infant was exposed prenatally to a drug or substance listed in § 13-3401, and that this exposure was not the result of a medical treatment administered to the mother or the newborn infant by a health professional. This subdivision does not expand a health professional's duty to report neglect based on prenatal exposure to a drug or substance listed in § 13-3401 beyond the requirements prescribed pursuant to § 13-3620(E). The determination by the health professional shall be based on one or more of the following: » Clinical indicators in the prenatal period including maternal and newborn presentation » History of substance use or abuse » Medical history » The results of a toxicology or other laboratory test on the mother or the newborn infant » A diagnosis by a health professional of an infant under age 1 with clinical findings consistent with fetal alcohol syndrome or fetal alcohol effects

Alaska Alaska Stat. § 47.17.290	A practitioner of the healing arts involved in the delivery or care of an infant who the practitioner determines has been adversely affected by, or is withdrawing from exposure to, a controlled substance or alcohol shall immediately notify the nearest office of the Department of Health and Social Services of the infant's condition.	'Neglect' means the failure of the person responsible for the child's welfare to provide the child necessary food, care, clothing, shelter, or medical attention. Exceptions Citation: Alaska Stat. § 47.17.020(d) A religious healing practitioner is not required to report as neglect of a child the failure to provide medical attention to the child if the child is provided treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner of the church or denomination.
Arkansas Ark. Code. Ann. § 12-18-103(14)(B)		'Neglect' shall include: • Causing a child to be born with an illegal substance present in the child's bodily fluids or bodily substances as a result of the pregnant mother's knowingly using an illegal substance before the birth of the child • At the time of the birth of a child, the presence of an illegal substance in the mother's bodily fluids or bodily substances as a result of the pregnant mother's knowingly using an illegal substance before the birth of the child As used in this subdivision, 'illegal substance' means a drug that is prohibited to be used or possessed without a prescription under the Arkansas Criminal Code, § 5-1-101, et seq. A test of the child's bodily fluids or bodily substances may be used as evidence to establish neglect under this subdivision. A test of the mother's bodily fluids or bodily substances may be used as evidence to establish neglect under this subdivision. A child is 'neglected' or 'dependent' if: The child tests positive at birth for either a schedule I or schedule II controlled substance, unless the child tests positive for a schedule II controlled substance as a result of the mother's lawful intake of such substance as prescribed.
California Cal. Civ. Proc. Code Ann. § 11165.13	A positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child pursuant to law. If other factors are present that indicate risk to a child, then a report shall be made. However, a report based on risk to a child that relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to a county welfare or probation department and not to a law enforcement agency.	

Colorado Colo. Rev. Stat. Ann. § 19-3-401(3)(b)-(c)		A newborn child who is in a hospital setting shall not be taken into temporary protective custody without an order of the court. The order must include findings that an emergency situation exists and that the newborn child is seriously endangered. A newborn child may be detained in a hospital by a law enforcement officer upon the recommendation of a county department of social services, a physician, a registered nurse, a licensed practical nurse, or a physician's assistant while a court order is being pursued, but the newborn child must be released if a court order is denied. Court orders shall not be required in the following circumstances: • When a newborn child is identified by a physician, registered nurse, licensed practical nurse, or physician's assistant engaged in the admission, care, or treatment of patients as being affected by substance abuse or demonstrating withdrawal symptoms resulting from prenatal drug exposure • When the newborn child is subject to an environment exposing the newborn child to a laboratory for manufacturing controlled substances § 19-1-103(1)(a) 'Abuse' or 'child abuse or neglect' means an act or omission in one of the following categories that threatens the health or welfare of a child: • Any case in which, in the presence of a child or on the premises where a child is found or resides, a controlled substance as defined in § 18-18-102(5) is manufactured or attempted to be manufactured • Any case in which a child tests positive at birth for either a Schedule I controlled substance, including opiates, opiate derivatives, hallucinogens, stimulants, and depressants that have no legitimate medical use [as defined in § 18-18-203], or a Schedule II controlled substance, including any potentially addictive substance that is used or manufactured contrary to its current accepted medical use [as defined in § 18-18-204], unless the child tests positive for a Schedule II controlled substance as a result of the mother's lawful intake of such substance as prescribed Rev. Stat. § 19-3-102(1)(g) A child is neglected or dependent if the child tests positive at birth for either a Schedule I controlled substance, as defined in § 18-18-203, or a Schedule II controlled substance, as defined in § 18-18-204, unless the child tests positive for a Schedule II controlled substance as a result of the mother's lawful intake of such substance as prescribed.
Florida Fla. Stat. Ann. §39.01(30)(a)(2), (g)		'Harm' to a child's health or welfare can occur when any person: • Purposely gives a child poison, alcohol, drugs, or other substances that substantially affect the child's behavior, motor coordination, judgment, or that result in sickness or internal injury • Exposes a child to a controlled substance or alcohol. Exposure to a controlled substance or alcohol is established by: • A test, administered at birth, that indicated that the child's blood, urine, or meconium contained any amount of alcohol or a controlled substance or metabolites of such substances, the presence of which was not the

