Administrative Policies and Procedures: 14.9

Subject:	**DCS Response to Allegations Involving Drug Exposed Children**
Authority:	TCA 37-1-401; 37-5-105 (3); 37-5-106; Comprehensive Addiction and Recovery Act of 2016 (CARA)
Standards:	**COA:** PA-CFS 3-5; PA-CFS 9.03
Application:	All Department of Children's Services Child Protective Services, Child Abuse Hotline and Special Investigations Unit Employees

Policy Statement:

The Child Abuse Hotline screen and assign allegations involving drug exposed children (DEC) and Child Protective Services or Special Investigations Unit staff respond timely based on the severity of or potential for physical, mental or emotional harm to the child.

Purpose:

To assist the CAH in determining track and priority response for allegations of DEC and to provide CPS Case Managers with guidance for classifying allegations.

Procedures:

A. Criteria for Assignment

1. A referral meets the definition of DEC based on ***Work Aid 1: CPS Categories and Definitions of Abuse/Neglect***.
2. A referral meets the criteria for the investigation track when one or more of the following applies:
   a) The alleged child victim (ACV) is age 0 through 3 months old;
   b) Meets the criteria for severe Drug Exposed Child per ***Work Aid 1: CPS Categories and Definitions of Abuse/Neglect***.
3. If the referral meets the screening definition for DEC (refer to ***Work Aid 1: CPS Categories and Definitions of Abuse/Neglect***), however, does not meet the criteria (in 2 a - b) above, the case is assigned to the assessment track. A referral meets the definition of DEC based on ***Work Aid 1: CPS Categories and Definitions of Abuse/Neglect***.

Specialized Drug Units:

1. A referral meets the definition of DEC based on ***Work Aid 1: CPS Categories and Definitions of Abuse/Neglect***.

	2. A referral meets the criteria for the investigation track when one or more of the following applies: a) The alleged child victim (ACV) is age 0 through 3 months old; b) The ACV is diagnosed with Neo-Natal Abstinence Syndrome; c) The ACV is diagnosed with Fetal Alcohol Spectrum Disorder. 3. If the referral meets the screening definition for DEC (refer to ***Work Aid 1: CPS Categories and Definitions of Abuse/Neglect***), however, does not meet the criteria (in 2 a - c, above), the case is assigned to the assessment track.
B. Responding to Allegations of Drug Exposed Child	The CAH assigns a priority response timeframe to reports of DEC based on the SDM Intake Assessment tool. 1. Priority Response one (1) is considered when one of the following circumstances are present: a) The ACV has been exposed to the use, manufacture or sale of drugs by the parent/caregiver who has recently caused or, without immediate response by CPS, is likely to cause physical, mental or emotional harm to the ACV and the ACV is in the care of the parent/caregiver at the time of the report. This includes infants born drug dependent as a result of the mother's illegal use or misuse of legal prescription medication as well as infants who have been diagnosed with FASD and/or NAS. b) The parent/caregiver is unable to function, as a result of drug use or misuse of prescription medication, in a manner that is adequate to meet the ACV's basic needs and the ACV is in the care of the parent/caregiver at the time of the report. c) The ACV has recently been exposed to the manufacturing of methamphetamine and/or there is a continued threat of exposure. **Note:** When CPS staff respond to cases involving drug exposed children, refer to ***Child Protective Service Tasks Manual*** and ***Safety Notice: Understanding Fentanyl and Avoiding Accidental Exposure***. d) The ACV has been administered or has ingested drugs (including legal medication not used as directed) which has recently caused or, without immediate response by CPS, is likely to cause physical, mental or emotional harm to the ACV and the ACV is in the care of the parent/caregiver at the time of the report. e) Postponing immediate response would compromise the ability to engage or contact the parent/caregiver or collect evidence. f) There is reason to believe the parent/caregiver will flee with the ACV. 2. Priority Response two (2) is considered when one of the following circumstances is present: a) The ACV is in a safe environment or with a protective parent/caregiver at the time of the report that is able to meet the child's basic needs. However, there is a concern that within the next two (2) business days, the ACV will

