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THE OPIOID CRISIS RESPONSE ACT OF 2018

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING AN ORIGINAL BILL ENTITLED, "THE OPIOID CRISIS RESPONSE ACT OF 2018"

APRIL 11, 2018

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C O N T E N T S

STATEMENTS

WEDNESDAY, APRIL 11, 2018

THE OPIOID CRISIS RESPONSE ACT OF 2018

Wednesday, April 11, 2018

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:08 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Isakson, Collins, Cassidy, Roberts, Murkowski, Murray, Casey, Bennet, Baldwin, Murphy, Warren, Kaine, Hassan, Smith, and Jones.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will come to order. This hearing is for reviewing the Opioid Crisis Response Act of 2018, which Senator Murray and I have recommended with input from virtually every Member of this Committee.

Our intention is to mark up the bill and report legislation to the full Senate on April 24th, along with cosmetics legislation and some other pending bipartisan legislation that we've been working on. I want to thank Senator Murray and her staff and our staff for the way we've been able to work on the opioid legislation.

This is our seventh bipartisan hearing since October. I think our work reflects the urgency of the need for a prompt response to our country's most serious public health crisis, which despite enormous efforts seems to get worse.

Senator Murray and I will each have an opening statement, and then we will introduce the witnesses. After the witnesses' testimony, Senators will each have 5 minutes for a round of questions.

Last week, I was in Tennessee, visiting the upper east Tennessee area. I was talking with our witnesses beforehand. I met with two of the four criminal judges in the upper east Tennessee area, who told me that out of the 6,000 cases that they addressed and closed last year that fully two-thirds of them were related to the opioid crisis.

Then a little later in the day, I went down to Greeneville, Tennessee, to the home of Andrew Johnson, President Andrew Johnson, and his upstairs bedroom is his son's bedroom, and there on the bedside table is a bottle laudanum. His son at age 35 died of basically an opiate overdose, probably mixed with alcohol, even

back then. So this is a severe crisis, and it's not a new phenomenon.

Last week, also, I visited the Neonatal Intensive Care Unit at Niswonger Children's Hospital in Johnson City, Tennessee. The hospital opened a new separate unit within their NICU last May to help deal with all the infants being born in drug withdrawal. Of the 30 babies in the unit last week, 10 were in drug withdrawal. The babies stay in the hospital for at least 5 days. Some stay for weeks.

While at Niswonger, I heard heartbreaking stories of how the opioid crisis has claimed the lives of loved ones too soon. One story is about a man named Dustin Iverson.

After serving two tours in Iraq and Afghanistan with the Mississippi National Guard, Dustin settled in a small town in Alabama. A year and a half ago, Dustin was found dead at 29 years old from an apparent overdose. His death turned a national crisis from a news headline into a painful personal experience for his aunt, Trish Tanner.

Trish is currently the Chief Pharmacy Officer at Ballad Health, a regional healthcare provider. She was enrolled in an executive fellowship program when Dustin died, and as part of her program, she worked on an in-depth project on ways to reduce opioid prescribing. She has said about the project, "I researched the opioid crisis in our region. As Dustin's aunt and as a pharmacist, I have a duty and a desire to bring about change now. This is a way for us to redeem what has been lost." As a result of Trish and her colleagues' efforts, the health system she was working for at the time, now part of Ballad Health, reduced the number of inpatient opiate doses administered in its hospitals by more than 40 percent last year.

In January, Sam Quinones testified before our Committee that we need a moonshot to solve this crisis. I think it may require the effort and resources of a moonshot, but I also think it will be different and harder than a moonshot because this is not something that can be undertaken by a single agency in Washington, DC. It will require all-hands-on-deck work and solutions from states, communities, and local partners.

However, the Federal Government can and should play an important role. Last Congress we passed new laws, the Comprehensive Addiction and Recovery Act and the 21st Century Cures Act, to help address the crisis. In the last 3 years, we have provided additional funding targeted at easing the opioid crisis, including $1 billion in state grants in Cures over 2 years and over $3 billion of additional funding in the omnibus bill we passed last month.

But the opioid crisis continues to destroy families and communities, and so we need to examine what more we can do and make sure we're best possible partner. In December, Senator Murray and I wrote to every Governor and state insurance commissioner asking for ideas on how we could do that. And this Committee has spent the last 6 months hearing from Governors, state officials, doctors, officials from the Food and Drug Administration, National Institutes of Health, Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Administration, families, and other experts at our hearings.

As we have heard, this crisis touches more than just those suffering from an opioid addiction. It touches children and grandparents and doctors and nurses and law enforcement. And so the response from the Federal Government must be bipartisan, urgent, and effective.

Last week, Senator Murray and I released this draft legislation based on the input we have heard, as well as ideas from Senators on both sides of the aisle, to give new authorities and create grants and programs at six Federal departments and agencies. So far in this draft, there are 29 proposals from nearly every Member of this Committee, including legislation introduced by Senators Murray, Young, Hassan, and myself to spur development of a non-addictive painkiller by giving the National Institutes of Health more flexibility. I see a non-addictive painkiller really as the Holy Grail of solving the opioid crisis.

There are millions of Americans who suffer from chronic pain, and I have heard from many of them. They rely on opioids for relief. Developing new, non-addictive ways to treat is crucial to helping prevent people from becoming addicted to opioids while ensuring those who need relief have access to it.

Our proposal would also give the FDA the authority to require drug manufacturers to package certain opioids for a set duration, like in a blister pack that contains medication for three or 7 days, and require manufacturers to give patients simple and safe ways to dispose of unused opioids. It would also help do a better job of stopping illegal drugs, such as fentanyl, at the border by strengthening coordination between the FDA and Customs and Border Protection.

At our hearings, we heard about the importance of sharing data, and how sharing data would help state prescription drug monitoring programs. So this draft would help states collect and share data so doctors and pharmacies can know if patients are doctor shopping. We asked for written comments on the draft by close of business today on what more the Federal Government can do. We look forward to hearing more about that from our witnesses.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you very much, Mr. Chairman, for your bipartisan work throughout this process.

I want to thank all of the witnesses who are here today. I look forward to your testimony.

As the Chairman said, 6 months ago, we began a series of bipartisan hearings on the opioid crisis, asking questions and seeking answers to learn more about its root causes and ripple effects and what meaningful action we can take to help our families and communities. In the course of listening to those most directly facing this crisis, both here and back home in my home State of Washington, I've heard many stories about this challenge: families who are strained by a loved one's battle with opioid addiction; parents who lost the children they would do anything for to a disease they felt helpless to do anything against; children separated from parents who are suffering from opioid addiction and unable to care for

them; grandparents, relatives, and others who have stepped up to support a victim's family.

The burden of this crisis isn't just borne by individuals or families, but by entire communities. An elementary principal back in Washington told me about the kids at his school who are unable to focus on their studies because of the trauma of their parents' disease and the teachers who have to face the challenge of supporting these students and addressing their trauma in the classroom. The staff at a hospital in Washington told me about how many of the babies they deliver are born to mothers suffering from addiction, including opioid addiction.

This Committee has heard from experts in the field who are fighting this epidemic. We've heard from community leaders and state officials about the tools they are using, the tools they still need, and the role of data and technology. We've heard from agency heads and researchers about the need for new resources and authorities and the potential for new discoveries to help treat those struggling with addiction.

We've heard from a journalist, who followed the crisis closely, about how we got here and how our communities are in the frontlines turning the tide. We've heard from Governors about the lessons they've learned in the laboratories of democracy that we can put to use on the national level. We have heard about the challenges and opportunities, the successes and failures, the hope and the heartbreak of this crisis. So today, we are responding with strong steps that build on our recent work to address it.

The bipartisan Opioid Crisis Response Act of 2018 was drafted with serious attention to the concerns we heard. It offers some serious solutions to help address them. This legislation answers the call for more resources to expand effective treatment programs on the state level by reauthorizing and improving the targeted response grants from the 21st Century Cures Act. It answers the call for better tools to diagnose, prevent, and treat pain and addiction by empowering the National Institutes of Health with more flexibility to support high impact research on public health threats, including this opioid epidemic.

It answers the call for new products and solutions by clarifying the Food and Drug Administration's authority to require special packaging and safe disposal options, encourage the development and review of non-addictive pain treatments, and keep illicit products from entering our country. The legislation addresses the need for better data and technology practices so health providers and pharmacies can spot patterns of potential misuse by expanding the Centers for Disease Control and Prevention's efforts to support states in improving Prescription Drug Monitoring Programs and encourage better and faster data collection and sharing between states.

It addresses the need to help our schools and children by developing a task force and grants to help support trauma-informed care programs, increasing access to mental health care for children, and supporting state efforts to improve plans of safe care for children born to mothers battling addiction. And it addresses the need to help our strained behavioral health workforce so that patients can get the care they need, even if they live too far from a doctor's of-

fice, by expanding loan repayment to behavioral health providers who practice in underserved areas, increasing access to behavioral health services in areas hardest hit by this epidemic and facing provider shortages, and authorizing new grants to target the workforce shortages in substance use and mental health treatment.

It addresses the need to increase access to treatment by allowing the Substance Abuse and Mental Health Services Administration to provide grants to help providers establish new recovery centers, by allowing health centers to treat addiction patients with innovative telehealth models and technology that can help them serve rural or remote areas, and by building on our work in the Comprehensive Addiction and Recovery Act to permanently allow nurse practitioners and physician assistants to prescribe medication-assisted treatment.

It addresses the need to give those affected by this disease a path forward by providing grants for workforce training to help them get back on their feet. And it addresses many other challenges, big and small, that we've heard from people across the country working to turn the tide of the opioid epidemic.

While this legislation will not be the last step we take to respond to this crisis, it is a major step. And I want to thank all of our colleagues, both on and off this Committee, from both sides of the aisle, for their bipartisan work and their dedication to getting this done.

I especially want to thank Chairman Alexander for working with me and for sharing my focus on bringing as many voices as possible to the table so that we could hear their stories, concerns, and needs firsthand.

This bill is a testament to the value of listening, and we're not done listening yet. Many of the policies presented here are still works in progress, and we are committed to working together with stakeholders to help make sure we can include as many of the good ideas out there as possible.

I look forward to hearing what our witnesses have to say today to add to this conversation as we work to get this very important bill to the finish line for families across the country.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray, and thank you for your words.

Each witness will have up to 5 minutes to give his or her testimony. That will allow more time for conversation with the Senators, with their questions.

I'm pleased to welcome you today. I thank you for taking the time to be here.

The first witness is Jennifer Donahue. She is Chief Abuse Investigation Coordinator in the Office of the Child Advocate for the Delaware courts. She's worked in family law since 2000, with the Office of the Child Advocate since 2007. She reviews cases involving substance-exposed infants and their families.

The second witness we'll hear from is Robert Morrison, Executive Director of Legislative Affairs at the National Association of State Alcohol and Drug Abuse Directors. That is a nonprofit organization that specializes in the development of effective alcohol and other

substance abuse prevention and treatment programs. He's been with the organization for 16 years.

Third is Jessica Hulsey Nickel, Founder, President, and Chief Executive Officer of the Addiction Policy Forum. The Addiction Policy Forum is a nonprofit that works to elevate awareness around addiction and improve public policy to help patients with substance use disorders and their families. Ms. Nickel's 25-year career focusing on addiction comes from personal experience, as both of her parents struggled with heroin addiction.

We welcome our witnesses, and, Ms. Donahue, let's begin with you.

STATEMENT OF JENNIFER DONAHUE, ESQ., CHILD ABUSE INVESTIGATION COORDINATOR, DELAWARE OFFICE OF THE CHILD ADVOCATE, GEORGETOWN, DE

Ms. DONAHUE. Chairman Alexander, Ranking Member Murray, and honorable Members of this Committee, thank you for the opportunity to speak here today about how the proposed Opioid Crisis Response Act of 2018 will further support and strengthen states' response to this problem.

My name is Jennifer Donahue, and I am an attorney with the Office of the Child Advocate in Delaware. In my role, I review and monitor cases involving serious physical injury, death, and sexual abuse of a child and infants with prenatal substance exposure.

My testimony today will focus on the following three areas of the proposed bill as it relates to infants with prenatal substance exposure and their families: providing further grant opportunities and technical assistance support to states for the implementation of Plans of Safe Care, providing further funding and support to states to strengthen their healthcare workforce to increase access to much needed substance use disorder treatment and access to mental health services in schools for our children, and providing grants to states to improve data collection.

My office extends its gratitude to this Committee and Congress for the passing of the 21st Century Cures Act and the Comprehensive Addiction Recovery Act. These pieces of legislation have helped states begin to address the damage that the opioid epidemic has caused to children and families.

Delaware has already embarked on developing draft Plans of Safe Care and implementing them in several of our area hospitals. However, additional funding and support from our Federal counterparts is critical. The Opioid Crisis Response Act of 2018 could be a means to that end.

The prevalence of pregnant women struggling with opioid addiction has increased substantially in Delaware, and access to treatment, particularly medication-assisted treatment, is often difficult. The number of notifications to Delaware's Child Welfare Agency involving infants with prenatal substance exposure has also increased. In 2015, there were 294 notifications, and that number jumped to 450 notifications in 2017.

The data further shows that for infants who are prenatally exposed to two substances, opioids were involved in 63 percent of those cases. For infants who are prenatally exposed to three or more substances, opioid exposure was present in 78 percent of

those cases. The correlation between these infants and the risk of future abuse and neglect cannot be ignored, particularly when parents have not been successful in accessing treatment.

From 2015 to 2017, 14 infants with prenatal substance exposure sustained serious physical injuries in Delaware, and nine died after being discharged home to their parents. Aiden was one of those infants. He was born in 2015 and was prenatally exposed to opiates. Aiden spent 17 days in the hospital after his birth, receiving morphine to assist with his withdrawal. He was subsequently released to his parents, both of whom were addicted to heroin.

During the 9-weeks Aiden was in the care of his parents, he sustained severe traumatic injuries to both his brain and his body. Aiden was hospitalized for 4 months and received extensive medical care, including life support measures. His child welfare treatment worker, Jennifer Perry, who is here with me today, spent countless hours by his side in the hospital to provide comfort and support. Aiden died in September 2015. His parents pled guilty to murder by abuse and neglect and are currently incarcerated.

Aiden's passing devastated our small State of Delaware, especially our local community. But it also compelled us to look more deeply and objectively into our state's and Federal policies and procedures that ultimately failed him.

The Delaware Child Abuse and Neglect Panel, known as the CAN Panel, reviews all child deaths and near deaths due to abuse or neglect. A review of the cases between 2010 and 2014 resulted in approximately 17 findings of policy failures that involved infants with prenatal substance exposure. As a result, in May 2015, we formed the Substance Exposed Infant Committee to address those areas of critical concern.

In an effort to further strengthen our response, Delaware, in August 2016, applied for in-depth technical assistance to the National Center on Substance Abuse and Child Welfare. During the past 2 years, our technical assistance leaders have worked with our team in drafting Plans of Safe Care, which are now being utilized in four of our six birthing hospitals.

No single agency has the resources to address the full spectrum and unique needs of this population and families.

Pending Delaware House Bill 140, known as Aiden's Law, reinforces the requirements under CAPTA and CARA. It's a non-punitive public health oriented bill, and it sets forth what we, as Delaware, believe should be included in the Plans of Safe Care.

However, states need more guidance and financial support. We are hopeful that the proposed Opioid Crisis Response bill will provide additional grant moneys to not only help us implement these plans, but also to provide us guidance on what we believe are the most important aspects of it: communication between those system partners and ongoing monitoring of the family. Plans of Safe Care are likely going to be monitored for much longer than a typical child welfare investigation. The child welfare workforce on a national level is already severely underfunded and cannot assume this additional responsibility without concurrent funding.

Approximately 34 percent of Delaware mothers who gave birth to an infant with prenatal substance exposure in 2017 also had a mental health condition or diagnosis, and that's probably an under-

reported number. Approximately 40 percent of mothers had a history of trauma or DFS involvement when they were a child.

Strengthening states' healthcare workforce, specifically substance use disorder treatment, coupled with trauma informed mental health services will likely reduce the number of infants born with substance exposure. Mental health services in school, ideally at the elementary level, will address the trauma that our youth has experienced that may often lead to mental health concerns and substance use. In 2015, Delaware created a specific independent Excel spreadsheet capturing data for this population.

The CHAIRMAN. We want to try to keep it within 5 minutes.

Ms. DONAHUE. Yes. I will finish up right now. Thank you.

As far as the data collection is concerned, we do have a small Excel spreadsheet for capturing this population. But we need more funding and support for comprehensive data collection and analysis of these infants and their families, and we believe this is a critical part of the bill.

Thank you very much for this opportunity to speak with you today, and I welcome any questions you may have.

[The prepared statement of Ms. Donahue follows:]

PREPARED STATEMENT OF JENNIFER DONAHUE

Chairman Alexander, Ranking Member Murray and honorable Members of the Committee, thank you for the opportunity to speak here today about the impact of the opioid epidemic on our nation's families and how the proposed Opioid Crisis Response Act of 2018 will further support and strengthen states' response to the problem.

My name is Jennifer Donahue and I am an attorney with the Office of the Child Advocate for the State of Delaware. In my role, I review and monitor cases involving serious physical injury and death of a child, sexual abuse of a child, and infants with prenatal substance exposure. My office facilitates a multidisciplinary team response with our child welfare partners in these cases to ensure child safety and that appropriate services are delivered to the family. My testimony today will focus on the following three sections of the proposed Opioid Crisis Response Act of 2018 as it relates to infants with prenatal substance exposure and their families:

1. Providing further grant opportunities and technical assistance support to states for the implementation of Plans of Safe Care for infants with prenatal substance exposure and their families;

2. Providing further funding and support to states to strengthen their healthcare workforce to increase access to substance use disorder treatment, including medication assisted treatment (MAT), and access to mental health services in schools; and,

3. Providing grants to states to improve data collection.

My office extends its gratitude to this Committee and Congress for the passing of the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act. These important pieces of legislation have helped states begin to address the damage that the opioid epidemic has caused to children and families in our Nation. Plans of Safe Care for infants with prenatal substance exposure and their families should not only ensure the safety of the infant, but also provide necessary treatment services to the family for long term success. Delaware has already embarked on developing draft Plans and piloting them in several area hospitals; however, additional funding and support from our Federal counterparts is critical for states' ultimate success. The Opioid Crisis Response Act of 2018 could be a means to that end.

SCOPE OF THE PROBLEM IN DELAWARE

The opioid epidemic has overwhelmed our entire nation and Delaware has not been spared. The problem is deep in our State and the consequences are tragic. The prevalence of pregnant women struggling with substance use disorders has increased substantially and access to treatment, particularly medication assisted treatment, is often difficult. Consequently, the number of notifications to Delaware's

child welfare agency (termed "DFS") involving infants with prenatal substance exposure has also increased. In 2015, there were 294 notifications to the child welfare agency. That number jumped to approximately 450 notifications in 2017.[1] The data further shows that for infants who were prenatally exposed to 2 substances, opioids were involved in 63 percent of those cases. Furthermore, for infants who were prenatally exposed to 3 or more substances, opioid exposure was present in 78 percent of those cases. The approximate number of infants who were treated for Neonatal Abstinence Syndrome (NAS) in Delaware in 2017 was 413 and approximately 191 of those infants required pharmacological interventions.[2]

The correlation between infants with prenatal substance exposure and the risk of future abuse or neglect cannot be ignored, particularly when parents have not been successful in engaging in substance use disorder treatment. During 2015 through 2017, 14 infants with prenatal substance exposure sustained serious physical injuries and 9 died after being discharged home to their parent(s). Aiden was one of those infants. He was born in 2015 at 34 weeks gestation and was prenatally exposed to opiates. Aiden spent 17 days in the hospital after his birth receiving morphine to assist with his withdrawal symptoms. He was subsequently released to his parents, both of whom were addicted to heroin. During the 9 weeks Aiden was in the care of his parents, he sustained severe traumatic injuries to both his brain and his body. Aiden was hospitalized for four months and received extensive medical care, including life support measures. His child welfare treatment worker, Jennifer Perry, who is here with me today, spent countless hours by his side in the hospital to provide comfort and support. Aiden succumbed to his injuries in September 2015. His parents pled guilty to murder by abuse and neglect and are currently incarcerated. Aiden's passing devastated our community but it also compelled us to look deeply and objectively into our state's policies and procedures that ultimately failed him.

ADDRESSING THE PROBLEM

The Delaware Child Abuse and Neglect Panel, known as CAN Panel, reviews all child deaths and near deaths due to abuse or neglect. The review of cases between the years 2010 and 2014 resulted in approximately 17 findings of system weaknesses or policy failures involving infants with prenatal substance exposure.[3] In May, 2015, the Substance Exposed Infant Committee (SEI Committee) was formed to address the identified areas of critical concern. The SEI Committee is co-chaired by myself and Dr. Allan Delong who is a pediatric child abuse expert at A.I. Dupont Hospital for Children. Our multidisciplinary team includes professionals from various domains including child welfare agencies, substance use disorder treatment providers, public health, medical care, mental health providers, home visiting nursing services, developmental disability agencies education and many more. In an effort to further strengthen our response to these infants and their families, Delaware filed an application in August 2016 for In-Depth Technical Assistance (IDTA) through the National Center on Substance Abuse and Child Welfare (NCSACW). During the past two years, IDTA change leaders have worked with our team on significant policy and practice changes. For example, the IDTA change leaders assisted our State with drafting a Plan of Safe Care and Family Assessment template (attached as Exhibit 1) which is now being utilized through our Plan of Safe Care Hospital Pilot Program. The Pilot Program was launched in 2 of our 6 birthing hospitals in October 2017 and has now expanded to 4 hospitals. There are currently 4 identified child welfare agency workers who are assigned to each of the 4 hospitals to handle the preparation, implementation and monitoring of the Plans of Safe Care. During the past 6 months, our Pilot Program teams have identified issues and concerns that need further assistance and support from our Federal Government. One thing is certain—no single agency has the resources or expertise to address the full spectrum of needs of infants with prenatal substance exposure and their families.

OPIOID CRISIS RESPONSE ACT OF 2018

1. Grant Opportunities for the Implementation of Plans of Safe Care

Pending Delaware House Bill 140, known as Aiden's Law (attached as Exhibit 2) reinforces the requirements under CAPTA and CARA that healthcare providers notify DFS of infants born with and affected by substance abuse, withdrawal symptoms or FASD. Our non-punitive, public health oriented bill sets out the parameters

[1] Investigation Coordinator SEI Data base.
[2] Delaware Perinatal Cooperative in partnership with the March of Dimes.
[3] Delaware Child Abuse and Neglect Panel Data 2015

of what we believe should be included in Plans of Safe Care. However, states need more guidance and financial support than CARA can provide. We are hopeful that the Opioid Crisis Response Bill will provide additional grant moneys to help us not only implement Plans of Safe Care but to also provide us guidance on what we believe are the most important aspects of it—communication between system partners who are involved with providing services under the Plan of Safe Care and the ongoing monitoring of the family to ensure both the safety of the infant and delivery of services, particularly substance use treatment. Parents who are struggling with an opioid addiction and the stress of parenthood often do not find their way to recovery quickly. If families and infants are to be supported through this time, the "monitoring" requirements for the Plans of Safe Care are likely going to be much longer than a typical child welfare investigation. As such, child welfare workers (or some other child welfare entity) who are already struggling with caseloads that are beyond the statutory limit, will have additional cases to monitor and for longer periods of time. The child protective services workforce is already woefully underfunded and cannot assume this additional responsibility without concurrent funding. The hospital Pilot Program teams have identified practical issues for consideration as well, such as what is the appropriate duration of monitoring of the Plans and how can we create an electronic version of a Plan of Safe Care that can be easily and confidentially shared with the plan participants.

