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State of Louisiana

Department of Health and Hospitals
Office of the Secretary

February 1, 2013

The Honorable Scott M. Simon, Chairman
Committee on Health and Welfare
Louisiana House of Representatives
Post Office Box 44486, Capitol Station
Baton Rouge, LA 70804-4486

The Honorable David Heitmeier, Chairman
Committee on Health and Welfare
Louisiana State Senate
Post Office Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

Re: HCR 161 of 2012

Dear Chairman Simon and Chairman Heitmeier:

This report is offered to the House Committee on Health and Welfare and the Senate Committee on Health and Welfare in response to House Concurrent Resolution 161 of the 2012 Regular Session of the Legislature.

The concurrent resolution urges and requests the Department of Health and Hospitals to study prospective changes to Louisiana statutes and policies which could reduce the incidence of fetal exposure to controlled dangerous substances and alcohol. To that end, the department has conducted a review of current policy, legislation, practice and trends in the subject matter area. The following is submitted for your review. The populations of focus for this report are both females of reproductive age and persons who may come in contact or influence exposure to controlled dangerous substances and alcohol to females of reproductive age. The ideal strategies to reduce exposure to controlled dangerous substances and alcohol will include an array of prevention, early intervention and treatment services.

Overview

HCR 161 targets exposure to two separate factors that pose a danger to the fetus: the use of alcohol, and the use of controlled dangerous substances. While there is more research on the use and effects of alcohol during pregnancy, prevention and intervention efforts for both are similar, target the same population, and have similar consequences. Numerous studies exist which demonstrate that brief interventions are successful in decreasing the use of alcohol and drugs during pregnancy, thus decreasing the incidence of Fetal Alcohol Spectrum Disorders (FASDs) and Fetal Alcohol Syndrome (FAS) (Ceperich, S., & Ingersoll, K., 2011; Floyd, et al, 2007. Several evidence-based prevention programs have been developed and are being used in various settings with good results. These include Project Choices: Changing High-Risk Alcohol Use and Increasing Contraception Effectiveness Study, and Project Choices Plus: A Preconception Approach to Reducing Alcohol & Tobacco-Exposed Pregnancies (Project Choices Research Group, 2002).

Fetal Alcohol Spectrum Disorders (FASDs) are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. These effects can include physical problems and problems with behavior and learning. Often, a person with an FASD has a combination of these problems. There is no known amount of alcohol that is safe to drink while pregnant. There is also no safe time to drink during pregnancy and no safe kind of alcohol to drink while pregnant. To prevent FASDs, a woman should not drink alcohol while she is pregnant, or even when she might get pregnant. This is because a woman may be unaware of her pregnancy for several weeks or more. In the United States, half of all pregnancies are unplanned, and the first four weeks of gestation are a critical period for organ development. Fetal Alcohol Syndrome (FAS) represents the severe end of the FASD spectrum. Fetal death is the most extreme outcome that may result from drinking alcohol during pregnancy. People with FAS might have abnormal facial features, growth problems, and central nervous system (CNS) problems. People with FAS also can have problems with learning, memory, attention span, communication, vision, hearing, or some combination of these problems. People with FAS often have difficulty in school and trouble getting along with others. While these disorders may have significant impact on individuals, families and society, they are preventable with sustained efforts directed toward women of child bearing age and the professionals with whom they come into contact.

Use of alcohol: A Centers for Disease Control and Prevention (CDC) report from 2010 indicates that among women 18-44 years of age, almost 40 percent consume alcohol, while nearly 13 percent reported binge drinking. In addition, there may be as many as three times the number of Fetal Alcohol Spectrum Disorders (FASDs) cases as FAS cases (http://www.cdc.gov/ncbddd/fasd/data.html). The use of alcohol during pregnancy appears to occur across all socio-economic strata. In addition, the level of alcohol use prior to pregnancy is a strong predictor of alcohol use during pregnancy, which indicates that the prevention of alcohol use should begin at an early age (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5819a4.htm?s_cid=mm5819a4_e).

Use of controlled dangerous substances: While there is less information concerning the use of illicit drugs during pregnancy, a report from the Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that the current illicit drug use in the combined 2009-2010 data was 16.2 percent among pregnant women aged 15 to 17, 7.4 percent among pregnant women aged 18 to 25 and 1.9 percent among pregnant women aged 26 to 44 with an overall 4.4 percent for pregnant women aged 15 to 44, including the use of marijuana, cocaine, Ecstasy and other amphetamines, and heroin (SAMHSA, 2010), further evidence that prevention and intervention must begin early. Screening for drug use is usually verbal and many women do not report accurately their use due to fear of consequence (Madgula, Groshkova, & Mayet, 2011); therefore, it may be assumed that the prevalence of use is higher. As with alcohol use, drug use is often not identified prior to conception and is likely to continue through at least the early stages of pregnancy due to the woman's lack of knowledge of her pregnancy.

