REPORT OF THE
SECRETARY OF HEALTH AND HUMAN RESOURCES
AND THE
SECRETARY OF EDUCATION ON

# The Perinatal Drug Exposure Task Force

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA


# HOUSE DOCUMENT NO. 44

COMMONWEALTH OF VIRGINIA
RICHMOND
1992

**Task Force on Perinatal Drug Exposure**

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House Bill 1602
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## Executive Summary

For most women, pregnancy is a time of intense joy, pride, anticipation, and excitement. However, for the increasing number of women who use alcohol and other drugs throughout their pregnancies, the birth of a child can be a time of great despair with, too often, a tragic outcome.

Pregnant women who use alcohol and other drugs risk their infants' normal health and development. These substances cross the placenta during pregnancy and can cause a host of adverse effects on the newborn including growth retardation, mental retardation, and developmental disorders. In addition to pregnancy complications, substance abuse increases the risk of poor maternal-infant relationships. The addicted mother typically leads a disorganized, chaotic life which is not at all conducive to providing predictable and positive experiences that newborns require to develop normally.

Addiction to alcohol and/or other illicit drugs is a complicated illness that causes severe problems in every area of life. Seldom does an individual become addicted to a single illicit drug. Most often individuals who abuse illicit substances use them in combination with each other and with alcohol and cigarettes. The problems presented by drug addiction are intensified and compounded when the addict is pregnant. Perinatal addiction exacerbates the usual risks already associated with pregnancy and child birth.

The media has focused significant attention on the problems and challenges of drug-exposed infants. Virginia is not immune to these challenges. The Department of Medical Assistance Services found that 3,248 women screened for high risk pregnancies through the BabyCare Program in 1991 had problems with drug, alcohol, and/or tobacco use. A 1990 study conducted in Florida found drug use among private obstetric patients and those receiving public health services to be about the same. The problem crosses all social and economic groups.

Because of growing concern about the impact of perinatal substance abuse, the 1990 General Assembly created a joint subcommittee to study the problem in Virginia. In 1991, the General Assembly requested (through House Bill 1602 and House Joint Resolution 388) that the Secretary of Health and Human Resources and the Secretary of Education convene a task force to recommend appropriate interagency and interdisciplinary approaches to provide prevention, early intervention, and treatment services for drug-exposed children and their families. The task force was specifically charged with addressing identification of drug-exposed children and their families, hospital discharge planning, the monitoring roles of service providers, interagency collaboration, model programs, data collection, and training needs.

At the outset, the task force adopted a general philosophical approach that laid a framework for later discussions and recommendations. Central to this approach is the belief that the Commonwealth should be sensitive to the complex medical and social issues associated with drug dependency and perinatal drug exposure. Punitive and excessively bureaucratic responses to the problem should be avoided.

The task force affirmed that regular prenatal care plays a dramatic role in effectively reducing the neonatal costs of maternal cocaine use. In one study, estimated neonatal costs for infants born to cocaine-using women without prenatal care exceeded $6,000 while the costs for infants whose cocaine-using mothers had received prenatal care were less than $3,000.

Altogether, the task force's recommendations represent a continuum of intervention and treatment designed to identify substance-abusing women and their children early, link them with appropriate services, collect information about their demographics, needs and the cost of services, and prepare professionals to better address their clients' needs.

The recommendations of the task force follow. They are described in greater detail in corresponding sections of the report.

Identification:

1. Procedures for taking medical histories should specifically include questions about substance abuse. Toxicology tests are not reliable when used solely at birth or in isolation of other detection tools.

2. Health care practitioners should be required to establish protocols that will ensure that they elicit information about drug use while the patients' medical history is being recorded.

3. Professional associations should encourage their members to use appropriate medical history screening processes.

4. When necessary and appropriate, the screening should be followed with a more extensive substance abuse evaluation.

Hospital Discharge Planning:

1. Hospitals should establish protocols for discharging women who are known to have abused drugs during pregnancy and their infants so they will receive referrals for appropriate services.

2. Written discharge plans should be provided to the patients and appropriate professionals who will be involved with the patients' follow-up care.

3. Postpartum, substance-abusing women and their infants should receive priority attention when referrals for services for services are made, and service agencies should pursue all appropriate means to assure the family receives an evaluation and follow-up care.

Monitoring:

1. Follow-up for both substance-abusing mothers and their infants should occur throughout the clinical treatment process as recommended in the discharge plan or any later plan prepared by agencies involved in the treatment program.

2. Follow-up responsibilities should cease when the child is two years old, unless an agency's treatment plan indicates otherwise.

Interagency Collaboration:

During their pregnancies and following their births, substance-abusing mothers may need additional resources in the form of housing, child care, transportation, or other supportive services. Coordination among providers of these services is essential to meet the families' needs as well as to make optimal use of the community services available.

1. Communities should have the autonomy to try different methods of coordinating services and should strive for flexibility.

2. Collaborative interagency efforts should be thoroughly evaluated to provide reliable data on the benefits of programs and the gaps in services.

3. The Community Services Boards should develop protocols to give priority for substance abuse treatment services to pregnant, substance-abusing women.

4. Substance abuse treatment facilities should also be required to develop similar protocols.

5. The Commissioner of Insurance should evaluate both the availability of insurance coverage for substance abuse treatment and recent trends in coverage.

Data Collection:

Collecting data about substance abuse and perinatal drug exposure at the state level is critical for two reasons: policy decisions and resource allocation.

1. The Secretary of Health and Human Resources should designate an agency to serve as a clearinghouse for pertinent data. The agency should prepare an annual report for the Governor and the General Assembly that provides a picture of the problem in Virginia and includes data on the prevalence, costs, and the extent of state and local efforts to address the problem.

2. To collect information on the prevalence of perinatal substance abuse and drug exposure statewide, the confidential portion of the birth and fetal death certificates should be revised to require information about the types of drugs used, the frequency of use, and the source of insurance coverage.

3. Agencies that provide or finance services should modify their data collection systems to improve their ability to gather relevant information.

4. Every service-providing system should monitor treatment costs to evaluate the impact of treatment and the cost benefits.

5. To continue high standards of care, the Virginia Obstetrical and Gynecological Society should encourage the use of standardized antenatal medical records that include a medical history screening tool for determining if patients have used or are using drugs. Medical records that are designed to include this information routinely would greatly assist in identifying and capturing data on substance-abusing women.

Training:

1. Training should be readily available to implement the recommendations for screening, discharge planning, making referrals, and providing services to pregnant, substance-abusing women and their children.

2. Training should be coordinated and incorporated into the variety of existing educational forums.

## Perinatal Drug Exposure Task Force

## Recommendations Requiring Legislative Action

Statute

1. Every health care practitioner in Virginia should be required to establish and implement a protocol whereby pregnant women and infants are screened for substance abuse and drug exposure via routine procedures for taking medical histories. The medical history screening should include an assessment of the need for treatment and services.

2. Every hospital should be required to establish and implement a protocol for written discharge plans for both women who are known to have abused substances during pregnancy and their infants so they will be assured of referrals to appropriate services. The discharge planner should discuss the plan with the patient and document referrals.

