

## **Section 2 Overview**

Section 2 focuses on intake, or the point of entry for a family. The information in this section will assist staff in understanding the procedures throughout the entire intake process, from initial contact with the Child Abuse and Neglect Hotline Unit (CANHU), through the process of an investigation or family assessment. Completing a thorough family assessment or investigation will help staff identify the service needs of the family.

## **Chapter 6 Overview**

This chapter contains information pertaining to Newborn Crisis Assessment referrals and the process county staff members should follow in response.

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## **Memoranda History:**

[CD06-34](#)

## 6.1 The Children's Division's Role In Drug-Involved Cases

Division staff may become involved in drug-involved cases in one of the following ways:

- **A child abuse/neglect report is received in which the referral contains the above criteria and alleges that abuse or neglect is present.** Services will be offered to the family and case opened, regardless of the outcome of the investigation, as the Division is mandated by the legislation to provide services when those criteria are present and a physician has referred the case for services.
- Referrals made by physicians/health care providers to the CA/N Hotline which contain information regarding signs of drug involvement of the infant, but do not allege child abuse or neglect, **are not accepted as child abuse and neglect reports.** CD staff can make the physician/health care provider aware the DHSS "Service Coordinator" will involve Children's Service Workers in the planning and provision of services.
- **A physician/health care provider requests CD to conduct a home assessment prior to releasing the child from the hospital, or at the time the child is released.** This home assessment is described in the section entitled "Newborn Crisis Assessment." The request may come through the Child Abuse/Neglect Unit or the county office.
- **A physician makes a referral to DHSS for service coordination without first requesting a home assessment from CD.** The DHSS "Service Coordinator" will contact CD and DMH staff within 72 hours to involve them in providing services to the family. CD staff will provide necessary preventive services to the family, with the DHSS "Service Coordinator" taking the lead role.

If there is a "preponderance of evidence" finding, the Children's Service Worker will be the case manager for the case. If a preventive services case is opened, the case "Service Coordinator" and the worker will make a joint decision on which agency will take the lead in coordinating services to the family.

NOTE: For Department of Health and Senior Services, Special Health Care Needs (SHCN) Service Coordination, contact the appropriate regional office. (See [Service Coordination Regional Map](#))

**Chapter Memoranda History:** (prior to 01-31-07)

[CD06-34](#)

**Memoranda History:**

## 6.2 “Newborn Crisis Assessments”

In these cases, a home assessment is requested by a physician or other medical personnel when they have serious reservations about releasing an infant from the hospital who may be sent home to a potentially dangerous situation. Many times a drug-involved mother may continue using drugs, so an assessment of the home situation is needed prior to, or at the time the infant is released from the hospital. There may also be other non-drug related situations in which a physician/health care provider is concerned about releasing a newborn infant from the hospital. **Non-drug involved referrals will be accepted until the child is one year of age.**

- If the physician/health care provider is concerned about releasing the infant from the hospital, in the case of a drug-involved infant, and needs an assessment of the home before DHSS becomes involved (as it will be 72 hours before DHSS makes initial contact), they may request assistance from CD. The request for a “Newborn Crisis Assessment” may be received by the Child Abuse/Neglect Unit or county office staff, and may be made prior to, or at the time of, the infant’s release from the hospital. **If there is an open family-centered services or out-of-home care case, the county may elect to have the assigned worker complete the assessment rather than an investigative worker.**
- Although this will not be a child abuse/neglect report, county staff will handle the referral as an emergency, **requiring the worker to assure the child’s immediate safety.** Depending on the situation assuring safety may require immediate face to face contact **or** may consist of phone contact with the reporter or hospital to confirm the child is safe and to discuss the plan for discharge. The assessment should include a recommendation as to whether the infant should be released from the hospital with the mother.
- If the worker feels the child should not be released with the mother, a referral to the juvenile court would be in order. The feedback will be provided by telephone or in person. Newborn Crisis Assessments should be documented using the NCAAT, Newborn Crisis Assessment Tool (or comparable assessment tool approved by Central Office), as well as the CD-17, and CD-18 (if required).

