

IDENTIFYING, REPORTING,  
AND RESPONDING TO  
SUBSTANCE EXPOSED NEWBORNS:

AN EXPLORATORY STUDY OF  
POLICIES & PRACTICES



*A service of the Children's Bureau*

— 2005 —

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Funded by the Robert Wood Johnson Foundation's  
Substance Abuse Policy Research Program

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## SUMMARY

Substance abuse during pregnancy remains a significant public health concern that affects hundreds of thousands of newborns every year in the United States, and impacts many systems. States across the country have established various laws designed to identify, ensure the safety of, and provide services to substance exposed newborns and their mothers. Prior to 2003, however, no federal policy on this issue existed. As a result, policies vary widely among states, and several states remain silent on the issue. Further, based on the study reported herein, hospital and child welfare practices do not necessarily reflect state law. Although based on only eight large urban areas throughout the country, this study revealed that, regardless of state policy, hospital staffs report virtually all newborns that test positive for an illicit drug and, with varying degrees of expedience, child welfare agencies investigate almost all such reports. Whereas most hospitals have a protocol to determine who to test for substances, these protocols are used inconsistently with resulting bias in who gets tested. Moreover, some hospitals do not even test delivering women or newborns for alcohol, and child welfare agencies are inconsistent in their response to reports of prenatal alcohol exposure. Thus, it is likely that not all substance exposed newborns are being identified or offered services.

Additionally, according to the nursing and social work staff in participating hospitals, very little data is collected on the numbers of mothers and newborns that are tested for substances or the outcomes of the tests. Further, hospital staff generally do not track or follow-up on referrals that they make to drug treatment services, and many limit their involvement in this area to providing women with a list of treatment providers. Nonetheless, almost all of them identify a lack of appropriate treatment programs as a significant problem for pregnant and parenting substance users.

This report describes a study that explored policies and practices related to the treatment of substance exposed newborns at the time of delivery. Specifically, it presents the methodology, results from the study, and a discussion of policy and practice implications with regard to testing for illicit drugs and alcohol, informed consent, referrals to and response from Child Protective Services, prenatal intervention, and substance abuse treatment.

## INTRODUCTION

Substance use among pregnant women continues to present a significant public health challenge that impacts many systems. According to the *2004 National Survey on Drug Use and Health*, 4.6% of pregnant women reported using illicit drugs, 11.2% reported alcohol use<sup>1</sup>, and 18% reported using cigarettes in the last month (Substance Abuse and Mental Health Services Administration [SAMHSA], 2005). The rates of illicit drug use during pregnancy for white, black, and Hispanic women are 4.2%, 7.8%, and 5% respectively (SAMHSA, 2005). An estimated 10%-11% of all newborns are prenatally exposed to alcohol or illicit drugs (Vega et al., 1993; Young, 2005). This translates to approximately 400,000 – 480,000 substance-exposed births last year. Other estimates put the number of newborns exposed to alcohol alone at approximately 823,000 per year (Ebrahim & Gfroerer, 2003; National Institute on Drug Abuse, 1997).

### *Effect of Perinatal Substance Exposure on Children*

Prenatal alcohol exposure has been associated with learning deficits, behavioral problems, poor academic performance, adult alcohol problems, and lower weight and height in adolescence (Baer, Sampson, Barr, Connor, & Streissguth, 2003; Day et al., 2002; Goldschmidt, Richardson, Cornelius, & Day, 2004; Sood et al., 2001; Willford, Richardson, Leech, & Day, 2004). Significant relationships have been found between greater prenatal alcohol use (e.g., heavy or binge drinking) and attentional/behavioral/learning problems in pre-school children and adolescents (Streissguth, 1997; Olson et al., 1997). Although less is known about the impact of social or “lighter” drinking, more subtle effects, while less obvious to detect, have been associated with lower drinking levels as well (Burden, 2005). Additionally, because the types of challenges caused by fetal alcohol exposure are seen more in demanding, complex cognitive tasks that involve the integration of working memory, affected children may not be detected until they enter school and are faced with such tasks (Burden, 2005). Thus, whereas the specific thresholds remain unclear in terms of level, time and duration of exposure, and not all exposed children are affected, researchers generally agree that there is no safe dosage of alcohol use during pregnancy (Streissguth, 1997).

The research on outcomes of prenatal exposure to illicit drugs is less universally conclusive. In-utero opiate exposure has been associated with low birth weight and sleep disturbances (Hulse, Milne, English, & Holman, 1998; O'Brien & Jeffery, 2002). The effects of amphetamines have not been well documented and can be unpredictable (National AIA Resource Center, 2004), and some medical professionals warn that media reports of babies prenatally exposed to methamphetamines may be sensationalized (retrieved 8-23-05 from [jointogether.org/sa/files/pdf/Meth\\_Letter.pdf](http://jointogether.org/sa/files/pdf/Meth_Letter.pdf)). Further, the National Toxicology Program, Center for the Evaluation of Risks to Human Reproduction (2005) cautioned that “in terms of the potential adverse reproductive and developmental effects of meth exposure, . . . studies that focused upon humans were uninterpretable due to such factors as a lack of control of potential confounding factors and the issue of the purity and contaminants of the methamphetamine used by the drug abuser” (p. 191).

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<sup>1</sup> 4.5% and .5% of pregnant women reported binge alcohol use (5 or more drinks on the same occasion on at least 1 day in the past 30 days) and heavy alcohol use (five or more drinks on the same occasion on each of 5 or more days in the past 30 days) respectively.

Most of the research in prenatal substance use over the last two decades has focused on cocaine exposure. Although once thought to have uniformly catastrophic results on the development of the fetus, differences of opinion and conflicting findings exist on the short- and long-term effects of prenatal cocaine exposure on children. Some researchers have found that use of cocaine during pregnancy has no effect on weight, length, or head circumference of newborns born prenatally exposed (Frank, Augustyn, Knight, Pell, & Zuckerman, 2001); others have found exposed newborns to have lower gestational ages, birth weights, lengths, and head circumferences than non-exposed newborns (Singer et al., 2002). Additionally, studies have found that cocaine-exposed children have lower levels of cognitive functioning than do non-exposed children, and they are more likely to be classified as mentally retarded (Lester, LaGasse, & Seifer, 1998; Singer et al., 2002). Yet, some researchers posit that there is not enough evidence to decidedly determine effects of prenatal cocaine exposure on IQ and motor skills after controlling for such potential confounders as tobacco use, at least for children up to six years of age (Frank et al., 2002).

Further, a growing body of research suggests that most negative effects of prenatal substance exposure can be overcome, or exacerbated, depending on the post-natal environment (Berger and Waldfogel, 2000), and that the environmental factors associated with substance use most likely supersede the physiological effects of a substance (Carta et al., 2001; Hulse et al. 1998). Carta et al. and Bauer and Barnett (2001), for instance, maintain that what happens in the home after birth has a greater effect on growth and development than in-utero exposure to drugs. Inconsistent care from an addicted parent and other social risk factors, including mother's education level and the child's home environment, have been shown to play a greater role in a child's development past infancy than low birth weight or gestational age (Berger & Waldfogel, 2000; Boardman, Powers, Padilla & Hummer, 2002). As things stand, the incomplete and contradictory evidence suggest that it may be possible to circumvent many problems, at least somewhat, with early intervention and a nurturing environment after birth.

However, prenatally substance-exposed children tend to experience higher levels of child abuse and neglect and are less likely than non-exposed children to be in the care of their biological parents in early childhood, up to age 6 (Delaney-Black et al., 2000; Singer et al., 2002). Estimates of children who were placed in foster care due to parental substance use (by at least one parent) have been detailed in national reports. For instance, the National Center on Addiction and Substance Abuse (1999) reported that substance use is to blame for the dramatic rise in child welfare cases in the last two decades, and the U. S. General Accounting Office (1994) found that the number of foster children with at least one substance-using parent increased from 52% in 1986 to 78% in 1991. In another study of state child welfare agencies, it was found that parental substance use was a factor in child removal in at least 53% of cases (Child Welfare League of America, 2003).

### ***Policy Response***

Prior to 2003, there was no federal policy regarding the reporting of or services for substance-exposed newborns (SEN) or their mothers. Thus, state laws vary considerably from supportive to punitive approaches, and several states have no laws at all regarding this issue. The Keeping Children and Families Safe Act of 2003 recognized the serious impact of the post-natal environment on a substance exposed infant's development, and the need for services to help this population. This legislation amended the Child Abuse Prevention and Treatment Act (CAPTA) to, among other things, require that all states have in place a protocol for responding to the problem of SEN. The amendment is

intended to link child welfare services with developmental, mental health, early intervention, and health services in order to access supportive help for at-risk children. Specifically, it requires states to have

*policies and procedures (including appropriate referrals to child protection service systems and other appropriate services) to address the needs of infants born and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants, except that such notification shall not be construed to—*

*(I) establish a definition under Federal law of what constitutes child abuse; or*

*(II) require prosecution for any illegal action*

(Keeping Children and Families Safe Act [KCFSA], 2003, section 106(b)(2)(A)(ii)).

By July 2004, states were required to provide assurances of these provisions to be eligible for CAPTA grants; however, federal oversight or accountability in this area remains unclear. Further, the federal law is silent on the issue of how to identify SEN, and practices vary widely throughout the country. Noting differential treatment of various ethnic and socioeconomic classes in regard to who gets tested for substance use and subsequently referred to child protective services, some experts advocate for universal testing in order to promote more fair and equitable practices and maximize the likelihood of identifying at-risk infants (Barth, 2001; Ondersma, Simpson, Breston, & Ward, 2000). Conversely, The American Academy of Pediatrics opposes involuntary universal screening and mandatory reporting because it violates women's rights to privacy and confidentiality, and it threatens the trusting relationship between patient and health care provider that is necessary in order to provide effective care (American Academy of Pediatrics, 1995). Berger and Waldfogel (2000) also oppose universal testing and reporting because of the unreliability of testing, and the lack of intrinsic proof that a mother who uses drugs while pregnant cannot adequately parent.