Resolution

1. Professional health care associations should encourage the use of appropriate procedures for taking medical histories to determine substance abuse among pregnant women. To maintain high standards of care, the Virginia Obstetrical/Gynecological Society should encourage the use of standardized antenatal medical records that include an updated medical history screening instrument for identifying substance-abusing women.

2. Agencies should designate pregnant, substance-abusing women and their children a high priority and should coordinate services and programs accordingly. These agencies should periodically evaluate their efforts to coordinate and collaborate on services for pregnant, substance-abusing women and their children.

3. The Community Services Boards should develop protocols to give priority to pregnant, substance-abusing women for substance abuse treatment services. The Department of Mental Health, Mental Retardation and Substance Abuse Services should develop a model protocol for the Community Services Boards and review each Board's protocol to assure that it meets the objective.

4. Every substance abuse treatment facility licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services should be required to develop protocols to give priority to pregnant, substance-abusing women.

5. Anecdotal evidence suggests that insurance coverage for substance abuse treatment is decreasing dramatically or being eliminated. The Commissioner of Insurance should evaluate both the availability of insurance coverage for substance abuse treatment and recent trends in insurance coverage for substance abuse treatment and report his findings to the legislative subcommittee.

6. The Secretary of Health and Human Resources should designate an agency to be the clearinghouse for data regarding perinatal substance abuse and drug exposure. The responsible agency should prepare an annual report for the Governor and the General Assembly that provides a picture of the problem of perinatal substance abuse and drug exposure in Virginia. The report should include the prevalence, costs, and the extent of state and local efforts to address the problem. Agencies that participate in the development of the report should review the data annually to ensure the most relevant information is being collected. Responsibility for preparing the annual report should cease five years from the date of the initial report unless the General Assembly designates otherwise.

7. The following efforts should be undertaken to improve and expand techniques for collecting data regarding perinatal substance abuse and drug exposure.

   - The High Priority Infant Tracking Pilot Program (Richmond and Petersburg), administered by the Virginia Department of Health, should include substance abuse treatment for parents as an item for tracking. When the program becomes statewide, referrals for services should be reported to the state health department at the time of enrollment as well as in regular follow-up reports.

   - The Virginia Department of Health should explore ways to correlate data from the High Priority Infant Tracking System and VaCARES with the state vital records system.

   - The Department of Mental Health, Mental Retardation and Substance Abuse Services should require that community services boards report the number of pregnant women who are receiving substance abuse services. The expanded data collection system should be operational by July 1, 1993.

   - The Department of Medical Assistance Services should determine and implement ways to better assess and record the substance abuse treatment needs of participants in the BabyCare Program.

- The Department of Social Services should pursue ways to collect data on:

    - the number of child abuse and neglect reports filed that involve substance abuse in the home

    - the number of foster care placements due to parental substance abuse

- Every service-providing system should monitor substance abuse treatment costs for pregnant, substance-abusing women to evaluate the impact of treatment and the cost benefits.

8. Training about substance abuse should be more available and accessible.

- Professionals in the fields of health, mental health, social services, education, law, early childhood education and religion should have a basic understanding of substance abuse and its ramifications.

- Private and public agencies at the state and local levels should make appropriate personnel available to conduct and receive substance abuse training, e.g. orientation programs for new employees.

- Graduate school programs for the professions identified above should incorporate into their core curricula basic information about substance abuse, its ramifications, and treatment strategies.

- Regulatory boards that administer licensing and certification exams for health, mental health, and other appropriate professions should incorporate questions about substance abuse into their exams.

- Continuing education programs for the professions identified above should regularly offer units on substance abuse. University continuing education offices should assist in efforts to develop and make available substance abuse training programs.

- Professional associations with members in the professions identified above should offer training about substance abuse to their members.

Budget Amendment

1. Fund additional model programs of interagency collaboration for pregnant, substance-abusing women (e. g., Project LINK).

2. Fund a statewide program to amend the confidential section of the birth and fetal death certificates to collect data regarding maternal drug history and the source of insurance coverage.

3. Fund training programs for health professionals and hospital personnel to assist them in developing and implementing appropriate, effective protocols for substance abuse screening and discharge planning.

4. Fund the enhancement of the Community Services Boards' data collection system to collect information on the number of pregnant women who receive substance abuse services.

5. Fund the statewide distribution of a standardized medical record to assist health professionals in assessing substance abuse among their patients and collecting uniform data.

6. Fund perinatal substance abuse resource centers to provide training and technical assistance.

7. Fund substance abuse training programs for professionals in the fields of health, mental health, social services, education, law, child care and early childhood education.

8. Fund outreach programs designed to locate pregnant, substance-abusing women who may need services.

## General Philosophical Approach

Over the last several years, concern about the prevalence of substance abuse during pregnancy has increased dramatically. Use of alcohol, cocaine, marijuana, heroin, and other drugs during pregnancy has been documented in urban, rural, and suburban areas. Women of all socioeconomic levels abuse these substances; many will not stop when they become pregnant.

Regular prenatal care is necessary to monitor the health of every pregnant woman, but it is especially critical for pregnant women who are abusing chemical substances. For a variety of reasons, these women may not volunteer information about their drug use to health care providers. Any efforts to assist them must acknowledge the complexities of their dependence while persistently encouraging health care and substance abuse treatment options in a non-threatening manner.

For pregnant, substance-abusing women, the threat of punitive action can be a serious deterrent to seeking prenatal care. Women who think they will immediately be reported to child welfare officials may choose to abstain from obtaining any medical attention during their pregnancies. A recent study indicates that prenatal care is effective in reducing the neonatal costs of maternal cocaine use. Estimated neonatal costs for infants born to cocaine-using women without prenatal care exceeded $6,000 while the costs for infants whose cocaine-using mothers had received prenatal care were less than $3,000. Research conducted at the Medical College of Virginia shows that substance-abusing women who received regular prenatal care and substance abuse treatment have delivered appropriately grown, healthy babies.

Current child abuse and neglect laws in Virginia do not include use of drugs during pregnancy as an indicator of abuse or neglect. Any evidence of statutory abuse or neglect of an infant while in the care of a substance-abusing mother, however, should be reported and investigated promptly. The task force does not recommend changes to these laws.

It is essential that the policies of the Commonwealth facilitate access to treatment and prenatal care. Priority should be placed on prevention, education, and early identification.

**Recommendations**

1. The Commonwealth should be sensitive to the complex medical and social issues associated with drug dependency and perinatal drug exposure and should avoid punitive or excessively bureaucratic approaches.

2. Detection of substance abuse should be the beginning of the identification process and should lead to a positive approach.

3. The task force opposes criminal prosecution or coercive actions taken solely on the basis of drug use during pregnancy.

4. Substance abuse during pregnancy should not be the sole factor in determining child abuse.

5. Personalized education, clinical services, and social services should be integral parts of the treatment and prenatal care provided to pregnant, substance-abusing women.

6. The General Assembly should endorse and support state efforts to coordinate the prevention and treatment of substance abuse.

