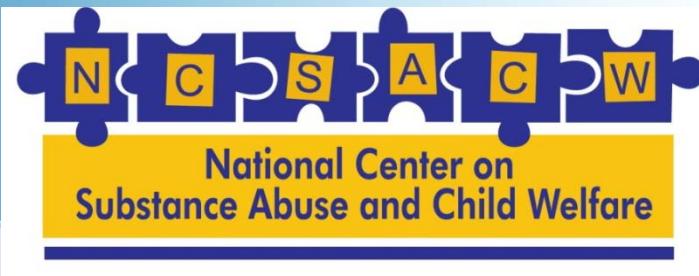


Responding to Prenatal Exposure: The Potential for Policy and Practice Changes

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September 9, 2009





A Program of the

**Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment**

and the

**Administration on Children, Youth and Families
Children's Bureau
Office on Child Abuse and Neglect**



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Administration for Children and Families
www.samhsa.gov**



An Overview of the Challenge

- **Of all children, 9% live with one or more parent who is dependent on alcohol or illegal drugs**
- **Of children entering the child welfare system, 40-80% are affected by their parents' or caretakers' substance abuse**
- **Prenatal screening studies document 15-20% of newborns prenatally exposed to alcohol, tobacco, or illegal drugs**





What Do the Numbers Mean?

- Colorado Births: 70,805 preliminary 2007 data
- National alcohol use rate applied to Colorado = 8,213 births exposed; CO PRAMS data (last 3 months only) 11.4% = 8,072 Prenatally Exposed (PNE) births
- National Tobacco use rate applied to Colorado= 12,037 births exposed; CO PRAMS data (last 3 months only) 10.8% = 7,647 PNE births
- National illicit drug use rate applied to Colorado = 2,761 births
- Assuming overlap, total exposure is in the range of 15,000 to 20,000 SENs

That means there are 90-120,000 preschool children who were prenatally exposed and an overlapping 100,000 0-18 year olds living in a family where one or more parents is alcoholic or dependent upon an illegal drug.



Legal drugs affect far more children

- PRAMS Colorado data says 2007 rate of alcohol use in LAST 3 months of pregnancy was 11.4% (= 8,072 newborns)
- PRAMS Colorado data says 2007 rate of tobacco use in last three months was 10.8% (= 7,647 newborns)
- National estimates of illicit drug use 2.3 % last trimester (= 2,761 newborns)





Where do these children go?

- **They are the children who arrive at kindergarten unready for school**
- **They are in special education caseloads**
- **They are disproportionately in foster care**
- **They are in juvenile justice caseloads**
- **They are in residential treatment programs**





No One Agency: a Classic Services Integration Issue

The issue of prenatal exposure does not “belong to” any one agency, because it demands

- **comprehensive services**
- provided along a **continuum of prevention, intervention and treatment**
- at different **developmental stages** in the life of the child and family

No single agency can deliver all of these; an interagency, integrated services effort is critical



How “Ripe” is the Issue in 2009?

VERY RIPE, because of

- New federal attention to home visiting models for high-risk births and expanded Early Head Start funding
- States assurances of CAPTA compliance
- The state will be preparing its Performance Improvement Plan in response to the Child and Family Services Review
- Perinatal treatment programs have accomplished a great deal—for a small portion of the problem
- SEN project (C-SIMI) funded from U.S. Children’s Bureau



How are we doing at identifying substance-exposed infants?

Most are not identified
and...





Most go home...

**75-90% of substance-exposed infants
are undetected and go home.**

Why?

- **Many hospitals don't test or don't systematically refer to CPS**
- **State law may not require report or referral**
- **Tests only detect very recent use**

