Bridging the Gap: Harm Reduction & Drug Courts

Center for Court Innovation
September 29, 2021

Bureau of Justice Assistance (BJA)

Residential Substance Abuse Treatment (RSAT)
Program for State Prisoners

Training and Technical Assistance Resource

This project was supported by grant No. 2019-J2-BX-K001 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Point of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice.

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AHP Advocates for Human Potential, Inc.

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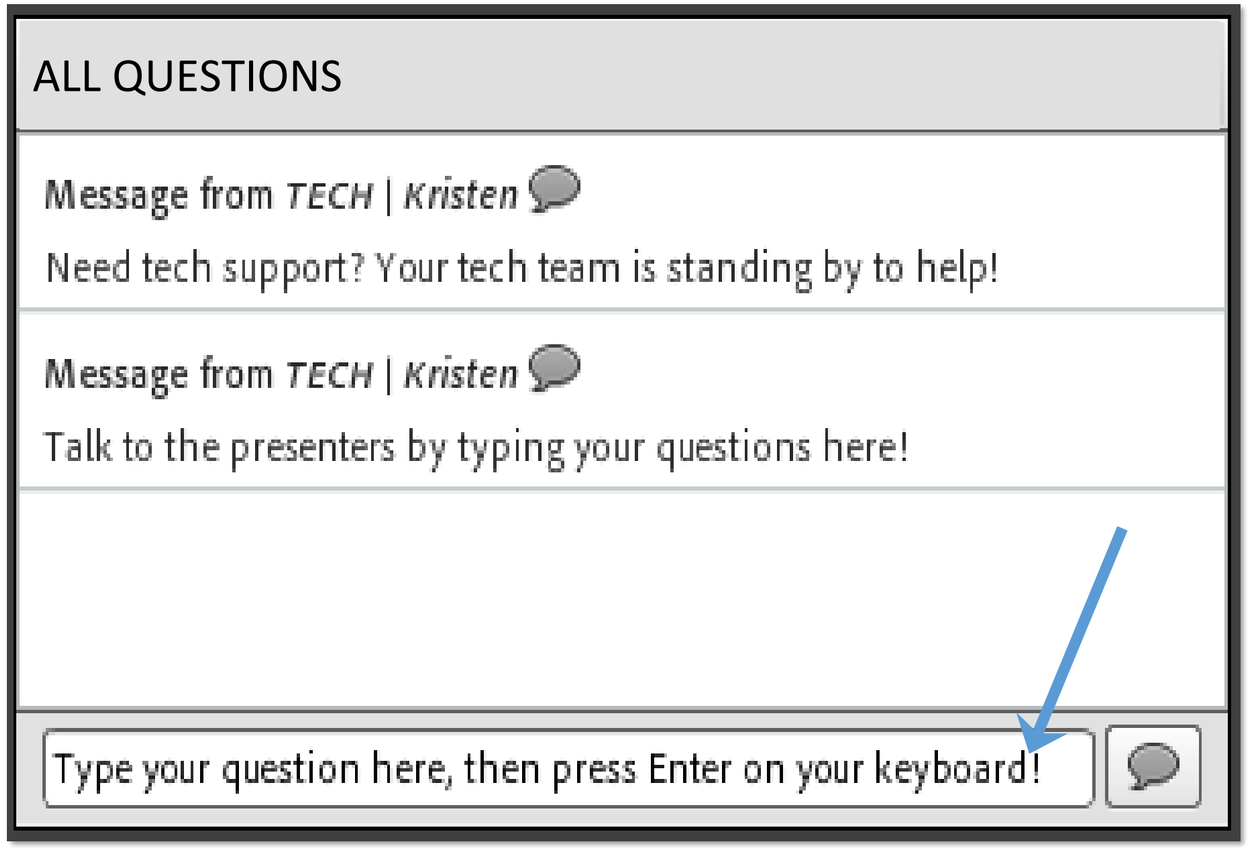

