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ABSTRACT

A research project acquired and compiled information on the services (from state and federally funded programs in California) available for chemically dependent pregnant and parenting women and young drug-exposed children from birth to age 3. The research methods consisted of a literature review and a survey of 13 key state and federally funded programs financing alcohol and/or drug treatment and recovery services, health care, social services, and early intervention services for young children. Findings showed that: (1) there is a wide gap in services between what is appropriate and necessary and what currently exists; (2) significant variation exists in the types of services available through the programs; (3) the eligibility criteria for services and the process for obtaining eligibility presented problems for the target population attempting to receive the services; (4) service coordination appears to be widespread; (5) data are lacking at both the state and local levels; (6) state budget deficits have resulted in the creation of few new services as well as minimal increase or reduction in funding of existing services. New proposals for funding and/or organizing services were suggested. Policy recommendations were made related to the six areas mentioned above with a view to evolving the model of care described earlier. A major outcome of this project was a family-centered, comprehensive, and coordinated model of care for women, children, and families affected by perinatal alcohol and drug use. (A 73-item annotated bibliography and survey instruments are appended.) (BAC)

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Perinatal Alcohol and Drug Use

Access to Essential Services in 12 California Counties

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The research on which this report was based was commissioned by the Policy Research Program of the California Policy Seminar. The views and opinions expressed in this report are those of the authors and do not necessarily represent the California Policy Seminar or the Regents of the University of California.

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EXECUTIVE SUMMARY

Perinatal Alcohol and Drug Use: Impact on Women and Children

Perinatal alcohol and drug use — i.e., use during pregnancy and the first year of a child's life — is a serious problem for women of child-bearing age, their children, and their families. Although increasing numbers of women appear to need treatment and recovery programs, few are receiving these services. Pregnant women find it particularly difficult to find services. In one national survey, 280,000 pregnant women were estimated to need drug treatment in 1990, yet fewer than 11% were receiving it. Similarly, a U.S. General Accounting Office survey found that all women routinely wait weeks, even months, for entry into treatment. Pregnant and parenting women also lack access to many other critical health and social services, including perinatal health care.

Estimates of the prevalence of prenatal drug exposure (i.e., drug use during pregnancy) in the U.S. and California are inexact, and those that exist tend to concentrate on cocaine, disregarding other commonly used drugs that are potentially injurious to fetuses (e.g., alcohol, heroin, amphetamines, methamphetamines, and PCP).

Accurate and comprehensive information is also lacking on the long-term impact of prenatal drug exposure on children. In cases where alcohol and drug exposure is associated with developmental problems, the effects of other factors — such as parental alcohol and drug addiction — often cannot be ruled out. Whether children's development is compromised by physiological exposure to alcohol and other drugs, by the effects of impoverished, high-risk families, including those profoundly affected by alcohol and drug use, or by both, early intervention and support services can play a critical role in preventing or ameliorating poor developmental outcomes.

Pregnancy may offer an excellent opportunity for intervention in a woman's alcohol and drug use, as her pregnancy and concern for her newborn often provide compelling motivation to enter treatment. The relationship between pregnancy and parenthood and recovery suggests the importance of services for pregnant and parenting women with alcohol and drug problems, as the relationship between early intervention and good outcomes for children suggests the importance of children's services.

In California, although access to specific services for women and children has been examined, there has been no comprehensive, reliable information on the services available for chemically dependent pregnant and parenting women and young drug-exposed children. To provide the needed information, we designed a research project consisting of a literature review, development of a comprehensive model of care for the target population that reflects consensus among a statewide panel of experts, and surveys to identify and then assess state and federally funded programs financing a range of health and social services provided to a population that *might* include chemically dependent pregnant and postpartum women and drug-exposed children from birth to age 3.

Research Questions and Methods

Thirteen programs from five state departments were identified (see Table 1). The first of two questionnaires elicited information from state, county, regional, and local administrators of the 13 programs regarding their programs' eligibility requirements, range of services, program funding, efforts to coordinate services for the target population, and number of children served, with an additional section for state and county administrators of county social services focusing on their policies concerning the removal of drug-exposed children from their mothers. A second questionnaire was designed for county coordinators of the Comprehensive Prenatal Services Program, asking how many women CPSP serves in the county, the number eligible who are not being served, waiting times and waiting lists for services, and whether the county compiles estimates of the number of women and children affected by perinatal alcohol and drug use.

The surveys were conducted in 12 counties to represent a strategic sample, including (1) counties with significant populations of young drug-exposed children and (2) those which, at the time of the survey, were administering state Options for Recovery perinatal pilot projects. Counties meeting these criteria were clustered in the state's two large urban regions. Urban, suburban, and rural counties were also included so that the sample reflected the state's ethnic and geographic diversity. The 12 counties surveyed were Alameda, Humboldt, Kern, Los Angeles, Monterey, Orange, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Tulare.

Thirteen state administrators, 64 county administrators, 46 local administrators, and 29 regional administrators were interviewed, for a total of 152 respondents. Survey data represent 65 programs that serve women and 84 programs that serve children, with 9 serving both. Only one survey was completed for each program included in the project.

Findings and Policy Implications

Model of Care

A major product of this research project was a family-centered, comprehensive, and coordinated model of care for women, children, and families affected by perinatal alcohol and drug use. This model of care, the result of consensus among a statewide panel of experts, provides a template for both researchers and concerned communities to compare existing services with what should be in place for vulnerable women and children.

Access to Services

Findings clearly showed that the comprehensive, family-centered, coordinated service system described in the model of care does not exist in the surveyed counties. There is a wide gap in services between what is believed to be appropriate and necessary for the target population of women and children and what currently exists. Barriers to existing services as well as the lack of important services for women and children were identified as serious impediments to access to care. Among the barriers to access identified were the following:

- the exclusion of women based upon their pregnancy, parenting, and medical status (e.g., women with high-risk pregnancies, women with both alcohol/drug use and mental illness, women with children);

• overly restrictive eligibility criteria for early intervention services for children, resulting in service access only for children with severe disabilities or who demonstrate developmental delays at the time of assessment;

• the Medi-Cal application process, including a long, complicated application form and stringent requirements for documentation;

• long waiting lists for services for almost half (47.5%) of all surveyed programs that serve women. Women waited an average of more than 5 weeks and as long as 9 weeks for access to CPSP. The wait for access to residential treatment for women ranged from 1-6 months. Adolescents seeking access to Adolescent Family Life Programs (AFLPs) waited an average of 12 weeks and could wait as long as 6 months for services;

• waiting times of 2-3 months for access to children's services;

• the lack of prenatal and pediatric providers;

• the lack of bilingual and/or bicultural health care and other providers, resulting in a lack of culturally appropriate services.

Other critical services simply do not exist for women and children. The survey indicated wide agreement that the following additional services are needed in the sample counties: alcohol and drug treatment, including residential treatment for women *with their children*, medical detoxification, day treatment, methadone maintenance; early intervention services for children, including infant/parent psychotherapy, developmental assessments, and followup with children who are at risk for but have not yet demonstrated developmental delay; parenting skills and training; case management; housing. In addition, the lack of child care and transportation was consistently cited as limiting women's ability to take advantage of existing services.

Program Services

The extent of the variation of services provided by similar programs in different counties results in gaps in services for women and children based solely on their county of residence. Although 10 of the 13 surveyed programs exist in all 12 sample counties, there were often great differences in the extent and comprehensiveness of these services. Three of the 13 programs, in particular, displayed great variability across counties: Prenatal Care Guidance (PCG) within the Child Health and Disability Prevention program; Part H Early Intervention Services for Infants and Toddlers; and county alcohol and drug programs. To give some examples: the services provided in some PCG programs consist only of phone and/or mail contacts for referral and followup with pregnant women; those provided by the 56 programs funded under Part H range from limited parent support, education, and case coordination to a full package of comprehensive family services, counseling, intake, case management, infant assessment, and early intervention services; methadone maintenance was not available in one-quarter of the target counties; 42% of the counties had *no* residential treatment facility for women with their children; and 17% lacked detoxification services for women.

Eligibility Criteria and Process

Both the eligibility criteria and the process for obtaining eligibility presented problems for women and children attempting to receive services from the programs we surveyed. The health-related criteria for entry into major programs that serve

children are often very stringent, and ultimately exclude many at-risk children from services.

Both the Comprehensive Perinatal Services Program and the Child Health and Disability Prevention program use Medi-Cal eligibility and the Medi-Cal application as the point of entry for service. Even with recent eligibility expansions, Medi-Cal eligibility criteria still exclude many low-income women and children, and the application itself is viewed as a major hurdle. Access to the CHDP program also requires meeting complicated income and age criteria that are often confusing to both service providers and potential clients, and may operate as barriers to service.

Coordination of Services

As measured by both formal and informal linkages to coordinate services for women and children affected by alcohol and drug use, coordination appears to be widespread in each of the 12 counties surveyed. At least 64% of the programs in each county reported formal linkages, such as membership in task forces or councils and interagency agreements, among a range of county agencies. County mental health programs were the *least likely* of the major county agencies to be involved in either formal or informal coordinating activities, often showing far less involvement than other health and social services. At the same time, survey respondents noted that dual diagnosis is a growing issue for treatment and recovery providers.

Data Collection

Data are lacking at both the state and local levels regarding the prevalence of perinatal alcohol and drug use, the number of women and children eligible for services, and the number who currently receive services. Many of the programs we surveyed do not collect county prevalence data. Few programs not directly involved in alcohol or drug treatment (such as family planning) appear to be asking women clients about their use of such substances, and so are unaware of the extent of the problem among the women they serve. Even when programs do estimate incidence and prevalence of perinatal alcohol and drug use, there is such variation among the estimates that they often differ among programs within the same county. A state prevalence study now being conducted by the Department of Alcohol and Drug Programs may begin to answer some questions regarding the extent of perinatal alcohol and drug use in California.

Comprehensive Perinatal Services Programs in particular lack data on the number of women served by the program, and county coordinators reported that, in general, little information is collected from private CPSP providers. The lack of data on CPSP makes it virtually impossible to estimate the unmet need for these services. Moreoever, at the time of the survey, the age categories used in compiling county social services data were not standardized, making it difficult to assess the impact of perinatal alcohol and drug use on the social services system for young children.

Funding Issues

Program funding stability relates largely to funding source, and is often profoundly affected by whether the funding is federal, state, or county, or in what proportions these funding sources are combined. State budget deficits of the past few years have resulted in creation of few new services as well as minimal increases or actual reductions in funding of existing services.

Options for Recovery, the one program of comprehensive services specifically designed for chemically dependent pregnant and parenting women and their children, will receive state funding only through December 31, 1993, after which time counties interested in maintaining it will have to assume complete financial responsibility for doing so. The state perinatal initiative, an infusion of $23 million to create and expand treatment and recovery services for pregnant and parenting women, allows counties to support treatment services that survey respondents believe are sorely needed, but this initiative is not designed to support the comprehensive, coordinated, case-managed system of care that underlay Options and that is recommended in this project's model of care.

Grant funding — from such sources as the federal Office for Substance Abuse Prevention, the National Institute on Drug Abuse, the state Office of Child Abuse Prevention, and private foundations — appears to play a prominent role in supporting unique and comprehensive services for these populations of women and children by allowing programs to create services that more traditional federal, state, or county funding sources have not supported.

Policy Recommendations

A comprehensive, family-centered, coordinated system of care for chemically dependent women and drug-exposed children does not exist in any of the 12 counties we surveyed. We believe that policy recommendations proposing expansion of services, changes in both eligibility criteria and the determination process, enhanced funding for services, and improvements in data collection ultimately will support the development of a comprehensive and coordinated system of care for chemically dependent women and drug-exposed children in California.

Identification and Assessment of Target Population

Health and psychosocial screening/assessment should be a routine part of care for all women and children, not only those suspected of alcohol and/or drug use or exposure. Implementation of the following recommendations will improve the identification of chemically dependent women and drug-exposed children:

1. The Office of Family Planning should encourage family planning programs to expand their role in identifying chemically dependent women. The office could:

- assist programs in training their staff to recognize and intervene when alcohol and drug problems are present and to develop appropriate referral resources;
- encourage programs to develop links with local alcohol and drug treatment and recovery programs, including residential services for women; and
- encourage programs to add questions concerning women's use of alcohol and other drugs to the program intake risk assessment process and disseminate model risk assessments.

The office should ensure that evaluation of the family planning projects under the state's $10 million family planning initiative include an assessment of the programs' effectiveness in identifying, intervening with, and assisting in obtaining treatment for chemically dependent women and adolescents, including those who are pregnant.

2. The departments of Health Services and Alcohol and Drug Programs should encourage local programs, including prenatal care clinics, CPSP providers, and

hospitals, to incorporate questions regarding women's use of alcohol and drugs in history-taking and risk assessments, as recommended in the Model Needs Assessment Protocol under SB 2669. Private obstetric and gynecological providers should also be encouraged, through professional associations, to screen their clients for alcohol and drug use.

3. The departments of Health Services, Alcohol and Drug Programs, and Developmental Services should work with professional organizations to encourage providers to evaluate newborns immediately after delivery for actual or potential medical and developmental problems and to ensure that children receive periodic assessments during their first three years of life to identify developmental delays that are not immediately evident. Screenings after three years of age should also be encouraged to identify delays with late onset.

Access to Program Services

Implementing the following recommendations would improve the range of services available to chemically dependent women and drug- exposed children:

1. The state should expand existing programs that have proven effective in providing services to women and children. AFLP and HRIF are examples of effective programs that cannot meet the demand from eligible populations. Existing services for this population that have been designed to be comprehensive, coordinated, and case-managed, such as the Options for Recovery projects, should be maintained and expanded.

2. New services should be established when necessary to ensure the availability of service slots to meet women's current needs for perinatal care, alcohol and drug treatment and recovery, and family planning services, as well as children's needs for early intervention services and health care. Programs should also be expanded to meet the needs of women and children in geographic areas that have no existing services. Programs should be encouraged to develop a "one-stop shopping model," providing comprehensive services for women and children on site when possible, and linking clients to additional services in the community through coordination and case management.

3. The needs of special populations of at-risk women and children should be considered and planned for as any new proposals for delivery of health care are developed. For example, in developing plans to expand services, the Department of Health Services should seek to create a seamless system of health services for all low-income children, so that a single, comprehensive package of services is available to all children from birth to age 21 with incomes to at least 200% of the Federal Poverty Level. The state should consider expanding this system to include children in the 200-300% of FPL bracket. Newly implemented programs or those under development, such as AIM and CheckUp, should also provide for comprehensive care.

4. Critical support services such as transportation and on-site child care should be funded to facilitate access to services.

5. The state should implement steps to attract and maintain private-sector Medi-Cal, CHDP, and CPSP providers, including increased provider rates and streamlined paperwork. Such steps are critically important because the lack of providers so often is a major barrier to service.

Eligibility

Both the eligibility criteria and the process for obtaining eligibility present problems for women and children who attempt to receive services from the programs surveyed. The health-related criteria for entry into major programs that serve children (California Children's Services, High Risk Infant Follow-Up, Part H, Regional Centers' prevention programs, and special education programs) are often very stringent and exclude many at-risk children from services.

In addition, two major health programs for women and children, CPSP and CHDP, use Medi-Cal eligibility and the Medi-Cal application as the point of entry for service. Medi-Cal eligibility criteria, however, exclude many low-income women and children, and the application as well as determination process are often major hurdles for women and children applying for services.

Implementation of the following recommendations would improve access to services:

1. The state should consider broadening eligibility criteria for existing programs that provide early intervention services to allow for the provision of services to children who are at risk of, but have not yet manifested, developmental delay. These should provide for reevaluating children who previously were found not to manifest delay. The age limitations in these programs should also be expanded to allow continuous services for at-risk children from birth to at least 3 years of age.
2. The state should streamline the Medi-Cal application so that it ceases to act as a barrier to access to care, drawing on the experiences of other states that have implemented shorter applications, as well as the shorter application currently being piloted in San Bernardino County.
3. The state should station more Medi-Cal eligibility workers in the community to facilitate the eligibility process. Additional sites should include sites serving high proportions of low-income women and children.
4. The state should expand Medi-Cal eligibility to include presumptive eligibility for pregnant women and continuous eligibility for women to at least one year postpartum, instead of the current 60 days.

Coordination of Services/Case Management

Service coordination — strategies that create and foster linkages among programs, agencies, and departments — appears to be widespread, with the vast majority of program administrators citing the importance of information-sharing, of having a forum for policy and protocol development, and of multidisciplinary, interagency education. Case management, or strategies that link individuals with services, has been recognized as a key to ensuring access to services and assisting women and children to successfully complete treatment. The extent and availability of case management varied greatly among the 12 surveyed counties and among the 13 categories of programs.

The following recommendations are proposed to improve access to services by supporting interagency coordination and case management:

1. State-level coordination efforts should continue, such as the State Interagency Task Force. State departments should also support and assist in funding local coordination activities so as not to divert money or staff from the provision of direct services.

2. State departments now concerned with perinatal alcohol and drug use should develop a working relationship with the Department of Mental Health in order to coordinate services for women who are both alcohol and/or drug dependent and mentally ill.

3. County, local, and regional organizations should involve mental health-related organizations in coordination efforts concerning perinatal alcohol and drug use, including local coalitions and task forces.

4. County and local programs should continue to participate in local coordinating and planning bodies. Services for individual clients should be coordinated through case management, with a primary case manager agreed on by all agencies participating in a client's service plan.

5. Counties that have received funding through the $23 million state perinatal alcohol and drug initiative (57 of California's 58 counties) should be encouraged to coordinate their existing and new treatment, perinatal, and support services for women and their children through such mechanisms as case management. They should be permitted, for example, to use initiative funds to support case management by paying salaries of public health nurses to provide these services.

Funding

State budget deficits of the past few years have resulted in the creation of few new services as well as minimal increases or actual reductions in funding of existing services, including surveyed programs such as AFLP, HRIF, Black Infant Mortality, Regional Centers, and county social services. As mentioned earlier, Options for Recovery, the one program providing comprehensive services designed for the target population of women and children, will receive no state funding after December 31, 1993. Federal funds and particularly Medicaid dollars must be maximized to augment funding for services that are currently supported primarily through state funds.

We recommend the following approaches to enhance financing for this population:

1. The state should commit to the development of a comprehensive, family-centered, and coordinated system of care, such as that recommended in the model of care, for alcohol- and drug-affected women and children. New funding initiatives for services for these women and children should contribute to that goal. The state should explore the combining of funding from multiple state and federal sources to create comprehensive, integrated services. The Options for Recovery perinatal pilot projects, which originally received funding from three state departments, can serve as a model for this approach.

2. The state should exploit all existing sources of funding for case management services. Targeted case management, an optional Medicaid benefit, should be implemented for specific populations including chemically dependent pregnant and parenting women and adolescents. Targeted case management for adolescents has already been mandated by AB 2764 (Chapter 720, 1990), but not yet implemented. In addition, case management for children should be covered through Medi-Cal when this service has been identified as necessary through a federally mandated Early Periodic Screening, Diagnosis, and Treatment Program exam (EPSDT is run by CHDP in California). This coverage is required under the federal Omnibus Budget Reconciliation Act (OBRA, 1989), but has not yet been implemented in California.

3. Counties should be encouraged to fund case management for women and children with the assistance of federal matching dollars under Medi-Cal, as permitted under SB 910 (Chapter 1179, 1991).

4. The state should fund medical detoxification for women under Medi-Cal.

5. The state should use maternal and child health block grant funds to provide comprehensive assessments, early intervention, and other services for children at risk, either because of drug exposure or other factors that increase their risk of health and/or mental health problems or developmental delays. OBRA requires that 30% of these funds be used for services for children with special health care needs, and that these services promote family-centered, community-based, coordinated care. California has not yet tapped these funds to support programs for at-risk children, which would be a very appropriate use of the block grant.

6. The state should continue to participate in the Part H early intervention program beyond the fourth planning year, utilizing federal Part H dollars to enhance the delivery of early intervention services.

7. The state should continue to invest in alcohol and drug prevention education programs, perhaps looking to the cost-effective tobacco education campaign as a model.

Data Collection

Implementation of the following recommendations would improve data collection among programs at both the state and local levels.

1. The state and counties should work together to standardize collection so that county data are comparable. County social services departments in particular should collect data by the same age groups, including the birth-to-3 age group. They should also collect retrievable data on the role of prenatal and familial alcohol and drug use in Child Protective Services interventions and custody removal decisions.

2. The Department of Alcohol and Drug Programs should encourage counties to use its raw and aggregate data in planning and developing programs. In addition, the department should release state prevalence study data as soon as they become available to assist in the county and agency planning process. The new California Alcohol and Drug Data System (CADDS) should im-prove the collection and analysis of alcohol and drug treatment data at the state level, and the state prevalence study now under way should also provide valuable information on the extent of perinatal alcohol and drug use. Information from both data collection projects should be made available to counties on a timely basis to enhance planning.

3. The Department of Health Services should improve data collection in the CPSP program to obtain information on the number of women served, program costs, and the criteria used by local CPSP providers to admit women to their practices for perinatal care.

INTRODUCTION

Perinatal Alcohol and Drug Use: Impact on Women and Children

Perinatal alcohol and drug use is a serious problem for women of child-bearing age, their children, and their families. Alcohol and drug use among women is now believed to occur at much higher rates than previously thought. The National Institute on Drug Abuse (NIDA) estimates that 60% of all women of child-bearing age drink alcoholic beverages. During their peak reproductive years (ages 18-34), 10% of all women are estimated to consume an average of two or more drinks per day, or 14 or more drinks per week, an amount that clearly poses risks to a pregnant woman and her fetus. In addition, NIDA estimates that nearly 10% of all women of child-bearing age use illegal drugs.[1] Estimates of the percentage of women who actually use alcohol and other drugs during pregnancy vary. The California Department of Alcohol and Drug Programs estimates that as many as 90,500, or almost 15%, of the more than 600,000 live births in the state in 1990 involved perinatal alcohol and drug exposure.[2]

Increasing numbers of women appear to need recovery programs for alcohol and drug abuse. In 1991, for example, 39% of all California admissions to drug treatment programs were women. Of these, 93% were women of child-bearing age (ages 15-44).[3] Nationally, the Institute of Medicine estimates that 10% of the women identified in the NIDA survey as using illegal drugs *clearly* need treatment, and another 20% *probably* need treatment.[4] There is evidence, however, that women are not obtaining treatment for their alcohol and/or drug use. Studies report men outnumbering women in treatment facilities at ratios higher than 4:1.[5] For example, a 1987 national study of state-funded alcohol and drug programs found that fewer than 20% of all admissions were for women.[6] Pregnant women find it particularly difficult to find accessible alcohol and drug services. A 1990 survey conducted by the National Association of State Alcohol and Drug Abuse Directors estimated that 280,000 pregnant women nationwide need drug treatment, yet fewer than 11% of them are receiving these services. Similarly, a national survey by the U.S. General Accounting Office found that women, including pregnant women, routinely wait weeks, even months, for entry into treatment.[7] Many programs do not admit women or treat them in far smaller numbers

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[1] In Cook, P.S., Peterson, R.C., and Moore, D.T. (1990). *Alcohol, Tobacco, and Other Drugs May Harm the Unborn.* Rockville, MD: Office for Substance Abuse Prevention.

[2] California Department of Alcohol and Drug Programs. (1992). *Data Sheet on Perinatal Drug and Alcohol Use and Women in Treatment.* Sacramento, CA: Author.

[3] California Department of Alcohol and Drug Programs, op cit.

[4] Gerstein, D.R., and Harwood, H.J. (Eds.). (1990). *Treating Drug Problems: Volume I.* Washington, DC: National Academy Press.

[5] Harrison, P.A., and Belille, C.A. (1987). "Women in treatment: Beyond the stereotype." *Journal of Studies on Alcohol*, 48 (6), 574-578.

[6] Butynski, W., and Canova, D.M. (1988). "Alcohol problem resources and services in state supported programs, FY 1987." *Public Health Reports*, 102, 611-620.

[7] U.S. General Accounting Office. (1990). *Drug-Exposed Infants: A Generation at Risk.* Washington, DC: Author.

than men.[8] Many of the treatment facilities that do accept women, including public ones, are reluctant to accept pregnant women, believing that pregnancy is a medical condition that the program is unequipped to handle.

Financial barriers to treatment severely limit women's access to services. California does not mandate insurance coverage of alcohol and drug treatment, as do a number of other states. Mandatory insurance coverage might make services in the private sector more available for those women with health insurance. Publicly funded programs are often the only treatment option for most women with alcohol and drug problems. The U.S. General Accounting Office in its 1991 study found that inadequate treatment capacity, coupled with lack of appropriate services, was the primary barrier to treatment in the public sector for pregnant women.[9] Medi-Cal, California's state Medicaid program, provides reimbursement for some alcohol and drug treatment for low-income women, including methadone detoxification and maintenance, outpatient drug-free services, intensive day treatment services, and provision of Naltrexone. The state is now in the process of developing standards to add Medi-Cal coverage of residential treatment for pregnant and postpartum women who use alcohol and drugs, as required by the passage of AB 390.[10]

Chavkin's study of drug treatment facilities in New York City illustrates the impact of financial barriers and program bias against pregnant women: 54% of all programs surveyed categorically do not accept pregnant women as clients; 67% do not accept pregnant women on Medicaid; and 87% do not accept a pregnant woman on Medicaid who is addicted to crack cocaine.[11] Furthermore, although race and class differences regarding use of alcohol and other drugs appear to be minimal, race and class bias clearly plays a role in how chemically dependent women may be treated. For example, one study found that African American women are almost ten times as likely as white women to be reported to child welfare services for drug use.[12]

Pregnant and parenting women also lack access to many other critical health and social services. Obstetric services are virtually impossible to find in some areas of the state, particularly for women on Medicaid. Nationally, one-third of all private obstetricians do not accept Medicaid patients.[13] Twenty-five percent of all American women do not receive prenatal care early in pregnancy, and more than 5% receive

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[8] Blume, S.B. (1986). Women and alcohol: Public policy issues. In *Women and Alcohol: Health-Related Issues* (pp. 294-311). Research Monograph No. 16. Washington, DC: National Institute on Alcohol Abuse and Alcoholism; Reed, B.G. (1987). "Developing women-sensitive drug dependency treatment services: Why so difficult?" *Journal of Psychoactive Drugs*, 19(2), 151-164.

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[10] Speier, J. Chapter 429 (AB 390), California State Legislature, 1991.

[11] Chavkin, W. (1990). "Drug addiction and pregnancy: Policy crossroads." *American Journal of Public Health*, 80, 483-487.

[12] Chasnoff, I.J., Landress, H.J. and Barrett, M.E. (1990). "The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida," *New England Journal of Medicine* 322(17): 1202-1206.

[13] Children's Defense Fund. (1991). *The State of America's Children, 1991*. Washington, DC: Author.

little or no care at all.[14] These figures hold true for women in California as well. More than 5 million of the state's citizens — over 20% of the state's population — have no health insurance coverage at all, ranking California ninth on the list of states with the highest rates of uninsured. Most uninsured persons in California are women and their children.[15]

Estimates of the prevalence of prenatal drug exposure in both California and the United States are inexact.[16] According to a 1989 National Drug Control Strategy report, an estimated 100,000 infants are exposed to cocaine each year. (The report did not address alcohol, or drugs other than cocaine.) The National Association for Perinatal Addiction Research and Education has estimated that as many as 375,000 infants may be exposed to illicit drugs each year, most commonly cocaine. Neither alcohol nor legal drugs are included in this estimate.[17] As mentioned above, California's estimates of the incidence of drug exposure among newborns are based on the application of two different formulas. Some of these estimates are based on toxicological urine screening of women and newborns at delivery. Prenatal exposure to cocaine appears to have peaked in 1989, using positive toxicological screen reports at public hospitals as the gauge. Oakland, San Francisco, and Los Angeles all reported percentages of newborns with positive screens at 10–15% of deliveries in 1988-89. As of mid-1991, that percentage appears to have dropped somewhat and leveled off at 9–10%, with Oakland showing the steepest decrease.[18] These figures are based on toxicological screens at public hospitals, and only on screens of babies whose mothers met specific risk criteria.

In sum, the incidence and prevalence data on perinatal alcohol and drug use are imprecise. The figures do not as a rule reflect alcohol use, and tend to concentrate on cocaine exposure rather than drugs known to be both commonly used and potentially injurious to fetuses (e.g., heroin, amphetamines, methamphetamines, and PCP). Evidence shows that a significant proportion of the state's highest-cost newborns were exposed to drugs prenatally. On the basis of a survey of all Neonatal Intensive Care Units during one week in August 1988, the Department of Health Services estimates that more than 20% of all infants admitted to these units statewide were drug-exposed.[19]

Accurate and comprehensive information on the long-term impact of prenatal drug exposure on children is also lacking. Fetal Alcohol Syndrome, for example, has only

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[14] Brown, S.S. (1988), Preventing low birthweight. In H.M. Wallace, G. Ryan, Jr., and A.C. Oglesby (Eds.), *Maternal and Child Health Practices* (pp. 307-324). Oakland, CA: Third Party Publishing Co.

[15] Romney, B. (1990). *Code Blue: The Medi-Cal Emergency.* San Francisco, CA: Consumers Union; U.S. General Accounting Office (GAO). (1991). *Health Insurance Coverage: A Profile of the Uninsured in Selected States.* Washington, DC: Author; Pepper Commission. (1990). *A Call for Action.* Washington, DC: U.S. Government Printing Office.

[16] Gomby, D.S. and Shiono, P.H. (1991). "Estimating the number of substance-exposed infants." *The Future of Children*, 1(1), 17-26.

[17] U.S. GAO, 1990, op cit.

[18] Alameda County Health Care Services Agency. (1991). *Alameda County Children and Youth Report Card 1991.* Oakland, CA: Author.

[19] California Department of Alcohol and Drug Programs, op cit.

been identified in the literature as recently as 1973.[20] Although several longitudinal studies of children diagnosed with Fetal Alcohol Syndrome document the impact of high-dose alcohol exposure on physical and cognitive development, similar information is lacking on the potential long-term impact on children of lesser amounts of prenatal alcohol exposure.[21] The medical literature on the effects of other drugs, such as heroin, methadone, and cocaine, has grown in the last two decades, with great expansion in the 1980s as researchers began to study prenatally drug-exposed infants as they enter childhood. In cases where alcohol and drug exposure is associated with developmental problems, the effects of other factors — such as parental alcohol and drug addiction — often cannot be ruled out.[22]

Whether children's development is compromised by physiological exposure to alcohol and other drugs, by the effects of impoverished, high-risk families, including those profoundly affected by alcohol and drug use, or by both, it is clear that early intervention and similar support services can play a critical role in preventing or ameliorating poor developmental outcomes.[23] Unfortunately, these important services do not seem to be widely available for children.[24]

Clinicians and researchers have noted that pregnancy may offer an excellent opportunity for intervention in a woman's alcohol and drug use since her pregnancy and concern for her newborn often provide compelling motivation to enter treatment.[25] The relationship between pregnancy and parenthood and recovery suggests the importance of services for pregnant and parenting women with alcohol and drug problems, as the relationship between early intervention and good outcomes for children suggests the importance of children's services. Although there have been reports examining access to specific services for women and children, there is a lack of comprehensive, reliable information regarding what services are available in California for chemically dependent pregnant and parenting women and for young drug-exposed children.

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[20] Jones, K.L., Smith, D.W., Ulleland, C.N., and Streissguth, A.P. (1973). "Pattern of malformation in offspring of chronic alcoholic mothers." *Lancet*, 1, 1267-1271.

[21] Cook et al., op cit.

