CENTER FOR YOUTH WELLNESS
health begins with hope

February 16, 2018

Dear Chairman Hatch and Senator Wyden,

The Center for Youth Wellness (CYW) is writing this letter in response to your request dated February 2, 2018 for policy recommendations to address the opioid epidemic.

Established in 2012 by pediatrician Nadine Burke Harris, CYW started screening children for Adverse Childhood Experiences (ACEs) to mitigate the impact of toxic stress on young children's brains and bodies. Today, we work to increase awareness of ACEs and toxic stress through public education, transforming pediatric care to integrate ACEs screening into clinical practices, and advancing research in the field. As Dr. Robert W. Block, former president of the American Academy of Pediatrics, noted: "Children's exposure to Adverse Childhood Experiences are the greatest unaddressed public health threat facing our nation today."

Adverse Childhood Experiences (ACEs) are potentially traumatic events or severe stressors that occur during critical windows of development in childhood. These experiences include physical, sexual, or emotional abuse, neglect, exposure to a parent treated violently, parental incarceration, parental separation or divorce, and parental substance use or mental illness. These events, in particular when experienced repeatedly in the absence of a buffering adult support system, can accumulate at a biochemical level and overtax the body's stress response in a way that creates lasting effects on the brain, immune and hormonal systems, as well as how our DNA is read and transcribed - a process that is now being referred to as toxic stress. These changes in the brain and body can lead to lasting impacts on children's health and development that can persist into adulthood.

Though not all individuals with opioid dependency have experienced ACEs or trauma, decades of research on severe childhood adversity have consistently found a strong relationship between these early experiences and substance use. The seminal study on ACEs found that for adults reporting 4 or more ACEs, odds of illicit drug use were 4.5X greater than for those with no ACEs, and 11.1X greater for injection drug use, which includes non-prescription opioid use[1]. A study seeking to understand the trauma profile of individuals with prescription non-medical opioid addiction found that 100% of their sample had experienced ACEs, with the first traumatic event having been experienced, on average, by age 9 years old[2]. A further study found that each ACE increased the likelihood of early initiation into illicit drug use by 2- to 4-fold[3].

Children with parents who are substance dependent are at risk for toxic stress, and may inherit a genetic predisposition to substance dependence as well, putting them at greater risk for becoming substance dependent themselves. However, extensive research shows that parents and caregivers are a critical source of support and buffering for children against toxic stress. Therefore, approaches and programs that reduce exposure to traumatic events such as ACEs, and support both parents and children, are essential for healing.

Given the association between opioid dependence and trauma, and the potential for multigenerational effects, policy approaches to addressing this epidemic should include strategies for early identification and prompt two-generation focused interventions. In addition,

continued research that incorporates an understanding of trauma and toxic stress as it relates to opioid addiction and treatment will be critical to best guide the allocation of resources in the most effective and precise ways.

More specifically, we encourage the Senate Committee on Finance to consider the following legislative actions:

1. ***Create incentives and remove barriers for ACEs screening and intervention through primary care***

   Medical providers can use systematic approaches, such as routine and universal ACEs screening, to identify children and families with ACEs, including those children that have previously been or are currently being exposed to substance dependence in their home. Primary care medical providers, in particular those in pediatric primary-care, are in a unique position to identify children, who are experiencing ACEs, due to their long term and often trusted relationship with the family and their training in disease prevention.

   Resources to support medical providers in addressing ACEs and trauma in children and families exist. For example, the National Pediatric Practice Community on Adverse Childhood Experiences (see NPPCACES.org) focuses explicitly on supporting medical practices to integrate an ACEs and toxic stress framework into their practice 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.

   Screening, in conjunction with linkages to support services and evidence-based interventions, can help address current opioid dependence in the families, reducing exposure for children, while also providing children with the support they need to interrupt the potential longer term impacts of toxic stress.

   Lack of reimbursements for screening and challenges in billing for interventions to address trauma are a barrier to screening adoption. Challenges may include: inability to bill for parent and child consult in the same visit, barriers to billing different forms of integrated care (e.g. navigators or co-located care), and lack of reimbursement for interventions considered wellness services or parenting programs. Congress should direct the Centers for Medicare and Medicaid (CMS) to review all of its practices and policies to insure that ACE screening and interventions, including parenting support programs, are fully covered by Medicaid and the Children's Health Insurance Program (CHIP).

2. ***Support primary prevention through multi-level and multi-generational awareness raising efforts***

   In our own national research with families and caregivers we have found that there are low levels of awareness about the long-term health effects of ACEs. However, once knowledgeable about these health effects, parents are willing to talk to their medical providers about these exposures, a critical opening for identifying those at risk and enabling access to treatment. Primary prevention of opioid dependency should include a strategy for non-judgmental public education about ACEs and its effects. One such campaign, based on this science has just launched (www.stress-health.org), however

continue effort to ground this public education at the community and individual levels should be included in a far-reach strategy for opioid dependency prevention. Primary prevention programming could be supported through DHHS and the Administration for Children and Families. In addition, CMS should be asked to educate medical practices billing Medicaid on providing individual and family 1 on 1 education on ACEs and toxic stress.

3. ***Incentivize the development of new and require evaluation of interventions/treatment programs***
   More research is needed to better understand the intergenerational impact of opioid dependence, its relationship to childhood trauma, the biomedical mechanisms that increase risk for dependence, and effective interventions that leverage this important and evolving body of knowledge. Currently, most evidence-based programs are focused on outcomes related to mental and behavioral health (ie. substance use in the individual and related psychological/psychiatric outcomes). By integrating our growing understanding of the bio-social mechanisms of toxic stress, we can better understand the multiple pathways by which ACEs and addiction are related. This will provide an unprecedented opportunity to develop more precise and effective interventions, allowing us to prevent the perpetual cycle of adversity and substance dependence. Funding should be allocated to the innovation of new programs under DHHS programs as well as to support existing best practices. All programs should be required to integrate appropriate evaluation mechanisms that include an understanding of ACEs, trauma and toxic stress and a multigenerational perspective so that we can learn what is most effective for who.

We thank you for your leadership on this topic and appreciate you taking the time to consider our recommendations. We are hopeful this process will bring much needed interventions and support to families and communities dealing with opioid dependence.

Thank you for your consideration of these recommendations.

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References:

1. Felitti et al. 1998. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. American Journal of Preventive Medicine 14(4): 245-258.
2. Lawson, K. et al. 2013. A Comparison of Trauma Profiles among Individuals with Prescription Opioid, Nicotine or Cocaine Dependence. Am J Addict. Mar-Apr; 22(2): 127–131.
3. Dube, SR et al. 2003. Pediatrics. 2003 Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. Mar;111(3):564-72.