

**Perinatal
Substance Use:
Promoting Healthy
Outcomes**





Perinatal Care

To promote healthy maternal and infant outcomes, the *Code of Virginia* sets forth screening and reporting requirements for health care providers and hospitals. This brochure discusses Virginia's legal requirements and the implications for practice.

As a health care provider, you have an important role in reducing substance use during pregnancy and postpartum. You can improve maternal and infant outcomes by providing regular prenatal education on:

- Regular prenatal care
- Nutrition
- Prevention of sexually transmitted infections (STI) and human immunodeficiency viruses (HIV)
- Effects of substance use on fetal development

and provide:

- Substance use screening
- Brief intervention
- Referral for substance abuse evaluation/treatment.



Explaining the significance of a healthy environment to a mother is critical in helping her build one.

Pregnant women who use alcohol, tobacco, or illicit drugs risk their infant's health and development. Abuse of prescription or over-the-counter medications can also create health risks. As a health care provider, you have an important role in reducing substance use during pregnancy and postpartum.

LEGAL REQUIREMENTS

§54.1-2403.1 of the *Code of Virginia*

- Licensed practitioners shall, as a routine component of prenatal care, establish and implement a medical history protocol to screen all pregnant patients for substance use to determine the need for further evaluation.
- Practitioners shall counsel all pregnant women with positive medical history screens and/or substance evaluations on the potential for poor birth outcomes and appropriateness of treatment.
- The results of the medical history screen and/or substance use evaluation shall not be admissible in any criminal proceeding.

HEALTHCARE PRACTICE IMPLICATIONS

Substance use by pregnant women occurs in all ethnic, geographic, and socioeconomic groups. Research indicates that among those who use drugs, polysubstance use is the norm. In addition, many women use drugs in combination with alcohol and tobacco. Research has also shown that many women who abuse substances have co-occurring mental health problems and/or histories of trauma. Most substance users exhibit no signs on physical examination.

Substance Use History

During pregnancy, women are often motivated to change risky behaviors. Routine gynecologic and obstetric visits provide excellent opportunities for patient education and substance use screening.

Substance use screening can be easily incorporated into a routine medical history and supplemented by drug toxicology when maternal risk indicators are present. Screening should occur at least once per trimester since patterns of use may change over time.

A substance use history screening should include questions concerning:

- Frequency and amount of alcohol consumption prior to and during pregnancy;
- Frequency and amounts of over-the-counter, prescription, and “street” drugs used prior to and during pregnancy.

Patterns of use prior to conception are risk indicators for prenatal and postpartum use. A substance use history screening should include questions concerning:

- Effects of substance use on life areas such as relationships, employment, legal, etc.
- Parent and partner substance use.
- Previous referrals for substance use evaluation/treatment.
- Previous substance use treatment or efforts to seek treatment.

Screening tools such as the 5P’s, 4P’s, T-ACE or TWEAK can be easily integrated into a medical history and quickly administered. Providers can also use a high risk screening tool such as Virginia’s Behavioral Risk Screening Tool, which screens for substance abuse, mental health and intimate partner violence. If a urine or blood toxicology screen is medically indicated during the perinatal period, informed consent should be obtained.

Patient Discussion

Most women want what is best for their newborns. Continued use of substances during pregnancy may be due to habituation or addiction rather than a lack of information or concern regarding the effects of substance use. A woman who continues to use during pregnancy, despite your interventions, should be referred for a substance abuse treatment assessment.

Substance use discussion needs to occur within a health context to lessen the stigma associated with the topic and convey concern for the health of the mother and baby. A supportive, non-confrontational discussion should include:

- The health care benefits of not using drugs, alcohol or tobacco.
- Other related risky behaviors that may impact the health and well-being of the infant.
- Maternal health, obstetrical, and neonatal complications that may result from continued use.
- Evaluation and treatment options.
- Encouragement to accept a substance use assessment referral.

Habitual alcohol and other drug use may suppress appetite, impair metabolism, and alter nutrient absorption, thus affecting both maternal and fetal nutrition. The chaotic lifestyle and other risky behaviors of some substance abusing woman may lead to self-neglect, including poor diet. Though abstinence is the goal, any steps towards reducing use and/or related risk factors, e.g., poor nutrition, exposure to STI, etc. should be encouraged to improve birth outcomes. Some approaches to reduce the harmful effects of substance use include decreasing use, interspersing use with periods of abstinence, and avoiding drug-using friends.

