

Focus Groups on Substance Exposed Newborns

SUMMARY REPORT

FEBRUARY 2009



A Service of the Children's Bureau

About the National Abandoned Infants Assistance Resource Center

Funded by the Children's Bureau, Administration for Children, Youth and Families, U.S. Department of Health and Human Services, the National Abandoned Infants Assistance Resource Center (NAIARC) was established in 1991 at the University of California at Berkeley. The Center's mission is to enhance the quality of social and health services delivered to infants and young children affected by drugs or HIV, and their parents or caregivers, by providing training, technical assistance, research, resources, and information to professionals who serve these families.

Publication of this report was made possible by grant #90-CB-0126 from the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The contents are solely the responsibility of the authors and do not represent the official views or policies of the funding agency. Publication does not in any way constitute an endorsement by the Department of Health and Human Services. Readers are encouraged to copy and share this material, but please credit the National AIA Resource Center.

Introduction

During the summer and fall of 2008, The National Abandoned Infants Assistance Resource Center (NAIARC) conducted a series of focus and discussion groups with three separate populations: child welfare administrators, pediatricians (PEDs), and obstetricians (OBs). This included a 90-minute in-person discussion group with 23 State Liaison Officers for Child Abuse and Neglect (SLOs)¹ representing 18 states and the District of Columbia; two 90-minute in-person focus groups with a total of 22 pediatricians from 18 states; and two 90-minute focus groups conducted via teleconference with a total of 13 obstetricians and one maternal and child health director from 13 states. For each session, the facilitator used a discussion guide with questions pertaining to the identification, referral, and treatment of pregnant substance users and their newborns. The discussion guides were based largely on findings from an earlier study conducted by the NAIARC in 2005 with funding from the Robert Wood Johnson Foundation². Feedback on the discussion guides also was provided by a small advisory group consisting of a pediatrician, child welfare administrator, obstetric nurse, substance abuse treatment director, professional focus group moderator, and researcher. This report includes a brief description of the focus group participants and a summary of the combined findings.

¹ SLOs are the designated staff person in each of the 50 states, the District of Columbia and the Commonwealths/Territories of Puerto Rico, Guam, American Samoa, the Northern Mariana Islands and the Virgin Islands with responsibilities for the Child Abuse Prevention and Treatment Act (CAPTA) grant and associated requirements.

² Drescher-Burke, K. & Price, A. (2005). *Identifying, Reporting and Responding to Substance Exposed Newborns: An Exploratory Study of Policies and Practices*. Berkeley, CA: National Abandoned Infants Assistance Resource Center

Participants

Participants in the two focus groups with pediatricians consisted of 22 physicians from the following cities: Las Vegas, NV; the Bronx, NY; various small cities in Northern NJ; PA (Philadelphia & Upland); Silver Spring, MD; Madison, WI; Keene, NH; MI (Detroit & Cheboygan); Miami, FL; Wilmington, DE; Richmond, VA; Hartford, CT; MA (Boston & New Bedford); Savannah, GA; Shreveport, LA; Phoenix, AZ; Oklahoma, OK; CA (Monterey and Los Angeles). This includes small, medium, and large cities; a couple of suburban communities; and one rural area. Participants included neonatologists, hospital-based pediatricians, general pediatricians in private practice, and one emergency pediatrician. Several were university professors, and a few were heads of hospital departments (e.g., nursery, pediatrics). The years that they have been practicing ranged from 1.5 years to 34 years. They were evenly split between male and female, and were racially diverse (e.g., Asian, Caucasian, African American, Latino).

A total of 12 physicians participated in the OB focus groups. All participants were obstetricians except for one who was a county maternal and child health director. They represent the following urban, suburban, and rural localities: Anchorage, AK; Ventura and Oxnard, CA; Honolulu, HI; Kansas City, KS; Lansing, MI; St. Paul, MN; St. Louis, MO; Littleton, NH; Long Island, NY; Tullahoma, TN; and South Hill, VA. Like the PEDs, the OB participants were evenly split among men and women, and varied in their years of practice from a third year resident to 40 years in practice.