2. Access to Substance Use Disorder Treatment, MAT and Mental Health Services in Schools

Federal resources need to be funneled toward prevention and awareness programs. Primary care physicians and obstetricians/gynecologists must routinely screen pregnant women for substance use disorders and link them to appropriate treatment prior to the birth event. Appropriate treatment should include access to medication assisted treatment and trauma-informed mental health services. Last year, our. Division of Public Health issued educational materials to medical providers on how to screen pregnant patients for substance use disorders and alcohol abuse, a fact sheet on the negative effects of different drugs during pregnancy, and about *www.helpisherede.com*, a website that provides information about where and how to seek substance use disorder treatment in Delaware. (See Exhibit 3)[4]. Approximately 34 percent of Delaware mothers who gave birth to an infant with prenatal substance exposure in 2017 also had a mental health condition or diagnosis. In addition, approximately 40 percent of mothers had a history of trauma or DFS involvement as a child.[5] Strengthening states' healthcare workforce, specifically substance use disorder treatment providers and trauma-informed mental health services in schools, through additional funding opportunities under the Opioid Crisis Response Act, will likely reduce the number of infants born with substance exposure. Ideally, women of childbearing age will be able to access necessary treatment for their opioid addiction and seek recovery. Mental health services in schools will address the trauma that our youth have experienced and break the cycle of multigenerational trauma that may often lead to mental health concerns and substance use.

3. Data Collection for Policy Change and Research Studies

Collecting rich and informative data will help identify system weaknesses, determine the effectiveness of services delivered to families and support research studies. Under CARA and the Opioid Crisis Response Act, states are required to collect and report out on data involving substance exposed infants and Plans of Safe Care—information that has not been routinely collected in the past and for which current data bases may not have the capability to track. Funding will be necessary to update data bases so that child welfare agencies may comply with the reporting requirements under CARA. In 2015, Delaware created a specific independent Excel spreadsheet for infants with prenatal substance exposure and their families to gather information about maternal and infant characteristics and specific information about the type of exposure, and many other areas. Our office and the child welfare agency have also partnered with the child abuse experts at A.I. Dupont Hospital for Children to conduct a research study on this population. We are hopeful that this study will identify maternal risk factors and infant characteristics that will help us determine which families are in need of more in-depth treatment services. Certainly, a system cannot be sustained long term on an Excel spreadsheet and would not be viable in the vast majority of states. Funding and supports for comprehensive data collection and analysis of these infants and their families is a critical component of this bill.

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[4] Delaware Health and Social Services, Division of Public Health.
[5] Delaware Investigation Coordinator data base 2017

STATE OF DELAWARE

PLAN OF SAFE CARE

For Infants with Prenatal Substance Exposure and their Families

INTRODUCTION: This Plan of Safe Care (POSC) is being developed to ensure that necessary services and supports are in place for the mother, infant and family. The POSC is developed by gathering information from the mother and her family, from the birthing hospital medical record and social worker notes, as well as input from community partners involved in supporting the mother and infant. The Family Assessment Form may be used as an information gathering tool to assist with the preparation of the POSC. A copy of this POSC will be shared with the identified "Plan Participants" in Section C of this document with the consent of the family.

A. FAMILY INFORMATION

DATE: _____

INFANT

Infant's Name (as it appears on birth certificate): _____ DOB: _____ Gender: ____

PARENT(S)

Mother's Full Name: _____ DOB: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Contact/Cell Number: _____

Mother's Employer: _____ Employer Contact/Number: _____

Father's Full Name: _____ DOB: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Contact/Cell Number: _____

Father's Employer: _____ Employer Contact/Number: _____

DO NOT COPY

SECONDARY CAREGIVER(S) (If one parent is not involved):

Name	DOB	Relationship to Parent

SUPPORT PERSON(S) for Parents and/or Child

Name	DOB	Relationship to Parent(s) and/or Child

SIBLING(S) of Child

Name	DOB	Resides with? (Name/address/City/State/Zip)

DO NOT COPY

B. PLAN OF SAFE CARE COORDINATOR ("POSC Coordinator")

***The primary role of the POSC Coordinator is the preparation, implementation and oversight of the POSC for the family. The POSC Coordinator will be responsible for ensuring appropriate referrals for services are made for the infant and family. The POSC Coordinator will act as the primary point of contact for the family and Plan Participants during the development and implementation period. The POSC Coordinator will share information, with informed consent, with the Plan Participants.**

POSC Coordinator's Name: _____

Phone: _____ **Email:** _____

Fax: _____

POSC Coordinator's Supervisor's Name: _____

Phone: _____ **Email:** _____

Fax: _____

POSC Coordinator's Agency Name: _____

DO NOT COPY

C. PLAN PARTICIPANTS for Infant and Family Care

***The Plan Participants are the partners involved in the development and implementation of the POSC. All identified Plan Participants below will receive a copy of this POSC from the POSC Coordinator within 48 hours after the Plan of Safe Care Discharge Meeting.**

1. Birthing Hospital and Social Worker Name: _____
   Phone: _____
2. DFS/Child Welfare Worker Name: _____
   Phone: _____
3. Infant's Primary Care Doctor Name: _____
   Phone: _____ Next Appointment Date: _____
4. Infant's Specialist Physician Name: _____
   Phone: _____ Next Appointment Date: _____
5. Infant's MCO Coordinator: _____
   Phone: _____ Next Appointment Date: _____
6. Home Visiting Nurse Agency and Provider Name: _____
   Phone: _____ Next Appointment Date: _____
7. Mother's PCP/OB/GYN Name: _____
   Phone: _____ Next Appointment Date: _____
8. Mother's SUD or MAT Treatment Provider Name: _____
   Phone: _____ Next Appointment Date: _____

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9. Father's SUD or MAT Treatment Provider Name: _____

Phone: _____ Next Appointment Date: _____

10. Mother's Mental Health Treatment Provider Name: _____

Phone: _____ Next Appointment Date: _____

11. Father's Mental Health Treatment Provider Name: _____

Phone: _____ Next Appointment Date: _____

12. Peer Recovery Coach Name: _____

Phone: _____ Next Appointment Date: _____

13. Other: _____

Phone: _____ Next Appointment Date: _____

D. IDENTIFIED NEEDS, RISKS AND INTERVENTIONS FOR THE FAMILY

***Based upon the information gathered by the POSC Coordinator during the family assessment phase, the following section identifies the needs of the infant, mother, father or other caregiver, and the referrals that are being made for appropriate services and treatment for the family.**

1. INFANT RISKS/NEEDS **REFERRALS MADE BY POSC COORDINATOR AT HOSPITAL DISCHARGE**

a) Exposure/Withdrawal Symptoms

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

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b) Developmental Needs/Child Development Watch/Smart Start

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

c) Other Medical Conditions

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

Special Medical Equipment needed? _____

d) Other Infant Needs/Risks

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

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2. MOTHER'S NEEDS

REFERRALS MADE BY POSC COORDINATOR

a) Substance Use/Abuse

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

b) Alcohol Use/Abuse

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

c) Mental/Behavioral Health

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

d) Parenting Skills/Attachment/Bonding

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

DO NOT COPY

e) Family Planning Needs

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

f) Basic Needs Housing/Food/Transportation

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

g) Other

Describe: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

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3. FATHER'S (or other caregiver's) NEEDS **REFERRALS MADE BY POSC COORDINATOR**

a) Substance Use/Abuse

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

b) Alcohol Use/Abuse

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

c) Mental/Behavioral Health

Reason for Referral: _____

Currently Engaged in Treatment? If so, name of Current Provider: _____

If not, Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

d) Parenting Skills/Attachment/Bonding

Reason for Referral: _____

Agency Referred to: _____

DO NOT COPY

Agency Contact Person and Phone: _____

Date Referred: _____

e) Family Planning Needs

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

f) Basic Needs Housing/Food/Transportation

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

g) Other

Reason for Referral: _____

Agency Referred to: _____

Agency Contact Person and Phone: _____

Date Referred: _____

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E. OTHER SUPPORT SERVICES FOR FAMILY

TYPE OF SERVICE	REFERRALS MADE BY POSC COORDINATOR
a) Home Visiting Nursing Program	Date Referred: _____ Agency Referred to: _____ Agency Contact Name and Phone: _____
b) WIC	Date Referred: _____ Agency Referred to: _____ Agency Contact Name and Phone: _____
c) Employment/Training	Date Referred: _____ Agency Referred to: _____ Agency Contact Name and Phone: _____
d) Financial Assistance	Date Referred: _____ Agency Referred to: _____ Agency Contact Name and Phone: _____
e) Parenting Class	Date Referred: _____ Agency Referred to: _____ Agency Contact Name and Phone: _____

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f) Other

Date Referred: _____

Agency Referred to: _____

Agency Contact Name and #: _____

_____ Hospital Education Provided to Mother/Father or other Caregivers (check all that apply):

_____ Safe Sleeping	____ Newborn Safety
_____ SIDS	____ NAS Withdrawal Symptoms and Management
_____ Abusive Head Trauma	____ Family Planning
_____ Infant Feeding	____ Other: _____

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G. DISCHARGE AND FOLLOW UP

Date of Discharge for Mother: _____

Date of Discharge for Infant: _____

Infant Discharged to whom (primary caregiver(s): _____

Discharge destination (primary caregiver(s) address): _____

Secondary/Part-time destination (name of caregiver and address): _____

Frequency that infant will reside/visit at Secondary/Part-time address: _____

DFS Child Safety Agreement in addition to POSC? _____

If yes, provide details: _____

_____

Explain Frequency of Contact by Plan of Safe Care Coordinator and Plan Participants with the Family (ie.weekly):_____

_____

_____

_____

Date of Next Multidisciplinary Meeting (in person or via teleconference) with Plan Participants to monitor POSC progress and challenges: _____

_____

Plan of Safe Care Progress/Challenges/Additional Needs: _____

_____

DO NOT COPY

H. CONSENT FOR INFORMATION SHARING

By signing below, Mother, Father or other caregiver(s) acknowledge that the Plan of Safe Care has been prepared, reviewed and thoroughly discussed. It is understood that medical information will be shared/disclosed with the Plan Participants (Section C) under this written consent as provided by HIPPA (45 CFR 160, 164). It is also understood that substance use treatment information will be shared/disclosed with the Plan Participants under this written consent per 42 CFR Part 2. The Mother, Father or other caregiver(s) hereby consent to the sharing of the POSC with the Plan Participants.

The Plan Participants will regularly communicate and share information to ensure that timely referrals for services are made by the POSC Coordinator and that the appropriate services are delivered to the family. The POSC Coordinator and Plan Participants agree to ensure confidentiality of the information received through the POSC and agree to only share information with the identified Plan Participants.

The POSC Coordinator hereby confirms that the Division of Family Services has been notified of the infant's birth, this Plan of Safe Care has been prepared for the infant and family and a copy of the Plan has been provided to the Plan Participants listed in Section C of this document with mother's consent.

Plan of Safe Care Coordinator: _____ Date _____

Supervisor: _____ Date _____

Parent Signature: _____ Date _____

Parent Signature: _____ Date _____

Other Caregiver: _____ Date _____

Other Support Person: _____ Date _____

Other plan participant: _____ Date _____

Other plan participant: _____ Date _____

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STATE OF DELAWARE

FAMILY ASSESSMENT FOR PLAN OF SAFE CARE

For Infants with Prenatal Substance Exposure and their Families

***Plan of Safe Care Coordinators may choose to use this Family Assessment or their own tools to gather information about family functioning in order to prepare the Plan of Safe Care. The completed Assessment shall be included in the POSC Coordinator's records and shall not be shared with the Plan Participants.**

A. INFANT'S NEEDS

1. PRENATAL SUBSTANCE EXPOSURE: _____ YES _____ NO

Date(s) of testing: _____

Results of testing: _____

2. LABOR AND DELIVERY

Infant Urine or Meconium Drug Test: _____ YES _____ NO

If yes, result: _____ Positive _____ Negative

Type of Positive Substance(s): _____

Withdrawal symptoms? _____ YES _____ NO

If yes, describe: _____

Medication treatment needed? ____ YES ____ NO Comments: _____

Fetal Alcohol Spectrum Disorder? ____ YES ____ NO Comments: _____

Premature (less than 37 weeks): ____ YES ____ NO Comments: _____

Other Medical conditions? ____ YES ____ NO Comments: _____

Other: _____

3. ATTACHMENT AND BONDING

_____ Normal behavior/interaction with infant Comments: _____

_____ Regular visits and calls while in hospital Comments: _____

_____ Bed sharing with infant in hospital Comments: _____

_____ Infant supplies obtained Comments: _____

_____ Crib/safe sleeping arrangements Comments: _____

_____ Other strengths or concerns Comments: _____

B. MOTHER'S NEEDS

1. PRENATAL CARE: _____ YES _____ NO _____ Unknown

IF YES: OB/Gyn Provider Name: _____ Contact number: _____

Date when prenatal care began: _____ Regular visits: ___ YES _____ NO _____ Unknown

If no, explain: _____

Prenatal Drug Testing Conducted: _____ YES _____ NO _____ Unknown

Dates of Testing: _____

Results of Testing: _____

Valid Medication Prescription? : _____ YES _____ NO

If yes, please list substance, for what condition and prescribing provider name:

1. Substance: _____ Condition: _____ Provider: _____

   Verified Valid: ____ YES ____ NO Comments: _____

2. Substance: _____ Condition: _____ Provider: _____

   Verified Valid: ____ YES ____ NO Comments: _____

Referral made by OB/GYN for substance use treatment for mother? _____ YES _____ NO _____ Unknown

If yes, date of referral: _____ Agency name/contact #: _____

Indicate other substances of concern during pregnancy per maternal self-report: _____

2. MATERNAL SUBSTANCE USE

Maternal Urine Drug Test at Labor/Delivery: _____ YES _____ NO

If yes, result: _____ Positive _____ Negative

Name(s) and Type(s) of Positive Substances: _____

_____

Valid Prescription for Positive Substance(s)? _____

If yes, please list substance, for what condition and prescribing provider:

Substance: _____ Condition: _____ Provider: _____

Verified Valid: ____ YES ____ NO Comments: _____

Substance: _____ Condition: _____ Provider: _____

Verified Valid: ____ YES ____ NO Comments: _____

Substance: _____ Condition: _____ Provider: _____

Verified Valid: ____ YES ____ NO Comments: _____

Substance: _____ Condition: _____ Provider: _____

Verified Valid: ____ YES ____ NO Comments: _____

Maternal history of substance use disorder? ___ YES ___ NO Comments: _____

Mother actively engaged in substance use treatment? ___ YES ___ NO

If yes, what agency/clinic? _____ Counselor name/contact #:_____

Date treatment began: _____

Verified compliant with treatment (ie. regular attendance, no positive illicit drugs)? _____

Comments/Strengths/Concerns: _____

_____

Mother actively engaged in Medication Assisted Treatment? ____ YES ____ NO

If yes, what agency/clinic? _____ Counselor name/contact #:_____

Verified compliant with MAT (ie. regular attendance, no positive illicit drugs)? _____

Comments/Strengths/Concerns: _____

_____

Maternal history of *prior* substance use treatment? ____ YES _____ NO _____ Unknown

If yes, list date(s) and provider(s): _____

Successfully completed treatment or discharged non-compliant? _____

Prior Infant(s) born with prenatal substance exposure? ____ YES ____ NO

If yes, date(s) of prior SEI birth(s): _____

Substance(s): _____

3. DOMESTIC VIOLENCE/CRIMINAL ACTIVITY

Domestic violence concerns in mother's home? Explain: _____

Criminal activity concerns in mother's home? Explain: _____

What referrals to be provided? _____

Adverse Childhood Experiences (ACEs): use optional screening tool to determine mother's ACE score.

C. PATERNAL OR OTHER CAREGIVER SUBSTANCE USE

Paternal (or other caregiver) current substance use or abuse disorder? ____ YES ____ NO ____ Unknown

If yes, type of substance: _____

Paternal (or other caregiver) actively engaged in substance use treatment? ____ YES ____ NO ____ Unknown

If yes, what agency/clinic? _____ Counselor name/contact #:_____

In treatment since? _____

Verified compliant with treatment (ie. regular attendance, no positive illicit drugs)? _____

Paternal (or other caregiver) history of *prior* substance use treatment? ____ YES ____ NO ____ Unknown

If yes, list date(s) and provider(s): _____

Successfully completed treatment or discharged non-compliant? _____

Domestic violence concerns in father's home? Explain: _____

Criminal activity concerns in father's home? Explain: _____

What referrals to be provided? _____

Adverse Childhood Experiences (ACEs): use optional screening tool to determine father's ACE score.

D. PRIOR HISTORY OF DFS INVOLVMENT WITH MOTHER, FATHER OR OTHER CAREGIVERS

***The below information shall remain in the POSC Coordinator's records only and shall not be shared with Plan Participants.**

____	No DFS history			
____	DFS case is currently ACTIVE	____ Mother	____ Father	____ Other Caregiver
____	Prior DFS history of abuse or neglect allegations	____ Mother	____ Father	____ Other Caregiver
____	Prior DFS history of children removed from the home	____ Mother	____ Father	____ Other Caregiver
____	Prior DFS substantiation of abuse or neglect	____ Mother	____ Father	____ Other Caregiver
____	Infant's siblings currently placed out of the home	____ Mother	____ Father	____ Other Caregiver

____ Infant's siblings in DFS custody ____ Mother ____ Father ____ Other Caregiver

____ Prior termination of parental rights ____ Mother ____ Father ____ Other Caregiver

Comments for Check marks above : _____

_____

_____

_____

_____

*Name of Person who completed this form: _____

*Date form completed: _____

30

SPONSOR: Rep. M. Smith & Rep. Briggs King & Rep. Longhurst & Sen. Henry & Sen. Lopez & Sen. Townsend
Reps. Heffernan, Q. Johnson, Miro, Osienski, Ramone, Viola, Wilson; Sens. Hocker, Lavelle, Marshall, Sokola

HOUSE OF REPRESENTATIVES
149th GENERAL ASSEMBLY

HOUSE BILL NO. 140

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO INFANTS WITH PRENATAL SUBSTANCE EXPOSURE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 16 of the Delaware Code by inserting a new chapter to read as follows:

Chapter 9B. Infants with Prenatal Substance Exposure.

§ 901B. Purpose.

The child welfare policy of this State shall serve to advance the best interests and secure the safety and well-being of an infant with prenatal substance exposure, while preserving the family unit whenever the safety of the infant is not jeopardized. To further this policy, this chapter:

(1) Requires that notifications of infants with prenatal substance exposure be made to the Division by the healthcare provider involved in the delivery or care of the infant.

(2) Requires a coordinated, service-integrated response by various agencies in this State's health and child welfare systems to work together to ensure the safety and well-being of infants with prenatal substance exposure by developing, implementing, and monitoring a Plan of Safe Care that addresses the health and substance use treatment needs of the infant and affected family or caregiver.

§ 902B. Definitions.

As used in this chapter:

(1) "Division" is as defined in § 902 of this title.

(2) "Family assessment and services" is as defined in § 902 of this title.

(3) "Healthcare provider" is as defined in § 714 of this title.

(4) "Infant with prenatal substance exposure" means a child not more than 1 year of age who is born with and identified as being affected by substance abuse or withdrawal symptoms or a Fetal Alcohol Spectrum Disorder. The

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healthcare provider involved in the delivery or care of the infant shall determine whether the infant is affected by the substance exposure.

(5) "Investigation Coordinator" is as defined in § 902 of this title.

(6) "Internal information system" is as defined in § 902 of this title.

(7) "Plan of Safe Care" or "Plan" means a written or electronic plan to ensure the safety and well-being of an infant with prenatal substance exposure following the release from the care of a healthcare provider by addressing the health and substance use treatment needs of the infant and affected family or caregiver, and monitoring these plans to ensure appropriate referrals are made and services are delivered to the infant and affected family or caregiver. The monitoring of these plans may be time limited based upon the circumstances of each case.

(6) "Substance abuse" means the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of this title.

(7) "Withdrawal symptoms" means a group of behavioral and physiological features in the infant that follow the abrupt discontinuation of a drug that has the capability of producing physical dependence. Withdrawal symptoms resulting exclusively from a prescription drug used by the mother or administered to the infant under the care of a prescribing medical professional, in compliance with the directions for the administration of the prescription as directed by the prescribing medical professional, its compliance and administration verified by the healthcare provider involved in the delivery or care of the infant, and no other risk factors to the infant are present, is not included in the definition and does not warrant a notification to the Division under § 903B of this title.

§ 903B. Notification to Division; immunity from liability.

(a) The healthcare provider who is involved in the delivery or care of an infant with prenatal substance exposure shall make a notification to the Division by contacting the Division report line as identified in § 905 of this title.

(b) When two or more persons who are required to make a notification have joint knowledge of an infant with prenatal substance exposure, the telephone notification may be made by one person with joint knowledge who was selected by mutual agreement of those persons involved. The notification must include all persons with joint knowledge of an infant with prenatal substance exposure at the time the notification is made. Any person who has knowledge that the individual who was originally designated to make the notification has failed to do so, shall immediately make a notification.

(c) A notification made under this section is not to be construed to constitute a report of child abuse or neglect under § 903 of this title, unless risk factors are present that would jeopardize the safety and well-being of the infant.

(d) The immunity provisions under § 908 of this title will also apply to this chapter.

§ 904B. Notification information.

(a) Upon receipt of a notification of an infant with prenatal substance exposure, the Division shall enter it into the Division's internal information system.

(b) Upon receipt of a notification of an infant with prenatal substance exposure, the Division shall notify the office of the Investigation Coordinator of the notification in sufficient detail to permit the Investigation Coordinator to undertake its duties as specified in § 906 of this title.

§ 905B. State response to notifications of infants with prenatal substance exposure.

(a) In implementing the Division's role in protecting the safety and well-being of infants with prenatal substance exposure, upon receipt of a notification under § 903B of this title, the Division shall do all of the following:

(1) Determine if the case requires an investigation or family assessment.

(2) Develop a Plan of Safe Care.

(3) Provide copies of the Plan of Safe Care to all agencies and providers involved in the care or treatment of the infant with prenatal substance exposure and affected family or caregiver.

(4) Implement and monitor the provisions of the Plan of Safe Care.

(b) For any case accepted by the Division for investigation or family assessment, the Division may contract for services to comply with § 906 of this title and § 905B of this chapter.

(c) For cases that are not accepted by the Division for investigation or family assessment, or those cases accepted for family assessment where the report does not involve a multidisciplinary case under § 906(e)(3) of this title, but that still meet the definition of an infant with prenatal substance exposure, the Division shall contract for services to do any of the following:

(1) Protect the safety and well-being of the infant with prenatal substance exposure following release from the care of healthcare providers while preserving the family unit whenever the safety of the infant is not jeopardized.

(2) Develop a Plan of Safe Care.

(3) Provide copies of the Plan of Safe Care to all agencies and providers involved in the care or treatment of the infant with prenatal substance exposure and affected family or caregiver.

(4) Implement and monitor the provisions of the Plan of Safe Care.

(5) Provide a final report to the Division to assist the Division in complying with Section 906B of this Chapter.

(d) For any case referred for contracted services under this chapter, the contractor shall immediately notify the Division if it determines that an investigation is required or is otherwise appropriate under § 906 of this title. The contracted

staff who have conducted the assessment may remain involved in the provision of services to the child and family as appropriate.

(e) In implementing the Investigation Coordinator's role in ensuring the safety and well-being of infants with prenatal substance exposure, the Investigation Coordinator, or the Investigation Coordinator's staff, shall have electronic access and the authority to track within the Department's internal information system each notification of an infant with prenatal substance exposure.

§ 906B. Data and reports.

(a) The Division shall document all of the following information in its internal information system for all notifications of infants with prenatal substance exposure under this chapter:

(1) The number of infants identified as being affected by substance abuse, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder.

(2) The number of infants for whom a Plan of Safe Care was developed, implemented and monitored.

(3) The number of infants for whom referrals were made for appropriate services, including services for the affected family or caregiver.

(4) 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.

(b) The Department of Health and Social Services, the Investigation Coordinator and healthcare providers shall assist the Division in complying with this section.

(c) In addition to any required federal reporting requirements, the Division, with assistance from the Department of Health and Social Services and the Investigation Coordinator, shall provide an annual report to the Child Protection Accountability Commission and Child Death Review Commission summarizing the aggregate data gathered on infants with prenatal substance exposure.

