Maternity Care Coalition

Strengthening families, inspiring change

Testimony

Submitted on behalf of Maternity Care Coalition

Public hearing on Opioid epidemic impact on infants and children

Before the:

Pennsylvania House Children and Youth Committee

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Submitted by:

Rosemarie Halt RPh. MPH.

Director of Health Policy and Practice

2000 Hamilton St.

Suite 205

Philadelphia PA 19130

215-989-3582

www.maternitycarecoalition.org

Chairwoman Katharine M. Watson, Chairman Scott Conklin and members of the Pennsylvania House Children and Youth Committee:

Maternity Care Coalition (MCC) has been providing family support services to pregnant women, infants and families for over thirty years. Many of you know us as "The MOMobile" or as one of Pennsylvania's leading providers of the evidenced-based home visiting programs Early Head Start and Healthy Families America. You may not know that MCC works with pregnant and parenting women who are incarcerated at Riverside Correctional Facility and that we partner with DHS to provide parenting classes at residential drug treatment facilities and homeless shelters in Philadelphia. We have seen firsthand how Pennsylvania's current opioid crisis is affecting pregnant women and their infants.

Scope of the problem:

While today's testimony focuses on the impact of the opioid epidemic on infants and children, it is important to remember that children come in families. It is estimated that for every drug- or alcohol-addicted adult, seven additional adults and children are impacted. Over the last decade the United States has seen a dramatic increase in overdoses and deaths from opioid addiction. The most recent federal statistics reported a record 28,647 deaths in 2014, showing that opioid overdoses have quadrupled since 2000. Meanwhile, Pennsylvania saw 2,732 accidental opioid-related deaths in 2014, which is a 12.9% increase from 2013. To put this in perspective, in 2014 opioid use caused 40% more deaths than car crashes.

These increases in death rates from opioids have correlated with dramatic increases in the prescribing of opioids in the United States which has quadrupled since 1999. In Pennsylvania in 2012 there were 82.2- 95 opioid prescriptions per 100 people. That means that every man, woman and nearly all our children in Pennsylvania could have at least a 30 day supply of opioid pain killer!

What does this mean for pregnant women and their babies? This means that 14% to 22% of pregnant women will fill a prescription for an opioid. We also know that 86% of pregnancies are unintended among women who abuse opioids. Every 3 minutes a women goes to the emergency department for prescription painkiller misuse or abuse, with the majority of these women being of childbearing age. The Pennsylvania Cost Containment Council calculated that in 2015 2,691 newborns were hospitalized in Pennsylvania for substance-related problems and that 82% of these newborns were born addicted to opioids that their mothers took during pregnancy. This means that of the 138,000 infant hospitalizations in 2015, nearly 2% were due to opioids. This represents 250% increase in drug-related newborn hospitalizations since the year 2000. These medically-fragile infants require longer hospital stays than healthy infants, with an average hospital stay of 16 to 30 days. Furthermore, the care is expensive: in 2015 the cost of infant care to Pennsylvania Medicaid was $20.3 million.

The Infants and child impact:

Use of prescription opioids (such as Vicodin, OxyContin, and Percocet) and opioids used in medication-assisted treatment (such as Methadone and Buprenorphine) during pregnancy has been linked to physical defects in a developing infant's heart, neural tube (brain and spinal cord), and abdominal wall. Other complications of prenatal opioid exposure are miscarriage, preeclampsia, placental abruption, preterm birth, low birth weight, and sudden infant death.

Infants born dependent on opioids are often diagnosed with neonatal abstinence syndrome (NAS). NAS symptoms may include tremors, hyperactive muscle tone, seizures, and gastro-intestinal dysfunction. It is important to note that the diagnosis of NAS can vary significantly, as there is no standard definition in Pennsylvania. Additionally, infants born with NAS may not show signs until after being released from the hospital. This is particularly worrisome for infants whose mothers are still using opioids (whether the drugs are prescribed or not) and lack the proper support from social services. Indeed many

hospitals are reluctant to refer mothers and their at-risk infants to social services if the infant's NAS was caused by opioids that were prescribed as part of the mother's medically-assisted treatment; hospital staff are afraid that the mother will be accused of child abuse even though she was being proactive about receiving treatment for her addiction.

