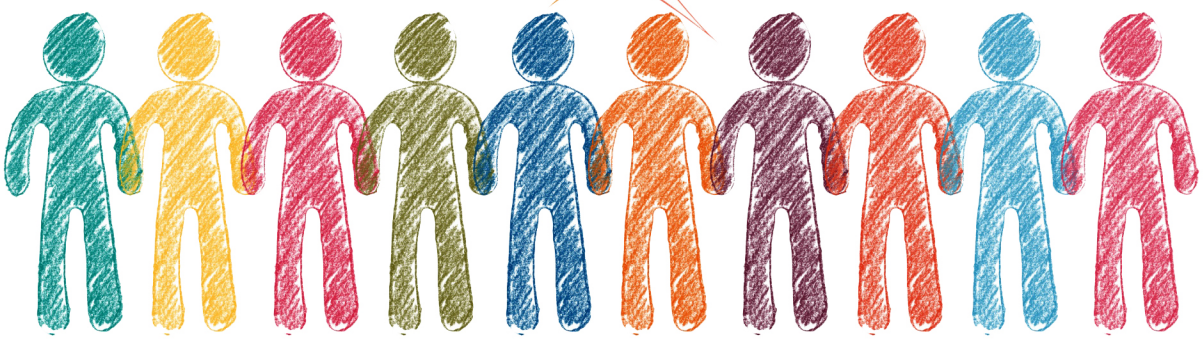
2019 State Roundtable Report
Drug & Alcohol

"Alone we can do so little; together we can do so much."

Helen Keller



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A Call for Collaboration: Addressing the Issue of Substance Abuse in Child Welfare

The mission of the Drug and Alcohol Workgroup is to promote child safety, permanence, and well-being for families touched by substance use disorders by providing access to a continuum of services that include early engagement, cross-systems collaboration, and clinical integrity.

BACKGROUND:

During its 2013 meeting, the Pennsylvania State Roundtable (SRT) spent several hours discussing the subject of substance abuse in the context of child welfare. As was heard clearly in all of the Leadership Roundtables, and as common knowledge within the field, substance abuse is an ever-increasing problem in communities across the Commonwealth. It was decided that a workgroup be created to explore the issue of substance abuse as it intersects with the child welfare population. Ultimately charged with making recommendations that will improve practices for families in the child welfare and the dependency system that are affected by substance use disorders, areas of focus for the workgroup were as follows, in priority order:

- Changing the culture, beliefs, and approaches to addiction, including the manner in which addiction is treated
- Finding effective treatment for substance abusers and their families
- Recovery/relapse supports
- Funding issues
- Identifying and overcoming barriers to successful treatment
- Drug & alcohol assessments
- Research, investigate, review, and visit successful programs and evidence-based practices and report positive outcomes
- Dual diagnosis, co-occurring disorders
- Collaboration

The Drug and Alcohol Workgroup (Workgroup) was convened in August, 2013 led by the Honorable Jonathan Mark, Court of Common Pleas of Monroe County and Wendy Hoverter, LCSW, Children and Youth Administrator of Cumberland County. In 2015 Kerry Browning, LSW, Deputy Director, Department of Human Services, Office of Youth and Family Services of Lackawanna County replaced Wendy Hoverter as co-chairperson upon her retirement. The Workgroup, with a membership that covers a broad spectrum of state and local level positions within the courts, child welfare, substance abuse and mental health fields, met monthly to explore the issue of substance abuse in Pennsylvania.

Brainstorming at its first full meeting, the Workgroup discussed issues, barriers to service, and the individual and collective strengths and weaknesses of our systems. Even with a more diverse group of participants than the SRT, the results of the discussion mirrored the SRT for its concerns and priority areas of focus: changing beliefs and cultures surrounding substance abuse, effective treatment at objectively proper levels of care, cross-systems education and training, and funding. At the end of the meeting, one member remarked, “Wow! We are people in systems who work

side-by-side every day but who don't know each other." That prescient in-the-moment statement foreshadowed a common theme that the Workgroup has heard, loud and clear, from numerous sources: collaboration between child welfare, treatment providers, and the courts is essential to improving the lives of and the provision of services to children and families affected by substance abuse.

Research validates the position of both the SRT and Workgroup that collaboration is key when working with the substance abusing child welfare population. The Center for Disease Control and Prevention's National Center for Injury Prevention and Control (2014), identified risk and protective factors associated with child maltreatment. Included on its list of individual risk factors for perpetration of child maltreatment is substance use. The connection between child maltreatment and substance use necessitates collaborative and coordinated delivery of services by two interveners, the child welfare professional and the substance abuse treatment provider. However, barriers exist. According to Lee, Esaki, and Greene (2009), several factors can serve as barriers to genuine and effective collaboration between these two primary interveners including but not limited to different perceptions and loyalties, segregated delivery of services, conflicting policies and biases and differential treatment which inhibit communication, and consequently collaboration.

An extensive literature review confirmed the beliefs of the SRT and the Workgroup. In its simplest form the literature showed:

- ✓ The importance of treatment interventions including the whole family.
- ✓ The need for collaboration and cross-training between the courts, child welfare, mental health and drug and alcohol.
- ✓ The need to recognize addiction as a disease in order to move forward with helping individuals and families affected by SUDs.

To assist with the priority charge given by the SRT, culture change regarding substance using people and facilitate change at the local level, the Workgroup sought the assistance of the National Center on Substance Abuse and Child Welfare (NCSACW). The partnership assisted the Workgroup in identifying, fleshing out, and better understanding the unique features of the issues in Pennsylvania through an established program known as In-Depth Technical Assistance (IDTA). Simultaneously, the IDTA process provided direct assistance to eight diverse counties known as the "core counties" in the IDTA program. The Workgroup gained a deeper understanding of how substance abuse affects children and families. Now that the IDTA process is complete, issues which have been deferred will be comprehensively addressed and research and evidence-based practice recommendations for Pennsylvania will be developed.

In addition to examining the issues counties are facing with the opiate addiction epidemic and the accessibility and quality of services, the Workgroup continues to refine the national IDTA program into to a Pennsylvania specific process, the Pennsylvania Drug & Alcohol In-Depth Analysis that can be replicated in counties that could not be part of the national program.

