Virginia DUI/Specialty Dockets Training
BUILDING BRIDGES to CONNECT COMMUNITIES & COURTS
September 18-20, 2023 | Norfolk Waterside Marriott

AGENDA

Monday, September 18, 2023

7:30am – 8:30am	**Continental Breakfast/Registration**
8:30am – 8:35am	**Norfolk Welcome** Hon. Jerrauld Jones, Judge, Norfolk Circuit Court
8:35am – 8:45am	**Welcome and Remarks** Hon. Jack S. Hurley, Judge, Tazewell Circuit Court, Vice -Chair Virginia Drug Treatment Courts Advisory Committee
8:45am – 10:00am	**Stop Judging, Start Healing: How a Judge Can Judge Without Judging** Hon. Jack S. Hurley, Judge Tazewell Drug Treatment Court
10:00am – 10:15am	**Break**
10:15am – 11:45am	**The Opposite of Addiction is not Sobriety – It's Connection** Robert "Keith" Cartwright, Adverse Childhood Experiences Coordinator, DBHDS
11:45am – 12:45pm	**Opioid Abatement Authority** Tony McDowell, Executive Director
12:45pm – 1:45pm	**Lunch**
1:45pm – 2:30pm	**Best Practices Part 1** Aaron Arnold, Chief Development Officer, All Rise
2:30pm – 2:45pm	**Break**
2:45pm – 4:15pm	**REVIVE Opioid Overdose and Naloxone Education Training** Beth Cline, R-CPRS-T, Education & Training Coordinator, The Chris Atwood Foundation
4:15pm	**Adjourn**

Where Treatment and Accountability Meet Justice

VIRGINIA

SPECIALTY DOCKETS

Department of Judicial Services, Office of the Executive Secretary, Supreme Court of Virginia

Virginia DUI/Specialty Dockets Training
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AGENDA

Tuesday, September 19, 2022

7:30am – 8:30am	**Judges Breakfast – The Least of Us** Sam Quinones, Journalist, Author, Photographer
7:30am – 8:30am	**Continental Breakfast/Registration**
8:30am – 9:45am	**Drug Testing** Patricia Pizzo, B.S., BCFE, Director of Toxicology, Alere Toxicology Services, Inc.
9:45am – 10:00am	**Break**
10:00am – 11:15am	**The Future of Treatment Courts** Aaron Arnold
11:15am – 12:45pm	**The Least of Us** Sam Quinones, Journalist, Author, Photographer
12:45pm – 1:45pm	**Lunch**
1:45pm – 3:00pm	**Best Practices Part 2** Terence Walton, Chief Operating Officer, All Rise
3:00pm – 3:15pm	**Break**
3:15pm – 4:00pm	**Harm Reduction Practices: What Fits and What Doesn't** Terence Walton
4:00pm – 5:00pm	**Prosecutor and Defense Counsel: Working Effectively on the Treatment Court Team** Tammy Westcott, Director of Toxicology, Oklahoma Department of Mental Health and Substance Abuse Services
5:00pm	**Adjourn**

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AGENDA

Wednesday, September 20, 2023

7:30am – 8:30am	**Continental Breakfast/Registration**
8:30am – 9:30am	**Leveraging the VA in Identifying Veterans in the Criminal Justice System (VRSS and the SQUARES Application)** Mark Panasiewicz, Project Director, Justice for Vets
9:30am – 10:30am	**The 10 Guiding Principles in '23: Examining Effective Practices with High-Risk/High-Need Impaired Drivers** Jessica Lange, Project Director of Impaired Driving Solutions, All Rise
10:30am – 10:45am	**Break**
10:45am – 12:00pm	**Suicide Prevention and Awareness: What every VTC Team Member Needs to Know and Do!** Mark Panasiewicz
12:00pm – 1:00pm	**Lunch**
1:00pm – 2:30pm	**Harm Reduction** Tiffani D. Wells, M.S., B.S, CPRS, Harm Reduction Coordinator, DBHDS
2:30pm – 2:45pm	**Drug Court Graduate** Mr. Gary
2:45pm – 3:00pm	**Closing Remarks**

Stop Judging; Start Healing

How a Judge can judge without judging?

IDENTIFYING THE PROBLEM

Rural Communities - Devastated by the Opioid and Prescription Drug Crisis since the 1990s

107,622 Individuals Died the United States From Drug Overdoses in 2021

Aerial shot of the Soccer City Stadium, Soweto packed full of over 100,000 people

US overdose deaths hit record 107,622 in last year

- While prescription painkillers once drove the nation's overdose epidemic, they were supplanted first by heroin and then by fentanyl, a dangerously powerful opioid, in recent years. Fentanyl was developed to treat intense pain from ailments like cancer but has increasing been sold illicitly and mixed with other drugs.

- The number of Americans killed by the drug has jumped **94** percent since 2019.

- On average, **one** person dies of a fentanyl overdose in the United States every **seven minutes**.

Washington faltered as fentanyl gripped America - Washington Post, Dec 12, 2022

Fentanyl Contamination

- "What's really driving the surge in overdoses is this increasingly poisoned drug supply," said Shannon Monnat, an associate professor of sociology at Syracuse University who researches geographic patterns in overdoses. "Nearly all of this increase is ***fentanyl contamination*** in some way. Heroin is contaminated. Cocaine is contaminated. Methamphetamine is contaminated.“

https://richmond.com/news/national/us-overdose-deaths-hit-record-93-000-in-pandemic-last-year/article_6ac24f78-d0c8-5369-af8f-4b0406834e8e.html

Lockdowns and other pandemic restrictions isolated those with substance use disorders and made treatment more difficult to access

107,622 Individuals Died the United States From Drug Overdoses in 2021

(City of Tuscaloosa + City of Orange Beach)

FENTANYL

- Fentanyl is now the leading cause of death for Americans ages 18 to 49, according to a Post analysis.
- “It is a new, deeper, more deadly threat than we have ever seen, and I don’t think that the full extent of that harm was immediately seen in 2015,” DEA Administrator Anne Milgram said.
- The CDC continues to count the death toll for 2021 — in a provisional tally seven months ago, it calculated the overall number of drug overdoses at 107,622. Two-thirds were due to fentanyl.

Shame or Survival

“. . . survival has to trump shame.”

Dopesick, pg. 141

WHAT IS STIGMA?

Stigma is a discrimination against an identifiable group of people, a place, or a nation. Stigma about people with substance use disorder (SUD) might include inaccurate or unfounded thoughts like they are dangerous, incapable of managing treatment, or at fault for their condition.

Source: *National Institutes of Health, National Institute on Drug Abuse*

HOW DOES STIGMA AFFECT PEOPLE WITH SUD?

- Feeling stigmatized can reduce the willingness of individuals with SUD to seek treatment.

- Stigmatizing views of people with SUD are common; this stereotyping can lead others to feel pity, fear, anger, and a desire for social distance from people with SUD.

- Stigmatizing language can negatively influence health care provider perceptions of people with SUD, which can impact the care they provide.

Source: *National Institutes of Health, National Institute on Drug Abuse*

Self-Stigma and Societal Stigma

- When perceived societal stigma is internalized (ie, self-stigma), it can result in loss of self-respect, decreased self-esteem, and loss of self-efficacy. These feelings may harm the individual's chances of recovery from substance use disorders.

Guilt vs. Shame

- “Guilt: I’m sorry. I made a mistake.

- Shame: I’m sorry. I am a mistake.”

“Blaming someone tells the other that he or she did something wrong; shaming someone tells you that the other is bad.”

- Howard Adelman

WHAT CAN YOU DO TO REDUCE STIGMA?

1.) Understanding addiction and what it is so you can educate yourself and others and better understand those participants in our recovery courts and in our legal system as a whole

2.) Using non-stigmatizing language

UNDERSTANDING SUBSTANCE USE DISORDER

Addiction, clinically referred to as a *substance use disorder*, is a complex disease of the brain and body that involves compulsive use of one or more substances despite serious health and social consequences. Addiction disrupts regions of the brain that are responsible for reward, motivation, learning, judgment and memory.

Source: *Partnership to End Addiction*

The medical/disease model is one of the most well-known and is accepted by the American Society of Addiction Medicine (ASAM). It defines addiction as "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and a client's life experiences."

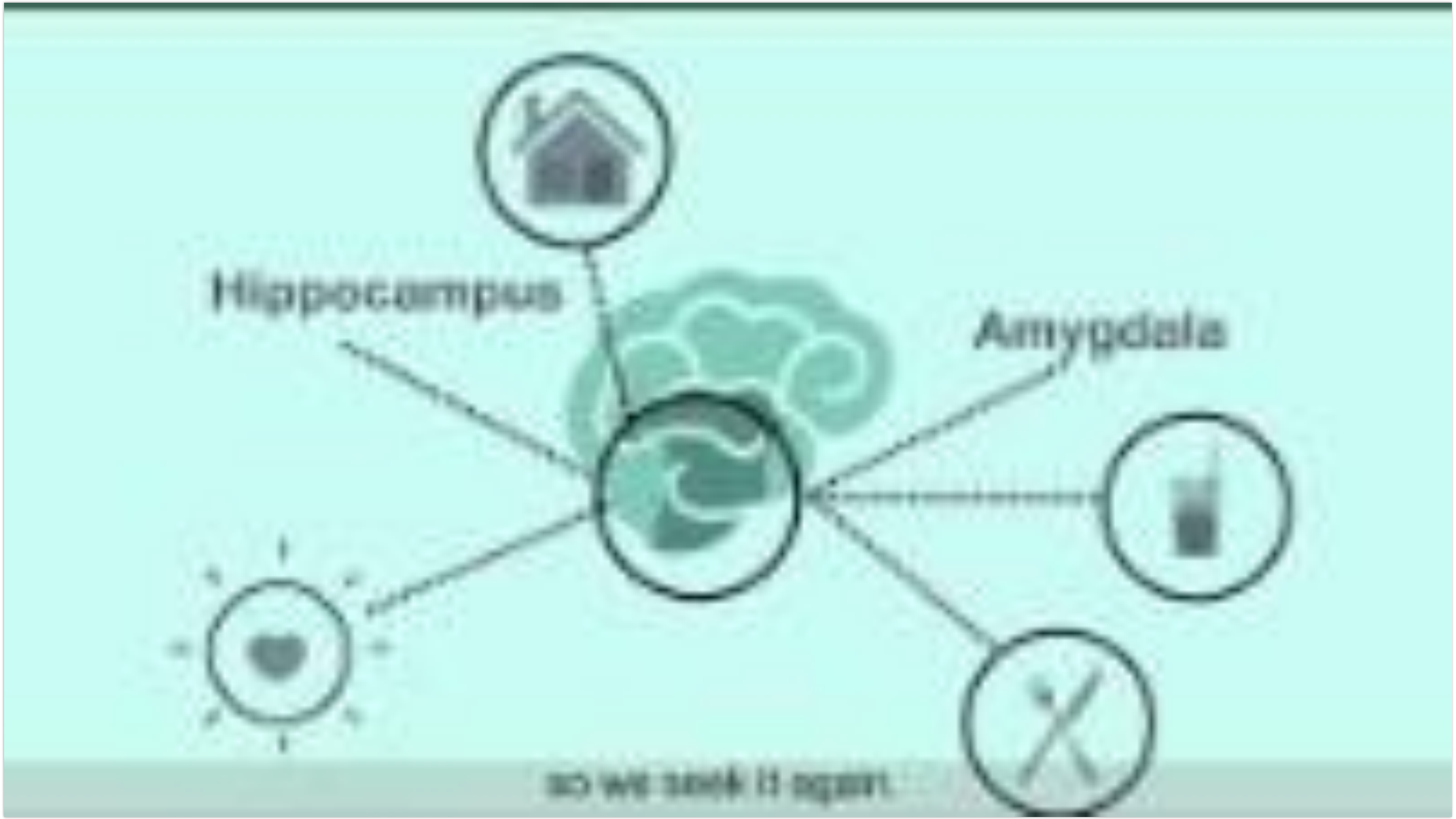
- AMERICAN SOCIETY OF ADDICTION MEDICINE

MYTHS VS FACTS

GET THE TRUTH ABOUT SUBSTANCE USE DISORDER.

People who can't stop using drugs are weak or immoral.	1	People who become dependent on drugs or alcohol are victims of a real illness.
People with SUD quit using drugs any time they want.	2	Substances can rewire the brain, flooding it with pleasure. It is short-lived and later gives way to anxious cravings, creating a powerful hold on both body and mind.
Substance use disorder is only a problem in a lower income or socio-economic layers of society.	3	Substance use disorder impacts every layer of society.
Treating drug addiction with public funds is a waste.	4	Every dollar spent on treating drug use saves seven dollars that might otherwise be spent on jail, medical bills, or legal costs.

SUBSTANCE USE



Factors

- Genetics (family history)
- Environment
- Trauma – e.g. Adverse Childhood Experiences (ACEs)
- Social Availability

REDUCING STIGMA:
A Legacy of First Lady Betty Ford

Image Courtesy of Betty Ford Center

A very public **story** of recovery belongs to former First Lady Betty Ford, who had alcoholism and also became addicted to opioids in the early 1960s after a pinched nerve. Following a family intervention in 1978 (a year after leaving the White House), she became a recovery advocate noted for her openness and honesty.

"I liked alcohol," she **wrote** in her 1987 memoir. "It made me feel warm. And I loved pills. They took away my tension and my pain."

Now the **Hazelden Betty Ford Foundation** offers programs focused on older adults, such as **Recovery@50Plus**.

The program addresses age-specific addiction issues, the importance of rediscovering purpose and meaning in life, and "the stigma of addiction and the impact of shame on recovery."

Source: Heartache, Pain, and Hope: Rural Communities, Older People and the Opioid Crisis

Dick Van Dyke


MARVEL STUDIOS
IRON MAN
MARVEL STUDIOS
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Robert Downey, Jr.

USING NON-STIGMATIZING LANGUAGE


#ENDSTIGMA
The negative stigma around substance use disorder often keeps people from seeking treatment. Let's start a conversation about the reasons for substance use disorder, the words we use, and why.
WORDS MATTER.
Together we have the power to change someone's life and even save it.
AMHC
This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $200,000 with 100% percentage funded by HRSA/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA/HHS, or the U.S. Government.

WORDS MATTER

HELP END STIGMA

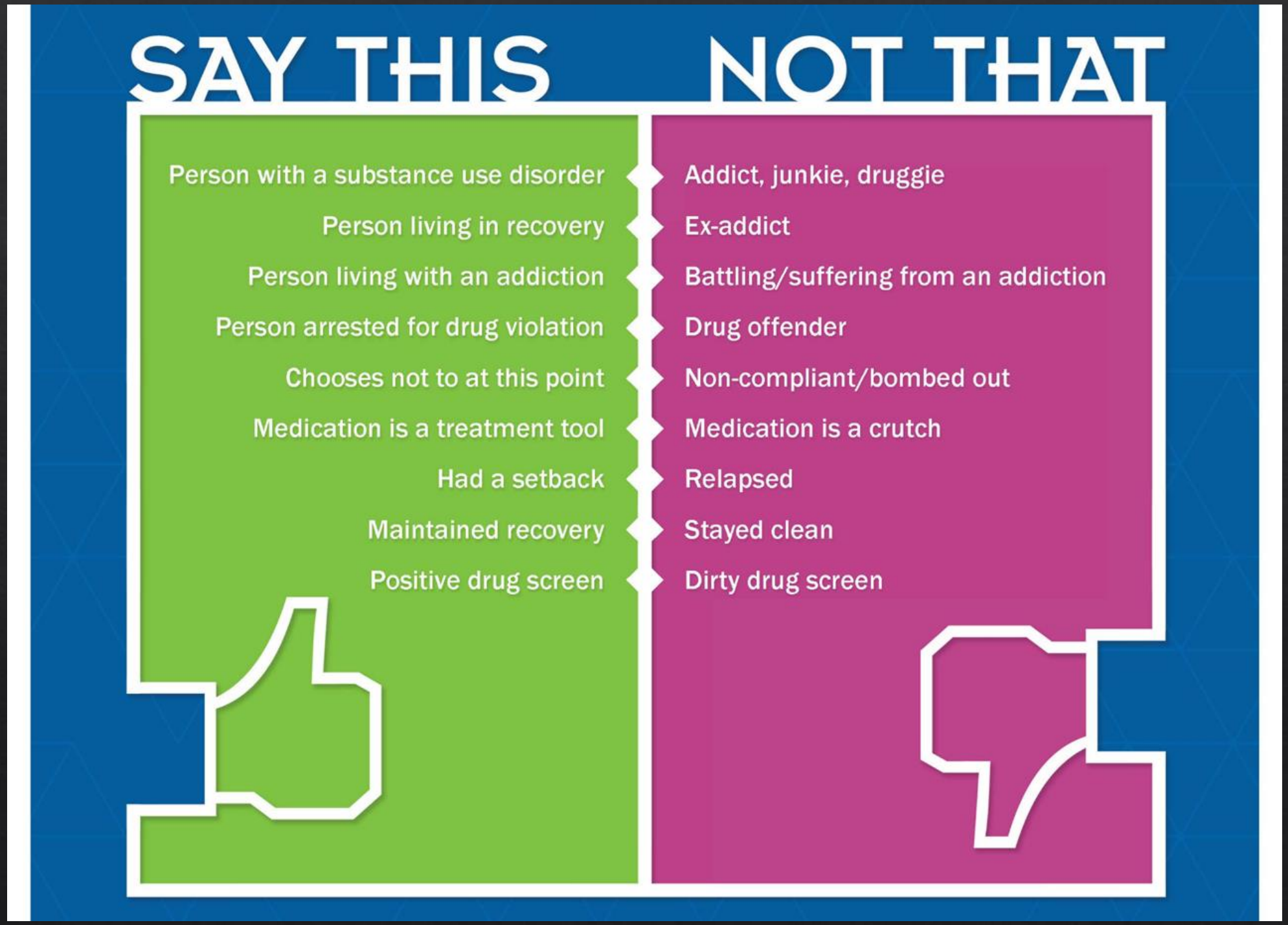
WHAT YOU SAY	WHAT PEOPLE HEAR	TRY SAYING THIS
Drug or Substance Abuse	I am an abuser or it is my fault.	Substance Use or Misuse.
Junkie, Druggie, or Drunk	I am hopeless.	People who use drugs or a person with substance use disorder.
Drug Addict or Town Drunk	I am a criminal.	Person with substance use disorder.
Relapse	I am a failure.	Return to use or recurrence.
Former or Reformed Addict	I am cured.	Person in recovery or long-term recovery.

Terms to Avoid, Terms to Use, and Why

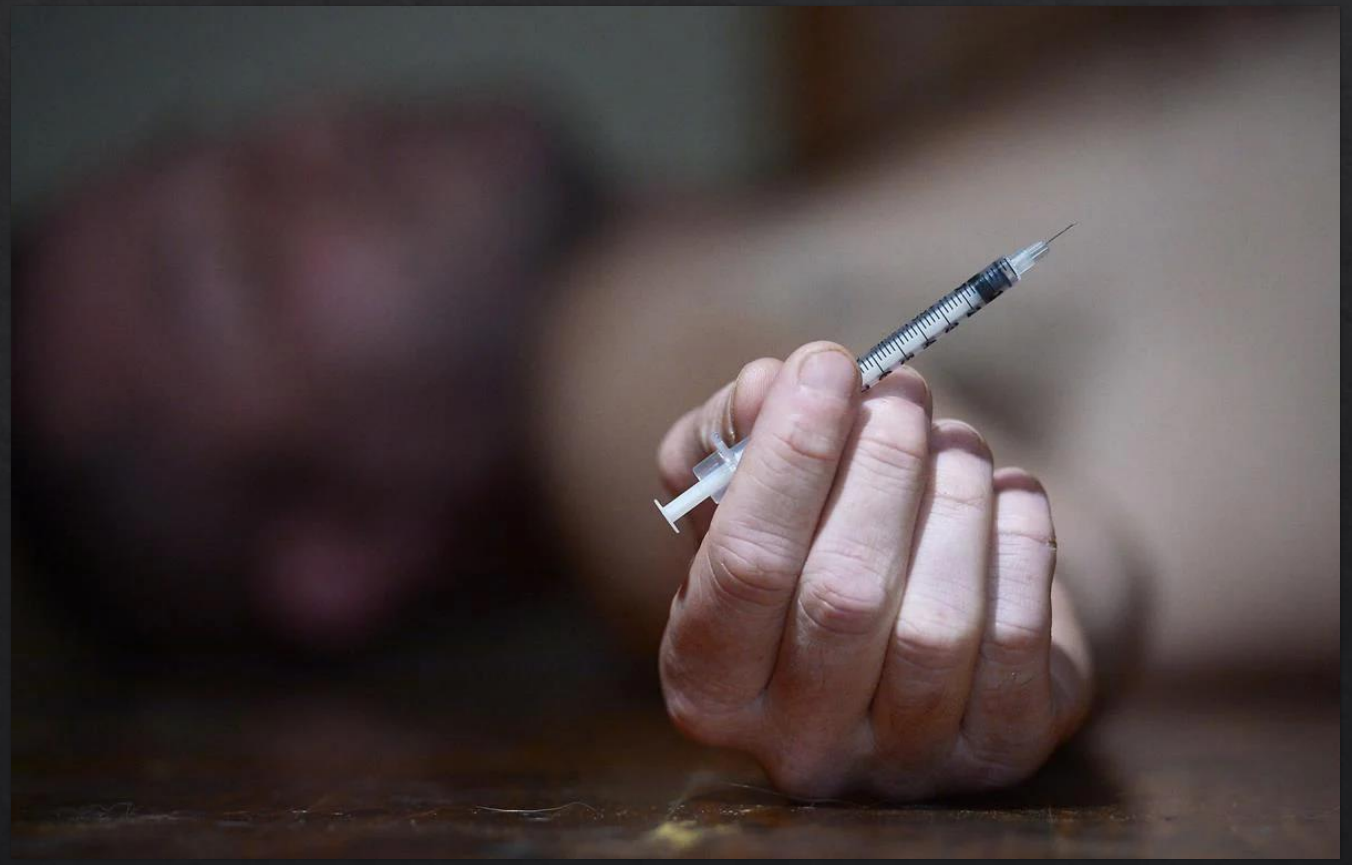
Consider using these recommended terms to reduce stigma and negative bias when talking about addiction.

Instead of...	Use...	Because...
• Addict • User • Substance or drug abuser • Junkie	• Person with substance use disorder[8] • Person with opioid use disorder (OUD) or person with opioid addiction [when substance in use is opioids] • Patient	• Person-first language. • The change shows that a person "has" a problem, rather than "is" the problem.[7] • The terms avoid eliciting negative associations, punitive attitudes, and individual blame.[7]
• Alcoholic • Drunk	• Person with alcohol use disorder • Person who misuses alcohol/engages in unhealthy/hazardous alcohol use	
• Former addict • Reformed addict	• Person in recovery or long-term recovery • Person who previously used drugs	
• Habit	• Substance use disorder • Drug addiction	• Inaccurately implies that a person is choosing to use substances or can choose to stop.[6] • "Habit" may undermine the seriousness of the disease.
• Abuse	**For illicit drugs:** • Use **For prescription medications:** • Misuse • Used other than prescribed	• The term "abuse" was found to have a high association with negative judgments and punishment.[9] • Legitimate use of prescription medications is limited to their use as prescribed by the person to whom they are prescribed. Consumption outside these parameters is misuse.

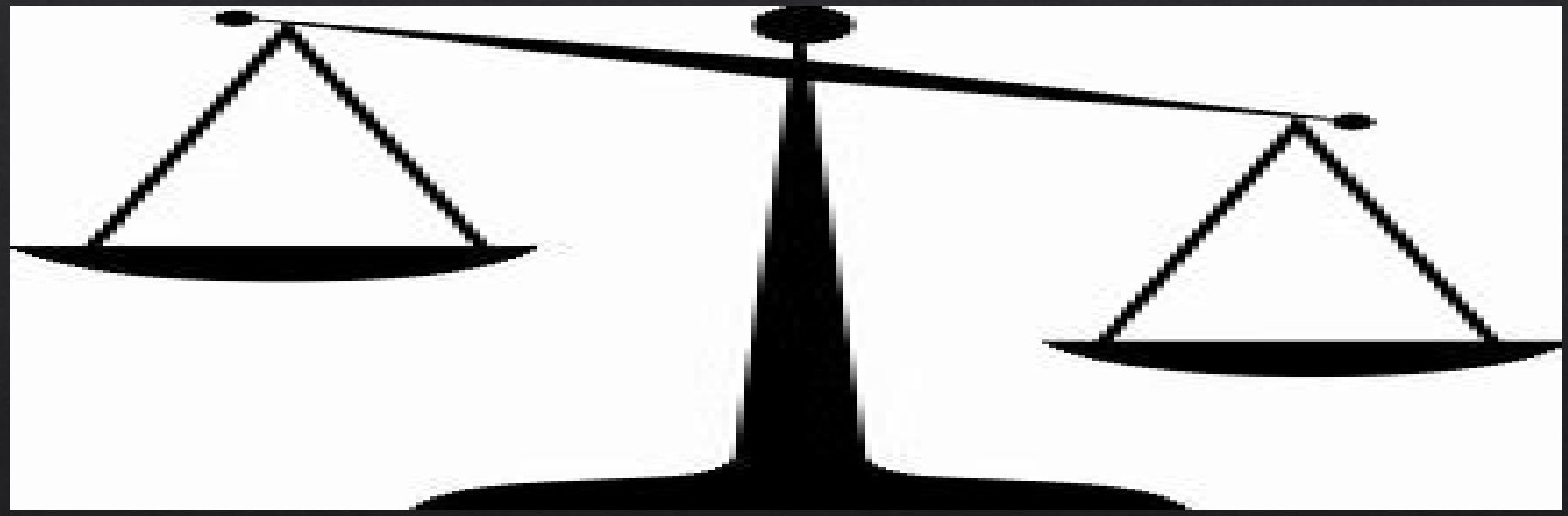
Source: *NIH: National Institute on Drug Abuse*


SAY THIS
NOT THAT
Person with a substance use disorder
Addict, junkie, druggie
Person living in recovery
Ex-addict
Person living with an addiction
Battling/suffering from an addiction
Person arrested for drug violation
Drug offender
Chooses not to at this point
Non-compliant/bombed out
Medication is a treatment tool
Medication is a crutch
Had a setback
Relapsed
Maintained recovery
Stayed clean
Positive drug screen
Dirty drug screen

WORST STIGMA OF ALL IS :
“THESE PEOPLE BROUGHT THIS PROBLEM ON THEMSELVES”



CRIMINAL JUSTICE SYSTEM MEETS SUBSTANCE USE DISORDER



JUSTICE/ACCOUNTABILITY
COMMUNITY PROTECTION

MERCY/RESTORATION OF PERSONS WITH A BEHAVIOR-ALTERING DISEASE

DRUG TREATMENT COURTS

As an alternate to traditional court processing, ***drug treatment court dockets*** *have proven successful in deterring addicts from future criminal acts.*

The ***Recidivism Rate*** *of drug court graduates are approximately half or less than the re-arrest rates of non-drug court graduates.*

Drug Treatment Courts

"Providing Treatment, Promoting Recovery, and Saving Lives"

Drug Treatment Courts

"Providing Treatment, Promoting Recovery, and Saving Lives"

Drug Courts

- Target high risk/high need, non-violent offenders struggling with substance use disorder(s)
- Combine intensive treatment with intensive legal supervision and monitoring
- Hold participants accountable with frequent, non-adversarial contacts with the Drug Court Judge

Drug Treatment Courts

"Providing Treatment, Promoting Recovery, and Saving Lives

- Individualize behavior responses to address continued use, cravings, withdrawal, failure to make progress, and other issues related to his/her substance use disorder(s)
- Impose graduated sanctions for failure to adhere to program rules and expectations
- Provide rewards and incentives for positive behaviors, appropriate decision making, progress in treatment, etc.
- Utilize Evidenced Based treatment and support services

Drug Treatment Courts

"Providing Treatment, Promoting Recovery, and Saving Lives"

Interdisciplinary Drug Court Teams meet frequently to review each participant's progress or lack of progress and to assess the need for therapeutic interventions, incentives, and/or sanctions.

Chaired by the Drug Court Judge, includes:
Commonwealth Attorney
Treatment
Defense Attorney
Probation/Community Supervision
Law Enforcement

Stigma

NO Access to treatment resources

Learned helplessness – rather than risk experimenting in new options they stay stuck in the fear they know

Drugs **HIJACK** the reward system of the brain

Shame – feel unworthy/unable to change

FEAR – fear rejection, incarceration, unable to change, not safe, abuse or victimize

TRAUMA – substance use is defense mechanism to numb feelings from traumatic event

Harm Reduction – critical distinctions between general population with substance use and justice involved population.

STIGMA WITH MAT

Mediation Assisted Treatment

- MAT is greatly underused, in part due to the **misconception that MAT is substituting one drug for another** (SAMHSA)
- **MAT does not substitute one drug for another**
  - **With the proper dose**, MAT medications have no adverse effects on an individual's intelligence, mental capability, physical functioning, or employability
- Research has proven time and again that MAT is **effective when prescribed and used appropriately**
- MAT is much **underused**, in part due **to discrimination against MAT patients**, despite state/federal laws prohibiting it (SAMHSA)

Medication Assisted Treatment Saves Lives

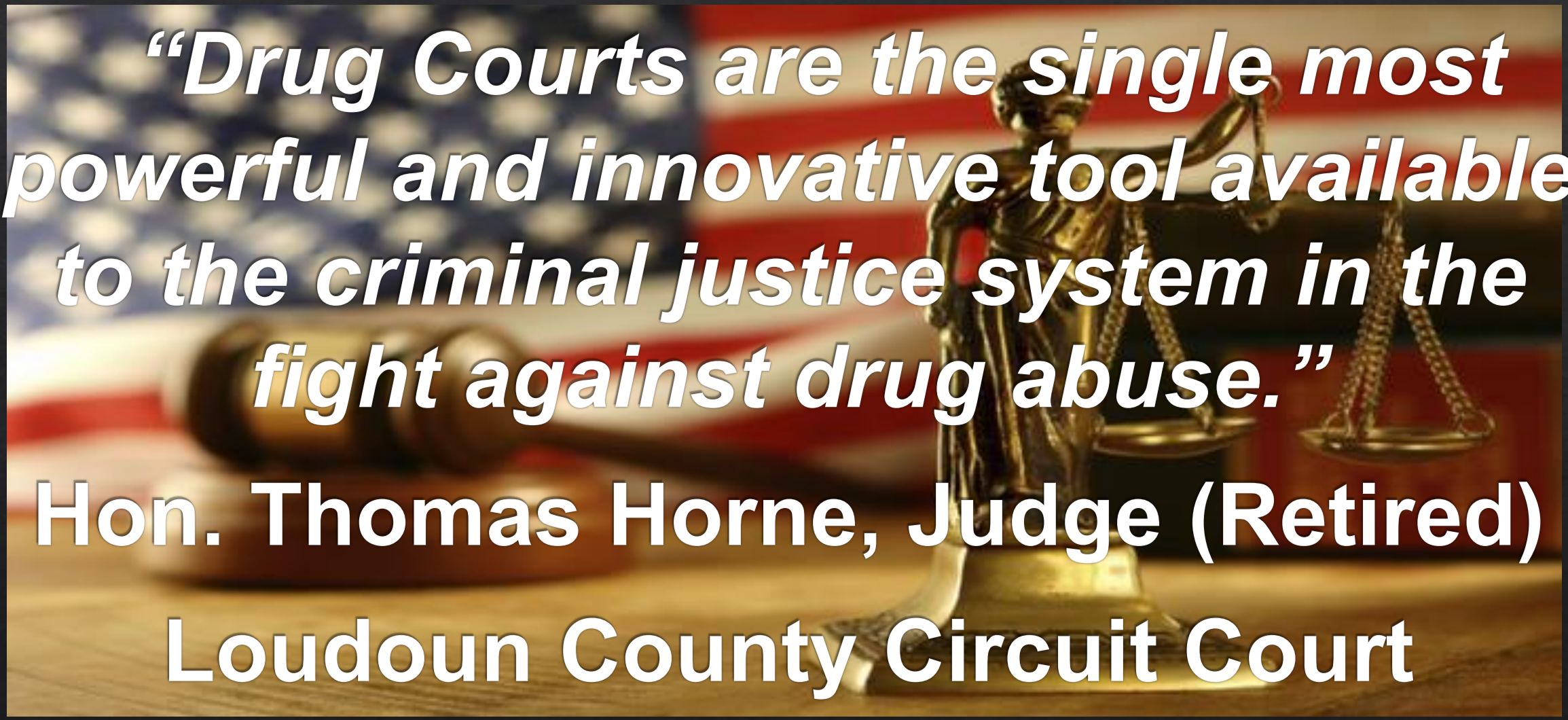
Critical MAT

- Critical - individuals struggling with substance use disorder must have access to **all** FDA approved MAT options and related services and access to competent providers experienced in the treatment of substance use disorders……including Drug Court participants

- Critical - individuals must have access to the MAT option **most appropriate** for his/her needs……..including Drug Court participants

- Critical - individuals and agencies must work together to address and **reduce the stigma** associated with the use of MAT, especially for the treatment of opioid use disorder…..including Drug Court Teams and Drug Court Advisory Committees

- Critical - individuals and agencies must recognize and accept that **there is no recommended maximum duration for MAT maintenance treatment** and that some individuals may need MAT indefinitely, maybe even for the rest of his/her life – including Drug Court Teams and Drug Court Advisory Committees


“Drug Courts are the single most powerful and innovative tool available to the criminal justice system in the fight against drug abuse.”
Hon. Thomas Horne, Judge (Retired)
Loudoun County Circuit Court

Stop Judging; Start Healing

A Judge CAN judge (behaviors) without judging (the person)!

Drug Treatment Courts

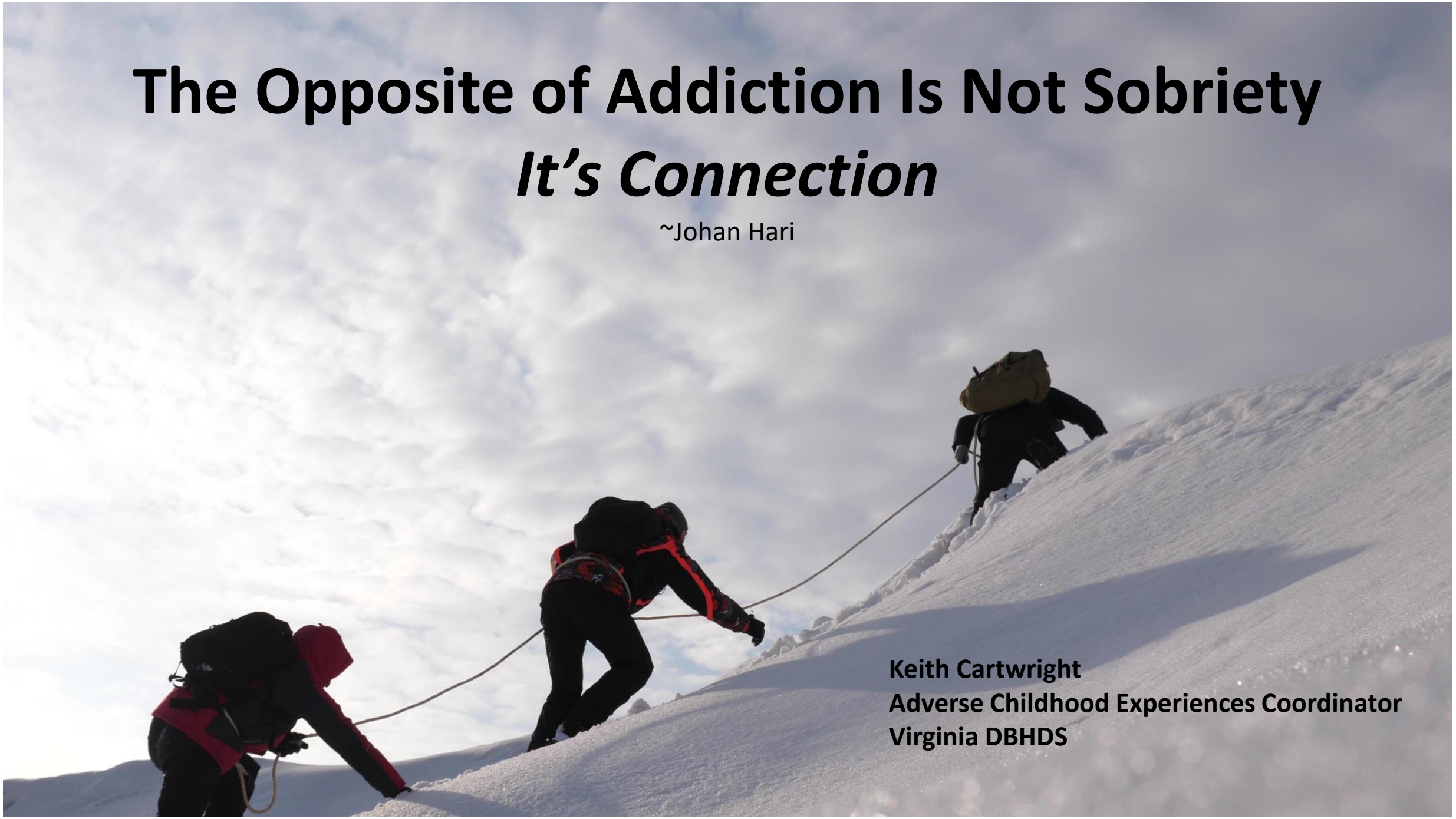
"Providing Treatment, Promoting Recovery, and Saving Lives"

Who's on Board?

The Opposite of Addiction Is Not Sobriety

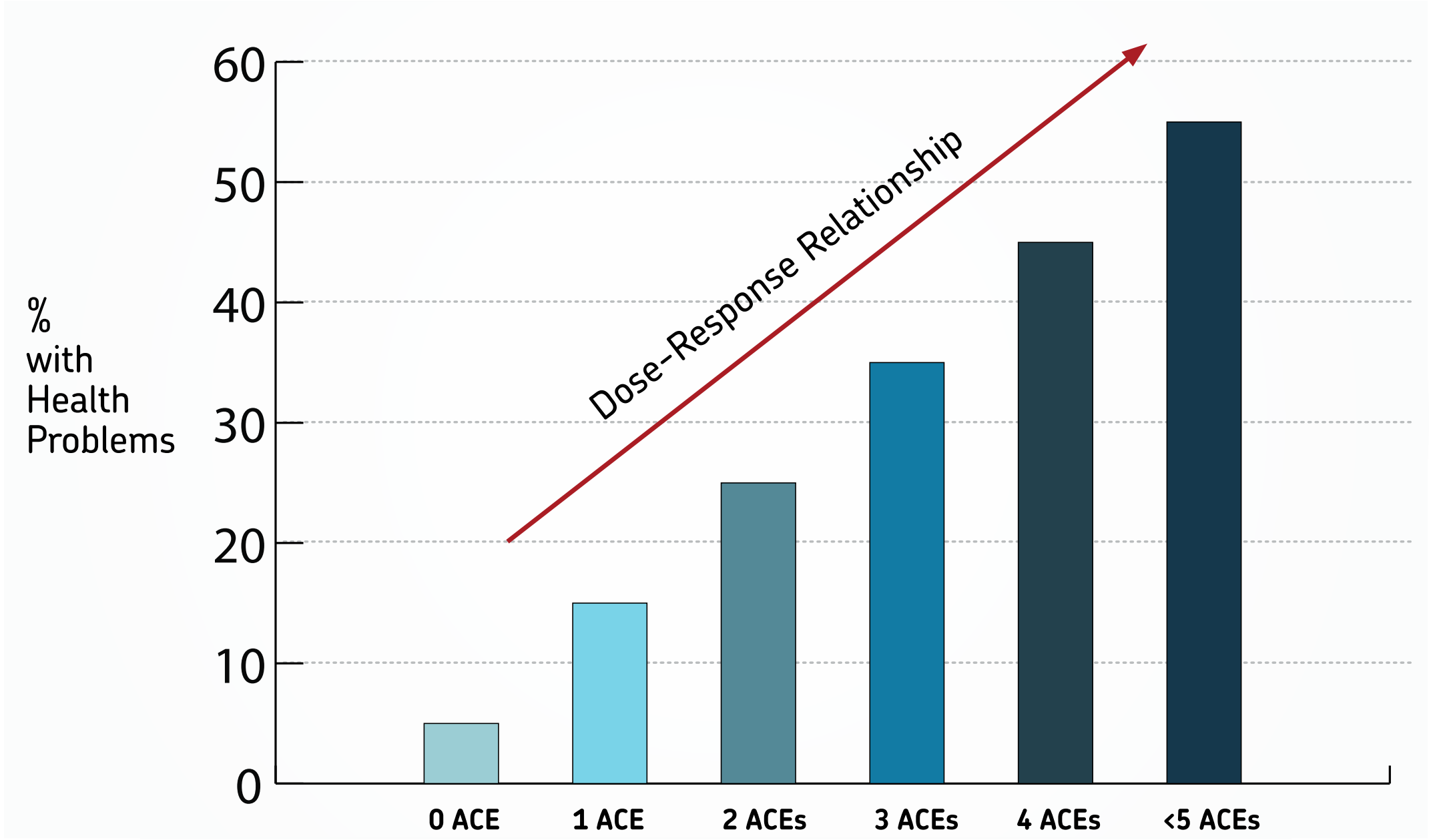
It's Connection

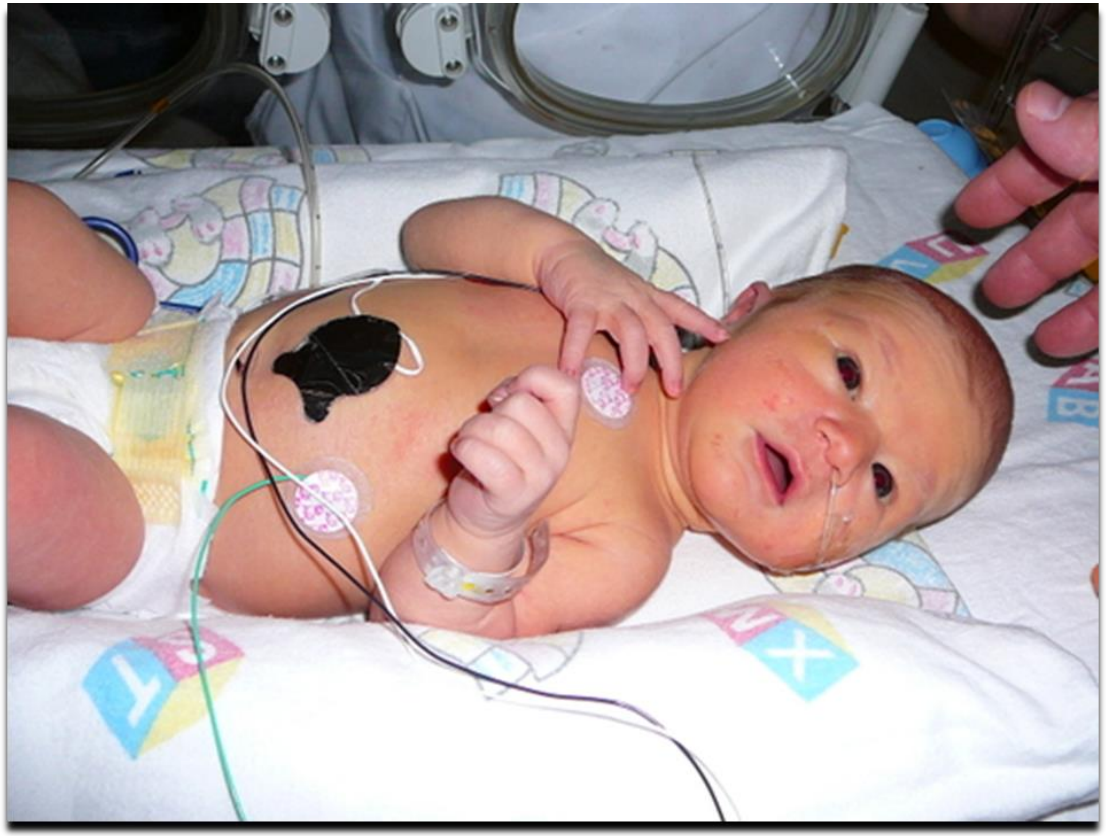
~Johan Hari



Keith Cartwright
Adverse Childhood Experiences Coordinator
Virginia DBHDS

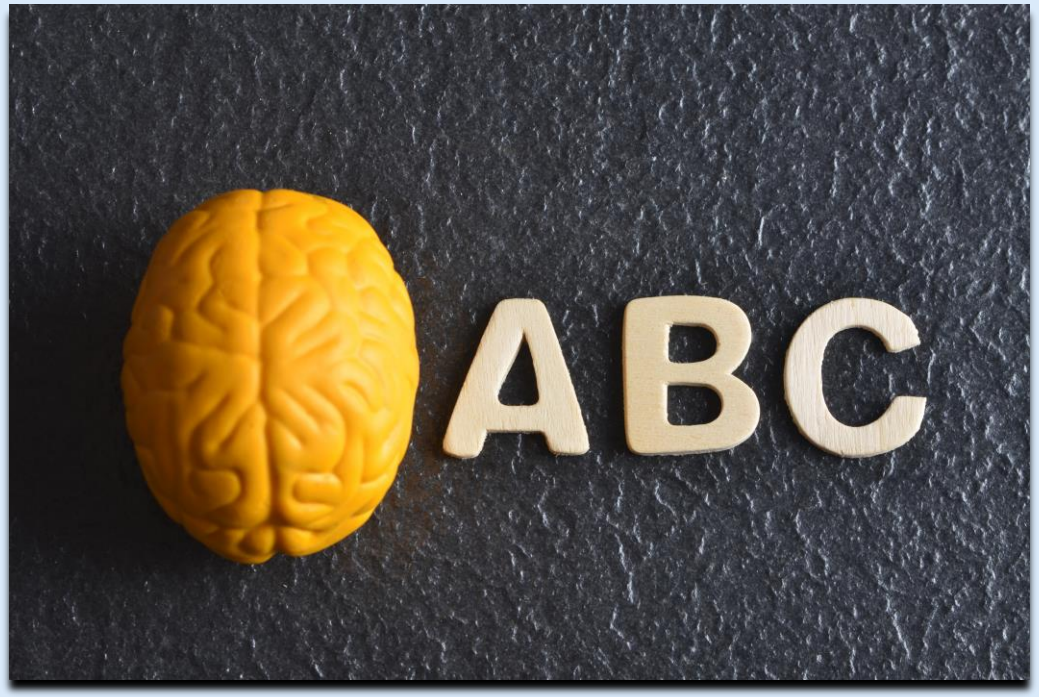
ACE Score and Health Problems





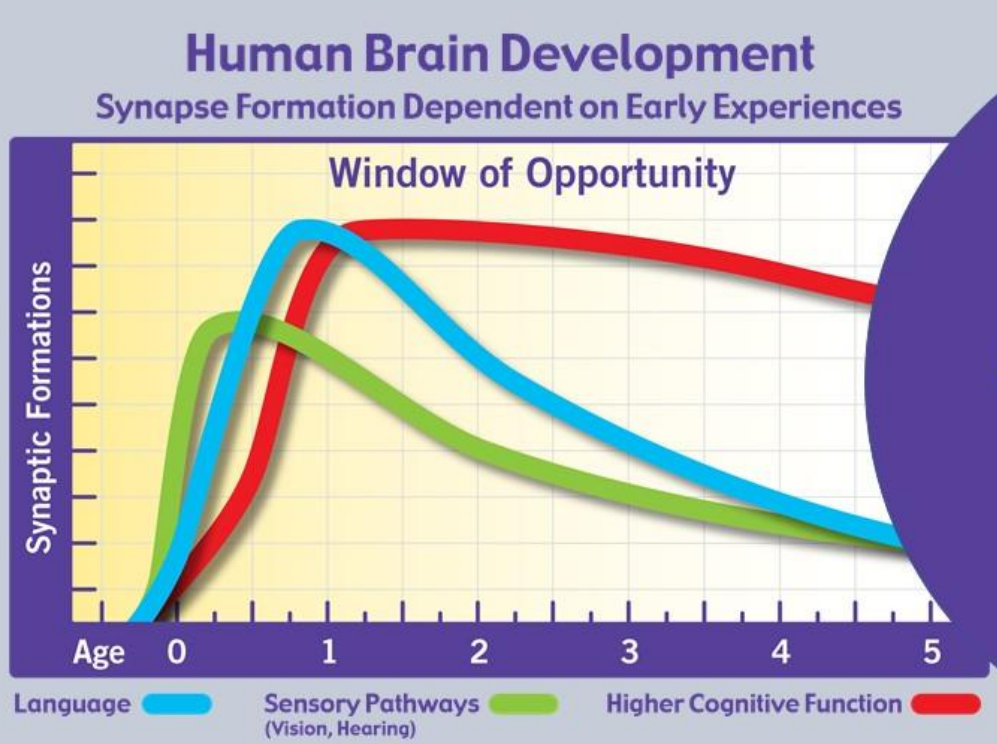
We come into the world looking for someone who is looking for us

~Dr. Curt Thompson

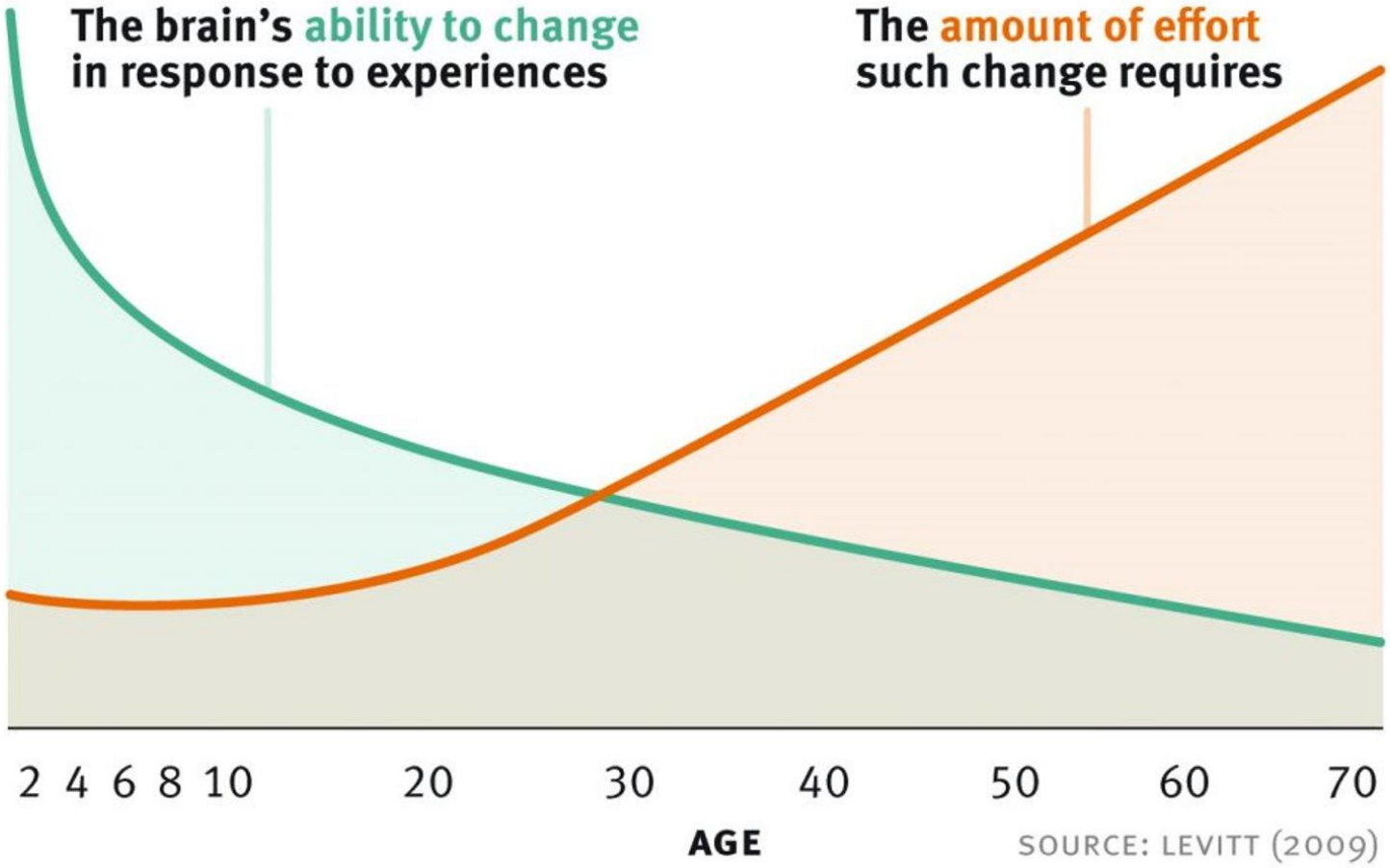


We come into the world with about 100 billion neurons.

