HOPE Advisory Council Meeting

Act 88 of 2017 Legislative Session: Advisory Council on **H**eroin and **O**pioid **P**revention and **E**ducation

July 10, 2025

LOUISIANA DEPARTMENT OF HEALTH

Time	Agenda
9:00 AM - 9:05 AM (5 min)	**1. Call to Order** **2. Roll Call** **3. Introduction/Welcome New Members** **4. Review and Approval of July 10, 2025 Agenda** **5. Approval of April 2025 Minutes**
9:05 AM - 10:05 AM (60 min)	**6. Presentations:** a. Substance Use and Use Disorder in Pregnancy and Parenting b. Kratom: A Primer c. Project M.O.M
10:05 AM - 10:50 AM (45 min)	**7. General Updates** a. Office of Behavioral Health • Louisiana Crisis Response System • Compassionate Overdose Response and Related Recommendations b. Community Impact Group – New Lead c. Healthcare Impact Group d. Public Safety Impact Group e. Other Updates
10:50 AM -10:55 AM (5 min)	**8. HOPE 2024 Year End Report Update**
10:50 AM - 10:55 AM (5 min)	**9. Public Comments**
10:55 AM - 11:00 AM (5 min)	**10. Discussion & Next Steps** *a. Impact Workgroups:* HOPE@LA.GOV *b. Next Meeting:* Thursday, October 9th **Bienville Building Room 118**
11:00 AM	**11. Adjourn** ***Future HOPE Council Meetings***: Thursday, October 9th Thursday, January 29th

Welcome

Review

Discussion

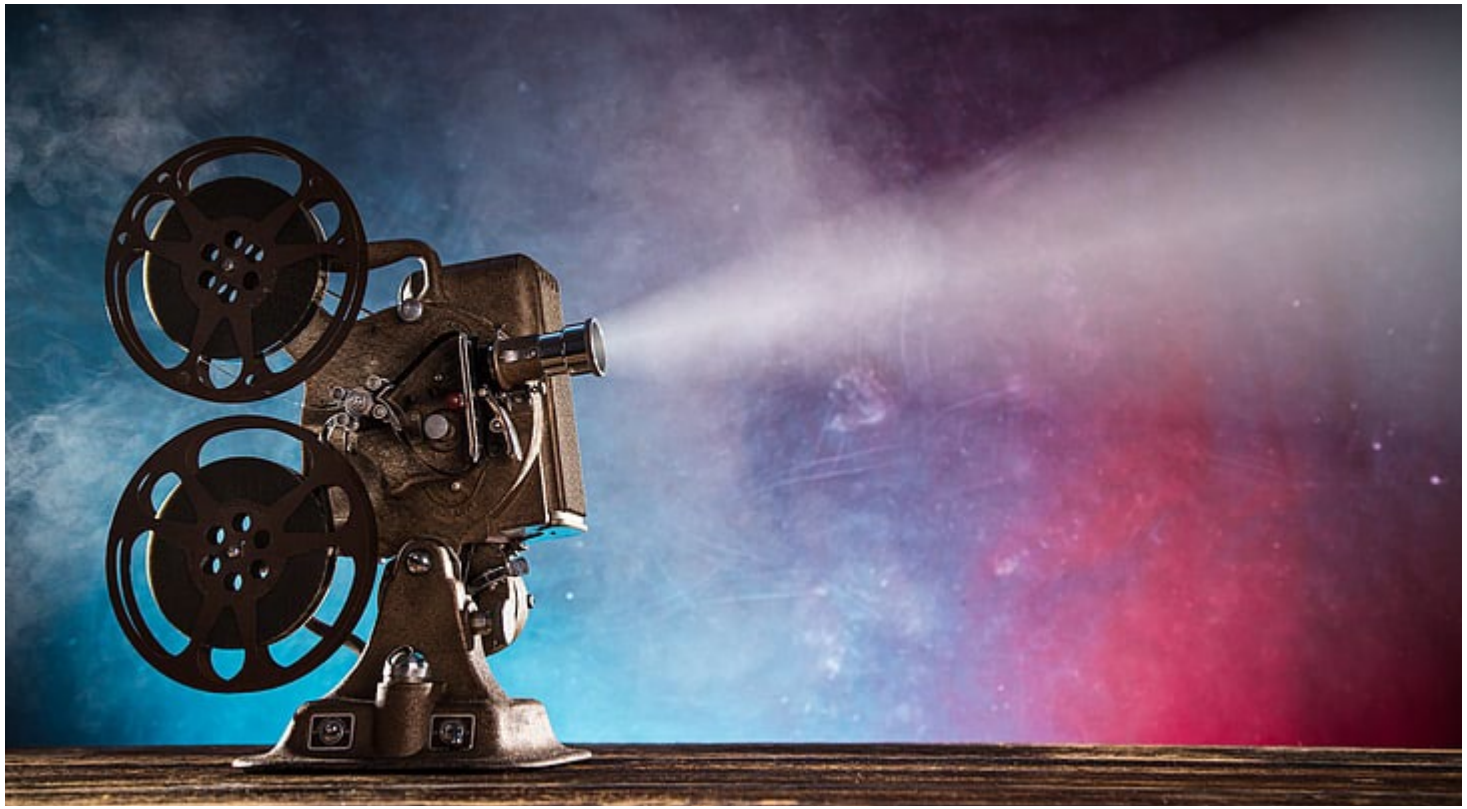
Next Steps / Adjournment

LOUISIANA DEPARTMENT OF HEALTH

HOPE Council Members

- **Chair:** Dr. Vanessa de la Cruz, Office of Behavioral Health
- Dr. Allison Smith, Program Administrator, Board of Regents
- Etrena Gerard, DCFS Child Protective Services Program Manager
- Susan Dupont, Dept. of Education Healthy Communities Section Leader
- Shelly B. Edgerton, Dept. of Public Safety and Corrections
- Lieutenant William Bosworth, Superintendent of State Police designee
- Ronald Callegari, RN Program Manager, Veterans Affairs
- Dr. Jason Picard, Louisiana Workforce Commission designee
- Senator Regina Barrow, President of Senate designee: District 15
- Troy Prevot, Speaker of the House designee
- Vacant, Louisiana Attorney General's Office
- Crystal Lewis, Commissioner of Insurance designee
- Juan Pickett, Judge from Drug Court

Presentations



Substance Use and Use Disorder in Pregnancy and Parenting

Mishka Terplan MD MPH
Medical Director, Friends Research Institute
Substance Use Warmline Clinician, UCSF

FRI FRIENDS RESEARCH INSTITUTE
Advancing research to promote health and well-being

Why would a pregnant person use drugs?

Drug Use is Common and Not everyone who uses drugs becomes addicted

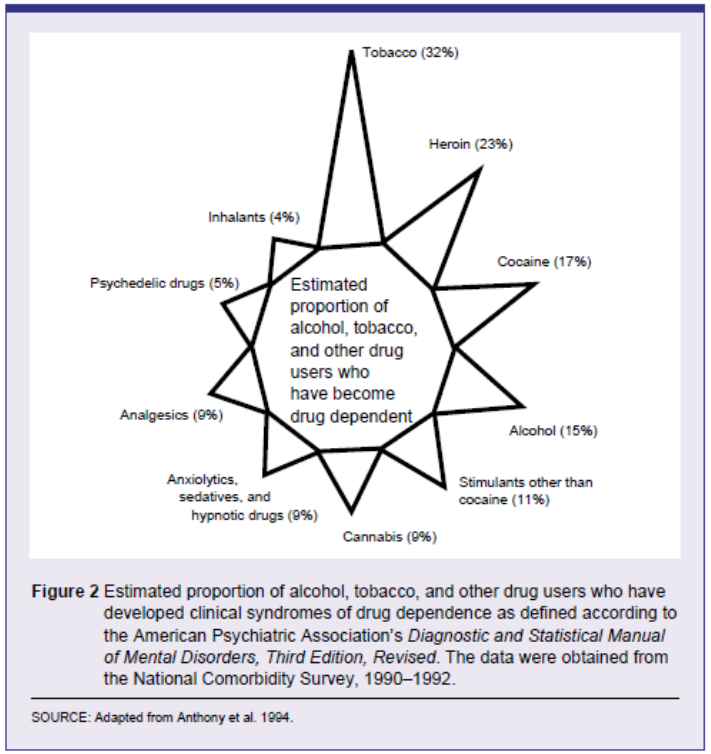
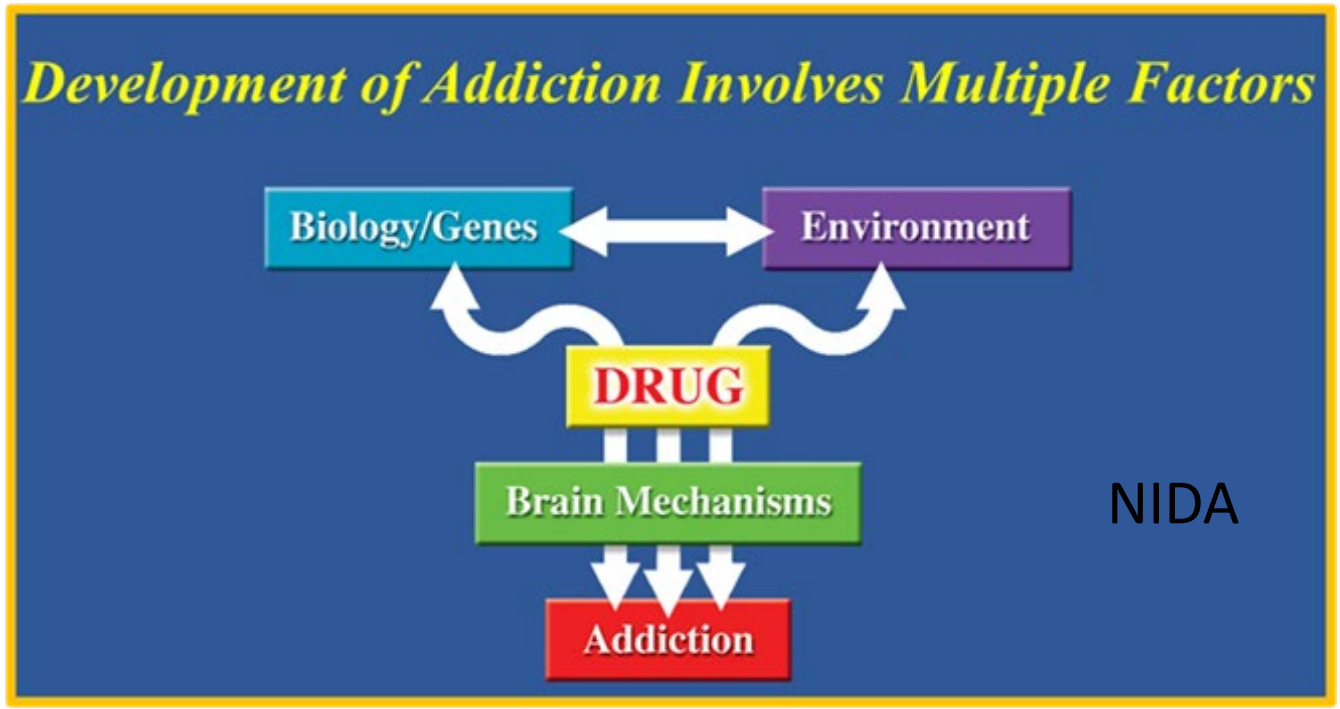


