

IRP

focus

Vol. 36, No. 2

May 2020

ISSN: 0195-5705

Human services programs and the opioid crisis, Part 2

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*In September 2019, the Institute for Research on Poverty hosted a forum to examine how the opioid epidemic has affected the delivery of human services, and what role those services can play in mitigating the negative effects of the crisis on individuals, families, and communities. Entitled *Human Services Programs and the Opioid Crisis*, the event was convened in partnership with the Office of Human Services Policy, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. The forum had three objectives:*

- *To understand how the opioid crisis is hindering human services programs in meeting their objectives;*
- *To understand how human services programs can facilitate successful treatment and recovery for individuals with opioid use disorder; and*
- *To understand how human services programs can address the effects of the opioid crisis on their objectives.*

The forum brought together over 200 stakeholders representing 29 states from a broad range of organizations including eight federal agencies as well as numerous state and local governments, nonprofit organizations, and universities. This is the second of two issues of Focus to feature material from the forum. This issue contains six articles, three that explore how the opioid crisis is hindering human services programs in meeting their objectives, and three that address how human services programs can support successful treatment and recovery for individuals with opioid use disorder.

Rural communities' challenges in accessing treatment services

Patricia Strach, Elizabeth Pérez-Chiqués, and Katie Zuber

TAKEAWAYS

Despair is not killing rural Americans, easy access to opioids and lack of treatment is.

Existing infrastructure to treat addiction is not located where the problem has hit hardest.

Opioids have a broad effect on communities, including on foster care, schools, and the labor force.

People in local communities often feel forgotten—they want their government officials to listen to them and understand the problems they are facing.



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The following three articles explore how the opioid crisis is hindering human services programs in meeting their objectives. Patricia Strach, Elizabeth Pérez-Chiqués, and Katie Zuber describe the challenges of accessing treatment services in rural communities; Pamela Petersen-Baston details individual and systems barriers to addressing the opioid crisis; and Randi Walters and Brandi Stocksdales present Maryland's challenges in serving families struggling with substance use disorder.

In an effort to help state and federal lawmakers understand the day-to-day realities of the opioid crisis, including the challenges of accessing services in remote rural communities, we are conducting an in-depth study of the opioid crisis in three communities in New York State: a rural county (Sullivan), a suburban county (Orange), and an urban county (Queens). So far, we have conducted more than 170 interviews with law enforcement officers, lawyers, judges, doctors, nurses, social workers, government officials, activists, family members, and people in recovery, as well as state and some federal officials across the three areas. Our research is ongoing, and we hope to expand to more state and federal officials. We anticipate another 40 interviews, concluding in 2021. In this article, we focus in particular on rural Sullivan County, located 90 miles northwest of New York City (but with little public transportation access to the city).¹ Sullivan has one of the highest opioid-related overdose death rates of any New York county. Our research questions include:

- What does the opioid crisis look like in the local community?
- How has the community responded?
- What do people on the ground need from the government to address the crisis?

Access to opioids

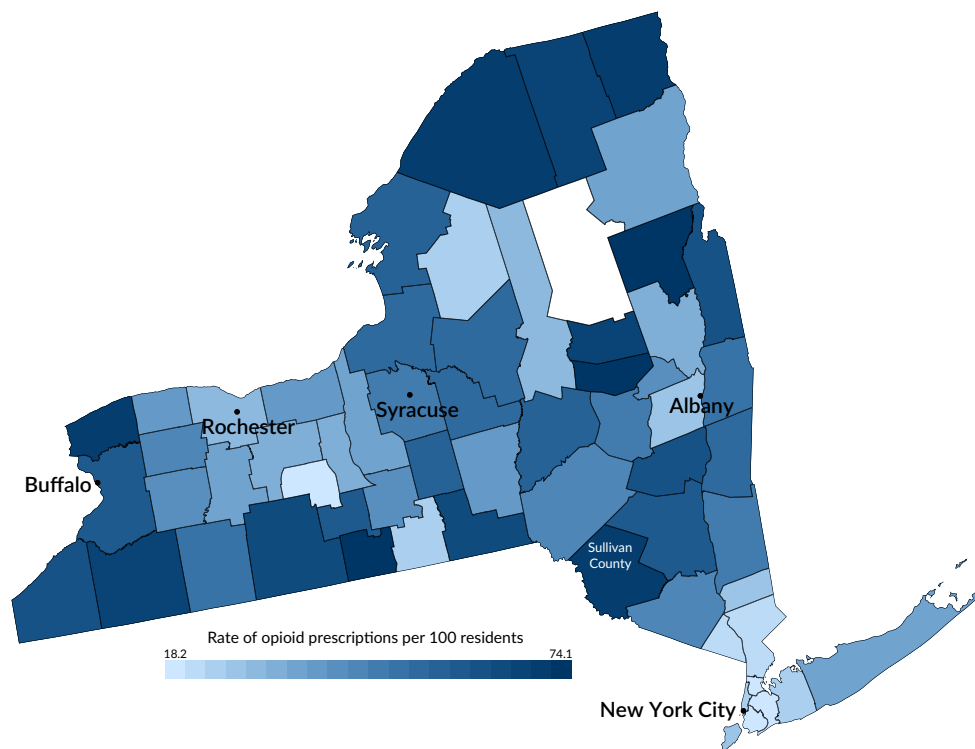
Opioid use is disproportionately more common among white, rural Americans, though national data indicate that drug overdose deaths in suburban and urban communities have now surpassed those in rural communities.² The media narrative around the opioid crisis has primarily been one of “deaths of despair.” According to this perspective, people living in small and economically depressed communities turn to drugs as a means of escape. This narrative, however, makes it too easy to write off communities rather than taking the time to understand and address how the opioid crisis has evolved in these communities. We wanted to look in more detail at the mechanisms through which drugs get into communities and affect particular groups of people. We found that rather than a black cloud of despair, rural communities have easy access to opioids but lack access to treatment.

