The Honorable Orrin Hatch
Chairman
Senate Finance Committee
Washington, D.C. 20515

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
Washington, D.C. 20515

February 15, 2018

Dear Chairman Hatch and Senator Wyden:

As your Committee begins consideration of actions to be taken to address the current drug epidemic of opioids, the Child Welfare League of America offers the following comments. We offer several proposals for Committee consideration to be taken in addressing not just the current crisis but the ongoing challenges that substance use disorders play each and every year.

We thank the Committee for past actions taken to address this challenge. This includes the most recent Families First Act which we hope will eventually add a critical tool in addressing both substance use and behavioral health challenges that play a role in both foster care and child maltreatment. We also thank you for the past creation and extensions of the Regional Partnership Grants (RPGs)

Recent research presented by the Assistant Secretary for Planning and Evaluation, indicates that a 10 percent increase in drug overdose death rates correlate to a 4.5 percent increase in the foster care rate (per 100,000). That is not surprising in the fact that the 2016 Foster Care population was at 437,000 compared to 397,000 in 2012. Anecdotally we hear and read the results of a stretched system of foster care placements and shortages of kin families. There are other family related impacts that may get overlooked. Two we highlight are reports of increased addiction among young people. The second is an item we referenced in our comments to the President's Commission:

"A recent report by the Washington Post focused on the efforts and research of a child psychiatrist in the Cincinnati, Ohio. Daniel Nelson has found a trend that suggests that heavy opioid addictions and fatalities among adults is contributing to an alarming and dramatic increase in children and youth suicides. Dr. Nelson is working with coroners across the nation to examine if this pattern holds beyond Hamilton County, Ohio. The CDC has already documented a doubling of national suicide rates for children age 10 through 14 since 2007, with suicides hitting a 40-year high for older teenage girls in 2015. According to Nelson, Hamilton County has experienced an increase in teen suicides nearly three times the national rate over the past year."

Here are some items to consider within the **jurisdiction of child welfare programs:**

Just last week, you extended the **Regional Partnership Grants (RPGs) Program**. This is an important tool since the Families First Act will not be immediately available; as a result, these grants are even more important. To extend the reach of these programs the Administrations first full budget proposes an expansion of funding from $20 million to $60 million. Their rationale aligns with a similar proposal in the last budget of the Obama Administration which also argued for the increase. The new funds would extend the reach of these grants to all 50 states. Such an expansion may allow for grants and strategies that could lay the ground work and strategies as well as a host of evidence-based approaches to be used by states when Families First services funding comes on line.

Parental substance abuse is directly correlated with the rise in the number of children in foster care. The Regional Partnership Grant (RPG) program, first created in 2006, is a competitive grant program with funding over a five-year period to implement "regional partnerships" in states, tribes, and communities to improve outcomes for children and families who were affected by parental SUDs. The program includes a strong evaluation component and has been tremendously successful. Much of what we know about "what works" to serve this population of children and families comes from the RPG program, and the programs have led to improved rates of recovery, family preservation, family reunification, repeat maltreatment, and re-entry into the child welfare system.

Provide funding to expand the **Family Drug Court model**. There have been several briefings over the years on effective examples of these family courts. It is time to bring them to scale. This funding could flow through OJJDP and SAMHSA (which currently provide funding). A second option would be to fund them through child welfare by funding an increase or earmark or set-aside in the Court Improvement Program (CIP) and requiring that money be spent to scale the FDC model.

Family Drug Courts (FDCs) – also known as Family Treatment Courts or Family Dependency Treatment Courts – offer an important and effective way to address substance use disorders and parenting within the child welfare and court systems. The over 370 existing FDCs help child welfare agencies meet their core safety and permanency outcomes for children by helping parents gain access to substance use disorder treatment, achieve recovery, and reunify with their children. Since the inception of the model in 1994, the number of FDCs has grown in response to the need, but existing FDCs are serving only a fraction of the families who could benefit from the interventions and services.