Since women who use illicit drugs typically engage in other unhealthy behaviors that put their pregnancy at risk, such as alcohol and tobacco use, poor nutrition, and developing sexually transmitted infections, it is often difficult to determine the exact effect of the drug on the pregnancy. However, a meta-analysis of 42 studies suggested unique effects of prenatal cocaine or methamphetamine exposure on 4- to 13-year old children, particularly in the areas of behavior problems, attention, language, and cognition (Lester & Lagasse, 2010).

Efforts to reduce exposure in other states

The table below summarizes the Fetal Alcohol Spectrum Disorders Legislation Report from the Substance Abuse and Mental Health Services Administration (SAMHSA), issued on October 31, 2012. The table summarizes the number of bills that address fetal alcohol spectrum disorders by six defined subject matter areas.

		Nationwide Since 2003	
Category of Legislation	**Description**	**Bills Introduced**	**Bills Passed**
Criminalization	Prohibits or enables prosecution of women for alcohol use during pregnancy or for giving birth to a child affected by a FASD.	37.5	11
Funding	Appropriating or repealing funds for FASD prevention or treatment.	71	9
Involuntary Commitment	Permits a State to involuntarily commit a woman into treatment where there is evidence of alcohol use during pregnancy.	5	1
Prevention	Mandates or supports research, public information, training, and programs on FASD issues.	121	51
Treatment	Treatment for individuals affected by a FASD or for women who drink during pregnancy.	33.5	9
Requirements for Professionals	Includes teacher certification, physician licensing, mandatory training, and reporting requirements.	22	6
	Total	**290**	**87**

There are several trends noted by SAMHSA in their review of FASD-related legislation over the last ten years. The most frequent categories of legislation focused primarily on preventing FASD and learning more about FASD, rather than punitive measures against either the birth mother or the individual with the disorder. Over the time period there were a higher percentage of bills signed into law in these categories.

As noted above, addressing these issues through punitive measures is less common. These approaches include criminalization, which enables prosecution of women for alcohol use during pregnancy or for giving birth to a child affected by an FASD, or allows for protective incarceration or involuntary commitment of a woman until her child is born. Other states consider the presence of drugs in a child's system at birth child abuse which typically results in the child being removed from the mother.

Most of these methods have not often proven to be successful. Jails and psychiatric or addiction facilities are sometimes not equipped to provide for adequate prenatal care or education. Typically the infant is removed from the mother after birth and cannot be breastfed. In addition, women may avoid prenatal care in an effort to keep their alcohol or drug use unknown to others. These types of consequences could also be considered discriminatory since research has demonstrated that African American women who are using drugs are 10 times more likely to be prosecuted than Caucasian women (Bulger, 1999; Mills, 1998). Other, more successful methods tried are funding for prevention and treatment, training, research and public education. Drug courts have also been shown to be successful if the woman is closely monitored and receives treatment quickly after arrest. Additionally, the length of treatment must be intensive and sufficient to meet each woman's special needs.

In 2003, the World Health Organization (WHO) conducted an extensive review of the literature that focused on policy relevant prevention and intervention strategies. WHO recommended policy relevant interventions and strategies including the regulation of the physical availability of alcohol, particularly to younger people. By controlling the location of outlets, sales to minors can be discouraged. Research has shown that when outlets are close together, more underage drinking occurs Gruenewald, et al., 2010; Treno, et al., 2003). Other methods, according to WHO are pricing and taxation, altering the drinking context, education and persuasion, regulating the promotion of alcohol, drinking and driving counter measures, and treatment and early intervention.

WHO noted the following strategies as best public policy practices: stricter enforcement of the minimum legal purchase age for alcohol, an increase in alcohol taxes, sobriety checkpoints, lowered blood alcohol limits, suspension of driver's license, and brief interventions that may include: use of feedback on drinking behavior, advice to change substance using behavior, goal setting for change, provider training and additional staff or system supports for screening or assessment. In addition, changing the setting for the purchase of alcohol could contribute to a reduced amount of alcohol purchased. In other states the sale of alcohol is carefully controlled and is sold only in stores specifically licensed by an alcohol beverage control agency, making it difficult for minors to access alcohol.