The SLOs represented child welfare agencies in the following states: Alabama, Arizona, California, Delaware, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Missouri, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Virginia, and Washington, DC.

What is a physician's role in serving pregnant substance users and their newborns?

OBs identified four distinct components to their role, which varied depending on their type of practice: education, screening, referral, and support.

- **Education:** Educate patients about the acute effects of substance abuse, the potential harm to the fetal-maternal unit during pregnancy, and the long-term damage to the family.
- **Screening:** All participants who see patients prenatally indicated that their role involves screening. Some screen all patients using the ACOG standard form or another tool (e.g., 4 Ps Plus in Ventura County); whereas others screen based upon history or risk factors.
- **Referral:** Most participants refer to hospital social services (most typically) and/or directly to Child Protective Services (CPS) for further assessment and/or services. They see themselves as conduits to available preventative services during pregnancy. Some also arrange home health nurses for follow-up after delivery. An OB from NY mentioned the Prenatal Care Assistance Programs (PCAP) for Medicaid eligible clients. This includes routine pregnancy medical check-ups, information about labor and delivery, HIV counseling and testing, help in applying for entitlements, health care for at least two months after delivery for the mom and one year after birth for the baby, and family planning services.
- **Support:** One participant noted the importance of praising patients who move in a positive direction (e.g., reduce use, quit smoking, follow through with pre-natal care). Another noted the need for OBs to provide a place for pregnant women to go where they feel safe to admit their use without fear of CPS or doctors who judge, which ultimately prevents them from obtaining prenatal care. They also empower patients to work with CPS so they can retain custody of their children by participating in treatment. One participant tells patients that if they consistently test positive, the baby will be tested at birth, and CPS will be notified in order to obtain support services for mom.

PEDs' perceptions of their roles seem to be influenced by their positions. For instance, those who work solely in an outpatient setting generally identified their role as follow-up; whereas those who work in newborn nurseries saw their role as identification (of drug exposed newborns or, more specifically, children at risk for withdrawal), initial health management after diagnosis, and, in some cases, working with the neonatologist, hospital social worker, discharge planning nurse, CPS and/or another hospital for ongoing treatment. A few physicians saw their role as bifurcated or encompassing all of this. One stated that her role is "to make sure I'm not missing new drugs, be supportive

of the infants, and help to get the mom into treatment.” Another general pediatrician also mentioned his role in addressing feeding and irritability issues, and providing ongoing surveillance. A pediatrician who works in emergency medicine noted that she doesn’t generally see newborns in their first few weeks of life, but she sees the “fall out” when foster parents or biological parents don’t know how to care for their infants. In the case of foster parents, this typically is because they are not told that the baby was drug exposed let alone the drugs to which they were exposed. Finally, one pediatrician noted that her role depends on the substance: if a newborn is exposed to illicit drugs, her role is to identify and refer to CPS; whereas, if only alcohol or tobacco is involved, her role is to educate.

What guides decisions regarding the identification of pregnant women and newborns?

Several SLOs expressed concern about the lack of consistent standards for the identification of SEN. This concern was validated by the varied responses from physicians.

For the most part, OBs in private practice stated that they do not routinely order toxicology tests in the office, but rely on verbal screening and medical history (see discussion below). A couple of private OBs noted that they test if there is concern or certain conditions present (e.g., track marks or unusual behavior). These doctors use an opt-out policy similar to HIV screening; if the patient opts out of the test or refuses to sign the consent, it is noted in the chart.

Although testing of women in the hospital seems to be much more common, there is great variability among hospital policies and their implementation. Both OBs and PEDs referred to a mix of hospital policies, department guidelines, general practice, one’s own beliefs and experiences, and, as one physician put it, “the general gestalt” to guide their decisions about if and when to test a pregnant woman or newborn. With a few exceptions of hospitals that practice universal testing or random testing of all women at least once during pregnancy, most OBs identified some combination of the following conditions that automatically trigger a toxicology test at the time of delivery: no or limited prenatal care, preterm labor, preeclampsia, placental abruption, vaginal bleeding, or a known history of substance abuse. Additional circumstances that PEDs noted for warranting a test on a baby include family background, previous SEN, teen mothers, low socioeconomic status, prematurity, small for gestational age, and “irritability.” Only one pediatrician stated that, with a few exceptions, a toxicology test is routinely performed on all newborns in the nursery.

