Virginia DUI/Specialty Dockets Training
Charting the Course
September 19-21, 2022
Hotel Roanoke and Conference Center

AGENDA

Monday, September 19, 2022

7:30 a.m. – 8:30 a.m.	**Continental Breakfast/Registration**
8:30 a.m. – 8:35 a.m.	**Roanoke Welcome** Hon. David B. Carson, Judge, Roanoke City Courthouse
8:35 a.m. – 8:50 a.m.	**Welcome and Remarks** Hon. Robert M.D. Turk, Judge, Montgomery Circuit Court Chair Planning & Development Committee/Virginia Drug Treatment Courts Advisory Committee
8:50 a.m. – 10:00 a.m.	**Sleep Hygiene** Brian Meyer, Ph.D., Psychology Program Manager and Supervisory Psychologist, Community-Based Outpatient Clinics, Central Virginia VA Health Care System, Assistant Professor, VCU Department of Psychiatry
10:00 a.m. – 10:15 a.m.	**Break**
10:15 a.m. – 11:30 a.m.	**Foundations of Successful Adolescent Recovery: A Trauma Informed Systemic Approach** Bill Maher, CIP, CADC, BRI II, ACI and Adrienne Loker, LCSW, Seeking Depth to Recovery, LLC
11:30 a.m. – 12:30 p.m.	**Role of Peer Support Specialists** Kim Boyd, MS, CSAC, CPRS, QMHP, Region 3 Recovery-Oriented Services Coordinator, Office of Recovery Services, DBHDS
12:30 p.m. – 1:30p.m.	**Lunch**
1:30 p.m. – 2:30 p.m.	**Self-Recovery: Finding the Balance of Care in Self and Others** Nancy Johnston LPC, LSATP
2:30 p.m. – 2:45 p.m.	**Break**
2:45 p.m. – 3:45 p.m.	**Recovery Fitness** Hon. H. Lee Harrell, Judge, Giles County Circuit Court and Walter Midkiff, Giles County
3:45 p.m. – 4:45 p.m.	**The Role of Defense Counsel in Specialty Courts and Dockets** Catherine French, Chief Appellate Counsel, Virginia Indigent Defense Commission

Charting the Course
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AGENDA

Tuesday, September 20, 2022

7:30 a.m. – 8:30 a.m.	**Judges Breakfast – A View from the Bench…and the Trench:** By Joseph R. Carico, Executive Director, Southwest Legal Aid
7:30 a.m. – 8:30 a.m.	**Continental Breakfast/Registration**
8:30 a.m. – 9:45 a.m.	**Breaking Conventional Rules to Combat Unconventional Epidemic** Hon. Karl Leonard, Sheriff, Chesterfield County and Bailey Hilliard, MSW, Inmate Rehabilitation Programs Manager
9:45 a.m. – 10:00 a.m.	**Break**
10:00 a.m. – 11:00 a.m.	**DWI Courts: Overcoming Perceived Pitfalls of DUI Courts** Hon. Julie Kepple, District Court Judge and NADCP Consultant
11:00 p.m. – 12:30 p.m.	**Substance Use Disorders as Biopsychosocial Chronic Diseases: a public safety + public health intersection that holds promise** David Hartman, MD and Cheri Hartman, PhD
12:30 p.m. – 1:30 p.m.	**Lunch**
1:30 p.m. – 2:15 p.m.	**Equity and Inclusion Tool** Lindsey E. Wylie, JD, PhD, Court Research Associate, National Center for State Courts
2:15 p.m. – 2:30 p.m.	**Break**
2:30 p.m. – 3:30 p.m.	**Substance Use Disorder (SUD), Medicaid, and the Legal-Carceral Population** Ashley Harrell, LCSW, ARTS Senior Program Manager, Virginia Department of Medical Assistance Services
3:30 p.m. – 4:45 p.m.	**Dopesick: America's Epidemic** Beth Macy, Author
4:45 p.m. – 5:00 p.m.	**Adjourn**

Charting the Course
September 20-22, 2021
Veterans Specialty Dockets Training
Charting the Course
September 19-21, 2022
Hotel Roanoke and Conference Center

AGENDA

Wednesday, September 21, 2022

7:30 a.m. – 8:30 a.m.	**Continental Breakfast/Registration**
8:30 a.m. – 9:30 a.m.	**Military Cultural Competency** Leanna Craig, West Region Director, Department of Veteran Services and Daniel Judd, West Region Assistant Region Manager, Department of Veteran Services
9:30 a.m. – 9:45 a.m.	**Break**
9:45 a.m. – 10:45 a.m.	**Suicide Awareness and Prevention: What every VTC Team Member Needs to Know and Do!** Scott Tirocchi, M.A., M.S., L.P.C., Division Director, Justice for Vets, Major, U.S. (Army Retired)
10:45 a.m. – 11:00 a.m.	**Break**
11:00 a.m. – 12:00 p.m.	**Reform and Responsibility in DWI Courts** Hon. Julie Kepple, District Court Judge and NADCP Consultant
12:00 p.m. – 1:00 p.m.	**Lunch**
1:00 p.m. – 2:30 p.m.	**Intimate Partner Violence** Dr. Casey T. Taft, Ph. D., staff psychologist at the National Center for PTSD in the VA Boston Healthcare System, and Professor of Psychiatry at Boston University School of Medicine and NADCP Consultant
2:30 p.m. – 3:00 p.m.	**Veterans Docket Graduate**
3:00 p.m. – 3:15 p.m.	**Closing Remarks**

HOW TO DECREASE INSOMNIA THROUGH BETTER SLEEP HYGIENE

Brian L. Meyer, Ph.D., LCP

Psychology Program Manager
Community-Based Outpatient Clinics
Central Virginia VA Health Care System
Richmond, VA

Assistant Professor
Department of Psychiatry
Virginia Commonwealth Univ.
Richmond, VA

September 19, 2022

DISCLAIMER

The views expressed in this presentation are solely those of the presenter and do not represent those of the Veterans Administration, the United States government, or the National Association of Drug Court Professionals.

With thanks to Meghan Geiss, who contributed several slides to this presentation.


"SLEEP IS THAT GOLDEN
CHAIN THAT TIES HEALTH
AND OUR BODIES
TOGETHER."
Thomas Dekker

INSOMNIA

DEFINITION OF INSOMNIA IN DSM-V

- Dissatisfaction with the amount or quality of sleep along with:
  - Difficulty falling asleep
  - Difficulty staying asleep
  - Early-morning awakening
- Causes clinically significant distress or impairment
- Happens at least 3 nights per week
- Has lasted at least 3 months
- Not better or adequately explained by:
  - Inadequate opportunity for sleep
  - Another sleep disorder (e.g., sleep apnea, narcolepsy or a circadian rhythm sleep disorder)
  - Substance use
  - Other mental or medical disorders

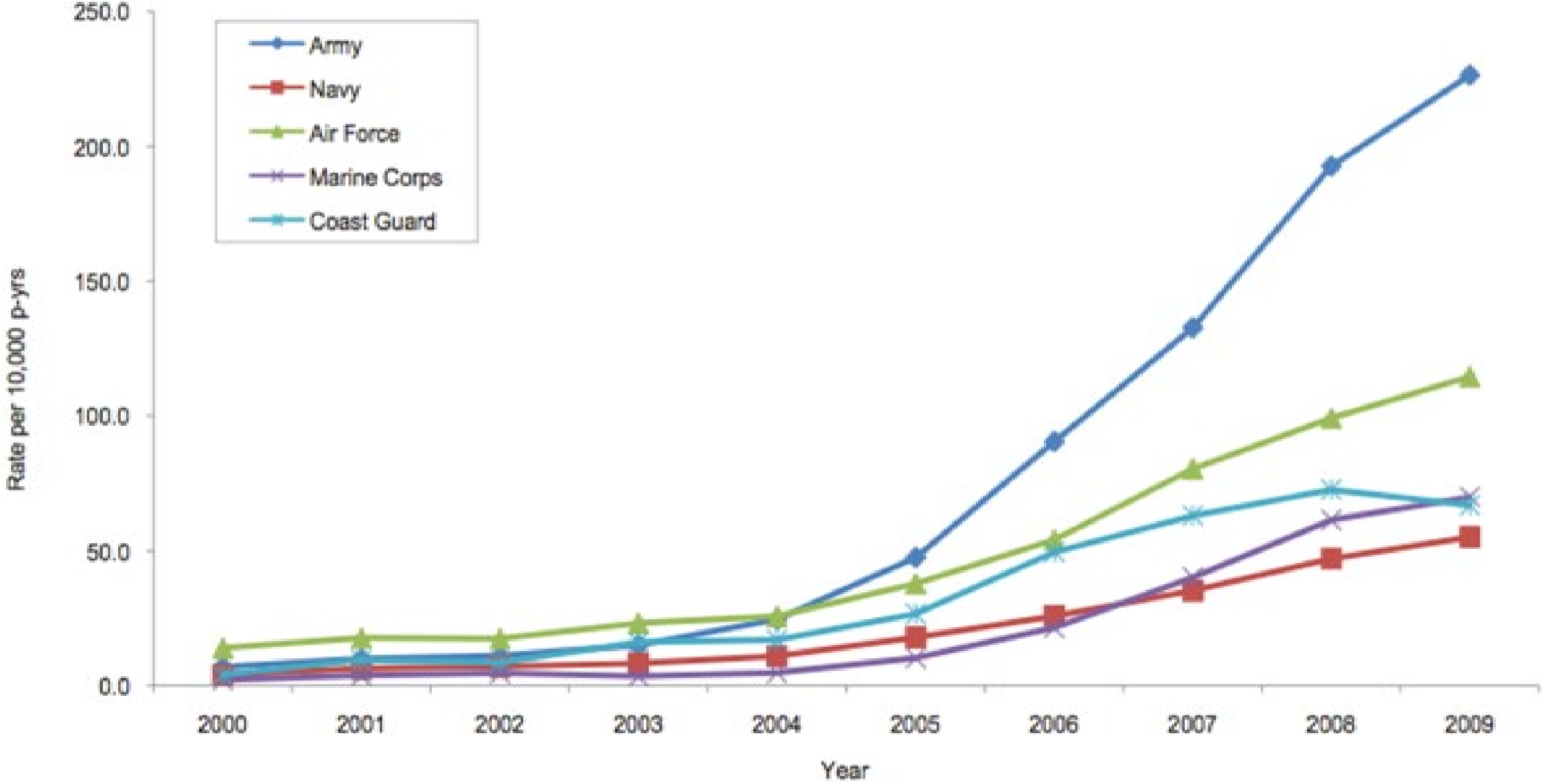
IMPACT OF INEFFICIENT SLEEP

- Overworked neurons become less effective in coordinating processes to access learned information
- Diminished
  - Focus
  - Attention
- Alters interpretation of events
- Decreased ability to assess, plan, and enact behavior
- Impaired judgment

MILITARY TRAINING AND COMBAT REINFORCEMENT OF INSOMNIA

- Long hours
- Night shifts
- Light sleeping
- Insomnia becomes an adaptive survival skill
- Consumption of coffee, energy drinks, stimulants, etc.

Figure 1. Annual incidence rates of insomnia, by Service and calendar year, active component, U.S. Armed Forces, 2000-2009



INSOMNIA IN THE MILITARY

Insomnia is the most common symptom reported by Veterans returning from deployment (McLay et al., 2010)

From 2001-2009, diagnoses of insomnia in the military increased 19 times (DOD, 2010)

Almost 1/3, or approximately 600,000, military personnel returned from post 9/11 deployments with sleep disturbances (Seelig et al., 2010)

Insomnia is a symptom of many other common military problems, including PTSD, TBI, depression, and pain

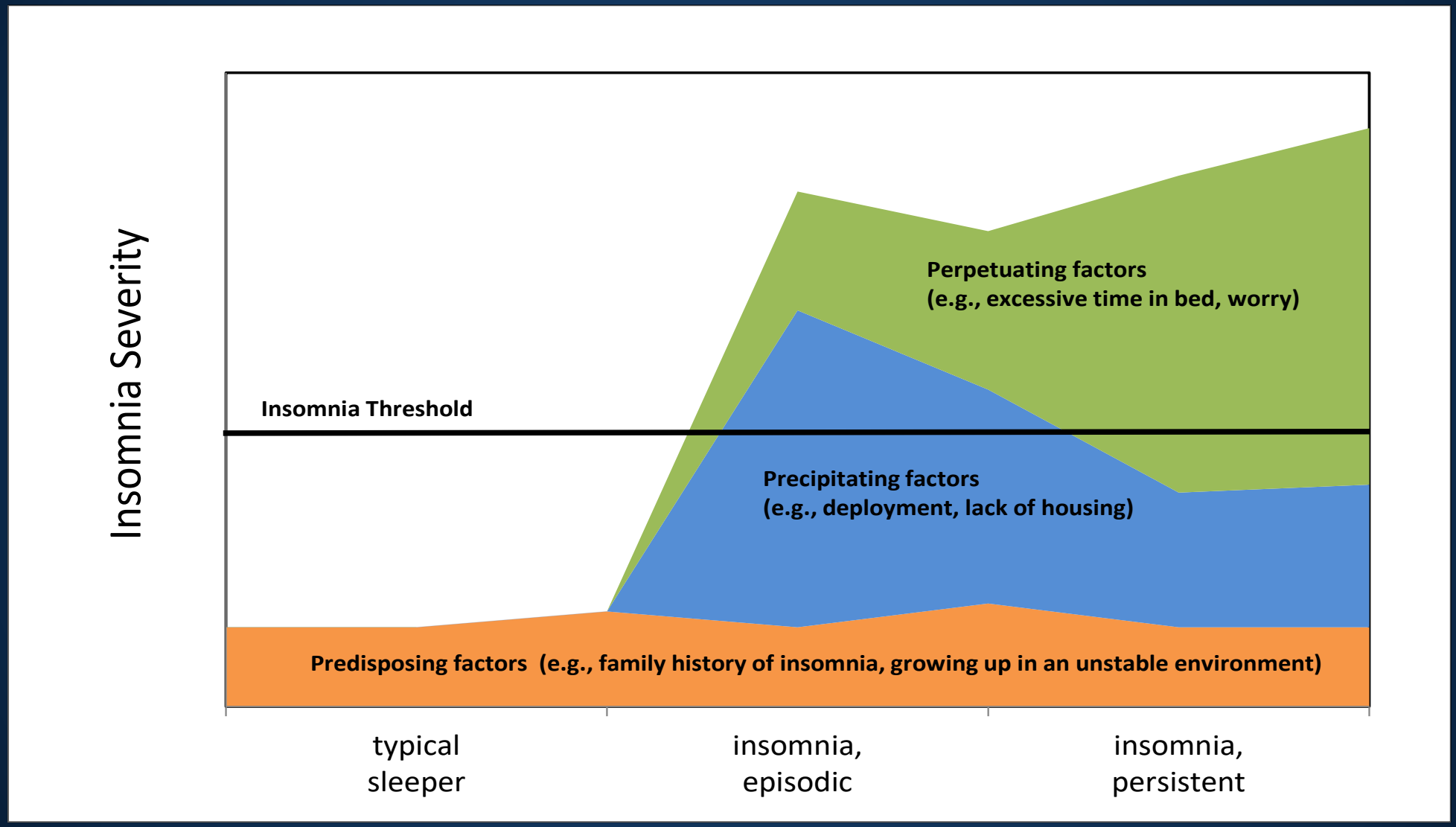
MILITARY SERVICE AND SLEEP DISORDERS

- 98.5% of OEF-OIF Veterans have a sleep disorder (Orr et al., 2010)
- 69% of OEF/OIF Veterans are at high risk for obstructive sleep apnea (Colvonen et al., 2015), and 54% have OSA (Orr et al., 2010)
- 52% of Vietnam Veterans in combat report significant nightmares (Neylan et al., 1998)

INSOMNIA IS COMMON AMONG VHA PATIENTS

- Approximately 40% of Veterans in primary care (Mustafa et al., 2005) have probable insomnia vs. 19% general community (Ohayon, 2002)
- Increased prevalence rates in:
  - Depression
  - PTSD
  - Substance Use
  - Pain/medical disorders
  - Aging

FACTORS INVOLVED IN INSOMNIA



Harvey & Spielman, 2011

INSOMNIA SEVERITY INDEX

Patient name	
Date	

1. Please rate the current (i.e. last 2 weeks) SEVERITY of your insomnia problem(s).

	None	Mild	Moderate	Severe	Very severe
a Difficulty falling asleep:	0	1	2	3	4
b Difficulty staying asleep:	0	1	2	3	4
c Problem waking up too early:	0	1	2	3	4

2. How SATISFIED/dissatisfied are you with your current sleep pattern?

Very satisfied				Very dissatisfied
0	1	2	3	4

3. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)

Not at all interfering	A little	Somewhat	Much	Very much interfering
0	1	2	3	4

4. How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all noticeable	Barely	Somewhat	Much	Very much noticeable
0	1	2	3	4

5. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all	A little	Somewhat	Much	Very much
0	1	2	3	4

Score
Official use only

Question	1a	1b	1c	2	3	4	5	Total
Score								

Guidelines for Scoring/interpretation
Total score ranges from 0–28
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

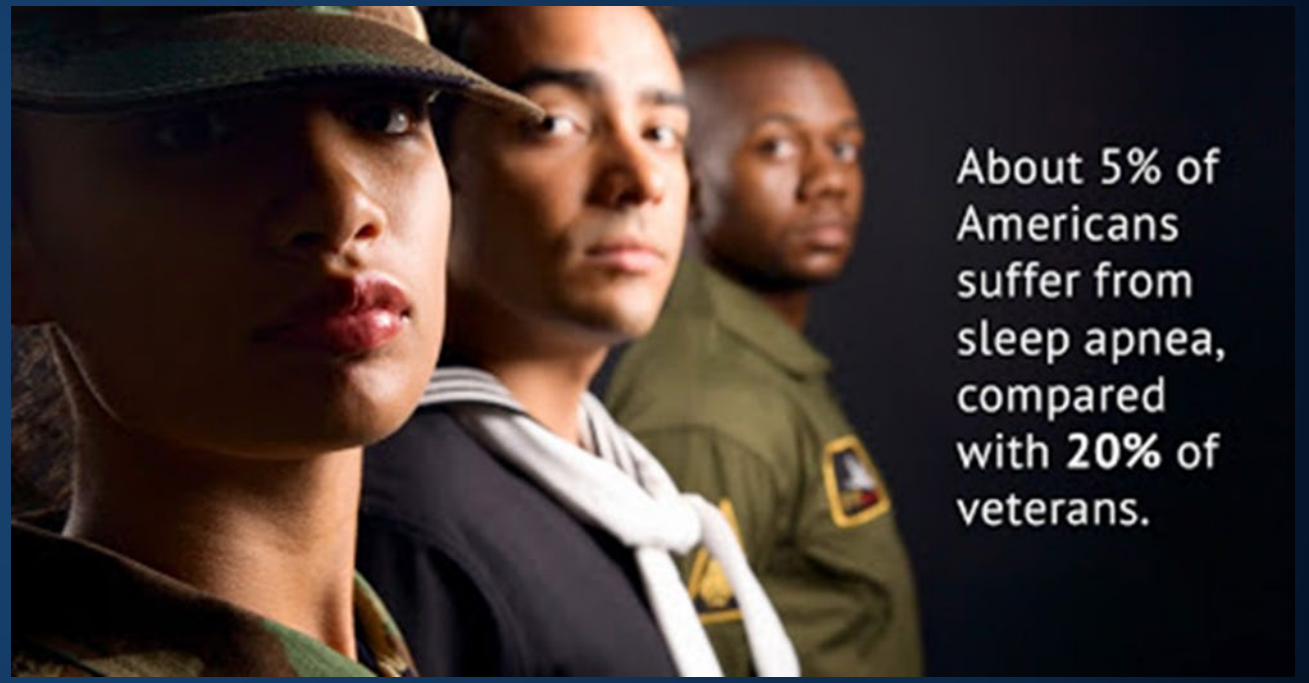
FACTORS TO CONSIDER IN A SLEEP ASSESSMENT INTERVIEW

ASSESS COMORBID SLEEP DISORDERS

- Obstructive Sleep Apnea (OSA)
- Restless Leg Syndrome (RLS)
- Circadian Rhythm Disorders
- REM Sleep Behavior Disorder

OBSTRUCTIVE SLEEP APNEA (OSA)

- Repetitive episodes of complete or partial upper-airway obstruction occurring during sleep
- Most common form of sleep apnea
- 39-58% of individuals with OSA suffer from insomnia (Chung et al., 2005; Smith et al., 2006)
- Bi-directional relationship



You cannot treat insomnia with sleep hygiene interventions if a person has OSA

Figure 4. Conditions diagnosed concurrently with obstructive sleep apnea, active component members, U.S. Armed Forces, 2000-2009

OSA HAS MANY CO-OCCURRING CONDITIONS IN THE ARMED FORCES

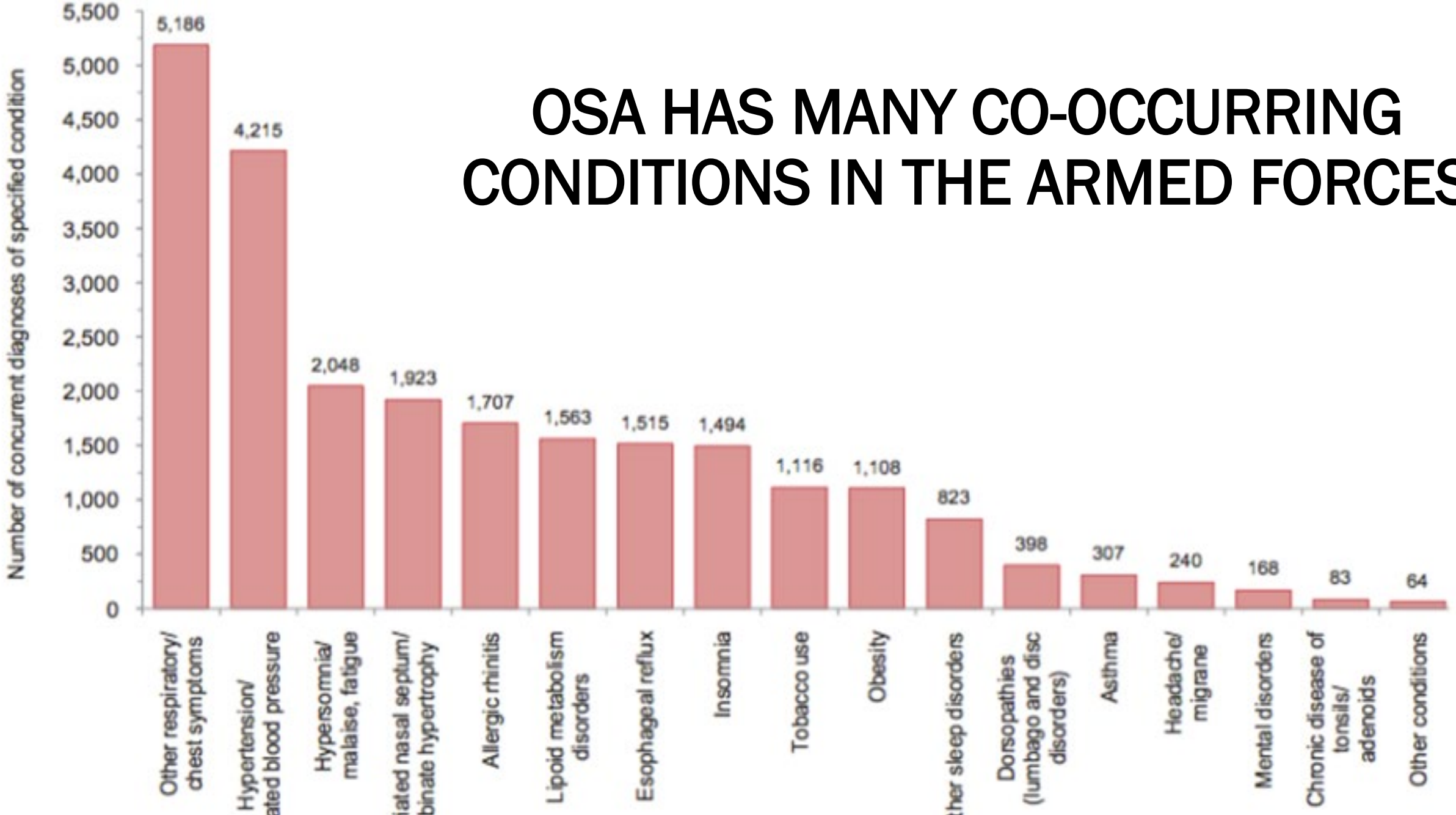


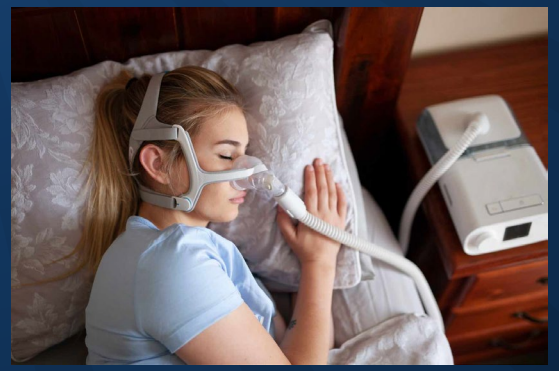
TABLE 2
STOP-BANG questionnaire*

STOP		
S (snore)	Do you *snore* loudly (louder than talking or loud enough to be heard through closed doors)?	Yes/No
T (tired)	Do you often feel *tired*, fatigued, or sleepy during daytime?	Yes/No
O (observed)	Has anyone *observed* you stop breathing during sleep?	Yes/No
P (blood pressure)	Do you have or are you being treated for high blood *pressure*?	Yes/No
BANG		
B (body mass index [BMI])	*BMI* > 35 kg/m^2?	Yes/No
A (age)	*Age* > 50 years?	Yes/No
N (neck)	*Neck* circumference > 40 cm?	Yes/No
G (gender)	*Gender* male?	Yes/No

Yes to ⩾ 3 questions = high risk of obstructive sleep apnea
Yes to < 3 questions = low risk of obstructive sleep apnea
*Adapted from Chung et al.[20]

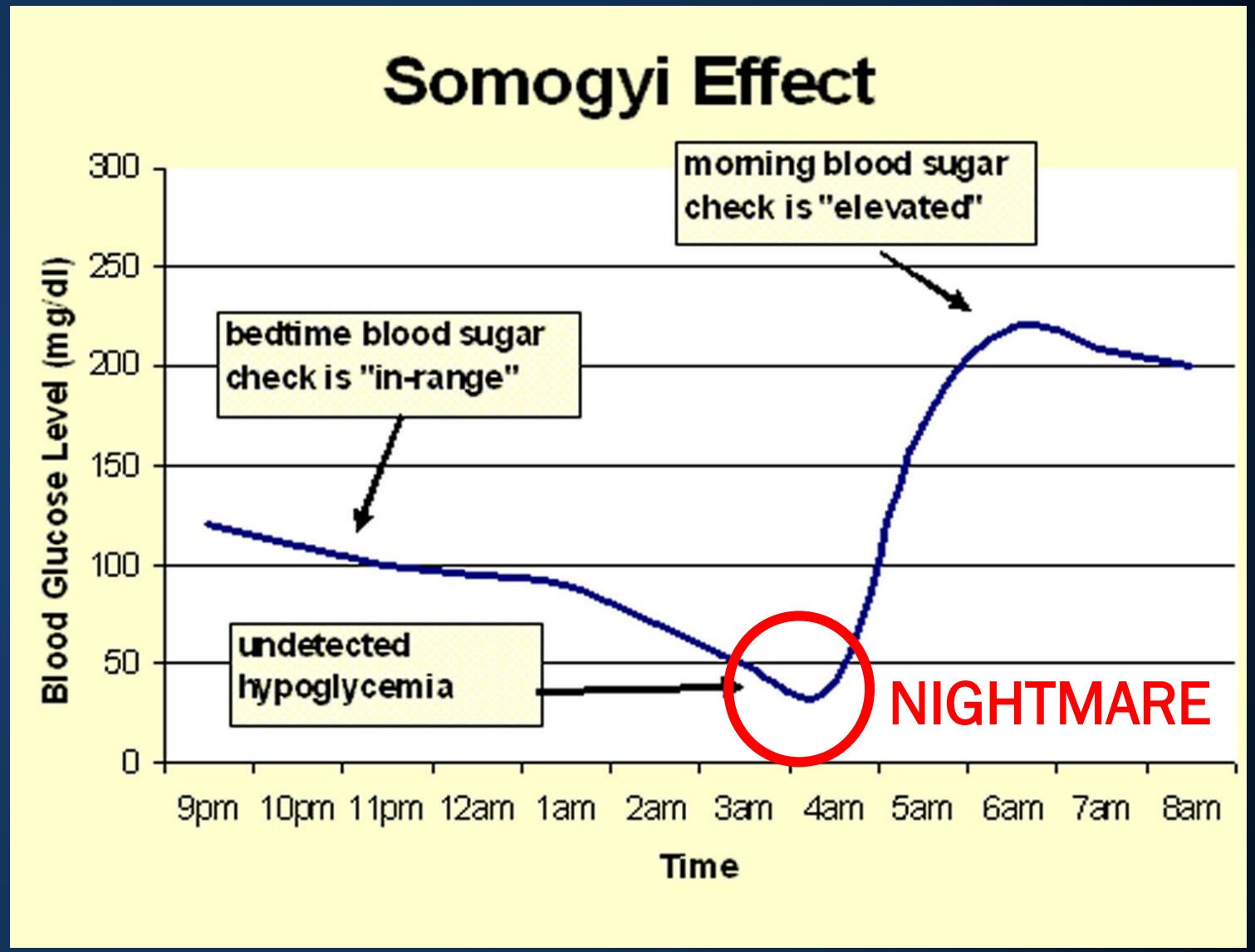
OSA ASSESSMENT: THE STOP BANG QUESTIONNAIRE

- If score is ≥ 3, then refer to overnight sleep testing
- If OSA is present, then the person needs either a CPAP or an APAP, or a dental appliance



DIABETES AND NIGHTMARES

- Hypoglycemia can cause night sweats and nightmares
- These nightmares can have post-traumatic content
- This is especially true for Vietnam Veterans, who may have developed diabetes due to Agent Orange exposure

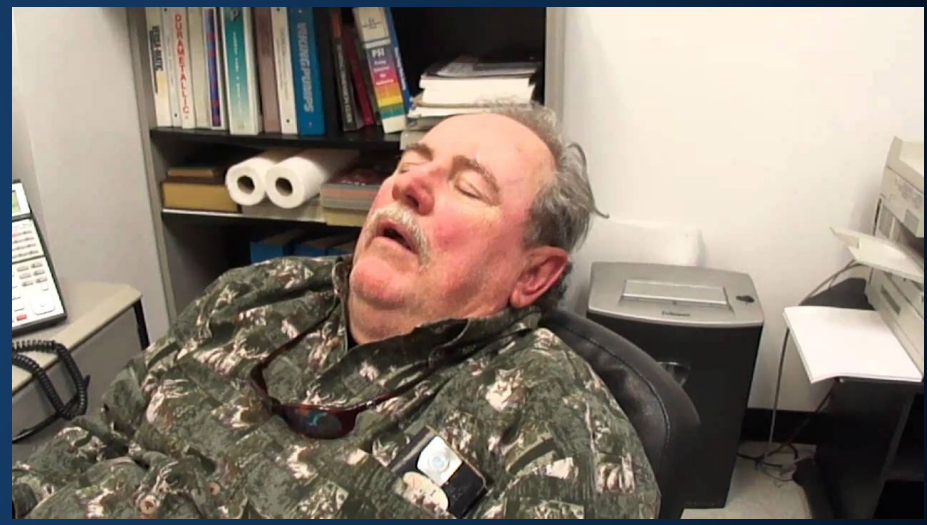


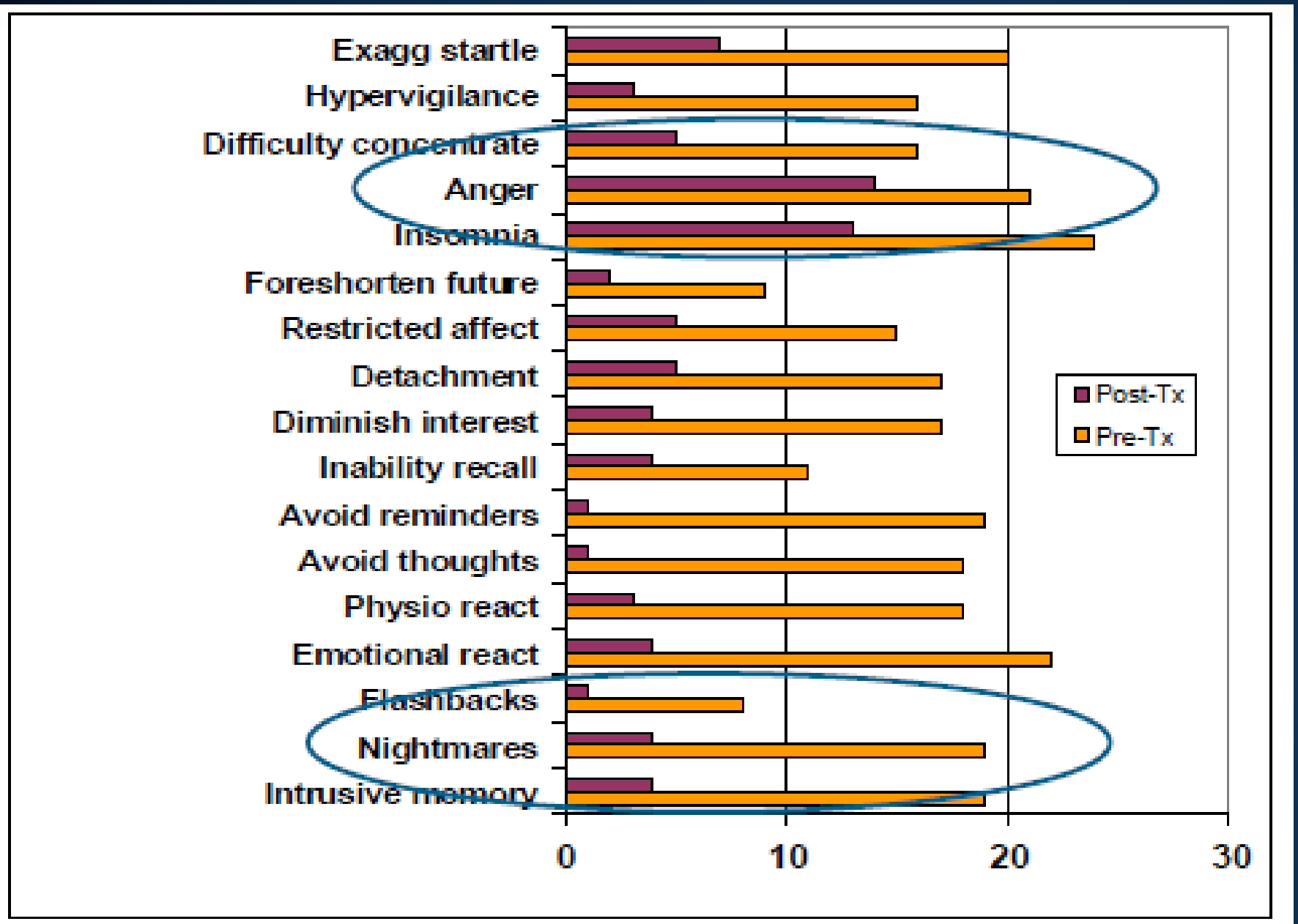
PTSD AND SLEEP

- Insomnia is one of 20 defining characteristics of PTSD
  - It frequently continues even after PTSD is successfully treated
- Nightmares are also defining characteristic of PTSD
  - Both nightmares and avoidance of nightmares can cause insomnia

PTSD AND INSOMNIA

- 90-100% of Vietnam Veterans with PTSD have insomnia (Lewis et al., 2009; Neylan et al., 1998)
- 92% of OEF-OIF Veterans with PTSD have insomnia, compared to 28% without PTSD (Seelig et al., 2010)
- Insomnia after a traumatic event is s a significant risk factor for PTSD (Wright et al., 2011)
- 54% of combat Veterans with PTSD also have OSA (Orr et al., 2010)





SYMPTOMS AFTER PTSD TREATMENT

Zayfert & Deviva, 2004

REASONS WHY PEOPLE WITH PTSD USE SUBSTANCES

- They include:
  - To go to sleep
  - To prevent nightmares

SUBSTANCE ABUSE AND INSOMNIA

- Substance Abuse can create sleep disorders
  - Every stimulant abuse worsens insomnia: cocaine, caffeine, nicotine, ADHD medications, etc.
- Too much coffee or energy drinks can cause Caffeine-Induced Sleep Disorder
- Marijuana decreases slow wave sleep and REM sleep
  - It also decreases sleep quality
  - It may be helpful in the short term to fall asleep, but frequent medical cannabis use is associated with problems falling asleep and increased waking up at night (Sznitman et al., 2019)

ALCOHOL AND INSOMNIA

- 28% of people with insomnia use alcohol to sleep
  - Drinking results in waking up 2½ - 3 hours later to urinate
  - Alcohol disrupts the sequence and duration of sleep states
  - Alcohol consumed within 1-6 hours of bedtime disrupts the 2nd half of sleep (NIH, 1998)
  - Drinking decreases total sleep time

OPIOIDS AND INSOMNIA

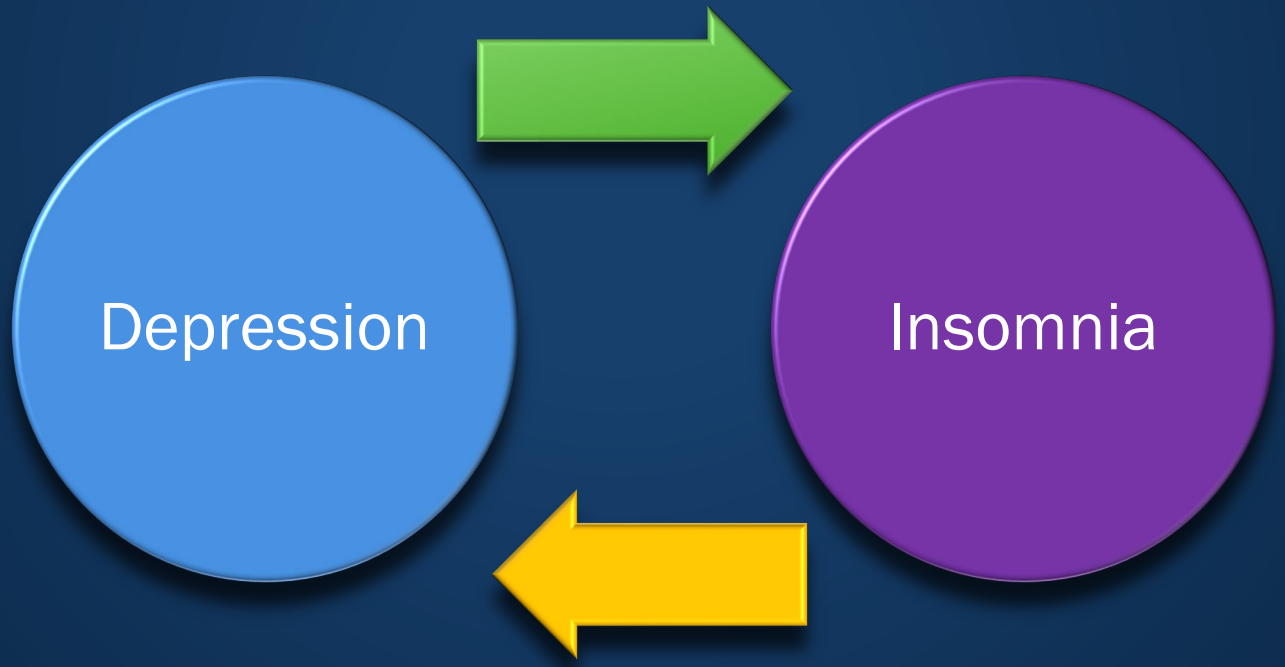
- Opioids cause both sedation and wakefulness (De Andres & Caballero, 1989)
  - Veterans with chronic pain who were prescribed opioids are more likely to report sleep disruption than those who did not take opioids (Morasco et al., 2014)
  - Heroin causes alternation between oversleeping due to sedation and severe sleeplessness
    - It also results in poor sleep quality
- Opioids can cause central sleep apnea

WITHDRAWAL FROM SUBSTANCES CAN WORSEN SLEEP

- Withdrawal from cocaine worsens sleep quality (Sofuoglu et al., 2005)
- Marijuana withdrawal can increase sleep problems (Bolla et al., 2010)
- Withdrawal from opioids can result in insomnia (Hillhouse et al., 2010)

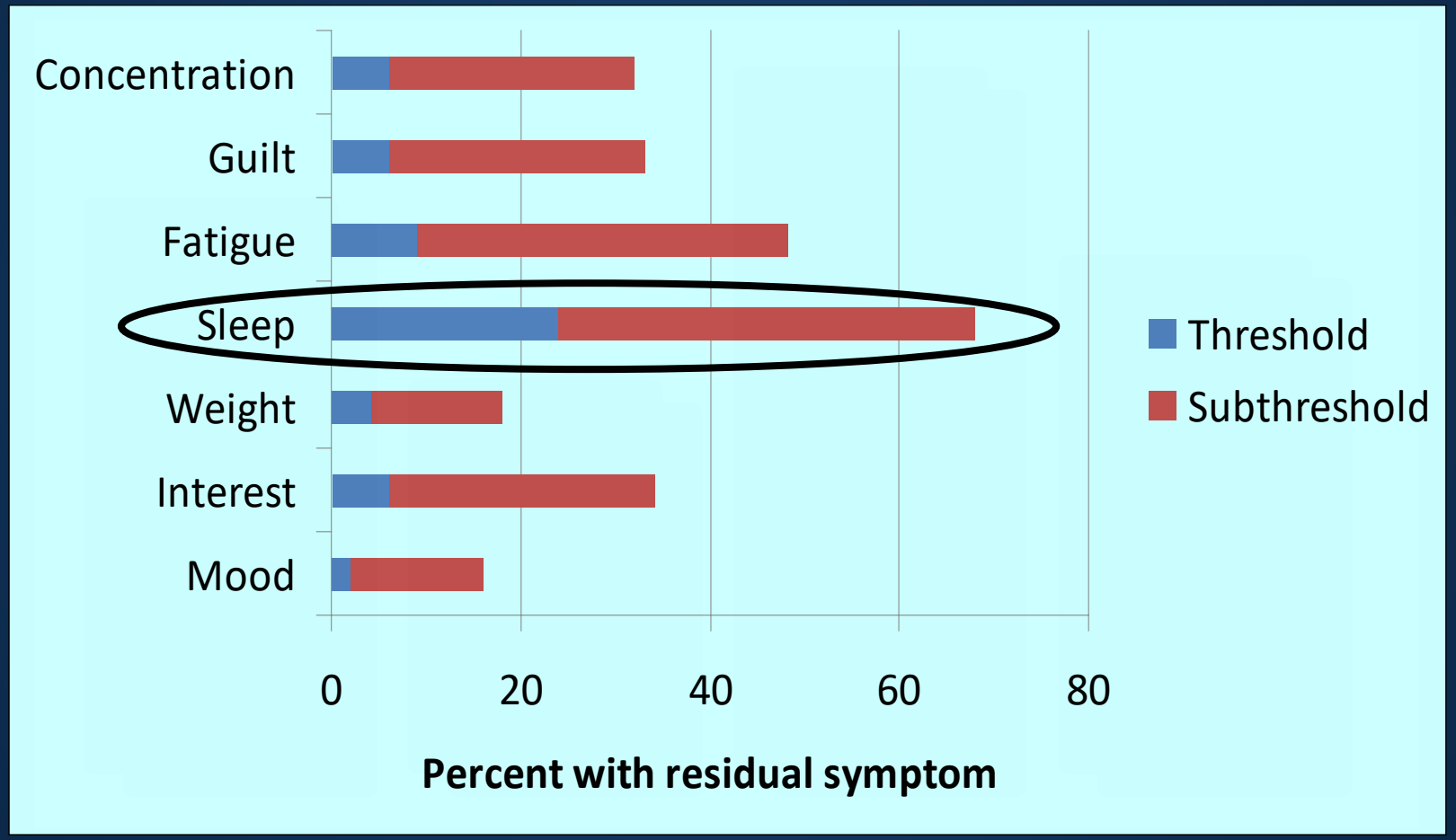
DEPRESSION AND INSOMNIA

83% of depressed people have insomnia (Nutt et al., 2008)



Insomnia predicts later Major Depressive Disorder (Buysse et al., 2008)

INSOMNIA LASTS AFTER TREATMENT FOR DEPRESSION

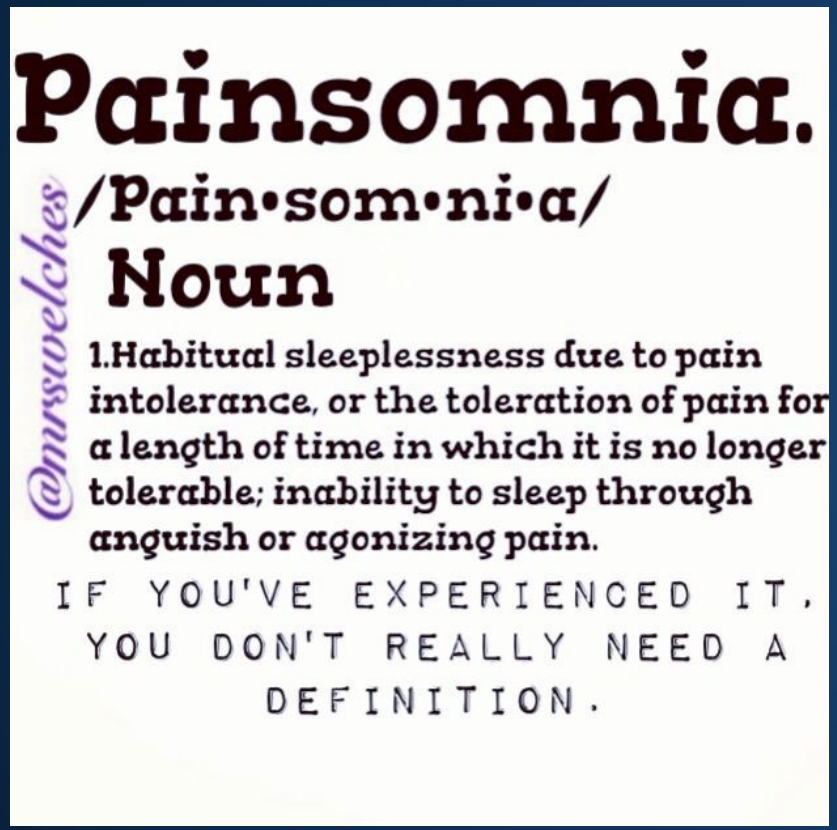


Nierenberg, 1999

TRAUMATIC BRAIN INJURIES AND SLEEP

- An estimated 20% of Veterans who have served since 2001 report experiencing a probable Traumatic Brain Injury (Mathias & Alvaro, 2012)
- Traumatic Brain Injuries have been associated with:
  - Alterations in Circadian Rhythms
  - Disrupted Sleep Patterns
  - Diminished Sleep Quality
- 20%-94% of Veterans with TBIs experience insomnia (Tanielian & Javcox, 2008; Mahmood et al., 2004; Farrell-Carnahan et al., 2013)

INSOMNIA AND PAIN



- Pain is the #1 medical cause of insomnia
  - Of those with chronic pain, 65% have insomnia
  - People with insomnia have higher pain sensitivity (Sivertsen et al., 2015)

Sleep and Violence in OEF-OIF Veterans

Risk Factors for Violence

- Age
- Etoh misuse
- PTSD
- Depression
- Homelessness
- Back pain
- Sleep Problems

Protective Factors

- Social Support
- Basic Needs Met
- Pain problems addressed
- Sleep problems addressed

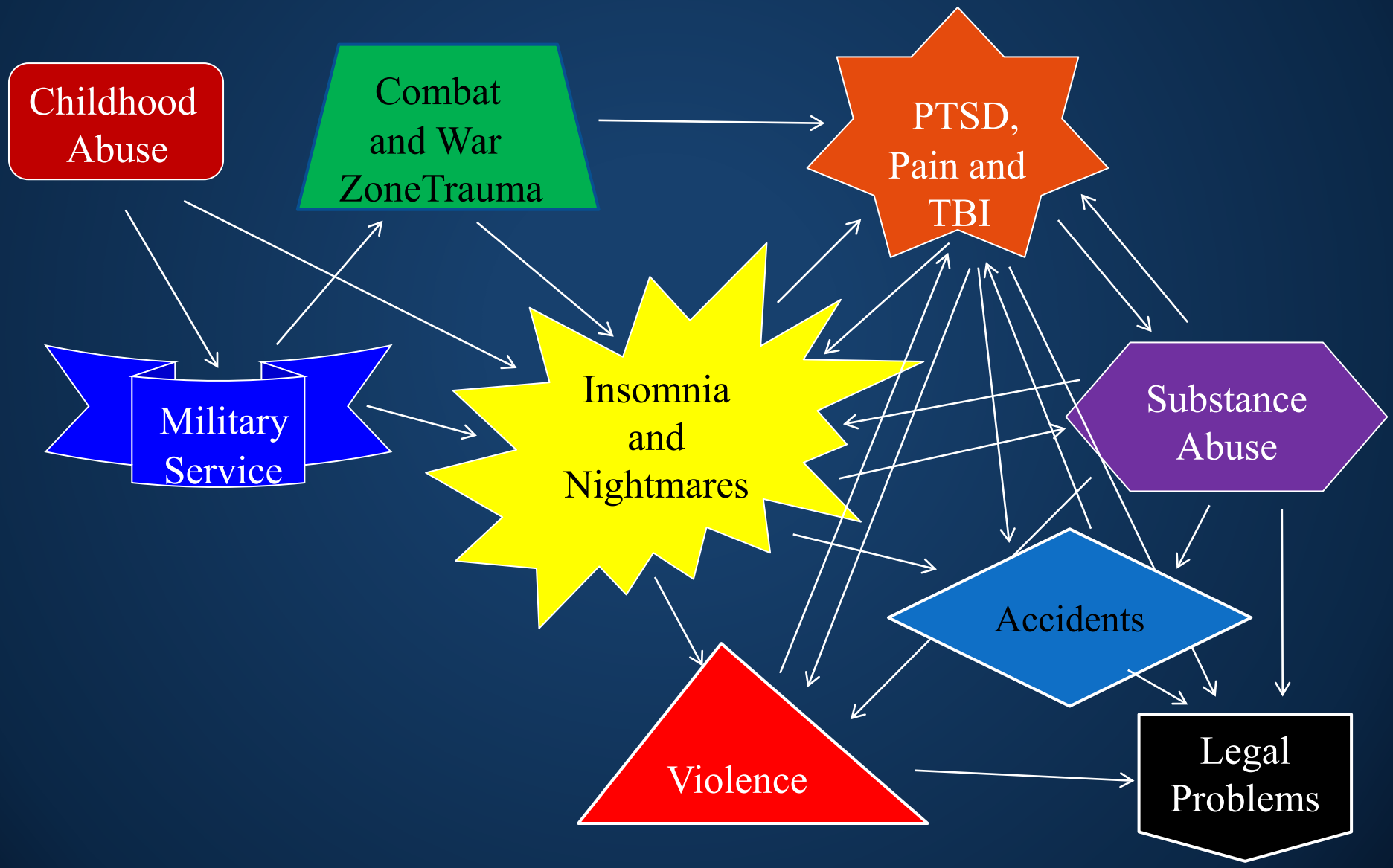
Elbogen, 2011

ONE MORE THING

What do insomnia, PTSD, substance abuse, and TBI have in common?

Accidents.

INVOLVEMENT OF INSOMNIA IN LEGAL PROBLEMS OF VETERANS



THE SLEEP HYGIENE INTERVIEW

DETERMINE THEIR SLEEP PATTERN

- What hours are you typically awake and typically asleep?
  - Include daytime, work schedule
  - Any naps?
- What parts of sleep are you having difficulty with?
  - Falling asleep (beginning of night)
  - Staying asleep (middle of night)
  - Waking up too early and not being able to fall back to sleep (end of night)
  - Difficulty waking up at intended time

NIGHTMARES

- How many nights per week?
- How many nightmares per night?
- What happens after nightmares?
  - Night sweats
  - Waking/how long?

DAILY EXPOSURE TO SUNLIGHT

- We need at least 20 minutes/day
- Optimally before noon
- Needed to set body clock
  - Body clock sets sleep/wake cycle
  - Also to combat depression

EXERCISE

- Aerobic exercise + strength training
- 3 hours/week minimum
- 30 minutes daily helps best with sleep
- Before 6 PM

How much caffeine?

12 oz
soft drink
30 to 40 mg

8 oz
green or black tea
30 to 50 mg

8 oz
coffee
80 to 100 mg

8 oz
energy drink
40 to 250 mg

LIMIT DAILY CAFFEINE INTAKE

- From all sources
  - Include caffeine tablets

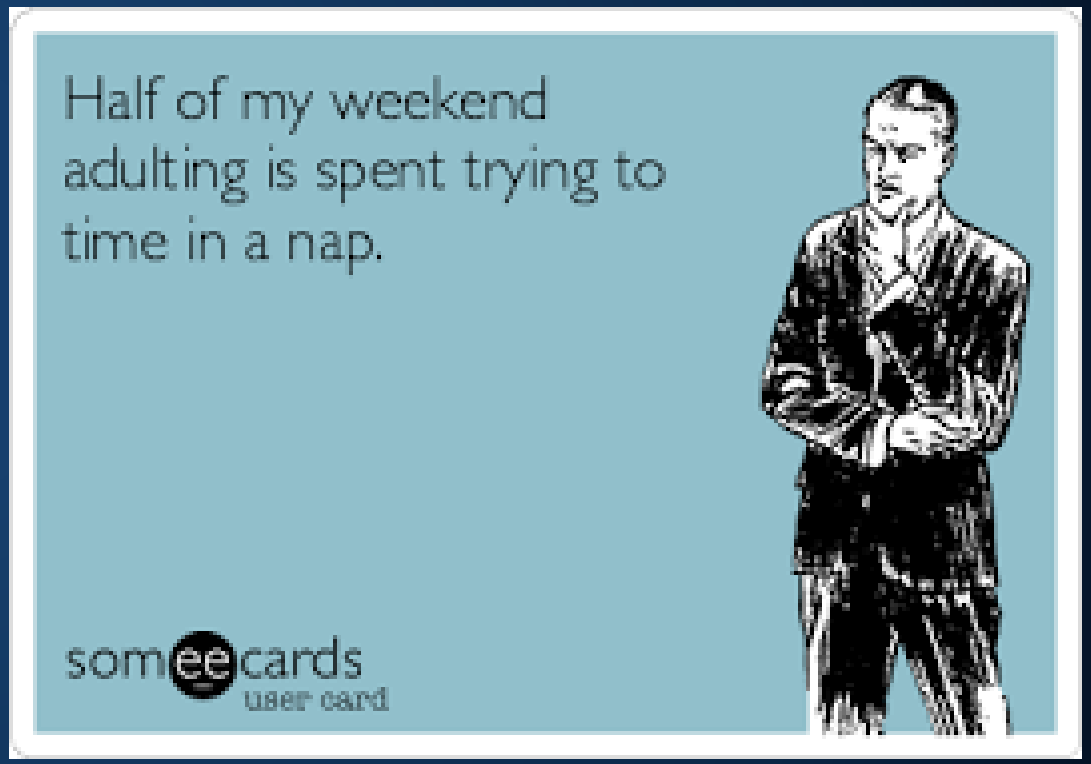
- No caffeine after 6 pm
- Daily limit is 250 mg.
- If they have more, then it interferes with sleep
- Need a plan to gradually withdraw (cut down, substitute decaf)

LIMIT DRUGS AND ALCOHOL

Watch out for cigarettes, too!

LIMIT NAPS

- To change a sleep schedule, practice sleep restriction
- No more than one nap lasting 30 minutes per day (sleep restriction)
- Otherwise it interferes with phases of the sleep cycle



HAVE THEM DESCRIBE EVERYTHING THEY DO FROM 6 PM ON

- Dinner, snacking
- All use of screens
- Routine in the two hours before bedtime
- Do showers relax them or wake them?
- When do they take their medicine?

NO MORE THAN TWO DRINKS PER DAY FOR MEN, ONE PER DAY FOR WOMEN

- Alcohol interferes with the sleep cycle
- No drugs
- No cigarettes at night

NO FOOD TWO HOURS BEFORE BEDTIME

- Digestion interferes with sleep
- Exception: persons with diabetes
- Exception: drinking warm milk or eating turkey

LIMIT EXPOSURE TO SCREENS

- No distressing content three hours before bedtime
- No screens two hours before bedtime

TAKE MEDICINE 30-45 MINUTES BEFORE GETTING IN BED

MAKE THE BEDROOM COMFORTABLE

- Set up for comfort
- 65 degrees or less
- Dark
- Soothing scents?
- If needed, white noise or repetitive sounds
  - e.g., waves, wind, rain, etc.

HAVE THEM DESCRIBE EVERYTHING THEY DO AFTER THEY LIE DOWN IN BED

- Use of the bed
- How long does it take to fall asleep?
- What do they do if they can’t fall asleep?

BEDS ARE FOR TWO THINGS ONLY

DON'T STAY IN BED MORE THAN 20 MINUTES WITHOUT FALLING ASLEEP

- Instead, get up and do something quiet in low light
  - Listen to calming music
  - Read
  - Work on a puzzle
- No smoking or drinking
- When they get tired, then go lay down in bed again

HAVE THEM DESCRIBE EVERYTHING THEY DO AFTER THEY WAKE UP

- Do they get out of bed?
- What do they do after they go to the bathroom?
- Do they check their doors and windows?
- What do they do if they can’t fall back asleep?

CREATE A SLEEP HYGIENE PLAN

Problem	Plan
• Wake up time	• If possible, wake in early light
• Caffeine intake and timing	• Limit caffeine to 250 mg. per day, all before 6 PM
• Naps?	• No more than one 30 minute nap
• Timing of exercise	• No exercise after 6 PM
• Timing of dinner	• No food after 7 PM
• Too much screen time	• Limit screen time, none for the 2 hours before bed
• Laying awake in bed	• Get out of bed after 20 minutes and do something quiet

WRITE A SLEEP HYGIENE PLAN

- Inoculate them by warning them that they may not like some parts of it or they may find it difficult
- Put it in the order of the things they have to do during the day
- Only include areas in which they have a problem
- Treat it like a prescription

SLEEP HYGIENE

HELPFUL TIPS TO HELP YOU SLEEP

What is sleep hygiene? "Sleep hygiene" is used to describe good sleep habits. Many of us don't pay attention to our sleeping habits but they are essential.

YOUR PERSONAL HABITS

FIX A BEDTIME AND AN AWAKENING TIME
The body "gets used" to falling asleep at a certain time, but only if this is relatively fixed.

AVOID NAPPING DURING THE DAY
Or make sure you limit the nap to 20-30 minutes.

AVOID CAFFEINE & ALCOHOL 4-6 HOURS BEFORE BED

EXERCISE, BUT NOT BEFORE BED
Strenuous exercise within two hours before bedtime can interfere with your ability to fall asleep.

YOUR SLEEPING ENVIRONMENT

USE COMFORTABLE BEDDING
Find comfortable bedding and a good temperature to keep the room well ventilated.

BLOCK OUT ALL DISTRACTING NOISE
Also eliminate as much light as possible.

RESERVE THE BED FOR THE THREE S's: SLEEP, SEX, AND SICKNESS
Don't use the bed as an office. Let your body "know" that the bed is associated only with the Three S's.

GETTING READY FOR BED

TRY A LIGHT SNACK BEFORE BED
Warm milk and foods high in the amino acid tryptophan, such as bananas, may help you sleep.

USE RELAXATION TECHNIQUES AND DON'T TAKE YOUR WORRIES TO BED

GET INTO YOUR FAVORITE SLEEPING POSITION
Don't toss and turn in bed. If you think it's been more than 30 minutes, get up, and do a relaxing activity (try light reading)

A WORD ABOUT ELECTRONICS

Using electronics before bedtime is often a bad idea. They are engaging objects that tend to keep people awake. Some people find that listening to music helps them fall asleep since it is a less engaging activity.

OTHER FACTORS

THE GOAL IS TO REDISCOVER HOW TO SLEEP NATURALLY.

Several physical factors are known to upset sleep. These include sleep apnea, pain, arthritis, acid reflux with heartburn, menstruation, headaches and hot flashes.
Many medications can cause sleeplessness as a side effect.
Psychological and mental health problems like depression, anxiety and stress are often associated with sleeping difficulty.

CAPS
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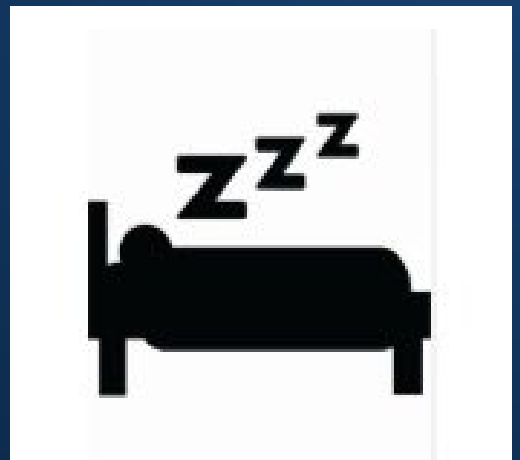
THE SECOND SESSION

SESSION TWO

- Discuss sleep over the past week
- Review the plan
  - Focus on areas that they did not fully implement
  - Ask what got in the way
  - Conduct motivational interviewing



- Develop a Safe (or Secure) Place
  - Somewhere they have been or that they can imagine
- Have them describe it using their 5 senses
- Have them select a name
  - Imagine the place while saying the name to themselves
- Test it against a recent negative memory (3-4 on SUDs scale of 0-10)

RELAXATION

Progressive Muscle Relaxation

Deep Breathing: breathe in to the count of 5 and out to the count of 7

WHAT IF THEY CHECK THEIR DOORS AND WINDOWS MULTIPLE TIMES EACH NIGHT?

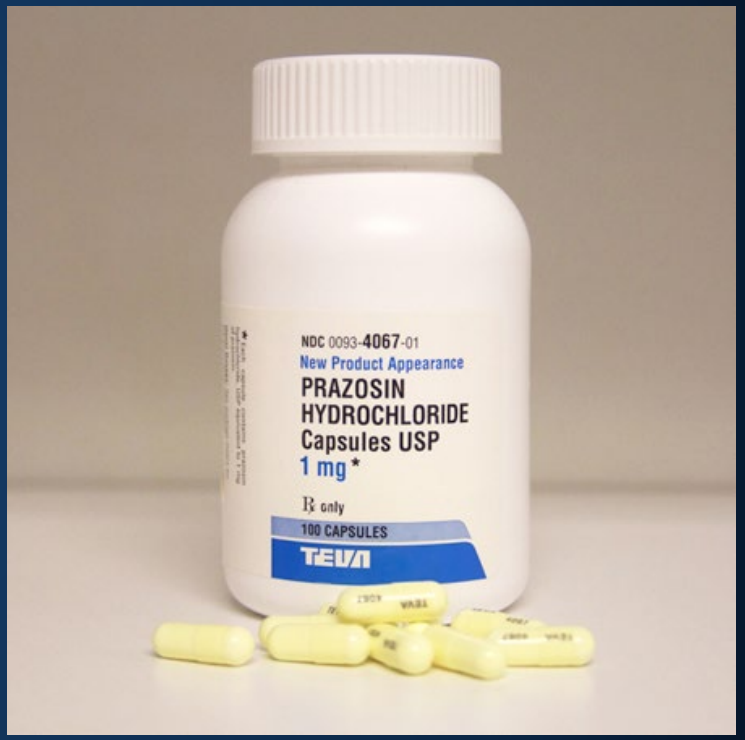
First, have them make sure their doors and windows are locked. Then:

The Don’t Get Out of Bed Plan

The Trust Your Dog Plan

MELATONIN AND L-TRYPTOPHAN

MEDICATIONS

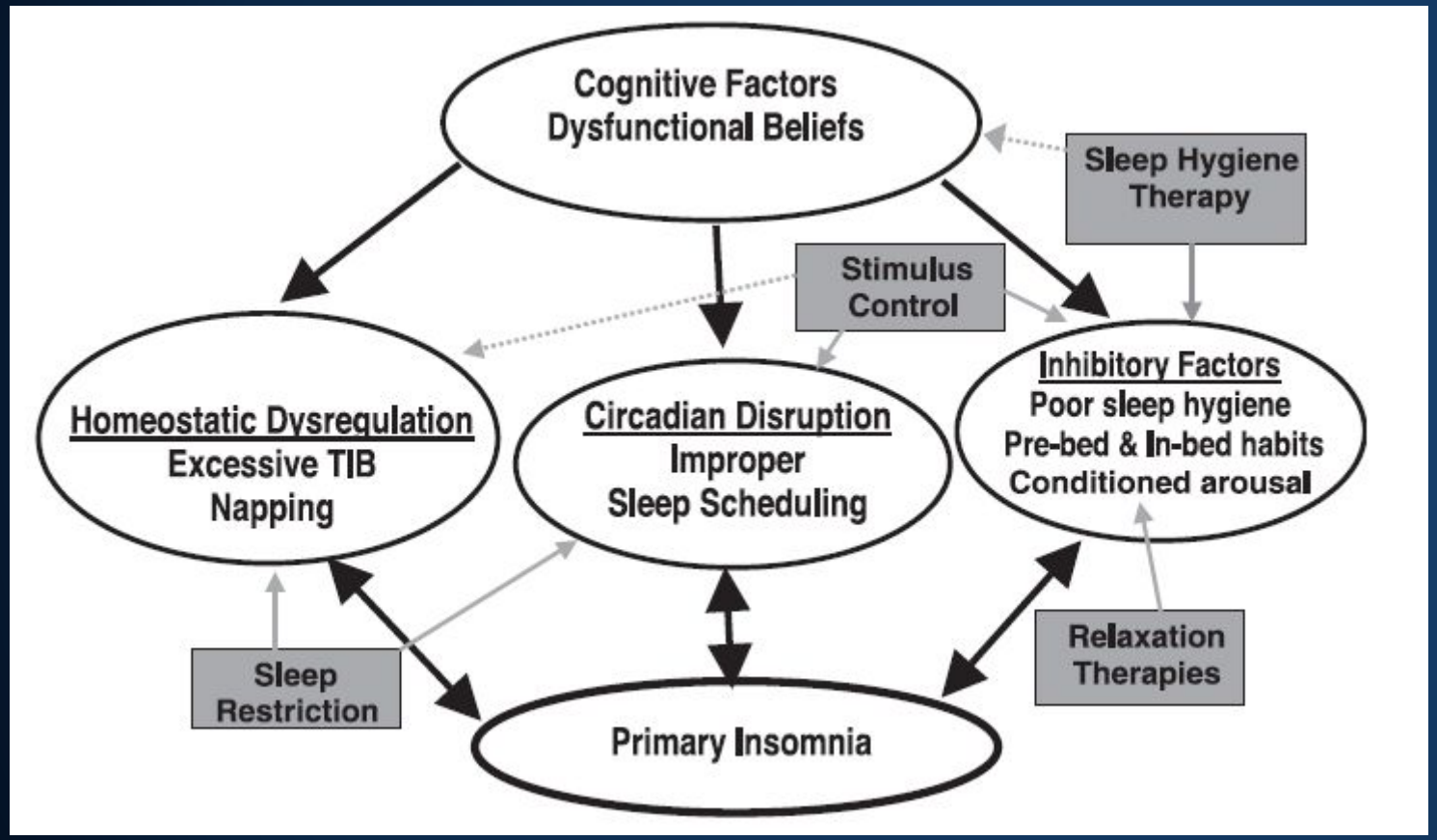


No hypnotics, anxiolytics, opioids, marijuana, etc.

