CTIPP
Campaign for Trauma-Informed Policy and Practice

Working for healthy, just, and resilient communities

TO THE SENATE FINANCE COMMITTEE (opioids@finance.senate.gov)

RESPONSE TO THE FEBRUARY 2, 2018 LETTER FROM THE FINANCE COMMITTEE SEEKING RECOMMENDATIONS ON WAYS THE PROGRAMS UNDER THE COMMITTEE'S JURISDICTION CAN BETTER ADDRESS THE OPIOID EPIDEMIC

Submitted By:
THE CAMPAIGN FOR TRAUMA-INFORMED POLICY AND PRACTICE

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February 16, 2018

Chairman Hatch
Ranking Member Wyden
Finance Committee
United States Senate

Dear Chairman Hatch and Ranking Member Wyden:

The Campaign for Trauma-Informed Policy and Practice, (CTIPP) a national non-profit devoted to promoting neuroscience-based, trauma-informed policies at the national level and neuroscience-based, trauma-informed practices in our communities, is pleased to submit the attached material in response to your February 2, 2018 letter requesting recommendations on ways programs under the Committee's jurisdiction can better help the country address the opioid epidemic.

Our response is in two parts. The first is a memo that explains the connection between neuroscience discoveries showing the relationship between early childhood adversity and opioid and other substance abuse. It then provides 12 specific recommendations on ways the programs subject to the Committee's jurisdiction can put the neuroscience discoveries to work to help prevent more people from becoming addicted, both now and in future generations, and to help those already addicted to fully heal and not relapse.

The second part consists of a serious of recommendations a CTIPP member in Portland Oregon put together after soliciting ideas from the Portland community. Many of them are not trauma-related but we believe they can be of great value to the Committee. We received them too late to integrate into our memo but wanted to share them with you.

Thank you for the opportunity to share our ideas with you. Please let us know if there is anything else CTIPP can do to assist you in your endeavor.

Sincerely yours,

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Dear Chairman Hatch and Ranking Member Wyden:

The Campaign for Trauma-Informed Policy and Practice (CTIPP) appreciates this opportunity to submit recommendations on actions the Finance Committee can take to help address the opioid epidemic, in response to the questions in your February 2, 2018 letter. Over the past twenty years, neuroscience has made some dramatic discoveries about the way early childhood adversity (also called childhood trauma or Adverse Childhood Experiences (ACEs)) produce changes in the brain that cause the person to be particularly vulnerable to substance abuse when they grow up. Recent studies have confirmed that, finding that persons who suffer extensive childhood adversity are three times more likely to become victims of Opioid Use Disorder (OUD) and five times more likely to engage in injection drug use. [i] Thus, persons who suffered multiple ACEs but are not yet addicted are much more vulnerable to OUD, while those who already suffer from OUD need to address their ACEs if they are to fully heal and not relapse.

In addition to discovering that ACEs and other forms of trauma are at least a cause, if not the major cause of OUD, neuroscience has provided guidance on ways to help people who have experienced multiple ACEs from continuing to be vulnerable to OUD and ways to treat those with multiple ACEs who are already suffering from OUD to overcome the effects of the ACEs so they heal fully. Programs and therapies that put this science to work are often called "trauma-informed". The focus of our recommendations below is on ways the Committee can put the neuroscience discoveries to work by incorporating trauma-informed initiatives into the programs under your jurisdiction in order to prevent the spread of OUD to those most vulnerable to addiction and provide neuroscience-based, trauma-informed treatment to those already addicted to help them heal and avoid a relapse

CTIPP is a national organization of individuals and groups from all sectors and walks of life working together to create a better future by promoting trauma-informed policy and practice.[ii] CTIPP works with local trauma-informed cross-sector coalitions that have been created around the country, including ones in Salt Lake City and Portland, to promote trauma-informed practice and to solicit ideas for policy changes that will promote trauma-informed policies and practices at the Washington level.

The core of trauma-informed policies and practices are based on the findings by the Kaiser Permanente-CDC Adverse Childhood Experience (ACE) Study[iii] that adverse childhood experiences (ACEs) such as physical, sexual, substance, physical or emotional abuse in the home leads to a host of social and health problems during adulthood, including greater likelihood of suicide, substance abuse, domestic violence, poor performance at school and work, obesity, diabetes, heart disease and cancer. The study found a direct dose response in that the more ACEs you had, the greater the likelihood that you will suffer from these outcomes.