Yet, only about 20% of them are connected.

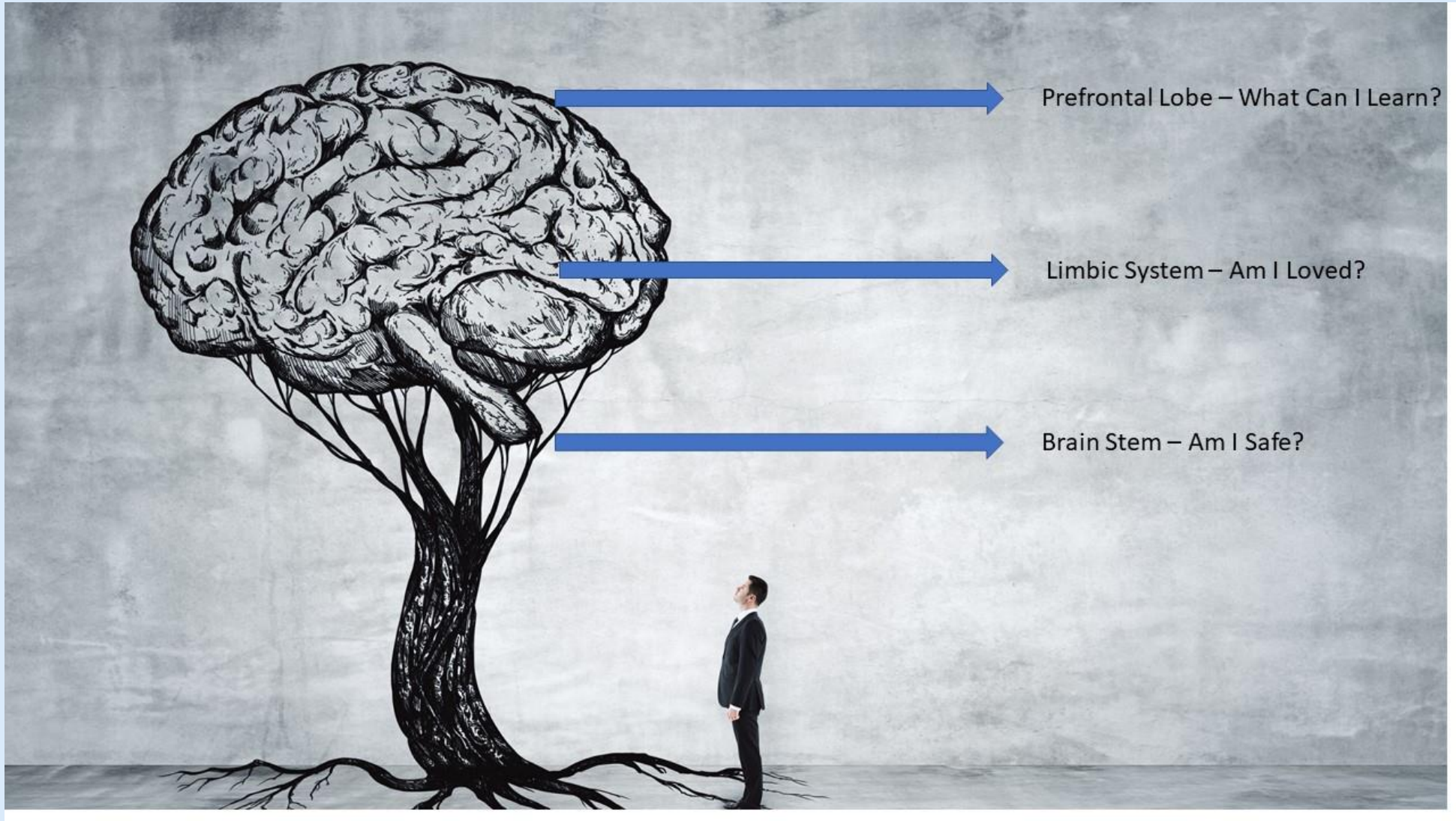


90% of brain growth happens in the first 5 years of life.

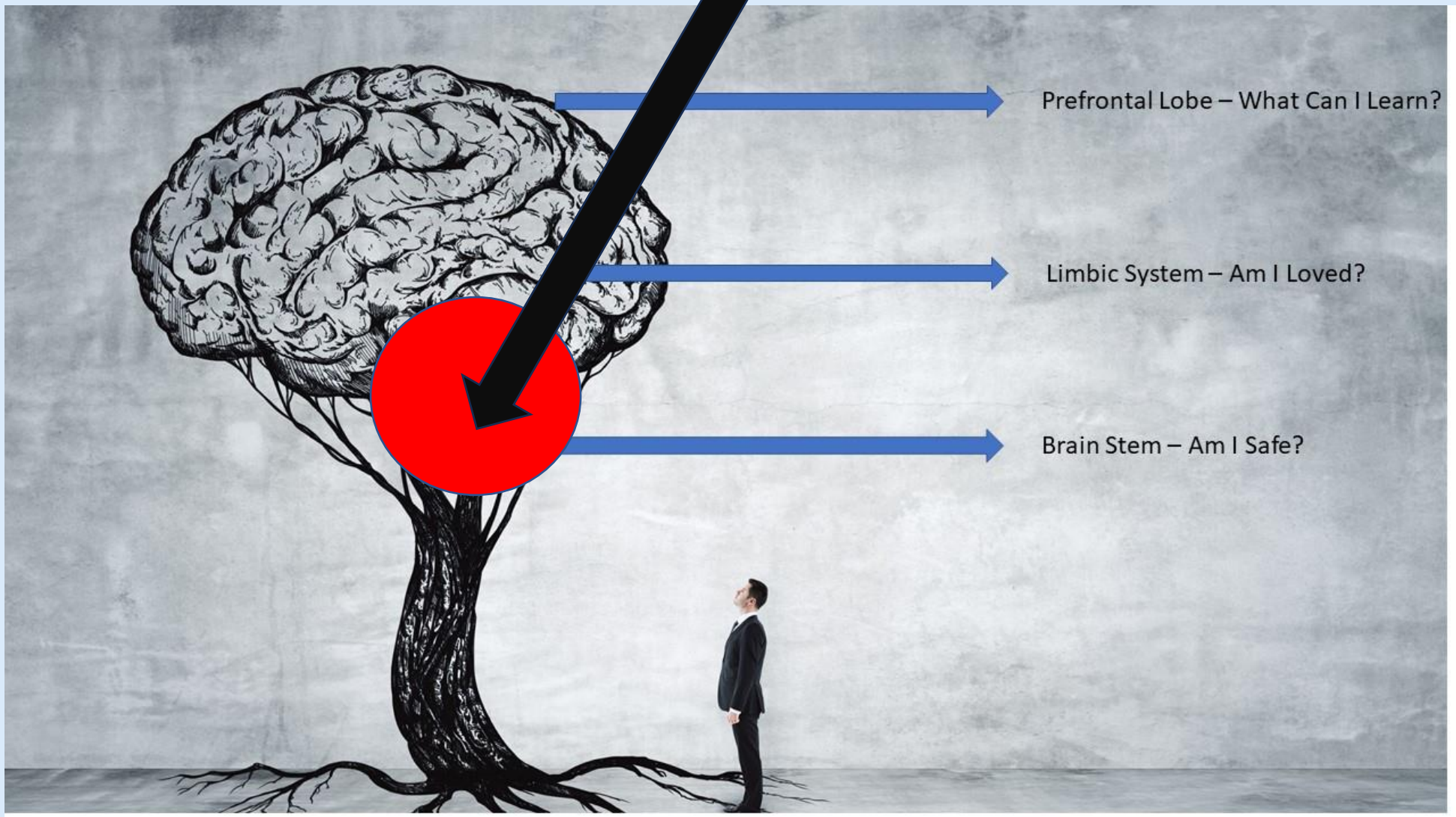


Center on the Developing Child HARVARD UNIVERSITY

http://developingchild.harvard.edu

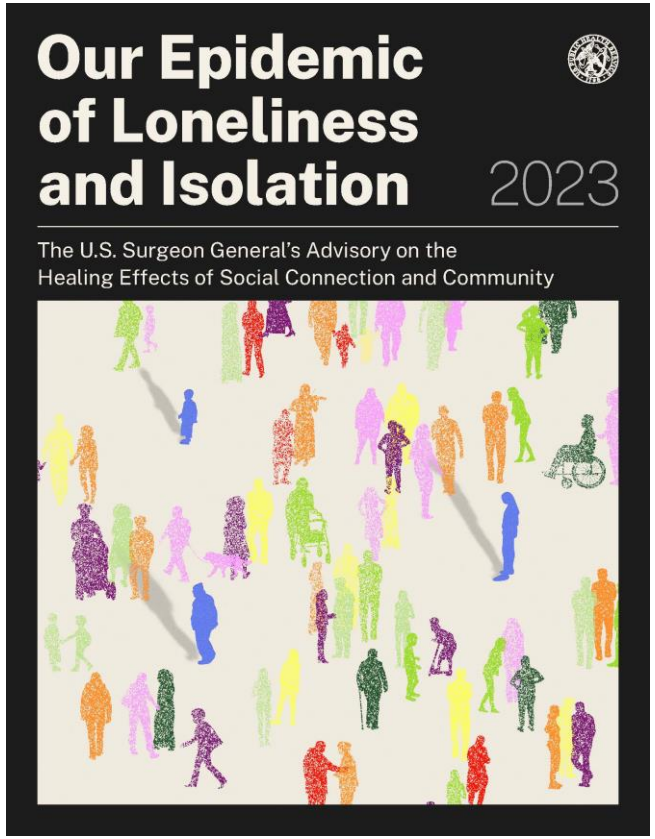

Prefrontal Lobe – What Can I Learn?
Limbic System – Am I Loved?
Brain Stem – Am I Safe?

What is trauma?



~Stephen Porges

"Trauma compromises our ability to engage with others by replacing patterns of connection with patterns of protection."

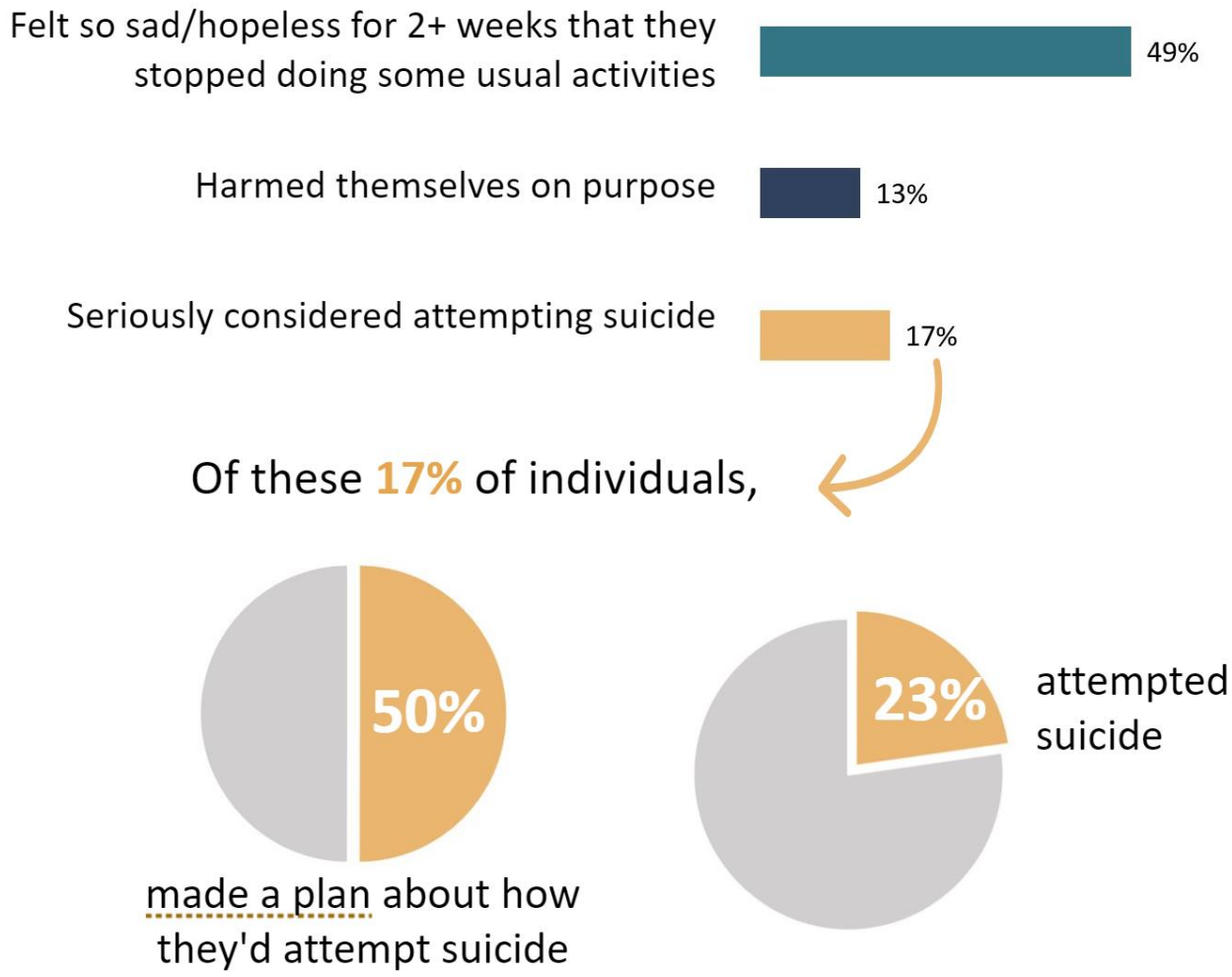


"Social isolation is arguably the strongest and most reliable predictor of suicidal ideation, attempts, and lethal suicidal behavior among samples varying in age, nationality, and clinical severity."[169]

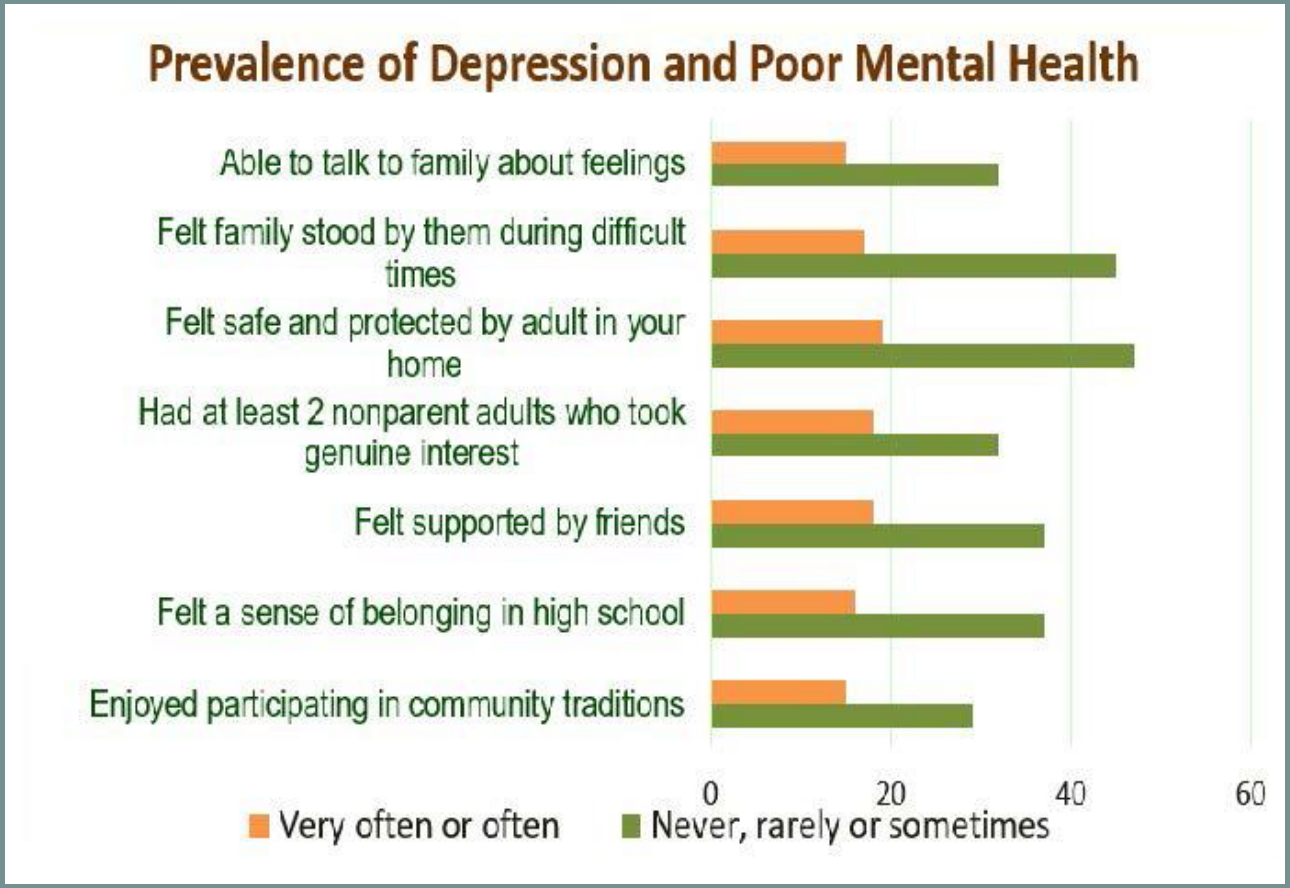
2010 Study, "The Interpersonal Theory of Suicide"

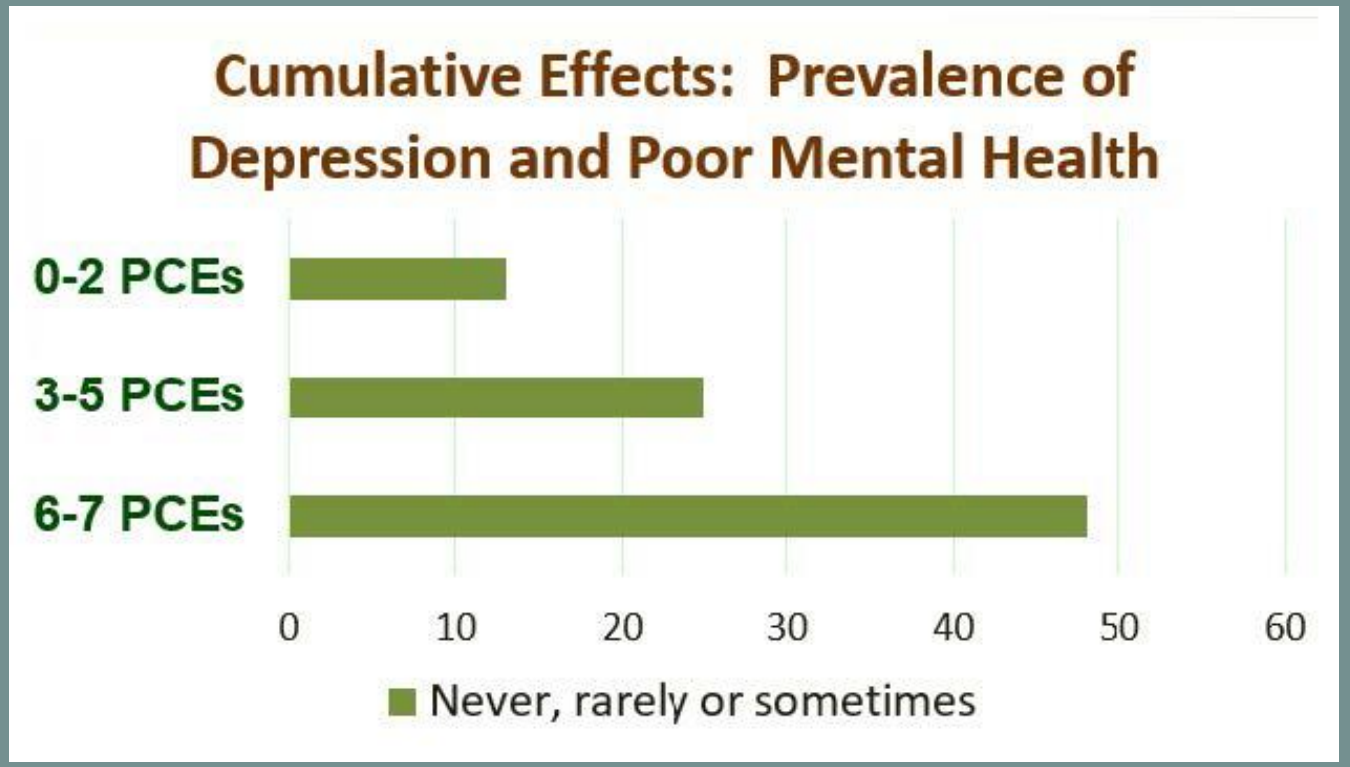
THE LONELINESS EPIDEMIC

Youth Mental Health

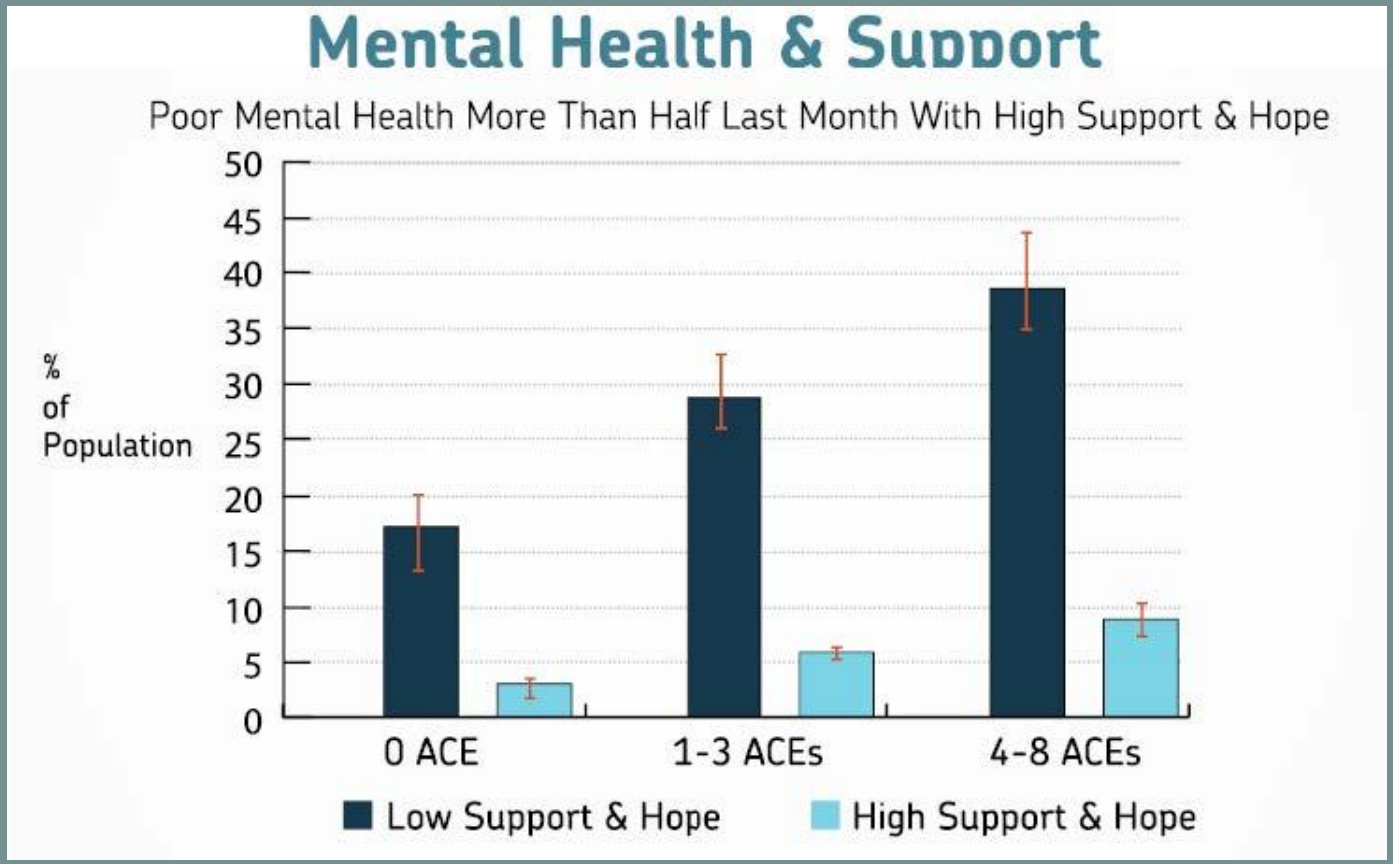


65% SAID THEY NEVER OR ONLY SOMETIMES HAVE SOMEONE TO TALK TO WHEN THEY ARE FACING SOMETHING HARD


Prevalence of Depression and Poor Mental Health
Able to talk to family about feelings
Felt family stood by them during difficult times
Felt safe and protected by adult in your home
Had at least 2 nonparent adults who took genuine interest
Felt supported by friends
Felt a sense of belonging in high school
Enjoyed participating in community traditions
0
20
40
60
Very often or often
Never, rarely or sometimes


Cumulative Effects: Prevalence of Depression and Poor Mental Health
0-2 PCEs
3-5 PCEs
6-7 PCEs
0
10
20
30
40
50
60
Never, rarely or sometimes

Mental Health & Support



We are dependent on relationship. If we can't find a meaningful relationship with SOME ONE, we will turn to a meaningful relationship with SOME THING.

LONELINESS AND ADDICTION ARE OFTEN ENGAGED IN A MUTUALLY REINFORCING CYCLE

Life is a WE thing

ANCHORS

What anchors you?

What makes you a good anchor for someone else?

Update on the Opioid Abatement Authority and the Opioid Settlement Funds

Virginia Supreme Court

Specialty Dockets Training

Presented at the Norfolk Waterside Marriott, Norfolk, VA

September 18, 2023

Opioid Litigation Involving States & Subdivisions

In late 2017 a federal judicial panel consolidated all Federal opioid related litigation into single multi-district litigation (MDL).

Judge Dan Aaron Polster


Carl B. Stokes United States Court House
Cleveland, Ohio

"the biggest and most complicated civil case in U.S. history . . . "
- Washington Post

The First National Settlement Agreements Paid to Cities and Counties in Virginia

The "Distributors"

Johnson and Johnson (Janssen Pharmaceuticals)

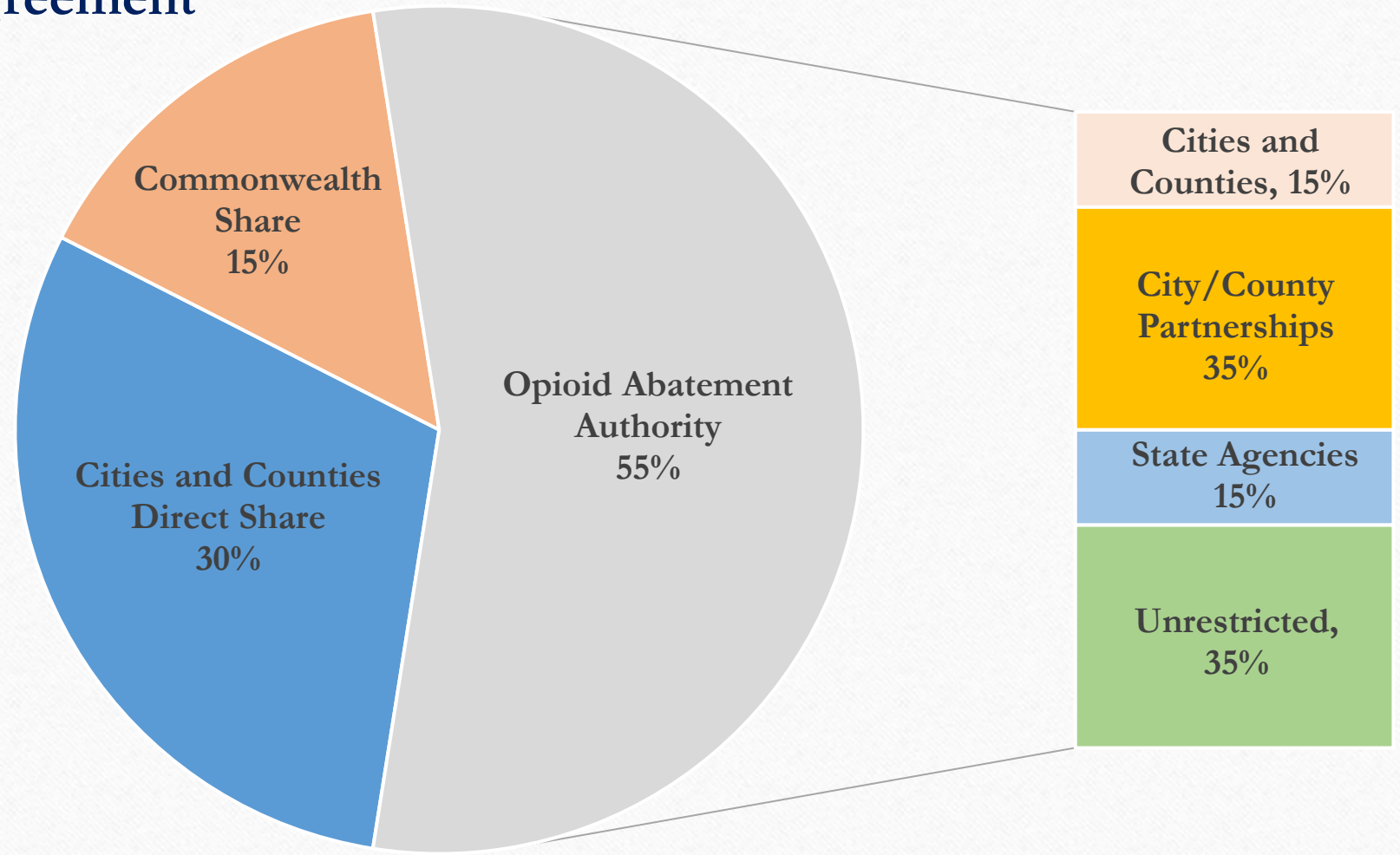
Virginia's Participation in National Settlements

- In late 2021-early 2022, the Virginia Attorney General's office worked with local attorneys and outside counsel representing localities, and with numerous associations, to encourage cities and counties to participate and drop individual suits.
  - ✓ Resulted in a signed **Virginia Allocation MOU** between all 133 cities/counties and the Commonwealth.
  - ✓ General Assembly passed a statute that closely mirrors the MOU.
  - ✓ The MOU and the statute specify that **only cities, counties, and state agencies are eligible to receive financial support from the OAA**.

OAA Board of Directors

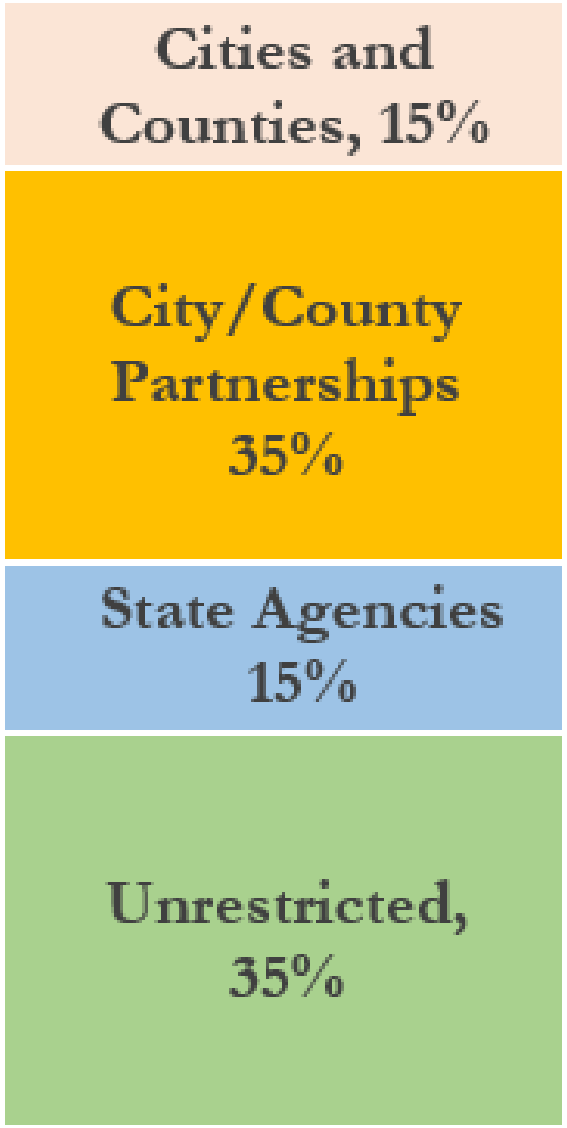
- Senator Todd Pillion (Chair)
- Dr. Sarah Melton (Vice Chair)
- Tim Spencer – Roanoke City Attorney (Secretary)
- Jim Holland (Treasurer)
- HHR Secretary John Littel
- Delegate Jason Ballard
- Dr. James Thompson – Master Center
- Sharon Buckman – Piedmont CSB
- Daryl Washington – Fairfax CSB
- Sheriff Joe Baron – Norfolk City
- Mike Tillem – Journey House

Virginia's Settlement Distribution Agreement



OAA Disbursements to Cities, Counties, and State Agencies.

Minimum Percentages



Settlement Negotiations in the Pipeline

Nationally Negotiated Settlement Agreements Specify How the Funds May be Used

- Each settlement is slightly different from the others.
- However, they all reference "Exhibit E," which is a list of approved uses.
- At least 85% of funds must be used for these approved "abatement" uses. In many cases that number is 100%.
- Varying rules about future versus past spending, supplanting.
- Enforcement and reporting is not always clear.
- Disputes will be resolved in civil court.
- Virginia and her 133 cities and counties share the risk under any such litigation.

Virginia's Requirements on the use of OAA Funds Exceed the Requirements of the National Settlement Agreements

- 100% of the OAA's disbursements to cities, counties and state agencies ***must be*** spent on abatement efforts.
- There is no reimbursement of previous costs or supplanting allowed.
- No indirect charges allowed.
- Recipients must report outcomes to OAA on an annual basis and allow OAA to monitor the programs.

More Background . . . What exactly is "ABATEMENT"

- Before we talk about how the funds are distributed, we first need to talk about what "abatement" means.
  - ✓ This term appears throughout the national settlement agreements
  - ✓ Also is key provision of the Virginia Allocation MOU and the State Code
  - ✓ Has specific legal meaning, and yet is broad in its applicability
- An understanding of what is – and is not – "abatement" is important.
- Part of the OAA Board's responsibility is to determine what qualifies as abatement when making decisions about financial support.

What is "Abatement"

Efforts designed to treat, prevent, or reduce opioid use disorder or the misuse of opioids or otherwise abate or remediate the opioid epidemic, which may include efforts to:

- Support treatment of opioid use disorder and any co-occurring substance use disorder or mental health conditions through evidence-based or evidence-informed methods, programs, or strategies;
- Support people in recovery from opioid use disorder and any co-occurring substance use disorder or mental health conditions through evidence-based or evidence-informed methods, programs, or strategies;
- Provide connections to care for people who have, or are at risk of developing, opioid use disorder and any co-occurring substance use disorder or mental health conditions through evidence-based or evidence-informed methods, programs, or strategies;

"Abatement" cont'd . . .

- Support efforts, including law-enforcement programs, to address the needs of persons with opioid use disorder and any co-occurring substance use disorder or mental health conditions who are involved in, or are at risk of becoming involved in, the criminal justice system through evidence-based or evidence-informed methods, programs, or strategies;
- Support drug treatment and recovery courts that provide evidence-based or evidence-informed options for people with opioid use disorder and any co-occurring substance use disorder or mental health conditions;
- Support efforts to address the needs of pregnant or parenting women with opioid use disorder and any co-occurring substance use disorder or mental health conditions and the needs of their families, including infants with neonatal abstinence syndrome, through evidence-based or evidence-informed methods, programs, or strategies;

"Abatement" cont'd . . .

- Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed methods, programs, or strategies;
- Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed methods, programs, or strategies; and
- Support efforts to provide comprehensive resources for patients seeking opioid detoxification, including detoxification services.

Examples of efforts that are likely to qualify as "abatement."

- Prevention programs including within schools
- Detox services that include opioid-related detoxification
- Naloxone purchase, training, and distribution
- Treatment services including medication for opioid use disorders (MOUD)
- Programs to divert people from jail to treatment, including drug courts.
- Recovery housing, linkages to transportation, job training, employment.
- Behavioral health crisis programs if there is a clear connection to serving people with opioid use disorders as a central component of the program.

How will Virginia track the use of funds

1. In accordance with *Code of Virginia § 2.2-2370* all expenditures of OAA funds shall be conducted or managed by a participating locality or state agency.
    - Every city and county is required by law to conduct an outside audit and report its expenditures to the state *(Code of Virginia § 15.2-2511)*.
2. Grant expenditures must also be reported directly to the OAA
    - Performance measures must be reported to the OAA
    - OAA will be performing site visits and inspections
    - Any concerns can result in detailed financial and programmatic reviews.

First Round of Grants to Cities and Counties (FY23-24)

- Application period for cities and counties ran January 19 –May 5
  - Resulted in $23 Million in awards to 76 cities and counties
  - Most applications were for cooperative partnerships
  - Other awards were for individual city/county efforts as well as planning grants

Next Round of Grants to Cities and Counties (FY24-25)

- Next application period for cities and counties will be October 1 – April 1
  - ✓ OAA is encouraging more individual applications
  - ✓ Slight changes in the application process envisioned
  - ✓ Individual awards can be made on a rolling basis

Funding for State Agencies

- OAA solicited RFPs from State Agencies from April 21 to June 21:
  - Received 16 proposals
    - ✓ Included 32 projects
    - ✓ Total of $22.7 million in requests
  - OAA Budget was $8 million
  - OAA staff worked with submitting agencies to define options
  - Awards announced by the OAA after August 18, 2023


Substance Use Disorders
Long-term community concern
High unemployment
Poverty
Sense of hopelessness
Barrier to economic development
OMNI RICHMOND HOTEL


Virginia Opioid Abatement Authority
Grant Programs Official Launch
January 19, 2023
Individual Cities & Counties Projects
Cooperative Projects Involving Multiple Cities and/or Counties


REVIVE!

For more information

Tony McDowell, Executive Director

Opioid Abatement Authority

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(804) 500-1808

www.voaa.us

Adult Drug Court Best Practice Standards, 2nd Edition: A Preview ~ Part 1

Aaron Arnold, Chief Development Officer
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Why Standards?

- ✓ Promote consistent adherence to evidence-based practices
- ✓ Prevent return to old habits (model drift)
- ✓ Protect the model from encroachment
- ✓ Define standards for ourselves

Why Standards?

- ✓ Reduce legal errors
- ✓ Promote equitable treatment and outcomes
- ✓ Provide justification for needed services and financial investment
- ✓ Demonstrate maturity of our profession
- ✓ Because we care about getting it right!

Structure

I. **General Principle**
   A. Provision
   B. Provision

✓ **Commentary**
   A. Justification
   B. Justification

✓ **References**

The Standards

I. **Target Population** *(all else follows from this)*

II. Equity and Inclusion

III. **Roles & Responsibilities of the Judge**

IV. Incentives, Sanctions, and Service Adjustments

V. Substance Use, Mental Health, and Trauma Treatment and Recovery Management

The Standards

VI. Complementary Services

VII. Drug and Alcohol Testing

VIII. Multidisciplinary Team

IX. Census and Caseloads

X. Monitoring and Evaluation

Standard I: Target Population

I. Target Population

A. Objective Eligibility and Exclusion Criteria
B. Proactive Recruitment
C. High-Risk and High-Need Participants
D. Valid Eligibility Assessments
E. Criminal History Considerations
F. Treatment Considerations

I. Target Population

2nd Edition Standard 1

A. Objective eligibility and exclusion criteria
B. Proactive recruitment
C. High-risk and High-need participants
D. Valid eligibility assessments
E. Criminal history considerations
F. Treatment considerations

Current Standard 1

A. Objective eligibility and exclusion criteria
B. High-risk and high-need participants
C. Validated eligibility assessments
D. Criminal history disqualifications
E. Clinical disqualifications

I. Target Population

A. Objective Eligibility and Exclusion Criteria

- Criteria must be objective and in writing
- **No subjective criteria or personal impressions (suitability)**
  - Motivation for change
  - Complex needs
  - Attitude
  - Optimism about recovery

I. Target Population

B. Proactive Recruitment

- Strive for rapid enrollment
- Educate stakeholders about the program
- Post information in strategic locations
- Offer immediate voluntary pre-plea services
- Ideal scenario: universal screening

I. Target Population

C. High-Risk and High-Need Participants

- Serve the intended population: HR/HN + prison bound
- High risk = likely to commit a new crime or fail on probation
- High need = moderate to severe SUD
  - Inability to reduce or control substance use
  - Persistent cravings
  - Withdrawal symptoms
  - Recurrent binges

I. Target Population

C. High-Risk and High-Need Participants

- If you must serve other populations (LR or LN), create separate tracks and adjust services and supervision accordingly

Do Not Mix High Risk and Low Risk Participants!!

I. Target Population

D. Valid Eligibility Assessments

- Validated risk assessment tool
  - Accurately predicts risk of reoffending or probation revocation
  - Valid for all cultural groups represented in the candidate pool
- Clinical assessment tool
  - Evaluates formal diagnostic criteria for moderate to severe SUD, including cravings, withdrawal symptoms, binge use patterns, and inability to reduce or control use
  - Mental health and trauma screening

I. Target Population

E. Criminal History Considerations

- Persons charged with selling drugs **are not categorically excluded**
- Persons charged with crimes involving violence **are not categorically excluded**
- Candidates are excluded based on current charges or criminal history ONLY if empirical evidence demonstrates that persons cannot be served safely or effectively in treatment court

I. Target Population

F. Treatment Considerations

- Candidates are not excluded because they:
  - have co-occurring mental health or trauma disorders, medical conditions, inadequate housing, or other specialized needs
  - have been prescribed medication for addition treatment, psychiatric medication, or other medications

Standard III: Roles and Responsibilities of the Judge

III. Judge

A. Judicial Education
B. Judicial Term
C. Pre-Court Staff Meetings
D. Status Hearings
E. Judicial Decision Making

III. Judge

2nd Edition Standard 3

A. Judicial education
B. Judicial term
C. Pre-court staff meetings
D. Status hearings
E. Judicial decision making

Current Standard 3

A. Professional training
B. Length of term
C. Consistent docket
D. Participation in pre-court staffing meetings
E. Frequency of status hearings
F. Length of court interactions
G. Judicial demeanor
H. Judicial decision-making

III. Judge

A. Judicial Education

- Judge attends training (conferences, seminars) at least annually on judicial best practices in treatment courts
  - Legal standards and ethics
  - Achieving cultural equity
  - Behavior modification
  - Communication with clients
  - Foundational information about treatment, community supervision, drug and alcohol testing, and performance evaluation

III. Judge

B. Judicial Term

- Judge is assigned to treatment court on a **voluntary basis**
- Judge presides over treatment court for **no less than two years** (and preferably much longer)
- Judge presides in treatment court **consistently**
- New treatment court judges receive training before taking over
- If feasible, replacement judges are assigned new enrollments while existing cases stay with the prior judge

III. Judge

C. Pre-Court Staff Meetings

- Judge attends pre-court staff meetings routinely
- Judge ensure that each team members contributes their observations and provides recommendation for action
- Judge considers each team members professional expertise and strategies effective responses with the team

III. Judge

D. Status Hearings

- Participants appear in court no less than every two weeks during the first phase or until they are clinically stable
- Participants continue to attend status hearings on at least a monthly basis for their first year in the program
- Judge interacts with participants in procedurally fair and respectful manner, develops working alliance, and holds participants accountable
- Judge's interactions with participants are 3-7 minutes long

III. Judge

E. Judicial Decision Making

- Judge must make final decisions concerning the imposition of incentives, sanctions, or dispositions
- Judge relies on qualified treatment professionals when setting court-ordered treatment conditions.
- Judge's decisions are made after carefully considering input from other team members
- Judge does **NOT** order, deny, or alter treatment conditions independent of expert clinical advice

Standard VIII: Multidisciplinary Team

VIII. Multidisciplinary Team
(Current Standard 8)

A. Team Composition
B. Pre-Court Staffing Meetings
C. Sharing Information
D. Team Communication and Decision Making
E. Status Hearings
F. Team Training

New Standards: Don’t Know Yet!

VIII. Multidisciplinary Team

A. Team Composition

- Team includes representatives from all partners agencies, including but not limited to:
  - Judge
  - Program coordinator
  - Prosecutor
  - Defense attorney
  - Treatment representative
  - Supervision officer
  - Law enforcement officer

VIII. Multidisciplinary Team

B. Pre-Court Staff Meetings

- All team members consistently attend pre-court staff meetings, where the team:
  - Reviews participant progress
  - Prepares for status hearings in court
  - Does not permit participants to attend (unless there is a compelling reason)
  - Does not allow the public to attend

VIII. Multidisciplinary Team

C. Sharing Information

- Team members share information as needed to gauge participants' progress in treatment and compliance with program conditions
- Agencies execute MOUs for information sharing
- Participants provide voluntary and informed consent to shared specified information regarding treatment progress
- Defense attorneys make it clear to participants and other team members whether they will share participants communications with the team

VIII. Multidisciplinary Team

D. Team Communication and Decision Making

- Team members contribute information, observations, and recommendations based on their professional knowledge, training, and experience
- Judge considers the perspectives of all team members before making decisions that affect participants' welfare or liberty interests
- Judge explains the rationale for decisions to team and participants

VIII. Multidisciplinary Team

E. Status Hearings

- Team members consistently attend status hearings
- During status hearings, team members contribute relevant information or recommendations when requested by the judge or as necessary to improve outcomes or protect participants' legal interests

VIII. Multidisciplinary Team

F. Team Training

- Before starting a treatment court, team members attend formal pre-implementation training to learn best practices and develop effective policies and procedures
- After launching the court, team members attend continuing education workshops at least annually
- New staff receive a formal orientation training on best practices

Standard IX: Census and Caseloads

IX. Census and Caseloads
(Current Standard 9)

A. Drug Court Census
B. Supervision Caseloads
C. Clinical Caseloads

New Standards: Don’t Know Yet!

