Substance-Exposed Infants: Policy and Practice

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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
Mission

To improve outcomes for families by promoting effective practice, and organizational and system changes at the local, state, and national levels

- Developing and implementing a comprehensive program of information gathering and dissemination
- Providing technical assistance
Overview

- The practice issues
- Policy context
- Some numbers
- A policy and practice framework
- The 10-State study
- State policy and practice: Findings, models and implementation
- Opportunities for advancing policy
Substance-Exposed Infants

The Practice Context
Substance-Exposed Infants and Fetal Alcohol Spectrum Disorder

“Of all the substances of abuse (including cocaine, heroin, and marijuana), alcohol produces by far the most serious neurobehavorial effects in the fetus.”

—IOM Report to Congress, 1996
“Fetal alcohol spectrum disorders” (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy.

Effects may include lifelong implications

- Physical
- Mental
- Behavioral, and/or
- Learning disabilities
FASD

- Not a diagnostic term used by clinicians. It refers to conditions such as:
  - Fetal alcohol syndrome, including partial FAS
  - Fetal alcohol effects (FAE)
  - Alcohol-related neurodevelopmental disorder
  - Alcohol-related birth defects
Terminology

- There is no consensus on the terms for the diagnostic descriptions of the effects of prenatal alcohol exposure other than FAS.
  - CDC has convened a working group of experts in the field to work toward agreed-on terminology.

- **Fetal alcohol effects (FAE):** Drs. Smith and Jones coined this term to describe a small group of children who had similar patterns of cognitive difficulties, growth deficiencies, and mothers who drank heavily during pregnancy but did not have the distinctive facial features seen in FAS.

- **Alcohol-related birth defects (ARBD):** The Institute of Medicine created this term in its 1996 volume on FAS to describe physical anomalies only.
**Terminology**

- **Alcohol-related neurodevelopmental disorder (ARND):** The Institute of Medicine created this term to refer to neurodevelopmental abnormalities or a complex pattern of behavior or cognitive abnormalities inconsistent with developmental level that cannot be explained by family background or environment alone.

- **Partial FAS (pFAS):** The Institute of Medicine also coined this term in its 1996 report on FAS. The term refers to children who have some of the facial features of FAS, along with evidence of growth retardation, neurodevelopmental abnormalities, or a complex pattern of behavior or cognitive abnormalities inconsistent with developmental level that cannot be explained by family background or environment alone.
Fetal Alcohol Syndrome

- Binge drinking may be more harmful to the fetus than ongoing drinking of a lower quantity (Maier & West, 2001; Streissguth, et al., 1990).
  - When the mother consumes alcohol, the baby’s blood alcohol level reaches levels as high or higher than the mother’s. Thus, consuming large amounts of alcohol in a short period could be particularly damaging to the developing fetus.

- Alcohol affects multiple systems and especially targets the brain, which develops throughout pregnancy.

- Alcohol can cause damage to the developing brain in a multiple ways, including early cell death and faulty migration of cells within the brain.
Fetal Alcohol Syndrome

- In July 2004, CDC published *Fetal Alcohol Syndrome: Guidelines for Referral and Diagnosis*
- Scientific working group from across the United States
- Four areas identified in the guidelines as necessary for a diagnosis of FAS have been used for a number of years.

1. **Prenatal maternal alcohol use:** The guidelines call for either confirmed or unknown prenatal alcohol exposure.
2. **Growth deficiency:** “Confirmed prenatal or postnatal height or weight, or both, at or below the 10th percentile, documented at any one point in time (adjusted for age, sex, gestational age, and race or ethnicity).”

http://www.cdc.gov/ncbddd/fas/default.htm
3. **Central nervous system (CNS) abnormalities:** The guidelines identify three components of CNS abnormalities: structural, neurologic, and functional deficits.

- **Structural deficits** are identified as head circumference at or below the 10th percentile adjusted for age and sex or clinically significant brain abnormalities observable through imaging.

- **Neurologic deficits** are identified as neurologic problems not due to postnatal insult or fever, or other soft neurologic signs outside normal limits.

