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The Challenge of Opioids: Moving Toward an Injury Model for Trauma-Responsive Family Courts

BY KRISTAN N. RUSSELL AND SHAWN C. MARSH

Overview

The opioid crisis has created widespread and disastrous outcomes for families throughout this nation. Family courts are deluged with cases stemming from the consequences of this epidemic.

The need for collaboration between service providers who work with individuals with substance use disorder (SUD) and family courts has never been greater than it is now.

In this issue of the Unified Family Court Connection, we offer a variety of perspectives on the issue of the opioid crisis.

- **Kristan N. Russell,** M.A., a doctoral candidate in social psychology, and **Shawn C. Marsh,** Ph.D., the director of the Judicial Studies Graduate Degree Program and Associate Professor of Judicial Studies, Communica-tion Studies, and Social Psychology at the University of Nevada, examine the challenge of opioids and moving toward an injury model response to the crisis for trauma-responsive family courts.
- **Judge Peggy Fulton Hora** (Ret.), who served on the Superior Court of California for 21 years, writes about how evidence-based treatment in family courts is helping battle the opioid crisis.
- **Judge Denise Herman McColley**, who presides over Henry County Family Court in Ohio, **Melissa Peper Firestone**, a magistrate in the Henry County Family Court, and **Abigail Badenhop**, the Henry County Family Intervention Court Coordinator, write about how specialized dockets in family courts can help stem the opioid crisis.
- **Abigail M. Judge,** Ph.D., a clinical and forensic psychologist, and **Stephanie Tabashneck,** Psy.D., J.D., a forensic psychologist and attorney, discuss the value added when family court professionals collaborate with substance use disorder service providers to inform referrals to evidence-based care, reduce court involvement, enhance compliance with court orders, and improve family outcomes.

The widespread and disastrous outcomes associated with opioid abuse in the United States over the last decade are well documented. As with other human service systems, family courts are facing firsthand the tragic consequences of what many consider to be a crisis of epidemic proportions.

Parents and guardians facing issues of addiction, usually coupled with various forms of family discord such as divorce, neglect allegations, and domestic violence, constitute a large portion of cases appearing in family courts. They are cases that require a substantial amount of time, resources, and thoughtfulness to process effectively. Unfortunately, many courts are not prepared to handle the onslaught of these cases—oftentimes lacking even a basic conceptual model to better understand the issues at hand and to generate meaningful interventions.

We briefly review here the scope of the problem facing courts in the midst of rampant opioid abuse across much of the nation, the impact these cases have on families involved in the justice system, and the impact on family courts serving this population. We then propose application of the expanding scholarship on trauma-responsive justice to move courts toward a public health orientation that in part reframes opioid addiction as a maladaptive coping mechanism stemming from injury gone awry—versus an inherent pathology—that developed from repeated attempts to self soothe with substances that initially "almost worked." Lastly, we present four basic policy and practice recommendations for courts that evidence suggests show promise in improving practice and that deserve more attention from practitioners and scholars alike.

SCOPE OF THE PROBLEM

The number of people impacted by the opioid epidemic in the United States is staggering. By 2016, there were an estimated 2.1 million Americans with an opioid use disorder. In 2017, there were nearly 70,500 reported drug overdose deaths in the United States, with the main source of those deaths being synthetic opioids, representing an increase in opioid related deaths of 45 percent from the prior year. By 2018, data indicate that more people in the United States died of opioid overdoses than they did of cancer, gunshot wounds, or car accidents—at the rate of nearly 120 opioid overdose deaths per day. Responding to this crisis also has incurred substantial material cost. In 2019, nearly $1.5 billion was apportioned to the National Institute on Drug Abuse for research on this issue alone. Perhaps even more dramatically, the Council of Economic Advisers estimates the incurred cost associated with opioid misuse in the United States was more than $2.5 ***trillion*** for the four-year period from 2015 to 2018.