PROGRESS AND UPDATES:

The Workgroup identified the following charges as their priorities for 2018-2019:

- Test Pennsylvania's Drug & Alcohol In-Depth Analysis process
- Explore the implications of co-occuring substance abuse and mental health issues
- Explore how legalization of marijuana may impact child welfare
- Develop a resource on supporting the child prenatally exposed to drugs and alcohol

❖ TEST PENNSYLVANIA'S DRUG & ALCOHOL IN-DEPTH ANALYSIS PROCESS:

Luzerne County has volunteered to test Pennsylvania's Drug & Alcohol In-Depth Analysis (PA D&A IDA) process. The PA D&A IDA mimics the In-Depth Technical Assistance process that was used in Pennsylvania by the National Center on Substance Abuse and Child Welfare. The mission of the PA D&A IDA is to promote child safety, permanence, and well-being for families touched by substance use disorders by providing access to a continuum of services that include early engagement, cross-systems collaboration, and clinical integrity.

The following are the goals of the PA D&A IDA:

1. Develop cross system values, principles, goals, and objectives for serving substance affected families.
2. Increase timely access to services, including education, for substance-affected families.
3. Maximize knowledge and use of existing best practice treatment and resources.
4. Encourage awareness and utilization of sustainable supports for lifetime recovery.

The PA D&A IDA process for Luzerne County will include:

- Developing a core team to identify and address county issues related to substance use disorder
- The local Children's Roundtable providing oversight to the core team
- Completing and analyzing a Collaborative Values Inventory survey
- Collecting baseline cross-system data
- Conducting case reviews
- Completing an initial drop-off analysis
- Conducting a systems walk-through to review current practices and identify gaps
- Developing a work plan to guide changes in practice
- Providing assistance and support from members of the Drug & Alcohol Workgroup and county core team members that were involved in the National Center on Substance Abuse and Child Welfare's In-Depth Technical Assistance in Pennsylvania.

A Kick-Off Event will be held in Luzerne County on May 14, 2019 at their local Children's Roundtable. At this meeting the purpose of the PA D&A IDA will be explained including a review of the mission and goals, members of the dependency court system, the child welfare system, the

drug and alcohol system, and mental health system will learn about each other's roles, how substance abuse is viewed and relevant issues to consider from the system's perspective.

The Systems Walk-Through is scheduled to occur on June 25, 2019 to demonstrate how to use the results from the Collaborative Values Inventory survey and how to develop their cross-system baseline data.

The overall goal of the PA D&A IDA process is two-fold: 1) to help Luzerne County make positive changes that impact the quality and/or accessibility of services to substance abusing families involved with child welfare, and 2) to have a process available for counties to execute on their own that improves their practices for substance abusing families involved with child welfare. To fine-tune this process, a representative from Luzerne County's Core Team has been asked to join the Drug & Alcohol Workgroup. At each Workgroup meeting the core team representative will have an opportunity to share successes and challenges happening at the local level, suggest ways to more efficiently complete tasks and provide input from the county perspective on how to improve the PA D&A IDA process.

❖ EXPLORE THE IMPLICATIONS OF CO-OCCURING SUBSTANCE ABUSE AND MENTAL HEALTH ISSUES:

According to the Substance Abuse and Mental Health Service Administration, in 2016 it was estimated that there were 44.7 million adults with mental illness, with 10.4 million of them having serious mental illness (they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities). It was also estimated that 19 million adults have substance use disorder. In the United States 8.2 million adults have co-occurring disorders (the coexistence of both a mental disorder and a substance use disorder) with an estimated 2.6 million of them co-occurring with serious mental illness.

Of the 8.2 million adults with co-occurring disorders, 38.2% received only mental health care and 2.9% received only specialty substance use treatment (refers to an inpatient hospitalization, inpatient or outpatient at a drug or alcohol rehabilitation center, or a mental health center). Only 6.9% of those receiving treatment, had both mental health care and specialty substance use treatment.

Among the 2.6 million adults who had co-occurring serious mental illness and substance use disorder, 51.2% received only mental health care, 2.3% received only substance use treatment and 12% received both mental health care and specialty substance use treatment. This means that approximately 1 in 3 adults with co-occurring disorders that have substantially interfered with or limited one or more of their major life activities, did not receive either types of these treatments, if any.

The high prevalence of co-occurring disorders between mental illness and substance use does not necessarily mean that one caused the other. Even if one appeared first, establishing causality and

directionality is difficult. According to the National Institute on Drug Abuse, there are three main pathways that can contribute to these co-occurring disorders:

1. Common risk factors can contribute to both mental illness and substance use.
2. Mental illness may contribute to substance use.
3. Substance use can contribute to the development of mental illness.

The high occurrence of co-occurring disorders between mental illness and substance use however does highlight the need for an integrated approach to treatment that involves identifying, evaluating and coordinating treatment to occur simultaneously. Integrated treatment has been found to be the most effective approach for individuals with co-occurring disorders rather than treating each disorder separately without consideration of the other disorder. **Given the commonality of co-occurring disorders, the Workgroup believes that it is essential for counties to have their mental health partners and managed care organizations included in their collaborative efforts in addressing substance use disorders.**

❖ EXPLORE HOW LEGALIZATION OF MARIJUANA MAY IMPACT CHILD WELFARE:

Given the passage of the Pennsylvania Medical Marijuana Act, the Workgroup began having discussions on how the use of medical marijuana might potentially impact the child welfare system. These conversations went even further by discussing how recreational use of marijuana would impact the child welfare system, should it become legalized in Pennsylvania. In May 2018, the Pennsylvania State Roundtable approved the Workgroup to explore how legalization of marijuana may impact child welfare.

LEGALIZTION OF MEDICAL MARIJUANA IN PENNSYLVANIA

In April 2016, the Pennsylvania Medical Marijuana Act was signed into law by Governor Tom Wolf. The law became effective on May 17, 2016 and was created with the intent to:

> (i) Provide a program of access to medical marijuana which balances the need of patients to have access to the latest treatments with the need to promote patient safety.
> (ii) Provide a safe and effective method of delivery of medical marijuana to patients.
> (iii) Promote high quality research into the effectiveness and utility of medical marijuana.

Pennsylvania Medical Marijuana Act - 35 P.S. § 10231.102 (3) [1]

The law further established a medical marijuana program for patients suffering from "serious medical conditions." This program, implemented and administered by the Pennsylvania Department of Health, Office of Medical Marijuana, provides necessary permits to organizations; regulates the growing and processing of medical marijuana; and provides training to medical providers among other things.