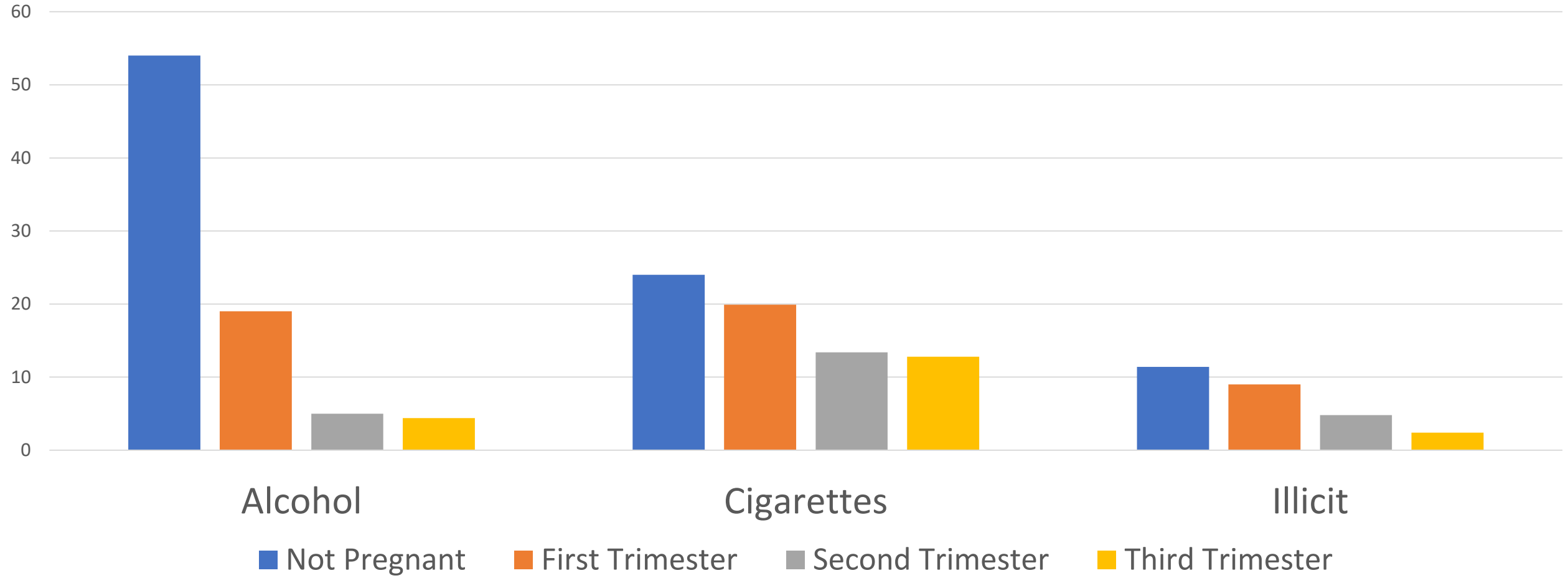
Figure 2 Estimated proportion of alcohol, tobacco, and other drug users who have developed clinical syndromes of drug dependence as defined according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised*. The data were obtained from the National Comorbidity Survey, 1990–1992.

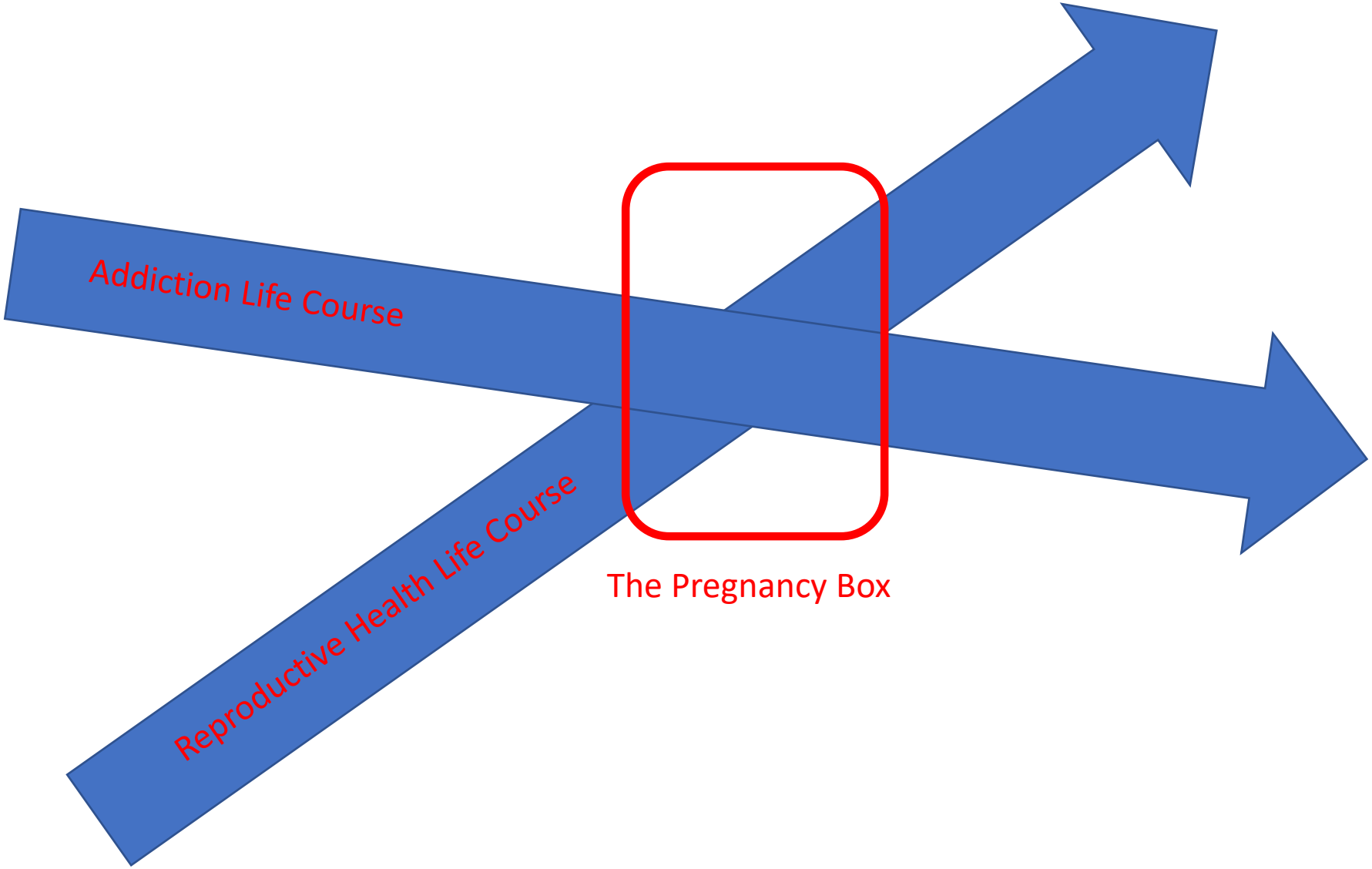
SOURCE: Adapted from Anthony et al. 1994.



NIDA

What happens when people who use drugs get pregnant?




Addiction Life Course
Reproductive Health Life Course
The Pregnancy Box

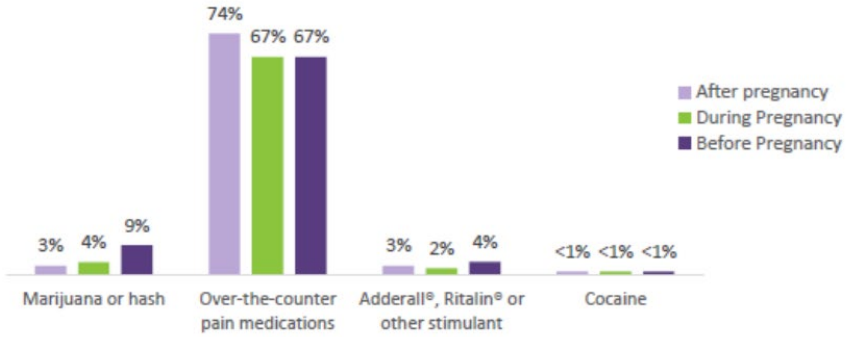
Maternal Drug & Alcohol Use

LOUISIANA PRAMS
Your voice. Your baby's voice.

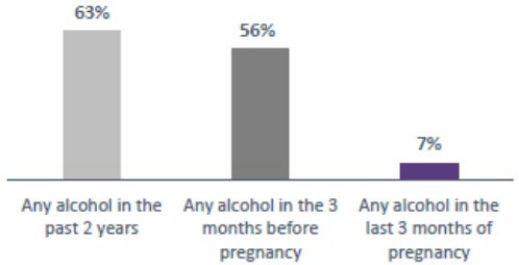
Drinking alcohol during pregnancy can cause miscarriage, stillbirth, and a range of physical, behavioral, and intellectual disabilities (CDC, 2022).
In general, drugs and pharmaceuticals should not be used during pregnancy without the guidance and approval of a medical professional, as they can cause preterm birth, miscarriage, low birthweight, heart defects, and neonatal abstinence syndrome (NAS) (CDC, 2023).

67% of women used over-the-counter (OTC) pain relievers such as aspirin, Tylenol®, Advil®, or Aleve® during pregnancy. Women should talk to their health provider before taking OTC medicines (March of Dimes, 2020).
Not all OTC medicines are safe to use during pregnancy.

Mother's use of over-the-counter, prescription, and illegal drugs before, during, and after pregnancy



Women's alcohol consumption before and during pregnancy



78% of mothers who reported drinking during pregnancy consumed less than one drink per week

Snapshot of Pregnancy-Associated Deaths

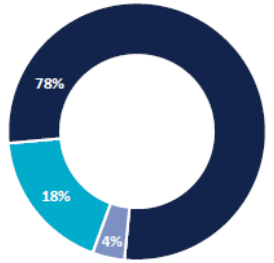
In 2020, Louisiana had 82 confirmed pregnancy-associated deaths. This represents a pregnancy-associated mortality ratio of 143.3 deaths per 100,000 births.

BREAKDOWN OF PREGNANCY-RELATEDNESS

Of the 82 deaths reviewed, the committee determined:

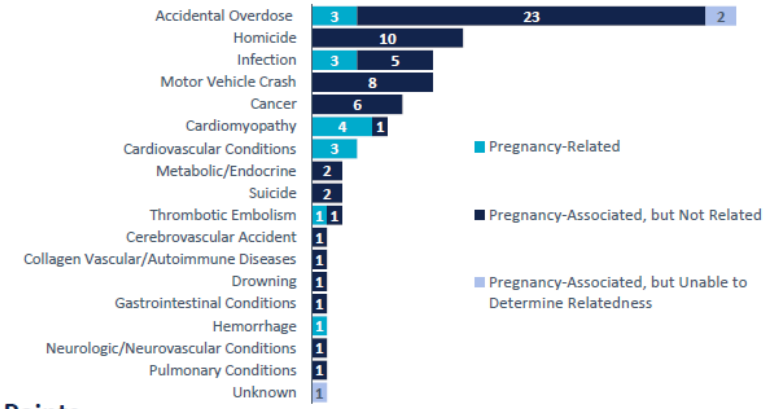
- 15 deaths (18%*) were classified as pregnancy-related.
- **64** deaths (78%) were classified as **pregnancy-associated, but not related.**
- 3 deaths (4%*) were classified as pregnancy-associated, but the committee was unable to determine relatedness.

*Percentages based on counts fewer than 20 are considered unstable and should be interpreted with caution.