# Identification

## Purpose

Identification of substance abuse should be considered a routine part of every pregnant woman's prenatal care. Health care providers need to know about their patients' family history, diet, chemical substances in order to anticipate complications and offer responsive, appropriate health care. While the patient may not take steps to change her substance abuse habits, the health care provider can take her substance abuse into account when developing her prenatal treatment plan. A plan for preventive care, in the form of regular prenatal visits, good nutritional practices, and associated treatment recommendations, may overcome the detrimental fetal effects of her substance abuse.

Identification of pregnant, substance-abusing women also provides a window of opportunity for substance abuse counseling. When informed about the implications of their drug use, pregnant women sometimes feel more motivated to pursue substance abuse treatment if they know it may improve the future health of their babies.

Ideally, early identification during the prenatal period would lead to an assessment of psychosocial needs, e.g., housing. Advance planning for housing needs before the baby is due enhances the likelihood of locating secure living arrangements for the mother and infant upon their release from the hospital.

Following birth, identification of drug-exposed infants is important for assessing physical or developmental disabilities that may require early intervention services.

Finally, identification plays an important role in documenting the extent of the problem and consequently the need for policies and resources to address the problem.

## Methods

### A. Medical History Screening

Regular procedures for taking medical histories offer an excellent opportunity for early identification of substance abuse. Health professionals use medical history screening tools, usually a series of questions, to elicit information about the types of drugs used, the history and frequency of use, and any perceived physical, psychological, or social side effects. If drug use is indicated, a trained substance abuse professional may administer a thorough evaluation which consists of more precise questions and discussions regarding drug use.

B. Toxicology Tests

While often mentioned as a tool for determining substance abuse, toxicology tests may only verify drug use for periods as brief as the previous 48 hours. When used solely at birth or in isolation of other tools, they are not reliable. If health practitioners are going to employ testing as a detection tool, they will gain the most reliable results of patient drug use by testing randomly throughout pregnancy.

Optimally, toxicology tests should be used in conjunction with a medical history screening tool. Toxicology tests are expensive, and regular use of them can increase health care expenses dramatically. Task force members with expertise in this area report, however, that once medical history screening practices are established and patients know what to expect, regular questions regarding drug use may preempt the need to verify self-reported usage with a toxicology test.

## Definitions

To successfully identify perinatal substance abuse and perinatal drug exposure, standard definitions would be useful. Perinatal substance abuse can be defined as maternal use of licit or illicit drugs including alcohol during pregnancy. Drug use may be determined through self-reported information or laboratory tests.1 Drug-exposed children can be identified by the mother's use of drugs during pregnancy, the detection of drugs at birth through toxicology tests conducted on either the mother or the infant, or a diagnosis of drug withdrawal syndrome in either the mother or the infant. Drug exposure does not necessarily indicate physiological or developmental problems.

## Recommendations

1. Drug detection should not be based solely on a urine toxicology test.

2. Every health care practitioner in Virginia should be required to establish and implement a protocol whereby pregnant women and infants are screened for substance abuse and drug exposure via routine procedures for taking medical histories.

3. Professional health care associations should encourage the use of appropriate medical screening processes for all pregnant women.

4. The medical history screening should determine the need for a specific substance abuse evaluation.

5. Where necessary and appropriate, an evaluation should be followed with a treatment plan, i.e., a needs assessment.

6. People have the choice to accept or reject medical treatment.

7. Sanctions should not be imposed for failure to follow a treatment plan.

8. Any actions to detect substance abuse or its effects should have a specific purpose, e.g., research, data collection, or treatment.

## Hospital Discharge Planning

The hospital discharge planning process serves as a vehicle to link patients departing the hospital to appropriate community services. Plans vary from a single referral for medical treatment to a multidisciplinary strategy that addresses health and social needs. Both hospital and community resources may be identified for the patient. Discharge plans are sometimes written but most often oral. They may include family members who will assist the patient after she leaves the hospital.

While every hospital has some form of discharge planning, each has its own method for preparing and implementing the plan. Some hospitals use a multidisciplinary team of health professionals while others employ designated discharge planners who personally review charts and consult individual practitioners before making referrals.

Hospital discharge planning is especially important for drug-exposed infants and their mothers. When infants are identified at the hospital with drugs in their systems or their mothers are known to have used drugs during pregnancy, a unique opportunity exists to focus on health and psychosocial needs of the family. In these cases, hospitals can provide a vital link to services in the community through the development of a plan that ties the patients to specific agencies or programs.

As envisioned by the task force, hospital staff entrusted with the responsibility for discharge planning for postpartum, substance-abusing women should identify the needs, discuss recommendations with the patient, and make appropriate referrals. When making the referrals, the discharge planner should note the high priority status and document her contact with the referral agencies. The planner should keep the patient informed of her efforts to implement the discharge plan.

Constructing viable, comprehensive plans for postpartum women and their newborns within a swiftly changing medical environment is very difficult. Women typically remain in the hospital only 24-48 hours after delivery. Such quick stays leave very little time to conduct a thorough study of patients' needs regarding substance abuse before making contacts for follow-up services. Because hospitals must attend to the needs of the patients within their walls, they cannot and should not be responsible for the actions of patients who have been released.

It is to the hospitals' advantage to establish protocols that prescribe a routine procedure for assessing needs, contacting community agencies, and documenting the contact for future reference. Once the hospital has made a referral to a local agency, the agency should assume the responsibility for following up if the woman does not keep her appointments. Hospitals should be given the flexibility to draw on existing systems and resources for their discharge planning procedures.

The increasing cost of health care requires prudent consideration of actions that may ultimately contribute to higher costs. The following recommendations reflect the task force's sensitivity to these concerns while reinforcing the vital role hospitals play as a key link to services for drug-exposed infants and their mothers.

**Recommendations**

1. Every hospital should be required by law to have a protocol for discharging both women who are known to have abused substances during pregnancy and their infants so they will be assured of referrals to appropriate services.

2. Each woman who is known to have abused substances during pregnancy and her infant should receive written discharge plans that address medical and psychosocial needs and are coordinated to provide referrals for appropriate treatment and services.

3. Pediatricians, obstetricians, and other health care providers should contribute information for the discharge planning process as necessary and appropriate.

4. When the hospital discharge planner deems appropriate, information about the mother and infant should be shared with the pediatrician so follow-up care will be provided.

5. If there is a history of substance abuse, the infant should be linked to services and tracking systems based on his/her developmental problems or disabilities, e.g., coordinated, comprehensive early intervention services for infants and toddlers with disabilities and their families as described in Public Law 99-457.

6. Hospitals should contact the local department of social services during the discharge planning process if a need for family-oriented prevention services is identified.

7. If the agency to whom a referral is made determines that the mother of a drug-exposed infant is not following the discharge plans and that her failure to follow the discharge plan is endangering the infant's health, the agency should contact the child protective services unit of the local department of social services.

8. Professionals engaged in the screening, evaluation, treatment, or discharge planning processes should make every effort to refer the mother and child to appropriate services and assist them in gaining access.

9. Referrals from discharge planners regarding postpartum, substance-abusing women or their children should receive priority attention.

