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NATIONAL COUNCIL OF
JUVENILE AND FAMILY COURT JUDGES
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# RESOLUTION IN MEMORIAM
# of
# The Honorable Sheri Capes Roberts

**WHEREAS**, the members and staff of the National Council of Juvenile and Family Court Judges (NCJFCJ) are deeply saddened by the passing of Judge Sheri Capes Roberts of Covington, Georgia; and

**WHEREAS**, Judge Roberts was appointed to the juvenile court bench in 2009 as Alcovy Circuit's first female jurist, where she served with distinction as a juvenile court judge for 10 years; and

**WHEREAS**, Judge Roberts was known by her colleagues as an inspirational and innovative jurist, who brought wisdom, caring, and passion to the juvenile and family court bench; and

**WHEREAS**, Judge Roberts approached each case holistically by addressing the needs of the entire family in a child's case; and

**WHEREAS**, Judge Roberts was known for her numerous accomplishments and dedication to addressing issues faced by dual-status youth; and

**WHEREAS**, Judge Roberts' leadership and commitment to juvenile justice reform led to the selection of the Newton County Juvenile Court as a site for a juvenile justice reform initiative sponsored by Robert F. Kennedy Children Action Corps, and as a Juvenile Detention Alternative Initiative site through the Annie E. Casey Foundation; and

**WHEREAS**, Judge Roberts frequently served as an NCJFCJ faculty member and presenter for conferences and seminars held in Georgia and nationwide, teaching on, among many topics, the importance of reasonable efforts on behalf of abused and neglected children; and

**WHEREAS**, Judge Roberts received numerous honors and appointments throughout her career, including the Lucy Louisa Flower Champion for Change Award from the MacArthur Foundation in 2014; and

**WHEREAS**, Judge Roberts participated as a member in good standing of the National Council of Juvenile and Family Court Judges for many years, contributed to the work of numerous committees, and served as a Board member making her instrumental in furthering the reputation, mission, and impact of the NCJFCJ.

**NOW, THEREFORE, BE IT RESOLVED**, the National Council of Juvenile and Family Court Judges notes with sincere regret the passing of Judge Sheri Capes Roberts and extends to her family and community its deepest sympathy.

Adopted this 18th day of July, 2020
By the NCJFCJ Board of Directors

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# RESOLUTION IN MEMORIAM
# of
# Dean Louis W. McHardy

**WHEREAS**, the members and staff of the National Council of Juvenile and Family Court Judges (NCJFCJ) are deeply saddened by the passing of Louis W. McHardy of Baton Rouge, Louisiana; and

**WHEREAS**, Louis McHardy was instrumental in advancing the work of the NCJFCJ through his leadership and position as Executive Director from 1972-1999, also serving as Dean of the NCJFCJ's National College of Juvenile and Family Justice during that time; and

**WHEREAS**, the NCJFCJ benefited from Dean McHardy's expertise, dedication, and passion for improving practice in child welfare, juvenile justice, and juvenile and family courts throughout his more than 25 years of employment with the NCJFCJ; and

**WHEREAS**, Dean McHardy demonstrated lifelong commitment and leadership to the development and improvement of the juvenile and family court system through his efforts as an educator by creating judicial education and training programs, authoring and contributing to publications and resources; and

**WHEREAS**, Dean McHardy served as the Chief Juvenile Probation Officer for East Baton Rouge Parish, was selected to become the Administrator of the Juvenile Circuit Court, City of St. Louis in 1964; and

**WHEREAS**, Dean McHardy was a founding member of the Board of Directors of the Children's Cabinet in Nevada in 1985, where his work was instrumental in the development of innovative responses that are adaptable to the ever-changing needs of children and families within his community; and

**WHEREAS**, Dean McHardy was awarded The Honorary Degree of Doctor of Laws from the University of Nevada – Reno in 1987, and the first annual President's Award from the NCJFCJ in 1992; and

**WHEREAS**, Dean McHardy's contributions to the mission and work of the NCJFCJ have been invaluable and have made a difference in many communities and in the lives of many professionals, children, and families; and

**WHEREAS**, Dean McHardy was known for his caring, kindhearted, sincere persona and always greeted you with his warm, infectious smile.

**NOW, THEREFORE, BE IT RESOLVED**, the National Council of Juvenile and Family Court Judges observes with sincere regret the passing of Dean Louis W. McHardy and extends to his family and community its deepest sympathy.

