

APPENDIX C

- Perinatal Substance Abuse
Virginia Legal Requirement**
- Tobacco Use, Prevention and
Control**
- Fetal Alcohol Syndrome**

Substance Abuse Screening of All Pregnant Women (1992)

§ 54.1-2403.1. Protocol for certain medical history screening required.

A. As a routine component of every pregnant woman's prenatal care, every practitioner licensed pursuant to this subtitle who renders prenatal care, regardless of the site of such practice, shall establish and implement a medical history protocol for screening pregnant women for substance abuse to determine the need for a specific substance abuse evaluation. The medical history protocol shall include, but need not be limited to, a description of the screening device and shall address abuse of both legal and illegal substances. The medical history screening may be followed, as necessary and appropriate, with a thorough substance abuse evaluation.

B. The results of such medical history screening and of any specific substance abuse evaluation which may be conducted shall be confidential and, if the woman is enrolled in a treatment program operated by any facility receiving federal funds, shall only be released as provided in federal law and regulations. However, if the woman is not enrolled in a treatment program or is not enrolled in a program operated by a facility receiving federal funds, the results may only be released to the following persons:

1. The subject of the medical history screening or her legally authorized representative.
2. Any person designated in a written release signed by the subject of the medical history screening or her legally authorized representative.
3. Health care providers for the purposes of consultation or providing care and treatment to the person who was the subject of the medical history screening.

C. The results of the medical history screening required by this section or any specific substance abuse evaluation which may be conducted as part of the prenatal care shall not be admissible in any criminal proceeding.

D. Practitioners shall advise their patients of the results of the medical history screening and specific substance abuse evaluation, and shall provide such information to third-party payers as may be required for reimbursement of the costs of medical care. However, such information shall not be admissible in any criminal proceedings. Practitioners shall advise all pregnant women whose medical history screenings and specific substance abuse evaluations are positive for substance abuse of appropriate treatment and shall inform such women of the potential for poor birth outcomes from substance abuse.

Physician Referral of Suspected Substance Exposed Infants (1998)

§ 63.2-1509 Physicians, nurses, teachers, etc., to report certain injuries to children; penalty for failure to report.

A1. For purposes of subsection A, "reason to suspect that a child is abused or neglected" shall include (i) a finding made by an attending physician within seven days of a child's birth that the results of a blood or urine test conducted within forty-eight hours of the birth of the child indicate the presence of a controlled substance not prescribed for the mother by a physician; (ii) a finding by an attending physician made within forty-eight hours of a child's birth that the child was born dependent on a controlled substance which was not prescribed by a physician for the mother and has demonstrated withdrawal symptoms; (iii) a diagnosis by an attending physician made within seven days of a child's birth that the child has an illness, disease or condition which, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance which was

not prescribed by a physician for the mother or the child; or (iv) a diagnosis by an attending physician made within seven days of a child's birth that the child has fetal alcohol syndrome attributable to in utero exposure to alcohol. When "reason to suspect" is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report.

B. Any person required to file a report pursuant to this section who fails to do so within seventy-two hours of his first suspicion of child abuse or neglect shall be fined not more than \$500 for the first failure and for any subsequent failures not less than \$100 nor more than \$1,000.

Hospital Referral of Identified Substance Using Postpartum Women to Their Community Service Board (CSB) for Assessment and Services (1998)

§ 32.1-127 B 6 Regulations.

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan.

Tobacco Use, Prevention and Control

Treating Tobacco Use and Dependence is a Public Health Service sponsored Clinical Practice Guideline, which is the product of the Tobacco Use and Dependence Guideline Panel of consortium representatives, consultants, and staff. These guidelines are relevant to all tobacco users for the purpose of providing clinicians; public health professionals; tobacco dependence specialists; health care administrators, insurers, and purchasers; and tobacco users, with evidence-based recommendations regarding clinical and systems interventions that will increase the likelihood of successful quitting. The interventions suggested are used with men and women.