		result of medical treatment administered to the mother or the newborn infant • Evidence of extensive, abusive, and chronic use of a controlled substance or alcohol by a parent when the child is demonstrably adversely affected by such usage For the purposes of this paragraph, the terms ‘drugs’ and ‘controlled substances’ mean prescription drugs not prescribed for the child or the parent or not administered as prescribed, and controlled substances as outlined in Schedule I or Schedule II of § 893.03.
Illinois Comp. Stat. Ch. 705, § 405/2-3(1)(c)		Those who are neglected include any newborn infant whose blood, urine, or meconium contains any amount of a controlled substance as defined in § 102(f) of the Illinois Controlled Substances Act, or a metabolite of a controlled substance, with the exception of controlled substances or metabolites of such substances that are present in newborn infant as the result of medical treatment administered to the mother or the newborn infant.
Indiana IC §§ 31-34-1-10; 31-34-1-11		Except as provided in statute, a child is a ‘child in need of services’ if: • The child is born with fetal alcohol syndrome or any amount, including a trace amount, of a controlled substance or a legend drug in the child’s body. • The child has an injury, has abnormal physical or psychological development, or is at a substantial risk of a life-threatening condition that arises or is substantially aggravated because the child’s mother used alcohol, a controlled substance, or a legend drug during pregnancy. • The child needs care, treatment, or rehabilitation that the child is not receiving or is unlikely to be provided or accepted without the coercive intervention of the court.

	§ 232.77(2) If a health practitioner discovers in a child physical or behavioral symptoms of the effects of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs, or combinations or derivatives thereof, which were not prescribed by a health practitioner, or if the health practitioner has determined through examination of the natural mother of the child that the child was exposed in utero, the health practitioner may perform or cause to be performed a medically relevant test, as defined in § 232.73, on the child. The practitioner shall report any positive results of such a test on the child to the Department of Human Services. The department shall begin an investigation pursuant to law upon receipt of such a report. A positive test result obtained prior to the birth of a child shall not be used for the criminal prosecution of a parent for acts and omissions resulting in intrauterine exposure of the child to an illegal drug.	
Kentucky KY Rev. Stat. Acts Ch. § 600.020	§ 214.160(2)-(6) The Cabinet for Health and Family Services shall, as often as necessary, publish a list of the five most frequently abused substances, including alcohol, by pregnant women in the Commonwealth. Any physician and any other person legally permitted to engage in attendance upon a pregnant woman in this State may perform a screening for alcohol or substance dependency or abuse, including a comprehensive history of such behavior. Any physician may administer a toxicology test to a pregnant woman under the physician's care within 8 hours after delivery to determine whether there is evidence that she has ingested alcohol, a controlled substance, or a substance identified on the list provided by the cabinet, or if the woman has obstetrical complications that are a medical indication of possible use of any such substance for a nonmedical purpose. Any physician or person legally permitted to engage in attendance upon a pregnant woman may administer to each newborn infant born under that person's care a toxicology test to determine whether there is evidence of prenatal exposure to alcohol, a controlled substance, or a substance identified on the list provided by the cabinet, if the attending person has reason to believe, based on a medical assessment of the mother or the infant, that the	