Adopted this 18th day of July, 2020
By the NCJFCJ Board of Directors

# RESOLUTION REGARDING
# ACCESS TO MEDICATION-ASSISTED TREATMENT FOR ADOLESCENTS AND ADULTS IN THE JUVENILE AND FAMILY JUSTICE SYSTEM

**WHEREAS,** the juvenile, family, and tribal justice systems are experiencing increased burdens due to substance use, including alcohol, opioids, and methamphetamines;

**WHEREAS**, these burdens include the foster care system in the United States, which has experienced an upward trend of youth in care from its modern day low of 396,000 in 2012 to 443,000 in 2017;[1,2]

**WHEREAS**, risk factors, including alcohol and drug misuse, are defined as "characteristics of caregivers that may increase the likelihood of child maltreatment."[3]

**WHEREAS**, opioid-related deaths of pregnant and post-partum women is estimated to have doubled from 2007 – 2016, and are associated with warning signs, such as major depression, substance use disorder, and intimate partner violence;[4]

**WHEREAS**, in 2018, an estimated 946,000 (3.8 percent) adolescents aged 12 to 17 had a substance use disorder (SUD), and an estimated 5.2 million (15.3 percent) young adults aged 18 to 25 had a SUD (i.e., met the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) criteria for either dependence or abuse for alcohol or illicit drugs);[5]

**WHEREAS**, in 2018, only 159,000 (0.6 percent) adolescents aged 12 to 17 received any substance use treatment, and only an estimated 547,000 (1.6 percent) young adults aged 18-25 received any substance use treatment in the past year for the use of alcohol or illicit drugs;[6]

**WHEREAS**, the rates of substance use disorder for individuals involved in the criminal justice system are more than four times that of the general population;[7]

**WHEREAS**, the $7.7 billion of the economic burden connected to opioid use disorder are borne by the criminal justice system and are directly funded by state, tribal, and local governments;[8]

**WHEREAS**, there are effective, evidence-based, Food and Drug Administration (FDA)-approved medication treatment (referred to as medication-assisted treatment or MAT) options available to adolescents and adults with substance use disorders;[9]

**WHEREAS**, MAT is defined as the use of medication in combination with behavioral health services to provide an individualized approach to the treatment of substance use disorders, including opioid use disorder;[10]

**WHEREAS**, hundreds of studies have been conducted on the use of MAT to treat opioid use disorder in adults[11] and have found the following positive outcomes:

- reductions in illicit opioid use
- increased retention in treatment
- benefits of extended medication-assisted treatment (i.e., continued or sustained use of MAT)
- improved access to MAT is associated with declines in opioid mortality
- increased abstinence of opioid use
- longer periods of time between relapse
- significantly less medication is required to treat babies with neonatal abstinence syndrome when mothers received MAT during pregnancy, as well as significantly shorter durations in treatment and significantly shorter hospital stays
- increased retention of custody of children;[12]

**WHEREAS**, forms of MAT are FDA approved opioid agonists or antagonists that block the effects of other narcotics and reduce the risk of withdrawal;[13, 14]

**WHEREAS**, individuals who need or receive MAT to treat their substance use disorder are often prohibited from receiving MAT by the court system or other government agencies, which conflicts with evidence-based practices;[15]

**WHEREAS**, discriminatory practices often include: restricting visitation, barring graduation from specialty court, or increased sanctions for those using safe and legal MAT;

**WHEREAS**, ordering individuals to refrain from, decrease, or stop using MAT as prescribed is a violation of federal laws that prohibit discrimination on the basis of disability (i.e., Americans with Disabilities Act, Rehabilitation Act of 1973);[16]

**WHEREAS**, the Office for Civil Rights of the U.S. Department of Health and Human Services and Department of Justice have provided guidance to juvenile, family, and criminal justice agencies on the removal of discriminatory barriers to MAT;[17]

**WHEREAS**, there is wide-ranging support and guidance to increase access to the safe and legal use of MAT for adolescents and adults, including pregnant women, with substance use disorder among experts in the fields of medicine, science, and law:

- American Academy of Pediatrics[18]
- Conference of State Court Administrators[19]
- Conference of Chief Justices[20]
- Legal Action Center[21]

- National Academies of Sciences[22]
- National Association of Drug Court Professionals[23]
- National Center for State Courts[24]
- National Sheriffs' Association[25]
- State Justice Institute[26]
- Substance Abuse and Mental Health Services Administration[27]
- The American College of Obstetricians and Gynecologists.[28]

**NOW, THEREFORE, BE IT RESOLVED:**

The NCJFCJ recognizes that the juvenile and family justice system may be a primary referral source for substance use treatment, including medication-assisted treatment, so professionals working in these systems must be well-informed on the delivery of MAT.

