

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

June 1, 2016

Testimony for the record on behalf of the
American Academy of Pediatrics

Comments before the
**U.S. House Committee on Ways and Means Committee Human Resources
Subcommittee**

**“The Heroin Epidemic and Parental Substance Abuse: Using Evidence
and Data to Protect Kids from Harm”**

Thank you Chairman Buchanan, Ranking Member Doggett, and Members of the Human Resources Subcommittee for the opportunity to provide testimony for the record on this important hearing on parental substance use and child protection.

The American Academy of Pediatrics (AAP) is a non-profit professional organization of 64,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. The AAP develops its policy on the health needs of children in foster care through its Council on Foster Care, Adoption, and Kinship Care. This group comprises preeminent national experts on the intersection of child welfare and health, with a rich understanding of the how to address child trauma and support children involved with the child welfare system.

The ongoing opioid epidemic has substantial negative effects on children and families. Parental substance abuse is one of many adverse childhood experiences, in addition to maltreatment and poverty, that can contribute to toxic stress. In turn, toxic stress can lead to poorer health, developmental, social, and economic outcomes across the life span. Federal policy that supports at-risk families through health and social interventions is an important means to promote resilience and buffer the effects of adversity, including parental substance use.

The impending need to reauthorize Title IV-B of the Social Security Act affords substantial opportunities for the Committee on Ways and Means to consider and craft comprehensive policies to improve the linkages between health and child welfare services and contribute to better child wellbeing. Ameliorating the negative child health impact of parental substance use will be a critical component to this effort. This testimony outlines broad aspects of federal policy change that we respectfully submit for your consideration to address this ongoing problem and improve health outcomes for vulnerable children.

Advancing the Important Policies of the Family First Act

As you consider how to improve the ways in which the child welfare system serves children affected by parental substance use, we respectfully encourage you to incorporate the critical policies of the *Family First Act* into these policy discussions. The AAP strongly supports the *Family First Act* for the improvement it would create in balancing incentives to states by allowing them to use the best lessons from Title IV-E waivers and provide time-limited services to children at-risk for entering foster care and their caregivers to prevent entry into foster care. Parenting skills training, mental health services, and substance abuse treatment are targeted categories of services that aim at key drivers of family crisis and disruption, including parental substance use. Importantly, these services target both children and their caregivers, offering an opportunity to meaningfully address the reasons a child may otherwise enter foster care. In addition to the prevention policies, the AAP also supports the bill's new requirements to assure the appropriateness of congregate care placements. We urge you to use the current child welfare policy discussions as an opportunity to concurrently advance the bipartisan policies of the *Family First Act*.

Promoting Safe and Stable Families

The Promoting Safe and Stable Families program provides essential funding for states to engage in services that strengthen family capacity to care for their children and help families in crisis remain together. This program supports four key service categories: family support; family preservation; time-limited reunification; and adoption promotion and support. Children fare best when they are raised in families equipped to meet their needs. These services help maintain intact families during challenging times and are a critical means to preventing the need for out-of-home placements for reasons such as parental substance use. These investments have also complemented work under state Title IV-E waivers, which are due to expire in 2019. Given the experience and evidence to support the critical work states provide through IV-B, we recommend increasing IV-B resources and also considering how to best align these programs with the policies of the *Family First Act*.

Regional Partnership Grants

The Regional Partnership Grants under Promoting Safe and Stable Families fund effective multi-disciplinary interventions designed to address the impact of parental substance abuse on the child welfare system. These are important programs that support comprehensive family-centered services to treat substance abuse and keep families together where possible and appropriate for the needs of children. Given the successes of these programs and the growing impact of the opioid epidemic on families and the child welfare system, we suggest expanding this program to reach additional communities. It will be critical to continue the program's focus on the whole family to ensure that all children receive support and services for needs arising from parental substance abuse. Neonatal Abstinence Syndrome (NAS) incidence is increasing, and the AAP suggests ensuring that approaches to address NAS include consideration of the needs of additional children in the home, to support the healing of the whole family.

Medical Directors of Child Welfare Agencies

The health and well-being of children involved in the child welfare system is of critical importance to their long-term health and developmental outcomes. This is particularly true for children who have experienced deleterious effects from parental substance use. Child welfare agencies oversee important aspects of the coordination and provision of health services to children, and medical professionals can play an important role in ensuring that these services are of high quality and are optimally coordinated. A means through which some states, such as Illinois and Massachusetts, have developed an intentional infusion of this expertise into their systems is to have a pediatrician serve as the medical director of their child welfare agency. The experience of those states that have used this model demonstrates improved coordination of care, reduced costs, and better understanding of health and well-being for the child welfare staff working with the medical director.

Despite the promise of this model and the efforts of the AAP to ascertain the extent to which states are employing physicians as child welfare medical directors, there is no existing inventory of which states use medical directors and in what capacity. We suggest the development of a U.S. Government Accountability Office study to survey all child welfare agencies to assess

whether they are using physician medical directors, the structure in which those medical directors work, and the state's perception of the medical director's impact on organizational effectiveness and child health outcomes. This information will help improve our understanding of how these positions can be most effective, and will be important in ensuring the effective inclusion of a child health provider perspective when overseeing children with complex experiences of trauma in the child welfare system, including parental substance use.

Court Improvement Program

The judicial system makes critical decisions about children's permanency plans, health services, and other services affecting child health and wellbeing. The Court Improvement Program is an important policy tool for ameliorating the judicial experience of families in crisis. One addition to this program that we suggest is an expansion to expressly allow states to use the program funds to provide training on child trauma and child development to judges, attorneys, and law enforcement personnel involved with the courts serving the child welfare population. This training should be evidence-based or evidence-informed to ensure its effectiveness.

Access to expanded training of this kind would ensure that decision-makers within the courts better understand the experience, needs, and behavior of children and parents in the child welfare system, including those affected by substance use. This will lead to more effective placement and permanency decisions and greater assurance of access to appropriate treatment services. This would also serve as a logical outgrowth of the Court Improvement Program, as it would facilitate improved court processing of complex cases and result in better outcomes, while allowing states to tailor the programs to the needs of their particular populations. In a related effort, we also suggest updating the requirements for IV-B funds used to assess and improve foster care court proceedings, in order to determine the extent to which states use these funds for training on child trauma and child development. This will enable monitoring of how states are pursuing this type of training.

Health Oversight and Coordination Plans

As a component of their Title IV-B child welfare services plans, states are required (under 42 U.S.C. § 622(b)(15)(A)) to develop Health Oversight and Coordination Plans (HOCPs) that outline how states ensure children in foster care receive needed health services. This requirement came into effect under the *Fostering Connections to Success and Increasing Adoptions Act of 2008* (P.L. 110-351) and was further updated by the *Child and Family Services Improvement and Innovation Act* (P.L. 112-34). As part of their HOCPs, states must include in the Child and Family Services Plan an enumeration of each of the following elements:

- a schedule for initial and follow-up health screenings that meet reasonable standards of medical practice; (The AAP has clear guidance around this and that guidance has been adopted by many states, but not by others.)
- how health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home;
- how medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;

- steps to ensure continuity of health care services, which may include the establishment of a medical home for every child in care;
- the oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;
- how the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children; and
- steps to ensure achievement of the components of the transition plan development process required under section 475(5)(H) to address the health care needs of children aging out of foster care, including: the requirement to include options for health insurance; the requirement for information about a health care power of attorney, health care proxy, or other similar document recognized under State law; and the requirement to provide the child with the option to execute such a document.