- **Functional deficits** include “global cognitive or intellectual deficits (e.g., decreased IQ) representing multiple domains of deficit (or significant developmental delay in younger children) with performance below the 3rd percentile (2 standard deviations below the mean for standardized testing) or functional deficits below the 16th percentile (1 standard deviation below the mean for standardized testing) in at least three of the following domains: cognitive or developmental deficits or discrepancies; executive functioning deficits; motor functioning delays; problems with attention or hyperactivity; social skills; other, such as sensory problems, pragmatic language problems, memory deficits, etc.”
Fetal Alcohol Syndrome

4. **Dysmorphic features:** The diagnostic guide states that all three features must be present.
   - A number of other syndromes have some of these features, but very few have all three.
   - The scientific working group adopted the three features identified in the University of Washington’s original diagnostic guide written by Sterling Clarren and Susan Astley in 1997.
   - They developed a lip-philtrum guide that the scientific working group adopted.
   - Individuals with FAS score 4 or 5 on the lip-philtrum guide

Available from the University of Washington FAS Diagnostic and Prevention Network, http://depts.washington.edu/fasdppn/
Diagnosing Fetal Alcohol Syndrome

- Prenatal maternal alcohol use
- Growth deficiency
- Central nervous system abnormalities
- Dysmorphic features
  - Short palpebral fissures
  - Indistinct philtrum
  - Thin upper lip

Differential Diagnosis of Features of FAS

Differential diagnosis is very important because:

- Many syndromes can cause features that look like FAS.
- Facial features alone cannot be used to diagnose FAS.
Children with ARND have central nervous system deficits but not all the physical features of FAS

- Refers to various neurologic abnormalities, such as:
  - Problems with communication skills
  - Memory
  - Learning ability
  - Visual and spatial skills
  - Intelligence
  - Motor skills

- Problems may include:
  - Sleep disturbances
  - Attention deficits
  - Poor visual focus
  - Increased activity
  - Delayed speech
  - Learning disabilities
ALCOHOL-RELATED BIRTH DEFECTS

- Alcohol-related birth defects (ARBD) describe defects in the skeletal and major organ systems.
- Virtually every defect has been described in some patient with FAS.
- They may include abnormalities of the heart, eyes, ears, kidneys, and skeleton, such as holes in the heart, underdeveloped kidneys, and fused bones.
Strengths of Persons With an FASD

- Friendly
- Likable
- Desire to be liked
- Helpful
- Determined
- Have points of insight
- Not malicious

Dubovsky, Drexel University College of Medicine (1999)
Strengths of Persons With an FASD

- Cuddly and cheerful
- Happy in an accepting and supportive environment
- Loving, caring, kind, sensitive, loyal, and compassionate
- Energetic and hard working
- Fair and cooperative
- Spontaneous, curious, and involved
Strengths of Persons With an FASD

- Highly verbal
- Kind with younger children and animals
- Highly moral—deep sense of fairness
- Able to participate in problem solving with appropriate support

Photo courtesy of Microsoft.

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Center on Excellence on Fetal Alcohol Spectrum Disorder
samhsa.hhs.gov
Strengths of Persons With an FASD

- Build on strengths of persons with an FASD, such as giving them opportunities to help in the classroom.

- Use teaching strategies that focus on strengths.

- Find jobs that use the person’s strengths.

Photo courtesy of Microsoft
Overall Difficulties for Persons With an FASD

- Taking in information
- Storing information
- Recalling information when necessary
- Using information appropriately in a specific situation
Primary Disabilities of Persons With an FASD

- Lower IQ
- Impaired ability in reading, spelling, and arithmetic
- Lower level of adaptive functioning; more significantly impaired than IQ

Streissguth, et al. (1996)
Typical Difficulties for Persons With an FASD

Sensory Integration Issues

- Are overly sensitive to sensory input
  - Upset by bright lights or loud noises
  - Annoyed by tags in shirts or seams in socks
  - Bothered by certain textures of food

- Have problems sensing where their body is in space (i.e., clumsy)
Typical Difficulties for Persons With an FASD

Memory Problems

- Multiplication
- Time sequencing
Typical Difficulties for Persons With an FASD

Information Processing Problems

- Do not complete tasks or chores and may appear to be oppositional
- Have trouble determining what to do in a given situation
- Do not ask questions because they want to fit in
Typical Difficulties for Persons With an FASD