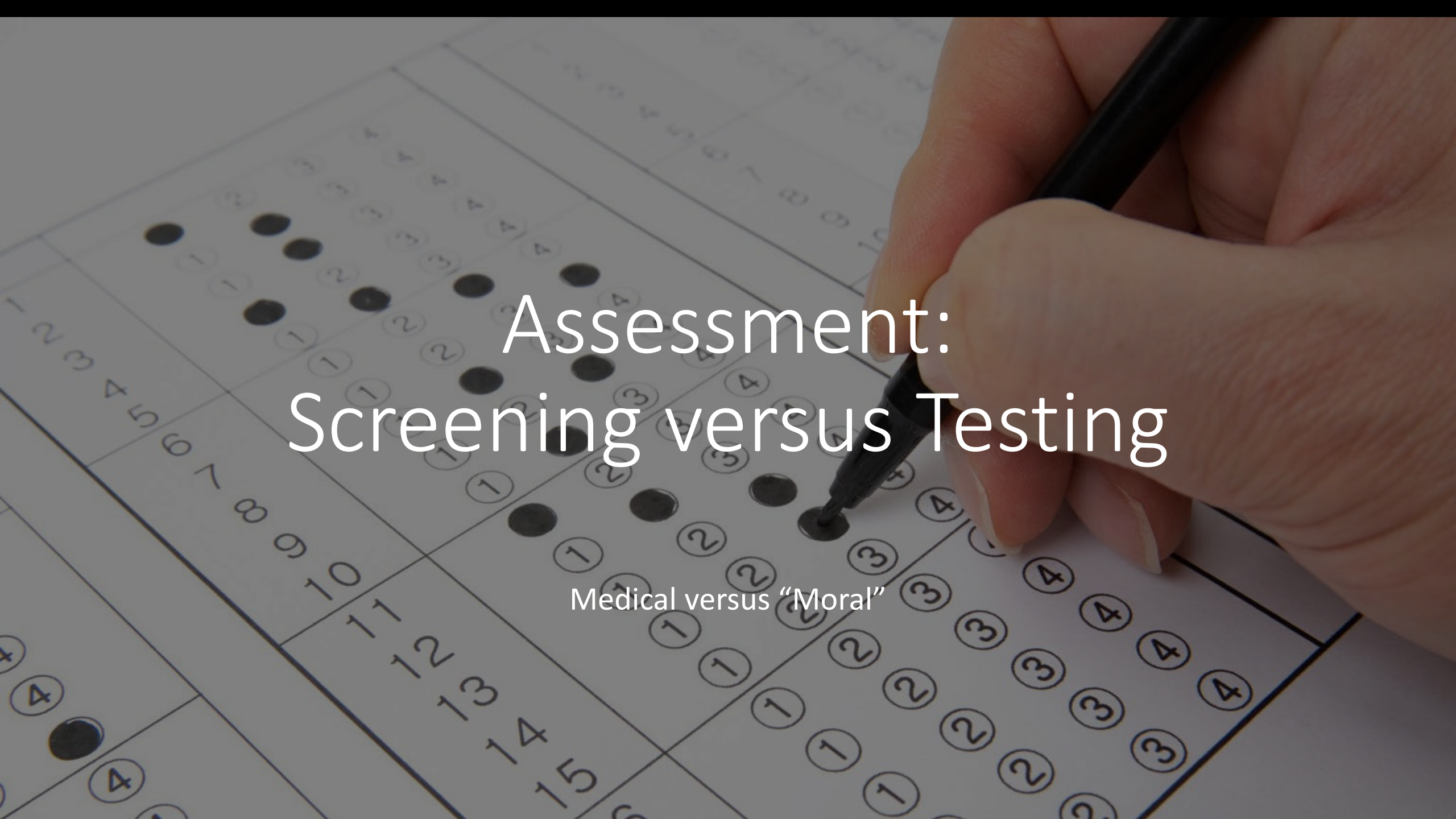
CAUSES OF DEATH

Pregnancy-Associated Deaths by Relatedness and Cause of Death as Determined by the Committee:



Key Points

- The leading causes of pregnancy-associated deaths were accidental overdose (34%) and homicide (12%).
- ***Pregnancy-associated, but not related*** deaths accounted for the majority of deaths (78%).
- Nearly 1 in 5 (18%*) deaths were determined to be ***pregnancy-related***, with cardiomyopathy being the leading cause.



Assessment: Screening versus Testing

Medical versus “Moral”

Screening vs. Testing Professional Society Recommendations

Universal Screening:

Recommended (ACOG, ASAM, SMFM, AAP, SAMHSA, CDC)

- Voluntary (ACOG, SAMHSA, CDC)

Testing:

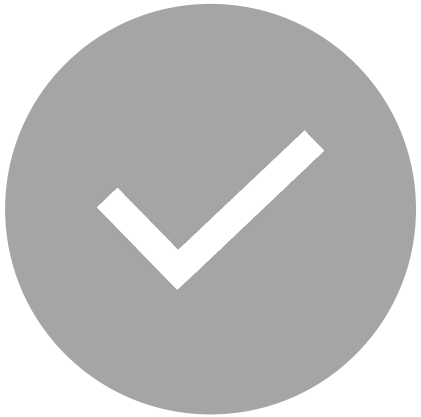
Drug Test NOT an Assessment of Addiction
Positive Drug Test NOT sign of health or ill health
Positive Drug Test NOT evidence of harm
Positive Drug Test NOT criteria for discharge
(ACOG, ASAM, SAMHSA, CDC, AAP)

ASAM: Definitive testing required “when the results inform decisions with major clinical or non-clinical implications for the patient”

- Consent required (ACOG, ASAM, SMFM, SAMHSA)

Clinical Pathway

SCREEN



DIAGNOSE

TREAT

Matern Child Health J (2017) 21:893–902
DOI 10.1007/s10995-016-2190-y

The Prevalence and Impact of Substance Use Disorder and Treatment on Maternal Obstetric Experiences and Birth Outcomes Among Singleton Deliveries in Massachusetts

Milton Kotelchuck[1] · Erika R. Cheng[2] · Candice Belanoff[3] · Howard J. Cabral[3] · Hermik Babakhanlou-Chase[4] · Taletha M. Derrington[5] · Hafsatou Diop[6] · Stephen R. Evans[3] · Judith Bernstein[3]

Core Principle of Prenatal Care:

Optimize maternal health via chronic disease management

	No Addiction	Treated Addiction	Untreated Addiction
Preterm Birth	8.7%	10.1%	19.0%
Low Birthweight	5.5%	7.8%	18.0
Fetal Death	0.4%	0.5%	0.8%
Neonatal Mortality	0.4%	0.4%	1.2%
Post Neonatal Mortality	0.05%	0.03%	0.1%

Most People Receive no Treatment in Pregnancy

Table 3
Past year substance use disorder treatment receipt among reproductive age women in need of treatment.

Substance use disorder diagnosis	Total[a]	Not pregnant nor parenting	Pregnant[†]			Parenting	P values[‡]
			1st trimester	2nd trimester	3rd trimester		
Any past year substance use disorder	9.3% (8.4–10.2)	8.8% (7.7–9.8)	12.8% (8.7–16.9)			9.9% (8.5–11.4)	0.063
treatment need[§]			12.5% (7.3–17.7)	9.4% (4.7–14.0)	18.7% (5.5–32.0)		0.246
Alcohol use disorder	7.4% (6.6–8.3)	6.8% (5.9–7.7)	11.8% (7.2–16.5)			8.2% (6.6–9.9)	0.021
			11.7% (5.8–17.6)	9.0% (3.3–14.7)	16.2% (2.6–29.9)		0.505
Illicit drug use disorder[‖]	17.1% (15.5–18.7)	17.0% (14.8–19.2)	21.8% (13.9–29.6)			16.5% (13.7–19.3)	0.439
			26.0% (15.1–36.8)	13.2% (5.1–21.3)	29.2% (8.5–49.9)		0.187
Opioid use disorder[¶]	23.6% (18.9–28.2)	31.1% (27.0–35.1)	34.7% (20.7–48.7)			23.6% (18.9–28.2)	0.033
			54.2% (30.2–78.1)	20.0% (3.5–36.5)	31.1% (0.0–63.7)		0.152

Martin, 2020, DAD

Only half of pregnant people in specialty addiction treatment for OUD receive medication

