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Knowing the Unknown: Innovative, Interdisciplinary Treatment for Safely Surrendered Infants

Micah J. Orliss, Ph.D., Sheela Rao, M.D., and Karen C. Rogers, Ph.D.

Financial Disclosure Requirement

- I, Micah Orliss, have no commercial relationships to disclose
- I, Sheela Rao, have no commercial relationships to disclose
- I, Karen Rogers, have no commercial relationships to disclose

Objectives

- Objective 1: Participants will become familiar with the safe haven intervention model.
- Objective 2: Participants will be able to correlate typical characteristics of surrendered infants with the implications for infant and family support.
- Objective 3: Participants will acquire an understanding of best practice models for medical and developmental care of surrendered newborns.

Scenario

- *Imagine you are expecting a child you know you cannot care for. What might be going through your mind? How might you be feeling?*
 - What if you're in high school?
 - What if you're homeless?
 - What if your current living situation is unsafe?
 - If you're struggling with addiction?
 - If you're experiencing mental illness?
 - If the pregnancy is the result of non-consensual sex?

A Problem as Old as Humanity

“Infanticide has been practiced on every continent and by people on every level of cultural complexity, from hunter gatherers to high civilizations, including our own ancestors. Rather than being an exception, then, it has been the rule.”

– Anthropologist Laila Williamson

The Rise of Adoption

- Prior to the 20th century, children outside the care of their biological family primarily received institutional care
- In the US, the legal structure severing a child's ties with the biological parent and assigning a different parent was developed in the 1850's. It was widely viewed as a legal fiction.
- Between the 1930's and 1970's, infant adoption became more widespread.

US and California Adoptions (2008)

United States

- 135,813 children
- Adoption from foster care: 55,303 (41%)
- International adoptions: 17,416 (13%)
- Other adoptions*: 63,094 (46%)

California

- 12,207 children
- Adopted from foster care: 7,777 (64%)
- International adoptions: 1,371 (11%)
- Other adoptions*: 3,059 (28%)

History of surrendered infants

- Baby Moses
- Foundling wheel
- Baby hatches
- Orphanages
- Texas law 1999

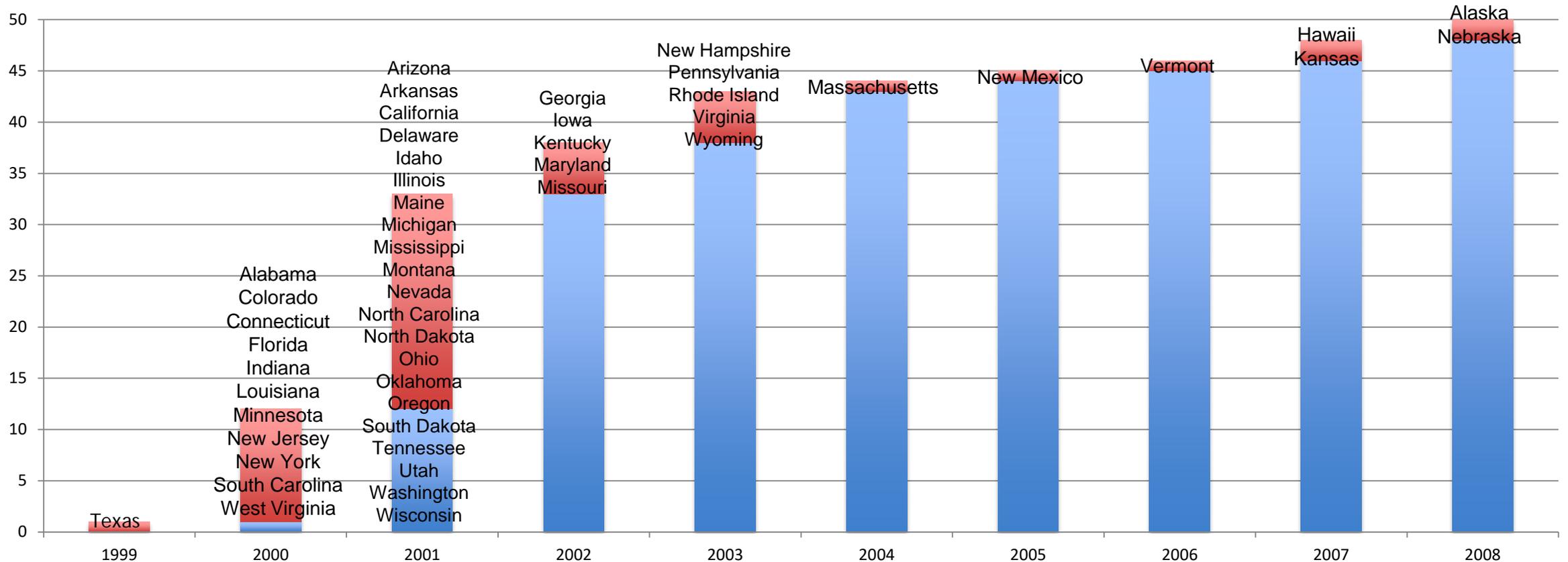


Recent U.S. History of Safe Surrender

- 1999: Texas becomes first state to enact infant safe haven laws (“Baby Moses laws”)
- Legal parental agent can surrender a newborn baby safely, anonymously, and without risk of prosecution for abandonment or neglect
- Today: All 50 states plus the District of Columbia and Puerto Rico have implemented safe haven laws
- Age at surrender limitation varies by state
 - Some states limit age to less than 72 hours old, others up to 1 month old

History of Safe Surrender Laws in the U.S.