Women may face different stressors and barriers to quitting that may be addressed in treatment. Providers will need to consider factors such as depression, concerns for weight control, hormonal cycles and pregnancy to name a few. A recommendations for pregnant women because of the serious risks of smoking to the women and the fetus are the following: whenever possible pregnant smokers should be offered psychosocial interventions that exceed minimal advice to quit; offer effective smoking cessation interventions to pregnant smokers at the first prenatal visit and throughout the pregnancy; and consider pharmacotherapy for pregnant smokers who have been unable to quit using psychosocial interventions.

Cigarette smoking in pregnancy has been shown to cause adverse fetal outcomes, including stillbirths, spontaneous abortions, decreased fetal growth, premature births, low birth weight, placental abruption, sudden infant death, cleft palates, and cleft lips, and childhood cancers. The health care professionals can encourage a pregnant women motivated to quit by reinforcing the knowledge that cessation will reduce health risk for the fetus, newborn and her.

The first step is to assess for the use of tobacco. Health care providers should assess for tobacco use at each visit and intervene with those individuals who are willing to quit. The five major steps to interventions are the “5A’s”: Ask, Advise, Assess, Assist, and Arrange. These strategies are designed to be brief, requiring 3 minutes or less of direct clinicians’ time.

Reference :

U. S. Department of Health and Human Services, Public Health Service (2000). *Treating Tobacco Use and Dependence*, Rockville, MD.

Treating Tobacco Use and Dependence: PHS Clinical Practice Guideline

What is the PHS Clinical Practice Guideline?

Treating Tobacco Use and Dependence, a Public Health Service-sponsored Clinical Practice Guideline, is the result of an extraordinary partnership among Federal Government and nonprofit organizations comprised of the:

- Agency for Healthcare Research and Quality.
- Centers for Disease Control and Prevention.
- National Heart, Lung, and Blood Institute.
- National Institute on Drug Abuse.
- Robert Wood Johnson Foundation.
- University of Wisconsin Medical School's Center for Tobacco Research and Intervention.

"Progress in tobacco control has been recognized as one of the 10 greatest public health achievements of the century, but we still have a long way to go."

—Richard H. Carmona, MD, MPH, FACS
U.S. Surgeon General

It is the product of a 2-year effort by a panel of tobacco dependence experts, representatives from the sponsoring organizations, and professional staff. The panel employed an explicit science-based methodology and expert clinical judgment to develop recommendations on the successful treatment of tobacco use and dependence. The purpose of the guideline is to provide clinicians; public health professionals; tobacco dependence specialists; health care administrators, insurers, and purchasers; and tobacco users, with evidence-based recommendations regarding clinical and systems interventions that will increase the likelihood of successful quitting.

Internet Citation:

What is the PHS Clinical Practice Guideline? U.S. Public Health Service.
<http://www.surgeongeneral.gov/tobacco/whatisphs.htm>

Last Revised: April 23, 2004

Treating Tobacco Use and Dependence: PHS Clinical Practice Guideline

Developing a Successful System-Wide Tobacco Cessation Program—Clinicians

Clinicians

Physicians, pharmacists, nurses, physician's assistants, and other professions working with patients who use tobacco.

Clinicians should identify tobacco users at each visit and intervene with those individuals who are willing to quit (go to [Five Major Steps to Intervention \[The "5 A's"\]](#)). Tobacco users willing to make a quit attempt should receive both counseling and pharmacotherapy, except in the presence of special circumstances.

"In my view, a doctor isn't providing an appropriate standard of care for his or her patients if he or she doesn't ask two key questions —'Do you smoke?' and 'Do you want to quit?'—and then work with that individual to make it happen."

—Michael C. Fiore, MD, M.P.H., Director
Center for Tobacco Research and Intervention
University of Wisconsin Medical School

For patients not willing to make a quit attempt now, clinicians should motivate the patient to consider quitting (go to [Patients Not Ready To Make a Quit Attempt Now \[The "5 R's"\]](#)).

Because of the chronic nature of tobacco dependence, the guideline offers clinicians information on how to prevent relapse, especially in the first 3 months after cessation. All tobacco users have the potential to successfully quit, and every clinician should commit to delivering treatment that can help.

