>> This presentation is entitled "Ethics And The Law."

I will now pass it off to Dr. Jackie Landess and Dr. Brian Holoyda for this session.

>> Hi, everybody, and thank you for joining us for this virtual conference.

My name is Brian Holoyda.

I am a forensic psychiatrist with a clinical practice at Martinez Detention Facility in the bay area of California.

And also speaking today is Dr. Jacqueline Landess.

She is a clinical assistant professor of psychiatry at the Medical College of Wisconsin and a forensic psychiatrist with a

clinical practice at Mendota Mental Health Institute in Madison, Wisconsin.

We are now going to be discontinuing our videos for the remainder of the session.

Today, we're going to be talking about ethics and the law in addictions treatment.

To begin with, we want to note that we have no financial disclosures to make regarding this presentation.

Dr. Landess does not, nor do I.

We'd like to start with a brief agenda of the topics that we will be discussing today.

First, I will be covering basic ethical principles in medicine and addictions treatment.

Then moving on to more complicated topics like informed consent, privacy and confidentiality.

I will be discussing the Controlled Substances Act and Prescription Drug Monitoring Programs.

And then Dr. Landess will focus on special topics in addictions and the law.

So to begin with, let's review some of the basic ethical principles that underlay addictions treatment and

medicine in general.

The first is autonomy.

This refers to patients' self-determination or self-governance

and is sometimes also referred to as moral independence.

Basically, autonomy means that a patient has the right to make his or her own decisions regarding treatment.

An example in addictions treatment would be a patient who has an upper GI bleed coming into the emergency department

and receiving treatment and subsequently refusing voluntary in-patient addiction psychiatry admission when it is found that

he has a severe alcohol use disorder that is contributing to recurrent upper GI bleeds.

If we are to respect the patient's autonomy and self-determination, we

would allow this patient to leave against medical advice.

A second ethical principle is that with beneficence.

This refers to actions that should promote a patient's well-being.

An example in addictions treatment of beneficence would be

a primary care provider referring a patient

with severe heroin use disorder to an inpatient

detoxification center and community recovery resources.

It is important to note that various ethical principles may come

into conflict. For example, if a patient requires involuntary admission,

for example, three psychiatric unit, the patient

may not want to do that.

We might have to violate that patient's autonomy

in favor of beneficence and to do what is best for that patient.

A third ethical principle that elated to

beneficence is that of nonmaleficence. This is the

do no harm principle, which in practical treatment is

often doing as little harm as necessary in order to help the patient.

An example of this would be if a patient were on

or experiencing her went detoxification on inpatient unit

and we want to reduce the suffering while the patient undergoes that,

we would provide them with comfort measures

to assist.

Justice has many different definitions in medicine and addictions. Justice

can refer to the fairness of medical decisions.

The equal distribution of resources and new treatments,

and simply upholding the law in medical practice.

>> Physicians often

have a role in advocating for what they feel is just and most appropriate

for their patience. An example in

addictions treatment would be a physician speaking with an insurance provider

after that insurance provider has deemed inpatient

treatment not clinically indicated for a patient when it

is that physicians opinion that inpatient treatment would

be most appropriate.

>> A few final basic ethical principles

are somewhat self-explanatory but relevant to an addiction. First is

respect for people. This refers to treating patients in a manner that acknowledges

their intrinsic dignity. This can be difficult and addictions because

folks with addictive disorders often suffer from severe stigma,

and so, it's important as providers we treat

them in a manner that acknowledges a respect for them. Then there is

truth telling which simply refers to being honest

and in medical practice, sharing information with patients as it becomes available

instead of withholding important information

from patients.

I am going to present a complex ethical scenario that demonstrates how

various ethical principles may arise in addictions treatment.

This is the case of a 40-year-old female anesthesiologist.

