Mothers may not talk about it. You may not see it until the one or two year child visit when you find an adverse developmental screen. It is a secret that affects our children's ability to form attachments, control their behavior, to succeed in school and their future as productive citizens in our community. It does not have to be this way. Perinatal drug use is a known problem in our county. Pregnant women's use of alcohol and illegal substances is a recognized factor in infant morbidity and mortality.

National studies on illicit drug use in pregnant women have found:

- 4.4% of used illicit drugs such as marijuana, cocaine, heroin, ecstasy and other amphetamines.
- The rate of illicit drug use in pregnant women was 16.2% among women aged 15 to 17, 7.4% for ages 18 to 25, and 1.9% for ages 26 to 44.
- From 2000 to 2009, the number of pregnant women using or addicted to opiates (including drugs such as heroin, Vicodin, OxyContin, Darvon, and codeine) increased from 1.19 per 1000 women giving birth in a hospital to 5.63.
- The number of newborns diagnosed with drug withdrawal tripled from 1.2 per 1000 hospital births in 2000 to 3.39 in 2009.

The economic cost of women using drugs and alcohol during pregnancy:

- Children with prenatal cocaine exposure are 1.5 times more likely to need special education services in school. Special education costs for this population are estimated at $23 million per year.
- The lifetime cost of one individual with Fetal Alcohol Syndrome is estimated to be more than $2 million including $1.6 million for medical treatment, special education and residential care, and $0.4 million for productivity losses.
- In 2009, the average cost of caring for a newborn diagnosed with drug withdrawal was $53,400; in comparison the average cost for all other hospital births was $9,000. 77.6% of the costs for babies diagnosed with drug withdrawal in 2009 were paid by Medicaid.

The Public Health Department’s Maternal Child and Adolescent Health (MCAH) Field Nursing Program in Santa Barbara County found 14% of their clients had a current history or risk of substance use in fiscal years 2012-2014. Santa Barbara County has begun to address this crucial issue and by identifying the problem early we can act to prevent and reduce the adverse consequences to the child, family and community. Brochures that address available resources for families that have mothers with substance use and postpartum mental health issues are now available by region. ‘Parent Links Healthy Coping’ North County, Mid County and South County’. The state Family Health Outcomes Project (FHOP) and MCAH have developed a fact sheet: Alcohol and Illicit Drug Use during Pregnancy The Integrated Screening Tool is suggested. These brochures, the fact sheet and screening tool are available at www.countyofsb.org/phd/mcah under the Community Resource link on the left side of webpage.
Mandated reporters will be required to submit all communicable disease reports via the California Department of Public Health’s CalREDIE Provider Portal effective January 2014. The CalREDIE Provider Portal is a web-based system that allows providers to submit communicable disease reports timely and securely to the Public Health Department. The Santa Barbara County Public Health Department has been notifying and enrolling providers over the past year and receiving positive feedback on the ease of enrollment and use of the system. Under California law, (CCR, title 17, Section 2500) health care providers are required to report specified diseases or conditions, within specific timeframes, to the local health officer in the jurisdiction where the patient resides.

Providers are encouraged to enroll now to avoid disruption in operations and delays in reporting as faxed submissions will result in telephone calls to offices requiring immediate enrollment. Enrollment is simple and available by visiting the Santa Barbara County Public Health Department’s website at www.sbcphd.org/dcp. Please contact the Disease Control Program if you have CalREDIE Provider Portal enrollment or communicable disease reporting questions at 805-681-5280.

The local outbreak of Invasive Meningococcal Disease (IMD) in undergraduate students at UCSB, continues as a fourth case of IMD was recently confirmed. The symptom onset dates for the four cases were November 11, 13, 18, and 21, 2013. All cases are undergraduate students (freshmen and sophomores) at UCSB, and all are serogroup B. Note that serogroup B is not covered by the meningococcal vaccine currently used in the United States. Through our contact investigation we have identified and provided prophylaxis for over 500 students who were close contacts to the index cases. We continue to provide antibiotic prophylaxis (Ciprofloxacin 500 mg orally in a single dose) to contacts as appropriate. Note that this chemoprophylaxis is given in an effort to prevent a person from carrying the bacterium N. meningitidis in their pharyngeal flora; it is only effective for 1-2 days. Thus, if a person is re-exposed to a second case of IMD, they should receive a second dose of chemoprophylaxis. This is being administered by UCSB and the SBCPHD. At this time, and based on our ongoing epidemiologic investigation, we do not believe the Santa Barbara community at-large is at any increased risk of contracting IMD. We are not recommending mass chemoprophylaxis for either UCSB students or the community. We continue to communicate daily with the California Department of Public Health (CDPH) and the Centers for Disease Control and Prevention (CDC), and these discussion have included the possibility of obtaining an investigational vaccine that helps protect against serogroup B.

Patient Evaluation for Meningococcal Disease – Guidance for Providers

While many healthcare providers are familiar with the fulminant and abrupt presentation that is considered typical of meningococcal disease, it is extremely important to note that the onset of disease can also be insidious and non-specific. Indeed, two of the four cases thus far in the UCSB outbreak had presented to a healthcare provider at least once prior to their admission. Meningococcal disease was either not considered at all or was felt to be unlikely due to the subtle nature of their initial presentation. **Serogroup B disease may have a particular propensity for vague and non-specific early manifestations.** Invasive infection usually results in meningococcemia, meningitis, or both.

**Meningococccemia:**
- Early on, may resemble viral URI with coryza and pharyngitis.
- Other non-specific features often include fever, N/V, headache, chills, malaise, and myalgias (often severe).
- In the four UCSB cases, fever, myalgias, nausea and rash were common. Vomiting, chills, and rhinorrhea were also seen. Although high fevers are often described with meningococcal disease, the fevers in these cases are often low-grade.
- The pharyngitis, which in meningococcal disease is nonsuppurative, is sometimes misdiagnosed as streptococcal pharyngitis.
- The skin manifestations of meningococcemia, especially early in the course, can be extremely variable.

**Meningitis**
- Fever, HA, vomiting, irritability and/or stiff neck are often present early in illness.
- Meningococcal meningitis may also be present.
- Rash is present in 2/3 of cases.
- Importantly, around 10% of CSF culture positive meningitis cases have a normal CSF profile. Therefore, a 'normal' CSF profile does not rule out meningococcal disease.

**We are recommending that suspected cases of meningococcal disease be immediately sent to the Emergency Room for a full evaluation and blood work.** Physicians should have a very low threshold to obtain blood cultures, CBC and inflammatory markers in UCSB students who present with vague, influenza-like illnesses. **All suspected cases should be reported to Disease Control at (805) 681-5280.** We will continue to work with UCSB, CDPH, and the CDC to respond to this outbreak in a proactive, timely manner. New information and recommendations will be provided as they become available.