Related Subject: Section 2, Chapter 9.2, Assessment of Safety
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### 6.2.1 The Newborn Crisis Assessment, at A Minimum, Shall Include:

1. Contact with physician or health care provider who made the referral to gather information on: delivery complications, signs and symptoms of exposure at birth OR mother/infant toxicology (obtain written medical documentation of the signs or symptoms of exposure at birth or toxicology test results), mother/infant behavior while hospitalized, and other concerns;

2. Visit with the mother at the hospital, if still hospitalized, or in her home to assess plans and abilities for caring for the infant upon release. At the time of initial face to face contact with the mother and/or family, provide the Description of the Newborn Crisis Assessment, CS-24B, taking time to answer any questions they may have about the process before proceeding. The following should be determined while interviewing the mother:
  - prenatal care;
  - pregnancy complications (i.e., premature labor);
  - physical, emotional, intellectual functioning;
  - observation of attachment and bonding with the infant;
  - parenting skills (infant and other children);
  - planning for birth/hospital discharge (i.e., infant's baby supplies, crib, bottles, formula);
  - behavior associated with alcohol/drug use;
  - self identifying problems associated with alcohol/drug use; and
  - criminal history;
3. Observation of the infant. Note: If a mother and infant are in the hospital in another county, staff may request a courtesy assist from CD staff in that county to visit the hospital and provide information to the county of residence. Observation of the infant should include:
  - Signs of withdrawal;
  - Medical complications (NICU); and
  - Special health care needs (home health care recommended by Doctor).
4. Visit to the mother's home, and/or home the infant will go upon hospital discharge to assess the following:
  - Children, if any, in the home (i.e., school attendance, prior juvenile office involvement);

- Support systems in place, which may include family, friends, or other agencies involved. Staff may use genogram and ecomap in CD-14 to gather information;
  - Presence of supplies for infant's arrival (i.e., crib, clothes, bottles);
  - Condition of the home;
  - Observation/names of individuals residing in the home; and
  - Domestic relations (i.e., father or parent substitute is supportive)
5. Contact with all children, if any, in the home within 72 hours to assure safety.
  6. Contact with other adults/children in the home to assess the following:
    - Verification of readiness for infant's arrival;
    - Expression of concern regarding mother's alcohol/drug use;
    - Other household member's description of available support; and
    - School attendance of other children in the home.
  7. Contact with other agencies involved with the family to determine and coordinate support, if appropriate;
  8. Contact with Juvenile Court if it is determined the infant will be subjected to further drug exposure, or neglect if he/she remains in the mother's custody; and
  9. Summary of strengths/concerns and recommendations regarding CD case opening determination, as well as, placement plans for the infant.
  10. Generate a child abuse/neglect report if abuse or neglect of another child in the home is observed or suspected.
  11. Provide information to the referring physician/health service provider, in person or by telephone. The information provided will include a recommendation as to whether the infant should be released from the hospital with the mother. If the worker feels the infant should not be released with the mother, the worker will make a referral to the juvenile office.

12. Document on the newborn crisis assessment tool, CD-17, and CD-18 (if required), the information provided. If the division becomes involved with the family, or there is currently an open file, combine this information with the case record.
13. For all drug-involved newborn crisis assessment referrals, contact DHSS/SHCN if the physician has not already done so, by referring directly to the local SHCN Service Coordination Regional Office. Upon notification of acceptance from or request for additional information, provide the following documents:
  - Medical documentation of signs and symptoms consistent with controlled substances or alcohol exposure in the infant (up to 28 days of age, according to DHSS's perinatal definition) at birth; OR
  - Confirmed positive toxicology test for controlled substances performed at birth on the mother and/or child; AND
  - Written assessment and recommendations.

If CD is opening a case based on the assessment, the SHCN referral must include a statement that the infant is at risk of child abuse/neglect for the referral to be complete.

**Chapter Memoranda History:** (prior to 01-31-07)

[CD06-34](#)

**Memoranda History:**

CD11-44, CD11-86

### **6.3 DHSS/CD Service Coordination**

“Service Coordination” is assigned by DHSS/SHCN, but may be contracted out. Service Coordinators case-manage services to families referred by health care providers. They may also accept families referred by CD staff for care coordination services. This would include families whom CD staff has identified as needing treatment and who are willing to be referred to DHSS. CD staff may make referrals to DHSS “Service Coordinators” by referring directly to the local SHCN Service Coordination Regional Office.

Services from DHSS to the family will include a coordination of social services, health care and mental health services. They will notify CD and DMH within 72 hours and initiate services within the same time frame. They will complete an assessment and will determine the risk for or existence of CA/N and will make a hotline report if indicated.

The Department of Mental Health (DMH) has developed Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs throughout the state. The three types of CSTAR programs serve:

- **Women and children;**
- **Adolescents; and**
- **Adults.**

Though women can be served in the adult program, child care services are not available at those programs. The programs for women and children must provide child care and therapeutic activities for children while the mother participates in treatment. At those programs, first preference is given to pregnant women, second to women with children, and third to women without children. CSTAR treatment services are covered by Medicaid at all the facilities.

It will be important for CD and DHSS staff to collaborate on new referrals and coordinate service provision. This may include the initial home assessment to determine the risk for child abuse and neglect and to ascertain the needs of infants and families.

