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PRESENTATION ON
SUBSTANCE-EXPOSED INFANTS

BEFORE:
HONORABLE KAREN BOBACK, MAJORITY CHAIRWOMAN
HONORABLE BARBARA GLEIM
HONORABLE JONATHAN HERSHEY
HONORABLE JOSHUA KAIL
HONORABLE NATALIE MIHALEK-STUCK
HONORABLE BRETT MILLER
HONORABLE TEDD NESBIT
HONORABLE TODD POLINCHOCK
HONORABLE MEGAN SCHROEDER
HONORABLE WENDI THOMAS
HONORABLE TARAH TOOHIL
HONORABLE JOSEPH PETRARCA, DEMOCRATIC CHAIRMAN
HONORABLE KRISTINE HOWARD
HONORABLE BRIAN KIRKLAND
HONORABLE BEN SANCHEZ
HONORABLE WENDY ULLMAN
HONORABLE DAN WILLIAMS

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Pennsylvania House of Representatives
Commonwealth of Pennsylvania

I N D E X

TESTIFIERS

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SUBMITTED WRITTEN TESTIMONY

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P R O C E E D I N G S

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MAJORITY CHAIRWOMAN BOBACK: Good morning, and welcome to today's public hearing held by the House Children and Youth Committee. My name is Karen Boback, and it is my privilege to serve as Chair of the Committee. The focus of today's hearing is on substance-exposed infants. This is a horrible consequence of the opioid abuse epidemic that continues to plague us here in this great State and in our Nation. These children are the truly innocent victims of that epidemic.

Children are born with symptoms of withdrawal after being exposed to drugs while in the womb. The diagnosis is neonatal abstinence syndrome, or you may hear it as NAS. Symptoms of withdrawal may begin as early as 24 to 48 hours after birth or as late as 5 to 10 days. Among the most common symptoms are tremors, irritability, sleep problems, high-pitched crying, tight muscle tone, hyperactivity, stuffy nose, sneezing, poor feeding and suck, vomiting, diarrhea, dehydration, sweating, and fever or unstable temperature. And it pains me even to read those symptoms.

The type and severity of symptoms varies depending on the type of substance used, the last time it was used, and whether the baby is full-term or premature.

In 2018 roughly 2,300 newborns in Pennsylvania were born with NAS. Today, we'll learn more about what's being done to care for these infants and their mothers who are trying to recover from the substance abuse disorder.

Before we begin the hearing, I'd like to mention that many of our Members, you'll see some coming and going. There are voting meetings throughout the capital, so they'll come back. And I don't want you to be upset with disruption. We're so used to it here, so please be advised if you see that happening, that's why.

I would like to introduce my counterpart, Chairman Joe Petrarca. Mr. Chairman, would you like to offer any comments before we start?

DEMOCRATIC CHAIRMAN PETRARCA: Thank you, Chair Boback.

I think Rep. Boback laid out certainly the issue very well. This is a problem that I think we've been dealing with in society for a number of years. I want to thank the Committee Members for being here and certainly our testifiers. Like many Pennsylvanians, we are looking for solutions to this problem, and I think it's certainly devastating when we look at this epidemic with children, with babies who obviously have no choice in this at all. So I look forward to the testimony and, again, thoughts and ideas on how we could work together to hopefully rid

Pennsylvania of this problem. Thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Chairman Petrarca. Now, I'd like to welcome our first testifier this morning. It's Robin Adams. Robin is the adoptive mother of a young son Asa who was a substance-abused infant. At the time she adopted him, he was substance-exposed.

In addition to being a devoted mom, Robin is a leading advocate on this issue. She is the Founder of Asa's Place, a residential recovery center for substance-exposed infants and their mothers. Thank you, Robin, for making the trip down from Wellsboro this morning to be with us. You may begin your testimony when you're ready.

MS. ADAMS: Thank you. Good morning, Chairwoman Boback, Chairman Petrarca, distinguished Members of the Committee. My name is Robin Adams. My husband Sean and I reside in Wellsboro, Tioga County, where we are raising our now-four-year-old son Asa. I've brought with me a picture of Asa from a few months ago at his firefighter birthday party. He had just turned four in November.

I join you today as both an adoptive mother of a baby born dependent and diagnosed with NAS and as the Founder and Executive Director of Asa's Place.

When it comes to deciding how much information I should share about Asa's story, I had to make a decision

early on. Essentially, I could have made the choice to keep his story private. We had made it out of the fire after all. Or I can make the choice to share his story, grab a few buckets of water, and walk back toward the flames to help other babies like him. I grabbed the buckets of water and headed back. I have since left speechwriting to dedicate my energy and efforts to Asa's Place.

Asa's Place is positioned to become Pennsylvania's first residential pediatric recovery center for infants with NAS with rooming-in for postpartum mothers. For two years I've worked diligently to build local stakeholder support and to earn a response from multiple State departments of DOH, DHS, and DDAP regarding licensing. The local stakeholder response has been incredible. Hundreds of individuals spanning health care, child welfare, the dependency court, mental health, early head start, substance abuse treatment, and local elected officials have all stepped forward to lift Asa's Place.

Regrettably, the State-level response has been a bit slower until recently when Deputy Secretary Sally Kozak of OMAP agreed to speak with me by phone and then more recently replied to a letter of inquiry submitted by my local Human Services Administrator and Tioga County Commissioners that was submitted to the Governor's Office.

I'm so pleased that Deputy Secretary Kozak has expressed interest in facilitating further conversations with department heads to explore the possibility of licensing residential pediatric recovery centers in Pennsylvania.

The cost savings for Medicaid promises to be substantial thanks to the Federal bipartisan opioid bill signed into law by President Trump last fall. The SUPPORT Act important clarifies the ability of States under Medicaid to provide care for infants with NAS in nonhospital settings.

This morning, I've chosen to focus on Asa and his story rather than Asa's Place. My minutes with you this morning are too important to get bogged down in the birth story of a nonprofit. Instead, I would rather share with you the birth story of my son. Asa's story is a First Corinthians kind of story, especially in that love always protects and does not fail. It started a little over four years ago when a caseworker named Daniel arrived at our door with a tiny infant who was three and a half weeks old and had just been discharged from a neonatal intensive care unit. For perspective, I brought with me the outfit Asa arrived in. Even in a preemie outfit, the sleeves were cuffed and his feet didn't reach the bottom.

The caseworker placed the car seat on our table, and I leaned in to smile at the baby boy and say hello. As

soon as our eyes met and I whispered hello, sweetheart, he began to cry. He cried inconsolably for hours on end and nearly continuously for the next three months.

Initially, he would not tolerate more than an ounce or two of formula every few hours. He was sleeping in 15- to 20-minute increments. He was at a heightened risk for failure to thrive, sudden infant death syndrome, and of choking on his own saliva. Asa choked and aspirated quite a bit for the first six months of his life because his autonomic nervous system was underdeveloped and his brain often sent the wrong signal to swallow versus breathe. He also had low human growth hormone levels, a low functioning pituitary, ketotic hypoglycemia, which would cause his blood sugar to plummet without warning, which was life-threatening and required hospitalization. He had cradle cap, eczema, atopic dermatitis, intolerance to several different formulas, gastric reflux, respiratory problems, an exaggerated startle response, hypersensitivity to light and sound, excessive sneezing, and constant hiccups.

If that constellation of symptoms or problems weren't enough, he also had gross motor delays, truncal weakness, sensory processing disorder, a tongue tie, a lip tie, myoclonic jerks well past infancy. Essentially for the first year I rarely left my house due to Asa's high

level of needing care.

At age one, my one-year-old was not like most other one-year-olds. He was not crawling, not self-feeding with a pincher grasp or swallowing correctly, and walking wouldn't come until 18 months. And he was nowhere near sleeping through the night, more like 30 minutes to an hour at a time.

During Asa's infancy, my husband and I hung double curtains in our first-floor windows to keep out the smallest shred of sunlight. If, when carrying Asa through the house, he encounter bright sunlight, he would cry, scream really, and it would take hours to calm him down. We ate with paper plates and plastic utensils to avoid the clanging of silverware and dishes. We spoke to each other in gestures rather than words because even a hushed whisper would wake him.

Yet we had a steadfast determination to put Asa's needs ahead of our own no matter what. You see, even before he drew his first breath he had already survived six and a half months of exposure to heroin, prescription painkillers, crystal meth, marijuana, cocaine, tobacco, alcohol, and bath salts, all while still in the womb. He had already survived in-utero exposure to toxic stress and domestic violence, and he had survived a premature birth. Surely we were not only not going to fail him, but we were

committed to making it up to him.

On any given day it took all we had to give and then some. We had announced and unannounced visits from Children and Youth caseworkers, scheduled visits from foster care workers, and three three-hour-long visits with the biological parents in our home every week, including no-shows and cancellations due to the parents being under the influence and even nodding out while holding Asa and once nearly dropping him.

We had early intervention service workers visiting three times a week for speech, occupational, and physical therapy. We had numerous court hearings to attend, concurrent planning meetings to attend, and what seemed like countless appointments with Asa's pediatrician and specialists.

Fortunately, as I mentioned earlier, I was on contract when Asa arrived, so I was able to dial back my work for a period of time. Yet because of writing about substance abuse and mental illness for so many years, I knew a lot about the dismal success rates for treating heroin addiction. I knew the data and the studies that highlight the extraordinarily high relapse rates. I knew about the barriers to treatment, and I knew a lot about how little addicts actually know about their own illness.

Having had this professional experience and

background, I knew that Asa's biological parents had a rough road ahead of them to regain their health and get Asa back, but I also knew I had to give it my all to help them succeed because I believed then that recovery is possible and families can be reunified and recovering addicts can be good parents. I still believe that, but in Asa's case I was wrong.

Yet on top of carrying for Asa I allowed myself to commit to caring for them. I called often, texted pictures, drove them to their treatment, to therapy appointments, to support groups, fed them, and on a few occasions I even found myself defending them. A year into Asa's placement with us I realized I had to stop. It had been a whirlwind of a year, a sleepless year, and my husband and I had been abruptly thrown into foster care as an emergency kinship placement for Asa. We weren't looking to adopt a child, and we knew very little about the child welfare system and even less about NAS.

Two years passed from the day Asa came to us to the day we finalized his adoption. One day when he is old enough we will tell Asa his story. We will try to choose the right time and the right words. We will tell him that his biological parents couldn't recover from their addiction even with treatment. We will tell him that they loved him, but the court determined he would not be safe if

he returned to them. When he is old enough, we will focus on the positive. We won't tell him about the multiple overdoses, multiple arrests, and, God willing, we will not have to tell him about their deaths.