Internet Citation:

Developing a Successful System-Wide Tobacco Cessation Program—Clinicians. U.S. Public Health Service. <http://www.surgeongeneral.gov/tobacco/systemsclin.htm>

Recommended Protocol for Treating Tobacco Use and Dependence

Step 1: Office Environment

Establish an environment conducive to smoking/tobacco use cessation by:

- **SIGN(S):** Prominent display of no smoking sign (s)
- **POSTERS:** Use of posters that encourage cessation
- **MATERIALS:** Making patient education materials available in the lobby/exam rooms (including information on nicotine replacement products and medications)
- **MAGAZINES:** Providing magazines in the lobby that don't contain tobacco product ads

Step 2: Screen Patients

Identify every patient at every visit by:

- **ASK STATUS:** Asking about smoking/tobacco use (e.g., using vital signs sticker)
- **TAG CHARTS:** Identifying smoking/tobacco use status in/on chart in a prominent manner (e.g., using color-coded chart stickers, stamps) as a "reminder"
- **ASK READINESS:** Asking patient about readiness/willingness to quit
- **CHARTING:** Charting patient's smoking/tobacco use status and level of readiness to quit (e.g., using tobacco cessation progress record form)

Step 3: Intervene with Patients

Intervene at every visit with every patient who smokes/uses tobacco by:

- **ADVISE/MOTIVATE:** Providing advice appropriate to patient's level of readiness to quit (e.g., use the 5A's for those ready and the 5R's for those not ready)
- **MATERIALS:** Providing education materials relevant to the individual patient
- **REFERRALS:** Providing comprehensive referrals for those ready to quit (e.g., using the postcard and/or PHS handout for referral to: 1. Classes/Self-Help, 2. Support and 3. Pharmacotherapy)
- **FOLLOW-UP:** Providing follow-up when appropriate (e.g., when prescribing pharmacological adjuncts, referring to a cessation specialist)

Step 4: Track Progress

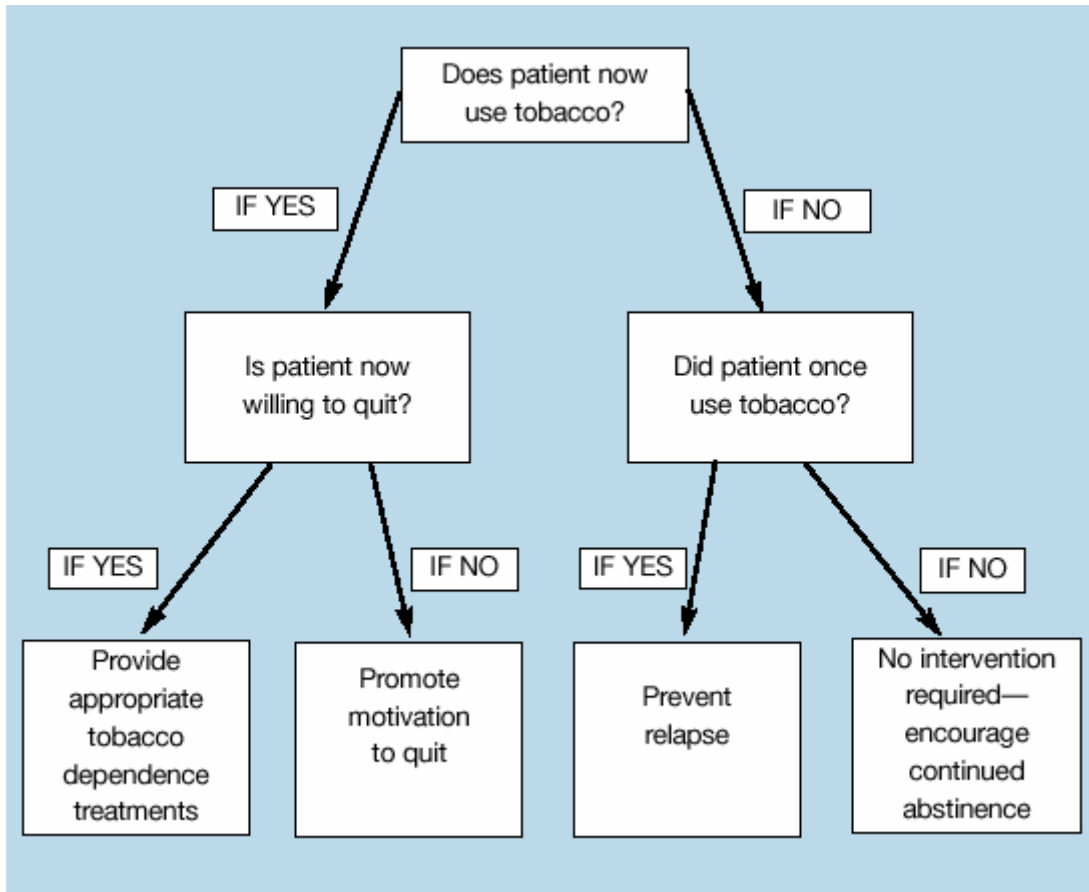
Monitor patient progress each visit by:

- **CHARTING:** Charting readiness to quit and type of assistance given (e.g., using tobacco cessation progress record form)

- **FOLLOW-UP:** Following up on patients who select a quit date (e.g., phone or office contact soon after patient's quit date)

Treating Tobacco Use and Dependence: PHS Clinical Practice Guideline

Screen for Tobacco Use Status



Recent surveys show that 25 percent of all adult Americans smoke.

Internet Citation:

Screen for Tobacco Use Status. U.S. Public Health Service.
<http://www.surgeongeneral.gov/tobacco/screen.htm>

Treating Tobacco Use and Dependence: PHS Clinical Practice Guideline

Five Major Steps to Intervention (The "5A's")

Successful intervention begins with identifying users and appropriate interventions based upon the patient's willingness to quit. The five major steps to intervention are the "5 A's": Ask, Advise, Assess, Assist, and Arrange.

Tobacco is the single greatest preventable cause of disease and premature death in America today.

"Starting today, every doctor, nurse, health plan, purchaser, and medical school in America should make treating tobacco dependence a top priority."

—David Satcher, MD, Ph.D.
Former U.S. Surgeon General
Director, National Center for Primary
Care, Morehouse School of Medicine

Ask

Identify and document tobacco use status for every patient at every visit. (You may wish to develop your own vital signs sticker, based on the sample below).

Advise

In a clear, strong, and personalized manner, urge every tobacco user to quit.

Assess

Is the tobacco user willing to make a quit attempt at this time?

Assist

For the patient willing to make a quit attempt, use counseling and pharmacotherapy to help him or her quit. (See Counseling Patients To Quit and pharmacotherapy information in this packet).

Arrange

Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date.

VITAL SIGNS

Blood Pressure: _____

Pulse: _____ **Weight:** _____

Temperature: _____

Respiratory Rate: _____

Tobacco Use: **Current** **Former** **Never** (*circle one*)

** Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.*

Internet Citation:

Five Major Steps to Intervention (The "5A's"). U.S. Public Health Service. Agency for Healthcare Research and Quality. Rockville, MD.
<http://www.ahrq.gov/clinic/tobacco/5steps.htm>

Treating Tobacco Use and Dependence: PHS Clinical Practice Guideline

Patients Not Ready To Make A Quit Attempt Now (The "5 R's")

Approximately 46 percent try to quit each year. Most try to quit "cold turkey." Of those, only about 5 percent succeed. Most smokers make several quit attempts before they successfully quit for good.

Patients not ready to make a quit attempt may respond to a motivational intervention. The clinician can motivate patients to consider a quit attempt with the "5 R's": Relevance, Risks, Rewards, Roadblocks, and Repetition.

Relevance

Encourage the patient to indicate why quitting is personally relevant.

Risks

Ask the patient to identify potential negative consequences of tobacco use.

Rewards

Ask the patient to identify potential benefits of stopping tobacco use.

Roadblocks

Ask the patient to identify barriers or impediments to quitting.