(d) To protect the privacy of the affected family or caregivers, including the infant named in a report, this chapter is subject to the privacy and confidentiality provisions in § 906 and § 909 of this title.

Section 2. This Act shall be known and may be cited as "Aiden's Law."

Ssynopsis

This non-punitive, public-health oriented bill seeks to codify certain sections of the federal law known as the Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Comprehensive Addiction and Recovery Act (CARA), that requires states to have policies and procedures in place to address the needs of infants born with and identified as being affected by substance abuse, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder, including a requirement that healthcare providers involved in the delivery or care of such infant notify the child protection services system. This bill

formalizes a uniform, collaborative response protocol for the development of a Plan of Safe Care for infants with prenatal substance exposure and their affected family or caregivers.

Fact Sheet for Medical Providers:

SUBSTANCE USE DURING PREGNANCY

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Delaware law requires that medical providers educate pregnant patients about the dangers of substance use:

DE Code, Title 24, Chapter 17, § 1769A. Required warning to pregnant women of possible effects of using alcohol, cocaine, or other narcotics.

(a) A person certified to practice medicine who treats, advises, or counsels pregnant women for matters relating to the pregnancy shall post warnings and give written and verbal warnings to all pregnant women regarding possible problems, complications, and injuries to themselves and/or to the fetus from the consumption or use of alcohol or cocaine, marijuana, heroin, and other narcotics during pregnancy.

(b) A person who treats, advises, or counsels pregnant women pursuant to subsection (a) of this section and who is certified to practice medicine may designate a licensed nurse to give the warnings required by this section.

(c) The Director of the Division of Public Health shall prescribe the form and content of the warnings required pursuant to this section.

QUICK SUMMARY OF SUBSTANCE EFFECTS

	Nicotine	Alcohol	Marijuana	Opioids	Cocaine	Methamphetamine
Short-term Effects/Birth Outcome						
Fetal Growth	Effect	Strong Effect	Effect	Effect	Effect	Effect
Anomalies	?	Strong Effect	?	No Effect	No Effect	?
Withdrawal	No Effect	Effect	Effect	Strong Effect	No Effect	Effect
Neurobehavior	Effect	Effect	Effect	Effect	Effect	Effect
Long-term Effects/Birth Outcome						
Growth	?	Strong Effect	No Effect	No Effect	?	*
Behavior	Effect	Strong Effect	Effect	Effect	Effect	*
Cognition	Effect	Strong Effect	Effect	?	Effect	Effect
Language	Effect	Effect	No Effect	Effect	Effect	*
Achievement	Effect	Strong Effect	Effect	*	?	*

? No Consensus on Effect * Limited or no data available

Updated by the Delaware Division of Public Health in 2017. Original source: Behnke, M. & Smith, V. C. (2013). Technical Report. Prenatal substance abuse: short and long-term effects on the exposed fetus. American Academy of Pediatrics, 131(3), e1009- e1024.

WHAT TO TELL YOUR PATIENTS

No amount of alcohol, marijuana, or other illegal drugs is safe for you or your baby. Prescription opioids should be taken exactly as prescribed and babies may experience neonatal abstinence syndrome (NAS) after birth, which will likely need medical intervention.

From the American College of Obstetricians and Gynecologists:

"A drug's effects on the fetus depend on many things: how much, how often, and when during pregnancy it is used. The early stage of pregnancy is the time when main body parts of the fetus form. Using drugs during this time in pregnancy can cause birth defects and miscarriage. During the remaining weeks of pregnancy, drug use can interfere with the growth of the fetus and cause preterm birth and fetal death."

(December 2013: www.acog.org/Patients/FAQs/Tobacco-Alcohol-Drugs-and-Pregnancy).

OPIOIDS: LEGAL AND ILLEGAL

what your patients need to know

Opioids are a highly addictive substance, and their use and abuse is driving the current addiction epidemic. Opioids can cause life-threatening withdrawal symptoms in babies, better known as neonatal abstinence syndrome (NAS). Symptoms include excessive crying, high-pitched cry, irritability, seizures, and gastrointestinal problems, among others. NAS requires hospitalization of the affected infant and possibly treatment with morphine or methadone to relieve symptoms. Treatment should also include non-pharmacological interventions like skin to skin contact and rooming in.

The research on the long-term impacts of opioid use during pregnancy is still evolving but there is some evidence to suggest behavorial and potential cognition effects on children whose mother used opioids.

No patient should be counseled to immediately stop using opioids, including heroin. Suddenly stopping use could send the fetus into distress, threaten the pregnancy, and even cause miscarriage. Consistent with ACOG guidelines, physicians should discuss a broad range of treatment options, including Medication Assisted Treatment (MAT). For information on treatment programs or to learn more about MAT for pregnant women, call 1-800-652-2929 in New Castle County or 1-800-345-6785 in Kent and Sussex counties.

COCAINE AND METHAMPHETAMINE (STIMULANTS)

what your patients need to know

Pregnant women who use cocaine are at higher risk for maternal migraines and seizures, premature membrane rupture, and placental abruption (separation of the placental lining from the uterus). Cocaine could exacerbate cardiac problems--sometimes leading to serious problems with high blood pressure (hypertensive crises), spontaneous miscarriage, preterm labor, and difficult delivery.

Babies born to mothers who use cocaine during pregnancy may also have low birth weight and smaller head circumferences, and are shorter in length than babies born to mothers who do not use cocaine. They also show symptoms of irritability, hyperactivity, tremors, high-pitched cry, and excessive sucking at birth.

Resources

For information on detox, recovery, intervention, and treatment resources, visit: www.helpisherede.com.

To help patients connect with home visiting and a variety of prenatal supports, call 2-1-1 for "Help Me Grow."

ALCOHOL

what your patients need to know

Alcohol is the number one cause of preventable birth defects. When a pregnant woman drinks alcohol, the alcohol reaches the baby through the placenta. While an adult liver will break down the alcohol, a baby's liver cannot and so the alcohol is significantly more toxic. Drinking alcohol during pregnancy can cause: damage to a baby's organs, physical, emotional and behavorial problems as they grow, difficulties in learning or memory, and higher incidence of Attention Deficit Hyperactivity Disorder (ADHD). The damage caused by drinking alcohol is well-documented and vastly underestimated.

MARIJUANA

what your patients need to know

Marijuana use should not be viewed as a "safe" alternative to other drugs, and, contrary to reports, marijuana can be addictive. The American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) state that marijuana cannot be used safely during pregnancy. There is research to suggest impaired neurodevelopment in fetuses, as well as low birth weight and problems in behavior and cognition in childhood. But, more research must be done. And, as ACOG suggests, the adverse effects of smoking to mother and fetus are well-documented.

TOBACCO

what your patients need to know

While this brief focuses on alcohol, illegal substances and prescription drug abuse, the negative impact of tobacco use on birth outcomes is well-documented. If a patient indicates they smoke, consider referrals to the Delaware Quitline for free cessation resources and tools at www.quitnow.net/delaware or by calling 1-866-409-1858."

Sources

ACOG Committee Opinion Number 637, July 2015, "Marijuana Use during Pregnancy and Lactation"

ACOG FAQ170, December 2013: Tobacco, Alcohol, Drugs, and Pregnancy

ACOG Committee Opinion 479, March 2011, Reaffirmed 2017, "Methamphetamine Abuse in Women of Reproductive Age

Centers for Disease Control and Prevention: Fetal Alcohol https://www.cdc.gov/ncbddd/fasd/

National Institute of Drug Abuse https://www.drugabuse.gov/publications/research-reports/substance-use-in-women/substance-use-while-pregnant-breastfeeding

Delaware Fetal Alcohol Task Force

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

DE THRIVES

Guidance for Medical Providers:

How to Screen Pregnant Patients for Substance Use Disorder and Alcohol Use

RECOMMENDATION

All pregnant women should be educated on the dangers of substance use during pregnancy and screened for substance use disorder and alcohol use, particularly during the first and third trimesters.

The American College of Obstetricians and Gynecologists (ACOG) recommends universal screening with brief intervention and treatment referrals for cannabinoids, alcohol, club drugs, dissociative drugs, hallucinogens, opioids, stimulants, tobacco, and other compounds such as anabolic steroids and inhalants.

BACKGROUND

No amount of alcohol, marijuana, illegal drugs, or tobacco is safe for the mother or baby. Alcohol is still the number one cause of preventable birth defects, and even minimal alcohol exposure can hurt a fetus. Data shows there are short- and long-term negative impacts of alcohol, tobacco, opioids, and other drug use on the mother and baby.

For further information on the dangers of substance use during pregnancy, see *Fact Sheet for Medical Providers: Substance Use During Pregnancy* on www.HelpIsHereDE.com.

Legal prescription drugs, including opioids, should be closely monitored and used exactly as prescribed. For mothers who consumed opioids legally as part of a treatment plan, their infant will still likely need treatment for neonatal abstinence syndrome (NAS) following birth.

Any pregnant woman who is on legal or illegal opioids should not cease her use immediately or there may be significant risks to the fetus. Conversion to Medication Assisted Treatment (MAT) is preferred for women seeking to discontinue use of illegal or legal opioids during pregnancy (see page 4).

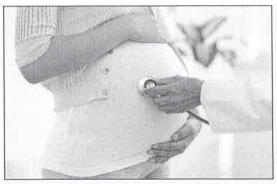
To learn more about MAT treatment locations for pregnant women, visit the Substance Abuse and Mental Health Services Administration (SAMHSA) website at www.samhsa.gov or call 1-800-652-2929 in New Castle County and 1-800-345-6785 in Kent and Sussex counties.

OPIOIDS AND PAIN MANAGEMENT

Legally prescribed opioids are a proven pipeline to opioid dependence. Nearly 80 percent of heroin users report they started with prescription opioids. And, the benefits of long-term opioid therapy for chronic pain are not well supported by the evidence.

Prescribers of opioids for pain management should consider recommending alternatives to opioid medications, including non-opioid medications, exercise and physical therapy, behavioral therapy, and relaxation techniques. For patient and physician opioid fact sheets and links to new prescription regulations, visit Help is Here: www.helpisherede.com/Health-Care-Providers.

CONSIDERATIONS



Substance use disorder is a chronic disease. Similar to diabetes and other illnesses that can harm a mother or her baby during pregnancy, a potential substance use problem should be identified and addressed early through screening using a validated screening tool.

ACOG recommends that routine screening for substance use disorder be applied equally to all people, regardless of age, sex, race, ethnicity, or socioeconomic status.

You have an important role in educating women on the dangers of substance abuse during pregnancy, screening women for substance use disorder, and referring those with a potential substance use disorder. The goal is to help the mother and her baby. Education, screening, and referrals should be integrated seamlessly into regular prenatal visits.

Be nonjudgmental and reassuring. You are more likely to get honest responses if the patient feels comfortable and safe. When asking about substances, pregnant patients may naturally be concerned about admitting drug or alcohol use. They may fear stigma or that they will be reported to child protective services.

Pregnant women cannot be penalized for substance use during pregnancy under the law. Medical providers do not have a legal requirement or obligation to report substance use in pregnant women or to perform testing to confirm suspected use. In fact, child protective services will not take a report for behavior while pregnant as that is outside their legal authority.

Under federal law, pregnant women must receive priority substance abuse treatment. To learn more about what treatment services are available, visit www.HelpIsHereDE.com.

GENERAL SCREENING RECOMMENDATIONS

STEP ONE: START THE CONVERSATION

Following the SBIRT model (Screening, Brief Intervention and Referral to Treatment), start the conversation in a reassuring and compassionate manner. "Can I ask you about drug or alcohol use? This information is important to working with you to have a healthy pregnancy."

Be reassuring. Be clear the information will not be used against the patient or impact her ability to keep custody of the child. Emphasize the importance of your commitment to help her have a healthy pregnancy.

STEP TWO: DO THE SCREENING

Use the screening tool that works best for your practice and your population. The next page includes three validated screening tools that can be used easily in a health care setting. All seek to identify potential issues that would require further dialogue with the patient and referrals to treatment providers for further assessment.

These screening tools are in the public domain and recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA).

GENERAL SCREENING TOOLS

"Screening" means using a validated screening tool to ask questions aimed at understanding the patient's potential substance use. There are several validated screening tools for pregnant women, including 4P's, T-ACE, and CRAFFT for adolescents and young adults.

THE 4 P'S

4 P's for Substance Abuse:

1. Have you ever used drugs or alcohol during **Pregnancy**?

2. Have you had a problem with drugs or alcohol in the **Past**?

3. Does your **Partner** have a problem with drugs or alcohol?

4. Do you consider one of your **Parents** to be an addict or alcoholic?

Scoring: Any "yes" should be used to trigger further discussion about drug or alcohol use. Any woman who answers "yes" to two or more questions should be referred for further assessment.

Source: Adapted from Ewing H Medical Director, Born Free Project, Contra Costa County, 111 Allen Street, Martinez, CA. Phone: 510-646-1165.

T-ACE

ACOG recommends the T-ACE screening tool for alcohol, specifically developed for use with pregnant women. Ask patients four questions:

(T) Tolerance: How many drinks does it take to make you high?

(A) Have people annoyed you by criticizing your drinking?

(C) Have you ever felt you ought to cut down on your drinking?

(E) Eye opener: Have you ever had a drink the first thing in the morning to steady your nerves or get rid of a hangover?

Scoring: Any woman who answers more than two drinks is scored two points. Each "yes" to the additional three questions scores one point. A score of two or more is considered a positive screen, and the woman should be referred for further assessment.

Source: Sokol RJ, Martier SS, Ager JW. 1989. The T-ACE questions: Practical prenatal detection of risk drinking, American Journal of Obstetrics and Gynecology 160 (4).

CRAFFT – SUBSTANCE ABUSE SCREEN FOR ADOLESCENTS AND YOUNG ADULTS

C - Have you ever ridden in a **CAR** driven by someone (including yourself) who was high or had been using drugs or alcohol?

R – Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?

A – Do you ever use alcohol or drugs while you are by yourself, **ALONE**?

F – Do you ever **FORGET** things you did while using drugs or alcohol?

F – Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?

T – Have you ever gotten in **TROUBLE** while you were using alcohol or drugs?

Scoring: Two or more positive items indicate the need for further assessment.

Source: Center for Adolescent Substance Abuse Research, Children's Hospital of Boston. The CRAFFT screening interview. Boston (MA) CeASAR; 2009.

TOBACCO

While this guidance focuses on alcohol, illegal substances, and prescription drug abuse, screening for tobacco is still recommended. The negative impact of tobacco use on birth outcomes is well documented. If a patient indicates they smoke, consider referrals to the Delaware Quitline for free cessation resources and tools at www.quitsupport.com or by calling **1-866-409-1858**.

STEP THREE: EDUCATE THE PATIENT AND PROVIDE REFERRALS

If the screening tool does not identify a potential problem:

- State law requires that all medical providers serving pregnant women counsel them on the dangers of any alcohol, marijuana, or other drug use during pregnancy. Recommend they cease use with the exception of opioids, which require special considerations and may need to involve Medication Assisted Treatment. For further information on the dangers of substance use during pregnancy, see *Fact Sheet for Medical Providers: Substance Use During Pregnancy* on www.HelpIsHereDE.com.

If the screening tool does identify a risk for substance use disorder:

- Be clear that you know the mother wants to be as healthy as possible for her baby and herself, and that she can reduce the health risk to them both by stopping the use of alcohol and drugs. If eligible, connect her with a Care Coordinator through her medical insurance.

- Discuss possible strategies for her to stop — individual or group counseling, 12-step program, or substance use disorder treatment. If she is struggling with opioid addiction, Medication Assisted Treatment should be discussed.

- Recommend women visit www.HelpIsHereDE.com or call 1-800-652-2929 in New Castle County and 1-800-345-6785 in Kent or Sussex counties to learn more about services for pregnant women.

MEDICATION ASSISTED TREATMENT

Medication Assisted Treatment (MAT) is an important part of the treatment regimen for pregnant women and is proven to improve outcomes. According to ACOG, "the rationale for Medication Assisted Treatment during pregnancy is to prevent complications from illicit opioid use and narcotic withdrawal, encourage prenatal care and drug treatment, reduce criminal activity, and avoid risks to the patient associated with a drug culture." *(ACOG Committee Opinion, Opioid Abuse, Dependence and Addiction in Pregnancy, Number 524, May 2012, page 2).*

The two main medications involved in MAT for pregnant women are methadone and buprenorphine (without Naloxone). The decision regarding the most appropriate medication should be made jointly with the MAT provider, the obstetrician, and the woman.

METHADONE	BUPRENORPHINE (WITHOUT NALOXONE)
• May have better treatment retention	• Probably less severe NAS; works best in patients needing less monitoring
• No risk precipitating withdrawal	• Reduced risk of overdose during induction
• Patients with more severe opioid use disorder	• Reduced risk of overdose if children are exposed to medication.

Source: Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/.

SOURCES

For a full list of sources, call the Division of Public Health at 302-744-4704.

[SUMMARY STATEMENT OF JENNIFER DONAHUE]

Infants with prenatal substance exposure and their parents struggling with opioid addiction have multiple and complex needs that require a collaborative response by a multidisciplinary team. The 21st Century Cures Act and the Comprehensive Addiction and Recovery Act have helped states begin to address the damage that the opioid epidemic has caused to children and families in our nation.

Plans of Safe Care for infants with prenatal substance exposure and their families should not only ensure the safety of the infant, but also provide necessary treatment services to the family for long term success. Delaware has already embarked on developing draft Plans and piloting them in several area hospitals; however, additional funding and support from our federal counterparts is critical for states' ultimate success.

Additional grant opportunities under the Opioid Crisis Response Act for states to implement and monitor Plans of Safe Care, to strengthen their healthcare workforce to increase access to substance use disorder treatment, including medication assisted treatment (MAT), and access to mental health services in schools, as well as support to collect rich and informative data, is another beneficial step forward in our fight against the devastating effects of the opioid epidemic on our infants and families.

Thank you very much for the opportunity to speak with you today about infants with prenatal substance exposure and I welcome any questions you may have.

The CHAIRMAN. Thank you, Ms. Donahue.

Mr. Morrison, welcome.

STATEMENT OF ROBERT I.L. MORRISON, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS, WASHINGTON, DC

Mr. MORRISON. Thank you very much. Chairman Alexander, Ranking Member Murray, Members of the Committee, I appreciate this opportunity to testify. It's a privilege.

I'm Rob Morrison. I do serve as Executive Director of the National Association of State Alcohol and Drug Abuse Directors, or NASADAD. We're nonprofit, serving state alcohol and drug agency directors. Our board is led by our president, Cassandra Price, from the great State of Georgia. Our members are grateful for the program funding authorized by this Committee. These programs are housed in HHS agencies, such as SAMHSA, CDC, HRSA, and NIH.

I'd like to thank you for your work to draft and approve the 21st Century Cures Act, which, among other provisions, included the creation of a $1 billion fund known as the STR Grant. STR is supporting innovative and lifesaving programs across the country. We're also very thankful for the work to draft and pass the Comprehensive Addiction Recovery Act.

It's a privilege to offer observations regarding the discussion draft titled the Opioid Crisis Response Act of 2018. In general, we offer the following principles.

First, we recommend ensuring that provisions work through and coordinate with a state alcohol and drug agency to promote efficiency, effectiveness, and to avoid creating parallel or duplicative systems of care.

Second, ensure consistent, predictable, and sustained Federal resources to avoid creating a fiscal cliff by extending the duration of Federal grants beyond the typical one or 2-year funding cycle and allow states more time to expend dollars provided by the annual appropriations process.

Third, continue to work to address the opioid crisis, but also elevate efforts to address all substance use disorders.

Fourth, maintain investments in SAMHSA, as a lead agency within HHS focused on substance use disorder service delivery.

I'd like to focus on the benefits of working through the State Alcohol and Drug Agency. Our members draft and implement coordinated statewide plans for program service delivery. This plan is comprehensive, utilizes cross-agency collaboration, and spans a continuum of prevention, treatment, and recovery.

From child welfare to transportation, employment to criminal justice, our members work with a diverse set of state level agencies and stakeholders who are NGO's to coordinate an interconnected system of care.

State alcohol and drug agencies ensure oversight of providers through tools such as performance management and reporting, contract monitoring, corrective action planning, onsite technical reviews, and technical assistance. Our members also work to promote quality through state established standards of care, promoting evidence-based practices, collecting and analyzing data, and using these tools to drive management decisions.

The foundation of this work is SAMHSA's Substance Abuse, Prevention, and Treatment Block Grant. This program is designed to be flexible to meet the unique needs of states and addresses all substance use disorders for the Nation's poor and most vulnerable. Twenty percent of the SAPT Block Grant is dedicated to much needed substance abuse prevention programming. In fact, of the budgets our members manage for prevention, on average, 70 percent comes from the SAPT Block Grant.

I look forward to a dialog on the discussion draft's current provisions, ways to improve the text, and ideas and enhancements. One idea for the Committee's consideration is adding a section to authorize a new grant program within SAMHSA's Center for Substance Abuse Prevention. This initiative would help enhance collaboration between state alcohol and drug agencies and state education agencies to enhance their ability to partner on statewide planning and implementation of evidence-based, school-based prevention activities.

I'll end by noting I recently visited programs funded by STR in South Carolina and North Carolina to see how these dollars were making a difference in the battle to address the opioid crisis. This trip included a visit to the Charleston Center, which is in Charleston, South Carolina. This complex, which is supported in part by our South Carolina member, Sara Goldsby, and her department, offers all three FDA medications for opioid use disorders, residential services for pregnant and postpartum women, therapeutic services for kids, outpatient services, recovery support, and much more. The Program Director, Dr. Chandra Brown, concluded the tour by simply saying, "Thank God for STR."

Now, in addition to the Almighty, I thought I would take a minute to thank you, this Committee, and reiterate that your efforts are truly making a difference. We've lost too many lives. We have a lot more to do. But I believe our collective work is making a difference, and we can and will tackle this problem.

Thank you.

[The prepared statement of Mr. Morrison follows:]

PREPARED STATEMENT OF ROBERT MORRISON

Chairman Alexander, Ranking Member Murray, and Members of the Committee, my name is Rob Morrison and I serve as Executive Director of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Thank you for the opportunity to testify before the Committee today to discuss The Opioid Crisis Response Act.

About NASADAD: NASADAD is a private, not-for-profit educational, scientific and informational organization originally incorporated in 1971 and located in Washington, DC. NASADAD's mission is to promote effective and efficient state substance use disorder prevention, treatment and recovery systems. NASADAD seeks to:

- Serve as the national voice of state alcohol and drug agencies,
- Foster partnerships among states, Federal agencies and other key national organizations,
- Develop and disseminate knowledge of innovative substance use disorder programs policies and practices,
- Promote key competencies of effective state alcohol and drug agencies, and
- Promote increased public understanding of substance use disorder prevention, treatment and recovery processes and services.

In the process, NASADAD works closely with the National Governors Association (NGA). Governors across the country have been providing critical leadership regarding the opioid crisis. We appreciate NGA's recommendations related to the opioid issue that was released in January 2018 *(https://www.nga.org/files/live/sites/NGA/files/pdf/2018/OGR/NGA percent20Recommendations percent20for percent20Federal percent20Action percent202018.pdf).*

Further, we are pleased to coordinate with other state-based groups, such as the Association of state and Territorial Health Officials (ASTHO), the National Alliance for State and Territorial AIDS Directors (NASTAD), the Safe States Alliance, the National Association of State Mental Health Program Directors (NASMHPD) and many others.

Critical role of the state alcohol and drug agency: Each state's alcohol and drug agency plays a critical role in overseeing and implementing the publicly funded prevention, treatment and recovery service system.

Planning, oversight and accountability: To begin, all state alcohol and drug agency directors work to craft and implement annual plans for statewide program and service delivery. In the process, our members capture data and information describing top challenges, populations served and the types of services provided. State alcohol and drug agencies use such tools as performance management and reporting, contract monitoring, corrective action planning, onsite technical reviews and technical assistance.

Promoting quality: State agencies work to ensure quality services through state established standards of care. NASADAD members are dedicated to continuous quality improvement and participate in initiatives to promote innovative practices and programs. For example, state directors use data described above to help advance these practices and drive management decisions.

