EXECUTIVE SUMMARY

Working in Partnership

Needs and Opportunities for Improving Perinatal Substance Abuse Services in California

This publication was made possible by grant numbers H96 MC00067-04, 4 H96 MC 00002-09-03, 5H96MC00068-04, and 6H96MC00062-0451RO from Department of Health and Human Services, Health Resources Services Administration (HRSA) grants to Healthy Start Projects in San Bernardino, Alameda, and Fresno counties, and Shields for Families in Los Angeles, respectively; and supported by funds received from the State of California, Department of Health Services, Maternal and Child Health Branch's County Allocation to San Diego County. The contents, analysis, interpretation, or conclusions are solely the responsibility of the authors and do not necessarily represent the official views of HRSA or the State of California.

Working in Partnership

EXECUTIVE SUMMARY

Needs and Opportunities for Improving Perinatal Substance Abuse Services in California

Prepared for the California Conference of Local Directors of Maternal, Child, and Adolescent Health by BARBARA AVED ASSOCIATES
July 2002

Introduction

Perinatal substance abuse—drug and alcohol use during and following pregnancy—is a major public health problem with significant consequences for children and families. The issues are complex and range from lack of agreement about the nature and extent of the problem, to organizational differences in opinions about screening, to boundaries in forming interagency linkages.

This Executive Summary presents highlights from a study sponsored by the California Conference of Local Directors of Maternal, Child, and Adolescent Health (CCLDMCAH) Directors. The study examined issues related to perinatal substance abuse and how it is being addressed in California by maternal, child, and adolescent programs; mental health and alcohol and drug jurisdictions; and child welfare, detention, court systems, and health care providers. (To obtain a copy of the full report, contact the Maternal, Child, and Adolescent Health Director at your county's public health department.) Perinatal substance abuse has been identified as a high-priority issue by MCAH programs in many counties.

Data were collected by 31 local MCAH Directors from counties representing approximately 80% of the births in California. The survey covered the continuum of care, including identification during pregnancy and screening, treatment services, recovery and support services, local and state collaboration, and cooperation among involved organizations. MCAH

Directors also gave their perspectives on needs and service gaps. A literature search for best practices and policies was conducted and experts were interviewed as part of the study. Approximately 50 MCAH and other experts from various state and local disciplines convened in Sacramento and reached consensus on opportunities to improve services for pregnant and parenting substance-abusing women, and made recommendations for action and next steps.

BARBARA AVED ASSOCIATES, a Sacramento-based health consulting firm, carried out the study, which was funded through federal Healthy Start grants to Alameda, Fresno, and San Bernardino counties and Los Angeles Shields for Families, and the Title V allocation to San Diego County. A multidisciplinary advisory committee provided guidance to the project.

Prevalence

The last prevalence study in California was conducted in 1992 by the State Department of Alcohol and Drug Programs. Although the information is 10 years old and probably a conservative estimate, these are the best data available. Applying those prevalence estimates, 69,000 infants were born substance-exposed in California in 2000, or 11.4% of all births.

Findings from Research

Much has been learned about perinatal substance abuse in the past 20 years—best practices, effective policies, successful outcomes—and much of it is now evidence-based. California is recognized as a national leader in developing alcohol and other drug services for women, and its programs have contributed to these research findings. Studies reveal that:

- Because the patterns, consequences, and reasons that women abuse alcohol and other drugs (AOD) differ from men, gender-specific as well as culturally appropriate services are crucial.
- The social context of a woman's life must be taken into account. Pregnant and parenting women abusing AOD are more likely to have been victims of physical, sexual, and emotional abuse as children and adults. Men frequently play a major role in their initiation to and maintenance of chemical addiction.
- A woman's connections to her children are important in prevention, treatment, and recovery. No woman ever gives birth intending to harm her baby.
- Serious and chronic mental health problems are a common co-occurrence in substance-abusing women.
- A comprehensive, coordinated approach ideally includes appropriate drug screening, treatment, and prenatal care, in addition to a wide range of support integral to helping link women to the services they need.
- Providing therapeutic, developmentally appropriate child care and related support services is critical for the children who accompany their mothers to treatment.
- The medical literature documents the impact of AOD on the developing fetus, but intervention during pregnancy can significantly improve birth outcomes. Early intervention with children can also have an enormous beneficial impact on outcomes.

Perinatal Substance Abuse Funding

AOD services in California are funded in large part through state and federal funds administered by the State Department of Alcohol and Drug Programs (ADP). County AOD agencies have discretion to prioritize use of a large percentage of these funds. The statewide ADP perinatal-related budget allocation for FY 2000–01 was $43,785,970. The federal and state definition of "perinatal" for AOD funding purposes extends parenting to women with children up to age 18, unlike the medical community, which defines perinatal as the period from conception of pregnancy through age one.