### ***Impact of Policy on Practice***

The impact of policy on practice remains unclear. A study on the impact of state substance exposed newborn (SEN) reporting laws on child maltreatment reports in California found considerable variation in the interpretation and implementation of state policy among and within counties (Albert, Klein, Noble, Zahand, & Holtby, 2000). In fact, despite a state law specifically stating that a positive drug test of a newborn is not alone sufficient grounds for making a report to CPS (SB2669)<sup>2</sup>, numerous hospitals within California have internal policies that mandate an automatic report in such cases. Further, "county-level child welfare staff have differing views and policies regarding the need to intervene in situations where parental substance abuse is the only identifiable problem" (Albert et al., p. 181).

A more recent study of perinatal substance use in California found that, according to county Maternal, Child, and Adolescent Health staff, nearly all of the delivery hospitals in the reporting counties have formal protocols for identification and follow-up of SEN (Barbara Aved Associates, 2002). However, only 31% of the reporting counties indicated that all hospitals routinely implement existing protocols, and just over half (58%) of them indicated that all of the protocols are consistent with state law. The study also found that, when data were available, the percentages of

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<sup>2</sup> Chapter 1603, Statutes of 1990, creating Health and Safety Code 10900-10902 and amending Penal Code 11166, Child Abuse and Neglect Reporting Law. These laws require that: (1) cases shall not be reported as suspected child abuse or neglect solely on the basis of a positive toxicology screen of the mother or newborn; (2) a positive screen should be followed by a hospital assessment of mother and infant, conducted by a health practitioner or medical social worker before the infant is released from the hospital, with a report to CWS only if other risk factors are present; and (3) CWS was not to notify law enforcement of suspected child abuse cases based solely on parental substance abuse.

women with positive toxicology tests referred to CPS varied widely among hospitals from 14% to 100% in one county alone.

The study described herein builds upon the current knowledge base by exploring and comparing the relationship between state laws and practice in hospital and child welfare systems in eight cities across the United States. The study's objective is to provide information to assist states, counties, and localities in the development, revision, and implementation of their policies and practices regarding SEN. Additionally, as one of the first studies to be conducted since the enactment of the CAPTA amendments, it will provide baseline data that will be useful for subsequent studies assessing the impact of the CAPTA amendment on state policy and practice.

## OVERVIEW OF STUDY

The National Abandoned Infants Assistance Resource Center (NAIARC) was awarded a grant from the Substance Abuse Policy Research Program of the Robert Wood Johnson Foundation to perform an exploratory study of policies and practices related to the testing and reporting of SEN, and child welfare's response. The study was conducted by two researchers: the Associate Director of NAIARC and a Graduate Student Researcher. Our goal was to gain a basic understanding of how hospitals decide which newborns and delivering mothers are tested for substances, and for which substances they are tested; who gets reported to Child Protective Services (CPS); and if, how, and when CPS responds. The study also explored whether or not there are differences among states with varying laws; whether or not practices and policies differ among hospitals within the same city; and whether or not practices are consistent with state laws. Finally, the study sought to identify model communities that have developed a consistent, coordinated approach to identifying and meeting the needs of SEN and their mothers. This report summarizes the findings, highlights some model practices, and identifies implications for the development of future policy and practice in regards to testing for illicit drugs and alcohol, obtaining informed consent, CPS reporting and response, prenatal intervention, and substance abuse treatment.

## METHODS

### *Recruitment and Instruments*

The study consisted of two phases. The first phase involved in-depth interviews with hospital nursing and social work staff. The initial plan was to interview the labor and delivery nurse manager and social work supervisor in each identified hospital. However, given the varying structure of hospitals, these positions did not always exist or were not always the most appropriate people to answer questions about testing and reporting of SEN. This was most apparent with social work staff, in that most hospitals have general social work supervisors to oversee all social work units in the hospital. In the majority of cases, general supervisors referred us to the social worker(s) in the labor and delivery unit, who would have more detailed knowledge about the specific relevant policies and procedures.

Individuals were initially contacted by phone to inform them about the study, to determine if they were the most appropriate person to respond to the research questions, and to invite them to participate in the study. This was

followed by a formal invitational letter and consent form, which was to be returned before the scheduled interview time. Generally, nursing managers were much more difficult than social workers to contact, as reflected in the final sample. Our strategy for contacting people included up to three phone calls and one letter, plus up to two e-mails in the few cases where we had e-mail addresses. All interviews were conducted by phone and took an average of 30 minutes. A copy of the survey instrument for hospital workers is included as Appendix A.

Individual phone surveys also were conducted with child welfare administrators in the state or county where the hospitals are located. This included intake or hotline supervisors, as well as agency or unit directors, depending on the structure of the agency. In one instance, we were referred to the Department of Social Services' Alcohol and Drug Coordinator. As with hospital staff, individuals were contacted by phone, followed by a formal invitational letter and consent form. The survey instrument for CPS staff is included as Appendix B.

At the conclusion of the individual phone surveys, we informed participants about the next phase of the study, which involved focused discussion groups conducted via telephone with direct service practitioners in the eight study sites. With their approval, we mailed or e-mailed informational fliers to everyone interviewed for dissemination to their staff. We scheduled two discussion groups with hospital staff (nurses and social workers) and two with front end child welfare workers. (See Appendices C and D for discussion questions.) Additionally, we held one group for community-based family support agencies serving SEN and their families in the eight cities. (See Appendix E for the discussion questions.<sup>3</sup>)

The data were analyzed both quantitatively, using SPSS, and qualitatively, by reading through the surveys and coding responses to identify themes or common replies. Study limitations are identified in the discussion of this report. However, it is important to note upfront that the quantitative data are almost exclusively based on estimates by the interviewees and, therefore, should be interpreted cautiously.

### ***Subjects***

Given the limited resources, timeframe, and scope of this study, we chose to focus on only eight localities throughout the country. First, we identified eight geographically varied states, representing four categories of current state laws related to the reporting of SEN to child protective agencies. The categories were as follows: (1) SEN defined as abused or neglected child with mandated reporting to CPS; (2) mandated reporting to CPS, but SEN *not* explicitly defined as abused or neglected child; (3) referral to CPS only if other risk factors are present, with judgment left to the discretion of a health care professional; and 4) no current laws. A major city within each state was then chosen.

We attempted to contact people at 32 hospitals, and we got participants from 29 hospitals. According to participants' classification, this included 10 public hospitals, 4 private for-profit hospitals, 12 private non-profit hospitals, and 3 hospitals for which respondents gave conflicting classifications as to the type of hospital. Five of the private hospitals had a religious affiliation. We were able to interview two people (our goal) from each of 10 hospitals, and one person from each of 19 hospitals, for a total of 39 interviews. This included 9 nursing supervisors, 5 social work supervisors, 21 social workers, and 4 from other categories (e.g., administrator, perinatal outreach worker). See Appendix F for a summary of the hospitals and interviewees from each location.

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<sup>3</sup> During the focused discussion groups, we did not ask all the questions listed in the appendices. Rather, the questions listed served as guides for the discussions.

Additionally, we interviewed ten child welfare administrators. This included one from each of four cities, and two from each of three cities. In one city we were unable to interview anyone. The child welfare participants included front-end (e.g., hotline or intake) supervisors, program managers, office or unit directors, and, in one city, a drug and alcohol coordinator.

Six participants, representing three hospitals from three cities, participated in the hospital focused discussion groups. All hospital participants were social workers; no nurses participated. Six child welfare workers from two cities participated in the child welfare discussion groups. Three participants from three cities participated in the focused discussion group with community-based family support agencies. In sum, 15 individuals from four cities participated in the discussion groups.

## RESULTS

The results reflect responses from the individual interviews and the focused discussion groups. The bulk of the information is based on the interviews because we had more respondents. However, the responses elicited through the discussion groups largely supported those of the individual interviews.

### *Hospital Drug Testing Policies*

*Illicit drugs.* Hospital participants were asked whether the hospital has a policy for testing for *illicit* substances. Of the 38 hospital social workers and nurses who responded, 36 responded in the affirmative.<sup>4</sup> Although there was not always internal consistency within hospitals, the majority (89%) of those with policies stated that the decision about whether or not to test is based on an assessment. The other four reported that the hospital does universal testing.<sup>5</sup>

Subjects identified a range of factors that are considered in the assessment protocols, whether formal or informal. The most frequently identified triggers for testing were the lack of prenatal care and/or a known history of drug use (60% each). As illustrated in Table 1, other commonly noted triggers include generic “suspicion” (i.e., a provider suspects use, even if none of the other factors is present), placental abruption, withdrawal symptoms in the newborn, being obviously under the influence of a substance, preterm labor, home delivery, and a history with child welfare services. Three or fewer people mentioned the following factors: partner’s use, young mother, track marks, past births of SEN, low birth weight, homeless mother, or incarcerated mother.

Lack of prenatal care	60%
Known history of drug use	60%
General suspicion of drug use	56%
Placental abruption	33%
Withdrawal symptoms in newborn	20%
Obviously under the influence of drugs	15%
Preterm labor	13%
Home delivery	10%
History with child welfare services	10%

<sup>4</sup> The two who indicated that there is no policy are from hospitals that recently merged or reinstated their labor and delivery unit.

<sup>5</sup> In two of the four cases where universal testing was reported, another respondent from each of the same two hospitals indicated that testing is based on assessment.

The assessment protocols serve as general guides in determining who should be tested. In almost all cases, the physician has to order the test and, therefore, has final authority in determining who gets tested. However, in a few cases, the nurse or social worker respondent indicated that they can encourage the doctor to order a test on a mom or baby.

*Alcohol.* By omission, the CAPTA legislation does not require reporting of infants prenatally exposed to alcohol. However, because of the documented impact of prenatal alcohol exposure (Baer et al., 2003; Day et al., 2002; Goldschmidt et al., 2004; Sood et al., 2001; Willford et al., 2004), we specifically asked hospital staff whether or not their hospital has a policy for testing delivering women or newborns for alcohol. Of the 37 participants who responded, half said yes and half said no. However, 16 respondents (43% of total), independent of the existence of a policy, reported that pregnant women are never or very rarely tested for alcohol.

The most commonly cited reason to test for alcohol was obvious alcohol intoxication (41%). Other criteria that trigger a test for alcohol include history of alcohol use (11%), suspicion (8%), and universal testing (5%). Ten people reported that the same triggers that indicate a test for illicit drugs also indicate a test for alcohol; and four reported that alcohol is automatically included in the test for illicit drugs. Five people explicitly stated that a separate test is required for alcohol.