Lawful Uses of Marijuana under the Pennsylvania Medical Marijuana Act

The Pennsylvania Medical Marijuana Act provides that medical marijuana may only be dispensed to patients and caregivers (as defined by the act). Further, it limits the forms in which it may be dispensed to the following: 1) pills; 2) oils; 3) topical forms (such as gels, creams, or ointments); 4) vaporizers and nebulizers (vapes); 5) tinctures; and 6) liquids. Other forms of consumption, such as smoking and the eating of commercially produced marijuana edibles are considered unlawful.[2]

How to get Medical Marijuana (for Patients)

According to the Commonwealth of Pennsylvania's Guide, Getting Medical Marijuana, prior to being able to purchase medical marijuana legally, a patient must first complete several steps:

1. Register for the Medical Marijuana Program
2. Obtain a Medical Marijuana Patient Certification
3. Complete Registration to get Medical Marijuana ID Card

How to Register for the Medical Marijuana Program:

An individual interested in becoming a medical marijuana patient will first need to register with the Pennsylvania Department of Health at the following web address: https://www.medicalmarijuana.pa.gov

Applicants must have proof of Pennsylvania residency in the form of a Pennsylvania driver's license or a Pennsylvania state issued ID card with their current address. Patients and caregivers also must have a working email address.

Once a patient has successfully registered (which is confirmed via email), they can then move on to the next step: obtaining patient certification.

How to Obtain a Medical Marijuana Patient Certification:

An approved doctor can issue a patient certification to qualifying prospective patients. Only patients diagnosed with one of the following "serious medical conditions" may currently participate in Pennsylvania's Medical Marijuana Program:

[1] 35 P.S. § 10231.102(4) It is the further intention of the General Assembly that any Commonwealth-based program to provide access to medical marijuana serve as a temporary measure, pending Federal approval of and access to medical marijuana through traditional medical and pharmaceutical avenues.

[2] 35 P.S. § 10231.304(c). The Medical Marijuana Act does, however, allow patients or caregivers to make marijuana edibles at home in order to aid in its digestion by the patient.

- Amyotrophic lateral sclerosis
- Autism
- Cancer, including remission therapy
- Crohn's disease
- Damage to the nervous tissue of the central nervous system (brain-spinal cord) with objective neurological indication of intractable spasticity, and other associated neuropathies
- Dyskinetic and spastic movement disorders
- Epilepsy
- Glaucoma
- HIV/AIDS
- Huntington's disease
- Inflammatory bowel disease
- Intractable seizures
- Multiple sclerosis
- Neurodegenerative diseases
- Neuropathies
- Opioid use disorder for which conventional therapeutic interventions are contraindicated or ineffective, or for which adjunctive therapy is indicated in combination with primary therapeutic interventions
- Parkinson's disease
- Post-traumatic stress disorder
- Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain
- Sickle cell anemia
- Terminal illness

How to Complete Registration to get Medical Marijuana ID Card:

Once patient certification has been obtained, the individual will receive an email from the Department of Health directing them to pay for their medical marijuana card. Patients are responsible for purchasing their medical marijuana ID card annually, currently $50. Patients may qualify for a discount if they participate in any of the following government programs: Medicaid, PACE/PACENET, CHIP, SNAP, and WIC.

Once these steps have been successfully completed, the individual will receive a medical marijuana card and may visit a dispensary listed on the Department of Health's website for their products. At this time, insurance companies do not cover the cost of medical marijuana. Cost vary depending on the type of marijuana, the amount of the product and dispensary prices.

DECRIMINALIZATION OF RECREATIONAL MARIJUANA IN PENNSYLVANIA

Recreational use of marijuana in Pennsylvania is currently illegal. Under the Controlled Substance, Drug, Device and Cosmetic Act, 35 P.S. 780-113 (a)(31), a person is guilty of Possession of a Small Amount of Marijuana if the individual: possesses a small amount of marijuana only for

personal use; the possession of a small amount of marijuana with the intent to distribute it but not sell it; or the distribution of a small amount of marijuana but not for sale.

- Possession of 30g or less is currently regarded as a third-degree misdemeanor that carries penalties of a fine up to $500, up to 30 days in jail and a driver's license suspension.
- Possession of over 30g is a third-degree misdemeanor that carries penalties of a fine up to $5000, and up to 1 year in jail, and driver's license suspension.

Despite state law Philadelphia, Pittsburgh, State College, Harrisburg, York, Erie, Allentown, and Lancaster, all have ordinances to decriminalize the possession of a small amount of marijuana for personal consumption (https://norml.org/legal/item/pennsylvania-local-decriminalization). These ordinances do not make marijuana legal, but in these municipalities the offense would result in the issuance of a civil citation instead of a misdemeanor.

FEDERAL LEGISLATION ON MARIJUANA

To make this subject even more complicated, through the Controlled Substances Act (CSA), 21 U.S.C. § 811, marijuana use remains illegal. The federal government places every controlled substance on a schedule, and the schedule system takes into account the drug's potential for abuse, as much as a drug's medical value. Marijuana is viewed by the federal government as being highly addictive with no medical value, therefore is classified as a Schedule I drug, same as heroine.