	Mother used any such substance for a nonmedical purpose during the pregnancy. The circumstances surrounding any positive toxicology finding shall be evaluated by the attending person to determine if abuse or neglect of the infant, as defined under § 600.020(1), has occurred and whether investigation by the cabinet is necessary. No prenatal screening for alcohol or other substance abuse or positive toxicology finding shall be used as prosecutorial evidence. No person shall conduct or cause to be conducted any toxicological test pursuant to this section on any pregnant woman without first informing the pregnant woman of the purpose of the test.	
Louisiana Ch. Code Art. 610(G)	If a physician has cause to believe that a mother of an infant unlawfully used a controlled dangerous substance during pregnancy, the physician shall order a toxicology test upon the infant, without the consent of the infant's parents or guardian, to determine whether there is evidence of prenatal neglect. If the test results are positive, the physician shall report the results as soon as possible. If the test results are negative, all identifying information shall be obliterated if the record is retained, unless the parent approves the inclusion of identifying information. Positive test results shall not be admissible in a criminal prosecution. The version below, as amended by Acts 2007, No. 396, § 1, shall not become effective unless and until sufficient funds are appropriated by the legislature for such purposes	603(24) 'Prenatal neglect' means the unlawful use of a controlled dangerous substance, as defined by Rev. Stat. § 40:961, et seq., by a mother during pregnancy, that results in symptoms of withdrawal in the infant or the presence of a controlled substance in the infant's body.
Maine 19-A M.R.S.A. § 4011-B	A health-care provider involved in the delivery or care of an infant who the provider knows or has reasonable cause to suspect has been born affected by illegal substance abuse or is suffering from withdrawal symptoms resulting from prenatal drug exposure, whether or not the prenatal exposure was to legal or illegal drugs, shall notify the Department of Health and Human Services of that condition in the infant.	§ 4004-B The department shall act to protect infants born identified as being affected by illegal substance abuse, demonstrating withdrawal symptoms resulting from prenatal drug exposure, whether the prenatal exposure was to legal or illegal drugs, or having fetal alcohol spectrum disorders, regardless of whether the infant is abused or neglected. The department shall: • Receive notifications of infants who may be affected by illegal substance abuse or demonstrating withdrawal symptoms resulting from prenatal drug exposure or who have fetal alcohol spectrum disorders • Investigate promptly notifications received of infants born who may be affected by illegal substance abuse or demonstrating withdrawal symptoms resulting from prenatal drug exposure or who have fetal alcohol spectrum disorders as determined to be necessary by the department to protect the infant • Determine whether each infant for whom the department conducts an investigation is affected by illegal substance abuse, demonstrates withdrawal symptoms resulting from prenatal drug exposure, or has fetal alcohol spectrum disorders • Determine whether the infant for whom the department conducts an investigation is abused or neglected and, if so, determine the degree of harm or threatened harm in each case

		For each infant whom the department determines to be affected by illegal substance abuse, to be demonstrating withdrawal symptoms resulting from prenatal drug exposure, or to have fetal alcohol spectrum disorders, develop, with the assistance of any health-care provider involved in the mother's or the child's medical or mental health care, a plan for the safe care of the infant and, in appropriate cases, refer the child, mother, or both to a social service agency or voluntary substance abuse prevention service
Michigan M.C.L.A § 722.622	§ 722.623a A person who is required to report suspected child abuse or neglect and who knows, or from the child's symptoms has reasonable cause to suspect, that a newborn infant has any amount of alcohol, a controlled substance, or a metabolite of a controlled substance in his or her body shall report to the department in the same manner as required of other reports.	'
Minnesota Minn. Stat. Ann. § 626.5561, Subd.	1 Except as provided below, a mandated reporter shall immediately report to the local welfare agency if the reporter knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including, but not limited to, tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive. A health-care professional or a social service professional who is mandated to report is exempt from reporting a woman's use or consumption of tetrahydrocannabinol or alcoholic beverages during pregnancy if the professional is providing the woman with prenatal care or other health-care services. 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, including, but not limited to, tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.	Ann. Stat. The term 'neglect' includes: • Prenatal exposure to a controlled substance, as defined in § 253B.02, sub d. 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or on the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder • Chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety
Missouri MO Rev. Stat. § 191.737(1)- (3), (5)	Notwithstanding the physician-patient privilege, any physician or health-care provider may refer to the Department of Health families in which children may have been exposed to alcohol or a controlled substance as defined by law as evidenced by: • Medical documentation of signs and symptoms consistent with controlled substances or alcohol exposure in the child at birth • Results of a confirmed toxicology test for controlled substances performed at birth on the mother or the child • A written assessment made or approved by a physician, health-care provider, or the Division of Family	