Management of the Substance Abuse Prevention and Treatment (SAPT) Block Grant: An important role played by NASADAD members is the management and oversight of the SAPT Block Grant—a $1.8 billion Federal formula grant that is allotted to NASADAD members. By statute, 20 percent of the SAPT Block Grant must be dedicated to critical primary substance abuse prevention programming. We have attached a two-page issue brief for the Committee's convenience that provides additional details regarding the SAPT Block Grant.

Promoting coordination across state government: NASADAD members promote cross-agency collaboration given the impact of alcohol and other drug use has on other sectors. For example, state directors engage with criminal justice entities on issues like offender reentry, drug court programs and diversion initiatives. State alcohol and drug agencies also coordinate with sectors related to child welfare, transportation, employment, education and others.

Unique relationship with the provider community: State alcohol and drug agencies have a very unique and important relationship with the provider community. State agencies observe this connection is critical given the increased pressures on those

delivering prevention, treatment and recovery services. NASADAD members assist providers by offering training, continuing education, oversight and other support.

Reporting data: The management of the SAPT Block Grant requires states to collect and report data describing the services and programs funded by this important funding stream. This data includes information on the number of people served by the SAPT Block Grant. In addition, states collect and report data to help demonstrate the positive impact services have on: reducing the use of alcohol and other drugs; the impact of services on employment status; the impact of services on criminal justice involvement and more.

States appreciate action taken by Congress to address the opioid crisis: NASADAD is appreciative of this Committee, along with Congress and the Administration in general, for work to address the opioid crisis.

We applaud passage of the 21st Century Cures Act which included the creation of a $1 billion fund for fiscal year 2017 and fiscal year 2018 to help state alcohol and drug agencies enhance treatment, prevention and recovery services. This funding, known as the State Targeted Response to the Opioid Crisis (STR) Grants, is supporting innovative and lifesaving programs across the country. We are also thankful for the additional resources provided to the Substance Abuse and Mental Health Services Administration (SAMHSA) in the fiscal year 2018 omnibus package that included an additional $1 billion to further enhance prevention, treatment and recovery efforts.

STR dollars at work: We include below of some specific state examples of STR grant dollars at work:

Tennessee: The funds prioritize addressing neonatal abstinence syndrome (NAS) given a tenfold increase in NAS in Tennessee over the past 10 years. STR funds will help expand access to services for pregnant women. The state is also moving forward to expand access to services through outpatient tele-health initiatives—an important initiative given the difficulties in reaching rural parts of the state. The funding is allowing the state to conduct Train-the-Trainer events on the Stanford Chronic Pain Self-Management Program (CPSMP)—an evidence-based approach to managing chronic health conditions that helps avoid readmissions. STR funds are also supporting a statewide media campaign and allowing the state to share resources and information to educate the public about the opioid crisis. The funds are supporting opioid overdose trainings and helping purchase and distribute overdose safety kits and naloxone to selected areas of the state.

Washington State: In Washington State, STR funds are expanding statewide access to Medication Assisted Treatment (MAT) and reducing unmet need by developing and implementing 6 Hub and Spoke model initiatives. Hubs are regional centers serving a defined geographical area. Spokes (there are five per hub) are facilities providing opioid use disorder treatment, primary health care, and wrap around services. STR grant funds are also supporting a collaboration with the Washington State Department of Corrections (DOC) to develop and operate programs. For example, one program is identifying incarcerated individuals with opioid use disorders, expected to be released, and connecting these individuals with MAT services in the county of their release and expedite their enrollment in an Medicaid health plan. STR grant funding is allowing the state to develop community prevention initiatives in 5 high need communities to support local strategic planning and decisionmaking to focus on addressing local needs by implementing evidence-based strategies and programs. STR is supporting the state to design, test and disseminate various public education messages that promote public education with tribes to meet their community needs.

Alaska: In Alaska, the STR grant has been distributed to launch office-based opioid treatment (OBOT) services to expand treatment to persons with an opioid use disorder, including those recently incarcerated, veterans, and young adults. For example, the Cook Inlet Council on Alcohol and Drug Abuse (CICADA) in Kenai received STR grant dollars to help provide comprehensive substance use disorder services, including Medication Assisted Treatment (MAT) for those struggling with an opioid use disorder. The Council partners with the Peninsula Community Health Services, a local federally Qualified Health Center (FQHC), to provide access to MAT and, in collaboration with community organizations, provide access to an array of comprehensive services. The STR grant provides technical assistance for physicians and care managers to address questions and concerns related to OBOT services. The STR grant has also facilitated reducing the amount of unused prescription opioids in Alaskan communities through the ongoing statewide distribution of medication deactivation disposal bags in communities. To date, 28,000 of these bags have

been distributed, successfully allowing Alaskans to destroy over 1 million opioid tablets.

Connecticut: In Connecticut, STR grant funds allowed the state to expand the number of hospitals, from 4 to 8, with on-call recovery coaches in their Emergency Departments. Through STR funding, the state alcohol and drug agency worked with the Department of Corrections (DOC) to implement MAT induction at the Osborne DOC pre-release center and to expand DOC's "Living Free" re-entry initiative that involves extensive in-reach, pre-release, followed by treatment during post-release. The STR funds are helping to expand the number of outpatient clinics that have MAT available with a subset of these clinics receiving support to provide employment services, peer coaching and case management. STR grant funds support important prevention efforts by providing 75 mini-grants to community coalitions with preference given to local prevention councils. STR also supports a peer prevention program in which youth facilitators coach their peers on skills to make healthy choices.

Georgia: STR funds in Georgia are supporting increased prevention, treatment and recovery services across the state's 5 Service Regions. The STR grant is supporting a school transition pilot program for opioid/prescription drug misuse and abuse prevention. STR funds will help implement recovery specialist programs in 2 hospital Emergency Departments. In addition, the state is directing STR funding to ensure fidelity to the Georgia Association of Recovery Residences recovery housing standards. Further, the funds are enabling a pilot program by the Department of Community Supervision to use vivitrol before release. The state is also utilizing STR dollars to support naloxone education for first responders, law enforcement and public safety.

Louisiana: The STR grant is Louisiana helped the state alcohol and drug agency enhance collaboration with providers across the state regarding opioid use disorders. For example, STR grant is supporting the existing Strategic Prevention Framework (SPF) infrastructure as a basis to prevention prescription drug misuse and abuse through statewide awareness and education campaign with special activities planned within the state's ten Local Governing Entities (LGE) and coordination with the state's 10 opioid treatment programs (OTPs). The STR grant supported collaboration between the state alcohol and drug agency and the State Department of Corrections (DOC) to allow treatment services for opioid use disorders for offenders participating in reentry programs at 2 designated facilities. The STR grant is also helping build capacity for the 10 LGE regions to increase access to recovery support specialists.

Missouri: STR funds in Missouri have been used to train 4,000 students on prescription opioid misuse prevention. These funds have helped over 1,600 uninsured individuals with opioid use disorders to receive evidence-based treatment services. Over 3,600 naloxone kits have been distributed to individuals at risk of experiencing or witnessing an overdose. Additionally, STR funds have afforded 8,000 providers and community members the opportunity to receive training on effective opioid use disorder prevention, treatment, and recovery strategies.

New Hampshire: In New Hampshire, STR grant funding is supporting the expansion of MAT in integrated care settings (substance use services, obstetrics, pediatric, and primary care) for pregnant and postpartum women. This includes parenting education and supports to hospitals dealing with neonatal abstinence syndrome (NAS), including funding for childcare to enable women to be able to participate in the programming. Additionally, STR funds support peer recovery support services for pregnant and parenting women. Grant funds are also being used for Regional Access Points across the state, which are in-person and telephone links to rapid evaluations and referrals to services, case management, continuous recovery monitoring.

North Carolina: The state has placed an emphasis on increasing the number of individuals gaining access to MAT and supportive services for opioid use disorders. The STR grant allocations are made largely to the Local Management Entities/Managed Care Organizations (LMEs/MCOs) and contracts then move forward to accomplish programmatic goals. The STR grant in North Carolina is helping purchase 6,600 naloxone kits statewide. The state is investing STR funds in recovery support services that include culturally and linguistically appropriate services that assist individuals and families working toward recovery. The state is including such services as peer coaching and mentoring, services to aid in accessing sober housing, life coaching, and more as identified through individual comprehensive clinical assessments and person-centered treatment and recovery plans. In addition, North Carolina is investing STR funds to expand effective prevention strategies for non-medical

use of prescription drugs in high need counties. This includes support for local community coalitions to address prescription drug misuse.

South Carolina: The STR grant in South Carolina is supporting the expansion of peer support specialists to facilitate the transition from prisons and jails back to the community in Anderson and Spartanburg counties. In addition, peer support specialists shall work with hospital Emergency Departments to help connect overdose survivors to services post release. STR funds are supporting the development of community recovery centers in York County and Horry County. The grant is also supporting the statewide multi-media campaign that will include Public Service Announcements (PSAs) in Columbia, Charleston, Myrtle Beach/Florence and Greenville. South Carolina is also directing STR funds to help expand clinically appropriate, evidence-based practices for adolescents with opioid use disorders by supporting the Adolescent Community Reinforcement Approach/Assertive Continuing Care model in Horry and Pickens Counties.

Virginia: In Virginia, STR grant funding is supporting 25 community-based treatment providers to help serve individuals with MAT and other clinical supports to address their opioid use disorder. The grant supported the purchase of 3,664 units of Narcan (1,600 for local departments of health to distribute and 2.064 for state Police to carry). These funds supported the development of a video-training curriculum about opioid use disorders for child protective service workers and early intervention home visitors. STR has supported a Recovery Warm Line in each of Virginia's five health planning regions. In addition, STR grant funds help support community coalition building in at least 25 communities.

More on the importance of Cures and CARA: The 21st Century Cures Act also included key provisions reauthorizing SAMHSA. This included the reauthorization of programs within SAMHSA's Center for Substance Abuse Treatment (CSAT), Center for Substance Abuse Prevention (CSAP), Center for Behavioral Health Statistics and Quality (CBHSQ), and the creation of the National Mental Health and Substance Use Policy Laboratory. NASADAD supports actions to ensure a strong SAMHSA and appreciates the leadership of Dr. Elinore McCance-Katz, who serves as Assistant Secretary for Mental Health and Substance Use—a position created by the 21st Century Cures Act. NASADAD is grateful for the Committee's work to pass the Comprehensive Addiction and Recovery Act (CARA), which authorized programs seeking to promote a coordinated and multi-sector approach to address the opioid crisis. CARA created several important initiatives, including:

Improving Treatment for Pregnant and Postpartum Women (Section 501): Reauthorized the Residential Treatment for Pregnant and Postpartum Women program to help support family centered treatment services—where women and their children can receive the help they need together in a residential setting. CARA also created a pilot program to afford state alcohol and drug agencies flexibility in providing new and innovative family centered substance use disorder services in non-residential settings. Earlier this year, Virginia, Massachusetts and New York were the first three states to receive resources for this pilot.

State Demonstration Grants for a Comprehensive Opioid Response Grant (Section 601): This initiative is designed to help promote coordinated planning on issues related to substance use disorders for those involved with the criminal justice system. For state applications for this grant, there is an emphasis on coordination between an applicant's state alcohol and drug agency and its corresponding state administering authority for criminal justice.

Community Coalition Enhancement Grants (Section 103): This section authorizes the Office of National Drug Control Policy (ONDCP), in coordination with SAMHSA, to make grants to community anti-drug coalitions to implement community-wide strategies to address their local opioid and methamphetamine problem.

Building Communities of Recovery (Section 302): Authorizes SAMHSA to award grants to recovery community organizations (RCOs) to develop, expand and enhance recovery services, RCO's across the country are doing an excellent job of helping individuals with the assistance they need to once again contribute to their families, employers and communities.

States are now working diligently to implement these and many other important provisions authorized in CARA and Cures.

NASADAD's overarching recommendations:

- *Ensure provisions work through state alcohol and drug agencies to promote coordination and avoid creating parallel, duplicative, or bifurcated systems of care:* As noted earlier, state alcohol and drug agencies play a

critical role in overseeing and implementing a coordinated prevention, treatment and recovery service system. These agencies develop annual statewide plans to ensure an efficient and comprehensive system. Further, state alcohol and drug agencies promote effective systems through oversight and accountability.

A core recommendation for the Committee's consideration is to ensure Federal programs and policies designed to address substance use prevention, treatment and recovery flow through the state alcohol and drug agency. This approach allows Federal initiatives to enhance and improve state systems and promotes an effective and efficient approach to service delivery. Federal policies and programs that do no link with the state agency run the risk of creating parallel or even duplicative publicly funded systems and approaches.

- *Ensure consistent, predictable and sustained resources to avoid a financial cliff*: As indicated earlier, NASADAD appreciates the resources provided by Congress to support prevention, treatment and recovery services. state alcohol and drug agencies appreciate the $1 billion in STR grants initially authorized in the 21st Century Cures Act. NASADAD applauds Congress for its work in raising the caps and passing the Bipartisan Budget Act of 2018 which paved the way to clear a final fiscal year 2018 omnibus appropriations bill. This bill included the second installment of STR grants and added $1 billion for states to continue this critical work.

  This predictable and sustained provision of resources is key to allow states and providers to plan and rely on future year commitments. It can be difficult if not impossible to successfully plan and operate programs if providers are not confident resources will be available beyond a 1-year commitment. NASADAD strongly supports NGA's call to extend the duration of Federal grants beyond the typical one-or 2-year funding cycle.

  Further, the financial burden associated with substance use disorders is staggering. The National Institute on Drug Abuse (NIDA) estimates that illegal drugs, alcohol, and tobacco cost society roughly $700 billion every year or $193 billion for illegal drugs, $224 billion for alcohol, and $295 billion for tobacco. According to SAMHSA's 2016 report, National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2014, expenditures for substance use disorder services represented only 1.2 percent of all health expenditures in 2014.

  As we look at the SAPT Block Grant, this critical program has not kept up with health care inflation. In particular, over the past 10 years, the SAPT Block Grant has experienced a 29 percent decrease in the real value of funding. In order to restore the SAPT Block Grant to the purchasing power the program had in 2006, Congress would need to allocate an additional $542 million to the SAPT Block Grant in fiscal year 2019.

  Yet the National Institute on Drug Abuse (NIDA) notes that for every dollar spent on substance use disorder treatment programs, there is an estimated $4 to $7 reduction in the cost of drug related crimes. With outpatient programs, total savings can exceed costs by 12 to 1. Substance abuse prevention is also a cost-effective way to reduce the financial burden of substance abuse and substance use disorders. According to the Surgeon General's 2016 Report on Alcohol, Drugs, and Health, every $1 spent on effective, school-based prevention programs can save an estimated $18 in costs related to problems later in life.

- *Continue to work to address the opioid crisis but also elevate efforts to address all substance use disorders, including those linked to alcohol and other substances:* The opioid crisis is one of the worst public health tragedies in our Nation's history. The sheer volume of death linked to this epidemic is difficult to grasp. We also know this country faces distinct challenges related to all substances—whether it's prescription drug misuse, heroin, alcohol, marijuana, methamphetamine, cocaine or others. According to SAMHSA's National Survey on Drug Use and Health (NSDUH), alcohol remains the No. 1 problem in the country with 15 million Americans battling an alcohol use disorder. As we look at those receiving treatment, 36 percent of all admissions to treatment had a primary alcohol use disorder; 30 percent had a primary heroin or other opiate problem; 15 percent had primary marijuana use disorder. State directors in certain states are also observing increases in problems related to methamphetamine and cocaine. As a result, NASADAD promotes policies that can be

flexible yet also address the specific needs associated with the current opioid crisis. The flexibility included in the SAPT Block Grant also affords states the opportunity to target resources to address all substances.

- *Maintain a strong SAMHSA:* We support maintaining investments in SAMHSA as the lead agency within HHS focused on substance use disorders in general, and opioid use disorders in particular. The nation benefits from a strong SAMHSA given the agency's longstanding leadership in the field and the stewardship of Assistant Secretary McCance-Katz. NASADAD appreciates the role Assistant Secretary McCance-Katz plays in coordinating work across HHS to promote a coordinate Federal response to the opioid crisis.

  NASADAD also appreciates SAMHSA's focus on a healthy state-Federal partnership as the cornerstone of sound public policy. This theme is demonstrated through several important state-based programs support by SAMHSA in addition to the SAPT Block Grant. One example is the Strategic Prevention Framework (SPF) Partnerships for Success (PFS) Grants. These 5-year grants, administered by SAMHSA/CSAP, help states strengthen prevention capacity and infrastructure at the state level while addressing the state's top prevention priorities. The grants use a five-step model (assessment, capacity, planning, implementation, evaluation); promote the principles of cultural competency and sustainability; and enhance the link between state alcohol and drug agencies and community anti-drug coalitions to promote local solutions.

NASADAD's observations on selected provisions: NASADAD offers the following observations on the Committee's discussion draft based in part on those principles described above.

- *Reauthorization and Improvement of State Targeted Response Grants (Section 101).* NASADAD applauds the Committee for recognizing the need for predictable and sustained funding to address the opioid crisis by considering the reauthorization and improvement of the STR grants. As discussions on the provision move forward, we hope these resources would continue to align with the plan and work of state alcohol and drug agencies to continue the momentum gained to date from the STR grants. Further, NASADAD would be eager to engage in discussions regarding ways to utilize the SAPT Block Grant as an effective and efficient way to funnel resources through its well-established system.
- *Comprehensive Opioid Recovery Centers (Section 401):* NASADAD members certainly support the goal of enhancing access to holistic care and the array of services that help people enter recovery. This includes our strong support for access to Medication Assisted Treatment (MAT). NASADAD will continue to review the details of this proposal and work with the Committee. As noted above, consistent with the Association's principles, we would recommend Federal proposals flow through the state alcohol and drug agency to ensure coordination and maximize effectiveness and efficiency.
- *National Recovery Housing Best Practices (Section 403):* NASADAD applauds the provision that would require the Secretary of Health and Human Services (HHS) to identify or facilitate the development of best practices for operating recovery housing. We would hope that state alcohol and drug agencies would be specifically referenced as a stakeholder to help with the development of these models. NASADAD has been engaging in a dialog about this important issue with our members and other important groups such as the National Association of Recovery Residences (NARR). NARR's mission is to support persons in recovery from substance use disorders by improving their access to quality recovery residences. In 2011, NARR released a national standard for recovery residences. This standard defines the spectrum of recovery oriented housing and services and distinguishes four different types, which are known as levels or levels of support. This work was then updated in 2015. We hope the Committee consider NARR as a valuable partner in this effort.
- *Addressing Economic and Workforce Impacts of the Opioid Crisis (Section 404):* NASADAD is still reviewing the details and assessing the implications associated with this section. There is certainly no doubt that substance use disorders impact job performance or cause people to be underemployed or unemployed. We are also aware of jobs that remain unfilled

because certain skilled workers are unable to pass a drug test. As the Association dialogs with the members and others about this provision, NASADAD will continue to support the creation of Federal programs that flow through or collaborate with the state alcohol and drug agency. This ensures the enhancement of the state system as opposed to the creation of a duplicative or parallel set of services.

- *Plans of Safe Care (Section 406):* We support the provision that proposes to amend the Child Abuse Prevention and Treatment Act (CAPTA). Specifically, this provision would authorize grants to help state child welfare agencies, state alcohol and drug agencies and others facilitate collaboration in developing, updating and implementing plans of safe care. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) Research Brief, The Relationship between Substance Use Indicators and Child Welfare Caseloads, found that nationally "rates of drug overdose deaths and drug-related hospitalizations have a positive relationship with child welfare caseload rates. After accounting to county socioeconomic and demographic characteristics, counties with higher overdose death and drug hospitalization rates have higher caseload rates." As a result, we look forward to working with you on this important issue.
- *Loan Repayment for Substance Use Disorder Treatment Providers (Section 410):* We applaud the discussion draft's inclusion of a provision to help with our Nation's substance use disorder workforce. Specifically, we support the provision that would authorize funding for a loan repayment program for substance use disorder treatment providers. There is no doubt that more must be done to bolster our Nation's substance use disorder workforce. This is particularly true in our rural and frontier states. As the Committee deliberates on the discussion draft, we would like to offer our assistance in promoting support for our substance abuse prevention workforce as well. State alcohol and drug agencies seethe value in utilizing Certified Prevention Specialists (CPS). These certified professionals are trained in industry standards and evidence-based practices and represent an important component of the field.
- *Surveillance and Education Regarding Infections Associated with Injection Drug Use and Other Risk Factors (Section 510):* We support the provision seeking to improve data and therefore our knowledge about infections associated with injection drug use and other risk factors. According to the Centers for Disease Control and Prevention (CDC), 30 states are experiencing, or at risk for, significant increases in viral hepatitis or an HIV outbreak due to injection drug use. In addition, between 2004 and 2014, the CDC found that admissions to substance use treatment programs for those who inject opioids increased by 93 percent while acute hepatitis rose in parallel by 133 percent. As mentioned earlier, we appreciate our partnership with NASTAD at the national level and engage in work to promote similar collaboration between our members at the state level.

NASADAD's considerations for additional provisions: NASADAD appreciates the tremendous amount of work that went into developing the discussion draft. We also appreciate the Committee's request for additional ideas to help strengthen the draft. We offer the following recommendations for consideration:

- *Enhancing School-based Substance Abuse Prevention Through Coordination Between State Alcohol and Drug Agencies and State Educational Agencies:* Substance abuse prevention programs and activities are critical given the benefits of delaying the use of alcohol and other drugs during adolescence. For example, compared to youth who wait until their 20's to initiate alcohol use, adolescents who initiate by 15 years of age are five times more likely to abuse alcohol or become dependent (Grant & Dawson, 1997). State alcohol and drug agencies recognize the fact that the education system represents an important partner given the importance of school-based prevention activities. As a result, NASADAD recommends the authorization of a grant program within SAMHSA/CSAP to enhance collaboration between state alcohol and drug agencies and state educational agencies to enhance their capacity to support the implementation of effective, school-based substance abuse prevention activities. This would also help support a comprehensive planning process in addition to the implementation of evidence-based programs.

- *Recovery coaching in the emergency department:* On November 30, 2017, NASADAD Board Member Rebecca "Becky" Boss, State Director in Rhode Island, presented testimony during a hearing before this very Committee. Director Boss discussed the 2014 launch of a pilot program developed in Rhode Island using recovery coaches to respond to overdose survivors while they were receiving treatment in hospital Emergency Departments. She noted that on-call coaches respond to overdose survivors and offer support, referrals, resources, family support and training on naloxone. Becky noted that the coaches helped engage clients with an 85 percent follow-up rate with treatment and/or recovery support services. We understand there are proposals in the House and Senate to enhance the use of this model. We support these initiatives and recommend that any final version (1) specifically references coordination with and connection to state alcohol and drug agencies and (2) ensures the program is placed within SAMHSA.

Thank you: Thank you very much for inviting NASADAD to testify. We look forward to working with the Committee as the process moves forward.

NASADAD
National Association of State Alcohol and Drug Abuse Directors
May 2017
1919 Pennsylvania Ave NW, Ste. M-250 • Washington, DC 20006 • T: (202) 293-0090 • F: (202) 293-1250 • Website: www.nasadad.org

Substance Abuse Prevention and Treatment (SAPT) Block Grant

SAPT Block Grant Funding

- FY 2017: $1.858 billion
- FY 2016: $1.858 billion
- FY 2015: $1.820 billion
- FY 2014: $1.820 billion
- FY 2013: $1.710 billion (after 5% sequestration cut)
- FY 2012: $1.779 billion (Congress appropriated $1.8 billion, but HHS redirected $21.5 million to other programs)
- FY 2011: $1.783 billion
- FY 2010: $1.799 billion
- FY 2009: $1.779 billion

Overview

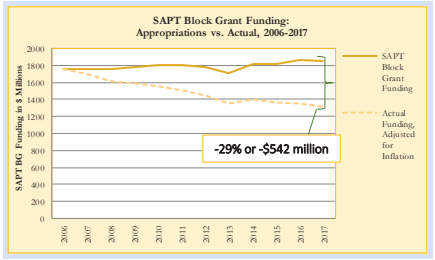
The Substance Abuse Prevention and Treatment (SAPT) Block Grant is distributed by formula to all States and Territories. **It is the cornerstone of States' substance abuse prevention, treatment, and recovery systems**. The SAPT Block Grant is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), within the Department of Health and Human Services (HHS).