County MCAH Survey Findings

Despite the programs that exist in California, most counties do not have the benefit of a comprehensive spectrum of gender-specific and culturally appropriate identification, treatment, and support services to address the needs of pregnant women and families involved with substance abuse. Waiting lists, cumbersome administrative processes, unreliable data, lack of support for training, and competition with other organizational priorities have been barriers to improving perinatal substance abuse services.

What Common Problems or Gaps Were Identified?

- Data that could be helpful in improving the planning and delivery of services were lacking or unreliable. For example, the amount and type of funding related to AOD for pregnant and parenting women with children under 12 months was nearly impossible to identify; child welfare cases due to substance abuse are not collected in California; and not all hospitals keep or track data on referrals to Child Protective Services for women with positive alcohol or drug tests.
- Compliance with Senate Bill 2669, which requires specific protocols for assessing and referring women with positive toxicology screens to appropriate services, varied widely among hospitals. Only 30% of the MCAH Directors reported that these protocols were routinely implemented in all hospitals in their counties.
- Many residential treatment facilities limited the age and particularly the number of children who could accompany their mothers to treatment. Age six as an upper age limit appeared to be the most common cut-off for facilities.
- In addition to overall inadequacies in service capacity, the issues of transportation, language difficulties/cultural differences, and housing were listed as "most significant" among the top 15 barriers for women receiving AOD treatment services.
- Although county detention facilities usually provided many AOD-related services for pregnant and parenting women and adolescents, *transition services* to help women after release were provided less often, particularly for younger women.
- Although obtaining exact figures was difficult, experts estimated that an average of 70 – 80% of children placed in foster care or relative care were there due to parental AOD use.
- County mental health programs were the least likely of the major county services to be involved with county AOD and MCAH services for perinatal substance abuse in either formal or informal coordinating activities.
- The majority of county MCAH programs did not have formal agreements or relationships with their local AOD and mental health agencies. Nearly one-third reported not having worked directly in some capacity with their local AOD department in the past two years.

What are the Top Needs in California?

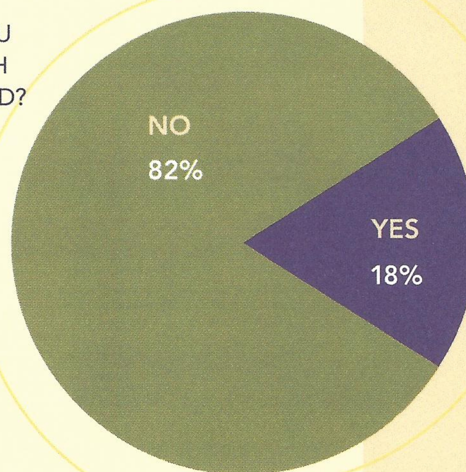
Consistent with identified gaps in systems, resources, and services, the most common needs identified by county MCAH Directors in a wish list for change included:

- Universal screening of pregnant women by all prenatal care providers, private and public.
- Improved access to early, high-quality prenatal care services for pregnant substance-abusing women with stronger linkages to AOD and mental health services.
- Increased residential and intensive outpatient treatment slots, to include infants and children who accompany their mothers to treatment.
- More targeted outreach to identify AOD-using women, along with early and intense case management.
- Higher priority for perinatal substance abuse among all local service sectors and between state and local systems—more collaboration, more coordination.
- Redeployment of available resources, targeting more for pregnant and parenting women and their children.
- Increased support services that aid recovery, such as assistance with drug-free housing, transportation, child care, and job training.

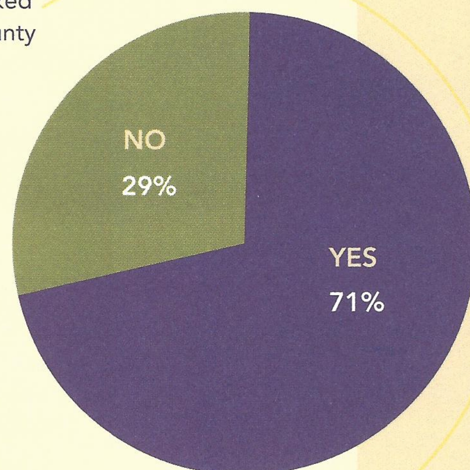
INVOLVEMENT

Relationship Between MCAH Programs and County AOD Programs (N=28)

Is there an MOU between MCAH and county AOD?



Has MCAH worked directly with county AOD in the last two years?



