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ISSUE BRIEF

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Substance Exposed Infants: Noteworthy Policies & Practices

In the 1980s, widespread concern arose in response to the dramatic increase in newborns prenatally exposed to drugs—primarily crack cocaine. Many states developed policies, procedures, and/or programs to address the needs of these infants.* Yet, in the absence of specific federal policy, no national uniformity existed. In fact, state approaches continue to vary considerably, from extremely punitive to more supportive and service oriented. Disagreement about the best approach persists, often with child advocates pitted against advocates for pregnant women, and with civic and constitutional rights at the core of the discussion. As Dr. Barry Lester notes, “A general problem in the field is that policies for pregnant women/mothers may be in conflict with policies for the fetus/child.”¹

In the past couple of decades, we have learned more about effective treatment approaches for women. We also have a better understanding of the impact of prenatal drug exposure on infant and child development, and the powerful role that the environment, early intervention, and

comprehensive services can have on the outcomes for exposed infants and their families. Fueled by this emerging knowledge, the Keeping Children and Families Safe Act (P.L. 108-36) of 2003, which reauthorized the Child Abuse Prevention and Treatment Act (CAPTA), is the first piece of federal legislation that directs states to establish policies and procedures addressing the safety and well-being of infants affected by prenatal drug exposure. It does this through the following two core provisions: (1) a requirement that health care providers notify child protective services (CPS) in the event that an infant is born identified as affected by illegal substances or withdrawal symptoms due to substance exposure in-utero; and (2) the development of a “plan of care” for the affected infant.

These provisions are indicative of a profound and mounting concern by many child advocates that the needs of substance exposed infants were not being adequately addressed. Thus, the intent of the CAPTA amendment is to bring substance exposed infants (SEI) to the attention of the child

* To address this issue, the National Abandoned Infant Assistance Resource Center hosted a national conference, *Substance Exposed Newborns: Weaving Together Effective Policy & Practice*, in October 2005. The focus of this conference was on the needs and circumstances of substance exposed newborns and their families and the presentation of exemplary policies and practices from around the nation. For more about this conference, visit the Center’s conference archive: http://aia.berkeley.edu/training/2005_conference/archive_2005.html.



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welfare, early intervention, and community support systems in order to assess and address developmental issues that may result from prenatal exposure, and to help ensure a safe and stable caregiving environment. The legislation was further designed to ensure that “timely and appropriate” services are made available to these infants.

Given the controversial and often polarized nature of this issue, the CAPTA amendment represents an important, proactive step toward improving services for this vulnerable population. Whereas it guides states in a certain direction and provides strong impetus for change, the law also leaves states with ample opportunity to make policy decisions on a wide range of issues. For instance, the law does not establish a definition of child abuse or neglect. Nor does it suggest, much less require, that any legal action be taken to prosecute pregnant substance users. Further, the law is silent on the issue of intervention with pregnant substance users to reduce the incidence of SEI, the identification of substance-exposed infants, and prenatal exposure to alcohol, which has a documented negative effect on birth outcomes. Moreover, although compliance with the directive is tied to eligibility for federal CAPTA funding, no other penalties for non-compliance were applied, and no additional monies earmarked to finance the expansion of services in the states.

Therefore, policy and procedural challenges remain for states to work out. These include: (1) identifying all substance using women and infants in need of services; (2) ensuring a fair, equitable, consistent and supportive response by the child welfare system; (3) creating access to necessary treatment, family support, and developmental services for those who need them; and (4) intervening earlier to reduce the incidence of SEI and prevent the need for child welfare involvement once the child is born.

This issue brief outlines the relevant policy issues and challenges facing states and presents differing perspectives in terms of both policy and practice that affect pregnant substance users and their infants. It also highlights a few approaches taken by states to

address these issues. The examples are not offered as models of best practices necessarily, but to demonstrate how different states and localities are approaching the complex issue of in-utero substance exposure. Finally, the brief poses some parting thoughts and recommendations for future exploration and research.

IDENTIFICATION OF INFANTS AFFECTED BY SUBSTANCE ABUSE

Although several state statutes (e.g., MN, IA, KY, ND, VA) currently require health practitioners to administer toxicology tests if they suspect prenatal use of illegal substances,² hospitals, clinics, and health centers, rather than states, generally determine testing and screening policies and procedures. As a result, health facilities within any given locality often have different policies, resulting in differential treatment of pregnant women and possible bias against poor, urban women of color.