IX. Census and Caseloads

A. Drug Court Census

- The drug court does not impose arbitrary restrictions on the number of participants it serves
- The drug court census is based on local needs, resources, and ability to apply best practices
- When the court census reaches 125 active participants, operations are monitored carefully to ensure consistency with best practices

IX. Census and Caseloads

B. Supervision Caseloads

- Caseloads for probation officers or other community supervision professionals must permit sufficient opportunities to:
  - Monitor participant performance
  - Apply effective behavioral consequences
  - Report pertinent compliance information during pre-court staff meeting and status hearings

IX. Census and Caseloads

B. Supervision Caseloads

- When supervision caseloads exceed 30 active participants per officer, operations are monitored carefully to ensure that officers can evaluate participant performance accurately
- Supervision caseloads do not exceed 50 active participants per officer

IX. Census and Caseloads

C. Clinical Caseloads

- Clinical caseloads must permit sufficient opportunities to access participant needs and deliver effective dosages of treatment and complementary services
- Programs operations are monitored carefully to ensure adequate services are being delivered when caseloads exceed:
  - 50 participants for clinicians providing clinical case management
  - 40 participants for clinicians providing individual therapy or counseling
  - 30 participants for clinicians providing both CCM and individual therapy

Standard X: Monitoring and Evaluation

X. Monitoring and Evaluation
(Current Standard 10)

A. Adherence to Best Practices
B. In-Program Outcomes
C. Criminal Recividism
D. Independent Evaluations
E. Historical Discriminated Against Groups
F. Electronic Database
G. Timely and Reliable Data Entry
H. Intent-to-Treat Analyses
I. Comparison Groups
J. Time at Risk

New Standards: Don't Know Yet!

X. Monitoring and Evaluation

A. Adherence to Best Practices

- Drug court monitors its adherence to best practices at least annually
- Develops remedial action plan to fix deficiencies
- Examines the success of remedial actions
- Outcome evaluations describe the effectiveness of the drug court in relation to its adherence to best practices

X. Monitoring and Evaluation

B. In-Program Outcomes

- Drug court continually monitors participant outcomes
  - Attendance at appointments
  - Drug and alcohol test results
  - Graduation rates
  - Lengths of stays
  - In-program technical violations and new arrests

X. Monitoring and Evaluation

C. Criminal Recidivism

- Drug court monitors participants' new arrests, new convictions, and new incarcerations within three years of program entry
- Offenses are categorized according to severity (felony, misdemeanor, violation) and nature (person, property, drug, traffic) of the crime

X. Monitoring and Evaluation

D. Independent Evaluations

- A skilled and independent evaluator examines the drug court's adherence to best practices and participant outcomes at least every five years
- The drug court develops a remedial action plan to implement recommendations from the evaluator to improve adherence to best practices

X. Monitoring and Evaluation

E. Historically discriminated against groups

- Drug court continually monitors admission rates, services delivered, and outcomes achieved for members of groups that have historically experienced discrimination
- Drug court develops a remedial action plan and timetable to correct disparities and examines the success of the remedial actions [see also Standard II, Equity and Inclusion]

X. Monitoring and Evaluation

F. Electronic Database

- Information relating to services provided and participants' in-program performance is entered into an electronic database
- Statistical summaries from the database provide staff with real-time information concerning the Drug Court's adherence to best practices and in-program outcomes

X. Monitoring and Evaluation

G. Timely and Reliable Data

- Staff members are required to record information concerning the provision of services and in-program outcomes within forty-eight hours of the respective events
- Timely and reliable data entry is required of each staff member and is a basis for evaluating staff job performance

X. Monitoring and Evaluation

H. Intent-to-Treat Analysis

- Outcomes are examined for all eligible participants who entered the Drug Court regardless of whether they graduated, withdrew, or were terminated from the program

X. Monitoring and Evaluation

I. Comparison Groups

- Outcomes for drug court participants are compared to those of an unbiased and equivalent comparison group
- Individuals in the comparison group satisfy legal and clinical eligibility criteria for participation in drug court, but did not enter drug court for reasons having no relationship to their outcomes
- Comparison groups do not include individuals who refused to enter the drug court, withdrew or were terminated, or were denied entry

X. Monitoring and Evaluation

J. Time at Risk

- Drug court participants and comparison groups have an equivalent opportunity to engage in conduct of interest to the evaluation, such as substance use and criminal recidivism
- Outcomes for both groups are examined over an equivalent time period beginning from a comparable start date
- If participants in either group were incarcerated or detained in a residential facility for a significantly longer period of time, the length of time participants were detained or incarcerated is accounted for statistically in outcome comparisons

Thank You

Adult Drug Court Best Practice Standards, 2nd Edition: A Preview ~ Part 1

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REVIVE!

Virginia's Opioid Overdose and Naloxone Education Program

Lay Rescuer Training

Updated February 2022

Virginia Department of Behavioral Health & Developmental Services

REVIVE!
OPIOID OVERDOSE AND NALOXONE EDUCATION FOR VIRGINIA

REVIVE!

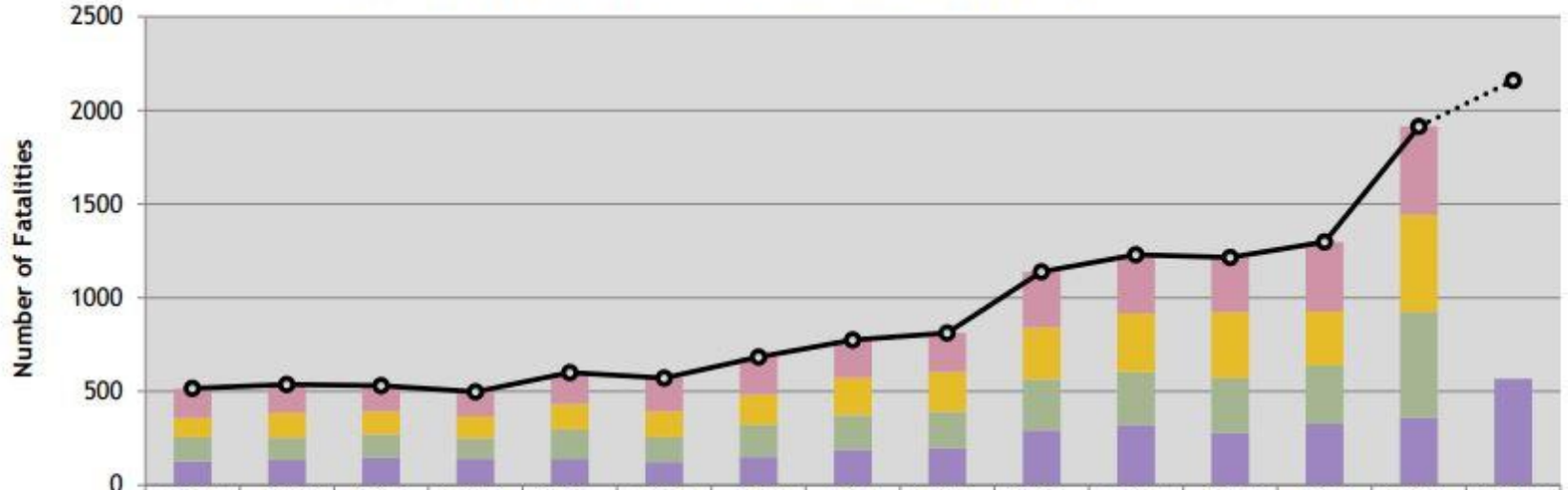
Learning Objectives

- Understand the REVIVE! program and legislation
- Understand addiction
- Understand how opioid overdose emergencies happen and how to recognize them
- Understand how naloxone works
- Identify risk factors that may make someone more susceptible to an opioid overdose emergency
- Dispel common myths about how to reverse an opioid overdose
- Learn how to respond to an opioid overdose emergency with the administration of naloxone

ALL OPIOIDS

From 2007-2015, opioids (fentanyl, heroin, U-47700, and/or one or more prescription opioids) made up approximately 75% of all fatal drug overdoses annually in Virginia. However, this percentage is increasing each year due to the significant increase in fatal fentanyl and/or heroin overdoses which began in late 2013 and early 2014. In 2020, 83.0% of all fatal overdoses of any substance, were due to one or more opioids. In 2020, all fatal opioid overdoses increased 47.5% from the previous year.

Total Number of Fatal Opioid Overdoses by Quarter and Year of Death, 2007-2021*
Data for 2021 is a Predicted Total for the Entire Year



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021*
Q4	156	151	136	131	168	179	202	201	208	298	312	292	371	472	
Q3	104	134	122	116	136	137	158	202	213	275	312	351	286	519	
Q2	130	120	128	109	156	134	173	185	195	272	284	292	314	564	
Q1	126	133	144	142	141	122	151	187	196	293	321	280	327	360	568
Total Fatalities	516	538	530	498	601	572	684	775	812	1138	1229	1215	1298	1915	2160

[1] 'All Opioids' include all versions of fentanyl, heroin, prescription opioids, U-47700, and opioids unspecified
[2] 'Opioids Unspecified' are a small category of deaths in which the determination of heroin and/or one or more prescription opioids cannot be made due to specific circumstances of the death. Most commonly, these circumstances are a result of death several days after an overdose, in which the OCME cannot test for toxicology because the substances have been metabolized out of the decedent's system.
[3] Fatal opioid numbers have changed slightly from past reports due to the removal of fentanyl from the category of prescription opioids, as well as the addition of buprenorphine, levorphanol, meperidine, pentazocine, propoxyphene, and tapentadol added to the list of prescription opioids.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

REVIVE!

Legal Protections in Overdose Response

Virginia's Good Samaritan Law (applies to any lay rescuers responding to overdose)

Any person who:

21. In good faith administers naloxone or other opioid antagonist used for overdose reversal to a person who is *believed to be* experiencing or about to experience a life-threatening opioid overdose in accordance with the provisions of subsection Z of § 54.1-3408 shall not be liable for any civil damages for any personal injury that results from any act or omission in the administration of naloxone or other opioid antagonist used for overdose reversal, unless such act or omission was the result of gross negligence or willful and wanton misconduct.

Subsection Z of § 54.1-3408:

Z. A person who is not otherwise authorized to administer naloxone or other opioid antagonist used for overdose reversal may administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose.

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Safe Reporting of Overdoses

(applies to people involved in an overdose situation)

§ 18.2-251.03 Arrest and prosecution when experiencing or reporting overdoses

No individual shall be subject to arrest or prosecution for

- the unlawful purchase, possession, or consumption of alcohol pursuant to § 4.1-305,
- possession of a controlled substance pursuant to § 18.2-250,
- possession of marijuana pursuant to § 18.2-250.1, intoxication in public pursuant to § 18.2-388,
- or possession of controlled paraphernalia pursuant to § 54.1-3466 if:

1. Such individual (i) in good faith, seeks or obtains emergency medical attention (a) for himself, if he is experiencing an overdose, or (b) for another individual, if such other individual is experiencing an overdose, or (ii) is experiencing an overdose and another individual, in good faith, seeks or obtains emergency medical attention…
2. Such individual remains at the scene of the overdose or at any alternative location to which he or the person requiring emergency medical attention has been transported until a law-enforcement officer responds to the report of an overdose. If no law-enforcement officer is present at the scene of the overdose or at the alternative location, then such individual shall cooperate with law enforcement as otherwise set forth herein;
3. Such individual identifies himself to the law-enforcement officer who responds to the report of the overdose; and
4. The evidence for the prosecution of an offense enumerated in this subsection was obtained as a result of the individual seeking or obtaining emergency medical attention.

Note: C. The provisions of this section shall not apply …during the execution of a search warrant or during the conduct of a lawful search or a lawful arrest.

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The Standing Order and Naloxone Access

A *standing order* has been issued for the State of Virginia allowing for individuals to go to any pharmacy to purchase naloxone without first obtaining a prescription from your doctor.

Naloxone can be obtained from:

Local health departments (no-cost)

Community services boards (no-cost)

Community pharmacies (insurance or out of pocket payment)

****Call your health department or community services board before going to ask about naloxone availability.****

Understanding Addiction

REVIVE!

People don't plan to get addicted to drugs.

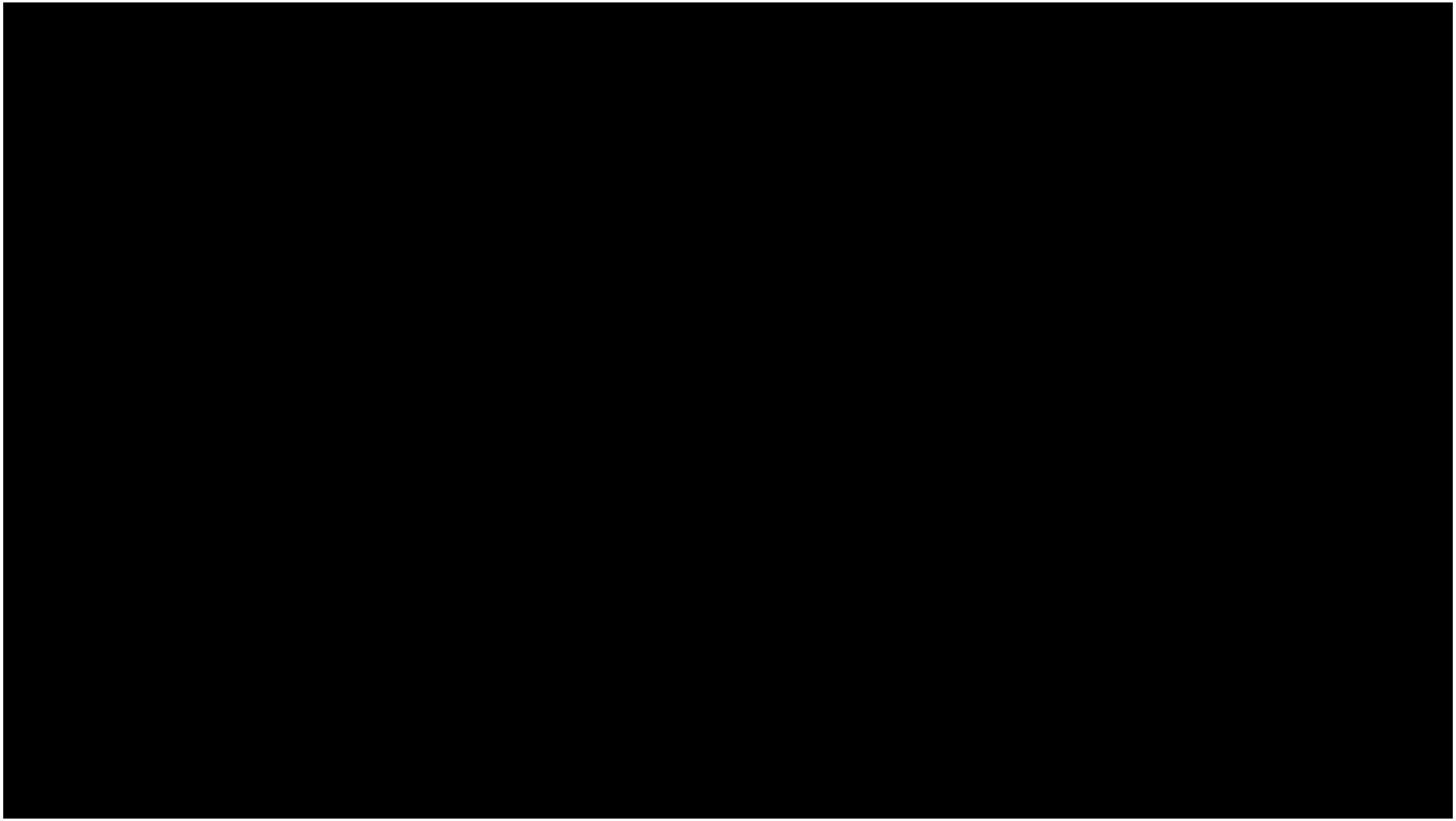
When people first take a drug, they might like how it makes them feel. They believe they can control how much and how often they take the drug. But drugs can take away people's control. Drugs can change the brain.

Addiction refers to substance use disorders at the severe end of the spectrum and is characterized by a person's inability to control the impulse to use drugs even when there are negative consequences.

https://easyread.drugabuse.gov/content/what-addiction

Nuggets Video

REVIVE!



Video Courtesy of Filmbuilder and Friends. Online the video can be accessed at https://youtu.be/HUngLgGRJpo

REVIVE!

WHAT IS AN OPIOID?

Opioids are a class of drugs that include:

- Heroin
- synthetic opioids *(like fentanyl)*
- pain relievers available legally by prescription *(like oxycodone (OxyContin®), hydrocodone (Vicodin®), morphine, etc.)*

HHS.GOV/OPIOIDS

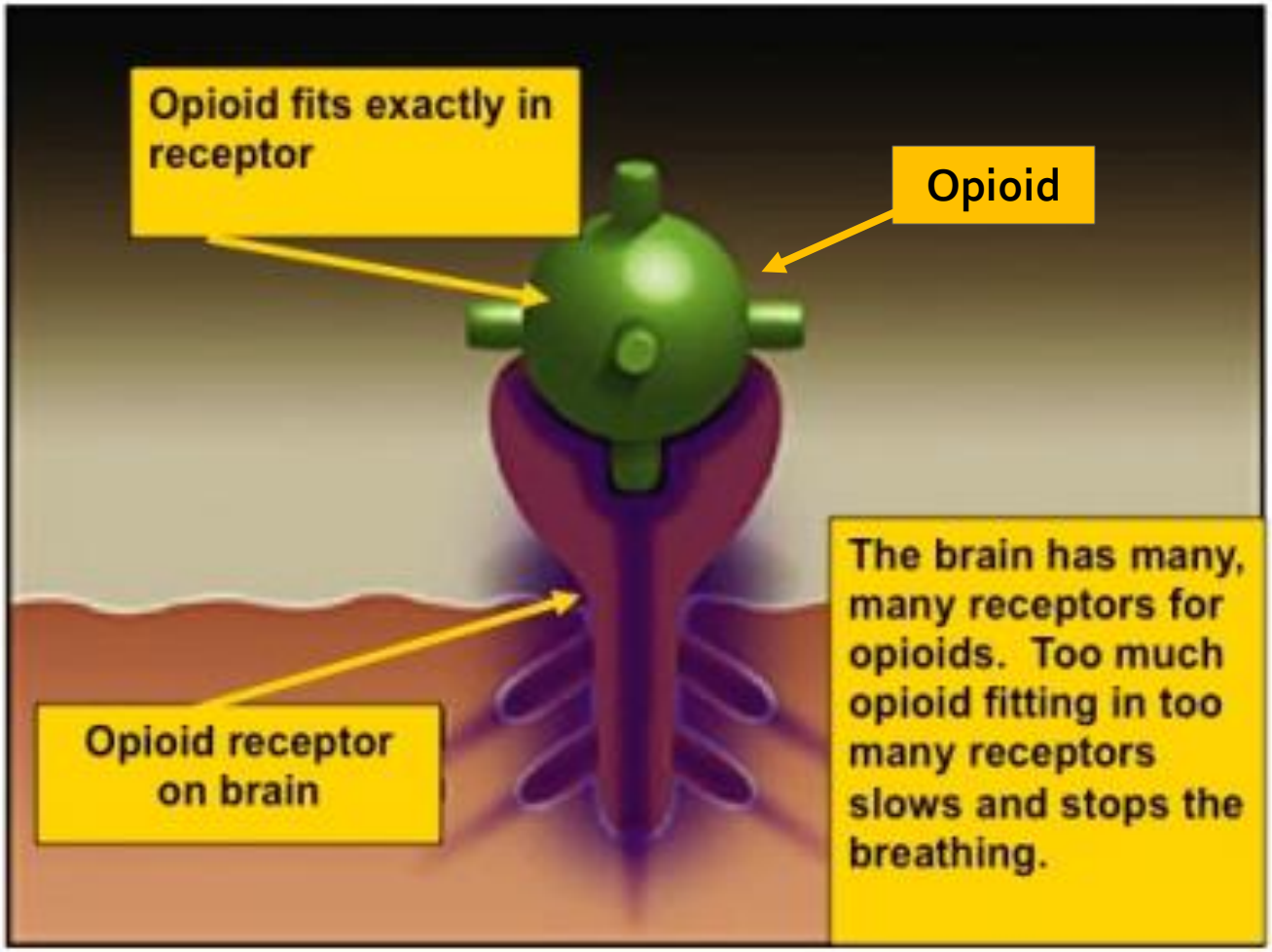
Common Opioids

REVIVE!

Generic	Trade	Street
Hydrocodone	Lortab, Vicodin	Hydro, Norco, Vikes
Oxycodone	Oxycontin, Percocet	Ox, Oxys, Oxycotton, Kicker, Hillbilly Heroin
Morphine	Kadian, MSContin	M, Miss Emma, Monkey, White Stuff
Codeine	Tylenol #3	Schoolboy, T-3s
Fentanyl	Duragesic	Apache, China Girl, China White, Goodfella, TNT
Carfentanil	Wildnil	Drop Dead, Flatline, Lethal Injection,
Hydromorphone	Dilaudid	Dill, Dust, Footballs, D, Big-D, M-2, M-80s, Crazy 8s, Super 8s
Oxymorphone	Opana	Blue Heaven, Octagons, Oranges, Pink, Pink Heaven, Stop Signs
Meperidine	Demerol	Dillies, D, Juice
Methadone	Dolophine, Methadose	Meth, Junk, Fizzies, Dolls, Jungle Juice
Heroin	Diacetylmorphine	Dope, Smack, Big H, Black Tar, Dog Food
Buprenorphine	Bunavail, Suboxone, Subutex,	Sobos, Bupe, Stops, Oranges
Tramadol	Ultram, ConZip	Chill Pills, Trammies, Ultras

REVIVE!

What Is an Opioid Overdose?



REVIVE!

What are risk factors
that can make someone more
likely to experience an overdose?

REVIVE!

Risk Factors for Opioid Overdose

Certain people are at higher risk for opioid overdose emergencies, including:

- Prior Overdose
- Reduced tolerance – previous users who have stopped using due to abstinence, illness, treatment, or incarceration
- Mixing drugs – combining opioids with other drugs, including alcohol, stimulants or depressants. Combining stimulants and depressants DO NOT CANCEL EACH OTHER OUT
- Using alone
- Variations in strength or quantity or changing formulations (e.g., switching from quick acting to long lasting/extended release)
- Medical conditions such as chronic lung disease or kidney or liver problems

REVIVE!

How can you tell the difference between someone who is high and someone who has overdosed?

REVIVE!

Signs of an Opioid Overdose

Really High	Overdosed
Muscles become relaxed	Face is very pale or clammy
Speech is slowed or slurred	Breathing is infrequent or has stopped
Sleepy-looking, "nod out"	Deep snoring or gurgling (death rattle)
Responsive to shouting, sternal rub or ear lobe pinch	Unresponsive to any stimuli
Normal heart rate and/or pulse, Normal skin tone	Slow or no heart rate and/or pulse
Pupils will contract and appear small "pinpoint pupils"	For lighter skinned people, the skin tone turns bluish purple, for darker skinned people, it turns grayish or ashen.

If someone is making unfamiliar sounds while "sleeping" it is worth trying to wake him or her up. Many loved ones of users think a person was snoring, when in fact the person was overdosing. These situations are a missed opportunity to intervene and save a life.

REVIVE!

What are some myths you have heard about ways to reverse an opioid overdose?

REVIVE!

Myths on Overdose Response

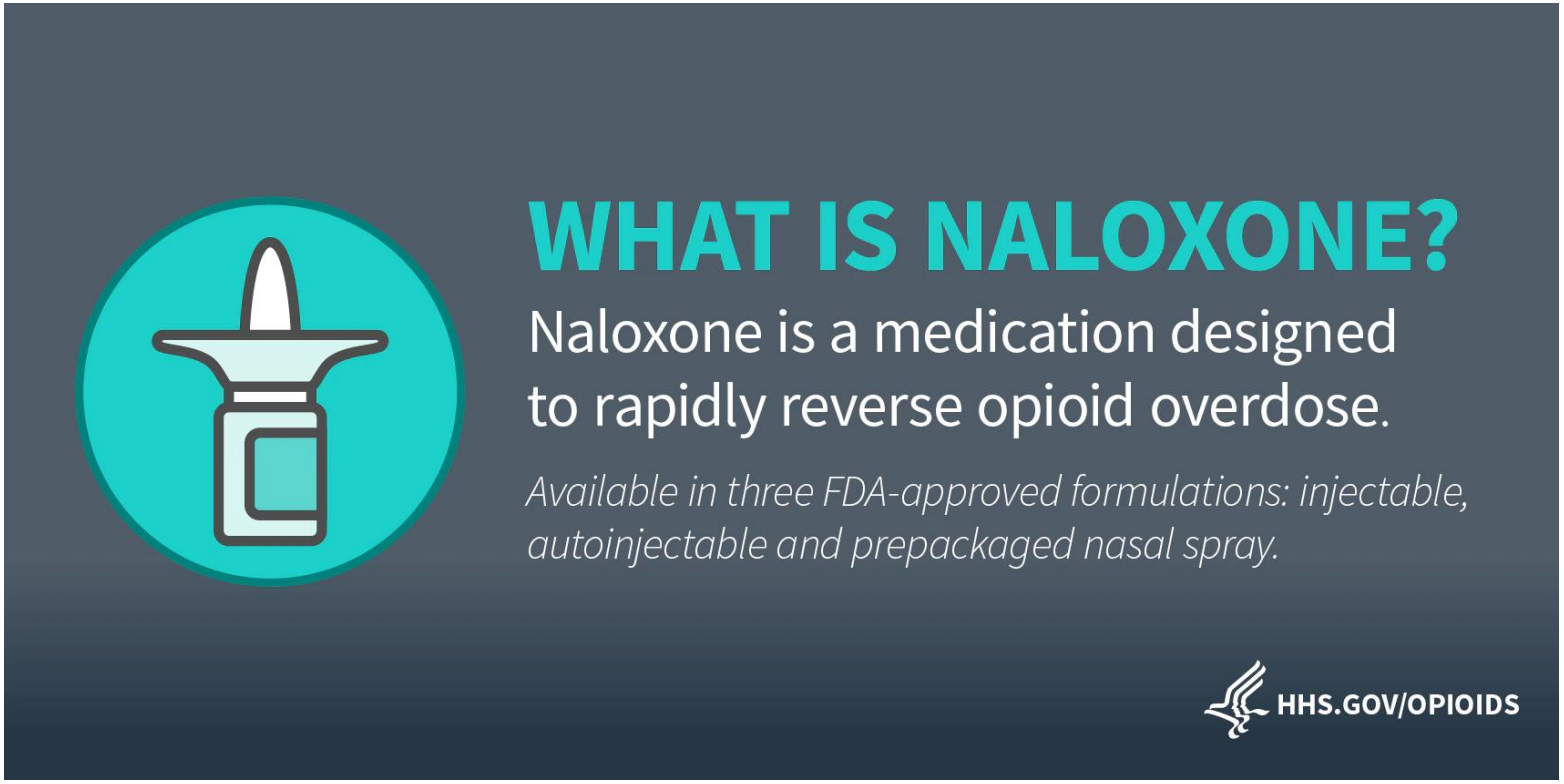
There are many myths about how to reverse an opioid overdose. Here are some, and why you SHOULD NOT DO THEM.

- DO NOT put the individual in a bath. They could drown.
- DO NOT induce vomiting or give the individual something to drink. They could choke.
- DO NOT put the person in an ice bath or put ice in their clothing or in any bodily orifices. Cooling down the core temperature of an individual who is experiencing an opioid overdose emergency is dangerous because it can further depress their heart rate.
- DO NOT try and stimulate the individual in a way that could cause harm, such as slapping them hard, kicking them, or other more aggressive actions that may cause long-term physical damage.
- DO NOT inject them with any foreign substances (e.g., salt water or milk) or other drugs or force them to eat or drink anything. It will not help reverse the overdose and may expose the individual to bacterial or viral infection, abscesses, endocarditis, cellulitis, choking, etc.

REVIVE!

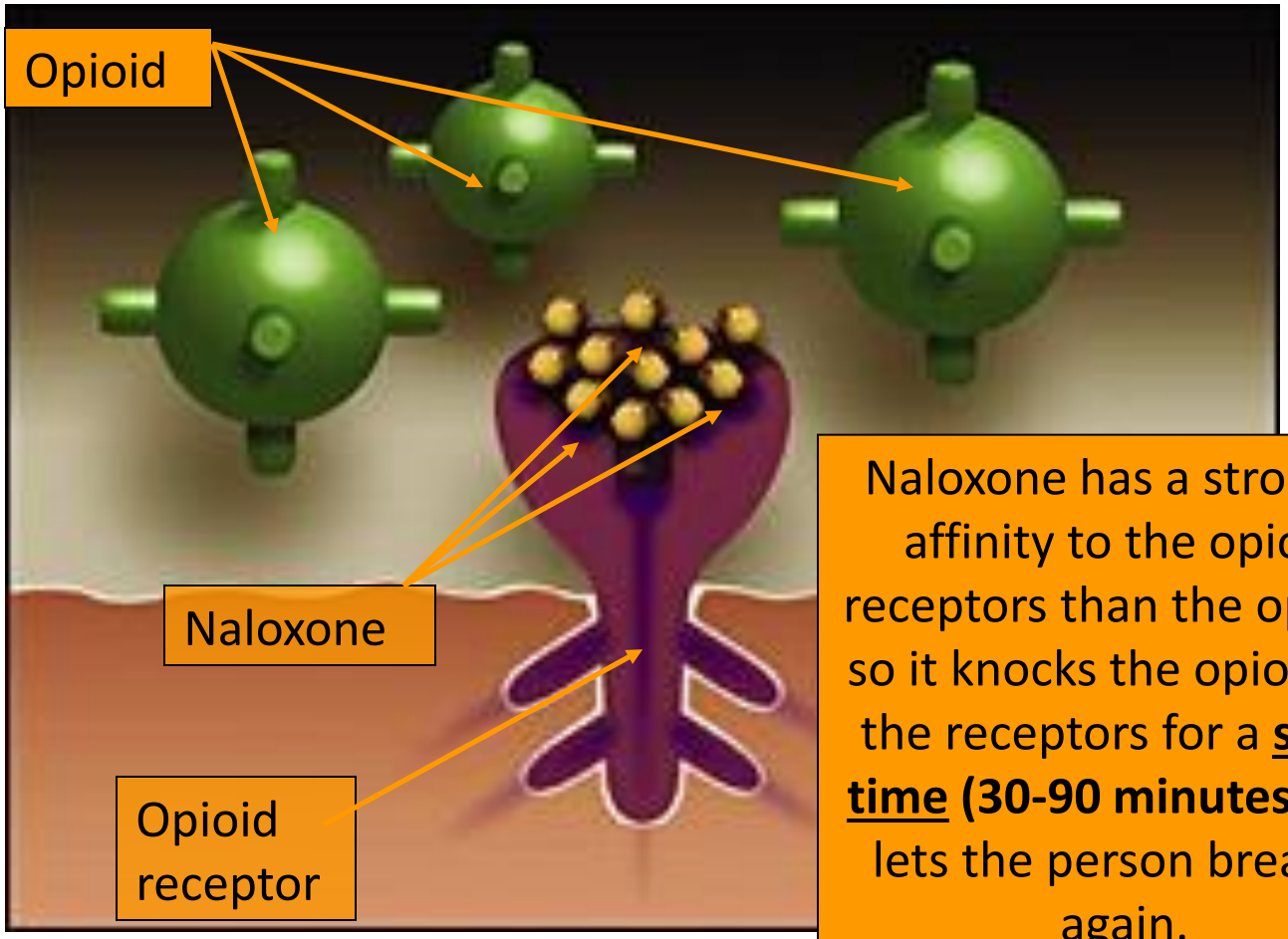
Naloxone is the only effective response to an opioid overdose emergency!

REVIVE!


WHAT IS NALOXONE?
Naloxone is a medication designed to rapidly reverse opioid overdose.
Available in three FDA-approved formulations: injectable, autoinjectable and prepackaged nasal spray.
HHS.GOV/OPIOIDS

REVIVE!

How Naloxone Works



Naloxone has a stronger affinity to the opioid receptors than the opioid, so it knocks the opioid off the receptors for a **short time (30-90 minutes)** and lets the person breathe again.

REVIVE!

Narcan Nasal Spray

2 doses in each kit

HOW TO USE
NARCAN® NASAL SPRAY

In opioid overdose emergencies, **recognizing symptoms** and taking prompt action is critical to potentially saving a life. If you suspect an opioid overdose, administer NARCAN® Nasal Spray and get emergency medical assistance right away.

KEY STEPS TO ADMINISTERING NARCAN® NASAL SPRAY:

PEEL

Peel back the package to remove the device. Hold the device with your thumb on the bottom of the plunger and 2 fingers on the nozzle.

PLACE

Place and hold the tip of the nozzle in either nostril until your fingers touch the bottom of the patient's nose.

PRESS

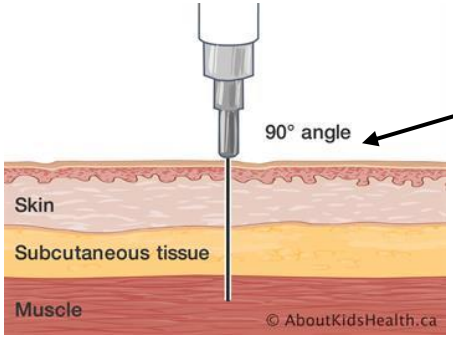
Press the plunger firmly to release the dose into the patient's nose.

https://youtu.be/xa7X00_QKWk

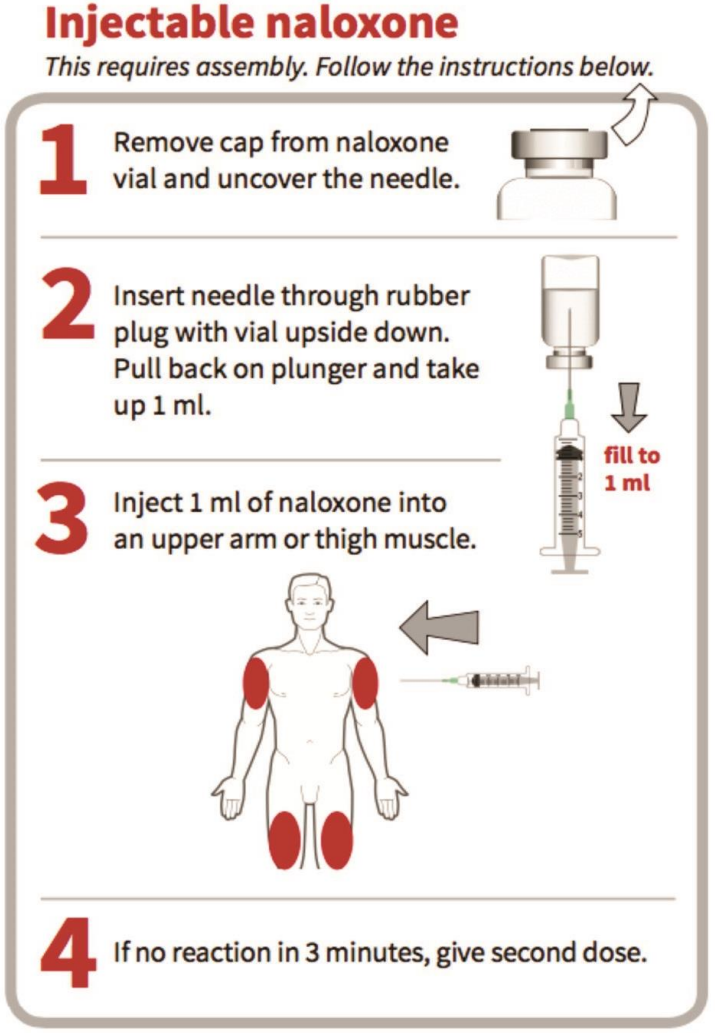
REVIVE!

Injectable naloxone

- Use a long needle: Virginia requires a (3mL) syringe with 23-25 gauge and 1-1.5 inch intramuscular (IM) needle
- If available, clean the skin with an alcohol swab first.
- It is ok, to inject through clothing if necessary.



90° angle to make sure you reach the muscle



REVIVE! – IM Administration

Administering Injectable Naloxone – Step by Step:

Step 1: Pop off the flip-top from naloxone vial.

Step 2: Insert needle into vial and draw up 1cc of naloxone into syringe.

Step 3: Use alcohol wipe to clean injection site – shoulder, thigh or buttocks.

Step 4: Inject needle straight into muscle (through clothes, if necessary), then push in plunger.

Do not inject naloxone into the person's heart, chest or back!

REVIVE! – Background

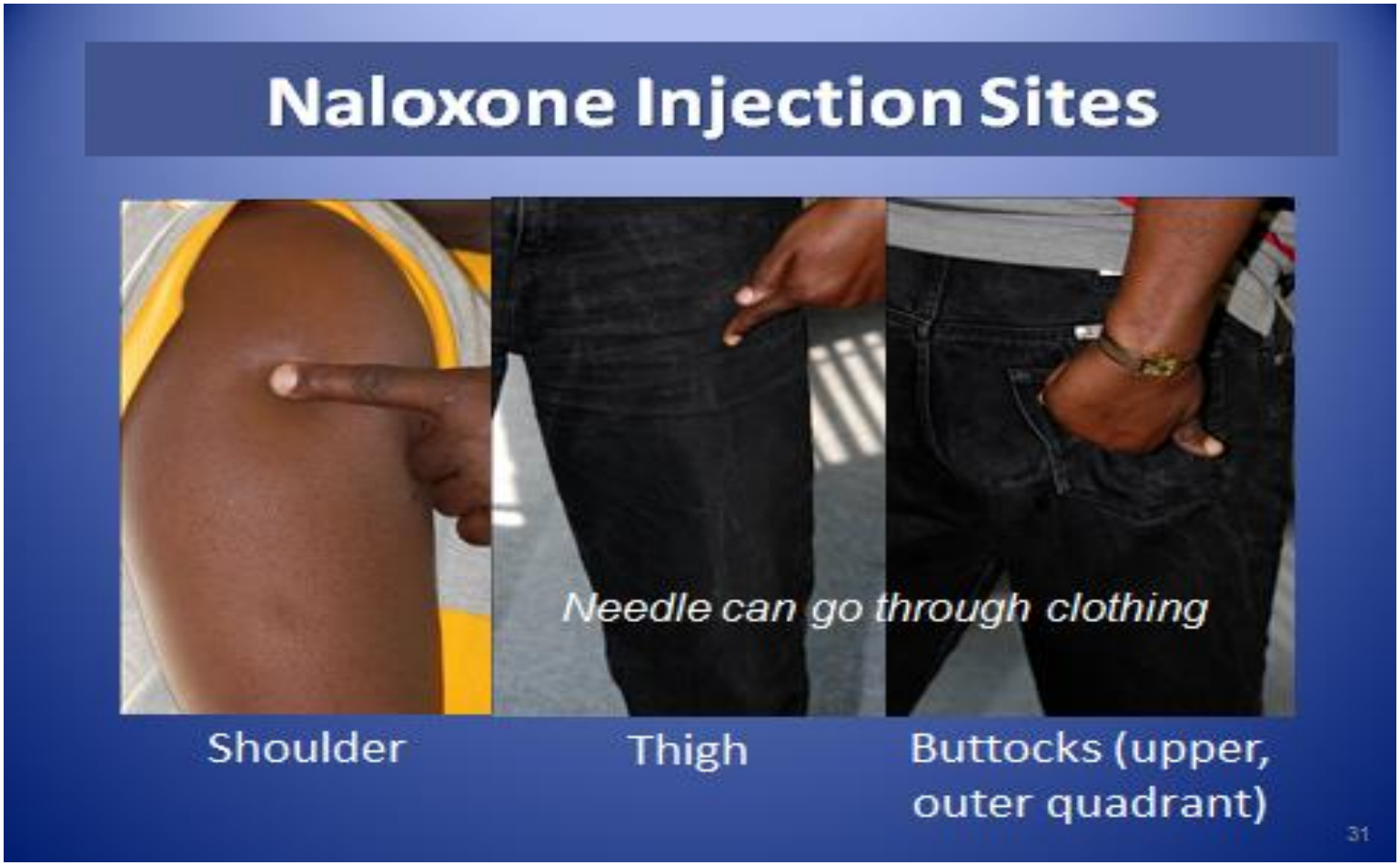
Administering Injectable Naloxone – Step by Step

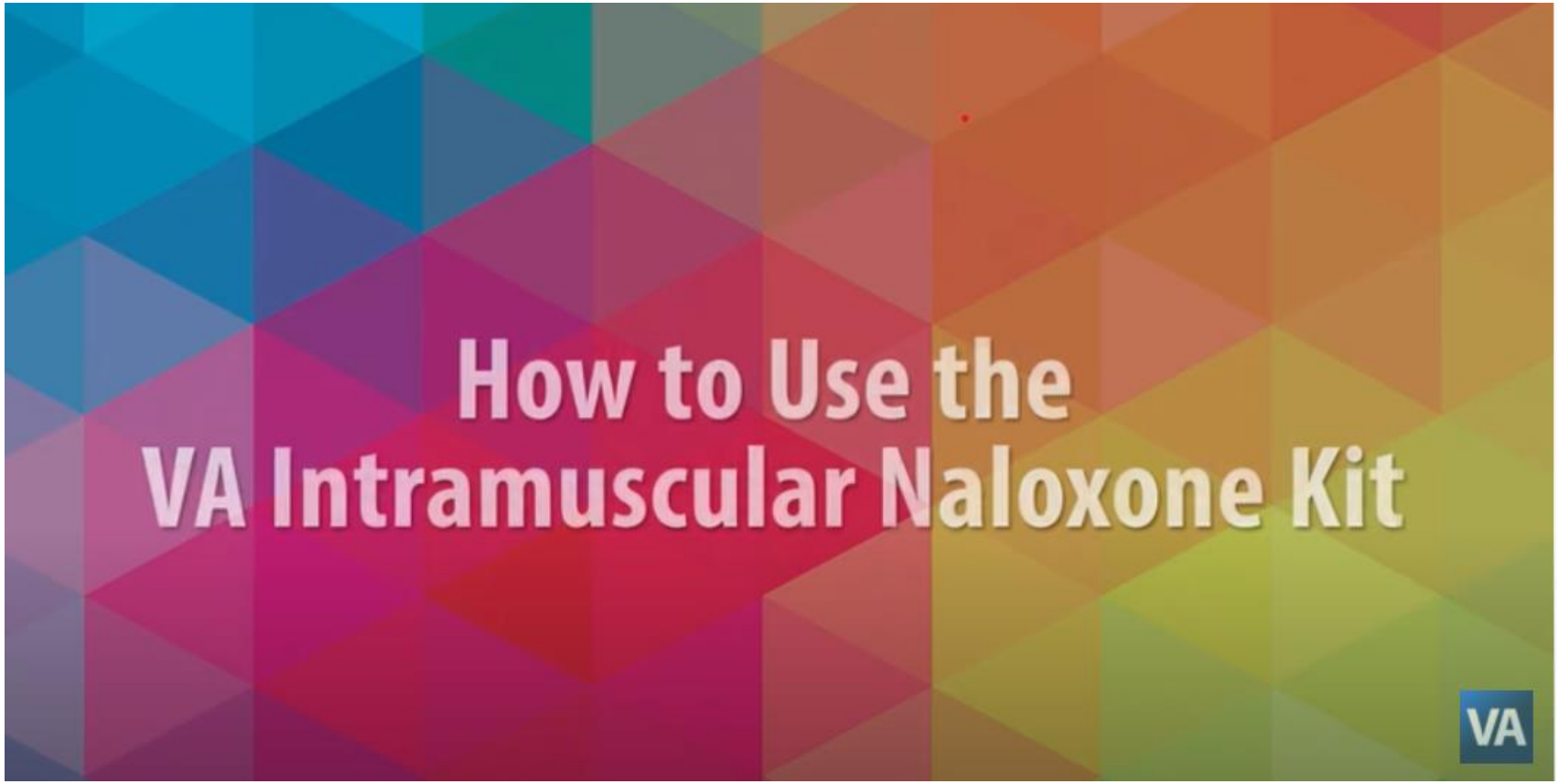
Step 5: Allow 1-3 minutes for the naloxone to work. Continue resuscitation as necessary.

Step 6: If breathing is not restored after 2-3 minutes, ***give another dose*** of naloxone (see **Steps 1 - 4**). Continue resuscitation as necessary.

Step 7: Stay with person and provide care as directed until medical help arrives.

REVIVE! – Naloxone Injection Sites





https://youtu.be/lg1LEw-PeTE

How to Store Naloxone

- Naloxone has a shelf life of approximately 3 years (check the label on your product.) Store between 59°F to 77°F.
- Naloxone may be stored for short periods up to 104°F.
- Do not store naloxone in the car on hot summer days.
- Do not freeze or leave naloxone in a car during the winter.
- Naloxone may not be as effective if it is not stored properly. Only discard the naloxone once you have a replacement for it. If you don't replace naloxone before it is needed, it is better to use it, even if it hasn't been stored properly.
- Naloxone does no harm when expired, so you may use an expired dose in an emergency if new doses are not available.
- Store in a dark place and protect from light.
- Keep out of reach and sight of children.

Safety of Naloxone

Serious side effects from naloxone use are very rare.

Using naloxone during an overdose far outweighs any risk of side effects. If the cause of the unconsciousness is uncertain, giving naloxone is not likely to cause further harm to the person. Reported side effects are often related to acute opioid withdrawal.

Naloxone will not reverse overdoses from other drugs, such as alcohol, benzodiazepines, cocaine, or amphetamines.

Naloxone has no abuse potential.

Naloxone has the same dose for an adult and a child.

REVIVE!

Steps to Respond to an Opioid Overdose

1. Check for **Responsiveness**
2. **Call 911**, if you must leave the individual alone, place them into recovery position.
3. Give **2 Rescue Breaths** (if the person is not breathing)
4. Administer **Naloxone**
5. Continue **Rescue Breathing**
6. Assess and respond based on outcome of first naloxone administration

****If you must leave an unresponsive person at anytime, put them in recovery position****

1. Check for Responsiveness

REVIVE!

- Try to stimulate them. You can shout their name, tap their shoulder, or pinch their ear lobe.
- Give a sternum rub. Make a fist and rake your knuckles hard up and down the front of the person's sternum (breast bone). This is sometimes enough to wake the person up.
- Check for breathing. Put your ear to the person's mouth and nose so that you can also watch their chest. Feel for breath and watch to see if the person's chest rises and falls.
- If the person does not respond or is not breathing, proceed to step 2

2. Call 911

REVIVE!

Calling 911 immediately when responding to an overdose is vital. An individual who has overdosed needs to be **assessed by medical professionals.**

- If there is more than one person around instruct another individual to call 911.
- If with a cell phone call 911, put call on “speakerphone” and place phone on the ground.
- Report that the person’s breathing has slowed or stopped, he or she is unresponsive, it is a suspected overdose, and give the exact location.

RECOVERY POSITION SETUP

3. Give 2 Rescue Breaths

1. Place the person **on their back**.

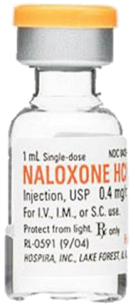
2. Tilt their chin up to open the airway.

3. Plug/pinch their nose with one hand, and **give 2 even, regular-sized breaths**. Blow enough air into their lungs to make their chest rise. If you don't see their chest rise out of the corner of your eye, tilt the head back more and make sure you're plugging/pinching their nose.

https://youtu.be/31GdwcBdwRo

REVIVE!

4. Administer Naloxone



Naloxone usually starts working within 30-45 seconds after it is given, but we give the person up to 3 minutes to respond. While you wait for naloxone to take effect, immediately begin Step 5.

REVIVE!

5. Rescue Breathing or CPR (if rescuer is CPR trained or instructed to do so by 911)

1. Place the person **on their back**.

2. **Tilt their chin up** to open the airway.

3. **Plug/pinch their nose** with one hand, and **give 2 even, regular-sized breaths**. Blow enough air into their lungs to make their chest rise. If you don't see their chest rise out of the corner of your eye, tilt the head back more and make sure you're plugging/pinching their nose.

4. **Repeat**, give 1 breath every 5 seconds.

PLEASE NOTE - You may have heard that recent CPR guidelines recommend "hands-only CPR," or only chest compressions instead of rescue breathing and chest compressions. These guidelines are for layperson response to *cardiac arrest*, and **NOT overdose**. It is still recommended that you perform rescue breathing for an overdose, where the primary issue is respiratory depression, and not cardiac arrest. Brain damage can occur after three to five minutes without oxygen. Rescue breathing gets oxygen to the brain quickly. Once you give naloxone, it may take some time for it to be take effect, so the person may not start breathing on their own right away. Continue rescue breathing/cpr for them until the naloxone takes effect or until emergency medical services arrive.

REVIVE!

6. Assess and Respond

Most individuals will recover after a single dose of naloxone is administered. Ideally, while performing Step 5 the person will begin breathing on their own.

However, there are **two cases** in which you may need to administer a second dose of naloxone:

- **SITUATION A:** If the individual has not responded to the initial dose within three minutes
- **SITUATION B:** If the individual has relapsed into an overdose again after having previously recovered with the initial dose.

REVIVE!

When to give a 2nd dose of naloxone

SITUATION A: The individual has not responded to the initial dose within three minutes

When this occurs:

- Naloxone should take effect within 30-45 seconds but may take longer
- Wait three minutes (continue rescue breathing/cpr during this time)
- At three minutes, if still no response, administer second dose of naloxone
- If person remains unresponsive after the second dose is administered, continue rescue breathing/CPR until emergency medical services arrives.

****If the individual has not responded to the initial dose or naloxone, administer the 2nd dose in the opposite nostril when using nasal spray****

REVIVE!

