



**VIRGINIA DUI DRUG TREATMENT COURTS**  
**Restoring Lives, Reuniting Families and**  
**Making Communities Safer**  
**September 20-21, 2010**  
Williamsburg Marriott, Williamsburg, VA

**AGENDA**

**Monday, September 20, 2010**

- |                                |  |
|--------------------------------|--|
| <b>9:00 a.m. – 10:30am</b>     | <b>Registration</b>  |
| <b>10:00 a.m. - 10:15 a.m.</b> | <b>Welcome and Introduction</b><br>Paul DeLosh & Michelle White                                    |
| <b>10:15 a.m.-11:45 p.m.</b>   | <b>Drug Court Legal Aspects</b><br>Honorable Charlie Sharp, Judge<br>Stafford County Circuit Court |
| <b>11:45 a.m.-12:45 p.m.</b>   | <b>Lunch</b>   |
| <b>12:45 p.m.- 2:00 p.m.</b>   | <b>Drug Court Best Practices</b><br>Doug Marlowe, J.D., Ph.D.<br>NADCP                             |
| <b>2:00 p.m.-3:15 p.m.</b>     | <b>Project Remote</b><br>Dr. Mary McMasters, MD<br>Comprehensive Health Systems                    |
| <b>3:15 p.m. -3:30 p.m.</b>    | <b>Break</b>   |
| <b>3:30 p.m.– 4:30 p.m.</b>    | <b>Legal Defense Issues in Drug Courts</b><br>Jim Gochenhour, Esq.<br>Hampton Adult Drug Court     |
| <b>4:30 p.m. – 5:00 p.m.</b>   | <b>Virginia Drug Court Association Open Meeting</b>  |
| <b>5:00 p.m.</b>               | <b>Adjourn</b>   |

**Tuesday, September 21, 2010**

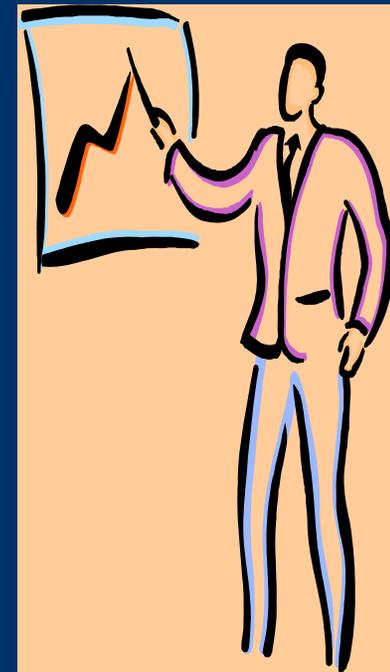
- 8:00 a.m.-9:00 a.m. Continental Breakfast/Registration**
- 8:30 a.m.-9:00 a.m. Keynote/Presentation of Certificates of Appreciation**  
Honorable Jerrauld Jones, Judge  
State Drug Treatment Court Advisory Committee
- 9:00 a.m.-11:00 a.m. Resistance to Change & Benefits to Motivational Interviewing**  
Ray Ferns, M.S., Restorative Correctional Services
- 11:00 a.m.-11:15 a.m. Break**
- 11:15 a.m.-12:00 p.m. Drug Court Treatment Issues**  
V. Morgan Moss, Jr., Ed. S., LPC, Center for Therapeutic Justice
- 12:00 a.m.-1:00 p.m. Lunch**
- 1:00 p.m.-2:15 p.m. DWI Drug Court Issues/Judges' Perspective**  
Honorable Kent Lawrence, Judge  
Chair, National Center for DWI Courts Task Force
- 2:15 p.m.-3:00 p.m. Integrating Law Enforcement into Drug Courts**  
Cynthia Herriott, National Drug Court Institute
- 3:00 p.m. - 3:15 p.m. Break**
- 3:15 p.m. – 3:30 p.m. Wrap-up**  
Anna Powers & Michelle White

**Adjourn**

# Best Practices in Drug Courts

**Douglas B. Marlowe, J.D., Ph.D.**

***National Association of Drug Court  
Professionals***



# Meta-Analyses

<b>Citation</b>	<b>Institution</b>	<b>Number of Drug Courts</b>	<b>Crime Reduced on <u>Avg.</u> by . . .</b>
<b>Wilson et al. (2006)</b>	<b>Campbell Collaborative</b>	<b>55</b>	<b>14% to 26%</b>
<b>Latimer et al. (2006)</b>	<b>Canada Dept. of Justice</b>	<b>66</b>	<b>14%</b>
<b>Shaffer (2006)</b>	<b>University of Nevada</b>	<b>76</b>	<b>9%</b>
<b>Lowenkamp et al. (2005)</b>	<b>University of Cincinnati</b>	<b>22</b>	<b>8%</b>
<b>Aos et al. (2006)</b>	<b>Washington State Inst. for Public Policy</b>	<b>57</b>	<b>8%</b>

# Cost Analyses

<b>Citation</b>	<b>No. Drug Courts</b>	<b><u>Avg. Benefit Per \$1 Invested</u></b>	<b><u>Avg. Cost Saving Per Client</u></b>
<b>Loman (2004)</b>	<b>1 (St. Louis)</b>	<b>\$2.80 to \$6.32</b>	<b>\$2,615 to \$7,707</b>
<b>Finigan et al. (2007)</b>	<b>1 (Portland, OR)</b>	<b>\$2.63</b>	<b>\$11,000</b>
<b>Carey et al. (2006)</b>	<b>9 (California)</b>	<b>\$3.50</b>	<b>\$6,744 to \$12,218</b>
<b>Barnoski &amp; Aos (2003)</b>	<b>5 (Washington St.)</b>	<b>\$1.74</b>	<b>\$2,888</b>
<b>Aos et al. (2006)</b>	<b>National Data</b>	<b>N/A</b>	<b>\$4,767</b>
<b>Bhati et al. (2008)</b>	<b>National Data</b>	<b>\$2.21</b>	<b>N/A</b>

# Best Practices Research

\*Shannon Carey et al. (2008). *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs.* Portland, OR: NPC Research.

\*Shannon Carey et al. (2008). *Drug courts and state mandated drug treatment programs: Outcomes, costs and consequences.* Portland, OR: NPC Research.

\*Michael Finigan et al. (2007). *The impact of a mature drug court over 10 years of operation: Recidivism and costs.* Portland, OR: NPC Research.

Deborah Shaffer (2006). *Reconsidering drug court effectiveness: A meta-analytic review.* Las Vegas, NV: Dept. of Criminal Justice, University of Nevada.

\* [www.npcresearch.com](http://www.npcresearch.com)

# Key Component #1

*“Realization of these [rehabilitation] goals requires a **team approach**, including cooperation and collaboration of the judges, prosecutors, defense counsel, probation authorities, other corrections personnel, law enforcement, pretrial services agencies, TASC programs, evaluators, an array of local service providers, and the greater community.”*

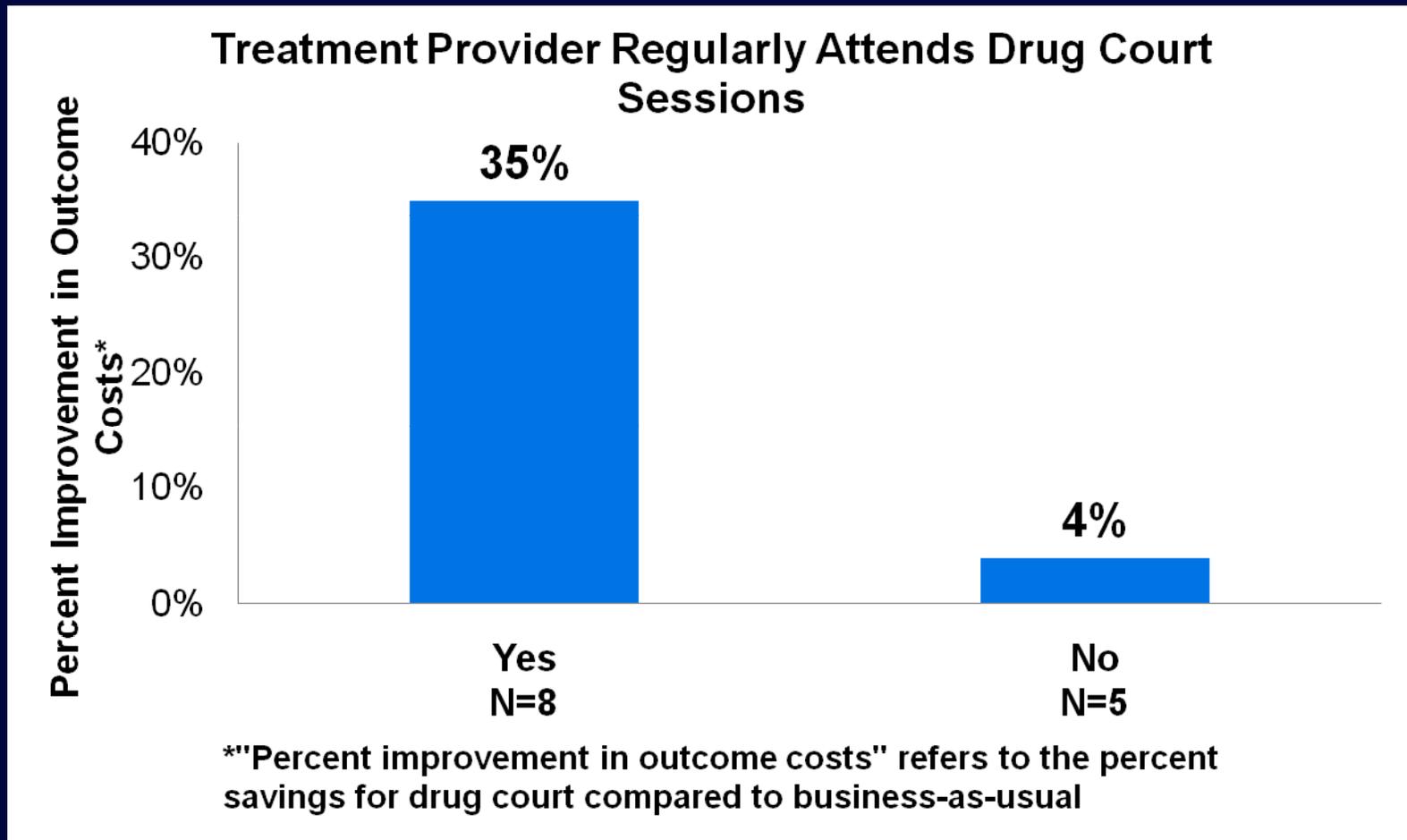
# Team Involvement

- Does it matter if the treatment provider attends court sessions?

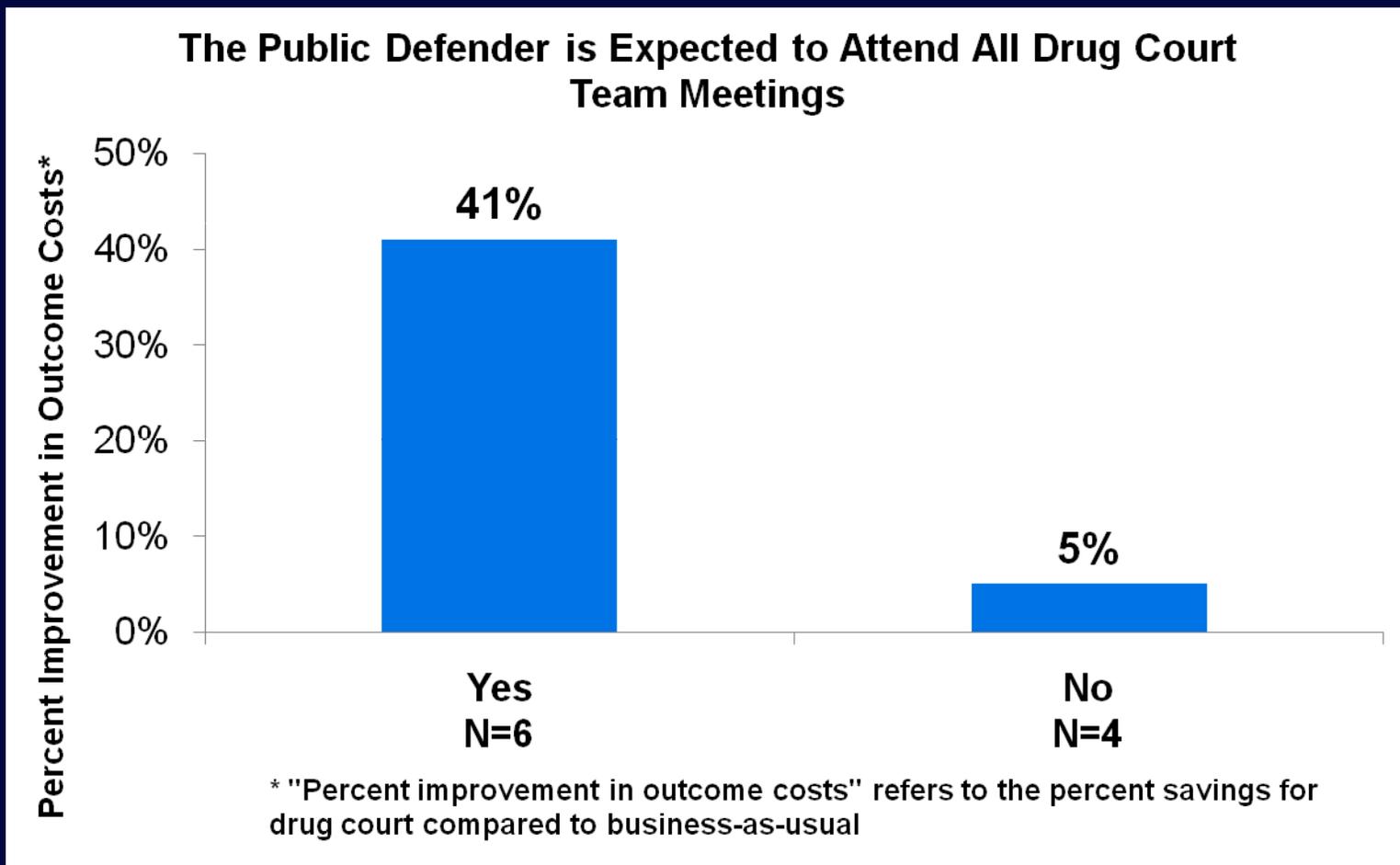


- Is it important for the attorneys to attend team meetings (“staffings”)?

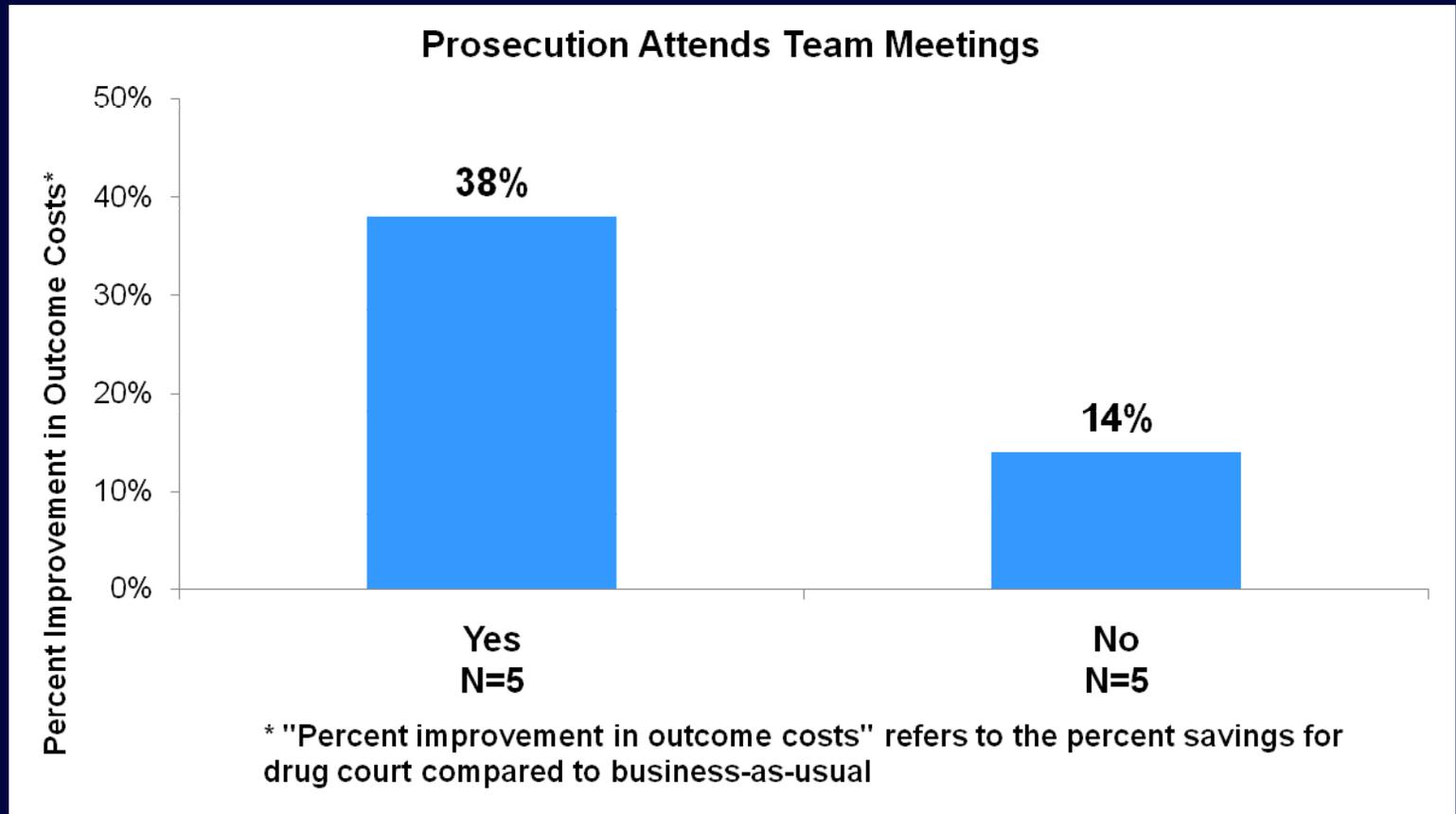
# Drug Courts That Required a Treatment Representative at Court Hearings Had 9 Times Greater Savings



# Drug Courts That Expected the Public Defender to Attend All Team Meetings Had 8 Times Greater Savings

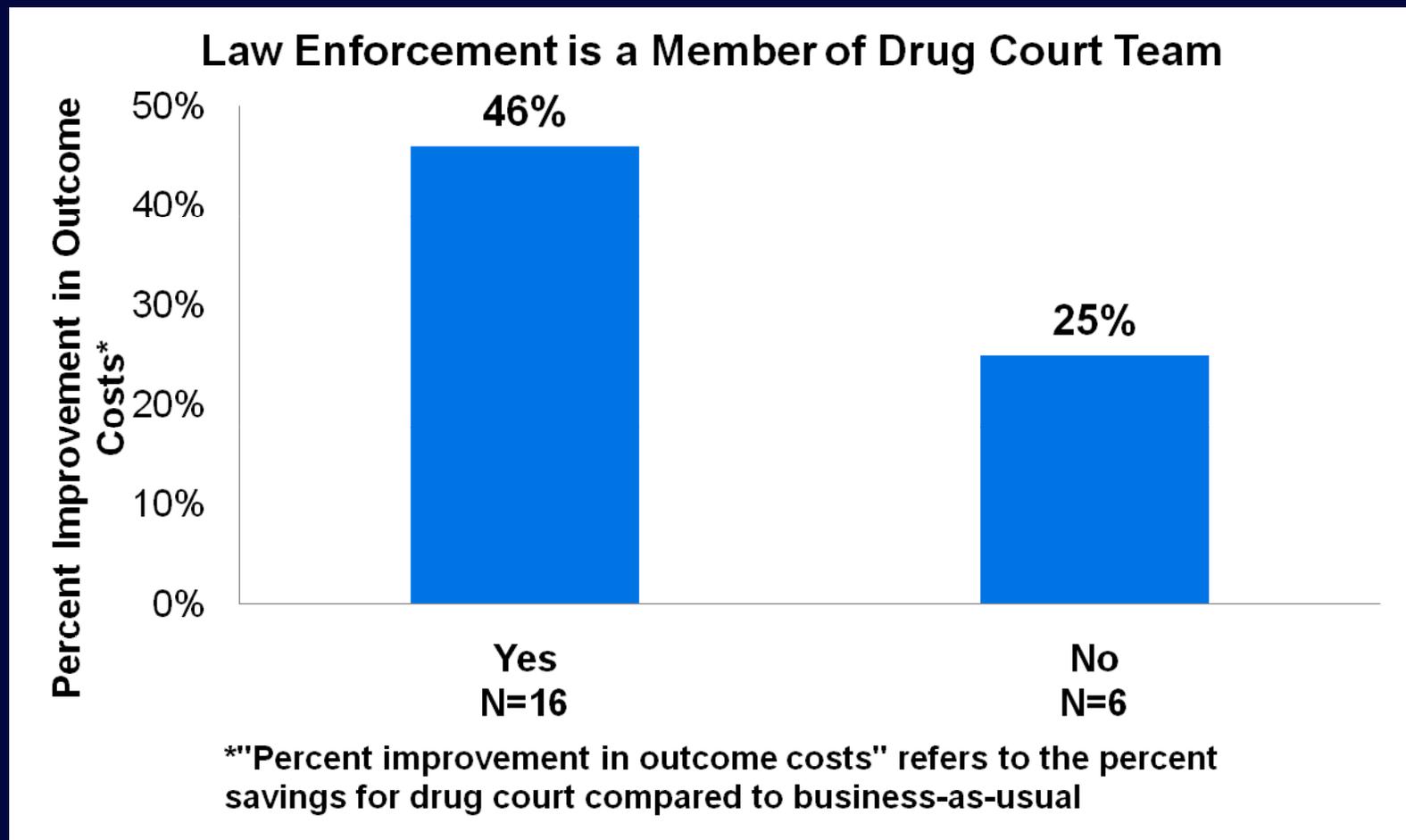


# Drug Courts That Expected the Prosecutor to Attend All Team Meetings Had More Than 2 Times Greater Savings



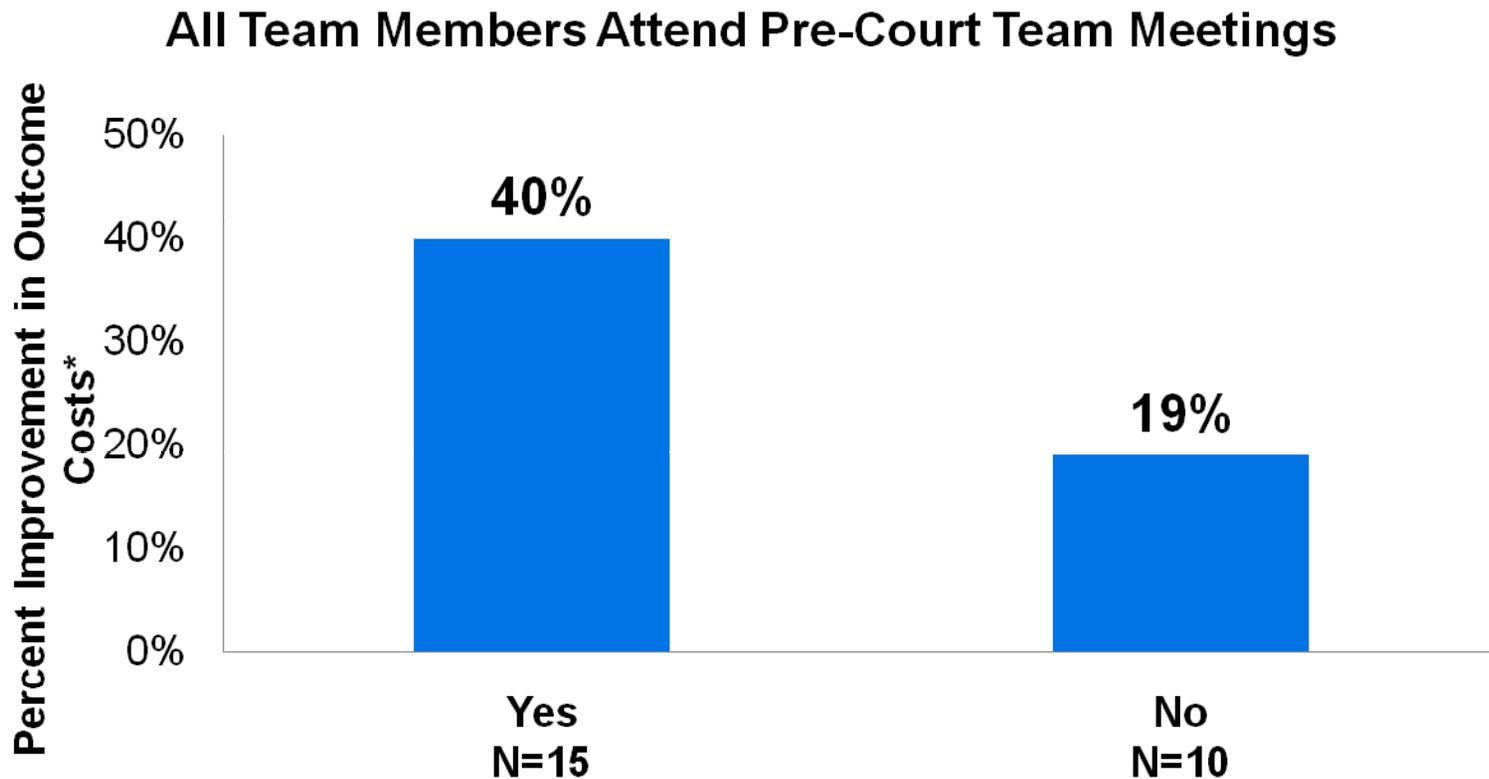
Note: Difference is significant at  $p < .05$

# Drug Courts that Included Law Enforcement as a Member of the Team Had Greater Cost Savings



Note: Difference is significant at  $p < .05$

# Drug Courts That Required All Team Members to Attend Staffings Had Twice the Savings



\*\*\*"Percent improvement in outcome costs" refers to the percent savings for drug court compared to business-as-usual

Note 1: Difference is significant at  $p < .05$

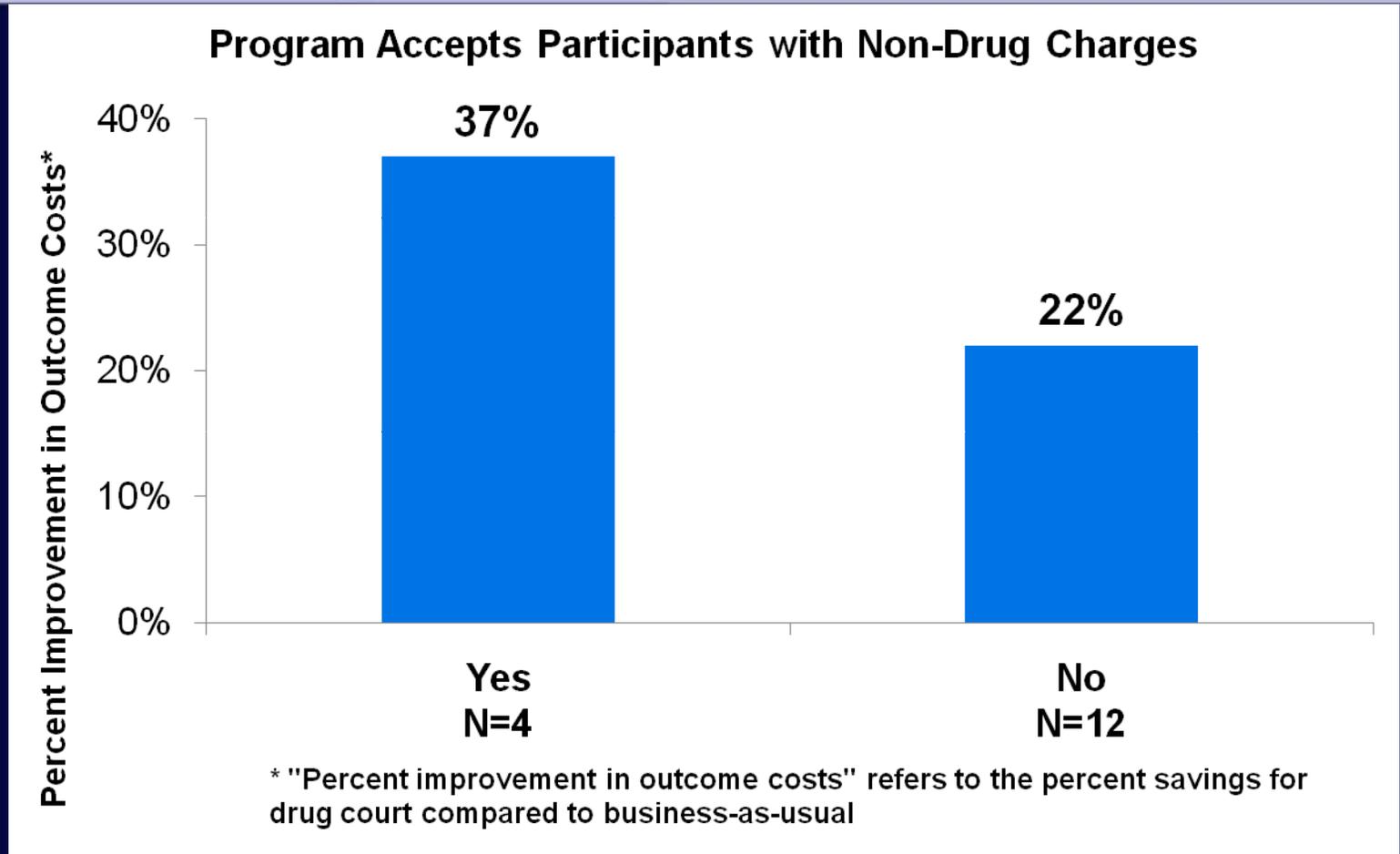
Note 2: "Team Members" = Judge, Both Attorneys, Treatment Provider, Coordinator