### **Consent**

Respondents were asked four separate questions regarding informed consent: (1) Are moms informed that they will be tested for drugs? (2) Are moms informed that their newborns will be tested? (3) Is mom’s consent required before she can be tested? and (4) Is mom’s consent required before her newborn can be tested? There was a fair amount of consistency among hospital responses.

About 87% of the hospital respondents reported that mothers are informed that they will be tested, and 8% reported that mothers are sometimes informed they will be tested. The rest reported that mothers are not informed they will be tested. Similarly, 83% reported that mothers are informed that their newborns will be tested, and 8% reported that mothers are sometimes informed that their newborns will be tested. The rest reported that mothers are not informed that their newborns will be tested. Please see Table 2.

Mother Informed	Mom (n = 37)	Newborn (n = 36)
No	5%	8%
Yes	87	83
Sometimes	8	8

Consent	Mom (n = 34)	Newborn (n = 35)
No	41%	66%
Specific consent	41	0
General consent	18	11
No, if medically necessary (newborn only)	NA	23

When asked about consent, however, the figures are quite different. As reflected in Table 3, of the 34 hospital employees who responded, 41% stated that consent is not required for mothers to be tested, 41% reported that specific consent is required, and 18% reported that the consent is included in the hospital's general admission consent. In contrast, a greater number reported that consent is not required for the newborn to be tested: 66% of the respondents indicated that consent is not required for the newborn to be tested, 23% reported that consent is not required for the newborn *if* the test is medically necessary, and 11% noted that the consent to test the newborn is included in the hospital's general consent. It is important to note that *no respondents* reported that a mother's consent is explicitly required to test a newborn.

Although the sample size was too small to run any reliable tests, there does not appear to be any significant difference in testing or consent policies among hospital type (i.e., public, private for-profit, or private non-profit).

### ***Hospital Data Collection***

This study was not designed to collect or report substance use prevalence data; however, we were interested in whether or not hospitals routinely collect this information. We also wanted a sense of how hospital staff perceive the extent of the substance exposed newborn problem. Only 18% of respondents reported that the hospital routinely or systematically collects data on the number of mothers or newborns tested for drugs or on the outcomes of the tests. An additional 20% did not know whether data are collected, and almost two thirds (62%) reported that the hospital does not collect these data. When asked for an estimate about the numbers tested, about one quarter of respondents declined to offer an estimate. Of those who ventured a guess, about one-third said less than 5% of delivering women are tested, and half of respondents estimated that more than 75% of those tested test positive. These figures should be taken for what they are—best guesses. What is most noteworthy is the apparent lack of data that are routinely collected according to study participants. However, it is possible that hospital labs maintain records of the numbers tested and the outcomes of the tests, of which the respondents were unaware.

The one respondent who had data available reported that 23% of newborns during the last year were tested, and 38% of them tested positive for an illicit drug. This translates to 8.5% of the 800 newborns delivered in that hospital during the year, only slightly lower than the national estimate of 10% -11%. On the other hand, a respondent from a hospital that does universal testing of mothers, estimated that 20% test positive. Note that these data only reflect two hospitals in two different cities and, therefore, do not necessarily reflect national trends.

### ***Reporting Policies***

Regardless of the states' laws, most (87%) of the 39 respondents indicated that all identified SEN are reported to CPS. A positive toxicology test alone appears to trigger a report in most cases. Table 4 below provides a state by state comparison of state laws and practices regarding SEN reporting and CPS response, as reported by study participants working in both hospitals and child welfare agencies.

<b>City</b>	<b>Law</b>	<b>Respondents</b>	<b>Practices &amp; Procedures as reported by study participants</b>
1	If a child “is determined to be physically dependent upon an addictive drug at birth” state law requires the health care provider to immediately orally report the situation to CPS, who, in turn, is required by law to investigate the allegation and notify the parent of the “social services that the department intends to provide to the child or his family” within 60 days of receiving the report. Further, an “injured, abused or neglected child” includes a child “who is determined to be physically dependent upon an addictive drug at birth.”	2 CPS, 6 hospital	Five of the hospital respondents reported that all cases of substance exposure are reported to CPS, and one reported that, in accordance with law, cases are reported only if the newborn shows “signs or symptoms of withdrawal, which most do.” If the screens are only positive for methadone and there are no other risk factors, it is usually determined that there does not need to be any further investigation. If there is a positive toxicology screen for any substance other than methadone, it is an automatic screen-in, and the investigation must be completed within 10 days.
2	In state law, “neglected child” includes “any child who is a newborn infant whose blood, urine or meconium contains any amount of a controlled substance... or a metabolite thereof, with the exception of a controlled substance or metabolite thereof whose presence in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.” Medically diagnosed withdrawal symptoms from barbiturates or narcotics, a medical diagnosis of FAS at birth, or proof that a newborn infant’s blood, urine, or meconium contains any amount of a controlled substance, are prima facie evidence of abuse or neglect. Further, a parent is considered “unfit” to care for her child if “there is a confirmed test result that at birth the child’s blood, urine, or meconium contained any amount of a controlled substance... and the biological mother of this child is the biological mother of at least one other child who was adjudicated a neglected minor.” Anyone required to report child abuse may refer any addicted pregnant person to the Department of Human Services, who must notify the local Infant Mortality Reduction Network service provider. The service provider must prepare a case management plan and assist the pregnant woman in obtaining counseling and treatment from a local substance use service provider, who, along with the local Infant Mortality Reduction Network service provider, must monitor the pregnant woman through the service program.	1 CPS, 5 hospital	According to the one CPS respondent, cases are automatically substantiated if the newborn or the mother is positive. However, hospital respondents were of the opinion that the newborn must test positive for an investigation to occur. Two hospital respondents said all cases are reported to CPS, and three said that they do not report cases of marijuana use alone. CPS comes out within 24 hours, they have 14 days to begin investigation, and then 60 days to make decision in the case. Usually families are given in-home services.
3	Every physician or surgeon, including doctors of medicine, licensed osteopathic physicians, residents and interns, or any other health care professional attending the birth of a child who tests positive for alcohol or a controlled dangerous substance shall promptly report the matter to the Department of Human Services.  A "deprived child" includes a child... who is in need of special care and treatment because ... at birth the child tests positive for alcohol or a	1 CPS, 7 hospital	Five of the hospital respondents said all cases of SEN are reported to CPS. One said that if there is a test run, the case is reported, regardless of the outcome of the test. One said that if the newborn is positive, the case is reported, but may or may not be if only the mother tests positive. The single CPS respondent reported that cases are usually automatically accepted and are treated as priority. The hospitals noted that if the mother used only marijuana, and she has no CPS history, CPS may take no action, or may decide to visit at home after

	controlled dangerous substance and, pursuant to drug or alcohol screen of the child and an assessment of the parent, is determined to be at risk for future exposure to such substances.		she is discharged from the hospital. The hospitals also noted that CPS usually takes custody if the drug used is cocaine or methamphetamine, and in these cases, they bring police escort.
4	SEN is <i>not</i> included in the state’s definition of child abuse or neglect. However, a person who is required to report suspected child abuse or neglect and “who knows, or from the child’s symptoms has reasonable cause to suspect, that a newborn infant has any amount of alcohol, a controlled substance, or a metabolite of a controlled substance in his or her body shall report” this to the state child protection agency in the same manner as other reports. A report is <i>not</i> required if the person knows that the alcohol, controlled substance, or metabolite, or the child’s symptoms, are the result of medical treatment administered to the newborn infant or his or her mother.	1 CPS, 4 hospital	All hospital participants indicated that they report all cases of SEN. According to hospitals, cases of SEN are automatically accepted, and CPS comes within 1-3 days. However, the hospital may discharge the mother and newborn before CPS visits if the substance used is not heroin, cocaine, or alcohol. Additionally, hospitals reported that CPS may also do a home visit prior to the baby’s discharge if the substance used is something other than marijuana.
5	In 1991, the State Health and Welfare Agency was required to develop a model needs assessment protocol for pregnant and postpartum substance using women in conjunction with the appropriate professional organizations in the areas of hospital administration, substance use prevention and treatment, social services, public health, and appropriate state agencies, to be used by local hospitals and agencies in the assessment of the needs of substance exposed infants with the propose of identifying needed services for the mother, child, and family, determining the level of risk to the newborn, and gathering data for information and planning purposes.  A positive toxicology screen at the time of the delivery of an infant <i>is not</i> in and of itself a sufficient basis for reporting child abuse or neglect. However, any indication of maternal substance use shall lead to a hospital assessment (by a health practitioner or medical social worker) of the needs of the mother and child, and, if other factors are present that indicate risk to a child, then a report to CPS shall be made. A report based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent’s substance use shall be made only to county welfare departments and not to law enforcement agencies.	2 CPS, 3 hospital	Two hospital respondents indicated that all cases are reported, and one noted that marijuana use alone is not reported. After the report, CPS decides if the case requires immediate (i.e., w/in 24 hours) attention; baby is safe to go home, but still needs to be investigated (have 10 days to visit); or that no action is needed. If the case requires immediate attention, CPS always sees mother and baby before they are discharged, and they may put a hold on the baby.
6	Any physician or health care provider <i>may</i> refer to the <i>Department of Health</i> families in which children may have exposed to a controlled substance or alcohol, as evidenced by: <ul style="list-style-type: none"> <li>▪ Medical documentation of signs and symptoms consistent with fetal alcohol or controlled substance exposure,</li> <li>▪ A confirmed positive toxicology test for controlled substances performed on either mother or child, and</li> </ul>	2 CPS, 4 hospital	One respondent from a private non-profit hospital reported that SEN are reported to CPS based on a psychosocial assessment; the other three reported that all cases are reported to CPS. One qualified that the cases are reported only if the baby tests positive. Cases of SEN are automatically classified as emergency, and CPS conducts an assessment before the newborn is sent home. However, the department classifies and treats them as an “at-risk newborn” rather than an allegedly abused or