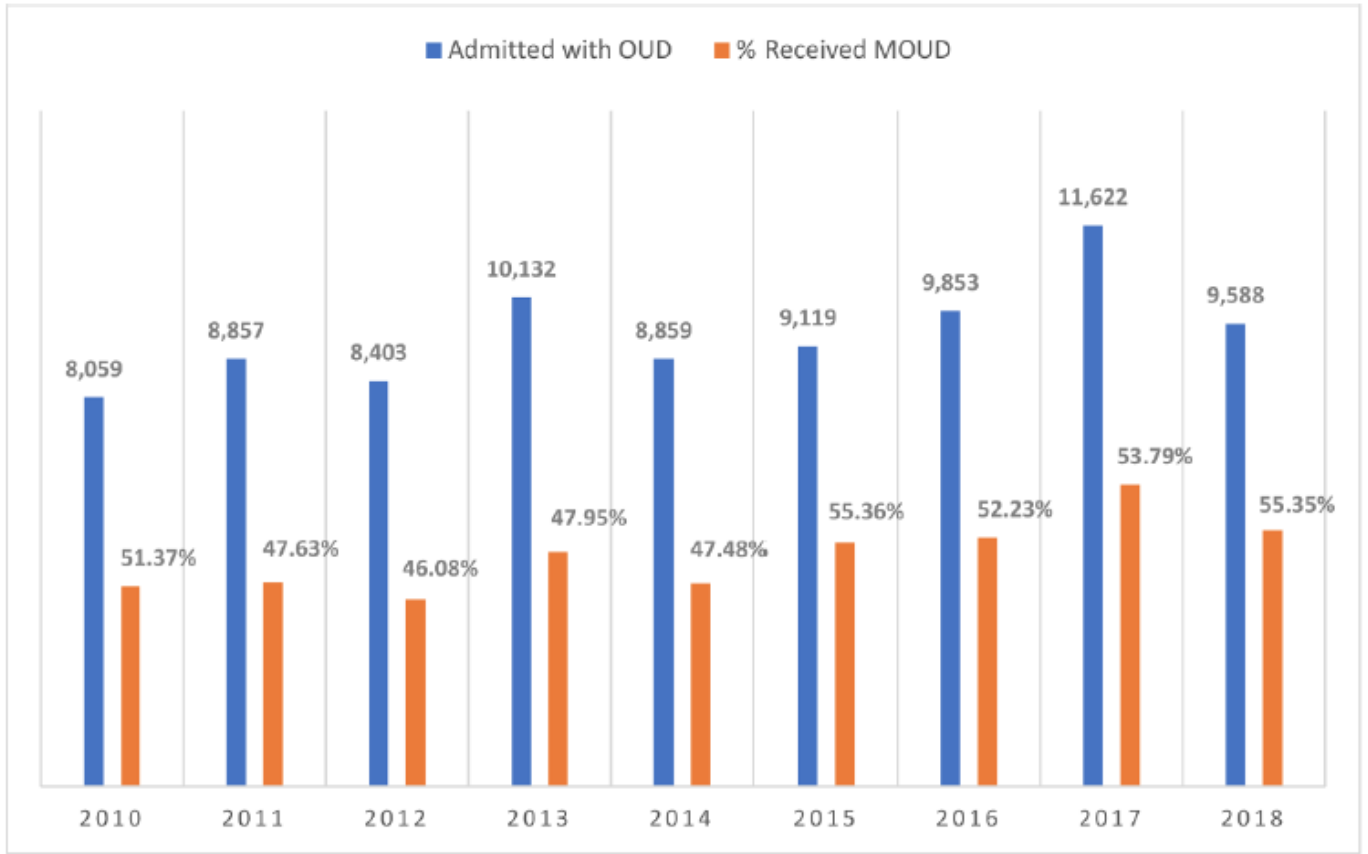
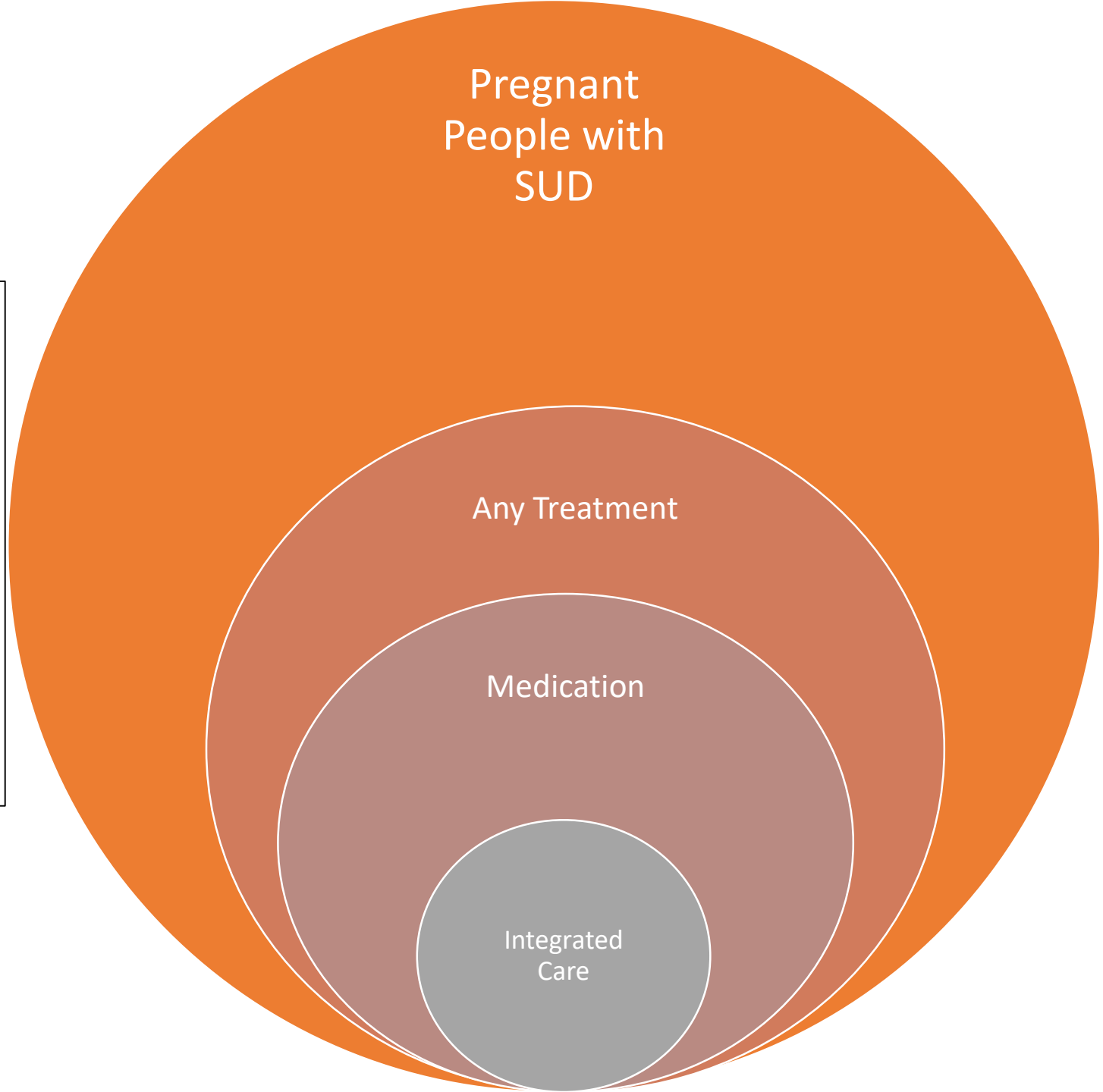


Fig. 1. Number of admissions of pregnant people experiencing OUD and percent (%) that received medication for OUD.

Comprehensive treatment and medication are rare and unavailable for most pregnant people with SUD



Stigma and the legitimate fear of child welfare are significant barriers to care

The Perception of Punishment Impacts Care

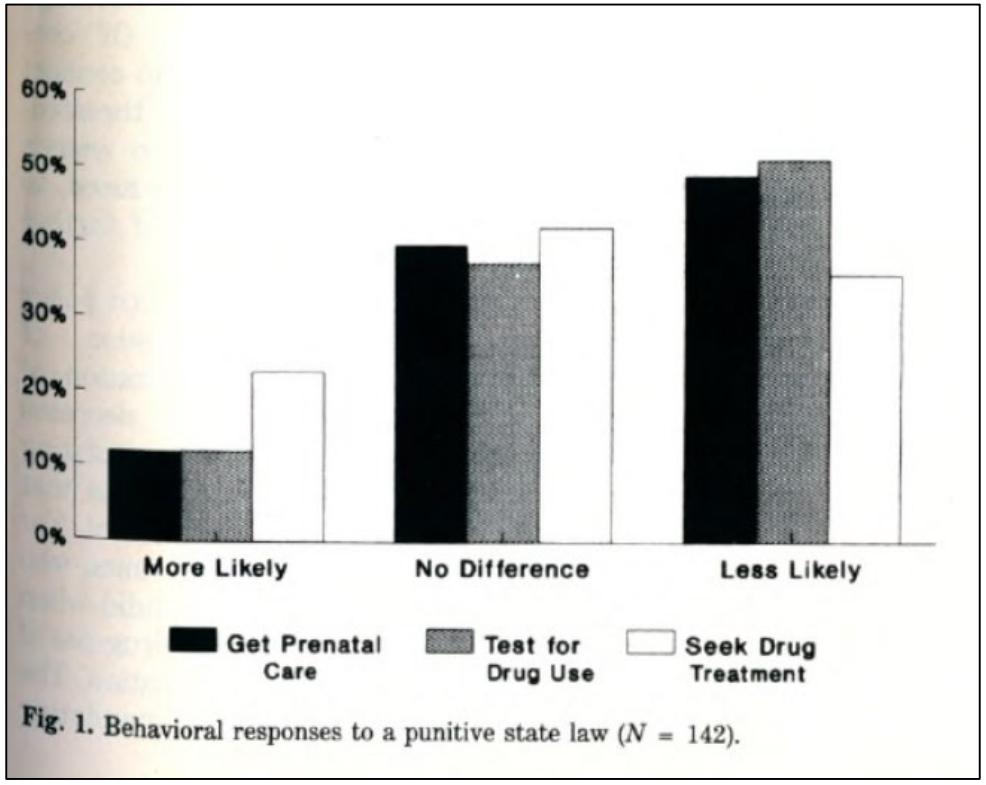


Fig. 1. Behavioral responses to a punitive state law (N = 142).

Drug and Alcohol Dependence, 31 (1993) 199–203
Elsevier Scientific Publishers Ireland Ltd.

Punishing pregnant drug users: enhancing the flight from care

Marilyn L. Poland[a], Mitchell P. Dombrowski[a], Joel W. Ager[b] and Robert J. Sokol[a]

[a]*Department of Obstetrics/Gynecology and* [b]*Department of Psychology, Wayne State University, 4707 St. Antoine, Detroit, MI 48201 (USA)*

(Accepted May 29, 1992)

One hundred forty-two low income women were interviewed postpartum to determine their attitudes regarding the potential effects of a punitive law on the behavior of substance-using pregnant women. The convenience sample was primarily black (85.2%) and single (81%) and 14.8% admitted use of illicit drugs during pregnancy. A goodness-of-fit chi-square analysis revealed that subjects believed a punitive law would be a significant deterrent to substance-using gravida seeking prenatal care, drug testing or drug treatment ($P < 0.01$). Comments indicated that substance-using pregnant women would 'go underground' to avoid detection and treatment for fear of incarceration and loss of their children.

Key words: pregnancy; substance use; incarceration

State Policies on Drugs and Pregnancy have Increased and are Increasingly Punitive

Punitive Policies Associated with:

- No Improvement in Birth Outcomes
- Increased Odds of Neonatal Abstinence Syndrome
- Increased Odds of Low Birth Weight
- Increased Odds of Preterm Delivery
- Decreased Odds of any Prenatal Care
- Decreased Odds of APGAR 7+

Mandatory Reporting Does Not Improve Population Health Outcomes

FAHERTY, ET AL., *ASSOCIATION BETWEEN PUNITIVE POLICIES AND NEONATAL ABSTINENCE SYNDROME AMONG MEDICAID-INSURED INFANTS IN COMPLEX POLICY ENVIRONMENTS.* ADDICTION, 2022

THOMAS, ET AL., *DRUG USE DURING PREGNANCY POLICIES IN THE UNITED STATES FROM 1970 TO 2016.* CONTEMPORARY DRUG PROBLEMS, 2018

CARROLL, *THE HARMS OF PUNISHING SUBSTANCE USE DURING PREGNANCY.* IJDP, 2021

ROBERTS, ET AL., *FORTY YEARS OF STATE ALCOHOL AND PREGNANCY POLICIES IN THE USA: BEST PRACTICES FOR PUBLIC HEALTH OR EFFORTS TO RESTRICT WOMEN'S REPRODUCTIVE RIGHTS?* ALCOHOL AND ALCOHOLISM, 2017

Motherhood, a Social Norm

Deviations from Norms of Motherhood:
"Deserving" versus "Undeserving" Motherhood
A Particular and Particularly Harmful Stigma

Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness

Libertas Academica
FREEDOM TO RESEARCH

Mishka Terplan[1,2], Alene Kennedy-Hendricks[3] and Margaret S. Chisolm[4]

[1]Behavioral Health System Baltimore, Baltimore, Maryland, USA. [2]Department of Epidemiology and Public Health, University of Maryland School of Medicine, Baltimore, Maryland, USA. [3]Department of Health Policy and Management, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland, USA. [4]Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA.

Supplementary Issue: Harm to Others from Substance Use and Abuse

ABSTRACT: In spite of the growing knowledge and understanding of addiction as a chronic relapsing medical condition, individuals with substance use disorders (SUD) continue to experience stigmatization. Pregnant women who use substances suffer additional stigma as their use has the potential to cause fetal harm, calling into question their maternal fitness and often leading to punitive responses. Punishing pregnant women denies the integral interconnectedness of the maternal-fetal dyad. Linking substance use with maternal unfitness is not supported by the balance of the scientific evidence regarding the actual harms associated with substance use during pregnancy. Such linkage adversely impacts maternal, child, and family health by deterring pregnant women from seeking both obstetrical care and SUD treatment. Pregnant women who use substances deserve compassion and care, not pariah-status and punishment.