CBT-I: CBT FOR INSOMNIA

- Cognitive-Behavioral Therapy for Insomnia (Perlis et al., 2008)
  - 6 sessions
  - Psychoeducation about sleep and what interferes with it
  - Sleep restriction
  - Stress management
  - Cognitive restructuring
  - Relapse prevention

CBT-I FOR INSOMNIA



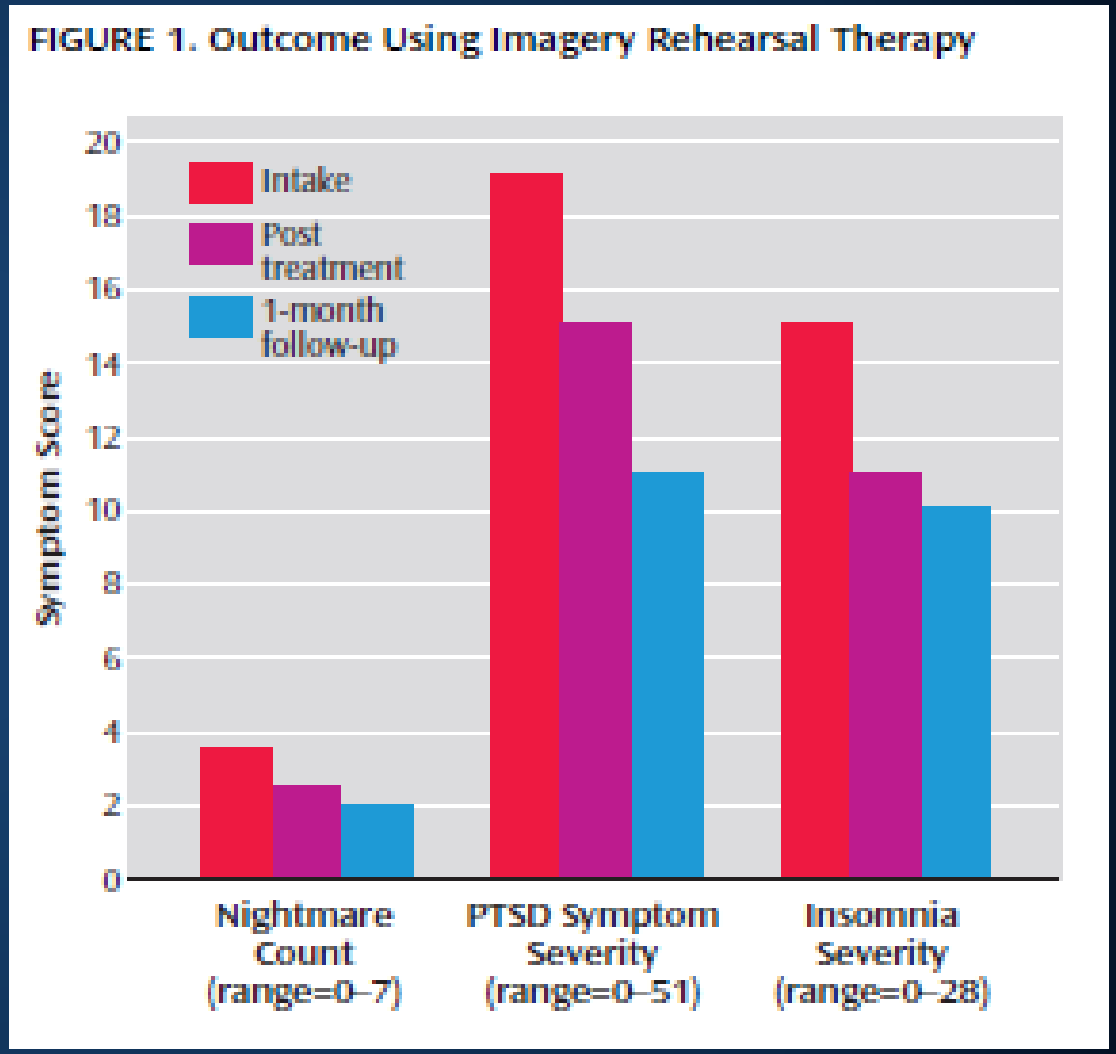
- CBT-I works (Smith et al., 2002)
- It also works in Veterans (Talbot et al., 2014)
  - Sleep improvements maintained after 6 months
- Group CBT-I works too (Koffel et al., 2015)

IMAGERY REHEARSAL THERAPY

- IRT is a five session cognitive-behavioral treatment for nightmares
- It is based on two concepts (Krakow & Zadra, 2006):
  - Repetitive nightmares become habits
  - Internal imagery can be changed through rehearsal
- Protocol
  - Learn about how nightmares function
  - Practice imagery rehearsal
  - Rewrite nightmare ending and rehearse rewritten nightmare

IRT IS EFFECTIVE

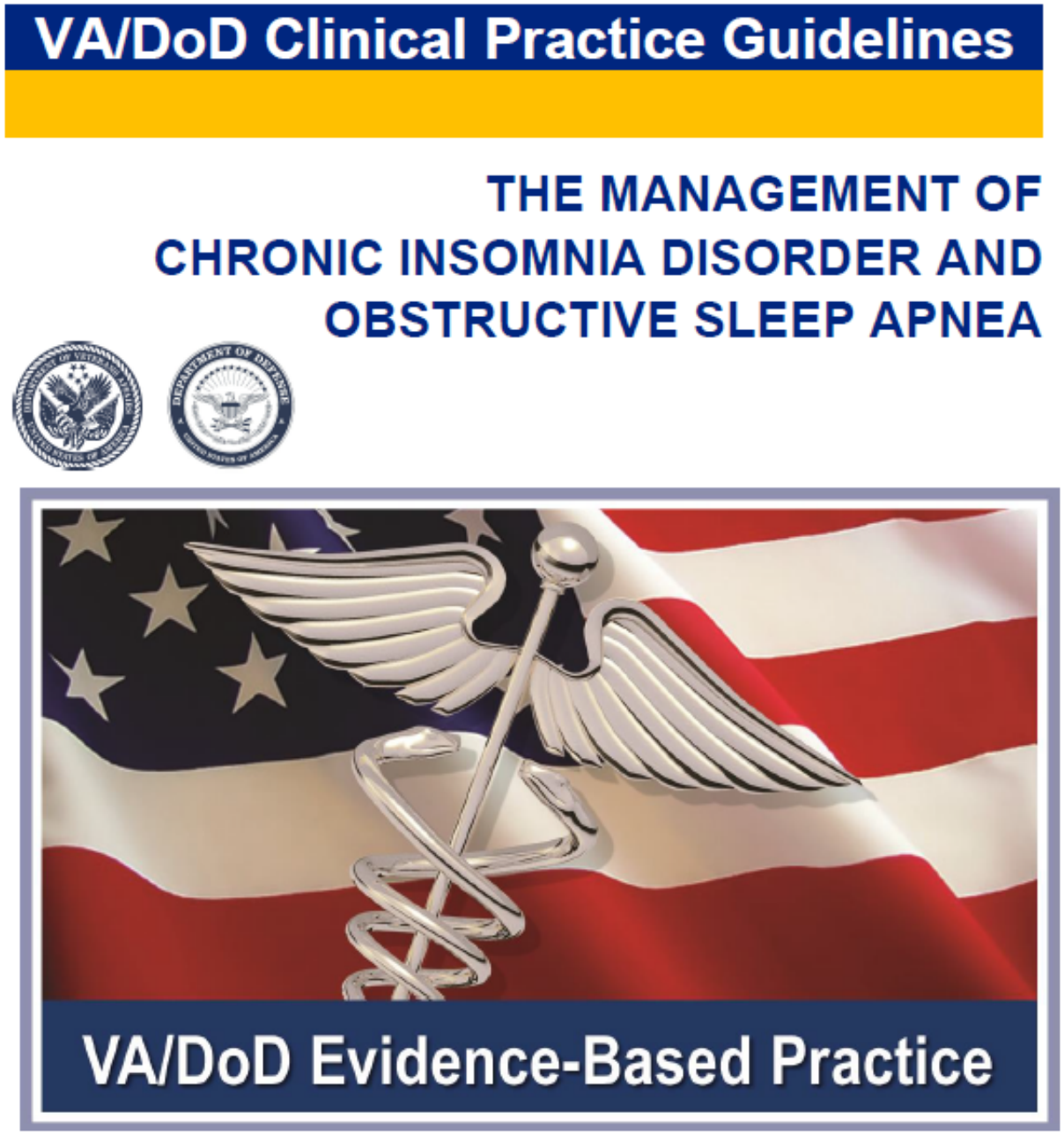
- 70% of patients experience clinically meaningful improvements in nightmares (Krakow & Zadra, 2010)
- IRT decreases nightmare distress (Krakow & Zadra, 2006)
- Changes are maintained over time, from 12-30 months (Forbes et al., 2003; Krakow et al., 1993)
- IRT also improves sleep quality (Krakow et al., 1995; Moore & Krakow, 2007; Nappi et al., 2010)

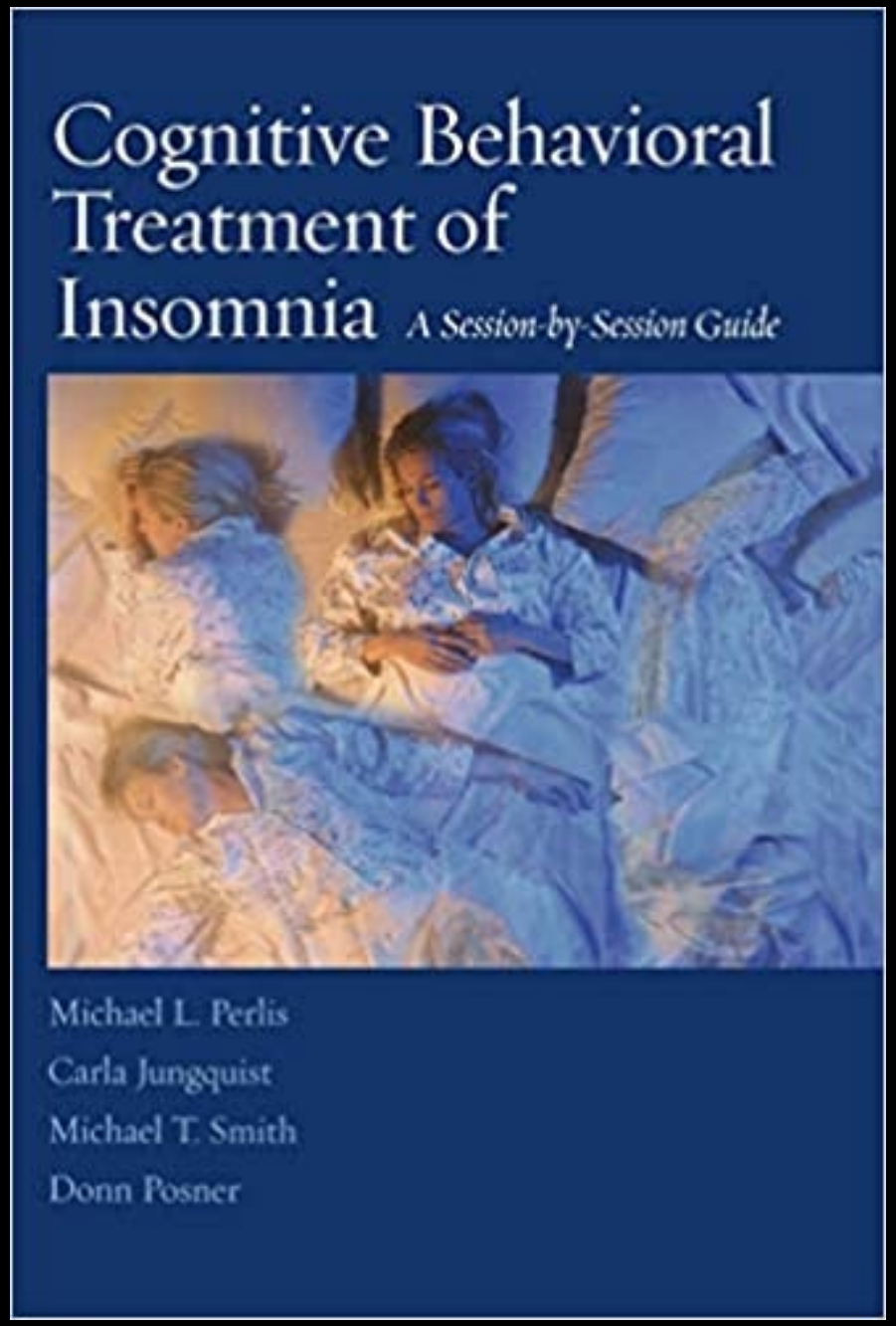


Moore & Krakow, 2007

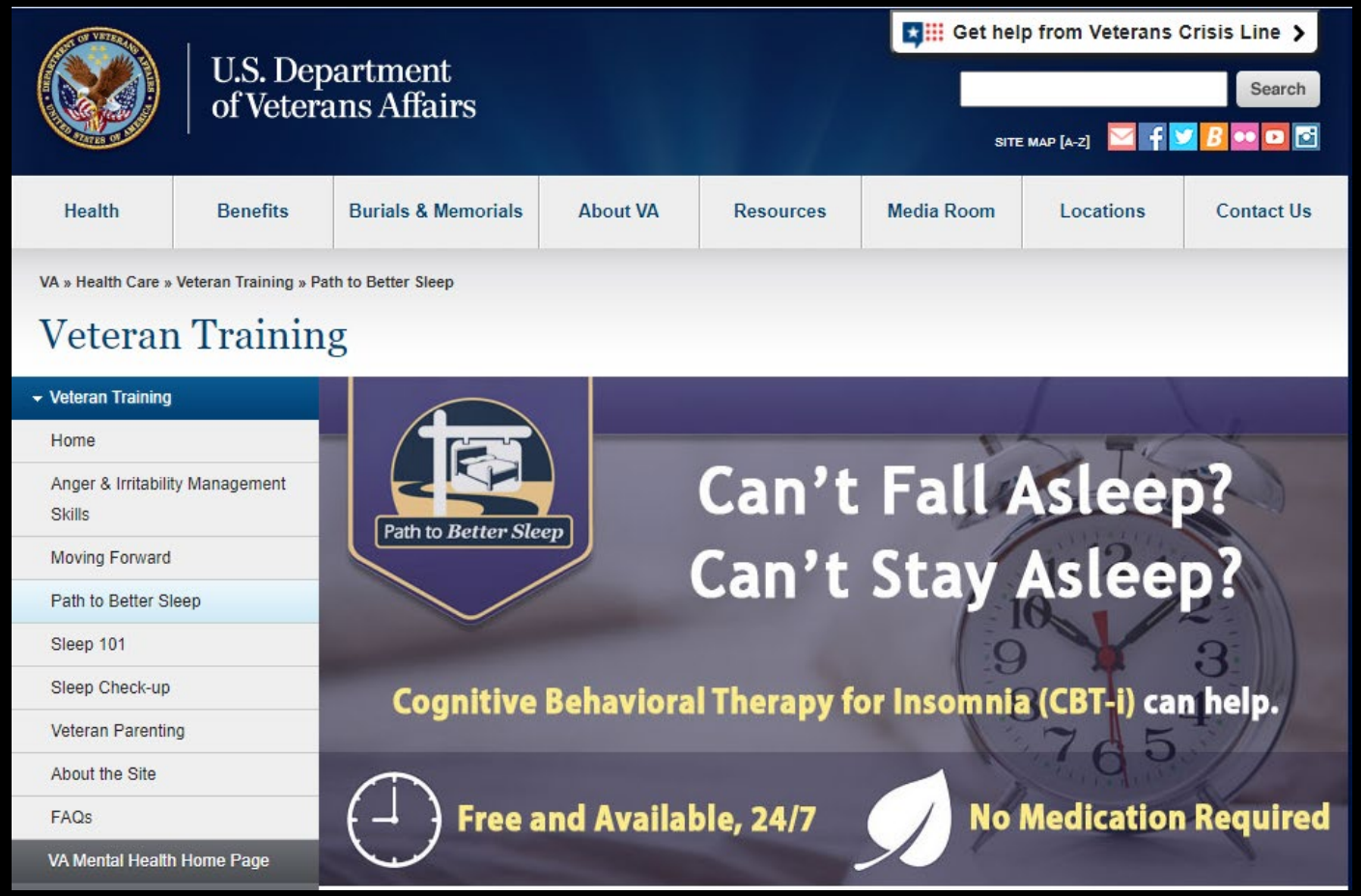
RESOURCES

VA/DOD TREATMENT GUIDELINES




Cognitive Behavioral Treatment of Insomnia
A Session-by-Session Guide
Michael L. Perlis
Carla Jungquist
Michael T. Smith
Donn Posner

CBT-I



CBT-I

Free online self-administered CBT-I: https://www.veterantraining.va.gov/insomnia/

IRT DESCRIPTION

Krakow, B., & Zadra, A. (2006). Clinical management of chronic nightmares: Imagery Rehearsal Therapy. *Behavioral Sleep Medicine, 4*(1), 45-70.

APPS

- www.rainymood.com

- Apps:

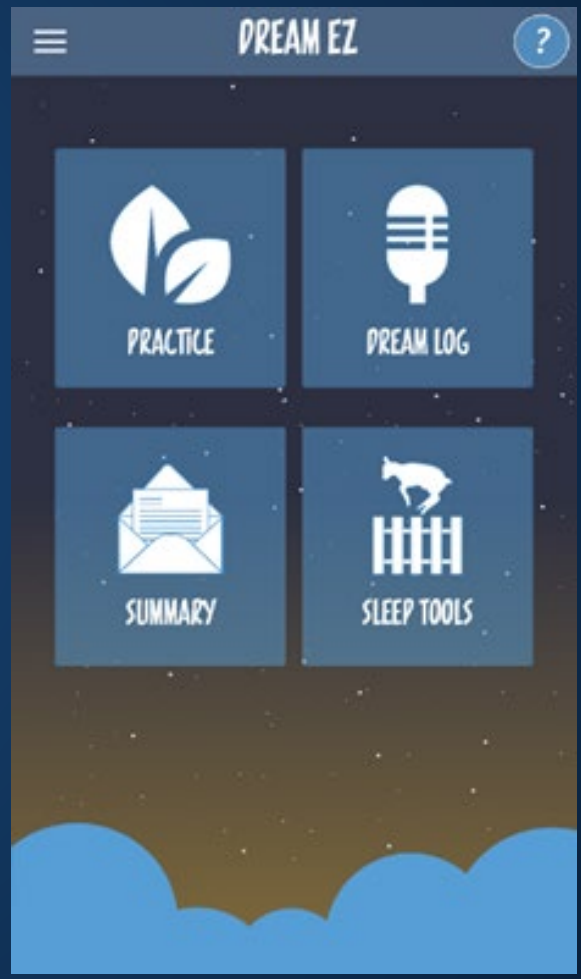
  Sleep Pillow

White Noise

Relax Melodies

IRT APP


Dream EZ
REWRITE YOUR NIGHTMARES


DREAM EZ
?
PRACTICE
DREAM LOG
SUMMARY
SLEEP TOOLS

Contact:

Brian L. Meyer, Ph.D.

BrianImeyerphd@gmail.com

Foundations of Successful Adolescent Recovery:
A Trauma-Informed Systemic Approach

BILL MAHER, CIP, CADC, ACI

ADRIENNE LOKER, LCSW,

EMDRIA CERTIFIED THERAPIST

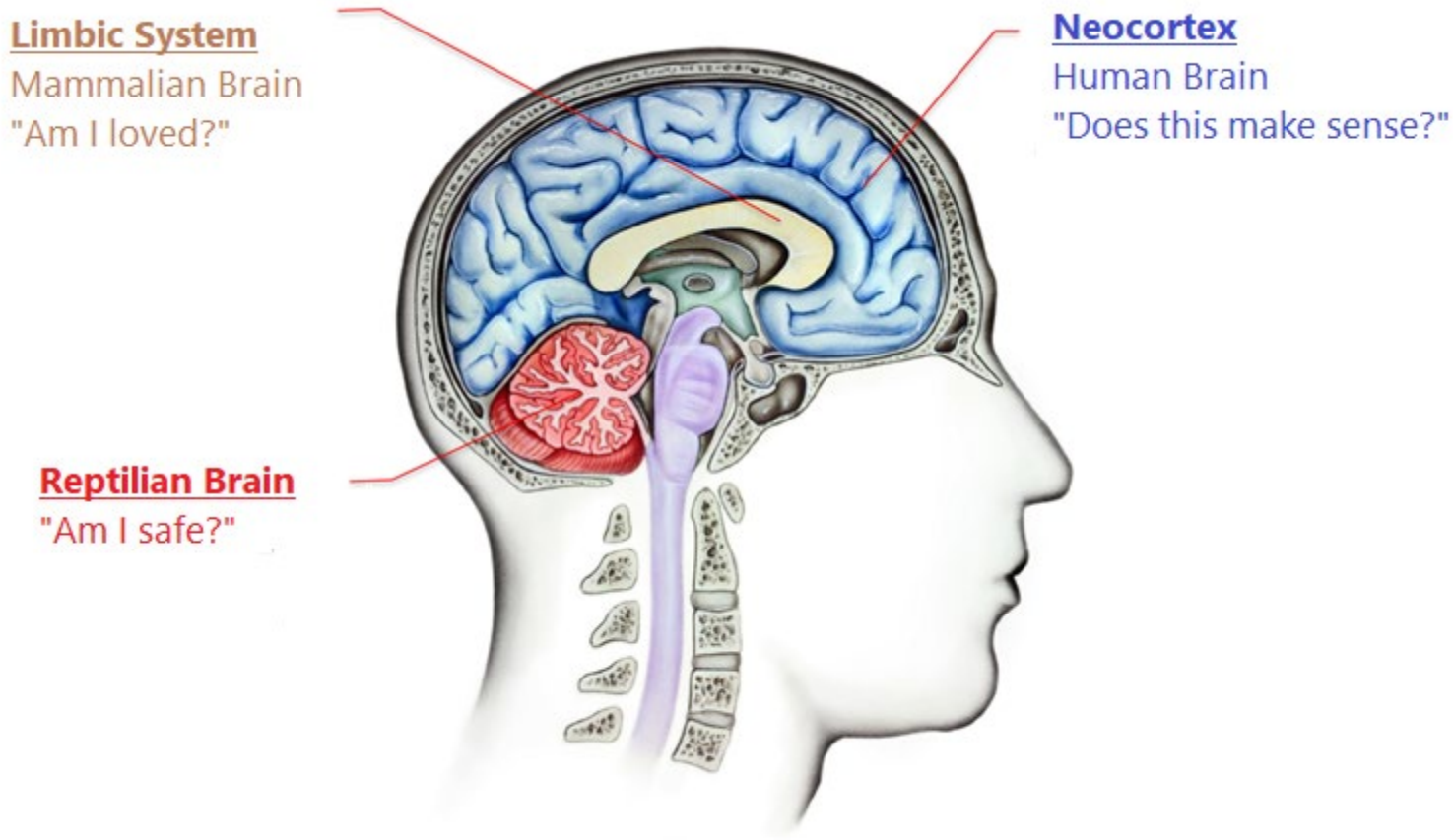
Today, we will explore….

- Implications of trauma in recovery
- Intervening on family dysfunction
- Realistic expectations

“Trauma is what we store inside in the absence of an empathic witness.”

DR. PETER LEVINE

Bottom-Up Processing



Traumatized Families

Rules of addiction:

- ❖Don’t talk
- ❖Don’t trust
- ❖Don’t feel

Rules, behaviors, and events

=

Overactivation of F/F/F

Families need an intervention to break these rules

What is an intervention?

- Ongoing process of disrupting collusion w/disease
- Expansion of support system
- Reorganization of family hierarchy
- Stabilizing family's anxiety

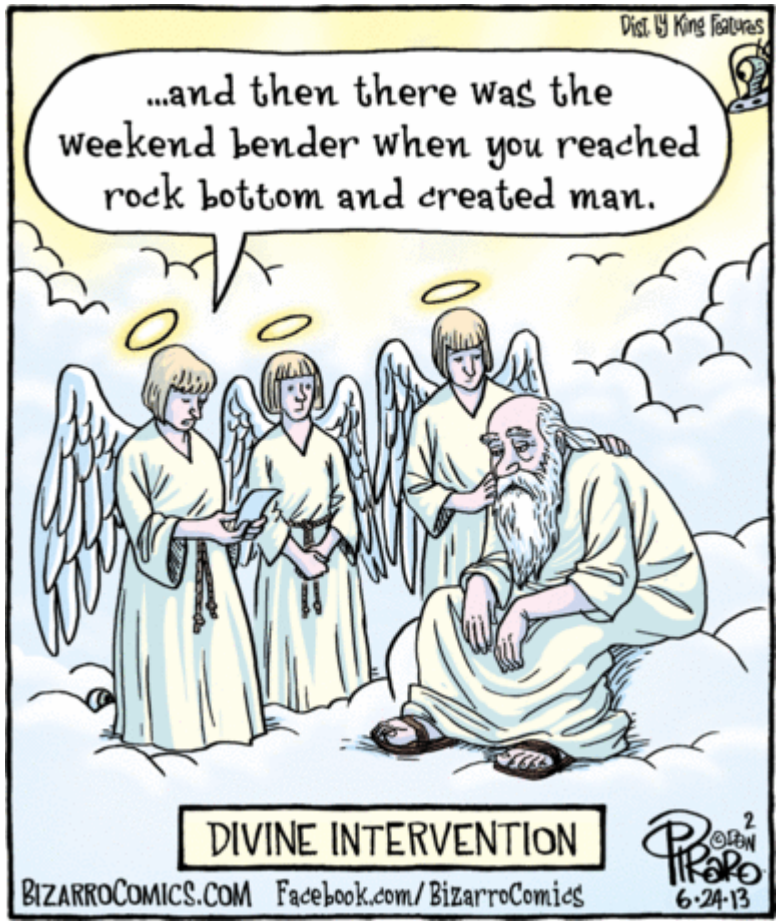
What is an intervention?

- An organized ~~confrontation~~ care-frontation by a professional
- The goal: **To take control away from a substance**
- A byproduct? **The loved one admits to treatment**

A “care-frontation” over a “confrontation” involves systemic planning and trauma-informed training

Who’d like to participate in an intervention?

6 volunteers please!

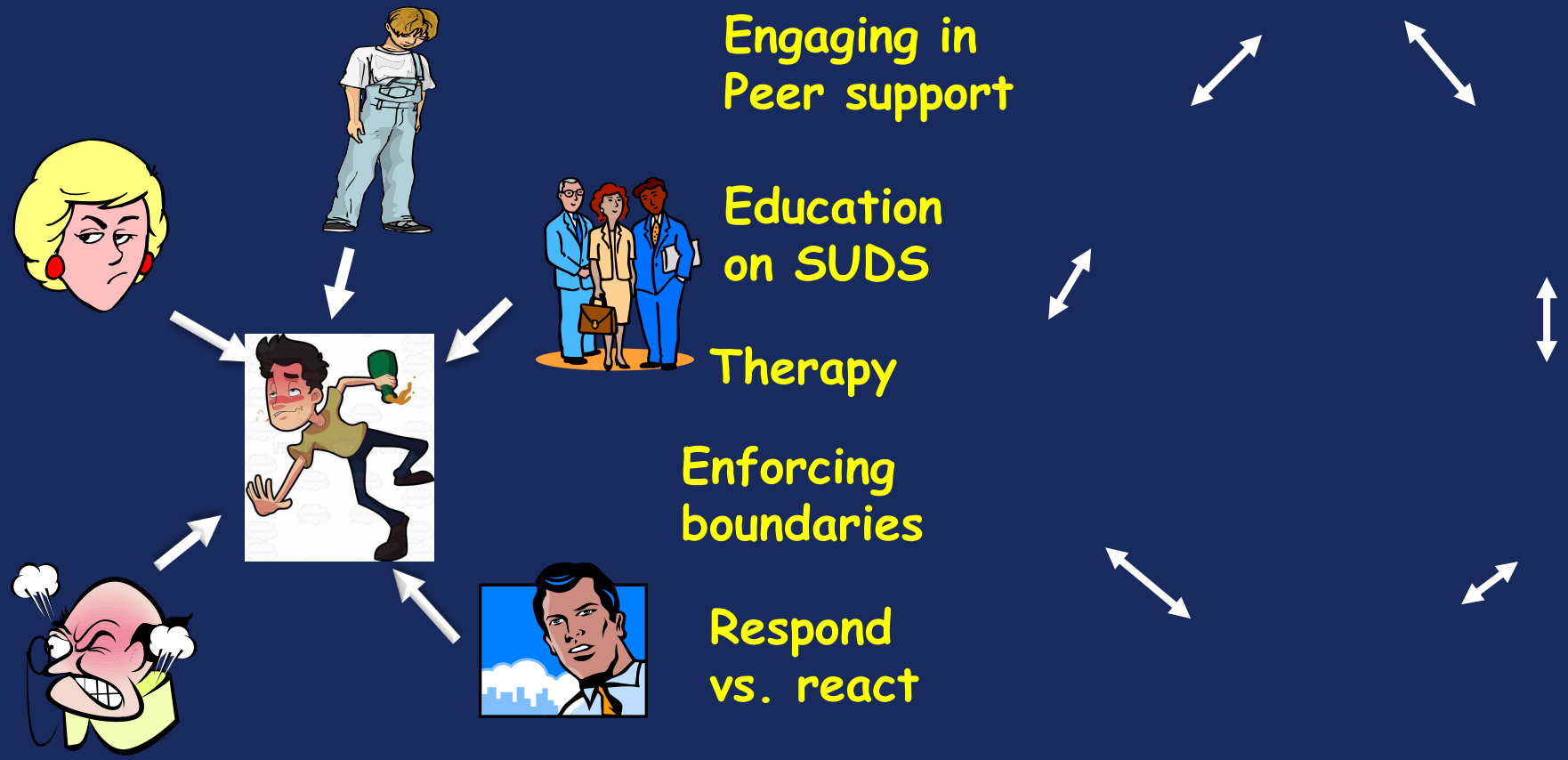


Reorganizing the System

Addicted System

Healthy System

Abstinence Contract



Engaging in Peer support

Education on SUDS

Therapy

Enforcing boundaries

Respond vs. react

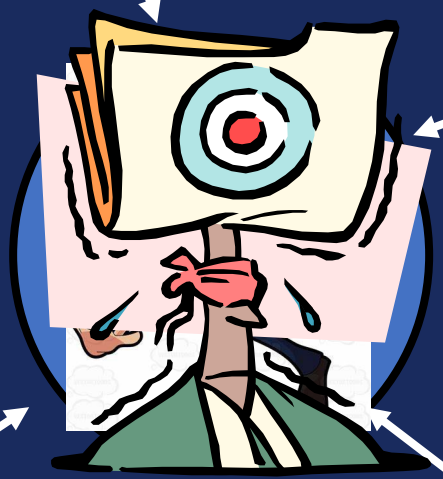
Collusion with the Disease

Anxious

Fearful

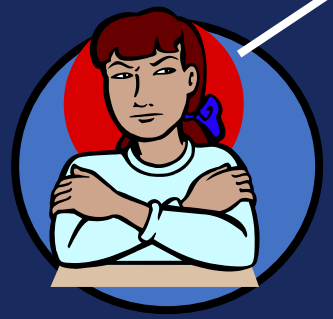
Distrustful

Eggshells



Resentful

Angry



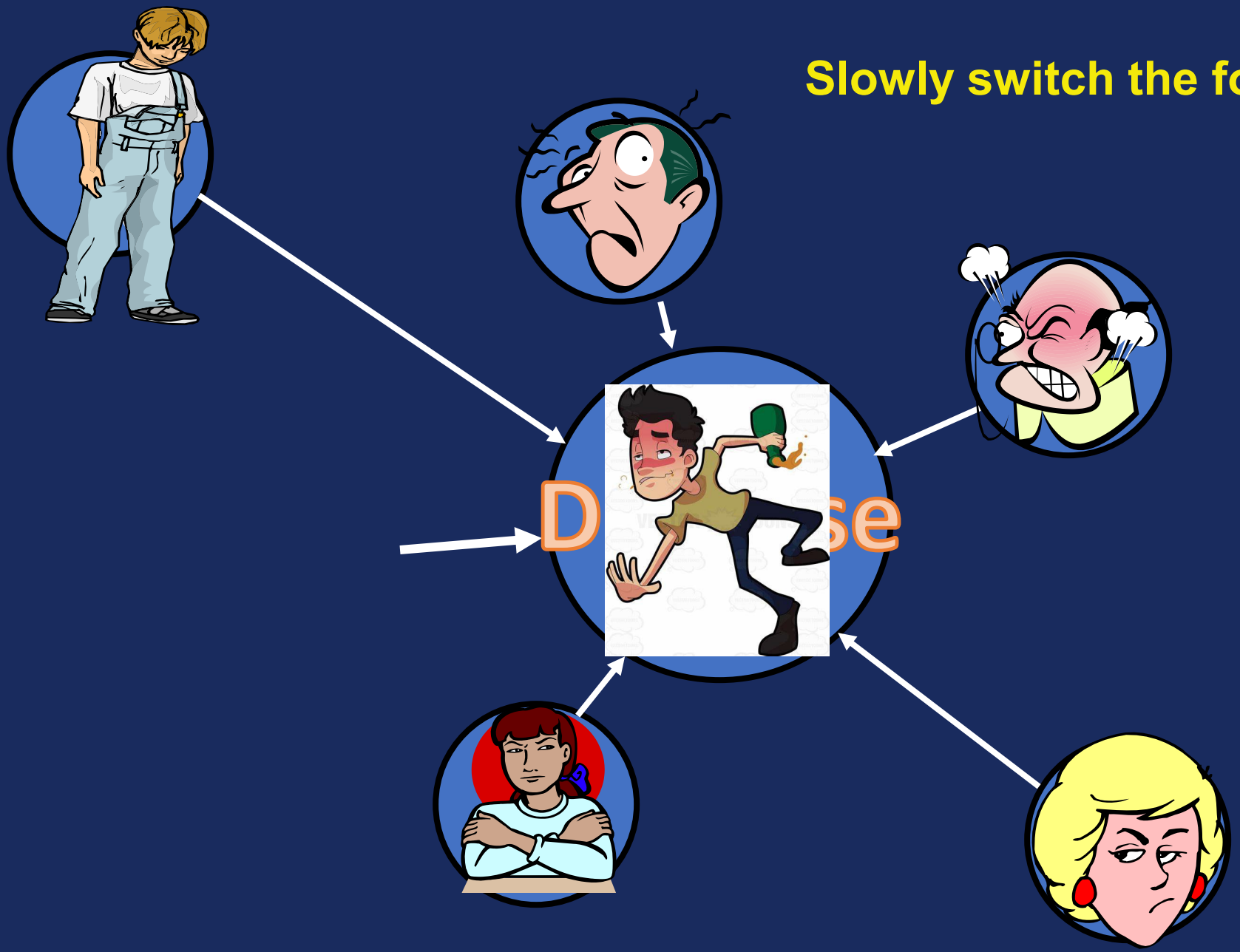
Disconnected

Avoidant

Peacekeeper

Overfunctions

Slowly switch the focus



There’s a 17-20% increase in long term success

when family’s get involved in their

own recovery….

….and ***also learn*** how to support their loved ones

suffering from SUD’s

Treatment is just the beginning

EARLY RECOVERY IS FIRST ~2 YEARS

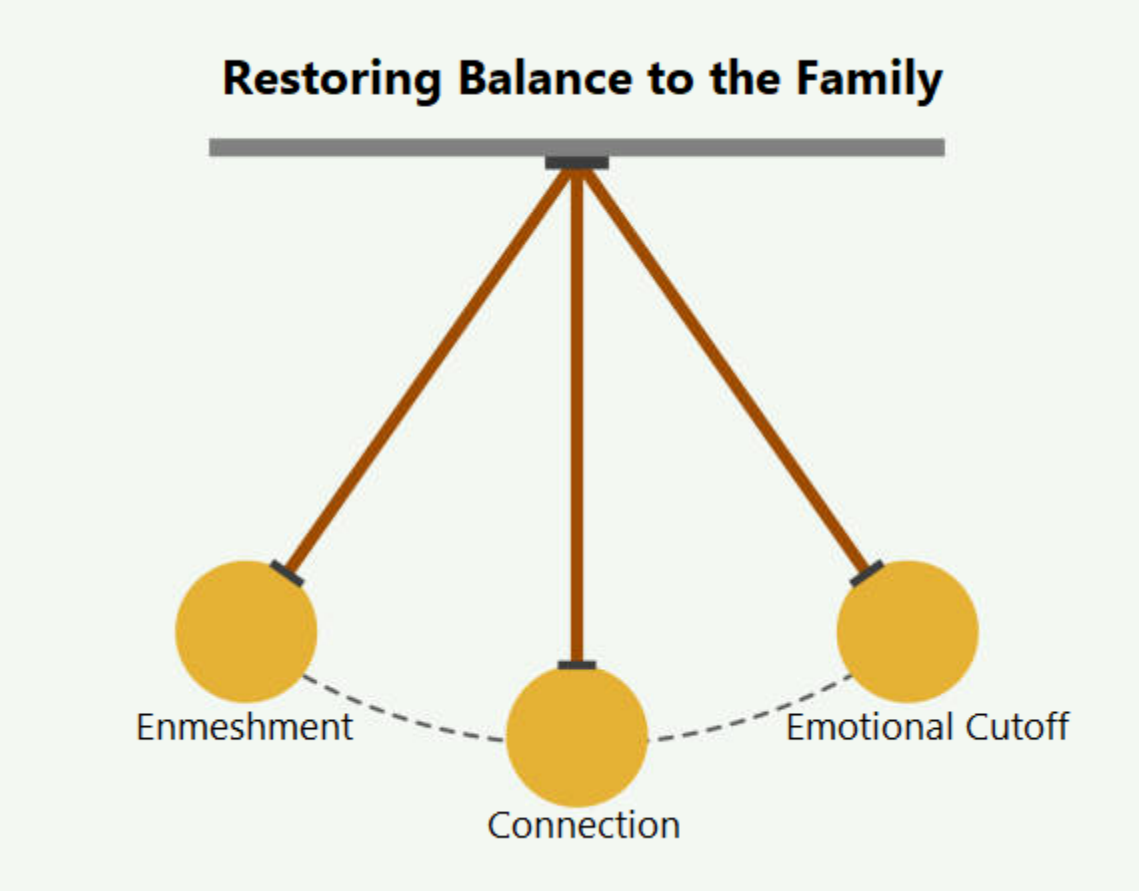
Old Thinking vs. New Thinking

- Get ‘em sober
- No more anger
- No more anxiety
- All problems solved

- Connect to self
- Connect to each other
- Move through big feelings together

Realistic Goals

- Harm reduction
- Skill acquisition:
  - Social
  - Vocational
  - Life
  - Emotional
- Family functioning
- **The goal is NOT long term sobriety**



As the family is supported in adopting effective dynamics, the loved one cannot comfortably continue their destructive behaviors

Redefine “The Patient” as the Family

- Everyone has been affected by the problem behavior
- Everyone participates in problem maintenance behavior
- Everyone has treatment needs

Family vs. Addiction

Make implicit rules explicit

- Hierarchy of power – who's really in control?
- Shake up family roles
- What's the function of these rules?
- Challenge the efficacy of these rules
- Replace ineffective tools

Acquisition of new skills

- *Enforcing* boundaries
  - Intermittent reinforcement video
- Implementation of self-care practices
- Respond vs. react
- No more secrets

It takes time to implement new behaviors intuitively.

RECOVERY IS A LIFELONG PROCESS

Further reading

"It Takes a Family" by Debra Jay

"The Whole-Brain Child" by Dan Siegel, MD and Tina Payne Bryson, PhD

"Memo to Self" video by Kevin McCauley

For more information, contact Bill Maher and Adrienne Loker at:

(804) 677-7728 and (804) 396-4668

www.InterventionCTR.com

www.SeekingDepthToRecovery.com

Virginia Department of Behavioral Health & Developmental Services

Peer Recovery Support in Specialty Courts

Annual Drug Court Conference

September 19th 2022

Kim Boyd MS, CSAC, CPRS, QMHP
Region 3 Recovery-Oriented Service Coordinator
Virginia Department of Behavioral
Health and Developmental Services

Learning Objectives

- Understand the purpose of Peer Recovery Specialists (PRS), Peer Support Services and the design.
- Understand what is not Peer Support.
- Understand how Peer Support Services promote a recovery-oriented system of care by reducing stigma.
- Be familiar with certification requirements in the state.
- Understand core competencies and competencies specific to drug court.
- Be familiar with how Peer Support services assist drug courts with meeting best practice standards and how to utilize peer support in the Sequential Intercept Model.
- Be familiar where to locate the code of ethics for Peer Support Specialist and how ethics might look different in the criminal justice system.
- Understand how peer support services impact outcomes.

What Is Peer Support?

- Peer support is the act of people who have had similar experiences with substance use challenges and/or mental health challenges giving each other encouragement, hope, support, and an understanding that aids someone on their recovery journey.
- These services may be provided prior to, during, and after treatment to an individual and/or family member of an individual with a substance use challenge and/or mental health challenge in an individual or group setting.

Isn’t This Is A New Service?

- The concept of peer support began in the 1970s when the self-help movement started. Survivors of the radical and harmful treatment in the psychiatric hospitals came together to support each other in a way only they could truly understand. They helped each other heal. This was the birth of peer support as we know it.
- 2017 Peer Support Services became a billable service under the ARTS program

What Does a PRS Do, Anyway?

- The **main role of a PRS** is to support someone along their recovery journey.
- We participate in a system of giving and receiving support founded on key principles of mutuality, respect, and shared responsibility.
- Provide support for self-advocacy & personal choice
- Person-centered, strength-based planning (focus on what is strong-not wrong)
- Builds trust within the criminal justice system
- Introduces and supports setback prevention planning.
- Promotes empowerment, self-determination, understanding, and coping skills.
- Link to recovery resources
- Share their personal experience, strength, and hope to bring **HOPE**.
- Support people in identifying their goals, hopes, and dreams, and creating a roadmap for getting there such as a recovery, resilience, and wellness plan (RRWP).
- Care coordination with other team members
- Promotes long-term recovery through modeling hope and wellness

Sharing Personal Recovery Story

- Using my experience, strength and hope as a skill to connect and relate to others is what distinguishes peer services from other behavioral health professionals.
- Self-disclosure should be helpful, relevant and strategic, not bragging. Telling my story demonstrates transparency and mutuality.
- PRS do not give advice but share what they have done as it relates to their lived experience, etc.
- PRS supports the individual as they optimize their autonomy and independence.
- I am not what I have done, I am what I have overcome.

It's Not My Job As A PRS….

- A sponsor
- A minster/spiritual adviser
- A medical provider
- A fixer
- A trauma counselor
- A best friend to the peer I am supporting
- Provide therapy (non-clinical service)
- A behavioral health technician
- A probation officer – peers should not be conduct urine screens, ensure medication compliance, provide medication counts, or be ask to impose disciplinary actions on those they serve. Mutual relationship.
- A spy at self-help meetings
- A spy for the participant (should not disclose what is discussed during team meetings with the participant).

Peer Support Services Should Promote

- Many pathways to recovery
- Self-directed care
- Recovery-oriented care
- Self-Advocacy
- Empowerment
- Hope
- Voice and choice
- Person-centered approach
- A strength-based approach
- Mutuality
- Based on peer support philosophy
- Be voluntary- If court-ordered to services, the participant may or may not build rapport with the PRS.

Peer Support Helps Reducing Stigma

- Stigmas mean a mark or a sign of shame, disgrace, or disapproval; of being shunned or rejected by others. It emerges when people feel uneasy or embarrassed to talk about behavior they perceive as different. **Cosco A. Williams, Veterans Health Administration, Atlanta Georgia**

- Changing how we think about and engage people with addiction is an important part of building recovery-oriented systems of care.
- When a person was described as a substance abuser as opposed to having a substance use disorder, clinicians perceived them as being responsible for their condition and were more likely to agree that the person should be punished rather than treated (Kelly et al., 2010). Further, recovery-oriented and strength-based approaches avoid creating more stigma surrounding person's experience or defining them by their condition or disorder.

Combating Stigma By Word Choice

Words to Avoid

- Addict
- Alcoholic
- Drug Problem, drug habit
- Clean
- Dirty
- Former/reformed addict/alcoholic

Words to Use

- Person with a substance use disorder
- Person with alcohol use disorder
- Substance use disorder
- Abstinent- not actively using
- Actively using
- Person in recovery- person in long-term recovery

How Do We Become Certified?

- Peers must complete the 72-hour DBHDS PRS training and accumulate 500 hours (under quality supervision) of direct service before testing.
- Must have a GED or High School Diploma
- One year of recovery is required to be eligible to test
- Once certified, peers are held to ethical standards by the Virginia Certification Board and to agency policy.
- If not certified, they are held accountable to agency guidelines
- 818 certified Peer Support Specialist's as of May, 2022

Peer Support Core Competencies

- 1. Current Body of MH/SUD Knowledge
- 2. Recovery Process - Promoting Services, Supports, and Strategies
- 3. Crisis Intervention
- 4. Values for Role of Peer Recovery Specialist
- 5. Basic Principles Related to Health and Wellness
- 6. Stage Appropriate Pathways in Recovery Support-
- 7. Ethics & Boundaries
- 8. Cultural Sensitivity and Practice- Knowledge of cultural sensitivity and practice-
- 9. Trauma and Impact on Recovery
- 10. Community Resources
- 11. Delivering Peer Services within Agencies and Organizations

Core Competencies Specific To Specialty Courts:

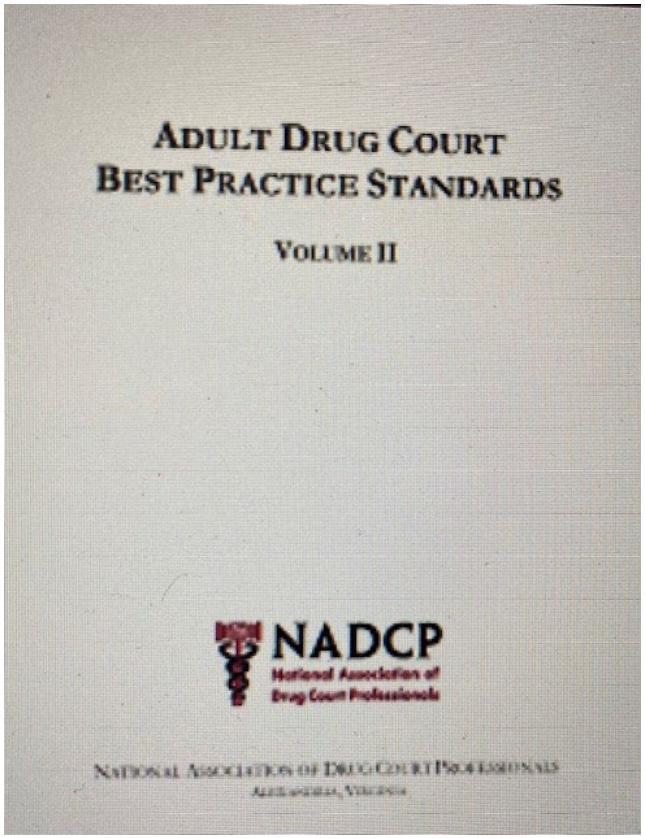
- Impact of culture of incarceration on behavior
- Understanding of incarceration and recidivism data in Virginia
- Discussion of trauma and its impact on community reintegration
- Lived experience of mandated recovery and self-driven recovery
- Lived experience in criminal justice system (ideal)
- Understand service gaps and opportunities for advocacy within each intercept of the Sequential Intercept Model (SIM).
- Understand the unique barriers faced by people involved in the criminal justice system in order to effectively advocate and navigate systems.
- Identify challenges and solutions when interacting with authority figures in the criminal justice system, such as probation, parole, court officers, corrections, police, etc.

Role of Peer Support Specialist in Specialty Courts

- Provide peer support based on the peer's lived experience, and knowledge of resources.
- Bridge the gap between other service providers and clients and also between Judge and the participant.
- Engage participants at orientation and give information about the program and the Peer Support role.
- Lead Recovery Support Groups (WRAP, Smart Recovery, Pathways to Recovery, etc.) Non-clinical groups.
- Connect individuals to resources in their community based on their need- build recovery capital
- Help individuals develop a recovery, resiliency, and wellness plan.
- Advocate for the individual in court and in staff meetings.
- Helps the individual plan for graduation/completion of the program by developing long-term recovery management plans.
- As a result of peer support services, system trust may be increased.

Drug Court Best Practice Standards: Standard 1

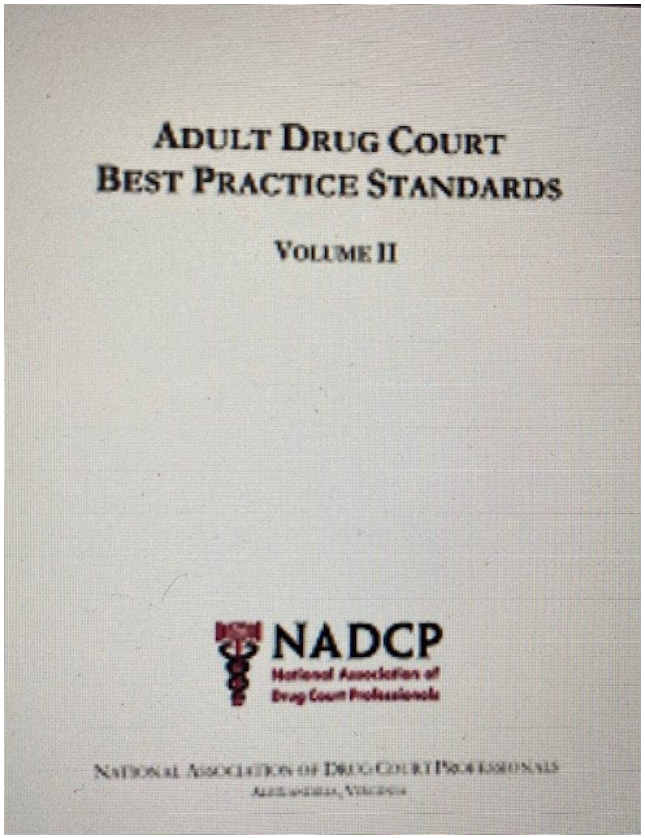
- **Standard 1: Target Population**
- A PRS can be a lifeline for potential participants, encourage engagement in the program, ask questions, begin building trust with criminal justice system.



Drug Court Best Practice Standards: Standard 4

- **Standard 4: Incentives, Sanctions, and Therapeutic Adjustments**

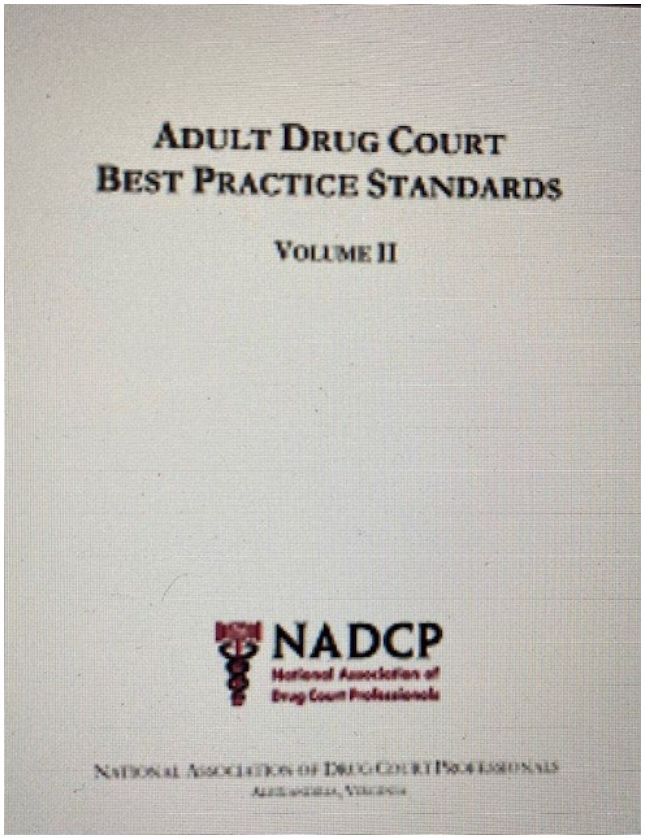
- PRS helps put setbacks in context (eg., jail visits), provide continued motivation for future decision-making, walk through opportunity to be heard, phase promotions.



Drug Court Best Practice Standards: Standard 5

- **Standard 5: Substance Use Disorder Treatment**

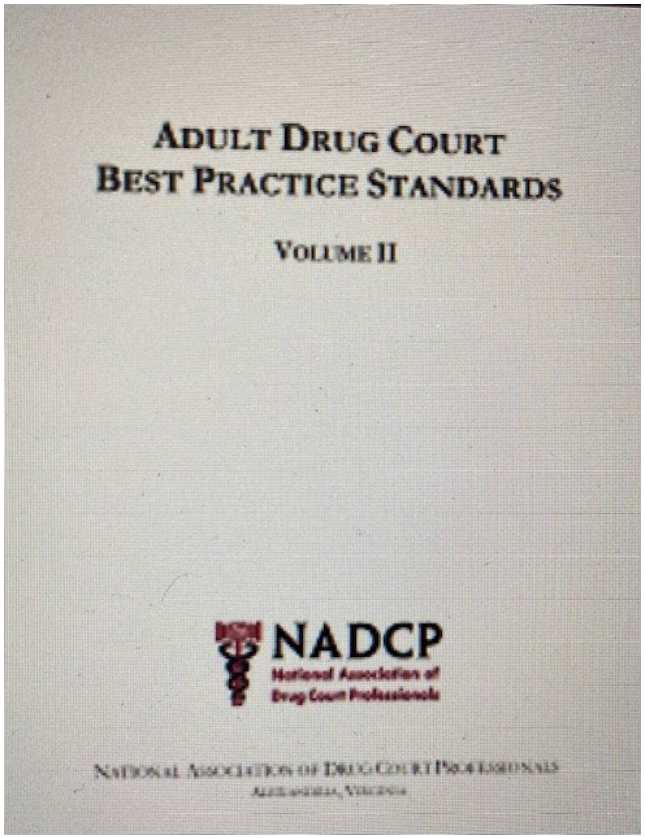
- PRS can facilitate peer support groups, improve treatment engagement, instill hope in wellness and recovery potential, aftercare. Evidenced Based Practice



Drug Court Best Practice Standards: Standard 6

- **Standard 6: Complimentary Treatment and Social Services**

- PRS can provide support and education about mental health treatment needs, wellness planning, reducing health risk behaviors, and act as the Bridger to other needed services.



Using the Sequential Intercept Model to Explore Peer Support Roles in Criminal Justice Settings

- **Intercept 0**: **Community Services**
- Prior to becoming involved in the criminal justice system individuals with untreated mental or substance use disorders may be engaged in the treatment and recovery process.
- Peer support activities at this intercept include general and targeted public outreach and engagement efforts, operating warm lines and crisis lines, serving on mobile crisis outreach teams, working in crisis stabilization units or act as a navigator or bridger in hospital emergency departments, serving on Assertive Community Treatment (ACT) teams, facilitating support groups, and providing a variety of peer support services in the community.

Using the Sequential Intercept Model to Explore Peer Support Roles in Criminal Justice Settings cont.

- **Intercept 1: Law Enforcement**
- Individuals in distress or crisis as a result of mental or substance use disorders who are encountered by law enforcement can be assisted into treatment and engaged in recovery through peer support services.
- Peer support activities at this intercept include involvement in Crisis Intervention Teams (CIT) and related training, co-responding with law enforcement and emergency services, and coordinating outreach and engagement efforts to follow up with individuals identified as being at risk for involuntary hospitalization and/or further involvement in the criminal justice system.

Using the Sequential Intercept Model to Explore Peer Support Roles in Criminal Justice Settings cont.

- **Intercept 2: Initial Detention/Initial Court Hearings**
- In situations where decisions are made to arrest individuals with mental or substance use disorders and charge them with specific crimes, peer support can help individuals process what has happened and prepare for what is coming next.
- Peer support activities at this intercept include explaining the arrest, detention, and arraignment processes; helping to ensure that the individual feels safe and respected; and giving the individual hope that they can recover from mental and substance use disorders and cope with criminal justice system involvement.

Using the Sequential Intercept Model to Explore Peer Support Roles in Criminal Justice Settings cont.

- **Intercept 3: Jails/Courts**
- After arrest, charges, and arraignment, additional opportunities exist to divert individuals with mental and substance use disorders from the criminal justice system. Many mental health, drug/recovery, and other problem-solving courts use peer support services.
- Peer support activities at this intercept include providing forensic peer support services on treatment court teams. In jails and prisons, peer support, particularly mentoring and facilitating support groups, is increasingly being made available to support individuals with mental and substance use disorders.

Using the Sequential Intercept Model to Explore Peer Support Roles in Criminal Justice Settings cont.

- **Intercept 4: Reentry**
- Individuals completing their sentences and transitioning from incarceration to the community are often facing significant challenges. Peer support is an important component of reducing relapse and recidivism.
- During reentry, peer support provides assistance with treatment planning and system navigation (accessing housing, employment, benefits, etc.). When begun prior to release, peer support activities include preparing individuals in jails and prisons to develop plans and identify resources to ensure uninterrupted treatment and connection with a recovery community.

Using the Sequential Intercept Model to Explore Peer Support Roles in Criminal Justice Settings cont.

- **Intercept 5: Community Corrections**
- Individuals who are placed on probation or parole benefit from peer support to assist them with understanding and adhering to the provisions and conditions of their probation or parole and to balance such responsibilities with sustaining treatment and recovery.
- Peer support providers work with both the individual as well as community corrections officers to access resources and services including housing, employment, and benefits.

Code Of Ethics

- Certified Peer Recovery Specialist are held to ethical guidelines set forth by the Virginia Certification Board – https://www.vacertboard.org/sites/default/files/VCBCodeOfEthicsFeb2014.pdf
- Registered Peer Recovery Specialist are held to ethical guidelines set forth by the Virginia Board of Counseling - https://www.dhp.virginia.gov/counseling/counseling_RPRS.htm

Developing Ethical Skills In The Criminal Justice System

- Working within the Criminal Justice System adds another layer of ethical responsibility.
- PRS's do not build character within the criminal justice by co-signing wrong doing. However we do not leave the individual, we support them through the issue.
- Personal recovery comes first!

Developing Ethical Skills In The Criminal Justice System (cont.)

- If I choose to ignore a wrong-doing, I am compromising myself ethically on a recovery level and a legal level.
- I could be held accountable for aiding and abetting an individual if I choose to ignore someone on probation telling me they are leaving the state without permission.
- Best Practice as a PRS is be to open and honest about your ethical responsibility early in the relationship. Example: share limits of confidentiality concerning coordination of care with other mentors, counselors, and supervisors.
- Peer Recovery Specialists maintain boundaries and resist the temptation to collude with individuals against the system, especially in the face of perceived or actual injustice. Similarly, Peer Recovery Specialists do not collude with the system against the individual, or act as an agent of the system ("Junior probation officer").

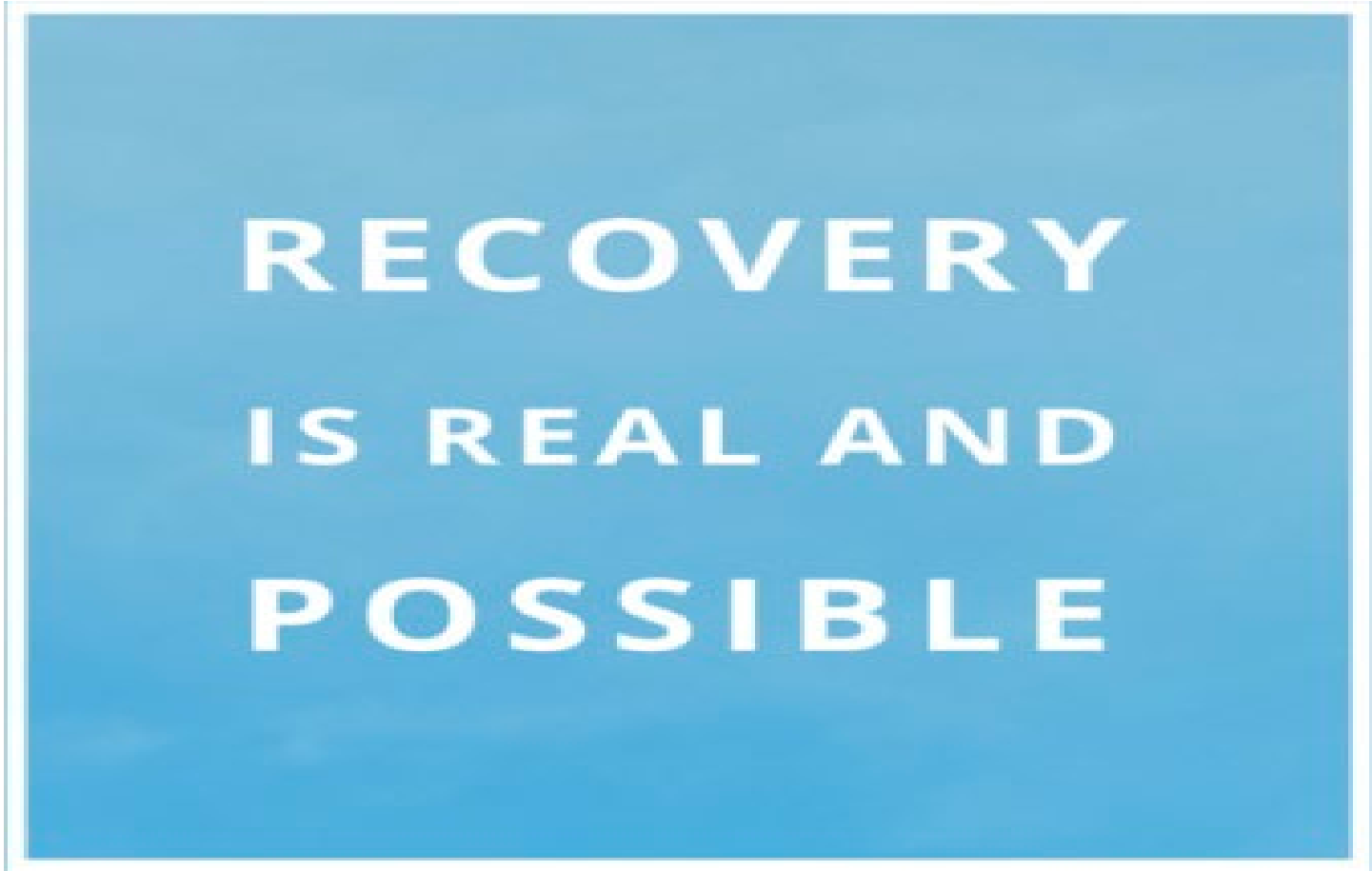
Developing Ethical Skills In The Criminal Justice System (cont.)

- Peer Recovery Specialists have a responsibility to know the guidelines and limitations to both HIPAA and 42-CFR Part 2 and other potential privacy laws.
- Peer Recovery Specialists have a clear understanding of the exceptions to confidentiality that include speaking with program staff, conversations with fellow mentors during staff meetings and when receiving permission from the mentee to contact others about a specific problem.
- Peer Recovery Specialists may need to report the following: drug use, violations of the terms of parole or probation, intention of self-harm, and intention to hurt others.
- Peer Recovery Specialists understand their obligations to report to the court/probation/parole and do not offer any more information than that which is required contractually or occupationally.

Do Peer Support Specialists Improve Participant Outcomes?

- Increased treatment engagement, retention, completion, and participant satisfaction
- Decreased use of emergency services and hospitalization
- Reduced risk of recurrence drug use
- Lower recidivism rate
- Better engagement in the drug court process
- Increased social adjustment
- Increased rates of employment
- Increase motivation and self-advocacy

HOPE



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SELF-RECOVERY:

FINDING *BALANCE* IN CARE OF SELF AND OTHERS

NANCY L JOHNSTON, MS, LPC, LSATP, MAC

INTRODUCTION

WITH GRATITUDE

SELF-RECOVERY INTRODUCED

HOW DID I/WE GET HERE?

CURRENT UNDERSTANDINGS

A research study (Dear, Roberts, & Lange, 2005) looked at 11 commonly used definitions for codependency and found **4 core features** in those definitions:

1- External focus
2- Self-sacrificing
3- Interpersonal control
4- Emotional suppression

CURRENT UNDERSTANDINGS

In 2020, Bacon et.al. published a study in which they interviewed individuals who identify as codependent. Wanting to know their lived-experience of codependence, they found 4 main themes:

- **Codependency feels real and tangible: "It explains everything."**
- **Lack of a sense of self**
- **Emotional and occupational imbalances**
- **Sense of abandonment and/or control in childhood**

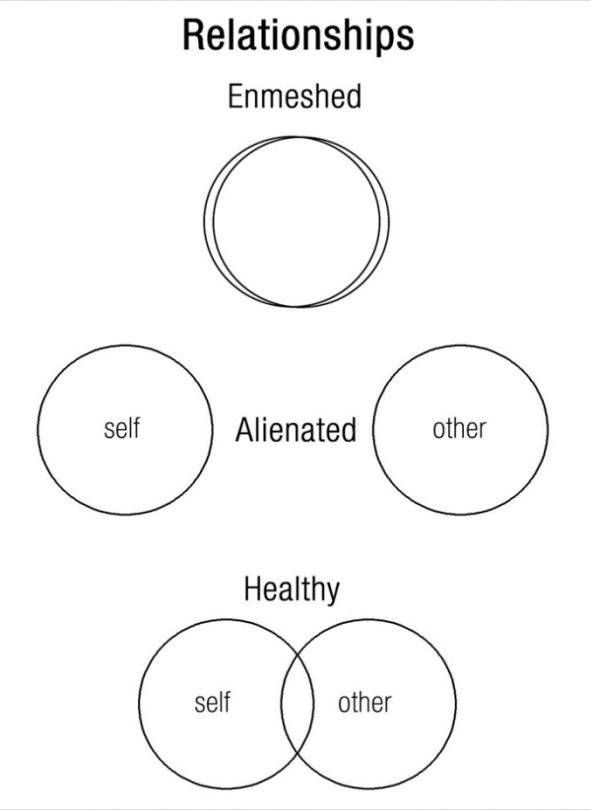
NANCY JOHNSTON'S CONCEPTUALIZATIONS OF CODEPENDENCE

In light of the progression of our history of codependence and research over the past two decades which highlight **external focus** and **lack of a sense of self** as significant features of codependence, I conceptualize codependence as:

- **Loss of Self in Someone Else**
- **Over-functioning for Others/Under-functioning for Self**

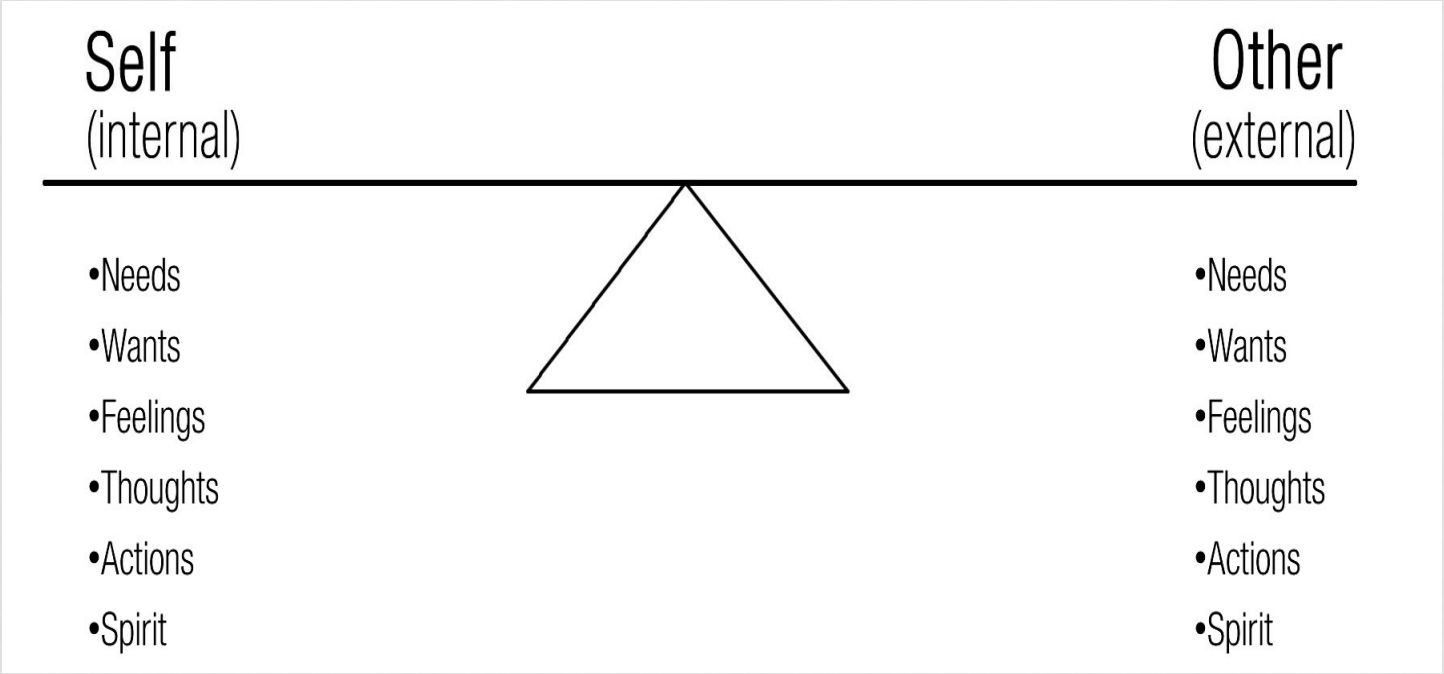
NANCY JOHNSTON'S CONCEPTUALIZATIONS OF CODEPENDENCE

LOSS OF SELF IN SOMEONE ELSE



NANCY JOHNSTON'S CONCEPTUALIZATIONS OF CODEPENDENCE

OVER-FUNCTIONING FOR OTHERS/ UNDER-FUNCTIONING FOR SELF



OUT-OF-BALANCE
WHAT DOES THIS LOOK LIKE?

WE MAY BE OVER-FUNCTIONING IN SOMEONE ELSE'S LIFE WHEN WE CARRY THESE BEHAVIORS TOO FAR:

- Giving
- Fixing
- Care-taking
- Helping
- Serving
- Thinking for others
- Speaking for others
- Taking over
- Controlling
- Doing for the other person what they need to do for themselves

NANCY JOHNSTON'S
CONCEPTUALIZATIONS OF CODEPENDENCE

A Continuum for Understanding and Managing Codependent Behaviors

Any particular **codependent behavior** can be examined along this continuum:

Okay	Too Far
Keeps connection with self	Loses connection with self
Able to be flexible and open	Rigid, obsessed
Causes no impairment in functioning	Causes impairment in functioning
Securely attached	Insecurely attached

OUT-OF-BALANCE
WHY WOULD WE DO THIS?

- Desire to help or fix
- Anxiety
- Fears
- Frustration
- Control
- Impatience

TAKE A MOMENT

for Curiosity about your Self

Do you have a tendency to over-function for others/under-function for self?

If you do, what are things you are neglecting in your own life when you are over-functioning for others?

(e.g. rest, time with family, your own health care, fun times with family and friends, reading a good book, etc.)

PAUSE

FOR REFLECTION

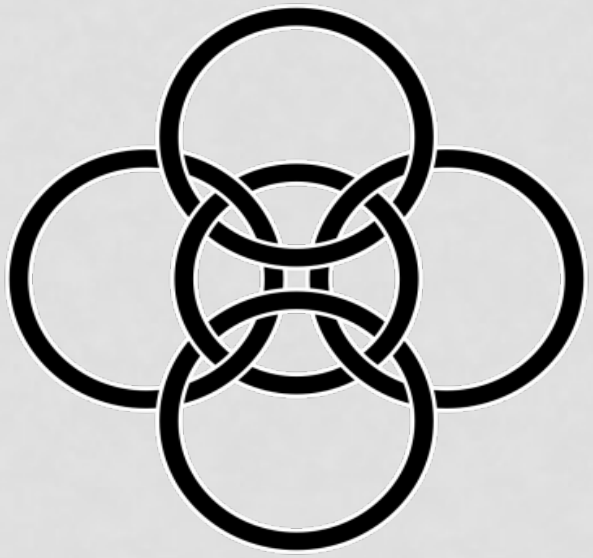
IN-BALANCE

THE HEALTH WE GAIN THROUGH SELF-RECOVERY

IN-BALANCE

4 ELEMENTS OF SELF-RECOVERY

- **Self-Understanding**
  With Compassion
- **Self-Awareness**
  With Calm Presence
- **Self-Competence**
  With Confidence
- **Self-Attunement**
  With Care



IN-BALANCE
4 ELEMENTS OF SELF-RECOVERY

Self-Recovery requires **the important shift from external focus to internal focus**. Making this shift requires:

Awareness

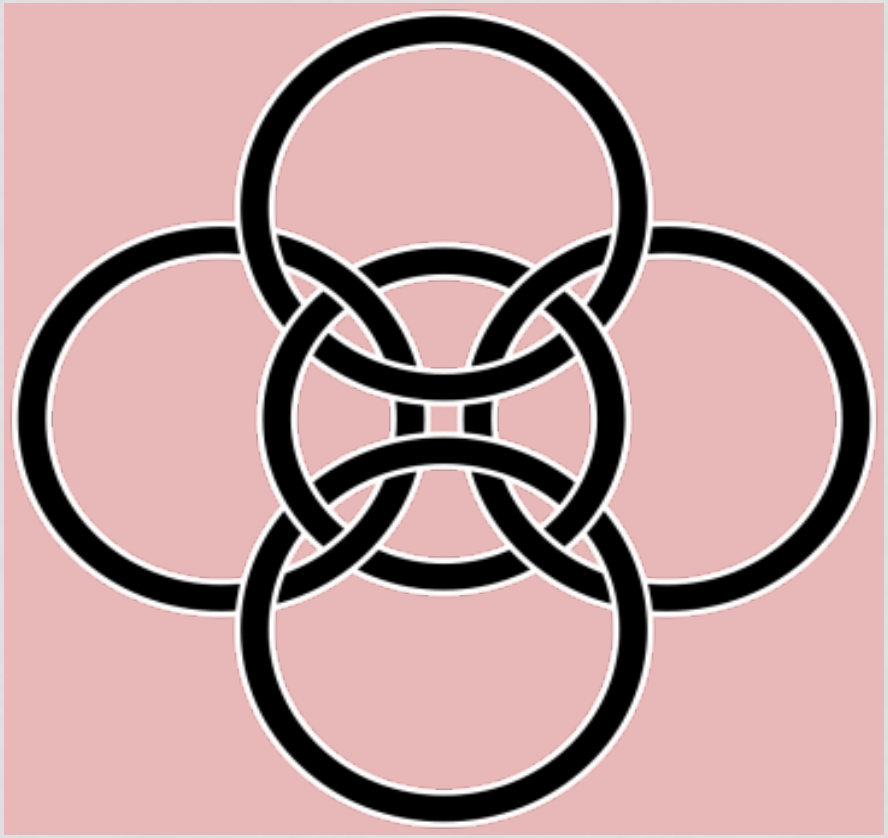
Willingness

Intentionality

4 ELEMENTS OF SELF-RECOVERY:

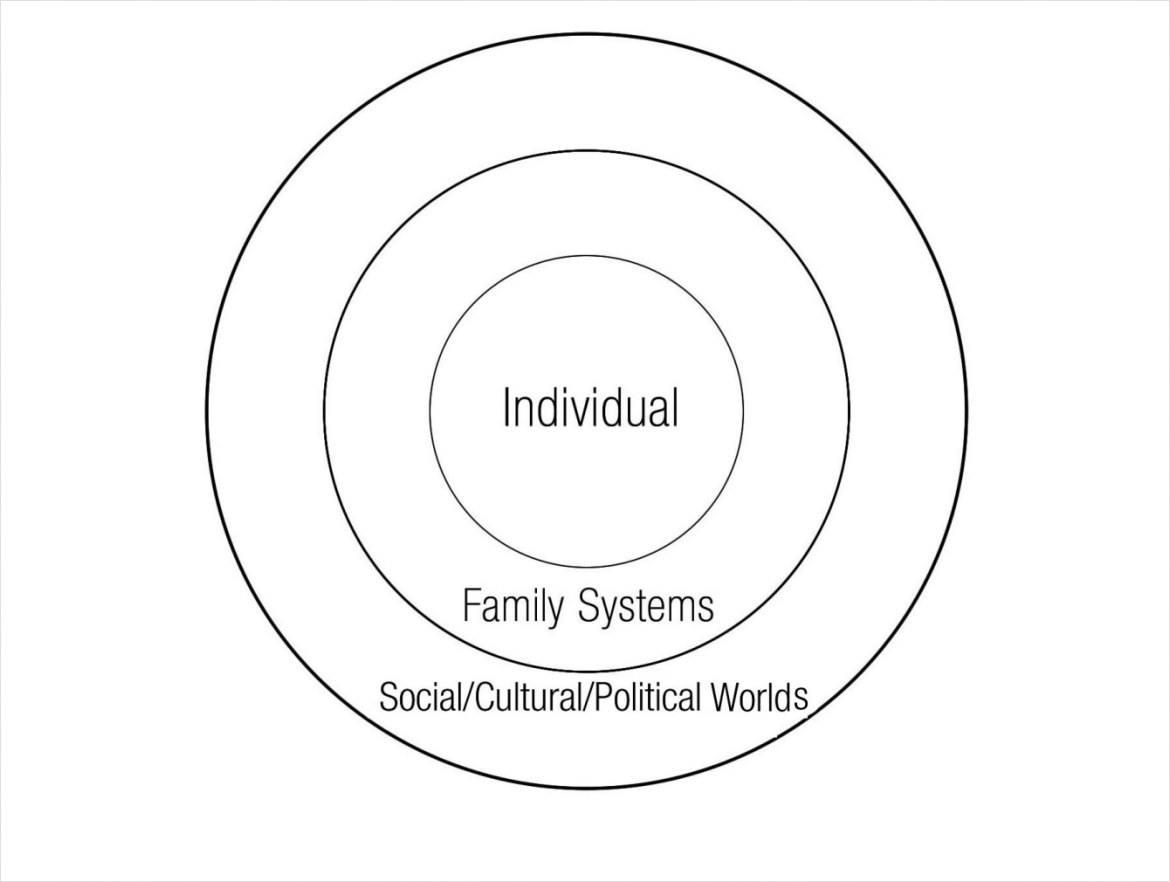
SELF-UNDERSTANDING

With Compassion



4 ELEMENTS OF SELF-RECOVERY:
SELF-UNDERSTANDING

Areas of Influence



4 ELEMENTS OF SELF-RECOVERY:
SELF-UNDERSTANDING

- **Individual Influences**
  - Nature
  - Tendencies
- **Family Systems**
  - Family Rules and Roles
  - Individuation vs. Fusion and Homeostasis
  - Trauma
- **Social/Cultural/Ethnic/Religious/Political Worlds**

4 ELEMENTS OF SELF-RECOVERY:
SELF-UNDERSTANDING

These **Influences** on development of self produce a variety of **parts** in each of us, parts that may be protective, creative, ambivalent, counter-productive. For example:

"Part of me wants to stay. Part of me wants to go."
"Part of me doesn't want to upset them."
"Part of me wants it done my way."
"Part of me feels guilty a lot of the time."

Acknowledging our parts, listening to them, and responding to them is part of Self-Recovery.

TAKE A MOMENT

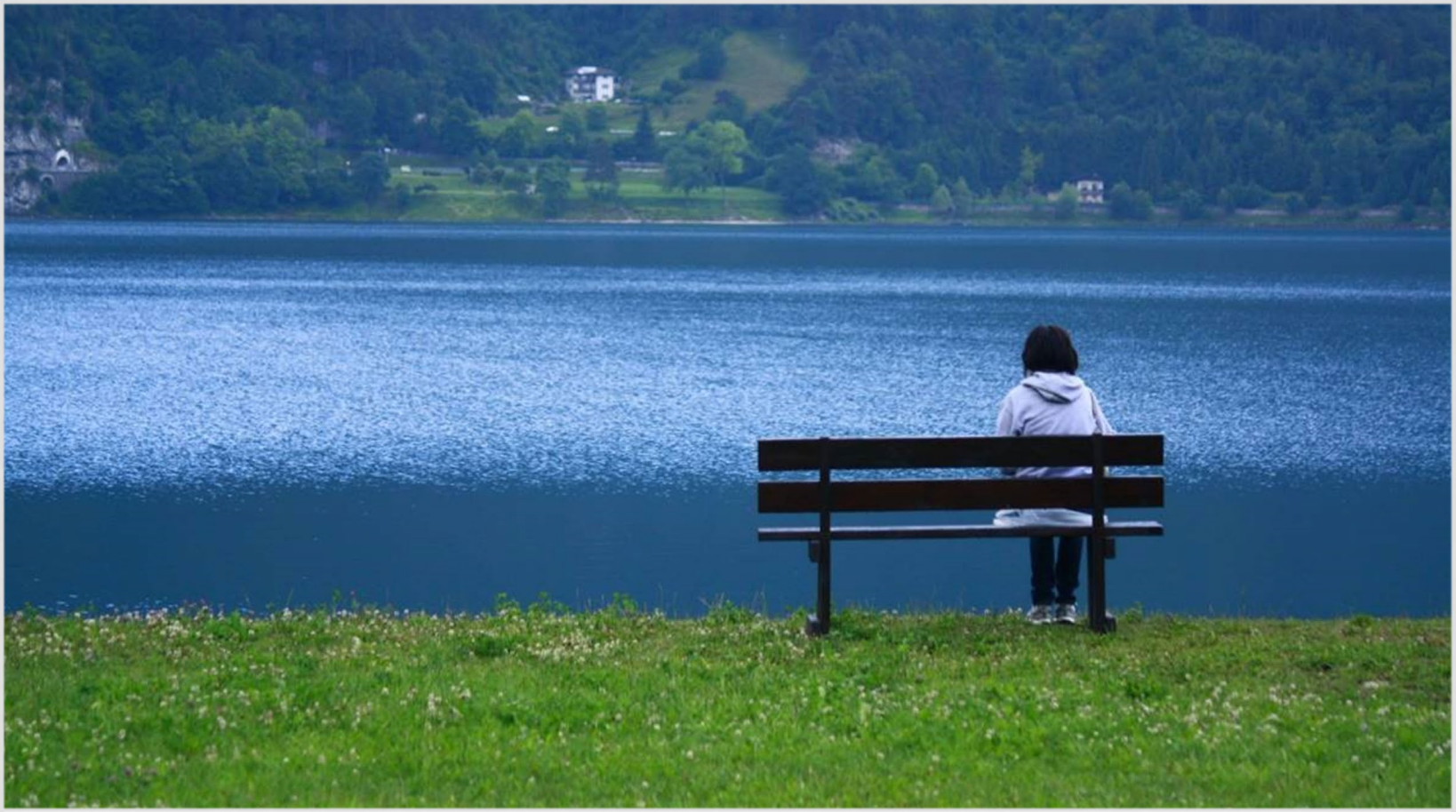
for Self-Understanding with Compassion

Can you recognize a part of you that has you overfunctioning for others and not connecting and responding enough to your self?