IMPACT ON FAMILIES AND FAMILY COURTS

Research suggests that when a parent or guardian is opioid dependent, they often struggle to meet their child's developmental and emotional needs, and their children are more likely to experience instability, abuse, and neglect. Estimates indicate that over 60 percent of child abuse and neglect cases include at least one custodial parent or guardian involved with substance use, and officials have attributed opioid abuse by a parent as being a top predictor of the decision to remove a child from their home. Once in the foster care system, children with opioid-misusing parents or guardians tend to be there longer and are less likely to reunify than are children whose parents or guardians do not misuse opioids. In fact, reports indicate that 2018 marked a record in adoptions from foster care—with opioids at least partially responsible for the uptick in these cases. Together, all this data only hints at the incredible stress that opioids have placed on our family courts and their resources; indeed, 55 percent of chief justices and state court administrators surveyed in 2017 reported the opioid epidemic was having a *severe* impact on court operations.

TRAUMA-RESPONSIVE JUSTICE

When families are affected by parent or guardian opioid abuse, family courts must develop effective strategies to help meet the unique needs of the family unit while prioritizing the safety and well-being of the children. Fortunately, work in the area of trauma-responsive justice over the last two decades offers some guidance for courts when dealing with the challenges of opioid-involved cases. As part of the foundation of this work, public health experts have largely endorsed moving away from conceptualizing people/cases as dichotomies (e.g., *sick* vs. *well*) toward more humanistic, relatable, and less value-laden frameworks that view outcomes of substantial human struggle as an *injury*.

This nuance is not just linguistic framing; it also suggests models of trauma-responsive justice that place courts as integral to the community of healing, as well as adoption of public health approaches (e.g., universal precautions that assume injury) that are beneficial for both consumers and administrators of justice. In some form, these approaches tend to promote conditions of safety, self-determination, and pro-social support across the domains of policy, practice, persons, and environment. Ultimately, a trauma-responsive justice framework helps court officials more productively conceptualize cases, more efficiently allocate critical resources, and more effectively encourage improved proximal and distal outcomes for those within the system.

RECOMMENDATIONS

Rooted in a trauma-responsive framework and our work with juvenile and family courts across the country, we offer four basic policy/practice recommendations as family courts seek to effectively respond to the opioid crisis:

Encourage effective and ongoing education. Substantial stigma and misunderstanding continue to surround opioid abuse, even amongst well-meaning and highly educated professionals. Improving the outcomes of families who are affected by the opioid crisis will require well-designed and rigorously evaluated training based in research surrounding the causes and correlates of opioid abuse, current abuse trends, evidence-based practices for treatment and intervention, and the association between substantial adversity/trauma and opioid abuse.

Implement trauma-responsive strategies. Adversity, toxic stress, and trauma are strongly associated with psychological, social, and/or behavioral challenges if left untreated. These challenges can include substance abuse, vocational/educational disengagement, relationship problems, and involvement in the justice system. Given the scope of the opioid crisis previously elucidated, and the fact that there are an estimated 6-plus million violent victimizations of people 12 years or older in the United States each year, adopting trauma-responsive approaches is essential to ending the all-too-common revolving door of injured persons and families in our courts.

Leverage judicial leadership. Judicial officers, both on and off the bench, are extremely well positioned to encourage community-wide engagement to improve practice and outcomes. For example, judicial officers can convene community/stakeholder meetings to educate others about the opioid crisis and its impact on families and courts. They also can train professionals working in this area on addiction and how to use trauma-informed approaches to improve outcomes and encourage meaningful and effective resource allocation. Further, judicial involvement in stakeholder collaboratives addressing the opioid crisis can provide not only critical leadership, but also important status to the group and valuable opportunities to encourage accountability.

Engage media and policymakers. Effectively addressing social/health crises such as those posed by opioids requires awareness of the challenges being faced "on the ground" in order to have consistent, targeted, substantive, and productive discussion and subsequent effective responses. Judges and allied court professionals should use their voices to engage media and other communication channels to ensure that attention remains on the issue and that meaningful resources are allocated to the work. In other words, this crisis has developed to the level that will no longer tolerate the tendency for systems to be expected to continually "do more with less." In this effort, we propose that securing access to and funding for robust prevention and treatment programs must be accompanied by aggressive cutting-edge research in the area of advanced medical, behavioral, and social interventions (e.g., leveraging advances in genetics, neuroscience, etc.).