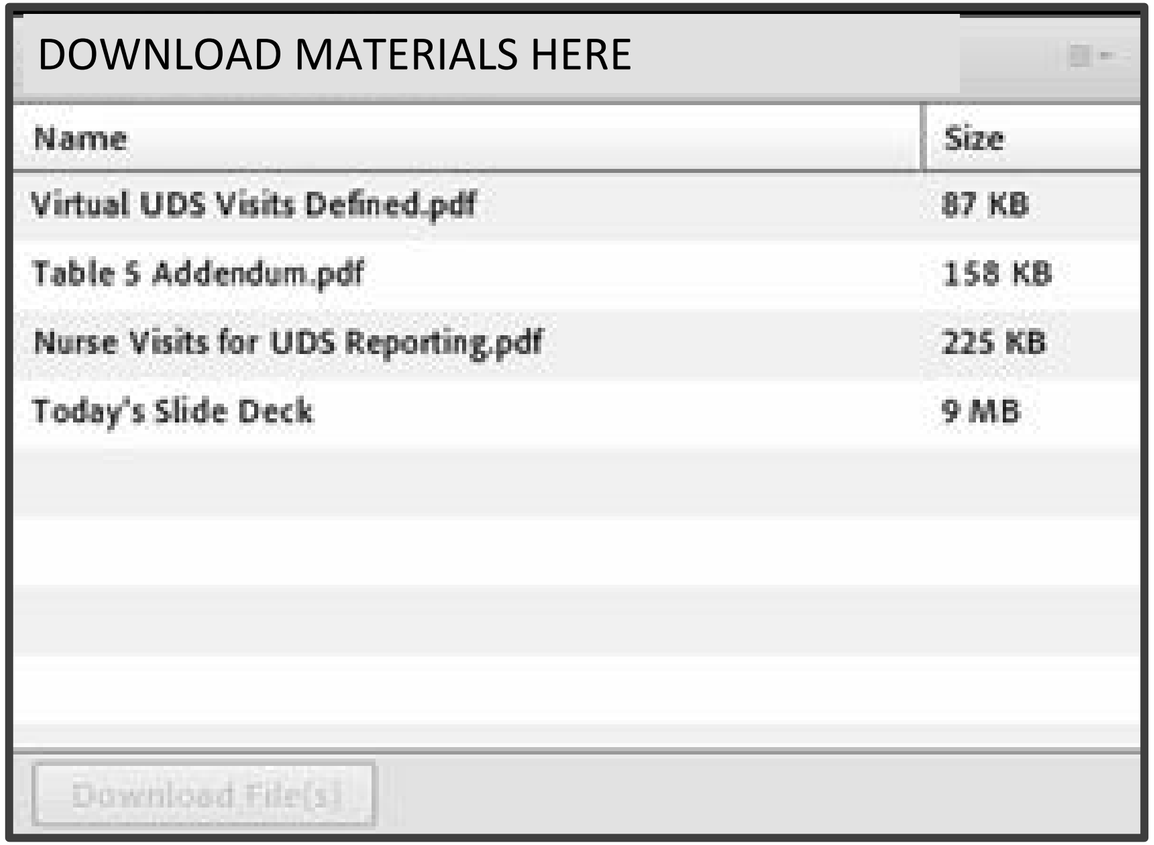

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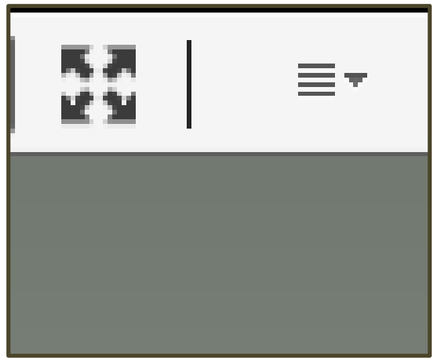

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AHP Advocates for Human Potential, Inc.

Today's Speakers

David Lucas, MSW

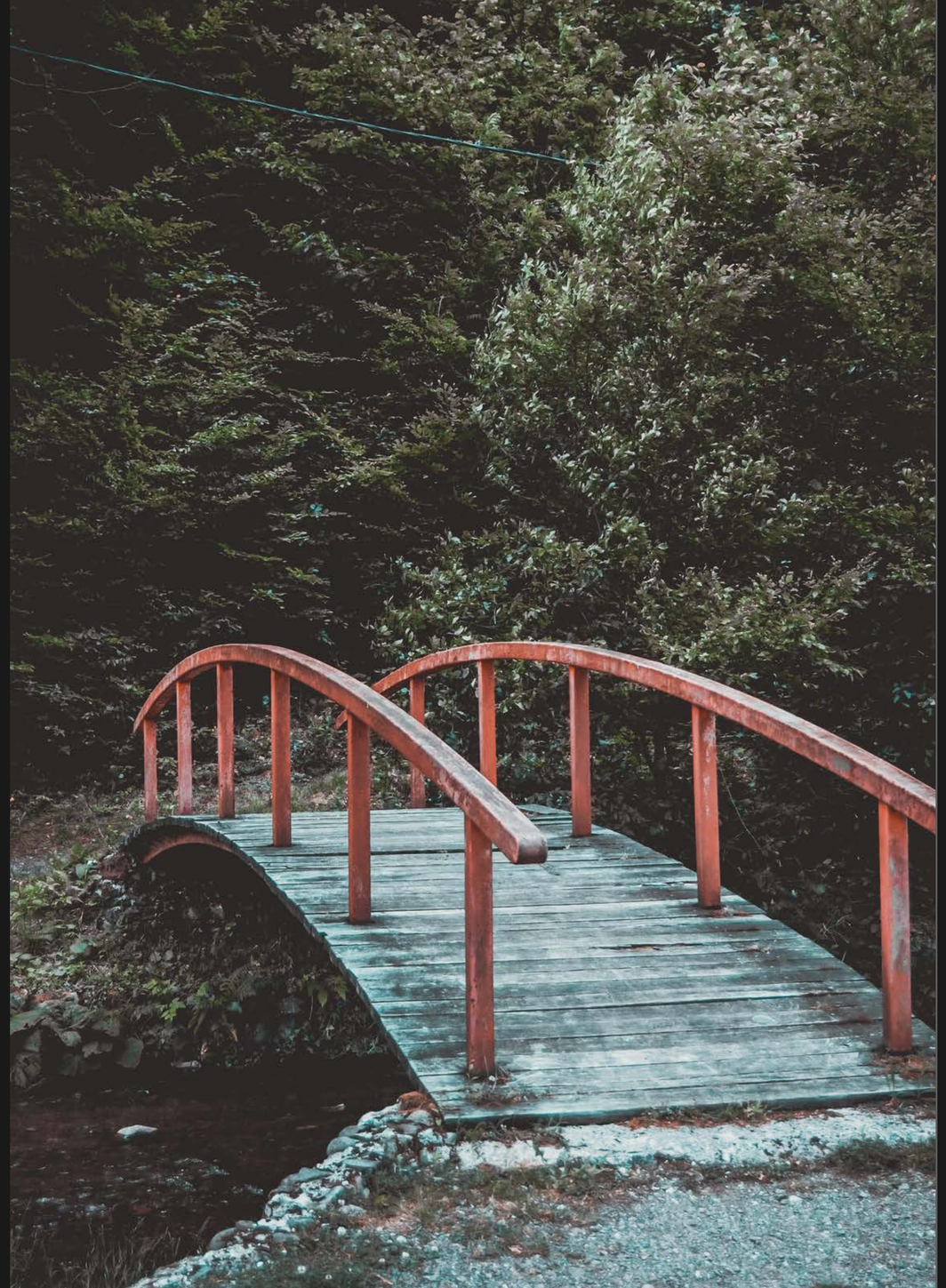
Clinical Advisor, Senior Program Manager, Center for Court Innovation