I want to tell you that above all other challenges we faced and continue to face raising Asa, managing my feelings of resentment towards his birth mother for her drug use while pregnant zapped my strength and challenged my emotional maturity in ways I hadn't imagined possible. Every time she used a dirty needle, she risked his life. Every time she lost consciousness and her pulse slowed, so did his. When she went without nutrition for days, so did Asa. Yet he survived that addiction and now I will move mountains to make it up to him and to the other babies born under similar circumstances.

That is why I've joined you today. I ask that you consider babies like Asa and not as collateral damage to the bigger opioid crisis of adults but as vulnerable individuals deserving our protection, our programs, and our services right now, not some distant time in the future when we figure out a better way to report their births or design a better and more robust data collection system. We need to recognize that, based on the Governor's Opioid Command Center data regarding infants, we are demonstrating over 2,300 babies born annually with NAS in Pennsylvania

who are potentially not on anyone's radar and for many are left to be cared for by mothers who are quite possibly unable to meet their own basic needs on any given day.

We need to face the issue of substance-exposed infants with greater urgency. We need to understand the dramatic and lifelong impact of neglect and abuse during infancy. Consider in the first year of life 700 to 1,000 new neurological connections form every second. Now imagine how many connections or neural pathways remain incomplete or altered when mom is unconscious for hours at a time and/or disconnected from the caregiver role while battling her own withdrawal symptoms. Attachment deficiencies and disorders are extremely harmful and very difficult to overcome in one's lifespan. We should also consider the possibility that mom may not want to or doesn't know how to care for her infant in the first place.

I offer a few points. The National Institutes of Health tells us 86 percent of all pregnancies among opioid-abusing women are unintended. The National Institute of Drug Abuse, NIDA, warns that relapse rates and rates of overdose deaths from postpartum women are significantly higher in the 6 to 12 months following the birth of the child. NIMH, the National Institute of Mental Health, estimate 60 to 90 percent of drug addicts have mental, emotional, or personality disorders leading to poor

parenting skills. The Children's Bureau warns that the incidence of child abuse has tripled with drug-abusing caregivers, and the most dangerous time for the at-risk infant is within his or her first month of life.

Yet despite data points like these and with all the Commonwealth's strides in increasing access to treatment for adults and increasing treatment capacity or treatment beds, we have forgotten treatment cribs. In part I blame semantics, even well-intentioned word choices. For example, when we say a baby like Asa is born dependent not addicted, we close the door to substance abuse treatment dollars for infants because we are not treating a disease. We then are simply focusing solely on pharmacological interventions to ease withdrawal symptoms for a brief period of time after birth. Softening from addicted to dependent implies it is less harrowing to detox at three days old than at 33 years old.

Additionally, we often hear the argument the babies are not born addicted because the child did not choose to ingest a substance, so there was no cognitive functioning to develop an addiction. I can't win that argument because it is obvious and evident that Asa wasn't able to take money and make his way to a street corner to buy heroin when he was a few months old.

But I invite this Committee to ponder the

question that if addiction is a brain disease and the developed adult brain is essentially hijacked and neural pathways are rewired to endlessly pursue a drug, then is it not possible that the developing fetal brain is not rewired per se but actually is built synapse by synapse to endlessly pursue a drug. Numerous studies link adolescent and adult substance use disorders to prenatal exposure. Perhaps we should be treating the infant's addiction, not merely dependence after all.

When we soften, I believe we also lesson. When we lessen the magnitude and severity of an issue, we get complacency. For instance, when leaders in the field of child advocacy, medicine, and women's rights repeatedly make the statement that there have been no reported long-term effects of maternal opioid use on the developing child, they are softening and lessening. My response to this statement is twofold. The absence of longitudinal studies and robust research does not equal the absence of long-term effects.

And, well, I wish you could meet Asa. When we are more worried about shaming an adult or stigmatizing an adult's behavior than making sure we are providing for the needs of that adult, helpless enough, and very ill child, we are saying in essence even after birth the parent's feelings are more important than the infants well-being.

Having met Asa's needs throughout his infancy, I could not disagree more strongly with this thought process. Instead of hoping that despite mother's addiction she can and will care for her high-needs baby, often alone while continuing to turn a blind eye out of the public pressure to not stigmatize her and to respect the mother-infant dyad, we are oftentimes failing the vulnerable children.

Consider UPMC Magee's Pregnancy Resource Center in Pittsburgh. It is a phenomenal program that treats addicted mothers throughout their entire pregnancies offering conversion to medicated assisted treatment, unparalleled obstetrical care, and behavioral health care, all in a completely judgment-free environment. Yet despite their incredible approach, which essentially eliminates all barriers to treatment, roughly 30 to 40 percent of their patients quit the program. These moms, whether they decide they don't want to do counseling or they go back on street drugs or fail their weekly drug screening tests, eventually quit.

Included in the background that Cathleen Palm with the Center for Children's Justice prepared for this hearing is a mention of retired Pennsylvania Congressman James Greenwood's work to secure the 2003 CAPTA amendment, which attempts to ensure that infants affected by prenatal drug exposure are referred for and connected to

interventions. Back in April of 2002 on the House Floor former Congressman Greenwood said this when he was introducing his amendment. "Today, children are born all over this country to mothers who have substance abuse problems. Their mothers are alcoholics or their mothers are drug addicts. These babies are born in hospitals. They are frequently underweight. They are frequently frail. Much money and effort is devoted to bringing them to health. These children do not meet any definition of child abuse and probably they should not, but what happens is they are sent home from hospitals every day in this country, and it is only a matter of time in so many instances until they return back to the hospital abused, bruised, beaten, and sometimes deceased. That is because we have not developed a system in this country to identify these children and intervene in their lives."

Distinguished Members of this Committee, I offer that we are still in this same place and time. Still we do not have a system in place to identify and intervene. In part I believe this is because we have been reluctant to take any decisive actions when babies are born exposed or dependent because we do not want to appear punitive or too judgmental or lacking empathy and compassion. Yet logic tells me that an adult with a substance use disorder can recover from a bruised ego much more readily than a child

can recover from a bruised brain.

The brain disease model or medical model of addiction tells us that a pregnant woman who is addicted cannot help herself and that she will continue to use because she has a brain disease. Then it asks us to understand that she is not responsible for her choices or actions because she is at the mercy of her addiction. If we are to believe that and to except that, then we must be okay with or at least at peace with the knowledge that that same woman may over and over again cook a shot of heroin rather than warm a bottle. I'm not okay with that, and if you have ever loved a child, you are undoubtedly uncomfortable with this choice as well.

When it comes to intervening and helping babies like Asa, we've got to stand up for the infants. We've got to find some middle model if you will halfway between the moral model of the early 20th century and the medical model of today, a model that recognizes treatment works, recovery is possible, and families can heal but not at the expense of children. While I agree we should not be accusatory, blameful, or moralistic, I believe we need to be aware, informed, and willing to act on behalf of our most vulnerable citizens, the Commonwealth's babies.

Asa is no longer a baby. He is a rambunctious, imaginative, playful preschooler. In his classroom today,

he is one of the most affectionate, thoughtful, and brightest students. He is advanced. He is a friend and buddy to many. At home, he suffers from anxiety and aggressiveness. He can demonstrate an explosive temper, a short fuse. We work bimonthly with his child psychologist on impulsivity issues and deficits in executive function, yet he is one of the lucky babies. He has a real shot at becoming a healthy adult because of one person, the hero of Asa's story, Dr. Michael Flores.

Dr. Flores is a neonatologist at UHS Wilson Medical Center in Johnson City, New York. Asa was born at Guthrie Robert Packer Hospital in Sayre, Pennsylvania, but he was immediately transferred to the closest hospital with an available NICU bed for treatment of his drug exposure and his prematurity. There, Dr. Flores did something remarkable. He noted the level of heroin in Asa's system and contacted Tioga County Children and Youth, Asa's county of origin, not county of birth, and across State lines. One hundred is the lab result which is needed to confirm morphine or heroin in a baby's meconium at birth. Asa's result was 1,600. He found out later that live births above 400 are rare. We truly don't know the amount of heroin in Asa's system when he was born because the test stops, tops out at 1,600. We were also told that the results go above 500 to allow science and opportunity for

postmortem analyses to examine the give and take, the pull and push between levels of in-utero exposure to opioids and things like organ failure, placental abruption, and fetal death.

I owe this physician a debt of gratitude that I will never be able to repay. I have called him and spoke with him to thank him personally for stepping forward to alert Child Protective Services that my son would not be an infant that could be carefully cared for by his addicted parents. Had he not, I cringe to think of what would have become of Asa. I cringe, as we all should, to think of what has become of the estimated 8,000-plus Pennsylvania babies born with NAS in the past four years since Asa's birth, while they and thousands more to come have waited in the wings for us to do something concrete and tangible that demonstrates real and meaningful outcomes for them.

I don't propose to know the way forward, but our collective inertia is costing millions of dollars, it's costing lives, and it's robbing substance-exposed infants of healthy childhoods.

Thank you for the opportunity to join you today. I remain grateful. Thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Robin. You commented that you wished we had the opportunity to meet Asa. I feel we did through your testimony. Thank you

so much for being with us.

MS. ADAMS: Thank you.

MAJORITY CHAIRWOMAN BOBACK: Next, we welcome Bawn Maguire, a clinical nurse specialist for 38 years who has spent the last 25 years at Magee-Womens Hospital at UPMC. She began the Maternal Methadone Conversion Program at Magee in 2002 in response to the closure of an area hospital and opened the therapeutic nursery at this time. Since 2002, Bawn has seen the Women with Substance Use Program grow to include the Pregnancy Recovery Center, Women's Recovery Center, and the Parent Partnership Unit.

Good morning, Bawn, and thank you so much for traveling from Pittsburgh to be with us today. You may begin your testimony when ready.

MS. MAGUIRE: Thank you. Good morning, Chairwoman Boback, Chairman Petrarca, and distinguished Members of the Committee. As Chairwoman Boback said, my name is Bawn Maguire. I am a Clinical Nurse Specialist at UPMC Magee-Womens Hospital. I've been there for 25 years. And 17 years ago in 2002 I started the inpatient methadone conversion program because a local hospital actually who had been doing this work before us closed their doors. And women who were heroin addicts and were pregnant arrived at our hospital requesting help. And since we had not previously seen those patients, we needed to quickly decide

how we were going to take care of them.

So I started that program after I contacted the State to make sure that we were able to do that as an acute hospital, and I started that program at the same time I opened a therapeutic nursery for the babies because, again, pregnant women, we realized we would have babies eventually. So I started that program 17 years ago, and since that time, I've had 4,500 women present for care to me.