Both white Americans and those living in rural areas have had greater access to opioid prescriptions than non-whites and those living in urban areas. Access to prescription drugs—and specifically prescription opioids—among white Americans is partly explained by the fact that they have greater access to

healthcare than their non-white counterparts. In addition, white Americans receiving care are prescribed pain killers at a higher rate than non-white Americans. A 2012 study found that while Hispanics in the United States were as likely as non-Hispanic white Americans to be prescribed some type of pain medication, they were 22 percent less likely to receive opioids. African Americans were 22 percent less likely to be prescribed *any* pain medication compared to white Americans, and 29 percent less likely than white Americans to receive opioids for similar conditions.³ For types of pain that require physician discretion to evaluate (such as backache or migraine, as compared to back surgery or an accident) the rates are even higher; African Americans were 34 percent less likely to receive opioids for similar conditions.⁴ The Centers for Disease Control and Prevention has documented that physicians in rural areas are much more likely to prescribe opioids compared to physicians in urban areas, potentially due to higher rates of injury.⁵

These patterns hold true in New York State where prescription rates are much higher in rural areas than in urban areas (Figure 1). The rates shown in the figure are from 2018, after opioid prescription rates had declined from their 2012 peak.⁶ Still, a great deal of variation between counties remained. For example, the 2018 opioid prescription rate in urban Queens County was 18.6 prescriptions per 100 people, compared to 59.0 in rural Sullivan County. The differences in prescribing rates may be explained by varying practices by doctors in each location and by differences in the populations they serve. As discussed above, prescribing varies by race and Sullivan County is majority white (72 percent), while Queens County is majority non-white (white population is 25 percent).⁷

Figure 1. Access to prescription opioids tends to be higher in more rural counties in New York.



Source: U.S. Centers for Disease Control and Prevention, U.S. County Prescribing Rates, 2018.

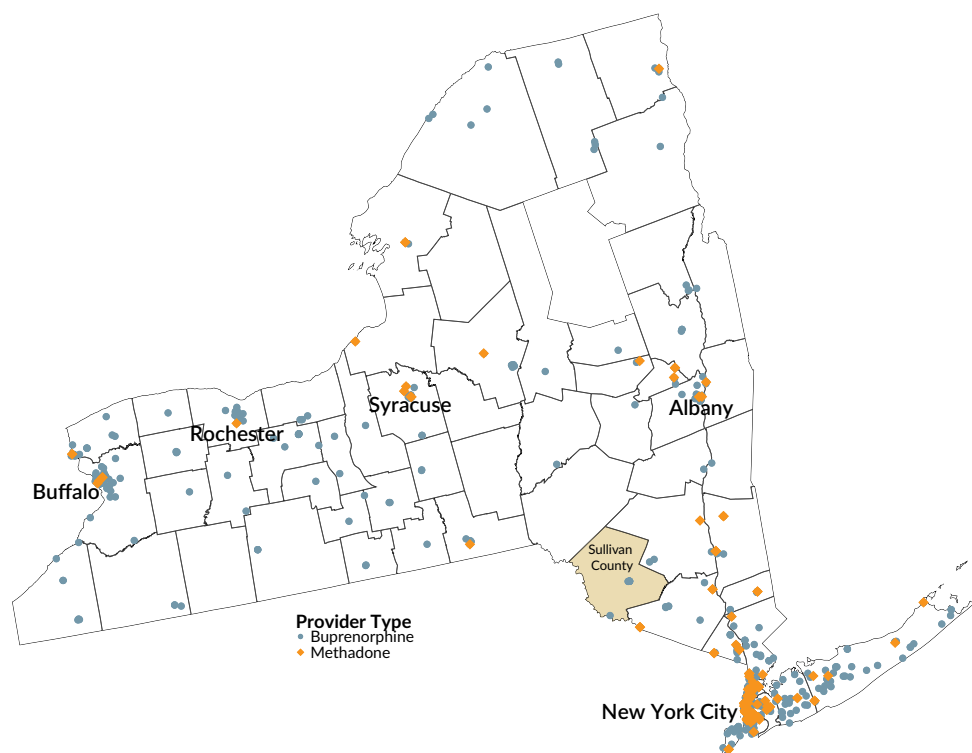
Rural challenges

The challenges raised in our discussions with policymakers, health officials, community activists, and providers in Sullivan are similar to those in many areas of the country; it is difficult to obtain appropriate treatment for opioid-use disorder, and even when an individual is able to successfully complete treatment, there are few wraparound services available to help them find housing and employment. However, these problems are exacerbated in rural areas like Sullivan, where both services and transportation are lacking.

Access to treatment

While accessing appropriate treatment is often a challenge, the particular issues that limit access vary. In an urban area like New York City, the primary challenge is often financial; services are generally available, but those who need them may not be able to pay. In a rural area like Sullivan County, however, some treatment services are simply not available at any price. Figure 2 shows the locations of treatment options in New York State. Sullivan, a county of 1,000 square miles, has three in-patient treatment options within the county, several buprenorphine practitioners who provide outpatient services, and no methadone clinics. Yet, even these listed options are not always available in practice.⁸ A recent article found that most doctors on the federal provider database had no available appointments, and those that did have appointments had wait times exceeding two weeks.⁹

Figure 2. Medication-assisted treatment options in New York State tend to be clustered around metropolitan areas.



Note: A single dot may represent more than one provider of the same type in the same location.

Source: Substance Abuse and Mental Health Services Administration Treatment Locator, Accessed July 19, 2019.

Because it is far enough away from New York City, but close enough to be accessible, Sullivan County has more options than other rural communities. Very few inpatient treatment facilities exist in rural areas of the state, with service providers relying primarily on outpatient treatment. These services, which may be available only during business hours, could be virtually inaccessible to those who work or have childcare issues.

While our study is being conducted in New York State, geographic variability in access to treatment exists nationwide. For example, more than half of all U.S. counties lack physicians who can prescribe buprenorphine—a medication used to block the effects of opiate withdrawal—leaving 30 million people without access in these mostly rural communities.¹⁰ Buprenorphine is an effective treatment for opioid use disorder and can be provided in office-based settings, but physicians must obtain a waiver from the Drug Enforcement Administration in order to prescribe it.

Transportation

Almost every person we interviewed in Sullivan County identified lack of transportation as a critical issue. Sullivan County, home to 78,000 people, is approximately the same size as the state of Rhode Island. However, the county has only two daily bus routes. Transportation is particularly challenging for those who do not have a valid driver's license or access to a car. While Medicaid will pay for taxis to medical appointments, it does not pay for transportation for other necessities, like going to and from work or to the pharmacy or grocery store. Ironically, we learned that the lack of transportation does not disrupt the flow of drugs into these communities. As one mother observed, “we can't get a pizza delivery, but we can get a heroin delivery.”

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Post-treatment services

People who successfully complete a drug treatment program further struggle with accessing post-treatment services. To stay in recovery most need help securing and keeping safe housing and stable employment. Unfortunately, in remote rural areas like Sullivan, these post-treatment services are also lacking.