	Services that documents the child as being at risk of abuse or neglect	
Mississippi MS Code § 43-21-105		
Montana Mont. Code Ann. § 41-3-102	§ 41-3-201(3) A physician or other health-care professional involved in the delivery or care of an infant shall report to the department any infant known to the professional to be affected by a dangerous drug, as defined in § 50-32-101.	§ 45-5-622(3), (5)(b) A person, whether or not the person is supervising the welfare of a child younger than age 18, commits the offense of endangering the welfare of children if the person, in the residence of a child, in a building, structure, conveyance, or outdoor location where a child might reasonably be expected to be present, in a room offered to the public for overnight accommodation, or in any multiple unit residential building, knowingly: • Produces or manufactures methamphetamine or attempts to produce or manufacture methamphetamine • Possesses any material, compound, mixture, or preparation that contains any combination of the items listed in § 45-9-107 with intent to manufacture methamphetamine • Causes or permits a child to inhale, be exposed to, have contact with, or ingest methamphetamine or be exposed to or have contact with methamphetamine paraphernalia
Nevada NV Rev. Stat. § 432B.220(3)	Any person who is a mandated reporter who delivers or provides medical services to a newborn infant and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that the newborn infant has been affected by prenatal illegal substance abuse or has withdrawal symptoms resulting from prenatal drug exposure shall, as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the newborn infant is so affected or has such symptoms, notify an agency that provides child welfare services of the condition of the infant and refer each person who is responsible for the welfare of the infant to an agency that provides child welfare services for appropriate counseling, training, or other services. A notification and referral to an agency that provides child welfare services shall not be construed to require prosecution for any illegal action.	
North Dakota NDCC § 50-25.1-02(13)		‘Prenatal exposure to a controlled substance’ means use of a controlled substance, as defined in chapter 19-03.1, by a pregnant woman for a nonmedical purpose during pregnancy as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery of 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.

South Carolina SC Code § 63-7-1660(F)(1)		It is presumed that a newborn is an abused or neglected child as defined in § 63-7-20 and that the child cannot be protected from further harm without being removed from the custody of the mother upon proof that: • A blood or urine test of the child at birth or a blood or urine test of the mother at birth shows the presence of any amount of a controlled substance or a metabolite of a controlled substance, unless the presence of the substance or the metabolite is the result of medical treatment administered to the mother of the infant or the infant. • The child has a medical diagnosis of fetal alcohol syndrome. A blood or urine test of another child of the mother or a blood or urine test of the mother at the birth of another child showed the presence of any amount of a controlled substance or a metabolite of a controlled substance, unless the presence of the substance or the metabolite was the result of medical treatment administered to the mother of the infant or the infant. • Another child of the mother has a medical diagnosis of fetal alcohol syndrome.
South Dakota SDCL § 26-8A-2(9)		‘Abused or neglected child’ includes a child: • Who was subject to prenatal exposure to abusive use of alcohol, marijuana, or any controlled drug or substance not lawfully prescribed by a practitioner as authorized by statute • Whose parent, guardian, or custodian knowingly exposes the child to an environment that is being used for the manufacture, use, or distribution of methamphetamines or any other unlawfully manufactured controlled drug or substance
Oklahoma 22 Okl. St. Ann. § 1-2-101	Every physician, surgeon, or other health-care professional, including doctors of medicine, licensed osteopathic physicians, residents, and interns, or any other health-care professional attending the birth of a child who tests positive for alcohol or a controlled dangerous substance shall promptly report the matter to the Department of Human Services.	The term ‘neglect’ includes the failure or omission to protect a child from exposure to the use, possession, sale, or manufacture of illegal drugs. A child in need of special care and treatment includes, but is not limited to, a child who at birth tests positive for alcohol or a controlled dangerous substance and who, pursuant to a drug or alcohol screen of the child and an assessment of the parent, is determined to be at risk of harm or threatened harm to the health or safety of a child.
Pennsylvania O.R.S. § 6386	A health-care provider shall immediately make a report or cause a report to be made to the appropriate county agency if the provider is involved in the delivery or care of a child under 1 year of age who is born and identified as being affected by any of the following: • Illegal substance abuse by the child’s mother • Withdrawal symptoms resulting from prenatal drug exposure • A fetal alcohol spectrum disorder	
Utah UT Code § 63-7-1660(F)(1)	It is presumed that a newborn is an abused or neglected child as defined in § 63-7-20 and that the child cannot be protected from further harm without being removed from the custody of the mother upon proof that: • A blood or urine test of the child at birth or a blood or urine test of the mother at birth shows the presence of any amount of a controlled substance or a metabolite of a controlled substance, unless the presence of the substance or the metabolite is the result of	