**Chapter Memoranda History:** (prior to 01-31-07)

[CD06-34](#)

**Memoranda History:**

#### **6.4 Sharing Of Information Between DHSS And CD**

It is critical that DHSS and CD share appropriate information with each other in order that services are provided to the drug-involved family. This should occur when cases are opened, as services are provided, and at the time of closing. Therefore, staff shall share any information which will assist in ensuring that families receive necessary services. The two departments have entered into an agreement regarding the exchange of information.

- The Child Abuse or Neglect Hotline Unit (CANHU) will send to DHSS, on a daily basis, information received on drug-involved women and infants;
- When DHSS receives referrals from medical personnel, they may call CD to obtain information on prior child abuse and neglect reports and the status of open or closed Family-Centered Services cases.
- On a county level, CD staff may share information with DHSS "Service Coordinators" obtained during investigations or during the provision of services which will assist them in ensuring that substance abusing women and their children receive services.

**Chapter Memoranda History:** (prior to 01-31-07)

[CD06-34](#)

**Memoranda History:**

## 6.5 Closing Cases Referred By Physicians/Health Care Providers

The Division may have cases open in which a physician or health care provider completed a written assessment that the child is at risk of abuse or neglect.

**The Division shall not “cease providing services for any child exposed to substance where a physician or health care provider has made or approved a written assessment which documents the child is being at risk of abuse/neglect until such physician, health care provider or designee authorizes such file to be closed.”**

The Children’s Service Worker shall discuss the planned case closing with the DHSS service coordinator, and make a joint visit with the coordinator, when possible.

The Division should then send their reasons for recommending closure in writing to the coordinator.

At least 15 days prior to the planned closing date, the DHSS service coordinator will send a letter to the referring physician/provider (or hospital/clinic if physician is no longer involved with this family) with the following information (the worker should provide as much of this information as is available in their written recommendation to DHSS):

- Reason for initial referral;
- Services provided by all agencies involved with the family and whether they agree that CD may close its case;
- How those services met the family’s needs;
- Name of infant’s current physician, and if different that the referring physician;
- How risk of abuse or neglect to the child has been reduced;
- Other agencies that plan to continue providing services;
- Projected closing date; and
- Request their written agreement that the case may be closed or that we will close the case on the specified date if we do not receive a response.

If there is no contact from the physician/health care provider, or the response is positive, the case shall be closed on the planned date. If a negative response is received, or there is a request for further clarification, the case cannot be closed.

Related Subject: Section 3, Chapter 8.4 Procedure for Closing a Case
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Effective Date: March 27, 2006  
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**Chapter Memoranda History:** (prior to 01-31-07)

[CD06-34](#)

**Memoranda History:**

## **6.6 Signs/Symptoms Of Drug Withdrawal:**

Some of the rural areas across the state do not have hospitals that routinely conduct drug testing on the mother and infant at delivery. As a result, hospital staff, and consequently CD staff, has to rely on signs and symptoms present at the time of birth and during hospitalization. With the newborn, signs and symptoms of drug withdrawal are easily confused with neurologic impairment, hypoglycemia (low blood sugar), hypocalcemia, and sepsis. The following are lists of general observable perinatal effects of alcohol, tobacco, and other drugs on the mother and infant.

Some general maternal complications that might be observed include:

- neurologic abnormalities;
- cardiovascular abnormalities;
- presentation of infectious diseases;
- respiratory abnormalities;
- gastrointestinal abnormalities;
- nutritional deficiencies, and
- psychiatric difficulties

Some general obstetrical complications might include:

- spontaneous abortions;
- preterm labor;
- abruptio placenta (placenta detaches from the uterine wall);
- placental previa (placenta presents before the neonate in the birth canal);
- fetal distress, and
- intrauterine fetal death

Some general neonatal complications that might be observed include:

- birth defects (e.g. Fetal Alcohol syndrome (FAS), cleft lip, cleft palate, genitourinary abnormalities, etc);
- intrauterine growth restriction (IURG);

- low birth weight;
- small for gestational age;
- neurobehavioral problems;
- prematurity, and
- Neonatal Abstinence Syndrome (NAS)

**W** - Wakefulness

**I** - Irritability

**T** - Tremulousness, temperature variation, tachypnea (respiratory cough)

**H** - Hyperactivity, high-pitched persistent cry, hyperreflexia (decreased fine motor control)

**D** - Diarrhea, disorganized suck

**R** - Rub marks, respiratory distress

**A** - Apneic attacks (temporarily stop breathing)

**W** - Weight loss or failure to gain weight

**A** - Alkalosis (abnormally high level of alkalinity in body fluids)

**L** - Lacrimation (excess secretion of tears)

**Chapter Memoranda History:** (prior to 01-31-07)

[CD06-34](#)

**Memoranda History:**