■ Previously Enacted ■ Newly Enacted



From Surviving to Thriving

- Why are we interested in developing best practices to identify and address unique needs of infants?
- Initial purpose of Safe Haven laws was to reduce infant deaths
- Safe Haven guarantees of anonymity make it difficult to know about this population of parents and infants
- Conditions leading to a child's surrender may increase vulnerability (Scenario)

Safe Surrender Process

- To be eligible for the safe surrender program in California, babies must be less than 72 hours old
- A 'parental agent' can surrender their baby at a designated Safe Surrender location
 - Hospital
 - Fire Station
- Parent is asked to complete a medical background questionnaire
- Care of the infant is then overseen by Child Protective Services and the Children's Court
- Barring serious medical issues, Safe Surrender infants are placed with adoptive families as quickly as possible
- Safe surrender adoptions tend to proceed more quickly than traditional adoptions.



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Safe Surrender Procedures

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

“SAFELY SURRENDERED BABY” Medical Questionnaire

THANK YOU FOR CHOOSING TO GIVE THIS BABY A SAFE AND SECURE FUTURE

NOTICE: THE BABY YOU HAVE BROUGHT IN TODAY MAY HAVE SERIOUS MEDICAL NEEDS IN THE FUTURE THAT WE DON'T KNOW ABOUT TODAY. SOME ILLNESSES, INCLUDING CANCER, ARE BEST TREATED WHEN WE KNOW ABOUT FAMILY MEDICAL HISTORIES. IN ADDITION, SOMETIMES RELATIVES ARE NEEDED FOR LIFE-SAVING TREATMENTS. TO MAKE SURE THIS BABY WILL HAVE A HEALTHY FUTURE, YOUR ASSISTANCE IN COMPLETING THIS QUESTIONNAIRE FULLY IS ESSENTIAL. THANK YOU.

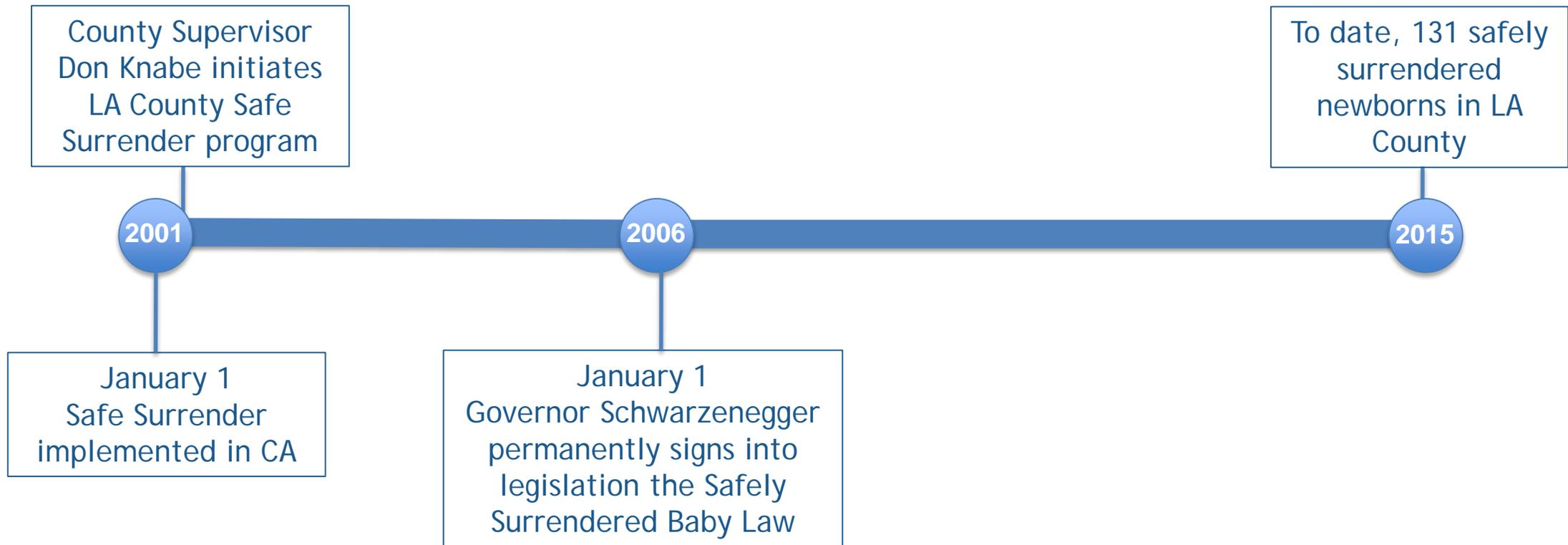
Please remember that these questions will allow us to provide the best supportive care possible to the baby. If you need help answering any of the questions, please ask. If you are uncomfortable answering any of the questions, skip them and answer the rest. Any information you provide will benefit the baby.

ALL INFORMATION IS CONFIDENTIAL AND WILL BE USED ONLY TO HELP CARE FOR THE BABY.

