REPORT OF THE TASK FORCE ON ALCOHOL AND DRUG USE DURING PREGNANCY

RESEARCH MEMORANDUM NO. 457

LEGISLATIVE RESEARCH COMMISSION

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LEGISLATIVE RESEARCH COMMISSION

State Capitol Frankfort, Kentucky 40601 502-564-8100

M E M O R A N D U M

TO: Vic Hellard, Jr., Director
Legislative Research Commission

FROM: Representative Charles Geveden, Chairman
Task Force on Alcohol and Drug Use During Pregnancy

SUBJECT: Report of the Task Force on Alcohol and
Drug Use During Pregnancy

DATE: December, 1991

House Concurrent Resolution 159 was adopted during the 1990 Session of the General Assembly. The resolution directed the establishment of a Task Force on Alcohol and Drug Use During Pregnancy to study the extent of alcohol and other drug abuse among pregnant Kentucky women, resources currently available to address the problem, and resources needed to increase access to desired services.

This memorandum presents the findings and recommendations of the Task Force.

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ENCLOSURE

Task Force on Alcohol and Drug Use During Pregnancy

Representative Charles Geveden, Chair
Wickliffe, Kentucky

Senator Richard Roeding
Ft. Mitchell, Kentucky

Roger J. Shott, M.D.
University of Louisville
Department of Pediatrics

William H. Miller, M.D.
University of Kentucky
Department of Psychiatry

Joan Callahan, Ph.D.
University of Kentucky
Department of Philosophy

Patricia K. Nicol, M.D.
Division of Maternal and Child Health
Cabinet for Human Resources

Peggy Wallace
Department for Social Services
Cabinet for Human Resources

Jeanna Mullins
Department of Education
Office of Education for Exceptional Children

Sgt. Jim Tipton
Kentucky State Police
Drug Enforcement

Beverly Garrett
Consumer

Alayne White
Women's Center of Central Kentucky

Ruth Staten, R.N.
University of Kentucky
School of Nursing

David Allen, M.D., MPH
Louisville/Jefferson County Health Department

Jeanne Keen
Bluegrass East Comprehensive Care Center

Sue Strong, Ph.D.
Bluegrass East Comprehensive Care Center

Mike Townsend
Division of Substance Abuse
Cabinet for Human Resources

Carol Sauers
Division of Substance Abuse
Cabinet for Human Resources

Staff

Dianna McClure
Ray Keesee
Rebecca Crawley

BACKGROUND

The Task Force on Alcohol and Drug Use During Pregnancy was created during the 1990 Regular Session of the Kentucky General Assembly by House Concurrent Resolution 159. The Task Force was charged with studying the following issues, developing findings and making recommendations, including any needed legislation, to the Legislative Research Commission by September 1, 1991, for the 1992 Kentucky General Assembly.

(1) The extent of alcohol and other drug abuse among pregnant Kentucky women;

(2) The current resources available to address this problem within the health care system, including substance abuse prevention and treatment programs, the social services system and the educational system; and

(3) The resources needed to increase access to prenatal health care services for alcohol- and drug-dependent women; promote prevention activities among women of child-bearing age in the Commonwealth; increase early intervention and treatment programs for alcohol and drug dependent pregnant women; and address the special education and social service needs of children exposed to alcohol and drugs before birth.

The Task Force on Alcohol and Drug Use During Pregnancy held eight meetings. The Task Force held one meeting in Louisville in conjunction with the Cabinet for Human Resources' conference on Caring for Babies Born Exposed to Alcohol and Other Drugs. During the Task Force's deliberations, findings of selected studies of the incidence and effect of alcohol and substance abuse during pregnancy were presented. A 1985 National Institute on Drug Abuse study has estimated that thirteen percent of reproductive age women abused alcohol or drugs, or both, during pregnancy. A 1987 National Association of Perinatal Substance Abuse study found that eleven percent of the pregnant women studied used illegal psychoactive substances. A Chicago hospital-based study found that twenty percent of newborns in neonatal intensive care had positive urine drug screens. The Task Force received data from a small Cabinet for Human Resources study in thirty-one hospitals of the use of drugs by pregnant women at the time of admission for the purpose of delivery. There were no hospitals in the sample which did not have patients who tested positive. The age group testing highest for positive toxicologies were teenage mothers. The Task Force recognized a need for a large, periodic, anonymous, hospital-based survey to determine the extent of alcohol and drug use during pregnancy.

Task Force members discussed the effect of prosecution of drug-abusing pregnant women on such women's willingness to seek prenatal care and treatment services. The Task Force sent a letter to the Attorney General for the Commonwealth urging a

moratorium on the prosecution of substance-abusing pregnant women until the Task Force had time to study the problem and make recommendations for legislation for the 1992 General Assembly.

The Task Force approved developing a resolution to send to the Governor and the Office for Policy and Management requesting funds for pilot projects for treatment and education of substance-abusing pregnant women.

The Task Force approved developing a resolution requesting the Kentucky Medical Association, Kentucky Academy of Family Practitioners, Kentucky Pharmacists Association and Kentucky OB/GYN Association to encourage their members to post signs warning of the dangers of alcohol and drug use during pregnancy.

The Task Force heard testimony from various state agencies about services available and unavailable for substance abusing of chemically dependent pregnant women.

The Task Force developed and adopted a series of recommendations under the broad areas of Defining the Problem of Alcohol and Drug Use During Pregnancy, Primary Prevention, Training of Service Providers, Client Evaluation, Treatment Resources, Judicial System Reform, Pediatric Service Expansion, and Pilot Projects.

In addition, the Task Force developed and adopted a legislative proposal for introduction during the 1992 Regular Session of the Kentucky General Assembly. A summary of 92 House Bill 192 is included in the final section of this report.

FINDINGS

The Task Force submits the following report containing narratives provided by Task Force members representing state agencies:

Alcohol and Drug Use During Pregnancy: The Scope of Kentucky's Problem

A significant number of Kentuckians are adversely affected by alcohol and drug abuse. Substance abuse rarely leaves individuals, families and communities untouched. Not only are families frequently fractured but jobs and health are lost, laws are broken, and the victims' sense of self worth and purpose are seriously compromised.

- 235,000 Kentuckians suffer from alcohol and drug abuse problems.
- Kentucky's portion of alcohol and drug abuse costs to the national economy is $2.16 billion annually, or $584 annually to each man, woman and child in Kentucky.

- 71 percent (or 6,200) of Kentucky's prisoners had a self-identified alcohol or drug abuse problem, as did 8,600 persons on probation and parole.

As if these consequences aren't disturbing enough, Kentucky now confronts the complex and heart-rending problem of maternal substance abuse.

Maternal substance abuse not only affects children currently in the home, but the unborn as well, who are physically affected by the use of alcohol and drugs during a mother's pregnancy. When a developing fetus is exposed to such harmful substances as alcohol, cocaine, marijuana and narcotics. The result may be low birth weight and neurobehavioral dysfunction. Longer term studies indicate that prenatal exposure to alcohol and drugs may result in problems that go well beyond infancy, problems such as difficulty in bonding with parents and other care givers, mental retardation, learning disabilities, brief attention span, articulation problems, hyperactivity, and severe problems with socialization.

While there may be physical, neurological and psychological damage to an unborn child as a result of the direct exposure to alcohol and other drugs, these are not the only factors in influencing the child's development, and they are not always the most important. The child's home environment in most cases is the most important long-term influence on the child's development. A home where substance abuse is a daily part of the environment can be chaotic; spouse and child abuse and child neglect may be common occurrences; the male partner is most commonly an alcohol or drug abuser himself; and the greatest concern facing the female substance abusing caregiver is having access to an adequate supply of alcohol or drugs.

How much of a problem is the use of alcohol and drugs during pregnancy in Kentucky? The following statistics tell the story.

- Conservative estimates indicate that there are 48,000 females in Kentucky with alcohol and drug abuse problems. Of this number, 43,000 are of child-bearing age; approximately 4,240 are under eighteen.

