TO: President's Commission on Combating Drug Addiction and the Opioid Crisis

DATE: Monday, September 18, 2017

Introduction

The Child Welfare League of America submits the following recommendations detailed below to President's Commission on Combating Drug Addiction and the Opioid Crisis.

The recommendations are made in support of the Commission's mission to identify and assess federal efforts and programs to assess treatment, prevention, and other efforts to combat addiction generally and the opioid crisis specifically.

The recommendations are submitted in the context of current existing laws, programs, and policies and how they can be strengthened and how funding priorities as well as new proposals could assist in addressing this great challenge.

CWLA Support for the Initial Commission Recommendations

Regarding the Commission recommendations offered in the initial report submitted on July 31, 2017, CWLA highlights several initial recommendations that we support:

- 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.

The 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.

- In addition to MAT and the traditional 28-day inpatient model for substance use disorder treatment, we also support access to community-based, home, and outpatient treatment options.

- We also support the Commission proposal to better align, through regulation, patient privacy laws specific to addiction with the Health Insurance Portability and Accountability Act (HIPAA) to ensure that information about SUDs be made available to medical professionals treating and prescribing medication to a patient. This could be done through the bipartisan Overdose Prevention and Patient Safety Act/Jessie's Law."

  Having all of the information necessary for safe, effective, high-quality treatment and care coordination that addresses all of an individual's health needs is vital in order to support prevention and treatment. The federal regulations governing the confidentiality of drug and alcohol treatment and prevention records (42 CFR Part 2) are outdated and incompatible with the way health care is delivered today. These requirements limit the use and disclosure of patients' substance use records among treating providers and effectively separate substance use treatment records from physical health medical records. These rules have limited the ability of providers to integrate mental health, substance use, and physical health care treatment for patients which impacts patient safety. These barriers also run counter to the intent of mental health parity. Thus, 42 CFR Part 2 should be aligned with the HIPAA (45 C.F.R. § 164.500 et al.) for the purposes of health care treatment, payment, and operations. The proposed OPPS Act, referenced in the Commission's recommendation, would align 42 CFR Part 2 with HIPAA for the purposes of health care treatment, payment, and operations. As we do not want patients with substance use disorders to be made vulnerable as a result of seeking treatment for addiction, the OPPS Act also strengthens protections of their records from criminal investigation or proceedings.

- CWLA strongly endorses the recommendation to fully enforce the Mental Health Parity and Addiction Equity Act (MHPAEA) with a standardized parity compliance tool to ensure health plans cannot impose less favorable benefits for mental health and substance use diagnoses verses physical health diagnoses.

  As the Commission highlights, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits health insurance plans that cover behavioral health from imposing benefit limitations on mental health or SUD treatment that are less favorable than limitations imposed on medical or surgical benefits. Benefit limitations can be

quantitative, such as visit limits, or non-quantitative, such as pre-authorization requirements. But not providing real parity is already illegal. We support actions by the Secretary of Labor to enforce this law aggressively and to penalize the violators.

CWLA also encourages the further development of some of the Commission's list of items for further funding, development and implementation:

- Evidence-based prevention programs for schools, and tools for teachers and parents to enhance youth knowledge of the dangers of drug use, as well as early intervention strategies for children with environmental and individual risk factors (trauma, foster care, adverse childhood experiences (ACEs), and developmental disorders).

- Improvements in treatment programs, based on adherence to principles of evidence-based treatment, continuum of care, outcome measures, and patient education on quality treatment.

- Research initiatives and opportunities to combat the epidemic and enhance treatment options, including alternative pain management strategies, and treatment for vulnerable populations such as pregnant women, and substance-exposed infants through work by the NIH, HHS, CDC, FDA, SAMHSA, and pharmaceutical partners.

- Opportunities for patient protections providing better information about the risks and benefits of taking prescription opioids.

The Impact of Substance Use and Opioid Addiction on Child Welfare

Recent headlines and studies have highlighted the dramatic increase in drug-related deaths and overdoses. We use this statement as an opportunity to focus Commission attention on what is both a direct and an indirect impact of this drug crisis on the child welfare and child protection systems across the 50 states. We point out the fact that substance use disorders are a consistent factor in determining the number of children that come into foster care and child protection systems.

