Increasing Access to Medication-assisted Treatment for Opioid Addiction in Drug Courts and Correctional Facilities and Working Effectively With Family Courts and Child Protective Services

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Introduction

This is the third of three policy papers that the American Association for the Treatment of Opioid Dependence (AATOD) has developed for the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services. The aim of these three policy papers is to provide a blueprint for more innovative and integrated service delivery for opioid treatment programs (OTPs) and authorized prescribers under the Drug Addiction Treatment Act of 2000 (DATA 2000), which primarily use buprenorphine to treat opioid addiction.

This paper describes opportunities for OTPs and authorized prescribers under DATA 2000 to work with drug courts, correctional facilities, probation and parole offices, and family courts and Child Protective Services (CPS). It provides effective strategies to achieve challenging goals at a time when opioid abuse and addiction has increased sharply throughout the United States.

Each of the three sections of this paper has an important focus. The first describes how OTPs and authorized prescribers under DATA 2000 can best engage drug courts. Doug Marlowe provides excellent examples of how to achieve this end result. He indicates in this section of the paper that the most effective way to garner support for medication-assisted treatment (MAT) is "to educate drug court team members about its use when a contentious case is not presently at issue." Mr. Marlowe goes on to say that "OTPs and other MAT providers may find it necessary to engage in proactive outreach strategies to educate drug courts in their communities." Harlan Matusow et al. (2013), who conducted a survey among drug court professionals, found that 56 percent of drug courts referred their participants to OTPs for MAT and 44 percent did not. The survey also found that only about half of the drug courts that did not offer MAT reported having a blanket policy against MAT (Matusow et al., 2013).

To quote the Adult Drug Court Best Practice Standards, from the National Association of Drug Court Professionals (2013):

> Numerous controlled studies have reported significantly better outcomes when addicted offenders receive medically assisted treatments including opioid agonist medications such as Naltrexone, opioid antagonists such as methadone, and partial agonist medications such as buprenorphine. Therefore, a valid prescription for such medications should not serve as the basis for a blanket exclusion from a drug court.

The point of including Doug Marlowe's section, with recommendations on how OTPs and DATA 2000 practices can better engage and educate drug courts in the United States, is to break through the existing isolation which prevents drug court participants from gaining better access to the three federally approved medications to treat opioid addiction (methadone, buprenorphine, and combination naltrexone products). This is especially critical in an era of increasing opioid addiction, which has been repeatedly reported by federal agencies and professional journals for many years. The National Institute on Drug Abuse (2012) has established that MAT "increases patient retention and decreases drug use, infectious disease transmission, and criminal activity."

The second section of this paper provides recommendations to OTPs and authorized prescribers under DATA 2000 about methods of improving access to pharmacotherapy for opioid use disorders within the criminal justice system. Many studies have pointed to the need to increase access to MAT for opioid addiction when people are under legal supervision. In fact, a key recommendation from the National Institutes of Health (1997) indicated that "all opioid dependant persons under legal supervision should have access to methadone maintenance therapy." Though this recommendation was made in 1997, few correctional facilities in the United States have provided access to such care. In this section of the paper, Drs. Sarah Wakeman and Jody Rich describe ways to work with U.S. correctional facilities to improve access to MAT. They focus on several models that exist at the present time, including having OTPs delivering medication to correctional settings and, alternatively, locating the OTP within the correctional setting.

In its groundbreaking paper, *Legality of Denying Access to Medication Assisted Treatment in the Criminal Justice System,* the Legal Action Center (2011) makes the case very well:

> An estimated 65% of individuals in United States' prisons or jails have a substance abuse disorder, and a substantial number of these individuals are addicted to opioids. Rates are at least as high in all other phases of the criminal justice system. This enormous amount of substance use among individuals with criminal justice involvement has far reaching consequences, including higher recidivism rates, harm to families and children of criminal justice involved individuals, and negative public health effects, including the transmission of infectious diseases and overdose deaths…. Denial of access to MAT at any level of the criminal justice system violates the ADA [Americans with Disabilities Act] and the Rehabilitation Act where the denial is pursuant to a blanket policy prohibiting MAT or is carried out on a case by case basis without the required objective, individualized evaluation.

Federal agencies and state correctional entities need to develop arrangements so that people under legal supervision who are opioid addicted can get access to the three federally approved medications to treat opioid addiction in the United States. Drs. Wakeman and Rich make the point succinctly:

> Among state prisoners with a drug use disorder in 2004, only 0.8 percent received detoxification services, 0.3 percent received maintenance pharmacotherapy, and 6.5 percent received counseling by a professional. According to the World Health Organization, incarcerated individuals should have access to the same treatments offered in the community, including opioid agonist therapy.

The third and final section of this paper focuses on how OTPs and DATA 2000 practices can work with Child Protective Services (CPS) and family courts. Pamela Peterson Baston makes a critical point: "Failure of the child welfare and SUD treatment system to work together to identify, assess, connect to, and stabilize in treatment, parents with children in out of home placement, results in fiscally and emotionally costly consequences including termination of

parental rights." The author provides excellent recommendations on how substance abuse treatment programs can work to educate representatives in CPS and family courts.

Ms. Peterson Baston makes another observation as well:

> Cross-training is needed for all relevant parties in the opioid treatment and CPS sectors on how to timely identify and respond to parents with opioid use and other SUDs including the importance of MAT. New Jersey and Pennsylvania are in various stages of expanding and improving SUD training.

One final point, to preface the sections that follow, is provided by SAMHSA (2005) in its Treatment Improvement Protocol (TIP) 43, *Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*:

> Discussions about whether addiction or a medical disorder is a moral problem have a long history. For decades, studies have supported the view that opioid addiction is a medical disorder that can be treated effectively with medications administered under conditions consistent with their pharmacological efficacy, when treatment includes comprehensive services, such as psychosocial counseling, treatment for co-occurring disorders, medical services, vocational rehabilitative services, and case management services.

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Increasing Access to Medication Assisted Treatment in Drug Courts

Douglas B. Marlowe, J.D., Ph.D.

Introduction

Drug courts provide fertile ground for increasing access to medication-assisted treatment (MAT) for justice involved individuals. Drug courts are, first and foremost, *courts*; as such, the constitutional principle of due process applies to most of their operations. Drug court judges are bound by legal precedent, must consider relevant evidence before making factual decisions, and must explain the rationales for their decisions in a written record if requested, and their decisions may be overruled by an appellate court. This level of treatment accountability is virtually nonexistent in other criminal justice and substance use disorder (SUD) treatment settings.

Evidence suggests drug courts offer MAT considerably more often than most other criminal justice and SUD treatment programs. A national survey of 93 drug courts found that more than half (56 percent) of the programs offered MAT (Matusow et al., 2013). This figure compares quite favorably to rates ranging from 4 to 17 percent for probation programs (Chandler, Fletcher, & Volkow, 2009; Friedmann et al., 2012) and 7 to 13 percent for non-OTP community treatment programs (Aletraris, Edmond, & Roman, 2015; Kleber, 2008; McLellan, Carise, & Kleber, 2003; National Center on Addiction and Substance Abuse, 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

Of the 44 percent of drug courts in the national survey that did not offer MAT, about half (20 to 25 percent of all drug courts in the survey) reported having a blanket prohibition against MAT (Matusow et al., 2013). Many drug courts (approximately 25 to 30 percent of all drug courts) reported confronting practical barriers that prevented them from using MAT. The most common barriers were insufficient funding and a dearth of MAT providers in their communities. Expanding access to MAT providers and increasing third-party reimbursement for MAT could, therefore, be expected to substantially increase adoption of MAT in many drug courts.