The AAP strongly supported the creation of HOCPs, as this is a critical means through which to improve child health and wellbeing. Unfortunately, implementation of this aspect of the law has not been effective for two key reasons: 1) states do not report comparable information or do so in a comparable structure, making it difficult to compare state progress or draw out best practices and challenges; and 2) sentinel evidence suggests that state adherence to HOCPs is not effective.

Pediatricians have reported, for several years, discrepancies between their states' plans and what they see for the children in foster care for whom they provide care. In 2015, the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) released the report "[Not All Children in Foster Care Who Were Enrolled in Medicaid Received Required Health Screenings](#)". The OIG report examined the provision of health screenings to children in foster care in four states: California, Illinois, New York, and Texas. The report found that in those four states, nearly one-third of children in foster care enrolled in Medicaid did not receive at least one health screening, and over one-quarter received at least one screening late. The provision of initial and follow-up health screenings is one required element for state HOCPs, but the evidence of this discrepancy continues to raise concerns about states' fidelity to their HOCPs.

We believe that states could more effectively implement their HOCPs with additional resources and clear guidance and oversight from HHS on HOCP development and reporting. In particular, new guidance from HHS offering a model for HOCP development and structure and background resources would provide states a clear framework within which to prepare their plans and make it easier for HHS to assess and oversee HOCP development. We also believe the provision of additional resources to support plan development and implementation, as well as oversight, are critical. This would promote lower overall costs through better coordinated and managed health services for this vulnerable population. An increased federal matching rate reimbursement for meeting certain HOCP benchmarks could also provide an incentive to states to more effectively manage health services for children in foster care. Some states utilize

the *Bright Futures* guidelines; this resource could be used to help develop such HOCP benchmarks and plan development.

In addition, given ongoing concerns regarding potentially inappropriate prescription of psychotropic medication to children in foster care, we recommend the addition of a new required element to state HOCPs: How the state ensures access to evidence-based trauma-informed psychosocial services. This element would serve a complementary role to the psychotropic medication oversight requirement and signal to states the importance of expanding non-pharmaceutical treatment options. Pediatricians continue to stress that if services are truly meant to support family reunification, the services must take a two-generation approach, with significant attention to the trauma history and trauma reactions of the parents. We will achieve greater success among biological families if we address those underlying issues.

Importance of Evidence-Based Services

The AAP strongly supports the use of evidence-based services for children and families. We suggest prioritizing and emphasizing the use of evidence-based services wherever possible in child welfare, including when serving children who have experienced parental substance use and their caregivers. In addition, we suggest providing support for the development of an inventory of those services. While we understand that individual communities may not have the necessary supply of evidence-based services to meet demand, we urge caution in the allowance of programs that are not at least evidence-informed or promising practices. It is possible that services without an evidentiary basis could have a harmful effect on children, further exacerbating the already significant trauma to which this population is exposed. We also encourage collaboration between child welfare and state Medicaid agencies in identifying and making available services for children and families under this legislation. We also suggest the inclusion of funding for innovative means of making evidence-based programs more broadly accessible, such as through telehealth. This will be particularly important for rural areas or under-served areas in large cities. It is important to ensure that the duration of services children and families receive provides sufficient dosage of an evidence-based intervention to generate the evidence-based treatment effect. Clear, timely, and instructive HHS guidance on all of these criteria will be essential to ensuring the safety, quality, and efficacy of these services.

Consent for Health Services

The issue of consent for medical services for children once they enter foster care can act as a barrier to timely assessment and receipt of appropriately tailored services and psychosocial interventions targeting children and their caregivers. Timely access to these services can ultimately reduce the length of stay in out-of-home care. Currently, there is variability in who may provide consent for children as they enter care, which can lead to children not receiving needed services in a timely manner. While there is understandably a balance to strike in respecting the appropriate exercise of parental rights, lack of parental consent to medical care during extreme family crisis should not preclude a child from accessing care. In particular, we believe that child welfare agencies should have the authority to consent for comprehensive health assessments when children enter care, as well as any services the assessing professionals finds

are indicated for that child. This can be particularly important in instances of parental substance use.

For example, if a young child presents to the child welfare system with a case of lice, but the parent will not consent to medical treatment of that lice, that young child may have to spend days in a shelter because foster homes will not take children until they are treated. This, for an already traumatized child, is an unnecessary and devastating stop-over, and one that could be avoided by allowing the child welfare agency to consent to care on behalf of the child pending adjudication of the case. Even routine problems, such as head lice, can become a crisis for the child if untreated. Entry into foster care is a critical window in which timely intervention can help begin to address a child's trauma and related health needs, improving their well-being and likelihood of permanency. This is also an important means to identifying potential services for serving children and their caregivers together. Treatment within the parent-child dyad can be an effective means to serve this vulnerable population, especially for very young children.

Recruitment and Retention of Foster Families

When maintaining a child in their home is not safely feasible, it is critical to have a sufficient supply of high-quality family foster homes available to care for children. Subpart 1 of IV-B includes a requirement that states include in their child welfare services plan how they will "provide for the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the state for whom foster and adoptive families are needed." Given the need to expand recruitment broadly and to also better support and retain foster families and kinship caregivers, we recommend updating this requirement to require "diligent recruitment and retention of potential foster, kinship, and adoptive families, including efforts to:

- Ensure that foster, kinship, and adoptive families reflect the ethnic and racial diversity of children in the state for whom foster, kinship, and adoptive families are needed;
- Meet the placement needs of LGBTQ children and ensure that LGBT families do not face discrimination in serving children;
- Meet the placement needs of children with special health care needs;
- Ensure availability of placements for adolescents, including pregnant or parenting adolescents; and
- Provide evidence-based or evidence-informed child development, parenting skills, and trauma training to all foster, kinship, and adoptive families as a requirement for licensure or re-certification."

We recommend these changes to ensure that child welfare systems effectively recruit and retain foster, kinship, and adoptive families that can serve the needs of their population. In addition, we recommend expanding resources to states to support recruitment and retention. Transformation of the foster care system to be truly trauma-informed and designed to meet children's needs will necessitate effectively training and reimbursing families for quality care.

Conclusion

Thank you again for the opportunity to provide testimony for the record. The AAP looks forward to the opportunity to work with you as you consider these important policy issues. If you have any questions, please do not hesitate to contact Zach Laris in the Washington, D.C. office at 202/347-8600 or zlaris@aap.org.



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“The Heroin Epidemic and Parental Substance Abuse: Using
Evidence and Data to Protect Kids from Harm”
Human Resources Subcommittee Hearing
Statement for the Record
Amy Herbst, Vice President, Child Well-Being
Children’s Hospital of Wisconsin

Chairman Buchanan and Ranking Member Doggett, thank you for holding this important hearing on protecting children from harm.

Children’s Hospital of Wisconsin (Children’s) is the region’s only independent health care system dedicated solely to the health and well-being of children. We serve children from every county in the state of Wisconsin. Children’s, with hospital locations in Milwaukee and Neenah, is recognized as one of the leading pediatric health care centers in the United States. It is ranked in nine specialty areas in U.S. News & World Report’s 2015-16 Best Children’s Hospitals report.