# Non-Drug Charges

**Does allowing non-drug charges threaten public safety?**



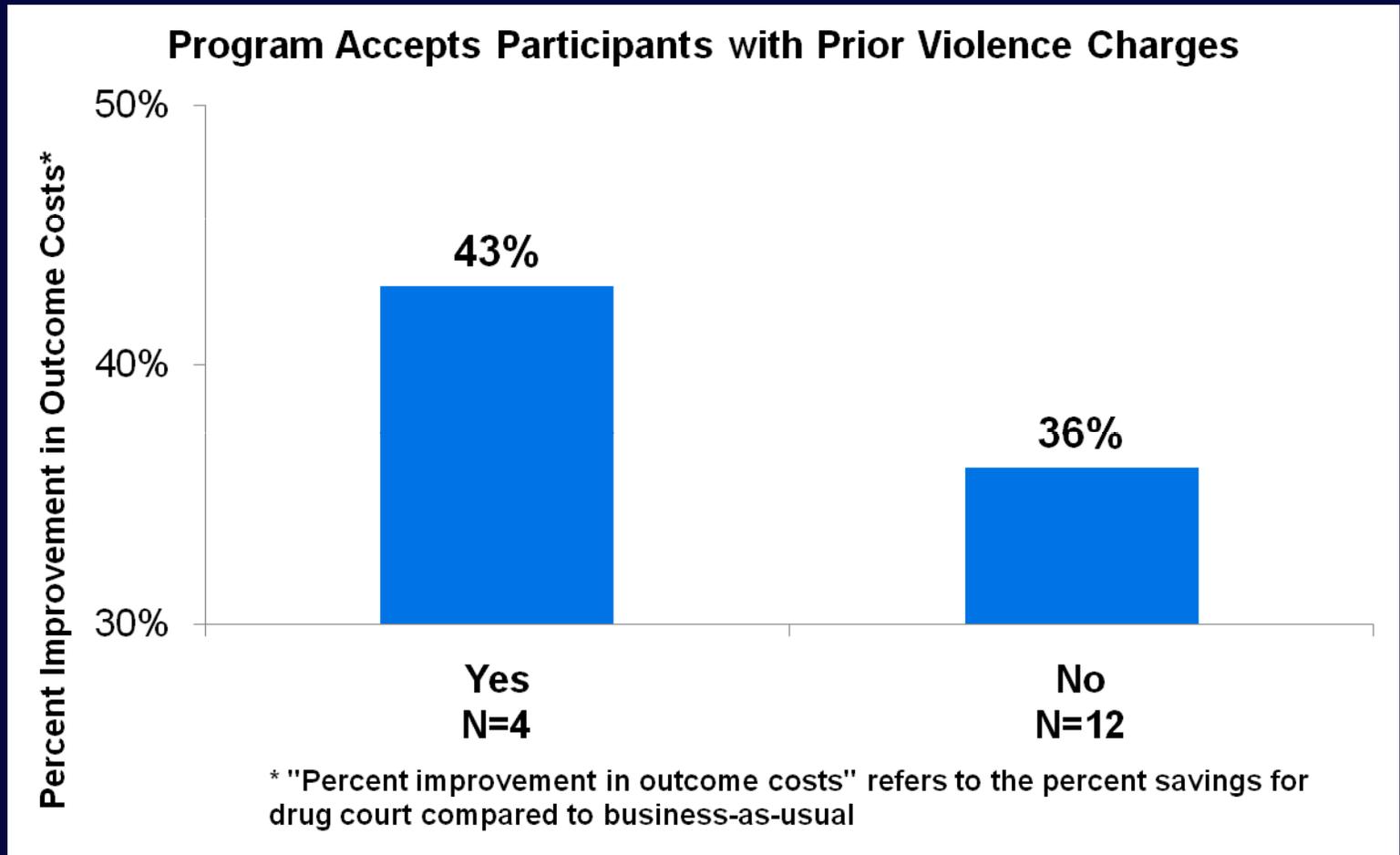
# Drug Courts That Accepted Participants With Non-Drug Charges Had Nearly Twice the Savings



**Note 1: Difference is significant at  $p < .05$**

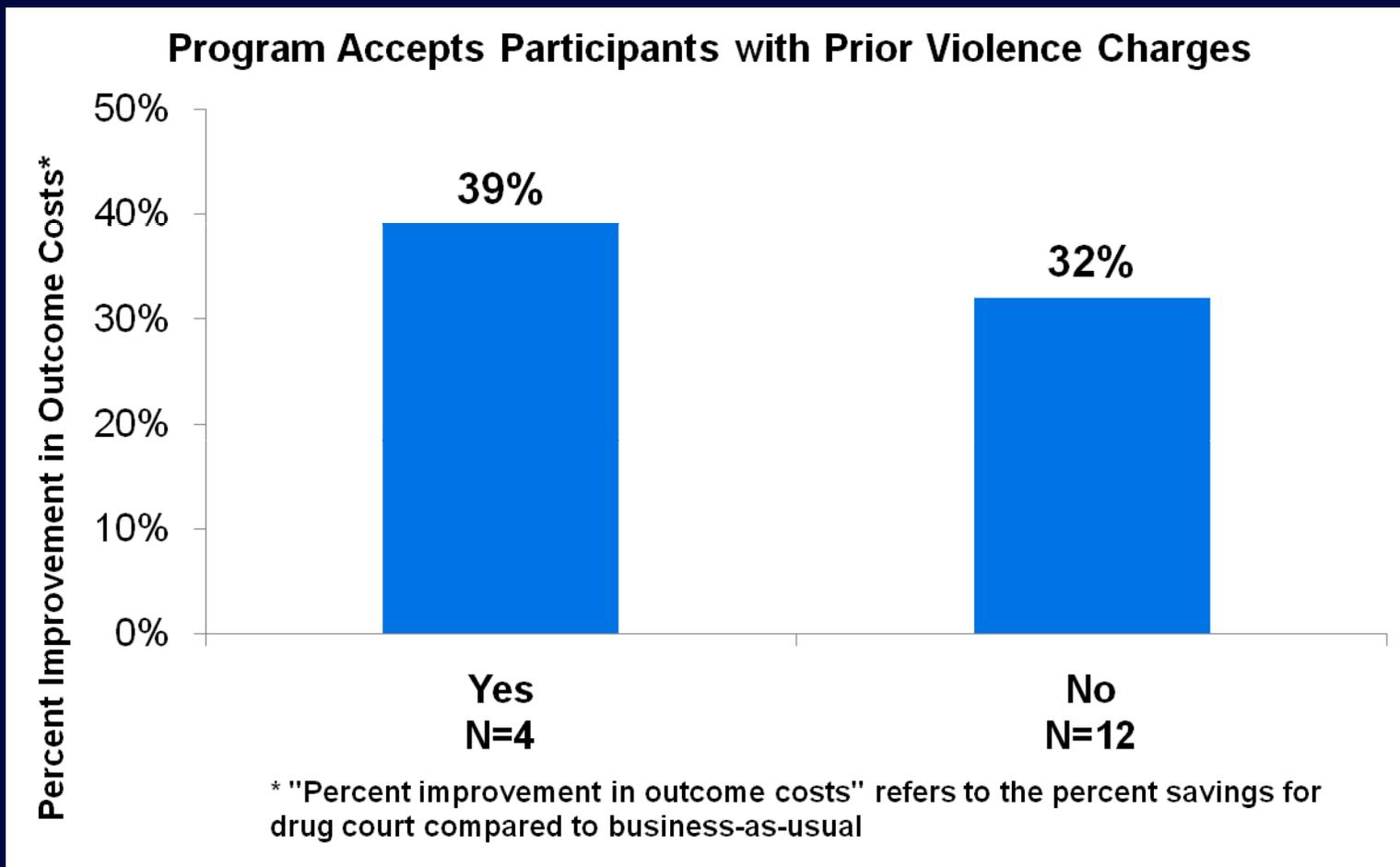
**Note 2: Non-drug charges include property, prostitution, violence, etc.**

# Drug Courts That Accepted Participants with Prior Violence Had No Differences in Graduation Rates



**Note: Difference is NOT significant**

# Drug Courts That Accepted Participants with Prior Violence Had No Differences in Cost Savings



**Note: Difference is NOT significant**

## Key Component #3

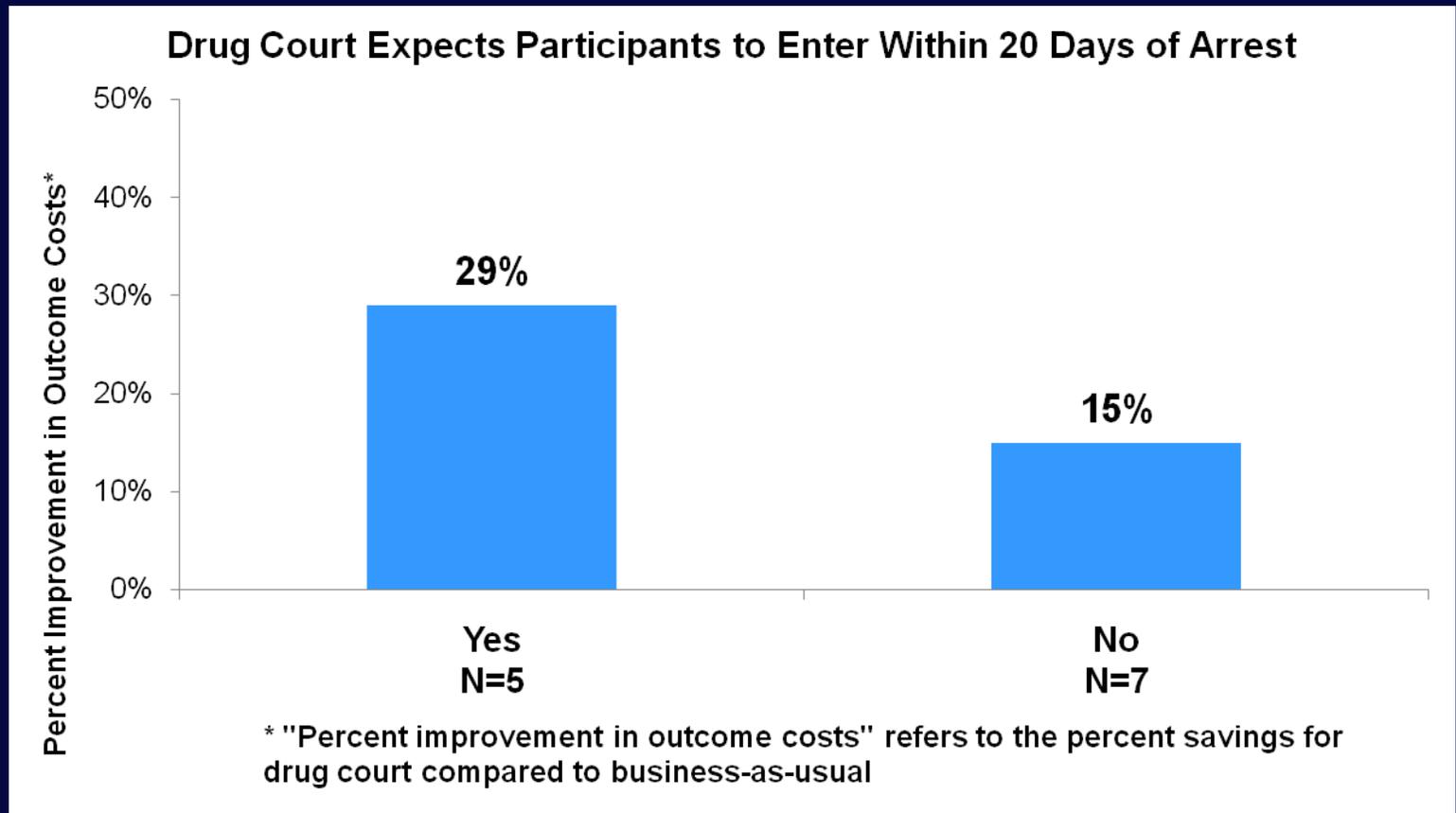
*“Eligible participants are identified early and promptly placed in the drug court program.”*

# Prompt Treatment

- **Is it really important to get participants into the program quickly? And what is quickly?**



# Drug Courts In Which Participants Entered the Program Within 20 Days of Arrest Had Twice the Savings



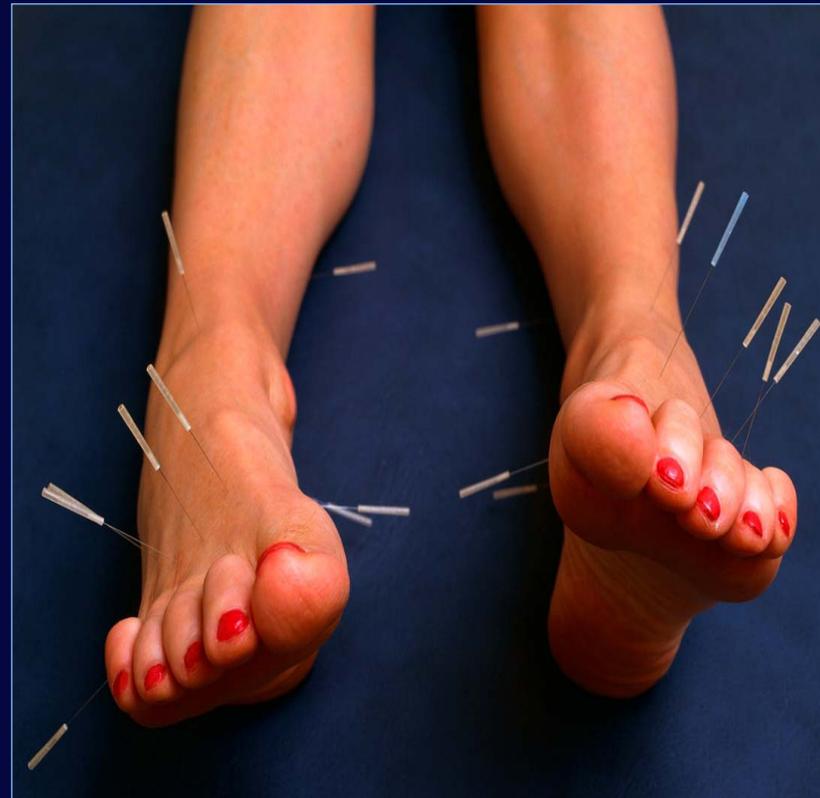
**Note: Difference is significant at  $p < .05$**

# Key Component #4

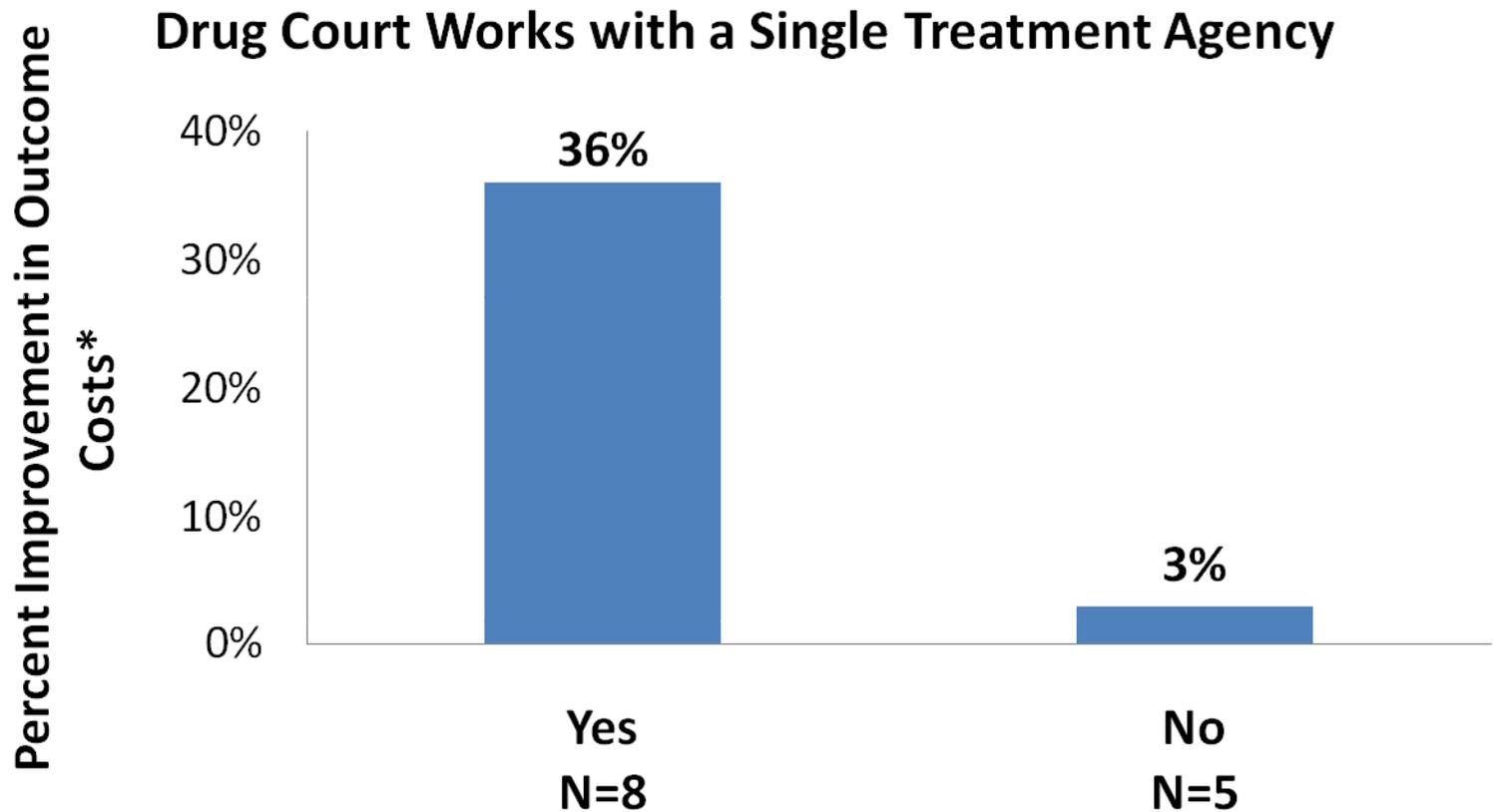
*Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.*

# Effective Treatment

- Is it better to have a single treatment agency or to have multiple treatment options?
- How important is relapse prevention?



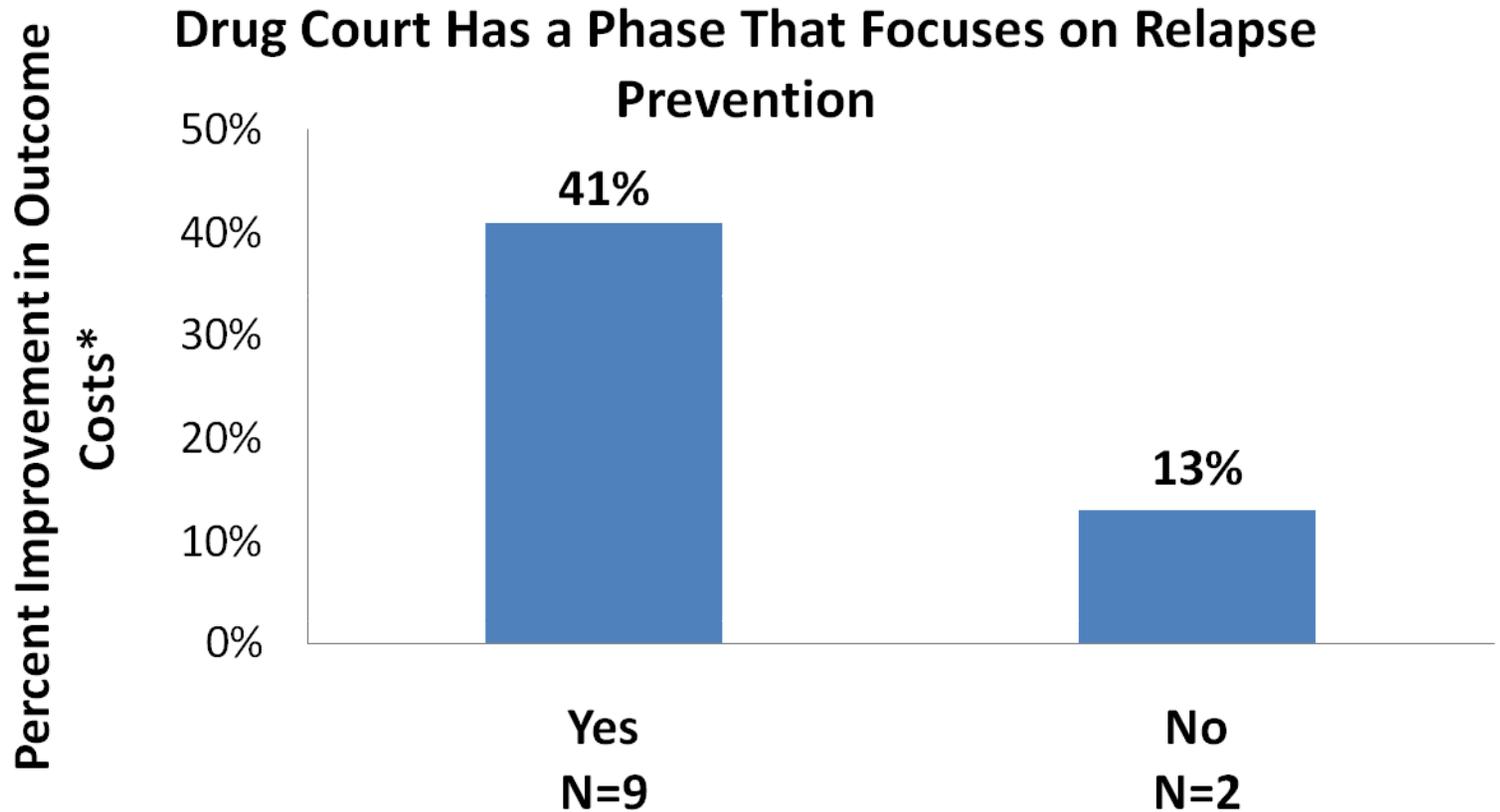
# Drug Courts That Used a Single Coordinating Treatment Agency Had 10 Times Greater Savings



\* "Percent improvement in outcome costs" refers to the percent savings for drug court compared to business-as-usual

Note: Difference is significant at  $p < .05$

# Drug Courts That Included a Phase Focusing on Relapse Prevention Had Over 3 Times Greater Savings



\* "Percent improvement in outcome costs" refers to the percent savings for drug court compared to business-as-usual

Note: Difference is significant at  $p < .05$

# Key Component #7

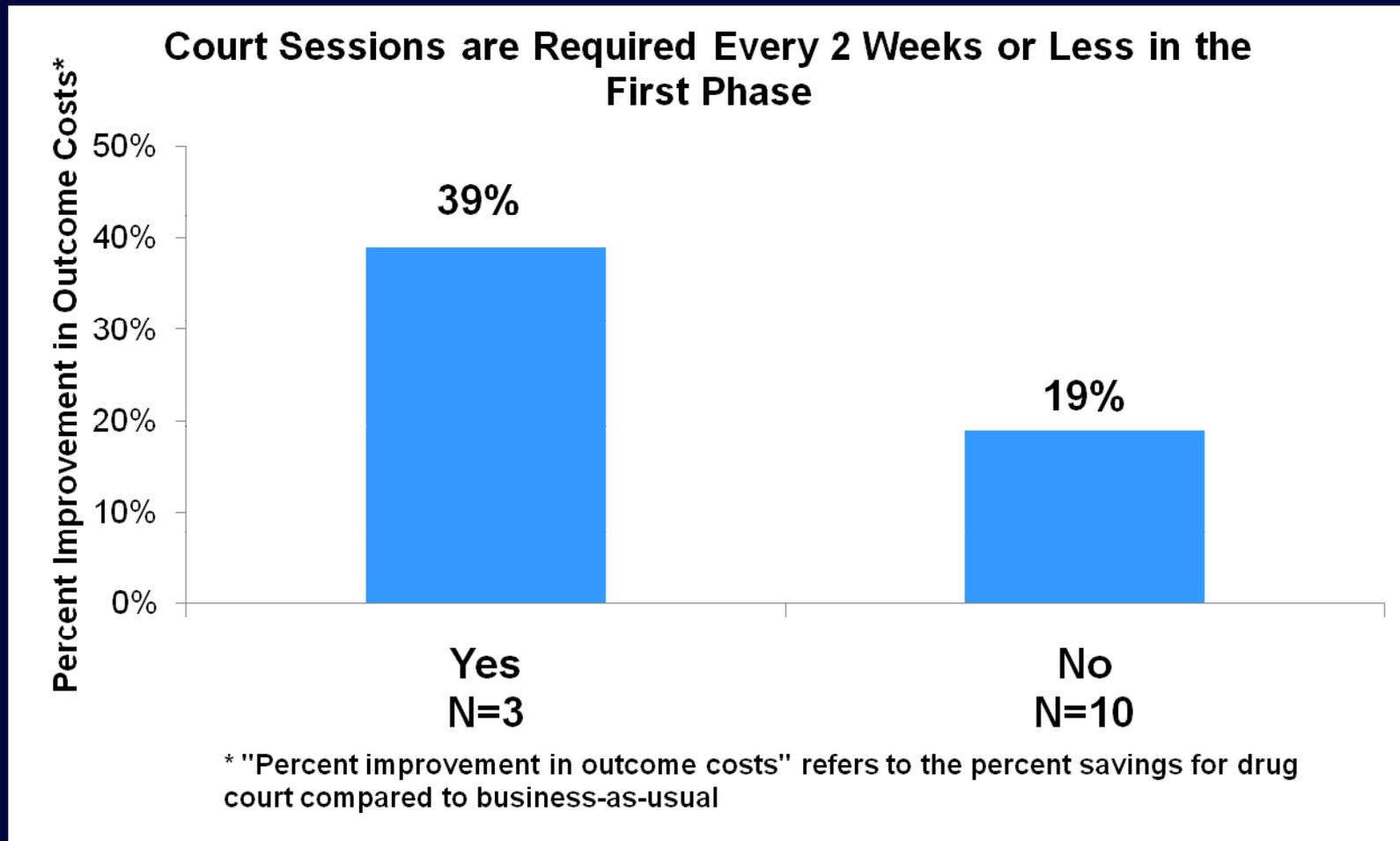
*“Ongoing judicial interaction with each drug court participant is essential.”*

# The Judge

- **How often should participants appear before the judge?**
- **How long should the judge stay on the drug court bench? Is longevity better or is it better to rotate regularly?**

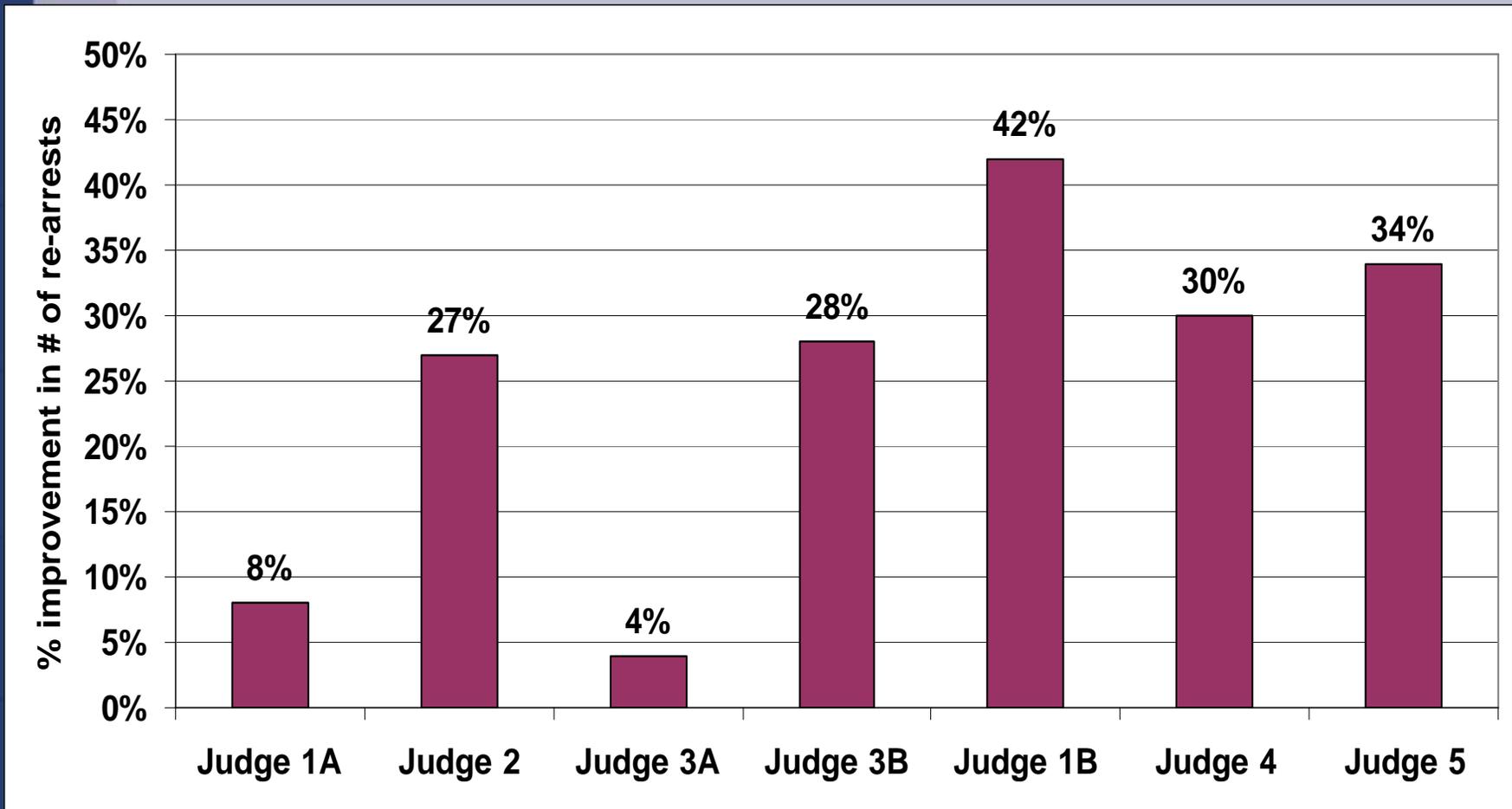


# Drug Courts That Held Status Hearings Every 2 Weeks During Phase 1 Had 2 Times Greater Cost Savings



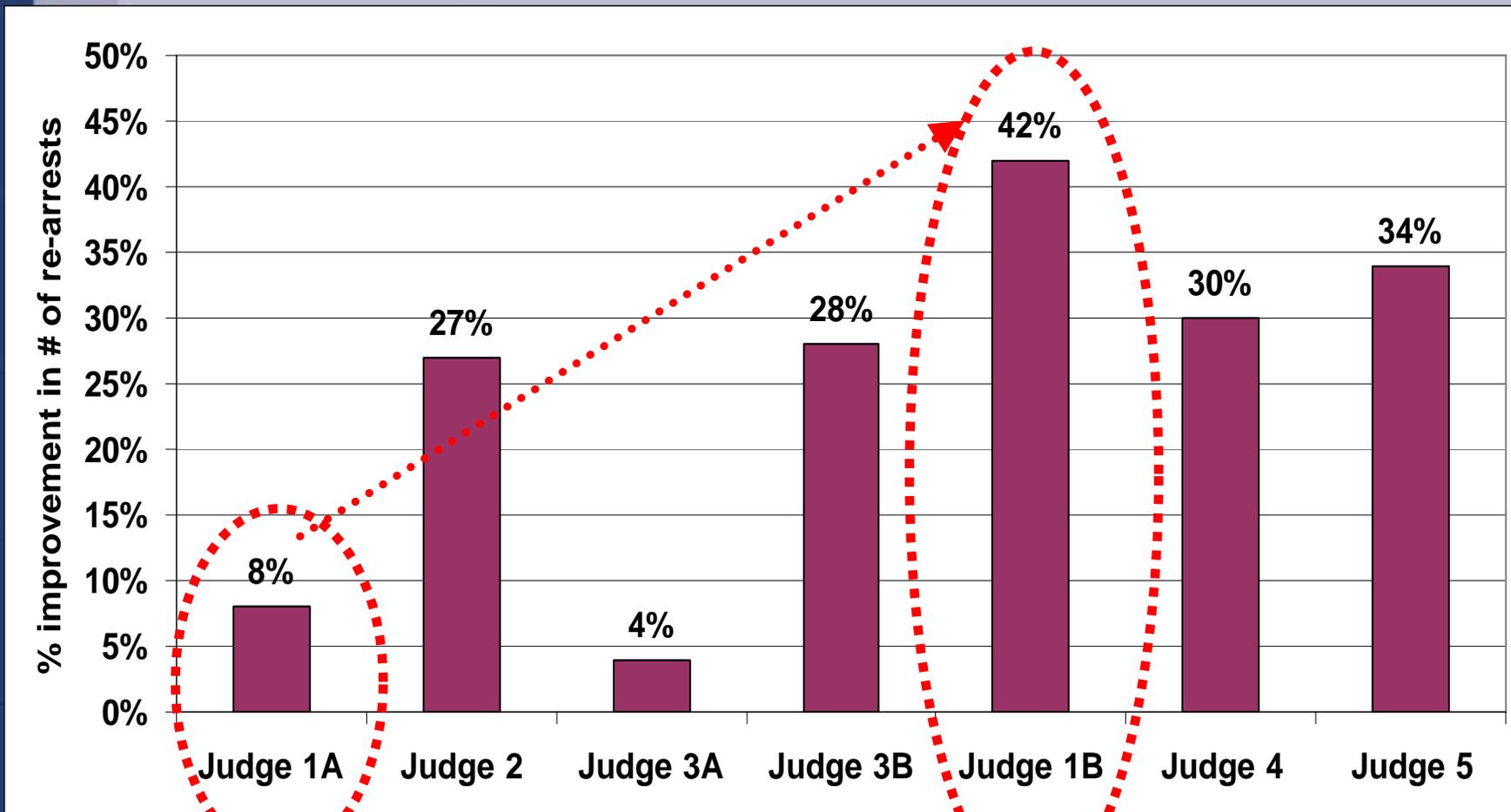
**Note: Difference is significant at  $p < .05$**