Over many years, she began using opioid medications

to help with anxiety and depression. She began taking opioid medications from

the hospital and using them at home, and she would subsequently

replace the medicines with saline. Her addiction progressed and should

begin obtaining oral opioid pain medications

from physicians and using them on the job

while at the hospital. However, she states she

has no problems with this. This woman comes to you

seeking treatment for her opioid use disorder. She tells you all this information and

immediately says, please don't tell anybody about this.

The hospital can't know and the state medical board can't know.

What are you supposed to do in this situation?

There are many ethical principles that are coming

into conflict. What is best for this patient?

Is the best that you not to disclose

the information that she has provided to you? Would be more just for you to

notify the authorities and

reduce the risk that she harms a patient while on the job? It is clearly demonstrating

ethical principles can come into conflict.

>> Now that we have covered those basic

principles we are going to be moving onto our

complicated topics. The first of which is informed

consent. We have an audience response question. Which of the following is

not true regarding informed consent?

It must be given voluntarily. An individual must possess

decisional capacity. Patients with psychosis cannot give

informed consent. Involves the disclosure of

information between the physician and the patient.

Please enter your response in the chat box. Again, the question is,

which of the following is not true regarding

informed consent?

The answer is, C,

patient with psychosis cannot give informed consent. Patient

with psychosis maybe able to provide informed consent

with treatment. Depending on severity of systems

and what capacities may be affected by those symptoms. Most physicians think

informed consent simply refers to a form that inpatient signs

after receiving a bunch of information about a treatment

and agreeing to go along with it. Informed consent is actually a

process that involves various

elements including voluntariness, and form

information disclosure, and decisional capacity, which

I will cover each in turn.

The first element of an informed consent is voluntariness, which

simply means a person's decision is really made. This means there is

no coercion. Coercion can take various forms. Including punishing a patient

in some manner for not going along with the

recommended treatment or promising excessive rewards if they do go along

with a treatment offered. It's important to note that

coercion differs from persuasion and influence. As a physician, you can persuade

your patient's to do things by using information about

their condition and recommended treatment and by giving

them your recommendation for what would be best. Influence

is the effect of external sources.

For example, in addictions many patients present

because their family members have threatened to cut them off

if they don't get treatments. These influences may have an impact somewhat

on voluntariness but they are not things as physicians

we can necessarily control. It's also

important to recognize that voluntariness may be context dependent

and there may be risk of infringing on it. For example, in custody, certainly in

drug court where patients may have to agree to treatment

in order to have their charges lessened or dropped.

Then inpatient treatment there's some restrictions on freedoms that can infringe on voluntariness

of treatment decisions.

>> Information disclosure is the component of informed

consent that most physicians think of.

We know that we have to talk with the patient about the nature of their

illness, the treatment options, risks and benefits of

those treatments, consequences of not receiving treatment. Different standards have been

delineated from case law on what degree of information

disclosure is necessary.

The most liberal standard is that of the reasonable person standard, which means

you disclose as much information as a reasonable person

in the same situation would want to know about their condition.

In addictions, there may be treatments that have a high standard

of disclosure. For example,, if you're going to be

prescribing addictive medication, it's important for the patient to know that.

Or medications that may have harmful effects like

disulfiram or potentially dangerous complications. For example, methadone

and cardiac risks.

>> The last element of informed consent is decisional

capacity. This means a patient is able to communicate a choice.

They are able to understand all of that information you shared with them.

They are able to appreciate the situation and consequences and

they are able to rationally manipulate information that is provided to them

in order to reason about the different treatment options. Often

times in psychiatry, we talk about a sliding scale approach

to decisional capacity. This means for those choices

that have a low risk of harm and a high potential benefit,

we are less concerned about a patient's

decisional capacity but a patient where patient is facing

a treatment option that has a low likelihood of benefit, potentially

life-threatening risks, we truly want to make sure the patient

understands the decision they are making. In

addictions, patients may be potentially impaired in their capacity. For example,

if they are acutely intoxicated or have

neurocognitive problems related to a history of

substance use or the have a dual diagnosis. For example, schizophrenia

and a methamphetamine use disorder.