Finding safe housing is particularly challenging for those who complete drug treatment. As a lawyer explained to us, once people with addictions finish a program, they are typically forced back into the same communities they came from and they relapse: “aftercare treatment is homelessness.” People in recovery are “thrown back into the street, thrown back into their parents' house, they're just thrown back into the same place they were, but without the right tools . . . to succeed.” Those completing treatment thus often end up in the same communities—and the same conditions—that they came from, increasing their likelihood of relapsing.

People who have addictions (and possibly criminal records, often because of their addictions), frequently have difficulty finding and maintaining steady employment in any environment, and these issues are likely exacerbated in rural communities. The agricultural and tourism industries that once drove Sullivan's economy have declined substantially,

leaving few jobs that pay a living wage. For some, transportation issues may put these few good jobs even further out of reach.

Capacity to provide needed services

A final challenge that rural communities face is a lack of capacity—through resources and infrastructure—to provide needed services. Even if local officials have the will to address the problem of drug addiction in their community, including spillover effects on areas such as foster care (see text box), they often lack an effective way to implement a solution. Local officials with whom we spoke noted that they are at a severe disadvantage when applying for competitive state grants, because the number of people to be served may be below the grant threshold and because they do not have professional grant writers to make their case.

This lack of capacity can be illustrated when considering the issue of inpatient treatment. From our very first day of doing interviews, we heard about “beds” from grassroots organizers who told us “there are no beds,” to a state official who said, “getting a bed is a wait.” However, the state has a database showing that the physical capacity exists to treat more than a thousand people in an inpatient setting. While these treatment slots may be technically available, they are in practice inaccessible to people who need them, due in part to staffing shortages. Half of all agencies specializing in treating substance use disorder say they have difficulty filling open positions, primarily due to a lack of qualified applicants. Shortages of treatment professionals is a problem across the United States, but it is especially challenging in rural areas that lack physicians, social workers, credentialed alcohol and substance abuse counselors, nurse practitioners, and support staff. If an inpatient treatment slot is available but there is no receptionist to answer the phone, then the bed will go unfilled.

People in local communities want to be heard

We asked all of our interviewees: “What do you want state and federal policymakers to know?” The answers we heard surprised us. While people did note the need for additional resources, they spent the most time talking about how they wanted to be heard and understood. One provider, referring to state and federal officials, said:

Foster care:

When discussing how to address the opioid epidemic, policymakers often frame it around the people with addictions and treating those addictions. However, the implications of those addictions spill over and affect families, schools, and communities. As such, policy and program strategies must consider effects in these other areas. A prime example is the child welfare system. One of the most challenging aspects of opioid addiction, to both families and the systems designed to support them, is the removal of children from the home in the context of parental drug abuse.

As the opioid epidemic has developed, the number of children removed from home and placed in foster care has been growing. Nationwide, the number of children in foster care rose about 10 percent from 2012 to 2018 after a decade of decline.¹ Rural Sullivan County has seen an even more dramatic rise in foster care placements over the same time period. In 2012, there were only 75 children in foster care in the county, but by 2018 there were 122, an increase of over 60 percent. However, Sullivan County’s experience stands in contrast with the rest of New York State; foster care placements declined during this same time period in both New York City and Upstate New York.²

While a causal link between opioid use disorder and the rise in foster care rates has not been established, child welfare data show that substance use is a challenge for many parents in that system. For example, in 2017, more than a third of children placed in foster care nationwide had parental drug use listed as a reason for removal.³ In addition, the rate of children entering foster care due to parental drug use rose each year from 2011 to 2017, up to 131 per 100,000 children in the U.S.⁴ Finally, studies have shown that parents who use opioids are less likely than other drug users to retain custody of their children.

Increases in foster care placements affect not only family well-being, but also government budgets. Children in foster care have higher rates of behavioral, emotional, and health issues, both because of the family circumstances that put them into the foster care system in the first place and as a result of the system itself.⁵ Foster care is also expensive. Increases in foster care placements lead to increased costs for counties, straining their already tight foster care budgets. For example, in New York State, the average annual cost for a child in foster care was over \$56,000 in fiscal year 2010–2011.⁶

¹<https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/afcars>

²<https://www.acf.hhs.gov/cb/resource/trends-in-foster-care-and-adoption>

³<https://www.childtrends.org/one-in-three-children-entered-foster-care-in-fy-2017-because-of-parental-drug-abuse>

⁴<https://www.childtrends.org/one-in-three-children-entered-foster-care-in-fy-2017-because-of-parental-drug-abuse>

⁵J. J. Doyle, “Child Protection and Child Outcomes: Measuring the Effects of Foster Care,” *American Economic Review* 97, No. 5 (December 2007): 1583–1610; M. E. Courtney and A. Dworsky, “Early Outcomes for Young Adults Transitioning from Out-Of-Home Care in the USA,” *Child & Family Social Work* 11, No. 3 (2006): 209–219.

⁶G. Wallace and R. Johnson, New York State - Child Welfare Costs and Kinship Services, New York State Kinship Navigator, Rochester, NY, n.d. available at: <http://www.nysnavigator.org/pg/professionals/documents/NewYorkStateChildWelfareCostsandKinshipCare.pdf>

The information that's down here, the people that are in the trenches, doesn't get up there. It just doesn't. And then they make decisions based on a disconnect. And then people scream loud enough and in 10–20 years we come back around and are having the same argument all over again. If that makes sense. So, besides the obvious, I really think they need to turn off their brains, turn on their ears.

Another provider in an urban area told us:

People are suffering. People are hurting...Walk into one of these rat den buildings that they rent out in Newburgh. And say “if I had to live there every night, what would it be like for me?” You know. How easy would it be to get up and look for a job if I...have rats and cockroaches...where I have to put cotton balls in my kid's ears so a roach doesn't crawl into their ear and get stuck there. You know, see what people live through, not with [a] camera, by yourself. Go out with one of my caseworkers one day. And see what they have to do in a day to help families.

People in local communities felt forgotten by their state and federal officials. As one mother observed, “If it's a crisis, why don't you treat it like one?”

