

INDIANA DRUG ENDANGERED CHILDREN (DEC) COMPREHENSIVE CARE PROTOCOL

To be administered by medical, mental health, developmental and dental professionals after a child has been removed from a meth lab or home to assure the child’s physical, emotional, and developmental well-being.

Drug Endangered Children are children under age 18 found to be living in homes: (a) with caregivers who are manufacturing methamphetamine in/around the home (“meth labs”) or (b) where caregivers are dealing/using methamphetamine. Meth labs and certain meth homes fall within Indiana’s statutory definition of child abuse/neglect. Children will be provided with appropriate health care as outlined in this protocol. See separate protocols, Indiana DEC Response Protocol and Indiana DEC Decontamination Protocol regarding actions taken at the scene by initial responders.

For information on coverage of health care charges for DEC children, see Indiana DEC Health Coverage Guide.

A Timing: Ideal: Immediate No later than: 2 hours after removal from a meth lab and within 24 hours of discovery at a meth home if no signs or symptoms of a problem	PRELIMINARY MEDICAL ASSESSMENT (For child with obvious critical injury or illness, bypass this assessment and transport immediately to a medical facility) The onsite assessment is done to determine whether children discovered at the scene are in need of Emergency Care (Procedure B). Medically trained personnel (e.g. EMT or paramedic) must do the assessment. If no medical personnel are available at the scene, the child must be taken to a medical facility for this assessment. In either case, a medical assessment should be done for each child within 2 hours of discovering children at a meth lab and within 24 hours of discovery at a meth home if no signs or symptoms of a problem. 1. Perform medical assessment consisting of: Vital signs (temperature, blood pressure, pulse, respirations) Pediatric Triangle of Assessment (Airway, Breathing, Circulation) 2. For life-threatening findings, seek immediate medical attention. Transport to a facility capable of pediatric emergency response appropriate to findings. 3. Refer to Indiana DEC Response Protocol Procedure E for information about removal of child’s clothing, decontamination of child’s skin, etc. If there are no pressing clinical findings, short-term shelter or other secure placement should be implemented by Indiana Department of Child Services (DCS) Family Case Manager (see Indiana DEC Response Protocol Procedure H)
B Timing: Immediately upon identification of any critical needs	EMERGENCY CARE <i>(For critical health problems only)</i> Problems requiring Emergency Care are those that cannot wait 24 hours to be fully evaluated and treated at the Complete Evaluation (see Procedure C). Emergency Care must be provided as soon as possible after critical health problems are identified in the Preliminary Medical Assessment (above). Emergency Care must be provided in a hospital emergency room or pediatric or urgent care facility depending on the severity/urgency of the problem and the time of day. 1. Perform the Preliminary Medical Assessment if it was not done at the scene (follow Procedure A above). 2. Administer tests and procedures as indicated by clinical findings. A urine specimen for toxicology screening should be collected from each child. Use appropriate chain of evidence procedures and request that the screen be conducted at 50 nanograms or lower and that confirmatory tests results be reported at any detectable level. 3. Call Indiana Poison Center (IPC) if clinically indicated (1-800-222-1222). 4. Follow steps in Complete Evaluation (see Procedure C below) if appropriate to medical site and time permits or get assurance from DCS Family Case Manager that Complete Evaluation will be completed within 24 hours of child’s removal from a meth lab or home (or 12 hours if urine has not been collected and urine screen was determined necessary by DCS and LEA). 5. Secure the release of the child’s medical records to all involved agencies, including DCS, law enforcement, and prosecution, to ensure ongoing continuity of care. If DCS onsite, ask Family Case Manager to complete a “release of medical information” form to facilitate this process. DCS Family Case Manager (FCM) should evaluate placement options and implement. FCM should get assurance that the child will be closely observed for possible developing symptoms
C Timing: Within 24 hours of removal from a meth lab or home* *Exception: This evaluation must be conducted within 12 hours of removal from a meth lab or home if urine was not previously collected.	COMPLETE EVALUATION AND CARE A Complete Evaluation must be given by medical personnel within 24 hours of removing a child from a meth lab or home to ascertain a child’s general health status. Prompt assessment is warranted due to the risk of toxicologic, neurologic, respiratory, dermatological, or other adverse affects of methamphetamine lab chemicals and/or other drug exposure, and the high probability that the child has suffered from neglect/abuse. 1. Obtain child’s medical history from DCS Family Case Manager. 2. Perform complete pediatric physical exam to include as much of the Early Periodic Screening, Detection, and Treatment (EPSDT) exam as possible. Pay particular attention to: Neurologic screen Respiratory status Development 3. Call the Indiana Poison Center (IPC) if clinically indicated (1-800-222-1222) 4. Perform required medical evaluations: Temperature (otic, rectal, or oral) Oxygen saturation levels Liver function tests: AST, ALT, Total Bilirubin and Alkaline Phosphatase. Kidney function tests: BUN and Creatinine Electrolytes: Sodium, Potassium Chloride, and Bicarbonate Complete Blood Count (CBC) Chest x-ray (AP and lateral) Urinalysis