I am not going to linger too long on issues

related to folks lacking capacity.

I would like to note that a durable power of attorney is a document that

identifies the patient's surrogate decision-maker if he or

she becomes into custody which differs from advanced

directive a living will, which is a form that describes

specific wishes and specific medical context of a patient if he or she

becomes incapacitated.

Then there is a guardian or conservator of the person. This

refers to a court-appointed person who makes care decisions

when a patient is incapacitated.

>> Very briefly. From this section, I

want you to remember the various ethical principles that underlie addictions and how

they may come into conflict. I want you to understand

that informed consent is a process involving various elements.

And that certain treatment settings have the potential to infringe

on the voluntariness of medical decisions.

>> Moving on to more complicated

topics. The first is that of privacy and confidentiality. Privacy

refers to a patient's right to the protective of sensitive health information.

You can remember this because privacy begins with

PR and that is the patient's right. Clinicians obligation to

protect sensitive information

is confidentiality. You can remember that because confidentiality

begins with CO.

Privacy and confidentiality are different sides of the

same coin. One being the patient's side and the other being the clinician's

eye. There two relevant rules that we should discuss if we

are talking about addictions and privacy and confidentiality. The

first is title 42 of the code federal regulations Part

2 known as the confidentiality of alcohol

and drug abuse patient records and HIPAA. Now,

before we talk about covered programs under

42 CFR Part 2 it's important to recognize this law came into

effect when most addictions treatment was provided in standalone facilities

outside of general medical units.

>> However, it's important to

recognize what a covered program is and there are some confusion about

this last year. I have made sure to cover

it in depth and provide statutory definitions.

Under Part 2, cover program is any individual, entity identified unit within a general medical

facility that provides substance use disorder diagnosis, treatment, or

referral for treatment. It also includes medical personnel or

staff within the facility who have the same function.

In order for somebody's treatment to qualify under Part 2,

that covered entity has received federal assistance. This

is much broader than it may initially sound. Federal assistance means

that the treatment is conducted in a federal department or agency, supported

by federal funds, which includes of federal funds

distributed to states or counties and further distributed or carried out

under a licensed or

registration from the federal government. This includes folks who provide care

under Medicare. Folks who are authorized to conduct maintenance

treatment or withdrawal management. And treatment that is

conducted under registration under controlled substances act

meaning under a DEA license to dispense a substance used

in the treatment of substance abuse disorders, so very broad.

>> Under Part 2, programs may only

release patient information with the patient's consent.

There are some exceptions included which

I will list here. I will read those for you. It's important to note that violation

of Part 2, failure to follow the guidelines can result in

criminal call penalty or fine.

>> Things changed a little bit with HIPAA

and the privacy rule of 2000. Under these

rules, all personal health information is protected. That means that

a patient has to give consent for any medical records

to be released. Again, there are some exceptions.

If this seems confusing to you, don't worry

because it is confusing. SAMHSA is working

to revise 42 CFR Part 2 so that it falls in line more with the

rules established under HIPAA and the privacy rule.

>> Okay.

Going to be switching gears now and talking about the controlled substance act. This

act was enacted in 1970s by Richard Nixon. Largely in the context of

concern about rampant drug use in that era.

This act regulates the classification of

controlled substances, their manufacturing, distribution,

exportation and sale.

Most relevant for us is the regulation and

classification of these drugs. Under this part of

the law, the DEA licensure requirement was established.

As well as the schedule

one through five of addictive substances or controlled substances.

Schedule one refers to illegal drugs that have no reported

an equal use.

Cannabis, MDMA and methaqualone continue to fall under this schedule.

The reschedule two through five including

compounds with decreasing addictive potential.

>> Related to the controlled substance act is the

concept of ethical prescribing.