[22] Cook et al., op cit.

[23] National Institute on Drug Abuse, (1989). *Drug Abuse and Pregnancy.* Rockville, MD: Author; Cook et al, op cit; Rogan, A. (1985). "Issues in the early identification, assessment, and management of children with fetal alcohol effects," *Alcohol Health and Research World* 10(1): 28-31; Lief, N. (1985). "The drug user as parent." *The International Journal of the Addictions*, 20(1), 63-97; Lewis, K.D., Bennett, B., and Schmeder, N.H. (1989). "The care of infants menaced by cocaine abuse." *Maternal and Child Nursing*, 14, 324-329; Corkery, L. (1992). "Prenatal exposure to drugs of abuse: What we know and don't know about developmental outcome." *Newsletter.* San Francisco, CA: UCSF Clearinghouse for Drug-Exposed Children; Dixon, S.D., Bresnahan, K., and Zuckerman, B. (1990). "Cocaine babies: Meeting the challenge of management." *Contemporary Pediatrics*, June 1990.

[24] U.S. GAO, 1990, op cit; Connor, K. (1990). *California's Drug-Exposed Babies: Undiscovered, Unreported, Underserved.* Sacramento, CA: Senate Office of Research.

[25] Jessup, M. (1990). "The treatment of perinatal addiction." *Western Journal of Medicine*, 152, 553-558; Weiner, L., Rosett, H.L., and Mason, E.A. (1985). "Training professionals to identify and treat pregnant women who drink heavily." *Alcohol Health and Research World*, 10(1), 32-35.

In this project we analyzed a sample of programs that fund, administer, or directly provide services that may be used by chemically dependent pregnant and postpartum women and drug-exposed children from birth to age 3. The analysis is focused on developing a picture of the services available to these populations and identifying gaps and barriers that affect access to these services.

RESEARCH METHODS

Project Goals/Research Questions

Six research questions were posed:

- What kinds of services are believed to be necessary, appropriate, and effective for the target populations? What do experts in the field see as a desirable comprehensive model of care for these women and children?
- What are the gaps in services in 12 selected counties based on comparing the programs we surveyed with the desired model of care?
- What are the gaps and barriers in both the eligibility criteria and processes in the target counties based on such a comparison? What other barriers and factors affect access to the surveyed services?
- What are the target counties' problems in financing services for the target populations?
- What is the level and perceived success of service coordination in the target counties?
- What is the status of data collection regarding incidence, prevalence, numbers of women and children eligible for services, and numbers receiving services?

Finally, we sought to identify potentially effective and feasible policy strategies that address the problems, gaps, and barriers identified in the project research.

Service Needs of the Target Population

To identify the range of services believed to be necessary, appropriate, and effective for pregnant and postpartum women who use alcohol and/or other drugs and their drug-exposed children from birth to age 3, researchers conducted a survey of the literature and convened a panel of experts to develop a model of care for the target population.

Survey of the Literature

A comprehensive literature review was conducted to gather currently available information on the incidence of perinatal alcohol and/or drug use, treatment options for women and children, and policy options. Collection of articles focused on the following topics:

- the incidence of alcohol and drug use among women, focusing on, but not limited to, pregnant women (national and state-specific data were collected)
- the incidence of children born exposed to alcohol and/or other drugs (national and state-specific data were collected)

- the range of services required to meet the specific needs of chemically dependent pregnant women, including the diagnosis of alcohol and/or drug use, alcohol and drug treatment and recovery services, health and social services
- the range of services required to meet the needs of drug-exposed children from birth to age 3, including early intervention, health, and social services
- judicial interventions, including the criminal prosecution of women and termination of parental rights
- policy recommendations focusing on development and financing of appropriate services for the target population

See Appendix A for the annotated bibliography that resulted from the literature survey.

Model of Care

Twelve experts from throughout the state who work in the fields of perinatal addiction, alcohol/drug treatment and recovery, child development, public health nursing, and pediatrics were invited to participate in a one-day conference to clearly delineate the components believed critical to a comprehensive model of services for pregnant and postpartum women who use alcohol and/or other drugs and their drug-exposed children to age 3. The model was to be *family-centered*, to address the mother-child dyad as well as the woman's partner and family; to be *comprehensive*, drawing on all the services appropriate to the often complex and multiple needs of these women and children; and to be *coordinated* to draw together multiple services, with direct collaboration among services where possible. In addition, the model was to provide a template by which researchers could identify gaps in services in the publicly funded service delivery system currently serving the target population of women and children.

Each participant was given a workbook of materials to provide a framework for developing the comprehensive spectrum of services. The workbook included a syllabus of articles and background material, as well as a series of worksheets using a matrix format, to assist panelists in outlining the components of the continuum of care. The worksheets addressed the full range of services identified in the literature as necessary for this group of women and children.

The matrix focused the panel on nine categories of services that appear to be essential components of a model continuum of care: women's and children's health care, alcohol and drug treatment and recovery services, early intervention services, preschool programs, social and support services, outreach, and public health nursing. Panelists met in small groups to complete specific service categories for each of five developmental stages in women's and children's lives (prepregnancy, prenatal, labor and delivery, women to three years postnatal, children from birth to age 3).

The panel considered the following topics in completing the matrix:

- the specific services to be included
- the desired location of these services (e.g., service "co-location")
- coordination of services
- the role of case management
- eligibility for services

- methods for guaranteeing that services reflect cultural diversity and sensitivity

Afterwards, each group reported back to the entire panel, allowing everyone to comment on all components of the model of care.

Once the matrix was completed it was circulated to panel members for their review and comments. Researchers incorporated panel members' comments into the matrix, which was then converted into a narrative description of the model. In the process, the model was organized by five major themes: (1) health education and prevention; (2) outreach; (3) health and psychosocial screening/assessments; (4) direct services; and (5) case management. All issues and service components included in the matrix are contained in the model of care report, which has been published separately.[26]

Implementation of Key Federal and State Programs

To identify gaps in services and barriers affecting access for the target population, we surveyed 13 key state and federally funded programs financing alcohol and/or drug treatment and recovery services, health care, social services, and early intervention services for young children. The programs were identified through a review of state and federally funded programs in California. Thirteen programs from five state departments were identified (see Table 1) as serving a population of women and children that might include chemically dependent pregnant and postpartum women and drug-exposed children from birth to age 3. An analysis of program eligibility and service criteria indicated that only one of the programs was specifically designed to serve chemically dependent women (Options for Recovery). None of these programs is specifically designed to serve young drug-exposed children. Chemically dependent pregnant and postpartum women and/or drug-exposed children were, however, among the eligible populations served by all of the programs.

The programs surveyed differed in the level of availability as well as state and county oversight. Five programs[27] were administered through county departments of health or social services with services available countywide. State oversight was greatest for these programs. Another five programs[28] were administered by local providers under contract with the state, with little or no county oversight. Availability of these programs statewide differed markedly. Two programs were administered under contract with the state but had a regional focus.[29] We surveyed state and county administrators of the 13 programs identified in 12 counties (Table 2 lists the 12 counties), as well as administrators of local and/or regional programs that operated without direct

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[26] Soman, L.A., Dunn-Malhotra, E., and Halfon, N. (1992). *Model of Care for Chemically Dependent Pregnant and Postpartum Women and Their Drug-Exposed Children from Birth to Age Three.* Berkeley, CA: University of California, California Policy Seminar.

[27] CCS, CHDP, county alcohol and drug programs, Options for Recovery, county social services (Family Maintenance and Family Reunification).

[28] AFLP, Family Planning, HRIF, CPSP, special education, Black Infant Mortality projects.

[29] Regional Centers and Part H.

Table 1

DEPARTMENTS AND PROGRAMS

Department of Health Services	Adolescent Family Life Program (AFLP)
	Black Infant Mortality Program
	California Children's Services (CCS)
	California Health and Disability Prevention Program (CHDP)
	Comprehensive Perinatal Services Program (CPSP)
	Family Planning
	High Risk Infant Follow-Up Program (HRIF)
Department of Developmental Services	Regional Centers
	Part H Early Intervention Program for Infants and Toddlers (P. L. 99-457)
Department of Alcohol and Drug Programs	Options for Recovery (Perinatal Pilot Projects)
	Alcohol and Drug Treatment Programs
Department of Education	Special Education Infant Development Programs
Department of Social Services	Family Reunification and Family Preservation Services

county oversight.[30] The counties selected represent a strategic sample, chosen to include both counties with significant populations of young drug-exposed children, and those that were administering state Options for Recovery perinatal pilot projects at the time we conducted the survey. Counties with pilot projects were clustered in the two large urban regions of California. However, urban, suburban, and rural counties were included in the study so that the sample more adequately reflects the state's ethnic and geographic diversity.

Table 2

COUNTIES SURVEYED

Alameda	Sacramento
Humboldt	San Bernardino
Kern	San Diego
Los Angeles	San Francisco
Monterey	Santa Clara
Orange	Tulare

Survey Instruments

Two questionnaires were designed for the project (see Appendix B). The first elicited information from state, county, and local administrators regarding the range of services their programs funded or provided, eligibility requirements, program funding, efforts to coordinate services for the target population of women and children, and number of women and children served. An additional section designed for administrators of state and county Child Protective Services focused on their policies concerning the removal of drug-exposed children from their mothers. The questionnaire was pretested in two state and four county programs.

The second survey was designed for county coordinators of the Comprehensive Prenatal Services Program. CPSP services are furnished by local clinics and/or private providers (e.g., doctors, nurses, etc.) that contract with the state to deliver the CPSP package of services. County CPSP coordinators monitor the program locally but usually have only general information about the contract providers. The CPSP survey, therefore, asked about the number of women served by CPSP in the county, the number of eligible women who were not served by the program, waiting times and waiting lists for services, and whether the county had compiled estimates of the number of women and children affected by perinatal alcohol and drug use.

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[30] These programs included the following: the Adolescent Family Life Program, Options for Recovery, High Risk Infant Follow-up Programs, Family Planning, Part H Early Intervention Program, Regional Centers' Prevention Programs, Special Education, and Black Infant Mortality Program.

Sampling Procedures, Response Rates, Data Analysis

We wrote to administrators in the departments of Health Services, Developmental Services, Alcohol and Drug Programs, Social Services, and Education describing the study and explaining study procedures and goals, and sent a copy of the survey to all state, county, regional, and local administrators of the 13 relevant programs administered by those departments. Interviews were conducted by phone by one of the project's two policy analysts or research assistant from November 1990 through April 1991, lasting between 30 and 45 minutes each.

A total of 174 state, county, local, and regional administrators were sent copies of the survey. Table 3 displays the number of administrators interviewed at the county, regional, and local levels: 13 state administrators, 64 county administrators, 46 local administrators, and 29 regional administrators, for a total of 152 respondents. Table 4 displays the programs, by county, whose administrators failed to respond. Of the 22 nonrespondents, 13 were administrators of family planning clinics who chose not to participate because their clinics did not serve pregnant women, and therefore the survey would not be relevant to their programs. The remaining 7 nonrespondents represented six different programs in seven counties. All nonrespondents were contacted numerous times throughout the survey period by phone and mail to encourage participation.

Most of the information discussed in this report is based on interviews with a total of 140 administrators of local, county, and regional programs. Survey data represent 65 programs that serve women and 84 programs that serve children; 9 of them serve both women and children. Since only one survey was completed for each program included in the project, we use the terms "program" and "respondent" interchangeably in the discussion of survey results.

All survey responses were coded and entered into a computer. Data analysis consisted of frequency and mean distributions; no statistical tests were performed. Qualitative data from the surveys, such as respondents' opinions on issues, were compiled and analyzed by hand.

Project Limitations

The purpose of this project was to collect information on the availability of services from state and federally funded programs in California. This focus precluded a comprehensive assessment of the availability of all services in the counties surveyed, since we were unable to survey programs funded through other sources such as foundations or special federal grants, including programs funded through the federal Office for Substance Abuse Prevention (OSAP). In addition, administrators of several key programs did not participate in the survey, including the San Francisco drug program; Tulare County's CHDP and CCS programs; and family planning programs in six counties.

Table 3

RESPONDENTS BY PROGRAM

Program	Respondents		
	County	Local	Regional
Adolescent Family Life Program (AFLP)		14	
Black Infant Mortality Program		1[a]	
California Children's Services (CCS)	10		
California Health and Disability Prevention Program (CHDP)	11		
County Alcohol and Drug Programs	19[b]		
Comprehensive Perinatal Services Program (CPSP)	12[c]		
Family Planning Programs		6	
High Risk Infant Follow-Up Programs (HRIF)		10	
Part H Early Intervention Program for Infants and Toddlers (P.L. 99-457)			12
Perinatal Pilot Projects (Options for Recovery)		4	
Regional Centers for the Developmentally Disabled			17
Social Services: Family Reunification and Family Preservation Services	12		
Special Education		12[d]	
Total Number of Respondents	64	46	29

[a]There are 2 Black Infant Mortality Programs in our survey counties; only 1 responded to the survey.

[b]Some counties have both an alcohol and a drug program administrator; other county alcohol and drug programs share an administrator. The 19 administrators who responded represent alcohol and drug programs in all 12 counties. The San Francisco drug program did not participate in the survey.

[c]There are 19 family planning programs in our survey counties; 6 responded to the survey.

[d]Developmental programs are administered through regional organizations called special education local plan areas (SELPAs). Each SELPA is required to adopt a plan which details the provision of special education services among the member districts. The SELPA may consist of a single school district, a group of districts, or the county office of education in combination with the districts.

Table 4

NONRESPONDENTS

AFLP	San Diego
CHDP	Tulare
CCS	Monterey, Tulare
County Drug Program	San Francisco
HRIF	Los Angeles
Black Infant Mortality	Alameda

Given the budgetary and time constraints of this project, survey respondents were limited to administrative staff of the programs surveyed. We were unable to survey other program staff, providers of local direct services, or program participants (consumers). Moreover, we were unable to investigate and report on a number of important policy issues whose impact was suggested by many of our survey respondents, including the criminalization and prosecution of pregnant women who use alcohol and other drugs.

Finally, it is important to recognize that the survey results reported represent a description of services as they existed at the time the surveys were completed (November 1990 through April 1991). The delivery of services to chemically dependent women and drug-exposed children is in great flux; many changes are already evident since we conducted the survey. Significant changes that occurred after the survey was completed, particularly in the funding of services, are noted in the text.

The following sections describe the research findings, beginning with a summary of the model of care and followed by an analysis of the survey data. Individual sections focus on services, eligibility, coordination, data collection, access to services, and funding.

MODEL OF CARE

The model of care focuses on the education and service needs of the mother/child dyad and family. Where appropriate, it includes women's partners, parents, and other children because of the influence of social and family relationships on women's alcohol and/or drug use, treatment, and recovery.

Two broad policy statements serve as the foundation for the model of care. First, perinatal alcohol and drug use occurs in a social/environmental context in which individual behaviors are only one factor. Prevention, intervention and treatment services, in order to be effective, must be designed with this in mind. Second, professionals and funders addressing perinatal alcohol and drug use should avoid use

of the term "drug-exposed children" as a distinct diagnostic category and adopt a risk model that hinges on comprehensive assessments of children, which would be the basis for appropriate interventions.

The narrative description of the model of care has been organized in five categories, including: health education and prevention; outreach; health and psychosocial screening/assessment; direct services (health, social services, alcohol and drug treatment and recovery services, specific services for drug-exposed children, services for partners and/or family members); and case management. The following is a brief summary of the model's components. A full description of the model of care is available from the California Policy Seminar.[31]

Prevention and Health Education

Prevention and health education efforts should:

- Address the risks involved in using alcohol and other drugs during pregnancy.
- Address the needs of children who have been exposed to alcohol and/or other drugs prenatally and disseminate information on parenting and child development.
- Address the needs of women of child-bearing age (e.g, family planning, sexuality, and pregnancy).
- Provide information on how women and children can gain access to the health, social services, and alcohol/drug treatment and recovery services they need — specifically, how to access Medi-Cal, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program (Child Health and Disability Prevention program, or CHDP in California), AFDC, WIC, and food stamps, as well as alcohol and drug treatment and recovery programs.
- Be available at a wide variety of community sites, including schools, community centers, drug and alcohol treatment and recovery programs, churches, and jails. Information should be targeted to specific populations at risk (for example, adolescents, women in jails) with programs tailored to meet specific needs.

Outreach

Outreach programs should be developed to educate adolescents, women, and men on the consequences of alcohol and drug use during pregnancy, and also promote access to services for women and their children. The panel recommended using media, community neighborhood workers, and eligibility workers stationed at health and social service and alcohol and drug treatment sites frequented by pregnant women and women with young children to facilitate access to Medicaid, EPSDT, and social services. Outreach efforts should ensure that appropriate referrals are made for women and children.

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[31] Soman, L.A., Dunn-Malhotra, E., and Halfon, N., op cit.

Health and Psychosocial Screening and Assessment

Health and psychosocial screenings and assessments should be a routine part of care for all women and children, not just those suspected of alcohol/drug use or exposure.

These assessments must include screening to evaluate alcohol and drug use by a wide variety of health and social service providers (including private practitioners) for all women, including those who are pregnant and postpartum. Screenings should be completed by a wide range of providers including family planning providers, mid-level practitioners (nurse practitioners and physicians' assistants), social workers, and alcohol and drug treatment staff. Assessments, however, must be completed by practitioners trained in identifying women at risk for alcohol and drug problems and intervening to assist them into treatment.

Children should be assessed periodically throughout the first three years of life in order to identify developmental delays that may not become evident until a child is over 18 months, as well as to promote children's access to early intervention services.

Assessments should address mother/child/family relationships. Home visits should be scheduled as needed to complete assessments.

Direct Services

A comprehensive array of health, social services, and alcohol and drug treatment and recovery services should be available. These services should be culturally appropriate and sensitive to different cultures' approaches to family planning, child-rearing, and child development.

Family planning services can play an integral part in ensuring that women have an alcohol- and drug-free pregnancy. Family planning should be provided in a number of settings, both traditional (health care clinics) and nontraditional (e.g., housing projects), in order to reach a population that may not use family planning clinics. The availability of these services is essential because family planning may (and often does) provide the point of entry to primary care services for women, and offers an excellent opportunity to identify women at risk for alcohol and drug problems, provide education, and, through referrals, ensure access to appropriate services.

All women screened and identified as using alcohol and/or other drugs during their pregnancy, regardless of their income, should receive a minimum of one home visit to include a risk assessment and appropriate referrals.

When women are identified during pregnancy or delivery as being chemically dependent, a treatment plan for both mother and child should be developed following delivery. The plan should address alcohol and drug treatment, social support services, housing needs, early intervention services for the child, and, if appropriate, referral to Child Protective Services. Delayed discharge should be considered for women identified as being at high risk for child abuse or neglect to provide time for medical and psychosocial assessments of mother and child.

Home visits should be made to women at risk to link them to services, provide education and training, and enable ongoing assessments of women and children.

All program models for alcohol and drug treatment should be available to women. Services should not only accommodate women but be sensitive to their unique needs

and those of their children. Whether these services are provided on-site or through linkages with other community providers, they should include a full spectrum of services specific to the needs of women: job training; family planning; therapy focusing on sexual assault/abuse, domestic violence, and codependency; and health education. On-site child care should be available in all treatment and recovery programs, and staff should assure that children are receiving adequate medical care. Early intervention services should be available for children on-site or through referrals to community programs.

Children exposed to alcohol and/or other drugs require ongoing medical care, including well-baby checks and immunizations. Since drug-exposed children are at risk for developmental delays, additional services may be needed. Newborns of women believed to have used alcohol and/or other drugs during their pregnancies should receive pediatric exams in the hospital shortly after as well as three to four days following birth to identify withdrawal symptoms. Ideally, a minimum of 10 home visits during the first six months and monthly visits until 12 months of age should be scheduled for ongoing assessments of mother and child and health education. Home visits should be scheduled less frequently after the first year of life but should continue through the child's third birthday to enable ongoing monitoring of the child's physical, cognitive, and emotional development.

Early intervention services should be available if potential delays are identified. Enriched preschool programs should be offered to children between the ages of 2 and 4 to fill gaps in services for them.

A wide array of social support services should be available to women, including transportation and child care, to facilitate access to services for mothers and their children.

Case Management and Coordination

Chemically dependent women and their drug-affected children should have access to case management services. Typically case management should include the following components: intake and outreach, assessment of client needs, development of an individual care plan, brokering of services, counseling and support, advocacy with programs on behalf of the client, monitoring and followup, and evaluation of achievement of the care plan.

A single staff person should be identified as the primary case manager. This policy can be implemented with collaborative decisionmaking among agencies through a comprehensive policy or on a case-by-case basis.

Coordination of services among programs, agencies, and departments should be encouraged at the systemic level to ensure access to services. Activities can include cross-agency policy and protocol development and grantwriting. Coordination should also be pursued across different service and professional disciplines, as well as within a single professional discipline (e.g., between obstetricians and pediatricians) to facilitate client access to services and compliance with case plans. Interdisciplinary collaboration can be enhanced through networks, shared protocols among providers, and protocols to assure client followup.

PROGRAM SERVICES

Thirteen programs were surveyed in the course of this project. They are described below, categorized by the type of services provided:

Health Services

- *California Children's Services (CCS)*
  California's Title V "Children with Special Needs Program," financing specialty medical services
- *Child Health and Disability Prevention Program (CHDP)*
  Finances (1) health, vision, hearing, and dental assessments for low-income children, and (2) helps pregnant women obtain prenatal care through the Prenatal Care Guidance program (PCG)
- *Family Planning*
  Provides family planning and specialty medical services
- *Comprehensive Perinatal Services Program (CPSP)*
  Finances prenatal and postpartum health care for Medicaid-eligible women

Alcohol/Drug Treatment and Recovery Services

- *County Alcohol and Drug Programs*
  Administer local alcohol and drug treatment and recovery services
- *Options for Recovery*
  State-funded, county-based pilot projects for chemically dependent pregnant and parenting women

Family Maintenance and Family Reunification Services

Out-of-home care, respite care, parenting training and support and other services financed through county social services departments

Early Intervention Services for Children

- *California's Part H Program (PL 99-457)*
  Early intervention services for infants and toddlers under the age of 3
- *High Risk Infant Follow-Up Program (HRIF)*
  Child development and other intervention services for children from birth to age 3 who have been discharged from neonatal intensive care units
- *Regional Centers' Prevention Programs*
  Developmental assessments, therapy, and other services financed through the Department of Developmental Services for children from birth to age 3 at risk of developmental delays
- *Special Education Infant Development Programs*
  Assessments, therapy, and other services offered through school districts for children with specific disabilities

Case Management Programs

- *Adolescent Family Life Programs (AFLP)*

Comprehensive case management services for pregnant and parenting teens

- *Black Infant Mortality Programs*
  Medical case management for pregnant and parenting African American women with children under the age of 1

Although 10 of the 13 programs surveyed exist in each of the 12 sample counties, the extent and comprehensiveness of these services vary greatly. For example, while case management was provided by 10 of the programs, it was defined differently by each program, ranging from comprehensive, long-term, face-to-face services to limited activities that focus on linking women and children to specific types of medical care.

Three of the 13 surveyed programs displayed great variability across counties: Prenatal Care Guidance within the Child Health and Disability Prevention program, Part H Early Intervention Services for Infants and Toddlers, and county alcohol and drug programs. In these programs, counties or local entities (such as the Part H local planning areas) are free to determine the services to be provided or funded.

In some PCG programs, services consist only of phone and/or mail contacts for referral and followup with pregnant women. Services provided by the 56 programs funded under Part H in the target counties range from parent support, education, and case coordination to comprehensive family services, counseling, intake, case management, infant assessment, and early intervention services. County-administered alcohol and drug services also display this variation. Methadone maintenance was not available in one-quarter of the counties surveyed; 42% of the counties had no residential treatment facility for women with their children; and 17% of counties lacked detoxification services for women. Clearly, the extent of this variation of services provided in different counties results in gaps in services for women and children based on their county of residence.

Most of the 13 programs are available in the majority of counties surveyed, as shown in Table 5. In some cases the county has more than one of a specific program surveyed. For example, some counties have several AFLP or HRIF programs. While one Regional Center serves both Santa Clara and Monterey counties, Los Angeles has seven Regional Centers. In other cases a specific program is found in only some of the 12 counties. For example, at the time of the survey only four of the counties had Options for Recovery programs (although Los Angeles has two program sites). HRIF and Black Infant Mortality programs are administered through state contracts with local programs; only two of the counties have Black Infant Mortality programs, and seven counties have HRIF. CHDP's Prenatal Care Guidance program is a county option that only nine counties have implemented.

In addition to variation in the availability of programs across counties, there appears to be significant variation in the *types of services* available through the programs. Table 6 summarizes the package of benefits common to a particular program across all counties. The actual services, organization, and intensity of services vary by program. For example, although only two programs — county alcohol and drugs and Options for Recovery — officially provide alcohol and drug treatment and recovery services, in several counties the local departments of social services will pay for these

Table 5

COUNTY-BY-COUNTY PROGRAM AVAILABILITY AND PROGRAMS SURVEYED

	AFLP	Black Infant	CCS	CHDP/EPSDT		County Alcohol / Drug	CPSP	Family Planning	HRIF	Part H P.L. 99-457	Regional Centers' Prevention Program	Social Services	Options for Recovery	Spec. Ed.
				CHDP/ EPSDT	PCG									
Alameda	X[a]	0	X	X	X	X	X	0	X	X	X	X	X	X
Humboldt	X		X	X	X	X	X	0	X	X	X	X		X
Kern	X		X	X	X	X	X	X		X	X	X		X
Los Angeles	X[b]	X	X	X	X	X	X	X	X[c]	X	X[d]	X	X[e]	X
Monterey	X[f]		0	X		X	X	0	X	X	X[g]	X		X
Orange	X		X	X		X	X	X	X[h]	X	X	X		X
Sacramento	X		X	X	X	X	X	X	X	X	X	X	X	X
San Bernardino	X		X	X	X	X	X	0		X	X	X		X
San Diego	0		X	X	X	X	X	0	X	X	X	X	X	X
San Francisco	X		X	X	X	X/0[i]	X	0		X	X	X		X
Santa Clara	X		X	X	X	X	X	X		X	X[g]	X		X
Tulare	X		0	0		X	X	X		X	X	X		X

X indicates counties that have a program. O indicates counties with a program that did not participate in the study.

[a]Two AFLP programs in Alameda county were surveyed.

[b]Three AFLP programs in Los Angeles county were surveyed.

[c]Three High Risk Infant Programs were surveyed in Los Angeles County; one program did not respond.

[d]Seven Regional Centers in L.A. County were surveyed.

[e]Los Angeles County has two Options for Recovery project sites.

[f]This AFLP program is supported by county rather than state funds.

[g]Santa Clara and Monterey Counties are served by one Regional Center.

[h]Two HRIF Programs were surveyed in Orange County.

[i]San Francisco's County Alcohol Program completed a survey; the Drug Program did not.

Table 6

SERVICES AVAILABLE IN EACH OF THE PROGRAM TYPES SURVEYED[a]

	Health Care Services	Alcohol/Drug Treatment and Recovery Services	Social Services	Case Management	Early Intervention Services	Other
Adolescent Family Life Programs			• Counseling services • Support groups • Education	Comprehensive and continuous services including outreach, assessments, referral, follow-up, advocacy		
Black Infant Mortality Projects			• Counseling • Transportation • Parent support and training	Medical case management to identify and assist women in securing prenatal care; assess service needs; refer for services; and follow-up.		
California Children's Services	• Specialty medical services • In-home nursing and respite care (limited) • Medical supplies and equipment • OT/PT in special centers		• Transportation (limited)	Medical case management for CCS eligible condition.	• Infant assessments for OT/PT • Vision, hearing, and developmental assessments for children birth to 2 discharged from ICN with no problems.	
CHDP/EPSDT	*For children*: health, vision, hearing, dental, assessments; immunizations		Assist families with scheduling and transportation	• Assist women so they receive early and appropriate prenatal care. • Follow-up to ensure that Medi-Cal eligible children receive treatment for conditions identified during a CHDP exam.	Developmental assessments (to degree performed by individual practitioners).	

[a]The table summarizes the package of benefits common to program across counties. The organization and intensity of services, however, may vary by program.

Table 6 (cont.)

	Health Care Services	Alcohol/Drug Treatment and Recovery Services	Social Services	Case Management	Early Intervention Services	Other
County Alcohol/Drug Programs		Package of services varies by county. May include: • detoxification • in-patient treatment • day treatment • support groups • residential care • methadone maintenance	Package of services varies by county. May include: • Transportation • Counseling • Job training • Transitional housing/sober living			
Comprehensive Perinatal Services Program	• Prenatal/postpartum health care • Health education • Nutrition counseling		• Counseling • Parent support groups • Education • Housing assessment and referral	Medical and social service case management		
Family Planning	• Family planning services • Specialty medical services (e.g., sterilization, infertility. STDs)		• Education • Clinical professional training for health care providers			
High Risk Infant Follow-Up Program			• Crisis intervention ◦ Parent counseling/ education • Parent support network	• Case coordination/ collaboration to link families to services	Home interventions/ support services, e.g., health and developmental assessments and monitoring; therapeutic consultation and interventions (e.g.,OT, PT, speech pathology)	Technical assistance to other providers of high risk infant services regarding specific infants (through home visits, hospital visits, office visits, telephone conferences)

Table 6 (cont.)

	Health Care Services	Alcohol/Drug Treatment and Recovery Services	Social Services	Case Management	Early Intervention Services	Other
Part H (PL 99-457)	Health services that are not surgical or purely medical in nature are covered (e.g., tracheostomy care, tube feeding, equipment)		• Transportation • Respite services • Interpreter	Case coordination, assessment, referral	• Family training, counseling, home visits • OT/PT • Speech, language pathologh • Audiology • Parent support/ resource centers	Availability of services varies substantially in the state. Direct service projects are determined at the local level following a planning and needs assessment process.
Regional Centers' Prevention Program	• Health, nursing, nutritional assessments • Health services related to child's disability if not otherwise covered by CCS or Medi-Cal		• Respite services • Transportation • Psycho/social assessments • Counseling/therapy	Includes development of a service plan, family support, parent education, linkage to services, advocacy	• Developmental assessments • OT/PT • Speech, language pathology • Parent support and training	
Social Services			• Counseling • Transportation • Family maintenance and family reunification services (e.g., out-of-home care, respite, emergency shelter, parenting/training)	Case management including client assessment, development of a service plan, referrals, linkages to services, and advocacy		

Table 6 (cont.)

	Health Care Services	Alcohol/Drug Treatment and Recovery Services	Social Services	Case Management	Early Intervention Services	Other
Options for Recovery Perinatal Pilot Projects		• Detoxification • Day treatment • Outpatient treatment • Support groups • Residential care	• Counseling • Referrals to job training • Parent support and training • Family maintenance and family reunification services through DSS • Child care • Transportation • Foster parent recruitment and training through DSS	Social service and medical case management primarily through local HRIF, AFLP, and CPSP programs		
Special Education			• Transportation • Parent support and training		Wide range of services including OT/PT, assessments, parent support and training,	

services for chemically dependent mothers of drug-affected children. In addition, the services available through county alcohol and drug programs may vary quite a bit among the counties, with a large package of services available in one county, and significantly fewer services available in another.

This variability in services among specific program types was evident at the local, county, or regional levels in three of the programs. These programs include CHDP's Prenatal Care Guidance, Part H (99-457), and county alcohol and drug programs. The type of case management available at the county level provides another illustration of variation in services. These differences are discussed in the following sections.