In addition to offering high quality, specialized pediatric medical care, Children’s is the largest not-for-profit, community-based child and family serving agency in Wisconsin. Through our Community Services work, we provide a continuum of care to more than 15,000 children and families annually. This includes family preservation and support, child and family counseling, child welfare, child advocacy and protection; and foster care and adoption services.

Children’s is one of two non-profits that provide all of the case management, out-of-home care and intensive home counseling services in Milwaukee, where a third of the state’s foster care population resides. We are also the largest provider of treatment foster care in the state, contracting with 33 of 72 Wisconsin counties, and are proud to report the best optimal outcomes when it comes to reunification, adoption or guardianship. Additionally, Children’s has partnered with the State through our Children’s Community Health Plan—the largest Medicaid Health Maintenance Organization in the state—to implement a medical home program for children in foster care in six southeastern Wisconsin counties.

We are committed to improving the health and well-being of children and families, now and over the trajectory of their lives. That is why we serve the holistic needs of a child and family through comprehensive, coordinated systems of care that address the physical, mental and social well-being of children.

We appreciate the focus on the heroin epidemic and parental substance abuse as we see firsthand the devastating impact of these issues on children’s health and well-being. In 2014, 27 percent of children entering foster care in Wisconsin had caregiver drug or alcohol abuse as a contributing factor to their removal from the home, a six percent increase from 2011. At Children’s, 60 percent of children entering our foster care program in 2015 had a parent screen positive for alcohol or drug abuse, which is rarely the sole challenge for a family involved with child welfare. Often these parents also struggle with housing instability, domestic violence and mental health issues stemming from the trauma of their own adverse childhood experiences.

Furthermore, we know through empirical research that children who experience neglect, violence or other adverse situations are increasingly likely to face a lifetime of complicated physical and emotional health



challenges. For example, children who have experienced maltreatment are 25 percent more likely to have mental health problems, low academic achievement and substance abuse,¹ as well as more likely to exhibit low self-esteem, aggression toward others and risky sexual behaviors.²

While there are a number of evidence-based interventions, such as Parent Child Interaction Therapy, that can be employed to mitigate the impact of maltreatment, more must be done to provide access to these services for high-risk families. Importantly, as a result of our work and evidence-based research, we believe it is important to intervene with high-risk families as early as possible in order to ensure a healthy trajectory for children and families and avoid costly foster care placements.

At Children's we have invested in several programs aimed at doing just that. Our *Strong Families, Thriving Children* work is a comprehensive child and family well-being model—customized to meet each family's unique needs— which focuses on healthy developmental functioning combined with a nurturing environment that helps children thrive into adulthood.

This approach consists of evidence-based interventions and tailored plans; emphasis on child development outcomes; and strength-focused comprehensive functional assessments. It leverages new interventions designed to break the cycle of maltreatment, utilizing more comprehensive trauma assessments of both children and adults that pinpoint priority areas for our services, individualized plans and a more comprehensive approach to supporting families we serve.

In 2014, we provided parenting training and support to over 4,000 individuals at our Family Resource Centers located throughout the state; we served over 400 individuals through our Community Response program that provides service coordination and family support to families at risk for child abuse and neglect; and served over 600 families through our Home Visiting Program that provides individualized, home-based parenting education and support.

We are encouraged by statements made at the hearing that the Ways & Means Committee is interested in “shifting foster care funding into services that help prevent abuse and neglect.” We strongly support changes to the child welfare financing model that currently favors one intervention, foster care, to one that provides more flexibility and funding for targeted, evidence-informed, preventive services for children and families.

To that end, Children's strongly supports the Senate Finance Committee's proposed Family First Act provisions that would allow funds under Title IV-E of the Social Security Act to be used for the first time for evidence-based prevention services to help keep children at risk of placement in foster care safely at home with their parents or with kin. We recruit and provide kin placements and believe family connections are important for the child's long-term well-being.

¹ Barbara Tatem Kelley, Terence P. Thornberry, Ph.D., and Carolyn A. Smith, “In the wake of childhood maltreatment”, *Office of Juvenile Justice Bulletin* (1997)

² J Briere and M Runtz, “Differential adult symptomatology associated with three types of child abuse”. *Child Abuse & Neglect* (1990), 14, 357-364.



Finally, we firmly believe that in order to ensure the healthy functioning of children and adults, and to make the best use of our federal and state dollars, outcomes related to safety and permanency are not enough. More must be done to prioritize assessments, interventions and measures that address child well-being and better position children to thrive into adulthood.

The Family First Act makes progress towards this goal by focusing on evidence-based interventions, assessment tools and requiring the Secretary to assess the extent to which programs and services improve child well-being. Children's believes that better defining child well-being and integrating measures into the child welfare system are critical towards achieving better outcomes for children, society and taxpayers.

We strongly support your work to improve the lives of at-risk children and families and hope to serve as a resource and partner as the Committee works to advance legislation.



Written Testimony of Donna Butts, Executive Director, Generations United

“The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm”

Ways and Means Human Resources Subcommittee Hearing Wednesday, May 18, 2016, 2:00 PM

Generations United is pleased to submit this written testimony to the Ways and Means Human Resources Subcommittee. We applaud Chairman Buchanan, Ranking Member Doggett and other members of the Subcommittee for their leadership in holding this hearing addressing parental substance abuse and the opioid epidemic with the goal of protecting children from harm.

Consistent with Generations United’s mission and our longstanding work through our National Center on Grandfamilies, we will focus our testimony on “grandfamilies” and the value of prevention services for all three generations in these families -- parents, children, and caregivers. Prevention services, as proposed by the Family First Act, help protect children from harm. With these types of vital services extended to those children who are at imminent risk of entering the foster care system, children may be able to remain safely in their families and consequently may not need to enter the system. But, if they do, the families will also get services and supports that may help the children reunify safely with parents or keep the grandfamily together.

Grandfamilies

2.5 million children are raised by grandparents, aunts, uncles, siblings and other extended family and close family friends who step forward to care for them when parents are unable.ⁱ Although data is limited, we know that parental substance abuse is the primary reason these grandfamilies come together.

With the recent increase in heroin abuse and opioid addiction, more grandparents and other relatives are raising these children than ever. Across the country, over 2.6 million grandparents are responsible for their grandchildren.ⁱⁱ The anecdotes are overwhelming: “At the time of the custody hearing, both my daughter and the children’s father were in jail on drug-related charges. I remember the judge asking me how long I thought it would be before the children’s parents would be capable of taking care of their children. I optimistically said, ‘Oh, about six months, your honor.’ Well, here we are more than 20 years later. ... It can be a third of your life caring for grandkids when addiction is in the picture.”ⁱⁱⁱ

Most of these grandfamilies are outside the child welfare system. They are often struggling with little or no support. For the over 113,000 children who are raised by grandfamilies in foster care, more support is available.^{iv} However, even in the system, there is limited help for

relative caregivers to raise the children, parents to address their substance abuse, mental health or other issues so they can parent again, and children to get the trauma and other services they need.