I am not going to get too in-depth on this

but prescribing in addictions can have risks for patients. I

briefly mentioned that before. Some of our substances can result

in actual substance use disorders if

you are treating patients with opioids. Of course, there is a risk for

diversion and many of our

compounds can result in exacerbation of comorbid medical

or psychiatric illness. You, as a provider,

can engage in certain practices to ensure ethical prescribing. For example, using your urine drug testing, medication contracts or reviewing information from prescription drug monitoring programs. There's also the concept of universal precautions in pain management in the city 10 universal precautions steps that we are documenting for pain management. I want to point out these same precautions can be used with any potentially addictive compound and in the treatment of addictions. It involves things you might expect. For example, making an appropriate diagnosis, obtaining informed consent. Agreeing with a patient on what the treatment plan is going to be. And reassessing overtime and reducing the doses of medications that may be risky. Of course, documenting everything thoroughly and appropriately.

>> I have a second audience response question focusing on missed prescribing. Which of the following is not an example of missed prescribing? A, providing a patient opioids at a dangerously high dose. B, providing a prescription for three months of opioids following in on the complicated outpatient surgical procedure. C, providing a friend a prescription for Ativan for no medical purpose. D, providing a patient a prescription for Ativan for short-term treatment of anxiety, only

later to learn your estate's PDM P that she had received
multiple prescriptions in the last week from different providers.
Please enter your response in the chat box.
Which of the following is not an example of
missed prescribing. The correct answer is, D.
I want to talk about legal consequences. Missed prescribing is
often defined as prescribing controlled substances for an
inappropriate rationale, an inappropriate dose or
inappropriate quantity.
Under the controlled substances act, it is illegal to
miss prescribed but certain conditions have to
be met. A physician must knowingly prescribe a
medication that has no legitimate medical purpose.
So the physician has to know they're doing it
without a medical purpose in a manner that is outside the course
of professional practice. A physician can be punished
at various levels. For example, state medical boards can
sanction the physician by putting their license
on a suspended status or revoking the license.
There were several remedies if the patient experiences damages.
He or she can sue under malpractice. There
are criminal sanctions. Violation of the controlled substances act is a
federal criminal offense and if a patient dies,
the physician may be charged with murder if there
were inappropriate prescribing practices at play.
>> Here is a recent case in the news of missed prescribing. This
is an osteopathic physician named Joel Smithers. He opened

up a private practice in 2015 and shortly thereafter within a short period of time made 500,000 scheduled to permit prescriptions primarily opioid medications. His prescribing was directly linked to the death of a West Virginia woman, and as mentioned, violations of the CSA are federal drug charges and he was hit with 800 of them for unlawful distribution. He received a 40 year sentence and a nearly $100,000 fine for his missed prescribing. This is a fairly extreme example, but it does demonstrate that missed prescribing can result in federal drug charges and severe criminal sentencing.

>> The last topic I'm going to be discussing is that of PDM P programs. 49 states have statewide drug monitoring programs. Missouri has a county based program right now. These were developed to mitigate the abuse and diversion of controlled substances, and they operate under various models as I'm sure many of you are aware. There is not admitted use where the information is sadly collected and made available but physicians are not required to use it. This proactive reporting where the PDM P may reach out to physicians with information if they have identified patients receiving high doses of controlled substances or controlled substances for multiple providers. Then there is mandated use. In California, before discharging a patient from an inpatient psychiatric facility, the physician with a prescription for a controlled substance, the

physician must review the PDM P report for that patient.

There are various criticisms of PDMP's. For example, inadequate information collection.

An effective utilization and clinical settings of the information provided

by them. Of course, these are state run programs so this limited

interstate sharing and patients can cross

state lines and receive controlled substances from providers

there and they may not have ability to obtain information about the

patients' prescriptions. There is mixed data on effectiveness, which

is not surprising given the different models,

and effectiveness differs by state.

>> Pearls from the second half of my

presentation include confidentiality of substance use treatment as governed by

42 CFR Part 2, HIPAA, and the Privacy Rule.

The CSA of 1970 established the DEA regulation

and classification of addictive drugs and criminal penalties for missed prescribing.