Best Practices

Best practices for perinatal substance abuse, according to MCAH Directors and other experts, include programs and services with the following characteristics:

- Gender-specific
- Culturally and linguistically appropriate
- Comprehensive, including support services that aid recovery
- Offer one-stop shopping, i.e., co-located services
- Provide for children who accompany mothers to treatment
- Standardized across private and public sectors, including prenatal care providers
- Linked/integrated with other systems, e.g., mental health and primary care

Status of Hospitals' Protocols for Identifying Prenatally AOD-Exposed Infants

	No		Yes, at some hospitals		Yes, at all hospitals	
	Number	Percentage	Number	Percentage	Number	Percentage
Are formal protocols in place? (N=27)	1	4%	7	26%	19	70%
Are protocols routinely implemented? (N=26)	5	19%	13	50%	8	31%
Are protocols consistent with SB 2669? (N=26)	3	12%	8	31%	15	58%

What is Working Well

Examples of successful programs and approaches in California, identified by MCAH Directors, that incorporate best practices included:

- **Shields for Families in Los Angeles** uses case managers—some of whom are women recovering from their own drug addiction problems—to provide one-on-one comprehensive services, including food, shelter, transportation, legal counseling, and mental health, and "absolutely no administrative barriers for getting help."
- **San Francisco's Homeless Prenatal Program** outreaches to and helps women access both medical and substance abuse treatment as well as support services.
- The **Kaiser Permanente** system brings "always available" substance abuse counselors to women in prenatal care rather than pregnant women having to travel elsewhere for counseling.
- **Fresno County's Human Services System**, after participation by nine local leaders in the National Training Institute's Leadership for Community Teams, implemented a countywide Screening, Assessment, Referral and Treatment (SART) model with the medical community that included children. They also trained community partners and created several substance abuse specialist positions to facilitate referrals. At the same time, they established a 250-slot treatment program for pregnant and parenting women, with a therapeutic child care center. They are currently establishing a residential treatment facility with capacity for 50 women and two children each up to age five.
- After its team attended the Leadership for Community Teams training, **Alameda County** implemented a similar SART that includes development of standards of care for perinatal substance abuse treatment sites, with the help of the county's Behavioral Health Care Services.
- **California drug court participants** (as of March 2002, there were 146 drug courts, 34 for juveniles) showed significant improvement in completion of drug treatment programs, attainment of high school diploma or GED, transition from homelessness, and reunification with families. The program has also been cost-effective.

Upper Age Limit for Children Accompanying Their Mothers to Treatment (N=30)

Age Group	Number	Percentage
Up to 12 months	1	3.2%
Up to 24 months	4	13.0%
Up to age 4	5	16.0%
Up to age 6	10	32.0%
Up to age 12	5	16.0%
Up to age 17	3	9.7%
No upper age limit	2	6.4%

Age cut-off reported by MCAH Directors for children at local AOD residential treatment facilities.

Policy Recommendations

An Action Agenda for MCAH and Its Partners

In May 2002, 50 State and local MCAH, AOD, and other perinatal substance abuse experts met in Sacramento to respond to the needs assessment findings. The consensus recommendations, listed below, represent a starting point for achieving identified opportunities; the door was left open to future strategies and other stakeholders whose participation is needed.

- Increase perinatal substance abuse as a social and political priority among legislators and community leaders, and educate them about the serious problems resulting from perinatal substance abuse and the ongoing impact of perinatal substance abuse to all systems of care for children and families.
- Ask the Governor and Legislature to convene a state-level policy group to improve collaboration and coordination on issues related to perinatal substance abuse. Include maternal and child health, alcohol and other drugs, child welfare, mental health, Children and Families Commission, and the justice system.
- Establish or rejuvenate strong and effective local interagency collaborations to highlight perinatal substance issues and improve joint programming. Include maternal and child health and public health, alcohol and other drug services, child welfare services, education, justice system, prenatal and pediatric providers, hospitals, local managed care plans, community foundations, businesses, and local Boards of Supervisors.
- Ask the State Department of Alcohol and Drug Programs to update the 1992 statewide perinatal substance abuse prevalence study to guide effective planning and analysis of the current problem.
- Create a plan for coordinated training and education programs at the local level among alcohol and drug providers, maternal and child health providers, and mental health providers to improve program effectiveness.
- Encourage the State of California to develop practice guidelines in collaboration with professional organizations for perinatal substance abuse services by delineating evidence-based and promising best practices of care and treatment.

Working in Partnership

Common Ground for MCAH/AOD/ Mental Health and Others to Work Together

- Consider these recommendations as only a starting place.
- Jointly advocate across programs wherever resources affecting perinatal substance abuse are in jeopardy.
- Take advantage of the power of local connections in advocating for state- as well as county-level change.
- Be sensitive to the potential for "criminalizing" when the objective is improving services or systems of care for women and children.