

Perinatal Substance Use: Promoting Healthy Outcomes



Virginia Legal
Requirements
and Health
Care Practice
Implications



A Guide for
Hospital and
Health Care
Providers





Prenatal 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 education on:

- Prenatal care
- Nutrition during pregnancy
- Prevention of sexually transmitted infections (STI) and human immunodeficiency viruses (HIV)
- Effects of substance use on fetal development
- Safe sleep environments for infants

and provide:

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

Substance Use Screening in Prenatal Care

Pregnant women who use alcohol, tobacco, or illegal drugs risk their infant's health and development. Abuse of prescription or over-the-counter medications can also create health risks. Health care providers 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 use 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.

HEALTH CARE 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 shown that many women who abuse substances have a co-occurring mental health diagnosis and/or histories of trauma. Most substance users exhibit no signs upon physical examination.

Substance Use History/Screening

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

Patterns of use prior to conception are risk indicators for prenatal and postpartum use.

A substance use history should include questions regarding:

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

A substance use screening should include questions regarding:

- Effects of substance use on life domains 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.

Evidence-based 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 use, 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. Substance use screening and referral are Virginia Medicaid reimbursable services.

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 use assessment and possible treatment.

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

- The health care benefits of not using drugs, alcohol or tobacco during pregnancy.
- 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 postpartum.
- Evaluation and treatment options.
- Encouragement to accept a substance use assessment referral.
- Education regarding safe sleep.





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 women who abuse substances may lead to self-neglect, including poor diet. Though abstinence is the ultimate goal, any steps towards reducing use 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.

Plans of Safe Care

Federal legislation (Child Abuse Prevention and Treatment Act-CAPTA) requires that all substance-exposed Infants have a Plan of Safe Care which addresses their needs and those of their mother. The Plan of Safe Care should address the use of both legal and illegal drugs including the use of medically assisted treatment (MAT). The Plan should be initiated as soon as the child is identified as substance exposed- whether this is prior to, during or after delivery. Ideally, the Plan of Safe Care should be initiated during the mother's pregnancy. All efforts to address substance use during pregnancy should be documented as a Plan of Safe Care.

A Plan of Safe Care is a guide developed with the mother, her health care provider, other service providers and her personal support system that identifies resources needed to address the unique challenges for substance-exposed infants and their caretakers.



A Plan of Safe Care aims to:

- Ensure that the mother and child are not exposed to additional harmful factors during pregnancy; and
- Identify and connect families and newborn infants with follow-up services to ensure the child's well-being as they age.

Plans of Safe Care will vary depending on the individual circumstances. A Plan of Safe Care should address:

- **Basic needs** such as safe housing, medical care, mental health treatment needs, etc.
- **Delivery and Discharge plans** that includes birthing location, supports, information sharing with hospital staff and other service providers, safe sleeping environment, etc.
- **Infant needs** such as basic care items, breast feeding, transportation, pediatric care, etc.
- **Supports after delivery** such as substance use treatment, home visiting services, child welfare involvement, etc.

Health care, treatment and service providers involved in caring for women who use(d) substances during pregnancy are expected to develop and help implement Plans of Safe Care. Providers may include OB/GYNs, nurse practitioners, midwives, Opioid Treatment Programs (OTP), CSB and home visiting services.

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 provided services within 48 hours of their request. The CSB can help develop and implement the Plan of Safe Care and provide oversight of a hospital discharge plan. Check with the CSB in your community to learn more about substance abuse and available services.



HIV Screening in Prenatal Care

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.

HEALTH CARE 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%.





Referrals of Substance-exposed Infants to Child Protective Services

LEGAL REQUIREMENTS

§63.2-1509 of the Code of Virginia

Health care providers are required to report suspected child abuse or neglect to local departments of social services or to the Child Abuse and Neglect Hotline (1-800-552-7096). Children diagnosed by health care providers as affected by exposure to alcohol or drugs during pregnancy are also required to be reported.

HEALTH CARE PRACTICE IMPLICATIONS

In utero exposure to substances 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 or unstable or otherwise stressful home environments present additional risks to these children.

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

Identification of substance-exposed infants

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

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

- A medical finding is made, within 6 weeks of birth, that the child was born affected by substance abuse;
- A medical finding is made, within 6 weeks of birth, that the child is experiencing withdrawal symptoms (this includes both legal and illegal substances);
- An illness, disease, or condition attributable to in utero substance exposure is diagnosed within four years of birth; or
- A child is diagnosed with a Fetal Alcohol Spectrum Disorder (FASD) within four years of birth.

Assessment Procedures

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 use, dependence and other addictive behaviors. Assessment and testing 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.

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 from a urine, meconium, or hair sample. Blood and urine testing is only accurate for recent use i.e., within 24-72 hours.

While drug testing is useful for diagnostic and treatment purposes, it is NOT legally required to make a report to CPS.

Records Release

When reporting substance-exposed infants to CPS, 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 or neglect information and records to CPS 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 later than 24 hours after having a reason to suspect a reportable issue. Health care providers reporting in good faith are immune from civil and criminal liabilities 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 the first failure and not less than \$1,000 for any subsequent failure to report.





Local Department of Social Services Response

Local departments of social services, which are supervised by the Virginia Department of Social Services, have the 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 a child's immediate safety.
- Complete a Family Assessment or Investigation by:
 - Observing the child;
 - Interviewing family, siblings, other professionals;
 - Observing the child's home, sleeping environment;
 - Checking for prior reports on the family;
 - Conducting a risk assessment; and
 - Arranging for or providing services.