Additionally, I recognized at the time that women who were incarcerated in the jail system in our area were just being given Vicodin by the jailhouse infirmary to stave off their withdrawal, so I contacted the jail because I didn't think that was a reasonable treatment for these women because the majority of them also had hepatitis C. So I talked to those wardens and the physician, the medical directors, and they now do pregnancy tests of all women and urine drug scene tests of all women who they bring into jail, and if they are positive for pregnancy and opiates, they now also bring them to Magee to be converted as well.

So we've had about 4,500 women come through our facility. We are the only facility in the area -- and I get women from 29 counties who will present to Magee, as well as from three States for this inpatient conversion.

In 2014, it took a long time for me to get the

program up and going, but I was able to open the Pregnancy Recovery Center, which was the initial program that we opened. That's an outpatient medical home model that has been designated as a Center of Excellence. And in the last two years we were able to expand that to a Women's Recovery Center as well, just meaning that once a woman gives birth, we're able to continue her in that program. And then also women who have never been pregnant can also enter that program area. That's an outpatient buprenorphine clinic, so that is the oral medication that is used to assist women who have opiate dependence disorders. We've had about 500 women go through that program.

For women who fail that program for one reason or another, we are able to offer to those women an inpatient methadone conversion, which is a higher level of care from the standpoint of that would be daily-observed dosing. So there are some women that buprenorphine is not the correct treatment for them. Their addiction really requires that they have daily-observed dosing. We can immediately offer them an immediate inpatient treatment with methadone so that that patient continues to have an option for recovery. And that really was for me the hallmark of my opening these programs to offer a pathway to recovery for women.

And because I'm a Clinical Specialist at Magee, it has always been for pregnant women from my standpoint,

so I have always been about offering a pathway to recovery for pregnant women. And I've tried to remove every barrier present so that women can present to the emergency room 24 hours a day. There's no appointment, there's no preop, there's nothing that's ever required. They just need to present, be pregnant, and say I'm looking for a path to recovery, and we're able to offer them that. That was important to me.

And then in 2018 we were able to open a unit called the Parent Partnership Unit. This is a unit where babies who have been exposed to opiates in utero, we keep them for five to seven days after delivery for observation to see if they're going to go on to require pharmacologic treatment for neonatal abstinence syndrome. In the past, the mother would be discharged when she was physically stable, which was typically two days if she had a vaginal delivery after birth, four days if she had a C-section. We were able to open this program whereby the baby stays as the patient and now the mother is able to stay in the same hospital room. The mother is no longer a patient, but she is an integral part of the baby's care because the mother really becomes the medicine for the baby. And we were able to open this small unit.

And what we've been able to do is during this period of time where we have mom, who is really there with

the baby 23 out of 24 hours a day, that the mom then becomes the baby's medicine. We use this time to teach the mom safe parenting, positive parenting, stress management, infant massage, all of these kind of skills. And what we found is that 93 percent of the babies that make use of this Parent Partnership Unit are able to be discharged without requiring medical management with pharmacologic intervention.

In the past when we looked head-to-head with the same number of babies, with the same babies who were exposed to opiates in utero, we found that 60 percent of our babies whose moms were using methadone would go on to require pharmacologic intervention to treat their NAS, and moms who were using buprenorphine to treat their opiate dependence, 30 percent of those babies would go on and require pharmacologic intervention. So by using this treatment, the Parent Partnership Unit, we were able to really find only 7 percent of those babies went on to require medication.

So the close interaction with mom, it's supervised. The baby is the patient. There's a nurse so the baby has nursing care, but the mother is really the treatment, so she is both the medicine and the magic that keeps mom and baby together with intense parenting skills that we're trying to teach mom.

So far, we've had 50 couplets go through. It's a new program. It's a young program. And mom is made aware of this during her pregnancy. If she has other children, she has to make arrangements because she can't bring her other children in, so she's got to make some arrangements to be able to be away from her other children, her other responsibility, and we don't provide treatment or care for mom during this period of time because she's not the patient. She has a bed. We provide her with meals. But if she's on methadone, as an example, she will have to go out every morning, take a bus, go get her methadone, come back. We are not providing her medication. If she's on buprenorphine she would have a script and there's a lockbox there so she can keep her medication safe in the room, but we're not providing her with treatment or care.

So that has been from our standpoint successful from that standpoint with the baby in terms of the baby being able to successfully go through the observation period and not require pharmacologic intervention. So that's been our latest programming where we're trying to expand the pieces.

We are sharing this with all of our UPMC maternity hospitals across our system so that we can be able to share this because I think, as you all are aware, the issue doesn't just exist in Pittsburgh. The issue of

opiate dependence with pregnant women and with all people is across the country, and so we share all of our findings readily with everyone so that they understand what we're doing and the success that we have and the challenges that we face as well.

The other thing that we're very much aware of is the fact that addiction is a chronic medical disease, but it's got some unique characteristics, and those are that it's physical, psychological, and behavioral, so it's got behavioral components as well. And the other part is that it's a relapsing disease. And we know that we need much more in the way of research, especially in the pregnancy and postpartum population.

Some of the things that we found is that in our population we know that women tend to have some period of relapse in the late third trimester, and we also know that women are at very high risk postpartum for some relapsing. And that's concerning to us because we know that the challenges of new parenthood are great in every woman, regardless of her chronic disease, whether she has addiction or not. We also know that depression is a common problem, and in fact it's the most common complication of pregnancy for all comers, whether a woman has addiction or not, that depression occurs in approximately 20 percent of all women. And so if you know that, you've got to layer on

addiction to pregnancy, then we have a tremendous risk and a tremendous concern for women in the postpartum period if they've got addiction on top of the postpartum period. So it's a concern that we have.

One of the things that when I talk with women, I meet with women who are admitted for opiate use disorder in pregnancy and they're looking for recovery, when we go through the conversion process and I meet with women, I talk with them very frankly about their disease. I talk with them about the fact that if they're using methadone, that they have to understand that the medication that we provide treats their symptoms, it doesn't treat their disease.

We really firmly believe in all of our treatment programs that the treatment for their disease is the counseling, and in fact what the counseling is going to teach them is coping skills. And the moms that I've cared for -- and that's all I can speak to are the moms that I care for -- they in fact do not have any positive coping skills. What has happened to them in their life is the only coping skills that they have are negative. And when something bad happens to them, they use escapism and denial through drug use. And as I always say to them, what happens is that when something bad happens to you, you use escapism with drug use, and when you wake up, the problem

is still there.

And what counseling can give you are positive coping skills because even when you're sober, bad things will still happen to you, and you need a positive coping skill to deal with them in your life because now you're talking about having a baby. And the baby's going to get sick and the baby's going to cry and the car is going to break down. You need positive coping skills to be able to deal with them in a positive way. And that's what counseling will give to you are positive coping skills. These are tools to live your life in a sober way, tools and a toolbox. And so that's what counseling does for you. The medication keeps you from getting sick, but the counseling gives you positive coping skills. And that's why we firmly believe that the counseling is the hallmark of treatment for our moms.

And so by the time they leave from our standpoint the patients are -- and we really are just doing an induction or a conversion with methadone and then sending patients out to methadone clinics because we're not a methadone clinic; we're doing a conversion. And so I have women all the time saying to me how soon can I get out till I get my toolbox? How soon can I get out till I get the toolbox? I need the toolbox because I need the positive coping skills.

And so the thing that I always say to them is it also takes time and practice to learn and use positive coping skills. You've got to have time in recovery to be able to use these skills. One of the things we do know is the longer a mom is in recovery, the longer she tends to stay in recovery. So we like to get moms to come in as early as possible in pregnancy to stay in recovery.

We take women at any point in pregnancy, but the earlier we get them, the better. And it's always self-referral unless they are coming from jail, but the vast majority of our patients self-refer into our program. They just present to the emergency room. And we admit them at any time night or day.

One of the other things that happens when moms deliver and one of the things that I see all the time is that what they really need to keep themselves and their baby in recovery is effective, intensive counseling. They also need transportation to the methadone clinic or to whatever clinic if they're going for their Subutex or buprenorphine, and they need safe, supportive housing. Those are the three things that are most important for our moms.

And the other thing is when I talk to moms, the three most important things on their mind when they're pregnant that they have questions about is, one, did my

drug use harm my baby? So they want to know that. The truth of the matter is if it is opiates -- and at this point they're talking about were there physical defects, so that's their number-one question. Their number-two question is, in their mind, is CYF going to take my baby? And their third question is -- and this takes time for them to have a relationship with the caregiver to be able to ask this piece -- is is my baby going to grow up to be an addict like me? And that's their true fear.

And sometimes we have had patients who have refused to allow their baby to be treated for NAS with opiates, and that quite frankly -- if the baby goes on to require pharmacologic intervention, that is the treatment where the baby is started on some sort of opiate and then is weaned off. And we have had some parents who have refused to have their baby started on opiates and have signed their baby out of the hospital AMA, you know, and people, you know, have decided what's wrong with these parents, you know, they take them, why won't they let their baby have them and have vilified the parents.

And I've tried to let people understand if they would sit down and talk with the parents, the parents are not doing this because they hate their baby. They are doing this out of tremendous fear that what this will do is almost in the parent's mind prime the pump for the baby to

become an addict like them. And no parent -- these moms love their babies the same way every woman loves her baby. She already knows what she's doing is harmful. What we try to do is figure out, you know, she loves her baby, can't she safely parent her baby? But this woman loves her baby. She's trying to figure out is my baby going to become an addict like me, and that's her greatest fear in life.

But unless you have a relationship with this parent and she can safely say this to you, this is her darkest fear in life, she is so defensive over the fact of what she's done that she's not going to be able to share that with you. And so the key for us is to really be able to establish relationships with our patients so that they feel open enough to tell us their darkest fears so that we can walk with them in this journey to keep them in recovery as long as possible so that we can help them to see that long-term recovery is possible.

We have had many, many success stories for our parents and for our moms, but what they really need is long-term safe recovery. There are model programs in other States where they provide long-term recovery for single moms with their babies, for families in recovery with their children where they're able to have long-term recovery support groups with teaching and education for moms on how to safely parent their children.

These children will have effects of opiate use in utero for a very long time. Even if it's just a single drug that the mom and the baby was exposed to, there really are long-term physical effects for this baby for a long time. And when you have a mom who really may well not have been effectively parented herself so that she has no role modeling from that standpoint or if she really has severed ties because of her behavior due to her drug use and so she doesn't have any support from that standpoint, then she really needs someone, some sort of supportive system that's going to be able to continue to provide her with education and support long-term in a supportive housing system probably for 18 to 24 months that provides her with some childcare, with some supportive education, with ongoing counseling.