- There were approximately 53,000 live births annually; about 9,000 of the mothers were teenage girls.

- Based on national statistics, it is estimated that in Kentucky there are approximately 65 babies born with Fetal Alcohol Syndrome (FAS), which includes the leading preventable form of mental retardation, and 450 with Fetal Alcohol Effects annually in Kentucky.

- Based on information reported in birth records, 1,764 infants were born with congenital abnormalities. Only ten infants were identified as suffering from FAS. This may indicate a need for additional training for health care providers, to assure that this problem is accurately identified.

- A preliminary study conducted at the University of Kentucky Medical Center in the summer and fall of 1990, found that ten percent of the pregnant women were using drugs at the time of their delivery. Twenty percent admitted to drinking daily or using an illicit drug in the month prior to conception. These statistics are compatible with a national survey of hospitals which found an 11 percent incidence of illicit drug use sometime during pregnancy.

- Based on preliminary studies at the University of Kentucky and national surveys, it is conservatively estimated that there may be 5,500 pregnant substance abusers in Kentucky who are in need of intervention and treatment.

- Research at the University of California, San Diego showed that:

  -25 percent of drug-exposed children have developmental delays;

  -40 percent experienced neurologic abnormalities that might affect their ability to socialize and function at school; and

  -Hospital costs for a cocaine-exposed infant may be ten times greater than costs for a nonexposed infant.

- Approximately 50 percent (25,000) of pregnancies in Kentucky are eligible for Medicaid coverage of prenatal and postpartum care. It is estimated that 2,750 of these births are to mothers with substance abuse problems.

- Access to proper prenatal care is an essential element in healthy birth outcomes.

- The Kentucky Department for Social Services reports that in Fiscal Year 1990:

  -Substance abuse was a factor in 20.7 percent of reported incidences of child physical abuse;

  -Substance abuse was a factor in 18.9 percent of reported incidences of child sexual abuse;

-Substance abuse was a factor in 28.1 percent of reported incidences of child neglect; and

-Substance abuse is a contributing factor in 41.6 percent of those Department for Social Services cases where the child is removed from the home.

The Department for Social Services believes that these estimates are very conservative. Preliminary surveys conducted by the Department indicate that substance abuse may be a contributing factor in more than 50 percent of these types of cases. The impact of prenatal exposure to drugs and alcohol has severe consequences. For example:

- One researcher has estimated that 42 to 52 percent of children thus exposed to drugs and alcohol will require special educational services.

- In one pilot project in Los Angeles the cost of providing an enriched school environment to address the special needs of alcohol-and drug-exposed children is estimated to be $17,000 a year per child.

The portrait of this problem indeed seems bleak when we realize that the impact of maternal substance abuse includes robbing us of stable and secure parents, handicapping the development of our future generations, and straining the resources of our already over-utilized health and human services. The greatest hope in addressing this problem is to provide services which focus on meeting the special needs of both the mother and child. The best interests of the child will be served by helping the mother into a program of recovery from substance abuse, where she can gain or regain her sense of self-esteem through the establishment of an alcohol-and drug-free lifestyle. It's only through this recovery process that the mother can hope to provide a stable and nurturing environment for her child's proper development. Kentucky must recognize the unique needs of the pregnant or postpartum substance-abusing women in developing needed treatment resources.

For the average woman this process of establishing an alcohol and drug-free life is filled with special problems and barriers that are more common to female than male substance abusers. The following are examples of these special concerns:

- Females with substance abuse problems experience a greater sense of shame about their addiction than their male counterparts, due to society's double standard regarding male and female use of alcohol and other drugs. This results in a lower sense of self-esteem and a tendency to hide or deny the problem.

- Women frequently use other drugs in combination with alcohol, placing themselves at a higher risk of physical and psychological impairments.

- Among blacks who drink, twice as many women as men report health problems due to drinking.

- Alcoholic women are disabled more frequently and for longer periods than alcoholic men, reflecting, in part, differences in the process of identification leading to diagnosis.

- One study found that in 20 percent of all spouse abuse cases the victims were using alcohol themselves.

- Up to 74 percent of alcohol-and drug-dependent women report incidents of sexual abuse, including rape and incest.

- In 1990, for all persons over age 25, only 40 percent of women and 37 percent of men had finished high school.

- In 1990, 15.7 percent of all Kentucky heads of families were women.

- Over one-half of the children in Kentucky's female-headed households are poor.

- Females are typically the primary caretaker of children.

- In most families where there is a parental substance abuse problem there are serious deficits in parenting skills.

Task Force Recommendations

In response to the aforementioned data supplied by the Division of Substance Abuse in the Department for Mental Health and Mental Retardation Services, the Task Force submits the following recommendations, to address the scope of the problem of alcohol and drug use during pregnancy:

- Conduct a comprehensive needs assessment to determine the extent of substance abuse among women of child-bearing age and among pregnant women.

- Create a permanent interagency work group to provide continuing focus on the problem on a statewide basis.

- Create a Center for Perinatal Substance Exposed Pregnancies, to work with appropriate professionals and state and local agencies to develop data bases for continued study and support services to pilot projects, to coordinate and provide training, to develop protocols

for use by state agencies in dealing with substance abuse during pregnancy, to work with local councils and to develop a clearinghouse of information for communities and professionals.

- Set up local councils consisting of local health agencies, Department for Social Services staff, Community Mental Health Center Substance Abuse staff, and local prosecutors, to develop local plans to address the problem, including investigation of positive urine toxicology reports, determining appropriate sanctions, and tailoring policies developed by the Center for Perinatal Substance Abuse to fit local community needs.

Current Federal and State Resources Available

What state agencies are charged with responsibility for treatment, rehabilitation, and education concerning alcohol and other drug abuse?

Kentucky law states that the Cabinet for Human Resources (CHR) is responsible for alcohol and drug education, treatment, and rehabilitation. KRS Chapter 222 designates CHR as the state agency responsible for planning and coordination of programs on alcoholism and drug abuse. This is to be carried out through designated interagency councils on both alcoholism and drug abuse.

These councils are to be composed of representatives from CHR, the Justice Cabinet, the Department of Education, the Labor Cabinet, and the Department of Personnel. The designee from each agency is required to be the person charged with responsibility for either drug or alcohol abuse programs within that agency. Each council is required to have a CHR appointed coordinator to implement the council and coordinate planning between CHR and the represented agencies.

CHR is further required by statute to establish and conduct programs for treatment of intoxicated persons and alcoholics, including juveniles and young adults. This mandate includes prevention and rehabilitation programs.

Kentucky law is very specific relating to the types of services CHR is required to provide individuals suffering from alcoholism. Pursuant to KRS 222.210-KRS 222.300, which may be cited as the Alcoholism Treatment and Rehabilitation Law, CHR is required to provide a comprehensive array of services to alcoholics and intoxicated persons. These services are to be made available through existing facilities, including regional community mental health centers (CMHCs) and private sector services, whenever possible.

KRS 222.220 specifically grants CHR authority to contract for services to alcoholics with other government cabinets and

departments, public and private agencies and facilities, physicians, and other persons whenever necessary, provided that all rates are established by CHR.

The required services include (1) detoxification services which meet the immediate medical and physical needs of intoxicated persons; (2) medical and hospital services on a 24-hour basis, utilizing existing general hospital facilities when possible; (3) rehabilitation services, including family care, residential aftercare and any appropriate therapy; (4) inpatient psychiatric hospitalization for alcoholics with serious alcohol-related mental disturbances, to be conducted within CHR whenever possible; and (5) training programs for professional and nonprofessional workers in the treatment and rehabilitation field.

All entities wishing to provide services under KRS Chapter 222 are required to be licensed by CHR for each facility they plan to operate. CHR is empowered to issue and enforce regulations necessary to establish requirements and standards for licensure. Criteria for licensure include: (1) the need for the facility in the community; (2) the health standards to be met by the facility; (3) accurate representation of the treatment afforded patients at a facility; (4) licensing fees, application and revocation procedures; and (5) the procedures for evaluation of treatment programs.