The underreporting of NAS is a significant public health issue. Pennsylvania failed to mandate hospital reporting under the 2003 CAPTA agreement and has never identified a uniform *Plan of Safe Care* for at-risk infants. With the recent dramatic rise in opioid abuse, there is a pressing need for the Pennsylvania legislature to take a collaborative approach in protecting our most vulnerable children.

Barriers to Treatment

Many, if not most, opioid-addicted pregnant women and mothers want to receive treatment for their addiction, but significant barriers prevent them from receiving care. One of the most influential barriers is stigma - not only from the community, but from medical professionals as well. Addiction is a chronic medical condition that requires consistent, long-term care. Yet many in the medical community fail to recognize this, thereby preventing patients from receiving adequate access to, and duration of, treatment. Women also face housing and job discrimination when they are in treatment. They struggle to bond with their infant who may be inconsolable due to suffering from NAS or adverse birth outcomes, adding to the mother's guilt.

Further exacerbating these challenges is the lack of early intervention services. For example, only 4% of the families that are eligible in Pennsylvania actually receive evidenced-based home visiting services such as Early Head Start, Nurse Family Partnership, Parents as Teachers, and Healthy Families America, which could provide the needed collaborative link for at risk families.

Unfortunately, this is not the first time MCC has encountered this sort of crisis. In 1988 we sponsored the first Philadelphia citywide meeting on Perinatal Cocaine Use and in 1989 we hosted a

"speak out" attended by hundreds on the topic of "Support for Families of Drug using Pregnant women". MCC was there to support women, children and families during for the crack-cocaine epidemic and as HIV and AIDs wreaked havoc in the lives of young families. Today we advocate again for decision-makers to help families address addiction. On September 21, 2016, MCC held a public policy forum on Opioids, Pregnant Women and Infants to examine the current crisis with addiction treatment specialists, medical professionals, behavioral health specialists and women from the community.

One of the special populations at even more at risk for opioid addiction are pregnant, incarcerated women. Many of which have a long history of addiction, as well as a history of suffering physical and mental abuse. These women often land in jail or prison partly from failure to treat the chronic medical condition of drug and alcohol addiction. Incarcerated women are also at greater risk for opioid overdose immediately after incarceration as a result of increased sensitivity to opioids. Incarcerated women who are pregnant need even more intensive services including behavioral and physical health care, addiction treatment, and prenatal care, nutrition counseling, and parenting education. During the MCC panel discussion, Kellie Phalen from Hour Children in New York City presented her personal and professional experience as an opioid-addicted, incarcerated pregnant mother. She credits her second chance and her recovery to the availability of a nursery in the jail which allowed her to bond with her baby. The attachment she developed to her baby inspired her to enter treatment, as well as into the post-incarceration reentry program run by Hour Children. Kellie's story resonated with forum audience. One attendee noted, "When we are in crisis, it's hard enough to just be able to get through the day, let alone get all the things done to make ourselves healthy as well as do all the things we need to do to ensure our children are getting all of the emotional, social and physical support they need to succeed. Having supportive services for them all in one place or at least in close proximity is critical for their children and them to thrive." Nine years later Kellie is a wonderful mother and program director for Hour Children Teen programs.

MCC's Riverside program experience and Kellie's firsthand knowledge capture what national research on incarcerated pregnant women have shown; a holistic approach to the incarcerated mother and her infant provide better outcomes than placing the child in foster care. Mothers whose infants are taken away often suffer from depression, making them more likely to have poor outcomes in drug treatment or to relapse. In addition, infants taken away from their mothers often suffer attachment issues. State policies that allow for prison nurseries and or family-based treatment as an alternative to incarceration would have a positive long term impact for these mothers and children.

To be sure, there is no quick fix for this sort of crisis. There is no silver bullet, but there are steps we can take to help ensure that mothers and their babies have the resources and support needed to turn their lives around and care for their children. The ongoing support of committed individuals and organizations is critical in helping keep babies and children safe, and to help parents through recovery.

It requires:

- State definitions of NAS and Plans of Safe Care
- Better data collection with more real time data
- Coordinated and integrated care of the pregnant mother and through the first critical year of the infants life
- Medical professionals to have appropriate opioid prescribing and monitoring *and*
- A long term financial investment and cooperation of government agencies

MCC is committed to conducting research and advocating for policies which help to improve maternal and child health and wellbeing through collaborative efforts of individuals, families, providers and communities. As always, our goal is to ensure that the particular needs of childbearing families are highlighted and that the voices of pregnant women and their families are part of the community dialogue.