10. The discharge planning process should involve, to the extent possible, the father of the infant as well as members of the patient's extended family who may participate in the follow-up care for both mother and infant.

## Monitoring

Monitoring or "follow-up" assures that various services are delivered as necessary.

Pregnant, substance-abusing women may be monitored to ensure that they keep appointments for medical care and gain access to necessary services. It must be remembered, however, that the patient or client has a legal right to refuse medical care or treatment for herself.

The purpose of monitoring drug-exposed children is to provide medical care and appropriate services, identify developmental disabilities, and intervene early to protect children from physical or mental harm. If the child of a substance-abusing woman needs but is not receiving services, the agencies providing the services have a responsibility to refer the mother to the local department of social services for appropriate actions.

Through discharge plans and other treatment recommendations, postpartum women may receive referrals to community agencies or services. When a postpartum, substance-abusing woman and her child are referred to a local agency, the agency should follow up to resolve any problems in gaining access to the agencies' services. The agency should continue to do all that is possible to assure that the family receives an evaluation and appropriate care. Each service-providing agency (i.e., health departments, community service boards, social services departments) has an existing system through which monitoring can occur.

Such efforts, in the long run, can save the Commonwealth money. Monitoring of health concerns can prevent later health care problems thereby lowering medical costs. Early and periodic identification and intervention for children at risk for developmental disabilities may reduce the need for disability assistance. Foster care placements and payments may also decline when families are provided with parenting education and other family preservation services.

### Recommendations

1. When postpartum, substance-abusing women and their children are referred to a local agency, that agency should be required to pursue all appropriate means to assure the family receives an evaluation and follow-up care.

2. Each service-providing system should monitor the clients and patients in its care.

3. Adequate resources should be available to accomplish follow-up activities.

4. Follow-up for both substance-abusing mothers and their infants should occur through the clinical treatment process as recommended in the discharge plan or any updated agency plan.

5. Follow-up responsibilities should cease when the child is two years old, unless an agency's treatment plan indicates otherwise.

## Interagency Collaboration

By definition, women who are both pregnant and abusing drugs need at least two types of services: prenatal health care and substance abuse treatment. Pregnant, substance-abusing women are much more likely to take advantage of these services if they are available in their communities. Substance abuse treatment programs, in particular, are in great demand. The lack of community treatment programs for women must be addressed immediately to help them receive the services that will prevent perinatal drug exposure.

A corollary issue is the availability of insurance coverage to pay for substance abuse treatment. Without insurance coverage, pregnant, substance-abusing women face severe financial limitations that prevent their access to treatment they need and want. Anecdotal evidence suggests that insurance coverage for substance abuse treatment is decreasing dramatically or being eliminated.

During their pregnancies and following the births, substance-abusing women may need additional resources in the form of housing, child care, transportation, or other supportive services. Coordination among the providers of these services is essential to meet the women's needs as well as to make optimal use of the community services available.

Coordination can improve the delivery of services, particularly when pregnant, substance-abusing women have multiple needs. If providers of health care and substance abuse treatment are familiar with one another's services and agree to confer on cases involving pregnant, substance-abusing women, the likelihood is greater that specific problems or complications will be identified early and addressed. If all service professionals in contact with clients who may be pregnant or postpartum substance-abusers understand the roles others play, they will be in a better position to make referrals, provide follow-up services, and communicate to the client the importance of maintaining a good program of care.

Through coordinated and collaborative efforts, service providers can also address clients' needs more efficiently. Some information acquired during the initial assessment may be shared, thus reducing the need for multiple intake procedures. Similarly, when clients can access several services in the same location, they do not have to spend time traveling to and from numerous offices.

The task force identified twenty core services that should be available to all pregnant, substance-abusing women in their communities. The task force noted that three other services are important and should be accessible when needed or requested (see Attachment A).

While some are designed to meet basic needs (health care and social services benefits), others are necessary to ensure the client can get to the service (transportation and child care). Still others do not routinely come to mind but are particularly significant for the well-being of the mother or infant. For example, women who suffer from a calcium deficiency while pregnant or lactating need access to dental care to prevent deterioration of their teeth.

In many cases, these services already exist in localities albeit to varying degrees. Not every pregnant, substance-abusing woman requires all of the services, but most require more than one. Localities must consider their own demographics in planning coordinated approaches and consider ways to augment the services that appear to be in greatest demand.

"Project LINK" is one interagency model that incorporates a majority of the identified core community services. Funded by the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Governor's Drug Policy Office, Project LINK began operation on July 1, 1991, in five sites: Charlottesville; Fredericksburg; Newport News; Roanoke; and Virginia Beach. The model involves the local departments of social services and health, community services boards, and cooperative extension agencies to provide prevention, public education, early intervention, treatment, and support services.

Project LINK operates on the premise that many localities already have the basic service components to meet the multiple needs of pregnant and postpartum women and their children but lack the mechanism to join the service systems in collaborative efforts. Sites were chosen, therefore, for the localities' current ability to coordinate programs and services. State funding allows the localities to hire a full-time systems coordinator who will assure appropriate and timely cross-agency referrals, determine the best utilization of available community resources, identify gaps in services, and serve as a means to coordinate service delivery and follow-up. Clients will be followed up to two years after birth. The Department of Mental Health, Mental Retardation and Substance Abuse Services will coordinate an external evaluation of the process and outcomes. At the initial stages, Project LINK appears a promising approach to interagency coordination.

Two final points should be noted. First, while the majority of the task force's discussion focused on women, children and families who receive services through public sector agencies, the task force agreed that collaboration should occur among public and private providers. Second, references to public systems should not be construed to apply only to indigent clients since many public health, substance abuse and other services are available without income restrictions.

**Recommendations**

1. Accessibility to the core community services identified by the task force should be maximized for pregnant, substance-abusing women according to local demand and demographics.

2. Pregnant, substance-abusing women should receive priority treatment from service providers.

3. The community services boards should develop a protocol to give priority to pregnant, substance-abusing women for substance abuse treatment services. The Department of Mental Health, Mental Retardation and Substance Abuse Services should develop a model protocol for the community services boards and review each community services board's protocol to assure that it meets the objective.

4. Every substance abuse treatment facility licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services should be required to develop a protocol to give high priority to pregnant, substance-abusing women.

5. The Commissioner of Insurance should evaluate both the availability of insurance coverage for substance abuse treatment and recent trends in insurance coverage for substance abuse treatment and report the findings of this study to the legislative subcommittee.

6. Programs and services should be coordinated to provide a continuum of appropriate care and attention.

7. Coordinated service systems should strive for flexibility in order to attend to the needs of clients at varying stages of pregnancy.

8. Communities should have the autonomy to try different approaches to coordinating services.

9. Methods of interagency coordination will necessarily vary by community but may include the following:

   - co-locating services;

   - "outstationing," i.e., assigning service providers to see clients at a location other than the agency;

   - assigning service providers to be "circuit riders," who travel regularly to several locations to see clients;

   - pooling resources in several localities to provide a more extensive array of services;

- creating multidisciplinary teams of service providers;

- using the discharge planning process to link the patient to community services;

- designating a case manager specifically for pregnant, substance-abusing women, drug-exposed infants, and their families; and

- providing vouchers that clients can redeem for free products or services at a reduced price.