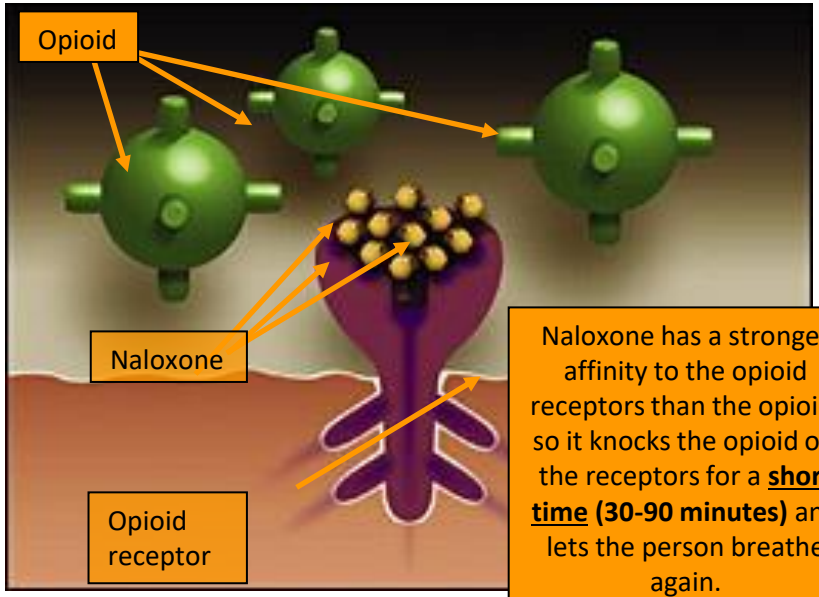
When to give a 2nd dose of naloxone

SITUATION B: The individual has relapsed into an overdose again after having previously recovered with the initial dose.

Naloxone has a very short half life – 30-90 minutes. In some cases, there is so much opioid in the system that the person can relapse back into overdose after the naloxone has worn off.

If this occurs:

- Repeat steps 1 through 5
- Continue rescue breathing/CPR until person recovers or until emergency medical arrives.



Naloxone has a stronger affinity to the opioid receptors than the opioid, so it knocks the opioid off the receptors for a **short time (30-90 minutes)** and lets the person breathe again.

REVIVE!

Aftercare of a Recovered Person

People wake up from an overdose differently.

While people are often confused and anxious, they are **rarely** violent or combative. **This is a person in psychological distress**.

Many times when people overdose they don't realize what has happened.

Explain what happened and emphasize the importance of waiting for emergency medical services to arrive so they can be assessed.

If the person is dependent on opioids they will be in withdrawal since opioids cannot attach to receptors while naloxone is present – even if they take more drugs it will not help.

Let them know that once naloxone wears off they could potentially relapse into an overdose again if opioids are still in their system.

REVIVE!

Hands-On Training

Take this time to practice mock scenarios responding to opioid overdoses.

1. Check for **Responsiveness**
2. **Call 911**, if you must leave the individual alone, place them into recovery position.
3. Give **2 Rescue Breaths** (if the person is not breathing)
4. Administer **Naloxone**
5. Continue **Rescue Breathing**
6. Assess and respond based on outcome of first naloxone administration

REVIVE!

REVIVE! Kits

- 2 Pairs of Vinyl Gloves
- 2 Pocket Face Shield
- 1 Instruction Card
- 1 Canvas Carrying Case

If you use your REVIVE! training let us know using the link found on the instruction card in your kit!

REVIVE!

Thanks for your attendance!

For more information:

REVIVE@dbhds.virginia.gov

http://www.dbhds.virginia.gov/individuals-and-families/substance-abuse/revive

Complete the evaluation for today's training!

https://ww.surveymonkey.com/r/SGL3NCX

REVIVE!

Acknowledgements

REVIVE! would not be possible without the help of many public and private partners, who DBHDS would like to acknowledge for their invaluable assistance:

- Boston Public Health Commission Bureau of Justice Assistance
- Chicago Recovery Alliance
- The Chris Atwood Foundation
- Delegate John O'Bannon, R-73
- Joanna Eller
- Harm Reduction Coalition
- The McShin Foundation
- Massachusetts Department of Public Health
- Multnomah County (OR) Health Department
- New York City Department of Mental Health and Hygiene
- New York State Division of Criminal Justice Services
- Ed Ohlinger
- One Care of Southwest Virginia
- Project Lazarus
- SAARA Recovery Center of Virginia
- San Francisco Department of Health/DOPE Project
- University of Washington Alcohol and Drug Abuse Institute
- Virginia Department of Criminal Justice Services
- Virginia Department of Health
- Virginia Department of Health Professions
- The Virginia Harm Reduction Coalition

DRUG TESTING BEST PRACTICES

PAT PIZZO

CONSULTANT

TODAYS TOPICS

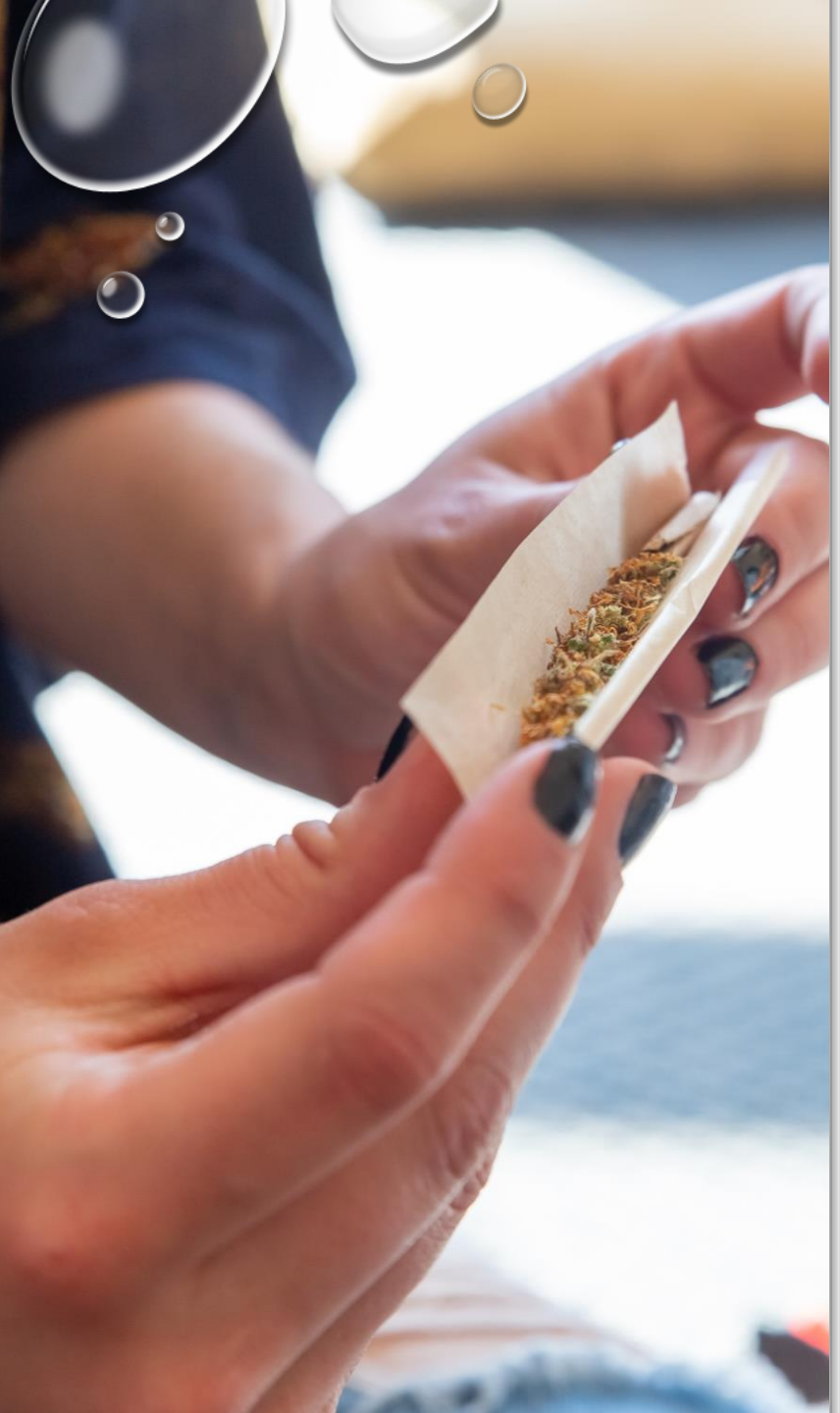
- HOW OFTEN SHOULD I TEST?
- SHOULD I TEST MORE THAN ONCE A DAY?
- SHOULD I USE DIFFERENT METHODOLOGY?
- WHAT IS PROPER COLLECTION PROTOCOL?
- WHAT NEW DRUGS ARE ON THE STREET?

HOW OFTEN SHOULD I COLLECT A SPECIMEN

- USAGE TYPE- SINGLE VS. MULTIPLE USE OR SOCIAL VS. CHRONIC
- DOSAGE
- CREATININE - NORMALIZATION
- ROUTE OF ADMINISTRATION
- TIME OF LAST DOSE TO TIME OF SPECIMEN COLLECTION
- SPECIMEN TYPE
- CUT OFF LEVELS

HOW OFTEN SHOULD I COLLECT A SPECIMEN AFTER LAST CLAIMED USE

Drug	Social/Single	Chronic
Marijuana	ASAP	weekly
Cocaine	ASAP	weekly
Cod/Mor	ASAP	weekly
Fentanyl	ASAP	weekly
Synthetic OPA	ASAP	weekly
Mamp/Amp	ASAP	weekly
Buprenorphine	ASAP	weekly



HOW LONG WILL A SOCIAL USER OF MARIJUANA TEST POSITIVE?

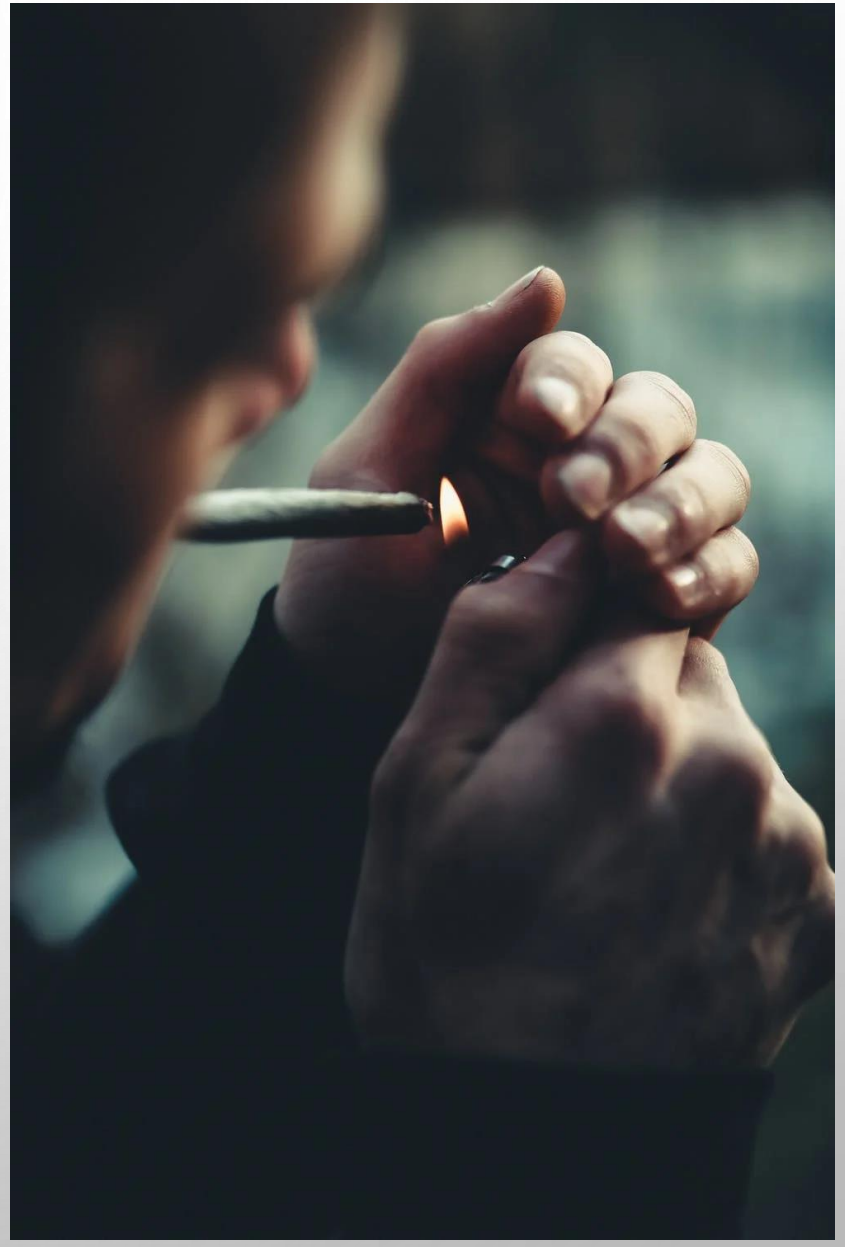
- DRS. HUESTIS AND SMITH (*JAT* 2009)
- THE CLEARANCE OF THC-COOH FROM THE URINE OF A SOCIAL USER IS 5 DAYS USING A 15 NG/MG CUT OFF LEVEL
- 7 DAYS USING A 6 NG/MG CUT OFF LEVEL.

HOW LONG WILL A MODERATE-CHRONIC USER OF MARIJUANA TEST POSITIVE ?

Starting level	Mean Detection	Last Positive
>150 ng/mg	15.4 days ± 9.8 days	29.8 days
50-150 ng/mg	9.7 days ± 6.4 days	25.3 days
<50 ng/mg	4.6 days ± 5.6 days	21.8 days

- 60 TEST SUBJECTS MIXED RACES AND GENDER

JAT October 2008 Dr. Huestis et al



PASSIVE INHALATION - URINE

- NOT A REALITY
- REALISTIC - < 5 NG/ML SCREENING
- FORCED - USING 11.3% THC < 50 NG/ML SCREENING
- FEDERAL GUIDELINES 50/15

HOW LONG WILL BENZOYLECGONINE BE DETECTED IN URINE AFTER A SINGLE DOSE

- BY JUFER, WALSH AND CONE PUBLISHED IN JAT IN SEPTEMBER 2006
- SINGLE DOSE: IV, INTRANASAL AND SMOKED
- MEAN CLEARANCE WITH 150 NG/ML CUT OFF WAS 1.32 DAYS WITH LONGEST DETECTION FROM INTRANASAL AT 2.47 DAYS
- MEAN CLEARANCE WITH 100 NG/ML CUT OFF WAS 1.94 DAYS WITH LONGEST DETECTION FROM INTRANASAL AT 2.61DAYS

HOW LONG WILL BENZOYLECGONINE BE DETECTED IN URINE- CHRONIC USE

- K. PRESTON ET.AL "URINARY ELIMINATION OF COCAINE METABOLITES IN CHRONIC COCAINE USERS DURING CESSATION"
- 953 SPECIMENS FROM 18 CHRONIC USERS.
- 300 NG/ML SCREENING CUT OFF LEVEL: A MEAN DETECTION OF BENZOYLECGONINE FOR 4.8 DAYS WITH A RANGE OF 3-6 DAYS.
- IF THE DATE OF LAST ADMITTED USE IS USED AS DAY ZERO, THE LAST POSITIVE OCCURRED AN AVERAGE OF 3.4 DAYS WITH A RANGE OF 1.4-6.7 DAYS AFTER THE LAST SELF-REPORTED USE.

PASSIVE INHALATION

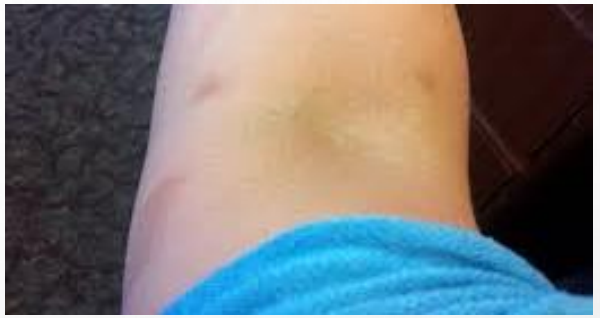
- Controlled studies
  - DR. ED CONE - 22-123NG/ML GC/MS
- Reports from ER
  - Positives detected on infants and children with no control of introduction of drug—believed to be passive
  - Could be oral, forced inhalation, or absorption

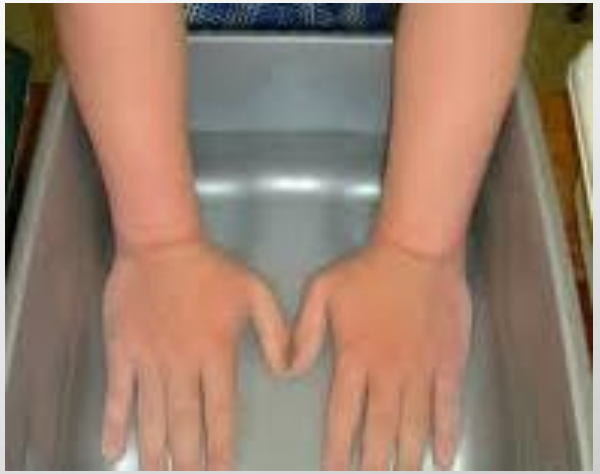
PASSIVE EXPOSURE

- OCCUPATIONAL COCAINE EXPOSURE OF CRIME LABORATORY PERSONNEL PREPARING TRAINING AIDS FOR A MILITARY WORKING DOG PROGRAM”
- GELHAUSEN, KETTLE AND STOUT IN JAT IN OCTOBER 2003
- 13 TEST SUBJECTS WERE EVALUATED FOR THE PERSONAL BREATHING ZONE AND DERMAL EXPOSURE.
- THE BASELINE: HIGHEST LEVEL ATTAINED WAS 47 NG/ML
- AFTER IMPLEMENTATION OF SAFETY PRACTICES, THE HIGHEST LEVEL ATTAINED WAS 17 NG/ML.
- THE URINE SPECIMENS WERE COLLECTED AT THE END OF THE WORKERS SHIFT “ (APPROXIMATELY 8 HOURS).

DERMAL ABSORPTION

- Baselt-5 mg free base applied to skin resulted in gc/ms level 55 - 9 ng/ml 12 to 84 hrs after exposure
- Frederick-2 mg cocaine HCl applied to skin resulted in 100 - 200 ng/ml 3 hrs after exposure
- Elsohly-hands and money immersed in 70% cocaine powder resulted in low level positives.



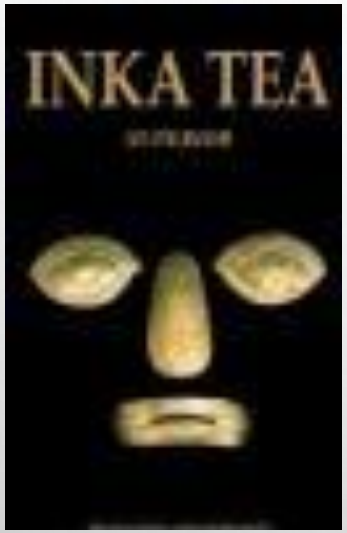


https://pubmed.ncbi.nlm.nih.gov/34482046/

SEXUAL TRANSMISSION OF COCAINE

- DR. ED CONE, FORMERLY WITH THE ADDICTION RESEARCH CENTER IN BALTIMORE, MARYLAND STUDIED THE EFFECTS OF COCAINE USE AND ITS DISTRIBUTION TO SEMEN AND VAGINAL SECRETIONS.
- USE OF COCAINE CAN BE CLASSIFIED FROM LOW (50 MG) TO HEAVY (250MG) WEEKLY.
- CONE ET AL. REPORTED 1 – 2.5 MG OF COCAINE HYDROCHLORIDE ADMINISTERED IV WAS NECESSARY TO PRODUCE AT LEAST ONE POSITIVE URINE DRUG TEST USING A 300 NG/ML SCREENING CUT OFF.
- BASED ON THE WORK OF DR. CONE EVEN CHRONIC OR HEAVY USE WOULD RESULT IN A SEMEN CONCENTRATION OF ONLY 0.2MG.
- BOTH SEMEN AND VAGINAL SECRETIONS ARE SLIGHTLY BASIC SO THE DISTRIBUTION TO EITHER FLUID SHOULD BE SIMILAR.
- EXPOSURE OR CONSUMPTION OF EITHER SEMEN OR VAGINAL FLUIDS OF A COCAINE USER WOULD NOT BE SUFFICIENT TO RESULT IN A POSITIVE DRUG SCREEN IN A NON-COCAINE USER PARTNER.

COCA TEA



- Health Inca Tea — each tea bag contains cocaine
- Can the use of coca teas cause a positive urine drug screen? Yes

INGESTION OF COCAINE

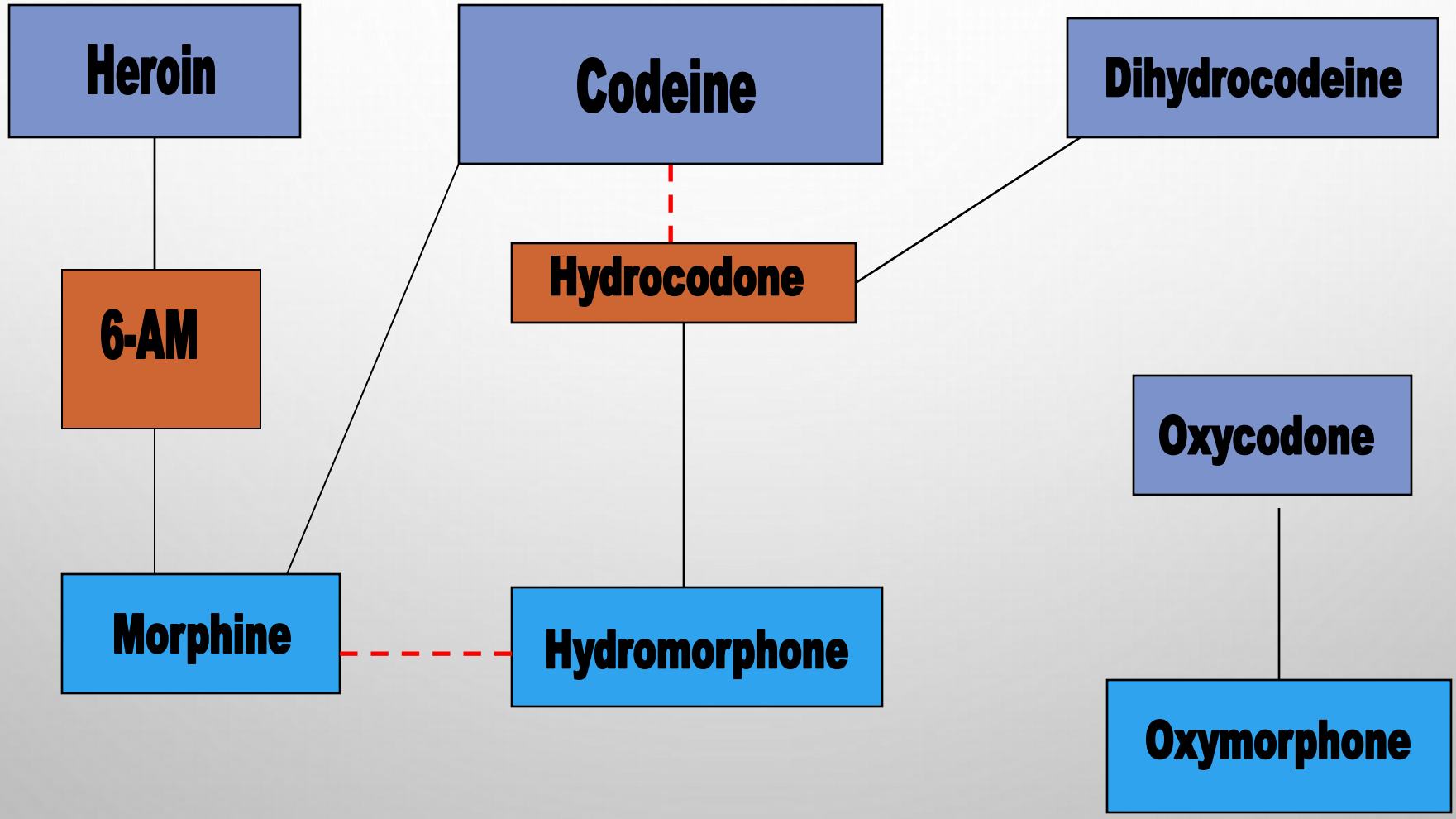
- Ingestion of 1 cup of Health Inca Tea – containing 1.87 mg of cocaine
- 4 test subjects
- Peak urine concentration of benzoylecgonine occurred 4-11 hrs after ingestion
- Concentration 140-280 ng/mL
- Screen Positive for 21-26 hrs after ingestion

INGESTION OF COCA TEA

	1 cup of Bolivian tea	1 cup of Peruvian tea
Cocaine in tea bag	3.94-5.02 mg	4.86-5.15 mg
Peak level	4155 ng/ml	3368 ng/ml
>300 ng/ml	19 hrs	17 hrs
>100 ng/ml	48 hrs	45 hrs

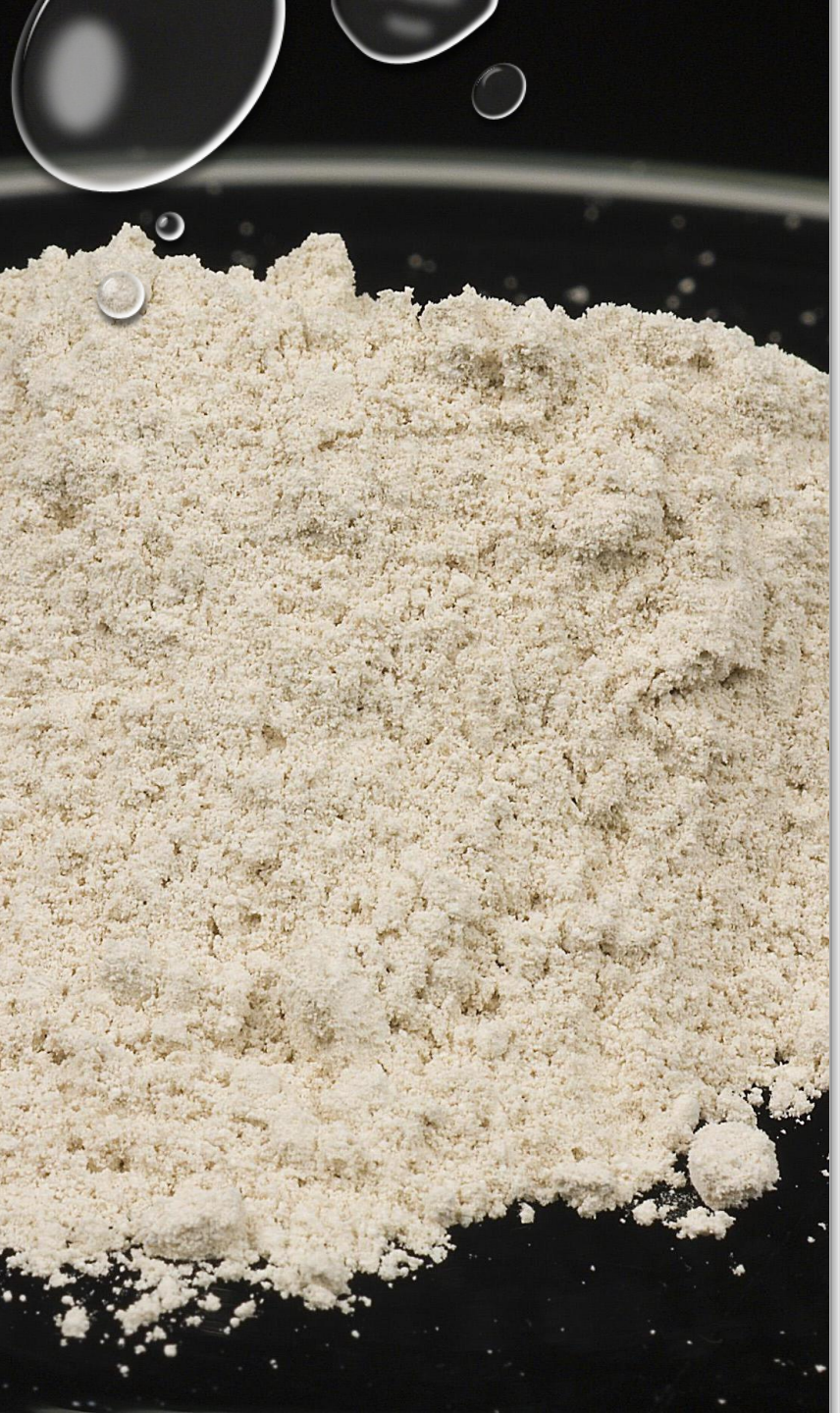
Jenkins, Llosa, Montoya and Cone:Forensic Science Int. Oct 1996

Metabolism of Opioids



HOW LONG WILL MORPHINE BE DETECTED AFTER HEROIN USE? SINGLE USE – STUDY 1

- Yeh, Gorodetzky and McQuinn in the Journal of Pharmacology Experimental Therapeutics 1976
- Reported conjugated morphine detectable for 96 hrs. after Heroin.
- Eighty-eight percent of the free morphine and 84% of the total morphine found in the urine was excreted in the first 8 hours.



HOW LONG WILL MORPHINE BE DETECTED AFTER CHRONIC USE OF HEROIN ?

- THE RESULTS OF THIS STUDY SHOWED THE LONGEST MORPHINE WAS DETECTED USING A 300 NG/ML CUT OFF WAS 10 DAYS FOR THE IV HEROIN USER GROUP AND THE CONCENTRATION AFTER 10 DAYS WAS 378 NG/ML. THIS OCCURRED FOR ONLY ONE OF THE TEST SUBJECTS.
- THE HIGHEST LEVEL DETECTED WAS 206374 NG/ML ON THE 1ST DAY OF INHALED HEROIN USE. ON THE FOURTH DAY THE MAX AFTER INHALED HEROIN WAS 30320 NG/ML. SIX DAYS AFTER USE THE HIGHEST LEVEL DETECTED WAS 2802 NG/ML.

PERILOUS PASTRIES
VARIOUS STUDIES

FOOD PRODUCT	Greatest Morphine Concentration	Greatest Codeine Concentration	Last screened Positive hours
DELI ROLL	Not Detected	Not Detected	NA
BAGELS	1,456	159	8
MUFFINS	730	21	12
CAKES	260	ND	5
SEEDS "GERMAN STYLE"	571	ND	8
STREUSEL (TYPE I)	11,571	4,861	24+
STREUSEL (TYPE II)	5,159	852	72+

CODEINE ONLY FROM THE INGESTION OF POPPY SEEDS

- RESEARCHERS FROM UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE, MARCH 2023, JOURNAL OF ANALYTICAL TOXICOLOGY. THEY DOCUMENTED CODEINE ONLY POSITIVES AFTER THE INGESTION OF A SPECIFIC BRAND OF POPPY SEEDS THAT HAD CODEINE VALUES MUCH HIGHER THAN THE MORPHINE VALUES.
- 11 TEST SUBJECT CONSUMED ONE OF 10 DIFFERENT POPPY SEED PRODUCTS.
- PEAK LEVELS OF CODEINE RANGED FROM 4 – 8 HR.
- 5 OF THE PRODUCTS HAD MUCH HIGHER CODEINE LEVELS THAN MORPHINE.
- PRODUCTS USED: PUBLIX GREEN WISE MINI POPPY SEED MUFFINS AND EVERYTHING BAGELS, NEW YORK STYLE EVERYTHING BAGEL CRISP, THOMAS EVERYTHING BAGELS, LENNY AND LARRY'S LEMON POPPY SEED COOKIES, MCCORMICK POPPY SEEDS, SNACK FACTORY EVERYTHING PRETZEL CRISPS

Poppy Seed Consumption May Be Associated With Codeine-only Urine Drug test Results; Reisfield, Teitelbaum and Jones, JAT March 2023. PGES 107-113

CLEARANCE OF FENTANYL SINGLE VS CHRONIC USE

	Fentanyl - days	**Norfentanyl - days**
Single	3 days	4 days
Chronic – Mean	7.3 (2.4 – 12.2) days	13.3 (6.4 - 20.2) days
Chronic - Max	19 days	26 days

HOW LONG WILL A USER TEST POSITIVE FOR METHAMPHETAMINE ?

- “DURATION OF DETECTABLE METHAMPHETAMINE AND AMPHETAMINE EXCRETION IN URINE AFTER CONTROLLED ORAL ADMINISTRATION OF METHAMPHETAMINE TO HUMANS”
- CLINICAL CHEMISTRY (2012) BY OYLER, CONE, HUESTIS ET.AL.
- LOW DOSE OF METHAMPHETAMINE (10MG) THE MEAN DETECTION TIME AFTER SINGLE, NON-CONSECUTIVE AND CONSECUTIVE DOSES WAS 42.7 HRS. USING A SCREENING CUT OFF LEVEL OF 500 NG/ML AND CONFIRMATION CUT OFF OF 200 NG/ML.
- HIGH DOSE (20 MG/ML) THE MEAN DETECTION TIME WAS 67 HRS.

DETECTION OF BUPRENORPHINE IN URINE

- IN THIS STUDY PUBLISHED IN JAT IN 2008, 18 SUBJECTS WERE ADMINISTERED A SINGLE DOSE (0.4MG SUBLINGUALLY). CEDIA WAS USED AS THE IMMUNE ASSAY SCREEN AND LC/MS/MS WAS USED FOR CONFIRMATION.
- LONGEST CONTINUES POSITIVE – MEAN 9 HRS. (RANGE 4-24 HRS.)
- LONGEST LC/MS/MS POSITIVE FOR BUPRENORPHINE USING A 0.5 NG/ML CUT OFF – MEAN 76 HRS (RANGE 23-96 HRS.).
- LONGEST LC/MS/MS POSITIVE FOR NORBUPRENORPHINE USING A 0.5 NG/ML CUT OFF – ALL SUBJECTED WERE STILL POSITIVE AT 96 HRS. (LAST SPECIMEN COLLECTED WAS 96 HRS).

J Anal Toxicol 2008 Oct;32(8):586-93.Urinary detection times and metabolite/parent compound ratios after a single dose of buprenorphine, Robert Kronstrand [1], et.al.

SUBLOCADE – BIG DIFFERENCE IN CLEARANCE

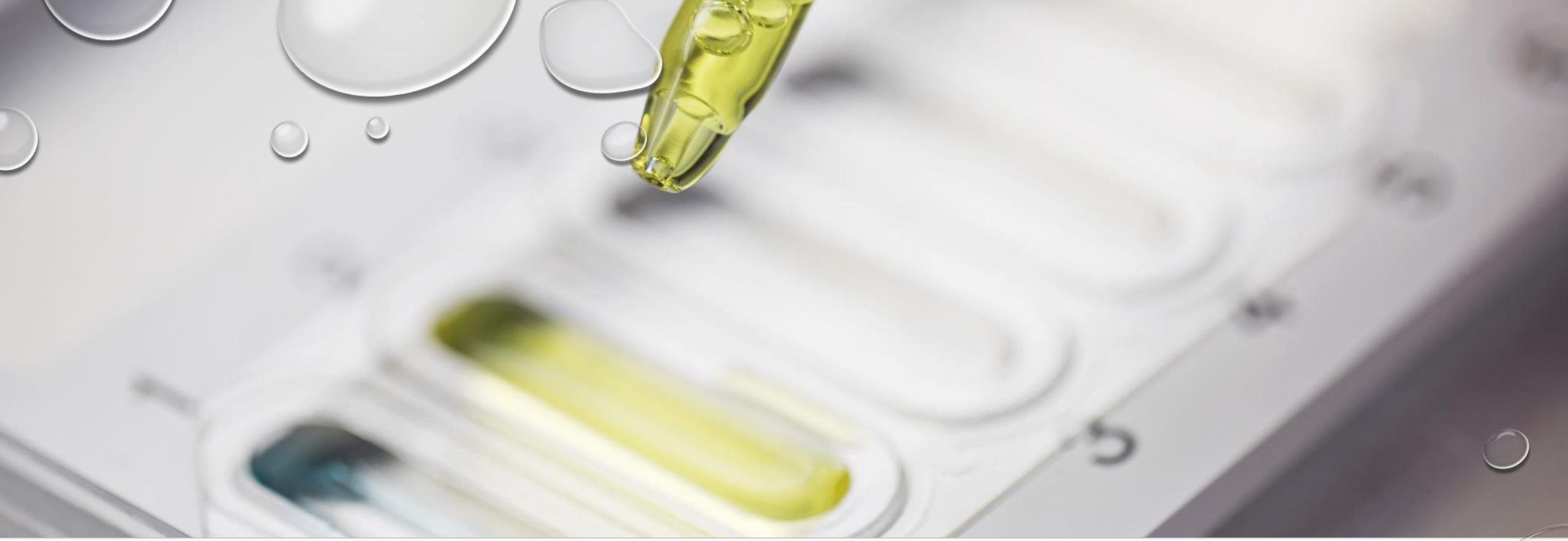
- THE TERMINAL HALF-LIFE OF SUBLOCADE INJECTION IS 43 -60 DAYS.
- GENERALLY, IT TAKES 4-5 HALF-LIVES FOR THE DRUG TO BE TOTALLY ELIMINATED FROM THE BODY.
- IN MOST PEOPLE, NO TRACE OF SUBLOCADE WOULD BE FOUND AFTER 172-300 DAYS.

SHOULD I TEST MORE THAN ONCE PER DAY

- NO, NO, NO, NO
- YOU CAN HAVE DIFFERENT RESULTS EVEN ON SPECIMENS COLLECTED ONLY A FEW MINUTES APART.
- WHY – VOLUME OF FLUIDS CONSUMED, CLEARANCE OF THE DRUG (HALF-LIFE), METABOLISM OF THE INDIVIDUAL

DOES MATRIX MATTER

Source	Detection window 1st - last	Approved under Federal Guidelines	Proficiency test specimens	Can you prove impairment
Urine	Hrs - weeks	YES	YES	NO
Oral Fluid	Hrs - days	YES	YES	In debate
Hair	Days - months	NO	YES	NO
Blood/serum	Min. - weeks	ETHANOL-YES	YES	YES
Sweat Patch	Days	NO	NO	NO



COLLECTION PROTOCOL

INFORMATION SOURCES

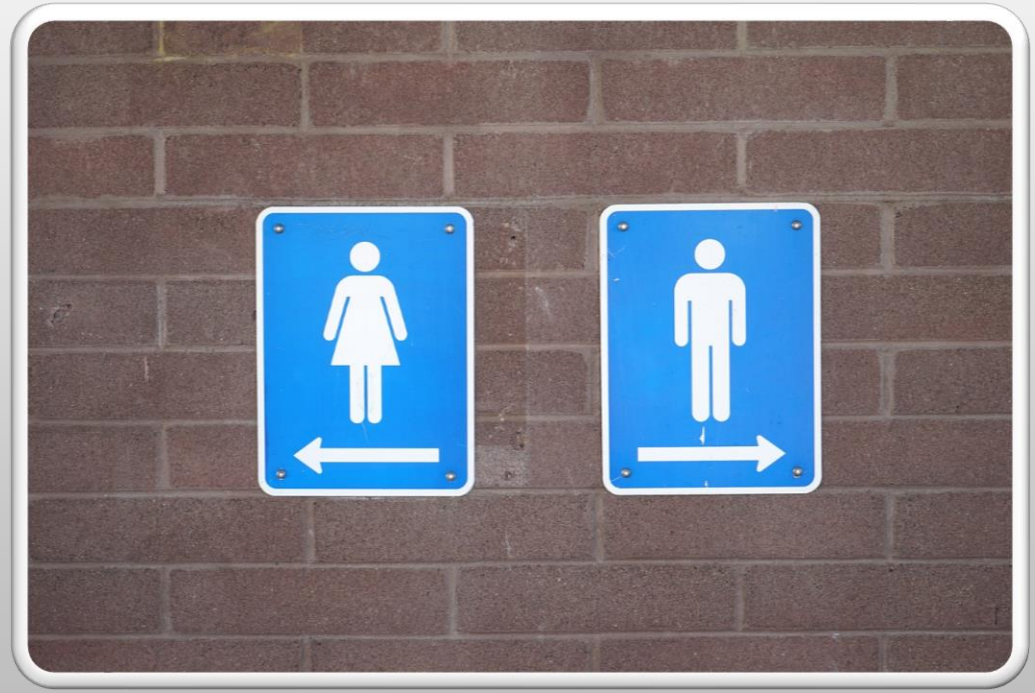
- HHS GUIDELINES: HTTPS://WWW.SAMHSA.GOV/SITES/DEFAULT/FILES/WORKPLACE/URINE-SPECIMEN-COLLECTION-HANDBOOK-OCT2017_2.PDF
- NADCP BEST PRACTICES: HTTPS://WWW.NADCP.ORG/STANDARDS/ADULT-DRUG-COURT-BEST-PRACTICE-STANDARDS/
- DOJ: HTTPS://WWW.OJP.GOV/PDFFILES1/DIGITIZATION/121383NCJRS.PDF

ELEMENTS OF A COLLECTION

- location
- paperwork
- concerns

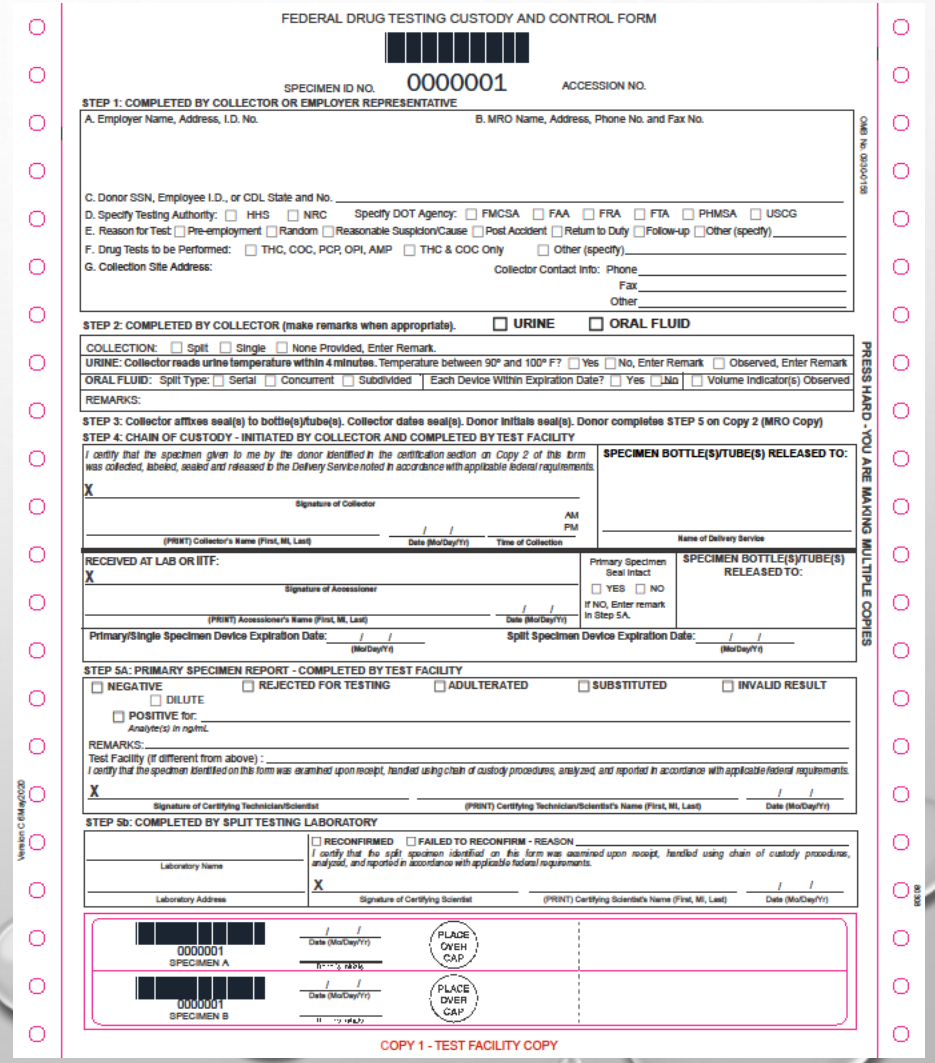
LOCATION

A SECURE PRIVATE LOCATION – DO NOT USE PUBLIC RESTROOMS IN PUBLIC BUILDINGS IF POSSIBLE. SAME SEX DONOR AND COLLECTOR. IF NOT POSSIBLE ASSURE PRIVACY. HAVE DONOR WASH AND DRY HANDS PRIOR TO COLLECTION. REMOVE LARGE BAGS AND HEAVY OUTER GARMENTS (COATS, JACKETS BULKY SWEATERS). IF THE TOILET HAS A TANK, SEAL WITH EVIDENCE TAPE. PUT BLUING AGENT IN THE BOWL. WEAR GLOVES WHEN HANDLING SPECIMEN. HAVE THE DONOR HAND THE SPECIMEN TO YOU. CHECK THE TEMPERATURE IMMEDIATELY AND OBSERVE ANY UNUSUAL COLOR OR ODOR.



PAPERWORK

- USE AN APPROVED CHAIN OF CUSTODY. THIS MAY BE FROM YOUR AGENCY OR THE REFERENCE LAB YOU USE. COMPLETE THE FORM CONTEMPORANEOUSLY WITH THE COLLECTION. MAKE SURE YOU SEAL THE CONTAINER IN THE PRESENCE OF THE DONOR. IF YOU ARE USING AN ON-SITE TEST CUP MAKE SURE TO READ THE RESULTS IN THE TIME SPECIFIED. NEVER ADD ANYTHING TO THE COLLECTION CONTAINER. IF YOU ARE USING A DIP STICK I WOULD ADVISE USING A STERILE PIPETTE OR POUR TO TRANSFER URINE FROM THE ORIGINAL CONTAINER TO THE STRIP OR A DISPOSABLE CONTAINER TO PLACE THE STRIP IN. ONLY COLLECT ONE SPECIMEN AT A TIME. COMPLETE THE PAPERWORK AND PACKAGE THE URINE PRIOR TO COLLECTING ANOTHER SPECIMEN.



FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM

[redacted]

SPECIMEN ID NO. 0000001 ACCESSION NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No. B. MRO Name, Address, Phone No. and Fax No.

C. Donor SSN, Employee I.D., or CDL State and No.

D. Specify Testing Authority: ☐ HHS ☐ NRC Specify DOT Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

E. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify)

F. Drug Tests to be Performed: ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify)

G. Collection Site Address: Collector Contact Info: Phone Fax Other

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate). ☐ URINE ☐ ORAL FLUID

COLLECTION: ☐ Split ☐ Single ☐ None Provided, Enter Remark.

URINE: Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark ☐ Observed, Enter Remark

ORAL FLUID: Split Type: ☐ Serial ☐ Concurrent ☐ Subdivided | Each Device Within Expiration Date? ☐ Yes ☐ No | ☐ Volume Indicator(s) Observed

REMARKS:

STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable federal requirements.

X Signature of Collector

(PRINT) Collector's Name (First, MI, Last) Date (Mo/Day/Yr) Time of Collection AM PM

SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

Name of Delivery Service

RECEIVED AT LAB OR IITF:

X Signature of Accessioner

(PRINT) Accessioner's Name (First, MI, Last) Date (Mo/Day/Yr)

Primary Specimen Seal Intact ☐ YES ☐ NO If NO, Enter remark in Step 5A.

SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:

Primary/Single Specimen Device Expiration Date: (Mo/Day/Yr) Split Specimen Device Expiration Date: (Mo/Day/Yr)

STEP 5A: PRIMARY SPECIMEN REPORT - COMPLETED BY TEST FACILITY

☐ NEGATIVE ☐ REJECTED FOR TESTING ☐ ADULTERATED ☐ SUBSTITUTED ☐ INVALID RESULT

☐ DILUTE

☐ POSITIVE for: *Analyte(s) in ng/mL*

REMARKS:

Test Facility (If different from above) :

I certify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable federal requirements.

X Signature of Certifying Technician/Scientist (PRINT) Certifying Technician/Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)

STEP 5b: COMPLETED BY SPLIT TESTING LABORATORY

Laboratory Name

Laboratory Address

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON

I certify that the split specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable federal requirements.