KEYWORDS: pregnancy, fetal exposure, public attitudes, public policy, pregnant women, opioid use in pregnancy, substance use in pregnancy, neonatal abstinence syndrome

SUBSTANCE ABUSE: RESEARCH AND TREATMENT 2015:9(S2)

Addiction Stigma and Discrimination is Common in Pregnancy and Parenting

TABLE 2. Participants' Attitudes Regarding Care of Infants With NAS (N = 54)

	Strongly Disagree n (%)	Disagree n (%)	Neither n (%)	Agree n (%)	Strongly Agree n (%)
I believe that infants with NAS should be cared for in a critical care environment such as the NICU.	9 (16.7)	23 (42.6)	5 (9.3)	16 (29.6)	1 (1.9)
I frequently blame the mother of an infant with NAS for the infant's health problems.	13 (24.1)	18 (33.3)	8 (14.8)	14 (25.9)	1 (1.9)
I find dealing with mothers of infants with NAS to be stressful or upsetting.	8 (14.8)	16 (29.6)	9 (16.7)	20 (37.0)	1 (1.9)
When interacting with a mother of an infant with NAS, I consider the potential circumstances surrounding her drug use.	1 (1.9)	4 (7.4)	8 (14.8)	19 (35.2)	22 (40.7)
I feel that the rewards of caring for an infant with NAS outweigh the challenges of caring for an infant with NAS.	0 (0)	6 (11.1)	11 (20.4)	23 (42.6)	14 (25.9)
I find it frustrating when the mother of an infant with NAS is infrequently present to provide care for her infant.	2 (3.7)	3 (5.6)	7 (13.0)	27 (50.0)	15 (27.8)
I believe that I am responsible for caring for the mother of an infant with NAS as well as the infant.	4 (7.4)	4 (7.4)	8 (14.8)	27 (50.0)	11 (20.4)

Abbreviations: NAS, neonatal abstinence syndrome; NICU, neonatal intensive care unit.

TABLE 3. Participants' Knowledge Regarding Care of Infants With NAS (N = 54)

	Strongly Disagree n (%)	Disagree n (%)	Neither n (%)	Agree n (%)	Strongly Agree n (%)
I feel that I have enough knowledge about NAS to provide adequate care for affected infants.	0 (0)	2 (3.7)	3 (5.6)	24 (44.4)	25 (46.3)
I know how to appropriately document the care I provide to an infant with NAS.	1 (1.9)	0 (0)	4 (7.4)	22 (40.7)	27 (50.0)
I have received adequate training on the use of assessment tools used with infants with NAS.	1 (1.9)	4 (7.4)	4 (7.4)	22 (40.7)	23 (42.6)
I have adequate knowledge about various maintenance/pain medications and their effects on the newborn infant.	0 (0)	15 (27.8)	5 (9.3)	23 (42.6)	11 (20.4)
I feel that I am knowledgeable enough about commonly used drugs used in treating NAS to safely administer them.	6 (11.1)	2 (3.7)	23 (42.6)	22 (40.7)	1 (1.9)
I feel that I have enough knowledge about addiction to appropriately deal with mothers of infants with NAS.	0 (0)	17 (31.5)	6 (11.1)	24 (44.4)	7 (13)
I am knowledgeable about in-home or outpatient treatment of infants with NAS.	20 (37.0)	20 (37.0)	6 (11.1)	6 (11.1)	2 (3.7)

Abbreviation: NAS, neonatal abstinence syndrome.

Romisher, *Adv Neon Care*, 2018

Schiff, *Sabu*, 2017

Question	Overall	Medical Students	Interns	Residents
I feel angry towards women who use drugs while they are pregnant	48%	55%	54%	37%
Mothers who use drugs during pregnancy should not be allowed to retain custody of their kids	38%	44%	34%	34%

Addiction and Pregnancy: Environment of Mutual Mistrust

Provider

Mistrust (often) misplaced

Rooted in discrimination and prejudice

Consequences of misplaced trust are minor

Patient

Mistrust warranted by people who experience oppression, justified due to historical trauma and current experiences of discrimination

Consequences of misplaced trust are severe

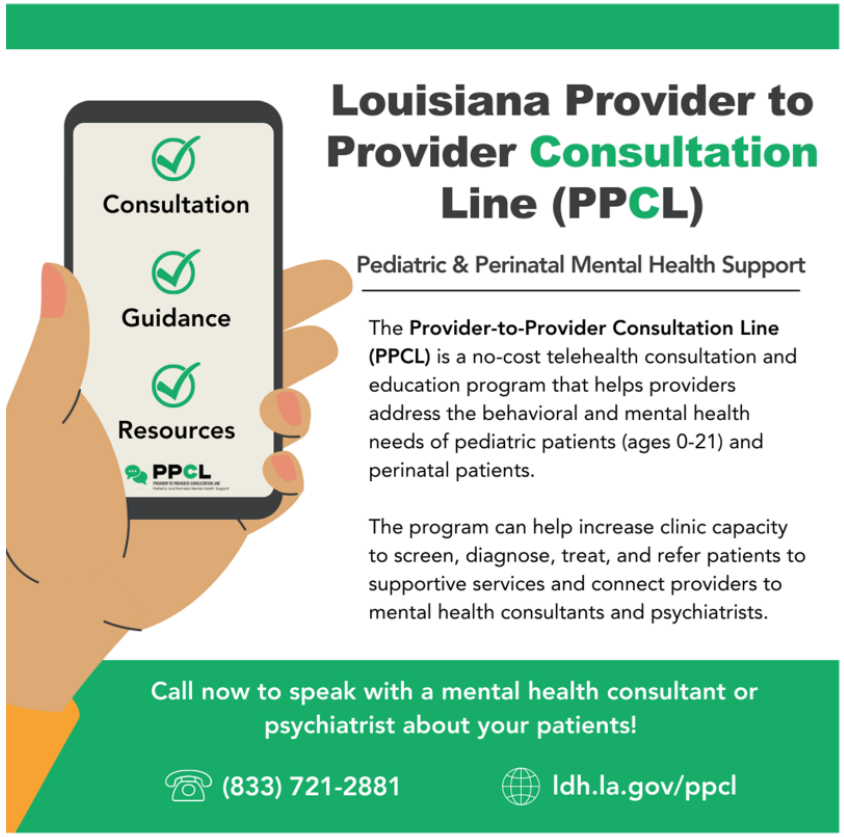
Power Differential

Responsibility for overcoming mistrust rests with providers

Thank You

Mishka Terplan mterplan@friendsresearch.org

- Consultation Line operates Monday-Friday from 8:00 a.m. to 4:30 p.m
- Statewide
- Any provider serving children/youth (birth to age 21) and pregnant and postpartum women
- Resource and referral support
- Psychiatrists are available for consultation
- OB/GYN and Addiction Medicine Specialist



Kratom:
A Primer

Benjamin Springgate MD, MPH

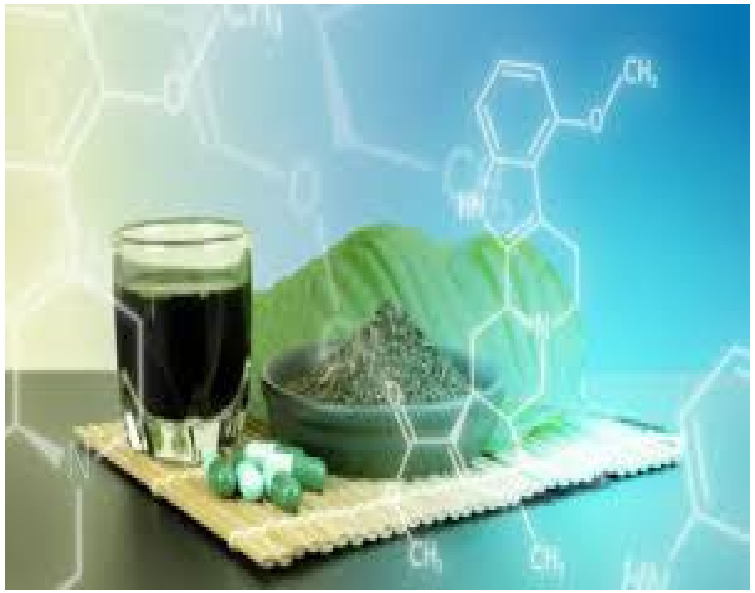
Professor of Medicine, LSU Health

HOPE Council

July 10, 2025

Kratom

- Kratom (*Mitragyna speciosa*)
  - Natural product derived from a tree native to Southeast Asia.
  - Kratom has been used for centuries in Malaysia and Thailand for its stimulant, analgesic, and antidepressant properties.



Kratom Uses and Adverse Effects

- In the US, kratom is used primarily as a remedy for chronic pain, self-treatment for opioid withdrawal, or in the setting of polysubstance use.
- Kratom is associated with acute adverse effects as well as dependence with chronic use.
- There are no FDA-approved, medical uses of Kratom.

Kratom Use is high among younger males

- In the US, an estimated 10 to 16 million people use kratom, with a prevalence between 1.3 and 6.1 percent.
- Young males (mean age 35 years) are the predominant demographic to use kratom, but others use kratom as well.
- In Thailand and Malaysia, younger individuals drink cocktails with kratom for the neuropsychiatric properties and to replace alcohol; these typically contain kratom, cough syrup, and cola.

Kratom – Poison Center Data

- In one study, 1807 kratom exposures were reported to US poison centers between 2011 and 2017; 32 percent were admitted to a health care facility. 11 deaths were reported.
- In another poison center study between 2014 to 2019, 3484 kratom exposures were reported; older adults (age >60 years) accounted for ~ 5 percent of kratom exposures with 23 older adult deaths (14 percent) associated with kratom use.

Kratom - Pharmacology

- Absorption – Following oral administration, kratom alkaloids are rapidly absorbed and achieve peak concentrations within one hour. In a study of nine volunteers drinking kratom tea, peak serum concentrations were reached in an average of 50 minutes.
- Mitragynine is the most prevalent alkaloid in kratom. Mitragynine, despite having a different chemical structure compared with traditional opioids, primarily binds at the mu-opioid receptor (MOR) where it is a weak opioid agonist with lower potency than morphine;
- Kratom does not produce the same euphoria and respiratory effects.

Kratom – Acute Clinical Effects

- Agitation/irritability – 23 percent
- Tachycardia – 21 percent
- Nausea – 15 percent
- Drowsiness/lethargy – 14 percent
- Vomiting – 13 percent
- Confusion – 11 percent
- Hypertension – 10 percent
- Seizures (single or multiple) – 10 percent
- Tremor – 7 percent
- Abdominal pain – 7 percent
- Dizziness – 5 percent
- Hallucinations – 5 percent

Kratom – Adverse Clinical Effects

- **Seizures** – There are multiple case reports of seizures following kratom use.
- **Mental status changes** – Kratom has been associated with various mental status changes, including agitation, irritability, lethargy, sedation, and coma.
- **Respiratory and cardiovascular effects** — Kratom use has been associated with respiratory depression, bradypnea, cyanosis, and apnea
- **Hepatotoxicity** — Kratom use is associated with reversible liver injury. Symptoms start following several weeks of kratom use and can include nausea, fatigue, pruritus, dark urine, and even jaundice. Liver test abnormalities typically include serum aminotransferase of 100 to 400 U/L, alkaline phosphatase of 150 to 300 U/L, and bilirubin of 2 to 6 mg/dL.
- **Psychiatric, dependence, withdrawal** — Frequent and prolonged ingestion of kratom has been associated with development of anorexia, weight loss, insomnia, depression, hallucinations, psychosis, dependence, and a use disorder. Greater than 50 percent of individuals who use kratom regularly for longer than six months develop severe dependence [64]. Signs and symptoms are similar to but less severe than those of opioid withdrawal.