10. Project LINK, a state initiative in interagency coordination, should be followed closely to determine its effectiveness and ability to be replicated.

11. Collaborative interagency efforts should be thoroughly evaluated to provide reliable data on the program benefits and gaps in services.

## Data Collection

### Purpose

Collecting data about substance abuse and perinatal drug exposure at the state level is critical for two reasons: policy decisions and resource allocation. Policy decisions must be based on sound evidence that points to one approach in preference to another. Without hard data on the prevalence of substance abuse among pregnant women and the extent of perinatal drug exposure, determining the type of policies needed and their potential impact is difficult.

Policy makers and service providers also face the challenge of making the best use of scarce resources. Information about demographics, prenatal care, and drug use assist in planning for and providing outreach, education, health care, substance abuse treatment and other services.

### Methods

Data can be collected on an individualized basis and by service system. Individualized data are initially collected from each case for clinical treatment purposes. Data are recorded in case notes or on intake forms that may later be collected in the aggregate to provide a general portrait of the clientele.

Some data are available only by service system. Because many staff may be involved in serving a number of patients or clients at one time, costs for counseling, treatment or other services are difficult to track on an individualized basis. Generally, agencies monitor this type of data, e.g., service costs and staff time, with their own management information systems. Agencies use a multitude of computer systems to track program data. Some data collection systems may be compatible with each other, but most are not.

To ascertain the full impact of perinatal drug use, both methods must be employed. Data should be available on the population of pregnant women using drugs and their children as well as on the costs entailed in providing care, treatment, and other services.

It is important to note that parity in data collection must be achieved to ensure meaningful, representative statistics and findings. Standard definitions for perinatal substance abuse and perinatal drug exposure will be necessary.

## Type of Data Needed

The task force approached the issue of data collection by considering the type of data that should be collected statewide for an annual report to the Governor and the General Assembly. The sole purpose of the report would be to assist in making decisions about policy and resources.

Accordingly, the task force developed a list of common data elements that should be collected from the general population. The task force considered which elements are already being collected and where gaps in information exist. Based on this review, instruments were identified to collect some of the currently unavailable information. For the remaining data, an instrument has yet to be identified (see Attachment B).

## Means of Gathering Data

A. Statewide --- Birth Certificates

To determine the prevalence of perinatal substance abuse and drug exposure, a data collection mechanism that will apply to the entire population is needed. The mechanism must collect data in a manner that allows for fairly easy retrieval and correlation with other available information.

Medical records appear to be the only means of gathering uniform information about pregnant women. In particular, birth and death certificates, which are completed for every birth and fetal death in Virginia and require the use of medical records as well as interviews with the health care provider and patient, seem to be the most reliable instrument to collect perinatal information. Perhaps most importantly, birth certificates include a confidential section precisely for the purpose of collecting and analyzing data. The confidential portion is mandatory and already requires the reporting of tobacco and alcohol use.

If the birth certificate is to be used to collect information about drug use, several issues must be considered. First, medical records technicians rely on prenatal care and hospital records to complete birth certificates. Some prenatal care providers use extensive forms to gather routine information; others use a more informal approach to assess the patients' status and needs. A baseline or standard assessment form for obstetricians and gynecologists may be necessary to capture consistent data.

Second, medical records technicians will require training to know what to look for in the medical records since drug use may not be clearly noted. Training on the types of drugs, their pharmacological and street names, and non-threatening ways to gain

information not recorded in the medical records may need to be offered in connection with any statewide data collection system. Likewise, the persons responsible for completing the medical records during pregnancy or at the time of delivery may need training on similar issues.

Third, augmenting the current vital records system to collect new information will require additional funds. The costs associated with computer programming, training hospital data entry personnel, and printing new birth and death certificate forms must be considered.

Of the recommended data elements for an annual report, three may be collected on the birth certificate: type of drug; frequency of use; and source of insurance coverage. Birth and fetal death certificates should be revised to collect this information statewide.

B. Specific Programs and Services

Each public agency in the health and human resources secretariat collects service data to some extent, usually in aggregate form. The Department of Health, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Medical Assistance Services, and the Department of Social Services operate separate management information systems to collect information about their clients by type of program or service. Opportunities exist to enhance the agencies' data collection systems to include pertinent information about perinatal substance abuse.

The Department of Health

The Department of Health currently operates two programs through which data relating to perinatal substance abuse are being collected: the High Priority Infant Tracking System and the Virginia Congenital Anomalies Reporting and Education System (VaCARES).

The High Priority Infant Tracking System is a pilot project in Richmond and Petersburg to promote early identification of infants and toddlers who require further evaluation and services for health and educational needs. Parents voluntarily enroll their infants in the tracking system at the time of initial discharge from the hospital or any time an infant or toddler (up to three years of age) is determined to meet one of the evaluation criteria.

Children who are diagnosed with toxic exposure via the placenta or breast milk, drug withdrawal syndrome, or severe attachment disorder (difficulty in bonding) immediately qualify for

further evaluation and referral services. Parents who have difficulty in providing basic parenting may also qualify. All data collected during enrollment are sent to the state health department, which tracks the child's progress every six months up to the child's third birthday.

Through VaCARES, the state health department collects data about every newborn and child up to the age of two who has been diagnosed with a congenital anomaly. Hospitals are required to report this information upon admission and every readmission. Hospitals may report as a diagnosis the presence of drugs that affect the fetus through the placenta or breast milk.

The Department of Mental Health, Mental Retardation and Substance Abuse Services

Through regular performance reports, the Department of Mental Health, Mental Retardation and Substance Abuse Services collects aggregate data from the community services boards. Currently, the community services boards report the number of women who received substance abuse services and the ages of clients who received services, but this information cannot be cross-tabulated to show by age group the number of women who received substance abuse services. At this time, the department does not collect information such as the number of women of child-bearing age receiving substance abuse services or the number of pregnant women receiving services.

The Individualized Client Data Element System (ICDE) is the data collection system community services boards use to enter data about clients they serve. It is data collected through the ICDE that the community services boards report in the aggregate to the Department of Mental Health, Mental Retardation and Substance Abuse Services. The ICDE was recently adapted to accommodate minimum data as required by the National Institute on Drug Abuse. It could be expanded to require community services boards to report the number of pregnant women who receive substance abuse services. The information would be reported to the department in regular quarterly performance reports.

The department is collecting extensive information about the number and needs of pregnant, substance-abusing women who are applying for services in the five Project LINK sites. When available, this data can be considered to assist in determining future data collection needs and procedures.

## The Department of Medical Assistance Services

The BabyCare Program pays for coordinated services for both Medicaid-eligible, pregnant women who are at high risk for poor birth outcomes and their infants up to age two. The enrollment procedure includes an initial maternity assessment to determine potentially harmful medical, social, and nutritional factors, followed by a pregnancy outcome report and an infant risk assessment. Maternal substance abuse is considered a medical risk factor that would necessitate care coordination. Assessment data and records on follow-up services are maintained in the department's data base, which allows the agency to compare information about pregnant, substance-abusing women identified in the program with data on the entire population enrolled.