Children Fare Well in Grandfamilies

As a society, it behooves us to support these grandfamilies, because research confirms that the children do well in these families. Compared to children in non-relative care, children in the care of relatives experience:

- **Increased stability**
 - Fewer placement changes^v
 - Fewer school changes^{vi}
- **Higher levels of permanency**
 - Less likely to re-enter the foster care system after returning to birth parents^{vii}
 - Relatives are willing to adopt or become permanent guardians when reunification with parents is not possible. In fact, 32% of children adopted from foster care are adopted by relatives.^{viii}
- **Greater safety^{ix}**
- **Better behavioral and mental health outcomes^x**
- **More positive feelings about placements^{xi}**
 - More likely to want current placement to be permanent home
 - Less likely to try to run away
 - More likely to like who they live with (93% vs. 79% for non-relative foster care, 51% for group care)
 - More likely to report they “always felt loved”^{xii}
- **Increased likelihood of living with or staying connected to siblings^{xiii}**
- **Greater preservation of cultural identity and family and community connections**

Services to Grandfamilies Improves Outcomes for Children

Research shows that when caregivers in grandfamilies are offered supportive services -- such as mental health care and kinship navigator programs that help link relative caregivers to a broad range of supports -- the social and mental health outcomes for these children are even better than for other children being raised by relatives not receiving services.^{xiv}

Family First Act

Providing prevention services

The proposed Family First Act would make great strides in protecting children from harm by offering prevention services and supports for children who are “candidates for foster care” being cared for by relatives. Under the proposal, for the first time, states will be able (but not required) to use Title IV-E funds for prevention services for families of eligible children in grandfamilies. Eligible children would be children who are candidates for foster care, identified by the state as being at imminent risk of entering or re-entering foster care, but who can safely

remain at home or with a kinship caregiver if provided services. Parents or kin caregivers of children at imminent risk of entering foster care could also get services.

The services are of the type that have been shown to improve outcomes for children: mental health care, substance abuse prevention, individual and family counseling, in-home parent skill-based services, access to kinship navigators, and short term financial assistance to kinship families.. All of these services are intended to support parents, kinship caregivers, and children so that children will not be harmed and can remain with family, whether it is their parents or other relatives.

The Act is carefully crafted to ensure that each child has a prevention plan that lists the services or assistance needed and identifies the permanency goal for the child, how services are tied to the placement and permanency goal, and are trauma-informed.

Addressing barriers to licensure of relatives

More than half of children placed with relatives under state supervision are in unlicensed homes, and consequently receive no or very little ongoing support.^{xv} If children end up needing to enter foster care, some of them may need the ongoing financial support and services of the system and the pathway to permanency through the Guardianship Assistance Program (GAP). These supports, services and GAP are only available to those children whose relatives are licensed. GAP, which is a federal option created by the Family Connections to Success and Improving Adoptions Act of 2008 (Fostering Connections Act), is now in 39 jurisdictions and allows children with a licensed relative foster parent to exit the system with ongoing financial support.

Unfortunately, becoming a licensed foster parent -- who is eligible for these services and supports -- is often not an option for some relatives due to barriers caused by state licensing standards. Standards that often go well beyond what is required by Federal law and are often nonsensical because they are based on litigation or middle class notions of what is suitable. For example, some standards prohibit certain breeds of dogs or require caregivers to own a car. To address these barriers, the proposed Family First Act directs HHS to release regulations on national model licensing standards, like those Generations United created with the American Bar Association and the National Association for Regulatory Administration. States must describe in their state plans how their practices deviate from the national standards. (Our Model Family Foster Home Standards are available at www.grandfamilies.org).

Adoption and Legal Guardianship Incentive Program

The Adoption and Legal Guardianship Incentive Payments Program, funded under Title IV-E of the Social Security Act, recognizes states for improved performance in helping children exit foster care to permanent homes through both adoption and guardianship. Guardianship is an important permanency option for children in relative care who wish to remain permanently with a relative without terminating the parental rights of their parents. The incentive program was revised and reauthorized through FY2016 in the Preventing Sex Trafficking and Strengthening Families Act of 2014. We urge reauthorization of that the incentive program for

an additional three to five years. It is important to maintain the changes made to the program in 2014 (i.e. the addition of incentives for exits to guardianship, determining incentives based on improvements in rate rather than numbers, etc.) because more states received incentives under the new incentive structure than from the former incentive program and more states earned larger incentive awards with the new incentive structure.

Family Connection Grants

Finally, two rounds of Family Connection Grants, authorized by the Fostering Connections to Success and Improving Adoptions Act of 2008 (Fostering Connections Act), have funded several kinship navigator programs, which have resulted in many positive outcomes for grandfamilies. According to the 2013 Report entitled [2009-Funded Grantees Cross-Site Evaluation Report - Final](#), positive outcomes for those receiving kinship navigator services included:

- Kinship caregivers receiving navigator services achieved identified safety goals for their families.
- The children in the care of kinship caregivers had higher rates of permanency through legal guardianship and reunification with parents.
- Well-being results showed that kinship navigator programs were successful at ameliorating the needs of grandfamilies.

The five year evaluation of Florida's 2012 kinship navigator grant was recently published and shows further compelling results for its 2956 participants^{xvi}:

- 99 percent of participants' children did not enter the child welfare system at the 12 month follow-up, showing placement stability and child safety.
- Cost of the program is less than half the costs associated with adjudicating a child dependent. Non-relative foster care is 6 times and residential group care is more than 21 times as expensive as the navigator program.

Unfortunately, the grants expired in 2015, and most states have not established kinship navigator programs leaving many grandfamilies without access to these important programs that can link them and their families to services like substance abuse prevention and counseling.

Conclusion

All of these services and supports improve outcomes for the children, as the research confirms. But, even more compelling, is the proof from the caregivers themselves. As one grandmother raising a child of a parent who is addicted to heroin put it, my grandson's teacher "said he was the saddest boy she's ever taught. At that, I said, 'I'm not enough for him anymore — I have to take him to therapy.' I found a wonderful therapist; things have turned around."^{xvii}

Thank you for the opportunity to offer written testimony for this important hearing. Please direct questions regarding this testimony to Jaia Peterson Lent, Generations United's Deputy

Executive Director, at jlent@gu.org or 202-289-3979 or to Ana Beltran, Generations United's Special Advisor at abeltran@gu.org.

About Generations United

Generations United is the national membership organization focused solely on improving the lives of children, youth, and older people through intergenerational strategies, programs, and public policies. Since 1986, Generations United has been the catalyst for policies and practices stimulating cooperation and collaboration among generations. We believe that we can only be successful in the face of our complex future if generational diversity is regarded as a national asset and fully leveraged. For almost twenty years, Generations United's National Center on Grandfamilies has been a leading voice for issues affecting families headed by grandparents or other relatives.

ⁱ Generations United. (2015). *The state of grandfamilies in america*. Washington, D.C.: Author.

ⁱⁱ Ibid.

ⁱⁱⁱ Seelye, K. (2016, May 21). Children of heroin crisis find refuge in grandparent's arms. *The New York Times*. Retrieved from <http://www.nytimes.com>

^{iv} See endnote i.

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Office of Children and Family Services

ANDREW M. CUOMO
Governor

SHEILA J. POOLE
Acting Commissioner

May 31, 2016

The Honorable Vern Buchanan
Chairman
House Ways & Means Committee Subcommittee on Human Resources
1102 Longworth HOB
Washington D.C. 20515

Dear Chairman Buchanan:

Thank you for the opportunity to offer testimony by submission to the record on the recent hearing regarding the heroin epidemic and child welfare. Your opening remarks made reference to a Senate proposal which I believe is the "discussion draft" legislation intended to improve the nation's foster care system. As Acting Commissioner of the New York State Office of Children and Family Services (OCFS), I oversee the administration of child welfare services for New York State. I have provided the Senate Finance Committee, Senator Wyden and several national and statewide advocacy groups our position on this proposal. I am still concerned that some of the provisions in the Senate proposal including those that limit federal funding for foster care may have detrimental consequences for the New York State's program that will ultimately affect the children it serves.