Largely due to the burden of proof required by courts, most hospitals rely, to varying degrees, on toxicology tests. This is a costly tool that relies on laboratory practices to determine the presence or absence of a substance, typically through a urine sample from the mother and/or infant. The underlying premise is that, whereas mothers may be unlikely to admit having used substances during pregnancy, testing provides evidence of exposure.

Some hospitals practice universal testing of all neonates to eliminate bias and increase the likelihood that those in need are identified. However, not everyone endorses this practice. For example, the American Academy of Pediatrics opposes universal testing, citing concern about women’s rights to privacy and confidentiality and the threat it poses to the trusting relationship between patient and health care provider.³ A universal approach also raises concern that some women will avoid the hospital altogether if they know they will be tested. Thus, most hospitals use targeted testing based on a protocol of triggering



factors and/or individual doctors' discretion. This practice likely reduces costs and concern of hospital avoidance. However, it introduces bias and internal inconsistencies in testing, and it decreases the chance of identifying all those in need of services.

Whether universal or targeted, drug testing is not without fault. For instance, toxicology tests typically only detect recent substance use (i.e., within the past 24-48 hours), and they determine neither the amount nor patterns of use. Further, most health centers routinely test for only certain types of substances; alcohol generally is not included unless the pregnant woman is clearly intoxicated prompting a separate blood test. Additionally, Oxycontin and other prescription drugs that are increasingly abused generally are not detected on a routine toxicology assay. Urine testing in infants is also problematic. The newborn's first urine contains the highest concentration of drugs and metabolites. However, if this first sample is missed, the test is unlikely to come out positive for substances. Meconium tests are more reliable, but also more costly.

Whereas testing remains the primary tool for identification, verbal screening tools are gaining increased attention as a viable alternative. Such methods include self-report, observation, and interview as means of identifying the extent or risk of substance abuse before, during and after delivery. Verbal screening tools may be more effective at determining the duration and quantity of use throughout the pregnancy in order to better identify the full extent of prenatal exposure. Also, through universal screening, interviewer partiality is reduced, as a structured interview guides the practitioner. While some professionals find screening to be a more accurate and equitable method, child welfare agencies and courts often require a toxicology test as legal proof. Further, solely relying on either self-reports or toxicology tests to identify substance abuse during pregnancy may result in under-identification of at-risk infants.

In any case, without clear standards, more opportunity for bias exists, and infants and children most at-risk may be overlooked. Standardized protocols will curb discrepancies

in practice and reduce bias. To ensure consistency and compatibility with child welfare laws and procedures, policies regarding the identification of pregnant substance users and their infants should be developed collaboratively by various staff from hospitals (e.g., risk management, nursing, medical, social services) and across agencies (i.e., child welfare agencies, drug treatment providers, courts).

The following examples illustrate two different states' approaches to testing and screening.

Arizona's Governor Janet Napolitano convened a statewide, multi-disciplinary team to develop a plan for addressing substance exposure among infants. The team included local physicians and representatives from Child Protective Services, Department of Health Services, Indian Health Services, Hospital Social Services, and the local chapter of Academy of Pediatrics. As part of the governor's resulting action plan for reform, in 2005, the state developed a policy that includes drug and alcohol abuse as a factor in determining child abuse or neglect, and developed statewide medical protocols for identifying substance exposed infants and providing appropriate treatment. The goals of this initiative were to effectively identify infants, to standardize screening guidelines for both mothers and children, and to improve the health and well-being of mothers and infants. The following were established as criteria for maternal drug testing: history of drug abuse (past or current) by mother and/or significant others in the home; non-compliance with prenatal care; unexplained poor weight gain during pregnancy; medical symptoms of withdrawal; signs of substance use

or abuse; history of Hepatitis B or C infection or HIV; previous or current history of placental abruption; history of stroke in the mother; and medical non-compliance. Drug testing for the infant is determined by the following conditions: signs of neonatal abstinence syndrome; small head (brain) size; low birth weight; stroke; intestinal blood flow compromise; or a positive drug screen in the mother.⁴ These criteria are similar to those used by many hospitals. The difference is that this protocol is standardized for all hospitals in the state of Arizona, thereby ensuring greater consistency in the treatment of pregnant women and newborns.