One pediatrician noted that these criteria alone are not cause for a test to be ordered without supporting clinical evidence, which is largely determined by the OB. Only one participant indicated that the state (MN) has a law mandating drug testing in labor and delivery if use is suspected. However, this OB noted that he does not test in his office, where the law does not apply. Yet another OB in private practice stated that it is good to have a toxicology test in the chart in the event that a parent comes back several years later and blames the OB if a child is having problems.

A few physicians described jointly developed policies for maternal and newborn testing. For example, if the mother has a positive test, the baby is automatically tested. A few other hospitals have policies for testing women but not infants, or vice versa. In at least one hospital, the baby is automatically tested if the mother refuses consent (discussed below).

Whereas some hospitals have testing protocols in the form of written policies, many (especially private hospitals) do not. Thus the decision about whether or not to order a test is determined by “whoever happens to be on duty.” A few OBs noted that a toxicology test on a woman can be ordered by a doctor, triage nurse, or midwife; while others stated that a physician or midwife has to order the test. A couple of OBs suggested that doctors more aware of drug use are more likely to test, and that long waiting lists for residential treatment for pregnant women, and limited options for helping women, influence decisions about whether or not OBs order tests.

With only one exception where nurses order the tests, all PEDs in the focus group indicated that a physician has this authority. However, one pediatrician did note that he relies strongly on the nursing staff to get critical information about a newborn, and several noted the importance of OB records in making testing and other decisions about newborns.

Several of the SLOs observed that the medical community is hesitant to test newborns or their mothers for fear that CPS will remove their children or the mothers will be prosecuted. This sense was not expressed by participating physicians, who generally see toxicology testing as a tool used to provide appropriate medical care. However, as discussed below, a few physicians did express concerns about the use of toxicology test results for punitive treatment of women and their children.

Should a woman's consent be required to test her for alcohol or other drugs?

Hospital policies regarding consent to test a woman are extremely varied, as are OBs' opinions about the issue. Some hospitals require it, some don't, and some require it for certain types of tests (e.g., blood but not urine). OBs who participated in the focus groups seem to be split on the issue. Approximately half believe that written consent should be required, either as part of the standard registration package, or specifically when a decision is made to administer the test. A few doctors expressed concern about the legal ramifications of *not* getting informed consent, particularly if the test results are reported to CPS. Others noted that the consent process provides an opportunity to educate mothers about the impact of drug use.

Conversely, other OBs believe that women's consent should *not* be required to test, arguing that addiction is a disease that affects the developing fetus and should, therefore, be part of the clinical assessment in order to provide necessary care to the mother and newborn. A few doctors believe in conditional consent, noting that there are situations when consent should not be required, or it should be required in private practice where patients will be responsible for the associated fee. A couple of doctors also noted creative ways of getting around the consent issue. For instance, one doctor noted that they can't take urine specifically for a drug test without consent, but they do collect urine to test for UTIs and test for drugs while they have it. She noted that there is no hospital policy on this; more of a "don't ask, don't tell" practice.

Thus, the field remains uncertain about the legality and ethicality of conducting an unannounced drug test on pregnant women. One identified concern is that if you tell a mother that you are going to test and they refuse, there is a good chance that they will go elsewhere for medical care or not get care at all. Yet, one doctor noted that although she informs patients that she will test several times throughout the pregnancy, she hasn't had any patient leave as a result.

There also appears to be significant variance regarding which party is responsible for getting women's consents. Responses included: the attending physician, the intake person, the nurse, or "whoever orders the test." One participating OB wasn't even sure if written consent is required in the hospital since nurses handle it and he's not involved. Regardless of who gets the consent, one doctor noted that they should receive training on how to obtain consent, and that the training should include observing others doing it.