And there are model programs in other States that have shown that that has been able to let this child grow up when they've looked at the milestones for the child, that the child has really met and hit every milestone, that the mom has been able to maintain recovery long term, that the mom has been able to move into effective jobs because of this. And there are some that are family-centered so if Dad is in the picture, Dad has been able to also then maintain work related to this and maintain recovery. It's those kind of pieces I think that mom really needs, the

transportation to the recovery center, she needs help with all these pieces.

When you can do those pieces, then you're really taking a look at somewhere where you can perhaps break this whole cycle and that you can take a young woman who has many, many years of employment in front of her, and then you can take a child that doesn't have to than become a ward of the State. You can take a child that really has a full potential, that you can move all those pieces forward with recovery. So those are the pieces.

What we've tried to do and we keep continuing to try to grow all of the pieces with substance use disorder is we always try to offer a pathway to recovery. We recognize that all of ours starts with relationship-building with women because when we can do a relationship-building, we can pull them back into the healthcare system. These are women who really have not been engaged in the healthcare system for a very long time, so when we engage them in, then we can really support them and they can open up and we can offer them a lot more services because we know if we can offer them the services and keep them in recovery, we have a much better chance of a positive outcome for mom and baby and then set the stage for them to stay maintained in the healthcare system, and that gives us a better outcome.

Thank you very much.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Bawn. Very compelling testimony and a very successful program. Thank you for sharing.

At this time I'd like to welcome Cathy Utz, DHS's Deputy Secretary who heads the Office of Children and Youth and Families. For the last year, Cathy has been deeply involved in a multidisciplinary workgroup that is developing policy and protocol for plans of safe care for these infants and their mothers.

Thank you, Cathy, for joining us today to brief the Committee on the progress of the workgroup and to lend your perspective on this issue. You may begin your testimony.

MS. UTZ: Good morning, Chairwoman Boback, Chairman Petrarca, Members of the Committee.

As the Chairman Boback said, my name is Cathy Utz, and I have the honor of serving as the Deputy Secretary for the Office of Children, Youth, and Families in the Department of Human Services. I would like to thank you for the opportunity to testify today regarding how the State is responding to the Federal requirements surrounding infants born affected by parental substance use. And I think it's important to note that we're looking at parental substance use, and I know a lot of times we focus on

opioids, but we're looking at substances at large.

Developing policies and procedures for supporting infants born affected by substance use and their families is a complex issue that requires a community approach crossing multiple service systems. We've learned over the past several years that this issue is not confined to one population, and there is no "one size fits all" or even a "one size fits most" approach.

The 2016 amendments to the Federal Child Abuse and Prevention Treatment Act, known as CAPTA, mirrored the amendments that we made in Act 54 of 2018, and we've shifted the focus from use of illegal substances by pregnant women to the use of any substance that affects an infant. With this change, we are engaging with a broader population of mothers and babies. This includes women who are using legally prescribed medications for chronic pain or other disorders who do not have a substance use disorder; women who are receiving medication-assisted treatment for an opioid use disorder and are actively engaged in treatment; and women who are misusing prescription drugs or are using legal or illegal drugs, who have not yet been assessed for a substance use disorder and are not actively engaged in treatment.

Following the Federal CAPTA amendments, DHS brought together a team of stakeholders with expertise in

the fields most relevant to the aforementioned populations to begin thinking through our approach and compliance with the law. The Multi-Disciplinary Workgroup on Infants Born Substance Exposed, often referred to as MDWISE, has met regularly for more than two years to discuss how best to meet the needs of infants and their families. The workgroup is comprised of experts from the medical field, including neonatologists, obstetricians, pediatric and family physicians and nurses, representatives from the child welfare field, the courts, law enforcement officials, substance use disorder specialists, child advocates, legislative staff, and our partners from the Departments of Health and Drug and Alcohol Programs.

The intent of the workgroup was defined early: to develop a Pennsylvania policy agenda supported by multiple system partners that addresses prevention, substance use screening, referral to treatment, coordination of care for both the infant and the family, development of protocols for the federally funded required plans of safe care for the infant, and tracking of referral outcomes to better inform our work moving forward.

The workgroup has assisted in the development of State guidance to inform healthcare providers, substance use treatment providers, child welfare professionals, and others who will join multidisciplinary teams for plans of

safe care regarding primary prevention, substance use screening and referral to treatment, coordination of care for the infant and the family, development of protocols for the plans of safe care for the infant, and tracking of our outcomes.

The guidance was jointly released by DHS, DOH, and DDAP on March 1st and serves as a resource to help professionals understand their roles in ensuring Pennsylvania is compliant with the CAPTA requirements. This is a true collaborative effort that was not undertaken solely by DHS or created in a vacuum. The workgroup modeled the guidance off a national example from the National Center on Substance Abuse and Child Welfare. The guidance document includes definitions of terms that are included in Act 54 to provide as much clarity as possible to those working directly with infants and their families.

The guidance document also provides direction for county-level teams as they begin the work of developing plans of safe care for infants identified as substance-exposed. These plans of safe care, as required by CAPTA, will be developed for any infant born and identified as affected by substance use, including alcohol, and will be monitored by a multidisciplinary team. Each plan will be unique to the child and family and will include the supports and services necessary to ensure everyone's safety

and stability.

DHS, DOH, and DDAP have worked collaboratively with the workgroup to develop the guidance from a public health perspective. The guidance recommends that healthcare providers universally screen all pregnant women through use of evidence-based tools to support early identification of potential risk to infants and to ensure that pregnant women are connected with necessary services and supports to address identified needs.

Consistent with the Federal statutory requirements, healthcare providers are required to notify ChildLine, DHS's statewide hotline that accepts referrals of child abuse and general well-being concerns when an infant is born exposed to substances, and notice will be provided to the county children and youth agency. Additionally, hospitals will initiate the convening of a local multidisciplinary team prior to the infant's discharge from the hospital. The MDT will identify which agency is best suited to implement and monitor the plan of safe care on an ongoing basis. Team members could include home visitors, substance use disorder treatment providers, pain management specialists, Center of Excellence staff or county children and youth agency professionals.

Developing and monitoring individualized plans of safe care for infants born exposed to substances and their

families requires intentional collaboration, as multiple systems will be working toward the safety and stability of the family. The lead agency will be responsible for convening the team, monitoring implementation of the plan, and ensuring progress is being made toward all identified needs. If at any time a team member is concerned for the child's safety, a Child Protective Services or general protective services referral may be made to ChildLine for further assessment or investigation by the county children and youth agency when they are not identified as the plan of safe care lead entity.

To assist counties in meeting the new requirements, DOH, DHS, and DDAP have partnered with the Governor's Institute to provide five regional in-person work sessions to begin the process of operationalizing new policies and procedures in their own counties. These sessions are scheduled between March and June of this year.

We know addiction does not discriminate and affects individuals and families across Pennsylvania. Rather than treating the addiction alone, DHS recognizes the need to treat the entire person through a team-based approach, integrating behavioral health, primary care, and, when appropriate, evidence-based medication-assisted treatment. This approach allows treatment to address an individual's substance use disorder and the underlying

physical and behavioral health issues that are often at the root cause of addiction. Our Centers of Excellence across the Commonwealth have begun this critical work as a response to the opioid crisis.

Further, as I mentioned previously, Act 54 also affects those who may be at risk due to chronic pain or other disorders that require use of medications throughout a pregnancy. Whether a pregnant woman is under the care of a physician or not, any infant born exposed to substances deserves our attention to ensure the child's safety and provide safe support to the parents and caregivers.

The Pennsylvania Supreme Court has ruled that a woman's use of opioids while pregnant, which results in a child born suffering from neonatal abstinence syndrome, does not constitute child abuse as defined by the Child Protective Services Law. In light of the recent decision, many individuals have expressed concern for the safety of infants whose mothers have knowingly exposed them to substances prenatally.

As we learn more about the psychological effects of the disease of addiction and instances in which a child may be born exposed, DHS supports CAPTA and Act 54's focus on creating unique plans of safe care in an effort to connect these infants and their families to the appropriate systems and to provide them with the most relevant supports

rather than face criminal charges. Some instances may result in formal child welfare involvement and placement into foster care, but others may simply require the support of a physician as a woman manages a chronic disease while pregnant.

The shift from a punitive approach to a supportive one is critical. We do not want mothers to feel isolated when trying to maintain a healthy pregnancy, birth, and infancy for her child while struggling with the disease of addiction.

DHS believes that protecting Pennsylvania's children and supporting their families is a shared responsibility that does not rest solely with the formal child welfare system, and we are glad to have the support of our colleagues across disciplines in this endeavor. We believe that a public health approach to this issue of infants born exposed to substances will enable families to receive the help that they need to protect their children and raise safe and healthy infants, obtain necessary treatment, and connect with community services and supports that safeguard the health and stability of their families.

I would like to thank the Committee for your dedication to ensuring the safety and well-being of Pennsylvania's children and their families and for the opportunity to testify today.

MAJORITY CHAIRWOMAN BOBACK: Thank you so much for your testimony, Deputy Secretary Utz. Thank you.

Our next presenter is Frank Cervone, and he's the Executive Director of the Support Center for Child Advocates. Mr. Cervone will offer his perspective on the recent Supreme Court decision ruling that abusing drugs while pregnant does not constitute child abuse.

Mr. Cervone, thank you so much for traveling in from Philadelphia to be with us this morning. You may begin your testimony when you are ready.

MR. CERVONE: Thank you, and thank you for having me.

The Support Center for Child Advocates is Philadelphia's volunteer lawyer program for abused and neglected kids. We offer the skills and dedication of lawyer-social worker teams, including Representative Kristine Howard, who I want to call out for her own volunteer services to us at a different day.

For more than 42 years we have served as a resource to this Legislature and its staff, and I thank you for the invitation to serve in this role again. When asked, we attempt to provide balanced and constructive and candid assessment of what our children need and how we're doing for our kids.

Today, we consider the impact of the opioid

epidemic on children and families, while acknowledging that a focus on opioids alone will be detrimental to Pennsylvania's children because daily we see the headlines and law enforcement reports remind us that meth and cocaine and even alcohol can also have serious impact. Others will chronicle the demographics of this crisis. Governor Wolf appropriately declared a state of emergency.