Variation in Programs at the Local Level

Prenatal Care Guidance

At the time of the survey, nine of the 12 counties surveyed had chosen to provide the PCG program through their counties' CHDP programs. All PCG programs assisted Medi-Cal-eligible pregnant women to obtain prenatal care.[32] Most of the programs depended on phone and mail contacts with women who were referred to service providers, and most women were also sent educational materials regarding pregnancy. Some programs assisted women who were encountering difficulties completing Medi-Cal application forms. Once linked to services, most women were no longer followed by PCG staff. Two-thirds of the responding programs targeted "high risk" women for intensive followup throughout pregnancy. The risk factors used by the programs to identify appropriate clients included alcohol and/or drug use, homelessness, a history of poor birth outcomes, geography, or other factors that made it difficult for women to keep prenatal appointments. Fifty-six percent of programs also relied on limited face-to-face contacts with a specially targeted group of women, such as homeless women or women in jail.

Most programs drew on computer printouts of pregnant women applying for Medi-Cal from county departments of social services and/or referrals from prenatal care providers, health and/or social service agencies, and schools to identify pregnant women and/or adolescents. Some programs, however, assigned staff to do outreach in targeted communities. In these instances, staff contacted women in shelters or obtained referrals from businesses and church staff who identified pregnant women who might need assistance. Table 7 highlights some of the differences among PCG programs.

Early Intervention Services for Infants and Toddlers — Part H (PL 99-457)

In California, decisions regarding the specific services funded through Part H are made at the local level. To achieve local interagency coordination, 26 local planning areas comprising one or more counties were established. The Department of Developmental Services, California's lead agency for Part H services, contracted with 26 nonprofit agencies to coordinate planning among the agencies that provide services in

[32] Women served through the CPSP program and those eligible for Medi-Cal with a share-of-cost are not eligible for PCG services. However, some programs served any woman who was pregnant, regardless of Medi-Cal eligibility determination.

Table 7

COMPARISON OF PRENATAL CARE GUIDANCE PROGRAMS

County	Phone/Mail Contact	Face-to-Face Contacts	Direct Outreach to Women	Comments
Alameda	X	X	X	• Two outreach workers and a public health nurse identify women in the community by contacts with businesses, churches, and community contacts • Generally follow women only until women get to their first prenatal appointment. Staff follow a limited number of "high risk" women until post-partum and children are in care.
Humboldt	X	X		• Staff determine whether women are followed weekly or monthly • Face-to-face contacts primarily for homeless women and women in jails
Kern	X			• Staff follow-up to verify that women continue to receive prenatal care once referrals are made
Los Angeles	X			• Staff will follow-up with "high risk" women to ensure they actually receive prenatal care
Sacramento	X	X		• Outreach to homeless women, • At time of survey, the program had received a special foundation grant to hire a community worker to do outreach to women without phones
San Bernardino	X	X	X	• Staff go into the community to identify women at shelters or get referrals from churches
San Diego	X	DK*		
San Francisco	X	X	DK	• Staff will do home visits
Santa Clara	X			• Some "high risk" women are eligible for intensive follow-up monthly until 2 months post-partum

*DK = Don't Know

education, alcohol and drug programs, health, social services, and mental health. Each planning area conducted comprehensive planning and needs assessment activities, identified direct service needs, and established projects to provide early intervention services. All service projects were approved by the participating local agencies and the Department of Developmental Services. Because decisions regarding projects were made at the local level, there is wide variation in the types of projects that have been funded statewide. This variation was reflected in the program descriptions obtained during the survey process. Table 8 provides an overview of the types of programs and services funded in each of the 12 counties surveyed.

Not all services described receive long-term financial support from Part H funding. Increasingly, Part H funds will be directed away from grant projects in order to support Part H components[33] mandated by federal law. If California continues to participate in Part H, all funding for grant programs will cease by October 1, 1993. Although the survey describes existing services at the time of the survey, it is unknown whether the projects described continue to receive Part H support and whether they are likely to secure alternate funding to sustain services in the future.

County Alcohol and Drug Programs/ Options for Recovery

California's counties determine the alcohol and drug treatment and recovery services available at the local level. Each county identifies services appropriate to local needs and priorities through an annual county planning process, then negotiates the final service package with the state Department of Alcohol and Drug Programs. As a result, the alcohol and drug services available, including those for pregnant and parenting women, vary greatly from county to county.

At the time of the survey most publicly funded county alcohol and drug services were not specifically targeted to women, including those who are pregnant or postpartum.[34] The Options for Recovery perinatal pilot projects, in contrast, were specially designed to reach this population. The Options programs offer a comprehensive array of alcohol and drug treatment and recovery, social services, and case management.[35] Priority for service is given to (1) pregnant women; (2) postpartum women; and (3) women with children to the age of 3.

Table 9 displays the services available through both county alcohol and drug programs and Options for Recovery, as well as differences in the programs among counties. Important services for women are unavailable in some counties, as shown in

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[33] These components include (in part): a central directory of information, public awareness program, a comprehensive child find system, comprehensive, multidisciplinary evaluation of referred children, individualized family service plans, a comprehensive system of personnel development, personnel standards, and procedural safeguards.

[34] In Fiscal Year 1991-92 the Department of Alcohol and Drug Programs distributed $23 million to county alcohol and drug programs to expand treatment services specifically for pregnant and parenting women. See the section on Funding Issues for a discussion of this funding.

[35] These were available in Alameda, Los Angeles, Sacramento, and San Diego at the time of this survey, and are now available in both Contra Costa County and a regional program serving Butte, Glenn, Shasta, Siskiyou, and Tehama counties.

Table 8

SERVICES FUNDED THROUGH PART H

County	Number of Projects Funded	Number of Projects for Drug-Exposed Children	Range of Services
Alameda	4	1	• All four projects provide mental health/family support services.
Humboldt	2	1	• Coordinated intake and case management services • Developmental assessment clinic for drug-exposed children
Kern	8	0	• Training projects for care providers • Parent "warmline" for families with children discharged from NICUs • Infant/Parent Groups for families with infants newly diagnosed with developmental delays
Los Angeles	7	1 (3 sites funded)	• Family training and counseling for eligible substance abusing families • Family training and counseling services to eligible homeless families • Family training and counseling services for eligible children of chronically mentally ill • Family training and counseling services for families with eligible children with chronic illnesses who are medically fragile • Family training and counseling services for families discharged from NICU • Support to families in transition from early intervention services
Monterey	4	1	• 6 months follow-up for drug-exposed infants including assessment, follow-up, parenting skills, home visits • Resource information for families regarding services in the county • Training of direct service staff • Transportation

Table 8 (cont.)

County	Number of Projects Funded	Number of Projects for Drug-Exposed Children	Range of Services
Orange	8	1	• Services to medical, developmental, and psychosocial evaluations and interventions for drug-exposed infants and their families • Interagency review team • Interagency trainings • Educational programs regarding the physical needs of disabled infants and toddlers • Training of day care providers regarding special care of children with special needs • Parent training • Child care to allow participation of parents in early intervention program with their disabled child • Resource development, educational video
Sacramento	6*		• Early medical interventions for children in foster care • Training of child care providers • Development of play area for children whose mothers are served by Options for Recovery • Parent support groups • Development of parent handbook • Photo exhibit
San Bernardino	2*	1	• Services for drug-exposed infants and their children including case management, counseling, parent education, transportation • Services for infants with severe motor delays and/or disorders

*Sacramento and San Bernardino participate in regional LPAs that are larger than one county; the total includes only programs physically located in those counties.

Table 8 (cont.)

County	Number of Projects Funded	Number of Projects for Drug-Exposed Children	Range of Services
San Diego	4	0	• Family resource center • Diagnostic and referral program for infants with extracorporeal membrane oxygenation • Salvation Army early intervention program • Respite program
San Francisco	2	0	• Family assessment service team • Resource and referral project
Santa Clara	7	1	• Early intervention services for children whose mothers are in drug/alcohol treatment • Case conferences with families • Discharge transition and tracking system using a medical passport • Public awareness project • Outreach program for non-English-speaking families • Family integration project • Training for parents and professionals
Tulare	2	0	• Parent support and education • Case coordination project
TOTAL	56	7	

Table 9

SERVICES PROVIDED BY COUNTY ALCOHOL AND DRUG PROGRAMS AND OPTIONS FOR RECOVERY PROGRAMS

	Health Care Services	Alcohol/Drug Treatment and Recovery Services	Social Services	Case Management	Child Development	Referrals
Alameda County		- detox - inpatient treatment - day treatment - recovery groups - residential care-women only - residential care-women and children - prevention/education - DUI programs - methadone maintenance - children's program as part of women's program*	- job training - housing referrals - alcohol-/drug-free housing - transportation - parenting classes - daily living skills - counseling/therapy*	- some day treatment programs under local contracts provide case management - Options for Recovery provides case management, including outreach, client assessment, service plan development, referrals and linkage, and advocacy for women and their children*	- infant assessment* - infant development* - parent support and training*	- health care for women - health care for children* - alcohol/drug services - child development - social services - mental health - vocational rehabilitation - employment - education - housing
Humboldt County	- health screening for children through Healthy Mothers, Healthy Babies project	- detox - day treatment - recovery groups - children's program	- counseling for women and children	- case management for women - case management for children through Healthy Mothers, Healthy Babies project	- infant assessment - infant development - parent support and training	- health care for women - health care for children - alcohol/drug services - child development - social services - mental health

*Available only in county Options for Recovery program

Table 9 (cont.)

	Health Care Services	Alcohol/Drug Treatment and Recovery Services	Social Services	Case Management	Child Development	Referrals
Kern County		- day treatment - recovery groups - residential care-women only - children's program as part of women's program	- counseling - vocational rehabilitation - parent support and training	- case management for women		- health care - alcohol/drug services - child development - social services - mental health - vocational rehabilitation
Los Angeles County		- detox - day treatment - recovery groups - residential care-women only - residential care-women and children - children's program - methadone maintenance*	- counseling - job training - housing referrals - alcohol-/drug-free housing - parent support and training - transportation	- case management including outreach, client assessment, service plan development, referrals and linkage, advocacy*	- infant assessment* - infant development* - respite care*	- health care for women - health care for children* - alcohol/drug services - child development - social services - mental health

Table 9 (cont.)

	Health Care Services	Alcohol/Drug Treatment and Recovery Services	Social Services	Case Management	Child Development	Referrals
Monterey County		- detox - day treatment - recovery groups - residential care-women only - residential care-women and children - children's program - methadone maintenance	- transportation - parent support and training	- case management for women		- health care - alcohol/drug services - child development - social services - mental health
Orange County	- physical exams for women entering treatment (including IVDUs, methadone maintenance, and pregnant women)	- detox (including inpatient) - day treatment - recovery groups - residential care-women only - residential care-women and children - children's program - methadone maintenance	- counseling - housing referrals - transportation - parent support and training - respite care	- case management for women	- infant assessment - infant development - parent support and training - respite care - educational services for children	

Table 9 (cont.)

	Health Care Services	Alcohol/Drug Treatment and Recovery Services	Social Services	Case Management	Child Development	Referrals
Sacramento County	- prenatal care for women in methadone maintenance	- detox - day treatment - recovery groups* - residential care-women only - residential care-women and children - children's program* - methadone maintenance	- counseling - parent support and training	- case management in Homeless Project and in Options for Recovery	- infant assessment* - infant development* - infant/parent psychotherapy* - counseling for children*	- health care for women - health care for children* - alcohol/drug services - child development - social services - mental health
San Bernardino County	- physical exams for women - urine screens for women	- detox - day treatment - recovery groups - residential care-women only - residential care-women and children - children's program	- counseling - transportation - job training - housing referrals - alcohol/drug-free housing - parent support and training	- case management, including public health nurse visits, for women		- health care for women - alcohol/drug services - child development - social services - mental health - vocational rehabilitation

Table 9 (cont.)

	Health Care Services	Alcohol/Drug Treatment and Recovery Services	Social Services	Case Management	Child Development	Referrals
San Diego County		- detox - day treatment - recovery groups - residential care-women only - residential care-women and children - children's program - methadone maintenance - homeless project for women - HIV intervention project - alcohol-related environmental prevention	- counseling - transportation - job training - housing referrals - alcohol/drug-free housing - transportation* - parent support and training - on-site child care*	- case management for women*		- health care - alcohol/drug services - child development - social services - mental health - community services like WIC, legal aid, etc.

Table 9 (cont.)

	Health Care Services	Alcohol/Drug Treatment and Recovery Services	Social Services	Case Management	Child Development	Referrals
San Francisco County (alcohol program only)	- prenatal care - family planning	- day treatment - recovery groups - children's program	- counseling - housing referrals - transportation - parent support and training	- case manageme for women		- alcohol/drug services - social services - mental health
Santa Clara County		- detox - day treatment - recovery groups - residential care-women only - children's program - methadone maintenance	- counseling - job training - parent support and training	- medical and social services case management for women and infants in perinatal program	- infant assessment - infant development - infant/parent psychotherapy - parent support and training	- health care - alcohol/drug services - child development - social services - mental health - vocational rehabilitation
Tulare County		- detox - day treatment - recovery groups - residential care-women only - children's program - methadone maintenance	- counseling - job training (through contract with Voc Rehab) - housing referrals	- medical and social services case management in outpatient drug-free and methadone maintenance services		- health care - alcohol/drug services - child development - social services - mental health - vocational rehabilitation

Table 10

GAPS IN AVAILABILITY OF ALCOHOL AND DRUG SERVICES BY COUNTY

County	Methadone Maintenance	Residential Women Only	Residential - Women with Children	Detoxification
Alameda	X	X	X	X
Humboldt				X
Kern		X		
Los Angeles	X	X	X	X
Monterey	X	X	X	X
Orange	X	X	X	X
Sacramento	X	X	X	X
San Bernardino		X	X	X
San Diego	X	X	X	X
San Francisco*	N/A	N/A	N/A	N/A
Santa Clara	X	X		X
Tulare	X	X		X
TOTAL (12)	**8**	**10**	**7**	**10**

*Only San Francisco Alcohol Program included; San Francisco Drug Program did not participate in the survey

Table 10. For example, methadone maintenance services are not available in one-quarter of the counties surveyed. While 10 of 12 counties (83%) have women-only residential treatment facilities, 5 of the 12 (42%) have no residential treatment facilities for women with their children. Two of the 12 counties (17%) lack detoxification facilities, a prelude to treatment for many women.

Case Management Services

Case management services were provided by 10 of the 13 programs surveyed, as Table 6 indicates, but were defined differently by various programs. For example, AFLP provided comprehensive case management as its primary program service, using face-to-face as well as phone contacts. Regional Centers and HRIF programs also provided comprehensive case management services, as did certain Part H-funded projects. In a number of counties, staff from these four programs reported that they participated in case conferences with other community agencies to discuss mutual clients.

Comprehensive Perinatal Services Programs provide both medical and social services case management to all women in the program. County social services staff provide case management for children and families receiving child welfare services, which includes family maintenance, family reunification, and permanency planning. The Options for Recovery perinatal pilot projects, targeted to chemically dependent pregnant, postpartum, and parenting women and their children, drew on three of these programs — CPSP, AFLP, and HRIF — to provide comprehensive case management services to clients.[36]

In contrast to the comprehensive services provided by the programs discussed above, CHDP and CCS provided limited case management services that focused on linking women and children to specific medical services. California Children's Services emphasized management of CCS-eligible conditions only, whereas CHDP staff linked women to prenatal care and children to health assessments as well as diagnosis and treatment services for conditions identified during screening exams. Both CCS and CHDP depended primarily on phone and mail contacts with families.

Three of the programs surveyed generally do not offer case management services at all, including county alcohol and drug programs, family planning, and special education, although case management may be available through these programs in certain counties.

Targeted Services to Chemically Dependent Women and/or Drug-exposed Children

Availability of Targeted Services

As Table 11 shows, 29 programs in our sample of 138 reported that they offer services specifically targeted to women who use alcohol and drugs during pregnancy. Another 22 programs have plans to either initiate services targeted to this population or to expand existing targeted services. (See Table 12.) Twenty-four offer services

[36] These case management services, previously provided through the Department of Health Services, are now funded and administered by the Department of Alcohol and Drug Programs.

Table 11

PROGRAMS TARGETED TO PREGNANT WOMEN WHO USE ALCOHOL/DRUGSAND/OR DRUG-EXPOSED CHILDREN BY COUNTY

	AFLP	Black Infant	CCS	CHDP		County Alcohol & Drug	CPSP	Family Planning	HRIF	Part H P.L. 99-457	Regional Centers	Social Services	Options for Recovery	Spec. Ed.
				CHDP/ EPSDT	PCG									
Alameda	W			C		W	N/A[a]		C	C	C	C	B[b]	
Humboldt					W	B	N/A[a]			C				
Kern							N/A[a]	W				B		
Los Angeles		W				W	N/A[a]			C	C	B	B[b]	B
Monterey						W	N/A[a]			C				
Orange						W	N/A[a]			C		B		
Sacramento						W	N/A[a]					B	W[b]	
San Bernardino						W	N/A[a]			C				
San Diego						W	N/A[a]					B	W[b]	
San Francisco						W[a]	N/A[a]					C		
Santa Clara						W	N/A[a]			C				
Tulare							N/A[a]					B		

W = programs targeted to women; C = programs targeted to children; B = programs targeted to both

[a]CPSP services are provided by individual practitioners/clinics; not known whether any of them provide special services to target populations

[b]All Options for Recovery programs provide child care and other services for women and their children; some Options programs also have early intervention and other services specifically designed for drug-affected children

[c]San Francisco alcohol program only; drug program not reporting

Table 12

NUMBER OF PROGRAMS WITH TARGETED SERVICES AND/OR PLANS TO INITIATE OR EXPAND TARGETED SERVICES BY PROGRAM CATEGORY

	Number of Targeted Services for Women Who Use Alcohol and/or Other Drugs During Pregnancy		Number of Targeted Services for Drug-Exposed Children from Birth to 3	
	# of Programs with Targeted Services	# with Plans to Initiate or Expand	# of Programs with Targeted Services	# with Plans to Initiate or Expand
AFLP	1	1		
Black Infant Mortality	1			
CCS				1
EPSDT/ CHDP	1	1	1	3
County Alcohol and Drug Programs	14* (10)	13* (10)	2* (2)	2* (2)
CPSP	N/A		N/A	
Family Planning	1	1		1
HRIF			1	1
Part H			7	1
Regional Centers			2	2
Social Services	6	4	8	3
Pilot Projects	4	2	2	1
Special Education	1		1	

*Includes either or both alcohol and drug programs in county; number of counties represented is in parentheses.

targeted to drug-exposed children from birth to age 3, and 15 indicated plans to either initiate or expand such services.

The programs most likely to have targeted services for women or to have plans to initiate or expand them were county alcohol and drug programs (74% of respondents in this category), county social services (50%), and Options for Recovery (100%). (As discussed above, the entire Options program is targeted to pregnant, postpartum, and parenting women who use alcohol and drugs.) The 14 county alcohol and drug programs that report targeted services for women represent 10 of the 12 counties in the survey sample: Alameda, Humboldt, Los Angeles, Monterey, Orange, Sacramento, San Bernardino, San Diego, San Francisco, and Santa Clara. County alcohol and drug programs in each of the two missing counties — Kern and Tulare — report that they have plans to initiate services targeted to this population. Eight of the two counties that already have targeted services also report plans to expand them.

Part H programs (58% of respondents in this category), county social services (67%), and Options (50%) were the most likely to already have services targeted to drug-exposed children from birth to age 3. Twenty-seven percent of CHDP program respondents, 25% of social services, and 25% of Options indicated plans to initiate targeted services or to expand existing ones.

The following sections review several examples of these targeted programs.

Options for Recovery

These programs, begun as perinatal pilot projects under a joint initiative of the state departments of Alcohol and Drug Programs, Health Services, Social Services, and Developmental Services, combined funding from three state sources (alcohol and drugs, social services, and health services) to provide a comprehensive package of services for pregnant, postpartum, and parenting women and their children.[37] The services available through Options and their relationship with the county alcohol and drug programs and local CPSP, HRIF, and AFLP programs have already been discussed. Options provides a model for the organization of comprehensive and case managed services for chemically dependent pregnant and postpartum women, coupled with child care and support services for mothers and their children.

Clinica Sierra Vista, Kern County

Clinica Sierra Vista, a family planning program in Kern County, operates Born Free, a program of services to pregnant and postpartum adolescents and women who use alcohol and other drugs. Born Free serves approximately 25 women a year and offers education and outreach (particularly to adolescents in high schools and juvenile justice facilities); outpatient alcohol and drug treatment, counseling, and recovery groups; case management; linkage with prenatal care through CPSP, on site; family planning services including health examinations; pediatric services for children including CHDP on site; infant assessment and infant-parent psychotherapy; and transportation.

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[37] The Options programs were initiated as a collaboration of the three state departments. The Department of Health Services has since dropped its involvement in the project. Options is now funded through and administered by Alcohol and Drug Programs.

These services are funded through a combination of federal maternal and child health funds, state sources such as the Office of Family Planning, the Cigarette and Tobacco Tax Fund, and a three-year grant from the state Office of Child Abuse Prevention. At the time of the survey the program was also applying to the federal Office for Substance Abuse Prevention for additional funding to expand the services.

County Social Services Programs

In Tulare County the Department of Social Services operates a Drug-Exposed Infants Unit (DEI) that provides or pays for direct services to pregnant and postpartum women with drug-exposed infants. DEI staff provide counseling, transportation, case management, parent support and training, intensive family maintenance/reunification services, and referrals. DEI pays for infant assessments and counseling for children, as well as alcohol and drug evaluation, detoxification, outpatient treatment, dual diagnosis treatment, and urine screens. Approximately 100 women each year receive these services, which are funded through the county child welfare services budget. At the time of the survey, Tulare was one of three counties we surveyed that automatically removed all newborns with a positive toxicological screen at birth. The services provided through DEI are critical to returning children to their biological mothers and preventing their placement in foster care by assisting women into treatment and stabilizing the home situation.

Several other county social service departments offer targeted services to pregnant and postpartum women and drug-exposed children. For example, under two grants from the National Institute on Drug Abuse, the Los Angeles Department of Children's Services provides outpatient treatment, intensive day treatment, followup, perinatal nurse specialist services, assessments of children, and parenting classes. The department also operates high-risk units for women who use alcohol and drugs as well as their drug-exposed children, with a single assigned social worker to provide intensive family maintenance services, linked with alcohol/drug treatment services, parenting classes, and support services.

Healthy Infant Program

The Healthy Infant Program (HIP) is funded by Alameda County's Oversight Committee on Infant Mortality, augmented with federal funding from CHDP. HIP utilizes CHDP/EPSDT's basic model of services in which CHDP staff link families to health assessments and diagnostic and treatment services. However, HIP provides more comprehensive case management services than are generally available through CHDP to drug-exposed infants whose Medi-Cal-eligible mothers receive limited or no prenatal care. Infants are identified while in the county hospital's newborn nursery and enrolled in HIP prior to discharge. A home visit is scheduled within one week. Monthly contact is made with the family for a full year following discharge, ensuring compliance with well-child appointments. A maximum of 120 infants is served by the program.

In addition to public health nurses, who generally staff CHDP programs, HIP staff include medical social workers, a community outreach worker, a psychologist/infant development specialist, and alcohol/drug counselors. HIP staff help women locate a provider, assist with transportation, and verify with the medical provider that

appointments are kept. Staff also work with parents to confront their drug dependency by offering counseling, group sessions, and referrals to a treatment program.

Adolescent Family Life Program, East Bay Perinatal Council

Alameda's AFLP program, administered through the East Bay Perinatal Council, provides case management services to pregnant and parenting teens. As part of that effort, staff comanage any adolescent referred to the Options for Recovery perinatal pilot project in Alameda County. In addition, through a contract with a West Oakland clinic, staff provide extended case management services to pregnant women and teens in West Oakland. Many of these pregnant women are known to use alcohol and/or other drugs. In addition to case management services, staff provide nutrition education, psychosocial intervention, and extensive followup.

Child Development Center, Children's Hospital Oakland

The Child Development Center at Children's Hospital Oakland offers a number of programs providing diagnostic and treatment, educational, and support services to families with infants who are developmentally delayed, disabled, or at risk. Among the programs offered is an HRIF program that is similar to other HRIF programs in the state. The Oakland program offers services to approximately 375 children discharged from the neonatal intensive care unit at Children's Hospital, as well as their families, who receive monthly to quarterly home visits and/or developmental followup clinic evaluations. The HRIF program also serves children in foster care and those who do not meet the geographic requirements of other programs offered at the center. Through a combination of HRIF and grant funding, the center has created a system that provides more intensive services to specific groups of children and their families than the HRIF program alone can provide, including five early intervention programs, two of which target drug-exposed infants.

ELIGIBILITY FOR SERVICES

Both the eligibility criteria and the process for obtaining eligibility presented problems for women and children attempting to receive services from surveyed programs. The health-related criteria for entry into major programs that serve children, including CCS, HRIF, Part H, Regional Center prevention programs, and special education programs, are often very stringent, and exclude many at-risk children from services. These five programs require very specific health problems or conditions for eligibility.

Both CPSP and CHDP use Medi-Cal eligibility and the Medi-Cal application as the point of entry for service. Medi-Cal criteria exclude many low-income women and children, and the application itself is viewed as a major hurdle. CHDP also has complicated, variable income criteria, coupled with age criteria, that are often confusing to service providers as well as potential clients.

Program Criteria

The project survey requested information concerning all the programs' eligibility criteria for services, including:

- health status criteria, such as women's pregnancy; use of alcohol and/or other drugs; known prenatal exposure to alcohol or drugs; acute or chronic illness or disability in children; or developmental delay or risk of such delay in children;
- income criteria, such as having a family income that is less than, equal to, or is at some percentage greater than the federal poverty level or sliding scale fees;
- residency criteria for services, such as US citizenship, state, or county residency;
- for children, the ages served by programs, such as birth to age 18 or only children from birth to age 3.

We inquired about any special eligibility criteria that apply to pregnant and/or postpartum women who use alcohol or other drugs, or to drug-exposed children from birth to age 3. Finally, we asked programs by what process women and children become eligible for services and how long it usually takes to become eligible. Table 13 summarizes the surveyed programs' eligibility criteria.

Differences Among Programs

The findings indicate that eligibility criteria present problems for a number of the programs. For example, the health-related criteria for entry into major children's programs are often very stringent, and exclude many at-risk children. As shown in Table 13, these programs require very specific health problems or conditions for eligibility:

- CCS requires that a child have a chronic illness or physical disability that meets the CCS list of eligible conditions;[38]
- In order to be eligible for High Risk Infant Follow-Up services, infants and toddlers to age 2 or 3 (age served is dependent on the local program) must be at significant risk for developmental delay following discharge from a neonatal intensive care unit. In some cases, children may also be referred to an HRIF program by a community agency. All children must demonstrate risk factors established by the Department of Health Services;[39]

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[38] State regulations define CCS-eligible conditions, which include, for example, orthopedic conditions, conditions requiring plastic reconstruction such as cleft lip, eye conditions leading to the loss of vision, phenylketonuria, hemophilia, convulsive disorders posing medical management problems or problems of diagnosis, neoplasms, chronic pulmonary conditions such as cystic fibrosis, and congenital anomalies. 22 C.C.R. §1800.

[39] These include both biological and environmental risk factors. Examples of biological risk factors are: prematurity (less than 37 weeks or 2500 grams); required assisted ventilation for longer than 40 hours during the first 28 days of life; sustained hypoxemia, acidemia, hypoglycemia, or repetitive apnea; neonatal seizures or seizures beyond the neonatal period; congenital anomalies; prenatal drug and/or alcohol exposure; and discharge on special equipment. Environmental risk factors include: concerns regarding parent-infant bonding; environmental chemical exposure; educational level of mother tenth grade or less; adolescent mother; and past or present maternal alcohol and/or drug use. State Department of Health: Specifications for High Risk Infant Follow-Up Program.

Table 13

OVERVIEW OF ELIGIBILITY CRITERIA FOR PROGRAMS SURVEYED

	Health Status	Income	Residency	Age	Other
Adolescent Family Life Programs	Pregnant or parenting teen	None	County residency	• 17 or younger at the time of enrollment • Generally serve until teen is 20. May serve teens with special needs (e.g, teens with physical or developmental disabilities) until 21	• Teen fathers or expectant fathers may be eligible for services through 19 • Individual programs use risk criteria to determine placement on waiting lists
Black Infant Mortality Projects	Pregnant woman or parenting woman with a child under the age of 1	Income to 200% of the federal poverty level	County residency	None	
California Children's Services	Children with chronic illnesses or physical disabilities defined as CCS eligible conditions	• Family income up to $40,000 • Families with incomes greater than $40,000 qualify if out-of-pocket medical expenses for the CCS condition exceed 20% of family income	County residency	Birth to 21	No income criteria are applied to determine eligibility for school-based OT/PT services

Table 13 (cont.)

	Health Status	Income	Residency	Age	Other
CHDP/EPSDT	• None for children • Women must be pregnant	• Medi-Cal-eligible children • Children from families with income up to 200% of federal poverty level • Women enrolled or potentially eligible for Medi-Cal (to 200% of the federal poverty level)	None	• Medi-Cal-eligible children from birth to 21 • Other children from birth to 18 (meeting income criteria)	Local CHDP programs are responsible for defining a target population of pregnant women that can be served with available resources
County Alcohol/Drug	Women who use alcohol and/or other drugs	Based on family income (sliding fee scale determined locally)	None	None	
Comprehensive Perinatal Services Program	Pregnant and post-partum women	Medi-Cal eligible (to 200% of the federal poverty line)	County residency	No specific age criteria applied to women, but a post-partum woman is only eligible until her child's first birthday	Child's eligibility is linked to mother's
Family Planning	None	• To 200% of the federal poverty line for free services •Medi-Cal and private insurance accepted	None	None	Once a woman is determined to be pregnant, she cannot be served until post-delivery or termination of the pregnancy

Table 13 (cont.)

	Health Status	Income	Residency	Age	Other
High Risk Infant Follow-Up Program	Infants at significant risk for developmental delays upon discharge from a NICU and/or community agency Biological and environmental risk factors established by state	None	None	Local programs serve either children to age 2 or 3	Individual programs apply criteria differently
Part H (PL 99-457)	Eligibility based on eligibility requirements for three state programs: Regional Centers' prevention program, HRIF program, and special education	Determined at the local level	Catchment area encompassing one or more counties	Birth to age 3	Criteria are developed for specific programs at the local level
Regional Centers' Prevention Program	DDS criteria defining a child at risk for developmental delays and eligibility for prevention program	None	Catchment area encompasses one or more counties (except for Los Angeles)	Birth to age 3	Individual programs may apply criteria differently
Social Services	None	None	None	Birth to 18 years	Must meet California Welfare and Institutions code: child in danger of abuse, neglect, or expoloitation

Table 13 (cont.)

	Health Status	Income	Residency	Age	Other
Perinatal Pilot Projects (Options for Recovery)	Pregnant, post-partum, or parenting women who use alcohol and/or other drugs	Based on family income (sliding fee scale)	Catchment area	None	Priority is given to pregnant women
Special Education	Children with hearing, visual or orthopedic impairments, autistic children; seriously emotionally disturbed children; children with 50% delay in one area or 25% delay in two or more areas of development as defined in statute	None	Special education local plan areas (SELPAs); can be a single school district or group of districts	Birth to 3	

- Prevention programs of the state's Regional Centers require children to be at risk for developmental delay according to criteria established by the Department of Developmental Services;[40] these criteria are often applied differently at the local level by individual Regional Centers;
- Special education programs require that children manifest a range of moderate-to-severe health conditions including hearing, visual, or orthopedic problems; serious emotional disturbance; or 50% delay in one area or 25% delay in two or more areas of development;
- Programs funded through Part H of PL 99-457 base eligibility on children meeting the criteria for one of three of the programs discussed above: Regional Center prevention, High Risk Infant Follow-Up, or special education.[41]

Although state criteria determined HRIF program eligibility, some programs we surveyed tended to favor one or more of the state criteria. For example, one only accepted children referred within a month of delivery; another required referrals within a month after discharge from intensive care. One program made birth weight (less than 1500 grams) the main criterion. Only one program noted that a drug-exposed child with an additional social factor could be eligible for services.