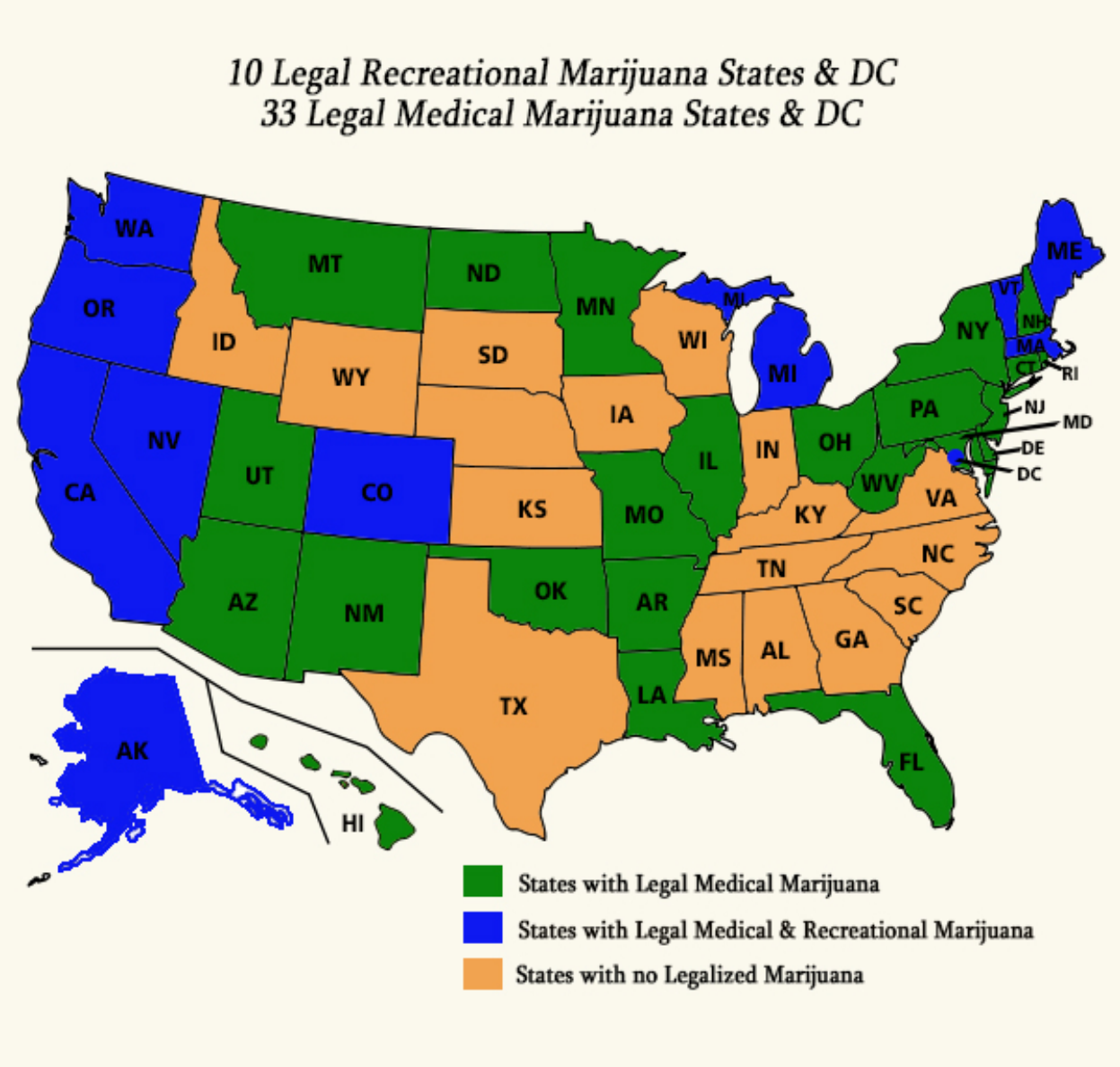
Schedule I drugs are effectively illegal for anything outside of research. The Drug Enforcement Administration (DEA) restricts how much marijuana can go into research. To obtain legal marijuana for research studies, studies must be approved by the Department of Health and Human Services **(**HHS**),** the Food and Drug Administration (FDA) and the DEA. Currently there is no scientific evidence available that passes the threshold required by federal agencies to acknowledge marijuana's potential as medicine.

In an attempt to manage the conflict between federal and state laws, several federal agencies issued guidelines and policy memorandums throughout the years. In January 2018, former Attorney General Jefferson Sessions issued a memorandum for all United States attorneys on marijuana enforcement (APPENDIX I). The memorandum states the federal government's position that the existing statutes "reflect Congress's determination that marijuana is a dangerous drug and that marijuana activity is a serious crime." Prosecutors were advised to follow the well-established principles that govern all federal prosecutions that are reflected in chapter 9-27.000 of the U.S. Attorney's Manuel. In addition, all previous guidance specific to marijuana enforcement was deemed unnecessary and were immediately rescinded.

In recent news, the Washington Times reported that on April 10, 2019, Attorney General William Barr testified during a hearing on Capitol Hill that something needs to be done regarding the conflicting federal and state marijuana laws that have created an "intolerable" situation for the Department of Justice. During his testimony Mr. Barr proposed two choices, "Personally, I would still favor one uniform federal rule against marijuana but, if there is not sufficient consensus to obtain that, then I think the way to go is to permit a more federal approach so states can make their own decisions within the framework of the federal law and so we're not just ignoring the

enforcement of federal law." Mr. Barr made these remarks in response to a question about bipartisan legislation that was introduced the week prior in the House and Senate – the Strengthening the Tenth Amendment through Entrusting States Act of 2019. This Act would amend the federal CSA to exempt marijuana-related activities involved in state-legalized marijuana industries.

Regardless of marijuana still being illegal under federal law, there are currently 33 states and the District of Columbia that have legalized medical marijuana. Ten states and the District of Columbia have also legalized recreational marijuana use (Wikipedia).



Please note that the following states do allow restricted use of medical marijuana (low – tetrahydrocannabinol (THC) cannabis/oils or cannabidiol (CBD) oils) and/or for clinical trials: Alabama, Georgia, Indiana, Iowa, Kansas, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, Wisconsin and Wyoming.

LEGALIZATION OF MARIJUANA IN COLORADO

Colorado has been described as an experimental lab for the nation to determine the impact of legalizing marijuana. Colorado legalized medical marijuana in 2000. Then in 2010, legislation was passed that included the licensing of medical marijuana centers (dispensaries), cultivation operations, and manufacturing of marijuana edibles for medical purposes. In November 2012, Colorado then became one of the first states to legalize recreational marijuana. Also, Colorado now allows licensing marijuana retail stores, cultivation operations, marijuana edible manufacturers, and testing facilities. Retail marijuana businesses became operational January 2014.

Given Colorado was one of the first states to legalize recreational marijuana, the Colorado legislature mandated that the Colorado Department of Public Health and Environment (CDPHE) study the potential impact of marijuana on public health. Although medical marijuana had been legalized in Colorado since 2000, it was viewed by many as a medical decision made between a doctor and patient, hence outside the scope of public health policy. The legalization of recreational marijuana and the potential for greater availability of marijuana in the community prompted a more thorough review of the potential health impacts of marijuana.

Recreational marijuana was now grouped with other substances like alcohol, tobacco, and prescription drugs which are legal but have the potential for abuse. The standard public health approach for these legalized substances is to monitor use patterns and behaviors, health care utilization and potential health impacts, and emerging scientific literature to guide the development of policies or consumer education strategies to prevent serious health consequences.