Kratom – Chronic Adverse Effects

- Compulsive kratom use, dependence, and withdrawal are recognized adverse event of longstanding kratom use.
- In a study of 357 adults who use kratom three or more times per week for more than four weeks, at least one-half of patients reported experiencing withdrawal symptoms, which increased with frequency of use. In patients with the most frequent use, approximately 40 percent reported at least one unsuccessful attempt to reduce or stop use.
- Case reports describe neonatal abstinence syndrome following regular maternal kratom use during pregnancy

Medical Treatment of Effects of Kratom

- **Sedation or respiratory depression** — Some clinicians administer naloxone to patients with sedation and respiratory depression.
- **Seizures or agitation** — In a patient with a prolonged seizure (>5 minutes) or recurrent seizures, first-line therapy is a benzodiazepine.
- **Withdrawal syndrome/use disorder** — In a patient with kratom dependence and withdrawal, some clinicians use buprenorphine for treating initial symptoms and for the long-term maintenance management. Induction and maintenance doses are typically less than those needed for opioid use disorder.

Regulation of Kratom

- Kratom is prohibited in some countries and some states in the United States (US).
- It is listed as a Drug and Chemical of Concern by the US Drug Enforcement Agency.
- The US Food and Drug Administration (FDA) has not approved kratom for any medical use and has issued multiple advisories on health risks with its use for opioid withdrawal.
- Kratom products can be purchased widely in the US. In a 2023 survey of 520 US tobacco specialty stores, 72 percent reported selling kratom products (80 percent in the 46 states and territories without kratom bans).
- Statewide Ban Effective August 1, 2025:
- Louisiana has enacted a statewide ban on the possession and distribution of kratom, which will go into effect on August 1, 2025.
- Senate Bill 154 (Act 41): Governor Jeff Landry signed this bill into law on June 4, 2025, formalizing the ban.

Project M.O.M.

July 10, 2025

Carrie Templeton, Project M.O.M. Director

Presentation to the HOPE Council

LOUISIANA DEPARTMENT OF HEALTH

Objectives

1. Introduce the HOPE Council to Project M.O.M.

2. Explore alignment between Project M.O.M. and the HOPE Council.

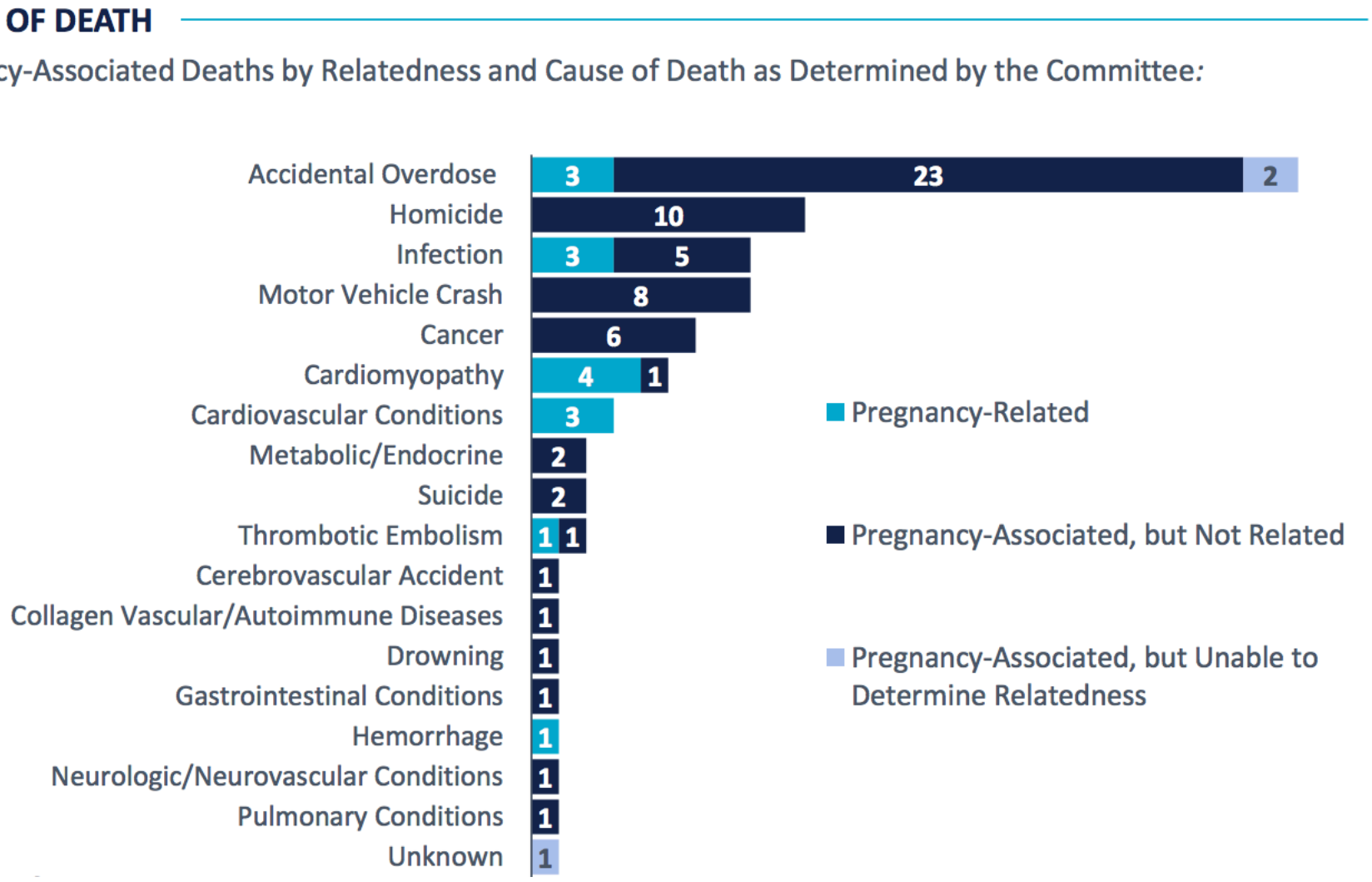
3. Highlight opportunities for collaboration with Project M.O.M.

Disclosures

None.

Relationship between overdose and maternal mortality

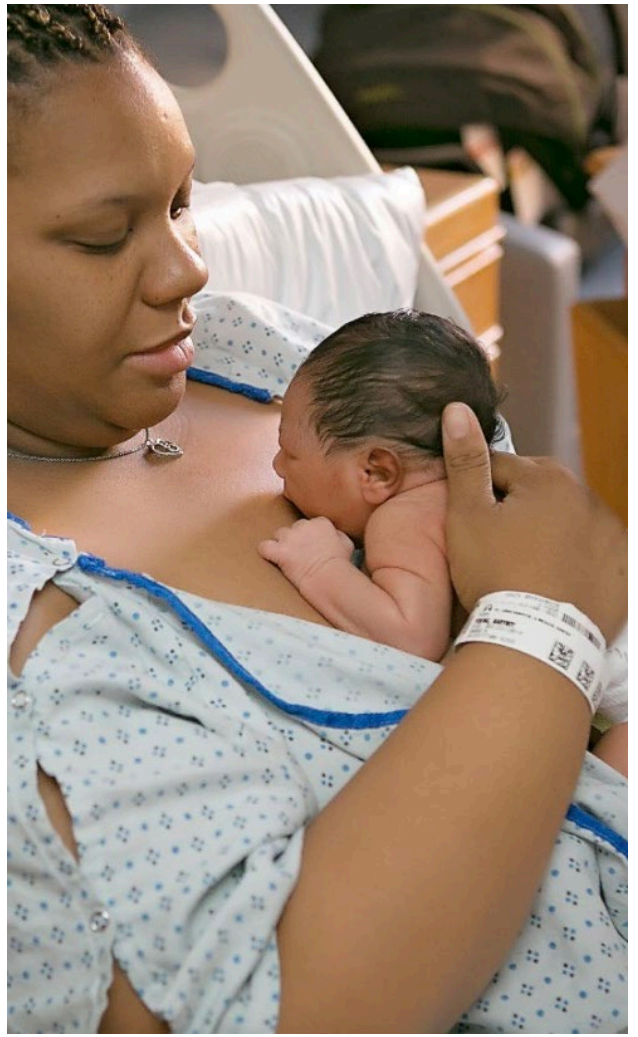
In 2020, 34% (28 deaths) of all pregnancy-associated deaths (82 total) were due to accidental overdose, making it the single biggest contributor to maternal mortality.



Source: 2020 Louisiana Pregnancy-Associated Mortality Review Report https://ldh.la.gov/assets/oph/Center-PHCH/FamilyHealth/2020_PAMR_Report_April2024.pdf

Relationship between overdose and maternal mortality

In a recent survey conducted by LDH, only 7% of respondents (mostly OB/GYNs) currently prescribe MOUD and only 22% reported being comfortable treating pregnant and postpartum individuals with SUD/OUD.



Survey conducted by LDH in 2023, as part of the Louisiana Perinatal Quality Collaborative (LaPQC) Improving Care for the Substance Exposed Dyad (ICSED) initiative.
https://lapqc.org/wp-content/uploads/LaPQC2023Report.pdf

Internal Policy Brief

April 2024

Maternal and Infant Mortality

LDH's Recommendations for Policy Action

To: Secretary Ralph Abraham
From: Louisiana Department of Health
Date: April 12, 2024

This policy paper provides an overview of the current maternal health landscape in Louisiana, including state-specific challenges, and outlines the Louisiana Department of Health's (LDH's) priority policy recommendations to address these challenges. It includes an overview of the data, high-level summary of major contributors to maternal and infant mortality, and suggested policy recommendations, where LDH serves as the primary stakeholder to implement these changes. These recommendations are divided into short-term and long-term solutions. The causes of maternal and infant morbidity and mortality are extensive with both clinical and social factors contributing. This Brief is intended to be a snapshot/summary of key contributors and policy levers and can be complemented by the most recent report published by the Louisiana Pregnancy-Associated Mortality Review (PAMR) Committee, which provides additional recommendations.

Vision

An 80% reduction in opioid overdose deaths among pregnant and postpartum women in Louisiana within three years.

Mission

To improve care and coordination for pregnant women with substance use disorder through policy, partnership, peer support, and practice transformation.

Goals

1. **Advance cross-agency collaboration.**

2. **Improve access to and coordination of prenatal and postpartum care.**

3. **Reduce stigma and improve access to and treatment for substance use disorder (SUD).**

4. **Increase patient engagement and retention in treatment programs.**

Supportive Programs

- The Louisiana Perinatal Quality Collaborative (LaPQC) Safe Births Initiative
- Louisiana Bridge
- Ally Initiative
- Provider to Provider Consultation Line
- Our Lady of Angels and LSU's specialized Family Medicine-OB Partnership
- Guiding Recovery and Creating Empowerment (GRACE) Program
- Naloxone Pilot Project
- Eat, Sleep, Console care model

Collaborate with us!

https://ldh.la.gov/page/project-mom

Project M.O.M. Initiative

Please select how you'd like to be involved in Project M.O.M: *

- ◯ Join a work group/collaborate with us (actively participate in meetings and projects)
- ◯ Receive updates only (stay informed via newsletters and announcements)
- ◯ Both

Organization Name: *

Organization Type: Please select the category that best describes your organization *

- ◯ Hospital or Health System
- ◯ Community Health Center/FQHC
- ◯ Health Department/Government Agency
- ◯ Behavioral Health Provider
- ◯ Primary Care Provider
- ◯ Medication Assisted Treatment Provider
- ◯ Academic/Research Institution
- ◯ Advocacy or Nonprofit Organization
- ◯ Residential Treatment Provider
- ◯ Other

If Other, Please Specify:

Project M.O.M. Summit

July 16, 2025 (1:30-4:30pm CT) - Louisiana State University, Baton Rouge

At-a-glance agenda:

- **Welcome and Setting the Context**
- **Lived Experience: A Journey Through Pregnancy and Recovery**
- **Project M.O.M. Overview**
- **Meeting Mothers Where They Are: Collaborative Approaches to Supporting Pregnant Women with Substance Use Disorder** (moderated discussion)
- **Breakout Sessions** (discuss opportunities, gaps, and challenges in several policy areas)
- **Report Outs + Group Discussion**
- **Call to Action and Closing**

Thank You

Carrie.Templeton@la.gov

LOUISIANA
DEPARTMENT OF HEALTH

The Louisiana Crisis Response System (LA-CRS)

HOPE Advisory Council

July 10, 2025

Ann Darling, LCSW
Director of Community Integration Best Practices
Office of Behavioral Health

Developing the Louisiana Crisis Response System: What is this all about?