Amidst this crisis it is imperative that any policy initiatives aimed at addressing this crisis include a plan of safe care for pregnant women and their infants.

Sources

http://www.cdc.gov/drugoverdose/data/statedeaths.html

http://www.cdc.gov/drugoverdose/media/index.html

http://www.fda.gov/downloads/drugs/newsevents/ucm454826.pdf

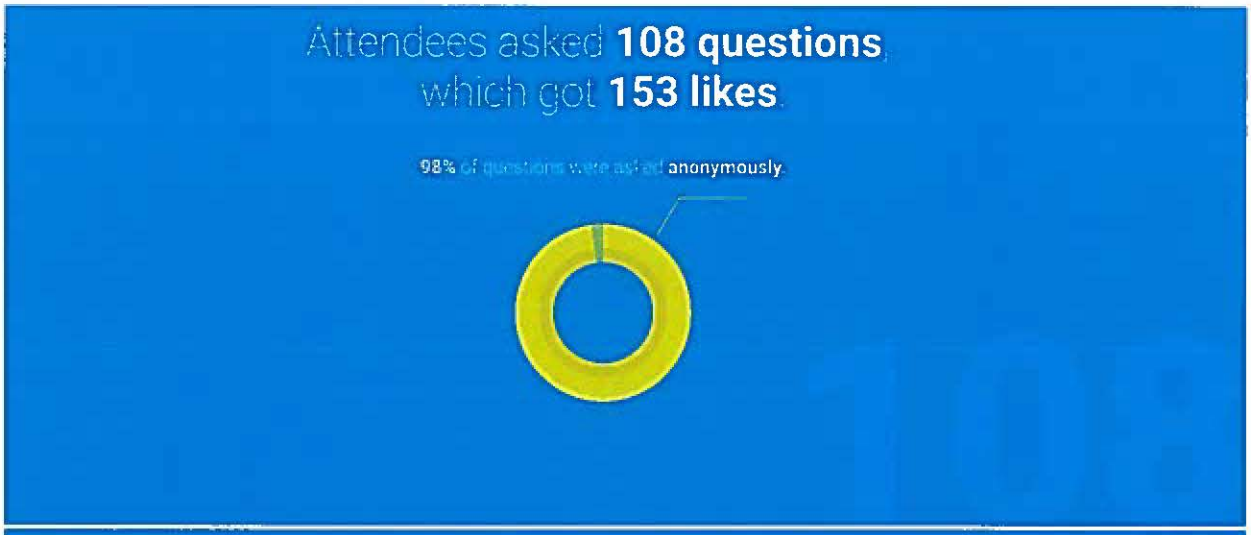
http://www.philly.com/philly/health/Report-More-Pa-babies-are-born-addicted-to-opioids.html