Several features would enhance the scope of the department's current data collection system. The maternal assessment form could specify the type of drug used and the frequency of use. Similarly, the infant risk assessment form could include substance abuse as distinct social risk category and again specify the type of drug used by the mother and the frequency of use. Finally, substance abuse treatment could be noted as a separate client need where applicable.

Additionally, the department collects data on the length of time Medicaid clients spend in the hospital as patients. Estimates of the average length of stay for pregnant, substance-abusing women and drug-exposed infants in the general population can be extrapolated from the data on Medicaid clients who have been identified as substance abusers or drug-exposed since the hospital care would be roughly equivalent.

## The Department of Social Services

Child welfare data is collected through two separate data bases within the Department of Social Services. One system maintains child abuse and neglect data, while another collects data for the foster care and adoption programs. The two systems are not compatible.

While information regarding substance abuse in the family may be recorded in a case file at the local level during a child abuse and neglect investigation, substance abuse is not a data element collected by the state department for statistical purposes. Each year, however, the department conducts a thorough survey of 10% of the child abuse and neglect reports filed. Substance abuse noted during the investigation must be recorded on the survey instrument. From this statistically reliable sample, the department can make inferences about the total number of child abuse and neglect

investigations that involved substance abuse.

The current data system for foster care and adoption services does not collect any information about substance abuse. Federal regulations scheduled to be implemented in Spring of 1992 would require that the department keep records on substance abuse by both the children receiving foster care and their parents. Although the federal government would pay 90% of the costs to upgrade the current data base, the department would have to provide the funding initially and later receive reimbursement. Given the Commonwealth's fiscal constraints, the department anticipates serious problems in meeting the mandate. The federal government has advised that fiscal sanctions will be imposed on states that do not comply with the regulations. The department is awaiting the final regulations that will detail the Commonwealth's responsibility for implementing the new reporting system.

The task force recommends that the department pursue ways to track the number of child abuse and neglect reports relating to substance abuse and the number of foster care placements due to parental substance abuse.

C. Costs of Service Delivery Systems

Data about the operational costs of programs are not only beneficial for making decisions about policy and resources but absolutely necessary in a time of shrinking budgets. If treatment programs prove to be cost-effective by preventing poor birth outcomes, thus saving thousands of dollars in neonatal intensive care expenses, resources should be devoted to increasing their availability. Conversely, programs and services that do not appear to help pregnant, substance-abusing women and their children should not continue to be funded.

Every service-providing system should monitor substance abuse treatment costs for pregnant, substance-abusing women to evaluate their impact and the cost benefits. Specifically, agencies should track the costs of treatment provided through their individual programs, Project LINK, the BabyCare Program (substance abuse treatment is covered), foster care, subsidized adoption, and early intervention services for children with developmental delays.

D. Unavailable Data

Data collection instruments could not be identified for all of the common data elements and several other desirable types of information. Collecting this information would require specially designed studies to correlate data from different sources, random sampling, or some other means. The data elements in this category are:

- point in pregnancy substance abuse was identified (mother)
- treatment at the hospital (mother)
- disposition at discharge (child)
- whether a urine toxicology test was conducted (mother and child)
- the trimester in which drug use occurred
- the gestational age of the fetus at the time substance abuse was identified
- the number of other children living with the substance-abusing mother

**Recommendations**

1. The Secretary of Health and Human Resources should designate an agency to be the clearinghouse for data regarding perinatal substance abuse and drug exposure. The responsible agency should prepare an annual report for the Governor and the General Assembly that provides a picture of the problem of perinatal substance abuse and drug exposure in Virginia. The report should include the prevalence, costs, and the extent of state and local efforts to address the problem. Agencies that participate in the development of the report should review the data annually to ensure that the most relevant information is being collected. Responsibility for preparing the annual report will cease five years from the date of the initial report.

2. To continue high standards of care, the Virginia Obstetrical and Gynecological Society should encourage the use of standardized antenatal medical records that include an updated medical history screening tool for identifying substance-abusing women.

3. The Virginia Department of Health should collect data regarding maternal drug history by using the birth and fetal death certificates. The certificates should be revised to collect the information statewide by January 1, 1993. Funding should be allocated for this purpose.

4. Agencies should make revisions to their data collection systems as follows.

   A. The High Priority Infant Tracking Pilot Program in Richmond and Petersburg, administered by the Virginia Department of Health, should include substance abuse treatment for parents as an item for tracking. When the program becomes statewide, referrals for services should be reported to the state health department at the time of enrollment as well as in the regular follow-up reports.

   B. The Department of Health should explore ways to correlate data from the High Priority Infant Tracking Pilot Program and VaCARES with the vital records system.

   C. The Department of Mental Health, Mental Retardation and Substance Abuse Services should require that the Individualized Client Data Elements System (ICDE) collect from community services boards the number of pregnant women who are receiving substance abuse services. The expanded ICDE should be operational by July 1, 1993.

   D. The Department of Medical Assistance Services should amend the data collection tools used in the BabyCare Program to assess drug use more thoroughly. The maternal risk assessment form should specify the type of drug used and the frequency of use. The infant risk assessment form should include substance abuse as separate item in the social risk category and should specify the type of drug used by the mother and the frequency of use. Substance abuse treatment should be noted as a separate service need where applicable.

   E. The Department of Social Services should pursue ways to collect data on the number of filed child abuse and neglect reports that involve substance abuse in the home and the number of foster care placements due to parental substance abuse.

5. Every service-providing system should monitor substance abuse treatment costs for pregnant, substance-abusing women to evaluate the impact of the treatment and the cost benefits.

## Training

### Background

Substance abuse is a pervasive problem that affects not only the physical and mental health of drug users but their relationships with family and friends as well. Both the causes and the consequences can be complex for all involved. Given the prevalence of substance abuse in our society, it is essential that people be prepared to recognize substance abuse, intervene as appropriate, and make referrals for treatment and services. One of the keys to preventing perinatal drug exposure lies in training professionals to identify and treat pregnant, substance-abusing women before and after they give birth.

While information about substance abuse is currently in great demand, training for the variety of professionals who need it has not always been widely available or accessible. Those who work in health care clinics, doctors' offices, hospitals, mental health centers, social services agencies, schools, early childhood programs, the courts, and police stations could specifically benefit from routine training programs (see Attachment C). Training that provides accurate, relevant information about drug addiction and its ramifications will enable these professionals to perform their jobs better.

### Training Opportunities

Because the vehicles for training differ by profession and place of employment, several approaches should be considered. In some cases, graduate training programs should be strengthened to require an introduction to substance abuse issues. Questions could be added to the licensing exams for certain professions to emphasize the importance of having a basic understanding of substance abuse. For working professionals, continuing education programs should offer courses on substance abuse. Private and public service agencies should develop orientation programs for new employees to familiarize them with substance abuse as it relates to their jobs. Professional membership associations can also help by making training available through their regular meetings and special conferences.