Certain facilities are exempted from licensure requirements under KRS Chapter 222, including hospitals licensed pursuant to other statutory provisions, a department, agency, or institution of the federal government, and the state or any of its political subdivisions. CHR is permitted to establish stricter standards and requirements for programs which provide contract services pursuant to KRS 222.220. Also specifically exempt from regulation under these statutes are programs run by Alcoholics Anonymous and similar alcohol rehabilitation organizations.

KRS 222.410-222.475 relate to drug abuse and addiction. These statutes require CHR to study drug abuse and addiction, formulate and carry out programs of education, establish facilities and employ personnel needed for diagnosis and rehabilitation of drug abusers and addicts, and accept for examination, diagnosis, guidance and treatment any person voluntarily requesting such services. CHR is empowered to contract with hospitals and private physicians for emergency hospitalization and care of drug abusers or addicts. CHR may also enter into cooperative arrangements with municipalities or other agencies operating drug abuse treatment facilities. CHR is granted broad authority to employ such medical, psychiatric, psychological, secretarial or other assistance deemed necessary, and to issue regulations governing admission criteria and fees for treatment.

KRS Chapter 222 further provides that any individual may

request treatment or rehabilitation for drug abuse, addiction, or dependency problems from either a physician, hospital, or other facility authorized by CHR to provide the appropriate care. The provider is held to a strict standard of confidentiality regarding the identity of persons requesting services under this chapter, prohibiting disclosure to law enforcement personnel and civil, criminal, administrative, or legislative proceedings. This confidentiality may be waived by the person requesting or receiving services. The confidentiality requirement prohibits persons receiving drug abuse treatment or rehabilitation services from disclosing the identity of other persons participating in the program.

All health care entities or other treatment or rehabilitation programs providing services to drug abusers, addicts, or dependent persons are required to report to CHR quarterly regarding the number of persons receiving treatment or rehabilitation services. CHR is to submit compilations of these statistics to the Justice Cabinet and other appropriate agencies.

All treatment programs licensed as chemical dependency treatment services are required to report to CHR regarding the programs' effectiveness, as a condition of receiving state or federal funds. The information to be contained in these annual reports includes:

(1) the total number of alcohol and drug abuse clients;

(2) the total number of referrals from the courts and the corrections cabinet;

(3) the client's change in substance use patterns from admission to discharge;

(4) the client's change in employment status from admission to discharge; and

(5) the change in client's involvement with the criminal justice system from admission to discharge.

The identity of individual persons receiving treatment is to be kept confidential. There is an exception to the confidentiality requirement regarding use of information by those engaged in research related to patterns of drug and alcohol abuse, effectiveness of treatment, or similar studies, providing such researchers agree in writing to maintain confidentiality.

All providers licensed as a chemical dependency treatment service are also required to submit, one year after each client receives services, follow-up reports which measure the person's status regarding current substance use patterns, employment, education, and involvement with the criminal justice system. These follow-up reports may be compiled from mail or telephone surveys of clients successfully discharged for one year. The

number of clients who do not participate in the survey is to be included in the reports (KRS 222.465).

An annual report on treatment effectiveness must be submitted by CHR to the Governor, including an inventory of all licensed chemical dependency treatment services in Kentucky and the information included in each facility's treatment effectiveness and follow-up reports (KRS 222.475).

CHR has designated the Department for Mental Health and Mental Retardation Services (DMH/MRS) as the lead organization in the substance abuse treatment and rehabilitation field. DMH/MRS has created the Division of Substance Abuse (DSA), to focus on the oversight of the comprehensive array of services mandated under KRS Chapter 222.

Prior to the adoption of the Kentucky Education Reform Act of 1990, there had also been a statutory requirement that local school districts provide each student with a state-approved alcohol and drug education curriculum. Under current state law there are no mandated substance abuse education programs; however, there is a federal initiative which addresses this matter through a grant program administered through the Kentucky Department of Education. This initiative will be discussed more thoroughly in the section on federal assistance to the states.

What federal agencies administer substance abuse education, treatment, prevention, and rehabilitation programs?

Federal statutes create the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), within the Public Health Service of Health and Human Services. (42 U.S. Code §290a et. seq.) ADAMHA is further divided into:

(1) The National Institute on Alcohol Abuse and Alcoholism (NIAAA);

(2) The National Institute on Drug Abuse (NIDA);

(3) The National Institute on Mental Health (NIMH); and

(4) The Office for Substance Abuse Prevention (OSAP).

Also within ADAMHA is the Office for Treatment Improvement (OTI), which administers funds and many programs targeted at substance abuse. The U.S. Department of Education is also empowered to fund and administer substance abuse education and prevention programs pursuant to The Drug Free Schools and Communities Act of 1986.

What federal funding initiatives are in place to provide assistance to Kentucky in addressing substance abuse prevention, education, treatment, and rehabilitation needs?

ADAMHA provides the bulk of funding for state substance abuse treatment and rehabilitation programs. Through a Block Grant Program initiated pursuant to Part B of Title XIX of the Public Health Service Act, OTI administers various initiatives. In FY 1990, $477 million was distributed to the states via the Alcohol, Drug Abuse, and Mental Health (ADAMH) Block Grant. Kentucky received about $11.6 million of that amount. Current projections call for $577 million to be distributed to the states for FY 1991, with Kentucky scheduled to receive about $12.6 million. According to Kentucky's 1991 ADAMH Block Grant Plan, just over 86% of these funds are to be allocated to substance abuse programs. The Plan also contains a 10% set-aside, or $1,260,000, for women's programs.

The Drug Free Schools and Communities Act of 1986 (Title V) provides another significant funding source for state drug prevention and education efforts. This program is expected to provide Kentucky's Department of Education with about $6.1 million this year. Federal law requires that 90% of these funds be distributed to local education agencies for use in developing curricula, training, and technical assistance for educators. These programs are required to focus on prevention strategies which provide a "no use" message targeted at specific age groups.

This Act also provides $1.5 million to the Governor's Office for a Drug Free Kentucky. These funds are distributed to local community groups, such as Champions Against Drugs, Project DARE, and Project Graduation. Federal law requires that 50% of Title V funds granted to the state's Executive Agency be used for grants and contracts for development and implementation of activities. Project DARE also receives 10% of these funds. Student Assistance Programs (SAP) are funded by these monies as well.

A number of demonstration projects across the nation are funded through grants administered by OTI. These grants, varying from project to project, are made available from OSAP as funding mechanisms for the development of innovative, model community-based programs designed to prevent young people from using alcohol and other drugs.

OSAP funds grants to public and private non-profit entities for a variety of demonstration projects for prevention, treatment, and rehabilitation of drug and alcohol abuse by the "high risk youth", defined as an individual under age 21 who is at a high risk of becoming or who has become a drug or alcohol abuser and who: (1) is identified as a child of a substance abuser; (2) is a victim of physical, sexual, or psychological abuse; (3) has dropped out of school; (4) has become pregnant

(emphasis added); (5) is economically disadvantaged; (6) has committed a violent or delinquent act; (7) has experienced mental health problems; (8) has attempted suicide; (9) has experienced long-term physical pain due to an injury; or (10) has experienced chronic failure in school.

The Administrator of ADAMHA is also empowered to make grants to public and private entities for demonstration projects of national significance. These include projects to:

> (1) determine feasibility and long-term efficacy of programs providing drug abuse treatment and vocational training in exchange for public service;
>
> (2) conduct outreach activities to intravenous (IV) drug abusers with respect to the prevention of exposure to and transmission of the etiologic agent for acquired immune deficiency syndrome (AIDS), and to encourage IV drug abusers to seek treatment for such abuse; and
>
> (3) to provide drug abuse treatment services to pregnant women, postpartum women, and their infants (emphasis added).