Alejandra Garcia, MSW

Senior Program Manager, Treatment Court Programs, Center for Court Innovation

BRIDGING THE GAP:

Harm Reduction & Drug Courts



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RSAT Training Series
September 29, 2021

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OVERVIEW

- Origin and evolution of harm reduction as a movement
- Principles, practices, and scope of harm reduction
- Intersection of harm reduction & drug courts
  - Overlap and tensions
  - Practical recommendations
  - Q&A

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WHO WE ARE:

The Center for Court Innovation works to achieve justice and equity; create safe, healthy, and thriving communities; and ultimately transform justice systems.

We do this in 3 ways:

- Operating programs
- Research & Policy
- Technical assistance

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WHO WE ARE:

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Who: drug court practitioners; other TA providers

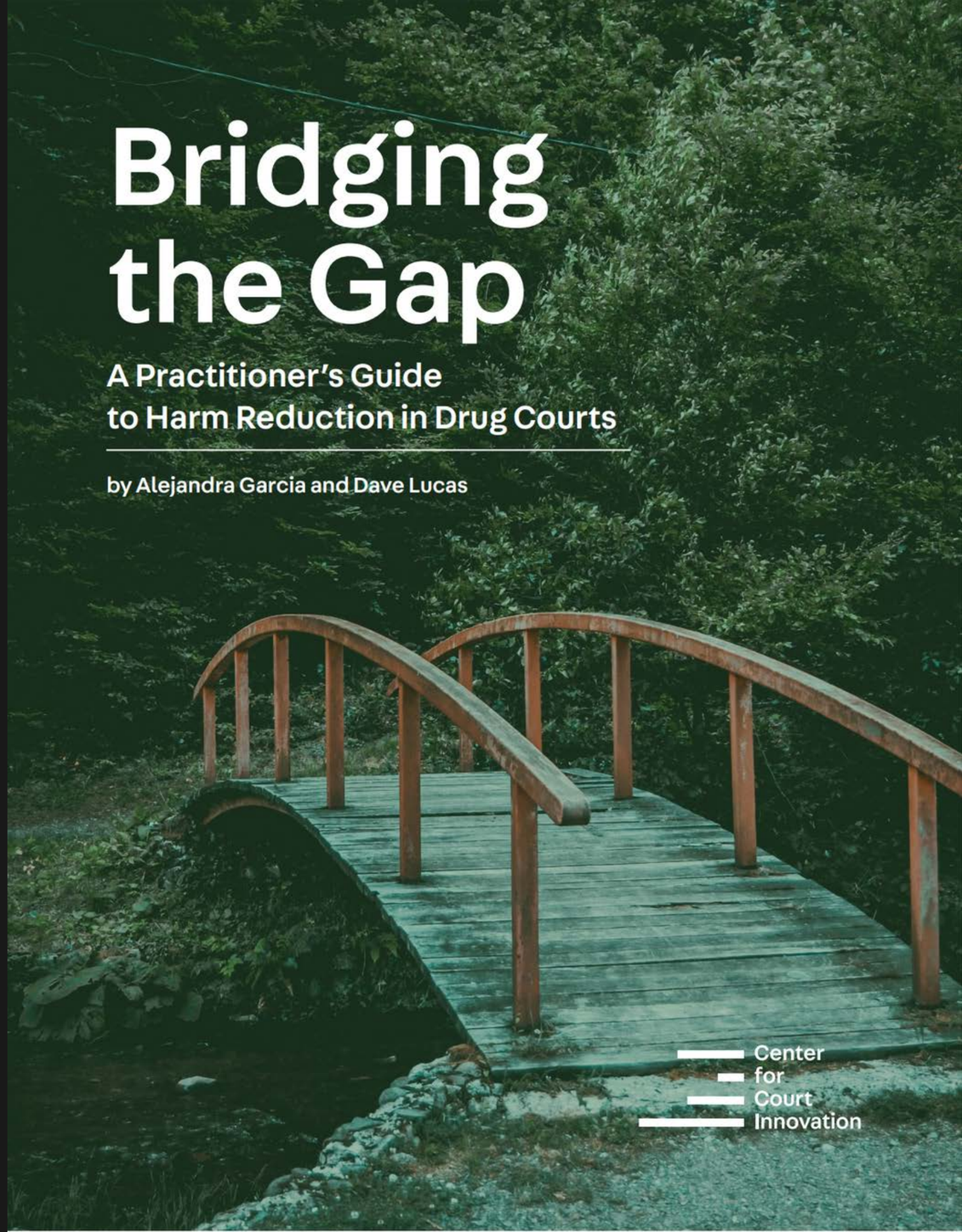
What: reflection of current practices; a suggested way forward

When: intersecting social and public health crises

Why: *looks around*

Goal: reduce harms; enhance participant safety & dignity

Challenges: some political, some logistical ...change is never easy



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HARM REDUCTION IN THE U.S. ORIGINS & EVOLUTION:

- 1964: methadone first used to treat opioid addiction
- 1971: FDA approves the naloxone antidote (for hospital use)
- 1971: first federal methadone program (post-Vietnam)
- 1970s: first movement to decriminalize drugs (marijuana, cocaine)
- Early 1980s: HIV/AIDS epidemic; National AIDS Brigade/Act UP
- 1988: expansion of SEPs nationally (~185, mostly unsanctioned)
- 1996: naloxone take-home distro (Chicago Recovery Alliance)
- 1998: drug testing kits/practices (e.g., DanceSafe)
- 2020: drug possession is decriminalized in Oregon
- 2021: White House/ONDCP sets harm reduction as priority
- Years ahead: overdose prevention sites; dec safe supply RXing???