Eligibility criteria used by Regional Centers also varied. Two Regional Centers reported that children eligible for prevention services had to be discharged from a neonatal intensive care unit. Most Regional Centers noted that a combination of risk factors was required to qualify a child for prevention services. Drug exposure was considered as one factor, and an additional high-risk factor or evidence of developmental delay was required to qualify a child for services. However, it appeared that four Regional Centers were more flexible than others in evaluating drug-exposed children. In Humboldt County, for example, drug exposure alone was reason enough to qualify a child, although cases were evaluated on an individual basis. In San Diego, prevention staff also considered a child's need for services and evaluated what services a child was receiving from an alternative source. In San Francisco, one high-risk factor could be sufficient to qualify a child for services, although most children referred usually had a combination of risk factors.

Finally, Alameda County accepted drug-exposed children without additional risk factors if the families were willing to participate in the program. However, a child who reaches age 2 without developmental delay is no longer eligible to receive services.

The Options for Recovery perinatal pilot projects employ a priority system of health-related eligibility criteria for women seeking entry. Priority is given first to

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[40] Prevention program criteria include medical and clinical factors. Examples of medical factors are: prematurity (less than 32 weeks gestation or birth weight equal to or less than 1500 grams); significant small-for-gestational age; severe respiratory distress requiring assisted ventilation for 48 hours or longer during the first 28 days of life; neonatal seizures or nonfebrile seizures during the first three years of life; central nervous system lesion or abnormality; positive neonatal toxicology screen or symptomatic drug withdrawal; and clinically significant failure to thrive. Examples of clinical factors are: infant born to a developmentally disabled parent; developmental delay as a consequence of biological and/or environmental factors; and persistent muscle tone abnormality.

[41] However, individual projects ultimately determine the eligibility criteria to be used.

pregnant women, second to postpartum women, and last to women with children under the age of 3.

Six of the 13 types of programs surveyed (Black Infant Mortality, CCS, CHDP, CPSP, family planning, and Part H) use some sort of income-based eligibility criteria. Five of the programs (AFLP, HRIF, Regional Centers, social services, and special education) do not use income criteria in determining eligibility. Two programs (county alcohol and drug programs and Options for Recovery) use a sliding-fee scale based on income, where no one is turned away for lack of ability to pay. The income criteria used in surveyed programs include Medi-Cal eligibility, income to 200% of the federal poverty level (FPL), and family income under a flat ceiling amount.

Two programs use Medi-Cal eligibility and Medi-Cal application as the point of entry for service: CHDP/EPSDT and CPSP. CHDP has complicated, variable income criteria that are often confusing to both service providers and potential clients. Children must be Medi-Cal-eligible to qualify for the federally funded EPSDT part of CHDP. Non-Medi-Cal-eligible families with incomes to 200% of FPL qualify for the state-funded CHDP program. As Chart 1 demonstrates, financial eligibility criteria for CHDP/EPSDT also intersect with age criteria in ways that are complex and often confusing for both families and service providers. For example, children from birth to age 1 are eligible for EPSDT under Medi-Cal with family incomes to 185% of FPL. Children from 1 to 6 years of age are eligible with family incomes to 133% of FPL. Furthermore, all Medi-Cal-eligible children are served from birth to age 21, but children eligible for CHDP alone (whose incomes are 200% of FPL) are served only from birth to age 18.

In counties with prenatal care guidance programs through CHDP, women must be pregnant at time of enrollment and must be eligible for Medi-Cal (for pregnant women, with income to 200% of FPL). Some program respondents commented that their programs provide guidance, including linkage with perinatal services, regardless of income.

The only eligibility criteria for AFLP programs are age and whether a teen is pregnant or parenting. Women must be 17 years of age or younger at the time of enrollment, although programs with waiting lists may not actually provide services until after a teen turns 18. AFLP services may be provided to enrolled women until they are 20, but these services are not available to women who are 18–20 years old at the time of application. Nine of the 14 AFLP programs we surveyed reported that they could not serve all eligible teens. These programs developed specific high-risk criteria in order to determine a teen's priority for services.

We found few discernible problems with program residency requirements, even for undocumented women. Some programs formally require state or county residency, but enforcement is rare. Some of the Options for Recovery programs serve a specific catchment area within a single county that may result in the exclusion of otherwise eligible women.

County social services programs base service eligibility on the child being at risk for abuse, neglect, or exploitation, as defined in Welfare and Institutions Code §300.[42]

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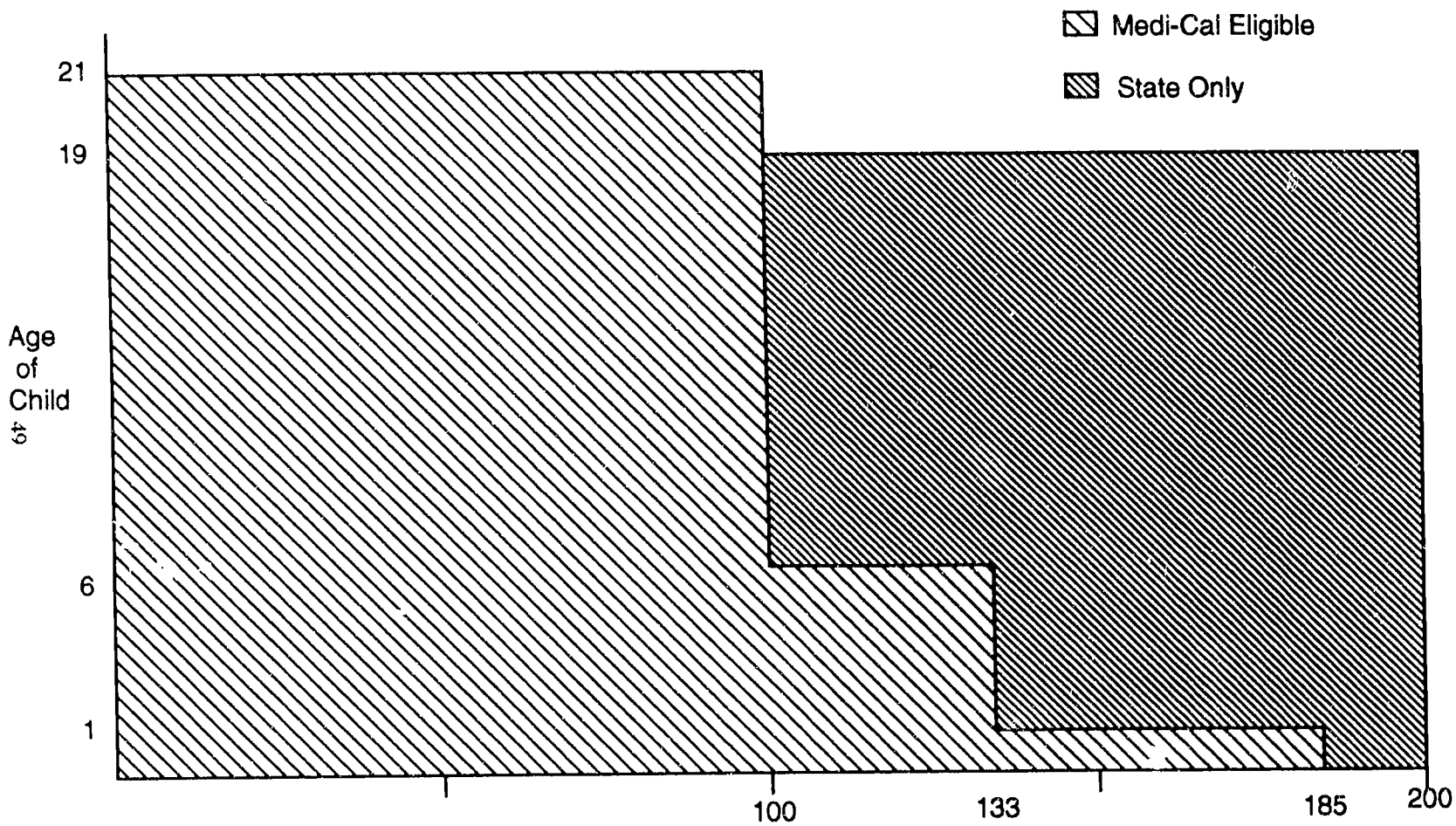
[42] Department of Social Services Regulation 30-14.11.

Chart 1

ELIGIBILITY FOR CHDP



Ellen Dunn-Malhotra, Youth Law Center
Laurie Soman, Center for the Vulnerable Child
Rebecca Schleifer, National Center for Youth Law

Two of the survey respondents commented that the need to meet this code definition puts individual social workers in the position of determining whether family circumstances constitute abuse or neglect, or risk of same. The respondents indicated that such individual interpretation can result in lack of intervention with children who in fact are in dangerous or potentially dangerous situations, as well as inappropriate intervention with families. One-quarter of the respondents noted that the need for children to be at risk of abuse or neglect, coupled with the stigma of social service intervention, kept families from voluntarily seeking assistance in preventing possible abuse or neglect.

COORDINATION OF SERVICES

Measures of Coordination

Coordination of services has long been a goal of human service programs. Several initiatives, such as Part H of PL 99-457, stress coordination as the primary mission of funding. The project survey questioned both state and local program administrators about the extent, activities, and perceived success of agencies' coordination of services for pregnant and/or postpartum women who use alcohol and other drugs and young drug-exposed children. These questions included:

- whether staff from the program surveyed meet formally or informally with staff from other programs specifically to coordinate services for these populations of women and children
- whether the program has signed interagency agreements pertaining to coordination of services for these women and children
- the activities undertaken through these linkages
- the perceived success of the program's coordination efforts on behalf of our target populations.

Formal coordination was defined as regular meetings of staff from different programs, such as an interagency council or task force. A subset of formal coordination included interagency agreements such as memoranda of understanding to coordinate services for pregnant or postpartum women or drug-exposed children. Informal coordination was defined as meetings of staff from different programs outside of regular, formal task forces or councils in order to coordinate services for the target population.

The survey of Comprehensive Perinatal Services Programs asked respondents if staff from the county maternal and child health program meet with CPSP providers in the county to coordinate services for pregnant women who use alcohol and/or other drugs. At least 125 program representatives responded to the questions concerning coordination in the general survey; all 12 county CPSP coordinators responded in the separate CPSP survey.

Coordination appears to be widespread in each of the 12 counties. At least 64% of the programs surveyed reported formal linkages among a range of county agencies. Ninety percent perceived these efforts as successful, citing the importance of information-sharing, of a forum for policy and protocol development, and of multidisciplinary, interagency education. Programs also cited problems with their county's coor-

dination activities, including lack of funding and staff time for these efforts, lack of funding for direct services that coordination participants identify as necessary, and lack of authority on the part of some coordinating bodies to address problems that their members identify.

County mental health programs were the *least likely* of the major county agencies to be involved in either formal or informal coordinating activities, often showing far less involvement than other health and social services. At the state level, similarly, mental health is not represented on the State Interagency Task Force that monitors the Options for Recovery programs. At the same time, however, a number of survey respondents from Options for Recovery and county alcohol and drug programs noted that dual diagnosis is a growing issue for treatment and recovery programs.

State Coordination Activities

Six state departments currently participate in either or both of two formal interagency coordinating bodies that consider issues concerning alcohol- and drug-affected children and families. The State Interagency Task Force (SITF), convened by the Department of Alcohol and Drug Programs, brings together ADP and the departments of Health Services, Social Services, and Developmental Services to coordinate planning, funding, and administration of the Options for Recovery perinatal pilot projects. The SITF continues to oversee implementation of the Options pilots. The Department of Developmental Services (DDS) convenes the Interagency Coordinating Council (ICC) to coordinate planning and activities under Part H of PL 99-457. The ICC includes representatives from DDS and the departments of Alcohol and Drug Programs, Health Services, Social Services, Education, and Mental Health. These state-level coordinating bodies meet four to six times each year, with additional meetings as needed; their activities are formalized with memoranda of understanding among the participating departments.

In addition to inquiring about departmental participation in state coordinating bodies, we also asked the state administrators of the individual programs we surveyed whether the programs participated in the state task forces. We were interested in knowing, for example, if the state administrators of such programs as family planning, CPSP, AFLP, HRIF, CHDP, CCS, and Black Infant Mortality (all within the Department of Health Services) had direct representation on either of the state task forces. Of the respondents, only HRIF is represented on the ICC; none of the programs are represented on SITF, although at the local level HRIF, CPSP, and AFLP provide case management to Options for Recovery clients. Several of the programs — family planning, Black Infant Mortality, CPSP — reported participating in coordination activities that do not directly address alcohol and drug issues, e.g., with Medi-Cal, with staff of other DHS programs, or on advisory committees.

Local Coordination Activities

Two types of local coordination efforts mirror those at the state level: the Part H Local Planning Area coordinating councils, similar to the state ICC, and county or regional Perinatal Substance Abuse Councils, similar to the SITF. The study reveals that coordination of services for the target population is widespread through these

coordinating councils as well as other local bodies in each of the counties we surveyed. Table 14 indicates the prevalence of the three measures of coordination we used in our survey: formal and informal linkages, as well as interagency agreements.

Counties reported quite high levels of coordination by our measures. In three (Humboldt, Monterey, and San Diego), all programs surveyed had formal links with the agencies we listed.[43] Most other counties had high levels of formal coordination. At least 64% of programs surveyed in each county had formal links with the agencies listed on the survey.

Formal coordination consisted of countywide task forces or councils such as the Perinatal Substance Abuse Councils, Part H Coordinating Councils, and AFLP Community Service Networks found in many counties that engage in networking, information-sharing, case conferences, planning and coordination of new services, development of countywide protocols and policies, and grantwriting. Most respondents found formal coordination to be valuable, although some cited the amount of time spent in meetings as a problem.

Two-thirds of the CPSP coordinators reported that they or other maternal and child health staff meet with county CPSP providers to coordinate services. In most cases, this coordination takes place through the Perinatal Substance Abuse Council.

Formal interagency agreements were also common in the counties we surveyed. Thirty-six percent of the county respondents reported being signatories to formal interagency agreements to coordinate services for alcohol- and drug-affected women and/or children.

Informal coordination activities were less likely to occur, with participation ranging from 60% to 100% of respondents within individual counties. On average, 77% of respondents in all surveyed counties participate in informal coordination activities, which usually consist of line staff keeping in touch with each other for information-sharing and networking. A number of respondents commented that their coordination energy is focused on the formal task forces and councils in their counties, and that they lack the time for additional, informal contacts.

As demonstrated in Table 15, responding agencies are most likely to have formal linkages (including formal interagency agreements) with county social service programs, followed by public health departments, Regional Centers, and alcohol/drug programs. Respondents were least likely to note formal linkages with school districts and mental health programs. They were most likely to engage in informal coordination activities with public health and social services, followed by school districts, Regional Centers, and alcohol/drug programs. Once again, mental health programs were the least likely to be involved. This pattern held across almost all 12 counties, with mental health programs often showing far less involvement in coordination efforts than other health and social services. The lack of involvement of mental health programs in service coordination is of particular concern because of the suspected prevalence of mental disorders among persons who are chemically dependent. Although the project survey did not formally inquire about dual diagnosis (the presence of both chemical depen-

[43] The agencies listed were: county alcohol and drug programs, Regional Centers, county public health, county social services, school districts, and county mental health.

Table 14

NUMBER OF PROGRAMS REPORTING COORDINATION ACTIVITIES FOR PREGNANT OR POST-PARTUM WOMEN AND/OR DRUG-EXPOSED CHILDREN BY COUNTY

County	Number of Programs with Formal Linkage[a]	Number of Programs with Informal Linkage[b]	Number of Programs with MOU[c]	Total Number of Program Respondents in County
Alameda	9 (90%)	6 (60%)	5 (50%)	10
Humboldt	9 (100%)	6 (67%)	4 (44%)	9
Kern	7 (78%)	6 (67%)	1 (11%)	9
Los Angeles	18 (86%)	19 (90%)	5 (24%)	21
Monterey	8 (100%)	8 (100%)	4 (50%)	8
Orange	10 (83%)	10 (83%)	4 (33%)	12
Sacramento	7 (64%)	7 (64%)	4 (45%)	11
San Bernardino	9 (90%)	6 (60%)	4 (40%)	10
San Diego	10 (100%)	9 (90%)	3 (30%)	10
San Francisco	7 (88%)	7 (88%)	2 (25%)	8
Santa Clara	10 (100%)	7 (70%)	5 (50%)	10
Tulare	6 (86%)	6 (86%)	2 (29%)	7
TOTAL	**110 (88%)**	**97 (77%)**	**43 (34%)**	**125**

[a]Formal linkages are defined as regular meetings of staff from different programs, such as an interagency council or task force, to coordinate services for pregnant or post-partum women or drug-exposed children

[b]Informal linkages are defined as meetings of staff from different programs outside of regular, formal task forces or councils to coordinate services for pregnant or post-partum women or drug-exposed children

[c]Memoranda of Understanding or interagency agreements pertaining to coordination of services for pregnant or post-partum women or drug-exposed children

Table 15

TYPES OF PROGRAMS MOST LIKELY TO PARTICIPATE IN COORDINATION ACTIVITIES FOR PREGNANT AND POST-PARTUM WOMEN AND/OR DRUG-EXPOSED CHILDREN

RANKING FROM MOST TO LEAST LIKELY TO COORDINATE	PARTICIPATION IN FORMAL LINKAGES[a]	PARTICIPATION IN INFORMAL LINKAGES[b]
1	County Social Services	Public Health
2	• Regional Centers • Public Health	County Social Services
3	Alcohol/Drug Services	School Districts
4	School Districts	Regional Centers
5	Mental Health	Alcohol/Drug Services
6		Mental Health

[a]Formal linkages are defined as regular meetings of staff from different programs, such as an interagency council or task force, or interagency agreements such as Memoranda of Understanding, to coordinate services for pregnant or post-partum women or drug-exposed children

[b]Informal linkages are defined as meetings of staff from different programs outside of regular, formal task forces or councils to coordinate services for pregnant or post-partum women or drug-exposed children

dency and mental illness) in the women served, a number of respondents from county alcohol and drug and Options for Recovery programs did comment on it, as well as on the difficulties these clients may pose to programs, particularly alcohol and drug treatment and recovery services.

Table 16 illustrates how the 12 surveyed counties rate their overall coordination efforts on behalf of the target populations. Clearly, the vast majority perceive their coordination efforts as successful: 90% of the sample rate these activities as "very successful" or "somewhat successful" (46% and 44% respectively). Only 3% of the respondents thought their efforts were "not very successful," and only 1 of the 125 respondents (less than 1%) thought these efforts were "not at all successful."

A number of respondents reported criticisms of the coordination efforts in their counties, which included the following:

- *Lack of additional funding or staff time for coordination*

  Respondents noted that coordination activities often are not allotted either budgets or staff time, yet the activities are regarded as important and staff are expected to participate, sometime in multiple task forces or coalitions.

- *Lack of real authority for coalitions to address the problems identified*

  Neither local coordinating bodies nor their individual members may have the authority in their counties or agencies to implement agreed-upon solutions to coordination problems.

- *Size of large councils or coalitions in some counties*

  Some respondents felt that these large groups became too unwieldy and/or bureaucratic to be able to function effectively.

- *Lack of funding for the direct services that participants identify as needed*

  Respondents noted that coordinating bodies are in an excellent position to identify needs for new or expanded direct services. However, members lack the authority to appropriate needed funding or are constrained by agency and county budget limitations.

- *Lack of understanding between practitioners of different professional disciplines*

  Some respondents noted that differing approaches and perspectives of participants in multidisciplinary bodies resulted in misunderstandings, territoriality, and other problems that functioned as barriers to coordination.

- *Difficulties posed in coordinating services in geographically large counties*

  County size, particularly in rural counties where most services are concentrated in only one or two locations for the entire county, was identified as a barrier to successful coordination.

Respondents also noted the positive aspects of coordination:

- the uses of coordination, including the importance of information-sharing to reduce fragmentation and duplication of services
- the opportunity in a multidisciplinary group to see clients as whole people and not just as pieces served by an individual program

Table 16

PERCEIVED SUCCESS OF COUNTY COORDINATION EFFORTS

COUNTY	Number of Programs Reporting Very Successful	Number of Programs Reporting Somewhat Successful	Number of Programs Reporting Not Very Successful	Number of Programs Reporting Not at All Successful	Number of Programs Reporting Don't Know	Number of Programs in Sample
Alameda	5 (50%)	3 (30%)	1 (10%)	0	1 (10%)	10
Humboldt	6 (67%)	3 (33%)	0	0	0	9
Kern	4 (44%)	4 (44%)	0	0	1 (11%)	9
Los Angeles	6 (29%)	11 (52%)	2 (10%)	0	2 (10%)	21
Monterey	6 (75%)	1 (13%)	0	1 (13%)	0	8
Orange	7 (58%)	4 (42%)	0	0	0	12
Sacramento	3 (27%)	6 (55%)	0	0	2 (18%)	11
San Bernardino	6 (60%)	3 (30%)	0	0	1 (10%)	10
San Diego	4 (40%)	5 (50%)	1 (10%)	0	0	10
San Francisco	4 (50%)	4 (50%)	0	0	0	8
Santa Clara	2 (20%)	8 (80%)	0	0	0	10
Tulare	4 (57%)	2 (29%)	0	0	1 (14%)	7
TOTAL (125)	**57 (46%)**	**55 (44%)**	**4 (3%)**	**1 (1%)**	**8 (14%)**	**125**

- the importance of a forum for identifying large issues and developing policies to address them
- the need for all disciplines to be educated about one another's skills, functions, and services.

DATA COLLECTION

Data are lacking at both the state and local levels regarding the prevalence of perinatal alcohol and drug use, the number of women or children eligible for services, and the number of women or children currently receiving services. Many of the programs surveyed have no prevalence data for their counties. Few (except for county alcohol and drug programs and Options for Recovery) appear to be asking women clients about their alcohol and drug use, and so are unaware of the extent of the problem in the women they serve. Even when programs do estimate incidence and prevalence of perinatal alcohol and drug use, there is such variation that these estimates often differ among programs within the same county. The state prevalence study now underway may begin to answer some questions regarding the extent of perinatal alcohol and drug use in California.

CPSP programs in particular lack data on the number of women served. The state Department of Health Services has acknowledged this lack of information as a problem. County coordinators who participated in the survey reported that little information is collected from private CPSP providers, from the number of patients seen to their criteria for accepting patients.

At the time we conducted the survey, county social services programs did not compile data in standardized age categories, making it very difficult to assess the impact of perinatal alcohol and drug use on the social services system for young children.

Three of the 12 counties automatically remove to temporary foster care newborns believed to have been prenatally exposed to alcohol and/or other drugs, a policy that may be in conflict with current law. At least one of these counties was reconsidering its policy in light of SB 2669, which stipulated that a positive toxicological screen does not in and of itself constitute child abuse or neglect. We were unable to assess the impact of SB 2669 on the policies of county agencies, as the counties were formally notified of the law by the state Health and Welfare Agency after the project survey had been completed.

State Data Collection

The statewide data collection effort concerning perinatal alcohol and drug use at the time we surveyed programs consisted of the California Drug Abuse Data System (CALDADS) and California Alcohol Program Statistics, both run by the Department of Alcohol and Drug Programs. Although drug programs provided fairly comprehensive information on services and clients to the state, alcohol program data collection was voluntary and could vary widely. As of July 1991 these two programs were replaced by a single entity, CADDS (California Alcohol and Drug Data System). Local service providers complete two CADDS forms per client, one at program entry and one at

discharge. The forms include a range of demographic information including race, ethnicity, sex, age, education, and employment status, as well as health-related information such as pregnancy and disability status, alcohol and other drug use history, and medical history. All information is "blind" and cannot be traced back to individual clients. Raw data forms are sent directly from local programs to the department. ADP collects and distributes salient facts from its data collection system in its periodic "Data Sheets on Perinatal Alcohol and Drug Use." In addition, counties can request copies of the raw data forms from the state, and quarterly reports of the aggregate data are sent to each county for planning purposes.

The state provides aggregate data to the National Institute on Drug Abuse for inclusion in its national assessments of alcohol and drug problems, as well as to the National Association of State Alcohol and Drug Abuse Directors.

Local Data Collection

The project survey asked a number of questions designed to elicit information about the state of data collection concerning the target population, including:

- the number of women and children served by the program
- the number served for whom alcohol/drug use is a factor
- whether the program has a designated number of service slots for either women or children affected by alcohol/drug use and, if so, what is the designated number
- whether the program uses an estimate of the number of women and/or children in the county affected by perinatal alcohol and drug use and, if so, the number or percentage.

The survey also included a specific section for county Child Protective Services that inquired about the number of reports of abuse and neglect filed on children from birth to age 3, the number of reports related to alcohol/drug use, the number of young children removed from their homes, and the reasons for removal. In addition, we asked whether it is county policy to automatically remove a newborn who has been exposed prenatally to alcohol and/or other drugs.

The separate survey used with Comprehensive Perinatal Services Programs asked basic questions such as the number of women served by CPSP in the county, the number of eligible women who were not served, and whether the county has compiled an estimate of the number of alcohol- and drug-affected women and children. In all cases data were requested for the 1989-90 fiscal year. There was only one respondent in the category of Black Infant Mortality programs, data for which are not presented here.

The study confirms many observers' belief that data are lacking at both the state and local levels regarding prevalence, numbers of women or children eligible for services, and numbers currently receiving services. Many of the responding programs have no data on the prevalence of alcohol and drug use by pregnant women or the number of alcohol/drug-exposed children in their counties. Few of the programs, with the exception of county alcohol and drug as well as Options for Recovery programs, appear to be asking women clients about their alcohol and drug use and so are unaware of the extent of the problem among the population they serve.

Of the 33 programs reporting that they compile estimates of the number or percent of this population in their counties, 10 base their estimates on such national studies as that conducted by the National Association for Perinatal Addiction Research and Education (NAPARE) in 1988, which concluded that 11% of births in the U.S. involve use of illicit drugs. This benchmark study, based on a national survey of 36 hospitals, cannot be viewed as representative of a diverse state like California. Moreover, as the NAPARE survey looked for evidence of cocaine, heroin, amphetamines, PCP, marijuana, and methadone but omitted alcohol and other illicit drugs, it is not a comprehensive measure of all perinatal alcohol and drug use.[44] Fifteen programs base their estimates on local studies, which measure such data as the percentage of positive toxicological screens at local hospitals. Six other programs estimate the incidence of alcohol and drug use among women and children in their county by applying statistics, usually in the 10-15% range, that program representatives attribute to "national data." Survey respondents often did not know the source of the national data, how the figures were derived, or what drugs were included. Two respondents cited other data sources, including the state Regional Center program and public health nurses. The variation in the data often leads to vastly different estimates within the same county.

State Prevalence Study

More comprehensive statewide information may be available in the near future. The state of California has just begun a two-year study of the prevalence of perinatal alcohol and drug use to attempt to obtain accurate population-based estimates of the number of pregnant women who use alcohol and other drugs. The first part of the study, being conducted under the aegis of the Department of Alcohol and Drug Programs, consists of "blind" urine toxicology screening of a large and representative sample of women at the time of hospital admission for delivery. The screen will test for alcohol, opiates, cocaine, marijuana, amphetamines, barbiturates, benzodiazepines, and PCP. Test results will be matched with demographic data to provide regional estimates of prevalence among women of different age, ethnic, and socioeconomic groups. ADP estimates that 30,000 women in over 200 hospitals in most of the state's 58 counties will be included in the study. A second component of the study will include interviews with approximately 500 pregnant women who use alcohol and other drugs, including tobacco, to identify their perceptions of treatment and outreach needs. Interviewees will be identified through treatment programs, prenatal clinics, community service programs, and other sources. Both components are expected to be completed by June 1993.[45]

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[44] NAPARE. (1989). "A First: National Hospital Incidence Survey." Press release issued September 1989.

[45] Department of Alcohol and Drug Programs. (1992). "California's Perinatal Substance Exposure Study." Memorandum issued February 20, 1992.

Local Program Data

In the absence of such data, we sought to collect information from individual programs in the 12 target counties. Following are the survey results on the nature of data collection in those programs concerning perinatal alcohol and drug use.

Comprehensive Perinatal Services Programs

Seven of the 12 counties have no figures on the number of women currently being served by CPSPs. Since the county coordinators do not know how many are being served, gauging the unmet need for CPSP services (i.e., the number of women eligible for but not receiving services) is highly problematic. CPSP currently has only one official mechanism for compiling statistics: specific coding on a newborn's birth certificate for "principal source of payment for perinatal care." The Department of Health Services reports that hospitals in most counties are not correctly identifying CPSP as the payment source on the birth certificate.[46] Since CPSP services are delivered at multiple sites, including private providers who rarely compile statistics on patients by their form of insurance, it is also difficult to compile the numbers at the county level. County coordinators reported that in general little information is collected from private CPSP providers, from the actual number of CPSP patients seen, to the local providers' criteria for accepting CPSP patients.

County Alcohol and Drug Programs

Nineteen of these programs participated in the survey, representing all 12 target counties' alcohol and drug programs except San Francisco's drug program (its alcohol program did respond). Five of the county programs surveyed collect data on the number of pregnant or postpartum women served, as shown in Table 17:

Table 17

NUMBER OF PREGNANT OR POSTPARTUM WOMEN SERVED

Orange Alcohol Program	95
San Diego Drug Program	3*
San Francisco Alcohol Program	25
Santa Clara Alcohol Program	211
Santa Clara Drug Program	109

* Most of the pregnant and postpartum women receiving alcohol/drug services in San Diego obtain them through Options for Recovery; those numbers are not included here.

Sacramento County, which is now collecting these data, was not doing so at the time of the study. Most of the counties we surveyed do not collect these data.

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[46] California Department of Health Services. (1991). *Coordination.* Sacramento, CA: Author; personal communication with DADP, 1992.

Respondents reported that client information is collected on forms for the state data system and sent directly to the Department of Alcohol and Drug Programs. Since many of the treatment and recovery services are contracted out to community programs, county respondents indicated that they would have to collect information from the programs in order to compile the statistics. According to the ADP, however, the department can provide these program data. Survey responses indicate that county staff either are not aware of this option or are not taking advantage of it.

As shown in Table 18, four of the 19 county program respondents reported that they have a designated number of service slots for pregnant women:

Table 18

DESIGNATED SERVICE SLOTS IN COUNTIES

Monterey Alcohol/Drug Program	55
San Bernardino Alcohol Program	140
San Bernardino Drug Program	180
Santa Clara Drug Program	8

These slots are not available to all pregnant women with alcohol/drug problems, however. In San Bernardino County, for example, some slots are reserved for alcohol programs and others for drug programs, requiring a woman to state whether she uses primarily alcohol or other drugs. In Santa Clara County, the slots are on the drug program side. Only in Monterey County are the designated slots available to a pregnant woman regardless of her primary drug of use. Several program respondents commented that the division of programs and services into alcohol and drug components resulted in staff assigning a "primary drug of addiction" to a woman based not on her use, but on which programs had openings.