The opioid crisis is one of the largest public health issues our country has faced in the last century. As such, solving this crisis will likely take years of collaborative, large-scale, and well-resourced efforts. Though judicial officers and allied professionals in family courts are unlikely to rectify the crisis themselves, they hold positions in the healing community that afford them the power to make substantial impacts on the problem. Through education, trauma-responsive justice approaches, compassionate decision-making, and leveraging leadership to help shift public perceptions and focus research priorities, family court judges, allied justice professionals, and the court system can be a critical component of efforts to end the opioid crisis and its toll on human suffering.

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Evidence-Based Treatment in Family Court Helps Stem the Opioid Crisis

By Peggy Fulton Hora

The opioid crisis, although waning, is still having a tremendous impact on family courts nationwide.

The National Judicial Opioid Task Force (NJOTF) found the "most significant impact of the [opioid] epidemic involves cases with children and families" (Nat. Jud. Opioid Task Force Final Report, *available at* ncsc.org/opioids). Of the 268,212 minor children removed from their families in FY 2017, 36 percent had parental substance use listed as the reason for their removal. (Kristin Sepulveda and Sarah Williams, *One in three children entered foster care in 2017 because of parental drug abuse*, *available at* https://www.childtrends.org/one-in-three-children-entered-foster-care-in-fy-2017-because-of-parental-drug-abuse).

A 2018 report by the Administration for Children and Families showed that after years of decline, the number of children entering the foster care system was on the rise. Not only does substance use contribute to the removal of children, but maltreated children of substance using parents remain in the child welfare system longer and experience poorer outcomes (*Bulletin for Professionals*, Child Welfare Information Gateway (Dec. 2003), https://www.childwelfare.gov/pubPDFs/subabuse_childmal.pdf).

Too often, parents are ordered into treatment that is for a general adult population and not specific to parents. Success rates of parents are lower as a result. Their children also suffer from a lack of holistic care provided to the entire family because few of these programs engage children in them. These problems, taken together, necessitate substance use treatment geared toward parents and their children. Further, evidence-based practices that can help parents will help keep children out of foster care and help children reunify quicker when they are removed. Juveniles also need treatment specific to their circumstances and development.

"ADDICTION" VS. "DEPENDENCY"

It is critical to understand the nature of substance use disorders if the stigma is to be eliminated. Many people use the terms "addiction" and "dependency" interchangeably. Those terms, however, refer to two different consequences of substance use. Addiction refers to the euphoria produced by the substance. Substance use disorder (SUD) is a spectrum disorder that ranges from mild to severe. A severe SUD is connected to the euphoria that the substance produces. This euphoria is the initial "benefit" the user receives when taking the substance. With opioids, particularly heroin, this euphoria is very intense. The user may become "addicted" to the pleasure and, thus, keep using the drug.

The part of the brain involved in SUDs is the pleasure center. Powered by the neurotransmitter dopamine, the pleasure center can be a powerful motivator. This has been referred to as "hijacking the brain" (Nora D. Volkow, et. al, *Neurobiologic Advances from the Brain Disease Model of Addiction*, 374 New England J. of Medicine 363–371 (2016)).

"Dependency," however, refers to the withdrawal effects that the substance produces. The body's response to a substance is like a pendulum. The effects of the substance may pull the body in one direction (alertness). When the substance wears off, the user experiences the opposite effect (drowsiness) as the pendulum swings in the opposite direction. The withdrawal effect of a substance is usually the opposite of the initial effects of the substance.

For opioids, the effects of pain relief and other physiological impacts are reversed during withdrawal. The user experiences significant pain (body aches) as well as severe stomach cramping and diarrhea. Users refer to this withdrawal as being "sick." Because opioids cause the individual to develop tolerance so quickly, the ability to experience the euphoria diminishes, and the user uses the substance mostly to avoid the withdrawal effects. The intensity and length of the withdrawal effects (about a week) make it difficult for a user to stop completely. SUDs are, therefore, medical conditions that affect the brain and body's physiology.