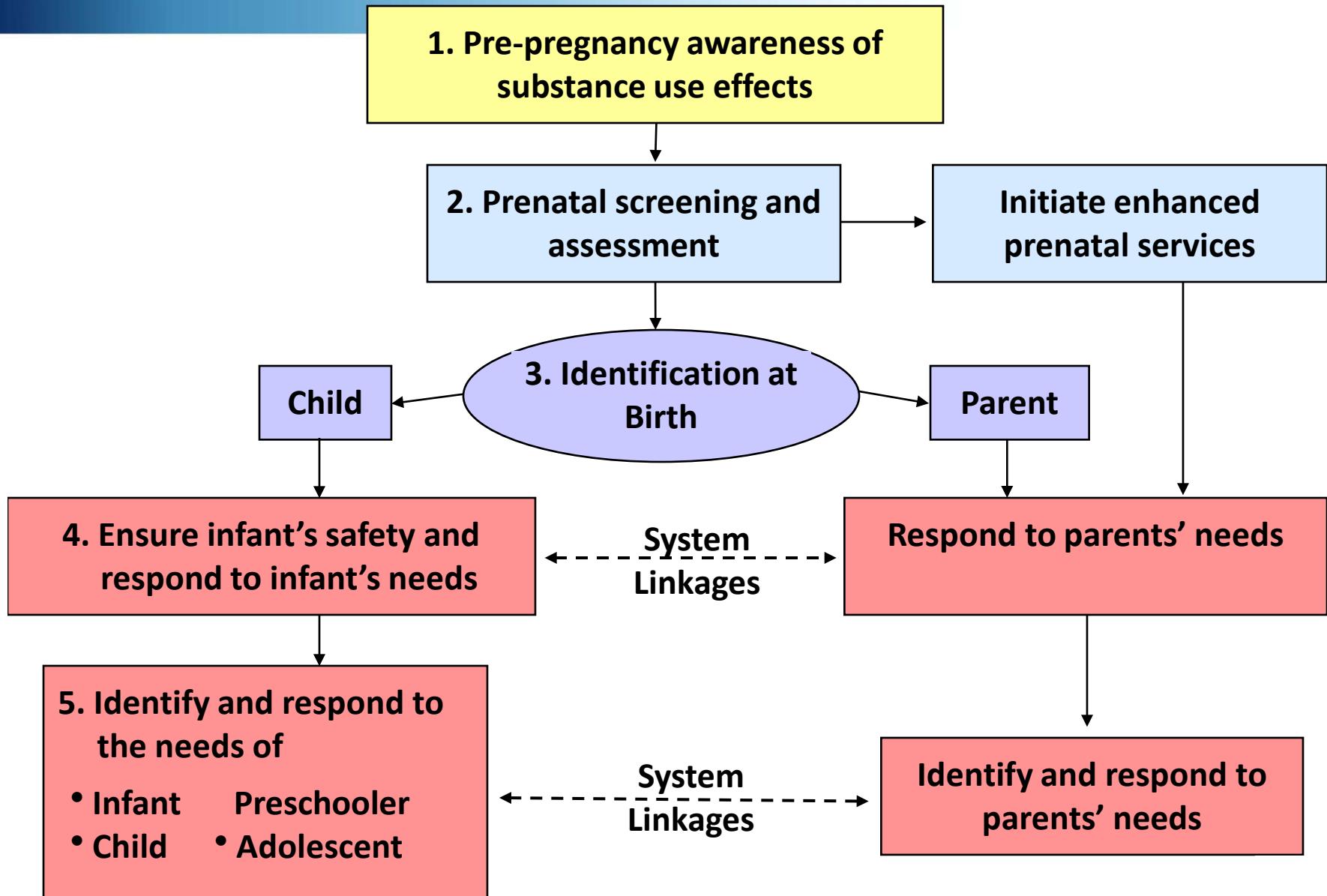


The Framework: Five Points of Intervention

- Pre-pregnancy and public awareness
- Prenatal screening and support
- Screening at birth
- Services to infants
- Services to parents

So—the birth event is one of *several* opportunities to make a difference, not the only one

Policy and Practice Framework: Five Points of Intervention





States have implemented several pieces of the puzzle:

- Pre-pregnancy: Ad campaigns
- Prenatal screening : 4PsPlus screening, other tools (WA)
- At birth: Model prevalence studies*
- Infants 0-2: Early screening projects combining Medicaid with mental health and developmental disabilities funding; CAPTA assessments (MA)
- Preschool 3-5: Head Start models, family treatment models

*Available at <http://ochealthinfo.com/seb/index.htm>





An Ethical Perspective on SENs

- Weighing the value of reducing lifetime risks to an innocent child through intervention vs. a woman's right to privacy
- The likelihood of inadequate prenatal care if screening is a deterrent to seeking care
- The possibility of a punitive rather than comprehensive response reducing treatment options
- The long-term costs to taxpayers of SEN consequences





An example of the ethical tradeoffs:

- **61% of physicians fear that criminal charges would be a barrier to women receiving prenatal care, but**
- **More than half support legislation allowing removal of children from any woman who abused alcohol or drugs.**



What Would a Statewide Interagency Response Look Like?

- It would be coordinated from the Governor's Office or an overhead agency
- It would include at least the state agencies with these functions:
 - Drug and alcohol treatment
 - Child welfare
 - Maternal and child health
 - Medicaid
 - Mental health
 - Education and special education
 - Developmental disabilities
 - Early childhood care and education





What Would a Statewide Interagency Response Look Like?

- It would compile baseline measures of the current problem across key agencies—for the first time—including CAPTA reports
- It would set targets and monitor them in an annual report card format—for the first time
- It would inventory current efforts and spending across agencies (as Oregon has)—for the first time
- It would spotlight and disseminate information on model programs at the local level
- It would work at all five levels of intervention





Opportunities for Advancing Policy

- **CFSR review II—spotlight on the child welfare system's SEI reunification outcomes**
- **Federal treatment information system changes**
- **Monitoring of child and family service state plans**
- **IDEA referrals under CAPTA**
- **Using Medicaid funding of births to leverage screening efforts**





The WADI and WATI Syndromes

- **WADI:** “We’re already doing it”
- **WATI:** “We already tried it”

Responses:

WADI: Great!—what % of the problem are you addressing; how are you measuring whether things are getting better?

WATI: Great!—you can build on that experience—why didn’t it work? How could that barrier be lowered?