Conclusion

The opioid epidemic is deadly, and it is particularly devastating for rural communities. Overdose deaths are explained primarily not by a cloud of despair hanging over communities, but by concrete mechanisms such as physician prescription patterns and a lack of treatment options. To better address the opioid crisis, policymakers must address the concrete challenges that communities face in order to connect people in need to appropriate treatment. ■

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¹This article draws on the both the presentation by Patricia Strach and Elizabeth Pérez-Chiqués at the September 2019 poverty research and policy forum, *Human Services Programs and the Opioid Crisis*, and on P. Strach, K. Zuber, and E. Pérez-Chiqués, *Stories from Sullivan: How a Rural Community Addresses the Opioid Crisis*, Volume 1, Rockefeller Institute of Government, June 27, 2018. Available at: <https://rockinst.org/issue-area/stories-from-sullivan-vol-1/>

²S.H. Woolf, and H. Schoomaker, “Life Expectancy and Mortality Rates in the United States, 1959–2017.” *JAMA* 322, No. 20 (2019): 1996–2016.

³S. H. Meghani, E. Byun, and R. M. Gallagher, “Time to Take Stock: A Meta-Analysis and Systematic Review of Analgesic Treatment Disparities for Pain in the United States,” *Pain Medicine* 13, No. 2 (February 2012): 150–174.

⁴S. H. Meghani, E. Byun, and R. M. Gallagher, “Time to Take Stock.”

⁵M. C. Garcia et al., “Opioid Prescribing Rates in Nonmetropolitan and Metropolitan Counties Among Primary Care Providers Using an Electronic Health Record System—United States, 2014–2017,” *Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report* 68, No. 2 (January 18, 2019); G.E. Metcalf and Q. Wang, “Abandoned by Coal, Swallowed by Opioids,” NBER Working Paper No. w26551, National Bureau of Economic Research, 2019. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3504435.

⁶Opioid prescription rates rose steadily from 2006 to 2012, peaking at a national average of 81.3 prescriptions per 100 people. The rate then declined from 2012 to 2017, to 58.7 prescriptions per 100 people. See <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html>, accessed February 4, 2020.

⁷U.S. Census Bureau, “2018 American Community Survey 5-Year Estimates,” Table DP05.

⁸P. Strach, K. Zuber, and E. Pérez-Chiqués, “Why Policies Fail: The Illusion of Services in the Opioid Epidemic.” *Journal of Health Politics, Policy, and Law* 45, No. 2 (2020): 341–364.

⁹L. Flavin, M. Malowney, N.A. Patel, M.D. Alpert, E. Cheng, G. Noy, S. Samuelson, N. Sreshta, and J. W. Boyd, “Availability of Buprenorphine Treatment in the 10 States with the Highest drug Overdose Death Rates in the United States.” *Journal of Psychiatric Practice* 25, No. 1 (2020): 17–22.

¹⁰R. Rosenblatt, C. H. A. Andrilla, M. Catlin, and E. H. Larson, “Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder,” *Annals of Family Medicine* 13, No. 1 (2015): 23–26.

Type of analysis: Qualitative

Data source: Interviews with law enforcement officers, lawyers, judges, doctors, nurses, social workers, government officials, activists, family members, and people in recovery.

Type of data: Interviews

Unit of Analysis: Counties

Sample definition: Three counties in New York State: Sullivan County (rural); Orange County (suburban); and Queens County (Urban, in New York City).

Time Frame: Study began in 2017 and is ongoing.

Limitations: This is a qualitative analysis, and the results are not necessarily representative of the entire population.

Barriers to addressing the opioid crisis

Pamela Petersen-Baston

TAKEAWAYS

No single approach can solve all the issues related to the misuse of opioids and other drugs.



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There are two types of barriers to addressing the opioid crisis:

those related to individuals, and those related to systems.

Although there is a considerable amount of research on the most effective ways to treat opioid use disorder, there are also many missed opportunities to apply common sense and compassion.

Individual barriers

While there is an extensive knowledge base about brain and behavioral science, the evidence does not always reach behavioral health professionals or other professionals who interact with people with substance use disorder. In particular, many such professionals have not received training about how opioid use disorder reduces an individual's ability to prioritize beneficial behaviors over destructive ones. They may also be unaware of the research that shows that those with substance use disorder have a limited ability to exert control over destructive behaviors, even when not dealing with these behaviors could lead to catastrophic results.

Lack of knowledge about brain and behavioral science findings on addiction may lead to stigmatization of opioid use disorder.

Lack of knowledge about brain and behavioral science findings on addiction may lead to stigmatization of opioid use disorder and other substance use disorders. When a provider inaccurately believes that a person has control over substance use disorder, they may blame the patient for developing the condition. In turn, people who experience this stigma may be less likely to seek out treatment services and access those services, and more likely to drop out of care early when they do access it.

While the initial decision to use substances may be voluntary (though coercion is sometimes a factor), the brain changes that occur in some substance users over time may challenge a person's self-control and ability to resist intense impulses to continue using substances.

Individuals struggling with opioid use disorder often have significant and complex histories of physical and sexual abuse, abandonment, loss, and associated trauma that adversely affect their ability to engage in and comply with treatment programs. Trauma-informed treatment has been shown to effectively address challenging behaviors exhibited by individuals with a history of trauma.

In addition, individuals often have complex family dynamics such as multi-generational substance use disorder, multi-age sibling groups who are themselves adversely affected by parental use, or drug-using partners who can sabotage recovery efforts. Failure to address these complex issues can result in

treatment failure for the individual, and missed opportunities to stabilize their family and environment.

Systems barriers

Punitive rather than therapeutic enrollment policies and excessive wait times contribute to a system that is extremely difficult to navigate, even for people who work in the field, let alone for people in need of treatment.

Punitive rather than therapeutic enrollment policies and excessive wait times contribute to a system that is extremely difficult to navigate

Only about 10 percent of people who need treatment get it, and treatment often begins years, and in some cases, decades, after the onset of drug dependence.¹ Overall, patients participating in addiction treatment programs have less than a 50 percent completion rate.² Some programs eject people for exhibiting behaviors that are the very symptoms of their substance use disorder, such as having a positive drug test. In the treatment of any other health condition—for example, diabetes or hypertension—a return of symptoms would lead to continuing or adjusting treatment rather than halting it. Further, treatment programs rarely accommodate families; only about 3 percent of residential programs allow mothers and children to stay together.³ We can and must do better.