(e.g. need to finish a task, worry about someone else, need to control how things get done, doubting the ability of others, being super-responsible, etc.)

Can you name that part? Can you listen to it a bit? What does it want you to know?

(e.g. Please take a break. Your health is important too. Your relationships are calling you. Go home. You can't do more. Let it go., etc.)



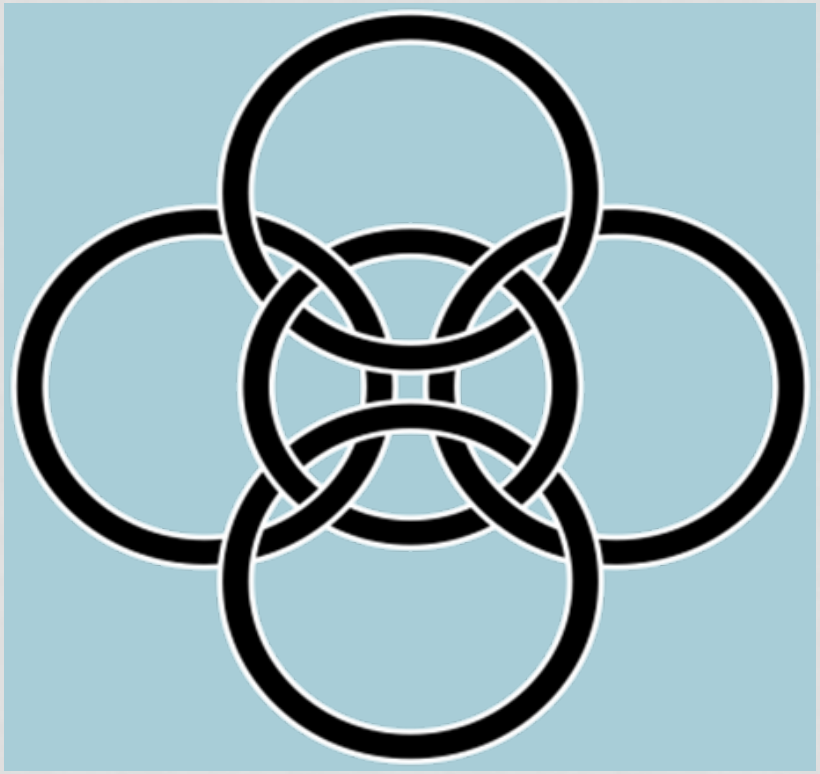
PAUSE

for Reflection

4 ELEMENTS OF SELF-RECOVERY:

SELF-AWARENESS

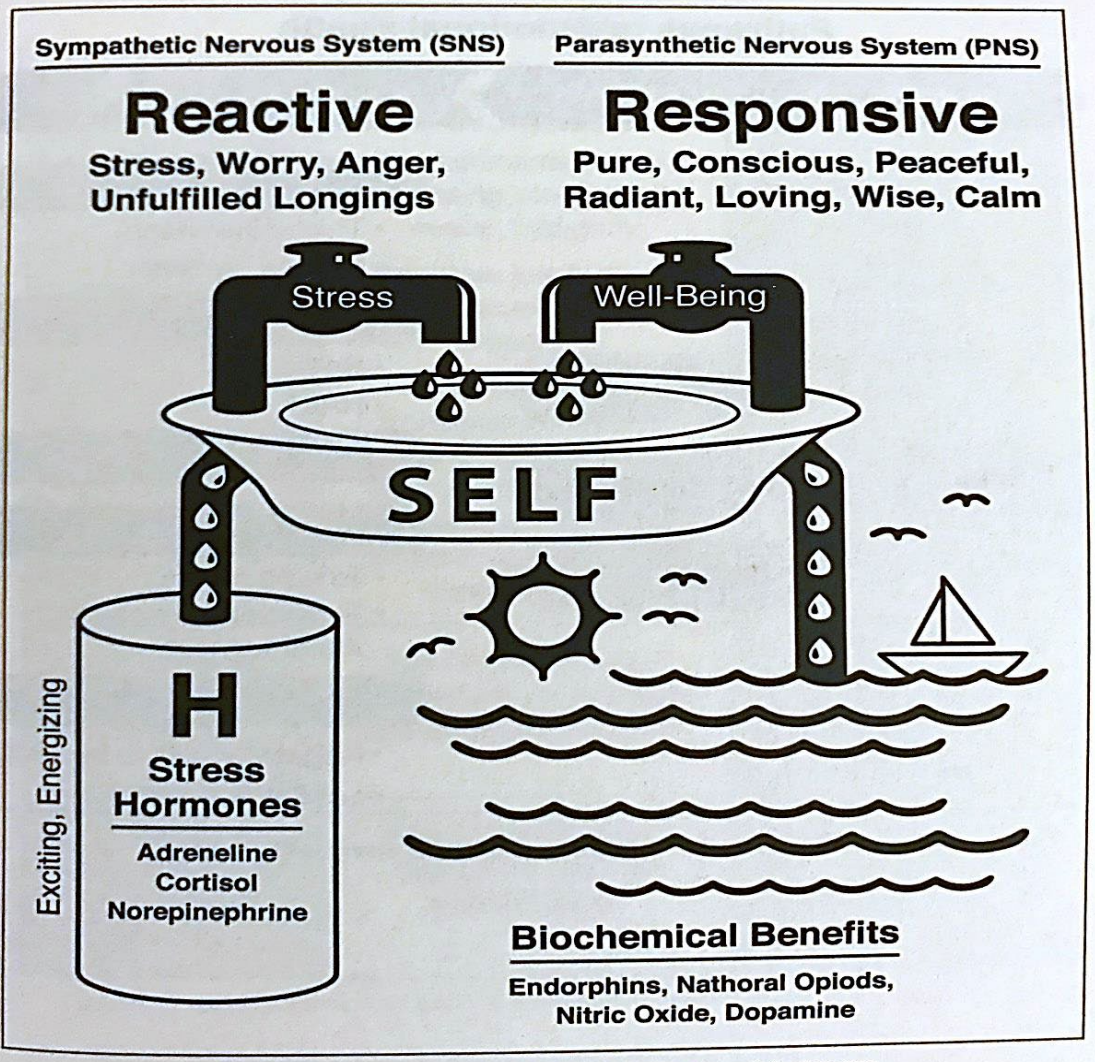
With Calm Presence



4 ELEMENTS OF SELF-RECOVERY: **SELF-AWARENESS**

- Becoming **Responsive not Reactive**
  - Shift from reacting to **responding**
  - Find **emotional balance** so you can:
    - See the situation more clearly
    - Respond in a way that is true for you

Illustration of Neurobiology and Self (Johnston, 2015)



Illustrated by Nancy L. Johnston, MS, LPC, LSATP – nancyljohnston.com
From the Writings of Rick Hanson, author of Buddha's Brain & Hardwiring Happiness.

4 ELEMENTS OF SELF-RECOVERY: **SELF-AWARENESS**

- Learning **Mindfulness Practices**
  - Mindful breathing
  - Gentle hatha yoga
  - Body scan
  - Paying attention to the five senses
  - Mindful eating
  - Mindful walking

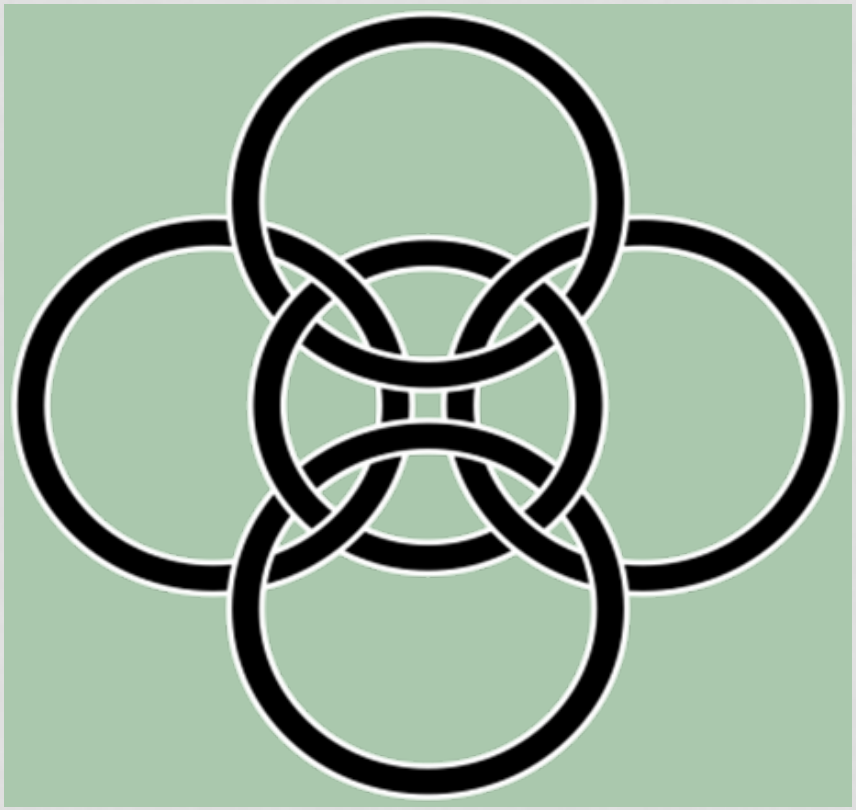
TAKE A MOMENT

for Self-Awareness with Calm Presence

4 ELEMENTS OF SELF-RECOVERY:

SELF-COMPETENCE

With Confidence



4 ELEMENTS OF SELF-RECOVERY: **SELF-COMPETENCE**

- Self-Recovery often involves **learning new skills sets** which increase Self-Competence.

- **New skill sets** may be needed in a number of areas including:

  - **Frustration tolerance**
  - **Anxiety management**
  - **Boundary setting**
  - **Guilt management**

4 ELEMENTS OF SELF-RECOVERY: **SELF-COMPETENCE**

Before we study some aspects of these skill sets, let's anchor ourselves in **5 Core Skills** that are involved in each of these skill sets.

These **5 Core Skills** are foundational and can help us **center our self** and then **tune in** to what we really want to say and/or do.

4 ELEMENTS OF SELF-RECOVERY:
SELF-COMPETENCE

5 Core Skills

1- Pause or Stop
2- Mindful breathing
3- Quieting thoughts
4- Releasing body tension
5- Present moment awareness

BOUNDARY SETTING

SKILLS

4 ELEMENTS OF SELF-RECOVERY: **SELF-COMPETENCE**

Boundary Setting

3 Areas of Work

1. **Setting boundaries**
   - Listening to your self
     - Thoughts
     - Feelings
     - Body
     - Spirit
   - Finding your "I" statement

4 ELEMENTS OF SELF-RECOVERY: **SELF-COMPETENCE**

Boundary Setting

3 Areas of Work

2. **Stating your boundaries assertively**
   - Express your boundary in a statement not a question
   - Stick with your boundary
   - Don't over-explain your reasons for your boundary
   - Stick with the specific topic
   - Stay in the present not pulling in old issues

4 ELEMENTS OF SELF-RECOVERY: **SELF-COMPETENCE**

Boundary Setting

3 Areas of Work

3. **Living with your boundaries**
   - Remember your reasons for your boundary
   - Employ your frustration tolerance skills to help you stay firm so as to reach the long-term goal(s)
   - Listen but be careful not to over-defend your choices
   - Know when to stop participating in a conversation about your boundary

TAKE A MOMENT

for Self-Competence with Confidence

Is there a boundary you need to set with someone? Or perhaps a boundary you want to set for yourself?

(e.g. not do someone else's work; leave work on-time; turn off your phone at a particular time of the day, etc.)

Begin by listening to your self:

What are your thoughts and feelings suggesting the boundary might be? What boundary is your body asking for? What is your gut telling you?

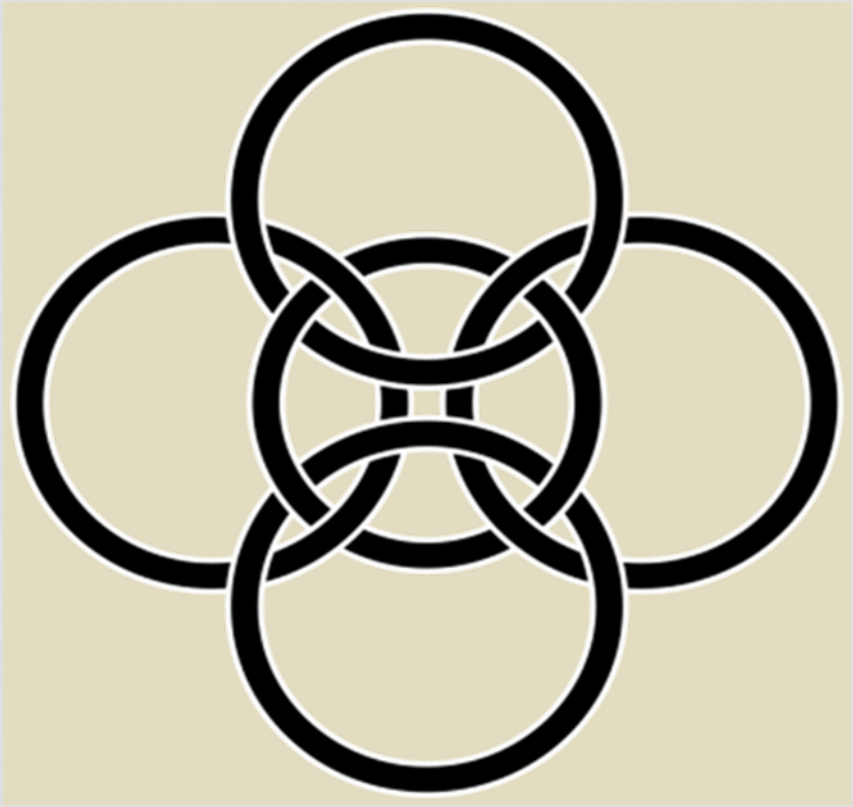
PAUSE

FOR REFLECTION

4 ELEMENTS OF SELF-RECOVERY:

SELF-ATTUNEMENT

With Care



4 ELEMENTS OF SELF-RECOVERY:
SELF-ATTUNEMENT

Drawing from data on Secure vs. Insecure Attachment Styles, **Self-Attunement** means we offer our self the following fundamental responses that promote our **internal security and growth.** We are building our **Relationship-with-Self**.

4 ELEMENTS OF SELF-RECOVERY:
SELF-ATTUNEMENT

- Attunement
- Mirroring
- Echoing
- Sensitivity
- Responsiveness
- Consistency
- Warmth
- Caring
- Trustworthiness
- Confidence
- Comfort
- Safe Haven

4 ELEMENTS OF SELF-RECOVERY:
SELF-ATTUNEMENT

We develop **our Relationship-with-Self** through:

- **Our Internal Connections**
  - Strong
  - Reliable
- **Self-Regard**
  - Valuing self
  - Trusting self
  - Being compassionate with self

4 ELEMENTS OF SELF-RECOVERY:
SELF-ATTUNEMENT

We develop **our Relationship-with-Self** through:

- **Self-Empowerment**
  - Act on things in your control
  - Let go of things not in your control
- **Our Secure Attachment with Self**
  - Attune to self
  - Respond to self
  - Be consistent with self
  - Be able to count on self
  - Provide safe haven for self

TAKE A MOMENT

for Self-Attunement with Care

How is your relationship-with-self?

(e.g. Do you listen to yourself? Do you value your self, trust yourself? Are you able to respond to your needs as you become aware of them?)

Would you like to improve your relationship-with-self? If so, what is one thing you could do to pay more attention to your self?

(e.g. Pause. Intentionally stop and listen. Be kind, open. Bring self into the present moment.)

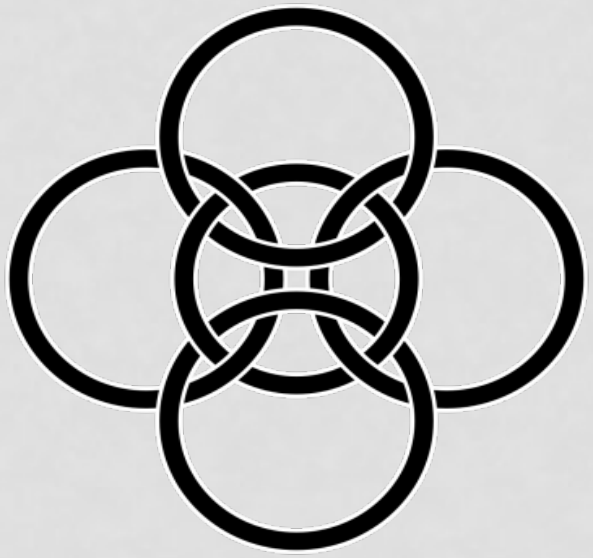
PAUSE

FOR REFLECTION

SELF-RECOVERY

FINDING *BALANCE* IN CARE OF SELF AND OTHERS

- **Self-Understanding**
  With Compassion
- **Self-Awareness**
  With Calm Presence
- **Self-Competence**
  With Confidence
- **Self-Attunement**
  With Care



A Continuum for Understanding and Managing Codependent Behaviors

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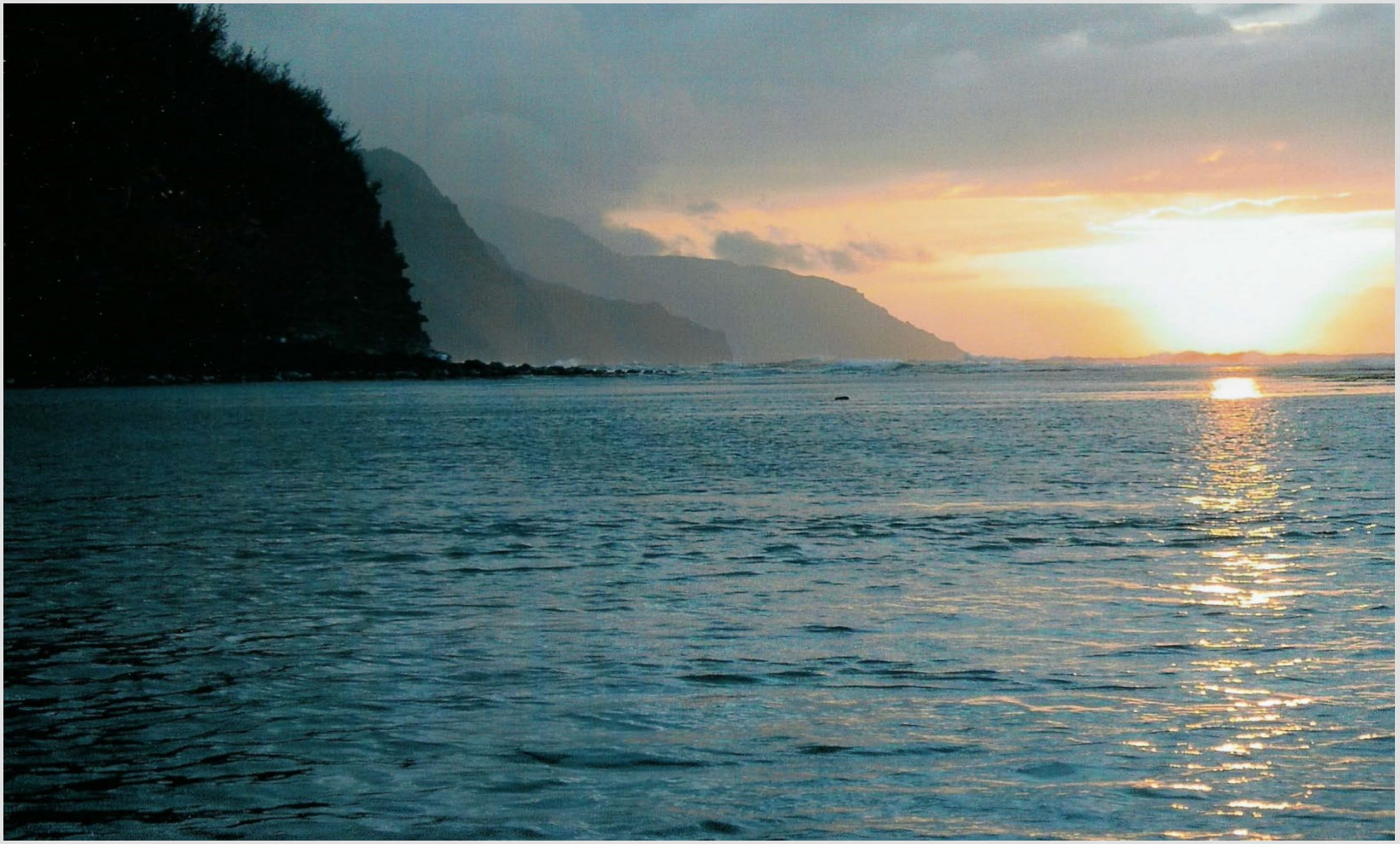
Okay	Too Far
Keeps connection with self	Loses connection with self
Able to be flexible and open	Rigid, obsessed
Causes no impairment in functioning	Causes impairment in functioning
Securely attached	Insecurely attached

BALANCE

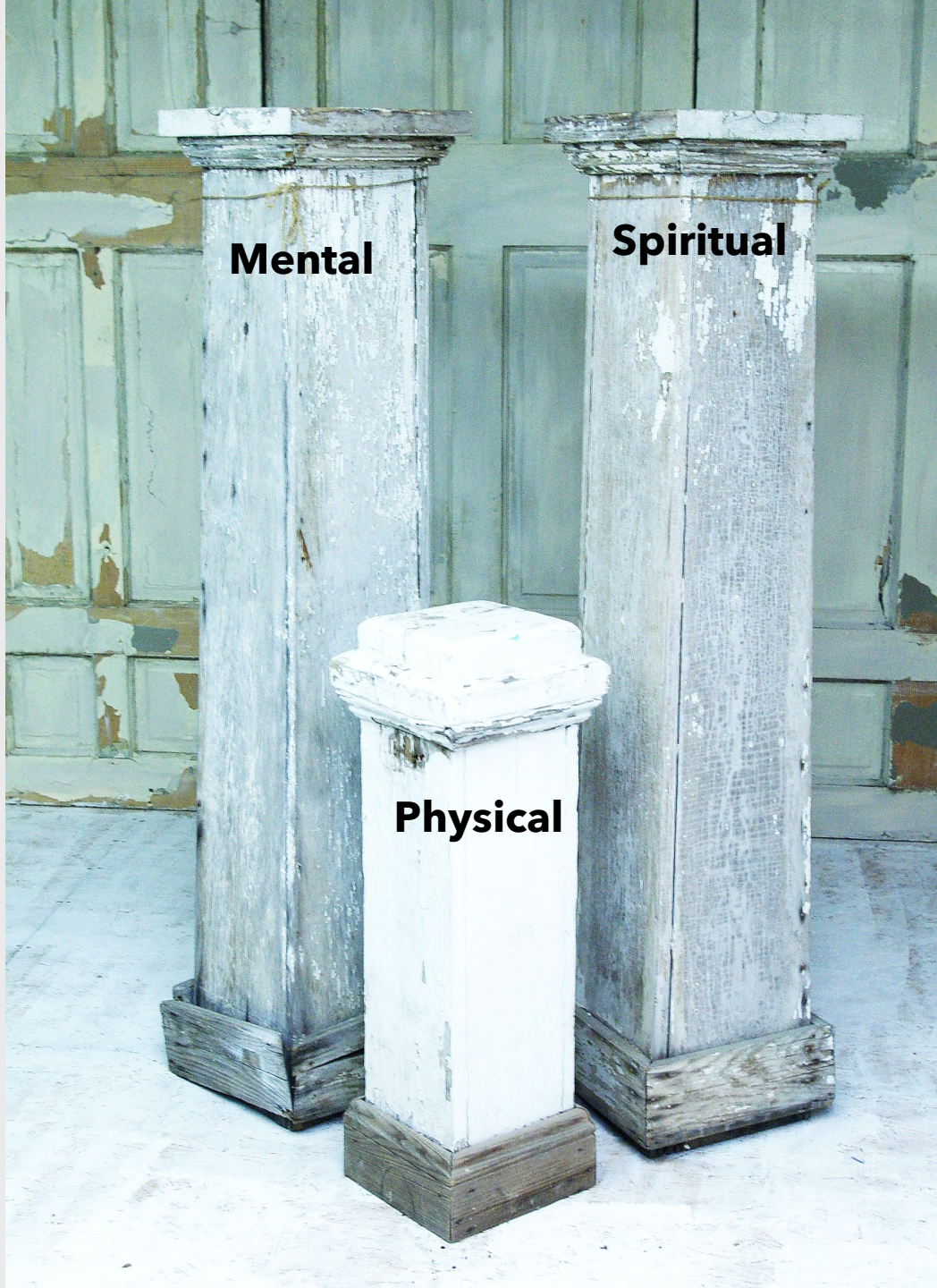
An Active, On-going Internal Process



Recovery Fitness

Honorable H. Lee Harrell and Walter Midkiff

The Three Pillars of Recovery



Displacement Activities

What we do?

GROUP FITNESS

AT HOME WORKOUTS

SIMPLE NUTRITION

Intimidation, Gym Fear, and Scaling

Squat

Why Exercise for Recovery?

Push Up

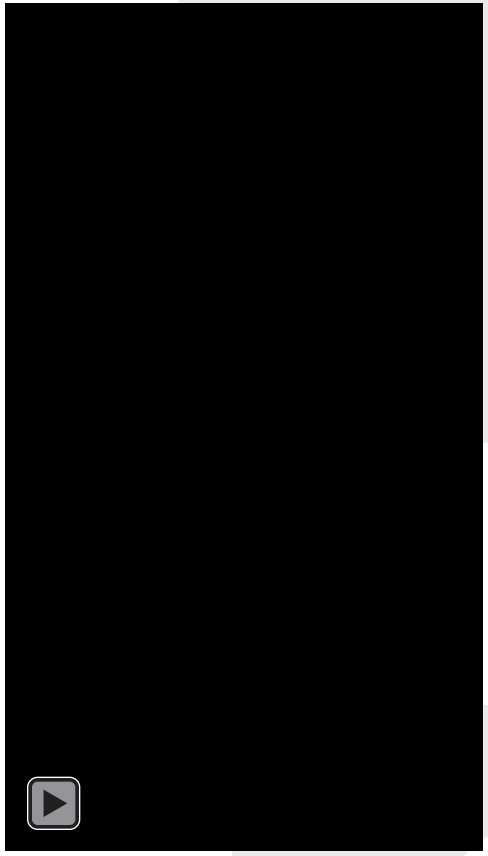
Endorphins and Dopamine

Dopamine levels

- Exercise 130%
- Food 130%
- Sex 160%

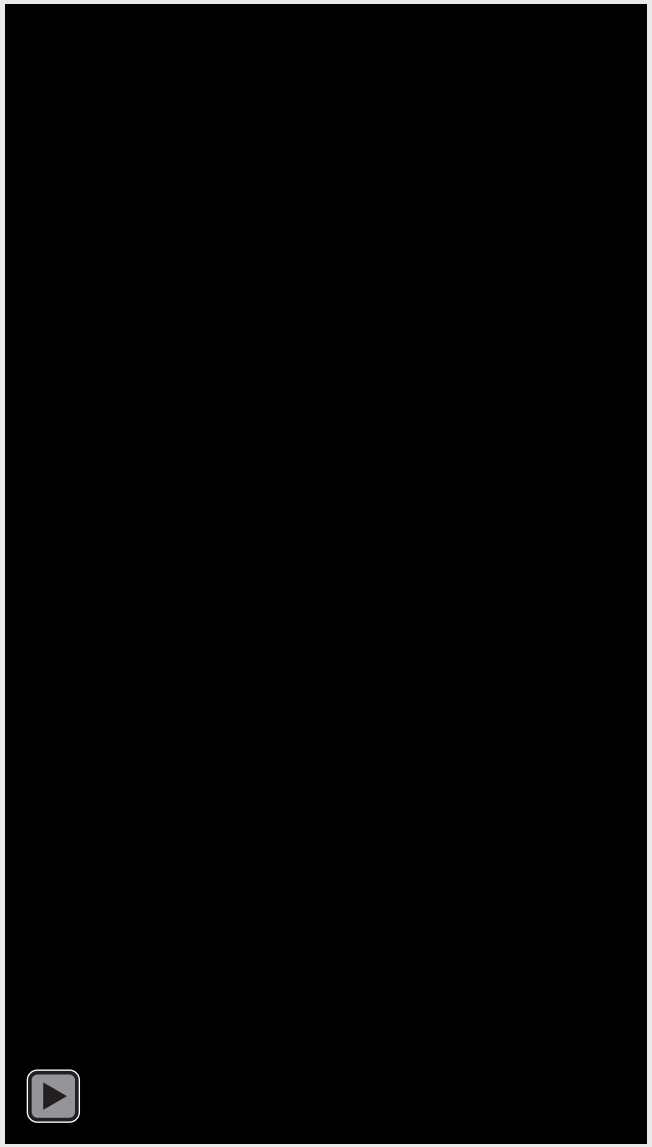
- Alcohol 200%
- Nicotine 225%
- Cocaine 350%
- Amphetamine 1100%

Jump Rope



But it hurts!

Burpee



”Is it mandatory?”

Sit up

Stopping Relapse

Integrity Bank

Sample workout

5 rounds for time

What about us?

Benefits to team members.

Recovery Fitness

www.recoveryfitness.org

walter@recoveryfitness.org

276-613-2972

The Role of Defense Counsel in Specialty Courts and Dockets

Prelude: What's My Source?

- "Adult Drug Court Best Practice Standards, Vol. 1-2," National Association of Drug Court Professionals (2018 text revision)
- "The Drug Court Judicial Benchbook," D. Marlow, J.D., Ph.D and Judge W. G. Meyer, National Drug Court Institute (2017)
- "Critical Issues for Defense Attorneys in Drug Court," National Drug Court Institute, Bureau of Justice Assistance (2003)

Prelude: What's My Source?

- "The Role of Defense Counsel in Drug Courts," G. Citrin and M. Fuhrmann, BJA Technical Assistance Project at American University—Justice Programs Office (2021)

- "Improving Responses to People With Mental Illnesses: The Essential Elements of a Mental Health Court," BJA, Justice Center, The Council of State Governments (2007)

Prelude: What's My Source?

- Supreme Court of Virginia website: Specialty Docket Services:
  - https://www.vacourts.gov/courtadmin/aoc/djs/programs/sds/home.html
  - Annual Reports, Standards, and Other Resources

- Virginia State Bar: Rules of Professional Conduct

1.
Traditional Role

Within Adversarial System

Adversarial System of Justice

Advocate

Stated Interests

Confidentiality

2.
New Role?

Within Specialty Courts and Dockets

Therapeutic Model

Advocate

The term “nonadversarial” does not have the same meaning as “nonadvocacy.”

NADCP Best Practice Standard

How does this reconcile with team approach?

Even under non-adversarial model, participants have rights, including due process.

“[P]articipants should never be required to waive the right to counsel.”

G. Citrin and M. Fuhrmann in “The Role of Defense Counsel in Drug Courts.”

Graduation and Termination Rates

Drug Court

G: 48.8%

T: 51.2%

BHD

G: 66.7%

T: 33.3%

Veterans Docket

G: 14 people

T: 2 people

3.

Defense Role at the Policy Level

SCV, State, Local

"CW's Attorneys and Public Defenders or defense counsel participate **in the design** [of the specialty court or docket], including criteria for screening, eligibility, and policies and procedures, **to safeguard due process rights** and make sure public safety needs are served."

Virginia's Adult Drug Treatment Court Standard 4.1

Screening, Eligibility, and Policies/Procedures

Safeguard Due Process

- Many Virginia jurisdictions have participants waive due process and other rights.
- Not Best Practice

A defendant should not be required to plead guilty (or no contest) in order to enter a specialty court or docket because there is no THERAPEUTIC value to such requirement.

Critical Issues for Defense Attorneys in Drug Court

4.

Defense Role Prior to Referral for Evaluation

Is the client a good fit for a specialty court or docket?

Client's Motivation

Other Options?

5.

Defense Role Prior to Formal Acceptance

Does the client really want to do this?


WAIVER

If Post-Plea Docket: Slow Down, Do Not Rush

Makes sure client understands prior to entry:

Make sure client understands prior to entry:

6.

Defense Role During Specialty Court or Docket

Advocate and Team Member

Scope of Involvement

Tensions between Roles of Team Member and Advocate

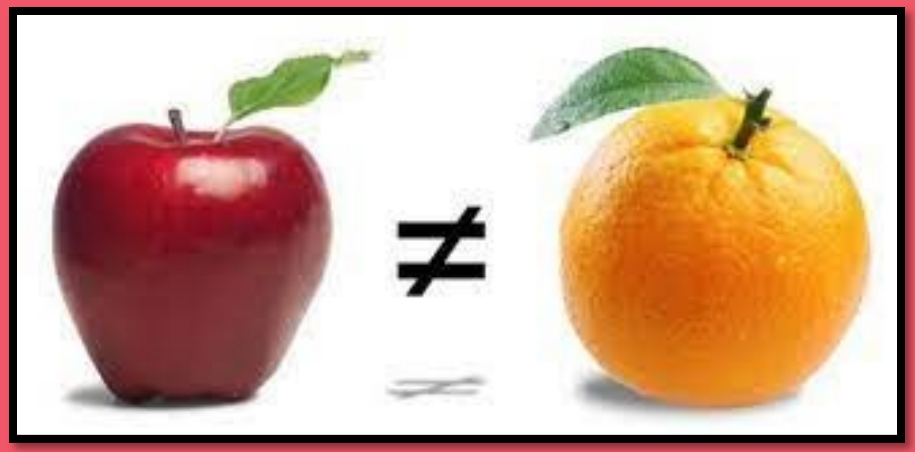
Encourage Best Practices

7.

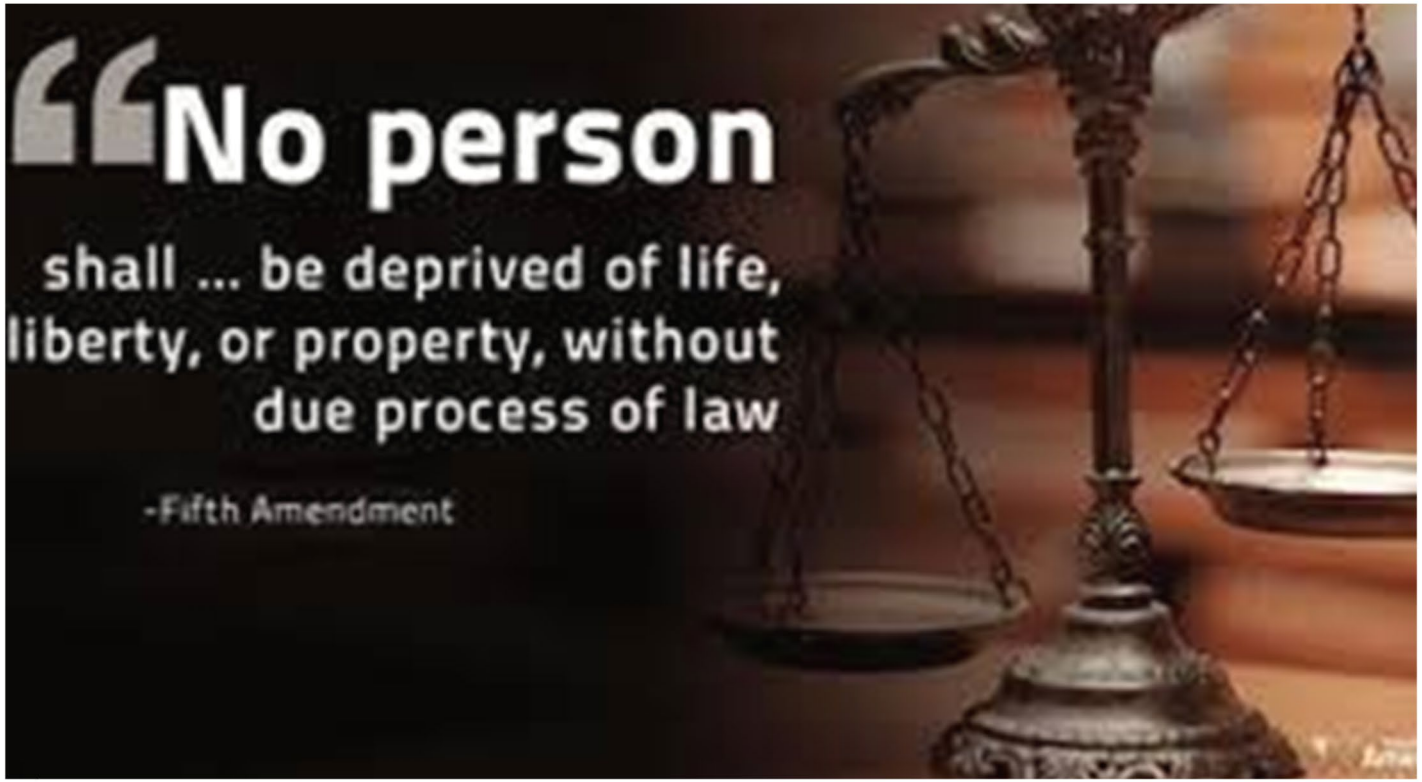
Defense Role During Termination and Revocation

End of the road?

Termination is a different decision than sentencing or revocation.



Termination



Sentencing/Revocation

Credits

Special thanks to SlidesCarnival for making and releasing for free this presentation template!

Chesterfield County Sheriff's Office

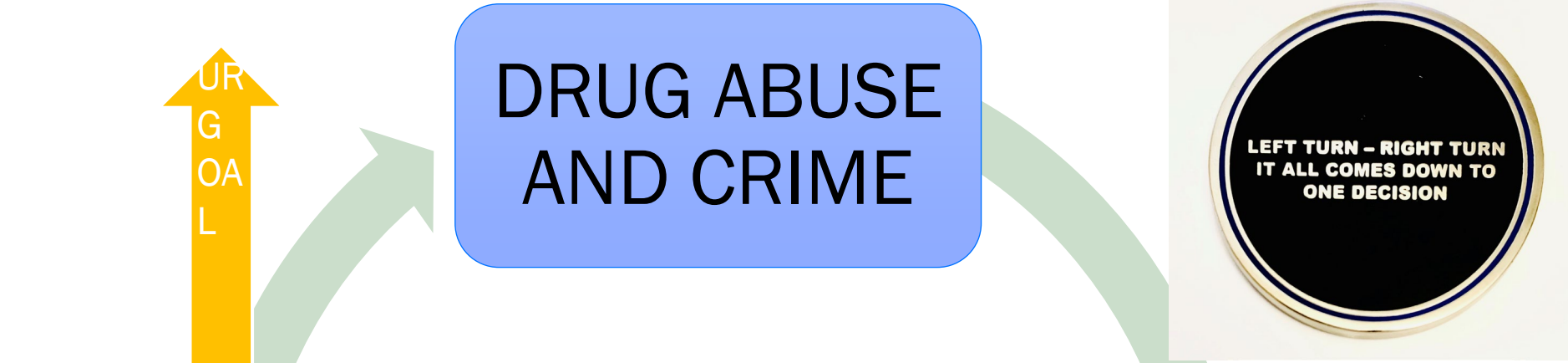
Breaking Conventional Rules to Combat Unconventional Epidemic

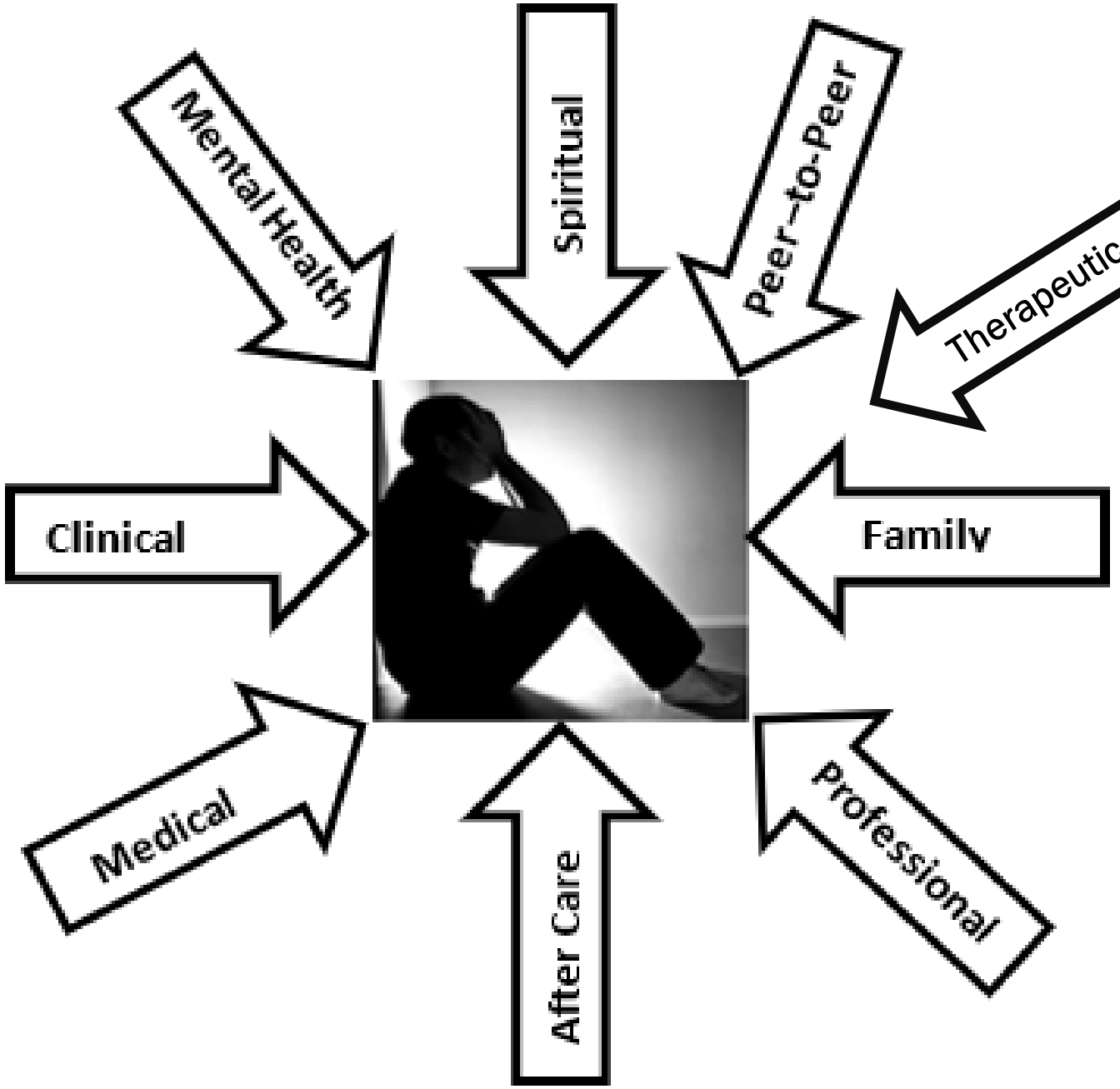
Sheriff Karl Leonard
Program Manager Bailey Hilliard

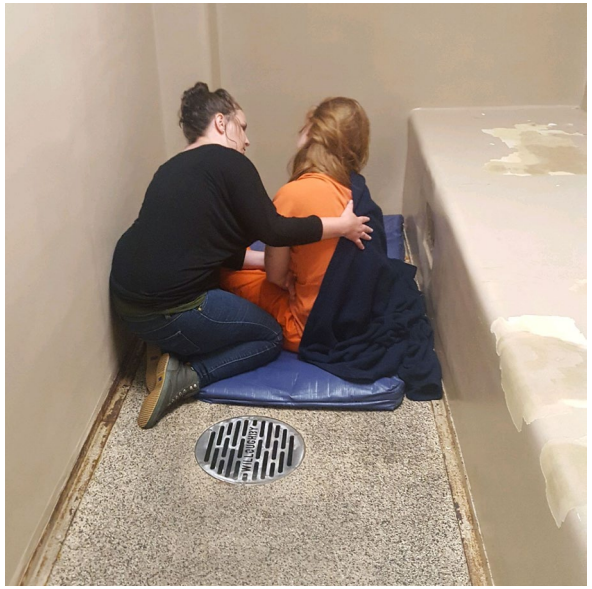
Presented to the Virginia DUI Specialty Dockets Training Tuesday, September 20, 2022

https://www.youtube.com/watch?v=NsChOwwWr8E

ENDING THE CYCLE BY ENDING THE ADDICTION




Mental Health
Spiritual
Peer-to-Peer
Therapeutic
Clinical
Family
Medical
After Care
Professional



SYSTEMATIC APPROACH INSIDE

MENTAL HEALTH/CLINICAL APPROACHES

- CORE CLASSES: THINKING ABOUT THINKING, MRT, MINDFULNESS ORIENTED RECOVERY ENHANCEMENT (M.O.R.E.)
- TRAUMA TREATMENT (EMDR, EFT, CBT)

PEER SUPPORTED RECOVERY

- NARCOTICS & ALOHOLICS ANONYMOUS (NA/AA)
- PEER RECOVERY SPECIALIST (PRS) TRAINING/CERTIFICATION/USE
- PEER FACILITATED GROUPS
- PEER RECOVERY CAPITAL GOAL SETTING

OTHER HOLISTIC SUPPORTS

- MEDICAL
- SPIRITUAL
- FAMILY
- JOB SKILLS CERTIFICATES/GED
- TATTOO REMOVAL

MENTAL HEALTH TREATMENT IS A MAJOR CONCERN/MAJOR ELEMENT

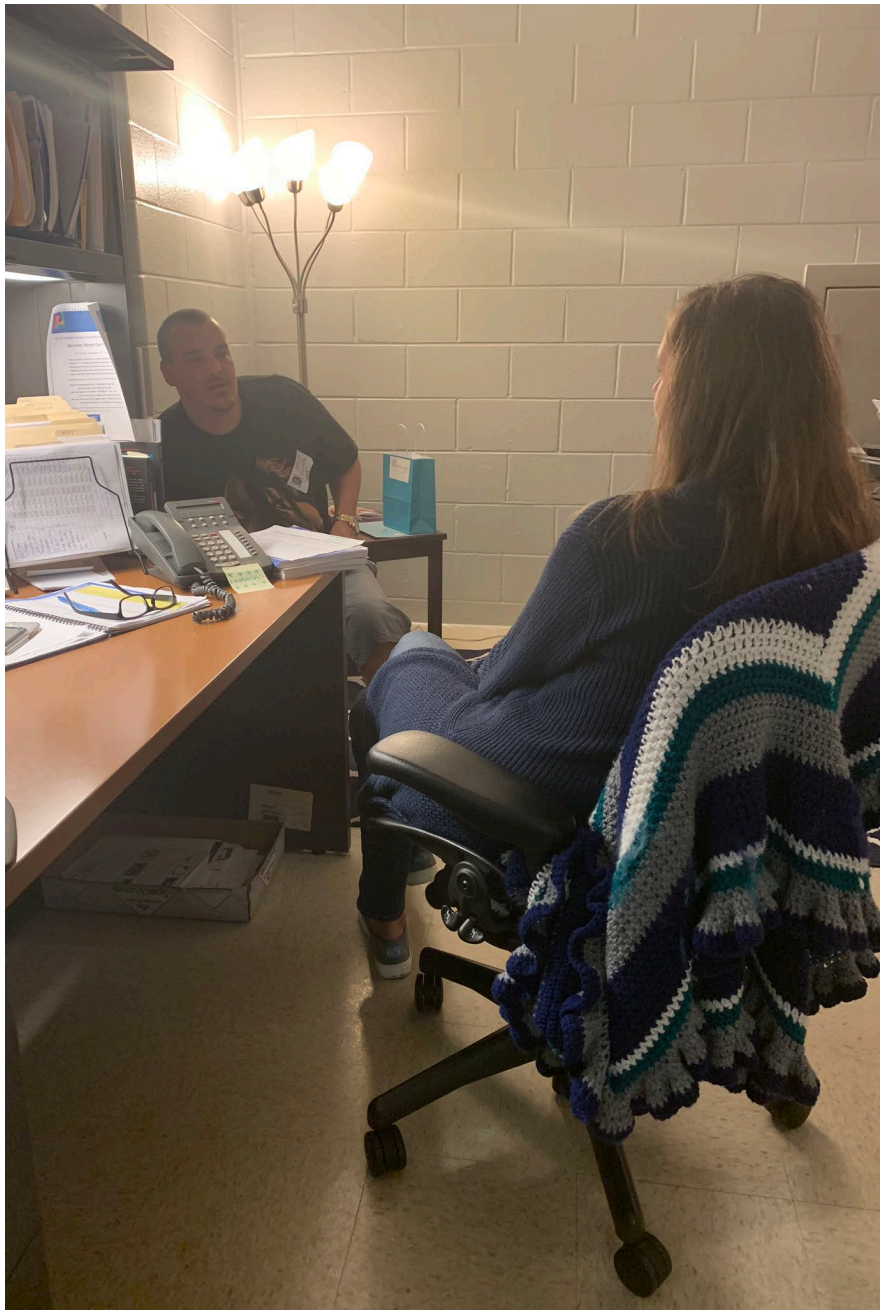
OFF THE STREET PARTICIPATION

COVID CHALLENGES

MEDICATION FOR OPIOID USE DISORDER (DURING AND AFTER)

- <u>WHAT IT TAKES</u>
  - Dr. Georges Mantovani Gay, Chesterfield County Jail Medical Director
  - MAT Grant Admin to provide linkage to services during and post- incarceration
  - Mental health clinician
  - Buprenorphine, Methadone, Vivitrol, Sublocade, Narcan
  - Harm reduction education
  - Implementation of SMART Program

- SYSTEMATIC APPROACH OUTSIDE
  - NARCOTICS & ALCOHOLICS ANONYMOUS (NA / AA)
  - PRS TRAINING/CERTIFICATION/USE
  - FAMILY SUPPORT
  - OFF-THE-STREET PARTICIPATION
  - ON-GOING SUPPORT GROUP
  - HAND-OFF TO MENTAL HEALTH/MEDICAL
  - RECOVERY HOUSING
  - HARP RVA



HARP Program Alumni

Private group · 498 members

+ Invite

CONNECTION WITH HARP DOES NOT TERMINATE AFTER RELEASE

QUESTIONS?

Sheriff Karl Leonard:
leonardk@chesterfield.gov

Mrs. Bailey Hilliard:
hilliardb@chesterfield.gov

NCDC
NATIONAL CENTER
FOR DWI COURTS

Overcoming Perceived Pitfalls of DWI Courts

Developed by:
National Center for DWI Courts

Pitfall #1

It's too risky

If Not Prison or Jail, Where?

- Repeat impaired drivers are still on supervision through a probation office

- ***Jail is not a level of care***
  - Treatment needs are not met in custody – no change

Alcohol Violations

- Public safety risk – using usually leads to driving
- DWI courts reliably detect and immediately respond
- Treatment needs vs. public safety

SUPERVISION/TESTING/TECHNOLOGY

- DWI courts have more contact with the client and address problematic behaviors immediately
- Witnessed random drug and alcohol testing is a tool to assist with recovery
- Research shows technology paired with supervision paired with treatment works

PARTNERSHIPS

- Partnerships are critical to implementation and sustainability
- Stakeholders and nontraditional partnerships
- Importance of the media

Pitfall #2

There's no carrot

PROCESSING

- The earlier the better
- Resolve case faster
- Pre-sentence conditions
- Voluntary vs. mandatory

SENTENCING

- Reduced confinement
- Ability to serve mandatory sentences in a less restrictive manner
- Reduced fines and costs
- Caution: Dismissal or reduction is not an option

PRIVILEGES

- Limited driver’s license
- Use of tools and technology
- Freedom

Life Changing

- (Early) Sobriety
- (Later) Recovery

Pitfall #3

We have a drug court… we can do DWI too

Demographics

- Not knowing the DWI population
- Repeat impaired drivers differ from typical drug court participants
- High functioning does not mean low risk
- Using invalid, unreliable risk and need tools

Structure and Case Management

- Supervision of high-risk and high-need impaired drivers
- Mixing risk and need populations
- Considering additional populations
- Treatment
- Court structure

Responses to Behavior/Attitudes

- Attitudes about alcohol
- Criminal thinking
- Don’t identify themselves as “drug addicts”
- Public safety risk

Pitfall #4

Focused on the drug, not the behavior

DUID

- Driving under the influence of drugs
- Presence of drugs ≠ impairment
- It does mean polysubstance use

TESTING

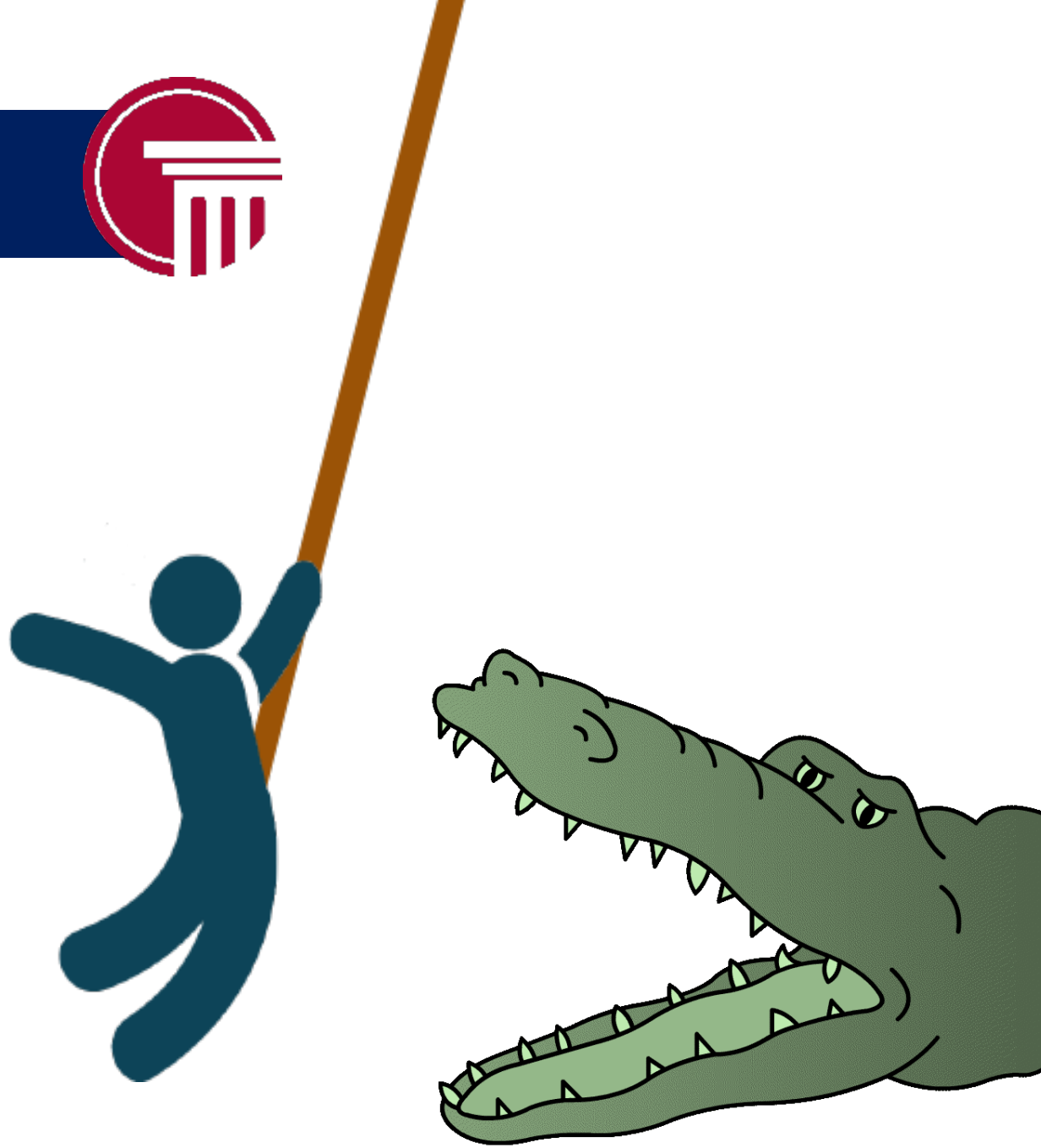
- Reliably detect use
- Alcohol testing
- Drug testing (polysubstance)

SUD

- Substance use disorder is a disease
- Prevalence of mental health disorders

DANGER...DANGER...

We are perfect



We Are Perfect

Fidelity to the model

Research shows an increase in criminogenic factors in clients for programs that do not follow the Guiding Principles or Best Practices

We Are Perfect

Michigan

An analysis of three counties in a 2-year period found that DWI court participants were 19 times less likely to be arrested for a DWI (2008).

Minnesota

An evaluation of nine DWI courts found that high-risk individuals had better outcomes, including up to 69% less recidivism (2014).

Campbell Collaboration

A meta-analysis of 28 evaluations found that DWI and general criminal recidivism was reduced by an average of 12%. The best DWI courts reduced recidivism by 50% to 60% (2012).

Georgia

Repeat offenders graduating from DWI court were 65% less likely to be rearrested for a new DWI, and between 47 and 112 repeat DWI arrests were prevented (2011).

We Are Perfect

San Joaquin County, California

DUI court participants were half as likely to be involved in an alcohol- or drug-related crash over a period of 18 months (2012).

We Are Perfect

Maryland

DWI courts produce net cost benefits to taxpayers of more than $1,500 per participant and more than $5,000 per graduate (2009).

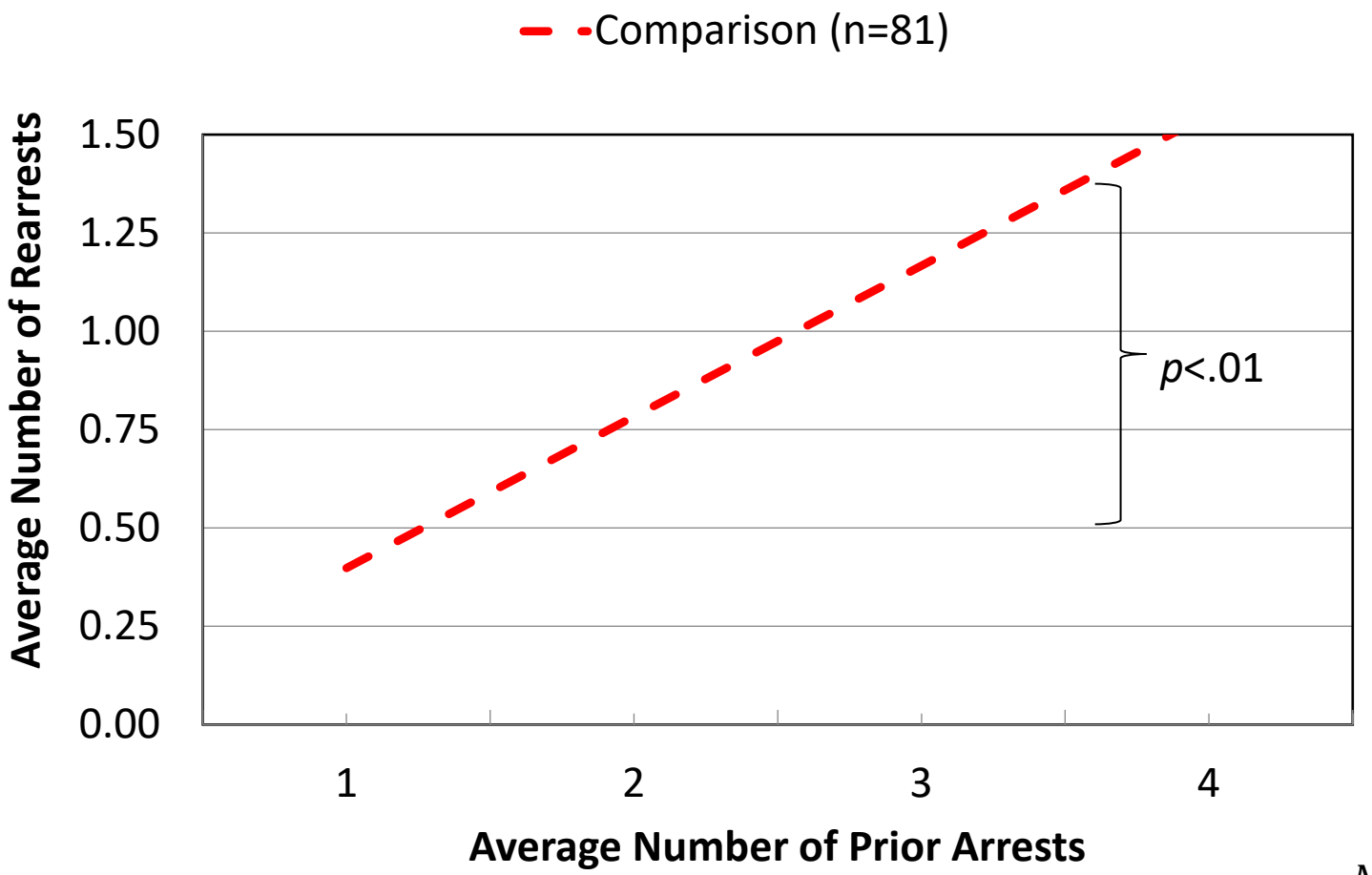
Minnesota

DWI courts saved taxpayers $700,000 annually and produced an average of $2.06 (a high of $3.19 in one court) in benefits for every $1 invested – a 200% return on investment (2014).

We Are Perfect

Average number of rearrests by number of prior arrests at 2 years

Minnesota DWI court study, 9 sites

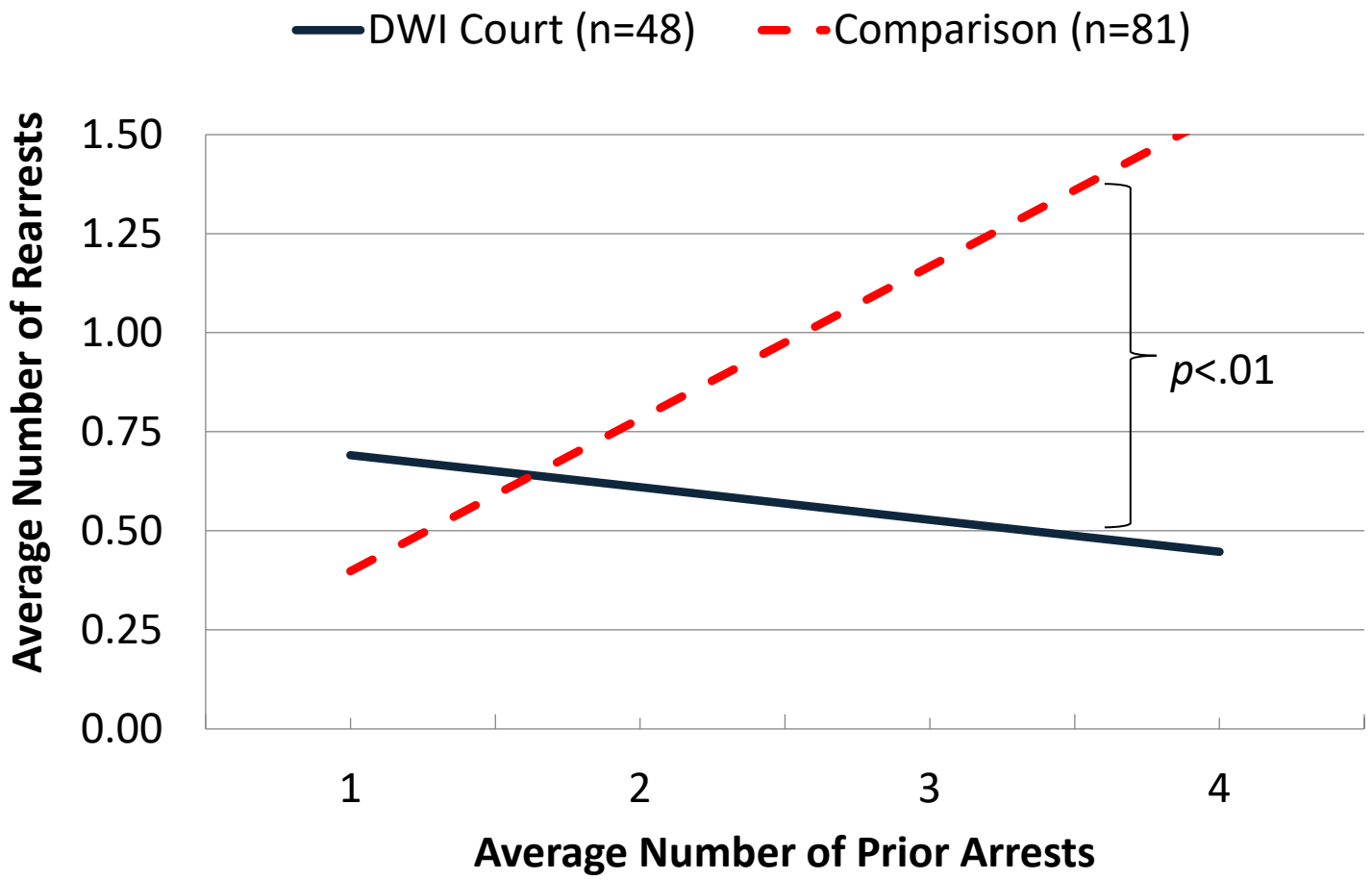


NPC Research

We Are Perfect

Average number of rearrests by number of prior arrests at 2 years

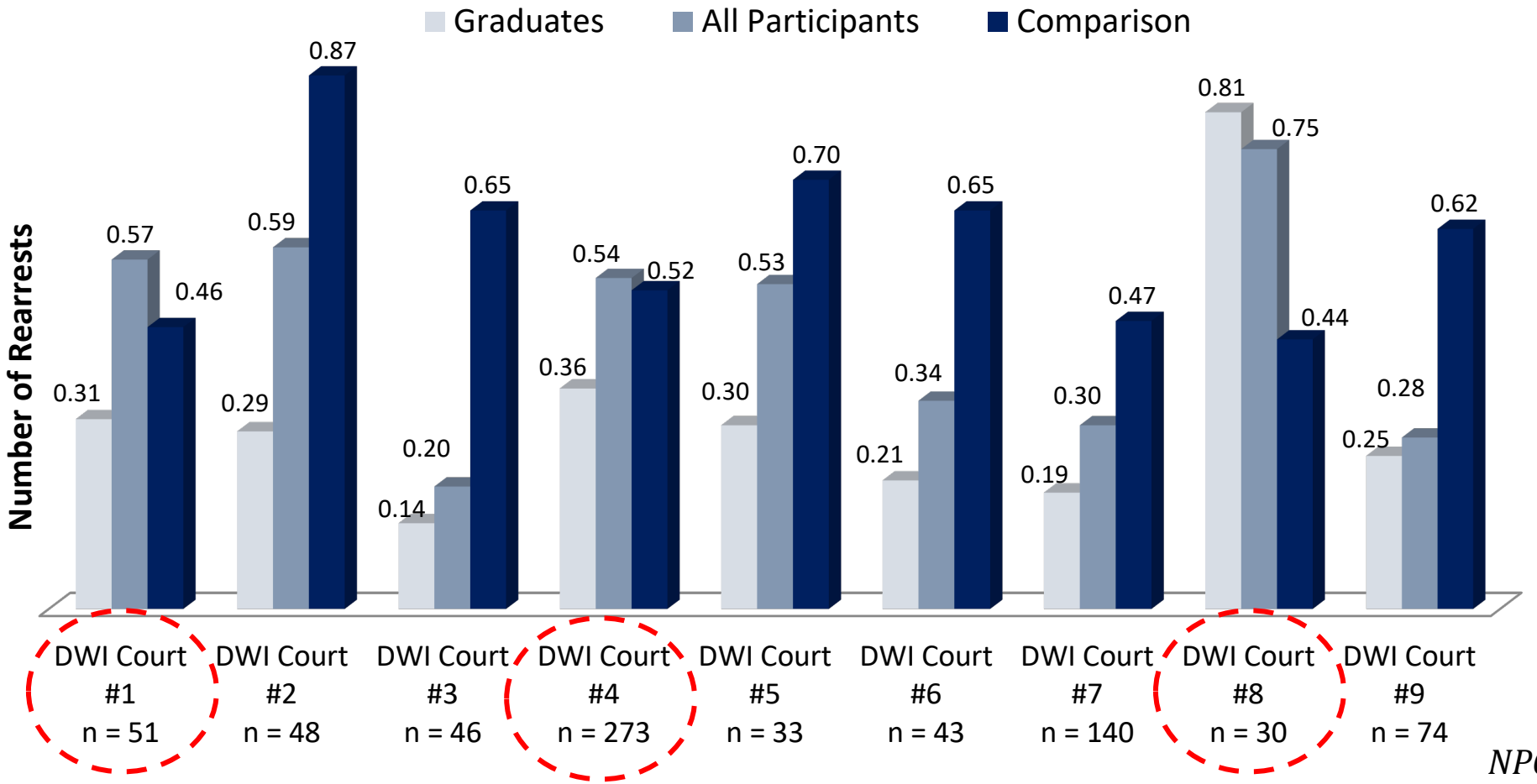
Minnesota DWI court study, 9 sites



NPC Research

We Are Perfect

Participants (regardless of graduation status) at the majority of Minnesota's 9 DWI courts had lower rearrest rates, but not all of them



NPC Research

Final Thoughts

- The best place for high-risk/high-need impaired drivers is a DWI court
- Incentivize participation
- Impaired drivers are different, the court needs to be different to meet their needs
- DWI court ≠ alcohol court
- Fidelity to the model is critical

Substance Use Disorders As Biopsychosocial Chronic Diseases: a public safety + public health intersection that holds promise

Presenter: David W. Hartman, M.D.
Psychiatrist in Adult Ambulatory Division, Sub-boarded in Addiction Medicine
Lead Physician, Office-based Opioid Treatment Program, Carilion Clinic
Associate Professor, Virginia Tech Carilion School of Medicine
Co-presenter: Cheri W. Hartman, Ph.D.
Program manager, Office-based Opioid Treatment (OBOT) Program
Psychiatry and Behavioral Medicine Department, Carilion Clinic
Assistant Professor, Virginia Tech Carilion School of Medicine

Objectives for Presentation

Presentation aims to enhance audience comprehension of Substance Use Disorders As Chronic Diseases, specifically understanding:

- Biopsychosocial nature of Substance Use Disorders
- Implications of the disease model for: reducing stigma, achieving successful prevention and treatment outcomes that benefit public safety and public health
- Medications for Opioid Use Disorder (MOUDs) as a critical treatment tool for managing the opioid use disorder – effective when combined with therapy and other recovery supports as built into the office-based opioid treatment (OBOT) model of the ARTS Initiative.

Virginia's overdose epidemic

Latest statistics are grim:

2021 is the deadliest year yet in Virginia from overdoses

Fentanyl is driving the increase in overdose rates

As the DEA has pronounced in a recent media campaign: "one pill can kill" – fentanyl is being compressed into "look alike" pills that appear to be Xanax bars; in Fairfax the ED reports seeing the effect of the blue pills, known as "blues." Overdose visit increases especially evident among our youth (teens).

This epidemic affects everyone – it respects no zip code, no demographic is spared. We all know someone whose life was either upended by the disease of addiction or was lost.

What can we do? Collaboration to prevent the tragic impact of this disease can succeed.

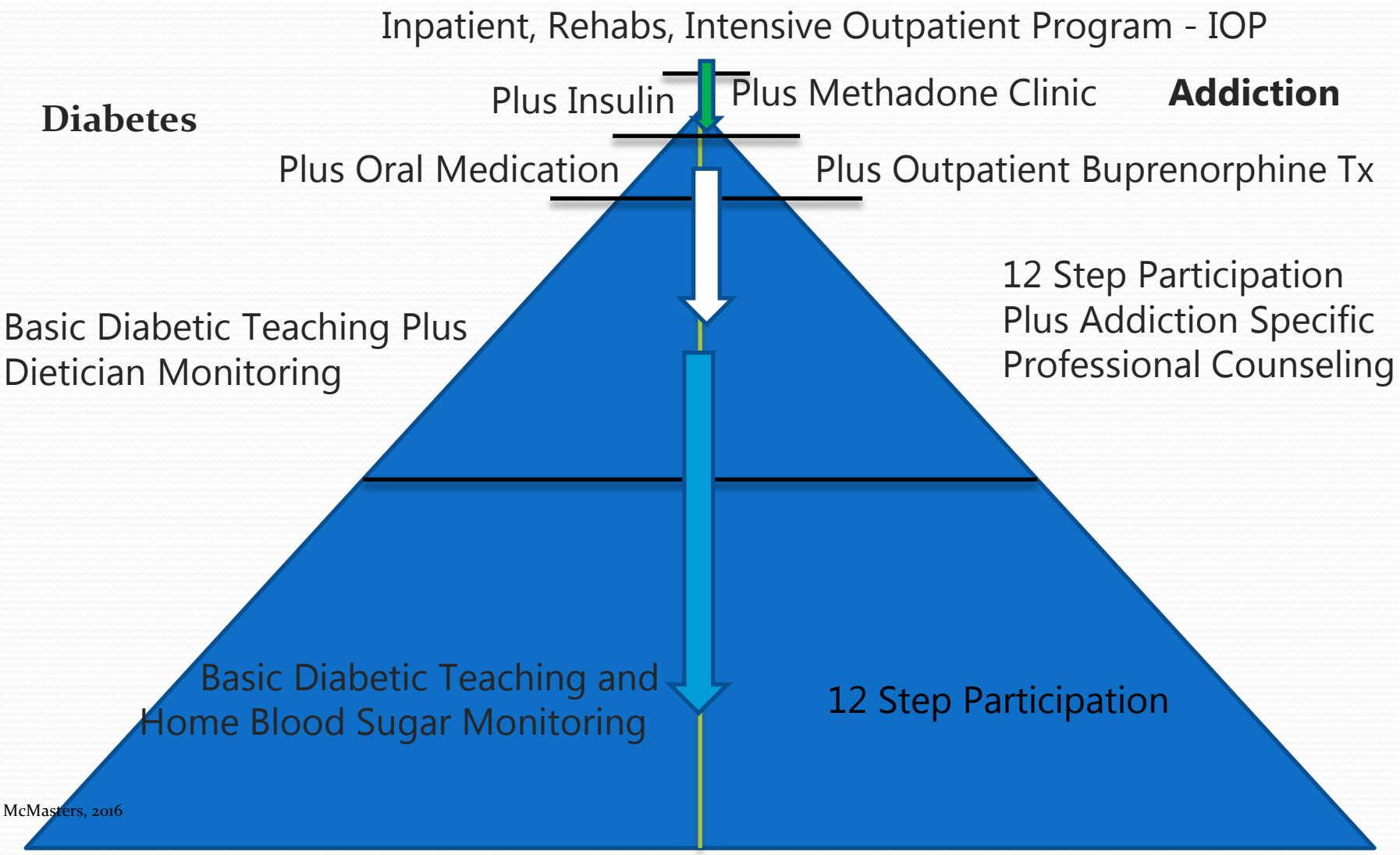
Complex chronic diseases like addiction– necessitate collaborative strategies for prevention and treatment

Substance use disorders are biopsychosocial complex chronic diseases that have biological, psychological, and social factors that affect their onset, severity and treatment efficacy.