For the minority of drug courts that continue to have blanket prohibitions against MAT, a number of strategies are available to challenge those prohibitions and increase the adoption of MAT in appropriate cases. A more difficult challenge is to convince drug courts of the need for MAT in contested cases, in which conflicting medical testimony is offered by opposing experts. Recommendations for challenging blanket prohibitions against MAT and making a convincing case for the use of MAT in contested cases are described below. A forthcoming National Association of Drug Court Professionals (NADCP) publication will provide more in-depth information to help drug courts evaluate requests for MAT in contested cases (Nordstrom & Marlowe, in press). [1]

[1] See Appendix for additional resources describing best practices for MAT in drug courts.

Best Practice Standards for MAT in Drug Courts

The professional standard of care for drug courts requires programs to allow MAT in appropriate cases.[2] In 2010, the board of directors of NADCP issued a unanimous resolution directing drug courts to (1) keep an open mind and learn the facts about MAT, (2) obtain expert medical consultation when available, (3) make a fact-sensitive inquiry in each case to determine whether MAT is medically indicated or necessary for the participant, and (4) explain the court's rationale for permitting or disallowing the use of MAT (NADCP, 2010). The resolution states explicitly that drug courts should not have blanket prohibitions against MAT.

In 2013, NADCP released Volume I of the *Adult Drug Court Best Practice Standards* (NADCP, 2013). Standard I (Target Population) provides that candidates for drug court should not be excluded from participation in the program because they have a legally valid prescription for an addiction or psychiatric medication. Standard V (Substance Abuse Treatment) further directs drug courts to offer MAT when prescribed and monitored by a physician with expertise in addiction psychiatry, addiction medicine, or a related medical specialty. Finally, Standard VI (Complementary Treatment and Social Services), released in 2015, directs drug courts to offer psychiatric medications for co-occurring mental health disorders when prescribed and monitored by a psychiatrist or other duly trained medical practitioner (NADCP, 2015).

Drug courts that ignore these provisions are operating below the recognized standard of care for the profession. These drug courts expose themselves to serious criticism, may find themselves ineligible for certain drug court funds, and may be overruled on appeal.

Legal Standards for MAT in Drug Courts

Best practice standards are derived from scientific evidence indicating which policies and practices produce the best outcomes in drug courts. Legal standards, in contrast, are derived from constitutional and other legal principles governing what actions may be taken in a court of law. Legal standards relating to MAT vary considerably, depending on whether a drug court is receiving federal funding and whether contrary medical evidence has been offered to challenge the propriety of a prescription.

Beginning in 2015, the Bureau of Justice Assistance (BJA) required drug courts receiving federal funding pursuant to the Adult Drug Court Discretionary Grant Program to attest in writing that they would not deny eligible candidates access to the program because of an individual's use of an FDA-approved medication for the treatment of an SUD, nor would participants be required to taper off such medications as a condition of graduating from the program (Bureau of Justice Assistance [BJA], 2015a, 2015b). The grant language creates a difficult-to-rebut presumption that MAT will be permitted if it is prescribed lawfully by a licensed medical practitioner who has examined the participant, diagnosed the participant as having a severe SUD, and determined the medication is appropriate to treat that disorder. Drug courts may overrule such determinations only if the judge makes an explicit finding that the participant is misusing, abusing, or diverting the prescription medication for illicit purposes.

[2] See Appendix for resources describing the standard of care and best practices for MAT in drug courts.

This mandate applies only to drug courts receiving BJA or SAMHSA funding; however, it offers an apt analysis for any drug court dealing with an uncontested prescription for MAT. The burden of proof in these matters is a relatively light standard referred to as a *preponderance of the evidence*. It must be more likely than not (more than 50 percent likely) that a prescription is medically indicated or medically necessary for the participant. (The terms *medical indication* and *medical necessity* are defined later.) If there is no opposing medical evidence suggesting that a prescription may be unnecessary or contraindicated, then this light burden of proof will be satisfied in most cases. Barring any medical evidence to the contrary, there is little justification for a drug court to deny a lawful prescription for MAT from a qualified physician who has diagnosed the participant and will continue to treat the participant going forward.

A more difficult challenge arises if a drug court is not receiving federal funding and is offered to suggest that, contrary to medical evidence, the prescription may not be medically necessary or indicated. If, for example, the prosecution offers its own medical evidence suggesting that a prescription is unnecessary, the judge will need to make a ruling on the matter after listening to medical evidence from both sides. In this relatively circumscribed set of cases, medical experts will be required to provide the drug court with a convincing rationale for using or not using MAT based on the facts of the case.

Unfortunately, many physicians are unaccustomed to having their medical decisions questioned by laypersons, and even competent physicians can have a difficult time explaining their decision-making process to nonmedical professionals. Some physicians may misinterpret legitimate questions about the basis for their opinion as an indication that drug courts are against MAT or that judges are practicing medicine without a license. This inference is not justified. A judge who questions the rationale for a medical expert's opinion in a contested case is practicing law, not medicine. A medical expert who refuses or is unable to answer such questions does a disservice to his or her patient and the administration of justice.

Educating the Drug Court Team

The most effective way to garner support for MAT is to educate drug court team members about its use when a contentious case is not presently at issue. Once a dispute about MAT has arisen in a specific case, staff members may feel compelled to defend current practices and the judge will be obligated to make a decision within a short period of time. These pressures can work against reconsideration of long-held beliefs. Staff will need time to reflect on the issues, deliberate with fellow drug court team members, and convince colleagues from their respective agencies to reconsider entrenched practices. Forcing the matter in light of a contentious case can lead to intransigence and unwillingness to revisit old policies.

Drug court training conferences are held every year at the national, state, and regional levels. Frequently, drug court teams attend these conferences together as a group. In addition, team members often attend conferences for their respective professions, such as conferences for judges, prosecutors, defense lawyers, probation officers, or treatment professionals. These conferences provide excellent opportunities to educate drug courts about MAT. Contrary to the assumptions of some physicians, evidence suggests drug court professionals are generally open to learning about MAT from qualified faculty and report more favorable attitudes toward MAT as a result (Matejkowski et al., 2015). Unfortunately, drug court professionals who do not attend

such conferences are often the ones most resistant to adopting evidence-based practices. OTPs and other MAT providers may find it necessary to engage in proactive outreach strategies to educate drug courts in their communities.

Many drug courts hold oversight meetings or staff retreats on a semiannual or annual basis, in which the team reviews the overarching policies and procedures for the program. It is common practice to invite outside experts to these retreats to give brief presentations about resources that are available in the local community, such as mentoring programs, vocational internships, or community-college scholarships. OTPs and other MAT providers are encouraged to contact the coordinator for the drug court or the judge's clerk to request an opportunity to speak about MAT at an oversight meeting. Most drug courts will gladly accept a free educational opportunity, especially if it includes an offer of refreshments or a brown bag lunch.