The National Institute on Drug Abuse reports that for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and a longer treatment period is recommended in order to maintain positive outcomes.⁴ For methadone maintenance, 12 months is considered the minimum, and some opioid-addicted individuals continue to benefit from methadone maintenance for many years, but many treatment programs are successful with a treatment period of less than one year.⁵ Similarly, while at least five years of continuing care is recommended to ensure that a person stays in recovery, few programs offer this.⁶

Medication assisted treatment, which combines behavioral therapy and medications, has proven to be a particularly effective treatment for substance use disorders.⁷ However, many programs do not offer this type of treatment. Finally, when substance use disorder recurs following treatment, this is generally attributed to a failure of the patient rather than a failure of the treatment method.

The combination of individual and systems barriers to addressing the opioid crisis suggests that no single approach can end the opioid crisis. However, it is possible to align and balance services, supports, and accountability with the challenges that individuals and families with opioid use disorder present to human services programs. Individuals directly and indirectly affected by opioid and other substance use disorders deserve nothing less. ■

Pamela Petersen-Baston is Technical Expert Lead on the opioid epidemic at JBS International.

¹E. Park-Lee, R. N. Lipari, S. L. Hedden, L. A. Kroutil, and J. D. Porter, “Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2016 National Survey on Drug Use and Health,” *CBHSQ Data Review*, Substance Abuse and Mental Health Services Administration, 2017.

²Substance Abuse and Mental Health Data Archive, Treatment Episode Data Set (TEDS), Discharges from Substance Abuse Treatment Services, November 21, 2018, accessed April 21, 2020 at <https://www.datafiles.samhsa.gov/study-series/treatment-episode-data-set-discharges-teds-d-nid13520>

³JBS International, Inc. and The Center for Children and Family Futures, Inc., “Family-Centered Treatment for Women with Substance Use Disorders—History, Key Elements, and Challenges,” Report submitted to the Substance Abuse and Mental Health Services Administration, 2007.

⁴National Institute on Drug Abuse, “Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition),” January 2018, available at <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition>

⁵National Institute of Drug Abuse, “Principles of Drug Addiction Treatment.”

⁶W. L. White, “Recovery Durability: The 5-year Set Point,” 2013, available at <http://www.williamwhitepapers.com/blog/2013/07/recovery-durability-the-5-year-set-point.html>

⁷National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy, Medication-Assisted Treatment for Opioid Use Disorder: Proceedings of a Workshop—in Brief, National Academies Press, Washington, D.C., 2018, available at <https://www.ncbi.nlm.nih.gov/books/NBK534504/>

Maryland's approach to the opioid crisis

Randi Walters and Brandi Stocksdales

TAKEAWAYS

Barriers associated with systems, and with service needs and availability, present challenges to addressing the opioid crisis at the state level.



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To better address the opioid crisis, Maryland officials are working to provide family-focused services that include both parents and children.

Barriers to serving families struggling with substance use disorder in Maryland

The state of Maryland has identified multiple challenges in its efforts to address the opioid crisis. Some of these challenges have to do with systems. There is a lack of coordination across state agencies, and it can be difficult to share information across agencies because of privacy restrictions. There are also many alternate funding streams, which can be difficult to understand and align. In addition, historically there has been an emphasis on collecting specific data points rather than looking for patterns; this may result in missing public health lessons about the population as a whole.

Other challenges have to do with service needs and availability. When assisting people with substance use disorder, trauma-informed services are needed. Because a large proportion of people with this issue also have a history of trauma, service providers need to be aware of what has happened to their clients and provide services in a way that addresses ongoing effects of that history. There has also been a steady increase in the number of substance-exposed newborns in Maryland. The additional barriers specific to treating these newborns include inconsistent testing and reporting practices among hospitals.¹ Finally, when an individual is ready for help with a substance use disorder, they should be able to access treatment immediately, but that is often not the case. Available services differ greatly by geographical location. There is also a notable shortage of inpatient treatment slots for parents with children.

Social safety net challenges and barriers

Policymakers need to acknowledge the intersection between poverty and opioid use disorder and take steps to address it. For example, individuals who are on assistance such as Temporary Assistance for Needy Families (TANF), may not ask for help related to their addiction for fear of losing benefits. For those who do seek help, there is a lack of opioid use disorder programs tailored specifically to the needs of low-income single mothers. Further, compliance-focused programs such as TANF have program rules—such as work requirements—that may be incompatible with providing a continuum of care services.

Child support challenges and barriers

Low-income noncustodial parents—generally fathers—often face multiple barriers to employment, including substance abuse, that hinder their ability to financially support their children. Like the social safety net, the child support system has focused heavily on compliance. Maryland is working to engage noncustodial parents in a different way by identifying and addressing the factors that stand in the way of their paying child support. Shifting from an

enforcement-oriented to a service-oriented approach will require allocating additional funding for noncustodial parent employment and training programs.

Policymakers need to acknowledge the intersection between poverty and opioid use disorder and take steps to address it.

Maryland faces a number of challenges in providing services to families struggling with the effects of opioid use disorder. The Maryland Department of Human Services is working to address these challenges. For example, we are providing cross-systems training for staff working in programs serving children to increase awareness of the rules and procedures in related programs and agencies, increasing coordination between systems, and understanding and aligning funding streams. ■

Randi Walters is the Director of the Baltimore City Department of Social Services; Brandi Stocksedale is the Deputy Director for Child and Family Services at the Baltimore City Department of Social Services.

¹For a summary of Dr. Stephen Patrick’s keynote address from the Forum, covering the topic of substance-exposed infants and their mothers in detail, see: S. W. Patrick, “Understanding the Needs of Families During the Opioid Crisis,” *Focus* 36, No. 1 (2020): 7–14.

The response of state courts to the opioid crisis

Deborah Taylor Tate

TAKEAWAYS

The state court justice system is the largest source of referrals to treatment for substance use disorder in the United States and is thus well-situated to develop innovative ways of addressing the opioid epidemic.

Substance use disorder affects every part of the court system, not just criminal justice, including referrals to foster care.

Addiction to other substances and mental health issues must also be considered in any strategies to address the opioid crisis.



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The following three articles address how human services programs can support successful treatment and recovery for individuals with opioid use disorder. Deborah Taylor Tate details how the justice system can lead the way in addressing the opioid crisis; Kimberly Hall describes Ohio's response; and Barbara Ramlow outlines Kentucky's Targeted Assessment Program.