Information Processing Problems

- Say they understand when they do not
- Have verbal expressive skills that often exceed their level of understanding
- Misinterpret others’ words, actions, or body movements
- Have trouble following multiple directions

Straighten up your room and put your toys away. *Do you understand?*

YES! (How do you straighten up? Make sure the bed/chair is straight?)
Typical Difficulties for Persons With an FASD

Executive Function Deficits

- Go with strangers
- Repeatedly break the rules
- Do not learn from mistakes or natural consequences
- Frequently do not respond to point, level, or sticker systems
- Have trouble with time and money
- Give in to peer pressure

I'm late! I'm late!
Typical Difficulties for Persons With an FASD

Self-Esteem and Personal Issues

- Function unevenly in school, work, and development
- Experience multiple losses
- Are seen as lazy, uncooperative, and unmotivated
- Have hygiene problems
Typical Difficulties for Persons With an FASD

Multiple Issues

- Cannot entertain themselves
- Have trouble changing tasks
- Do not accurately pick up cues
Secondary Disabilities of Persons With an FASD

- Mental health issues
- Disrupted school experience
- Trouble with the law
- Inappropriate sexual behavior
- Confinement in jail or treatment facilities
- Alcohol and drug problems
- Dependent living
- Employment problems

Streissguth, et al. (1996)
Secondary Disabilities of Persons With an FASD

Percent of Persons With FAS or FAE Who Had Secondary Disabilities

= Age 6+  
= Age 12+  
= Age 21+

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Factors Associated With Reduced Secondary Disabilities

- Stable home
- Early diagnosis
- No violence against oneself
- More than 2.8 years in each living situation
- Recognized disabilities
- Diagnosis of FAS
- Good quality home from ages 8 to 12
- Basic needs met for at least 13 percent of life

Streissguth, et al. (1996)
Substance-Exposed Infants

The Policy Context
The Policy Context

- Child Abuse Prevention and Treatment Act (CAPTA) amendments of 2003
  - Referrals of newborns identified as exposed illicit substances
    - Does not specifically include alcohol exposure although does not preclude States from State-specific policy
  - Referrals of children birth to age 3 to Early Intervention Services

- Increasing number of pregnant women and children affected by maternal use of methamphetamines

- Research on fetal alcohol spectrum disorders and alcohol-related neurodevelopmental disorders

- Renewed proposals of State legislation aimed at both fetal alcohol exposure and maternal abuse of illegal drugs
No One Agency

The SEI issue 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
The Needed Partners

- Collaboration on SEI issues requires roles for:
  - Hospitals
  - Private physicians
  - Health care management plans
  - Maternal and child health
  - Children’s and adult mental health
  - Domestic violence agencies
  - Child welfare
  - Drug and alcohol prevention, treatment and aftercare
  - Developmental disabilities agencies
  - Schools and special education
  - Family/dependency courts
  - Child care and development
  - Employment and family support agencies
  - And more…
Many Doors, No Master Key: Resources Needed for Brandan, Age 1-2 Years

**Health**
- Pediatrician
- Neurologists (2)
- Pediatric Ophthalmologist
- Audiologist
- Otolaryngologist
- Pharmacy
- Medical Supply Providers
- Gastroenterologist
- Feeding Specialist
- Nutritionist
- High-Risk Infant Clinic
- FAS Diagnostic Clinic
- Lab and X-Ray Services
- Surgeons
- Pulmonologist
- Respiratory Therapist

**Education**
- Physical Therapist
- Speech/Language Pathologist
- Infant Educator
- Cultural Recreational Therapy (e.g., drumming)
- Birth-3 Program: Occupational Therapist, Speech/Language Pathologist, Teacher, Aide, Play Therapist

**Social and Community Services**
- Local Indian Child Welfare Advisory Committee
- Tribal Social Worker
- Child Welfare/Case Worker
- Tribal Council
- Respite Providers
- Foster Care System