There are various models about the co-prescribing involved informed consent, regular

assessment and does planning and appropriate clinical documentation and PDMPs that are helpful, differ

their implementation and effectiveness.

>> I am going to turn the presentation

over to Dr.

Landess who will speak about addictions and the Law.

>> Thank you,
Dr. Holoyda.

I am going to get this set up.

I am Dr. Landess. I will next discuss the following topics

and give an overview of principles relevant to those legal and

ethical issues, which may arise when treating the special populations listed on

this slide.

First will take a closer look at ethical and legal issues that arise

when treating adolescents with substance use disorders. We will first look

at issues regarding informed consent.

Let's jump right in with another audience response question. Please feel free to

enter your answers in the chat box as I read through the question.

>> A 15-year-old patient comes to you requesting treatment for

alcohol use disorder. Which of the following scenarios most

likely requires guardian informed consent before

initiating treatment?

A, She is a mature minor.

B,She is married.

C, She is serving in the military.

D, She has run away from home.

E, She is experiencing severe withdrawal.

and to your answers.

The question again is, which of

the following scenarios most likely requires regarding informed consent?

The correct answer is D, if she has run away from home. This could be a scenario

in some states in which the teenager can make independent

medical decisions but not usually.

Running away from home alone does not necessarily emancipate a minor and

allow her to consent to treatment. The other scenarios

listed here with most

likely not require regarding consent, and we will discuss those next.

>> When is a person able to independently

consent to healthcare treatment?

The answer is, it depends, but generally speaking, when they reach the

age of maturity. This is 18 and most states but there

are a couple of states that set the age at 19. States

generally have different standards for

consent based upon the type of care the minor is seeking. Consent to general medical

care usually requires the most parental environment

consent with exception for treatment of pregnancy or

sexually transmitted infections. States generally allow minors

more freedom to independently consent to treatment which involves

mental health or substance use. Keep in mind that

any of these above scenarios there are certain situations in which

parental consent is not required because the minor may be considered emancipated.

Legal emancipation is by court order.

Although there are other circumstances that equal emancipation such as marriage or entry

in the military.

A minor may also be able to make their own medical

decisions in certain other situations such as if they

are considered a mature minor, which will talk about on

the next slide.

If they have children and/or have graduated from high school.

>> The mature minor doctrine is

also worth knowing about.

It is recognized in approximately 14 states.

States that follow this doctrine recognizes unemancipated minor may possess

sufficient maturity to provide informed consent for

medical treatment. The emphasis is "may."

If you are a provider in a state you must assess whether the

minor is mature before moving onto a decision-making capacity

assessment like Dr. Holoyda outlined.

Factors in determining which would include the chronological age.

Noted that most teens who are 14 or 15 usually have the capacity to consent

with proper education.

Maturity asking questions like what is the history of decision-making.

How do they view the current situation and

is irrational? Emotional capacity looking specifically

underlying mental health.

Other similar issues interfering with understanding? Intelligence

and is is a relatively high benefit but low risk procedure or treatment?

If so, you can be more confident

in the mature minor's ability to consent. If you determine the adolescent is sufficiently

mature, you must then assess

capacity to give informed consent.

Two areas I would focus on with teens in particular are the risk

of forgoing treatment and a long-term consequence of rejecting treatments.

Because teens often overvalue short-term incentives and rewards rather than

long-term risk and consequences. Keep in mind that adolescents do have an immature prefrontal cortex.

Is the area of the brain responsible for executive functioning and impulse control amongst other things. Be sure to document the teenager's decision is rational, not impulsive and has made a non-emotionally charged environment.

>> Next we will look briefly at consent laws for minors in regards to substance abuse treatment on a national level.

The laws here do vary quite a bit by state. Venom age of consent ranges from 12 to 16 years old.