The state court justice system is now the largest source of treatment referrals for substance use disorder in the United States. These courts are in a position to play a crucial role in addressing the opioid epidemic. Addiction to illegal and legally obtained opioids is not solely a criminal justice issue, but affects every part of the court system. This includes referrals to foster care for children whose parents cannot safely care for them in their homes due to substance abuse. Many people are arrested for crimes related to their substance use disorder, filling jails over capacity, especially in depressed and rural areas. Over three-quarters of those held in jails are not convicted of a crime; some have been recently arrested and will be released on bail, while others cannot afford bail and must remain in jail until their case comes to trial.¹ Jails also house individuals who are waiting for a treatment slot to become available after being sentenced by a judge in drug court to probation contingent on completion of a residential treatment program.²

Incarcerated women with substance use disorder face heightened challenges. Research suggests that the majority of women in county jails have substance use disorders, making them candidates for treatment; many also have mental health issues.³ However, there are fewer treatment beds available for women than for men. This problem has been exacerbated by the dramatic rise in female incarceration in recent decades—the incarceration rate for women in county jails has increased more than 800 percent since 1980.⁴ As a result, when women wait in jail for a residential treatment slot, the wait time is often much longer than that for men.

If courts can devise new strategies for handling cases related to substance use disorder and mental health issues, it may be possible for people who need treatment services to receive them without first having to be incarcerated.

The National Judicial Opioid Task Force

The need for the justice system to take a proactive approach to substance use disorder led the Conference of Chief Justices and the Conference of State Court Administrators to form the National Judicial Opioid Task Force in 2017. Since then, the Task Force has developed a Resource Center that includes tools and other resources to assist courts (and other entities) in addressing the opioid crisis.⁵ These resources include some specific to particular populations, such as American Indians and Alaska Natives who have cases in tribal courts rather than state courts. In November 2019, the Task Force released a final report detailing recommendations, tools, best practices, and examples of successful programs.⁶ The report found that:

- There is a lack of access to and education about the use of quality, evidence-based treatment for opioid use disorder, including medication assisted treatment that combines medication with counseling and behavioral therapies;
- The devastating effects of the opioid epidemic are most clearly seen in cases involving children and families;
- Although the opioid crisis is a national issue, state and local governments bear much of the burden, so it is necessary for Congress and federal agencies to recognize state courts as essential partners in the response to the opioid crisis; and
- State courts must design programs and resources that will provide an effective response to future addiction crises, not just the current opioid crisis.

Within the state court justice system, there are many examples of promising approaches to the opioid epidemic.

Examples of promising state programs and responses to the epidemic

Within the state court justice system, there are many examples of promising approaches to the opioid epidemic; a few of these are detailed below.

The power of judges as “conveners”

Individual judges, in their role as community leaders, have taken the initiative to convene emergency summits and to create state, regional, and local opioid task forces. These groups of stakeholders study the problems in their communities and craft targeted responses, utilizing all available resources.

The Sequential Intercept Model

The Sequential Intercept Model is a strategic planning tool that helps communities better understand the gaps and resources they have in helping those with mental illness or substance use disorders who are in the criminal justice system. The model identifies six key points during the criminal justice system process at which services can be provided: when a person seeks community services, encounters law enforcement, is detained and appears at initial court hearings, is in jail or at court, reenters the community after incarceration, or is on probation and parole. Judicial involvement at all of these points, not only when cases come to court, could help prevent issues from escalating and promote recovery.

Pretrial reform

Criminal justice reforms can help address the opioid crisis. For example, pretrial risk assessment tools could help get people into needed treatment rather than putting them in jail.

Faith and justice initiatives

Some states are combining faith-based and judicial approaches to the opioid crisis. For example, the Tennessee Faith & Justice Alliance trains congregants on issues related to substance use disorder and provides information on treatment options. To be considered a “recovery congregation,” faith-based organizations must meet the following six criteria:

provide spiritual and pastoral support to congregants; view substance use disorder as a treatable disease rather than a moral issue; embrace and support people in recovery; provide visible outreach in their community; share recovery information; and host recovery support groups.

Several states have developed or expanded family treatment drug courts in response to increasing numbers of parents with opioid use disorders whose children are in foster care.

Specialty courts

Traditional drug courts in many states have revised their operations and procedures in response to the opioid crisis, in part by ensuring access to all forms of medication assisted treatment. In addition, several states have developed or expanded family treatment drug courts in response to increasing numbers of parents with opioid use disorders whose children are in foster care because the parents are unable to properly care for them.

Examples of new specialty courts include:

- **Opioid Intervention Court** in Buffalo, New York; following an arrest, defendants are evaluated by medical professionals and the District Attorney to determine program eligibility. If they are deemed eligible, they are taken immediately through detox, and then begin residential or outpatient treatment. Program participants have strict curfews, and must appear in court each day for at least 30 days. After program completion, defendants are transitioned to traditional drug court programs.
- **Safe Baby Court** in Tennessee, a specialized rural court program for parents of infants and toddlers up to age 3. The program coordinates community resources, services, and long-term support, with a goal of connecting families with young children to their communities and providing a strong foundation for infant mental health.

Reducing the risk of overdose death during and after incarceration

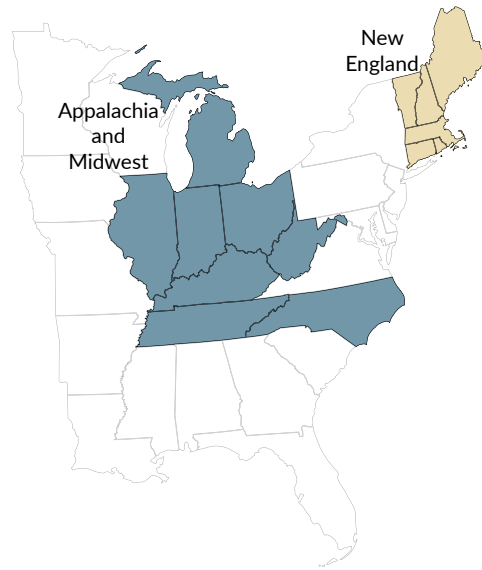
Examples of programs designed to reduce the risk of overdose death during a jail or prison sentence and after reentry include:

- **Medication Assisted Treatment Reentry Initiative** in Massachusetts, which provides both pre-release treatment and post-release referral for inmates with opioid or other substance use disorder, with the goal of providing comprehensive reentry services. Participants also receive Naltrexone, a medication that blocks the effects of opioids, including pain relief or feelings of well-being.
- **Access to Treatment for Inmates** in Rhode Island is an innovative statewide initiative that offers medication assisted treatment to every inmate in the system.