	Medical treatment administered to the mother of the infant or the infant. • The child has a medical diagnosis of fetal alcohol syndrome. Parental Drug Use as Child Abuse https://www.childwelfare.gov 26 This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. This publication is available online at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/drugexposed/. • A blood or urine test of another child of the mother or a blood or urine test of the mother at the birth of another child showed the presence of any amount of a controlled substance or a metabolite of a controlled substance, unless the presence of the substance or the metabolite was the result of medical treatment administered to the mother of the infant or the infant. • Another child of the mother has a medical diagnosis of fetal alcohol syndrome.	
Texas Tex. Code. Crim. Proc. Ann. Art.		Born addicted to alcohol or a controlled substance’ means a child: • Who is born to a mother who, during the pregnancy, used a controlled substance, as defined by the Health and Safety Code, other than a controlled substance legally obtained by prescription, or alcohol • Who, after birth as a result of the mother’s use of the controlled substance or alcohol: » Experiences observable withdrawal from the alcohol or controlled substance » Exhibits observable or harmful effects in the child’s physical appearance or functioning » Exhibits the demonstrable presence of alcohol or a controlled substance in the child’s bodily fluids
Virginia VA Code Ann. § 63.2-1509(B)	A report is required when, in his or her professional or official capacity, a reporter has reason to suspect that a child is abused or neglected. For purposes of this section, ‘reason to suspect that a child is abused or neglected’ shall include: • A finding made by a health-care provider within 6 weeks of the birth of a child that the results of toxicology studies of the child indicate the presence of a controlled substance not prescribed for the mother by a physician • A finding made by a health-care provider within 6 weeks of the birth of a child that the child was born dependent on a controlled substance that was not prescribed by a physician for the mother and has demonstrated withdrawal symptoms • A diagnosis made by a health-care provider at any time following a child’s birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance that was not prescribed by a physician	a child is abused or neglected’ shall include: • A finding made by a health-care provider within 6 weeks of the birth of a child that the results of toxicology studies of the child indicate the presence of a controlled substance not prescribed for the mother by a physician • A finding made by a health-care provider within 6 weeks of the birth of a child that the child was born dependent on a controlled substance that was not prescribed by a physician for the mother and has demonstrated withdrawal symptoms • A diagnosis made by a health-care provider at any time following a child’s birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance that was not prescribed by a physician for the mother or the child • A diagnosis made by a health-care provider at any time following a child’s birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol

	for the mother or the child • A diagnosis made by a health-care provider at any time	
Wisconsin Wis. Stat. Ann. § 48.205		A child may be held [in physical custody] if the intake worker determines that there is probable cause to believe the child is within the jurisdiction of the court and probable cause exists to believe that the child is an expectant mother, that if the child expectant mother is not held, there is a substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered by the child expectant mother's habitual lack of self-control in the use of alcoholic beverages, controlled substances, or controlled substance analogs, exhibited to a severe degree, and that the child expectant mother is refusing or has refused to accept any alcohol or other drug abuse services offered to her or is not making or has not made a good faith effort to participate in any alcohol or other drug abuse services offered to her.

ⁱ [https://www.childwelfare.gov/pubPDFs/drugexposed.pdf#page=2&view=Prenatal drug exposure](https://www.childwelfare.gov/pubPDFs/drugexposed.pdf#page=2&view=Prenatal%20drug%20exposure)