These large-scale dimensions are easy to learn about, but they are exceedingly difficult to solve for one well-known reason: addiction is a difficult nut to crack. Anyone who has a person who has an opioid use/substance use disorder in their family or work life knows that recovery and sobriety take tremendous investments of public and private dollars for counseling, treatment, housing, child care, employment supports and more. We know, too, that recovery and sobriety need even more the more precious investments of patience and courage and love.

I'll briefly explore what the law provides pertaining to the care and protection of children and what those who practice in child welfare and our related colleague fields can teach us about the way forward. I'll suggest some points of study for the Opioid Abuse Child Impact Task Force in House Bill 316 introduced by your colleague Representative Owlett to the extent that this Committee elects to move that forward.

But if we really want to help, we will need to get a lot more serious about our investment and not just our laws. I note the contributions to my remarks by the neonatologist Dr. Hallam Hurt and Dr. Fred Henretig, both specialists in pediatrics and emergency medicine. They contributed to an amicus brief that our office and others put forward in the recent Supreme Court case I'll mention in a second.

I also want to recognize the leadership and study of our colleague Cathleen Palm, the Founder of the Center for Children's Justice. Cathy's commitment to the needs of children and families is both legendary and profound, dating back to her collaborative work with Representative Jim Greenwood so many years ago. Cathy has kept her focus on the well-being of children and kept our focus on real and effective plans of their safe care.

We know from the decision of the Pennsylvania Supreme Court in December of 2018 that prenatal substance exposure is not child abuse, as defined by Pennsylvania's Child Protective Services Law, the CPSL. The case is called *In the Interest of: L.J.B., a Minor*, which found that a person cannot have committed child abuse unless she was a perpetrator, and a person cannot be a perpetrator unless there is a "child" at the time of the act. Thus a woman's use of opioids while pregnant, which results in a

child being born suffering from neonatal abstinence syndrome or NAS does not constitute child abuse under the law.

Was this a good decision? I think it was the right one, both on the law and as a practical matter for both the mothers and their young children. As I mentioned, our office and several other child advocacy organizations weighed in in that case in that way in several different amicus briefs.

The decision falls into line with the unanimous vote of this General Assembly when it approved Act 54 of 2018 altering the language of the CPSL, including to say that any notification by a health provider about an affected infant was not to equate with a child abuse report. This is a consistent theme of the law for more than a decade, and we think it's the right one.

I urge the General Assembly to protect the Court's decision and its own efforts in Act 54, by not reversing either with new legislation. Some of my remarks today come with that court decision in mind, which I know feels a bit counterintuitive to some people when they hear the stories of harm and suffering that infants suffer in withdrawal. Some in the Legislature may be interested in a different and more punitive course. Criminalizing pregnancy cannot be a good idea.

So what should we know about substance-exposed infants and their mothers? From our perspective the first question is about child protection indeed, recognizing that the safety of the child is paramount for all parties involved in the child welfare system. Pennsylvania's existing mechanisms can safely protect the safety of substance-exposed infants and children. We have sufficient mechanisms all across the body of law and our practice. The legal standard governing the removal of a child from his or her parent is clear necessity, and having your awareness and responsiveness as a parent compromised by opiates is one such necessity. Everybody agrees.

I feel certain in asserting that there is not a county in the Commonwealth that, once made aware of a situation that would allow a person actively who is under the influence of drugs to continue to care for a child. Being stoned gets your kids removed. That's the reality of practice in the child welfare system today.

Second, and consistent with Federal law, Pennsylvania law requires a report and assessment for all substance-exposed births. So it was a long time ago when babies were born in hospitals to substance-exposed moms where the child was him or herself born substance-exposed and everybody just ignored it, right? For many years now we have flagged this phenomenon, this event in I think an

effective way.

Now, whether in fact we're getting to all those reports is a subject that we should study. Whether all of those births are being reported is a legitimate question for our study. That's part of what Act 54 was pointing to, but as you'll see in my notes, we have been addressing this very question for a lot longer than that. Cathy Palm's organization chronicled four bills dating back to 2006 at least that have been addressing this issue.

It wasn't Congress that first got this started, right? It was neonatologists and pediatricians who called it to all of our attention. But Congress did indeed embrace this idea with the CAPTA legislation, and they have in a sense renewed it. What they have said is that once we have that situation in the hospital, we have a duty to respond. Thus, the plan of safe care, right, that somebody would have a plan in place that this child would be safely cared for. We'd have a plan.

Are plans of safe care being created and implemented now? I'm not certain. We should be impatient that these plans are not in many communities or that there is some question about whether they are being issued and whether they are being implemented.

Whether all substance-exposed births are getting reported, whether there are any biases or other

irregularities in the pattern of these reports and assessments, and whether the individualized plans of safe care are effective in defining and delivering on needed services, are among the questions that might be studied by a task force or by this Committee.

And my third point, the stories you will hear today about infants experiencing withdrawal can be quite upsetting. Ms. Adams, very compelling testimony about Asa is one such example, and all we can say about it is it is tremendous and we need to hear it. But any study of prenatal substance exposure must acknowledge that an infant experiences pain and other symptoms of withdrawal. You have to talk about that right at the beginning, right at the gate, right? And then ask the question what are we doing about that and what does it mean?

Evidence does not yet indicate that opioid exposure itself is life-threatening or causing permanent harm, but obviously there is some intuitive sense that there may be some lingering harm, but intuition doesn't get us there. At a minimum we can agree that there's been insufficient research on the question. One respected resource, which we cite, says that "There's been no reported long-term effects of maternal opioid use on the developing child. Longitudinal studies over 5 to 10 years have shown that children who experienced NAS as infants do

not exhibit signs of physical or cognitive impairment as they mature."

Now, we had a very important lesson for this more than a decade ago with the so-called crack baby epidemic. And I call your attention to my remarks on page 6 and the studies of two brilliant neonatologists Dr. Eileen Tyrala and Dr. Hallam Hurt. These two docs in two separate studies were happening quite literally simultaneously but separately in Philadelphia hospitals, they came to this same question. Does cocaine exposure in the womb result in long-term and permanent effects? Dr. Hurt's research showed that cocaine-exposed and nonexposed subjects, all from low socioeconomic backgrounds, did not differ in developmental or cognitive outcome. What was the lesson? That poverty and the effects of poverty were at least as damaging if not more so, so that we were in a way wrongheaded to think that it was the cocaine that was necessarily making the difference. And I don't do justice to their work. They are brilliant and articulate in their own right.

Fourth, public health disfavors construction of prenatal substance exposure as child abuse. It simply does. Such a punitive approach discourages necessary maternal and prenatal care, it ignores the effects of prenatal opioid exposure on infants and opens the door to

over-legislating the various decisions women make during pregnancies -- I'll come back to that -- and it disproportionately harms women of color, poor women, and rural women. Rather than promoting healthier children and pregnancies, construing prenatal substance exposure as child abuse will harm children and women.

The prevailing standard of care across the professions is that prenatal substance exposure is a health concern "best addressed through education, prevention, and community-based treatment, not through punitive drugs laws or criminal prosecution." In the medical model, treatment, not punishment, is the remedy to reduce the consumption of substances during pregnancy.

It begs the question: Can these moms get treatment? The answer very sadly in many communities is they cannot. They cannot get treatment that lasts, they cannot get treatment that matters, they can't get treatment that works, back to my question of patients and courage and investment.

Fifth, whether in screening and assessment protocols or in considering this more punitive approach, there's the possibility of confusing the motivations behind drug use, or perhaps of confusing the identification of the drugs themselves. So we heard from the Magee program, medication-assisted treatment that women are indeed -- and

their babies are given medications to help with the withdrawal process. Those medications can sometimes confuse the testing. They'll result in the immediate removal of a child. What happens to that child? She's in foster care, and we have a whole different kind of case.

Sixth, it would problematic -- and Pennsylvania lawmakers have to date declined -- to legislate lawful substances that a woman may choose to use during pregnancy such as alcohol and tobacco, which are known to cause more pain and long-term harm to infants. It's what Judge Strassburger in the Superior Court version of the *L.J.B.* case called the slippery slope. Public policy, as well as Constitutional law, warn against the slippery slope of intruding upon there myriad decisions of a pregnant woman that she could reasonably make, which might likely result in bodily injury to her child after birth. Should a woman engage in physical activity or restrict her activities? Should she eat a turkey sandwich, soft cheese, sushi? Should she drink an occasional glass of wine? What about a daily cup of coffee? Should she continue to take prescribed medication? Should she travel to countries where Zika is present? You see how it goes on and on. So we think that we have the answer when we want to legislate this idea of substance abuse during pregnancy, but the slippery slope is really very scary.

This suggests the conundrum of the *L.J.B.* case: What makes opioids different from smoking or other potential harmful acts? Now, the court made a decision based on the text of the CPSL, as I said at the beginning, whether this fetus is a person, whether at the time of the exposure there is a person, that the birth happens obviously well after the use of drugs, right? You could correct that. You could technically write that away. You'd still have this much more difficult problem of how to get at pregnancy and in a sense what we mean by a woman's body and her right to make all of these choices along the way of her pregnancy.

Should some pregnant women be tested? So ACOG, the American College of Obstetrics and Gynecology, has long recommended screening, not testing but screening. Screening is that initial set of questions that asks about risk factors. It might certainly result in testing, but I want to caution you even there. Testing, as I've developed in some detail here, poor and rural women will be disproportionately impacted, especially those receiving Medicaid programs. The inherent inaccuracy of drug-testing results and methods will implicate investigative methods and compromise the results of drug testing, right? It's just not as simple as it looks.

Thus, even in the routine practice or in cases of

mandatory drug testing for all women, positive screening is a reliable confirmation at the front end, but distinguishing between heroin and commonly used prescription opioids and other analgesics makes this a much more complicated test question. It's a very expensive question beyond in a sense the technology. How to get at this level of testing result to the satisfaction of courts of law and of medical professionals will be really difficult.

With cost-prohibitive second-level testing needed, it's hard to imagine a drug-testing rubric being administered routinely and well in all settings. I'd urge this Committee and the task force, were it to be convened, to study the subjective selection biases and drug-testing inaccuracies, the costs of these protocols, which might result in unlawful discriminatory practices that would disproportionately harm women of color, as well as poor and rural women.

Finally, interpreting prenatal exposure as child abuse may have lifelong impact on the mother and then on the child. We know that a person who is implicated in a child abuse case gets an indicated report. It wouldn't be hard to see if one were to call this phenomenon of prenatal exposure a form of child abuse that that indicated report would get converted to a founded report by some court of

law. Now that mom has a record that is almost as large as a criminal record and sometimes larger in the context of employment and other forms of benefits, right? Is that what we mean to do in a sense is subject this mom, who may have had an addiction issue at a young point in her life, to a lifelong restriction on income generation, on employment, on childcare work, on working in the health professions because of her drug use when she was young? It's another version of the slippery slope.