- These are services that have **not been historically available in most of the State**.
- In the absence of community-based crisis services, **many people have experienced more restrictive, intrusive and coercive interventions**.
- For some, this includes individuals who have experienced **longer-term stays in institutions with limited established pathways back to the community**.
- These new services are designed to remedy some of these issues by offering **safer crisis care.**
- The system **expands the array of response options** for a person in crisis.
- For more information about the LA-CRS, visit: **https://ldh.la.gov/crisis**

Safer Crisis Care Experience

Care is offered:	• Early • Voluntarily • Locally • In natural or community-based settings (e.g., schools)
Teams use approaches that are:	• Family/Person-centered and collaborative • Strength-based • Resolution-focused
There is minimal reliance on interventions experienced as coercive.	• Law enforcement involvement • Involuntary evaluations • Inpatient hospitalization—particularly if involuntary

Safer Crisis Care Experience (cont.)

- Significant shift in practice for much of the state
- Crisis treatment provided in the community rather than in the ED
- Engaging individuals & families not known to the team
- Responding to acute situations
- Maximizing use of voluntary interventions
- Use of less-restrictive solutions

Important that this work is also experienced as safe for the teams in the field!

This new crisis service array expands the options for a person in crisis or a concerned referrer.

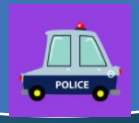
New Community-based Crisis Services

- **Voluntary**
- Timely, trained crisis care response
- **Resolution/relief-focused** at every point of contact
- **Warm hand-off** to community services/supports
- **Harm reduction**

EMS/ER

- **Potentially involuntary (lower buy-in to services)**
- **Immediate emergency care access (overdose, suicide attempt)**
- **Person unwilling to seek services voluntarily & imminent risk to harm self/others**
- **Medical co-morbidity, intoxication, significant agitation**
- **Unresolved mental health needs (recidivism)**

Coroner/Law Enforcement



- **Potentially involuntary**
- **Immediate, but limited MH response**
- **Potential for incarceration/avoidable legal charges**
- **Higher recidivism**

Louisiana Crisis Continuum

Someone to Talk to:

- **988:** Having a tough day, feeling stressed, anxious, depressed, or having thoughts of suicide, communicate with a helpline specialist who can help by calling or texting 988, or chat at 988lifeline.org/chat. Free, confidential, and available 24/7. For more information visit www.louisiana988.org.
- **Crisis Hub:** Statewide triage dispatch line to mitigate crises and access services outlined below

Someone to Respond (services available for Medicaid adults, youth and their families):

- **Mobile Crisis Response (MCR):** Two person teams of trained staff deploy to where the individual is located in the community.
- **Community Brief Crisis Support (CBCS):** ongoing support up to 15 days subsequent to initial crisis intervention.

A Safe Place for Help (services available for Medicaid adults 21 and older):

- **Behavioral Health Crisis Care (BHCC):** walk in centers offering support to an individual in crisis.
- **Crisis Stabilization (CS):** short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services, need ongoing support to remain in the community, and inpatient psychiatric care is not warranted.

Louisiana Crisis Hub Overview

Operator	Carelon Behavioral Health

Crisis Hub Requirements	• Operate 24/7/365 crisis call center
	• Access point to crisis services (Mobile Crisis, BHCC Walk-In)
	• Crisis Safety Platform
	  • Contact center documentation to support triaging and linkage
	  • Dispatching functionality, including GPS-informed monitoring and assignment (Includes Provider-Direct requests and 988 referrals – Providers and 988 access CSP to load their own dispatch information)
	  • BHCC Crisis Walk-In Tracking (Provider-loaded)
	  • Dashboarding and data reporting
	  • Follow-up module
	• Care Coordination for friendly faces (Peer Team)
	• Custom website
	• Develop Quality & Performance Reporting/Monitoring
	• Coordinate with Key Community and Crisis Stakeholders (Collaboratives)
	• Partner with OBH and LSU for training

Dates	Implemented: May 1, 2025

Training and Network Development

OBH is working with LSU Health – New Orleans School of Public Health's Center for Evidence to Practice to:

- **Collaborate with communities** throughout Louisiana, deploy a **readiness process for implementation** of these crisis services
- Deliver a **training curriculum for crisis providers**
- Identify workforce and **implement training** curriculum and **ongoing coaching** to ensure appropriate execution of services
- Continuous **quality monitoring & improvement**

LSU Health NEW ORLEANS School of Public Health

Center for Evidence to Practice

THANK YOU

Ann Darling, LCSW

Director of Community Integration Best Practices, Office of Behavioral Health

Ann.Darling@la.gov

LOUISIANA DEPARTMENT OF HEALTH

LOUISIANA DEPARTMENT OF HEALTH

Compassionate Overdose Response Overview

STI/HIV/Hepatitis Prevention Program (SHHP) Harm Reduction Team

HOPE Council, July 10, 2025

8/11/2025

Common Terms

- Opioids:
  - A class of drug that typically refers to all substances, natural and synthetic, that bind to the brain's opioid receptors (ex. fentanyl, hydrocodone)
- Depressant Overdose (OD):
  - Occurs when a person has too much of a depressant in their system, leading to the brain losing the ability to maintain normal bodily functions (ex. breathing)
- Harm Reduction:
  - A set of strategies used to reduce the negative consequences associated with drug use (**h**arm **r**eduction vs Harm Reduction)
- Naloxone Saturation:
  - The strategy aimed at increasing the distribution of naloxone into a specific area/community (ex. Louisiana naloxone saturation plan)
- High Dose Naloxone:
  - Naloxone doses greater than the standard dose (0.4 mg/mL IM, 3-4.0mg/mL nasal spray)
- Compassionate Overdose:
  - A form of overdose response that aims to: 1) focus on rescue breaths, not consciousness, 2) avoiding withdrawal symptoms, and 3) providing post-overdose care

What is an Opioid Overdose?

- Basic definition:
  - Occurs when a person has too much of an opioid in their system, leading to the brain losing the ability to maintain normal bodily functions (ex. breathing)
- General flow of an opioid overdose:
  - The brain is overwhelmed > The person stops breathing > A lack of oxygen reaches the brain
- Signs of an opioid overdose:
  - Blue/gray lips and fingernails/pale or ashy skin; unresponsive to voice or touch; slowed, stopped, or irregular breathing; gurgling or snoring sound (ex. death rattle); cold, clammy skin
- An opioid overdose can be reversed by naloxone
  - While naloxone is safe to use, higher doses of naloxone can cause prolonged precipitated withdrawal symptoms

Overdose Data: Rates and Shifts

National Data:

- **Total Number Of Non-fatal Opioid Overdose Emergency Department Visits, 2023 (CDC)**
  - 131,620 Overdoses
- **Total Number of Opioid-Involved Overdose Deaths, 2023 (CDC):**
  - 55,529 Deaths (Age-Adjusted Rate of 27.4 deaths per 100,000 people)
- **23% Annual Decrease in All US Suspected Opioid Overdoses, January 2024 Compared to January 2023 (CDC)**

Louisiana Data:

- **Total Number of Overdoses Reported through Emergency Department Visits and Hospital Admissions, 2023 (LODSS):**
  - 5,893 Overdoses
- **Total Hub-Reported Overdoses, 2023:**
  - 9,634 Overdoses
- **Total Hub-Reported Overdose Reversals, 2023:**
  - 9,116 Reversals
- **Total Number of Opioid-Involved Deaths, 2023 (LODSS):**
  - 1,097 Deaths (Roughly a 21% decrease from 2022)

How Naloxone Works

- Safe and effective, with the caveat that it can lead to precipitated withdrawal symptoms
- Naloxone is an “opioid antagonist”
  - Strong affinity to opioid receptors, stronger than opioids themselves
  - Naloxone knocks opioids off of the opioid receptors, and attaches to the receptors without activating them
- Negates the effect of the opioids and the body begins automatic functions like breathing
- Does not have effect on overdoses caused by non-opioid substances

Naloxone History Timeline

- **1961** - Naloxone is invented by Dr. Jack Fishman, a Jewish pharmaceutical researcher who fled Nazi-occupied Poland as a child, and later immigrated to the US.
- **1971** - Naloxone approved by FDA. Only medical professionals have access.
- **1980s** - Small quantities of naloxone quietly distributed by EMTs & paramedics.
- **1996** - Chicago Recovery Alliance begins the world's first naloxone distribution program.
- **2014** - Act 392. Louisiana's Good Samaritan Law. When 911 is called, legal immunity for bystander and person who overdosed.
- **2015** - Act 192. Laypersons may administer naloxone without fear of liability.
- **November 2015** - FDA approves Narcan nasal spray.
- **2016** - Act 370 allows for statewide naloxone standing order.
- **January 2017** - Louisiana Secretary of Health Dr. Rebekah Gee issues a standing order for naloxone.
- **2022** - Statewide Harm Reduction Distribution Hub launches.
- **March 2023** - FDA approves first over-the-counter naloxone nasal spray (Narcan).
- **July 2024** - FDA approves the first generic over-the-counter naloxone nasal spray.

Current Harm Reduction Efforts

- Louisiana Office of Public Health (OPH) STI/HIV/Hepatitis Program (SHHP) Statewide Harm Reduction Distribution Hub:
  - Program Overview: a centralized platform, where institutions can apply to be distribution sites and request harm reduction materials to distribute to the general public
  - 67 active sites and representation in all 9 Louisiana regions
- Distribution Data (Dec 2022 to May 2025):
  - 180,857 Narcan kits
- 119,784 people educated on overdose response

Naloxone Saturation

- Naloxone saturation is achieved when there is both sustainable and equitable access to naloxone to distribute to:
  - People who use drugs
  - Others who might respond to an overdose like community members, family, harm reductionists
- Achieved by robust community distribution and outreach efforts, including overdose education (overdose education and naloxone distribution, OEND)
- LDH naloxone saturation plan
  - Via LaSOR funding, naloxone is purchased and distributed to community partners via a hub and spoke model (Harm Reduction Hub)
  - 67 participating sites in all 9 Public Health Regions

Naloxone Dosage: Standard Dose vs. High Dose

- There are a variety of overdose-reversal products for community use available across the globe (Russell, et al)
  - In Europe, the standard doses are: 0.4-1.0 mg/mL IM naloxone and up to 2 mg/0.1 mL intranasal spray
  - In the United States: 0.4 mg/mL IM naloxone and 3-4.0 mg/0.1 mL intranasal spray
    - Higher dose and longer-lasting overdose reversal products are also sold in the US, under the messaging that higher-dose/longer-acting are more effective in reversing synthetic opioid-related overdoses, etc. (Hill, et al)
    - These high dose naloxone products are more expensive, cause more precipitated withdrawal effects, and are not shown to be more effective than standard dose naloxone products (Russell, et al)

