Fetal Alcohol Spectrum Disorders (FASD) and Drug-Affected Babies (DAB): Framework, Challenges & Opportunities

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Maine Office of Substance Abuse and Mental Health Services (SAMHS)
Presentation Goal: SHARING

I like sharing, so...I hope you leave here today with ONE “TALKING POINT” you can share with your peers that would encourage supportive discussions about pregnant women who are addicted to/using substances.

My 7-year old twin daughters – NOT always fans of sharing.
Fetal Alcohol Spectrum Disorders (FASD) and Fetal Alcohol Syndrome (FAS): What’s the Difference?

- **Fetal Alcohol Spectrum Disorders (FASD)**
  - *Umbrella term* describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy.
  - May include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.
  - Not a diagnosis.

- **Fetal Alcohol Syndrome (FAS)**
  - The term “FAS” was first used in 1973
  - *Specific birth defect* caused by alcohol use while pregnant.
  - FAS is a diagnosis.
Diagnostic Terminology

Pregnancy + Alcohol

May result in

• Alcohol-related neurodevelopmental disorder (ARND)
• Partial FAS (pFAS)
• Fetal alcohol effects (FAE)
• Alcohol-related birth defects (ARBD)
• Static encephalopathy (an unchanging injury to the brain)
Healthcare professionals look for the following signs and symptoms when diagnosing FAS:

- **Abnormal facial features**
- **Growth problems**
  Children with FAS have height, weight, or both that are lower than normal (at or below the 10th percentile). These growth issues might occur even before birth. For some children with FAS, growth problems resolve themselves early in life.
- **Mother’s Alcohol Use during Pregnancy**
  Confirmed alcohol use during pregnancy can strengthen the case for FAS diagnosis. Confirmed absence of alcohol exposure would rule out the FAS diagnosis. It’s helpful to know whether or not the person’s mother drank alcohol during pregnancy. But confirmed alcohol use during pregnancy is not needed if the child meets the other criteria.
Healthcare professionals look for the following signs and symptoms when diagnosing FAS (cont’d):

- **Central Nervous System:** The central nervous system is made up of the brain and spinal cord. It controls all the workings of the body. When something goes wrong with a part of the nervous system, a person can have trouble moving, speaking, or learning. He or she can also have problems with memory, senses, or social skills. There are three categories of central nervous system problems:
  - **Structural:** Smaller-than-normal head size for the person’s overall height and weight (at or below the 10th percentile). Significant changes in the structure of the brain as seen on brain scans such as MRIs or CT scans.
  - **Neurologic:** There are problems with the nervous system that cannot be linked to another cause. Examples include poor coordination, poor muscle control, and problems with sucking as a baby.
  - **Functional:** The person’s ability to function is well below what’s expected for his or her age, schooling, or circumstances. To be diagnosed with FAS, a person must have cognitive deficits or significant developmental delay in children who are too young for an IQ assessment or Problems in at least three of the following areas:
    - Cognitive deficits (e.g., low IQ) or developmental delays
    - Executive functioning deficits (poor organization, poor judgment)
    - Motor functioning delays (delay in walking, balance problems)
    - Attention problems or hyperactivity (inattentive, easily distracted)
    - Problems with social skills (lack a fear of strangers, be immature)
    - Other problems can include sensitivity to taste or touch, difficulty reading facial expression, and difficulty responding appropriately to common parenting practices (e.g., not understanding cause-and-effect discipline)
A diagnosis of FAS requires the presence of all three of the following findings:

- All three facial features
  - Smooth ridge between the nose and upper lip (smooth philtrum)
  - Thin upper lip
  - Short distance between the inner and outer corners of the eyes, giving the eyes a wide-spaced appearance.
- Growth deficits
- Central nervous system problems. A person could meet the central nervous system criteria for FAS diagnosis if there is a problem with the brain structure, even if there are no signs of functional problems.

These criteria have been simplified for a general audience. They are listed here for information purposes and should be used only by trained health care professionals to diagnose or treat FAS.

http://www.cdc.gov/ncbddd/fasd/diagnosis.html
Facts About FASDs

- Leading known cause of preventable mental retardation.
- Affects an estimated 40,000 newborns each year in the United States.
- More common than autism.
- Effects last a lifetime.
- People with an FASD can grow, improve, and function well in life with proper support.