And the minor's ability to consent is based on the kind or type of treatment they are seeking. For instance, in Wisconsin, some as young as 12 can consent to detox but they cannot independently consent to treatment for medication such as buprenorphine unless it is given solely for withdrawal. In a state where a minor can independently consent to substance abuse,, parental notification may still be required which is not the same as informed consent.

>> This is a summary of states and based upon a 2009 article, so some of this is outdated.

In some states, only the minor must give informed consent to the treatment.

And others, either the parent or minor can consent and still others requires both parties were only the parent. It really is a hodgepodge. As I mentioned,

even if the minor is allowed to give informed consent

without parental involvement, you may still have to notify the

parent that the minor is in treatments.

>> This is a slight I created to discuss

the importance of parental involvement

in treatments. Even if the minor is able to independently give consent to

treatment. For the sake of time, I will skip over this slide. Please

refer to the handout that we provided for

further information.

>> These are the main takeaways of this section.

Keep in mind state laws do vary quite a bit regarding minor consent

requirements and I would consult with your law to determine what those are including whether

a mature minor can consent to treatment. Adolescents

in general legally are provided greater autonomy

to consent for substance treatment compared to other treatments including

mental health treatment. When treating adolescent patients, it is best

and best outcomes involving parents

when possible.

>> Our

next topic is legal or ethical issues which may arise

when treating pregnant women with substance abuse disorders.

First, there are potential legal consequences both criminal

and civil when a woman uses substances

or alcohol during pregnancy. Pregnant women in at least 30 states

have been charged with a crime related to their substance use. There are examples of

these laws which have been used to charge and

prosecute women ranging from feticide laws all the

way to direct criminalization of substance use during pregnancy. There are many

examples but one I want to share with you is that

of a woman named Regina McKnight who is charged with homicide having

giving birth to a stillborn infant.

The infant if had cocaine in his system. She

was ultimately convicted and sentenced to prison for 12 years but released on

appeal after eight years in prison when the court determined

it was not clear the infant had died due to her

cocaine use. On the civil side, there are 23 states

and D.C. which consider substance use during pregnancy to be considered child

abuse under existing child welfare laws. And note there are

a very small minority, few states, that you allow civil commitment of

a woman who uses substances while pregnant on

the ground that she is posing a danger to her fetus.

>> I want to next touch on the providers role

when it comes to reporting

prenatal drug use and/or substance exposed newborns. All states of course have mandated

reporting requirements for child abuse and neglect. The tick of a legal standard

here is quite low and can be subjective.

It is a reasonable belief or suspicion for abuse.

Use of substances during pregnancy may trigger

reporting requirements and/or function as present

evidence of neglect or abuse. Additionally, the majority of states

have laws concerning substance

exposed newborns. Where evidence of substance use at birth, usually

in the form of a positive toxicology,

the infant coming up positive for some substance

will trigger a child welfare report.

These criminal and civil penalties,

I would say they certainly deter a pregnant women from seeking needed

prenatal care.

And furthermore laws such as these tend to have a disparate impact

on women of color and from disadvantaged backgrounds. How should a provider brooch

this topic with their patients? Especially when it

comes to substance testing, toxicology's

and drug screens. At the outset of treatment,

I would advise that you disclose the limits of

confidentiality to the patient and any mandating reporting requirements as part of

the informed consent. Just of note, ACOG does oppose mandatory

testing or reporting of substance use of pregnant women.

>> In summary, a person who

uses substances during pregnancy could be subjected to civil or

criminal penalties in many states.

The mandated reporting requirements of perinatal substance use does

vary across states. Always obtain informed consent

before drug testing. Including notification of any mandatory reporting

requirements.

>> Next

topic is justice involved populations.

We have another audience response question.

While I'm reading this, feel free to enter your answers into the chat box.

>> Approximately what percentage of women who are incarcerated

in jail have a substance use disorder?

A, 25%.

B, 33%.

c, 50%.

D, 75% E, 905.

The correct answer is 75%. The U.S.

has the highest number of incarceration.