(Des Jarlais, 2017; Szalavitz, 2021)

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PRINCIPLES, PRACTICES, & SCOPE OF HARM REDUCTION

PRINCIPLES:

- Reducing the harms associated with drug use and sexual activity;
- valuing, validating, and respecting the autonomy of people who use drugs;
- equitable access to key health determinants such as housing, healthcare, and income security;
- social inclusion and equity along the lines of race, class, gender, ability, and sexual identities
- centering the voices of drug users in program and policy development;

PRACTICES:

- drug user and sexual health education and supplies
- low-barrier accessibility via community-based hub and outreach
- overdose prevention, drug testing, bad drug/date alerts, medical care, service referrals
- peer-driven advocacy, counseling, and activism

SCOPE:

- Individual: enhance drug user safety, access, and autonomy
- Community: address institutional drug user exclusion/mistreatment; improve public safety
- Culture/Policy: overhaul inhumane and punitive drug policy; expand safer use options

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Poll Question # 1

Which of the following harm reduction practices have you had experience within your work?

- Client-driven treatment plans
- Trauma-informed responses to recovery setbacks
- Overdose prevention trainings & Naloxone distribution to clients
- Overdose prevention trainings & Naloxone distribution to family members
- Safer sex and BBV education
- Equity and inclusion trainings
- Bad drug/bad date alerts
- Drug testing kit distribution

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TIMELINE OF DRUG POLICY SHIFTS & IMPACTED GROUP

- 1830s: alcohol (Indigenous peoples)
- 1870s: opium (Chinese immigrants)
- 1900s: cocaine (emancipated Black Americans)
- 1930s: cannabis (Mexican immigrants)
- 1970s: Nixon & the War on Drugs (poor Black Americans)
- 1980s: Reagan & crack (100:1 sentencing)
- 1989: drug courts (disp. White Americans)
- 1990s: Mandatory minimums (disp. Black Americans)
  2010s: overdose crisis 1st/2nd wave (a "white rural problem") ...”We can’t arrest our way out of this problem.”

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THE INTERSECTION OF HARM REDUCTION & DRUG COURTS

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OVERLAP & TENSIONS

- Treatment > Jail
- Social Determinants of Health
- Race & gender disparities
- Service gaps

- Coerced treatment
- Abstinence focus
- Use of Jail
- Drug testing

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RECOMMENDATIONS

RELATIONAL STRATEGIES shape the therapeutic alliances the court develops with its participants. Strong alliances lead to participants feeling valued, respected, and empowered by the court. These alliances are also needed to overcome the legal and medical mistrust that results from intergenerational mistreatment.

Strong alliances also promote open and honest conversations, necessary for proactive safety planning around overdose and other risks. Participants who feel judged, unheard, or fearful of punishment, are less likely to disclose the risks they may be facing, including those not specific to drug use.

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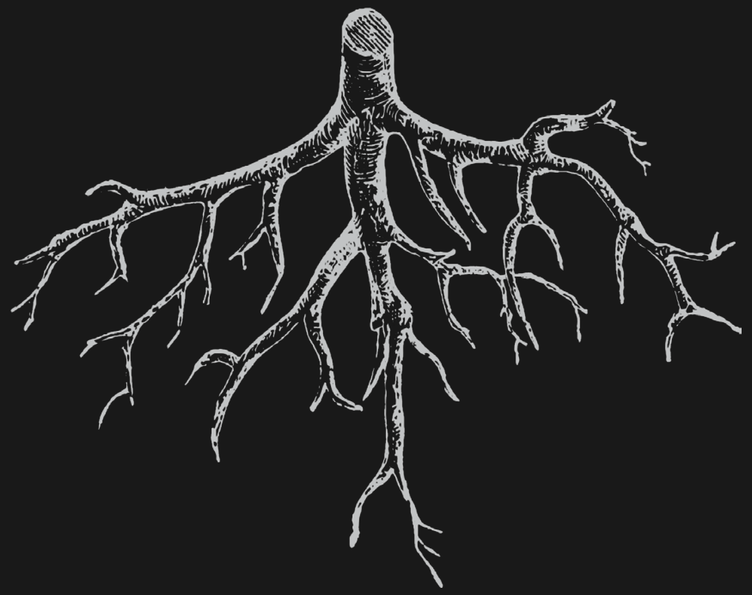
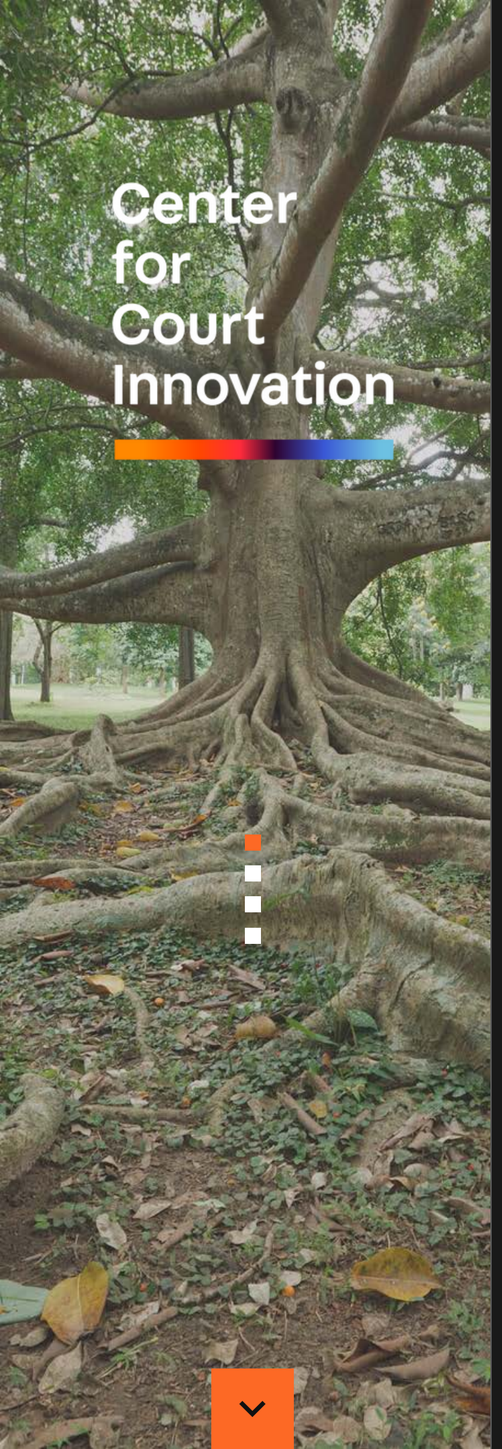
RECOMMENDATIONS