These findings have been reinforced by the neuroscience findings that explain how ACEs lead to these outcomes –that early and extensive adversity during childhood causes changes in the brain that lead the body to continually pump the stress hormone cortisol into the person's blood stream throughout the lifespan, even after there is no longer anything threatening that person. This causes the person to live in fear and under stress even though there is nothing in real world that is threatening. People too frequently deal with this continued stress by drinking, using drugs, beating up a spouse or child, overeating, and other dysfunctional behavior. Their continual focus on this fear makes the person a poor student and a poor worker. The continual flow of cortisol also harms the body, leading to the diseases listed above that are correlated with multiple ACEs.[iv]

One way to look at it is to think of two buildings, one with a weakened foundation and one with a solid foundation. When the earth is quiet, both will stand without any problems and the weakened foundation will go unnoticed. However, when tremors occur, the solid one can withstand them with little or no damage, while for the one with a weakened foundation even a minor tremor can result in cracked walls or even the collapse of the building. Patching the

cracked walls will provide temporary relief but at the next tremor the walls will crack again. What needs to be done is to shore up the walls so they can withstand the tremors, and in cases where too much damage to the building has occurred, it will be necessary to dig deep and strengthen the foundation.

Similarly, a person whose foundation was weakened during childhood by multiple ACEs is more vulnerable to the "tremors and earthquakes" in their lives, such as job loss, a community collapse, divorce, or the oversupply of pills in a community, in that the tremors make them more vulnerable to addiction. Just as it is impossible to stop earthquakes it is impossible to stop the tremors that shake the lives of people and communities and experience has shown it is impossible to eliminate the availability of drugs when there is a demand. Providing Medically-Assisted Treatment and related protocols for those addicted and particularly those overdosing saves lives but those patched walls will likely crack the next time there are tremors in that person's life and they will return to drugs. An opioid strategy must shore up the walls of those who suffered severe trauma to keep them from becoming addicted and, for those already addicted, help them rebuild their foundations through the use trauma-informed therapies that will get their bodies to stop the constant flow of cortisol so they are no longer as vulnerable to addiction.

What is significant about the ACE Study and the neuroscience for the purposes of the Committee's February 2nd letter is the fact that there were studies long before the opioid epidemic began, that showed a very strong correlation between multiple ACEs during childhood and substance abuse.[v] More recent studies have confirmed the same correlation applies to opioid use disorder. One study found that 54% of those using painkillers to get high and 78% of those engaged in IV drug use suffered adverse childhood experiences.[vi] The data on opioids, coupled with the data on ACEs and substance abuse generally[vii] and the neuroscience findings on what ACEs do to the brain, lead to the conclusion that ACEs are one of the significant underlying causes of OUD and misuse of related drugs such as heroin that are connected to OUD.

Knowing an underlying cause of a problem opens the door to solutions. (It also tells you when you are devoting resources to treating symptoms of the problem rather than the underlying cause.

This appears to be the present situation in the case of OUD, which helps to explain why present efforts have had such little effect on slowing down the epidemic.) It is somewhat similar to the situation 175 years ago when the infectious diseases were killing hundreds of thousands of people each year. The approaches being used then to stop the epidemic were not working because they were not addressing the underlying cause – germs. Then germ theory was discovered and it was learned that the germs in sewage, feces, and similar unclean objects were a major cause of these infectious diseases. American governments, city, state and Federal mobilized to put sewage in pipes rather than running it down the street, to build sanitary facilities, to educate people to wash their hands after going to the bathroom, etc. Within a short time influenza was no longer a major health problem.

While we believe we now know that ACEs and adult trauma such as rape or wartime trauma are one of the major causes of OOU and SUD, solutions are still a work in progress. We do not have a pill or an inoculation to enable people that overcome the effects of ACEs. However, there are solutions in the form of techniques and therapies that can be help people with multiple ACEs prevent the cortisol from drive them to engage in destructive behaviors. To carry forward the building analogy, there are approaches that have proven successful in shoring up the walls of those who suffered multiple ACEs so small tremors in their lives do not drive them to opioids or other drugs for relief.

There are also intensive therapies to enable people to overcome the effects of the ACEs. Under the analogy it means there are therapies that dig down into the foundation to remove the rotten parts that are making it weak. .Finally, we know that the long-term solution is to eliminate ACEs in future generations by promoting healthy families. Under the analogy it means making sure all of the houses build in the future have strong foundations.

These three approaches represent the core of our recommendations. But they clearly do not provide a complete solution. Just as the discovery of germ theory was just the beginning of the search for solutions, so the techniques and therapies recommended in this paper should be viewed as just the beginning of the effort to use the neuroscience discoveries to prevent and treat OUD. While not necessarily within the jurisdiction of this Committee, Congress needs to fund

research to develop even more effective solutions based on the neuroscience. Given that the White House has concluded that the opioid epidemic is costing the country $500 billion a year, funding such research is clearly a good investment.