Like your home state of Florida, New York is also large and diverse. However, we are a state supervised and county administered child welfare services system, which is divided into 58 local social services districts. One district encompasses the five boroughs comprising New York City, and the other districts correspond to the 57 counties that make up the rest of the state, and one federally-recognized tribe. The districts' compositions vary widely with respect to their percentages of urban, suburban and rural areas and their available economic opportunities, resulting in diverse populations with differing needs. Consequently, the state gives its local social services districts as much flexibility as possible to provide child welfare services in a manner that works best for their particular populations. It is important that any new federal child welfare laws afford similar flexibility to the states and their localities.

New York has been providing preventive services to children and families for a long time. In 1979, New York enacted a statewide preventive services program designed to prevent the placement of children in foster care and to enable children in foster care to return home sooner. The state law preceded the enactment of federal Title IV-B funding in 1980. New York has consistently devoted significant state and local funds to preventive services in addition to using other available federal funding for such purposes, including Title IV-E candidacy funding. Our continuous focus has been to reduce the number of out-of-home placements to only those that are absolutely necessary to protect the children. As a result, the total foster care population in New York State has decreased from 53,902 in 1995 to 17,452 in 2015 despite some upward trends with opioid abuse, overall we are continuing on a downward track.

The children and youth currently in foster care out of home placements in New York primarily are hard-to-place or have special needs. The goal of preventive services for these children and youth is to safely reunite them with their families or find other placements for them. New York's Title IV-E waiver demonstration project is focused on reducing the number of foster care placements even further through the increased options available under the waiver's flexible funding structure.

New York may be unique in the approach it has taken in providing preventive services to reduce out-of-home placements. It is our understanding that many states do not invest in preventive programs at all. Therefore, while we applaud your efforts to encourage more states to focus their work on reducing foster care through preventive services, we have serious concern about the proposal's one-size fits-all approach.

Regarding the heroin/opioid epidemic, I must first state for the record that the states' child welfare administrators are not charged with the responsibility for substance abuse screening and treatment. These programs are operated by the states' departments of health. Therefore, federal funding should not be shifted from necessary child welfare programs to health programs, which could potentially cause a shortfall in child welfare programs and services. This would seem to be counterproductive. Considering also that the bill language of the Senate proposal is still unavailable and the poor Congressional Budget Office (CBO) score given to it, we certainly urge the committee to recommend that the heroin/opioid issue be handled within another legislative vehicle that is appropriately funded.

The Wyden/Hatch Senate proposal is more aligned to a funding scheme for preventive services. New York proposes that this draft be amended to make both Part 1 and Part 2 optional for states as there are many states like New York that commit robust resources to preventive funding. As previously stated, New York State has made numerous comments on the Wyden Hatch proposal. I can certainly provide you with our letters should you be interested in reading them. As far as Part 1, since it is optional, I will not get into the details at this time. However, Part 2 of the proposal is mandatory in its current form and will provide unintentional detrimental effects for children, families and the states' child welfare programs.

It is Part 2 of the Wyden Hatch Senate proposal that is particularly alarming. This provision essentially takes the decision of children's placements out states' authority and narrowly defines those placements for which the federal government would provide Title IV-E reimbursements to the states. The second part of this proposal would eliminate almost all funding for congregate care. The provision paints all congregate care placements with the same broad brush and is considered not acceptable to children of certain ages. It would establish a national definition of foster family homes. It would involve the courts deciding if placements are acceptable and sets time frames on when the courts should be reviewing placements of foster children in congregate placements. In New York, the busy court calendars would not have the time to conduct these sorts of reviews. Additionally, the provision is asking judges to be expert social workers. Nowhere in this bill is consideration for hospitalized children, unaccompanied alien children (UAC), and children placed in juvenile justice facilities. These children and youth are not in a one-size-fits-all category; their care must be considered and funded. In this portion of the proposal, the ACF Secretary will decide what facilities would be considered acceptable Qualified Residential Treatment Programs (QRTPs) eligible for federal funding for these specific vulnerable populations hang in the balance. A brief fiscal forecast indicates that this could cost NYS up to \$600 Million.

Even with the eventual release of bill language to clarify some of the concerns and questions we have, there is also the uncertainty of rule promulgation. We are still awaiting federal guidance

required under the Preventing Sex Trafficking and Strengthening Families Act, rules from the sex trafficking legislation passed in 2014 (PL 113-183). As you well know, rule promulgation is a lengthy process and with the upcoming change in administration, this would add another level of scrutiny to the work left by the current administration. We, in New York believe that the entire Wyden/Hatch bill should be left up to the states via optional participation.

Preventing out of home placements is a priority for all states. The heroin/opioid trend is not the only factor that could place children in foster care settings. On the same note, not all prevention services are related to any sort of abuse of substances. The heroin/opioid problems and foster care should be addressed on their own merits while flexible, robust federal funding for preventive child welfare services stand alone.

Thank you for this opportunity.

Sincerely,

A handwritten signature in black ink, appearing to read 'S. Poole', written in a cursive style.

Sheila J. Poole
Acting Commissioner

This statement for the record, in support of the Honorable Karen Bass' webinar presentation "The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm," is submitted by witness Dr. Kathryn Icenhower, Chief Executive Officer of SHIELDS For Families, 11601 S. Western Ave., Los Angeles, CA 90047, tel 323-242-5000, fax 323-242-5011.

Sophie's Choice: Stop Making Substance Abusing Women Choose Between their Children and Treatment

Too often, parents seeking substance abuse treatment are forced to make a 'Sophie's choice' between two life-changing options: enter treatment and risk removal of their children from their home, or avoid treatment and continue to suffer, in isolation, the deleterious effects of addiction. Either option puts the children of substance-abusing parents at great risk. Children of people who abuse substances are likely to have a range of developmental, behavioral, and emotional difficulties (Substance Abuse and Mental Health Services Administration (SAMHSA), 2007). These children incur exceptional risk due to genetic, prenatal, and environmental influences include physical illness and injury, emotional disturbances, educational deficits, and behavior problems (Johnson and Leff, 1999; Metsch et al., 1995). These problems are often compounded when children are removed from their parents' homes and placed in foster care, which is known to produce poor social outcomes, such as high delinquency rates, high teen birth rates, and lower earnings (University of Pennsylvania Collaborative on Community Integration).

Integrating children into parental substance use treatment changes the treatment dynamic and offers an integrated way of addressing the needs of families with multiple problems (SAMHSA, 2007). Family-centered treatment offers a solution to tackling the challenges of

addressing substance use disorders among pregnant and parenting women, as well as to ameliorating the effects such disorders have on children. Family-centered treatment results in improved treatment outcomes for individual women as well as improved outcomes for children and other family members, including decreased incidence of developmental delays, improved school success and school readiness, reductions in costs for substance-exposed births, and treatment outcomes in both substance abuse and mental health settings (SAMHSA, 2007).