SAPT Block Grant Outcomes

According to SAMHSA's Substance Abuse Prevention and Treatment Block Grant Program Profile, **SAPT Block Grant funds annually provide treatment services for 1.5 million Americans**. At discharge from block grant-funded programs, 70% of clients demonstrate abstinence from illegal drug use and 83% are abstinent from alcohol use. Additionally, of clients discharged from treatment, 89% have stable housing, and 93% have had no arrests.

Funding Decreasing over Time

The SAPT Block Grant is a critical safety net program. **Over the last 10 years, SAPT Block Grant funding has not kept up with health care inflation, resulting in a staggering 29% decrease in the real value of funding by FY 2017 (to $1.312 million)**. As inflation increases, the actual purchasing power of the same funding decreases. In order to restore the SAPT Block Grant's 2006 purchasing power, Congress would need to allocate an additional $542 million for FY 2018. As States work to maintain their systems with fewer resources, the demand for services continues to rise. According to the National Survey on Drug Use and Health (NSDUH), past month use of illicit drugs has been on the rise over the past decade, increasing from 8.3% of individuals aged 12 or older in 2006 to 10.1% in 2015.



Financial Burden of Substance Use Disorders

According to NSDUH, 21.7 million people aged 12 or older needed treatment for an alcohol or illicit drug use problem in 2015 (met criteria for abuse or dependence). During the same year, only 3 million received treatment for such a problem. As a result, over 18 million Americans needed but did not receive services for a substance use problem in 2015. The economic impact of substance use disorders is staggering. The **National Institute on Drug Abuse (NIDA) estimates that illegal drugs, alcohol, and tobacco cost society roughly $700 billion every year** or $193 billion for illegal drugs, $224 billion for alcohol, and $295 billion for tobacco.

Substance Use Disorders Represent Tiny Fraction of Overall Health Expenditures

According to SAMHSA's 2016 report, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2014*, spending on substance use disorders decreased as a share of all health spending from 2.0 percent in 1986 to 1.1 percent in 2002, and remained stable ever since. **Expenditures for substance use disorder services represented only 1.2% of all health expenditures** in 2014. That translates to approximately $34 billion for substance use disorders vs. $3.2 trillion for all health expenditures.

Investments in Substance Abuse Saves Money

In 2006, the National Institute on Drug Abuse (NIDA) noted that for every dollar spent on substance use disorder treatment programs, there is an estimated $4 to $7 reduction in the cost of drug related crimes. With outpatient programs, total savings can exceed costs by 12 to 1. Substance abuse prevention is also a cost-effective way to reduce the financial burden of substance abuse and substance use disorders. According to the Surgeon General's 2016 *Report on Alcohol, Drugs, and Health*, every $1 spent on effective, school-based prevention programs can save an estimated $18 in costs related to problems later in life.

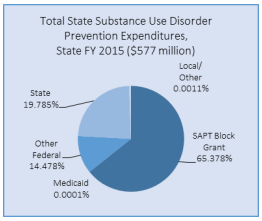
SAPT Block Grant Produces Results

An independent study of the SAPT Block Grant, released in June 2009, found that the program was effective in:

1) Producing positive outcomes as measured by increased abstinence from alcohol and other drugs, increased employment, decreased criminal justice involvement, and other indicators;
2) Improving States' infrastructure and capacity;

NASADAD

3) Fostering the development and maintenance of State agency collaboration; and
4) Promoting effective planning, monitoring, and oversight.



Prevention Matters: SAPT Block Grant Prevention Set-Aside

Federal statute requires States to direct at least 20% of SAPT Block Grant funds toward primary prevention of substance abuse. This "prevention set-aside" is managed by the Center for Substance Abuse Prevention (CSAP) within SAMHSA, and is a core component of each State's prevention system. On average, **SAPT Block Grant funds make up 65% of primary prevention funding in States and Territories**. In 18 States, the prevention set-aside represents 75% or more of the State agency's substance abuse prevention budget. In 4 of those States, the prevention set-aside represents 100% of the State's primary prevention funding.

SAPT Block Grant and Vulnerable Populations

States using SAPT Block Grant funds must provide additional protections and/or funding for certain vulnerable populations that are identified in statute. Priority populations include: pregnant and parenting women, injection drug users, individuals with HIV/AIDS, and individuals with tuberculosis (TB).

Pregnant and Parenting Women

Pregnant women must be given priority in treatment admissions, and those that are referred to the State for treatment must be placed within a program or have interim arrangements made within 48 hours. Further, States are required to allocate a dedicated amount of SAPT Block Grant funds to support pregnant and parenting women.

Persons Who Inject Drugs

SAPT Block Grant funded treatment programs that serve persons who inject drugs must keep the State informed about their admissions capacity. This allows the State to monitor whether individuals are placed into treatment in a timely manner or provided with interim services if an opening is temporarily unavailable.

Individuals with HIV/AIDS

For States with HIV infection rates of 10 or more per 100,000, early HIV intervention services must be provided to individuals undergoing substance use disorder treatment. These services are to be available in the areas of the State with the highest disease burden. Early intervention services include pre-testing counseling, testing, post-testing counseling, and appropriate treatment.

Individuals with Tuberculosis (TB)

SAPT Block Grant funded treatment programs must directly (or through arrangements) make tuberculosis services available to everyone who receives treatment. TB services include counseling, testing, and clinically appropriate treatment.

SAPT Block Grant Funds Treatment Services: Prescription Drug and Heroin Use on the Rise (TEDS, 2014)

As noted below, almost one-third (30.3%) of individuals admitted to treatment in the publicly-funded system cited heroin or prescription opioids as their primary substance of use. In 2014, admissions for heroin addiction exceeded admissions for alcohol alone as primary substance of use. According to NASADAD data, in 2015, 39 States reported an increase in treatment admissions for heroin. In addition to the troubling increase in treatment admissions, opioid overdose deaths have also been on the rise—in 2015, over 33,000 Americans lost their lives to a prescription opioid or heroin overdose.

Primary Substance	% (estimate)
Heroin	22.1% (357,293)
Alcohol only	20.3% (327,694)
Marijuana	15.3% (247,461)
Other Opiates	8.2% (132,387)
Amphetamines	8.9% (144,427)
Cocaine (smoked)	3.6% (57,493)
Cocaine (other route)	1.9% (30,017)
PCP	0.3% (4,910)
Hallucinogens	0.1% (1,864)
Inhalants	<.05% (791)

Age at Admission	% (estimate)
12-17	4.8% (77,812)
18-24	16.6% (268,319)
25-29	17.2% (276,860)
30-34	15.1% (242,742)
35-39	10.9% (175,051)
40-44	9.4% (151,336)
45-49	9.5% (153,383)
50-54	8.5% (137,574)
55-59	4.9% (79,559)
60 and older	3.0% (48,211)

Race/Ethnicity	% (estimate)
White	62.3% (981,107)
Black/Afr American	17.9% (281,403)
Am Ind/AK Native	2.5% (38,959)
Asian/Pac Islander	1.0% (16,529)
Hispanic	13.0% (205,564)
Other	3.3% (51,648)

Gender	% (estimate)
Male	66.4% (1,068,950)
Female	33.6% (541,502)

Role of State Substance Abuse Agencies

NASADAD represents State substance use disorder agency directors from the fifty States, the District of Columbia, and the five U.S. Territories. States work with counties and local communities to ensure that public dollars are dedicated to effective programs using tools such as: performance data management and reporting, contract monitoring, corrective action planning, onsite reviews, and technical assistance to community coalitions. State substance abuse agencies work with providers to use evidence-based prevention practices.

NASADAD Contact Information: Robert Morrison, Executive Director, (202)293-0090 or rmorrison@nasadad.org.
Shalini Wickramatilake-Templeman, Federal Affairs Manager, (202) 293-0090 or swickramatilake@nasadad.org.

[SUMMARY STATEMENT OF ROBERT MORRISON]

About NASADAD: NASADAD is a private, not-for-profit organization that promotes effective and efficient State substance use disorder (SUD) prevention, treatment and recovery systems. NASADAD seeks to: serve as the national voice of State alcohol and drug agencies; foster partnerships among States, Federal agencies and other national organizations; develop and disseminate knowledge of innovative SUD programs policies and practices; and promote key competencies of effective State alcohol and drug agencies.

Critical role of the State alcohol and drug agency: Each State's alcohol and drug agency plays a critical role in overseeing and implementing the publicly funded prevention, treatment and recovery service system. In addition to planning and oversight, these State agencies: ensure quality services through State-established standards of care; manage the Substance Abuse Prevention and Treatment (SAPT) Block Grant; promote coordination across State government; maintain a unique relationship with providers by offering training, continuing education, oversight, and other support; and collect and report data that describes the services/ programs in the publicly funded system.

States appreciate action taken by Congress to address the opioid crisis: NASADAD applauds passage of the 21st Century Cures Act and the resulting State Targeted Response to the Opioid Crisis (STR) Grants. The State alcohol and drug agencies are working diligently to use these STR funds to enhance evidence based prevention, treatment, and recovery services for individuals impacted by the opioid crisis. NASADAD is also grateful for the Committee's work to pass the Comprehensive Addiction and Recovery Act (CARA). CARA created several initiatives. States are working to implement the many important provisions authorized in CARA.

NASADAD's overarching recommendations:

- Ensure provisions work through and coordinate with State alcohol and drug agencies to promote efficient and effective systems and avoid creating parallel, duplicative, or bifurcated systems of care.
- Ensure consistent, predictable and sustained resources to avoid a fiscal cliff by extending the duration of Federal grants beyond the typical one- or 2-year funding cycle.
- Continue to work to address the opioid crisis but also elevate efforts to address all SUDs.
- Maintain investments in SAMHSA as the lead agency within HHS focused on SUDs.

NASADAD's observations on selected provisions of the Opioid Crisis Response Act:

Reauthorization and Improvement of STR Grants: NASADAD applauds the Committee for considering the reauthorization and improvement of the STR grants. As discussions on the provision move forward, we hope these resources would continue to align with the plan and work of State alcohol and drug agencies. NASADAD is eager to discuss how the SAPT Block Grant could also be utilized to efficiently direct funds to support service delivery.

National Recovery Housing Best Practices: We applaud this provision and hope that State alcohol and drug agencies would be specifically referenced as a stakeholder to help with the development of these models.

Plans of Safe Care: We support the provision and look forward to working to address SUDs in child welfare system.

Loan Repayment for Substance Use Disorder Treatment Providers: We applaud this provision that supports loan repayment for SUD treatment providers, and recommend support for substance abuse prevention workforce as well.

Surveillance and Education Regarding Infections Associated with Injection Drug Use: We support this provision that seeks to improve data and therefore our knowledge about infections associated with injection drug use.

NASADAD's recommendations for additional provisions:

Enhancing school-based substance abuse prevention through enhanced agency collaboration: NASADAD recommends the authorization of a grant program within SAMHSA/CSAP to enhance collaboration between State alcohol and drug agencies and State educational agencies to enhance their capacity to support the implementation of effective, school-based substance abuse prevention activities.

The CHAIRMAN. Thank you, Mr. Morrison.
Ms. Nickel, welcome.

STATEMENT OF JESSICA HULSEY NICKEL, PRESIDENT AND CEO, ADDICTION POLICY FORUM, WASHINGTON, DC

Ms. NICKEL. Thank you, Chairman Alexander, Ranking Member Murray, and Members of the Committee, for your focus on this important issue, and I'm honored to be here with you today.

My name is Jessica Hulsey Nickel, and I'm the President of the Addiction Policy Forum. I started APF to focus on a comprehensive response to this issue that has prevention, treatment, recovery, overdose reversal, law enforcement, and criminal justice at the table, but also has families and patients at the table. We have one goal: a world where fewer lives are lost and help exists for the millions of Americans that are affected by addiction.

I'm grateful to discuss this issue and also pleased with the many provisions and amazing ideas found in the Opioid Crisis Response Act, and I'm here to be supportive as that legislation moves forward.

I know firsthand what this crisis does to families. I've actually been in this field for 27 years, which gives away my age, so I try not to mention that all the time. But I lost both of my parents to heroin use disorder, and as a child impacted by this disease, for me, that meant homelessness and hunger. It meant foster care and, ultimately, being raised by my maternal grandparents.

I lost my dad when he was 48, and he never made his way out of this disease and died on the streets. I lost my mom when she was 50 because of the long-term health consequences of addiction, even though she was in recovery at the time. I'm not alone. There are millions of families like mine that are suffering and isolated and looking for help and not always able to find it every single day.

We lose 174 people every day to drug overdoses in this country. That's like a plane crash every day. Now, if there was actually a plane crash, we'd have sort of things that we could do. We would fix that air traffic issue. But, as Chairman Alexander mentioned, this is a complicated issue, and it requires multiple committees and agencies and all of us to come together in a different and a new way to tackle this disease.

I think it's important to remember the individuals and the families that are at the epicenter of this crisis. So I'd like to take a few minutes to share stories from our families.

This is Courtney. Doug and Pam lost their daughter, Courtney, when she was just 20 years old. He describes Courtney as a shining star. The room lit up when she walked in, and everyone loved her. We were told that because it's not a matter of life or death, there would be no coverage for treatment, and on the advice of local authorities, they were told that they should ask her to leave their home and cancel her insurance so she would be homeless. By doing this, she could be eligible to receive treatment. Courtney died alone, away from home, the day before she was scheduled to enter treatment.

Lorraine describes her brother, Larry, her twin brother, as amazing, charming, funny, popular, and the most talented drummer you've ever heard. Larry died from a drug overdose, leaving behind

his 1-year-old son, who Lorraine raised, making her a single parent overnight.

This is my friend, Aimee, and her son, Emmett. He died of a drug overdose at just 20 years old. He was in college, studying computer science. He liked BMX bikes, taught Sunday school, and Emmett was a hero to his younger siblings, Zachery and Alice.

After they lost Emmett, they found out that he had seven overdoses reversed at local hospitals, seven. But family had never been notified, primary care had never been notified, healthcare systems within the college campus had not been notified or engaged. So we had seven missed opportunities to get Emmett the help that he needed.

This is Dylan. My friend Jennifer lost Dylan when he was just 19. She says, "Every day when I walk into my house, I see Dylan's shoes sitting on the floor where he kicked them off and his jacket draped across the bannister where he left it," and she can't move those. He will never have a chance to get married, to have kids, to travel, to do all the things that a 19-year-old should have the chance to experience.

I commend the Committee for your leadership on these issues, and I cannot tell you how important that leadership is for us, the millions of families that want to see a different path forward for our families, for our loved ones, for people in recovery, our whole community. There are many components of the Opioid Crisis Response Act that are critical to see moved forward, to be out in our communities to help us improve care for our patients and families, and we're here as a partner and a resource as families and patients any time we can be of help.

It gives us hope to see leadership from Congress to move this in a direction that treats this disease with new advancements in medicine, with treatments, with medications to treat the disease of addiction, and a comprehensive response that includes all these key components. So we're very grateful to you for your time.

[The prepared statement of Ms. Nickel follows:]

PREPARED STATEMENT OF JESSICA HULSEY NICKEL

I would first like to thank Senate Health, Education, Labor and Pensions Committee Chairman Lamar Alexander, Ranking Member Patty Murray, and the Members of the Committee for hosting this series of hearings and for inviting me to testify on behalf of important legislation that can help address our Nation's addiction crisis.

My name is Jessica Hulsey Nickel, and I am the President of the Addiction Policy Forum. I started the non-profit to help patients, families and stakeholders across the country advocate for a comprehensive response to addiction—including prevention, treatment, recovery, overdose reversal, criminal justice reform and law enforcement. We convene key partners from throughout the field around one table with a shared goal: to help create a world where fewer lives are lost to addiction and help exist for the millions of Americans who need it.

I am grateful to be with you today to discuss the need for a comprehensive response to address the addiction crisis. I know firsthand the devastating impact that addiction can have on families. Both of my parents struggled with heroin addiction and ultimately lost their lives to this preventable, treatable disease. My story is just one of the millions repeated daily across our nation—and I have heard these stories from the thousands of mothers, fathers, sisters, brothers and other loved ones who have reached out to the Addiction Policy Forum in need, in grief, in hope and wanting to be a part of the solution to this crisis.

Last December the Centers for Disease Control (CDC) released a haunting report stating that over 63,300 people died from a drug overdose in 2016—a 21 percent

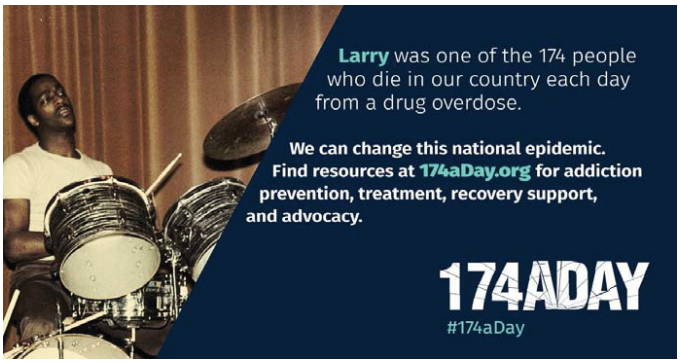
increase from the previous year, largely due to an increase in opioid overdose deaths.

In 2016, 174 people died every day from a drug overdose in our country. 174. That's equivalent to more than two commuter planes crashing every day for an entire year. But you can bet that if those planes were actually going down the FAA would stop operations until they found out exactly what was going on. Addiction is a more muted killer. In 2016, the Addiction Policy Forum launched the 129aDay campaign to honor those we have lost and their families, who sit at the epicenter of this crisis. Each year, we update the campaign to reflect the increasing number of lives that are lost each year. The latest data available show 174aDay and all indications suggest that this number is continuing to rise.

Amidst the horrific numbers, it's important to put real faces to the scope of this crisis and I'd like to take a moment to share the stories of some of our families.

Doug lost his daughter, Courtney, when she was just 20 years old. He describes Courtney as "a shining star. The room lit up when she walked in and everyone loved her." Doug writes: "We were told that because 'it is not a matter of life or death' there would be no coverage for treatment. On the advice of our local authorities, we asked [Courtney] to leave our home and canceled her insurance. By doing this, she would be homeless and then could be eligible to receive treatment. Courtney died alone, away from our home and the day before she was scheduled to enter a treatment facility."

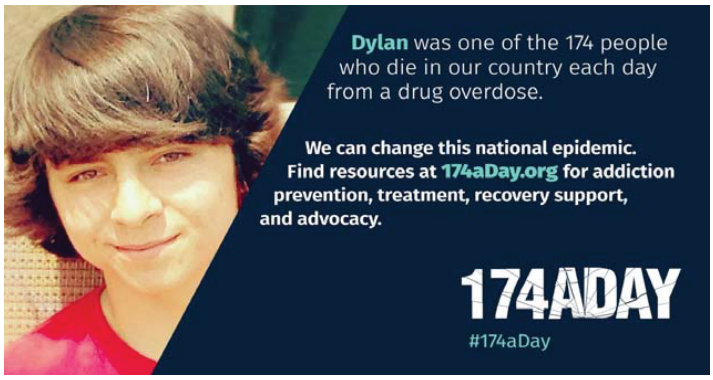
Lorraine describes her twin brother, Larry, as "amazing, charming, funny, popular and the most talented drummer you've ever heard." Larry died from a drug overdose almost 30 years ago, leaving behind his 1-year old son, who Lorraine raised as a single parent.



Aimee describes her son, Emmett, as "the average American teen; he loved video games and BMX biking. He was a caring, funny, smart young man with the potential for greatness. He was the adored older brother to Zachary (age 18) and Alice

(age 9). He had a smile and charm that could light up a room—but heroin stole that from him, and from us."

Jennifer describes the day her son, Dylan, died: "I don't remember much about that day, but I do know that my life will never be the same. Every day when I walk into my house, I see Dylan's shoes sitting on the floor where he kicked them off and his jacket draped across the banister where he left it. We will never have another one of our midnight snacks. He will never have the chance to get married, have kids, travel and do all of the things that a 19-year-old should have the chance to experience."



Of the 21 million people that need treatment for a substance use disorder, only about 10 percent will receive it. Ten percent. Can you imagine a world where only 10 percent of cancer, Alzheimer's, or diabetes patients got the treatment they needed? We lose 174 sisters, sons, husbands, daughters, and mothers every single day.

A Comprehensive Response to Addiction

As a community of families, patients and key stakeholders, we have long been advocating for a comprehensive response to addiction in this county and are excited to see this approach reflected in the numerous legislative proposals that are being considered.

Last year, through rigorous dialog and consideration, we identified key priorities for action and we are grateful to this Committee and its Members for focusing on so many of the following crucial components.

1. Help Families in Crisis

In our field there is a profound lack of accurate resources and guidance available for individuals and families who are in crisis and need proper treatment and care. We consistently hear families describe desperate, agonizing attempts to get help-turning to Google to search for treatment options and basic information, reaching out to physicians or local contacts who have neither answers nor referrals, not

knowing who to call without being judged, or calling what seemed like leads but turn out to be dead ends with no capacity and a 3-month wait list, no insurance coverage, or the haunting drone of a disconnected number.

Additionally, there is a lack of readily available information regarding what we do know about substance use disorders in all of their complexity. Addiction shares many features with other chronic illnesses such as diabetes, cancer and heart disease, including a tendency to run in families, an onset and progression that is influenced by behavior and an ability to respond to appropriate treatment, which can include both medication and lifestyle modifications. Even relapse rates for substance use disorders are similar to those of comparable chronic illnesses. There is also an alarming lack of cultural understanding with regard to what we know about effective treatment, recovery, prevention, early intervention, overdose reversal and other key topics.

2. Expand Treatment Access and Integration into Healthcare

Substance use disorder (SUD) remains one of the only illnesses that is treated outside of general healthcare systems. Because of this there is little, if any, communication between specialty SUD treatment providers and primary care doctors. This affects the overall quality of care and health outcomes of the patient. We need to close the gap between the number of people who need treatment for an SUD and the number of people who actually receive it.

Evidence-based SUD treatment needs to be integrated into general healthcare systems, including primary care, emergency departments, inpatient, mental health programs, etc. Ideally, SUD would be treated like any other chronic, relapsing disease. Patients could receive treatment and care coordination from their primary care doctor, who would bring in specialty providers as needed, as would be the case for a patient diagnosed with diabetes or heart disease.

Studies have shown that the mainstream healthcare workforce is inadequately trained to deal with SUD-related issues, and that the substance-use-related workforce does not currently have the capacity to handle the population of patients who need care.

Major investments are needed in both arenas if a proper and sustainable integration of care delivery is to take place. Because physical health conditions impact and are impacted by SUDs integrating substance-use-related services in healthcare systems promises to add value to both systems, reduce health disparities and costs. and improve general health outcomes.

Healthcare systems have many shoes to fill in the configuration of a comprehensive, effective plan to address SUDs: expand efforts to identify patients in need of treatment; integrate comprehensive assessments for patients who screen positive for substance use problems; treat patients along the wide spectrum of SUD severity, including intervening early when substance misuse is identified in order to curtail escalation of the disorder and related health consequences; connect patients with the appropriate treatment provider and proceed to coordinate care across both healthcare and social services systems (criminal justice, housing and employment support, child welfare); and implement long-term patient monitoring and recovery support follow-up.

3. Drive Discovery in Research and Cures

Innovative scientific advancements in the field from many arenas within phromacotherapy and technology are emerging, but funding for research remains scant and the number of addiction-related scientists too few. As a result. new discoveries that could help people struggling with SUD are slow to emerge.

To achieve our vision of a world free of addiction and all of its associated burdens we must dramatically increase research investments in order to attract and enable experts throughout the scientific, medical and technology communities to work together to accelerate progress.