With these caveats, our recommendations below focus on steps to put the existing solutions to work since with hundreds of people dying every day from OUD, we cannot wait for the perfect solution:

- **Immediate Prevention – Solutions that help those who have suffered multiple ACEs , and therefore are among the most vulnerable to OUD, from becoming addicted;**
- **Long-term Prevention -- Preventing ACEs in the next generation so members of that generation and the ones that follow do not grow up vulnerable to OUD; and**
- **Trauma-informed Treatment – Using trauma-informed approaches to treat persons already addicted. Because these approaches address the underlying cause of their addiction, it increases their ability to heal fully and to not relapse.**

Our recommendations follow:

A. Recommendations for Immediate Prevention Activities Through the Implementation of Resiliency Programs

- **Provide Funding for Community-wide Coalitions to Develop and Implement Community-wide Strategies for Addressing the Opioid Epidemic**

Life-saving actions are critical for those already addicted. However, if upstream preventive measures are not also taken, the epidemic will continue to grow, overwhelming the medical system and further destroying communities and families. Given the correlation between multiple ACEs and OUD, teenagers and adults who suffered multiple ACEs as a child are the ones most vulnerable to becoming the next victim of OUD. As indicated above, multiple ACEs lead to continual stress throughout the lifespan, which leads to the seeking of relief, which opioids and other drugs offer. If those who suffered multiple ACEs are provided with what are called **resiliency** techniques, techniques that enable them to control their stress without turning to drugs, they are less likely to become the next victim of OUD.

Resilience can be achieved through strong families and close supportive relationships. It can also be achieved through a set of activities that studies have shown actually cause changes in the brain to help reeducate the brain to prevent the childhood adversity from driving them to drug use and other destructive behavior. Proven resilience techniques include yoga, mindfulness and meditation. While some people may consider mindfulness, meditation and yoga to be non-medical, superficial "hippy" practices, multiple studies have shown that they work in promoting resilience and actually produce physiological changes in the brain.[viii] While some people may also think that some segments of the population would not touch such practices, the Kansas City Police Department has enthusiastically embraced yoga.

Every institution in the community can play a part in reaching a different segment of that community in order to educate that group about trauma, to promote strong families, and to teach the people in that segment about resilience techniques, including; schools, churches, synagogues, and mosques, social clubs, law enforcement departments, city governments, chambers of commerce, Boys and Girls Clubs, and others. For example, "Lakeside Global Institute located outside Philadelphia, has launched a state-wide initiative providing trauma education to over 10,000 professionals who provide services to trauma-impacted and opioid-addicted clients.

However, there must be an entity in the community that coordinates all of these efforts. Therefore, the effort to prevent OUD going forward requires cross-sector comprehensive coalitions in communities hard-hit by the opioid epidemic to educate the community about the connection between ACEs and to coordinate the diverse range of programs needed to provide the community with the comprehensive and integrated neuroscience-based resilience programs.

The opioid epidemic is a community-wide problem so it can only be solved through a community-wide effort, It cannot be solved just by the police, medical personnel, EMTs, or other individual entities. As Laura Porter concluded after working with eight communities in the State of Washington, "[t]he answer lies in helping communities develop the capacity to reshape their own culture, from one that perpetuates cycles of trauma to one that reduces the array of ACE-related problems simultaneously and promotes health."[ix] Community resilience is defined as the sustained ability of a community to utilize available resources to withstand, and to recover from

adverse situations. Resilience community initiatives align and leverage assets across multiple sectors to maximize residents' ability to cope with adversity. For example, community education about the connection between adverse childhood experiences and opioid use disorder is critical, but it will have little impact unless there are resources in place for people who recognize they suffer from such childhood adversity to go to in order to learn resiliency techniques. The health, mental health, education, law enforcement, judicial, business, government, and other institutions in the community must come together to develop and implement a comprehensive strategic plan.

There is no need to reinvent the wheel on this regarding what a comprehensive cross-sector community-wide effort would look like. There are a growing number of states, cities, tribes and community collaboratives that have or are in the process of developing comprehensive strategies to address the causes and effects of early childhood and adult adversity (often called trauma-informed initiatives). A group in St. Louis has created a program called *Alive and Well* that brings all of the above listed entities together to attack childhood trauma. A group in Salt Lake City has created the Utah ACEs Coalition. In Portland, with assistance from the Building Resilient Communities program at the George Washington School of Health, a group has created the Portland Building Resilient Communities Coalition. The Mobilizing Action for Resilient Communities facilitated by the Health Foundation of Philadelphia is assisting fourteen communities build such coalitions and the Change in Minds initiative led by the Alliance for Healthy Families and Communities is assisting 15 communities. However, these initiatives have all been funded through foundation grants, but there is no existing Federal program to fund such programs, while communities hard-hit by the opioid epidemic are already strapped for funds.