# The Longer the Judge Spent on the Drug Court Bench, the Better the Client Outcomes



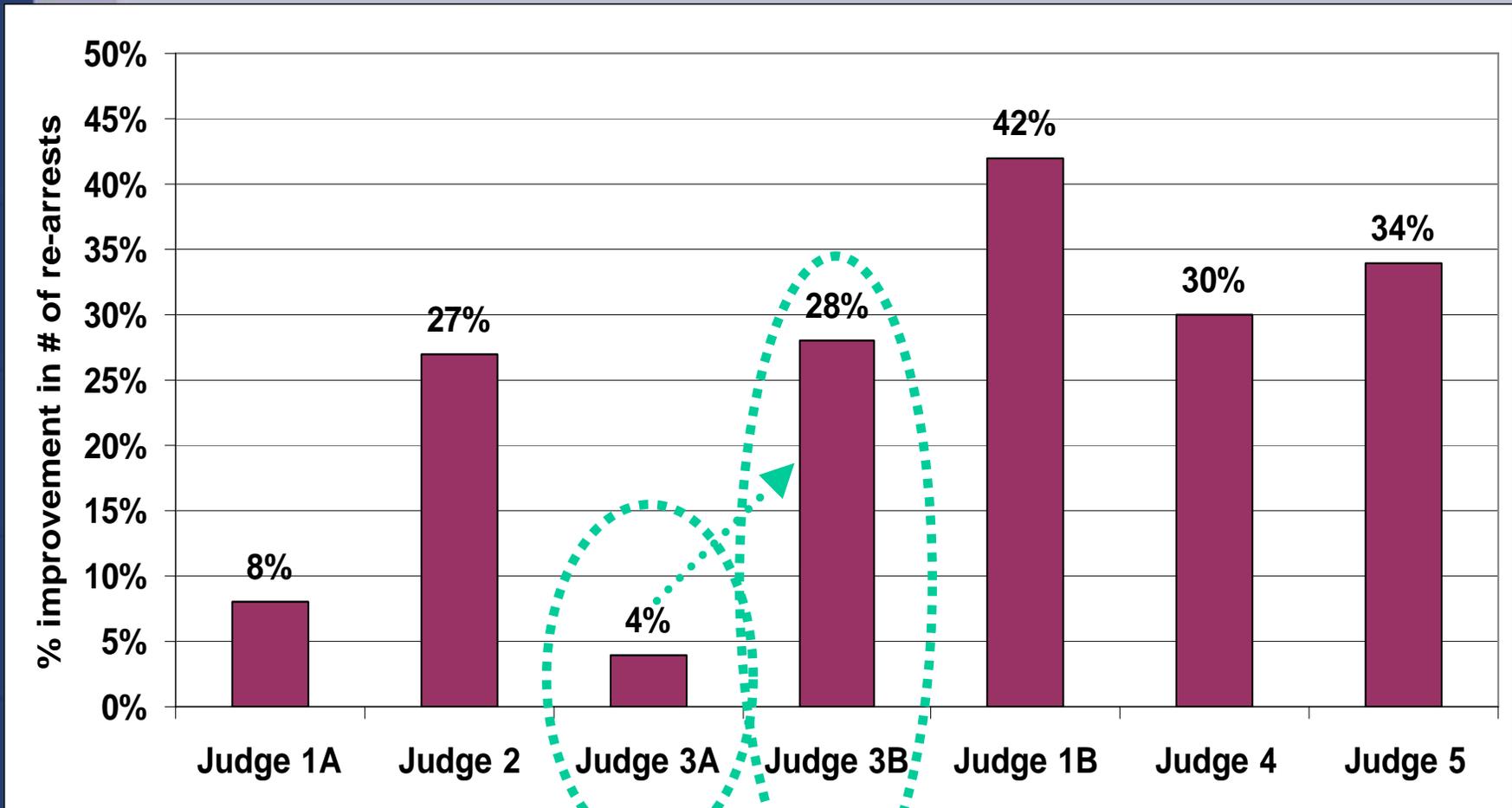
➤ Different judges had different impacts on recidivism

# The Longer the Judge Spent on the Drug Court Bench, the Better the Client Outcomes



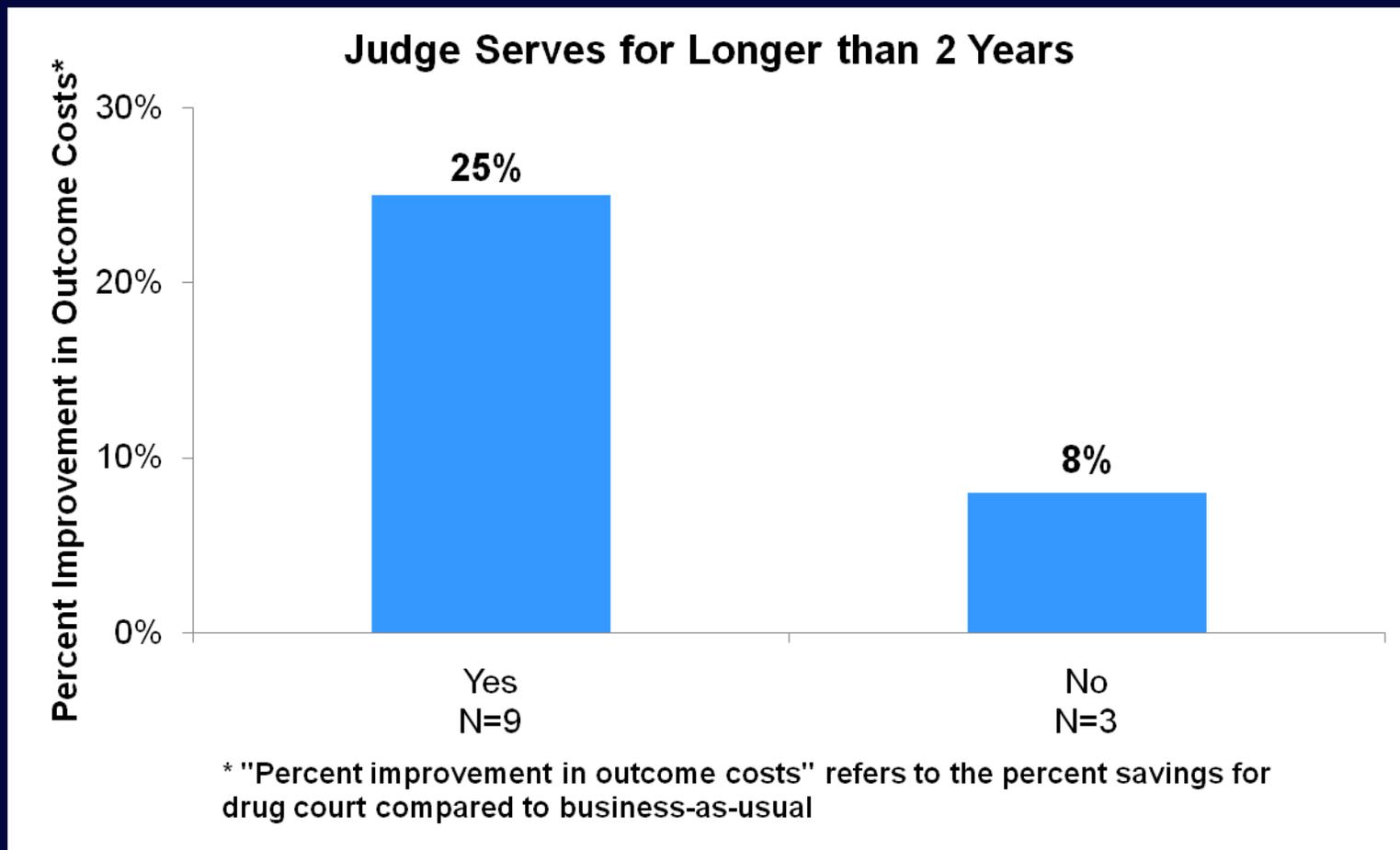
- Different judges had different impacts on recidivism
- **Judges did better their second time**

# The Longer the Judge Spent on the Drug Court Bench, the Better the Client Outcomes



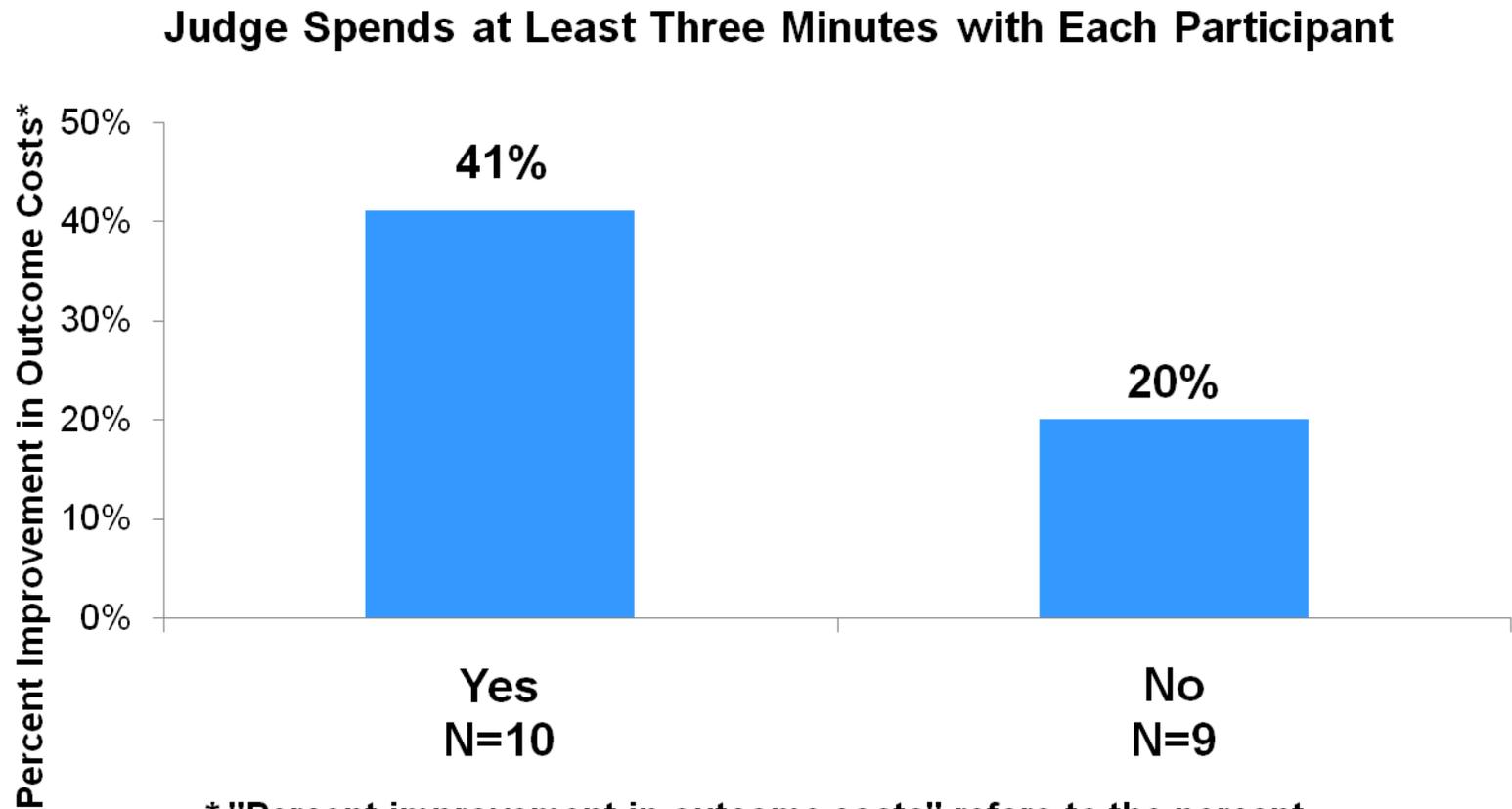
- Different judges had different impacts on recidivism
- **Judges did better their second time**

# Drug Courts That Have Judges Stay Longer Than Two Years Had 3 Times Greater Cost Savings



**Note: Difference is significant at  $p < .05$**

# Judges Who Spent at Least 3 Minutes Talking to Each Participant in Court Had More Than Twice the Savings



\* "Percent improvement in outcome costs" refers to the percent savings for drug court compared to business-as-usual

**Note: Difference is significant at  $p < .1$**

# Key Component #5

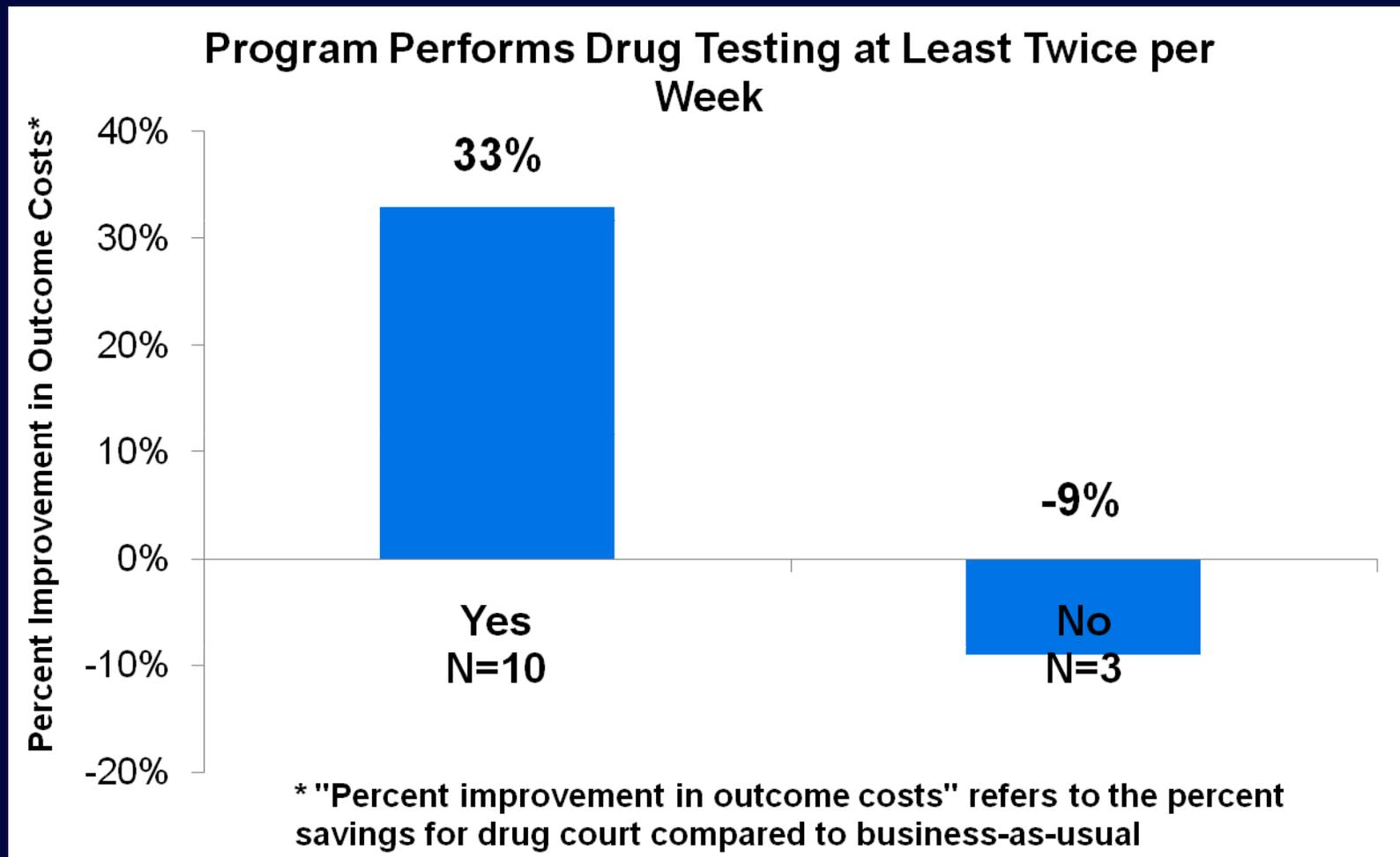
*“Abstinence is monitored by frequent alcohol and other drug testing.”*

# Drug Testing

- **How frequently should participants be tested?**
- **How quickly should results be available to the team?**

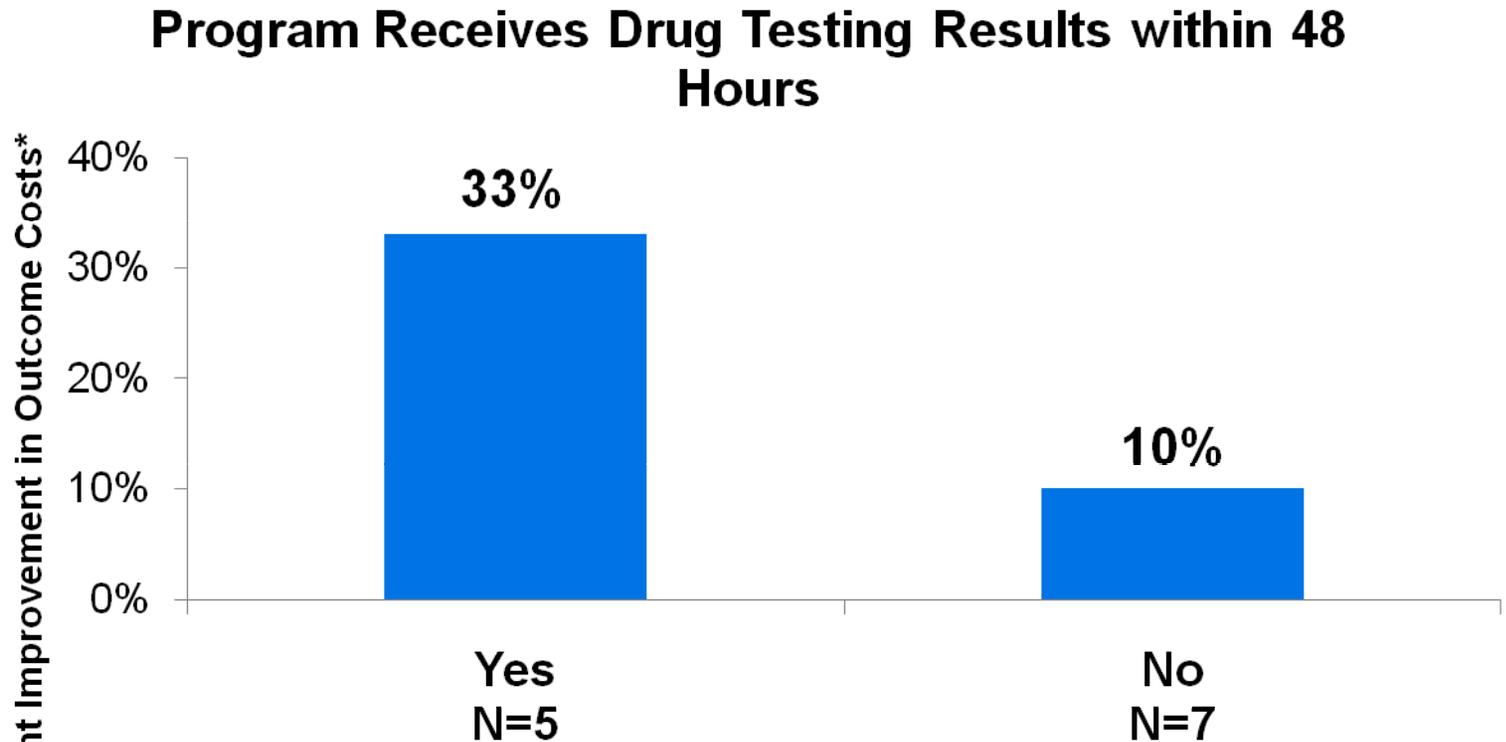


# Drug Courts That Performed Drug Testing 2 or More Times Per Week During Phase 1 Had Savings



Note: Difference is significant at  $p < .05$

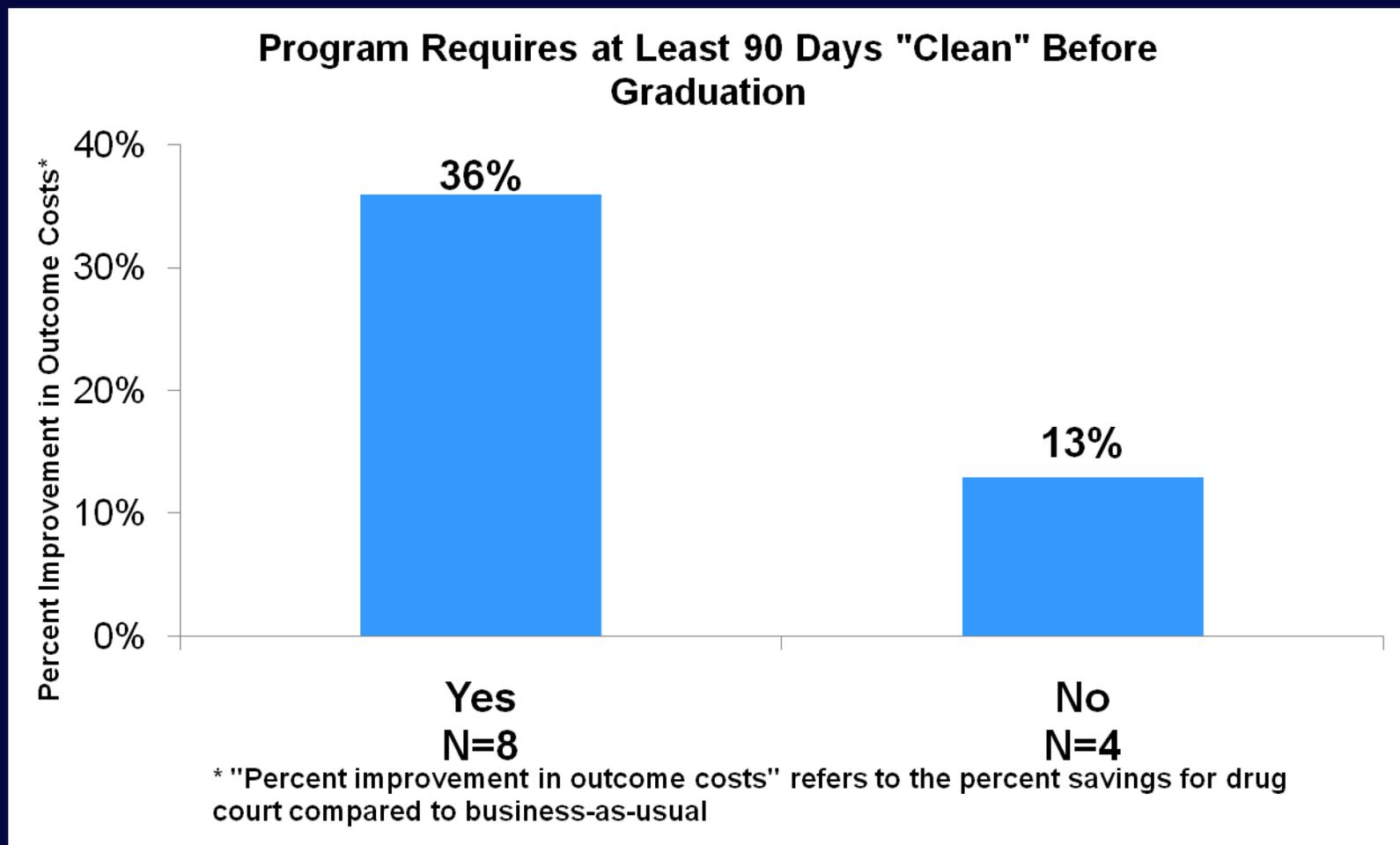
# Drug Courts That Received Drug Test Results Within 48 Hours Had 3 Times Greater Savings



\* "Percent improvement in outcome costs" refers to the percent savings for drug court compared to business-as-usual

Note: Difference is significant at  $p < .05$

# Drug Courts That Required Greater Than 90 Days of Abstinence Had Larger Cost Savings



Note: Difference is significant at  $p < .05$

# Key Component #6

*“Drug courts establish a coordinated strategy, including a continuum of responses, to continuing drug use and other noncompliant behavior . . .*

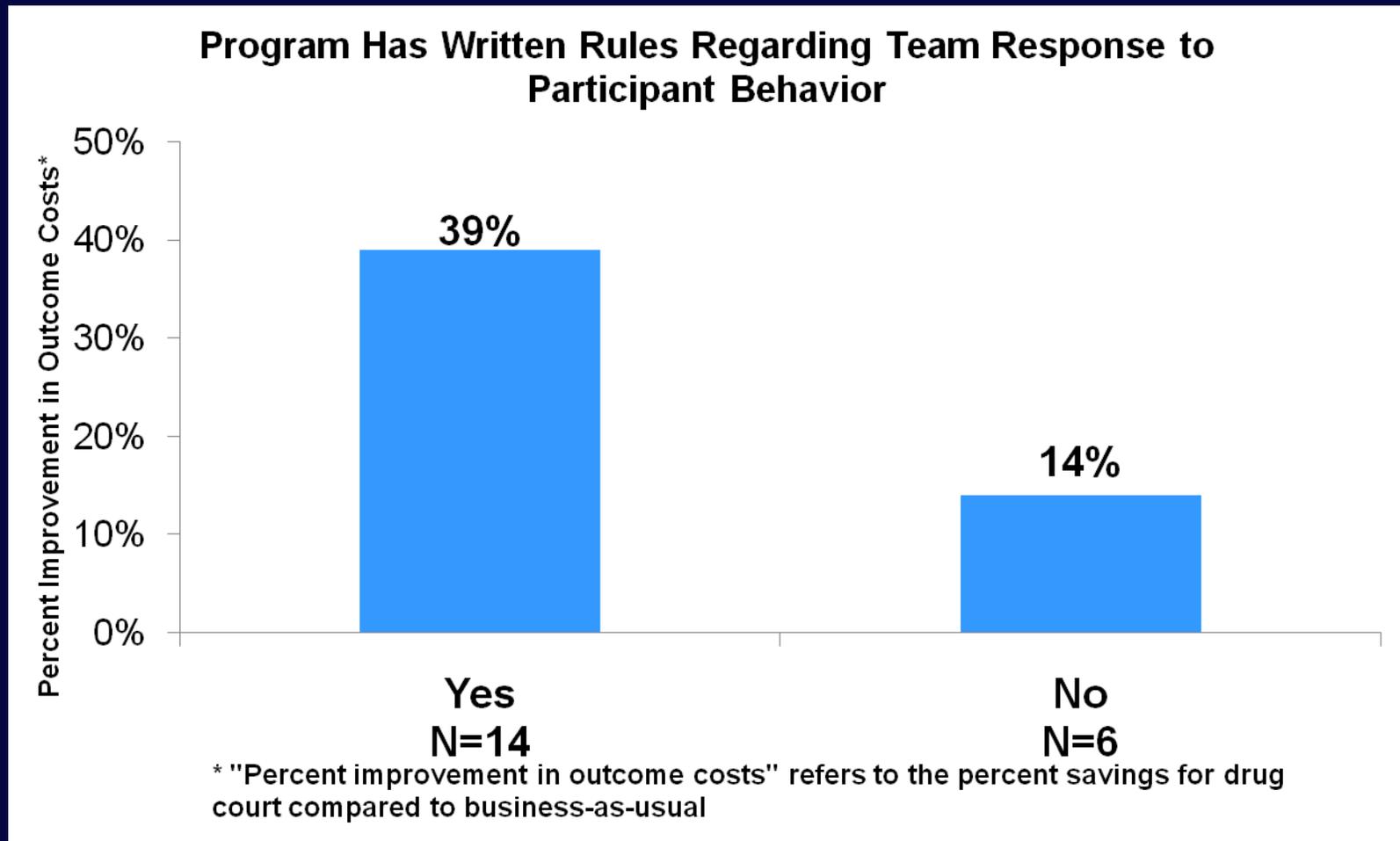
*Reponses to or sanctions for noncompliance might include . . . escalating periods of jail confinement”*

# Written Sanction and Incentive Guidelines

- **Do your guidelines on team responses to client behavior really need to be in writing?**



# Drug Courts That Had Written Rules for Team Responses Had Nearly 3 Times the Cost Savings



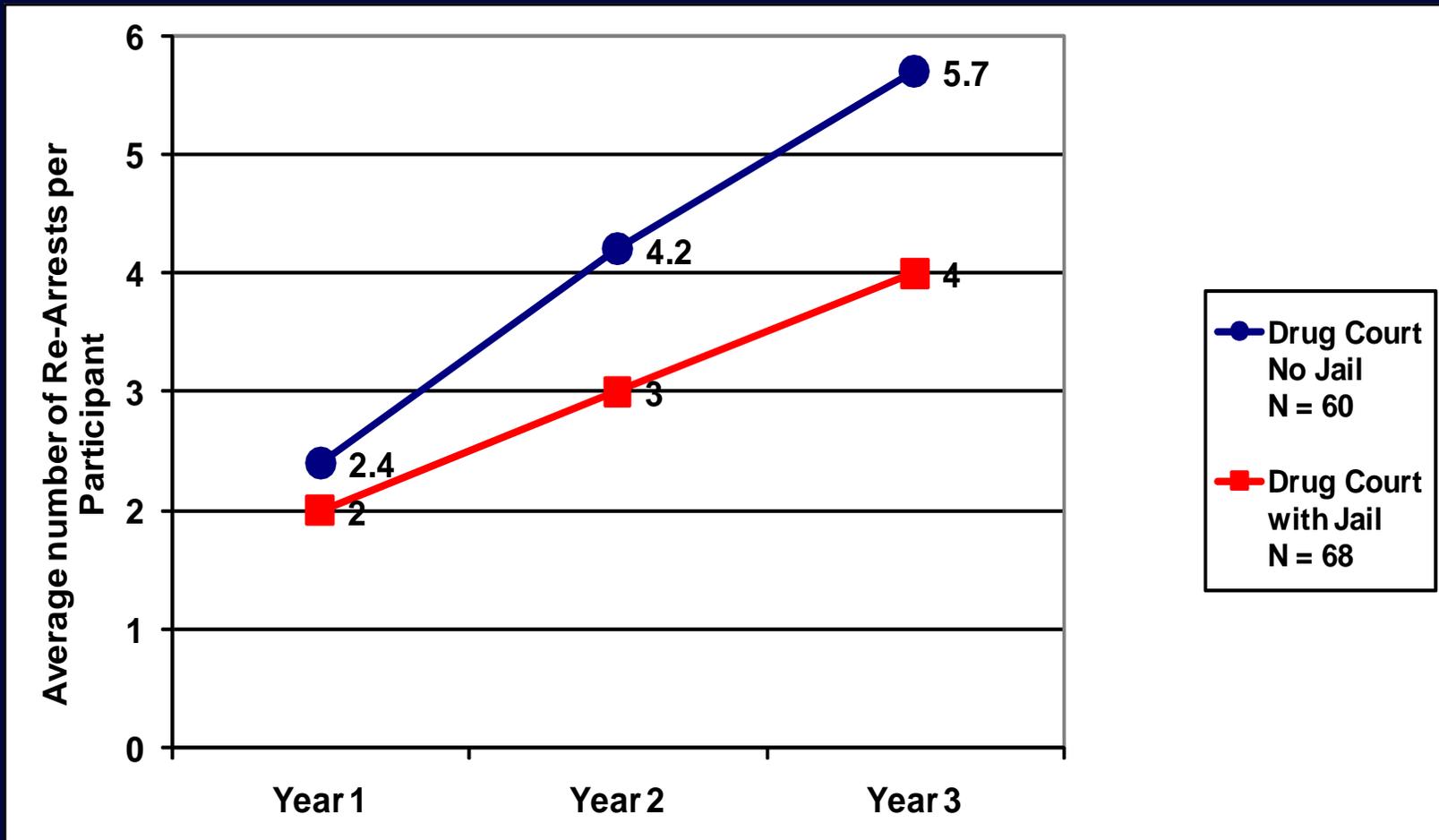
Note: Difference is significant at  $p < .05$