	be exposed to the use, manufacture or sale of drugs. b) The alleged perpetrator (AP) does not have access to the ACV within the next two (2) business days (e.g., the ACV is admitted to a medical unit and remains there for an extended period of time such as the Neonatal Intensive Care Unit). 3. Priority Response three (3) is considered when the ACV is able to self-protect, or is visible in the community, and one of the following apply: a) The ACV is in a safe environment at the time of the report and there are no concerns that the AP will have access to the ACV within the next three (3) business days; b) The parent/caregiver's ability to function in a manner that is adequate to meet the ACV's basic needs is not impacted; or c) The ACV has not been directly exposed to the use, manufacture or sale of drugs.
C. Plans of Safe Care	Referrals received for infants (age 0 up to 12 months of age) born with or identified as being affected by: ♦ Substance abuse; ♦ Withdrawal symptoms resulting from prenatal exposure from the use of illegal drugs or the misuse of legal drugs or chemical substances; ♦ Diagnosed with Neonatal Abstinence Syndrome; and/or ♦ Diagnosed with Fetal Alcohol Spectrum Disorder. These types of cases will be identified as a Comprehensive Addiction and Recovery Act (CARA) case when this information is reported or confirmed by or on behalf of a medical provider. These infants must have a Plan of Safe Care to include services that ensure the safety and well-being of infants (refer to DCS Policy ***14.12, Family Permanency Planning for Child Protective Services Non-Custodial Cases***).
D. Addressing Concerns of Drug Exposed Children on open CPS Assessment Cases	1. If, during an open CPS assessment case, the CPS Case Manager becomes aware of new allegations of a DEC, he/she consults with the assigned assessment Team Leader (TL) to determine if the allegation can be addressed within the existing open case. If the CPS assessment Case Manager and assigned assessment TL determine the allegations cannot be addressed in the current case, the assessments TL and the investigations TL meet to discuss the information gathered from the open case in order determine next steps. Refer to DCS Policy ***14.2, Screening, Priority Response and Assignment of Child Protective Services Cases*** for time frame requirements. *2.* If during an open CPS assessment case, the allegation(s) meets the level of severe abuse, the assigned assessment TL confers with the investigations TL to discuss the information gathered during the open assessment case to determine if the case is transferred to investigations or if the track is changed to investigation and remains with the current Case Manager. Factors to

	consider include the remaining investigative tasks and timeframe to case closure (refer to DCS Policies ***14.6, Child Protective Services Case Tasks and Responsibilities*** and ***14.7, Multi-Disciplinary Team: Child Protection Investigation Team***). **Note:** If the assessment case has already been classified, the track assignment can be changed by request through the Field Customer Care Representative (FCCR) and remain with the assessment Case Manager or transferred to investigations. 3. A case open for less than thirty (30) days may be transferred to investigations in cases where ACV's age limits the ability to self-protect or reduces the visibility by others, and one of the following exists: a) The parent/caregiver has a positive drug screen for illegal drugs or non-prescribed legal medications, and the use of illegal drugs or non-prescribed legal medications impairs the parent/caregiver's ability to meet child-care responsibilities resulting in the child being unsafe causing physical, mental, or emotional harm. b) The child has a positive drug screen for illegal drugs or non-prescribed legal medications. c) It is discovered that the child is exposed to or living within close physical proximity to where illegal drugs or non-prescribed legal medications are manufactured. d) A parent/caregiver refuses to submit to a drug screen, and the parent/caregiver's ability to meet child-care responsibilities is impaired, and there is circumstantial evidence of illegal drugs or non-prescribed legal medications.
E. Classifying Allegations of Drug Exposed Children in Investigation Cases	For investigation cases, the following information is considered when substantiating allegations of DEC: 1. A positive drug screen for the parent/caregiver and other evidence that indicates the parent/caregiver is unable to function in a manner that is adequate to meet the ACV's basic needs (e.g., there is a lack of food, housing, medical care, supervision or proper hygiene). 2. A positive drug screen for a newborn infant or the infant is born drug dependent as a result of the mother's use of illegal drugs or misuse of legally prescribed medication during her pregnancy. This includes, but is not limited to, a validated diagnosis of Fetal Alcohol Spectrum Disorder (FASD) and/or Neonatal Abstinence Syndrome (NAS). 3. Evidence collected, such as a positive drug screen, indicating the ACV was administered or ingested illegal drugs or prescription medications that were not prescribed to the ACV or used in a manner other than as directed and caused or was likely to cause physical, mental or emotional harm. 4. Evidence shows that the ACV was living in or exposed to an environment where the use, manufacture or sale of drugs took place. The manufacturing of methamphetamine in the same structure as an ACV is always considered