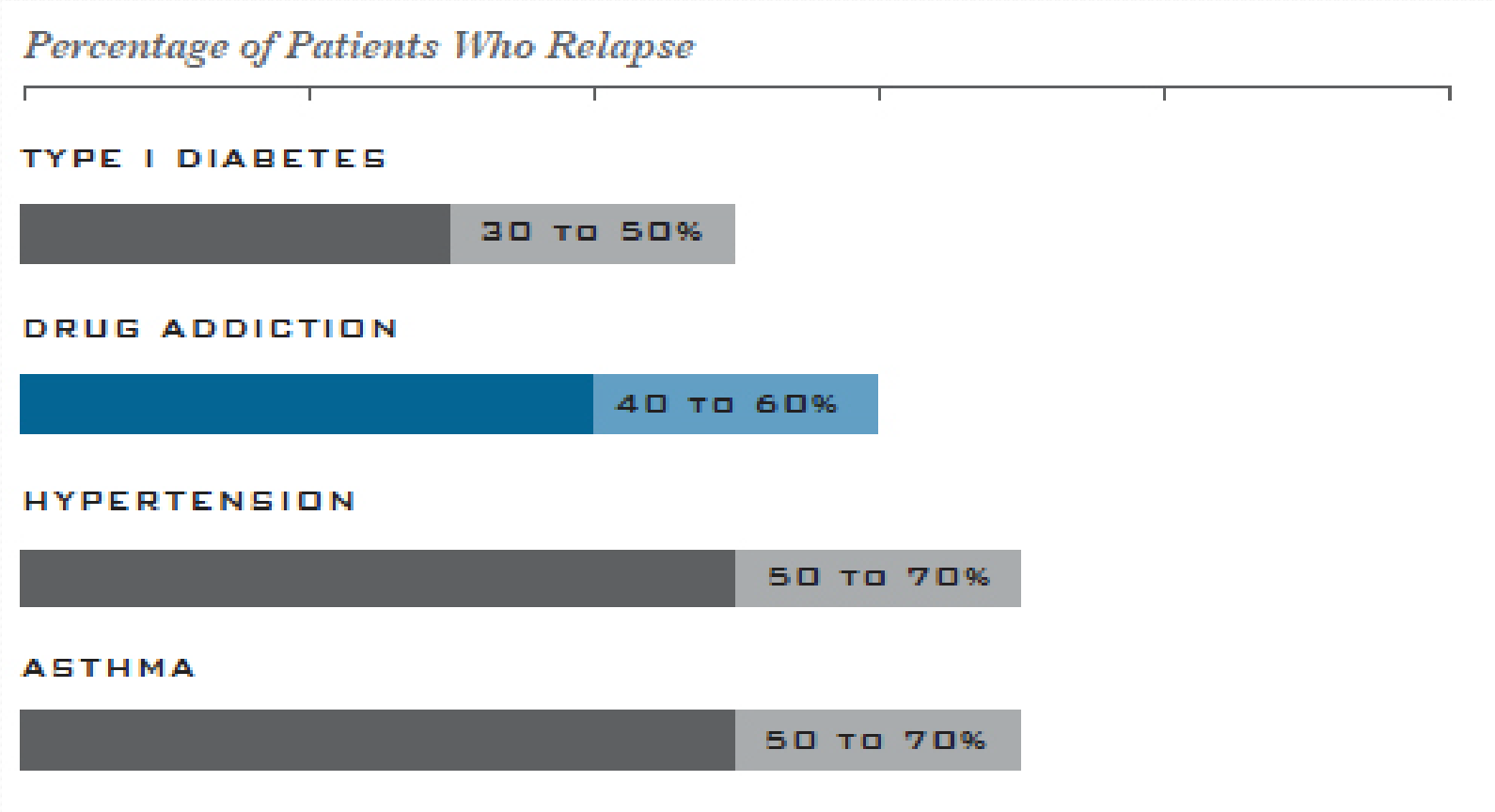
- Biological influences include genetics: not everyone prescribed pain pills will develop an opioid use disorder; strong hereditary component.
- Psychological influences (trauma in one's childhood creates risk; psychiatric co-morbidities need to be treated alongside the addiction)
- Social factors (unemployment, homelessness, isolation, cultural endorsement of substance use like drinking as a rite of passage to adulthood; marijuana use as cool and medical endorsement mythology)
- "Protective factors" to prevent addiction are biopsychosocial = effective prevention strategies involve everyone in the community – we can all play a role to prevent, identify and encourage our neighbors to reach out for help.
- Understanding addiction as a chronic disease of the brain helps to de-stigmatize persons with this disease. Stigma is a key barrier to getting help.

Stigma prevents people from getting treatment, exacerbating the problem; community education and professional training needed.

Addiction As a Chronic Disease: comparing diabetes w/addiction



Relapse Rate



http://www.drugabuse.gov/publications/principles-drug-addiction-treatment/frequently-asked-questions/how-effective-drug-addiction-treatment

Brain disease perspective on addiction

- Substance Use Disorders are medically diagnosed.
- They are not moral failings.
- Although there are behavioral manifestations of the disease that you can see, the invisible neurological changes are physical - not something you can see without being part of an fMRI study.
- The neurological impact of the disease is difficult to reverse, but treatment programs are available that do help someone achieve disease management and recovery.
- Treatment takes time –a chronic disease lingers and takes time to go into remission and is likely to be accompanied by relapse.

Genetics and Addiction

As a disease addiction is strongly influence by our genetics:

1990 – gene identified that was described as being directly associated with alcoholism. Further studies concluded that this is an oversimplification.

It is estimated that:

- Alcoholism is 50% - 60% inheritable.
- Marijuana use disorders are 60% – 80% inheritable
- Tobacco use disorder = 70% inheritability
- Cocaine use disorder strongly influenced by genetics as well.

Environment plays a key role in "turning genes on or off" modifying inheritability.

Substance use Disorders are too rarely identified and treated -- Only 10% getting into treatment

We need to do a better job of referring people into treatment who need it.

Only about 10% of people with a substance use disorder get the treatment they need.

We need to equip more social workers, probation officers, and health care team members (nurses and doctors) in the best practices of screening for addiction, how to provide helpful appropriate brief interventions, and how to make referrals into treatment (SBIRT).

- Convey a hopeful optimistic and non-judgmental outlook about treatment – It can work! More will access the necessary and effective treatment as a result!
- Peers with lived experience are especially well equipped to be an effective bridge into treatment and source of support throughout treatment and the transitions in people's lives during their recovery journey. Powerful benefit of peers has been documented.

Timely treatment and continuity of care are crucial

- Timely treatment with no break in care keeps cravings at bay, prevents withdrawal, avoids relapse, and helps patients stay on the path to recovery.
- This underscores importance of collaboration across systems. Probation officers and treatment providers need to be on same page: + drug screens for an illicit drug is better addressed with the treatment provider input rather having an immediate punishment response.
- Getting individuals with OUD into treatment (for example,getting Medication for their OUD plus therapy and care coordination) leads to positive outcomes from both a public safety and treatment perspective.
- Again – peers with lived experience are powerful supports for these patients to help them navigate the transition in care from incarceration to release into the community and into treatment.

DSM-5: Diagnosing Substance Use Disorders (dependence does not equal addiction)

A pathological pattern of behavior related to the use of the substance(s) in the past year; there are 11 criteria that fit into four groupings:

- Impaired control
- Social impairment
- Risky use
- Pharmacological criteria

Impaired Control

1. The individual may take the substance in larger amounts or for longer periods of time than originally intended.

2. The individual is unsuccessful in cutting down or regulating the use of the substance.

3. The individual spends a great deal of time using the substance, looking for the substance, or recovering from the effects of the substance.

4. Craving

Social Impairment

5. Recurrent use of the substance may result in a failure to meet important obligation at work, school, or at home.

6. Patient continues to use the substance in spite of social or interpersonal problems.

7. Important social, occupational or recreational activities are given up due to the use of the substance.

Risky Use of the Substance

8. Continuous use of the substance in dangerous situations.

9. Continuous use of the substance in spite of psychological or physical problems, which are caused or exacerbated by the use of the substance.

Pharmacological Criteria

10. Tolerance: when more and more of the substance is needed to obtain the same effect, or the effect is reduced with continuous use of the same amount.

11. Withdrawal: a syndrome which occurs when the content of the substance in the blood or tissues decreases in an individual, who has been using the substance in large amounts for a long period of time.

Severity levels of the substance use disorder

- Mild: 2 to 3 criteria
- Moderate: 4 to 5 criteria
- Severe: 6 or more

One criteria alone is not enough. Withdrawal – reflecting dependence – is not addiction without the other criteria.

A prisoner who is not using substances while incarcerated leaves prison/jail at risk for overdose

- Overdose deaths accounted for 85% of all releasees' deaths during the first week following release (2017).
- A recent study (2019) in North Carolina found that, in the first two weeks after being released from prison, former inmates were 40 times more likely to die of an opioid overdose than the general population.
- When restricted to heroin overdoses only, formerly incarcerated individuals' likelihood of overdose death increased to 74 times the norm within the first two weeks after release.

Violation of ADA Rights Case Settlement paved the way for MAT in Washington

- The ACLU of Washington in 2019 filed a civil rights lawsuit against the federal Bureau of Prisons (BOP) for denying people with opioid use disorder (OUD) medications necessary to treat their addiction. The lawsuit, brought on behalf of Melissa Godsey, challenges BOP's policy of refusing to provide people access to "Medication-Assisted Treatment" (MAT), including Suboxone (buprenorphine combined with naloxone), even though it provides other clinically appropriate medications to inmates.
- The case was settled allowing Melissa Godsey her continuation on this medication needed to manage her chronic disease. The Godsey settlement builds on state and local efforts by the ACLU-WA to increase access to MAT.
- In April 2019, the Whatcom County Jail agreed to provide MAT to all medically appropriate inmates with opioid use disorder as part of the settlement agreement in the ACLU-WA lawsuit, Kortlever et al v. Whatcom County.

Use of Sublocade (XR- Bup) for the incarcerated: a possible solution

- Why XR (extended release) buprenorphine (XRB: monthly) (trade name = Sublocade) in jail could be a solution for providing ongoing opioid use disorder treatment:
- The injection provides an alternative to perceived stigmatization and privacy concerns associated with daily in-jail sublingual buprenorphine film administration;
- The injection once a month involves fewer pharmacy visits;
- The injection engenders less concerns with buprenorphine diversion.
- XR-Buprenorphine (injection) benefits include perceived efficacy for opioid use disorder treatment, easier adherence to treatment, and blockade effects upon the use of heroin/fentanyl following release reducing risk of overdose, and the impact on averting the risk of further criminal activities to fund opioid use. No product is directly supplied to the individual receiving treatment.

Cheng et al. (2022)
https://clinicaltrials.gov/ct2/bye/rQoPWwoRrXS9-i-wudNgpQDxudhWudNzlXNiZip9Ei7ym67VZRF8EKCRag0VA6h9Ei4L3BUgWwNG0it

Lee JD, Malone M, McDonald R, Cheng A, Vasudevan K, Tofighi B, Garment A, Porter B, Goldfeld KS, Matteo M, Mangat J, Katyal M, Giftos J, MacDonald R. Comparison of Treatment Retention of Adults With Opioid Addiction Managed With Extended-Release Buprenorphine vs Daily Sublingual Buprenorphine-Naloxone at Time of Release From Jail. JAMA Netw Open. 2021 Sep 1;4(9):e2123032. doi: 10.1001/jamanetworkopen.2021.23032. PMID: 34495340; PMCID: PMC8427378.

Legal and medical communities together = improved public safety + public health

- It would be ideal if court orders and drug courts allowed offenders to get medically/psychiatrically diagnosed and to receive the appropriate level of care, the type of treatment, as recommended by an expert in the field of substance use disorder. If they are already in treatment, it would benefit the person if the courts would coordinate/communicate with their current provider.
- Drug courts are very effective – especially when working in coordination with health care providers. We want to work with you!
- "Candidates should not be disqualified from participation in the Drug Court because of co-occurring health or medical conditions or because they have been legally prescribed psychotropic or addiction medication." (2018 – see link below to The Verdict Is In)
- Today we will review the relevant medications for treatment of the opioid use disorder– there is very strong evidence supporting the effectiveness of such medications as: buprenorphine, methadone and naltrexone.

The Verdict Is In (nadcp.org) (2018) ADULT DRUG COURT BEST PRACTICE STANDARDS

OUD Treatment: important considerations

- Acute opioid withdrawal in detoxification centers is not treatment for this chronic disease. Detoxification from opioids creates a high vulnerability to overdose. Post-detoxification is associated with overdose risk, including the risk of fatality.
- Evidence-based practices for effectively treating persons with an opioid use disorder are the FDA approved medications for the opioid use disorder (MOUDs) combined with counseling and care coordination as we provide in Virginia – evidence-based means the science backs up the conclusion that such treatment works!
- Thanks to the ARTS Initiative led by DMAS–a set of policies governing our comprehensive office-based opioid treatment programs, providers are paid to use best practices. Patients are involved in weekly relapse prevention and recovery-promoting therapies and case management to remove barriers blocking the path to recovery, in addition to taking their medications. The patients can and do reshape their lives.

Opioid Use Disorder Treatment

Full agonist: Methadone (synthetic agonist, opioid replacement therapy approved in pregnancy)

Partial agonist: Buprenorphine

Buprenorphine–monoproduct or combined product with naloxone

- Long acting, potent, partial (mu receptor) agonist
- Less euphoria, less addictive
- Treats cravings for opioids while decreasing overdose risk
- Prescribed by waivered physicians/nurse practitioners (mid-level providers)
- Protective preventing overdoses

Full antagonists: naloxone and naltrexone

Methadone, Full Agonist

- Only obtained from specially licensed treatment centers, such as the Roanoke Treatment Center.
- Very successful at retaining patients with addiction.
- Methadone maintenance programs have reduced crime, infections, and improved patient functioning.
- Methadone maintenance is the standard of care for opiate addicted pregnant women.
- Maybe treatment of choice for severely addicted individuals.
- Maybe especially effective for patients with severe chronic pain and addiction.

Buprenorphine

- Buprenorphine is a partial agonist, thus has both some opioid euphoria, but also acts as a opioid blocker.
- Buprenorphine adheres strongly to MU receptors at the nerve sites, thus **blocking the receptors** on the nerve cells where heroin or other opioids would adhere and activate a reaction.
- Buprenorphine has a slow disassociation from the receptor, thus allowing it to remain on the receptor for several days giving a prolonged protective effect.
- Buprenorphine has a low opioid antagonistic action, thus, when it is taken too soon after methadone or other opioids, it will cause withdrawal. Someone must already be in withdrawal to be started on buprenorphine. Otherwise, it can precipitate withdrawal.

Maintenance Best Practices

- Often behavioral patterns are hard to change, the brain takes time to reshape, and we need to maintain treatment long term.
- For a brain to rebound from the harm of addiction requires a very long time – even when the disease goes into remission it can resurface without the appropriate level of supports. This can mean years of needing a medication for their opioid use disorder.
- If a patient relapses on eating too much sugar, we intensify therapy in diabetes treatment – similarly this is recommended for treating relapse of substance use.
- If our addicted patients have "positive" urines, we require them to attend more counseling sessions or enter an intensive outpatient program (IOP) or consider residential treatment.
- KEEP PATIENTS IN TREATMENT!

Opioid antagonists

Naloxone

- Works only when given IM, IV or intranasally, **not** when orally ingested.
- Is quick and short acting (as short as 30 minutes).
- Is used to revive /reverse overdoses.

Naltrexone

- Works when orally ingested, pill form lasts for 24 hours
- Naltrexone XR is long acting (Vivitrol)
- Given IM once a month, injection must be intramuscular
- Effective at curbing cravings

Naltrexone: full blocker

- Naltrexone is a pure antagonist (fully blocks MU receptors).
- Naltrexone is given orally, naltrexone XR is the long acting form which is given IM once a month.
- Patients must be clean for 7 to 10 days before starting naltrexone.
- Patients must be motivated to benefit from this treatment.
- One should monitor liver enzymes during this treatment.
- The injection is given in the gluteal muscle and is described as painful.
- Might consider this treatment for opioid addicted patients who have detoxed and can tolerate naltrexone. The injection could be given as the patient leaves a detoxification facility or prison.
- Naltrexone (especially the XR format – the injection that lasts for a month) has been found to be highly effective at reducing cravings for opiates.

Naltrexone: full blocker

It is so effective at curbing cravings and protecting from overdose, it is being ordered by some judges for all inmates with a history of an OUD, upon release from prison.

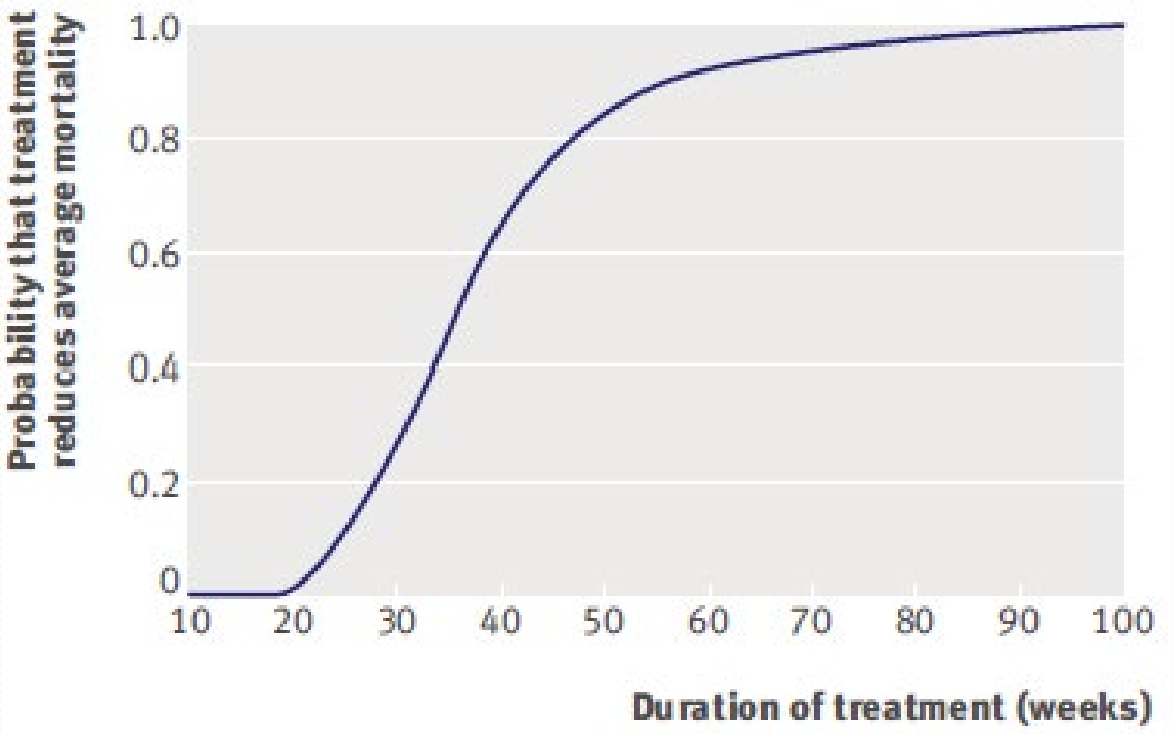
Like all forms of MOUD, naltrexone is most effective when combined with counseling, case management, and community support, such as 12 step programs, or spiritual programs. The XR format has been found to be more effective in treatment than the daily pill format, due to medication compliance challenges.

Problem is lack of retention; patient feels they are cured and stop treatment. Upon stopping the medication, the cravings return.

This could trigger a relapse that puts a person at very high risk for a fatal overdose due to their reduced "tolerance" for opioids.

Keeping patients in treatment: relapses notwithstanding…prevents death

Probability That Treatment Reduces Overall Mortality: N= 5277



Cornish, R et al. (2010) British Medical Journal. 341: 5475
Study was conducted in the United Kingdom; treatment = MAT

Stigma steals treatment options from substance use disorder sufferers

- Stigma stains the lives of all persons with addiction,
- ESPECIALLY our patients with an opioid use disorder.
- Even if they are doing the right thing, receiving medication for their opioid use disorder, and adhering to their comprehensive treatment plan coming weekly to group therapy, getting their drug screens, making appointments are patients have been considered ineligible for Drug Court because they are in treatment for their opioid use disorder.
- Community supports are withheld due to stigma: AA and NA too often go against their official policy: if a medication is needed to be healthy it should be exempt from judgment; our patients report that they feel shamed at AA and NA meetings just for being on medication for their disease.
- Rethink recovery: Individuals on a medication for their opioid use disorder ARE in recovery.

Conclusions: working together improves public health and safety!

Substance use disorder (SUD) is a chronic, relapsing illness, progressive, if untreated. Biopsychosocial-and behavioral in nature (many contributing factors), requiring comprehensive treatment approaches beyond just medications but inclusive of the medicines for an opioid use disorder.

Virginia's ARTS Initiative incentivizes through its Medicaid policies the integration of behavioral health, addiction medical treatment, and primary care combined with care coordination and peer supports to achieve sustainable, positive treatment outcomes. This is what's offered here in VA.

Research shows: counseling alone without medication, that helps the brain recalibrate and reshape itself, is much less likely to be effective for individuals struggling with opioid use disorder than our comprehensive programs that include medication + therapy to support the path to recovery.

Success stories abound: our patients are highly successful businessmen, school teachers, even lawyers – who have reclaimed their lives. They are grateful for feel like themselves again, NORMAL, able to restore relationships – marriages are saved, families are reunified, criminal activity avoided.

Positive results make our work rewarding when we get to provide the full scope of uninterrupted treatment, working with probation officers, drug courts.

Tragedies are avoided: Patients overdosing, committing suicide or criminal acts that put them back in jail. We can work well together! Public health and public safety both benefit as we achieve more success with very vulnerable members of our society.

Thank you!

- Thank you for taking the time today to learn some very hopeful and optimistic medical facts that bode well for our chances of success at working together.

Drs. Cheri and David Hartman

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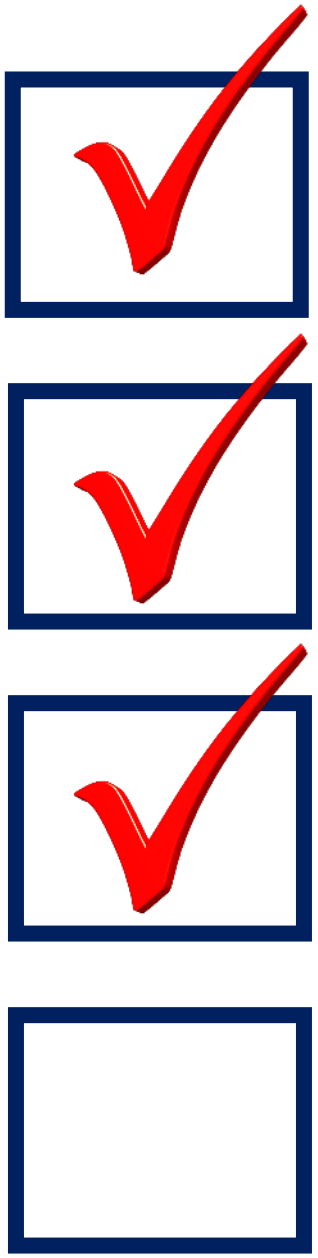
540-521-7817 David Hartman MD

540-981-7099 Cheri W. Hartman PhD



Measuring Inclusion and Equity in Specialty Courts: The Equity and Inclusion Assessment Tool (EIAT)

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Court Research Associate

Acknowledging the contributions to the development of the EIAT of Fred L. Cheesman, Ph.D., Neil LaFountain and Brittany Via, formerly of NCSC as well as Kathyryn J. Genthon, M.A., Erika Bailey and Jacqueline Gilbreath, Court Research Analysts for NCSC, and from NADCP, Carolyn Hardin, M.P.A., Chief of Training and Research and Doug Marlowe, J.D., Ph.D., Senior Scientific Consultant.

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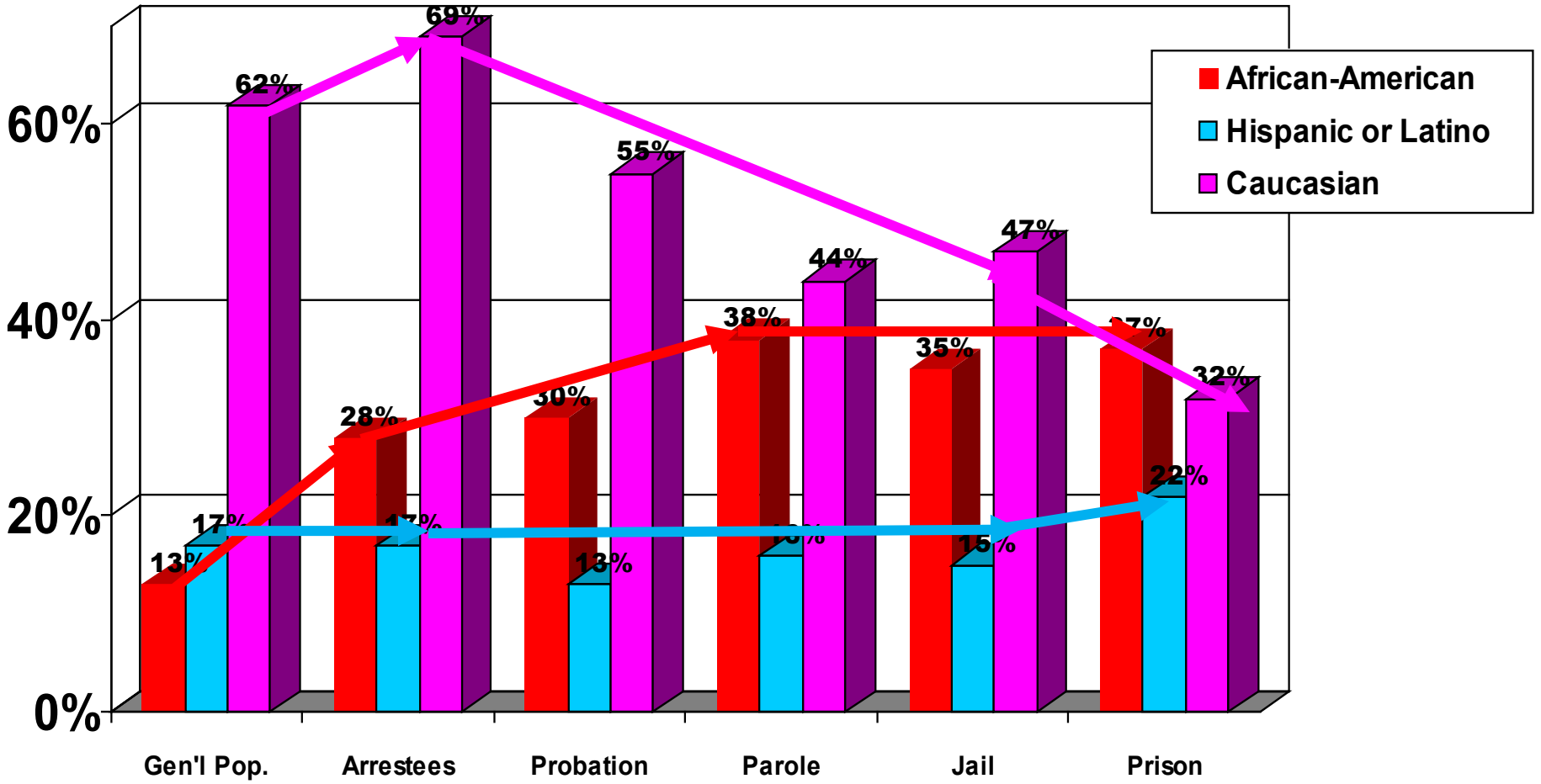
Agenda

- Introduction
- Project Background
- Equity and Inclusion Assessment Tool (EIAT) Demonstration
- How to use EIAT output
- Next Steps

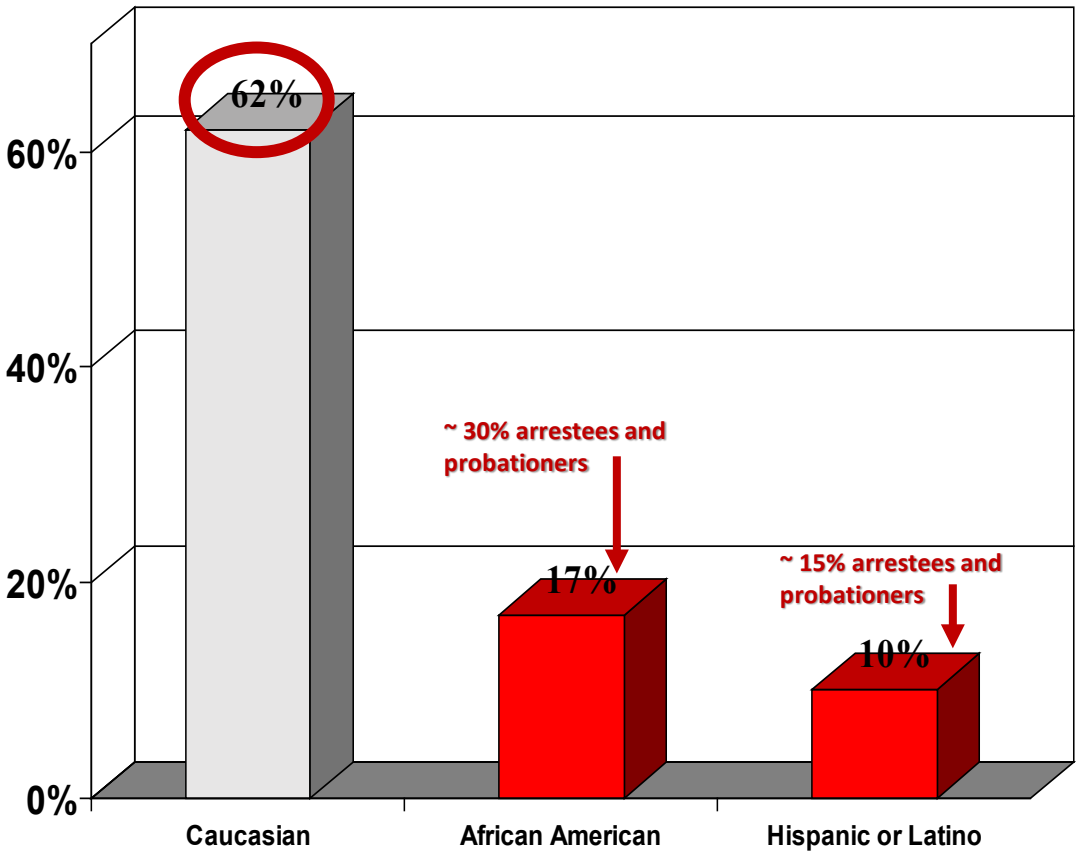
What is it?

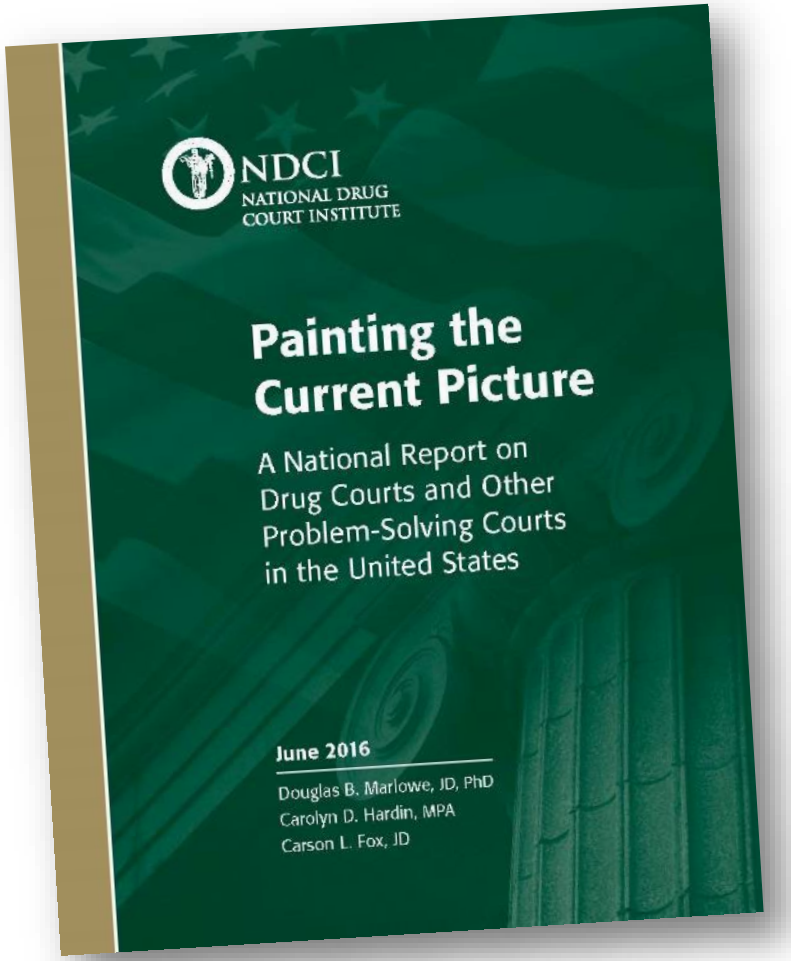
- Diagnostic tool
- Examines proportional differences in referral, admission and graduation rates between demographic groups to assess whether disparities exist by age, race, ethnicity, gender identity, and sexual orientation
- Users provide the reasons for non-entry or non-completion, useful to develop and implement remedial strategies.
- EXCEL-based and provides useful statistics and graphics to interpret results, though the underlying logic is easily adaptable to large main-frame drug court databases
- Part of a suite of tools developed or supported by the National Association for Drug Court Professionals (NADCP) and the National Center for State Courts (NCSC) to assess disparities in drug court processes and to develop strategies to remediate such disparities if they are found to exist.

Racial & Ethnic Representation



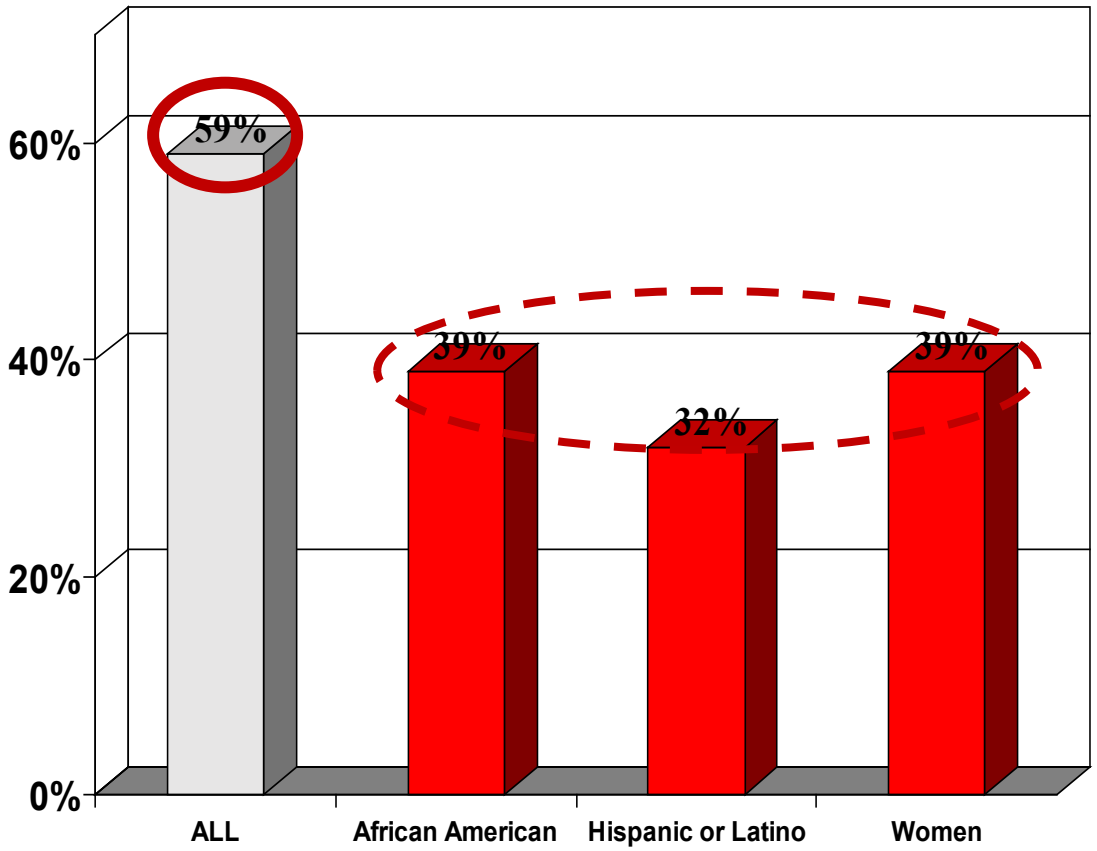
Drug Court Access

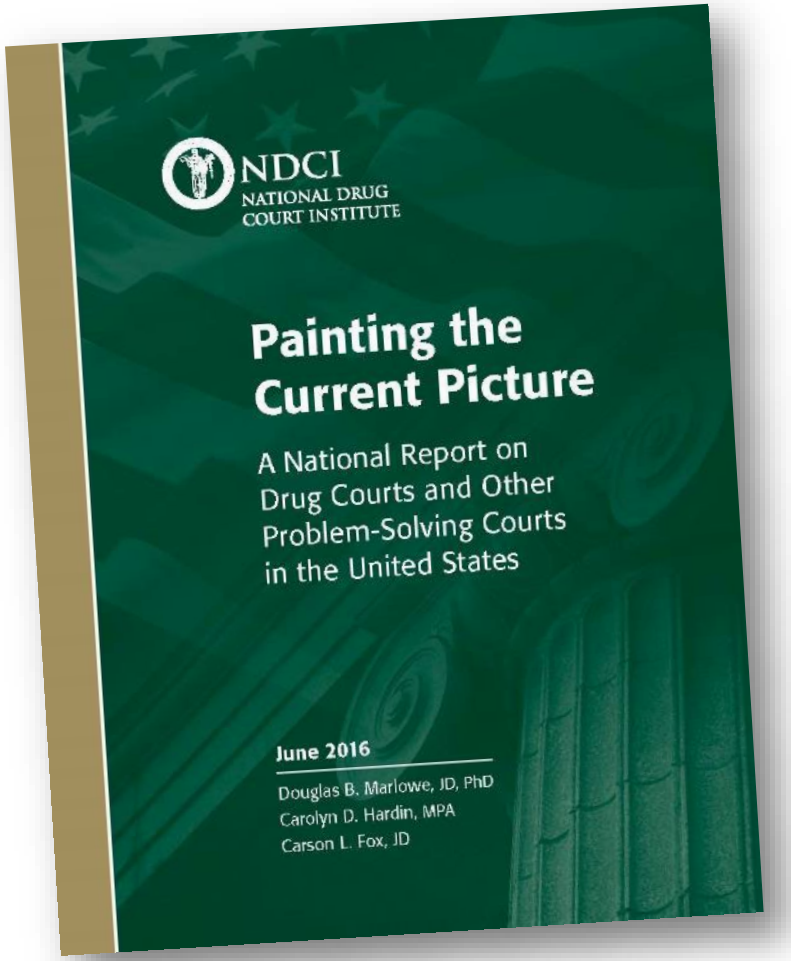




Marlowe et al., 2016

Graduation Rates

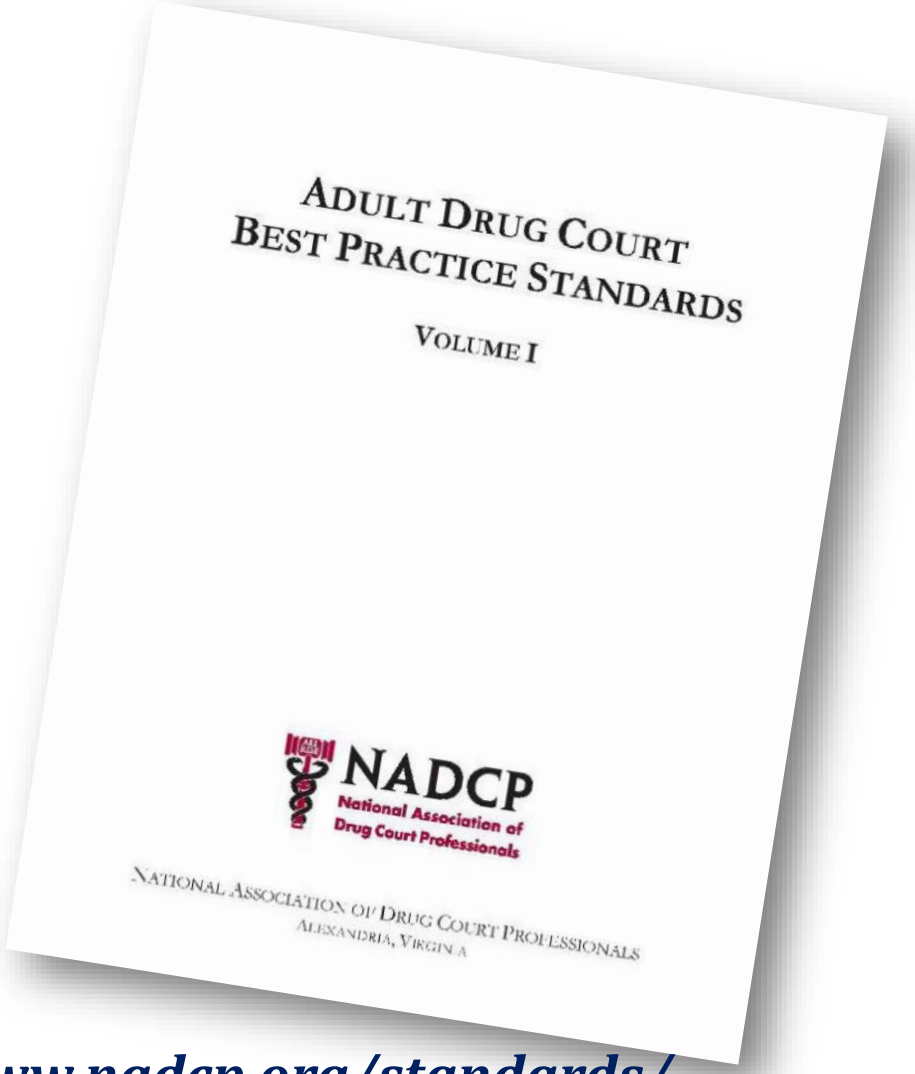




Marlowe et al., 2016

BEST PRACTICE STANDARDS

- Duty to avoid disparities in access, services, and impacts ***regardless of intent***
- ***Affirmative obligation to know*** **whether disparities exist**
- ***Take corrective actions*** **unless doing so would demonstrably threaten public safety or program effectiveness**
- ***Evaluate success of the corrective actions*** **and adjust until disparities are eliminated**



https://www.nadcp.org/standards/

Practitioner Tool Kits

- Methods for diagnosing disparities (e.g., EIAT)
- Methods for recruitment and social marketing
- Culturally proficient curricula (e.g., HEAT)
- Gauging participant and stakeholder perceptions, misperceptions, and recommendations

Background

EIAT is based on a performance measure developed by NCSC and implemented in several states (e.g., Kentucky, Maryland, Iowa); See Cheesman, Genthon, and Marlowe (2019).

SPECIFICATIONS

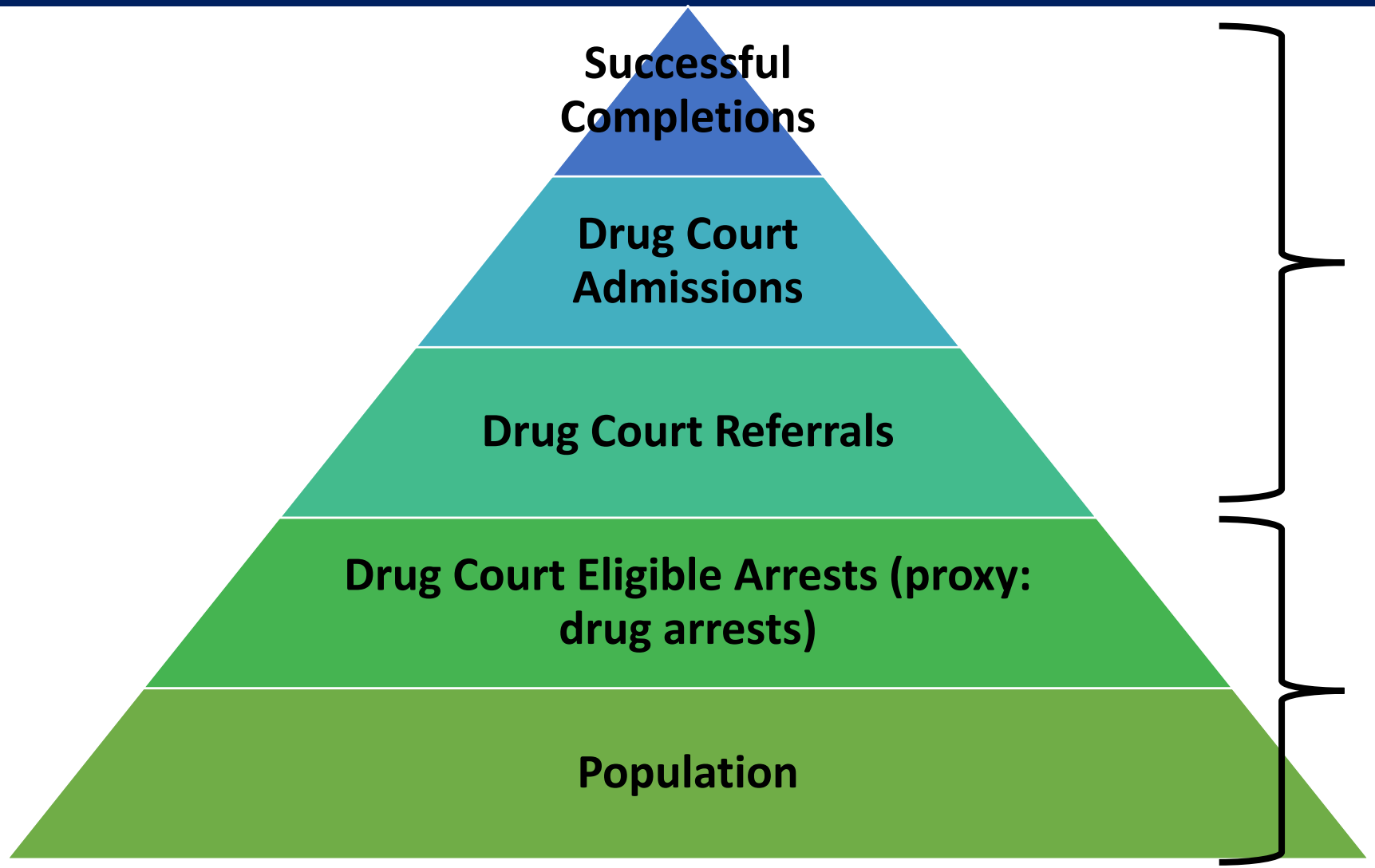
1) Target key ***processing points*** as the focus for analysis.

2) Use ***referral cohorts*** to create groups for analysis.

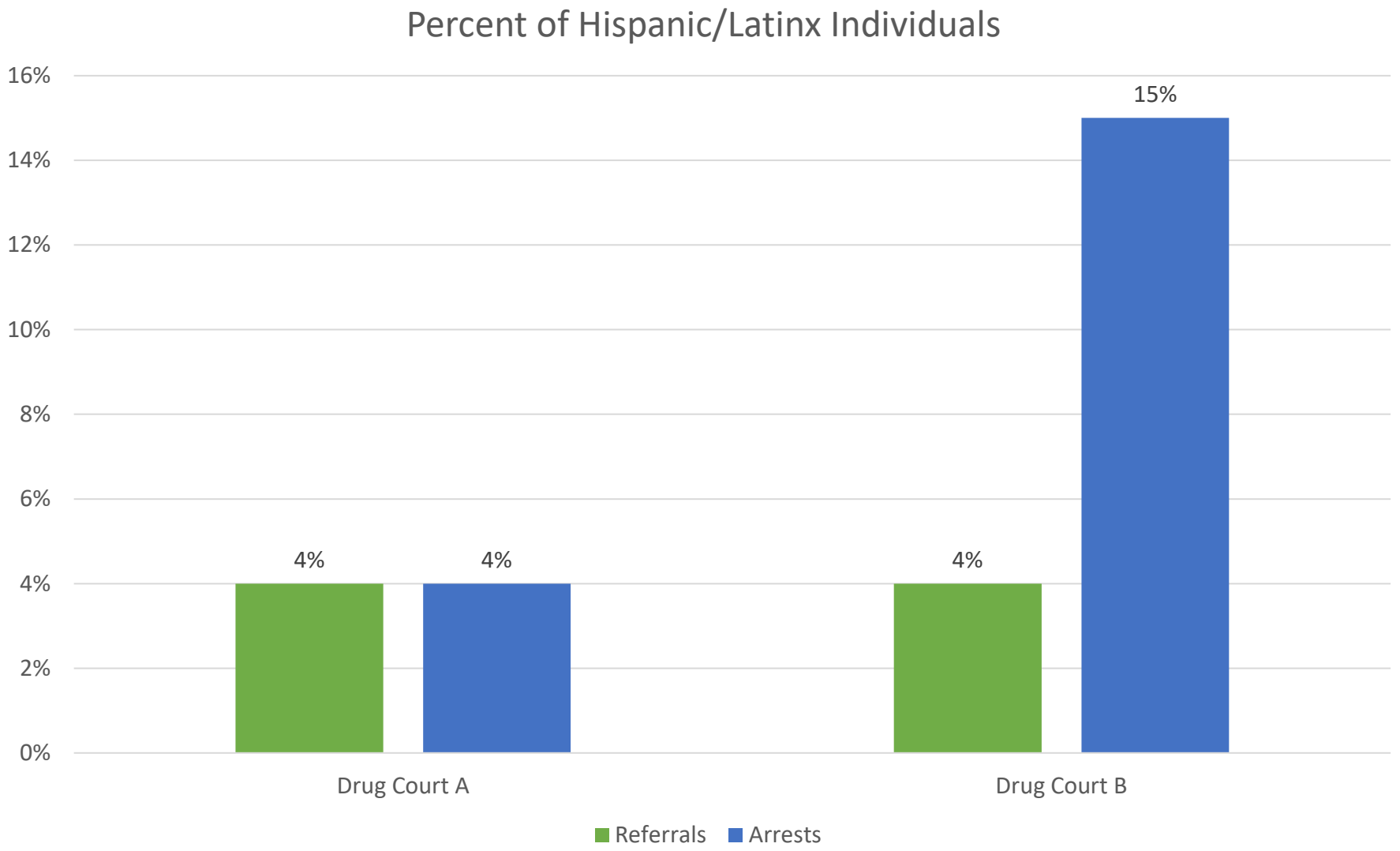
3) Calculate ***transition probabilities*** to assess equity within those groups.

For any demographic characteristic of interest included in the EIAT, assess the probability of an individual progressing through key processing points

Processing Points



Assessing Data in Context



Processing Points

Successful Completions

Drug Court Admissions

Drug Court Referrals

Drug Court Eligible Arrests (proxy: drug arrests)

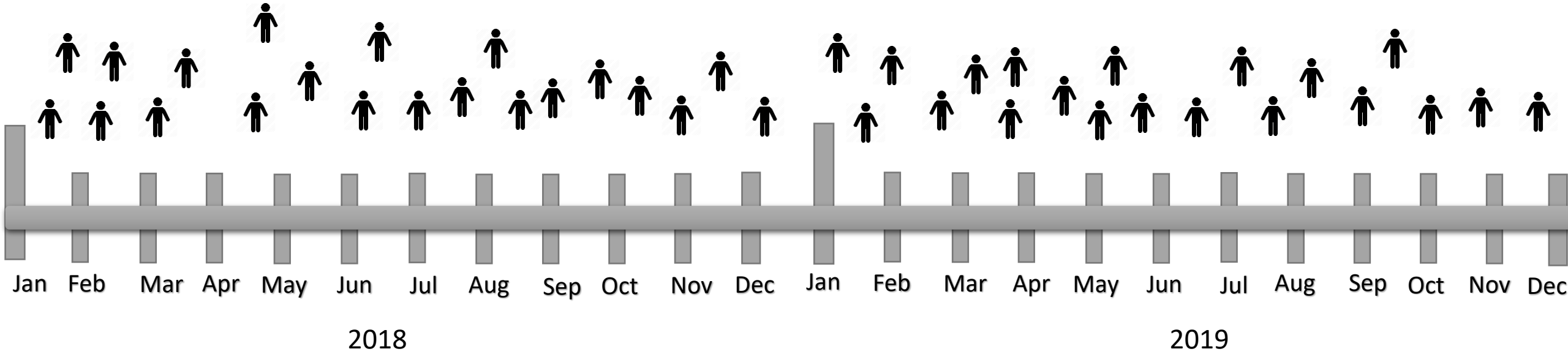
Population

Cohorts

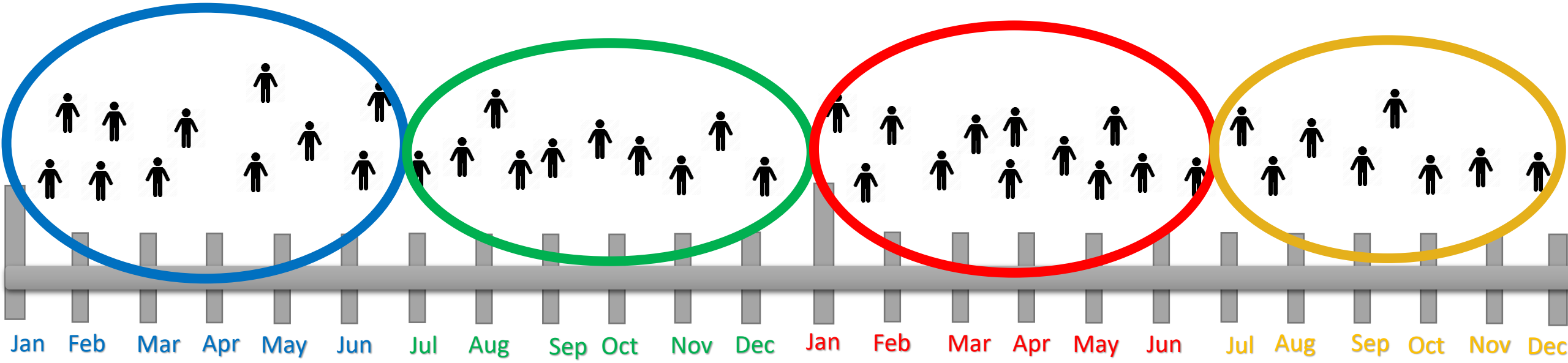
Drug Court Data

External Data

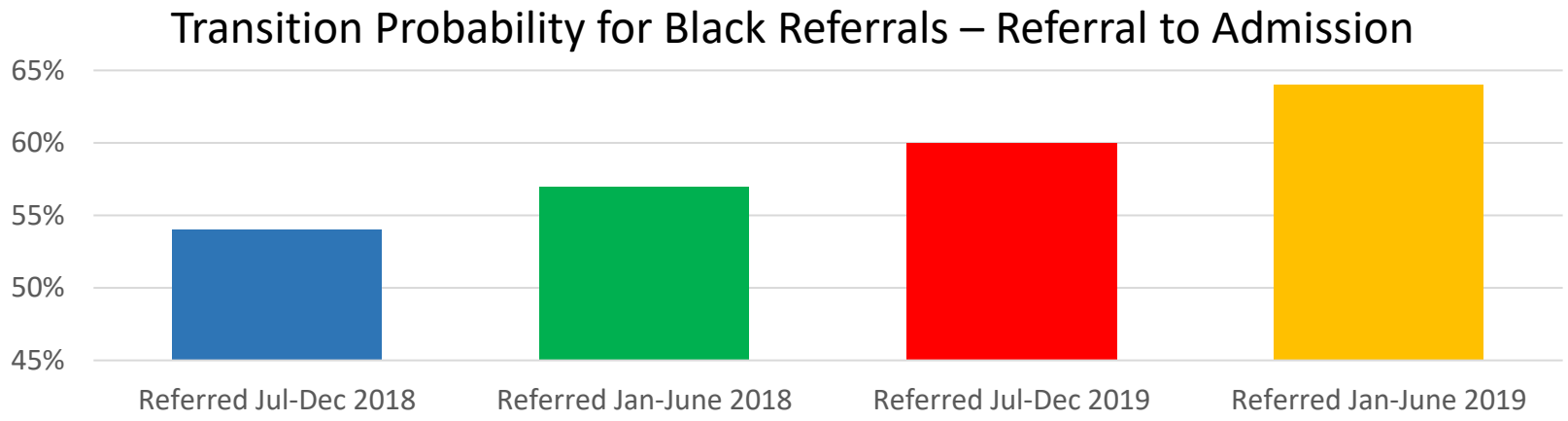
Referral Cohorts



Referral Cohorts



2018 2019



TRANSITION PROBABILITIES

1) Probability of a person arrested for a Drug Court-eligible offense being referred to Drug Court

- Use proxies since an exact probability cannot be calculated
  - Compare demographic composition of offenders arrested for drug offenses to demographic composition of referrals.

2) Probability of a referral being admitted by demographic characteristic of interest

3) Probability of an admission successfully completing Drug Court by demographic characteristic of interest

Comparing Transition Probabilities to Proportions

Transition Probabilities vs. Proportions

Race	Referrals						Percent of:	
	Total	Admitted	Successful	% Referrals	% Admissions	% Successful Completions	Total Referrals Admitted	Admitted Referrals Successful
White or Caucasian	**160**	80	60	33.3%	24.2%	24.0%	50.0%	75.0%
Black or African-American	**130**	100	80	27.1%	30.3%	32.0%	76.9%	80.0%
American Indian or Alaska Native	**50**	40	30	10.4%	12.1%	12.0%	80.0%	75.0%
Asian	**70**	70	60	14.6%	21.2%	24.0%	100.0%	85.7%
Pacific Islander	**40**	20	10	8.3%	6.1%	4.0%	50.0%	50.0%
Other	**30**	20	10	6.3%	6.1%	4.0%	66.7%	50.0%
Total	**480**	**330**	**250**	**100.0%**	**100.0%**	**100.0%**	**68.8%**	**75.8%**

EIAT requires Additional data

Drug Courts need to collect additional data on the following to get the most from the EIAT:

1. **Adult Population**
2. **Local Drug Arrests**
3. **Referrals to drug court**

All disaggregated by race, ethnicity, gender, and age

EIAT requires Additional data

1. **Additional participant data:**
   - **Date of referral**
   - **If not admitted, reason for non-admission (pull down)**
   - **Day-to-Day life Gender (pull down)**
   - **Sexual Orientation (pull down)**

Drug Arrests per 1000 Population

		Arrest/Population Ratio	
Jurisdiction	**Time Period**	**White**	**Black**
State A	2015	14	25
State B	2016	7	14

Average Annual Drug Court Referrals per 1000 Drug Arrests

		Referral/Arrest Ratio	
Jurisdiction	**Time Period**	**White**	**Black**
State A	2006-2015	45	30
State B	2010-2016	64	44

Drug Court Referrals, Admissions and Successful Completions

		Average Probability of Transitioning from Referral to Admission			Average Probability of Transitioning from Admission to Successful Completion		
Jurisdiction	**Time Period**	**White**	**Black**	**Difference**	**White**	**Black**	**Difference**
State A	2006-2015	64%	52%	12% ***	39%	31%	8% ***
State B	2010-2016	59%	31%	27% ***	53%	39%	14% ***

Sample of Raw Data

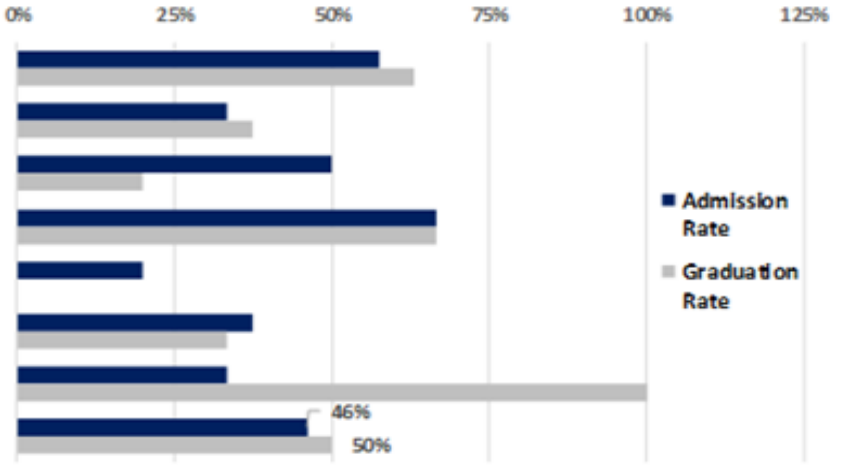
	SECTION 2: DEMOGRAPHIC INFORMATION				
S2_dob	S2_gender	S2_sexorient	S2_race	S2_ethnicity	S2_religion
Date of Birth	**Gender**	**Sexual Orientation**	**Race**	**Ethnicity**	**Religion**
6/25/1980	2	u	4	1	u
7/26/1950	1	u	4	1	u
8/14/1979	1	u	5	2	u
12/31/1980	1	u	4	1	u
5/19/1964	2	u	4	1	u
8/5/1980	1	u	4	1	u
6/29/1973	2	u	5	2	u
4/7/1985	2	u	1	1	u
7/7/1961	2	u	4	1	u

DATA USING EIAT

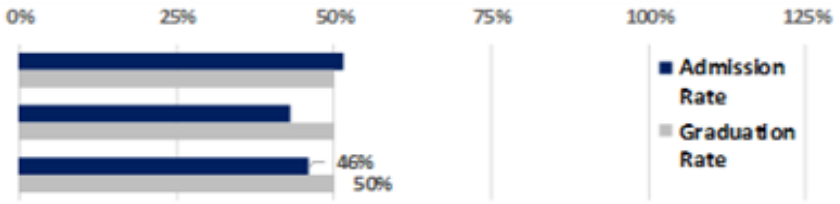
Figure 4: Example of Interpreting Differences in Admission and Successful Completion Rates

Admission and Graduation Rates - Page 1 of 2

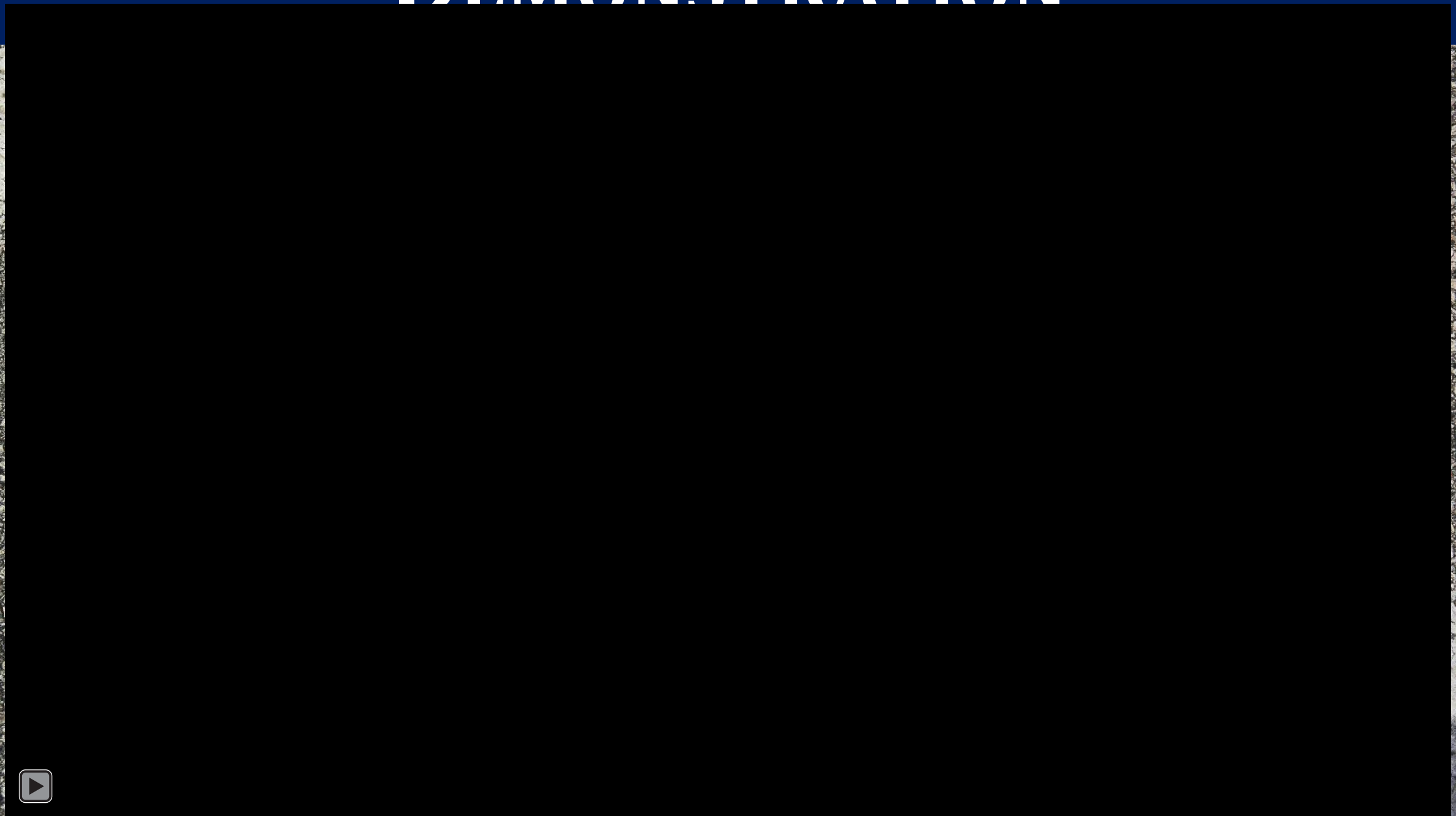
Race	Referrals Total	Referrals Admitted	Referrals Successful	Admission Rate	Graduation Rate
White or Caucasian	33	19	12	58%	63%
Black or African-American	24	8	3	33%	38%
American Indian or Alaska Native	10	5	1	50%	20%
Asian	9	6	4	67%	67%
Pacific Islander	5	1	0	20%	None
Blended Race	16	6	2	38%	33%
Other	3	1	1	33%	100%
Total	100	46	23	46%	50%



Ethnicity	Referrals Total	Referrals Admitted	Referrals Successful	Admission Rate	Graduation Rate
Hispanic or Latinx	35	18	9	51%	50%
Not Hispanic or Latinx	65	28	14	43%	50%
Total	100	46	23	46%	50%



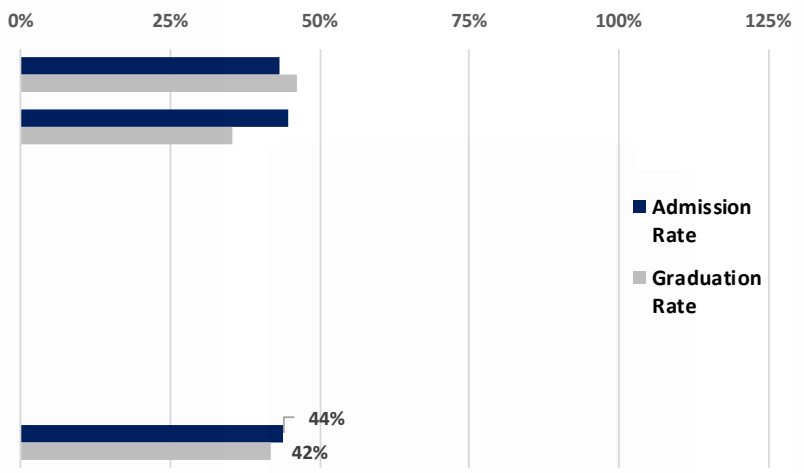
Demonstration



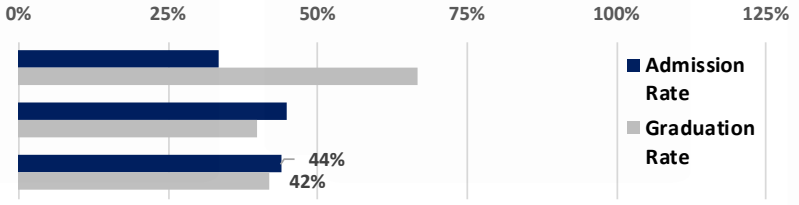
DATA USING EIAT

Admission and Graduation Rates - Page 1 of 2

Race	Referrals Total	Referrals Admitted	Referrals Successful	Admission Rate	Graduation Rate
White or Caucasian	**60**	26	12	43%	46%
Black or African-American	**38**	17	6	45%	35%
American Indian or Alaska Native	**0**	0	0	None	None
Asian	**0**	0	0	None	None
Pacific Islander	**0**	0	0	None	None
Blended Race	**0**	0	0	None	None
Other	**0**	0	0	None	None
Total	**98**	**43**	**18**	**44%**	**42%**



Ethnicity	Referrals Total	Referrals Admitted	Referrals Successful	Admission Rate	Graduation Rate
Hispanic or Latinx	**9**	3	2	33%	67%
Not Hispanic or Latinx	**89**	40	16	45%	40%
Total	**98**	**43**	**18**	**44%**	**42%**



Aggregated Data, 2016-2017

Total	Total	Admitted	Successful
White or Caucasian	189	86	41
Black or African-American	126	43	20
Total	315	129	61

ARE ANY OF THESE DIFFERENCES SIGNIFICANT?

Total	Total	Admitted	Successful
White or Caucasian	189	86	41
Black or African-American	126	43	20
Total	315	129	61

- Use a *test of the significance of the difference between two independent proportions* (see, for example, http://vassarstats.net/propdiff_ind.html)

ARE ANY OF THESE DIFFERENCES SIGNIFICANT? (CONT.)

The Significance of the Difference Between Two Independent Proportions

This page will calculate the z-ratio for the significance of the difference between two independent proportions, p_a and p_b. For the notation used here, n_a and n_b represent the total numbers of observations in two independent samples, A and B; k_a and k_b represent the numbers of observations within each sample that are of particular interest; and p_a and p_b represent the proportions k_a/n_a and k_b/n_b, respectively. Thus, if sample A shows 23 recoveries among 60 patients, $n_a=60$, $k_a=23$, and the proportion is $p_a=23/60=0.3833$. If sample B shows 18 recoveries among 72 patients, $n_b=72$, $k_b=18$, and the proportion is $p_b=18/72=0.2500$. The difference between the two proportions is $diff=p_a-p_b=0.3833-0.2500=0.1333$.

To perform the calculation, enter the values of n and k for samples A and B in the designated places, then click the «Calculate» button. Please note that this procedure can be validly employed only if both samples satisfy the standard binomial requirement: that n(p) and n(1−p) must both be equal to or greater than 5.

The one-tailed and two-tailed probabilities associated with the resulting value of z will be calculated and displayed in the designated text cells.

Sample A		Sample B	
k_a =		k_b =	
n_a =		n_b =	
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		

Reset Calculate z = --------

Probability	
One-Tail	Two-Tail

http://vassarstats.net/propdiff_ind.html

Are any of these differences Significant? (cont.)

Enter Total Whites Number.

Sample A		Sample B	
k_a =		k_b =	
n_a =	189	n_b =	
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		

Reset Calculate

z = --------

Probability	
One-Tail	Two-Tail

Are any of these differences Significant? (cont.)

Enter Whites Admitted Number.

Sample A		Sample B	
k_a =	86	k_b =	
n_a =	189	n_b =	
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		

Reset Calculate

z = --------

Probability	
One-Tail	Two-Tail

Are any of these differences Significant? (cont.)

Sample A		Sample B	
k_a =	86	k_b =	
n_a =	189	n_b =	126
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		
Reset	Calculate	z =	--------

Enter Total Blacks Number.

Probability	
One-Tail	Two-Tail

Are any of these differences Significant? (cont.)

Sample A		Sample B	
k_a =	86	k_b =	43
n_a =	189	n_b =	126
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		

Enter Total Blacks Number.

Reset Calculate

z = --------

Probability	
One-Tail	Two-Tail

Are any of these differences Significant? (cont.)

Sample A		Sample B	
k_a =	86	k_b =	43
n_a =	189	n_b =	126
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		

Reset Calculate

z = --------

Probability	
One-Tail	Two-Tail

Are any of these differences Significant? (cont.)

Sample A		Sample B	
k_a =	86	k_b =	43
n_a =	189	n_b =	126
p_a =	0.455	p_b =	0.3413
$p_a - p_b$ =	0.1138		

Reset Calculate

z = 2.011

Probability	
One-Tail	Two-Tail
0.0222	0.0443

One-Tail
Number is < .05.

Are any of these differences Significant? (cont.)

Sample A		Sample B	
k_a =	86	k_b =	43
n_a =	189	n_b =	126
p_a =	0.455	p_b =	0.3413
$p_a - p_b$ =	0.1138		
Reset	Calculate	z =	2.011

Probability	
One-Tail	Two-Tail
0.0222	0.0443

Two-Tail
Number is < .05.

Are any of these differences Significant? (cont.)

Enter Total Whites Admitted.

Sample A		Sample B	
k_a =		k_b =	
n_a =	86	n_b =	
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		

Reset Calculate

z = --------

Probability	
One-Tail	Two-Tail

Are any of these differences Significant? (cont.)

Enter Whites Completed.

Sample A		Sample B	
k_a =	41	k_b =	
n_a =	86	n_b =	
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		
Reset	Calculate	z =	--------

Probability	
One-Tail	Two-Tail

Are any of these differences Significant? (cont.)

Sample A		Sample B	
k_a =	41	k_b =	
n_a =	86	n_b =	43
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		
Reset	Calculate	z =	--------

Enter Total Blacks Admitted.

Probability	
One-Tail	Two-Tail

Are any of these differences Significant? (cont.)

Sample A		Sample B	
k_a =	41	k_b =	20
n_a =	86	n_b =	43
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		
Reset	Calculate	z =	--------

Enter Total Blacks Completed.

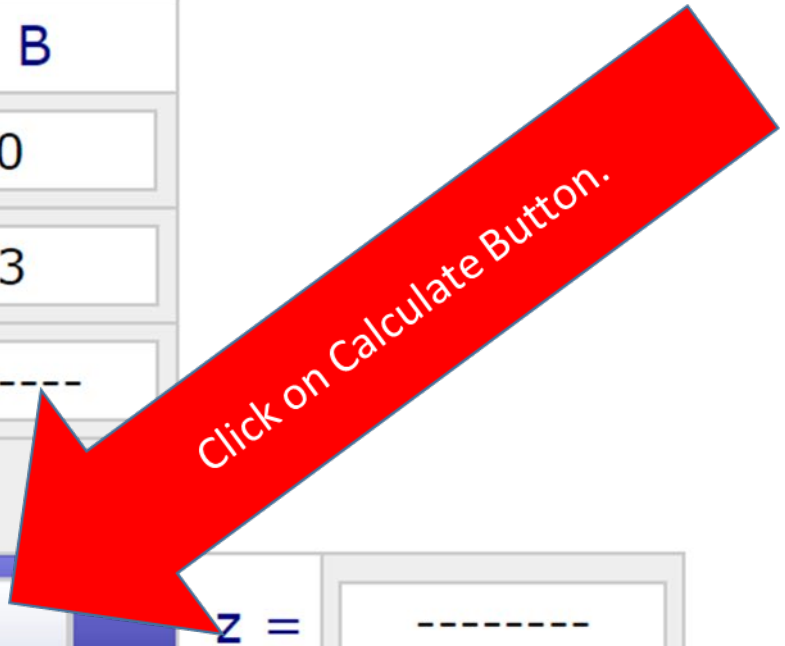
Probability	
One-Tail	Two-Tail

Are any of these differences Significant? (cont.)