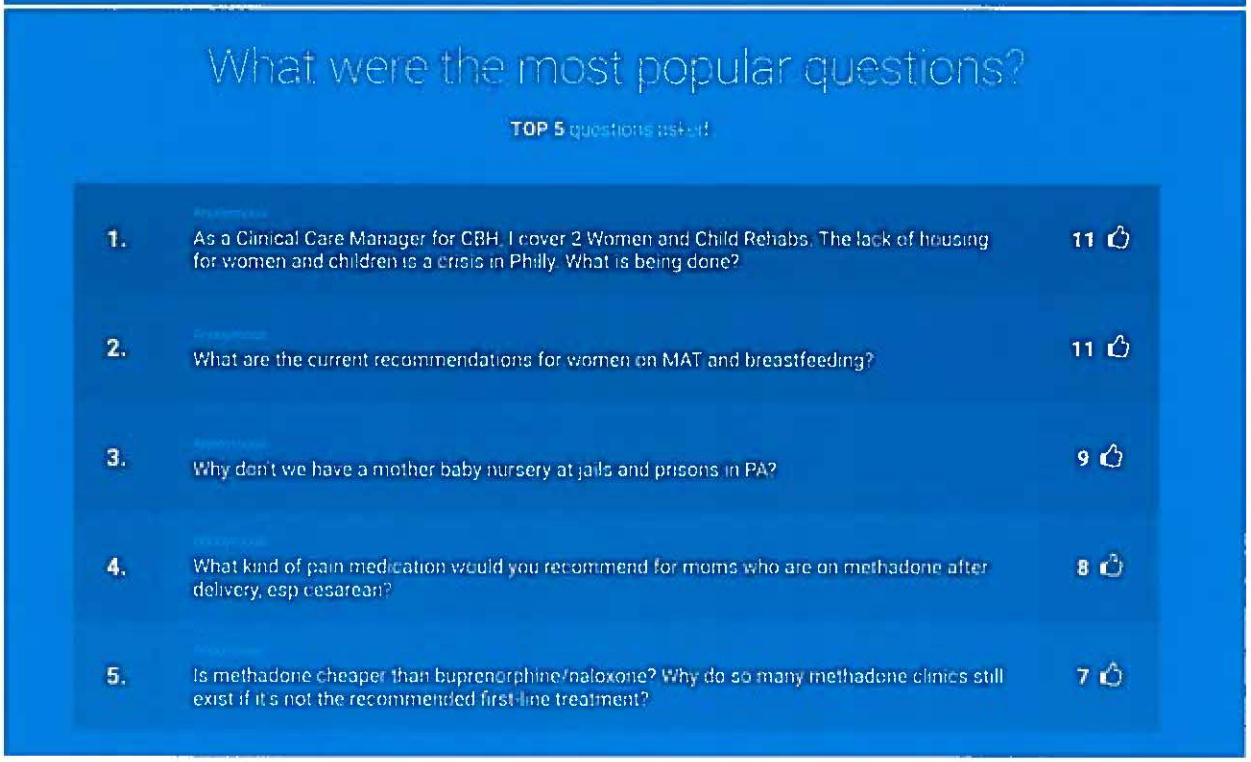
http://www.nwlc.org/sites/default/files/pdfs/mothersbehindbars2010.pdf

Attachments

Attached please find the feedback collected via sli.do at the MCC Fall Policy Forum on Pregnant Women, Infants and the Opioid Crisis

MCC Fall Policy Forum *Pregnant Women, Infants and the Opioid Crisis* Feedback





Inter-agency collaborations and integrated care models are becoming the recommended approach for the treatment of opioid addiction. In implementing these approaches, what barriers do you anticipate, particularly for the treatment of mothers and infants?

77

Effective coordination/communication with systems interacting with this population: e.g. Health care (Hospitals pediatricians, Obstetricians, NICU); Behavioral Health, Law enforcement/Criminal Justice and Child Welfare

48 %

Funding limitations

39 %

Identifying and engaging pregnant women

8 %

Education and training of staff to promote "buy in" and a common treatment approach

4 %

Other

1 %

What do you think are the most pressing areas needing to be addressed by policy makers in Pennsylvania?

77

Lack of safe and supportive housing for women and children
40 %

Intensive monitoring and case management for women and babies, including home-visiting models
21 %

Shortage of treatment programs for women and children
16 %

Increase availability of Medication Assisted Treatment (MAT) including Buprenorphine and Methadone
13 %

Policies surrounding the testing and screening of pregnant women and newborns for opioids and other substances and providing clear guidelines for follow-up
6 %

Other
3 %

Protective services for babies with Neonatal Abstinence Syndrome (NAS)
1 %

What do you think is the primary barrier for pregnant women and women with young children engaging in treatment?

82

Fear of child protective services and having their baby removed from their custody

63 %

Stigma and shame

17 %

Lack of access to treatment

7 %

Transportation and childcare

4 %

Other

4 %

Difficulty keeping appointments due to their addiction

2 %

Living in families and communities that do not support recovery

2 %

Source: Lancaster Intelligncer Journal/New Era **Date:** 9/12/2016

Born addicted: Lancaster County hospitals grapple with caring for opioid-addicted newborns

National Recovery Month: A special LNP report

By Susan Baldridge

There's an unnerving, high-pitched wail rising from neonatal units in hospitals across Lancaster County.

It's a reminder that some victims of the heroin crisis here are too tiny and too young to speak for themselves.

While abuse of both prescription and illicit opioids has soared, so too has the number of babies born with strong addictions to the substance, data provided by local hospitals show.

The surge in infants born addicted to the powerful drug is straining local hospital staffs and forcing nurses and doctors to scramble to find new ways to treat them.

"The thing you notice first is the crying, lots and lots of crying," said registered nurse Meggin Santiago, who works in the neonatal intensive care unit of Wellspan Ephrata Community Hospital. "It's loud and shrill and constant."