High Dose Naloxone Products

Product Name	Active Drug	Dosage	Delivery Method
ZIMHI	Naloxone	5mg/0.5mL	Pre-filled syringe
Kloxxado	Naloxone	8mg/0.1mL	Nasal spray
Opvee	Nalmefene	2.7mg/0.1mL	Nasal spray
Zurnai	Nalmefene	1.5mg/0.5mL	Autoinjector
Rezenopy	Naloxone	10mg/0.1mL	Nasal Spray

Naloxone Dosage and Overdose Reversal

- Despite claims that multiple (more than 2) doses of naloxone/high-dose products are necessary to reverse overdoses, the research indicates otherwise
  - These claims are often thought to be due in part to availability bias caused by media reporting on synthetic opioids, alarmist misinformation about passive exposure to fentanyl, etc. (Hill, et al, Beletsky et al)
  - In addition, adulterants in the supply (e.g., xylazine, benzodiazepines) also can suppress breathing but cannot be reversed by naloxone, leading to the myth that naloxone does not work
- Bell, et al: Despite rising fentanyl in the drug supply in Pittsburgh, 89.3-95.3% of reported overdose reversals accomplished with 1-2 doses of 0.4mg IM naloxone
- Lemen, et al: Most fentanyl overdoses can be reversed with no more than 2 standard IM or nasal doses of naloxone
  - Carfentanil overdoses might require ≥ 3 doses
- Hill, et al., Klebacher et al: Additional doses of naloxone, increasing the dose or half-life of a single product does not reverse an opioid overdose more quickly

Payne, et al. CDC MMWR: New York State DOH Study

- In 2022, NY State DOH partnered with NY State Police to field-test 8mg nasal naloxone and compare its effects to those of 4mg nasal naloxone in a real-world setting
  - Study took place March 26, 2022-August 16, 2023
  - 3 troops received only 8mg nasal naloxone, 8 troops received only 4mg nasal naloxone
  - 99% survival with 8mg and 99.2% survival with 4 mg (p=0.86: no significant difference)
  - Average 1.58 doses 8mg used (12.6mg) and average 1.67 doses 4mg used (6.7mg), the mean number of doses did not differ significantly between formulations (p=27)
  - People who received 8mg nasal naloxone were roughly 2x as likely to experience opioid withdrawal symptoms, including vomiting (p<0.001)

Payne, et al. Data Table

TABLE. Reported outcomes and postnaloxone signs and symptoms among persons who received naloxone for suspected opioid overdose, by intranasal naloxone formulation as reported by New York State Police personnel (N = 354) — New York, March 2022–August 2023

Characteristic	Naloxone doses administered, no. (%)		RR (95% CI)	p-value for RR
	8 mg (n = 101)	4 mg* (n = 253)		
Reported outcome				
Survived	100 (99.0)	248 (99.2)	0.81 (0.07–8.99)	0.86
Perceived anger or combativeness	11 (10.9)	20 (7.9)	1.42 (0.66–3.09)	0.37
Refused transport to hospital	19 (19.0)	66 (26.6)	0.65 (0.36–1.15)	0.14
Postnaloxone sign or symptom				
Opioid withdrawal sign or symptom, including vomiting†	38 (37.6)	49 (19.4)	2.51 (1.51–4.18)	<0.001
Vomiting only	21 (20.8)	35 (13.8)	1.64 (0.90–2.98)	0.11
Disorientation	67 (66.3)	148 (58.5)	1.40 (0.86–2.27)	0.17
Lethargy	53 (52.5)	110 (43.5)	1.44 (0.90–2.28)	0.13

Abbreviation: RR = relative risk.

* Referent group.

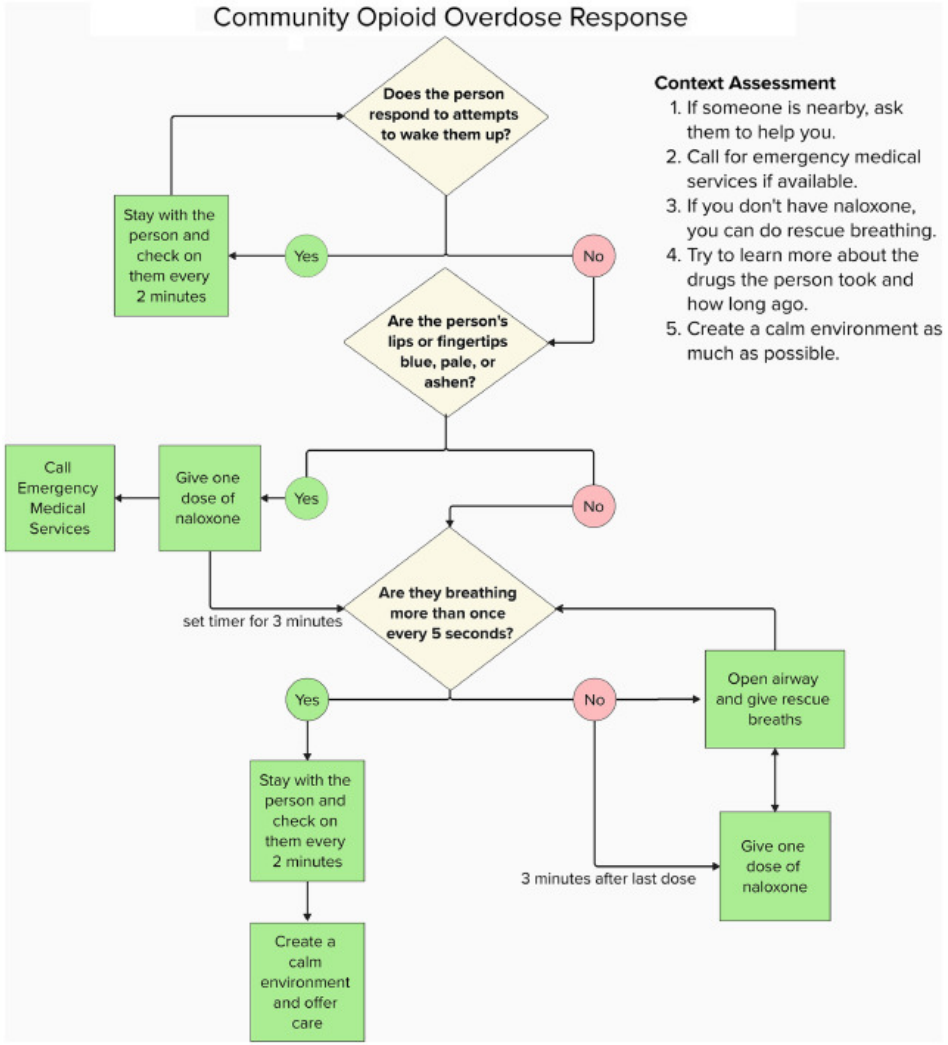
† New York training materials for law enforcement naloxone administration include nausea, vomiting, and withdrawal (sick feeling) as the key components of opioid withdrawal signs and symptoms for which to monitor after naloxone administration.

Unintended Consequences of High Dose Naloxone

- Though naloxone does not cause any direct damage or dependency, the precipitated withdrawal effects after an overdose reversal should not be ignored (Russell, et al)
  - Withdrawal symptoms include nausea, vomiting, agitation, pain, and aspiration
  - There is a risk that people experiencing withdrawal symptoms will use more opioids to relieve symptoms, thus increasing risk for overdoses
  - The desire to mitigate withdrawal symptoms has been shown to result in an increased risk of less safe practices
- High dose naloxone dosing is often viewed as punitive, especially if administered by law enforcement or EMS
  - Consequence of this is that people may choose to use alone, can sow distrust
- Pricing of these high dose products should also be considered, especially when naloxone saturation is the goal

Compassionate Overdose Response

- What is it?
  - Compassionate overdose response involves a focus on restoring breathing, not consciousness, avoiding withdrawal symptoms, and providing post-overdose care.
- Why should we focus on compassion?
  - Overdoses are life-threatening, uncomfortable, scary, and traumatizing. Every step should be taken to mitigate negative side effects of opioid overdoses to ensure the comfort and safety of those involved.



Russell, et al. A Call for Compassionate Overdose Response. International Journal of Drug Policy 133 (2024). https://doi.org/10.1016/j.drugpo.2024.104587

Compassionate Overdose Response: Breathing vs. Consciousness

- During an overdose, the danger of death lies in the body losing the automatic function of breathing, not in the loss of consciousness
  - Main goal of overdose response is to get oxygen to the brain
- If the person is breathing, but not conscious, they are not in immediate danger and **do not need naloxone**
  - Stay with them, check in periodically, and reassess as needed
- If they are not breathing/have ashen, pale, or blue lips and/or fingertips:
  - Administer naloxone and give rescue breaths
- WAIT 3 minutes between naloxone doses
  - Give rescue breaths during this time
- Once they are breathing, stop administering naloxone
  - They may not regain consciousness immediately

Compassionate Overdose Response: Rescue Breathing

- Gently position person on their back
- Place your palm on their forehead and other hand on their chin, gently tilting the head back and the chin up to open the airway
- Pinch the nose, create a seal by placing your mouth over theirs, and prepare to give two breaths
- Give the first breath, watching to see if their chest rises
  - If it rises, give a second breath
  - If it does not rise, the airway may not be open; repeat the head tilt/chin lift maneuver, ensure there is nothing visible blocking their airway, and give a second breath
- Repeat with one breath every 5 seconds, being careful not to breathe with too much force

Compassionate Overdose Response: Aftercare

- Most people will wake up confused and may not remember what happened
  - Some may be irritated, but this is not due to “the high being ruined”
- Help orient the person to their surroundings, use a calm, gentle voice
- Provide emotional support and reassurance
  - Support their immediate physical and emotional needs (i.e. water, nausea medication if feeling ill)
- Offer to help advocate for them with EMS if they would like
- Avoid discussing referrals to treatment or behavioral changes
  - Negative confrontation with responders may lead the person to avoid using drugs around others in the future, putting them further in harms’ way

Compassionate Overdose Response: Context Matters

- No two overdose responses will look exactly the same. Responders may differ in their tools available, ability to respond, and level of training. Other aspects that can change depending on the situation are:
- Whether or not to call 911
  - Will it be just EMS or will police respond as well?
  - A person may fear law enforcement involvement for a variety of reasons
  - Law enforcement may focus on punitive measures instead of ensuring the person's immediate safety
- Length of time the responder can stay and the level of aftercare they can give
- The presence of other drugs or alcohol
  - For this, the use of rescue breaths is even more important as naloxone will not reverse the depressive effects non-opioids like alcohol or benzodiazepines
- Comfort level of responder with providing rescue breaths
  - Community CPR training and distribution of pocket masks can be prioritized to mitigate this as much as possible

Contact Information

- Mary Beth Campbell – Harm Reduction Supervisor (Mary.Campbell2@la.gov)
- Charlotte Willcox – Viral Hepatitis Coordinator (Charlotte.Willcox@la.gov)
- Milo Malone – Statewide Syringe Service Program Monitor (Milo.Malone@la.gov)
- Aaron Elkins – Statewide Harm Reduction Distribution Hub Monitor (Aaron.Elkins@la.gov)

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UPDATES

- Other General Updates?

Other Member/Agency Updates/Announcements?

Public Comment

Welcome

Organization

Discussion

Next Steps

LOUISIANA DEPARTMENT OF HEALTH

Discussion & Next Steps

Discussion & Next Steps

Impact Workgroups: HOPE@LA.GOV

Adjourn

Next Meeting: *Thursday, October 11th*

Future HOPE Council Meetings

Thursday, October 11th

Welcome

Organization

Discussion

Next Steps

LOUISIANA DEPARTMENT OF HEALTH

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LOUISIANA DEPARTMENT OF HEALTH