Drug courts also have weekly case reviews or staffings prior to holding court sessions. At these staffings, team members share their observations about participants' performance in the program and may offer recommendations to the judge for suitable rewards, sanctions, or treatment conditions to impose. Every drug court team includes a treatment representative who provides expertise on clinical matters. The treatment representative may request permission for an MAT expert to attend a staffing and provide medical information related to a specific case. As a practical matter, medical experts are more likely to be invited to attend staffings if they are already familiar to the drug court team and they have provided educational trainings previously.

Challenging Blanket Prohibitions

Despite best efforts at education and outreach, some drug courts may continue to deny MAT as a matter of policy. Under such circumstances, it may become necessary to challenge lawfulness of such policies. Assuming an adversarial posture should be a strategy of last resort, because it may undermine collaborative decision making, inadvertently pit staff sentiments against a participant's therapeutic interests and usually requires considerable time to reach a resolution. In many instances, simply demonstrating a willingness to challenge an existing policy will be sufficient to lead a drug court to reconsider its actions.

Drug court judges, like all trial judges, are bound by a constitutional due process requirement of *reasonableness* or *rationality* when ordering conditions of treatment and supervision for persons on probation or in comparable community dispositions (Petersilia, 1998; Roberts v. U.S., 1943). The conditions may not be unnecessarily broad or arbitrary, and they must be reasonably related to the person's crime, likelihood of rehabilitation, or risk of future criminality (Commonwealth v. Hartman, 2006; People v. Beaty, 2010; State v. Philipps, 1993). Judges are also required to impose individualized or particularized conditions (Commonwealth v. Wilson, 2010; In re. Victor L., 2010; U.S. v. Carter, 2009). This means every defendant has a right to introduce relevant evidence specific to his or her case. It is fundamentally unfair (i.e., unconstitutional) for a judge to make a factual determination in one case and to assume, conclusively, that the same facts apply in other cases.[3]

[3] An exception is when courts take *judicial notice* of facts that are so well established there is no need to relitigate the issues in individual cases. For example, a court might take judicial notice of the fact that buprenorphine is approved by the Food and Drug Administration (FDA) for the treatment of opioid dependence. Courts have not taken judicial notice of facts that would justify a blanket prohibition against MAT.

These constitutional principles require drug court judges to (1) consider relevant information before making a factual decision, (2) hear arguments from both sides of a controversy (typically from the defense and prosecution), and (3) receive evidence from scientific experts if the subject matter of the controversy is beyond the common knowledge of laypersons (Meyer, 2011). Medical evidence is typically beyond the knowledge of laypersons; therefore, it must usually be introduced or explained by a qualified medical expert (e.g., *Federal Rule of Evidence 702*, 2015).

A drug court judge who enforces a blanket prohibition against MAT (or against particular medication, such as methadone or buprenorphine) is, in effect, prejudging a factual matter before hearing evidence from both sides and considering the particularized facts of the case. Refusing to consider relevant evidence before making a factual determination is likely to be viewed by an appellate court as an abuse of judicial discretion. Appellate courts will frequently overrule such baseless decisions and return the case to the trial court to reconsider the matter.

Candidates for drug court are nearly always represented by defense counsel during the admissions process. Once admitted to drug court, participants usually retain their own defense counsel or are represented by another defense attorney (typically an assistant public defender) who is a core member of the drug court team. Defense attorneys are entitled to request a hearing on the question of whether MAT should be permitted for a given participant. The judge is not required to grant a full and separate proceeding on the matter but must allow a reasonable opportunity for the participant or the participant's legal representative to present an argument. If the judge refuses to grant such a hearing or otherwise indicates the matter is not open for consideration, that refusal may serve as an immediate basis for an interlocutory (interim) appeal. The participant may file an appeal immediately and does not have to wait until after he or she has completed or been discharged from the program. An alternative strategy is to petition an appellate court for a *writ of mandamus*, which directs the drug court to hold a hearing on the matter of MAT, or a *writ of prohibition*, prohibiting the drug court from enforcing an unreasonable policy.

As stated previously, hopes are this process can be avoided and an appeal will not be necessary. Often, requesting a hearing on the question of MAT will be sufficient to convince a drug court of the need to reconsider current practices.

Contested Matters

In the typical health care setting, the physician makes most medication-related decisions in collaboration with the patient. The matter is settled in most instances if (1) the physician has legal authority to write the prescription, (2) the medication is indicated to treat the patient's illness, (3) the prescription was not obtained fraudulently, and (4) the patient agrees to take the medication as prescribed. As was discussed previously, drug courts receiving federal funds from BJA or SAMHSA are now required to apply this same analysis unless the judge determines that a participant is misusing, abusing or diverting the medication illegally. For drug courts not receiving federal funding, the analysis is essentially the same for noncontested cases in which there is no contrary medical evidence suggesting a prescription may be unnecessary or contraindicated.

The matter becomes more complicated if a drug court is not receiving federal funding and the question of MAT is contested by opposing medical evidence. The prosecution, for example, might wish to offer evidence from its own medical expert that a prescription is unnecessary or contraindicated, or that the prescribing physician failed to consider important facts which should have changed his or her medical opinion. Under such circumstances, the judge must weigh the medical evidence offered by both sides and decide by a preponderance of the evidence which side's testimony is more convincing.

In evidentiary terms, a valid prescription in a contested case provides prima facie (facially valid) evidence that a prescription is legally authorized, but the judge must make a further determination of whether the prescription is *medically necessary* or *medically indicated*. As was stated earlier, this determination ordinarily requires medical input because it is beyond the ken of a layperson. The judge cannot make this determination based solely on his or her personal beliefs or the arguments of legal counsel. The decision should be based, at least in part, on medical information provided by trained medical experts.

It is an open question which evidentiary standard—medical necessity, medical indication, or perhaps some new standard yet to be articulated—applies to drug court proceedings, and case law is a bit murky in defining these terms. Most cases have defined these terms in legal contexts that were very different from drug courts, such as interpreting contractual provisions in insurance policies. As a general matter, medical necessity calls for more stringent proof than medical indication and requires or permits the judge to take a wider range of factors into consideration (Garber, 2001). In the insurance context, medically necessary treatment has been interpreted to mean treatment that (1) is generally accepted by the medical community for treating the disorder in question; (2) is provided at the most appropriate level and intensity of care; (3) takes into consideration the risks and benefits of the treatment, as well as alternative treatments which may also be available for the same condition; and (4) is proven to be effective at improving health outcomes (e.g., Hawaii Medical Service Association v. Adams, 2009). For example, if a participant requests permission to use buprenorphine, the judge would be required or permitted to consider, among other factors, the relative risks and benefits of buprenorphine as compared to other generally accepted treatments for opiate dependence, such as methadone, naltrexone, or drug-free counseling.

Medical indication is an easier standard to meet than medical necessity and may include elective, optional, or experimental treatments (Garber, 2001; Hawaii Medical Service Association v. Adams, 2009). Several treatments could be medically indicated for the same disorder, and the judge would not necessarily be called upon to balance the relative risks and benefits of each. This does not, however, mean that the judge must defer entirely to a physician's recommendation. The judge must still decide whether the medication is reasonably calculated to help the participant in question. Methadone, for example, is indicated generally for the treatment of opiate dependence; nevertheless, it may not be indicated for a drug court participant who provided incomplete or misleading information to OTP staff or has misused methadone in the past.