RECOMMENDATION #1 *– The single most important recommendation in this paper, because it is the key to the success of most of the others, is the establishment of a funding stream to fund comprehensive cross-sector community-wide initiatives in communities hard-hit by the opioid epidemic to develop and implement a comprehensive, integrated approach for addressing the epidemic, designing an approach that meets the communities unique needs and culture. The Finance Committee should recommend increased funding authorization from the funds the Budget Agreement allocated for the opioid epidemic to any one of a number of programs under its jurisdiction to provide states with funds to award grants to communities to create such cross-sector community-wide coalitions. Possible committee programs include the Title XX Social*

Services Block Grant Program; Child Care and Development Block Grants and the Promoting Safe and Stable Families Program.

- **Recommendations to Assist Targeted Vulnerable Groups Receive Resiliency Training**

Below are recommendations for targeted programs within the Committee's jurisdiction to promote and teach resilience techniques among those segments of the population that are the most vulnerable to becoming the next OUD victim.

- **Implementing Resiliency training in Job training programs** --An example of what can be done in a targeted area under the jurisdiction of the Committee is in the area of job training. The opioid epidemic has removed a substantial number of persons of working age from the workforce. There is already a shortage of workers in some parts of the country. When one adds in the millions of jobs the tax reform legislation, is projected to create, employers are going to have trouble finding enough workers to fill their vacancies if workers keep dropping out of the workforce because they are suffering from OUD or SUD. Therefore a priority area of prevention should be to teach reliance techniques to those participating in job training programs so they join the ranks of the employed rather than the ranks of those with OUD.

  It is likely that given the population that participates in Federally-funded job training programs, many of them have suffered multiple ACEs, making them vulnerable to OUD. Teaching them resilience techniques as part of the training can help ensure they will become the next gainfully employed worker rather than the next OUD victim. A study by Rutgers University found that the resilience components contained in the Camden New Jersey job training program called Hopeworks produced a 20% increase in the job training retention rate.[x]

RECOMMENDATION #2 *– The Committee should direct HHS to require the job training programs funded by TANF to incorporate trauma-informed reliance techniques into their training programs and provide the grantees with additional funding from the $6 billion allocated for the opioid epidemic to enable them to do so. This will produce a double benefit – reduce the*

epidemic and better insure the tax reform legislation will promote increased employment and economic growth as intended.

- **Authorizing Medicaid to Pay for the Provision of Resiliency Training in Schools –** One of the best places to provide resiliency training is in the schools. A University of Cincinnati study found that teaching mindfulness yoga to youth "…helped them develop long-term coping skills and concluded such programs are needed in earlier ages in schools to help vulnerable youth to channel their skills more effectively….These findings highlight the importance of implementing positive coping strategies for at-risk youth particularly for reducing illicit drug use and risky sexual behavior." [xi] This is not recommending simply educating students about drugs. The evidence shows that such programs as D.A.R.E have little impact. Rather it is recommending education coupled with resiliency training. The best people to provide school resiliency training are behavioral health personnel, which an increasing number of schools are deploying. But while such personnel may bill Medicaid for services provided to an individual student, they are not permitted to bill for school-wide education programs. Permitting such payments will repay themselves many times over in light of the conclusion by the author of the Cincinnati study that for resilience programs in the schools "the return on investment may be substantial especially if they can reduce arrests, repeat offenses and other negative outcomes for risk-taking youth."[xii]

RECOMMENDATION # 3 *– The Committee should give CMS the authority to grant waivers to permit school behavior health personnel to bill Medicaid for educating students about opioids and teaching them resilience techniques.*

- **Paying Pediatric Medical Providers to Screen for and Treat Patients with Multiple ACEs**

Opioid addiction can be both a direct cause of ACEs, through parent consumption, and an outcome of ACEs, producing an increased risk for substance dependence. In both cases, pediatric medical providers play a crucial role. Pediatric medical providers, in particular those in primary-care, are in a unique position to identify children who are experiencing ACEs, and other

potentially traumatic events, given their long term and often trusted relationship with the family and their training in disease prevention. Medical providers can use systematic approaches, such as routine and universal ACEs screening, to identify children and families with ACEs, and link them to prompt intervention to reduce exposure and thus risk of negative outcomes. CTIPP does not recommend mandatory ACE screening but rather, recommends that pediatricians, particularly those in areas hard-hit by the opioid epidemic, be given the tools they need to identify child and family ACEs in an effective and sensitive manner and have resources for referrals to assist the child and family get the treatment they need and the ability to bill Medicaid, CHIP and other third-party payors for providing those services.

Effective procedures for medical providers to use when addressing ACEs and trauma in children and families exist. Under the director of Dr. Nadine Burke-Harris, the Center for Youth Wellness' National Pediatric Practice Community on Adverse Childhood Experiences aims to enhance the quality of pediatric care and improve health outcomes by providing technical support, tools, training, resources and learning opportunities for pediatric medical providers, with the goal of widespread integration of ACEs screening and intervention into pediatric medicine. Many other institutions, such as the Johns Hopkins School of Public Health, are providing training for pediatricians on how to identify and treat ACEs. The American Academy of Pediatrics has developed a toolbox for trauma-informed primary care physicians called the Resilience Project Toolkit. There are a number of other ACEs toolkits available. The problem is that some of the services that these toolkits recommend be provided are not covered by Medicaid or CHIP so the provider may not bill for them.