Should a woman's consent be required to test a newborn for alcohol or other drugs?

There was general consensus among PEDs that consent is not needed to test a newborn. Even when a mother must be informed that her baby is going to be tested, the doctor can still order the test without her consent in order to provide appropriate medical care.

Consistent with the PEDs' perspective, most OBs indicated that consent is not and should not be required to test newborns. In fact, in some instances, if there is suspicion about the mother's drug use but she refuses consent or the doctor doesn't want to ask for it, the baby is tested instead.

Thoughts about screening pregnant women for alcohol and other drugs

There was general consensus among both physician groups that good screening and/or medical histories are more sensitive and effective than toxicology tests and should be the standard in prenatal care. OBs generally see it as their responsibility to screen for substances and anything else that could impact the fetus; and one doctor suggested that all patients should be screened at the first visit, the annual visit, and whenever anything changes. One participant suggested that a woman's relationship with her physician is "the only hope for changing behavior." If the goal is to change behavior, voluntary participation is critical, so screening is more effective than toxicology testing. In fact, several participants noted the nonchalance with which many patients admit their use of alcohol, tobacco, or marijuana. With these patients, it is important to follow-up and specifically ask about harder drugs, to which they may be less likely to admit due to stigma and/or perceived or real legal ramifications. One participant explained that they get more honest responses when the screening is done in an honest, matter-of-fact, non-judgmental way as part of the routine care.

At the same time, OBs noted great variability in screening among doctors. Some have trepidation about asking "stable" women, particularly in private practice, and others expressed concern about conducting universal screening until there are more effective ways and resources to change behavior. Nonetheless, it was noted that one's impression of a patient is not the best screening mechanism,

and that all patients should be treated the same. “Doctors must recognize drug use as a disease that they can diagnose and make it part of their routine care.” They also need to recognize the complicated context in which women use substances and screen for domestic violence, mental health, and HIV. One doctor also suggested that the ACOG³ form, which mentions alcohol, tobacco, and street drugs, is not specific enough. It should include the exact drugs that are included in a toxicology test, e.g., prescription drugs, methamphetamines.

Finally, although several physicians emphasized the importance of documenting everything, and all endorsed the need for routine screening, this may not be sufficient evidence for the child welfare system. According to the SLOs, most child welfare agencies will accept referrals of SEN without a toxicology test, but many judges require test results as evidence of abuse or neglect, regardless of what a mother’s medical history may include.

Are substance using pregnant women and their affected newborns being identified?

With a couple of exceptions, neither OBs nor PEDs advocated for universal toxicology testing of women due to cost, discrimination/fairness, and lack of efficiency or effectiveness, noting the relatively high incidence of false positives and false negatives. Further, PEDs noted that it is “too late” by the time the baby is born. Women need to be identified pre-conceptually or prenatally in order to improve outcomes for babies and prevent them from being removed from their parents. And both pediatricians and obstetricians expressed concern that, while some OBs do a good job of screening, many women still are not being identified. A few groups, in particular, who were identified as slipping through the cracks are Hispanic women who tend not to seek prenatal care; teens who become pregnant before they ever see an OB; and women (especially middle and upper class) who drink alcohol or abuse prescription drugs during pregnancy.

One pediatrician estimated that approximately 15-20% of pregnant substance users in private hospitals are missed because doctors there neither take complete histories, nor routinely test for substance use, and/or because OBs may be reluctant to test women that they know. Case in point, an OB cited a recent study in which universal toxicology testing was conducted on pregnant women in two hospitals and found 80% positive tests in the public hospital and 40% in the private hospital.

³ ACOG is the American College of Obstetricians and Gynecologists.

The general sense is that private hospitals and practitioners are only identifying a fraction of pregnant substance users, particularly among alcohol users. In fact, there was great concern among PEDs and OBs about the lack of a good test for alcohol, which is believed by both groups to cause the biggest problems and go undetected most frequently. Several doctors commented that the “long term impact of alcohol dwarfs the impact of any other drugs.” One pediatrician also expressed concern that prenatal alcohol exposure frequently isn’t detected until children are school age and begin to demonstrate problems.