The NCJFCJ supports and commits to the development of training and technical assistance to specifically disseminate information related to the use of FDA approved methadone, buprenorphine, and injectable naltrexone, which are the prescription medications used to treat addiction to opioids (i.e., heroin, morphine, and codeine, oxycodone, fentanyl, and hydrocodone).[29]

The NCJFCJ supports and commits to the development of training and technical assistance to disseminate information related to the use of FDA approved disulfiram, acamprosate, and naltrexone, which are the prescription medications used to treat alcohol use disorder.[30]

The NCJFCJ encourages funding for additional research on use of MAT for adolescents.

The NCJFCJ commits to delivering training and technical assistance that promotes the use of evidence-based practices.

The NCJFCJ resolves to target training to address and correct misconceptions regarding the use of MAT to treat substance use disorders.

The NCJFCJ encourages juvenile and family court judges, attorneys, and other court stakeholders to follow the guidance from the Department of Justice related to ensuring access to MAT, as well as the use of MAT as prescribed.

The NCJFCJ recommends following guidance found in 42 C.F.R. 8 and the Substance Abuse and Mental Health Services Administration (SAMHSA) regarding services for individuals who are prescribed MAT.

The NCJFCJ recognizes that denying access to the use of safe and legal MAT to persons in need is a violation of federal anti-discrimination laws (i.e., Americans with Disabilities Act, Rehabilitation Act of 1973).

The NCJFCJ commits to collaborating with allied organizations, as well as state, tribal, and federal partners to provide comprehensive services to juvenile and family justice professionals through a myriad of resources to improve knowledge and decision-making capabilities among judges, attorneys, and other court stakeholders regarding effective substance use treatment, including MAT.

*Adopted by the NCJFCJ Board of Directors, November 14, 2019, Pittsburgh, Pennsylvania.*

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42 C.F.R. 8 § 8.2*. Medication Assisted Treatment for Opioid Use Disorders.* Retrieved July 11, 2019 from Electronic Code of Federal Regulations: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efc45&ty=HTML&h=L&n=pt42.1.8&r=PART#se42.1.8_11.

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Endnotes

[1] Stein, P., & Bever, L. (2017). *The opioid crisis is straining the nation's foster-care systems: Foster children are in need at younger and younger ages, and there aren't enough homes to take them, state officials say*.

[2] Children's Bureau. (2019, July 10). *Trends in Foster Care and Adoption.*

[3] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). *Child Maltreatment 2017*, page 23.

[4] Mangla, K., Hoffman, C. M., Trumpff, C., & O'Grady, S. (2019). Maternal self-harm deaths: an unrecognized and preventable outcome, page 3. The article states "Gemmill et al reviewed trends in opiate-related deaths between 2007 and 2016 in 22 states

that had adopted the pregnancy checkbox. The group concluded the maternal mortality involving opiates doubled during this time period. By 2016, 70% of deaths involving opioids occurred during pregnancy and up to 42 days post-partum. Most of the opioid-related deaths in 2016 involved heroin and synthetic opioids."

[5] Substance Abuse and Mental Health Services Administration. (2019). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health*, page 40.

[6] *Supra* note 5, page 50.

[7] National Institutes of Health. *Addiction and the Criminal Justice System*.

[8] Florence, C., Luo, F., Xu, L., & Zhou, C. (2016). *The economic burden of prescription opioid overdose, abuse and dependence in the United States*.

[9] Substance Abuse and Mental Health Services Administration. *Medication and Counseling Treatment*.

[10] 42 C.F.R. 8 § 8.2.

[11] The current research available focuses on adults using MAT to treat substance use disorders. More research is needed to further identify the effectiveness in treating substance use disorders in adolescents. See the Annotated References in the appendix for more information related to recommendations by the research community.

[12] Refer to the Annotated References in the appendix for the full literature review.

[13] Substance Abuse and Mental Health Services Administration. *Medication-Assisted Treatment* (MAT).

[14] Methadone is a clinic-based opioid agonist that does not block other narcotics; Naltrexone is an office-based non-addictive opioid antagonist that blocks the effects of other narcotics; and Buprenorphine is an office-based opioid agonist/ antagonist that blocks other narcotics while reducing withdrawal risk.