Medication-based treatment

Medication-based treatment (MBT) is the gold standard for opioid use disorder (OUD). One study found that 60 percent of parents receiving MBT were more likely to retain custody of their children than parents who did not receive medication. Additionally, MBT for nine months resulted in parents being 90 percent more likely to retain custody of their children. With MBT for 14 months, parents were 140 percent more likely to retain custody of children. (Martin T. Hall, Jordan Wilfong, Ruth A. Huebner, Lynn Posze, & Tina Willauer, *Medication-Assisted Treatment Improves Child Permanency Outcomes for Opioid-Using Families in the Child Welfare System*, 71 J. of Substance Abuse Treatment 63 (2016)). Among those parents seeking to reunify with their children, however, only 24 percent are referred to MBT. The NJOTF found there is a lack of access to education about the use of quality, evidence-based treatment including MBT, and there continues to be a prejudice against it in many family courts. (Sam Choi & Joseph P. Ryan, *Completing Substance Abuse Treatment in Child Welfare: The Role of Co-Occurring Conditions and Drug of Choice*, 11 Child Maltreatment 313 (2006)).

Stigma associated with MBT, particularly methadone and buprenorphine, has been a major obstacle to its use to treat OUD. Many people, including judges, law enforcement, families, and treatment professionals, have viewed the use of methadone and buprenorphine as "just replacing one addiction with another." People receiving MBT have been told that they are not in "real recovery," making it difficult for them to seek assistance and support in self-help meetings. Reducing the stigma can help encourage professionals to accept the use of MBT in parents involved in family court.

There are two general types of medications for OUD. The first type includes opioid replacement medications (methadone and buprenorphine) that imitate some of the effects of the opioids. They target eliminating the withdrawal symptoms, which also reduces craving for the medication. Properly dosed, the two medications will not produce significant euphoria or sedation. The individual will look and behave normally. The person will be capable of meeting all responsibilities, including working, caring for children, driving, etc. It is critical for courts to recognize that being a patient on an opioid replacement medication does not automatically make them an unfit parent. Taking the medication as prescribed does not impair their ability to care for their children.

The second type of MBT for OUD is naltrexone. Long acting injectable naltrexone, Vivitrol, blocks opioid receptors in the brain, preventing any opioids from working. The short-term version, naloxone/Narcan, is used to reverse the effects of an overdose. Injectable naltrexone will block the receptors for approximately one month. One of the main benefits of naltrexone is that it will prevent overdose if a person relapses. It also can reduce cravings for some people.

The choice of which medication to use is up to the doctor. There are certain elements that may indicate that one medication is better for an individual. Research continues to identify which factors are indicative of the efficacy of various types. It is also critical that judges recognize that only a doctor is authorized to make decisions about medications.

MBT needs to be the first line treatment for OUD. Many people think that users should try to quit without medication, and if they fail, then try the medication. This approach is very dangerous. When someone stops using for even a few days, their tolerance will be reduced, but their cravings may increase. If a person relapses, that person is at a very high risk for an overdose because of the decreased tolerance. Studies have shown that individuals who received buprenorphine are more likely to remain in treatment and eliminate illicit opioid use than those who do not receive the medication. In one study, 20 percent of the non-medicated group experienced a fatal overdose, while none in the medicated group did (John Kakko, et. al, *1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial*, 361 *The Lancet* 662 (2003)). Twenty percent is a one-in-five chance. To put that in context, Russian roulette generally has safer odds—one-in-six.

MBT includes psychotherapy

The best outcomes will be achieved if the person receives both medication and psychotherapeutic treatments. Eliminating withdrawal symptoms with medications is critical, but so is addressing the person's other needs. Trauma is a major contributing factor to alcohol and other drug use, criminal activity, and parenting problems. Unless the trauma and other issues are addressed, there will be continued high risk for relapse. Even if the person is interested in medication, but not in counseling, they should still be prescribed the medication. Making the medication contingent on participation may result in people walking away and continuing their use. Engaging someone with the medication and then working to help them be ready for additional strategies are the recommended courses of action. Use of medication may reduce the hold the substance has on someone long enough for the person to begin to want psychotherapeutic treatment. The psychotherapy is necessary, but it does not have to exist from the beginning of treatment in order for treatment ultimately to be successful.