As a country, we have taken significant strides in reducing the nation's foster care numbers in this century. Foster care caseloads stood at 568,000 in 1999.[1] By 2012, the number of children and youth in foster care had decreased to 397,000.[2]

Last fall (2016), the Department of Health and Human Services released their latest official child welfare data. That data showed that in 2015, 427,910 children were in foster care, an 8% increase since 2012. New data suggests that drug abuse by the parent was the primary reason for the

[1] House Ways and Means Committee. (2000). *The Greenbook*. Retrieved from https://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=&packageId=GPO-CPRT-106WPRT61710

[2] Department of Health and Human Services, Administration for Children and Families. (2016). *The AFCARS Report Number 23*. Retrieved from https://www.acf.hhs.gov/cb/resource/afcars-report-23

child's removal in 32% of cases, and a parent's inability to cope was a factor in a child's removal in 14% of cases.[3]

As a follow up, officials at the Administration on Children, Youth and Families (ACYF) interviewed child welfare directors in states experiencing the highest increase in foster care numbers. State officials informed ACYF on what the data suggest: "*A rise in parental substance use is likely a major factor driving up the number of children in foster homes. Citing opioid and methamphetamine use as the most debilitating and prevalent substances used, some state officials expressed concern that the problem of substance use is straining their child welfare agencies."*

A recent report by Health Resources & Services Administration (HRSA) indicated that overall, the percent of victims from FY 2012 to FY 2014, with the risk factor designation of parental drug abuse has increased from 19.8% to 25.5%. However, within this group, the percent of infants with the risk factor designation of parental drug abuse has increased 8.1% (from 25.7% to 33.8%).

As HRSA pointed out, based on 2014 federal data, at least 89% of people who met the definition for a drug use disorder didn't get treatment. This can increase the likelihood of involvement from child welfare agencies, and the potential disruption of families through placement of children in foster care.

Examples of Opioids and Other Substance on Child Welfare

- In one state, Florida, the ***number of children in foster care in Florida increased from 18,040 to 22,364*** between 2013 and 2015. Entries into foster care increased from 14,310 in 2013 to 17,677 in 2015—a number that has not been exceeded since 2007.[4]

  As recently reported, in Florida's 12th Judicial Circuit (Manatee, Sarasota and De Soto Counties), over the past 20 years child welfare caseworkers would bring in approximately 30 to 40 children a month, and about half would go into foster care. But now, according to local advocate Brena Slater, "We've had a 120 percent increase in the last three years." Substance abuse tops the list of reasons cited for child removal this year. Substance abuse can include alcohol, marijuana or other drugs, but Slater says she's seen a clear connection to the rise in opioid use, pointing out that "our area never had more than one or two parents die a year of overdose and we have already had 23 parents die this year (2017)."

- According to a recent article in the *Washington Post*, "More than 1,000 children are born addicted to drugs in Maine each year, many of whom end up in foster care. According to

[3] Ibid.
[4] Department of Health and Human Services, Administration for Children and Families. (2016). *The AFCARS Report Number 21, June 2014 and The AFCARS Report Number 23*. Retrieved from http://www.acf.hhs.gov/programs/cb

the report, there were more than 1,800 in foster care across the state in 2016, a nearly 45 percent increase in foster children here since 2011." That same article indicated that, "More than 1,000 children are born addicted to drugs in Maine each year, many of whom end up in foster care."[5]

- A recent report to the Governor of Indiana stated that "…national research indicates that 61% of infants and 41% of older children in out-of-home care are from families with some form of active SUD. These figures are increasing in Indiana where the percentage of children removed from homes due to parental SUD increased from 48% (5,101 children) in State Fiscal Year 2015, to 52.2% (6,223 children) in State Fiscal Year 2016."

In that same report, authors pointed to recent trends in Indiana's child welfare system:

CHILDREN IN INDIANA DEPARTMENT OF CHILD SERVICES CARE		
Service	2015	2016
In-Home Care	5,487	6,107
Relative Care	6,239	7,492
Traditional Foster Care	5,808	6,567
Residential Foster Care	862	952
Other	225	256

As CWLA highlighted in recent letters to Capitol Hill, other state trends include the following samples:

- The ***number of children in foster care in Alaska increased from 1,982 to 2,653*** between 2013 and 2015. ***In 2010 Alaska's Foster Care population had decreased to 1,791. Entries into foster care*** in 2010 had decreased to 887 children but by 2015 that number ***had increased by over 70%, to 1,513 children entering care.*** [6]

- The ***number of children in foster care in Arkansas increased from 3,797 to 4,548*** between 2013 and 2015. In addition, entries into foster care increased from 3,798 in 2013 to 4,065 in 2015. This is the highest number of entries since 2009, when the figure reached 4,161.[7]