Sample A		Sample B	
k_a =	41	k_b =	20
n_a =	86	n_b =	43
p_a =	--------	p_b =	--------
$p_a - p_b$ =	--------		

Reset Calculate

z = --------



Probability	
One-Tail	Two-Tail

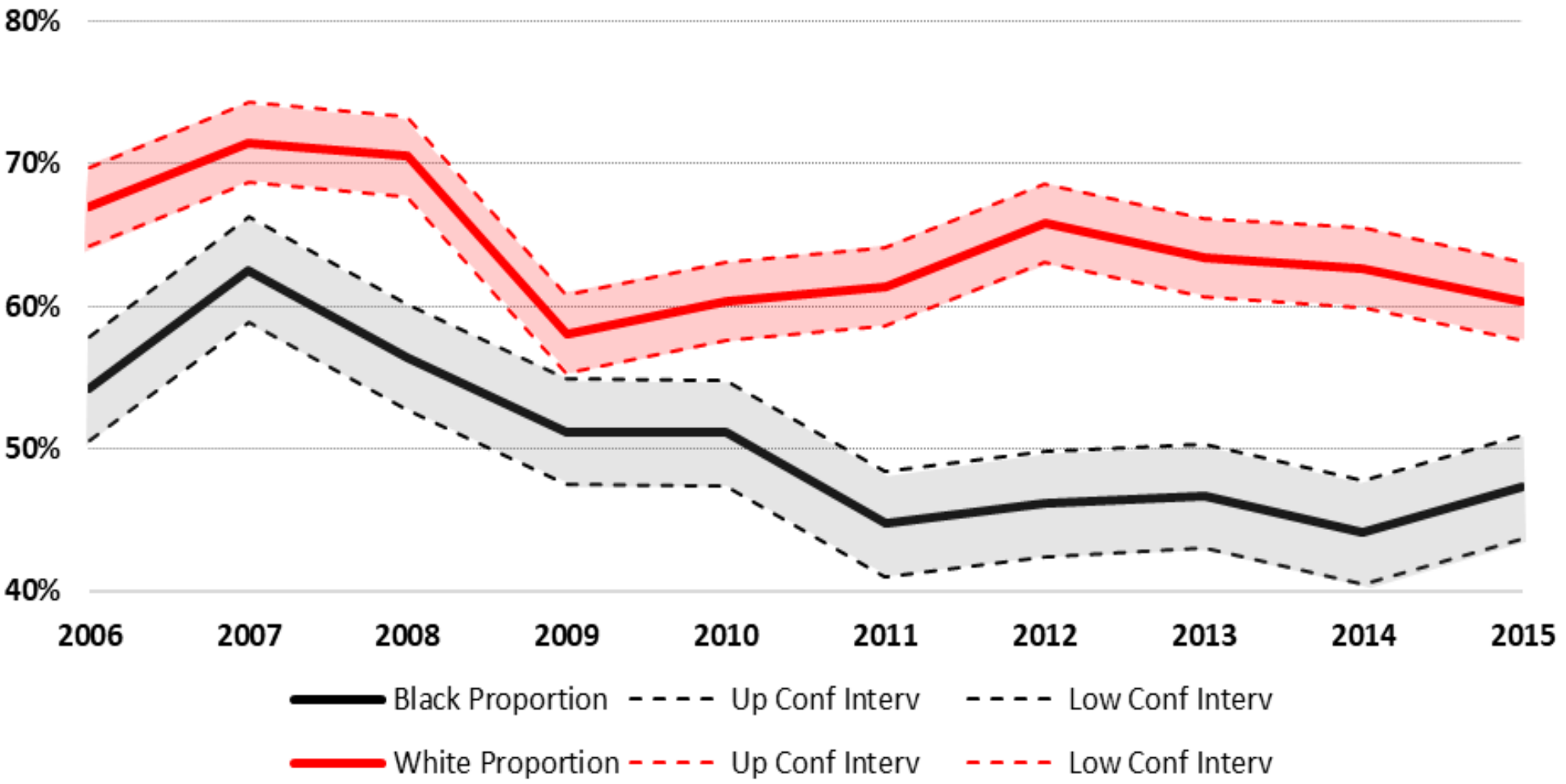
Are any of these differences Significant? (cont.)

Sample A		Sample B	
k_a =	41	k_b =	20
n_a =	86	n_b =	43
p_a =	0.4767	p_b =	0.4651
$p_a - p_b$ =	0.0116		
Reset	Calculate	z =	0.125

One-Tail Number is

Probability	
One-Tail	Two-Tail
0.4503	0.9005

Are any of these differences Significant?



Next Steps

- Make EIAT tool and User's Guide available to specialty courts. EIAT has been pilot-tested and is ready for use.
- Courts should begin to collect additional data if not doing so already.
- Courts should use the EIAT to assess their compliance with Adult Drug Court Best Practice Standards: Volume I, Standard II, *Equity and Inclusion.*

Substance Use Disorder (SUD), Medicaid, and the Legal-Carceral Population

Ashley Harrell, LCSW, ARTS Senior Program Advisor
Jason Lowe, MSW, SUPPORT Act Grant Manager
Virginia Department of Medical Assistance Services (DMAS) – Virginia Medicaid

Understanding Substance Use Disorders: Addiction

Addiction is a **treatable, chronic medical disease** involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

Understanding Substance Use Disorders: Myths and Reality

Myth 1 – It doesn't matter what kind of language I use when I talk about substance use disorders.

We need to use "Person-Centered language"

- Not "Addict," but **Person who uses drugs or Person with a substance use/behavioral disorder**
- Not "Addiction," but **Substance Use Disorder (SUD)**
- Not "Abuse," but **Use**
- Not "Clean," but **In Recovery or Testing Negative**
- Not "Dirty," but **Testing Positive**
- Not "Relapse," but **Return to Use**

Be cognizant that some people may describe themselves as "alcoholics," "junkies," etc., or may refer to "clean time" as how long they have been in recovery (and we need to respect this).

Understanding Substance Use Disorders: Myths and Reality

Myth 2 – It is a bad habit that people can stop whenever they want

This is one of the most **harmful and untrue misconceptions to have about SUD, yet it is one of the most prevalent**. Even though we might not say it explicitly, it can be reflected in the way that people with SUD are treated by their loved ones and society as a whole.

Not only does SUD affect a person's ability to control substance use, but **studies show that over half of those with SUD also have a co-occurring mental disorder and vice versa**. Certain risk factors can put people at a higher risk for mental disorders, which can in turn trigger brain changes that might lead to other types of disorders.

Understanding Substance Use Disorders: Myths and Reality

Myth 3 – It is easy to tell if someone has a substance use disorder

There is a **misconception that people with SUD have a specific look, or that they all behave a certain way**, but this kind of thinking is based on harmful, false stereotypes.

Everyone is susceptible to SUD, meaning it's basically impossible to tell when someone is misusing substances.

There are certain warning signs that someone might be misusing substances— for example, it's **possible to notice physical symptoms — but these things alone are not enough to guarantee someone has SUD, nor do all people with SUD have obvious physical symptoms**.

By getting ourselves to challenge what we believe a person with SUD looks like or acts like, we can start to reshape how it is treated in our society.

Understanding Substance Use Disorders: Myths and Reality

Myth 4 – Individuals with SUD have to "hit bottom" before they can begin their recovery.

Recovery can begin at any time! Given the impacts on the brain and possible consequences of SUD, the earlier one can get treatment, the better. The longer the SUD continues, the harder it is to treat. Get help early rather than holding out for a low point.

Utilize **key touchpoints to engage individuals into treatment**. A survey conducted by the Substance Abuse and Mental Health Services Administration (SAMSHA) found that **as many as 90 percent of people who need drug rehab do not receive it[1].**

1.Substance Abuse and Mental Health Services Administration. (2020). *National Survey of Drug Use and Health*.

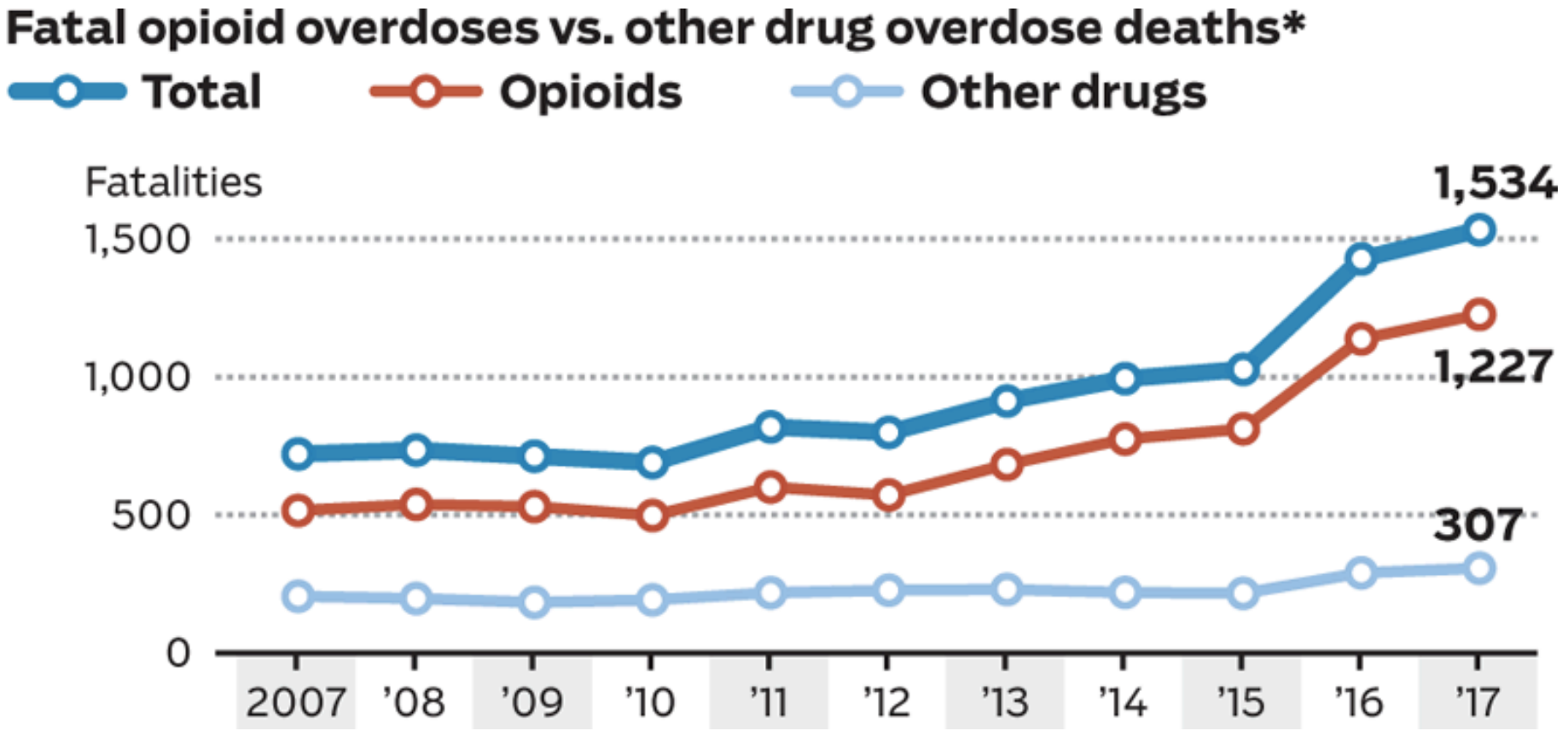
Willpower is all one needs to beat addiction.

Myth 5 – Willpower is all anyone needs to overcome addiction.

Prolonged substance use alters the way the brain works The brain sends signals of powerful and intense cravings, which are accompanied by a compulsion to use. These brain changes make it extremely difficult to quit and **often a treatment program is required**.

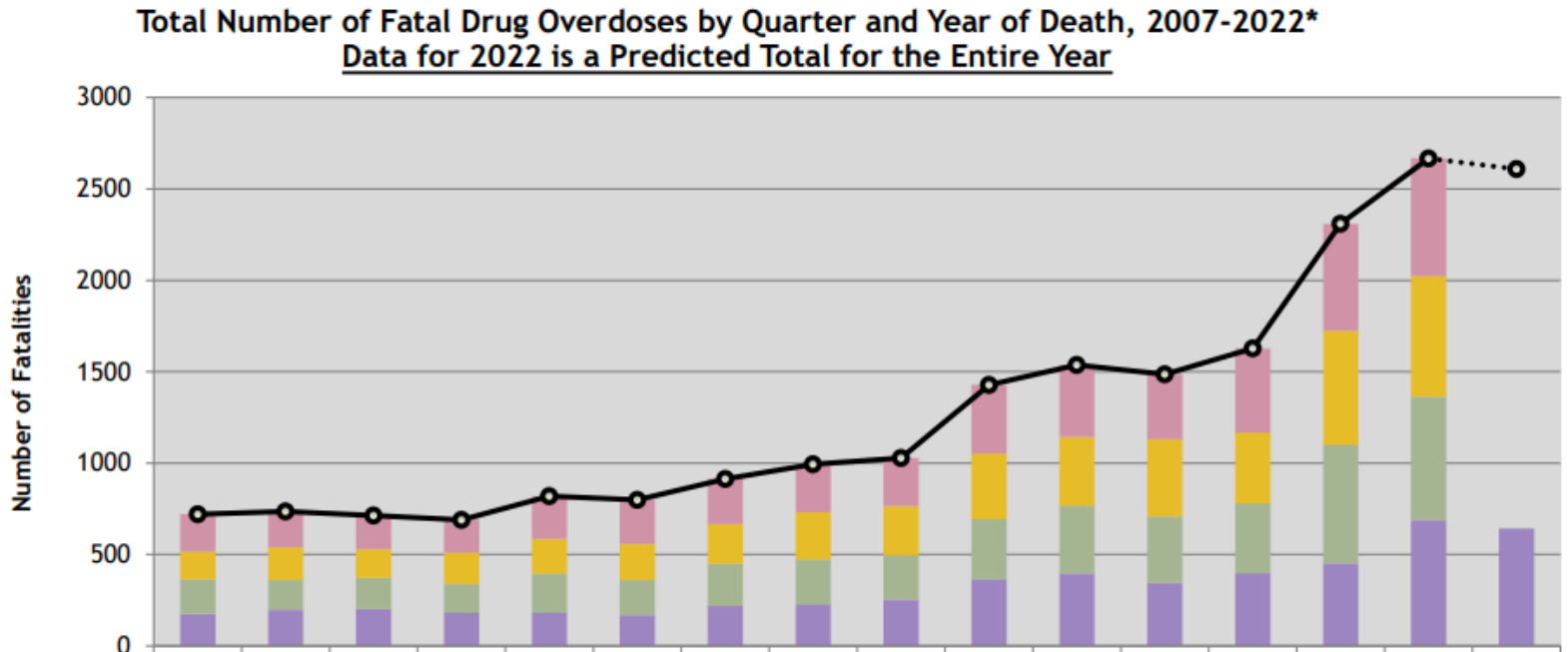
How can Medicaid help with treatment options for individuals with Substance Use Disorders?

Virginia's Overdose Crisis 2007-2017



Virginia Department of Health, Daily Press Analysis

VDH: Fatal Drug Overdose Report Quarter 1 2022



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022*
Q4	205	195	183	179	232	240	248	263	262	375	393	354	459	585	643	
Q3	152	180	157	170	191	199	217	257	270	359	376	423	389	624	660	
Q2	188	162	172	159	215	190	230	246	243	332	371	363	380	647	676	
Q1	176	198	201	182	181	170	219	228	253	362	397	346	399	453	688	642
Total Fatalities	721	735	713	690	819	799	914	994	1028	1428	1537	1486	1627	2309	2667	2608

https://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

COVID-19 Accelerated Overdose Deaths Nationally

Drug overdose deaths in 2020 hit highest number ever recorded, CDC data shows

By Maggie Fox, CNN
Updated 10:17 AM ET, Wed July 14, 2021

"As we continue to address both the COVID-19 pandemic and the opioid crisis, **we must prioritize making treatment options more widely available** to people with substance use disorders."

CDC Data: Fatal overdose rates increase by 30% in 2020 –

100,306 people died in 2020

https://www.cnn.com/2021/07/14/health/drug-overdose-deaths-2020/index.html
https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm

Coverage is Critical for the Legal-Carceral Population

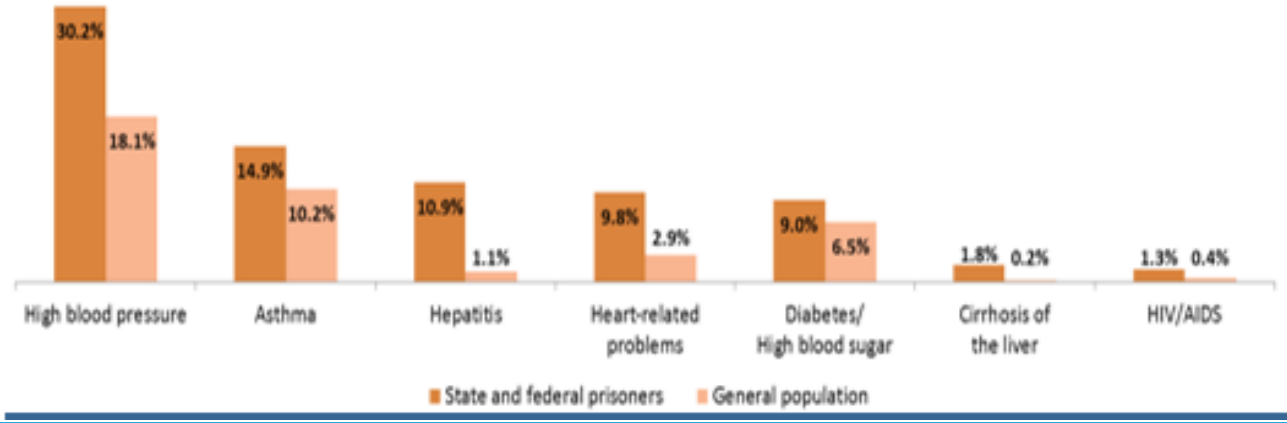
Justice-involved populations have considerable physical and behavioral health care needs that can impact health outcomes and rates of recidivism. Ensuring that justice-involved populations are enrolled in health insurance prior to their release can help them get the health care treatment and supports they need to re-enter the community safely and avoid re-incarceration.

64% of jail inmates, 56% of state prisoners, and 45% of federal prisoners were found to have a mental health problem.

2 of 3 inmates have a substance use disorder

In VA, approximately 68% of the DOC prison and non-prison (probation/parole) population have a need for SUD treatment.

Rates of Chronic Physical Health Conditions for State and Federal Prisoners as Compared to the General Population



The mortality rate in the two weeks after release from prison is **12.7 times** the normal rate, driven largely by overdoses

Source: State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid (Commonwealth Fund, Jan. 2019).

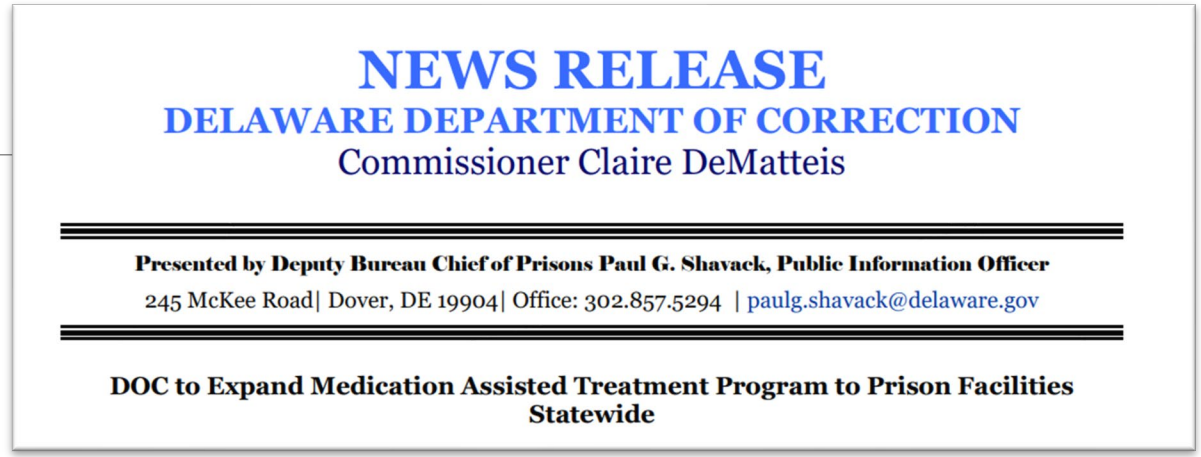
Incarceration and Reentry without medications for opioid use disorder (MOUD) lead to increased death

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Release from Prison —
A High Risk of Death for Former Inmates

Ingrid A. Binswanger, M.D., Marc F. Stern, M.D., Richard A. Deyo, M.D., Patrick J. Heagerty, Ph.D., Allen Cheadle, Ph.D., Joann G. Elmore, M.D., and Thomas D. Koepsell, M.D.



NEWS RELEASE

DELAWARE DEPARTMENT OF CORRECTION

Commissioner Claire DeMatteis

Presented by Deputy Bureau Chief of Prisons Paul G. Shavack, Public Information Officer

245 McKee Road| Dover, DE 19904| Office: 302.857.5294 | paulg.shavack@delaware.gov

DOC to Expand Medication Assisted Treatment Program to Prison Facilities Statewide

A seminal study in the United States demonstrated that after controlling for demographic factors, individuals released from prison in Washington State had a **129 x greater risk of drug overdose** in the first 2 weeks post-release relative to the general population.

"…Delaware's record 400 overdose deaths in 2018, **30% had previously been detained with the Delaware Department of Correction.**

Moreover, of those individuals reviewed who had been previously detained, **50% suffered a fatal overdose within three months of release** and **75% died from an overdose within one year of release**."

Virginia Medicaid's Role in Treatment

What is MEDICAID?

HEALTH INSURANCE

Largest source of health coverage

Major payer for Behavioral Health Services

Federal program, jointly funded by each state

Independently state administered

Not the same as Medicare

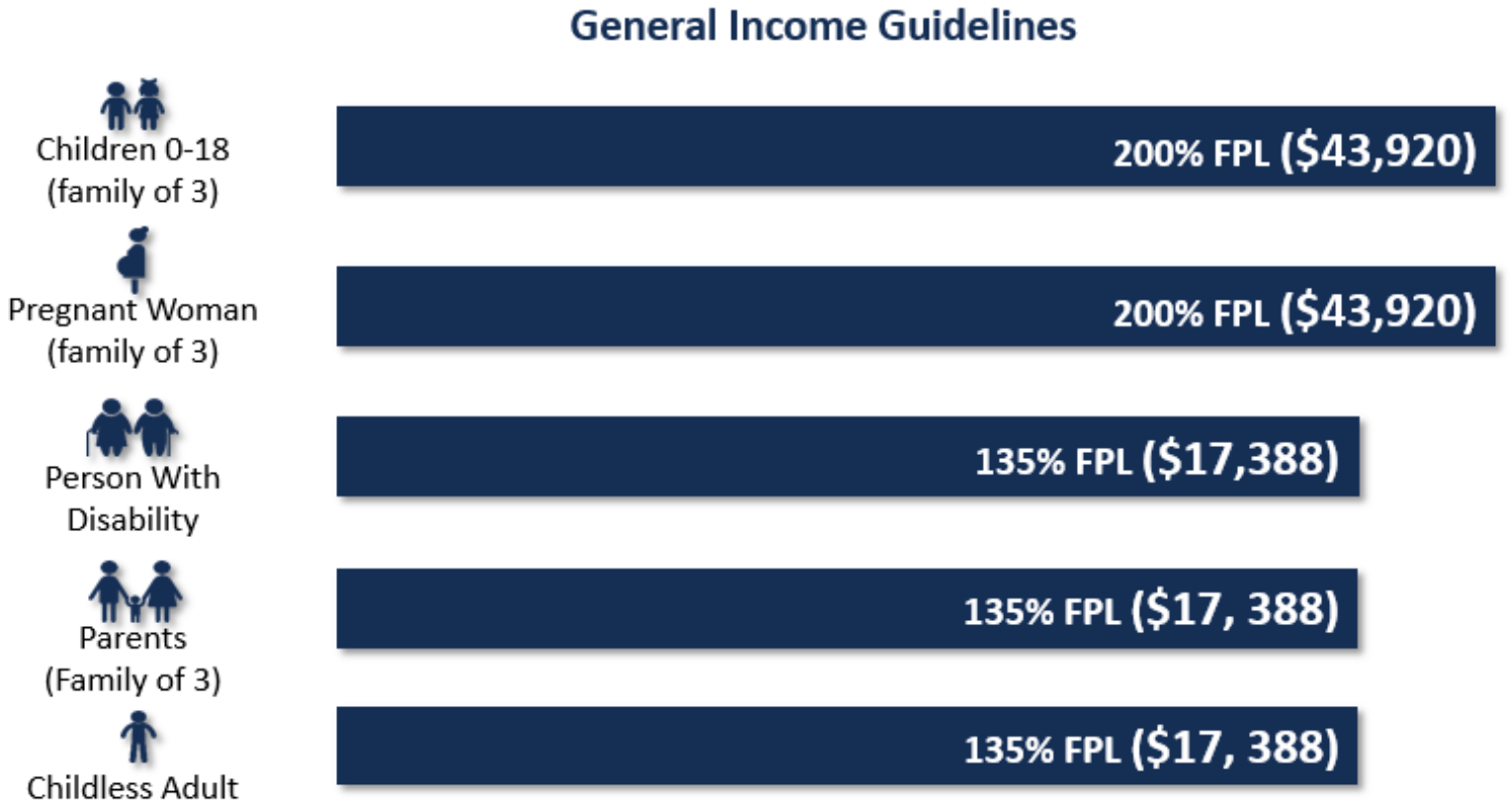
Medicaid	Medicare
Operated by the state government with funding and approval through the federal government	Operated by the federal government
Mostly income based	Mostly aged based
Covers long-term nursing facility care	Typically does not cover long-term nursing facility care

Who Does Medicaid Serve?

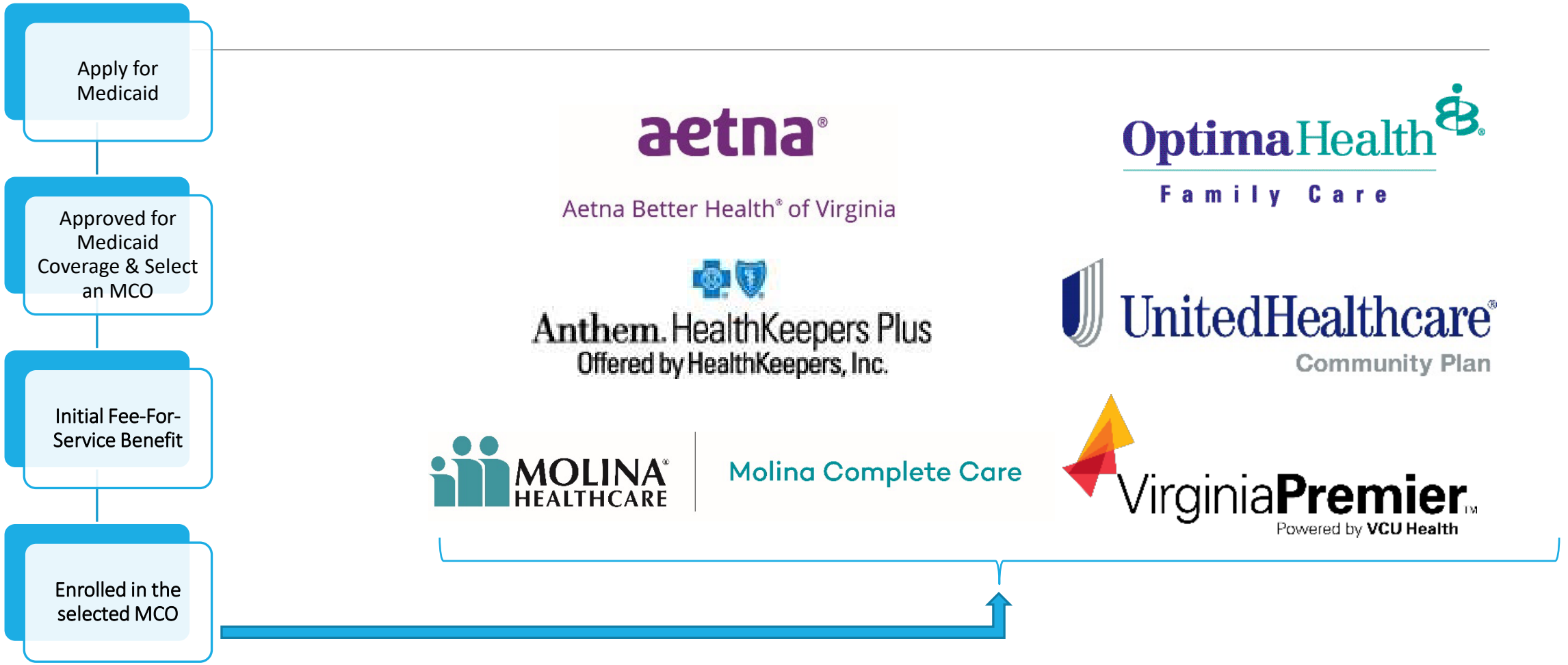
Medicaid plays a critical role in the lives of over 2 million Virginians

2019 Medicaid Expansion add access to over 660,411 adults

(as of May 15, 2022)



Medicaid Delivery Systems & Managed Care Organizations (MCO)



Over 96% of full-benefit Medicaid & FAMIS members are served through Medicaid MCOs

Medicaid MCO Advantages

Focuses on **quality of care** for individuals

Offers a network of **high quality providers**

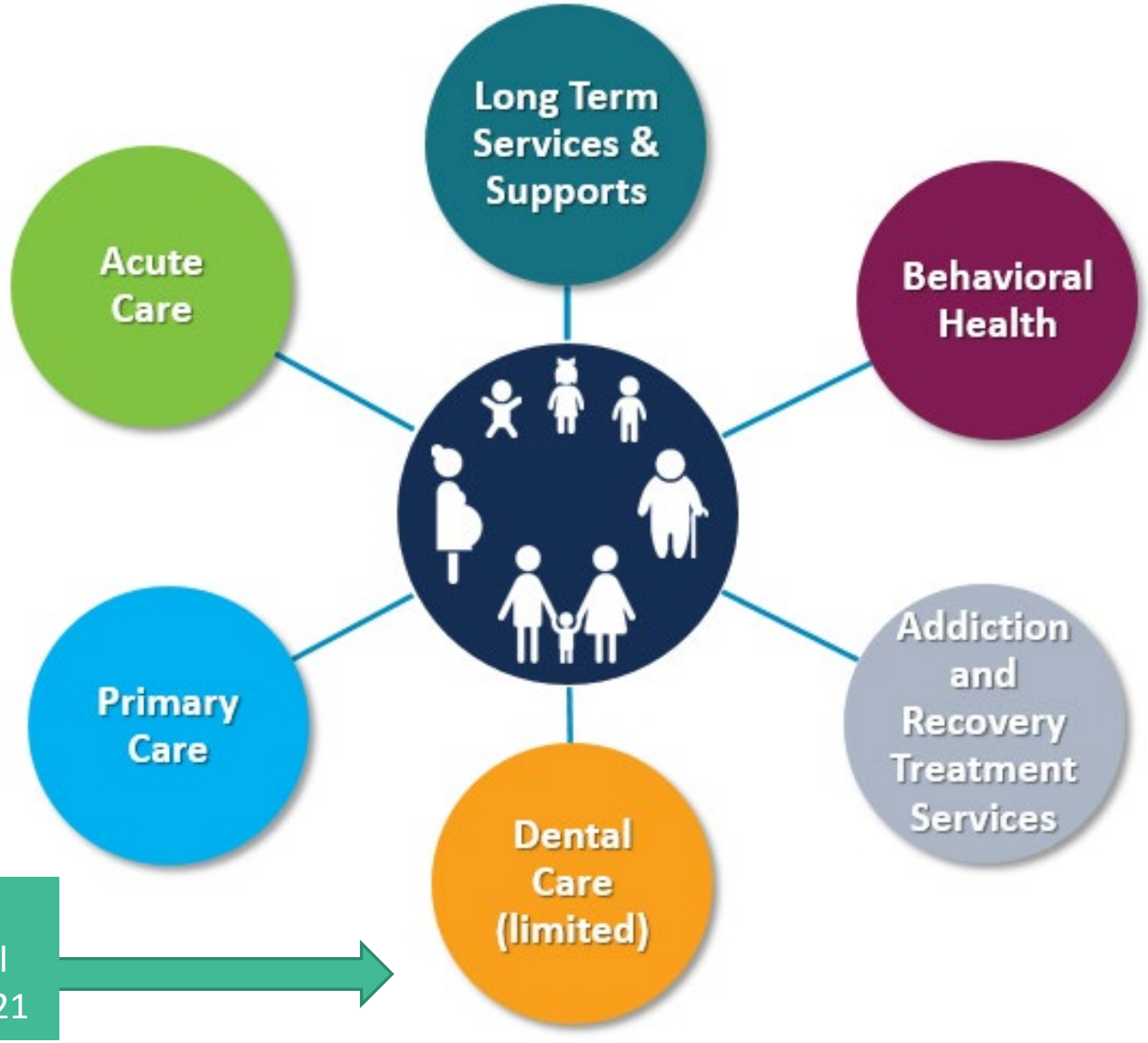
Health plans offer **enhanced benefits**

Health plans provide **comprehensive health coverage** and **focus on prevention**

Assistance with food, stable housing, and other community resources

Medicaid covers a wide variety of services, which may include:

FFS Benefit:
When members are newly enrolled, they are in fee-for-service, or straight Medicaid. Members are responsible for choosing in-network providers and coordinating their care for all services with the exception of behavioral health which is managed by a Behavioral Health Services Administrator, Magellan of Virginia.



Adults with full Medicaid benefits now have dental coverage as of July 1, 2021

Role of Medicaid MCOs:
Most Medicaid members will transition to Medicaid MCOs, either through the Medallion 4.0 or CCC Plus programs. An MCO is a health service organization that coordinates these health care services through a network of providers including primary care providers (PCPs), specialists, hospitals, clinics, medical supply companies, transportation service providers, drug stores, and other medical service providers. Medicaid MCOs have care coordinators to help members access services.

Benefits: Adults eligible for full-coverage Medicaid

Newly eligible adult enrollees will receive coverage for all Medicaid covered services including evidence-based, preventive services

Doctor, hospital and emergency services, including primary and specialty care

Prescription drugs

Laboratory and X-ray services

Maternity and newborn care

Home health services

Behavioral health services, including Addiction & Recovery Treatment Services(ARTS)

Rehabilitative services, including physical, occupational and speech therapies

Family planning services

Dental (NEW in July 2021!)

Medical equipment and supplies

Preventive and wellness services, including annual wellness exams, immunizations, smoking cessation and nutritional counseling

Managed Care Organization case management/care coordination services

Transportation to Medicaid-covered services when no alternatives are available…and more!

Medicaid's Role in Supporting Recovery

Over the past 5 years, Virginia has dramatically changed who Medicaid covers and the services it provides.

More People Covered

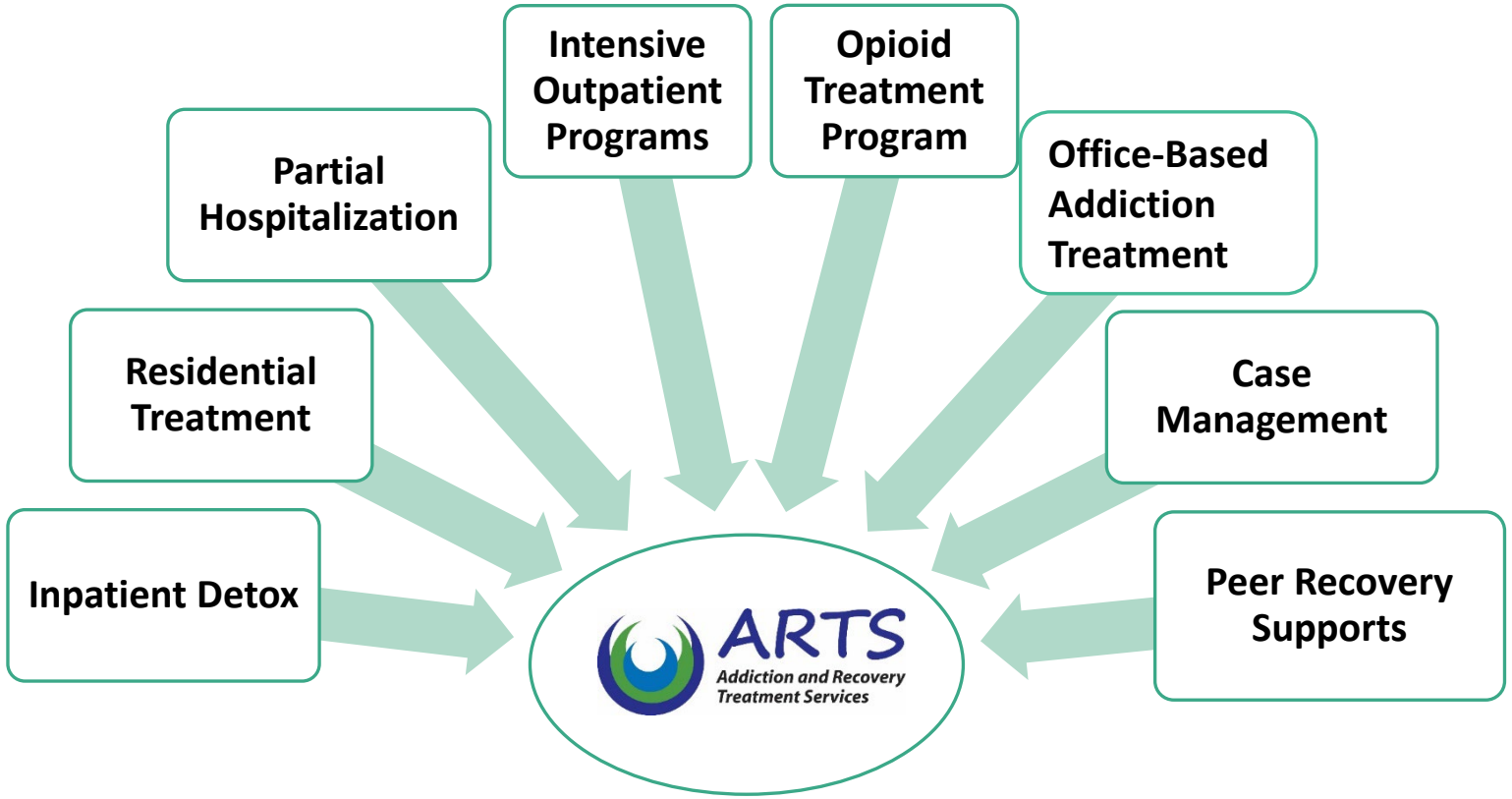
- In 2019 Virginia expanded its Medicaid program.
  - As of September 1, 2022 – **Over 682,760 adults are enrolled in Medicaid Expansion, and almost 70,000 of these members** received an ARTS service
- Now, most individuals who have lower incomes can qualify for free health coverage through Medicaid.
- Including many individuals who are incarcerated.

New Substance Use Disorder (SUD) Treatment Services Added

- In 2017, Virginia Medicaid expanded access to a continuum of SUD treatment services.
- Services now include community-based treatment, inpatient detox, and residential SUD treatment.

ARTS
Addiction and Recovery Treatment Services

Addiction and Recovery Treatment Services (ARTS)



Goal is to ensure that members are matched to the right level of care to meet their evolving needs as they enter and progress through treatment.

ARTS offers a fully integrated physical and behavioral health continuum of care.

ARTS Member Fact Sheet

Substance use can affect lives differently and it is known that many people who experience issues with substance use benefit from treatment.

Several new treatment approaches are covered by your Medicaid benefit and we are here to help you understand the available options.

Treatment options range from outpatient to inpatient services to include Medication Assisted Treatment (MAT) for prescription drugs or other opioids.

You can talk with your primary care doctor about treatment options for substance or alcohol use. Your doctor and/or health care team will work with you to find the best program for you. Or you can:

- Contact the ARTS Care Coordinator at your Managed Care Organization (*see contact info on the back of this sheet*).
- Visit the DMAS ARTS Google Map at www.dmas.virginia.gov/#/arts for treatment options in your local area.

ARTS
Addiction and Recovery Treatment Services

- ✓ Inpatient Detox
- ✓ Residential Treatment
- ✓ Partial Hospitalization
- ✓ Intensive Outpatient Programs
- ✓ Opioid Treatment Programs
- ✓ Office-Based Opioid Treatment
- ✓ Case Management
- ✓ Peer Recovery Supports

For Medicaid members who are enrolled in the Commonwealth Coordinated Care Plus (CCC Plus) Program, you can also speak with your CCC Plus Care Coordinator who will help manage your overall care. Your Care Coordinator will work with your ARTS Care Coordinator to ensure that all of your medical providers and services are considered in your overall health care plan.

MCO	ARTS Care Coordinator	CCC Plus Care Coordinator
Aetna Better Health & Aetna Better Health of Virginia	Steve Ratliff, LPC Phone: 540-488-4725 Fax 860-900-1229 RatliffS@aetna.com	1-855-652-8249 Press 1 for Care Coordinators
Anthem HealthKeepers Plus	Phone:1-855-323-4687 Option 2, then option 4 (Medallion 4 and CCC+)	1-855-323-4687 Press 4 TTY: 711
Molina Complete Care of Virginia	Theo Appiah-Acheampong, LCSW, CCTP Dir, Healthcare Services (804) 217-4843 Theodora.Appiah-Acheampong@molinahealthcare.com Greta McCray, RN (CCC+) (757) 709-9508 Greta.McCray@molinahealthcare.com Lisa Owsley, M.Ed., LPC (Medallion 4) (804) 215-7517 Lisa.Owsley@molinahealthcare.com	1-800-424-4524 Press Option 3, then 4 for Substance Use assistance
Optima Family Care	Phone: 1-888-946-1168	1-866-546-7924 757-552-8398
United Healthcare Community Plan	1-800-548-6549 Ext. 66789, 67604, or 67605	1-866-622-7982
Virginia Premier	Phone: 1-855-214-3822 Option 2 for ARTS Care Coordinator	1-877-719-7358
Magellan of Virginia (Fee-for-service members)	Shahla Nikpour 804-823-5029 SNikpour@magellanhealth.com	n/a

English: https://www.dmas.virginia.gov/media/3658/arts-member-one-pager-03-08-2022.pdf
Spanish: https://www.dmas.virginia.gov/media/4486/arts-member-one-pager-03-08-2022-spanish.pdf

Addiction Treatment Providers Serving Medicaid Members*

Provider Type	# of Providers Before ARTS	# of Providers in ARTS Year 5	% Increase in Providers
Inpatient Detox (ASAM 4)	N/A	70	NEW
Residential Treatment (ASAM 3)	4	95	↑ 2,275%
Partial Hospitalization Programs (ASAM 2.5)	N/A	40	NEW
Intensive Outpatient Programs (ASAM 2.1)	49	209	↑ 327%
Opioid Treatment Programs	6	44	↑ 633%
Preferred Office-Based Addiction Treatment Providers	N/A	198	NEW
Outpatient practitioners billing for ARTS services (ASAM 1)	1,087	6,184	↑ 469%

*Magellan of Virginia – BHSA Network July 2022

Providers for Medications for Treatment of Opioid Use Disorder (OUD)

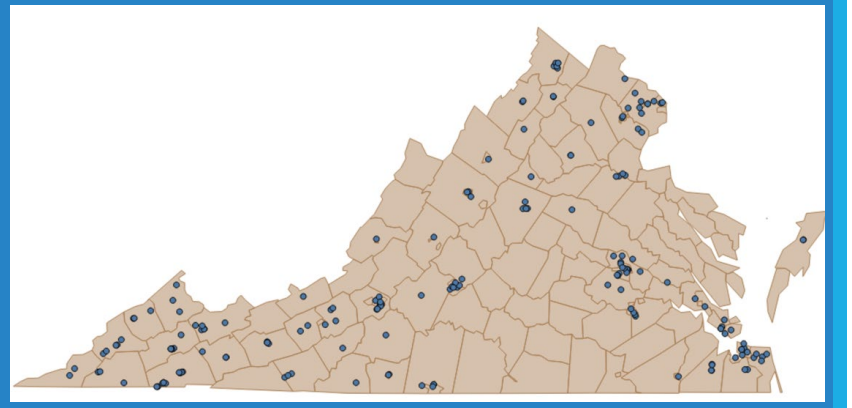
PREFERRED OFFICE-BASED ADDICTION TREATMENT (OBAT)

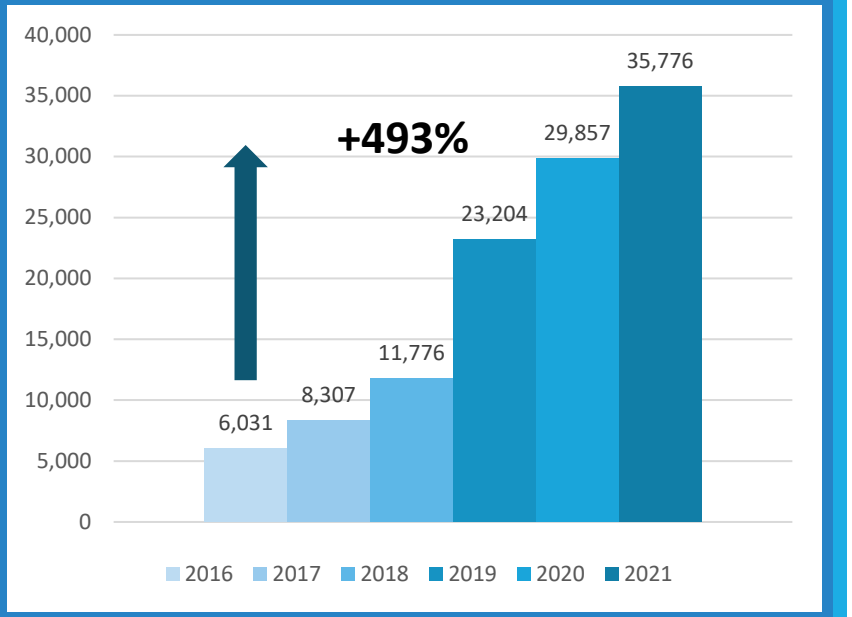
- Physicians/Nurse Practitioners with a buprenorphine waiver in private primary care clinics, outpatient health system clinics, psychiatry clinics, Federally-Qualified Health Centers (FQHC), Community Services Boards (CSB), Health Departments, and physician offices.
- Co-located licensed behavioral health practitioners
- Intensive care coordination
- Medications to help treat OUD and AUD

OPIOID TREATMENT PROGRAMS (OTP)

- Heavily regulated by federal agencies and involve the direct administration of medications on a daily basis without prescribing of medications.
- Allows for “take-home” doses
- Co-located licensed behavioral health practitioners
- Only entity that can dispense methadone for treatment of OUD

198 OBAT Sites Approved in VA





Office-Based Addiction Treatment and Access to Care

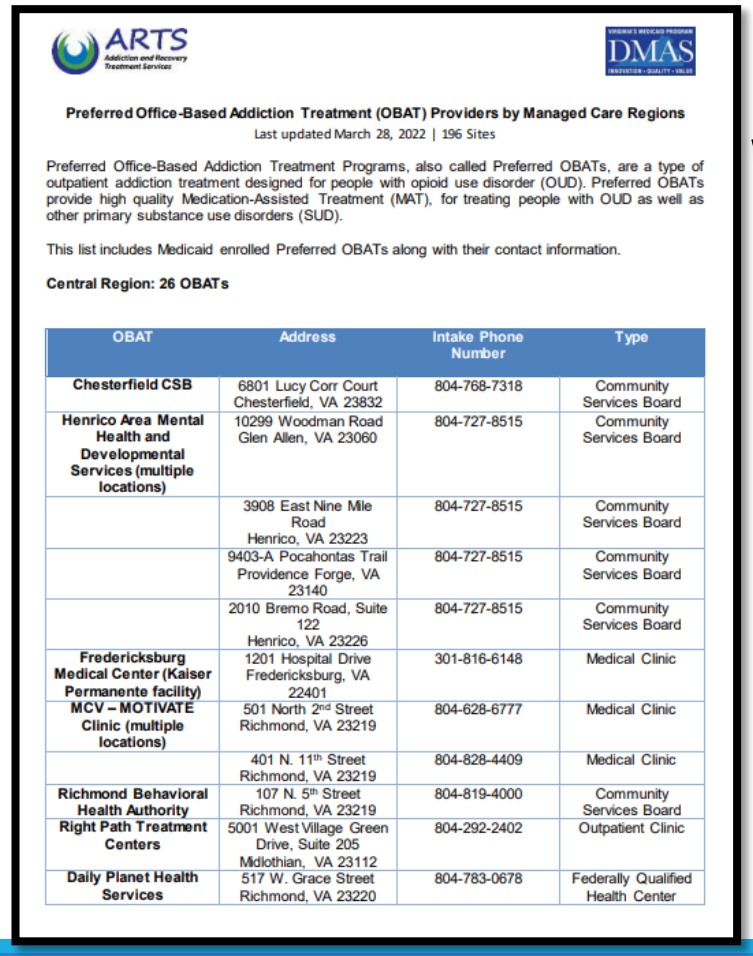
Leveraging the Evidence-Based model for Opioid Use Disorder

Care coordination services provided by Preferred OBAT and Opioid Treatment Programs **facilitate integration of addiction treatment services** with physical health and social service needs.

Rates of MOUD use were higher during episodes of treatment at Preferred OBAT providers (81%), compared to other outpatient providers (56%).

Co-prescribing of opioid pain medication and benzodiazepines declined for members receiving treatment for OUD through Preferred OBATs.

Office-Based Addiction Treatment and Access to Care



ARTS Addiction and Recovery Treatment Services

DMAS

Preferred Office-Based Addiction Treatment (OBAT) Providers by Managed Care Regions

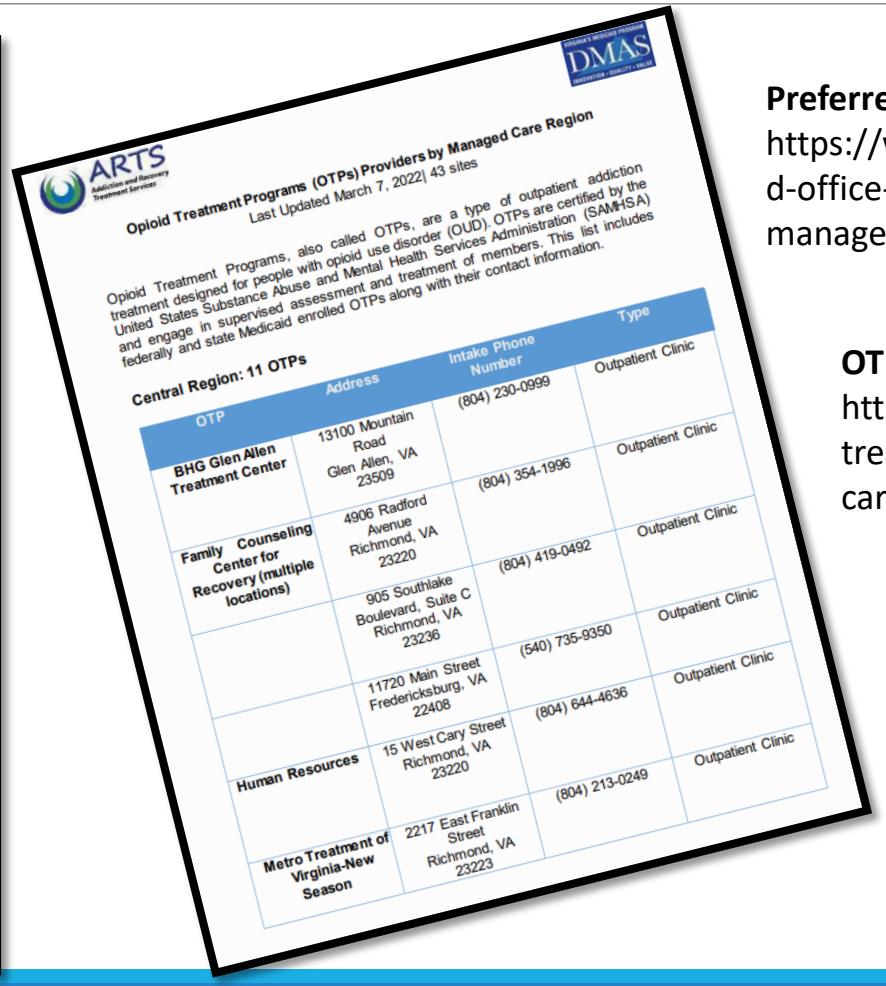
Last updated March 28, 2022 | 196 Sites

Preferred Office-Based Addiction Treatment Programs, also called Preferred OBATs, are a type of outpatient addiction treatment designed for people with opioid use disorder (OUD). Preferred OBATs provide high quality Medication-Assisted Treatment (MAT), for treating people with OUD as well as other primary substance use disorders (SUD).

This list includes Medicaid enrolled Preferred OBATs along with their contact information.

Central Region: 26 OBATs

OBAT	Address	Intake Phone Number	Type
Chesterfield CSB	6801 Lucy Corr Court Chesterfield, VA 23832	804-768-7318	Community Services Board
Henrico Area Mental Health and Developmental Services (multiple locations)	10299 Woodman Road Glen Allen, VA 23060	804-727-8515	Community Services Board
	3908 East Nine Mile Road Henrico, VA 23223	804-727-8515	Community Services Board
	9403-A Pocahontas Trail Providence Forge, VA 23140	804-727-8515	Community Services Board
	2010 Bremo Road, Suite 122 Henrico, VA 23226	804-727-8515	Community Services Board
Fredericksburg Medical Center (Kaiser Permanente facility)	1201 Hospital Drive Fredericksburg, VA 22401	301-816-6148	Medical Clinic
MCV – MOTIVATE Clinic (multiple locations)	501 North 2nd Street Richmond, VA 23219	804-628-6777	Medical Clinic
	401 N. 11th Street Richmond, VA 23219	804-828-4409	Medical Clinic
Richmond Behavioral Health Authority	107 N. 5th Street Richmond, VA 23219	804-819-4000	Community Services Board
Right Path Treatment Centers	5001 West Village Green Drive, Suite 205 Midlothian, VA 23112	804-292-2402	Outpatient Clinic
Daily Planet Health Services	517 W. Grace Street Richmond, VA 23220	804-783-0678	Federally Qualified Health Center



ARTS Addiction and Recovery Treatment Services

DMAS

Opioid Treatment Programs (OTPs) Providers by Managed Care Region

Last Updated March 7, 2022| 43 sites

Opioid Treatment Programs, also called OTPs, are a type of outpatient addiction treatment designed for people with opioid use disorder (OUD). OTPs are certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) and engage in supervised assessment and treatment of members. This list includes federally and state Medicaid enrolled OTPs along with their contact information.

Central Region: 11 OTPs

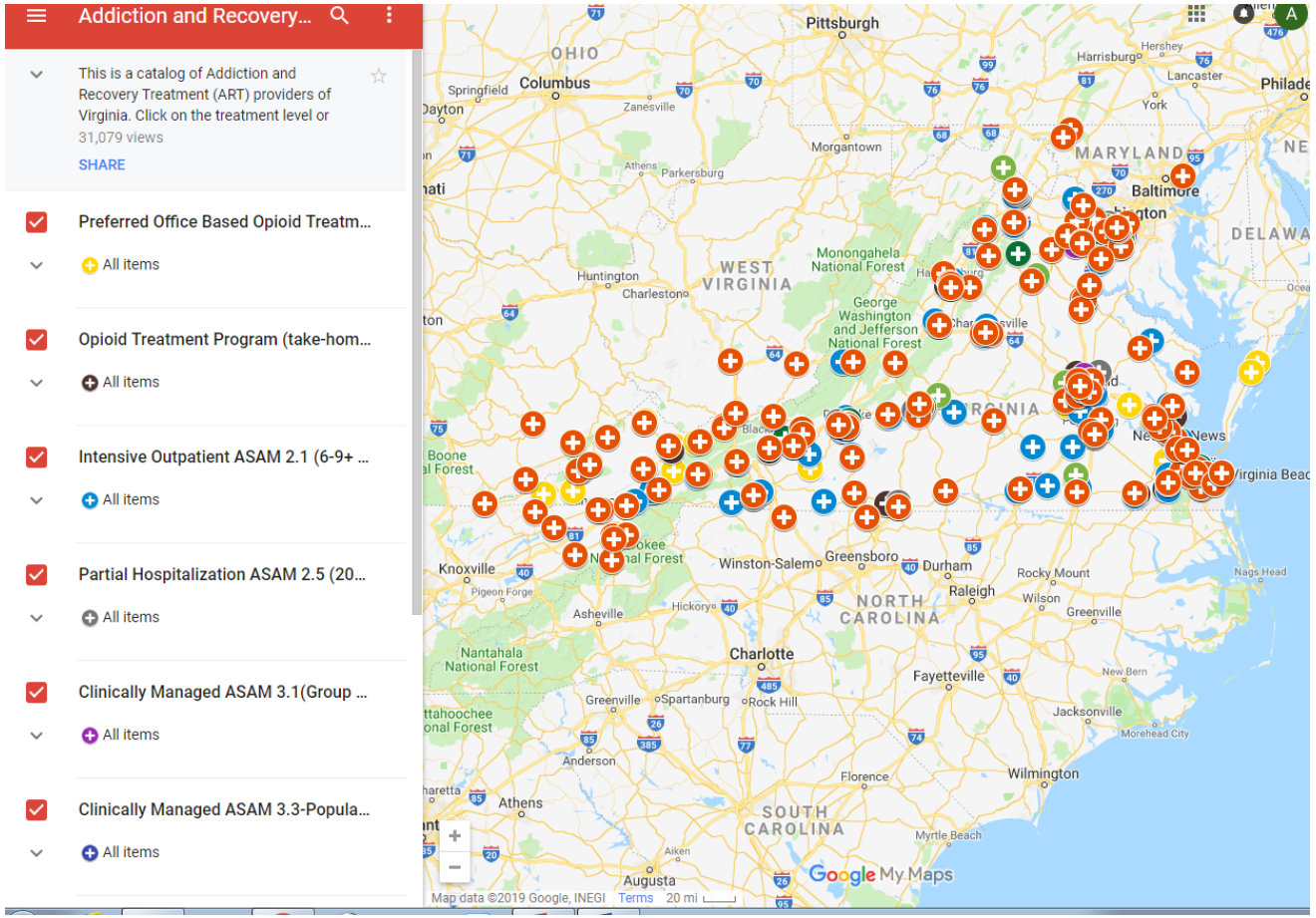
OTP	Address	Intake Phone Number	Type
BHG Glen Allen Treatment Center	13100 Mountain Road Glen Allen, VA 23509	(804) 230-0999	Outpatient Clinic
Family Counseling Center for Recovery (multiple locations)	4906 Radford Avenue Richmond, VA 23220	(804) 354-1996	Outpatient Clinic
	905 Southlake Boulevard, Suite C Richmond, VA 23236	(804) 419-0492	Outpatient Clinic
	11720 Main Street Fredericksburg, VA 22408	(540) 735-9350	Outpatient Clinic
Human Resources	15 West Cary Street Richmond, VA 23220	(804) 644-4636	Outpatient Clinic
Metro Treatment of Virginia-New Season	2217 East Franklin Street Richmond, VA 23223	(804) 213-0249	Outpatient Clinic

Preferred OBATs:
https://www.dmas.virginia.gov/media/4158/preferred-office-based-opioid-treatment-obot-providers-by-managed-care-region-12-09-2021.pdf

OTPs:
https://www.dmas.virginia.gov/media/4157/opioid-treatment-programs-opt-providers-by-managed-care-regions.pdf

ARTS Resources Available on the DMAS ARTS Website

Visit the DMAS ARTS website to locate providers with Google Maps: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/



Enrolling in Medicaid

Who is Eligible for Medicaid?

Previous incarceration or legal-carceral system involvement do not impact eligibility for Medicaid.

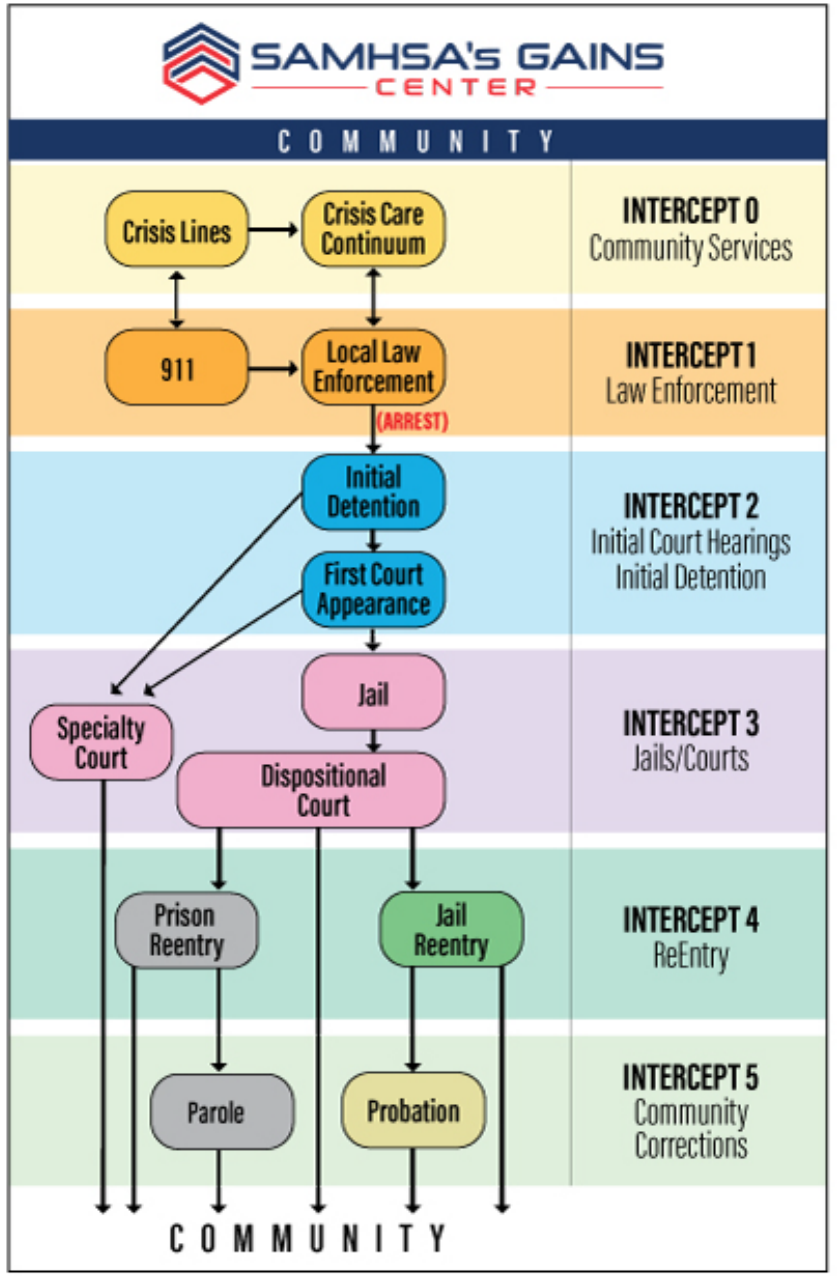
The vast majority of currently incarcerated individuals are eligible for Medicaid.

However, currently incarcerated individuals receive a limited-benefit package.

Who qualifies for Virginia Medicaid?			
	Childless adult	**Parent (family of 3)**	**Person with disability**
Before 2019:	Not eligible	Eligible with annual income at or below $7,068	Eligible with annual income at or below $9,992
In 2021:	Eligible with annual income at or below $17,775	Eligible with annual income at or below $30,305	Eligible with annual income at or below $17,775

Community vs Incarcerated Medicaid Coverage

Medicaid Inmate exclusion policy: Section 1905(a) of the Social Security Act **prohibits federal Medicaid funds, known as federal financial participation, from being used to pay for services for inmates of public institutions**, even if they are otherwise eligible for Medicaid.



Community vs Incarcerated Medicaid Coverage

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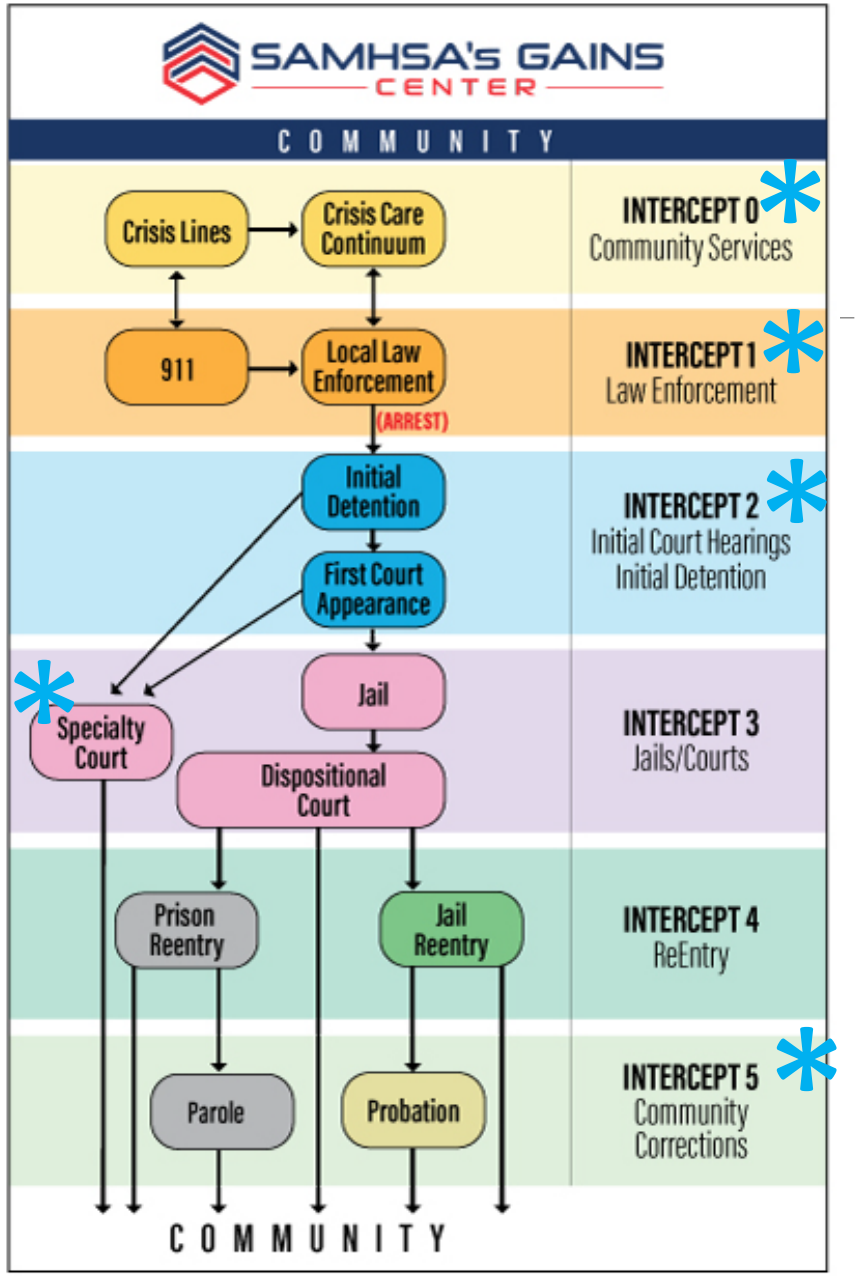

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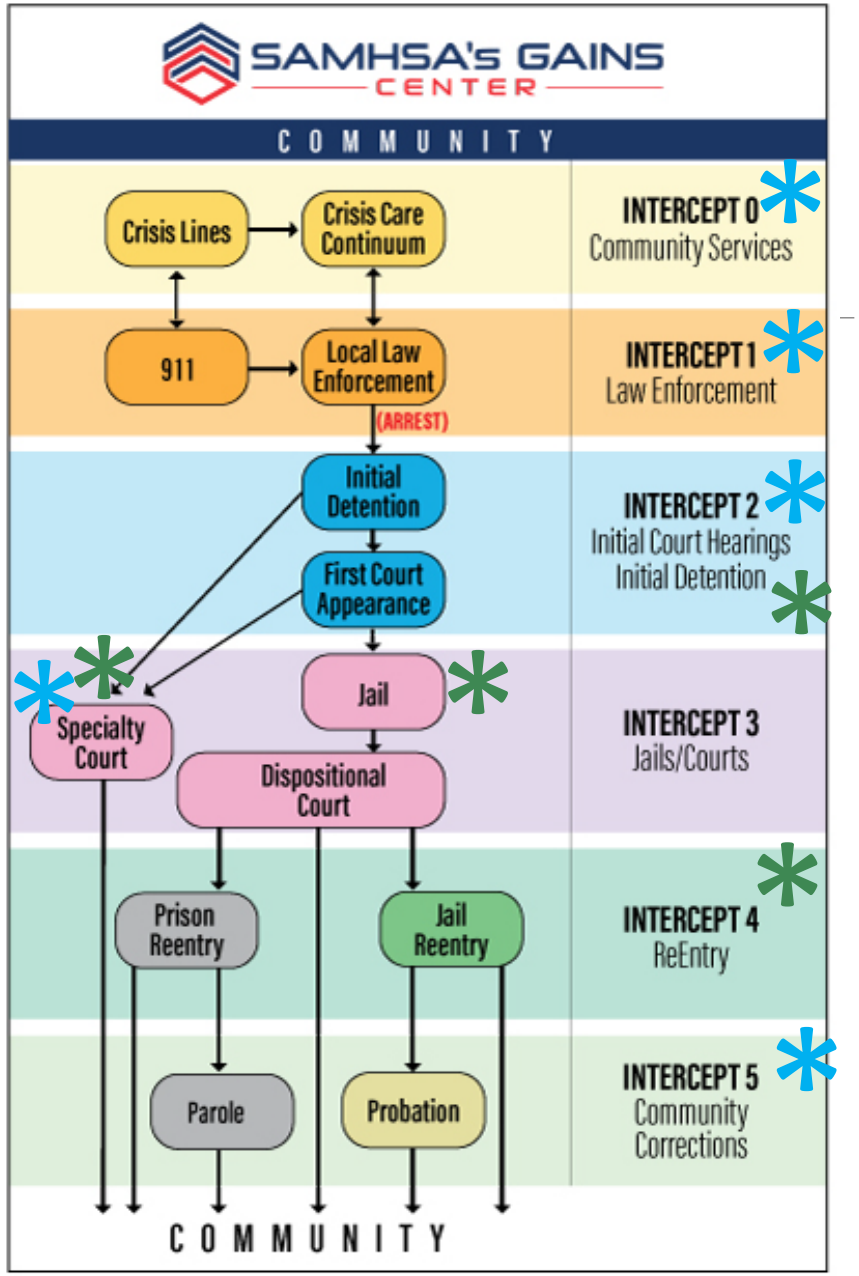
Note: At any point along this intercept model, eligible members can apply for Medicaid
***Eligibility – determined by income**



Medicaid for Individuals who are Currently Incarcerated

MEDICAID COVERAGE DURING INCARCERATION

- Medicaid covers hospital costs & other charges incurred during a hospital admission of 24-hours or more
  - Does not cover follow up care.
  - Does not cover any other outpatient treatment or treatment within a jail or prison.
  - Does not cover MAT or other SUD treatment services during incarceration.
  - DOES COVER INPATIENT PSYCHIATRIC STAYS!
- Individuals can apply for Medicaid at any time while incarcerated through the Cover VA Incarcerated Unit (CVIU).

Partnership between DMAS & VADOC/Jails

- 2104 – Governor's Task Force on Prescription Drug and Heroin Abuse
  - Co-chaired by the Secretary of Health and Human Resources and Secretary of Public Safety and Homeland Security
  - Includes representatives from the Office of the Attorney General, legislature, and judiciary, as well as relevant state and local agencies, law enforcement, health and behavioral health care professionals, providers, community advocates, and individuals with personal experience with addiction
- 2018 - HB 5002
  - Required Medicaid (DMAS) to establish a new central application process for individuals who are incarcerated, data exchanges, apply for community coverage
- 2019 Medicaid Expansion
  - Medicaid coverage access to a larger group of adults
- GA 2022 – Directs Medicaid and DOC to identify currently enrolled and eligible Medicaid members in order to apply or prepare for Medicaid coverage upon release. Also includes language for MCOs to perform in-reach 30 days prerelease for their members

Medicaid's COVER VIRGINIA INCARCERATED UNIT (CVIU)

https://coverva.org/en

- The Cover Virginia Incarcerated Unit (CVIU) is the designated unit at Cover Virginia for assisting incarcerated individuals in applying, obtaining, and maintaining Medicaid healthcare benefits.
- There are 2 units within the CVIU:
  - The CVIU has an Eligibility Unit that is responsible for processing Medical Assistance applications, changes, renewals and ongoing case maintenance, and
  - The CVIU has a Call Center that accepts telephonic applications, case changes and case inquiries

Medicaid and VA Courts

- Screen for health insurance or Medicaid enrollment
  - Do you have health insurance? / Do you have Medicaid coverage?
- If not covered, screen for Medicaid eligibility
  - Income guidelines - https://coverva.org/en/our-programs
  - Eligibility screening tool - https://coverva.org/en/am-i-eligible
- Assist with Medicaid enrollment
- Provide information:
  - Medicaid Benefits – https://www.dmas.virginia.gov/for-members/
    - New Adult Eligibility FAQ - https://coverva.org/sites/default/files/2021-03/exp_faq_english.pdf
  - ARTS Benefits, how to connect to SUD treatment and contact the MCO ARTS Care Coordinators – ARTS Fact Sheet - https://www.dmas.virginia.gov/media/3658/arts-member-one-pager-03-08-2022.pdf

How to Help Someone Apply for Medicaid in the Community (for Community Providers)

Call the Cover Virginia Call Center (Main Line) at 1-855-242-8282 (TDD: 1-888-221-1590)

Complete an online application at Common Help: www.commonhelp.virginia.gov

Complete an online application at The Health Insurance Marketplace: www.healthcare.gov

Mail or drop off a paper application to your local Department of Social Services (mailing may take longer than other methods of applying.) ***Find your nearest local Department of Social Services by visiting: http://www.dss.virginia.gov/localagency/index.cgi***

Call the Virginia Department of Social Services Enterprise Call Center at 1-855-635-4370 (if you also want to apply for other benefits)

Medicaid and VA Courts

- If enrolled with Medicaid – Connect to Care
  - VA Medicaid "Find a Provider" - https://www.dmas.virginia.gov/for-members/find-a-provider/ or call member number on the card of the Medicaid card.
- Connection to ARTS Services:
  - ARTS Map - **https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/**
  - OBAT list - https://www.dmas.virginia.gov/media/4158/preferred-office-based-opioid-treatment-obot-providers-by-managed-care-region-12-09-2021.pdf
  - OTPs: https://www.dmas.virginia.gov/media/4157/opioid-treatment-programs-opt-providers-by-managed-care-regions.pdf
  - ARTS Care coordinators - https://www.dmas.virginia.gov/media/3156/arts-fact-sheet-for-members.pdf

Leverage the member's MCO Care Coordinator to help with determining the most appropriate level of care, securing an assessment and locating a treatment provider.

Access to Medications for Opioid Use Disorder (MOUD)

The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery

Does the ADA protect individuals who are taking legally prescribed medication to treat their opioid use disorder?