RECOMMENDATION #4 –

- *That the Committee direct CMS, together with other DHHS agencies, to collect and evaluate the various ACE toolkits and disseminate the ones identified as the best practices to enable pediatricians to apply the ACE study in their practice;*
  - *That the Committee direct CMS to review all of its practices and policies to insure that all aspects of ACE screening and treatment are fully covered by Medicaid and CHIP and insure that primary care and mental health services can be billed the same day. If CMS identifies any gaps in the legislation that bar it from covering all such*

services, it should be directed to report them to the Committee to address legislatively.

- *That the Committee require that ACE screening and treatment be part of the mandatory coverage required of insurers by the Affordable Care Act.*

- **Mothers-to-Be.** One of the most heart-wrenching effects of the opioid epidemic is the growing number of babies suffering from Neonatal Abstinence Syndrome (NAS) because they were born to addicted mothers.

RECOMMENDATION #5 *– CMS should be directed to grant Medicaid waivers to States with communities hard-hit by the opioid epidemic to enable health workers to bill Medicaid when:*

- *educating mothers-to-be about the effects of the drug on their babies;*
- *when they educate obstetrical providers about ACEs so they can refer mothers to-to-be with multiple ACEs to resilience programs early in pregnancy and refer mothers-to-be with OUD to treatment programs.*

- **Billing for Wrap-Around Services to Families in Which A Member is Addicted.** Since family members of those addicted are among the most vulnerable for addiction themselves, there is a need to provide funding for site teams in communities hard hit by the opioid epidemic composed of law enforcement, educators, child welfare, behavioral health and other professionals to work with families in which a family member has been identified as suffering from opioid or other addiction.

RECOMMENDATION # 6 -- *Congress should pass the Families First Prevention Act to allow, among other provisions, federal child welfare funds to be used to enhance family stability and decrease foster care placements by addressing the substance misuse and mental health care needs of families at-risk of being child welfare involved.*

- **Resilience programs for patients who are being prescribed opioids**: Another group within a community that is highly vulnerable to becoming addicted and therefore needs to be targeted for resilience training is the one composed of patients who are have been

issued or are being considered for opioid prescriptions and who have multiple ACEs. The challenge is to help the patients avoid becoming addicted, while at the same time avoid denying people in pain the relief that opioids offer. CTIPP does not support the imposition of mandatory screening for ACEs of patients receiving opioid prescriptions. Instead, we recommend Congress direct HHS to work with the Association of Addictive Medicine to identify existing or develop new trauma-informed guidelines for prescribers of opioids that advise them on how to explore the patient's past without re-traumatizing the patients and how to recommend resilience programs to which the patients who appear to have had adversity in their past can be referred.

RECOMMENDATION #7 -- *That the Committee direct CMS to review the guidelines developed pursuant to the recommendation above to determine if any of the procedures recommended in those guidelines are not billable under Medicaid and to report back to the Committee so it can plug any holes in the Medicaid legislation that prevent providers from being able to bill for all of the procedures called for by the guidelines.*

- **Providing Resiliency Training to Prevent Secondary Trauma Among First Responders, Teachers and other Providers Who Daily Come into Contact with Traumatized Persons** -- There is now strong evidence that persons who work intensively with traumatized persons, including police, first responders, health personnel, teachers, social workers, justice-involved workers, foster parents, workers at homeless shelters are vulnerable to secondary trauma, which is as deadly as primary trauma. For years it has been called burnout, but the neuroscience has concluded that it causes physiological changes in their brains similar to those found in persons traumatized by multiple ACEs or severe adult trauma. These workers could benefit from the same resilience techniques recommended for those in target areas. For example, as mentioned above, in Kansas City, the police department has provided yoga training to its entire force to help them deal with secondary trauma. The police say that not only does it make them better officers, but it makes them better husbands and wives because it provides them with a way to leave their stress behind when they return home after being out on the streets. We need to protect our first responders from secondary trauma, which is a danger for any profession that works closely with persons who are traumatized.

RECOMMENDATION #8 *– The Committee should earmark funding under the Social Services Block Grant or another program under its jurisdiction to pay for the provision of secondary trauma prevention training for local police departments, the emergency medical treatment workers, critical care and hospital emergency department workers, and others who are regularly engaging with persons addicted to opioids.*

- **Native American Communities** --The opioid epidemic and other drug problems have hit Indian reservations and Alaska Native villages particularly hard. The populations of these communities suffer from the dual traumatic effects of high ACEs and historical trauma, which make them particularly vulnerable to addiction. On the other hand, these communities have traditional approaches for preventing and treating trauma, ones that have been passed down for many generations. While not "evidence-based" they have withstood the test of time and are accepted as effective by their communities, a critical part of any healing approach. Some states will permit Native American healers to bill Medicaid for such services but others do not.