So, finally, with due respect to the witnesses earlier, I don't believe it's a tension between a mother's feelings and ego and a child safety. I believe it's a tension of resources, of will, of treatment options, really of the profound commitment that everyone in the circle of a person or an addict's life that we need to make a difference, to turn that drug user into a safe mom and a safe parent. And I would urge you to take that in a sense more courageous though obviously harder approach. Thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you so much, Mr. Cervone.

Before we go to the next speaker, I just wanted to tell our audience that this is being taped so that all 203 Members of the House will have access to all of your testimony. Thank you.

MR. CERVONE: Thank you.

MAJORITY CHAIRWOMAN BOBACK: Next up, we welcome Dr. Jumee Barooah, who is a Medical Director of The Wright Center for Community Health in Scranton. The Wright Center is a partner in the Healthy Moms Collaborative. Good morning, Dr. Barooah, and please correct me on the pronunciation. And then you can begin your testimony.

DR. BAROOAH: Thank you, Chair Karen Boback. I am Dr. Jumee Barooah from The Wright Center. Good morning, everyone, Chair Karen Boback and Chair Joe Petrarca and Members of the Committee. Thank you for your time today and for inviting me to speak with you about opioid use disorder, its impact on pregnant women and babies, and our initiatives to address it.

I am a dually board-certified internist with The Wright Center for Community Health and its affiliated entity, The Wright Center for Graduate Medical Education. I am board-certified in addiction medicine and internal medicine, and I have served as a physician faculty at The Wright Center in northwestern Pennsylvania since I came back here two and a half years ago. In 2013, I completed my residency with The Wright Center for Graduate Medical Education under the guidance and leadership of now-President and CEO Dr. Linda Thomas-Hemak, and I am privileged to serve our community in my role today. I

attained my addiction medicine certification in 2017, and that is the reason why I'm here today to speak to you.

What is our rationale behind doing what we are doing? As we all know, addiction is not a new problem, particularly here in the great Commonwealth of Pennsylvania. It is a tragedy that we have seen cause irreparable damage to individuals and families across the Commonwealth. Addiction knows no boundaries, affecting individuals despite their race, gender, age, or socio-economic status. It does not discriminate; it does not relent. But thanks to groundbreaking investment at the State and Federal levels, it can, and it will end.

The gravity of substance abuse challenges is not amiss to my colleagues and me. As a primary care provider, I am committed to helping my patients lead the healthiest and most whole lives that they can. Substance use disorder has woven its way into the fabric of many of my patients' lives, as well as their families, often compounding already complex medical conditions.

More than ever, treating patients effectively in our practices requires providing a full spectrum of comprehensive health services, including oral health, behavioral health, and addiction medicine, amongst many more. One of our organization's key foci is also one of our region's most vulnerable populations: expectant moms

and their babies. I am proud to be a member of an organization that sees the value of comprehensive care for all, no matter their insurance status or their inability or ability to pay for services.

The Wright Center for Community Health's all-encompassing patient-centered medical home model has enabled the organization to grow its service offerings all under one roof, to include behavioral health and recovery services, a growth process that has made our organization better. We are also signees of the Opiate Pledge, have three physicians board-certified in addiction medicine, over 10 providers certified in medication-assisted treatment, or MAT. We are in the process of providing certification to many more. Why is that? Because 7 out of 10 cases of opioid misuse began as a result of prescribed medications. Our profession's contribution to the problem is sobering and has created a moral obligation to be part of a solution through proactive service offerings and our training of future physicians within our residency and fellowship programs.

I am impressed by my local government's interest in learning more about our steps towards creating a healthier Pennsylvania, as demonstrated by our time here today.

What is the reality? In order to clarify the

context, I would like to acknowledge the reality of our current situation across the Commonwealth. As healthcare providers, we know that helping our patients traverse the depths of addiction is not an easy fight, but rather, one that requires the engagement of our community partners and the investment of our local, State, and Federal officials. Within The Wright Center for Community Health's five-county services alone, there are currently over 500 individuals receiving treatment for opioid use disorder. In 2016 alone, 4,642 citizens of the Commonwealth lost their battle with opioid addiction. We are talking about 13 people every single day. That is up by 37 percent in 2017, and it's climbing.

One of the factors at the core of increasing mortality rates is the chemical makeup of some of the most prevalent substances in our region, namely opiates, which are constantly changing and are often cut with lethal additives including fentanyl and carfentanil. These potent drugs have the ability to change the receptors in the brain, making treatment immeasurably more difficult. One of the solutions with demonstrated success for combating these altered substances is medication-assisted treatment.

MAT is the use of controlled, regulated, and physician-observed prescription medications to help "coat" the receptors in the brain, quieting their cries for

opioids. MAT allows patients a nonpsychoactive way to help silence their brain's call for opioids, while focusing on changing their lifestyle and habits to support a life in recovery. MAT is neither a cure-all, nor is it a fit for everybody, but it is an option that, when paired with counseling and community support resources, can help reduce a patient's potential harm.

Though addiction can affect anyone, one of The Wright Center for Community Health's core foci is expectant mothers and their unborn children. In 2016, 2,250 newborns in the Commonwealth were born with neonatal abstinence syndrome, or NAS. NAS is a term used to describe a group of problems a baby experiences when withdrawing from exposure to drugs. Expectant moms who are using opioids and women undergoing MAT treatment for opioid use disorders may give birth to babies with NAS.

Treatment for babies born with NAS is unique and it's highly individualized to meet each baby's needs. Some may need medications to treat severe withdrawal symptoms that include high-pitched crying, seizures, temperature instability, sleep problems, feeding difficulty and tremors. Some babies will need extra fluids given intravenously to help prevent dehydration or high-caloric baby formula for babies who need extra calories to help them grow. Most babies with neonatal abstinence syndrome

who get treatment get better in about 5 to 30 days.

Though women undergoing medication-assisted treatment for substance use disorders may give birth to babies born with NAS, they are encouraged to participate in a MAT program. As per the American Society of Addiction Medicine Guidelines, medication-assisted treatment is the only form of assisted drug detoxification that is recommended in expectant moms. There is ambiguity in the management of these highly complex situations, and we are nowhere near to understanding is all.

The overarching goals of therapy for substance use disorders during pregnancy are to provide medical support to prevent withdrawal symptoms during pregnancy, minimize fetal exposure to harmful substances, and empower the mom to become a leader in her recovery. It's all about harm reduction. Such engagement provides the mom with the opportunity to receive medical and social support services, which improve both outcomes during and after pregnancy.

The pivotal time in an expectant mom's journey is where our Healthy MOMS program comes in. So what is our response to this? The Healthy MOMS -- with the M-O-M-S standing for maternal opiate medical supports -- program is made possible through the engagement of community partners in the healthcare, social services, education, legal sectors, and the generous support of the Pennsylvania

Department of Drug and Alcohol Programs and AllOne Foundation.

Through each partnering organization's engagement, moms-to-be and their families have access to a full spectrum of services to begin their lives in recovery and deliver happy and healthy babies. Our collective ability to engage expectant moms at this crucial time in their recovery means that, for every mom we treat, we are effectively touching two lives.

For moms seeking support, there is no wrong way to enter the Healthy MOMS program. In fact, we have received patient referrals from social services agencies, drug and alcohol treatment court, healthcare providers, and even our criminal justice system. The key to the Healthy MOMS program's success has been unparalleled leadership and support of partnering organizations such as the Lackawanna-Susquehanna Office of Drug and Alcohol Programs, the Lackawanna County Department of Human Services, St. Joseph's Center, Outreach Center for Community Resources, Maternal and Family Health Services, and many others. The breadth of the program's partnerships and the depth of each member's commitment to compassionate care means that each partnering agency operates at the height of their ability, providing unmatched service, support, and follow-up to this exceptionally vulnerable population.

We all know that, even in perfect circumstances, raising a child takes a village. The complex struggles surrounding opioid addiction can make pregnancy an even tougher time. Access to high-quality care and the courage to make the first step towards recovery are the two greatest barriers that we have seen moms in our program face. Our Healthy MOMS program here in Pennsylvania has been modeled after one such program in Ohio that also focuses on breaking down barriers of access to care. We like to say that there is no wrong door through which to enter our program, meaning that no matter the way a mom accesses one of our team's resources, she will have an immediate support system to connect her to all other services that she may need throughout the course of pregnancy and after.

As medical providers, our time with our patients is often limited to the face time that we have with each during a visit. We all know that life continues well beyond the constraints of the exam room, and, in fact, it is there where moms with opioid use disorder often need the most support. It is foolish of us to assume that any medical treatment we provide will stand the test of the immense chemical imbalance that opioids create without other social, behavioral, and community-based supports. In this regard, the Healthy MOMS program increases the

efficacy of our supports for each mom-to-be we see by surrounding them each with a full suite of services to suit their needs.

As a physician, I have directly seen and felt the benefit of the program, witnessing moms-to-be more able than ever to adhere to treatment plans, becoming more confident in their own strength and ability, and, more importantly, learning how to begin their lives in recovery and motherhood.

I would like to leave you today with one final thought. I have spoken today about the challenges that our community is facing, but I have left out a handful of things that, until recently, have shaped the discourse surrounding addiction and recovery. Throughout our time here today, you have not heard me say the words epidemic, statistic, death, tragedy, overdose, addict, user, junkie. I could keep going. Actualizing the change that we want to see within our community begins with changing a bit ourselves.

We all have the same goal: to create a happier and healthier Commonwealth. Our government's investment to date has given our community the boost that they need to jumpstart their lives in recovery. Continued investment at all levels will allow us to scale our current efforts to communities across the Commonwealth and continue to provide

accessible, nonjudgmental programming to help moms-to-be begin their lives in recovery.

Thank you all for your time and attention today. We have made incredible progress in recovery services, but our work is far from being over. Please continue to support legislation and funding for the Healthy MOMS program and related services. Your support has already helped countless moms-to-be and their babies across the Commonwealth, and it is imperative to continue doing the good work. We do all recover together. Thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Doctor. Thank you so much for sharing your precious time with us today.

Next, we have Lisa Pretko. Lisa joins us from Dallas, and that's in my legislative district. Lisa was a foster parent to a substance-exposed infant and agreed to share her personal story with the Committee today. And actually, Lisa, your testimony to me was instrumental in developing this hearing, so thank you from all of us.

MS. PRETKO: Thank you.

MAJORITY CHAIRWOMAN BOBACK: And you can begin when you're ready.