PROGRAMMATIC STRATEGIES refer to the formalized policies, protocols, and memorandas of understanding (MOUs) that govern drug court and its partner agency practices. These have the potential to affect the quality of care, risk of overdose, and likelihood of future legal system involvement.

Treatment courts should review program documents to ensure all protocols are evidence-based with respect to reducing overdose risk and other harms.

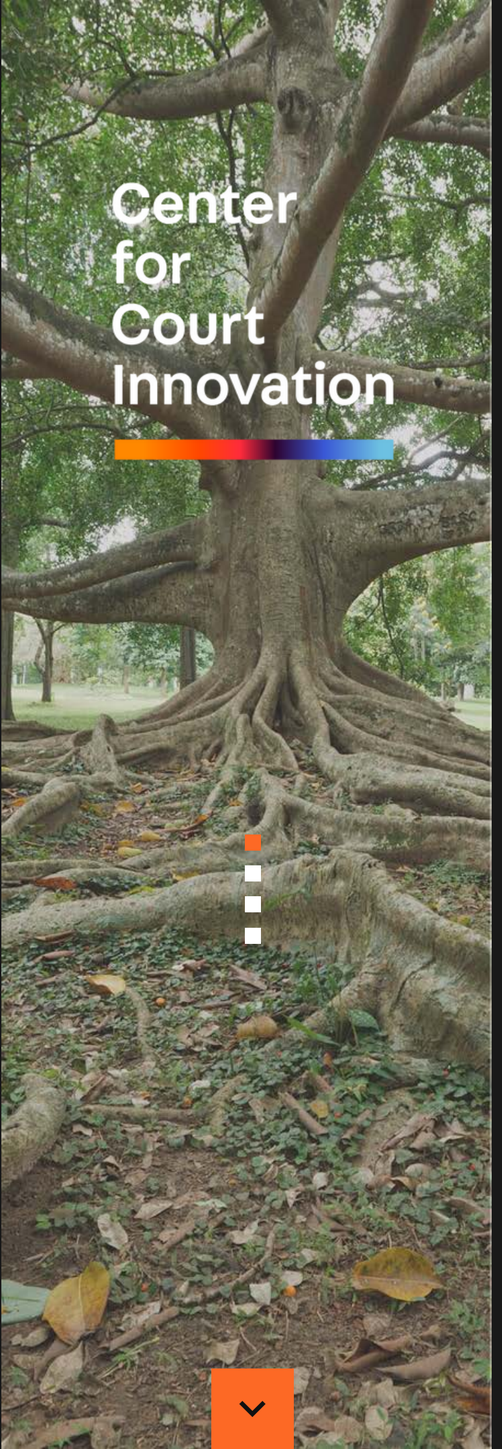
RELATIONAL STRATEGIES





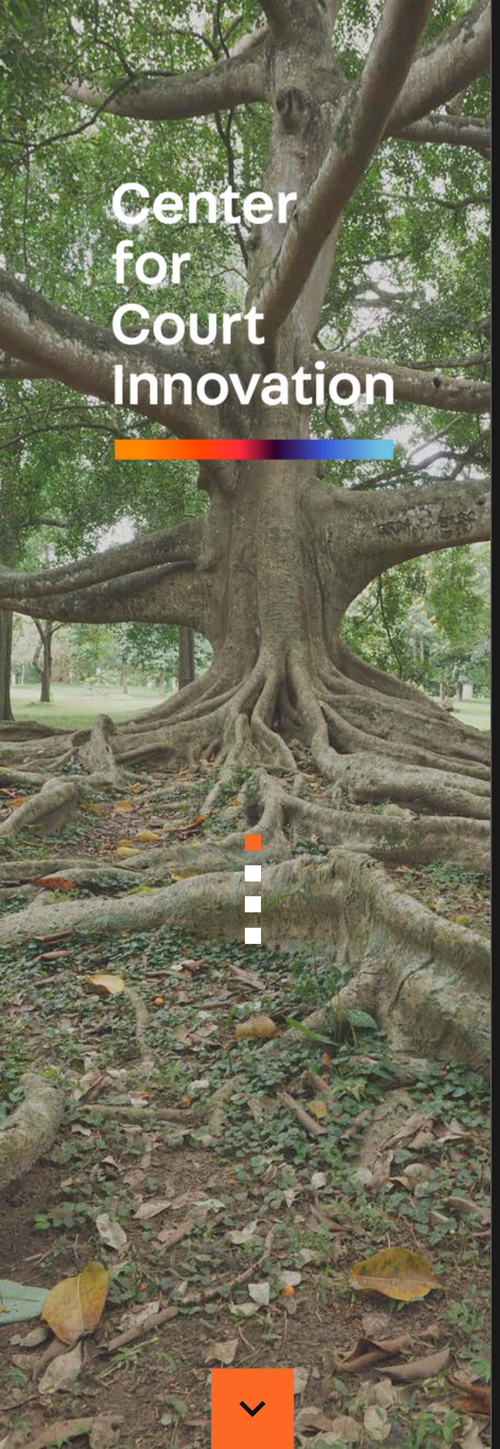
TREATMENT PLANNING

- Develop individualized treatment plans with meaningful participant input (i.e., agreed-upon treatment goals, level and type of care, and metrics of success)