With these issues in mind, SHIELDS for Families (SHIELDS)' approach to family-centered treatment is distinguished by a simultaneous focus on supportive residential housing that allows the entire family to live together, as well as comprehensive, multidisciplinary youth services. Incorporated in 1991, SHIELDS is a comprehensive, community-based non-profit organization dedicated to developing, delivering, and evaluating culturally sensitive, comprehensive service models that empower and advocate for at-risk families in South Los Angeles. SHIELDS' programs are built on the premise that substance use disorders are family diseases, and that the delivery of comprehensive services can transform families into healthy, functioning entities able to break the intergenerational cycle of substance use and related consequences. To this end, SHIELDS currently employs over 380 full time employees, with an annual budget of over \$30 million to serve over 10,000 families annually in 39 programs, including the Exodus Family-Centered Day Treatment program, the Heros and Sheros Youth Program, and adjunct components that provide critical supportive services.

Stable housing can often make the difference between success and failure in substance use disorder treatment. For women, particularly those with children, housing represents more than just shelter: it is a crucial support for recovery; it represents safety both for a woman and for her children, and a lack of housing support negatively affects all other domains of family well-

being (SAMHSA, 2007). Residential facilities that allow the entire family to live together offer multiple benefits. Residential facilities empower families by offering the structure, meals, and safe housing that many children and adults affected by substance use disorders need (SAMHSA, 2007). Keeping the entire family together provides opportunities for fathers and extended family members to be involved in the child's upbringing, as well as provides opportunities for staff to engage with the family in "teachable moments" to provide support as they build healthy relationships and life skills. Furthermore, it increases the likelihood that women will emerge from treatment with successful outcomes, since they are motivated and bolstered by the support of their families.

Originally funded through the SAMHSA Center for Substance Abuse Treatment's (CSAT) perinatal initiatives in 1994, SHIELDS' Exodus program utilizes a unique model in which comprehensive family-centered treatment, follow-up and related social services are provided to women and their families on-site at a SHIELDS-owned housing complex. While undergoing treatment for substance use disorders, women are able to reside on the property in either individual apartments or in lodgings that accommodate the entire family. In addition to evidence-based substance use disorder treatment, the Exodus program offers counseling, child development, vocational, mental health, medical care, family support and family reunification services. After completion of treatment services, which typically last 12-18 months, families are able to remain in their housing for a transitional period of up to one year, allowing for adequate time to develop the supportive systems necessary for ongoing recovery and family maintenance.

Since implementation, the Exodus program has seen tremendous successes in treating substance abuse disorders, increasing family reunification rates, and improving critical indicators of health for both women and children. Throughout the history of the program, completion rates

have never been less than 70%, and in the past seven years, an average of 81% of our families have successfully completed all phases of our treatment services. The rates of family reunification, defined as when children in temporary out-of-home care return to their families of origin, have averaged 85% since implementation. Furthermore, over the past five years, our model of services has facilitated improvements in maternal and infant health indicators. The total rate of substance-exposed births has been less than 4%; less than 5% of newborns were born at a low birth weight, and none at a very low birth weight. 100% of our children ages 0-5 now have established, permanent medical homes, and 90% of all children have scored in the normal range on relevant developmental assessments.

As discussed above, children of substance-abusing parents represent a special population at risk of alcohol and drug abuse. These children are more likely to be placed for adoption or foster care, and to have behavioral and educational problems, and are more likely to be overrepresented in the foster care system and the juvenile justice system. Furthermore, teenagers are more likely to use drugs if their father, mother, or older siblings also used drugs, indicating that even low levels of use by parents could influence drug experimentation by teenagers (Gfroerer, 1987).

SHIELDS' Heros and Sheros program is a prevention and treatment program specifically designed to serve the children of the low income families enrolled in our substance abuse programs. Heros and Sheros consists of five youth programs that provide prevention and early intervention services and mental health services for children ages 6-18. Two of the sites are located at SHIELDS' substance abuse programs, including Exodus; one is at the Jordan Downs Housing Development (Jordan Downs Family First); two others are charter schools (College Bridge Academy) in Watts and Compton. SHIELDS utilizes a "community ecosystems"

research-based approach to alcohol and drug prevention, which emphasizes problems as a function of the larger whole rather than as pieces existing in isolation. In order to identify needs specific to our target population in South Los Angeles - primarily African-American and Hispanic youth, particularly children of substance abusers - the program provides a comprehensive assessment upon enrollment and develops a detailed service plan to monitor youth progress and development. These assessments look beyond the individual to consider how family, social and community experiences shape an individual by decreasing risk factors and increasing protective factors in five specific domains: Individual, Family, School, Peers, and Community.

The core program components of Heros and Sheros include (1) individual and group counseling, designed to provide mentorship and guidance for youth, provided by both an on-site therapist and a family counselor a minimum of once per week and in two-hour weekly peer counseling group sessions; (2) case management services designed to ensure the coordination of comprehensive services, advocacy for family needs, and linkage and referral to supports within SHIELDS and the community; (3) social and life skills training designed to improve youth problem-solving and decision-making skills as well as cultural activities designed to reinforce positive cultural identity, pride, and an understanding of other cultures; (4) educational classes and tutoring provided through SHIELDS' College Bridge Academy, a grade 9-12 charter school, as well as after-school tutoring in both academic subjects and computer literacy designed to improve youth academic performance, and (5) recreational activities, including a weekend camp held six times a year, sports, arts and crafts, field trips to local landmarks and events, and dance and musical performances.

Blending these youth services with parental substance abuse treatment has proven an effective way to equip families in our community with the skills and knowledge necessary to decrease the incidence of substance abuse, succeed in vocational and educational pursuits, and improve family cohesion. In the past year, over 91% of our youth increased their knowledge of alcohol and drug (ATOD) issues through developing community campaigns that focus on anti-drug messages, by participating as speakers in community and agency events, and through sharing their own stories about the destructive influence of drug addiction in onsite counseling groups as well as public settings. Over the past five years, over 76% of our children have improved both their attitudes towards school as well as attendance and grades. Finally, perhaps most importantly, in the past year, 76.1% of our parents demonstrated improved family cohesion as measured by the closure of child protective services cases, referrals and re-referral for child abuse and neglect, and level of participation in treatment.

Organizations seeking to implement family-centered treatment are faced with a unique set of challenges, and for many, successful treatment of the family as a unit requires a paradigm shift away from traditional treatment methods. The service-delivery experience at SHIELDS has demonstrated that providing comprehensive, family-centered services requires a certain kind of organization: one that operates and feels like "family;" where conditions are created that make staff want to remain in the long-term; where decisions are made in multidisciplinary teams; where mechanisms are in place to give clients a voice; where collaborations with other service providers are a fundamental way of doing business, and where funding streams are blended to create a cohesive programmatic experience for clients. These organizational practices create a stable yet flexible and responsive organization that keeps clients' needs and experiences front and center.

Staff and clients alike describe SHIELDS as a place that feels like family. What this means is that *people's experiences matter* and *relationships have value*. Our program model fosters this culture in a number of ways. Women are treated in the context of their families, based on the conviction that her health and the health of her children and family are interdependent. Clients are active participants in our intake and assessment process, and given ample opportunity to describe what they see as their primary issues and concerns and lead the conversation about how to address them. Staff at all levels—right up to the Chief Executive Officer—maintain an open-door policy so they are accessible to clients and workers alike. The Client Council is a formal vehicle for giving clients' experiences a shaping role in the organization. As an organization, SHIELDS is in a constant process of *becoming*, that is, being shaped by the experience of the people who work there and the people they serve.