	severe abuse. 5. An admission of the use, manufacture or sale of illegal drugs or the misuse or sale of legal prescription medication when the ACV is present or placed in a dangerous environment as the result of the activity. 6. Assessments or evaluations indicating that as a result of the use, manufacture or sale of drugs or misuse of prescription medication by a parent/caregiver, the ACV has experienced physical, mental or emotional harm. 7. Any and all evidence collected during the investigation relevant to the allegation, including evidence that suggests the parent/caregiver's ability to function in a manner adequate to meet the ACV's basic needs, was impacted by the use, manufacture or sale of drugs or misuse of prescription medication.
F. Classifying Allegations of Drug Exposed Children in Assessment Cases	For assessment cases, the following information is considered when determining the recommendation or requirement for services: ♦ Parent/caregivers who have positive drug screens; ♦ Parent/caregivers who have admitted to the use of illegal drugs or misuse of legal prescription medication; ♦ Other information, such as interviews with collateral contacts or health care providers, which indicates the probable use of drugs or misuse of prescription medication by the parent/caregiver; ♦ The refusal of the parent/caregiver to submit to a drug screen when there is evidence to suggest recent drug use and there is a reason to believe this impacts the parent's ability to provide care; ♦ Assessments or evaluations that suggest the parent/caregiver has used drugs or misused prescription medication and that current use or relapse is probable; and ♦ The potential for the ACV to be present or have access to the environment where the use, manufacture or sale of drugs occurs. The ACV does not currently live in or have access to the dangerous environment, but the parent/caregiver has the ability to alter that arrangement at any given time.
G. Drug Team: Child Protective Services	Upon assignment from the CAH, the Intake Analyst/Team Leader will assign the case to the appropriate Drug Team Case Manager. The Case Manager will: ♦ Respond to the hospital within twenty-four (24) hours by phone or in person; ♦ Determine the mother's anticipated discharge date/time; ♦ Conduct a face to face visit with the alleged child victim (ACV) within the assigned priority response timeframe; ♦ Maintain weekly contact with the hospital until the child is discharged (See Hospital Protocol) to discuss updates, discharge planning, family involvement;

- Complete the investigative process and begin discharge planning with the parent(s), infant, third party caretakers, hospital and/or any other involved parties on the initial day of contact;
- A home visit will be conducted prior to discharge, *review safe sleep* with all family members and observe the sleeping arrangements for the infant ***(to be completed each month)***;
  - If an infant is discharged home prior to making response, Safe Sleep is assessed during the first home visit and monthly thereafter.
  - If notification of infant discharge from a hospital is received prior to completion of a home visit, a home visit will be conducted including assessment of safe sleep.
- Conduct a Child and Family Team Meeting (CFTM) at the hospital when possible/necessary;
  - The Drug Team Case Manager includes in the invitation to the CFTM those partner agencies involved with the following programs where applicable:
    - Single Team/Single Plan
    - Multi-Agency Collaborative
    - Safe Baby Court
- Complete a Plan of Safe Care (Non-Custodial/Family Permanency Plan, (refer to DCS Policy ***14.12, Family Permanency Planning for Child Protective Services Non-Custodial Cases***);
  - A Plan of Safe Care is not required in TFACTS with supervisory approval in consultation with regional legal counsel when:
    - The family refuses services;
    - Intervening family or court action occurs.
- Refer parent(s) for any identified services, including but not limited to an Alcohol and Drug Assessment, when needed;
- If the investigation requires court involvement or removal into a third-party placement, the Case Manager should schedule a CFTM to include the Family Support Services (FSS), if applicable;
  - DEC Case Manager may refer for services prior to the CFTM, in which case the provider should be included in the CFTM.
  - Team members will use the Non-Custodial/Family Permanency Plan for the Plan of Safe Care which is also used in the Single Team/Single Plan approach, when appropriate.

	♦ Refer to the Drug Exposed Child FSS team when services are implemented and there is a need for long term case management of the services **Note:** Not all cases transferred to FSS team will require court involvement or DCS paid services.
H . Drug Team: Family Support Services (FSS)	1. Drug Team FSS Case Managers and supervisors reference DCS Policy ***14.18, Family Support Services Program*** except for provided below. 2. The FSS TL and Drug Exposed Child TL in the region/unit will identify cases for transfer to FSS and will discuss by phone/email/face to face meeting. The TLs will ensure the cases meet criteria and agree on those cases for transfer. a) Criteria for Transfer to FSS-A minimum of one criterion must be met: ♦ FAST score of moderate or high risk; ♦ Court involvement or court request for continued services; ♦ A removal from the parent(s) or caregiver and placement with a third party with services identified or in place, and may include an Immediate Protective Agreement (IPA); ♦ Services can be paid by DCS or community based and initiated to reduce the risk of harm and/or the risk of custody; or ♦ FAST score of minimal BUT including at least one of the above criteria. b) Once the TLs determine the case will be transferred to FSS, a CFTM will be conducted to transfer the case to the FSS Case Manager. c) Assigned Case Manager will complete the referral process for services when identified as follows: ♦ Submit a Case Service Request (CSR) request by completing the CSR form for any service needs; ♦ Complete the Release of Information, ***CS-0559***, if necessary, and uploaded in TFACTS; ♦ Enter any requests in TFACTS; ♦ Monthly progress of the assigned case to include compliance with court orders and accomplishment of goals on Permanency Plan or Plan of Safe Care and document in TFACTS; ♦ Entry of the FAST reassessment to meet compliance with DCS Policy; ♦ Review and upload into TFACTS monthly provider reports and enter the Plan of Safe Care into TFACTS; ♦ Face to Face Home visit conducted monthly (within each calendar month) with the child in their current placement and *safe sleep will be reviewed and observed;* ♦ Face to Face visit with the parent and/or third-party caretaker must be