# Jail



- **How important is jail as a sanction?**

# Participants Facing the Possibility of Jail as a Sanction Had Lower Recidivism



- Drug court with same judge and same team had better outcomes for participants when the option of jail as a sanction was available

# Key Component #9

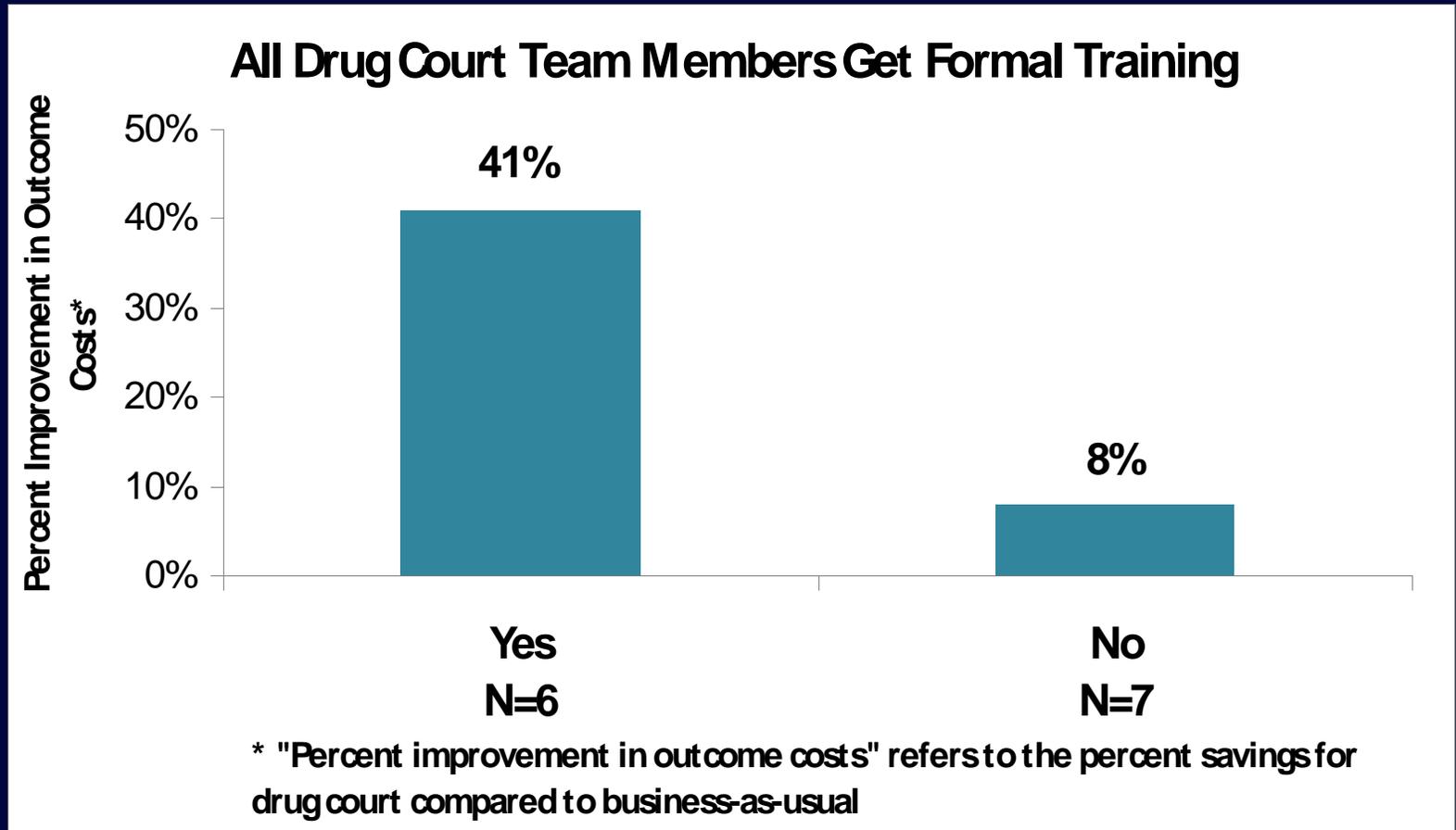
*“Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.”*

# Training

- How important is formal training for team members?
- Who should be trained?
- *When* should team members get trained?

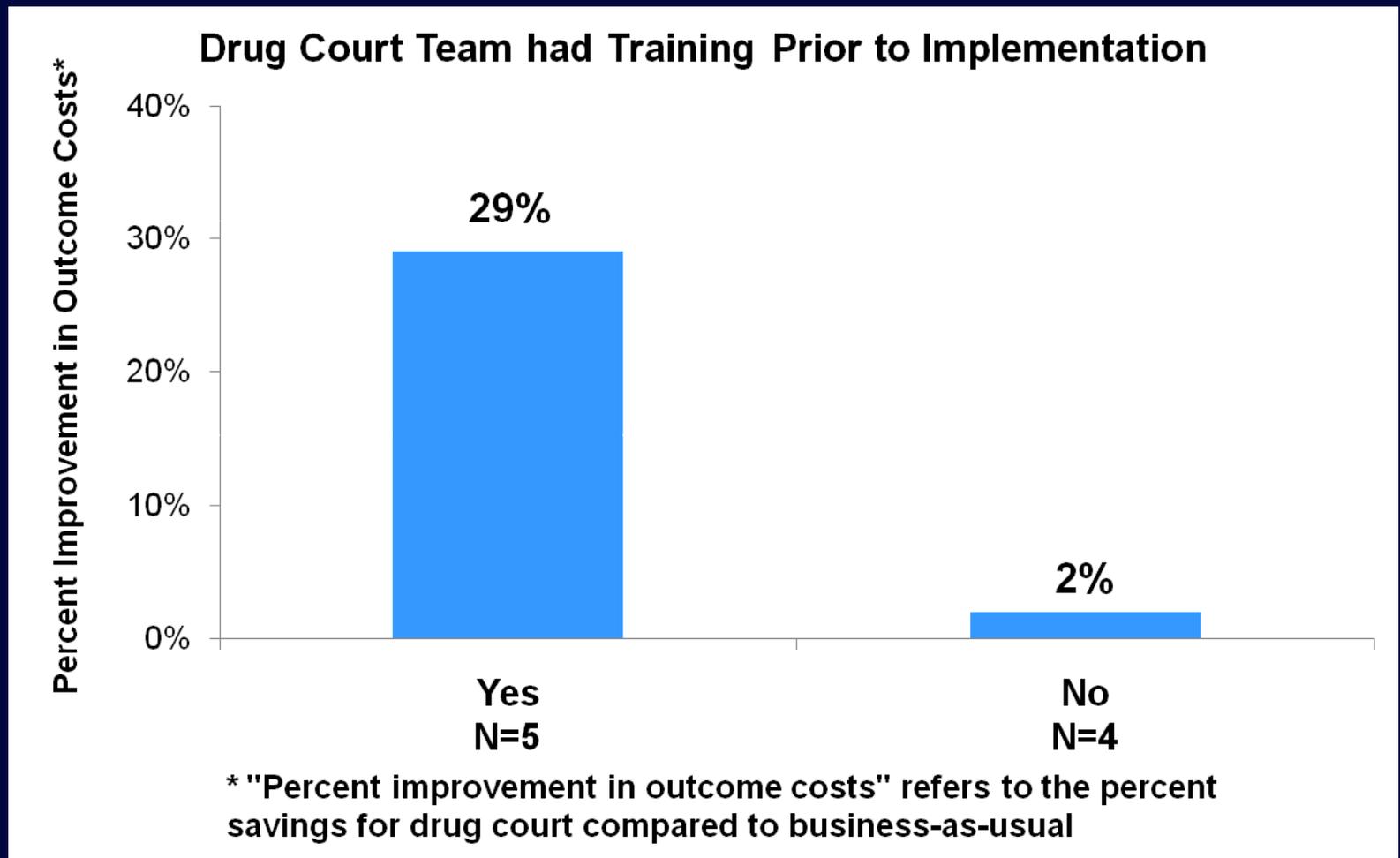


# Drug Courts That Provided Formal Training for All Team Members Had 5 Times Greater Savings



Note: Difference is significant at  $p < .05$

# Drug Courts That Received Training Prior to Implementation Had 15 Times Greater Cost Savings



Note: Difference is significant at  $p < .05$

# Key Component #8

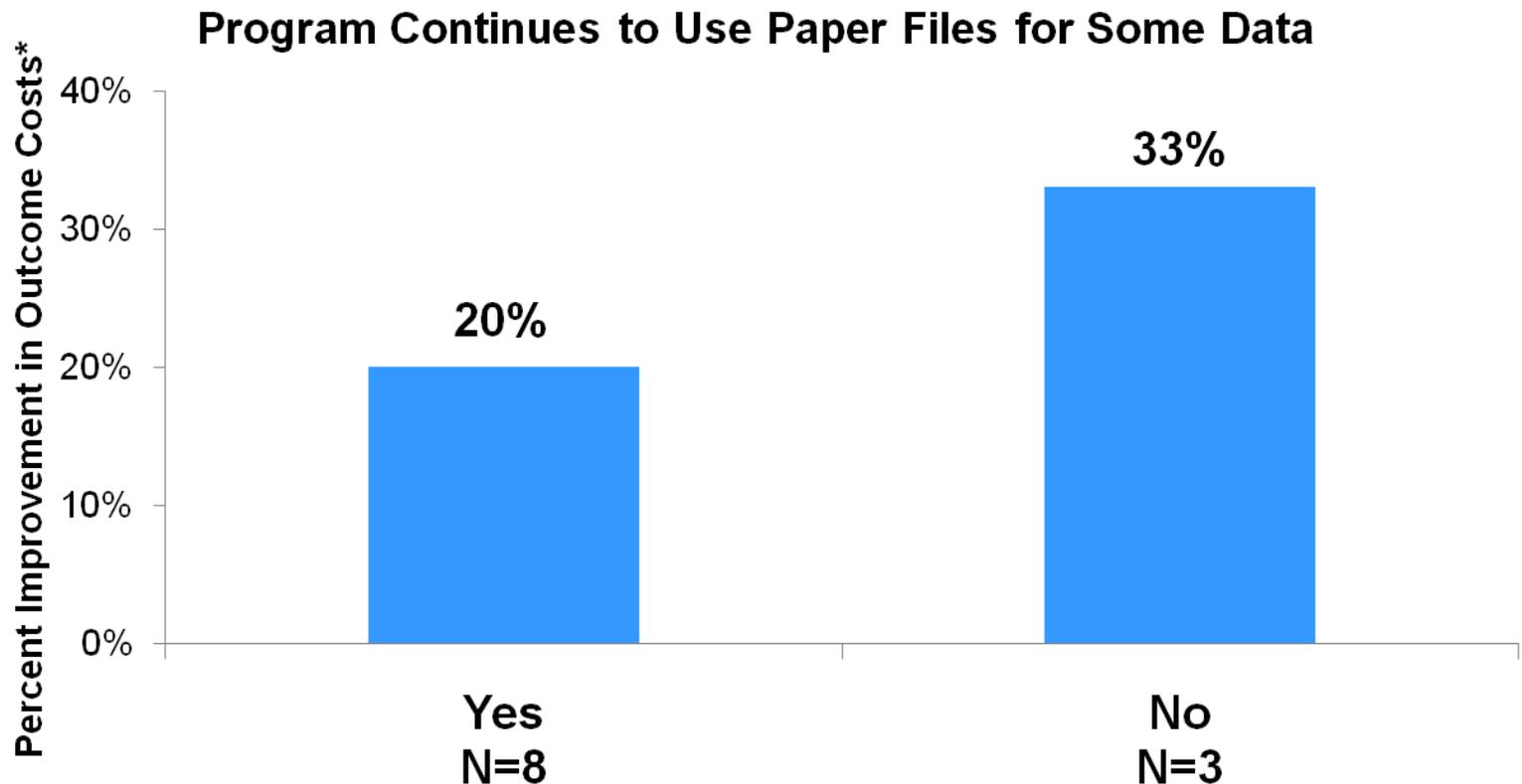
*“Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.”*

# Monitoring and Evaluation

- Does it matter whether data are kept in paper files or in a database?
- Does keeping program stats make a difference?
- Do you really need an evaluation? What do you get out of it?



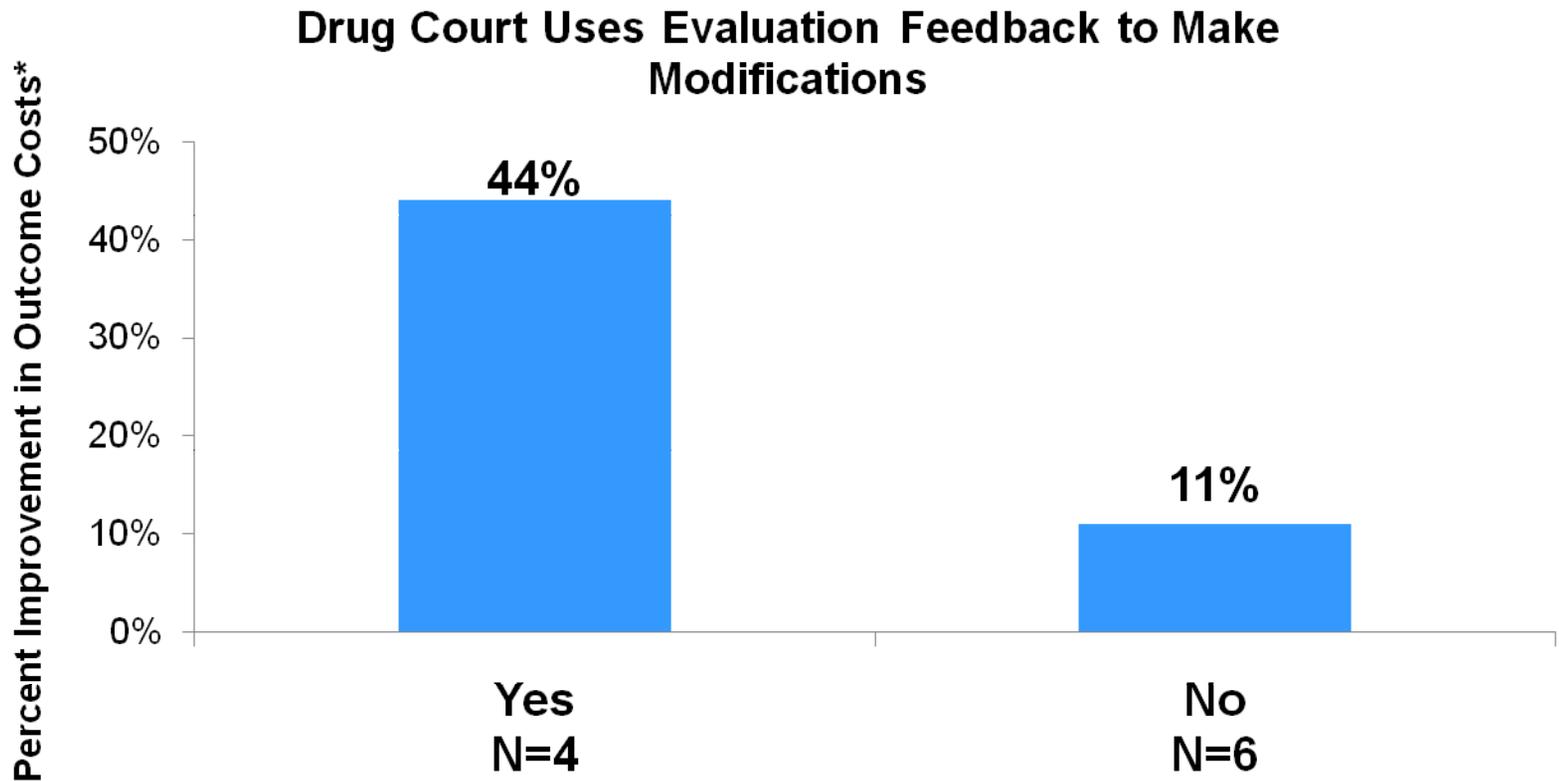
# Drug Courts That Used Paper Files Rather Than Electronic Databases Had Less Savings



\* "Percent improvement in outcome costs" refers to the percent savings for drug court compared to business-as-usual

Note: Difference is significant at  $p < .05$

# Drug Courts That Used Evaluation Feedback to Make Modifications Had 4 Times Greater Cost Savings



\* "Percent improvement in outcome costs" refers to the percent savings for drug court compared to business-as-usual

Note: Difference is significant at  $p < .05$

# Key Component #10

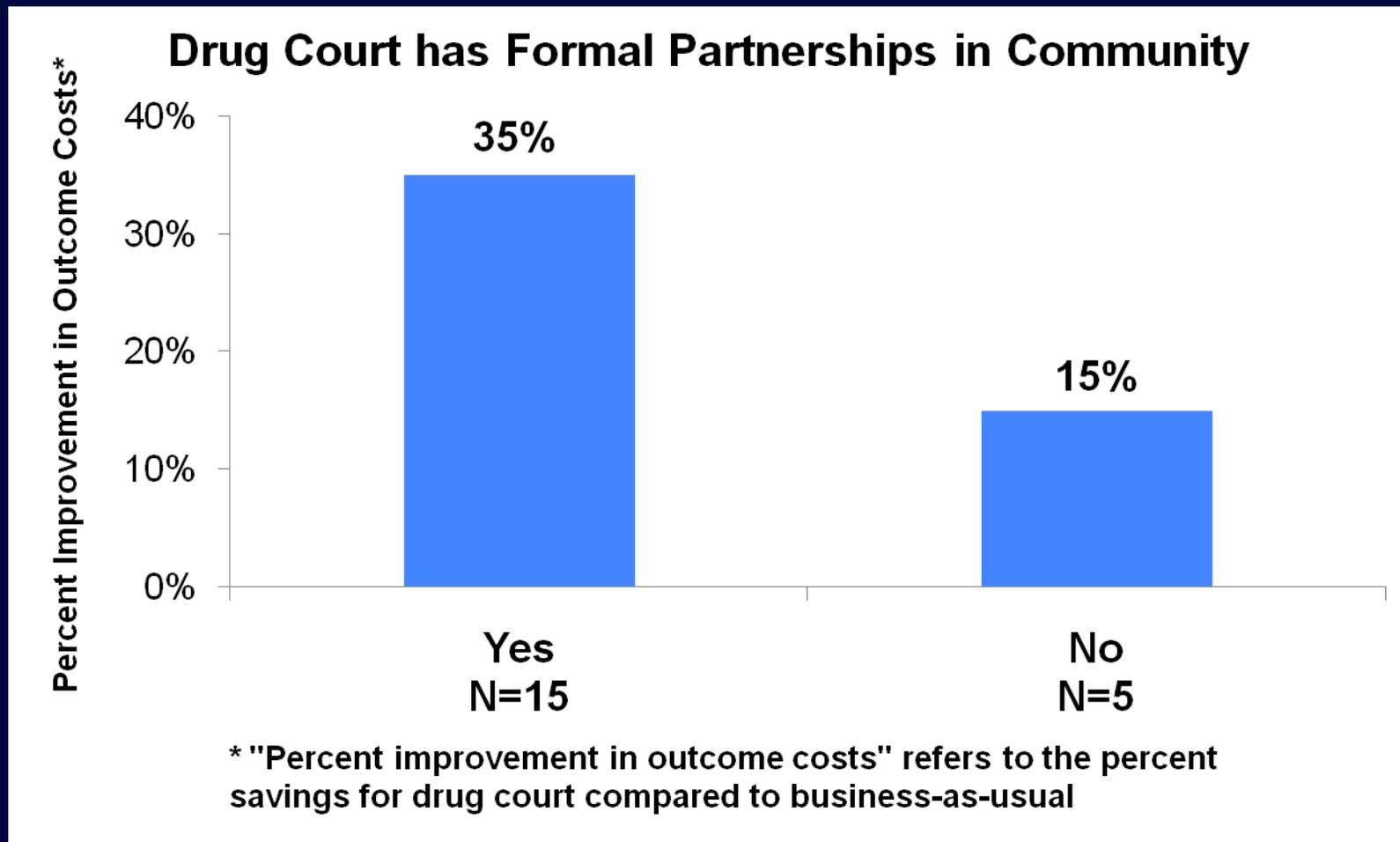
*“Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.”*

# Community Partnerships

- How important are partnerships in the community for your drug court?



# Drug Courts That Had Formal Partnerships with Community Organizations Had More than Twice the Savings



Note: Difference is significant as a trend at  $p < .15$

# Recipes for Failure

- **Water down the intervention**

- **Drop essential elements**

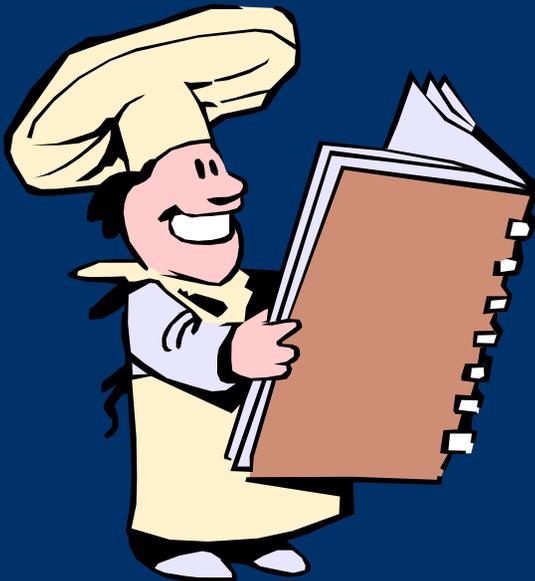


**“It’s not scalable”**

- **Accept imitations**



**“We’re just like a drug court”**



# Recipes for Failure

- **Change course with new populations**



• “It won’t work here”

• “My clients are different”

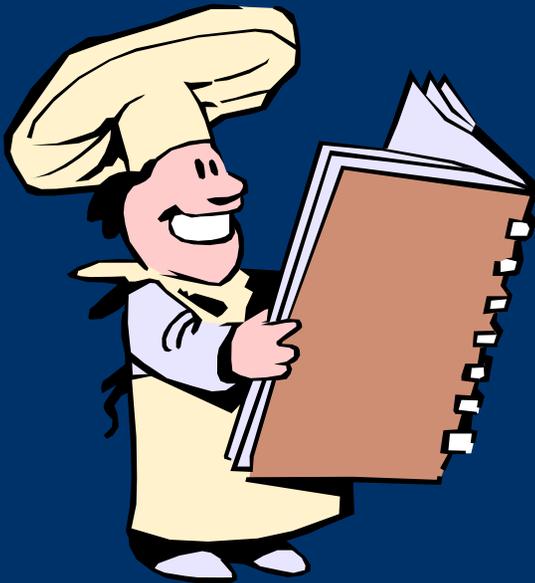
# Recipes for Failure

- **Stepped Care**

- **Start with less and ratchet up if you need to**

“It’s more economical”

“It’s less burdensome on clients”



# Recipes for Failure

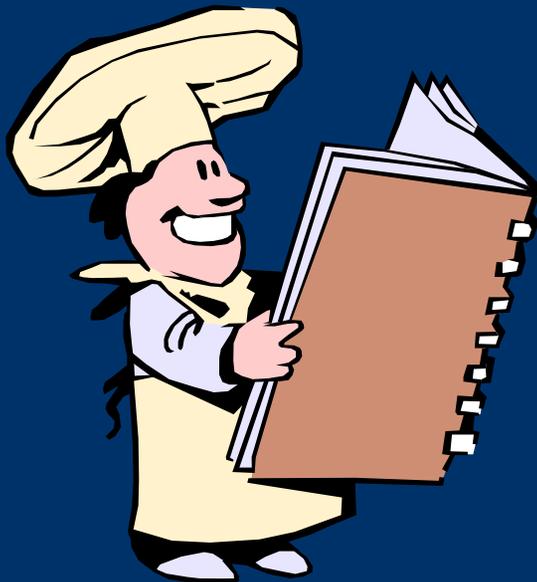
- **Target the wrong people**

- 1st-time offenders

◀..... “It’s safer”

- Low risk and low needs

◀..... “It’s a form of prevention”



◀..... “They’re more deserving”

# Recipe for Success

- Send us the high-value cases
- Fidelity to the *10 Key Components* until proven otherwise!
- Ongoing judicial authority
- Inter-agency team approach
- Branching model
  - Get it right the first time



**PROJECT REMOTE**

# Educational Objectives

- Understand the difference between physical dependence, diversion, substance abuse and addiction
- Understand addiction as a chronic lifelong neurobiological disease
- Understand that addiction is a treatable disease
- Understand what REMOTE is and why it is effective

# Mary G. McMasters, MD, FASAM

- Board Certified Internal Medicine
- Board Certified Addiction Medicine
- Board Certified Hospice and Palliative Care
- Co-Medical Director Project REMOTE
- Expert Witness USDOJ
- Old Country Addictionologist

# CONTACT INFORMATION

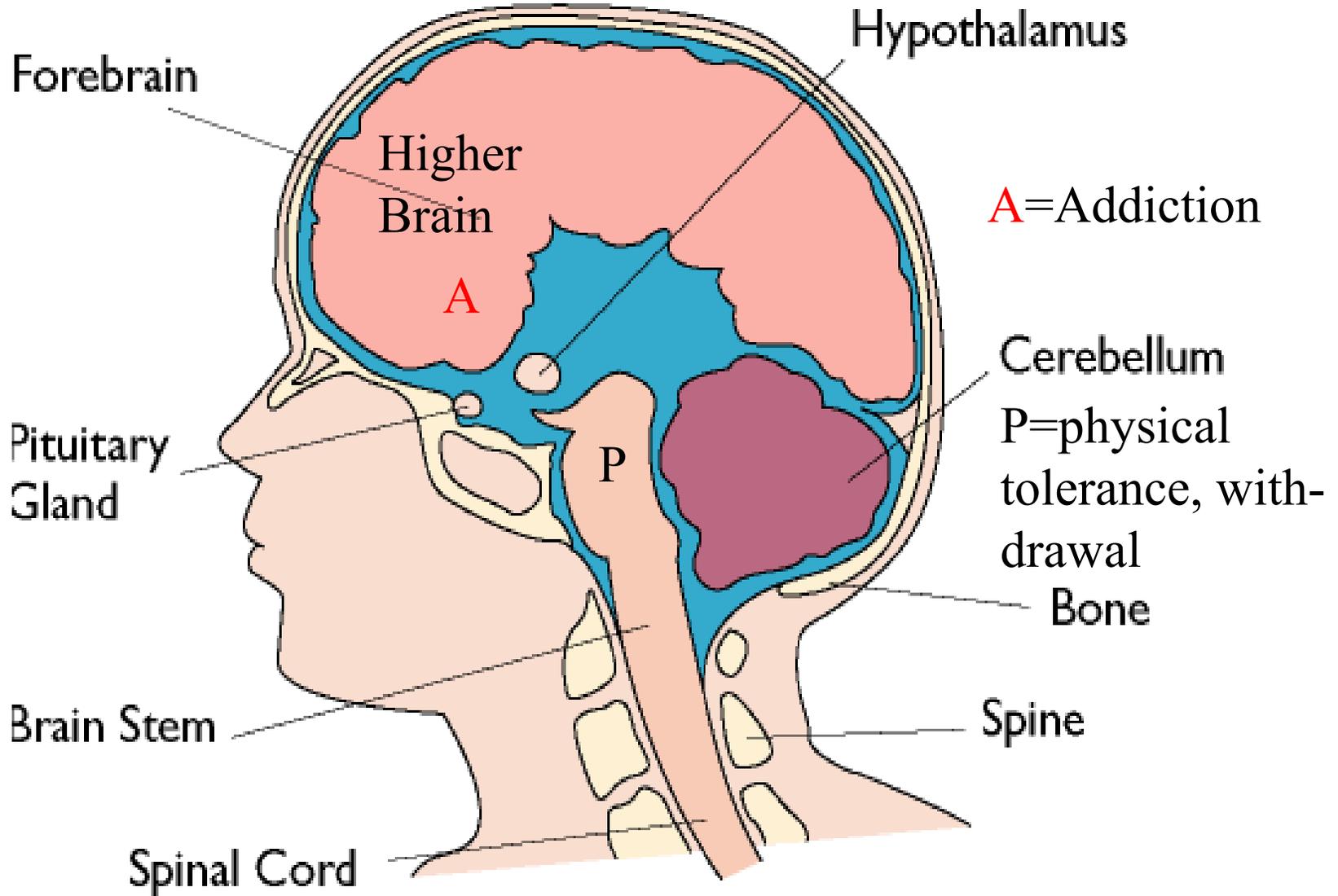
- 540-941-2500
- [mcmaste1@msu.edu](mailto:mcmaste1@msu.edu)
- 57 N. Medical Park Dr. Box 105  
Fishersville, VA 22939
- Physician Clinical Support System Mentor,  
SAMHSA, [www.PCSSmentor.org](http://www.PCSSmentor.org)

# Cheat Sheet

- Suboxone = Buprenorphine PLUS Nalaxone
- Subutex = Buprenorphine
- BNZs = Benzodiazepines
  - Antianxiety- ativan, xanax, valium, etc
  - Hypnotics (sleeping pills) – Lunesta, Ambien, etc.
- Controlled Substances- opiates (including suboxone), stimulants, benzodiazepines

# DEFINITIONS

- Physiological Adaptations to Medications
  - Tolerance
  - Withdrawal
- Substance Misuse Disorders
  - Diversion
  - Substance Abuse
  - Addiction



# Physical Adaptations

- Tolerance and Dependence
  - PHYSICAL
  - Physiological adjustment to MANY medications
    - Anti-depressants
    - Anti-hypertensives
  - NOT the same thing as addiction

# “Detoxing”

- Means to **WEAN** or slowly discontinue a medication to avoid painful physical symptoms.
- **ONLY** treats the physical dependence, **NOT** the addiction which is a higher brain malfunction.
- Just “detoxing” patients addicted to opiates is dangerous: it reduces resistance to respiratory depression while doing **NOTHING** for the addiction. Without strategies to resist their cravings, people relapse to opiates and they **DIE.**
- It is **AGAINST THE LAW** to detoxify a patient addicted to opioids by using other opioids (unless the reason is to treat a separate medical condition).

\*Heit HA; Dear DEA, Pain Medicine Vol 5 #3, 2004, 303-308

Substance Misuse Disorders:  
Dysfunction of the Higher Brain  
Some are a choice,  
Some ARE NOT

# DIVERSION

- Obtaining mood altering substances under false pretenses and diverting them to other people
  - To get high
  - FOR PROFIT.
- **DIVERSION IS BIG BUSINESS!!!!!!**

# SUBSTANCE ABUSE

- “the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological (or social or occupational) problem that is likely to have been caused or exacerbated by the substance.”

# ADDICTION

- “the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological (or social or occupational) problem that is likely to have been caused or exacerbated by the substance.”

» *AND*

- “persistent desire or unsuccessful efforts to cut down or control substance use.”