The CDPHE conducted a systematic literature review process to search and grade the existing scientific literature on health effects of marijuana. The findings were synthesized into evidence statements to summarize the quantity and quality of supporting scientific evidence. From their literature review on marijuana use and its health effects, we will only focus on the finding with the following evidence statements:

- Substantial evidence which indicates robust scientific findings that support the outcome and no credible opposing scientific evidence.
- Moderate evidence which indicates that scientific evidence supports the outcome, but these findings have some limitations.

Please see Appendix II for the substantial and moderate findings from their systematic literature reviews (2014-2018) on the health effects of marijuana use that could potentially impact the child welfare system.

Impact of Legalizing Marijuana in Colorado:

The Rocky Mountain High Intensity Drug Trafficking Area (RMHIDTA) is tracking the impact of the legalization of marijuana for medical and recreational use in the state of Colorado. Annually the RMHIDTA gathers and examines data, and identifies trends. There are three different eras in Colorado's legislation history that are compared, when possible, in these reports:

2000 – 2008: Medical marijuana pre-commercialization era
2009 – Present: Medical marijuana commercialization and expansion era
2013 – Present: Recreational marijuana era

The following are some of their findings that could potentially impact the child welfare system:

- **Medical Marijuana Use:**
  - 2001-2008 – There were only 5,993 patient applications received. There were **4,800** actual medical marijuana registry identification card holders in 2008.
  - 2009 – New patient applications jumped by an additional 38,000 in one year. There were now **41,039** medical marijuana registry identification card holders.
  - 2012 – There were **108,526** medical marijuana registry identification card holders.

- **Youth Marijuana Use:**
  - Youth (ages 12-17) past month marijuana use **increased 12%** in the three-year average (2013-2015) since Colorado legalized recreational marijuana compared to the three-year average prior to legalization (2010-2012).
  - In school year 2015/2016:
    - 62% of all drug expulsions and suspension were for marijuana violations.
    - 73% of all drug related referrals to law enforcement were for marijuana violations.
  - According to Colorado School Resource Officer Survey in 2017:
    - Predominant Marijuana Violations:
      - 44% students were under the influence during school hours
      - 36% student in possession of marijuana
    - Where do students get their marijuana:
      - 39% from friends who obtained it legally
      - 26% from the black market
      - 23% from parents

- **Adult Marijuana Use:**
  - College age (ages 18-25) past month marijuana use **increased 16%** in the three-year average (2013-2015) since Colorado legalized recreational marijuana compared to the three-year average prior to legalization (2010-2012).
  - Adult (ages 26+) past-month marijuana use **increased 71%** in the three-year average (2013-2015) since Colorado legalized recreational marijuana compared to the three-year average prior to legalization (2010-2012).

- Top demographics of those who report current marijuana use:
  - Black, Non-Hispanic
  - Gay/Lesbian/Bisexual
  - Males

- **Marijuana-Related Exposure (Calls to the Poison and Drug Center):**
  - Marijuana-related exposures **increased 139%** in the four-year average (2013-2016) since Colorado legalized recreational marijuana compared to the four-year average (2009-2012) prior to legalization.
  - Marijuana-related exposures in children (ages 0 to 5) nearly tripled in the four-year average (2013-2016) since Colorado legalized recreational marijuana compared to the four-year average (2009-2012) prior to legalization.
  - Marijuana-only exposures more than doubled (**increased 210%**) in the four-year average (2013-2016) since Colorado legalized recreational marijuana compared to the four-year average (2009-2012) prior to legalization.

- **Emergency Department and Hospital Marijuana-Related Admissions:**
  - The yearly rate of emergency department visits related to marijuana **increased 35%** after the legalization of recreational marijuana (2011-2012 vs. 2013-2015).
  - The yearly number of marijuana-related hospitalizations **increased 72%** after the legalization of recreational marijuana (2009-2012 vs. 2013-2015).

- **Treatment:**
  - Marijuana treatment data from Colorado in years 2006 – 2016 does not appear to demonstrate a definitive trend. Colorado averages **6,683** treatment admissions annually for marijuana abuse.
  - Over the last 10 years, the top two drugs involved in treatment admissions were alcohol and marijuana.
    - Interestingly, both legalized drugs.

Impact of Legalizing Marijuana on the Child Welfare System in Colorado:

Similar to Pennsylvania, the child welfare system in Colorado is state supervised and administered by each of their 64 counties. Not surprising, there is variation between the counties on how to interpret the child maltreatment law, whether or not they screen in or screen out a report of suspected child abuse or neglect and how they respond. Given the legalization of medicinal and recreational marijuana use, this variation amongst the counties is even more problematic when marijuana is the reason for the report. In addition, this variation in response by county agencies has created challenges for mandatory reporters who work within multiple counties. Although in general, many mandatory reporters have expressed uncertainty in when they should make a report when marijuana is involved.

The Colorado School of Public Health, in collaboration with The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect and the Children's Hospital of Colorado completed a Health Impact Assessment (HIA) in 2015 to provide evidence-informed recommendations to the

state, Colorado Department of Human Services, related to mandatory reporting and child welfare decision making practices when marijuana use is involved. In addition, the recommendations informed the development of House Bill (HB) 16-1385, which would update and modernize the definition of child abuse and neglect in Colorado as it relates to substances. These recommendations are based on their review of relevant scientific evidence, expert opinion from county child welfare workers, and stakeholder input.

Findings from the Health Impact Assessment:

Literature Review & Professional Expertise:

- Lack of research is available related to the impact of marijuana on parenting and caregiving of children.
    - They only discovered one study by Freisthler, Gruenewald and Wolf (2015)[3] which examined the relationship between marijuana use, medical marijuana dispensaries, and abusive and neglectful parenting. Marijuana use was positively related to frequency of physical abuse, however was negatively related to physical neglect (inability to provide for a child's basic needs). There was no relationship between supervisory neglect (lack of adequate supervision) and marijuana use. In addition, the density of medical marijuana dispensaries was positively related to the frequency of physical abuse.
- Existing research supports that physical hazards in marijuana grow-operations pose a threat to children residing there. Many homes with such operations tend to have illegal wiring or electrical bypasses, pesticides and chemicals present, unlocked access to the grow operation, and mold.
- Dr. George Sam Wang, Pediatric Emergency Medicine and Medical Toxicology at Children's Hospital of Colorado, is a stakeholder of the HIA. Dr. Wang shared data from his pediatric marijuana research that there has been an increase in children being evaluated for unintentional marijuana ingestion post legalization of marijuana.
    - Examples of clinical effects of marijuana exposure includes drowsiness/lethargy, ataxia/dizziness, agitation, vomiting, tachycardia, dystonia/muscle rigidity, respiratory depression, bradycardia/hypotension, and seizures.
    - Many of the pediatric exposures involve edible marijuana infused products like brownies and gummy bears that naturally appeal to children. In most cases the marijuana product belonged to a parent, family member or friend, and the exposure