SHIELDS has created organizational conditions that lead to high staff satisfaction and retention by offering its staff the same kind of support and promotion it offers clients, resulting in a more experienced, contented staff with the power to build stable relationships with clients. This is achieved through a variety of organizational policies and strategies aimed at making the atmosphere of empowerment and respect organizationally pervasive. First, SHIELDS offers a higher level of compensation (in salaries and benefits) as compared to the industry standard. Compensation includes 14 paid holidays a year, a week-long sabbatical between Christmas and New Year's, and generous vacation accrualment. Second, SHIELDS promotes personal and professional growth and development and encourages staff to further their education. SHIELDS' educational-leave policy allows staff to use three hours of paid time per week toward schooling, and a partnership with a local California State University offers staff (and clients) the chance to get their degrees while getting clinical hours within the organization. Finally, SHIELDS has

made it an organizational priority to both hire staff that were once clients, and to promote staff from within the organization. Approximately 20 percent of our staff were once clients. It is not unusual for a staff member to have been with the organization for many years, starting at an entry-level position and working over time in many programs and capacities.

Providing comprehensive services for every member of the family would not be possible without a multidisciplinary team overseeing all aspects of client care. This approach ensures that in every decision, all members of the family and all aspects of the client's recovery are taken into consideration. This approach requires implementing both an intake and review team as well as multidisciplinary case conferences. At SHIELDS, staff representatives from all the programs meet weekly to review client intake and assessment forms and decide together which program is the best match for each client and her family members. Case conferences, attended by all staff involved in the client's treatment, are also held weekly, and provide an opportunity to talk about the family's progress and address any outstanding concerns. The open lines of communication among staff of the various program components ensure that individual family members are always regarded as part of a unit.

At SHIELDS, clients are empowered to have a voice, not only in their own assessment and treatment processes, but in how and which programs and services are delivered. The Client Council is a segment of the client population whose purpose is to represent all clients in treatment, and to help build, shape, and formulate some of the program policies as they relate to daily client procedures and rules as well as to cultural sensitivity and responsiveness of the program. The Council meets weekly, and clients elect an executive board and manage the meetings. Issues, recommended changes, and concerns are presented to the program administrative staff. Representatives from the Client Council also are elected to represent the

program on the SHIELDS Consumer Advisory Board, which assists with policy development and agency-wide activities. The Client Council ensures that the experience of clients is always central in determining the direction of the organization.

Any one organization would have difficulty providing for the wide range of needs of a client and her children and family. The most practical and effective way of providing a comprehensive set of services along the spectrum of care is to partner with other organizations—public, nonprofit, and private. SHIELDS engages community partners at every level and in every program component. Treatment and housing case managers work closely with child welfare case managers for clients who have open cases, creating joint treatment plans, engaging child welfare dollars to help fund client housing costs, and ensuring that clients are using the Exodus program effectively to meet the reunification requirements of child welfare. The educational and component of the Exodus program offers basic literacy, high school equivalency, and computer classes through its partnership with the Los Angeles and Compton Unified School Districts. Vocational training is provided in partnership with a wide range of private employers, many of whom accept clients with criminal histories and guarantee job placement for any client who has received the SHIELDS certification. Building collaborations is not only an effective strategy for providing comprehensive services to the entire family, it also builds capacity in the community. SHIELDS makes a point of not duplicating services with other local service-providing agencies, and instead brings those service providers on board for collaboration.

One of the primary challenges of providing comprehensive services for the entire family along the spectrum of care is that the funding streams available to service providers are *categorical* rather than *comprehensive*. In this funding environment, the solution is this: service-delivery organizations committed to providing comprehensive services must *blend* categorical

funding sources. The challenge for providers is to piece together a seamless pathway of services from various funding sources. At SHIELDS, for example, treatment funding comes from the Los Angeles County Office of Substance Abuse Prevention and Control, while mental health services at Heros and Sheros comes from the County Department of Mental Health Services. Housing is funded primarily by the rental income for program spaces, while funding for child development activities comes from the County Health Department. The mother's educational classes are made possible by a partnership with the L.A. Unified School District, while the youth participates in a charter school funded by a State grant in partnership with a local educational non-profit. The work of piecing together funding is ongoing. Over time, funding sources shift as policy priorities change, as do families' needs. Service-providing agencies must continue to be creative in finding and blending funding sources to provide for a changing array of services.

These strategies can eliminate the need for mothers seeking substance abuse treatment to be forced into making a 'Sophie's choice' between their own well-being and that of their children. As demonstrated by SHIELDS' successes, implementing a family-centered treatment program results in improved treatment retention/outcomes for individual women as well as improved outcomes for children and other family members. When family-centered services are delivered according to these service-delivery strategies—with comprehensive services, on-site services and programs, culturally competent services, community-based programming, relationship-centered treatment, and client-centered treatment—a program ensures successful outcomes not only for current clients but also for future generations.

Written Testimony
Of
The American Congress of Obstetricians and Gynecologists
Submitted by:
Hal C. Lawrence, III, MD, FACOG
Before the
House Ways and Means Subcommittee on Human Resources
Regarding
The Heroin Epidemic and Parental Substance Abuse:
Using Evidence and Data to Protect Kids from Harm
May 18, 2016

Chairman Buchanan, Ranking Member Doggett, and distinguished Members of the Subcommittee on Human Resources, thank you for giving the American Congress of Obstetricians and Gynecologists (ACOG), representing more than 57,000 physicians and partners in women's health, the opportunity to submit written testimony in response to your May 18, 2016 hearing titled "The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm." We appreciate the thoughtful way that the Subcommittee approached this sensitive topic. I hope you will view ACOG as a resource and trusted partner as you continue to examine this issue.

I am the Executive Vice President and Chief Executive Officer at ACOG and in this capacity am keenly aware of the increase in opioid dependence and its impact on the women we serve and their families. My testimony will focus on the need for greater access to evidence-based treatment for pregnant and parenting women and its positive impact on family preservation.

The instance of opioid use disorder has risen dramatically over the past few years. Especially important are pregnant and parenting women with opioid dependence and their children. The unplanned pregnancy rate among women with an opioid use disorder is 86%, a number that far surpasses the national average of 46%.¹ Not only does that speak to the need for increased access to contraception among women with opioid addiction, but also elucidates the fact that many of these women were not expecting to be pregnant.

All pregnant women are concerned for the health of their baby-to-be and are motivated to change unhealthy behaviors. From population level data, we know the natural history of substance use during pregnancy – most women who use substances including opioids quit or cut back. Those who cannot stop using, by definition, meet criteria for having a substance use disorder. In other words, continued substance use in pregnancy is pathognomonic for addiction, a chronic, relapsing brain disease.

Evidence-based treatment for pregnant and breastfeeding women with substance use disorders includes the use of medication-assisted treatment (MAT) such as methadone and buprenorphine. When treating pregnant women with opioid addiction, in most instances withdrawal or detoxification is not clinically appropriate. Medically supervised tapered doses of opioids during

¹ Heil S, Jones H, Arria A, et al. "Unintended pregnancy in opioid-abusing women." J Subst Abuse Treat. 2011 Mar, 40(2): 199-202.

pregnancy often result in relapse to former use within a short period of time, adding increased risk to the fetus and increasing the mother's risk for overdose postpartum. Abrupt discontinuation of opioids in an opioid-addicted pregnant woman can result in preterm labor, fetal distress, or fetal demise.²

Tragically, drug overdose is now the number one cause of maternal mortality in a growing number of states. Threats of incarceration, immediate revocation of child custody, and other punitive responses drive pregnant and parenting women away from seeking vital prenatal care and addiction treatment. Alternatively, non-punitive public health approaches to treatment have resulted in better outcomes for both moms and babies. Immediately postpartum, women who bond with their babies, including via breastfeeding, are more likely to stay in treatment and connected to the healthcare system.