Harm reduction

Harm reduction practices are effective in addressing OUD (Kathryn Hawk et. al, *Reducing Fatal Opioid Overdose: Prevention, Treatment and Harm Reduction Strategies*, 88 *Yale J. Bio. & Medicine*, 235 (2015)). Harm reduction strategies include medication, availability of naloxone for overdose reversal, needle exchanges, and safe injection sites. The harm reduction strategies are effective in reducing overall use, overdoses, and other health problems including HIV and Hepatitis C that are associated with drug injection. While there is still significant stigma around some of these strategies (i.e., safe injection sites), they are helpful in decreasing fatal overdoses and encouraging treatment participation (Jennifer Ng et. al, *Does evidence support supervised injection sites?*, 63 Canadian family physician Medecin de famille canadien 866 (2017)).

Conclusion

Family courts continue to be overwhelmed by the effects of the opioid crisis. As discussed elsewhere in this issue, many family courts are addressing these issues through specialized courts. Those courts go a long way toward helping families stay together. Those specialized courts, however, currently exist only in cases involving child welfare agencies and are few in number. It is imperative that all family court participants understand best practices for addressing OUDs. A first step could be starting someone on medication where appropriate to reduce effects of and craving for opioids. Finally, integrating psychotherapy or other tools are necessary to address the reasons for use. Addressing OUDs is not an immediate, one-stop fix. It takes time and understanding of the winding road to recovery. People must be supported along the way, and courts cannot allow stigma to interfere with the science behind OUD treatment. The science is clear that MBT is the best way to reduce overdose deaths and help families remain together.

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Specialized Court Dockets Address the Opioid Crisis Nationwide

By Denise Herman McColley, Melissa Peper Firestone and Abigail Badenhop

It is that time of year when all the numbers come out - numbers reporting on how many more people overdosed in the past year than the previous year; numbers that indicate how opioid, methamphetamine, or cocaine use has grown; or numbers indicating the up-tick in unintentional overdoses involving drugs laced with other lethal substances, such as fentanyl. The charts with the upward climbs, detailing statistics with the rising numbers, have all but become the norm.

The United States' epidemic of drug use and overdose deaths continues to grow each year. It is a story of families from every socio-economic level—from the wealthy, the middle class, and the poor. It is a story involving no gender or racial bias. It is a story of repeated relapses, incarcerations, grandparents raising grandchildren, and the heartbreaking loss of loved ones.

Ohio has been hit hard. In 2017, the state had the second highest rate of drug overdose deaths in the United States. Increasing numbers of those deaths involved cocaine, methamphetamine, or other psychostimulants laced with a synthetic opioid such as fentanyl. In that year, there were 4,293 reported deaths or 39.2 deaths per 100,000 persons - more than double the national average rate of deaths of 14.6 per 100,000 persons (Ohio Department of Health).

The criminal court system has been overwhelmed by this crisis. The ripple effect cuts a wide path. Family courts have been swamped with abuse, dependency, neglect, and custody cases that arise when parents have been affected by illicit drug use. Additionally, delinquency cases are flooding the juvenile courts with youth who are starting to use at younger ages or are following in the footsteps of their parents.

There is, however, a ray of light and hope in this story. After years of punishing and incarcerating drug offenders or removing their children from their care, some court systems have been adopting new ways to address the epidemic. By initiating specialized dockets and ordering treatment and rehabilitation, courts are seeing families eventually reunified, fewer repeat offenders, and lives being saved from overdoses.

Prior to the use of specialized drug dockets, when children were removed from a parent's home because of drug use or drug violations, the parent would be required to work with children's services on a plan to remedy the situation with the goal of returning the child to the home or preventing removal from the home. There were very few court hearings and, while the parent might be ordered to do drug treatment, it was up to the parent to get that arranged and to attend. In cases in which juveniles were found to be delinquent due to drug-related charges, the juvenile may have been detained and ordered into drug treatment. Even after completing treatment, the likelihood of these parties returning to their old friends and habits following the conclusion of their cases was extremely high. Relapses and repeat offenses were the norm, and children being removed and not returning to a parent's care or youth being charged with another offense happened frequently.

In abuse, neglect, and dependency cases, the family dependency (drug) treatment court (FDTC) and, in juvenile delinquency or unruly child cases, the juvenile treatment court are models being used throughout the country and in Ohio. The family dependency treatment court presents a multi-disciplinary collaborative team approach designed to improve the outcomes for recovery, reunification, and family wellness in Ohio's child protection system (Supreme Court of Ohio, Ohio Family Dependency Treatment Courts Resource Guide 101: Implementing a FDTC). Through the use of these dockets, a court sets aside what are often times arbitrary timelines and, instead, develops programming individually designed for the benefit of the parties.