California Statistics

Year	Reclaimed	Safely Surrendered	Total Abandoned	Abandoned Surviving	Abandoned Deceased
2001	0	2	20	7	13
2002	0	17	25	13	12
2003	0	25	13	5	8
2004	1	33	19	7	12
2005	0	52	11	4	7
2006	0	65	26	10	16
2007	1	47	8	4	4
2008	0	61	12	3	9
2009	1	57	8	2	6
2010	5	71	5	2	3
2011	2	48	5	1	4
2012	4	72	3	0	3
2013	2	62	4	2	2**
2014	0	74	5	4	1**
2015	6	84	5	5	0
TOTAL	22	770*	169	69***	100***

Safe Surrender in Los Angeles County



Criticisms of the Safe Surrender Programs

- Does it really prevent infant abandonment?
- Does it steer mothers away from more traditional (and safer) adoption processes?
- Do surrendering parents receive any supportive counseling when making their decision?
- Does it disempower fathers? Can you be certain that the person surrendering the baby speaks for all family members?
- Does it disempower the infants?
- Does it address the circumstances that lead to babies being surrendered, including gender dynamics and power inequities?

Safe Surrender Infants in California: Who are they?

- Think about a parent who chooses to surrender an infant through the program. What would you be curious about?
- Think about an infant, newly surrendered. What might be helpful to know?

Safe Surrender Infants in Los Angeles County: Who Are They?

- Sample size was 80 infants.
- 40 male, 40 female
- Ethnicity
 - Latino - 36 (45%)
 - White - 20 (25%)
 - African-American - 18 (23%)
 - Asian/Pacific Islander - 4 (5%)
 - Other - 2 (3%)
- Note that ethnicity is often not known, so the accuracy of these statistics is unclear

Ethnic Differences

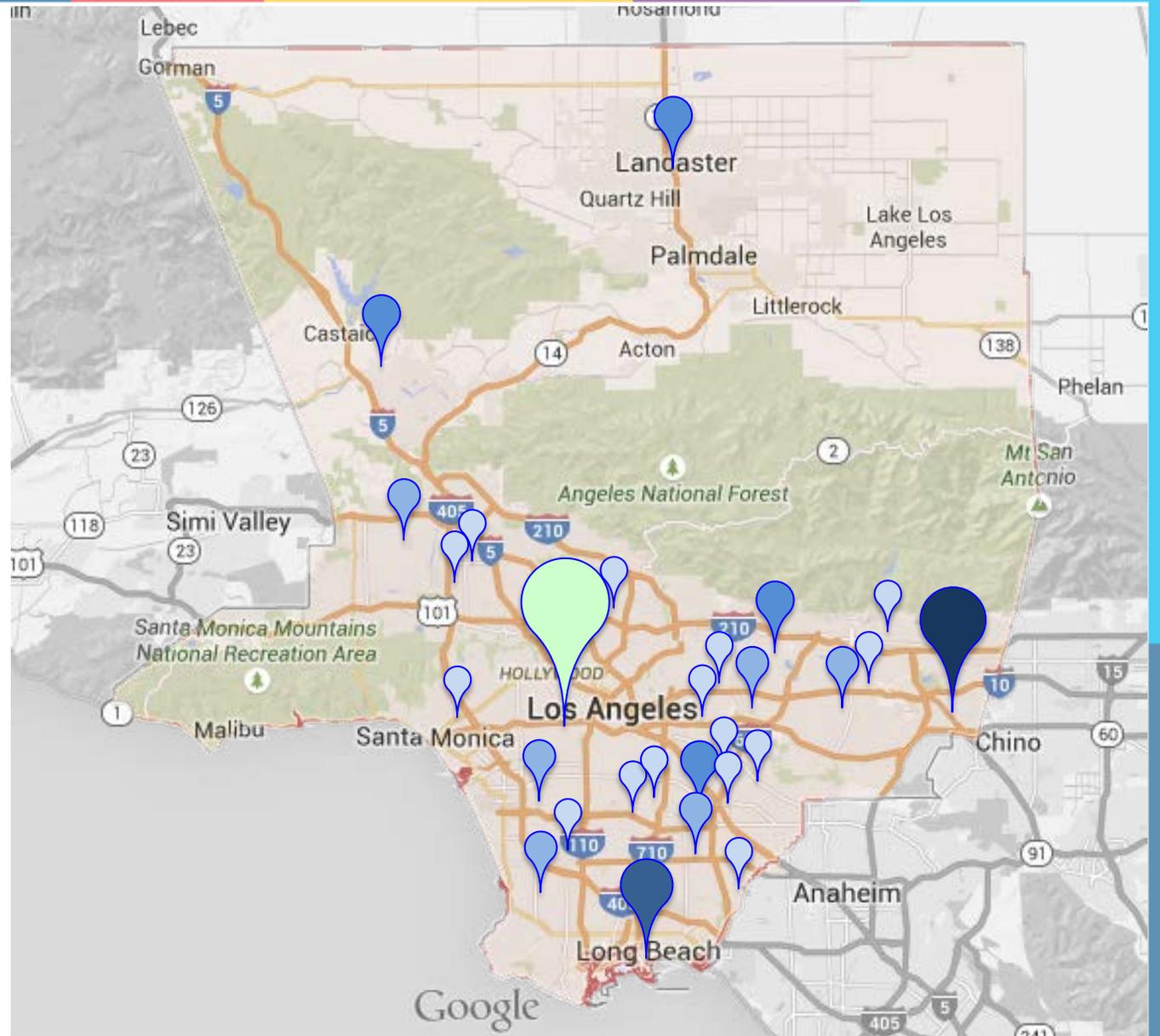
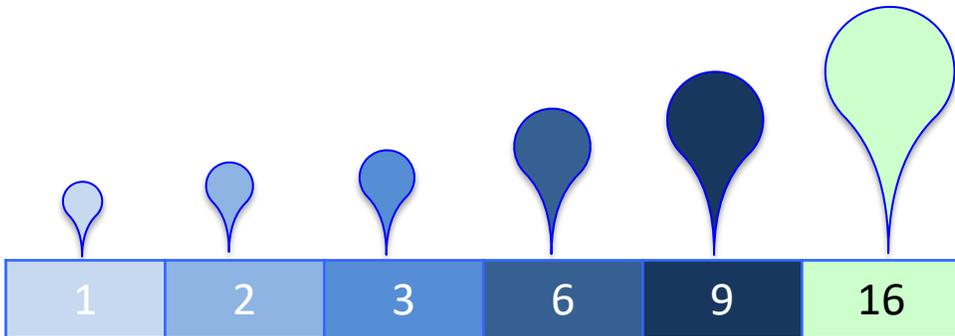
- Although it is difficult to know the true ethnicity of the babies in our sample, the reported proportions are roughly in line with white and Latino demographics of Los Angeles County (2010 U.S. Census). However, African-Americans appear overrepresented in our sample, while Asians appear underrepresented.
 - Latino - (47.7% of L.A. County vs. 45% of sample)
 - White - (27.8% of L.A. County vs. 25% of sample)
 - African-American - (8.3% of L.A. County vs. 23% of sample)
 - Asian - (13.5% of L.A. County vs. 5% of sample)
- There was no significant interaction between gender and ethnicity, though with greater sample size, trends may emerge.
 - Though different ethnic groups may have different cultural norms around gender, there is no evidence that girls or boys are surrendered at disproportional rates