Demonstration projects funded under this provision are to focus on a comprehensive approach to problems associated with drug abuse evidencing broad community involvement and support. Private businesses, local governments, law enforcement agencies, schools, and health care providers are encouraged to participate. These projects are to focus primarily on adolescents, pregnant women and female addicts, and their children (emphasis added).

Kentucky also receives funds for drug abuse treatment, prevention, and education through the Community Services Block Grant (CSBG) program established by P.L.97-35. This Act and P.L.101-164, the Anti-Drug Abuse Activities Under the CSBG Act, fund specific activities, including drug counseling, drug referral, drug abuse prevention pamphlets, transportation to and from drug and hospital treatment facilities, treatment program fees, and medical assistance for drug-related problems. These services are to be available through local Community Action Agencies (CAAs). In Fiscal Year 1990, all 23 CAAs received allocations under this grant; four chose not to participate and returned their funds, which were reallocated to an adjacent CAA. These Emergency Drug Funds allocated for fiscal year 1990 totaled $17,474.

How Does Kentucky distribute the Alcohol, Drug Abuse and Mental Health Block Grant funds?

Kentucky has designated the Department for Mental Health and Mental Retardation Services (DMH/MRS) within the Cabinet for Human Resources as the lead agency for Alcohol, Drug Abuse and

Mental Health Block Grant funds. The Division of Substance Abuse (DSA) within DMH/MRS is charged with responsibility for administration of the state's substance abuse programs. This is accomplished primarily through a series of contracts with 14 Regional Mental Health and Mental Retardation (MH/MR) Boards, which provide statewide coverage. These Regional MH/MR Boards provide a comprehensive array of substance abuse programs through various initiatives, including a network of Community Mental Health Centers (CMHC).

The Prevention Research Institute receives funds through the ADMS Block Grant to provide a statewide prevention program based on the lifestyle risk reduction model. The Jefferson County Health Department also receives funding for its methadone maintenance program through this grant.

Primary Prevention

A key component of the effort to reduce substance abuse problems among pregnant women is a communitywide prevention program. This prevention program would include providing education for a lifetime to women on low-risk choices in the use of alcohol and drugs. It would include specific information on the use of alcohol and drugs prior to conception and during pregnancy. The curriculum could be based on the Lifestyle Risk Reduction Model of substance abuse prevention programming, developed by the Prevention Research Institute in Lexington, Kentucky. The communitywide prevention effort would also include a media component and the identification and development of support groups to help women address high-risk situations for abusing substances, such as divorce, single parenthood, and unemployment. These services would be integrated into the substance abuse prevention services already in place in the local community mental health centers. These prevention specialists would market this curriculum to gatekeeper agencies and be responsible for developing a cadre of trainers to deliver this curriculum in the community.

Task Force Recommendations

- Require posting "warning notices" on certain products, in establishments selling alcohol, and in pharmacies.
- Target women of child-bearing age for specialized educational programs designed by substance abuse prevention professionals, and require that Community Mental Health Centers Substance Abuse staff receive the necessary training to deliver these programs.
- Develop brochures and media spots which educate the general population about the negative effects of perinatal substance abuse.

- Reinstate family life education and drug abuse prevention in state education reform statutes.

Training of Service Providers

Training is needed for service providers on the dynamics of chemical dependency, special problems during pregnancy, how to conduct a substance abuse screening, dealing with client denial that a problem with substance abuse exists, and motivating the substance abusing female client for treatment.

Training should be provided to various agencies in the community that come into contact with significant numbers of females of child bearing age who could be at risk of substance abuse. Such agencies would include various health department clinics with a primary focus on prenatal care, the Women, Infants and Children Program, and family planning agencies, the Department for Social Services, the Department for Social Insurance (the JOBS programs), Spouse Abuse Shelters, Rape Crisis Centers, Family Resource Centers, and local physicians.

Task Force Recommendations

- Encourage civic, professional and religious organizations to develop competencies necessary to establish gatekeeping mechanisms to screen substance-abusing women of child-bearing age and to refer them to appropriate level of treatment.

- Require that health care providers be trained in recognizing substance abuse as part of the AIDS education requirement.

Client Evaluation

Identification of the pregnant woman with substance abuse problems would need to occur in two stages. The first stage is for gatekeeper agencies to do preliminary screenings for substance abuse problems among their female clientele. For those pregnant women who are suspected of having a substance abuse problem, a more indepth evaluation of the substance abuse problems needs to be conducted, along with an assessment of functioning in other areas of the client's life. Recommendations for treatment would follow this period of client assessment.

Task Force Recommendations

- Expand outreach programs to bring prenatal care to additional low-and medium-income families.

- Develop two pilot community-based teams to provide outreach and follow-up in-home services to 50-60 families. These services would include education, health care, parenting skills education, case management and necessary referrals.

- Utilize Family Resource and Youth Service Centers to direct specialized prevention programming and therapeutic intervention to children being raised in substance dependent homes.

- Mandate that all women determined to be "at risk" receive a urine toxicology upon the first prenatal visit. (They would be assured that urinalysis report may not be used as evidence in any criminal prosecution.)

- Mandate a urine toxicology on all women and infants at delivery, if defined as "at risk" of substance abuse. Require that positive tests be reported to the Department for Social Services.

- Establish community evaluation unit for perinatal substance abuse to receive referrals from gatekeeper agencies and private physicians regarding pregnant women with a potential substance abuse problem. This evaluation unit would be staffed by a nurse/chemical dependency specialist and would operate primarily out of the local health department, as well as other community clinics or hospitals.

Treatment Resources

The Kentucky Department for Mental Health and Mental Retardation Services administers funds for a variety of substance abuse treatment programs for women and men. The Division of Substance Abuse states that as of January 1992, there were nine facilities in Kentucky providing non-medical detoxification services. There were a total of 88 beds available, 27 for women. There were 11 co-educational, non-medical residential treatment programs in Kentucky (227 beds total, 62 for women). In addition, a new residential treatment program for adolescents has opened in Mount Sterling (14 beds total, 6 for girls, and 8 for boys). There are also 10 transitional living facilities (halfway houses) in Kentucky (6 for men and 4 for women). A total of 43 beds are available for women. All the programs described in this paragraph which serve women will also admit pregnant women for services.

There are 134 outpatient substance abuse treatment sites which will serve pregnant women. There are two outpatient/case management programs targeted for chemically dependent women that provide education, counseling, transportation and child care services in Ashland and Morehead. The only outpatient program in

Kentucky designed specifically for pregnant women is the Perinatal Recovery, Infant Development and Education Program (PRIDE) in Lexington. The PRIDE program is a collaboration between the University of Kentucky prenatal care and pediatric program and the Bluegrass Community Mental Health Center which provide substance abuse services. This outpatient program uses case management and offers prenatal care, birthing education, substance abuse assessment, education and treatment. Thirty-four clients were served in Fiscal Year 1991.

Currently, there is an intensive outpatient treatment program for women operating in Covington. An intensive outpatient program for women in Louisville is targeted at serving women with substance abuse problems who are referred by the Child Protective Services staff of the Department for Social Services. This program will include child care and transportation, as well as treatment services tailored to the unique needs of chemically dependent women. The program expects to serve 75 clients on an annual basis and will operate 5 days a week. Clients are expected to remain in the program for one year on average. A second program is being developed by the Corrections Cabinet in conjunction with the Cabinet for Human Resources for implementation during Fiscal Year 1992. This cooperative venture is to establish an in-prison substance abuse treatment program at the Kentucky Correctional Institute for Women that will also include halfway house services in the community.

There are 348 private inpatient chemical dependency treatment beds. The average occupancy rate for these facilities is 51.1 percent. Finally, there are 106 acute care hospitals which offer alcohol and drug abuse detoxification services reimbursable through Medicaid.