Repetition

The motivational intervention should be repeated every time an unmotivated patient has an interaction with a clinician. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

Internet Citation:

Patients Not Ready To Make A Quit Attempt Now (The "5 R's"). U.S. Public Health Service. Agency for Healthcare Research and Quality. Rockville, MD.
<http://www.ahrq.gov/clinic/tobacco/5rs.htm>

Treating Tobacco Use and Dependence: PHS Clinical Practice Guideline

Counseling Patients To Quit

Effective smoking cessation counseling can be divided into practical and supportive counseling advice.

Practical counseling advice (problemsolving/skills training)	Examples
Recognize danger situations. Identify events, internal states, or activities that increase the risk of smoking or relapse.	<ul style="list-style-type: none">• Negative affect.• Being around other smokers.• Drinking alcohol.• Experiencing urges.• Being under time pressure.
Develop coping skills. Identify and practice coping or problem-solving skills. Typically, these skills are intended to cope with danger situations.	<ul style="list-style-type: none">• Learning to anticipate and avoid temptation.• Learning cognitive strategies that will reduce negative moods.• Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure.• Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention).
Provide basic information. Provide basic information about smoking and successful quitting.	<ul style="list-style-type: none">• Any smoking (even a single puff) increases the likelihood of full relapse.• Withdrawal typically peaks within 1-3 weeks after quitting.• Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating.• Smoking is addictive.

Supportive counseling advice	Examples
Encourage the patient in the quit attempt.	<ul style="list-style-type: none"> • Communicate belief in the patient's ability to quit. • Note that effective tobacco dependence treatments are now available. • Note that half of all people who have ever smoked have now quit.
Communicate caring and concern.	<ul style="list-style-type: none"> • Ask how the patient feels about quitting. • Directly express concern and willingness to help. • Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings.
Encourage the patient to talk about the quitting process.	<p><i>Ask about:</i></p> <ul style="list-style-type: none"> • Reasons the patient wants to quit. • Concerns or worries about quitting. • Success the patient has achieved. • Difficulties encountered while quitting.

Internet Citation:

Counseling Patients To Quit. U.S. Public Health Service. Agency for Healthcare Research and Quality. Rockville, MD. <http://www.ahrq.gov/clinic/tobacco/counsel.htm>

Patients Who Have Recently Quit and/or Relapsed

"Anyone who has ever been addicted to nicotine recognizes that quitting tobacco use is among the most difficult challenges he or she will ever face."

"Each quit attempt makes the next one more successful than the last."

—Michael C. Fiore, M.D., M.P.H.
Director, Center for Tobacco Research and Intervention
University of Wisconsin Medical School

Patients who have recently quit tobacco use should be offered reinforcement in their decision to quit, a review of the benefits of quitting, and assistance in resolving problems arising from quitting. Because of the chronic relapsing nature of tobacco dependence, clinicians should provide brief relapse prevention treatment.

Although most relapse occurs early in the quitting process, some relapse occurs months or even years after the quit date. Prevention interventions can be delivered by clinic visits and telephone calls.

Internet Citation:

Patients Who Have Recently Quit and/or Relapsed. U.S. Public Health Service. Agency for Healthcare Research and Quality. Rockville, MD.
<http://www.ahrq.gov/clinic/tobacco/recent.htm>

Treating Tobacco Use and Dependence: PHS Clinical Practice Guideline

Pregnant Women

"Smoking during pregnancy is the single most preventable cause of premature birth and low birthweight babies."

—Cathy Melvin, Ph.D., M.P.H.
Chair, The National Partnership to Help Pregnant Smokers Quit

Many women are motivated to quit during pregnancy because of the risks to the woman and the fetus.

Clinicians can reinforce the understanding that cessation will reduce health risks.

Quitting tobacco use prior to conception or early in pregnancy is most beneficial, but health benefits result from abstinence at any time.

A pregnant tobacco user should receive encouragement and assistance throughout the pregnancy.

Pregnant tobacco users should be offered extended or augmented psychosocial interventions that exceed minimal advice to quit.

Thirty percent of pregnant smokers who quit start again after the baby is born.