These observations about alcohol were not intended to diminish the impact of other drugs, which one pediatrician referred to as “dire”—not necessarily because of the prenatal exposure, but because of all the other challenges that these families face, particularly mental health issues. Yet, with better detection, the long-term effects can be diminished with appropriate medical care, early intervention, and other support for the family.

How and when should a referral be made to Child Protective Services?

One SLO pointed out that, although most state statutes and CAPTA⁴ include language about “referral,” it is not operationalized for doctors. Not surprisingly, none of the physicians in the focus groups mentioned the CAPTA requirements; a few referred to state laws, but responses about CPS referrals varied considerably among PEDs and OBs. About half of the OBs stated that a positive toxicology test on a mother or her baby at the time of delivery is a mandated or automatic referral to CPS. One pediatrician suggested that a referral should be made if a mother admits use, and two PEDs stated that a referral to CPS is or should be based solely on a positive toxicology test. Arguing against automatic referrals, one pediatrician noted that we are “trying to apply a medical model to a social problem... there should be some index of suspicion upon which to base these decisions,” and services available to support these families.

In some states, like Maryland, where state statute does not define SEN as abuse or neglect, the SLOs suggest that doctors tend not to refer SEN to CPS. Comments from physician focus group participants did not necessarily support this perception, but most PEDs talked of CPS as a “broken” or

⁴ Federal Child Abuse Prevention and Treatment Act

“overwhelmed” system that can’t possibly respond to all identified SEN. Even in states like Georgia, where an identified SEN is an automatic referral to CPS, each county child welfare agency has a different way of responding. In Alabama, a SEN referred with a positive toxicology test is considered abused or neglected, whereas one without a positive toxicology test is referred to alternative response.

Several PEDs mentioned hospital policies that mandate a referral of all identified substance users to a hospital social worker; and most OBs noted that they refer women to the hospital social worker who makes the decision, often in collaboration with the doctor, about whether or not to refer to CPS. Several PEDs noted that CPS is always contacted before a known SEN can leave the hospital. Following are two examples of states that have institutionalized pre-discharge meetings:

- In OR, a SEN team, which includes a family advocate, child welfare worker, hospital social worker, drug and alcohol counselor, and medical provider, meets at the hospital before a newborn’s discharge to collectively determine the best plan of care for each family.
- In DE, a child welfare worker is supposed to do a pre-discharge meeting with a doctor in the hospital for each SEN. However, it doesn’t always work due to lack of time/workload issues for CPS and hospital staff, late referrals from some hospitals (e.g., couple hours before discharge), and hospital insistence that CPS provide something in writing for the hospital record prior to discharge.

One OB indicated that she will step in if she disagrees with the social worker’s decision about referral. Another expressed his reluctance to refer to CPS because too many children are removed from their parents; whereas several others stated that very few newborns get removed. Some PEDs believed that they should have a say in which children stay with their families and which are removed; others preferred to leave that decision to child welfare and the courts. Several SLOs noted that judges want to remove newborns if there is a positive toxicology test. Yet many SLOs believe that a toxicology test is not sufficient evidence; impairment in the parent’s capacity to care for the child must also be evident. For instance, Oregon’s state policy requires “severe harm or threat of severe harm” for removal. And Minnesota’s law, which requires toxicology tests, is clear that, although the results are used to report to CPS, they are not evidence that can be introduced in court.

Prenatal referrals to CPS and other services

Most OBs in private practice indicated that they rely on their clinical judgment and the patient's history to make decisions about referrals. However, most stated that they refer pregnant substance users that they identify prenatally to community resources, or they work with hospital social workers to get them into treatment. They rarely refer to CPS, typically because CPS won't get involved prenatally.