In addition to these training options, professionals in the field need on-going technical assistance to deal with unfamiliar and problematic cases. Treatment providers and case managers are calling for a centralized resource center to which they may turn for professional guidance, the latest research findings, and

clinical experience. State AIDS resource centers and university-based technical assistance centers for educators of preschool-age handicapped children have shown remarkable success in meeting the demand for formal training and periodic technical assistance. Similar resource centers should be developed for perinatal substance abuse and perinatal drug exposure. The centers should be multidisciplinary, multimedia, and culturally sensitive, and should offer opportunities for individual clinical supervision as well as group training.

## Core Training Curriculum

At a minimum, regardless of where people receive training, they should learn the same core information. The components of a suggested core curriculum are outlined in Attachment D. This information could be incorporated into a specialized training program for any profession.

## Training Resources in Virginia

In Virginia, three new programs are underway to provide basic training to an array of people who regularly come into contact with substance abuse. The Virginia Institute for Developmental Disabilities (VIDD), funded by a grant from the Governor's Drug Policy Office, has trained six interdisciplinary teams to provide training about perinatal substance abuse on a regional basis throughout the state. The teams are composed of an outreach educator, a doctor, a nurse, a substance abuse treatment counselor, a child welfare social worker, an early intervention/child development specialist, a prevention specialist, and a law enforcement officer. Over the next two years, each team will host four or five two-day training sessions for departments of health and social services, school divisions, community services boards, local extension offices, court service units, and others. VIDD estimates that the teams will train 2500 professionals.

The second training opportunity is through the Virginia Institute for Social Services Training Activities (VISSTA), a training system for local social services agencies. VISSTA will train social workers who demonstrate a need for substance abuse education through a formal assessment process. The training program will provide general information about substance abuse and teach skills to assist the social worker in identifying substance abuse problems, making appropriate referrals, and managing the cases. The course is currently being tested as a pilot program but will soon be available to social workers and their supervisors throughout the Commonwealth.

The Virginia Council on Child Day Care and Early Childhood Programs and the Governor's Drug Policy Office are sponsoring a third initiative that will provide substance abuse training to Head Start personnel, child care and early childhood program providers, and parents over the next two years. The training will focus on substance abuse indicators, parenting in the context of substance abuse prevention, the relationship of substance abuse to other patterns of abuse and violence, and coordination with community resources.

National Training Resources

Many national training resources are also available. For example, the Office of Substance Abuse Prevention (OSAP) sponsors a national training system through which curricula are developed for professional associations. Recent recipients include the American Nurses Association, the American Medical Association and the American Psychological Association. A national volunteer center funded by OSAP will soon begin offering substance abuse training to clergy, service club officers, and community leaders. The National Association for Perinatal Addiction Research and Education offers annual training conferences and seminars on a variety of issues for professionals in many fields.

**Recommendations**

1. The first priority for funding should be to provide the training necessary to implement the task force's recommendations for screening, discharge planning, making referrals, and providing services to pregnant, substance-abusing women and their children. Health care practitioners and hospitals who are required to establish screening and discharge protocols will need training to design and implement the protocols. Training should be provided to familiarize hospitals and health care workers with community resources so they can make appropriate referrals for treatment and services. Actions to improve data collection procedures will also necessitate some training.

2. Training efforts should be coordinated.

3. All professionals in the health, mental health, social services, education, law, and early childhood education, and religion should have a basic understanding of substance abuse and its ramifications.

4. Graduate school programs for the professions identified in Attachment C should incorporate into their core curricula basic information about substance abuse, its ramifications, and treatment strategies.

5. Regulatory boards that administer licensing and certification exams for professions identified in Attachment C should incorporate questions about substance abuse into their exams.

6. Continuing education programs should regularly offer units on substance abuse. University continuing education offices should develop substance abuse training programs for appropriate professionals.

7. State and local public service agencies should encourage their staff to receive substance abuse training and facilitate such training.

8. Private and public service agencies should incorporate substance abuse training into their orientation programs for new employees.

9. Professional associations should be encouraged to offer training on substance abuse to their members.

10. Resource centers should be created to serve as central locations for technical assistance for professionals who treat and provide services to pregnant, substance-abusing women and their children. The resource centers should offer opportunities for supervised clinical training.

Attachment A

## Core Community Services

Prenatal health care

Substance abuse treatment
- counseling
- methadone maintenance

Outreach programs

Infant early intervention services

Parenting skills training

Social services benefits

Infant and child health care

Education

Vocational training (JOBS Program)

Child care

Transportation

Family planning

Nutrition counseling

The Women, Infants, and Children (WIC) Program

Resource Mothers/Mentoring Programs

Interpreters (where necessary)

Primary Care

Mental health services

Dental services

Housing

## Additional Community Services

Legal services

Life skills education (home and money management)

Preconception counseling

Attachment B

## Common Data Elements

| | |
|---|---|
| **zip code** | (mother) |
| **race** | (mother) |
| **age** | (mother) |
| **birth outcome** | (child) |
| **type of drug used*** | (mother) |
| **frequency of drug use*** | (mother) |
| **source of insurance coverage*** | (mother and child) |
| **length of hospital stay** (Department of Medical Assistance Services) | (child) |

* **Would need to amend birth and fetal death certificates.**

Attachment C

## Professionals Who Need Training

Health Care

- primary care physicians
- nurses and nurse practitioners
- health educators
- social workers
- nutritionists

Mental Health

- alcohol and drug counselors
- psychologists
- psychiatrists
- licensed clinical social workers
- licensed professional counselors
- marriage counselors

Hospitals

- discharge planners
- medical records technicians
- social workers

Schools

- school nurses
- school guidance counselors
- teachers
- student assistance counselors
- school social workers

Social Services

- child protective services investigators
- foster care workers
- foster parents
- adoption social workers
- benefits workers

Legal System

- law enforcement officers
- lawyers
- judges

Other

- early intervention specialists
- child care, early childhood program providers, and Head Start staff
- staff in domestic violence and homeless shelters
- clergy

Attachment D

## Core Training Curriculum

I. Background

- Substance abuse is pervasive in society.
- Members of all socioeconomic groups can be substance abusers.
- The causes and effects of substance abuse.
- Current drugs of choice.
- The definition of perinatal substance abuse.
- The long-range impact of perinatal drug use is not known.

II. Philosophical Approach

- Addiction is a chronic condition that requires treatment.
- Professional attitudes should be non-threatening.
- Prenatal care and other interventions are effective in preventing poor birth outcomes and developmental problems.
- Services should be provided in a coordinated, multidisciplinary manner.
- Service providers should know the resources in their localities.

III. General Substance Abuse Information

- Percentage of the population affected by drug use.
- Drugs of abuse (classes) and their effects.
- How to identify a substance abuse problem.
- The medical, psychological, developmental, social, educational and vocational consequences for the mothers, drug-exposed infants, toddlers, and school-age children.

IV. Current Laws

- Confidentiality requirements.
- Protection of rights in cases of child abuse and neglect.

V. Treatment Resources

- Levels of care.