**Legal and Financial Services**
- Daycare
- Div. of Dev. Disabilities/Case Worker and Family Resource Coordinator
- Substance Abuse Treatment (birth mother)
- Mental Health Counseling (birth mother)
- Parenting Education (birth mother)
- SSI
- Medicaid
- Guardian Ad Litem
- Judge-Foster Care Issues
- Attorneys for Birth Parents

~ About 40 service providers
## Many Doors, No Master Key: Resources Needed for Brandan, Elementary School Years

### Health
- Pediatricians (2)
- Neurologist
- Pediatric Ophthalmologist
- Audiologist
- Otolaryngologist
- Pharmacy
- Psychiatrist
- Allergist
- Nutritionist

### Education
- High-Risk Infant Followup Clinic
- FAS Clinic
- Lab and X-Ray Services
- Surveys
- Occupational Therapist
- Speech/Language Pathologist
- Counselor

### Social and Community Services
- Local Indian Child Welfare Advisory Committee
- Tribal Social Worker
- Child Welfare/Case Worker
- Tribal Involvement
- Special Education Bus
- Guitar Lessons
- Respite Providers
- Daycare
- Div. of Dev. Disabilities Case Manager
- Special Olympics
- FASD Family and Community Support Group
- Swimming Lessons
- Medicaid Personal Care Provider

### Legal and Financial Services
- SSI
- Medicaid
- Adoption Support

~ About 50 service providers
Substance-Exposed Infants

The Numbers
The Numbers

- Use during pregnancy
- Women and pregnant women needing and receiving treatment
- Substance-exposed infants
## Use During Pregnancy

SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003

<table>
<thead>
<tr>
<th>Substance Used (Past Month)</th>
<th>1st Trimester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Illicit Drug</td>
<td>7.7% women</td>
</tr>
<tr>
<td></td>
<td>315,161 infants</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>19.6% women</td>
</tr>
<tr>
<td></td>
<td>802,228 infants</td>
</tr>
<tr>
<td>Binge Alcohol Use</td>
<td>10.9% women</td>
</tr>
<tr>
<td></td>
<td>446,137 infants</td>
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Use During Pregnancy

SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003

<table>
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<tr>
<th>Substance Used (Past Month)</th>
<th>1st Trimester</th>
<th>2nd Trimester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Illicit Drug</td>
<td>7.7% women 315,161 infants</td>
<td>3.2% women 130,976 infants</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>19.6% women 802,228 infants</td>
<td>6.1% women 249,673 infants</td>
</tr>
<tr>
<td>Binge Alcohol Use</td>
<td>10.9% women 446,137 infants</td>
<td>1.4% women 57,302 infants</td>
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# Use During Pregnancy

SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003

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<th>2nd Trimester</th>
<th>3rd Trimester</th>
</tr>
</thead>
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<tr>
<td>Any Illicit Drug</td>
<td>7.7% women 315,161 infants</td>
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<td>2.3% women 94,139 infants</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>19.6% women 802,228 infants</td>
<td>6.1% women 249,673 infants</td>
<td>4.7% women 192,371 infants</td>
</tr>
<tr>
<td>Binge Alcohol Use</td>
<td>10.9% women 446,137 infants</td>
<td>1.4% women 57,302 infants</td>
<td>0.7% women 28,651 infants</td>
</tr>
</tbody>
</table>
How are we doing at identifying and providing services to pregnant and parenting women who need treatment?
Women and Pregnant Women in Treatment

- There are four million births annually, and six and a half million women of child-bearing age who need treatment.

6.55 million women of child-bearing age who need treatment for alcohol or illicit drug use

565,400 women admitted to a public treatment program

15,277 pregnant women in publicly funded treatment

- Of those who need treatment...
  9.7% of men
  7.4% of women

...receive treatment
Number of Substance-Exposed Infants

Estimates are that 10-11% of all newborns are prenatally exposed to alcohol or illicit drugs; this translates to:

- An estimated 400,000-480,000 substance exposed births nationwide last year
- A cumulative 7.3 million of the 73 million children ages 0 to 17 years old
A Graphic View

82.7 million children and youth age 0 to 17 years

8.3 million children age 0 to 17 years born substance-exposed

4.09 million births annually

409,000 estimated substance-exposed births annually

984,000 child victims of abuse or neglect (all ages)