Age at Surrender

- To be eligible for the safe surrender program in California, babies must be less than 72 hours old.
 - The mean age of babies surrendered in our sample was 1 day old with a standard deviation of two days.
 - The modal age was 0 days old.
- Of the 64 babies in our sample whose age was recorded, 36 (56%) were zero days old.
 - 12 were one day old (19%).
 - The remaining 16 babies (25%) were two days old or greater when surrendered.
 - Note that with increasing age comes increased risk of exposure to abuse and neglect, which increases the risk for medical, developmental, and psychological problems for these babies.

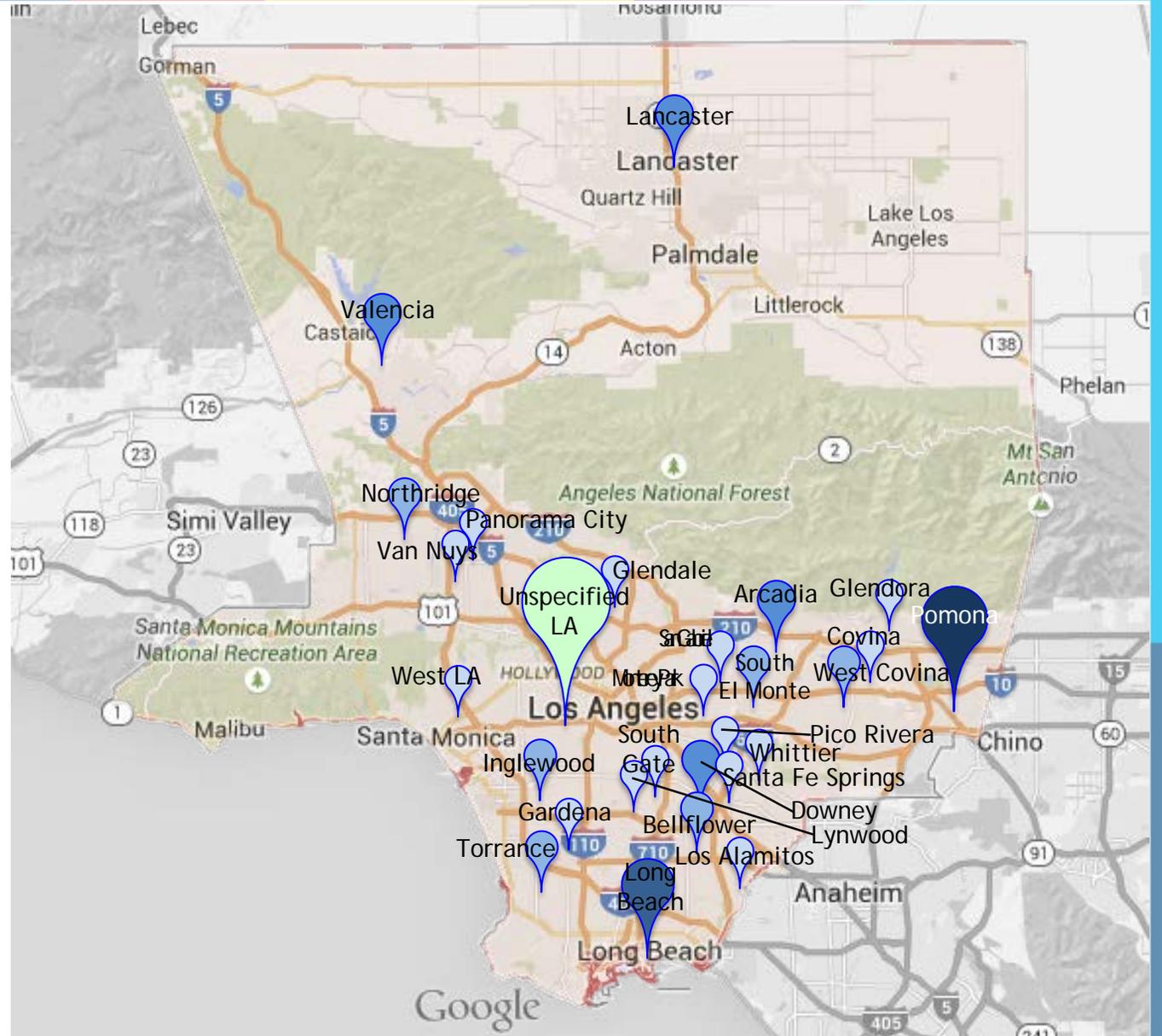
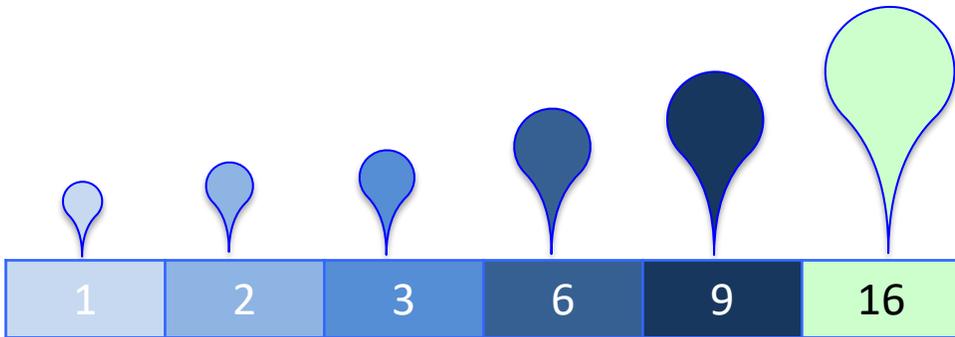
Safe Surrender in LA County