[3] Freisthler, Gruenewald and Wolf (2015). A limitation for this study is that it does not identify if the marijuana use was medically prescribed or if the use was illegal (Data collected in 2009 and recreational marijuana was not legalized in California until 2016). Another limitation for this study is that some of the individuals also reported using alcohol (co-substance users), therefore the outcomes of this study is not based solely on marijuana use.

occurred at home as a result of poor child supervision or because the product was not stored in a safe manner.

Policy Review & Interviews with County Department Directors and Managers:

- All counties indicated that referrals involving marijuana were typically treated the same as referrals involving other substances.
    - Some counties treated marijuana referrals similar to alcohol, due to both substances being legal but there is still the potential for abuse.
    - Some counties treated marijuana referrals similar to prescription drugs, because while both substances have medical applications, there is still the potential for abuse.
    - Other counties treated marijuana referrals similar to methamphetamines, because either of these substances was perceived to be a serious concern.
- Most counties shared that they screened in marijuana referrals that included:
    - Evidence of physical abuse
    - Evidence of neglect
    - Prior criminal history
    - Co-substance use
    - Previous history with CPS
    - Documentation of marijuana effects
    - Inadequate environmental conditions
- Variability between counties on responses to referrals on:
    - Breast feeding mothers who use marijuana
    - Newborns who tested positive for tetrahydrocannabinol (THC)
    - Adolescent marijuana use
- Most counties had no current set protocol for approaching open cases or treatment related to marijuana use.
- Most counties stated that treatment for open cases involving marijuana always involved a form of education, discussion and implementation of safety or treatment plans, and/or treatment for the substance use.
- Most counties found it rare for open cases to only present marijuana use, and that most open cases involved co-occurring substance use.

<u>Recommendations from Health Impact Assessment:</u>

Recommendations for Mandatory Reporters Regarding Marijuana Use and Exposure:

1. A child protection report should be made when use of marijuana by a parent, guardian, relative, or adult who cares for a child threatens or results in harm to the health or welfare of the child.
    - Marijuana use resulting in impairment in the ability to supervise or provide age-appropriate care, as suggested by a statement or behavior, should be reported.

- Marijuana use that results in an environment that is injurious to the child should also be reported.
- Marijuana use during pregnancy and/or while breastfeeding should be reported if it results in a specific concern of harm or threat to the health or welfare of a child.

2. A child protection report should be made when a newborn tests positive for tetrahydrocannabinol (THC) at birth. Consideration should be given if the positive test is the result of the mother's intake of medical marijuana as recommended and monitored by a licensed healthcare provider who is aware of the pregnancy.
3. A child protection report should be made when there is a reasonable suspicion of pediatric exposure to or ingestion of marijuana as a result of knowing, reckless or negligent access.
    - Exceptions to this recommendation are:
        - Pediatric use of marijuana that is medically justified and under the supervision of a licensed physician;
        - The use of cannabidiol (CBD) oil medicinally.
4. A child protection report should be made when the manufacture, distribution, production, cultivation practices of marijuana is suspected of creating an environment that is injurious to the child.

Recommendations for Child Welfare Screening Regarding Referrals Related to Marijuana:

1. Child welfare should assign a report for assessment when use of marijuana by a parent, guardian, relative, or adult who cares for a child threatens or results in harm to the health or welfare of the child. Adult use with no other concerns should not be assigned. Consideration should be given if there is an alternative caregiver providing age-appropriate care.
    - This may include behavior suggesting impairment that impacts the ability to supervise or provide age-appropriate care.
    - This may also include marijuana use that results in an environment that is injurious to the child.
2. Child welfare should assign a report for assessment when a newborn test positive for tetrahydrocannabinol (THC) at birth.
    - An exception to this recommendation is if there is evidence that the positive test is the result of the mother's intake of medical marijuana as recommended and monitored by a licensed healthcare provider who is aware of the pregnancy.
3. Child welfare should assign a report for assessment when there is a reasonable suspicion that pediatric exposure or ingestion of marijuana has threatened or resulted in harm or the child's health or welfare.
    - An exception to this recommendation is an adolescent acquiring and using marijuana without parental knowledge.
4. Child welfare should assign a report for assessment when the manufacture, distribution, production, cultivation practices of marijuana is suspected of creating an environment that is injurious to the child through the exposure to a specific hazard.

Other Recommendations involving the Child Welfare System:

1. Enhancement to the Colorado TRAILS (official system of records for child welfare) database to tease out marijuana and other substances.

2. Systematic analysis of fatality, near fatality, and egregious harm data and examine associations with marijuana.

CONSIDERATIONS FOR PENNYLVANIA

In January 2019, Governor Wolf and Lieutenant Governor Fetterman announced that a listening tour would be launched statewide to hear from Pennsylvanians about the possibility of legalizing recreational marijuana. Governor Wolf said, "More and more states are successfully implementing marijuana legalization, especially those surrounding Pennsylvania, we should learn from their efforts, and better understand the potential impacts of this reality before taking any collective action."

Colorado's RMHIDTA advises citizens and policymakers in states considering legalizing marijuana to consider delaying any decision on this important issue until there is sufficient and accurate data to make informed decisions. According to the National Center on Substance Abuse and Child Welfare (NCSACW), the national average for cases where the prevalence of parental substance use was a contributing factor for reason for a child's removal increased 16.8% from 2000 (18.5%) to 2016 (35.3%). In 2016, 241,765 children were removed from their homes due to parental substance use and NCSACW cautions that there is still significant undercount in some states despite efforts to improve data collection.

On April 26, 2017, Ted Dallas, former Secretary of the Department of Human Services and Cathy Utz, former Deputy Secretary of the Department of Human Services, Office of Children, Youth and Families, testified at a public hearing to the House Children & Youth Committee about the impact parental substance use has on children and families becoming involved in the child welfare system, specifically the dependency in infants during the opioid epidemic.