The President's Commission included in their recommends addressing the shortage of the broader drug courts indicating that 44 percent of counties lack these types of treatment courts. They proposed establishing federal drug courts within the federal district court system in all 93 federal judicial districts. The Committee might also examine strategies to combine and leverage funding with drug courts.

Allow **Title IV-E Training Dollars to be used for joint trainings for workers across systems touching children and families.** Currently the use of Title IV-E training funds is based on Title IV-E eligibility with states allowed to draw funding based on how large or small a worker's IV-E eligible caseload is set at (i.e. if 40 percent of the caseload is covered by Title IV-E, 40 percent of the training costs can be matched by federal funds).

At a recent CWLA webinar we learned of new research by HHS that indicates the benefits of co-locating child welfare and substance abuse staff. Such expanded training may increase these strategies. In addition to strategies there is also some suggestion that workers are facing hazards and other trauma based on the nature of this drug epidemic. Dealing with substances such as Fentanyl presents a different and sometimes dangerous challenge for the workforce. Additional training in safety and dealing with *worker trauma* are important. If a permanent expansion is not possible, then the committee should consider a shorter term of perhaps three to five years.

Finally, the Committee may want to think over the long term of revisiting the bipartisan legislation introduced by Senators Olympia Snowe and Senator Jay Rockefeller in 2000 (S.2435) and later Congresses. It would have created a state grant program to better coordinate and provide services between the state child welfare agency and the state substance abuse agency to address SUDs – thus building an infrastructure for child welfare agencies to more effectively respond to future drug abuse crises. The goal of the grants is to increase the capacity of both systems to address, comprehensively and in a timely manner, the needs of families to improve child safety, family stability, and permanence, and to promote recovery from SUDs.

Other areas:

We also repeat some of our recommendations to the President's Commission:

- CWLA supports the recommendation to increase treatment capacity by granting waiver approvals for all 50 states to quickly eliminate barriers to treatment resulting from the federal Institutes for Mental Diseases (IMD) exclusion within the Medicaid program.

- We support mandating prescriber education initiatives with the assistance of medical and dental schools across the country to enhance prevention efforts. This includes medical education training in opioid prescribing and risks of developing a substance use disorder (SUD) by amending the Controlled Substance Act to require all Drug Enforcement Administration (DEA) registrants to take a course in proper treatment of pain. The Department of Health and Human Services (HHS) should work with partners to ensure additional training opportunities, including continuing education courses for professionals.

- CWLA supports efforts to enhance access to Medication Assisted Treatment (MAT). Require that all modes of MAT are offered at every licensed MAT facility and that those decisions are based on what is best for the patient. We also support efforts to partner with the National Institutes of Health (NIH) and the industry to facilitate testing and development of new MAT treatments.

CWLA highlights the importance of Medicaid in its support for MAT treatments. Some of the states that are struggling the most with the spread of opioid addiction, including West Virginia, Ohio, and Kentucky, have funded a significant or a majority of their MAT treatment through Medicaid. As a result, we strongly oppose efforts that would cut or cap Medicaid services and funding.

Within all these proposed recommendations are the unique needs of certain sometimes-isolated communities, such as Tribal and Native American communities and rural areas including frontier lands. Tribal governments are frequently unable to obtain the needed funds to match federal grants and as a result, while eligible for funds, they cannot draw on these funds. Every one of these proposals must extend to Tribal communities even when the main challenge may be another substance. In addition to struggling with substance use disorders, people in these areas may face a lack of resources. This includes not just limited or nonexistent funding in services, but a lack of available service providers and agencies.

In closing we also urge coordination with your counterparts on the HELP Committee. We hope you will join with us in calling for significant funding through the Child Abuse Prevention and Treatment Act (CAPTA). This historic law is intended to both strengthen state child protection systems and better coordinate the *prevention of child maltreatment*. Under CAPTA we need greater funding and coordination to implement that law's mandate to implement "plans of safe care." CAPTA also has the ability to better coordinate a range of services and strategies through the CDC, NIH and the Surgeon General.

Thank you for your commitment to our nation's children.

Sincerely,

John Sciamanna
Child Welfare League of America