- In Arizona, the ***number of children in foster care increased from 14,399 to 17,738*** between 2013 and 2015. In addition, entries into foster care increased from 10,790 in 2013 to 12,722 in 2015. At one point, in 2006, entries stood at 7,460.[8]

[5] Stein, P., & Bever, L. (2017). The Opioid Crisis is Straining the Nation's Foster-Care Systems. *The Washington Post.* Retrieved from https://www.washingtonpost.com/national/the-opioid-crisis-is-straining-the-nations-foster-care-systems/2017/06/30/97759fb2-52a1-11e7-91eb-9611861a988f_story.html?utm_term=.a6187d223112

[6] Department of Health and Human Services, Administration for Children and Families. (2014/2016). *The AFCARS Report Number 21, June 2014 and The AFCARS Report Number 23, June 2016.* Retrieved from http://www.acf.hhs.gov/programs/cb

[7] Ibid.

[8] Ibid.

- In Georgia, ***the number of children in foster care increased from 7,607 to 10,935*** between 2013 and 2015. Entries into foster care increased from 6,005 in 2013 to 8,581 in 2015—a number considerably higher than the lowest number of the recent past of 5,469, reached in 2010.[9]

- In Kansas, the ***number of children in foster care increased from 6,441 to 7,223*** between 2013 and 2015. For many years, many observers and advocates at the national level would refer to the state's child welfare system and highlight the progress being made; in fact, ***in 2009, the Kansas Foster Care population stood at 5,691.*** Today these numbers have increased by nearly 27%.[10]

- The ***number of children in foster care in Louisiana increased from 3,955 to 4,545*** between 2013 and 2015. In addition, entries into foster care increased from 3,475 in 2013 to 4,099 in 2015. This is the highest number of entries in more than ten years and much higher than the low of 3,131 entries in 2012.[11]

- In Missouri, placements of ***children in foster care increased from 10,624 to 12,160*** between 2013 and 2015. Entries into foster care increased from 6,401 in 2013 to 6,906 in 2015—much higher than the lowest number of the past ten years of 4,557, reached in 2008.[12]

- Montana, which still feels the impact of the earlier meth-amphetamine epidemic, experienced an increase of ***2,232 to 2,807 children in foster care*** between 2013 and 2015. Entries into foster care increased from 1,434 in 2013 to 1,940 in 2015. **The 2015 number of *entries into foster care is more than all of 2009 and 2010 combined.*[13]**

- In North Carolina, the increase went from ***9,036 to 10,324*** between 2013 and 2015. Entries into foster care increased from 5,300 in 2013 to 5,597 in 2015. The 2015 number of entries is much more than North Carolina's recent low point of 4,769 in 2010.[14]

- The ***number of children in foster care in North Dakota increased from 1,227 to 1,359 between 2013 to 2015.*** The number of children taken into foster care on an annual basis rose from ***951 to 1,037 within that same time frame—far more than the decade low of 789 in 2011.*** The ***number of children served (counting any time in care during the year) rose from 1,769 in 2011 to 2,332 in 2015***.[15]

[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Ibid.

- In Ohio, the ***number of children in foster care increased from 12,223 to 13,205*** between 2013 and 2015. In addition, entries into foster care increased from 9,875 in 2013 to 10,360 in 2015. This is the highest number of entries since 2007.[16]

- The ***number of children in foster care in West Virginia increased from 4,389 to 4,959*** between 2013 and 2015. In addition, entries into foster care increased from 3,467 in 2013 to 3,950 in 2015. In 2010, entries stood at 2,955.[17]

Opioids may include other impacts on children that are not readily obvious. 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.[18]

Recommendations:

1. The Protect the Role of Medicaid

The Commission should come out forcefully against actions that would cut or cap Medicaid. Medicaid has always been a source of treatment for substance abuse and mental health services. In some instances, a lack of access to such behavioral health services will result in children entering the child protection system. Medicaid helps state and local agencies get treatment to children in foster family homes, children with special needs in residential treatment, children who move from foster care to guardianship, and those with special needs adopted from foster care. Medicaid allows for important therapeutic case management and therapeutic treatment; colocation of health experts in child welfare offices; services and treatment for children in foster care with multiple complex needs; and assistance for their parents, which helps shorten children's stays in foster care and reunite families.

