Healthy Infant Program: An Alternate Approach to Families of Drug-Exposed Infants

Mildred Thompson

Follow this and additional works at: https://scholarlycommons.henryford.com/hfhmedjournal

Part of the Life Sciences Commons, Medical Specialties Commons, and the Public Health Commons

Recommended Citation
Available at: https://scholarlycommons.henryford.com/hfhmedjournal/vol38/iss2/14

This Article is brought to you for free and open access by Henry Ford Health System Scholarly Commons. It has been accepted for inclusion in Henry Ford Hospital Medical Journal by an authorized editor of Henry Ford Health System Scholarly Commons.
Healthy Infant Program: An Alternate Approach to Families of Drug-Exposed Infants

Mildred Thompson*

The Healthy Infant Program at Highland Hospital in Oakland, CA, is primarily targeting women who deliver drug-exposed babies in this county hospital. Our team of workers, under the Public Health Service in Alameda County, is based at Highland Hospital and includes social workers, public health nurses, community outreach workers, substance abuse counselors, and psychologists. The program is funded through federal, state, and county funds. Our clients are identified in the hospital after the mothers have delivered babies who have a positive toxicology screen for cocaine, opiates, or amphetamines.

California does not have consistent regulations that apply if a woman delivers a drug-exposed baby. Many cities across the country have instituted various protocols or specific legal consequences. Because of the association between no prenatal care and positive toxicology screens, women who present without any prenatal care are automatically screened, and those who test positive are referred to our program.

Program Services

We contact these women as soon after delivery as possible; a worker is by their side within 24 hours of delivery. We try to approach them in a nonthreatening way; we offer our services and solicit their cooperation. If a woman does not want our assistance, we explain the alternative that Child Protective Services (CPS) will become more actively involved if we do not. Because many of the women know that CPS, which is often overburdened, will not do much, the threat is often ineffective. However, we use it in an attempt to motivate these women while they are removed from their environment.

We assist mothers in obtaining whatever services they need to ensure that their babies will have a healthy first year of life and to reduce the risk of developmental, medical, and social problems. We follow families for one year and in some instances extend the care to two years. We assist with transportation, in finding community resources, and in obtaining health care in their neighborhood or in clinics at the hospital. Initially, we may assist them in actually scheduling medical appointments; later, we encourage them to do this on their own. We also refer the families to entitlement programs. Many of the women are not aware that they are eligible for certain benefits. We refer them to Women, Infant and Children—a federal program which provides nutritional education and vouchers for milk, juice, cereal, and cheese for pregnant and postpartum women and their children—and to MediCal. We do not fill out the forms for them, but we try to reduce the frustration inherent in applying for such benefits by helping them to be better prepared when they go for their appointment. These clients often become frustrated easily; their coping mechanisms may not be the same as ours. Our challenge is to accept them as they are but begin to instill in them an awareness of the need for follow-up services.

We ask mothers why they did not come for prenatal care. Whatever barriers were encountered must not prevent the baby from getting needed care. Our primary focus is to ensure the health of that baby for the first year of life.

Funding Sources

The Healthy Infant Program is funded through Child Health and Disability Prevention (CHDP), which is a state arm of the federal program called Early Periodic Diagnostic and Screening Program. Other communities may be eligible to receive those kinds of funds.

Our program is the first of its kind in the country to use the money in this manner. Initial resistance gave way to the benefit of getting well-child care for the children. CHDP provides 75% of our funding, and the remainder is provided by the county. Alameda County, as in most urban cities, has a serious problem in infant mortality. Because the rates were beginning to increase, a special fund was set aside to attack the problem. Our program was funded because we were trying to reduce infant mortality in a population of high-risk infants.

The program has been operational for one and a half years. Initially we thought we could serve every woman at the hospital who screened positive for drugs, but we have not reduced the magnitude of the problem. In 1988, 17% of all infants born at the hospital were drug-exposed. In the first six months of 1989 the number had risen to 23%. These are only deliveries of mothers

*Program Director, Healthy Infant Program, Alameda County, Oakland, CA. Address correspondence to Ms. Thompson, Healthy Infant Program, Highland Hospital, 1411 East 31st Street, Oakland, CA 94602.
who had no prenatal care. Obviously there may well be women using drugs who had prenatal care and thus were not identified. We have our hands full.

**Client Evaluation**

To begin our evaluation, we establish contact with the mother. We try to determine how prepared she is for the baby and begin a psychosocial assessment at the same time. We evaluate how well she is bonding with her baby and get a sense of her support network to find out whether she has someone to help her, a place to go, and adequate housing. We try to determine whether this mother should leave the hospital with her baby.

In Alameda County, a drug-exposed baby is not sufficient reason for the infant to be removed from the mother nor for a referral to CPS. There has to be additional risk factors, which may be social as well as medical.

We see few teenagers in our program. Ours is a county hospital that provides services to people who are uninsured and have limited choices. Our typical mother is about 26 years old and already has children. With the need for crack cocaine, very often there is an exchange of sex for drugs, and having babies is totally unplanned. Many of the women are married and their partners also use drugs. Accordingly, we have to involve the whole family, not just work with this mother alone and send her back to the same environment.

When the mother can take her baby home, we make every effort to help her keep her baby at home. To further this effort, we created several support groups at our hospital; the parent support group, grandparents support group, and cocaine anonymous groups meet once a week. The response has been surprisingly good. We are seeking legislative action to have grandparents compensated in the same way as foster parents; normally supportive relatives do not receive much assistance.

It is essential to coordinate our program with other services and other hospitals. One of our workers is stationed at Children's Hospital in Oakland because we learned that many babies were transferred there from our hospital. Children's Hospital is our tertiary care facility in Oakland for seriously ill babies. Our worker there provides the same kind of support services that are in place at Highland Hospital, but services are focused on drug-exposed babies with more acute medical problems.

Three to four days after the mother has been discharged, workers visit the home and carry out the second stage of the enrollment process, assessing the home, the mother's support system, and the general environment where the baby will be living. Thereafter they make at least monthly contact with families but many times are involved much more frequently.

We want to be seen as a resource for our clients and are gratified when they call us. Sometimes the women are not initially receptive; this is a population that's very suspicious. Training is essential. Our staff try to establish a trusting relationship with the mother who must believe that it really will be beneficial to become involved with our program.

**Follow-up Services**

With our primary funding, we are allowed to provide only those services aimed to guarantee the child having well-child medical visits. For other services we have sought different funding sources and now have about eight different funders. Accordingly, we now can work not only to get the babies in for care but also to talk to the mothers about dealing with their drug problem and parenting. Because a major corporation provides us funding for family planning, we are able to schedule the infants' appointments for the pediatric provider and also the mothers' appointments for a family planning provider. We call the providers to ensure that the family is receiving such services.

Another grant underwrites parenting classes separate from the parent support groups. In parenting classes the curriculum involves proper disciplining and alternative ways of parenting. Our clients often need help in basic lifestyle practices, money management, and job skills training.

If we can find a way to improve people's self-esteem, there may be a decrease in the need for drugs or in the need to escape reality. We attempt to build peer support among the parent support groups but must be very careful to avoid pairs who might end up using drugs together since many of the women still use drugs.

For several reasons we do not emphasize drug treatment at this point in our program. Most importantly, our funding sources do not support it. Moreover there is a lack of adequate treatment facilities in our area. Money to fund our program was not easy to come by. It took a lot of lobbying, but slowly we've had a response from the government. The state of California's Maternal and Child Health Division allocated $1.4 million and appointed a statewide task force to deal specifically with the issue of black infant mortality.

We can do much to affect this serious issue.