F I S C A L I M P A C T R E P O R T

SPONSOR Chasey **ORIGINAL DATE** 02/25/11 **LAST UPDATED** **HM** 14

SHORT TITLE Substance Abuse & Prenatal Care Task Force **SB**

ANALYST Esquibel

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY11	**FY12**		
N/A	N/A	N/A	N/A

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Commission on the Status of Women (CSW)
Department of Health (DOH)

SUMMARY

Synopsis of Bill

House Memorial 14 (HM14) requests UNM Health Sciences Center form a task force to oversee and implement the recommendations of the Governor's Council on Women's Health submitted to the Legislative Health and Human Services Committee in November 2010. SM19 was passed by the First Session of the Forty-Ninth Legislature and compiled a comprehensive plan for the state to address the needs of pregnant and postpartum women with substance abuse problems and address the well being of the children and families of those women. HM14 also proposes the submission of an interim report of the task force to the Legislative Health and Human Services Committee by November 1, 2011 and a final report by November 1, 2012.

FISCAL IMPLICATIONS

The Office of the Governor's Council on Women's Health is administratively attached to the Commission on the Status of Women which indicates the work of the task force could be accommodated within current resources.

SIGNIFICANT ISSUES

The Department of Health (DOH) indicates HM14 continues the work of the SM19 Task Force that was convened as a result of the 2009 legislative session. The goal of HM14 is to provide oversight for implementing the recommendations of the SM19 Task Force, which are to: 1) reduce unnecessary referrals to CYFD and increase home visitation; 2) increase access to high quality substance abuse treatment, prenatal care and family planning for women; 3) increase access to supportive services; 4) increase treatment over incarceration for non-violent, drug-related crimes; 5) change attitudes about substance use; and 6) increase research and data collection around substance abuse

(http://nmwellwoman.com/attachments/article/63/Executive%20Summary%20SM19.pdf).

Though rates of substance abuse typically decline in pregnancy, several studies estimate that as many as 4% of pregnant women continue to use alcohol and/or illicit substances throughout pregnancy (Helmbrecht GD & Thiagarajah S. Management of addiction disorders in pregnancy. J Addict Med, 2008: 2 (1); 1-16). New Mexico may have even higher rates, as 2008 data indicated that 6.9% of all pregnant women surveyed used alcohol in the last 3 months of pregnancy. (NM Pregnancy Risk Assessment Monitoring System (PRAMS) via http://ibis.health.state.nm.us/query/selection/prams/PRAMSSelection.html). Specific data on rates of illicit substance abuse in pregnant women in NM is lacking, but in other states it is approximately 3%. Therefore, using PRAMS estimates, of the 30,156 births to New Mexican women in 2008, approximately 2,080 would have been to women using alcohol in the last 3 months of pregnancy and 905 to women using an illicit substance in the last 3 months of pregnancy. This does not account for likely overlap between these two groups, nor does it account for early pregnancy exposure to alcohol or drugs.

Substance abuse during pregnancy can lead to increased obstetric risks which can affect both maternal and child health. These health risks can be broken down into the medical conditions commonly co-occurring in substance-abusing women and those that primarily relate to the pregnancy. Some of the medical conditions linked to substance abuse include anemia, infections, depression/anxiety, diabetes and sexually transmitted infections. Obstetric complications include placental abruption, uterine infections, fetal growth restriction, fetal hypoxia and brain injury, neonatal abstinence, miscarriage, stillbirth, preterm labor and hypertensive disorders/preeclampsia (Helmbrecht GD & Thiagrajah S, 2008). Rates of these co-morbid conditions and complications are higher in substance-abusing women compared to the general population, yet these women are less likely to obtain regular prenatal care due to active substance abuse, stigmatization, and logistical barriers to care.

Regular prenatal care can improve birth outcomes whether or not a woman is able to stop using drugs in the short term of pregnancy (A. Racine et al., The Association Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City, 270 JAMA 1581, 1585-86, 1993). Threats of exposure and loss of child custody deter women from seeking prenatal care and appropriate drug treatment. According to a report published by the U.S. Department of Health and Human Services, National Center on Substance Abuse and Child Welfare, “One key reason for this lack of prenatal care is fear on the part of the pregnant woman of punitive action and/or the possible loss of custody of the child as a result of her drug use. Because quality prenatal care is such a critical factor in increasing the likelihood of good birth outcomes, everything possible should be done to ensure that the physician’s office is seen as a

safe and supportive resource to all pregnant women" (Young, et al., 2007, Screening and Assessment for Family Engagement, Retention, and Recovery, available at http://www.ncsacw.samhsa.gov/files/SAFERR.pdf)

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

HM14 relates to:

- SB353, which proposes that a publicly funded health facility that provides a substance abuse treatment program shall assess a patient for their need of family planning services.

RAE/mew