X Signature of Certifying Scientist (PRINT) Certifying Scientist's Name (First, MI, Last) Date (Mo/Day/Yr)

[redacted] 0000001 SPECIMEN A Date (Mo/Day/Yr) PLACE OVER CAP

[redacted] 0000001 SPECIMEN B Date (Mo/Day/Yr) PLACE OVER CAP

COPY 1 - TEST FACILITY COPY

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

OMB No. 0930-0158

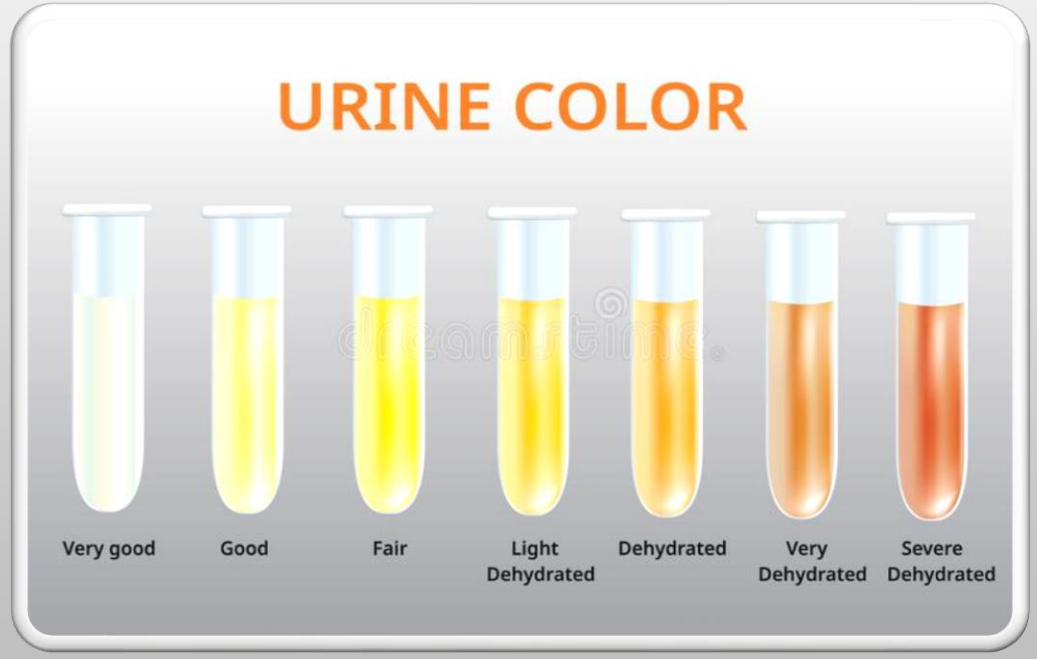
Version C 04/2020

CONCERNS

- WHAT IS A NORMAL URINE
- SUBSTITUTION
- ADULTERATION
- DEGRADATION

COLOR

- NORMAL - STRAW YELLOW
- BLUE TO GREEN – MEDICATION (METHYLENE BLUE) USED TO TREAT UTI
- ORANGE TO RED ORANGE – PYRIDIUM CHLOROCHROMATE A MEDICATION USED TO TREAT UTI OR CHROMATE AND ADULTERANT
- RED – BLOOD
- BROWN – IODINE
- BRIGHT YELLOW – B VITAMINS



CLARITY/SEDIMENT

NORMAL – CLEAR

CLOUDY

1. MEDICATIONS
2. DEHYDRATION
3. UTI INFECTIONS
4. KIDNEY DISEASE
5. DIABETES
6. PROSTATE DISEASE
7. PREGNANCY
8. STD
9. SOME AUTOIMMUNE DISEASE

ODOR

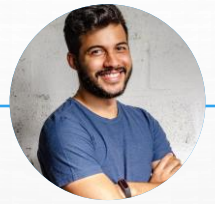
- 1. DEHYDRATION – AMMONIA ODOR
- 2. DIABETES – FRUITY OR SWEET ODOR
- BUT COULD ALSO BE
- GLUTERALDEHYDE AN ADULTERANT
- 3. UTI – STRONG URINE ODOR
- 4. FOOD – ASPARAGUS, ONIONS, GARLIC
- AND COFFEE
- 5. POOL OR SPA – BLEACH OR BROMINE

WHY DOES DILUTION WORK?

- Normal urine production is 1 ml/min.
- Drink 1 liter of water and the urine production goes to 7.5 – 8.5 ml/min from 30 – 150 min post consumption.
- Drink 2 liters of water and urine production peaks at 1 hr at 16ml/min and stays as high a 6 ml/min for 4.5 hrs.

CREATININE: RANDOM URINE SPOT CHECKS:

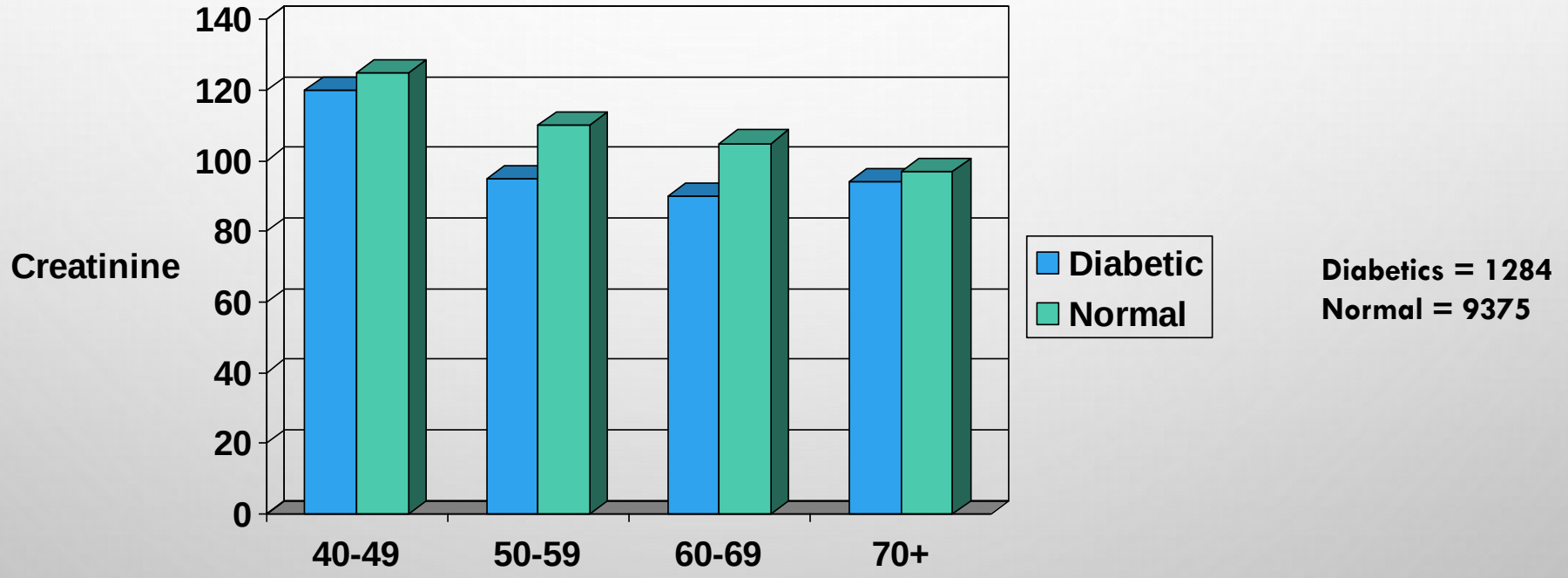
- **TOTAL NUMBER = 534**
  AVERAGE = 176
  MG/DL



- **TOTAL MALE = 385**
  AVERAGE = 190
  MG/DL

- **TOTAL FEMALE = 149**
  AVERAGE = 141
  MG/DL

CREATININE NORMAL VS. DIABETIC POPULATION



D. Barr et al,2005 N. de Fine Olivarius et al., 2006

WILL THE USE OF CREATIN RESULT IN INCREASED CREATININE LEVELS

- BASED ON THE STUDIES LISTED BELOW THE ANSWER IS NO
- BURKE DG, SMITH-PALMER T, HOLT LE, HEAD B, CHILIBECK PD. THE EFFECT OF 7 DAYS OF CREATINE SUPPLEMENTATION ON 24-HOUR URINARY CREATINE EXCRETION. J STRENGTH COND RES. 2001 FEB;15(1):59-62. PMID: 11708707.
- ROPERO-MILLER JD, PAGET-WILKES H, DOERING PL, GOLDBERGER BA. EFFECT OF ORAL CREATINE SUPPLEMENTATION ON RANDOM URINE CREATININE, PH, AND SPECIFIC GRAVITY MEASUREMENTS. CLIN CHEM. 2000 FEB;46(2):295-7. PMID: 10657393.

WHAT IS NORMALIZATION?

- THIS IS THE CONSIDERATION OF HOW THE DILUTION OR CONCENTRATION OF A URINE SPECIMEN IMPACTS THE RESULTS OF A DRUG SCREEN TEST. DRUGS ARE MEASURED IN NG/ML, THE MORE DILUTE THE URINE THE LOWER THE DRUG CONCENTRATION.
- THE PROCESS OF NORMALIZATION IS USED TO DETERMINE NEW USE OR RESIDUAL ELIMINATION.
- NORMALIZATION PUTS ALL THE SPECIMENS ON THE SAME PLAYING FIELD.

CALCULATION OF NORMALIZATION

NG DRUG X 100 = NG DRUG/MG MG CREATININE

MG CREATININE

20 X 100 = 200 NGDRUG/MG CREATININE

10

UNUSUAL DRUGS ABUSED ON THE STREET

- Xylazine (Tranq)- Humans-anesthesia, sedation and muscle relaxant. Veterinarian – emetic (mainly cats).
- Medetomidine – Originally used to kill barnacles. Approved by FDA in 2022 for veterinary use as a sedative for dogs.
- Isotonitazene – synthetic opioid, Estimated to be 20-100 times more powerful than fentanyl.
- Phenibut- Depressant originally from Russia. Benzodiazepine type effect. Sold online and gaining popularity in US.

REPURPOSING DRUGS

HEROIN USED TO TREAT OPIATE ADDICTION

- SURPRISINGLY MOST OPIATE ADDICTS DO NOT USE HEROIN. THERE ARE MANY PHARMACEUTICALS AND SYNTHETIC PRODUCTS AVAILABLE THAT PROVIDE A BETTER HIGH.
- OPIATE ADDICTS ARE OFTEN USERS OF ALCOHOL AND BENZODIAZEPINES ATTEMPTING TO MODERATE SYMPTOMS.
- DR. TORSTEN PASSIE OF THE HANNOVER MEDICAL SCHOOL IN GERMANY – HAS BEEN PERFORMING RESEARCH ON USING HEROIN AS A TREATMENT FOR OPIATE ADDICTION. WHEN DR. PASSIE COMPARED HEROIN TREATMENT TO METHADONE TREATMENT THE RESULTS WERE SURPRISING. THE HEROIN USERS REDUCED THE USE OF OTHER DRUGS BY 1/3 AND 60% STOPPED THE USE OF OTHER DRUGS WITHIN ONE YEAR.

KETAMINE USED TO TREAT BIPOLAR DISORDER

- DR. DEMITRI PAPOLOS PUBLISHED A PAPER IN 2012 ON THE USE OF KETAMINE FOR THE TREATMENT OF BIPOLAR DISORDER IN CHILDREN. HE FOUND THE CHILDREN SHOWED IMMEDIATE IMPROVEMENT IN THEIR SYMPTOMS WITH MINOR SIDE EFFECTS.
- CURRENT MEDICATION THERAPY CAN TAKE WEEKS OR MONTHS TO ESTABLISH THE CORRECT TREATMENT COMBINATION.
- ON 3/5/2019 THE FDA RELEASED A PRESS RELEASE APPROVING ESKETAMINE FOR USE IN TREATING DEPRESSION. ESKETAMINE IS THE S-ENANTIOMER (MIRROR IMAGE MOLECULE) OF KETAMINE WHICH IS MADE UP OF TWO ENANTIOMERS – S AND R

MDMA USED TO TREAT PTSD

- AUSTRALIA APPROVED THE USE OF MDMA FOR MEDICAL USE ON 7/1/23.
- MDMA IS KNOWN TO INCREASE SEROTINE, DOPAMINE, AND NOREPINEPHRINE.
- CURRENTLY RESEARCH IN THE US IS INVESTIGATING THE USE OF MDMA TO TREAT PTSD, EATING DISORDERS AND ANXIETY DISORDERS.

LSD USED TO TREAT ALCOHOLISM

- SEVERAL CLINICAL TRIALS IN THE US HAVE USED LSD TO TREAT ALCOHOLISM AND FOUND IT VERY SUCCESSFUL.
- LSD HAS BEEN USED IN RESEARCH TO TREAT CHRONIC HEADACHES, CLUSTER HEADACHES AND ANXIETY IN CANCER PATIENTS.

PSILOCYBIN USED TO TREAT DEPRESSION

- AUSTRALIA APPROVED THE USE OF PSILOCYBIN FOR MEDICAL USE ON 7/1/23.
- JOHN HOPKINS PUBLISHED A STUDY ON 2/15/22 IN THE JOURNAL OF PSYCHOPHARMACOLOGY ON THE USE OF PSILOCYBIN TO TREAT DEPRESSION.
- PSILOCYBIN NOT ONLY PRODUCES SIGNIFICANT AND IMMEDIATE EFFECTS, IT ALSO HAS A LONG DURATION, WHICH SUGGESTS THAT IT MAY BE A UNIQUELY USEFUL NEW TREATMENT FOR DEPRESSION," SAYS DR. ROLAND GRIFFITHS.

CBD AND OTHER CANNABINOIDS

CBD

- 100% PURE CBD WILL NOT CONVERT TO THC IN THE BODY
- UNFORTUNATELY, NONE OF THE CBD IS 100%
- MOST CBD HAS CONSIDERABLY MORE THC THAN ALLOWED BY THE 2018 FARM BILL
- THERE IS NO OVERSITE OR REGULATION OF THE AMOUNT OF THC IN CBD PRODUCTS
- CAN CAUSE LIVER DAMAGE AND INTERACT WITH MEDICATIONS

CANNABINOIDS

- DELTA 8 THC
- DELTA 10 THC
- THCP
- THCO
- THCV
- ???????

HOW LONG CAN CBD BE DETECTED: URINE 5 TEST SUBJECTS

Dose mg	Route	Max CBD ng/ml	CBD Last Detected	Max THCA ng/ml	THCA Last Detected
100 CBD	oral	2941	103 hrs	2.9	103 hrs
100 CBD	Vaped	631.1	102 hrs	2.0	95 hrs
100 CBD/**0.37% THC**	Vaped	539.1	97 hrs	29.9	95 hrs

1. Peak THCA excretion 4-6 hrs
2. Same test subject had all of the highest levels
3. Federal Cut Off on confirmation is 15 ng/ml

Spindle, Cone et al JAT Nov 2019

THANK YOU

PAT PIZZO

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The Future of Treatment Courts: Building on Success, Adapting to Change

Aaron Arnold, Chief Development Officer

NADCP
National Association of Drug Court Professionals

NDCI
NATIONAL DRUG COURT INSTITUTE

NCDC
NATIONAL CENTER FOR DWI COURTS

JUSTICE FOR VETS

NADCP
National Association of Drug Court Professionals

Stage 1

A New Model

The Early Years: A Revolutionary Approach

NADCP
National Association of Drug Court Professionals

- Court-supervised treatment
- Ongoing judicial monitoring
- Multidisciplinary team
- Non-adversarial approach
- Incentives and sanctions
- Generally, a pre-plea model

The Early Years

NADCP
National Association of Drug Court Professionals

- Rapid expansion
  - 1989: Miami (first adult drug court)
  - 1992: Phoenix
  - 1994: Federal funding begins
  - 1997: 370 treatment courts nationally
  - 2007: 1,000+ treatment courts nationally
  - Today: 3,000+ treatment courts nationally

NADCP
National Association of Drug Court Professionals

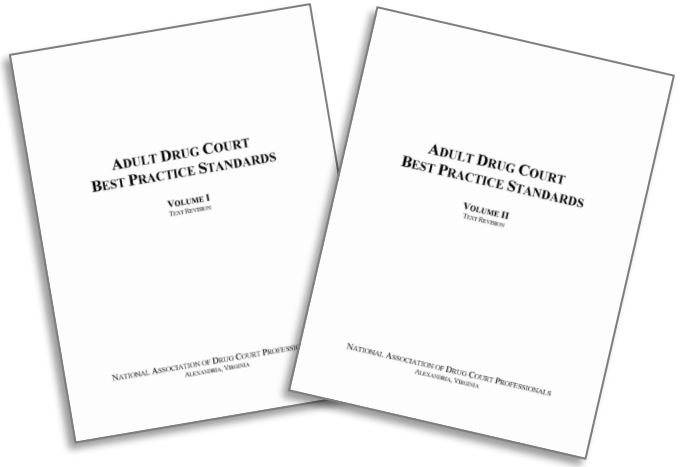
Stage 2

Treatment Courts Work

Treatment Courts Work

- 30 years of treatment court model refinement
  - Ten Key Components (1997)
  - Tons of research (e.g., NIJ's Multi-Site Adult Drug Court Evaluation, 2011 (23 courts in 6 states)

- Adult Drug Court Best Practice Standards
  - Volume 1 (2013)
  - Volume 2 (2015)



NADCP
National Association of Drug Court Professionals

Stage 3

Fidelity to the Model

Fidelity to the Model

NADCP
National Association of Drug Court Professionals

- Adherence to best practices
  - Identifying the most appropriate offenders (high-risk/high-need)
  - Routing them to treatment court quickly
  - Providing evidence-based treatment and services
  - Using evidence-based supervision and behavior modification techniques
  - Getting good results
- Statewide fidelity programs
  - State certification
  - Peer review

NADCP
National Association of Drug Court Professionals

Stage 4

A New Wave of Reform

A New Wave of Reform

- In recent years, several ripples have converged into a new wave of justice system reform
  - Upstream approaches/shrinking the system
  - Criticisms of the treatment court model
  - Spotlight on poor treatment court practices

Upstream Approaches/Shrinking the System

- Growing recognition that justice system involvement can **cause harm** and **worsen outcomes**

Disruption of support systems
\+ Imposition of trauma

Harm to individuals/communities and higher likelihood of reoffending

Upstream Approaches/Shrinking the System

NADCP
National Association of Drug Court Professionals

- Overwhelming evidence that jail is:
  - Ineffective
  - Harmful
  - Expensive

Upstream Approaches/Shrinking the System

- But it's not just jail…probation, intensive monitoring, drug testing, etc. all raise similar concerns
- Technical violations drive ~15-25% of jail admissions
- Volume of obligations make failure likely for many people

Upstream Approaches/Shrinking the System

- Jail reduction efforts (e.g., Justice Reinvestment Initiative, Safety and Justice Challenge)

- Criminal law reforms
  - New York (2009)
  - California (2014)
  - Utah (2015)
  - Oregon (2020)

Upstream Approaches/Shrinking the System

- Court-based diversion
  - Buffalo C.O.U.R.T.S. program
  - Brooklyn Justice Initiatives
- Prosecutor-led diversion
  - Missoula's Calibrate diversion program
  - NYC's Project Reset
- Police and police/community diversion
  - Law Enforcement Assisted Diversion (LEAD)
  - CAHOOTS

Upstream Approaches/Shrinking the System

- Bail/pretrial supervision reform
  - Numerous states have eliminated or curtailed the use of cash bail
  - Backlash in some places, but evidence does not support criticisms
- Community-based violence prevention programs
- Lots more

Criticisms of the Treatment Court Model

- Some common criticisms of the treatment court model:
  - Coercive
  - Overly punitive
  - Contrary to health-focused approach
  - Replicate racial disparities in the larger justice system
  - Dominate available treatment resources and can make voluntary treatment harder to get

Criticisms of the Treatment Court Model

- These and other critiques have led some prominent voices to call for the elimination of treatment courts

Spotlight on Poor Treatment Court Practices

NADCP
National Association of Drug Court Professionals

- Hard truth: The treatment court model is complex and not easy to implement well
- Best practice standards are lengthy and highly technical
- Takes time to get good at this
- Ongoing training is needed to stay sharp

Spotlight on Poor Treatment Court Practices

- Some ongoing practice concerns include:
  - Accepting the wrong population
  - Overuse of jail sanctions
  - Inappropriate medical decisions
  - Fines and fees
  - Inadequate training
  - Lack of support from key stakeholders

So, What's Next?

- To recap, there's a new wave of reform happening
  - Upstream approaches/shrinking the system
  - Criticisms of the treatment court model
  - Spotlight on poor treatment court practices
- What does this all mean for the future of treatment courts?

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Stage 5

The Future of Treatment Courts

The Future of Treatment Courts

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- Let's remember, treatment courts are **THE** evidence-based practice
- When done right, treatment courts improve treatment outcomes, decrease reoffending, reduce the use of jail, and save money
- The answer is not to pull back on treatment courts
- It's to revitalize treatment courts to **strengthen practice** and **reduce harm**

Call to Action #1

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- **Focus resources on high-risk/high-need individuals facing significant prison time**
  - Treatments courts are the most effective intervention for high-risk, high-need individuals facing significant prison time
  - However, they are not appropriate in most other cases
  - Lower-risk, lower-need individuals and those facing less punitive sentences should be off-ramped from the justice system earlier
  - To this end, jurisdictions should build prearrest and pretrial diversion programs

Call to Action #2

- **Eliminate the ban on violent crimes**
  - Drug treatment courts have historically excluded individuals charged with violent crimes
  - This approach is not rooted in evidence
  - In fact, individuals charged with violent crimes are often the high-risk, high need individuals who stand to benefit most from treatment court
  - Local jurisdictions should open drug treatment courts to this population
  - Note: Intimate partner violence poses special concerns

Call to Action #3

NADCP
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- **Leave treatment to the professionals**
  - Only the participant's treatment provider and physician should make treatment and medical decisions.
  - Provide individually tailored treatment plans designed by clinical professionals
  - Never require a participant to undergo a level of treatment that is not clinically appropriate
  - Allow participants to use all three FDA-approved medications for opioid use disorder as medically prescribed
  - Recognize that addiction is often driven by underlying trauma, and ensure that treatment services are trauma responsive

Call to Action #4

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- **Eliminate racial and ethnic disparities**
  - Commit to identifying and addressing racial disparities in access, sanctions, graduation, and long-term outcomes using data
  - Offered culturally responsive treatment and recovery support services, such as H.E.A.T., a manualized treatment approach for young Black men (prainc.com/heat-afrocentric-holistic-recovery)
  - Train team members in how to serve participants in a culturally relevant manner
  - Identify individual decision points that may contribute to disparities and develop measures to alleviate disparate outcomes at those points

Call to Action #5

NADCP
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- **Reduce the use of jail sanctions**
  - Jail is a traumatic experience, even in small doses, and it often has a counterproductive effect on recovery and recidivism
  - Jail frequently interferes with treatment plan
  - Understanding these facts, treatment courts should use jail sparingly
  - Don’t use jail as a sanction for continued drug use
  - Never use jail to “help” a participant until a treatment bed opens
  - Possible uses of jail: when a participant commits a new crime but will continue in the program

Call to Action #6

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- **Think beyond legal leverage**
  - Legal leverage has played a central role in the treatment court model by motivating participation and program compliance
  - New justice system reforms like decriminalization or reclassification of drug offenses are removing some of this leverage
  - Use these changes as an opportunity to shift toward a more strengths-focused approach that elevates incentives over sanctions, prioritizes strong therapeutic relationships, and centers procedural fairness
  - Treatment courts can move away from the threat of jail and toward the promise of help with fewer strings attached

Call to Action #7

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- **Expand measures of success**
  - Treatment courts should reexamine how they measure success
  - Rates of reoffending and cost savings should not be the only indicators
  - Maintaining a job, completing school, strengthening family, addressing health issues, and serving as a peer mentor are important benchmarks as well
  - Partner with qualified researchers to create expanded performance measures, and evaluate the true impact of treatment court programs on the well-being of individuals, families, and communities

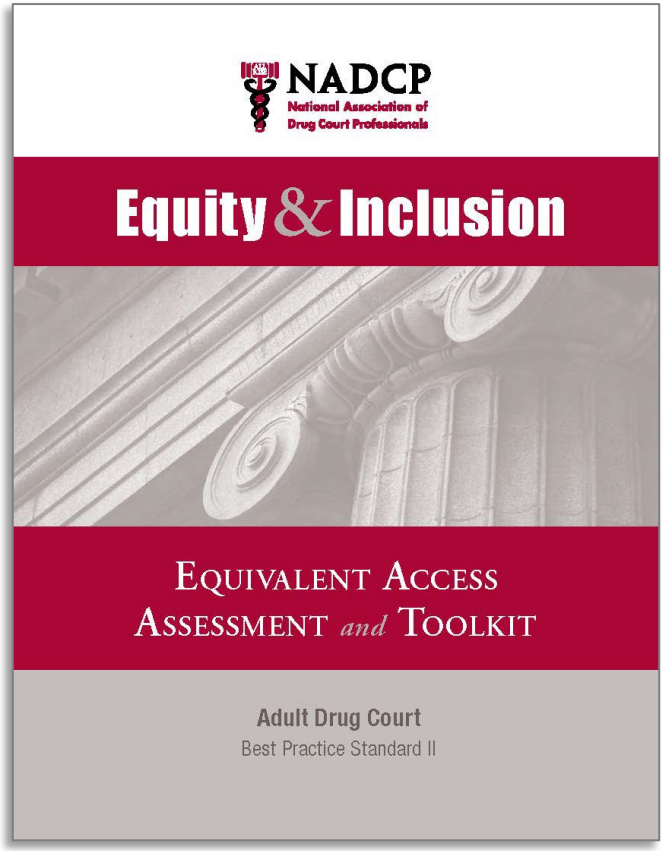
Conclusions

- Times are changing; new reform movements are afoot
- Treatment courts must adapt by strengthening practice and reducing harm
- The future of treatment courts is bright if we all work to continue improving model

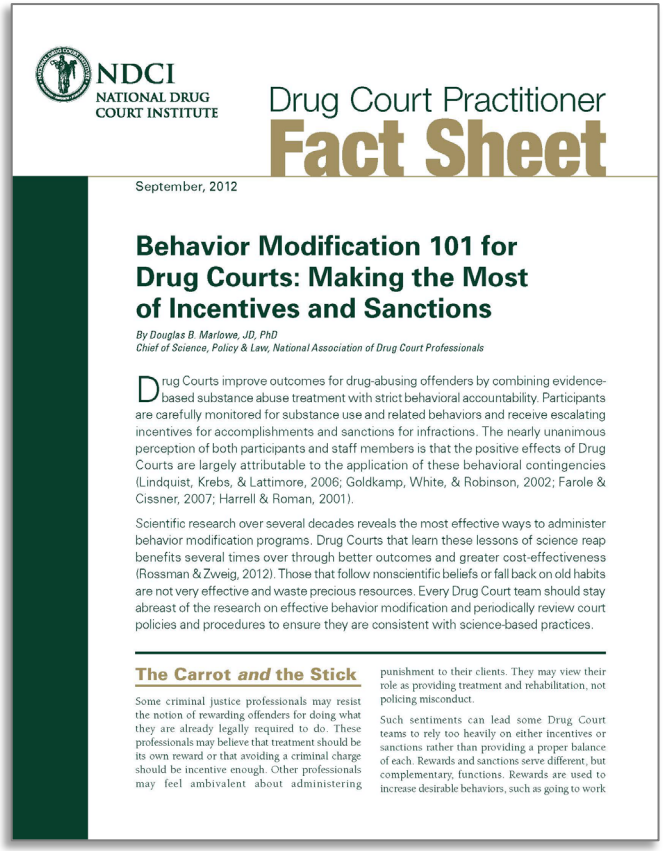
NADCP Resources

NADCP
National Association of Drug Court Professionals

[MOUD Toolkit]



[Equity & Inclusion Toolkit]



[Training, fact sheets, practice guides, and more]

Contact

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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

Adult Drug Court Best Practice Standards, 2nd Edition: A Preview ~ Part 2

Terrence Walton, Chief Operating Officer
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The Standards

I. Target Population

II. **Equity and Inclusion**

III. Roles & Responsibilities of the Judge

IV. **Incentives, Sanctions, and Service Adjustments (new title)**

V. **Substance Use, Mental Health and Trauma Treatment and Recovery Management** (new title)

The Standards

VI. **Complementary Treatment and Social Services** (New Title TBD)

VII. **Drug and Alcohol Testing**

VIII. Multidisciplinary Team

IX. Census and Caseloads

X. Monitoring and Evaluation

Standard II: Equity and Inclusion

II. Equity and Inclusion

A. Staff Diversity
B. Staff Training
C. Equity Monitoring
D. Cultural Outreach
E. Equitable Admissions
F. Equitable Treatment and Complementary Services
G. Equitable Incentives, Sanctions, and Dispositions
H. Fines, Fees, and Costs

II. Equity and Inclusion

2nd Edition Standard II

A. Staff Diversity
B. Staff Training
C. Equity Monitoring
D. Cultural Outreach
E. Equitable Admissions Procedures
F. Equitable Treatment and Complementary Services
G. Equitable Incentives, Sanctions, and Dispositions
H. Fines, Fees, and Costs

Current Standard II

A. Equitable Access
B. Equivalent Retention
C. Equivalent Treatment
D. Equivalent Incentives & Sanctions
E. Equivalent Dispositions
F. Team Training

II. Equity and Inclusion (2nd edition)

- All persons meeting evidence-based eligibility criteria for treatment court receive the same opportunity to participate and succeed in the program regardless of their sociodemographic characteristics or sociocultural identity, including but not limited to their race, ethnicity, sex, gender identity, sexual orientation, age, socioeconomic status, national origin, native language, religion, cultural practices, and physical, medical, or other conditions.
- The treatment court team continually monitors program operations for evidence of cultural disparities in program access, service provision, or outcomes, takes corrective measures to eliminate identified disparities, and evaluates the effects of the corrective measures.

II. Equity and Inclusion ~ Highlights

- What about bias within risk and need assessment tools?
- Which is the bigger risk—bias from a tool or bias from subjective decision making?
- Use culturally-validated tools to determine risk and need levels
- 2nd edition includes an appendix that indicates which commonly used risk and need assessment tools have ben validated for certain culture groups and translated into other languages

II. Equity and Inclusion ~ Highlights

- All team members are trained to :

1. define key performance indicators of cultural equity in their program
2. record requisite data
3. identify cultural disparities in program operations and outcomes
4. implement corrective measures.

- Team members receive at least annual training on evidence-based and promising practices for identifying and rectifying cultural disparities.

II. Equity and Inclusion ~ Highlights

- Conditions that require participants to pay fines, fees, treatment charges, or other costs can disproportionately burden members of some cultural groups.
- Such conditions are imposed only for persons who can meet the obligations without experiencing financial, familial, emotional, or other distress. Monetary conditions, if required, are imposed at amounts that are unlikely to impose undue stress on participants that may impede treatment progress.

Standard IV: Incentives, Sanctions, & Service Adjustments

IV. Incentives, Sanctions, and Service Adjustments

Current title:

Incentives, Sanctions, and Therapeutic Adjustments

2nd Edition Standard IV

A. Goal Classification
B. Advance Notice
C. Reliable and Timely Monitoring
D. Incentives
E. Service Adjustments
F. Sanctions
G. Jail Sanctions
H. Prescription Medication and Medicinal Marijuana
I. Phase Advancement
J. Program Discharge

Current Standard IV

A. Advance Notice
B. Opportunity to Be Heard
C. Equivalent Consequences
D. Professional Demeanor
E. Progressive Sanctions
F. Licit Addictive or Intoxicating Substances
G. Therapeutic Adjustments
H. Incentivizing Productivity
I. Phase Promotion
J. Jail Sanctions
K. Termination
L. Consequences of Graduation & Terminations

IV. Incentives, Sanctions, and Service Adjustments

- The treatment court applies evidence-based and procedurally fair behavior modification practices that are proven to be safe and effective for high-risk and high-need persons.
- Incentives and sanctions are delivered to enhance compliance with program goals or conditions that participants can meet and sustain for a reasonable time, whereas service adjustments are delivered to help participants achieve goals that are too difficult for them to accomplish currently.
- Team decisions relating to setting program goals and choosing safe and effective responses are predicated on input from qualified treatment professionals, social service providers, peer recovery specialists, and supervision officers with pertinent knowledge and experience.

IV. Incentives, Sanctions, and Service Adjustments ~ Highlights

- For participants who are at risk for drug overdose or other serious health threats, treatment adjustments include evidence-based health-risk prevention strategies if legally authorized, such as educating participants on safer-use and safer-sex practices and distributing naloxone (Narcan) overdose-reversal kits, fentanyl test strips, or condoms.

- Unless there is imminent public safety risk, jail sanctions are not imposed for distal goals before participants are psychosocially stable and in early remission from their substance use or mental health disorder, they are no more than three to seven days in length, and they are delivered in the least disruptive manner possible

IV. Incentives, Sanctions, and Service Adjustments ~ Highlights

- The treatment court does not deny admission, impose sanctions, or discharge participants unsuccessfully for the prescribed use of prescription medications, including MAT, psychiatric medication, and medications for other medical conditions such as pain or insomnia.

- Staff deliver sanctions pursuant to best practices if nonprescribed use reflects a proximal or willful infraction, such as ingesting more than the prescribed dosage to achieve an intoxicating effect, combining the medication with an illicit substance to achieve an intoxicating effect, providing the medication to another person, or obtaining a prescription for another controlled medication without notifying staff.

IV. Incentives, Sanctions, and Service Adjustments ~ Highlights

- The treatment court does not deny admission, impose sanctions, or discharge participants unsuccessfully for the prescribed use of prescription medications, including MAT, psychiatric medication, and medications for other medical conditions such as pain or insomnia.
- Staff deliver responses pursuant to best practices for the non-medicinal or "recreational" use of marijuana.
- In jurisdictions that have legalized marijuana for medicinal purposes, staff adhere to the provisions of the medical marijuana statute and case law interpreting those provisions.

Standard V: Substance Use, Mental Health, and Trauma Treatment & Recovery Management

Current title:

Substance Use Disorder Treatment

2nd Edition Standard V

A. Treatment Decision Making
B. Collaborative Person-Centered Treatment Planning
C. Continuum of Care
D. Counseling Modalities
E. Evidence-Based Counseling
F. Treatment Duration and Dosage
G. Recovery Managements Services
H. Medication for Addiction Treatment
I. Co-occurring Substance Use and Mental Health or Trauma Treatment
J. Custody to Provide or While Awaiting Treatment

Current Standard V

A. Continuum of Care
B. In-Custody Treatment
C. Team Representation
D. Treatment Dosage & Duration
E. Treatment Modalities
F. Evidence-Based Treatments
G. Medications
H. Provider Training & Credentials
I. Peer Support Groups
J. Continuing Care

V. Substance Use, Mental Health, and Trauma Treatment & Recovery Management

- Participants receive evidence-based treatment for substance use, mental health, trauma, and co-occurring disorders from qualified treatment professionals that is acceptable to the participants and sufficient to meet their validly assessed treatment needs.

- Recovery management interventions that connect participants with recovery support services and peer recovery networks in their community are core components of the treatment court regimen and are delivered when participants are motivated for and prepared to benefit from the interventions.

V. Substance Use, Mental Health, and Trauma Treatment & Recovery Management ~ Highlights

- Participants collaborate with their treatment providers or clinical case managers in setting treatment plan goals and choosing from among the available treatment options and provider agencies.

- Team members serve complementary roles in both supporting participants' treatment preferences and ensuring adequate behavioral change to protect participant welfare and public safety.

- Adjustments to the level or modality of care are based on participants' preferences, validly assessed treatment needs, and prior response to treatment and are not linked to programmatic criteria for treatment court phase advancement.

V. Substance Use, Mental Health, and Trauma Treatment & Recovery Management ~ Highlights

- Participants receive a sufficient duration and dosage of CBT interventions and other needed services (e.g., housing assistance, medication for addiction treatment) to stabilize them, initiate abstinence, teach them effective prosocial problem-solving skills, and enhance their life skills.
- No study has examined effective dosages of counseling sessions in treatment courts. The most closely analogous studies were conducted in community corrections centers and halfway houses and involved samples made up primarily of white men. These studies found that at least 200 hours, and as much as 300 hours, of evidence-based substance use counseling and other CBT counseling was required for effective outcomes among high-risk and high-need individuals

V. Substance Use, Mental Health, and Trauma Treatment & Recovery Management ~ Highlights

- All members of the treatment court team receive at least annual training on trauma-informed practices and ways to avoid causing or exacerbating trauma and mental health symptoms in all facets of the program, including courtroom procedures, community supervision practices, drug and alcohol testing, and the delivery of incentives, sanctions, and service adjustments.
- Participants are not detained in jail custody to achieve treatment or social service objectives. Before jail is used for any reason other than for sanctioning repeated willful infractions or because of overriding public safety concerns, the judge has found that custody is necessary to protect the individual from imminent harm and the team has exhausted all other less restrictive means to keep the person safe.
- Fearing that a person might overdose or be otherwise harmed is not sufficient grounds, by itself, for jail detention.

Standard VI: Complementary Treatment and Social Services

VI. Complementary Treatment and Social Services (Current Standard 6)

A. Scope of Services
B. Sequence and Timing of Services
C. Clinical Case Management
D. Housing Assistance
E. Mental Health Treatment
F. Trauma-Informed Services
G. Criminal Thinking Interventions
H. Family & Interpersonal Counseling
I. Vocational & Educational Services
J. Medical & Dental Treatment
K. Prevention of Health-Risk Behaviors
L. Overdose Prevention & Reversal

VI. Complementary Treatment and Social Services (Current Standard 6)

Participants receive complementary treatment and social services for conditions that co-occur with substance use disorder and are likely to interfere with their compliance in Treatment court, increase criminal recidivism, or diminish treatment gains.

VI. Complementary Treatment and Social Services (2nd Edition Likely Changes)

Moved to Standard 5:

- Clinical Case Management
- Mental Health Treatment
- Trauma-Informed Services
- Prevention of Health-Risk Behaviors
- Overdose Prevention & Reversal

- **Added Content:**

Recovery Capital

Standard VII: Drug and Alcohol Testing

VII. Drug and Alcohol Testing
(Current Standard 7)

A. Frequent Testing
B. Random Testing
C. Duration of Testing
D. Breadth of Testing
E. Witnessed Collection
F. Valid Specimens
G. Accurate & Reliable Testing Procedures
H. Rapid Results
I. Participant Contract

VII. Drug and Alcohol Testing
(Current Standard 7))

Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout participants' enrollment in the treatment court.

VII. Drug and Alcohol Testing

(2nd Edition Possible Changes)

- Testing consideration for newer substances and medication interactions
- Practice guidance on mitigating risk of re-traumatization and other harm from observed urine testing

Potential Harms from Observed Drug Testing

ALTHOUGH USUALLY NECESSARY IN TREATMENT COURTS, POTENTIAL HARM MAY RESULT FROM CONDUCTING OBSERVED URINE COLLECTION, FOR EXAMPLE:

- Some individuals, especially those who have survived sexual trauma, may be re-traumatized or otherwise caused distressed by being observed while urinating.
- Being alone in a private, enclosed space with a participant may expose the observer or participant to inappropriate sexual conduct, inuendo, or related allegations.
- The need to match genders between observer and participant may result in mis-gendering of transgender or binary participants.

Mitigating Potential Harms from Observed Drug Testing

1. Observation should be conducted in manner that helps to ensure that no adulterant is being used or bogus urine is being submitted but should be in no closer proximity than necessary. No part of the participant's body or clothing being worn should ever be touched by the observer/collector.
2. Do not insist on being able to directly observe genitals.
3. Use private observation windows when available.
4. Do not use video to observe urines. Even if the camera monitors but does not record video, the observer could inappropriately record the collection on a different device or be accused of doing so.

Mitigating Potential Harms from Observed Drug Testing

5. If allowed by personnel policy and other regulation, allow participants to be observed by someone that matches the gender with which they identify.
6. Consider using two observers if available and preferred by the participant.
7. Seek alternatives to urine testing for individuals whom treatment professionals indicate are likely to be retraumatized by being observed.

Adult Drug Court Best Practice Standards, 2nd Edition: A Preview ~ Part 2

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Harm Reduction Strategies in Treatment Court

What Fits and What Doesn't

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Disclaimer

This presentation, including its handouts, is intended for informational purposes only. Information you receive during this presentation is not intended to be a substitute for professional advice, including professional legal, health, and/or ethics advice. Please consult with an independent professional concerning your specific concerns.

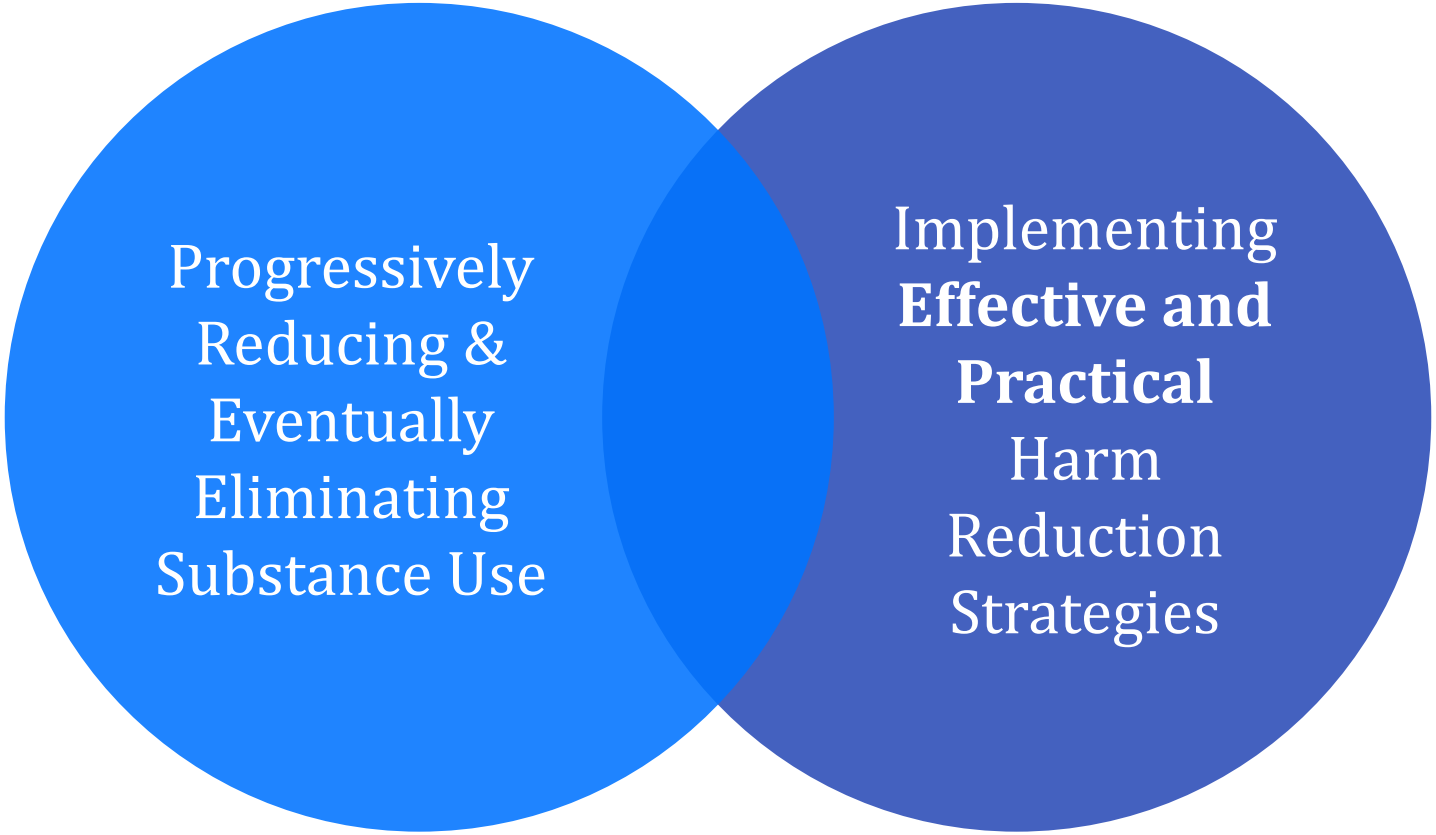
Here's What's Coming

1. Define and understand harm reduction
2. Consider which harm reduction practices can be implemented fully in treatment court and which likely cannot
3. Explore critical issues involving harm reduction in treatment courts

What Is Harm Reduction?

- A set of strategies and ideas to promote public health by reducing the negative consequences associated with drug use
- Aims to reduce risks and improve quality of life for people who use drugs

How Treatment Courts Reduce Overdose Risk



Standards and Reducing Harm

- Target population
- Medication for addiction treatment
- Proper use of jail sanctions
- Trauma-informed observed drug testing

SAMHSA On Harm Reduction

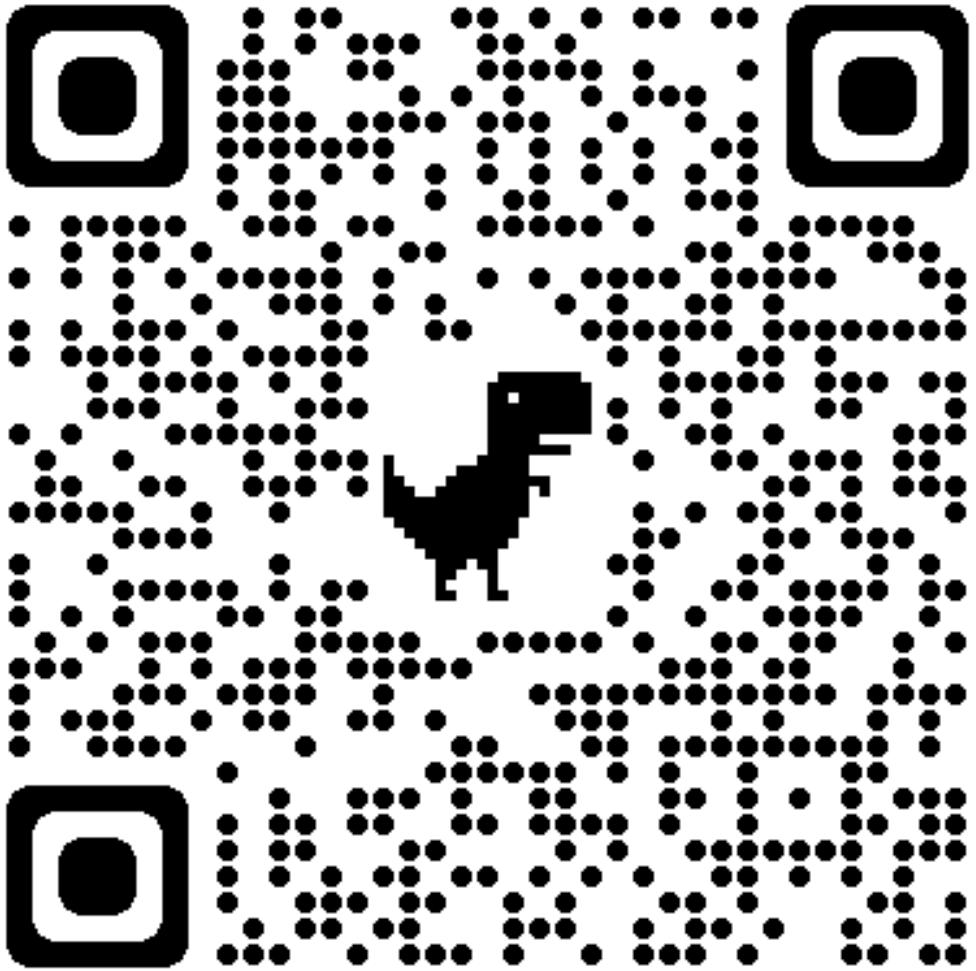
Harm reduction is an approach that emphasizes engaging directly with people who use drugs to **PREVENT** overdose and infectious disease transmission, **IMPROVE** the physical, mental, and social wellbeing of those served, and offer **LOW-THRESHOLD OPTIONS** for accessing substance use disorder treatment and other health care services.

SAMHSA On Harm Reduction

Harm reduction organizations incorporate a spectrum of strategies that meet people **"WHERE THEY ARE" ON THEIR OWN TERMS,** and may serve as a **PATHWAY** to additional prevention, treatment, and recovery services. Harm reduction works by addressing broader health and social issues through improved policies, programs, and practice.