As you can see from the graph, there was a rapid rise in the number

of prisoners starting in the late 1980s into the 90s. There

were several factors responsible for this which include the

war on drugs and passage of laws which enacted

harsher and longer sentences. Even for nonviolent drug crimes.

Research has shown anywhere from 50% to 80% of people

who are incarcerated have a substance abuse problem ranging from mild to

severe. When you look at women who are incarcerated

numbers are much higher with some estimates being

at or above 75%.

Unfortunately, despite the high

numbers of people with substance use disorders who are incarcerated, only a small portion

received treatment. Somewhere in the range of 10%

to 15%.

>> We will next talk about barriers to treatment

in these settings.

Most jails and prisons, unfortunately did not provide substance abuse treatment

including MAT.

There is a great need for MAT. At approximately

75% of people with substance use disorder relapse within three

months of release

whether it be prison or jail. There 100 times more likely as compared to someone in

the general population with a substance problem to die of overdose within

two weeks of release.

This would seem to communicate the great need. However,

the barriers that exist are some of the

following. One is a lack of education about how MAT

is actually a solution for substance abuse disorder rather than

a perpetuation of substance use. Correctional

staff may also be concerned about inmate selling

drugs in the course of the problem because the counties are usually footing the bill

for meds and treatment in jail systems and last but not least a very real

issue of not having a community provider to continue MAT once the

person is released. On the flipside, I

would say there has been increased attention to

the lack of substance treatments and corrections and there have

been more funding and pilots of MAT in jails in the U.S. across

the past five to seven years.

>> I also wanted to mention

under this topic of justice involved populations the existence

of problem-solving or treatment courts. This is another way

people in the justice system may be diverted from the jail and into treatment. Here

are some examples of problem-solving courts.

Today we will focus more so on drug courts.

The concept of the initial drug court which started

in the 1990s and others that followed was

granted on the theory of therapeutic jurisprudence.

Which essentially means finding ways to help a

defendant recover and reform rather than simply punishing him

or her while still complying with legal mandates.

The judge and the problem-solving court plays a

key role. The judge in this type of

court is highly engaged and hands-on with participants

engaging them in robust discussions about treatment and also motivating

them to complete and graduate the program. There were

now over 3000 drug courts that exist in all 50 states and also the

federal level.

In terms of entry, eligibility, structure and sanctions, please

refer to your handout from for detailed information.

The take-home is that participants are incentivized to

be in drug court because they will usually avoid prison time

or as Dr. Holoyda mentioned, they will have a

lesser sentence or time on probation. And potentially be

linked to treatment faster. If they fail to complete

the requirements of drug court or have a

number of new charges or a relapse, multiple relapses on substances,

they could then face prison time or other sanctions.

Do drug courts work? Outcomes are mixed but by a large analyses

have shown drug court to receive dues recidivism. This

is usually measured by rate of rearrest as compared

to people who were dispositioned on standard probation.

At least one study has shown a decrease in future drug use

as well. Keep in mind that treatment providers may be in a dual role if they're both

treating a patient who is a participant in

drug court and reported to the drug courts. Be

aware of ethical conflicts. This also

is changing but there are some drug courts which

actually do not allow the participants to receive MAT. In particular

buprenorphine.

>> All right.

To finish things up, I want to briefly touch

on the last three topics.

Civil commitment, Americans with disabilities act and impaired physicians.

>> Civil commitment laws exist in

every state and allow physicians, police, or other mental health professionals

to detain individuals were both dangerous and

mentally ill. Mental illness is usually vaguely defined in the law but refers

to conditions such as severe psychotic or

mood disorders but can also encompass developmental disabilities.

What to remember is that there must be

an axis between someone's mental illness and dangerousness or

grave disability in order to be a proper subject for civil commitment. Grave

disability usually means an inability

to care for basic needs such as eating, showering, toileting

and activities of daily living.

There are states that offer civil commitment based on a substance use disorder alone.