- Ensure treatment plans are flexible and account for the non-linear nature of SUD recovery
- Consider overdose risk when setting the pace of treatment (i.e., too much, too soon, could increase risk)



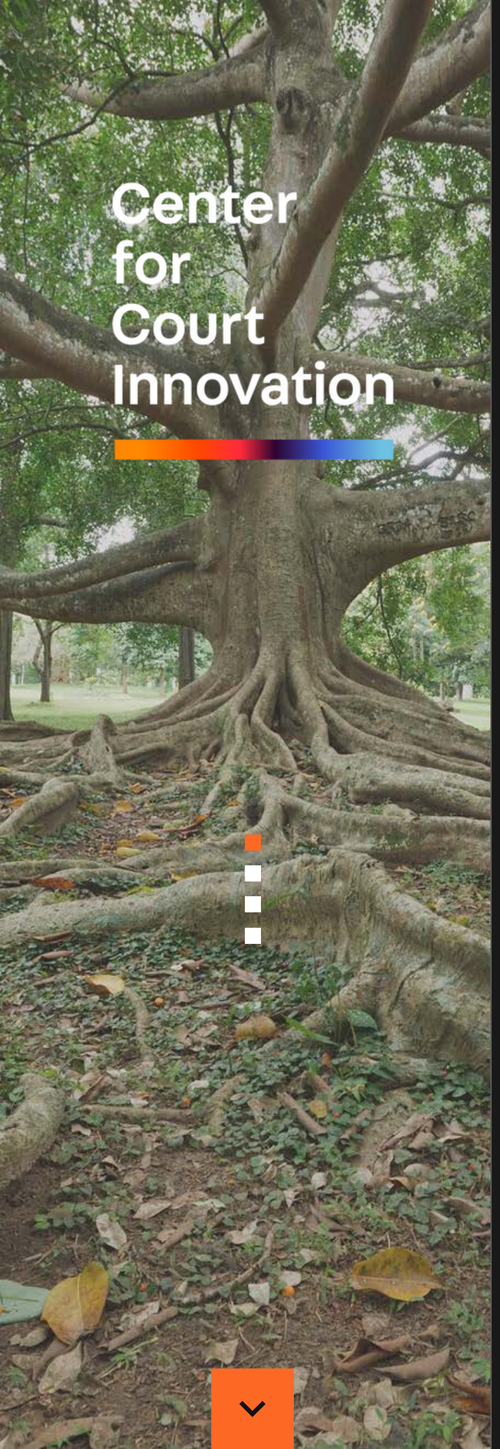
TRAUMA-FOCUSED CARE

- Use scientific and non-judgmental language when referring to substance use, drug test results, or recovery achievements
- Recognize that “honesty” issues (e.g. deception, failure to disclose) are likely trauma responses
- Develop MOUs [memorandums of understanding] with partner agencies (treatment, housing, etc.) outlining expectations around trauma-informed care