# THERE WAS A LOT OF ***DIVERSION*** GOING ON DURING THESE RIOTS:

- Underaged drinking (people over 21 were selling alcohol to minors)
- Ketamine was in use (diverted from veterinary use)
- Diverters (dealers) were making a lot of money (methadone is \$1/mg on the street)
- Drug dealers **VERY SELDOM** have the disease of addiction



# THERE WAS A LOT OF ***SUBSTANCE ABUSE*** GOING ON

- Fines
- Jail time
- Expelled from MSU
- ANGRY parents

These are effective in convincing substance abusers to quit or to be more responsible.



Police

POL.

12

Some of these students have the  
disease of ***ADDICTION***  
(they cannot stop abusing mood  
altering substances without help)

What Makes a Substance  
Addictive or Psychoactive or  
Reinforcing or Abuseable???

# Natural Rewards

Food  
Water  
Sex  
Nurturing

What is needed to trigger the natural reward center (elevate Dopamine) in the Forebrain?

- The substance must get into the blood
- The substance must cross the blood-brain barrier and get into the brain
- The substance must elevate Dopamine in the forebrain

# How Quickly can you get chemicals into the blood?

- Swallowing- VERY Slow
- Rub on Mucosa- Slow
- Inhale- Fast
- Inject into Blood- VERY Fast

# Well, This Is One Way Around That Pesky “Slow Release”

Abused  
Oxycontin



# Once Inside the Brain, What do Substances of Abuse DO?

- Trigger the Natural Reward System
  - Increase Dopamine in the Forebrain
    - The **FASTER**
    - The **HIGHER**
      - THE MORE ADDICTIVE
- **MANY** more things than Abused Substances can trigger this system

# Which Substances Elevate Brain Dopamine the BEST?

- Remember, the FASTER a substance elevates dopamine and the HIGHER it elevates it, the better the buzz
  - Low and Slow: methadone (used correctly), buprenorphine
  - A Little Bit Better: methadone misused, alcohol (depending on ETOH content), non-altered oxycontin
  - Still Better: Heroin rubbed on mucosa, dilaudid
  - THE “BEST”: methamphetamine, nicotine, injected heroin, altered and injected oxycontin

# Street Value

- 100 Vicodin \$500-\$800
- 100 Xanax 2mg \$1,000
- 4 Fentanyl patches 100ug \$400
- 100 Dilaudid 8mg \$4-8,000
- 100 Oxycontin 80mg \$8-16,000
- Methadone 1\$ per milligram

\* Beard, J Tobias, "Coke is the Real Thing; Fifty bucks and you're in with Charlottesville's favorite powder", C'VILLE CHARLOTTESVILLE NEWS & ARTS, 2/11/2008

# Non-controlled substances with street value

- Muscle Relaxants
- Remeron
- HIV medications
- Prednisone

***It's not about the Substance.***

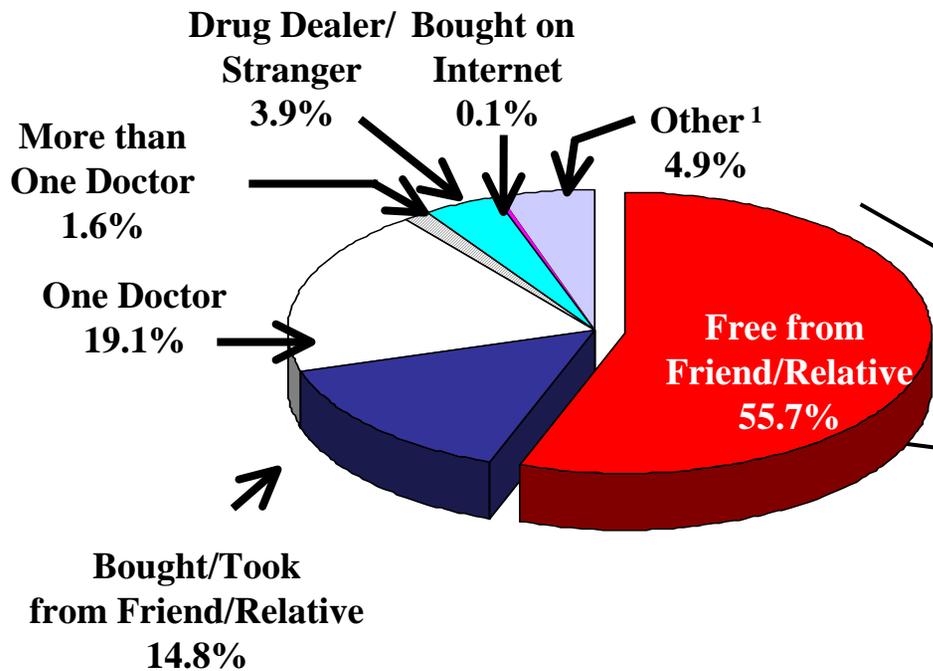
***It's about the Brain.***

# TRAMADOL

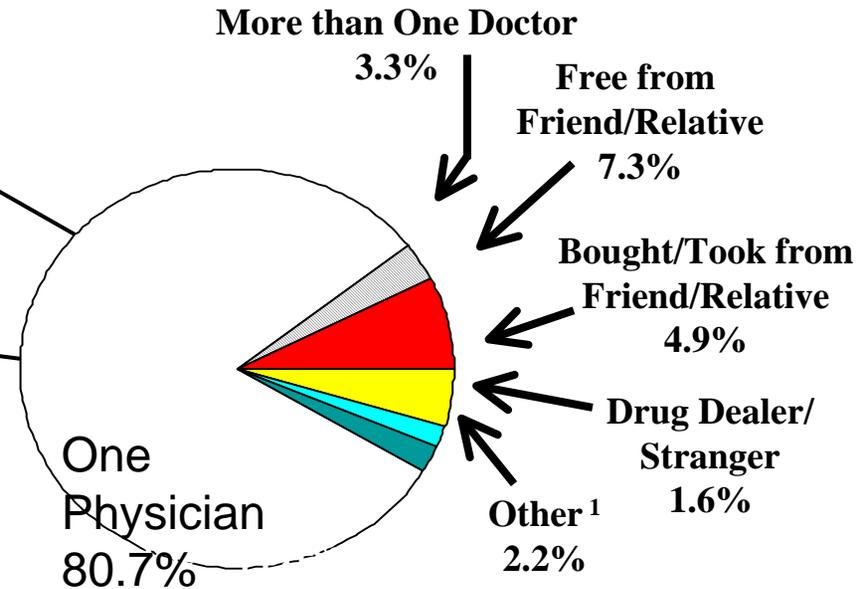
- **Hamas burns recreational drugs**  
Associated Press 4/20/2010
- GAZA CITY, Gaza Strip
- GAZA CITY, Gaza Strip (AP) — Gaza's Hamas rulers on Tuesday burned nearly 2 million pills of a painkiller many Gazans take recreationally

# Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2006

**Source Where Respondent Obtained**

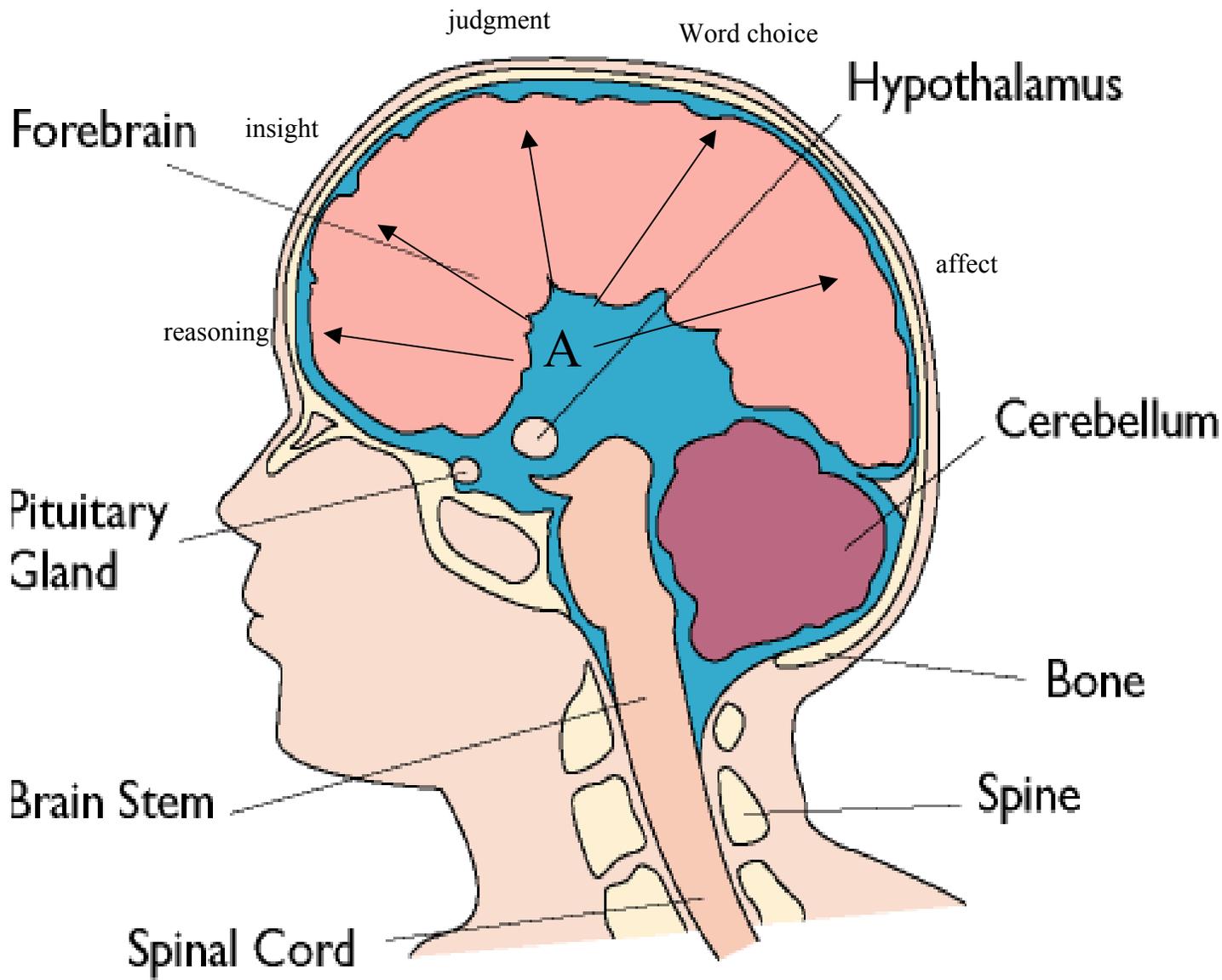


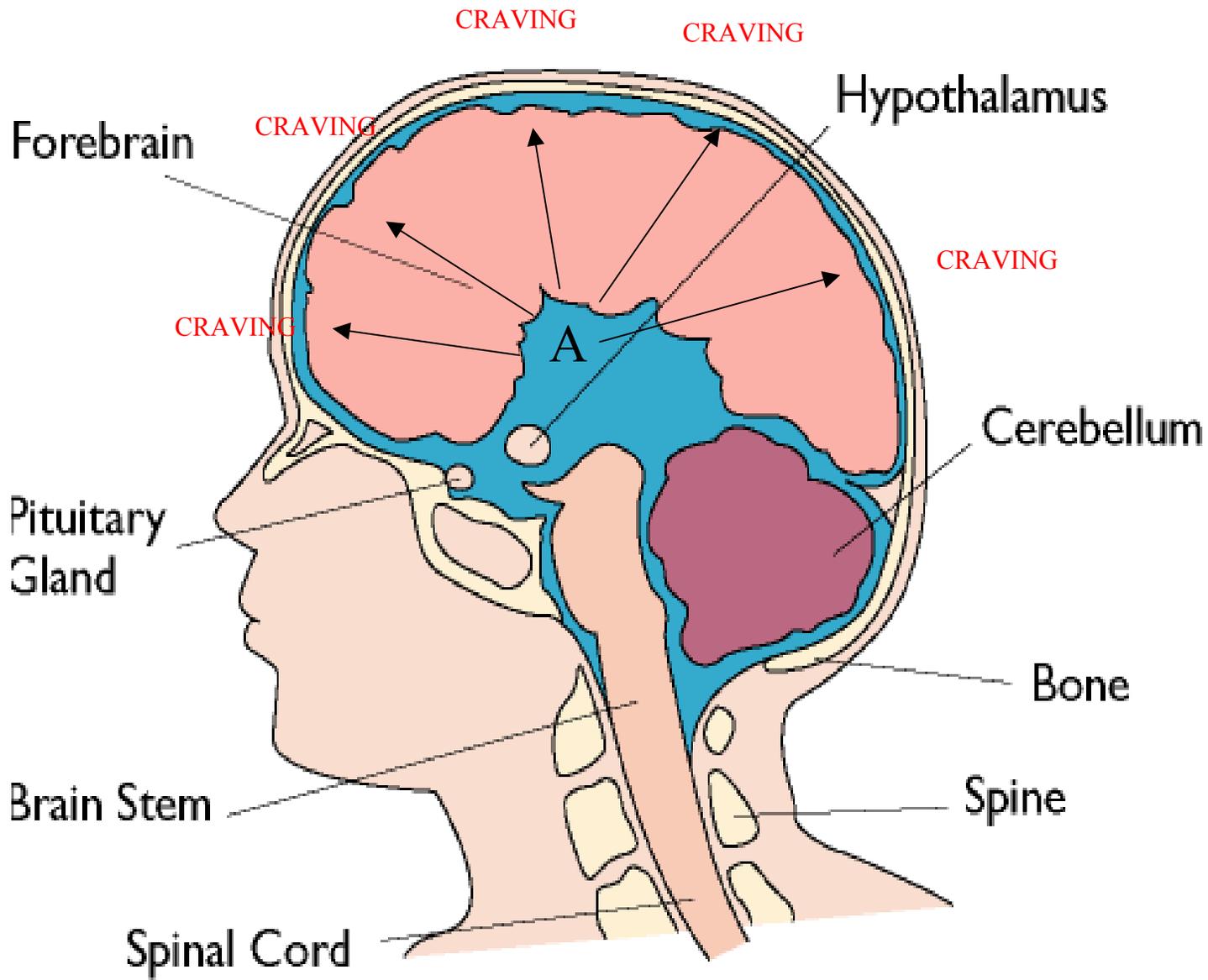
**Source Where Friend/Relative Obtained**



# What Changes Does Addiction Make to the Brain?

- Hard-wiring from the activated genetic disease
  - The reptile brain “hijacks” the mammalian brain
- Chemical induced damage
  - Reversible
  - Not reversible



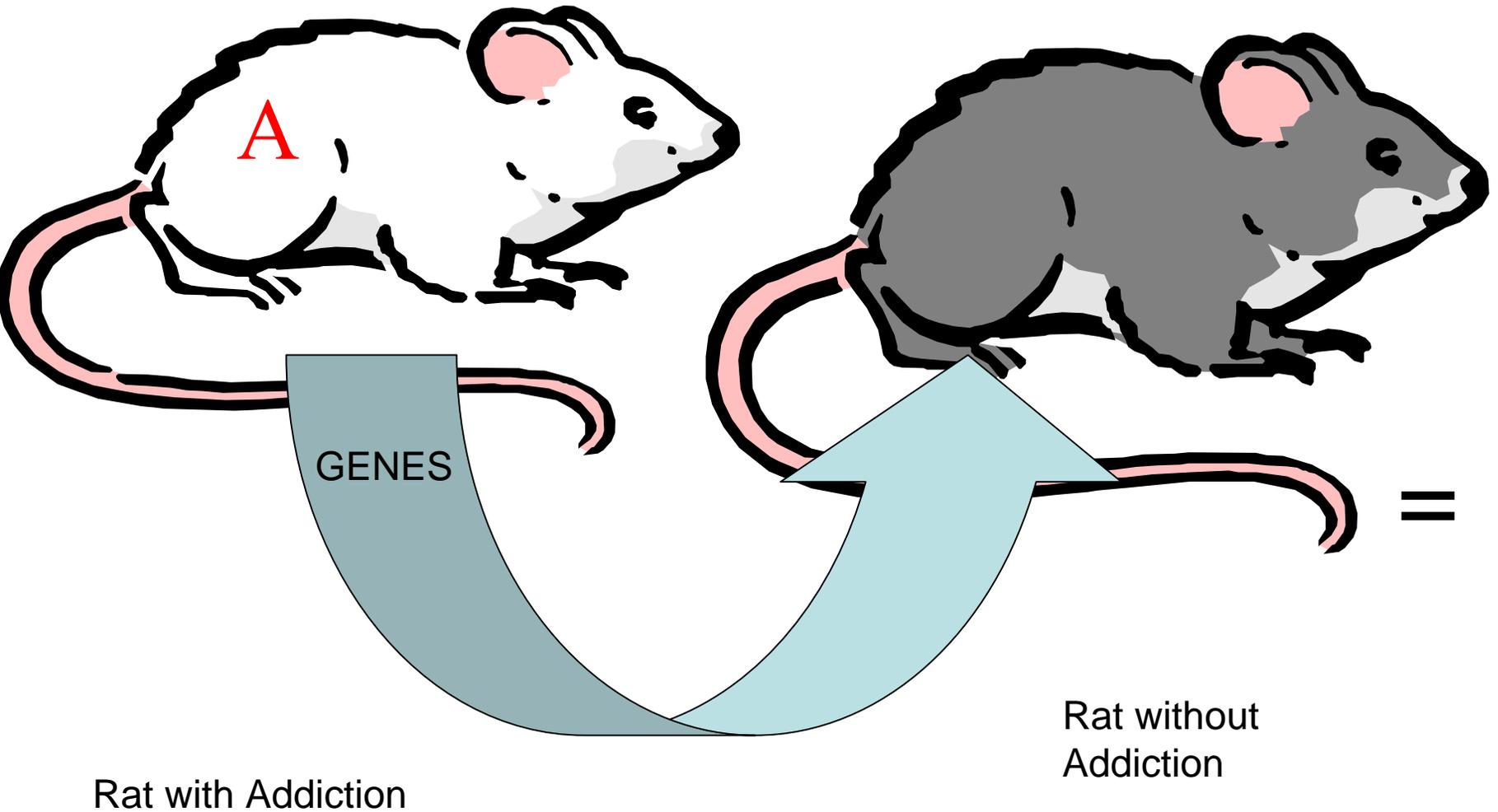


**ADDICTION IS NOT**  
**SUBSTANCE SPECIFIC!!!**

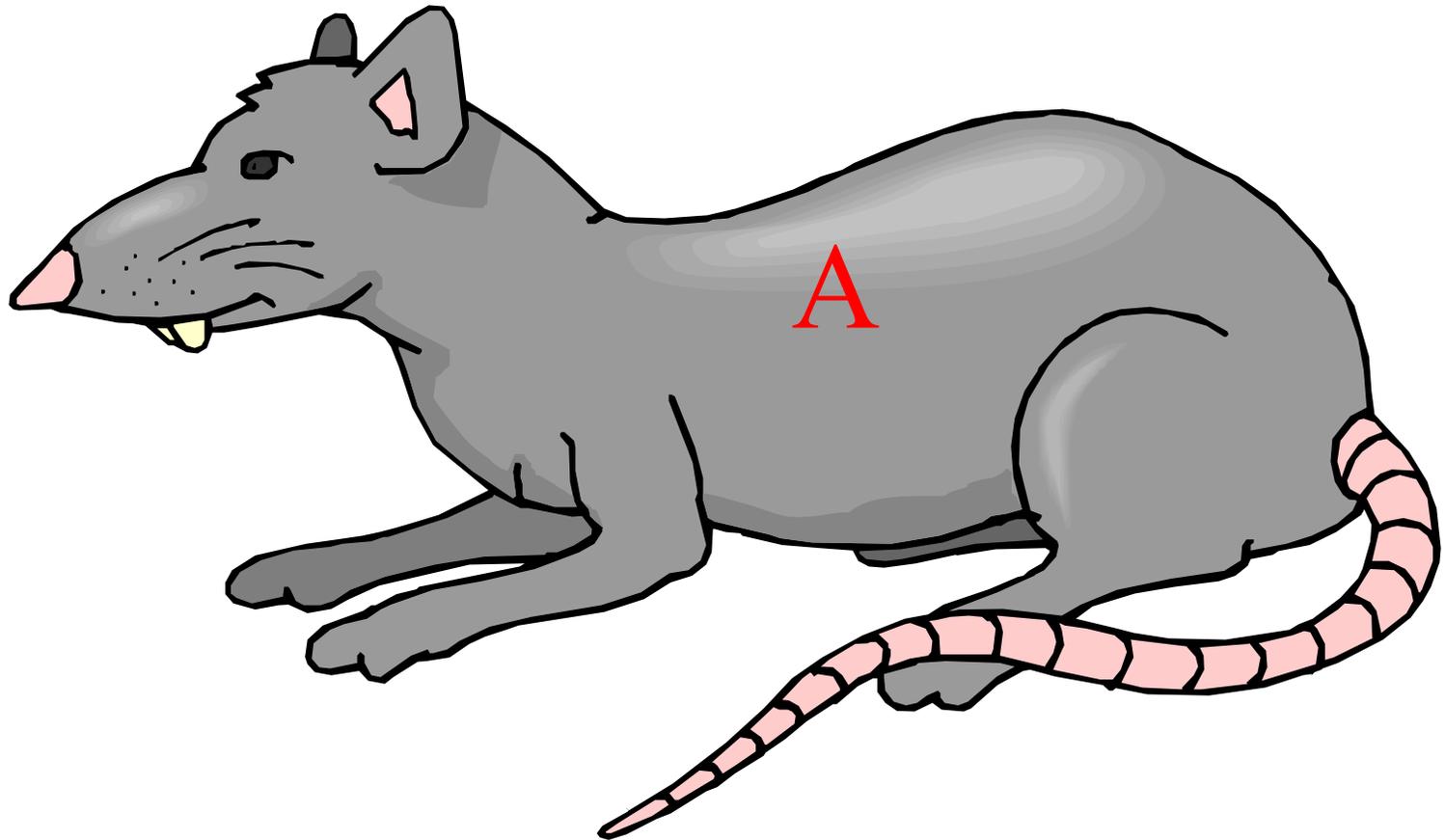
# What do you need to develop the disease of addiction?

- Genetic Predisposition  
AND
- Exposure to Psychoactive Substances

# Animal studies



# Rat with Addiction



# Genetic Predisposition

- Some people get *a lot* of genetic predisposition
  - Some American Indian nations
  - 60% inherited
- Some people don't have any genetic predisposition
  - CANNOT become addicted
  - CAN become physically dependent

# Exposure to Psychoactive Substances

- Long exposure to substances with low addictive potential
  - Many years of social drinking
    - Usually progresses from social to problem to addiction
- Short exposure to substances with high addictive potential
  - Snort cocaine, shoot heroin (or altered oxycontin)

Can people given pain medications  
for “real” pain develop the disease  
of Addiction?

YES!!!

Does that mean prescribers shouldn't treat  
patients  
with Addiction, or the genetic  
predisposition  
to develop Addiction, opioid pain  
Medication?

NO!!!

- Epidemiology- we have a staggering epidemic of prescription substance misuse
- Lethality- many people are dying due to substance abuse
- Cost- the price of substance misuse is a major contributor to the national debt
- Legality- prescribers are being scrutinized regarding their prescribing practices
- Pain continues to be poorly managed
- Prescriber Burn-Out

# Epidemiology

- While there are more opioid deaths in SW Virginia, no part of the state is immune to the Substance Abuse Epidemic
  - Equal amounts of abuse throughout the state
  - More lethal substances being used in SW Virginia

# Lethality

- In 2006, 12.5/100,000 Virginians died in MVAs\*
- In 2007, 11.3/100,000 Virginians aged 35-54 died due to drug poisoning (most polypharmacy deaths involving opioids)\*\*
- opioid dependent patients 13x more likely to die than their age- and sex- matched peers in the general population\*\*\*
- “Among people age 35 to 54 years old, unintentional poisoning surpassed motor vehicle crashes as the leading cause of death in 2005”\*\*\*\*

\*Kaiser State Health Facts <http://www.statehealthfacts.org/profileind.jsp?cat=2&sub=35&rgn=48>

\*\*DAWN [https://dawninfo.samhsa.gov/files/ME2007/ME\\_07\\_state.pdf](https://dawninfo.samhsa.gov/files/ME2007/ME_07_state.pdf)

\*\*\* Gibson A, Degenhardt L, Mattick RP, et al. (2008). Exposure to opioid maintenance treatment reduces long-term mortality

\*\*\*\*Reuters, “Prescription Drug Overdoses on the Rise in U.S.” Tuesday, April 06, 2010, Associated Press FOX News Network

# Cost

- Treated and untreated substance use including ETOH: 62 Billion dollars in 2008 for healthcare alone (more in crime and welfare costs)\*
- Audit of five large states 2006-7 found 65,000 Medicaid recipients improperly obtained potentially addictive drugs- \$65 million dollars\*\*
- 938,586 urine drug screens from over 500,000 patients prescribed chronic opiates showed only 25% taking their medications as directed\*\*\*

8Chalk, Mady, "Medical Costs of Unrecognized, Untreated substance Dependence: A Case for Health Reform", Behavioral Health Central, 2009

\*\*Kiely, Kathy, "GAO report: Millions in fraud, drug abuse clogs Medicaid, 2009. <http://www.usatoday.com/news/health/2009-09-29-Medicaid-drug-abuse-fraud.htm>

\*\*\*Leider, Couto, Population Health Management 9/3/2009

# The Economics of active substance misuse

- **Hundreds** of dollars per day (\$3000-4000/month, \$200-300 per day)
  - However, cessation of use often means cessation of money making activities associated with use
- Crime
- Disease transmission
- Disability
- Lack of productivity
- Death

# Economics of active substance use con't

## **(the myth of “self-medication”)**

- Misdiagnoses
  - DSM: **NO MAJOR MENTAL ILLNESS CAN BE DIAGNOSED UNTIL A PATIENT HAS BEEN SUBSTANCE FREE FOR AT LEAST SIX MONTHS**
  - Example:
    - Patient admitted for BAD mania
    - No UDS done, no questions asked
    - Using Methamphetamine
    - Cost of admission ???
    - Likely to be readmitted for same thing

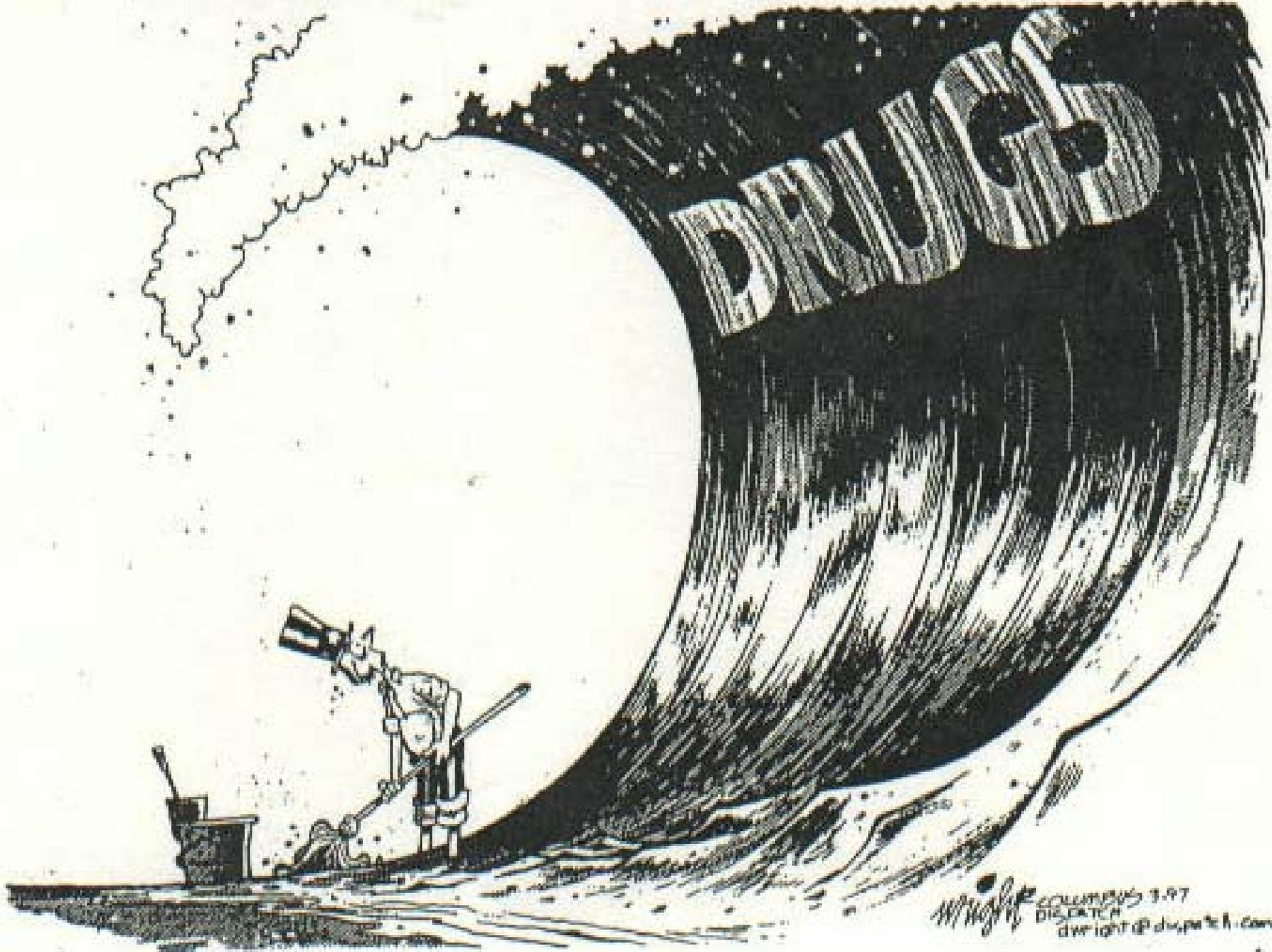
# The Economics of active substance use con't

- 24yo admitted for routine cholecystectomy
  - No UDS done
  - No questions asked
  - One week in ICU, another on the floor
    - Final diagnosis: “atypical reaction to anesthesia”
  - Addicted, actively using opiates and BNZs

# The Economics of active substance use con't

- 34yo diagnosed with depression, BAD
  - Meds\*
    - Buspar 30mg per day \$158.07/month
    - Lamictal 200mg twice per day \$389.99/month
    - Lexapro 20mg per day \$105.99/month
    - Atenolol \$14.99/month
    - Seroquel 50mg one or two per day \$506.97/month
    - Ativan 2mg 3x/day, \$65.97/month
      - » TOTAL: \$1241.98/month!!!!!!
  - UDS + for opiates, BNZs and PCP
  - Admits to only being substance free for four months since age 15.

\*drug prices from Drugstore.com



*W. Wright*  
COLUMBIAS 9-97  
DISPATCH  
dwright@dispatch.com

# Legality

- The DEA **IS NOT** out to get prescribers.
- The State Board of Medicine **IS NOT** listening outside the exam room door

HOWEVER

Prescribers **CAN** get into trouble for failing to practice good medicine when prescribing controlled substances

# From a VA Board of Medicine's Order of Summary Suspension 8/19/2009

- Dr. X prescribed BNZs and narcotics...without an adequate medical indication or diagnosis, developing and adequate treatment plan, performing urine drug tests... commenced prescribing narcotics without obtaining prior treatment records to verify.....
- Dr. X failed to appropriately respond to signs that the patient was misusing or abusing his medications (controlled substances)
- Failure to refer for substance abuse treatment
- Dr. X prescribed Suboxone to treat the patient's narcotics addiction even though he was not qualified or registered to dispense narcotic drugs for addiction treatment as required by Federal law and regulation (Controlled Substance Act of 1970, 21 U.S.C.801 et.seq. and Federal Regulations 21 C.F.R. 1306.04 and 1306.07).