Regardless of which standard applies, expert medical evidence will be required to satisfy the evidentiary burden of a preponderance of the evidence. If a prescribing physician refuses to

answer the court's questions or to explain the rationale for a prescription, the burden of proof may not be met and the prescription may be denied.

Making the Case for MAT

It should be clear from the foregoing discussion that acceptance of MAT is not an all-or-nothing proposition. Judges do not have the authority to refuse MAT as a blanket policy, but neither must they defer to a physician's recommendation with no further analysis. Judges always have discretion to disallow a prescription that is being misused, abused, or diverted for illicit purposes, and they are ultimately responsible for deciding whether or not to allow MAT in contested cases that are not covered by the federal funding attestation.

In contested cases, medical experts should be prepared to answer well-taken concerns about their choice of medication and the anticipated timeline for treatment, as well as about how they plan to address foreseeable side-effects of the medication and how they can assist the court to prevent the medication from being diverted to illicit drug markets. If physicians cannot or will not address these concerns, they risk being overruled by the drug court and doing a disservice to their patient.

Choice of Medication

In contested cases, drug courts have not only the authority, but the responsibility, to inquire why a medical expert would choose an agonist medication such as methadone, or a partial agonist such as buprenorphine, over an antagonist such as naltrexone. Methadone and buprenorphine can produce physiological dependence, may cause intoxication or euphoria in nontolerant individuals, have substantial illegal street value, and often require a slow and gradual tapering regimen (Bohnert et al., 2011; Kreek, 2008). Methadone also poses serious risks of side effects, including respiratory suppression and death. Naltrexone, in contrast, generally does not present these risks or side effects (O'Brien & Kampman, 2008).

Logic, therefore, might dictate starting with a presumption that the safer and less complicated medication would be selected as the frontline regimen (Bradley, 1991; Denig, Haaijer-Ruskamp, & Zijsling, 1988; Grant et al., 2007). A common, but unconvincing, response from some medical experts is that patient preference should be a controlling factor in selecting medications. Indeed, a few studies have reported that patient preference was the only factor predicting which medication for opiate addiction would be prescribed in a given case (Ridge, Gossop, Lintzeris, Witton, & Strang, 2009). In typical outpatient practice, where patient dropout is an ever-present concern, it is understandably necessary to accede to patient preference to ensure compliance with the medication regimen. In drug courts, however, the threat of an impending criminal sentence, coupled with intensive supervision by the court, are often sufficient to keep recalcitrant individuals compliant with their medications (Coviello, Cornish, Lynch, Alterman, & O'Brien, 2010; O'Brien & Cornish, 2006). Although patient preference is certainly one factor to be considered by drug courts, other medically relevant factors should also be taken into account in selecting an addiction medication.

A medical expert should be prepared to explain why the circumstances of a contested case justify using a relatively riskier or more complicated medication regimen. For example, prior response

to treatment is often a significant predictor of future response to the same treatment (Stine & Kosten, 2014). If a participant was treated successfully in the past on an agonist or partial agonist medication, reinstating the same regimen might be advisable. In addition, patients must be detoxified from opiates (approximately 7 to 10 days of consecutive abstinence) before beginning a naltrexone regimen (O'Brien & Kampman, 2008). Administering naltrexone prior to detoxification precipitates a severe and potentially medically hazardous withdrawal (SAMHSA, 2012). For participants who are unable to achieve an initial period of opiate sobriety, naltrexone might not be a feasible option. Another concern is that naltrexone reduces physiological tolerance to opiates; therefore, participants may be at risk for overdose and death if they stop taking naltrexone and resume using illicit opiates precipitously (SAMHSA, 2012). Because tolerance is not attenuated when patients are treated with agonist or partial agonist medications, methadone or buprenorphine may be a safer option for participants who have a history of overdose or are otherwise at high risk for overdose.

The above considerations are presented merely as *examples* of how a physician might respond to questions about the choice of an agonist or partial agonist medication in a contested case. Recall that the standard of proof is a preponderance of the evidence. Judges simply need a rational basis for following an expert's recommendation. Refusing to answer such questions or giving vague or patronizing responses interferes with the judge's decision-making function and may cause the physician's recommendation to be discounted and the prescription denied.

Tapering or Discontinuing the Medication

Given that most drug court programs are between 18 and 24 months in duration, it should not be expected that all participants receiving methadone or buprenorphine must be tapered from the medication as a condition of graduation (NADCP, 2013). Nevertheless, drug courts have an obligation to ensure that a physician has considered carefully the issue of tapering and developed a tapering plan or continuing care plan accordingly.

Physicians should give careful thought to this matter and be prepared to explain how they will decide whether and when to taper a medication regimen (American Society of Addiction Medicine, 2014). Specifically, what clinical signs and symptoms will the physician look for in deciding whether a taper is advisable? Are there clinical features in the case that might lead the physician to extend a maintenance regimen for a lengthier period of time, conduct a taper in a slow and stepwise manner, or maintain the patient on the medication indefinitely? For example, if a patient relapsed in the past after being tapered from an agonist or partial agonist medication, this result might suggest that the regimen should be maintained over a longer period of time, tapering should be conducted in a more progressive and stepwise manner, or the patient should be kept on an extended "tail" of the medication indefinitely. If a physician has given little apparent thought to this important question or is unable or unwilling to explain the decision-making process, this may raise a red flag about the level of care being provided and lead the court to deny the request.

It bears repeating that the intent here is *not* to substitute a judge's decision for that of a trained medical expert. The intent, rather, is to help judges understand how and why competent physicians make such decisions. Only then can a drug court judge assess the basis for a medical

recommendation in a contested case and articulate a rational reason for accepting or rejecting the recommendation.

Sedation or Euphoria

Drug courts will rightfully demand immediate and decisive action if a participant on an agonist or partial agonist medication appears to be sedated ("the nods"), euphoric, or disinhibited. Such symptoms may give a countertherapeutic message to other participants, interfere with the productivity of therapy groups or court hearings, and undermine the reputation of the criminal justice system. It may also pose a serious risk to public safety if the participant engages in hazardous activity, such as driving a car or operating heavy machinery. Such conduct cannot be tolerated by a court of law.

Drug courts need to understand how the physician will monitor and respond to such symptoms if they arise. The physician might, for example, reduce the dosage of the medication or reevaluate the patient to ensure an agonist or partial agonist medication is indicated. If clinical observation reveals a participant is not, in fact, tolerant to an opiate agonist, this might suggest the participant was not dependent on opiates to begin with (Kreek, 2008). Some substance-misusing criminal offenders mislead physicians, either intentionally or unintentionally, about the severity of their opiate use symptoms. Physicians who naively assume offenders do not lie or manipulate about such matters are apt to be discredited by criminal justice professionals. Being willing to reconsider one's initial diagnosis in light of new information demonstrates professional maturity and gives a drug court confidence that the physician can be trusted to manage the case.