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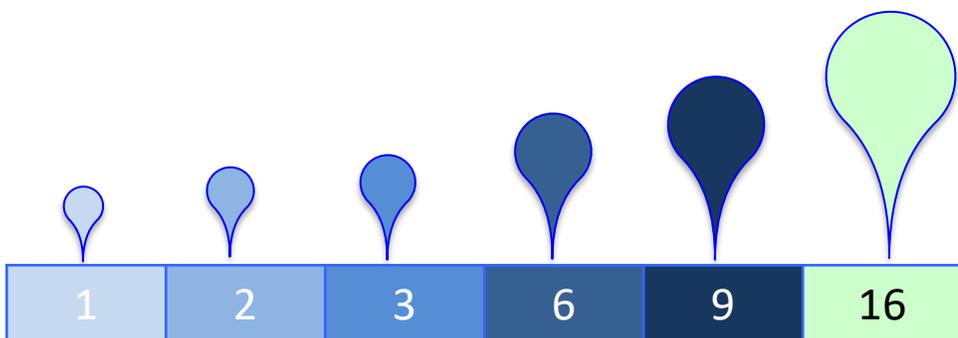


Safe Surrender in LA County

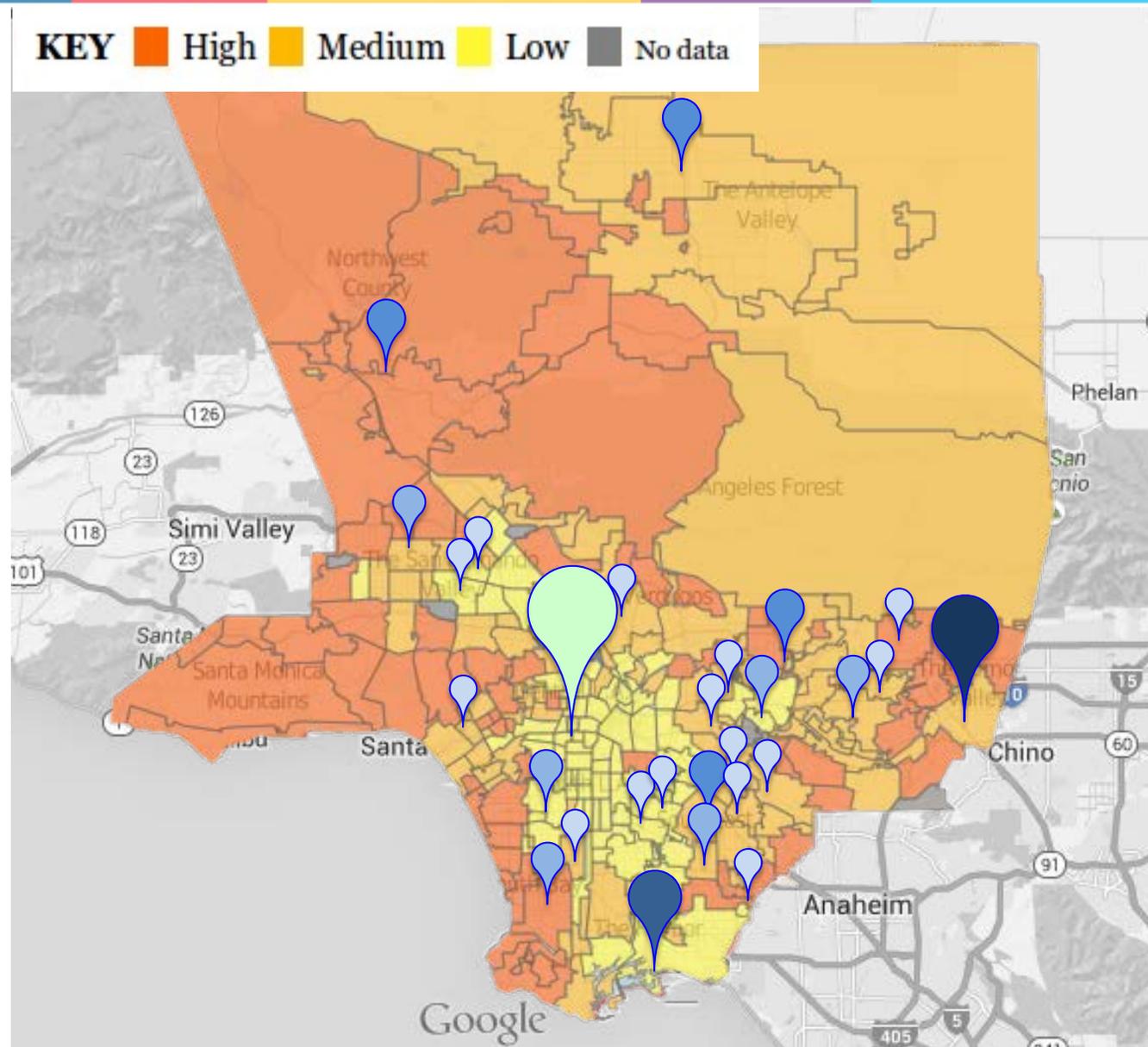
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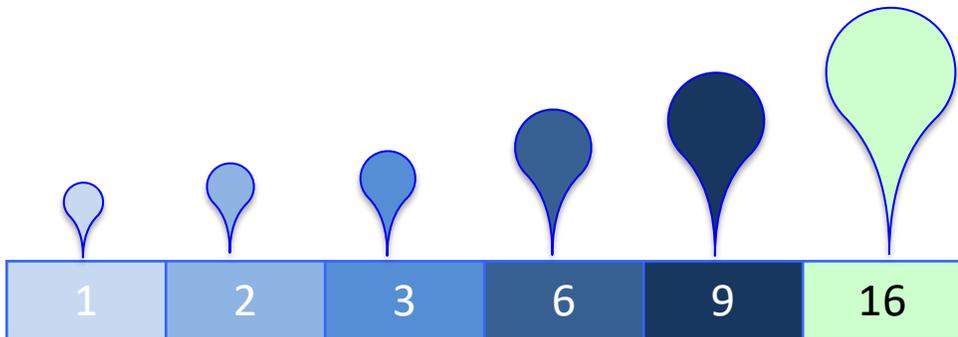