Persons seeking to improve access to appropriate treatment resources for the pregnant and postpartum substance abuser must recognize that for females to be adequately served, the resources must address the unique needs of this population. Many female substance abusers have a history of domestic violence, sexual abuse, and childhood incest, which contributes to low self-esteem, mental health problems, and inadequate parenting skills. These women may lack child care and transportation to treatment programs. Kentucky's chemically dependent pregnant women are often confronted with waiting lists in both the co-ed and all female residential facilities and are referred to programs that are incapable of meeting their special treatment and resource needs. Policymakers need to take steps to increase both the number of treatment slots and the capability of programs to address the special needs of these women.

The appendix contains the most current resource maps available from the Division of Substance Abuse showing the location of Substance Abuse Treatment Resources for pregnant women in the Commonwealth. The following should be used as definitions for service expansion of current and new treatment

resources:

- **Psycho-Educational and Support Groups on Substance Abuse and Pregnancy**

  A two-phased program that first includes a 12-week, once-a-week educational series that is offered to pregnant substance abusers. Phase II occurs during the last trimester and early postpartum and is heavily focused on parenting skills and weekly support groups for the women and their infants. Any interested substance abuser is welcome, though this program is primarily designed for those pregnant substance abusers who refuse "treatment." This program would typically be offered at a prenatal care clinic.

- **Detoxification**

  A period of planned withdrawal from alcohol or other drugs in either a medical or non-medical setting.

- **Methadone Treatment**

  A carefully controlled and managed treatment program for narcotic addiction that involves the administration of methadone, a synthetic narcotic. Methadone significantly reduces narcotic craving, therefore allowing the client to engage in gainful employment, normalize family relationships and cease criminal activity related to drug use. It also stabilizes a pregnant client to the point where she can participate in prenatal care.

- **Structured Outpatient Program**

  Rehabilitation services for women and children with substance abuse problems. Pregnant women would receive priority attention. Services would be offered several days a week for a minimum of 16-20 hours per week of program contact. High intensity services are provided for 3-6 months following birth, followed by a reduction in clinical services and an increase in activities related to self-support and sufficiency in the community. Special needs in the area of child care and transportation would be addressed.

- **Residential Treatment**

  A one to two month intensive period of substance abuse treatment within a 24-hour facility is provided. This type of placement is most appropriate when a client needs to be removed from her daily environment in order to initiate a drug-free lifestyle.

- **Halfway House**

  Halfway house services for 6 to 9 months in length, would be available for those pregnant women who have completed a Residential Treatment or a Structured Outpatient Program. These services provide an opportunity to work toward independent living in the community within a safe and sober environment. Specialized women's programming is included, as well as on-site or off-site child care.

- **Aftercare**

  Prior to a client's discharge from the Structured Outpatient or Halfway House program, an aftercare plan is established typically involving one or two contacts per week with an aftercare group, plus any needed individual counseling or case management services. In-home support services could be arranged at this time, depending on the client's and infant's needs. The period of involvement depends on the individual's needs, but typically the aftercare client will have at least two years of treatment program contact.

Task Force Recommendations

- Target specialized prevention and education programs at women of child-bearing age already involved in substance abuse treatment programs.

- Expand Family Preservation Services to serve substance abusing families in urban and rural areas. These intensive in-home services would be designed to correspond to the family's needs, based on the degree of dependence.

- Develop pilot day treatment programs as an alternative to more costly residential treatment programs. The day programs would include counseling, parenting classes, social services, health care, and prevention services. These programs would also include child care arrangements, to overcome a major barrier to those seeking treatment.

- Expand Medicaid funding under prenatal and postpartum care to include substance abuse treatment.

- Appropriate adequate funding to guarantee necessary treatment for maternal substance abusers and their infants.

Pediatric Service Expansion

Following the birth of a child, a pediatric examination is completed at the hospital. Any special medical intervention needed immediately is provided at the hospital, followed by the development of discharge plans, which include pediatric follow-up at the local health department or with local private physicians. Pediatric services in the health department would provide on-going follow-up of the infant and referral to Early Intervention Services in the community, if mental retardation or developmental disabilities are identified. Home visits would be a part of the services available under pediatric care. The professional making the home visits would be in a position to identify a potential maternal substance abuse problem (including potential for a relapse) and make a referral to the evaluation team for assessment. The home visit may also indicate the need for the state Department for Social Services to conduct a child abuse or neglect investigation.

Task Force Recommendations

See 92 House Bill 192.

Judicial System Reform

Criminal or civil means of coercing treatment are contra-indicated in the absence of thorough and comprehensive treatment and prevention programming. There is no clinical or experiential documentation that criminal or civil statutes are effective at encouraging women to seek treatment. However, from preliminary data, it appears that these means tend to alienate women most in need of treatment and prenatal care. Even if coercive means were proven as effective, the current lack of treatment and prevention resources renders ineffective this type of intervention. Appropriate legal sanction must be decided on a case-by-case basis. It is recommended that sanctions not be initiated until and unless all appropriate social and treatment resources are exhausted.

Task Force Recommendations

- Change current trafficking laws to include harsher penalties for selling controlled substances to pregnant women.
- Sanctions should not be initiated until and unless all appropriate social and treatment resources are exhausted.
- Require all DUI assessments to include questions regarding whether the woman is pregnant, so that appropriate referrals for education and treatment can be made.

Pilot Projects

Eight pilot projects should be established around Kentucky to demonstrate: (1) different methods of providing community prevention services; (2) agency coordination to better identify the pregnant substance abuser and other females who have substance abuse problems; (3) how to link the chemically dependent women, her children and other family members with community services and treatment; and (4) how to access Early Intervention Services for infants in need. These pilot projects would have an evaluation component. This approach will enable the Cabinet for Human Resources to do a more limited study of the arrays of services for pregnant women which seem to work best, based on client profiles and the geography of the setting (i.e., urban, small city, or rural) in which the service is taking place.

The suggested pilot project sites have been located as much as possible in areas where other services for women and adolescents are already in place, in order to build upon community expertise and to reduce costs in establishing new community programming.

The following counties are proposed as pilot locations for services targeted at adult women: Ballard, McCracken, Graves, Hopkins, Jefferson, Kenton, Campbell, Boyd, Greenup, Lawrence, Knox, Laurel, Whitley and Fayette.

The following counties are proposed as pilot locations for services targeted at adolescents: Hopkins, Jefferson, Montgomery, Bath, Menifee and Fayette.

Task Force Recommendation

See 92 House Bill 192.

Legislative Proposal

The Task Force developed a legislative proposal for introduction during the 1992 Regular Session of the Kentucky General Assembly. The major provisions of 92 House Bill 192 (92 RS BR 445, AN ACT relating to maternal health, include the following:

(1) Licensed retail vendors of alcoholic beverages would be required to post a sign warning patrons that drinking alcoholic beverages during pregnancy can cause birth defects;

(2) A Substance Abuse and Pregnancy Work Group would be created within the Cabinet for Human Resources to carry out planning and coordinating activities of the Commonwealth with regard to substance dependency and abuse during pregnancy;

(3) The Cabinet for Human Resources would be allowed to conduct periodic anonymous hospital-based surveys to determine within the Commonwealth the incidence of drug and alcohol use during pregnancy;

(4) The Cabinet for Human Resources would be required to periodically publish a list of the five substances most frequently abused by pregnant women;

(5) Physicians attending a pregnant woman would be authorized to screen the pregnant woman for alcohol or substance dependency;

(6) Physicians attending a pregnant woman would be authorized to administer to each newborn infant a toxicology test for prenatal exposure to alcohol or a controlled substance, if the attending physician had reason to believe the mother used drugs for a non-medical purpose during pregnancy;

(7) Positive toxicology findings would be prohibited from being used as prosecutorial evidence;

(8) The Cabinet for Human Resources would be required to establish a program to educate certain health care workers about the effects of substance abuse during pregnancy;

(9) The Cabinet for Human Resources would be allowed to establish four or more pilot projects to (a) demonstrate the effectiveness of differing methods of providing community services to prevent alcohol and substance abuse by pregnant females; (b) improve agency coordination, to better identify pregnant substance abusers; (c) link chemically dependent women and their children with community services; and (d) gain access to early intervention services for infants in need;

(10) The Cabinet for Human Resources would be required, if federal and state funds were available, to include substance abuse treatment for pregnant and postpartum alcohol- or drug-abusing women under the Medicaid program;

(11) A Center for Perinatal Substance-Exposed Pregnancies would be created by state government, to develop and disseminate data about the problem; and

(12) Penalties for trafficking in controlled substances with a pregnant woman would be established.