RECOMMENDATION #9 *– The Committee should direct CMS to require that all states approve Medicaid and CHIP payments for the use of traditional Native American healing practices that are used to address addiction.*

A. Preventing Childhood Adversity in Future Generations

According to the Medicaid Early Childhood Innovation Lab at the Center for Health Care Strategies, "Efforts to reduce early childhood trauma and ACEs could have major long-term payoffs, for individuals and the states and health care systems serving them as adolescents and into adulthood."[xiii] Not only can it help to reduce the half a trillion dollars the opioid epidemic is costing the country, it will save money in many other areas. For example, researchers have found statistical evidence showing that individuals reporting ACEs use more health and medical services throughout their lifetime in comparison to those reporting no ACEs.[xiv]

However, unless we cut off ACEs at their source, the country faces a future of continued drug epidemics, poor school performance, extensive obesity and diabetes and the other results of

ACEs. What makes this so sad is that we have the knowledge and the tools to prevent this. What is needed is the will and the funding. In her new book, "The Deepest Well", pediatrician Dr. Nadine Burke Harris ends with a picture of the world in 2040 when, as the result of community education and adequate funding for the kinds of programs listed below to help build healthy families, the United States has seen a 60% decrease in the number of Americans with four or more ACEs. Reduction in ACEs will lead to a comparable decrease in substance abuse generally and opioids specifically. These kinds of programs, that must be 2 gen programs that treat both the child and the parent. They include:

- The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Act that supports evidence-based home visiting programs in states.
- The Nurse Family Partnership has been shown in experimental trials to reduce state verified rates of abuse and neglect by 48%, reduce emergency room visits by 56%, and produce a 79% reduction in the number of days that children were hospitalized with injuries and ingestions during the first two years of life.[xv]
- The Triple P Program was demonstrated in a U.S. experimental trial to reduce the rates of child maltreatment in the counties in which it was implemented by 20% while also decreasing out of home placements and childhood injuries. [xvi]
- Parent Child-Interaction Therapy was shown in an experimental trial to reduce child abuse. It was shown in an experimental trial to reduce reported child abuse to 19% as against 49% in the control group."[xvii]
- Others are available at the SAMHSA document "Programs that Work "

RECOMMENDATION #10 -- *That Committee urge the Senate to allocate a portion of the funds the Budget Agreement allocated for the opioid epidemic to provide increased funding for programs that work to promote healthy families. The tendency will be to want to allocate all of the funds to programs that deal with the immediate crisis, but that kind of short-term thinking will guarantee that the opioid epidemic will become a multi-generational plague on the country.*

- **Keeping Children Out of Foster Care Through the Development of Trauma-Informed Juvenile Courts**

The opioid epidemic has created a three- to four-fold increase in children being place in foster care in communities hit by the opioid epidemic. Children placed in foster care are much more likely to end up with multiple ACEs, thereby continuing the vicious cycle. Foster care is also very expensive so reducing or eliminating the time a child needs to spend in foster care represents a substantial cost savings. However, nobody wants to keep or send a child back to a home that is so dysfunctional that the child will suffer more trauma than they would experience in foster care. Finally, the entire judicial process can often re-traumatize those involved in it.

A growing solution to this dilemma is the creation of what are often called Baby Courts or Family Treatment Courts. Rather than just making legal decisions about the custody of a child, the court teams with caseworkers, counselors and others from outside of the judicial system. This coordinated effort using trauma-informed, two-generation approaches, assists the parents overcome their addiction through treatment outside of the criminal justice system, and provides intensive counseling to both the parents and the children that are tailored to each participant's needs. The social worker and the presiding judge closely track their progress. When it is safe they will leave the child in the home. When it is not, they will work to get the child back in the home as soon as possible, reducing trauma and saving money.