Regional Judicial Opioid Initiatives

The Conference of Chief Justices and Conference of State Court Administrators have created and supported two cross-border collaborations in areas hardest hit by the opioid epidemic. These are judicially led initiatives among groups of states that are similarly affected by the opioid crisis. States share information about the reach of the crisis, data, and successful programs and practices. As shown here, the two groups are:

- **Appalachia and the Midwest**, including Illinois, Indiana, Kentucky, Michigan, North Carolina, Tennessee, Ohio, and West Virginia; and
- **New England**, including Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.



Continuing efforts

While the justice system has already taken many actions to help address the opioid crisis, more remains to be done. The final report of the National Judicial Opioid Task Force, released in November 2019 and described above, contains recommendations and resources for continued judicial efforts across the country. Most importantly, it is clear that the current crisis is not just an opioid problem, but includes addiction to other substances and mental health issues. The Task Force is thus expanding its focus to a broader addiction and mental health approach. ■

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³C. A. McNeely, S. Hutson, T. L. Sturdivant, J. M. Jabson, and B. S. Isabell, “Expanding Contraceptive Access for Women with Substance Use Disorders: Partnerships Between Public Health Departments and County Jails,” *Journal of Public Health Management and Practice* 25, No. 3 (2019): 229–237; S. Fazel and J. Danesh, J (2002) “Serious Mental Disorder in 23000 Prisoners: A Systematic Review of 62 Surveys.” *Lancet* 359, No. 9306 (2002): 545–550.

⁴McNeely, Hutson, Sturdivant, Jabson, and Isabell, “Expanding Contraceptive Access for Women with Substance Use Disorders.”

⁵National Judicial Opioid Task Force, Tools and Resources for Courts. Accessed April 30, 2020 at <https://www.ncsc.org/~media/Files/PDF/Topics/Opioids-and-the-Courts/NJOTF%20Resources/NJOTFToolsandResources111819.ashx>

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Ohio's actions to address the opioid crisis

Kimberly Hall

TAKEAWAYS

State and local agencies must work together in a collaborative and integrated way to combat the opioid crisis.



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In Ohio, opioid misuse is a public health crisis; each day 13

Ohioans die from unintentional overdose.¹ The crisis affects not just individuals, but also families; when parents are unable to safely care for their children for any reason, including substance misuse, those children may be placed in foster care. The number of Ohio children in foster care has risen from about 12,800 in 2013 to nearly 16,000 in 2018.

Ohio Governor Mike DeWine created the RecoveryOhio initiative, a statewide effort to address opioid misuse, with three goals: to offer direction for the state's prevention and education efforts; make treatment available to Ohioans in need; and provide support services for those in recovery and their families. RecoveryOhio uses a collaborative approach, with partners across state government, in the criminal justice system, and throughout communities. As part of this initiative, Governor DeWine created The RecoveryOhio Advisory Council, composed of stakeholders from across the state. The Governor asked the council to provide recommendations to improve mental health and substance use prevention, treatment, and recovery support services in Ohio. In 2019, the council released an initial report that offered recommendations in a variety of areas including prevention, treatment and recovery supports, reducing stigma, and workforce development.² The council is continuing to meet and form solutions that address its recommendations. Examples of the council's recommendations include:

- Coordinating statewide prevention activities;
- Commissioning a statewide campaign to address stigma against people with mental illness and substance use disorders;
- Ensuring that each patient's treatment activities are determined by a qualified clinical professional;
- Promoting insurance coverage of medically necessary services; and
- Creating a comprehensive plan for safe, affordable, and high-quality housing for individuals with mental health issues and substance use disorders.

The council expects that the recommendations will serve as a framework for implementing a new continuum of care that includes prevention, treatment, and support services (see text box).

RecoveryOhio seeks to streamline and build on the many statewide initiatives that are already in place to address the opioid crisis. These include:

- **Take Charge Ohio**—designed to educate Ohioans about the risks of taking prescription opioids;
- **Start Talking**—gives parents, guardians, and educators the tools to start conversations with children and young adults about living healthy, drug-free lives;
- **Project DAWN (Deaths Avoided With Naloxone)**—provides free take-home kits containing Naloxone (also

Prevention	Early Intervention	Crisis Services	Treatment	Recovery Supports	Sustained Recovery
Interventions to help individuals develop the skills to act in a healthy manner and to create environments that support healthy behavior.	Screening, brief intervention, and referral to treatment for individuals exhibiting symptoms of a mental health or substance use disorder.	Services for individuals who experience an emergency including drug overdose, psychosis, or a suicide attempt.	Outpatient, residential, and other services for individuals with a mental health or substance use disorder.	Services to help individuals who have completed treatment to rebuild their lives, including assistance with housing, family reunification, and employment.	Support to help individuals maintain wellness and recovery, including peer support and workforce development.

known as Narcan), a medication that blocks the effects of opioids on the brain and thus can temporarily reverse an overdose;

- **Ohio’s Automated Rx Reporting System**—tracks the dispensing of all controlled prescription drugs to patients to help avoid potentially life-threatening drug interactions, and also to identify those who are fraudulently obtaining prescription drugs from multiple providers; and
- **Ohio START (Sobriety, Treatment and Reducing Trauma)**—a family-centered early intervention program for families struggling with substance use disorder aimed at ensuring that more children can remain safely in their home, increasing rates of reunification for children placed in out-of-home care, and reducing the recurrence of child maltreatment.

In addition to these programmatic efforts, money has been allocated in the state budget to:

- Fund a public awareness education campaign;
- Create school prevention curricula and provide professional development for school personnel;
- Increase capacity in treatment centers;
- Expand specialized drug courts that provide supervision, drug and alcohol testing, treatment services, and immediate sanctions and incentives;
- Create the Ohio Narcotics Intelligence Center, a specialized criminal intelligence unit supporting local law enforcement in drug trafficking investigations; and
- Invest in Drug Task Forces.