Appendix

(1) Resource Maps Displaying Public and Private Substance Abuse Treatment Resources for Pregnant Women, Cabinet for Human Resources, Department for Mental Health and Mental Retardation Services, Division for Substance Abuse, May 5, 1991.

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Resource Maps Displaying Public and Private Substance Abuse Treatment Resources for Pregnant Women

Resource maps have been developed to display substance abuse treatment resources across Kentucky for pregnant women with alcohol and drug abuse problems. Four (4) individual maps have been designed and include:

- A summary map of all the private and public treatment resources available to this population.
- A map which displays only the publicly funded treatment resources available through the fourteen (14) Community Mental Health Centers (CMHC) and their affiliates. Payment for services is determined by a sliding fee scale based on ability to pay.
- A map which displays treatment resources that are available through the private sector where payment for services is through insurance or client fees.
- A map which displays those treatment resources specifically designed to address the significant barriers and special services needed by pregnant women and women in general. Examples of these barriers and services are: child care; transportation; case management services; child birth education; parenting classes; linkages to pediatric care; nutrition; and services for domestic violence and sexual abuse problems.

SOURCE: Cabinet for Human Resources, Department for Mental Health/Mental Retardation Services, Division of Substance Abuse (Mike Townsend), May 5, 1991.

A **Legend** has been provided on each map to identify the specific types of services available in each county. Service definitions for each of the alpha symbols are as follows:

A. CMHC Detox: Co-ed detoxification services offered through the community mental health centers (CMHC) for the purpose of safely withdrawing the dependent person from alcohol and drugs. Length of stay is three (3) to seven (7) days.

B. CMHC Residential: Co-ed, non-medical residential treatment offered through the CMHCs, for persons diagnosed as alcohol or drug dependent. These programs provide an intensive array of counseling, education and exposure to self-help groups such as Alcoholics Anonymous and Narcotics Anonymous. A specialized women's group is typically provided. Length of stay is typically 30 days.

C. CMHC Residential Women Only: All female, non-medical residential treatment offered through the CMHCs for women diagnosed as alcohol or drug dependent. Specialized services such as victimization groups, education on substance abuse and pregnancy, co-dependency, etc. are provided.

D. CMHC Residential Women/Child Care: All female, non-medical residential treatment offered through a CMHC affiliate. **This program accepts both women and their children into the facility.**

E. CMHC Halfway House Women: All female halfway house offered through the CMHCs or affiliates to help alcohol and drug dependent women make social and vocational adjustments prior to returning to family or independent living in the community. Specialized services for women are offered.

F. CMHC Halfway House Women/Child Care: All female halfway house offered through a CMHC affiliate. **This program accepts both women and their children into the facility.**

G. CMHC Halfway House Pregnant Women: A halfway house program exclusively for pregnant women with substance abuse problems offered through a CMHC affiliate. Specialized services available to address both the pregnancy and female substance abuse issues.

H. CMHC Outpatient: Individual and where available group treatment services for male and female substance abusers and their family members. Some outpatient sites offer a special women's group to address unique needs of this population.

I. CMHC Outpatient Women's Services/Child Care: Comprehensive outpatient treatment program for women that includes specialized treatment services, case management, child care and transportation.

J. CMHC Outpatient Pregnant Women/Child Care: Comprehensive outpatient program offered through CMHC and an affiliate designed specifically for chemically dependent pregnant women and their infants. Child care and transportation are provided.

K. CMHC Intensive Outpatient: An outpatient program for chemically dependent males and females and their family that provides a minimum of six (6) hours of education and substance abuse treatment weekly for approximately four (4) to six (6) weeks. Some specialized women's groups may be provided.

L. CMHC Intensive Outpatient Women Only: An intensive outpatient program offered through the CMHC for women only.

M. Private Chemical Dependency Hospital: Medical facility licensed to provide inpatient substance abuse treatment for typically 14-30 days. Insurance and patient fees are primary sources of payment.

N. Acute Care Hospital Detox: Withdrawal from alcohol or drugs in an acute care hospital setting. Insurance and patient fees are primary sources of payment.

O. Private Outpatient Practitioners: Treatment professionals in private practice who provide outpatient individual or group treatment for chemically dependent persons and their families. Patient fees are the primary source of payment.

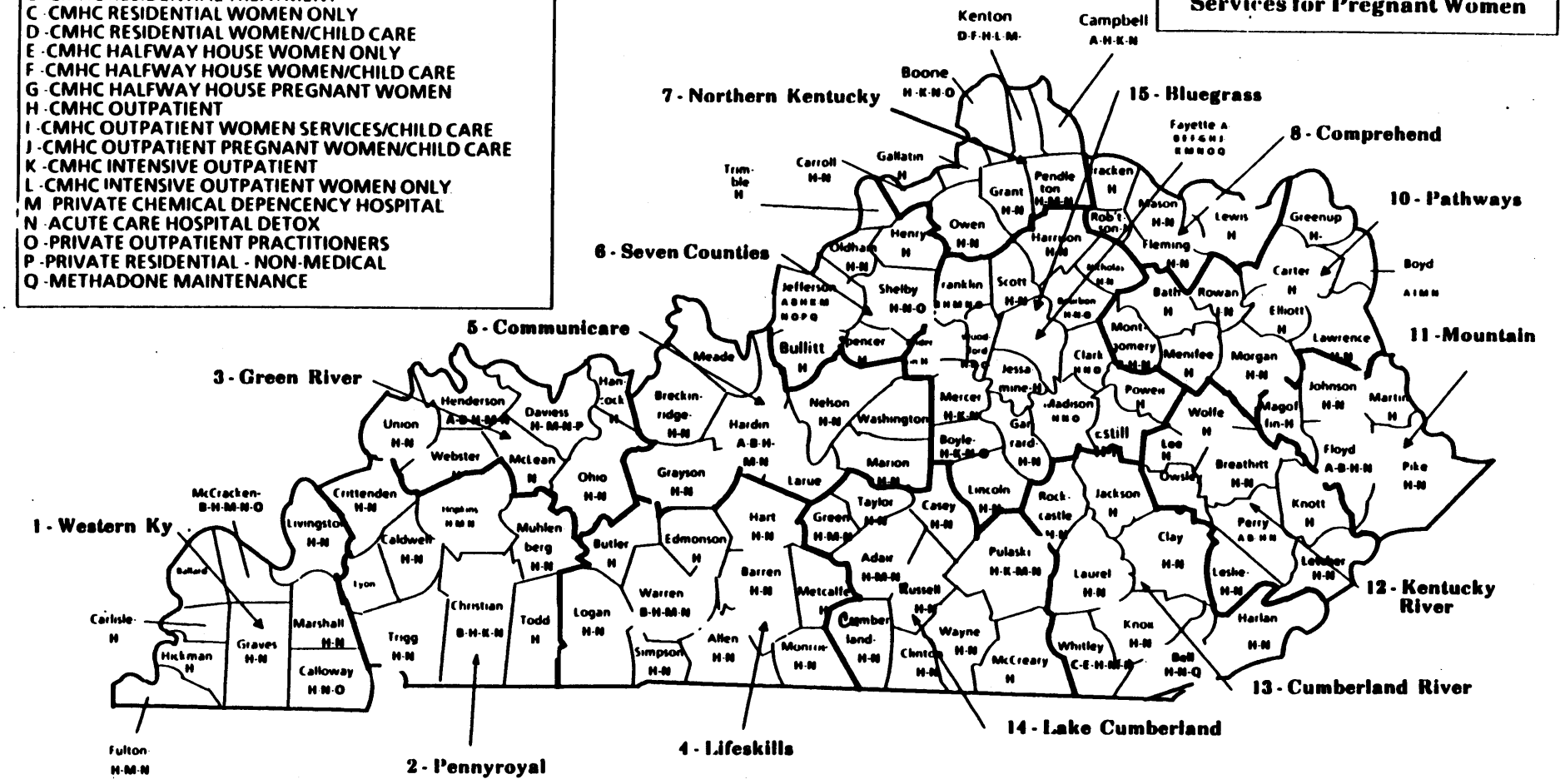
P. Private Residential Non-Medical: Co-ed residential treatment for chemically dependent persons. Length of treatment is 30 days. Primary source of payment is patient fees and insurance.