The expanded access to health care through Medicaid and private health insurance resulting from the Affordable Care Act (ACA) has provided more than $5.5 billion in substance use and mental health services, according to recent research by Dr. Richard Frank and Dr. Sherry Glied of

[16] Ibid.
[17] Ibid.
[18] Murgia, M. (2017). Mapping Out the Causes of Suicide in Teenagers and Children. *The Washington Post.* Retrieved from https://www.washingtonpost.com/national/health-science/mapping-out-the-causes-of-suicide-in-teenagers-and-children/2017/08/22/c146cc6c-770e-11e7-8839-ec48ec4cae25_story.html?utm_term=.3312923ae066

Harvard Medical School and the Wagner School of Public Service at NYU.[19] It is critical that we keep these services in place.

According to Dr. Frank and Dr. Glied, a full repeal of the ACA would result in a loss of coverage for 2.8 million people with a substance use disorder, including 220,000 people who have an opioid addiction. Additionally, it would eliminate mental health coverage to 1.2 million people with a serious mental health disorder.[20]

According to the National Center on Behavioral Health, many states with the highest opioid overdose death rates have used Medicaid to expand access to Medication-Assisted Treatment (MATs). This includes 49.5% of medication-assisted treatment in Ohio, 44.7% in West Virginia, 44% in Kentucky, 34.2% in Alaska, and 29% in Pennsylvania.[21] Imagine the impact on foster care caseloads, child maltreatment, and other areas of child welfare if the expanded behavioral health and substance use treatment is repealed, cut back due to state options, or cut out due to a state hitting their annual Medicaid per capita cap.

Early in 2017, *USA Today* highlighted mental health programs developed by the Montefiore Health System in the Bronx. They quoted psychiatrist Henry Chung, chief medical officer of Montefiore's care management organization, as saying the success of these programs is contingent upon patients getting early treatment in primary care. He went on to say the new mental health provisions in the recently enacted 21st Century Cures Act that improve access to treatment need "…to be combined with strong, affordable insurance. You can't have one without the other or some of that progress will be taken away."[22]

This conclusion is further supported by *Facing Addiction in America*, a 2016 comprehensive report by the U.S. Surgeon General. One of that reports recommendations states:

"*Full integration of the continuum of services for substance use disorders with the rest of health care could significantly improve the quality, effectiveness, and safety of all of health care."*

That report goes on to emphasize that policy changes, particularly at the state level, are needed to better integrate care for substance use with the rest of health care. CWLA believes that efforts to cut Medicaid or cap funding will push states in the opposite direction.

[19] Frank, R.G., & Glied, S.A. (2017). Keep Obamacare to keep progress on treating opioid disorders and mental illnesses opinion contributors. *The Hill*, January 11, 2017.
[20] Ibid.
[21] Blue, S.C, & Rosenberg, L. (2017). *Americans with Mental Health and Substance Abuse Disorders: The Single Largest Beneficiaries of the Medicaid Expansion*, the National Counsel of Behavioral Health. Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2017/01/Medicaid-Expansion-Behavioral-Health-UPDATED-1-24-17-1.pdf
[22] O'Donnell, J., & DeMio, T. Obamacare repeal jeopardizes mental health, addiction coverage. *USA Today*, January 9, 2017.

2. Provide Increased Funding of the Child Abuse Prevention and Treatment Act (CAPTA) Plans of Safe Care

In 2016, the Congress amended the requirements under CAPTA for plans of safe care for infants born and affected by substance use.

Specifically, this part of CAPTA (amended in the previous two reauthorizations) directs:

"The development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of health care providers, including through:

> addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver;
>
> and
>
> the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver."

These CAPTA requirements include, "procedures for the immediate screening [at birth], risk and safety assessment, and prompt investigation of such reports."

While Congress was eager to amend CAPTA and expand this important mandate on states, they failed to provide the needed funding for this challenging and important screening, treatment, and follow up. Currently CAPTA state grants are less than $26.5 million, below what it was more than a decade ago.

We urge the Commission to include recommendations that would help develop and fund this provision of CAPTA. Under current state grants more than a dozen states receive less than $150, 000 a year for the entire state regardless of population or geography. First, there should be significant funding by the federal government to fund and develop these plans and secondly these plans should then be implemented across the 50 states with adequate funding by the federal government. HHS should be directed to work with the states in determining what it will cost to effectively implement the congressional mandate.