Substance Abuse Services

Public substance abuse services are provided by Virginia’s Community Services Boards (CSB). Pregnant, substance-using women receive treatment priority at CSBs and are offered services within 48 hours of their request. Check with the CSB in your community to learn more about substance abuse and available services.



A baby can contract HIV from the mother while in utero, during childbirth, or through breast-feeding.

LEGAL REQUIREMENTS

§54.1-2403.01 of the *Code of Virginia*

- Licensed practitioners, as a routine component of prenatal care, shall advise all pregnant patients of the value of testing for HIV and request consent to test.
- Practitioners shall counsel pregnant women with HIV positive test results on the dangers to the fetus and the advisability of receiving treatment in accordance with current Centers for Disease Control and Prevention recommendations.

HEALTHCARE PRACTICE IMPLICATIONS

An infant can contract HIV from the mother in utero, during childbirth, or through breast feeding.

Women have the right to refuse consent for testing and treatment. Women diagnosed with HIV should seek help from experts specializing in HIV and perinatal transmission.

Antiretroviral therapy administered to the mother during pregnancy, labor and delivery, provision of antiretroviral therapy for the newborn and elective cesarean section for women with high viral loads (more than 1,000 copies/ml) can reduce the rate of perinatal transmission to 2% or less. If medications are started during labor and delivery, the rate of perinatal transmission can still be reduced to less than 10%.



LEGAL REQUIREMENTS

§63.2-1509 of the *Code of Virginia*

- Health care providers are required to report suspected abuse or neglect to local departments of social services or the Child Abuse and Neglect Hotline (1-800-552-7096). Newborns diagnosed by health care providers as exposed to alcohol or controlled drugs not prescribed by a physician are also required to be reported.

HEALTHCARE PRACTICE IMPLICATIONS

In utero substance exposure can cause or contribute to premature birth, low birth weight, increased risk of infant mortality, neurobehavioral, and developmental complications. Post-natal environmental factors associated with maternal substance use such as poverty, neglect, unstable, or stressful home environments present additional risks for these children.

Interventions to reduce adverse outcomes and promote healthy home environments are critical to the well being of substance-exposed children.

Identification of Substance-exposed Newborns

Identification of substance-exposed newborns is determined by clinical indicators that include maternal and infant presentation at birth, substance use and medical histories, and/or toxicology results.

Health care providers are required to immediately make a report to Child Protective Services (CPS) if any one of the following occurs:

- Toxicology studies conducted on the infant, within 6 weeks of birth, is positive.
- A medical finding is made, within 6 weeks of birth, of newborn dependency or withdrawal symptoms.
- An illness, disease, or condition attributable to in utero substance exposure is diagnosed.
- A child is diagnosed with a Fetal Alcohol Spectrum Disorder (FASD).

Drug Testing

While drug testing is useful for diagnostic and treatment purposes, it **is not legally required to make a report to CPS**. Toxicology studies may include blood or urine testing, hair analysis, or meconium testing. Laboratories routinely do a gas chromatography with mass spectrometry or other confirmatory test whenever they obtain a positive finding on a urine, meconium, or hair sample. Blood and urine testing is only accurate for recent use i.e., within 24-72 hours.

Hospital policies should establish patient assessment procedures to determine the care needed by each patient. These assessments should identify each patient's medical needs and complicating conditions, including substance abuse, dependence and other addictive behaviors. Assessment and screening procedures should include:

- Specific, evidence-based criteria for testing the mother and/or her newborn.
- Expectations regarding the timing of tests, test types and consent.

Some hospitals request consent for testing while others assume it within the patient's general consent for care. To learn your hospital's policy, check with its risk management office.

Records Release

When reporting substance exposed newborns, health care providers are required by the *Code of Virginia* to release, upon request, medical records that document the basis of the report of suspected child abuse or neglect.