Median Household Income



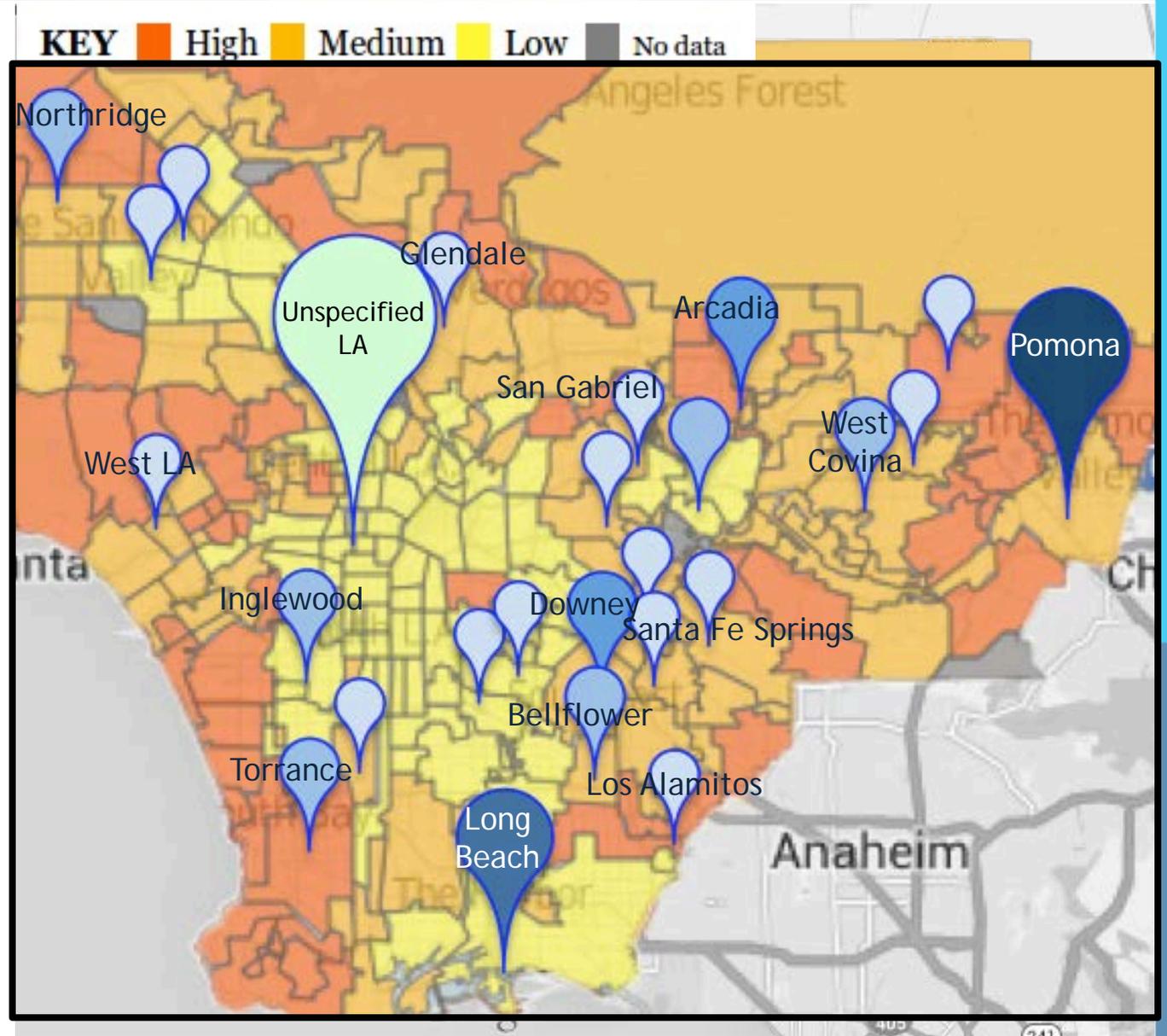
Source: Los Angeles Times, Mapping L.A. (2015). *Median income* [Graphic representation]. Retrieved from <http://maps.latimes.com/neighborhoods/income/median/neighborhood/list>