None of the county programs that have designated slots for pregnant and postpartum women are in counties with Options for Recovery programs. In the four counties with Options programs, the alcohol and drug program respondents were likely to answer the question about designated slots by pointing to Options as the program for pregnant women.

Options for Recovery: Perinatal Pilot Projects

All four Options for Recovery programs responded to our survey. At the time, two of the programs, in Alameda and Sacramento counties, were not yet completely implemented. Alameda's residential service component had not yet opened, and Sacramento's program had just opened. As a result, neither had statistics on the number of pregnant and postpartum women served. The Los Angeles program opened in July 1990 and San Diego's in November 1990, and statistics were available from these two programs. Los Angeles served 103 women and San Diego served 168; all had alcohol and drug problems.

As shown in Table 19, all four Options for Recovery programs have designated program slots for pregnant and postpartum women, for a total of 748 slots:

Table 19

DESIGNATED SERVICE SLOTS IN OPTIONS FOR RECOVERY

Alameda	200
Los Angeles (two sites)	250
Sacramento	125*
San Diego	173

* 125 can be served in the treatment component; 200 overall will receive case management services.

None of the programs have designated slots or service numbers specifically for drug-exposed children. Their children's services, including residential care with mothers in treatment, generally are not limited to children known to have been drug-exposed prenatally.

County Child Welfare Services

The responses of the 12 county social services departments clearly demonstrated that counties collected data in different age categories. Only three of the 12 counties we surveyed kept statistics on children in the 0–3 age group:

Table 20

NUMBER OF CHILDREN SERVED

Santa Clara	5,500
San Francisco	5,984
Tulare	60

Of these children, San Francisco estimates that 90%, or 5,386, are prenatally drug-exposed; Tulare counts all 60 young children, or 100%, as prenatally drug-exposed, based on positive toxicological screens. Santa Clara does not know how many of the children it served in that age group may have been prenatally drug-exposed.

Two additional counties, Los Angeles and Monterey, keep statistics by different age groups. Los Angeles County's statistics are collected for age groups 0–2 and 3–4, and the county has 15,565 children in those combined age groups in the social services system. The department estimates that 2,247 have been drug-exposed. Monterey keeps statistics on children aged 0–2 and 3–6. The department estimates there are 2,250 children in the 0–3 age group, and that approximately 50% of them are drug-exposed.

Of the remaining seven counties, Alameda (which keeps statistics in the 0–8 age group) and San Bernardino (which does not keep data by age group) are setting up a data base with the 0–3 age group. With this lack of data by age, it is difficult to determine the impact of perinatal alcohol and drug use on the social services system for the target population of children.

The survey also asked county social services departments about the numbers of abuse and neglect reports filed, children removed, and dependency petitions filed and sustained, for both the population of children from birth to age 3 and those believed to be affected by maternal alcohol and drug use. Four of the counties keep some or all of these statistics. Table 21 shows the number of reports of abuse and neglect as a result of maternal alcohol and drug use in those counties.

Table 21

NUMBERS OF ABUSE/NEGLECT REPORTS RELATED TO ALCOHOL/DRUG USE

Los Angeles	5,386
Monterey	9
Sacramento	500
Tulare	60

These four counties' estimates of the role of alcohol and drug use in dependency cases ranged from 40–90%, although these figures reflect familial, not just maternal, use. Statistics on the prevalence of drug exposure among the children served are usually estimates based on staff perceptions of the extent of alcohol and drug use, including use by pregnant women. Tulare County bases its statistics on toxicological screens performed in the county's hospitals.

Three of the counties — Humboldt, San Diego, and Tulare — had automatic removal policies affecting newborns believed to have been prenatally exposed to alcohol and/or other drugs, which required putting a hold on these children until their mothers could be interviewed by Child Protective Services staff. Of these counties, only Tulare compiles statistics on the role of alcohol and drugs in removal decisions.

The passage of SB 2669 (1990) raises questions about the application of automatic removal policies by county social services departments. The law clarifies that a positive toxicology screen at the time a newborn is delivered is not, in itself, a sufficient basis for reporting child abuse or neglect. Under SB 2669, any indication of maternal alcohol or drug use should prompt an assessment of the needs of both mother and child. If an assessment indicates risk to a child, it should result in a report to Child Protective Services, as now required under existing abuse and neglect reporting rules.[47] One of

[47] Presley, R. Chapter 1603 (SB 2669), California State Legislature, 1990.

the counties with an automatic removal policy reported that its social services department would be reviewing that policy in light of SB 2669.

Of the 12 county social services departments surveyed, only one has designated service slots for drug-exposed children. San Francisco reports 189 slots for these children in three special programs.

California Children's Services

CCS programs typically do not keep statistics on age of children or their prenatal exposure to alcohol and other drugs. Only one respondent, from Sacramento County, could report the number of children served from age 0–3 (1,200). No respondents knew the number believed to be prenatally exposed. CCS is not a direct service provider, nor does it target specific populations of children for services. It functions as a program to fund services for chronically ill children, and therefore has no "designated slots" for eligible children, including those who are drug-exposed.

Family Planning

Only six of 19 family planning programs in the 12 counties agreed to participate in the survey. Officials of many of the 13 programs that declined to participate based their doing so on not seeing any connection between family planning programs and a study on perinatal alcohol and drug use. The six programs that responded are in six of our target counties (Kern, Los Angeles, Orange, Sacramento, Santa Clara, and Tulare.)

None of these programs compile statistics on the number of pregnant or postpartum women served who use alcohol and other drugs, primarily because, as family planning programs, their contact with the woman generally ends with a positive pregnancy test. None of the programs, with the exception of a program in Kern County, provide services designed for these women. (This program, discussed earlier, provides outpatient alcohol and drug treatment to 25 pregnant or postpartum women and adolescents.)

Child Health and Disability Prevention Programs

Eleven of the 12 county CHDP programs responded to the survey. All 11 counties compile statistics on the number of children served by the CHDP program, but San Diego is the only county to estimate how many of the children are exposed to drugs prenatally. None of the programs have designated service slots for women who use alcohol and/or other drugs. One program in Alameda County, however, has a designated number of slots (120) for drug-exposed children.

Only six of the programs keep statistics on how many women are served in the Prenatal Care Guidance component; of these, only one (San Diego County) estimates the number of women in the program who are using alcohol and/or other drugs.

Special Education Programs

Ten of the 12 special education programs in the target counties responded to the survey. Of these, only one (Tulare) did not know how many young drug-exposed children have been served by the program. The number of children served by the other

nine programs ranged from three in San Francisco to 75 in San Diego. Drug-exposed children often comprised a substantial proportion of the total number of children served in the program, ranging from 8% to 25%, as shown in Table 22.

Table 22

PERCENT OF DRUG-EXPOSED CHILDREN SERVED IN SPECIAL EDUCATION PROGRAMS

Humboldt	21
Kern	20
Monterey	5
Orange	11
Sacramento	10
San Bernardino	25
San Diego	25
San Francisco	8
Santa Clara	25

Part H Local Planning Areas

Seven of the 12 LPAs that participated in the survey have targeted services and slots for drug-exposed children, as shown in Table 23.

Table 23

DESIGNATED SERVICE SLOTS

Alameda	64
Humboldt	100
Los Angeles	105
Monterey	30
Orange	300
San Bernardino	9
Santa Clara	85*

* 50 mothers are also served

High-Risk Infant Follow-up Programs (HRIF)

All 10 of the HRIF programs surveyed keep statistics on the number of children served from birth to age 3 and the number of these children who were exposed to drugs prenatally (see Table 24). None of the HRIF programs have a number of service slots specifically designated for drug-exposed children.

Table 24

CHILDREN SERVED BY HRIF PROGRAMS

COUNTY	# SERVED	# DRUG-EXPOSED (%)[a]
ALAMEDA	173	23 (13%)
HUMBOLDT	40	8 (20%)
LOS ANGELES[b]	546	166 (30%)
MONTEREY	56	2 (4%)
ORANGE[c]	521	80 (15%)
SACRAMENTO	110	61 (55%)
SAN DIEGO	1000	177 (18%)
TOTAL	2446	517 (21%)

[a]Proportion of total children served who are drug-exposed is in parentheses

[b]Numbers include three HRIF programs in Los Angeles

[c]Numbers include two HRIF programs in Orange County

Adolescent Family Life Projects

AFLP programs, similarly, do not maintain designated service slots for adolescent clients who use alcohol and/or other drugs. Of the 14 programs surveyed, all know the total number of women they serve. Nine either compile or could estimate the number of women with alcohol and drug problems; the other programs could not. (See Table 25.)

Regional Center Prevention Programs

Seventeen Regional Centers participated in the survey. Seven of them serve areas within Los Angeles, and one serves both Santa Clara and Monterey counties. The remaining nine each serve a single one of the counties surveyed. All of the centers compile statistics on children served from birth to age 3, and all but two (one in Los Angeles and the center in Tulare) also have data on the number of drug-exposed children served. None of the Regional Centers report having designated service slots for these children. (One Los Angeles center did not know if there were designated slots.) (See Table 26.)

ACCESS TO SERVICES

Survey findings clearly showed that the comprehensive, family-centered, coordinated service system described in the model of care does not exist in the surveyed counties. There is a wide gap in services between what is believed to be appropriate and necessary for the target population of women and children and what currently exists. Barriers to existing services and the lack of important services for women and children were identified as serious impediments to access to care.

Assessing Access to Services

One of the project's goals was to assess the target population's access to the range of services believed necessary, appropriate, and effective for them. To address this goal, the survey was designed to elicit information regarding:

- services not currently provided by programs that, if provided, would enhance their ability to serve the target populations
- barriers to services posed by program eligibility requirements
- barriers to services posed by the process of determining eligibility
- what programs do if there are discrepancies between the number of eligible women or children and the number of available service slots
- program waiting lists and waiting times

Respondents were not specifically asked to comment on programmatic barriers unrelated either to eligibility requirements or the process of determining eligibility, nor on barriers posed by factors unrelated to their program's organization or service delivery. However, many respondents did so, noting such barriers as the lack of prenatal and pediatric providers in their communities, which limits their ability to furnish services to the target populations.

Table 25

WOMEN SERVED BY AFLP

COUNTY	# SERVED	# USE ALCOHOL/ DRUGS (%)[a]
ALAMEDA[b]	710	75 (11%)[c]
HUMBOLDT	100	35 (35%)
KERN	200	50 (25%)[c]
LOS ANGELES[d]	1206	DK[e]
MONTEREY	200	100 (50%)[c]
ORANGE	280	DK
SACRAMENTO	100	2 (2%)
SAN BERNARDINO	374	25 (7%)
SAN FRANCISCO	500	55 (11%)
SANTA CLARA	297	DK
TULARE	200	20 (10%)
TOTAL	2446	517 (21%)

[a]Proportion of total women served who use alcohol/drugs is in parentheses

[b]Numbers include two AFLP programs in Alameda County

[c]Both numbers and percentages are estimates

[d]Numbers include three AFLP programs in Los Angeles

[e]DK= Don't Know

Table 26

CHILDREN SERVED BY REGIONAL CENTERS' PREVENTION PROGRAMS

COUNTY	NUMBER SERVED	NUMBER DRUG-EXPOSED (%)[a]
ALAMEDA	547	109 (20%)
HUMBOLDT	150	35 (23%)
KERN	240	72 (30%)
LOS ANGELES[b]	2820	908 (32%)
MONTEREY/ SANTA CLARA	291	20 (7%)
ORANGE	718	65 (9%)
SACRAMENTO	700	210 (30%)
SAN BERNARDINO	500	50 (10%)
SAN DIEGO	420	140 (33%)
SAN FRANCISCO	200	100 (50%)
TULARE	450	DK[c]
TOTAL	7036	1709 (24%)

[a]Proportions are in parentheses

[b]Los Angeles figures are for six of seven Regional Centers; the seventh serves 678 children from 0-3, but does not know how many are drug-exposed

[c]DK= Don't Know

CPSP programs were not asked about eligibility criteria or process, but were questioned about waiting lists and times, as well as how they handled discrepancies between eligible population and available service slots.

Respondents' comments regarding both the survey and barriers in their community will be summarized in the following section. This information provides a focused analysis of the barriers and limitations affecting each of the programs surveyed and permits a comparison among similar programs in the 12 target counties.

As a final step in assessing access to services, we used the model of care delineated by an expert panel as a template by which to identify gaps in services in the publicly funded system of care for women and children. We examine the total range of services offered by the programs surveyed and assess whether the comprehensive array of services deemed critical for drug-exposed women and children exists in California's publicly funded service system.

Additional Service Needs

Respondents overwhelmingly noted a need for additional services in their communities for the target populations. Of the 13 state program administrators interviewed, 54% noted the need for additional services, as did 68% of the respondents from local, county, and regional programs. Of the 65 county, local, or regional programs serving women, 45 programs, or 90% of respondents, noted additional service needs. Of the 84 programs serving children, 56 programs, or 67%, noted additional service needs.

The greatest number of respondents (41, or 29% of the total, predominantly among programs serving women) noted the need for additional alcohol and/or drug treatment for women, particularly pregnant women, in their communities. The additional services noted included:

- residential treatment for women and their children
- day treatment
- methadone maintenance for pregnant women (both outpatient and residential)
- inpatient medical detoxification
- 12-step groups
- alcohol and drug treatment specifically for adolescents

In addition, eight respondents noted the need for improved staff training or education of professionals regarding perinatal alcohol and/or drug use. Finally, one AFLP program respondent noted the need for better screening material to enable the staff to make appropriate referrals for adolescents who are using alcohol and other drugs.

The next greatest number of respondents (29, or 21% of the total, predominantly among programs serving children) noted the need for additional early intervention services for children, such as parent/infant psychotherapy, developmental assessments, and preschool. In addition, respondents noted the lack of followup and regularly scheduled assessments for children from birth to age 3 who do not currently qualify for program services and are at risk of manifesting developmental delays. Although the survey focuses on services for very young children, respondents often noted the lack

of services for 3- to 5-year-olds and the need to monitor this population for developmental disabilities. Respondents also noted the need to target early intervention services to children whose mothers are participating in alcohol and/or drug treatment programs and to provide additional sources of education regarding parenting skills for mothers, foster parents, and relative caregivers.

Large numbers of respondents among women's programs also noted such needs as child care services (21 respondents), transportation (20), case management/coordination (17) and housing (17). One-quarter (3) of the county social services respondents also noted the lack of voluntary prevention services for families. They cited a combination of factors including current eligibility criteria, the stigma resulting from social services intervention, and inadequate number of program staff. Table 27 provides the full range of service needs noted by respondents.

Table 27

SERVICE NEEDS NOTED BY RESPONDENTS

Responses Ranked Most Often Among Respondents

Alcohol and/or drug treatment services for women
Early intervention services for children
Parenting skills/training
Child care/day care
Transportation
Case management/case coordination
Housing (including specialized residential facilities for adolescents)

Additional Responses Noted by Respondents

Activities to improve women's and children's self-esteem
Additional adolescent-specific services (such as additional AFLP programs)
Culturally appropriate staff
Family support services, including in-home services and respite for mothers and other caregivers
On-site perinatal care (at programs such as alcohol/drug services and family planning)
Outreach (particularly to underserved minority populations and pregnant women)
Prenatal and pediatric care
Services in languages other than English
Staff training to deal with specialized populations of children
Specialized foster homes with staff trained to serve drug-exposed children
Vocational training for women

Not all respondents believed additional services were appropriate for their own programs. Thus the figures cited above include respondents from children's programs who noted the need for additional alcohol and/or drug services for women, as well as respondents from women's programs who noted the lack of early intervention services for children in their communities.

State administrators' comments mirrored those of respondents from local, county, and regional programs. Administrators in the Department of Alcohol and Drug Programs noted the need statewide for additional women's services, particularly expansion of the Options for Recovery perinatal pilot project. In addition, administrators of Regional Centers, HRIF programs, and ADP noted the need for additional early intervention services.

Barriers Related to Eligibility Criteria

Programs Serving Women

Of the 53 respondents from women's programs, 20 (38%) noted barriers related to eligibility criteria. Table 28 notes the number of respondents citing such barriers, by program type. For these programs, barriers posed by eligibility requirements were most often related to exclusions based on pregnancy and parenting. For example, women experiencing high-risk pregnancies are excluded from one county's alcohol and drug treatment services. Those who use alcohol and/or drugs and who experience mental illness are often excluded from substance abuse treatment programs because of their need for medication. Two alcohol and drug treatment program respondents noted that publicly funded residential alcohol and/or drug treatment programs did not accept women with children. Several of the alcohol and drug treatment program respondents commented that although there is no written policy on the issue, agencies that provide local services under contract to the county apparently do not accept pregnant women. Since family planning programs as a rule don't serve women once they are pregnant, these programs do not play any role in identifying women at risk of perinatal drug or alcohol use, assisting them, or referring them for treatment.

Four of the 14 responding AFLP programs saw the program's age criteria as presenting a barrier to services. According to these criteria, pregnant and parenting teens can be enrolled in the program only until age 17 (although if they are enrolled they can continue until age 20). Respondents believed, however, that older adolescents could benefit from AFLP case management services. Adolescents between 16 and 17, although theoretically eligible for the program, have a lower priority on waiting lists than younger adolescents and are therefore be less likely to be served. Two respondents noted that their programs required teens to sign service contracts with program staff. These contracts specified the goals and/or tasks the adolescent was expected to meet (including regular meetings with case managers) — an approach that worked well for motivated teens. Teens who were less motivated, however, including those suspected of using alcohol and/or other drugs, were unable to meet this requirement and thus were less likely to receive case management services.

Finally, one CHDP program noted that the Prenatal Care Guidance Program could not serve two groups of Medi-Cal-eligible women: those served by CPSP, and women qualifying for Medi-Cal who pay a share of cost. However, because of the scarcity of prenatal care providers, both groups of women were believed to need assistance in locating providers, a function often provided by case managers.

Table 28

Barriers To Services Posed by Program Eligibility Criteria

Programs Serving Women

Programs Reporting	Yes	No	Don't Know	Total Number of Respondents
AFLP	5	9		14
Black Infant Mortality	0	1		1
CHDP/EPSDT	2	7		9
County Alcohol and Drug	8	11		19
Family Planning	3	3		6
Options for Recovery	2	2		4
Total	20	33		53

Programs Serving Children

Programs Reporting	Yes	No	Don't Know	Total Number of Respondents
CCS	6	4		10
CHDP/EPSDT	2	9		11
HRIF	5	5		10
Part H (P.L.99-457)	2	10		12
Regional Centers	5	11	1	17
Social Services	3	9		12
Spec. Education	7	4		11
Total	30	52	1	83

Programs Serving Children

Of the 83 respondents from programs serving children, 30 (36%) noted barriers related to eligibility criteria (see Table 28). Nineteen (23%) noted that eligibility criteria restricted drug-exposed children's access to services, particularly those related to early intervention. These included 5 of 9 HRIF respondents, 6 of 17 from the Regional Centers, and 5 of 12 respondents from special education programs. (The other respondents included 2 from CCS and 1 Part H Coordinator.) Although drug-exposed children are at risk for developmental delays, programs providing early intervention services (HRIF, Regional Center prevention programs, and special education) serve only those with severe disabilities. Without these stringent criteria respondents thought they would be overwhelmed with large numbers of eligible children. As a result, however, no program was continuously monitoring children, and the only children being served were those who already demonstrated developmental delays at the time of assessment.

The two CCS respondents cited as a barrier to service the program's requirement that drug-exposed children be discharged from a neonatal intensive care unit (NICU) in order to be eligible for the CCS followup component. These respondents have requested a change in CCS guidelines to permit the entry of drug-exposed children without NICU discharge.

Three respondents noted age as a barrier for HRIF and Regional Center prevention programs. HRIF programs generally enroll children only until the age of 3 months and prevention programs may not accept children older than 2, yet these programs were the most likely to provide the types of services required by drug-exposed children.

Three respondents from county social services programs (25% of surveyed counties) commented that voluntary preventive services are not available to families that do not meet existing eligibility criteria for Child Protective Services intervention. These families may, however, be in need of parenting education and other family support services. Since familial alcohol and drug use (including perinatal use) is linked to parenting problems and to placing infants under protective custody, voluntary preventive services may be particularly valuable to drug-affected children and their families.

Barriers Posed by Eligibility Determination

Programs Serving Women

Fifteen (28%) of the 53 respondents from women's programs noted barriers related to eligibility determination, as shown in Table 29. Respondents from programs whose clients have to establish Medi-Cal eligibility said the process presents a prominent barrier to access. One CPSP coordinator specifically cited the Medi-Cal application process as discouraging women from entering CPSP. Forty-four percent of CHDP respondents (4 of 9 respondents) also noted the Medi-Cal application process as a barrier. Respondents from several CCS programs commented that their counties determine eligibility in only one or two locations, which poses a hardship to parents without transportation.

Table 29

Barriers to Services Posed by the Process of Eligibility Determination

Programs Serving Women

Programs Reporting	Yes	No	Don't Know	Total Number of Respondents
AFLP	4	10		14
Black Infant Mortality	0	1		1
CHDP/EPSDT	4	5		9
County Alcohol and Drug	4	15		19
Family Planning	1	5		6
Options for Recovery	2	2		4
Total	15	38		53

Programs Serving Children

Programs Reporting	Yes	No	Don't Know	Total in Sample
CCS	6	4		10
CHDP/EPSDT	5	5	1	11
HRIF	1	9		10
Part H (P.L.99-457)	2	9	1	12
Regional Centers	7	9	1	17
Social Services	0	12		12
Spec. Education	2	9		11
Total	23	57	3	83

AFLP program (2 of 14, or 14%) and PCG program respondents (3 of 9, or 33%) noted difficulties contacting eligible clients because of the mobility of the eligible population. The PCG program in particular depends on phone contacts and often has difficulties tracking women.

Programs Serving Children

Of the 83 respondents of children's programs, 23 (28%) noted barriers related to eligibility criteria (see Table 29). Among these programs, only respondents of Regional Centers (7 of 17, or 41% of prevention programs) reported problems due to their center's eligibility process.

Some centers, for example, use different processes depending on children's age: those younger than 4 months are able to use a streamlined eligibility process, but older children, using the regular process, experience delays of 45 days or more. Regional Centers in general use an eligibility process that was developed to serve a stable, middle-class population and is inadequate for families with multiple needs, such as those affected by the use of alcohol and/or other drugs. These families may require home visits or other followup services on site to complete the child's application.

Indicators of Unmet Need

Programs Serving Women

Among women's programs, four types of programs — AFLPs, alcohol and drug programs, Options for Recovery perinatal pilot projects, and CPSP — noted discrepancies between the number of eligible women and the number that could be served. Thirty programs (47.5% of 61) had waiting lists: 9 of 14 AFLP programs, all 4 Options for Recovery programs, 5 CPSP programs, and 14 of 19 county alcohol and drug programs. Of the 37 women's programs that reported having waiting lists, 86% (32) were in those four categories.

The number of women on waiting lists varied among programs: for AFLP programs it ranged from 9 to 260 teens (an average of 68 teens), with waiting times up to 180 days (an average of 83 days); for the perinatal pilots it ranged from 4 to 18 (an average of 9 women) with waits up to 56 days (an average of 35 days); for alcohol and drug programs it ranged from 7 to 40 (an average of 19 women), with waits up to 180 days (an average of 49 days).

Seven of the 12 CPSP programs reported that women applying for perinatal services had to wait from two to nine weeks, or more than five weeks on average (37 days). CPSP programs also reported that substantial numbers of eligible women in their counties were not receiving services. As Table 30 demonstrates, the five counties that have calculated their level of unmet need (the number of Medi-Cal-eligible deliveries minus the number of CPSP deliveries) report 1,832 to 9,750 unserved women. In addition, two respondents from counties that don't keep statistics on the number of women served had the impression that large numbers of women are not being served, but reported that these numbers are not reflected in their counties' figures on waiting time. CPSP program respondents who reported unmet needs and waiting times for service thought the reason was too few service providers. In two of the five counties with statistics on women receiving prenatal care, eight CPSP providers

Table 30

COMPREHENSIVE PERINATAL SERVICES PROGRAMS

COUNTY	# OF CPSP PROVIDERS	# OF WOMEN SERVED	# OF WOMEN ELIGIBLE BUT UNSERVED[a]
ALAMEDA	24[b]	DK[c]	DK
HUMBOLDT	6	DK	DK
KERN	11	DK	DK
LOS ANGELES	58	DK	DK
MONTEREY	6[d]	700	1832
ORANGE	4	DK	DK
SACRAMENTO	17	DK	DK
SAN BERNARDINO	3	250	9750
SAN DIEGO	39	8769	8331
SAN FRANCISCO	18	DK	DK
SANTA CLARA	3	1000	4000
TULARE	7	2050	2000

[a]Programs calculated this figure as the number of Medi-Cal-eligible deliveries minus the number of CPSP deliveries
[b]Only 19 of these providers are currently taking patients
[c]DK=Don't know
[d]Only 3 of these providers are currently taking patients

(five in Alameda and three in Monterey) are not taking new patients. As the table shows, some counties with large populations (e.g., Orange, Santa Clara, and San Bernardino) have very few CPSP providers. Santa Clara and San Bernardino also report large numbers of unserved women. The CPSP respondent in San Bernardino County reported that the county's population increased more than 50% in the last decade, but the number of Medi-Cal providers has not increased since 1985.

Programs also varied widely in the amount of time it took women to establish eligibility and begin receiving services. For adolescents the lag could take up to 60 days because of AFLP staff difficulties in locating and enrolling teens. County alcohol and drug programs could complete the eligibility process in 21 days, and Options for Recovery took between 1 and 10 days. The process for family planning programs took between 1 and 7 days.

Programs Serving Children

Children's programs generally reported no discrepancy between the numbers eligible and the number they can serve, and few reported having waiting lists (15 of 84 programs, or 18%). At least one program in each category, with the exception of CCS, reported having a waiting list, although no specific pattern was evident. Respondents from HRIF and Regional Centers reported that ineligible children were referred to other programs for services. HRIF programs often referred children to Regional Centers, which in turn made referrals to public health nurses. Respondents indicated that applicants to services provided by CCS, Regional Centers, special education programs, or local Part H projects could wait between 60 and 90 days.[48] In contrast, county social services provided assistance within 1 to 3 days and HRIF within 14 days.

Additional Barriers

Other barriers to services were unrelated to either program eligibility criteria or the determination process. Although respondents were not specifically asked about these additional barriers, they cited the following factors as obstacles to services:

- The lack of funds to expand services to the existing pool of *eligible* women and children
- The lack of funds to expand staff positions, which would allow case managers to reduce their caseload, increase the intensity of services provided, and expand such services as outreach to communities and families to encourage them to seek care
- Programs' inability to deal with families affected by alcohol and/or drug use, caused by a variety of factors: need for staff training on perinatal alcohol and drug use; lack of staff time to provide effective followup services once a woman or child is identified as being chemically dependent or exposed; and inadequate services to meet the specific needs of drug-exposed children
- The shortage of prenatal and pediatric providers, which often interferes with the ability of program staff to link women and children to the medical services they

[48] Under the new state budget, Regional Centers may now take up to 120 days to complete the eligibility process, thus effectively creating a waiting list for clients.

need (This is especially true for such programs as CHDP's Prenatal Care Guidance Program, the Adolescent Family Life Program, and the Comprehensive Perinatal Services Program.)

- The lack of bilingual and/or bicultural providers, resulting in a lack of culturally appropriate services for Native Americans, Latinos, and Southeast Asians, among others
- The fear of both the criminal justice system and Child Protective Services on the part of women who are chemically dependent, inhibiting their entry into health and other services.

Model of Care

Our findings clearly show that the *comprehensive, family-centered, coordinated service system* described in the model of care does not exist in the surveyed counties, and that there is a wide gap between the services deemed necessary for our target population of women and children and those currently available through California's publicly funded programs. Professionals in the programs that do exist (such as HRIF, AFLP, Regional Centers, Options for Recovery, some local social services programs) recognize the need to focus on the mother/child dyad, and have structured their services accordingly. In general, however, services provided by the programs we surveyed are all too easily divided into separate categories of "women's" or "children's."

The model of care, as mentioned previously, was organized according to five major themes: (1) health education and prevention; (2) outreach; (3) health and psychosocial screening/assessments; (4) direct services; and (5) case management. Below, we compare the services proposed in the model with those available through the publicly funded system.

Among the programs surveyed, *prevention and health education* efforts are not widely available, particularly for women. For example, most of the family planning programs we contacted, including 13 programs that declined to participate, did not see a role for family planning in preventing perinatal alcohol and/or drug use. Information on the availability of services was readily accessible to women participating in specific programs, notably AFLP and PCG, as well as alcohol- and drug-focused services like county alcohol and drug programs and Options for Recovery. How readily available such information is to women and adolescents who don't participate in these programs could not be assessed. Similarly, information on the needs of drug-exposed children was readily available for those families served by HRIF or Regional Centers. However, these programs serve only a small number of drug-exposed children, and we could not assess whether information on the provision of services within a given community is widely available to families with young children.

Outreach efforts to promote access to services for women and children are not widely available through the programs surveyed. Programs such as CHDP and AFLP depended on referrals from other organizations (such as county social services or providers) to identify eligible women and/or adolescents. Outreach efforts to community organizations were important tasks noted by respondents, but few programs

(see Table 6) were providing direct outreach services, either through community workers or public health nurses, to promote access to services for women and children.

Health and psychosocial screening and assessments to identify chemically dependent women and/or drug-exposed children are readily available in three of the programs surveyed (county alcohol and drug programs, HRIF, Regional Centers) and in programs specifically developed for the population (e.g., HIP in Alameda County, Options for Recovery, and programs funded through Part H). However, programs that intervene with pregnant women and teens report that staff lack the training to do such screens or are unable to do them, since women are screened by phone. As noted, family planning programs, which are often the first to identify a woman's pregnancy, do not routinely ask questions about women's alcohol and drug use in intake and medical history interviews.

Although such programs as the HRIF and Regional Center prevention employ staff who can identify children's needs, only small numbers of drug-exposed children are referred for services. As specifically targeted programs providing screening and assessments, usually for both mother and child, are not readily available throughout the counties we studied, large numbers of drug-exposed children who are at risk for developmental delays do not receive developmental assessments. Even among programs that provide assessments, children may only be assessed during the first year of life. We found no program that reevaluated children to assess whether developmental delays occurred later, if none had been identified at the time of referral.

There are standardized protocols for screening and assessing alcohol and drug use in pregnant and postpartum women. For example, SB 2669 required the state Health and Welfare Agency to develop a Model Needs Assessment Protocol for this group of women. Under the law, each county, including county health departments, welfare departments, and all public and private hospitals, must establish protocols for assessing the needs of alcohol- and drug-exposed newborns as well as a process for referring them to appropriate services. The recommended protocol has three stages: (1) an initial screen to be performed on every pregnant woman to identify risk factors for further exploration; (2) a comprehensive needs assessment, performed on all women and their newborns when risk factors are identified in the initial screen; and (3) development of a service plan for women and children based on the results of the needs assessment.[49] The model protocol was distributed to all counties for their use in September 1991, approximately six months after we completed our survey.