Illegal Diversion

There is no denying that agonist and partial agonist medications have substantial street value and are sold or traded illegally by individuals receiving lawful prescriptions for the medications. Because buprenorphine may be prescribed outside of licensed and federally regulated OTPs, it has emerged as a prevalent drug of misuse in illegal drug markets (CESAR, 2011). Although many individuals report using nonprescribed buprenorphine to manage cravings and withdrawal (Lofwall & Havens, 2012), buprenorphine is also used frequently by individuals who are nontolerant to opiates for the explicit purpose of becoming intoxicated (Bazazi, Yokell, Fu, Rich, & Zaller, 2011; Daniulaityte, Falck, & Carlson, 2012; Johanson, Arfken, diMenza, & Schuster, 2012). Drug courts cannot permit themselves to be complicit in an illegal drug market.

Several practical measures can be taken by physicians to help drug courts reduce or eliminate the risk of medication diversion. These measures include observing medication ingestion directly, performing drug testing on a random basis to confirm the medication is being taken reliably, conducting random callbacks to the clinic for pill counts, or obtaining reports from prescription drug monitoring programs (PDMPs) where authorized. A physician who fails to recognize the need for such precautions is unlikely to earn the confidence of a drug court.

Conclusion

If OTPs and other MAT providers cannot establish a foothold in drug courts, they are unlikely to do so elsewhere in the criminal justice system. Although some drug courts may need reminding,

the courtroom forum is designed specifically to examine unproven assumptions and discover truth. Due process requires a fair hearing on factual matters and forces all parties to prove the logic and correctness of their assertions. Increasing the use of MAT in drug courts may also create legal precedent and "proof of concept" for other criminal justice programs, such as probation, parole, community correctional centers, jails, and prisons.

Science reveals that some opiate addicted individuals need MAT for a period of time, others may need it indefinitely, and still others will not need it at all. For those who do need MAT, some will be well suited for treatment with an antagonist medication, and others will require an agonist or partial agonist medication. The role of a competent physician and OTP is to determine, based on the best available information, which regimen is most likely to be effective for a given patient. It is also the role of a physician to explain this decision-making process to nonmedical persons, including the patient, the patient's loved ones, and third-party payers. Asking physicians to do the same for criminal justice professionals is entirely consistent with their professional duties and an unavoidable requirement of the law. Additionally, physicians should provide an individualized response to the court with regard to either oversedation or the potential of suboptimal dosing, which would result in ongoing drug use.

Physicians and OTP personnel are likely to find the quality of their medical practice improves significantly when they are asked to articulate their decision-making process to nonmedical professionals. Giving words to one's actions and describing one's thought processes to interested third parties has a way of sharpening clinical skills and enhancing treatment results. Developing collaborative working relationships between physicians and criminal justice professionals is likely to raise the bar for both professions and optimize outcomes for drug addicted persons, the judicial system, and the public at large.

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APPENDIX

National Association of Drug Court Professionals (NADCP)
Resources on Medically Assisted Treatment for Drug Courts

Resolution of the NADCP Board of Directors on the Availability of Medically Assisted Treatment (MAT) for Addiction in Drug Courts
http://www.nadcp.org/sites/default/files/nadcp/NADCP%20Board%20Statement%20on%20MAT.pdf

Adult Drug Court Best Practice Standards (Standards I.E. and V.G.)
http://nadcp.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf

The Drug Court Judicial Benchbook (Chap. 4, §4.14)
http://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf

Quality Improvement for Drug Courts: Evidence-Based Practices (Chap. 4)
http://www.ndci.org/sites/default/files/nadcp/Mono9.QualityImprovement%20new_0.pdf

Extended-Release Naltrexone (NDCI Practitioner Fact Sheet)
http://ndci.org/sites/default/files/nadcp/NDCI%26SAMHSA-Naltrexone-FS%20%281%29%20%281%29.pdf

Improving Access to Pharmacotherapy for Opioid Use Disorder within the Criminal Justice System

Sarah Wakeman, M.D., and Jody Rich, M.D.

Introduction

Nearly two-thirds of incarcerated Americans have a substance use disorder (SUD) (National Center on Addiction and Substance Abuse at Columbia University [CASA], 2010). In addition, half of federal prisoners are incarcerated for drug offenses, and 85 percent of all prisoners are substance involved, meaning they have an SUD, they were under the influence at the time of arrest, or their crime was committed to obtain money to buy drugs (CASA, 2010; Mumola & Karberg, 2006). Despite the high prevalence of alcohol and drug use disorders within correctional facilities, a minority of affected individuals receives any specific treatment. Among state prisoners with a drug use disorder in 2004, only 0.8 percent received detoxification services, 0.3 percent received maintenance pharmacotherapy, and 6.5 percent received counseling by a professional (Mumola & Karberg, 2006).

According to the World Health Organization, incarcerated individuals should have access to the same treatments offered in the community, including opioid agonist therapy (World Health Organization, 2007). While incarceration provides a period of relative abstinence for some individuals with SUD, many relapse to drug use post-release amidst the hectic demands of the re-entry period. Furthermore, lowered tolerance increases susceptibility to overdose during this time. The risk of death due to overdose in the 2 weeks immediately following release from incarceration is 129 times higher than among community populations (Binswanger et al., 2007). This increased mortality post release from incarceration among people with SUD seems to persist far longer than just 2 weeks (Chang, Lichtenstein, Larsson, & Fazel, 2015). Although imprisoning people, especially long term, is generally counterproductive to recovery from SUD, incarceration can offer an important opportunity to provide diagnosis, treatment, and linkage to aftercare for those with SUD.

There are three major points of intervention where the criminal justice system is well positioned to provide treatment. During the initial period of entry to a facility, medical staff can systematically screen incoming individuals for opioid use disorder (OUD), manage withdrawal, and assess treatment that has already been initiated in the community. During incarceration, providers can work with the patient to develop a tailored treatment plan, implement this plan, and continuously monitor treatment and adjust accordingly. Finally, during discharge planning, medical staff can link patients to treatment in the community and coordinate care prior to release.

Screening for Opioid Use Disorder, Withdrawal, and Initial Treatment Evaluation

All detained or incarcerated individuals should be screened for OUD during initial intake and medical evaluations. Patients who screen positive should be assessed for acute intoxication, overdose, and withdrawal, which may require immediate attention. Patients already on medication assisted treatment (MAT), including buprenorphine or methadone, should be continued on agonist therapy during incarceration (Rich et al., 2015). Those who screen positive

for opioid use disorder but are not currently receiving pharmacotherapy should be offered medical treatment for withdrawal and assessed for further treatment.

Developing Individualized Treatment Plans

Providers ideally would work with the patient, as well as discharge planning staff to develop a treatment plan for both the period of incarceration and the transition back into the community. In developing the treatment plan, the team should take into account the patient's particular needs, being sure to:

- Assess past treatment history successes and failures.
- Address any co-occurring mental or physical illness.
- Assess barriers to transition to, engage in, and adhere to treatment.
- Assess how long they will be under correctional care.

Once an individualized treatment plan is determined, patients should receive ongoing monitoring, evaluation, and adjustment as necessary. Additionally, the treatment plan should be carefully documented in the patient's medical record and shared with receiving community providers to ease vulnerable care transitions following release.