It can occur with a more traditional definition of mental illness

such as psychotic or mood disorder.

There are states in which does alcohol use disorder and/or another substance use

disorder qualifies you potentially for civil commitment if you

are also dangerous. Civil commitments

since it involves a significant deprivation

of personal liberty does involve a formal legal process. In

most states, how this works is that the legally designated person can detain

the patient for some time period usually on the order of days

while they petition the court for involuntary commitment.

The court then makes the final determination and

order of involuntary commitment after a formal hearing.

The hearing --the patient is provided with due

process including notice to the patient, the right to

have an attorney to cross-examine witnesses and

reheard by a neutral factfinder, which is usually

the judge. If the commitment is granted, individuals are committed to the least restrictive

setting, which, in fact, could be

outpatient for a certain period of time. Usually on the order of months

before their commitment is reviewed. One less thing I want

to mention, which is related to this slide, but I had a

question about this last year was what to do

if a person is threatening to harm a third-party.

States set different standards about what constitutes what is

known as the duty to protect. Third parties from

threatened violence. Some of this is in state law. Sometimes it is in court

decisions.

Generally speaking, psychotherapists, psychiatrists

and/or other mental health professionals have this duty

but it may extend to other providers depending on the state. In

order to discharge this duty, you may need to warn

the threatened party, which is usually defined as a readily

identifiable victim.

Hospitalize a patient, call the police, and/or take other

protective measures.

>> All right. The ADA, just to touch

on this quickly, I included this because you may work

with patients who are involved in or otherwise affected by ADA

discrimination lawsuits.

The quick of it it is the ADA

was passed in 1990 and established protections with

people for mental or physical disabilities.

To be disabled under the ADA, you must have an impairment that will

list one or more major life activities.

I won't go into all of those here but any basic activity of

daily living. Or you have a history of

a physical or mental impairment or even if you don't have a history, others

see you and regard you as having an impairment.

>> How does this relate to substance use?

Do substance use disorders qualify as impairment under the ADA?

Interestingly, the ADA recognizes alkyl use disorder in all its forms,

past and present as a disability. When it comes to the

use of illegal substances and substance use disorder

stemming from that, the ADA does not protect everyone.

It only protects people with substance use disorders,

except alcohol, only if they are not currently

using drugs and they either currently or have been

in treatment. Someone who is currently using drugs or has

a quarter equal casual user is not protected under the

ADA. Please note there are also exceptions to

the ADA protections. For instance, just because you have an alcohol use disorder

they cannot show up to work intoxicated

and states they are protected under the ADA. The ADA does not apply if

someone poses a, quote, direct threat to others or self and 88 is not

expect employers to put others in the work environment at

risk.

This is the last quick topic.

I will not cover this entire slide.

The other thing I want to mention, Dr. Holoyda did

touch on state medical boards and medical practice acts. These do exist

in all states.

They define the practice in medicine and delicate authority to enforce

the law to a state medical board I wanted to also

comment related to this are physician health programs and treatment of impaired physicians.

There usually physicians who are referred to due to a mental health or substance

use problem. These do exist in nearly every state. The

primary goals of a PHP are to evaluate, treat, monitor

healthcare professionals and the physician may self referred to treatment

for many may be mandated to treatment through

the state medical board and or their employer. If they do not complete

the program, they may be subject to

termination of employment, license, suspension or

revocation. Note that if you work with a physician

self-referred involuntary as any of the patient would, those are

often required to consent to sharing of information with the

board and employer due to the conditions of their treatment.

What's to know about PHPs is that the existing research does show quite a high success rate on the order of 70%-plus in

terms of risk of relapse.

So again, just due to time, I'm not going to cover this last piece.

This is about the duty to report impaired physicians.

Please review this on your own time and also refer to our handout from our information about this topic.

Alright, so with that, we'll wrap up.

Please do not hesitate to reach out to one or both of us with any questions that you have.

We can also provide a bibliography to you on request.

And thank you for your time and listening.