SAMHSA 2022

SAMHSA On Harm Reduction

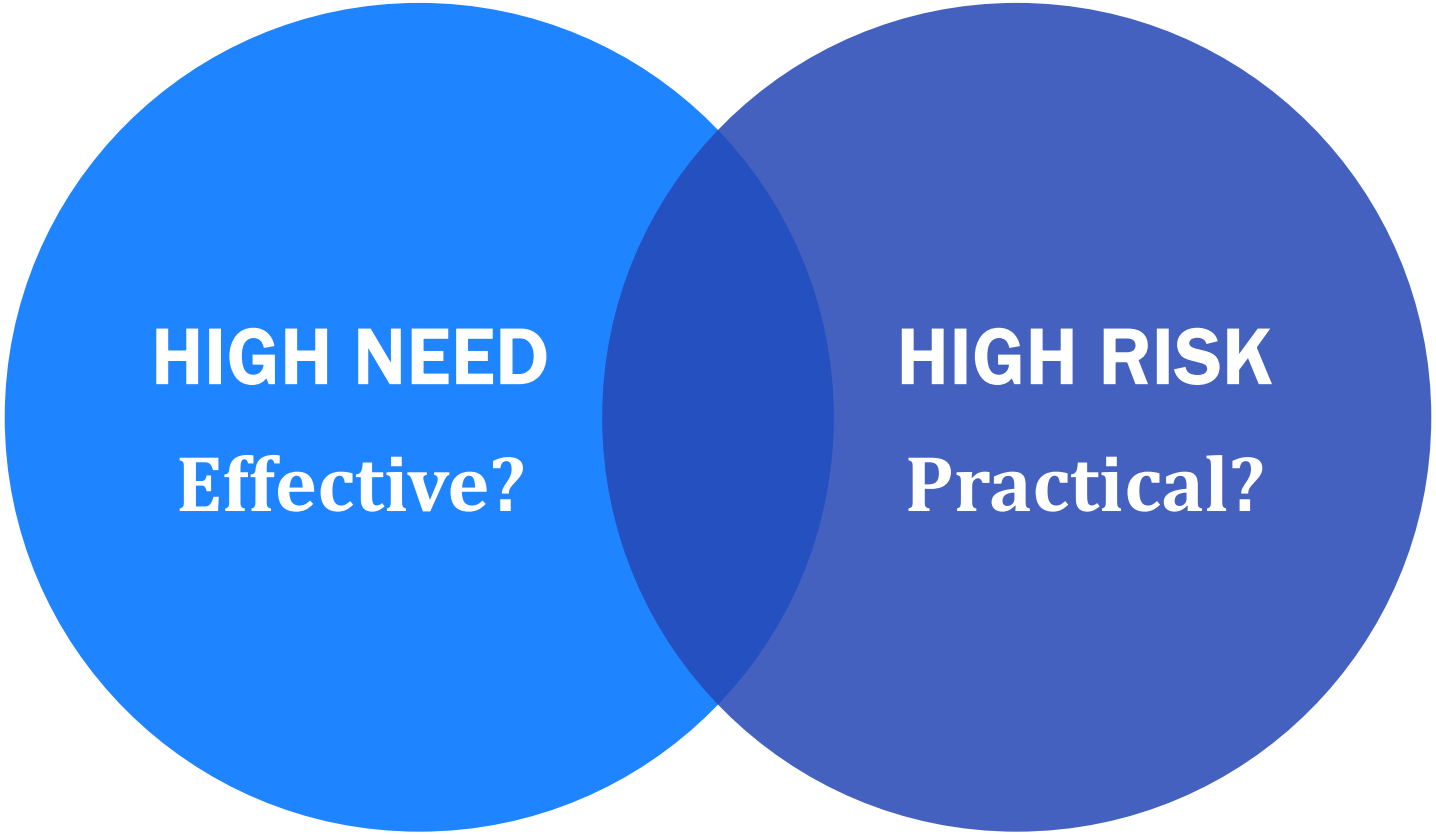


Harm Reduction Practices and Treatment Courts

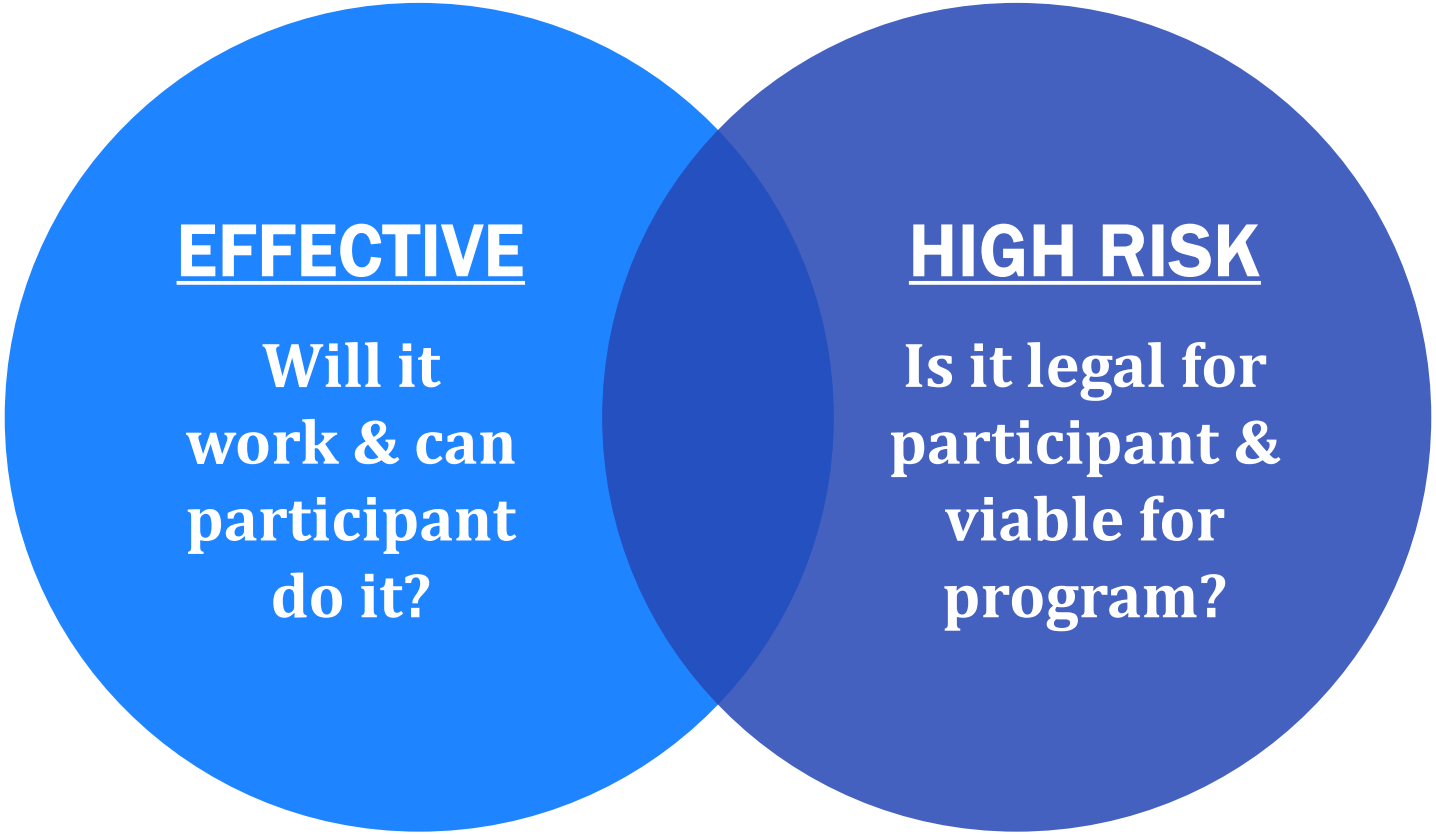
Harm reduction has primarily been focused on individuals outside of justice system

Some harm reduction strategies fit in treatment court, and some may not - ineffective and/or impractical

The Treatment Court Population Is Different



The Treatment Court Population Is Different



Harm Reduction Practices

1. Harm reduction education: overdose prevention, available harm reduction services, etc.
2. Narcan/Naloxone kits
3. Fentanyl test strips
4. Psychoactive substances used to treat disorders (other than MAT)
5. Controlled or safer, yet continuing substance use as a final goal of treatment
6. Syringe service programs—needle exchange; sterile injection or smoking equipment
7. Safe consumption sites

Harm Reduction Practices

- Being a poor fit for treatment court indicates that the practice is not a core service that is directly provided within or connected to the treatment court program
- Being a poor fit for treatment court **DOES NOT** indicate that the treatment court would object to any harm reduction service/practice being available in the community
- Being a poor fit for treatment court **DOES NOT** indicate that the treatment court would prevent participants from being informed about or from using such services, unless there is a legal reason to do so
  e.g., prohibition against possessing illicit drug use paraphernalia.

Harm Reduction Practices

Ultimately, each jurisdiction (neighborhood, city, county, state, region) will determine which harm reduction practices fit in their communities and in their treatment courts. Based on the treatment court logic model, decades of drug court research, our commitment to reduce overdose risk, and the absence of research on harm reduction with high-risk/high-need individuals,
here is All Rise's position…

Harm Reduction Practices

FITS:

1. **Harm reduction education: overdose prevention, available harm reduction services, etc.**
2. **Narcan/Naloxone kits**
3. **Fentanyl test strips**

Depends (on applicable state regulations)

4. **Psychoactive substances used to treat disorders (other than MAT)**

Doesn't Fit as A Core Service Within a Treatment Court

5. **Controlled or safer, yet continuing substance use as a final goal of treatment**
6. **Syringe service programs—needle exchange; sterile injection or smoking equipment**
7. **Safe injection sites or sanctuaries**

Harm Reduction Practices

- Treatment courts should educate participants on all legal harm reduction services and resources available in their community, even if not directly provided in or connected to the treatment court.
- Those services that are not a part of treatment court would likely not appear in the participation agreement, handbook, or supervision plan; however, they might be in the treatment plan developed by the treatment professional.
- By profession, treatment professionals are obligated to deliver or directly connect participants to all legal harm reduction services available in the community,
  even if not a core treatment court service.
- Unless legally required to do so, treatment courts should not sanction or otherwise discourage participants from accessing legal harm reduction services.

Harm Reduction Strategies in Treatment Court

What Fits and What Doesn't

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Additional Handout Slides

Harm Reduction Strategies in Treatment Court

The remaining slides are not fully covered during the presentation and are provided for post-session study and elaboration

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HANDOUT SLIDE

Abstinence

- The abstinence definition in treatment courts **is avoiding the self-prescribed or recreational use of all potentially addictive, intoxicating, or mood-altering substances.**
- Self-prescribed indicates that participants can't use anything not prescribed by the doctor. Avoiding recreational use means that, even if prescribed by the doctor, participants may not use or misuse it to get high. This includes all such substances, not just the category to which the participant is addicted.

HANDOUT SLIDE

Abstinence

- NADCP recognizes that it may be possible that, for example, an individual who is in sustained remission from an opioid use disorder might (or might not) eventually be able to use other substances, such as alcohol or marijuana, without developing an SUD for those substances; and without recidivating. However, there is not yet sufficient research or clinical/diagnostic guidance to determine in advance which individuals might fit into this category. Therefore, for the high risk/high need treatment court participant, whose substance use has led to serious crimes, complete abstinence is required for successful completion.
- NADCP supports the need for research that seeks to determine whether and in which circumstances a goal less than complete abstinence might be safe and effective for some in our target population.
- Use of any FDA-approved medication to treat addiction is allowable and does not violate the abstinence-based requirement.

HANDOUT SLIDE

Person-Centered Treatment

- **Treatment professionals are not "arms of the court"** and must honor their professional code of ethics, including adopting a person-centered, "meet the person where they are" approach. Even when the participant must achieve abstinence in order to complete treatment court successfully, as opposed to "enforcing" the abstinence requirement, the treatment professional's job is to help the participant accept that reality, navigate their mandates, and achieve their goal of successful program completion.
- This is the same as they would do for a client who needed to achieve abstinence in order to maintain a professional license, keep a job, play on a sports team, or remain in a marriage.
- **Justice professionals** practice meeting the participant where they are as well but **must also balance the participant's preferences against what is necessary to protect public safety** for the high risk/high need individual who is being allowed to remain in the community while being treated for SUD.
- Treatment professionals working with treatment court participants should also consider public safety when treatment planning. Addiction-related criminal activity or associates should be reflected in the Recovery and Living Environment The ASAM Criteria dimension.

HANDOUT SLIDE

Person-Centered Treatment

- **In the traditional person-centered approach, despite what the treatment professional recommends, the client's wishes rule** regarding the treatment setting (e.g., outpatient vs residential), treatment modality (i.e., group, individual, family), intervention (e.g., CBT, MAT), treatment dosage (e.g., how much, how many hours per week), and duration (e.g., 90 days, 6 months).
- Hopefully, the treatment professional will be able to negotiate a treatment plan to which the client agrees. If not, then the person-centered approach indicates that the client's wishes are to govern the treatment plan.

HANDOUT SLIDE

Person-Centered Treatment

- However, in treatment courts, the judge will typically defer to the treatment professional's recommendation (not the participant's) who is required to recommend the least restrictive/intensive treatment that is likely to successfully treat the high risk/high need individual.
- Treatment professionals should be aware that guidance from the American Society of Addiction Medicine is that if the client is persistently unwilling to accept the recommend treatment, **if it is safe to do so,** the treatment professional should attempt treatment at the level/intensity the client is willing to engage in, even if they fear it will not be sufficient.
- If the treatment professional concludes that the participant **cannot be safely treated** at the lower level/intensity treatment preferred by the participant, then then he or she should communicate that to the judge. And generally, the judge would concur with that recommendation.

HANDOUT SLIDE

Person-Centered Treatment and Medication For Addiction Treatment

METHADONE, SUBOXONE, & NALTREXONE

- Medication for addiction treatment should be fully implemented (but not mandated) in treatment court, including methadone, Suboxone, naltrexone, & extended release naltrexone.
- For the high risk/high need population prescribed MAT, psychosocial treatment is also needed.
- Premature interruption of MOUD increases overdose risk.
- Long term use of methadone and Suboxone **are not** associated with crime or other public safety risks—therefore should not raise concerns for justice professionals.
- Person-centered care requires treatment professionals to fully embrace, support, and facilitate a participant and medical providers decision to use medications, regardless of the treatment professional's views.

HANDOUT SLIDE

Person-Centered Treatment and Level of Care

UPDATED GUIDANCE FROM THE UPCOMING THE ASAM CRITERIA 4TH EDITION

Appendix A- Level of Care Assessment Considerations

After level of care determination is made by a treatment professional, he or she considers the newly defined ASAM Dimension 6 (Readiness and Resources) as follows:

1. **Is the patient able to attend the recommended Level of Care?**
    - Are any services or resources needed to enable the patient to participate in the recommended Level of Care (e.g., transportation, childcare, financial, etc.)?
    - Are these services/resources available to the patient and sufficient to enable them to participate in the recommended LOC?
    - If not, how should the LOC be adjusted?

HANDOUT SLIDE

Person-Centered Treatment and Level of Care

2. **Assuming the patient has sufficient resources and services are available, is the patient willing to attend the recommended Level of Care?**
    - If not, what treatment services are acceptable to the patient?
    - If the patient's preferred treatment setting is adjudged to be unsafe or is unlikely to be effective, what can be done to increase the patient's willingness to attend treatment at the recommended Level of Care (e.g., motivational enhancement therapy, family counseling)?
    - Is the patient being compelled to follow clinical recommendations by an external source? If so, what are the requirements?

HANDOUT SLIDE

Person-Centered Treatment and Duration and Dosage of Care

UPDATED GUIDANCE FROM THE UPCOMING ADULT DRUG COURT BEST PRACTICE STANDARDS 2ND EDITION

Standard 5 ~ Substance Use, Mental Health, and Trauma Treatment and Recovery Management

Participants collaborate with treatment professionals or clinical case managers in setting treatment plan goals and choosing from among the available treatment options and provider agencies. Team members serve complementary functions in both supporting participants' decision-making autonomy and ensuring adequate behavioral change to protect participant welfare and public safety.

HANDOUT SLIDE

Person-Centered Treatment and Duration and Dosage of Care

UPDATED GUIDANCE FROM THE UPCOMING ADULT DRUG COURT BEST PRACTICE STANDARDS 2ND EDITION

Standard 5 ~ Substance Use, Mental Health, and Trauma Treatment and Recovery Management

Participants receive a sufficient duration and dosage of substance-use and other CBT counseling to stabilize their clinical symptoms, initiate abstinence, teach them effective prosocial problem-solving skills, and enhance their preparatory skills needed to fulfill adaptive roles like employment or household management. Evidence suggests that 200 to 300 hours of professionally delivered CBT counseling over 9 to 15 months may be required to achieve these aims for high risk and high need persons.

Critical Issue – Use of Jail

- Absent an imminent public safety risk, participants usually do not receive stringent sanctions if they are otherwise compliant with their treatment and supervision requirements but are struggling to maintain abstinence.
- Responses to participant behavior must be informed by his or her **ability** to consistently control that behavior
- Used in conjunction with incentives, the possibility of stringent sanctions (including brief jail stays for repeated willful non-compliance) may help the high-risk/high-need participant consistently engage in treatment sessions, court hearings, and other requirements.
- Jail is not treatment, safe housing, nor an effective harm reduction/overdose prevention strategy. Even when necessary, jail can do harm.
- Be intentional about reducing the potential harms of jail sanctions.

HANDOUT SLIDE

Potential Harms From Jail

1. Exposure to other high-risk individuals
2. Risk of assault or other physical or emotional harm
3. Increased lethality risk
4. Interruption of life saving medication for addiction or mental health treatment
5. Interruption of psychosocial treatment and recovery management services
6. Re-traumatizing
7. Loss of job
8. Loss of housing

HANDOUT SLIDE

Potential Harms From Jail

9. Separation from children
10. Increased risk of opioid overdose following release due to reduction in opioid tolerance following even a brief period of incarceration-related opioid abstinence (same dose required to get high, but takes less to stop respiration)
11. Any period of juvenile detention has been found to be especially harmful to adolescents and should not be used a sanction in juvenile treatment court, in the absence of an imminent, serious public safety risk.
12. The potential for harm is increased the longer the individual is incarcerated

HANDOUT SLIDE

Mitigating Risk of Harm From Jail

1. Avoid using jail while awaiting or instead of residential treatment.
2. Recognize that jail is not an effective strategy for preventing opioid overdose. The reverse is true. Use other strategies for reducing risk to those who are continuing to use opioids **e.g., a) fully utilize MOUD, b) increase intensity of community-based OP/IOP treatment in the absence of or while awaiting a residential placement, c) increase mutual support group participation if recommended by treatment professional, d)increase court appearances, supervision contact, enforce a curfew, etc.**
3. In the absence of a related imminent public safety risk, generally do not use jail as a sanction for drug use alone for the person living with addiction who has not yet developed ability to abstain, unless that drug use was preceded by or led to missing treatment sessions, failures to appear for court, supervision, drug testing; violations of curfews, commission of new crimes warranting incarceration—other than simple drug possession or probation violation. In all circumstances, mitigate the risk of the abstinence violation effect.

HANDOUT SLIDE

Mitigating Risk of Harm From Jail

4. Utilize brief jail-based treatment and recovery management while the participant is jailed for any reason
5. Absent an associated imminent public safety risk, do not jail unless currently prescribed medications for addiction or mental health treatment can continue uninterrupted—without forcing the participant to taper off medications
6. Consider the appropriateness of work-release or weekend jail to allow jail sanctioned-participants to maintain employment
7. Use jail sanctions as a last resort and never for more than a few days

Critical Issue – Why Observed Urine Testing?

1. High risk population
2. For accurate detection
3. Motive to deceive
4. Positive external motivator
5. Justice personnel observers versus treatment staff observers
6. Mitigating risk of re-traumatization/ Reducing potential harms

HANDOUT SLIDE

Why Observed Drug Testing?

1. **HIGH RISK POPULATION**
   Requires more intense accountability measures; more likely to attempt to "beat the test"

2. **FREQUENCY AND SCHEDULE**
   Frequent, random testing required to detect use when participant is not yet fully committed to abstinence or to being honest about struggles to abstain. This is also required to effectively apply behavior modification (Operant Conditioning), which requires detecting and responding to behavior consistently and swiftly.

3. **MOTIVE TO DECEIVE**
   All people participating in court-involved SUD treatment who face sanction or loss of desired benefits for continuing substance use have an inherent motivation to try to hide use if they are not yet committed to, or not yet able to consistently abstain.

HANDOUT SLIDE

Why Observed Drug Testing?

4. **POSITIVE EXTERNAL MOTIVATOR**
   Realizing that it is very difficult to continue using in treatment court without detection can assist in helping the participant to begin to more fully engage in treatment and recovery management. Testing less rigorously can delay the participant reaching that conclusion.

5. **JUSTICE PERSONNEL OBSERVERS VERSUS TREATMENT STAFF OBSERVERS**
   Rigorous chain of custody and observation are essential for drug testing conducted by the court or probation. Chain of custody and observation is less important for treatment agencies if test results will not be used in the legal matters involved in treatment court—i.e., if the results are only used to guide clinical decisions and cannot result in sanction. It is probably best if the individual delivering the direct treatment services is not also the person who observes the urine.

HANDOUT SLIDE

Potential Harms From Observed Drug Testing

ALTHOUGH USUALLY NECESSARY IN TREATMENT COURTS, POTENTIAL HARM MAY RESULT FROM CONDUCTING OBSERVED URINE COLLECTION, FOR EXAMPLE:

- Some individuals, especially those who have survived sexual trauma, may be re-traumatized or otherwise caused distressed by being observed while urinating.
- Being alone in a private, enclosed space with a participant may expose the observer or participant to inappropriate sexual conduct, inuendo, or related allegations.
- The need to match genders between observer and participant may result in mis-gendering of transgender or binary participants.

HANDOUT SLIDE

Mitigating Potential Harms From Observed Drug Testing

1. Observation should be conducted in manner that helps to ensure that no adulterant is being used or bogus urine is being submitted but should be in no closer proximity than necessary. No part of the participant's body or clothing being worn should ever be touched by the observer/collector.
2. Do not insist on being able to directly observe genitals.
3. Use private observation windows when available.
4. Do not use video to observe urines. Even if the camera monitors but does not record video, the observer could inappropriately record the collection on a different device or be accused of doing so.

HANDOUT SLIDE

Mitigating Potential Harms From Observed Drug Testing

5. If allowed by personnel policy and other regulation, allow participants to be observed by someone that matches the sex with which they identify.
6. Consider using two observers if available and preferred by the participant.
7. Seek alternatives to urine testing for individuals whom treatment professionals indicate are likely to be retraumatized by being observed.

HANDOUT SLIDE

Harm Reduction Research

HARM REDUCTION STUDIES

- Safe injection sites. Studies on safe injection sites show they help reduce drug overdose deaths, prevent public drug use, and improve community health through preventing the transmission of bloodborne disease. For example, one 2011 study in The Lancet showed Vancouver's overdose deaths decreased by 35% two years after their safe injection site opened.[1]
- Managed alcohol programs. Several small studies have demonstrated the effectiveness of MAPS. For example, one study published in the *Canadian Medical Association Journal* showed that residents of a MAP had a decrease in interactions with the police and emergency services. Another study in the *Harm Reduction Journal* showed that people in MAPs had fewer admissions to hospitals, detox treatments, and arrests.[2]
- Naltrexone for alcohol reduction. A study in the journal *Substance Abuse* found that extended-release naltrexone combined with harm reduction counseling was effective at reducing alcohol use and alcohol-related harm in homeless alcoholics.[3]

[1] Ducharme, J. (2018). *The Country's First Safe Injection Facility May Soon Open in Philadelphia. Here's What You Need to Know*. *Time*
[2] Chapin. S. (2018). *Could Managed Consumption Be a Better Form of Treatment for Alcoholism?* *Pacific Standard.*
[3] Collins, S., Duncan, M., Smart, B., Saxon, A., Malone, D., and Ries, R. (2014). Extended-release Naltrexone and Harm Reduction Counseling For Chronically Homeless People with Alcohol Dependence. *Substance Abuse, 36(1), 21-33.*

HANDOUT SLIDE

Harm Reduction Research

HARM REDUCTION STUDIES

- A clinical review in *Psychiatric Services in Advance* on the effectiveness of methadone in MAT showed methadone use is associated with improved treatment retention and reduced opioid use in individuals with opioid addiction; reductions in drug-related HIV risk behaviors, mortality, and criminality; and improvements in fetal outcomes in pregnant women with opioid addiction.[4]
- A National Institute on Drug Abuse study that examined the effectiveness of buprenorphine and naloxone in people who were addicted to opioids found that half were abstinent 18 months after they started MAT. After 3.5 years, the number of people who were abstinent rose to 61% and less than 10% met the criteria for opioid use disorder (addiction).[5]

[4] Fullerton, C., Kim, M., Thomas, C., Lyman, R., Montejano, L., and Delphin-Rittman, M. (2014). Medication-Assisted Treatment With Methadone: Assessing the Evidence. *Psychiatric Services in Advance, 65(2), 146-157.*
[5] National Institute on Drug Abuse. (2015). *Long-Term Follow-Up of Medication-Assisted Treatment for Addiction to Pain Relievers Yields "Cause for Optimism"*

HANDOUT SLIDE

Overdose Prevention in Drug Court

From Adult Drug Court Best Practice Standards, Volume II (TR), Complementary Treatment & Social Services, pages 17-18

OVERDOSE PREVENTION AND REVERSAL

- Unintentional overdose deaths from illicit and prescribed opiates have more than tripled in the past fifteen years (Meyer et al., 2014). Individuals addicted to opiates are at especially high risk for overdose death following release from jail or prison because tolerance to opiates decreases substantially during periods of incarceration (Dolan et al., 2005; Strang, 2015; Strang et al., 2014).
- Drug Courts should educate participants, their family members, and close acquaintances about simple precautions they can take to avoid or reverse a life-threatening drug overdose. At a minimum, this should include providing emergency phone numbers and other contact information to use in the event of an overdose or similar medical emergency.
- As permitted by law, Drug Courts should also support local efforts to train Drug Court personnel, probation officers, law enforcement, and other persons likely to be first responders to an overdose on the safe and effective administration of overdose-reversal medications such as naloxone hydrochloride (naloxone or Narcan). Naloxone is nonaddictive, nonintoxicating, poses a minimal risk of medical side effects, and can be administered intranasally by nonmedically trained laypersons (Barton et al., 2002; Kim et al., 2009). The Centers for Disease Control and Prevention (2012) estimates that more than 10,000 potentially fatal opiate overdoses have been reversed by naloxone administered by nonmedical laypersons. Studies in the U.S. and Scotland confirm that educating at-risk persons and their significant others about ways to prevent or reverse overdose, including the use of naloxone, significantly reduces overdose deaths (National Institute on Drug Abuse, 2014; Strang, 2015).

Harm Reduction Strategies In Treatment Court

What Fits and What Doesn't

twalton@allrise.org

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Prosecutor and Defense Counsel

Working Effectively on the Treatment Court Team

DISCLOSURE

This plenary is being made possible by funding from the Bureau of Justice Assistance (BJA); opinions or points of view expressed in this plenary by the speaker do not necessarily represent the official position or policies of the United States Department of Justice, Bureau of Justice Assistance.

If not us, then who?

In treatment courts, our roles provide the opportunity for a unique collaboration to effectuate positive change within the criminal justice system.

While prosecutors and defense counsel may disagree on individual participants and legal matters, we have the common goal of ensuring that the treatment court produces the best possible outcomes.

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If not us, then who?

The Prosecutor and the Defense Counsel also have the shared goals of reduced recidivism and increased community safety.

Effective collaboration between the prosecutor and the defense counsel is vital for ensuring the treatment court operates effectively, avoids pitfalls, identifies areas needing improvement, and provides equal opportunities to participate.

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The ABA Criminal Justice Standards

Standard 3-1.2 Functions and Duties of the Prosecutor:

(e) The prosecutor should be knowledgeable about, consider, and where appropriate develop or assist in developing alternatives to prosecution or conviction that may be applicable in individual cases or classes of cases……

Standard 4-1.2 Functions and Duties of Defense Counsel:

(f) Defense counsel should be knowledgeable about, consider, and where appropriate develop or assist in developing alternatives to prosecution or conviction that may be applicable in individual cases, and communicate them to the client.

The ABA Criminal Justice Standards

Standard 3-1.2 Functions and Duties of the Prosecutor:

…The prosecutor's office should be available to assist community efforts addressing problems that lead to, or result from, criminal activity or perceived flaws in the criminal justice system.

Standard 4-1.2 Functions and Duties of Defense Counsel:

…Defense counsel should be available to assist other groups in the community in addressing problems that lead to, or result from, criminal activity or perceived flaws in the criminal justice system.

Target Population

- **Examine data of justice population**
  - Who's on community supervision?
  - Who's in jail?
  - What offenses, other than drug possession, are being committed because of substance use or mental health issues?
    - Felonies? Misdemeanors? DWIs? Probation Violators?

Are we targeting the population that will generate the greatest impact in our community?

Who are we bringing into our treatment courts?

	High Risk	Low Risk
High Needs (dependent)	Standard Track Accountability, treatment, and habilitation	Treatment Track Treatment and habilitation
Low Needs (abuse)	Supervision Track Accountability and habilitation	Diversion Track Secondary prevention

Target Population

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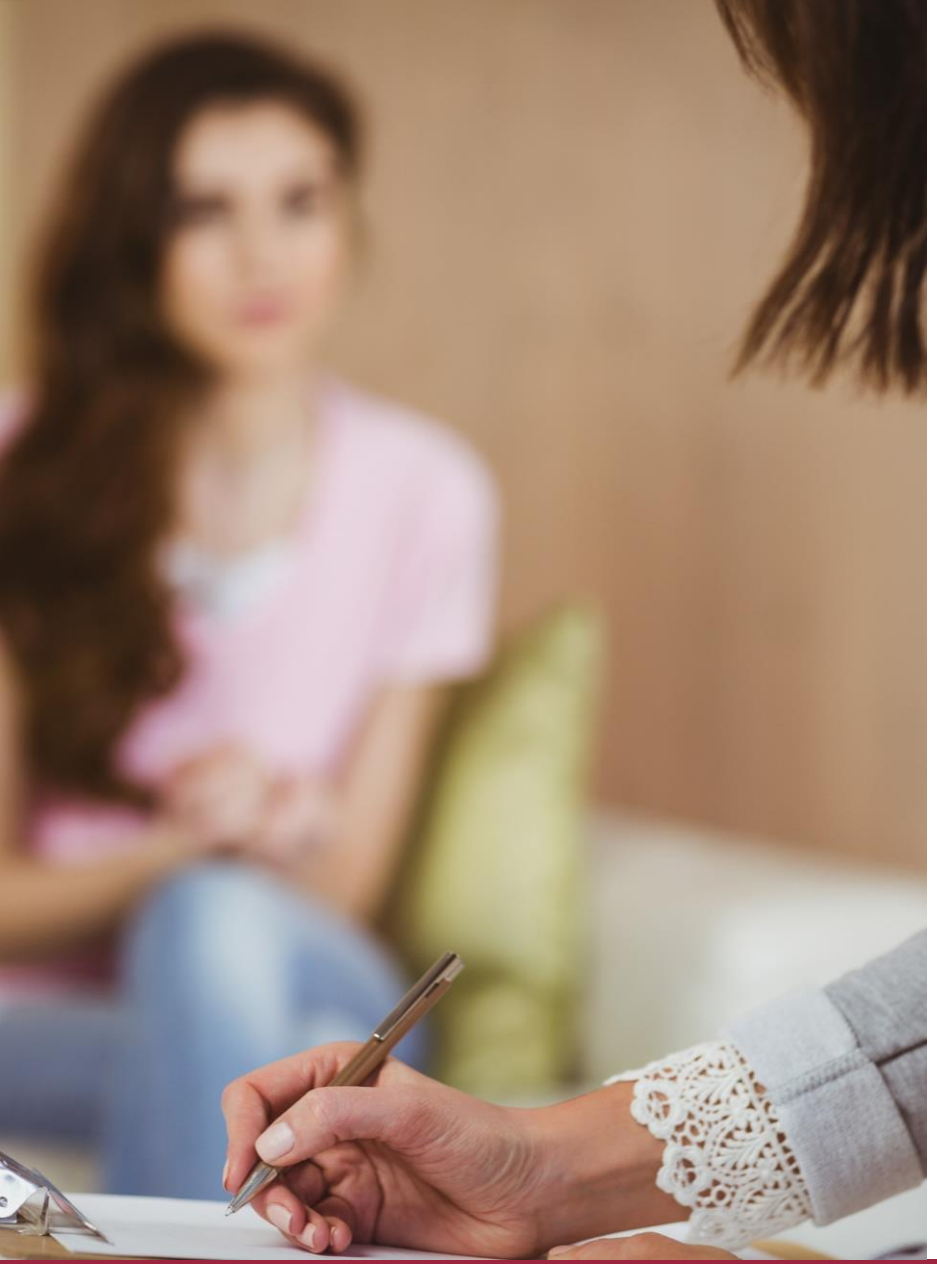
Risk Level

Reminder

"Risk" refers to the likelihood that the offender will not succeed adequately on standard supervision and will continue to engage in the same behavior that got him or her into the trouble in the first place.

Risk does NOT refer to danger to the community.

Risk levels need to be separated.



Clinical Need

Reminder

"Need" is whether the client needs treatment and what kind of treatment he/she needs.

The higher the need level, the more intensive the treatment or rehabilitation services should be, and vice versa.

Eight Central Factors of Criminal Behavior

- **History of Antisocial Behavior**
- **History of Antisocial Personality Patterns**
- **Antisocial Cognitions**
- **Antisocial Associates**

Known as the Big Four. These are most likely to reduce recidivism if directly addressed.

- **Family/Marital Circumstances**
- **School/ Work**
- **Leisure/Recreation**
- **Substance Use**

Treatment Courts usually focus on these four factors.

The Psychology of Criminal Conduct, Bonta & Andrews, 6th edition.

Program Structure

- **Examine Program Structure**
  - Pre-Plea/Diversion
  - Post-Plea
    - Deferred Sentencing
    - Probation
  - Probation Revocation
  - Re-Entry
  - Mixed Models

What's the legal incentive to participate?

Eligibility Criteria

Eligibility Criteria – written and objective characteristics that define who within your offender population may be admitted to treatment court.

- **Legal Eligibility**
- **Risk Level**
- **Clinical Need**

No voting!

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Legal Eligibility

- **Only Drug Possession Cases?**
  - Greater effects with theft and property offenders
  - Often not jail or prison bound
- **Dealers?**
  - Do just as well in treatment court.
- **Violent Offenders?**
  - Do just as well in treatment court.

Barring legal prohibitions those charged with dealing or violent histories should not be excluded automatically

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Fact Sheets

Targeting the Right Participants:

http://www.ndci.org/wp-content/uploads/2019/04/Targeting-The-Right-Participants.pdf

Alternative Tracks in Drug Courts:

http://www.ndci.org/resources/alternative-tracks-in-adult-drug-courts/

Selecting and Using Risk and Need Assessments:

http://www.ndci.org/resources/selecting-and-using-risk-and-need-assessments/

Entry Process

What process gets clients into the treatment court?

- **Referral/Application**
  - Who and When?
- **Legal Screening**
  - Who and When?
- **Risk and Clinical Assessments**
  - Who and When?

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Entry Process

What barriers must be overcome along the way?

- Court processes or procedures?
- Lack of buy in by defense counsel?
- Limited resources?

Common Legal Issues

- **Confidentiality**
  - 42 CFR Part 2
  - HIPPA
  - Staffings
  - Open Courtrooms
  - Law Enforcement
- **Ex Parte Communication**
- **Judicial fraternization and impartiality**

- **Due Process**
- **First Amendment**
- **Probation Restrictions**
- **Preventive Detention**
- **Jail Sanctions**
- **Medication Assisted Treatment**
- **Medical Marijuana**

Treatment Courts and MAT

- **The Dept. of Justice is actively investigating treatment courts in violation of American Disabilities Act (ADA) by prohibiting or limiting the use of medication to treat Opioid Use Disorder.**
- **Courts denying MAT or requiring discontinuance as condition of program completion are creating liability.**

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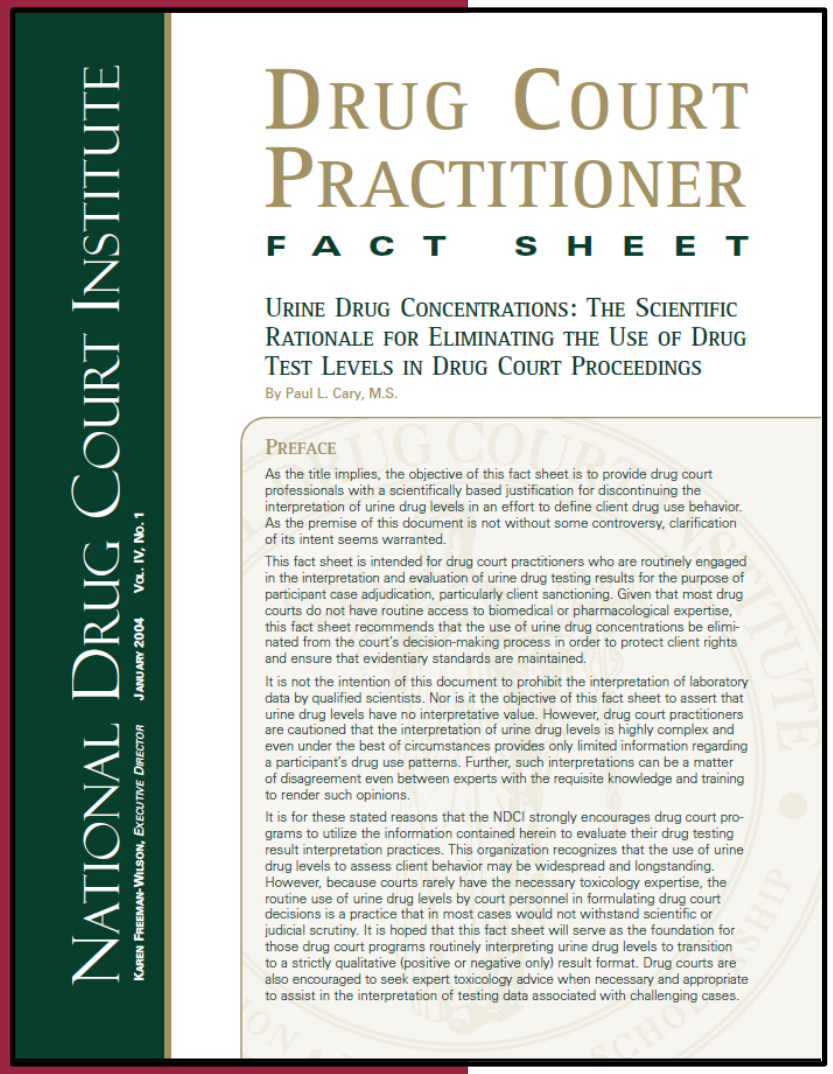

Drug Testing Fact Sheets

Urine Concentrations:

[Urine_Drug_Concentrations.pdf]

Creatinine:

[https://www.ndci.org/wp-content/uploads/2021/08/Use-of-Urine-Creatinine_Paul-Cary_Aug-2021.pdf]

THC Window Detection:

[https://www.ndci.org/wp-content/uploads/THC_Detection_Window_0.pdf]

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Effective Communication

<u>Staffing:</u>

Yes!

- Ensure Inclusiveness
- Ensure everyone “stays in their own lanes”

No!

- Regularly engage in adversarial behavior
- “Voting” on client eligibility

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Effective Communication

<u>Email Communication</u>

Yes!

- For updates on clients
- Arrange special staffing sessions
- Keep team updated on any changes

No!

- Arguing Positions
- Sarcasm

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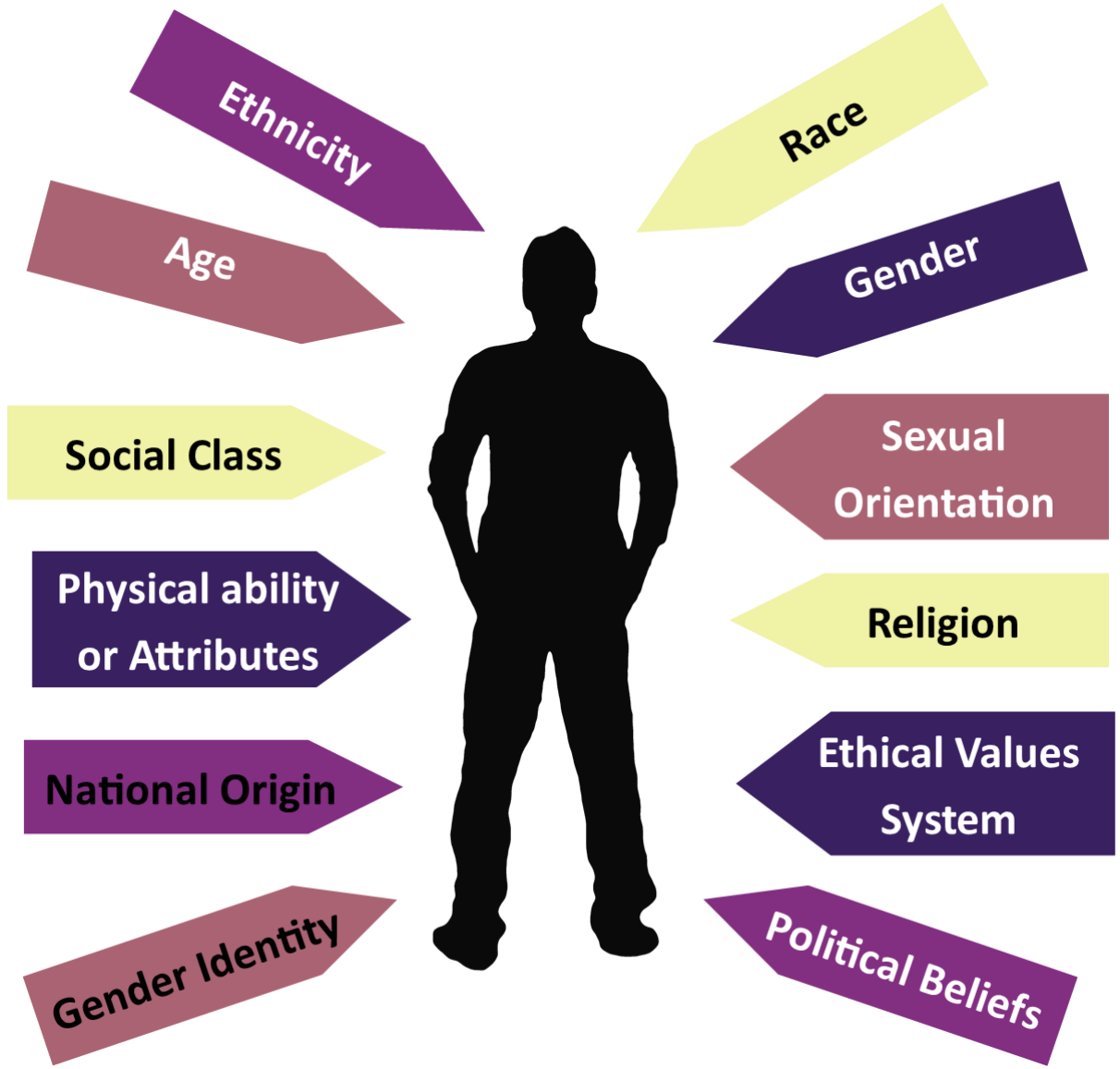
Standard II: Equity and Inclusion

Regularly Review Data:

- Referrals
- Admissions
- Exits
  - Absconders
  - Voluntary withdrawals
  - Involuntary Termination
  - Successful Completion

Diversity is a Fact

- Diversity is the range of human differences
- Inclusion is an act and takes practice
- Equity is the goal

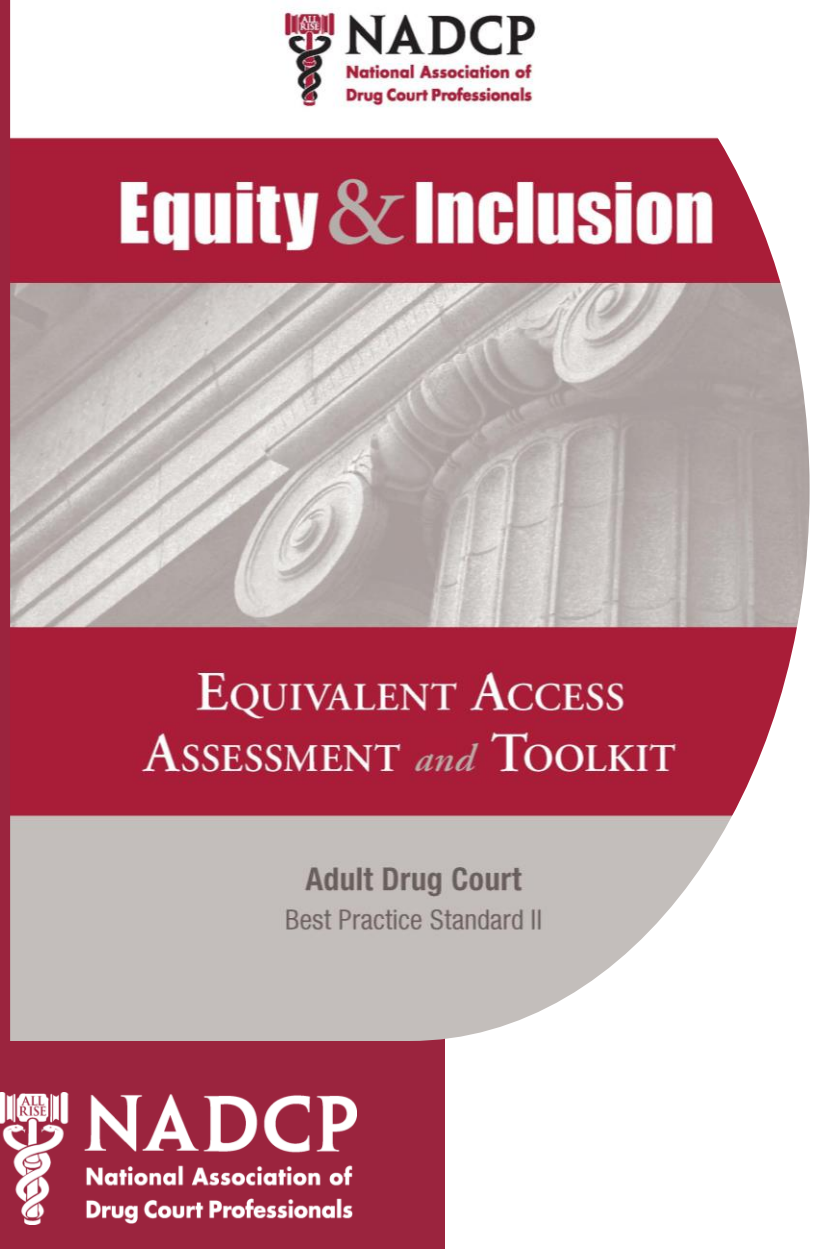


Equity and Inclusion

Regularly Review Criteria:

- Legal Criteria
- Program Fees
- Transportation
- Housing
- Sobriety

Intent vs. Impact



Equity and Inclusion Resources

Journal of Advancing Justice:

https://www.ndci.org/resource/publications/journal-for-advancing-justice/

Equity and Inclusion Toolkit:

https://www.ndci.org/wp-content/uploads/2019/02/Equity-and-Inclusion-Toolkit.pdf

Regularly Review Program's Written Materials

- **Policy and Procedures Manual**
  - Updated and Accurate?
- **Participants Manual**
  - Understandable resource?
- **Participants Contract**
  - Explains expectations and consequences?
- **Memorandums of Understanding**
  - Identifies specific responsibilities?

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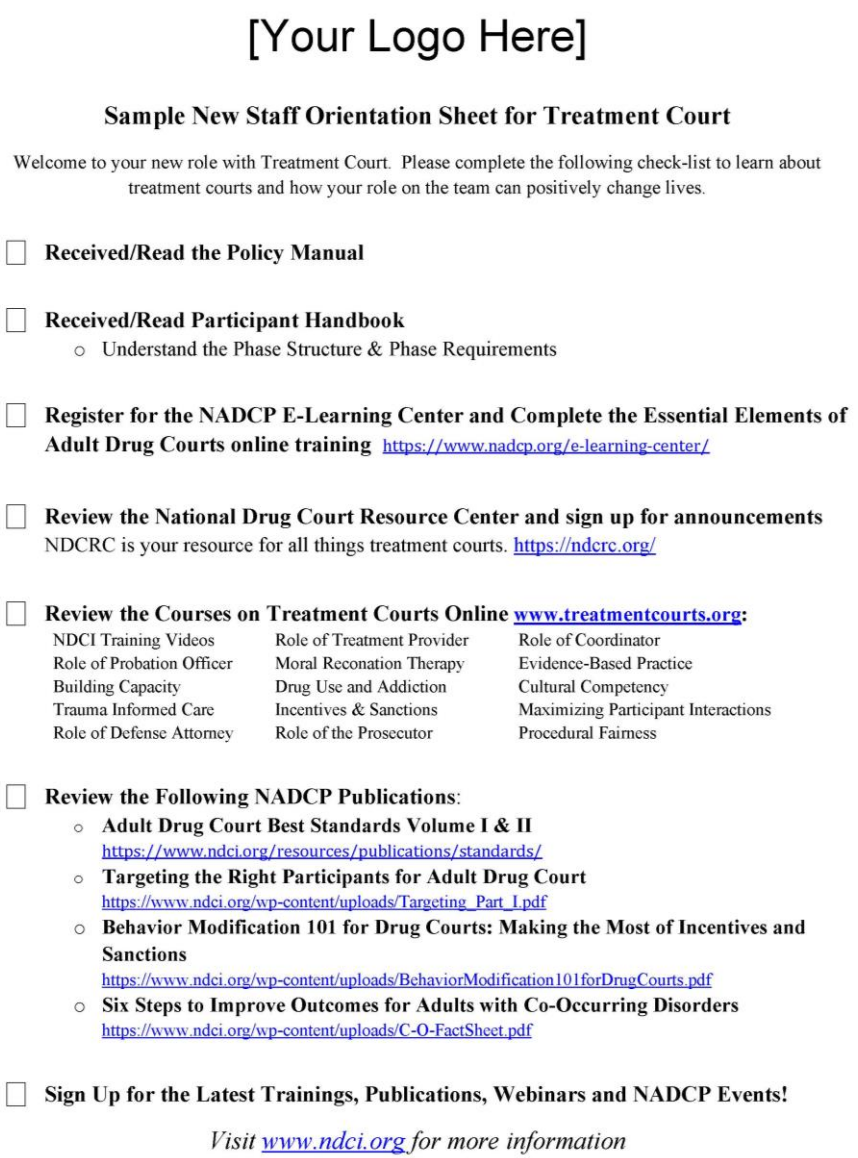

[Your Logo Here]

Sample New Staff Orientation Sheet for Treatment Court

Welcome to your new role with Treatment Court. Please complete the following check-list to learn about treatment courts and how your role on the team can positively change lives.

- ☐ **Received/Read the Policy Manual**
- ☐ **Received/Read Participant Handbook**
  - Understand the Phase Structure & Phase Requirements
- ☐ **Register for the NADCP E-Learning Center and Complete the Essential Elements of Adult Drug Courts online training** https://www.nadcp.org/e-learning-center/
- ☐ **Review the National Drug Court Resource Center and sign up for announcements**
  NDCRC is your resource for all things treatment courts. https://ndcrc.org/
- ☐ **Review the Courses on Treatment Courts Online www.treatmentcourts.org:**

NDCI Training Videos	Role of Treatment Provider	Role of Coordinator
Role of Probation Officer	Moral Reconation Therapy	Evidence-Based Practice
Building Capacity	Drug Use and Addiction	Cultural Competency
Trauma Informed Care	Incentives & Sanctions	Maximizing Participant Interactions
Role of Defense Attorney	Role of the Prosecutor	Procedural Fairness

- ☐ **Review the Following NADCP Publications**:
  - **Adult Drug Court Best Standards Volume I & II**
    https://www.ndci.org/resources/publications/standards/
  - **Targeting the Right Participants for Adult Drug Court**
    https://www.ndci.org/wp-content/uploads/Targeting_Part_I.pdf
  - **Behavior Modification 101 for Drug Courts: Making the Most of Incentives and Sanctions**
    https://www.ndci.org/wp-content/uploads/BehaviorModification101forDrugCourts.pdf
  - **Six Steps to Improve Outcomes for Adults with Co-Occurring Disorders**
    https://www.ndci.org/wp-content/uploads/C-O-FactSheet.pdf
- ☐ **Sign Up for the Latest Trainings, Publications, Webinars and NADCP Events!**

Visit www.ndci.org for more information

Ongoing Team Training

E-learning:

https://www.nadcp.org/e-learning-center/

10 Key Components:

Ten Key Components - National Drug Court Institute - NDCI.org

Drug Court Best Practice Standards Vol. I & II:

Standards - National Drug Court Institute - NDCI.org

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QUESTIONS?