Opioid agonist treatment during incarceration has been shown to decrease heroin use, injection, and syringe-sharing while in prison (Hedrich et al., 2012). In addition, initiating opioid agonist treatment prior to release increases treatment entry and retention after incarceration (Hedrich et al., 2012). Continuing methadone for those who enter the system also leads to prompter transition to care and greater rates of treatment engagement after release (Chang et al., 2015). Longer treatment duration and appropriately adjusted doses of agonist therapy during incarceration also significantly improve health and social outcomes (Stallwitz & Stöver, 2007). The opioid antagonist, naltrexone, also has some demonstrated efficacy among incarcerated populations. A recent small study of extended-release naltrexone prior to release from jail showed it led to decreased rates of opioid use but also had no impact on recidivism, injection drug use, or overdose; however, larger studies are underway (Lee et al., 2015).

Although the World Health Organization recommends allowing opioid agonist treatment inside correctional facilities, as many other countries do, most United States facilities currently do not offer pharmacotherapy (Nunn et al., 2009). Half of the facilities in this country that do offer methadone limit treatment to detoxification, maintenance of pregnant women, and rarely, management of chronic pain (Nunn et al., 2009). Individuals who are incarcerated while on methadone and buprenorphine maintenance in the community are forced to discontinue treatment, resulting in the severe discomfort of withdrawal. Data indicate that such policies dissuade those at risk of incarceration from engaging in treatment while in the community by fostering fear of withdrawal (Fu, Zaller, Yokell, Bazazi, & Rich, 2013).

Some of the most frequently cited barriers to opioid agonist provision in corrections include limited knowledge of the evidence base for such treatments among administrators, philosophical aversion, and security concerns (Friedmann et al., 2012; Nunn et al., 2009). Structural limitations include lack of qualified staff and misperceptions about the requirements for a facility to become an opioid treatment program (OTP). However, these are surmountable barriers. A

recent multi-site study found correctional staff to be receptive to educational interventions about opioid agonist treatments and organizational linkages to community treatment agencies (Friedmann et al., 2015). Additionally, the study found correctional staff were more likely to make referrals to care after undergoing the intervention. Correctional facilities can promote the acceptability of agonist treatment by educating staff, clarifying misconceptions, and creating linkages with community treatment programs.

Logistics of Providing Opioid Agonist Treatment Within Corrections

Even after surmounting philosophical barriers to opioid agonist treatment (OAT), there are very real logistical challenges to implementing an OAT program within corrections. Learning from existing models that have been successfully implemented can provide useful blueprints for expanding treatment across facilities.

One model successfully implemented at the Rhode Island Department of Corrections was to partner with a community-based methadone maintenance program. In this model, individualized, measured and labeled doses of methadone for each patient are delivered daily by the community agency to the correctional facility. The methadone is picked up at the control desk and passed through multiple security checkpoints, counted, recorded, and ultimately placed in locked storage. Inmates are administered methadone by the correctional nursing staff and observed during and after dosing, and nurses communicate patient response and any side effects to a physician who may adjust the dose as needed. One benefit of this model is that the partnership with the community agency makes it unnecessary for the Department of Corrections to obtain SAMHSA certification to become an OTP. Some challenges with this model include the additional expense, regulation, and the time required from correctional nurses who, unlike staff at community methadone maintenance treatment programs, may not have the expertise in providing this treatment and may be resentful of the additional burden (McKenzie, Nunn, Zaller, Bazazi, & Rich, 2009).

An alternative model is directly licensing a correctional facility as an OTP. New York's Riker's Island program, called the Key Extended Entry Program (KEEP), is a jail-based methadone maintenance program that has been treating detainees since 1987 (Althoff et al., 2013; Nunn et al., 2010). Unlike the Rhode Island model, Project KEEP is a SAMHSA-certified OTP and utilizes both nursing and a correctional officer in its implementation to minimize diversion.

Additionally, prevention of diversion is a crucial component of any program, especially one within corrections. A previous study of male jail inmates found that 1 percent of methadone patients and 10 percent of buprenorphine patients attempted to divert these medications (Jacob Arriola, Braithwaite, Holmes, & Fortenberry, 2007). There are many anecdotes of creative ways that patients have tried to divert medication, including cheeking an absorbent material such as a tampon or foam rubber from a seat cushion or just regurgitating the dose. Working with correctional staff to develop a protocol for managing diversion collaboratively in anticipation of initiating a treatment program may be important.

Lastly, implementation of a buprenorphine treatment program requires attention to unique components which are distinct from methadone. Since buprenorphine is taken sublingually, a protocol to ensure tablets or films are adequately dissolved under the tongue is necessary

(Magura et al., 2009). This requires nursing staff to observe each patient, which can take up to 10 minutes per participant, and requires developing a dosing time that is not interrupted by other schedules (Magura et al., 2009). Lastly, induction with buprenorphine requires awareness of the risk of precipitated withdrawal, although this is generally less of a concern in the correctional setting where there is usually less use of illicit opioids.

Linkage to Care and Community Resources

Providing linkage to treatment in the community and ensuring continuity of care are crucial to preventing relapse, overdose, and return to criminal behavior. There are meaningful steps that correctional facilities and health care providers can take to promote positive health outcomes and treatment engagement among those returning to the community. Developing relationships with community providers and OTPs will help establish clear referral pathways and facilitate linkage of patients to treatment prior to release. These relationships will also improve communication and coordination between past, present, and future providers. The importance of direct communication between correctional care providers and community providers cannot be overemphasized. Transitions of care both in and out of correctional facilities represent vulnerable periods for the individual; ensuring the care plan is known to all providers can help minimize harm.

During the high-risk post-release period, patients face numerous challenges and competing priorities that can prevent engagement in community treatment. There are several interventions that could be implemented to improve treatment adherence and patient outcomes. Discharge planners must have adequate knowledge of patients' treatment and social needs so that they can help address barriers—such as lack of food, housing, employment, social support, or transportation—that might impede treatment adherence or successful attendance of initial appointments. Patients should be involved in the planning process to ensure they are fully informed and engaged in the treatment plan. Patient navigators, sometimes called recovery coaches, could also provide a crucial linkage if they are connected to patients prior to release and helped to bridge the vulnerable time period during reentry. Lastly, all released prisoners with a history of an OUD should leave a correctional facility having received overdose education and with a naloxone rescue kit for use in case of an overdose.

In addition to their treatment needs, patients being released from correctional facilities will face other challenges that may jeopardize efforts at recovery. Intensive case management and wraparound services can address these needs, for example by linkage to health care (including mental health care) and housing programs and by ensuring enrollment in Medicaid, Supplemental Security Income, and food assistance. Successful models of wraparound services and support exist, particularly from the HIV/AIDS treatment sphere, and they have demonstrated that services such as discharge planning, disease management sessions, transportation, adherence assistance, and support by dedicated case managers facilitate retention in care and reduce risk behaviors (Althoff et al., 2013; Nunn et al., 2010; Rich et al., 2001).