	<ul style="list-style-type: none"> <li>▪ A written assessment made by a physician that documents the child as being at risk of abuse or neglect.</li> </ul> <p>Absent these conditions, nothing precludes a physician or other mandated reporter from reporting abuse or neglect of a child as required by the state's child abuse reporting laws. Upon notification of an SEN, the Department of Health shall offer the family service coordination of social services, health care, mental health services, and needed education and rehabilitation services, which shall be initiated within seventy-two hours of notification. The Department of Health shall notify the department of social services and the department of mental health within seventy-two hours of initial notification. Any physician or health care provider complying with the provisions of this section, in good faith, shall have immunity from any civil liability that might otherwise result by reason of such actions. Referral and associated documentation provided for in this section shall be confidential and shall not be used in any criminal prosecution.</p>		<p>neglected child.</p> <p>Note: Whereas the law requires reports to be made to the Department of Health, we were informed that, because the Department of Health was not set up to accept emergency calls, by default, the calls go to the Department of Social Services instead. However, reports of SEN are sent to a separate unit for "at-risk newborns." (See discussion for more information).</p>
7	The state currently has no law directly addressing the testing, reporting or treatment of SEN.	0 CPS, 5 hospital	Based on hospital interviews, all cases where the newborn tests positive are reported to CPS. CPS investigates all reported cases as long as newborn tests positive, but they may do only a home visit after the baby is discharged. If they need to come to the hospital, they must come out within 24 hours. They make a home visit on every case, but more severe drugs may get a home visit sooner than for marijuana or alcohol.
8	The state currently has no law directly addressing the testing, reporting or treatment of SEN.	1 CPS, 5 hospital	One hospital respondent reported that they generally do not report marijuana use, and two reported that they do not report alcohol use. The others from hospitals reported that regardless of substance, all cases are reported to CPS. All positive screens on babies are considered suspected neglect or endangerment and are given priority, which means they are investigated within 24 hours. The CPS respondent reported that even if the baby has a negative test, the case may still be investigated, but may be assigned a lower priority.

*State policies included in this table were compiled from the following sources: Christian (2004); National Clearinghouse on Child Abuse & Neglect Information website (<http://nccanch.acf.hhs.gov/>); Paltron, Cohen, & Carey (2000).*

Note: although child welfare agencies have different names in different states (e.g., Department of Social Services, Department of Public Welfare, Division of Children & Family Services), we refer to it as CPS in all states in order to avoid confusion.

### ***CPS Response***

When a hospital worker makes a report to CPS in any of the study sites, it generally goes to either a centralized statewide intake unit or to the district office where the family resides. The CPS screener, along with his or her supervisor, decides whether or not there is sufficient reason to open a case or send a worker to investigate, and how urgently this needs to happen. Approximately 60% of the hospital respondents stated that CPS accepts all cases of SEN reported by the hospital. However, five people from four cities reported that CPS will not open a case if the newborn does not specifically have a positive toxicology screen. That is, even if the mother tests positive at birth, or admits use, if the baby is not tested or tests negative, CPS will not accept the case.

As noted in Table 4 above, only one of the study sites has state law specifically requiring CPS to investigate any allegation of a SEN reported by a health care provider. However, according to study participants, a hospital report of a SEN triggers an automatic response in four of the eight sites. In three of those sites, such reports are given “priority” or “immediate” status, which is defined differently in every site.

Based on participants’ accounts, the other four cities included in the study leave more discretion to the screener to decide if, how, and when to respond. One of these cities uses Structured Decision Making to determine if the case requires immediate attention (within 24 hours and before the baby is discharged), if the baby is safe to go home but still requires an investigation within 10 days, or if no action is needed. The other sites appear to be less structured in their responses.

For the most part, CPS reportedly responds to SEN referrals before the babies are medically ready to leave the hospital. Participants from only one city indicated that newborns are routinely held beyond medical discharge for longer than one or two days due to delays in CPS responses. However, as several respondents noted, many SEN are experiencing withdrawal or have other medical conditions requiring longer hospitalizations, which gives CPS more time to thoroughly investigate the families’ situations. Most respondents indicated that when newborns are held in the hospital, their mothers are permitted to visit them as long as they are not behaving “inappropriately.” However, a few respondents indicated that children exposed to heavier substances, such as cocaine, heroin, or methamphetamines, may be taken into legal state custody and removed from their parents immediately.

### ***Differential Treatment among Drugs***

Of the 38 respondents from hospitals who answered the question “Are there differences between hospital policies or procedures for different types of substances?” 27 (71%) reported that there are no differences, and 11 (29%) reported that there are.<sup>6</sup>

Almost one quarter of the hospital respondents mentioned differential treatment for marijuana. Two people stated that hospitals do not test for marijuana. A few reported that they do not report marijuana because CPS will not accept cases where marijuana use is the only risk factor; others stated that they do report marijuana, even though CPS will not accept the case if there are no other risk factors. According to the hospital respondents, sometimes when a case involving only marijuana use is accepted by CPS, it is considered less urgent than cases involving other drugs, and often times CPS workers will wait to visit these families at home after they are discharged from the hospital.

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<sup>6</sup> Staff from two hospitals provided conflicting reports: one person from each of the two hospitals reported differences, and another from each reported no differences.

The 10 responses from CPS staff were consistent with these statements. Six respondents indicated that all drugs are treated the same. However, in three cities, CPS respondents reported that marijuana use alone, without the presence of any other risk factors, often means that an investigation will not be conducted, or it will be treated as lower priority.

Despite these reported practices, none of the states included in the study has a law that specifies differential treatment for marijuana. As noted in Table 4, those states that have laws governing the treatment of SEN, refer to “controlled” or “addictive” substances, which would include marijuana.

Alcohol was another exception identified in the hospital interviews. As previously noted, almost half of the respondents stated that hospitals do not test for alcohol, and one person mentioned that, if alcohol is the only drug present, they do not report it to CPS. Two CPS respondents from different cities indicated that they believe alcohol is not adequately screened for or reported by the hospitals, and one CPS respondent noted that, as with marijuana, cases of alcohol use alone are not always investigated. Again, despite these reported practices, alcohol is included, either generally or explicitly, in five of the six state laws addressing SEN.

In some states, methadone is not reported if the mom is participating in a maintenance program and has no other risk factors. When it is reported in these states, it generally is screened out by CPS unless other risk factors exist.

### ***Relationships between Hospitals and CPS***

Twelve hospital participants, primarily representing two cities, reported that there is a formal, multi-disciplinary task force comprised of representatives from hospitals, child welfare, and, in some cases, other agencies (e.g., drug treatment, courts, community based programs, health and/or mental health departments). These task forces are specifically designed to address system and policy issues related to the treatment of SEN. The CPS respondents in those two cities also mentioned these task forces. Although a few participants from another city mentioned some form of regular group meeting, they were inconsistent in their responses and descriptions, and others from that city (including the CPS participant) were not aware of it.

When asked about their relationships with CPS, hospital workers’ responses varied. Some (about 20%) observed that CPS workers are overworked. In addition, many noted that CPS workers are “under-educated” about SEN and slow to respond, and that CPS agencies are understaffed and have a high turnover rate. One person observed that the local CPS agency is “so overworked that they cannot get a good grasp on the problem” and that there should be more education for CPS workers because “decisions are often made out of ignorance.” Another remarked that CPS is “understaffed, and some workers are so burnt out that they don’t care anymore.”

Some hospital respondents also reported that CPS is inconsistent in its response to cases of SEN, noting significant variation among offices and individual workers. For instance, it was reported that some offices or individuals seem to be easier to work with in that they respond quickly, evaluate cases on an individual basis, and communicate well with the families and hospital staff; whereas other offices tend to be slower to respond, have high turnover rates, resolve cases too quickly without much communication, or are inconsistent in their response to reports. Those from hospitals who expressed unfavorable opinions were overwhelmingly social workers. Only one nurse manager reported an unfavorable opinion: that CPS is understaffed and overworked.

At the same time, about a third of the hospital respondents reported that they have good communication or regular contact with CPS workers or administrators. About 15% of hospital staff reported that they meet at least monthly with CPS staff to review specific cases. Six of ten CPS respondents reported that they meet regularly (e.g., weekly, monthly, or quarterly) with hospital staff.

CPS workers' opinions about their relationships with hospitals also varied. Half of the ten CPS respondents reported that their relationships with hospitals are positive. One noted that the relationships are neutral, and two stated that they vary by hospital. Two had no opinion; one of these does not have any direct contact with hospital staff.

Two CPS respondents from different cities stated that hospitals are inconsistent in testing and reporting. Two others, from one city, noted that relationships with hospitals are strained because the hospitals believe that CPS should accept more cases than they do, and that hospitals seem to be unclear about the role of CPS. As one suggested, "hospitals get upset because we don't respond to all reported cases, but we just don't have the resources to do that, and it's not the law, the policy, or our philosophy. There's a lack of education about what we do."

### ***Linkage with Other Services***

Most of the hospitals included in the study have only one social worker for the labor and delivery unit, and in some places, this worker also covers the neonatal intensive care nursery. Therefore, they have limited time to spend with each patient. Also, as previously noted, the vast majority of identified SEN are reported to CPS, who generally intervenes with the family before the baby leaves the hospital, or shortly thereafter. Thus, hospital social workers typically spend their limited time obtaining services to meet the basic needs of the mother and baby (e.g., baby supplies, housing, food, clothing, transportation, WIC, and Medicaid).

Whereas most hospital nurses and social workers in the study indicated that they provide women with a list of treatment providers, and a few actually make the referrals, many noted that they defer to CPS to make the referrals to treatment programs and to other services. Some also indicated that treatment providers will not accept referrals from hospitals; the women must contact the programs directly. A couple of hospitals in the study have in-house treatment programs to which they refer women.

On the other hand, most hospital participants indicated that SEN are routinely referred for developmental services, and that their families often are referred to community-based programs that address social and environmental issues, including parenting skills. These referrals typically are made by the pediatrician. It also was noted that a large percentage of SEN end up in the specialized nursery where they receive a more thorough developmental evaluation and indicated services.

According to hospital respondents, data collection and follow-up on referrals made by hospital staff are sparse and inconsistent. A few noted that they collect data on the number of women referred to treatment or other services, but most did not; virtually all said that they do not have the time to do any follow-up. An exception is when women or babies remain or return to the hospital for medical treatment. Thus, because SEN often stay in the hospital for longer periods of time or receive ongoing medical care through the hospital, their referrals to specialized services (e.g., developmental services) tend to be monitored more closely by hospital staff, whereas substance use treatment referrals and follow-up are more frequently left to CPS.