The Chief Judge of the Memphis-Shelby County has required all staff in the system to be trauma-informed and to implement trauma-informed practices throughout the system.[xviii] A judge in upstate New York has implemented the approach described above and through it has allowed more children to avoid foster care without putting them in danger at home.[xix]

RECOMMENDATION #11 – *Presently, there is no specific funding source to develop such courts. It is recommended that the Committee provide that funds from the Social Services Block Grant program and any other program designed to reduce the number of children in foster care may be used to fund Family Treatment Courts and, if possible to provide supplemental funding for states, counties, and cities to use to set up such courts. Once again, the money spent will save many times more that amount in the cost of foster care, as well as save many children the multiple ACEs they too often experience being in foster care.*

- **Providing Trauma-Informed Treatment Approaches to Help Those Already Addicted to Fully Recover and Not Relapse**
  - Once their addiction has been stabilized with appropriate evidence-based medical care and they have passed the life-saving stage, people who are suffering from opioid use disorder need treatments that address their underlying trauma in order to help them heal faster and fully and to reduce the likelihood of relapse. A recent study found that addicted persons with multiple ACEs are more likely to relapse during treatment.[xx] Specifically, it found that each unit increase of ACEs score was associated with a 25% higher odds of relapse over the course of opioid use disorder treatment using Burprenorphine. That is happening because nothing was done to help them deal with the underlying problems that were caused their multiple ACEs. The study also found that the longer patients remained in treatment that included trauma-informed counseling, the less likely they were to relapse.

    There are a number of proven trauma-informed therapies for treating the underlying trauma for people with substance abuse. Trauma-informed Cognitive Behavioral Therapy is one. Group therapy is another (and is required with the prescribing of Burprenorphine). In addition, techniques for resilience discussed above, yoga, mindfulness and meditation have also been shown to be effective in helping to treat persons suffering from Opioid Use Disorder. So has Equine Assisted Psychotherapy. The site, "Effective Treatments for Youth Trauma" by the National Child Traumatic Stress Network (NCTSN) links to fact sheets that provide descriptive summaries of some of the clinical treatments, mental health interventions, and other trauma-informed service approaches that the NCTSN and its various centers have developed and/or implemented as a means of promoting the Network's mission of raising the standard of care for traumatized youth and families.

    Mindfulness has been proven through numerous studies to be an effective therapy for reducing the likelihood of relapse. www.mindfulrp.com/Research.html provides summaries of over 20 studies that found that Mindfulness-Based Relapse Prevention

(MRPB) has this result. For example, a 2016 study by Zemestani, M and Ottaviani. C., concluded after conducting a controlled group study that: "Results suggest that MRBP could be implemented as an effective intervention for patients with comorbid depression.[xxi]

- Seeking Safety, an approach developed by Dr. Lisa Najavits, uses cognitive behavior therapy to treat toxic stress (aka "emotional trauma") and substance abuse. Seeking Safety was awarded the highest level of evidence by the International Society for Traumatic Stress Studies,[1]. Seeking Safety can be delivered by peers as well as by counselors or other professionals. A recent randomized controlled trial found that both peers and professionals produced positive outcomes on both trauma problems and addiction, with no difference between peers and professionals. Seeking Safety has shown especially strong results for heavy drug users. [xxii]

- Keeping Children Out of Foster Homes Through the Use of Trauma-Informed Courts

RECOMMENDATION #12 – *That the Committee work with CMS to remove all barriers to payment for the provision of these trauma-informed treatment programs under the Medicaid and Medicare programs. In addition, it should remove all limits on the length of treatment for opioid use disorder. There is no "right" length of time for such treatment programs. Just as someone with diabetes may need insulin injections all of their lives, some people suffering from opioid use disorder may need treatment for long periods of time or for all of their life. Since the cost of treatment is far less than the cost of having another addicted person in society who is placing demands on the EMTs, the emergency rooms, the police, the foster care system and on and on, it is cost-effective to permit a physician to prescribe a treatment for as long as he or she concludes it is necessary.*

D. FUNDING

The Committee should advocate with the decision-makers in the Senate:

[1] See www.seekingsafety.org

1. To direct a portion of the funding the budget agreement allocated for the opioid epidemic for programs of the kind recommended in this memo that promote resilience, with priority for those communities hard-hit by the opioid and other drug epidemics;
2. That a portion of that funding for trauma-informed opioid prevention and treatment programs be allocated for data collection and evaluation studies. While the science on trauma is so powerful, it is also very new so there is a shortage of evaluations and a shortage of data.
3. For funding for research to develop even better neuroscience-based solutions for the prevention and treatment of OUD.

END NOTES

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RECOMMENDATIONS FROM THE PORTLAND HEALTH AND SOCIAL SERVICES COMMUNITY

1. How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing OUD or other SUDs?

- Focus payment incentives on improving functional status that addresses functional participation in activities of daily living and instrumental activities of daily living and independent living skills. In order to accomplish this there must be recognition of the impact of functional cognition and executive function on an individual's ability to meaningfully take care of himself.
- Incentivize Supported Employment, the IPS model, with those who have chemical dependency issues.
- Biofeedback

2. What barriers to non-pharmaceutical therapies for chronic pain currently exist inMedicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate?