MS. PRETKO: Thank you, Representative Karen Boback, for inviting me here today and the Members of the Committee so we could tell our story about having a baby

that was born addicted and basically taking care of her.

And I'm not going to go into the effects of that because Robin had already stated it so well, the withdrawal and the pain and suffering that a child goes through when they are going through withdrawal, but I am going to tell you about my family's story and how it affected us personally.

I was taking care of a baby that was born addicted, along with my family. She is actually my great-niece. And when I met Karen the one night at dinnertime, I introduced the baby to Karen. Karen thought that was my granddaughter, and I said no, this is my great-niece, and we need to do something as far as protecting these babies that are born addicted.

First, I would like to ask, how many thousands of dollars are spent on rehabilitation for mothers to babies that have been born addicted in one year? And for all those thousands of dollars that we are spending on the mothers through rehabilitation to the point where they can care for their babies, I asked the same question to a caseworker that had over 20 years' experience working with Children and Youth. She had told me mothers that are currently using drugs and alcohol, there are very few if ever at all they are truly rehabilitated to the point where they could be wonderful mothers.

With that said, I would like to share our family's story. On August 7th, 2017, a baby was born addicted to five illegal drugs: opioids, codeine, methadone, cocaine, and morphine. In addition, the mother tested positive for cocaine within 24 hours of giving birth. On August 21st, 2017, I brought the baby home from the hospital. The baby didn't come home with just a car seat and a diaper bag, but she came home experiencing the extreme and painful symptoms of withdrawal. She was prescribed phenobarbital twice a day to help ease the pain, which we continued to give her through the beginning of November. And again, if anybody ever watched or experienced to see a baby going through withdrawal is actually heart-wrenching.

The mother of the baby was receiving services from Wyoming Valley Drug and Alcohol Counseling, CleanSlate, and attended Northeast Counseling for many years. Upon completion of a six-week program with Wyoming Valley Drug and Alcohol Services, she came to our home for a visitation, and she was intoxicated the day that she received her first coin.

Children and Youth had communicated to me that she was also eliminated from the program CleanSlate, that she was dismissed from that program because she kept failing. I believe the mother agreed to six more weeks of

Wyoming Valley Drug and Alcohol Counseling, and the program still had not changed her behavior. So again I ask, how much services are we going to give to mothers and it isn't working? We need to really come up with a plan that maybe we institute more birth control to avoid this issue altogether, education as well.

As the mother struggled with addiction, my family and I discovered that the father of the baby is a convicted drug dealer and an illegal immigrant. When asked the mother, she refuses to admit in court under oath that she is aware of the father's baby, and neither the mother or the father currently has a job or income, which makes me assume that they are continuing to use drugs and alcohol and deal drugs within the community.

I'm going to fast-forward to current events. On October 25th, 2018, a court hearing with the mother's attorney was held, and her attorney requested unsupervised visits. The Judge granted two hours per week of unsupervised visits with this child. The Judge also questioned Children and Youth if they had done any unannounced visits to the mother's house, and the answer was no. They have done announced visits to check up, but they have not done any unannounced to see who actually is living with the mom.

On October 27, 2018, the mother of the baby was

again intoxicated. However, during the course of the following week, the mother went for her urine screening test, and those tests continued to come out negative. So my question is why are these urine tests that the mother is doing coming out negative when in fact I know she is still being intoxicated? And I can tell you all today why those tests come out negative is because you can currently buy urine online, as well as the catheters to insert it. So not only are these women that are doing drugs in the process of trying to get their children back, but they're not even using the current urine or their own urine to be tested, which we're spending a ton of money on all of these tests, and we're not even testing the correct urine or making decisions based on processes we should be.

I had asked Children and Youth, the caseworker, if they could do hair follicle testing, which would give a better picture of what the mother had consumed in the past three months. I was told no because it's too expensive. On Wednesday, November 14, 2018, I had texted Children and Youth and asked if they had any way that they could do a hair follicle test, and the caseworker had repeated no, that they would not do that. They continued to use urine testing. However, hair follicle screening would not be an option. I also agreed that I would offer to pay for the service if we could keep this particular baby safe, and

they would not allow that to happen.

During the week of December 20th, 2018, Children and Youth approved overnight visits for this baby to go with his mother and his father and overnight from Christmas Eve through Christmas Day. Previous to this, again, they had no unannounced home visits to see in fact who was living there.

I am here to ask and even beg that the laws be changed currently or procedures for testing of mothers that have given birth to babies born addicted, that the current system with using urine testing is not currently working. And I even asked my niece, who is the mother of this baby, if somebody goes in while the testing is being done, and she had told me no. Sometimes somebody is there, but most of the time they hand you a cup and you go and urinate and that's what you have tested.

Our story does not end well. As Robin had indicated, she adopted her son, now four years old. On February 25th, the mother received custody of this baby at court. Judge Jennifer Rogers had given the mother the custody of the baby back. So now this baby is in a home potentially with drug dealers, an illegal immigrant, and with a mother that is currently still using. And my question to you is how could the system fail so badly? And how many other children are out there suffering at the

hands of the system that may not be working for everybody?

When I had a conversation with my niece and asked her why she did not go for help when she was pregnant with the baby, and she told me she did not go for help out of basic fear. I asked her what she did and the drugs that she had taken and if she had prenatal care, and her answer was no prenatal care. She took drugs every time she would feel the baby shake because she knew the baby was going through withdrawal, and she wanted to get high so she no longer had to feel that baby shaking inside of her.

The baby currently -- or when she was with us -- went to see a specialist, a neuro specialist, and at that point she was already three months behind in development because of the amount of drugs that she was addicted to from birth.

So I am here today again to say I know it's a long process and I know it's going to take time, but if there is any way possible we could implement hair testing to people that have gone through the ugly, ugly addiction of drugs for these children prior to the parents getting their children back, I would be forever grateful.

And again, I thank you for your time and for listening.

Also, for the past 18 months, I have put together information what our family has gone through, a letter that

I wrote to Judge Jennifer Rogers, when I contacted the police department about this situation, which in fact they tell me it was not their problem, it was Children and Youth's problem, but detailed information of everything. Again, I have 25 copies. I can give them to you, Karen, and if you're willing to share them, it tells the whole story in much more detail. But thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Lisa.

MS. PRETKO: Does anybody have questions for me?

MAJORITY CHAIRWOMAN BOBACK: What we'll do is we have one more testifier. I've been watching the clock. We're on the floor at 11:00. So after our last testifier, anybody, if you would stay, and anyone from Committee who has questions, if that would be all right with our testifiers.

MS. PRETKO: Thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you.

Now, I welcome Dawn Hennessey, Director of Angel Arms, a community care center in Latrobe, Pennsylvania, which is in Chairman Petrarca's district. Angel Arms provides support for recovering moms and their babies. Good morning, Dawn.

MS. HENNESSY: Good morning.

MAJORITY CHAIRWOMAN BOBACK: You may begin when you're ready.

MS. HENNESSY: I have to apologize I don't have a speech written out for you because I think I rewrote it about 25 times. There was a wealth of information given today, and, as I was sitting there listening, I decided that I'm going to just put on my mom hat, my professional had as a therapist that specializes in drug and alcohol, and also I'm doing dissertation work for my Ph.D. on children and infants and addiction.

So I have a few different areas that I'm coming out at you, but I'm going to speak from my heart and kind of try not to cry because it's touching.

I listened to Robin's story and when she sat down I said you read my speech. Robin I just met. I messaged her two days ago and just said I look forward to meeting you but we knew nothing about each other's story. And then I listened to Lisa's story. These are real stories, what's happening to our children.

My story started about six years ago when a couple walked into my center, one of the centers that I've opened in Latrobe, just to use the phone. It was the middle of February and freezing cold. It was one of our colder winters. And this couple walked in and proceeded to tell me that she was pregnant and they were living on the streets and both of them were addicted to drugs. Neither one of them would allow us to help them to find them a

place to stay. They wanted to continue to be on the street because they wanted to continue to use.

The lady went out. She was in her 30s, went out and was standing on the street, so I walked out with her and just said, well, what can I do, you know, just trying to build some type of connection with her because I could see that she was very upset. She kind of cussed me up and down and said you don't get it, and I said you're right, I don't, but I want to try to do something. And she left, and my heart broke because I knew she was pregnant. She was going to abort the baby but she decided to keep him, but they're living on the streets.

And so I made a point and personally I prayed. I was like I want to see her again. I want to help her. And I would see her in the weirdest places. I would see her at Walmart, I would see her across the street. Wherever I would see her, I would walk to her and say do you remember me, can I help you? This went on for several months, and through that time, we built a relationship. And she began to trust me. And so I proceeded to try to find her different services.

By this time the birth father was back in jail, and she started living with a distant relative. She didn't trust anybody, really didn't talk to too many people, and honestly all the services that I did try to provide for her

just wasn't fitting or she didn't want to participate in. Most of them were hospital services and such, and she was very scared of the justice system because she had already lost her daughter earlier or several years before.

Long story for a time but there's so much to the story, at about seven months she called me out of the blue and she said to me, she said will you take my baby? And I kind of was taken back by it because, quite honestly, my husband and I between us have seven children. My oldest was in college, my youngest one started school and I was like I'm free, you know? But at the same time my heart was tugging because I'm always telling people we need to go the extra mile.

So I thought I should ask my husband first and so I said, you know, I'll get back to you. So I talked to my husband and he said, you know, absolutely. We have to do this. Now, you have got to know something about my husband. Before I met him he was a heroin addict for over 20 years. He's now almost 18 years clean, so he understood something that I'll never understand. So we agreed to take our little Isaac in, but we didn't push. We waited to see what was going to happen.

Much like Robin's story, Isaac was born at three pounds. He was a very, very sick little baby. Not to repeat what the others have said, but you all get the idea

of how sick these little guys are. He was in the hospital for almost two months. I would go and visit with -- and she allows me to use her name -- Christine. It's the birth mother. I would go in with her. We'd hold the baby. We would soothe the baby. Again, I didn't know what was going to happen, so I was still kind of taken aback to see it and just trying to help her in any way I can or could.

Well, the baby was discharged. At that point when she had him Westmoreland County was not as of yet having mandatory drug tests, but they did at that point due to some other reasons found out that she did shoot up heroin that night and also was close to overdosing on Xanax at the same time, so child services were alerted and also due to the fact that she had lost her other daughter who at the time is -- well, she's now 12 years old.