### ***Perceived Impact of CAPTA***

Three of 39 hospital respondents (8%) and 3 of 10 CPS respondents (30%) were familiar with the CAPTA amendment regarding SEN. None of the 10 CPS respondents indicated that there had been any changes in policy since the enactment of this law in July of 2004. Eight hospital respondents reported that there had been changes in their hospital's policy and/or procedures since that time, although they were unsure if this was in response to CAPTA or merely coincidental. About half of hospital respondents reported that the policy of reporting SEN has been established for a while so there is no need to alter their reporting policies to be in compliance with the CAPTA legislation. A few hospital respondents reported that CPS seems to respond more quickly than they used to, or take more cases than in the past. However, some respondents expressed concern that CPS is not prepared to handle the increased volume of cases that may come with CAPTA, and that additional community services are crucial to address the growing need. It was further noted that the CAPTA provisions are ineffectual if there is no enforcement or accountability.

### ***Problems with Current Policies or Practices and Participant Recommendations***

Hospital respondents identified the following problems with current systems and practices, and made the corresponding recommendations.

**Insufficient treatment and other services.** The most widely reported problem among hospital and CPS respondents is the lack of sufficient drug treatment programs. Some noted that a mandate to report mothers whose newborns have a positive toxicology test is useless if there is no help available. One participant mused, "Why are users identified if services are not even available? They're scarlet lettering when help is not available. With no services, it seems punitive simply identifying them." Many also noted the lack of sufficient gender-specific programs that allow women to live with their newborns or provide child care for their older children, as well as a lack of inexpensive and free treatment. Many respondents also identified a need for other services such as housing and domestic violence programs. As one CPS worker stated, "It is difficult for a family already on the edge to participate in treatment when other needs are not met."

**Testing bias.** The majority of participants from all disciplines indicated that bias exists in determining who gets tested. For example, poor women and women with no private insurance are more likely to be tested than are women with more financial resources and private insurance. One participant noted that "minorities and poor women are over-represented because private physicians don't report;" and others suggested that there is a bias against people who appear to be disorganized, but with those "from certain ZIP codes or who appear put together, doctors and nurses act like everything is totally fine." Further, some respondents believe that doctors have too much discretion in determining who gets tested. They expressed concern that some physicians are uncomfortable asking their patients for consent to test or informing them that they will be tested, and that some are reluctant to order drug tests for fear of offending their patients or compromising relationships that they have developed with them. Others suggested that doctors are hesitant to do drug tests before the birth of the baby because they fear the pregnant woman will not return. Still others indicated that physicians may not believe that drug use is a problem among their patients, or "if they bring it up, they have to do something about it" which may be beyond their perceived scope of responsibilities. They also may be reluctant if services aren't available or if they are not aware of them. As a result, many respondents expressed concern that hospitals are missing a lot of SEN who should be identified and referred for services.

When asked for a solution, the most common recommendation among hospital workers was to universally test all delivering women, acknowledging the resulting expenses and time constraints. Similarly, a few CPS respondents suggested universal testing in order to reduce bias and identify a greater number of cases. As one hospital respondent noted, a plethora of tests exist for congenital diseases, most of which are very rare; yet we don't routinely test for substance exposure, despite its relatively common occurrence.

Both hospital employees and CPS workers widely suggested an improved testing protocol, either as the next favorable option beyond universal testing or as a first preference. The protocol would outline an established set of guidelines in order to eliminate bias, improve consistency, and decrease discretion. Further, it was noted that women know which hospitals are more lenient on drug testing within a city, and that if every city had a single established set of criteria for screening, this problem would be reduced.

Whereas one CPS respondent noted that if there is suspicion to test a mother, she should be tested even without giving consent, others felt that mothers should give informed consent before being tested. Moreover, several participants expressed concern about "an over reliance on bodily fluids," suggesting that good screenings can be just as effective as toxicology tests. Finally, several participants noted that physicians might be more likely to test and report if they know that services are available for their patients.

**Repeat cases.** Many respondents, from both hospitals and CPS, believe that the needs of families with SEN are being insufficiently addressed as evidenced by the large number of repeat cases<sup>7</sup>. A number of causal factors were suggested. For instance, many hospital respondents mentioned that the current response for pregnant women who are known to be using drugs is ineffective, particularly with no ability to mandate treatment until a child is born and CPS becomes involved. One community provider noted that, although state law requires pregnant women to be counseled about the use of alcohol and other drugs and referred for services, there is no accountability or oversight to ensure that this happens. A few hospital respondents believe that prenatal substance exposure is not addressed punitively enough, and that it should be treated as child abuse and prosecuted accordingly. The majority of respondents, however, believe that mothers need more social and supportive services to reduce the risk of future SEN.

As a response, many participants mentioned the need for services, such as prenatal care and drug treatment for pregnant users, to reduce the incidence of SEN. One discussion group participant summed it up: "It doesn't do anybody any good to come in after birth when the baby tests positive." At the same time, there was a call to intervene intensively with families of SEN to prevent repeat occurrences.

**CPS changes.** A few hospital respondents mentioned that they would like an improved relationship with CPS, including better communication. Others wanted CPS to respond to SEN reports more quickly, treat cases more consistently, provide more services, and do more follow-up with families. At the same time, there seemed to be a level of empathy for CPS workers, illustrated by other suggestions among hospital respondents, including hiring more CPS workers, decreasing their workload, increasing their pay, and increasing their level of training to better prepare them to handle SEN cases.

**Education.** Another common theme among hospital workers, which did not emerge among CPS respondents, was education. Respondents believe there is a need to educate many populations including the following:

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<sup>7</sup> Respondents that noted the common phenomenon of repeat cases did not have numbers to support their impressions; they were purely anecdotal and experiential.

- the community about available help and generally about drug use during pregnancy,
- medical providers about the dangers of using substances during pregnancy and how to identify cases,
- CPS about how to work with SEN and their families, and
- pregnant women and mothers about the implications of prenatal substance exposure.

**DISCUSSION & IMPLICATIONS**

***Focus & Limitation of Study***

Perinatal substance use is a complex issue that impacts many systems and requires a multi-faceted, multi-disciplinary approach. Although it is a problem that starts pre-conception and can continue throughout the child’s life, in line with the CAPTA legislation, we chose to focus on a single point in time—delivery. Whereas this approach produced interesting and useful information, it does not provide a complete picture. It is limited by the lack of information about what happens prenatally, when there is potentially a greater chance of improving the outcomes of the newborn, and what happens after CPS’s initial response to a report of a substance-exposed newborn. Further, by limiting our hospital sample to nursing and social work staff, we missed a critical piece of the puzzle—physicians. Other important players that also could have been included in the sample are drug and alcohol treatment providers and maternal and child health agencies.

Despite these limitations, although there was not necessarily consistent agreement about solutions, several key themes emerged in the identification, reporting, and treatment of SEN. These issues, along with examples of promising approaches and policy and practice implications, are discussed briefly below.

***Testing for Illicit Drugs***

Policies on testing or screening at birth generally are set by hospitals rather than states. Whereas most hospitals in this study reportedly have some protocol for determining who gets tested, the apparent lack of standardization results in differential treatment among hospitals within the same city. Most protocols include an assessment of various factors that trigger a test, most commonly lack of prenatal care and a known history of drug use. However, despite existing protocols, bias appears to influence who gets tested, with a disproportionate number of poor, “disorganized” women of color falling into that category. This leads to inequitable treatment and under-identification of women and newborns in need of services. In response, many hospital social workers expressed a preference for universal testing to eliminate bias, though they generally expressed concern about the associated costs. Further, “a single, positive drug test cannot determine whether a person occasionally uses a drug, is addicted, or suffers any physical or emotional disability

**Promising Practice**

In one study site, the Director of the Mother-Baby Unit in one of the hospitals pulled together various players from the hospital to develop *Guidelines for Obtaining Maternal and Neonatal Urine Drug Screening* for pregnant women and their newborns. The guidelines are to be used for all units within the hospital. Additionally, they were approved by the County Ad Hoc Committee on Child Abuse and Neglect with the expectation that they will be adapted by all local hospitals in order to provide greater consistency among all hospitals in the county.

from that addiction [and it is] not predictive of a person's parenting ability" (Center for Reproductive Rights, 2001, p.7). Thus, in order to eliminate bias and identify women and newborns in need of services, it is imperative for communities to work together to develop screening and testing protocols that are implemented consistently within and among hospitals in any given region.

**Policy and practice implications:**

- Conduct prevalence studies and related research to determine if current screening and testing protocols are adequately identifying women and newborns in need of services.
- Develop statewide or citywide testing protocols to eliminate variations among hospitals.
- Develop or utilize existing screening tools (including verbal screens) that reduce bias, policies that require the use of these tools, and education on how to administer these tools in order to get more meaningful information about a woman's substance use throughout her pregnancy and minimize reliance on toxicology tests at the time of delivery.

***Testing for Alcohol***

Respondents from both hospitals and CPS were in agreement that alcohol use is neither routinely tested for nor reported, and that prenatal exposure to alcohol alone is not typically investigated by CPS when it is reported. However, with the exception of one discussion group with three hospital social workers, this was not identified as a problem. In fact, one hospital-based community provider noted that, even though they are highly trained in identifying fetal alcohol spectrum disorders, they are not seeing as many affected infants as they would expect, given the number of women they know use alcohol during pregnancy.

Although the CAPTA legislation clearly omitted any reference to newborns exposed to alcohol, prenatal exposure to high levels of alcohol has been found to adversely affect developing fetuses (Baer et al., 2003; Day et al., 2002; Goldschmidt et al., 2004; Sood et al., 2001; Willford et al., 2004); and the Centers for Disease Control reports that more than 130,000 pregnant women per year in the United States consume alcohol at levels shown to increase the risk of having a baby with a FASD (Centers for Disease Control, 2003). Yet if newborns do not show the facial dysmorphism of Fetal Alcohol Syndrome, they may go undiagnosed until later when they begin to display developmental, mental, or behavioral problems. Further, based on this study, hospital and child welfare policies and practices suggest that maternal alcohol use is not perceived as placing a child at as great a risk as maternal use of illicit drugs.