Yes, if the individual is not engaged in the illegal use of drugs. Under the ADA, an individual's use of prescribed medication, such as that used to treat OUD, is not an "illegal use of drugs" if the individual uses the medication under the supervision of a licensed health care professional, including primary care or other non-specialty providers. This includes medications for opioid use disorder (MOUD) or medication assisted treatment (MAT). MOUD is the use of one of three medications (methadone, buprenorphine, or naltrexone) approved by the Food and Drug Administration (FDA) for treatment of OUD;

- On March 24, the department into a Settlement Agreement with the Massachusetts Trial Court to resolve allegations that its drug court violated the ADA by discriminating against individuals with OUD.
- On Feb. 24, the department filed a lawsuit against the Unified Judicial System of Pennsylvania, alleging that it prohibits or otherwise limits participants in its court supervision programs from using medication to treat OUD.

https://www.ada.gov/opioid_guidance.pdf
https://www.justice.gov/opa/pr/justice-department-issues-guidance-protections-people-opioid-use-disorder-under-americans

Success story

DMAS received a call from a member's mother who requested assistance for her son, who was in the process of turning himself in for a violation of probation that would result in incarceration. The mother reported her son has significant SUD issues and was willing to seek help and even went to the CSB to be assessed.

DMAS obtained the contact information for her son's public defender and engaged them to share the ARTS benefit, and the member still had full Medicaid benefits and was enrolled in an MCO that could help identify treatment options. The public defender agreed to talk with the MCO Care Coordinator. The MCO Care Coordinator contacted the CSB to obtain the assessment then contacted the public defender and shared the CSB determined inpatient SUD treatment was the appropriate setting through the clinical assessment. The MCO was able to assist in locating a residential provider who reviewed the member's assessment and was willing to admit them.

The public defender shared this during the court proceedings and the Judge sentenced him to the residential provider in lieu of incarceration.

Questions and Discussion

FAQ: https://www.dmas.virginia.gov/media/4347/faq-va-medicaid-and-re-entry-02-11-2022.pdf

- CAN WE ASSUME THAT IF THEY HAVE DOC MEDICAID THEY WILL QUALIFY FOR REGULAR/STRAIGHT MEDICAID WHEN RELEASED?
  - No, it is not 100% guaranteed that an individual will be eligible for full benefit Medicaid upon release as they still have to meet Medicaid eligibility requirements such as income. Carceral institutions can help with the community-based Medicaid eligibility evaluation process by sending Cover Virginia Incarcerated Unit (CVIU) a completed pre-release application, within 45 days before the individual's release date. If a pre-release review occurs, and if the member is approved and remains eligible for ongoing Medicaid coverage, their limited incarcerated Medicaid benefit will be converted to the full benefit as of the date of release. The majority of the pre-release reviews are approved by the CVIU.

- HOW TO JAILS CONTACT THE COVER VIRGINIA INCARCERATED UNIT (CVIU) TO ESTABLISH ASSISTANCE/RELATIONSHIP IN ORDER TO EFFICIENTLY PROCESS APPLICATIONS?
  - The best place to start is with Raynette Adams. She is the DMAS Medicaid Corrections Liaison.

    Raynette Adams Medicaid Corrections Liaison Eligibility and Enrollment Services Division-DMAS

    Raynette.Adams@dmas.virginia.gov

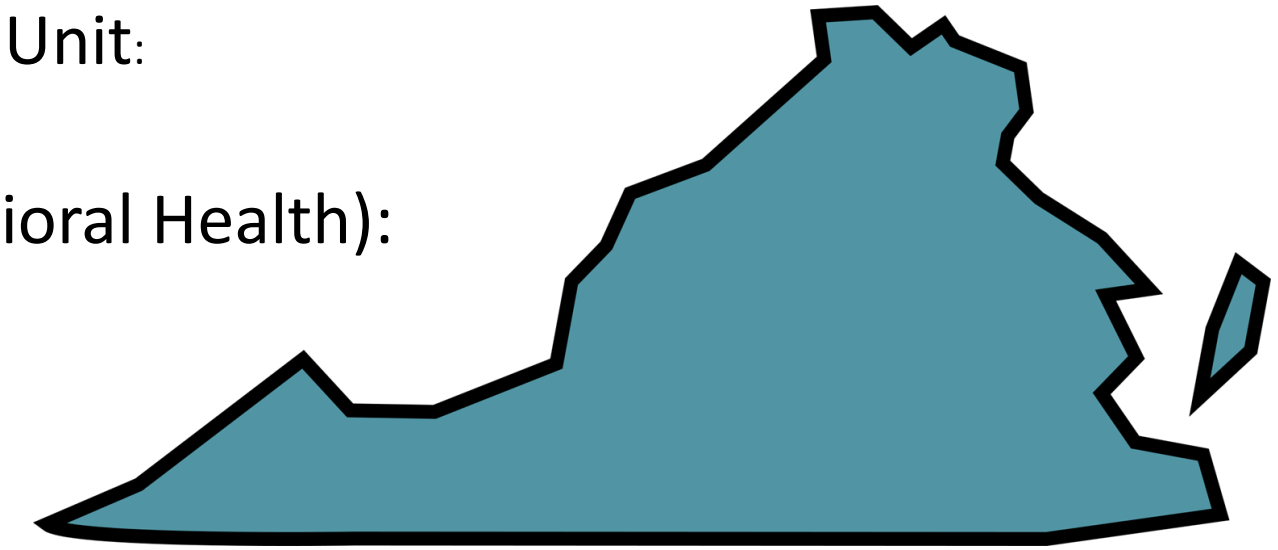
    Remote Availability: Mon - Fri 8:00 am - 4:30 pm

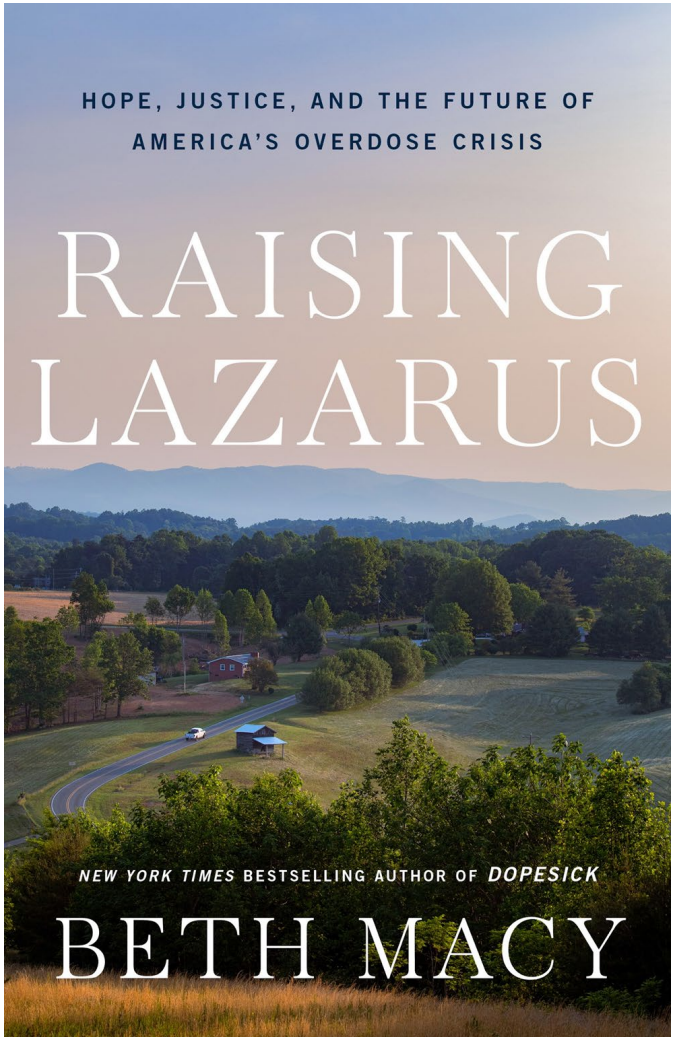
    Cell: (804)971-8243

- IS IT A MYTH THAT MEDICAID IS "TURNED OFF" AFTER A MONTH OF INCARCERATION?
  - Medicaid is not “turned off” when someone becomes incarcerated, but the type of Medicaid coverage changes. During incarceration, coverage shifts from community coverage, which is typically full-benefit coverage, to Incarcerated Coverage, which is limited-benefit coverage and covers only Medicaid-covered services that are provided during an inpatient hospital admission of 24-hours or more.

Thank you!

- OBATs in VA:
  https://www.dmas.virginia.gov/media/4096/preferred-office-based-opioid-treatment-obot-providers-by-managed-care-region-11-08-2021.pdf
- Cover Virginia Incarcerated Unit:
  https://www.coverva.org/en/cviu
- Magellan of Virginia (Behavioral Health):
  www.magellanofvirginia.com





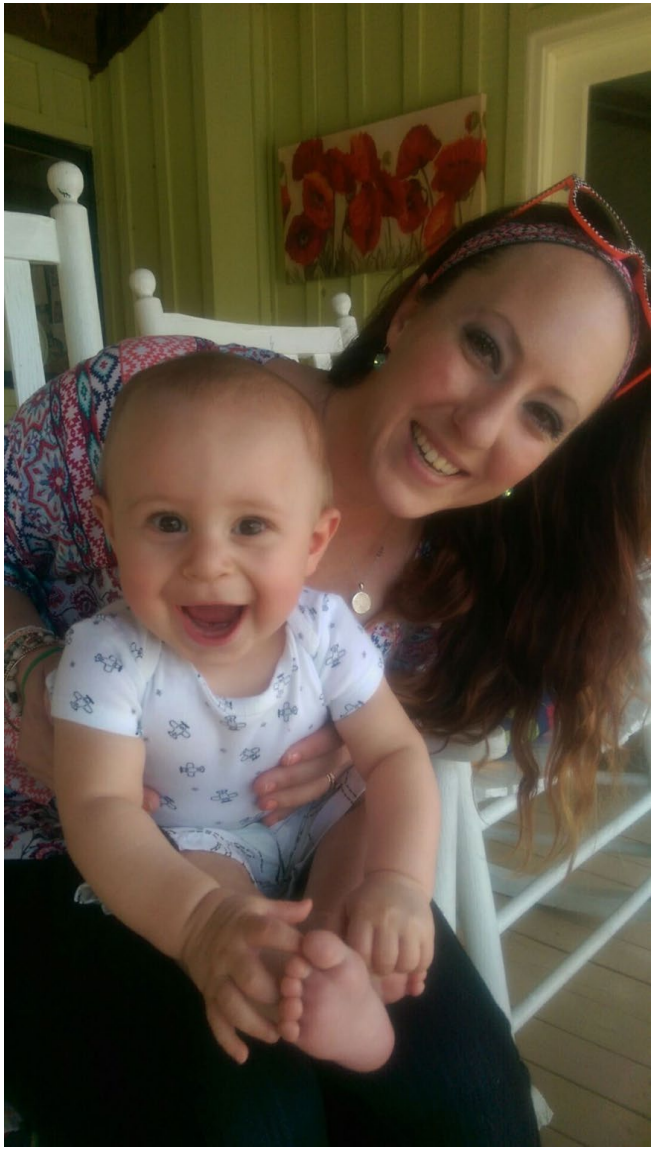
Hope and Help: America's Overdose Crisis

Virginia's Specialty Dockets

September 20, 2022

Overdose deaths: by the numbers

- The United States lost a record 108,000 people to drug overdose last year. 1 million Americans have died of drug overdose since OxyContin launched.
- One-third of the nation's families have been affected.
- 6.7 million to 7.6 million American adults are estimated to have OUD—roughly four times more than previously known.
- Addiction is a chronic, relapsing disease. It takes four to five treatment episodes over an average of eight years for a person with SUD to get one year of sobriety.
- TREATMENT GAP=87 percent: Only 12 percent of Americans with OUD managed to get care in the past year. Most treatment facilities don't offer medicines, when the CDC, NIDA and WHO all believe methadone and buprenorphine is the gold standard of care (SAMHSA, 2016). Eighty percent of people with OUD don't need inpatient care.
- Every dollar spent on treatment can save $12 or more on reduced criminal justice and health care costs (NIH)—more important now than ever with opioid litigation money beginning to flow.



Tess was right.
She knew exactly
what she needed.

“We need urgent care for the addicted.”
—Tess Henry, 2015

More access to MOUD
(The Hartmans + public pressure=change.)

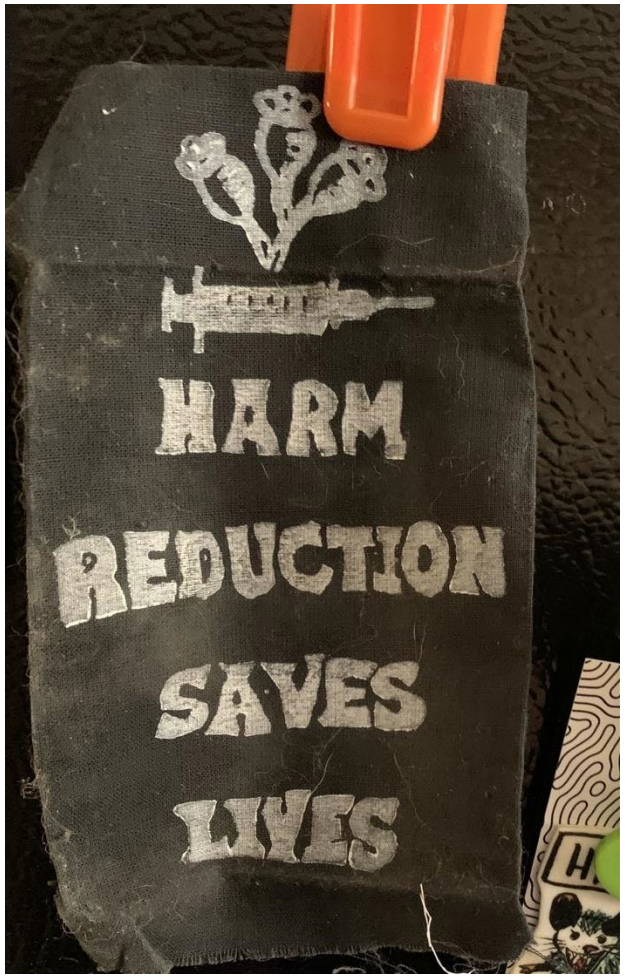
Photo by Josh Meltzer

One person* can make a huge difference, even within opposing systems.

“You have to work in mental health to fully understand that what she’s done just doesn’t exist.” — Dr. Christopher Dull, Indianapolis

* **With a lot of passion**

“Any positive change as a person defines it for him or herself is our definition of recovery.” — Dan Bigg, Chicago Recovery Alliance



“I’m alive today because of a sandwich.”
—Steven Cobb, executive director, Mental Health Association, Jamestown, N.Y.

Acta Non Verba

That’s Latin, Michelle told me, for “Do shit. Don’t just talk about it.”

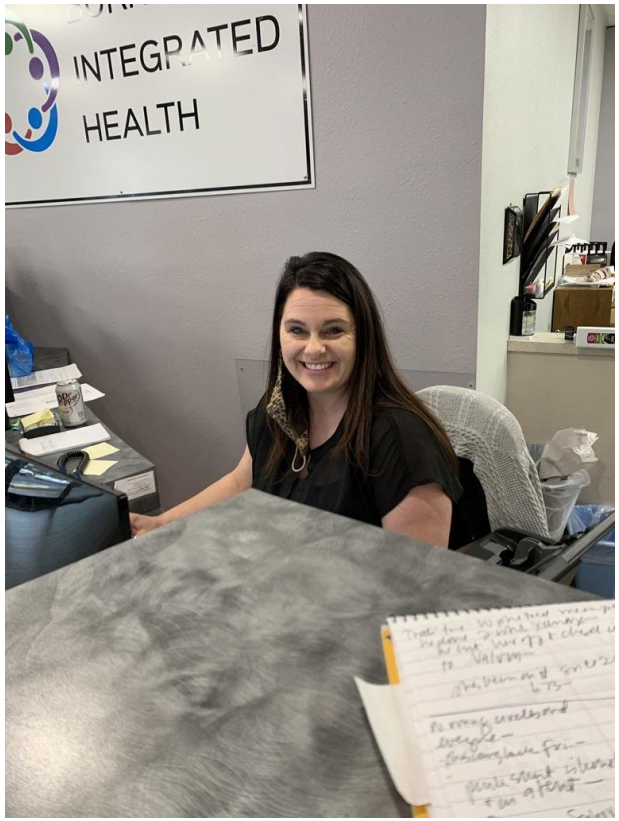
Build trust; the power of peers

Olive Branch had hired one of its first peers, 31-year-old Jessica Maloney, after meeting her in a jail-based education program—she was wearing shackles.

Nurse practitioner Tim Nolan meets people where they are (and then empowers them to do the same)

Photo by Josh Meltzer

Just. Be. Nice.



An author of a study based in Fresno, Calif., looked at the behaviors of 500 people
with SUD who managed to stay in treatment. As an aside, she told me, the professional most key to a person's initiation of recovery wasn't their doctor or even their nurse. It was the **attitude of the person running the front desk**.

“We had to let some [deputies] go.”

Fairfax County (Va.) Detention Center

Bring health care into the courts

“Call it a pilot.”

Improvise, overcome, adapt

Mark Willis

How to create urgent care for the addicted

- On-demand access to MOUD/MAT, period, with social supports.
- Harm reduction should come first; harm reduction isn't harm eradication.
- We need to meet *both* sides where they are.
- "Call it a pilot!" Baby steps. . . .
- "BBQ and sweet tea," no doughnuts!
- Courage. The power of one.
- Use your social capital for good. Go for 25 percent.
- Stronger leadership is urgently needed at all levels.

Beth Macy
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On the Web: BethMacyWriter.com
Twitter: @papergirlmacy
Facebook: @authorBethMacy
Instagram: @bethmacy

Supporting Veterans & Families

Engaging with the Service Member, Veteran, and Family (SMVF) population

Virginia Veteran & Family Support

Presentation Overview

This training provides an overview of military service, transition, and post-military experiences with specific focus on unique challenges that Service Members, Veterans and their Families (SMVF) may encounter. This training explores variances between military branches, individual experiences, reintegration into post-military civilian life, impact on families, and how any of these may cause SMVF to intersect with the community and emergency services personnel.

Why This Is Important

1 in 11 Virginia residents is a veteran

Most veterans also have multiple immediate family members

Many veterans have unique backgrounds/experiences/needs

Virginia Department of Veterans Services (VDVS) can assist and so can you!

Myth or Fact?

- Deployment is the leading cause of suicide in service members
- The majority of service members who die by suicide had a mental illness
- Approximately one-half (51.5%) of Service members who died by suicide received some form of care (though not necessarily suicide- or behavioral health-related care) via the Military Health Service (MHS) in the 90 days prior to death
- The suicide rate is higher in combat veterans than non-combat veterans

Learning Objectives

- Review the lifecycle of military service from time of entry to discharge and reintegration
- Describe military organizational structure, rank, branches of service, core values, and demographics
- Identify differences between the Active, Reserve components, and National Guard
- Identify best practices to enhance behavioral health, treatment options, and connection to resources for military SMVF and caregivers
- Discuss the prevalence and characteristics of suicide among military service members and veterans

Virginia Veterans

Total Veterans	**Virginia has approximately 713,000 veterans**
Population	**Virginia currently has the 7th largest veteran population in the nation, however by 2023, Virginia is projected to be ranked 5th**
Young	**Virginia ranks 4th in younger veterans (age 17 – 39) 33% of the Virginia veteran population is under the age of 50**
Female	**Virginia has the largest number of women veterans 107,201 to total women veterans 2,045,384**

Source: National Center for Veterans Analysis and Statistics
www.va.gov/vetdata as of 9/30/2021

Virginia Veterans

VA | U.S. Department of Veterans Affairs

Virginia

Population Change	Virginia	Total
Veteran Population 2018	739K	20.3M
Veteran Population 2048	537K	12.2M
Annual Percentage Change	-1.06%	-1.68%

Virginia		9/30/2018	9/30/2023	9/30/2028	9/30/2033	9/30/2038	9/30/2043	9/30/2048
Age	Less than 40	138,125	125,096	114,159	107,969	107,133	106,174	106,327
	40-64	334,721	310,834	283,851	263,443	244,732	234,479	220,300
	65+	265,789	260,674	259,596	251,106	237,887	220,367	210,331

Virginia		9/30/2018	9/30/2023	9/30/2028	9/30/2033	9/30/2038	9/30/2043	9/30/2048
Gender	Male	631,057	586,421	546,109	510,627	478,603	451,784	430,760
	Female	107,577	110,183	111,497	111,891	111,150	109,237	106,198

Virginia		9/30/2018	9/30/2023	9/30/2028	9/30/2033	9/30/2038	9/30/2043	9/30/2048
Period of Service	WWII	12,126	2,698	384	34	2	0	0
	Korea	35,227	17,366	5,898	1,277	176	15	1
	Vietnam	204,310	169,664	131,518	91,730	54,430	25,774	9,222
	Gulf War	388,820	422,076	436,890	424,676	403,382	377,695	339,715

Note: The total for Period of Service does not equal the total Veteran Population because peace time veterans were excluded

Virginia		9/30/2018	9/30/2023	9/30/2028	9/30/2033	9/30/2038	9/30/2043	9/30/2048
Race	White, Not Hispanic	506,611	463,985	427,887	401,476	383,054	371258	365,633
	Minority	232,024	232,619	229,719	221,042	206,698	189,763	171,324

Note: Minorities are all races/ethnicities except non-Hispanic White Veterans

Source: National Center for Veterans Analysis and Statistics
www.va.gov/vetdata as of 9/30/2019

Culture of the Military

- Abides by its own legal system (Uniformed Code of Military Justice - UCMJ)
- Each service follows its own set of traditions
- The military has its own terminology
- Follows an organized rank structure
- Strong work ethic, accountability, personal responsibility, MISSION FIRST
- Stoic, overcomes challenges, flexible and resilient

Military Ethos

The **military ethos** reflects how military professionals:

- View themselves (identity)
- How they fulfill their function (expertise)
- How they relate to their government and to society (responsibility)

Military Creeds

All services have creeds. A creed is an oath or saying that provides a value structure by which to work, live, and think. These set the tone of life in each service branch.

Service Force Inception

					
14 June 1775	13 Oct. 1775	18 Sept. 1947	10 Nov. 1775	4 Aug. 1790	20 Dec. 2019
Reserve: 23 Apr. 1908	Reserve: 3 Mar 1915	Reserve: 14 Apr. 1948	Reserve: 29 Aug. 1916	Reserve: 19 Feb. 1941	
National Guard: 13 Dec. 1636		National Guard: 18 Sept. 1947			

Army - Soldier

- **Mission:** To fight and win our nation's wars with sustained land dominance across a full range of military operations
- Oldest and largest branch; main ground force
- Built to execute large-scale and long-term ground operations
- **Core Values**: Loyalty, Duty, Respect, Selfless Service, Honor Integrity & Personal Courage
- **Motto**: "This We'll Defend"

www.army.mil

Marine Corps - Marine

- **Mission**: As America's expeditionary force in readiness since 1775, the Marines are forward deployed to win our nation's battles swiftly and aggressively in times of crisis
- A component of the Department of the Navy
- *Maintains amphibious, air, and ground units for contingency and combat operations*
- ***Core Values:*** *Honor, Courage, and Commitment*
- ***Motto:*** *"Semper Fidelis" Always Faithful*

www.marines.mil

Navy - Sailor

- **Mission:** To recruit, train, equip and organize to deliver combat ready Naval forces to win conflicts and wars while maintaining security through sustained forward presence
- The Navy is America's forward deployed force and is a major deterrent to aggression around the world
- Operates on, above and below water
- **Core Values:** Honor, Courage, and Commitment
- **Motto:** *No official Motto*

www.navy.mil

Air Force - Airman

- **Mission:** To fly, fight and win—in air, space and cyberspace. We are America's Airmen
- The Air Force provides a rapid, flexible and lethal air and space capability that can deliver forces anywhere within hours
- Controls air and space operation and controls two-thirds of our nuclear capabilities
- **Core Values:** Integrity first, Service before self, and Excellence in all we do
- **Motto:** "Aim High…Fly-Fight-Win"

www.af.mil

Coast Guard – Coast Guardsman

- **Mission:** To ensure our nation's maritime safety, security and stewardship
- The oldest continuing seagoing service in the U.S
- Operates under the Department of Homeland Security but can be transferred to the US Navy by the President in times of war
- **Core Values:** Honor, Respect, and Devotion to Duty
- **Motto:** Semper Paratus
  "Always Ready"

www.uscg.mil

Space Force - Guardians

- **Mission:** The USSF is responsible for organizing, training, and equipping Guardians to conduct global space operations that enhance the way our joint and coalition forces fight, while also offering decision makers military options to achieve national objectives
- Ground-based and space-based systems monitor ballistic missile launches around the world to guard against a surprise missile attack on North America
- First new branch of the armed services in 73 years
- **Core Values:** Organizational agility, Innovation, and Boldness
- **Motto:** Semper Supra "Always Above"

https://www.spaceforce.mil/

Armed Forces Reserve

- The purpose of each reserve component is to provide trained units and qualified persons available for active duty in the armed forces, in time of war or national emergency, and at such other times as the national security may require

- Minimum duty requirements are one weekend per month, plus two weeks of training per year, members of the Reserves are considered part-time employees of the DOD.

Reserve Components

- There are 800, 000 + in the Reserve Components
- Five services (branches) have reserve components, Space Force does not
- Army, Navy, Air Force, and Marines fall under the Dept. of Defense
- Coast Guard falls under the Dept. of Homeland Security

Virginia National Guard (Army and Air)

- 9,100 Soldiers, Airmen, Virginia Defense Force personnel and civilian employees
- Unique dual-status force with a potential for federal or state activation or mission assignment.
- Domestic response capabilities: mission command, high mobility ground transportation, ground and aerial damage assessment, imagery analysis, resupply, medical treatment, decontamination, cyber security and vulnerability assessment
- On the federal side: train Army and Air Force combat and support units, air dominance, weather support, intelligence operations, unmanned aerial vehicles, sustainment support and cyber operations

Activation of National Guard

- Title 10 – President orders National Guard to active duty – can be voluntary or not, duration is determined by the type of activation. There are seven different types of activation

- Title 32 – State Active Duty (SAD). The Governor can activate National Guard personnel to "State Active Duty" in response to natural or man-made disasters or Homeland Defense missions. Allows the Governor, with the approval of the President or the Secretary of Defense, to order a member to duty for operational Homeland Defense activities

https://uscode.house.gov/browse/prelim@title10/subtitleE/part2/chapter1209&edition=prelim

Federal Definition: Veteran

What is a Veteran?

Title 38 of the Code of Federal Regulations defines a veteran as; "a person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable."

*https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section101&num=0&edition=prelim

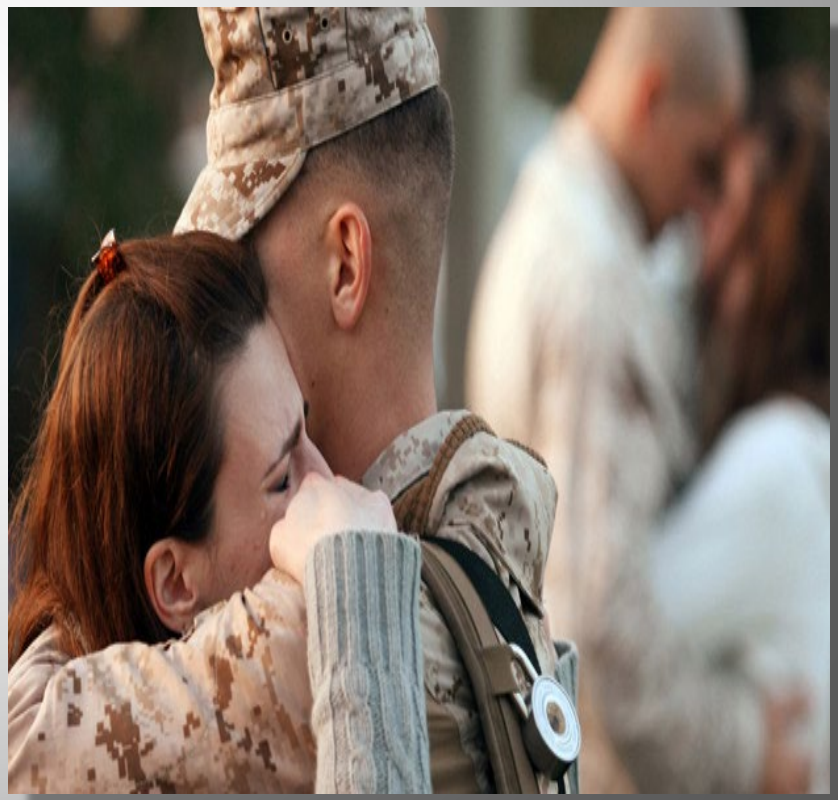
Stressors of Military Life

Frequent Moves:
For children: changing schools, loss of friends, new routines
For spouses: job change, periods of un/under- employment, search for new doctors, loss of friends

Separation Due to Deployments:
Spouse becomes single parent
Children: loss of parent, uncertainty, worry

Financial: Inability to sell home, unforeseen moving costs, additional day care costs

Limited Support System: Separation from extended family, constant change of friends



Characteristics of OIF/OND/OEF/OIR/OFS

- Heavy dependence on National Guard & Reserve
- Longer deployments with multiple combat deployments and infrequent breaks in between
- High intensity urban warfare
- Chronic threat of IEDs and RPGs
- New advancements in body armor, tactical vehicles
- Fewer fatalities and more wounded survive than ever before

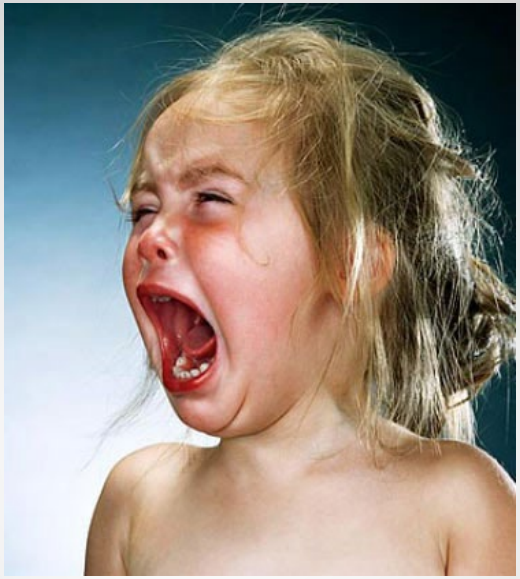
Everyone is Affected by Combat

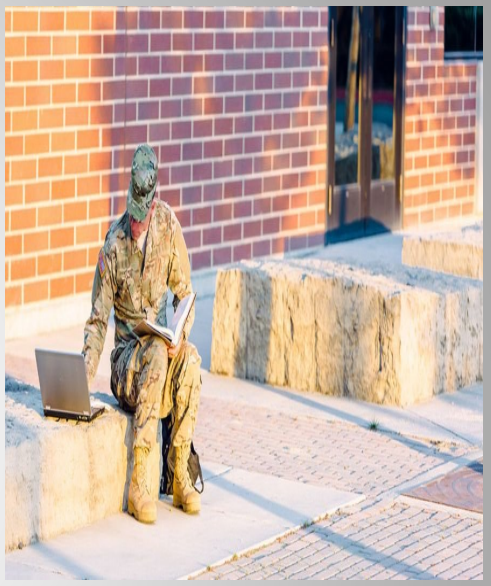
Moving from this….


ALISBROOKS
THALES
ALISBROOKS


MCCLAIN
WOSIK
BLYTHE

To This:





Transitioning Home from Combat

"There is nothing normal about war. There's nothing normal about seeing people losing their limbs, seeing your best friend die. There's nothing normal about that, and that will never become normal…"

Lt. Col. Paul Pasquina from "Fighting for Life"

This video discusses transitioning home from combat, presented by Charles Hoge, M.D. Colonel (Ret.)

https://youtu.be/WIx5T1wboxw

Stressors of Combat

Transition Stress:

- Stress as a result of the loss of a sense of place and self that many within the military felt regardless of their service or experiences.

Combat Stress Reaction:

- Reactions to the traumatic stress of combat and the cumulative stresses of military operations

Serious Injuries:

- Long lasting impact, some leading to medical discharge from the military

Specific to Guard and Reserves:

- Returning to civilian life and not a military base, readjusting to civilian income, employment and often-times having been “cross leveled” (not deploying or coming home as a unit)

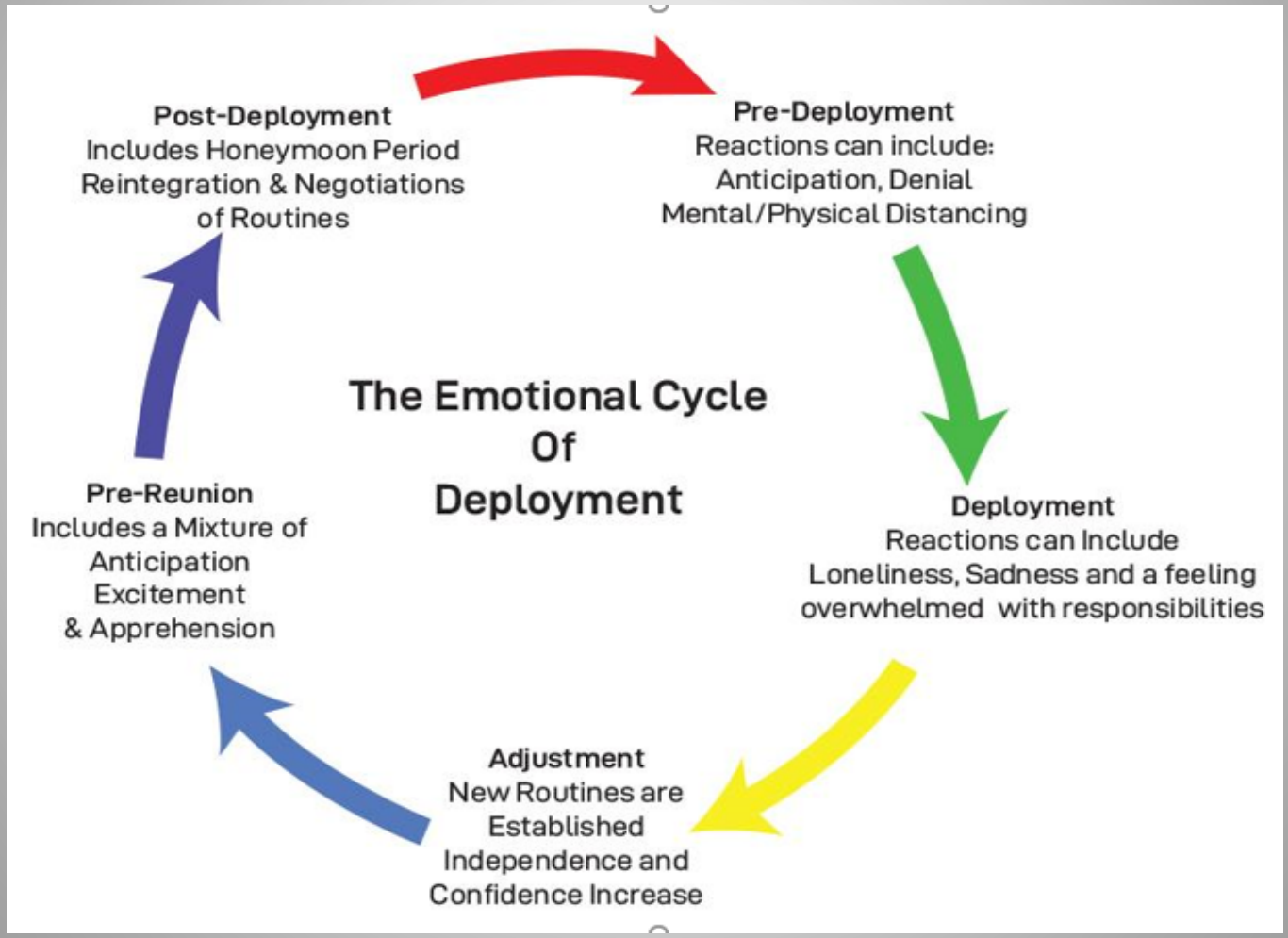
Conflict Casualty Statistics

Conflict	Total Deaths	Battle Deaths	Other Deaths	Wounded
World War II	405,399	291,557	113,842	670,846
Korean War	36,574	33,739	2,835	103,284
Vietnam War	58,220	47,434	10,786	30,3644
Persian Gulf War	382	147	235	467
OEF As of 1 March 2022	2,349	1,845	504	20,149
OIF As of 1 March 2022	4,418	3,481	937	31,994

Medical and technology advances have enabled far more to survive catastrophic injuries, but this presents an emerging dilemma for the medical and broader community. Lack of diagnosis/treatment, quality life, etc.

*https://dcas.dmdc.osd.mil/dcas/pages/summary_data.xhtml

Emotional Cycle of Deployment



Post-Deployment: Readjustment to Family Life

- Difficulty communicating
  - Unsure what to share about their deployment/or can't share at all
  - Lack of sensitivity toward partner
  - Minimizing partner's stressors and challenges
- Irritability and anger
- Domestic violence
- Decreased sex drive
- Emotional numbing
- Role changes
- Infidelity
- Instant marriages prior to deployment

Post-Deployment Transition for Family

- Fitting the deployed spouse/parent back into the home routine—reintegration
- Re-establishing role within the family dynamic
- Getting to know the deployed spouse/parent again
- Worrying about the next deployment
- Dealing with the deployed spouse/parent's mood changes
- Children worrying about how their parents are getting along

Video
"Cover Me"

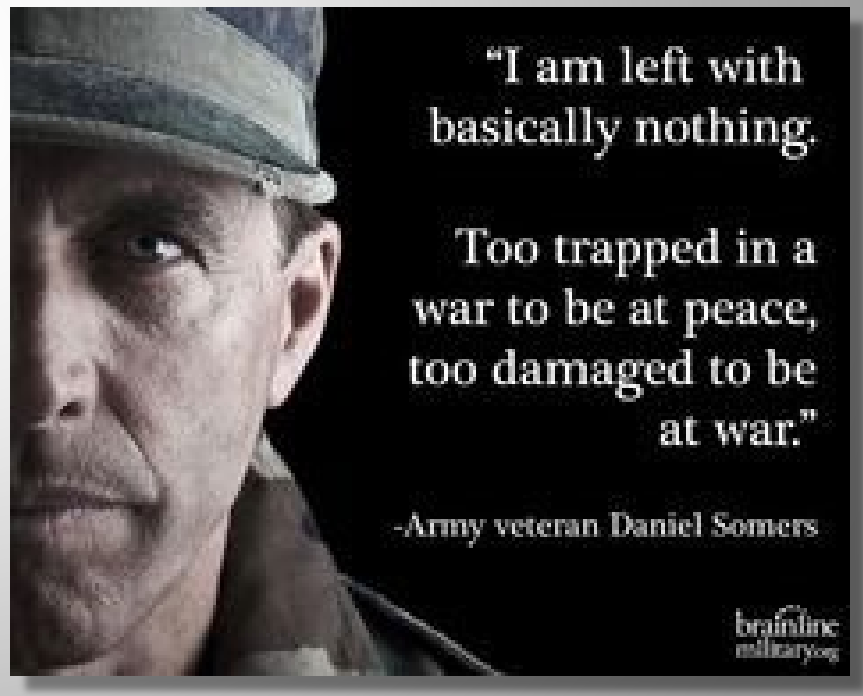
This video depicts a service member who returns from combat and is experiencing difficulty in transitioning. This video portrays transition periods, cycles of deployment, isolation, substance use, reintegration, relationship issues and survivor's guilt.

Note: *This video contains material which could be concerning/trigger*

https://youtu.be/KEnFCa-5p9E

Possible Complications From Military Service

- PTSD
- TBI
- MST
- Moral Injury
- Anxiety/Depression
- Substance Use Disorder



Our Brain During a Traumatic Event

- Function of the brain during a traumatic event: survival
- Fight-Flight-Freeze response
  - Stress activates immune and defense systems
  - The brain interprets the traumatic experience as dangerous
  - The brain generates powerful memories

Individuals with PTSD sometimes lose the ability to discriminate between past and present experiences or interpret environmental contexts correctly

The Traumatic Experience

- The brain interprets the experience as dangerous (traumatic)
- Activates Fight-Flight-Freeze response
- Physiologically: Stress activates immune and defense systems (physical & psychological)
- The brain generates powerful memories

Common Coping Mechanisms for Military Stressors

- Hypervigilance and increased security awareness
- Isolation
- High adrenaline, high risk behavior
- Self medication

PTSD

"A Normal Reaction to an Abnormal Situation"

VIDEO

David Lynch Foundation
“Sounds of Trauma”

Warning: Contains combat imagery, weapons and sounds of gunfire/explosions

https://www.youtube.com/watch?v=bgpRw92d1MA

What Is PTSD?

- PTSD (posttraumatic stress disorder) is a mental health issue that some develop after experiencing or witnessing a life-threatening event, like combat, a natural disaster, a car accident, or sexual assault.

- At first, it may be hard to do normal daily activities, like go to work, go to school, or spend time with people you care about. But most people start to feel better after a few weeks or months.

- If it's been longer than a few months and you're still having symptoms, you may have PTSD. For some people, PTSD symptoms may start later on, or they may come and go over time.

* NATIONAL CENTER FOR PTSD

Military Sexual Trauma (MST)

- "Sexual assault or repeated, unsolicited, threatening acts of sexual harassment that occurred while a veteran was serving on active duty or active duty for training"

- 1 in 5 females and 1 in 12 males

Sexual Assault in the Military

Fiscal Year 2018: Sexual Assault in the Military

DoD Sexual Assault Prevalence

0.7% indicated an experience of sexual assault

6.2% indicated an experience of sexual assault

More Service Members Are Coming Forward to Make a Report

After experiencing a sexual assault, how many Service members reported it to a DoD authority?

Individual Service Sexual Assault Prevalence

	Army	Navy	Marine Corps	Air Force
2018	**Women: 5.8%** Men: 0.7%	**Women: 7.5%** Men: 1.0%	**Women: 10.7%** Men: 0.8%	Women: 4.3% **Men: 0.5%**
2016	Women: 4.4% Men: 0.6%	Women: 5.1% Men: 0.9%	Women: 7.0% Men: 0.7%	Women: 2.8% Men: 0.3%

Bolded text indicates a statistically significant increase from 2016

Of **female Service members** who indicated an experience of sexual assault and reported it:

- About 21% endorsed experiences consistent with legal criteria for retaliatory behavior

Note: The estimate for men was not reportable due to small sample size.

Sexual Harassment Rates in the Military

6.3% indicated an experience of sexual harassment

24.2% indicated an experience of sexual harassment

Sexual harassment is a leading factor affecting the unit climate on sexual assault. Controlling for paygrade, Service, and deployment status...

- **1 in 5 women** who experienced sexual harassment also experienced sexual assault
- **1 in 12 men** who experienced sexual harassment also experienced sexual assault

Service Members' Satisfaction with Response Resources

- **76%** Satisfied with support from Victim Advocate
- **74%** Satisfied with support from Special Victims Counsel/ Victims Legal Counsel
- **72%** Satisfied with support from Sexual Assault Response Coordinator

Data represent respondents who interacted with response resources after filing an Unrestricted Report for a sexual assault that occurred in the past year

Bystander Intervention

93% of respondents who noticed inappropriate or risky behavior **intervened**. Interventions included:

- Speaking up (**62%**)
- Talking to those who experienced it (**58%**)
- Intervening in another way (**37%**)
- Telling someone while it was happening (**24%**)
- Telling someone after it happened (**24%**)

2018 WGRA results showed that 27% of Service members indicated witnessing a high-risk situation in FY18, and of those who observed, 93% acted to address the situation. Percentages in this section do not add to 100 percent because respondents could choose more than one intervention.

Department of Defense Annual Report on Sexual Assault in the Military Fiscal Year 2018

Sources: *2018 Workplace and Gender Relations Survey of Active Duty Members. 2018 Workplace and Gender Relations Survey of Active Duty Members, DoD Office of People Analytics, Defense Sexual Assault Incident Database, and DoD Sexual Assault Prevention and Response Office

Four Main Symptom Clusters of PTSD

RE-EXPERIENCING

1. Unwanted memory of event
2. Nightmares
3. Flashbacks
4. Distress after exposure to a reminder of the event

AVOIDANCE

- 1. Traffic or reminders of IEDs on roads
- 2. Noises
- 3. Smells (burnt-meat, sulfur)
- 4. Images
- 5. Unknown (reminders of the memory)

NEGATIVE COGNITION

- 1. Negative / Distrusting feelings about the world
- 2. Survivor's guilt
- 3. Feelings of isolation or the need to isolate
- 4. Inability or discomfort w/ emotion closeness
- 5. Depression & Anxiety
- 6. Decreased interest in activities

AROUSAL / REACTIVITY

1. Physiological Reactions (Adrenaline)
2. Irritability & Aggression
3. Threat assessment & hypervigilance
4. Risky, destructive, or thrill-seeking behavior
5. Difficulty concentrating or sleeping

Consequences of PTSD

Personal Struggles	Justice Involvement
• Substance Addiction: High Correlation • Domestic Violence • Health Problems • Difficulty Managing Stress	• Three most common interactions with CJS: 1. Domestic Violence 2. DUI/possession of controlled substance 3. Assault and Battery • Veteran Treatment Dockets • Justice involvement may be an important intercept point for connecting to treatment

Notable Differences Between Military and most Civilian PTSD

- Trauma may reoccur over months or years (e.g. handling body parts every day, being under fire on a regular basis, repeat deployments)
- Experience is impacted by unit support, command and leadership and national support
- Service members may have adapted to dangerous situations, which increases their tendency for adrenaline addiction, changes in brain chemistry

PTSD by the Numbers

Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF): About 11-20 out of every 100 Veterans (or between **11-20%**) who served in OIF or OEF have PTSD in a given year

Gulf War (Desert Storm): About 12 out of every 100 Gulf War Veterans (or **12%**) have PTSD in a given year

Vietnam War: It is estimated that about 30 out of every 100 (or **30%**) of Vietnam Veterans experience symptoms of PTSD in their lifetime.

**The National Center for PTSD*

Holistic & Alternative Treatments for PTSD

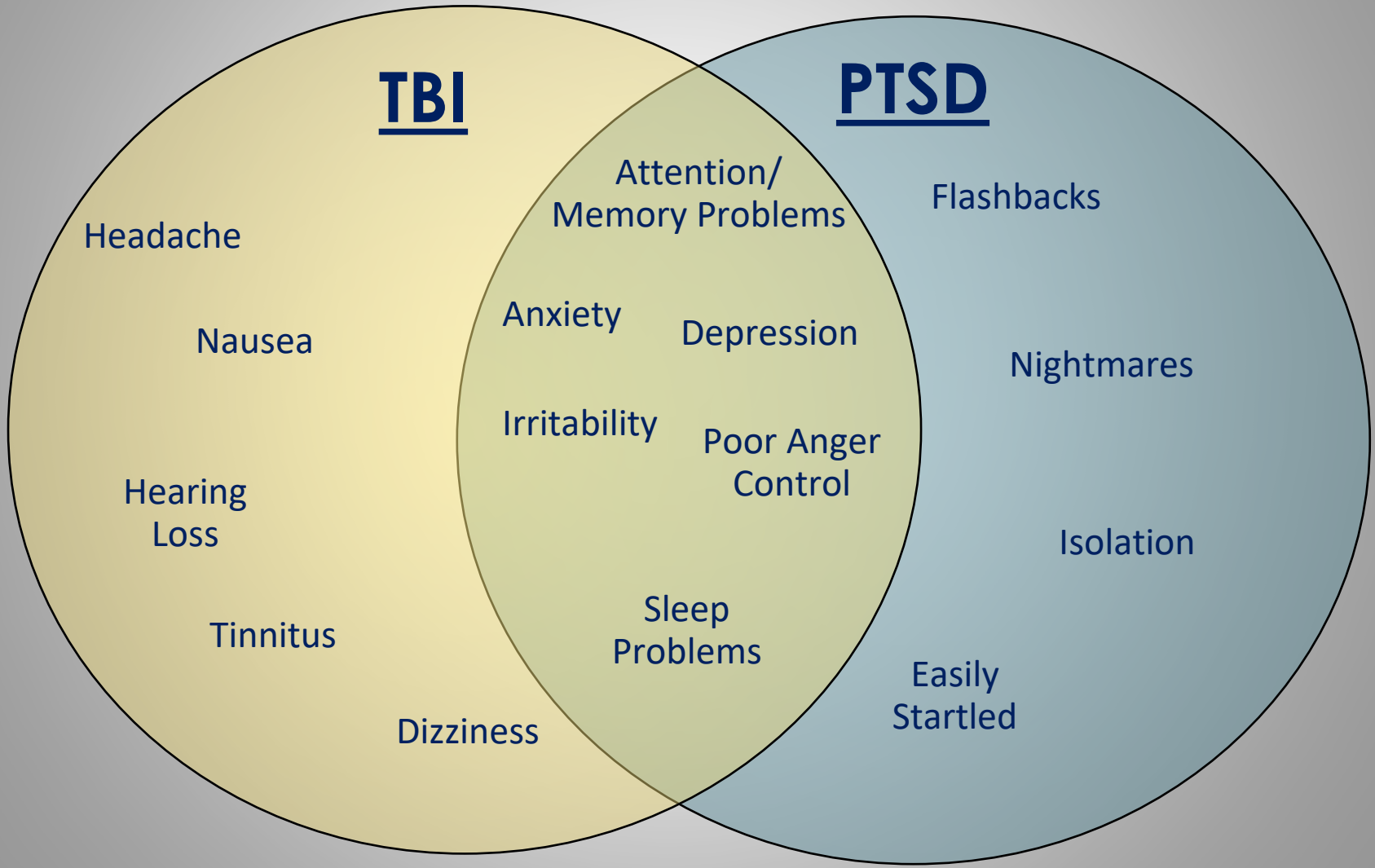
Treatments include:

- Individual Peer Support & Peer Groups
- Meditation
- Yoga
- Equine Therapy
- Art Therapy
- Involving Support from Spouse and Friends
- Outdoor Activity
- Sobriety
- Remembering or discovering new hobbies
- Post-Traumatic Growth: Loss causes re-evaluation of life/world perceptions greater value of time in life/family; drives energy for needed change. Growth from Struggle.

Uncontrolled Anger

- Common in both PTSD and TBI
- Over reaction to simple situations
- Difficulty with self de-escalation
- Everything feels out of control
- Negative impact on family system
- Impact on career

PTSD/TBI Symptom Overlap



Traumatic Brain Injury

TBI is a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head, or penetrating head injury.

Blast injuries caused by exposure to improvised explosive devices, rocket-propelled grenades, land mines, mortar/artillery shells, motor vehicle crashes, falls and assaults

Even those who were not obviously wounded in explosions or accidents may have sustained a brain injury

More than half of the military TBIs don't come from combat situations

Traumatic Brain Injury

Between 19% and 30% of all services members in OIF/OEF experienced a TBI

The Defense and Veterans Brain Injury Center (DVBIC) reported nearly 414,000 TBIs among U.S. service members worldwide between late 2000 and 2019.

Combat Related Traumatic Brain Injury

- Closed brain injuries – very common
- May not exhibit physical wounds
- Many will not report the incident
- Many will not even be aware they've experienced a TBI
- Do not need to physically hit head to cause a TBI
- Overpressure from explosion may scar brain tissue

Traumatic Brain Injury Symptoms

Impact on cognition and memory

Impact on emotion

Impact on behavior

Transitioning from Military Life

- Finding a new identity/purpose ("I was a Soldier" vs. "I worked for the Army")
- Still feel like a sheepdog
- Establishing a new support system
- Choosing a permanent home
- Healthcare
- Employment
- Benefits
- College
- GI Bill

Moral Injury

Moral Injury is the **damage done to one's own conscience** when that person perpetrates, witnesses or fails to prevent acts that violate one's own moral beliefs (what is right and wrong).

- In order for moral injury to occur, the individual must feel like a transgression occurred and that they or someone else crossed a line with respect to their moral beliefs.

Moral Injury Video:

https://www.youtube.com/watch?v=zKGSn0VuaV8&feature=youtu.be

Moral Injury

Examples

1. Using deadly force in combat and causing the harm or death of civilians, knowingly but without alternatives, or accidentally
2. Giving orders in combat that result in the injury or death of a fellow service member
3. Following orders that were illegal, immoral, and/or against the Rules of Engagement (ROE) or Geneva Convention
4. Failing to provide medical aid to an injured civilian, service member or combatant
5. Returning home from deployment and hearing of the executions of cooperating local nationals
6. A change in belief about the necessity or justification for war, during or after one's service

Consequences

Four Hallmark Emotional Reactions: Guilt, shame, disgust and anger.

- Guilt involves feeling distress and remorse regarding the morally injurious event (e.g., "I did something bad.").
- Shame is when the belief about the event generalizes to the whole self (e.g., "I am bad because of what I did.")
- Disgust may occur as a response to memories of an act of perpetration
- Anger may occur in response to a loss or feeling betrayed
- ***The inability to self-forgive***, and consequently engaging in self-sabotaging behaviors (e.g., feeling like you don't deserve to succeed at work, relationships; or live at all)

Moral Injury

Myth or Fact?

- **Deployment is the leading cause of suicide in service members**

  False – In the military, failed or failing relationships in the 90 days prior to death were reported in 36.9% of active-duty suicides

- **The majority of service members who die by suicide had a mental illness**

  False - The majority of service members who die by suicide were not diagnosed with a mental illness

- **Approximately one-half (51.5%) of Service members who died by suicide received some form of care (though not necessarily suicide- or behavioral health-related care) via the Military Health Service (MHS) in the 90 days prior to death**

  True - Although it is not known whether these individuals were suicidal at the time of contact, these contacts could represent opportunities for identification and treatment of suicidal risk

- **The suicide rate is higher in combat veterans than non-combat veterans**

  False - Historical data suggests that combat and increased rates of suicide do not appear to be associated, suicide is not higher for troops or veterans who saw combat than for those who did not.

Suicide and 2019 Virginia Statistics

- Virginia veteran suicide deaths in 2019:
  - Male – 176
  - Female – 12
- **National** veteran suicide rate – 31.6
- **Virginia** veteran suicide rate – 25.8
- 71.8% of **Virginia veteran** suicides are completed with a firearm
- 50.8% of the **total national** suicides are completed with a firearm

Source – U.S. Department of Veterans Affairs

Suggestions When Working with Veterans

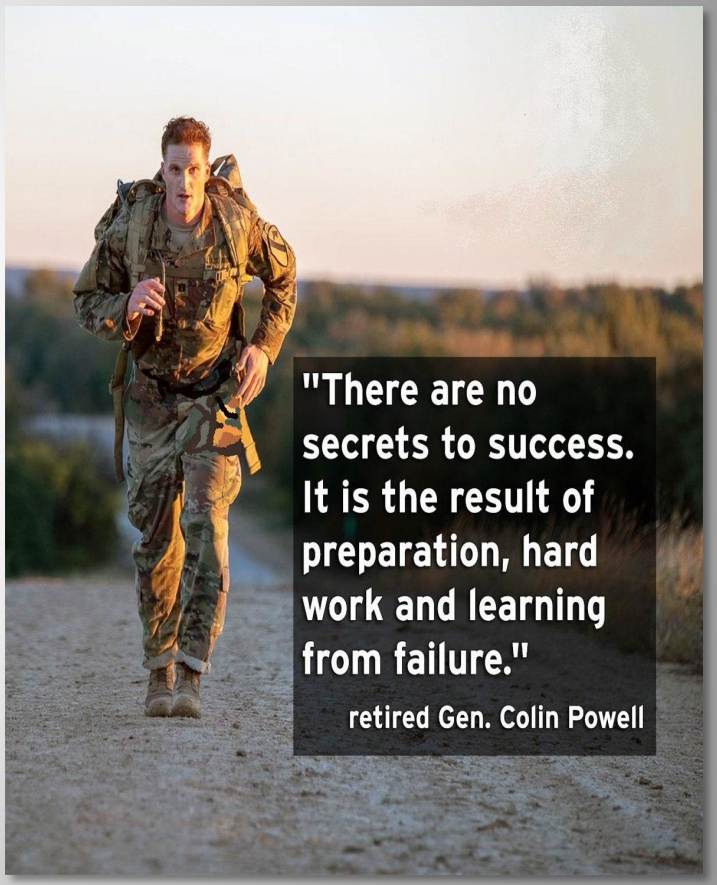
- Be military culture competent, but “know what you don’t know”
- Connect the service member with other veterans - help them develop a peer support network
- Don’t make field diagnosis of others, encourage them to seek care
- Do not share your personal views on war or politics –ACTIVELY listen to the veterans needs
- Consider loss of identity/purpose (“I was a Soldier/Marine”)
- Refer to support services/organizations

Suggestions When Working with Combat Veterans

- Do not say "You understand what they have experienced" unless you have experienced combat or military service yourself
- Involve the veteran's primary support system
- Long term- recognize importance in discussing grief and survivor's guilt and the impact of experiences on the veteran's spirituality and belief system
- Refer to other professionals as appropriate

Strengths Resulting From Military Service

1. Leadership
2. Team Work
3. Diversity
4. Flexibility/Adaptability
5. Systematic Planning and Organization
6. Work under pressure/meet deadlines



This video discusses veterans issues with mental health as well as their positive attributes

https://www.youtube.com/watch?v=6VmUulPab4M

Summary

We reviewed the life cycle of military service to include: you decide on a branch, you join the military, receive career training, detailed military culture and history training, you are then placed or assigned to a duty station and then potential deployments and/or operations follow. We then learned about the stressors of military life, transitioning home from deployments, operations and training assignments. During this, we learned about the stressors of combat including the emotional cycle of deployment, reintegration, post deployment dealing with behavioral health and medical issues, transitioning from military life/career back into the civilian sector.

We learned about the military organizational structure, the UCMJ, the 6 different branches of service, their core values and demographics of Virginia Veterans. We learned that every branch (except the Space Force) has a reserve component and that the Army and Air force have a National Guard component.

We reviewed and learned about Active Duty service branches, their mission and their capabilities. Reserve components provide trained units and personnel who are available for AD support including in time of war or national emergency. We learned the National Guard components provide both state and federal support to include war, natural disasters and homeland defense.

Learned how to engage with the SMVF population, therapy and alternative treatments for behavioral health including PTSD, TBI, MST and Moral Injury. We learned about including treatment resource connections, engaging family support, peer support, and crisis services in the treatment plan and to refer early and often.

We learned myths v. facts around the characteristics of suicide. We provided suicide rates with national and local data. We also have provided the Veteran Crisis Line number and multiple suicide prevention trainings available.

Resources

DVS--Virginia Veteran and Family Support www.dvs.virginia.gov
National Resource Directory www.nationalresourcedirectory.gov
Defense Centers of Excellence for
Psychological Health & Traumatic Brain Injury www.health.mil/dcoe.aspx
Defense and Veterans Brain Injury Center www.dvbic.org
Department of Veterans Affairs www.va.gov
DoD Disabled Veterans www.dodvets.com
Vocational Rehab/Employment www.vetsuccess.gov
Center for Deployment Psychology http://deploymentpsych.org/military-culture-course-modules
National Center for PTSD www.ptsd.va.gov
VetsPrevail https://www.vetsprevail.org/

Questions??

Microsoft Word Document

Available Suicide Prevention and Mental Health Awareness Trainings
* Click icon to open

Handouts

Suicide Awareness and Prevention:
What Every VTC Team Member Needs to Know and Do!

JUSTICE FOR VETS

Review of Session Description

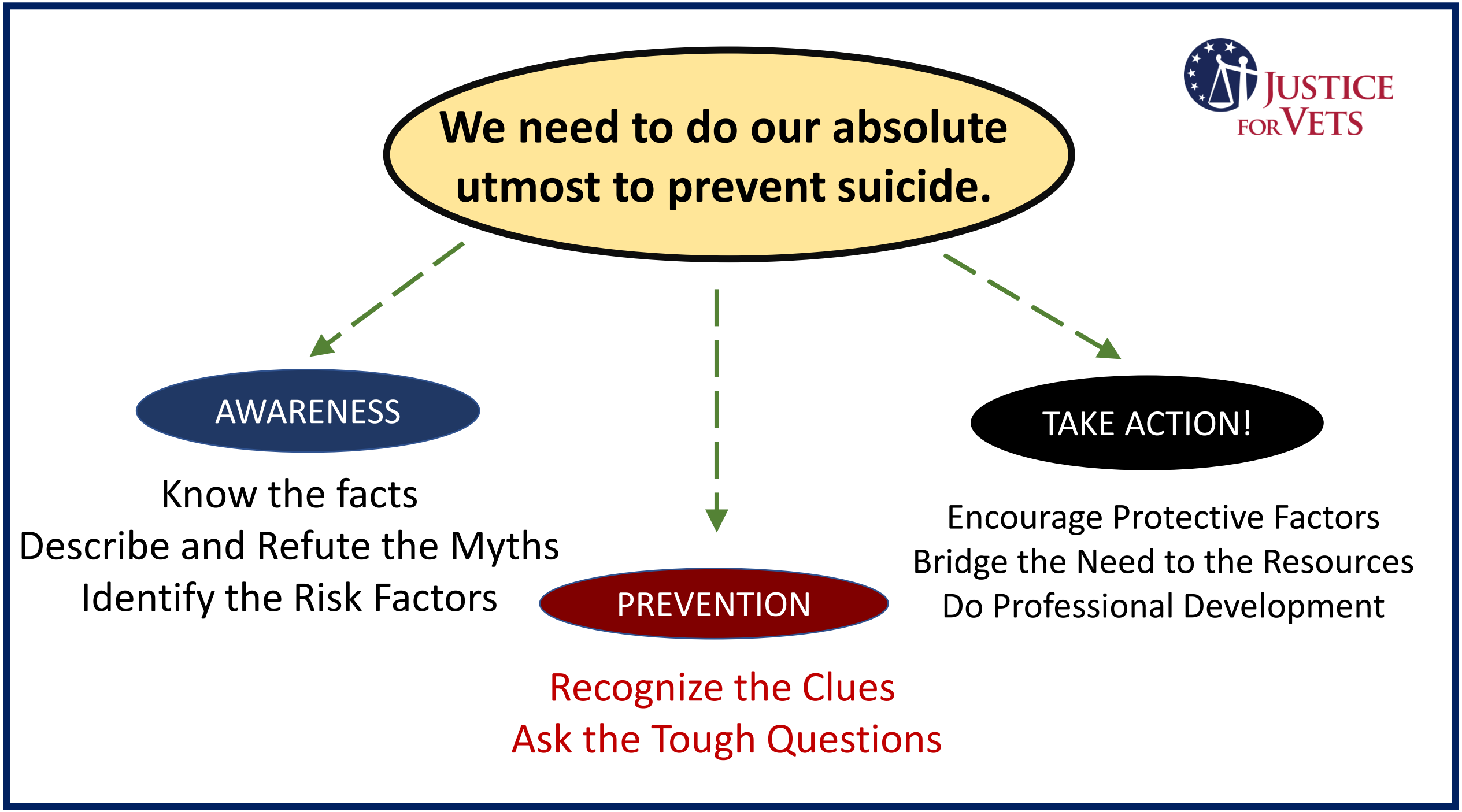
Suicide Awareness and Prevention:
What every VTC Team Member Needs to Know and Do!

Suicide Prevention is everyone's responsibility. Common myths and causes for suicide are refuted and replaced with facts that will inform the field. Prevention that emphasizes dialogue and proactive intervention skills are shared, and most importantly, this session provides the VTC team member - regardless of role, the ability to take steps and actions that can significantly reduce a participant's risk of self-harm.

Starting Point: Need to know 988

In July 2020, the FCC adopted rules designating a new phone number for anyone in crisis to connect with suicide prevention and mental health crisis counselors.

Veterans Crisis Line | Military Crisis Line
1-800-273-8255 PRESS 1
911
Dial 911


We need to do our absolute utmost to prevent suicide.
JUSTICE FOR VETS
AWARENESS
Know the facts
Describe and Refute the Myths
Identify the Risk Factors
PREVENTION
Recognize the Clues
Ask the Tough Questions
TAKE ACTION!
Encourage Protective Factors
Bridge the Need to the Resources
Do Professional Development

Awareness

- *Know the facts*
- *Describe and Refute the Myths*
- *Identify the Risk Factors*

AWARENESS

Refute the Myths!

JUSTICE FOR VETS

<u>Myth 1</u>: Talking about suicide could give someone the idea to do it.

FACT: Openly discussing suicide is one of the best ways you can help someone in a suicidal crisis. Silence is dangerous. A person is either thinking of it or they are not.

<u>Myth 2</u>: There is nothing you can do to stop a person who wants to die by suicide.

FACT:

- ✓ You can intervene; intervention can be effective
- ✓ The possibility of preventing a suicide lasts until the final moments

AWARENESS

Refute the Myths!

JUSTICE FOR VETS

Myth 3: Suicide happens without warning.

FACT: In most cases, people who die by suicide show many warning signs or clues before making a suicide attempt.

Myth 4: Once suicidal, always suicidal.

FACT: A suicidal crisis is a temporary condition. People can overcome the crisis and go through life without ever experiencing another suicidal episode.

Refute the Myths!

<u>Myth 5</u>: Military service members don't kill themselves. They're too tough for that; they can handle anything.

FACT: Service members and veterans from all ranks and branches die from suicide.

?

AWARENESS

Risk Factors

Veterans and Military Personnel ***Specific***

1. Relationship problems
2. Legal problems: Administrative and Punitive
3. Work-related and financial stress
4. Loss of social support
5. Stigma and help-seeking behaviors
6. Perception of mental illness

In order of Importance

2014 DOD Active Duty Attempts (report); cited by Houston, M.E., 2107

Crisis

A crisis occurs when unusual stress renders a person physically and emotionally unable to cope.

Case scenario - Gene is a participant in the VTC. He is visibly agitated and informs you that when he stopped for coffee before meeting with you today, he saw his girlfriend sitting in conversation with another man in the same coffee house. Because he did not recognize the other man, he rushed out of the store without her seeing him. ***Is this a crisis?***

Facing the
Challenge

What can I do?

Prevention

- *Recognize the clues*
- *Ask the tough questions*

PREVENTION

Recognize the Clues:

Take all signs seriously

DIRECT

1. Talking or writing about death, dying or suicide or threatening to hurt or kill self.
2. Looking for ways to take one's life.
3. Preparing for suicide: expressing or showing intent; taking steps toward implementing a plan; making arrangements for dependents, wills, finances; saying goodbye to loved ones.

INDIRECT

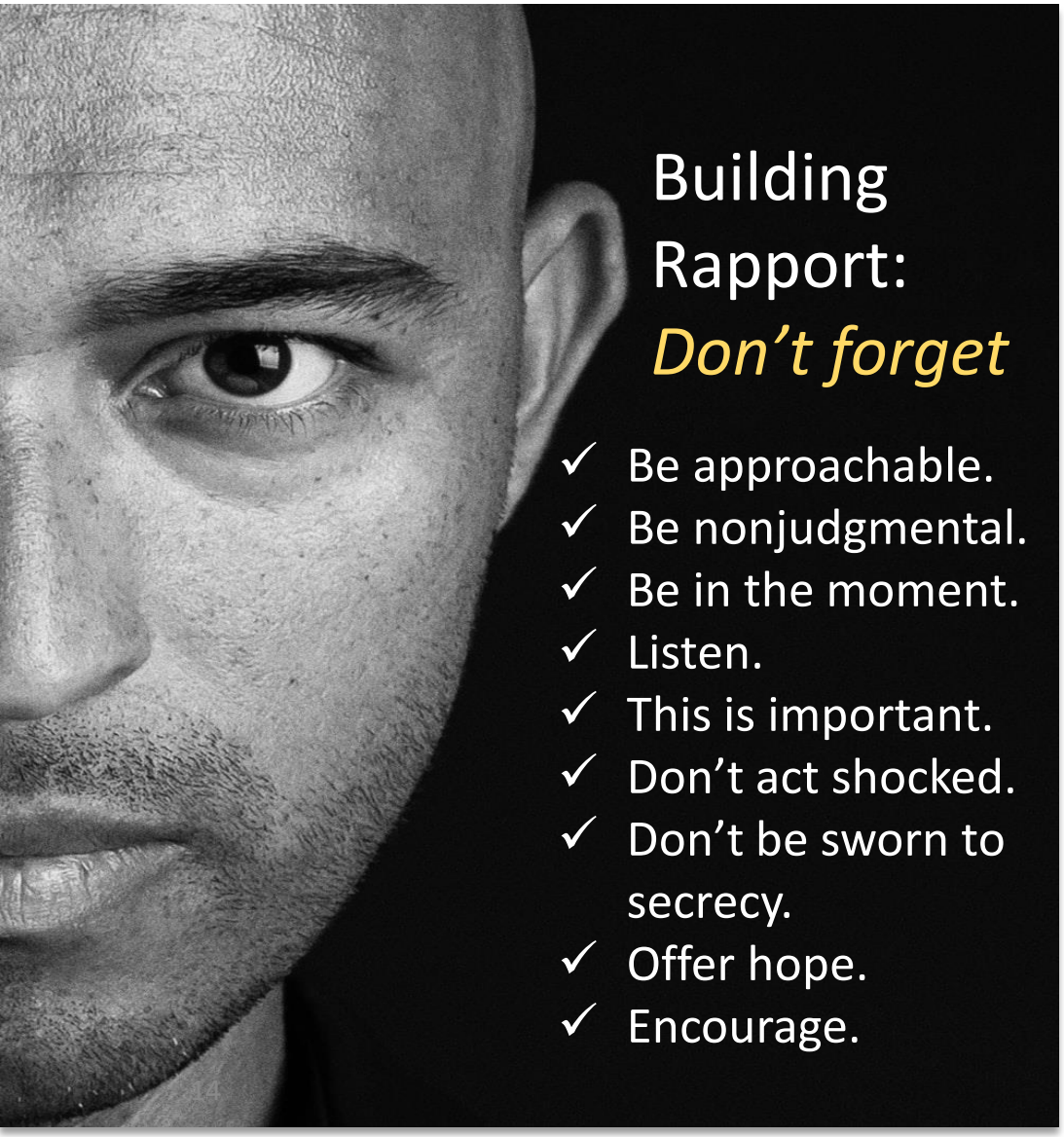
Expressed Hopelessness **Anger** **Feeling Trapped** **Mood Changes** **Anxiety**

Social Withdrawal **Increased Substance Use** **Giving Away Possessions**

Recklessness **Guilt and/or Shame** **Purposelessness** **Sleep Changes**

PREVENTION

Case scenario – Miguel, a participant in the VTC



As a case manger on a VTC team, you have known Miguel for about 9 months.

During his routine check in for this week, Miguel informs you that he is thinking about doing some "crazy things" and wonders aloud why he should even go on showing up for his court appearances and treatment sessions.

He seems sad and a little agitated. He is disheveled and looks sleep deprived.

His comments and appearance seem uncharacteristic for the Miguel you are used to seeing who is usually outgoing and upbeat.

PREVENTION

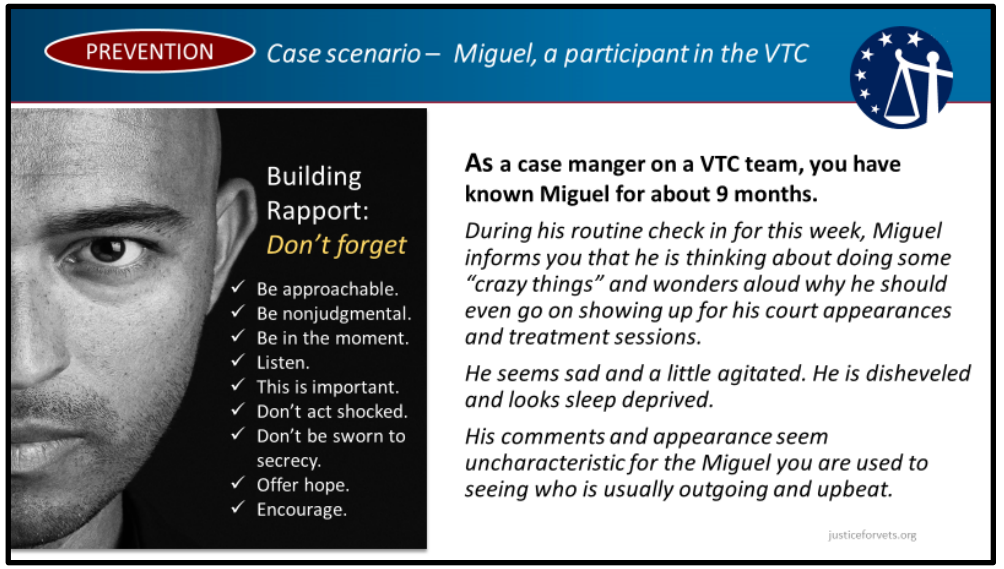
Continuing the conversation

What's happening that has you wondering about not going to court or treatment?

I've been worried about you lately.

I haven't heard you talk this way before; can you tell me more?

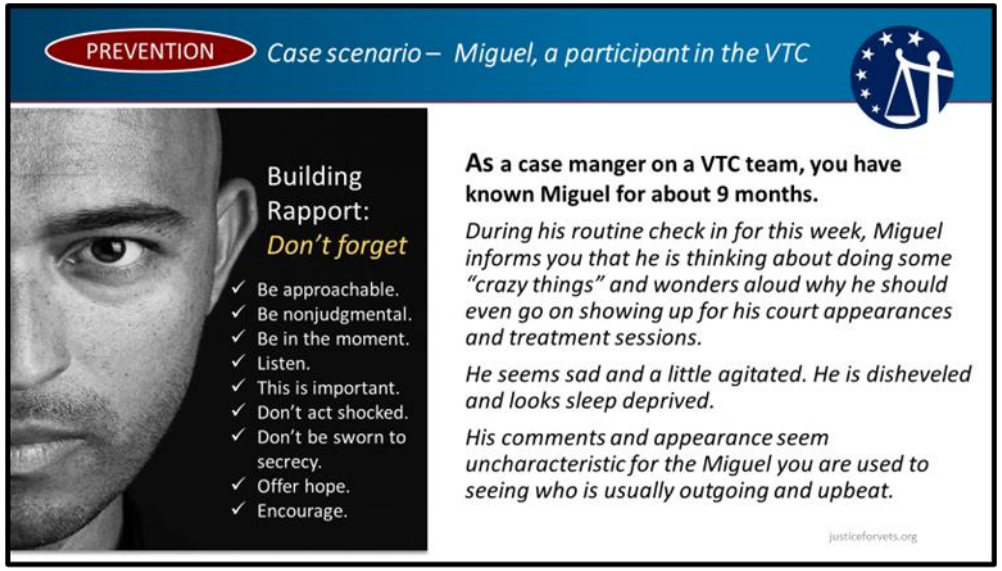
What do you mean when you say, *crazy* things?



PREVENTION

The conversation shifts

"I can't …



stop feeling sad."
see a future without pain."
get control."
sleep, eat or work."
get anyone's attention."
see any way out."
think clearly."
make decisions."

PREVENTION

ASK THE TOUGH QUESTIONS

INDIRECT APPROACH

- When did you first start feeling like this?
- Did something happen that made you begin to feel this way?
- Have you been very unhappy lately?
- Have you been so unhappy lately that you have been thinking about harming yourself?
- What can I do to support you now?
- Have you thought about getting help?