According to the SLOs, some states (e.g., DE, UT) will not accept referrals of pregnant, substance using women unless there are older children involved. In contrast, most states will accept referrals, but will only open a case if there is a born child; other pregnant substance users are assigned to an alternative response track or referred to other community based agencies or treatment providers. The state of Kansas developed *Health in Pregnancy*, a family preservation project to serve drug using pregnant women. Most referrals come from law enforcement, the health department and probation due to an allegation that a pregnant woman is using drugs. After a 22-month pilot, they had a 74% engagement rate, and 96% of the participating women had substance free deliveries.

Collaboration

Many PEDs expressed concern and frustration about the lack of client level information OBs share with them. And only two OBs specifically mentioned that they routinely share information with PEDs, although most agreed that individual relationships—having one person to connect with in each agency—along with communication and information sharing, are key. OBs further noted that collaborative partnerships should be formed with family practitioners, mental health therapists, social services, child welfare, treatment providers, and other medical professionals (e.g., dermatology, vascular). Furthermore, it is ideal if any of these agencies or disciplines is co-located. Despite this general sense, only a few physicians mentioned having working relationships with CPS, and several OBs noted that they don't have any relationships with drug treatment providers.

On the other hand, many SLOs reported that their states have multi-disciplinary work groups or task forces to address issues related to SEN. Interestingly, though, these groups typically do not include pediatricians or obstetricians as regular members.

Barriers to collaboration

Participants identified the following barriers to collaboration. These barriers or challenges were identified by all three groups (OBs, PEDs, and SLOs) except where otherwise indicated.

- Lack of, or categorical, funding.
- Physicians identified a fear in some of their colleagues of getting involved in drug treatment and child welfare issues; and SLOs noted difficulty in engaging doctors, particularly OBs.
- Lack of understanding among some about long-term savings from early identification and intervention.
- Ignorance about substance abuse.
- Lack of time.
- No leadership; need someone with time to spearhead collaborative efforts.
- Syntax and semantic differences among disciplines.
- Pediatricians noted troubled or lack of communication between OBs and PEDs, particularly in larger hospitals or communities.
- Pediatricians also expressed concern about poor or lack of collaboration or reciprocal information sharing with CPS. Many SLOs are aware of these concerns; in fact, one noted that doctors are reluctant to refer SEN to CPS because they don't know what happens once they make that referral. However, according to several SLOs, current child welfare policies and practices prevent CPS from providing a safety plan report for the hospital record.

Recommendations

In every focus or discussion group, some reference was made to the inconsistent implementation of policies and practices among hospitals, child welfare agencies, judges and/or state attorneys. The following recommendations, which emerged from the various groups, are intended to improve the identification and treatment of SEN (or, in some cases, reduce the incidence), and move toward a more consistent response by physicians and CPS. The recommendations are organized into three general categories: education, identification, and referrals/services. Collaboration and communication impact all of these areas and, therefore, are interwoven throughout the recommendations.

Education

1. Provide more education about the harmful impact of substance use during pregnancy. Specifically, a widespread need exists for pre-conceptual, inter-conceptual, and prenatal education about the impact of all drug use—including alcohol, marijuana and prescription drugs—during pregnancy. Currently, a mixed message is being publicized about alcohol; because no one knows what safe exposure is, the message must promote no alcohol during pregnancy. Also, as one physician put it, “It is too late by the time most substance using women present for prenatal care” or, in too many cases, delivery. To have an impact, public education needs to start for girls and boys in middle school. For instance, Louisiana State University medical residents go to middle and high schools to provide education about drug use; and a pediatrician from Hartford, CT gives talks on “sperms and germs.” The message needs to come for a coalition of organizations such as March of Dimes, PTAs, church groups, and other national and community organizations.

2. Educate doctors. Many doctors still ignore that the problem of substance use during pregnancy exists, or they don’t want to ask the questions because of fear of insulting their patients. Local American Academy of Pediatrics (AAP) chapters could bring this to forefront. A recommendation also was made to create a hotline for doctors to ask questions about drug use and treatment.