**FASDs are 100% preventable.**
Facts About FASDs

- **No amount of alcohol consumption during pregnancy is proven to be safe.**
- FASDs are NOT always caused by intentionally by the mother (though some women who know they’re pregnant do continue to use)
  - Many women simply may not know when they are first pregnant
  - May not be aware of the harm that alcohol consumption during pregnancy can cause.
- All alcoholic beverages are harmful.
- **Binge drinking is especially harmful.***
- Not every woman who drinks during pregnancy will have a child with an FASD
- Any time a pregnant woman consumes alcohol, it becomes possible that her baby will have an FASD.
- Each person absorbs and metabolizes alcohol differently.

* Binge = 4 or more standard drinks on one occasion for women
When the mother consumes alcohol, the baby’s blood alcohol level reaches levels as high or higher than the mother’s. Thus, consuming large amounts of alcohol in a short period could be particularly damaging to the developing fetus.
“Of all the substances of abuse (including cocaine, heroin, and marijuana), alcohol produces by far the most serious neurobehavioral effects in the fetus.”

Possible Signs of an FASD (prenatally, at birth and beyond)

Signs that may suggest the need for FASD assessment include:

- Sleeping, breathing, or feeding problems
- Small head or facial or dental irregularities
- Heart defects or other organ dysfunction
- Deformities of joints, limbs, and fingers
- Slow physical growth before or after birth
- Vision or hearing problems
- Mental retardation or delayed development
- Behavior problems
- Maternal alcohol use
### Risks of Not Accurately Identifying/Treating an FASD

**For the individual with an FASD:**
- Unemployment
- Loss of family
- Homelessness
- Jail
- Premature death
- **Increased substance abuse**
- Wrong treatment or intervention is used

**For the family:**
- Loss of family
- **Increased substance use**
- Premature death
- Financial strain
- Emotional stress

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*Labeled as “Secondary Disabilities”*

*(i.e.: the attention deficits are a primary disability; the academic problem is the secondary disability)*
Among pregnant women, the highest prevalence of reported alcohol use was among those:

- Aged 35-44 years (14.3%)
- White (8.3%)
- College graduates (10.0%)
- Employed (9.6%)
**State-Specific Alcohol Consumption Rates for 2008: State-Specific Weighted Prevalence Estimates of Alcohol Use Among Women Aged 18-44 Years—BRFSS, 2008**

<table>
<thead>
<tr>
<th></th>
<th>Any Use*</th>
<th>Binge **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>50.3</td>
<td>14.7</td>
</tr>
<tr>
<td><strong>Maine</strong></td>
<td>58.7</td>
<td>18.2</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>63.1</td>
<td>19.5</td>
</tr>
<tr>
<td>NH</td>
<td>61.2</td>
<td>12.5</td>
</tr>
</tbody>
</table>

*One or more drinks during the last 30 days.

**4 or more drinks on any one occasion during the last 30 days.

Facts about Alcohol Use Among Pregnant Women: Maine

- **2010 Maine PRAMS* Data Brief, March 2012**
  - 39% of mothers reported their pregnancy was unintended.
  - Most women (89%) reported they received prenatal care as early as they wanted to. Of those who did not, 45% did not know they were pregnant.
  - **Alcohol and Tobacco Use**
    - 34% of women reported smoking in the 3 months prior to pregnancy. 41% reported having smoked some cigarettes in the past 2 years
    - 18% reported smoking during the last trimester.
    - 25% reported smoking at the time of the survey.
    - 77% reported drinking at least some alcohol in the 2 years prior to pregnancy, and 41% reported at least one binge (4+ drinks/sitting) during the 3 months before pregnancy

*Pregnancy Risk Assessment Monitoring System

Facts about Alcohol Use Among Pregnant Women: Maine

Office of Substance Abuse, TDS

Since 2007, about five percent of all women who have been admitted to substance abuse treatment were pregnant; in 2011, this represented 262 women.