A comprehensive array of *health, social services,* and *alcohol and drug treatment and recovery services* is not uniformly available in the counties surveyed. Although these services may exist, (e.g., through CPSP, county alcohol and drug programs, CHDP, and county social services), they may not be accessible to all *eligible* women and children. As discussed earlier, this lack of access may be the result of several factors:

- Not all necessary service components exist in all counties. For example, a woman who needed methadone maintenance services could not obtain them if she lived

[49] Presley, R., op cit.

in four of the counties surveyed. Similarly, residential care for a woman with her children was unavailable in four counties.[50]

- Even when services exist, they may not be accessible because not enough providers participate in the program to be able to meet the demand for service. CPSP and CHDP are examples of this problem.
- Some programs, including ones with these targeted services, are not accessible to all women and children because of geographic limitations. For example, the two Options for Recovery sites in Los Angeles have specific, geographically defined catchment areas that exclude women outside their boundaries.

Other women and children are denied access to services because they do not meet the programs' stringent eligibility criteria. For example, early intervention services are not widely available in the counties surveyed. These services are generally available only to the most severely affected children, even though respondents noted that drug-exposed children are at risk for developmental delays.

Also lacking are services that facilitate access to important services for women and children, such as transportation and child care. Other services that may be critical to recipients' successful participation in programs, such as housing, particularly alcohol- and drug-free housing, are also difficult to find.

Case management of one type or another is available through 10 of the programs surveyed. (Family planning, county alcohol and drug programs, and special education generally have no case management component.) The actual services provided under this rubric vary greatly, however, as individual programs define it differently. Several responding programs stressed that families affected by alcohol and drug use need case management to both obtain and maintain their participation in needed services.

Coordination, as measured by the level of both formal and informal links between agencies (including signed agreements or memoranda of understanding), is widespread in each of the 12 counties surveyed. The model of care recommended coordination within and across disciplines and agencies, which appears to be taking place through local perinatal councils and coalitions, Part H coordinating councils, and other networks. County mental health agencies, however, were found to be the least likely of the major health and social services programs to participate in coordination efforts.

FUNDING ISSUES

Sources of Funding

Survey respondents were asked about the sources and amount of their budgets for Fiscal Year 1989-90 and 1990-91. We originally planned to compare budgets and funding sources from one fiscal year to the next, and comment on budget fluctuations. However, many of the staff we interviewed were not familiar with their program's funding. Programs whose budgets were easily described share similar characteristics,

[50] The status of residential care for women with children in San Francisco was unclear, because the county drug program did not respond to the survey.

such as one to three specific, defined sources of funding. Examples include High Risk Infant Follow-Up, Child Health and Disability Prevention, and the Adolescent Family Life Program.

Those whose budgets were not easily described tend to have very complex funding, with multiple sources. County social services departments, for example, have a difficult time differentiating their child welfare budgets from other social services, and often cannot separate federal from state sources of funding. Regional Centers do not have a separate budget line for prevention services.

The Comprehensive Perinatal Services Program is funded through Medi-Cal, and staff claim that its costs cannot be separated from the huge state Medi-Cal budget. An estimate could be generated by multiplying the average cost of the CPSP service package by the number of women who receive CPSP services, but the state doesn't have an accurate count of the number of women in the CPSP program. (This is discussed more fully in the section on data collection.) Consequently, total CPSP costs are unknown, which clearly has implications for state program and financial planning.

It was thus difficult to gauge the costs of the services surveyed or to comment on funding patterns. An in-depth look at these funding patterns for federally, state, and locally funded programs would require a study of its own.

Table 31 delineates the sources of funding for the 13 types of programs we surveyed. As noted, 12 of the 13 receive some kind of state funding, including funds from special sources such as the tobacco and alcohol excise taxes. One program — Part H, PL 99-457 — is totally federally funded. Nine receive funding from one or more federal sources.[51] Counties provide some funding for approximately one-half of the programs surveyed, either by required matching funds or voluntary contributions.

State Fiscal Crisis

This report was prepared against the backdrop of a state fiscal crisis. A major recession, accompanied by reduced state revenue and increased program caseloads, has left the state facing major budget deficits for the last several years. The Fiscal Year 1991-92 deficit mushroomed to $12 billion. Even after program cuts in FY 1991-92, the governor's office estimated that a $1.3 billion deficit would be carried over into FY 1992-93. Because of declining state revenue, the 1992-93 shortfall is expected to be even higher; the Legislative Analyst's Office projects a two-year deficit of as much as $8.4 billion.[52] The final budget for the 1992-93 fiscal year includes budget cuts of approximately $1 billion in health and welfare programs, including Medi-Cal. Since almost all of the programs we surveyed receive state funding, reductions in state revenues endanger support for these programs.

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[51] The state family planning program does not receive federal funds. Federal Title X family planning funds are received in California, but are administered through the California Family Planning Council and the Los Angeles Regional Planning Council. These are private organizations that work with and may also receive funding from the state family planning program.

[52] Legislative Analyst's Office. (1992). *Analysis of the 1992-93 Budget.* Sacramento: Author. The LAO estimates a deficit for 1993-94 of between $7.5 and $9.3 billion, raising the possibility of more budget cuts in the future.

Table 31

SOURCES OF FUNDING FOR SURVEYED PROGRAMS

PROGRAM	FEDERAL SOURCES	STATE	COUNTY
AFLP		X	X[a]
Black Infant Mortality	Title V (MCH)	X	
CCS	Title V (MCH)	X	X
CHDP/EPSDT	Title XIX (Medicaid)	X	X
County Alcohol and Drug	ADMS Block Grant, other federal grants	X	X[b]
CPSP	Title V, Title XIX	X	
Family Planning		X	X[a]
HRIF		X	
Options for Recovery	ADMS Block Grant	X	X[a]
Part H	PL 99-457		
Regional Centers		X	
County Social Services	Title IVB, Title IVE	X	X
Special Education	PL 94-142	X	

[a]Some counties contribute additional funding to the programs surveyed
[b]Some counties have a required county match

Programs that receive a substantial portion of county funding face a budget crisis at both state and local levels, as reduced state funding means less money for local services. For the programs we surveyed this combined budget crisis has meant static or reduced operating budgets, coupled with increasing and increasingly difficult caseloads.

Federal Funding

Program security is often profoundly effected by whether its funding is federal, state, or county or in what proportions these funding sources are combined. Federal sources for surveyed programs include Title XIX (Medicaid), the Education for All Handicapped Children Act (PL 94-142), the Alcohol, Drug Abuse, and Mental Health Services Block Grant (ADMS), Title IV-B and Title IV-E (Child Welfare Services), Title V (Maternal and Child Health), and Part H of PL 99-457 (Education of the Handicapped Act Amendments of 1986).

In general, federal sources have offered fairly stable, secure funding, often with statutorily mandated services, and both the state and its counties have made good use of these funds. For example, the ADMS Block Grant includes a 10% set-aside earmarked for women's programs. California has an excellent track record for using these funds to provide critical alcohol and drug treatment and recovery services for women, including during pregnancy and after delivery. In a seven-state review of drug treatment services, the US General Accounting Office cited California as one of three states that provide "extensive services" for pregnant women, and lauded the state for committing significant state funding in addition to the ADMS women's set-aside.[53]

However, federal funds may also bring restrictions that function as barriers to delivering some services. Until recently PL 99-457 Part H funds had supported direct services at the local level for children at risk, such as young drug-exposed children. In the first two years approximately 30% of Part H funds were allocated to direct services to infants, toddlers, and their families, supporting 114 projects statewide. Thirty-five of these projects, with $1.3 million in funding, supported projects specifically targeted to alcohol- or drug-exposed infants and their families. Now, however, this funding is available only for planning and coordination of early intervention services, and not for providing direct services. Increasingly, Part H funds will be directed away from grant projects to support Part H components[54] mandated by federal law. If California continues to participate in Part H, funding for all grant programs will cease by October 1, 1993.

Until very recently, because federal Medicaid law and regulation were unclear as to what alcohol and drug treatment services were Medicaid reimbursable, many states (including this one) did not provide a wide array of these services through Medicaid.

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[53] US General Accounting Office. (1991). *ADMS Block Grant: Women's Set-Aside Does Not Assure Drug Treatment for Pregnant Women.* Washington, DC: Author.

[54] These components include (in part): a central information directory; a public awareness program; a comprehensive child find system; a comprehensive, multidisciplinary evaluation of referred children; an individualized family service plans; and a comprehensive system of personnel development, personnel standards, and procedural safeguards.

This picture is changing in California, as intensive day treatment services have been added to the already reimbursable methadone maintenance, methadone detoxification, outpatient drug-free services, and provision of Naltrexone. The state is also in the process of adding residential treatment for women to the list of reimbursable services. However, other alcohol and drug services available under Medicaid are not yet offered in California for pregnant and parenting women, including home and community-based services such as case management and respite care.

In addition, other restrictions specific to Medicaid limit its use in funding services for our target populations. Despite the expansion of Medicaid in recent years, stringent income limitations leave low-income but non-Medicaid-eligible people uncovered. In California, as in most states, most of these persons are women and children. Many programs, including a number of the state's alcohol and drug treatment and recovery services, provide social, rather than medical, model services and thus do not meet Medicaid standards for coverable services. Also, the state matching funds requirement may prohibit states from expanding Medicaid-coverable services.

Federal dollars bring not only stability but mandates for specific services. Medicaid dollars fund health assessments and diagnostic and treatment services for Medi-Cal-eligible children through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. In California, although screening services are financed through the state's Child Health and Disability Prevention (CHDP) Program, diagnosis and treatment services are financed through Medi-Cal. Because EPSDT is a federally mandated entitlement program, the scope of services is defined by federal legislation and program regulations. Services must be made available to all eligible children. In recent years more children have become eligible as Congress has improved Medicaid eligibility rules. In addition, because of changes in EPSDT legislation in 1989,[55] eligible children are now entitled to expanded treatment services. However, because the state must match federal Medicaid spending, California has not fully implemented EPSDT reforms that would result in increased state expenditures. These reforms mandate that, when a need for services is identified during an EPSDT examination, states must finance any of the services that can be covered under Medicaid, whether or not that service is offered through the state's Medicaid plan. For example, if services such as case management or private duty nursing are identified as necessary during an EPSDT examination, they must be covered under Medi-Cal. States may not limit the amount, duration, or scope of services to those specified in a state's Medicaid plan, but must finance services based on medical necessity.

State Funding

Programs that depend on state funding, as noted above, are extremely vulnerable to the vagaries of the state's fiscal condition. The budget deficits of the last few fiscal years have resulted in the creation of few new services and minimal increases or reductions in funding of existing services, including many of the programs we surveyed, such as AFLP, HRIF, Black Infant Mortality Programs, Regional Centers, and county social services.

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[55] Omnibus Budget Reconciliation Act of 1989 (PL 101-329).

The family planning program is an exception to this pattern, since it has benefited from a large infusion of state funds. The program was awarded a $10 million increase in 1991, as this research project was underway, specifically earmarked for services targeted to adolescents and chemically dependent women. The family planning budget was also substantially increased in 1990 when most of the 38% budget cut the program sustained in 1989 was restored. In addition, perinatal and pediatric services for low-income women and children have been significantly expanded in the last four years through such program additions as CPSP and CHDP's prenatal care guidance program. Much of this expansion has been supported by funds made available by a new tobacco tax.[56]

The Options for Recovery programs, which were funded as pilot projects, will lose their funding on January 1, 1994. At that point, counties with Options programs will have to decide whether to assume complete financial responsibility for the programs through their usual state alcohol and drug services funding. County decision-making may be influenced by the results of a program evaluation that is now under way.

County Funding

County-administered programs are unable to count on stable state funding for maintenance of existing services, and often are themselves financially fragile and unable to fill in the gaps with local funding. Some counties have been able and willing to substitute county funds for reduced state money for specific services. For example, Monterey County funds its Adolescent Family Life Program entirely with county money, and Santa Clara County has committed additional county funds to maintain its level of child welfare services in the face of state cutbacks. Some have been unable to tap existing sources of funds that would expand their services or increase their capacity to meet demand because they can't afford the required local match. At the time of the survey, for example, Monterey lacked the resources to match federal funding for the Prenatal Care Guidance Program within CHDP; Kern County had been unable to draw on Waiting List Reduction funds from the state Department of Alcohol and Drug Programs because it has no assurance it can meet the required state match.

Other Funding Sources

Given the limitations and restrictions in federal, state and local funding, many programs are looking beyond the usual funding streams to maintain services or create new and innovative projects. The federal Office for Substance Abuse Prevention is a common source of funds for programs that address our target populations of chemically dependent pregnant and parenting women and young drug-exposed children. Some programs are also tapping private foundations.

Fifty-four survey respondents reported providing services specifically targeted to chemically dependent pregnant and postpartum women and/or drug-exposed children from birth to age 3, and use federal funding of some sort to support the services. This usually consists of ADMS Block Grant funds plus 3–5 year grants from either the

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[56] Legislative Analyst's Office. (1991). *Analysis of the 1991-92 Budget*. Sacramento: Author.

Office for Substance Abuse Prevention or the National Institute on Drug Abuse. Three of the counties we surveyed have OSAP grants and two have grants from NIDA. Almost all the programs report using state funding, and approximately half use county funds. Three report private foundation grants, and six report other sources of funds for targeted services, including support from the local Regional Center or school district. One family planning program provides targeted services through a grant from the state Office for Child Abuse Prevention. Although grant funding from the federal government or private foundations can enable the development of creative projects, such grants are time-limited and usually leave programs and their sponsors searching for stable sources of support at the end of the grant period.

NEW PROPOSALS FOR FUNDING AND/OR ORGANIZING SERVICES

Much of the stability of program funding relates to the funding source, and is often profoundly affected by whether this funding is federal, state, or county, or in what proportions these sources are combined. Programs that depend on state funding are vulnerable to the state's fiscal situation. Accordingly, budget deficits over the past few years have resulted in the creation of few new services and minimal increases or reductions in the funding of existing services, including surveyed programs such as AFLP, HRIF, Black Infant Mortality, Regional Centers, and county social services. California's current budget crisis may well have a long-term impact on the stability of programs that depend heavily on state funding sources.

Options for Recovery, the one program of comprehensive services specifically designed for chemically dependent pregnant and parenting women and their children, has been funded by the state until the end of 1993. As of January 1, 1994, counties interested in maintaining Options programs will have to assume complete financial responsibility for them. The state perinatal initiative, an infusion of $23 million to create and expand treatment and recovery services for pregnant and parenting women, will allow counties to support treatment services that survey respondents believe are sorely needed, including methadone maintenance, residential services for women and children, and outpatient and structured day treatment. However, this initiative was not designed to support the comprehensive, coordinated, case-managed system of care that underlay the Options pilot projects and is recommended in this project's model of care.

Grant funding (from such sources as the federal Office for Substance Abuse Prevention, the National Institute on Drug Abuse, the state Office of Child Abuse Prevention and private foundations) appears to play a prominent role in supporting unique and comprehensive services that more traditional federal, state, or county funding sources have not supported.

State Perinatal Initiative and Targeted Family Planning Funds

In Fiscal Year 1991-92 the state Department of Alcohol and Drug Programs made available to the counties an additional $23 million in state funds to support alcohol and drug treatment and recovery services for pregnant and parenting women. The funds were intended to increase a county's capacity to provide any of four types of treatment: residential, outpatient services, structured day treatment, and methadone maintenance. The funding must be used for creation of new treatment services or augmentation of existing ones; it cannot be used for case management or other support services. Funding may be used to support salaries of public health nurses, for example, but the nurses must provide treatment, not case management. Fifty-seven of the state's 58 counties have applied for the funding and are developing new and expanded services. Several of the counties have proposed regional services. The projected totals of new programs under the initiative are 119 statewide, with 85 proposed expansions. In the 12 counties we surveyed, 39 new programs were proposed and 61 expanded programs, including residential services for women and their children. The department anticipates that counties will require approximately two years to implement these services.

In FY 1991-92 the state Office of Family Planning also received an increase of $10 million to target expanded family planning services to teenagers and women who use alcohol and other drugs. In implementing this mandate the office increased funding for current contractors to expand services to the two target populations and issued a request for applications to fund 10 demonstration projects focused on teens or chemically dependent women. The family planning initiative, like the Options for Recovery pilots, includes an evaluation component to assess effectiveness.

Realignment

In 1991, in a move to address the huge state budget deficit, the state legislature passed a package of bills that fundamentally alter the way services are provided in California. This state and local realignment transferred responsibility for the financing of public health and mental health programs from the state to the counties and increased the county share of costs for many social service programs. In return for these additional responsibilities and costs the state allocated funds to the counties through an increase in vehicle license fees and a half-cent increase in the sales tax. Theoretically, realignment saved the state $2.2 billion and provided counties a secure funding base with an estimated 7–8% annual growth rate. Some programs were transferred outright to the counties for administration, and counties must now bear an increased share of cost for other programs.[57] Of the programs we surveyed, two are affected by realignment: social services, including child welfare services, foster care, and adoption assistance; and California Children's Services. Although the latter is a

[57] Programs affected by realignment include public and indigent health services including AB 8 and local health services funds and medically indigent services program funds; mental health services, including community assistance, state hospitals, and institutes for mental disease; in-home supportive services; and GAIN.

health program, CCS was lumped with social services programs in the realignment configuration.

While the child welfare services budget (i.e., funds for emergency response, family maintenance, family reunification, and permanency planning) will probably remain unaffected by realignment, funding for foster care and group care may be heavily affected. The two latter programs are now 95% funded by federal and state sources; under realignment the counties may pay as much as 60% of these program costs, encouraging counties to consider investing more heavily in family maintenance. Under realignment, counties could opt to restructure their system with a greater focus on family support, including additional services to maintain the family unit for pregnant and parenting women with alcohol and drug problems.

CCS is also affected by realignment, as its state/county funding ratio shifts from 75/25 to a 50/50 split for diagnosis, treatment services, and therapy, putting a substantially greater burden on the county for funding this potentially very expensive program. Only 5% of the CCS budget consists of stable, federal funding.

State Shift Toward Private-sector Managed Care

The state is now implementing one private, insurance-based managed care program, Access for Infants and Mothers (AIM), and has proposed a second, CheckUp, for young children. AIM provides prenatal care and other medical care as needed for women who are pregnant and postpartum to 60 days. Their income must be under 250% of the federal poverty level, and they must not be Medi-Cal eligible. Children whose mothers were supported by AIM are also provided full medical care up to age two. Services are provided through contracts with health maintenance organizations certified to participate in the program. AIM provides medical services, not the comprehensive package of case management, nutrition, and counseling available through CPSP.

CheckUp, the proposed new state-supported private insurance plan for children to age 5, would provide primary health care (no inpatient coverage) for non-Medi-Cal-eligible children with family income to 300% of the federal poverty level (FPL). Services for children from families with income under 200% of the FPL would be financed by the state with a subsidized insurance premium for children from families with higher incomes. Health assessments for non-Medi-Cal-eligible children, currently financed through CHDP, would be financed through CheckUp. The plan would not cover followup services to ensure that children receive periodic health assessments or diagnostic and treatment services.[58]

Both these programs raise issues for child health in general and for several of the programs surveyed in this project, primarily CPSP and CHDP. Both AIM and CheckUp, while expanding access to certain health services, particularly for women and children in the 200–300% of FPL bracket, represent a move away from the comprehensive, case-managed approach to health and support services that our project research supports. The model of care we developed stresses the importance of a

[58] The 1992-93 budget eliminated CheckUp, at least for the current fiscal year; however, a pilot CheckUp-type project ("California Kids") is now being implemented in Los Angeles.

comprehensive, coordinated, and case-managed system of services for both chemically dependent women and children at risk of prenatal drug exposure. The importance of such a system is echoed by our survey respondents' call for comprehensive services for women and children.

The 1992-93 budget mandates a major shift in Medi-Cal from a fee-for-service system to one of managed care, with Medi-Cal recipients to be enrolled in private HMOs beginning January 1, 1993. This shift raises a number of questions concerning the accessibility and cultural appropriateness of the services to be provided once recipients are administratively assigned to Medi-Cal. The impact of the shift on the programs we surveyed is unknown.

Merger of CHDP and CCS

Beginning in 1992, CHDP and CCS were to be administered by the newly created Children's Medical Services Branch within the Department of Health Services, and state CHDP staff indicated that a number of the programs' functions will be merged. At the time this report was written, however, it was unclear what functions would be merged and/or whether service provision would change in either or both programs.

POLICY RECOMMENDATIONS

A comprehensive, family-centered, coordinated system of care for chemically dependent women and drug-exposed children does not exist in any of the surveyed counties. We believe that policy recommendations proposing expansion of services, changes in both eligibility criteria and the determination process, enhanced funding for services, and improvements in data collection ultimately will support the development of a comprehensive and coordinated system of care for chemically dependent women and drug-exposed children in California.

Identification and Assessment of Target Populations

Health and psychosocial screening/assessment should be a routine part of care for all women and children, not only those suspected of alcohol and/or drug use or exposure. Although few family planning programs in the surveyed counties participated in this study, such programs can be invaluable in identifying chemically dependent women and adolescents, including those identified as being pregnant. Local programs such as community clinics, particularly those providing prenatal or pediatric care, CPSP providers, social service providers, and hospitals also have a role in identifying chemically dependent women, adolescents, and children. Following are recommendations to improve the identification of chemically dependent women and drug-exposed children:

1. The state Office of Family Planning should encourage family planning programs to expand their role in identifying chemically dependent women. Its role could include:

- assisting programs in training their staff to recognize and intervene when alcohol and drug problems are present and to develop appropriate referral resources
- encouraging programs to develop links with alcohol and drug treatment and recovery programs, including residential services for women, and
- encouraging programs to add questions concerning women's use of alcohol and other drugs to the program risk assessment process and disseminating model risk assessments

The office should ensure that evaluation of the family planning projects under the $10 million family planning initiative include an assessment of the programs' effectiveness in identifying, intervening with, and assisting in obtaining treatment for chemically dependent women and adolescents, including those who are pregnant.

2. The departments of Health Services and Alcohol and Drug Programs should encourage local programs, including prenatal care clinics, CPSP providers, and hospitals, to incorporate questions regarding women's use of alcohol and drugs in history-taking and risk assessments, as recommended in the Model Needs Assessment Protocol under SB 2669. Private obstetric and gynecological providers should also be encouraged, through professional associations such as the American College of Obstetrics and Gynecology, to screen their clients for alcohol and drug use. All risk assessment and screening protocols should protect women's confidentiality.
3. The state should evaluate the implementation of SB 2669 (and barriers to implementation) at the local level, and should consider ways to assist and encourage implementation.
4. The departments of Health Services, Alcohol and Drug Programs, and Developmental Services should work with professional organizations (the American College of Obstetrics and Gynecology, the Academy of Pediatrics, the California Nurses Association, and the National Association of Social Workers) to encourage providers to evaluate newborns immediately after delivery for actual or potential medical and developmental problems and to ensure that children receive periodic assessments during their first three years of life to identify developmental delays that are not immediately evident. Screenings after three years of age should also be encouraged to identify delays with late onset. Public health nurses can provide ongoing home assessments of children and the mother/child relationship.

Access to Services

Program Services

The extent and comprehensiveness of available program services vary greatly in the 12 surveyed counties, resulting in gaps in services for women and children based on their county of residence. Furthermore, there is a wide gap between the services that experts think are appropriate and necessary for the target population and the services that currently exist. Implementing the following recommendations would

improve the range of services available to chemically dependent women and drug-exposed children:

1. The state should expand existing programs that have proven to be effective in providing services to women and children. AFLP and HRIF are examples of effective programs that cannot meet the demand from eligible populations. Existing services for this population that have been designed to be comprehensive, coordinated, and case-managed, such as the Options for Recovery projects, should be maintained and expanded.
2. New services should be established when necessary to ensure the availability of service slots to meet women's current needs for perinatal care, alcohol and drug treatment/recovery, and family planning services, as well as for children's needs for early intervention services and health care. Programs should also be expanded to meet the needs of women and children who live in geographic areas that have no existing services. The $23 million state perinatal alcohol and drug initiative is an example of state efforts to expand specific treatment modalities for women. However, this initiative does not directly promote the development of a thorough, coordinated system of services for women and children. Programs should be encouraged to develop a "one-stop-shopping model," providing comprehensive services for women and children on-site when possible, and linking clients to additional services in the community through coordination and case management.
3. The needs of special populations of women and children at risk should be considered and included when any new proposals for health care delivery are developed. For example, in developing plans to expand services, the Department of Health Services should seek to create a seamless system of health services for all low-income children, so that a single, comprehensive package of services, including treatment and case management, is available to all children to age 21 whose family incomes are at least 200% of the federal poverty level. The state should consider expanding this system to include children in the 200–300% of FPL bracket. Newly implemented programs or those under development, such as AIM and CheckUp, should also provide for comprehensive care.
4. Critical support services such as transportation and on-site child care should be funded to facilitate access to services.
5. The state should implement steps to attract and maintain private-sector Medi-Cal, CHDP, and CPSP providers, including increased provider rates and streamlined paperwork.

Other reports on this issue have already detailed specific recommendations for achieving this goal. These steps are critically important because the lack of providers so often serves as a major barrier to services.

Eligibility

Both the eligibility criteria and the determination process present problems for women and children who attempt to receive services from the programs surveyed. The health-related criteria for entry into major programs that serve children (CCS, HRIF, Part H, Regional Center prevention programs, and special education programs) are

often very stringent, and exclude many at-risk children from services. In addition, two major health programs for women and children, CPSP and CHDP, use Medi-Cal eligibility and application as the point of entry for service. Medi-Cal eligibility criteria exclude many low-income women and children. Furthermore, the application and determination process are often major hurdles for women and children applying for services under CPSP and CHDP.

Implementation of the following recommendations would improve access to services:

1. The state should consider broadening eligibility criteria for existing programs that provide early intervention services for children (including High Risk Infant Follow-Up, Regional Center prevention programs, special education, and Part H programs) to allow for providing services to children who are at risk of developmental delay but have not yet manifested delays. These should include evaluating children who may have been assessed earlier and were found to be without delay. The existing age limitations in these programs should also be expanded to allow continuous services for at-risk children from birth to at least 3 years of age.
2. The state should streamline the Medi-Cal application so as not to bar access to care. Other states have implemented shorter applications, a process that is currently being piloted in San Bernardino County. The state should draw on these experiences to redesign the application.
3. The state should station more Medi-Cal eligibility workers in the community to facilitate the application process. Additional sites should include not only the federally mandated disproportionate share hospitals and federally qualified health centers, but also other sites serving high proportions of low-income women and children.
4. The state should expand Medi-Cal eligibility to include presumptive eligibility for pregnant women and continuous eligibility for women to at least one year post partum, instead of the current 60 days.

Coordination of Services/Case Management

Coordination of services refers to a series of systemic strategies that create and foster linkages among programs, agencies, and departments. Coordination of services, as measured by the extent of formal and informal linkages to specifically coordinate services for women and children affected by alcohol and drug use, appears to be widespread in the counties surveyed. The vast majority of program administrators perceived these coordination efforts as successful, citing the importance of information-sharing, of having a forum for policy and protocol development, and of multidisciplinary, interagency education. They identified such limitations as lack of funding and staff time for these efforts in addition to providing essential direct services, and the coordinating bodies' general lack of authority to address problems. County mental health programs were the least likely of the major county agencies to be involved in coordinating activities, often showing far less involvement than other health and social services.

Case management, or strategies that link individuals with services, is recognized as a key to ensuring access to services and assisting women and children to successfully

complete treatment. The extent and availability of case management varied greatly among the 12 surveyed counties and among the 13 categories of programs.
following recommendations are proposed to improve access to services by supporting interagency coordination and case management:

1. State-level coordination efforts should continue, such as the State Interagency Task Force. State departments should also support and assist in funding coordination activities at the local level so that coordination does not divert money or staff from the provision of direct services.
2. State departments now concerned with perinatal alcohol and drug use (including members of the State Interagency Task Force) should develop a working relationship with the Department of Mental Health in order to coordinate services for women who are both chemically dependent and mentally ill.
3. County, local, and regional organizations should involve county mental health and local mental health-related organizations in coordination efforts concerning perinatal alcohol and drug use, including local coalitions and task forces.
4. County and local programs should promote coordination through continued participation in local coordinating and planning bodies. Services for individual clients should be coordinated through case management, with a primary case manager agreed on by all agencies participating in a client's service plan.
5. Counties that have received funding through the $23 million state perinatal alcohol and drug initiative (57 of California's 58 counties) should be encouraged to coordinate their existing and new treatment, perinatal, and support services for women and their children through such mechanisms as case management. They should be permitted, for example, to use initiative funds to support case management by paying salaries of public health nurses to provide these services.

Funding

State budget deficits of the past few years have resulted in the creation of few new services as well as minimal increases or actual reductions in funding of existing services. Options for Recovery, the one program of comprehensive services specifically designed for chemically dependent pregnant and parenting women and their children, will receive no state funding after December 31, 1993. Federal funds and particularly Medicaid dollars must be maximized to augment funding for services that are currently supported primarily through state funds.

We recommended the following approaches to enhance financing for the target population of women and children:

1. The state should commit to the development of a comprehensive, family-centered, and coordinated system of care, such as that recommended in the model of care, for alcohol and drug-affected women and children. New funding initiatives for services for these women and children should contribute to that goal. The state should explore the combining of funding from multiple state and federal sources to create comprehensive, integrated services. The Options for Recovery perinatal pilot projects, which originally received funding from three state departments, can

serve as a model for this approach. To this end, state funding and support for these programs should be maintained after the proposed sunset in January 1994.

2. The state should exploit all existing sources of funding for case management services. Targeted case management, an optional Medicaid benefit, should be implemented for specific populations including chemically dependent pregnant and parenting women and adolescents. Targeted case management for adolescents has already been mandated by AB 2764 (Chapter 720/1990), but not yet implemented. Case management for children should be covered through Medi-Cal, when this service has been identified as necessary through an EPSDT (CHDP) screening exam. This coverage is required under federal law (Omnibus Budget Reconciliation Act -- OBRA, 1989), but has not yet been implemented in California.
3. Counties should be encouraged to fund case management for women and children, with the assistance of federal matching dollars under Medi-Cal, as permitted under SB 910 (Chapter 1179/1991).
4. The state should fund medical detoxification for women under Medi-Cal.
5. The state should use maternal and child health block grant funds to provide comprehensive assessments, early intervention, and other services for children at risk, either because of drug exposure or other factors that increase their risk of health and/or mental health problems or developmental delays. OBRA requires that 30% of maternal and child health block grant funds be used to serve children with special health care needs and that services promote family-centered, community-based, coordinated care. California has not yet tapped these funds to support programs for at-risk children; support of such services would be a very appropriate use of the block grant.
6. The state should continue to participate in the Part H early intervention program beyond the fourth planning year, utilizing federal Part H dollars to enhance the delivery of early intervention services.
7. The state should continue to invest in alcohol and drug prevention education programs, perhaps looking to the tobacco education campaign as a model.

Data Collection

Both the state and counties lack data on the prevalence of perinatal alcohol and drug use, the number of women or children eligible for services, and the number of those currently receiving services. Many of the programs surveyed have no data on prevalence in their counties. Few programs not directly involved in alcohol and drug treatment appear to be asking women clients about their alcohol and drug use, and so are unaware of the extent of the problem among their target population. CPSP, for example, does not have accurate data on the number of women it serves.

At the time of the survey, the age categories used in compiling county social services data were not standardized, making it very difficult to get a picture of the children served, or assess the impact of perinatal alcohol and drug use on the social services system for young children.

1. Data collection should be improved among and across programs at both the state and local levels. The state and counties should work together to standardize

collection so that county data are comparable. County social services departments in particular should collect data by the same age groups, including the birth-to-3 age group. These departments should also collect retrievable data on the role of prenatal and familial alcohol and drug use in Child Protective Services interventions and custody removal decisions.