Disclosure of child abuse/neglect information and records to CPS agencies is also permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and federal Confidentiality of Alcohol and Drug Abuse Patient Information Regulations. (CFR 42 Part 2)

Reporting Liability

All mandated reporters are required to file a report as soon as possible, but no longer than 24 hours after having a reason to suspect a reportable offense. Health care providers reporting in good faith are immune from civil and criminal liability pursuant to Section 63.2-1512 of the *Code of Virginia*. Mandated reporter failure to report could result in criminal liability punishable as a misdemeanor with an imposed fine of not more than \$500 for first failure and not less than \$1,000 for any subsequent failures to report.



Local departments of social services, which are supervised by the Virginia Department of Social Services, have legal responsibility, under the *Code of Virginia*, to respond to reports of suspected child abuse or neglect.

Local departments of social services are required by the *Code of Virginia* to:

- Respond to valid reports of suspected child maltreatment.
- Evaluate child's immediate safety.
- Complete a Family Assessment or Investigation by:
 - Observing the child
 - Interviewing family, siblings, other professionals
 - Observing the child's home
 - Checking for prior reports on the family
 - Conduct a risk assessment, and
 - Arrange for/provide services.

CPS services are provided to abused and neglected children and their families regardless of income. The primary goal of CPS is to strengthen and support families in preventing the (re)occurrence of child maltreatment through community-based services. If the child cannot be safely maintained at home, a temporary placement is sought.



LEGAL REQUIREMENTS

§32.1-127 of the *Code of Virginia*

Hospitals shall implement protocols requiring written discharge plans for substance abusing, postpartum women and their infants.

- The discharge plan must be discussed with the patient and appropriate referrals made and documented.
- The discharge plan shall involve, to the extent possible, the child's father and members of the extended family who may participate in follow-up care.
- Hospitals shall immediately notify the local Community Services Board (CSB) on behalf of the substance abusing, postpartum woman to appoint a discharge plan manager.

HEALTHCARE PRACTICE IMPLICATIONS

Postpartum, substance-using women and their newborns have multiple health care, treatment, safety, and environmental needs. Their hospital discharge plans should include:

- A referral of the mother to the local Community Services Board (CSB) for substance use assessment and implementation of the discharge plan.
- Information and medical directives regarding potential postpartum complications and, as appropriate, indicators of substance use withdrawal.
- A referral to CPS if the newborn has been born substance-exposed or there are other abuse or neglect concerns identified by the health care providers.
- A follow-up appointment for pediatric care within 2-4 weeks.
- A referral to early intervention Part C services for developmental assessment and early intervention services for the infant.
- A follow-up appointment for the mother for postpartum gynecologic care and family planning.

Patient follow-through on substance use and health care referrals is voluntary. Timely, coordinated outreach services provided by the health care provider, the CSB, and CPS can provide incentives and the necessary leverage to motivate the mother to follow through with discharge planning recommendations. A woman is more likely to follow through with the CSB referral if she has contact with the provider prior to her discharge from the hospital. Interagency protocols are recommended to facilitate service coordination.

Confidentiality of Substance Abuse Patient Information (CFR 42, Part 2)

Federal regulations protect the confidentiality of individuals who seek treatment for substance use disorders. Information that reveals a person is receiving, has received, or has applied for services for a substance use disorder cannot be released or disclosed without a valid written release from the patient.

A general consent form or medical release form is not acceptable. To be valid, a written consent form for the release of confidential information must specify:

- Patient's name.
- Purpose of the disclosure.
- Name of the person/organization receiving the information.
- Information to be released.
- Patient's right to revoke consent at any time, except to the extent that action taken is irrevocable.
- Patient's right to revoke consent verbally or in writing.
- Date or condition when consent expires.
- Date signed.
- Patient's signature.

The information disclosed must contain a written statement prohibiting redisclosure and may not be used in a criminal investigation or prosecution.

Information sharing can be facilitated by developing policies and procedures that can be incorporated into interagency protocols. HIPAA does permit sharing information with CPS and should be included in the procedures.

LEGAL REQUIREMENTS

§32.1-134.01 of the *Code of Virginia*

Every licensed nurse midwife, licensed midwife, or hospital providing maternity care shall, prior to releasing each maternity patient, make information available to the patient about:

- The incidence of postpartum blues and perinatal depression.
- Abusive Head Trauma and the dangers of shaking infants.