The Commission should also include in their recommendations, along with the necessary funding stricter accountability for hospitals and medical professionals around ensuring infants with Neonatal Abstinence Syndrome (NAS) will be safe, have a safe plan of care in place, and will be under sufficient monitored before being discharged should their symptoms not fully be resolved or ameliorated before discharge. Greater resources need to be dedicated to research, understanding opioid misuse, substance use disorders, and the establishment of evidence-based treatment guidelines for NAS.

The CAPTA requirements predate the current opioid crisis, as a result we should not, under these recommendations and in others here, ignore the role of other substance use problems. A study by the National Institute on Drug Abuse found alcohol use disorders in 38% of opiate-using patients who sought treatment.[23] An earlier review of literature on the prevalence of heavy drinking among drug users enrolled in a methadone maintenance treatment found prevalence rates of 13% to 25% (Chen 2011), whereas more recent cross-sectional studies report prevalence rates of 33% up to 50%.[24]

3. Reauthorize and Increase Funding for Regional Partnerships

The Regional Partnership Grants (RPG) are authorized under Title IV-B part 2 (Social Security Act), Promoting Safe and Stable Families (PSSF) program. It is currently funded under a one-year extension and is due to expire on October 1, 2017.

The program, administered by the Children's Bureau, Administration for Children and Families, Department of Health and Human Services supports activities and services to better address the impact of substance use on child welfare. Past efforts and research include the creation or expansion of family treatment drug courts, improvement of system-wide collaboration, expanded access to comprehensive family-centered treatment, use of evidence-based practice approaches such as motivational enhancement therapy, parent advocates, and recovery management approaches to drug treatment monitoring. These projects and services are also helping to build evidence and research models for effective substance use treatment.

These are competitive grants set at $20 million since the 2006 creation and authorization. In 2017 HHS indicated that raising funding to $60 million would allow enough funding to expand these grants to cover all fifty states. The Commission should urge Congress to extend the program for five years with $60 million in funding.

4. Reauthorize and Increase Funding for Court Improvement Programs(CIP)

The State Court Improvement Program (CIP) was originally created in 1993 as part of Title IV-B part 2 at $5 increasing to $10 million per year. It provides federal funds to state child welfare agencies and Tribes for preventive services and services to families at risk or in crisis. Awards are made to the highest state courts. In 2006 funding was expanded to approximately $30 million per year with the current program extended under a one-year extension that will expire on October 1, 2017.

Funding is currently used for projects that included training of court personnel, improving data collection and data use to track children in the child welfare, assessments of state legal systems and supports mediation and other projects training for judges, lawyers and others involved in the dependency courts.

[23] Hartzler, B., Donovan, D.M., & Huang, Z. (2010). Comparison of opiate-primary treatment-seekers with and without alcohol use disorder. *Journal of Substance Abuse Treatment, 39*(2),114-123. doi:10.1016/j.jsat.2010.05.008.
[24] Islam, M. Mofizul, et al. (2013). Self-perceived problem with alcohol use among opioid substitution treatment clients. *Addictive Behaviors*, 38(4), 2018-2021

Congress needs to reauthorize this program for at least five years and assure that mandatory funding at no less than $30 million a year. In addition, in an effort to address this current substance use crisis, the Commission should include in its recommendations a special, if not permanent, allocation to expand the use of family drug treatment courts where there is strong oversight of cases involving parents that are using including opioids.

Family drug courts have been demonstrating an important tool to assist families address those addictions and to stay together. Parents are more likely to engage in treatment and follow through with treatment. According to the National Association of Drug Court Professionals family drug court participants had 20% to 30% higher treatment completion rates than non-participants. This has also resulted in higher family reunification rates for families separated and involved in child welfare cases.

5. Allocating Special Training funds for Child Welfare Workforce

With the significant increase in opioid-related cases, we need to increase funding for states to better address the training needs of the child welfare workforce. The increasing caseloads, the lack of placement options and the demand that places on recruitment efforts, and lack of treatment options all increase the challenges and stress on the child welfare workforce.

In addition to these workforce challenges that result from increasing caseloads, there are greater complexities and demands of working with families with substance use. This is an issue in particular with opioids due to safety issues for the staff dealing with the families similar to the safety issues for the police. This may include handling of especially toxic substances as well as the potential danger these frontline workers face in light of the increasing use of illegal substances.

There are at least two avenues that Congress can use to assist states. Additional funding can be provided through Child Welfare Services (Title IV-B part 2, CWS) now in need of a five-year reauthorization. It is currently funded at $269 million a year and additional funding could be set-aside through this funding stream and dedicated to worker training and supports (such as digital and other technology), which can enhance worker safety.