Q. Methadone Maintenance: Treatment program for narcotic addicts offered through CMHCs and the Louisville-Jefferson County Health Department. Program provides supervised dispensing of the medication methadone, in conjunction with counseling and vocational services. Pregnant women are considered a priority for services.

Summary of Private & Public Substance Abuse Treatment Services for Pregnant Women

LEGEND

- A CMHC DETOX
- B CMHC RESIDENTIAL TREATMENT
- C CMHC RESIDENTIAL WOMEN ONLY
- D CMHC RESIDENTIAL WOMEN/CHILD CARE
- E CMHC HALFWAY HOUSE WOMEN ONLY
- F CMHC HALFWAY HOUSE WOMEN/CHILD CARE
- G CMHC HALFWAY HOUSE PREGNANT WOMEN
- H CMHC OUTPATIENT
- I CMHC OUTPATIENT WOMEN SERVICES/CHILD CARE
- J CMHC OUTPATIENT PREGNANT WOMEN/CHILD CARE
- K CMHC INTENSIVE OUTPATIENT
- L CMHC INTENSIVE OUTPATIENT WOMEN ONLY
- M PRIVATE CHEMICAL DEPENCENCY HOSPITAL
- N ACUTE CARE HOSPITAL DETOX
- O PRIVATE OUTPATIENT PRACTITIONERS
- P PRIVATE RESIDENTIAL - NON-MEDICAL
- Q METHADONE MAINTENANCE

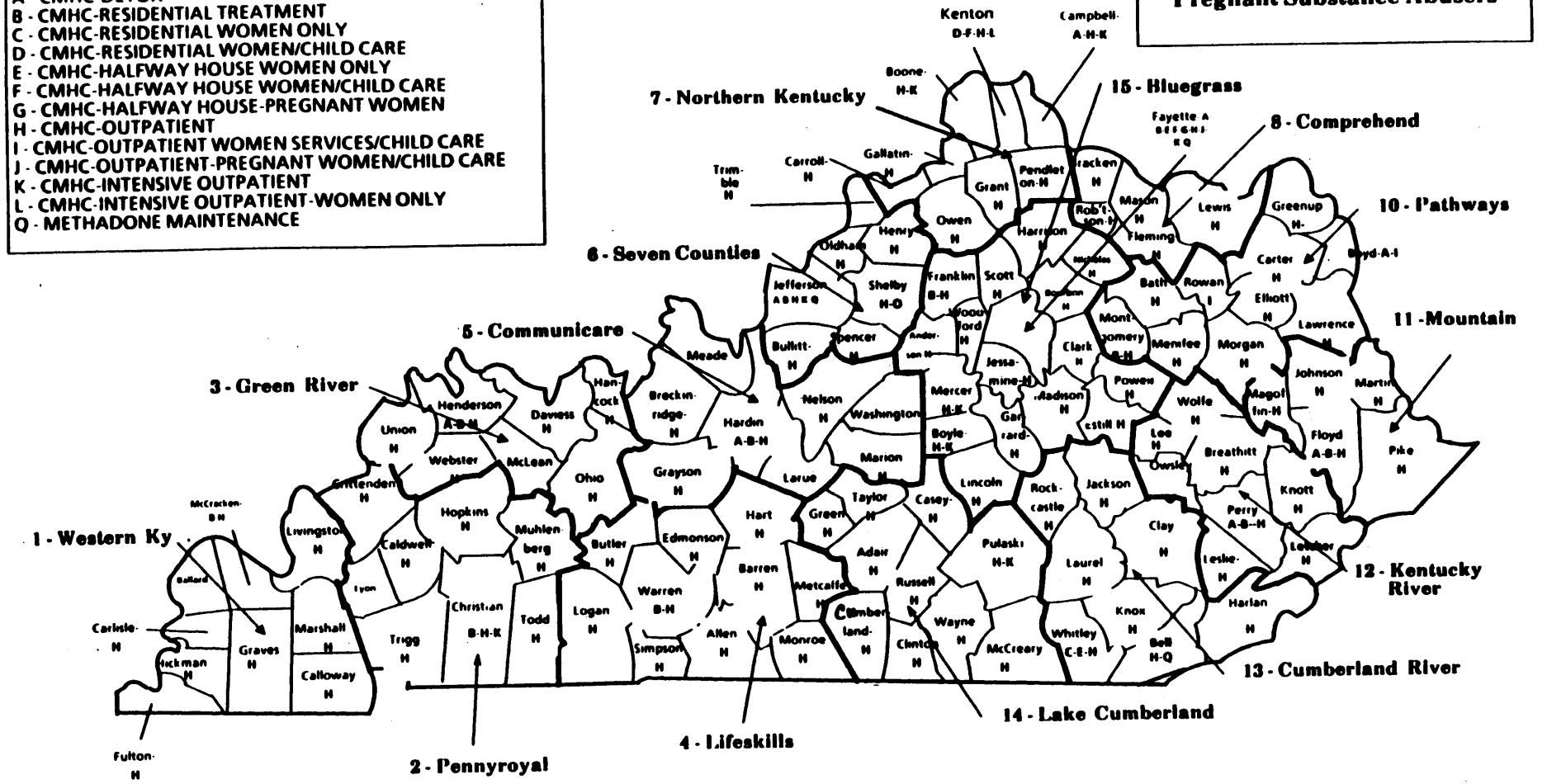


SOURCE: Cabinet for Human Resources, Department for Mental Health/Mental Retardation Services, Division for Substance Abuse
May 5, 1991

Summary of Community Mental Health Centers' Services for Pregnant Substance Abusers

LEGEND

A - CMHC-DETOX
B - CMHC-RESIDENTIAL TREATMENT
C - CMHC-RESIDENTIAL WOMEN ONLY
D - CMHC-RESIDENTIAL WOMEN/CHILD CARE
E - CMHC-HALFWAY HOUSE WOMEN ONLY
F - CMHC-HALFWAY HOUSE WOMEN/CHILD CARE
G - CMHC-HALFWAY HOUSE-PREGNANT WOMEN
H - CMHC-OUTPATIENT
I - CMHC-OUTPATIENT WOMEN SERVICES/CHILD CARE
J - CMHC-OUTPATIENT-PREGNANT WOMEN/CHILD CARE
K - CMHC-INTENSIVE OUTPATIENT
L - CMHC-INTENSIVE OUTPATIENT-WOMEN ONLY
Q - METHADONE MAINTENANCE