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Methods of Engaging Family Courts and Child Protective Services Through Opioid Treatment Programs and DATA 2000 Practices

Pamela Petersen-Baston, M.P.A., CAP, CPP

This section will provide a strategic blueprint for all relevant parties in the opioid treatment and Child Protective Services (CPS) sectors and policy arenas as they work together on the intersection of child maltreatment and opioid and other substance use disorders (SUDs). The blueprint provides an approach for how medication-assisted treatment (MAT) and other SUD treatment providers, CPS, family courts, and interested parties can work together in the coming years in early identification, screening, assessment, treatment, and recovery support services for families affected by opioid and other drug disorders and child maltreatment.

Different Systems, Same Missed Opportunities

Nationally, between 60 and 80 percent of substantiated child abuse and neglect cases involve a parent or guardian abusing substances (Young, Boles, & Otero, 2007). Any seasoned child welfare worker or family court judge will confirm the same or cite higher prevalence estimates and will also note that substance-involved families consume the most resources. Yet there are few, if any, child welfare systems in the country whose identification of substance use as a factor in child maltreatment comes even close to these prevalence estimates. So why is something so prevalent and loaded with such dire physical, emotional, and fiscal consequences so underprioritized?

In 2011, the State of Nebraska proactively undertook an effort to establish SUD prevalence and to identify treatment barriers. The Nebraska Court Improvement Project conducted an in-depth study of 400 randomly selected child welfare cases to identify and establish a number of important Nebraska-specific baselines, including the prevalence of substance-involved families and the time it took to connect parents with SUDs to treatment. This study found that 56 percent of child welfare cases had substance use identified as a problem in the case record and determined that many of these substance use problems were not identified until late in the progression of the case, after much time and many resources were unproductively expended.

A cross-disciplinary team composed of Nebraska's behavioral health, child welfare, state court system, Medicaid, criminal justice, family advocates, and managed care organizations and others worked with representatives from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Center on Substance Abuse and Child Welfare (NCSACW) to identify possible treatment access policy and practice barriers that Nebraska subsequently clarified or addressed. Nebraska's cross-disciplinary team is currently developing a best practice protocol to guide future practice with these high-need families.

Other states are encouraged to follow Nebraska's lead. While there was a small cost associated with Nebraska's initiative, the costs and consequences of not identifying such problems *at the earliest possible opportunity* are borne every day in states and vastly exceed this nominal investment. A few such consequences are well known:

- Missed appointments
- Crowded court dockets
- Public health and safety risks
- Compromised parenting for other children in the home
- Greater out-of-home placement rates
- Greater fatalities
- Higher risk of recidivism in both CPS and criminal justice involvement
- Multigenerational impact related to children who end up with developmental delays, other compromised child-wellbeing conditions, or foster care or adoption plans

Failure to identify and treat substance use in women of childbearing age, particularly pregnant women, can include dramatically higher medical costs associated with late or no prenatal care, and substance-exposed infants (SEI), including those with neonatal abstinence syndrome (NAS) from maternal opioid use during pregnancy. This is a very real and growing problem as the proportion of pregnant women reporting any prescription opioid misuse increased substantially from 2 percent (n = 351) in 1992 to 28 percent (n = 6,087) in 2012 (Martin, Longinaker, & Terplan, 2015). The proportion of pregnant women admitted to treatment who reported prescription opioids as the primary substance of misuse similarly increased from 1 percent (n = 124) in 1992 to 19 percent (n = 4,268) in 2012. Between 2000 and 2009, the rate of newborns diagnosed with NAS nearly tripled, and the number of mothers using or dependent on drugs more than quadrupled, while costs associated with treating these infants increased by 35 percent. Medicaid was the primary payer for over 75 percent of these births (National Association of Medicaid Directors, 2014).

Yet in spite of these well-known consequences and high costs to many state health and human service sectors, CPS worker training on how to identify substance use as a child maltreatment factor is often 2 hours or less in length. Also, it does not always address the growing problem of prescription opioid use, the importance of MAT, or the need for collaborative practice with MAT and other SUD treatment providers.

Similar missed opportunities for early identification and intervention occur in the MAT and other SUD treatment system as well. Child maltreatment prevalence has proven a bit harder to establish. A cross-state analysis of the Treatment Outcomes and Performance Pilot Studies (TOPPS-II) looking at data from 16 States found that 58.5 percent of persons admitted to treatment had a child younger than age 18 (Ahmed, 2006). The Hser et al. (2003) study found that 27.1 percent of parents in SUD treatment had one or more children removed from their custody and that 36.6 percent of those parents with a child who was removed had their parental rights terminated. Among parents with a child removed by CPS, 29 percent in outpatient programs, 53 percent in residential programs, and 80 percent in OTPs had their parental rights terminated.

In SUD assessment and intake, an individual's parenting status and child welfare referral source are captured on forms but infrequently addressed as part of treatment. Traditionally, SUD treatment programs view the substance user as the "primary" or "identified" patient, and attention paid to the impacts of parental opioid or other SUD on minor children is scant or indirect at best. This happens despite the well-established research literature and practitioner

firsthand knowledge that, without therapeutic or preventive intervention, these children may become tomorrow's patients. The reasons for this narrow approach are numerous and include reimbursement structure limitations, productivity requirements, regulatory standards that do not accommodate a family-centered approach, and other competing priorities. The approach reflects a workforce that lacks sufficient education, training, and clinical supervision to effectively address family issues, including prevention and identification of child maltreatment and therapeutic responses.

While not all parents who use opioids, alcohol, or other drugs mistreat their children, such use can adversely impact attachment, relationships, and family dynamics and significantly affect the likelihood the children will have traumatic experiences in childhood. While most MAT and other SUD treatment provider staff are intuitively aware that the minor children of their treatment clients may have experienced various forms and levels of trauma as they unwittingly accompanied their parents through their addiction journey, not enough is done to stabilize and heal these families and to prevent the need for CPS involvement. These children are not typically given continued support after their parent's treatment to resolve feelings and adjust to new roles, rules, and behaviors, as well as new fears and anxieties. Additionally, few MAT or SUD treatment programs are aware of, or connect their relevant clients to, the preventive child welfare services and supports that could potentially prevent CPS involvement.

An additional complication is that most MAT and other SUD practitioners providing services to child welfare involved parents are unaware of the Adoption and Safe Families Act (ASFA), which requires states to move to terminate parental rights of children who have been in foster care for 15 out of the last 22 months. Failure of the child welfare and SUD treatment system to work together to identify, assess, and connect to parents who have children in out-of-home placement, and stabilize them in treatment, results in fiscally and emotionally costly consequences, including termination of parental rights. The consequences of waiting lists, bureaucratic barriers, missed appointments, and waiting for clients to move out of a "precontemplation" stage can be a heavy burden for any parent to shoulder, but for parents for whom the ASFA clock ticks, permanent loss of their children can result.

Cross-training is needed for all relevant parties in the opioid treatment and CPS sectors on how to timely identify and respond to parents with opioid use and other SUDs, and on the importance of MAT. New Jersey and Pennsylvania are in various stages of expanding and improving SUD training.