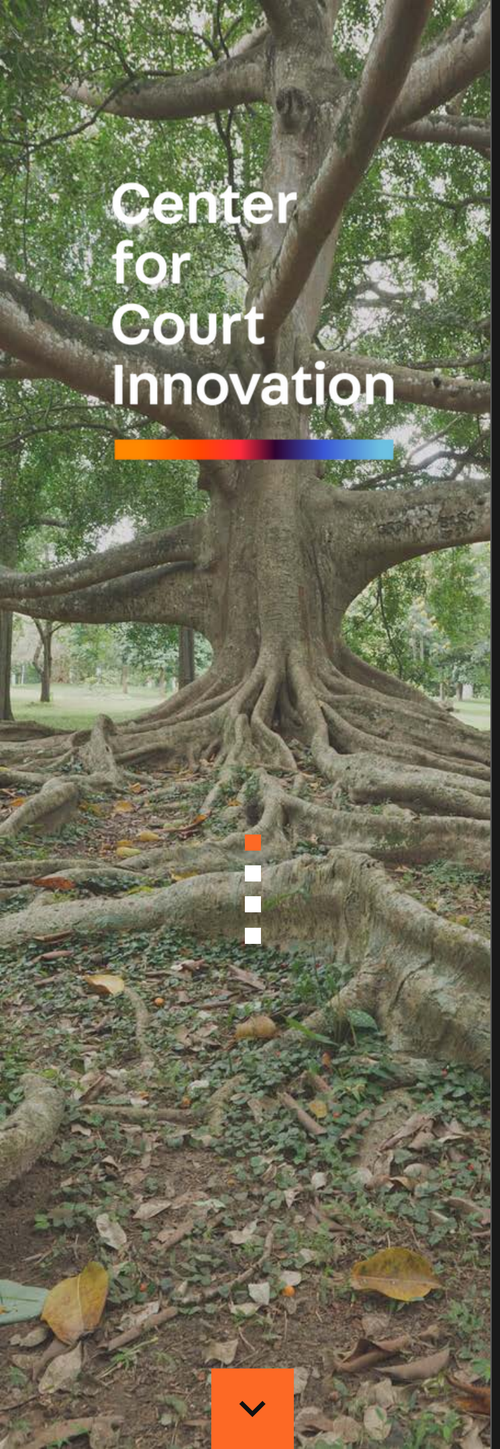
RESPONDING TO USE

- Provide supportive, non-judgmental, and clinical response to recurrences of use (not sanctions)
- Provide responses that are tailored to participants needs and situational risks and protective factors (e.g., not all instances warrant a change to the treatment plan)
- Avoid framing use in binary terms like good or bad, dirty or clean, sober or sick



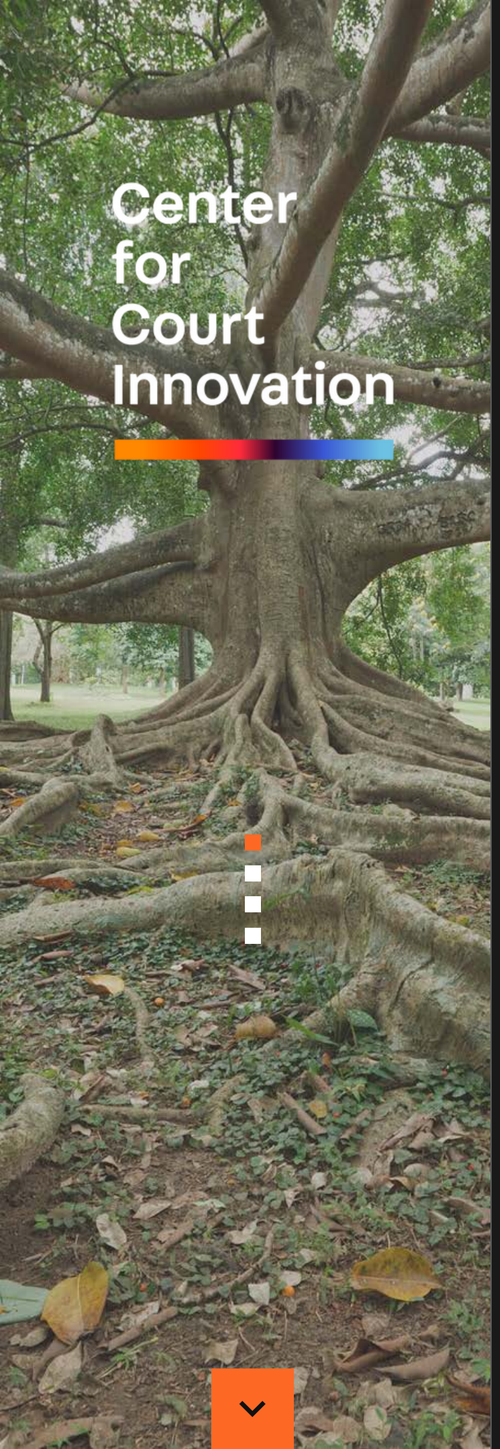
RACIAL EQUITY

- Provide team trainings on existing and historical racial disparities
- Examine court admission, retention, and graduation data through a racial equity lens
- Interrogate existing partner agency practices for cultural safety and responsivity
- Prioritize equitable access to key health determinants (housing, healthcare, employment) in a participant's treatment plan



HEALTH EQUITY

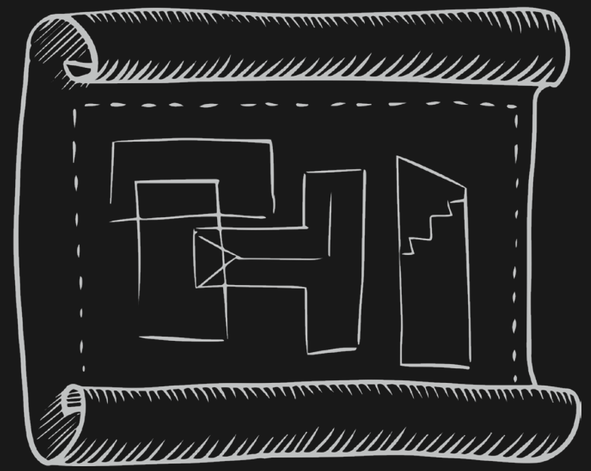
- Recognize and center the participant’s existing protective factors, skills, and survivorship
- Partner with low-barrier, non-abstinence-based, service providers (i.e., housing, vocational)
- Ensure that program compliance and progress is being measured relative to the quality and availability of services



PARTICIPANT VOICE

- Establish protocols to gather accurate and anonymous participant feedback (including from non-graduates)
- Monitor and evaluate the integration of feedback on practice and outcomes
- Establish a drug court advisory board that includes participants as well as a broad range of community members

PROGRAMMATIC STRATEGIES



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USE OF JAIL

- Consider risks of incarceration (i.e., associated rates of post-release mortality, overdose, injection drug use-initiation, and suicidality) when using jail
- End the use of jail holds as sanction for substance use or program non-compliance
- End the use of jail holds to house participants waiting for treatment
- Collect and analyze data related to the use of jail and post-termination prison sentences

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MEDICATIONS FOR OPIOID USE

- Ensure all three FDA-approved medications are equally accessible to people who want to use them
- Ensure a participant's use of MOUD is not impediment to enrollment, phase advancement, or graduation
- Partner with MOUD-affirming treatment and housing agencies
- Defer to healthcare professionals regarding dose and duration of care