- Of those, 52 percent were seeking treatment for synthetic opioids, followed by alcohol (12 percent), methadone/buprenorphine (11 percent), and heroin/morphine (seven percent).

- The proportion of pregnant women who were admitted for treatment primarily due to synthetic opiates has increased since 2007, from 38 percent. Over the same period, the proportion of pregnant women admitted for alcohol, heroin and crack/cocaine has decreased.

Substance Abuse Trends in Maine State Epidemiological Profile 2012
The Substance Abuse Mental Health Services Administration (SAMHSA) issued a report July 2, 2012 on drug-related emergency room (ER) visits in 2010. There were 4.0 million drug-related ED visits made by patients aged 21 or older in 2010. Of these visits, 1.9 million, 47.2 percent, involved drug misuse or abuse.

Between 2004 and 2010:

- The total number of drug-related ED visits increased 94 percent from 2004 (2.5 million visits) to 2010 (4.9 million visits).
- ED visits involving misuse or abuse of pharmaceuticals increased 115 percent
- ED visits involving misuse or abuse of narcotic pain relievers increased 156 percent
- ED visits involving misuse or abuse of oxycodone products increased 255 percent
- ED visits involving misuse or abuse of benzodiazepines increased 139 percent

The headline “About One Baby Born Each Hour Addicted to Opiate Drugs in U.S.” was splashed across media outlets on April 30, 2012

“...physicians found that the diagnosis of neonatal abstinence syndrome, a drug withdrawal syndrome among newborns, almost tripled between 2000 and 2009.”

“Although our study was not able to distinguish the exact opiate used during pregnancy, we do know that the overall use of this class of drugs grew by 5-fold over the last decade and this appears to correspond with much higher rates of withdrawal in their infants.”

More on this in a few slides...
## Drug Affected Babies: Maine

DAB Reports to OCFS by Calendar Year (CY)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TOTAL</th>
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<tr>
<td>CY 2006</td>
<td>201</td>
</tr>
<tr>
<td>CY 2007</td>
<td>274</td>
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<td>CY 2008</td>
<td>342</td>
</tr>
<tr>
<td>CY 2009</td>
<td>451</td>
</tr>
<tr>
<td>CY 2010</td>
<td>572</td>
</tr>
<tr>
<td>CY 2011</td>
<td>667</td>
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<tr>
<td>1st Quarter of CY 2012</td>
<td>200...</td>
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</table>

**Maine DHHS Division of Child Welfare, DAB Report 2005-2011**
## Drug Affected Babies: OCFS Reports

<table>
<thead>
<tr>
<th>Office</th>
<th>Assign to CIP</th>
<th>Referred to Public Health Nursing</th>
<th>Completed No Intervention Necessary</th>
<th>CPS Assessment</th>
<th>Total</th>
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<tr>
<td>Bangor</td>
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<td>69</td>
<td></td>
<td>1</td>
<td>51</td>
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<tr>
<td>Biddeford</td>
<td>4</td>
<td>9</td>
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<td>24</td>
<td>37</td>
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<tr>
<td>Caribou</td>
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<td>14</td>
<td></td>
<td>18</td>
<td>34</td>
</tr>
<tr>
<td>Central Office</td>
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<td>48</td>
<td></td>
<td>1</td>
<td>49</td>
</tr>
<tr>
<td>Ellsworth</td>
<td>8</td>
<td>10</td>
<td></td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Houlton</td>
<td>2</td>
<td></td>
<td></td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Lewiston</td>
<td>19</td>
<td>12</td>
<td>11</td>
<td>67</td>
<td>109</td>
</tr>
<tr>
<td>Machias</td>
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<td>4</td>
<td>2</td>
<td>9</td>
<td>23</td>
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<tr>
<td>Portland</td>
<td>5</td>
<td>20</td>
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<tr>
<td>Rockland</td>
<td>7</td>
<td>26</td>
<td>10</td>
<td>17</td>
<td>60</td>
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<tr>
<td>Sanford</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Skowhegan</td>
<td>17</td>
<td></td>
<td></td>
<td>22</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>118</strong></td>
<td><strong>179</strong></td>
<td><strong>72</strong></td>
<td><strong>298</strong></td>
<td><strong>667</strong></td>
</tr>
</tbody>
</table>