Substance use disorder treatment that supports the family as a unit has proven effective for maintaining maternal sobriety and child well-being. However, in 2015 the Government Accountability Office found that “the program gap most frequently cited was the lack of available treatment programs for pregnant women...”³ While there are in-patient treatment programs specific to this population, including programs that allow women to bring their minor children, the demand far surpasses the supply. In addition, many of these women are the sole caregiver or breadwinner in their families and would benefit from increasing the availability of out-patient treatment options that are responsive to their complex obligations.

The Improving Treatment for Pregnant and Postpartum Women Act (HR 3691), passed by the House of Representatives on May 11th, has the potential to improve access to evidence-based treatment. This bipartisan and bicameral legislation reauthorizes residential treatment programs for pregnant and postpartum women and creates a pilot program to enhance flexibility of state funds to improve access to care, including nonresidential services. The legislation is due to be conferenced by the House and Senate in the coming days, but its positive impact will be stunted if it is not authorized at the introduced level of \$40,000,000. I therefore strongly encourage you to support this legislation at the authorized level.

As Chairman Buchanan said in his opening statement, strong families make for a strong community. Empowering opioid dependent pregnant and parenting women with access to evidence-based family-centered treatment will improve outcomes for both mothers and their children and foster family preservation. Thank you again for the opportunity to submit written testimony, and for your thoughtful approach to this issue. I hope that you will consider ACOG a trusted partner in this space and will let us know if we can provide any additional assistance.

² Opioid abuse, dependence, and addiction in pregnancy. Committee Opinion No. 524. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2012;119:1070–6.

³ U.S. Government Accountability Office. (2015, February). *Prenatal Drug Use and Newborn Health: Federal Efforts Need Better Planning and Coordination*. (Publication No. GAO-15-203). Retrieved from <http://www.gao.gov/products/GAO-15-203>

Statement for the Record

Submitted by

The Premier healthcare alliance

The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm

House Ways and Means Human Resources Subcommittee

May 18, 2016

The Premier healthcare alliance appreciates the opportunity to provide a statement for the record on the House Ways and Means Committee hearing, titled “The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm.” Premier is a leading healthcare improvement company, uniting an alliance of approximately 3,600 U.S. hospitals and 120,000 other providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, and advisory and other services, Premier enables better care and outcomes at a lower cost. Premier, a Malcolm Baldrige National Quality Award recipient, plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide.

We applaud the leadership of Chairman Buchanan and Ranking Member Doggett for holding this important hearing today that builds on the House’s action last week to approve much-needed legislation to address the opioids epidemic that is hitting so many of our communities and the patients that our Premier alliance members serve. We appreciate the House Ways and Means Committee’s leadership in urging the Centers for Medicare & Medicaid Services (CMS) to remove barriers to providers’ access to substance use data in order to support insight and innovation in healthcare delivery. Empowering the providers who are on the front lines of care delivery with the information they need to diagnosis and effectively treat patients who use opioids and other controlled substances is absolutely central to these national efforts. Standing in the way of this is a 40 year-old law that essentially makes it impossible for providers to identify patients with substance use disorders, which are often associated with behavioral health issues. This creates blind spots that limit the delivery of informed, coordinated care, as well as substance

use treatment and addiction counseling. These outdated regulations run counter to new, innovative delivery care models, such as ACOs and bundled payments, that require a holistic knowledge-base and approach to improving health outcomes. The Premier healthcare alliance and a wide range of other organizations, including those representing patients, hospitals, physicians, Medicaid directors, the mental health community and others, are calling on Congress to allow healthcare providers engaged in these care models access to their patients' Medicare, Medicaid and CHIP data on substance use in a way that maintains strong patient confidentiality.

Providers are “flying blind” when it comes to substance use, putting patients and their families at risk and stymieing care coordination

CMS provides participating providers of Medicare ACO and bundled payment organizations with monthly Medicare Parts A, B and D claims under data use agreements that include criminal penalties for misuse. However, a 1970s rule governing the confidentiality of drug and alcohol treatment and prevention records (42.C.F.R. Part 2 (Part 2)) that predates HIPAA and its robust patient confidentiality protections prevents CMS from disclosing or allowing the use of patients' information on substance use without complex and multiple patient consents. Thus, CMS has interpreted this to require the agency to remove claims where substance use disorder is a primary or secondary diagnosis before sending data to researchers or providers who are part of ACOs, bundled payment and other alternative payment models. Removing this data translates to providers missing roughly 4.5 percent of inpatient Medicare claims and 8 percent of Medicaid claims¹, despite being accountable for the outcome of their patients' health and cost of care.

This poses a serious safety threat to patients with substance use disorders considering the potential for drug contraindications and co-existing medical problems. As this hearing brings into focus, it also poses a threat to the family members of those who are struggling with substance use disorders. The lack of data to cue physicians, hospitals and other providers that patients may suffer from substance use disorders means these patients will not benefit from efforts to improve care and efficiency in care coordination models in the same way as other patients, whose comprehensive medical information is available to their providers. This could result in patients being denied critically needed treatment and other social support services because of a decades-old law that does not reflect current models of care, nor account for the strong patient confidentiality protections subsequently put in place by HIPAA.

Moreover, this outdated law creates a costly administrative burden for the government by requiring CMS to scrub substance use data from medical records before transmitting to ACOs and bundled payment organizations. At a time when we are looking to inject more efficiency into our healthcare system, this adds complexity and costs to the system, in addition to laying on the line patient safety and care coordination needs.

To the extent that we start scaling alternative payment models and moving to multi-payer models, including those in the Medicaid program, these problems will only compound.

A broad range of stakeholders support opening up substance use data for our healthcare providers to analyze and improve care in the communities they serve

Premier has joined a broad array of other organizations in calling on Congress to ensure that the Medicare, Medicaid and CHIP data feeds sent to providers that are participating in alternative payment models include all claims, including those involving substance use disorder. House Leadership and Committee members have received multiple coalition letters ([May 12 stakeholder letter](#), [May 10 stakeholder letter](#)) to this effect. Also as part of the [Health Care Transformation Task Force](#), a consortium of private sector stakeholders committed to accelerating the pace of delivery system transformation, and the [National Coalition on Health Care](#), an alliance of leading national healthcare consumer, labor and business groups, we are urging Congress to amend Part 2 regulations to allow participants of alternative payment models access to these data to promote effective valued-based care. In addition, the National Association of Medicaid Directors sent a [letter](#) to House leadership on the need to amend privacy laws to fully address the opioid crisis, and ensure individuals with substance use disorders receive integrated care delivery and benefit from patient-centered models.

We thank the Subcommittee again for holding this critical hearing today. If you have any questions or comments, please contact Duanne Pearson, Director of Federal and Affairs, at duanne_pearson@premierinc.com or 202.879.8008.

ⁱ <http://www.nejm.org/doi/full/10.1056/NEJMp1501362>