A more appropriate avenue may be to increase the current $20 million per year through PSSF, Title IV-B part 2, which is allocated to the 50 states for workforce development if that state meets a requirement to visit, at least monthly, each child in foster care. Since this funding stream is already tied to workforce and tied to monthly visits, it would be the most appropriate avenue to expand training and support for the child welfare workforce. The commission should recommend a significant temporary, if not permanent, increase in this funding.

In addition, other social service system workers should be coordinated with the health care system to help address the social and environmental factors that contribute to substance use disorders. The Surgeon General's report states:

"Social workers can play a significant role in helping patients with substance use disorders with wrap-around services that are vital for successful treatment, including finding stable housing, obtaining job training or employment opportunities, and accessing recovery supports…"

We suggest that programs such as TANF be revised in a way that focuses on recovery and supporting recovery rather than on punitive measures such as required drug-testing and restrictions on services and supports as a result of a previous drug history.

Regarding training, the role of peers is important in supporting recovery and resiliency. Individuals with mental health or substance use disorders require an array of supports to get well, reach recovery and resiliency, and continue to reside and live in their community. Having strong peer supports and engagement with their social network and community can directly influence an individual's ability to manage their health and stay well, live independently, work, and stay out of institutional care.

Questions remain, however, about how to define and train the peer workforce, how to encourage clinical providers to offer or facilitate access to non-medical peer support, and how peer support providers can improve outcomes and community engagement. We support additional research to identify evidence-based peer support practices that assist individuals in achieving resiliency and recovery and address health outcomes.

6. Expansion of Title IV-E Funding for Evidence-Based Services Including Substance Use Treatment

Last year, Congress debated child welfare legislation referred to as the Families First Prevention Services Act. That legislation included an important provision that would have allowed states to draw down through the Title IV-E entitlement funding 12 months of services. This included up to 12 months of substance use services. The legislation restricted this funding to only those services that met an evidence-based standard, were included in a state plan, and met the approval of the Department of Health and Human Services.

For reasons unrelated to this important and innovative approach to the use of Title IV-E foster care funding, the measure failed to pass.

We urge the Commission to recommend the enactment of this provision without regard to the other controversies that were part of this legislative debate. Such an expansion should be done now (the legislation required a three-year delay). If enacted it will do several things: it will allow greater access to substance use treatment for families involved with child welfare, it will build the list of evidence-based practices; it will allow for an increase in-home services, it will allow services to follow a child home in a post-reunification setting; and it will allow for the expansion of residential treatment programs—including specialized parent-child interaction and parenting programs targeted specifically to the parent who is using substances—that allow the child to remain with their parent.

CWLA has been informed that in addition to increased foster care caseloads, many states have increased demands for in-home services. This change in law would help address that need.

Treatment programs and approaches that support keeping the parent in their home, and keeping the child at home and out of out-of-home care, can succeed in stopping parents' use of substances and support their success in caring for their children.

As noted earlier in reference to a recent *Washington Post* article, there appears to be some evidence that there may be a correlation between the parents' opioid use and child/youth suicides. We need to ensure that any treatment for the parent also includes treatment for the children/family.

7. Address the Needs of Rural and Tribal Communities

Within all of 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.

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.

The Commission needs to make sure that any recommendations pay special focus on Tribal and rural areas through tools such as funding set-asides, special grants and funding streams, and use of technology such as telemedicine and other emerging innovations.

Conclusion

Substance use and mental health issues continue to plague the child welfare system and contribute to the number of children who are maltreated and children that grow up without a permanent family. The opioid crisis is the latest example in a list of substance dependencies that have included methamphetamines, crack cocaine, and earlier heroin epidemics.

We hope the Commission will take this opportunity to shine a bright light on the needs of these families and children involved with state child welfare and protective services systems.

We need to advance a child welfare continuum of care based on prevention, intervention, placement, and permanency: prevention of child abuse before it happens; intervention to keep families together when it is best for the child; placement in foster care that must be short and must be quality care; and permanency for families that reunify, adopt, or are kinship families, helping to secure a future for youth who exit to adulthood.

Substance use disorders, whether through the current opioid crisis or other ongoing and new substances, has always had a significant impact on each part of this child welfare continuum.

We hope the Commission will consider our recommendations and include them in your final recommendations to the President.

We stand ready to expand on our recommendations and to assist you in any way possible.

Thank you for your attention on behalf of children.

Sincerely,

Christine James-Brown
President/CEO, Child Welfare League of America