Finally, the Department of Job and Family Services has several workforce initiatives aimed at expanding the number of workers in careers that address the effects of the crisis and promote economic growth and employment. This effort is supported by two grants from the U.S. Department of Labor to provide support to both employers and individuals. The first, the Trade and Economic Transition National Dislocated Worker grant, will permit Ohio’s 16 participating counties to provide training and career services to dislocated workers seeking reentry into the workforce. The second, the National Health Emergency Disaster Recovery Dislocated Worker grant, provides disaster-relief jobs and employment services to individuals in Ohio affected by the health and economic effects of widespread opioid use, addiction, and overdose. Collectively, these initiatives will help Ohio address the opioid crisis. ■

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¹Ohio Department of Health, “2017 Drug Overdose Report,” September 28, 2018, available at: https://odh.ohio.gov/wps/wcm/connect/gov/5deb684e-4667-4836-862b-cb5eb59acbd3/2017_OhioDrugOverdoseReport.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIKoNoJOooQO9DDDDM3000-5deb684e-4667-4836-862b-cb5eb59acbd3-moxPbu6

²RecoveryOhio Advisory Council Initial Report, March 2019, available at: https://governor.ohio.gov/wps/wcm/connect/gov/243a2827-052c-40e0-8b4f-fbd638add11a/RecoveryOhio_062019.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIKoNoJOooQO9DDDDM3000-243a2827-052c-40e0-8b4f-fbd638add11a-mJT5EDP

Supporting treatment and recovery in human services programs

Barbara Ramlow and Carl G. Leukefeld

TAKEAWAYS

A comprehensive assessment program that identifies all barriers to work and is coordinated with other systems offers promise in helping low-income women with substance use disorder and other issues become self-sufficient.



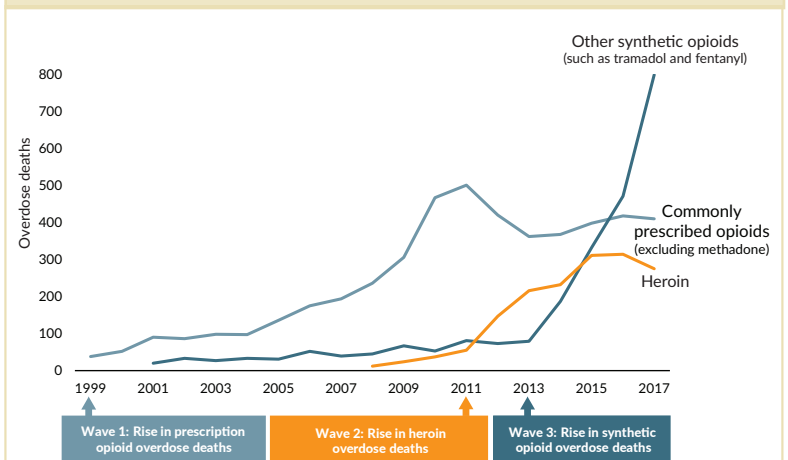
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In 2017, the rate of opioid-related overdose deaths in Kentucky was almost 28 per 100,000 people, nearly twice as high as the national average of 14.6 deaths per 100,000 people.¹ Trends in opioid-related overdose deaths in Kentucky, shown in Figure 1, largely mirror the patterns seen in the United States as a whole. As in Kentucky, the rise of opioid-related overdose deaths in the United States has occurred to date in three waves; first with prescription opioids, then with heroin, and most recently with synthetic opioids.²

Figure 1. The rise of opioid-related overdose deaths in Kentucky has occurred in three waves; first with prescription opioids, then with heroin, and most recently with synthetic opioids.



Source: Mortality data from the Centers for Disease Control and Prevention, National Center for Health Statistics, multiple cause of death data, 1999–2018 on CDC WONDER.

This article focuses on women struggling with opioid use disorder and describes how Kentucky officials have been working to identify and remove the barriers these women face on their path to recovery. In particular, we outline an innovative program that situates trained specialists in public assistance and child welfare offices in order to identify and address all barriers to self-sufficiency—including opioid use disorder—and help to integrate service delivery among multiple providers.

Targeted Assessment Program (TAP)

Kentucky's Targeted Assessment Program (TAP) evaluates and addresses barriers that could impede low-income mothers' participation in the workforce or interfere with their parental responsibilities. These barriers could include substance use disorder, depression, anxiety, intimate partner violence, learning disabilities and deficits, and unmet basic needs such as housing, transportation, and childcare. Research suggests that women who receive public assistance such as Temporary Assistance for Needy Families (TANF) have significantly more barriers to self-sufficiency than women who are not on public assistance.³ It is common for women with substance use disorder to experience multiple barriers.⁴

TAP places experienced staff in state child welfare and TANF agencies to work with participants, agency staff, and community

partners. TAP began as a pilot program in one county in 2000, near the onset of the opioid epidemic, and now operates in 35 of Kentucky's 120 counties.

TAP specialists assess participants to identify barriers and strengths, then customize treatment plans aimed at reducing or eliminating barriers.

TAP specialists assess participants to identify barriers and strengths, then customize treatment plans aimed at reducing or eliminating barriers. The goal of assessment is to identify the whole spectrum of barriers to self-sufficiency and determine how they interact. Specialists provide pretreatment services such as motivational interviewing, coordinate services in the community, provide case management, and assist participants in following through with treatment recommendations. Assessments and other services may be provided in the participant's home or in other convenient and safe settings in the community. Specialists use a trauma-informed approach that acknowledges and addresses the high incidence of adverse childhood experiences (ACEs) and adult trauma within the population.⁵ Studies suggest that individuals who have experienced trauma are more likely to abuse opioids as a coping mechanism, which in turn increases their risk of experiencing additional trauma such as sexual violence, resulting in a continuing cycle of trauma and opioid misuse.⁶

Because TAP specialists are located in TANF and child welfare agencies, they are able to support agency staff by providing training and consulting on cases to help address barriers to participant progress. TAP is designed to be responsive to community needs. Community partners participate in establishing new TAP programs, and in providing ongoing program guidance.

A 2012 study of over 300 TANF-eligible TAP participants found that six months after initial assessment, the percentage of individuals assessed as having substance use as a barrier had declined from 48 percent to 38 percent.⁷ Note that factors other than TAP could have contributed to this change. The percentage of individuals assessed with other barriers such as mental and physical health issues, intimate partner violence, and learning problems also decreased, and participants reported decreases in unmet basic needs such as transportation and childcare.⁸ These findings suggest that an approach like TAP has potential for addressing substance abuse and other barriers to self-sufficiency. ■

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⁵National Institute on Drug Abuse, "Kentucky: Opioid-Involved Deaths and Related Harms," April 2019, available at <https://www.drugabuse.gov/opioid-summaries-by-state/kentucky-opioid-summary>

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Focus is the flagship publication of the Institute for Research on Poverty.

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Edited by Emma Caspar.

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This publication was supported by Cooperative Agreement number AE000103 from the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation to the Institute for Research on Poverty at the University of Wisconsin–Madison. The opinions and conclusions expressed herein are solely those of the author(s) and should not be construed as representing the opinions or policy of any agency of the Federal government.



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