Internet Citation:

Pregnant Women. U.S. Public Health Service. Agency for Healthcare Research and Quality. Rockville, MD. <http://www.ahrq.gov/clinic/tobacco/pregnant.htm>

Support and Advice From Your Prenatal Care Provider

Help for Pregnant Smokers

Now Is a Good Time to Quit for You and Your Baby

Both you and your baby benefit when you quit smoking. The benefits for both of you are explained below, as are the key steps to quitting successfully.

All information is based on scientific research about what will give you the best chances of quitting.

Good Things Happen as Soon as You Quit

For Your baby:

- Your baby will be healthier.
- Your baby will get more oxygen.
- Your baby will be less likely to be born too soon.
- Your baby will be more likely to come home from the hospital with you.
- Your baby will have fewer colds and ear infections.
- Your baby will cough and cry less.
- Your baby will have fewer asthma and wheezing problems.

For you:

- You will have more energy and breathe easier.
- You will save money that you can spend on other things.
- Your clothes, car, and home will smell better.
- Your skin and nails won't be stained, and you will have fewer wrinkles.
- Food will smell and taste better.
- You will feel good about quitting.

Keys for Quitting

1. Get Ready

- Think about how quitting will help you and your baby.
- Set a quit date and stick to it—not even a single puff!
- Get rid of ALL cigarettes and ashtrays in your home, car, or workplace. Make it hard to get a cigarette.
- Set up smoke-free areas in your home, and make your car smoke-free.

2. Get Support and Encouragement

- Tell your family, friends, and coworkers you are quitting and ask for their help.
- Ask smokers not to smoke around you.
- Talk to women who quit smoking when they were pregnant.
- Talk with your prenatal care provider about your plan to quit.

3. Learn New Skills and Behaviors

- Try to change some of your daily habits to lower your chances of smoking.
- Plan something fun to do every day.
- Practice new ways to relax.
- When you want to smoke, do something else: find a way to occupy your hands, your mouth, and your mind.
- Think about your reasons for quitting.

4. Be Prepared to Handle "Slips"

- If you "slip" and smoke, don't give up.
- People who quit after they "slip" tell themselves, "This was a mistake, not a failure."
- Set a new date to get back on track.
- Remember that by quitting, you are protecting your baby's health and your own.

Your Quit Plan

1. Your reasons to quit:

Your Quit Date: _____

2. Friends and Family Who Can Help You:

3. Skills and Behaviors You Can Use To Help You Quit:

4. Ways You Can Handle "Slips":

Your Prenatal Care Provider's

Name: _____

Telephone number: _____

Next appointment date: _____

Quitting smoking is one of the most important things you can do for you and your baby.

Follow up plan: _____

Other information: _____

Referral: _____

PNCP: _____ Date: _____

U.S. Department of Health and Human Services

Public Health Service

Smoke-Free Families

www.smokefreefamilies.org

A national program supported by The Robert Wood Johnson Foundation

Current as of March 2002

Internet Citation:

Help for Pregnant Smokers. Support and Advice from Your Prenatal Care Provider.

Consumer Tear Sheet, March 2002. U.S. Public Health Service. Agency for Healthcare Research and Quality. Rockville, MD. <http://www.ahrq.gov/clinic/tobacco/prenatal.htm>

Frequently Asked Questions about Quitting Smoking

Are you or someone you know trying to quit smoking? If so, the following information may help you. These 10 questions and answers are excerpted from a new consumer brochure by the U.S. Surgeon General.

Question: Why should I quit?

Answer: You will live longer and feel better. Quitting will lower your chances of having a heart attack, stroke, or cancer. The people you live with, especially children, will be healthier. If you are pregnant, you will improve your chances of having a healthy baby. And you will have extra money to spend on things other than cigarettes.

Question: What is the first thing I need to do once I've decided to quit?

Answer: You should set a quit date—the day when you will break free of your tobacco addiction. Then, consider visiting your doctor or other health care provider before the quit date. She or he can help by providing practical advice and information on the medication that is best for you.

Question: What medication would work best for me?