2. The Department of Alcohol and Drug Programs should encourage counties to use its raw and aggregate data in planning and developing programs. In addition, the department should release state prevalence study data as soon as they become available to assist in the county and agency planning process. The new CADDS data collection system should improve the collection and analysis of data at the state level, and the state prevalence study now underway should also provide valuable information on the extent of perinatal alcohol and drug use. Information from both data collection projects should be made available to counties on a timely basis to enhance planning.
3. The Department of Health Services should improve data collection in the CPSP program to obtain information on the number of women served, program costs, and the criteria used by local CPSP providers to admit women to their practices for perinatal care.

Appendix A

ANNOTATED BIBLIOGRAPHY

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CLINICAL

Blume, S.B. (1986). Women and alcohol: A review. Journal of the American Medical Association, 256, 1467-1470.
Blume's article, which addresses drinking patterns; heredity; physiology and pathophysiology; psychological factors; clinical features; diagnosis; and treatment, is an excellent review of the literature on women and alcoholism.

Chasnoff, I.J. (1988). Drug use in pregnancy: Parameters of risk. Pediatric Clinics of North America, 35, 1403-1412.
Chasnoff summarizes information on the clinical effects on infants of a variety of licit and illicit drugs used during pregnancy, and discusses other factors, including a drug-seeking environment and poor parenting, that may also hurt the development of these children. HIV infection in mothers and infants is also addressed.

Dattel, B.J. (1990). Substance abuse in pregnancy. Seminars in Perinatology, 14, 179-187.
A basic review of clinical effects of drug use during pregnancy, this article is useful because it addresses alcohol, nicotine, PCP, and prescription substances as well as cocaine and narcotics.

Dixon, S.D. (1989). Effects of transplacental exposure to cocaine and methamphetamine on the neonate. Western Journal of Medicine, 150, 436-442.
This article offers detailed discussions of cocaine and methamphetamine effects, and is the best available information on methamphetamine. The author notes that most methamphetamine users also use alcohol.

Kaye, K., Elkind, L., Godberg, D., & Tytun, A. (1989). Birth outcomes for infants of drug abusing mothers. N.Y. State Journal of Medicine, 89, 256-261.
This New York City study compared the birth outcomes of 585 infants of drug users and the same number of controls. Infants of cocaine and opiate users had lower birthweights than the controls, even after socioeconomic variables, including prenatal care, were controlled. Infants of polydrug users had lower birthweight and gestational age and longer hospital stays.

Keith, L.G., MacGregor, S., Friedell, S., Rosner, M., Chasnoff, I.J., & Sciarra, J.J. (1989). Substance abuse in pregnant women: Recent experience at the Perinatal Center for Chemical Dependence at Northwestern Memorial Hospital. Obstetrics & Gynecology, 73, 715-720.
The authors compared maternal and fetal outcomes for 137 drug-using and 123 non-using pregnant women, and found that the study group had significantly more prenatal

hospitalization, anemia, chorioamnionitis, and premature rupture. Gestational age at delivery and infant's birth weight were also lower. Two-thirds of the cocaine and cocaine/opiate users in the study continued to use despite comprehensive care. The authors caution that the results are insufficient to establish a causal role of any single drug, that lifestyle factors other than substance use are not controlled, and that the control group received no toxicology screens. This is a useful article to compare with other outcome studies.

Lutiger, B., Graham, K., Einarson, T.R., & Koren, G. (1991). Relationship between gestational cocaine use and pregnancy outcome: A meta-analysis. Teratology, 44, 405-414.

The authors combined and reviewed the results of 20 studies of the effects of cocaine use during pregnancy on birth outcomes, with interesting and important results. When cocaine users were compared with non-drug users, the effects generally included lower head circumference, gestational age, birth weight, and birth length. However, because of other risk factors in the cocaine users, these results cannot with certainty be attributed to cocaine alone. When polydrug users who used cocaine were compared to polydrug users who did not, only the likelihood of genitourinary malformations was increased. In this meta-analysis, perinatal cocaine use failed to increase significantly the risk of abruptio placenta, cardiac malformation, and SIDS, effects commonly associated with cocaine use. The analysis indicates that a variety of adverse effects assumed to be associated with cocaine may be caused by confounding factors.

Lynch, M., and McKeon, V.A. (1990). Cocaine use during pregnancy: Research findings and clinical implications. JOGNN: Journal of Obstetric, Gynecologic, and Neonatal Nursing, 19, 285-292.

A sensible article which provides an overview of the pharmacology of cocaine, prevalence of use, pregnancy complications and fetal/neonatal complications. It also offers a specific and detailed discussion of possible nursing interventions for the cocaine-using pregnant woman and for the affected neonate.

Zuckerman, B., Amaro, H., Bauchner, H., & Cabral, H. (1989). Depressive symptoms during pregnancy: Relationship to poor health behaviors. American Journal of Obstetrics and Gynecology, 160, 1107-1111.

In a study of 1014 low-income, African-American and Hispanic young pregnant women, the investigators found that depression was negatively associated with income and employment, and positively associated with low weight gain, smoking, and alcohol and cocaine use. When income was controlled, however, the association between prenatal depression and cocaine use disappeared, although the alcohol and nicotine associations remained. The study suggests that for poor women, environmental stresses may result in depressive symptoms, which then influence health behaviors (nutrition, cigarette, alcohol, and cocaine use), which in turn influence infant outcomes. The authors suggest that it is important for the obstetrician to identify depressive symptoms in pregnant women and to understand their potential relationship to poor health behaviors.

INCIDENCE

Abel, E.L. & Sokol, R.J. (1987). Incidence of fetal alcohol syndrome and economic impact of FAS-related anomalies. Drug and Alcohol Dependence, 19, 51-70.

Considering only the most severe consequences of Fetal Alcohol Syndrome, the authors conservatively estimate that FAS costs $321 million each year, while NIAAA spends only $2.9 million annually on FAS research. They also estimate that 11% of mental retardation residential and support services are due to FAS alone. This article is useful for policy makers and advocates.

Abma, J.C., & Mott, F.L. (1991). Substance use and prenatal care during pregnancy among young women. Family Planning Perspectives, 23, 117-128.

Using data from the National Longitudinal Survey of Youth, the authors determined the use of alcohol, nicotine, and marijuana by young women (ages 15-30) during pregnancies leading to first births. They found that 45% of all respondents had used at least one of these substances during pregnancy, with white women more likely than African-American or Hispanic women to have used any of the three substances, and almost twice as likely to have smoked cigarettes during pregnancy. 19% of the women in the study did not receive early prenatal care, but this finding was not significantly associated with substance use. Both behaviors, however, were linked to the prospective father's absence from the home.

Amaro, H., Fried, L.E., Cabral, H., & Zuckerman, B. (1990). Violence during pregnancy and substance use. American Journal of Public Health, 80, 575-579.

Seven percent of a sample of 1,243 pregnant women reported violence during pregnancy. A strong association was found between violent incidents, the use of alcohol by the pregnant woman, and the use of illicit drugs by the male partner. The authors emphasize that the study does not address the causal ordering of depression, violence, and drug use; however, the linkage of substance use and battering is critically important.

Amaro, H., Zuckerman, B., & Cabral, H. (1989). Drug use among adolescent mothers: Profile of risk. Pediatrics, 84, 144-151.

In a study of 253 pregnant adolescents at Boston City Hospital, those who used drugs (cigarettes, alcohol, cocaine, and other drugs) during pregnancy were more likely than nonusers to be African-American; to be older; to have a history of abortion and sexually transmitted disease; to have more negative life events, including violence during pregnancy (although no more depression); and to have a partner who also used drugs. Overall, half of the participants used alcohol while pregnant, 31% used marijuana, and 13% used cocaine.

Besharov, D.J. (1989). The children of crack. Public Welfare, 47, 6-11, 42.

Besharov estimates that 30,000 to 50,000 infants are born exposed to "crack" cocaine each year, and this figure is often cited as a conservative prevalence estimate. The article advocates increased access to treatment, as well as increased intervention by child welfare authorities.

Chasnoff, I.J., Landress, H.J., & Barrett, M.E. (1990). The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. New England Journal of Medicine, 322, 1202-1206.

This study found an overall prevalence of drug use during pregnancy of 14.8%. Rates of use were similar for African-American and white women; however, African-American women were reported to health authorities at ten times the rate of white women. The study's methodology leads to an underreporting of alcohol use, and drug differentials (marijuana v. cocaine) are not well-addressed, but this is an excellent article of great policy value.

Department of Alcohol and Drug Programs, State of California (March, 1991). Data sheet on perinatal drug and alcohol use. Sacramento: Author.

Using incidence rates from its own records and from national studies (Chasnoff et al., 1990), the DADP estimates that between 72,000 and 85,000 -- 12.6 to 14.8% -- of live births in California in 1989 involved prenatal drug and alcohol exposure. DADP's brief report also summarizes information on women in drug abuse treatment in California in fiscal year 1989-1990.

Deren, S., Frank, B., & Schmeidler, J. (1990). Children of substance abusers in New York State. New York State Journal of Medicine, 90, 179-184.

The authors estimate at least 500,000 children (under age 17) of substance abusers in New York State in 1986, or approximately one of every 10 children. Their methodology, which involves a wide variety of sources and some extrapolations from New York City, is interesting in its own right.

Land, D.B., & Kushner, R. (1990). Drug abuse during pregnancy in an inner-city hospital: Prevalence and patterns. Journal of the American Osteopathic Association, 90, 421-426.

The investigators conducted urine toxicology screens on 290 patients admitted to labor at Michigan Health Center in Detroit in early 1989. 27% of the subjects had positive screen results: 44.9% for cannabinoids, 42.3% for cocaine, 25.6% for opiates, and less than 10% for barbiturates, benzodiazepines, and amphetamines. The authors advocate universal screening in inner-city hospitals.

Little, B.B., Snell, L.M., Gilstrap, L.C., Gant, N.F., & Rosenfeld, C.R. (1989). Alcohol abuse during pregnancy: Changes in frequency in a large urban hospital. Obstetrics and Gynecology, 74, 547-550.

Comparing charts for obstetric patients from the period 1977 to 1980 and from the year 1987, the investigators found a general increase in alcohol abuse (2 or more ounces of alcohol per day) from .7% in the earlier period, to 1.4% in 1987. The increase was due primarily to a doubling of the number of white women who abused alcohol.

Little, B.B., Snell, L.M., Gilstrap, L.D., & Johnston, W.L. (1990). Patterns of multiple substance abuse during pregnancy: Implications for mother and fetus. Southern Medical Journal, 83, 507-518.

Although the investigation is through self-report and must therefore be read very critically, this article offers some interesting statistics on polydrug use. The authors attempted to

determine the users' primary drug, as well as the use of other drugs. Findings include that 75% of women in the study used more than one drug, and that alcohol use was very high among users whose primary drugs are "T's and blues," heroin, and cocaine. In contrasts to Dixon's article (1989), this study found that methamphetamine users, who tended to be younger and 94% of whom were white, used fewest other drugs.

Matera, C., Warren, W.B., Moomjy, M., Fink, D.J., & Fox, H.E. (1990). Prevalence of use of cocaine and other substances in an obstetric population. American Journal of Obstetrics and Gynecology, 163, 797-801.

This study assessed drug use during pregnancy through urine toxicology screens of 509 patients at Sloane Hospital for Women in New York City. Cocaine use was found in 14% of the clinic population and 1.4% of the private population, and amphetamine use was detected in 13% of the study sample overall (although the screen could not distinguish between amphetamines and some other drugs, including cold remedies). The high prevalence of amphetamine use in this study is not reported elsewhere. The study's other finding -- that standard medical histories rarely detected the drug use -- is critical.

Schutzman, D.L., Frankenfield-Chernicoff, M., Clatterbaugh, H.E., & Singer, J. (1991). Incidence of intrauterine cocaine exposure in a suburban setting. Pediatrics, 88, 825-827.

This study found a high prevalence of cocaine exposure among newborns in a suburban hospital. The meconium of 6.3% of the infants whose mothers had private insurance tested positive for cocaine, as did the meconium of 26.9% of the babies of mothers who had Medicaid or no insurance, for a total prevalence of 11.8%. This high prevalence may be due to the increased sensitivity of meconium testing. Women in the study were also surveyed anonymously on a variety of subjects including substance use; only five subjects (all in the clinic population) admitted using cocaine. This article raises critical questions about the validity of self-reports and of urine testing, and expands the range of cocaine use estimates significantly.

POLICY

Bays, J. (1990). Substance abuse and child abuse: Impact of addiction on the child. Pediatric Clinics of North America, 37, 881-904.

This article reviews the literature on perinatal drug use, and points to a strong correlation between drug use and child abuse. The author recommends strategies of both "compassion" and "control," including expanded drug treatment and comprehensive services to families, as well as early termination of parental rights for women who don't comply with treatment, and prosecution for drug-related abuse and neglect. This is an important policy piece, and includes an excellent summary of studies.

California Advocates for Pregnant Women (1990). A model for advocacy and treatment: The role of perinatal toxicology testing. CAPW Newsletter, (11), 1-3.

This policy is a crucial resource for advocates and policy-makers. It calls for expanded

treatment services that are sensitive and appropriate, and takes a reasoned, conservative approach to toxicology testing of pregnant and postpartum women and newborn infants. CAPW advocates separate informed consent for toxicology screens, and cautions that a single test by itself is not a useful tool to diagnose addiction.

Chasnoff, I.J. (1991). Drugs, alcohol, pregnancy, and the neonate: Pay now or pay later. Journal of the American Medical Association, 266, 1567-1568.

In a commentary on the article by Phibbs et al., reviewed below, Chasnoff reviews estimates of the prevalence of fetal exposure to cocaine and other drugs, and suggests that annual costs of caring for drug-exposed neonates could range from $385 million to $3 billion per year. These costs are due in large part to lack of prenatal care, leading to prematurity and low birthweight, and the estimates do not include the costs of addressing long-term consequences. . Chasnoff urges physicians to advocate for treatment services for their patients.

Chavkin, W., & Kandall, S.R. (1990). Between a "rock" and a hard place: Perinatal drug abuse. Pediatrics, 85, 223-225.

This editorial on perinatal drug use policy calls for comprehensive services and condemns policies of criminalization. The authors urge pediatricians to advocate for expanded services, combining counseling with gynecologic, prenatal, and pediatric care, and parenting and job training. This is a strongly argued and very readable piece.

Chavkin, W. (1990). Drug addiction and pregnancy: Policy crossroads. American Journal of Public Health, 80, 483-487.

This thoughtful article is an excellent introduction to perinatal drug use and to the three predominant policy responses: child protection and the disruption of maternal custody; criminal prosecution; and drug treatment. Chavkin provides a history of all three approaches and argues in favor of expanded treatment.

Chavkin, W. (1991). Mandatory treatment for drug use during pregnancy. Journal of the American Medical Association, 266, 1556-1561.

Focusing on mandatory chemical dependency treatment as a policy response to perinatal drug use, Chavkin argues that the efficacy of mandatory treatment is unproven and that proposals to require treatment for pregnant women who use illicit drugs are illogical, inequitable, and will probably be ineffective. The article includes policy recommendations, including development of treatment services and encouragement of voluntary enrollment.

Colten, M.E. (1982). Attitudes, experiences, and self-perceptions of heroin addicted mothers. The Journal of Social Issues, 38, 77-92.

Colten compared 170 heroin-addicted and 175 non-addicted women, and found that their attitudes toward motherhood were highly similar. Motherhood was of central importance for all the participants, but addicted women were more likely to feel inadequate in the role. Addicted women were also less strict and less physically punitive with their children. This article raises useful questions about the importance of motherhood for women who use drugs during or after pregnancy.

Escamilla-Mondanaro, J. (1977). Women: Pregnancy, children, and addiction. Journal of Psychedelic Drugs, 9, 59-68.

The author analyzes narcotic-dependent women as "product[s] of battering," and examines their experience and expectations of pregnancy, childbirth, and parenting. The role of the male partner, and particularly his behavior during pregnancy, are addressed. The article also directs attention to cognitive and affective inadequacies preceding addiction. The implications for treatment programs are also addressed in this excellent discussion of women and heroin addiction.

English, A. (1990). Prenatal drug exposure and pediatric AIDS: New issues for children's attorneys. Clearinghouse Review, 24, 452-459.

Written for attorneys but useful for all advocates, this analysis of legal issues related to drug-exposed and HIV-infected infants and children addresses a number of critical topics, including identification and toxicology screening; criminal sanctions; dependency; reasonable efforts; barriers to placement; discrimination; and access to health care. English argues that the issues faced by drug-exposed and HIV-infected children are similar to those faced by most children in the welfare system, but that attorneys must understand the particular concerns of drug use and HIV in order to protect these vulnerable populations.

Fanshel, D. (1975). Parental failure and consequences for children: The drug-abusing mother whose children are in foster care. American Journal of Public Health, 65, 604-612.

Fanshel found that the children of drug-using mothers (mostly heroin addicts) were "locked into" foster care at a disproportionately high rate, spent significantly longer in care than did other children, and performed slightly worse in school. However, they had no developmental, emotional, or intellectual lags in comparison to other children in foster care. Fanshel raises difficult questions about the termination of parental rights, and advocates a closer relationship between foster care and addiction treatment staffs.

Feig, L. (1990). Drug exposed infants and children: Service needs and policy questions. Washington, DC: Division of Children Youth and Families, United States Department of Health and Human Services.

This is an excellent summary of various issues affecting drug-exposed infants and children: epidemiology, clinical effects, service needs, and existing programs. Feig discusses a number of policy issues and advocates expanding treatment, providing child care in treatment programs, and educating women on reporting laws. The discussion of foster care issues and the description of federal programs serving drug-exposed children are particularly useful.

Gates, D., & Beck, D. (1990). Prevention and treatment: The positive approach to alcoholism and drug dependency. Clearinghouse Review, 24, 472-489.

This valuable resource article presents public payment mechanisms for chemical dependence prevention and treatment. The authors discuss Office for Substance Abuse Prevention (OSAP) initiatives; barriers to Medicaid eligibility and strategies to overcome them; and federal treatment programs for pregnant women and mothers (ADAMHA, Medicaid, Emergency Child Abuse Prevention Services), among other topics.

Henry, M. (Ed.). (1990). Legal issues affecting drug exposed infants: Special issue. Youth Law News, 11(1), 1-44.

This special issue of Youth Law News, written for attorneys and other children's advocates, includes articles on: the limits of knowledge about the incidence of drug exposure and the service needs of drug-exposed infants; mandatory child abuse reporting; drug use as a factor in juvenile court dependency proceedings; boarder babies in U.S. hospitals; foster care placement; and the use of Medicaid waivers and early intervention programs to help drug-exposed children.

Jessup, M., & Roth, R. (1988). Clinical and legal perspectives on prenatal drug and alcohol use: Guidelines for individual and community response. Medicine and Law, 7, 377-389.

This article offers a good history of the legal status of the fetus and of public policy related to perinatal alcohol and drug use. The authors argue that punitive actions against pregnant addicts are unconstitutional and ineffective, and suggest the following goals of a successful approach: 1) better pregnancy outcomes; 2) treatment of alcohol and drug problems; 3) training in parenting; and 4) recognition of the use and limits of the law in eradicating problems. The article does not distinguish significantly between different illicit drugs.

Johnsen, D. (1987). A new threat to pregnant women's autonomy. Hastings Center Report, 17, 33-40.

Using the 1986 Pamela Rae Stewart case as her primary example, Johnsen analyzes the development of so-called "fetal rights" philosophies. She argues that policies which put mother and fetus in adversarial roles ignore the physical relationship between a pregnant woman and her fetus, cede control to the medical establishment, and constitute a reproductive rationale for exclusion. Johnsen advocates improved medical and social services, to benefit both the pregnant woman and her fetus.

Karan, L.D. (1989). AIDS prevention and chemical dependence treatment needs of women and their children. Journal of Psychoactive Drugs, 21, 395-399.

Many chemically dependent women are also affected by HIV, and many more are at risk of infection. This paper examines the barriers to treatment and recovery, addressing health, psychological and societal factors that impede recovery and contribute to the risk of HIV infection for this population. The article has excellent citations, but offers no policy suggestions.

Koren, G., Shear, H., Graham, K., & Einarson, T. (1989). Bias against the null hypothesis: The reproductive hazards of cocaine. Lancet, 2(8677), 1440-1442.

The authors reviewed 58 abstracts submitted to the Society of Pediatric Research between 1980 and 1989, all addressing the reproductive hazards of cocaine. Of 9 abstracts showing no adverse effects, only 1 was accepted, while 28 of the 49 abstracts showing negative birth outcomes were accepted. The authors warn that the bias shown in abstract acceptance "may lead to distorted estimation of the teratogenic risk of cocaine."

Morris, R.A., & Sonderegger, T.B. (1986). Perinatal toxicology and the law. Neurotoxicology and Teratology, 8, 363-367.
The authors examine the interaction between perinatal drug research and law, addressing drugs of abuse, licit drugs, and environmental toxins. Their broad definition of "drug" is thought-provoking and provides a useful perspective on perinatal drug use.

Moss, K.L. (1990). Legal issues: Drug testing of post-partum women and newborns as the basis for civil and criminal proceedings. Clearinghouse Review, 23, 1406-1414.
A detailed summary of legal issues surrounding toxicology screening of pregnant and post-partum women and their infants, addressing informed consent, Fourth Amendment, and interests-of-child issues. The information on barriers to affirmative suits for deprivation of custody is particularly useful.

Office of Evaluation and Inspections, Office of the Inspector General, USDHHS. (1990). Crack babies (Draft). Washington, DC: Author.
The investigators surveyed 200 respondents (including child welfare services, hospital social services, private agencies, and foster parents) to determine how children exposed to "crack" cocaine are affecting the child welfare system. This report briefly describes new strategies of child welfare agencies and hospitals, and summarizes information on the current placement of drug-exposed infants. It includes good recommendations for future study and for federal agency policies to improve coordination of services.

Phibbs, C.S., Bateman, D.A., & Schwartz, R.M. (1991). The neonatal costs of maternal cocaine use. Journal of the American Medical Association, 266, 1521-1526.
A study of cocaine-exposed infants born at Harlem Hospital in 1985 and 1986 found increased hospital costs (+ $2610) and longer lengths of stay (+ 4 days) compared to unexposed infants. Maternal polydrug and crack use further increased hospital costs. Increased costs were concentrated among infants who required NICU care (generally related to low birth weight or prematurity), meaning much higher costs for a fairly small number of infants. Those children who remained in the hospital pending foster care placement also had greatly increased costs and lengths of stay. Chasnoff's commentary on this article is cited above.

Regan, D.O., Ehrlich, S.M., & Finnegan, L.P. (1987). Infants of drug addicts: At risk for child abuse, neglect, and placement in foster care. Neurotoxicology and Teratology, 9, 315-319.
A six-year study of 178 pregnant, drug-dependent women and 70 non-drug using controls found that the violence experienced by the study group far exceeded that experienced by the controls. The authors point to a relationship between child abuse and subsequent drug use, and further suggest that childhood sexual trauma and drug use combine to disrupt women's parenting ability. The article is a reminder to monitor depression and violence in the lives of pregnant and parenting women who use drugs.

United States General Accounting Office. (1990). Drug-exposed infants: A generation at risk. Washington, DC: Author.

This report estimates the incidence of drug-exposed neonates and addresses the effects of their exposure, including health costs and the impact on social welfare and educational systems. It details the lack of treatment services for women and recommends increased federal monies for prenatal care and drug treatment. The researchers used the National Hospital Discharge Survey, and records from 10 hospitals in five cities, to arrive at incidence and cost estimates. Alcohol use was not included in their definition of maternal drug use.

Weston, D.R., Ivins, B., Zuckerman, B., Jones, C., & Lopez, R. (1989). Drug exposed babies: Research and clinical issues. Zero to Three, 9(5), 1-7.

An excellent review of the research on drug-exposed infants emphasizes the limits of studies to date and the direct and indirect effects of maternal drug use, as well as the differences between addictive, toxic, and teratogenic drugs. A section on clinical issues addresses the danger of stereotyping; focusing the treatment effort; the impact of the work on helping professionals; and the development of a conceptual framework that assists clinical and research efforts. The authors also discuss the effects of depression, dual diagnosis, and addiction on the treatment process, and argue for a "risk model" as opposed to a "deficit model" in treating both mothers and infants.

Wilton, J.M. (1991). Compelled hospitalization and treatment during pregnancy: Mental health statutes as models for legislation to protect children from prenatal drug and alcohol exposure. Family Law Quarterly, 25, 149-170.

This law review article reviews two models for state interventions to protect the fetus from drug and alcohol exposure: child abuse statutes and mental health statutes. The author concludes that child protection law is a poor model for fetal health legislation because it does not protect women's rights to bodily integrity, conceives of children's rights as independent of the mother's, and might implicate actions of pregnant women other than alcohol and drug use. Mental health legislation, however, contains procedural safeguards against infringement of the right to bodily integrity, traditionally provides for hospitalization for drug and alcohol addiction, and doesn't "perpetuate a perpetrator-victim view of alcoholism and addiction." Existing legislation cannot appropriately be extended to cover perinatal alcohol and drug use, and Wilson suggests new laws in the mental health model.

TREATMENT

Beckman, L.J., and Kocel, K.M. (1982). The treatment-delivery system and alcohol abuse in women: Social policy implications. Journal of Social Issues, 38, 139-151.

A survey of 58 alcoholism treatment facilities in two California counties found that the availability of child care is very important to women alcoholics seeking treatment. Programs that employed more female staff and that provided aftercare services also had greater participation by women.

Edelin, K.C., Gurganious, L., Golar, K., Oellerich, D., Kyei-Aboagye, K., & Hamid, M.A. (1988). Methadone maintenance in pregnancy: Consequences to care and outcome. Obstetrics and Gynecology, 71, 399-404.

Methadone maintenance during pregnancy was only somewhat successful in improving perinatal outcome in this study, possibly because only 20% of the women receiving methadone had "adequate" care (despite their enrollment in a high-risk prenatal clinic), and because most continued to use illegal drugs. However, even fewer of the drug-using women not enrolled in the methadone program received adequate prenatal care. Infants in both of these groups had significantly lower birthweights than the infants of a control group.

Fitzsimmons, J., Tunis, S., Webster, D., Izes, J., Wapner, R., & Finnnegan, L. (1986). Pregnancy in a drug-abusing population. American Journal of Drug and Alcohol Abuse, 12, 247-255.

The program described in this report offers comprehensive prenatal care and daily methadone for opiate addicts; some study participants received methadone, while others did not. Women receiving methadone therapy were more likely than others to present for regular prenatal care, and the investigators found that the number of prenatal visits was predictive of birthweight and gestational age at delivery. (The authors also suggest, however, that women who receive prenatal care more regularly may have less chaotic lives in general, and that this may also account for their improved birth outcome.) Both methadone-maintained and non-maintained women had high rates of birth complications. As in Edelin's 1988 study, most women continued to use illicit substances, as well as nicotine.

Halmesaki, E. (1988). Alcohol counselling of 85 pregnant problem drinkers: Effect on drinking and fetal outcome. British Journal of Obstetrics and Gynecology, 95, 243-247.

In this project, conducted in Helsinki in 1985-1986, women received counseling at 2-4 week intervals about the effects of alcohol, and were urged to abstain or to reduce their intake. 65% of the women in the study reduced their drinking by at least 50%. Halmesaki argues that mass media education is not sufficient to change behavior, while personal counseling does work for many women.

Hoegerman, G., Wilison, C.A., Thurmond, E., & Schnoll, S.H. (1990). Drug-exposed neonates. Western Journal of Medicine, 152, 559-564.

A review of the literature on pharmacology and teratogenic effects points out that confounding effects of nutrition, genetic susceptibility, and environmental factors make it difficult to ascribe effects to a specific drug. The article also includes a number of specific suggestions on treatment of the pregnant woman and the neonate, including the use of phenobarbital to treat neonatal withdrawal and breast-feeding by methadone-maintained mothers, and argues that specific informed consent is not necessary for toxicology screening.

Jessup, M. (1990). The treatment of perinatal addiction: Identification, intervention, and advocacy. Western Journal of Medicine, 152, 553-558.

In a critical article on services and model programs, Jessup advocates using a complete health history to identify addiction. She includes a detailed plan for intervention, with

sample dialogue, and discusses the possibility of dual diagnoses for non-compliant women. Jessup also advocates informed consent for toxicology screening, and reporting to child welfare when diagnostic and treatment options are exhausted. Much of the data is specific to California.

Jessup, M., & Green, J.R. (1987). Treatment of the pregnant alcohol-dependent woman. Journal of Psychoactive Drugs, 19, 193-203.

A comprehensive and specific article addressing clinical effects of alcohol consumption on both infant and mother, suggestions for identification and intervention, and policy issues related to child protection and advocacy. It includes excellent ideas for intervention and advocacy.

Kronstadt, D. (1989). Pregnancy and cocaine addiction: An overview of impact and treatment. San Francisco: Far West Laboratory for Educational Research and Development (unpublished).

Kronstadt reviewed the literature and interviewed research and clinical specialists to produce a good list of recommended interventions. Programs should be comprehensive, confidential, coordinated, intensive, and supportive. Residential treatment, parenting education, and child care should be available. The study does not include citations, but offers a useful list of model programs, and the interviews provide a good summary of recommended interventions.

Lawson, M.S., and Wilson, G.S. (1979). Addiction and pregnancy: Two lives in crisis. Social Work in Health Care, 4, 445-457.

The authors advocate comprehensive care for the pregnant addict, with the understanding that pregnancy and childbirth is often a good time for intervention. They review the physiological and psychological effects of addiction, emphasizing heroin, and discuss therapeutic interventions that can be taken, especially immediately post-partum. The epidemiology of the article is dated, but the interventions are well-described.

Lewis, K.D., Bennett, B., & Schmeder, N.H. (1989). The care of infants menaced by cocaine abuse. MCN: Journal of Maternal and Child Nursing, 14, 324-329.

Despite the alarmist title, this article by nursing specialists from the Napa Infant Program is very useful, and provides a good chart of interventions to use with drug-exposed infants. It includes a basic review of the clinical effects of various substances, and a general discussion of parenting training for the caretakers of drug-exposed infants.

Lief, N.R. (1985). The drug user as a parent. The International Journal of the Addictions, 20, 63-97.

Lief evaluates the parenting component of the Pregnant Addicts/Addicted Mothers comprehensive care program at New York Medical College. The discussion includes detailed descriptions of the program's curriculum, which has been very successful in teaching addicted women (primarily heroin users) to care for their children.

MacGregor, S.N., Keith, L.G., Bachicha, J.A., & Chasnoff, I.J. (1989). Cocaine abuse during pregnancy: Correlation between prenatal care and perinatal outcome. Obstetrics and Gynecology, 74, 882-885.

This important study followed two groups of cocaine-using pregnant women, one enrolled in prenatal care and the other not, and compared both groups to controls who did not use cocaine. The authors found that prenatal care by itself cannot eliminate perinatal morbidity, but that it may improve perinatal outcome. The authors emphasize that cocaine's relation to perinatal morbidity is an "association," not a "cause," and that other environmental factors may also contribute to adverse outcomes.

Marsh, J.C. (1982). Public issues and private problems: Women and drug use. Journal of Social Issues, 38, 153-165.

A theoretical discussion of women-oriented services, Marsh's article criticizes "medical model" definitions of women's drug use as detrimental to women's involvement in treatment, in part because they ignore the concrete problems of drug-using women and fail to recognize situational and societal factors in drug use. The author advocates decentralized services and client participation in designing programs for women, and includes useful general guidelines for comprehensive services.