Identification

3. Universally screen all women prenatally. It is widely believed among pediatricians and obstetricians that not all pregnant substance users, particularly middle and upper income and those who use alcohol and/or prescriptions drugs, are being identified. In a Ventura County, CA study in which all pregnant women were screened using the 4 Ps Plus, 70% were identified as users. A comparable study using the same instrument with women in an upscale community in San Luis Obispo identified 35% as users (primarily alcohol). Universal screening should be a standard of care and must include alcohol. Several recommended strategies were offered for changing policies regarding screening. One pediatrician asked about the possibility of moving ACOG to change their standard practice of care to include screening as part of routine prenatal care. Another recommended the development of national guidelines, collaboratively developed and supported by ACOG and AAP. Yet another suggested the need to go beyond OBs and PEDs to get consensus from the American Medical Association and the American Academy of Family Physicians, for instance.

4. Improve sharing of information between OBs and PEDs so that OBs give PEDs a “heads up” if they have concern about prenatal drug exposure in a particular case. This seems to be more

feasible in smaller hospitals or communities where, in one case for instance, the PEDs do high risk OB rounds twice a month. There also may be better communication in larger tertiary hospitals that utilize electronic medical records. Yet one pediatrician shared that her hospital determined it is a HIPPA violation for a pediatrician to look at a mother's chart without her consent. So, there is need for a clear standard of care with regard to information sharing. There was also a recommendation to offer collaborative continuing medical education units between OBs and PEDs.

5. Work collaboratively to develop and provide education about hospital testing and referral policies. Involving hospital social workers, child welfare agencies, attorneys and judges in the development of these policies will help to ensure that all parties are in agreement about the type and level of evidence required in order to obtain needed medical, developmental and/or child safety intervention. In South Carolina, for instance, hospital social workers have been invited to help develop hospital protocols. In Delaware, the Division of Family Services is developing a Memorandum of Understanding with hospitals to include high risk infant criteria. Additionally, several of the SLOs provided examples of cross-disciplinary training on testing and referral. For example, a federally funded project in Oregon trains labor and delivery nurses on issues related to testing, assessment and referral. Conversely, in Kentucky, nurses train child welfare workers to understand the different types of tests and the implications of them, and they train doctors about substance abuse and when to refer a SEN to CPS. Through the Medical Elements of Child Abuse and Neglect (MECAN) Series, they also provide training on newborn drug testing. This is a collaborative effort among the state Department for Public Health, Department for Community Based Services, and the Medical Examiner's Office. The Virginia Department of Social Services developed "A Guide for Hospitals and Health Care Providers—Perinatal Substance Use: Promoting Healthy Outcomes" detailing legal requirements and health care practice implications.⁵

Referrals/Services

6. Create team approaches. Working in multi-disciplinary teams helps to improve communication and address the complex social, medical, and developmental challenges that many of these families face. For instance, it is ideal to have counselors or prenatal coordinators (e.g., RN or social worker) located at primary care and prenatal clinic sites. It also is helpful to employ a non-physician to gather information from patients; they have more time than doctors, and patients may be

⁵ The guide is available at <http://www.dss.virginia.gov/files/division/dfs/cps/publications/B032-01-0037-01-eng.pdf>

more willing to share sensitive information with them. Because these are community-based efforts, a suggestion was made to conduct focus groups with recovering women in one's own community to learn what might work there.

Several SLOs offered examples of team or multidisciplinary approaches to address substance abuse and other issues in families involved in the child welfare system.

- Kentucky has a targeted assessment program through which alcohol and drug counselors assess child welfare clients for their level of motivation and chance of recovery. They also have a case worker, separate from the child welfare worker but contracted through CPS, to help facilitate and coordinate services for families involved in the child welfare system.
- Maryland and Washington, DC co-house alcohol and drug counselors in CPS to assess and refer clients; DC also has nurses housed at their child welfare agency who visit SENs in the hospital.
- The Oregon legislature funds Addiction Recovery Teams that include a child welfare worker, alcohol/drug counselor, and alcohol/drug outreach worker. They used to include a public health nurse as well, but lack of funding eliminated that component.
- Delaware Division of Family Services has a Memorandum of Agreement (MOA) with the DE Department of Social Services Division of Substance Abuse and Mental Health to evaluate CPS clients through their substance abuse contract providers.⁶