Many of the newborns suffer the nearly two dozen telltale signs of addiction including stiff muscles, convulsions, sweating, hypothermia, excessive yawning and sneezing, said Dr. Michael Bruno, a Wellspan neonatologist.

The condition, neonatal abstinence syndrome, is painful for the newborns. They vomit. They have diarrhea. They have itchy skin. Some are so irritated by the feeling of withdrawal they rub their skin raw.

Finding what works

Dr. Constance Andrejko, the head of neonatology at Wellspan Ephrata, said the neonatal nurses can be "stretched thin" by the amount of care the opioid-addicted babies need.

The babies often spend several weeks in the hospital and need to be held and rocked more than those born under normal circumstances. Addicted newborns are also more likely to become upset because of too much stimulation, doctors say.

Nurses must formally evaluate addicted newborns every three hours. They administer morphine, another opioid, and carefully wean the newborns off the drug over the course of weeks. "Sometimes we have to increase the support," said Andrejko. "The more the baby is withdrawing, we may have to up the dose or sometimes add a second medication."

They also dim the lights in the neonatal unit and use a device called a MamaRoo to gently move infants like their mothers would, which sometimes helps.

"It's a really big challenge to console them and get them to calm down. It's also stressful for the staff when the babies are not consolable," Andrejko said.

She is a big advocate of letting the moms stay with the babies as long as possible. "It's a win for everybody," said Andrejko. "The nurses in the NICU get help holding the babies, the babies do better and the moms bond with their newborns."

But some moms don't get to take their newborns home.

That's because the county's Children and Youth agency, which intervenes in cases of abuse and neglect, is notified when a child is born with neonatal abstinence syndrome. Director Crystal Natan said the effect on families brought on by the heroin epidemic has been "overwhelming."

A mother can go home with her newborn if is she is in a treatment program and has adequate support from family.

"But often children lose their parents to the drugs and the impact can be felt for generations," Natan said.

Heroin in a small town

Wellspan Ephrata Community Hospital lies in the northern part of the county and is surrounded by small towns and farmland. It's as likely to see Plain sect clients through its doors as anyone else.

The number of babies born with opioid addiction at the 130-bed hospital has more than doubled since 2014 and now represents nearly one of every 10 newborns treated in the neonatal intensive care unit, officials said.

Bruno, a neonatologist there, said those numbers are surprising to even him. "Heroin was always around but to think that 10 percent of the babies in the unit this year will probably be addicted? That's astonishing," he said.

Dr. Sharee Livingston, an obstetrician with OB/GYN of Lancaster who delivers babies at Heart of Lancaster Regional Medical Center in Lititz, said the increase in opioid-addicted babies is "a huge problem."

"Any physician interacting with moms and babies has probably seen more than a doubling of the number of addicted prenatal patients," she said.

Doctors at the 533-bed Lancaster General Hospital said the number of opioid-addicted babies born there has tripled in the last five years.

The increases here reflect statewide and national trends. The number of babies born with neonatal abstinence syndrome doubled between 2010 and 2014 in Pennsylvania. A baby addicted to opioids is born every 25 minutes nationwide, according to the National Institute on Drug Abuse.

Hospitals like Heart of Lancaster not only do a mental health assessment in the hospital of new moms but also soon after they return home.

"That is so important in these cases," Livingston said.

THE PEW CHARITABLE TRUSTS

STATELINE

How Heroin is Hitting the Foster Care System

October 09, 2015

By Sophie Quinton

Tamica Jeffers was charged with two counts of child endangerment after Ohio police say she overdosed on heroin while her children were nearby. State officials say the opiate epidemic is a reason more children are landing in foster care.

Timothy Dick's office receives all kinds of reports of child abuse and neglect. Perhaps a child

has a broken bone, or is underfed, or has been left home alone for too long.

But when caseworkers drive to the child's home to investigate, they often discover the same root cause. "What we're finding more and more is that the parents are addicted to opiates. And more often than not, it's heroin," said Dick, assistant director of child protective services in Clermont County, Ohio.

In Ohio and other states ravaged by the latest drug epidemic, officials say substance abuse by parents is a major reason for the growing number of children in foster care. In Clermont County, east of Cincinnati, more than half the children placed in foster care this year have parents who are addicted to opiates, Dick said.

The number of children living in foster care started rising in 2013 after years of decline. Last year, about 415,000 children were living in foster care, according to federal statistics released last week. Fifteen percent of them hadn't yet passed their second birthday.