102,500 child victims under age 1 year 25%
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
A Policy and Practice Framework

Five Points of Intervention
The 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

1. Pre-pregnancy awareness of substance use effects

2. Prenatal screening and assessment

3. Identification at Birth

4. Ensure infant’s safety and respond to infant’s needs

5. Identify and respond to the needs of
   - Infant
   - Preschooler
   - Child
   - Adolescent

Initiate enhanced prenatal services

Respond to parents’ needs

Identify and respond to parents’ needs
The 10-State Study

Methods and Design
The 10-State Descriptive Study

- Purpose was to better understand and describe States’ policy regarding substance exposed infants
- Coordinated with AIA study
- Reviewed Federal and State legislation
- Reviewed State publications
- Reviewed other national assessments of substance exposed infant and family issues
The 10-State Study

- Selected 10 States for in-depth interviews based on efforts in one or more of the first points of intervention
  - California, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Rhode Island, South Carolina, Virginia, and Washington

- Developed interview guide based on the policy and practice framework five points of intervention
What Kinds of Policy

- Federal laws
- State legislation
- State regulations and guidelines
- State budget allocations
- State interagency bodies with policy responsibilities
- The implementation of policy
  - Respondents’ view of what happens in the field
  - Reviewed State and national data that may indicate how policy had been implemented
The 10-State Study

- Conducted 1- to 2-hour interviews as an open-ended guided discussion
  - Contacted the Women’s Treatment Coordinator in each State
  - Identified officials from several departments across agencies
    - 3 to 4 respondents in each State
The 10-State Study

Findings, Models and Implementation
State Policy, Practice and Models

- 10-State Study
  - Findings
  - Models
  - Implementation

- Within the Five Points of Intervention
  1. Pre-pregnancy and public awareness
  2. Prenatal screening and support
  3. Screening at birth
  4. Post-natal services to infants
  5. Post-natal services to parents
1. Pre-Pregnancy

**Findings**

- States have developed public education campaigns
  - Warning signs at point of sale
    - 3 out of 10 study States
    - 37% of all States
  - Warning signs at other venues
    - 3 out of 10 study States
    - 24% of all States
1. Pre-Pregnancy

Findings

- States have worked with institutions of higher education in disseminating this message
- Federal "Drug Free Schools and Communities Act Amendments of 1989"
  - Universities and educational institutions that accept federal funding must notify their employees and students that use of alcohol during pregnancy may have detrimental effects on their children
  - Model: University of Massachusetts
1. Pre-Pregnancy

Implementation

- Rates of first trimester use suggest that the message is not getting through to a critical group of pregnant women

- Use during 1st Trimester
  - 7.7% women used any illicit drug (315,161 infants)
  - 19.6% women used alcohol (802,228 infants)
  - 10.9% women engaged in binge alcohol use (446,137 infants)

SAMHSA, OAS, National Survey on Drug Use and Health, 2002 and 2003
2. Prenatal Screening and Services

Findings

- All States had some prevention efforts and some form of prenatal screening efforts
  - Model: Washington State has developed detailed guidelines for prenatal screening, and a quality improvement effort that seeks “universal screening” for substance use
  - Some jurisdictions within States had screening policies
- All States gave pregnant women priority status in entering treatment, in accord with federal requirements
2. Prenatal Screening and Services

Implementation

- No States *require* prenatal screening for substance abuse
- Medicaid funds 37% of births, but it is typically not used for encouraging nor requiring screening programs
2. Prenatal Screening and Services

Implementation

- Referrals of pregnant women to treatment and progress in treatment are not monitored on a Statewide basis
- Wait lists persist in some States—particularly for residential care
- Admissions of pregnant women are a very small percentage of total admissions
3. Screening and Testing at Birth

Findings

- Policies on screening at birth are generally not at the State level
  - Local hospital policy dictates screening practices such as who is screened

- Reporting requirements
  - 5 of 10 study States require reporting to CPS at birth
    - 2 study States require as mandated reporters
  - 37% of all States
  - Recent legislation proposed or enacted in some States has expanded requirements for referrals when drug exposure is detected -- AR, CO, LA, NV, WA
3. Screening and Testing at Birth

Findings

- Defining substance exposure as evidence of child abuse or neglect
  - 7 out of 10 study States
  - 40% of all States
  - Policies vary for different substances
    - “controlled substance,” “addictive drug,” “non-prescription, controlled substance or signs of fetal alcohol syndrome,” “cocaine, heroin or a derivative thereof”

- FASD issues have received new attention in some States - HI, MD, MN, ME
3. Screening and Testing at Birth

**Implementation**

- Hospitals’ policies vary widely with few standardized protocols that are consistently implemented.