> "During calendar year 2015, there were a total of 7,966 valid general protective services reports as a result of parental substance use. Of these, 799 were specific to children under the age of one. Further analysis of this data shows that 301 were specific to children who presented with withdrawal symptoms from prenatal exposure, three were identified as having fetal alcohol spectrum disorder (FASD), and 495 were identified as being affected by illegal substance use by the mother. Additionally, during the same year, 169 reports of child abuse were substantiated noting that parental substance use was a contributing factor in the child's abuse. For substantiated abuse cases, this is not limited to prenatal substance exposure.
>
> Parental substance use, particularly drug use, is identified as one of the leading reasons children enter out-of-home care in Pennsylvania. Based on placement data provided by county children and youth agencies, on September 30, 2015, approximately 16,000 children were in out-of-home care and of those children nearly 55% were removed from their homes as a result of parental drug use. Further analysis of data specific to children entering out-of-home care as a result of parental drug use suggests that 32% of those children had no other removal reason noted, while 24% also noted neglect and 14% noted inadequate housing as co-occurring reasons for removal."

In February 2019 the first Child Abuse Fatality/Near Fatality Trend Analysis Team Report was released by the Department of Human Services. The report details the analysis conducted for incidents that occurred in calendar years 2015 and 2016. There were 20 substantiated fatality and near fatality incidents where the use of a substance by the perpetrator directly impacted the incident. Out of these 24 perpetrators, 9 (38%) consumed prescribed medications, 13 (54%) consumed illegal drugs, and 12 (50%) consumed alcohol. Almost half (46%) of these perpetrators consumed more than one substance, 8 out of the 11 (30%) used both alcohol and marijuana. Furthermore, in 6 of the 9 (67%) fatality incidents, the use of a substance by the perpetrator was directly related to the incident of co-sleeping with aggravated circumstances. Four of these fatal incidents involved a perpetrator that combined alcohol with either a prescription medication or with marijuana.

The potential impact of legalizing marijuana on child welfare, including the dependency system, was further explored at the Spring 2019 Leadership Roundtable meetings. The following questions were asked on behalf of the Workgroup:

1. What impact, if any, has the legalization of medical marijuana had in your county?

2. If recreational marijuana use were to become legal in Pennsylvania, what are your thoughts/concerns?

Although some counties have encountered some issues with cases involving a parent being prescribed medical marijuana, the discussions were dominated by responses regarding Pennsylvania considering the legalization of recreational marijuana. Their comments varied from "legalize marijuana and just treat it like alcohol" to "legalizing marijuana will be a disaster… we will be opening Pandora's Box." The concerns and comments that were expressed about legalizing marijuana at the Spring 2019 Leadership Roundtables mirrored the same dialogs that have been discussed by members of the Workgroup.

On April 23, 2019, at the Pennsylvania Children's Roundtable Summit, Dr. Brian Feuhrlein gave a presentation on "Substance Use Disorders and Treatment." Dr. Fuehrlein is the Director of the Psychiatric Emergency Room at the VA Connecticut Healthcare System and an Assistant Professor of Psychiatry at Yale University. Dr. Fuehrlein discussed the various substance abuse disorders and medically managed treatment options. In addition, he discussed the science behind the latest clinical approaches to better understand the complex issues of addiction. At the conclusion of his presentation, he had enough time for one question – "Where does marijuana fit in?"

Dr. Feuherlein responded, "It's a good question and really difficult. Again, it's sort of like alcohol, where marijuana is becoming more legal and a little bit more accepted. Addiction psychiatry tends to believe that marijuana is still a very dangerous addictive substance that just because it's legal, does not endorse it to be safe."

In his response, Dr. Feuherlein mentioned the high risks for marijuana use in adolescents and young adults due to the plasticity of their brains and that their brains are still developing. He went on to say, "Marijuana tends to lead to other problems. People who are 13 years old who

want to experiment with marijuana but then say, well I can experiment with alcohol. I can experiment with cocaine. I can experiment with… So there is this whole gateway hypothesis, something that has been around for a very long time. But the first drug used by the vast majority of people with an addiction, the first drug used remains marijuana."

Dr. Feuherlein ended with what he believed was very important for the attendees at the Summit to hear, "If someone has a heroine use disorder, an opiate use disorder, and they're still smoking pot every day, I would say that they are not in recovery and are not sober. People who have addictions to alcohol, any drugs, they need to be sober. They need to be in recovery. They need to be off all substances."

A great amount of work has been done exploring how legalization of marijuana may impact child welfare but there still remains questions that are unanswered:

- **The intersect between "legal" marijuana and a child welfare:**
  - Difference between marijuana use and marijuana abuse?
  - Parent test positive for Tetrahydrocannabinol (THC), but has a medical prescription or if legalized?
    - Prenatal use?
    - Breast feeding mothers?
    - Limits their parental capacities?
  - Parent prescribed medical marijuana but can't afford so uses street marijuana instead.
  - Dependent child being prescribed medical marijuana knowing the impact on brain development?
  - Effect of marijuana use in a home where children reside? Especially for newborns.
  - Licensing and federal funding of homes for foster care and kinship with prescribed medical marijuana use or if becomes legalized?
  - Is there a correlation between the use of marijuana and infant rollover deaths?

- **Drug Testing & Treatment:**
  - Difference between legal vs. illegal usage?
  - What impact will the medical marijuana or if legalized marijuana have on Drug & Alcohol treatment?
  - What amount of use becomes a concern?
  - Is there a standard level for impairment?
  - What level becomes intoxication?
  - What are standard therapeutic levels if prescribed medical marijuana?
  - Different test for medical marijuana versus street marijuana?
  - What is the shelf life?
  - Is it a gateway drug? Very few use only marijuana.

- **Medical Marijuana Monitoring & Dispensaries:**
  - What are the uses of the different types of marijuana?
  - What are considered safe levels in the bloodstream?
  - How to monitor recommended use, misuse or illegally selling?
  - Are warning labels required?

- **Impact on System Partners:**
  - Impact on Specialty Courts?
    - Drug Treatment Courts?
    - Mental Health Courts?
  - Impact on Adult Probation?
  - Impact on Juvenile Probation?