It's not clear how many child-welfare cases nationwide involve parents abusing drugs or alcohol, said Nancy Young, director of the federally funded National Center on Substance Abuse and Child Welfare.

But she suspects that most cases do: "That's what all the caseworkers and judges are saying."

Added Pressure on State Systems

Numbers emerging from the states show how rising heroin use is putting pressure on child-welfare systems.

In Ohio, 23 percent of child-welfare cases investigated in 2013 involved heroin or cocaine, up from 19 percent in 2010, state records show. Seventy percent of children less than a year old who were placed in foster care that year had parents who were using those drugs, according to the Public Children Services Association of Ohio (PCSAO), a coalition of county child-welfare agencies.

In neighboring Indiana, Republican Gov. Mike Pence linked the spike in children moving through the child-welfare system—18,925 as of July—to drug abuse, especially of heroin, and hired 113 new caseworkers this year to help handle the load.

And in Vermont, substance abuse was cited in more than a third of phone calls to the state's child-protection hotline. Last year, 1,326 Vermont children were in state custody, up 33 percent in one year.

"Young children are coming into state custody in unprecedented numbers. This is primarily being driven by parental heroin use," writes Cindy Walcott, Vermont's deputy commissioner for family services.

Social workers point out that drug abuse does not always result in child neglect. But parents might be so consumed by addiction that all they think about is getting high.

Officials in the three states say child-welfare cases that involve drug addiction are particularly challenging because parents have limited time to prove that they're able to safely care for their children and get them back.

But kicking a drug habit—particularly when the drug is heroin—can be a lifelong battle.

Federal law requires that a child be reunited with his family or put up for adoption after spending 15 consecutive months in foster care (or any 15 over a 22-month period). "As soon as the child-protection agency files the case with the court, the clock starts ticking," said Angela Sausser, executive director of PCSAO.

Many parents can't recover in time. Relapse is common with opioids and heroin, Sausser said. And that's assuming parents can start drug treatment. Waiting lists are often long in Ohio and Vermont, particularly for intensive services like clinics where parents can detox with the help of medication.

When a parent has to wait three to six months simply to enter a treatment program, that's critical lost time, Sausser said.

Pursuing Better Approaches

Several states are tackling the problem by expanding addiction services.

Ohio, for example, has launched a pilot program aimed at helping pregnant women who use opiates deliver healthy babies. It's also working to license more drug addiction treatment providers, the state Department of Mental Health and Addiction Services said.

The Ohio agency's services are administered locally. Since the state expanded Medicaid under the Affordable Care Act, local boards have been able to take money that used to go to assisting uninsured residents and shift it toward nonmedical services, such as drug-free residential housing for recovering addicts.

Young, of the national substance abuse center, backs the expansion of the kind of hands-on, and often small-scale, programs that have been adopted in some states. In Illinois, three counties are served by a "recovery coach" program paid for by a federal funds and administered by a nonprofit. Parents get help navigating addiction treatment and additional support, such as parenting classes and help finding jobs and housing.

Specialized court dockets, such as family drug courts, can also help. Ohio's Supreme Court has certified such dockets in 20 courts. Participating families go to court every week or two, along with their caseworkers from child protective services and their drug treatment provider, so the court can check up on them. The extra accountability pushes parents into treatment faster, and helps them complete treatment and reunite with their children, Dick said.

Vermont is expanding a program that wraps more support around parents. The state Department of Children and Families divides the state into 12 districts. In six of them, when caseworkers go out to a home to investigate a possible case of child abuse, a social worker from the Lund Family Center, a nonprofit based in Burlington, goes with them.

"Our staff goes out on that first call and screens the family for substance abuse right then," said Kim Coe, director of residential and community treatment at Lund. Lund staffers help get parents spots in treatment programs and try to ensure that they actually start treatment, whether that means offering encouragement or finding transportation to their first appointment.

Although a Lund screener only monitors the parent until he or she enters treatment, that's enough to improve outcomes for families, Coe said. If the Vermont Legislature approves the necessary funds, she said, the program will expand to serve the whole state.

Over the years, community organizations, states and the federal government have tested new approaches.

Those that serve families best, Young said, help parents get into treatment and stay sober. Often, such approaches bring together everyone involved, from child-welfare caseworkers to the judge overseeing the case. "We now know what works," she said.

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