So child services were contacted, and she had to produce an address, and so she gave an address where she was getting discharged. We didn't know what was going to happen. And the day after they were discharged she called us, said will you give us a ride, so we did. Again, not knowing what was going to happen but kind of going with it and saying we're here for you, she asked us to take us to a location in Latrobe, and also she's like, okay, thanks for the ride. And we're like, okay, your baby? And she said thank you so much for taking him. She literally got out of

the car and left.

I didn't see her until four months later. I did try to contact her. I was getting a little concerned, wasn't sure what was going on, but, you know, at the same time feeling very blessed to have this little guy. This is my little Isaac right here, one of the pictures of him, and we did see her again at four months and sporadically in the next year.

The story with Christine, though, and his birth mom and what I went through Isaac, you know, I shamefully say as a drug and alcohol counselor I didn't understand the face of addiction, what these children were facing. I didn't see that side of addiction. I worked with the adults. I worked with the moms. I worked with the grandparents. I worked with the dads and individuals, but I had no idea what these little ones were facing.

And respectfully I say this to you. If you've never held one of these babies and worked closely, you can't compare a turkey sandwich to opioids. I'm sorry. Now at the same time I don't think -- I truly don't believe these moms were abusive moms. I'll say that 100 percent. But at the same time these babies are truly getting hurt when they're exposed to drugs while pregnant. How do you figure all that out? I don't know, but we can't deny one for the other to be honest with you. And we also can't

minimize what's going on.

So through that experience I did develop a program called Angel's Arms, and I would love to share more, but I'm doing it pretty quick here. But Angel's Arms was developed obviously because of the experience I had with my little guy Isaac, which I have to tell you there are long-term events -- there are symptoms that can happen in NAS babies. Not only are there cognitive and physical delays, my little Isaac only started talking really just about a year or so ago, a year and a half to where you can understand sentences. He's five years old. He'll be six in September. He sat up later, he walked later, he went through all the other different symptoms.

And one of the things that the doctor has told me that in these children, we're not even sure what the long-term events are due to the fact that we haven't been gathering data on NAS babies, so we again can't deny that there's long-term effects, but we have to start studying them.

But the one thing the doctor did tell me, many doctors and also within my own professional research, they had told me these babies will never remember the withdrawal that they went through, but one thing that will happen is their bodies will always remember that drug. So if they're in an accident someday when they're 20 years old or 25

years old and they are given some type of oxy or other opioids, their body will react to that. And that's something that has to be noted.

And as a drug and alcohol counselor, I can't tell you how many individuals came into my office and said, well, they were born addicted to heroin. But again, we weren't labeling it back then. And I had one man tell me -- he was in his 60s, his mother was a heroin addict, and he was in a motorcycle accident, and he said when his body had that opioid come into his body, he said, quoting him, "Oh, baby, where have you been?" And he reacted, and he is still fighting addiction.

Just to take a note, too, that with other drugs, crack babies, crack babies are harder to recognize at birth because the symptoms are very different. They don't withdraw the same as an NAS baby, but again, there's long-term effects with those babies, too. You will see there's cognitive effects, there's delays, there's educational and learning disabilities, memory issues. And oftentimes these babies are born with bowel obstructions and maybe a loss of fingers because of the circulation that happens with crack or meth in your bodies. I mean, there's a lot of things that we need to recognize. And, as Lisa said, I'm begging you to look into some of this because I feel like this little population has been overlooked. And, you know,

again, we need to start tracking them accurately.

So part of our program at Angel's Arms -- I'm sidetracking; that's why I should have written out the speech. But part of this program we have is we have evolved into five tiers. And Angel's Arms is only about two and a half years old, but we have been functioning almost at full service for the past year now. And I'm going to quickly go over some of those services that we have.

One of the things that we do provide is educational awareness and prevention programs. And I add on prevention because I think we need to let moms know what's going to happen. I believe that's a very effective prevention program. And so we will also conduct -- I've done trainings with drug and alcohol. I've done trainings in coalitions. I've spoken to Swan and other programs. And surprisingly, a lot of our human services workers do not understand the effects that NAS babies have or children in addiction, what they're going through, and I do think we need to boost that a little bit. But we do a lot of community events and that type of thing.

One of our other programs that we are presently doing is home visiting, so we are able to go into the homes because, as we know, transportation is an issue. And so we actually go into the homes and we spend time with the moms

and providing specialized drug and alcohol counseling with the moms, as well as parenting skills, life skills, and just building relationship and social skills, at the same time allowing us to have eyes on the baby, see how the baby is doing, is the baby's birth rate good, has he gone to his doctor's visit, I mean, all these different things. So we are able to now go in a few times a week and actually work with with the parents. And it's a little different than some of the other type of home visiting. We are really specialized in addiction and seeing the moms go forward.

Another program that we have started under our five tiers is the hotline. We right now have a 24-hour nationwide hotline. This hotline is specific to families in addiction, and there's information in these pamphlets I can get you later on it. But this hotline, we're seeing cause right now from Washington State, Iowa. Somehow we got a call from Costa Rica, I don't know that happened, but it's coming from all over the country. We're getting calls asking for resources in their area. We do the best we can to find them. We've gotten calls from moms who are addicted, found out that they're pregnant, and felt hopeless. We sat with them and helped them navigate to resources they have and that they don't have to feel hopeless and we've helped them.

We've gotten calls from grandparents. If you can

imagine, all of a sudden you're raising a four-year-old or a five-year-old and he needs to get registered for school, things have changed. We help them navigate through the system. We give supplies out, diapers.

But anyways, our hotline has really helped us, and we also have been connecting and collaborating with community programs all over the country. With this program we've been able to track what's going on and really trying to build some evidence-based methodology of research there that we can kind of put it together because it's something, again, that's not being tracked I think correctly. And so since November we have had over 200 calls just since November, and we're still just getting the word out it's even there. So that's one of our programs.

And then our other programs kind of work together. We have an outpatient program and a residential program. Our residential program is just weeks away. What our residential program will entail is we'll be able to take infants and children ages 0 to 5 years old so if mom needs to go away to rehab -- and I've heard some of the other panelists talk about this. If mom needs to go away to rehab but has a new baby or children at home, they need to make preparations for that. Well, that's not always doable, especially when you're withdrawing, especially when you're being kind of pushed to go there anyways. So what

we would offer is to actually take care of your child 30, 60, 90 days, however long it takes while you're in treatment, and then once they come back, we have also supplied housing. We have two locations now where the mom and baby can live together, and they can live together up to a year's time. We have developed a program which three months, three months, three months, and it's an incentive program.

During this time, too, we would also work with the children. You know, as much as the spotlight is on NAS babies, these NAS babies grow up. And children in addiction are suffering. Children in addiction are going through anxiety. Can you imagine a five-year-old being suicidal, having tummy problems because of what's going on in their homes? This is all real stuff.

I was at an event just two weeks ago and I had two teachers from two different school districts, Derry Area and Greater Latrobe, and they teach elementary. They came to me and they said who's tracking this kids because I know these kids are living in addicted homes. We don't know what to do. We're calling, we're trying to take care of it, but nothing is happening. Who's tracking them? And I said that's something I don't know but I'm going to work on it, you know, because it's true. You know, the NAS babies do grow up and there are side effects that will

continue with them. We need to reach these kids.

Our outpatient program, which was our first program, sort of coincides with our residential, but what that allows also is kind of the same idea. If mom is in treatment or programming, we will keep their infants during that time. So, say, for example, they come to us and we do an intake with them, we make a plan of care with them. We offer our own services but we don't stop there. We use other services in the community as well. So we work with drug court, we work with other programs, and actually our program at this point has become very successful. It's very early, but we have seen a difference, and it's become very, very successful.

I'm going to try to hurry. I know the time -- am I good? I'm sorry?

MAJORITY CHAIRWOMAN BOBACK: If you can summarize it, that would be good.

MS. HENNESSY: I will. Let me summarize this and just to --

MAJORITY CHAIRWOMAN BOBACK: And you have to give us those pamphlets because this is fascinating. You do have them, right?

MS. HENNESSY: I do. So I just want to make two points real quick if I can and I'll sum this up. You know, in 2015 the Protect Our Children Act was put into place,

and that started a conversation where we were recognizing NAS babies. But my concern is it's 2019 and we're still having the conversation. And I'm really fearful that what's happening is NAS babies and children addiction is becoming more of a maintenance issue rather than a solution-focused task. And I think that we can't just keep having conversations about it.

You know, I'm one of these people that I don't sit down; I stand up and I do something. I don't know how I'm going to do it, but I try to figure it out. So I have a ton of proposals that sometime I'll come I'd love to share, but can I just end with one quote? And I think it really sums it up. It's from Abraham Lincoln, and I love this quote, and I'm telling you when he wrote this he was not thinking of the opioid epidemic, but I think it's very appropriate.

And he says, "A child is a person who's going to carry on what we have started. He is going to sit where you are sitting, and when you are gone, attend those things which you think are important. You may adopt all the policies you please, but how they are carried out depends on him. He will assume control of your cities, states, and nations. He's going to move it and take over the churches, schools, and universities and corporations. The fate of humanity is in his hands."

And I think that sums it up that we have a population that's not being recognized that's getting lost, and we need to recognize them because they are our future. Thank you.

MAJORITY CHAIRWOMAN BOBACK: Wonderful testimony, Dawn. I want to see your initiatives, your incentives that you have. So are they written out so we can share with our Committee?

MS. HENNESSY: I need to write them out neater, and I will email them to you --

MAJORITY CHAIRWOMAN BOBACK: That would be wonderful --

MS. HENNESSY: -- if that's okay.

MAJORITY CHAIRWOMAN BOBACK: -- and I will share with our Committee because this is where good legislation begins, with testimonies --

MS. HENNESSY: This is a passion of mine so --

MAJORITY CHAIRWOMAN BOBACK: Ours, too.

MS. HENNESSY: So thank you so much for your time.

MAJORITY CHAIRWOMAN BOBACK: Thank you for your distance. So many of you traveled so far, and it's truly appreciated.

As I said, your testimony will be available to all 203 Members. Thank you so much.

And with that, Chairman Petrarca, any closing remarks?

DEMOCRATIC CHAIRMAN PETRARCA: No, just I really appreciate the testimony. We certainly have things to think about, and hopefully, we can work together to make Pennsylvania a better place. Thank you.

MAJORITY CHAIRWOMAN BOBACK: My head is spinning. You could see so many notes that we were taking, and we'll refer back to our tape so we get more ideas.

So once again, thanks again. Our doors are open. Contact us anytime. Thank you for coming.

(The hearing concluded at 11:10 a.m.)

I hereby certify that the foregoing proceedings are a true and accurate transcription produced from audio on the said proceedings and that this is a correct transcript of the same.

Christy Snyder

Transcriptionist

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