VI. Referral Strategies

# Appendix

# 1991 SESSION

LD5992584

## HOUSE BILL NO. 1602

Offered January 21, 1991

*A BILL to require the convening of a certain task force by the Secretaries of Education and Health and Human Resources.*

Patrons—Van Landingham, Cooper, Grayson, Martin, Plum, Marshall, Almand, Munford, Christian and Cunningham, J.W.; Senators: Miller, Y.B., Colgan, Gartlan and Miller, E.F.

Referred to the Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. *§ 1. Secretaries to convene certain task force.—The Secretaries of Education and Health and Human Resources shall convene a task force to assist in the development of an effective mechanism for provision of services to perinatally drug-exposed children and their families. The task force shall consist of no less than ten and no more than fifteen persons to be appointed by the Secretaries and shall be composed of personnel with expertise in one of the following areas: special education, early intervention services, drug rehabilitation programs or treatment, health care funding and service delivery, maternal and child health, child protective services, hospital discharge planning, and perinatalogy. The members of the task force shall represent the following entities: the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Education, the Department of Health, the Department of Medical Assistance Services, the Department of Social Services, the Virginia Hospital Association, the local school divisions, the local or district health departments, the Virginia Association of Community Services Boards, the local community services boards, physicians engaging in the practice of perinatalogy, and physicians engaging in the practice of obstetrics for high risk patients, and any other entity deemed essential by the Secretaries. The Department of Mental Health, Mental Retardation and Substance Abuse Services shall serve as the lead agency for such task force and shall provide such staff support as may be necessary to conduct its work.*

*The task force shall develop, in cooperation with the Joint Subcommittee Studying Maternal and Perinatal Drug Exposure and Abuse and the Impact on Subsidized Adoption and Foster Care, an effective mechanism for provision of services to such children and their families which shall include the following components: (i) a determination of the appropriate process for identification of such children and their families, which may include mandatory reporting by certain entities or professionals; (ii) a determination of the appropriate state or local agency to serve in the role of gate keeper for receipt of reports of perinatal exposure to alcohol and other drugs and for monitoring the developmental progress and well-being of the children; (iii) a development of an appropriate, nonthreatening role for the gate-keeping agency; (iv) the design and situs of a data collection system to determine the scope and define the impact of the problem of perinatal drug exposure; (v) a method for effective and efficient public and private interagency referral of such children and their families in order to ensure that prevention, early intervention, and treatment services will be provided; and (vi) an analysis of the cost of implementation of this mechanism.*

*In developing the mechanism for provision of services to such children, the task force shall consider the following issues: (i) ways to avoid stigmatization of such children; (ii) ways to encourage the development of viable families and avoid perceptions of threats or penalties; (iii) any relevant confidentiality requirements stipulated by federal law; and (iv) any inservice training for professionals which will be necessary prior to implementation of this mechanism. The task force shall take under advisement the alternatives developed during the 1990 interim by the Joint Subcommittee Studying Maternal and Perinatal Drug Exposure.*

*The task force shall report to the Governor, the General Assembly and the Joint*

*Subcommittee Studying Maternal and Perinatal Drug Exposure by December 1, 1991, in accordance with the procedures of the Division of Legislative Automated Systems for processing of legislative documents. However, in order to design any necessary implementing legislation and to plan for funding, the task force shall report to and confer with the Joint Subcommittee Studying Maternal and Perinatal Drug Exposure periodically as required by the Chairman.*

*This section shall expire on January 31, 1992.*

| Official Use By Clerks | |
|---|---|
| **Passed By The House of Delegates** | **Passed By The Senate** |
| without amendment ☐ | without amendment ☐ |
| with amendment ☐ | with amendment ☐ |
| substitute ☐ | substitute ☐ |
| substitute w/amdt ☐ | substitute w/amdt ☐ |
| Date: _____ | Date: _____ |
| Clerk of the House of Delegates | Clerk of the Senate |

# GENERAL ASSEMBLY OF VIRGINIA--1991 SESSION

## HOUSE JOINT RESOLUTION NO. 388

*Requesting the Secretary of Health and Human Resources, in cooperation with the Secretary of Education, to develop and implement an interagency and interdisciplinary approach to perinatal drug exposure.*

Agreed to by the House of Delegates, January 31, 1991
Agreed to by the Senate, February 21, 1991

WHEREAS, although there are no definitive data, an estimated 375,000 infants are prenatally exposed to drugs or alcohol; and

WHEREAS, the effects of perinatal exposure to alcohol and tobacco are well documented; however, the effects of other drugs are not as well understood and may include birth defects, hypersensitivity, excitability, developmental delays, inability to form attachments, poor regulation of behavior, abnormal play patterns, failure to thrive, and attention deficits; and

WHEREAS, children born with prenatal exposure to drugs must not be stigmatized for circumstances beyond their control and must be provided compassionate care and accorded the services necessary to assist them in becoming stable adults; and

WHEREAS, although the majority of substance abusers have historically been men, the 1988 National Household Survey on Drug Abuse indicated an alarming increase in the number of substance-abusing women; and

WHEREAS, frequently, women have turned to drugs for solace because of lives filled with unmentionable pain; and

WHEREAS, substance-abusing parents are often unable to nurture their children or to provide the necessary supervision and care; and

WHEREAS, such drug-compromised families frequently have many problems such as inadequate or no housing, unemployment, lack of education and work skills, poor nutrition, poor health and lack of access to health care, and emotional problems such as unpredictable and erratic behavior; and

WHEREAS, the many needs of these families cannot be met by a single agency; and

WHEREAS, although many services are available to these families, numerous agencies are responsible for the delivery of such services; and

WHEREAS, in these days of fiscal exigency, it is essential that the Commonwealth's agencies cooperate in the delivery of services in order to provide the most effective and efficient management of the available services; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Health and Human Resources, in cooperation with the Secretary of Education, is requested to develop and implement an interagency and interdisciplinary approach to providing services to women who are substance abusers and children who have been prenatally exposed to drugs.

The cooperating agencies shall provide a mechanism for an interagency, interdisciplinary, interdivisional approach to prevention such as education to health care providers in identifying substance abusers; education to consumers of health care, particularly pregnant women, on the risks of substance abuse and the effects of drug and alcohol use during pregnancy; parenting skills; information on the purposes of early intervention services; and the delivery of care and support services. These agencies shall also develop and implement a cooperative, coordinated system to (i) collect data, (ii) evaluate the extent of this problem, and (iii) deliver treatment and support services to the substance abusers and their families, including early intervention services and the use of community resources to reach substance abusers. The system shall include plans for providing child care, transportation, residential services, and employment training and shall focus on treating the whole family. The cooperating agencies shall consider forming public/private partnerships with employers and others in order to assist in the education of workers and to obtain assistance in reaching a wide variety of occupations and economic levels. The system may provide for private contributions for transportation services, public service announcements, educational materials, and other services or materials.

The agencies shall periodically report as directed by the Chairman to the Joint Subcommittee Studying Maternal and Perinatal Drug Exposure on the progress in developing this system.

The Secretary of Health and Human Resources shall submit the joint report of the agencies to the Joint Subcommittee Studying the Problems of Maternal and Perinatal Drug Exposure and Abuse and the Impact on Subsidized Adoption and Foster Care and the Governor and the 1992 Session of the General Assembly pursuant to the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.