Median Household Income



Source: Los Angeles Times, Mapping L.A. (2015). *Median income* [Graphic representation]. Retrieved from <http://maps.latimes.com/neighborhoods/income/median/neighborhood/list>



Median Household Income

Median Community Income Level	Observed Number of Surrenders
\$40,000 - 50,000	24
\$50,000 - 60,000	25
\$60,000 - 70,000	8
\$70,000 - 80,000	7
\$80,000 - 90,000	6

- N = 28 cities
- $X^2_{df=4} = 26.4286, P \ll 1\%$

Case Length

- Families who surrender an infant have a 14 day window in which they can reclaim their baby without encountering additional legal impediments
- Safe surrender adoptions tend to proceed more quickly than traditional Los Angeles County adoptions.
 - Without biological family members involved, there are fewer legal hurdles that must be met before family rights are terminated and adoption can proceed.
- In our sample, the mean case length was 515 days, with a standard deviation of 184 days.
 - Minimum length of time to case closure was 230 days
 - Maximum length was 1007 days.

Placement Type and Outcome

- Eight babies out of the sample of 80 were reclaimed by their parent(s).
- Of the remaining 72 babies in the sample, 71 were adopted by non-relatives.
- One child in the sample died while still in foster care.
 - This underscores the medical issues that many of the babies in the Safe Surrender program face.

Strengths of the L.A. County Safe Surrender Program

- Faster adoptions mean fewer stressors on the family
- Early placement with prospective adoptive families allows for babies to develop a secure early attachment to a single set of caregivers
- Families are well prepared and highly motivated to adopt
- Families are part of an informal Safe Surrender community, championed by Supervisor Knabe. This includes advocacy, community events, and the recent introduction of a scholarship to assist with higher education costs.
- This is not meant to suggest that this model should be used to address more traditional foster care adoptions, in which biological families have numerous opportunities to reunify with their children
 - Rather, the expedited adoption process is an advantage that Safe Surrender babies experience that helps to offset many disadvantages that they face

Challenges to Families of Safe Surrender Infants

- Despite best efforts, the prenatal and family medical and mental health history of these infants is often unknown, which can pose lifelong challenges in certain cases
- Not all providers will have expertise in treating Safe Surrender infants - babies may not get all the early medical screenings and interventions needed
- There is often a lack of coordination between care providers, despite Safe Surrender infants' need for greater interdisciplinary teaming

Unique Vulnerabilities

- Very little, if anything, is known about babies when they are surrendered
 - If a medical questionnaire is completed, it provides only a rough family medical history and mental health history
 - Even ethnicity is often only 'presumed'
- A disproportionate number receive inadequate prenatal care and/or are exposed to drugs or alcohol in utero
 - Premature birth rates higher
 - Significant medical challenges may make a parent more likely to surrender their baby
 - In our sample, 44 out of 80 infants were identified as having medical issues
- Conclusion: Safe Surrender infants are at increased risk for medical, developmental, and mental health issues

Medical Issues- A Tale of Two Adoptees

- Emily was once a safe surrender infant. She was officially adopted when her adoptive parents decided to pursue HIV and Hepatitis testing because of hearsay that her birth mother was positive for hepatitis
- This information was never confirmed or denied by social worker
- HIV Antibody screen was sent
- Hepatitis panel was sent

Results

- Hepatitis panel was negative but
- HIV antibody screen was positive!
- What additional information would you like to know at this point?