In 2005, the Washington State Department of Health, in collaboration with the Department of Social and Health Services, developed Guidelines for Testing and Reporting Drug Exposed Infants in Washington State.⁵ These guidelines are intended to promote consistency in screening, testing, and reporting of substance exposed infants among health care professionals and hospitals. However, while they establish certain standards and specifically discourage testing of infants without evidence of risk indicators, they do not establish a single policy for testing. Instead, the guidelines encourage hospitals to work with various specified parties to develop defined policy in collaboration with local/regional child protective service guidelines. In an effort to minimize discriminatory practice, the guidelines also indicate that testing be based on “specific criteria and medical indicators”, not “clinical suspicion.”

INFORMED CONSENT

Hospital policies and procedures regarding drug testing must address the issue of informed consent. Drug testing for purposes of criminal investigation without the mother’s consent has been ruled by the Supreme Court as a violation of rights covered by the Fourth Amendment.⁶ Therefore, if a positive toxicology test will result in possible legal actions against the mother (e.g., if providers are required to report evidence of drugs in pregnant women to law enforcement), the provider must obtain a specific written consent and discuss possible consequences.

If, on the other hand, the test will be used only to inform medical care and treatment, some maintain that the general consent for medical care that the woman signs upon hospital admittance is sufficient.⁷ In any case, by discussing drug testing with the mother prior to testing, the health care provider is positioned as an advocate on behalf of the family. Specifically, the provider can discuss the nature and purpose of the test, and the possible outcomes regarding the test results, including opportunities and consequences.

Policies regarding newborn toxicology tests also should address consent issues. Infants often are tested without parental consent on the grounds that it is a diagnostic test intended to improve the medical care of the newborn. However, as noted above, this may present an opportunity for the health care provider to educate the mother on the purpose of testing, the effect of maternal drug use on her newborn, and the potential outcomes of the test. For this to happen routinely and effectively, health care providers must receive training on how to engage women in meaningful discussions about these issues.

Washington State encourages open communication between health care providers and the patient, indicating that the providers should serve as advocates for the health of the mother and the infant. As noted in their state guidelines, all women are to be told of drug testing, with a rationale provided in the medical record. They are also to be told about the nature and purpose of the testing, as well as the potential benefits and consequences. If a mother refuses drug testing, this should be noted in the chart and testing should not be completed. However, state guidelines allow for newborn testing still to be done if it is deemed medically necessary and/or if there are maternal risk indicators, and it is consistent with the hospital's justification and process.⁸

CONFIDENTIALITY

Related to consent are issues of confidentiality for both the health care provider and the patient. Health practitioners should be knowledgeable about federal, state and local confidentiality regulations, as well as issues regarding testing for both mothers and infants^{9, 10} They must also understand their responsibility as mandated reporters and have knowledge of their state's laws and regulations regarding the reporting of SEIs.

Federal regulations provide for the confidentiality of patient information concerning alcohol and drug abuse, and federal laws take precedence over state laws, except in cases of child abuse.¹¹ Medical information about an infant is held under the protection of the parent or legal guardian, and cannot be released without their consent. However, laws vary from state to state, and parental consent may not be required in cases of medical emergencies or suspected child abuse, as defined by state law. Therefore, policies, procedures and related

training must clearly indicate what information can be shared, with whom, and under what conditions.

ALCOHOL USE DURING PREGNANCY

Although some state child abuse reporting laws include infants who test positive for alcohol or are diagnosed with fetal alcohol syndrome, procedures and practices concerning SEIs typically target only the use of *illegal* substances. This is also true of the federal CAPTA amendment, which includes no mention of alcohol exposure or its effects on infants. Because alcohol is legal for women over 21 years of age, states cannot criminalize women for its use. Yet, use of legal substances, such as alcohol and tobacco, definitely warrant attention. The effects of heavy alcohol consumption and tobacco use during pregnancy have been clearly associated with poor birth outcomes.^{12, 13, 14} In light of this evidence, and in order to provide appropriate medical intervention, it may be useful to include these substances in the list of drugs routinely tested for at birth. Due in large part to the National Organization on Fetal Alcohol Syndrome and the Congressional Caucus on Fetal Alcohol Spectrum Disorders (founded in 2004), advances are being made in the awareness and identification of infants prenatally exposed to alcohol, and several states (e.g., HI, MD, MN, ME) have a heightened interest in these issues.¹⁵