The further the Workgroup explored this topic, the more questions were raised about the potential impact of legalizing marijuana, not only on child welfare, but also on our system partners. **The Workgroup encourages our system partners to start reviewing what impact, if any, the legalization of medical marijuana may have on their systems. In addition, the Workgroup strongly encourages our system partners to be proactive and collaborate with other stakeholders to begin planning for the possibility of recreational marijuana becoming legal in Pennsylvania.** At a minimum, policymakers need to allow time for these systems to prepare should they elect to legalize recreational marijuana in Pennsylvania.

❖ DEVELOP A RESOURCE ON SUPPORTING THE CHILD PRENATALLY EXPOSED TO DRUGS AND ALCOHOL:

The Workgroup is respectfully requesting to be relieved of this charge. The Governor's Institute on Plans of Safe Care is addressing infants affected by prenatal substance exposure, including alcohol, and their families to meet the new requirements from the federal Child Abuse Prevention and Treatment Act (CAPTA).

CONCLUSION:

The Workgroup continues its mission to encourage collaboration between the courts, child welfare, drug and alcohol agencies and now mental health providers. Collaboration leads to a deeper understanding of each system and creates a culture conducive to developing shared values. Creating such, in the Workgroup's opinion, is vital to lasting cultural change, better service delivery, providing effective treatment and ultimately assisting families in achieving recovery.

RECOMMENDATIONS:

The Drug and Alcohol Workgroup respectfully submits to the Pennsylvania State Roundtable the following recommendations:

1. Continue to test the Pennsylvania Drug & Alcohol In-Depth Analysis process in Luzerne County.

2. Provide an informative WebEx on the importance of leadership, forming partnerships and collaboration to create a culture change around Substance Use Disorder for counties interested in the Pennsylvania Drug & Alcohol In-Depth Analysis.

3. Complete the Drug & Alcohol Resource Guide to serve as a reference for counties involved in the Pennsylvania Drug & Alcohol In-Depth Analysis.

4. Finalize the benchcard for judges and hearing officers regarding things to consider when a parent is using substances, either because of a substance abuse disorder or as part of treatment.

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Office of the Attorney General
Washington, D. C. 20530

January 4, 2018

MEMORANDUM FOR ALL UNITED STATES ATTORNEYS

FROM: Jefferson B. Sessions, III
Attorney General

SUBJECT: Marijuana Enforcement

In the Controlled Substances Act, Congress has generally prohibited the cultivation, distribution, and possession of marijuana. 21 U.S.C. § 801 *et seq*. It has established significant penalties for these crimes. 21 U.S.C. § 841 *et seq*. These activities also may serve as the basis for the prosecution of other crimes, such as those prohibited by the money laundering statutes, the unlicensed money transmitter statute, and the Bank Secrecy Act. 18 U.S.C. §§ 1956-57, 1960; 31 U.S.C. § 5318. These statutes reflect Congress's determination that marijuana is a dangerous drug and that marijuana activity is a serious crime.

In deciding which marijuana activities to prosecute under these laws with the Department's finite resources, prosecutors should follow the well-established principles that govern all federal prosecutions. Attorney General Benjamin Civiletti originally set forth these principles in 1980, and they have been refined over time, as reflected in chapter 9-27.000 of the U.S. Attorneys' Manual. These principles require federal prosecutors deciding which cases to prosecute to weigh all relevant considerations, including federal law enforcement priorities set by the Attorney General, the seriousness of the crime, the deterrent effect of criminal prosecution, and the cumulative impact of particular crimes on the community.

Given the Department's well-established general principles, previous nationwide guidance specific to marijuana enforcement is unnecessary and is rescinded, effective immediately.[1] This memorandum is intended solely as a guide to the exercise of investigative and prosecutorial discretion in accordance with all applicable laws, regulations, and appropriations. It is not intended to, does not, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any party in any matter civil or criminal.

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[1] Previous guidance includes: David W. Ogden, Deputy Att'y Gen., Memorandum for Selected United States Attorneys: Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana (Oct. 19, 2009); James M. Cole, Deputy Att'y Gen., Memorandum for United States Attorneys: Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use (June 29, 2011); James M. Cole, Deputy Att'y Gen., Memorandum for All United States Attorneys: Guidance Regarding Marijuana Enforcement (Aug. 29, 2013); James M. Cole, Deputy Att'y Gen., Memorandum for All United States Attorneys: Guidance Regarding Marijuana Related Financial Crimes (Feb. 14, 2014); and Monty Wilkinson, Director of the Executive Office for U.S. Att'ys, Policy Statement Regarding Marijuana Issues in Indian Country (Oct. 28, 2014).

Colorado Department of Public Health & Environment: Monitoring Health Concerns Related to Marijuana in Colorado

Substantial and Moderate Findings from Systematic Literature Review (2014-2018):

	Substantial Evidence	Moderate Evidence
Cognitive Effect of Marijuana Use	Daily or near daily use is associated with impaired memory for at least 7 days after last use	
Cognitive and Academic Effects on Adolescents & Young Adults	Weekly use is associated with a lower rate of graduating high school	Weekly use is more likely to have impaired cognitive and academic abilities for at least 28 days after last use Weekly use is associated with a lower rate of attaining a college degree (among those who start a degree program)
Combined Marijuana & Alcohol Use	Combined use increases impairment and motor vehicle crash risk more than use of either substance alone	
Prenatal Marijuana Use & Effects on Exposed Offspring		Associated with attention problems Decreased cognitive function Decreased IQ scores
Mental Health Effects	Daily or near daily use is associated with future psychotic disorders like schizophrenia Use is associated with future psychotic symptoms (likelihood increases with more frequent use)	

APPENDIX II

Colorado Department of Public Health & Environment: Monitoring Health Concerns Related to Marijuana in Colorado

Substantial and Moderate Findings from Systematic Literature Review (2014-2018):

	Substantial Evidence	Moderate Evidence
Substance Use, Abuse, & Addiction for Adolescents & Young Adults	Those who use marijuana can develop cannabis use disorder (addiction) Marijuana use is associated with future use and use disorders for alcohol, tobacco and other drugs Marijuana use is associated with future increased marijuana use and use disorder	
Treatment	Treatment for cannabis use disorder can reduce use and dependence Those using daily or near daily can experience withdrawal symptoms when abstaining	Quitting marijuana use lowers the risk of adverse mental health effects
Unintentional Marijuana Exposure in Children	Legal marijuana access increases unintentional marijuana exposure in children	Child resistant packaging reduces unintentional pediatric poisoning