4. Expand Recovery Supports

While evidence strongly suggests that effective treatment and recovery plans should cover a span of at least three to 5 years for an individual based on their needs and the severity of their disorder, we have a long way to go to adequately prioritize and fund the quality and amount of recovery support programs and resources needed in every community. Today, 23 million Americans are in recovery from SUD. As we work toward closing the treatment gap by providing services for more individuals who need them, investing in the necessary framework for sustained recovery is critical.

Key components of recovery-ready communities include a variety of programmatic supports, including recovery community organizations, alternative peer groups, col-

legiate recovery programs, jail and prison-based recovery, peer recovery coaching, medication-assisted recovery support, mutual aid groups, recovery high schools, recovery housing, and technology and tools for recovery support.

5. Advance Evidence-Based Prevention

We know that 90 percent of individuals with a SUD started using substances in adolescence. Increasing the age of initiation is key to ensuring that fewer people develop an addiction.

There are numerous evidence-based prevention interventions that have been shown to not only prevent or delay the onset of substance use, but also help prevent broader behavioral health problems. Early interventions can also help to prevent problematic substance use from progressing to a use disorder. Advancing implementation of these evidence-based programs will help prevent addiction as well as criminal justice system involvement that can happen when these disorders go untreated. Evidence-based prevention approaches (both individual and environmental) can lead to major societal cost-savings over time and dramatically reduce the prevalence of both substance use and mental illness.

Comprehensive school/community-based assessment and early intervention activities and programs, such as Student Assistance Programs (SAP) in middle and high school settings, can play a critical role in stopping the addiction cycle before the disorder becomes more complex and difficult to treat.

Prescription drug misuse can have serious medical consequences and its prevention is a key element of a comprehensive prevention strategy. Increases in prescription drug misuse over the last 15 years are reflected in increased emergency room visits, overdose deaths associated with prescription drugs and treatment admissions for prescription drug use disorders, the most severe form of which is addiction. Among those who reported past-year non-medical use of a prescription drug, nearly 12 percent met criteria for prescription drug use disorder. Unintentional overdose deaths involving opioid pain relievers have more than quadrupled since 1999, and have outnumbered those involving heroin and cocaine since 2002. To address prescription drug misuse, we must educate patients about its dangers and empower them with the tools to safeguard their own homes by securing medicine cabinets and disposing of unused medication.

6. Protect Children Impacted by Parental Substance Use Disorder

Over nine million children in the United States live in a home with at least one parent who uses illicit drugs, according to the National Alliance for Drug Endangered Children. These children are at an increased risk for depression, suicide, poverty, delinquency, anxiety, homelessness and most significantly, substance misuse. Children living with an addicted family member are four times more likely to misuse drugs or alcohol themselves, SAMHSA reports.

Many children who have a family member in active addiction live in kinship or foster care. Healthcare and child welfare organizations, as well as foster parents and guardians, need training so that they understand the complexities of SUD and can help impacted youth learn positive coping skills and strategies that can decrease their likelihood of developing a SUD of their own. There are promising interventions being implemented within the child welfare system. For example, START, a Child Protective Services program for Kentucky families with parental substance misuse and child abuse/neglect, is an integrated intervention that pairs a social worker with a family mentor to work collaboratively with a few families, providing peer support, intensive treatment and child welfare services. The program's goal is to make sure children are safe and reduce placement of these children in State custody, keeping families together when appropriate.

7. Reframe the Criminal Justice System:

Approximately 68 percent of people in jail, 53 percent of people in State prison and 45 percent of people in Federal prison have SUDs, compared to just 9 percent of the general US population. With limited access to treatment while in custody, people with SUDs often return to their communities and re-engage in the same behaviors that resulted in their incarceration in the first place. Criminal justice reform is necessary to stop this revolving door.

The current landscape provides a unique opportunity to re-envision how the criminal justice system responds to addiction. Within the criminal justice field, there is a growing focus on how to best approach mental illness and SUDs. Public opinion overwhelmingly supports rehabilitation through diversion to community treatment rather than past practice, which focused on punitive responses. The passage of the Comprehensive Addiction and Recovery Act (CARA) in 2016 marks a sea-change in

the role of criminal justice and provides additional resources for pre-arrest diversion and Medication Assisted Treatment (MAT) within criminal justice facilities.

As we envision and actualize much-needed reforms within and without criminal justice as we know it, emphasis should be placed on preventing individuals with SUDs from penetrating into the criminal justice system by "intercepting" them at the earliest point of contact. The Sequential Intercept Model is well-established in the mental health field and can easily be applied to SUD populations. The model provides a conceptual framework for communities to use when addressing concerns about the criminalization of people with SUDs and considering the ideal interface between the systems of criminal justice and treatment.

8. Educate and Raise Awareness

The field of addiction is steeped in myth and misinformation, which has kept our country from treating and providing for the disorder as we do any other medical condition. The stigma that unfortunately surrounds SUD also acts as a major barrier to treatment access. In order to transform the field of addiction, we must change the narrative that has misconstrued this disease and failed to provide for the millions of Americans who are struggling. By educating people of all ages about this disease by way of real stories instead of scare tactics and accessible language instead of statistics, we can help cultivate more compassionate, resourceful and knowledgeable communities.

These priorities were developed by the people and families struggling with substance use disorder; families and friends that have lost a loved one; policymakers, volunteers, researchers, health professionals, law enforcement officials and advocates. As an integrated whole, they realize an aggressive, comprehensive approach that includes practical tools, sound policies and new collaborations that will empower and equip communities to better treat and prevent addiction and ultimately, save lives.

Our community is energized by and united in our goal of helping to forge a world where fewer lives are needlessly lost to this disease. But our work is far from finished—as the opioid crisis worsens across the Nation, we are emboldened to do more. The legislative proposals being considered contain critical components that would help both to curb the opioid crisis and to ensure that the future of this field is one founded in hope and guided by science.

OPIOID CRISIS RESPONSE ACT OF 2018

I commend the Committee for your leadership and for the comprehensive approach you have taken to address this crisis as evidenced by the legislation being considered today. While there are many important provisions in this bill, I would like to focus specifically on a number of provisions supported by the Addiction Policy Forum.

COMPREHENSIVE OPIOID RECOVERY CENTERS

The Comprehensive Opioid Recovery Centers provision will help address these barriers through the development and promotion of integrated care models based on best practices, which will build a pathway toward the comprehensive healthcare infrastructure that must be achieved to ensure that everyone suffering with a substance use disorder has access to quality treatment. Specifically, the legislation will authorize resources to operate these centers, which will provide the full spectrum of evidence-based treatment services including intake evaluations and regular assessments, all Food and Drug Administration (FDA)-approved treatments for substance use disorders, detoxification, counseling, residential rehabilitation, recovery support services, pharmacy and toxicology services, and interoperable electronic health information systems.

The Addiction Policy Forum supports the quick enactment of CORCs, which will help fill the need for coordinated, comprehensive care for patients with opioid use disorder. In so doing, these Centers will also address those at risk for overdose, arrest or other criminal-justice involvement receive the healthcare they need to return to their families, work and a healthy life.

NATIONAL RECOVERY HOUSING BEST PRACTICES

Addiction is a chronic, relapsing disease and most patients who are treated for a substance use disorder (SUD) require long-term recovery support. While a wide range of evidence-based services, programs, and organizations have been developed to provide structured and supportive environments for people in recovery from an

SUD, the critical role of recovery in the continuum of SUD treatment is too often omitted from conversations regarding the current crisis. Despite extensive research showing that services such as recovery housing dramatically increase the likelihood that a patient will achieve long-term recovery, such programs tend to be in short-supply, lack dedicated funding and vary significantly in quality by payer and region due to a lack of widely recognized national standards and guidelines.

The Addiction Policy Forum supports the provision in this bill requiring the Department of Health and Human Services (HHS) to develop and disseminate guidelines for best practices in the operation of recovery housing.

FIRST RESPONDER TRAINING

Our nation's first responders serve daily on the front lines of the addiction crisis, and they encounter first-hand the effects that illicit substances can have on our communities. With the proliferation of substances like fentanyl in the illicit drug supply chain, first responders are at an increased risk to deadly exposure to these substances.

First responders need additional training and resources to safely respond to incidents of drug overdose involving fentanyl so they can more effectively carry out their duty to save lives, and the Addiction Policy Forum supports the Committees efforts to provide first responders with these essential resources.

IMPROVING ACCESS TO TELEMEDICINE

The use of telehealth is an important solution to be utilized in the diagnosis and treatment of SUDs, particularly in rural areas. There is a large workforce shortage of clinicians trained to treat SUDs, and while some regions of the Nation have strong SUD treatment workforces, increasing access to telehealth services would allow vital clinical services for SUDs to be provided in areas of the Nation that lack, or may not need, full-time addiction medicine specialties.

The Addiction Policy Forum supports the provision of the bill allowing mental health and addiction treatment centers to register with the Drug Enforcement Agency, which would expand the use of telemedicine and allow for the treatment of additional patients with SUD.

DISPOSAL OF CONTROLLED SUBSTANCES BY HOSPICE CARE PROVIDERS

Many of the first-time encounters with opioids happen in homes with leftover medications that were initially prescribed by a physician. The Journal of the American Medical Association reported that two-thirds of surgical patients end up with unused pain medications, such as oxycodone and morphine, after recovering from a procedure. These prescribed drugs are often neither secured nor disposed of properly, but stashed in medicine cabinets and bedside table drawers. Getting rid of a bottle of pills may seem like a shuffle step on the long path toward addressing the opioid crisis, but decreasing access to these medications is as crucial as it is easy.

Because of this, the Addiction Policy Forum supports giving hospice care providers greater ability to dispose of unused controlled substances for the deceased.

EDUCATION AND TRAINING FOR PROVIDERS

Medical education about the identification and treatment of substance use disorders needs to be improved for practicing healthcare professionals as well as those in training. While there is certainly good work going on to improve medical professional education related to substance use and addiction, we must ensure speedy dissemination of the most current research and best practices. Often, healthcare providers do not feel prepared to deal with what is commonly perceived as a difficult patient population. Because of the lack of education for students and experienced practitioners, patients are denied access to a large portion of evidence-based treatment options that are only available in medical settings. Physicians around the country also report not having had enough training on the prescribing of pain medication and alternative treatments for chronic pain. This particular gap in physician education in the midst of a worsening opioid epidemic must be addressed.

Providing additional educational resources to providers to both detect substance use disorders and address acute or chronic pain in order to mitigate the risk of a patient developing a substance use disorder is an important piece of a comprehensive response to our Nation's drug crisis. As such, the Addiction Policy Forum supports this provision.

Conclusion

I look forward to working with you and the Members on this Committee to advance meaningful legislation built on a comprehensive response that includes prevention, treatment, recovery, overdose reversal, law enforcement and criminal justice reform.

Thank you for the opportunity to testify today and for your commitment to addressing such an important issue that impacts millions of American families every day.

[SUMMARY STATEMENT OF JESSICA HULSEY NICKEL]

I started the Addiction Policy Forum to help patients, families and stakeholders across the country advocate for a comprehensive response to addiction—including prevention, treatment, recovery, overdose reversal, criminal justice reform and law enforcement. Our nonprofit convenes key partners from throughout the field around one table with shared goal: to help create a world where fewer lives are lost to addiction and help exists for the millions of Americans who need it.

In 2016, we launched 129aDay, an initiative to honor those we've lost to addiction and their families. Each year, we update the campaign to reflect the increasing number of lives that are lost. The latest data available show 174aDay and all indications suggest that this number is continuing to rise. We seek to put faces to the scope of the opioid crisis to further advocate for swift and aggressive reform. I know firsthand the devastating impact that addiction can have on families—both of my parents struggled with heroin addiction and ultimately lost their lives to this preventable, treatable disease.

Our community of families, patients and key stakeholders has long been advocating for a comprehensive response to addiction—one that is guided by science and energized by hope. I commend the Committee for your approach to, and leadership on this issue, which is evidenced by the important legislation being considered today.

I would like to focus your attention on a set of provisions within this bill that directly align with our strategic priorities and would immediately improve our current situation and lay the groundwork for better treatment outcomes.

These provisions include comprehensive opioid recovery centers, national recovery housing best practices, first responder training, improving access to telemedicine, disposal of controlled substances by hospice care providers, and increased education and training for providers. These and many other provisions in this bill are important components to the comprehensive response we need in our Nation to address the addiction crisis.

The CHAIRMAN. Thank you, Ms. Nickel, for your touching stories and your testimony, and to all of you for your work and your time for being here. As you can see, you have our full attention, and we welcome your advice.

We'll now begin a round of 5-minute questions with Senators.

Senator Collins.

Senator COLLINS. Thank you very much, Mr. Chairman, and thank you for the very important work that this Committee is doing.

In Maine, we experienced a record high number of overdose deaths last year, claiming some 418 lives. This past weekend, there were nine overdoses as a result of some fentanyl-laced heroin. Fortunately, first responders were able to save these individuals. But it's so clear that we need to take an all-of-the-above approach to addressing the opioid epidemic.

This week, I'm introducing three bipartisan bills to address this crisis, and I look forward to working with the Chairman and Ranking Member in the hopes of incorporating them into the Committee's tremendous legislative effort.

Ms. Nickel, I want to start with you, and I want to first thank you for sharing your extraordinary personal tragedy with our Committee and also telling us of other families that have been affected. It's very poignant. It puts a human face on this epidemic, and that's very important.

One way that families are finding support is through peer-to-peer recovery groups. I toured a volunteer-led Bangor Area Recovery Network in Brewer, Maine, last year that is a model for peer-led counseling and brings hope, recovery, and healing to those who are struggling with substance abuse. Have you seen peer-to-peer groups make recovery more sustainable? Do you have any advice for us on that approach?

Ms. NICKEL. Absolutely. Peer recovery support specialists are a key component to making sure we provide the services that are needed for folks that are in recovery, those that need treatment—individuals that have lived experiences and can make that connection. We've learned this with peer programs in the mental health lane, peer programs in veterans services, and it's the same for our patient group.

A few of the programs we've seen—Addiction Policy Forum has six peer recovery support specialists that work for us. They provide crisis support to individuals in recovery and the connection to services that are needed, and I think it's a critical element. In Rhode Island, there's an amazing program called AnchorED where peer recovery support specialists connect with a patient that's had a nonfatal overdose and gets them the services that they need.

I think we've learned on the ground and from a lot of anecdotal evidence that this is a key component. We need more research to make sure that we're putting this in the right direction, and we definitely need more funding support.

Senator COLLINS. Thank you, Ms. Nickel. The other issue that I want to bring up in my remaining time is the fact that when people are receiving hospice care in their homes, they frequently need powerful painkillers. I am a big proponent of hospice care. I believe that most people would prefer to die at home if they can, and, obviously, we want to provide effective relief.

Unfortunately, there oftentimes are powerful painkillers that are left over at the time of death, and yet hospice staff are not allowed to dispose of these unused medications, even after the patient has died. So this opens the door to diversion, to theft, to abuse. Another bill that I'm developing with Senators Warren, Hassan, and Rubio would allow hospice staff, nurses, physicians, and paramedics to dispose of unused medication, to collect them and take them out of the household.

Do you believe that this would be helpful in stopping some of the diversion and theft and misuse that occurs now?

Ms. NICKEL. Absolutely. We know that the disposal of unused prescription painkillers is a key component to making sure they don't fall into the wrong hands, whether that's diverted onto the streets, to be sort of picked up by an adolescent in that household. It's a critical component.

We have two programs every year to encourage our families to work with stakeholders in communities to make sure that we're disposing of medications. I think, particularly focusing on hospice

care, making sure that any of the barriers that those workers have to making sure that they have the authority to dispose of those medications is a key component to keeping our communities safe.

Senator COLLINS. Thank you so much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Collins.

Senator Murray.

Senator MURRAY. Thank you, Mr. Chairman, and thank you to all of our witnesses today.

When I talk to teachers and parents and other community members back at home, they tell me we need to prevent this generation of children from becoming the next generation of adults who have substance use disorders. It is really a heartbreaking conversation. Children of parents who struggle with substance use disorders—Ms. Nickel, you talked about that—too often experience trauma that puts them at a higher risk of negative health outcomes, including developing substance use disorders themselves and even early death.

Ms. Donahue, let me start with you. How do you see our discussion draft helping to address those issues, and what more could we do to address trauma among young people in light of this crisis?

Ms. DONAHUE. Thank you for your question. I think it's key that we provide mental health services in schools, particularly at the earliest possible time. Children who experience trauma will often have the adverse childhood experiences that will buildup over time if they are still in that dysfunctional home or environment. So if mental health services are provided early in schools and the school can sort of be that support person along with the teachers for that child, I think we will very much greatly reduce the number of children who grow up and develop mental health conditions themselves or turn to substance use. I think that is extremely important. I also—and I believe that bill covers that funding for that.

The other issue is for pregnant women who are struggling with addiction. I think mental health services coupled with their substance use disorder is key as well. Often, as my statistics indicated, there is a dual diagnosis of these women who are struggling with substance use and mental health conditions.

Senator MURRAY. Thank you very much.

In 2017, the Centers for Disease Control and Prevention supported grants in actually 43 states that enhanced prescription drug monitoring programs in support communities and health systems; prevention efforts as well as grants to 33 of our states for enhanced surveillance of drug overdoses. Those grants have actually played a very critical role in supporting many hard hit areas.

But they were not funded at a level to reach the entire nation until we just passed the recent omnibus, and I'm really glad we had bipartisan support for expanding these programs. I know on our side, Senators McCaskill and Tester worked really hard on those provisions that would promote this effort in the bill we're talking about today. But we know that successful prevention efforts need sustained commitments.

Mr. Morrison, let me ask you—in achieving your organization's mission for drug abuse prevention and treatment, how vital is national data?

Mr. MORRISON. Absolutely critical. Our members are beneficiaries from a lot of the data sets that are available at the Federal level. We also feed up data to SAMHSA, for example, through the Treatment Episode Data Set. But we know the National Survey on Drug Use and Health has about 75,000 people, looking at their use patterns, demographics, and the like, and SAMHSA has done a nice job to work with states in order to look at—to try to localize that data at state level estimates.

Senator MURRAY. How important is it that we have data from every state?

Mr. MORRISON. Critical. For example, you mentioned PDMPs. Our members very much appreciate the data from PDMPs, because they can utilize that data for hot-spotting, looking at the state, identify data to particular areas, and then you can target prevention messaging based on that hot-spotting in your state. That's done with a state-Federal partnership. The resources are important as well. It can be expensive.

Senator MURRAY. You know, over the past few years and even in the past few weeks, I've heard a lot about the gaps in our behavioral health workforce and how that is crippling our efforts to fight this crisis. I've heard about the need to make sure patients fighting addiction have support in navigating and access to comprehensive services, whether it's to stay on track with medication-assisted treatment once they have that, mental health treatment, rebuilding relationships, getting back into the workforce, all of that. But we don't have enough professionals who provide those critical services.

Mr. Morrison, let me ask you—what role do those providers, that workforce, play for patients fighting addiction?

Mr. MORRISON. They're critical, and the expertise and that therapeutic relationship they have with a particular person is a key predictor of success. We need them to have that expertise, but it can be a challenge. I was talking to Washington State—Chris Imhoff, the state director, just yesterday, and she expressed appreciation for the loan repayment provisions included in the proposal, because that can be a deterrent to going into the field, because we know also that salaries aren't—so any additional help, such as a loan repayment provision specific to substance use disorders is appreciated.

Senator MURRAY. Okay, I really appreciate that. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

Senator Roberts.

Senator ROBERTS. Thank you, Mr. Chairman. Let me make the observation that, once again, you and Senator Murray are working together in a bipartisan fashion with the rest of the Members of this Committee to address an extremely serious problem that we're facing in this country, and I thank you for your leadership, and, somehow, you are always able to pull the chestnuts out of the fire and get something done.

I want to thank the staff for working with my staff on legislation that I would like to introduce on behalf of Heidi Heitkamp, who is my Co-Chair of the Senate Rural Healthcare Caucus, with regard to telemedicine. So thank you for your efforts.

Ms. Nickel, Senator Collins referenced your testimony as being very poignant, and I was trying to think of a word that could trump that. I don't think I can. Thank you for that testimony, and I hope I'm not out of order in stating that I feel very sure that your mom and dad are very proud of you with regard to what you're doing and putting a face on this terrible scourge in our country with Courtney, Larry, Emmett, and Dylan.

That's the way to approach this, Mr. Chairman. I think we really need to do that. We can get some things done.

You made some suggestions on page 8, where you talk about getting our schools involved, which I think is pretty much a commonsense approach and would recommend that to our leadership here. You say comprehensive school, community-based assessment and early intervention activities, and programs such as student assistant programs—there's an acronym for that. Everything has to be an acronym—SAP. I don't think we're saps for considering it—but, at any rate, in middle and high school settings, can play a critical role in stopping the addiction cycle, and I certainly agree with that.

I'm popping over to page 13, where you address telemedicine. I've heard from many Kansans who have had to travel long distances, sometimes across state lines, in order to access any kind of substance use treatment. For example, the nearest methadone clinic for southeast Kansas is in Joplin, Missouri. We Kansans—still, when traveling to Missouri, it's a traumatic experience, Mr. Chairman. We're always glad to get back. But that shows you what we're facing.

Both Senator Heitkamp and I are very interested in telemedicine's potential to assist these patients in receiving the necessary diagnosis and treatment. We've been working with telemedicine just in terms of access to healthcare for a long time.

So, Ms. Nickel, what services can be used via telemedicine to best treat patients with substance abuse disorder?

Ms. NICKEL. Telemedicine is a key component to meeting our treatment capacity gaps that we have. Right now, only 10 percent of our 21 million people that need treatment are going to receive it this year. Can you imagine 10 percent of cancer patients receiving treatment? And, in particular, for rural communities, telemedicine can be a game changer on getting the treatment components that you need for a long-term recovery plan—treatment and recovery plan, and there's a couple of different pieces of that.

One is treatment itself: telemedicine's capability for prescription of medication-assisted treatment, which is particularly important if you're in a rural community and you don't have a provider that's even within hours of a drive and you need to be able to have that medication for that patient, but also telemedicine for counseling services, for behavioral health support, and even intervention such as cognitive behavioral therapy. There's some red tape that exists that makes this difficult to deliver these services across state lines and to streamline the availability. So all of these different components made available through telemedicine could be a game changer.

Senator ROBERTS. I appreciate your response.

Mr. Chairman, I also want to thank Ms. Donahue and Mr. Morrison for their contribution, and I'm going to yield back time, which I know is most unique for me, but——

The CHAIRMAN. We'll mark that as an important event. Thank you very much.

[Laughter.]

The CHAIRMAN. Thank you, Senator Roberts.

Senator Warren.

Senator WARREN. Thank you, Mr. Chairman.

You know, I'm very glad to see this Committee working together to address the opioid crisis. In Massachusetts, more than five people are dying every day, on average, from opioid overdoses, and we need action now on this. Senator Capito and I have been working together for several years on a bill to allow partial filling of opioid prescriptions so that people only get the opioids that they actually need. The idea is to reduce the number of pills that are in circulation.

We got this legislation passed in 2016, and we recently introduced a bill to improve implementation of this law by clarifying the FDA's authority to make sure that doctors and patients actually knew about the partial fill option. You know, this is one of those bipartisan, consensus, commonsense provisions that would reduce unused medications that are lying around in the home, and I'm hoping that we will be able to get it included in the final passage as it goes through Committee, and we'll continue to work together on this.

Let me just ask a question about the risk posed by unused medications.

Mr. Morrison, why might unused medications lying around the house pose a risk of misuse or diversion?

Mr. MORRISON. Sure. We know from data that SAMHSA collects that the source of the use of medications that are not prescribed to folks—about half come from that particular situation, friends and family. So efforts to make sure that doesn't happen are real important.

Senator WARREN. Right. And, for instance, family—they may not even know about it, but it's up there on the shelf and imposes a risk.

Mr. MORRISON. That's right.

Senator WARREN. Yes. So one of the times that individuals are most likely to use opioids to manage pain is at the end of life. But right now, in many states, hospice employees are not legally allowed to dispose of opioid medications on behalf of a patient who has passed away.