Clearly, societal values about the use of alcohol versus illicit drugs plays a role in determining our response to alcohol exposed newborns. Because alcohol use remains legal in this country, there are fewer tendencies to criminalize or otherwise penalize use during pregnancy. However, policies regarding alcohol testing still must reflect the potential medical and developmental impact of prenatal exposure to alcohol, as well as an alcohol abusing parent's capacity to adequately care for a newborn. Thus, the following two questions must be considered: (1) Is screening needed for early identification of newborns prenatally affected by alcohol in order to provide appropriate medical and developmental intervention? and (2) Is alcohol testing needed to identify alcohol-affected newborns in order to report them to CPS for their safety and well-being? Policies and corresponding practices should reflect the answers to each of these questions. For instance, the clear link between prenatal exposure to alcohol and developmental challenges suggests the need to

screen pregnant women and their newborns for alcohol in order to provide necessary medical and development interventions for affected newborns. However, the link between prenatal exposure to alcohol and child abuse/neglect is less clearly documented. Therefore, policies requiring newborns prenatally exposed to alcohol to be reported to child welfare services may be unnecessary, particularly without documentation of other risk factors, unless it is the only way to access services. Then we need to ask what services are needed, and is child welfare the most appropriate agency to provide access to them.

**Policy and practice implications:**

- Commission a major review of the impact of alcohol use during pregnancy on parenting capacity, and develop policies and practices that reflect the findings.
- Develop and utilize verbal screening tools (e.g., 4P's Plus) that more accurately capture the extent of use throughout the pregnancy rather than just at the time of delivery. This may help to determine the extent of in-utero exposure and develop appropriate interventions.
- Develop major educational campaigns to inform pregnant women (and all women of child bearing age) about the potential impact of any in-utero alcohol use on the child.

***Informed Consent***

Women generally are informed when they and their babies are tested for drugs. However, their consent is not always required for their tests, and it is almost never required to test their babies. Great controversy appears to surround this issue, often with legal staff and women's advocates standing on one side and medical professionals on the other. Our study demonstrates that hospital staff seem comfortable testing newborns without parental consent in the name of medical necessity. While this may be true, these tests also are being used as grounds to report mothers to CPS, to remove children from their parents' custody, and, in some cases, to prosecute women (Center for Reproductive Rights, 2000). As evidenced by the lack of consistency among reported practice in this study, the issue becomes even murkier when a woman's consent for her own test is considered. Part of the concern is physicians' willingness and ability to engage women in meaningful discussions about the purpose of the test, the impact of substance use on her and her newborn, and services available to them. Whereas doctors' reluctance to do this may stem from their discomfort in discussing these issues, it also may reflect their concern about limited service availability or their lack of knowledge about existing community services. If doctors turn a blind eye to a problem, they are not burdened, both by time constraints and emotional investment, with trying to connect a mother or pregnant woman with services that too often are not available.

**Policy and practice implications:**

- Educate physicians and nurses (that provide prenatal care and labor and delivery services) on how to engage women in meaningful discussions about substance use, and about available services and resources in the community, both prenatally and at the time of delivery.
- Improve collaboration between hospital physicians, nurses, social workers, and legal staff to develop alcohol and drug testing and reporting policies with which all parties are comfortable and that equally consider a woman's and newborn's rights, the medical necessity of the information provided by a test, and the legal use of the tests.

- Improve collaboration between hospital physicians, nurses, social workers, and legal staff to develop hospital policy for determining strategies for cases where a woman refuses consent, and for exploring alternative ways of eliciting useful information about a woman’s substance use.

### ***Reporting and CPS Response***

For the most part, regardless of state policy or lack thereof, hospitals in this study report virtually all newborns with a positive toxicology test to CPS. Because not all newborns are tested in most hospitals, this may not include all newborns that are exposed. Nevertheless, in most cases, CPS does at least a preliminary investigation of all reports, and they generally do so before the baby is medically discharged.

#### **Promising Practice**

To address concerns about inconsistent responses from CPS workers, the Department of Social Services/Human Services in two study sites established separate units that receive and assess all reports of SEN. The workers and supervisors of these units receive specialized training in substance use and working with substance affected families. They also work closely with referring hospitals, local treatment providers, family drug court, and other community-based programs serving this population. As a result, relationships among these groups appear to be more positive, and practice more consistent. Additionally, in one of these sites, a Newborn Crisis Assessment tool was developed to guide workers in assessing the level of safety and risk, and in determining the impact of substance use on the infant, mother, and family; the strengths and needs of the family; and the services required. This site also has a very active multi-disciplinary Task Force on Drug Exposed Infants that meets regularly to problem solve policy and practice issues related to SEN. The result is a more consistent, comprehensive, standardized approach to serving SEN, along with a certain level of accountability and oversight.

At the same time, many hospital staff report that CPS’s response is inconsistent and depends on the individual worker and the local office to which the report is made. Inconsistency may be the result of a number of factors. First, several respondents noted high turnover of child welfare workers and their perceived lack of knowledge about substance use. Similarly, in almost all the study sites, reports go to the first available worker. Each worker may have different views about and experiences related to substance-using women, which may result in differential approaches to SEN reports. Finally, different offices are under different supervision, which may mean that cases are not handled the same across offices or counties. Along with individual worker or office inconsistencies, more systemic differential treatment also was noted. For instance, several respondents noted that CPS will not accept a report if the baby does not have a positive toxicology test, even if the mother has a positive test or is a known substance user. Many participants felt that the newborn’s test, in and of itself, is an ineffectual means to determine whether or not to provide intervention. As one discussion group participant noted, “We have an over reliance on bodily fluids.”

Additionally, hospitals are less likely to report, and CPS less likely to respond, if the only drug identified is marijuana than if other substances are present. Many respondents noted a relatively high prevalence of marijuana use among delivering women, and most related state laws include all “controlled substances” in their reporting requirements. However, there seems to be a belief, more pervasive in some states than in others, that parental marijuana use generally does not place a child at as great a risk as use of other controlled substances.

### Policy and practice implications:

- Increase consistency in reporting and response through inter-agency coordination, review and oversight of agency policies, and cross-training of child welfare and hospital staff. Consider creating a separate unit to handle all SEN reports.
- Improve protocols for responding to cases of SEN based on some form of structured decision-making (e.g., newborn crisis assessment) that considers parental capacity to care for a newborn.
- Conduct a meta-analysis on the impact of prenatal exposure to marijuana on children's health, and the impact of maternal marijuana use on parenting capacity to inform appropriate policy and practice response.
- Conduct research to determine the long-term impact of reporting and response policies on the child welfare system and on outcomes for these children and families.

### *Prenatal Intervention*

Many participants expressed the need for more prenatal intervention that ideally would reduce the incidence or severity of SEN and, at a minimum, would better educate pregnant women about what to expect at the time of delivery. Currently, several realities challenge this very sensible idea. First, there is a general sense that doctors typically are reluctant to discuss substance use with their patients, either due to their own discomfort discussing the issue or their concern that women will not continue to come in for medical care. Further, many substance-using women do not receive prenatal care, which may be due to a variety of factors, including lack of access, fear of being discovered, or denial about their pregnancy (Lester, Andreozzi, & Appiah, 2004; Ondersma et al., 2000). Third is the perceived dearth of available and appropriate treatment programs for this population. Federal law requires that pregnant women be given priority for drug and alcohol treatment *if* space is available. Whereas this represents an important first step, the inadequate number of treatment programs that accept pregnant women, particularly those already with children, limits its effectiveness. Although beyond the scope of this report, it is worth mentioning the

### Promising Practice

One state has a law requiring all doctors that provide obstetric services to counsel all pregnant patients about the effects of cigarette smoking, and the use of alcohol and controlled substances on perinatal development. The law also requires a program to be created to provide education to doctors caring for pregnant women and providing gynecological care about how to take complete drug histories from pregnant patients; the effects of cigarettes, alcohol and controlled substances on pregnancy; and counseling techniques. Protocols are to be developed based on a "risk assessment profile" to identify high risk pregnancies, and coordinated services are to be offered to a woman identified as having a high risk pregnancy. Doctors must report high risk pregnancies to the Department of Health upon consent of the woman, but this referral cannot be used for criminal prosecution.

In a different state, one hospital universally screens and tests all women for substances at their first prenatal visit and randomly throughout the pregnancy. Any woman identified as using substances is referred to an in-house treatment and family support program that provides coordinated care throughout the pregnancy. The program informs the mother about the impacts of drug use on the fetus, and the potential of child welfare to become involved at the time of birth. The program also provides the labor and delivery unit with full reports on all patients who were referred to the program, regardless of whether they participated.

important work that Dr. Ira Chasnoff and others around the country are doing to educate physicians about how to screen pregnant women for substance use, discuss the potential impact of substance use with their patients, and connect them with appropriate treatment (see Chasnoff et. al, 2005).

**Policy and practice implications:**

- Develop policies that encourage doctors to screen pregnant women for substance use and educate them about the impact of substance use during pregnancy, in order to provide appropriate care for the woman and her newborn; require doctors to participate in training on how to engage women in the discussion in a supportive way; and provide oversight or accountability to ensure that, at a minimum, education is being provided.
- Develop linkages between primary care physicians, obstetricians, and treatment programs to provide continuous, supportive care coordination.
- Consider policies and practice that reflect a harm reduction approach as a strategy for engaging pregnant women in service.
- Develop affordable, accessible treatment programs for pregnant women that can also accommodate their children.

***Substance Abuse Treatment***

This study only reiterated what many in the drug and alcohol field and those in the medical profession largely know: pregnant and parenting women need improved access to appropriate treatment programs. Participants in the study identified a specific need for low-cost and free treatment, and for gender-specific treatment where child care is provided and new mothers are permitted to bring their newborns with them. In many places, this kind of treatment simply is not available, and in many places where it is available, there are long waiting lists for admittance. In addition to treatment, many participants called for more social support services, including housing and domestic violence services. Further, as one participant noted, residential treatment is not always the best or only modality for this population. With appropriate support services, child care, and transportation, outpatient treatment can be equally effective.

**Policy and Practice Implications:**

- Enact a federal program that encourages the development of substance abuse treatment programs designed specifically for pregnant and parenting women and their families.
- Enact a federal grant program that encourages the development of comprehensive social support programs to address the complex needs of pregnant and parenting substance users and their families.
- Encourage the development of family drug courts to provide judicially mandated services, specialized treatment, and close supervision to families affected by maternal substance abuse whose children are at risk of abuse or neglect.