CPS services are provided to abused or neglected children and their families regardless of income. The primary goal of CPS is to strengthen and support families through preventing the (re)occurrence of child maltreatment by partnering with community-based services. CPS can also help to ensure that a Plan of Safe Care is developed and implemented.

Hospital Discharge Planning for Postpartum Women who Use Substances and their Infants

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.





HEALTH CARE PRACTICE IMPLICATIONS

Postpartum, women who use substances and their newborns typically have multiple health care, treatment, safety, and environmental needs. Their hospital discharge plan, a critical component of the Plan of Safe Care, should include:

- A referral of the mother to a local CSB for a substance use assessment, implementation of the discharge plan and oversight of the Plan of Safe Care.
- Information and medical directives regarding potential postpartum complications and, as appropriate, indicators of substance use withdrawal.
- A referral to CPS if the child is identified as a substance-exposed infant or there are other child abuse or neglect concerns identified by the health care provider(s).
- A follow-up appointment for pediatric care within 2-4 weeks.
- A referral to early intervention Part C services for a 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, CSB, and CPS can help engage and motivate the mother to follow through with her Plan of Safe Care and 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/entity receiving the information.
- Amount and kind of 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 re-disclosure and may not be used in a criminal investigation or prosecution.

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

Discharge Education on Postpartum Blues, Perinatal Depression, Abusive Head Trauma, and Safe Sleep Environments

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.
- Safe sleep environments for infants, consistent with recommendations made by the American Academy of Pediatrics.

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.

HEALTH CARE PRACTICE IMPLICATIONS

Postpartum blues and perinatal depression

Research has shown that 6-15% of all pregnant women experience depressive symptoms during a pregnancy or in the first year following birth. About 10% of these 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. Women who experience perinatal depression may have symptoms that interfere with their ability to care for themselves, their infant and/or conduct normal activities. Perinatal depression often goes unrecognized because women may be reluctant to report their symptoms to their health care provider. 10-15% of postpartum women experience depression.



Patient Discussion

Education about postpartum blues and perinatal depression is best discussed within a health care context. A supportive discussion includes:

- Incidence of postpartum blues and perinatal depression.
- Signs and symptoms of postpartum blues and perinatal depression.
- The importance of sharing her symptoms and feelings with family, friends, and her health care provider(s).

Educational resources for health care providers and caretakers are available at www.mededppd.org.

Abusive Head Trauma

Abusive Head Trauma (formerly known as Shaken Baby Syndrome) is severe brain damage to or death of an infant or small child resulting from violent shaking or shaking and impacting the head. It is a form of child abuse. Every year there are 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 die as a result of injuries.

Patient Discussion

Information about Abusive Head Trauma is best discussed within a health care context. A supportive discussion includes:

- 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





Safe Sleep Environments

Approximately 3,500 infants die annually in the United States from sleep-related deaths, including: SIDS; ill-defined deaths; and suffocation or strangulation. Research shows that several factors put babies at higher risk for Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of death. The American Academy of Pediatrics published 18 recommendations to reduce the risk of SIDS or other sleep related deaths. Some of these include:

- Infants should be placed to sleep on their backs.
- Infants should sleep on a firm sleep surface.
- Bed sharing with infants is not recommended, room sharing is fine.
- Soft objects and loose bedding should not be in the infant's sleep area.
- Avoid exposing infant to second-hand smoke, alcohol or illicit drugs.
- Breastfeeding of infants is recommended.
- Pacifiers are recommended.
- Avoid overheating the infant.

Patient Discussion

Information about reducing the likelihood of SIDS or other sleep-related deaths is best discussed within a health care context. A supportive discussion includes what a caretaker can do before and after birth to reduce the risk of SIDS or other sleep related deaths.

Educational resources for parents and other caregivers, including grandparents, are available on the Safe to Sleep® website: <https://www.nichd.gov/sts/Pages/default.aspx>



Effective Practices

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

- Routinely screen all pregnant women regarding substance use, mental health, and risky behaviors.
- Conduct screening 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.

State Resources

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

Virginia Department of Health Division of Women's
and Infant's Health
<http://www.vdh.virginia.gov/vdhlivewell/women/>
(804) 864-7772

Department of Behavioral Health and Developmental
Services (DBHDS), Office of Adult Community
Behavioral Health Services
[http://www.dbhds.virginia.gov/individuals-and-families/
substance-abuse](http://www.dbhds.virginia.gov/individuals-and-families/substance-abuse)
(804) 786-3906

Early Intervention Part C Services Infant & Toddler
Connection of Virginia
<http://www.infantva.org/>
(800) 234-1448

Additional Resources

American Congress of Obstetricians and Gynecologists
<http://www.acog.org/>

American Academy of Pediatrics
[https://www.aap.org/en-us/about-the-aap/Committees-
Councils-Sections/Section-on-Child-Abuse-Neglect/
Pages/Child-Abuse-Neglect.aspx](https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-Child-Abuse-Neglect/Pages/Child-Abuse-Neglect.aspx)

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

American Society of Addiction Medicine
<http://www.asam.org/>

National Institute on Drug Abuse
<https://www.drugabuse.gov/>

Safe to Sleep®
<https://www.nichd.nih.gov/sts/Pages/default.aspx>

Substance Abuse and Mental Health Services
Administration
<https://www.samhsa.gov/>

Postpartum Blues and Perinatal Depression
<https://www.womenshealth.gov/>



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Brochure design by the Virginia Department of General Services,
Office of Graphic Communications

B032-01-0037-04-eng (07/17)