REPORTING SUBSTANCE EXPOSED INFANTS TO CPS

Prior to the 2003 reauthorization of CAPTA, state policies governed the reporting of SEIs to child protective services. Although federal law now requires health care providers to refer all infants identified as drug affected to CPS, state policy still determines whether or not an official CPS report is required. Currently, fewer than half of the states have laws specifically requiring the reporting of SEIs to CPS at birth.^{16, 17} According to a recent study of



hospital policies and practices, however, most hospitals were found to report infants with positive toxicology screens to CPS, regardless of the state policy governing this issue.¹⁸

State child welfare policies and practices also specify the burden of proof required for a report. For example, some child welfare agencies or courts require a positive toxicology test on the newborn, whereas others may accept a positive toxicology test on just the mother, or a clinical assessment. Additionally, state policy and local practice determine which substances warrant a referral or investigation. For instance, Drescher-Burke and Price found that health care providers are less likely to report, and CPS is less likely to respond, if the only drug identified is marijuana.¹⁹ Furthermore, even where state policies include alcohol exposure or a diagnosis of fetal alcohol syndrome in their definition of abuse, health care providers rarely refer newborns exposed only to alcohol.

Based on recommendations from the National Conference of State Legislatures, states should consider the following points when developing policies to guide the reporting of SEIs to CPS.²⁰

- What effect will the new policy have on the number of reports CPS receives?
- Does CPS have the capacity to respond to the estimated number of reports?
- How will infants' safety and well-being be assessed and addressed?
- What other agencies will be involved?
- Are there interagency protocols in place to ensure a coordinated response?
- What treatment and support services will be provided to the mother and other family members to ensure the safety of the infant?
- If the baby is placed in foster care, what supports and services will be provided to the foster parent and the child?
- What efforts are being made to identify and refer to treatment pregnant women who use drugs or alcohol before they give birth?
- What can be done to ensure that the new policy does not deter women from involvement with the health care system?

As indicated by these questions, it is critical that hospital staff—legal and clinical—work closely with CPS to ensure mutual understanding and consistent implementation of policies. Further, policies regarding reporting should not be established without considering the implication of those reports.

CPS RESPONSE

Ideally, CPS notification of SEIs leads to a greater identification of children at risk for poor developmental outcomes, and greater access to early intervention services. Furthermore, according to the Keeping Children and Families Safe Act, the primary role of CPS is to protect children who may be at risk for future maltreatment at the hands of their parents. Some believe that without a court mandate, it is unlikely that parents will enter substance abuse treatment. Moreover, because substance-affected families often have multiple problems, intensive and involuntary CPS monitoring may be one means of ensuring their children's safety and addressing the family's issues. Currently, about 40% of all states define prenatal substance exposure as child abuse or neglect²¹ and, therefore, potential grounds for terminating parental rights. Further, three states (MN, SD, WI) have statutes authorizing civil commitment (e.g., forced admission to inpatient treatment programs) for pregnant substance users.²²

Critics of this approach argue that CPS intervention may be inappropriate or

unnecessary for some substance affected families, and that a positive toxicology test at birth is insufficient cause for opening a case without other supporting information. Some also believe that automatic CPS involvement may discourage drug using pregnant women from seeking prenatal care and going to a hospital to deliver. Furthermore, infants—substance exposed or not—tend to have longer stays and more frequent re-entry into foster care, which may impede the development of healthy attachment relationships. Finally, as a result of bias in drug testing, such policies lead to a disproportionate number of African American children that are reported and, ultimately, removed from their homes.

Conversely, policies that leave more discretion to the individual worker may also result in inequitable treatment based on worker and/or departmental biases. Differing views among workers and high worker turnover rates also can lead to inconsistent treatment of SEI within and among CPS offices, particularly if poor relationships exist between hospital and CPS staff. As described below, Missouri has taken several steps to standardize assessments in order to minimize inconsistencies and bias in CPS' response to SEI reports. Other states (e.g., FL, MI), with assistance from the National Center on Substance Abuse and Child Welfare (NCSACW), also have developed protocols and guidelines for screening and responding to reports of SEI. These documents and other supporting information are available on the NCSACW website (<http://www.ncsacw.samhsa.gov/ta.asp>).