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OVERDOSE PREVENTION

- Develop partnerships with local harm reduction organizations (e.g. to provide naloxone trainings)
- Implement naloxone training protocols and best practices for MOUD in justice settings for staff and participants
- Talk openly about safer using practices with participants (e.g., drug, set, setting, virus transmission)

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DRUG TESTING

- Identify and implement the least intrusive drug testing practice available
- Measure progress holistically, limit reliance on test results
- Provide trainings on potential harms, incorporate voices of those with lived experience

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FINES AND FEES

- Drug courts should not impose additional fees for program participation (including treatment)
- Admission, phase advancement, and program graduation should not be contingent on payment of fines and fees
- Drug courts should offer financial support in the form of money planning (i.e., budgeting, debt support, assistance with applying for government benefits)

MEASURING SUCCESS

- Establish multiple pathways to program completion, including a non-abstinence tracks
- Review existing graduation criteria against drop-out and termination data
- Expand graduation criteria to include broader health/social outcomes

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Poll Question # 2

Which of the following harm reduction practices/ principles do you think will be scaled nationally in the next 10 years?

- Supervised consumption sites
- Regulated/safe supply prescribing
- Low level drug charge expungement
- All drug decriminalization
- None of the above nationally, but an increase at the state-level

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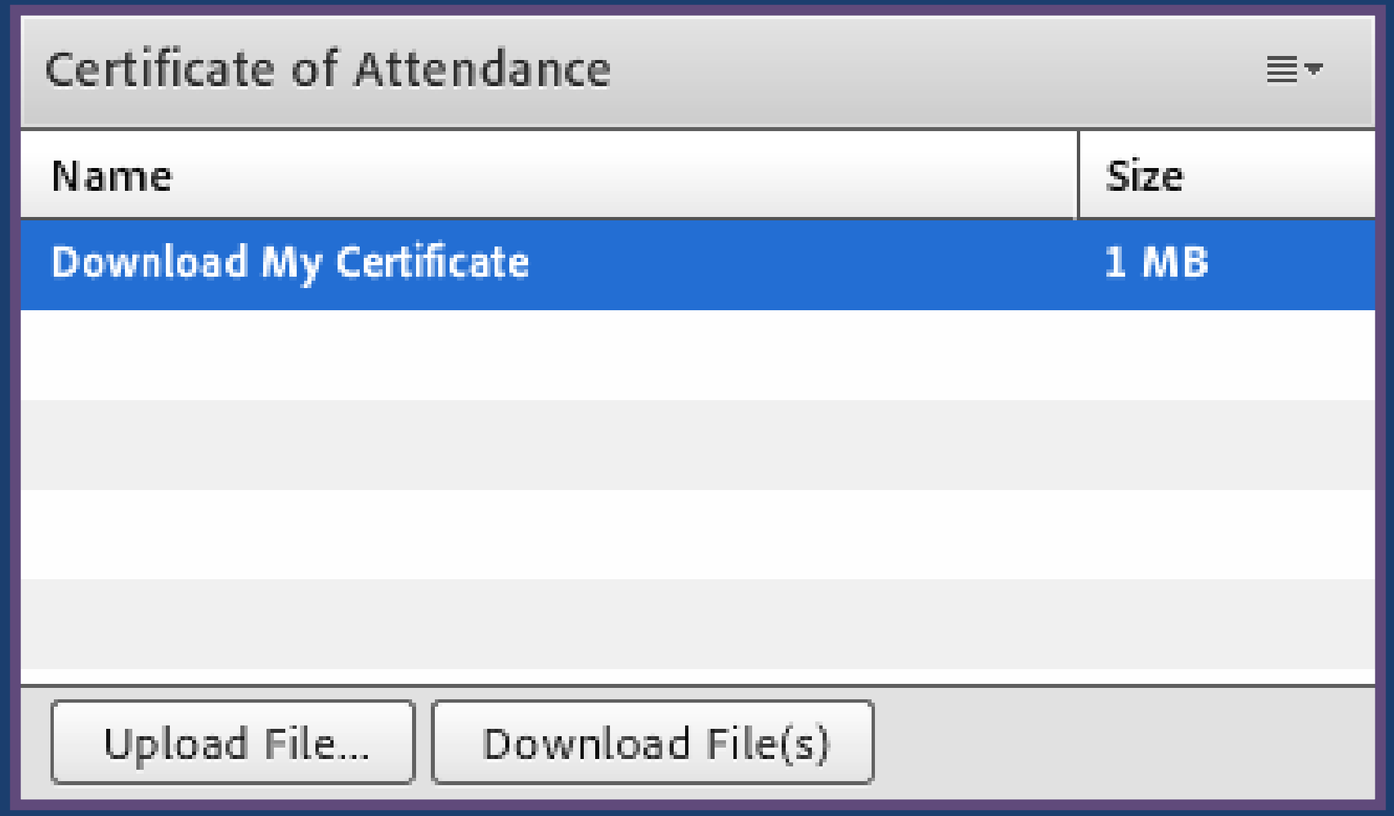
Q&A

For more information:

https://www.courtinnovation.org/sites/default/files/media/document/2021/Guide_TA_BridgingtheGap_082021.pdf

CERTIFICATE OF ATTENDANCE

Download Now!



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CERTIFICATE OF CONTINUING EDUCATION

1 Continuing Education Hour (CEH) approved by NAADAC, the Association of Addiction Professionals

Pass 10-question quiz with 7 correct answers

Download certificate upon completion of the quiz

September 29, 2021 RSAT webinar CEH quiz link:

https://survey.alchemer.com/s3/6548557/September-29-2021-RSAT-Webinar-CEH

CONTACT

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