## CONCLUSION

We found that policy, in the form of state law, does not necessarily directly impact hospital or child welfare practice. Whereas it may, and generally seems to, provide some guidance for practice, the lack of accountability or oversight results in inconsistent interpretation and application of the law. This is particularly evident in regard to marijuana and alcohol. Further, it appears that hospitals tend to err on the side of referring more known SENs to CPS when the state provides no statutory guidance, or when it leaves discretion to the providers. That is, even among the four cities in states that do not mandate reporting, the majority of study participants indicated that they report all identified SENs to CPS.

In addition, the state law, or lack thereof, did not seem to predict that a hospital would have a protocol for testing and reporting; indeed, virtually all of the hospital respondents indicated that they do. However, in the survey, we did not distinguish between formal and informal protocols, and we did not receive written copies of the protocols. Therefore, it is unclear how accurate the findings are, although they clearly reflect the perceptions of hospital staff responsible for implementing the protocols. Moreover, the lack of consistency in describing the protocols within and among hospitals in a given city causes concern about the consistency with which they are implemented. At the same time, the presence of an active interdisciplinary council or task force seemed to be associated with clearer, more consistently implemented policies and practices regarding the identification, reporting, and treatment of SEN.

It is still too early to assess the impact, if any, that the CAPTA amendment will have on local or agency policy or practice. Because hospitals in the study cities largely are already in compliance, the expected impact on them may be negligible; however, it is unclear the extent to which these hospitals represent others throughout the country.

CAPTA will likely have more impact on CPS agencies that must have in place appropriate response and support services. This small study, along with ancillary research, suggests that child welfare agencies with a coordinated response (e.g., a specialized unit with expertise in SEN), standardized assessment tools, and close interface with community agencies are better prepared to meet the demands of CAPTA. It may be that Congress needs to go a step further and require states to have these key elements in place. At a minimum, technical assistance in developing a coordinated response and necessary tools may be needed to help states struggling with this issue.

A study of eight urban areas in as many states clearly does not reflect what is happening across the country. Further, this study is primarily based on the opinions of hospital and child welfare staff rather than on hard data or written protocols. Therefore, the findings should be interpreted cautiously. At the same time, the several themes that clearly emerged from the varied group of cities, regardless of state law, provide a better picture of the challenges we face in identifying and addressing the needs of SEN, as well as some promising practices to meet these challenges. More importantly, the study helped to identify and clarify important policy and practice issues that require further attention in order to provide a more consistent, equitable approach to identifying and serving this population.

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**Questions for Nursing Administrators and Hospital Social Work Supervisors**

*Thank you for agreeing to participate in this study. As you know, the purpose of the study is to better understand the policies and practices related to the testing and referral of substance-exposed newborns, and the services available to them. This interview should only take approximately 30 minutes. All information that you provide will remain completely confidential. Neither your name nor the name of the hospital will be linked to the information you provide or identified in any written material resulting from this study. Do you have any questions before we begin?*

Name \_\_\_\_\_ Position/Title \_\_\_\_\_

Hospital \_\_\_\_\_ City \_\_\_\_\_

1. Is your hospital a \_\_\_\_ public (skip to #2), \_\_\_\_ private non-profit, or \_\_\_\_ for-profit organization?
  - (If not public) Does your hospital have any religious affiliation?
    - \_\_\_\_ Yes. What religion? \_\_\_\_\_
    - \_\_\_\_ No.
  
2. Approximately what percentage of your hospital's births are covered by
  - private insurance \_\_\_\_%
  - Medicaid \_\_\_\_%
  
3. Are there formal or informal policies for screening or testing newborns or their mothers for illicit substances?
  - \_\_\_\_ Yes. (skip to #4)
  - \_\_\_\_ No.
    - (If no) Do newborns or their mothers ever get tested for illicit substances?
      - \_\_\_\_ Yes. Please explain. (skip to #5)
      - \_\_\_\_ No. (skip to #5)
  
4. (If yes to #3) What are the policies (e.g., universal, random, based on assessment? determined by hospital, county, etc.)?
  - (If testing and screening are not universal) Who decides which newborns or mothers are screened or tested?
  - (If testing and screening are not universal) On what factors is the decision based (e.g., characteristics of the mother; type, frequency, or time of substance use; prenatal care; physical symptoms)
  - What kind of screening (e.g., 4 P's, medical records) or testing (e.g., urine, blood, meconium, psychosocial assessment) is used?

- At what point(s) in time is this done (e.g., first contact with hospital, at delivery)?

5. Are there formal or informal policies for screening or testing newborns or their mothers for alcohol?

- \_\_\_\_ Yes. (skip to #6)
- \_\_\_\_ No.
  - (If no) Do newborns or their mothers ever get tested for alcohol?
    - \_\_\_\_ Yes. Please explain. (skip to #7)
    - \_\_\_\_ No. (skip to #7)

6. (If yes to #5) What are the policies (e.g., universal, random, based on assessment? determined by hospital, county, etc.)?

- (If testing and screening are not universal) Who decides which newborns or mothers are screened or tested?
- (If testing and screening are not universal) On what factors is the decision based (e.g., characteristics of the mother; type, frequency, or time of substance use; prenatal care; physical symptoms)
- What kind of screening (e.g., 4 P's, medical records) or testing (e.g., urine, blood, meconium, psychosocial assessment) is used?
- At what point(s) in time is this done (e.g., first contact with hospital, at delivery)?

7. Does the hospital collect data on the numbers tested and the outcomes of the tests?

- \_\_\_\_ Yes. (Request the data)
- \_\_\_\_ No.

8. About what percentage of newborns and mothers would you estimate are tested for alcohol or drugs in your hospital?

\_\_\_\_\_

(Interviewer note: If don't know, ask if anyone in hospital might know)

9. Approximately what percentage of those test positive for substances? \_\_\_\_%

10. Are mothers informed that they will be tested?

- \_\_\_\_ Yes.
  - By whom? \_\_\_\_\_
- \_\_\_\_ No. (Skip to 12).

Are mothers informed that their newborns will be tested?

- \_\_\_\_ Yes.
  - By whom? \_\_\_\_\_
- \_\_\_\_ No. (Skip to 12)

11. Is consent by the mother required before she is tested?

- \_\_\_\_ Yes.
- \_\_\_\_ No.

Is consent by the mother required before her newborn is tested?

- \_\_\_\_ Yes.
- \_\_\_\_ No.

12. Are all newborns and mothers with positive toxicology screens reported to child protective services?

- \_\_\_\_ Yes. (skip to #13)
- \_\_\_\_ No.
  - (If no) Approximately what percentage of those with positive toxicology screens is reported to CPS?
  - (If no) How is it determined which newborns or mothers are reported?
  - (If no) Do you conduct any formal assessment of parenting capacity or ability?

13. Are there differences between hospital policies and procedures for different types of substances (e.g., between alcohol and illicit drugs, or between marijuana and cocaine)?

- \_\_\_\_ Yes. Please describe
- \_\_\_\_ No.

14. Please describe what generally happens once a CPS report is made.

- Is the baby held in the hospital when a CPS report is made?
  - \_\_\_\_ Yes.
    - For how long? \_\_\_\_\_
    - Are parents permitted to visit the baby while he or she is being held?
      - \_\_\_\_ Yes.
      - \_\_\_\_ No.
    - How often are babies held beyond medical discharge? \_\_\_\_\_
  - \_\_\_\_ No.
- Does CPS investigate all cases of SEN reported by the hospital?

- \_\_\_\_ Yes.
- \_\_\_\_ No. (do you know approximately what % are investigated? \_\_\_\_%)
- \_\_\_\_ Don't know.

15. Please describe the formal and informal relationships between your hospital and child protective services.

In general, would you say the relationship is positive, negative, or neutral?

Positive Negative Neutral

16. If a newborn or a mother tests positive for substances, or is suspected of being affected by drugs or alcohol, are there any in-house services available for the mother or the newborn?

- \_\_\_\_ Yes. Please describe.
- \_\_\_\_ No.

17. If a mother tests positive for substances, or is suspected of being affected by drugs or alcohol, are there treatment providers to which you refer the mother?

- \_\_\_\_ Yes. Please describe.
- \_\_\_\_ No. (skip to #18)

In general, would you say the relationship between your hospital and community treatment providers is positive, negative, or neutral?

Positive Negative Neutral

17a. Do you have data on the number of mothers referred for substance abuse treatment?

- \_\_\_\_ Yes. (Interviewer request data).
- \_\_\_\_ No. (go to #17b)

17b. Is there any follow-up to determine what happened as a result of the referral?

- \_\_\_\_ Yes. Please explain.
- \_\_\_\_ No.

18. Does hospital staff make referrals to services for infant developmental assessment or services?

- \_\_\_\_ Yes.
  - Please describe. (e.g., What kinds of services? What percentage of kids? Who makes the decision to refer? What is the decision based on?)
  - Do you have data on the number referred?
    - \_\_\_\_ Yes. (Interviewer request numbers or percentages)

- \_\_\_\_ No.
  - Is there any follow-up to determine what happened as a result of the referral?
    - \_\_\_\_ Yes. Please explain.
    - \_\_\_\_ No.
- \_\_\_\_ No. (go to #19)

In general, would you say the relationship between your hospital and infant development programs in the community is positive, negative, or neutral?

Positive Negative Neutral

19. Are there any other community-based organizations that serve moms or babies testing positive for substances to which you refer patients?

- \_\_\_\_ Yes.
- \_\_\_\_ No. (skip to #20)

\*\*\*\*Interview note: Complete the following for each agency.

Name or type of agency \_\_\_\_\_

In general, would you say the relationship is positive, negative, or neutral?

Positive Negative Neutral

Please explain.

20. Is there any kind of perinatal task force or coordinating council in your community?

- \_\_\_\_ Yes. Please describe (e.g., Who serves on it? What function does it serve? How active is it?)
- \_\_\_\_ No.

21. Are you familiar with the CAPTA amendment regarding the reporting of and services for substance-exposed newborns?

- \_\_\_\_ Yes.
- \_\_\_\_ No. (Interviewer, read the brief summary).