	conducted monthly (within each calendar month); ♦ During face to face visits with the caretakers (to include parents/caretaker) a review of the Plan of Safe Care/Non-Custodial Permanency Plans will be conducted and reviewed for compliance. This will be documented in TFACTs. ♦ Prior to a recommendation of a child being returned to a home where the child was removed from, a home visit must be conducted. In the event of a severe abuse case, DCS Policy ***16.12, Severe Abuse Review*** will be followed, prior to recommendation of return to parent/caretaker. d) The FSS Case Manager will close the case upon completion of services with supervisory approval and in compliance with any court involvement. e) Case Reviews with the TL, Team Coordinator (TC) and CPS Director/designee are conducted at day 120, 180 and quarterly thereafter to discuss: ♦ Engagement with the family; ♦ Efforts to locate missing family members; ♦ Ongoing service compliance; ♦ Court Action with DCS legal representative; and ♦ System barriers.
I. CPS Tasks and Responsibilities	Refer to DCS Policy ***14.6, Child Protective Services Case Tasks and Responsibilities*** and associated Work Aids referred to in those policies for a complete list of all the tasks associated with conducting CPS investigations and assessments including those specifically addressing allegations of drug exposed child.

Forms:	***CS-0680, Child Protective Services Intake*** ***CS-0050, Case Intake Documents and Native American Heritage Verification*** ***CS-4234, Office of Child Safety Regional Drug Team Quality Assurance Review***

Collateral Documents:	***Work Aid 1: CPS Categories and Definitions of Abuse/Neglect*** ***14.2, Screening Priority Response and Assignment of Child Protective Services Cases*** ***14.6, Child Protective Services Case Tasks and Responsibilities*** ***14.7, Multi-Disciplinary Team: Child Protection Investigation Team*** ***14.12, Family Permanency Planning for CPS Non-Custodial Cases*** ***14.18, Family Support Services Program*** ***16.12, Severe Abuse Review*** ***Child Protective Services Tasks Manual*** ***Safety Notice: Understanding Fentanyl and Avoiding Accidental Exposure*** ***Controlled Substance and Medication Work Aid***

Glossary:	
Term	***Definition***
Fetal Alcohol Spectrum Disorder (FASD)	Fetal Alcohol Spectrum disorders are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. These effects can include physical problems and problems with behavior and learning. Often a person with FASD has a mix of these problems.
Neonatal Abstinence Syndrome (NAS):	Neonatal Abstinence Syndrome is a condition in which a baby has withdrawal symptoms after being exposed to certain substances. Many times, the baby is exposed when the mother uses substances such as medications or illicit drugs during pregnancy and after the baby is born (and separated from the mother's body), the baby goes through withdrawal because it is no longer receiving the substances. Less commonly, very sick babies may receive medications after birth to help control pain or agitation, and once those medications are stopped, the baby may go through withdrawal. Medications that may cause withdrawal include those known as opioids (painkillers) or benzodiazepines (which help with anxiety or sleep). Illegal drugs such as cocaine may also cause withdrawal. Withdrawal can occur when a mother is using a medication as prescribed, (e.g., a mother who is receiving legally prescribed medication for pain or addiction); when a mother is misusing a prescription medication (e.g., using the medication too much or too often and/or taking a medication not prescribed to her); or the use of illegal drugs (Reference Tennessee Department of Health: ***https://www.tn.gov/health/nas.html***).
Self-Protect	The degrees to which a child can avoid, negate, or modify the impact of safety threats.
Visibility	Reference to the child's ability to be seen by others outside the care of the alleged perpetrator.
Vulnerability	Reference to the child's capacity to self-protect as related to age, disability, susceptibility to maltreatment, and visibility by others.