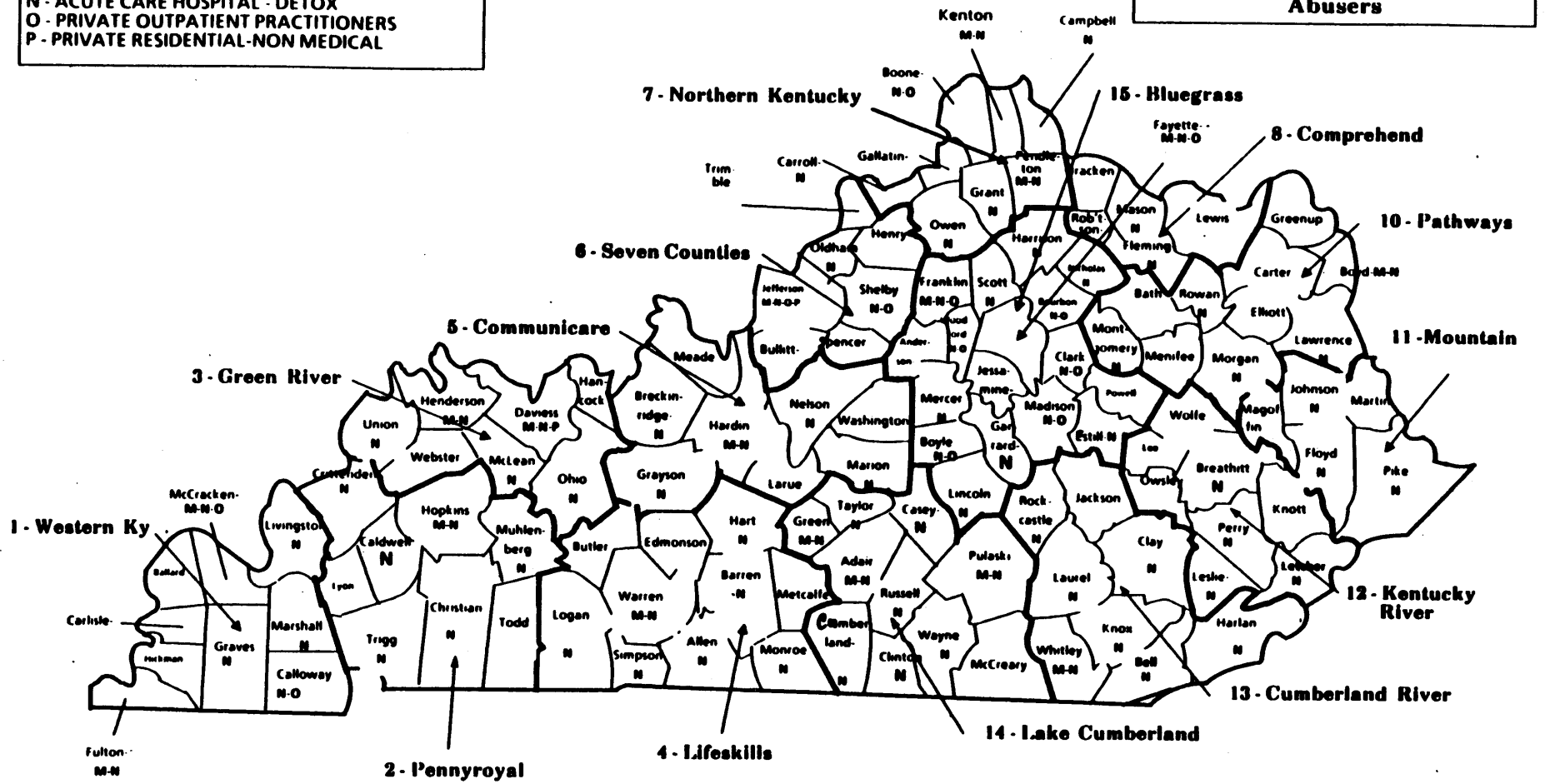


SOURCE: Cabinet for Human Resources, Department for Mental Health/Mental Retardation Services, Division for Substance Abuse
May 5, 1991

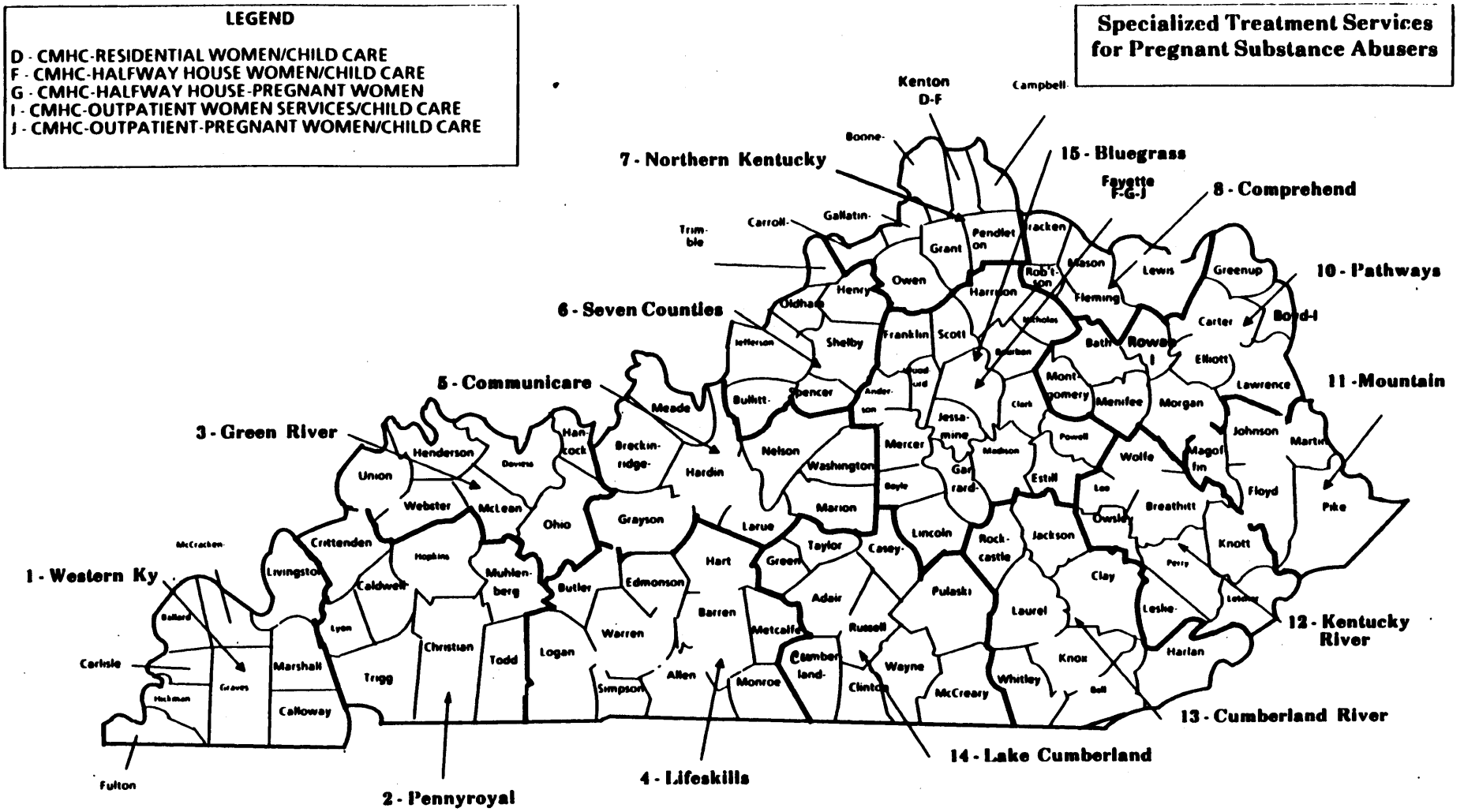
LEGEND

M - PRIVATE CHEMICAL DEPENDENCY HOSPITAL
N - ACUTE CARE HOSPITAL - DETOX
O - PRIVATE OUTPATIENT PRACTITIONERS
P - PRIVATE RESIDENTIAL-NON MEDICAL

Private Treatment Services Available for Pregnant Substance Abusers



SOURCE: Cabinet for Human Resources, Department for Mental Health/Mental Retardation Services, Division for Substance Abuse
May 5, 1991



SOURCE: Cabinet for Human Resources, Department for Mental Health/Mental Retardation Services, Division for Substance Abuse
May 5, 1991