There are significant knowledge gaps in each system that must be addressed before effective identification and screening practices can be realized. Cross-training is needed for all relevant parties in the opioid treatment and CPS sectors on how to timely identify and respond to parents with opioid use and other SUDs, and on the importance of MAT. States like New Jersey and Pennsylvania are in various stages of expanding and improving such training. New Jersey worked with SAMHSA's NCSACW and the Institute for Families (IFF) at the Rutgers School of Social Work to significantly expand SUD training for its child welfare

"Screening for substance use disorder should always be part of safety assessment conducted in response to a report of abuse or neglect. If screening indicates SUD, a referral to formal SUD services assessment must be made."

(Michigan Substance Abuse/Child Welfare State Team, 2009)

workers. Several Pennsylvania counties are also currently exploring expanded cross-training opportunities and methods.

Cross-disciplinary staff training is just one way to increase the identification of parents affected by opioid disorders and other SUDs and child maltreatment risk or incidents. Historically, the SUD system and child welfare system screen for identified problems in their respective fields in silo fashion: child welfare screens for abuse and neglect, SUD systems screen for substance use, and courts determine statutory compliance. In 2008, Michigan realized the need for its child welfare system to screen families for potential SUD and refer them for assessment and treatment when appropriate. It determined that SUD providers should assess the safety status of clients' children and collaborate in other ways with their child welfare system counterparts. Michigan developed a protocol based on the Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR) model described below.

Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR) (2006). SAFERR is a collaborative model to help child welfare, substance abuse treatment, and family court professionals make informed decisions when determining outcomes for children and families affected by substance use disorders. The guide provides strategies to help improve the collaborative capacities across systems. Available at https://ncsacw.samhsa.gov/files/SAFERR.pdf

SAFERR is a collaborative model to help child welfare, SUD treatment, and family court professionals make better informed decisions when determining outcomes for children and families affected by SUDs. It is based on the premise that when parents misuse substances and maltreat their children, the only way to make sound decisions is to draw from the talents and resources of at least three systems: child welfare, SUD treatment, and the courts. Although substance use alone is not the sole determinant of risk to children, the SAFERR model holds that because so many families involved with child welfare have these problems, there is a need for child welfare policies that call for initial and ongoing screening and assessment of possible SUDs with an assumption that those disorders are likely to exist. (That is, the practice should be to "rule out" SUDs.) Similarly, this correlation suggests a need for alcohol and drug policies that call for initial and ongoing assessment of child safety and risk of child maltreatment within families (Young, Nakashian, Yeh, & Amatetti, 2006). While not specific to the growing problem of opioid use and the need for MAT, the SAFERR model is inclusive of both and contains a number of helpful screening tools, communication protocols and more for improving cross-system collaboration.

Myths, Misinformation, Misperceptions, and Missed Placements?

Misperceptions regarding the benefits of MAT (including during pregnancy), ongoing prejudice, and actions by court or CPS agency personnel that counter evidence-based treatment strategies create a toxic and potentially deadly treatment and recovery environment. Research documents that treatment of OUD *without* MAT results in relapse rates over 75 percent. Despite well-published studies of the effectiveness of medications like methadone and buprenorphine for opioid addiction and naltrexone for opioid or alcohol addiction, parents involved with child welfare services rarely receive them. Choi and Ryan (2006), for example, found that only 24 percent of heroin users in a child welfare sample had been referred for methadone treatment, despite evidence of methadone's effectiveness in treating heroin addiction.

Despite our knowledge that long-term opioid and other drug use profoundly alters the brain, and that for most affected individuals MAT is the *only* treatment that can reduce their metabolic drug hunger, opioid dependent parents are often sent to a family court or treatment program without an MAT option, or worse yet, to one that condemns medical assistance as not "true recovery" or emphasizes willpower over chemistry. Set up to fail, too many opioid dependent parents receive this erroneous treatment placement and bear the inevitable consequences of its failure, a price which can include the loss of their children, or even their lives. We can and must do better.

In Pinellas County, Florida, Operation PAR and its partners figured out a solution to this problem by establishing a community-based program model that includes education, a safe environment, medically supervised MAT, and ongoing social and professional supports providing a promising path to improve SUD treatment effectiveness. The Motivating New Moms (MnM) program addresses system issues regarding women seeking MAT and the forced choice they make between treatment and child reunification by shifting the orientation from ongoing punishment to support for these women in recovery. The program maintains relationships with Pinellas Hospital neonatal intensive care units (NICUs) and Federally Qualified Health Centers (FQHCs), and it provides parenting education and support groups for these women and assists participants to engage in treatment. Lastly, the program provides case management services to appropriate women involved in referral or supervision through the child welfare system (Vargo, Griffin, & Gamache, 2012). A similar perinatal addictions program is provided in New Jersey, involving a JSAS HealthCare, Inc. (Jersey Shore Addiction Services) MAT program.

Another example is the Children and Recovering Mothers (CHARM) Collaborative in Burlington, Vermont, a multidisciplinary group of agencies serving women with opioid addiction and their families during pregnancy and through infancy. The CHARM Collaborative is focused on meeting the needs of pregnant and postpartum women and babies if there is a history of opioid use. It emerged in the late 1990s, in response to the increasing need for MAT resources for opioid dependent pregnant women. Today, the CHARM Collaborative includes 11 organizations that collectively provide comprehensive care coordination for pregnant women with opiate addiction and consultation for child welfare, medical, and addiction professionals across Vermont (*Children and Recovering Mothers*, 2014).

Ohio's opioid epidemic is of such grave concern that during his first 100 days in office, Governor Kasich created a Cabinet-level Opiate Task Force and new policies, investments and initiatives have begun. One such effort includes an MAT pilot providing $5 million to selected locations that coordinate with providers and local drug courts including Family Dependency Treatment Courts (FDTC). Moreover, the Governor's Cabinet Opiate Action Team has created a small pilot with streamlined Medicaid preauthorization procedures, which could be replicated for Medicaid-eligible parents in the child welfare system (*Child Welfare Opiate Engagement*, 2014).

But even the best evidence-based approaches cannot work in a vacuum. As long as MAT and other SUD treatment systems and child welfare systems avoid formal collaboration, parents dually affected by opioid and other SUD and child maltreatment will continue to suffer the consequences, as will their children. CPS and court workers' knowledge of MAT rarely includes

firsthand visits to, or collaboration with, MAT providers, and it is too often influenced by myths and misinformation stemming from second- and thirdhand accounts of clients being overmedicated and undermonitored or simultaneously using other substances. That is not to say that these circumstances do not occur. As is the case in *all* public and private sectors, some MAT programs are better than others. The frequency of MAT, other SUD providers, and child welfare staff actually meeting to address myths and misinformation or resolve real complaints is minimal at best, and nonexistent in many states and communities. This problem is exacerbated in states that do not include MAT in their publicly-funded system of care, with its associated quality improvement mechanisms. In itself, that sends a message and begs the question: if not evidence-based, then what?

While the need to increase early identification of parents affected by substance use and child maltreatment problems and connect them to effective treatment and recovery support is not a new problem, it has taken on more urgency as the number of parents using heroin, prescription pain medications, and other opioids has so drastically risen. Community stakeholders that have previously not worked together are now feeling collaboration as a mandate, rather than an option. Cross-system collaboration among CPS, MAT and other SUD treatment providers, and the courts shows promise in addressing the many needs of child welfare-involved families experiencing parental SUDs. Given what these families have at stake, they deserve nothing less.

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