I've, again, been working on a bipartisan basis with colleagues to try to address this issue and make sure that hospice employees can safely dispose of medications. Families dealing with the loss of a loved one shouldn't also have to worry about dealing with dangerous leftover drugs.

Here's something else that families shouldn't have to worry about, whether a sober living home is actually helping their loved ones recover or pushing them back into addiction.

Mr. Morrison, can recovery housing be an important piece of the puzzle for individuals in recovery from addiction?

Mr. MORRISON. It's a critical part of the continuum. I know in Massachusetts, you all worked with the National Association of Recovery Residences. They've developed a tier level of explanation about different options. We've been working closely with them, other states as well. Recovery housing is critical.

Senator WARREN. And can you just say another word about the quality of recovery housing? Is there some variation here?

Mr. MORRISON. There can be, and I think the bill that is before the Committee, the discussion draft, seeks to put out standards, models, so that states can look at those, talk to each other, and look at best ways to implement recovery housing with important standards.

Senator WARREN. Good. You know, most of these facilities do a great job, but there are too many examples of ones that don't. I led a bipartisan request to get the GAO to look into this problem, and this discussion draft also contains language that I've been working on with Senator Kaine and others to try to establish best practices for recovery homes to help patients make the best choices in their recovery.

My view on this is we need to use every single tool in the toolbox to tackle this epidemic, and these bipartisan efforts will help, and I'm glad to work on it. But let me be clear on this. Congress has nibbled around the edge of this problem for years, and the problem has gotten worse and worse. This latest round of policy changes is no substitute for giving communities the resources and the expertise they need to fight this fight on the ground.

That's why Congressman Cummings and I are introducing new legislation based on the Ryan White Care Act, the landmark bill that Senator Kennedy and Senator Hatch passed back in 1990 to tackle the HIV-AIDS epidemic. I hope Senators on both sides of the aisle will support it, because the AIDS crisis taught us that what it takes to beat an epidemic like this is that we really have to put the resources and the energy behind it, and, right now, I just don't think we're doing what it takes. We need to do better.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren, and thanks for your work on partial fill and the hospice legislation that you and Senator Collins and others—and, Senator Roberts, thanks for your work on the telecommunications provisions of the bill.

Senator Isakson.

Senator ISAKSON. Thank you, Mr. Chairman, and thanks to you and Ms. Murray for the job you all are doing on the opioid issue, which is a big issue.

Ms. Nickel, I agree with you that it's important to put a face on the problem, because it is a terrible problem in our country. My grandson died of an overdose in 2016. He was one of the 63,300 that you listed in your testimony who died in 2016 from an opioid overdose. He died two nights before he was going to get a summa cum laude diploma in mathematics from the University of Georgia Southern. He had been out of recovery for 4 years, had been in a great program. We thought he was back.

He was doing terrific in school, obviously, getting a summa cum laude diploma, but he also was working. He had a job when he finished. We were excited. Then we got the phone call late at night,

2 days before the graduation, that he had been found dead in his apartment in Statesboro, Georgia, which I bring up to say this. You never know where narcotics and opioids and overdose death is going to come from. You never know who it's going to affect. You never know how they got exposed, and many times, most of the subjects around it are a mystery.

But the better you can know your children, your kids and your grandkids, the more you can look for things and ask questions, the more you can try and be aware of the symptoms of drug abuse or addiction, the better off all of us are going to be, and addiction is the big problem. I mean, I'm personally—I mean, Charlie was a great kid, smart as he could be, but he was hooked, and no matter how long you stay out in recovery and are free of drugs, it only takes one, and that's all it took for him 4 years after he had gone into recovery. That's a sad testimony.

Yesterday, in a hearing we had in another Committee, we heard that children 13 to 26 are five times as likely to become addicted to narcotics as adults. Do you all agree with that number? Is that about right, in your mind?

[Nonverbal response.]

Senator ISAKSON. Well, that shows you, Mr. Chairman, one of the places we've got to put a face on the opioid epidemic is with our young people, to really know what they're facing and can happen. The meth project, which started in the upper Midwest with methamphetamine a few years, did a lot of good to knock down the growth rate in terms of meth laboratories and meth addictions in that part of the country, and it helped us in Georgia. We adopted a meth project in Georgia and put the billboards up like you've got with your examples with your speech.

But all that education, all that awareness, all that talking about the subject in public and with your kids and families is critically important, because awareness is the key to catching things early, if you're lucky enough to be able to do that. If you don't catch it early enough, catch it early enough to get treatment, and then sustain the treatment and the benefits of that treatment long enough so the person can lose the addictive habits that they developed in taking the narcotics or the opioids.

I just want to commend you on what you've focused on in terms of awareness and putting a face on it. It's a terrible tragedy that many, many Americans face every day and more are going to face in the future unless we do get our arms around it, and we can do it, but we've got to talk about it without fear. We've got to look for the symptoms without any prejudice. We've got to do everything we can to support those who are having problems rather than demonizing them because they have them. They need our support and our love and our assistance and our help, and we can help a lot of people end what is a terrible problem.

I would just say, Mr. Chairman—I want to end where I started. Addiction, to me, is the one thing that is so overpowering—I can't explain it. I know there are things I like to eat that I shouldn't eat. There are things that I buy at the grocery store and my wife goes crazy. It's a good thing that Oreos are not addictive, because I would be on them every day.

[Laughter.]

Senator ISAKSON. But addiction and the habits that come with it and the things you do to support the habit early on that are so detrimental to your health in the future and your life in the future—it's unbelievable. So what we're doing in this Committee, what the Chairman and the Ranking Member are doing, is critically important, and what all of us need to do in this country is make sure that drug abuse is not a stigma. It's a problem. And addiction is not a stigma. It's a disease, and that we treat it, we find a way to cure it, and we save lives in the future, and that's what this Committee is all about, and I commend you and Senator Murray for what you're doing to make that happen.

The CHAIRMAN. Thank you, Senator Isakson.

Senator Jones.

Senator JONES. Thank you, Mr. Chairman, and let me also thank the Chairman and the Ranking Member for the work on this. This is the work you're doing is why I came to the Senate, to that bipartisan work that we can really address this crisis.

Let me also say, Ms. Nickel, while I also appreciate your putting a face on this, I cannot help but say how much I appreciate Senator Isakson, who I admire so much, putting a personal face on this for the U.S. Senate. It's really important to do that. When you have a colleague that will do that and step out like that, it hits home to all of us, even more than I think the witnesses.

Thank you, Senator, for doing that.

Ms. Nickel, one of the things that seems to be in my state—we hear the stories. Senator Isakson's grandson was going to school. We hear people at employment—they seem to be fine below the radar with these problems. But yet it also seems to me that employment is an important part of recovery.

I was pleased to introduce the Jobs Plus Recovery Act with Senator Kaine and Senator Young about the need for employment and workforce development and helping people overcome these. The answer would seem to be obvious. But I'd like for you to just talk about that a little bit—Mr. Morrison, you may want to chime in too—about how important having that job and training will be to help these people overcome the addiction so they don't fall back into the crisis they were in.

Ms. NICKEL. Absolutely. I think employers are a key component of how we address addiction on two levels. For those that are in recovery and coming back into the workforce, having that job is so incredibly important. To have your sense of self-worth, your ability to provide for your family, and to get your life back in order is critical, and the stigma that is attached to this disease can make it—recovering and the family—make it difficult for the family as well. So how do we make sure that we make those connections so there's a pathway to employment, to having a job, to paying taxes, and being able to take care of your family as part of your recovery plan?

On the other side of it, though, this is a disease that worsens over time, like any other disease, and one of the first things that starts to happen is you lose your job as this disease starts to take hold. So employers that have programs, like employee assistance programs, and can initiate—instead of losing that job because you're late or you have a positive urinalysis screen—to connect that employee with the services that they need, and having that rela-

tionship with your boss, your employer, helps you to get the care that is really required.

Senator JONES. Thank you.

Mr. Morrison, do you briefly want to say anything about that?

Mr. MORRISON. Absolutely critical. Our members work with a variety of different agencies and support providers to help them with job readiness, job training, things such as how to write a resume, how to prepare for interviews. Charles Curie was a SAMHSA administrator quite some time ago, and he would always say critical indicators of what we're trying to do is help people get better, get housing, a place to live, a job, and a date on the weekend. And it kind of describes the goals of what we're trying to do with our folks.

Senator JONES. Right. Thank you, Mr. Morrison.

Shifting focus a little bit, the proliferation of the deadly synthetic drug, fentanyl, is also a real concern, I think, for Congress these days. Recently, we have seen a lot of warnings going out to first responders. I know that recently, DEA has been working on this a good bit. The surgeon general was just—an advisory recommending that all Americans, just about, carry naloxone—whatever that's called. I get real confused. Between acronyms and medical terms, I'm gone.

So, Ms. Nickel, what can we do? Do we need to provide more resources to first responders? Because these first responders—it would not take much, but a little bit of an inhalation or some kind of contact with fentanyl to be deadly to the first responders. As a former U.S. Attorney, I'm really especially into police, fire, medical personnel that get on the scene sometimes very quickly. They do such an incredible job, but they're facing this danger. What can we do to provide more resources?

Ms. NICKEL. Support and resources, training, wrap-around support for our first responders is critical, and I commend the Committee for having a component for training and resources in the draft legislation. Both our fire and police officers are on the front line, and both with the increasing threats because of synthetic opioids. Those warning systems to alert jurisdictions when we're seeing fentanyl enter that market is critically important; resources to provide naloxone—you got it right—to have naloxone on hand that we need to reverse overdoses; and then we need to make the connection between that reversal and connecting them to treatment.

If you treat someone with a heart attack and use the paddles, you get them to a cardiologist. If we treat someone with naloxone to reverse an overdose, we need to get them into treatment and use that opportunity as a life-changing moment for that individual and that family. And, absolutely, we need to help first responders with resources, training, the support that they need. This is a very difficult job. You're going to the same houses, oftentimes many times in a row, and it's tough work, and not having the resources to make those connections, I think, can be very demoralizing. So we need to wrap them up.

Senator JONES. Great. Thank you.

Thank you all for your presence here today.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Jones.

Senator Cassidy.

Senator CASSIDY. Thank you all.

Ms. Nickel—again, incredibly moving testimony, and, unfortunately, we all have an experience similar to that. One thing you said, though, that I—as a physician, my ears perk up—that one of the young men had been hospitalized or in the ER seven different times, and family never notified. I think, for the record, that is a misunderstanding of HIPAA laws, that is, HIPAA, which, normally, has confidentiality requirements.

I was trying to double check, but was specifically told yesterday by someone in a position to know that HIPAA does not—HIPAA does allow someone to call the family of somebody in an overdose and to inform them that they've been—any comment on that?

Ms. NICKEL. You are absolutely correct. We actually have drafted a memo for counsels at hospitals to fully explain that this is an allowable activity, to notify a family, to notify healthcare providers, after a nonfatal overdose, and we need to change a lot of the practices. How we respond to nonfatal overdoses in this country is the most important and one of the first things we should be doing. Of the nearly 64,000 people that we're losing annually to overdoses, 70 percent of them had a previous nonfatal overdose.

Senator CASSIDY. Let me just interrupt——

The CHAIRMAN. Well, let me interrupt just a moment without taking your time, Senator Cassidy.

Would it be a good idea to include in our legislation any language that would make it clearer, the point that you're making, so hospitals and their counsels would know that?

Senator CASSIDY. I was about to just ask you and the Ranking Member if we could something like that.

[Laughter.]

Senator CASSIDY. When I was on Energy and Commerce Committee, we once had a panel of HIPAA experts, and they were disagreeing with each other to the degree to which you could share with somebody. And I can tell you if you're the ER physician at 3 in the morning, you've got 10 people waiting, your default is to not share information. So the degree to which we can promulgate that ideally, put a tattoo on somebody's head saying, "Oh, yes, I remember that now"—we'll be doing an incredible service.

The CHAIRMAN. Why don't we, first, not deduct from your time for my interruption, and, second, why don't Senator Murray and I work with you? And if the witnesses would like to provide us with suggestions about how to do that—we respect the HIPAA law, but I think it's not just overdoses. It's emergencies where families can be notified, but people are afraid to do that.

Ms. NICKEL. That would be wonderful.

The CHAIRMAN. So, Senator Cassidy, if you would work on that, that would be very helpful.

Senator CASSIDY. Yes, absolutely.

Next—again, thank you all. My office has kind of initiated something we call Safer Families and Healthier Communities.

Ms. Donahue, you seem to be plugged into that. Indeed, the people you're serving, those children born of parents addicted, is kind

of the beginning of Ms. Nickel's testimony. You're acquiring all this great data. Can I ask what you are doing with that data?

Ms. DONAHUE. Yes. So in our data base, we are tracking maternal characteristics, such as where that particular woman resides. We are tracking what type of substance——

Senator CASSIDY. Try to speak quickly, because I have limited time.

Ms. DONAHUE. I'm sorry. We are tracking what type of substance is involved and whether or not the particular mother has prior substance-exposed infants.

Senator CASSIDY. But with that data, can you then say, "Okay, we know this child is born to a mother who is addicted. Therefore, we are going to proactively send support out there?"

Ms. DONAHUE. That's correct.

Senator CASSIDY. Now, you imply that there is, one, Federal resources that enabled you to begin, but a lack of resources for which to fully go to scale and/or continue. Is that true?

Ms. DONAHUE. Especially with the Plans of Safe Care, yes.

Senator CASSIDY. Now, there was in 21st Century Cures a lot of money which, apparently, has had a hard time getting out to the states. Is it just that this money hasn't gotten out, or that money which is even allocated will not be adequate?

Ms. DONAHUE. We've actually seen some of the benefits of the Cures Act through peer recovery coaches through our Delaware chapter of SAMHSA. So the peer recovery coaches are actually being utilized in some of our substance use treatment disorder centers, including the medication-assisted treatment for pregnant women, and the peer recovery coaches have been fabulous.

Senator CASSIDY. It is getting there, but perhaps not for this particular program.

Ms. DONAHUE. Correct.

Senator CASSIDY. Ms. Nickel, quickly, I think we have a shared interest in what we can do to improve access to addiction treatment medicine. One think I'll again point out—some addicts, after their recovery from an overdose, really don't want to be treated. They want to take another hit. So the issue is can we give them some sort of long-acting drug that, if they do take another hit, it'll be kind of "Oh, my gosh, I don't want to do that again." Any comments quickly on that?

Ms. NICKEL. We do have new long-acting formulations of medication-assisted treatment, and I think we need to clear some barriers to making that new medication available to our patients. I believe this Committee worked on some language to help with that in S. 916, I believe.

Senator CASSIDY. Yes, my bill. I love it.

[Laughter.]

Ms. NICKEL. Thank you for that. But I think as we have advancements in medications, we need to make sure we can actually get those medicines to our patients.

Senator CASSIDY. Yes, and this is—that one provision I'm not sure is in the final version so far. But just to say long-acting—again, to my colleagues, sometimes someone takes an overdose, and all they want is another hit.

Ms. NICKEL. Well, you wake up in active withdrawal, so you're having your worst day and feel crappy. The quickest way to fix that is to use again or to get someone connected——

Senator CASSIDY. But these long-acting preventions will be something which will then——

Ms. NICKEL. Exactly.

Senator CASSIDY ——although you're in withdrawal, you won't go back so immediately and, hopefully, get into recovery.

Ms. NICKEL. Absolutely.

Senator CASSIDY. Mr. Morrison, I had a question for you on accountability, but I'm almost out of time, so I'm going to yield back. But I am interested—for a question for the record—these programs that we're doing—we're interested in evaluating to make sure that they work. It's just not a place to send Federal dollars.

The question for the record you'll receive is: How do we consistently have outcome measures which tell us what we should do or perhaps what we should not do?

Senator CASSIDY. Thank you all for your good work.

The CHAIRMAN. I took—I stole at least a minute from you. So if you want to pursue that, please do.

Senator CASSIDY. Yes, I know. So how do we do that?

[Laughter.]

Senator CASSIDY. Because we're interested in that accountability, and I know there's some people who just make money off of government contracts, and I know that because I used to work for the government. But there's others who actually use it to good end. How do we have that accountability measure to know these programs are working well?

Mr. MORRISON. Sure. We work with SAMHSA on looking at different measures regarding the use of alcohol, the use of drugs, the impact of treatment on employment, the impact of treatment on criminal justice involvement, and then connectedness back with the society. So we're eager and actually embrace——

Senator CASSIDY. Do those measures work? I mean, sure, you're doing them. Do they work?

Mr. MORRISON. Well, they're helpful, and we also would benefit from additional resources to look at long-term studies, looking at post-discharge, six, 12 months——

Senator CASSIDY. I'm a minute over. I'll stop. But our QFR will ask you to put a finer point on that answer.

Mr. MORRISON. I look forward to it, sir.

Senator CASSIDY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cassidy, for your suggestions.

Senator Murphy.

Senator MURPHY. Thank you very much, Mr. Chairman.

Thank you all for being here today. While Senator Cassidy is still here, let me just put a plug in for the Mental Health Reform Act that we both worked on in consultation with the Chair and Ranking Member that passed in 2016. As part of that piece of legislation, we included some pretty important changes to the Mental Health Parity Law which allow for Federal regulators to make sure that insurance companies are not just putting in their statement of benefits your behavioral health and addiction benefit, but that

they are also administering your benefit in a way that is not discriminatory.

I wanted to maybe direct this question to you, Mr. Morrison. Secretary Acosta came before President Trump's Opioid Commission and talked about the lack of tools that he has in order to enforce this requirement under Federal law that when you have insurance, you have an equal addiction benefit to your non-addiction benefits. The reality is that anybody out there who has tried to access insurance reimbursement knows that it is a whole lot harder to get an insurance company to pay for addiction treatment than it is to fix your broken leg or to address heart disease.

He specifically—Secretary Acosta—asked Congress to give him two new authorities. He said, "I need the power to level civil fines." There are no civil fines right now in the Parity Law. And, second, he wanted to be able to come after not just the employers but the insurance companies themselves.

Let me just ask you a general question, which is: Do you believe that, as you look at it, there are still enforcement challenges when it comes to administering the Mental Health Parity Law?

Mr. MORRISON. I think there are. I think there's been studies, as you referred to, in terms of accessing the benefit, and there's been a look at accessing substance use disorder benefits as opposed to physical benefits, and there have been challenges and barriers. Our members know this issue based on folks that they see are uninsured or underinsured, and so they've worked with state health insurance commissioners, plans, and the like to educate them.

But the bottom line is we have a law on the books and resources to help enforce and implement the law would be helpful, and the Governor's Association has included that as part of their recommendations, as has the Commission that the President convened under Governor Christie.

Senator MURPHY. Well, Senator Alexander, we're lining up requests as we go through this hearing. But one of mine would be that we take a look at these authorities that the Secretaries ask for. They're actually included in President Trump's Commission's recommendations to us.

We have new reports that we've been given showing that there is just an unjustifiable disparity in terms of how insurance companies reimburse on the addiction side and the non-addiction side, and we have a Republican administration asking for some new authorities, I think some commonsense authorities, and I hope that we can talk about that.

Another subject I wanted to bring up to the panel is the subject of recovery coaches. I think, again, Mr. Morrison, you referenced it in your testimony. We've had a lot of success in Connecticut with recovery coaches. We've seen an increase across the country in emergency room visits for opioid overdoses by 30 percent. And I've had so many people in Connecticut talk to me about how we need to lengthen out the spend on addiction, treat it more like a chronic disease than simply a crisis illness, and recovery coaches are one of the ways to do that.

I'm maybe going to ask the question to you, Ms. Nickel, because it's already in your testimony, Mr. Morrison.

You talked about the need to get parents and family members more involved and have policy that facilitates them being part of this conversation. It seems to me that recovery coaches is a way to do that, to have somebody who can be that liaison but also bring in the family members. I just wanted to sort of ask your thought on whether it's worthwhile.

Senator Capito and I have two pieces of legislation that would do this. I just wanted to ask your opinion on this.

Ms. NICKEL. Absolutely. Addiction is a family disease. It affects every member of the family, and peer recovery support specialists, recovery coaches, can play an integral role in making sure that long-term plan is in place. We also know from literature that treatment and recovery plans need to be three to 5 years long, not 14 days, not 28 days. So you think about if you have a hip replacement, and what—my grandma had one last year—you have the recovery plan on the things that you need. It's the same with treatment for addiction, and we know that we need a much longer runway for the recovery support to make sure that patient is well and has the services they need.

Senator MURPHY. It's such a hard problem, because we need to spend more money, but we do need to be having a conversation about how we're spending the money today, whether it's best served, as we primarily do today, in intensive supports right up front or whether we need to lengthen out that span. Recovery coaches is a way to do that.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murphy, and we'll ask staff to follow-up Secretary Acosta's recommendations that you mentioned.

Senator Baldwin? Oh, excuse me. I didn't see Senator Murkowski.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

I wish that I had been here for the beginning. We're beginning Appropriations hearings, and we're all in different places at the same time. So thank you for your contributions here today. We've been so focused on what is going on with the opioid crisis and the epidemic in this country. Sometimes I worry that we forget we have other very serious significant issues as they relate to substance abuse.

Mr. Morrison, you have noted that we don't want to forget the other substances. In Alaska, it's alcohol, has been alcohol, will be alcohol. We just had two villages request by way of resolution to our Governor that he declare a state of emergency and to shut down a liquor store that had opened in an adjoining village, because one village is dry, and the other village sells alcohol. We've seen individuals go through the river, die—the tragedies continue.

As I've talked to our enforcement agencies in the state, they tell me it seems like that heroin is tapering off, but meth is now escalating through the roof. So I'm concerned that here in Congress we're so focused on opiates as the drug du jour, if you will, and that in 5 years or so, when this crisis ends or abates or tapers, that we're going to have a bunch of Federal programs that are specifi-

cally aimed at a problem that may not be as significant to the detriment of others who are dealing with other types of addictions.

Mr. Morrison, I'll ask you. Do you have similar concerns? Are we being too focused? Do we need to be broader to addiction, in general? How do we make sure that these policies are going to really be the umbrella that we need to help those who have such significant challenges?

Mr. MORRISON. Our members have expressed concern about not affording the flexibility needed in order to allow states to address the issues that they face that are unique to their state. The Substance Abuse Prevention and Treatment Block Grant, as you know, is a program that allows a state to target resources based on their own unique needs. Alaska receives about $6 million in that program. We also know your interest in fetal alcohol syndrome. Your leadership there is appreciated. There really isn't a Federal program within, particularly, SAMHSA that provides the service side, as you probably know.

But I must say the sheer volume of death connected to opioids is something that cannot be ignored, and I know you're not ignoring it. The ability, though, for states to address whatever it is the person walks in the door with is critical, and alcohol is, indeed, the No. 1 problem in the United States. So it's a balance, and we appreciate the leadership of this Committee.

That's why our members, again, appreciate the Substance Abuse Prevention and Treatment Block Grant and its flexibility. It's consistent, and there's a specific set-aside for prevention that is so critical. Seventy percent of our members' budget for substance abuse prevention, on average, comes from the block grant, so it's vital. So I appreciate the question.

Senator MURKOWSKI. That's good to keep in perspective.

Ms. Donahue, in your written testimony, you state that providing mental health services in schools will address the trauma that our youth have experienced and break the cycle of multi-generational trauma that may lead to mental health concerns and substance abuse, and we certainly agree. We see the multi-generational trauma in places like Alaska, perhaps higher there than anywhere else in the country. So much of this is tied to alcohol and other drug use, sexual assault, domestic violence, and it's not just limited to the family members who are addicted.

These are small villages, a couple of hundred people. There is not access to a licensed social worker or a psychiatrist or a psychologist. It's not feasible to fly the children into Anchorage for care, both from a practical and a financial standpoint. So I've been working with Senator Smith here to allow National Health Service Corps members to provide services in schools so we effectively bring the providers to the schools.

We're in a position where it's just really challenging, if not impossible, to fund a mental health professional in the schools that need them. Do we have other policies that we can perhaps look to get providers into schools without putting a burden on our already underfunded school districts?