PREVENTION

ASK THE TOUGH QUESTIONS

Asking someone directly about suicide intent lowers anxiety, opens up communication, and lowers the risk of an impulsive act. *- QPR Institute*

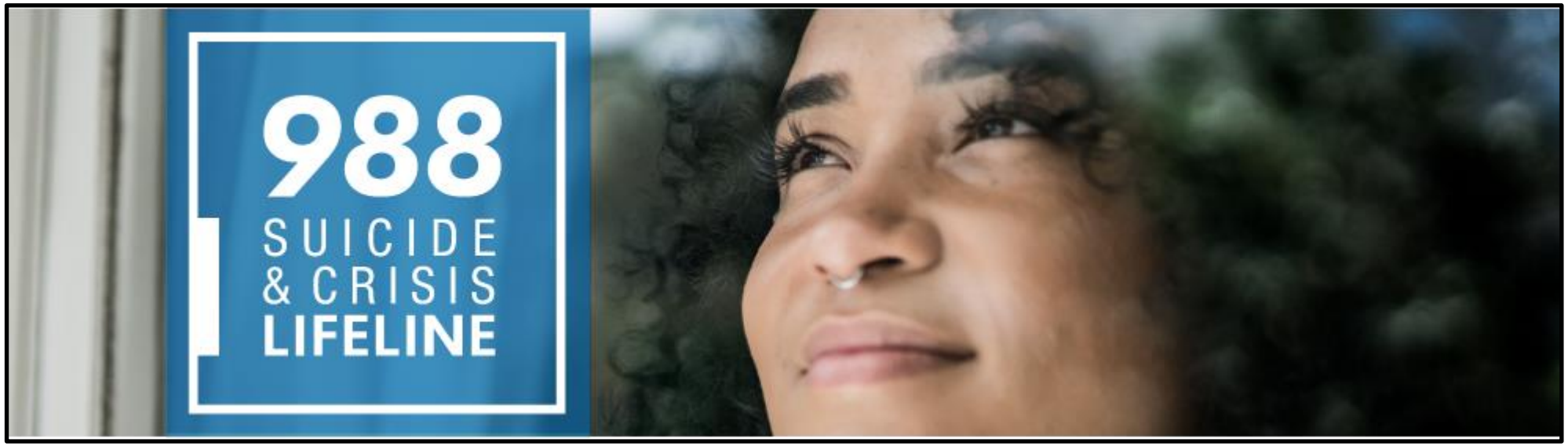
DIRECT APPROACH

- Do you have thoughts of hurting yourself?
- You look really troubled; I wonder if you're thinking about suicide?
- Are you having thoughts of suicide?
- **Are you thinking about killing yourself?**

SEEK SUPPORT | **YOU DON'T HAVE TO HAVE ALL THE ANSWERS !**

JUSTICE FOR VETS

NEED TO KNOW - REGARDLESS OF YOUR ROLE ON A VTC TEAM



988

" I need some help." OR

" I'm worried about someone and need some help."

Take Action!

- *Encourage Protective Factors*
- *Bridge the Need to The Resources*
- *Do Professional Development*

TAKE ACTION!

Encourage **Protective Factors**

Restoring Hope:

Advice that empowers individuals

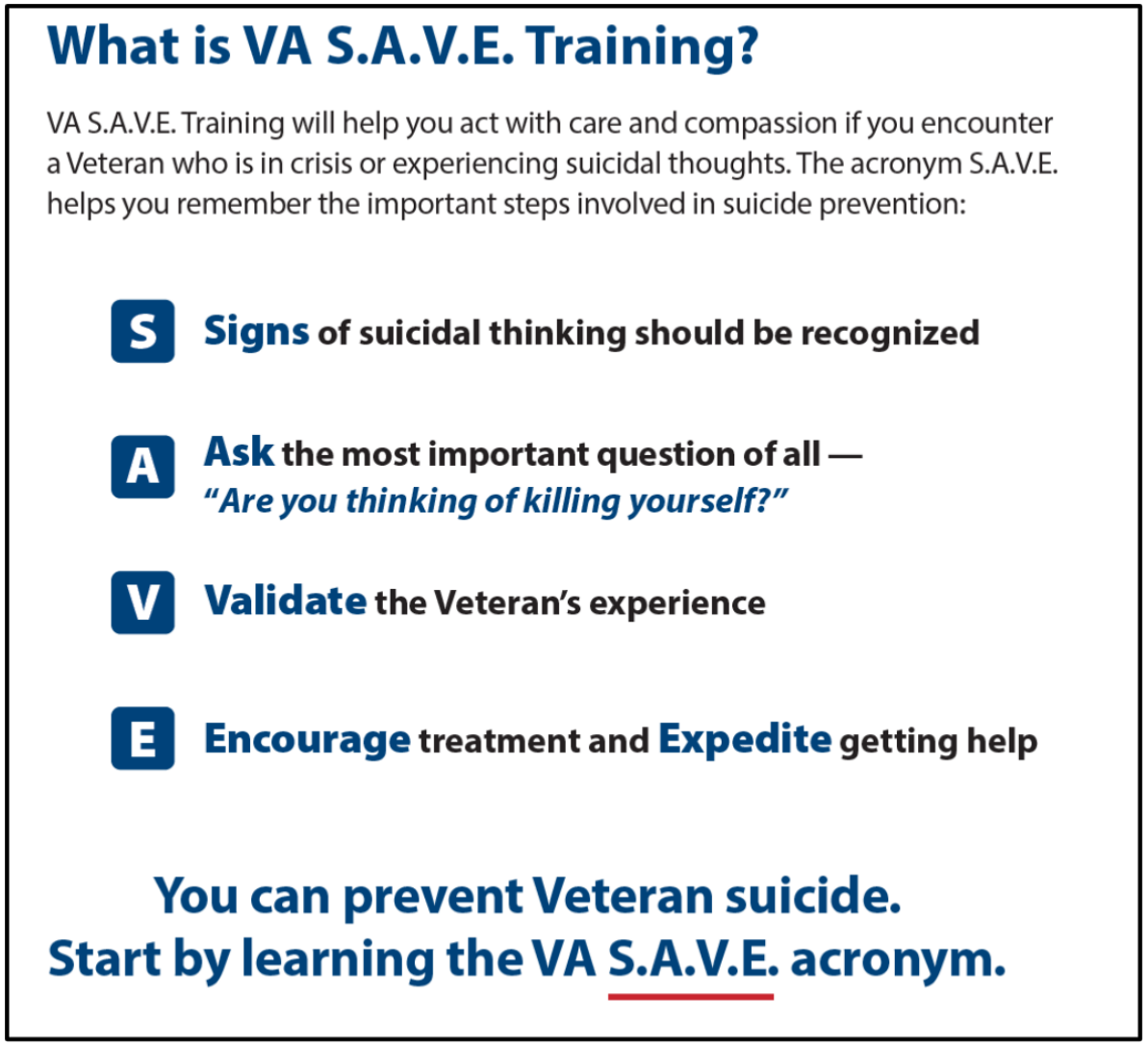
You are not alone in this.

I'm here for you.

I may not be able to understand exactly how you feel, but I care about you and want to help.

Our team is here for you; there is support."

In Sync with VA's S.A.V.E.



What is VA S.A.V.E. Training?

VA S.A.V.E. Training will help you act with care and compassion if you encounter a Veteran who is in crisis or experiencing suicidal thoughts. The acronym S.A.V.E. helps you remember the important steps involved in suicide prevention:

S **Signs** of suicidal thinking should be recognized

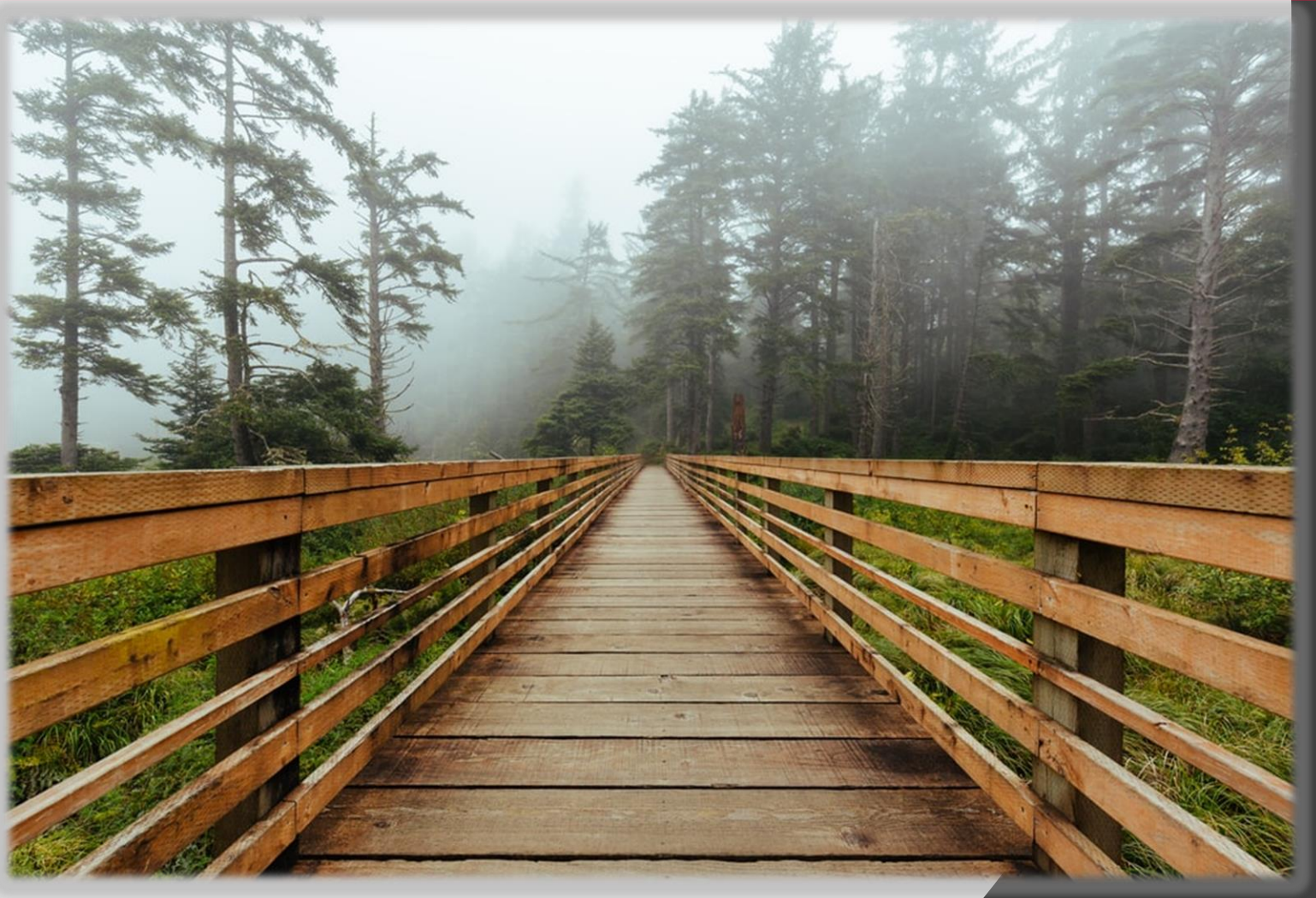
A **Ask** the most important question of all — *"Are you thinking of killing yourself?"*

V **Validate** the Veteran's experience

E **Encourage** treatment and **Expedite** getting help

You can prevent Veteran suicide.
Start by learning the VA S.A.V.E. acronym.

Moving on to ***Encourage*** and ***Expedite*** ….



Bridge the Need to the Resources

Resources

911
The default
(Go To)

Military OneSource (24/7)
(800) 342-9647
www.militaryonesource.mil

https://www.legion.org/buddycheck
Veterans looking after each other

www.maketheconnection.net/stories-of-connection

VA- Mental Health
www.mentalhealth.va.gov
www.vetselfcheck.org

https://www.mirecc.va.gov/visn19/consult
Suicide Risk Management Consultation Program

https://mobile.va.gov/appstore/veterans

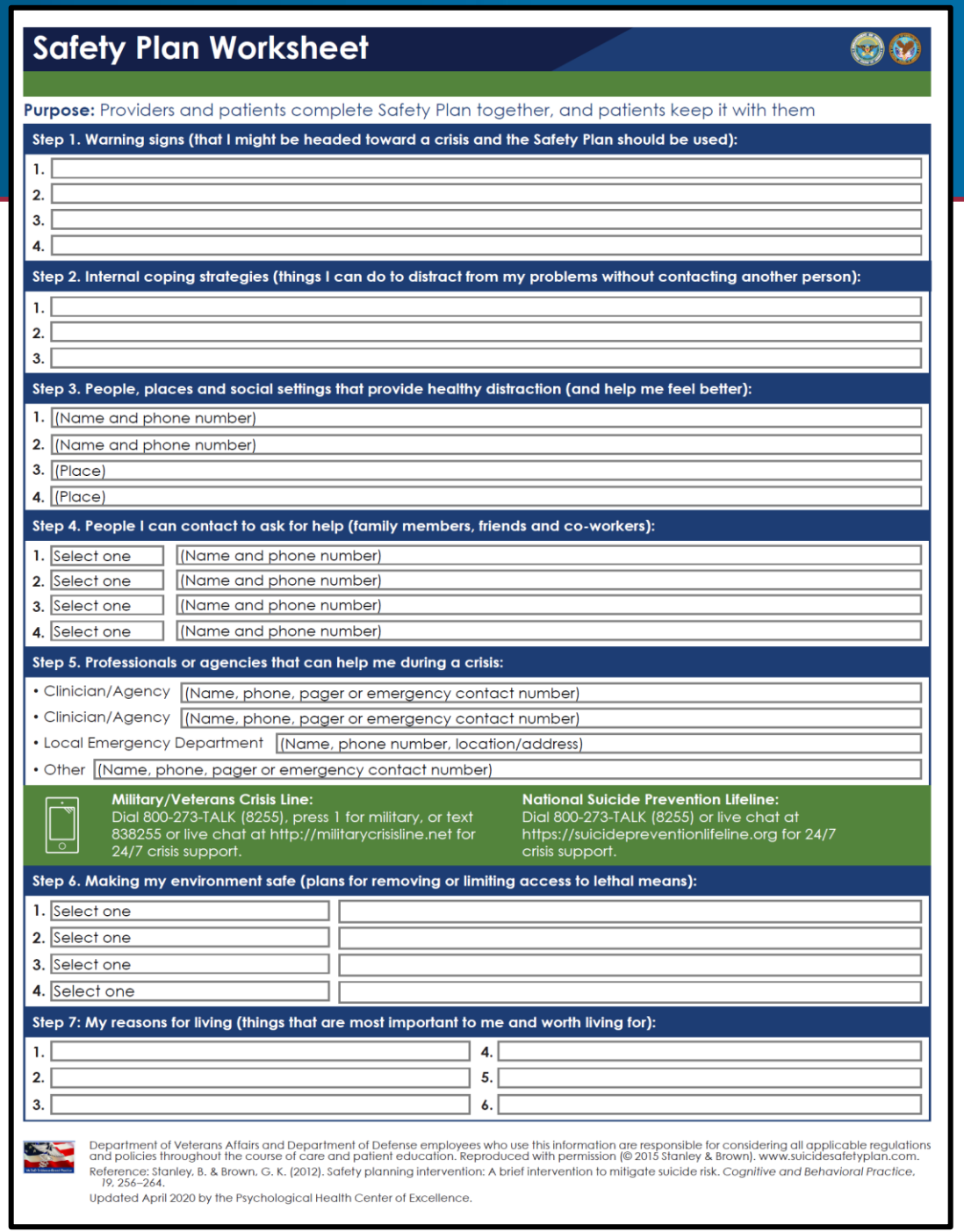
Treatment Provider Resources: *An all-Team FYI*

https://www.mirecc.va.gov/visn19/consult/learn-how-srm-helps.asp

Treatment Provider Resources *(continued)*

An all-Team FYI:

Regardless of your role, everyone on the team may experience similar challenges when working with individuals that are at risk for suicide – use a coordinated approach; inform each other, train together and don't ever be hesitant to seek further guidance!



Safety Plan Worksheet

Purpose: Providers and patients complete Safety Plan together, and patients keep it with them

Step 1. Warning signs (that I might be headed toward a crisis and the Safety Plan should be used):

1.
2.
3.
4.

Step 2. Internal coping strategies (things I can do to distract from my problems without contacting another person):

1.
2.
3.

Step 3. People, places and social settings that provide healthy distraction (and help me feel better):

1. (Name and phone number)
2. (Name and phone number)
3. (Place)
4. (Place)

Step 4. People I can contact to ask for help (family members, friends and co-workers):

1. Select one (Name and phone number)
2. Select one (Name and phone number)
3. Select one (Name and phone number)
4. Select one (Name and phone number)

Step 5. Professionals or agencies that can help me during a crisis:

- Clinician/Agency (Name, phone, pager or emergency contact number)
- Clinician/Agency (Name, phone, pager or emergency contact number)
- Local Emergency Department (Name, phone number, location/address)
- Other (Name, phone, pager or emergency contact number)

Military/Veterans Crisis Line:
Dial 800-273-TALK (8255), press 1 for military, or text 838255 or live chat at http://militarycrisisline.net for 24/7 crisis support.

National Suicide Prevention Lifeline:
Dial 800-273-TALK (8255) or live chat at https://suicidepreventionlifeline.org for 24/7 crisis support.

Step 6. Making my environment safe (plans for removing or limiting access to lethal means):

1. Select one
2. Select one
3. Select one
4. Select one

Step 7: My reasons for living (things that are most important to me and worth living for):

1.
2.
3.
4.
5.
6.

Department of Veterans Affairs and Department of Defense employees who use this information are responsible for considering all applicable regulations and policies throughout the course of care and patient education. Reproduced with permission (© 2015 Stanley & Brown). www.suicidesafetyplan.com.

Reference: Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*, 256–264.

Updated April 2020 by the Psychological Health Center of Excellence.

Proactive Planning Works

← *example (Handout)*

Do Professional Development

Question, Persuade, Refer (QPR)

Applied Suicide Intervention Skills Training (ASIST)

Assessing, Managing Suicide Risk (AMSR)

Do Professional Development

American Association of Suicidology

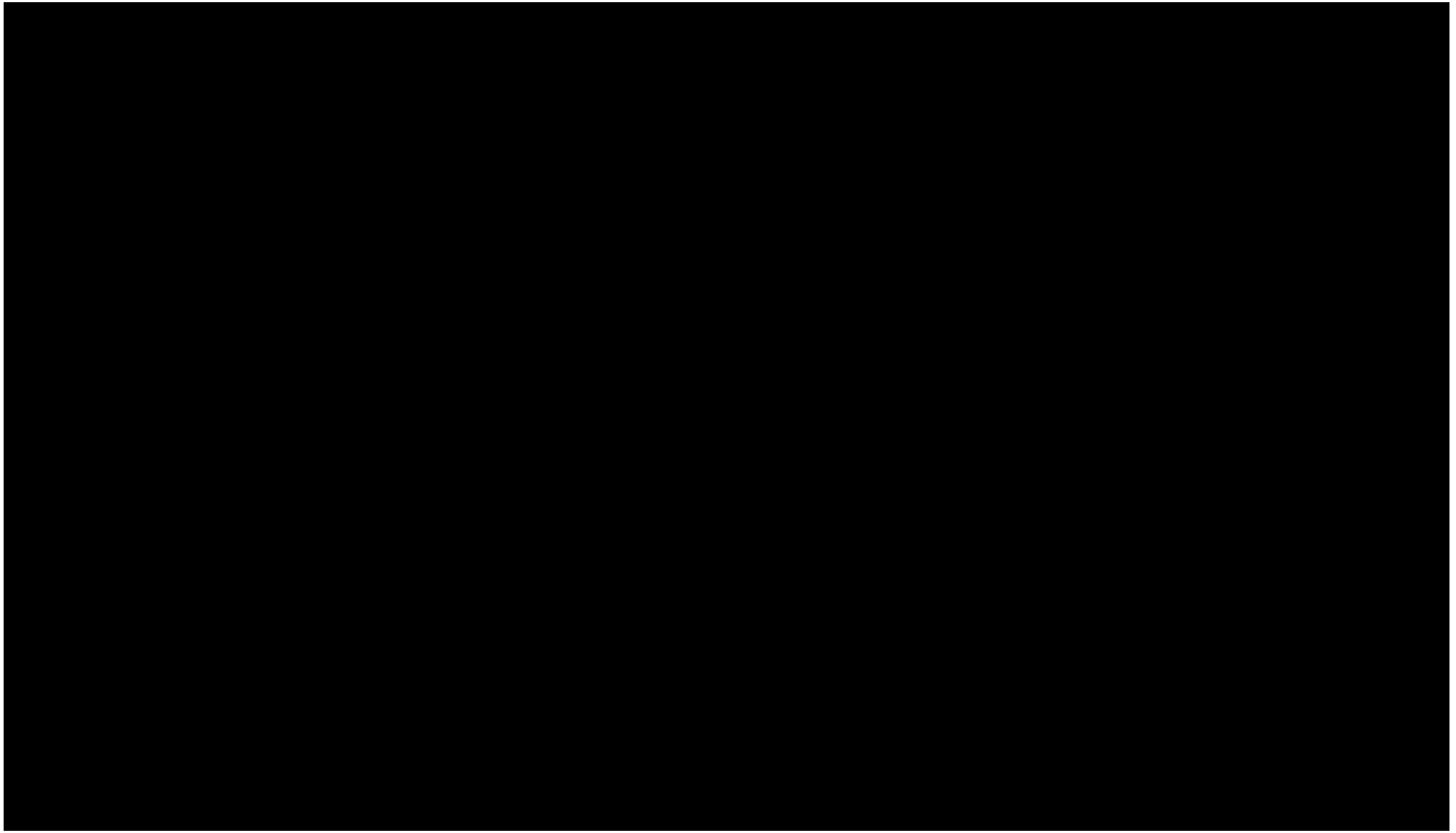
To promote the understanding and prevention of suicide and support those who have been affected by it.
www.suicidology.org

American Foundation for Suicide Prevention (AFSP)

AFSP raises awareness, funds scientific research and provides resources and aid to those affected by suicide.
www. afsp.org

The National Action Alliance for Suicide Prevention (Action Alliance)

Action Alliance is working with more than 250 national partners from the public and private sectors to advance the *National Strategy for Suicide Prevention (National Strategy)*.
https://theactionalliance.org/



Questions

JUSTICE FOR VETS

NADCP
National Association of Drug Court Professionals

NDCI
NATIONAL DRUG COURT INSTITUTE
est. 1997

NCDC
NATIONAL CENTER FOR DWI COURTS
est. 2007

JUSTICE FOR VETS
est. 2010

Selected References

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Pease, J.L., Billera, M., & Gerard, G. (2016). Military culture and the transition to civilian life: Risk and other considerations. Social Work, *61*(1), 83-86.

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Suicide Prevention Resource Center. (n.d.). *Risk and Protective Factors for Suicide.* Retrieved from https://www.sprc.org

U.S. Department of Veterans Affairs. (2018). *VA national suicide data report.* Washington, DC: Author.

Reform & Responsibility of Impaired Drivers

Virginia State Conference

Critical Issue

Impaired drivers engage in **behavior** that is dangerous and frequently causes serious injury or fatalities

The Problem

Applying the wrong intervention may have undesirable effects

Treatment alone

Intensive supervision

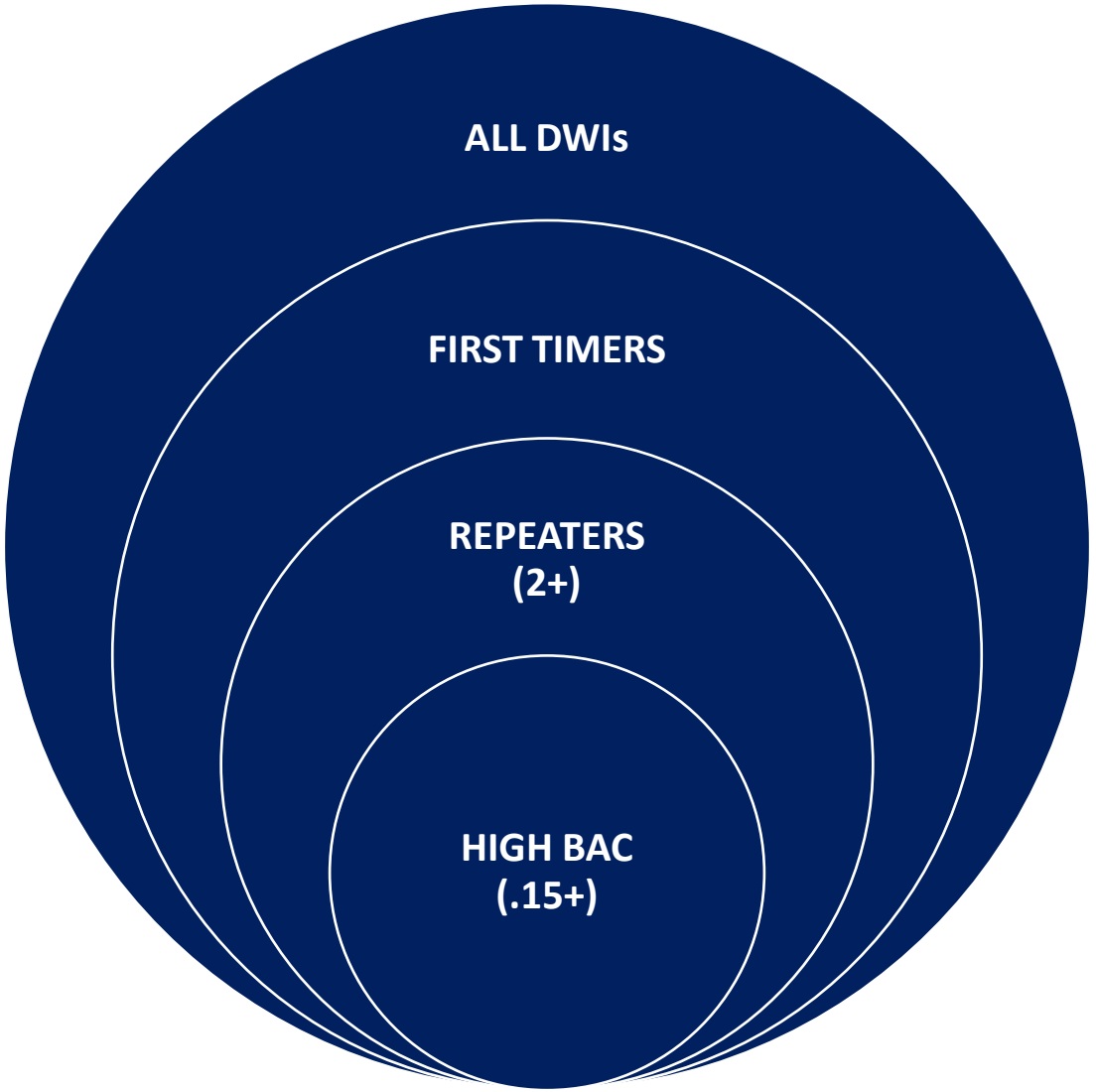
Frequent testing

Ignition interlock

Incarceration

DUI courts

TARGETING IMPAIRED DRIVERS



Risk-Need-Responsivity (RNR)

Model as a Guide to Best Practices

RISK

WHO

Match the intensity of the individual's intervention to their risk of reoffending

Deliver more intense intervention to higher-***risk*** offenders

NEED

WHAT

Target criminogenic needs: antisocial behaviors and attitudes, SUD, and criminogenic peers

Target criminogenic ***needs*** to reduce risk for recidivism

RESPONSIVITY

HOW

Tailor intervention to learning style, motivation, culture, demographics, and abilities of the offender

Address the issues that affect ***responsivity***

Substance Use Disorders

Approximately two-thirds of convicted impaired drivers are alcohol dependent (Lapham et al., 2001).

91% of male and 83% of female impaired drivers have met the criteria for alcohol use disorder at some point in their lives (Lapham et al., 2000).

In addition, 44% of men and 33% of women qualified for past-year disorders.

Substance Use Disorders

Approximately 11-12% of impaired drivers are multiple drug users who report significant involvement in drugs other than alcohol or marijuana (Wanberg et al. 2005).

38% of male and 32% of female impaired drivers have met the criteria for drug use disorder at some point in their lives (Lapham et al., 2001).

Co-occurring Disorders

While research has shown that impaired drivers frequently have a substance use disorder, many of them also have a psychiatric condition.

The presence of a substance use disorder actually ***increases*** an individual's likelihood of having other psychiatric disorders.

Co-occurring Disorders

In a study of repeat impaired drivers, it was found that 45% had a lifetime major mental disorder.

Another study that examined the prevalence of these disorders by gender found that 50% of female impaired drivers and 33% of male impaired drivers have at least one psychiatric disorder.

Mental health issues often linked to impaired drivers include:

- Depression
- Bipolar disorder
- Anxiety
- Conduct disorder
- Anti-social personality disorder
- Post-traumatic stress disorder (PTSD)

Mental Health

- ✓Very high level of psychiatric co-morbidity in DUI populations.
- ✓Mental health issues linked to recidivism.
- ✓Treatment has traditionally consisted of alcohol education or interventions that focus solely on alcohol or substance use.
- ✓Screening or assessment for mental health issues is not always available/performed.
- ✓Treatment providers rarely have the training/experience to identify mental health issues among their clients.

Subsequently, in many cases, problems are not identified or addressed.

Impaired Drivers are Unique

Often lack an extensive criminal history

High degree of denial and separation

- ✓**Alcohol is legal, highly prevalent, and encouraged by societal norms**
- ✓**Tend to be employed**
- ✓**May have a stable social network**
- ✓**Do not view themselves as "criminals"**

Repeatedly engage in dangerous behavior

Impaired drivers tend to score lower on traditional risk assessments

Screening & Assessment

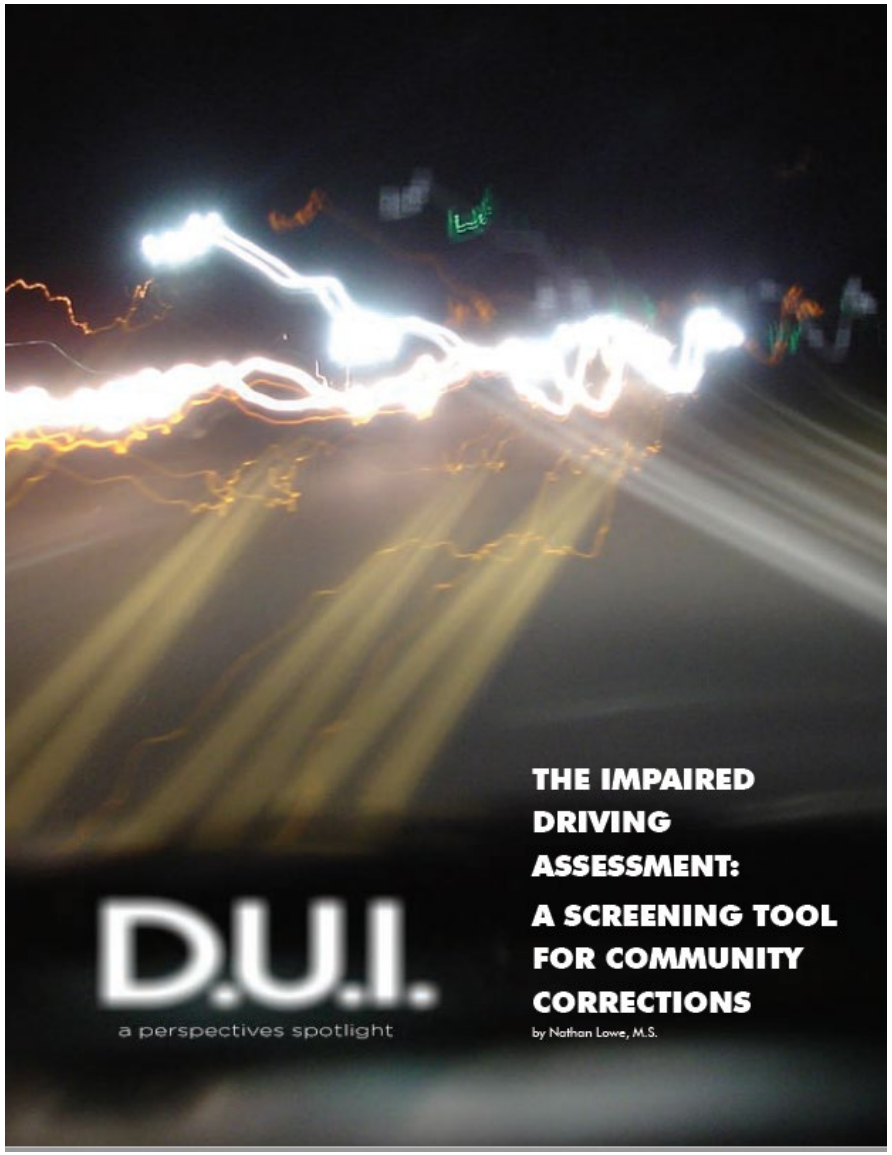
<u>Screening</u> versus <u>Assessments</u>

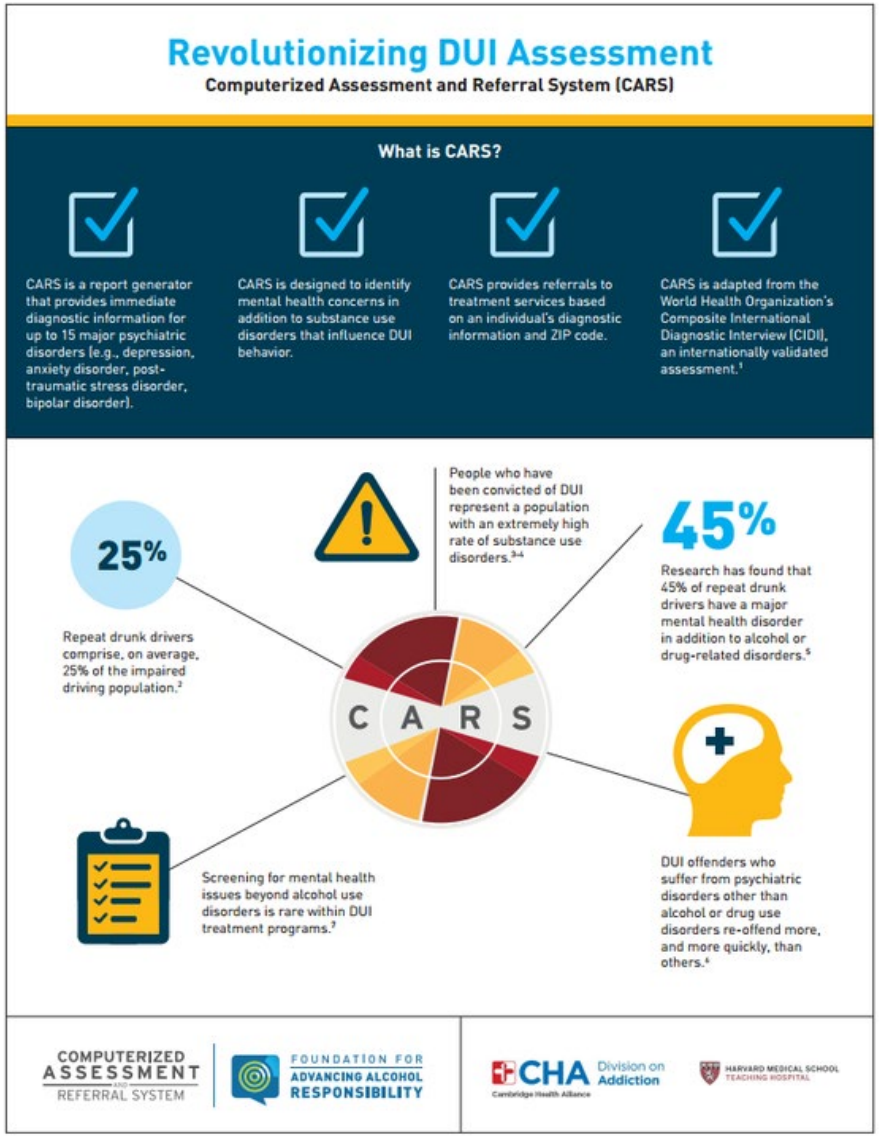
Timing: early and repeated

Validated assessments should be used to inform

- ✓**Sentencing decisions**
- ✓**Case management plans**
- ✓**Supervision levels**
- ✓**Treatment referrals and case planning**

Validated Assessments are Critical





VALIDATED ASSESSMENTS ARE CRITICAL

www.carstrainingcenter.org

Webinar

www.dwicourts.org

Webinar

www.dwicourts.org

Mark Stodola

APPA Probation Fellow

probationfellow@csg.org

Clinical Assessment

Need Principle

- Clinical syndromes or impairments (diagnosis)
- Cause crime ("criminogenic") or interfere with rehabilitation ("responsivity")
- Addiction is criminogenic and serious mental illness interferes with response to rehabilitation.
- The higher the need level, the more intensive the treatment or rehabilitation services should be, and vice versa.
- Mixing need levels in not advised

DSM-5

A ***substance use disorder*** is defined as having two or more symptoms in the past year resulting in distress or impairment.

The diagnosis is made separately for each substance.

Severity is rated by the number of symptoms present:

2–3 = mild
4–5 = moderate
6+ = severe

What is Need?

Clinical Need

Diagnosed:

= Substance Use Disorder (Mod to Severe)

= Mental Health Disorder

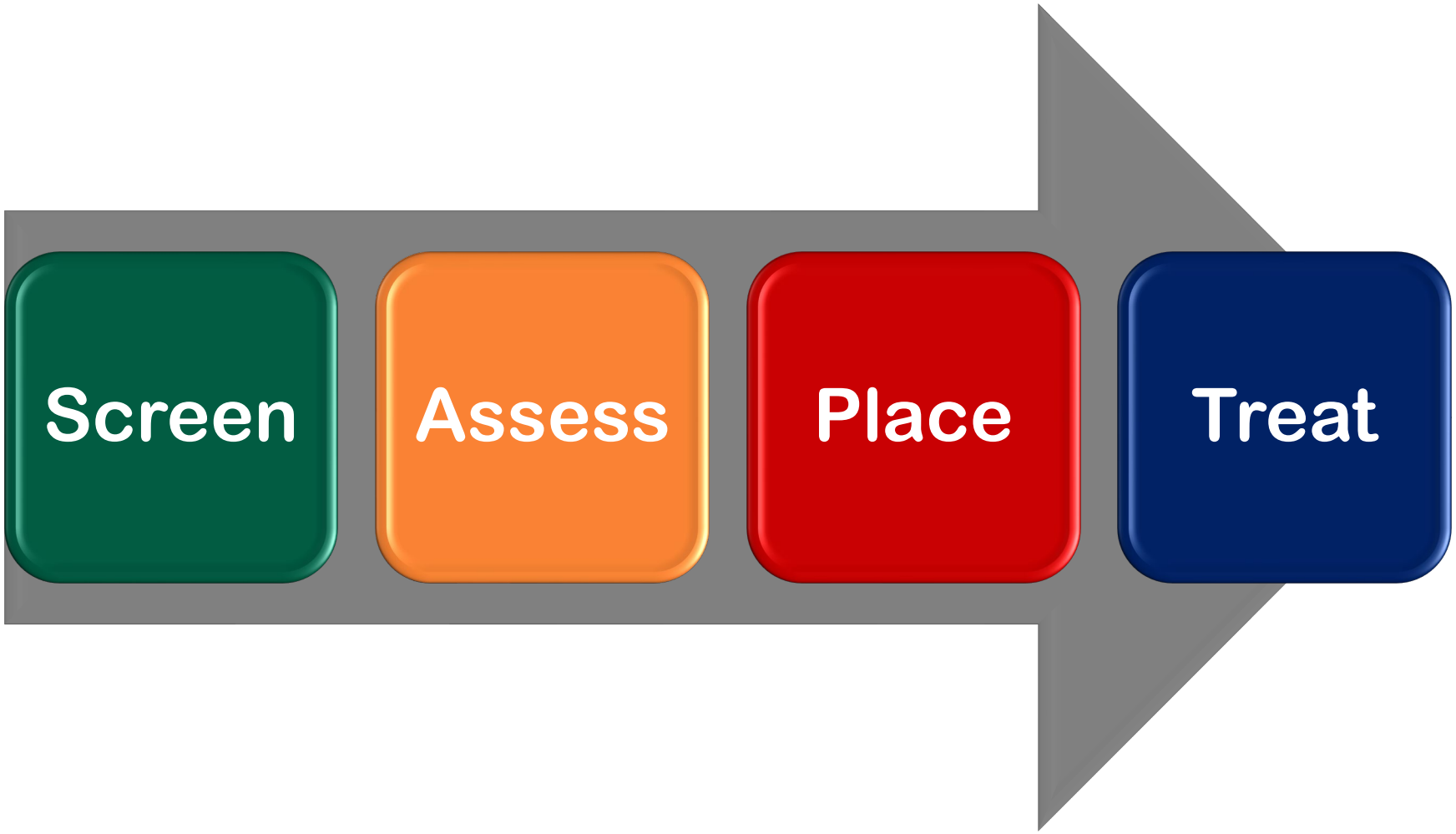
= Both

Need = What level and type of drug and alcohol/mental health treatment is required for recovery?

Is it life threatening? (e.g., detox, suicide watch)
Can they be treated safely in the community? (e.g., outpatient)

TREATMENT


120
DIAGNOSIS
TREATMENT
SUPPORT
RECOVERY


Screen
Assess
Place
Treat

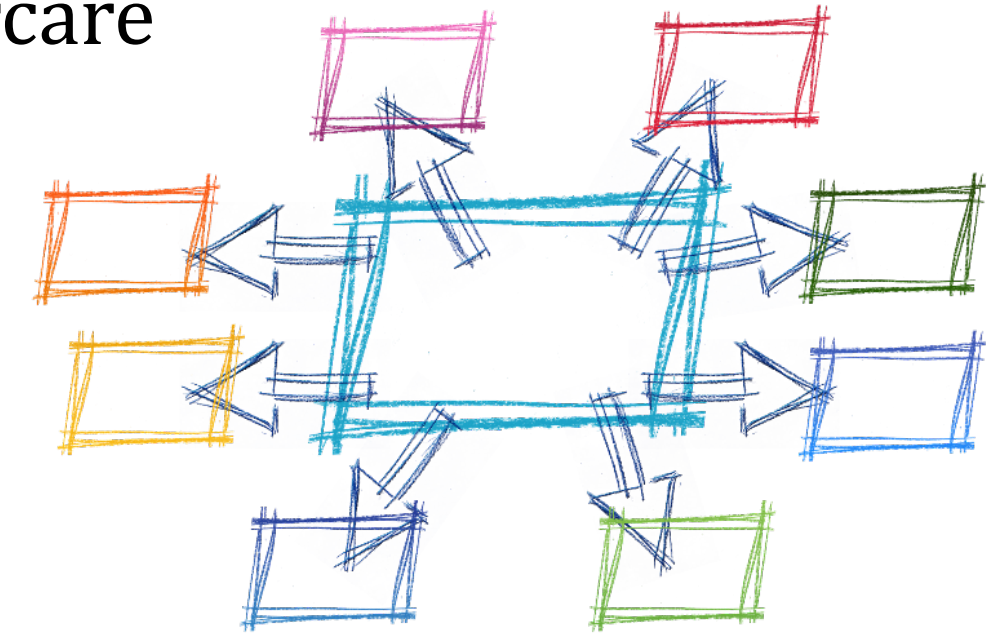
ASAM Criteria – Place

Placement Recommendation		Treatment Hours per Week
Level 0.5 – Early intervention	→	Education/minimal
Level 1 – Outpatient services	→	Less than 9 hours per week
Level 2.1 – Intensive outpatient	→	9 hours or more per week
Level 3.1 – Clinically managed low-intensity residential services	→	24-hour structure; 5+ hours clinical week

Unified Case Planning – Treat

Levels of Care

- ✔ Manualized treatment
- ✔ Individualized treatment plans
- ✔ Continuation of care/aftercare
- ✔ Recovery coaches
- ✔ Recovery support groups
- ✔ Peer mentors



High Risk

High Need

DUI Courts

Tony Overman/The Olympian: Reprinted with permission. Link to article: http://www.theolympian.com/news/local/crime/article118603968.html

WHAT IS A DUI COURT?

change behavior

collaborative team approach

court monitoring

holistic and comprehensive

accountability

high-risk / high-need

frequent alcohol and drug testing

long-term treatment

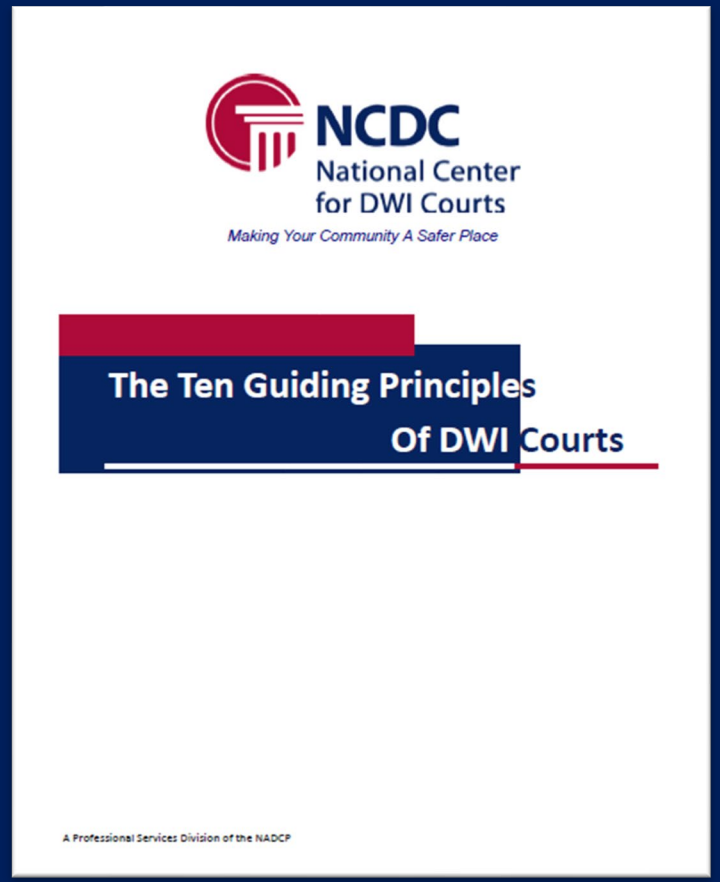
recovery

intensive supervision

non-adversarial

10 Guiding Principles

1. Target the Population
2. Provide a Clinical Assessment
3. Develop the Treatment Model
4. Supervise and Detect Behavior
5. Develop Community Partnerships
6. Take an Active Judicial Role
7. Provide Case Management
8. Solve Transportation Barriers
9. Evaluate the Program
10. Ensure Sustainability



GUIDING PRINCIPLE #1

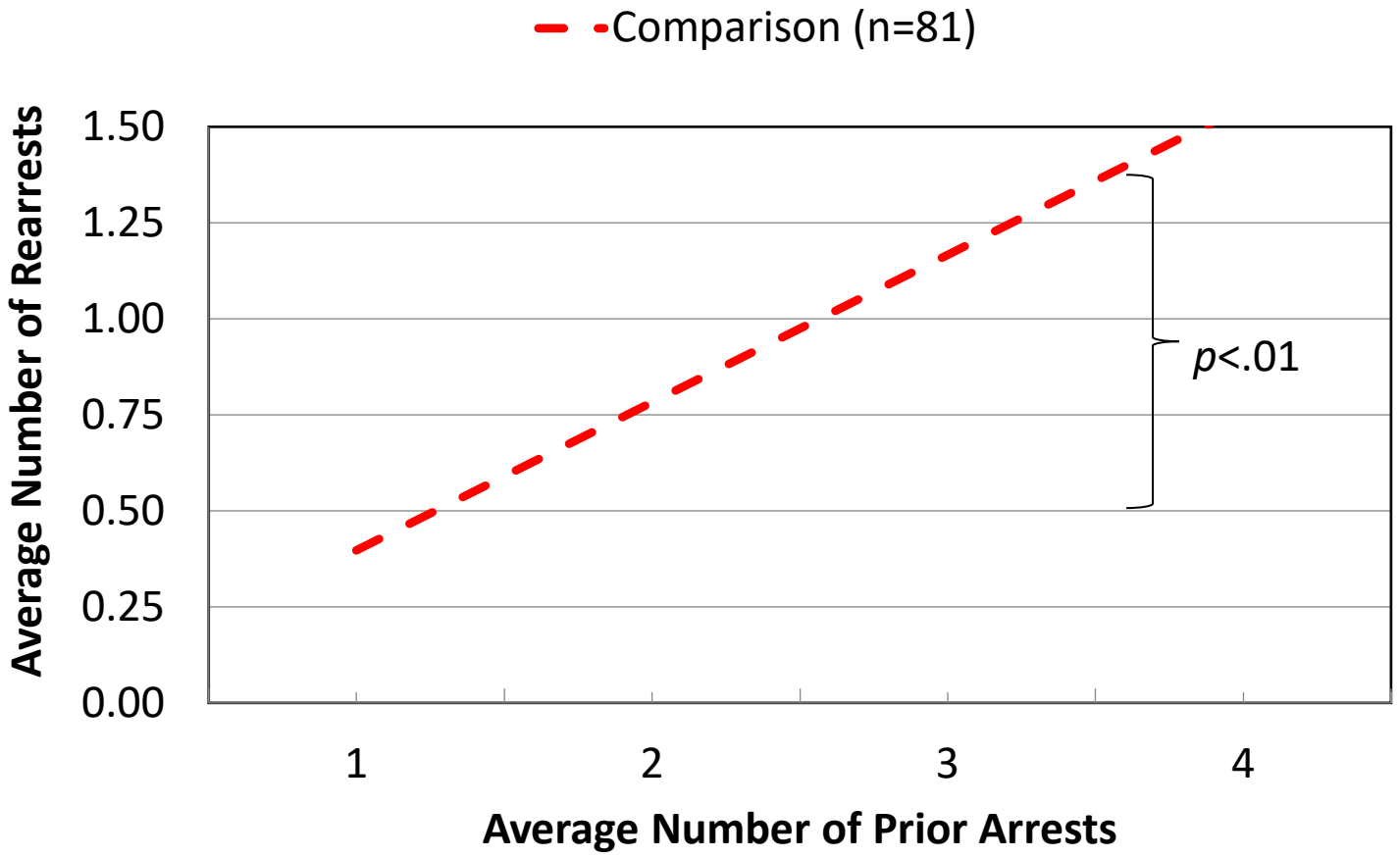
Determine the Population

- Public safety
- Assessments
- Victim(s)
- Prompt placement

EFFECTIVE: HIGH-RISK

Average Number of Rearrests by Number of Prior Arrests at 2 Years

MN DWI Court Study
9 Sites

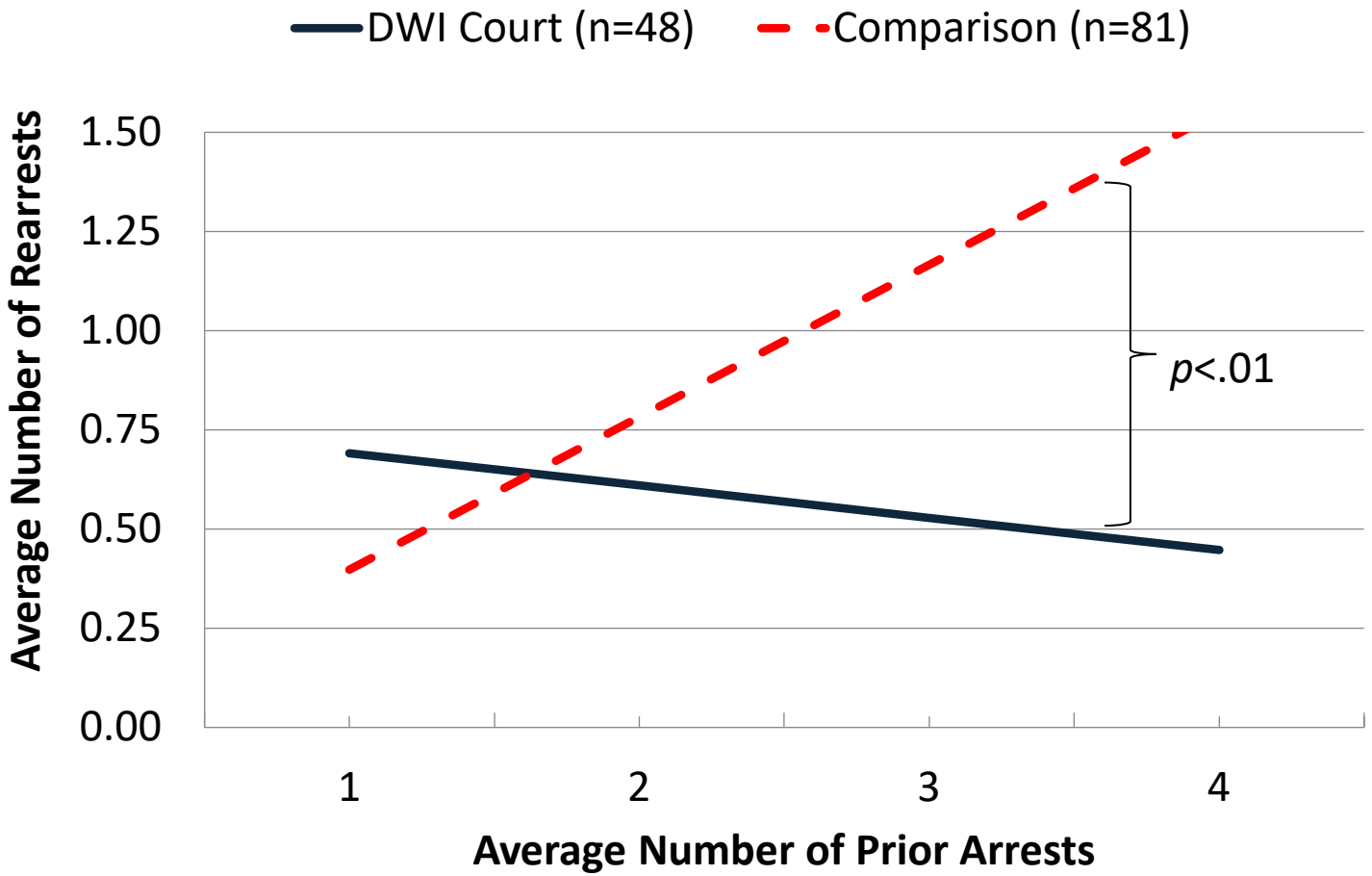


NPC Research

EFFECTIVE: HIGH-RISK

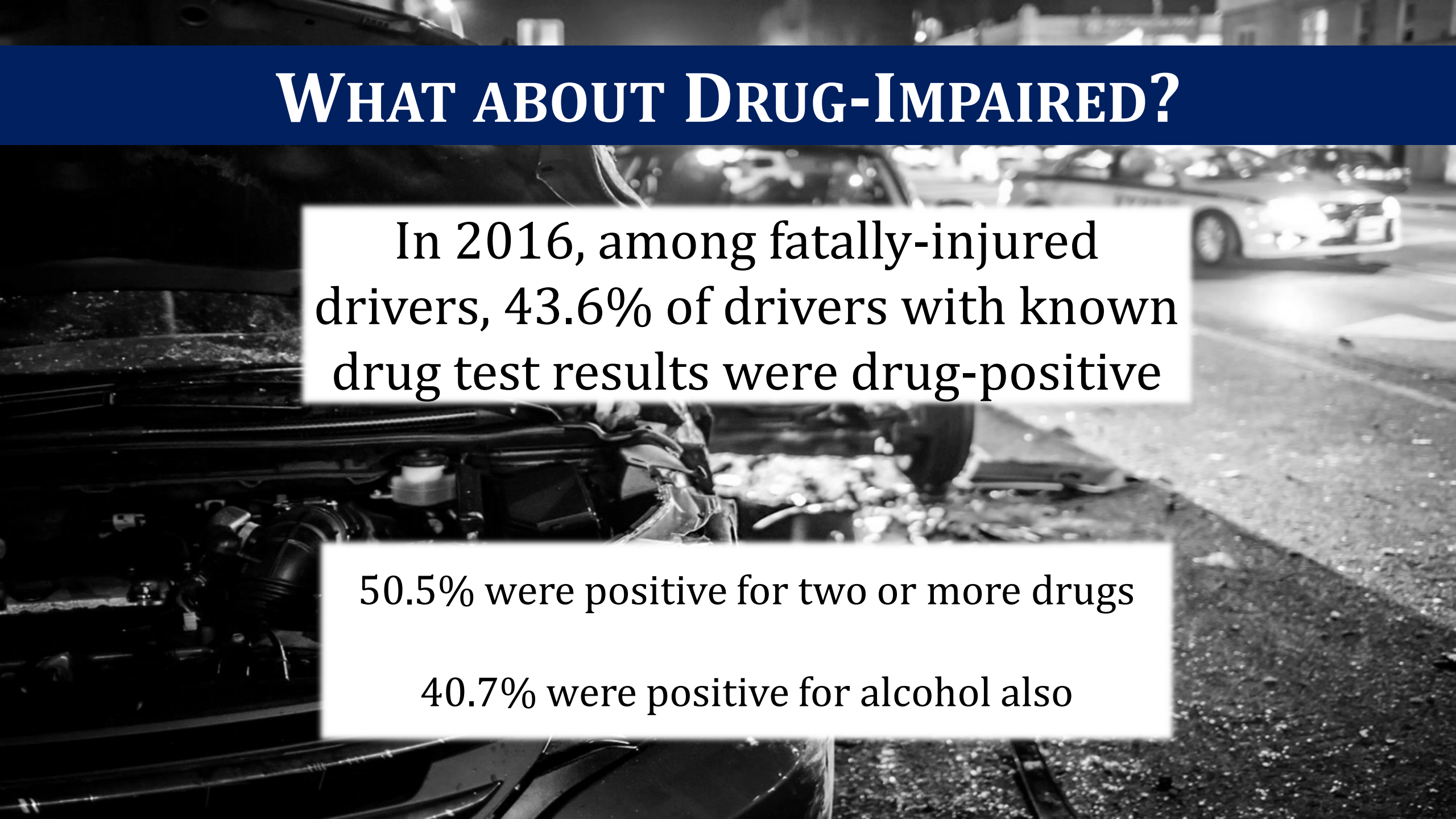
Average Number of Rearrests by Number of Prior Arrests at 2 Years

MN DWI Court Study
9 Sites



NPC Research

What about Drug-Impaired?



In 2016, among fatally-injured drivers, 43.6% of drivers with known drug test results were drug-positive

50.5% were positive for two or more drugs

40.7% were positive for alcohol also

Poly-Substance Use

Focus on the behavior,

not the drug of choice.

Addiction is a disease and

drug of choice is a moving target.

Female Impaired Drivers

- ✔ Ages range from late teens to 60's
- ✔ Diverse education, employment and family backgrounds
- ✔ More likely to be single (divorced or separated, never married)
- ✔ Often present with a more complex range of issues
  - ✔ Mental health disorders (often undiagnosed)
    - ✔ Trauma
    - ✔ Anxiety
    - ✔ Depression
- ✔ Women experience a more rapid development of alcohol use disorder

Female Impaired Drivers

- Many women define their experiences in terms of emotional reactions
  - shame
  - depression
  - anxiety
- They were concerned that emphasis was placed on the <u>offense</u> and not on the underlying facts
- Women reported that their sentence failed to account for life circumstances or address their issues

"You know my name, not my story."

GUIDING PRINCIPLE #4

Supervise the Offender

- Public safety
- Criminal thinking programming

Guiding Principle #4

Supervise the Offender

- Testing
  - Polysubstance users
  - Alcohol testing
    - Daily in first three phases (240 days)
    - 2x/week in the fourth phase (90 days)
    - Random in the final phase (90 days)
- Technology
  - PBT; EtG/EtS; transdermal; smartphone/mobile
  - Ignition interlock

GUIDING PRINCIPLE #5

<u>Forge Agency, Organization, & Community Partnerships</u>

- Victim advocacy groups
- MADD supports the use of post-adjudication DUI courts… also recommends should not be used to avoid a record of conviction or license sanctions
- Law enforcement

GUIDING PRINCIPLE #8

Address Transportation Issues

- Loss of license or restrictions
- Monitoring compliance
- Use of ignition interlock

2016 Michigan Sobriety Court Ignition Interlock Evaluation

- Interlock Program Participants (IPP) have the lowest recidivism rates after one, two, three and four years of follow-up
- IPP have substantially higher rates of educational improvement
- Multivariate analysis suggests that offenders in sobriety court who are not under interlock supervision have over 3 times the odds of failing out of the treatment court program when compared to sobriety court participants using ignition interlocks

GUIDING PRINCIPLE #9

Evaluate the Program

- Different or additional outcomes to measure
  - DUIs in addition to general crimes
  - Crashes

EFFECTIVE: CRASHES

San Joaquin County, California

DUI court participants were half as likely to be involved in an alcohol- or drug-related crash over a period of 18 months (2012).

GUIDING PRINCIPLE #10

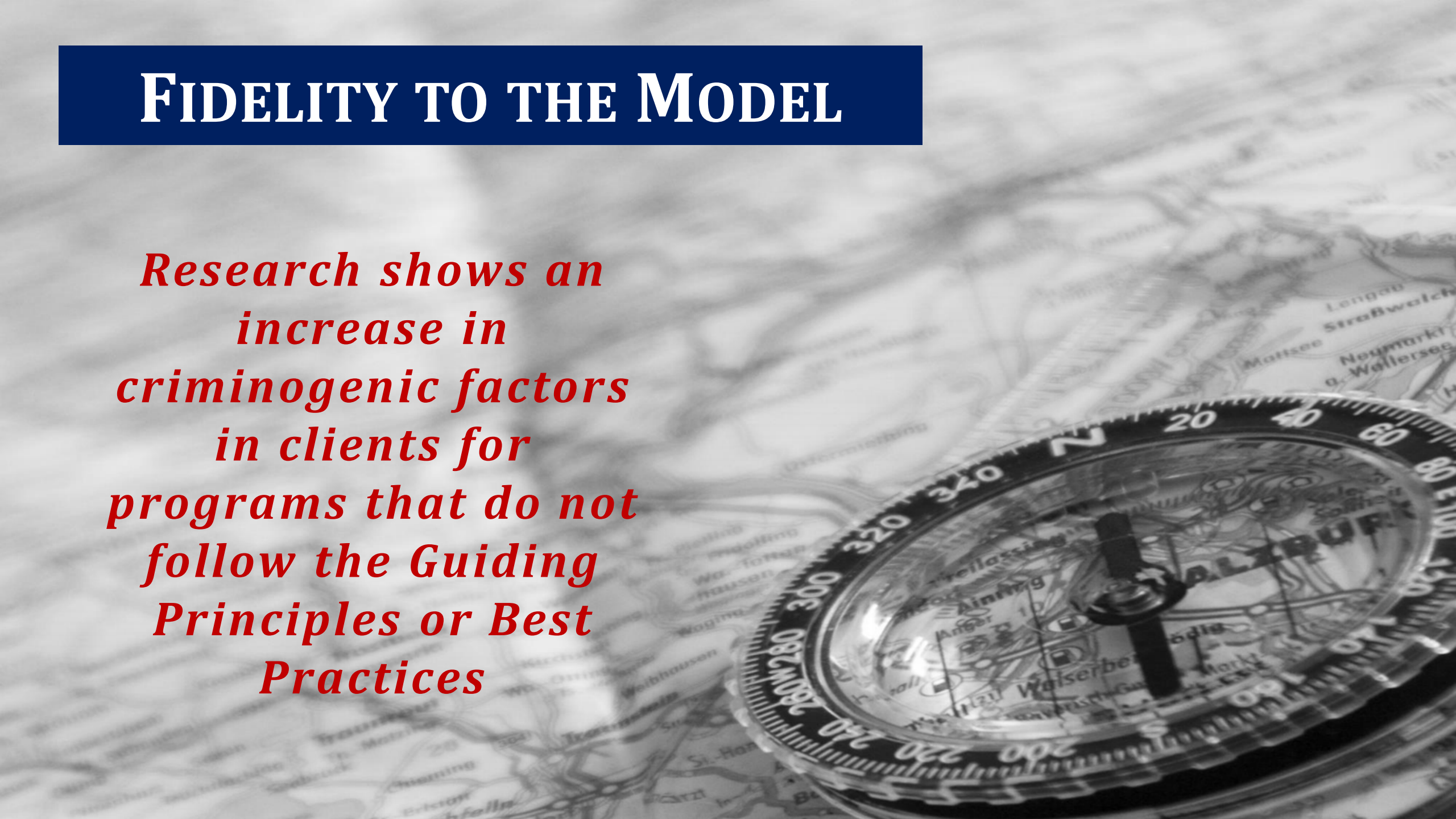
Ensure a Sustainable Program

- Funding sources
  - National Highway Traffic Safety Administration (NHTSA)
  - State Highway Safety Office (SHSO)
  - Non-traditional partners
- Public safety considerations

  …preparing for a tragic event

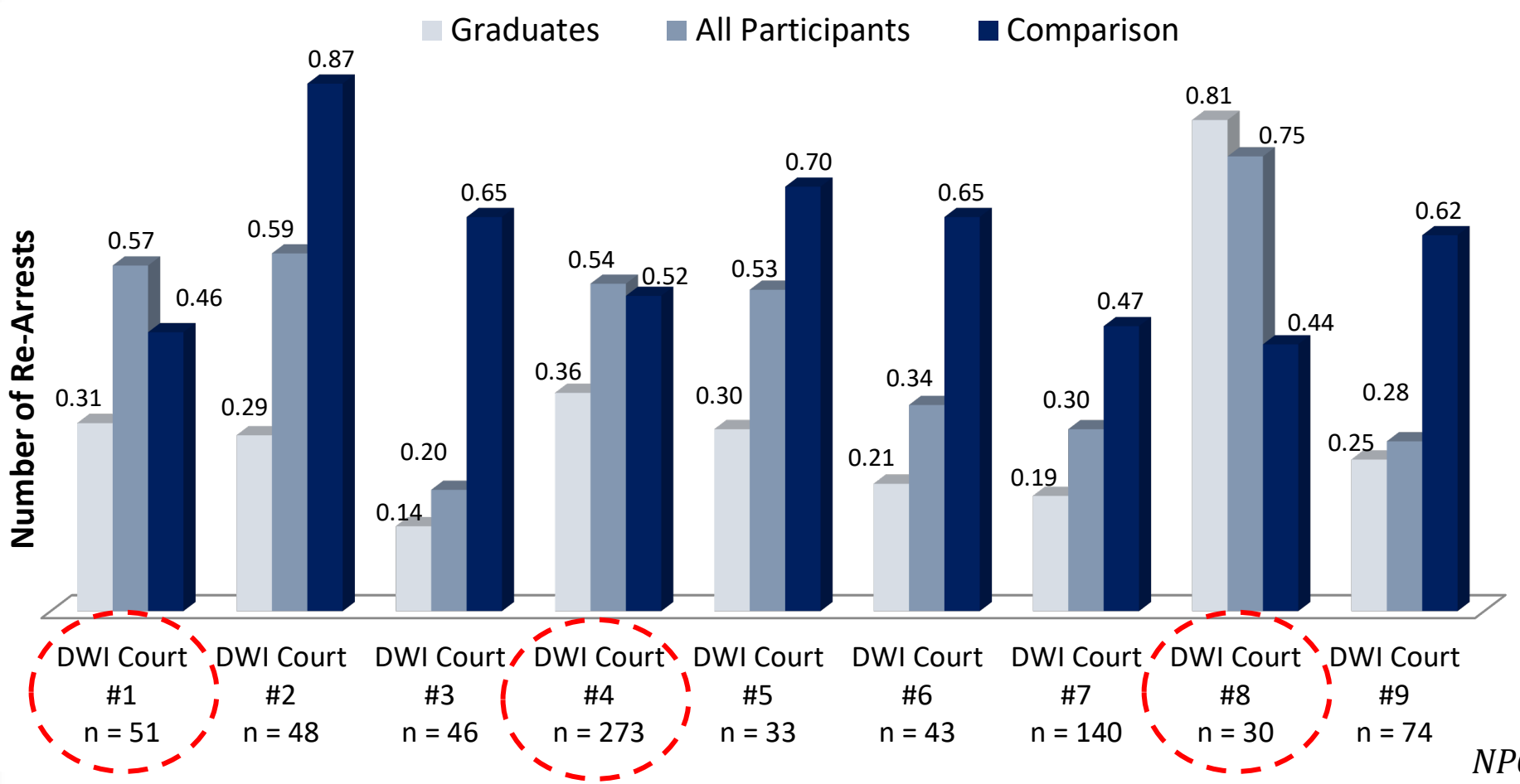
Fidelity to the Model

Research shows an increase in criminogenic factors in clients for programs that do not follow the Guiding Principles or Best Practices



Fidelity to the Model

Participants (regardless of graduation status) at the majority of MN's 9 DWI Courts had lower re-arrest rates but not all of them



NPC Research

STRENGTH AT HOME

Trauma and Intimate Partner Violence

Casey Taft, Ph.D.
National Center for PTSD, VA Boston Healthcare System
Boston University School of Medicine

National Center for PTSD
Posttraumatic Stress Disorder

ADVANCING SCIENCE AND PROMOTING UNDERSTANDING OF TRAUMATIC STRESS

Intimate Partner Violence Etiology

Survival Mode Model

- Vigilance to threats in warzone leads combat veteran to enter into survival mode inappropriately when stateside
- Perceive unrealistic threats
- Exhibit hostile appraisal of events
- Overvalue aggressive responses to threats
- Exhibit lower threshold for responding to the threat

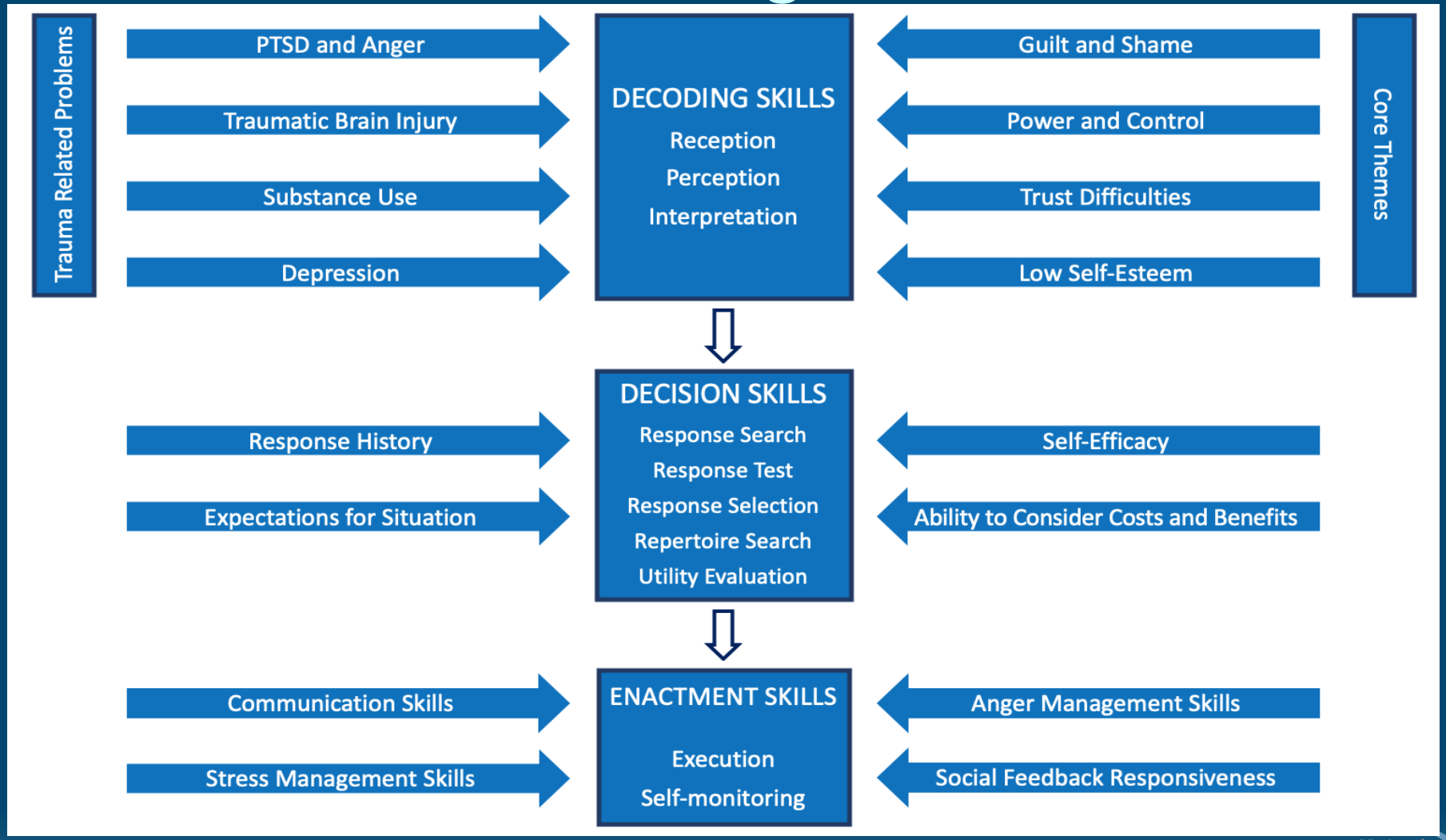
Chemtob et al., 1997

Social Information Processing Model

- Individuals using partner aggression exhibit cognitive deficits (e.g., faulty attributions) that impact interpretation (decoding stage)
- Individuals using partner aggression have deficits generating variety of nonviolent responses (decision skills stage)
- Individuals using partner aggression lack skills to enact competent response (enactment stage)
- Influenced by factors that impact executive functioning (e.g., alcohol use and traumatic brain injury), psychiatric factors (e.g., PTSD and depression), and core themes

Holtzworth-Munroe, 1992

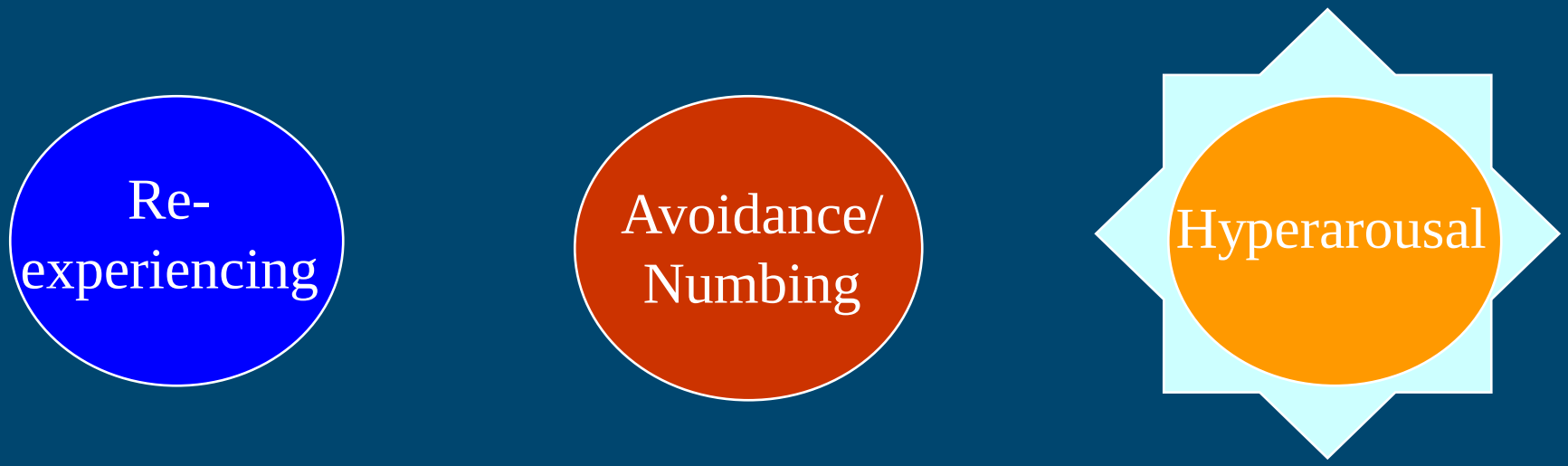
Trauma-Informed Social Information Processing Model