7. Increase capacity to serve substance using women. Many women who use drugs during pregnancy are in bad life situations that require more help than doctors can provide alone. Concerns were expressed about the prevalence of mothers with various health and mental health issues that go largely untreated, often because these women are not insured and/or connected to systems, and are often kicked out after missing one or two appointments. Thus, there is great need for more health, mental health, and general support services for women who use drugs during pregnancy. Specifically, there is need for more treatment programs, particularly residential programs that can accommodate pregnant women and women with infants and young children. Also critical is community-based psychological counseling, particularly to address the prevalent issue of sexual abuse, and for woman and children who are not adequately insured. Family supports also must be put in place as an alternative to removal of children when possible, and, for many, the support must be long-term.

⁶ See Memorandum of Agreement at http://www.kids.delaware.gov/pdfs/pol_mou_dscyf_MOA_DscyfDfsDhssDasmhDhssDss.pdf

8. Develop hospital policies to manage withdrawal in newborns. Hospitals/nurseries should have policies or at least a guide that they can refer to regarding how to manage withdrawal in newborns. This is especially important for nurseries where this issue comes up infrequently and specialized knowledge on how to manage withdrawal does not exist. These hospitals can learn from some of the bigger, urban hospitals that have well-developed policies.

9. Provide long-term follow-up by primary care physician after acute issues (e.g., withdrawal) have been addressed. There should be a standard practice of at least one home visit following hospital discharge for all SEN. Currently, for instance, it is standard practice at hospitals in the Bronx and in Keene, NH for doctors to order at least one follow-up visit within five days for all identified SEN, and they have a system to check if the family doesn't follow through with the appointment. In any case, if a newborn goes home with child welfare involvement, regular conferences between the family, doctor, and child welfare worker can help to ensure appropriate follow-up. It also is important for primary care physicians (e.g., family doctors, non-hospital based pediatricians) to understand signs and needs of SEN, who may or may not have been identified at birth. For instance, one veteran pediatrician noted that she looks at the mother's clinical signs including a sense of her preoccupation with something other than her newborn, a constant runny nose, track marks, and (admitting her bias) multiple tattoos, which she suggests are often covering up track marks. Additionally, she takes an extensive history, looking at what's happening in the home and what kind of support systems the family has. If she is concerned, she will bring back the mother multiple times for follow up, often encouraging her to bring a grandparent or best friend, which also gives her more information about the home situation.

Another pediatrician recommended the creation of a medical home for each child to avoid challenges in getting records, particularly from different states. AAP has proposed the use of electronic universal medical passports (or some sort of transportable documentation) like those used with immunizations. This would help with continuity of care and communication among physicians.

10. Increase early intervention capacity. Currently only the most symptomatic children get served. So there is great need for more early intervention providers.

11. Increase child welfare services capacity. Several doctors noted child welfare worker burnout, apathy, lack of education, and/or difficulty tracking them down. More resources, clearer policies, and standard protocols would result in a more consistent child welfare response.

12. Clarify CAPTA mandated plan of safe care. Confusion persists among child welfare agencies and workers about the difference between a case plan and a plan of safe care. More guidance is needed on the intent of the CAPTA legislation regarding this plan.

13. Collect data on the number and needs of SEN referred to CPS. This is critical in order to document and attempt to meet the need. Several states (e.g., VA, ND, LA, AZ) track the number of SEN referred to CPS. Alabama has three specific allegation codes related to SEN: positive test for alcohol or FAS; parent withdrawal or positive drug toxicology test; and chemical endangerment due to methamphetamine exposure. However, most states simply report parental substance use, but don't separate out SEN cases, which would require additional resources.

In an effort to further explore some of these recommendations, the National AIA Resource Center plans to convene a national conference on substance exposed newborns. Specifically, this conference will bring together representatives of the many disciplines that are involved in the identification and treatment of pregnant substance users and their newborns in an effort to identify effective policies and practices, as well as strategies for implementing some of the identified recommendations.

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