

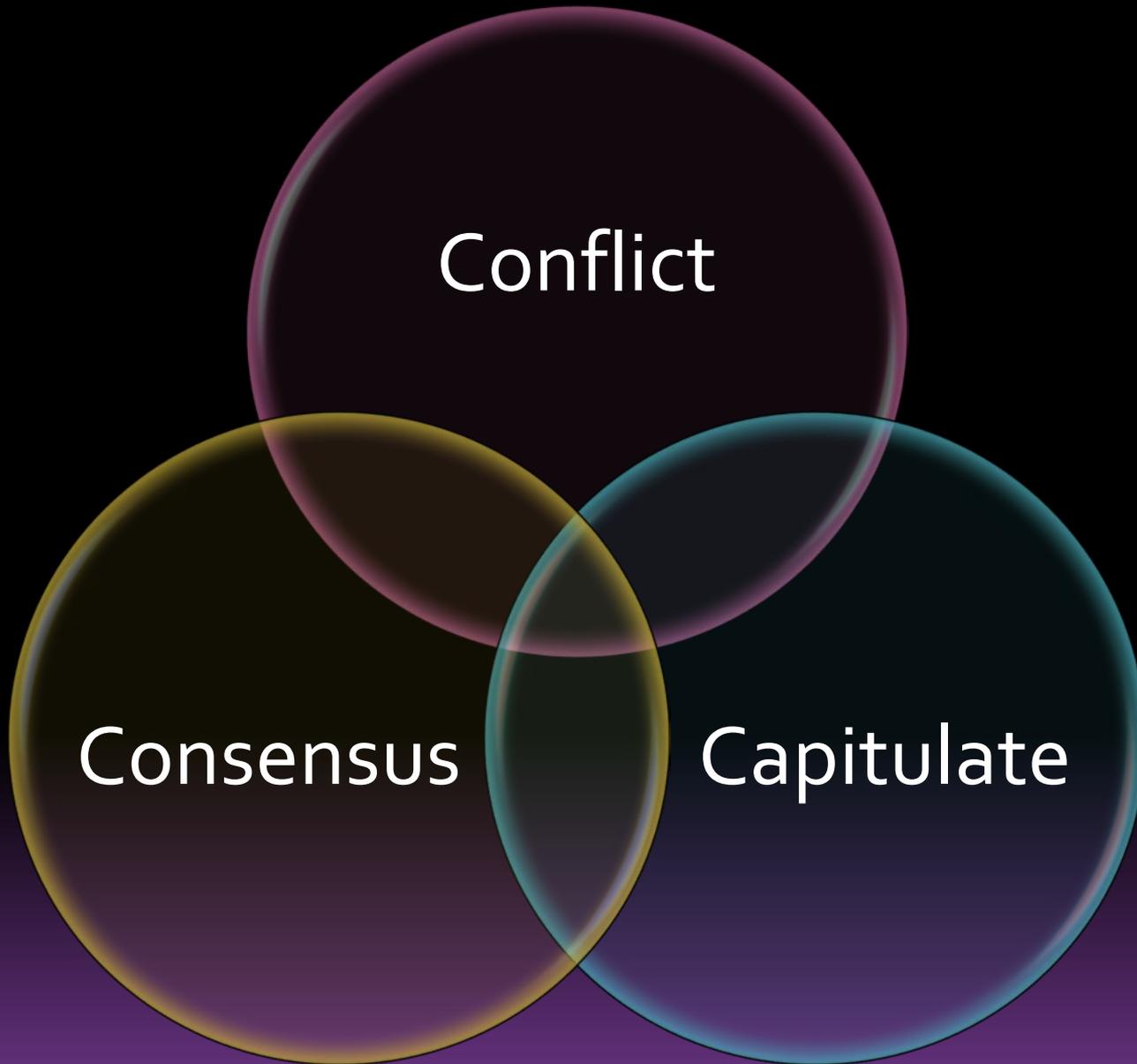
Communication in Problem Solving Courts:

Consensus, Conflict, or Capitulation

Carolyn Hardin, M.P.A.

Chief of Training

National Association of Drug Court Professionals



Conflict

Consensus

Capitulate

www.ndcrc.org

**Adult Drug Court Best Practices
Standards Volume II**

Multidisciplinary Team

A dedicated multidisciplinary team of professionals manages the day-to-day operations of the Drug Court, including reviewing participant progress during pre-court staff meetings and status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment and supervision services.

Multidisciplinary Team

Composition &
Training

Pre-Court Staff
Meetings & Status
Hearings

Team

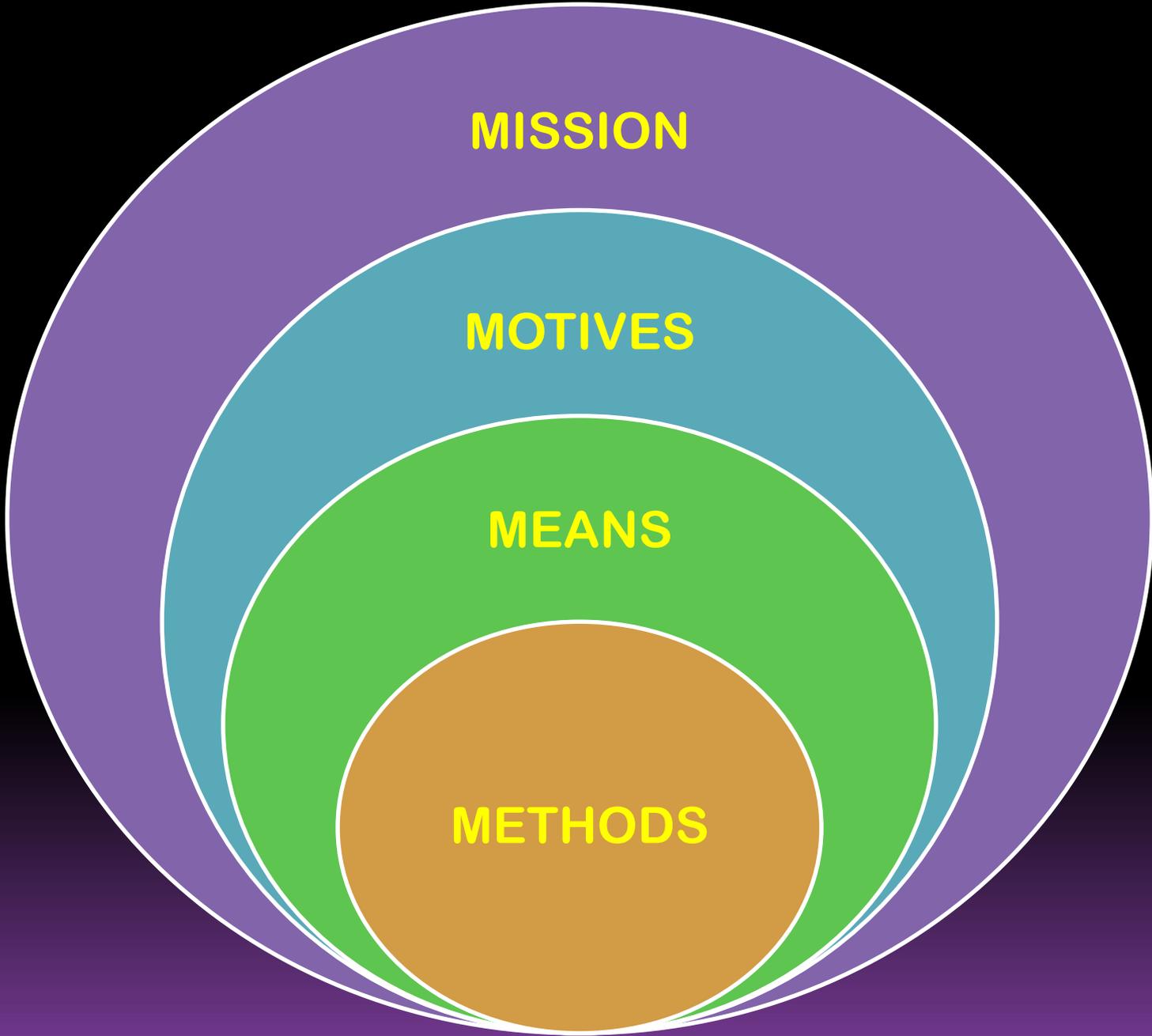
Sharing Information

Communication &
Decision Making

Multidisciplinary Team

- 1) Judge considers perspectives of all team member before making decisions that impact participants' welfare or liberty interests.**
- 2) Defense attorneys inform participants and team members whether they will share confidential information concerning participants with other team members.**

UNDERSTANDING MY PROFESSION



MISSION

MOTIVES

MEANS

METHODS

Whose the Customer?

- ▣ Client?
- ▣ Court?
- ▣ Community?
- ▣ Constituency?
- ▣ Concept?

UNDERSTANDING ME

My Focus

Field

Advocacy

Principles

Person

Bent

Bias

**UNDERSTANDING
MY TEAM
MEMBERS**

Priority and Perspective



Essential Considerations

1. Roles and Boundaries
2. Professional Ethics
3. Team Power Dynamics
4. Decisions Making Protocol
5. Participant Best & Expressed Interests
6. Program Best Interests
7. Public Best Interests

Aligning the Team

1. **Look for Good Matches, Value Diversity**
2. **Understand Condition, Culture, & Climate**
 - ▣ Profession & Provider
 - ▣ Resources (leadership, finances)
 - ▣ Motivation, Resources, Staff Attributes
 - ▣ Language & Lingo
3. **Express Empathy**
 - ▣ Appreciate Difficulty of Work & Limitations
 - ▣ Respect Expertise and Perspective

Aligning the Team

4. **Find Common Ground**
 - ▣ Recognize Strengths
 - ▣ Appreciate and Re-Frame Disagreements as Differences
5. **Communicate: Realistically, Regularly, and Reciprocally**
6. **Agree if There is Need for Change**
 - ▣ Desired Outcome
 - ▣ Drug Court Bottom Lines
 - ▣ Discipline Specific Bottom Lines

Pitfalls to Avoid

1. Secrets
2. Sub-Alliances
3. Splitting & Pitting
4. Professional Drift

**INFLUENCING
THE
TEAM**

**Value Understanding Over
Being Understood**

**Understanding Facilitates
Influence**

Consensus Training

- Network for the Improvement of Addiction Treatment (NIATx)
- Structured process to decide upon, implement, and review program change
- 6 Drug Courts received consensus training
- Increased Job satisfaction, improved program efficiency, higher admission rates, short wait times for treatment, reduced no show rates for appointments

10 Effective Communication Strategies Proven in Drug Court

Avoid Ego
Centered

Avoid
Downward

Attentive
Listening

Reinforce
Others First

Common
Ground

10 Effective Communication Strategies Proven in Drug Court

Reframe
Neutrally

Inclusive

Understand

Empathetic
Listening

Sum Up

Communication in Problem Solving Courts:

Consensus, Conflict, or Capitulation

The Honorable Jack S. "Chip" Hurley Jr., Judge
National Association of Drug Court
Professionals
Anaheim, CA
June 2016

Over-Prescribing a Nation, Can a Judge Make Sense of It?

Learning Objectives

- Understand the addictive disease
- Brief overview of prescription drug abuse nationally and rural southwest Virginia
- Over-prescribing case review and potential for cooperation between law enforcement, the judiciary and the medical profession

**DRUGS
KILL THE
PAIN**

**AND THE JOY
AND THE HOPE
AND THE BODY
AND THE BRAIN
AND FINALLY,
THE SOUL.**

Mountains of SWVA



Drug Stricken SWVA

TAZEWELL COUNTY CIRCUIT COURT GRAND JURY DOCKET, JULY 8 Narcotics cases



Addison Akers Anderson Barnett Belcher Bucklen Burge Burks Calfee Collins Conner Cox



Deal Green Grose Haner Harrison Hayes Jennelle B. Johnson R. Johnson Lamb Lewis McCraven



McGlothlin Moore Murray Olivo Panagopoulos Pauley Fendergrass Redmond Repass Rife Robertson Robinette



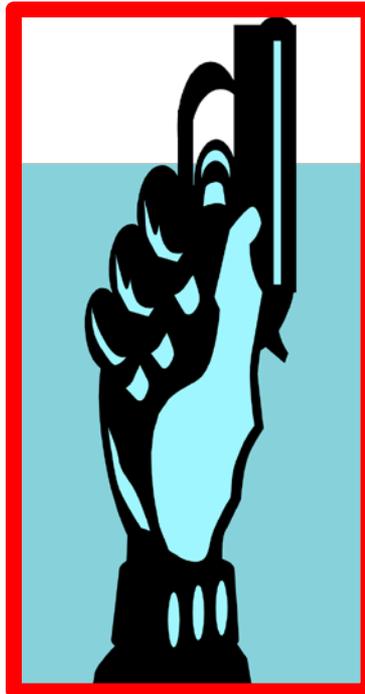
Shrader Signon Solis Stinson Thompson J. Tibbs M. Tibbs Vance White Whitt Wyatt

Which is the biggest threat?

CARS?



Guns?



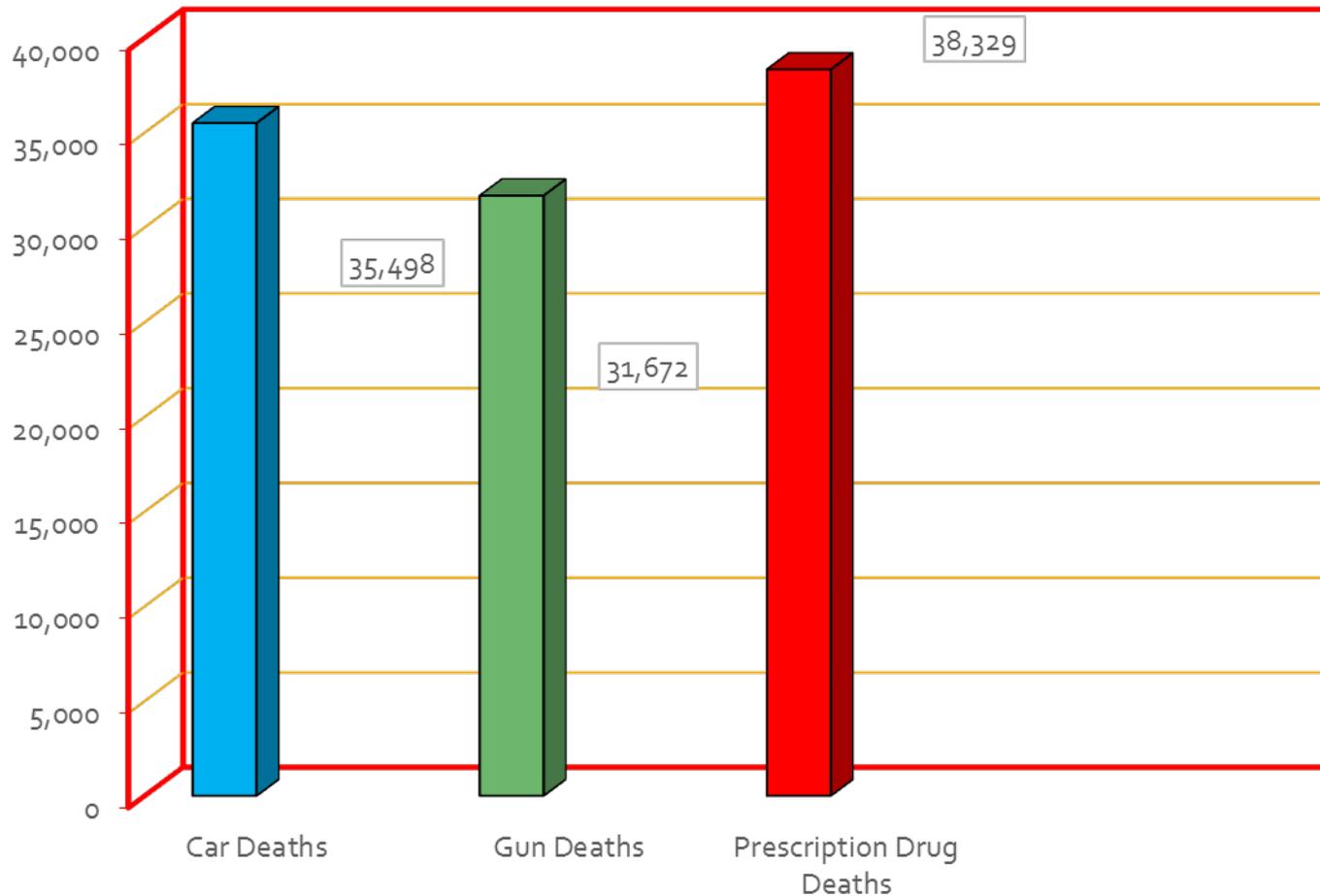
PRESCRIPTION DRUGS?



I WISH
I NEVER
STARTED

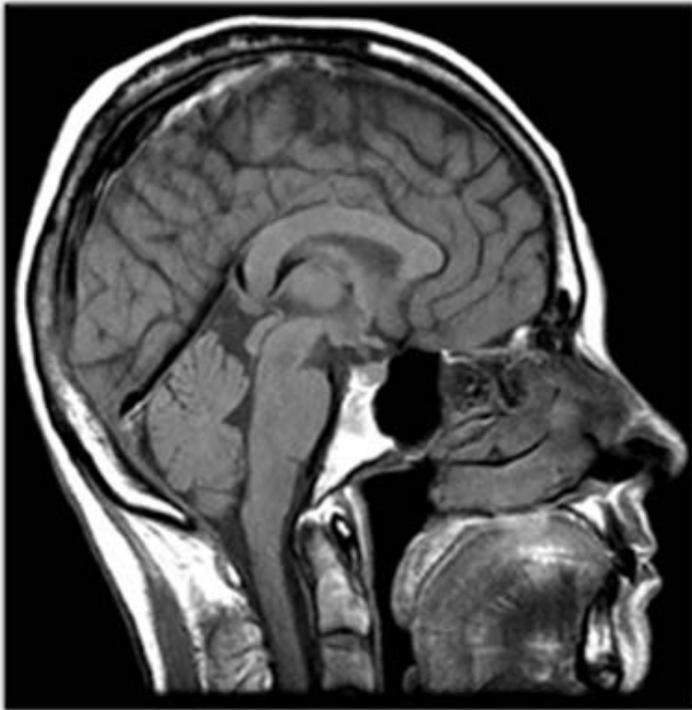
I WINS

CARS vs GUNS vs DRUGS



Opiate Effects on the Brain

Effects of Opiates on The Brain



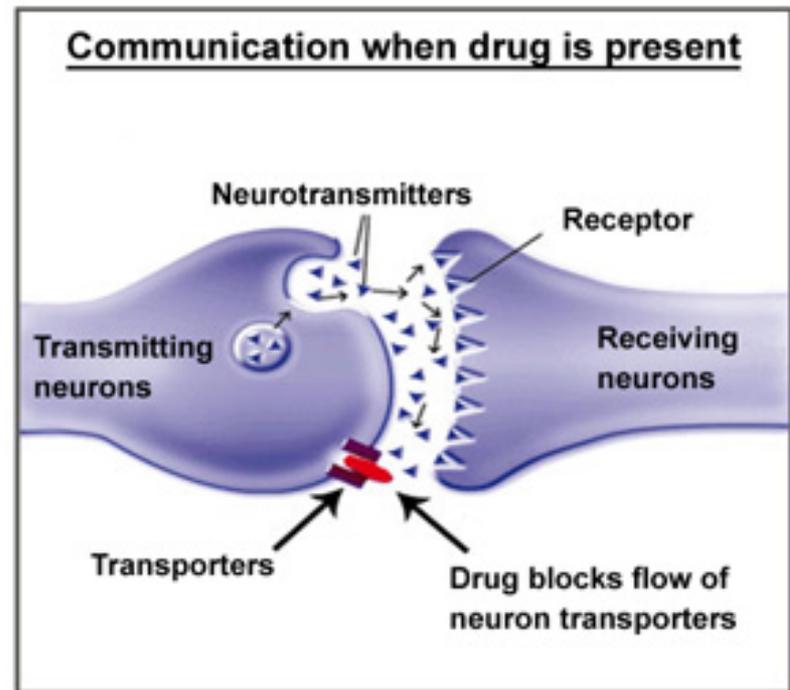
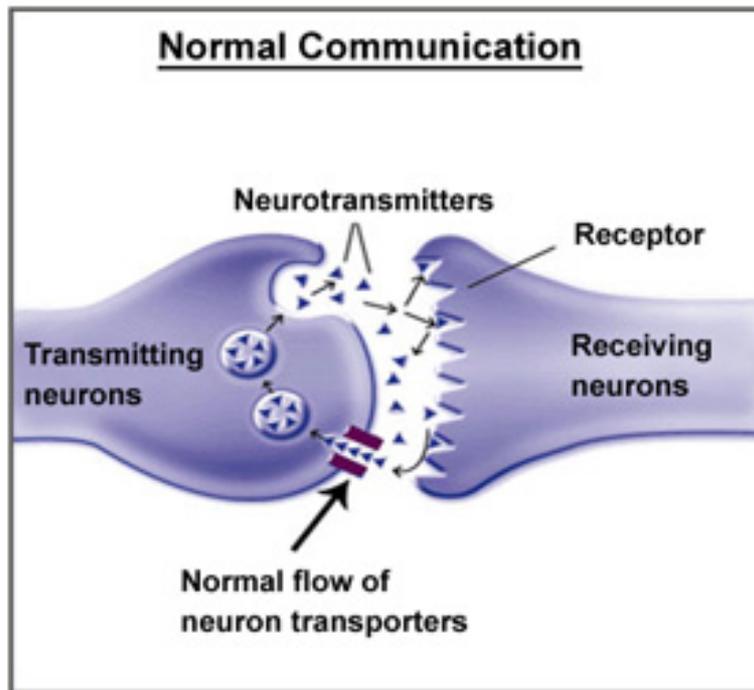
Opiates change the limbic system that control emotions & increases feelings of pleasure

Opiates change the brain stem, areas that controls automatic body functions

Opiates block pain messages transmitted by the spinal cord from the body

Brain Communication

Brain's Communication System on Drugs



- 52 Million people over the age of 12 have used prescription drugs non-medically in their lifetime
- 6.1 million people have used them non-medically within the past month
- The United States is only 5% of the world's population yet consumes 75% of the world's prescription drugs

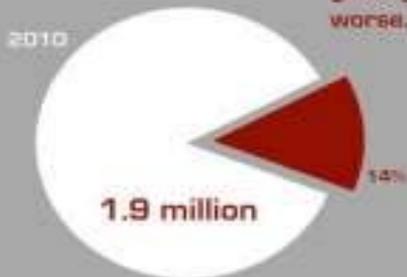
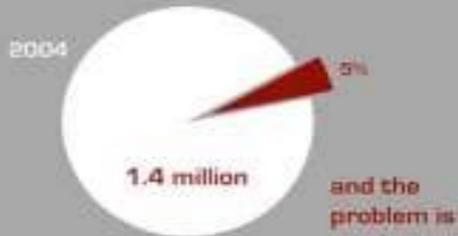
ABUSE OF PRESCRIPTION PAIN MEDICATIONS RISKS HEROIN USE

In 2010 almost 1 in 20 adolescents and adults – 12 million people – used prescription pain medication when it was not prescribed for them or only for the feeling it caused¹. While many believe these drugs are not dangerous because they can be prescribed by a doctor, abuse often leads to dependence. And eventually, for some, pain medication abuse leads to heroin.



PEOPLE WHO TAKE NON MEDICAL PRESCRIPTION PAIN RELIEVERS WILL TRY HEROIN WITHIN 10 YEARS²

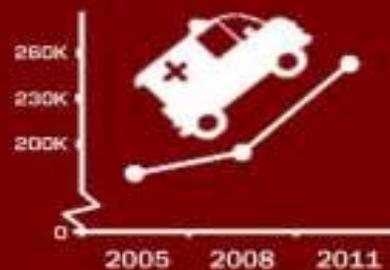
Number of People Who Abused or were
Dependent on Pain Medications and
Percentage of Them that Use Heroin³



Heroin users are **3X** as likely
to be dependent

14% of non medical prescription
pain reliever users are dependent.
54% of heroin users are dependent.⁴

Heroin Emergency Room Admissions Are Increasing⁵



A study from Yale University with members including Susan Busch, Hongyu Zhang, Stephen McLaughlin, & Rosanna Smith, showed a connection between prescription drug abuse and heroin use.

In 2010,

Enough prescription painkillers were prescribed to medicate
EVERY AMERICAN ADULT EVERY 4 HOURS

For 1 Month

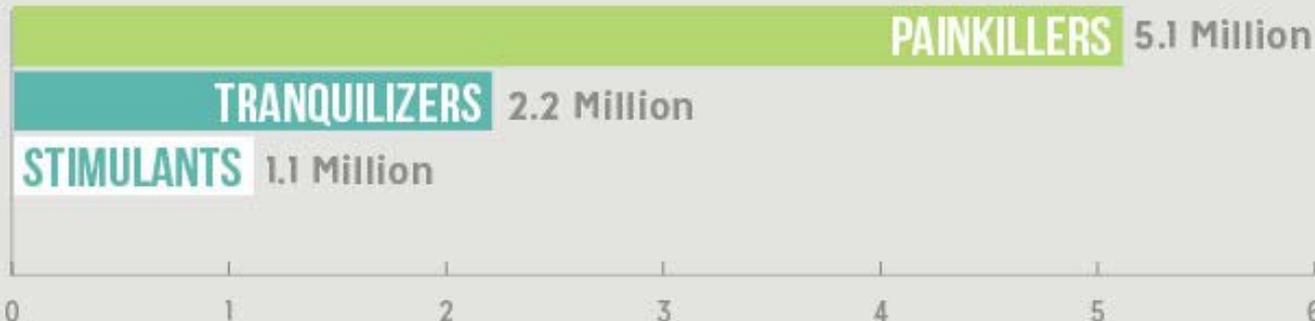
PBS 2013

The # of Prescription Medicine Abusers in 2010 was

8.76 MILLION

NSDUH 2011

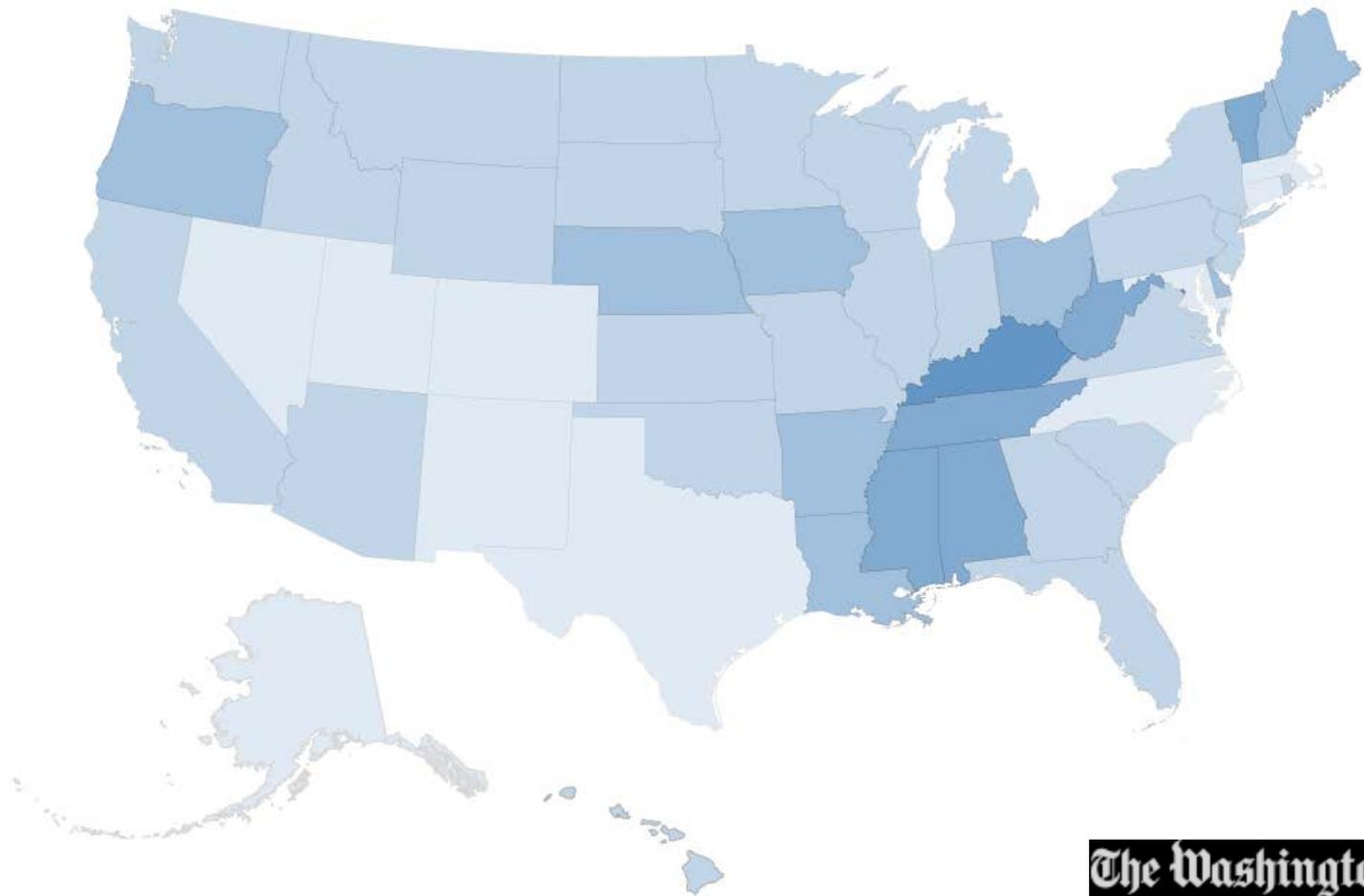
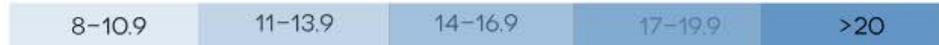
**Most abused prescription
Drugs fall under 3 categories:**



(# of Abusers of Prescription Drugs) DRUGABUSE.GOV

Map: The states taking the most prescription drugs

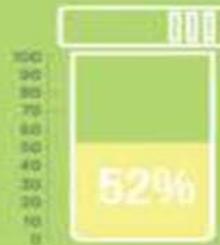
RETAIL PRESCRIPTION DRUGS FILED PER CAPITA (2013)



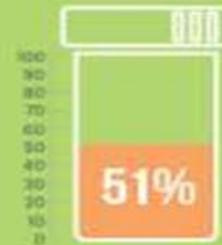
12 Reasons Teens USE PRESCRIPTION DRUGS



Easy to get from parent's medicine cabinets



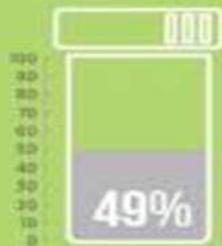
Available Everywhere



They are not illegal drugs



Easy to get through other people's prescriptions



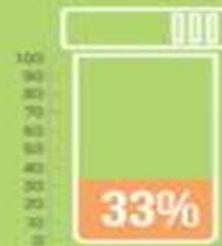
Can claim to have prescription if caught



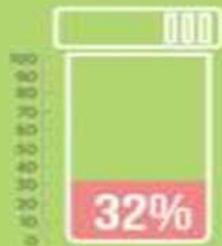
They are cheap



Safer to use than illegal drugs



Less shame attached to using



Easy to purchase over the internet



Fewer side effects than street drugs

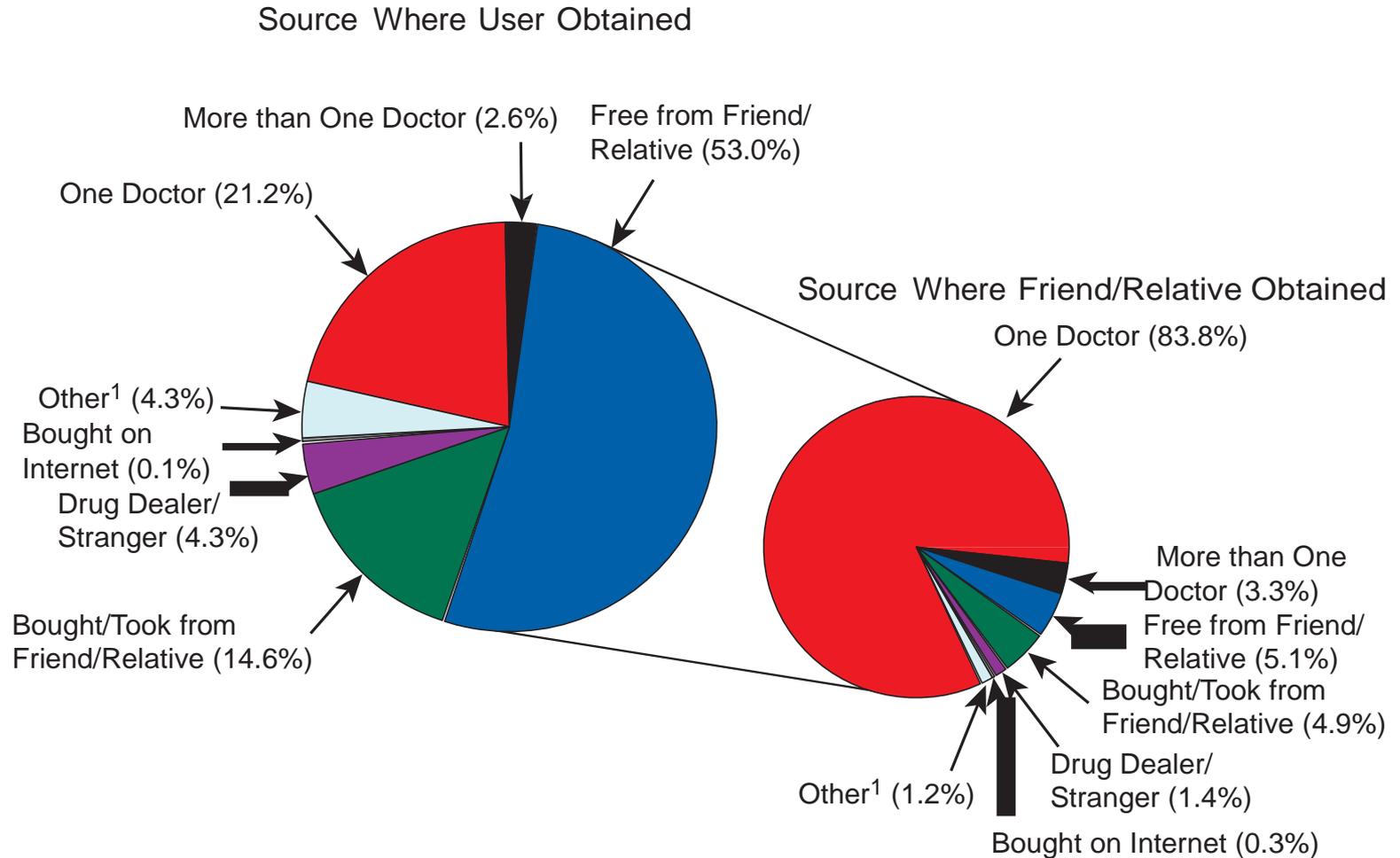


Can be used as study aids



Parents don't care as much if caught

Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2012-2013



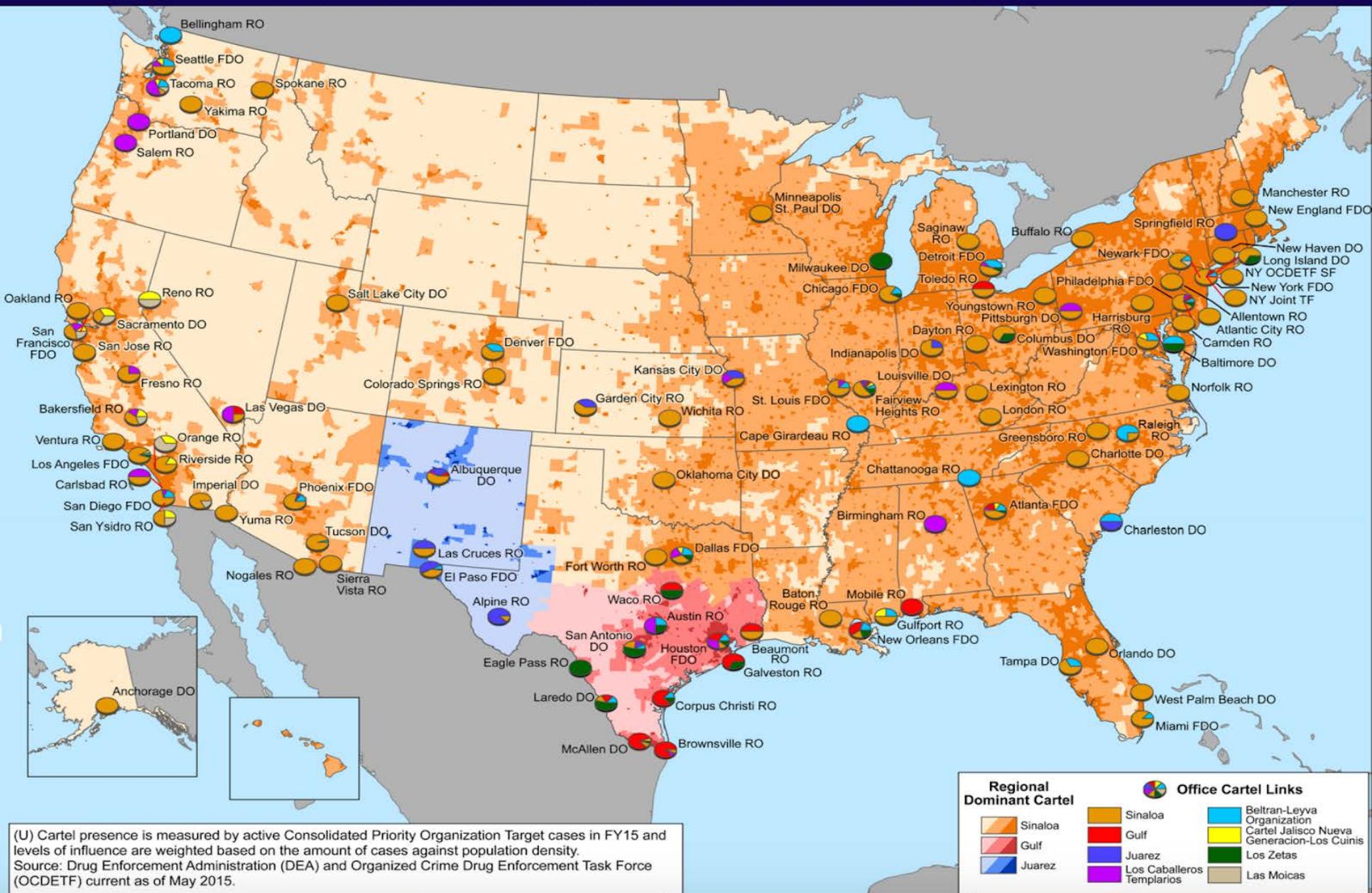
Economic Impact

- Estimated cost in the United States from non-medical use of prescription opioids for 2007
- \$55.7 billion:
- \$25.6 billion in workplace costs
- \$5.1 billion in criminal justice costs
- \$25 billion in health care costs

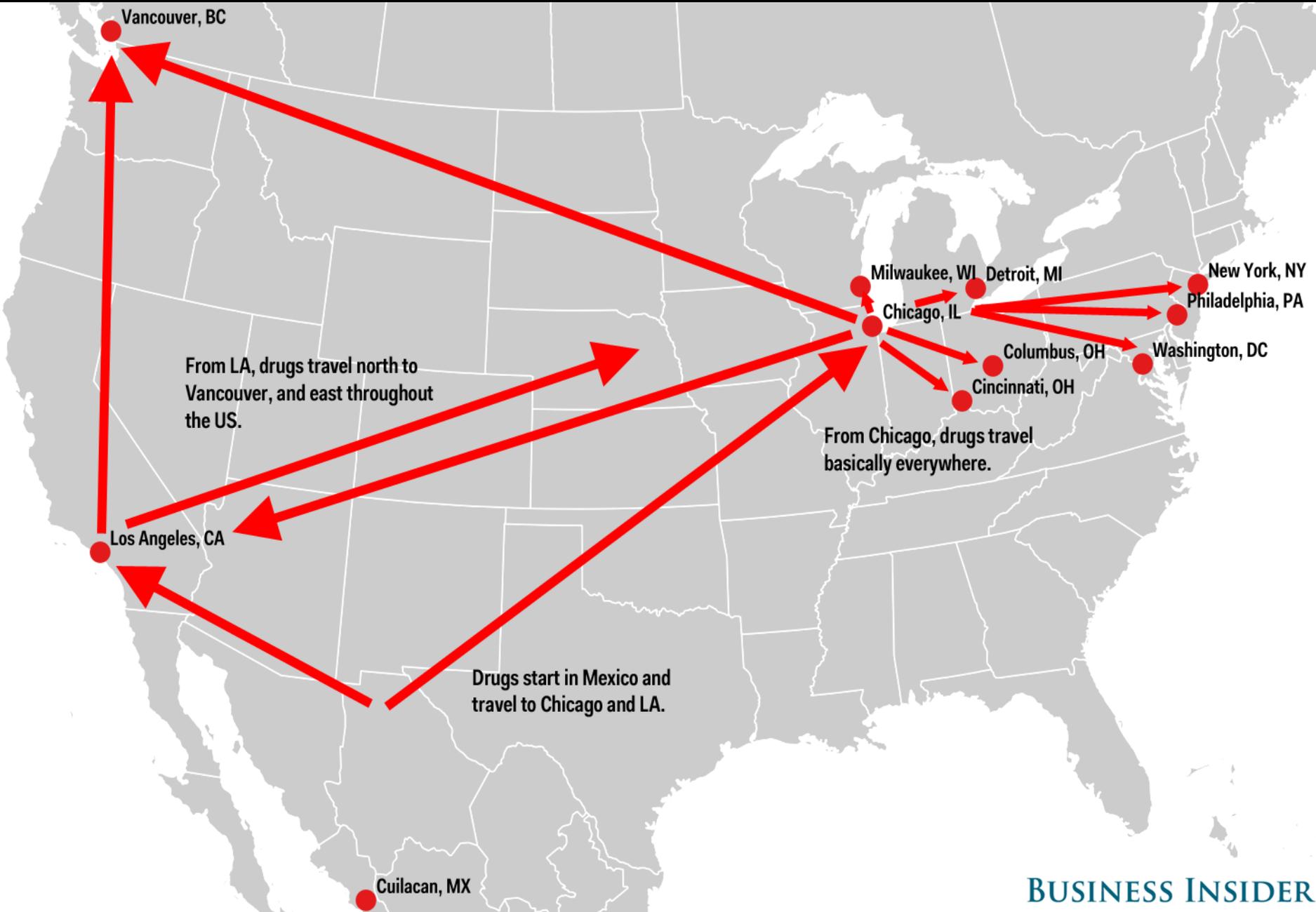
Birnbaum, H. G., White, A. G., Schiller, M. Waldman, T., Cleveland, J. M., & Roland, C. L. (2011). Societal costs of prescription opioid abuse, dependence, and misuse in the United States. *Pain Medicine*, 12: 657-667. Retrieved from: <http://www.asam.org/docs/advocacy/societal-costs-of-prescription-opioid-abuse-dependence-and-misuse-in-the-united-states.pdf>.

(U) Figure 2: United States: Areas of Influence of Major Mexican Transnational Criminal Organizations

FDO - FIELD DIVISION | DO - DISTRICT OFFICE | RO - RESIDENT OFFICE



(U) Cartel presence is measured by active Consolidated Priority Organization Target cases in FY15 and levels of influence are weighted based on the amount of cases against population density. Source: Drug Enforcement Administration (DEA) and Organized Crime Drug Enforcement Task Force (OCDETF) current as of May 2015.



Vancouver, BC

Los Angeles, CA

Cuilacan, MX

Milwaukee, WI

Detroit, MI

Chicago, IL

New York, NY

Philadelphia, PA

Washington, DC

Columbus, OH

Cincinnati, OH

From LA, drugs travel north to Vancouver, and east throughout the US.

From Chicago, drugs travel basically everywhere.

Drugs start in Mexico and travel to Chicago and LA.

(U) MAP 5. 2014 – CHANGE IN HEROIN TRAFFICKING IN THE CBP CORRIDORS



Erasing the Stigma

Judgmental Terms: Implications of Words That Cause Stigma

Subject	Terminology	Implication
Urine Test Results	Urine is termed "clean" or "dirty," rather than "positive," "expected," "negative," or "unexpected"	The test result is "positive" or "dirty" if an unexpected substance, such as an illicit opioid, is identified
Evaluation of OUD Patients	Patients are considered "clean" if in recovery or if managing their symptoms	Patients showing symptoms are considered "dirty"
Dosage Decreases of Methadone or Buprenorphine	Tapering often is called "detoxification"	Methadone and buprenorphine are toxic (poisonous)
Treatment That Doesn't Involve Medication	Treatment often is considered "drug-free," or patients "abstinent," only if patients are not taking any medication	A person cannot be drug-free if taking methadone or buprenorphine

MAT

- MAT is banned in almost 50% of drug courts nationwide.
- MAT is stigmatized; not just in society and drug courts, but in treatment and programs such as AA and NA as well.
- Drug courts will no longer receive federal funding if they ban MAT clients.

....BE IT RESOLVED THAT:

1. Drug Court professionals have an affirmative obligation to learn about current research findings related to the safety and efficacy of M.A.T for addiction.
2. Drug Court programs should make reasonable efforts to attain reliable expert consultation on the appropriate use of M.A.T. for their participants....
3. Drug courts do not impose blanket prohibitions against the use of M.A.T. for their participants. The decision whether or not to allow the use of M.A.T. is based on a particularized assessment in each case of the needs of the participants and the interests of the public and the administration of justice.

—*National Association of Drug Court Professionals*

Resolution of the Board of Directors

What can you

DO

??

"Embrace a philosophy of choice based on the assumption that there are multiple pathways to long-term recovery"

Avoid mandating AA or NA. Instead, welcome people in recovery to explore their options.

Monitor the reported recovery support groups

Work with local AA or NA groups, to locate medication-assisted treatment

Hold medication-free recovery meetings

Provide sample scripts for medications in recovery

Seek ongoing professional support among your colleagues

Infuse your setting with multiple recovery models and recovery outside of recovery

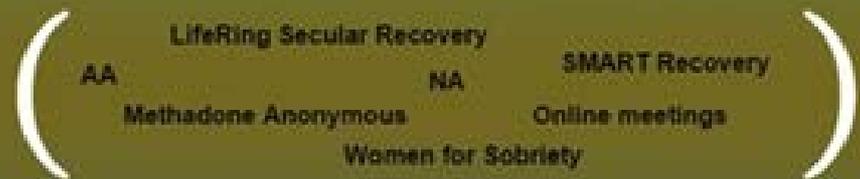
What can you

SUGGEST

??

"Explore your options for recovery support"

Consider the full range of available recovery support groups.



Find other people in medication-assisted treatment who share your recovery aspirations

Initially withhold your medication status until you have time to assess a personal fit with a recovery support group

Consider starting your own group

Adapted from White, W. (2011). Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Intellectual Disability Services.

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Visit ireta.org

Nine Components of Successful MAT Programs

- 1. Counseling and other services—plus medication— are essential.**
- 2. Courts are selective about treatment programs and private prescribing physicians.**
- 3. Courts develop strong relationships with treatment programs and require regular communication regarding participant progress.**
- 4. Screening and assessment must consider all clinically appropriate forms of treatment.**
- 5. Judges rely heavily on the clinical judgment of treatment providers as well as the court's own clinical staff.**

Nine Components of Successful MAT Programs

6. Endorsement of medication-assisted treatment by all members of the drug court team is the goal, but not a prerequisite.
7. Monitoring for illicit use of medication-assisted treatment medication is a key component of the program and can be accomplished in different ways.
8. Medications for medication-assisted treatment are covered through government and/or private insurance programs.
9. Medication-assisted treatment operates very similarly to other kinds of treatment.

What challenges does medication-assisted treatment pose?

- Insufficient treatment capacity for all three MAT medications, which can lead to heavy reliance on buprenorphine (though it, too, is limited).
- Stigma of MAT, including in support programs
- Lack of support
- Limited in jails

FDA- Approved Medications for Substance Use Disorders

Name	Naltexone (Vivitrol®)	Buprenorphine	Methadone
Molecular Structure:	Antagonist	Agonist	Agonist
Treatment Use:	Opioid Dependence	Opioid Dependence	Opioid Dependence
Controlled Substance?	Schedule 0	Schedule III	Schedule II
Abuse Potential:	No	Yes	Yes
Trade Name:	Vivitrol	Suboxone®* *Includes naloxone	Methadone
How Administered?	Intramuscular injection	Oral tablet or sublingual film taken once daily	Oral solution
How the Medication Works:	By blocking opioid receptors, it blocks cue-triggered cravings	A long acting partial opioid, it relieves withdrawal, decreases cravings, and prevents euphoria if other opioids are used	A long acting “full” opioid that relieves withdrawal, blocks cravings, and prevents euphoria if other opioids are used
Special Licensing or Credentialing Required?	No	Varies by state	Yes
Year Approved by FDA for Addiction Treatment	2006	2002	1947- approved dispersible tablet for treatment of addiction
Physician Training Required?	No	Yes- 8 hours of training required	No
Typical Duration:	Up to 30 days	1 day	1 day
Detoxification or Stabilization	Detoxification & 7-10 days of complete abstinence from opioids	Detoxification	Can be used for detoxification and/or stabilization

How do you let this happen?



**80% OF HEROIN USERS
INJECT WITH A FRIEND.
WHICH IS WEIRD,
BECAUSE 80% OF OVERDOSE VICTIMS
FOUND BY PARAMEDICS ARE**

ALL ALONE.

Here's to looking out for yourself. At least you won't be alone in that.

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- <http://atforum.com/2016/02/stigma-article-series-part-i-patients-opioid-addiction-continue-face-stigma/>
- <http://lac.org/resources/substance-use-resources/medication-assisted-treatment-resources/medication-assisted-treatment-in-drug-courts-recommended-strategies/>
- <http://iwishineverstarted.org/>

National Drug Court Institute

Drug Court Training

Revisiting Phases: Risk Matters

Developed by: National Drug Court Institute

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BJA
Bureau of Justice Assistance
U.S. Department of Justice

Why have Phases?

Structure

Recovery Process

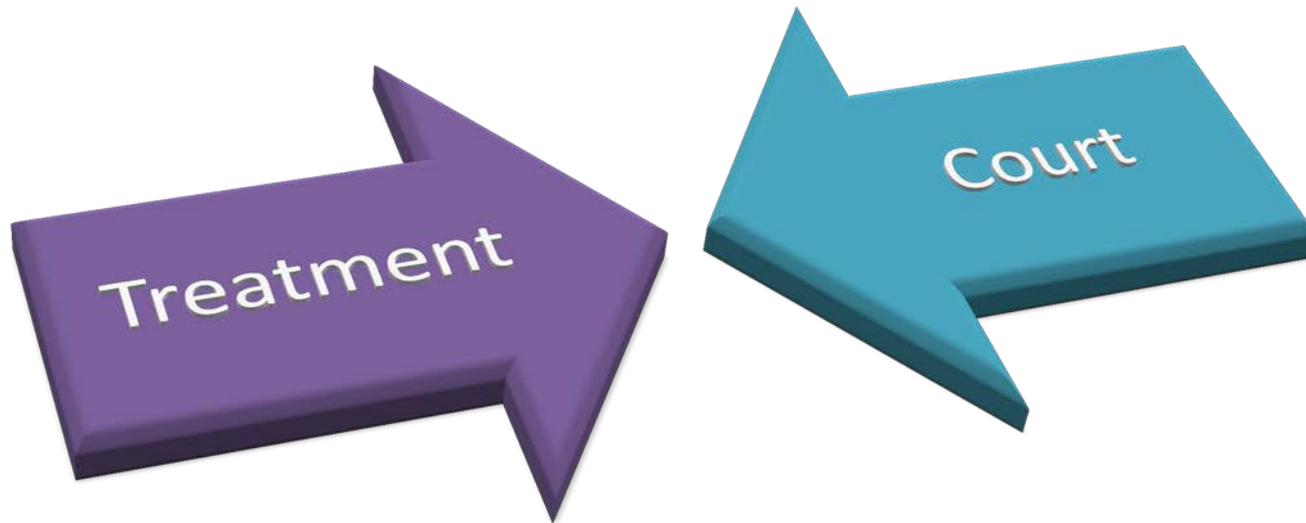
Incremental Progress



Congratulations



Types of Phases



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Court Requirements

- Comply with treatment
- Comply with supervision
- 12 Step / Support Meetings
- Community Service
- Employment
- Program Fees/Court Costs
- Phase Advancement
- Alumni/Continuing Care



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Court Requirements:

- Court Appearances
- Drug Tests
- Crime Free
- Clean Time
- Curfew
- Ancillary Services
- Case Management
- Educational/Vocational Training/GED
- Drug-Free/Pro-Social Activities

COURT APPROVED
Anger Management
Classes



Making Changes... for Good!



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Sample Phases



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Practical Implications

High Risk

Low Risk

<ul style="list-style-type: none"> ✓ Status calendar ✓ Treatment ✓ Pro-social & adaptive habilit. ✓ Abstinence is distal ✓ Positive reinforcement ✓ Self-help/alumni groups ✓ ~ 18-24 mos. (~200 hrs.) 	<ul style="list-style-type: none"> ✓ Status calendar (until stable) ✓ Treatment (separate milieu) ✓ Adaptive habilitation ✓ Abstinence is distal ✓ Positive reinforcement ✓ Self-help/alumni groups ✓ ~ 12-18 mos. (~150 hrs.)
<ul style="list-style-type: none"> ✓ Status calendar ✓ Pro-social habilitation ✓ Abstinence is proximal ✓ Negative reinforcement ✓ ~ 12-18 mos. (~100 hrs.) 	<ul style="list-style-type: none"> ✓ Noncompliance calendar ✓ Psycho-education ✓ Abstinence is proximal ✓ Individual/stratified groups ✓ ~ 3-6 mos. (~ 12-26 hrs.)

High
Needs
(dependent)

Low
Needs
(abuse)

Phase I

Acute Stabilization (60 days)

- Court weekly
- Comply with treatment
- Comply with supervision
- Develop case plan
- Weekly office visit
- Monthly Home visits
- Weekly random drug testing (minimum of 2)
- Address housing
- Obtain medical assessment
- Change people, places and things
- Curfew 9 pm

In order to advance:

Regular attendance at treatment, office visits, being honest

Clean time minimum of 14 consecutive days



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Phase 2

Clinical Stabilization (90 days)

- Court bi-weekly
 - Comply with treatment and supervision
- Review case plan
 - Weekly office visit
 - Monthly Home visits
 - Weekly random drug testing (minimum of 2)
 - Change people, places and things
- End of the phase begin to focus on Peer Support Groups(e.g., 12 step groups)
- Maintain housing
- Addressing financial (budget assessment)
- Curfew 10 pm



Phase 2

Clinical Stabilization (90 days)

In order to advance:

Compliance with treatment,

Compliance with supervision

Clean time minimum of 30 consecutive days



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Phase 3

Pro-Social Habilitation (90 days)

- Court monthly
 - Comply with treatment and supervision
 - Review case plan
- Relapse prevention
- Bi-weekly office visit
 - Monthly Home visits
 - Weekly random drug testing (minimum of 2)
 - Maintain housing
 - Address medical
 - Change people, places and things
- Begin Criminal Thinking
- Establish sober network
- Establish pro-social activity
- Curfew 11 pm



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Phase 3

Pro-social Habilitation (90 days)

In order to advance:

- Compliance with treatment
- Compliance with supervision
- Began pro-social activity
- Began sober support network
- Clean time minimum of 45 consecutive days



Phase 4

Adaptive Habilitation (90 days)

- Court monthly
- Comply with treatment and supervision
- Review case plan
- Bi-weekly office visit
- Monthly home visits
- Weekly random drug testing (minimum of 2)
- Maintain housing
- Addressing medical
- Change people, places and things
- Maintain Sober Network
- Maintain Pro-social Activity
- Curfew 12 am
- As need based upon assessment:
 - Job Training
 - Parenting/Family Support
 - Vocational Training



Phase 4

Adaptive Habilitation (90 days)

In order to advance:

Compliance with treatment,

Compliance with supervision

Maintain sober support network

Maintain pro-social activity

Began/maintain other areas (employment, etc.)

Clean time minimum of 60 consecutive days



Phase 5

Continuing Care (90 days)

- Court monthly
- Comply with treatment and supervision
- Review case plan
- Monthly office visit
- Monthly home visits
- Maintain housing
- Addressing medical
- Random drug testing
- Development of continuing care plan
- Demonstrate change of people, places and things
- Maintain Pro-Social Activity
- Maintain Sober Network
- Maintain as need based upon assessment:
 - Job Training
 - Parenting/Family Support
 - Vocational Training



Phase 5

Continuing Care (90 days)

In order to commence:

- Compliance with treatment
- Compliance with supervision
- Maintain Pro-Social Activity
- Maintain Sober Network
- Maintain as need based upon assessment:
 - Job Training
 - Parenting/Family Support
 - Vocational Training

Clean time minimum of 90 consecutive days



There's A Lot To Remember



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Sample Weekly Sheet

Date/Day	Time	Activity – Goal	Initials
Monday	06:00 am	Take prescription meds with breakfast	
Monday	08:00 am	Obtain picture I.D.	
Monday	2 – 4 pm	Attend Thinking for Change Group	
Tuesday	1 – 4 pm	Dialectical Behavior Therapy (DBT) Group	
Wed.	1 – 4 pm	Dialectical Behavior Therapy (DBT) Group	
Thursday	1 – 4 pm	Dialectical Behavior Therapy (DBT) Group	
Friday	1 – 2 pm	Individual Session	



Considerations

Population

Accountability

Resources

Culture

Challenges

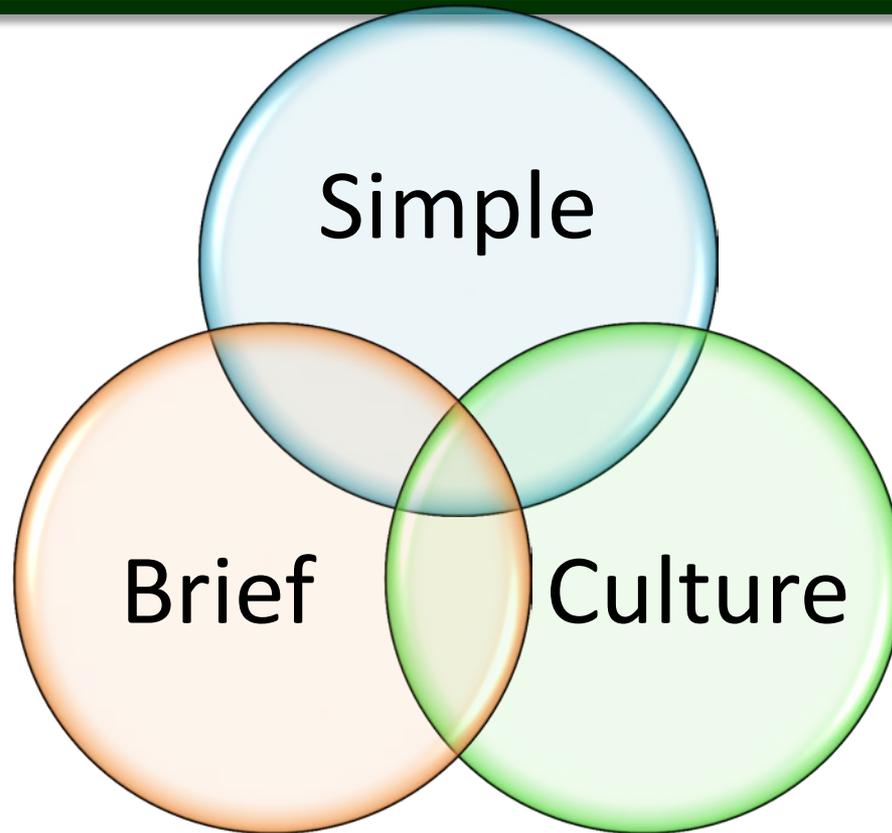
Realistic &
Recovery Focus



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Client Handbook/Contract



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EVALUATIONS

Please remember to fill out your
evaluations!



VIRGINIA DRUG COURTS EFFECTIVENESS WITH PRESCRIPTION DRUG USERS

AUGUST 29, 2016

Patty Moran, L.C.S.W., CSSGB

Knowledge Advisory Group

pmoran@knowledgeadvisorygroup.com



Presentation Overview



Virginia Drug Courts Effectiveness with Prescription Drug Users

- Purpose of Study
- Site Selection
- Sample Profile
- Descriptive Study
- Next Steps

Where Treatment and Accountability Meet Justice





Purpose of Study



Overall purpose: To determine how prescription drug users differ (or don't differ) from their counterparts enrolled in the same drug court.

- **Key Phases of Study**

- Select appropriate drug courts for inclusion in study
- Descriptive Study
- Effectiveness Study
- Cost Benefit Analysis

Where Treatment and Accountability Meet Justice





Site Selection



Specific site selection criteria were established to identify adult drug courts representing different geographical regions of the state, particularly those with a higher prevalence of prescription drug use

At least one of the drug courts chosen was planned to be from Southwest Virginia given its established profile as the state's premier prescription abuse region.

Where Treatment and Accountability Meet Justice





Site Selection

Primary Considerations



- **Availability of appropriate study data**
 - *Maturity level of the drug court*
 - *Case validation percentages for required data elements*
 - *Number of valid cases for each court within the established time frame*
- **Proportion of prescription drug users based on positive drug screens and reported drug of choice**

Where Treatment and Accountability Meet Justice





Site Selection

Secondary Considerations



Secondary considerations were examined for drug courts with relatively higher prescription drug use, based on the primary considerations

- **Community-specific data**
 - *Number of reported drug/poison deaths by fentanyl, hydrocodone, methadone and oxycodone in 2012*
 - *Types of drugs seized during drug arrests*
- **Location of each court based on the “Virginia Performs” region designation**

Where Treatment and Accountability Meet Justice





Site Selection

Supplemental Drug Testing



A preliminary group of potential drug court programs were identified as potential study sites based on the primary and secondary considerations

- *Supplemental drug testing was initiated over a 12-week period to provide consistent, additional information on current prescription drug use by participants enrolled in one of these identified programs*

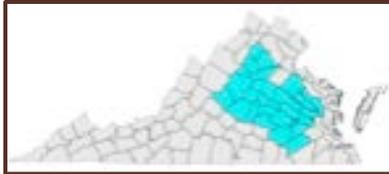
As a result of this selection process, seven adult drug court programs were recommended and approved by the Supreme Court of Virginia for inclusion in the study.

Where Treatment and Accountability Meet Justice





Seven Selected Drug Courts



**Chesterfield/Colonia
I Heights Drug Court**

Where Treatment and Accountability Meet Justice





Seven Selected Drug Courts



**Chesterfield/Colonia
I Heights Drug Court**



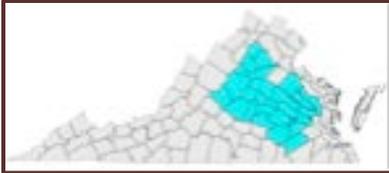
**Portsmouth Drug
Court**

Where Treatment and Accountability Meet Justice

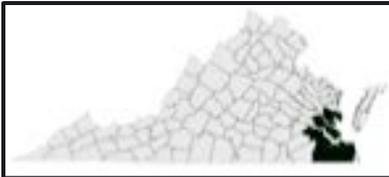




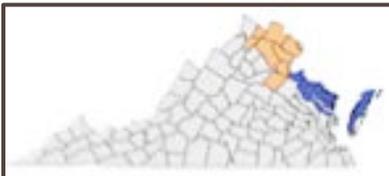
Seven Selected Drug Courts



**Chesterfield/Colonia
I Heights Drug Court**



**Portsmouth Drug
Court**



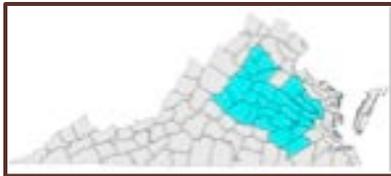
**Rappahannock
Regional Drug Court**

Where Treatment and Accountability Meet Justice





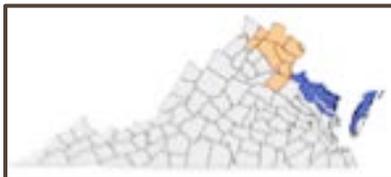
Seven Selected Drug Courts



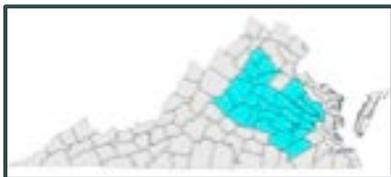
**Chesterfield/Colonia
I Heights Drug Court**



**Portsmouth Drug
Court**



**Rappahannock
Regional Drug Court**



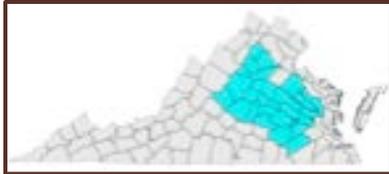
**Richmond Drug
Court**

Where Treatment and Accountability Meet Justice

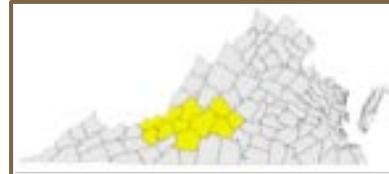




Seven Selected Drug Courts



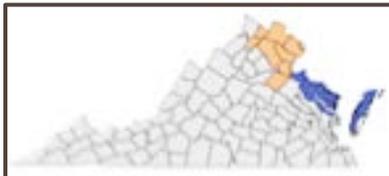
**Chesterfield/Colonia
I Heights Drug Court**



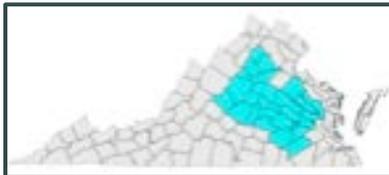
**23rd Judicial District
Drug Court**



**Portsmouth Drug
Court**



**Rappahannock
Regional Drug Court**



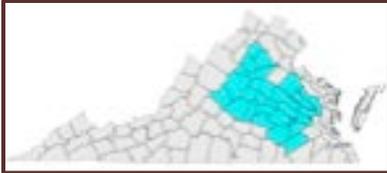
**Richmond Drug
Court**

Where Treatment and Accountability Meet Justice

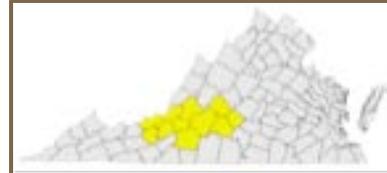




Seven Selected Drug Courts



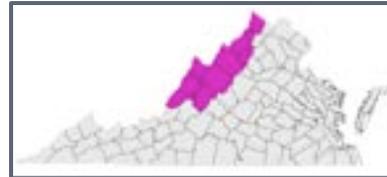
**Chesterfield/Colonia
Heights Drug Court**



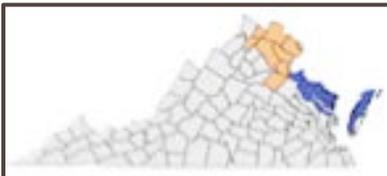
**23rd Judicial District
Drug Court**



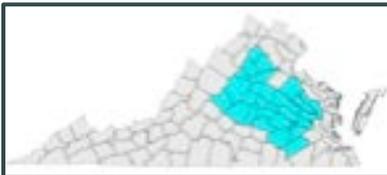
**Portsmouth Drug
Court**



**Staunton/Waynesbor
o Drug Court**



**Rappahannock
Regional Drug Court**



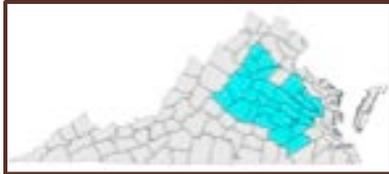
**Richmond Drug
Court**

Where Treatment and Accountability Meet Justice

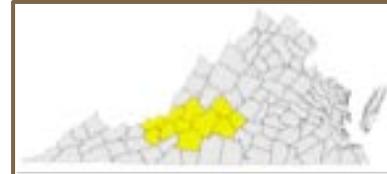




Seven Selected Drug Courts



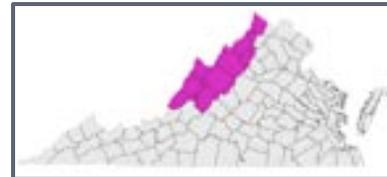
**Chesterfield/Colonia
I Heights Drug Court**



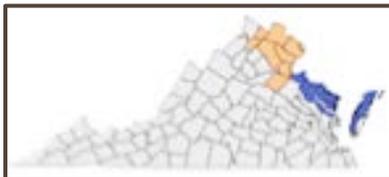
**23rd Judicial District
Drug Court**



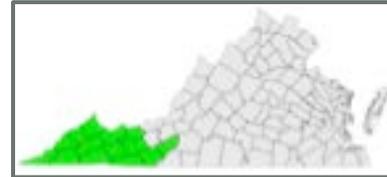
**Portsmouth Drug
Court**



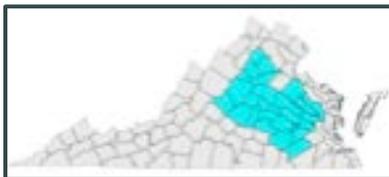
**Staunton/Waynesbor
o Drug Court**



**Rappahannock
Regional Drug Court**



**Tazewell County
Drug Court**



**Richmond Drug
Court**

Where Treatment and Accountability Meet Justice





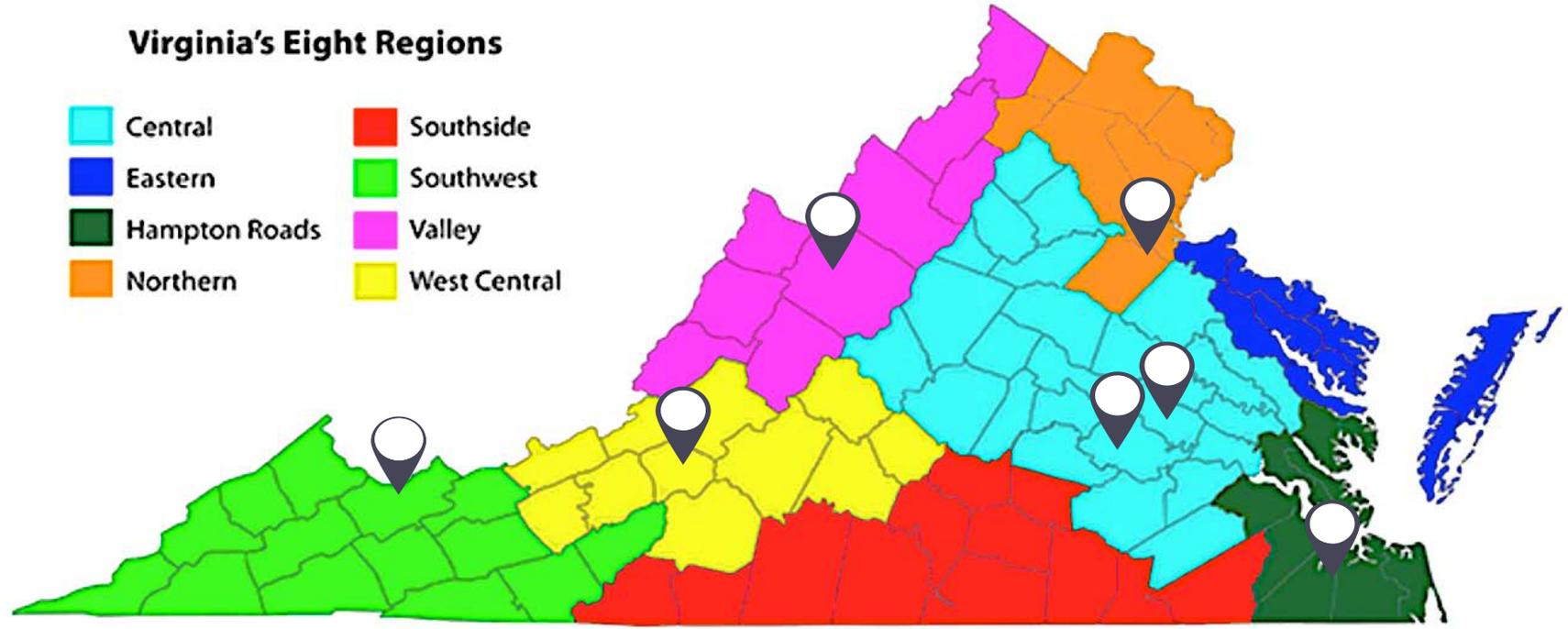
Regional Representation



Drug Court programs from seven of the eight regional areas of the state were represented in the study

Virginia's Eight Regions

- Central
- Eastern
- Hampton Roads
- Northern
- Southside
- Southwest
- Valley
- West Central



Where Treatment and Accountability Meet Justice





Sample Selection



Evaluation Period:
July 1, 2007 – December 31, 2014

Where Treatment and Accountability Meet Justice





Sample Selection



Number of referrals to one of the selected drug courts

2,983

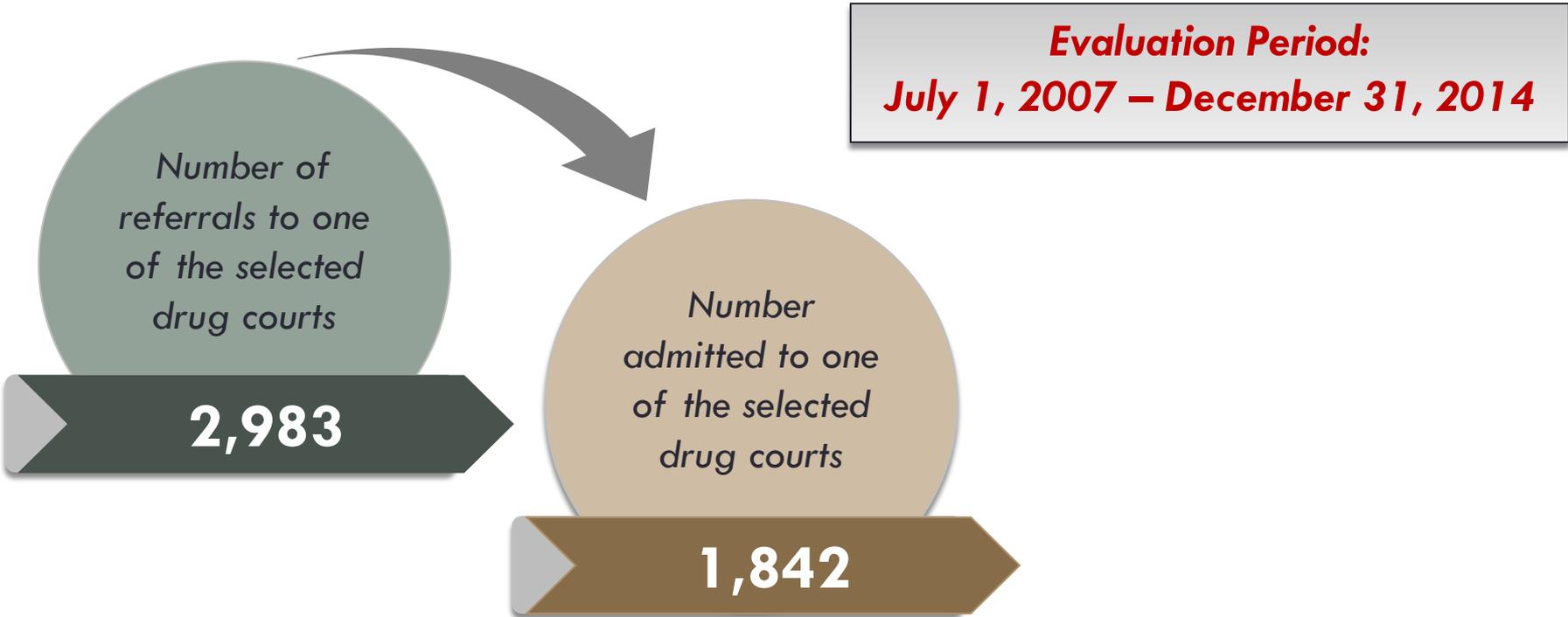
**Evaluation Period:
July 1, 2007 – December 31, 2014**

Where Treatment and Accountability Meet Justice





Sample Selection

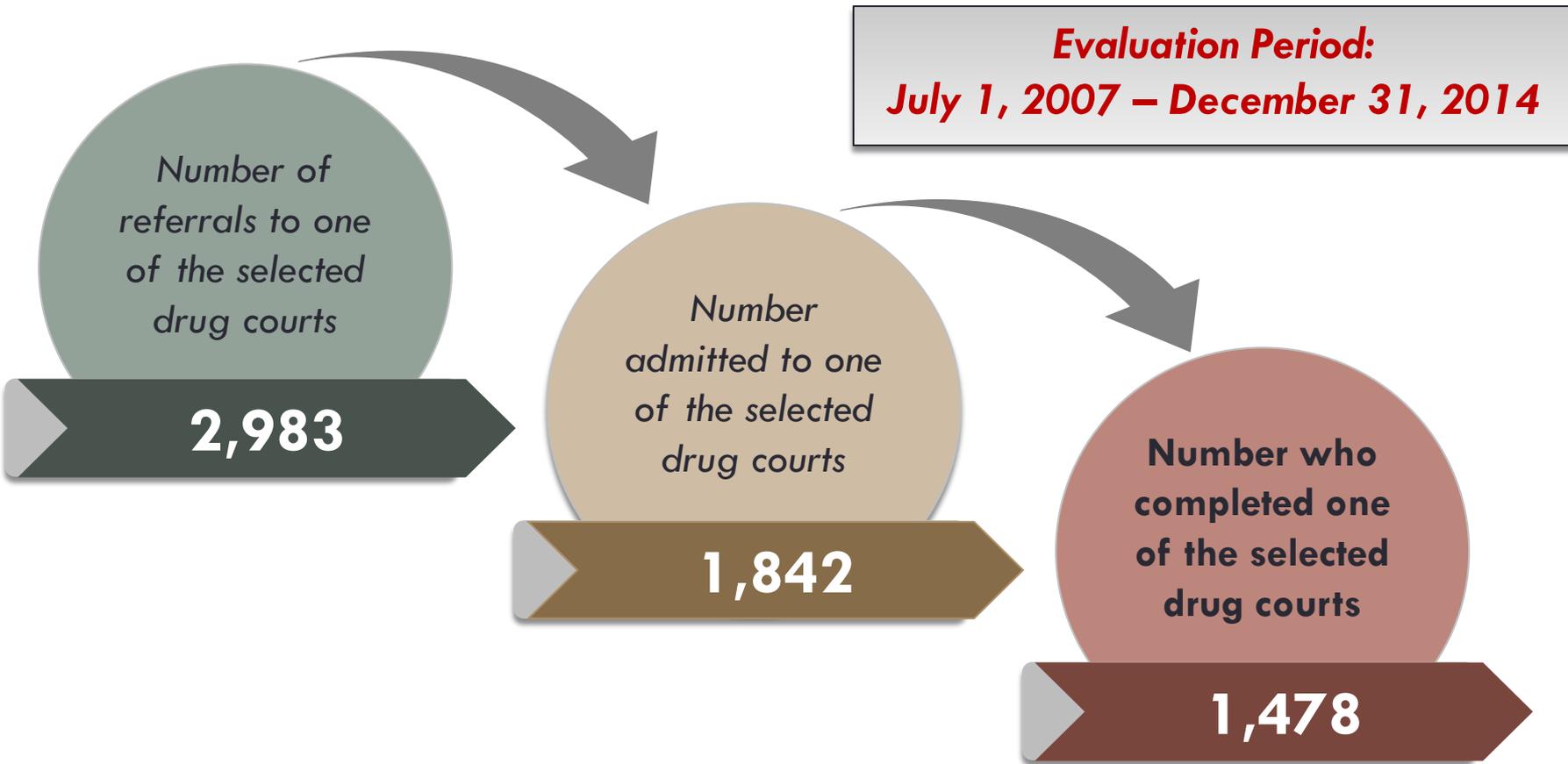


Where Treatment and Accountability Meet Justice





Sample Selection



Where Treatment and Accountability Meet Justice

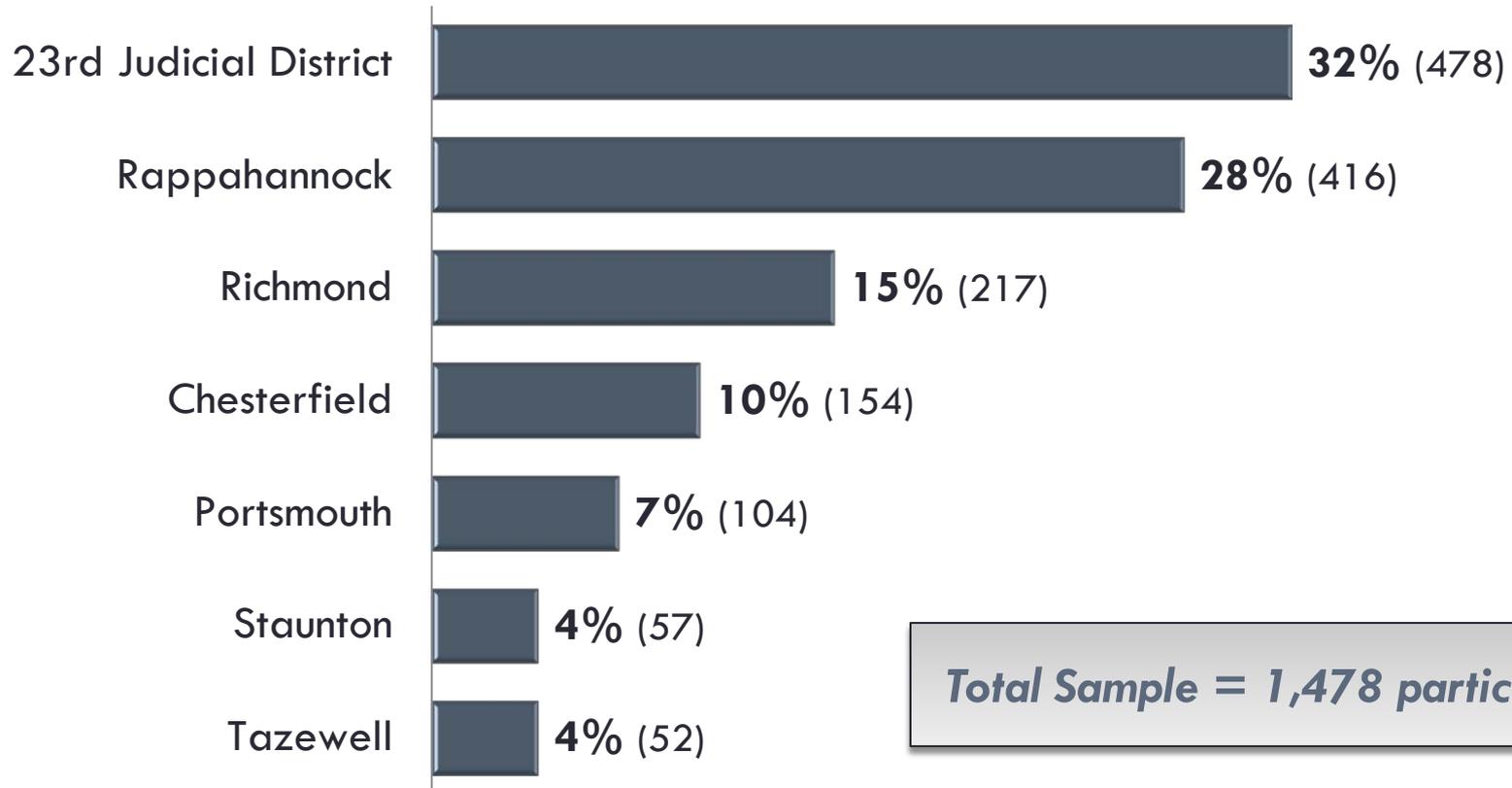




Study Sample



Sample by Locality

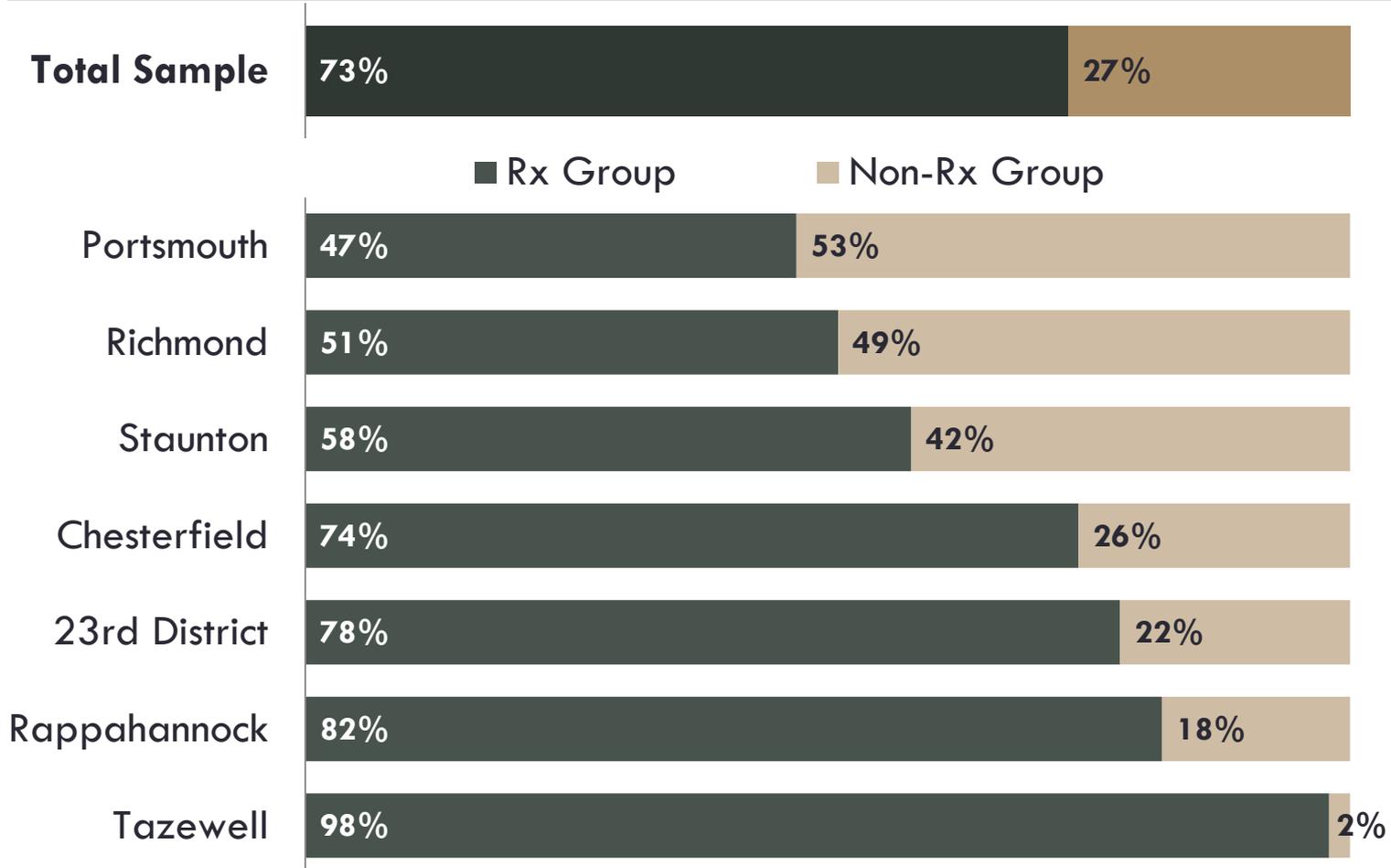


Where Treatment and Accountability Meet Justice





Study Sample



Where Treatment and Accountability Meet Justice

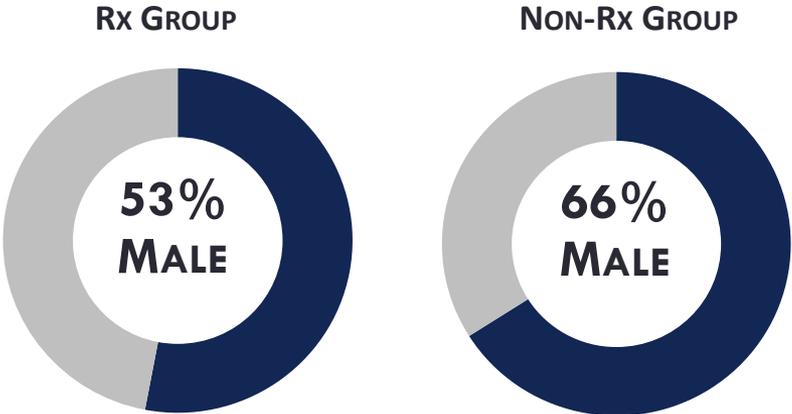




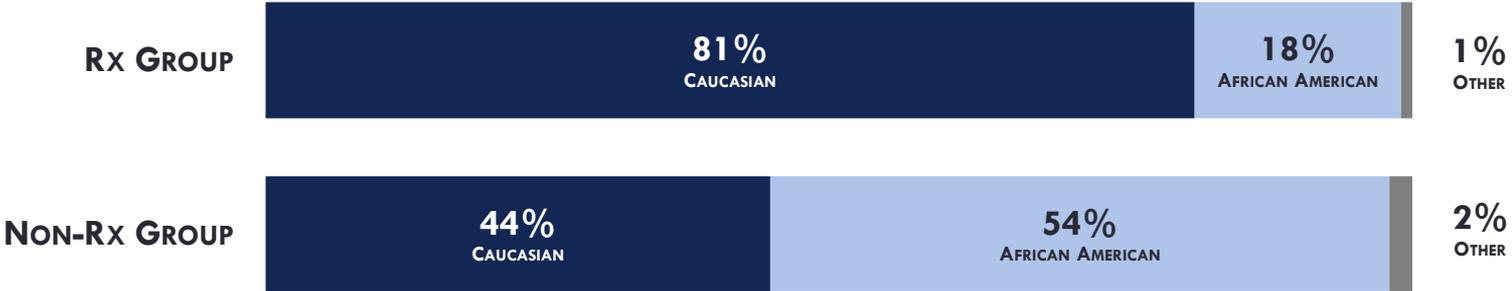
Demographic Data



GENDER



RACE



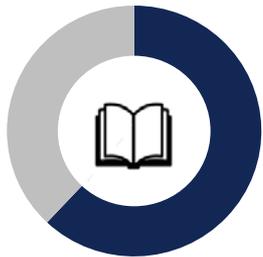


Demographic Data



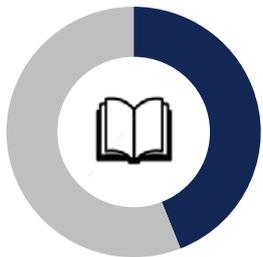
EDUCATION

RX GROUP



62%
High school graduate or above

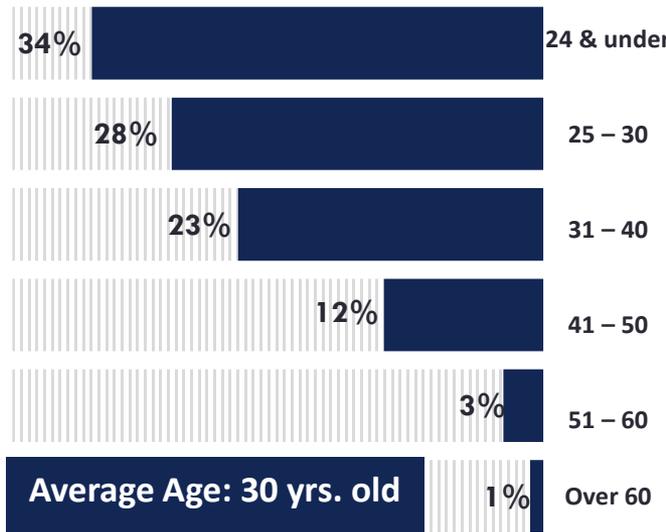
NON-RX GROUP



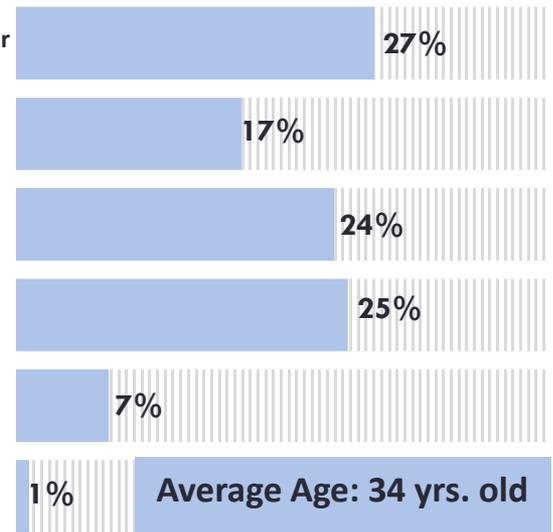
44%
High school graduate or above

AGE

RX GROUP



NON-RX GROUP

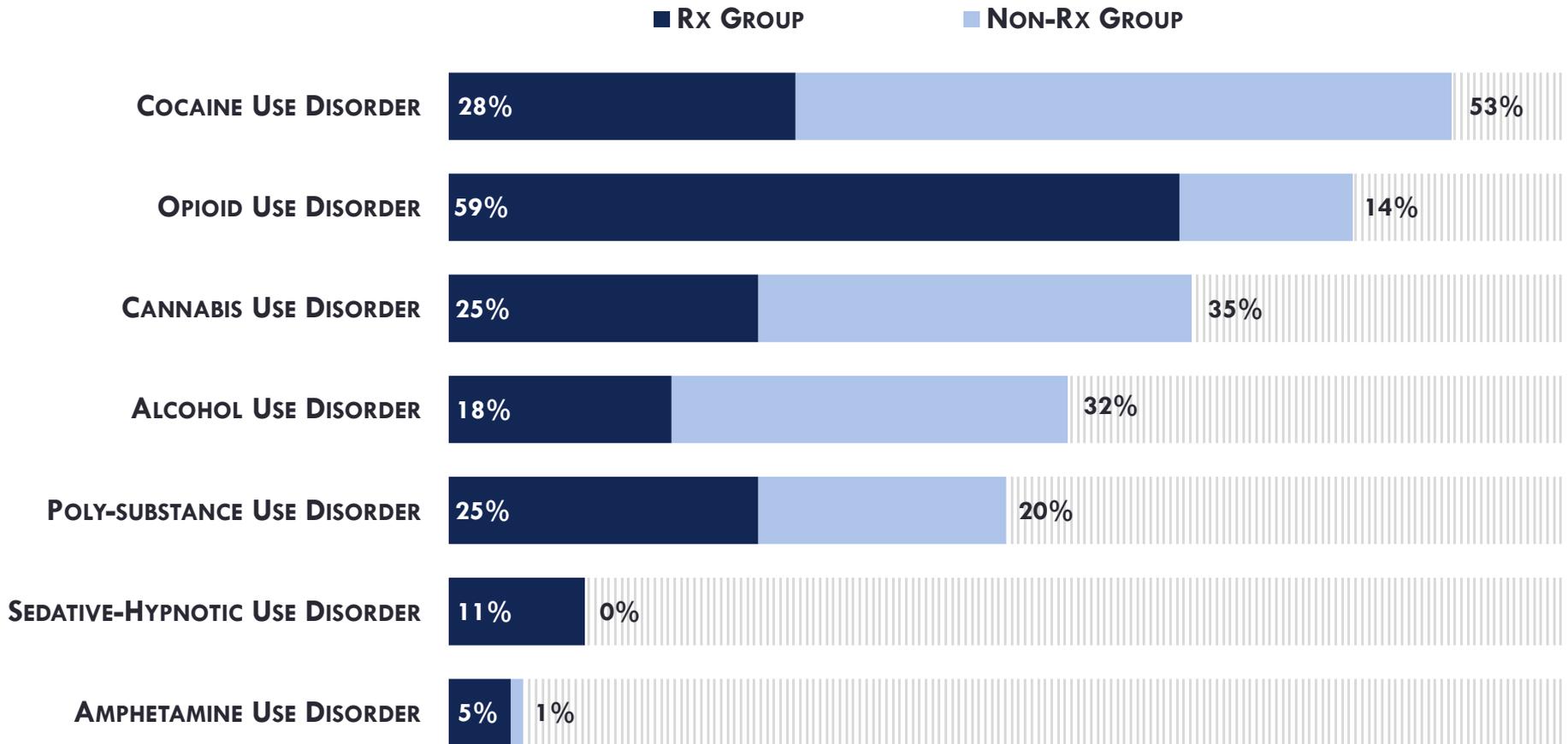


Where Treatment and Accountability Meet Justice





Substance-Related Diagnoses



Where Treatment and Accountability Meet Justice

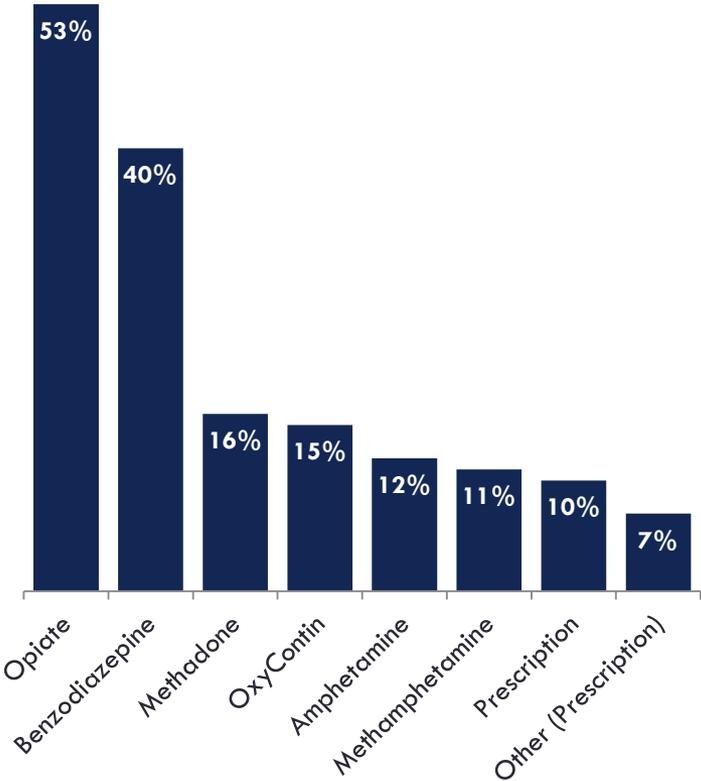




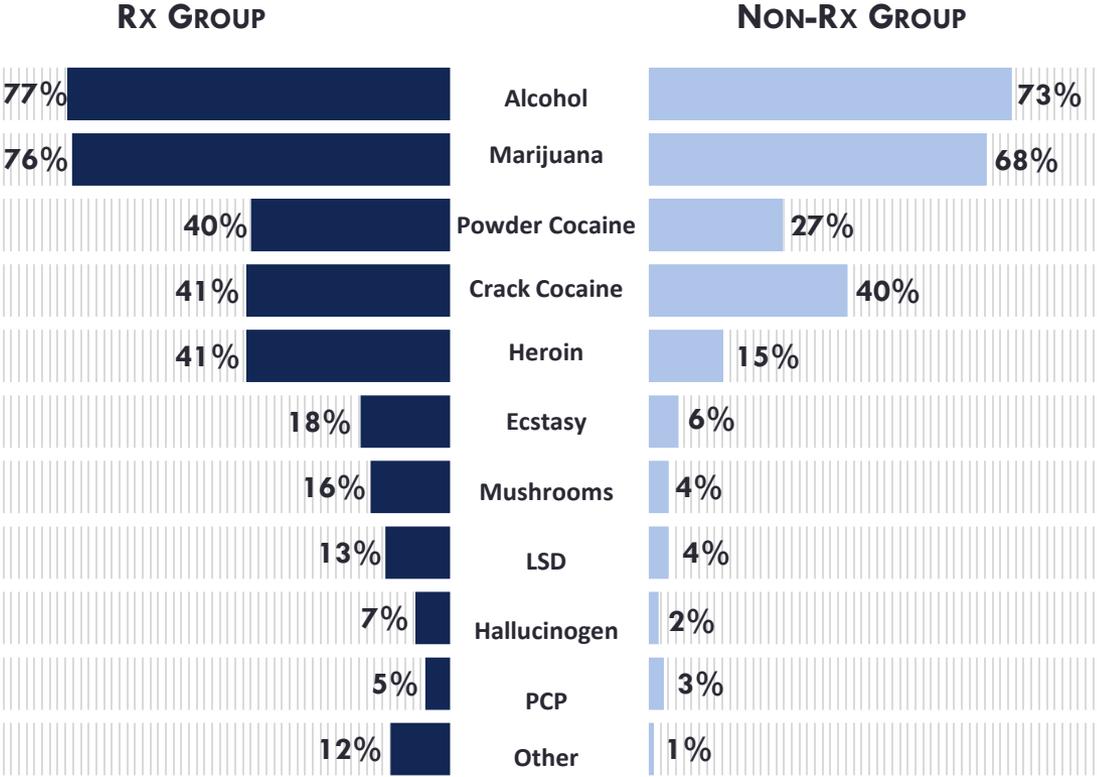
Primary Drug of Choice



Prescription DOCs



Non-Prescription DOCs





What's Next?



Outcomes

- Analysis of outcome measures for drug treatment courts
 - *Short-term progress towards goals*
 - *Sobriety within program*
- Analysis of recidivism data

Cost-Benefit

- Identification of costs and benefits to be measured within each locality
- Identification of required data sources
- Collection and analysis of cost-benefit data

Where Treatment and Accountability Meet Justice





Cells Talking Smack!

*How Drugs of Abuse Disrupt
Cellular Communication and
Cause Addiction*

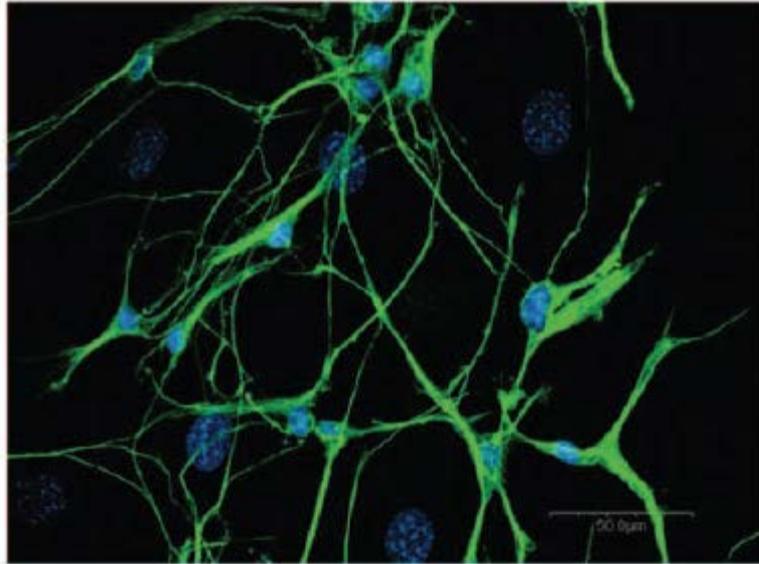
**Virginia DUI Drug Treatment Court Training :
Virginia Drug Court Best Practices**

August 29th, 2016

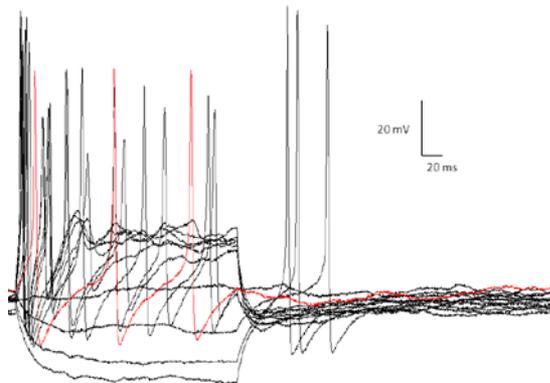
**Dr. Tricia Hardt Smith
hardtta@vcu.edu**



What I Love



Mouse Enteric Neurons



BJP BRITISH JOURNAL OF PHARMACOLOGY

BPS BRITISH PHARMACOLOGICAL SOCIETY

British Journal of Pharmacology (2010), 160, 454–466
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Journal compilation © 2010 The British Pharmacological Society. All rights reserved. 0007-1188/10
www.bjpharmacol.org

THEMED ISSUE: CANNABINOIDS

REVIEW

Cannabinoid CB₁ receptor-interacting proteins:
novel targets for central nervous system
drug discovery?

Tricia H Smith, Laura J Sim-Selley and Dana E Selley



OPEN ACCESS Freely available online

PLOS ONE

Morphine Decreases Enteric Neuron Excitability via Inhibition of Sodium Channels

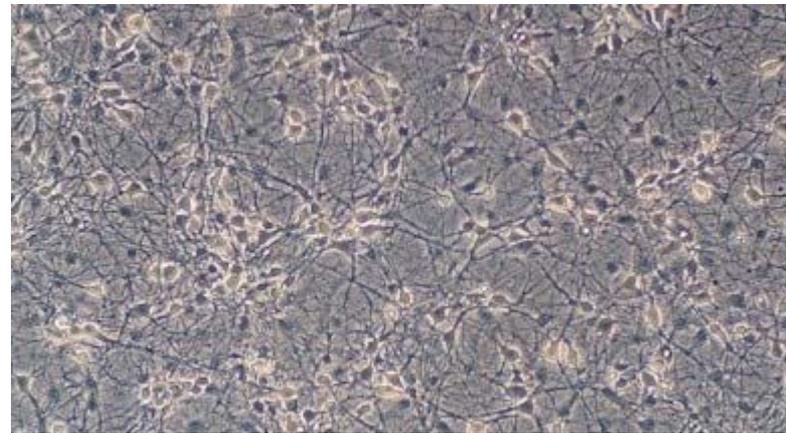
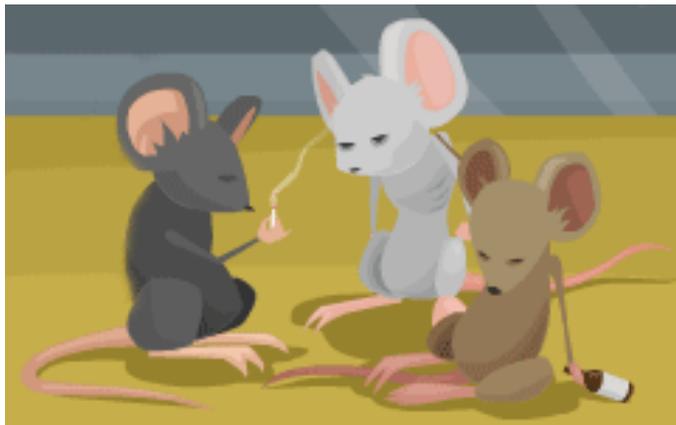
Tricia H. Smith¹, John R. Grider², William L. Dewey¹, Hamid I. Akbarali^{1*}

¹Department of Pharmacology and Toxicology, Virginia Commonwealth University, Richmond, Virginia, United States of America, ²Department of Physiology and Biophysics, Virginia Commonwealth University, Richmond, Virginia, United States of America

VCU

© Tricia H. Smith PhD.

These are my patients!



Let's talk molecular mechanisms of addiction!



GOOD NEWS!

There is no exam! 😊



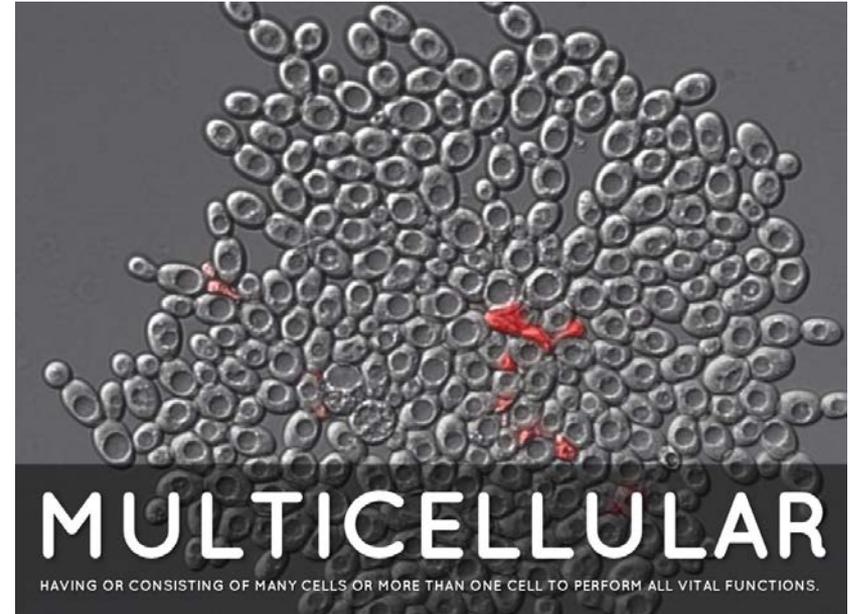
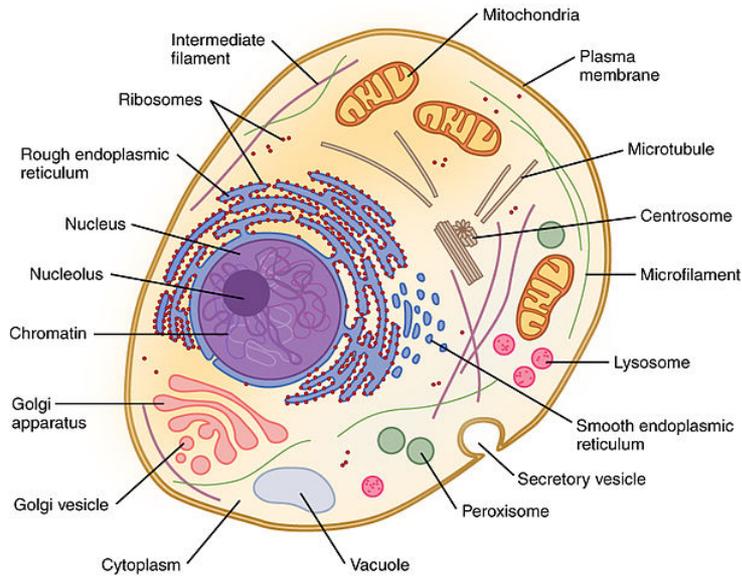
**KEEP
CALM
AND
NO
EXAM**

PART I:
How Drugs Affect Cells

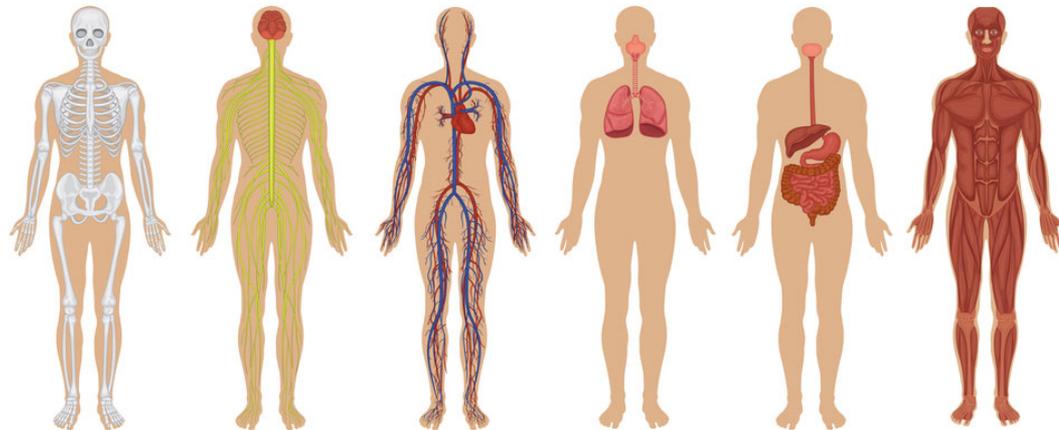
Later: PART II: How Drugs Affect the Brain!

What is the basic unit of life?

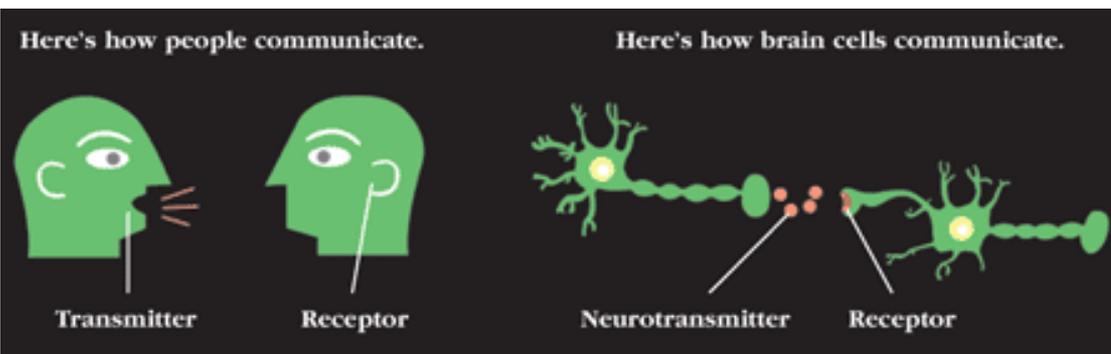
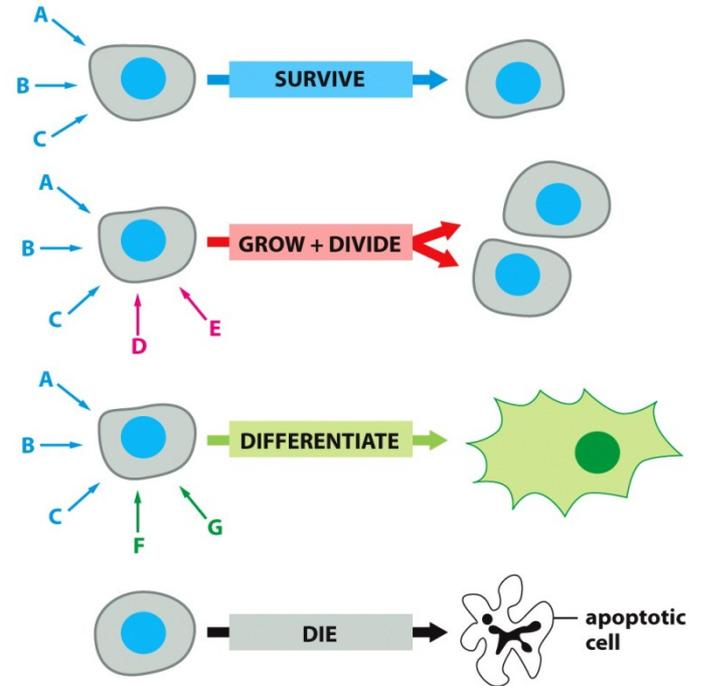
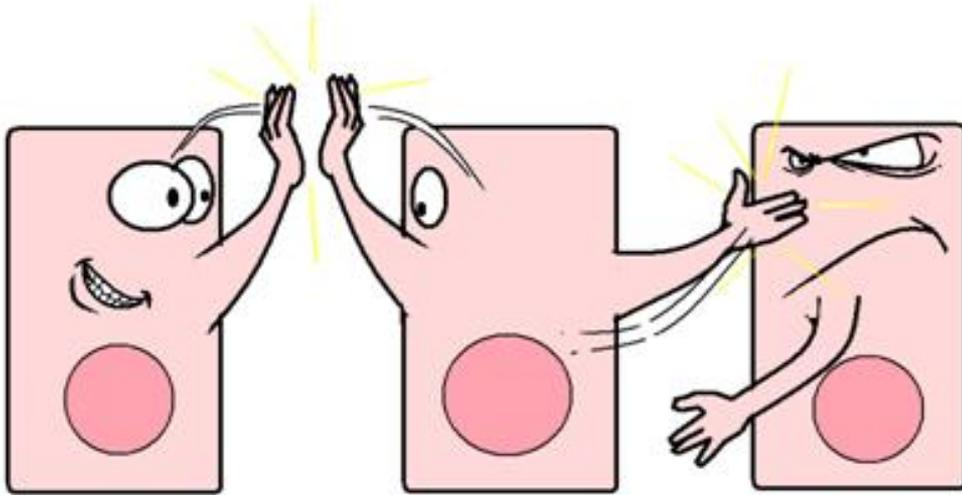
All life is made of cells!



BUT HOW DO WE GET COMPLEX ORGANISMS!?



Cells TALK!



Cell communication controls **EVERYTHING!**

Whether a cell lives or dies! What a cell becomes when it grows up! When it will divide! How it will behave! **EVERYTHING!**

Signaling cascades

Cells communicate their needs using signaling cascades!

Receptors receive information! This is how cells 'listen'!

Cell communication controls EVERYTHING!

Whether a cell lives or dies! What a cell becomes when it grows up! When it will divide! How it will behave! EVERYTHING!

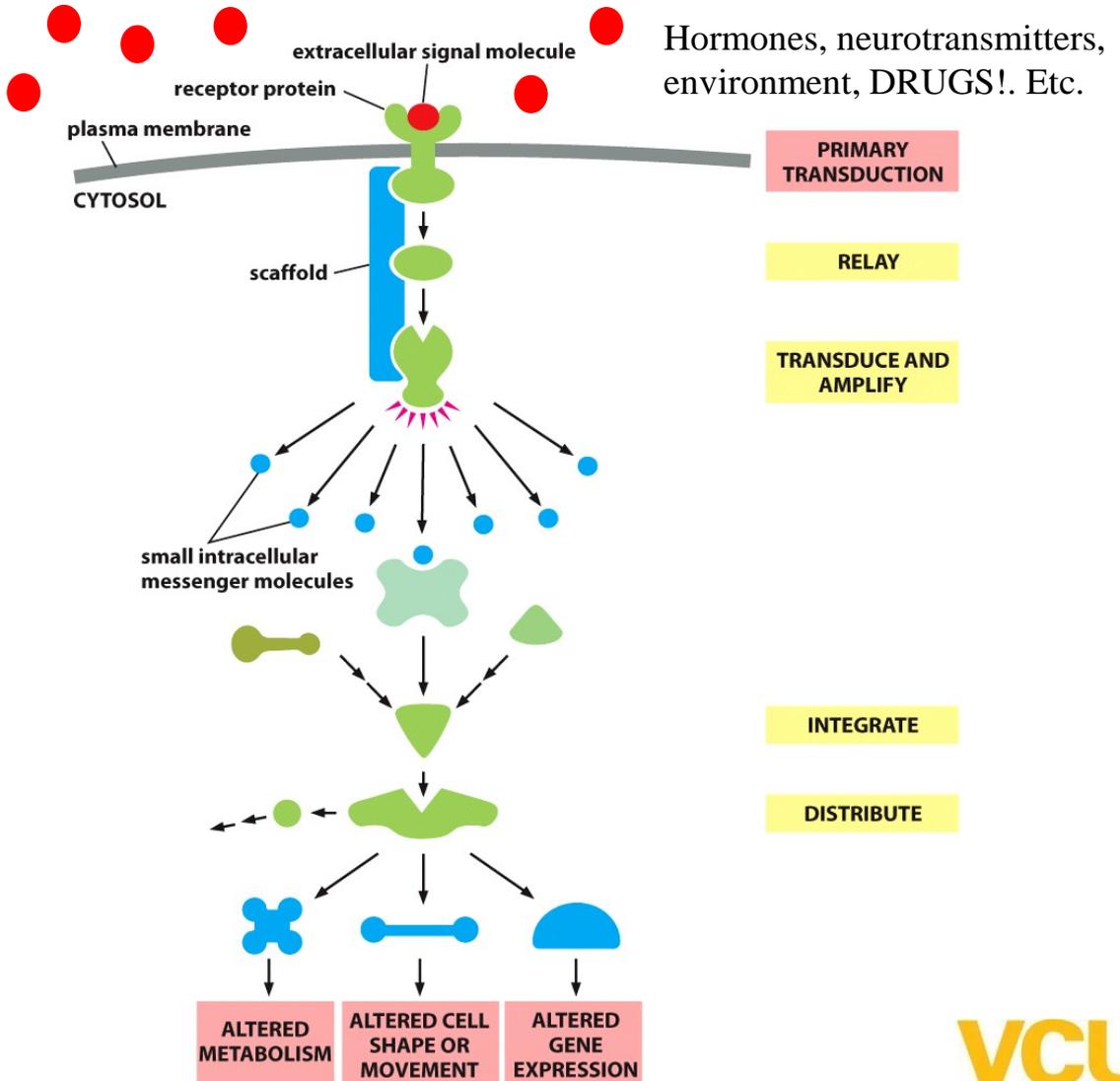
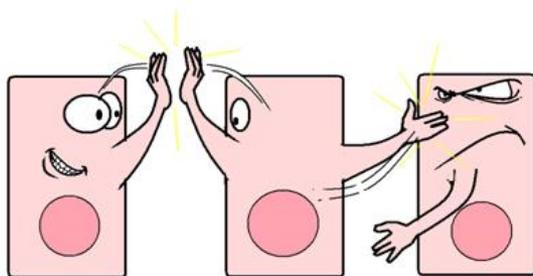


Figure 16-13. Essential Cell Biology, 4th ed. (© Garland Science 2014)

What is a drug?

Drug!

“A chemical substance that has a known biological effect on an organism”



Drugs affect signaling cascades!

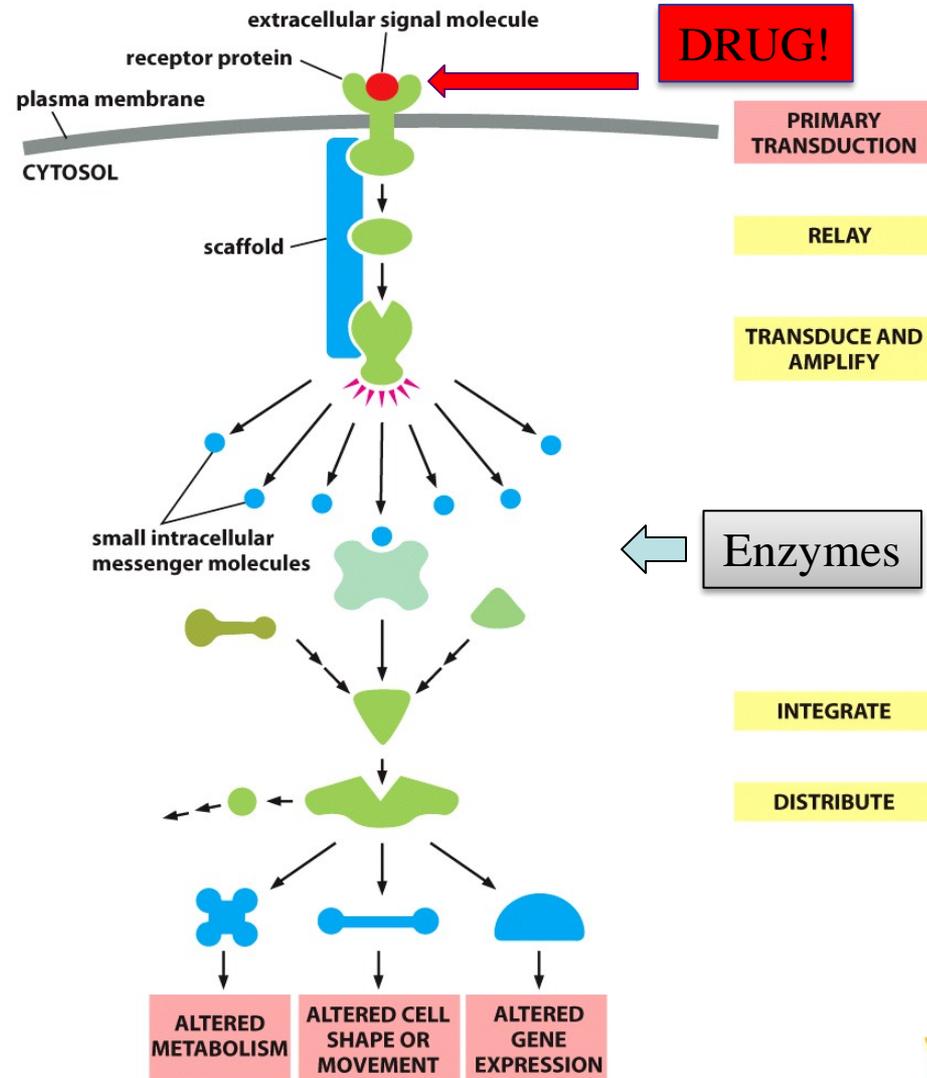
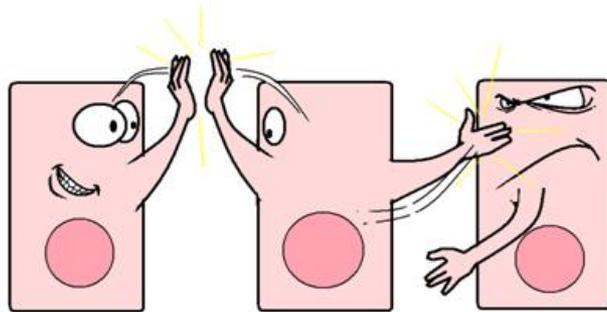


Figure 16-13 Essential Cell Biology, 4th ed. (© Garland Science 2014)

Drugs and toxins can act on cell surface receptors!

TABLE 16-2 SOME FOREIGN SUBSTANCES THAT ACT ON CELL-SURFACE RECEPTORS

Substance	Normal Signal	Receptor Action	Effect
Barbiturates and benzodiazepines (Valium and Ambien)	γ -aminobutyric acid (GABA)	stimulate GABA-activated ion-channel-coupled receptors	relief of anxiety; sedation
Nicotine	acetylcholine	stimulates acetylcholine-activated ion-channel-coupled receptors	constriction of blood vessels; elevation of blood pressure
Morphine and heroin	endorphins and enkephalins	stimulate G-protein-coupled opiate receptors	analgesia (relief of pain); euphoria
Curare	acetylcholine	blocks acetylcholine-activated ion-channel-coupled receptors	blockage of neuromuscular transmission, resulting in paralysis
Strychnine	glycine	blocks glycine-activated ion-channel-coupled receptors	blockage of inhibitory synapses in spinal cord and brain, resulting in seizures and muscle spasm
Capsaicin	heat	stimulates temperature-sensitive ion-channel-coupled receptors	induces painful, burning sensation; prolonged exposure paradoxically leads to analgesia
Menthol	cold	stimulates temperature-sensitive ion-channel-coupled receptors	in moderate amounts, induces a cool sensation; in higher doses, can cause burning pain

Table 16-2 Essential Cell Biology, 4th ed. (© Garland Science 2014)

Drugs (exogenous) are effective on our cell surface receptors because they are structurally similar to proteins we already make (endogenous)!

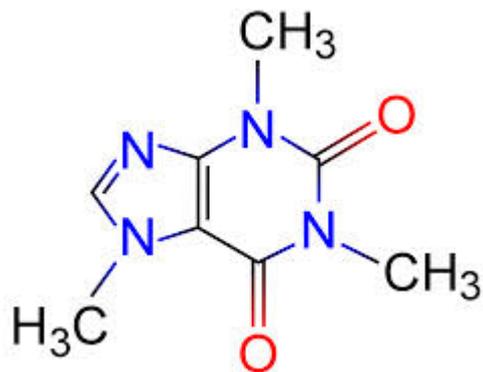
Who uses drugs?

What is the most commonly used recreational drug in the United States?

Caffeine!

90% of adults in the United States consume caffeine on a daily basis!

Most widely used psychoactive drug in the world!



“Drug Dealer”

What do we use drugs for?

Therapeutic Drugs

- Drugs can be used to treat (manage) or cure disease
 - Used clinically
- Antibiotics
- Analgesics
- Chemotherapeutic agents
- CNS Drugs
 - Antidepressants
 - Stimulants
 - Anesthetics
- Cardiovascular Drugs
 - Antihypertensives
 - Antiarrhythmics
- Gastrointestinal Drugs
- ETC.!



Laboratory Tools

Drugs and toxins are
used as tools to
manipulate biological
systems!

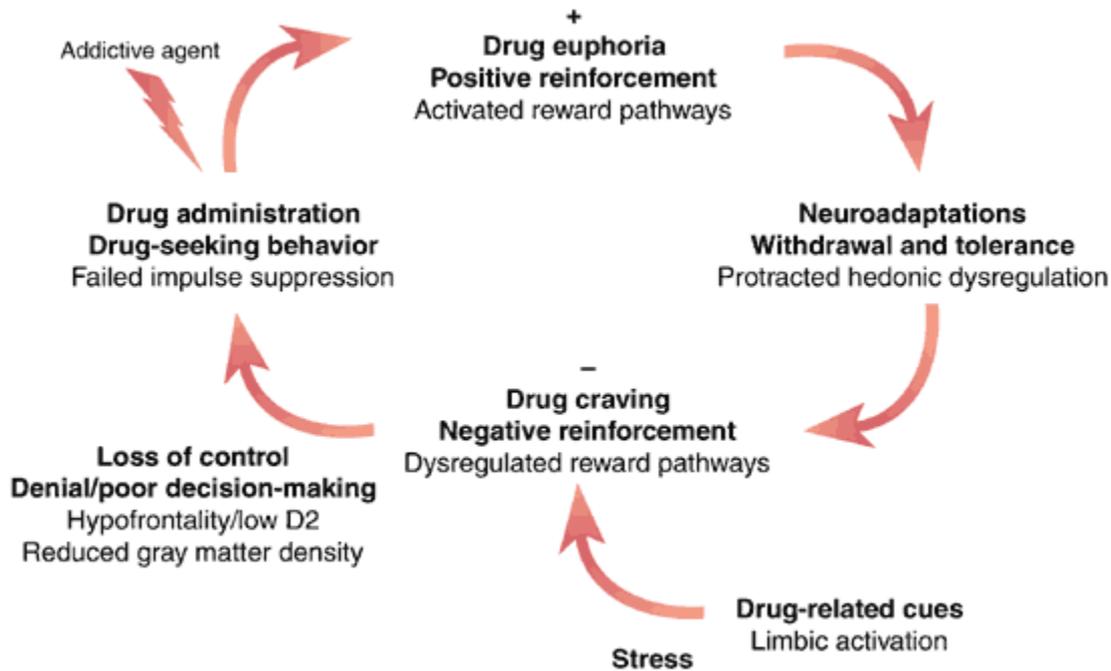


Recreation & Abuse

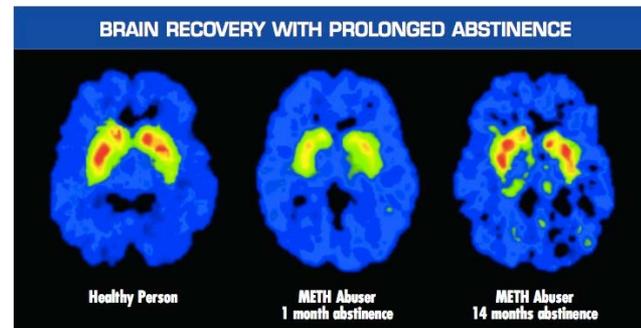
Drugs are taken for their psychoactive rewarding properties



Addiction: Disease of Choice?



- Compulsive Behavior
- **Continued abuse of drugs despite negative consequences**
- Persistent changes in the brain's structure and function
- Inability to choose better 'rewards' (family, friends, career, hobbies)



If we all use drugs who needs to know about them?

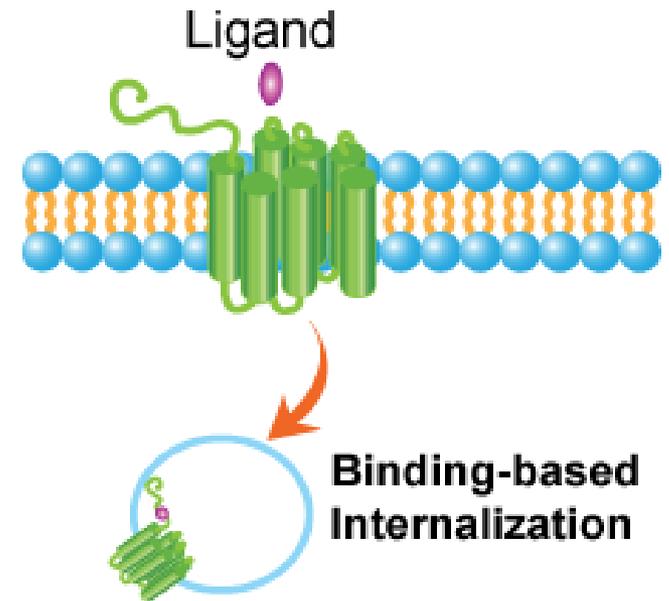
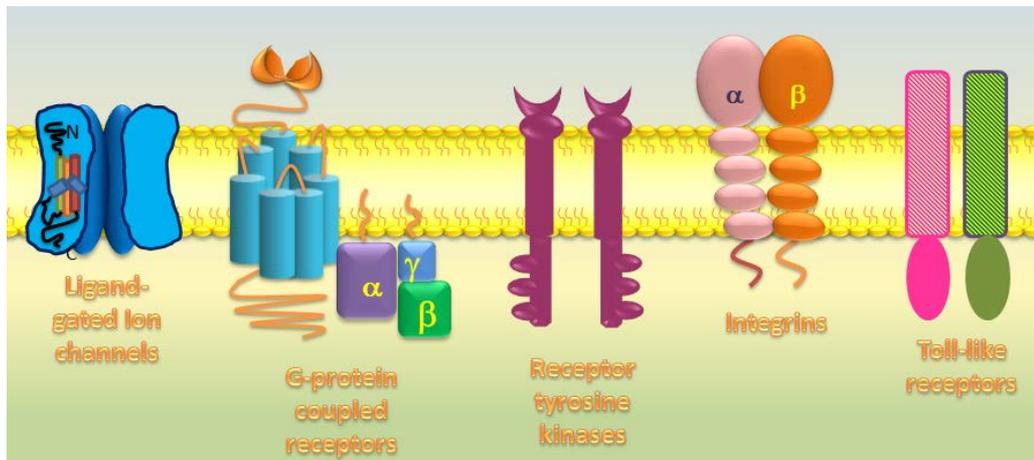
We all do!

- We control what drugs we put in our body and we need to knowledge to help us:
 - Pick the correct drug at the drug store
 - Understand what our doctor's prescribe us
 - Use them in our professional lives (research scientist, nurse, doctor, dentist, pharmacist, vet, etc.)
- **HELP US DEAL WITH ADDICTION!**

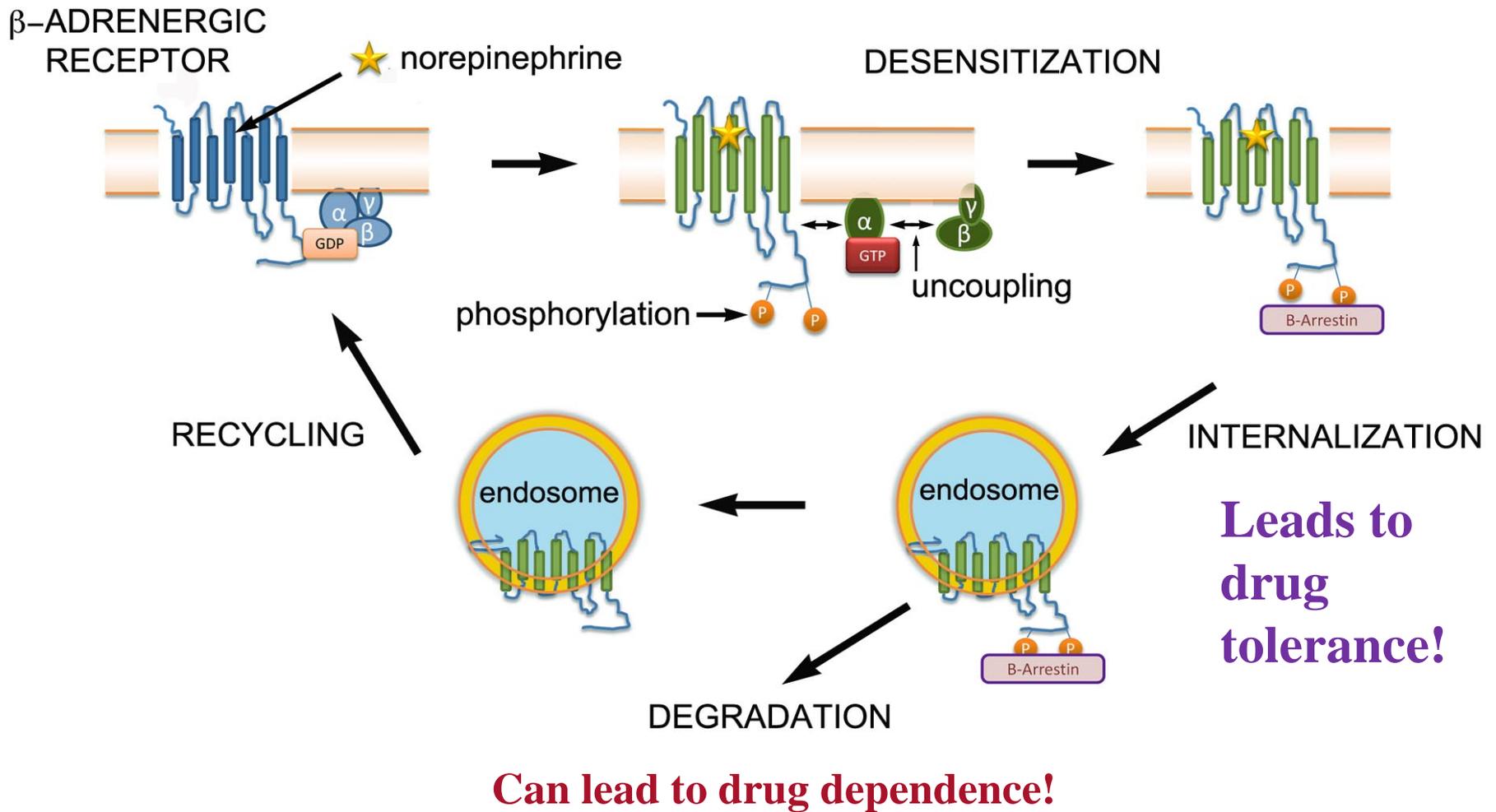


Drugs bind to Receptors!

Receptors can move!



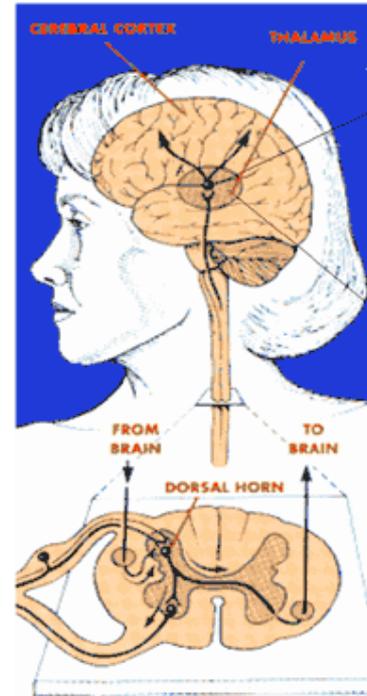
GPCRs maintain homeostasis by desensitizing after activation



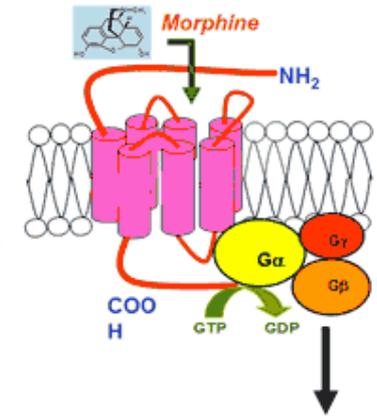
Opioids

Opioid Receptor

- Analgesia
- Constipation
- Euphoria
- CNS depression
- Respiratory depression
- Miosis
- Depression of cough reflexes



Mu Opioid Receptor:
located on the membrane of neuronal cells

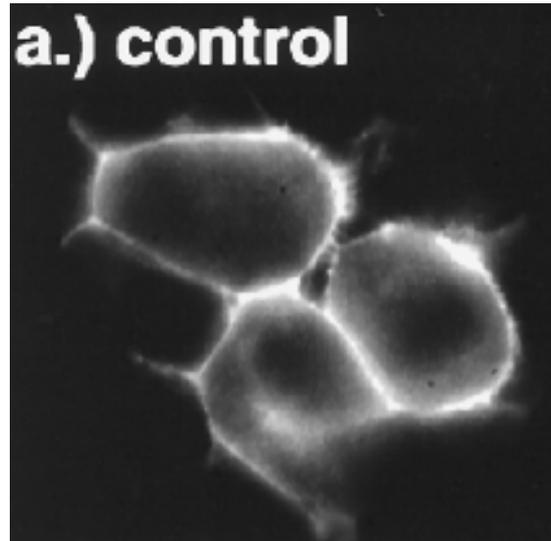


Affect the brain reward/pain system

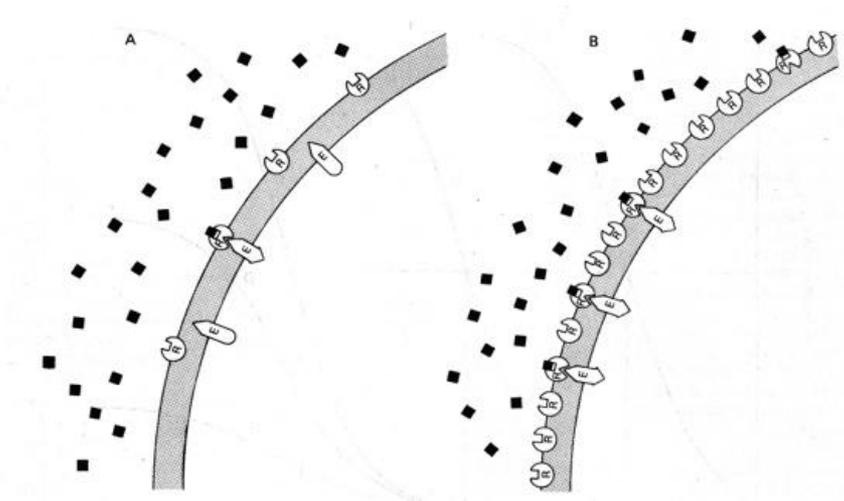
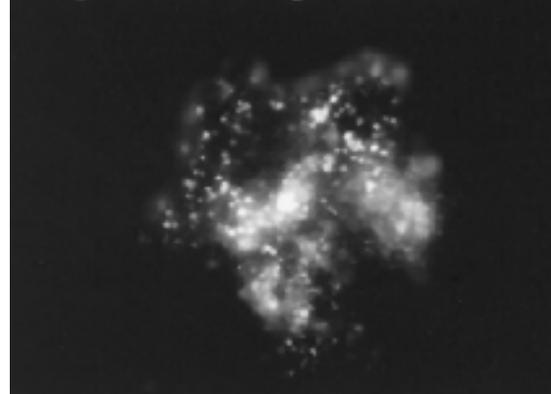


Receptor Downregulation

a.) control

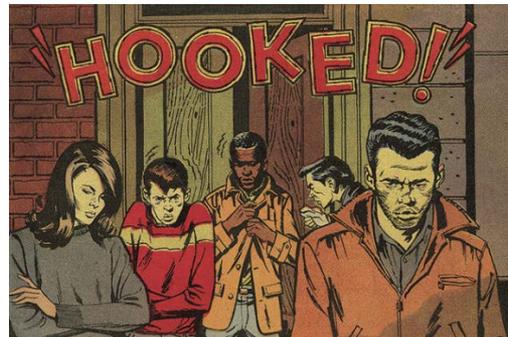


c.) +etorphine



Repeated
Administration

Control



Opioid Withdrawal



- Anxiety
- Insomnia
- Rhinorrhea (runny nose)
- Diarrhea
- Emesis
- Mydriasis
- Piloerection ('cold turkey')
- Restless leg syndrome ('kicking the habit')
- Tachycardia



Opioid Withdrawal

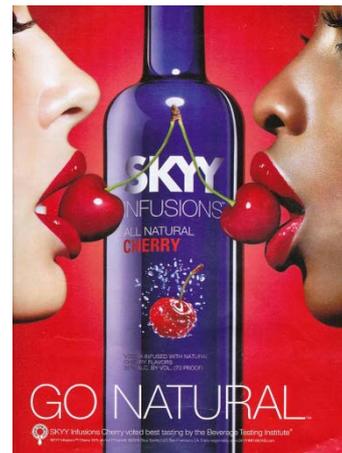
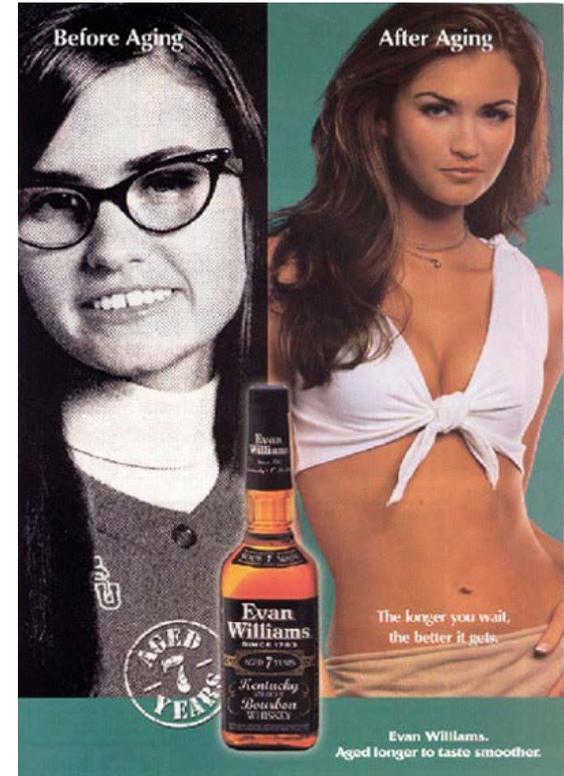
<https://www.youtube.com/watch?v=NaMgdlUcsko>

*Is downregulation all
receptors can do?*

UP-REGULATION!

Alcohol!

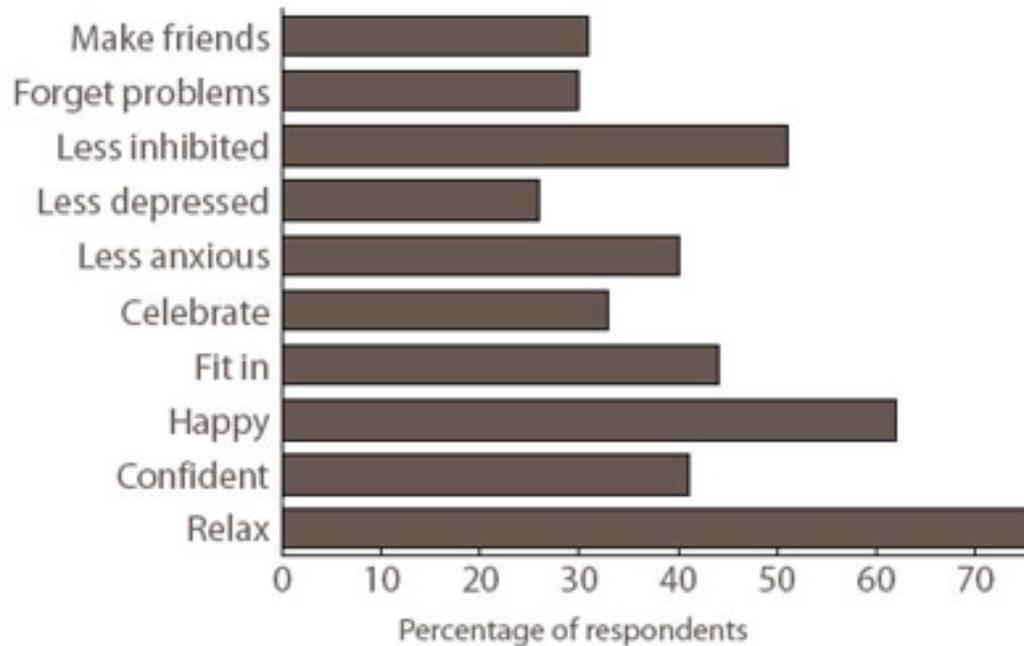
- It's socially acceptable!
 - It's what the 'cool' kids do
 - The corporations tell us so!



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Why do people drink?

Ethanol Effects

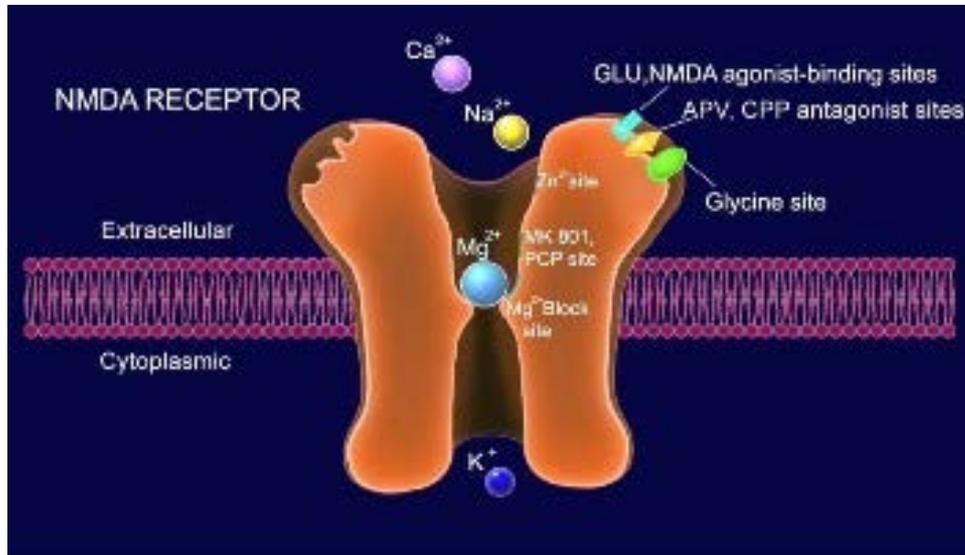


- Euphoria
- Decreased Inhibitions
- Impaired motor coordination
- Flushed appearance
- Increased sociability
- Delayed reactions
- Confusion
- Ataxia
- Blurred vision
- Incontinence
- Respiratory depression
- Coma, death



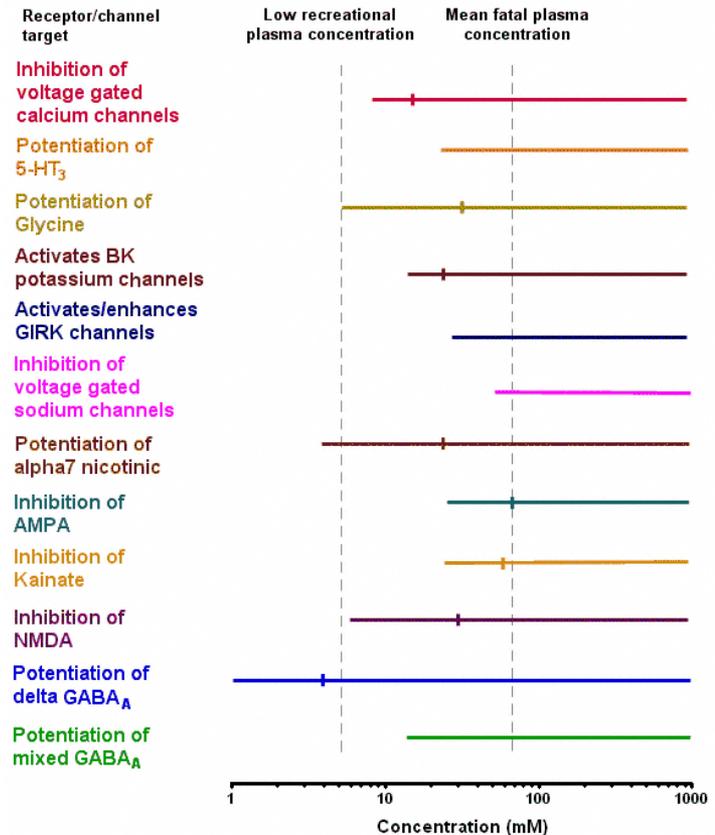
Source: Dube et al. (2001). Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span American Medical Association JAMA. 286:3089-3096

NMDA Receptor



NIH

- Ionotropic glutamate receptor
- Cations = exciting!
- Activation is stimulating and leads to learning and memory function!
- **Inhibited by alcohol**



Concentrations at which Alcohol is Active on Various Systems
Image by Bilz0r, © 2005 Erowid.org

DISCLAIMER: Ethanol hits LOTS of receptors, the difference is the dose! (GABA!)

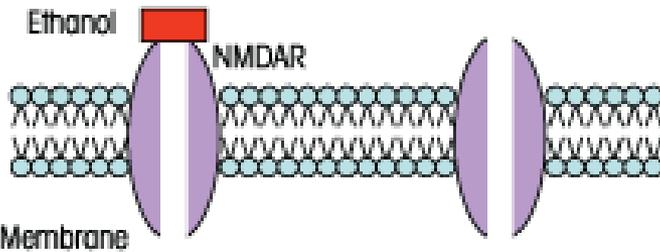
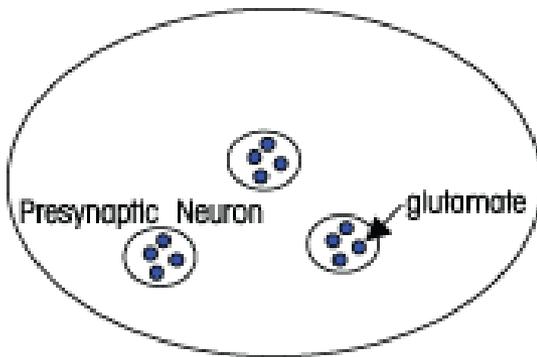
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Homeostasis: Receptor Upregulation

Acute

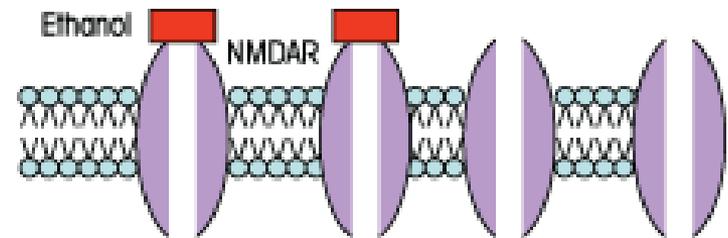
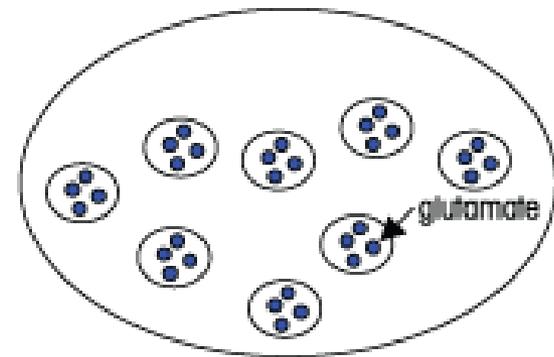
Chronic

A

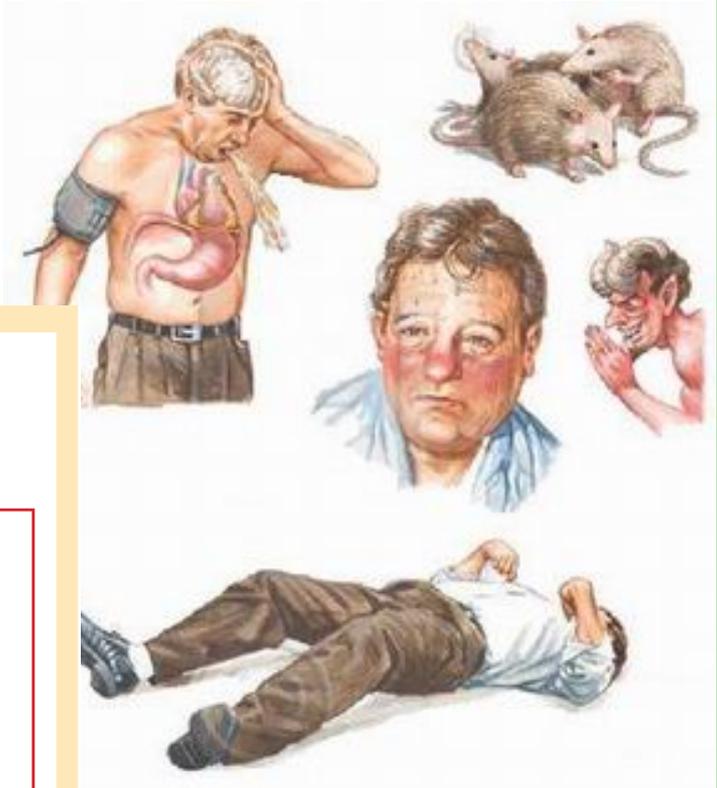


Postsynaptic Membrane

B



Alcohol Withdrawal



Minor Symptoms

Anxiety
Insomnia
Gastrointestinal upset
Headache
Palpitations
Anorexia

Alcoholic Hallucinosi*s*

Most commonly visual, also auditory or tactile

[Usually resolves within 48 hours]

Withdrawal Seizures

Generalized tonic-clonic convulsions

[May occur as early as 2 hours after alcohol cessation]

Delirium Tremens

Agitation
Hallucinations
Disorientation
Tachycardia
Hypertension
Fever
Diaphoresis

[Peak at 5 days, lasts up to 7 days]

Alcohol Cessation

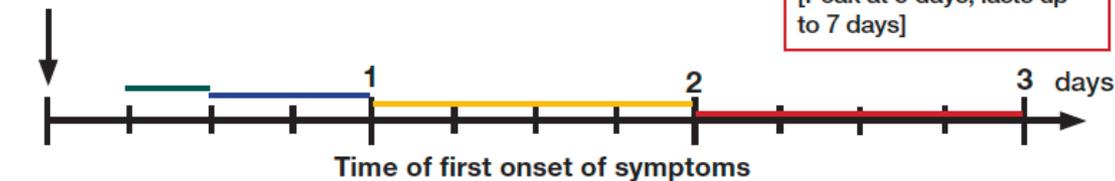


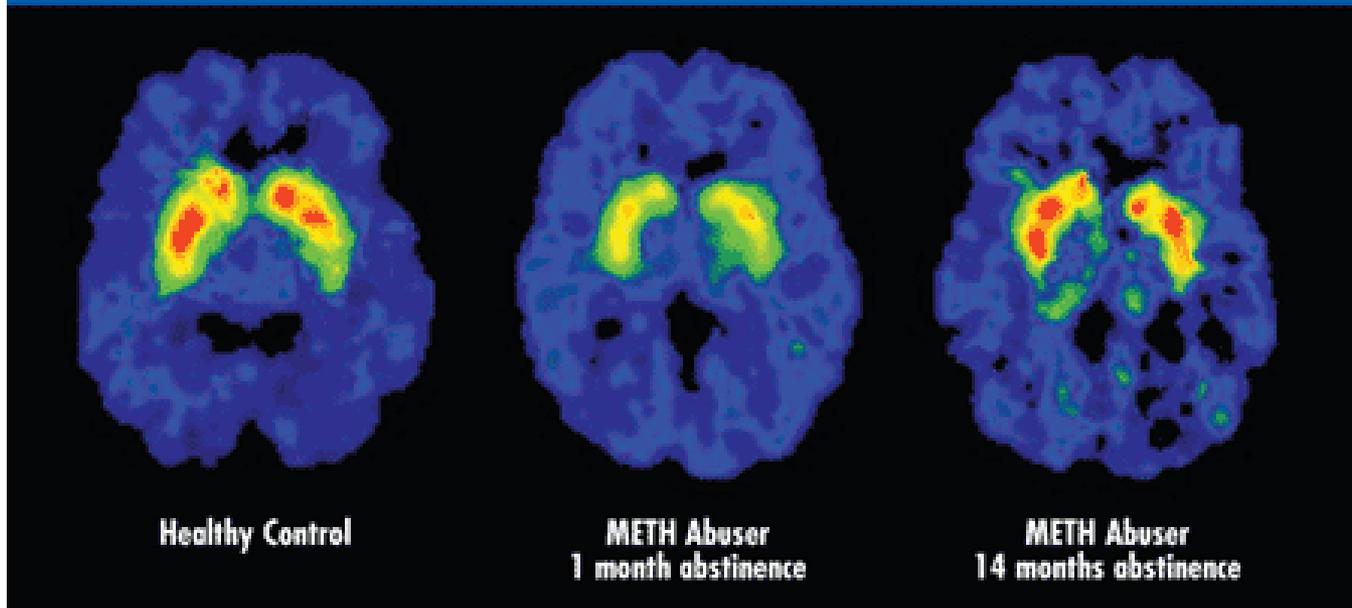
Figure. The four distinct conditions of alcohol withdrawal syndrome shown on a spectrum of severity and timeline scale. This figure was adapted with permission from Alcohol Withdrawal Syndrome.¹⁹ *American Family Physician*, ©American Academy of Family Physicians. All Rights Reserved.

What have we learned so far?

- Drug Addiction: Continued drug use **DESPITE** negative consequences!
 - Every time we take a drug, any drug, we change how our cells behave!
- What does this mean for us in a real, practical sense?
- Is this something we can just ‘snap out of’?
- Is it still all about the high?
- During withdrawal, what do we need? • **MEDICAL TREATMENT!**
- Is withdrawal a good time to learn new information and learn how to live a new life?
 - What would we think of something we were exposed to during a stomach bug?

Receptors can Recover!

RECOVERY OF BRAIN FUNCTION WITH PROLONGED ABSTINENCE



These images of the dopamine transporter show the brain's remarkable potential to recover, at least partially, after a long abstinence from drugs - in this case, methamphetamine.



<http://www.insynergystl.com/addiction-101.php>

The Journal of Neuroscience, 21(23):9414-9418. 200126

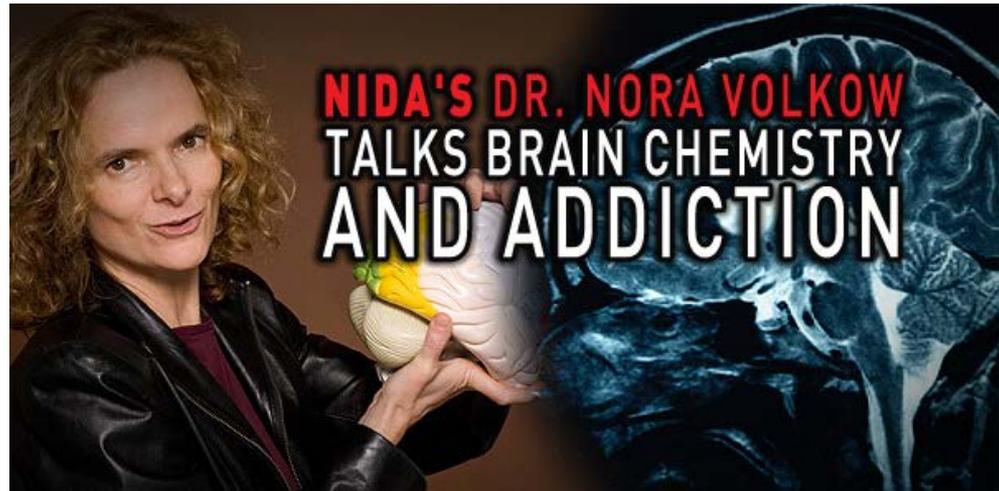
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© Tricia H. Smith PhD.

Drug addiction is more complicated than receptors!

<https://www.youtube.com/watch?v=ULwv1RcfEqM>

https://www.youtube.com/watch?v=JH7zq0_VA9U



LATER, watch her TEDMED talk! <https://www.youtube.com/watch?v=Mnd2-a14LCU>

PART II:

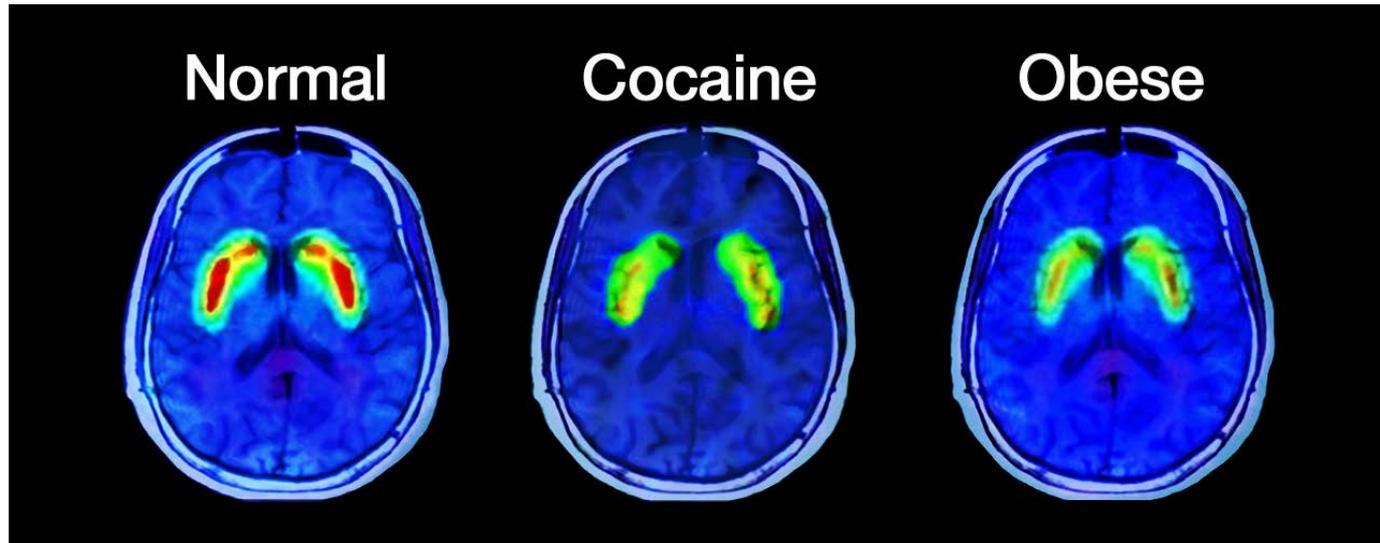
***How Drugs Affect the
Brain!***

Thank you to Dr. Claire Dixon for some of these slides! ☺

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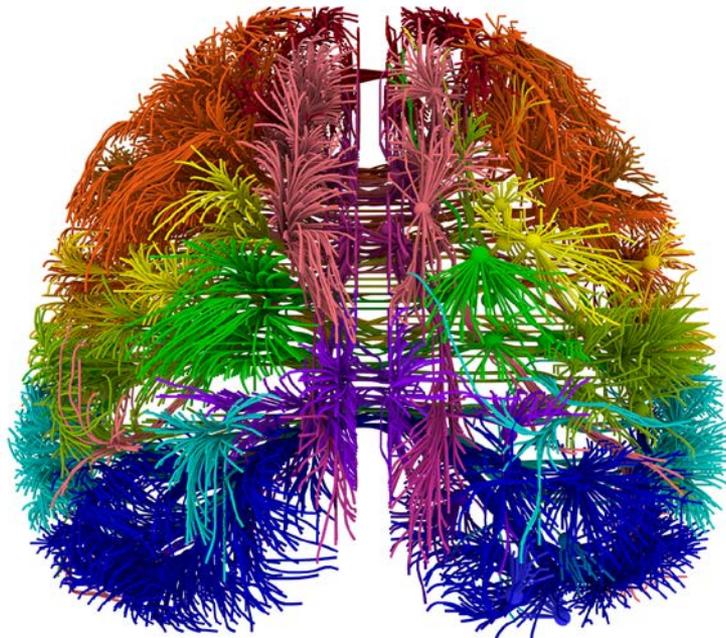
© Tricia H. Smith PhD.

Drugs and all addictive substances cause real, physical changes in the brain!



The BRAIN!

- ‘The most complex object in the known universe!’ -Christof Koch
- 100 BILLION NEURONS!



cortico-connections originating from multiple distinct cortical areas, visualized as virtual tractography using Allen Institute Brain Explorer software.

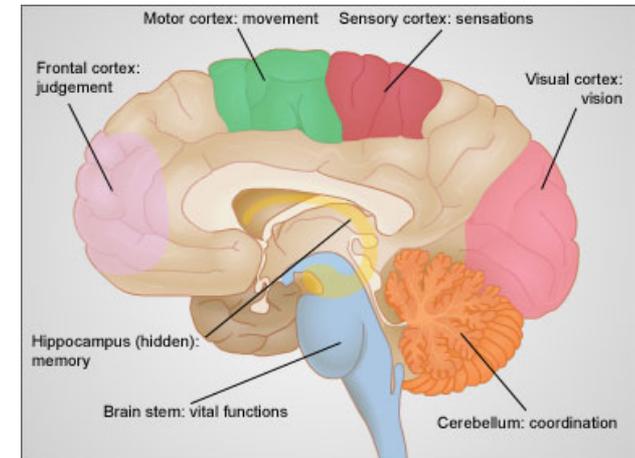
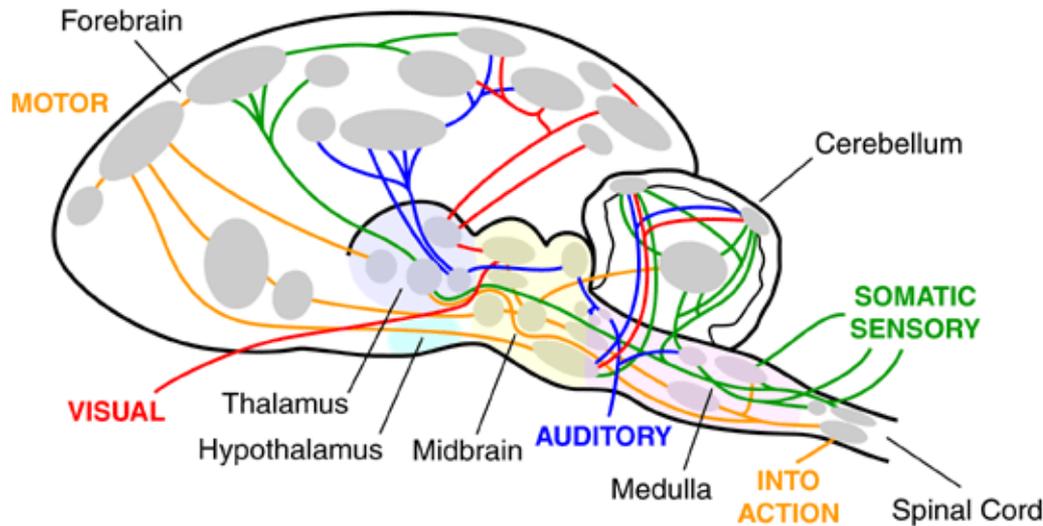


If the brain were so simple we could understand it, we would be so simple we couldn't. -Lyall Watson

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© Tricia H. Smith PhD.

Brain Circuits



Brain function:

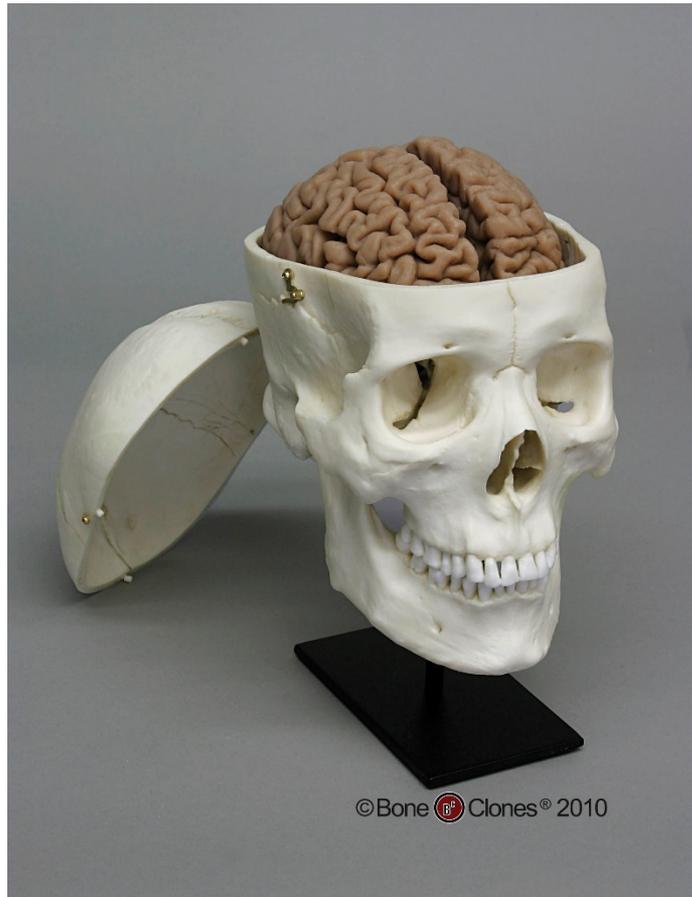
1. Detect the enormous variety of stimuli in the environment
2. Make sense of all these sensory events
3. Respond to all these features by expressing an elaborate behavioral repertoire
4. Make judgments, learn, and think about all these things

**Responsible for
how we think,
love, and who we
are!**

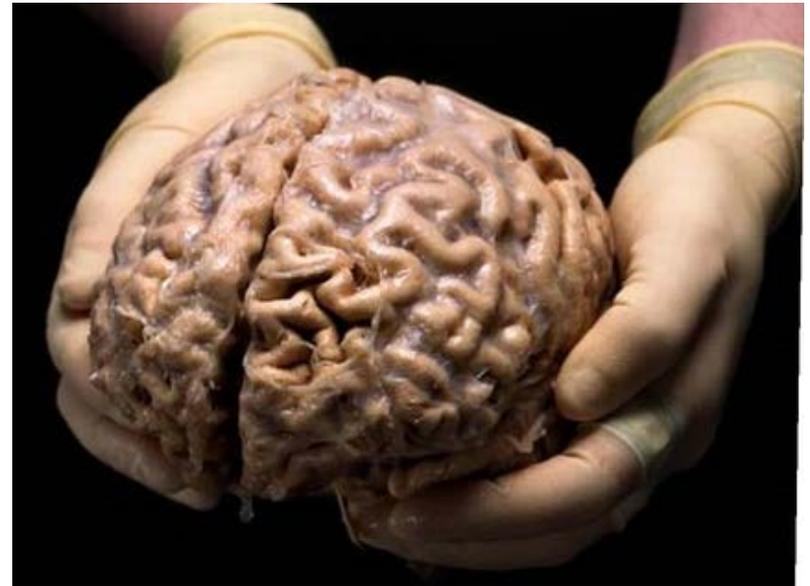
...AND
DRUGS

<https://www.youtube.com/watch?v=ULwv1RcfEqM>

How did we start to study the brain?



© Bone Clones® 2010



Let's start with a story...

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© Tricia H. Smith PhD.

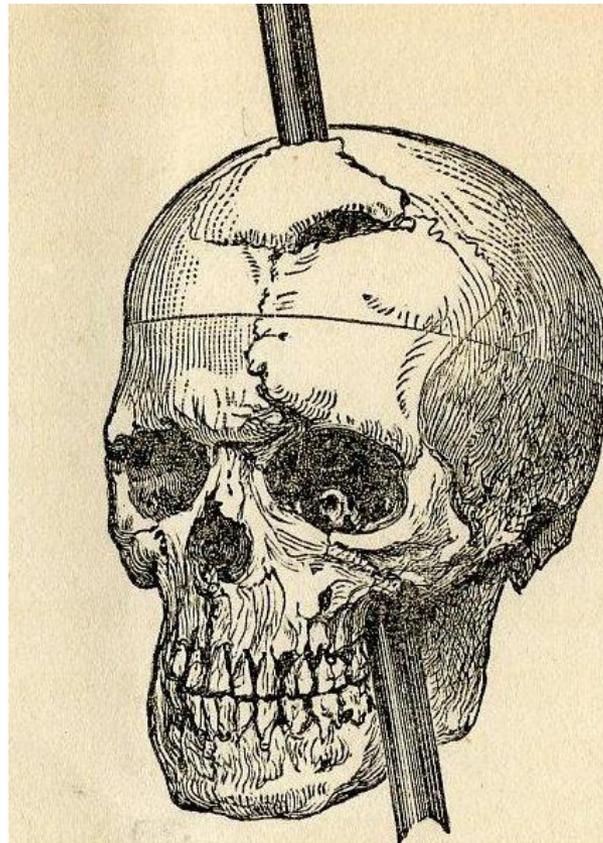
Frontal injury: Phineas Gage

- Phineas Gage (1823-1860) is one of the earliest documented cases of severe brain injury
- Gage was foreman of a railroad construction workers crew excavating rocks
- He had a bit of an accident involving some explosive powder and an iron rod...



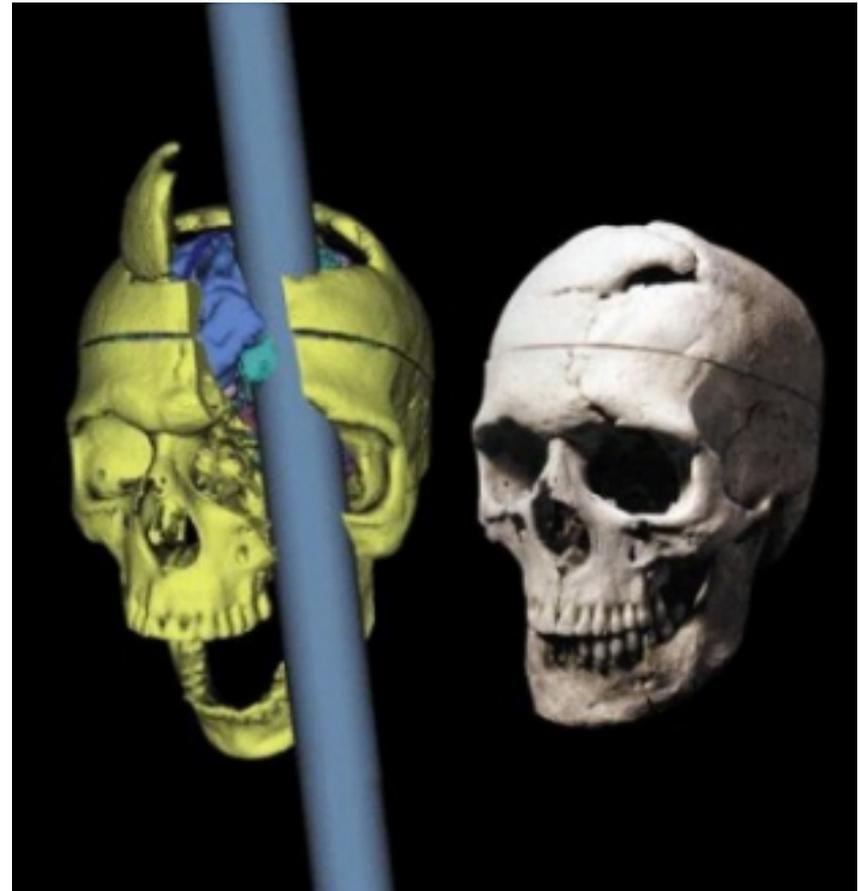
Frontal injury: Phineas Gage

Opps!



Frontal injury: Phineas Gage

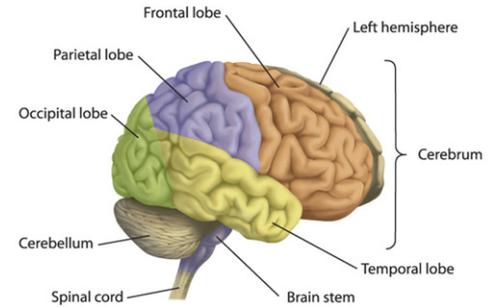
- Gage returned to full health apart from a few personality changes...
 - “Intellectual manifestations feeble”
 - “fitful, irreverent, indulging at times in the grossest profanity”
 - “impatient of restraint or advice when it conflicts with his desires”
- In others words, he was impulsive, more instinctual and lacking a cognitive observation of his behaviour



Digitally re-mastered by Ratiu et al, Neurotrauma, 2004.

Sound familiar??

Prefrontal cortex



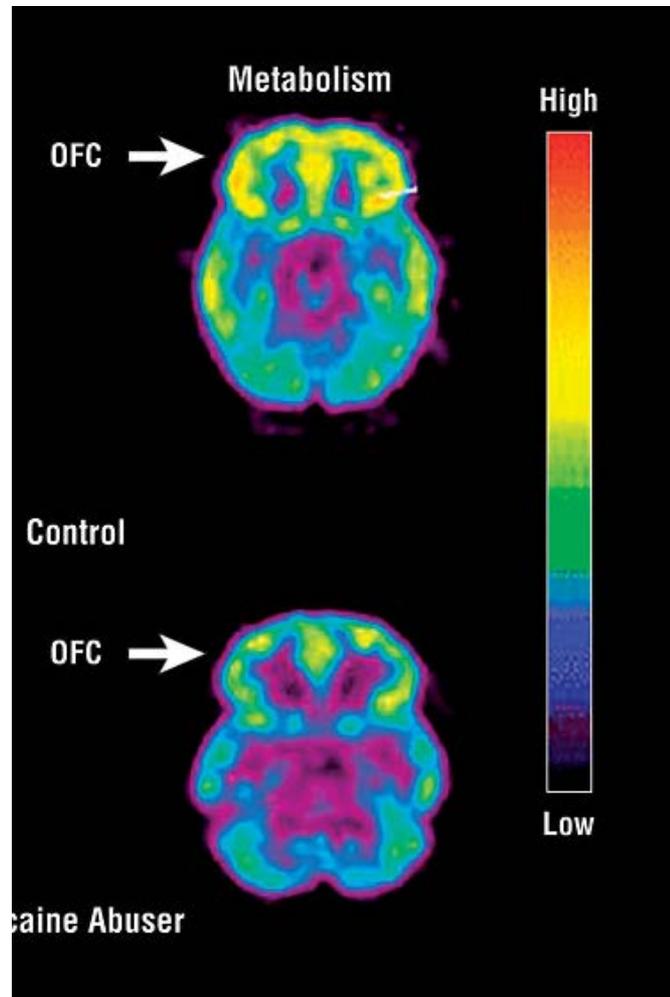
- Inhibitory Control
- Associative Learning
- Planning
- Practical Decision Making

Drug Addiction: The Habit

Other mechanisms: Dopamine & the Nucleus Accumbens

Drug Addiction is a Habit!

- Drug addiction is associated with reduced inhibitory control, indicative of reduced prefrontal cortex function.
 - Inhibitory Control
 - Learning
 - Planning
 - Decision making
- If frontal control is reduced, what is driving this compulsive behaviour?

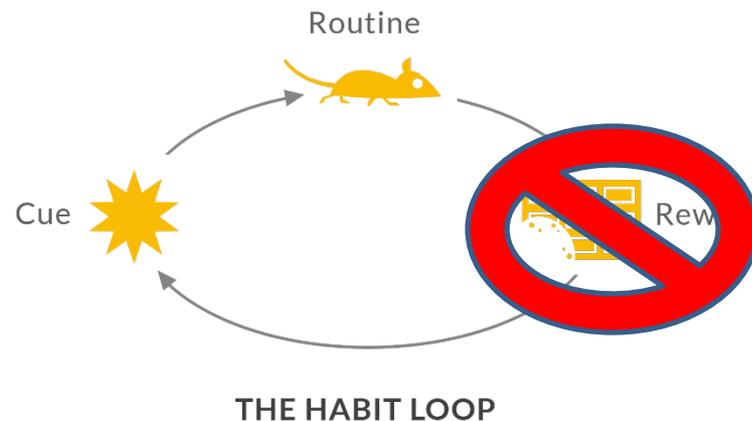


PET scan of glucose metabolism in control brains and cocaine abusers.

Volkow *et al*, 2001

What is a habit?

- An acquired pattern of behavior that often occurs automatically
- An act done repeatedly, sometimes unconsciously
- Progression of learning from the conscious level to unconscious level
- Can go unnoticed in persons exhibiting these behaviors



How do we learn habits?

When exposed to stimulus 'S'



if I perform action 'R'



then consequence 'O' will occur



How do we learn habits?

When exposed to stimulus 'S'



if I perform action 'R'



then consequence 'O' will occur



Behavior is modified by the outcome

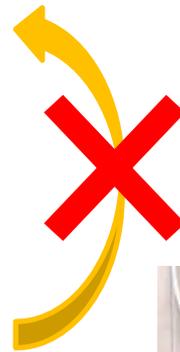
When exposed to stimulus 'S'



if I perform action 'R'



then consequence 'O' will occur



Habit!

- Behaviour is no longer modified by the outcome!

When exposed to stimulus 'S'



if I perform action 'R'



then consequence 'O' will occur



Learning (Action, Response-Outcome)

Stimulus



Response



Outcome



"I love the occasional cigarette, I find it so relaxing."

"I take a very pure energy booster sometimes.
it really boosts me up after a hard day at school/work."

"Only the occasional joint to relax."

"Well I smoke because ... its very enjoyable."

"It's about consciousness, y'know what I mean?"

"Don't do them...But I do like to drink a few drinks,
that's my calm drug."

Habit (Stimulus-Response)

Stimulus



Response

Outcome



"You know its not going to get you high but you want more anyway."

"It became the main focus of all our activities."

"Smoking went from a weekend activity to a daily activity -- even during work."

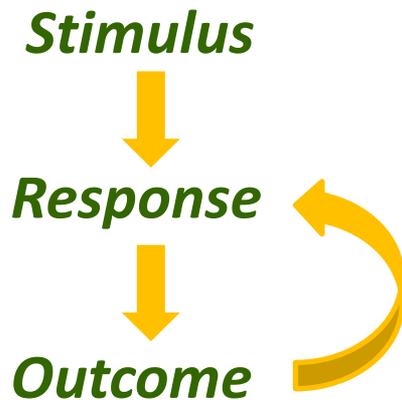
"Now when I took a hit, I skipped the pleasure and almost immediately went to paranoid."

"Consciously it never sat good. I didn't like it. But I had to have it."

"I hope I can quit this time."

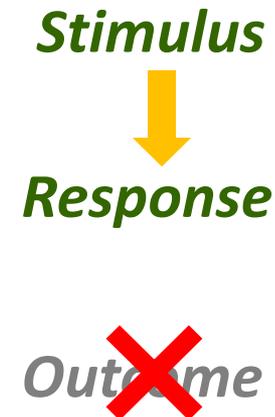
ACTION:
Response-Outcome

- Goal-directed
- Influenced by value of outcome
- Sensitive to devaluation
- Supported by expectation

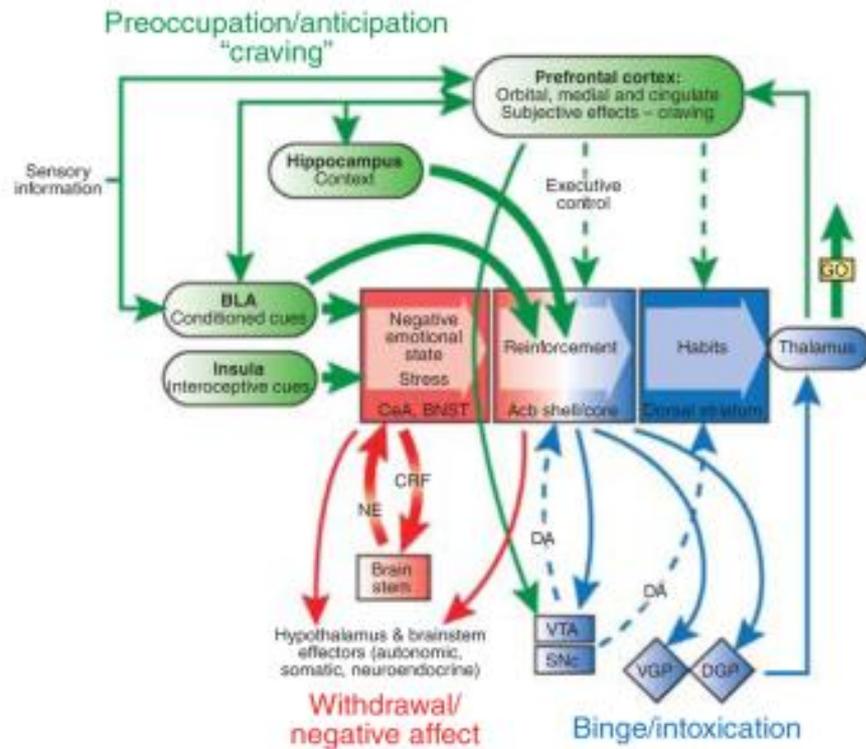
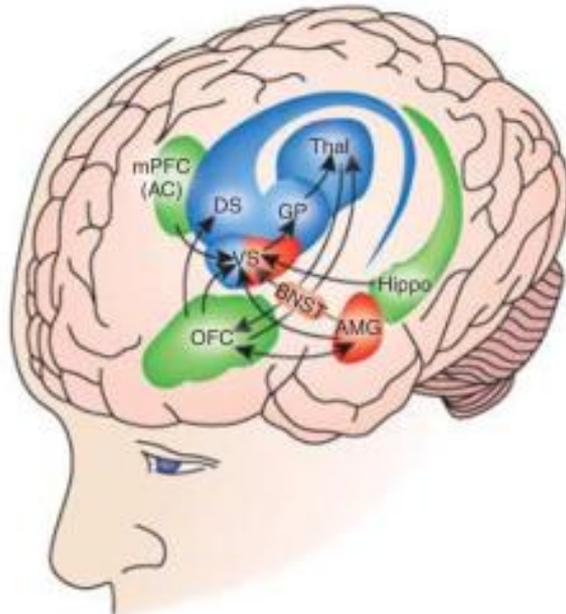


HABIT:
Stimulus-Response

- NOT influenced by value of outcome!
- Not sensitive to devaluation

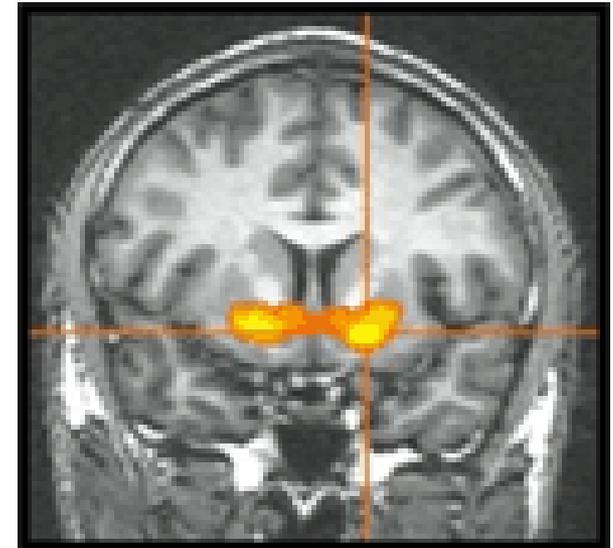
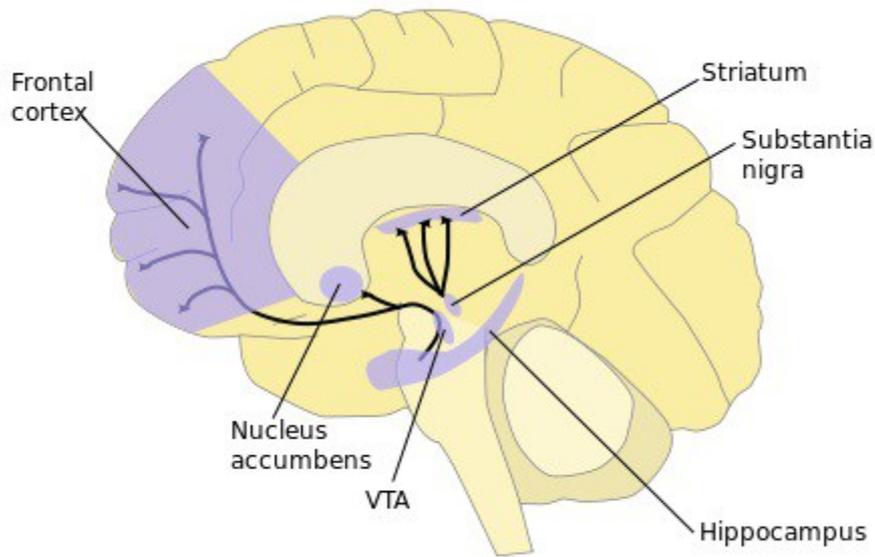


Where in the brain is habit mediated?



Robbins and Everitt, 2002

Dorsal striatum



- Motor control
- Coordinates motivation with motor output
- Involved in learning about action-reward contingencies
- Part of the limbic system: instinct, drives, moods, 'primitive'

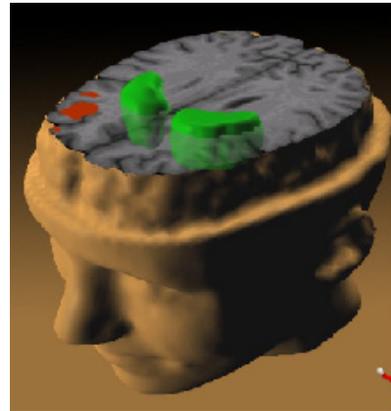
**HABITS KEEP
US ALIVE!**

Drug behavior switches from higher order parts of the brain (cortex) to more primitive control (limbic system)!

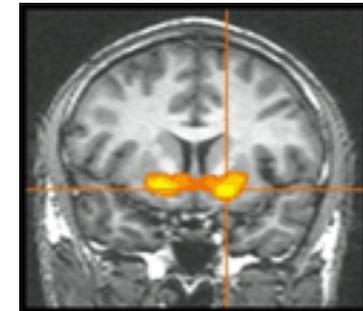
Voluntary Use → Involuntary Habitual Use → Compulsive Use



**Prefrontal
Inhibitory
Control**



**Striatal
control**



**Striatal
dominance**

Nelson and Killcross, Journal of Neuroscience, 2006; Pre-exposure to amphetamine accelerates transition to habit

Yin *et al*, Journal of Neuroscience, 2004; dorsal striatum is required for habit responding

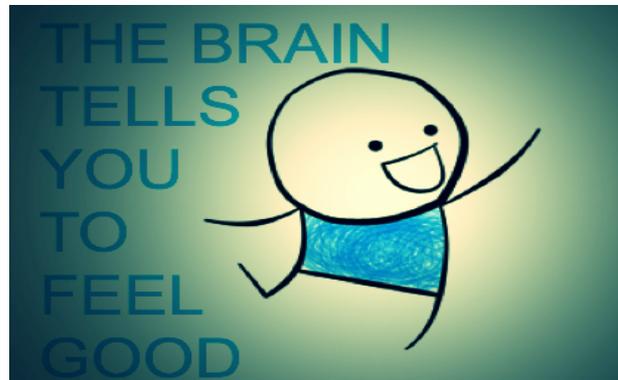
What have we learned so far about the brain and addiction?

- Drug cause real physiological changes in brain activity
- These changes are reinforced by continued drug administration
- Habits are real and very hard to break
- New habits will need to be formed

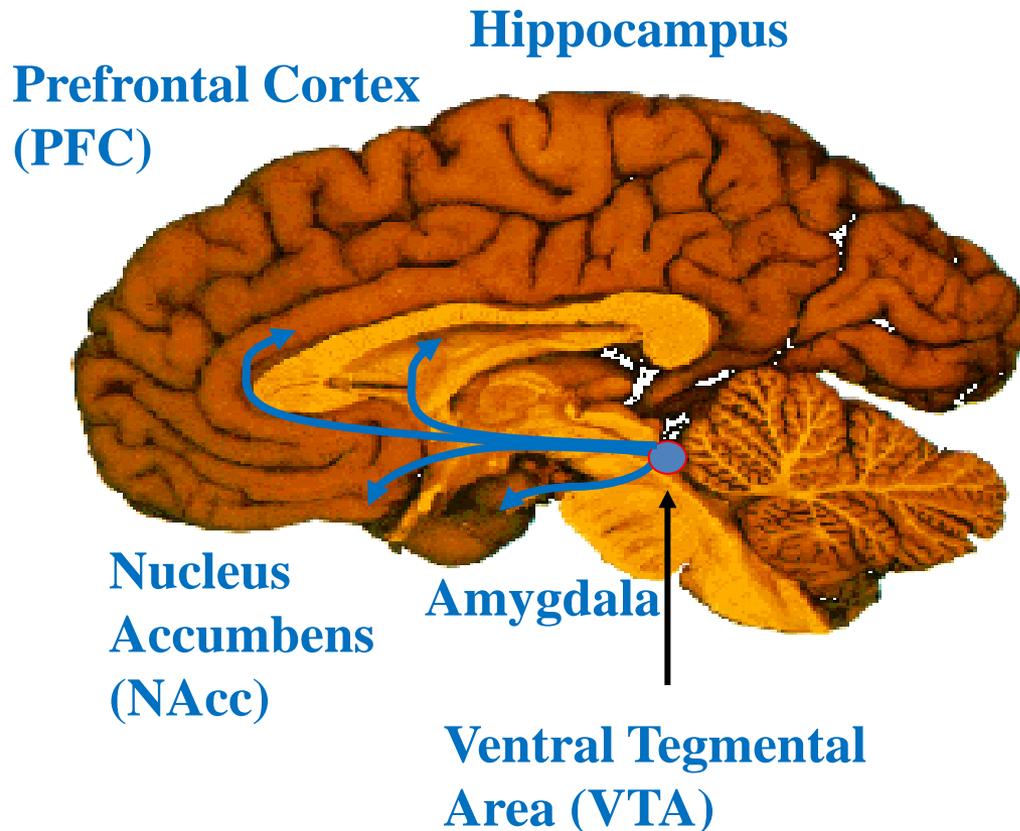
**‘The most complex object in
the known universe!’**

It's NOT that simple!..

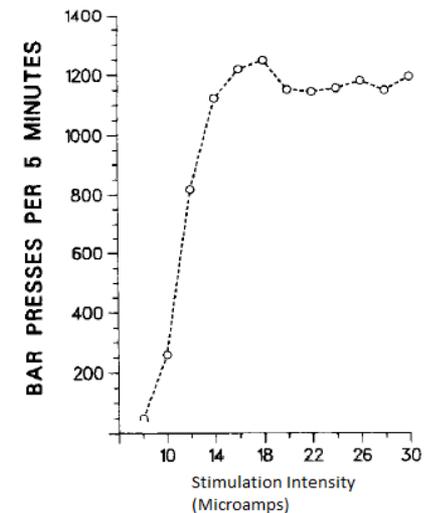
Dopamine & Nucleus Accumbens



Why do we even take drugs in the first place?

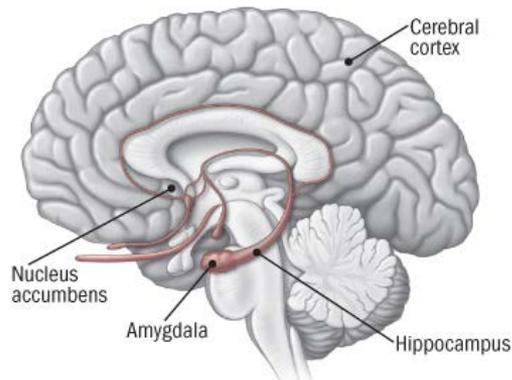


So good, rats will press a lever over 200 times per minute just to stimulate it!



Intra-VTA self stimulation
Fibiger *et al*, JoN, 1997

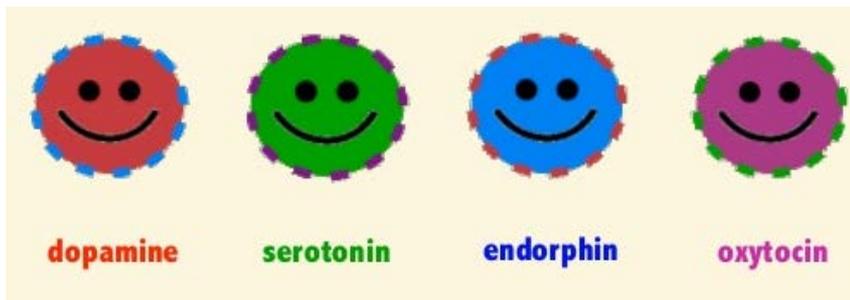
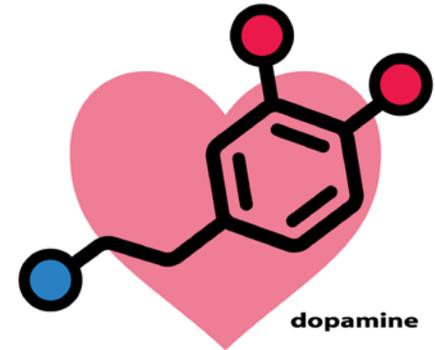
Nucleus Accumbens



- Receives dopamine directly from VTA
- Dopamine increases are seen after a variety of rewards, but it is not just a reward center
- Coordinates signals from control, sensory and emotion centers within the brain

Dopamine

- Released in response to anticipation of reward and reward
- Many different events trigger dopamine
- NOT the only happiness chemical out there!



REMEMBER? Signaling cascades

Cells communicate their needs using signaling cascades!

Receptors receive information! This is how cells 'listen'!

Cell communication controls EVERYTHING!

Whether a cell lives or dies! What a cell becomes when it grows up! When it will divide! How it will behave! EVERYTHING!

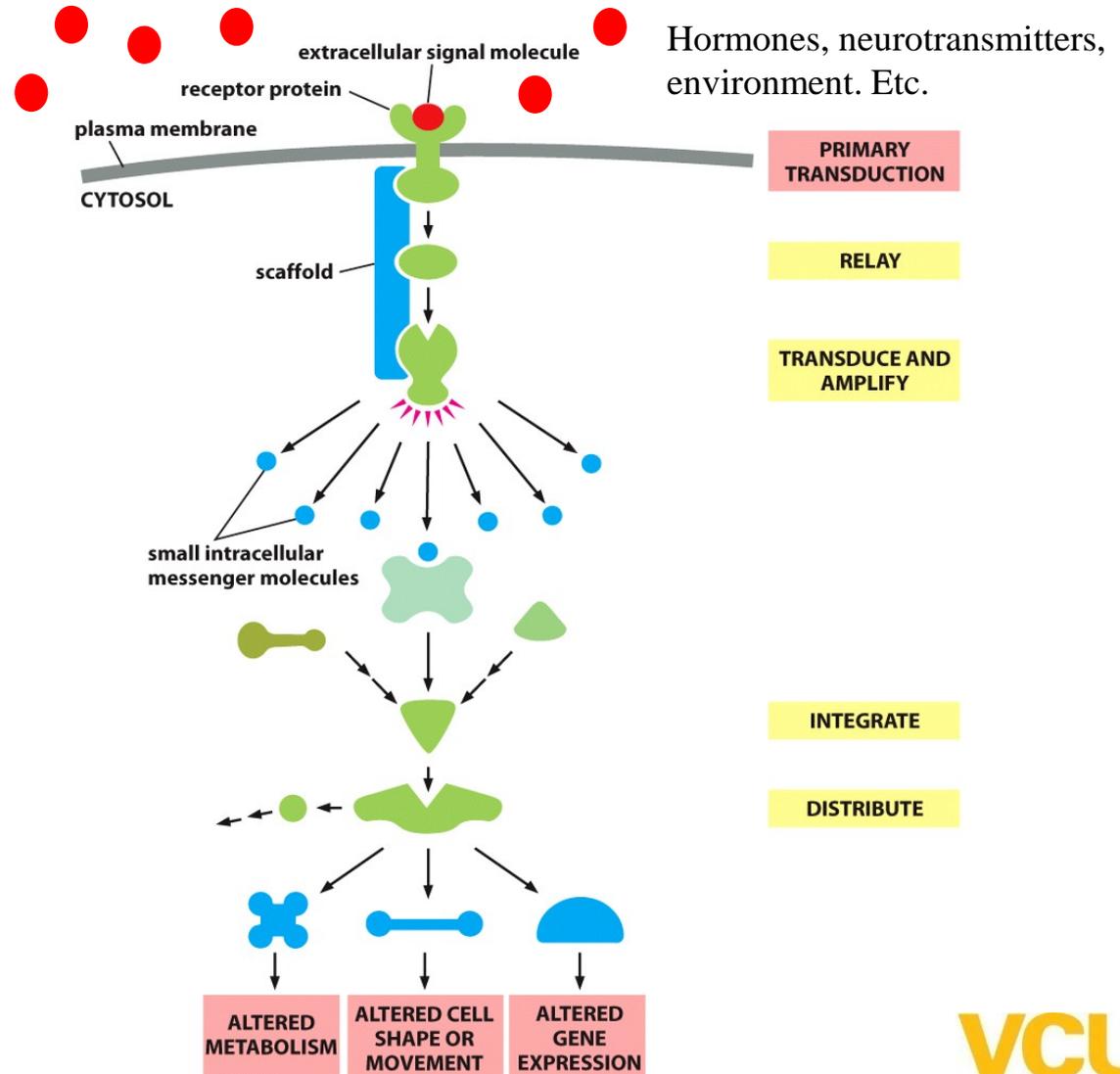
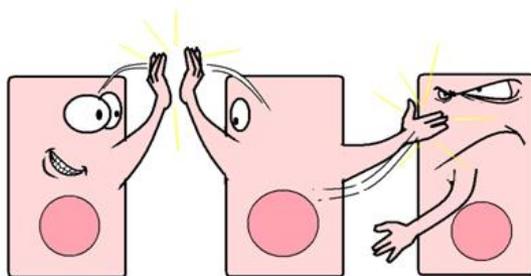
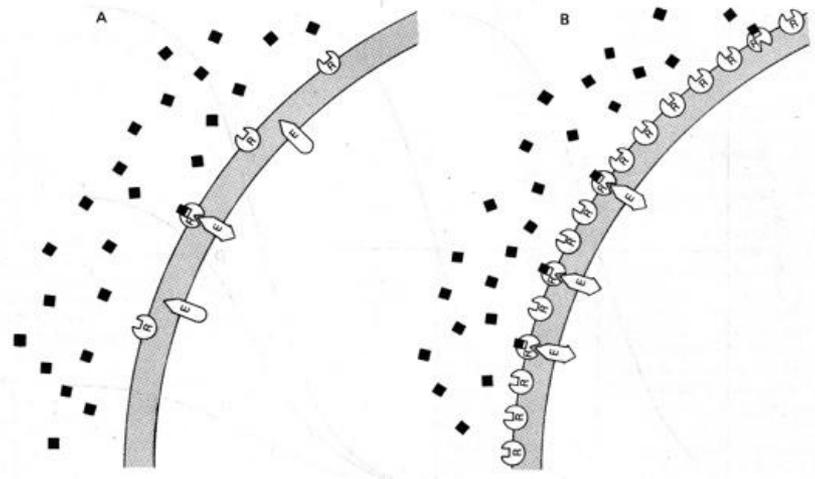
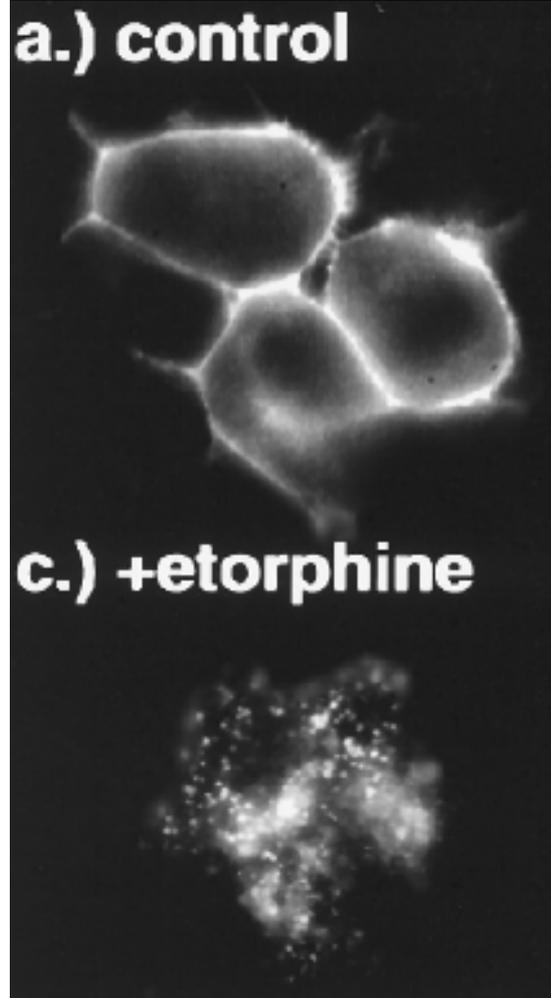


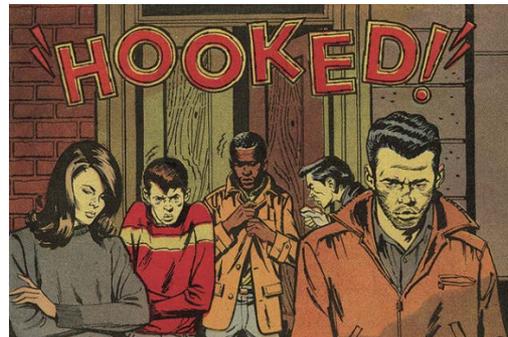
Figure 16-13. Essential Cell Biology, 4th ed. (© Garland Science 2014)

REMEMBER? Receptor Downregulation



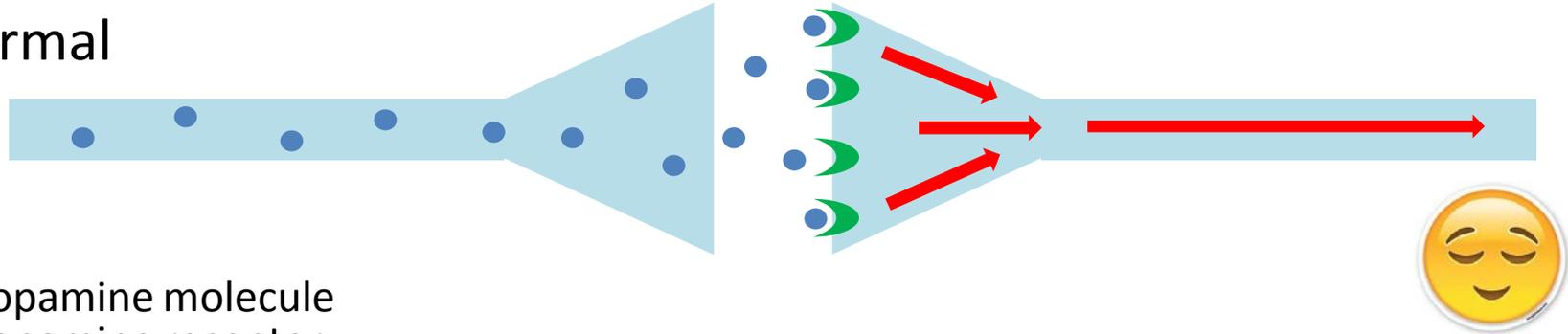
Repeated
Administration

Control



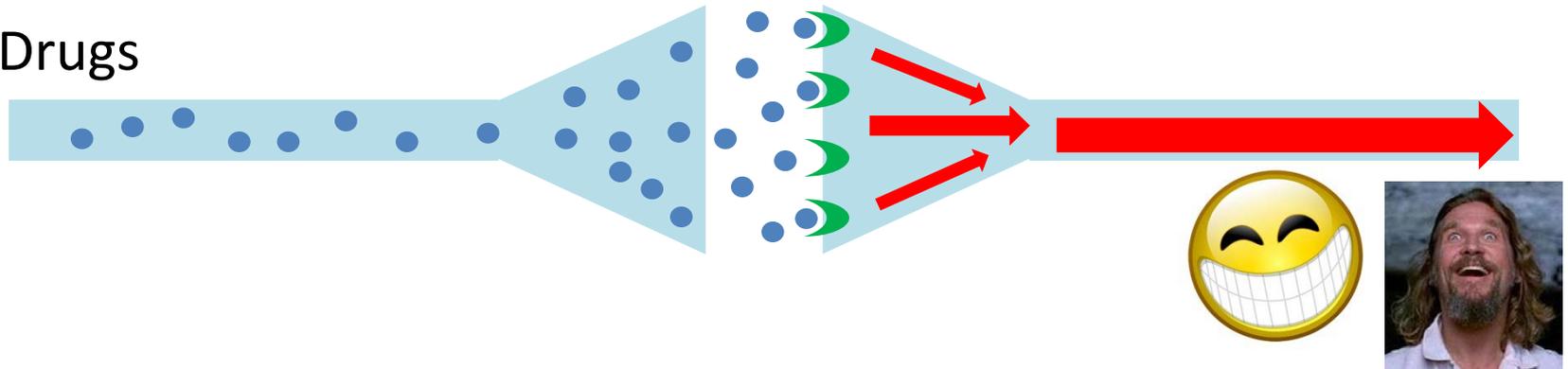
The Dopamine Hypothesis

Normal

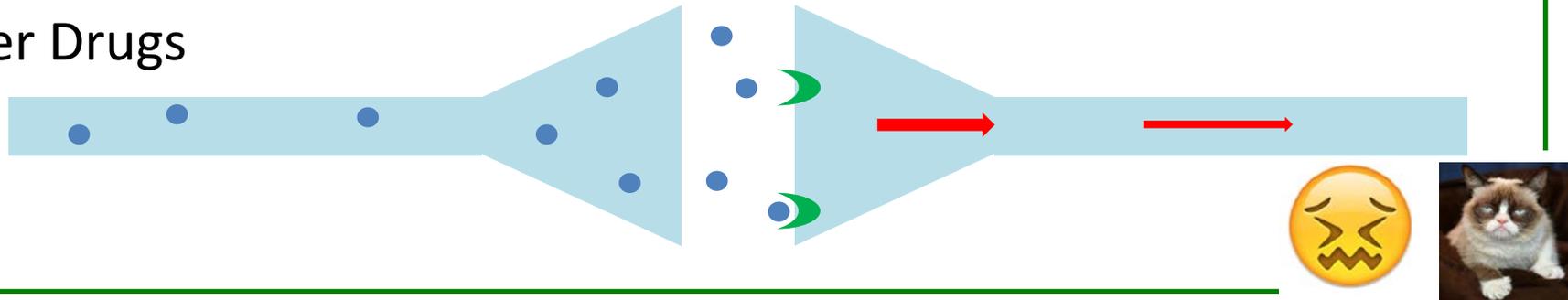


● Dopamine molecule
☾ Dopamine receptor

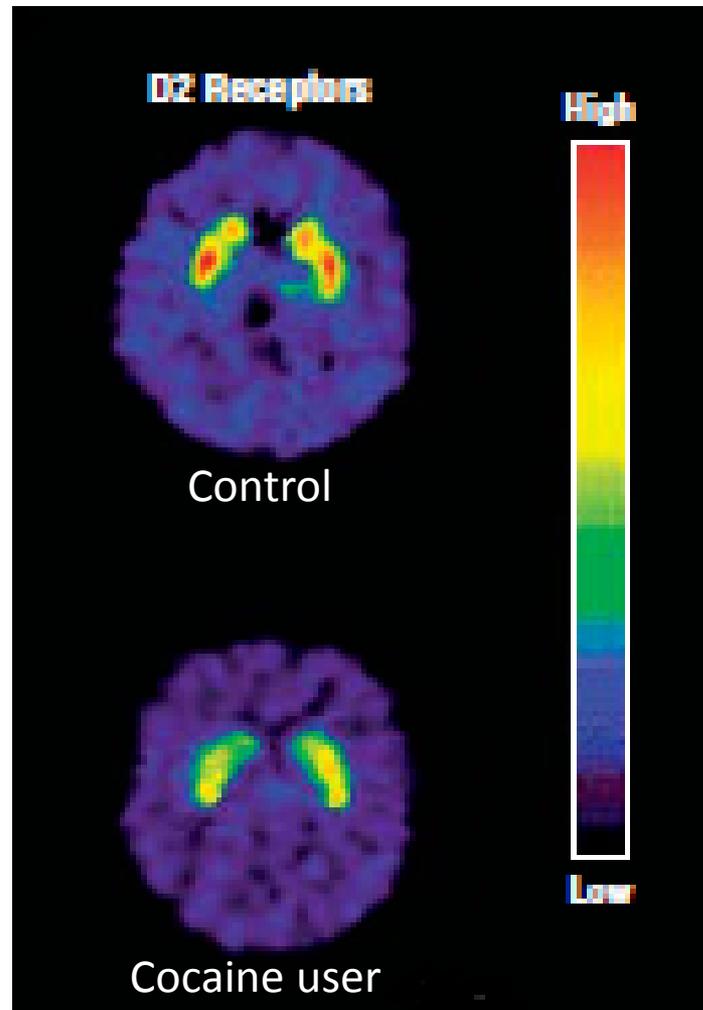
On Drugs



After Drugs



Drug users have fewer dopamine receptors



Volkow ND, Arch. Neurol, 2007

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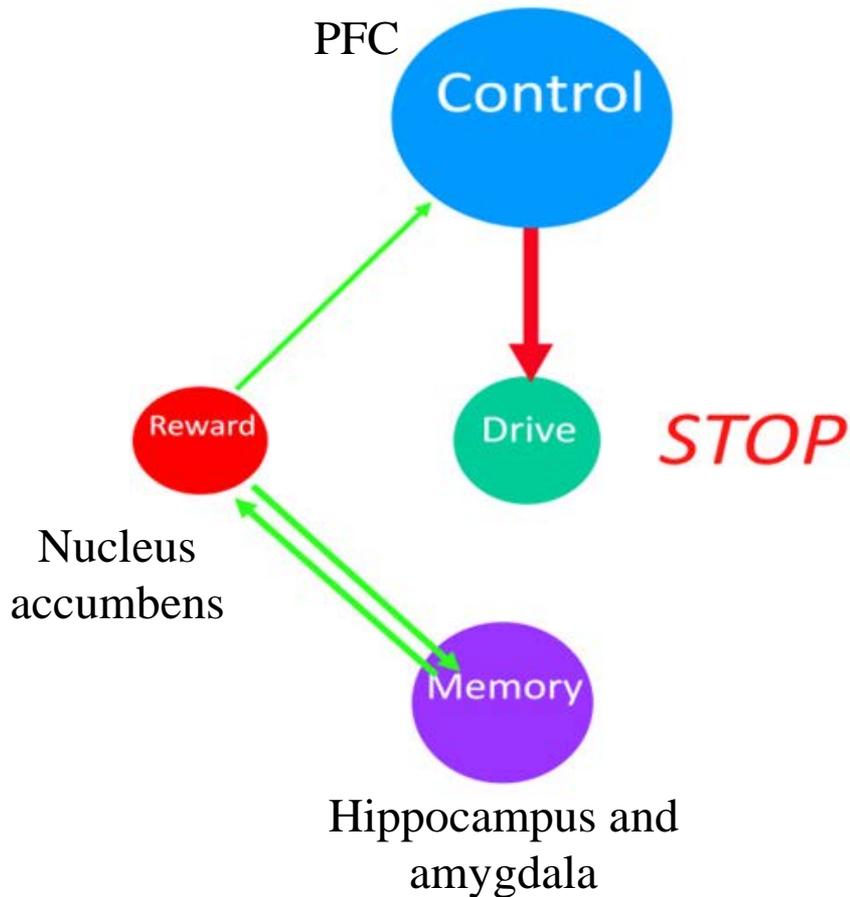
What does this tell us?

Therefore, the dopamine hypothesis states drug abusers have a blunted brain response to reward and are thus more likely to continue to pursue drug to achieve the desired “high”

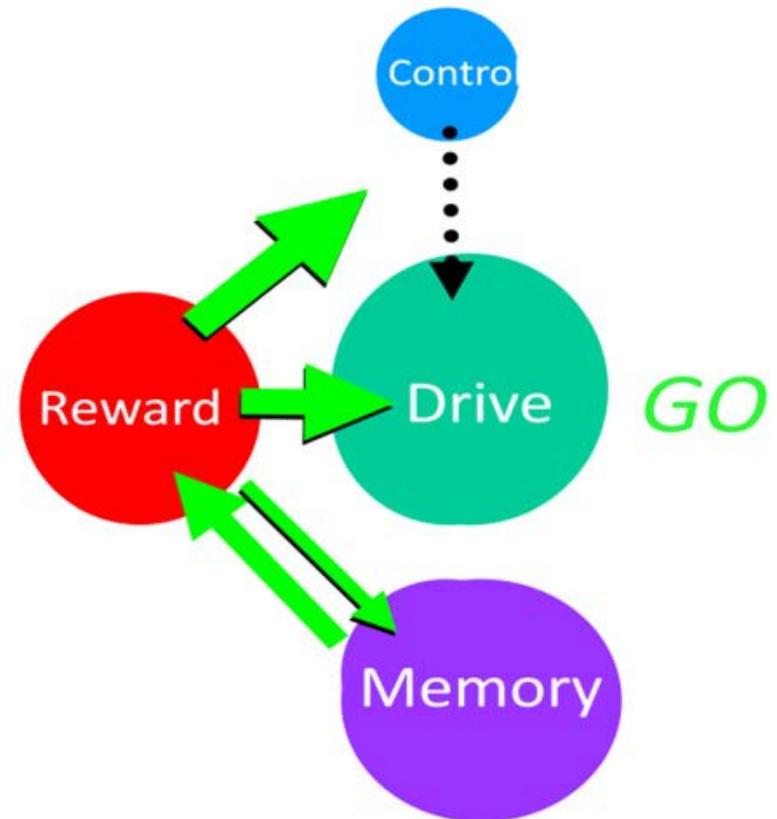
- Users do not feel ‘normal’ without drugs
- Users feel ILL without drugs!
- This is not something drug users can ‘just get over’
- Time is needed for receptors to recover!

Therefore, our cutting edge theory of addiction is...

Nonaddicted Brain



Addicted Brain



Volkow *et al*, Neuron, 2011



Are thought and action the same things?



It's complicated...Some days we clean when tired, some days have energy but just 'don't'.

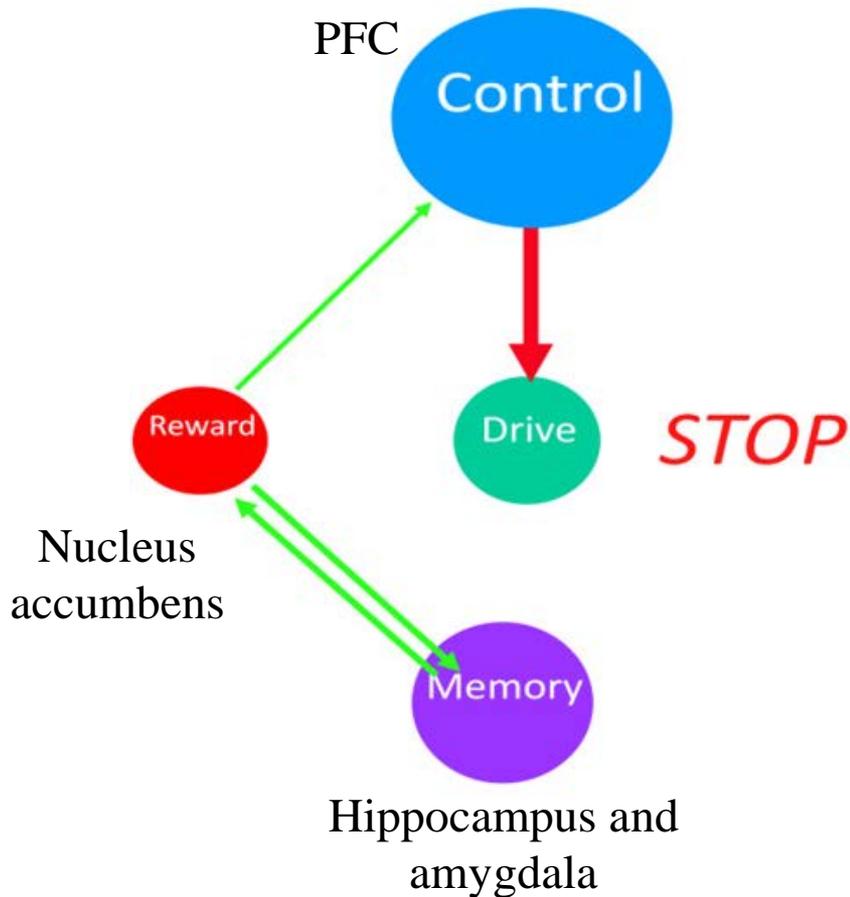


Addicts are teaching us about choice, since they have a 'lesion' in this area!

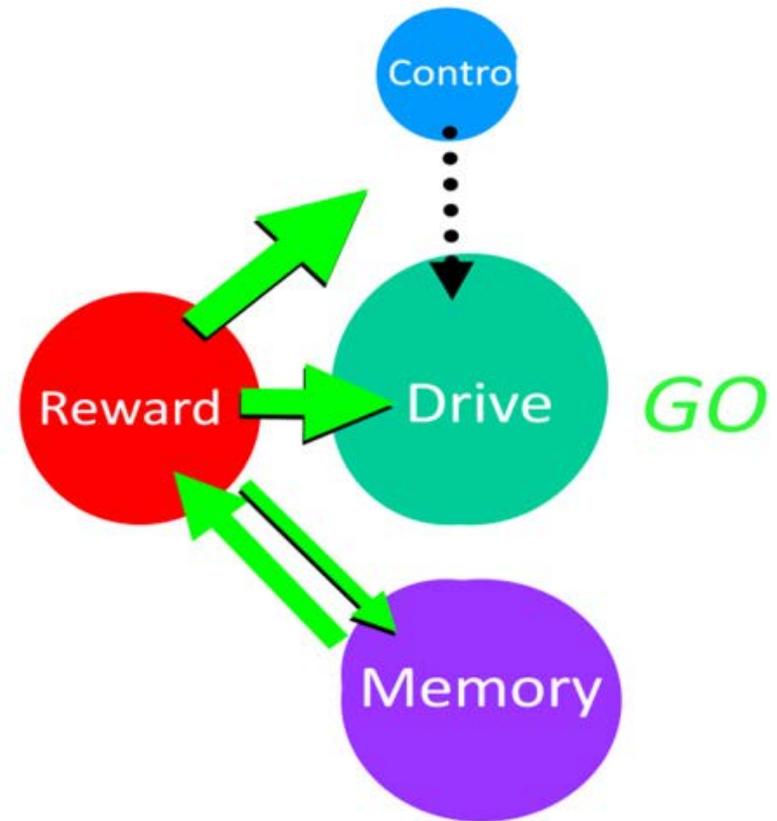


What if the choice were out of our hands?

Nonaddicted Brain



Addicted Brain



Volkow *et al*, Neuron, 2011

It's even more complicated!....

Other mechanisms:

GENETICS

-Certain genes lead to more OR less addiction!

EPIGENETICS

-Stress can modify **how** we express our genes!

-(Early life trauma, poverty, etc.)

-methylation of genes, histone tail modifications, etc.

Lack of Inhibitory Control

-Drugs addicts are more compulsive than general population

*How do we currently treat
addiction?*

Treat the Acute Withdrawal

- Withdrawal can be DEADLY!
 - Alcohol & Benzos (benzodiazepines)
 - Fatal seizures
 - Prevent seizures by tapering benzos
- Treat anxiety (benzos)?
- Diarrhea & vomiting (loperamide, ondansetron)?
- Antidepressants?
- ETC.



Replacement Therapy

- Opioids
 - Methadone (Dolodpine, Methadose)
 - Buprenorphine (Suboxone, Subutex)
- Tobacco
 - Nicotine gum
 - Nicotine spray
 - Nicotine patch
 - E-cigs!???



Block the Reward

- Naltrexone
 - Blocks opioids receptors
 - Can no longer feel 'reward'
 - Used for alcohol and opioids
- Disulfiram (Antabuse)
 - Blocks alcohol metabolism
 - Causes severe alcohol poisoning
 - Aversion Therapy
- Compliance?



Have we really treated the addiction?

Time and learning (**LOVE!**) are
our only way to restore cell
signaling, receptors and brain
pathways!

*How should we treat
addiction according to the
human experts?*

Actions for an Addicted Loved One...

1. Get Educated (Family & Loved One)
2. Get Support (SMART, Northstar, Al-Anon)
3. Get Treatment (Inpatient, long-term outpatient)
4. **BUCKLE UP FOR THE LONG HAUL**

Recovery is not binary; People tend to think of addiction in very black and white terms, Not drinking using=success, drinking/using=failure. This can be problematic as it leads to the oversimplification **“He can just not use and he’ll be fine.”** Recovery is about a life style change, and happens slowly over a long period of time. Often people have a slip or a lapse during that time. **Family member’s ability to respond compassionately, yet firmly during these lapses can make all the difference in recovery.**



Tom Bannard, Administrative Director for VCU’s COBE

How should WE react?



VCU

How do we punish a DUI?

- Statistics are alarming...
 - Drunk driving is common (2013: 9.9 million people self-reported DUI) [Substance Abuse and Mental Health Services Administration]
 - 1/3 of DUIs will be repeat offenders
 - (Fell, Jim. National Highway Traffic Safety Administration Traffic Tech No. 85, February 1995)
 - Repeat offenders may have cause-and-effect learning issues
 - (Kaser et. al., 2010, Alcohol Clin Exp Res)

Is this a sign of addiction?

If they can't learn, what do we do?!?



How do we punish a DUI?

If they can't (easily) learn, what do we do?!?

State	Administrative License Suspension/Revocation (1st/2nd/3rd Offense)	Mandatory Alcohol Education and Treatment/Assessment	Vehicle Confiscation Possible?	Ignition Interlock Device Possible?
VA	1y/ 3y/ permanent	Both	Yes	Yes

<http://dui.findlaw.com/dui-laws-resources/state-by-state-dui-penalties.html>

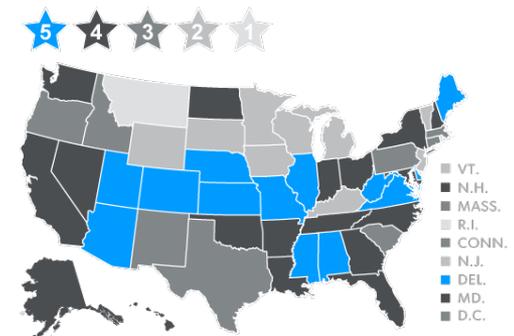
- incarceration
- special DWI facilities
- house arrest with electronic monitoring
- victim restitution
- community service
- ignition interlock on the vehicle (req. by Virginia (2012))
- increased fines and insurance rates
- public condemnation
- license plate tagging
- vehicle impoundment or confiscation

<http://www.nhtsa.gov/people/outreach/traftech/1995/TT085.htm>

HOW IS YOUR STATE DOING? DRUNK DRIVING PREVENTION EFFORTS ACROSS THE USA

Mothers Against Drunk Driving created a five-star system that rates individual state efforts at preventing drunk driving fatalities.

Each state gets one star for having legislation and action around each of the following categories: ignition interlocks, sobriety checkpoints, license revocation, child endangerment and no-refusal events.



SOURCE: Mothers Against Drunk Driving
Lori Grisham and Karl Gelles, USA TODAY



What have we learned?

- Is addiction a moral failure or a disease?
- Is this something we can 'get out of our system'?
- What can we do to recover!?



WE ARE ALL TRYING TO FIND OUT!!

These things may help!

-LOVE; we need to teach the brain a different kind of pleasure!

-Patience and perseverance: learning takes time

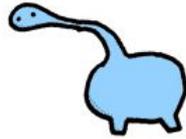
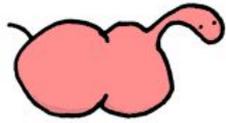
-Active treatment: all diseases need daily treatment. Life as we knew is before IS over, to extinguish those behaviors, we need a whole to life and we need to learn how to live it!

(BYE BYE TRIGGERS! Need new friends!)

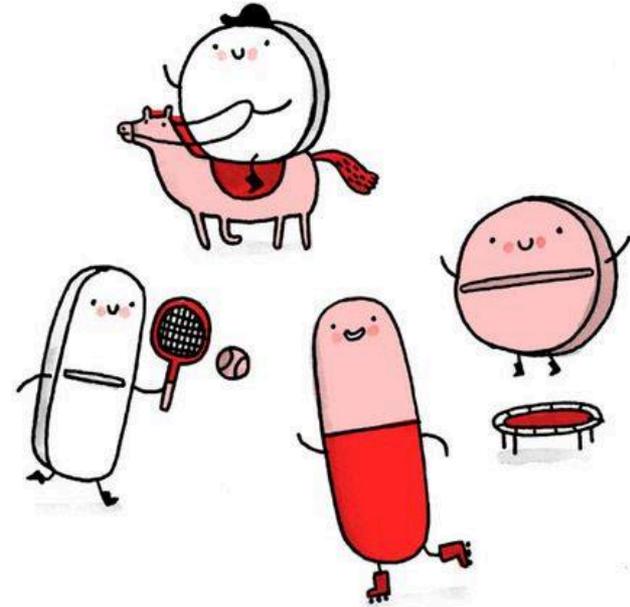
Addiction is a disease, not a choice!

Questions?

SEROTONIN & DOPAMINE



Technically, the only two things
you enjoy



RECREATIONAL DRUGS

GEMMA CORRELL



“ Whenever you feel sad
just remember that there are
billions of cells in your body
and all they care about
is you. ”

Predicting &
**Reducing DUI by Monitoring Alcohol
& Substance Abuse**



Presented by Jason Herzog

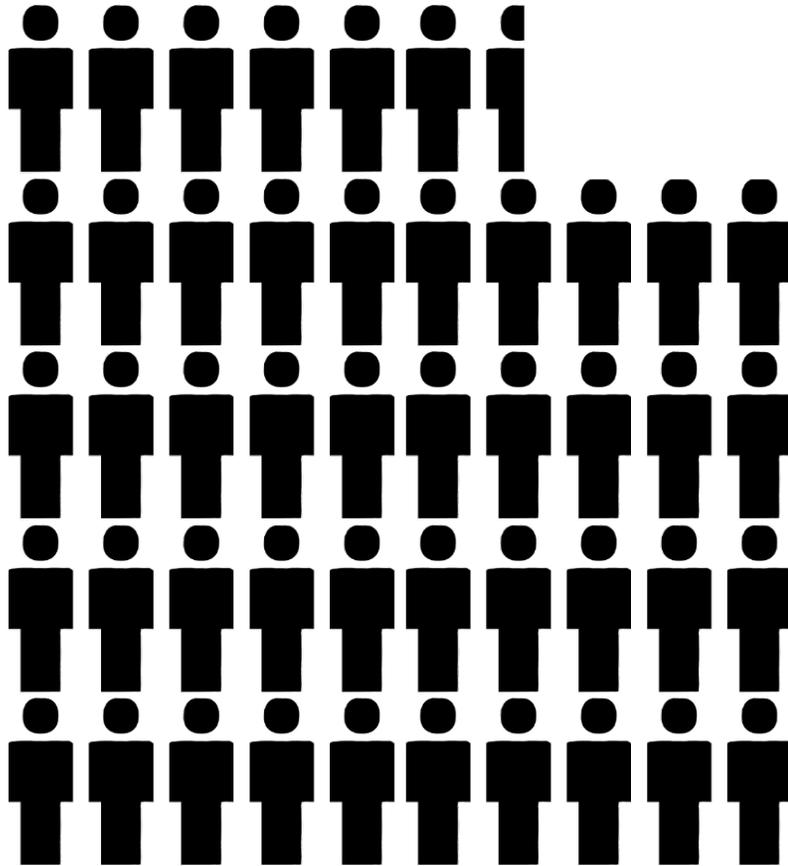


Much More Than Just a Test



Driving Under the Influence/While Intoxicated (“DUI”) – Snap Shot

About 10k fatalities annually, accounting for 31% of all motor vehicle deaths.¹



- Alcohol Impaired Driving crashes cost society \$44 Billion each year.²



- 21 to 24 Age Group had the highest percentage of drivers with 0.08 BAC or higher (30.0%).¹



- 1.1 million DUI arrests³, representing less than 1% of the 121 million self reported episodes⁴.

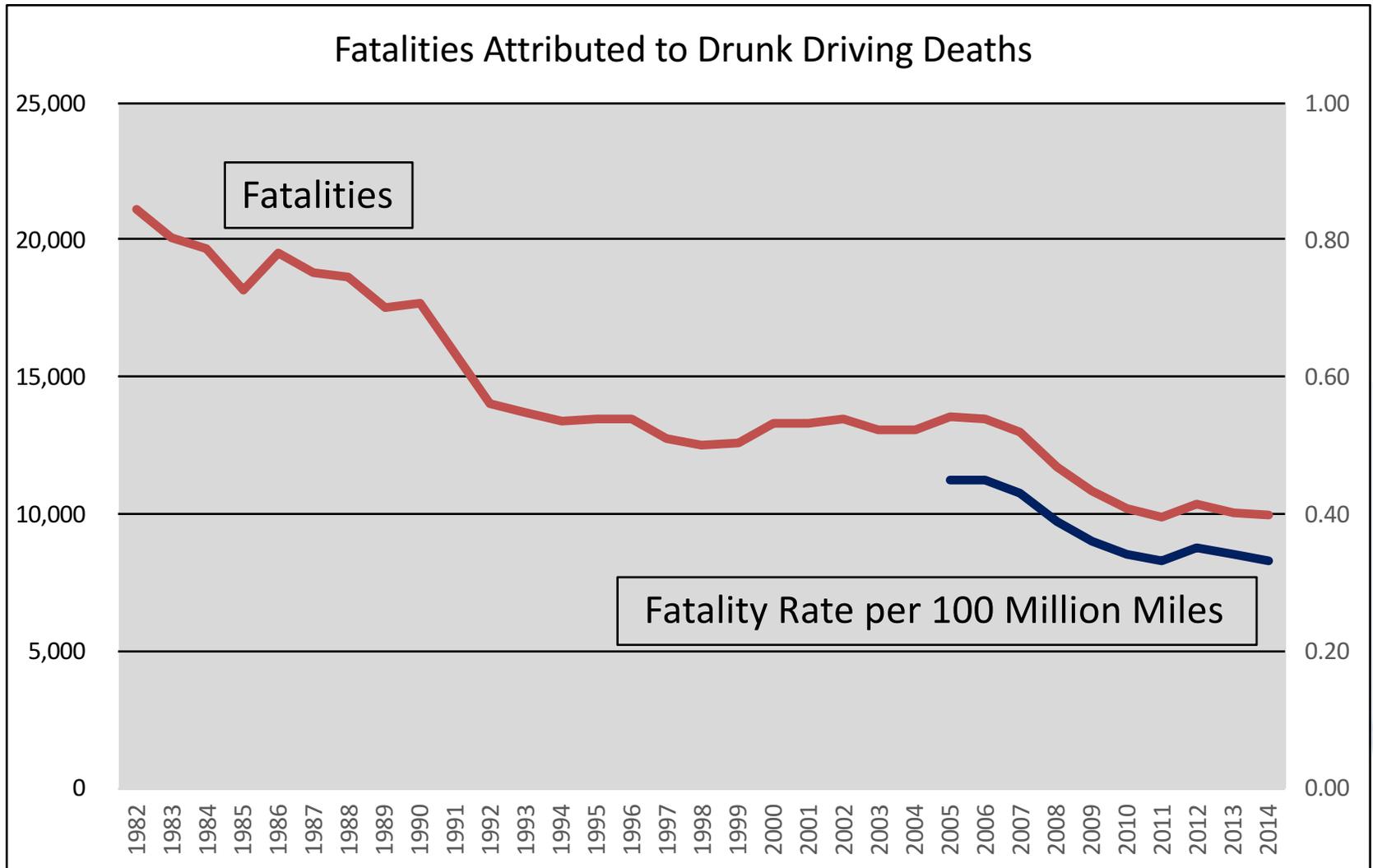


- Department of Transportation, National Highway Traffic Safety Administration.
- Blincoe, L. J., Miller, T. R., Zaloshnja, E., & Lawrence, B. A. (2014). *The economic and societal impact of motor vehicle crashes, 2010 (Revised)*.
- Department of Justice, Federal Bureau of Investigation (FBI). Crime in the United States 2014: Uniform Crime Reports. Washington (DC): FBI; 2015 [cited 2016 Feb 5].
- Jewett A, Shults RA, Banerjee T, Bergen G Alcohol-impaired driving among adults— United States, 2012. *MMWR Morbi Mortal Wkly Rep.* 2015;64(30):814-17.



DUI – Then and Now

Since the 1982, we have cut the annual number of drunk driving deaths by more than half from over 20,000/year to under 10,000/year.



Source: Department of Transportation, National Highway Safety Traffic Administration.



Across the Board Improvement

Fatalities declined across all demographic segments, which is attributed to a variety of factors.

Age 16 to 20



3,100 Fewer Fatalities



82% decline from 1982 to 2004

- ✓ Minimum Age of 21
- ✓ Zero Tolerance
- ✓ School-based Programing

Age 21 to 30



4,900 Fewer Fatalities



58% decline from 1982 to 2004

- ✓ Monetary Sanctions
- ✓ Sobriety Checkpoints
- ✓ Screening & Interventions

Over Age 31



3,000 Fewer Fatalities



35% decline from 1982 to 2004

- ✓ Treatment
- ✓ Mass Media
- ✓ Multi-component Interventions

- ✓ Mandatory Seatbelt Laws
- ✓ Safer Cars

Source: Department of Transportation, National Highway Safety Traffic Administration.

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What has Worked Less?



- 1 in 4 drunk driving motorists drive without a valid license.

- Stricter/more lenient laws do not correlate with lower fatality rates.
- Deter social drinkers but not heavier drinkers with substance abuse issues.
- Focus effort on identifying drunk drivers.



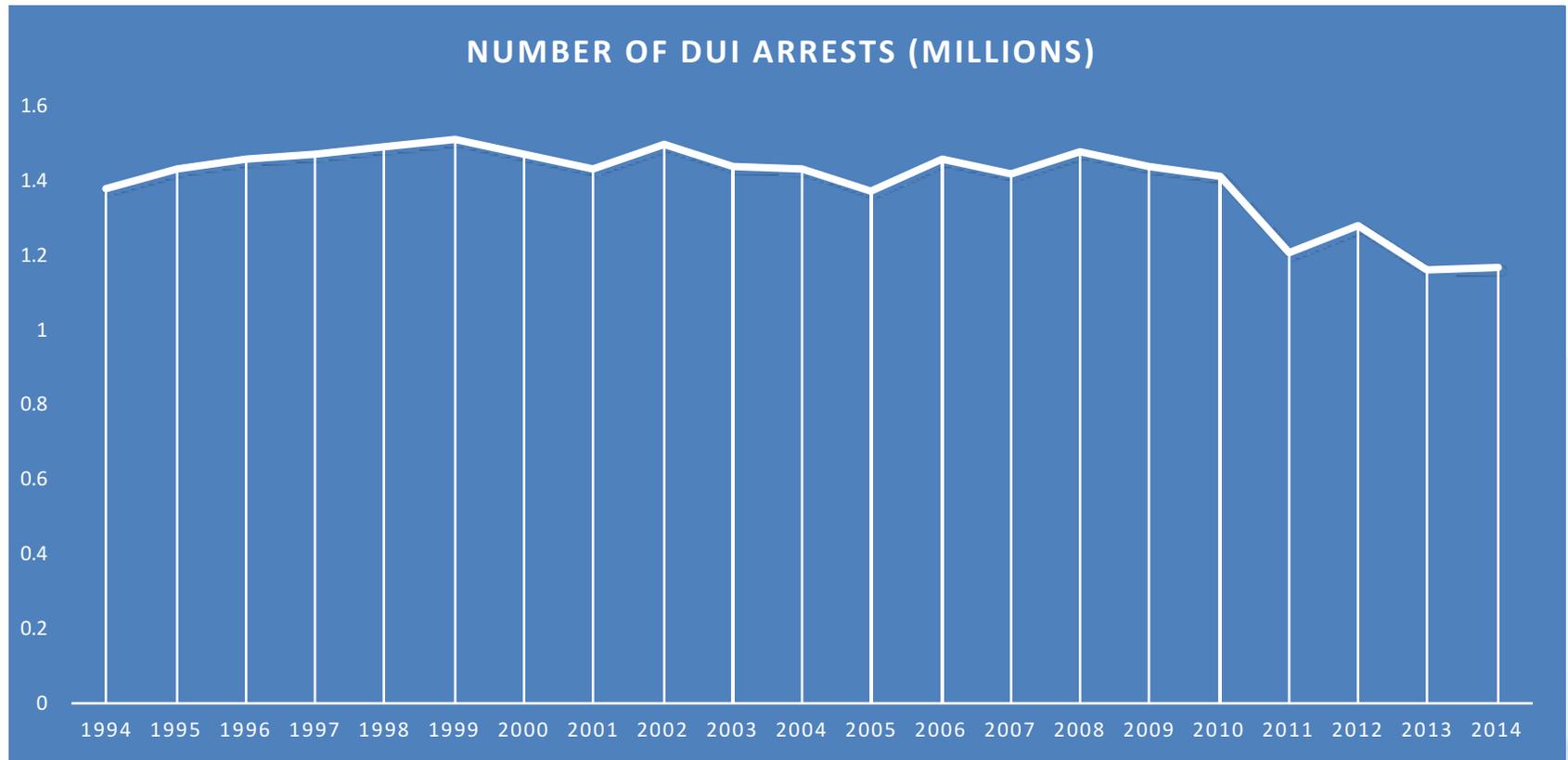
- Ignition interlock reduces recidivism while installed; however, less than one-quarter of DUI offenders comply with orders to install interlock devices, and clients do not develop lasting coping & refusal skills.

Source: NHTSA collision data from 2013, NHTSA Traffic Safety Facts, 2013 American Community Survey from the U.S. Census Bureau, US Government Accountability Office, 2014.



DUI Arrests (1994-2014)

Even as DUI related fatalities declined, the number of DUI arrests has remained relatively flat over the past 20 years.

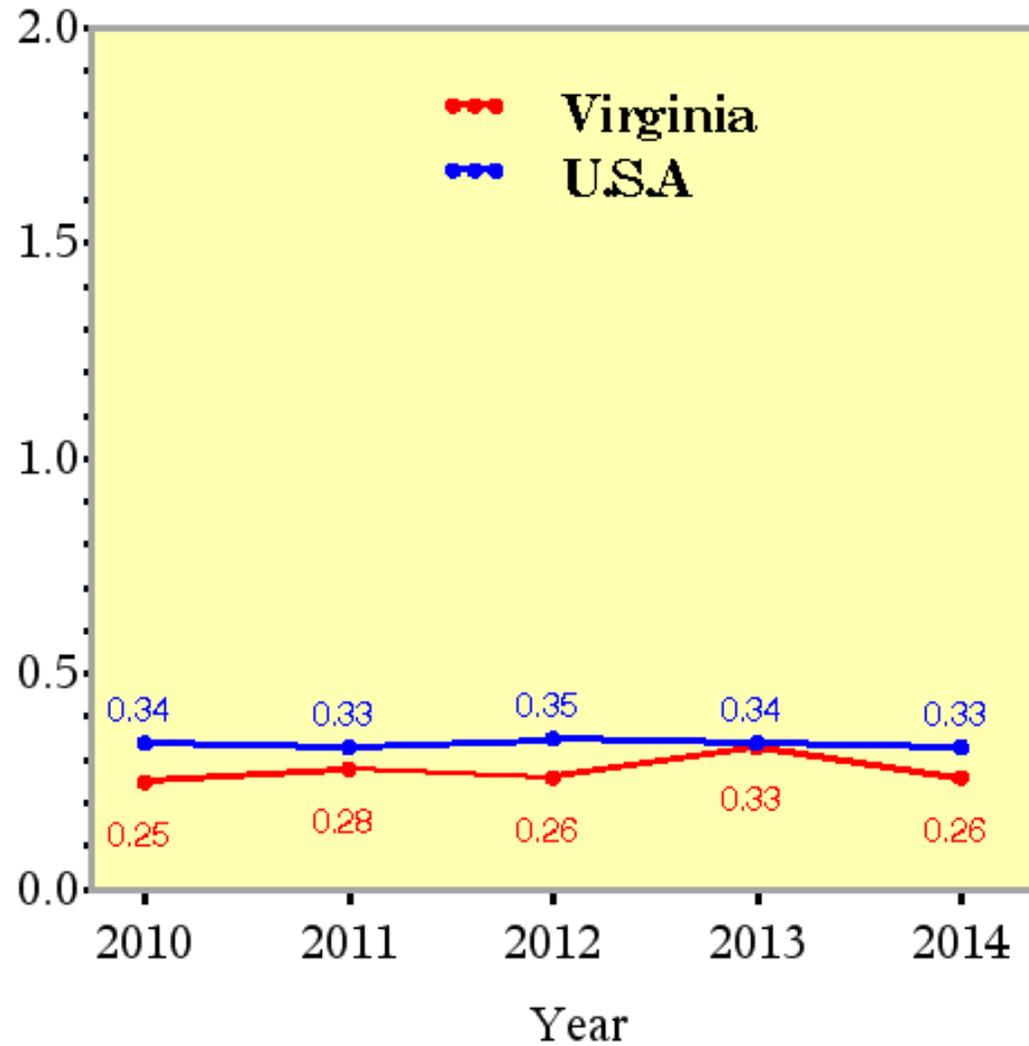


Source: Federal Bureau of Investigation, "Crime in the United States: 2014."



Alcohol-Impaired Driving Fatalities per 100 Million Vehicle Miles Traveled

Virginia drivers experienced fewer fatalities per mile driven!

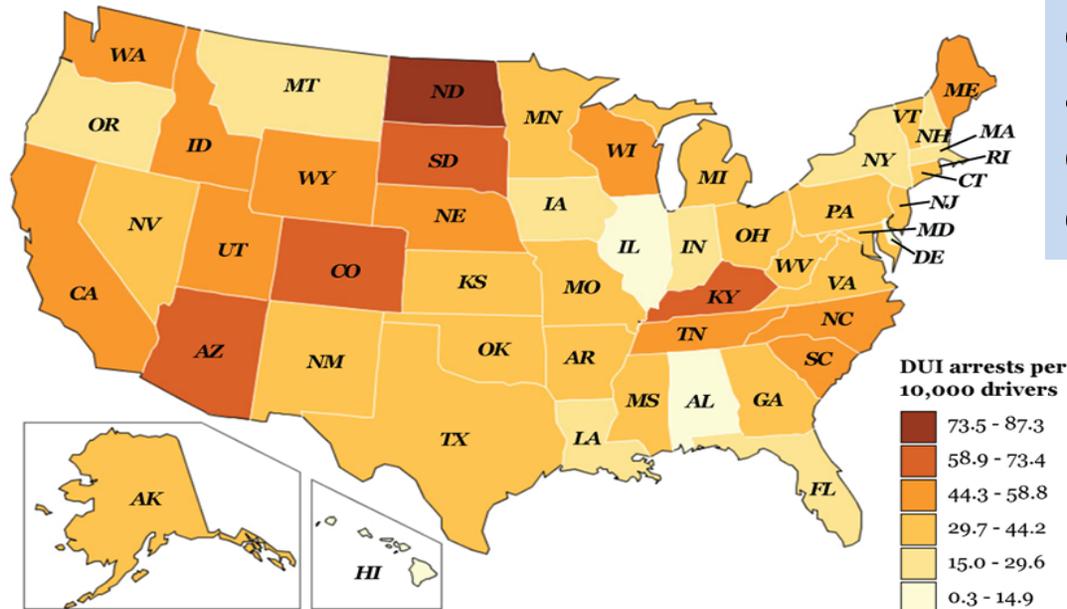


Source: NHTSA



DUI Arrests in 2013 per 10,000 drivers

VA ranks 28th for number of DUI arrests, with 36.3 arrests per 10,000 drivers equating to 27,333 DUI convictions.



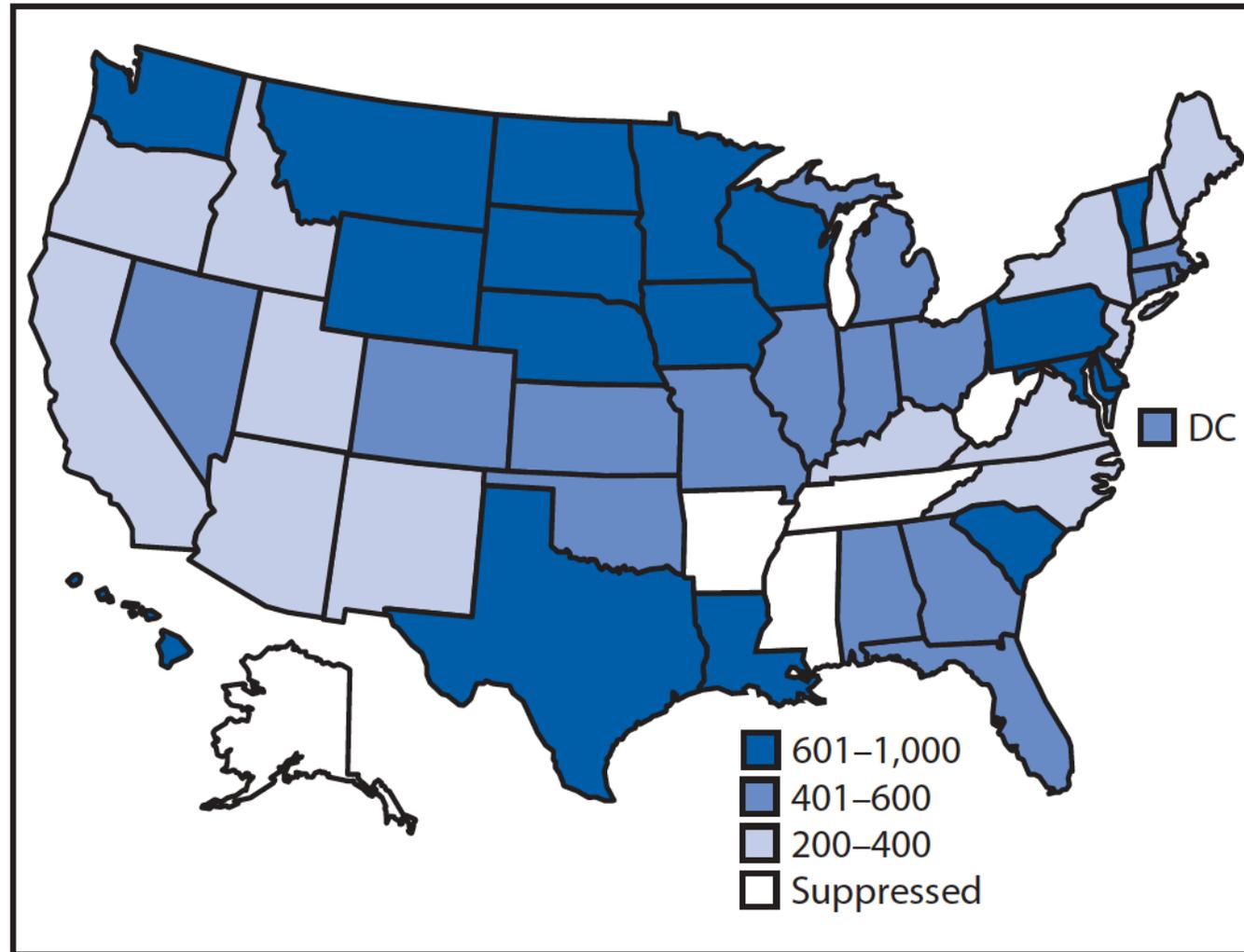
1-13		14-26		27-39		40-50	
1. North Dakota	87.3	14. Nebraska	48.7	27. Maryland	37.1	40. New Hampshire	28.4
2. South Dakota	63.1	15. South Carolina	48.5	28. Virginia	36.3	41. Iowa	28.0
3. Colorado	63.0	16. Utah	45.6	29. Michigan	35.4	42. Florida	26.8
4. Arizona	61.3	17. Pennsylvania	43.7	30. New Mexico	35.2	43. Indiana	20.5
5. Kentucky	59.8	18. Missouri	42.1	31. Alaska	34.7	44. Oregon	19.0
6. California	58.1	19. Minnesota	41.6	32. Georgia	33.9	45. Massachusetts	16.9
7. North Carolina	52.9	20. Nevada	41.5	33. Ohio	33.4	46. Louisiana	15.9
8. Wisconsin	50.9	21. West Virginia	40.9	34. Arkansas	31.5	47. Hawaii	8.1
9. Washington	49.8	22. Vermont	40.8	35. Connecticut	30.3	48. Illinois	3.8
10. Maine	49.4	23. Kansas	39.7	36. Rhode Island	30.2	49. Delaware	3.4
11. Idaho	49.3	24. Texas	38.7	37. New Jersey	30.0	50. Alabama	0.5
12. Tennessee	48.7	25. Oklahoma	38.5	38. Montana	28.9		
13. Wyoming	48.7	26. Mississippi	37.8	39. New York	28.7		
Above national average				Below national average			
				National average 37.4			

Source: United States Department of Justice, Federal Bureau of Investigation, (November 2014), Crime in the United States, 2013.



Self-Reported Alcohol Impaired Driving Episodes per 1000 People

1.4% of adults self-reported driving after drinking too much – #44th highest state.

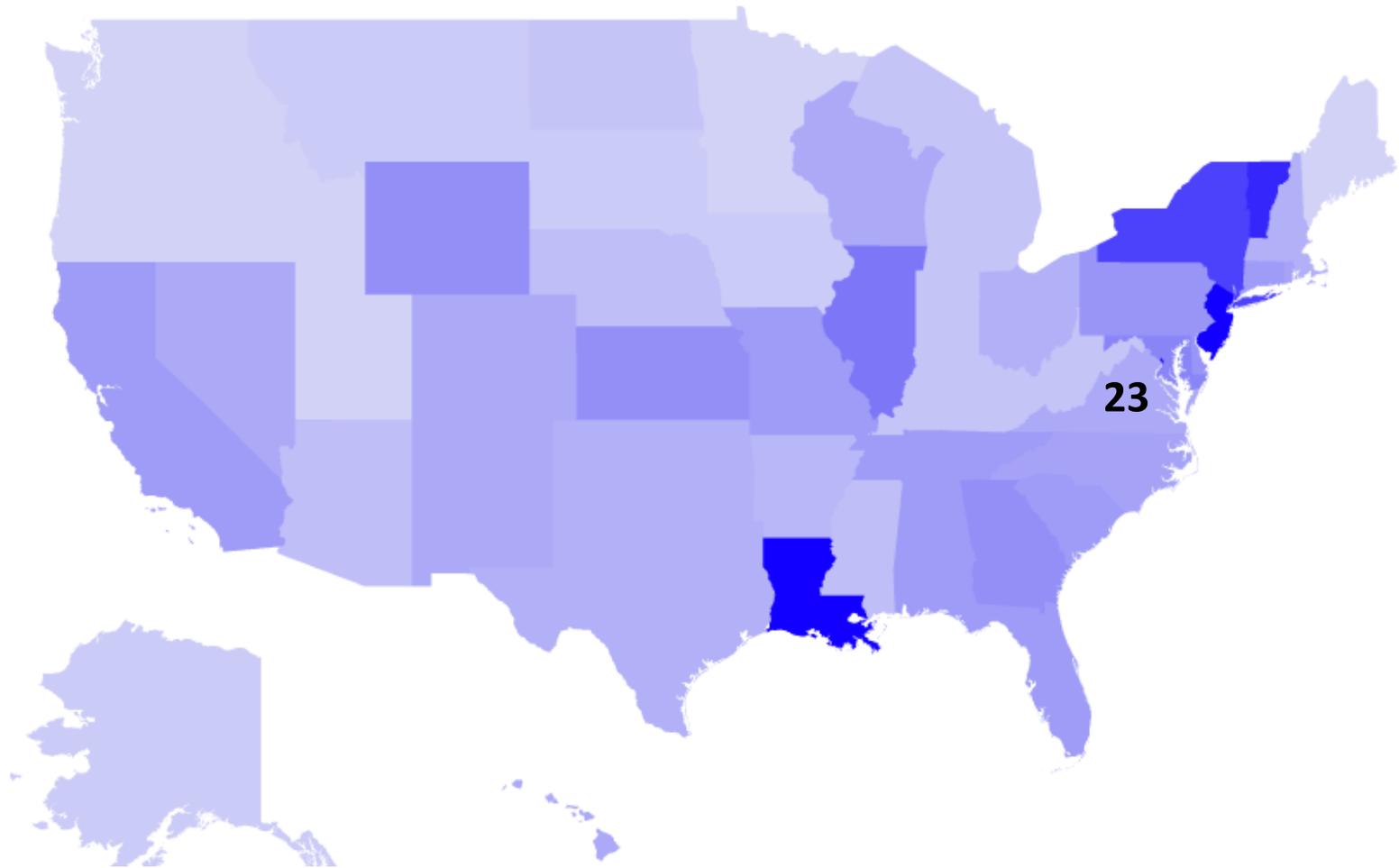


Source: Jewett A, Shults RA, Banerjee T, Bergen G Alcohol-impaired driving among adults— United States, 2012. MMWR Morbi Mortal Wkly Rep. 2015;64(30):814-17.



Officers Per Capita

At 23 law enforcement officer per 10,000 people, VA ranks 29th in officers per capita.



Officers Per Thousand

17.0

27.5

38.0

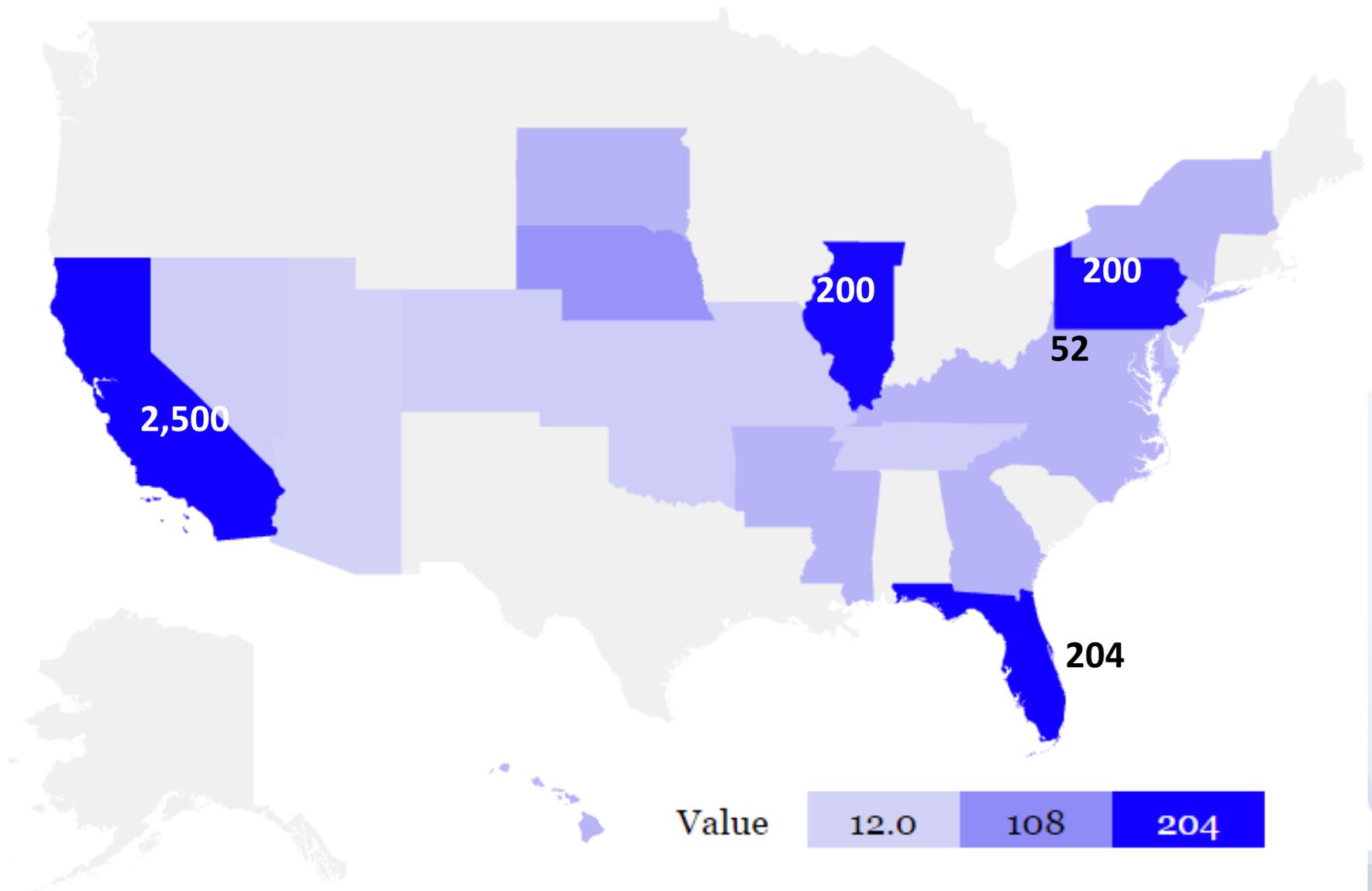
Source: FBI: Crime in the United States Report

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DUI Checkpoint Frequency

VA ranks towards the bottom of the middle third for the frequency of DUI checkpoints.





Drugged Driving

While alcohol-impaired driving declines, drug-impaired driving is increasing.

- Advancements in Oral Fluid testing, a method for measuring current intoxication, allow for better detection of drugged driving.
- Yet the reliability and research gap between BAC and Oral Fluid is as wide as the Grand Canyon.



Source: Findings are from the 2013-2014 National Roadside Survey of Alcohol and Drug Use by Drivers (NHTSA) and were compared to results from 2007. The results indicate only a measurable level of substances present in a driver not level of driver impairment.



Drugged Driving: 2007 to 2013

- About 20.0 percent of drivers tested positive for at least one drug in 2014, up from 16.3 percent in 2007.
- Some 12.6 percent of drivers had evidence of marijuana use in their systems, up from 8.6 percent in 2007.
- More than 15 percent of drivers tested positive for at least one illegal drug, up from 12 percent in 2007.
- The number of dead drivers who tested positive for drugs has increased from 29 percent in 2005 to 39.9 percent in 2013 (Governors Highway Safety Association).

Source: NHTSA, Roadside Survey





Drugged DUIs

Almost half of drivers killed in crashes who tested positive for drugs also had alcohol in their system.



Source: MADD, Governors Highway Safety Association, NHTSA, Federal Bureau Investigation.

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How Many People SELF-REPORTED Drugged Drive?

Nearly 10 million people self-reported driving under the influence of illicit drugs during the year (NIDA, 2013).



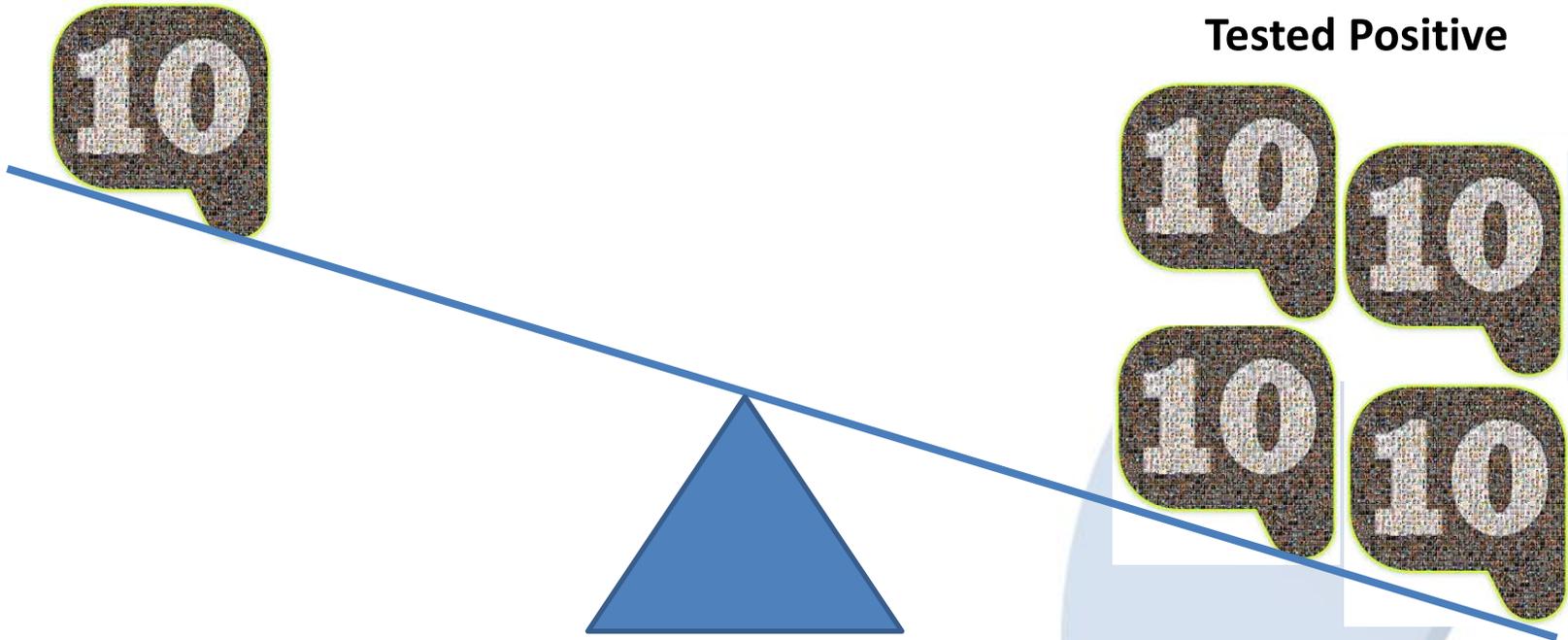
Source: MADD, NIDA, Governors Highway Safety Association



How Many People REALLY Drugged Drove?

- In 2013 and 2014, 22% of drivers tested positive for drugs (illegal or medications).
- Journal of Studies on Alcohol and Drugs July 2011 Researchers found that of all U.S. drivers who died in a crash, about 25% tested positive for drugs.

Self-Reported



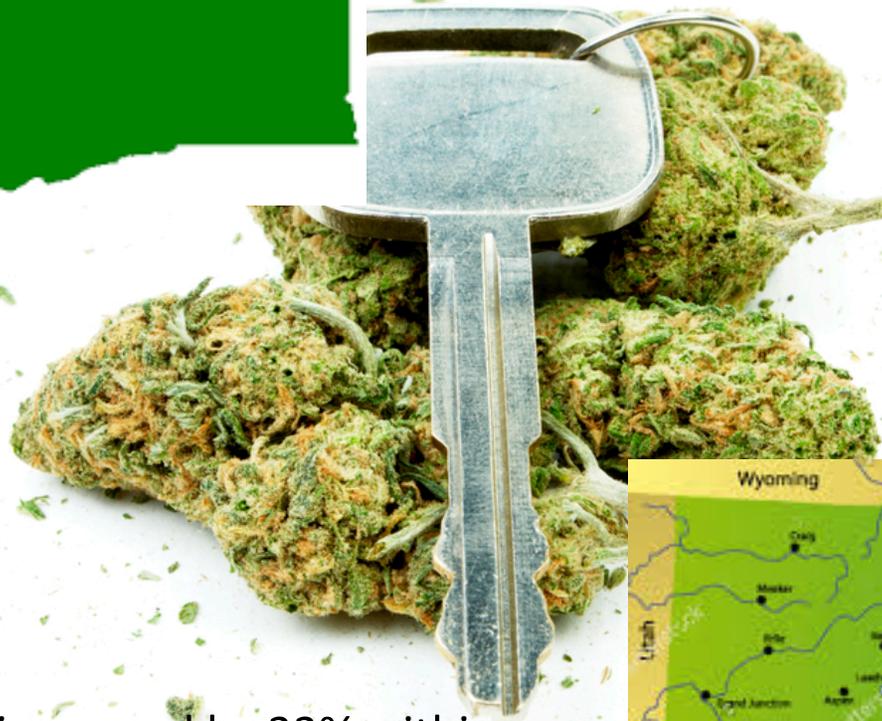
Source: 2013-2014 NHTSA Roadside survey of Alcohol and Drug Use by Drivers & PIRE, Romano and Voas.



DUIs in Marijuana Legal States



One year after legalization of recreational marijuana, the mix of fatal crashes due to drivers who recently used marijuana more than doubled



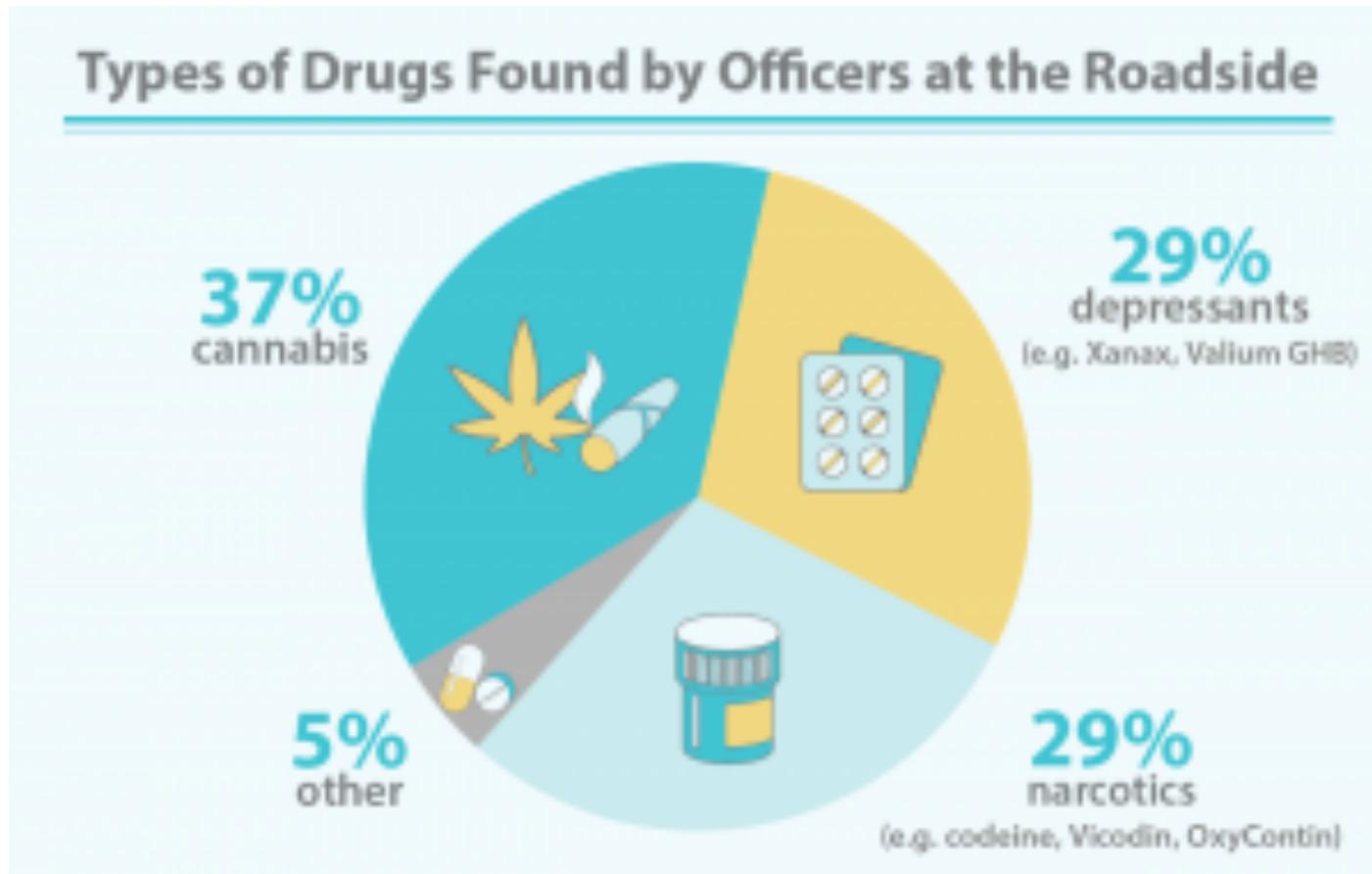
DUI fatalities increased by 33% within the same year marijuana became available in retail stores.





DUI Substance of Choice

Alcohol remains the substance of choice for drivers prone to impaired driving.

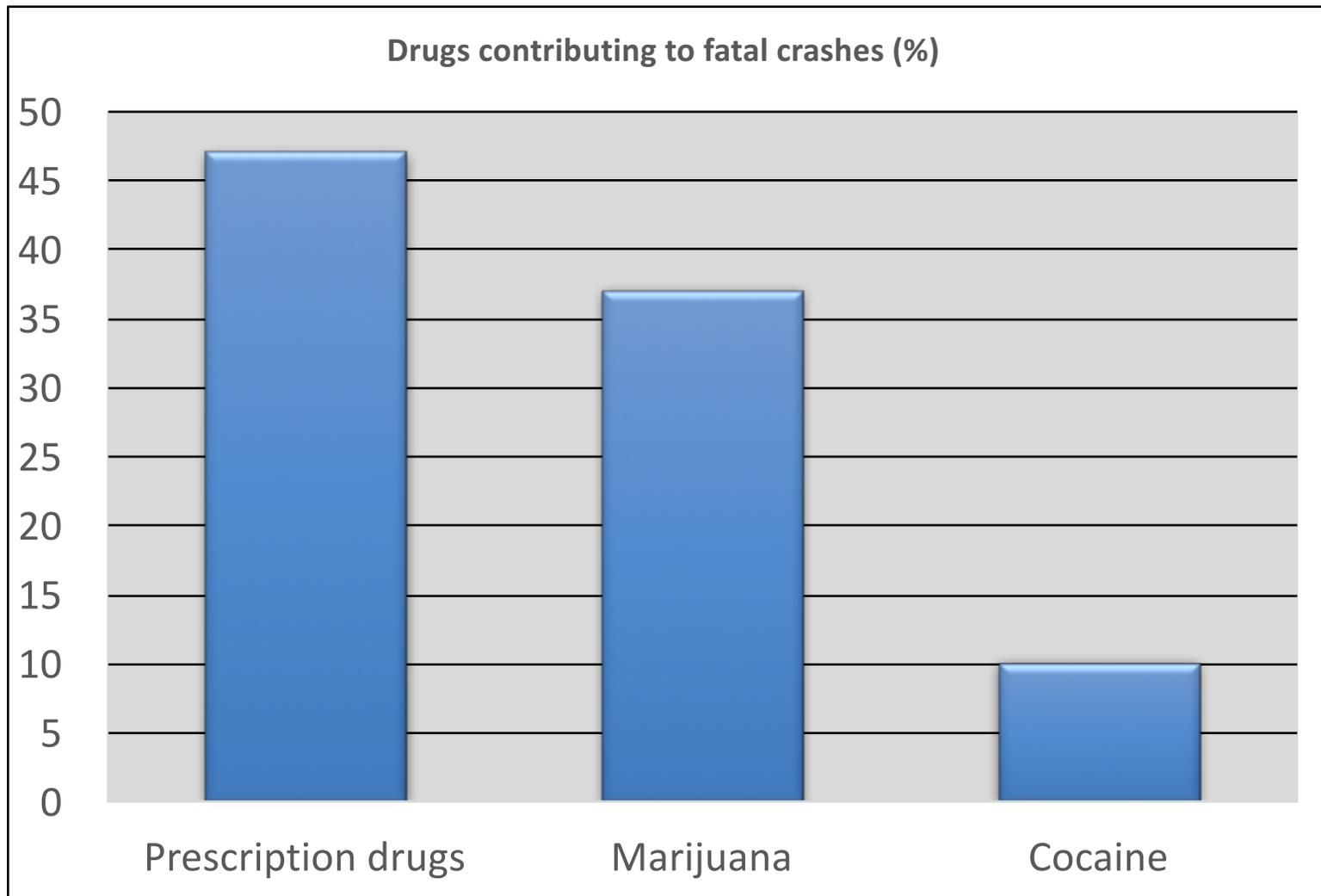


Source: Sobriety Testing Resource Center, 2013.



Drug-Impaired Fatality Substance of Choice

Prescription drugs account for nearly half of Drugged DUI fatalities.

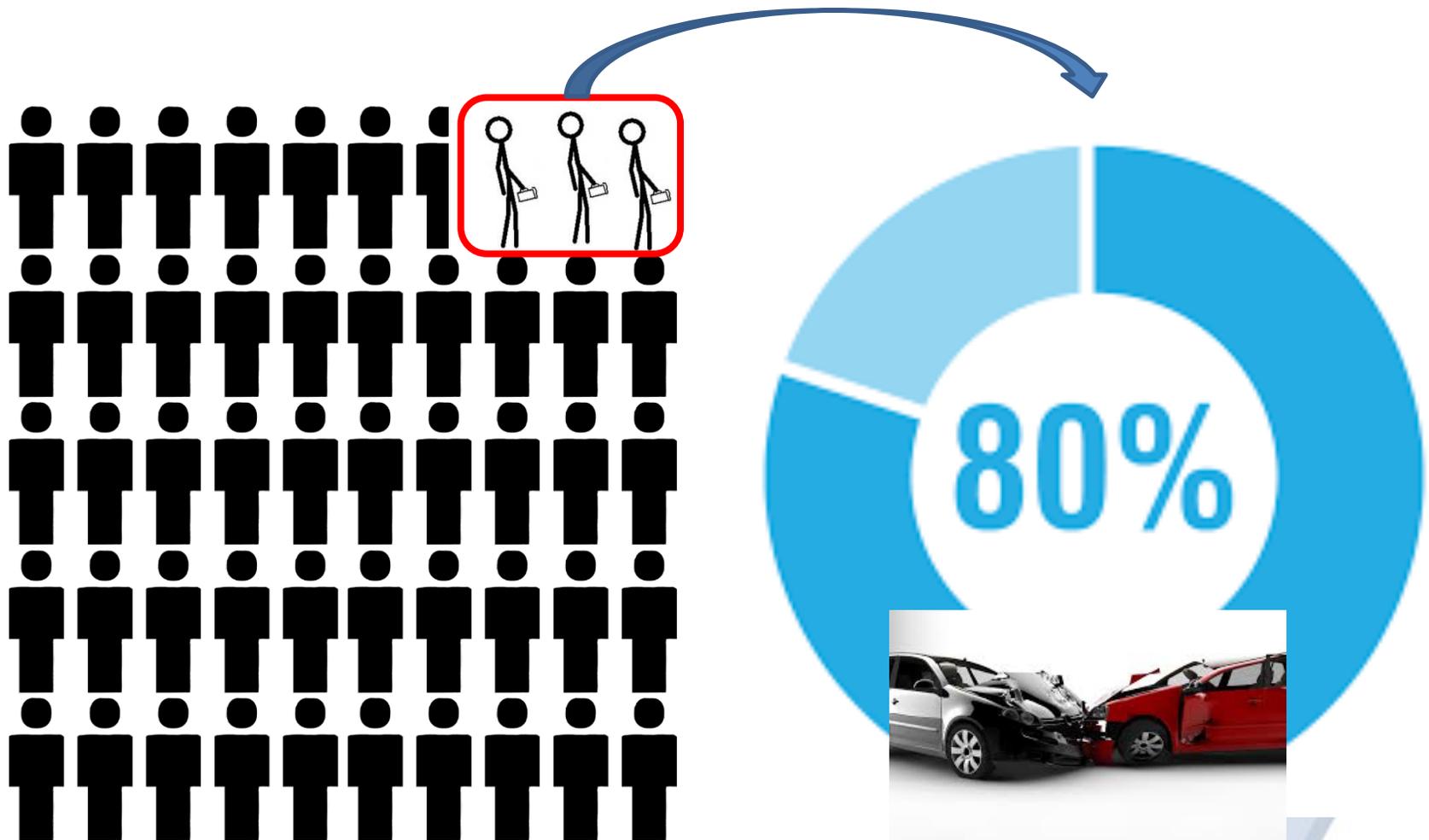


Source: NIH



How Do We Further Reduce DUI Fatalities?

Just 3-5% of drivers accounts for about 80% of the 121 million annual substance-impaired driving episodes.

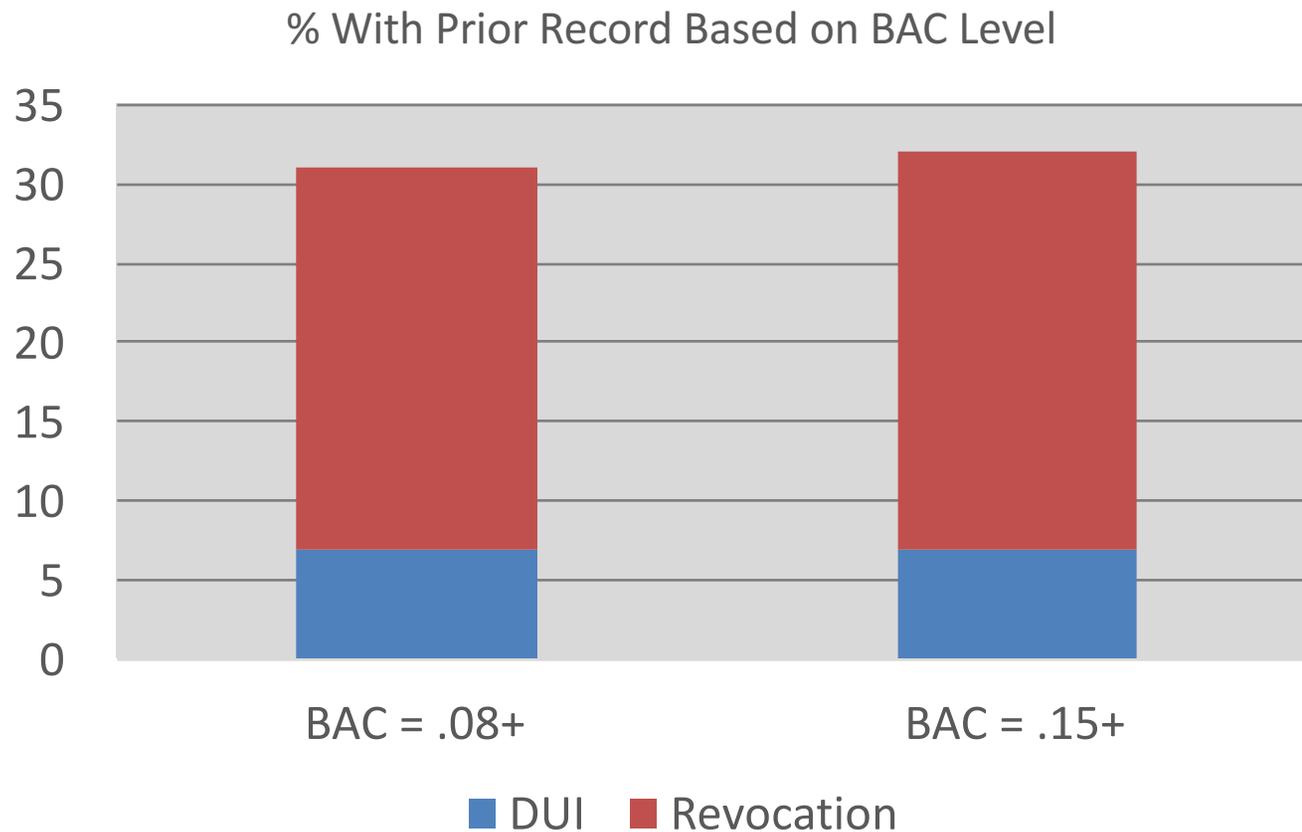


Sources: APPA, Predicting Repeat DWI, Risk Assessment, and Community Supervision, The epidemiology of Pyschiatric Disorders Among Repeat DUI Ofeenders Accepting a Treatment- Sentencing Option, : APPA, Predicting Repeat DWI, Risk Assessment, and Community Supervision Jewett A, Shults RA, Banerjee T, Bergen G Alcohol-impaired driving among adults— United States, 2012. MMWR Morbi Mortal Wkly Rep. 2015;64(30):814-17.



Social Versus Chronic/Addiction

Over 30% of DUI offenders have a previous DUI conviction and or license revocation.



Source: FARS 2014 ARF.



Repeat DUI Offenders

Drivers with a BAC of 0.08% or higher involved in fatal crashes are 7x times more likely to have a prior conviction for DWI than drivers with no alcohol in their system.



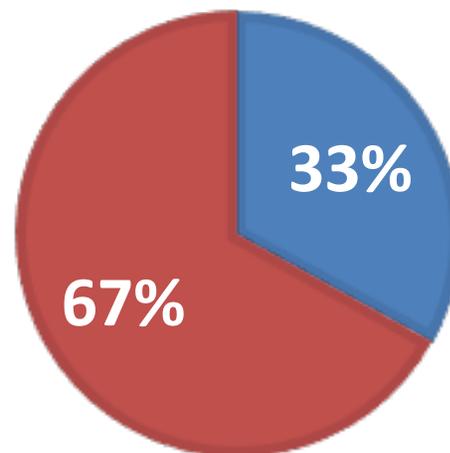
Source: MADD, APPA, Predicting Repeat DWI, Risk Assessment, and Community Supervision, NHTSA



Repeat Offenders

- About 1/3 of all drivers arrested or convicted of drunk driving are repeat offenders.
- In April 2008, there were two million three-time or more and 400,000 five time or more drunk driving offenders (MADD).
- It's estimated that 50 to 75 percent of offenders will drive drunk again, even if their licenses are suspended (MADD).

■ repeat offenders ■ first time offenders

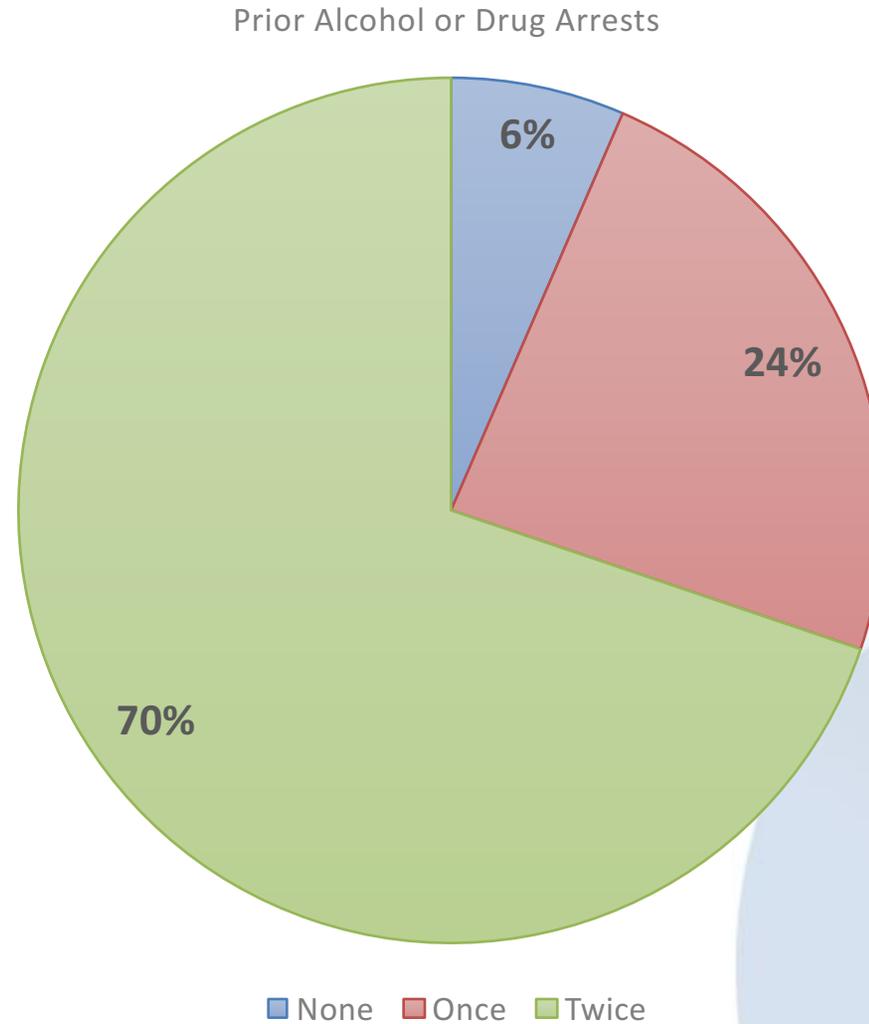


Source: Fell, Jim. "Repeat DWI Offenders in the United States." Washington, DC: National Department of Transportation, National Highway Traffic Safety Administration Traffic Tech No. 85, February 1995, MADD



DUI Repeat Offenders

94% of repeat DUI offenders have previously arrested for a drug or alcohol related offense

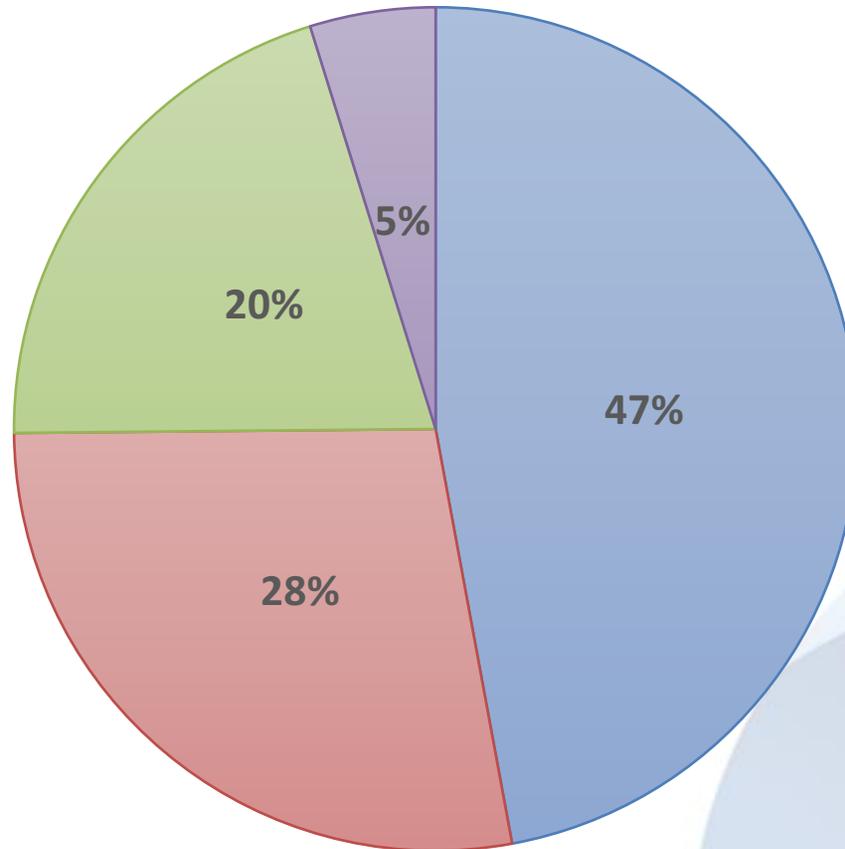


Source: APPA, A coffee can, factor analysis, and prediction of antisocial behavior: the structure of criminal risk, Kroner, Mills, and Reddon (2005)



DUI Repeat Offenders

DUI Prior Arrest Count



■ 1st time offender ■ 1 prior ■ 2-3 prior ■ 4+ priors

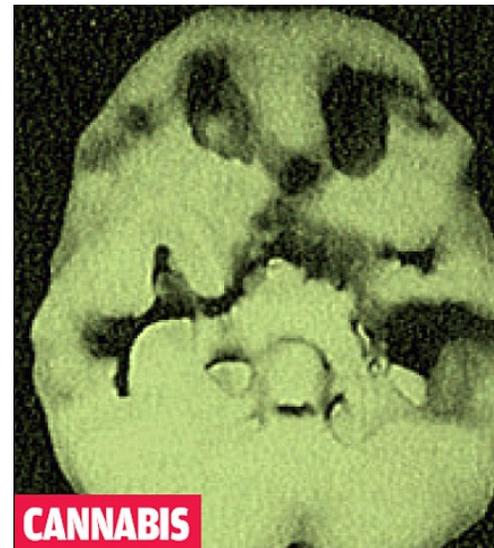
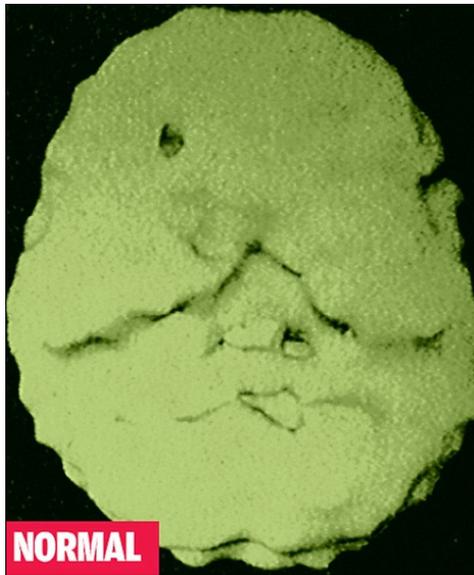
Source: APPA, A coffee can, factor analysis, and prediction of antisocial behavior: the structure of criminal risk, Kroner, Mills, and Reddon (2005)

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Visible Effects on Brain





What can be improved to reduce DUI?

- The risk for drunk driving can be predicted.
- Efforts to predict risk should be guided by research and evidence-based practices.
- Policies and practices developed from risk assessment research will further reduce the extent of future drunk driving.
- Predicting risk will not eliminate drunk driving completely, but it will help to reduce it.
- By identifying which offenders are most at risk for future drunk driving, policy makers and criminal justice officials will be in a position to develop control strategies that target those offenders most at risk for re-offending.



What can we do today to address DUI recidivism and continue to decrease DUI encounters?

- Drug Recognition Expert program
- Measurement based systematic monitoring
- Alcohol assessment/screening
- Alcohol Treatment
- DUI/ DWI Courts
- Increase understanding about habitual drunk driving





What can be improved to reduce DUI recidivism?

- Evaluating offenders for alcohol-related problems and recidivism risk.
- Selecting appropriate sanctions and remedies for each offender.
- Including provisions for appropriate alcoholism treatment in the sentencing order for offenders who require treatment.
- Monitoring the offender's compliance with treatment.
- Acting swiftly to correct noncompliance.



DUI Repeat Offenders in Virginia

Drivers Arrested for DWI (5 year range)

State	# of Drivers Arrested for DWI	# of Drivers With Prior DWI Arrest	Year	Percent Repeat DWI Offenders	Look-Back Period (years)
VA	179,081	35,414	2007-2011	20%	5



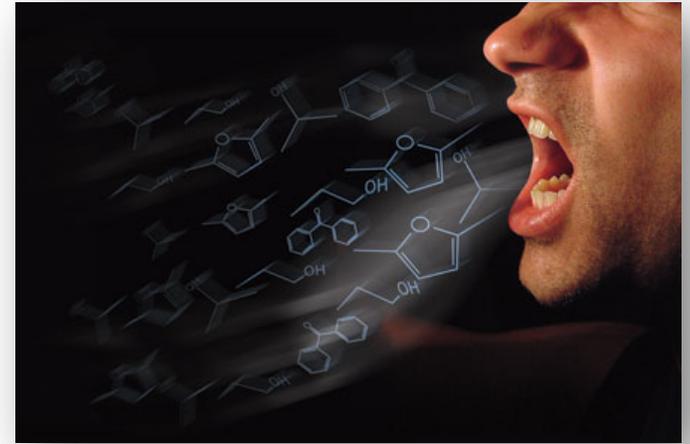
Breath Alcohol & 24/7 Programs

Advantage:

- Best for current intoxication and enhance immediate public safety

Disadvantage:

- Breath alcohol tests are administered when recent substance use is suspected or when substance use is more likely to occur, such as during weekends or holidays.
- Difficult for offenders to comply to 24/7 programs because it interrupts their schedule
- Not the best way to monitor low risk offenders/invasive
- Limited to testing solely alcohol





Transdermal

Advantage:

- Transdermal measurements are recorded twice each hour, thus it is more difficult to avoid detection over breath tests.
- They can be used as house arrest monitors by determining whether offenders are in their homes at designated times.

Disadvantage:

- Expense, inability to confirm low levels of drinking, inability to determine exact BAC levels. A less frequently occurring disadvantage also includes uncertainty about whether a violation occurred.
- Not the best way to monitor low risk offenders/ limits independence
- Limited to testing solely alcohol





ETOH Testing

Advantage:

Can be directly observed

- Can be used effectively for high-risk occurrences, such as weekends or holidays
- Evidence also suggests these tests can deter substance use effectively if they are administered on a daily basis, which can be extremely expensive, and is not random.

Disadvantage:

- Ethanol has a relatively short window of detection in urine.
- The normal clearance of ethanol from the urine is 8-12 hours. Typically cleared from blood generally within 24 hours. This makes them generally unsuitable for use as the primary testing method in Drug Courts.
- Ethanol can be generated in the presence of sugars and yeast/bacteria by a process of fermentation and could wrongly conclude an offender has consumed alcohol.





ETG

Advantage:

- Far superior testing method to ethanol testing in that it is both more sensitive and is more specific. EtG can show a stronger likelihood of someone drinking compared to traditional tools such as PBTs, blood, or saliva samples.
- The use of EtG or EtS can extend the time window for detecting alcohol consumption from several hours to several days. Depending on the amount consumed, EtG can be detected in the urine up to 72 hours after drinking. This represents improved monitoring capabilities for subjects in court-ordered abstinence or treatment programs.
- Because some Drug Courts may not perform drug or alcohol testing on weekends, weekday tests capable of detecting weekend substance use are crucial.

Disadvantage:

- Most courts have limited access to affordable EtG testing. If you do not work with a laboratory that can include the cost within your standard drug panel, the prices can vary dramatically.





Optimal Monitoring Solution

Breath alcohol testing- identifies immediate use and immediately aids in safety of others

EtG- will catch residual use

EtG/EtS alcohol testing positively affects participant program performance in multiple ways:

- Effect of EtG/EtS Testing in Drug Court—Participants subjected to weekly ethyl glucuronide/ethyl sulfate (EtG/EtS) alcohol testing completed the first two phases of a Drug Court significantly sooner than those undergoing standard ethanol urine testing.
- Detecting Weekend Alcohol Use in Drug Court— EtG/EtS testing in a Drug Court was more likely to detect alcohol use occurring over weekends than standard ethanol urine testing.
- Efficient EtG/EtS Testing in Drug Court—EtG/EtS testing is most likely to be cost-efficient when used with Drug Court participants diagnosed with an alcohol use disorder or suspected of recent alcohol use.

Source: Drug Court Review: Volume IX: Issue 1, National Drug Court Institute



Best Practice in DUI Courts

- Include representatives from the court, treatment programs, probation, defense bar, and prosecution on the DUI court team, and ensure they attend staff meetings and status hearings regularly
- Have the same judge preside over DUI court for at least two consecutive years, and avoid annually rotating judicial assignments
- Ensure rapid entry for participants into substance use disorder treatment, ideally no more than 30 days from arrest
- Restrict motor vehicle access through ignition interlock devices, driver's license suspensions or restrictions, or mandatory motor vehicle sales
- Monitor alcohol use continuously for at least 90 consecutive days using twice-daily breath testing or continuous alcohol monitoring bracelets
- Administer certain, swift, and moderate sanctions for alcohol use and other infractions
- Use jail sanctions sparingly in response to positive alcohol or drug tests, and limit the duration of jail sanctions to no more than a few days
- Require at least 120 days of consecutive abstinence from alcohol and other drugs prior to graduation from DUI court



Best Practices in Alcohol and Drug Testing

- **Frequent Testing**
- **Random Testing**
- **Duration of Testing**
- **Breadth of Testing**
- **Witnessed Collection**
- **Valid Specimens**
- **Accurate and Reliable Testing Procedures**
- **Rapid Results**
- **Participant Contract**

ADULT DRUG COURT BEST PRACTICE STANDARDS VOLUME II

**CARSON FOX
CHIEF EXECUTIVE OFFICER
NADCP**



Why Standards?



Volume I

- I. Target Population**
- II. Historically Disadvantaged Groups**
- III. Roles & Responsibilities of the Judge**
- IV. Incentives, Sanctions, & Therapeutic Adjustments**
- V. Substance Abuse Treatment**

Volume II

**VI. Complementary Treatment &
Social Services**

VII. Drug and Alcohol Testing

VIII. Multidisciplinary Team

IX. Census and Caseloads

X. Monitoring and Evaluation

Volume II

10 Big Things You Need to Know

Complementary Treatment

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

Complementary Treatment

- 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

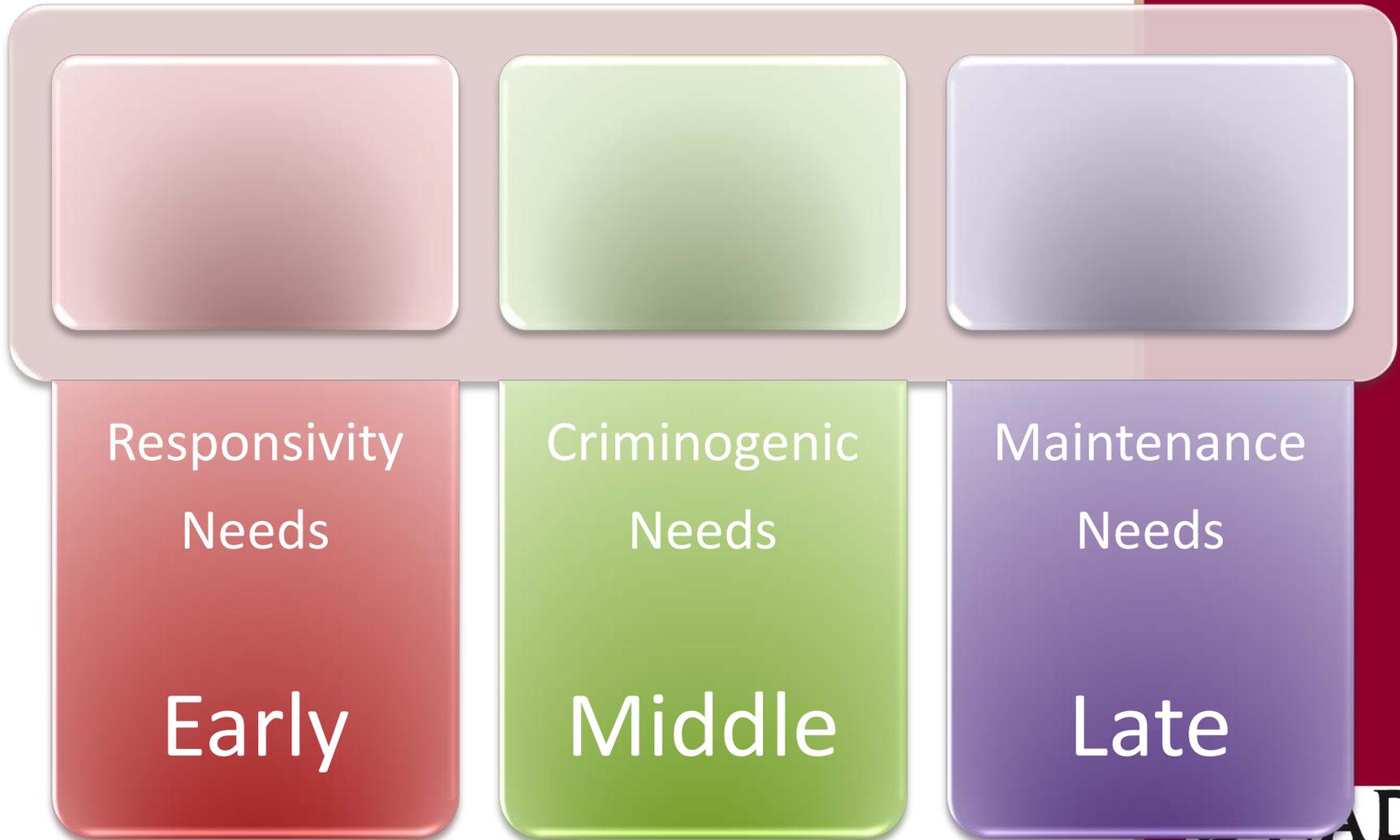
Complementary Treatment

- G. Criminal Thinking Interventions
- H. Family & Interpersonal Counseling
- I. Vocational & Educational Services
- J. Medical and Dental Treatment
- K. Prevention of High-Risk Behaviors
- L. Overdose Prevention & Reversal

Complementary Treatment

- 1) Do not begin criminal thinking interventions during Phase 1.
- 2) Enlist at least one reliable prosocial family member, friend, or daily acquaintance to provide feedback to staff and assist participant.

Timing Matters



Drug & Alcohol Testing

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

Drug & Alcohol Testing

- A. Frequent Testing
- B. Random Testing
- C. Duration of Testing
- D. Breadth of Testing
- E. Witnessed Collection

Drug & Alcohol Testing

F. Valid specimens

G. Accurate & Reliable
Testing Procedures

H. Rapid Results

I. Participant Contract

Drug and Alcohol Testing

- 1) Randomly test at least twice per week, including weekends and holidays and require participants to report within 8 hours of notification.
- 2) Continue testing randomly at least twice per week until participant is preparing for graduation in the final phase.

Avoid Respite from Detection

- A participant should have an equal chance of being called on any day of the week.
- Avoid randomizing in weekly blocks.
- Test routinely for all drugs commonly used by population.

Multidisciplinary Team

A dedicated multidisciplinary team of professionals manages the day-to-day operations of the Drug Court, including reviewing participant progress during pre-court staff meetings and status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment and supervision services.

Multidisciplinary Team

Composition &
Training

Pre-Court Staff
Meetings & Status
Hearings

Team

Sharing Information

Communication &
Decision Making

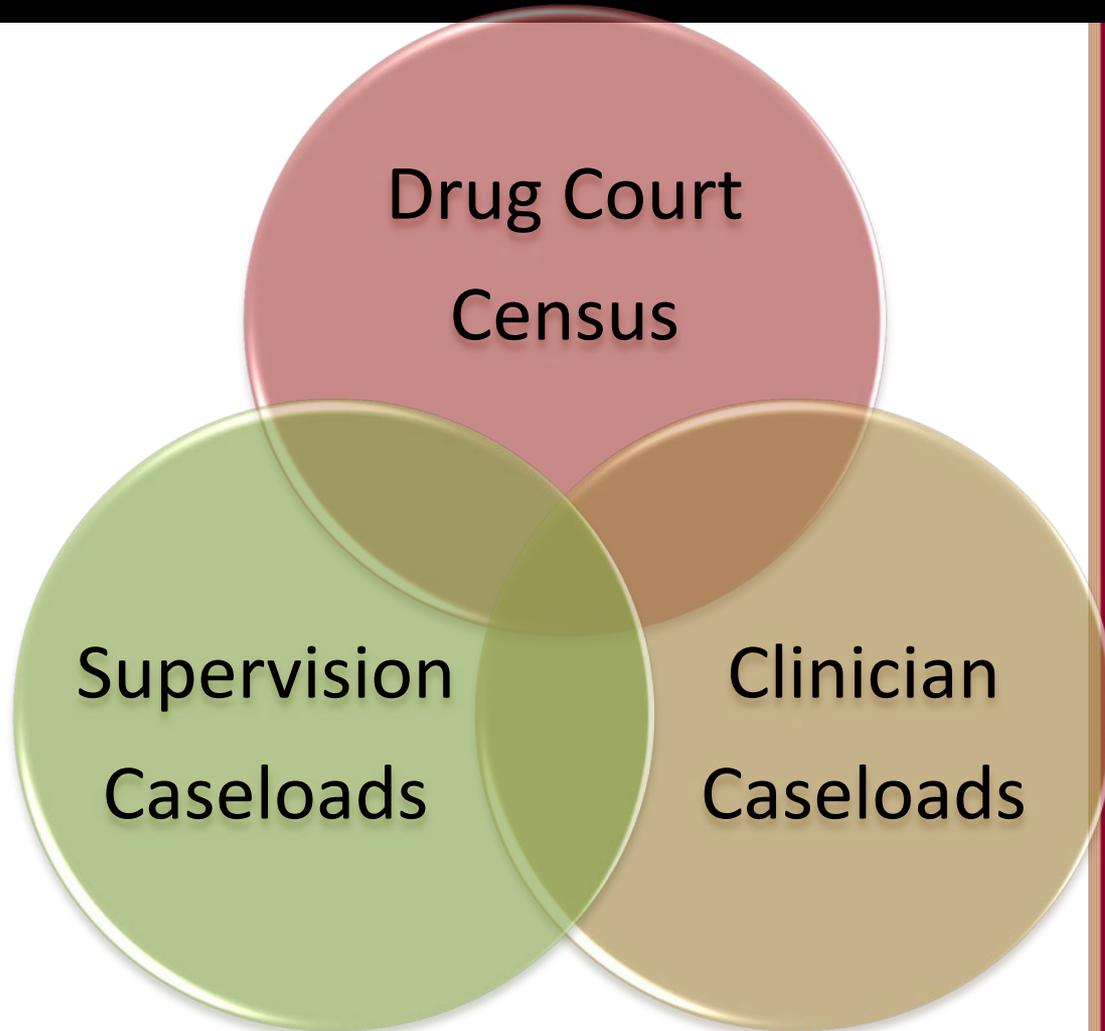
Multidisciplinary Team

- 1) Judge considers perspectives of all team member before making decisions that impact participants' welfare or liberty interests.
- 2) Defense attorneys inform participants and team members whether they will share confidential information concerning participants with other team members.

Census and Caseloads

The Drug Court serves as many eligible individuals as practicable while maintaining continuous fidelity to best practice standards.

Census and Caseloads



	High Risk	Low Risk
High Need	30 to 1 (or less)	Probation: 50 to 1 Treatment: 30: 1
Low Need	Probation: 30 to 1 Treatment: 50: 1	200:1 Don't Belong in Drug Court

Monitoring & Evaluation

The Drug Court routinely monitors its adherence to best practice standards and employs scientifically valid and reliable procedures to evaluate its effectiveness.

Monitoring & Evaluation

- A. Adherence to Best Practices
- B. In-Program Outcomes
- C. Criminal Recidivism
- D. Independent Evaluations
- E. Historically Disadvantaged Groups

Monitoring & Evaluation

- F. Electronic Database
- G. Timely & Reliable Data Entry
- H. Intent-to-Treat Analyses
- I. Comparison Groups
- J. Time at Risk

Monitoring and Evaluation

- 1) Analyze outcomes for all participants, including those who withdrew or were terminated early.
- 2) Staff members are required to record information regarding service provision within 48 hours.

ADULT DRUG COURT BEST PRACTICE STANDARDS VOLUME II

TWALTON@ALLRISE.ORG

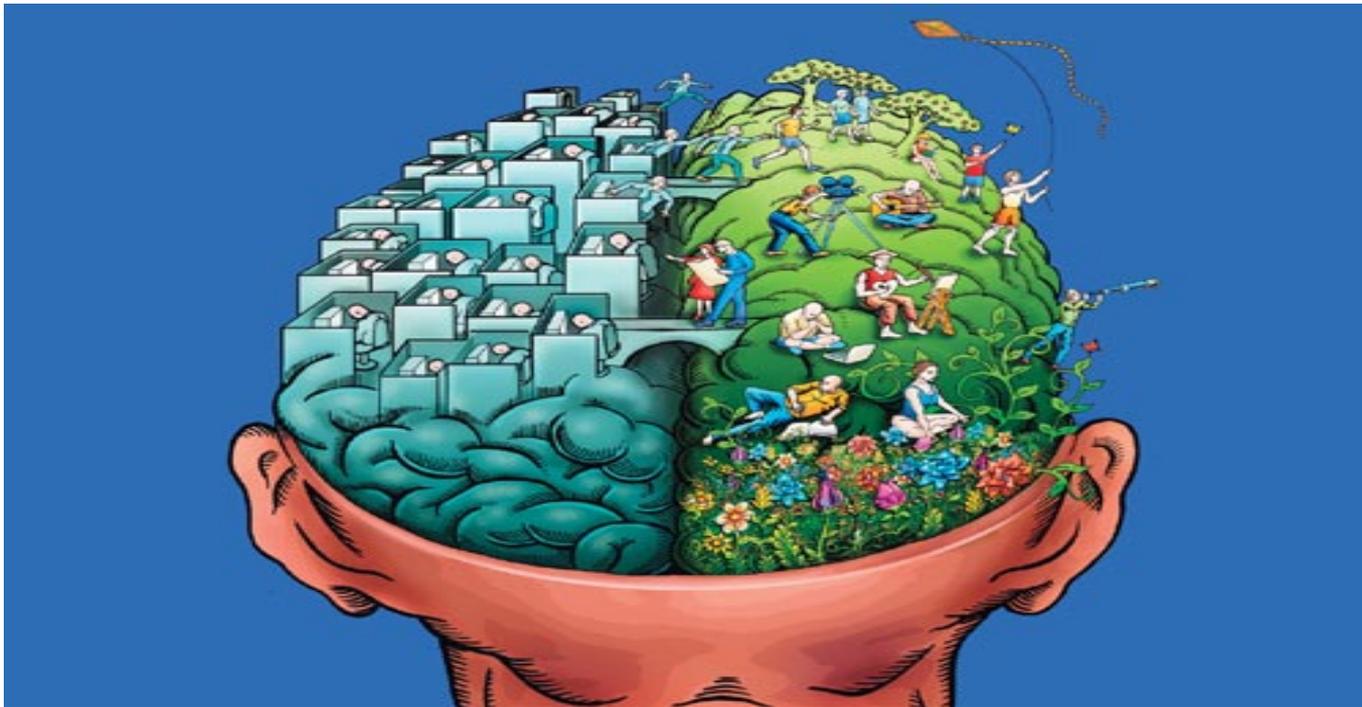
May the **FORSE** be with Us:

Building Trauma Informed Social Emotional Competence and Coping Skills with persons engaging in substance abuse



Dr. Allison Sampson-Jackson, LCSW, LICSW, CSOTP
Integration Solutions, Inc.
804-432-0056

Impact to Right and Left Hemisphere Talk



Look at the chart and say the COLOUR not the word

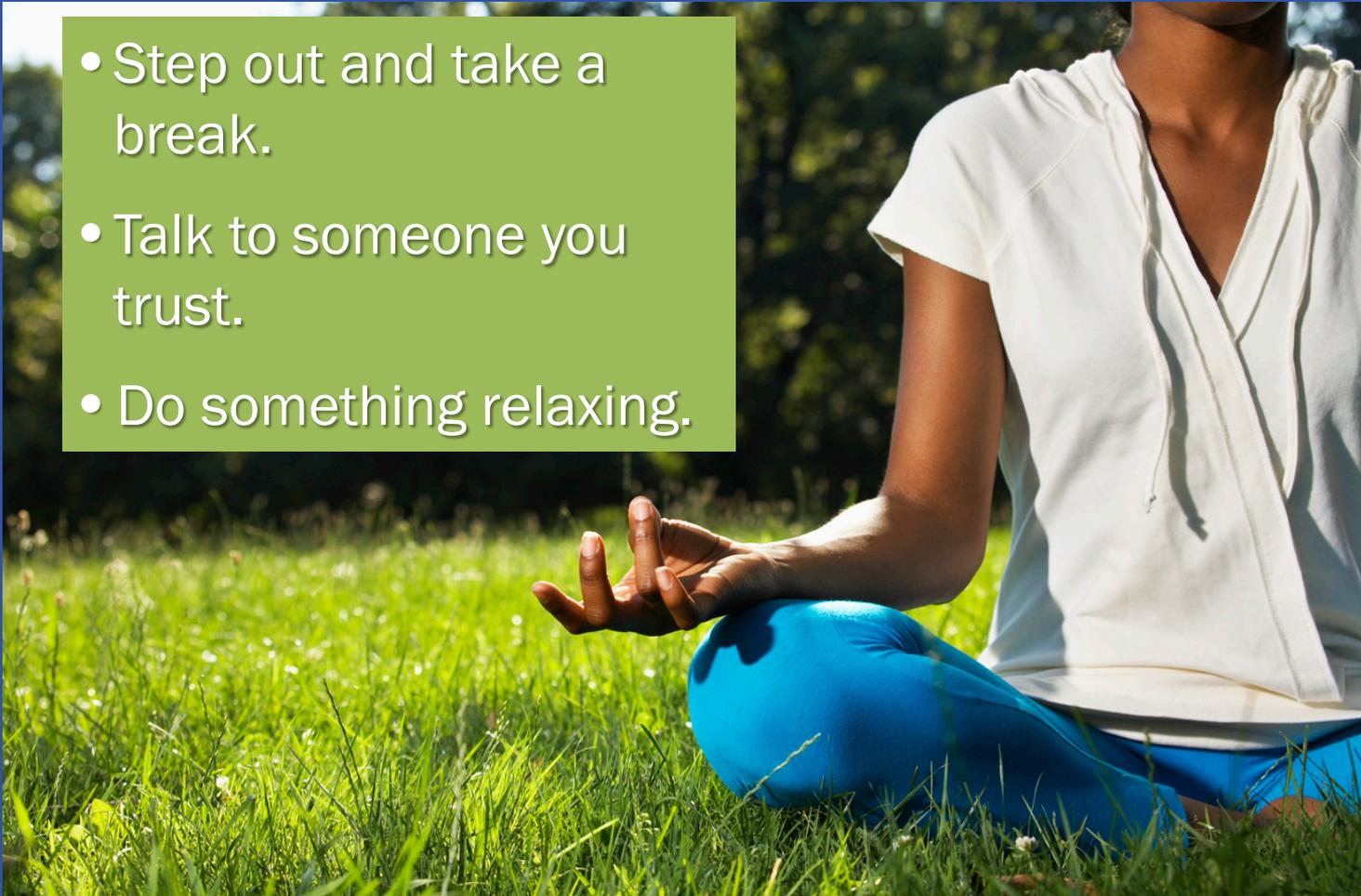
YELLOW	BLUE	ORANGE
BLACK	RED	GREEN
PURPLE	YELLOW	RED
ORANGE	GREEN	BLACK
BLUE	RED	PURPLE
GREEN	BLUE	ORANGE

Left - Right Conflict

Your right brain tries to say the colour but your left brain insists on reading the word.

Self-Care Alert!

- Step out and take a break.
- Talk to someone you trust.
- Do something relaxing.



**STOP
ACES**

violence abuse suicide crime
war murder assault disaster
sexual abuse family violence

TRAUMA

Fear terror shame guilt
nervous haunting panic
avoidance disconnected
numbness powerlessness

normal reactions to abnormal events

There is healing and hope
after trauma. Ask for help.



Defining Trauma

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

- SAMHSA definition 2014

What Trauma Informed Care?

- Definition of trauma (the three “Es”):
 - Event(s)
 - Experience of the event(s)
 - Effect
 - Definition of a trauma-informed approach (the four “Rs”):
 - Realize
 - Recognize
 - Respond
 - Resist re-traumatization
- SAMHSA definition 2014



Exposure to Violence in Childhood

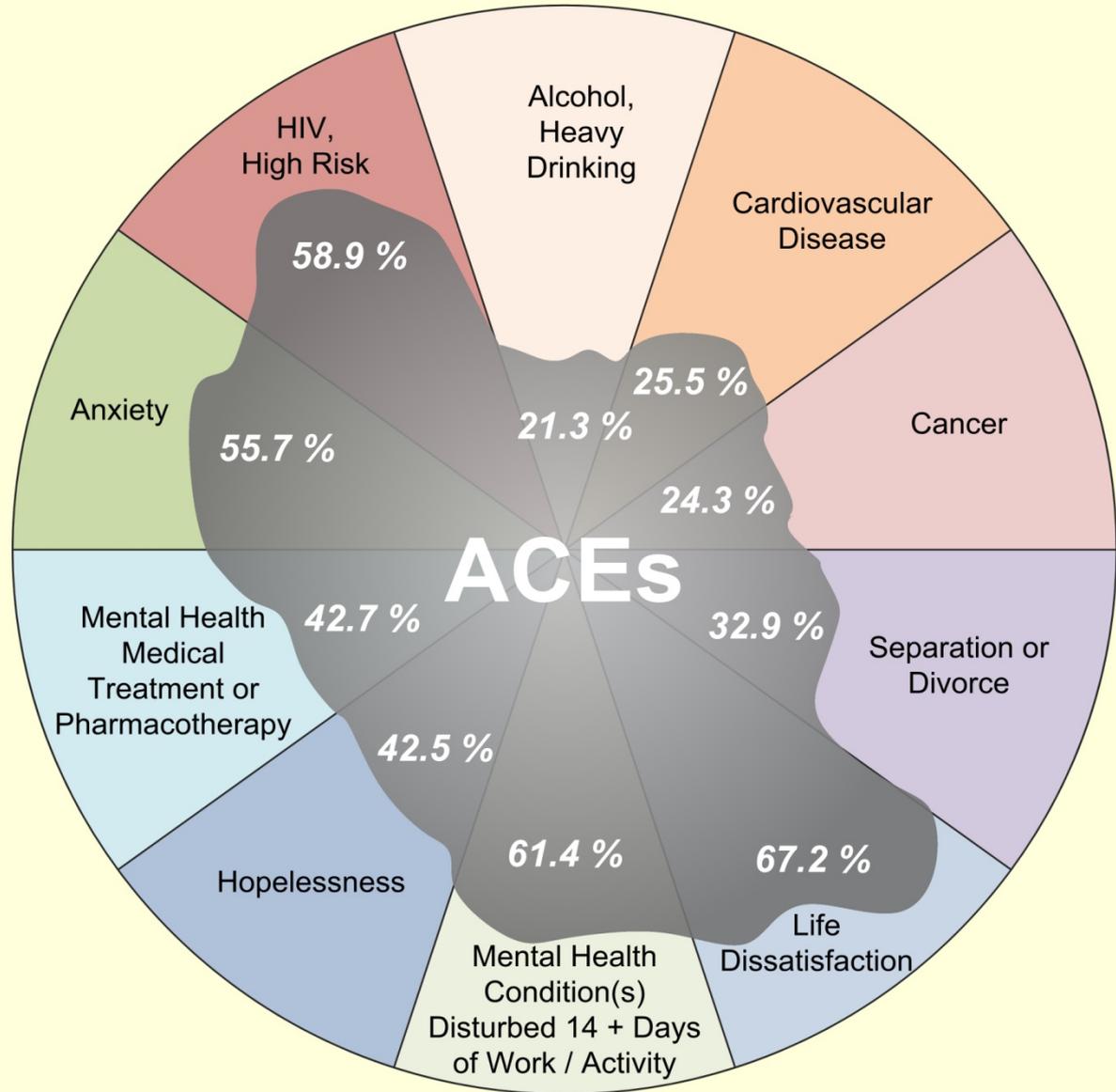
46 million of 76 million children
are exposed to violence, crime and
abuse each year

Finkelhor, D., et al. (2010). Trends in childhood violence and abuse exposure: evidence from 2 national surveys. *Archives of Pediatric and Adolescent Medicine*, 164(3), 238–242.

POPULATION ATTRIBUTABLE RISK

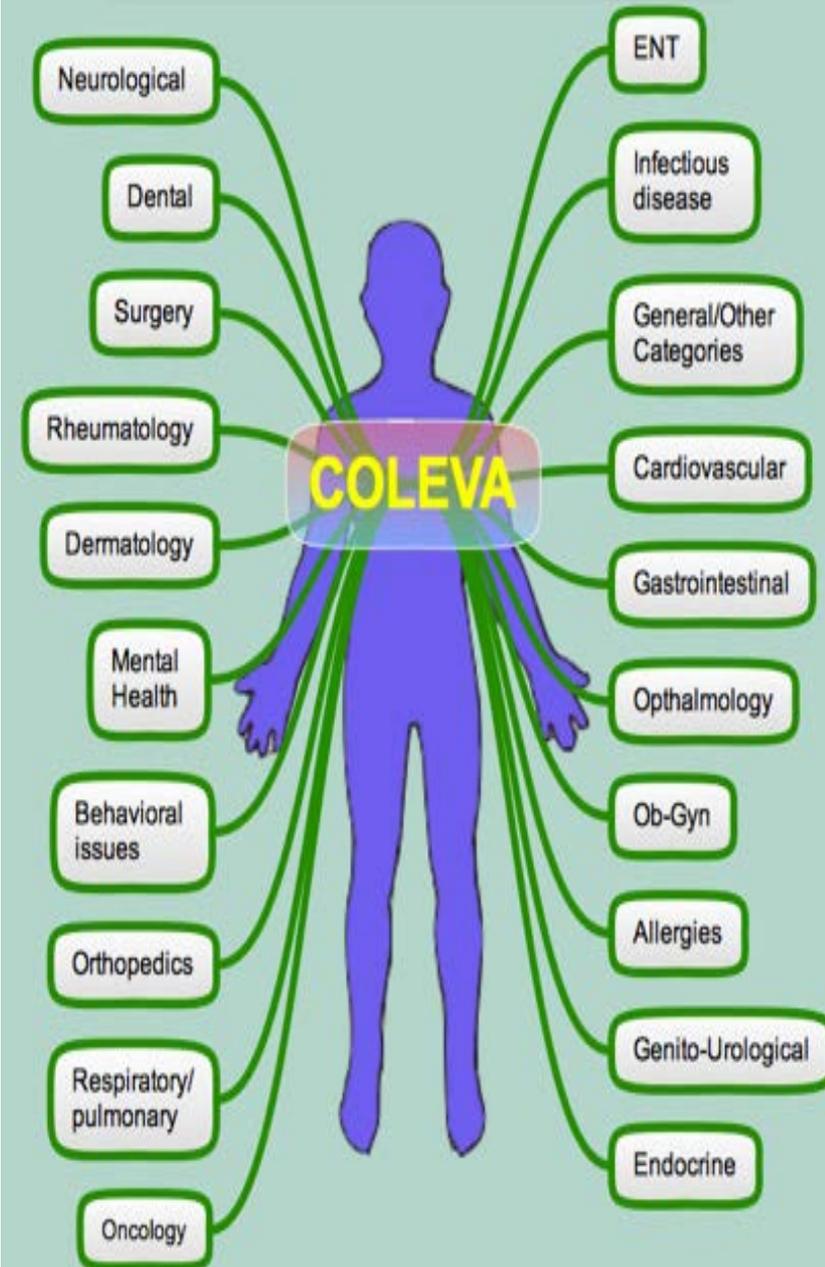
A large portion of many health, safety and prosperity conditions is attributable to Adverse Childhood Experience.

ACE reduction reliably predicts a decrease in all of these conditions simultaneously.



- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

Consequences of Lifetime Exposure to Violence and Abuse



Shift from an ACE Score of 0 to 4

Population Health

- **242% more likely to smoke**
- **222% more likely to become obese**
- **357% more likely to experience depression**
- **443% more likely to use illicit drugs**
- **1133% more likely to use injected drugs**
- **298% more likely to contract an STD**
- **1525% more likely to attempt suicide**
- **555% more likely to develop alcoholism**

1 year of violence=
124 billion dollars in recovery costs

The breakdown per child is:

- \$32,648 in childhood health care costs
- \$10,530 in adult medical costs
- **\$144,360 in productivity losses**
- \$7,728 in child welfare costs
- \$6,747 in criminal justice costs
- \$7,999 in special education costs

Trajectories of Risk Groups

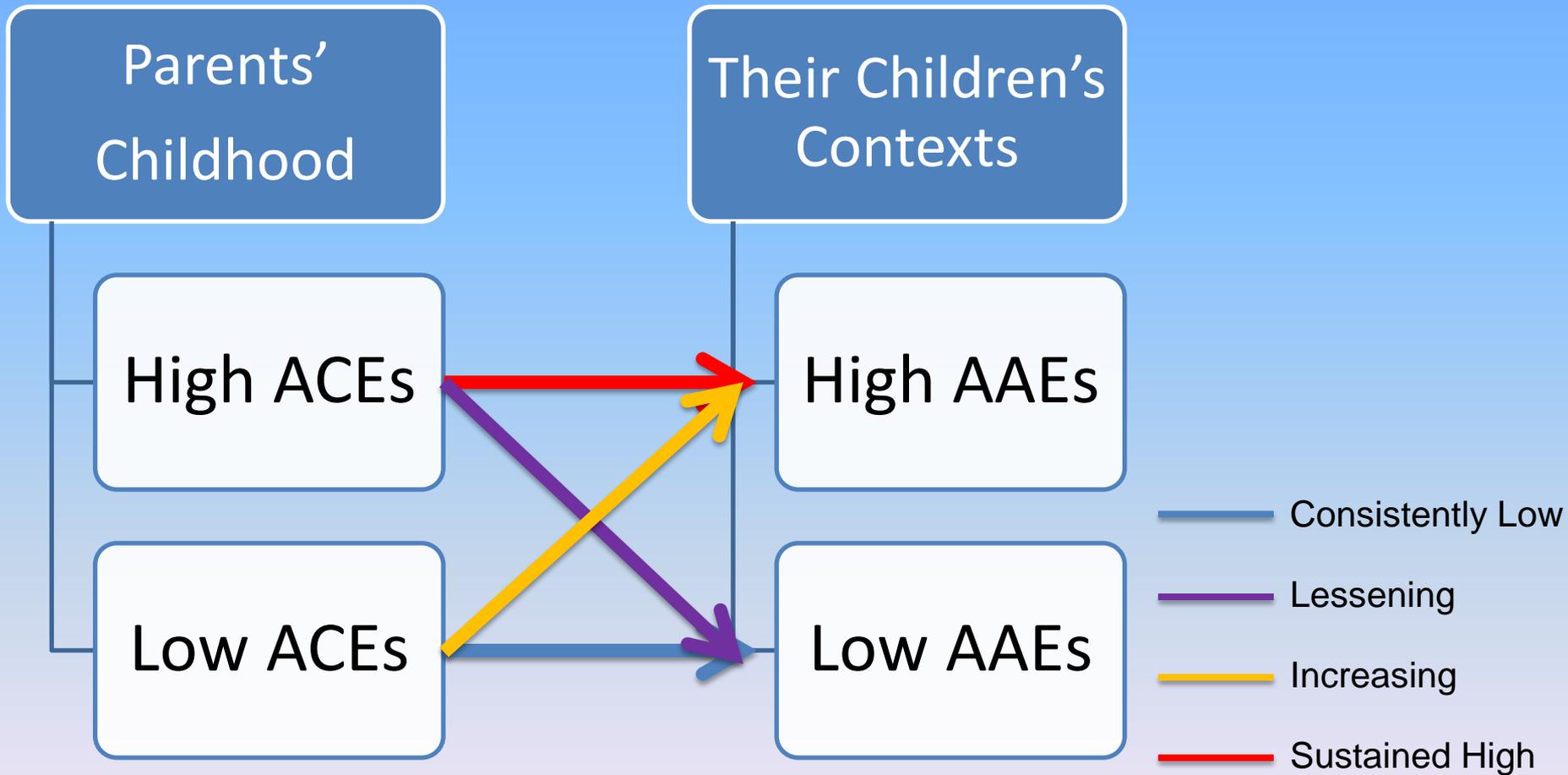
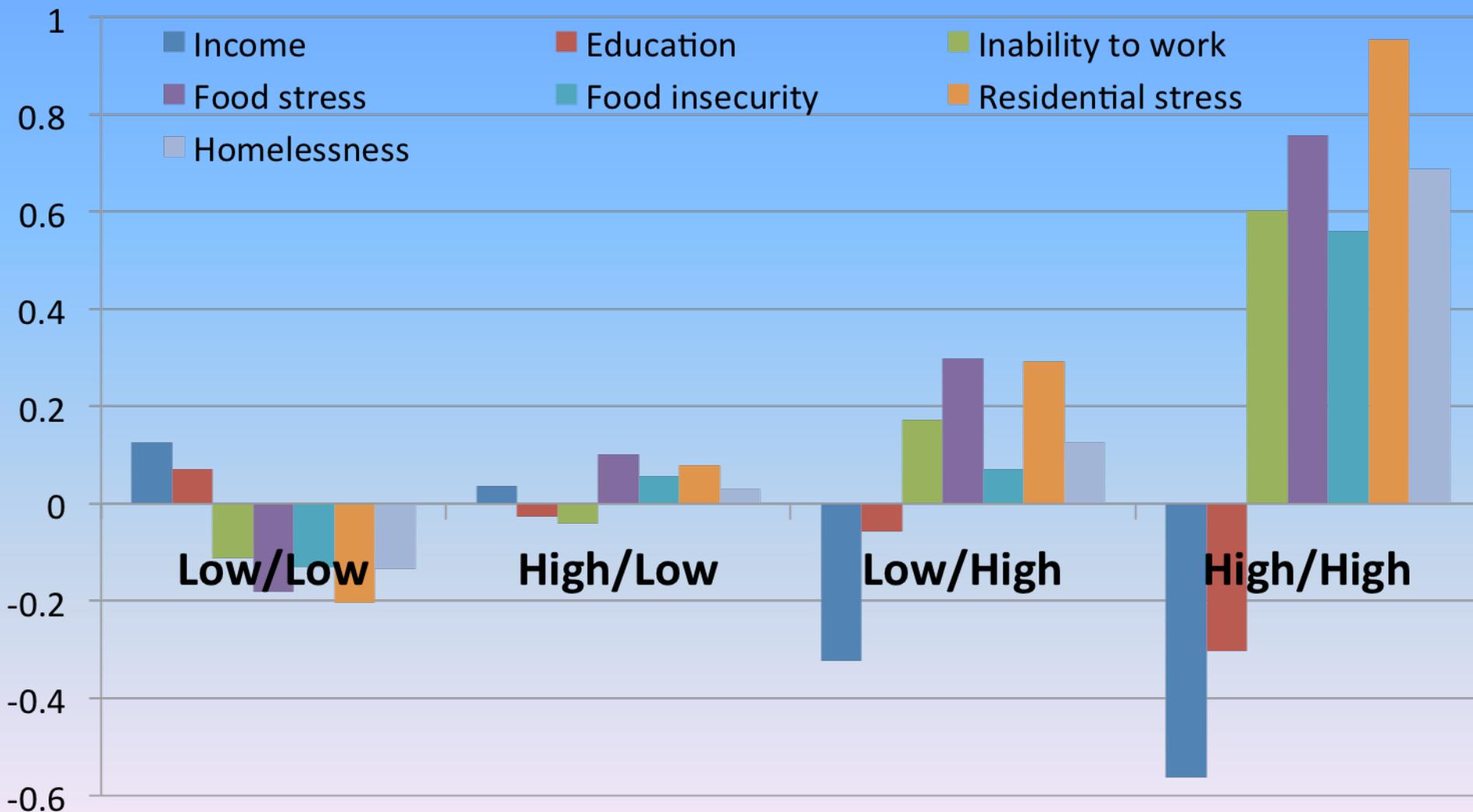
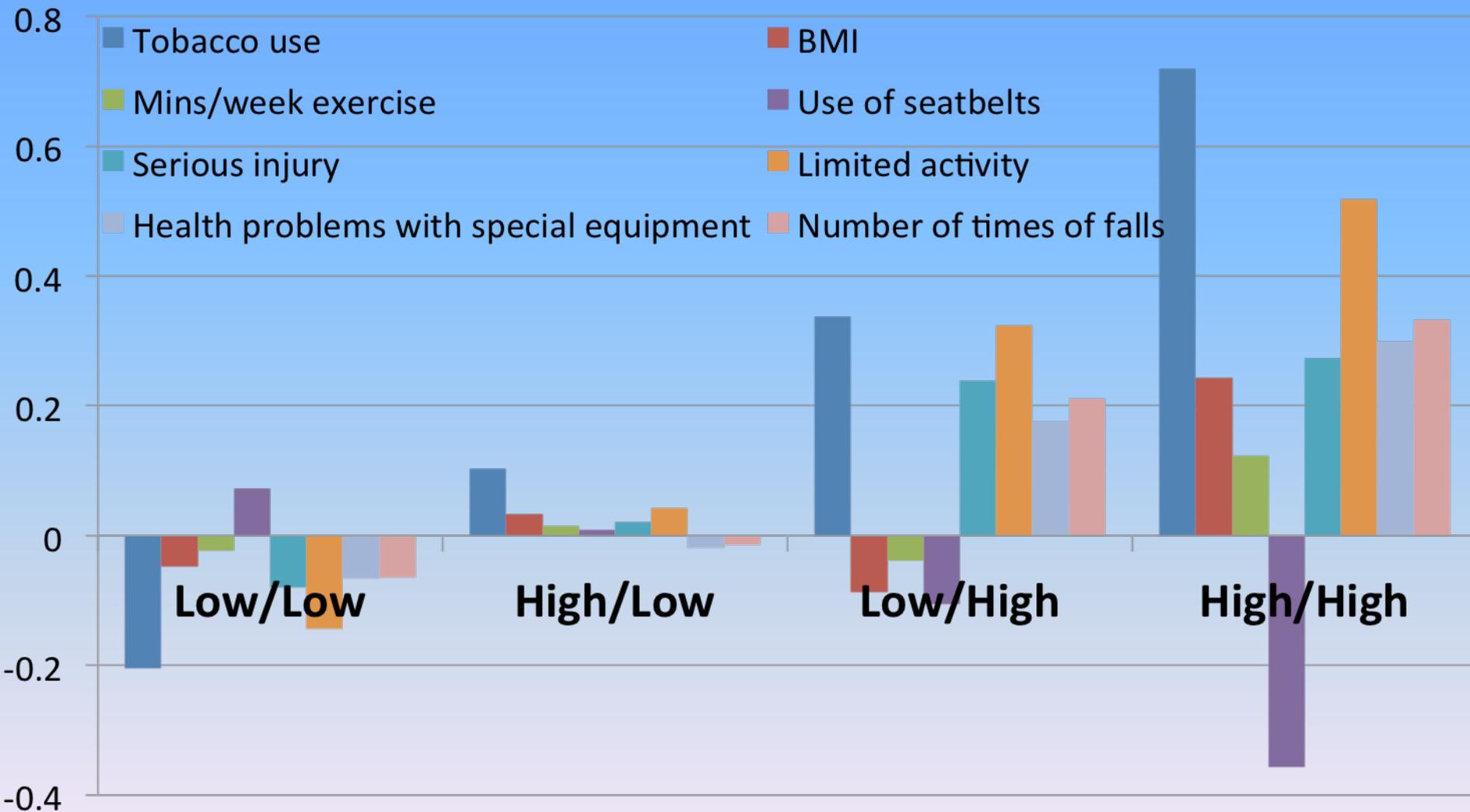


Figure 1. SES and Food/Housing Insecurity by Four Trajectories of Risk Groups



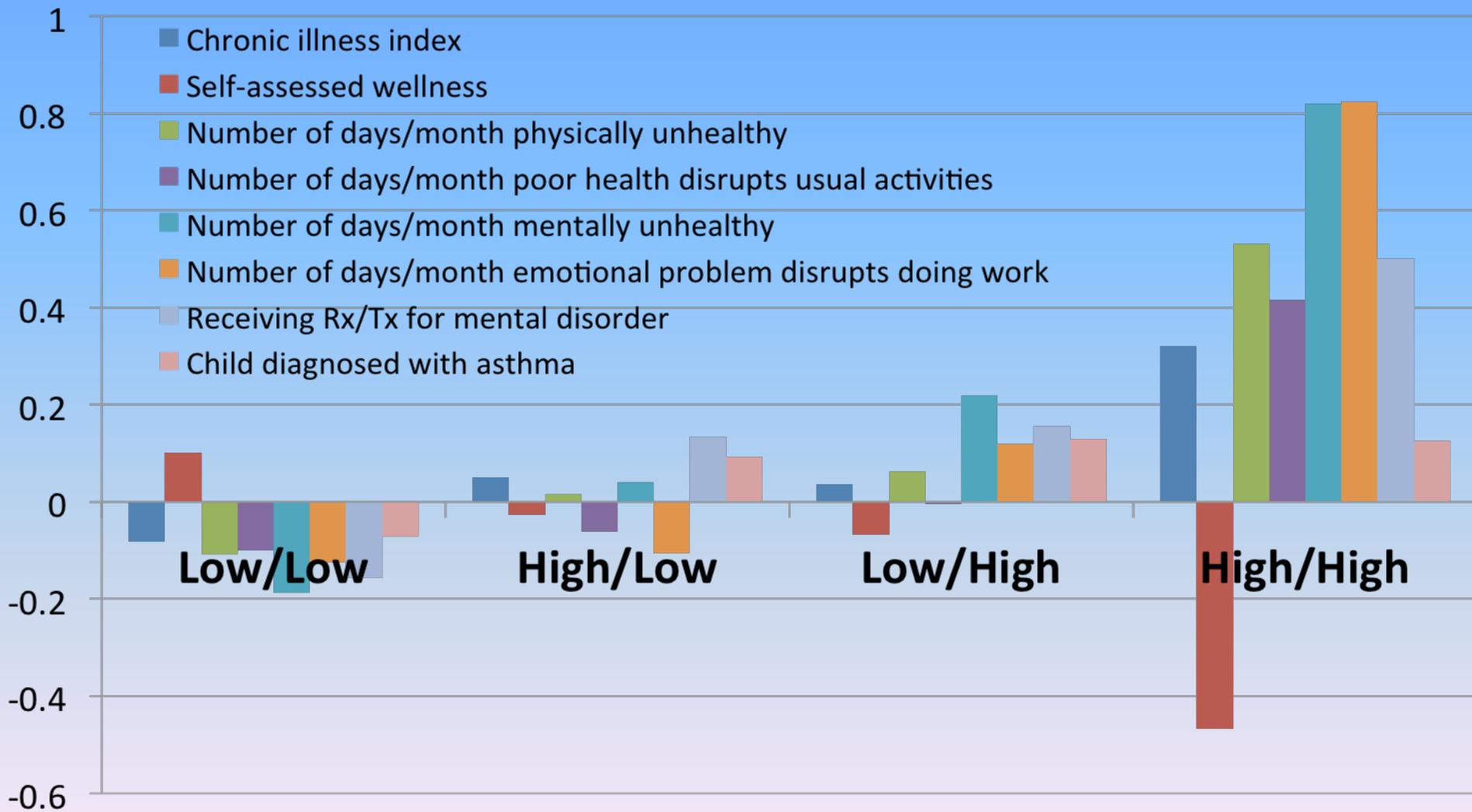
Note: All the indicators are standardized.

Figure 3. Health Behaviors and Disability by Four Trajectories of Risk Groups



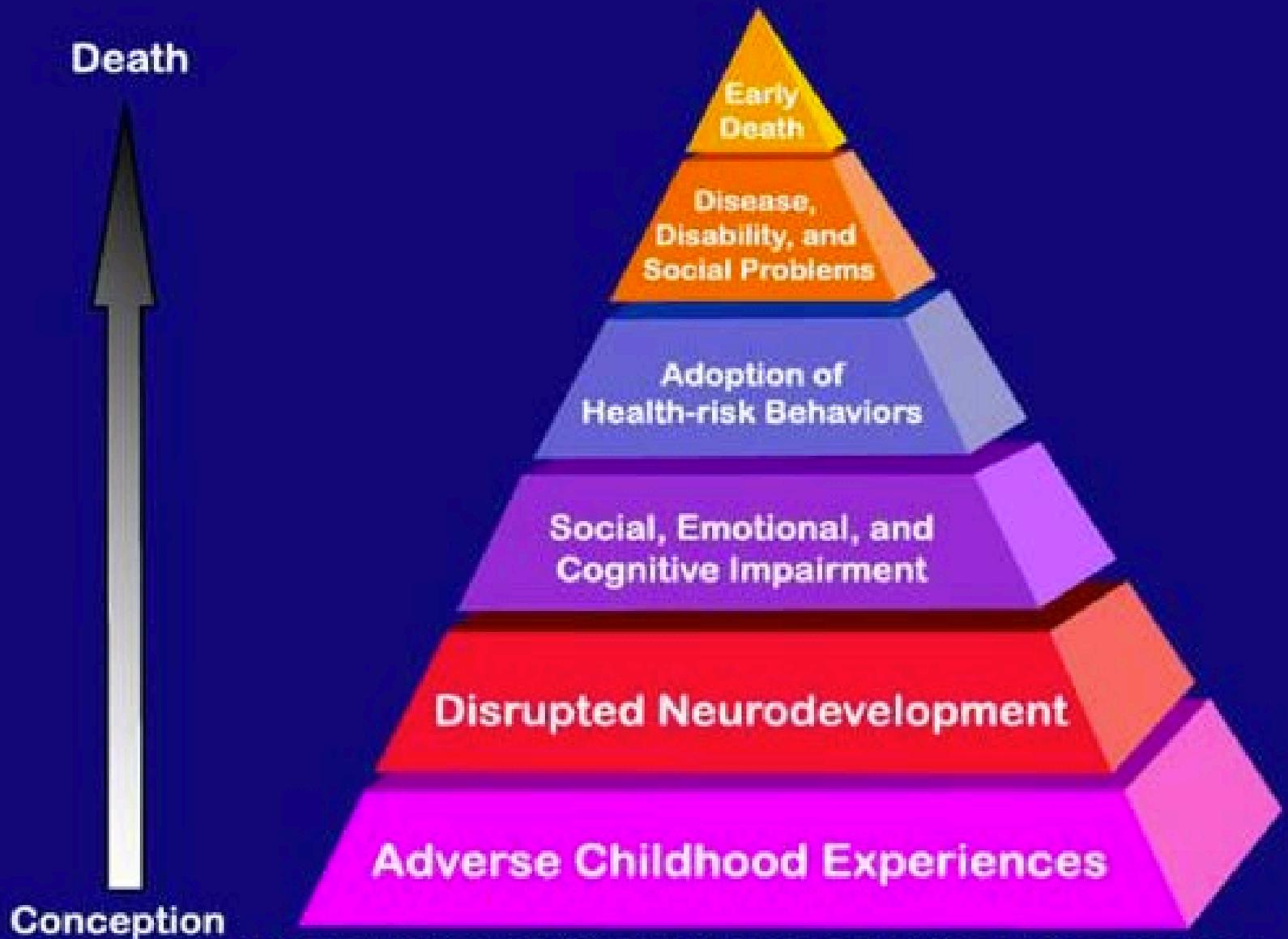
Note: All the indicators are standardized.

Figure 4. Physical Health, Mental Health, and Child Risk by Four Risk Transmission Groups



Listening to Our Youth

WHY DOES TRAUMA MATTER?

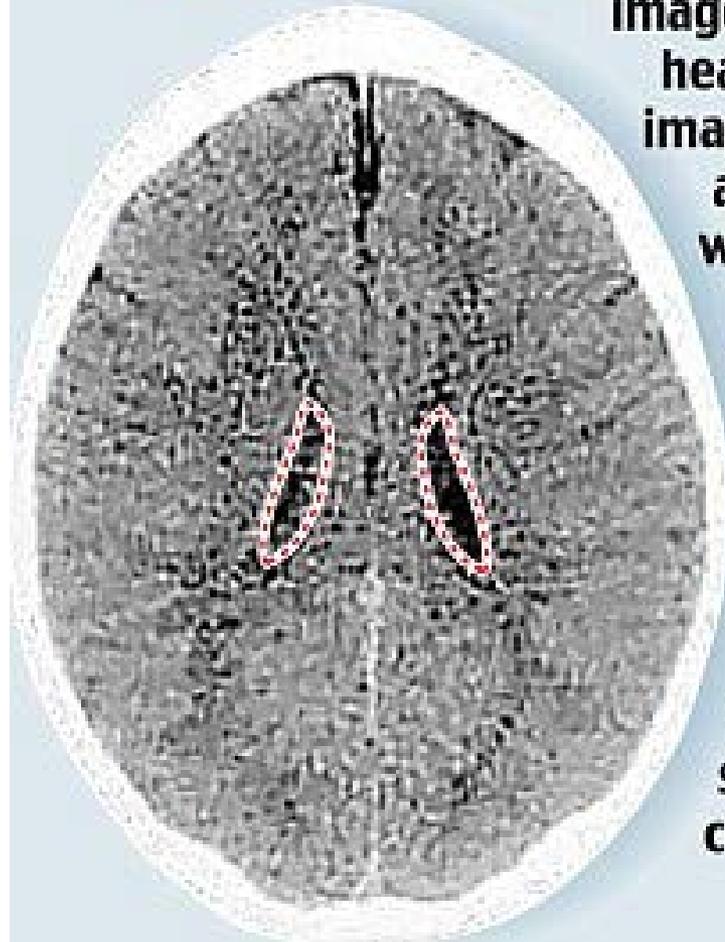


Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan



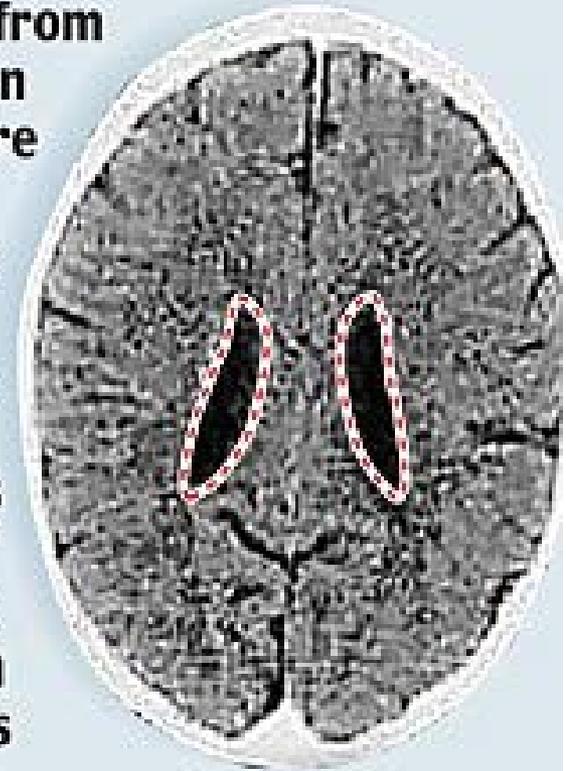
TRAUMA'S IMPACT ON THE BRAIN

NORMAL



These are the brains of two three-year-old children. The image on the left is from a healthy child while the image on the right is from a Romanian orphan who suffered severe sensory deprivation. The right brain is smaller and has enlarged ventricles - holes in the centre of the brain. It also shows a shrunken cortex - the brain's outer layer.

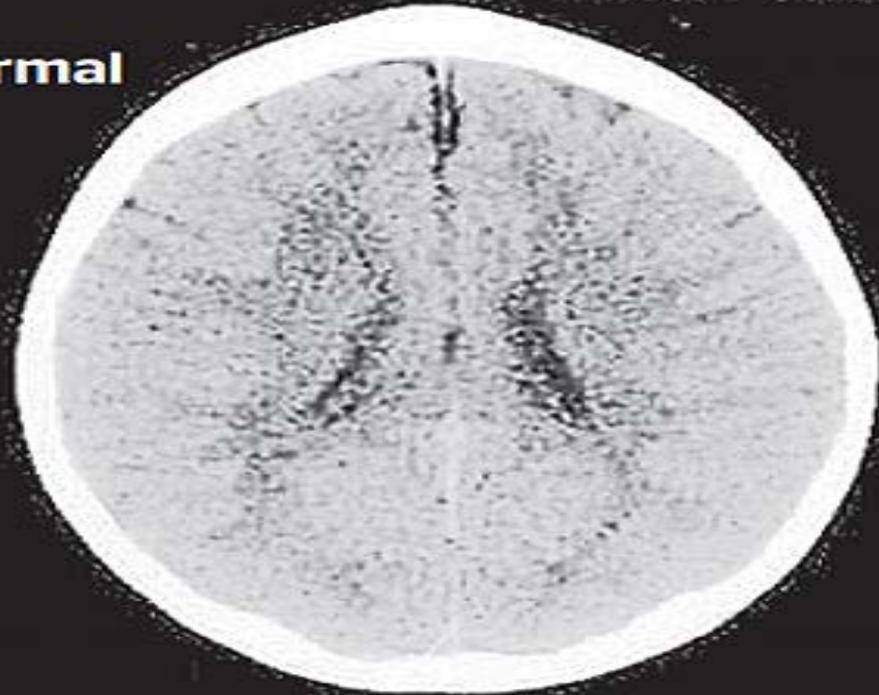
EXTREME NEGLECT



HOW STRESS CHANGES A CHILD'S BRAIN

3-YEAR-OLD CHILDREN

Normal



Extreme neglect



■ Prolonged exposure to trauma triggers physiological changes in the brain.

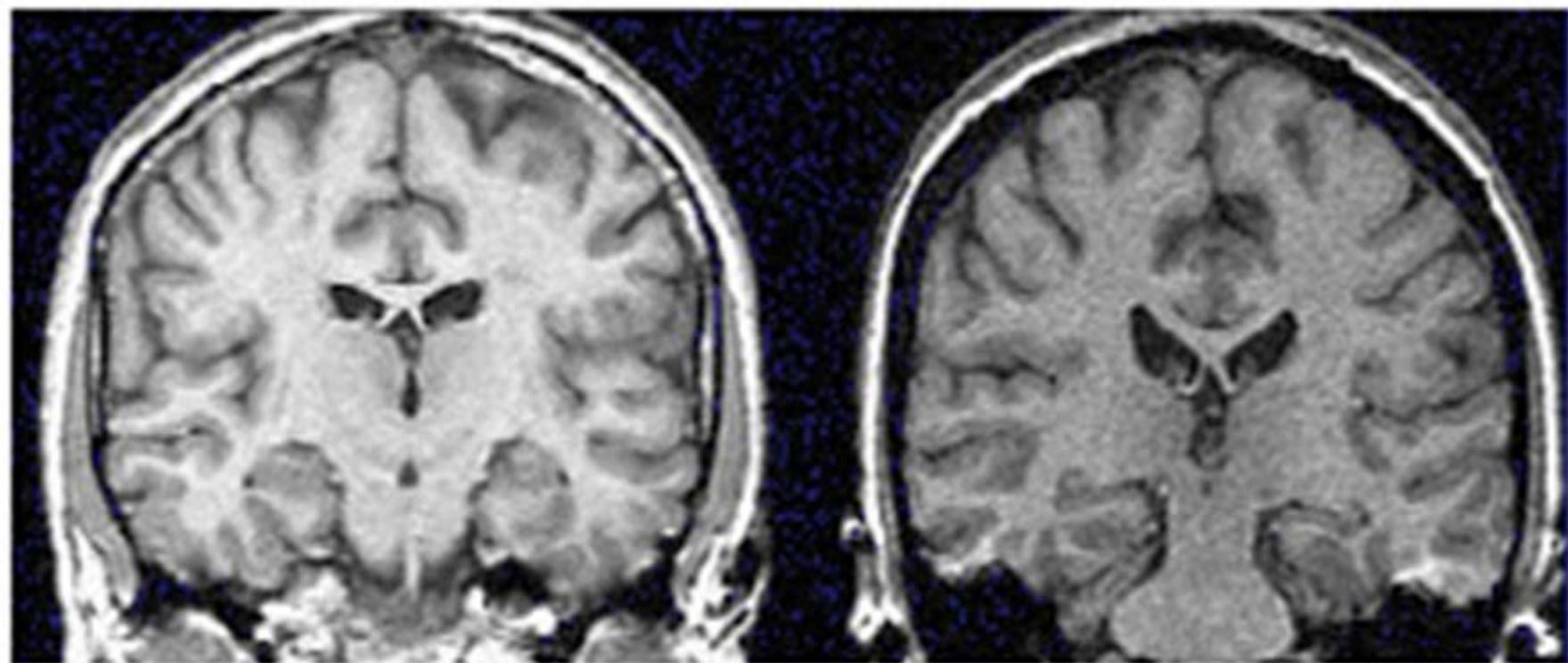
■ Neural circuits are disrupted, causing changes in the hippocampus, the brain's memory and emotional centre.

■ This can cause brain shrinkage, problems with memory, learning and behaviour.

■ A child does not learn to regulate emotions when living in state of constant stress.

■ Associated with greater risk of chronic disease and mental health problems in adulthood.

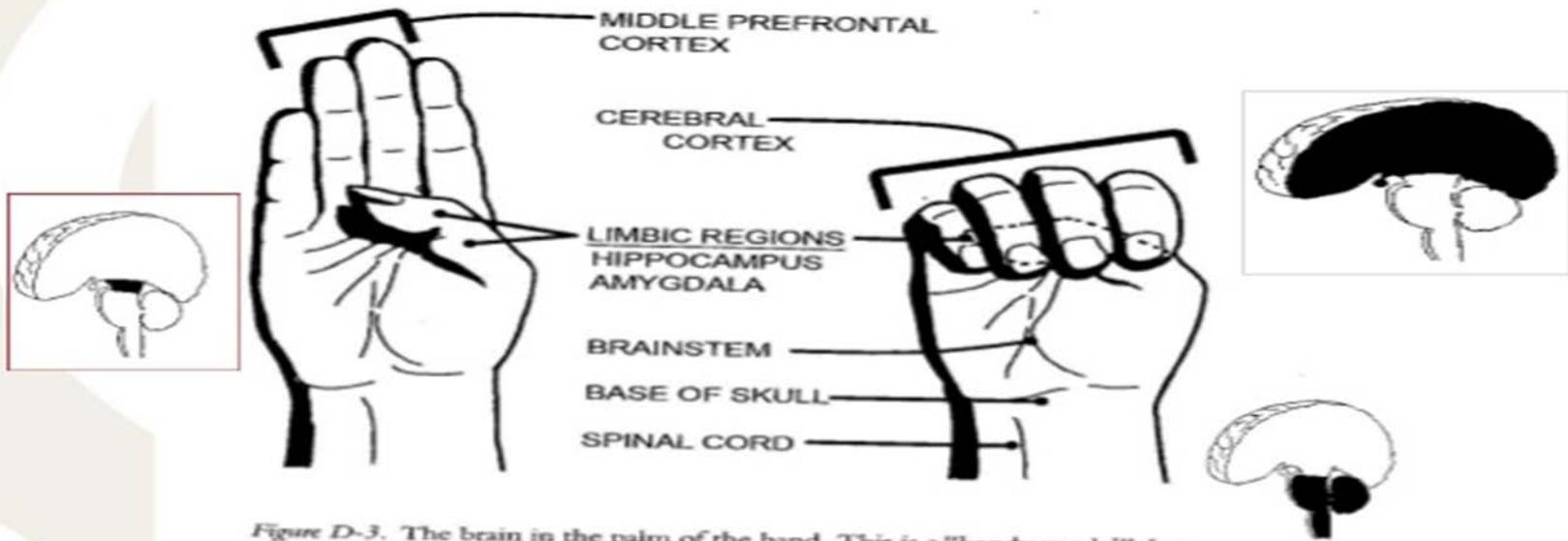
PTSD IS A REAL PHYSICAL INJURY



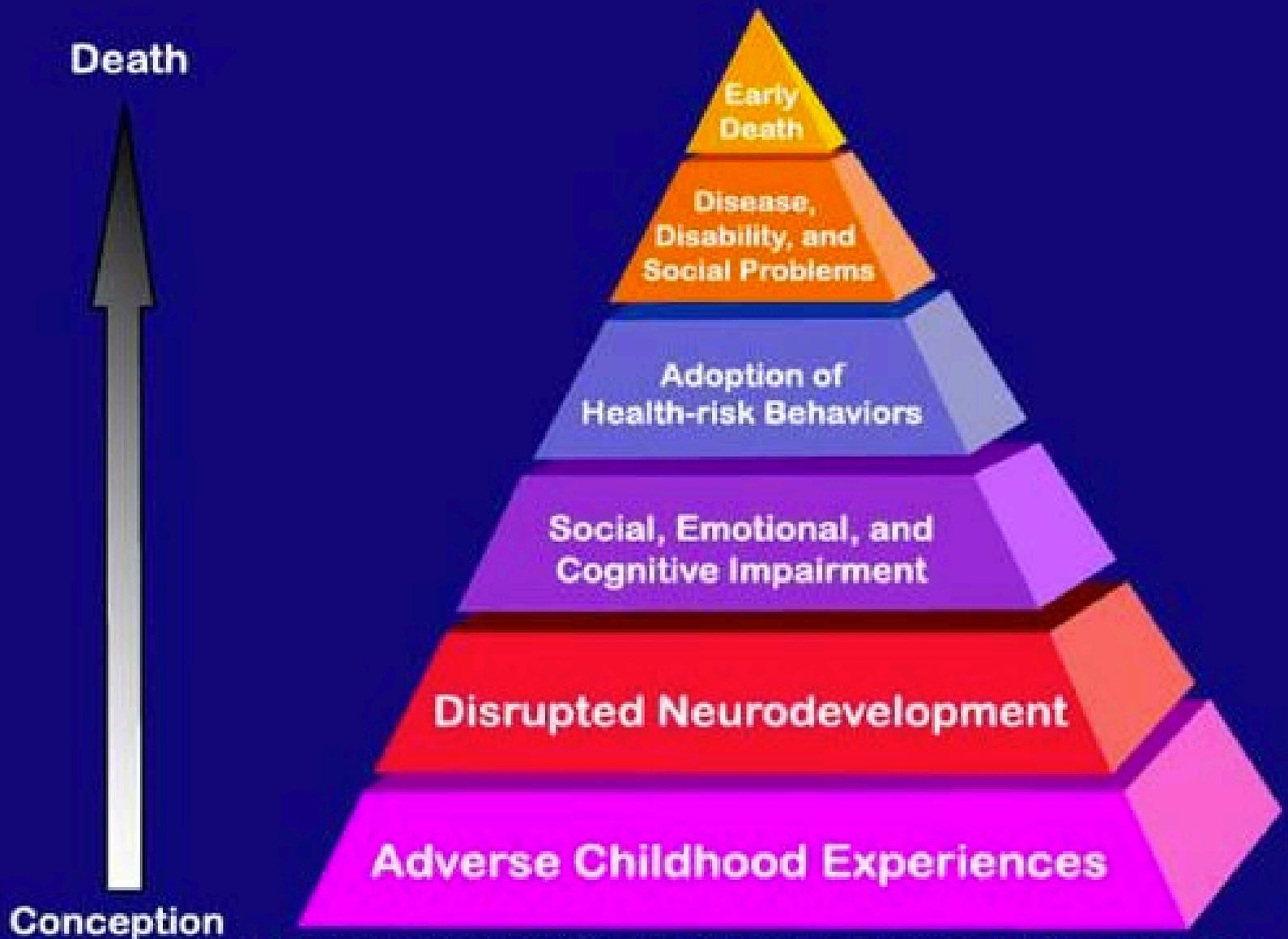
REGULAR

PTSD

NOT A SOCIAL OR POLITICAL OPINION.



*Figure D-3. The brain in the palm of the hand. This is a "handy model" that depicts the major regions of the brain: cerebral cortex in the fingers, limbic area in the thumb, and brainstem in the palm. The spinal cord is represented in the wrist. Please see text for explanation. Copyright © 2012 by Mind Your Brain, Inc. Used with permission by Daniel J. Siegel, M.D., from *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are* (2012).*

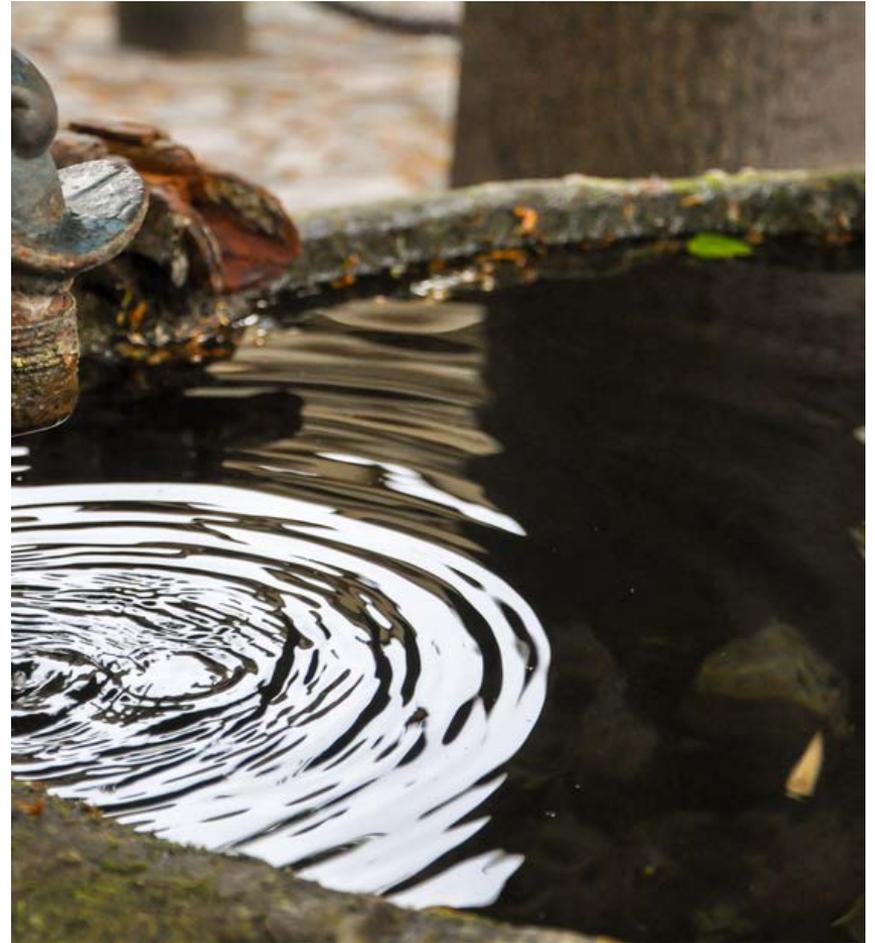


Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

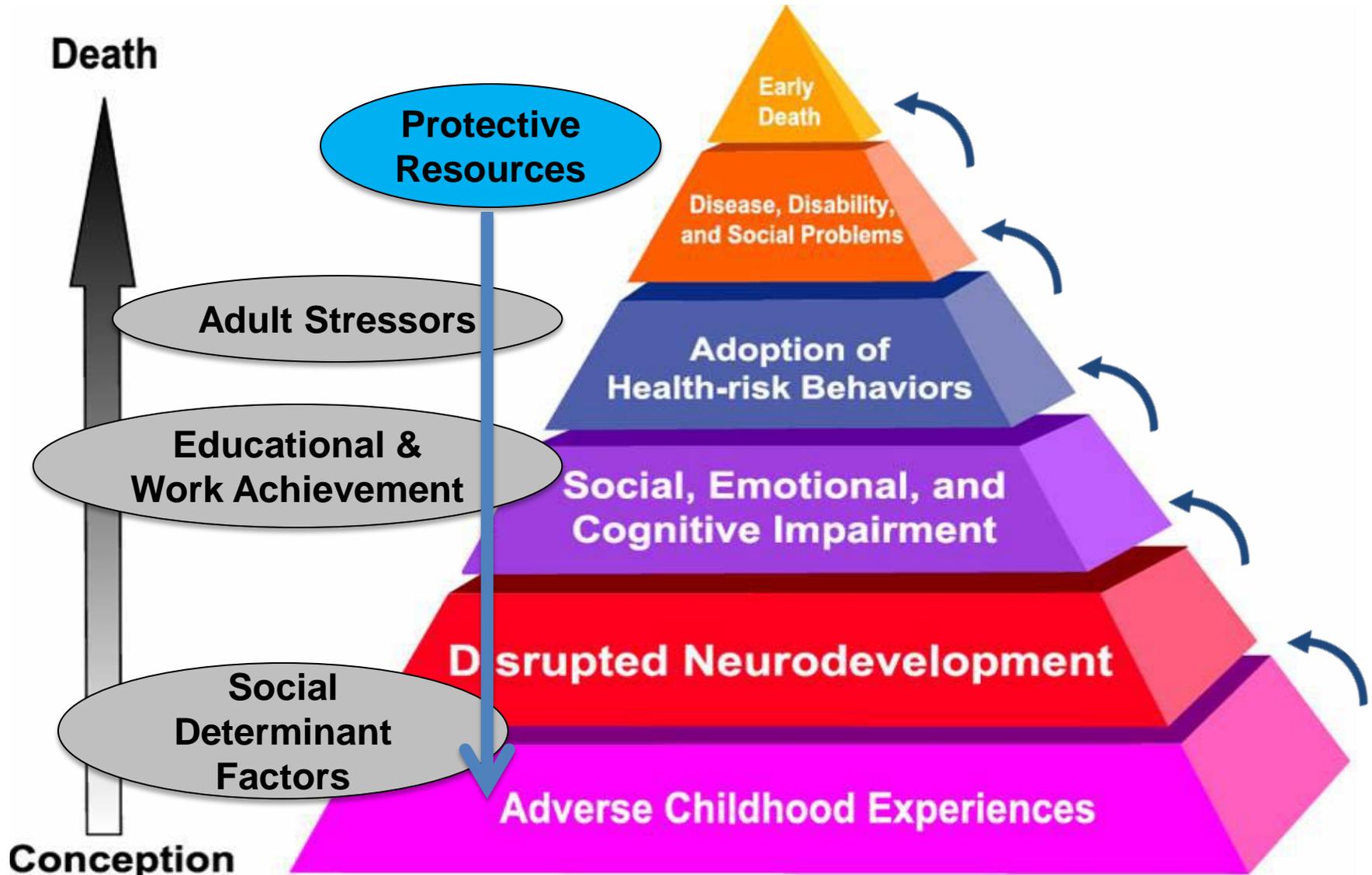
Respond to the need

Not react to the behavior

Do we go to the well ...
or react to the health risk behaviors?



Adding Context, Stress Proliferation, & Moderators (+/-) to ACE Influence on Lifespan Health and Functioning

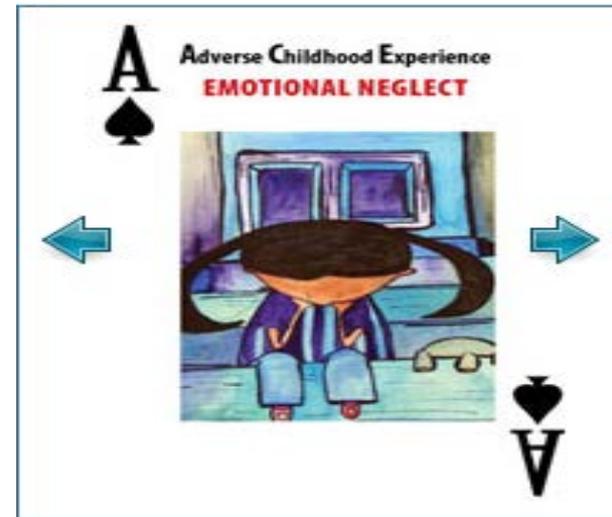


Resilience Trumps ACEs

Children's Resilience Initiative

Empowering community understanding of the forces that shape us and our children

Website: www.resiliencetrumpsaces.org



A Game of Hope Video

From Trish Mullen, Chesterfield Community services Board



INDIVIDUAL RESILIENCE

Three Targeted Areas for Building Individual Resilience

- Positive Self-Identity
 - Self-Regulation
- Co-regulation (Relationships)

Core Areas of Focus in Complex Trauma
Courtois, C. & Ford, J. (2009), Introduction (p.2)

Three basic building blocks to success:

Adapted from the research of Dr. Margaret Blaustein

Attachment - feeling connected, loved, valued, a part of family, community, world

Regulation - learning about emotions and feelings and how to express them in a healthy way

Competence - acting rather than reacting, accepting oneself and making good choices



SKILL BUILDING

Think: lack of skill **not** intentional
misbehavior

Think: building missing skills **not** shaming
for lack of skills

Think: nurture **not** criticize

Think: teach **not** blame

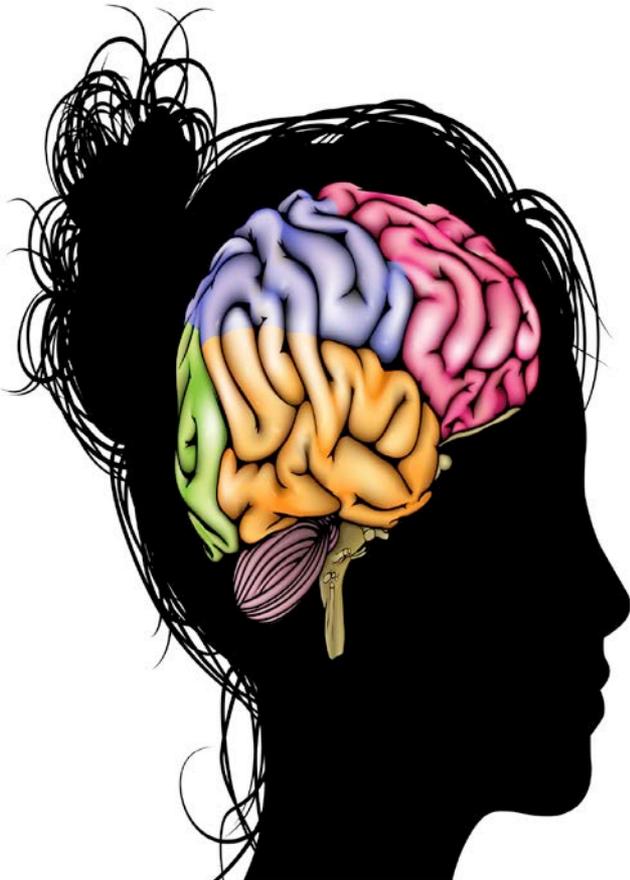
Think: discipline **not** punishment



Relationship Skills (Connection)



REGULATION SKILLS



Examples of Self Regulation

- Regulating body and emotion
- Building understanding of degrees of feelings
- Building toleration of arousal

Mindfulness

Art of being present in the moment

Ability to press pause ...

and be focused on one thing in this moment

Awaken Curiosity

Positive Self – Identity (Competence)



Messages Kids Often Have in their Mind and Bodies

- I'm not safe
- People want to hurt me
- People cannot be trusted
- World is dangerous
- If I am in danger no one will help me
- I'm not enough
- I'm not powerful
- Things will never get better

Shame, Vulnerability and the Power of Connection

DR. BRENE BROWN'S WORK

Defining Shame

- Guilt = I did something bad
- Shame = I am bad
- Embarrassment = Fleeting, can laugh about it later
- Humiliation = “I didn’t deserve that”

12 Categories of Shame

- Appearance and body image
- Money and work
- Motherhood/fatherhood
- Family
- Parenting
- Mental and physical health
- Addiction
- Sex
- Aging
- Religion
- Surviving trauma
- Being stereotyped or labeled

WHAT IS SHAME AND WHY IS IT SO HARD TO TALK ABOUT IT?

1. We all have it. Shame is universal and one of the most primitive human emotions that we experience.
2. We're all afraid to talk about shame.
3. The less we talk about shame, the more control it has over our lives

...shame is the fear of disconnection (68)

Shame Resilience

1. Recognizing Shame and Understanding Its Triggers. Shame is biology and biography.

Can you physically recognize when you're in the grips of shame, feel your way through it, and figure out what messages and expectations triggered it?

2. Practicing Critical Awareness.

Can you reality-check the messages and expectations that are driving your shame? Are they realistic? Attainable? Are they what you want to be or what you think others need/want from you?

3. Reaching Out.

Are you owning and sharing your story? We can't experience empathy if we're not connecting.

4. Speaking Shame.

Are you talking about how you feel and asking for what you need when you feel shame?



ONE MODEL FOR INDIVIDUAL RESILIENCE INTERVIEWING

Resilience and ACEs game/interview

Bread meat Bread

- Share 2-3 Resilience Attributes you have
- Share an ACE you have experienced
- Share 2-5 skills you want to build for yourself and in your family
- Remember for every adversity, there are resilient skills you can build

<http://resiliencetrumpsaces.org/docs/handbook.pdf>



**STARTING WITH WHAT IS STRONG...
NOT WHAT IS WRONG**

Walla Walla Washington

- Resilience Trumps ACEs Campaign
 - 10 ACEs
 - 42 Ways to Build Resilience
 - Focusing on Parent/Caregiver Resilience
 - Engaging Youth and Families to take the evidence and make it accessible

J
O
K
E
R

Adverse Childhood Experiences (ACEs)



Adverse Childhood Experiences are significant early traumas that affect brain development and can lead to serious physical, mental and emotional issues if left unaddressed. However, we know that resilience, built into our daily lives in simple ways, can act to offset the effect of ACEs

R
E
K
O
J

J
O
K
E
R

Adverse Childhood Experiences (ACEs)



Childhood physical abuse
Emotional neglect
Child sexual abuse
Child emotional abuse
Physical neglect
Drug addicted or alcoholic family member
Incarceration of a family member
Mentally ill, depressed or suicidal family member
Loss of a parent to death or abandonment
Witnessing domestic violence against mother

R
E
K
O
J

J
O
K
E
R

Resilience



A resilient individual is one who is emotionally healthy and equipped to successfully confront challenges and bounce back from setbacks. We were born with resilience. It can be nurtured and recaptured. These cards explain how to build resilience into the lives of children and adults.

R
E
K
O
J

J
O
K
E
R

Resilience Building Blocks (Some examples)



Attachment to a caring adult
Critical thinking skills
The ability to calm oneself
Developing self-esteem
Mastering a skill
Giving a child choices
Assigning chores to give responsibilities
Showing empathy
Working as a team
Learning responsibility

R
E
K
O
J

Showing Resilient Cards



Showing Resilient Cards



Show Resilient Cards



www.Resiliencetrumpsaces.org

Resilience Cards

- Showing empathy
- Critical thinking skills
- Helping appreciate cultural & ethnic heritage
- Sense of belonging
- Learning to accept help
- Hope
- Trust
- Sense of Belonging
- Letting Child Know you are Available for Help

Resilience Cards

- Learning Responsibility
- Teach Self Discipline
- Establish Consequences
- Model Problem Solving
- Sharing Something Important
- Family Meetings
- Clear Rules and Expectations
- Help a Child Learn to Express Feelings
- Accept Ownership for Behavior

Resilience Cards

- Work as a team
- Learn to show appreciation
- Master a Skill
- Assign a Responsibility
- Sense Triggers that create negative behavior
- Develop Communication Skills
- Helping a Friend
- Allowing Experience of Success or Failure

Resilience Cards

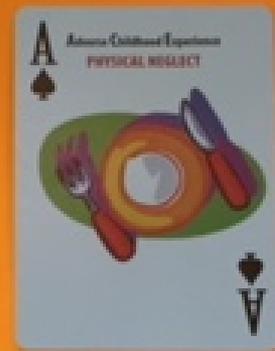
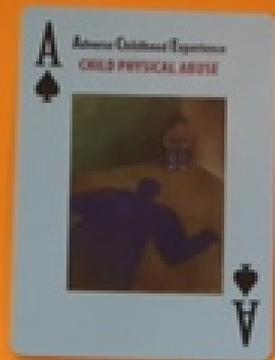
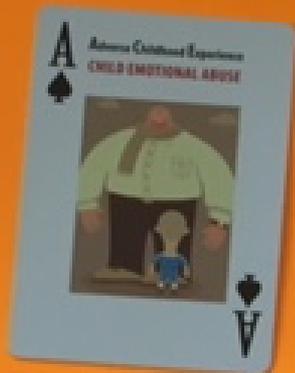
- Respect ability to make decisions
- Model appropriate behavior
- Help child develop problem solving skills
- Learning to ask for help
- Acknowledge when you are wrong
- Learn to self advocate
- Give back to community
- Giving a choice
- Ability to Calm Self

Resilience Cards

- Verbally say “I love you”
- Express Feelings
- Experience Success
- Develop Friendships
- Develop Self Esteem
- Attach to Caring Adult
- Learn to Solve Problems

Bad Chapter Titles

- Note that the transition is going to happen now to the “bad” chapter titles
- Lay out the ACE cards
- Offer options
 - Can ask the questions
 - Can read the questions
 - Can take listen to a recording of the questions
- First give the number
- Pick out the cards that have happened
- Remember the ground rules



Resilience and ACEs game/interview

Bread meat Bread

- Pick 2-3 Resilience Attributes you have
- Look out how choices in behavior are coping methods meeting a need
- Pick an ACE you have experienced
- Look at the chart of ACEs ... what resilience skills might be a good place to start
- Pick 2-5 skills you want to build for yourself and in your family
- Remember for every adversity, there are resilient skills you can build

<http://resiliencetrumpsaces.org/docs/handbook.pdf>

Expanding to Resilience

- Helps case planning
- Approach vs. Avoidance Case Planning Goals
- Helps know services and activities to link families to and how to coordinate with other agencies in a resilience plan

Community Resilience



Man in Arena Speech

“It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The **credit belongs to the man who is actually in the arena**, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat.”

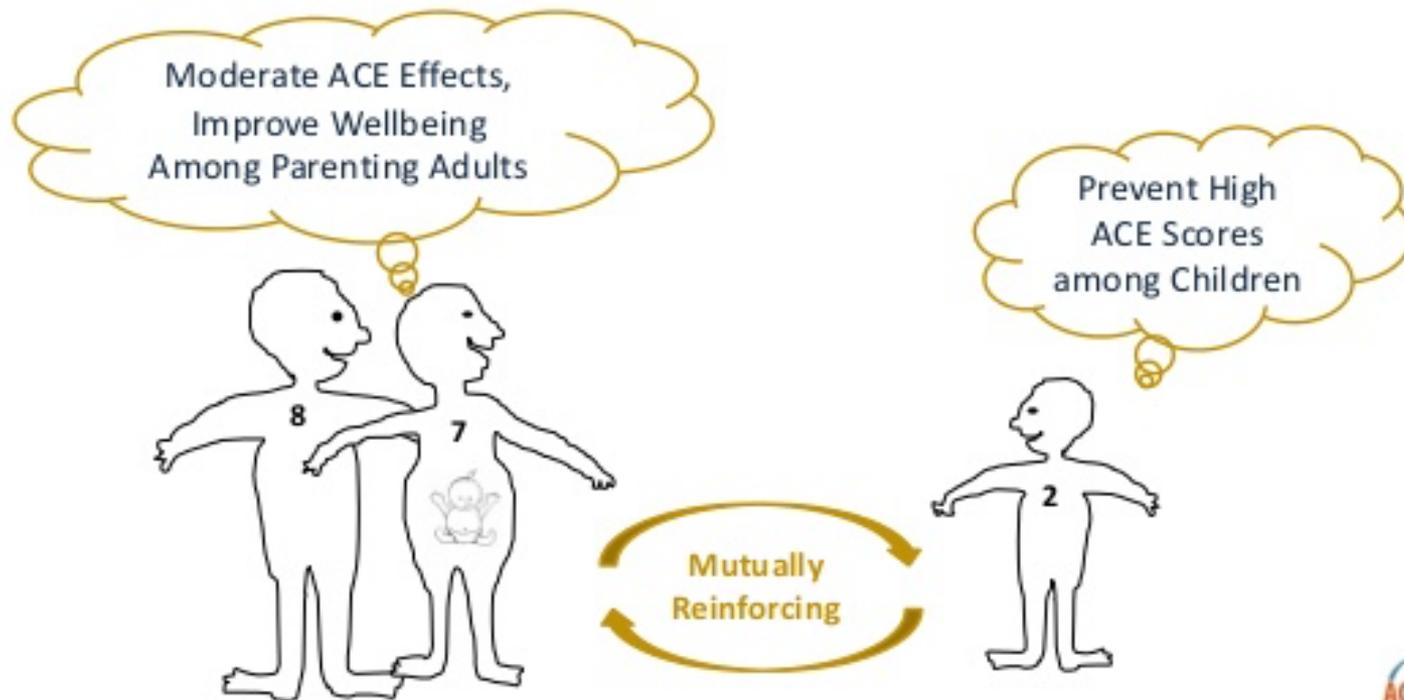
THE MAN IN THE ARENA

Excerpt from the speech "Citizenship In A
Republic" delivered at the Sorbonne, in Paris, France on
23 April, 1910

EXAMPLES OF COMMUNITY RESILIENCE

Creating the Virtuous Cycle

Promote Virtuous Cycle of Health

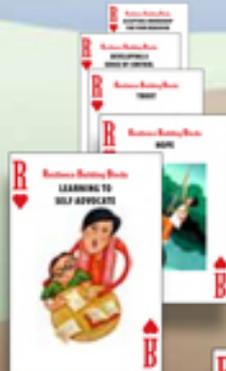


All roads lead to Resilience

Healthy family

ROAD TO PARENTAL RESILIENCE

Physical & emotional neglect



Mentally ill, drug/alcoholic family member



ROAD TO SOCIAL CONNECTIONS

ROAD TO CONCRETE SUPPORTS

Loss of Parent or Incarcerated Parent

ROAD TO KNOWLEDGE OF PARENTING & CHILD DEVELOPMENT

Physical, emotional & sexual abuse



ROAD TO SOCIAL & EMOTIONAL COMPETENCE

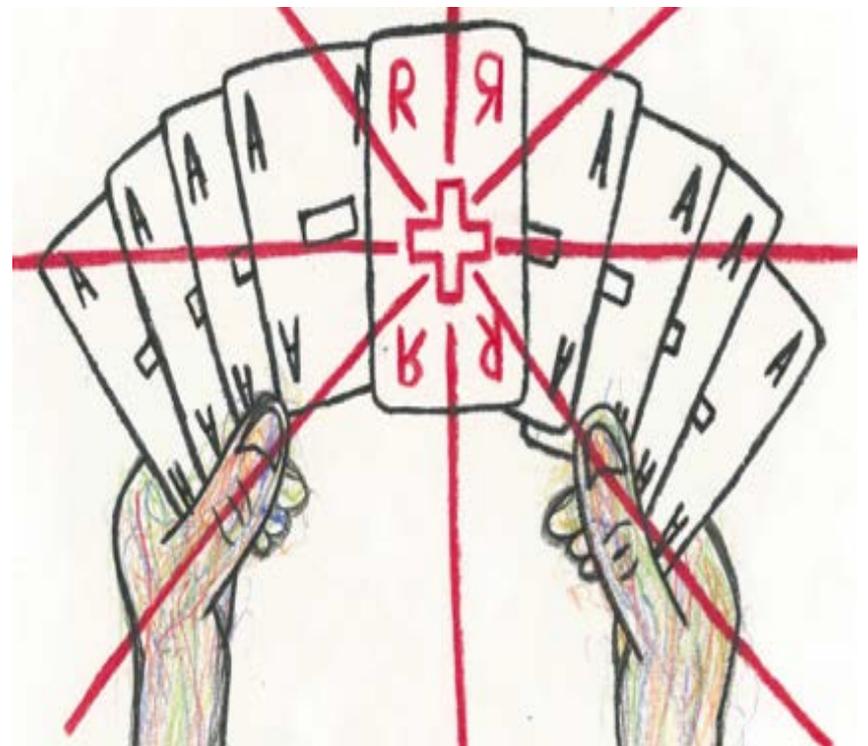
Witnessing domestic violence



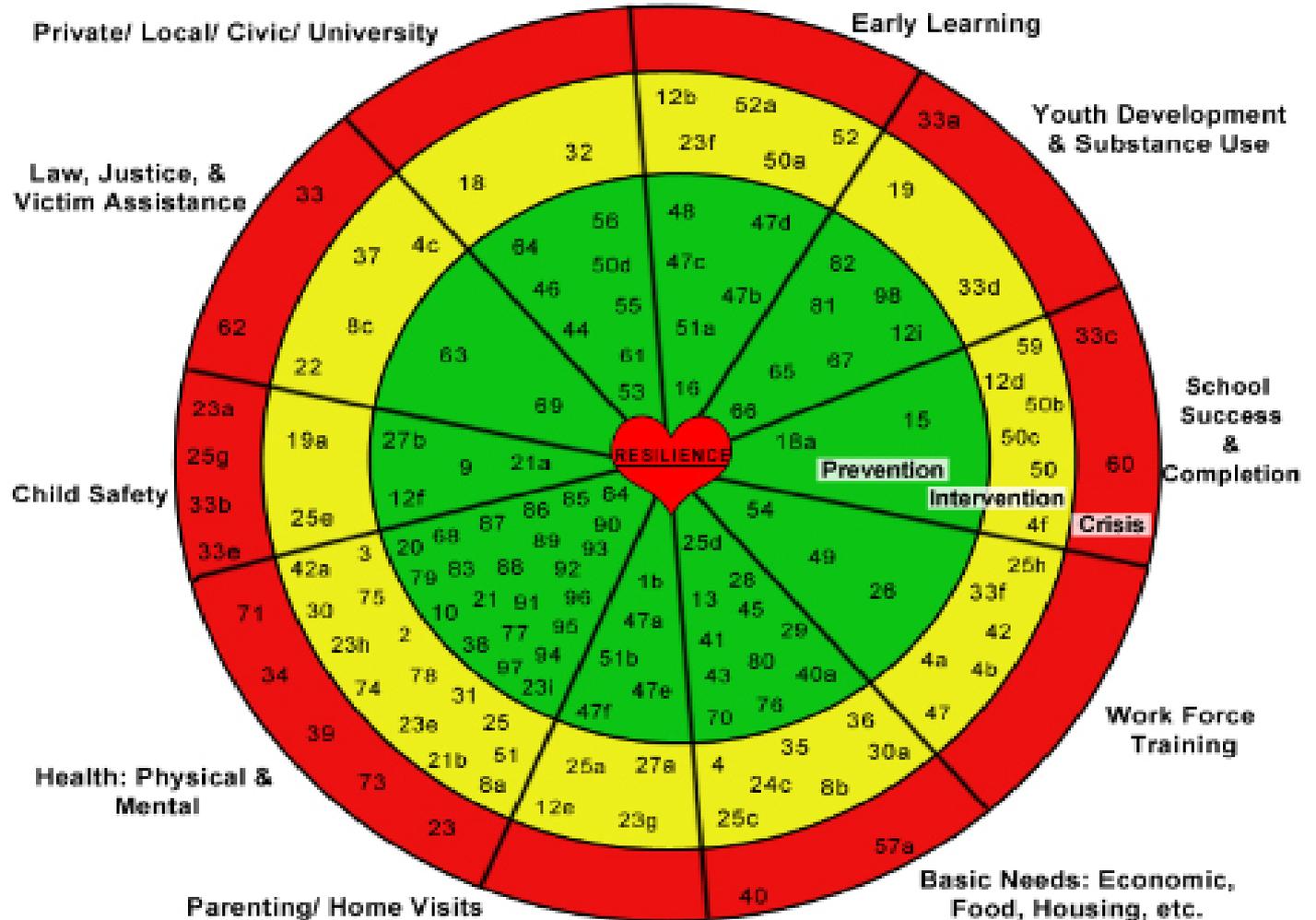
Be a **F.O.R.S.E.** in your community

Image by Lincoln High student Brendon Gilman

FOCUS
On
Resilience &
Social-Emotional



Walla Walla organizations that build resilience



Parents Home
 What Is Resilience?
 Deck of Cards & Handbook

Providers Home
 What Is Resilience?
 Building a thriving community
 Resources
 News & Events
 Deck of Cards & Handbook

Community Home
 More ACES = Greater Risks
 What Is Resilience?
 Building a thriving community

Find us on Facebook



Children's Resilience Initiative - Resilience Trumps ACES

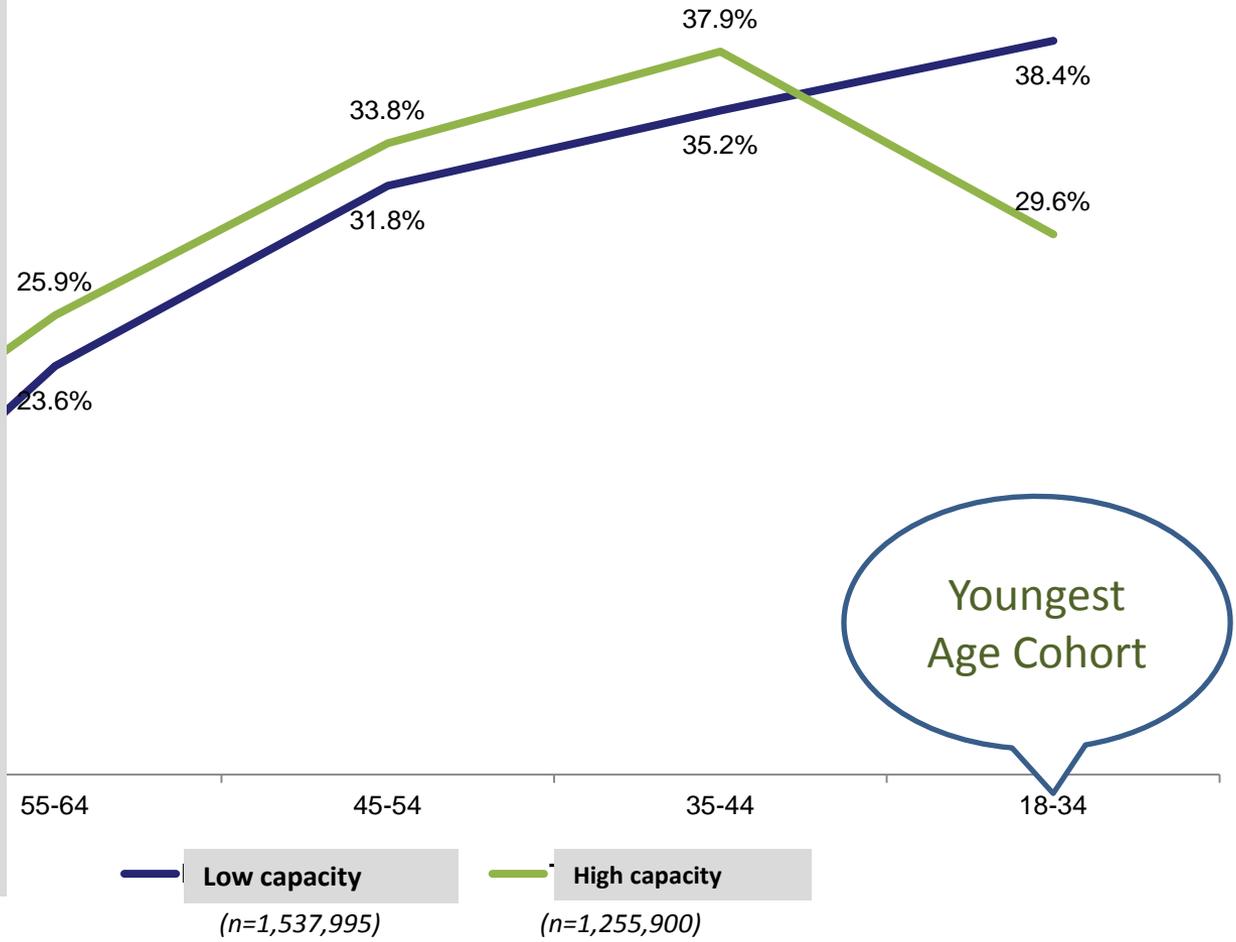
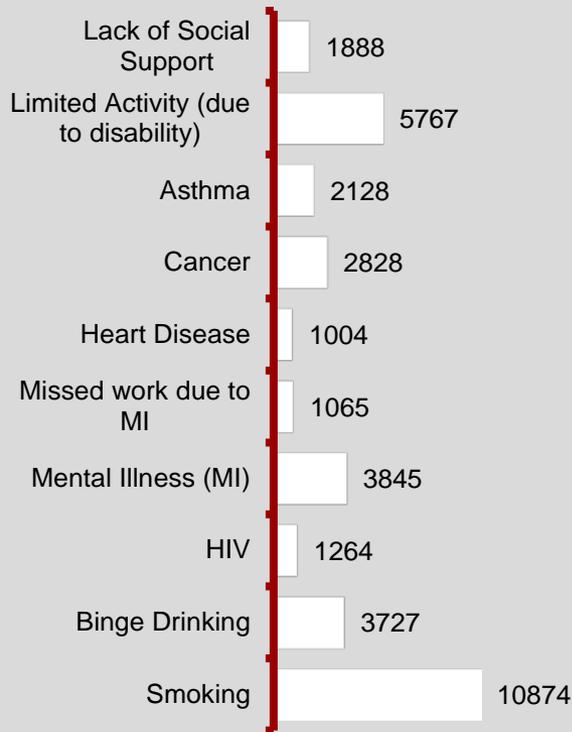
Like

19 people like Children's Resilience Initiative - Resilience Trumps ACES.



HIGH CAPACITY COMMUNITIES REDUCE PERCENT OF YOUNG ADULTS WITH ≥ 3 ACEs

POSITIVE ACE TREND MEANS REDUCED CASES:



ACE REDUCTION IS A WINNABLE ISSUE

Washington

- Funded Community Networks showed significant improvement in Severity Index
 - Out of home placement
 - Loss of parental rights
 - Child hospitalization rates for accident and injury
 - High School Drop Out
 - Juvenile Suicide Attempts
 - Juvenile arrests for alcohol, drugs, and violent crime
 - Juvenile offenders
 - Teen births
 - Low birth weights
 - No third trimester maternity care
 - Infant mortality
 - Fourth grade performance on standardized testing

HEARTs Initiative – New York

HEARTS are healthy environments and relationships that support people who have experienced trauma.

HEARTS also prevent the trauma and consequences of adverse childhood experiences (ACEs)

RIS – Restorative Integral Support

The HEARTS Initiative aims to help prevent and address ACE consequences in the following ways:

- Improve program and community responses to prevent ACE consequences
- Support the development of healthy families
- Empower youth
- Reduce substance abuse, homelessness, and crime
- Support "ACE-informed" delivery of mental health and other treatment services
- Strengthen communities

Camden NJ

Camden earned the dubious title of “most violent city in America” in 2012

67 homicides among its 77,000 residents

That year, someone in Camden was shot, on average, every 33 hours

Thirteen percent of the patients accounted for 80 percent of hospital costs; 20 percent of the patients accounted for 90 percent of the costs.

Changes in Healthcare Systems

Camden Coalition of Healthcare Providers

2003 - Physician Jeffrey Brenner founds the Camden Coalition of Healthcare Providers, an integrated health care system designed to provide preventive and primary care while also addressing patients' social needs

Camden Healthcare Providers

2011 - Brenner is the subject of a profile in The New Yorker that describes his use of data and mapping to identify “hot-spotters”—people with multiple and chronic ailments who are the heaviest users of health care—and respond with a team-based approach to help those patients manage their health, improve their stability and reduce the costs of their care

Brenner receives a MacArthur “genius” grant for his model of cooperative care, now being replicated by more than ten communities across the country

Healthcare Change

- The database identifies hospitalized patients with complicated medical and social needs.
- A *care management team*—consisting of a social worker, nurse, community health worker and health "coach" (an AmeriCorps volunteer who plans to go into medicine or nursing)—visits the patient in the hospital, reviewing prescribed medications, conferring with doctors and nurses, and helping plan the discharge.
- Team members visit the patient at home immediately after discharge and provide ongoing support for two to nine months, including connecting the patient to a primary care doctor, accompanying him or her to appointments, and helping line up needed social services. The goal is to leave patients with the ability to manage their health on their own.

Cost Savings and Improved Quality of Life

The first 36 patients averaged a total of 62 hospital and emergency room visits per month before the intervention compared to 37 visits per month afterward.

Their hospital bill total fell from a monthly average of \$1.2 million to just over \$500,000—savings that benefit the federal and state governments in reduced Medicaid spending and the hospitals in reduced charity care costs.



Trauma in the Health Care Setting

- Injuries
- Illnesses
- Preventive Health Care



Key Reminders for Health Care Professionals

- Trauma affects the entire family & broader systems
 - ✓ Don't forget to check the family trauma history
- A trauma response may look different in each person, but a consistent feeling is one of helplessness
 - ✓ Empower the patient and their family to assist in their care & recovery
- Trauma may impact child development, and a person's behavior, long-term health and mental health
 - ✓ Protective & promotive factors can reduce the adverse impact of trauma
- Culture is closely interwoven with traumatic experiences, response & recovery
 - ✓ Don't assume you understand a patient's culture and values...ask



Ideas to Assess & Respond to ACEs

One question - “Is there anything that scares or worries you?”

After the ABCs (Airway, Breathing, Circulation) consider the DEF

- Distress – Pain, fears or worries, grief and loss
- Emotional support – mobilize existing & identify new supports
- Family – assess parent & sibling distress, other needs beyond medical

Source: Medical Traumatic Stress, National Child Traumatic Stress Network

Assessments

- Psychosocial history gathering (patient & family)
- Organizational assessment (trauma informed policies, practices & environment)

Multidisciplinary Team approach

- Problem Based Learning (PBL) – facts, hypotheses, next steps, learning

ISSUES Source: NCTSN Learning Collaborative



Ideas for Responding to ACEs

Care for the Health Care Professional

- Secondary Trauma - the stress resulting from helping or wanting to help a traumatized or suffering person
- Vicarious Trauma - the **cumulative** effect of working with victims who experience traumatic life events

Professional Quality of Life Scale www.proqol.org

Psychological First Aid – method for debriefing

ABCs of Self Care

- Awareness
- Balance
- Connection

Implications & Future Directions

- Reduction of ACEs within linked lives context of parents and children
 - Better assessment of factors that serve as mechanisms of stress proliferation, coping and support erosion, disability and health outcomes: Macro, meso, micro
 - More data on children's well-being within parental trajectories
 - Main directions of Interventions should be on:
 - Strengthening “adaptive parental function”
 - Interrupting stress proliferation and stress embodiment
 - Resilience cannot thrive at any one level alone: Individual, family, community, structural needed

Resilience cannot thrive at any
one level alone: Individual,
family, community, structural
needed

Thank you !

Dr. Allison Sampson-Jackson, LCSW, LICSW, CSOTP

Integration Solutions, Inc.

804-432-0056



42 Ways to Build Resilience

(Taken from the Resilience Trumps ACEs Poster and Card Games
Developed in Walla Walla, www.ResiliencetrumpsACEs.org)

Resiliency Skills

- Showing empathy
- Critical thinking skills
- Helping appreciate cultural & ethnic heritage
- Sense of belonging
- Learning to accept help
- Hope
- Trust
- Sense of Belonging
- Learning Responsibility
- Teach Self Discipline
- Establish Consequences
- Model Problem Solving
- Sharing Something Important
- Accept Ownership for Behavior
- Work as a team
- Learn to show appreciation
- Master a Skill
- Assign a Responsibility
- Sense Triggers that create negative behavior
- Develop Communication Skills
- Helping a Friend
- Allowing Experience of Success or Failure
- Respect ability to make decisions
- Model appropriate behavior
- Learning to ask for help
- Acknowledge when you are wrong
- Learn to self advocate
- Give back to community
- Giving a choice
- Ability to Calm Self
- Verbally say “I love you”
- Express Feelings
- Experience Success
- Develop Friendships
- Develop Self Esteem
- Attach to Caring Adult
- Learn to Solve Problems

Specialized Resilience Skills for Parents

- Letting Child Know you are Available for Help
- Family Meetings
- Help a Child Learn to Express Feelings
- Clear Rules and Expectations
- Help child develop problem solving skills

Circle Skills that You Have Now
Tell A Story of How You Have Used This Skill

Event Type	Related Resilient Skills That May Be Helpful
Emotional Abuse	Showing Empathy Developing Self Esteem Developing a Sense of Control Developing Friendships
Physical Abuse	Attachment to Caring Adult Developing Self Esteem Learning to ask for help Expressing Feelings Learning to Self-Advocate
Sexual Abuse	Hope Sense of Control Learning to Solve Problems Trust Caregivers who let youth know they are available to help
Physical Neglect	Learning to ask for help Expressing Feelings Developing Self Esteem Developing Sense of Control Hope
Emotional Neglect	Attachment to Caring Adult Sense of Belonging Ability to Calm Oneself Expressing Feelings
Separation/Divorce Caregiver	Attachment to Caring Adult Sense of Belonging Ability to Calm Oneself Expressing Feeling
Witnessing Family Violence	Sense of Belonging Learning to ask for help Trust Appreciating Heritage Critical Thinking Skills
Incarceration of Family Member	Attachment to Caring Adult Trust Developing Self Esteem Verbally being told "I love you"
Member with Mental Health Challenge	Attachment to Caring Adult Learning to Express Feelings Developing a sense of control Hope
Family Member with Substance Abuse Challenge	Developing Friendships Developing Sense of Control Expressing Feelings Developing Self Esteem

Behavior Wheel Work
“Responding to the Needs, not Reacting to the Behavior”

At- Risk Health Behaviors

Health Coping Behaviors with New Strategy

42 Ways to Build Resilience

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Resiliency Skills

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- Clear Rules and Expectations
- Help child develop problem solving skills

Circle Skills You Want to Build

RESILIENCE SKILL	Resources Needed to Build/Practice	Time Period You Want to Start Building This Skill

Evidenced Based Protocols for Adult Drug Courts

Presented by
Shannon Carey, Ph.D.
NPC Research
NADCP/NDCI

Developed by: Jacqueline van Wormer, PhD
Washington State University
NADCP/NDCI

- “The first test of reform is in it’s record of implementation. A program must ultimately be judged by results, what actual benefits it brings, and what degrees of mischief it has created.....”
 - David J. Rothman, *Conscience and Convenience* (1980)

negative
outcome
recidivism
responsible
best
promising
effect
practice
no
evidence-based

Defining and Measuring Recidivism and Desistance

- Recidivism is a central concept when assessing the effectiveness of a program because policy makers and practitioners want to know what impact a program or sanction has on criminality.
- When a person reaches a permanent state of non-offending, it is called **desistance**. Desistance is the ultimate goal of all prevention and correctional intervention efforts.

What is evidence-based vs.
best practice?



Definition: Evidence-Based

- Multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.



Definition: Best Practice

- An approach, framework, principles or strategies supported by research.



Program versus Practice

What is the difference between programs and practices on CrimeSolutions.gov?

	Programs	Practices
Description	A specific set of activities carried out according to guidelines to achieve a defined purpose.	A general category of programs, strategies, or procedures that share similar characteristics with regard to the issues they address and how they address them.
Question Answered	How effective is this specific program according to the most rigorous evaluation(s) available?	How effective is this general practice on average across many evaluations?
Example	Did the ABC Mentoring Program in Anytown, USA achieve its goals?	Does mentoring usually achieve its goals?

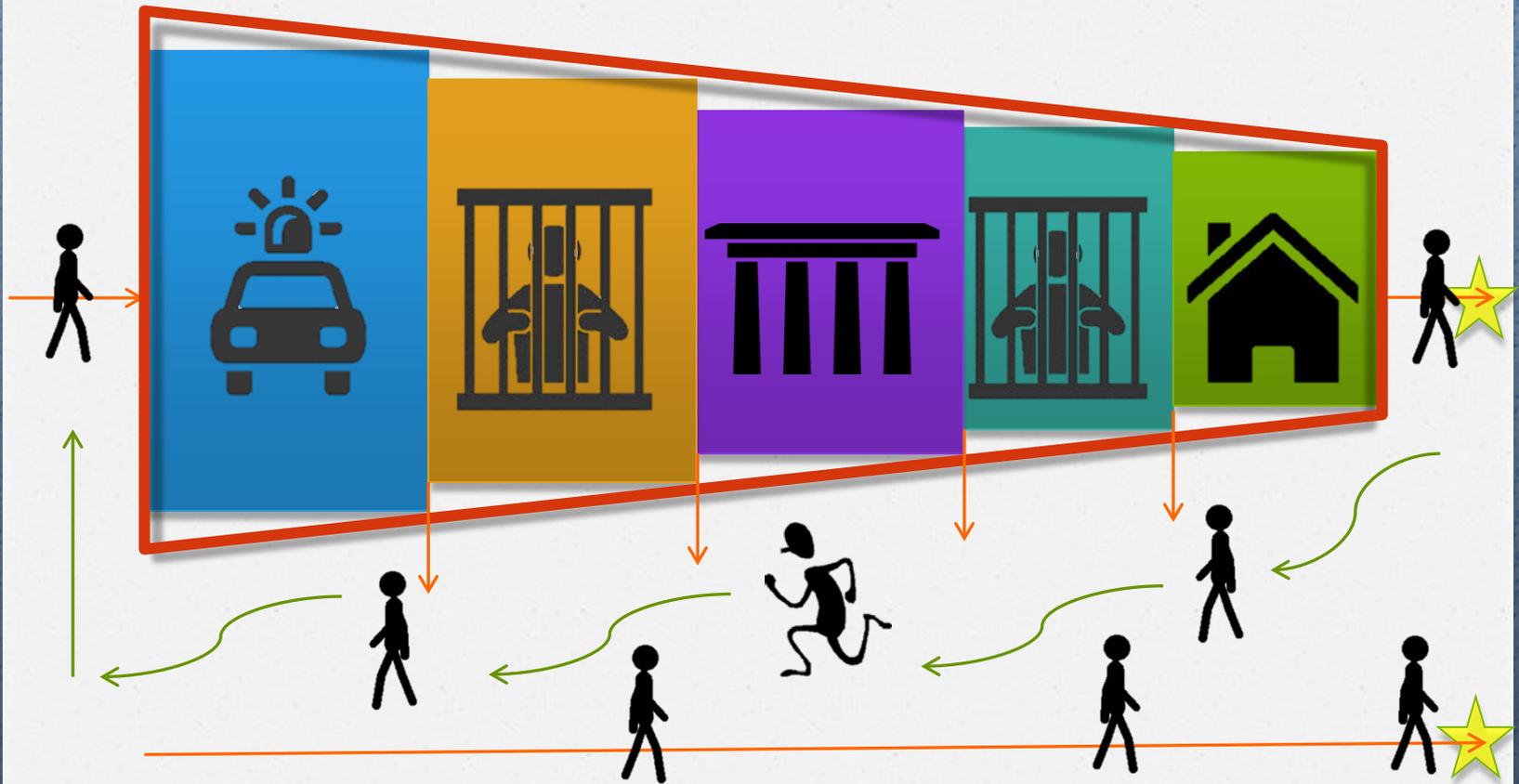
Definitions

- Oh, and so many others....
 - Research-based
 - Consensus-based
 - Promising practices

Why do we need “evidence-based” and “best” practices?



The Hydraulic Justice System



Drug Court Best Practices

- NADCP/NDCI Adult Drug Court Best Practice Standards Volume I & II
- State Best Practice Standards for Drug Courts

What does the research tell us?

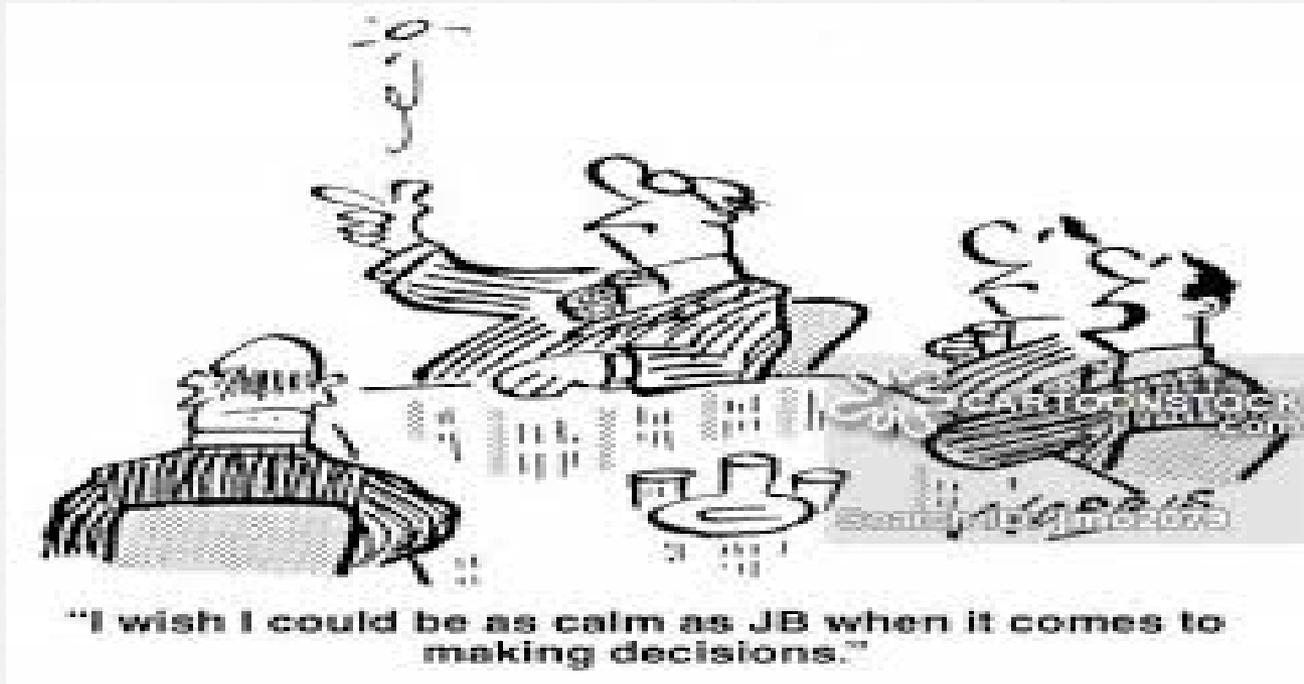
Reaching a state of best practices

- Use risk assessment tools to identify risk to reoffend and criminogenic needs.
- Direct programming and interventions to medium and higher risk offenders
- Focus interventions for medium and higher risk offenders on their *individual* criminogenic needs.
- Respond to misconduct with swiftness, certainty, and proportionality.
- Use more carrots than sticks
- Deliver services in natural environments where possible
- Pair sanctions with interventions that address criminogenic needs
- Assess and monitor outcomes

○ Source: NIC (2012)

Individualized

- Risk/Needs/Responsivity



R-N-R

- **RISK:** who to treat
- **NEED:** what to treat
- **RESPONSIVITY:** how to treat

The RISK Principle

- Because criminal behavior can be predicted, services should be matched to each person's risk of reoffending
- To reduce recidivism:
 - Higher risk youth/adults need additional services.
 - Lower risk youth/adults need little to no intervention

The (Criminogenic) NEED Principle

- The Central Eight
 - The Big Four (Tier I)
 - antisocial personality traits, thinking, and attitudes
 - criminal associations
 - Tier II
 - Substance abuse
 - Family/marital relationships
 - Education and employment
 - Positive leisure activities

○ Source: Andrews & Bonta (2010)

The RESPONSIVITY Principle

- Service delivery should be responsive to the learning style and capabilities of each individual client
- What protective factors does the client possess that will assist with participation in and completion of services?

Evidence-Based *Programs*

Public Policy Estimates as of October, 2006	Outcomes Percent change in crime outcomes & the number of evidence-based studies on which the estimate is based (in parentheses)	(Per Participant, Net Present Value, 2006 Dollars)			
		Benefits to Crime Victims (of the reduction)	Benefits to Taxpayer (of the reduction)	Costs (marginal program cost, compared to the cost of alternative)	Benefits (total) Minus Costs (per participant)
Notes: “n/e” means not estimated at this time Prevention program costs are partial costs, pro- rated to match crime outcomes					
<i>Programs for People in the Adult Offender System</i>					
Vocational education in prison	-9.0% (4)	\$8,114	\$6,806	\$1,182	\$13,738
Intensive supervision: treatment- oriented programs	-16.7% (11)	\$9,318	\$9,369	\$7,124	\$11,563
General education in prison (basic education or post-secondary)	-7.0% (17)	\$6,325	\$5,306	\$962	\$10,669
Cognitive behavioral therapy in prison or community	-6.3% (25)	\$5,658	\$4,746	\$105	\$10,299
Drug treatment in community	-9.3% (6)	\$5,133	\$5,495	\$574	\$10,054
Correctional industries in prison	-5.9% (4)	\$5,360	\$4,496	\$417	\$9,439
Drug treatment in prison (therapeutic communities or outpatient)	-5.7% (20)	\$5,133	\$4,306	\$1,604	\$7,835
Adult drug courts	-8.0% (57)	\$4,395	\$4,705	\$4,333	\$4,767

Topic Area/Program	Last Updated	Monetary Benefits			Costs	Summary Statistics		
		Total Benefits	Taxpayer	Non-Taxpayer		Benefits Minus Costs (net present value)	Benefit to Cost Ratio ¹	Measured Risk (odds of a positive net present value)

Benefits and costs are life-cycle present-values per participant, in 2011 dollars. The programs are listed by major topic area, although some programs achieve benefits in multiple areas. Also, some programs achieve benefits that we cannot monetize; see linked documents for program- specific details.

Adult Criminal Justice

Offender Re-entry Community Safety Program (dangerously mentally ill offenders)	April 2012	\$70,535	\$18,120	\$52,415	(\$32,247)	\$38,288	\$2.19	100%
Drug Offender Sentencing Alternative (drug offenders)	April 2012	\$22,365	\$5,318	\$17,047	(\$1,542)	\$20,823	\$14.51	100%
Supervision with Risk Need and Responsivity Principles (high and moderate risk)	April 2012	\$24,203	\$5,817	\$18,386	(\$3,543)	\$20,660	\$6.83	100%
Correctional Education in Prison	April 2012	\$21,426	\$5,238	\$16,188	(\$1,128)	\$20,298	\$19.00	100%
Electronic Monitoring (radio frequency or global positioning systems)	April 2012	\$18,745	\$4,438	\$14,307	\$1,067	\$19,812	n/e	100%
Vocational Education in Prison	April 2012	\$20,446	\$5,017	\$15,429	(\$1,571)	\$18,875	\$13.01	100%
Mental Health Courts	April 2012	\$20,424	\$4,998	\$15,425	(\$2,935)	\$17,488	\$6.96	100%
Drug Treatment in the Community	April 2012	\$17,711	\$4,206	\$13,504	(\$1,602)	\$16,108	\$11.05	100%
Drug Courts	April 2012	\$15,433	\$3,376	\$12,057	(\$4,178)	\$11,255	\$3.69	100%
Drug Treatment in Prison	April 2012	\$15,577	\$3,834	\$11,743	(\$4,603)	\$10,974	\$3.38	100%
Drug Offender Sentencing Alternative (property offenders)	April 2012	\$11,273	\$2,666	\$8,607	(\$1,540)	\$9,733	\$7.32	78%

(Continued)

Topic Area/Program	Last Updated	Monetary Benefits			Costs	Summary Statistics		
		Total Benefits	Taxpayer	Non-Taxpayer		Benefits Minus Costs (net present value)	Benefit to Cost Ratio ¹	Measured Risk (odds of a positive net present value)
<p>Benefits and costs are life-cycle present-values per participant, in 2011 dollars. The programs are listed by major topic area, although some programs achieve benefits in multiple areas. Also, some programs achieve benefits that we cannot monetize; see linked documents for program- specific details.</p>								
Adult Criminal Justice								
Cognitive Behavioral Therapy (moderate and high risk)	April 2012	\$9,695	\$2,308	\$7,387	(\$412)	\$9,283	\$23.55	100%
Intensive Supervision: With Treatment	April 2012	\$15,169	\$3,610	\$11,559	(\$7,874)	\$7,295	\$1.93	96%
Work Release	April 2012	\$7,117	\$1,749	\$5,368	(\$661)	\$6,456	\$10.77	99%
Correctional Industries in Prison	April 2012	\$7,042	\$1,713	\$5,329	(\$1,417)	\$5,625	\$4.97	100%
Employment Training/Job Assistance in the Community	April 2012	\$5,501	\$1,311	\$4,190	(\$135)	\$5,366	\$40.76	100%
Intensive Supervision: Surveillance Only	April 2012	(\$578)	(\$133)	(\$445)	(\$4,140)	(\$4,718)	(\$0.14)	11%
Domestic Violence Perpetrator Treatment Programs	April 2012	(\$4,908)	(\$1,165)	(\$3,742)	(\$1,359)	(\$6,266)	(\$3.61)	14%

Data

- Cannot reach a level of best practices without the use of data.
- Data should drive decision making, programming planning, caseloads, target populations.
- Monitor for racial/ethnic disparities in filings, referrals, jail stays, access to and completion of services.

Quality Assurance

- Why QA? To use multiple levels of data and information to measure impact, and to implement changes if necessary.
- To assist staff in improvement and controlling for program drift/mission creep.
- Multi-level Quality Assurance: State, County, Provider level.

- Source: Crime and Justice Institute at Community Resources for Justice, Kristy Pierce-Danford, & Meghan Guevara (2010). *Commonwealth of Virginia: Roadmap for Evidence-Based Practices in Community Corrections*.

The QA Process

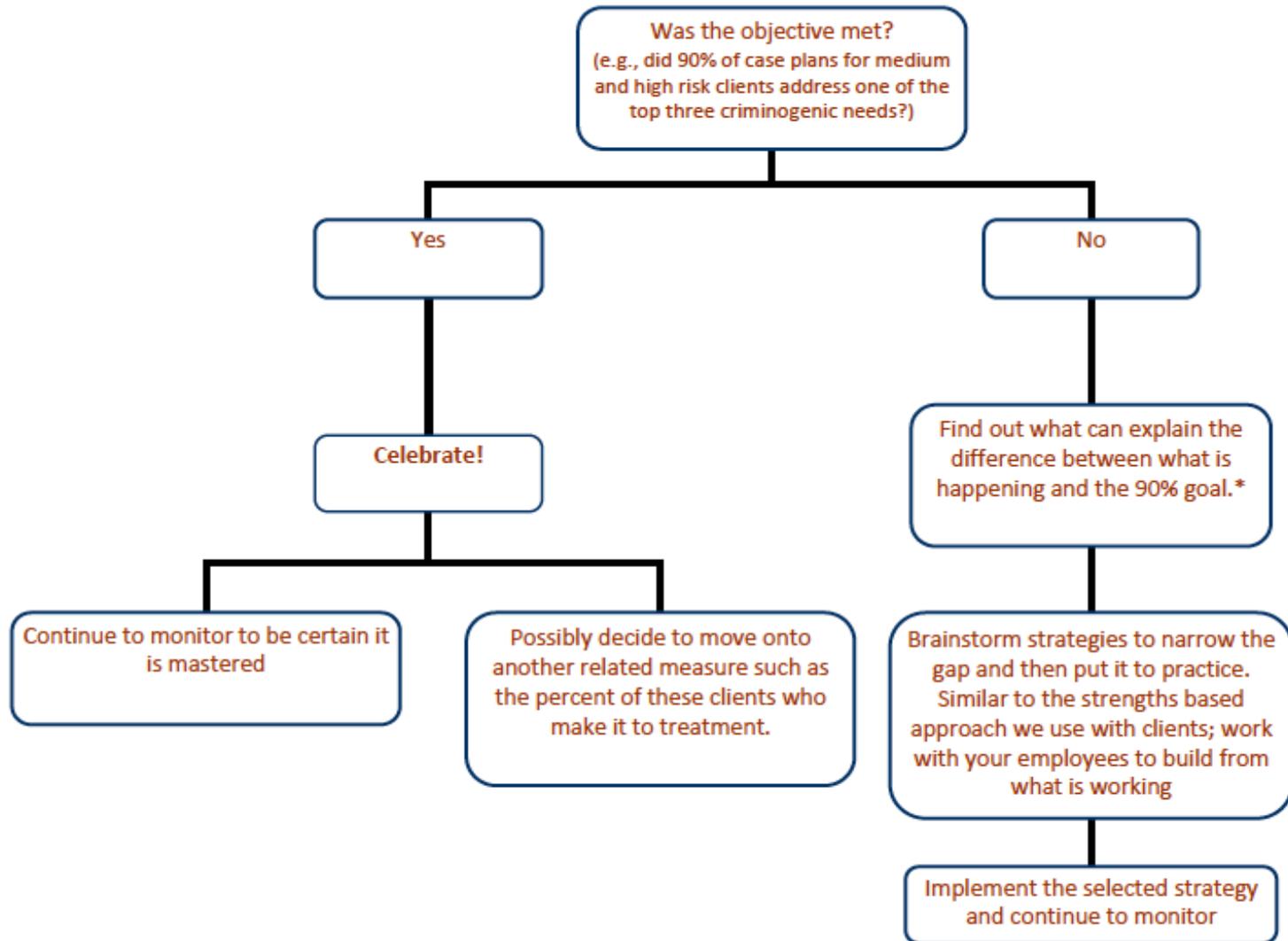
- How does each stakeholder define quality
- What are the goals for your ADC?
 - (e.g. Utilize RNR tool for program placement, individualized TX & Incentives and Sanctions)
- Logic Model – what do you intend to happen, and what are your short and long term outcomes?
- How will you measure the goals?
 - Data Review
 - Review: Peer review, audits, file reviews, interviews, checklists, client & staff surveys
 - Always communicate!

Figure 4 – 1: Example Logic Model Format

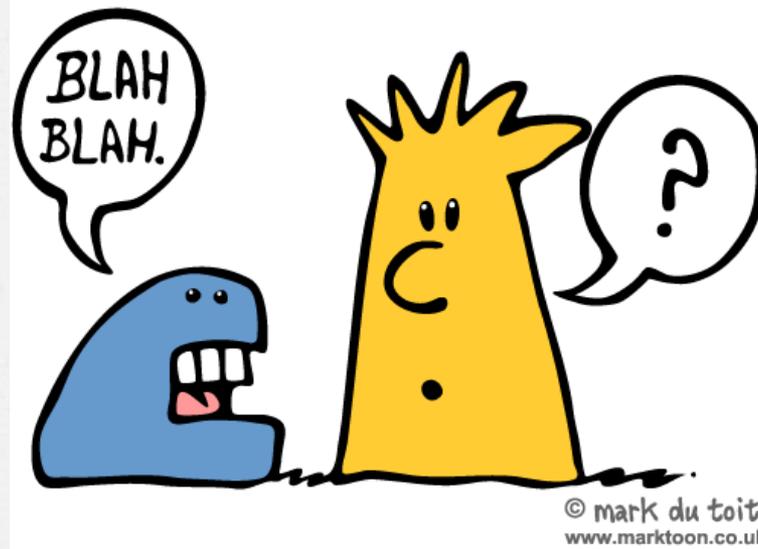
Inputs	Activities	Outputs	Outcomes		
			Short Term	Intermediate	Long Term
The resources being put into the program or project	What is being done	Direct product of the activities	Initial changes (e.g., Knowledge/Skill Gained)	The next step in the change (e.g., Knowledge/Skill Applied)	The ultimate goal (e.g., Desired Behavior Change)
Research Based					

Criteria	Poor	Needs Improvement	Good	Exceptional	N/A
1. Interviewer has been trained in the use of the assessment tool.	1	2	3	4	-
2. Interviewer describes the purpose of the interview.	1	2	3	4	-
3. Interviewer establishes the environment for the interview.	1	2	3	4	-
4. Interviewer references documentation (e.g., file and available records) for accuracy.	1	2	3	4	-
5. Interviewer avoids interrogation techniques (e.g., leading questions, extensive closed ended questions).	1	2	3	4	-
6. Interviewer stimulates dialogue with interviewee.	1	2	3	4	-
7. Interviewer avoids double-barreled questions.	1	2	3	4	-
8. Interviewer avoids barriers to listening (e.g., blaming or shaming).	1	2	3	4	-
9. Interviewer scores on the basis of patterns in behavior not single events.	1	2	3	4	-
10. Interviewer overcame problems (e.g., silence, excessive talking or resistance).	1	2	3	4	-
11. Total score is calculated accurately.	1	2	3	4	-

Figure 4 – 12: Putting Data to Use



Questions?



Contact Information

- Contact:

Shannon Carey, Ph.D.

NPC Research

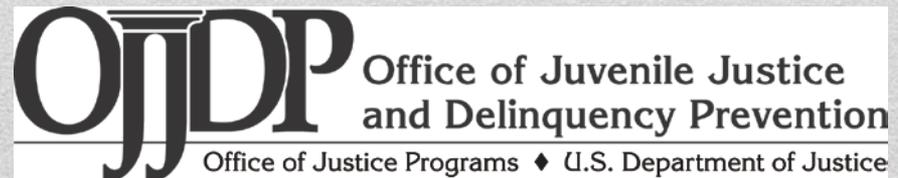
Portland, OR

carey@npcresearch.com

The Three Prong Approach: Individualizing Incentives and Sanctions in your Juvenile Drug Court

**Lindsey Lucero, Program Manager
2nd Judicial District Juvenile Drug Court, Albuquerque, New Mexico**

**Jemi Moore, Project Director/RFJDTC Court Assessor
Forsyth County, Winston-Salem, North Carolina**



- Points of view or opinions expressed in this presentation are those of the presenter(s) and do not necessarily represent the official position or policies of OJJDP or the U.S. Department of Justice.
-

- Participants will learn about privilege-reduction strategies to gain compliance over a single behavior – dirty UAs *AND* individualize incentives for clean UAs. Delivering a response every single time!
- Participants will learn how to create individualized behavior contracts to reward and motivate for positive behavior change in other areas (e.g., school attendance; family connectedness; community involvement).
- Participants will learn about program-wide incentives to motivate families to engage in the program, upward phase movement, and promote a strength-based atmosphere.

Objectives

If the court developed the perfect way to build an incentives and sanction structure, what would that look like?

- What type of incentives work best?
- What is the best way to respond with a sanction?
- What would happen if the court used incentives and sanctions correctly?



Perfect World

Research and theory tells us that we should use incentives and sanctions that are:

- Fair;
- Consistent;
- Immediate;
- Individualized; **AND**
- Meet a 4-to-1 ratio.

How easy is this?

JDC Incentives and Sanctions 1.0

- Lists of possible incentives
- Focus on monetary incentives (gift cards)
- Punitive sanction grids and misuse of detention

JDC Incentives and Sanctions 2.0

- Focus on the structured and measurable delivery of incentives and sanctions
 - Effort to increase incentives
 - Effort to decrease the misuse of detention
 - Focus on individualized and meaningful incentives
-

- Individualized privilege-reduction to gain compliance over a single behavior, dirty UAs *AND* individualized incentives for clean UAs – Every Single Time!
- Individualized behavior contracts to reward and motivate positive behavior change in other areas (school attendance; family connectedness; community involvement).
- Program-wide incentives to motivate families to engage in the program, upward phase movement, and promote a strength-based atmosphere.

A Three-Prong Approach

“Contingency management incorporates a relatively comprehensive framework in attenuating the negative effects of substance use risk factors while building protective factors such as social skills, family involvement, and contacts with prosaically peers.”

(Contingency Management for Adolescent Substance Abuse: A Practitioner’s Guide by Scott W. Henggeler, Phillippe B. Cunningham, Melisa D. Rowland, Sonja K. Schoenwald, and Associates, p. 3)

What is Contingency Management?

- Theories are based on cognitive behavioral therapy, which has been proven to work with adolescents, and is vastly used in outpatient settings
- It can be easily adapted within the JDC
- This is the court's therapeutic response
- In their study of six juvenile drug courts, Henggeler et al (2006) found stronger outcomes for those youth who received MST *AND* CM than standard process

Reasons Why JDCs Should Implement CM

- This is a privilege that the youth values and will work hard to earn
- Work with the youth and family to determine what the MVP is, preferably a family-based reward (i.e., video games, cell phone use, time w/ friends)
- The MVP is given or taken away with each drug screen

(Henggeler et al, p. 107-108)

The 1st Prong – The Most Valued Privilege

Practical reasons why JDCs should implement MVP

1. Provides for a response to dirty UAs that is fair and consistent.
 2. Decrease lengthy discussions in pre-court staffing about HOW to respond to dirty UAs (i.e., appropriate level of sanction).
 3. Decrease discussion about mitigating factors (e.g., was the youth honest, they got a flat tire and couldn't make it to the testing center).
 4. It will help track incentives and/or sanctions that correspond with clean or dirty UAs.
-

- The team will have to discuss how many times they will “go back to the drawing board” if the MVP selected isn’t working...2, 3 times?
- Then a graduated sanction is put in place
- This process gives the team objective measures to count before a graduated response is put in place (i.e., there were ___ # of times the youth did not earn the MVP)

Things to Consider

- “Rewards for Responsible Behavior in Other Domains” (Henggeler et al, p. 131)
 - Target specific behaviors (e.g., school attendance)
 - A step-by-step process for the youth to follow
 - Get youth working towards “things” they are interested in
 - As an increased response for non-compliance

The 2nd Prong – Behavior Contracts

Example of Youth Contract

Goal	Objectives/Tasks	Incentives	Non-compliance	Sanction	Support Services
Finish three lessons in your English Credit Recovery class before the next court hearing – 1 week to accomplish	<ul style="list-style-type: none"> - Determine how long each lesson takes - Determine how much time will be allotted each day to complete the lessons and set schedule - Complete lessons 	<ul style="list-style-type: none"> - Praise - Recognition - Points/tokens (if court uses a reward system) - closer to completing course 	Failure to complete three lesson plans	<ul style="list-style-type: none"> Unable to earn tokens or rewards Curfew reduction 	<ul style="list-style-type: none"> Tutoring assistance Use of computer

Youth's Signature of Agreement:

Caregiver(s) Signature of Agreement:

Case Manager's Signature of Agreement:

Contracts that build a step-by-step process

- Youth continues to violate a JDC rule despite privileges being taken away
- The goal of the behavior contract to help motivate the youth to follow the rules
- Youth and family are asked for impute on what motivates them
- Youth is asked in court by the Judge to report on the progress they have made towards achieving the behavior contract goal

Contracts as an increased response

Example of Behavior Contract – Graduated Response

Goal	Objectives/Tasks	Incentives	Non-compliance	Sanction	Support Services
Check in daily for two weeks	<p>You must call the JDC phone a minimum of once a day before your curfew.</p> <p>You need to call every time you leave your house</p> <p>You need to call every time you get home</p>	<p>Eligible to earn points</p> <p>Praise from parent and JDC team</p> <p>6:00 pm curfew</p>	<p>Not calling every day</p> <p>Not notifying the PO when leaving the house</p> <p>Not reporting when arriving home</p>	<p>One day of house arrest for every day you don't check in</p> <p>Curfew violation</p> <p>Weekend house arrest</p>	<p>Set a daily alarm</p> <p>Access to a phone</p>

Youth's Signature of Agreement:

Caregiver(s) Signature of Agreement:

Case Manager's Signature of Agreement:

Contracts as an increased response

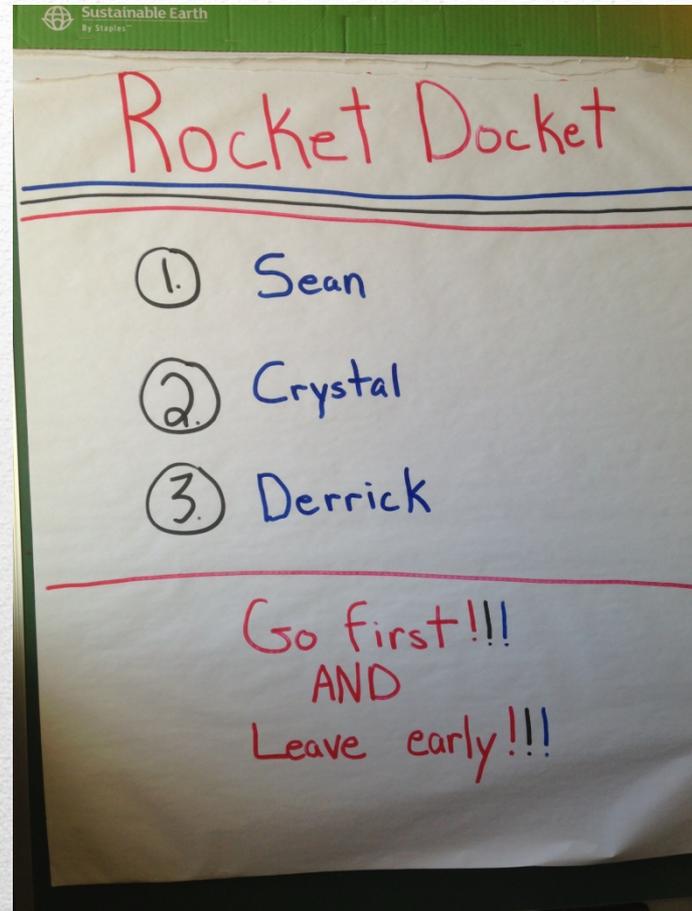
Special thanks to the Bernalillo County, NM JTDC team for the sample procedures.

- **Some examples are:**

- Rocket Docket – motivate youth and families on a weekly basis with an early out
- Positive peer-to-peer reinforcement
- Point-Level Reward System

The 3rd Prong – Program-Wide
Incentives

Go First
And
Leave Early!!!



Rocket Docket



- An incentive that is fairly easy to implement as a program-wide incentive
- An incentive that creates some positive peer pressure
- An incentive that allows the team to spread resources over a longer period of time

Positive Peer-to-Peer Reinforcement

Special thanks to the El Paso County, TX JTDC team for this innovative idea.

- JDC as an institutional setting, in which the team can create a micro-economy
- A token or point system that allows the team to objectively measure where a youth is at in the process, based on the amount of tokens or points earned.
- A way of codifying a specific reward system
- Determining what certain standard tasks are worth (TX attendance, school attendance)

Token Economy / Point Level Reward System

Earning full points	Amount	Earning partial points	Amount	Earning Zero points
Attend therapy and fully participate or present work.	2	Attend scheduled therapy appointment	1	Missing an individual or family therapy session
Attend school with no absences	2	Attend school with only one absence	1	Two or more school absences
Check in everyday	2	Check in 6 days	1	Fail to check in two or more days

Youth can earn points for...

Special thanks to the Bernalillo County, NM JTDC team for the sample procedures.

Assignment	Community Service	Bonus Points
Have a family dinner	2	4
Keep planner of assignments and appointments	2	4
Keep a daily journal	6	12
Explore alternative education program	2	4
Create a resume	5	10

Using points to promote pro-social activities

Special thanks to the Bernalillo County, NM JTDC team for the sample procedures.

Reward	Cost	Purchasing Guidelines
Credit for 1 hour of community service	4 points	No community service assigned with in the past week
Extend curfew on 1 day for 1 hour	10 points	Must be checking in, cannot be on house arrest or have a curfew violation in past 2 weeks
\$10 gift card	20 points	Must be attending therapy

Rewards the youth can purchase with earned points

Special thanks to the Bernalillo County, NM JTDC team for the sample procedures.

- Almost doubled the amount of incentives given out each month from Fiscal Year 2013 to Fiscal Year 2015.
- Reduced the average cost per incentive by \$3 (from \$5.91 to \$2.85)
- 78% of incentives give out in Fiscal Year 2015 cost \$5 or less
- 54% of those incentives were complete free

Data from New Mexico

How can all three prongs work together to create an overarching reward system or micro-economy?

- Youth who get maximum points for the week make it on the Rocket Docket
- Pro-Social activities that are used to get bonus points can be planned out via a youth contract
- ___# of MVP's earned in a row can earn up to ___ bonus points

Connecting the dots...

Phase	Cost
Move to Phase Two	50 points
Move to Phase Three	70 points
Move to Phase Four	70 points
Graduate	40 points

Connecting the dots, using points
to “phase-up”

Special thanks to the Bernalillo County, NM JTDC team for the sample procedures.

- Individualized privilege-reduction to gain compliance over a single behavior, dirty UAs *AND* individualized incentives for clean UAs – Every Single Time!
- Individualized behavior contracts to reward and motivate positive behavior change in other areas (school attendance; family connectedness; community involvement).
- Program-wide incentives to motivate families to engage in the program, upward phase movement, and promote a strength-based atmosphere.

A Three-Prong Approach

- Wait...you want us to take away a cell phone or a game system? We can't do that!!
- You want us to give these kids something for doing what they SHOULD be doing anyway?!?
- You want us to work with families...but THEY don't want to work with us.
- You haven't talked about sanctions at all...what the heck?!

Some thoughts that may have been running
through your head during this
presentation...

What?

So What?

Now What?



What did you learn?

- ***Contingency Management for Adolescent Substance Abuse: A Practitioner's Guide***, by: Scott W. Henggeler, Phillippe B. Cunningham, Melisa D. Rowland, Sonja K. Schoenwald and Associates
- ***Making Sense of Incentives and Sanctions in working with the Substance-Abusing Youth: Answers to Frequently Asked Questions*** (Juvenile & Family Justice TODAY. 2012, Volume 21, Number 2)
- ***Enhancing the Effectiveness of Juvenile Drug Courts by Integrating Evidence-Based Practices*** (Journal of Consulting and Clinical Psychology. 2012, Vol. 80, No. 2, 264-275)

Recommended Reading