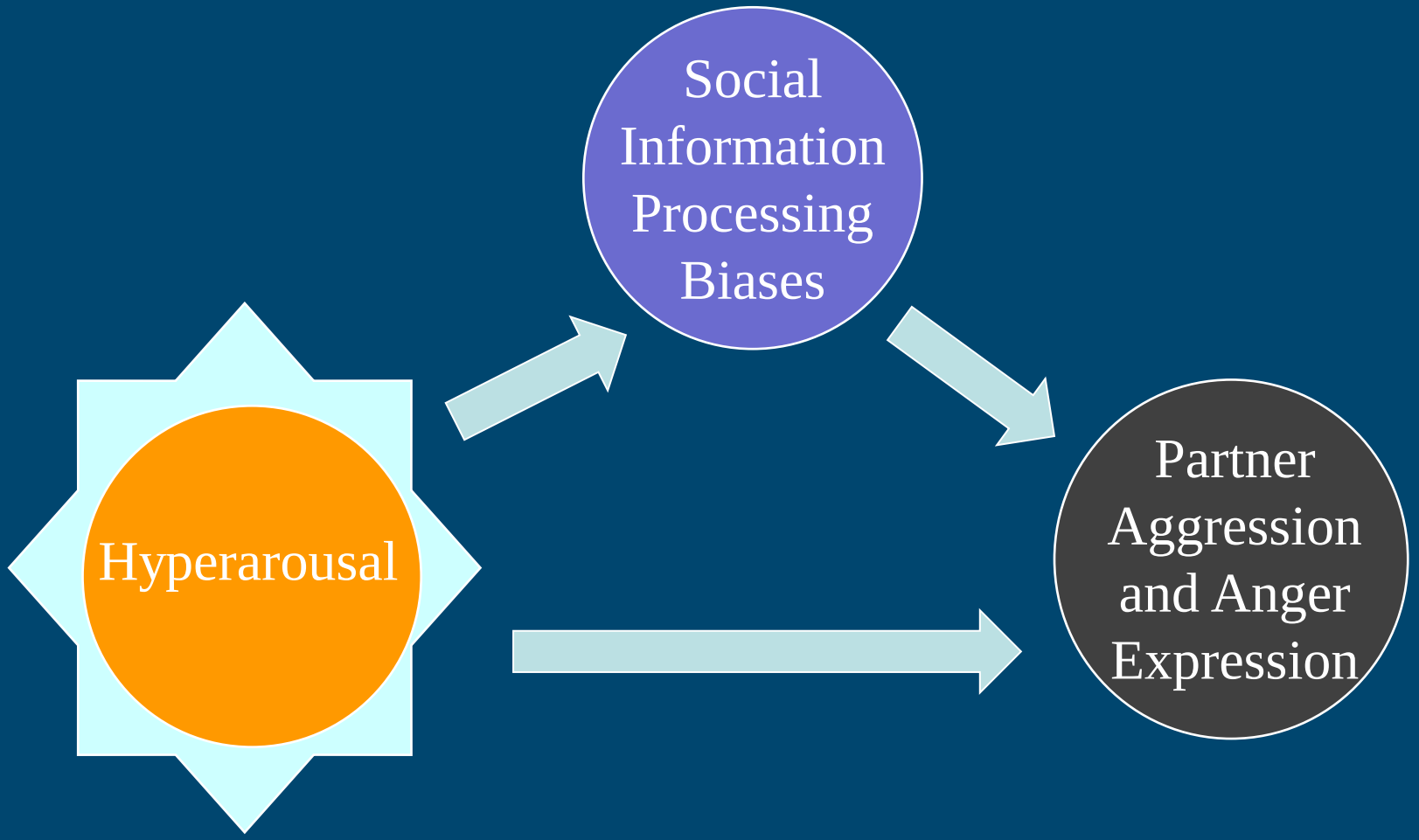
PTSD and Intimate Partner Violence

- Service members without PTSD not more aggressive than civilians (Bradley, 2007)
- Physical aggression in National Vietnam Veterans Readjustment Study (Kulka et al., 1990)
  - Veterans with PTSD = 33%
  - Veterans without PTSD = 13.5%
- Meta-analytic results (Taft et al., 2011)
  - PTSD and physical aggression: *r* = .42
  - PTSD and psychological aggression: *r* = .36

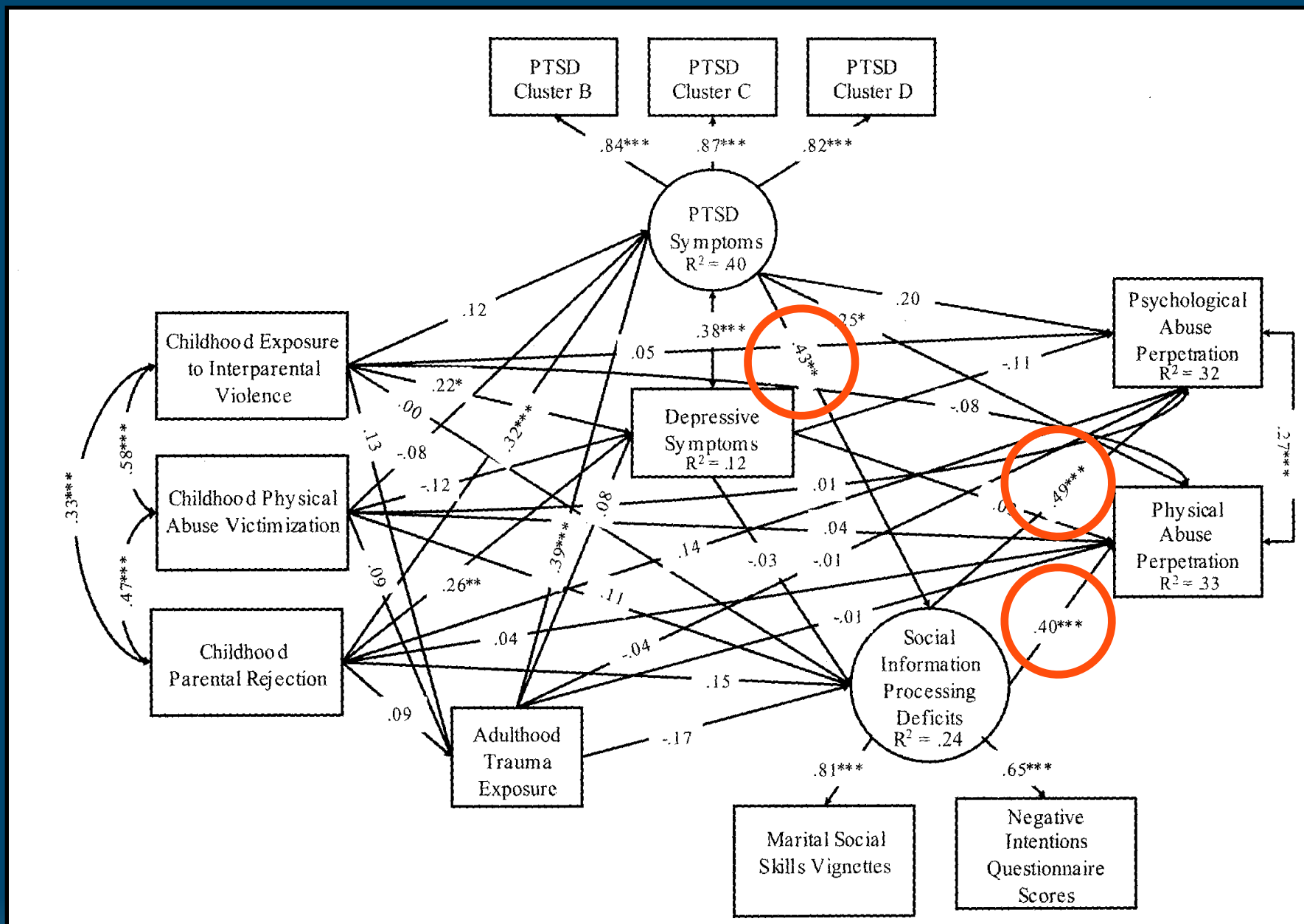
PTSD and Partner Aggression



e.g., Taft et al., 2007



Taft et al., 2015



Taft et al., 2008

Core Themes

1) Trust
2) Self-Esteem
3) Power Conflicts
4) Guilt and Shame

Trust

- Trauma may have been caused by someone who was supposed to be trustworthy
- Others may have made poor decisions or mistakes
- May feel they can't trust anyone or others are out to hurt or betray them
- Mistrust can carry over into relationships
- Controlling behavior may result

Self-Esteem

- May unfairly blame self for trauma
- Low self-esteem leads to relationship insecurity, controlling behavior, and partner aggression

Power Conflicts

- Partner aggression theories highlight power and control beliefs (Pence & Paymar, 1993)
- Exposure to trauma may contribute to a sense of powerlessness
- Feelings of powerlessness contribute to power conflicts in relationships
- Military communication regarding power and control may impact relationship communication

Shame

- Client may experience trauma-related shame
- Aggression may represent maladaptive effort to avoid shame and associated feelings of weakness, inferiority, and worthlessness (Gilligan, 2003)
- Shame hinders responsibility-taking

Intimate Partner Violence Intervention

National Center for PTSD
Posttraumatic Stress Disorder

Lack of Empirically Supported Interventions

- No prior randomized clinical trial has shown treatment effects in military population (e.g., Dunford, 2000)
- Those receiving interventions in other settings average 5% reduction in recidivism relative to untreated groups (Babcock et al., 2004)
- Barriers for randomized controlled trials
  - Randomizing violent individuals to no-treatment controls
  - Arrest and monitoring reduces partner aggression
  - Lack of partner contact

Limitations of Existing Interventions

- Often not trauma informed
- Often deemphasize psychiatric factors
- Many are not considered “therapy”
- Often large, impersonal groups

Strength at Home

National Center for PTSD
Posttraumatic Stress Disorder

Program Objectives

- Department of Defense
- Department of Veterans Affairs
- Model program for treating partner aggression in service members/veterans and civilians

Structure and Format

- Clients who have engaged in physical or psychological partner aggression
- Closed groups
- 12 weekly 2-hour sessions
- 3-8 clients per group
- Male and female co-therapist (preferred)
- Additional monitoring, treatment, and support

Intimate Partner Involvement

- Contacted before group begins and after group completion
- Safety planning, hotline numbers, mental health services, other support
- Perceptions of partner aggression
- Program feedback

Interventions Informing Strength at Home

- Intervention for partner aggression (Murphy & Scott, 1996)
- Cognitive Processing Therapy for PTSD (CPT; Resick & Schnicke, 1992)

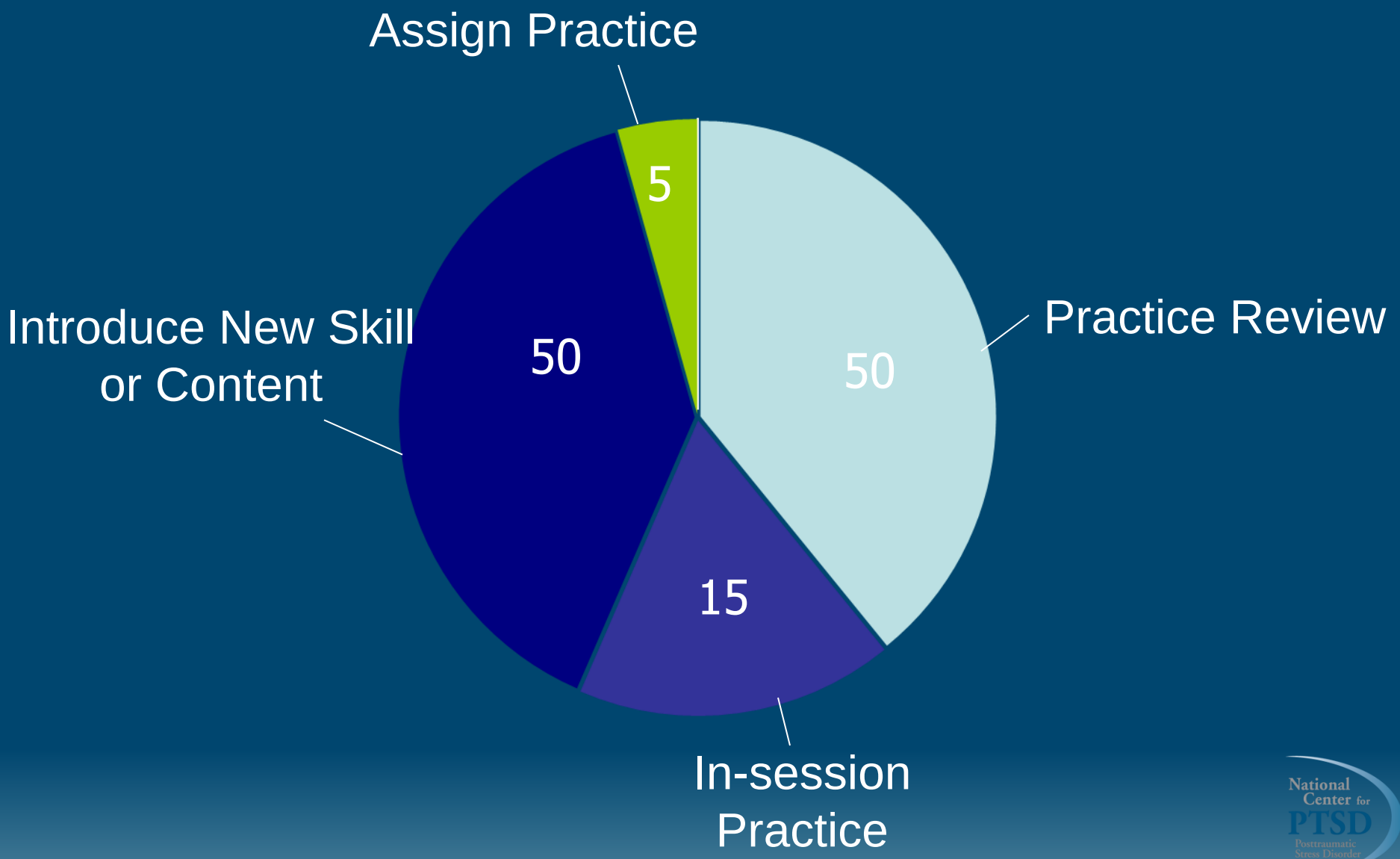
Program Stages

National Center for PTSD
Posttraumatic Stress Disorder

Strength at Home Stages

Stage 1 **Psychoeducation** **(Sessions 1-2)**	• Pros/cons of abuse • Forms of IPV and impacts of trauma • Core themes • Goals for group
Stage 2 **Conflict Management** **(Sessions 3-4)**	• The anger response • Self-monitor thoughts, feelings, physiological responses • Assertiveness • Time Outs to de-escalate difficult situations
Stage 3 **Coping Strategies** **(Sessions 5-6)**	• Anger-related thinking • Realistic appraisals of threat and others' intentions • Coping with stress • Problem-focused versus emotion-focused coping • Relaxation training for anger
Stage 4 **Communication Skills** **(Session 7-12)**	• Roots of communication style • Active listening • Assertive messages • Expressing feelings • Communication "traps"

Overall Session Structure



Studies in Service Members and Veterans

National Center for PTSD
Posttraumatic Stress Disorder

A Randomized Controlled Clinical Trial of the Strength at Home Men's Program for Partner Violence in Military Veterans

Casey T. Taft, PhD[a,*]; Alexandra Macdonald, PhD[a]; Suzannah K. Creech, PhD[b]; Candice M. Monson, PhD[c]; and Christopher M. Murphy, PhD[d]

ABSTRACT

Objective: We evaluated the efficacy of the Strength at Home Men's Program (SAH-M), a trauma-informed group intervention based on a social information processing model to end intimate partner violence (IPV) use in a sample of veterans/service members and their partners. To date, no randomized controlled trial has supported the efficacy of an IPV intervention in this population.

Method: Participants included 135 male veterans/service members and 111 female partners. Recruitment was conducted from February 2010 through August 2013, and participation occurred within 2 Department of Veterans Affairs hospitals. Male participants completed an initial assessment that included diagnostic interviews and measures of physical and psychological IPV using the Revised Conflict Tactics Scales and were randomly assigned to an enhanced treatment as usual (ETAU) condition or SAH-M. Those randomized to SAH-M were enrolled in this 12-week group immediately after baseline. Those randomized to ETAU received clinical referrals and resources for mental health treatment and IPV services. All male participants were reassessed 3 and 6 months after baseline. Female partners completed phone assessments at the same intervals that were focused both on IPV and on the provision of safety information and clinical referrals.

Results: Primary analyses using hierarchical linear modeling indicated significant time-by-condition effects such that SAH-M participants compared with ETAU participants evidenced greater reductions in physical and psychological IPV use ($\beta = -0.135$ [SE = 0.061], $P = .029$; $\beta = -0.304$ [SE = 0.135], $P = .026$; respectively). Additional analyses of a measure that disaggregated forms of psychological IPV showed that SAH-M, relative to ETAU, reduced controlling behaviors involving isolation and monitoring of the partner ($\beta = -0.072$ [SE = 0.027], $P = .010$).

Conclusions: Results provide support for the efficacy of SAH-M in reducing and ending IPV in male veterans and service members.

Trial Registration: ClinicalTrials.gov Identifier: NCT01435512

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Intimate partner violence (IPV) in veterans and service members is a serious public health problem, with notable elevations in IPV found among those who experience symptoms of posttraumatic stress disorder (PTSD).[1,2] The scope of this problem is underscored by the fact that 23 million veterans reside in the United States, and the total US military force currently includes over 1.4 million active duty personnel, of which 55% are married and 86% are male.[3]

There is a pressing need to deliver effective IPV intervention for veterans and military families. The Strength at Home Men's Program (SAH-M) was developed with this aim in mind. SAH-M is a cognitive-behavioral, trauma-informed group therapy program that is based on social information processing models of trauma and IPV.[4–6] Evidence from pilot studies suggests the effectiveness of SAH-M in reducing physical and psychological IPV,[7,8] but a more rigorous randomized controlled clinical trial is needed to demonstrate program efficacy.

To date, no randomized controlled trial in a military or veteran population has demonstrated the efficacy of an IPV intervention in reducing or preventing IPV use.[9] Although the research base is limited, negative findings mirror those from nonmilitary settings that have shown IPV intervention programs to have very modest effects, with those receiving IPV interventions averaging a reduction in recidivism of only 5% relative to untreated groups.[10]

We examined the efficacy of SAH-M relative to an enhanced treatment as usual (ETAU) condition in which the veteran/service member and their partner received referrals and monitoring. We hypothesized that men who were assigned to SAH-M would have greater reductions in physical and psychological IPV use than men assigned to ETAU, as assessed using reports from both the male participant and his collateral reporting female partner.

METHOD

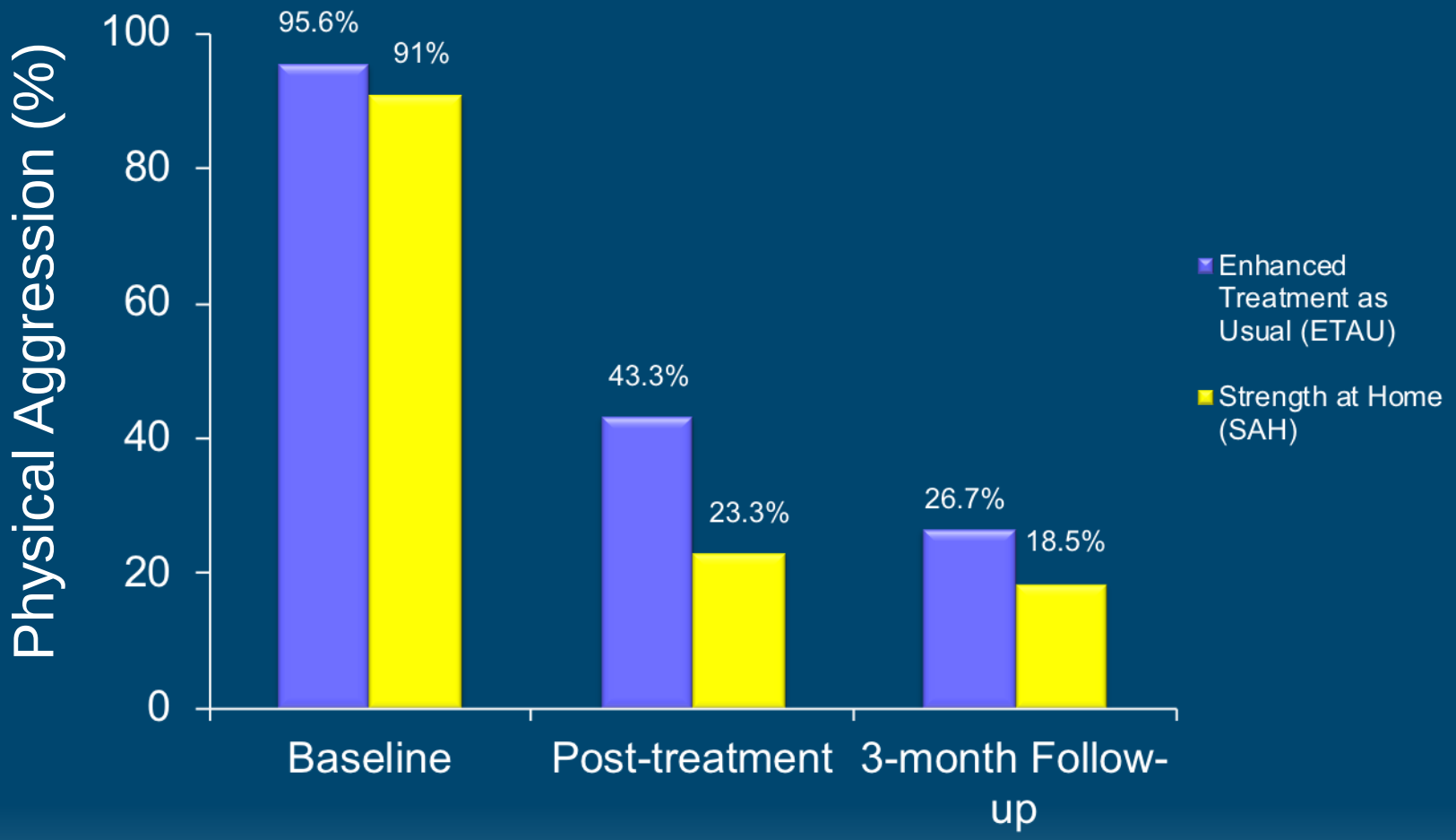
Participants & Procedure

This randomized controlled trial was registered at ClinicalTrials.gov (NCT01435512). Participants were recruited from February 2010 to August 2013 from 2 major metropolitan areas in the Northeast by clinician-referrals, self-referrals, and court-referrals. Inclusion criteria were (1) male participant and his partner were over 18 years of age, (2) male participant was a veteran or service member; (3) male participant provided partner contact consent; and (4) a self-, collateral- or court-report of at least 1 act of male-to-female physical IPV over the previous 6 months or of severe physical

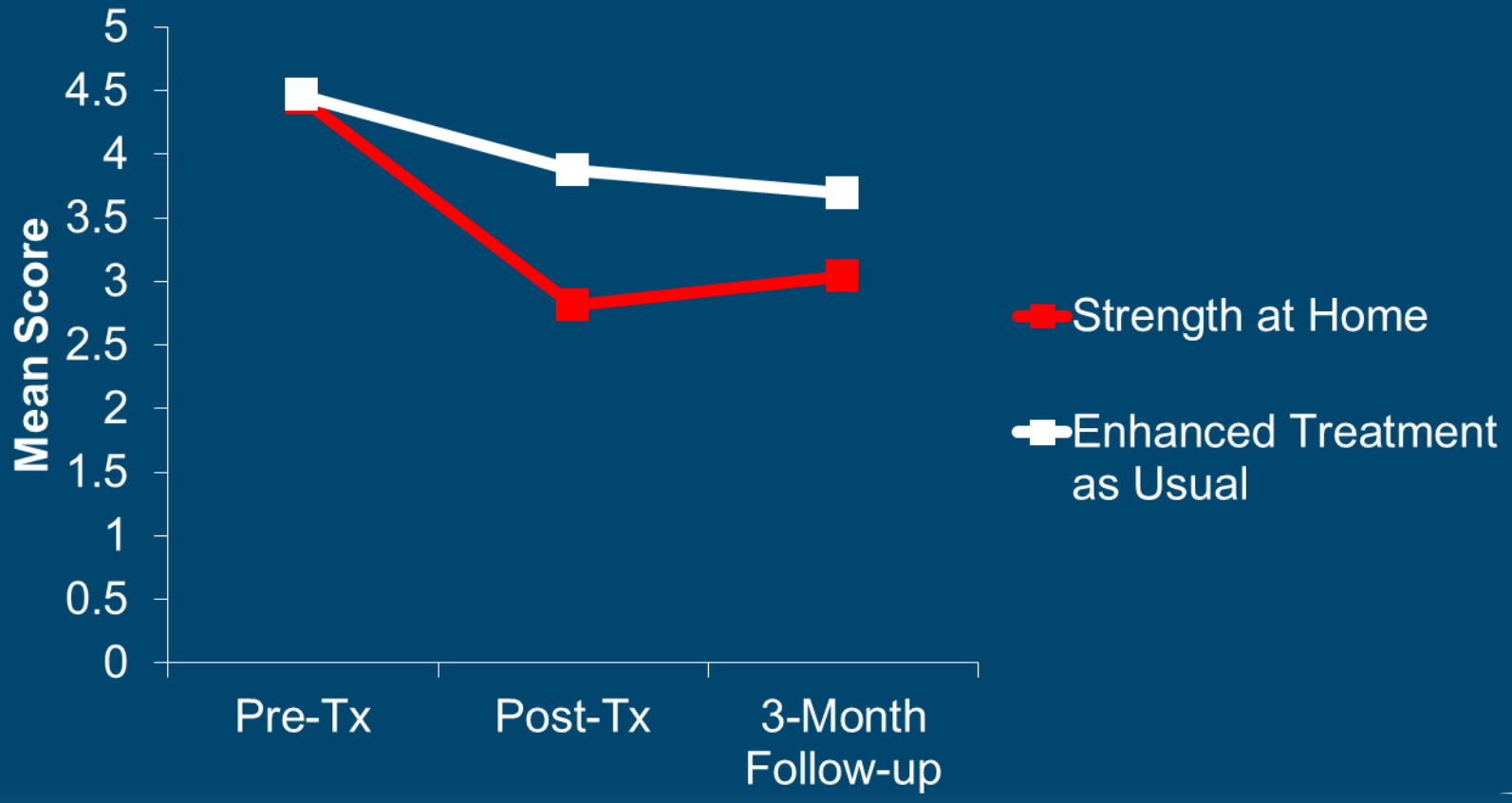
Sample Characteristics

- 135 enrolled in study
  - 67 randomized to Strength at Home
  - 68 randomized to Enhanced Treatment as Usual
- Average age = 38.10
- 77% White, 14% Black/African-American
- 34% married, 23% dating, 14% single
- 59% Court-involved
- 57% OEF/OIF/OND, 13% Vietnam, 8% Gulf War

Physical Partner Aggression

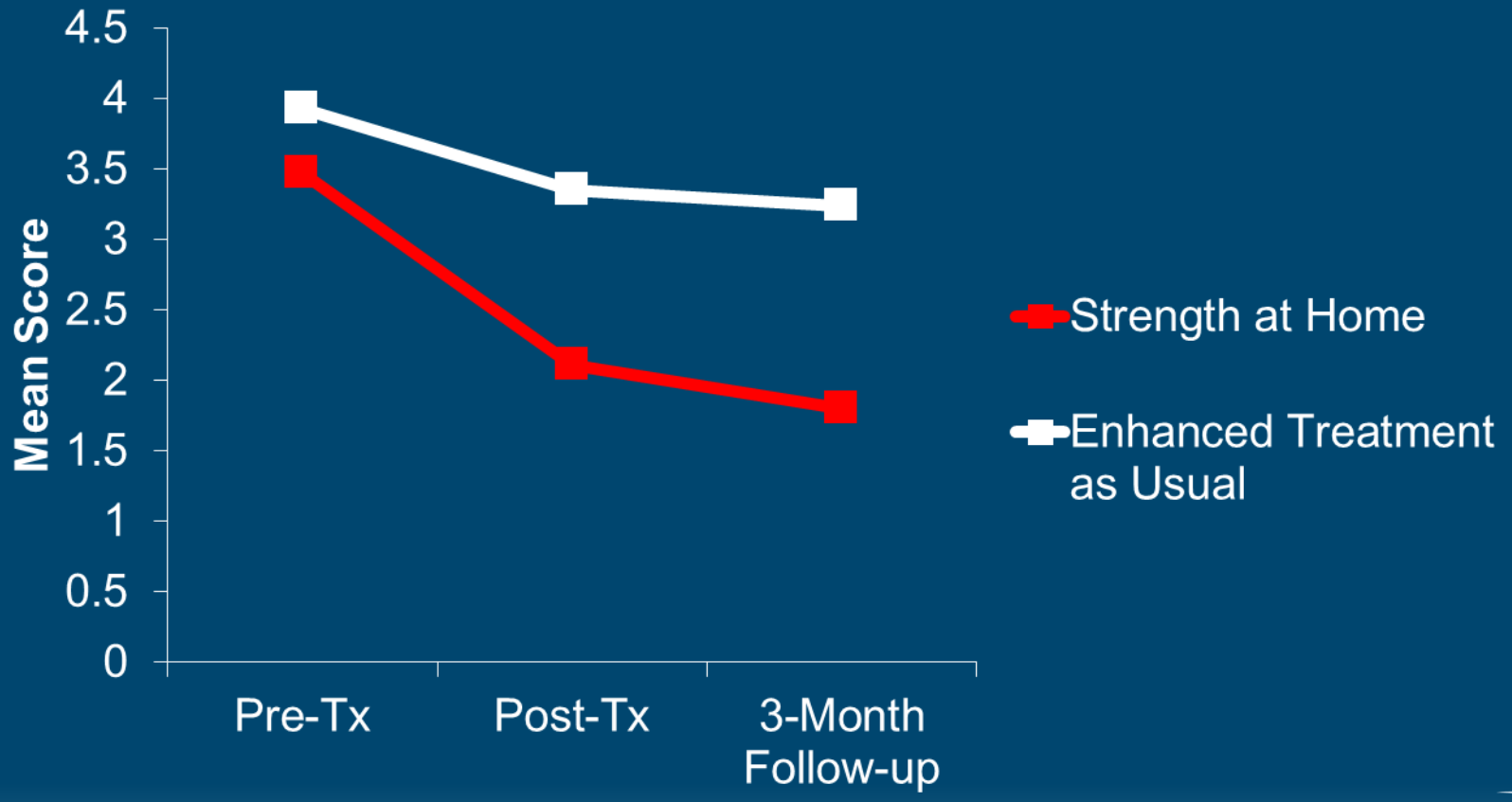


Psychological Partner Aggression



B = -0.304 (*SE* = .135)

Restrictive Engulfment



B = -0.072 (SE = .027)

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PTSD Symptoms Predict Outcome in Trauma-Informed Treatment of Intimate Partner Aggression

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Objective: This study sought to extend findings from a randomized controlled trial of the *Strength at Home Men's Program (SAH-M)* for intimate partner aggression (IPA) in military veterans by examining the impact of pretreatment posttraumatic stress disorder (PTSD) symptoms on treatment efficacy, and by examining new data on postintervention follow-up for individuals who received *SAH-M* after completing the *enhanced treatment as usual (ETAU)* wait-list control condition. ***Method:*** Using data from 125 male veterans who attended the *SAH-M* program immediately after an intake assessment or after waiting 6-month in the *ETAU* condition, this study used generalized linear modeling to examine predictors of physical and psychological IPA over a 9-month period of time. ***Results:*** PTSD symptoms at intake significantly predicted both physical and psychological IPA use, even after accounting for the effects of treatment condition, time, and number of sessions attended. PTSD had a strong association with both physical and psychological IPA. An interaction between PTSD and *SAH-M* was observed for psychological IPA but not physical IPA, and the magnitude of the effect was not clinically significant. There was a significant effect of *SAH-M* in reducing IPA in the full sample, including previously unanalyzed outcome data from the *ETAU* condition. ***Conclusion:*** The study results suggest that while *SAH-M* does not need to be modified to address the interaction between PTSD and treatment, outcomes could be enhanced through additional direct treatment of PTSD symptoms. Results extend prior analyses by demonstrating the effectiveness of *SAH-M* in reducing use of IPA in both the treatment and *ETAU* conditions.

Primary Findings

- Those in enhanced treatment as usual condition reduced aggression further after receiving Strength at Home
- Physical aggression 56% less likely for veterans receiving Strength at Home
- Participants with and without PTSD benefited from Strength at Home

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Optimizing trauma-informed intervention for intimate partner violence in veterans: The role of alexithymia

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ABSTRACT

Recent research supports the efficacy of *Strength at Home-Men's Program* (*SAH-M*), a trauma-informed group intervention designed to reduce use of intimate partner violence (IPV) in veterans (Taft, Macdonald, Creech, Monson, & Murphy, 2016). However, change-processes facilitating the effectiveness of *SAH-M* have yet to be specified. Alexithymia, a deficit in the cognitive processing of emotional experience characterized by difficulty identifying and distinguishing between feelings, difficulty describing feelings, and use of an externally oriented thinking style, has been shown to predict PTSD severity and impulsive aggression; however, no studies have investigated the relationship between alexithymia and IPV. As such, the current study examined the role of improvements in alexithymia as a potential facilitator of treatment efficacy among 135 male veterans/service members, in a randomized control trial *SAH-M*. After an initial assessment including measures of IPV and alexithymia, participants were randomized to an *Enhanced Treatment as Usual* (*ETAU*) condition or *SAH-M*. Participants were assessed three and six months after baseline. Results demonstrated a statistically significant association between alexithymia and use of psychological IPV at baseline. Moreover, participants in the *SAH-M* condition self-reported significantly greater reductions in alexithymia over time relative to *ETAU* participants. Findings suggest that a trauma-informed intervention may optimize outcomes, helping men who use IPV both limit their use of violence and improve deficits in emotion processing.

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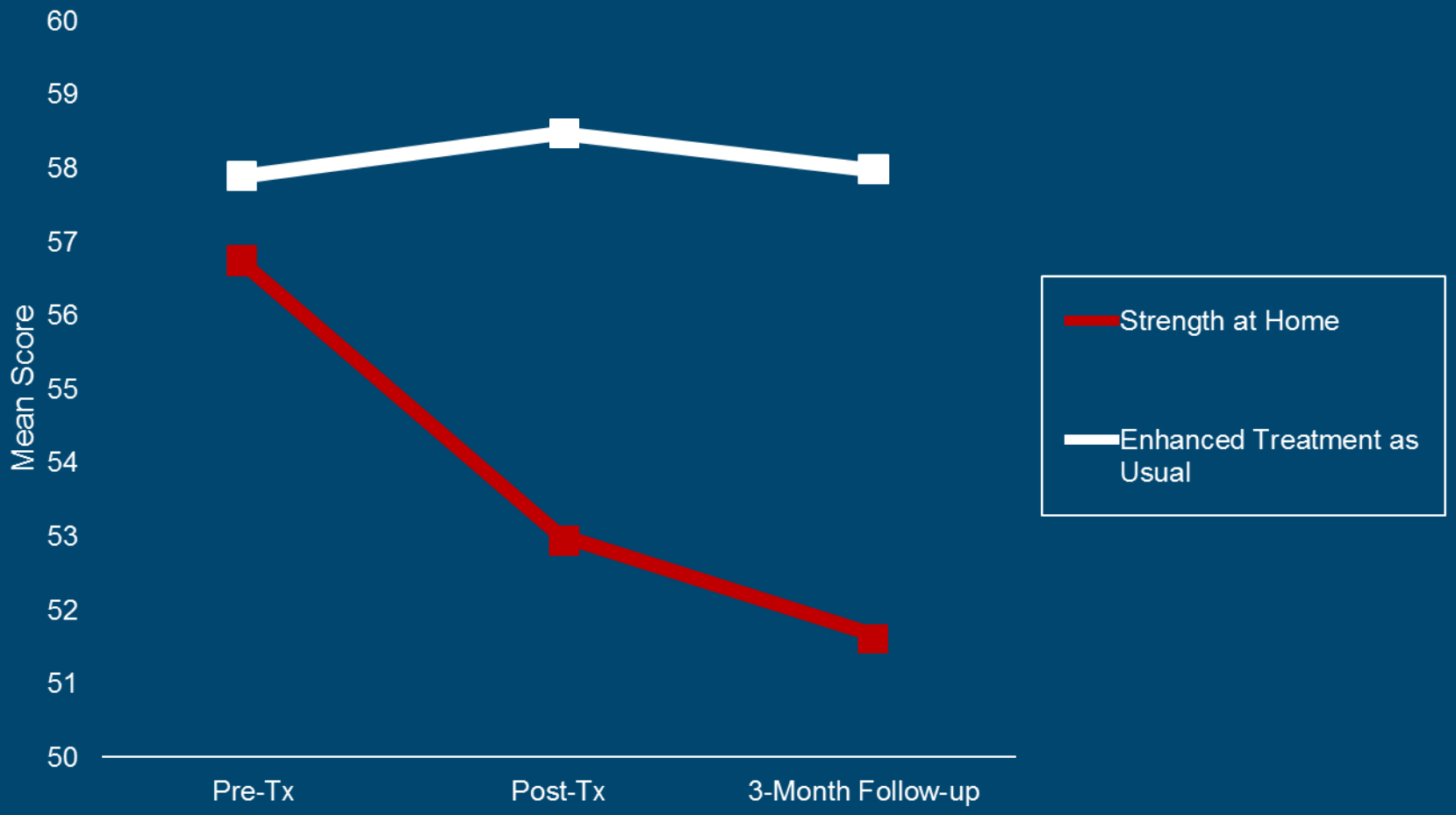
Alexithymia



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https://doi.org/10.1186/s12913-018-3401-6

BMC Health Services Research

RESEARCH ARTICLE Open Access

National implementation of a trauma-informed intervention for intimate partner violence in the Department of Veterans Affairs: first year outcomes

Suzannah K. Creech[1,2*], Justin K. Benzer[1,2], Tracie Ebalu[3], Christopher M. Murphy[4] and Casey T. Taft[5]

Abstract

Background: The U.S. Department of Veterans Affairs (VA) has recently implemented a comprehensive national program to help veterans who use or experience intimate partner violence (IPV). One important component of this plan is to implement *Strength at Home (SAH)*, a 12-week cognitive-behavioral and trauma-informed group treatment designed to reduce and end IPV use among military and veteran populations.

Method: The present study describes initial patient and clinician findings from the first year of a training program tasked with implementing *SAH* at 10 VA medical centers.

Results: Results from 51 veterans who completed both pre- and post-treatment assessments indicate *SAH* was associated with significant pre- to post-treatment reductions in the proportion of veterans who reported using physical and psychological IPV toward a partner, the types of IPV used, and posttraumatic stress disorder symptoms. Overall, veterans reported high satisfaction with the quality and nature of services received, and with the program materials. In addition, 70% of sites and 34% of the 79 clinicians trained were successful in launching the program in the first year. The mean number of days between site training and initiation of the first group session was 135.86 ($SD = 63.16$, range 72–252).

Conclusions: Results suggest that the training and implementation program was successful overall. However, average length of time between in-person training and initiation of group services was longer than desired and there were three sites that did not successfully implement the program within the first year, suggesting a need to reduce implementation barriers and enhance institutional support.

Keywords: Veterans, Intimate partner violence, Aggression, PTSD, Trauma, Implementation

Background

Over the past decade numerous research studies have indicated that high rates of intimate partner violence (IPV) among U.S. military veterans may convey risk for physical and mental health problems, as well as social, occupational, and legal difficulties [1, 2]. Women veterans are at high risk for experiencing IPV compared to their civilian counterparts [3], and male veterans with mental health disorders, particularly posttraumatic stress disorder (PTSD), evidence high rates of IPV use compared to both civilians and other veterans who do not have mental health disorders [4]. In response to this issue, in 2012 the Department of Veterans Affairs (VA) convened a Domestic Violence (DV)/IPV task force to develop recommendations for a national program. One year later, the task force finalized 14 recommendations to expand screening, prevention, and intervention for women and men veterans, as well as to introduce a VA employee assistance program for employees experiencing IPV [5]. The recommendations also included adopting non-stigmatizing language, specifically "IPV use" instead of IPV perpetration

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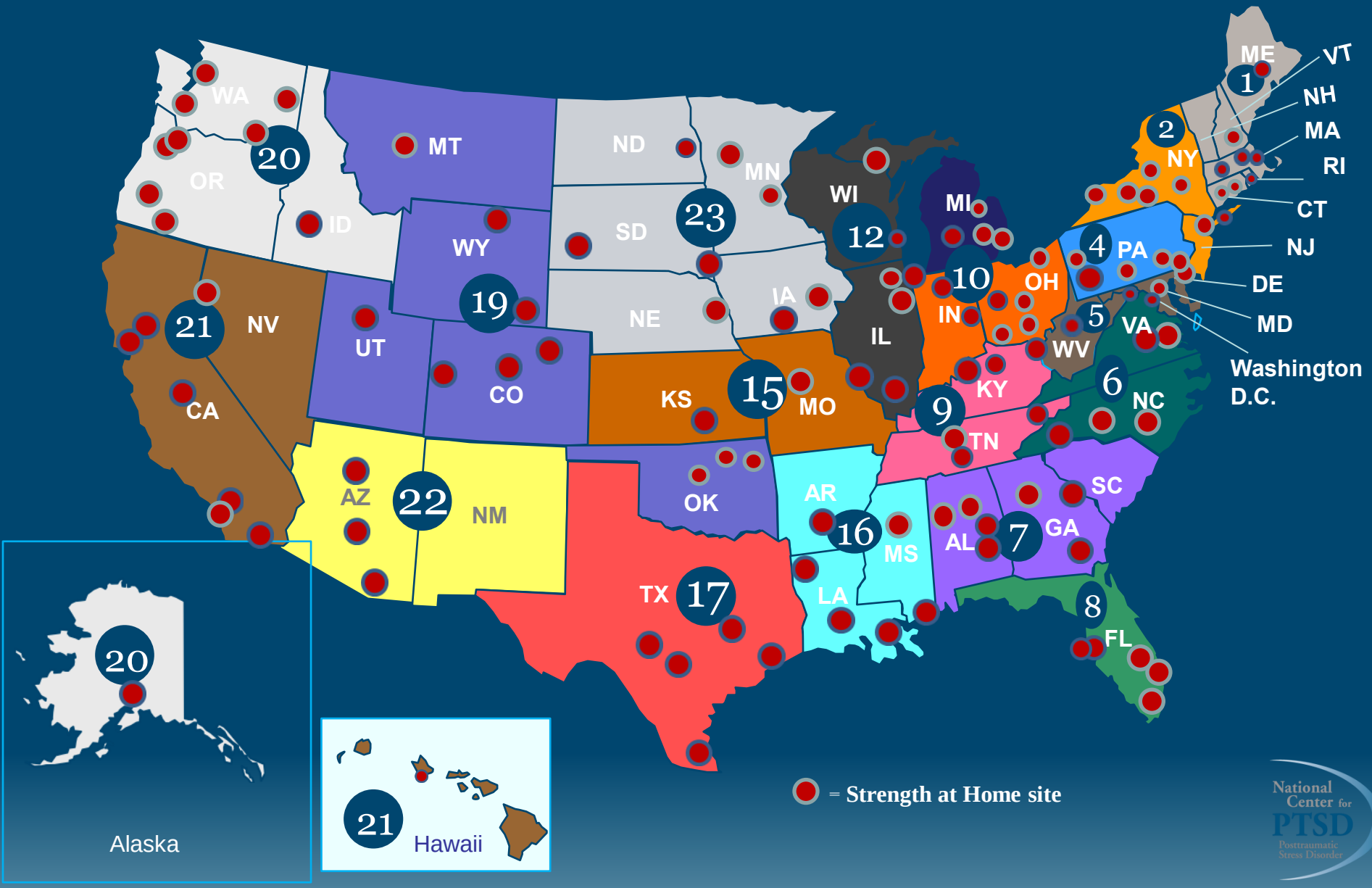
Full list of author information is available at the end of the article

Strength at Home Implementation Rollout



Strength at Home Rollout: Current Data

- Clinicians completed initial training: 1,224
- Veterans enrolled in group: 2,767
- Partners assessed: 475
- Groups started: 546
- Veterans graduated: 1,461

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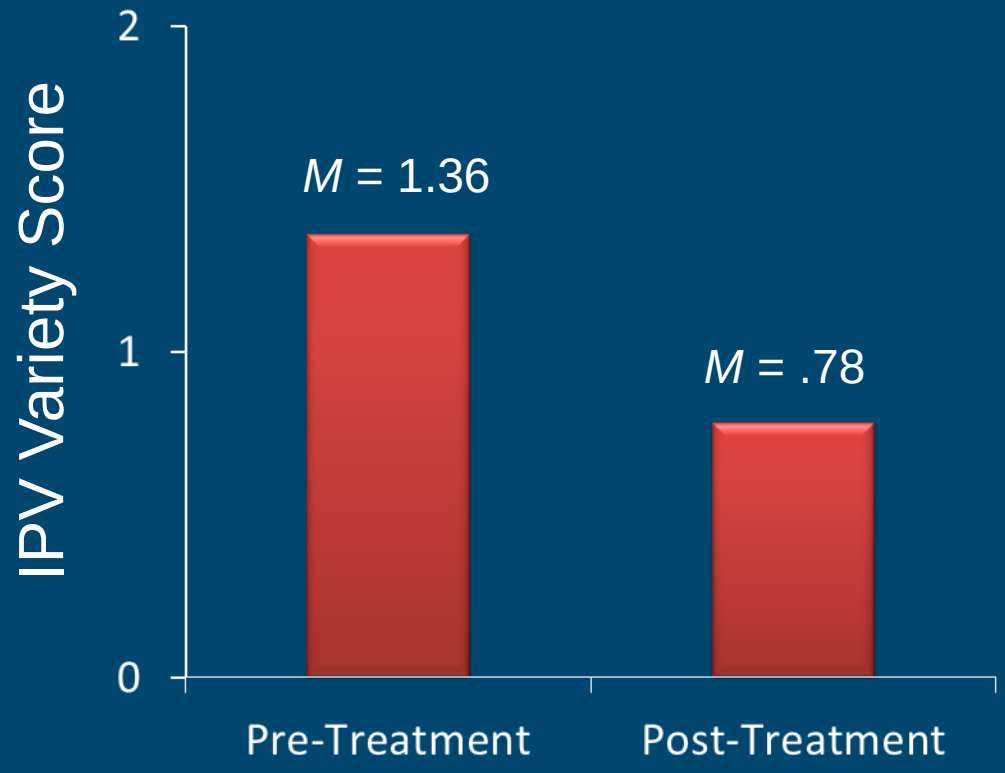
Change in Number of Types of IPV



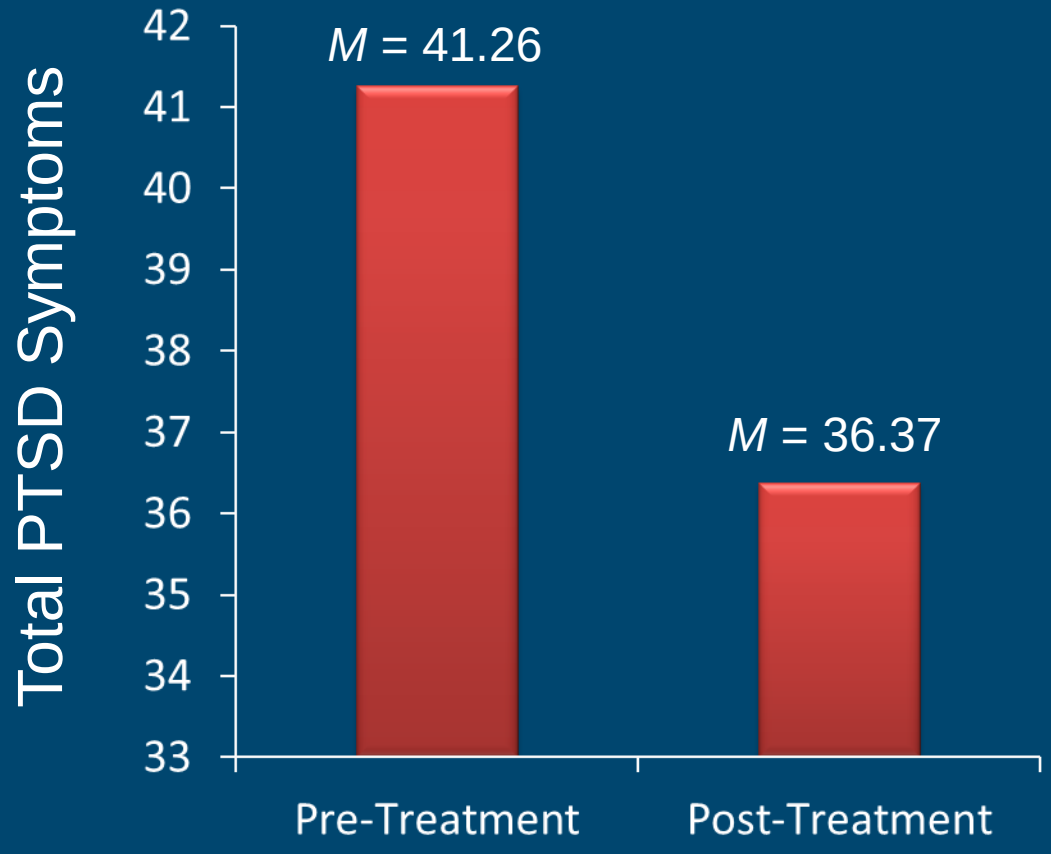
p <.01, Hedges g_{rm} = .48 (medium).

- *SAH* resulted in a significant decrease in types of IPV used (combining across all 4 types of IPV)

Change in Specific Types of IPV

- Significant changes in proportion of Veterans with self or partner reported:
  - Physical IPV ($p < .01$)
    - n=602 with physical IPV pre-treatment
    - 70% (n=424) no physical IPV at post-treatment
  - Psychological IPV ($p < .01$)
    - n=964 with psych IPV pre-treatment
    - 58% (n=565) no psych IPV at post-treatment
  - Coercive Control Behaviors ($p < .01$)
    - n=776 with coercive control at pre-treatment
    - 61% (n=479) no coercive control at post-treatment

Change in PTSD Symptoms



p <.01, Hedge's g_{rm} = .22 (small)

- Significant decrease in PTSD symptoms

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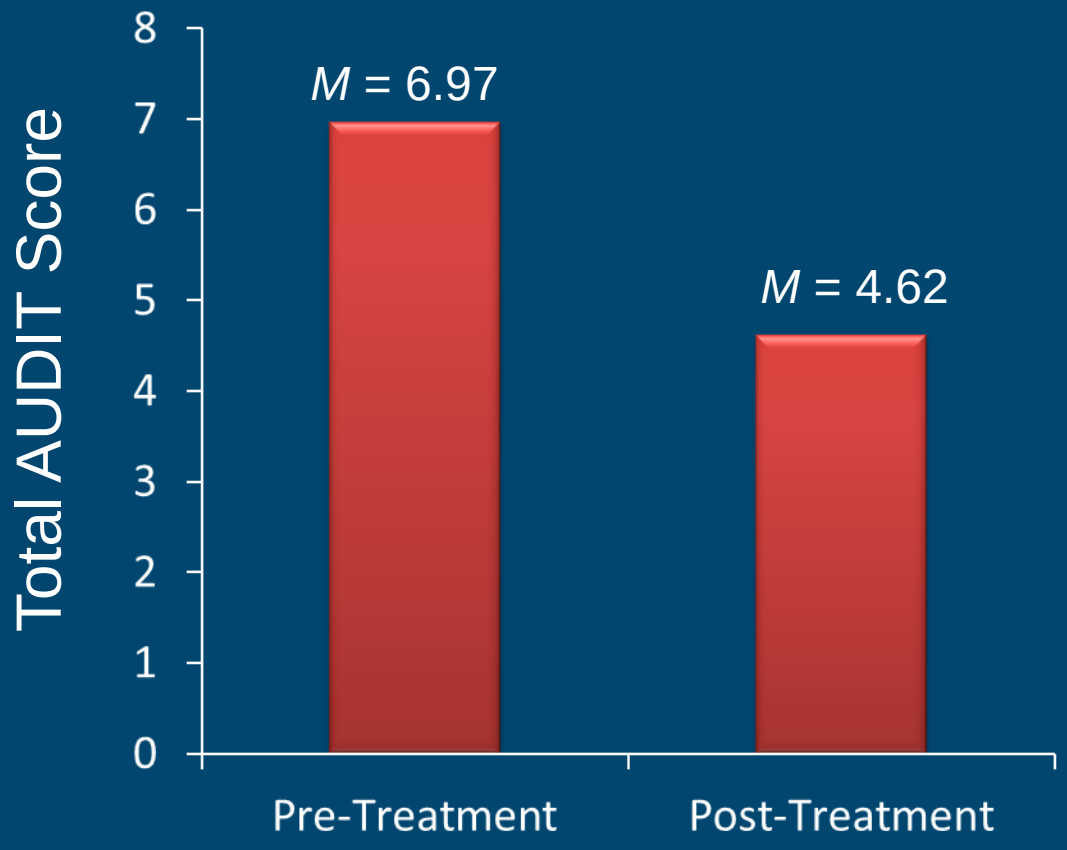
Change in Alcohol Misuse



p <.01, Hedge's g_{rm} = .30 (small)

- Significant decrease in alcohol misuse

Treatment Satisfaction

- Post-treatment satisfaction *M* = 24.38 (SD 3.35), possible range 6-27

- When asked if they would recommend program to a friend
  - 82% responded “Yes, definitely”
  - 17% responded “Yes, I think so”

- When asked how much the program helped them deal more effectively with their problems
  - 75% reported the program helped “a great deal”
  - 23% reported the program helped “somewhat”

Strength at Home in Civilians NIMH Study

National Center for PTSD
Posttraumatic Stress Disorder

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BRIEF REPORT

Examining Strength at Home for Preventing Intimate Partner Violence in Civilians

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The *Strength at Home* (*SAH*) intervention, a trauma-informed, cognitive-behavioral intervention for intimate partner violence (IPV), was examined in a sample of court-mandated men. Evidence from prior research indicates that *SAH* is effective in military veterans but the program has not been examined in civilians. It was expected that *SAH* participants would evidence reductions in physical and psychological IPV, as well as secondary outcomes of post-traumatic stress disorder (PTSD) symptoms and alcohol use problems. Participants included 23 men court mandated to IPV intervention. The sample was low income and 72.7% had a reported prior history of severe physical IPV perpetration. Data from these participants and collateral partners were examined across assessments reflecting baseline, post-treatment, and two 3-month follow-ups. The outcome variables were assessed at each time point to examine change over time and a post-treatment satisfaction measure was also administered immediately following the intervention. Participants showed a significant linear decrease between baseline and post-treatment in all of the primary and secondary IPV outcomes, which maintained at 3- and 6-month follow-up time points. Effect sizes across models were moderate to large. Participants reported high satisfaction with *SAH*. Study findings provide preliminary support that the *SAH* intervention is associated with reductions in IPV among civilians and addresses other trauma- and alcohol-related problems. Further research including larger randomized controlled trials are needed to determine the efficacy of this intervention.

Keywords: intimate partner violence, trauma, IPV intervention, Strength at Home, abuse

Intimate partner violence (IPV) is a prevalent national public health problem with high costs to society (Centers for Disease Control & Prevention (CDC), 2003). One approach to preventing continued IPV is through IPV intervention programs that are most commonly used for court-referred men who engage in IPV. Unfortunately, to date, randomized controlled trials have shown limited efficacy for IPV interventions in general, even while large numbers of individuals are court mandated to such programs each year (Eckhardt et al., 2013). Recent evidence suggests that trauma-informed approaches aimed at enhancing social information processing may amplify the effectiveness of IPV intervention (e.g., Romero-Martínez et al., 2018). Likewise, a growing body of research supports the effectiveness of the *Strength at Home* (*SAH*) program, a trauma-informed group IPV intervention based on a social information processing model (Taft, Murphy, et al., 2016). Multiple pilot studies (Love et al., 2014; Taft et al., 2013), a randomized controlled trial (Berke et al., 2017; Creech et al., 2017; Taft, Macdonald, et al., 2016), and implementation studies (Creech et al., 2018; Hayes et al., 2015) indicate the effectiveness of *SAH* among military veterans. The current study represents an initial examination of the *SAH* intervention for reducing IPV and other associated problems in a court-mandated civilian sample reporting high levels of physical and psychological IPV.

SAH derives from a fusion of prior interventions for trauma and IPV that were developed in the civilian community context, integrating elements of cognitive processing therapy for PTSD (CPT; Resick & Schnicke, 1992) and cognitive behavioral interventions for IPV (Murphy & Scott, 1996). The program addresses biases and deficits across stages of social information processing from decoding a situation to choosing and evaluating a response (McFall, 1982), recognizing that trauma-related problems (post-traumatic

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Dr. Taft receives royalties from the American Psychological Association. The authors report no other financial relationships with commercial interests. Some of the findings and ideas reported in this paper were presented at the annual meetings of the International Society of Traumatic Stress Studies and Association for Behavioral and Cognitive Therapies. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government. This work was supported by funds from the National Institute of Health and Boston University and with support and resources from the VA Boston Healthcare System. Dr. Franz was supported by a grant from the National Institute of Mental Health (5T32MH019836).

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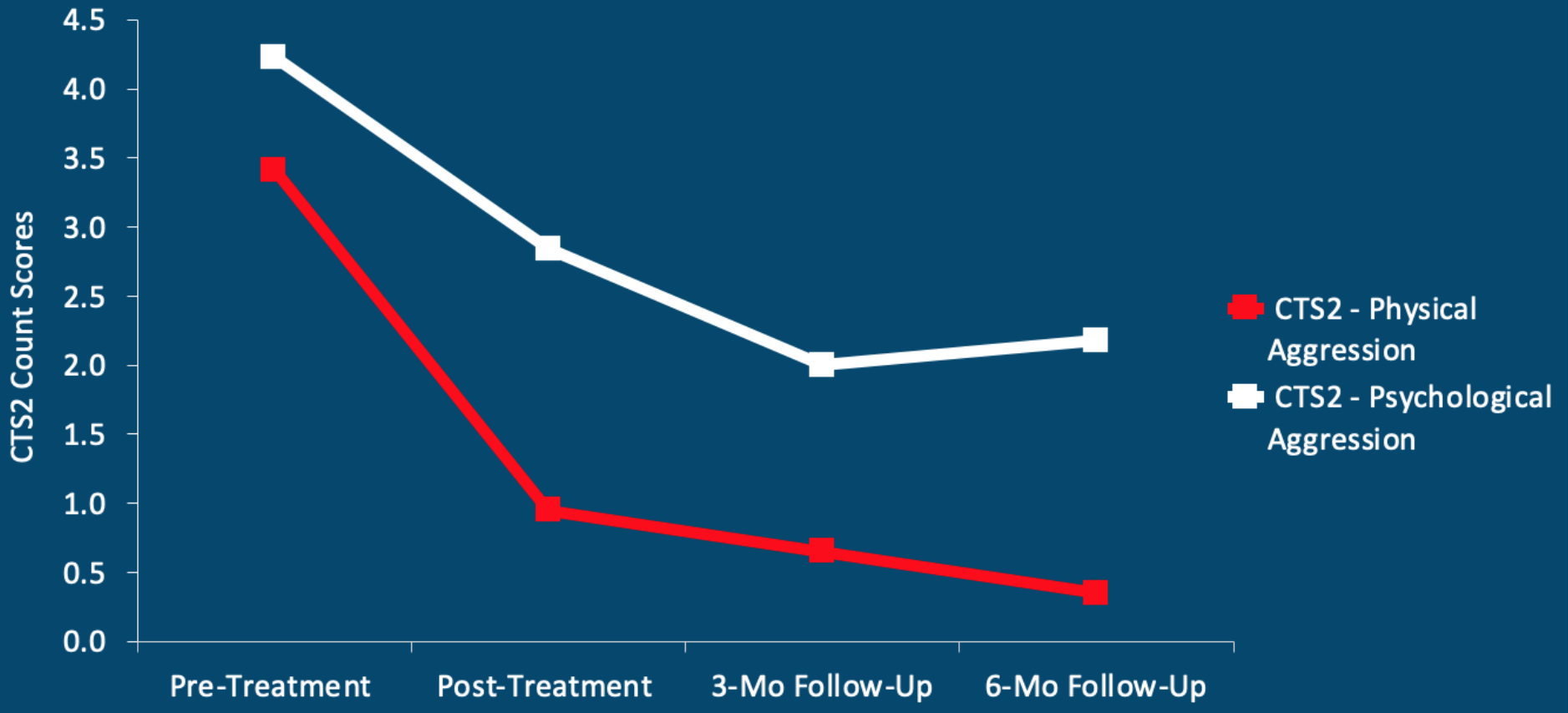
Sample Characteristics

- 23 men enrolled in study
- All court-mandated
- Average age = 38.3
- 87% identified as racial or ethnic minorities
- Entirely low-income
- 73% history of severe physical aggression
- 78% completed the program
- 61% of partners contacted at baseline
  - 71% reassessed at post-treatment and follow-up

CTS2 Physical and Psychological Aggression



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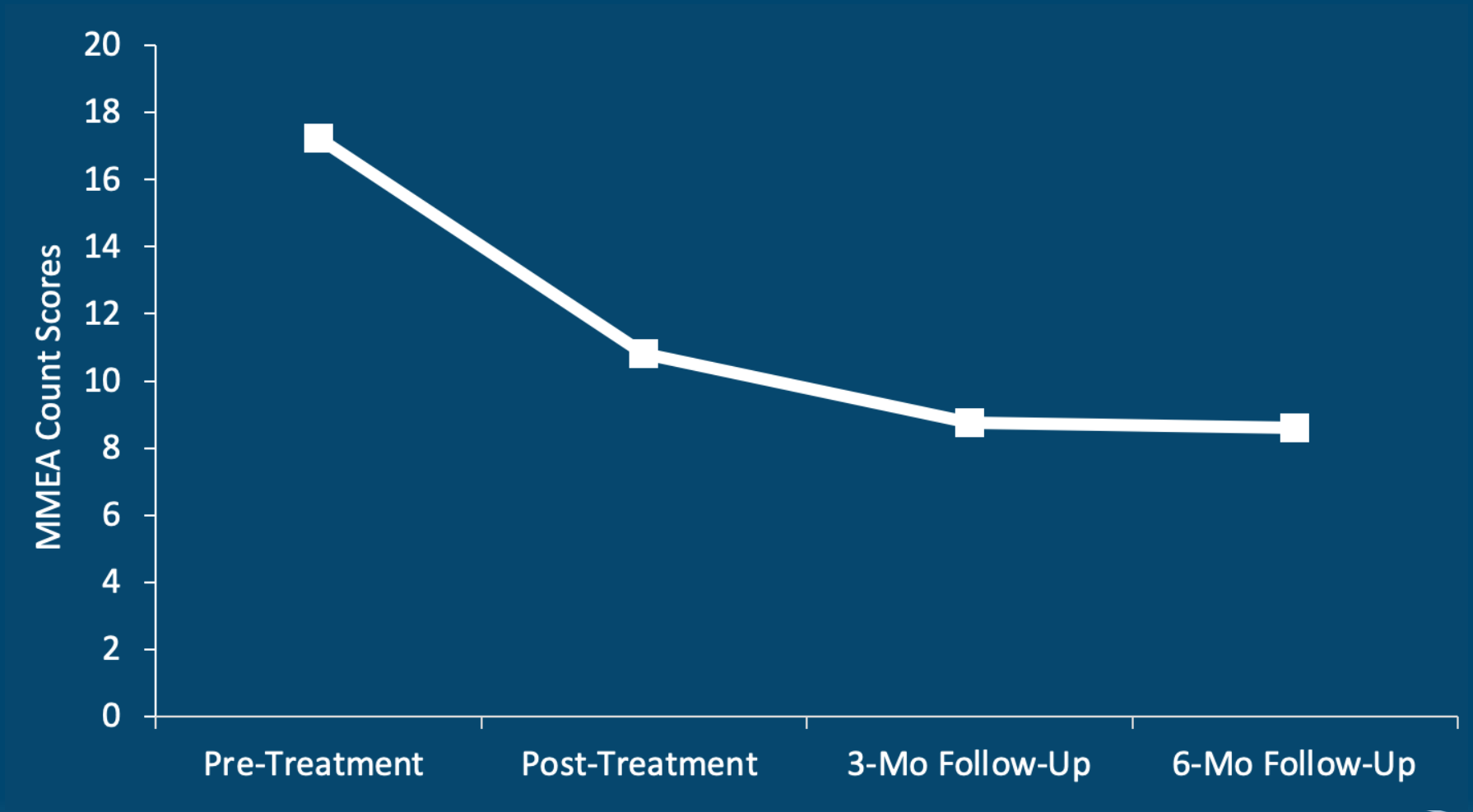
Multidimensional Measure of Emotional Abuse



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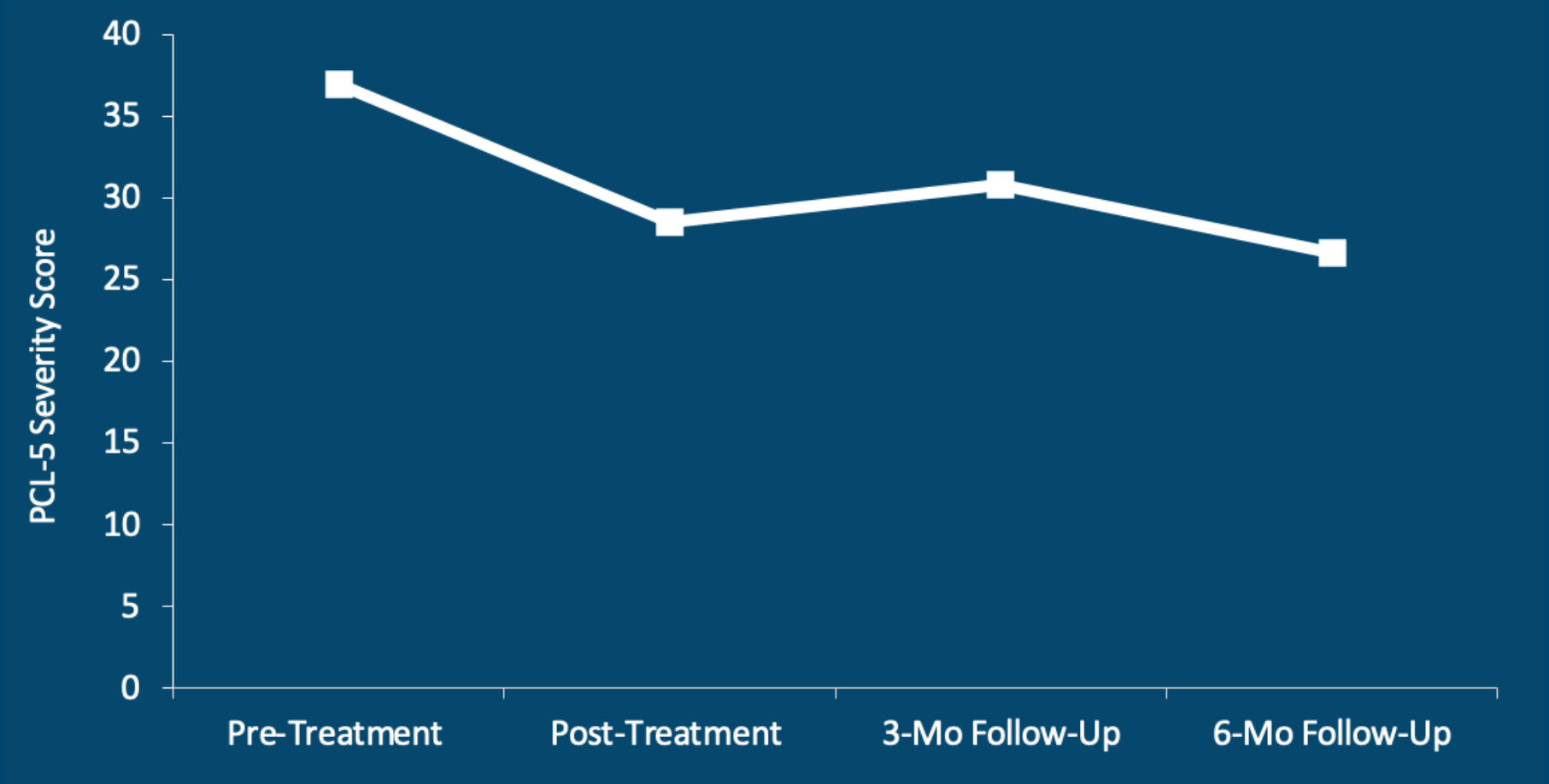
PTSD Symptoms (PCL-5)



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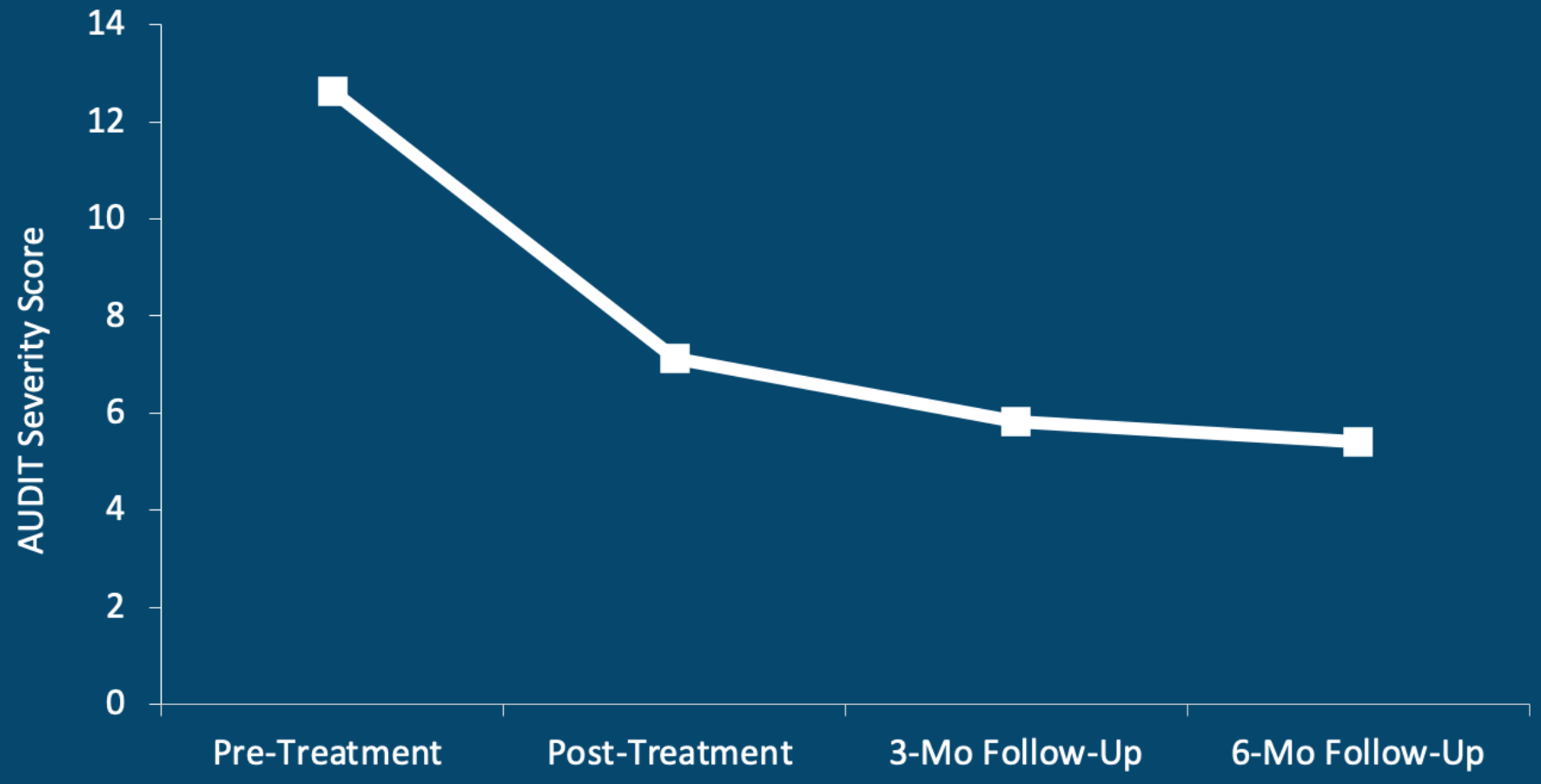
Alcohol Misuse (AUDIT)



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Treatment Satisfaction

	4	3	2	1
1. Quality of service	64.7% Excellent	35.3% Good	0% Fair	0% Poor
2. Kind of service desired	58.8% Yes definitely	35.3% Yes generally	0% No not at all	5.9% No definitely not
3. Met Needs	58.8% Almost all met	41.2% Most met	0% Only a few met	0% None met
4. Would recommend to a friend	88.2% Yes definitely	11.8% Yes I think so	0% No I do not think so	0% Definitely not
5. Satisfaction with help received	82.4% Very satisfied	11.8% Mostly satisfied	5.9% Indifferent or mildly dissatisfied	0% Quite dissatisfied
6. Helped with dealing more effectively with problems	100% Yes a great deal	0% Yes somewhat	0% No did not help	0% No made it worse
7. Overall satisfaction	88.2% Very satisfied	11.8% Mostly satisfied	0% Indifferent or mildly dissatisfied	0% Quite dissatisfied
8. Would use it again in the future	88.2% Yes definitely	11.8% Yes I think so	0% No I do not think so	0% No definitely not

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www.strengthathome.org

STRENGTH AT HOME

Trauma-Informed, Evidence-Based Programs for Relationship Enhancement and Domestic Violence Prevention and Cessation

Home | About Dr. Casey Taft | Trainings | Resources | CONTACT

Welcome to Strength at Home

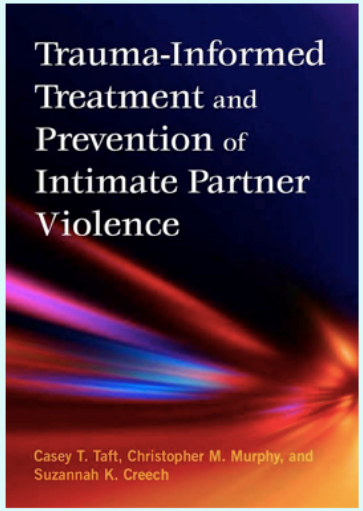
Welcome to the official website for the Strength at Home (SAH) programs, hosted by the primary program developer, Dr. Casey Taft.

About Strength at Home

Strength at Home consists of two separate cognitive-behavioral group intervention programs for intimate partner violence (IPV):

- **Strength at Home**: An "offender" or "abuser intervention" program for those self- or court-identified as having difficulties with IPV, delivered to individuals within groups; and
- **Strength at Home Couples**: A program focused on IPV prevention in couples prior to escalation to physical violence.

The Strength at Home program can be used for the civilian, military, or Veteran population, and often satisfies court requirements for IPV intervention. The Strength at Home Couples program is primarily for military



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