In Missouri, a specialized unit of the Department of Social Services' Children's Division (CD) is responsible for handling cases of substance exposed and other vulnerable infants. The unit consists of a supervisor and several workers. Referrals are made by physicians or other health care providers following

either a positive toxicology screen or medical documentation of signs and symptoms of substance exposure and an assessment documenting that the child is at risk of abuse or neglect. The special unit receives the referrals directly through its own 24-hour hotline designed for immediate response. Because staff has been specifically dedicated to this unit, hospital personnel have relationships with them, and know what information they need to provide and what to expect when they make a referral. Although not necessarily considered a child welfare report, each referral is treated as an emergency, and a Newborn Crisis Assessment is completed at the time of referral, typically at the hospital before discharge. In addition, a home visit is usually made. The Newborn Crisis Assessment Tool was developed through system reform efforts led by a multi-disciplinary task force. Following completion of the assessment, CD will determine whether opening a preventive case is warranted. If safety of the child is determined to be a concern, CD may make a recommendation for removal of the child. Finally, CD makes referrals to local contract agencies for service coordination for families.^{23, 24}

SUBSTANCE ABUSE TREATMENT AND OTHER SERVICES

The SEI amendment to CAPTA does not address the pervasive and ongoing lack of accessible and available substance abuse treatment options for parenting women. Drug treatment currently only constitutes 15% of the national budget for drug control, treatment and prevention. While this overall budget has increased, the majority of monies have been funneled

towards policing and enforcement, rather than treatment and prevention.²⁵ As a result, treatment options, particularly for women with children, remain extremely limited. Yet, if treatment and other services are not available for the parents, a referral to CPS almost certainly ensures removal of the child from their parent(s)' custody, at least temporarily.

Along with substance abuse treatment, an array of ancillary supportive services must be in place for affected families. These include housing and education/employment services; parenting education; mental health, trauma, and domestic violence services; child care; transportation; and case management to help access and coordinate the many services and agencies. In recent years, family treatment drug courts have emerged as a way to guide parents' compliance with legal and court requirements by taking custody of the child, closely monitoring parents' progress, and providing access to treatment and supportive services.

Rhode Island utilizes Family Treatment Drug Court to address drug treatment for identified pregnant substance users once CPS has become involved. The goal of this program is to help biological parents maintain custody of their children or reunify whenever possible. Working closely with this court, and providing intensive case management and advocacy, the Rhode Island Vulnerable Infants Project has reduced the length of hospital stays for substance exposed infants, reduced the number of such infants entering foster care, and increased the number of reunifications between biological mothers and infants who had been placed out-of-the-home.²⁶

PREVENTION THROUGH EARLY IDENTIFICATION AND INTERVENTION

Any discussion about SEI is incomplete without considering early identification of and interventions with pregnant substance users. Pregnant women who participate in drug treatment have decreased substance use, increased prenatal care, and, ultimately, improved birth outcomes. However, pregnant women who are using drugs are not likely to receive substance abuse treatment. Reasons for lack of treatment range from the unavailability of appropriate programs, to denial or unwillingness on the part of the mother due to fear of punitive measures. Although all states grant pregnant women priority access to drug treatment, there often is insufficient capacity, and the programs may not adequately address the needs of pregnant women, particularly those who already have children.

Similarly, providing pregnant women with education regarding potential effects on both their infant's and their own health may reduce the incidence or severity of substance exposure in infants. In fact, the American College of Obstetrics and Gynecology recommends that all pregnant women be questioned thoroughly about substance abuse.²⁷ However, drug using pregnant women often do not receive prenatal care for many of the same reasons that they do not receive drug treatment.

Most states have begun to take proactive measures to prevent prenatal alcohol exposure by posting warnings about the harms of drinking while pregnant in places that sell alcohol and on alcoholic beverage labels. However, this does not go far enough. The Institute for Health and Recovery (IHR), Dr. Ira Chasnoff's Children's Research Triangle, and others have begun to take further action by urging and training prenatal care providers to educate and screen patients for harmful use of alcohol and other drugs.