Next Steps taken

- Network with DCFS public health nurse
- Discussion with lab personnel
- Discussion with the adoptive parents

Definitive Testing Done

- Luckily HIV DNA PCR was negative; repeat testing done 2 weeks later remained negative
- DCFS records of this safely surrendered infant were sealed post adoption
- No confirmation of previous hearsay regarding birth parent
- The form that Emily's birth mother was supposed to complete never conveyed any of this information according to adoptive mother, but health care provider never saw this form

Factors Unseen

- 23 month old male infant Arnold was fast-tracked through Los Angeles DCFS and adoptive family has started court proceedings for adoption
- DCFS released all birth history and medical records when foster family started process of adoption
- Adoptive father discovers that birth mother is homozygous for Factor V Leiden deficiency
- Birth mother has had multiple deep venous thromboses and multiple pulmonary embolisms and has been in and out of rehabilitation
- This information was in records available to DCFS personnel but was not disclosed to foster caregivers until they became adoptive caregivers
- Adoptive parent brings child in for genetic testing

Gene tests

- Currently genetic testing is driven by family history; it is not standard of care to run genetic tests for all genetic conditions
- We do limited screening for some genetic conditions in newborn screening (81 in California) but these are not definitive diagnostic tests
- Tests for Factor V Leiden would only be done in a population cohort where the carrier rate is high
- Current state of the art testing for this coagulopathy involves sending a blood sample to look for common mutations associated with Factor V Leiden deficiency

Results for Arnold

- He is heterozygous for R506Q mutation for factor V Leiden deficiency
- Having this gene makes him 8-10 times more likely to clot compared to general population
- Carriage of this gene can have implications for Arnold as early as his second decade of life
- This medical information did not come to light until Arnold was on the adoptive path
- Birth mother has not had contact with adoptive family or with Arnold
- Stewardship of medical records for children not in safe surrender programs needs improvement

Comparison of 2 adoptees

Emily

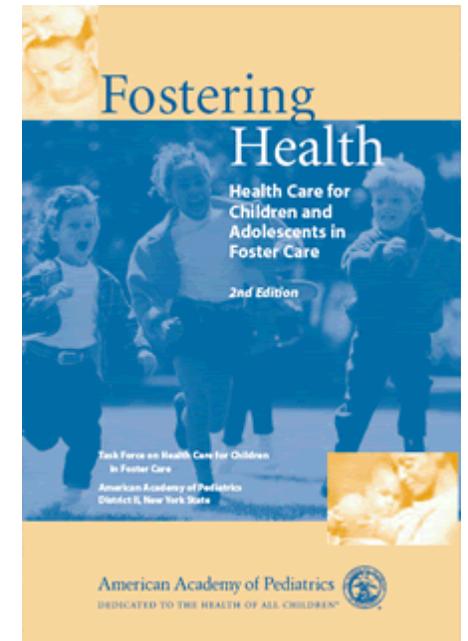
- Test driven by false history
- Family health history remains unknown
- Social workers had no access to protected health information

Arnold

- Test driven by actual family health history
- Sparse health records have emerged regarding birth mother
- Disclosure of health information dependent on legal matters

AAP Guidelines for Children in Foster Care

- Health information gathering at initial screening/ongoing data gathering
- Comprehensive assessment/follow up
- Periodic preventive health care
- Other encounters unique to foster care
- Care coordination in a medical home
- Health education for caregivers
- Medical consents for children in foster care
- Ongoing networking with child welfare agencies



Developmental and Mental Health Implications

- Safe Surrender infants should have their development tracked closely, particularly in the first years of their life
 - A comprehensive developmental evaluation at roughly a year old is warranted
- Mental health symptoms should be monitored closely as well, particularly as children transition to elementary school, and as they enter their teenage years
- There should be a coordination of care between Safe Surrender infants' medical care, mental health care, and developmental care, in order to address the interactions between medical issues, mental health, and development

Best Practices

- Medical
 - Meticulous recording of all birth information, previous histories
 - High index of suspicion for complex medical conditions
- Developmental
 - Regular monitoring by pediatricians, social workers, and infant specialists
 - Comprehensive evaluation at roughly a year old
- Mental health
 - Educate families about symptoms to monitor and critical transitions, including potential trauma exposure
 - Address issues related to adoption and Safe Surrender status
- Road map
 - Provide families with a thorough understanding of the legal process
 - Provide families with an expectation of how and when risk factors may emerge
 - Assist families in establishing relationships between medical, developmental, and mental health providers

The CHLA Safe Surrender Clinic

- Given their potentially complex and interrelated medical, developmental, and mental health needs, an interdisciplinary team with expertise in Safe Surrender infants is best equipped to meet their needs
- CHLA is uniquely positioned to provide this
 - Pediatric care of foster children
 - Early childhood mental health
 - Trauma psychologists with expertise in evaluating and treating foster youth
- Utilize CHLA's expertise in treating Safe Surrender infants
 - Nearly all Safe Surrender babies are seen for MAT Assessments at CHLA and many go on to receive developmental evaluations and pediatric care



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The CHLA Safe Surrender Clinic: Treatment Model

- Medical evaluations by pediatricians with expertise in treating Safe Surrender infants
- In-house referrals to specialized medical clinics at CHLA, as needed
- Developmental evaluations of infants, babies, and toddlers
- In-house linkage to occupational therapy services and speech and language services
- Mental health evaluations by trauma psychologists and early childhood psychologists
- In-house referrals for ongoing specialized mental health care
- Medical-Legal partnership with the Alliance for Children's Rights
- Educational material for prospective parents, provided both in person and online
- Ongoing relationship with families to provide guidance, consultation, or treatment in the future

Future Directions

- Gather additional outcome data post adoption
 - Family experience and later child experience
 - Case studies
- Comparisons of process and outcome data for Safe Surrender infants and other infants (non-safe surrender) adopted through DCFS.
- Implications of all results for best practices for providers and policy makers.
 - Integrated medical and mental health care
- Policy recommendations for improving practice
 - Child protective services (i.e. ensuring close developmental and mental health screening)
 - Legal system (i.e. allowing access to health care records prior to adoption)



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Questions?

- Thanks for your time and interest!