Leveraging the Department of Veterans Affairs in Identifying Veterans in the Criminal Justice System

JUSTICE FOR VETS

ATRise

Treatment Court Institute

Impaired Driving Solutions

Justice for Vets

Center for Advancing Justice

Founded As

NADCP National Association of Drug Court Professionals

About Us

DISCLOSURE

This plenary is being made possible by funding from the Bureau of Justice Assistance (BJA); opinions or points of view expressed in this plenary by the speaker do not necessarily represent the official position or policies of the United States Department of Justice, Bureau of Justice Assistance.

A Collaborative Effort

This plenary results from a collaborative effort among professionals working within the Department of Veterans Affairs, Veterans Health Administration, Homeless Program Office, Veterans Justice Programs, and Justice for Vets.

Additional information relevant to the content of this plenary may be found at https://www.va.gov/homeless/ and https://allrise.org/about/division/justice-for-vets/

Veterans Treatment Courts – Key Components #3

Eligible participants are identified early and promptly placed in the veterans treatment court program.

This can be challenging at times!

Self-Reporting – Asking the Question

Are you a veteran?

versus

Have you ever served in the Armed forces, including the Reserve and National Guard Components?

BUT

- Veterans may not self-report
- The Department of Justice Bureau of Justice Statistics estimates that 7-8% of the U.S. prison and jail populations are Veterans.

Example– The California Dept. of Corrections and Rehabilitation houses about 100,000 prisoners. By self-reporting, 2.7% of inmates identified themselves as Veterans. Using VRSS, 7.7% of inmates were determined to have a military service record. That five percent difference = approximately 5,000 previously unidentified inmates.

Veteran Identification Systems from the VA

Veterans Reentry Search Service (VRSS) & SQUARES

JUSTICE FOR VETS

Visit the VRSS website to apply for access

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

Purpose

- VRSS is part of the VA's major initiative to End Veteran Homelessness
- Incarceration is the most powerful predictor of homelessness
- Ending Veteran Homelessness is an urgent and enduring priority for VA
- The system is designed to enable outreach specialists involved with VA's Health Care for Re-Entry Veterans (HCRV) program (prison populations), and Veteran Justice Outreach (VJO) ("front end" jails and court populations) program to identify Veterans as early as possible and get them linked to VA services upon their release. Both programs are focused on preventing homelessness among justice-involved Veterans.

Programs are using VRSS but….

NOT ENOUGH PROGRAMS ARE USING VRSS!

Background

- **What is VRSS?**
  - VRSS is an online tool that allows external users (prison, jail, and court staff users) to identify the individuals in their facility with a military service record.
- **How it works**:
  - An external user logs into VRSS and uploads a file with basic information on their population (prison/jail inmates or criminal defendants).
  - After allowing **2 hours for processing**, the user receives a result file that identifies those individuals included in the original uploaded file with a military service record.
  - Matches are identified through a query mechanism that checks the record against the **VA DoD Identity repository (VADIR),** the VA's copy of the DoD's Defense Enrollment Eligibility Reporting System (DEERS).
  - At the same time, another version of the results file is sent to the VA VJO or HCRV specialist responsible for the facility/geographic area.

Technical Requirements & Getting Started

- To use the system, you must first set up a VRSS account. This involves identifying yourself and your facility by entering basic contact information into the system and choosing a username and password.

- The first screen you encounter is the Terms and Conditions of Use.
  - Contains assurances that the VA is upholding federal privacy and security laws while also outlining the limited purposes for which VA will use VRSS
  - VRSS is used only to identify Veterans and provide that information to the outreach specialists
  - The VA is not taking this information and building a registry or using the information to inform any other VA process
  - VRSS is a free-standing mechanism. The original information you submit is destroyed once you and the VA outreach specialist have retrieved the results.

Visit the VRSS website to apply for access

Submitting a File

- ❑ The file you will build and submit must be in .csv format, built using Excel.
- ❑ The file must have a header row and contain 14 fields (14 columns per 1 row/ record)
- ❑ **Six** out of 14 fields are required: First name, last name, SSN, PID, Facility Name, and Facility State. Each row/record must include data in these six fields or the entire file will be rejected.
  - Social Security Number must be the **full** SSN. The SSN is the most vital component for the algorithm to match your records against VA records.
  - The Personal Identification Number (PID) is the unique number assigned to the individual by the Correctional Facility or Court System that is submitting data. Because the VA cannot send Veterans' personal information outside the VA firewall, the PID also serves to identify Veterans to external users. **A PID in the return file indicates that**The VJP specialist can receive more detailed information, including the Character of Discharge and the Number of Days of Active-Duty Service (the 2 pieces critical for determining eligibility for VA healthcare and benefits). However, VRSS cannot definitively confirm a Veteran's eligibility for VA services.

Required Fields (6 of 14)
First Name
Last Name
SSN
PID (Unique Identifying #)
Facility Name
Facility State

Submitting a File (continued)

- All data in a file submitted to VRSS must meet the formatting standards in the VRSS User Guide.
  - Reference p. 3 of the VRSS File Format Specifications: length and content requirements
  - VRSS will let you know if there are problems with the file you submit via an automated email and file confirmation page that includes errors identified by row. This is intended to allow users to quickly and easily correct errors and submit a file successfully.
- Average processing time is about 2 hours.
- The Limited information returned to the facilities (**PIDs only**, indicating individuals for whom VRSS found a record of military service) is by design; it allows the system to conform to Federal privacy and VA information release requirements.

Results: Who gets what, and why?

- CF/CS User (court, jail, prison): PIDs (user-assigned unique identifiers) only – no names or other identifying information

- VJP User: name, DOB, SSN, discharge status, number of days active-duty service (all pulled from VA copy of DoD personnel records)

- WHY?
  - **An individual's Veteran status is not protected information, so when asked whether someone served, VA can answer yes or no.**
  - However, VA cannot provide VRSS users with names other identifying information without a Veteran's express permission – even though that information was included in the user's submission file
- **No restriction on VRSS users sharing results/Veteran status with partners**

VRSS: Common Questions

- **Which records should be included in the submission file?**
  - All users are encouraged to include their entire population in the file submission. The value of VRSS is identifying Veteran inmates or defendants that have not been previously identified by self-report or other means.

- **How often are VRSS users required to upload a file?**
  - The frequency of uploads is up to the end user. Communicating and coordinating with the VA VJO or HCRV specialist conducting outreach in your facility/area and who will be using the information in the file is essential.

- **How should we handle an inmate record with multiple SSNs or aliases?**
  - Include multiple rows/records for that inmate in your submission, each identical except for the SSN or alias. This will maximize the chance of VRSS finding a military service record for that individual if one exists.

- **What is the facility's responsibility once it receives the results?**
  - Integration of the information from the results file into your system varies by facility and is not monitored by the VA.

Visit the VRSS website to apply for access

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

SQUARES

Visit the SQUARES Website to apply for access

Status Query and Response Exchange System (SQUARES) is a web-based application that returns unique information regarding the Veteran's particular status and eligibility for healthcare and/or homeless program services in a secure environment. Depending on the SQUARES outcomes, VA employees and homeless service providers are provided with an eligibility determination so they can begin the enrollment or referral process to assist Veterans with accessing VA healthcare and homeless programs--Supportive Services for Veterans Families (SSVF), Grant and Per Diem (GPD), etc.

User Types

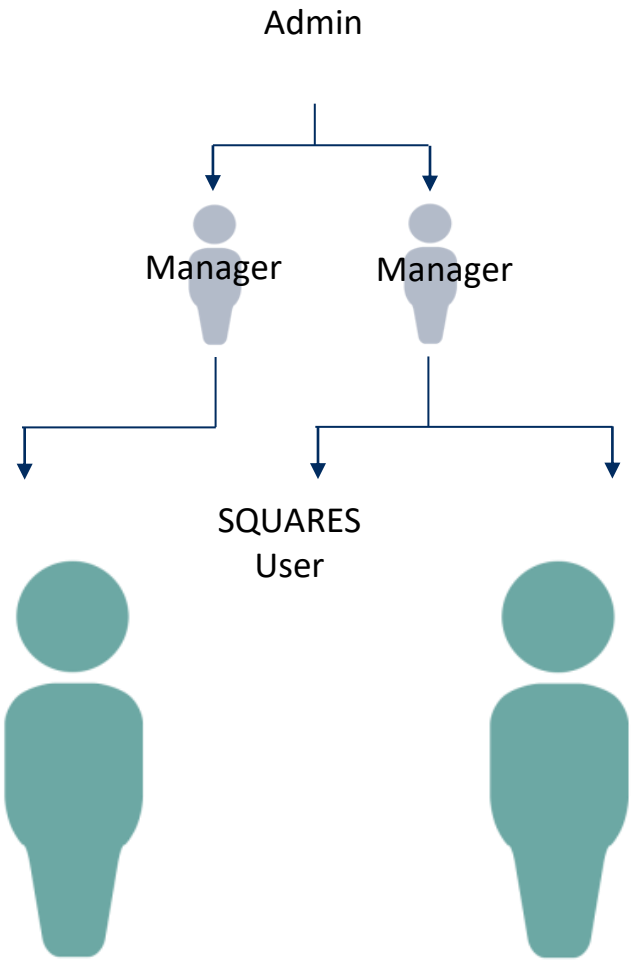
SQUARES Admin: Project Manager approves SQUARES Managers and VA Users

SQUARES Managers: Designated Approving Officials
for External Organizations (VA Grantees, Federal, State, Local Government Agencies and Law Enforcement*)

Standard SQUARES Users: VA Employees and External Organizations (VA Grantees, Federal, State, Local Government Agencies and Law Enforcement*)

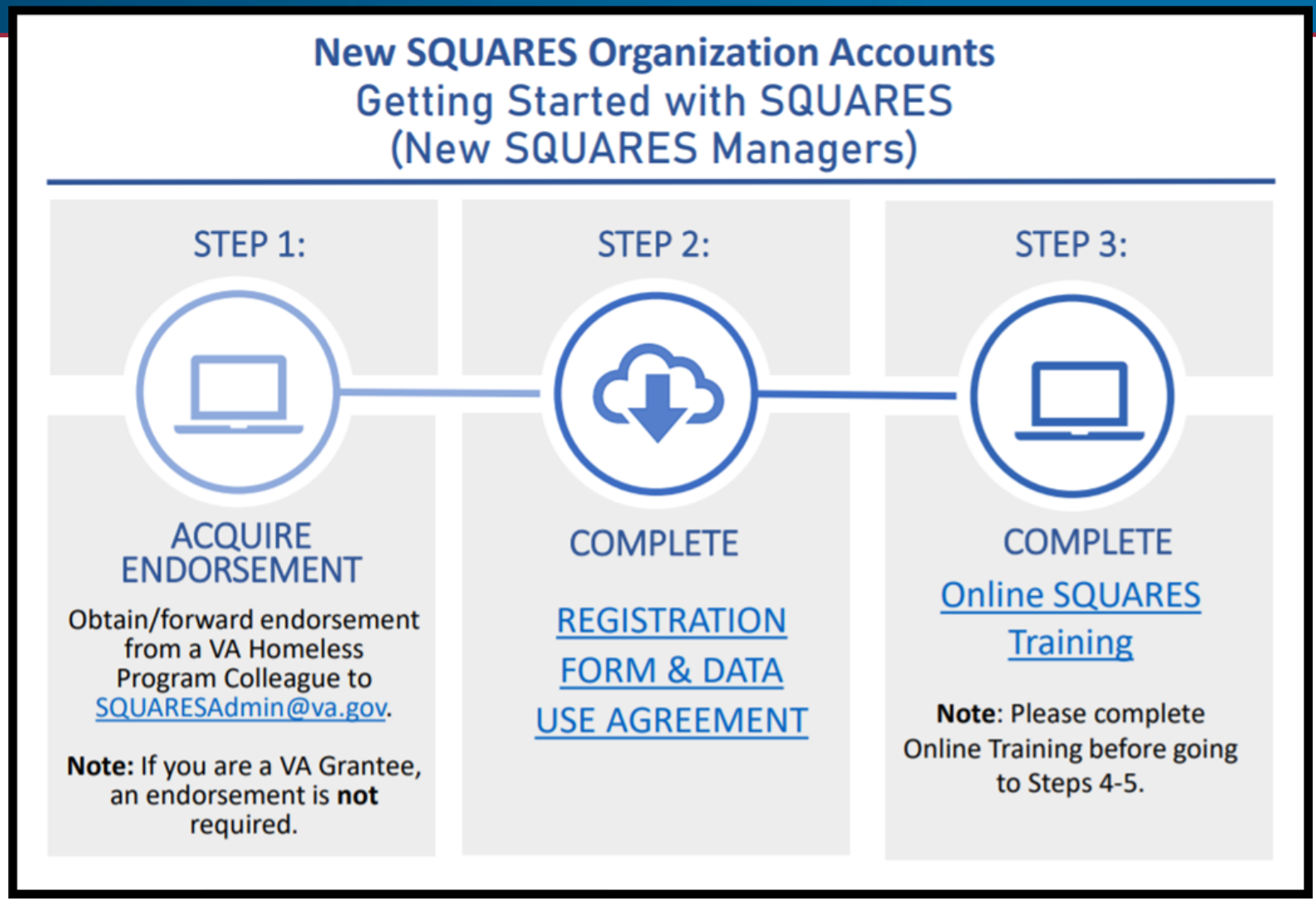
*Law Enforcement includes criminal justice agencies such as police departments, sheriff departments, courts and jails that may be one of the first agencies to encounter a homeless Veteran.

Approval Hierarchy



Application Process Steps

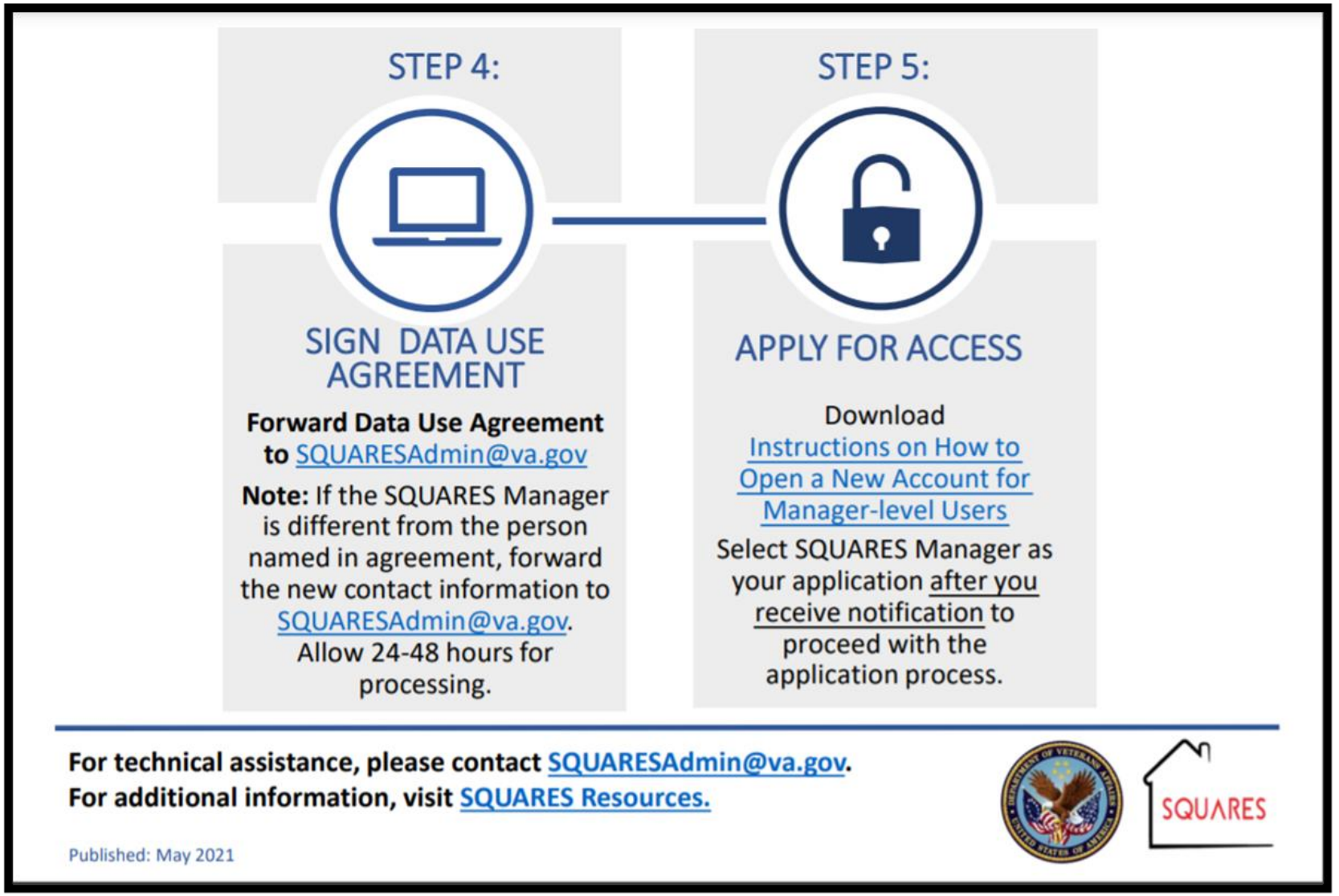
SQUARES Managers and Standard Users need to independently apply for access (using their specific application instructions).



Application Instructions are located on the SQUARES Resources Website

(Review the Getting Started with SQUARES and Access Instructions before applying for access)

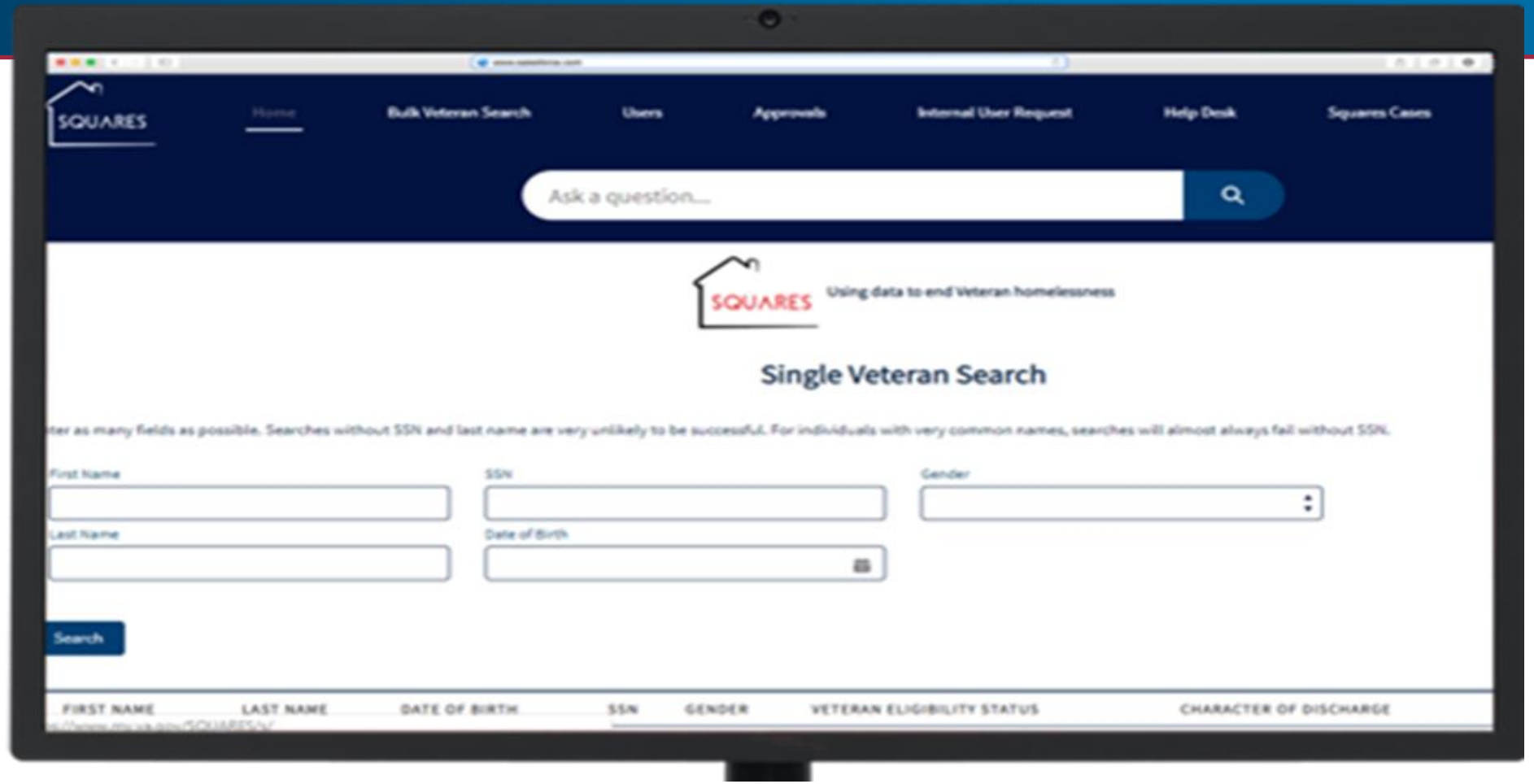
Application Process Steps (continued)



SQUARES Managers need to be granted access before Standard Users can apply.

SQUARES Users applications are automatically routed to their SQUARES Managers for approval.

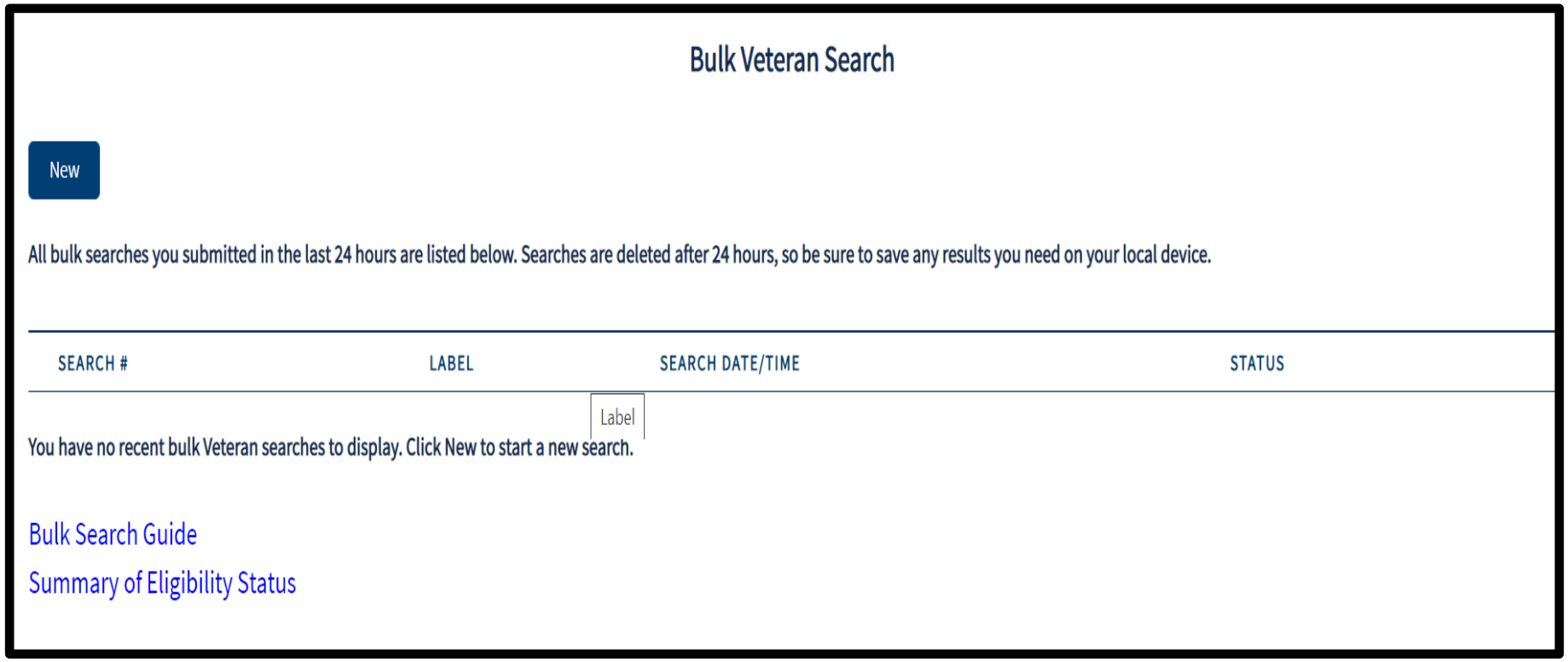
Single Search



Populate the fields with specific identity attributes (Name, DOD, SSN, Gender) and click on search. The system will return information regarding the Veterans' status and eligibility for homeless programs within 5 minutes. Refer to the Single Search Guide for more information.

(New feature was recently added to provide additional drill-down information)

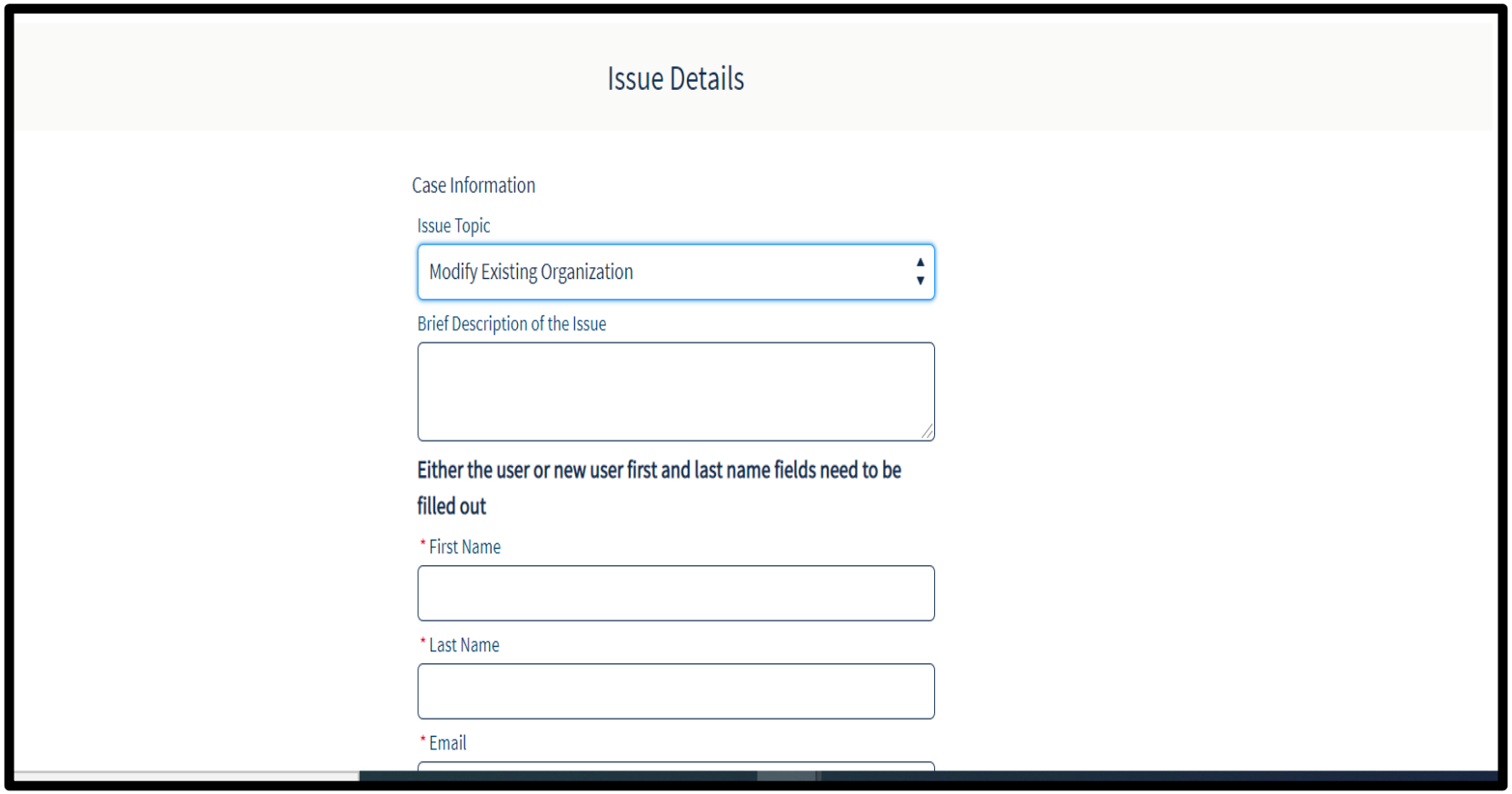
Bulk Search



Populate the pre-formatted spreadsheet with specific identity attributes (Name, DOB, SSN, Gender), save spreadsheet (as csv or xlsx file) and upload. The system will return information regarding the Veterans' status and eligibility for homeless programs within 24 hours. Refer to the Bulk Search Guide for more information.

If problems arise…

Help Desk



Use this form to create a VA Help Desk Issue Ticket.

SQUARESAdmin@va.gov will process requests within 24-48 hours

Helpful Resources

Online Training

All New SQUARES Users/Managers are encouraged to complete the 10-minute SQUARES Online Training before applying for access. Refer to SQUARES Website for access instructions.

Courses	Brief Description of Course Objectives
Lesson 1: Accessing SQUARES	• Acquire key tips for applying for a SQUARES account and accessing the system
Lesson 2: Conducting a Single Veteran Search	• Explain how to conduct a single search to identify an individual Veteran's benefits and eligibility information • Understand important data in the single search results • Understand the limitations of SQUARES results
Lesson 3: Conducting a Bulk Veteran Search	• State how to conduct a bulk Veteran search • Identify important data in the Veteran bulk

Helpful Resources (continued)

Training Materials

We strongly encourage you to take the 10-15 minute online SQUARES training course before applying for access or using the tool.

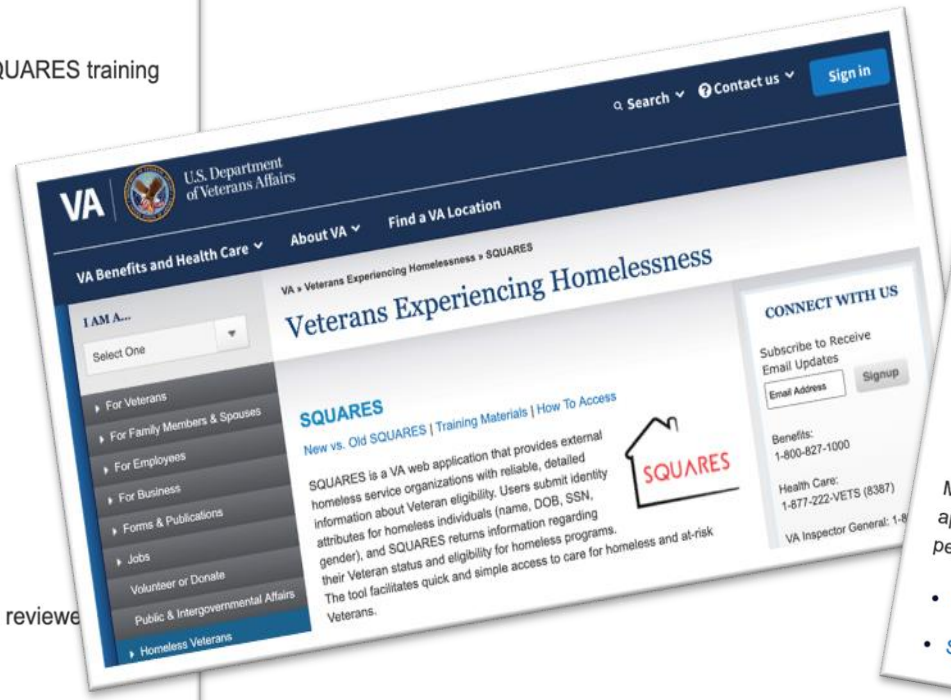
- Take the online SQUARES Training

The following Quick Reference Guides may also be helpful:

- Requesting and Accessing Your SQUARES Account
- Conducting a Single Veteran Search
- Conducting a Bulk Veteran Search
- Summary of SQUARES Eligibility Information

SQUARES Managers should additionally make sure they have reviewe
SQUARES Manager Guide:

- SQUARES Manager Guide



How do I request SQUARES access?

How you request SQUARES access depends on who you are:

VA Homeless Program Grantees (SSVF, GPD, CERS) and Other Contracted Organizations

Any staff member who works with Veterans at a VA homeless program grantee organization is authorized for SQUARES access. Each organization must select one employee to serve as SQUARES Manager. We will review Manager account requests and approve access if the applicant matches the program manager we have on file for your organization. If your organization would like someone new to serve as SQUARES Manager, have the documented program manager let us know via email at squaresadmin@va.gov.

Once the Manager is approved for access, he/she can use SQUARES to approve Standard User accounts for his/her fellow employees. Only Managers can approve Standard User account requests.

Managers and Standard Users both apply for access online. When completing this application, be careful to use your professional email address rather than a personal email (details).

- Apply For SQUARES Access
- Step-By-Step Application Guide

Quick Reference Guides **Website** **FAQs**

VRSS and SQUARES Compared

	VRSS	SQUARES
Getting Started	Sign up at https://vrss.va.gov/; view New User Orientation	Watch SQUARES Video Complete online training Review Application Instructions
File Requirements	14 requested fields (6 required); file in .csv format (details in VRSS User Guide)	Single Search: Returns in 5 minutes Bulk Search: Batch ≥50 returns within 24 hours
Single Query vs. Batch	Either, but designed for larger files/populations (User process is the same; ~2 hour processing time)	Single Search: Insert Name, DOD, SSN, and Gender (New feature was recently added to provide additional drill down information) Bulk Search: Complete Template
Results go to?	CF/CS user (PIDs only); VJP user (incl. more information from records)	2,700 Total SQUARES Users (VA and NonVA)
Technical Assistance available?	Yes: Help Desk (1-800-983-0935) and Tier 2 and 3 I.T. support teams	Contact SQUARESAdmin@va.gov Submit Help Desk Form

Application in the Field

Detention Facility or Jail

- Booking officer asks the self-report question.
- Administrative Staff utilizes VRSS to upload new individuals on an established schedule.
- Veteran Status noted in file for the court and attorneys
- Administrative Staff forwards roster with VRSS required data to other identified individual (VTC Court Coordinator) to upload.

Provides

- Court with additional information.
- Data collection to assist in determining community response needs.
- Detainee management – Consideration for a Veteran Pod/Mod.
- VRSS informs the VA (VJO) of justice-involved individuals for connection to services and community response needs.
- Earlier diversion and population reduction

Application in the Field

The Judiciary

- **Pretrial Court Staff** utilizes SQUARES account during an interview before 1st appearance/bond hearing.
  - Veteran Status noted in case file for the court.
- **Administrative Court Staff** utilize VRSS to upload new defendants on an established schedule.
  - Veteran Status noted in case file for all judicial actors

Provides

- Court with additional information
- Early VTC eligibility analysis.
- Data collection to assist in determining community response needs.
- informs the VA (VJO) of justice-involved individuals for connection to services and community response needs.

Application in the Field

Public Defender's Office

- Administrative Staff utilizes VRSS account to upload new clients on established schedule (daily, weekly, monthly etc.)
- Veteran Status noted in client file for assigned attorney

Provides

- Foundation for conversation around assessments
- Early VTC eligibility analysis
- Possible sentence mitigation factors
- Identifies the Justice-Involved veteran to the VA (VJO) to assist in connecting available services

Application in the Field

Probation and/or Pretrial Supervision

- Administrative staff utilizes VRSS to upload new clients on an established schedule (daily, weekly, monthly, etc.)
- Veteran Status noted in client file for assigned agent/case manager
- Agent/Case manager utilizes VRSS or SQUARES to determine the assigned individual's veteran status
- VRSS identifies justice-involved veterans to the VA (VJO) to assist in connecting available services
- Opens VA and veteran-specific community resources to address supervision case plan
- Allows for swift VTC consideration upon an individual's violation of conditions

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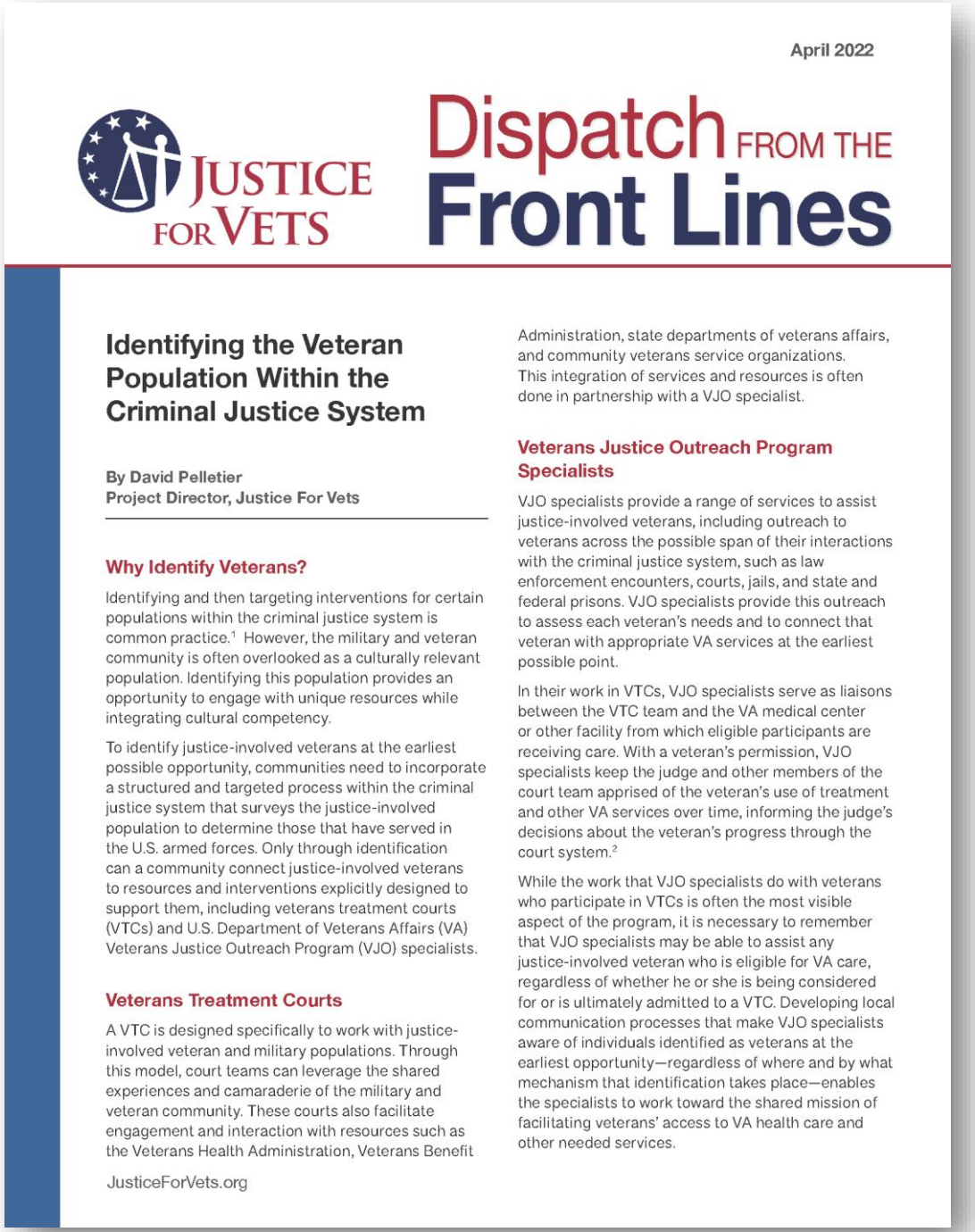
Resource Library

Dispatch From the Front Lines



April 2022

JUSTICE FOR VETS

Dispatch FROM THE Front Lines

Identifying the Veteran Population Within the Criminal Justice System

By David Pelletier
Project Director, Justice For Vets

Why Identify Veterans?

Identifying and then targeting interventions for certain populations within the criminal justice system is common practice.[1] However, the military and veteran community is often overlooked as a culturally relevant population. Identifying this population provides an opportunity to engage with unique resources while integrating cultural competency.

To identify justice-involved veterans at the earliest possible opportunity, communities need to incorporate a structured and targeted process within the criminal justice system that surveys the justice-involved population to determine those that have served in the U.S. armed forces. Only through identification can a community connect justice-involved veterans to resources and interventions explicitly designed to support them, including veterans treatment courts (VTCs) and U.S. Department of Veterans Affairs (VA) Veterans Justice Outreach Program (VJO) specialists.

Veterans Treatment Courts

A VTC is designed specifically to work with justice-involved veteran and military populations. Through this model, court teams can leverage the shared experiences and camaraderie of the military and veteran community. These courts also facilitate engagement and interaction with resources such as the Veterans Health Administration, Veterans Benefit Administration, state departments of veterans affairs, and community veterans service organizations. This integration of services and resources is often done in partnership with a VJO specialist.

Veterans Justice Outreach Program Specialists

VJO specialists provide a range of services to assist justice-involved veterans, including outreach to veterans across the possible span of their interactions with the criminal justice system, such as law enforcement encounters, courts, jails, and state and federal prisons. VJO specialists provide this outreach to assess each veteran's needs and to connect that veteran with appropriate VA services at the earliest possible point.

In their work in VTCs, VJO specialists serve as liaisons between the VTC team and the VA medical center or other facility from which eligible participants are receiving care. With a veteran's permission, VJO specialists keep the judge and other members of the court team apprised of the veteran's use of treatment and other VA services over time, informing the judge's decisions about the veteran's progress through the court system.[2]

While the work that VJO specialists do with veterans who participate in VTCs is often the most visible aspect of the program, it is necessary to remember that VJO specialists may be able to assist any justice-involved veteran who is eligible for VA care, regardless of whether he or she is being considered for or is ultimately admitted to a VTC. Developing local communication processes that make VJO specialists aware of individuals identified as veterans at the earliest opportunity—regardless of where and by what mechanism that identification takes place—enables the specialists to work toward the shared mission of facilitating veterans' access to VA health care and other needed services.

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Thank You

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

JUSTICE FOR VETS

Disclosure

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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

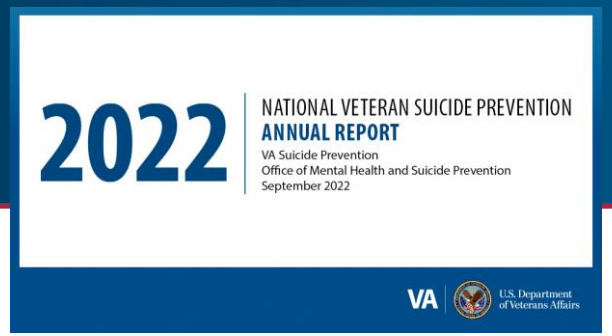
Awareness

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

AWARENESS

FACTS

- More than 47,511 people died by suicide in America in 2019.
- **In 2020**, there was an overall decrease in deaths by suicide (45,979) but rates increased in American Indian/Alaska Native (23.9 per 100,000; 5% increase from 2019).
- Native communities, especially among young men ages 15-24 account for nearly 40% of all deaths by suicide among Native Americans.
- **In 2020**, death by suicide was the 2nd leading cause of death for people ages 10-34 and among people ages 24-34.
- Veterans are 20% more likely to die by suicide than those who have not served.



FACTS

From 2019 to 2020, among Veteran men, the age-adjusted suicide rate fell by 0.7%, and among Veteran women the age-adjusted suicide rate fell by 14.1%. By comparison, among non-Veteran U.S. men, the age-adjusted rate fell by 2.1%, and among non-Veteran women the age-adjusted rate fell by 8.4%.

Comparisons of trends in Veteran suicide and COVID-19 mortality over the course of 2020 and across Veteran demographic and clinical subgroups did not indicate an impact of the COVID-19 pandemic on Veteran suicide mortality.

AWARENESS

Refute the Myths!

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Myth 1: 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.

Myth 2: 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!

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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?***

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**

Start the conversation

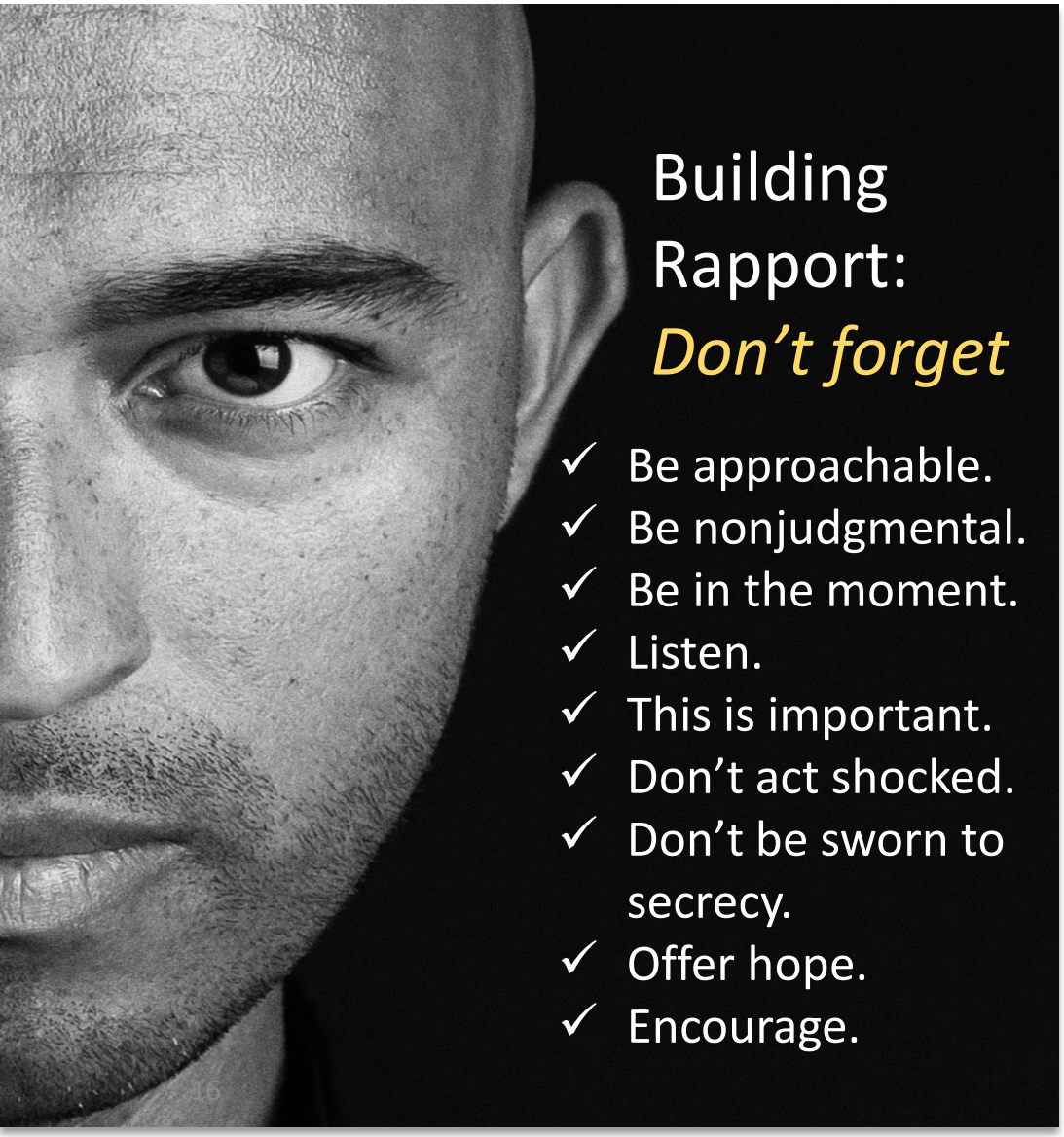
Do this!

- ✓ Be approachable.
- ✓ Be nonjudgmental.
- ✓ Be in the moment.
- ✓ Listen.
- ✓ This is important.
- ✓ Don’t act shocked.
- ✓ Don’t be sworn to secrecy.
- ✓ Offer hope.
- ✓ Encourage.

Building Rapport

PREVENTION

Case scenario – Miguel, a participant in the VTC



Building Rapport: *Don't forget*

- ✓ Be approachable.
- ✓ Be nonjudgmental.
- ✓ Be in the moment.
- ✓ Listen.
- ✓ This is important.
- ✓ Don't act shocked.
- ✓ Don't be sworn to secrecy.
- ✓ Offer hope.
- ✓ Encourage.