[15] Legal Action Center. (2011). *Legality of Denying Access to Medication Assisted Treatment.*

[16] *Supra* note 15, see pages 8-17.

[17] U.S. Department of Health & Human Services. (2018, October 25). *Nondiscrimination and Opioid Use Disorders Fact Sheet*; U.S. Department of Health & Human Services. (2018, October 25). *Fact Sheet: Drug Addiction and Federal Disability Rights Laws.*

[18] American Academy of Pediatrics Committee on Substance Use and Prevention. (2016). Medication-Assisted treatment of adolescents with opioid use disorder. Report has three main recommendations: 1) increase resources to improve access of MAT for Adolescents; 2) for pediatricians to offer MAT to adolescents; and 3) that more research is conducted to understand the effects of MAT on adolescents.

[19] The National Judicial Opioid Task Force, supported by the National Center for State Courts, State Justice Institute, and Conference of State Court Administrators, in *Medication-Assisted Treatment for Adolescents with Opioid Use Disorder*, cite recommendations from the American Academy of Pediatrics and the American Society of Addiction Medicine to provide guidance to juvenile and family court judges regarding the use of MAT for adolescents.

[20] The Conference of Chief Justices, through its work on the National Judicial Opioid Task Force (supported by the National Center for State Courts), recommend that 1) judges should use individualized assessments and appropriate treatment referrals and advocate for necessary treatment options, including medication-assisted treatment, that are accessible by and available to all; 2) courts should include medication-assisted treatment as one part of a comprehensive treatment plan, in all civil and criminal cases, and recognize the importance of making medication-assisted treatment available to incarcerated individuals; and 3) courts should allow the use of medication-assisted treatment for those who wish to participate in specialty court programs.

[21] The Legal Action Center recommends support, education, and outreach to criminal justice officials, stating that "many criminal justice agency policies that prevent access to MAT are based on stereotypes and stigma and have no basis in evidence accumulated in decades of research."

[22] National Academy of Sciences. *Medications for Opioid Use Disorder Save Lives: A Consensus Study Report*. With support from the National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration, and the National Academies of Sciences, Engineering, and Medicine released a report in March 2019. The report detailed seven recommendations related to MAT. For example, FDA-approved MATs are effective and continued use of MATs to treat OUD is associated with improved outcomes.

[23] Marlow, D.B., Wakeman, S., Rich, J.D., & Baston, P.P. (2016). *Increasing Access to Medication-assisted Treatment.* In 2010, NADCP issued a unanimous resolution directing drug courts to (1) keep an open mind and learn the facts about MAT, (2) obtain expert medical consultation when available, (3) make a fact-sensitive inquiry in each case to determine whether MAT is medically indicated or necessary for the participant, and (4) explain the court's rationale for permitting or disallowing the use of MAT.

[24] *Supra* note 19.

[25] National Sheriffs' Association. *National Sheriffs' Association supports the use of Non-Narcotic Evidence-Based Medication-Assisted Treatment (MAT) for Opioid Dependence in County Jails.* In 2017, the National Sheriffs' Association released a resolution supporting the use of non-narcotic, evidence-based medication-assisted treatment for opioid dependence after detoxification jail or other secure facilities.

[26] *Supra* note 19.

[27] Substance Abuse and Mental Health Services Administration. *Medication-Assisted Treatment (MAT)*. The SAMHSA website houses a comprehensive web-based resources dedicated to the safe and legal use of MAT.

[28] The American College of Obstetricians and Gynecologists recommend that "…pregnant women with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, which lead to worse outcomes." Retrieved on August 26, 2019 from: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy?IsMobileSet=false.

[29] As defined by the SAMHSA, methadone deceives the brain into believing that it is still getting the abused drug; buprenorphine, similarly, reduces cravings of the abused drug; naltrexone, acts differently by blocking the euphoric and sedative effects of the abused drug.

[30] As defined by the SAMHSA, disulfiram treats chronic alcoholism and is effective in people who have detoxed and/or who are in the initial stages of abstinence; acamprosate works to prevent people from drinking alcohol, but it does not prevent withdrawal symptoms; use generally begins on the fifth day of abstinence, reaching full effectiveness in five to eight days; naltrexone (used to treat alcohol dependency) works by blocking the euphoric effects and feelings of intoxication.