Answer: Different people do better with different methods. You have five choices of medications that are currently approved by the U.S. Food and Drug Administration:

- A non-nicotine pill (bupropion SR).
- Nicotine gum.
- A nicotine inhaler.
- A nicotine nasal spray.
- Nicotine patch.

The gum and patches are available at your local pharmacy, or you can ask your health care provider to write you a prescription for one of the other medications. The good news is that all five medications have been shown to be effective in helping smokers who are motivated to quit.

Question: How will I feel when I quit smoking? Will I gain weight?

Answer: Many smokers gain weight when they quit, but it is usually less than 10 pounds. Eat a healthy diet, stay active, and try not to let weight gain distract you from your main goal—quitting smoking. Some of the medications to help you quit may help delay weight gain.

Question: Some of my friends and family are smokers. What should I do when I'm with them?

Answer: Tell them that you are quitting, and ask them to assist you in this effort. Specifically, ask them not to smoke or leave cigarettes around you.

Question: What kinds of activities can I do when I feel the urge to smoke?

Answer: Talk with someone, go for a walk, drink water, or get busy with a task. Reduce your stress by taking a hot bath, exercising, or reading a book.

Question: How can I change my daily routine, which includes smoking a cigarette with my breakfast?

Answer: When you first try to quit, change your routine. Eat breakfast in a different place, and drink tea instead of coffee. Take a different route to work.

Question: I like to smoke when I have a drink. Do I have to give up both?

Answer: It's best to avoid drinking alcohol for the first 3 months after quitting because drinking lowers your chances of success at quitting. It helps to drink a lot of water and other nonalcoholic drinks when you are trying to quit.

Question: I've tried to quit before and it didn't work. What can I do?

Answer: Remember that most people have to try to quit at least 2 or 3 times before they are successful. Review your past attempts to quit. Think about what worked—and what didn't—and try to use your most successful strategies again.

Question: What should I do if I need more help?

Answer: Get individual, group, or telephone counseling. The more counseling you get, the better your chances are of quitting for good. Programs are given at local hospitals and health centers. Call your local health department for information about programs in your area. Also, talk with your doctor or other health care provider.

For More Information

To get a free print copy of the consumer brochure, *You Can Quit Smoking*, call any of the following toll-free numbers:

- Agency for Healthcare Research and Quality (AHRQ)
800-358-9295
- Centers for Disease Control and Prevention (CDC)
800-CDC-1311
- National Cancer Institute (NCI)
800-4-CANCER

More information on quitting is available online at the Surgeon General's Web site (<http://www.surgeongeneral.gov/tobacco>).

Current as of November 2000

Internet Citation:

Frequently Asked Questions about Quitting Smoking. November 2000. U.S. Public Health Service. <http://www.surgeongeneral.gov/tobacco/faq.htm>

Fetal Alcohol Syndrome (FAS) & Fetal Alcohol Effect (FAE)

Prenatal alcohol use is one of the leading preventable causes of birth defects and developmental disabilities. Drinking alcohol during pregnancy may cause Fetal Alcohol Syndrome, which is a lifelong, physical and mentally disabling condition. FAS is one of the most severe preventable causes of mental retardation and birth defects. Children exposed to alcohol during fetal development can suffer multiple disorders that range from subtle changes in I.Q. to profound mental retardation. They can also suffer growth retardation and be born with birth defects of major organ systems. FAS can contribute to problems with learning, memory, attention span, communication, vision, and/or hearing. FAS is 100% preventable, if a woman does not drink alcohol during her pregnancy. (CDC – National Center on Birth Defects and Developmental Disabilities, 2004)

Fetal Alcohol Effect (FAE) is used to describe children who have all of the diagnostic features of FAS, but are experiencing a milder or less severe clinical signs. In 1996, the Institute of Medicine replaced FAE with the terms alcohol-related birth defects (ARBD) and alcohol-related neurodevelopmental disorder (ARND), because not all babies exposed to alcohol develop the full syndrome. Children with FAS or ARND may have the following characteristics or exhibit the following behaviors:

- Small for gestational age or small in stature in relation to peers
- Facial abnormalities such as small eye openings
- Poor coordination
- Hyperactive behavior
- Learning disabilities
- Developmental disabilities
- Mental retardation or low IQ
- Problems with daily living
- Poor reasoning and judgment skills
- Sleep and sucking disturbances in infancy.