Drug Affected Babies: Maine Hospital Discharges

Of note: hospitals in Maine vary in their own “reporting” process (i.e.: whether or not the infant needs pharmacological treatment, etc... hence the discrepancy in DAB #s

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Marijuana**</th>
<th>Stimulants</th>
<th>Heroin/Opioids</th>
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</thead>
<tbody>
<tr>
<td>Pregnancy complications</td>
<td>No fetal growth effects</td>
<td>COCAINE</td>
<td>Stillbirth</td>
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<tr>
<td>Prematurity</td>
<td>No physical abnormalities</td>
<td>Prematurity</td>
<td>Prematurity</td>
</tr>
<tr>
<td>Decreased birth weight</td>
<td>Decreased birth weight</td>
<td>Decreased birth weight</td>
<td>Decreased birth weight</td>
</tr>
<tr>
<td>Decreased birth length</td>
<td>Decreased birth length</td>
<td>Decreased birth length</td>
<td>Decreased birth length</td>
</tr>
<tr>
<td>Decreased birth head circumference</td>
<td>Decreased birth head circumference</td>
<td>Decreased birth head circumference</td>
<td>Decreased birth head circumference</td>
</tr>
<tr>
<td>Sudden Infant Death Syndrome (SIDS)</td>
<td>Intraventricular hemorrhage</td>
<td>Neonatal Abstinence Syndrome (NAS)</td>
<td>Sudden Infant Death Syndrome (SIDS)</td>
</tr>
<tr>
<td>Increased infant mortality rate</td>
<td>METHAMPHETAMINE</td>
<td>Small for gestational age</td>
<td>Decreased birth weight</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**See next slide**

Addiction Science in Clinical Practice, 07/2011

Marijuana

- Even low concentrations of THC, when administered during the perinatal period, could have profound and long-lasting consequences for both brain and behavior (NIDA, 2008)
- New research 2012
  - “Marijuana Use May Cause Pregnancy Complications” (*The Journal of Biological Chemistry*, September 2012)
Maine Research

Dr. Marie Hayes
Professor of Psychology
Allied Senior Research Scientist and Lead Coordinator of the Neurogenetics Consortium, Maine institute for Human Genetics & Health

By studying the sleep patterns of opiate-addicted newborns going through withdrawal, University of Maine psychologist Marie Hays hopes to more clearly establish the connection between abnormal sleep and Sudden Infant Death Syndrome (SIDS) in high-risk babies, such as premature infants and those exposed during pregnancy to narcotics, medications, tobacco and alcohol.

MORE TO COME FROM UMAINE - STAY TUNED!

http://www.umaine.edu/development/home/dr-marie-hayes/
Safe Sleep Environments

- Particular risk factors for babies born substance-exposed
- “What does a safe sleep environment look like,” shows how to provide a safe sleep environment, and lists ways that parents and caregivers can reduce the risk for SIDS. The fact sheet is available at http://www.nichd.nih.gov/SIDS/
Breastfeeding & MAT

- “The benefits of breastfeeding often outweigh the effect of the tiny amount of methadone that enters the breast milk. Though breastfeeding generally is recommended, you should still discuss it with your doctor.” –SAMHSA
- “Maternal substance abuse is not a categorical contraindication to breastfeeding. –American Academy of Pediatrics (AAP)
- “…breastfeeding is associated with a 36% reduced risk of Sudden Infant Death Syndrome (SIDS).” –AAP
- “Maternal smoking is not an absolute contraindication to breastfeeding but should be strongly discouraged, because it is associated with an increased incidence in infant respiratory allergy and SIDS.” –AAP
Treatment of Pregnant Women

**Pregnancy Considerations**

- The continual cycle of intoxication/withdrawal can have significant adverse effects on a developing fetus.
- **Methadone is the gold standard treatment** for a pregnant woman who is opiate addicted.
  - Buprenorphine is not FDA approved for pregnancy use and has no long term neonatal outcome studies but is being utilized; research is ongoing (SAMHSA).
- Babies born to women on MAT (compared to illicit users or attempts at abstinence) are born full term, appropriate size, and healthy.

