

the Department." The data collected by DHS is limited to the information received from the health care professionals. While reporting from the large hospitals within the state is typically good, some of the smaller more rural hospitals do not have the capability to do the type of testing necessary, or do not have it on site, but this is improving. Title 10A, 1-1-105(22) was amended and became effective in November of 2012. It defines a drug-endangered child as a "...child who is at risk of suffering physical, psychological or sexual harm as a result of the use, possession, distribution, manufacture or cultivation of controlled substances, or the attempt of any of these acts, by a person responsible for the health, safety or welfare of the child...." Title 10A, 1-2-102(A)(3) directs DHS to conduct an investigation, not just an assessment, when allegations have been reported regarding a drug-endangered child. This includes children born drug exposed as well as older children who meet the above definition. DHS policy has been changed accordingly.

## Data

Most all of the large urban hospitals across the state routinely tested for illegal substances when women present at the hospital with the following circumstances.

- Presenting to a hospital far from their home, with no plausible explanation
- No prenatal care
- Premature birth or labor
- Placental abruption (while there are many possible causes, use of cocaine and excessive alcohol use are considered risk factors)
- Physical signs of substance use
- Self-reported substance use and/or history of substance use
- Previous positive test during pregnancy

The most reliable testing mechanism is the collection and testing of the newborn's meconium. The presence of substances in the meconium has been proposed to be indicative of in utero substance exposure up to 5 months before birth, a longer historical measure than is possible by urinalysis. As most