- States do not monitor screening and referrals.
  - Hospitals do not usually provide CPS agencies with totals of screenings at birth, results of tests, or number of referrals made to CPS.

- Detection of and response to FAS and FASD is inconsistent in policy and practice.
4. Post-Natal Services to Infants and Children

Findings

- Early intervention policies and process for referrals to IDEA are still emerging
  - Two out of 10 Study States (MA and RI) have strong links between IDEA referrals and SEIs in child protective service agencies
4. Post-Natal Services to Infants and Children

Implementation

- Too early for the 10 study States to have data on increased referrals due to CAPTA/IDEA changes.
- Child welfare developmental assessments are not consistently performed for SEIs or for older children of substance abusers who may be prenatally-exposed but entered child welfare at older ages.
4. Post-Natal Services to Parents

Findings

- Some States have supplemented federal funding set-asides for treatment for pregnant and parenting women
  - 5 of the 10 study States
  - 37% of all States
- Strong models of family-centered services have been developed
4. Post-Natal Services to Parents

Implementation

- Significant data gaps exist
  - TEDS requires “pregnant at admission” but not “parenting”

- Capacity of programs is not sufficient to serve all those in need of treatment for women and infants
States’ Coordination Efforts

Findings

- All study States have perinatal councils or other coordinating bodies that address SEI issues
  - IDEA interagency councils
  - Women’s treatment interagency councils
  - Early childhood coordinative councils
  - Interagency child welfare reform bodies
States’ Coordination Efforts

Implementation

None of the study States have an interagency process to monitor data, effectiveness or outcomes across agencies.
States’ Coordination Efforts

Implementation

- Information gaps make tracking progress difficult
  - Prevalence data gaps
  - SEI referral data gaps
  - Mothers treatment referral data gaps
  - Treatment outcomes data gaps

- Funding comprehensive services demands skillful efforts to access multiple funding sources; few States have current inventories of available funding
Summary

- These 10 States are responding to the SEI problem and the 2003 CAPTA changes with some strong programs.

- None of the study States have developed policy at each of the five points of intervention for mothers and infants.

- State policy implementation occurs across a diverse set of agencies requiring extensive coordination.
Substance-Exposed Infants: Policy and Practice

Opportunities for advancing policy
The barriers to collaboration on SEI issues

- Fear of flooding: “there are no treatment programs,” “we’ll get inappropriate referrals”
- Concern about punitive responses: if we report, removal of child will result
- Basic lack of information about other agencies’ services and policies
- Different missions: child safety, parents’ services needs, family stability
How could a state self-assess its current collaboration on SEI issues?

- Review the data—what do we know, where are the gaps, how can info systems be improved?
- Review all five levels of policy: inventory current resources in each of the five areas
- Review the results in each area—how do we measure progress or success?
- Review who is at the table and who is missing
- Review the options for a strategic plan across agencies with shared outcomes
An example: Self-assessing current prenatal services

- What are current practices of physicians in screening [are 4Ps Plus or other brief tools used?]
- How many Medicaid births [37% nationally] are screened?
- How many referrals are made to treatment from prenatal screening? What %?
- What estimates do we have for current prenatal exposure—how do numbers of referred women compare to the estimated need?
- What is the treatment gap and how does it compare to total of women entering treatment—is there an issue of priorities?
A second example: self-assessing screening at birth

- What are current hospital practices? How many screens, how many are positive, how many referrals?
- What happens after a CPS referral: A CPS report should *begin* the process of intervention
- What other services are available to parents? How many parents enroll? How many complete?
- What are the “handoffs” to family support, home visitation, CWS “front-end” voluntary services, CWS reunification?
- Who case manages these services?
The Message of the Missing Numbers

- Sherlock Holmes: the case of the dog that didn’t bark
- Sometimes it is what doesn’t happen that matters most—lacking the numbers to measure a problem may be the problem
- Caring enough to count is the heart of accountability
Why are substance-exposed births important?