Ms. DONAHUE. Thank you very much for that question. In Delaware, we do have behavioral health consultants that are in the middle schools for ages 12, 13, and 14, and those have been proven

to be very effective. However, the funding, as you said, with education is very difficult to overcome.

There are some models out there, such as the Compassionate School Model, that our office is working toward, which does incorporate trauma informed care. So that would, in essence, provide a team approach in the school to provide those children to have that access to mental health in a trauma informed environment where they can trust to come to school, and it's a safe place for them to speak about their trauma.

The prevalence of trauma in Delaware and children coming into foster care is putting an extreme toll on our child welfare workforce as well. So we have to also look at not only mental health access for these children, but also the fact that there will be child welfare protection services that must also be funded in order to keep these children safe when abuse or neglect is identified during that mental health treatment or school atmosphere.

Senator MURKOWSKI. Well, thank you for that. Know that these are issues that, working with Senator Smith and others, we'd like to pursue.

With that, Mr. Chairman, thank you.

The CHAIRMAN. Thank you, Senator Murkowski.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman.

I really appreciate the opportunity to have you here as witnesses today to talk about the discussion draft of the Opioid Crisis Response Act. I'm really grateful to my colleagues for some of the ideas that are being proposed for additional discussion and inclusion.

Mr. Morrison, I wanted to start with you. You've already been questioned about this. You noted it in your testimony. We have right now a place holder in this discussion draft in terms of renewal and improvement of the STR Grant. You noted the fiscal cliff, and you also made note of the flexibility that would be welcomed for dealing with drugs beyond those described as opioids.

I wanted to just mention in my travels around the State of Wisconsin—and I've been hosting roundtables with various stakeholders in various parts of my state for several years now, almost since I joined the Senate in 2013–2014. I have seen regions of the state that are dealing with a meth crisis and regions of the state that are dealing with an opioid crisis. It was very distinct when I first started.

Now, in the last couple of months when I've had recent roundtables, I'm being told that almost everybody who is either encountering law enforcement or is encountering emergency treatment has multiple drug—they're presenting with multiple drugs. There's no clean distinction, just as we were hearing from Senator Murkowski about Alaska, although I'm sure we have local differences.

I wonder if you could speak to the importance of that flexibility. It may be that what brings all of this together is just the spike we call it an epidemic, because between 2000 and today, whether it's the—pain is the fifth vital, or whatever other contributing factors there are, we've seen such a deluge, such a crisis. But it does seem to me like it's going from prescribed opioids to heroin and fentanyl

to now people accessing whatever they can when the addiction has really gripped them.

Mr. MORRISON. I agree that we should look at it, at its core as a problem with addiction, and look at ways to be flexible, allowing states to target areas of need based on their particular drug of choice. I think with the opioid epidemic, we also saw the need for medication-assisted treatment, and those efforts have been critical, and looking at evidence-based approaches to also keeping the families together—important work that this Committee did was to create a pilot program for pregnant postpartum women to look at different ways they could support family centered services. So the bottom line is in Wisconsin, about half of your admissions to treatment are from alcohol.

Senator BALDWIN. I know I'm not going to have time to ask all the questions I'd like. Let me just note a couple of issues on the record that I will hopefully be able to get answers after the hearing.

I wanted to add my words to Chris Murphy's question relating to recovery coaches. We have a very innovative program going on in the State of Wisconsin. Jesse Heffernan of Appleton, Wisconsin, a longtime advocate and recovery coach, was inspired by his own experience with substance use disorder to start a Recovery Corps program to integrate recovery coaches into the entire substance use care curriculum, and it's being piloted by Marshfield Health System. So I'd love to ask some specific questions for your feedback on that.

Senator BALDWIN. One other question, Ms. Nickel, if I can ask you, with clearly inadequate time to answer it now. We need everyone at the table to work together to appropriately combat this epidemic, and I'm encouraged that your organization is committed to a comprehensive response. But I'm also concerned with the pharmaceutical industry's role in the opioid crisis and believe that we need to do more to hold drug makers accountable.

More than half the counties in my state have filed lawsuits against pharmaceutical companies, and I've heard from Wisconsin's substance abuse and recovery leaders about their continued concerns with the drug companies' influence in our response efforts, and we certainly know of their influence here on Capitol Hill. So I would love to hear from you sort of best practices and how you work with many industry partners, including drug companies; what policies we need to enact to prevent conflicts of interest as we continue to fight this epidemic.

The CHAIRMAN. Ms. Nickel, we're out of time, but please go ahead and answer the question. Then you may want to follow-up with a written answer to Senator Baldwin.

Ms. NICKEL. Absolutely. You know, this is an issue about addiction, and we don't have a medication-assisted treatment for methamphetamine use disorder. We don't have a medication for cocaine use disorder, and we're seeing an increase in drug overdoses and drug overdose deaths, particularly in our African American communities, to cocaine use disorder overdoses. We don't have great medications for alcohol use disorder. We need more.

We firmly believe that in the treatment and the advancement of science and research and innovation and a cure that we need to be

partnering with scientists and universities and companies that have R and D budgets, because you don't cure a disease without having the smart white lab coats at the table with you. So our commitment to having everyone at the table includes those that can give us the medications that we need to survive this illness.

The CHAIRMAN. Thank you very much, Senator Baldwin.

Senator Hassan.

Senator HASSAN. Thank you very much, Mr. Chair, and I want to thank you and the Ranking Member for your bipartisan work on this discussion draft of this bill, and I want to thank the witnesses for being here.

I want to speak for a minute to the continuing work we're doing on the bill and note that as we continue our work together, it's really critical that we ensure that we are adequately prioritizing Federal funding for states that have been hardest hit by the opioid crisis, a priority that has bipartisan support. I appreciate you recognizing that this is something that needs to be included. I look forward to partnering with the Chair and Ranking Member and others on this.

You know, I just did a ride-along in my home State with the Manchester, New Hampshire, police department, and in my first hour and a half, we responded to three overdoses. So when we are hit hard right now with the fentanyl epidemic, in particular, that is so lethal, we really need to make sure that we're doing everything we can to help the hardest hit states and help the hardest hit states develop expertise.

I also appreciate that the draft legislation includes a number of other priorities I've championed, including the Comprehensive Opioid Recovery Centers Act, which I introduced with Senator Capito. There's a similar bipartisan bill in the House of Representatives as well.

The bill would create a pilot program allowing HHS to award grants to expand existing centers to serve as comprehensive opioid recovery centers. These centers would provide a full range of treatment and recovery services to not only treat patients but also to provide them with the wrap-around services they need to move to successful and drug-free lives.

The centers would also have outreach to community partners to provide information about the services available at the centers to help ensure that those seeking treatment know what their options are. The kind of wrap-around support offered by CORC is critical for those in recovery and is especially needed in states hardest hit by the opioid epidemic.

I want to just add my to-do list to Senator Murphy's and others. I hope that the Chair and Ranking Member will continue to work with me and others to make sure we're adequately prioritizing those hardest hit states in this provision concerning the CORC centers as well. I've heard from a number of providers and stakeholders in the granite state in support of this legislation, and I hope we can get this bill passed.

With that statement, now I do have actually a couple of questions.

To Mr. Morrison: During our hearings on the opioid crisis, we heard from a stakeholder from New England who is utilizing a

really unique model to increase access to medication-assisted treatment, a model I'm working on legislation to replicate on a national level. This model was actually developed with the help of our current Assistant Secretary for Mental Health and Substance Use, Dr. Elinore McCance-Katz, when she was working in Rhode Island.

Under this model, medical students are getting training in medical school on addiction issues and medication-assisted treatment. Once the students graduate, move on to their residencies, get licensed to practice, and get their DEA number, they can apply right away for a so-called data waiver to prescribe buprenorphine. They don't have to take an additional 8-hour course for it. They're just set to go.

I really think what they're doing in Rhode Island is a great idea. So I'm working on a bill that I hope will be included in the bipartisan Opioid Crisis Response Act, what we're talking about today, to facilitate this program for other medical schools who want to do it. My legislation, the Enhancing Access to Addiction Treatment Act, will provide voluntary grants to support medical schools and residencies in developing their own programs to train students and establish a new pathway to let these trained, practicing physicians apply right away to prescribe medication-assisted treatment, the same time they can start prescribing opioids.

Mr. Morrison, what do you think about this idea? Will it help to increase patient access to medication-assisted treatment?

Mr. MORRISON. I think it will, and I appreciate your leadership. I know our member, Becky Boss, when she presented testimony here, referred to that program as well, and she said it's a tremendous success to increase—or decrease barriers and make it easier to get waived and actually dispensing and providing the care we need, and we know we need additional folks prescribing and increasing MAT. So I look forward to working with you on it.

Senator HASSAN. Well, thank you very much. And in my last half a minute, I just wanted to also talk with you, Mr. Morrison, about some really important work being done in schools relating to substance use prevention. One of the overdoses we responded to—we got there—in Manchester, there were firefighters, EMTs, police, and DCYF, our child protection services, because the ripple effect here is hitting everyone. In the Laconia School District in New Hampshire, they've been really hit hard.

I think there is more to do to encourage collaboration and cooperation. We have some examples, and I will follow-up with you, because I'm already overtime, on your thoughts on how we can better address efforts for school and treatment, behavioral health collaboration to really help our kids and our families who are traumatized and struggling with this. I'll follow-up with you in writing. Thank you.

The CHAIRMAN. Thank you, Senator Hassan.

Senator Casey.

Senator CASEY. Mr. Chairman, thank you very much. I want to thank you and Ranking Member Murray for the work you've done, not only to bring us to this point with regard to the Opioid Crisis Response Act but also the hearings that have been undertaken over many weeks now. We're grateful for that help, and also thank you, in particular, for including provisions to further strengthen state

efforts to protect infants affected by substance abuse, known as the Plan of Safe Care provision of the Child Abuse Prevention and Treatment Act, so-called CAPTA legislation.

Chairman Alexander and I worked together on the Infant Plan of Safe Care Improvement Act in 2016, and I appreciate that work. This current bill builds on that law by providing a new grant program to support state efforts to provide these Plans of Safe Care. I'm also grateful for the additional $60 million in funding that was included in the omnibus for CAPTA at my request, and I look forward to advancing this new proposal to create a more permanent program to support states in this work.

Ms. Donahue, I know I'm the last questioner, so I'll get to questions now for you. I may not get to our other witnesses. But I wanted to start with a statement that you made at the end of your testimony, page 7, and I'm quoting at the bottom of page 7, quote, "Infants with prenatal substance exposure and their parents struggling with opioid addiction have multiple and complex needs that require a collaborative response by a multi-disciplinary team," unquote.

Can you talk about what that looks like in reality on the ground? Who are the multi-disciplinary participants involved in creating the typical Plan of Safe Care?

Ms. DONAHUE. Thank you. Our SEI Committee, our Substance Exposed Infants Committee, is made up of public health, family courts, social workers in the hospitals, child welfare workers. Every birthing hospital has representation on there. We have, of course, the substance use treatment providers, and, of course, our State is one of the smaller states, and we're doing this on a statewide basis. But we do have a very broad representation on our committee because of the fact that it's not just one agency that has their responsibility and accountability in this issue. It's very vast.

Our Plans of Safe Care—I did attach a copy of one of the drafts that we're utilizing right now in four of our six hospitals, and so far, it's been a challenge. It's been a very difficult challenge, not necessarily implementing it, but the monitoring piece. We know that this population of women are very vulnerable. Pregnant women struggling with addiction have a stigma that is great, and women fear coming to get prenatal care because of the possible stigma by medical providers. They are fearful that when the birth event comes, that child welfare will take their infant.

There's lots of aspects to this population that we have to be mindful of, and coming together in a collaborative way and, hopefully, having these Plans of Safe Care begin prenatally so that mother has the supports around her from all of these different multi-disciplinary members, the birth event will go much more smoothly and she'll have trust of all of us to move forward with helping her and her family.

Senator CASEY. I appreciate that, and I know you've emphasized the importance of those teams. Also, I wanted to indicate that you've noted that it's important to have a non-punitive, public health oriented approach to working with these vulnerable families, and we know that's critical. It's also something that's a key part of CAPTA. In fact, we have a former member of the Pennsylvania delegation, then Congressman Jim Greenwood, who is the

original sponsor of the Plan of Safe Care and has said that this was his original intent.

I would ask Chairman Alexander for unanimous consent to include in the record of the hearing a letter from former Congressman Greenwood in which he says the following. I'll just read portions of it in short fashion: "In 2003, I worked with my congressional colleagues to ensure that CAPTA was written so that this, quote, 'appropriate referral,' unquote, and the development of a Plan of Safe Care for the infant was not wrongly interpreted as Congress establishing a Federal law of what constitutes child abuse and neglect. Also, Congress' 2003 amendment of CAPTA did not advance a tool to encourage the criminal prosecution of a woman who consumed drugs or alcohol during pregnancy," unquote.

I'd ask consent to have the letter included.

The CHAIRMAN. It will be included, Senator.

Senator CASEY. Thank you, Mr. Chairman.

[The information referred to follows:]

JAMES C. GREENWOOD
MEMBER OF CONGRESS
1993 - 2005

The Honorable Josh Shapiro
Pennsylvania Office of Attorney General
Commonwealth of Pennsylvania
Strawberry Square
Harrisburg, Pennsylvania 17120

The Honorable Teresa D. Miller
Acting Secretary of the Pennsylvania Department of Human Services
Commonwealth of Pennsylvania
Post Office Box 2675
Harrisburg, Pennsylvania 17105-2675

Dear Attorney General Shapiro and Secretary Miller:

I am writing to request that the Office of Pennsylvania Attorney General (PA OAG) and the Pennsylvania Department of Human Services (PA DHS) immediately offer joint guidance to Pennsylvania counties regarding the provisions of the federal Child Abuse Prevention and Treatment Act (CAPTA) specifically 42 U.S. Code § 5106(b)(2)(B).[1]

I understand that, in consultation with a state-convened Multi-Disciplinary Workgroup on Infants with Substance Exposure, PA DHS is working, with intention, to review its own Child Protective Services Law (CPSL). This is promising, and I fully support the effort.

Still this focus on prevention and treatment strategies that will unfold in the future may well serve to disregard today's challenging reality - every day Pennsylvania infants are being born dependent on an opioid. Such dependence, often referred to as Neonatal Abstinence Syndrome (NAS), can result from exposure to illegal drugs (e.g., heroin) or legal drugs (e.g., Methadone or Hydrocodone).

In 2003, I authored an amendment to CAPTA to facilitate communication and coordination between child welfare agencies and health care providers when an infant is born "affected by" drugs and alcohol consumed by the infant's mother during pregnancy.

My efforts in 2003 required that states have "policies or procedures" to provide for the "appropriate referral" from the health care provider to the child welfare agency.

As a former children and youth caseworker, I did not envision this "referral" as a traditional child abuse report. Instead, I intended that such a call from the health care provider would trigger the development and

[1] https://www.law.cornell.edu/uscode/text/42/5106a

monitoring of an inter-disciplinary plan of safe care for the infant and his/her mother, upon the infant's discharge from the hospital.

I envisioned that health care providers, child welfare professionals, other social service agencies, the courts if needed and families would use the plan of safe care to address the mother's access (or barriers) to drug and alcohol treatment, connect the family to early intervention services and evidence-based home visiting services to help the family navigate the infant's health and development. Additionally, I expected that cross-system partners would explore if the family had access to stable and safe housing, particularly housing that supported persons in recovery from addiction.

In 2003, I worked with my Congressional colleagues to ensure that CAPTA was written so that this "appropriate referral" and the development of a plan of safe care for the infant was not wrongly interpreted as Congress establishing a federal law of what constitutes child abuse or neglect. Also, Congress' 2003 amendment of CAPTA did not advance a tool to encourage the criminal prosecution of a woman who consumed drugs or alcohol during pregnancy.

In 2016, Congress updated CAPTA, when it enacted the Comprehensive Addiction and Recovery Act (CARA). The CAPTA amendment resulted from the leadership of Pennsylvania's Congressional delegation following introduction of stand-alone *Infant Plan of Safe Care Improvement* bills introduced in the United States House of Representatives and United States Senate.

Federal lawmakers crafted the final version of CARA (S. 524) in response to "concerns about the increased number of infants born suffering from opioid withdrawal symptoms" and to ensure that "states are in compliance with the Child Abuse Prevention and Treatment Act (CAPTA)."[2] The Conference Committee Report accompanying S. 524 stipulated that Congress intended to clarify "the intent of safe care plans" and to advance "best practices for developing plans to keep infants and their caregivers safe and healthy."

In no way did Congress' 2016 actions erode CAPTA's earlier emphasis that the "appropriate referral" of and plan of safe care provisions not "be construed" as creating a federal definition of child abuse.

Pennsylvania infants born drug-dependent today and, in the upcoming months, urgently require two-generation plans of safe care focused on improving outcomes for the infant and his/her families.

Today, these infants should have access to some standardized approach within our health care and child welfare systems, including a shared vision that scarce resources be used to improve outcomes not to label the infant's mother a child abuser.

In conclusion, let me assure you that I understand that while Congress – in 2003 and again in 2016 – expanded the CAPTA requirements; Congress continues its historical pattern of under-funding CAPTA.

In federal fiscal year 2016, approximately $4.7 billion was available to pay for costs associated with foster care and adoption. Meanwhile, the federal funding stream designed to support and strengthen families received $355 million. By contrast, CAPTA and its smart policy initiatives, including creating plans of safe care, received only $26 million. This funding imbalance is unreasonable if, as a country, we genuinely [illegible]

[2] H. Rept. 114-669 – Comprehensive Addiction and Recovery Act of 2016.

want to protect our children, strengthen families, and prevent young children from dying because of the effects of being born into families struggling with the disease of addiction.

Sincerely,

James Greenwood

cc: Pennsylvania Congressional Delegation

Senator CASEY. I have one more question, but I'll maybe submit that for the record for Ms. Donahue, and I may have some questions for the other panelists. Thank you for your testimony and your good work. [6]

The CHAIRMAN. Thank you, Senator Casey.

Mr. Morrison, let me especially ask you this, although I'd be interested in other comments. You work with a lot of state agencies and state directors, and there's always a temptation when there's a problem to solve it from Washington, and we have to think about that, too—the difference between creating an environment in which states and communities and doctors and healthcare workers can solve a problem or creating mandates and orders from here which sometimes sound good at the beginning but get in the way.

Let me ask you about three or four areas. You've had conversation, I'm sure, with Governors, with state directors in this area. For example, 28 States have prescribing limits for—some limit on the number of opioids doctors can prescribe at one time. We don't create a Federal mandate. We leave that to states, although we do allow the Food and Drug Administration to create blister packs, which would be smaller doses.

Electronic prescribing—we've heard testimony that that's beneficial. Nine states are moving ahead to require that in one way or another, creating a digital record. We don't have a mandate for that, figuring that States from Alaska to New York are different and have better ways to make those decisions.

Prescription drug monitoring programs—about 45 States share data with other states, and 37 states require that doctors and pharmacists check their state's PDMPs to help prevent patients with substance abuse disorder from doctor and pharmacy shopping. We don't create a Federal mandate on PDMPs, but we do include support for states to improve their systems and their sharing of information, and we have appropriated a large amount—or approved a large amount of money, $356 million, 2 weeks ago to help states do a better job of that.

Then there's the medical education curriculum. I've mentioned dropping in on Governor Haslam in Tennessee, and he had everybody there who trains doctors and healthcare workers to talk about how they should adjust their curriculum to reflect the prescribing of opioids. We don't have a Federal mandate on telling states how to do that.

What's your comment on that? And can you think of other ways that our legislation can create an environment in which states might more easily prescribe appropriate limits, whatever those might be, encourage electronic prescribing, have more effective prescription drug monitoring programs, better medical education curricula? How can we do that without having the heavy hand of Washington tell everybody what to do?

Mr. MORRISON. I appreciate saving the easy stuff for last, Senator. But, absolutely. Our model at the association is a states helping states model, and they very much appreciate hearing from other states about best practices, about ways things are done that are working. And as much as it's important to know that they're

[6] No responses were submitted for the Record.

working, the question we get most often is: How did you do it? How did you get there? What are the components of your state's system? Because they are so different—the financing structure, the different rules and regs. But at its core, someone has to navigate all this to happen.

Our preference is best practices, these models. The recovery residences approach in your bill is a great example of what's extremely helpful to states—having a dialog about how a particular issue plays out, and then promoting, talking, and seeing how they play out.

Our default is to help states in terms of providing the most flexibility to then partner with the Federal Government and to make improvements that way. We absolutely adhere to the National Governors Association and their principles of how the Federal-state partner is critical. So we appreciate that perspective, and it's what we do every day, finding that sweet spot.

The CHAIRMAN. Let me ask one other question, Ms. Nickel and Ms. Donahue, or any of the three of you. In my visit to Tennessee last week, I mentioned to you the two criminal court judges that I talked with, who said the following: that they see—and I mentioned this—60,000 cases—well, this is not the figure—this is the other example. They said they see between 50 and 100 probation violations each month, about 75 percent involving offenders testing positive for drugs. But this is the point. About half of the 75 percent test positive because the offender has taken medication-assisted treatment that was prescribed for someone else.

We've talked a little bit today about allowing more people to provide medicated-assisted treatment and how important that treatment is to avoiding overdose. But what about the diversion of medication-assisted treatment? Are you seeing that in your states? I mean, what they're saying they see is that suddenly, the basically lower doses of opioids that are used for medicated-assisted treatment are being diverted and are showing up as more and more of the source of the problem. Do you have any comment on that?

Ms. NICKEL. I think we do need to make sure we give the right resources and tools to law enforcement and to our criminal justice systems to deal with diverted substances. But the other reality is that when you see a presence of medication-assisted treatment, particularly among our patient population who have an opioid use disorder, many are self-managing their own symptoms.

Like if you can get buprenorphine or methadone on the street, you can also probably get heroin, which is a much better high, and it's going to be a much more powerful drug. So, usually, it's almost an indicator that more treatment is needed in that community as well, because you have people like you and me that are trying to manage a very powerful disease on their own.

The CHAIRMAN. Ms. Donahue.

Ms. DONAHUE. Thank you. In the child welfare realm, many of our pregnant women are utilizing medication-assisted treatment, and it's very beneficial for her and her infant.

The CHAIRMAN. I also heard that at the hospital, too, that——

Ms. DONAHUE. Yes.

The CHAIRMAN ——many of the babies are the result of mothers with medication-assisted treatment. Is that what you're about to say?

Ms. DONAHUE. Yes. However, what we are seeing at times is that children may in the home access that medication——

The CHAIRMAN. Oh.

Ms. DONAHUE ——and we are seeing at times that two or 3-year-old siblings in the home—if the particular parents have take-home doses of their medication-assisted treatment, that has to be secured, because many of these cases are involving children overdosing on those types of medications in the home, and that's what——

The CHAIRMAN. They're young.

Ms. DONAHUE. Yes, if they're getting access to them. So in the child welfare realm, we have to be cautious as well that there are certain precautions in place for that type of medication.

The CHAIRMAN. Well, let me thank the three of you for very, as you've heard the Senators describe, poignant, sensible, and effective testimony as you reviewed our proposed legislation.

Just talking with the staff and with Senator Murray, we're on a schedule to mark that bill up on Tuesday, the 24th, which means we've got some work to do before that, I'll say to the staff, but they're working well together. And we also have other legislation that we hope to mark up on that day as well. This is our seventh bipartisan hearing on the subject. We hope we can make a contribution to the crisis.

Other committees are working on the area as well, and what we hope to be able to do is, after the end of this month, to take our bill to Senator McConnell and ask him to find time for it on the Senate floor, and then work with the Judiciary and Finance Committees to see what suggestions they might have to improve or amend the work that we have done.

I'd like to ask for unanimous consent that the statement from the Department of Health and Human Services be submitted into the hearing record. [7]

The CHAIRMAN. The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like.

Our Committee will meet again on Tuesday, April 24, at 10 a.m. to mark up the Opioid Crisis Response Act of 2018 and other important bipartisan legislation.

Thank you for being here today. The Committee will stand adjourned.

[Whereupon, at 12:01 p.m., the hearing was adjourned.]

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[7] Department of Health and Human Services statement was not submitted for the Record