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

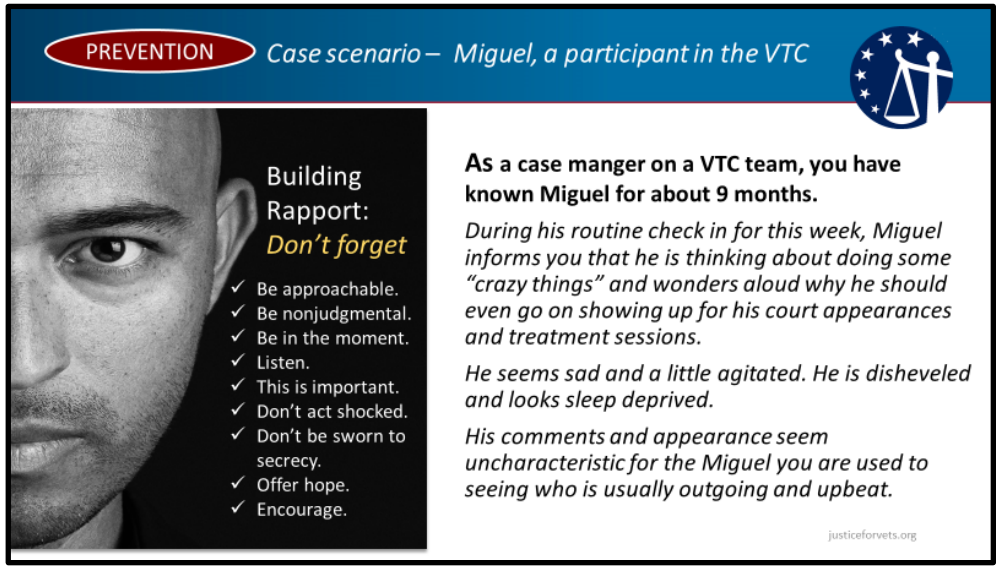
Continuing the conversation

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?

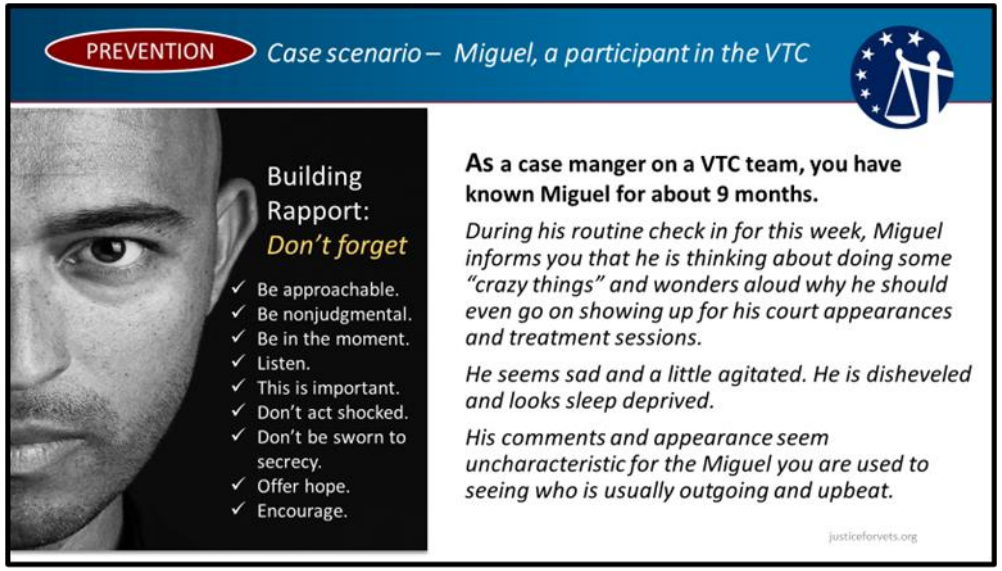
What do you mean when you say, *crazy* things?



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 !**

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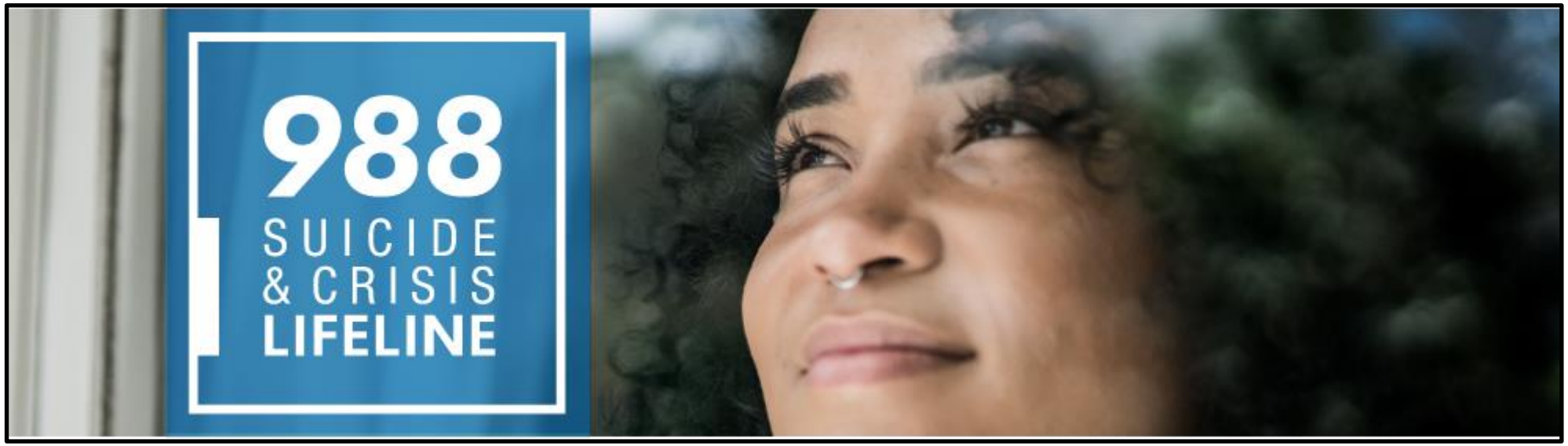
NEED TO KNOW - REGARDLESS OF YOUR ROLE ON A VTC TEAM



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

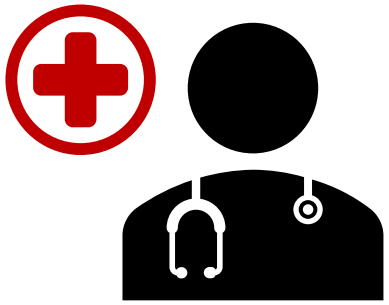
E **Encourage** treatment and **Expedite** getting help

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

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

TAKE ACTION!

Save Lives!



Ongoing Medical Care Relationships

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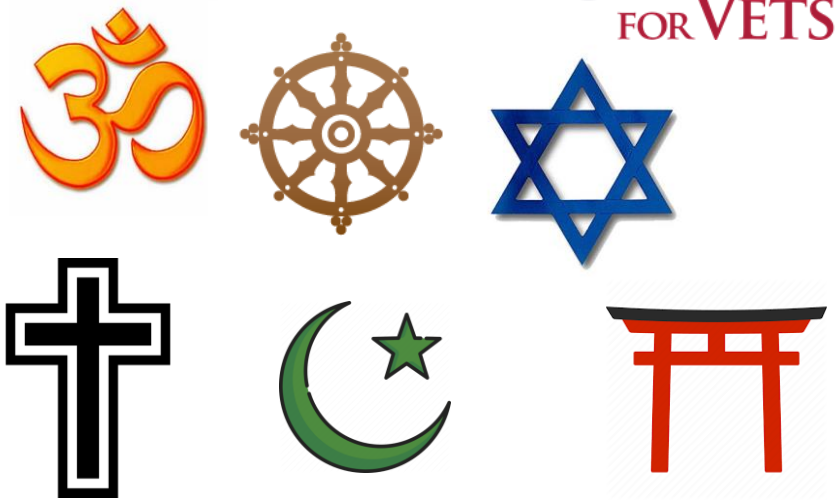
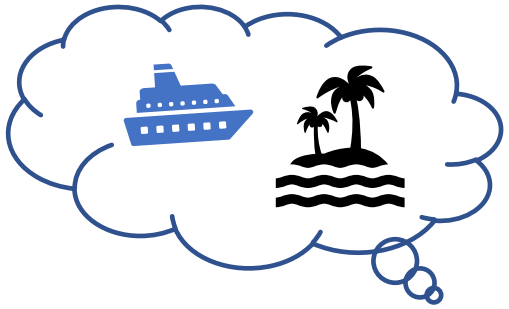


Religious or Moral Prohibitions

Encourage

Protective Factors



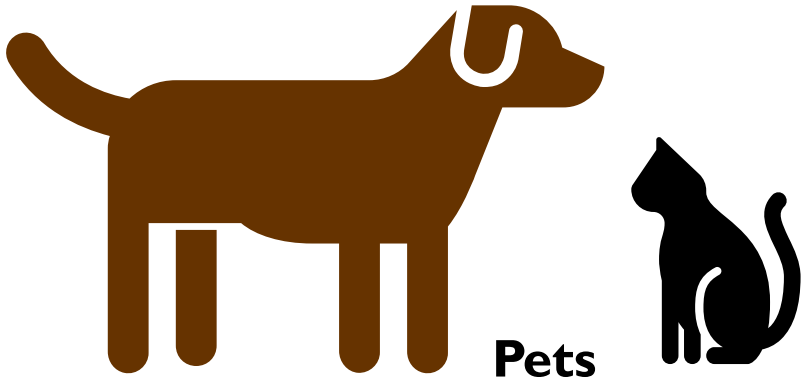
Future Oriented Thinking

Purposeful Activity

TAKE ACTION!

Save Lives!

JUSTICE FOR VETS



Pets

Social Connectedness

Encourage

Protective Factors

Interest/Hobby

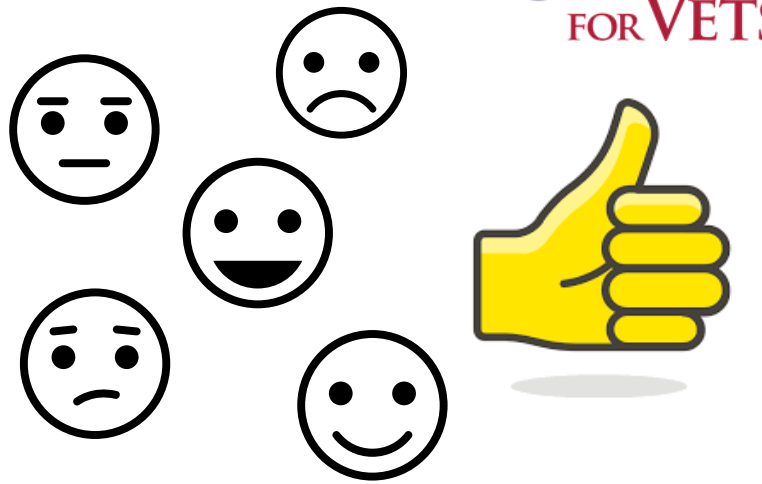
Sobriety

TAKE ACTION!

Save Lives!

Good Therapeutic Alliance

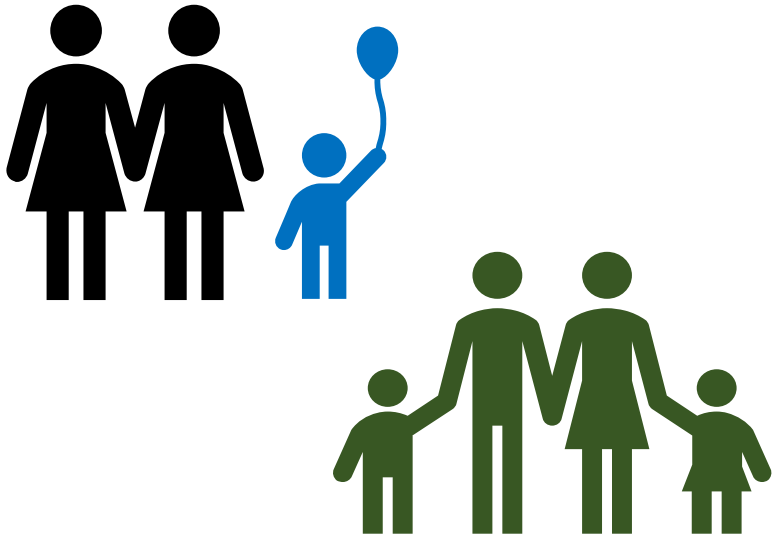
JUSTICE FOR VETS



Coping Skills/ Ability to Regulate Emotions

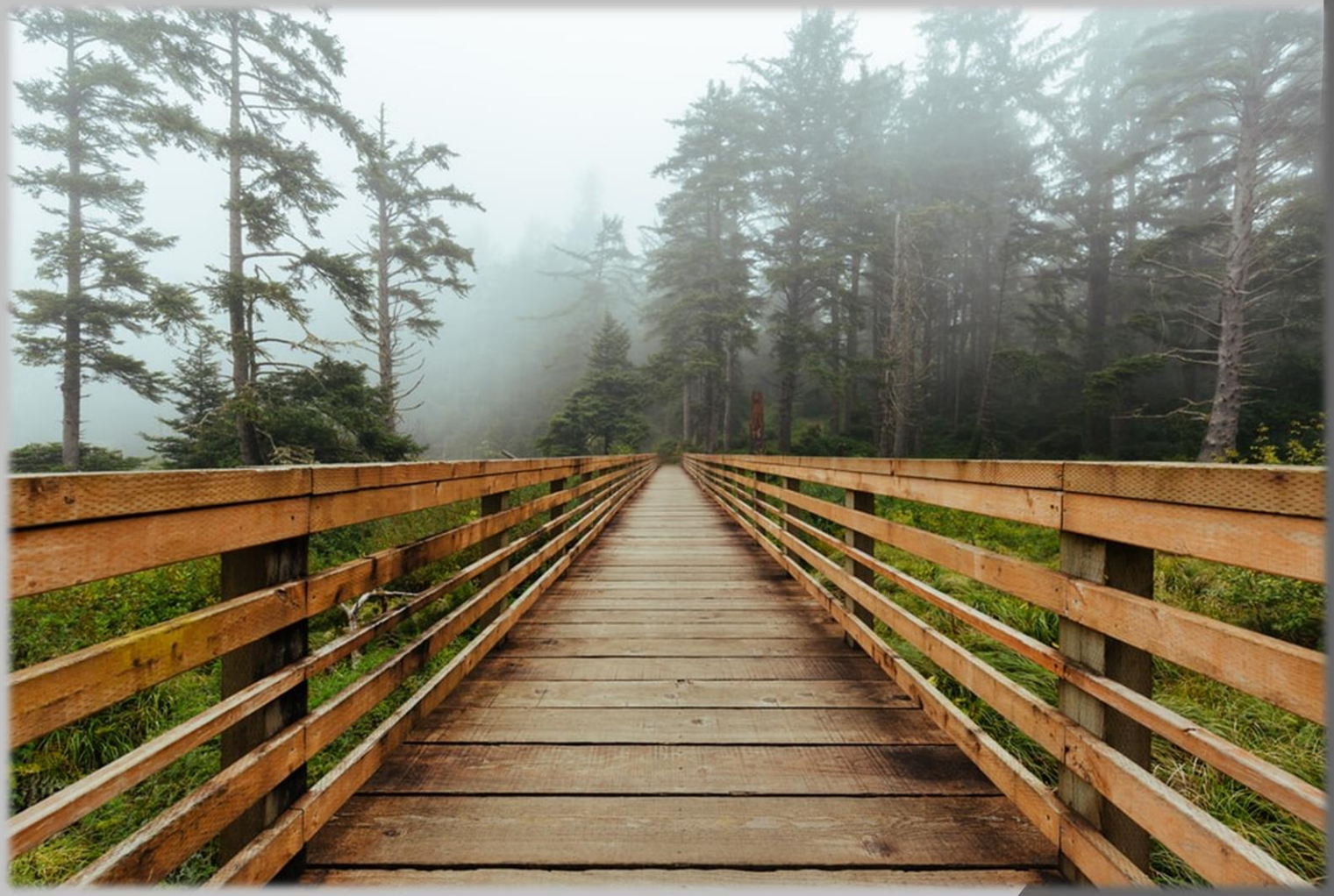
Encourage

Protective Factors



Family/Relationships

Resiliency



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

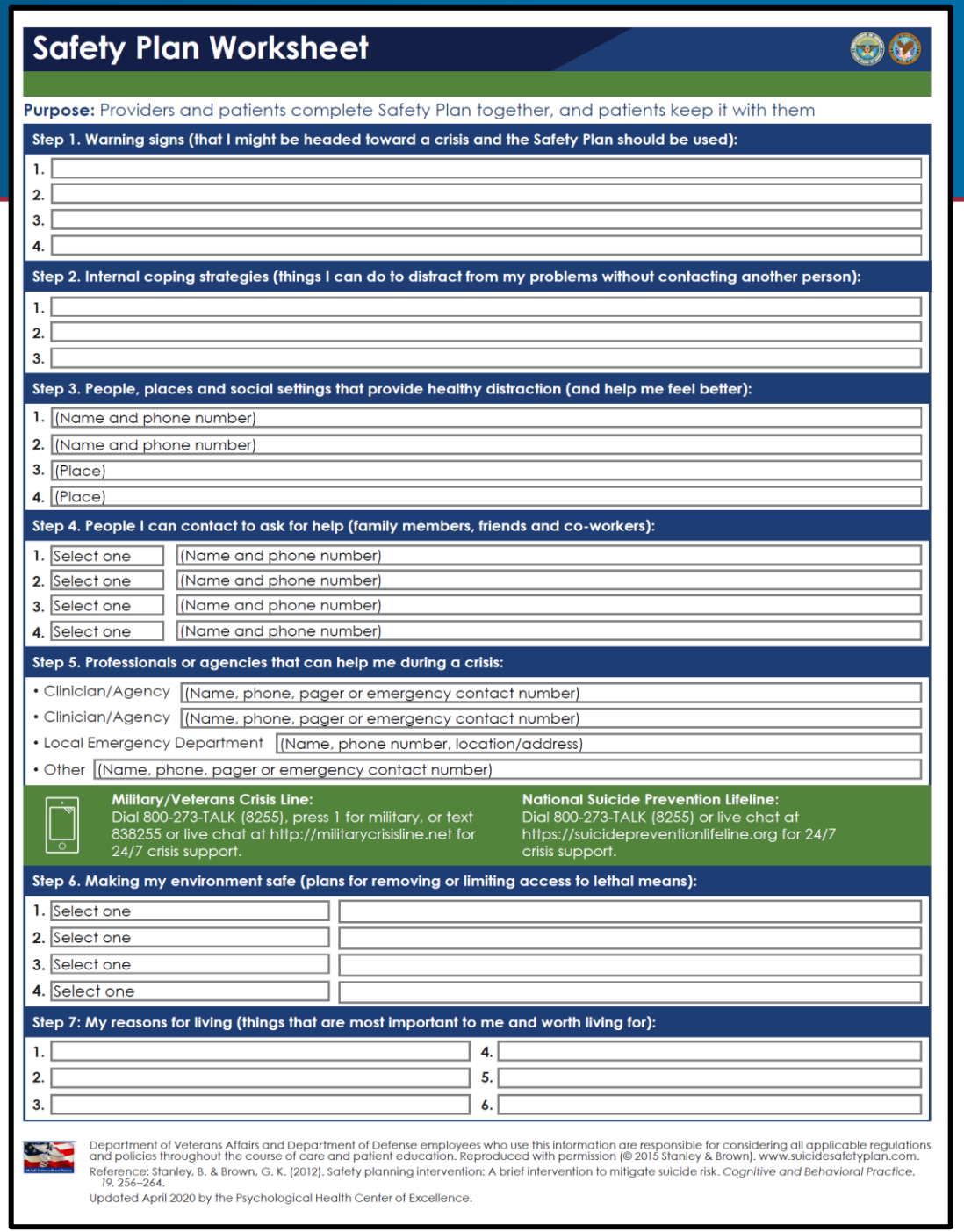
https://www.mirecc.va.gov/visn19/consult
Suicide Risk Management Consultation Program

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

Treatment Provider Resources *(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

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Virginia Department of Behavioral Health & Developmental Services

Essentials of Harm Reduction

Tiffani D. Wells, M.S., B.S., CPRS
Harm Reduction Coordinator
Virginia Department of Behavioral Health and Developmental Services

Objectives

- Highlight the history of Harm Reduction
- Define Harm Reduction
- Identify the Principles of Harm Reduction
- Discuss the Cycle of Addiction
- Recognize Virginia's CHRs
- Explain the Benefits of Harm Reduction from Treatment Providers
- Review Allowable and Successful Harm Reduction Services in Virginia
- Define law under the Virginia Code related to Harm Reduction

HISTORY OF HARM REDUCTION

- HARM REDUCTION WAS DEVELOPED TO DECREASE NEGATIVE AFFECTS OF THE USE OF SUBSTANCES, LEGAL AND ILLEGAL. MANY OF THE STRATEGIES WERE NOT ONLY USED TO PROTECT THE PERSON ENGAGING IN THE USE, BUT ALSO THOSE AROUND THEM. HOWEVER, THERE ARE OTHER AREAS WHERE HARM REDUCTION HAS PLAYED A MAJOR ROLE. HARM REDUCTION DATES TO THE 1960S AND HAS BEEN UTILIZED BY VARIOUS GROUP FOR DIFFERENT PURPOSES.

- 1960S – THE BLACK PANTHER PARTY HELD FREE BREAKFAST EVENTS FOR CHILDREN AND HEALTH CLINICS THROUGHOUT THE AREA
- THE YOUNG LORDS' IMPLEMENTED ACUPUNCTURE FOR THOSE WHO USED HEROIN
- 1970S – FEMINIST ACTIVIST ADVOCATED FOR WOMEN'S HEALTH BY STANDING FOR REPRODUCTIVE HEALTH
- 1980S – THERE WAS A GLOBAL RESPONSE THE AIDS CRISIS

History of Harm Reduction (Cont'd)

- One of the biggest harm reduction strategies was the banning of smoking in public places. In 1997, Former President, Bill Clinton, signed a bill to ban smoking relative to the Executive Branch of the Federal Government.
- Smoking was then later banned on flights by the United States Department of Transportation in 1998
- As of 2012, 56 countries have added health warning label to cigarette packages, depicting the harm of smoking
- As of late 2018, over 50% of the states in America have banned smoking in workplaces and public places
- Other areas that harm reduction strategies are used includes using sunscreen, wearing seatbelts, signage for speed limits, and birth control
- Some other strategies include syringe exchange, ride shares, disease testing, designated smoking areas, and other forms of smoking (Cook & Bera, 2009)

What is Harm Reduction?

(Subtance Use Disorders)

Harm Reduction is described as strategies utilized to reduce negative consequences associated with Substance Use Disorders (SUDs). Additionally, Harm Reduction is used to dispel stigmas and stereotypes surrounding misconceptions about individuals with a Substance Use Disorder and people who use drugs, as it pertains to human rights and justice (*What is harm reduction?* 2022).

The goal of Harm Reduction is to be accessible, cost-effective and evidence-based.

PRINCIPLES OF HARM REDUCTION

- Acceptance
- Non-judgmental
- Evidence-based
- Respectful
- Alternative to substance use
- Social Justice
- Advocacy

Keep People Alive

ACCEPTANCE

To begin to address an issue, it must first be acknowledged and accepted. Acceptance does not indicate that one agrees with the situation, but that they are aware of the reality of the issue. As it relates to Substance Use Disorder and/or people who use drugs, the reality is, it is a prominent part of our society. The substances being consumed are legal and illegal, but both can have negative consequences.

In harm reduction, we accept those with a Substance Use Disorder and people who use drugs for who they are and meet them where they are.

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NON-JUDGMENTAL

While Harm Reduction is accepting it is also non-judgmental. There is no separation in drugs, making one worse than the other. Harm reduction is also a person-first oriented. Terms such as “substance abuse”, “addict”, “alcoholic”, and “relapse” are no longer considered acceptable.

These terms are associated with stigmas and stereotypes. They create a negative narrative about those with a substance use disorder and could be a deterrent for seeking treatment and utilizing resources.

The terms are replaced with “substance use”, “person with a _____ (substance) use disorder”, or “return to use”.

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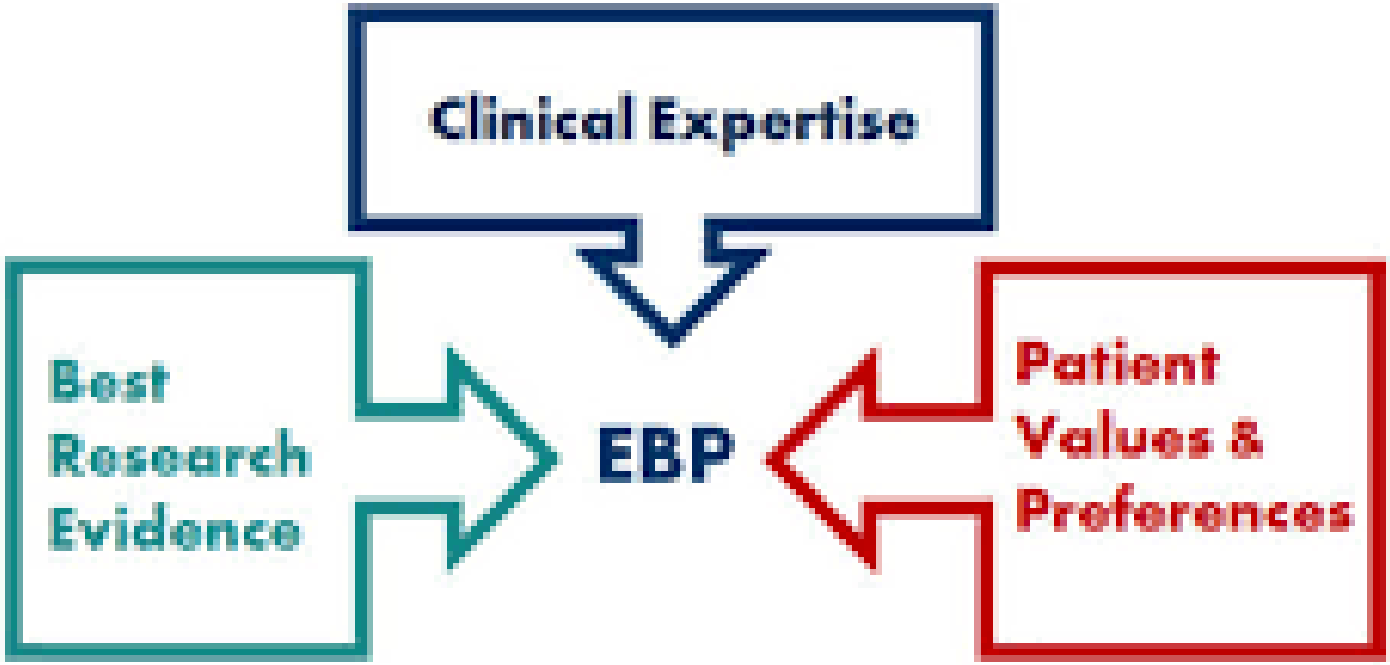


EVIDENCE-BASED

Although each case will be evaluated and treated on an individual basis, the ultimate goal is the same for each person. Any strategy used to implement harm reduction should be evidence-based and include the following characteristics:

- Practical – The strategy should have studies showing that it has been effective
- Feasible – The strategy should be reasonable and capable of being performed
- Safe – The goal is to reduce harm and negative consequences, therefore any strategies used should be safe to the individual and the community.
- Cost-effective – If any service is not covered by a third party, it should be affordable to those from diverse, economic backgrounds.

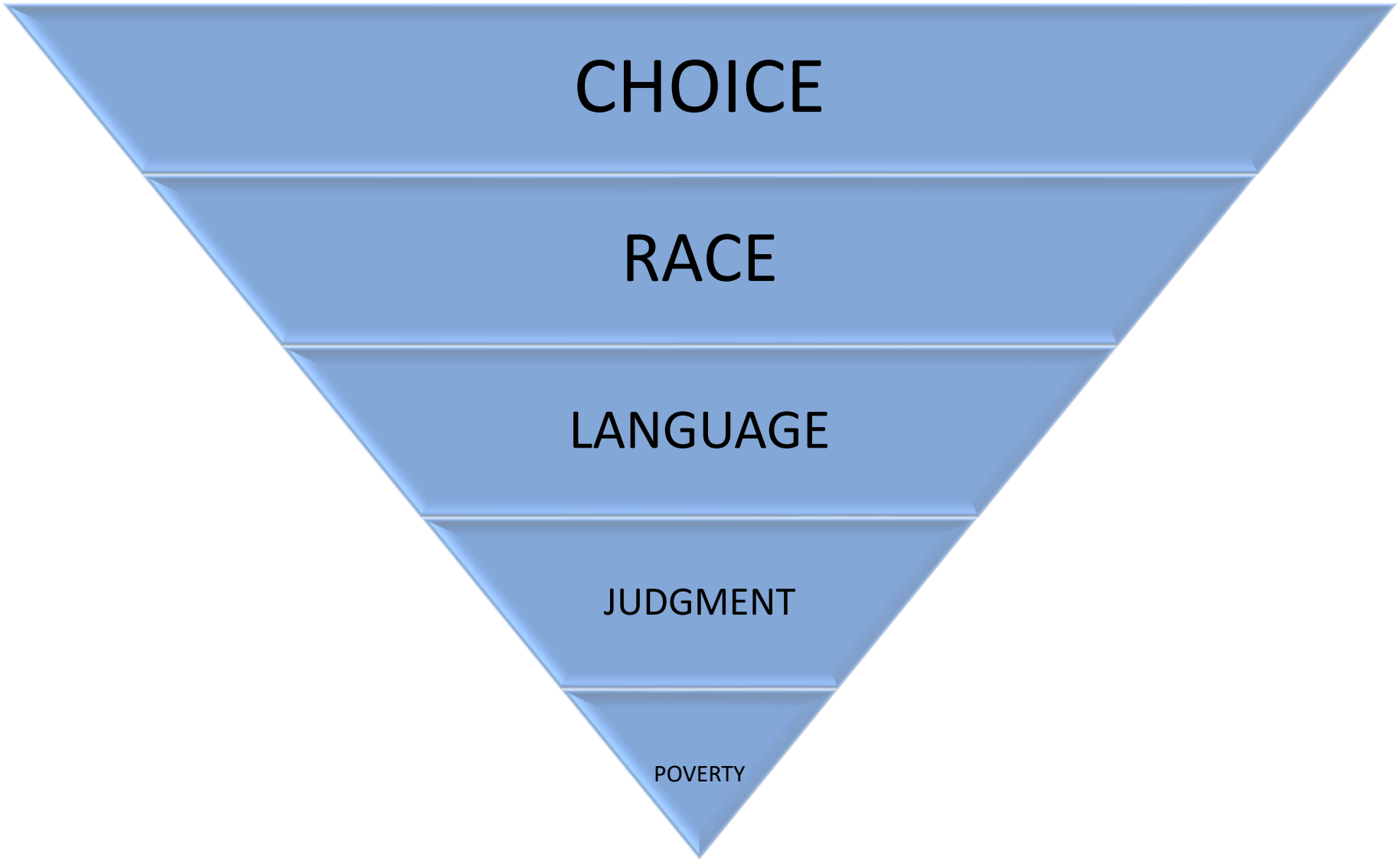
(*Principles of Harm Reduction,* 2022)

RESPECTFUL

One of the most common stigmas about Substance Use Disorders as it relates to addiction, is that is a choice. However, addiction is a disease that affects the brain by taking away a person's ability to control their substance use. Just like any other disease or chronic illness, substance use disorder requires treatment.

Those seeking help for a substance use disorder should be treated humanely. They should be treated with compassion, respect, and dignity. Services should not be denied to them because of the nature of their disease and their biopsychosocial background.

COMMON STIGMAS & STEREOTYPES



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The Real Stigma of Substance Use Disorders

In a study by the Recovery Research Institute, participants were asked how they felt about two people *"actively using drugs and alcohol."*

One person was referred to as a "substance abuser"

The other person as "having a substance use disorder"

No further information was given about these hypothetical individuals.

THE STUDY DISCOVERED THAT PARTICIPANTS FELT THE "SUBSTANCE ABUSER" WAS:

- less likely to benefit from treatment
- more likely to benefit from punishment
- more likely to be socially threatening
- more likely to be blamed for their substance related difficulties and less likely that their problem was the result of an innate dysfunction over which they had no control
- they were more able to control their substance use without help

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RECOVERY DIALECTS

Language matters but can change depending on the setting we are in. Choosing when and where to use certain language and labels can help reduce stigma and discrimination towards substance use and recovery.

	Mutual Aid Meetings	In Public	With Clients	Medical Settings	Journalists
Addict	✓	✗	✗	✗	✗
Alcoholic	✓	✗	✗	✗	✗
Substance Abuser	✗	✗	✗	✗	✗
Opioid Addict	✓	✗	✗	✗	✗
Relapse	✓	✗	✗	✗	✗
Medication-Assisted Treatment	✗	✗	✗	✗	✗
Medication-Assisted Recovery	✓	✓	✓	✓	✓
Person w/ a Substance Use Disorder	✓	✓	✓	✓	✓
Person w/ an Alcohol Use Disorder	✓	✓	✓	✓	✓
Person w/ an Opioid Use Disorder	✓	✓	✓	✓	✓
Long-Term Recovery	✓	✓	✓	✓	✓
Pharmacotherapy	✓	✓	✓	✓	✓

ALTERNATIVES TO SUBSTANCE USE

Treatment is a suggestion to help with substance use but should not be coerced or made an expectation on anyone. With harm reduction, there are alternatives to substance use.

- Therapy
- Abstinence
- Treatment
- MAT
- Discovering new hobbies
- Support Groups

SOCIAL JUSTICE

One of the main goals of harm reduction is to reduce the obstacles those with substance use disorder endure while seeking treatment and services. They should not be discriminated against or excluded from services because of their substance use as well as their race, gender, sex orientation, gender identity or socioeconomic status.

Harm reduction also values the input of those who use the services. They help to plan, assess, enforce programs that are proven to be effective based on positive outcomes.

ADVOCACY

Dating back to when to 1971, President Nixon started the “War on Drugs” campaign. It was designed to criminalize those who used drugs. Harm reduction develops strategies to decriminalize those who use drugs by improving drug laws, collaborating with law enforcement agencies, and revamping policies and procedures utilized by the justice system so that is does not interfere with the safety and security of those with a substance use disorder.

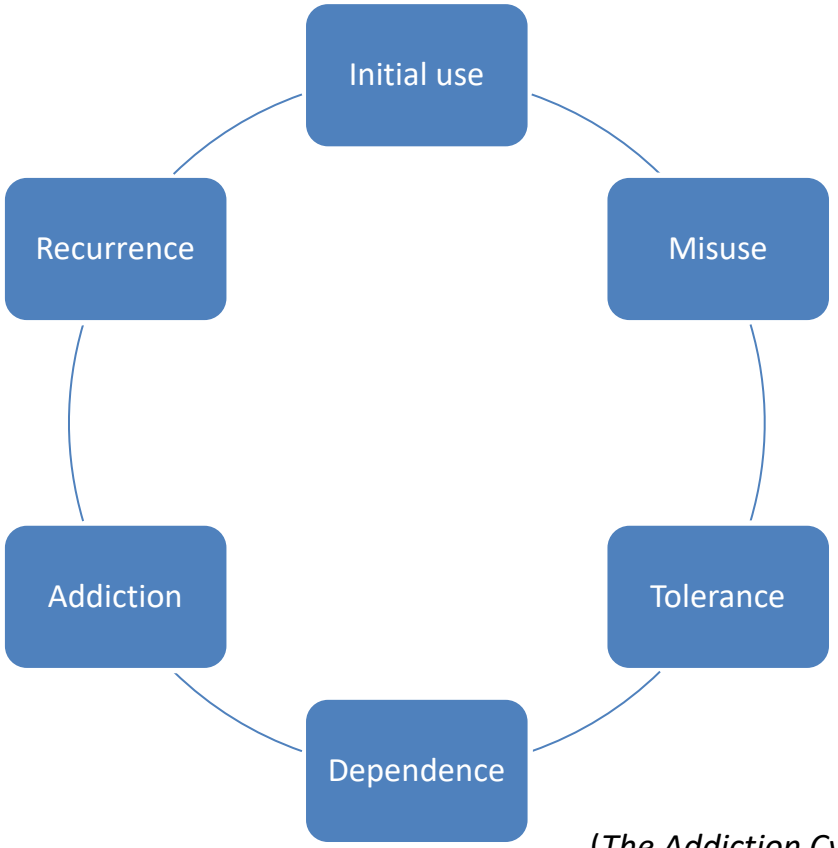
Advocating for harm reduction can give those who benefit from the services a voice and help to increase harm reduction programs, funding, and other support services.

Keep People Alive

The main goal of harm reduction is to keep people alive while they are in active use, until they are ready to seek treatment. However, harm reduction is not enabling.

Harm Reduction	Enabling
• Acceptance • Accountability • Support • Education • Non-judgmental • Compassion • Respect	• Denial • Avoidance • Justification • Taking on responsibilities that have been neglected • Engaging in substance use with individual • Passiveness

CYCLE OF ADDICTION



(*The Addiction Cycle: What Are The Stages of Addiction?* 2022)

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Alcohol

Naltrexone

Antabuse

Acamprosate

MAT

Opioids

Buprenorphrine

Methadone

Naltrexone

Other Substances

Vivitrol

Wellbutrin

Smoking

Gum

Nicotine Patch

Lozenges

Wellbutrin

E-Cigarettes

Opioids

Methadone

Suboxone

Pregnancy

Alcohol

Medication (recommended by a physician)

Mutual Aid Meeting

Counseling

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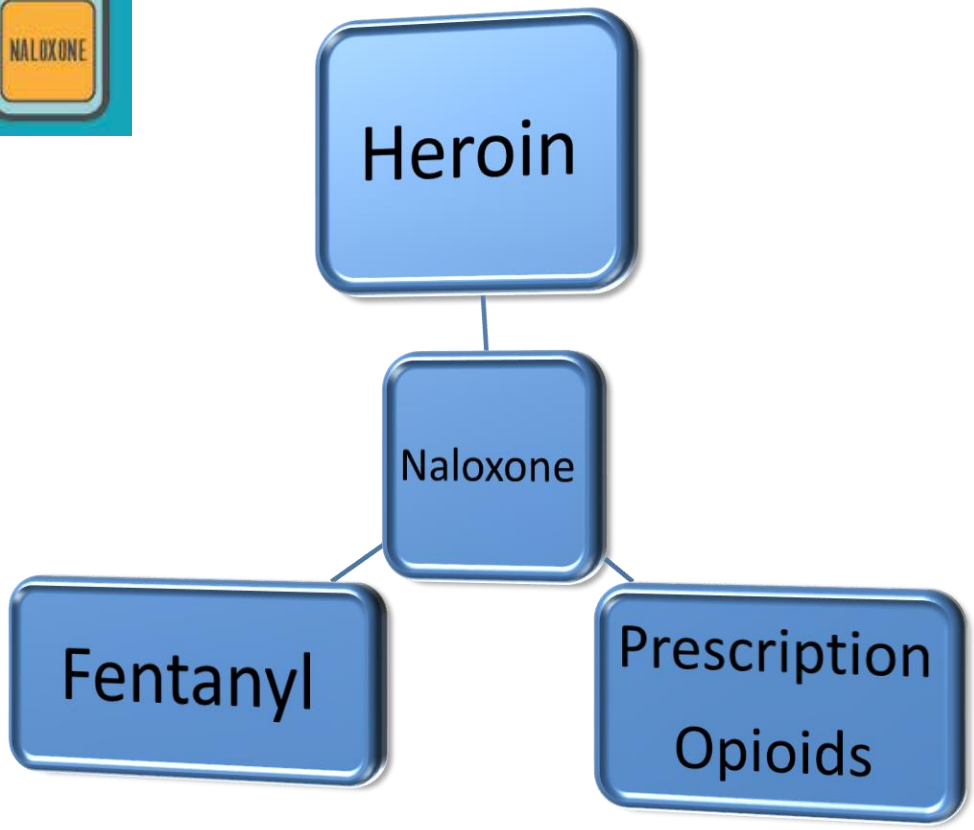

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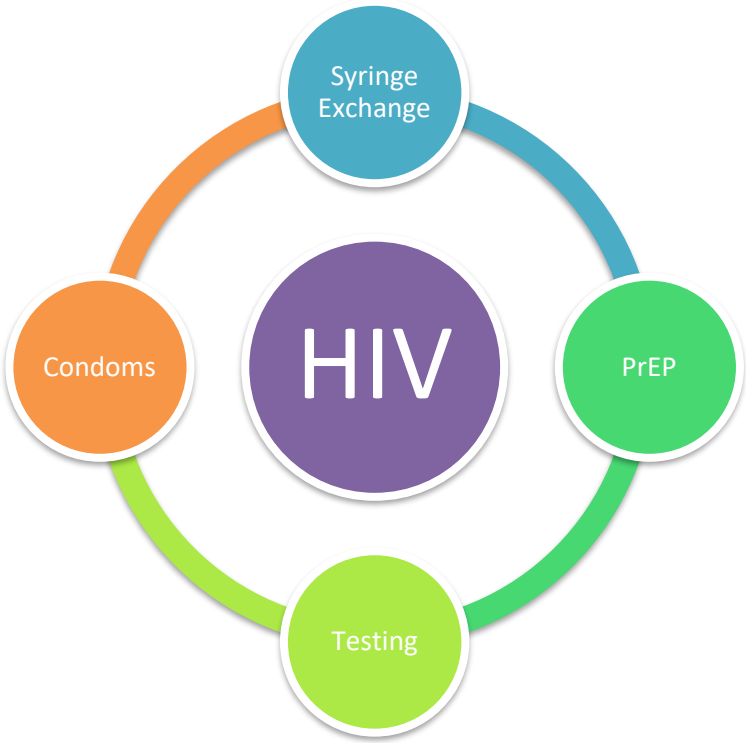

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CHRs

Comprehensive Harm Reduction Programs

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What is a CHR?

A Comprehensive Harm Reduction Program is a program that assists people with reducing dangerous risks based on their actions around substance use. The programs provide a safe and healthy environment while they may be in active use.

Some services provided by CHRs are:

- Providing safe supplies
- Disease testing
- REVIVE! Training
- Education about treatment
- Access to healthcare
- Peer Recovery Support Services

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COMPREHENSIVE HARM REDUCTION

§ 32.1-45.4. Comprehensive harm reduction programs.

- Promote scientifically proven methods of mitigating health risks associated with drug use and other high-risk behaviors.
- The objectives of such programs shall be to
  - (i) reduce the spread of HIV, viral hepatitis, and other blood-borne diseases in the Commonwealth;
  - (ii) reduce the transmission of blood-borne diseases through needlestick injuries to law-enforcement and other emergency personnel;
  - (iii) provide information to individuals who inject drugs regarding addiction recovery treatment services and encourage such individuals to participate in evidence-based substance use treatment programs;
  - (iv) prevent opioid overdose deaths through distribution of naloxone or other opioid antagonists; and
  - (v) incentivize the safe return and disposal of hypodermic needles and syringes.

COMPREHENSIVE HARM REDUCTION

§ 32.1-45.4. Comprehensive harm reduction programs.

A comprehensive harm reduction program established pursuant to this section shall include

- (i) the disposal of used hypodermic needles and syringes;
- (ii) the provision of hypodermic needles and syringes and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused;
- (iii) reasonable and adequate security of program sites, equipment, and personnel;
- (iv) the provision of educational materials concerning (a) substance use disorder prevention, (b) overdose prevention, (c) the prevention of transmission of HIV, viral hepatitis, and other blood-borne diseases, (d) available mental health treatment options, including referrals for mental health treatment, and (e) available substance use disorder treatment options, which shall include options for medication assisted treatment of substance use disorder, including referrals for treatment;
- (v) access to overdose prevention kits that contain naloxone or other opioid antagonist approved by the U.S. Food and Drug Administration for opioid overdose reversal; (vi) individual harm reduction counseling, including individual consultations regarding appropriate mental health or substance use disorder treatment; and
- (vii) verification that a hypodermic needle or syringe or other injection supplies were obtained from a comprehensive harm reduction program established pursuant to this section.

COMPREHENSIVE HARM REDUCTION

§ 32.1-45.4. Comprehensive harm reduction programs.

The provisions of §§ 18.2-250, 18.2-265.3, and 54.1-3466 relating to possession of a controlled substance, drug paraphernalia, and controlled paraphernalia shall not apply to:

- a person who dispenses or distributes hypodermic needles and syringes as part of a comprehensive harm reduction program established pursuant to this section.
- any person acting on behalf or for the benefit of a comprehensive harm reduction program when such possession is incidental to the provision of services as part of a comprehensive harm reduction program established pursuant to this section.
- any person receiving services from a comprehensive harm reduction program established pursuant to this section, when (i) such controlled substance is a residual amount contained in a used needle, used hypodermic syringe, or used injection supplies obtained from or returned to a comprehensive harm reduction program established pursuant to this section, or (ii) such paraphernalia is obtained from a comprehensive harm reduction program established pursuant to this section, as evidenced by the verification required pursuant to clause (vii) of subsection B.

(*Comprehensive harm reduction programs,* 2020)

CHRS in Virginia

Lenowisco Health District
134 Roberts Ave SW, Wise, VA 24293 (276) 328-8000

Mount Rodgers Health District
290 S. 6th Street, Wytheville, VA 24382 (276) 228-5507

Health Brigade
1010 N. Thompson Street, Richmond, VA 23230 (804) 358-6343

Council of Community Services
502 Campbell Ave SW, Roanoke, VA 24016 (540) 985-0131

Strength in Peers
917 N Main Street Unit 1, Harrisonburg, VA 22802 (540) 217-0869

Chris Atwood Foundation
P.O. Box 9282, Reston, VA 20195 (703) 662-6076

Virginia Harm Reduction Coalition
1917 Franklin Road SW, Roanoke, VA 24014 (540) 904-4718

MASS (Minority AIDS Support Services, Inc.)
2715 Huntington Ave, Newport News, VA 23607 (also has Norfolk Location)

(*COMPREHENSIVE HARM REDUCTION,* 2022)

CHR LOCATIONS

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Providers and Harm Reduction

Why Should Providers Endorse Harm Reduction?

Treatment for Substance Use Disorders should not be forced, but should be the choice of the individual

Not all people who use substances are ready to enter treatment, abstain, or enter recovery

Harm Reduction provides education about treatment options for those with SUDs and people who use drugs

Harm Reduction can help reduce overdoses, diseases, and death

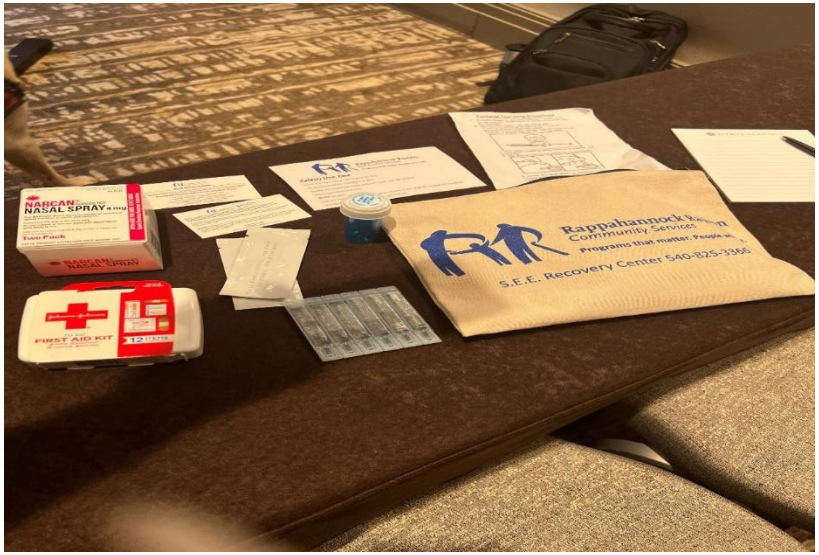
Access to resources

Gateway to Treatment!!

Allowable Harm Reduction activities in VA

- **Virginia Department of Health/Centers for Disease Control (VDH/CDC)**
  - **Syringe Exchange at Comprehensive Harm Reduction Sites (CHRs)* (§32.1-45.4)**

- **Community Service Boards (CSBs)**
  - **Fentanyl Testing Strips**
  - **Disease Testing**
  - **Medication Assisted Treatment (MAT)**
  - **Peer Support**
  - **Naloxone (Narcan)**
  - **REVIVE! Training**



Rappahanock Rapidan Community Services
Harm Reduction Kit

**CHRs must be approved by VDH*

Successful Harm Reduction Activities

- REVIVE! Training
  - Lay Rescuer and Training of Trainers
- Naloxone
  - Opioid Overdose Reversal Medication (FDA approved)
- Comprehensive Harm Reduction Programs (CHRs)
  - Lenowisco Health District (Wise, VA)
  - Mount Rogers Health District (Marion, VA)
  - Health Brigade (Richmond, VA)
  - Council of Community Services (Roanoke, VA)
  - Strength in Peers (Harrisonburg, VA)
  - Chris Atwood Foundation (Reston, VA)
  - Virginia Harm Reduction Coalition (Roanoke, VA)
  - MASS(Newport News & Norfolk, VA)
- HIV Programs (ACCESS) – www.accesscommunity.org

What you Should Know

- Harm Reduction is NOT enabling
- CSBs may apply for NO COST Naloxone to dispense to community members at no cost: https://redcap.vdh.virginia.gov/redcap/surveys/?s=RX9K7Y3KEKHarm Reduction can fill the gap between active use and treatment
- Other Harm Reduction Ideas:
  - Vending Machines
  - Infectious disease testing kits
  - Medication lock boxes
  - Naloxone kits
  - Safe sex & Safe smoking kits
  - Infectious disease screenings
  - Sharps disposal and medication disposal kits
  - FTS
  - Provide treatment to those with Opioid addiction to reduce overdose deaths
  - MASS (Minority AIDS Support Services) - https://minorityaidssupport.org/

How to Gain Community Support?

- Start in the schools
- Develop a relationship with Law Enforcement
- Educate the community
- Don't just hand out, EXCHANGE
- Use statistics "strength in numbers"
- CONFIDENCE

Virginia Department of Behavioral Health & Developmental Services

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QUESTIONS