*Mark Moran, LCSW (Eastern Maine Medical Center)*

“Perinatal Addiction: Providing Compassionate and Competent Care”
Legislation

- **Keeping Children and Families Safe Act (KCFSA), 2003**
  - Reauthorized Child Abuse Prevention and Treatment Act (CAPTA)
  - First piece of federal legislation that directs states to establish policies and procedures to address the safety and well-being of infants affected by prenatal drug exposure
  - Requires that healthcare providers notify CPS when an infant is born affected by illegal substances or has withdrawal symptoms due to in-utero exposure

- **The Intent of KCFSA/CAPTA**
  - To bring substance exposed infants to the attention of child welfare, early intervention, and community support systems in order to assess and address developmental issues that may result from prenatal exposure
  - To help ensure a safe and stable care giving environment
  - To ensure that timely and appropriate services are made available to these infants

*Mark Moran, LCSW (Eastern Maine Medical Center)*
“Perinatal Addiction: Providing Compassionate and Competent Care”
Maine Office of Child & Family Services/Notification Process

- **22 MRS §4004-B** “Infants born affected by substance abuse or after prenatal exposure to drugs”
- **22 MRS §4011-B** “Reporting of prenatal exposure to drugs”
- 1-A: This section and any notification made pursuant to this section may not be construed to establish a definition of “abuse” or “neglect.”
- **§4004-B and §4011-B** are currently being revised to include notification of FAS/D as well as marijuana exposure; if approved new language will be effective September 2013.
Creating a Common Language

*Mark Moran, LCSW (Eastern Maine Medical Center)
“Perinatal Addiction: Providing Compassionate and Competent Care”

Despite what you hear in the news...

BABIES ARE NOT BORN ADDICTED!

- Not an accurate term
- Labeling = Limiting
- Language imparts meaning
Creating a Common Language

- **“Drug Exposed”**
  - Drug/substance exposure happens when a pregnant woman ingests some licit or illicit substance.

- **“Drug Affected”**
  - A baby becomes drug affected when that substance (licit or illicit) creates a condition in the baby that except for the exposure to the substance, would otherwise be absent.

- **Neonatal Abstinence Syndrome (NAS)**
  - When a baby experiences a constellation of clinically significant withdrawal symptoms, a diagnosis of Neonatal Abstinence Syndrome is made.

*Mark Moran, LCSW (Eastern Maine Medical Center)*
“Perinatal Addiction: Providing Compassionate and Competent Care”
Neonatal abstinence Syndrome (NAS)

- NAS is a syndrome of drug withdrawal seen in newborns born to women who are physically dependent on drugs during pregnancy.
- Scoring system developed by Loretta Finnegan (1975) to guide therapy for babies of opiate-dependent mothers
  - It is estimated that 95% of newborns exposed to opioids in-utero will experience NAS. This withdrawal can be severe if not adequately assessed or treated. Therefore, it is essential that anyone caring for these infants must be able to assess for NAS with accuracy.
- **Maine is doing amazing work supporting these families BEFORE their babies are born**
  - Connecting families to service and support providers as well as introducing them to hospital staff/caregivers
  - Educating them on “what to expect” if their baby experiences NAS
NAS Symptoms

- Symptoms depend on the drug involved. They can begin within 1 - 3 days after birth, or they may take 5 - 10 days to appear. They may include:
  - Blotchy skin coloring (mottling)
  - Diarrhea
  - Excessive crying or high-pitched crying
  - Excessive sucking
  - Fever
  - Hyperactive reflexes

- Increased muscle tone
- Irritability
- Poor feeding
- Rapid breathing
- Seizures Sleep problems
- Slow weight gain
- Stuffy nose, sneezing
- Sweating
- Trembling (tremors)
- Vomiting
Caring for Families

- Common emotions parents encounter in the hospital
  - Guilt for “causing” the infant’s withdrawal
  - Shame related to their addiction
  - Fear of how they will be treated by medical staff
  - Anxiety regarding their child’s well-being
  - Anger regarding being “told” how to care for infant
  - Frustration with inability to meet infant’s needs on their own
  - Fear of losing their child to CPS
  - Fear of not knowing what to expect
  - Frustration with lack of control
  - Anxiety related to level of knowledge of support system
  - Isolation being far from home/supports/resources

- “Take Home Messages” for parents
  - The past can’t be changed, but the present and the future can.
  - The emotions they experience are normal.
  - Despite their addiction, they are human beings and deserve to be treated with respect.
  - Most DAB reports result in baby going home with parents, and DHHS workers can be a resource to help the family.
  - We want the parents to be active members of the treatment team for their baby, and feel positive about their role as parent.
  - Making use of formal and informal supports is critical to their success in the short term and the long term.