22. Have policies or procedures changed at all since the enactment of this legislation, effective July 2004?

- \_\_\_\_ Yes. Please describe.
- \_\_\_\_ No. Do you anticipate any changes as a result of this legislation?
  - \_\_\_\_ Yes. Please describe.
  - \_\_\_\_ No.

23. Do you think there are any problems with the current policies or procedures regarding drug testing, reporting, or provision of services for substance-exposed newborns?

- \_\_\_\_ Yes. Please describe.
- \_\_\_\_ No.

24. What do you think the policies regarding issue of substance-exposed newborns should be? (For example, how should it be decided who is tested, who is reported to CPS, and who is referred for community based services?)

25. Are there other system-wide changes that are necessary to better meet the needs of this population?

*This concludes our survey. Thanks so much for taking time out of your schedule to answer our questions. Do you have any questions at this time? To further enrich our study, we are also conducting focused discussion groups with front line staff of hospitals and CPS agencies. These groups will be conducted via telephone conference call to enable providers from different communities throughout the country to exchange information. We will provide participants with a toll-free number that can be accessed from any phone. Are there any nurses/social workers on your staff that you think would be willing to participate in a 60 minute discussion group on this topic? If so, can I send you announcements to distribute to them, or would you like to give me their information so I can contact them directly? Thanks again! Feel free to call me at \_\_\_\_\_ if you have any questions or other comments.*

### Questions for Child Welfare Services Directors and Emergency Response/Hotline Supervisors

Name \_\_\_\_\_ Position/Title \_\_\_\_\_

City/State/Region \_\_\_\_\_

*Thank you for agreeing to participate in this study. As you know, the purpose of the study is to better understand the policies and practices related to the testing and referral of substance-exposed newborns, and the services available to them. This interview should only take approximately 20-30 minutes. All information that you provide will remain completely confidential. Neither your name nor the name of the agency where you work will be linked to the information you provide or identified in any written material resulting from this study. Do you have any questions before we begin?*

1. Does your agency have specific formal or informal policies for handling hospital reports of newborns prenatally affected by substances?  
 Yes.  No.
  
2. Please describe what generally happens when your agency receives a report from a hospital for a prenatally substance-exposed newborn. For instance:
  - Who decides what action to take?
  - What factors is this decision based on (e.g., characteristics of the mother; type, frequency, and/or time of substance use; prenatal care; physical symptom)?
  
3. Are there differences between CPS policies and/or procedures for different types of substances (e.g., alcohol vs. illicit drugs; marijuana vs. cocaine)?
  - Yes. Please describe.
  - No.
  
4. Is a formal assessment of the mother's parenting capacity/ability conducted as part of the decision-making process?
  - Yes. Please explain.
  - No.
  
5. Approximately how many substance-exposed newborns are reported by hospitals to your agency each year?  
*(Interviewer: if they don't collect this data, ask for an estimate and an explanation for why this information is not collected.)*
  - What percentage of those cases is investigated? \_\_\_\_\_

- In what percentage of those cases is abuse or neglect substantiated? \_\_\_\_\_
- In what percentage of those cases is the child removed from the parent's custody (e.g., doesn't come home from the hospital with the mother)? \_\_\_\_\_
- What are the trends in these indicators over the past 5-10 years (e.g., more, less, etc.)?

6. Please describe the formal or informal relationships between your agency and birthing hospitals in the community.

In general, would you say the relationships are positive, neutral, or negative?

Positive    Neutral                      Negative

7. Does your agency have formal or informal relationships with any treatment providers in the community?

- \_\_\_\_\_ No.
- \_\_\_\_\_ Yes. Please describe.

In general, would you say the relationships are positive, neutral, or negative?

Positive    Neutral                      Negative

8. Does your agency make referrals to agencies for infant developmental assessments or services?

- \_\_\_\_\_ No.
- \_\_\_\_\_ Yes. Please describe. (e.g., What kind of services? What percentage of kids? Who makes the decision to refer? What is the decision based on?)

In general, would you say the relationships are positive, neutral, or negative?

Positive    Neutral                      Negative

9. Are there any other community-based organizations that serve prenatally substance-exposed newborns and their families?

- \_\_\_\_\_ Yes.
- \_\_\_\_\_ No. (skip to # 10).

Interviewer note: For each, ask name or type of agency, environment of relationship, and description.

Name or type of agency \_\_\_\_\_

In general, would you say the relationship is positive, neutral, or negative?

Positive    Neutral                      Negative

Please explain.

10. Are you familiar with the CAPTA amendment regarding the reporting of and services for substance-exposed newborns?

- \_\_\_\_ Yes.
- \_\_\_\_ No. (Interviewer, read the brief summary).

11. Have policies or procedures changed at all since the enactment of this legislation, effective July 2004?

- \_\_\_\_ Yes. Please describe.
- \_\_\_\_ No.
  - Do you anticipate any changes as a result of this legislation?
    - \_\_\_\_ Yes. Please describe.
    - \_\_\_\_ No.

12. Do you think there are any problems with the current policies or procedures regarding drug- testing, reporting, or provision of services for substance-exposed newborns?

- \_\_\_\_ Yes. Please describe.
- \_\_\_\_ No.

13. What do you think the policies regarding this issue should be? (For example, how should it be decided who is tested, who is reported to CPS, what action is taken when a report is received, and who is referred for community services?)

14. Are there other system wide changes that are necessary to better meet the needs of this population?

*This concludes our survey. Thanks so much for taking time out of your schedule to answer our questions. Do you have any questions at this time? To further enrich our study, we are also conducting focused discussion groups with front line staff of hospitals and CPS agencies. These groups will be conducted via telephone conference call to enable providers from different communities throughout the country to exchange information. We will provide participants with a toll-free number that can be accessed from any phone. Are there any screeners or ER workers on your staff that you think would be willing to participate in a 60 minute discussion group on this topic? If so, can I send you announcements to distribute to them, or would you like to give me their information so I can contact them directly? Thanks again! Feel free to call me at \_\_\_\_\_ if you have any questions or other comments.*

**Questions for Discussion Groups with Hospital Social Workers and Nurses**

1. I am a pregnant woman who has used drugs during my pregnancy. I am coming to your hospital to deliver my baby.
  - a. Can you explain what I should expect when I come in to deliver? For instance, will anyone ask me questions about my substance use? If so, who? What kinds of questions will they ask? Will I be tested? Will my baby be tested?
  - b. What will happen if my baby or I have a positive tox test? For instance, will I be reported to CPS? What will this decision be based on (e.g., parenting capacity, type of drug used, my personal characteristics, prenatal care, etc.)? Will I be offered any services on-site or in the community?
  - c. If I am reported to CPS, what will happen next? Will my baby be held in the hospital or taken away from me?
  - d. What will happen if my test is negative (or if I am not tested), but you suspect or I admit that I have used alcohol or drugs during pregnancy?
2. Do you think there are any problems with the current policies or procedures regarding drug-testing, reporting, or provision of services for substance-exposed newborns or their parents?
3. What do you think the policies regarding this issue should be? For example, how should it be decided who is tested, who is reported to CPS, and who is referred for community services?
4. Are there other system wide changes that are necessary to better meet the needs of this population?

**Questions for Discussion Groups with Child Welfare Emergency Response or Hotline Staff**

1. Please describe what happens when you receive a report of a substance-exposed newborn from a hospital? For instance:
  - What kind of information do you solicit?
  - How and by whom is the follow-up action determined?
  - Is a case automatically opened? Case plan developed?
  - If there is an “investigation” or team meeting, what is the time frame and who is involved (e.g., child welfare workers, substance abuse counselors, hospital staff, family members)?
  - Is the child automatically taken into custody?
  - What are these decisions based on (e.g., characteristics of mother, prenatal care, parenting capacity, previous CPS involvement)?
  - Do procedures differ for different types of substances?
  - Are families referred to any community services (e.g., drug treatment, early intervention, family support, public health nurse) in lieu of or in addition to CPS intervention? If so, what kind?
  
2. Do you think there are any problems with the current policies or procedures regarding drug-testing, reporting, or provision of services for substance-exposed newborns or their parents?
  
3. What do you think the policies regarding this issue should be? For example, how should it be decided who is tested, who is reported to CPS, what action is taken when a CPS report is received, and who is referred for community services?
  
4. Are there other system wide changes that are necessary to better meet the needs of this population?

**Questions for Discussion Group with Community-Based Program Staff**

1. Is there any kind of community-wide effort to address issues related to substance exposed newborns from a multi-disciplinary, multi-agency perspective? Please describe how and when it got started, who's involved, how active it is, and what the goals are.
2. Do you think there are any problems with the current policies or procedures regarding drug-testing, reporting, or provision of services for substance-exposed newborns?
3. What do you think the policies regarding this issue should be? For example, how should it be decided who is tested, who is reported to CPS, and who is referred for community services?

Appendix F

Hospital Participants			
City	Hospital	Classification*	Respondents**
1	1	Pu, NP***	2 (SW, NS)
	2	Pu, NP***	2 (SW, NS)
	3	NP	1 (SW)
	4	NP	1 (SW Sup)
2	1	Pu	1 (SW Sup)
	2	NP, Rel	2 (SW Sup, NS)
	3	NP, Rel	1 (NS0
	4	Pu	1 (SW)
3	1	FP	1 (SW)
	2	FP	2 (SW, Perinatal Outreach Coordinator)
	3	NP, Rel	2 (SW, NS)
	4	NP, Rel	2 (SW, NS)
4	1	Pu	1 (SW)
	2	Pu	2 (SW, NS)
	3	Pu	1 (SW)
5	1	NP	1 (SW)
	2	NP	1 (SW)
	3	Pu	1 (SW)
6	1	FP	1 (SW)
	2	Pu	1 (SW)
	3	NP	1 (SW Sup)
	4	NP	1 (SW Sup)
7	1	NP, FP***	2 (SW, NS)
	2	NP	1 (SW)
	3	Pu	1 (Administrative Director)
	4	Pu	1 (NS)
8	1	FP	2 (SW, NS)
	2	NP, Rel	1 (SW)
	3	Pu	2 (SW, NS)
Total	29		39
* Hospitals have 4 classifications: NP = Non-profit; NP, Rel = Non-profit religious; FP = For-profit; Pu = Public			
** SW Sup = Social Work Supervisor; SW = Social Worker; NS = Nursing Supervisor			
*** Respondents from same hospital classified hospital differently			