# UNIVERSAL PRECAUTIONS FOR PRESCRIBING CONTROLLED SUBSTANCES<sup>[i]</sup>: **EVERY PATIENT, EVERY TIME**

- IDENTIFY: Ask for picture identification. Confirm the diagnosis
- Try the less risky interventions for pain first: PT, NSAIDS, etc. *TREATING PAIN WITH NON-NARCOTIC INTERVENTIONS IS TREATING PAIN.*
- Get informed consent: Controlled Substance Agreement. This should always include permission to query the Virginia Prescription Monitoring Program.
- Do a UDS. This protects the patient AND YOU.
- Assess Risk Factors for Substance Misuse Disorders
  - Family History (Addiction is a GENETIC disease)
  - Current Addictions (This includes smoking)
  - Behaviors symptomatic of a Substance Misuse Disorders (Legal problems, MVAs, DUIs, etc)
- Assess Functioning
- Do a Time limited Trial (Expectations: No problematic behavior, IMPROVED FUNCTIONING)
- Have an Exit Strategy (know how to wean what you start; know where to refer patients with substance misuse problems)
- Periodic Reassessment
- Give the fewest number of pills possible with the lowest abuse potential
- DOCUMENT, DOCUMENT, DOCUMENT

## ***THE BOTTOM LINE: FUNCTIONING***

IF YOU ARE TREATING PAIN, FUNCTIONING GETS BETTER  
IF YOU ARE FEEDING AN ADDICTION, FUNCTIONING GETS WORSE

## ***THE BOTTOM LINE:***

# **FUNCTIONING**

- IF YOU ARE TREATING PAIN,  
FUNCTIONING GETS BETTER
- IF YOU ARE FEEDING AN ADDICTION,  
FUNCTIONING GETS WORSE

# PILL MILLS AND THEIR PROVIDERS

- Patients pay money for the prescribing of controlled substances instead of responsible medical care
- Includes controlled medications for pain, addiction, ADHD, anxiety, etc.
- Very hard to prove- what is the standard of care?
- Cross State Lines- hard to regulate
- Undermines good pain management and addiction treatment
- LUCRATIVE

# THE GOOD NEWS

- Substance Abuse and Diversion are preventable
- Addiction is treatable
- Health Care Reform includes measures to address the Addiction epidemic

# OUR COMMUNITY...OUR RESPONSIBILITY

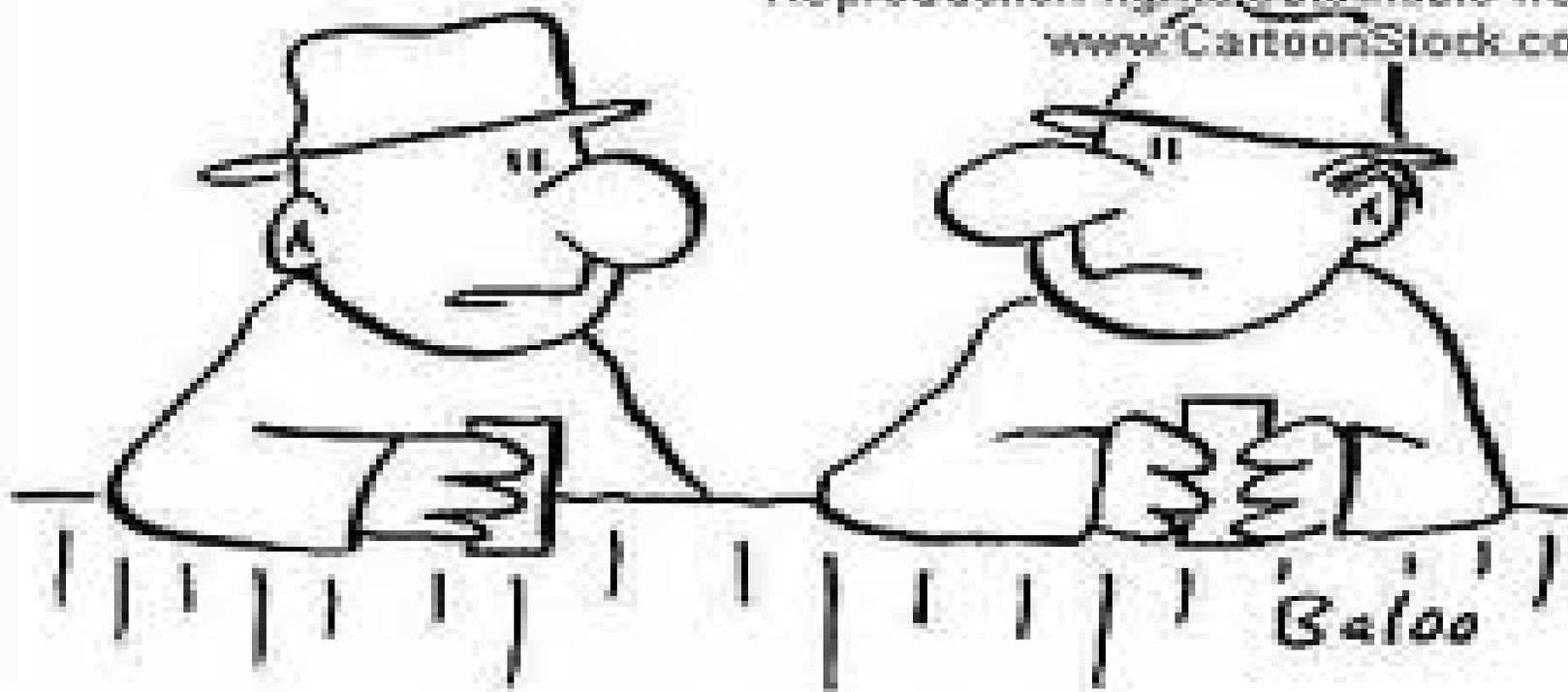


Appalachian Substance Abuse Coalition for Prevention & Treatment

# TREATING ADDICTION

- THE MAINSTAY OF ADDICTION TREATMENT IS ABSTINENCE COUNSELING
- 12 STEP PROGRAMS **ARE** EFFECTIVE AND COST EFFECTIVE
  - FREE
  - WIDELY AVAILABLE
- MEDICATIONS AS ADJUNCT

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search ID: mman2524

"I'd like to join Alcoholics Anonymous,  
but I'm afraid of getting mixed up  
in a cult."

# MEDICATION ASSISTED ADDICTION TREATMENT- primarily **decrease cravings**

- Medication- (FDA approved)
  - Nicotine
    - Varenicline
    - Nicotine Replacement
  - Alcohol
    - Acamprosate
    - Naltrexone (pills and injections)
  - Opioids
    - Methadone (Methadone Maintenance Therapy- MMT)
    - Buprenorphine

WHAT ABOUT  
METHADONE CLINICS????

# The Problem

- In the United States, very few people addicted to narcotics who WANT to stop using have access to treatment
- DEA control “unique for an approved and effective medical therapy” MMT
  - Process-oriented not treatment-oriented
- Primarily urban
- Patients must be present 6-7 days/week for up to 2 years
- No funding. Patients pay out-of-pocket

# Impact of MMT

- Reduction death rates (Grondblah '90)
- Reduction IVDU (Ball & Ross '91)
- Reduction crime days (Ball & Ross)
- Reduction rate of HIV seroconversion (Bourne '88, Novick '90, Metzger '93)
- Reduction relapse to IVDU (Ball & Ross)
- Improved employment, health & social function (J. Thomas Payte, MD)

# Before Buprenorphine con't

- Increasing high rates seroconversion among IVDA
  - HIV
  - Hepatitis
- Crime (though this was not mentioned as a reason in government documents)
  - 80% incarcerated prisoners there due to drug crimes

# New Initiatives- Buprenorphine

- 2000 Drug Addiction Treatment Act
  - Exemptions for ***office-based*** opioid agonist treatment
    - DEA Waivered Physicians
      - Special training
      - Special license
    - Buprenorphine
      - Limited # of patients
    - **MUST** ensure counseling

# Who Should Get Suboxone?

- Strong cravings
- Many failed attempts to quit
- Relapse despite a “good program”
- Long history of active addiction
  - Not just opiates
- Strong family history

# Safe Suboxone Prescribing

- Do not prescribe suboxone to patients who are not utilizing abstinence counseling
- Avoid using subutex (more abuse able)
- Do frequent urine drug screens
- Do not ignore the results of urine drug screens
- ***Do not detoxify patients using suboxone (or any other opioid). This is BAD MEDICINE and AGAINST THE LAW***
- Do not wean patients prematurely from suboxone
- Monitor functioning

# What to Look For in a Suboxone Provider (or a MMT Program?):

- Follows the Universal Precautions for ALL controlled substance prescribing
- Communicates freely with the court system
- Works as part of a team to devise a treatment plan for the patient/client
- Sets good limits
- Result oriented, not process oriented
- Follows TIPS

# Abuse of Suboxone

- Is it REALLY Suboxone being abused???
- SL buprenorphine formulations have a low rate of abuse based on toxico-surveillance data, Smith MY, ABUSE OF BUPRENORPHINE IN THE UNITED STATES:2003-2005, Journal of Addictive Diseases Vol 26 Issue 3, 1055-0887

# Abuse of Suboxone con't

- Increase in abuse, then decrease
  - “the poly-substance-abusing population, for whom buprenorphine is intended, experimented with this medication for its mood-altering effects for a period of time, but presumable because of its lack of euphorogenic properties, its use has now dissipated.” Cicero TJ, Surratt HL, Inciardi J, USE AND MISUSE OF BUPRENORPHINE IN THE MANAGEMENT OF OPIOID ADDICTION, Journal of Opioid Management 2007 Nov-Dec;3(6):302-8

# Abuse of Suboxone con't

- So, if it isn't a "good buzz", why is Suboxone on the street?
  - Avoiding withdrawal until the good stuff comes in
  - Stockpiling for dry spells
  - Enables short periods of good functioning
  - Self-treatment of Addiction
- The same reasons most methadone is on the street

# Treatment and REMOTE



# TREATMENT EFFECTIVENESS

The California Drug and Alcohol Treatment Assessment (CALDATA) Findings on the Effectiveness of Treatment (1994)[\[1\]](#)

- Health care findings included one-third reductions in hospitalizations after treatment
- Criminal activity declined by two-thirds after treatment
- Alcohol and drug use declined by two-fifths after treatment
- Improved employment and economic situations
- Treatment effective for a variety of substances including stimulants (crack cocaine, powdered cocaine, methamphetamines), ETOH, heroin
- No difference in gender, age or ethnicity
- Benefits to taxpayers persisted through 2nd year of follow-up
- Most financial benefits gleaned through reduction in crime

# Con't

- Cost-benefits ratio: the benefits of alcohol and other drug treatment outweighed the costs of treatment by ratios from 4:1 to greater than 12:1, depending on the type of treatment.

New York City sees 70% drop in homicides, “New York also turned aggressively to drug treatment and mental health counseling”

[ii]

[i] Gerstein DR, Johnson RA, Larison CL, “Alcohol and other Drug treatment for Parents and Welfare Recipients: Outcomes, Costs and Benefits”, USDHHS HHS-100-95-0036, <http://aspe.hhs.gov/hsp/caldrug/calfin97.htm#Table%20of%20Contents>

[iii] [Michael Powell](#), Washington Post Staff Writer, Friday, November 24, 2006; Page A03

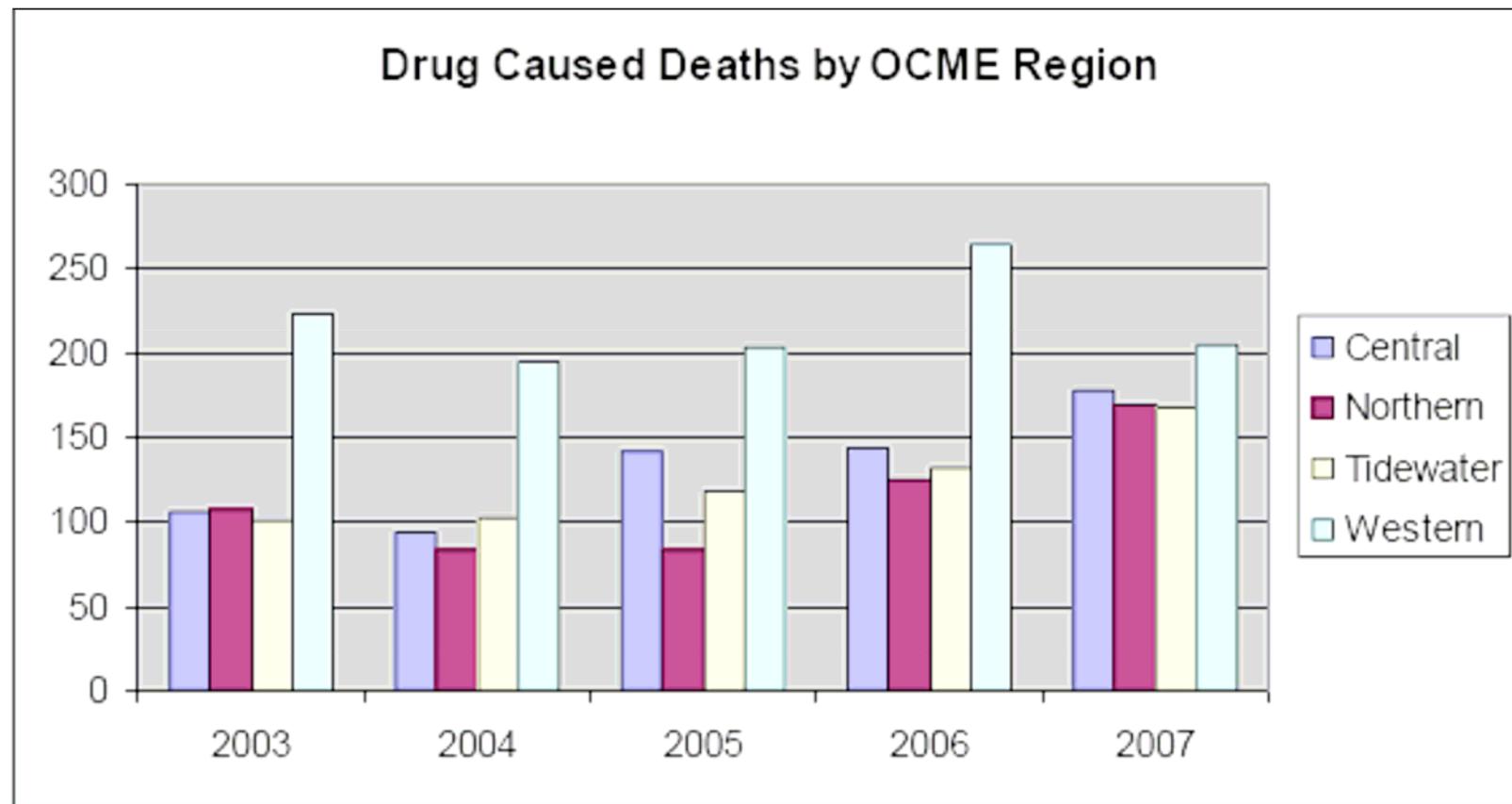
# RURAL ENHANCED MODEL FOR OPIOID TREATMENT EXPANSION

- Buchanan, Dickenson, Lee, Russell, Scott, Wise counties, City of Norton
- Improve availability of treatment for addiction and substance abuse
- Recruit and train physicians in addiction medicine
- Increase detoxification services
- Increase outpatient counseling services

# Con't

- Expand peer support and family support groups
- Increase recovery support services to sustain the positive effects of treatment, prevent relapse and facilitate re-entry to a higher level of service if relapse occurs
- Focused on treating persons addicted to opiates through abuse of prescription medications

# Virginia SUD Epidemiology



OCME Annual Reports, 2003-2007

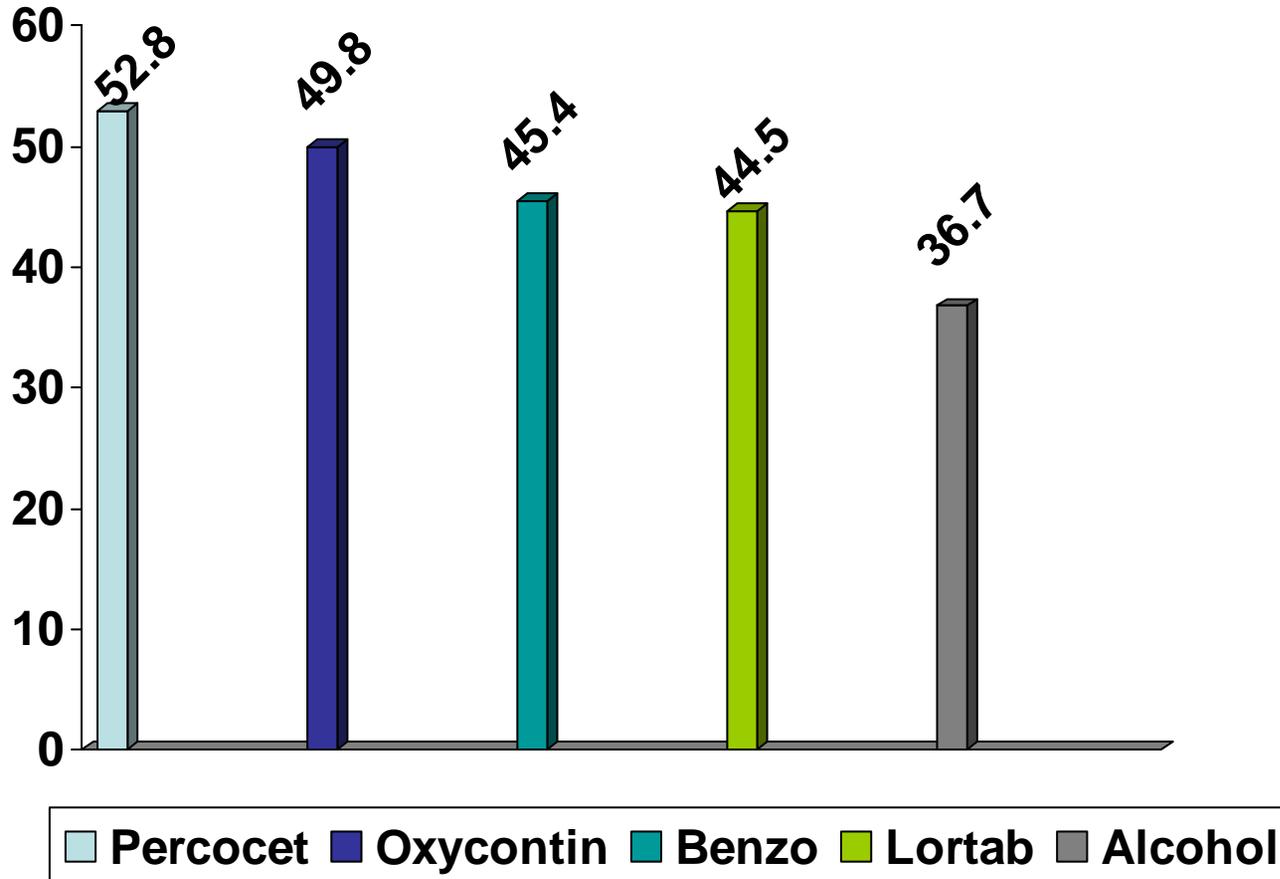
# Funding

- SAMHSA Treatment Capacity Expansion grant TI17318 SJ318
- Delivered through publicly funded community service boards in SW VA
- Funded for three years, \$500,000 each year 2007-2009
- NOT a research grant though it included stringent outcomes data collection

# Funding con't

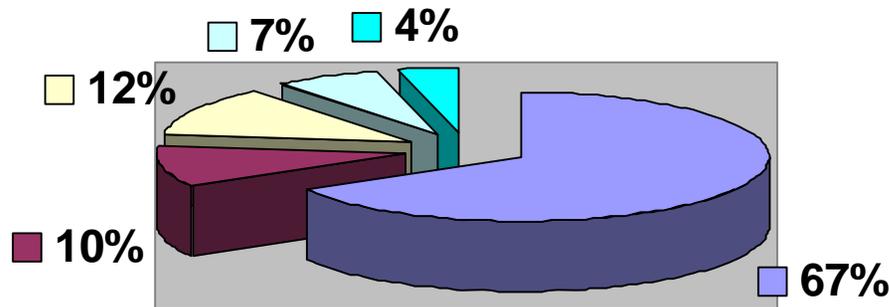
- Participants paid half, if able
- Utilized Medicaid and private insurance when available
- Unit SAMHSA cost (including other payment options) \$3,082

Project REMOTE  
Drug Use Report on Intake  
229 enrolled  
*Stats from intake GPRA*



# Project REMOTE

## Treatment Referral Options



- Buprenorphine induction w/follow-up Office Based Treatment
- Buprenorphine induction w/follow-up opioid treatment (methadone)
- Buprenorphine induction with follow-up opioid treatment (buprenorphine)
- Drug-Free
- Never Started Treatment

# Project REMOTE

## What services were provided?

- Treatment is not just about medication. It is about changing habits and lifestyles to support recovery.
- A complete continuum of services was available to participants:
  - Outpatient (Suboxone and evidence-based counseling practices) -3,430 hours

# Project REMOTE

What services were provided? (continued)

- Case Management (transportation, coordination with physicians, help finding income supports)-3,513 hours
- Opioid Treatment Services (methadone and counseling): 408.75 hours
- Residential detoxification (includes Suboxone): 293 days

# Did it Work?

- Goals
  - Increase availability of Addiction treatment
    - Suboxone
      - Increased # providers
  - Decrease deaths
  - Improve functioning among people receiving Suboxone

# Increase in Suboxone Providers

- # physicians trained and licensed to provide suboxone treatment in REMOTE service area and “open to all comers”:13
- # physicians trained and licensed to provide suboxone treatment in Albermarle County/Charlottesville and “open to all comers”:1
- From zip code search Buprenorphine Physician Locator, SAMHSA and categorization by myself and Karen Smith, REMOTE coordinator.

# Death Rates

## Drug Deaths (actual):Drug Deaths/100,000

COUNTY	2005		2006		2007		2008	
Augusta	2	2.9	2	2.8	6	8.5	11	15.4
Buchanan*	11	44.4	8	32.8	7	29.3	10	42.5
Dickenson*	6	36.9	8	49.4	10	61.9	11	67.1
Lee	8	33.8	5	21	4	17	2	8.5
Norton (city)	1	27.2	1	27.4	0	0	2	54.0
Russell	11	38	12	41.7	9	31.2	5	17.3
Scott			0	0	4	17.6	3	13.1
Wise	10	23.8	21	50.1	25	60	8	19.2

\* Did not have a providing physician until last 6 months of the grant

From Annual reports, Virginia Office of the Chief Medical Examiner  
<http://www.vdh.virginia.gov/medExam/Reports.htm>

# Percentage Fentanyl, Hydrocodone, Methadone, Oxycodone Deaths

## COUNTY 2008

- Augusta 55%
- Buchanan 70%
- Dickenson 73%
- Lee 100%
- Norton (city) 50%
- Russell 80%
- Scott 100%
- Wise 63%

From Annual reports,  
Virginia Office of the  
Chief Medical Examiner  
<http://www.vdh.virginia.gov/medExam/Reports.htm>

# Who was Served?

- Served 229 individuals in 3 years
- 46% male, 54% female
- 71% younger than 35
- All opiate dependent due to abuse of prescription pain medication

# Project REMOTE

## What was the impact of services?

- Decrease in injection drug abuse - 86%
- Increase in abstinence – 405%
- Increase in employment/educational activity – 65%
- Decrease in alcohol or illegal drug-related health, behavioral or social consequences – 138%
- Increase in permanent, stable housing- 15%
- Crime and Criminal Justice – 92.7% had no arrests in the past 30 days.

# Project REMOTE

What was the impact of services?

(continued)

- Increase in recovery support services in the community (AA/NA, Celebrate Recovery, Al-Anon, and faith based services)
- Increase in Treatment compliance
- Increase in compliance with Probation and Parole (paying fines, etc.)
- No suicides, overdoses or deaths by accident due to impairment while participants were enrolled in REMOTE
- No one involved in accidents or injuries due to impairment while enrolled in REMOTE

# Project REMOTE

## What made it work?

- Use of evidence-based practices, including:
  - Clinically appropriate medication-assisted treatment
  - Counseling using evidence-based approaches
  - Wrap-around services (case management to access other supports)
  - Involvement with Recovery Oriented Support Organizations such as AA/NA, Celebrate Recovery, Al-Anon and other faith based support systems
  - Strong community involvement (Appalachian Substance Abuse Coalition and other partners)

# Project REMOTE

## What made it work? (Continued)

- Heavy emphasis on community health professional education about addiction, pain management, use of the Prescription Monitoring Program
- Utilized resources of Recovery Oriented Support Community (i.e. AA/NA, Celebrate Recovery, Al-Anon, and faith based recovery support supports)
- Received referrals from Probation, Drug Court, and Department of Mines, Minerals, and Energy

# Project REMOTE

## What made it work? (Continued)

- Used Evidence Based Interventions
- Tailored for the community
- Avoided DRAGONS

# DRAGONS 101



# Dragons 101 from J.R.R. Tolkien

- Dragons are mean
- Dragons are greedy
- Dragons love gold
  - They don't display it
  - They don't make pretty things out of it
  - They aren't even sure what is in their gold collection
  - They hoard gold sometimes for centuries
- They sleep on their gold collections
- They foul their beds of gold

# Dragons 101 con't

- BUT, if anyone else shows an interest in their beds of gold, they

***SMOKE THEM!!!!!!!!!!!!***

# Pile of gold



LOST LIVES

ECONOMIC  
COSTS:

CRIME

WELFARE

NATIONAL  
SECURITY  
THREAT

DISABILITY

# Examples of Dragons: The Quack

“My pill (procedure, treatment, etc) will fix everything!! You won’t have to work very hard and your problems will soon be over. Buy now-----”





THE ROTTEN RESEARCHER:  
“Addiction is a chronic life-long brain disease and my research shows that my treatment provides an effective long-term cure (up to 16 weeks). By the way, **NOTHING ELSE WORKS**, particularly not that 12 step stuff (because it doesn’t make my BIG pharmaceutical company any money).”

“There’s no way but NA.”



“This is a moral issue, nothing more!!”



“This is a law enforcement issue, nothing more!!!”



## “Self-medication” Dragon

“I know why you abuse Oxycontin. You hate your Grandmother! Your puppy dog died when you were eight! Your wife is frigid! Your last doctor was an idiot! You’ve never gotten the right antidepressant/ADHD medication/anxiety pill (fill in the blank) for your depression/ADHD/anxiety (fill in the blank)! “



# Project REMOTE

## What made it work? (Continued)

### ADVISORY BOARD

- Legislators
- Coalfield Coalition
- Other treatment providers
- Local law enforcement and DEA
- Attorney General's Prescription Drug Task Force
- Physicians
- Pharmacists
- Medical Schools and health provider training programs
- Directors of local health departments and community health centers
- Educators
- Faith-based organizations
- Office of Substance Abuse Opioid Treatment Consultant and Pharmacist
- Mid-Atlantic ATTC
- Recovering residents of target communities

# PROJECT REMOTE



# References

- All REMOTE data from Karen Smith, CMCSB, PO Box 810, Cedar Bluff, VA 24609, 276-964-6702, ksmith@cmcsb.com
- Anton et al, Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence, The COMBINE Study: A Randomized Controlled Trial, JAMA 2006;295:2003-2017
- Federation of State Medical Boards
  - Report of the Center for Substance Abuse Work Group
  - Model Policy Guidelines for Opioid Addiction Treatment in the Medical Office

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- The Economic Costs of Drug Abuse in the United States 1992–2002 Office Of National Drug Control Policy  
[http://www.whitehousedrugpolicy.gov/publications/economic\\_costs/](http://www.whitehousedrugpolicy.gov/publications/economic_costs/)
- Heit HA; Dear DEA, Pain Medicine Vol 5 #3, 2004, 303-308
- Buprenorphine in the Treatment of Opioid Dependence, [www.aaap.org](http://www.aaap.org)

# More References

- USDHHS, Office of the Surgeon General, “At a Glance, Suicide in the United States”, <http://www.surgeongeneral.gov/library/calltoaction/fact1.htm>
- Source: Mokdad, Ali H., PhD, James S. Marks, MD, MPH, Donna F. Stroup, PhD, MSc, Julie L. Gerberding, MD, MPH, ["Actual Causes of Death in the United States, 2000,"](#) Journal of the American Medical Association, March 10, 2004, Vol. 291, No. 10, pp. 1238, 1241.

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- Hojsted J, Sjogren P; European Journal of Pain 11 (2007) 490–518 2006 European Federation of Chapters of the International Association for the Study of Pain. Published by Elsevier Ltd.  
doi:10.1016/j.ejpain.2006.08.004
- <http://www.facebook.com/asacpt>



**GETĂTENI TURMENTAȚI**

## **LEGAL DEFENSE ISSUES IN DRUG COURTS**

### **ZEALOUS REPRESENTATION vs. BEING PART OF DRUG COURT TEAM**

What if there is a viable defense to my charge? Let's try that suppression hearing first and then think about Drug Court.

I need treatment but those drugs were not mine so I'm not pleading guilty.

You are my attorney. How can you vote that I be sanctioned to 10 days in jail?

They are not treating me fair. They want to put me out of Drug Court and I didn't do what they say I did or if I did others did worse and got to stay. Are you going to defend me in the revocation hearing? Will there be a hearing so the judge hears my side?

My sentencing guidelines call for probation but Drug Court might be good for me. What should I do?

If I commit a crime in City X I have to serve 2 years but if I commit the same crime in City Y I can do Drug Court – how is that fair?

I'm not a religious person. Can Drug Court make me go to all those AA/NA meetings?

I can't get into Drug Court because of a couple of domestic assault conviction in my past? How can that be? I wouldn't have caught those charges if I had been sober.

That B&E was 9 years ago – why can't I get in Drug Court?

I read the statutes and entry criteria and know I should be eligible for Drug Court – how can the Commonwealth's Attorney keep me out?

Drug Court is not working for me. Can you get me into another program instead?

A scenic mountain landscape with a snow-capped peak in the distance and evergreen trees in the foreground. The text is overlaid on the image.

# Understanding Resistance To Change and the Benefits of Motivational Interviewing

# National Institute of Corrections (NIC) Evidence-Based Practices Model



**Risk Control:**

**Skills: Firm, Fair, Consistent**

**External focus**

**Punishments**

**Behavior**

**Consequences**

**Risk Reduction:**

**Cognitive Structure**

**Internal focus**

**Skills:**

**Dynamic Risk Factors**

**Effective communication skills**

**Anti-social attitudes and beliefs**

**Reflective listening**

**Elicit self motivating  
statements**

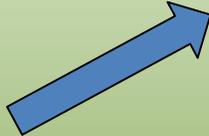
**Roll with resistance**



# Theory

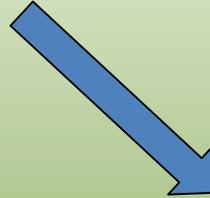
- Social Learning Theory
  - Human behavior can be best understood and predicted based on the interaction between three forces.
  - Environment; Cognitive Structures; Behavior, a triadic, dynamic interaction.

Data



Behavior

Justify  
Excuse  
Blame  
Minimize



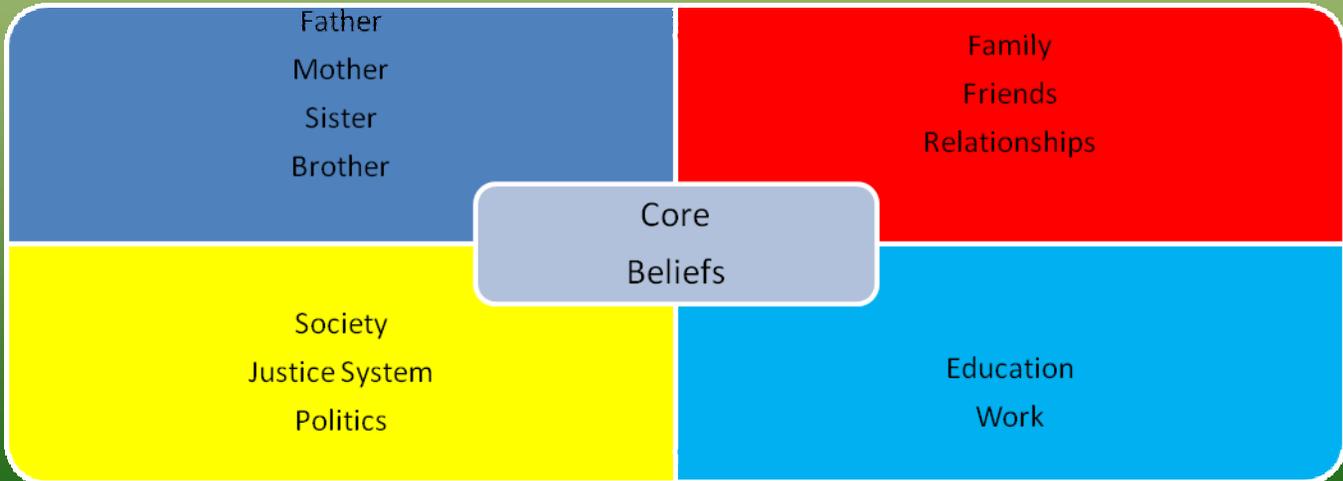
New Skill

Reject  
Debate  
Minimize



Reject  
Debate  
Fake it

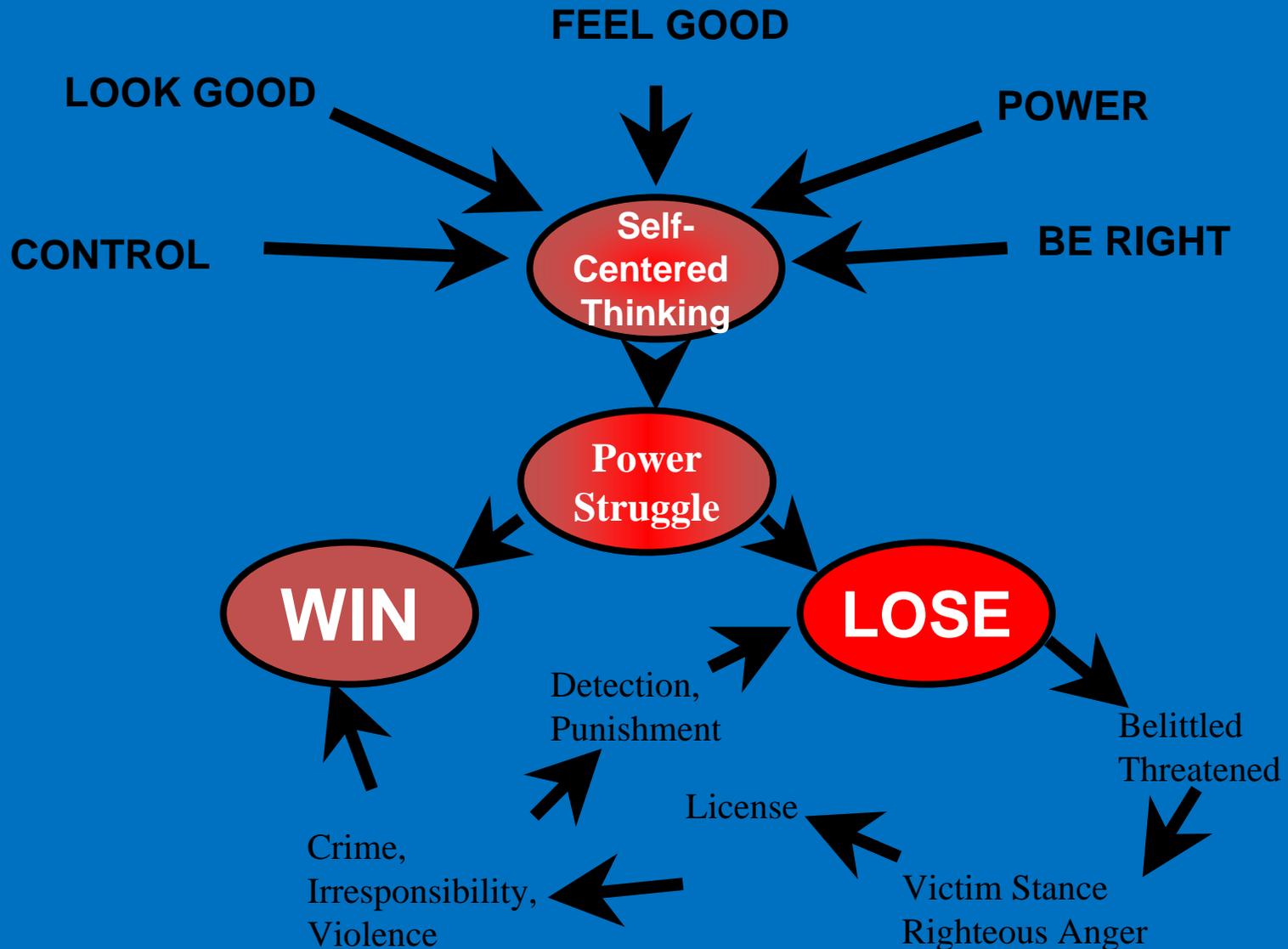
Win Self Image Lose



# Core Beliefs in Corrections

- You can get any study (research) to say anything you want it to.
- This is just a fad, this to will fade away over time.
- We don't have enough time to do this.

# Learning the Rewards of Self-Centered Thinking



# What is MI?

- A counseling method designed to evoke intrinsic motivation for health behavior change.
- Client-centered in style, drawing heavily on the insights of Carl Rogers (1951), yet directive in momentum (Rollnick and Miller, 1995).
- MI draws on concepts and research from social psychology, emphasizing the resolution of immobilizing ambivalence. According to Daryl Bem's self-perception theory (1972), people learn their own views and attitudes in the same way that others do: by hearing themselves talk.
- MI seeks to elicit from the person his or her own reasons for change, using reflective listening in a directive manner to reinforce such change talk (Miller & Rollnick, 1991).
- There is reasonably good evidence from controlled trials that MI is effective in evoking change in a range of health behaviors (e.g., Brown & Miller, 1993; Noonan & Moyers, 1997; Scales, 1998; Smith, Heckmeyer, Kratt & Mason, 1997; Trigwell, Grant & House, 1997).

# General Strategy

- Listen more than you talk
- Seek ways that let people freely express their resistance
- Listen reflectively- what are the underlying attitudes/beliefs that have not been said.
- No debates
- Look for and leverage discrepancies

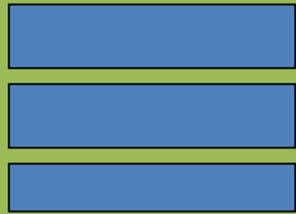
# Guiding Principles



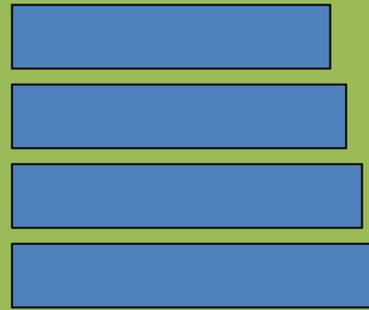
- ✘ No debates
- ✘ Self Efficacy
- ✘ Through their eyes
- ✘ Express accurate empathy
- ✘ Roll with resistance
- ✘ Look for and leverage discrepancies
- ✘ Listen reflectively
- ✘ Get to a choice

# Motivating Change- The THC Model

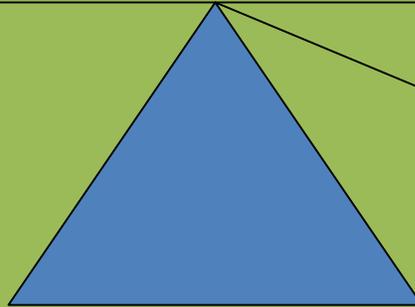
Step 1: Get at the **T**hinking  
Behind the Behavior.



Step 2: Get in the  
**H**allway



Step 3: Get to a **C**hoice



# Restorative Correctional Services

- Ray Ferns
- [rcogman@aol.com](mailto:rcogman@aol.com)
- 509-427-7998
- <http://restorativecorrectionalservices.com>

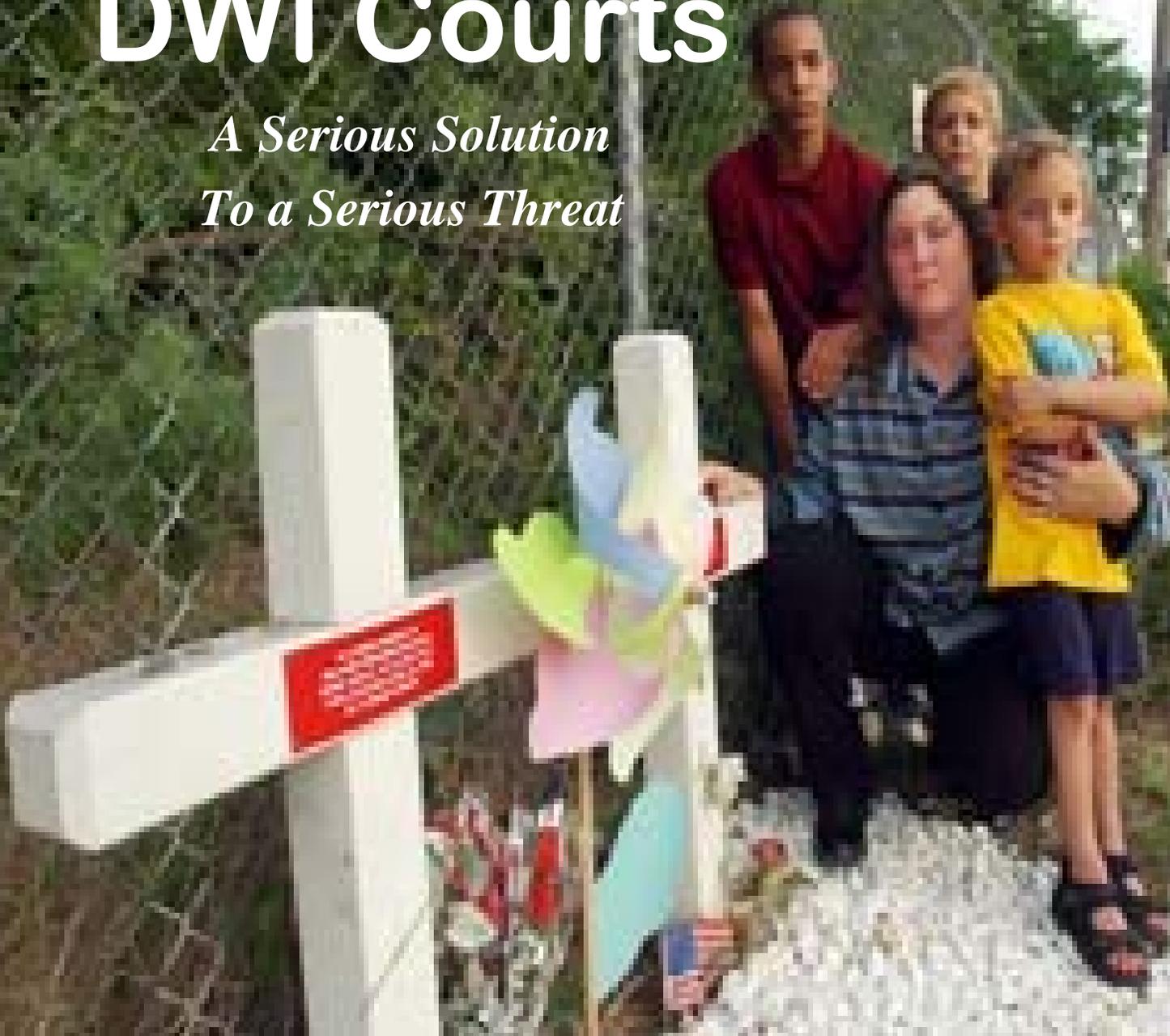
# The Promise of DWI Courts

Kent Lawrence, Judge  
State Court of Clarke County



# DWI Courts

*A Serious Solution  
To a Serious Threat*



# Crime, Crash, and Arrest Clock

## Crime

- 1** murder every **31** minutes
- 1** violent crime every **22.4** seconds
- 1** aggravated assault every **36.8** seconds
- 1** property crime every **3.2** seconds

## Crash

- 1** traffic fatality every **14** minutes
- 1** traffic injury every **13** seconds
- 11** law enforcement reported crashes every **1** minute
- 1** alcohol-impaired driving fatality every **45** minutes (at least one driver has BAC = .08+)



## Estimated Arrests

- every **1** hour
- 167** DUI arrests
  - 51** aggravated assault arrests
  - 70** violent crimes arrests
  - 14** robbery arrests
  - 2** murder arrests

Figures are rounded and represent the average per unit of time.  
Data sources:

Crime- from U.S. Department of Justice - Federal Bureau of Investigation (DOJ/FBI) 2006 Crime Clock, *Crime in the United States 2006*, September 2007

Crashes- from U.S. DOT's NHTSA, *Traffic Safety Facts 2008 Data, Overview, and 2008 Fatality Analysis Reporting System, General Estimates System 2008 Data Summary*

Estimated Arrests- from DOJ/FBI, *Crime in the United States 2006*, September 2007 (rounded)



# Impacts of Impaired Driving

- Over 1.4 million people arrested for DWI, one-third of them at least one prior DWI conviction

# Impacts of Impaired Driving

- Two million people with 3 or more DWI convictions , and 400,000 with 5 or more, are driving on our nation's roads and highways

# Impacts of Impaired Driving

- Nearly 12,000 people in 2008 were killed in U.S. highway crashes involving drivers with illegal BACs of .08 or higher; more than half having a BAC of .15 or higher

# What is a DWI Court?

- DWI Court operates in a post-conviction model using intensive supervision and treatment to permanently change the behavior of the hardcore offenders

# How is a DWI Court Different?

- DWI uses a team approach involving all the criminal justice stakeholders (judge, prosecutor, defense attorney, law enforcement, probation, and treatment) in a cooperative approach to ensure accountability

# The Good News

34%



**Life  
Saving  
Traffic  
Safety  
Strategies**



# National Campaigns



Don't get  
cuffed & stuffed.

Cops are cracking down.



**DRUNK DRIVING**  
OVER THE LIMIT. UNDER ARREST.



**DRUNK DRIVING**  
OVER THE LIMIT. UNDER ARREST.

Cops are cracking down.



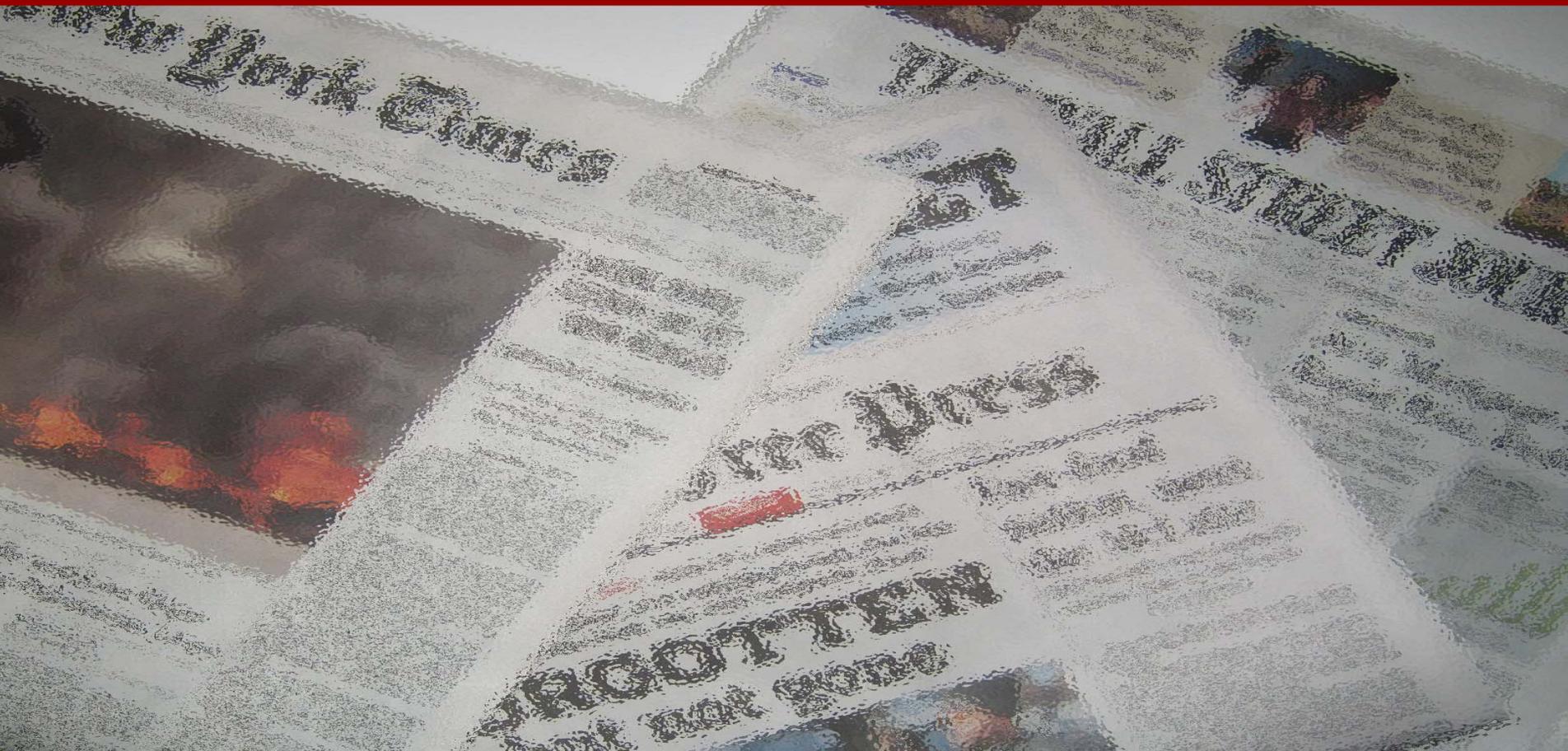
ON IT'S THE LAW

**BOOZE IT & LOSE IT.**

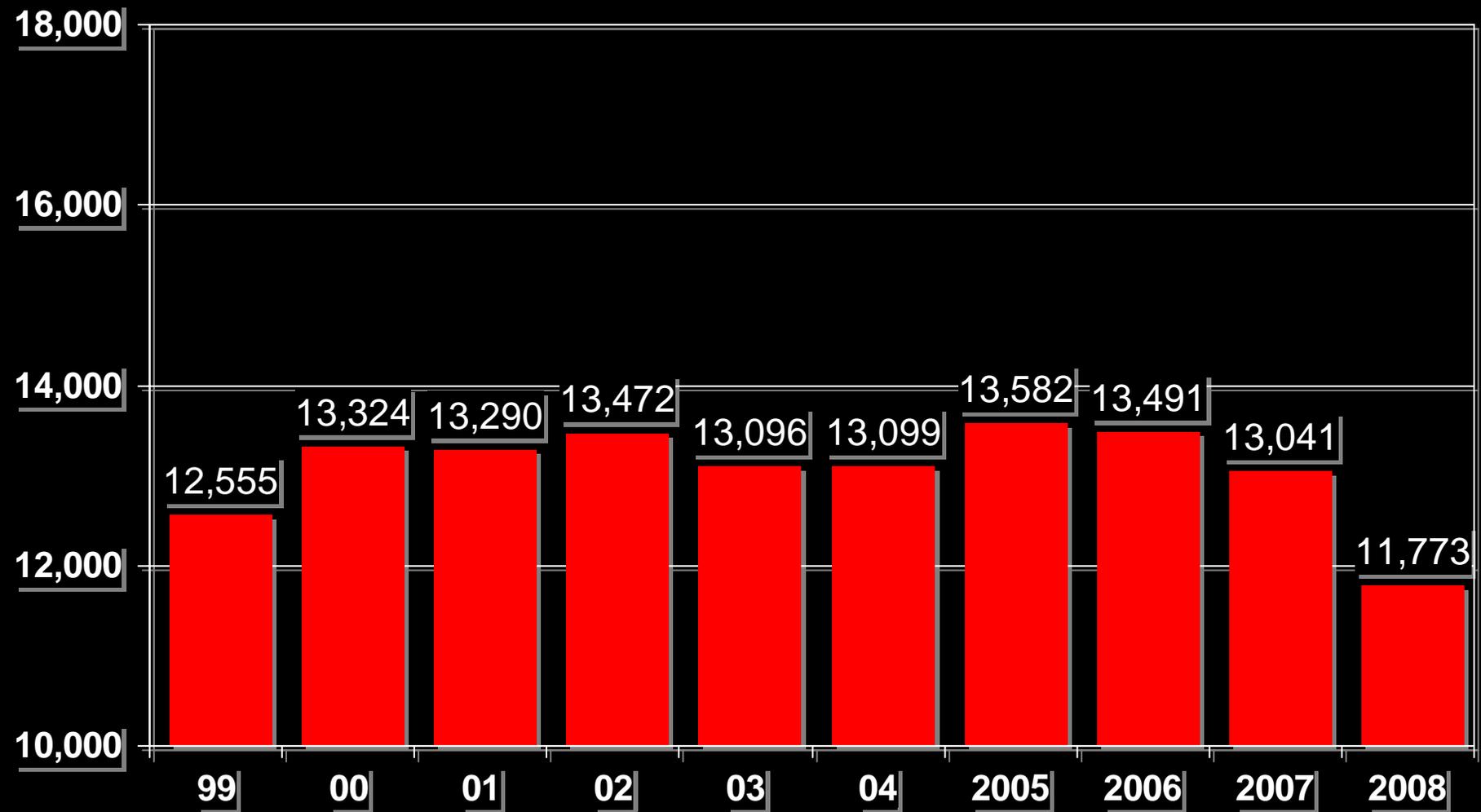
DUI Checkpoint

Don't Drink and Drive

# The Not-So Good News



# Alcohol-Related Fatalities 1999 – 2008



Source: FARS/NHTSA

*Honest, Officer all I had  
was a couple of beers!*



# How Do We Protect Our Communities?

Punishment  
or  
Rehabilitation



**Traditional sentences for  
the “High Risk Repeat DWI  
Offender” seldom work!**



**Why Can't  
People Just  
Change?**

**Treatment  
can work . . .  
BUT**



# Research Findings



# Research Findings

The length of time a patient spent in treatment was a reliable predictor of his or her post treatment performance.



# Research Findings

Coerced  
patients tend  
to stay longer



# Research Findings

Legal coercion becomes more crucial in large CJS programs



**Program  
Completion  
is KEY**



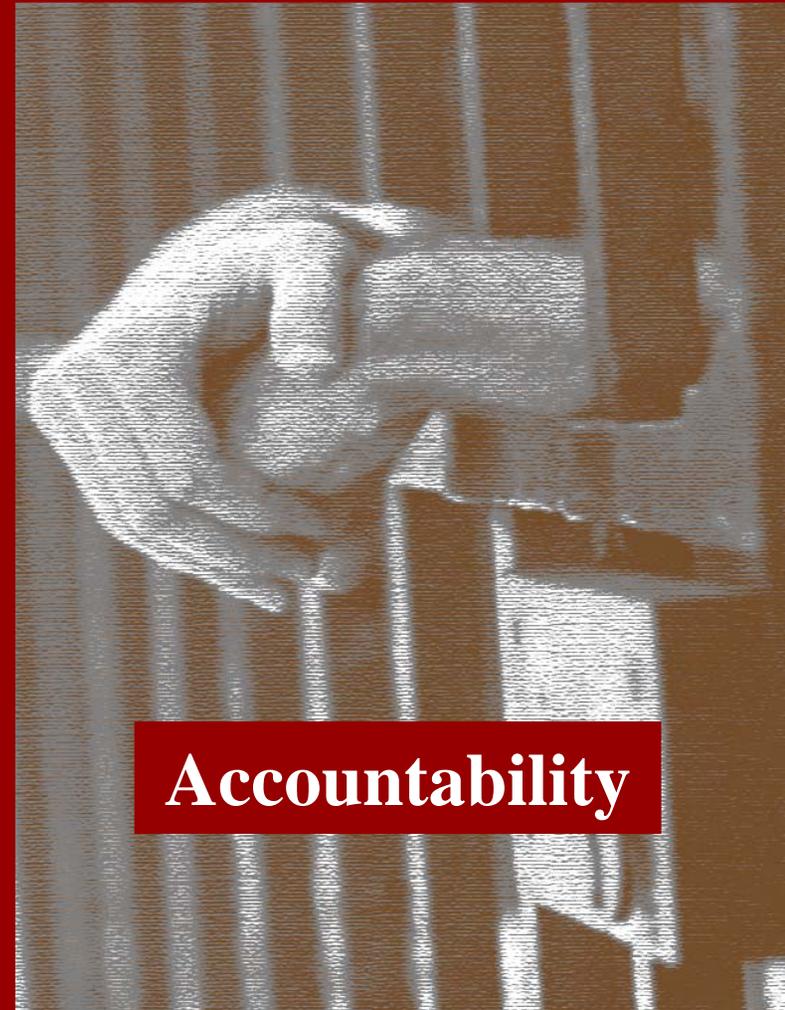
# What Ingredient Can We Add to Convince DWI Offenders to Participate?



# The Answer is the COURTS



**Treatment**



**Accountability**



# Courts as a Problem- Solver

# What is a DWI Court?

Post-Conviction

Hardcore

Quick  
Accountability

Intensive



**DWI Courts  
are  
Accountability  
Courts**

**Public Safety**





**A well  
designed  
supervision  
program can  
help ensure  
no one re-  
offends.**

**But it is no  
guarantee**

**What makes a  
DWI Court Different  
from Traditional Court?**

# Teamwork

Law  
Enforcement

Prosecutors

Important  
components



Court  
Coordinator

Treatment  
Provider

# A Coordinated Effort

Judge

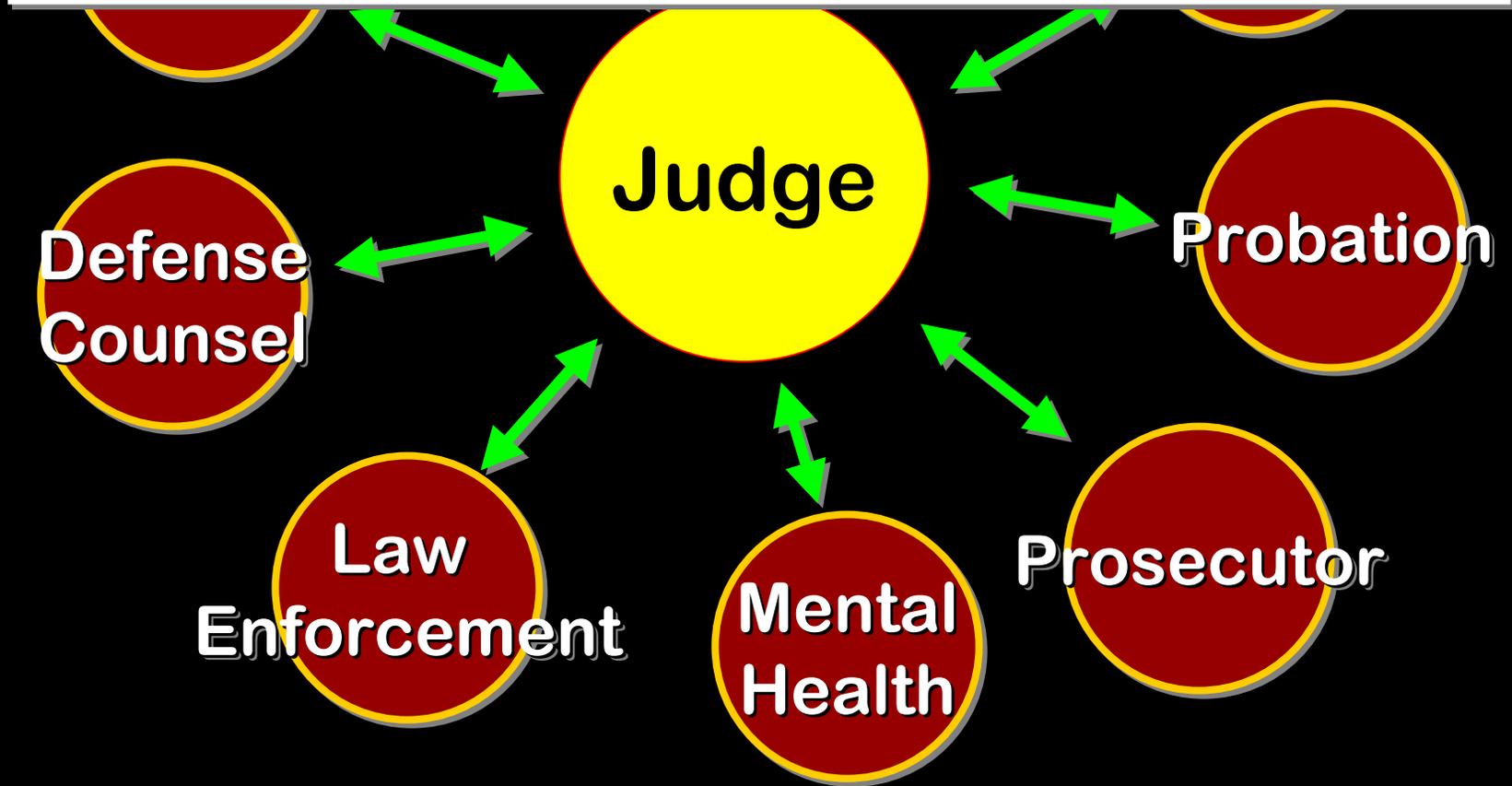
Defense  
Counsel

Probation

Law  
Enforcement

Mental  
Health

Prosecutor



# Intensive Probation Supervision

- Frequent reporting to probation officer (daily, weekly, bi-weekly, etc)
- House checks
- Curfew monitoring
- Electronic monitoring (Home confinement , Global Positioning System-GPS, SCRAM)
- Frequent, random and observed drug testing
- Bar sweeps
- Petitions and/or warrants issued for failure to comply with program requirements

# Incentives!

- Reduced jail time
- Court fines reduced by 50% upon graduation
  - 2<sup>nd</sup> conviction
  - 3<sup>rd</sup> conviction
- Earn 240 community service hours credit without doing physical labor by meeting program guidelines
- Ancillary services

# Graduated Sanctions

- Verbal reprimand
- Additional community service
- Adjustments to treatment plan
  - Additional 12-step meetings
  - Additional counseling sessions
  - Inpatient and outpatient services
  - Residential recovery placement
- Increased drug screening

# Graduated Sanctions

- Phase regression
- Additional “structure”
  - Curfews
  - Home confinement
  - Increased check-ins with probation or treatment staff
  - Electronic monitoring
- Jail confinement (wide range of hours to weeks)
- Removal from program

# Treatment Phases

- Phase 1: confinement, orientation, document execution, NEEDS assessment, clinical evaluation, family history review
- Phase 2: Extended Assessment & Evaluation (minimum of 8 weeks)

# Treatment Phases

- Phase 3: Treatment and Early Recovery (minimum of 24 weeks)
- Phase 4: Relapse Prevention (minimum of 16 weeks)
- Phase 5: Maintenance & Continuance of Care (minimum of 60 days)

# Treatment Services

- Preliminary NEEDS assessment to determine dependence and/or addiction level
- Genogram
- Clinical evaluation of offender by certified addiction counselor

# Treatment Services

- Individual counseling sessions
- Group counseling sessions
- Sharing of life story
- Inpatient and outpatient placement
- Residential recovery placement
- Drug testing of program participants
- Attend 12-step meetings

# Ancillary Services

- **Transportation Assistance**
  - **Bicycle and helmet loan program**
  - **Unlimited bus tokens/passes**
    - **Attend treatment**
    - **Visits to probation office**
    - **Call-ins for drug testing**
    - **School and work programs**
    - **Attend 12-step meetings**
    - **Attend court status conferences**

# Ancillary Services

- **Educational Assistance**
  - GED completion
  - Enrollment of college
  - Placement in vocational or technical school
- **Employment Assistance**
  - Community sponsors who employ program participants
  - Coordination with local DOL office

# Ancillary Services

- **License Reinstatement Assistance**
  - Assist program participants with Department of Driver Services for license reinstatement
  - DDS waives the minimum 17 week multiple offender program cost of \$595 upon program graduation
- **Other Health Services**
  - Referrals for medical and health services and family counseling
  - Assistance with food, dietary issues and eating disorders

# What is the Cost to Participate?

- Monthly program fee of \$240 which includes the following:
  - NEEDS assessment
  - Clinical evaluation by certified addiction clinician
  - Case management
  - Individual counseling
  - Group counseling
  - Multiple Offender Program license reinstatement cost
  - Drug and alcohol screening
  - Probation supervision fee

# What is the Cost to Participate?

- Indigent (reduced or “no pay”) slots are available for those who qualify
- All participants are required to work if physically able or be enrolled in school fulltime
- Insurance is accepted for those who have coverage
- Upon entry to Phase 5, program costs are reduced to \$50 per month until graduation

# Total Program Cost = \$2,880

2<sup>nd</sup> DWI Conviction

3<sup>rd</sup>+ DWI Conviction

\$2,880 (12 months)

\$2,880 (12 months)

– \$648 (50% fine reduction)

– \$788 (50% fine reduction)

– \$595 (Multiple Offender Program)

– \$595 (Multiple Offender Program)

\$1,637 (net cost to participant)

\$1,497 (net cost to participant)

A Small Price for...

Recovery

# The Costs of Not Participating

- No reduction of jail time
- No reduction of fines
- No waiver of 240 hours of community service
- No transportation assistance
- No employment assistance
- No residential recovery placement
- No inpatient or outpatient assistance
- No medical or health assistance
- No license reinstatement assistance

# The Costs of Not Participating

- Probation fees
  - Clinical Evaluation (min.)
  - NEEDS Assessment
  - Multiple Offender Prog.
  - Drug testing
  - DUI School
  - Court Fines
  - No recovery
- \$480/year (\$40/month)
  - \$95
  - \$15
  - \$595
  - \$60 (4@\$15 each)
  - \$285+
  - \$1,296
  - Unknown

No Change in Behavior =  
Increased Risk of Re-arrest

\$2,826 or more

# DWI Courts



**Why Do You  
Believe DWI  
Court is the  
Answer?**

**DWI  
COURTS  
December  
31, 2007**

**110 Stand-Alone DWI  
Courts  
286 Hybrid DWI  
Courts**

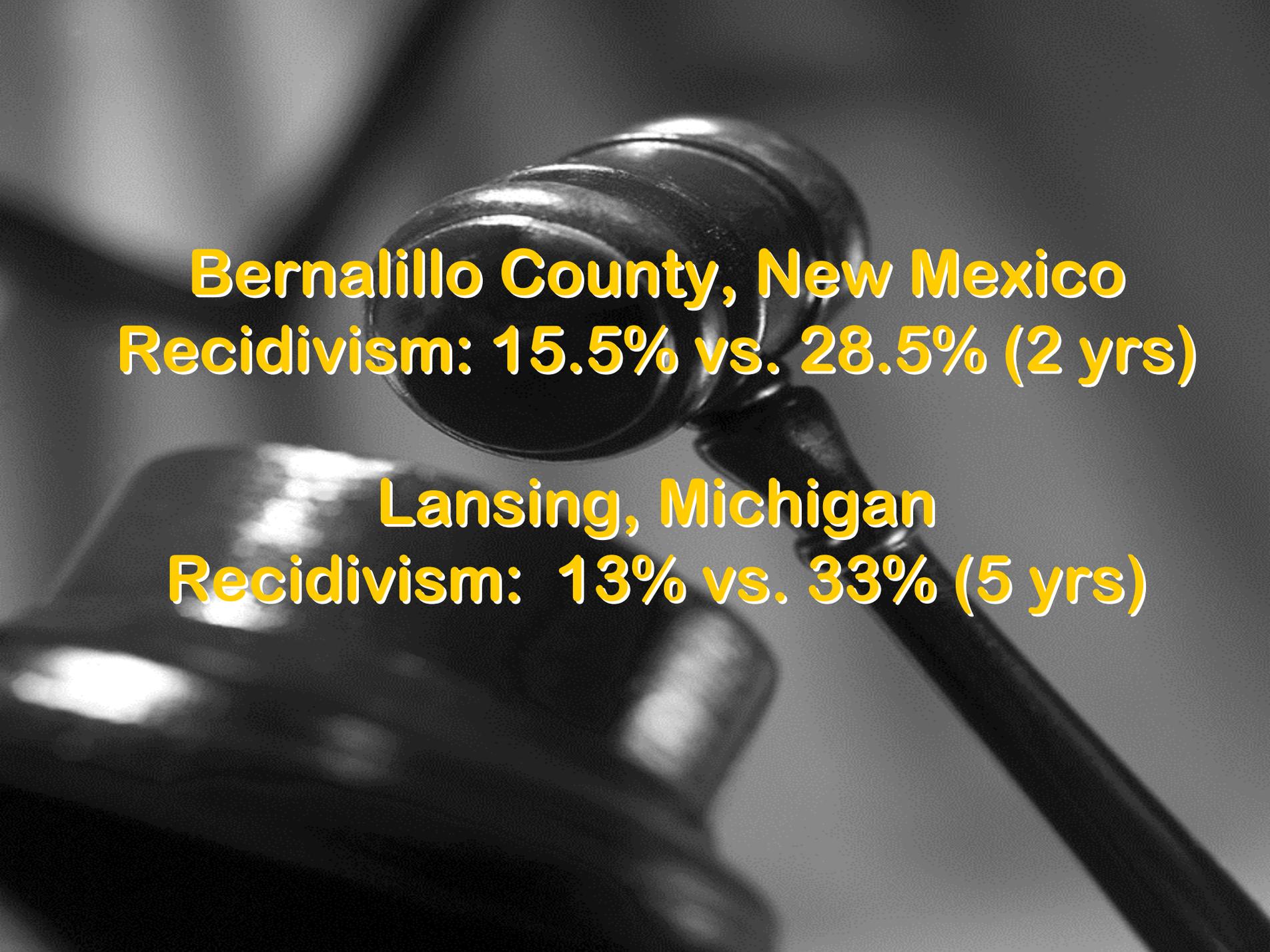


**DWI  
COURTS  
September  
1, 2010**

**144 Stand-Alone DWI  
Courts**

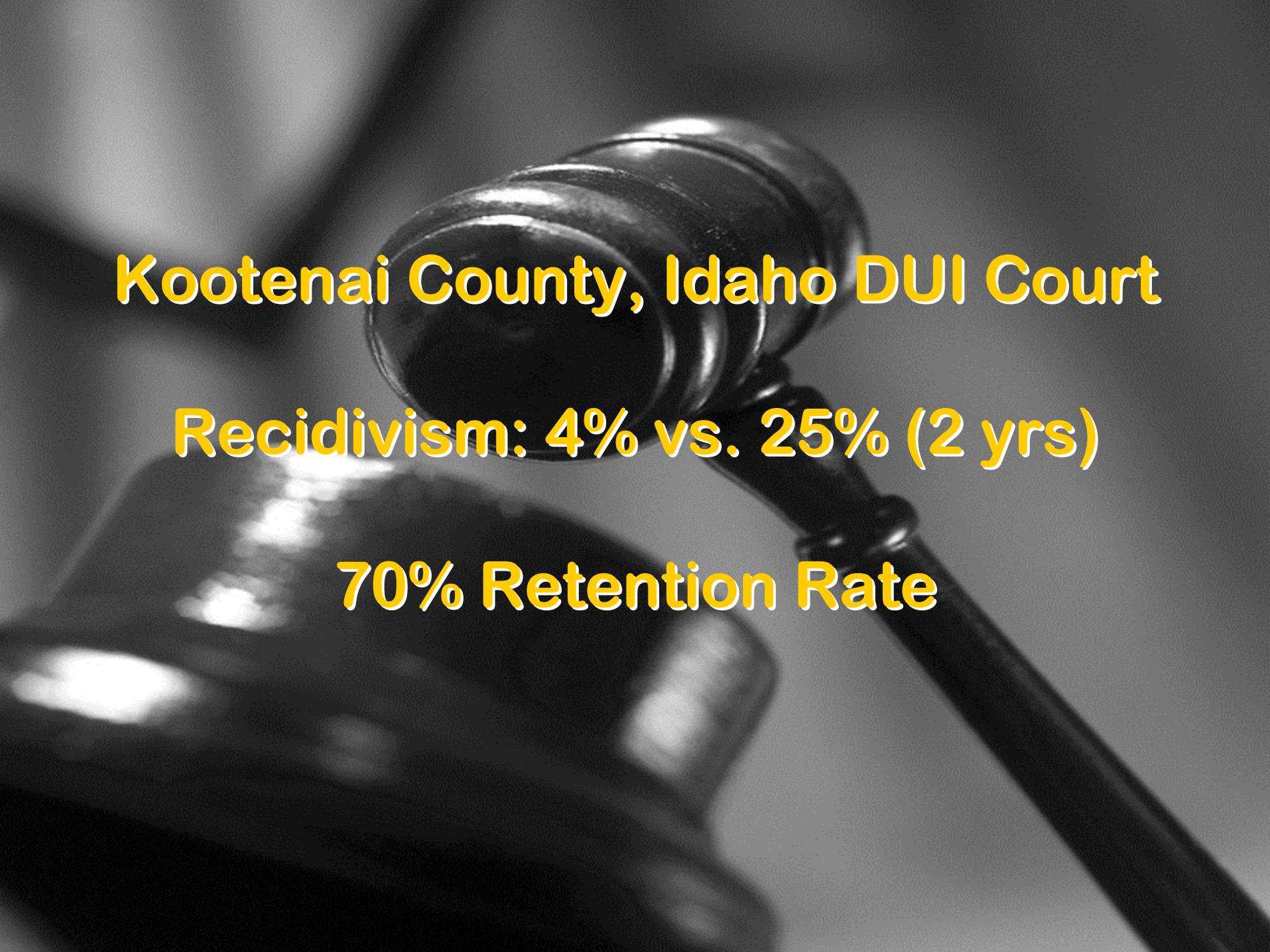
**382 Hybrid DWI  
Courts**





**Bernalillo County, New Mexico**  
**Recidivism: 15.5% vs. 28.5% (2 yrs)**

**Lansing, Michigan**  
**Recidivism: 13% vs. 33% (5 yrs)**



**Kootenai County, Idaho DUI Court**

**Recidivism: 4% vs. 25% (2 yrs)**

**70% Retention Rate**

# Michigan Study

Reduced  
recidivism

Fewer re-arrests

Cost savings



# Why DWI Courts?

- In a 2008 study DWI Court offenders were found to be up to 19 times less likely to be re-arrested than a DWI offender in a traditional court.

**Who Will Support  
Our DWI Courts?**



## Approved GHSA Resolution

**“GHSA supports DWI courts and urges states to work with their state criminal justice agency counterparts to implement them where appropriate. GHSA also recommends that NHTSA evaluate DWI courts to determine their effectiveness”**

# Approved MADD Resolution



**“MADD supports the use of post-adjudication DUI/DWI courts that employ the strategies of close supervision, frequent alcohol and other drug testing, and ongoing judicial interaction to integrate alcohol and other drug treatment services with the justice system. MADD recommends that DUI/DWI courts should not be used to avoid a record of conviction and/or license sanctions.”**

**MADD National Board of Directors**



INTERNATIONAL ASSOCIATION *of* CHIEFS OF POLICE

*global leadership in policing*

**RESOLVED**, that Highway Safety Committee of the IACP supports the DWI/DUI courts concept as promoted by the National Highway Traffic Safety Administration.

**Approved IACP  
Resolution**



# National Sheriff's Association

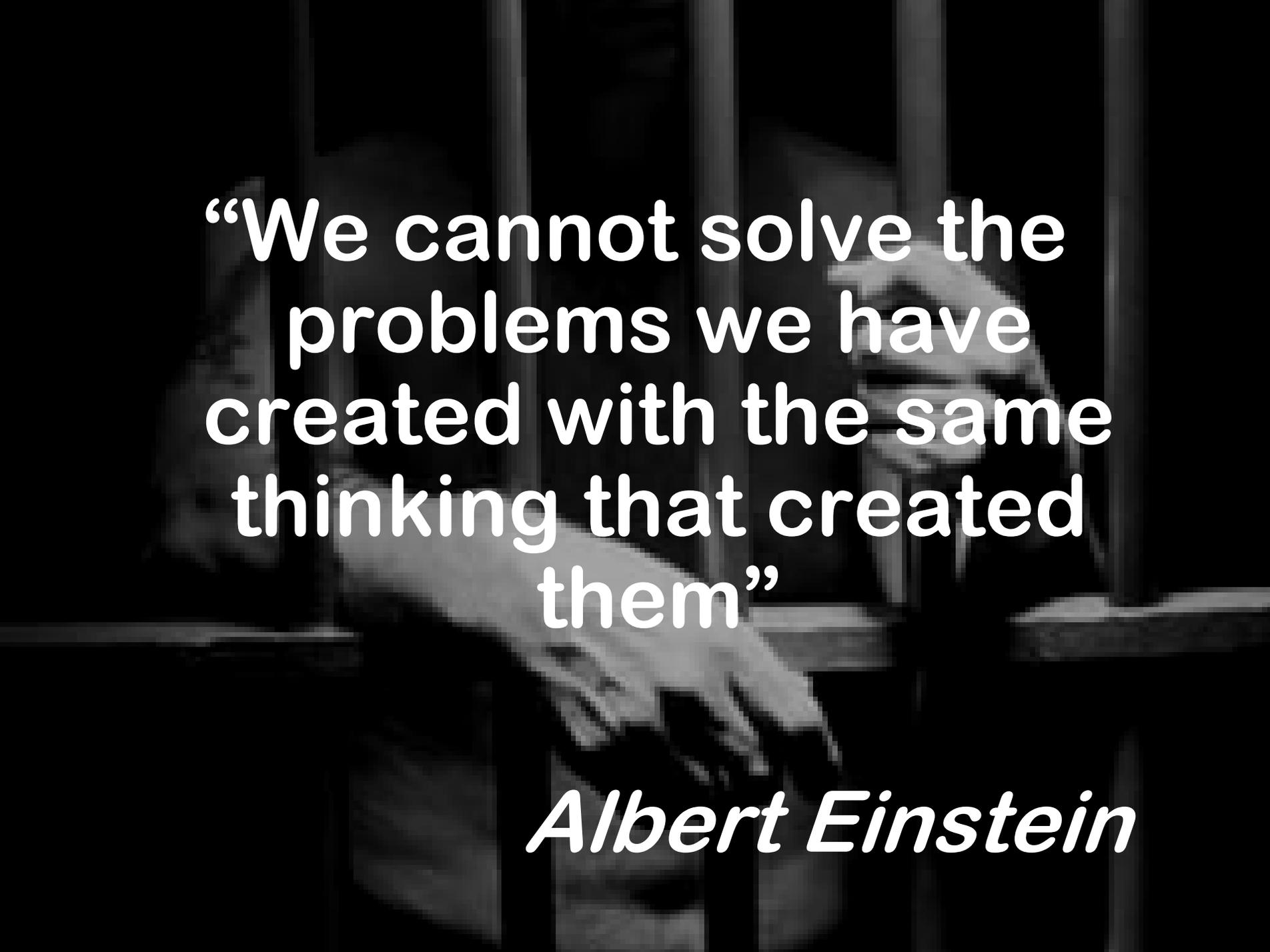
**RESOLVED**, that the National Sheriffs' Association support DWI Courts as promoted by the National Highway Traffic Safety Administration, and be it;

**FURTHER RESOLVED**, that the National Sheriffs' Association urges states to implement DWI Courts where appropriate.



# National Alcohol Beverage Control Association

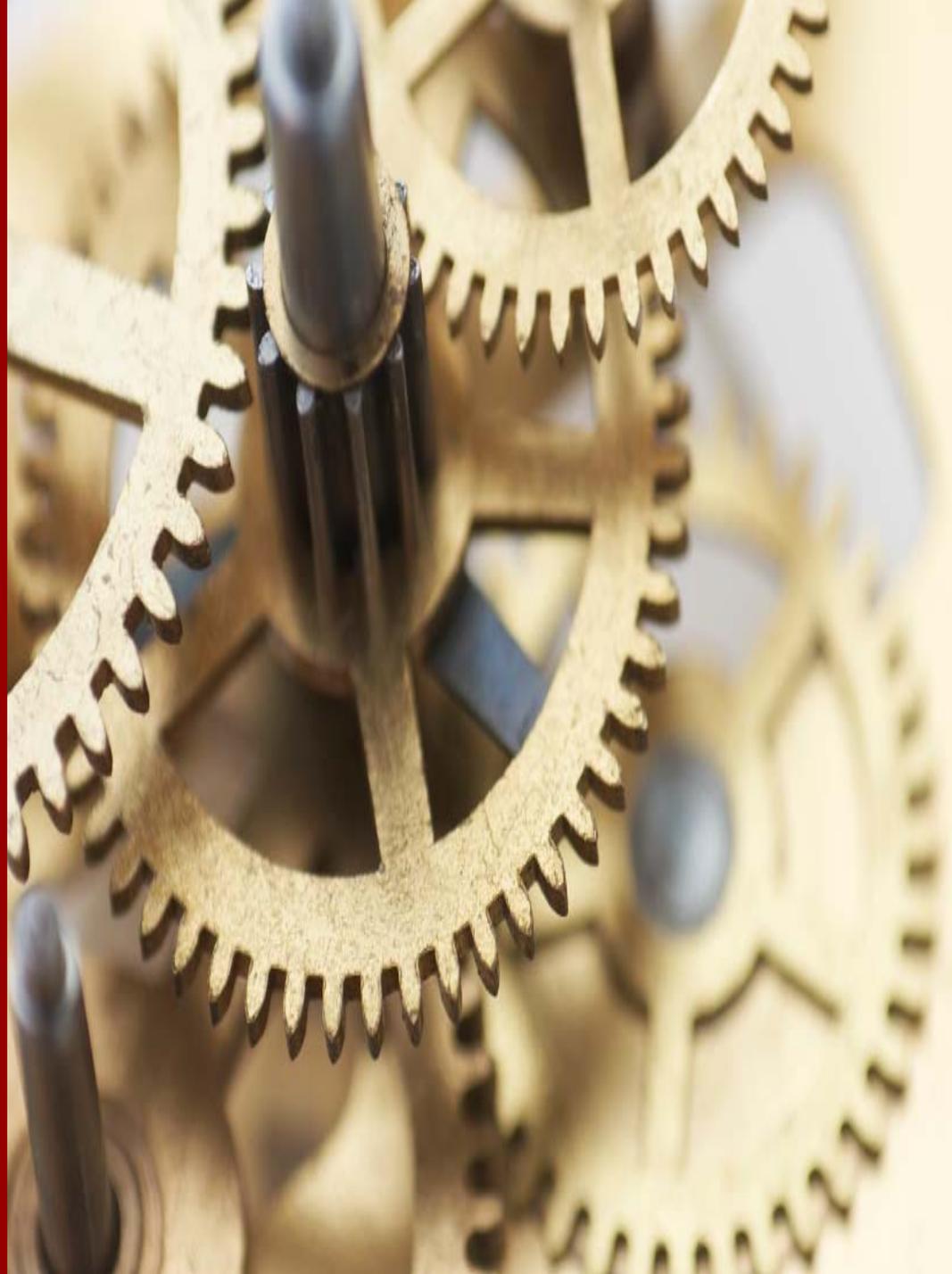
**NOW, THEREFORE BE IT RESOLVED,  
that NABCA does hereby support the  
continued development and study of  
DWI Courts to eliminate repeat  
DWI/DUI Offenses.**



“We cannot solve the  
problems we have  
created with the same  
thinking that created  
them”

*Albert Einstein*

**The Promise  
of a  
Coordinated  
Approach**



# So why be involved?

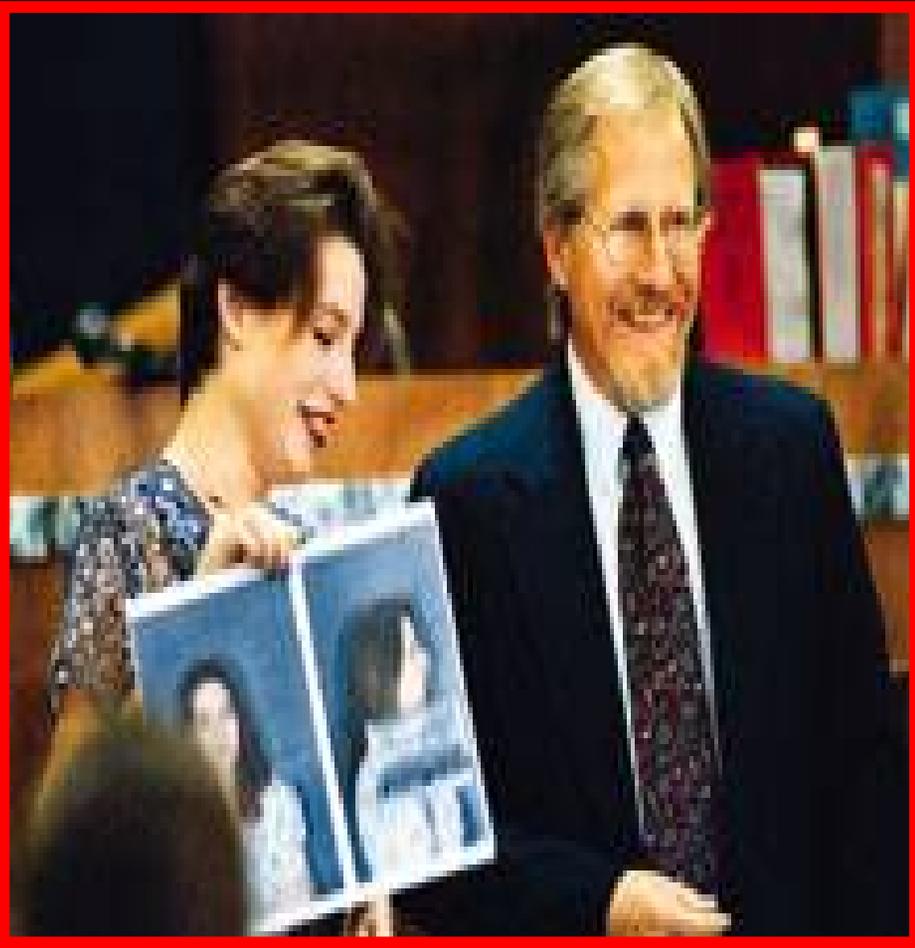
Cost savings

Trials

Jail

Staffing issues





**Work**

**DWI Courts**



# Contact Information

Kent Lawrence, Judge  
State Court of Athens-Clarke County  
Room 425, Clarke County Courthouse  
Athens, Georgia 30601  
(706) 613-3200

[kentlawrence@co.clarke.ga.us](mailto:kentlawrence@co.clarke.ga.us)

# **Integrating Law Enforcement Into Drug Court**

**Virginia DUI-Drug Treatment Court  
2010 Training Conference**

**Cynthia Herriott – Deputy Director National Drug Court  
Institute**

**[cherriott@ndci.org](mailto:cherriott@ndci.org)**

© NDCI, September 2010

The following presentation may not be copied in whole or in part without the written permission of the author or the National Drug Court Institute. Written permission will generally be given without cost, upon request.

# Experience

- Twenty-four years of law enforcement
- Professional Affiliations – IACP, NOBLE etc.
- Instructor Certification
- Master's Degree

**Today's law enforcement executive has dwindling resources. Many of the community-based programs such as Drug Courts and Reentry Courts that prevent recidivism may be in danger of being impacted by a law enforcement agency's reduction of core services. The consequences of these cuts can be increased crime and violence and less secure communities.**

# Why We're Here

- **State why law enforcement involvement is critical to the success of Drug Courts**
- **Outline strategies to make it happen.**

# Critical Areas for Law Enforcement

- Key Component #6
  - A coordinated strategy governs drug court responses to participants' compliance.
- Key Component #10
  - Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

# What the Research Found

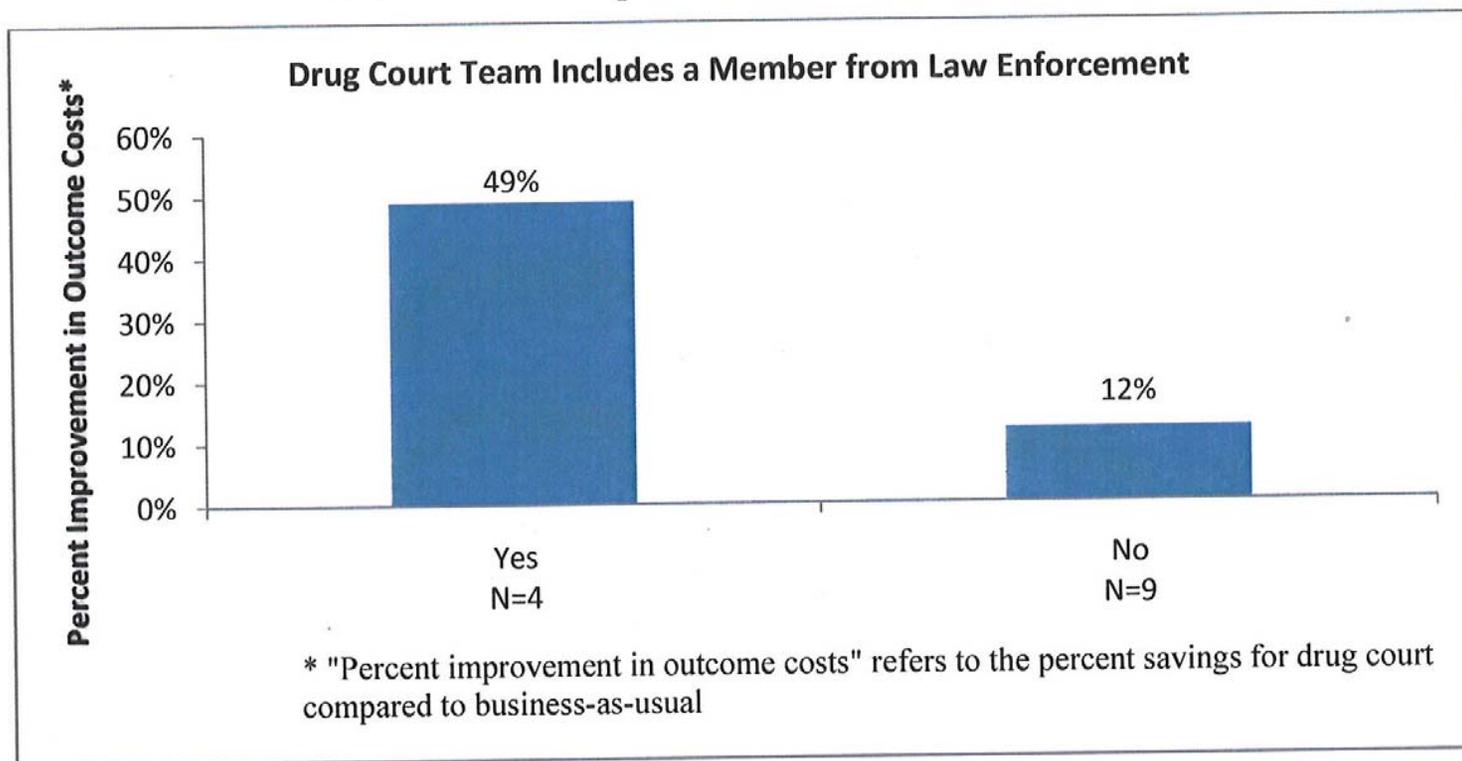
- Having a member from law enforcement on the team was associated with higher graduation rates - 57% compared to 46% for those that did not have law enforcement on the team
- Drug Court teams that included law enforcement had a 49% improvement in lowering outcome costs.

# Evaluation Research



Exploring the Key Components of Drug Courts:  
A Comparative Study of 18 Adult Drug Courts on Practices, Outcomes and Costs

**Figure 32. Drug Courts with a Representative From Law Enforcement on the Team Had Greater Improvement in Outcome Costs**



**REMEMBER**

**NO...**

**Confidential...**

**Informants**

# The Law Enforcement Dilemma

- Who do we serve?
- What is law enforcement's mission?
- Where do we learn how to integrate Drug Courts with traditional policing?
- When should law enforcement embrace the concept?
- How do we address ethical concerns?

# What you Needed:

- A large 24-hour team
- Additional resources
- Street-savvy intelligence
- Another perspective

# What we Wanted:

- To be an equal partner on the Drug Court Team
- To participate in staffing meetings
- Training in the Drug Court model for law enforcement
- A separate NADCP Conference Training Track
- A new strategy for dealing with a long-standing problem

# When a Police Executive is Asked for an Officer for the Drug Court Team...

- There may be staffing concerns
- Will this impact the department's budget?
- Political concerns
- Will this conflict with the commitment to the community?
- Resentment – if left out of the planning
- Another unfunded mandate?

# What we Got:

- Sometimes a way to solve one of the Chief's problems
  - Good assignment for “liberal non-performer,” or “retired-in place,” personnel
- Home visits became safer with police as partners in the process

# What we Got:

- An education on addiction and it's impact upon the human brain
- A cost-effective crime strategy
- An active voice in problem-solving
- Increased credibility and accountability

# Mutual Trust and Respect

- You will have a relationship of trust, and access to other specialized units through your law enforcement agency:
  - Task Force Units
  - Tactical Units
  - Narcotics Officers
  - Warrant Teams
  - Federal Agencies

# NADCP 2010 Conference

## Meeting Law Enforcement's Needs



SESSION **SB-23**

### Law Enforcement and Problem-Solving Courts: Strategies Every Officer Should Know

Hynes, 208

#### Police Executive Support for the Drug Court Officer

- Why its Essential
- How to Make it Happen

**(9:00 – 9:50 a.m.)**

Today's Law Enforcement Executive has dwindling resources. Many of the community-based programs such as Drug Courts and Reentry Courts that prevent recidivism may be in danger of being impacted by a law enforcement agency's reduction of core services. The consequences of these cuts are increased crime and violence and less secure communities. Law enforcement executives will discuss why its essential for law enforcement to support Drug Courts, and provide strategies on how to make it happen.

#### **Michael Bosse**

*Assistant Chief*

Bureau of Professional Standards

Lexington County Government Division of Police

Lexington, Kentucky

#### **Ronald Thrasher**

*Deputy Chief*

Oklahoma Police Department

Stillwater, Oklahoma

# What's next

- Talk to each other - Police ride-along (case manager, treatment, director),
- Keep law enforcement in the loop about their arrests, i.e. case details, progress reports
- Invite officers to court, particularly graduation
- Provide “Certified” police training (CEUs or P.O.S.T.)

# Begin With the End in Mind

The single most effective strategy for getting law enforcement on board is to ensure that the police are involved in every facet of planning and implementing the drug court program.

“Drug Courts, Chiefs of Police and Sheriffs: A Broader Look at Law Enforcement” © 2003 NADCP

# Final Thoughts

- “It is law enforcement that will make the revolving door a thing of the past”
- “If supporting drug court is going to result in less crime, then I think we have an ethical obligation to stand behind it.”
- “You get to a point where you realize you have to do something else.”
- “If leadership doesn’t believe in drug court, you can’t expect the cops to believe in it.”
- “It’s that 80/20 rule thing”

AllRise.org

NDCI.org