Summary of current efforts in Louisiana

The Office of Behavioral Health (OBH), through multiple funding sources, notably both the federal Temporary Assistance for Needy Families and Substance Abuse Prevention and Treatment block grants, has invested in various prevention activities to impact the population of focus. In Louisiana, Act 396 of 2007 revised the Children's Code to expand the definition of prenatal drug exposure, so that a newborn with observable and harmful effects in his appearance or functioning (due to drug exposure) is accepted as a report of prenatal neglect, even if blood, urine, or meconium tests results are negative.

The department currently offers services to women of child bearing age, which will make a significant impact on a decrease in fetal exposure to alcohol and drug abuse.

- LA HART (Louisiana Health Assessment Referral and Treatment), a web-based system for prenatal behavioral health screening - bridges the gap between screening for substance abuse & brief interventions as well as referral & utilization of existing support resources throughout the state.

- OBH has created the Louisiana Behavioral Health Partnership to manage behavioral healthcare statewide and partners with the Bayou Health plans to manage physical healthcare. These efforts have allowed us to increase the reach and availability of services to the population of focus.

- The Nurse Family Partnership (NFP) is a home visitation program for first time mothers that showed in FY11 an over fifty percent reduction in the use of marijuana during pregnancy from program intake to 36 weeks gestation. NFP works to improve pregnancy outcomes, child health and development, and the economic self-sufficiency of the family; however, the current level of funding does not allow NFP to reach the population of focus in every parish.

Additionally, OBH has numerous addiction resources for women. These include screening, assessment and referral sites that are known to most low-income women with children. At these sites women with addiction issues can go to access services. Residential treatment programs for women, pregnant women and women with dependent children are available in various areas of the state, while outpatient substance abuse treatment clinics are available throughout the state. The funding sources for these include State General Fund (SGF), federal Substance Abuse Prevention and Treatment (SAPT) block grant, Self-generated Revenues (SGR) and prior to cuts federal Temporary Assistance for Needy Families (TANF) block grant funds.

Prospective changes to Louisiana statutes and policies

There are several enhancements to current efforts by the State of Louisiana that will reduce the incidence of fetal exposure to controlled dangerous substances and alcohol. These actions include:

- Continuation of existing prevention and treatment efforts for programs that both identify and treat these women with the goal of increasing access to prevention, intervention and treatment. All such efforts should be family-centered and culturally sensitive to address the pregnant woman as well as her partner and family in the context of their community. These efforts should also be comprehensive to draw on all services appropriate to the social, economic and emotional needs of these women.

- Collaboration among agencies serving women of child bearing age, and women who are pregnant, to educate, identify, intervene, refer and provide treatment. Since the problem of alcohol and drug use typically begins prior to, or at the same time females reach child-bearing age, it is essential that prevention efforts begin at a young age. For example, collaboration currently exists between Bayou Health and Magellan in order to ensure that both physical and behavioral needs are met. The population of focus would benefit from increased interaction among other agencies such as the Women, Infant, and Children programs, Economic Stability Self Sufficiency, and others which serve women of child-bearing age. Targeting those agencies with information on accessing behavioral health services in the new managed care system is one method for increasing collaboration.

- Education in middle, junior high and high school health classes regarding the effects of substance use on fetal development will impact a greater number of individuals who have yet to become pregnant.

- Access to screening information and services through school-based health clinics could encourage communication with a health professional about proper prenatal care, including the avoidance of substances.

- Public education campaigns would raise awareness of FASDs and the impact of drug use on fetal development.

- Ensuring that typical locations for identifying and intervening with pregnant women such as emergency rooms, college campuses, middle, junior and senior high schools, primary care settings, and public health units, have the information and resources necessary will have a positive impact on this population. When these settings have provided screening and brief interventions, alcohol use has been reduced for at least 12 months (Reducing Alcohol Exposed Pregnancies, USDHHS, March 2009). An effective intervention is often only one 30-minute session.

- Professionals, including doctors, nurses, and social service agencies, who come into contact with women of reproductive age should be trained on ways to educate these women of the dangers of drug and/or alcohol exposure to the fetus, motivational interviewing, and resources.

- Encourage alcohol and drug addiction treatment services to incorporate the needs of women, including transportation and daycare, into their program design (Canadian Pediatric Society, 1997). Pregnant women seeking help are currently given high priority at alcohol and drug addiction treatment centers.

- Private settings that participate in the partnerships need to be encouraged to use evidenced based tools for drug and alcohol screening on all pregnant women. This would involve training of the staff and continued support of the screenings through Medicaid coverage.

Thank you for the opportunity to address these important issues. Should you require additional information on this correspondence or the issues contained herein, please do not hesitate to call me at 225.342.7092. Thank you.

Sincerely,

Kathy Kliebert
Deputy Secretary

cc: The Honorable Members of the House Committee on Health and Welfare
The Honorable Members of the Senate Committee on Health and Welfare

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