- Though a small percentage of CWS cases, these children are disproportionately affected by many lifetime conditions.
- Prenatal exposure to alcohol is the leading cause of mental retardation.
- Special education classrooms contain a disproportionate number of children who were prenatally exposed to drugs.\(^3,4\)
- SEBs require a higher level of public spending than many other target groups.
An Ethical Perspective on SEBs

- 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
- The possibility of a punitive rather than comprehensive response
- The long-term costs to taxpayers of SEB consequences
Issues for State Consideration

Toxicology Screens

- Blood tests only identify patients with long-term use in whom secondary symptoms have occurred
- Timing – Urine toxicologies identify only recent use (within the past 24-72 hours)
- Urine tests are not reliable for alcohol
- Cost of toxicology screening
  - $8-$80 depending on type of test – blood vs. urine, extent of drug panel, sensitivity, cut-off level, etc.
Issues for State Consideration

Verbal Screening Tools

4 Ps

- Has either one of your Parents had a problem with drugs or alcohol?
- Does your Partner have a problem with drugs or alcohol?
- Have you had a problem with drugs or alcohol in the Past?
- Have you used any drugs and alcohol during this Pregnancy?

Studies have found that past alcohol and tobacco use are excellent predictive factors for substance use during pregnancy and suggest adding questions to the Four P’s screening tool specific to tobacco and alcohol use in the month prior to pregnancy.
Issues for State Consideration

**Testing/ Identification**

- Voluntary testing vs. universal testing vs. testing based on valid screening and assessment practice
- Given the current bias in testing, Universal testing is the only unbiased approach
  - raises issues of privacy and intrusiveness
  - must consider cost, false positives and confirmations of those tests
- “Upstream” prenatal screening is much preferable, and done correctly, is just as accurate or more so
Issues for State Consideration

The Role of Dependency/ Family Court

- A significant number of dependency petitions are filed in response to positive tox screens
  - Many states and localities lack data on removals based on SEB; the court can upgrade its information systems to require this data
- The court is a key collaborative partner—but it needs to be a true partner, aware of the roles of the other players and willing to monitor its own outcomes as part of an annual accountability review
The Policy Questions

- Can a pregnancy screening (like 4Ps) be the trigger for “upstream” services and referral to treatment?

- Can a mandated SEB report to CPS be the trigger for “downstream” follow-up services to child and parent(s)?
  - Home visiting, family support, parenting skills, child development and developmental screening

- Is our interagency collaboration strong enough to guarantee that these results will happen and be monitored over time?
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
Opportunities for Advancing Policy

- IDEA referrals under CAPTA
- Renewed focus on school readiness issues
- Using Medicaid funding of births to leverage screening efforts
Conclusions

Four key policy challenges:

- There are many opportunities *before and after the birth event* to intervene—a balanced policy would address all five stages of the SEI problem.
- To address all five stages, States need much stronger coordination that monitors progress across multiple agencies.
Conclusions

Four key policy challenges:

- States don’t track SEIs and treatment for mothers well enough to measure whether they are making progress on the problem or to justify additional resources.

- Treatment programs do not admit enough pregnant and parenting women in comparison to those who need treatment services.
Recent Products

  (A short monograph for front-line workers)

- On-Line Training – Now Available
  - Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals
  - Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals

Visit [www.ncsacw.samhsa.gov](http://www.ncsacw.samhsa.gov)
ANNOUNCING

Putting the Pieces Together for Children and Families
The National Conference on Substance Abuse, Child Welfare and the Courts

- January 30, 2007
  - Pre-conference symposium on substance-exposed infants with Dr. Ira Chasnoff

- January 31 to February 2, 2007
  - National Conference

- Disneyland Hotel, Anaheim California
  - Sign up for information at conference@cffutures.org
Sources