*Mark Moran, LCSW (Eastern Maine Medical Center)*

“Perinatal Addiction: Providing Compassionate and Competent Care”
So what can we do???
We Can All Talk About Alcohol and Drug Use

• **Talk about the effects of alcohol and other drugs on an individual and on a fetus:**
  • Begin at an early age, such as elementary school.
  • Indicate that stopping drinking at any time during pregnancy will help the fetus.
  • Let women know that stopping any opiate use abruptly while pregnant poses serious risks to the fetus; treatment is the best option!
Prevention Starts With Asking!

All women of childbearing age should be asked about alcohol and drug use:

- Routinely at every medical appointment.
- At appointments in various systems.
- In a nonjudgmental manner.
- Via effective screening tools.
- And about possible prenatal exposure.
- Imbed questions about alcohol and drug use in general health questions (e.g.: wearing seat belts, taking vitamins, smoking, etc...)
So what does all of this mean for me and you in Maine?

COLLABORATION ACROSS THE SPECTRUM!

Preconception Health  Pregnancy  Infancy  Childhood  Parenting/Adulthood

Medical Providers  Families  Coalitions  Educators  Professionals

Everyone!
Strategic & Sustainability Planning
- Logic model
- TA from SAMHSA
- Education/social marketing campaigns/e-newsletter
- Community training
- Policy development
- Workgroups
  - Safe Sleep/MAT
  - Toddler Ingestions

Addressing Gaps
- Data collection (hospital vs. OCFS)
- Diagnostics/Treatment of FASDs
Media/Research

- **Key Findings: Lifestyle During Pregnancy Study – Low to Moderate Alcohol Use During Pregnancy and the Risk of Specific Neurodevelopmental Effects in Five Year-Old Children (CDC, July 2012)**
  [http://www.cdc.gov/ncbddd/fasd/key-findings-alcohol-use.html](http://www.cdc.gov/ncbddd/fasd/key-findings-alcohol-use.html)

- **Alcohol & Pregnancy: Another Perspective on the Disputed Danish Studies – WA State FAS Diagnostic & Prevention Network of clinics Response (July 2012)**

- **Alcohol Use and Binge Drinking Among Women of Childbearing Age — United States, 2006–2010 (CDC/MMWR, July 2012)**
  [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6128a4.htm?s_cid=mm6128a4_e%0d%0a](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6128a4.htm?s_cid=mm6128a4_e%0d%0a)

- **Alcohol in Pregnancy: It’s Never Safe, Especially Not in the First Trimester (TIME, January 2012)**

- **About One Baby Born Each Hour Addicted to Opiate Drugs in U.S. (ScienceDaily, April 2012)**
  [http://www.sciencedaily.com/releases/2012/04/120430190537.htm](http://www.sciencedaily.com/releases/2012/04/120430190537.htm)

- **Epidemic of Prescription Drug Abuse and Neonatal Abstinence (JAMA - Mark Brown, M.D., Marie Hayes, PhD, April 2012)**
National Resources

- **American Academy of Pediatrics (AAP)**

- **Centers for Disease Control and Prevention (CDC)**

- **March of Dimes**

- **National Organization on Fetal Alcohol Syndrome (NOFAS)**
  - [http://www.nofas.org](http://www.nofas.org)

- **The SAMHSA FASD Center for Excellence**
  - [http://www.fasdcenter.samhsa.gov](http://www.fasdcenter.samhsa.gov)
Amanda Edgar
amanda.edgar@maine.gov
(207) 287-2816
www.maine.gov/dhhs/samhs
So...

Will you be sharing?
QUESTIONS?