Psychiatric problems, criminal behavior, unemployment, and incomplete education occur frequently with children with FAS. Although there is no cure for FAS or ARND, children identified early and receive help early may perform better in school and with life. (CDC – National Center on Birth Defects and Developmental Disabilities, 2004)

References :

CDC - National Center on Birth Defects and Developmental Disabilities (2004). 13 April, Fetal Alcohol Information, Atlanta, GA.

Resources:

CDC

www.cdc.gov

March of Dimes, Virginia Chapter

VA474@marchofdimes.com

National Organization on Fetal Alcohol Syndrome
www.nofas.gov

U.S. Department of Health and Human Services
Center for Substance Abuse Prevention
www.samhsa.gov

Substance Abuse-Mental Health, CSBs

Healthy People 2010 indicates self-reported use of illicit drugs, such as cocaine and marijuana, is quite rare, with 98 percent of pregnant women reporting abstaining from these drugs. Unintentional alcohol exposure is particularly likely to occur early in pregnancy, before a woman knows she is pregnant. (Healthy People 2010) Tobacco, alcohol, and drug use can adversely affect pregnancy. Assessing substance abuse is a critical part of each prenatal care visit. Specific questions should be asked using a screening tool. Health care professionals have the basic skills to identify and refer women for treatment. (Gabbe et al.) Several tools are available. Information on screening for substance abuse can be found in "Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health", website www.ncemch.org/pubs/PDFs/SubAbuse.pdf.

The National Institute on Drug Abuse (NIDA) response to how a pregnant woman's abuse of drugs affects the fetus: "Many substances including alcohol, nicotine, and drugs of abuse can have negative effects on the developing fetus because they are transferred to the fetus across the placenta. For example, nicotine has been connected with premature birth and low birth weight as has the use of cocaine. Scientific studies have shown that babies born to marijuana users were shorter, weighed less, and had smaller head sizes than those born to mothers who did not use the drug. Smaller babies are more likely to develop health problems." (NIDA)

"Whether a baby's health problems, if caused by a drug, will continue as the child grows, is not always known. Research does show that children born to mothers who used marijuana regularly during pregnancy may have trouble concentrating, even when older. Our research continues to produce insights on the negative effects of drug use on the fetus." (NIDA)

Alcohol use in pregnancy is associated with fetal alcohol syndrome. This congenital syndrome is characterized by three findings: growth retardation, facial abnormalities, and central nervous system dysfunctions. Skeletal abnormalities and structural cardiac defects are also seen in the fetal alcohol syndrome, but it is the performance deficits that are most obvious. Decreased IQ, fine motor dysfunction, and hyperactivity are all common findings. (ACOG, 1994)

Cocaine use in pregnancy poses maternal as well as fetal hazards. Some of these stem from the intense vasoconstriction associated with cocaine (malignant hypertension, cardiac arrhythmias, and cerebral infarction). Cocaine has been associated with premature rupture of membranes, preterm labor and delivery, growth retardation, cognitive development delays, and placental abruption. There are also documented cases of in utero fetal cerebral infarction. (MacGregor, 1987)

Opiate addiction during pregnancy also poses serious risk to the mother as well as the fetus. Newborn infants of narcotic-addicted mothers are at risk for several complications, including the potentially fatal narcotic withdrawal syndrome. Withdrawal syndromes may

appear 24 hours after birth, but may be delayed as long as 10 days after birth. (Levy, 1993)

Resources:

March of Dimes, Virginia Chapter

VA474@marchofdimes.com

Substance Abuse and Addiction Recovery Alliance

www.saara.org

U.S. Department of Health and Human Services

Center for Substance Abuse Prevention

www.samhsa.gov

Virginia Department of Mental Health, Retardation and Substance Abuse Services

www.dmhmrzas.state.va.us