Massachusetts' Alcohol Screening Assessment in Pregnancy 2 (ASAP2) Project trains prenatal care providers in the value and use of the 5 P'S screening tool and National Institute for Alcohol Abuse and Addiction's brief intervention model, and works with staff to incorporate this model into their existing framework of patient counseling and education. They also implemented a public education/media campaign to normalize conversations about use of alcohol and other drugs during pregnancy. Finally, the ASAP2 Project developed a training curriculum for prenatal providers on the use of the screening tool, brief intervention, and clinical decision tree/protocols to foster the replication of the ASAP2 model.²⁸

Similarly, with assistance from Children's Research Triangle for eight years, Fresno, CA provides community outreach and education, and professional education about use of alcohol and drugs during pregnancy. Additionally, every pregnant woman is screened using the 4Ps Plus© tool, which includes five questions and takes less than one minute. Women who are not identified as using drugs receive prevention and education, while woman who are identified as users are offered one of five levels of care ranging from brief intervention to inpatient treatment. After three years of implementation, Fresno has reduced alcohol and drug use in pregnancy by 25%.²⁹

The Washington State Department of Health also promotes universal screening for substance abuse among pregnant women, which they recommend as an integrated and routine component of prenatal care services. All women should be screened at least once each trimester, but ideally at each visit. Thus, using state funds, the Perinatal Substance Use Screening Program, an educational outreach activity of the four Regional Perinatal Outreach Programs for the State of Washington, prepares educational materials for physicians and other health care providers to encourage universal screening of pregnant women through interview, observation and self-report. Examples of screening tools that are recommended include the T-ACE, TWEAK, CAGE and 4P's. These can be administered in less than 10 minutes and have been validated for use with pregnant substance abusers. Through activities such as conferences, websites, grand rounds, and in-service trainings, regional trainers deliver educational forums on screening practices. Despite these comprehensive efforts, however, the trainers still had difficulty engaging providers and scheduling education sessions with them. The trainers also encountered providers who felt that they already had adequate knowledge regarding screening or who expressed concern about a lack of treatment options or difficulty with interventions following identification.

Some suggestions to address the challenges faced by Washington State include working with key professional organizations (e.g., American College on OBGYNs) to develop and maintain a standard of care, and identifying physicians who will advocate to change peer practice. Additionally, states must provide ready access to substance abuse treatment and a coordinated system of support services for pregnant women.

FINAL THOUGHTS

SEIs continue to pose significant policy and practice challenges that impact many systems and disciplines. Therefore, the time-worn adage, “It takes a village” still holds true. Multiple partners and agencies must be involved to effectively address this complex dilemma through prevention, intervention, and treatment. Collaborating partners should, at a minimum, include the following: hospitals (legal, medical, social work staff), private physicians, health care management plans, maternal and child health, children and adult mental health, domestic violence agencies, child welfare, drug and alcohol treatment and prevention, schools and special education, early intervention, and family/dependency courts. Further, collaboration must exist on an administrative and policy level, as well as on the direct service level. With comprehensive, coordinated efforts, states can begin to narrow the variations in practices with aims of standardizing screening, testing, and reporting procedures; formulating a cohesive, consistent, and equitable child welfare response; and improving access to appropriate treatment and related support services for pregnant and parenting women and their families.

Some states are further along than others in their efforts to provide a coordinated, comprehensive and systemic approach to assisting families and infants affected by substance abuse. Other states can learn from their experiences and the emerging collection of knowledge and resources. Furthermore, existing mechanisms (e.g., monitoring,

regulatory reviews) can be utilized to raise awareness and influence change related to SEIs. For instance, state and federal administrators can be encouraged to highlight referrals and outcomes of SEIs in the second round of the Children and Family Services Review process. Because prenatal substance use is such an emotionally charged and polarizing issue, it is imperative that policies and related practices be based on data (e.g., prevalence, referral, treatment outcomes). Armed with accurate information about the scope of the problem and evidence about effective interventions, informed policy and practice can be developed to prevent, identify, and improve the outcomes of substance exposed infants.

*“We have made tremendous strides in the past 20 years when it comes to understanding drug addiction and treatment. We have the opportunity to keep families together today in ways that were not possible only a few years ago. We should be optimistic about our ability to reduce addiction and save future generations of children though treatment. Failure to take advantage of what we have learned is not only a missed opportunity, but a giant step backward.”*³⁰

— Barry Lester, PhD

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