- A primary barrier is the lack of reimbursement for functional and movement-based therapies like occupational therapy and associated therapeutic groups, and vocational rehab and supportive employment. Such groups provide positive peer interactions and when such groups are facilitated by professionals trained in the biopsychosocial model and group interventions, such as occupational therapists, they can provide significant patient education and opportunities to practice self-management techniques.
- Neurosensory processing has significant impact on the experience of pain and sensory based interventions that address sensory processing can significantly improve functional participation in daily activity and decrease pain symptoms.
- Another barrier to non-pharmacological services is the lack of reimbursement for adaptive equipment or assistive devices for such items as sock aides, long-handled sponges, or toilet hygiene aids. Occupational therapy assessment for and training in the use of equipment can help patients compensate for reduced functional activity tolerance, loss of range of motion, and practice energy conservation. Furthermore, use of adaptive equipment allows patients to engage in meaningful ADL more independently and with reduced pain, which can help rebuild the self-efficacy that is typically lost as individuals live with chronic pain. Unfortunately, because many patients have limited financial resources or ability to independently acquire such equipment, they are unable to access function improving devices.
- Increase access by increasing providers of non-pharmaceutical therapies in communities, telemedicine – OSHU ECHO (http://www.ohsu.edu/xd/health/for-healthcare-professionals/telemedicine-network/for-healthcare-providers/ohsu-echo/index.cfm) and Oregon Psychiatric Access Line for kids (OPAL-K), transportation.
- Reimbursement for regulation therapies for youth and adults.
- Reimbursement for peer support services.
- Fund research on effectiveness of non-pharma. It is a hard sale to the medical model b/c of limited validated studies.
- Change metrics for interventions from medical model short solution to long term social determinant of health impact.

3. How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?

- Increase flexibility for payments of interprofessional care within primary care that includes occupational therapy, behavioral health, dental and don't limit ability for same day services.

Allow for establishment with primary care providers that include non medical providers in order to facilitate relationship with primary care that will promote engagement.

- Reimbursement and support to add screening for OUD/SUD in primary care assessments.
- Screening for adversity and resilience as a prevention measure to OUD/SUD.
- Pain assessments and sleep assessment in drug court and other intervention services.
- Teaching social-emotional learning in preK – 3rd grade to prevent adversity and promote resilience
- Trauma Informed community and state initiatives focused on prevention of adversity and intervention in a coordinated continuum of care.
- V.A. online PTSD interventions using technology and peer support to engage and manage symptoms.
- Increase access by increasing providers of non-pharmaceutical therapies in communities, telemedicine – OSHU ECHO (http://www.ohsu.edu/xd/health/for-healthcare-professionals/telemedicine-network/for-healthcare-providers/ohsu-echo/index.cfm) and Oregon Psychiatric Access Line for kids (OPAL-K).
- Fund transportation to services especially in rural areas if telemedicine is not utilized.
- Reimbursement for regulation therapies for youth and adults.
- Reimbursement for peer support services.
- Supportive housing services.
- 1st 30 day and last 30 days assessment and planning for incarcerated populations.
- Funding for culturally specific regulation interventions.

4. Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?
   - Consider limiting the dosing ability for opiates, for example, limiting to 7 day supply.

5. How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?
   - Build robust relationships between primary care providers and legislators to advance opportunities for clinical input. Connect with state associations for those nontraditional pain management practitioners like occupational therapy. Consider programs like Explain the Pain Program.
   - Prescribing professionals may be under-educated on the non-pharmacological treatment methods for pain. Requiring or providing continuing education that trains such providers on the evidence for multidisciplinary treatment under the biopsychosocial - rather than biomedical - model for pain would be useful. In addition, if providers do not work in interprofessional clinics already, they may have limited awareness or coordination with professionals such as occupational therapists and behavioral health workers that could be helpful in supporting their patients.
   - Provide some structure to medical student education that includes learning from biopsychosocial focused providers to learn about non pharmacological interventions
   - Develop accessible training materials for prescribers about the connections between adversity and OUD/SUD (videos, phone apps).
   - Telemedicine that includes relevant content and case consults with biopsychosocial providers.
   - Peer support/community health workers trained and located in high prescribing settings.
   - Education regarding poly-prescribing;

- Education on psychiatric Rx prescribing especially for youth (offering anti-anxiety to youth in dental appts when it is not needed). Standard of Care for psychiatric Rx.

6. What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug MonitoringPrograms
   - Identify high prescribing facilities in addition to providers for example, emergency departments.
   - Overlap social and structural determinants of health with OUD/SUD data for 'hotspotting' intervention needs.
   - Data systems to identify poly-prescribing.

7. What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

8. What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?
   - Increased emphasis on older adults and medication issues and other aging on medication challenges, consider MHFA Oregon as a community education initiative.
   - Ban the Box to increase job opportunities post treatment.
   - Grandparents/relatives raising children supports (http://www.childreninc.org/registration-open-gap-conference/)
   - Supporting housing and transportation.