The Henry County Family Dependency Treatment and Juvenile Treatment Dockets are within the Henry County Family Court, a unified domestic relations and juvenile court. Henry County is in northwest Ohio, and, even though the county is small and primarily rural, it suffers from the same issues as counties throughout the country. Henry County's Family Court was formed in 2005, well before the current opioid crisis. Due to increasing caseloads in which drug usage was a problem, in 2016, the court's Juvenile Treatment Docket was certified and, in 2017, its Family Dependency Treatment Docket was certified by the Ohio Supreme Court.

The Henry County Family Dependency Treatment Docket, like many other specialized dockets, is conducted with the goal of helping parents succeed in recovery for the long term, not just while they are in the program, thereby allowing them to keep their children with them or be reunited with children who have been removed from their care. Joining the docket is voluntary, but for many of the participants, the alternative of having their children removed presents a strong incentive to be involved in the treatment court. By entering this specialized docket, participants consent to be monitored closely by the intervention court coordinator; have random, frequent, and observed drug screens; and participate in a rehabilitation program that usually starts with residential treatment. In addition, they agree to attend frequent court hearings and report on their progress as they move through the treatment court phases. A treatment team is convened that meets and attends court hearings regularly. The team consists of therapists, caseworkers, the child(ren)'s guardian *ad litem*, the party's attorney, and others who provide updates. The participants are not alone in their efforts to change—they have gained an entire team working with them toward recovery.

Very few of the participants enter the court enthusiastically. In fact, most of them are initially opposed, indicating they do not need the assistance and believe they can turn their lives around by themselves. Many indicate that their drug use is not that serious and that they will attend drug treatment on their own. For most, however, that unfortunately is not the case. Being involved in the specialized docket offers participants constant support, accountability to stay clean, small incentive rewards, therapy, resources for jobs, housing and transportation, and the idea that they have support to succeed.

The process consists of phases, starting with the residential phase (if the participant is initially in residential treatment) and moving through four additional phases. Court appearances range from once per week in Phase 1, and gradually reduce to once every four weeks in Phase 4.

In each phase, participants are asked to meet various goals in order to progress to the next phase. With each progression, participants may earn more time with their children, fewer court appearances, and more autonomy. The higher the phase, the less intensive therapy becomes as the participant moves toward graduation and reunification with his or her children—and a drug-free life.

Relapses are common and to be expected. These relapses may occur after months of sobriety, or sometimes even after graduation. Relapse is disappointing but does not mean treatment has failed. It means treatment may need to be modified or the participant must restart treatment. The chronic nature of addiction requires that treatment include changing deeply rooted behaviors, and sometimes cutting off close ties to family and friends who have shared or enabled substance abuse.

For many participants, being sober means life looks very different from when they went into treatment. It may mean finding new associates, moving to a different home and working a job with regular hours. Interestingly, we have found that some participants who have graduated from the program willingly return to the treatment court program when a relapse occurs.

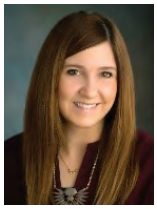
In most cases, the transformation of the participants is obvious to treatment team members. Little by little, participants begin to look healthier, smile more, and become more eager to report to the court about how many days they have been clean and sober. As participants progress, they may receive incentives at the hearing, such as snacks, toiletries, journals, or gasoline cards. Simple as these may seem to others, for participants they are deeply appreciated—a positive acknowledgment in the long, hard fight toward sobriety.

When a participant completes the phases of the program, which can take anywhere from nine months to a year or more, a graduation ceremony is held. The participant is able to invite those who have supported him or her in recovery to the ceremony. At the graduation, the participant is asked to address the attendees, and a reception is held in his or her honor. It is often an emotional experience for participants, who frequently state they originally never thought they could accomplish this. One of the first graduates of the treatment court expressed a sentiment to the treatment team often repeated by other participants, "You believed in me more than I believed in myself."

Years of court experience has taught us that the specialized docket approach has provided more success stories for the long term than the simple solution of detaining someone or removing their children and hoping they will successfully complete treatment.

The epidemic of drug abuse may never be eliminated, but, with better treatment, supervision, and rewards for success, lives can be saved. Through these treatment dockets, courts have unwittingly become first responders in the opioid epidemic, with successful rehabilitation as the goal rather than punishment or separation of families.





Judge Denise Herman McColley presides over the Henry County Family Court in Ohio. **Melissa Peper Firestone** is a magistrate in the Henry County Family Court and **Abigail Badenhop** is the Henry County Family Intervention Court Coordinator.

One Size Does Not Fit All: Person-Centered Collaboration Between Substance Use Service Providers and the Family Court

By Abigail M. Judge and Stephanie Tabashneck

The national opioid crisis has prompted the need for collaboration between service providers who work with individuals with substance use disorder (SUD) and family courts, creating an opportunity for family court professionals to positively shape the trajectory of recovery for individuals and families.

These groups, however, are not accustomed to collaboration. The service providers are tasked with making recommendations in a field that is replete with outdated notions about treatment and high levels of stigma.

This article describes the value added when family court professionals, such as judges, attorneys, and probation officers, collaborate with SUD service providers to inform referrals to evidence-based care, reduce court involvement, enhance compliance with court orders, and improve family outcomes. This article also introduces readers to several aspects of SUD care to help foster collaboration and shared decision-making in the hopes of improving clients' engagement in SUD services.

CONSIDERATIONS FOR COURT ORDERED TREATMENT

Judges frequently order clients' involvement in SUD services and treatment, and attorneys draft stipulations related to the same. There exist various levels of knowledge among family court professionals about what effective treatment for SUD looks like. Many outdated ideas pervade the SUD treatment landscape, which can confuse judges and attorneys who are tasked with crafting informed court orders. To overcome these challenges, we start with a summary of the SUD providers who make up a client's treatment team. We also refer readers to expert sources that provide education about SUD in the legal system (www.asam.org).

Roles

If medication assisted treatment (MAT) is prescribed, a *physician or other medical provider is* likely to fulfill this role. Ideally, this physician is board certified in addiction medicine, but there is a national shortage of such providers. When psychiatric medication is required, a *psychiatrist or other qualified prescriber* may be involved (e.g., advanced practice registered nurse (APRN); physician assistant (PA); nurse practitioner (NP). This clinician would ideally be board certified in addiction psychiatry and/or have specialized training in the psychiatric management of SUD. Again, there is a national shortage of providers with these credentials.

A *clinical psychologist or clinical social worker* may be involved to provide mental health support because medication assisted treatment is paired with counseling and behavioral interventions. These individuals may be involved as family therapists to support the entire family system. Although board certification in SUD is not available for these disciplines, it is critical for therapists to specialize in SUD. Notably, many mental health professionals have limited training in SUD or see this as outside the scope of their role. Thus, even if a parent is receiving mental health services, it does not necessarily mean that they are receiving SUD treatment.

A *recovery coach* is a form of peer support that is increasingly common throughout addiction medicine. Recovery coaches are peers who have lived through addiction and recovery and use this experience as a source of expert knowledge to support clients in recovery. A systematic review of research on the effectiveness of peer-delivered recovery coaching found overall positive contributions to SUD outcomes, including improved system navigation and social support.

It is important for treatment teams to maintain communication with each other to ensure consistent treatment. It is important for clients to sign releases for the treatment team to communicate freely, a provision that can be included in court orders. Whenever possible, someone from

family court should invite input from the client's SUD treatment team to ensure that ordered treatment is consistent with what has been clinically recommended. This may introduce questions regarding therapeutic privilege, which should be considered in advance of any clinical information being released.

Why input from SUD providers matters

It is increasingly accepted that there is no "one size fits all" treatment approach for substance use and that various evidence-based treatments are required to meet the diverse preferences and needs of this population. Regardless of the treatment modality, it is widely recognized that the main goal is to *keep clients engaged in care*.

Emphasizing engagement helps ensure that when individuals relapse, they are more likely to stay involved in managing their illness. SUD is a chronic, relapsing illness and treatment engagement is understood as one of the most important predictors of substance use outcomes. Engagement is enhanced when involved professionals collaborate. Such engagement also can be undermined when clients receive contradictory recommendations in the form of ill-informed court orders. The concepts of *person-centered care* and *recovery capital* often help enhance provider and family court collaboration.

Building recovery capital through person-centered care

Person (or patient) centered care is a core tenet of SUD treatment. The Health and Medicine Division of the National Academies of Sciences, Engineering and Medicine defines patient-centered care as: "Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."

Court-ordered treatment means that the justice system has concerns about a client that necessitate judicial input in that person's life. There is an unavoidable tension when treatment is ordered, because involuntary treatment makes implementation of person-centered care more complex. Inviting input from the involved clinicians, who have integrated the views and needs of the client, is one way to address this tension and to ensure that mandated treatment is as person-centered as possible.

To provide an example of why person-centered care is important, consider this example:

> A psychologist discussed with a patient's probation officer the client's court mandated SUD treatment. When the probation officer learned that the patient had attended three peer support meetings per week, he insisted that the patient was "slipping in her recovery" because she was not following the "90 in 90" tradition recommended by one peer support fellowship - attending 90 peer support meetings in 90 days. The officer's knowledge of SUD was informed primarily by one peer support model, which may not be equally relevant to all clients. In fact, there were clinical reasons that the patient attending that many meetings was not appropriate given the extent of her PTSD symptoms following a recent trauma. (Factors such as transportation access or childcare needs could make compliance with such a requirement exceptionally difficult, resulting in increased stress to the individual and jeopardizing recovery.) Without this person-centered clarification, the probation officer may have responded more punitively to what was actually the patient's efforts to balance SUD recovery with her own safety.

A concept related to person-care is "recovery capital," which may help align the efforts of family court professionals and SUD providers. Recovery capital encompasses the interrelated domains of social support, spirituality, religious beliefs, life meaning, and 12-step affiliation. Higher levels of recovery capital are associated with improved coping and enhanced life satisfaction and predict higher quality of life, sustained recovery, and lower stress at one-year follow-up.

Most SUD research focuses almost exclusively on substance use outcomes, when in fact other aspects of functioning are equally critical and create the building blocks of long-term recovery. The disease of substance dependence affects all areas of functioning, including social, emotional, physical, and vocational, and recovery from SUD is also "much more than the absence of substance use in an otherwise unchanged life." Recovery capital is a framework that family court professionals can use to identify supports most relevant to an individual client.

Consistent with person-centered care, recovery capital is highly individualized and is not "one size fits all." It also should be tailored to a person's stage of illness. Early recovery, for example, is appropriately focused on maintaining abstinence, but this does not mean ignoring other facets of recovery capital given their association with overall wellbeing. This means that persons of greatest support to a client may or may not embody traditional roles. For example, a pastor, advocate, or sponsor may be as vital to the client in recovery as other SUD professionals. Inquiring about sources of recovery capital in an individual's life is essential. Consider ways that court professionals and involved SUD providers can collaborate to enhance recovery capital across domains.

Integrated treatment

Clients with SUD and co-occurring mental health diagnoses are at risk for falling through the cracks of our systems. Estimates suggest that approximately 41 percent of individuals with Alcohol Use Disorder and 60 percent with a drug use disorder have a co-occurring mental illness. There are particularly elevated rates of PTSD among individuals with Opioid Use Disorder, and the role of psychological trauma is pervasive in the lives of many clients presenting to family court.

The standard of care for SUD with co-occurring mental health diagnoses is *integrated treatment*, which refers to services that address both substance use and mental health problems at the same time. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) Co-Occurring Center for Excellence, individuals with co-occurring disorders "are best served through an integrated screening, assessment and treatment planning process that addresses both SU and MH disorders, each in context of the other." Unfortunately, even though integrated treatment is the standard of care, SUD and mental health treatment systems are historically siloed and disconnected. Family court professionals should understand that fragmented systems are an artifact of antiquated thinking rather than a reflection of what clients with SUD actually need.

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Suggestions for practice *(Continued from page 7)*

It is challenging to build collaborations between family courts and SUD providers, but the potential gains for an individual in recovery are substantial. SUD providers can be a valuable resource for family courts. For example, providers can clarify treatment goals, describe the expectations of a given program, and explain the boundaries or limitations of their role. They can help family courts to stay up to date on best practices and developments in addiction research.

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