The *Code of Virginia* requires health care providers to share certain information with the maternity patient and others. This information shall be discussed with the maternity patient and the father of the infant, other relevant family members, or caretakers who are present at discharge.

HEALTHCARE PRACTICE IMPLICATIONS

Research has shown that 6% to 15% of women experience depressive symptoms during a pregnancy or in the first year following birth. About 10% of those women experience a major depressive episode. Women who abuse drugs or alcohol often have a co-occurring mental health disorder.

The most common condition is **postpartum blues**, which is a normal period of hormonal readjustment following delivery. The woman with perinatal depression will have symptoms that interfere with her ability to care for herself, her infant and/or conduct normal activities. Perinatal depression often goes unrecognized because women may be reluctant to report their symptoms to their healthcare provider. 10-15% of postpartum women experience depression.

Abusive Head Trauma is severe brain damage to or death of infant or small child resulting from violent shaking or shaking and impacting the head. It is a form of child abuse. Every year there is an estimated 1,200-1,400 children in America who are injured or killed because of Abusive Head Trauma. These numbers are considered to be under estimated as this type of injury or death is believed to be under detected. Approximately one in three babies dies as a result of injuries.

Patient Discussion

Education about **postpartum blues**, **perinatal depression** and **Abusive Head Trauma** is best discussed within a healthcare context. A supportive discussion includes:

Postpartum Blues and Perinatal Depression

- Incidence of postpartum blues and perinatal depression.
- Signs and symptoms of postpartum blues and perinatal depression.
- The need for the mother to share her symptoms and feelings with family, friends, and her health care provider.

Educational resources are available at www.mededppd.org

Abusive Head Trauma (formerly Shaken Baby Syndrome)

- Dangers of shaking a baby.
- Developmental role of crying in infants.
- Techniques to help parents and caregivers cope with a crying baby.
- Stress management techniques.

Educational resources for parents and caregivers of newborn infants are available on the National Center on Shaken Baby Syndrome Web site: www.dontshake.com

EFFECTIVE PRACTICES

Strategies to promote prevention and intervention with women who use drugs or alcohol during pregnancy include:

- Routinely screen all pregnant women regarding substance use, mental health, and risky behaviors.
- Conduct screenings in a private and confidential manner.
- Learn more about addiction and recovery.
- Know how and where to refer women for assessment and treatment.
- Be supportive and nonjudgmental.
- Follow up; discuss concerns at subsequent visits.

A photograph of a woman with dark hair pulled back, smiling warmly as she holds a young child. The woman is wearing a light-colored, ribbed top. The child is wearing a white top with a floral pattern. The background is plain white.

Up-front case management is necessary to enhance women's treatment motivation and prolong treatment retention.

State Resources

Child Abuse and Neglect Hotline
1-800-552-7096

Virginia Department of Health
Division of Women's and
Infant's Health
www.vahealth.org/wih
(804) 864-7772

Department of Behavioral Health
and Developmental Services
(DBHDS),
Office of Substance Abuse
Services
www.dbhds.virginia.gov
(804) 786-3906

Early Intervention Part C Services
Infant & Toddler Connection
of Virginia
www.infantva.org
(804) 786-3710

Internet Resources

American College of
Obstetricians and Gynecologists
www.acog.com

American Academy of Pediatrics
www.aap.org

National Organization on Fetal
Alcohol Syndrome
(NOFAS) www.nofas.org

American Society of
Addiction Medicine
www.asam.org

National Clearinghouse for
Alcohol and Drug Information
www.health.org

Physicians & Lawyers for
National Drug Policy
www.plndp.org

National Institute on Drug Abuse
www.nida.nih.gov

Substance Abuse and Mental
Health Services Administration
www.samhsa.gov

Mid-Atlantic Technology
Transfer Center
www.attcnetwork.org

Postpartum Blues and
Perinatal Depression
www.womanshealth.gov

Fetal Alcohol Spectrum Disorders
Center for Excellence
www.fascenter.samhsa.gov

The persons portrayed in this brochure are models.
Photos are intended for illustrative purposes only.

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