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C (Cont.) Timing: Within 24 hours of removal from a meth lab or home* *Exception: This evaluation must be conducted within 12 hours of removal from a meth lab or home if urine was not previously collected.	i. Urine for toxicology. Use appropriate chain of evidence procedures if possible. Urine screens should be quantitative for level of meth (performed at 50 nanograms or lower with confirmatory results reported at any detectable level) and qualitative for drugs of abuse. 5. Perform optional clinical evaluations as appropriate given child's condition: a. Complete metabolic panel (Chem 20 or equivalent) b. Pulmonary function tests c. CPK d. Lead level (on whole blood) e. Coagulation studies g. Carboxyhemoglobin level 6. If the Indiana Department of Child Services (DCS) is not already involved with the child, file a report of child abuse/neglect with the DCS (1-800-800-5556) and Law Enforcement. (Note: Hospitals may not release child to parent without consent of DCS or a court order after report is made) 7. Measure and record the height of the child . 8. Conduct a developmental screen. This is an initial age-appropriate screen, not a full-scale assessment; may need referral to a pediatric or occupational/physical/speech specialist (OT/ PT/ST). Note: If the child is between the ages of zero and three, the developmental screen may be completed by First Steps. The DCS Family Case Manager will make a First Steps referral. Appropriate services should be arranged for any abnormal screening results. 9. Conduct a preliminary mental health screen to detect any critical issues that need immediate attention. Refer for immediate mental health assessment or crisis intervention services if critical issues detected; otherwise, DCS Family Case Manager will make a referral for an assessment within 30 days. 10. Conduct a preliminary dental screen to detect any critical issues that need immediate attention. Refer for immediate dental services if critical issues detected; otherwise refer child for a full dental exam to be completed within 30 days. 11. Secure the release of the child's medical records to all involved agencies, including DCS, law enforcement, and prosecution, to ensure ongoing continuity of care. If DCS onsite, ask Family Case Manager to complete a "release of medical information" form to facilitate this process. Note: Child welfare personnel may not have immediate legal access to certain (historical) health care records. Every effort should be made to facilitate transfer of medical records, by providing information about where, when, and to whom records should be transferred. 12. For any positive findings, follow-up with appropriate care as necessary. If not already completed, placement options should be evaluated and implemented as necessary by a DCS Family Case Manager.
D Timing: 30 days from removal from a meth lab or home	INITIAL FOLLOW-UP EXAM AND CARE A visit for Initial Follow-up Care occurs within 30 days of the Complete Evaluation (Procedure C) to reevaluate comprehensive health status of the child, identify any latent symptoms, and ensure appropriate and timely follow-up of services as the child's care plan and placement are established. If possible, the visit should be scheduled late in the 30-day time frame for more valid developmental and mental health results. 1. Follow-up of any abnormal baseline test results. 2. Repeat developmental screen (see Procedure C, Item 8). Communicate with the child's provider of developmental services if any abnormal results. 3. Conduct mental health history and evaluation (requires a qualified pediatric professional). 4. If abnormal findings on any of the above, schedule intervention and follow-up as appropriate to the findings; then proceed with Long-term Follow-up (Procedure E, below). 5. Based on the results of these follow-up exams, the adequacy of child's shelter/placement situation should be reviewed by the DCS Family Case Manager and modified if necessary. 30 days from removal from meth a lab or home.
E Timing: 12 months from removal from a meth lab or home	LONG-TERM FOLLOW-UP EXAM AND CARE Long-term follow-up care is designed to 1) monitor physical, emotional, and developmental health, 2) identify possible late developing problems related to the methamphetamine environment, and 3) provide appropriate intervention. Follow-up exams should be conducted according to the American Academy of Pediatrics recommended schedule. At minimum, a pediatric visit is required 12 months after the Complete Evaluation (Procedure C) was administered. a. Follow-up for previously identified problems. b. Perform comprehensive (EPSDT) physical exam. c. Repeat developmental screen (see Procedure C, Item 8). Communicate with the child's provider of developmental services if any abnormal results. d. Perform mental health evaluation (requires a qualified mental health professional, pediatrician, licensed therapist, child psychologist, or licensed child mental health professional). 2. Plan follow-up and treatment or adjust existing treatment for any medical problems identified. Medical records should continue to accompany the child's course of care. 3. For children in out-of-home care, the adequacy of the child's placement will be reviewed by the child's DCS family case manager and modified as necessary. 4. Plan follow-up strategies for developmental, mental health or placement problems identified. 5. As needed, conduct home visits by pediatrically-trained PHN or other nurse, at 3, 9, 15, and 18 months post Complete Evaluation (Procedure C). Ensure that home visits occur between the pediatric clinic visits until the last visit at 18 months.