National Institute on Alcohol Abuse and Alcoholism (1985). "My baby ... strong and healthy": Preventing alcohol-related birth defects. Alcohol Health and Research World, 10(1), 1-77.

A summary of research findings, including the effects of prenatal ethanol exposure; interventions with pregnant women who abuse alcohol; a 10-year followup of FAS patients; economic implications of FAS; prevention strategies for alcohol-related birth defects; and other topics.

Office of Evaluation and Inspections, Office of the Inspector General, USDHHS. (1990). Crack babies: Selected model practices. Washington, DC: Author.

The investigators surveyed exemplary programs in 12 metropolitan areas and report on their successes and failures with outreach, comprehensive services in one location, education of drug-exposed children, case management, professional training, management practices, interagency coordination, and private initiatives. The discussion of training and management programs is very useful.

Reed, B.G. (1987). Developing women-sensitive drug dependence treatment services: Why so difficult? Journal of Psychoactive Drugs, 19, 151-164.

Reed describes some of the administrative and organizational requirements for women-oriented drug treatment services, including programs for children, linkage to other community organizations, and development of a service mission that appropriately addresses women's needs.

Reed, B.G. (1985). Drug misuse and dependency in women: The meaning and implications of being considered a special population or minority group. The International Journal of the Addictions, 20, 13-62.

Reed's article is a comprehensive and thoughtful review of chemical dependence treatment issues related to women's minority status. Using a cross-cultural approach, it compares the characteristics of chemically dependent women and the characteristics of most treatment programs, explaining the problems women face in a male-oriented treatment setting. The article does not focus on pregnancy, but will be helpful to people working in this field, and includes an extensive bibliography.

Rogan, A. (1985). Issues in the early identification, assessment, and management of children with fetal alcohol effects. Alcohol Health and Research World, 10(1), 66-67.

A brief review of the literature, focusing on interventions for children affected by FAS and FAE and on training providers to identify and assist these children. Rogan emphasizes the importance of linking children to programs that address the nature of their problem and not its etiology. Rogan's article also alerts us to the paucity of literature on the development of FAS and FAE affected children -- a lack equally apparent in the literature on illicit drug use.

Rosner, M.A., Keith, L., Chasnoff, I. (1982). The Northwestern University Drug Dependence Program: The impact of intensive prenatal care on labor and delivery outcomes. American Journal of Public Health, 144, 23-27.

A study of 58 women, conducted from 1976 to 1980, found that subjects who received intensive psychological counseling, prenatal care, and low-dose methadone maintenance if heroin-addicted, bore infants with good birthweight and length. The study population was primarily heroin-using. Many subjects had high-school educations and were upper middle-class, and their outcomes are generally better than those of "drug-addicted clinic populations" studied by other researchers.

Stevens, S., Arbiter, N., & Glider, P. (1989). Women residents: Expanding their role to increase treatment effectiveness in substance abuse programs. International Journal of the Addictions, 24, 425-434.

The authors report on changes made in the Amity, Inc. treatment program in Tucson, AZ, to make it more responsive to women. Amity began women's groups, increased female staff, hired a woman counselor, and accepted children. As a result, the program saw an increase in the percentage of women participants, a decrease in sexual harassment, and an increased length of stay for both women and men. The article provides helpful details on making treatment more woman-oriented.

Taylor, W.A., & Gold, M.S. (1990). Pharmacologic approaches to the treatment of cocaine dependence. Western Journal of Medicine, 152, 573-577.

In an interesting article, the authors summarize the biochemistry and potential medical complications of cocaine use, and discuss research on pharmacologic agents used to lessen withdrawal symptoms, dysphoria, and craving. In general, these pharmacologic agents have been found to be only moderately useful, and that only in the initial phase of abstinence. The authors emphasize that pharmacologic agents are at best adjuncts to comprehensive

treatment.

Tittle, B., St. Claire, N. (1989). Promoting the health and development of drug-exposed infants through a comprehensive clinic model. Zero to Three, 9(5), **18-20.**
The authors describe the C.A.R.E. (Chemical Addiction Recovery Efforts) Clinic at Children's Hospital, Oakland, which offers medical care, material aid, support services, and social events to mothers and infants. This article also includes an eloquent discussion of the value of comprehensive services to this population.

Unger, K.B. (1988). Chemical dependency in women: Meeting the challenges of accurate diagnosis and effective treatment. Western Journal of Medicine, 149, **746-750.**
This is a good background piece on women and chemical dependency -- pregnancy is not a focus of the article. Unger describes chemical dependency, co-dependency, and the clinical course of addiction, including thorough definitions, and addresses the process of chemical dependency diagnosis in detail. Treatment issues receive less attention.

Waterson, J., & Ettorre, B. (1989). Providing services for women with difficulties with alcohol or other drugs: The current U.K. situation as seen by women practitioners, researchers, and policy makers in the field. Drug and Alcohol Dependence, 24, **119-125.**
In the view of British women who practice in the field of drug and alcohol addiction, the greatest barriers to access to treatment services for women are the lack of child care, and the stigmatization of chemically dependent women.

Weiner, H.D., Wallen, M.C., & Zankowski, G.L. (1990). Culture and social class as intervening variables in relapse prevention with chemically dependent women. Journal of Psychoactive Drugs, 22, **239-248.**
This article analyzes factors contributing to women's relapse, including low self-esteem, dependency, poor coping skills, and family issues. It describes a comprehensive care model designed to prevent relapse which includes group, individual and adjunctive therapy; twelve-step programs; family assessment; educational seminars; nursing, medical and psychiatric care; back-to-work, relapse prevention, and aftercare planning.

Appendix B

SURVEY INSTRUMENTS

CENTER FOR THE VULNERABLE CHILD/YOUTH LAW CENTER

PERINATAL DRUG USE: AN ANALYSIS OF POLICIES AND PROGRAMS IN CALIFORNIA

INTRODUCTION TO THE SURVEY

This survey is part of a study of the policies and programs in California that concern pregnant women who use alcohol and other drugs and their prenatally drug-exposed children. The study is funded by the California Policy Seminar, a joint project of the University of California and state government. The study is being conducted by staff from the Center for the Vulnerable Child at Children's Hospital Oakland and the Project on Children with Special Medical Needs of the Youth Law Center and National Center for Youth Law in San Francisco.

The purpose of this survey is to collect information on county programs that *may* serve pregnant and postpartum women who use alcohol and other drugs and their prenatally drug-exposed children. The survey focuses on five areas: services, eligibility, funding, coordination of services, and data collection. **The survey will be administered by phone and will take approximately 1 hour.**

PART A: SERVICES INFORMATION

SECTION I: PREGNANT AND/OR POST-PARTUM WOMEN WHO USE ALCOHOL AND/OR OTHER DRUGS

We would like to know the range of services _____ administers, funds, or provides for pregnant and/or postpartum women who use alcohol and/or other drugs. If women are not your program's primary clients, please turn to Section II on page 4.

1.0. Please select all services that your program funds, administers or provides to pregnant and postpartum women who use alcohol and/or other drugs.

1.1. Health Care
- A. ___ No Services
- B. ___ Prenatal/Postpartum Care
- C. ___ Primary Health Care for Women
- D. ___ Specialty Medical Services. If yes, specify.
- E. ___ Family Planning
- F. ___ Other Services. Please specify.

1.2. Alcohol/Drug Treatment and Recovery Services
- A. ___ No Services
- B. ___ Detoxification
- C. ___ In-Patient Treatment
- D. ___ Day Treatment or Recovery Services
- E. ___ 12 Step/Recovery Support Groups
- F. ___ Residential Care for Women Only
- G. ___ Residential Care for Women and Children
- H. ___ Children's Program as Part of Woman's Treatment and Recovery Program
- I. ___ Other. Please specify.

1.3. Social Services
- A. ___ No Services
- B. ___ Counseling/Therapy
- C. ___ Job Training
- D. ___ Housing
  - i. ___ referral only
  - ii. ___ provision of shelter or housing
- E. ___ Transportation
- F. ___ Parent Support and Training
- G. ___ Family Maintenance/Family Reunification
  - i. ___ out-of-home respite
  - ii. ___ counseling
  - iii. ___ emergency shelter
  - iv. ___ temporary in-home caretakers
  - v. ___ teaching and demonstrating homemakers
  - vi. ___ parenting training
  - vii. ___ transportation
  - viii. ___ Other

H. ___ Other. Please specify.

1.4 Case Management Services
- A. ___ No Services
- B. ___ Medical Case Management. If yes, please define:

- C. ___ Social Services Case Management
  - i. ___ Outreach, case-finding
  - ii. ___ Client assessment, diagnosis
  - iii. ___ Development of service case plan
  - iv. ___ Service referrals, linkage, coordination, brokering
  - v. ___ Advocacy for client
  - vi. ___ Evaluation of service delivery
  - vii. ___ Other. Please specify.

D. ___ Other. Please specify.

1.5. Referrals to Other Programs
- A. ___ No Referrals Made
- B. ___ Health Care Services
- C. ___ Alcohol/Drug Treatment and Recovery Services
- D. ___ Child Development/Early Intervention Services
- E. ___ Social Services
- F. ___ Mental Health Services
- G. ___ Other

1.6. ___ Other Services. Please specify.

2.0. How are these services provided?
- 9. ___ Don't Know
- 1. ___ Directly by program staff
- 2. ___ Contracted out to local programs
- 3. ___ Other. Please specify.

3.0. Do clients of these services have to go to more than one site to obtain the services?
9. ___ Don't Know
1. ___ No; all services are provided on-site and/or in a client's home
2. ___ Yes; services are located at two or more different sites
3. ___ Other. Please specify.

4.0. Are any services and/or funds *specifically targeted* to pregnant and/or postpartum women who use alcohol and/or other drugs?

___ Yes
___ No
___ Don't Know

4.1. If yes, what are the targeted services?

4.2. Are there specific eligibility criteria for these targeted services?

___ Yes
___ No
___ Don't Know

4.3. If yes, what are they?

4.4. How many women are served each year by these targeted services?

_____ #

4.5. How are these services funded?
A. ___ Federal Funds. Please specify name(s) of source.
B. ___ State Funds. Please specify name(s) of source.
C. ___ County Funds. Please specify name(s) of source.
D. ___ Private Foundations. Please specify name(s) of source.
E. ___ Other. Please specify.

5.0. Do you have any plans to initiate targeted services to pregnant or postpartum women who use alcohol and/or other drugs?
___ Yes
___ No
___ Don't Know

6.0. Are there any services that your program does not currently fund/provide that you believe would enhance your ability to serve pregnant and/or postpartum women who use alcohol or other drugs?
___ Yes
___ No
___ Don't Know

If Yes, please specify.

SECTION II: CHILDREN FROM BIRTH TO AGE THREE WHO HAVE BEEN EXPOSED PRENATALLY TO ALCOHOL AND/OR OTHER DRUGS

7.0. Please select all services that your program funds, administers, or provides for drug-exposed children aged birth to three.

7.1. Health Care
- A. ___ No Services for Children
- B. ___ Primary Health Care for Infants and children
- C. ___ Provision of Specialty Medical Services for Children. If yes, please specify.

D. __ Other Services for Children. Please specify.

7.2. Child Development and Early Intervention Services
- A. ___ No Services
- B. ___ Infant Assessment
- C. ___ Infant Stimulation/Development
- D. ___ Infant/Parent Psychotherapy
- E. ___ Parent Support and Training
- F. ___ Respite Care
- G. ___ Other. Please specify.

7.3. Social Services
- A. ___ No Services for Children
- B. ___ Transportation
- C. ___ Counseling/Therapy for Children
- D. ___ Counseling/Therapy for Parent(s)

E. ___ Other Services for Children. Please specify.

F. ___ Other Services for Parent(s). Please specify.

7.4 Case Management Services
- A. ___ No Services
- B. ___ Medical Case Management. If yes, please define:

C. ___ Social Services Case Management
- i. ___ Outreach, case-finding
- ii. ___ Client assessment, diagnosis
- iii. ___ Development of service case plan
- iv. ___ Service referrals, linkage, coordination, brokering
- v. ___ Advocacy for client
- vi. ___ Evaluation of service delivery
- vii. ___ Other. Please specify.

D. ___ Other. Please specify.

7.5. Referrals to Other Programs
- A. ___ No Referrals Made
- B. ___ Health Care Services for Children
- C. ___ Alcohol/Drug Treatment and Recovery Services for Parents
- D. ___ Child Development/Early Intervention Services
- E. ___ Social Services for Children
- F. ___ Social Services for Parent(s)
- G. ___ Mental Health Services for Children
- H. ___ Other

7.6. ___ Other Services. Please specify.

8.0. How are these services provided?
- 9. ___ Don't Know
- 1. ___ Directly by program staff
- 2. ___ Contracted out to local programs
- 3. ___ Other. Please specify.

9.0. Do clients of these services have to go to more than one site to obtain the services?
- 9. ___ Don't Know
- 1. ___ No; all services are provided on-site and/or in a client's home
- 2. ___ Yes; services are located at two or more different sites
- 3. ___ Other. Please specify.

10.0. Are any services and/or funds *specifically targeted* to children aged 0 to three who have been exposed prenatally to alcohol and/or other drugs?

___ Yes
___ No
___ Don't Know

10.1. If yes, what are the targeted services?

10.2. Are there specific eligibility criteria for these targeted services?

___ Yes
___ No
___ Don't Know

10.3. If yes, what are they?

10.4. How many children are served each year by these targeted services?

_____ #

10.5. How are these services funded?

A. ___ Federal Funds. Please specify name(s) of source.
B. ___ State Funds. Please specify name(s) of source.
C. ___ County Funds. Please specify name(s) of source.
D. ___ Private Foundations. Please specify name(s) of source.
E. ___ Other. Please specify.

11.0. Do you have any plans to initiate targeted services for drug-exposed children aged birth to three?

___ Yes
___ No
___ Don't Know

12.0 Are there any services that your program does not currently fund/provide that you believe would enhance your ability to serve children aged 0 to three who have been exposed prenatally to alcohol and/or other drugs?

___ Yes
___ No
___ Don't Know

If Yes, please specify.

PART B: ELIGIBILITY

SECTION 1: PREGNANT AND/OR POST-PARTUM WOMEN WHO USE ALCOHOL AND/OR OTHER DRUGS

Please select all the criteria that apply to your program for pregnant and postpartum women.

13.1. Health Status Criteria

A. ___ Don't Know
B. ___ No Health Status Criteria
C. ___ Woman Must Be Pregnant.
D. ___ Woman Uses Either or Both Alcohol and Other Drugs
E. ___ Other. Please Specify.

13.2. Income Criteria

9. ___ Don't Know
1. ___ No Income Criteria are Used by the Program.
2. ___ Family income is less than or equal to the federal poverty guidelines [$9,435 for a family of 3]
3. ___ Family income is greater than the federal poverty guidelines. Please specify percentage of guidelines or dollar amount.
   _____% $_____
4. ___ Sliding Scale. Please specify.
5. ___ Other. Please specify.

13.3. Residency Criteria
- A. ___ Don't Know
- B. ___ No Residency Criteria Are Applied.
- C. ___ Requires U.S. Citizenship or Permanent Residency
- D. ___ Requires State Residency
- E. ___ Requires County Residency
- F. ___ Other. Please specify.

14.0. Are there any other eligibility criteria that apply to pregnant and/or postpartum women who use alcohol and/or other drugs that we should know about?
- ___ Yes
- ___ No.
- ___ Don't Know.

14.1. If yes, please specify the criteria.

15.0. In your opinion do any of these *eligibility criteria* present barriers to pregnant women's access to services?
- ___ Yes
- ___ No
- ___ Don't Know

15.1. If yes, please describe.

15.2. If no, why do you think this is so?

16.0. What is the *process* by which a woman is determined to be eligible for services?

16.1. How long does it usually take for a woman to become eligible for services?

1. ___ Days
2. ___ Weeks
3. ___ Months
9. ___ Don't Know

17.0. To your knowledge does the *eligibility process* present barriers to pregnant women who are applying for services?
- ___ Yes
- ___ No
- ___ Don't Know

17.1. If yes, please describe.

17.2. If no, why do you think this is so?

SECTION 2: CHILDREN FROM BIRTH TO AGE THREE WHO HAVE BEEN EXPOSED PRENATALLY TO ALCOHOL AND/OR OTHER DRUGS

I'd like you to tell me all the criteria that apply to your program for children.

18.1. Age Criteria
- 9. ___ Don't Know
- 1. ___ Program Serves Children Birth to 18 Years of Age.
- 2. ___ Program Serves Only Children From Birth to Three Years of Age.
- 3. ___ Other age criteria. Please specify.

18.2. Health Status Criteria
- A. ___ Don't Know
- B. ___ No Health Status Criteria.
- C. ___ Child Must be Known to Have Been Exposed Prenatally to Either Alcohol or Other Drugs.
  - i. ___ Positive Toxicology Screen
  - ii. ___ History of Maternal Drug Use
  - iii. ___ Other. Please specify.
- D. ___ Child Must Have an Acute or Chronic Illness or Physical Disability
- E. ___ Child Must Be Developmentally Delayed or At Risk for Developmental Delay. How do you define *at risk*?
- F. ___ Other. Please specify.

18.3. Income Criteria
- 9. ___ Don't Know
- 1. ___ No Income Criteria
- 2. ___ Family income less than or equal to federal poverty guidelines [$9,435 for a family of 3]
- 3. ___ Family income is greater than the federal poverty guidelines. Please specify percentage of guidelines or dollar amount: _____% $_____
- 4. ___ Sliding Scale. Please specify.
- 5. ___ Other. Please specify.

18.4. Residency Criteria
- A. ___ Don't Know
- B. ___ No Residency Criteria Required.
- C. ___ Requires U.S. Citizenship or Permanent Residency for Child
- D. ___ Requires State Residency
- E. ___ Requires County Residency
- F. ___ Other. Please specify.

19.0. Are there any other eligibility criteria that we should know about that apply to children from birth to three?

___ Yes
___ No
___ Don't Know

19.1. If yes, please specify the criteria.

20.0. Are there any eligibility criteria that apply *specifically* for children aged 0 to 3 who have been exposed prenatally to alcohol and/or other drugs?

___ Yes
___ No
___ Don't Know

20.1. If yes, please specify the criteria.

21.0. To your knowledge do any of these *eligibility criteria* present barriers to these children's access to services?

___ Yes
___ No
___ Don't Know

21.1. If yes, please describe.

21.2. If no, why do you think this is so?

22.0. What is the *process* by which a child is determined to be eligible for services?

22.1. How long does it usually take for a child to become eligible for services?

1. ___ Days
2. ___ Weeks
3. ___ Months
9. ___ Don't Know

23.0. To your knowledge does the *eligibility process* present barriers to children who are applying for services?

___ Yes
___ No
___ Don't Know

23.1. If yes, please describe.

23.2. If no, why do you think this is so?

PART C: PROGRAM FUNDING

INTRODUCTION TO PART C:

The third part of our survey focuses on program funding. We would like to know the sources and amounts of your program's funding for FY 89-90.

ACTUAL FUNDING FY 1989-90

Source of Funding	Specific Name of Funding Source	Amount of Funding	How Funding Is Determined*	% of Funds
Federal				
State				
County				
Other				

*For example, population based formula or number of clients served.

Notes:

24.0. What is your program's actual budget for FY 1989-90?

25.0. What was appropriated for your program in your county budget for FY 1990-91?

PART D: AGENCY COORDINATION

INTRODUCTION TO PART D:

The fourth part of our survey focuses on the coordination of services for pregnant and/or postpartum women who use alcohol and/or other drugs and their drug-exposed children from birth to age three.

26.0. Does staff from your agency meet *formally* * with representatives from other county agencies and/or community programs specifically to coordinate services for pregnant and post-partum women and/or drug-exposed infants?

___ Yes
___ No
___ Don't Know

* i.e. meet regularly with other program staff or participation in such groups as interagency councils

26.1. If yes, with which agencies?

A. ___ County Alcohol and Drug
B. ___ Regional Center
C. ___ County Public Health
D. ___ County Social Services
E. ___ School Districts
F. ___ County Mental Health
G. ___ Other. Please specify.

26.2. What do you do (e.g., name a concrete product or outcome)?

26.3. How often do you meet?

1. ___ Monthly
2. ___ Quarterly
3. ___ Biannually
4. ___ Annually
5. ___ Other. Please specify.

26.4. Is this formal arrangement:

1. ___ Useful 2. ___ Somewhat Useful 3. ___ Not Very Useful 9. ___ Don't Know

26.5. In what ways is this arrangement _____? (As answered above).

27.0. Has your agency signed any interagency agreements pertaining to the coordination of services for pregnant and post-partum women and/or drug-exposed infants?

___ Yes
___ No

27.1. If yes, with which agencies?
- A. ___ County Alcohol and Drug
- B. ___ Regional Center
- C. ___ County Public Health
- D. ___ County Social Services
- E. ___ School Districts
- F. ___ County Mental Health
- G. ___ Other. Please specify.

28.0. Does staff from your agency meet *informally* with representatives from other county agencies and/or community programs specifically to coordinate services for pregnant and post-partum women and/or drug-exposed infants?
- ___ Yes
- ___ No
- ___ Don't Know

28.1. If yes, with which agencies do you meet?
- A. ___ County Alcohol and Drug
- B. ___ Regional Center
- C. ___ County Public Health
- D. ___ County Social Services
- E. ___ School Districts
- F. ___ County Mental Health
- G. ___ Other. Please specify.

28.2. What do you do (e.g., name a concrete product or outcome)?

28.3. Is this informal arrangement:

1. __ Useful 2. __ Somewhat Useful 3. __ Not Very Useful 9. __ Don't Know

28.4. In what ways is this arrangement _____? (As answered above.)

29.0. How successful do you think your coordination activities are?
1. ___ Very successful
2. ___ Somewhat successful
3. ___ Not very successful
4. ___ Not at all successful
9. ___ Don't Know

Why do you think this is so?

PART E: DATA COLLECTION

The final section of our survey focuses on data collection.

SECTION 1: PREGNANT AND/OR POST-PARTUM WOMEN WHO USE ALCOHOL AND/OR OTHER DRUGS

30.0. How many pregnant and postpartum women were served by your program in 1989-90?
_____ #
___ Don't Know

31.0. How many of these women served do you estimate used alcohol or other drugs during pregnancy?
_____ #
___ Don't Know

32.0. Does your program have a specifically designated number of service slots for pregnant and postpartum women who use alcohol and/or other drugs?
___ Yes
___ No
___ Don't Know

32.1. If yes, what is this number?
_____ #
___ Don't Know

33.0. If there is a discrepancy between the number of women eligible for services and the number of service slots, how do you determine who gets services?

34.0. Does your program have a waiting list?
___ Yes
___ No
___ Don't Know

34.1. If yes, what is the average number of women on a waiting list for these services at any given time?
_____#
___ Don't Know

34.2. What is the average amount of time a woman waits until she is able to receive services?
1. ___ No Waiting Time
2. ___ Number of Days
3. ___ Number of Weeks
4. ___ Number of Months
9. ___ Don't Know

34.3. In your opinion why do women have to wait this length of time before obtaining services?

34.4. What does a woman have to do to get her name on a waiting list for services?

34.5. How does she maintain her place on the waiting list?

35.0. Does your program use an estimate of the number of pregnant women in your county who use alcohol and/or other drugs for program planning or other purposes?
___ Yes
___ No
___ Don't Know

35.1. If yes, what is this number?

35.2. On what data is this figure based?

35.3. What drugs, including alcohol, are included in these data?

SECTION II: CHILDREN FROM BIRTH TO AGE THREE WHO HAVE BEEN EXPOSED PRENATALLY TO ALCOHOL AND/OR OTHER DRUGS

36.0. How many children from birth to age three were served by your program in 1989-90?
_____ #
___ Don't Know

37.0. How many of these children served do you estimate were exposed prenatally to alcohol and/or other drugs prenatally?
_____ #
___ Don't Know

38.0. Does your program have a specifically designated number of service slots for children aged birth to three who were exposed prenatally to alcohol and/or other drugs prenatally?
___ Yes
___ No
___ Don't Know

38.1. If yes, what is this number?
_____ #
___ Don't Know

39.0. If there is a discrepancy between the number of children eligible for services and the number of service slots, how do you determine who gets services?

40.0. Does your program have a waiting list?
___ Yes
___ No
___ Don't Know

40.1. If yes, what is the average number of children on a waiting list for these services at any given time?
___#
___ Don't Know

40.2. What is the average amount of time a child waits until he/she is able to receive services?
1. ___ No Waiting Time
2. ___ Number of Days
3. ___ Number of Weeks
4. ___ Number of Months
9. ___ Don't Know

40.3. In your opinion why do children have to wait this length of time before obtaining services?

40.4. What does a child's family have to do to get the child's name on a waiting list for services?

40.5. How does the child maintain a place on the waiting list?

41.0. Does your program use an estimate of the number of children in your county between birth and three who were exposed prenatally to alcohol and/or other drugs for program planning or other purposes?
___ Yes
___ No
___ Don't Know

41.1. If yes, what is this number?

41.2. On what data is this figure based?

41.3. What drugs, including alcohol, are included in these data?

QUESTIONS FOR COUNTY CHILD PROTECTIVE SERVICES

42.0 In your county in 1989 how many reports of abuse or neglect were filed for children aged 0 to 3?

_____ #

___ Don't Know (999)

43.0. In your county in 1989 how many reports of abuse or neglect as a result of maternal alcohol or drug use were filed for children aged 0 to 3?

_____ #

___ Don't Know (999)

44.0. In your county in 1989 how many children aged 0 to 3 were removed from their parents?

_____ #

___ Don't Know (999)

45.0. In your county in 1989 how many children aged 0 to 3 were removed from their mothers because of maternal alcohol/drug use?

_____ #

___ Don't Know (999)

45.1. What were the stated reasons for these children's removal (indicate all that apply):

A. ___ Don't Know
B. ___ Positive Tox Screen of Woman Before/After Delivery
C. ___ Positive Tox Screen of Newborn
D. ___ Mother's Believed Alcohol/Drug Use During Pregnancy
E. ___ Abuse/Neglect Related to Mother's Alcohol/Drug Use
F. ___ Other. Please specify:

45.2. Which of these is the *primary* reason for removal in your county?

9. ___ Don't Know
1. ___ Positive Tox Screen of Woman Before/After Delivery
2. ___ Positive Tox Screen of Newborn
3. ___ Mother's Believed Alcohol/Drug Use During Pregnancy
4. ___ Abuse/Neglect Related to Mother's Alcohol/Drug Use
5. ___ Other. Please specify.

46.0. In your county in 1989 how many dependency petitions were filed on children aged 0 to 3?

_____ #

___ Don't Know (999)

47.0. In your county in 1989 how many dependency petitions were filled on children aged 0 to three as a result of maternal alcohol and/or drug use?

_____ #

___ Don't Know (999)

47.1. What were the stated reasons for these petitions? (indicate all that apply):

A. ___ Don't Know
B. ___ Positive Tox Screen of Woman Before/After Delivery
C. ___ Positive Tox Screen of Newborn
D. ___ Mother's Believed Alcohol/Drug Use During Pregnancy
E. ___ Abuse/Neglect Related to Mother's Alcohol/Drug Use
F. ___ Other. Please specify:

47.2. How many of these petitions were sustained?

_____ #

___ Don't Know (999)

48.0. Does your county have a policy of automatic removal of a newborn believed to have been prenatally exposed to alcohol and/or other drugs?

___ Yes

___ No

___ Don't Know

48.1. If yes, what is the policy? **Please send a copy of your written policy.**

48.2. If no, what criteria are used to decide to remove a newborn believed to have been prenatally exposed to alcohol and/or other drugs? **Please send a copy of the criteria.**

mac/county survey
1/28/91

CENTER FOR THE VULNERABLE CHILD/YOUTH LAW CENTER

PERINATAL DRUG USE: AN ANALYSIS OF POLICIES AND PROGRAMS IN CALIFORNIA

SURVEY QUESTIONS REGARDING COMPREHENSIVE PERINATAL SERVICES PROGRAMS AND OTHER MCH SERVICES

1.0 What is the number of CPSP providers in your county?

_____ #
___ Don't Know

_____ #
999

2.0 What is the number of women who were served by CPSP in your county in 1989?

_____ #
___ Don't Know

_____ #
999

3.0 What is the number of women who were *eligible for* CPSP services but *not served* by the program in the last year for which you have data?

_____ #
___ Don't Know

_____ #
999

4.0 If there is a discrepancy between the number of women eligible for CPSP services and the number of service slots available, how is it determined who gets services?

5.0 Is there a waiting list for CPSP services in your county?

___ Yes
___ No
___ Don't Know

Y-1
N-0
DK-9

5.1 If Yes, what is the average number of women on a waiting list for these services at any given time?

_____ #
___ Don't Know

_____ #
999

5.2 What is the average amount of time a woman waits until she is able to receive CPSP services?

A.1. ___ No Waiting Time
2. ___ Number of Days
3. ___ Number of Weeks
4. ___ Number of Months
9. ___ Don't Know

B. _____ # of Days

A. 1
2
3
4
9

B. _____ #

5.3 In your opinion why do women have to wait this length of time before obtaining CPSP services?

5.4 What does a woman have to do to get her name on a waiting list for CPSP?

5.5 How does she maintain her place on the waiting list?

6.0 Do staff from County Maternal and Child Health meet with CPSP providers in your county to coordinate services for pregnant women who use alcohol and/or other drugs?

___ Yes
___ No
___ Don't Know

Y-1
N-0
DK-9

7.0 Does the County Maternal and Child Health Department use an estimate of the number of pregnant women in the county who use alcohol and/or other drugs (eg, for program planning or other purposes)?

___ Yes
___ No
___ Don't Know

Y-1
N-0
DK-9

7.1 If Yes, what is this number?

_____ #

_____ #

7.2 On what data is this figure based?

7.3 What drugs, including alcohol, are included in these data?

8.0 Does the County Maternal and Child Health Department use an estimate of the number of children in the county aged birth to three years who were exposed prenatally to alcohol and/or other drugs (eg, for program planning or other purposes)?

___ Yes
___ No
___ Don't Know

Y-1
N-0
DK-9

8.1 If Yes, what is this number?

_____ #

_____ #

8.2 On what data is this figure based?

8.3 What drugs, including alcohol, are included in these data?

9.0 Are there any services provided, funded, or administered by County Maternal and Child Health that are specifically targeted to pregnant and post-partum women who use alcohol and/or other drugs?

___ Yes
___ No
___ Don't Know

Y-1
N-0
DK-9

9.1 If Yes, what are these services?

9.2 How are these services funded?

9.3 What is the name and phone number of a contact person whom I can talk to about these services?

10.0 Are there any services provided, funded, or administered by County Maternal and Child Health that are specifically targeted to children aged birth to three years who were exposed prenatally to alcohol and/or other drugs?

___ Yes
___ No
___ Don't Know

Y-1
N-0
DK-9

10.1 If Yes, what are these services?

10.2 How are these services funded?

10.3 What is the name and phone number of a contact person whom I can talk to about these services?

11.0 Do public health nurses in your department make home visits or provide other services to pregnant or post-partum women who use alcohol and/or other drugs?

___ Yes Y-1
___ No N-0
___ Don't Know DK-9

11.1 If Yes, what services do public health nurses provide to these women?

12.0 Do public health nurses in your department make home visits or provide other services to children from birth to age three who were exposed prenatally to alcohol and/or other drugs?

___ Yes Y-1
___ No N-0
___ Don't Know DK-9

12.1 If Yes, what services do public health nurses provide to these children?

Name of Person Completing Survey:_____
_____
Title:_____
Department:_____
County:_____
Phone:_____
Date:_____

NOTES: