# Harm Reduction Strategies in Treatment Court

## *What fits and what doesn't*

Terrence Walton, Chief Operating Officer
National Association of Drug Court Professionals

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# Disclaimer

This presentation, including its handouts, is intended for informational purposes only. Information you receive during this presentation is not intended to be a substitute for professional advice, including professional legal, health, and/or ethics advice. Please consult with an independent professional concerning your specific concerns.

# What is Harm Reduction?

- A set of strategies and ideas to promote public health by reducing the negative consequences associated with drug use
- Aims to reduce risks and improve quality of life for people who use drugs

# Harm Reduction and Treatment Courts

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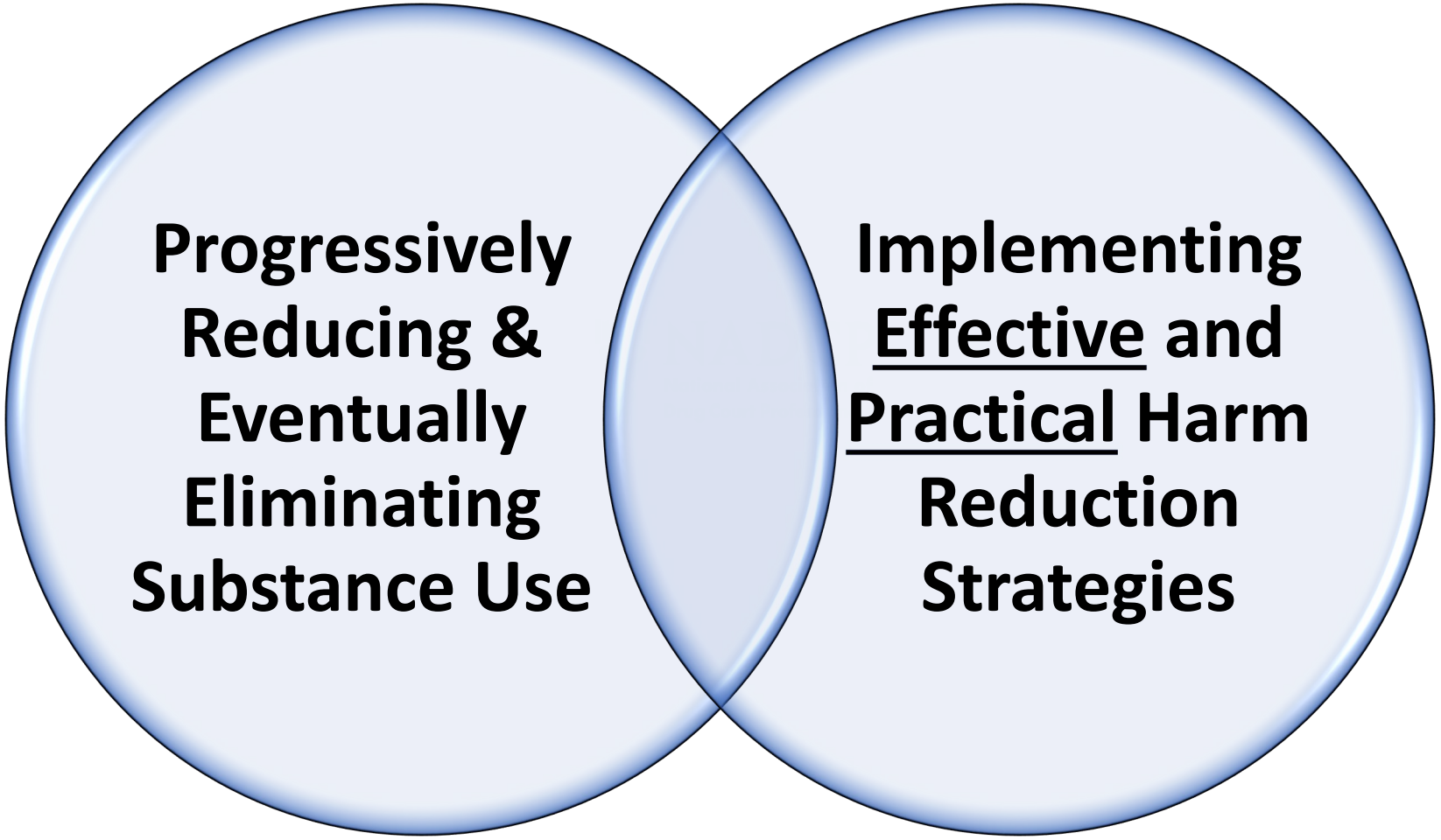
## Treatment Courts:

- Reduce harms by rigorously abiding by best practice standards
- Reduce harmful drug use by providing effective treatment and recovery management
- Focus on reducing harm to the individual, their family, and the community
- Keep people in effective treatment long enough for them to find their path to a lifetime of recovery
- Reduce systemic harms by providing a viable alternative to incarceration for people with SUD
- Reduce overdose risk

# How Treatment Courts Reduce Overdose Risk



# SAMHSA on Harm Reduction

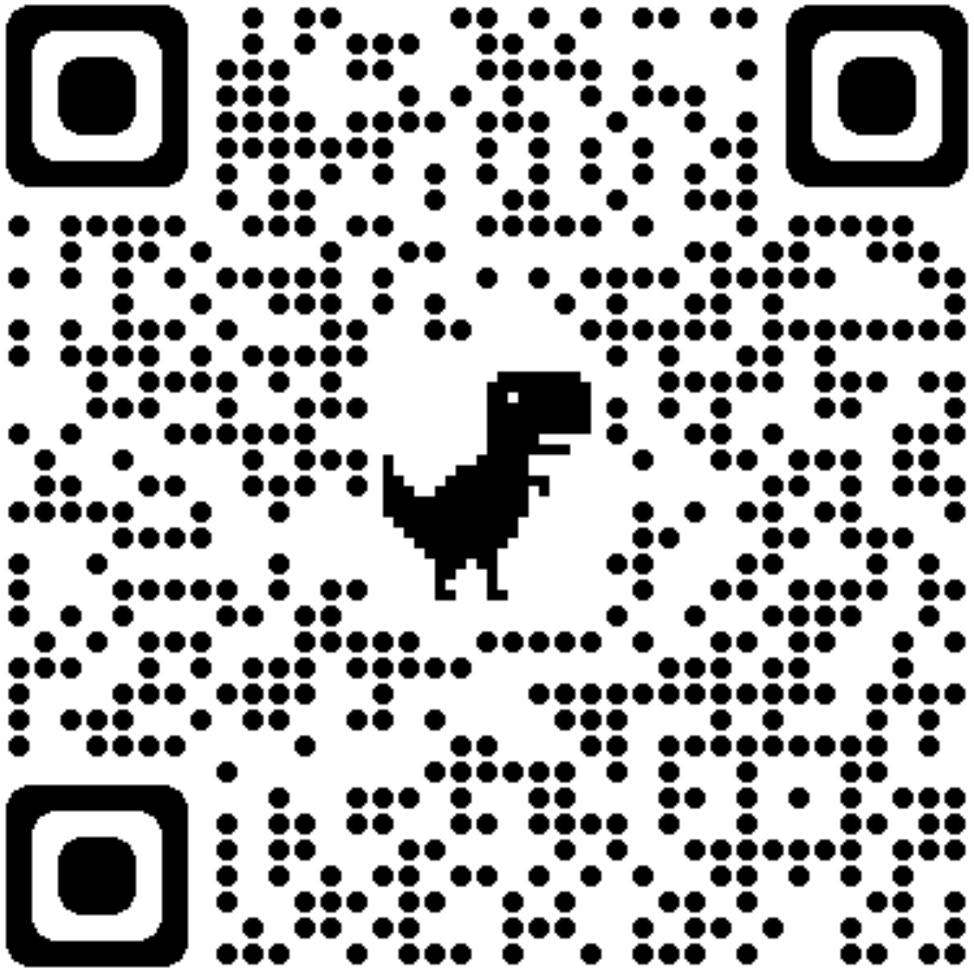
Harm reduction is an approach that emphasizes engaging directly with people who use drugs to **prevent** overdose and infectious disease transmission, **improve** the physical, mental, and social wellbeing of those served, and offer **low-threshold options** for accessing substance use disorder treatment and other health care services.

# SAMHSA on Harm Reduction

Harm reduction organizations incorporate a spectrum of strategies that meet people "**where they are**" **on their own terms**, and may serve as a **pathway** to additional prevention, treatment, and recovery services. Harm reduction works by addressing broader health and social issues through improved policies, programs, and practice.

SAMHSA 2022

# SAMHSA on Harm Reduction



# Harm Reduction Practices and Treatment Courts

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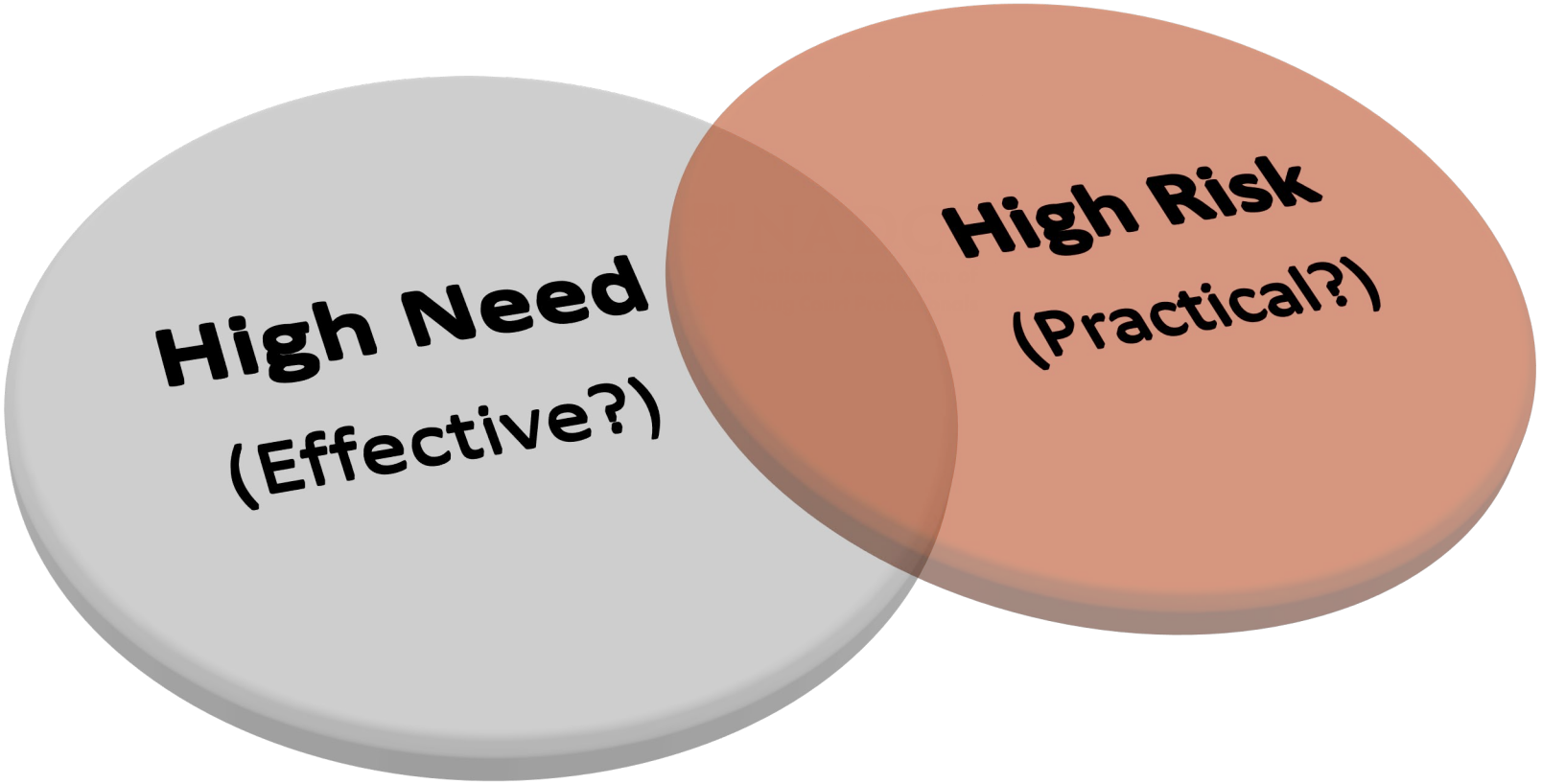
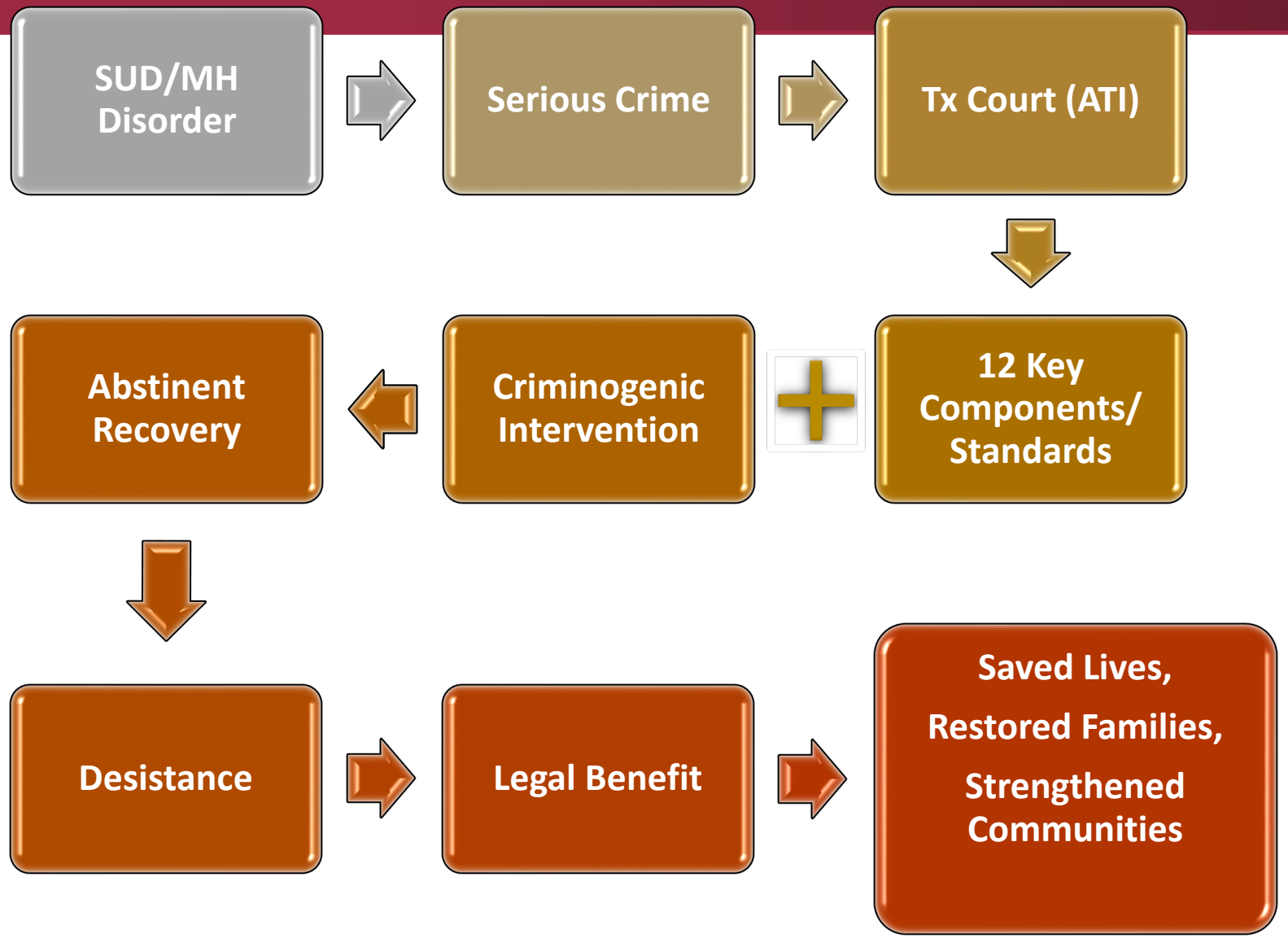
**Harm reduction has primarily been focused on individuals outside of justice system**

**Some harm reduction strategies fit in treatment court, and some may not—ineffective and/or impractical**

# The Treatment Court Population IS Different



# The Treatment (Tx) Court Logic Model



# Harm Reduction Practices

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1) Overdose prevention education: risk factors, all available harm reduction services, etc.

2) Medication for addiction treatment

3) Access to Narcan/Naloxone kits & fentanyl test strips

4) Psychoactive substances used to treat addiction or MH disorder (other than MAT)

5) Controlled or safer, yet continuing substance use as a final goal of treatment

6) Syringe service programs—needle exchange; sterile injection or smoking equipment

7) Safe injection sites or sanctuaries

# Harm Reduction Practices: What Fits?

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1. Fits
2. Doesn't Fit
3. Maybe/Depends

# Harm Reduction Practices

- **Being a poor fit for treatment court indicates that the practice is not a core service that is directly provided within or connected to the treatment court program**
- **Being a poor fit for treatment court does not indicate that the treatment court would object to any harm reduction service/practice being available in the community**
- **Being a poor fit for treatment court does not indicate that the treatment court would prevent participants from being informed about or from using such services, unless there is a legal reason to do so** (e.g., prohibition against possessing illicit drug use paraphernalia.)

# Harm Reduction Practices

**Ultimately, each jurisdiction (neighborhood, city, county, state, region) will determine which harm reduction practices fit in their communities and in their treatment courts. Based on the treatment court logic model, decades of drug court research, our commitment to reduce overdose risk, and the absence of research on harm reduction with high-risk/high-need individuals, here is NADCP's position…**

# Harm Reduction Practices

| |
|---|
| **1) Overdose prevention education: risk factors, all available harm reduction services, etc.** |
| **2) Medication for addiction treatment** |
| **3) Access to Narcan/Naloxone kits & fentanyl test strips** |
| **4) Psychoactive substances used to treat addiction or MH disorder (other than MAT)** |
| **5) Controlled or safer, yet continuing substance use as a final goal of treatment** |
| **6) Syringe service programs—needle exchange; sterile injection or smoking equipment** |
| **7) Safe injection sites or sanctuaries** |

# Harm Reduction Practices

- Treatment courts should educate participants on all legal harm reduction services and resources available in their community, even if not directly provided in or connected to the treatment court.
- Those services that are not a part of treatment court would likely not appear in the participation agreement, handbook, or supervision plan; however, they might be in the treatment plan developed by the treatment professional.
- By profession, treatment professionals are obligated to deliver or directly connect participants to all legal  harm reduction services available in the community, even if not a core treatment court service.
- Unless legally required to do so, treatment courts should not sanction or otherwise discourage participants from accessing legal harm reduction services.

# Harm reduction positions and issues that may be at odds with treatment court best practices

1. **Non-abstinence treatment options**
2. **Person-centered, non-coerced treatment; no forced abstinence**
3. **No jail for substance use, including jail sanctions**
4. **Limited drug testing and non-observed drug testing**
5. **Decriminalization or legalization of drugs**

# Critical Issue – Abstinence Requirement

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## An Abstinence Definition

**Avoiding the self-prescribed or recreational use of all potentially addictive, intoxicating, or mood-altering substances**

# Critical Issue – Abstinence Requirement

- Eventual abstinence is one of the expected outcomes of and completion requirements for treatment courts.
- Long term use of medications for addiction treatment is fully consistent with abstinence-based treatment.
- Addicted participants often don't yet have the recovery skills to consistently adhere to abstinence.
- **Treatment courts help participants stay alive long enough to achieve sustained abstinence.**
- Treatment courts seek to reduce the harms of recent drug use for participants who have not yet achieved abstinence or who experience a return to use after having done so.
- Treatment courts should institute practices that encourage honesty about drug use without fear of stringent sanctions, unless an imminent public safety risk exists.

# Critical Issue – Person Centered Treatment

- What it means for the treatment professional?
  1. Meeting participants where they are
  2. Using motivational interviewing to respectfully move them forward
  3. Helping participants to accept their realities, including helping them navigate their mandates

- What it means for the justice professional?
  1. Meeting participants where they are
  2. Balancing participant preferences with public safety concerns and justice system mandates

- Treatment: setting, modality, intervention, dosage, & duration—especially when participant and treatment professional disagree

# Person-Centered Treatment and Level of Care

Updated Guidance from the upcoming *The ASAM CRITERIA 4TH Edition*

(Appendix A- Level of Care Assessment Considerations)

After level of care determination is made by a treatment professional, he or she considers the newly defined ASAM Dimension 6 (Readiness and Resources) as follows:

1. Is the patient able to attend the recommended Level of Care?
   - Are any services or resources needed to enable the patient to participate in the recommended Level of Care (e.g., transportation, childcare, financial, etc.)?
   - Are these services/resources available to the patient and sufficient to enable them to participate in the recommended LOC?
   - If not, how should the LOC be adjusted?

# Person-Centered Treatment and Level of Care

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2. Assuming the patient has sufficient resources and services are available, is the patient willing to attend the recommended Level of Care?
   - If not, what treatment services are acceptable to the patient?
   - If the patient's preferred treatment setting is adjudged to be unsafe or is unlikely to be effective, what can be done to increase the patient's willingness to attend treatment at the recommended Level of Care (e.g., motivational enhancement therapy, family counseling)?
   - Is the patient being compelled to follow clinical recommendations by an external source? If so, what are the requirements?

# Person-Centered Treatment and Duration and Dosage of Care

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**Updated Guidance from the upcoming *Adult Drug Court Best Practice Standards 2nd Edition***

(Standard 5 ~ Substance Use, Mental Health, and Trauma Treatment and Recovery Management)

Participants collaborate with treatment professionals or clinical case managers in setting treatment plan goals and choosing from among the available treatment options and provider agencies. Team members serve complementary functions in both supporting participants' decision-making autonomy and ensuring adequate behavioral change to protect participant welfare and public safety.

# Person-Centered Treatment and Duration and Dosage of Care

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Participants receive a sufficient duration and dosage of substance-use and other CBT counseling to stabilize their clinical symptoms, initiate abstinence, teach them effective prosocial problem-solving skills, and enhance their preparatory skills needed to fulfill adaptive roles like employment or household management. Evidence suggests that 200 to 300 hours of professionally delivered CBT counseling over 9 to 15 months may be required to achieve these aims for high risk and high need persons.

# Critical Issue – Use of Jail

- **Absent an imminent public safety risk, participants usually do not receive stringent sanctions if they are otherwise compliant with their treatment and supervision requirements but are struggling to maintain abstinence.**
- **Responses to participant behavior must be informed by his or her ability to consistently control that behavior**
- **Used in conjunction with incentives, the possibility of stringent sanctions** (including brief jail stays for repeated willful non-compliance) **may help the high-risk/high-need participant consistently engage in treatment sessions, court hearings, and other requirements.**
- **Jail is not treatment, safe housing, nor an effective harm reduction/overdose prevention strategy. Even when necessary, jail can do harm.**
- **Be intentional about reducing the potential harms of jail sanctions.**

# Critical Issue – Why Observed Urine Testing?

1. High risk population
2. For accurate detection
3. Motive to deceive
4. Positive external motivator
5. Justice personnel observers versus treatment staff observers
6. Mitigating risk of re-traumatization/Reducing potential harms

# Tell The Whole Story

## Measuring Success

- Measure and monitor interim improvements in quality of life and risk reduction—including for those who do not complete successfully
- Imagine how broadening our metrics influence our treatment/service planning and decision making.

# Summary & Next Steps

- Treatment court is an abstinence-based public health model that fully embraces unfettered access to medication for addiction treatment and other harm reduction strategies that are appropriate for individuals whose continuing substance use has led to serious crimes or child endangerment.
- All harm reduction practices discussed have life-saving public health value. However, not all practices can be directly facilitated in treatment courts. Those that can should be implemented.

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- NADCP to host a summit in 2023 to discuss and seek consensus around harm reduction in treatment courts.
- NADCP to publish written guidance on harm reduction in treatment courts following the summit.

# Harm Reduction Strategies in Treatment Court

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# Harm Reduction Strategies in Treatment Court

# Handout Slides

The remaining slides are not fully covered during the presentation and are provided for post-session study and elaboration

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# Handout Slide—Abstinence

- The abstinence definition in treatment courts **is avoiding the self-prescribed or recreational use of all potentially addictive, intoxicating, or mood-altering substances**.
- Self-prescribed indicates that participants can't use anything not prescribed by the doctor. Avoiding recreational use means that, even if prescribed by the doctor, participants may not use or misuse it to get high. This includes all such substances, not just the category to which the participant is addicted.

# Handout Slide—Abstinence

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- NADCP recognizes that it may be possible that, for example, an individual who is in sustained remission from an opioid use disorder might (or might not) eventually be able to use other substances, such as alcohol or marijuana, without developing an SUD for those substances; and without recidivating. However, there is not yet sufficient research or clinical/diagnostic guidance to determine in advance which individuals might fit into this category. Therefore, for the high risk/high need treatment court participant, whose substance use has led to serious crimes, complete abstinence is required for successful completion.

- NADCP supports the need for research that seeks to determine whether and in which circumstances a goal less than complete abstinence might be safe and effective for some in our target population.

- Use of any FDA-approved medication to treat addiction is allowable and does not violate the abstinence-based requirement.

# Handout Slide— Person-Centered Treatment

- **Treatment professionals are not "arms of the court"** and must honor their professional code of ethics, including adopting a person-centered, "meet the person where they are" approach. Even when the participant must achieve abstinence in order to complete treatment court successfully, as opposed to "enforcing" the abstinence requirement, the treatment professional's job is to help the participant accept that reality, navigate their mandates, and achieve their goal of successful program completion.
- This is the same as they would do for a client who needed to achieve abstinence in order to maintain a professional license, keep a job, play on a sports team, or remain in a marriage.
- **Justice professionals** practice meeting the participant where they are as well but **must also balance the participant's preferences against what is necessary to protect public safety** for the high risk/high need individual who is being allowed to remain in the community while being treated for SUD.
- Treatment professionals working with treatment court participants should also consider public safety when treatment planning. Addiction-related criminal activity or associates should be reflected in the Recovery and Living Environment *The ASAM Criteria* dimension.

# Handout Slide— Person-Centered Treatment

- **In the traditional person-centered approach, despite what the treatment professional recommends, the client's wishes rule** regarding the treatment setting (e.g., outpatient vs residential), treatment modality (i.e., group, individual, family), intervention (e.g., CBT, MAT), treatment dosage (e.g., how much, how many hours per week), and duration (e.g., 90 days, 6 months).
- Hopefully, the treatment professional will be able to negotiate a treatment plan to which the client agrees. If not, then the person-centered approach indicates that the client's wishes are to govern the treatment plan.

# Handout Slide— Person-Centered Treatment

- However, in treatment courts, the judge will typically defer to the treatment professional's recommendation (not the participant's) who is required to recommend the least restrictive/intensive treatment that is likely to successfully treat the high risk/high need individual.
- Treatment professionals should be aware that guidance from the American Society of Addiction Medicine is that if the client is persistently unwilling to accept the recommend treatment, if it is safe to do so, the treatment professional should attempt treatment at the level/intensity the client is willing to engage in, even if they fear it will not be sufficient.
- If the treatment professional concludes that the participant cannot be safely treated at the lower level/intensity treatment preferred by the participant, then then he or she should communicate that to the judge. And generally, the judge would concur with that recommendation.

# Handout Slide – Person-Centered Treatment and Medication for Addiction Treatment

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## Methadone, Suboxone, & Naltrexone

- Medication for addiction treatment should be fully implemented (but not mandated) in treatment court, including methadone, Suboxone, naltrexone, & extended release naltrexone.
- For the high risk/high need population prescribed MAT, psychosocial treatment is also needed.
- Premature interruption of MOUD increases overdose risk.
- Long term use of methadone and Suboxone are not associated with crime or other public safety risks—therefore should not raise concerns for justice professionals.
- Person-centered care requires treatment professionals to fully embrace, support, and facilitate a participant and medical providers decision to use medications, regardless of the treatment professional's views.

# Handout Slide – Person-Centered Treatment and Level of Care

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Updated Guidance from the upcoming *The ASAM CRITERIA 4TH Edition*

(Appendix A- Level of Care Assessment Considerations)

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# Handout Slide – Person-Centered Treatment and Level and Length of Care

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2. Assuming the patient has sufficient resources and services are available, is the patient willing to attend the recommended Level of Care?
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# Handout Slide – Person-Centered Treatment and Duration and Dosage of Care

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**Updated Guidance from the upcoming *Adult Drug Court Best Practice Standards 2nd Edition***

(Standard 5 ~ Substance Use, Mental Health, and Trauma Treatment and Recovery Management)

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# Handout Slide—Potential Harms from Jail

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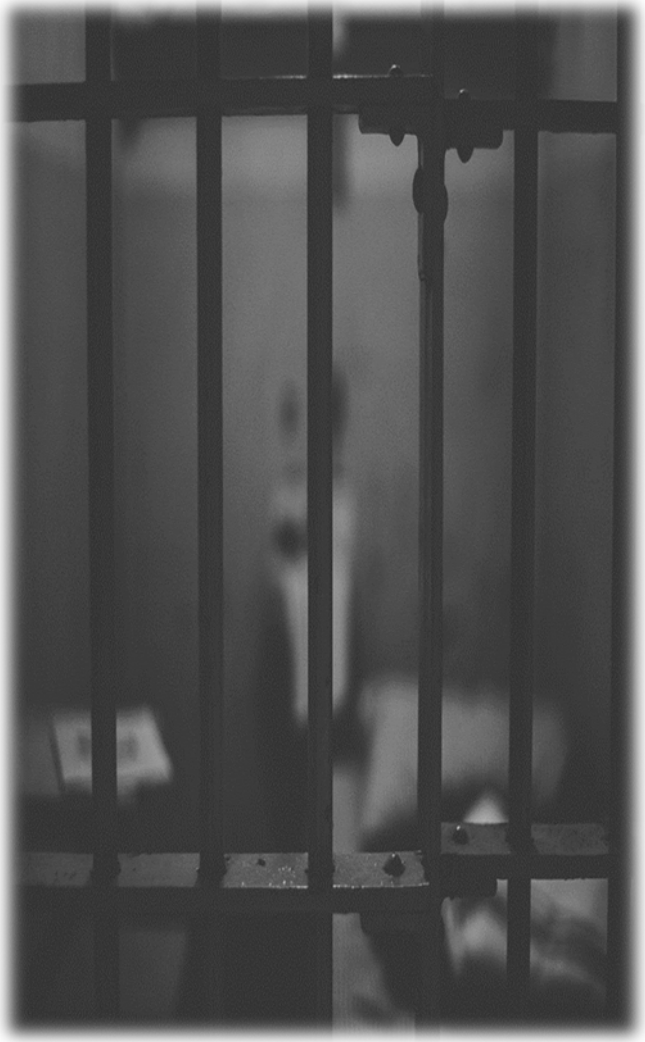
1. Exposure to other high-risk individuals
2. Risk of assault or other physical or emotional harm
3. Increased lethality risk
4. Interruption of life saving medication for addiction or mental health treatment
5. Interruption of psychosocial treatment and recovery management services
6. Re-traumatizing
7. Loss of job
8. Loss of housing

# Handout Slide—Potential Harms from Jail



9. Separation from children
10. Increased risk of opioid overdose following release due to reduction in opioid tolerance following even a brief period of incarceration-related opioid abstinence (same dose required to get high, but takes less to stop respiration)
11. Any period of juvenile detention has been found to be especially harmful to adolescents and should not be used a sanction in juvenile treatment court, in the absence of an imminent, serious public safety risk.
12. The potential for harm is increased the longer the individual is incarcerated

# Handout Slide—Mitigating Risk of Harm from Jail

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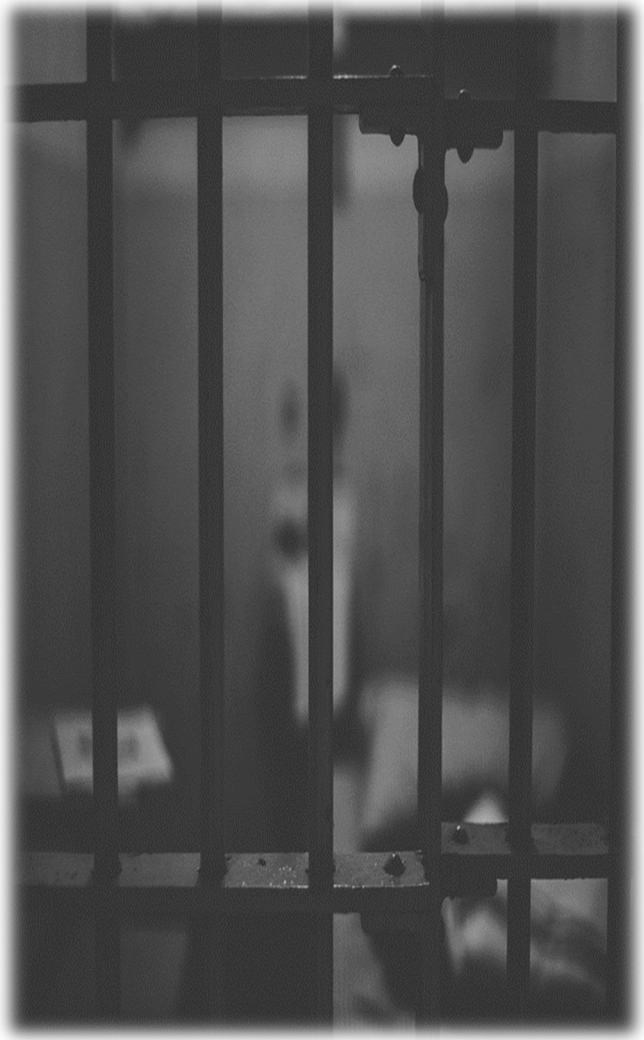
1. Avoid using jail while awaiting or instead of residential treatment.

2. Recognize that jail is not an effective strategy for preventing opioid overdose. The reverse is true. Use other strategies for reducing risk to those who are continuing to use opioids—e.g., **a) fully utilize MOUD, b) increase intensity of community-based OP/IOP treatment in the absence of or while awaiting a residential placement, c) increase mutual support group participation if recommended by treatment professional, d)increase court appearances, supervision contact, enforce a curfew, etc.**

3. In the absence of a related imminent public safety risk, generally do not use jail as a sanction for drug use alone for the person living with addiction who has not yet developed ability to abstain, unless that drug use was preceded by or led to missing treatment sessions, failures to appear for court, supervision, drug testing; violations of curfews, commission of new crimes warranting incarceration—other than simple drug possession or probation violation. In all circumstances, mitigate the risk of the abstinence violation effect.

# Handout Slide—Mitigating Risk of Harm from Jail

4. Utilize brief jail-based treatment and recovery management while the participant is jailed for any reason
5. Absent an associated imminent public safety risk, do not jail unless currently prescribed medications for addiction or mental health treatment can continue uninterrupted—without forcing the participant to taper off medications
6. Consider the appropriateness of work-release or weekend jail to allow jail sanctioned-participants to maintain employment
7. Use jail sanctions as a last resort and never for more than a few days



# Handout Slide—Why Observed Drug Testing?

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1. **High risk population** (Requires more intense accountability measures; more likely to attempt to "beat the test")

2. **Frequency and schedule** (Frequent, random testing required to detect use when participant is not yet fully committed to abstinence or to being honest about struggles to abstain. This is also required to effectively apply behavior modification (Operant Conditioning), which requires detecting and responding to behavior consistently and swiftly.)

3. **Motive to deceive** (All people participating in court-involved SUD treatment who face sanction or loss of desired benefits for continuing substance use have an inherent motivation to try to hide use if they are not yet committed to, or not yet able to consistently abstain.)

# Handout Slide—Why Observed Drug Testing?

4. **Positive external motivator** (Realizing that it is very difficult to continue using in treatment court without detection can assist in helping the participant to begin to more fully engage in treatment and recovery management. Testing less rigorously can delay the participant reaching that conclusion.)

5. **Justice personnel observers versus treatment staff observers** (Rigorous chain of custody and observation are essential for drug testing conducted by the court or probation. Chain of custody and observation is less important for treatment agencies if test results will not be used in the legal matters involved in treatment court—i.e., if the results are only used to guide clinical decisions and cannot result in sanction. It is probably best if the individual delivering the direct treatment services is not also the person who observes the urine.)

# Handout Slide—Potential Harms from Observed Drug Testing

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Although usually necessary in treatment courts, potential harm may result from conducting observed urine collection, for example:

- Some individuals, especially those who have survived sexual trauma, may be re-traumatized or otherwise caused distressed by being observed while urinating.
- Being alone in a private, enclosed space with a participant may expose the observer or participant to inappropriate sexual conduct, inuendo, or related allegations.
- The need to match genders between observer and participant may result in mis-gendering of transgender or binary participants.

# Handout Slide—Mitigating Potential Harms from Observed Drug Testing

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1. Observation should be conducted in manner that helps to ensure that no adulterant is being used or bogus urine is being submitted but should be in no closer proximity than necessary. No part of the participant's body or clothing being worn should ever be touched by the observer/collector.
2. Do not insist on being able to directly observe genitals.
3. Use private observation windows when available.
4. Do not use video to observe urines. Even if the camera monitors but does not record video, the observer could inappropriately record the collection on a different device or be accused of doing so.

# Handout Slide—Mitigating Potential Harms from Observed Drug Testing

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5. If allowed by personnel policy and other regulation, allow participants to be observed by someone that matches the sex with which they identify.
6. Consider using two observers if available and preferred by the participant.
7. Seek alternatives to urine testing for individuals whom treatment professionals indicate are likely to be retraumatized by being observed.

# Handout Slide - Harm Reduction Research

**Harm Reduction Studies**

•Safe injection sites. Studies on safe injection sites show they help reduce drug overdose deaths, prevent public drug use, and improve community health through preventing the transmission of bloodborne disease. For example, one 2011 study in *The Lancet* showed Vancouver's overdose deaths decreased by 35% two years after their safe injection site opened.[1]

•A clinical review in *Psychiatric Services in Advance* on the effectiveness of methadone in MAT showed methadone use is associated with improved treatment retention and reduced opioid use in individuals with opioid addiction; reductions in drug-related HIV risk behaviors, mortality, and criminality; and improvements in fetal outcomes in pregnant women with opioid addiction.[4]

•A National Institute on Drug Abuse study that examined the effectiveness of buprenorphine and naloxone in people who were addicted to opioids found that half were abstinent 18 months after they started MAT. After 3.5 years, the number of people who were abstinent rose to 61% and less than 10% met the criteria for opioid use disorder (addiction).[5]

•Managed alcohol programs. Several small studies have demonstrated the effectiveness of MAPS. For example, one study published in the *Canadian Medical Association Journal* showed that residents of a MAP had a decrease in interactions with the police and emergency services. Another study in the *Harm Reduction Journal* showed that people in MAPs had fewer admissions to hospitals, detox treatments, and arrests.[2]

•Naltrexone for alcohol reduction. A study in the journal *Substance Abuse* found that extended-release naltrexone combined with harm reduction counseling was effective at reducing alcohol use and alcohol-related harm in homeless alcoholics.[3]

**Sources**


1.Ducharme, J. (2018). *The Country's First Safe Injection Facility May Soon Open in Philadelphia. Here's What You Need to Know*. *Time*

2.Chapin. S. (2018). *Could Managed Consumption Be a Better Form of Treatment for Alcoholism?* *Pacific Standard.*

3.Collins, S., Duncan, M., Smart, B., Saxon, A., Malone, D., and Ries, R. (2014). Extended-release Naltrexone and Harm Reduction Counseling For Chronically Homeless People with Alcohol Dependence. *Substance Abuse, 36(1), 21-33.*

4.Fullerton, C., Kim, M., Thomas, C., Lyman, R., Montejano, L., and Delphin-Rittman, M. (2014). Medication-Assisted Treatment With Methadone: Assessing the Evidence. *Psychiatric Services in Advance, 65(2), 146-157.*

5.National Institute on Drug Abuse. (2015). *Long-Term Follow-Up of Medication-Assisted Treatment for Addiction to Pain Relievers Yields "Cause for Optimism"*

# Handout Slide - Overdose Prevention in Drug Court

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**From Adult Drug Court Best Practice Standards, Volume II (TR), Complementary Treatment & Social Services, pages 17-18**

**Overdose Prevention and Reversal**

- Unintentional overdose deaths from illicit and prescribed opiates have more than tripled in the past fifteen years (Meyer et al., 2014). Individuals addicted to opiates are at especially high risk for overdose death following release from jail or prison because tolerance to opiates decreases substantially during periods of incarceration (Dolan et al., 2005; Strang, 2015; Strang et al., 2014).
- Drug Courts should educate participants, their family members, and close acquaintances about simple precautions they can take to avoid or reverse a life-threatening drug overdose. At a minimum, this should include providing emergency phone numbers and other contact information to use in the event of an overdose or similar medical emergency.
- As permitted by law, Drug Courts should also support local efforts to train Drug Court personnel, probation officers, law enforcement, and other persons likely to be first responders to an overdose on the safe and effective administration of overdose-reversal medications such as naloxone hydrochloride (naloxone or Narcan). Naloxone is nonaddictive, nonintoxicating, poses a minimal risk of medical side effects, and can be administered intranasally by nonmedically trained laypersons (Barton et al., 2002; Kim et al., 2009). The Centers for Disease Control and Prevention (2012) estimates that more than 10,000 potentially fatal opiate overdoses have been reversed by naloxone administered by nonmedical laypersons. Studies in the U.S. and Scotland confirm that educating at-risk persons and their significant others about ways to prevent or reverse overdose, including the use of naloxone, significantly reduces overdose deaths (National Institute on Drug Abuse, 2014; Strang, 2015).

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