Virginia DUI Drug Treatment Court Training:
Virginia Drug Court Dockets are Best Practice Solutions to New Challenges
Hotel Roanoke
AGENDA

Monday, August 7, 2017

7:15 a.m. – 8:30 a.m.	**Registration**
8:30 a.m. – 8:40 a.m.	**Welcome to Roanoke** Hon. Sherman Lea, Mayor, City of Roanoke
8:45 a.m. – 9:00 a.m.	**Welcome and Remarks** Hon. Jack "Chip" Hurley, Judge, Tazewell Circuit Court, Vice Chair Virginia Drug Treatment Court Advisory Committee
9:00 a.m. – 10:15a.m.	**The Real Deal: Drug Court Best Practices & Cost-Savings** Carson Fox**,** Chief Executive Officer, NADCP
10:15a.m. - 10:30 a.m.	**Break**
10:30 a.m. – 12:30 p.m.	**"May the FORSE be with us: Building Trauma Informed Social Emotional Competence and Coping Skills with Adolescents engaging in substance abuse"** Dr. Allison Jackson, LCSW, CSOTP
12:30 p.m. – 1:15p.m.	**Lunch**
1:15 p.m. – 2:45 p.m.	**The Three-Legged Stool: Supervision, Treatment and Technology for Reducing DUI Recidivism** Jacquie Sheehey, SmartStart and Mark Stodola, APPA Fellow
2:45 p.m. – 3:30 p.m.	**Personal Impact of Virginia Drug Treatment Court**
2:45–3:00	Leroy Robinson, Pulaski Drug Court Graduate
3:00-3:15	Alethea Lambert, Hampton Drug Court Graduate
3:15-3:30	Si'Andra Blackwell, Tazewell Drug Court Graduate
3:30-p.m. - 3:45 p.m.	**Break**
3:45 p.m. - 5:00 p.m.	**Trauma, Drama, Drinking & Drugging: A Look at Co-Occurring Clients** Dr. Christa Marshall, NDCI

Where Treatment and Accountability Meet Justice

VIRGINIA

DRUG TREATMENT COURTS

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

Virginia DUI Drug Courts Training:

Virginia Drug Court Dockets are the Best Practice Solutions to New Challenges

Hotel Roanoke

AGENDA

Tuesday, August 8, 2017

7:15 a.m. – 8:15 a.m.	**Judges' Breakfast: From Brain Science to Public Health: Addiction as Disease** *By Dr.* Mishka Terplan
7:30 a.m. – 8:15 a.m.	**Continental Breakfast/Registration**
8:15 a.m. – 8:25 a.m.	**The Hon. Charles S. Sharp Drug Court Award Presentation** Virginia Association of Drug Court Professionals (VADCP)
8:25 a.m. -8:35 a.m.	**Special Recognition** Hon. Jack S. Hurley, Judge, Tazewell County & Paul F. DeLosh, Director, Dept. of Judicial Services, Supreme Court of Virginia
8:35 a.m - 9:45 a.m.	**Constitution & Legal Issues that Impact Drug Courts** Hon. Margaret Spencer, Judge (ret), Chief Training Judge, NDCI
9:45 a.m. – 10:40 a.m.	**The Roanoke Valley Response to the Opioid Crisis** Hon. Tom Bowers, Commonwealth's Attorney, Salem Janine Underwood & Nancy Hans
10:40 a.m. – 11:25 a.m.	**Choices and Chicanery** Hon. Robert M. Lilly, Jr., Commonwealth's Attorney, Giles County
11:25 a.m. – 12:20 p.m.	**Cultural Humility** Warren Rodgers, Jr., BSW
12:20 p.m. – 1:10 p.m.	**Lunch**
1:10 p.m. – 2:05 p.m.	**Shifting the Lens: Alternative Approaches in Drug Treatment Courts** Dr. Christa Marshall, NDCI
2:05 p.m.	**Twenty-third Judicial Circuit Graduation** Reception/Break immediately following
3:30 p.m.	**Adjourn**

NDCI
NATIONAL DRUG COURT INSTITUTE

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

The Real Deal

Best Practices: Following the Research

Developed by:
National Drug Court Institute

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Practices Related to Positive Outcomes

Recidivism & Outcome Costs

Important Issues

Promising Practices Related to Positive Outcomes in Drug Courts

Team Engagement

All team members should attend case staffings and court sessions

judge, prosecutor, defense, coordinator, supervision, treatment, law enforcement

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STAFFING

Treatment attends staffing
Recidivism ↓ 105%

Judge, prosecutor, defense attorney, treatment, program coordinator, and probation attends staffing
Recidivism ↓ 50% Costs Savings ↑ 20%

Defense attorney attends staffing
Recidivism ↓ 21%
Costs Savings ↑ 93%

Law enforcement is a member of the team
Recidivism ↓ 87%
Costs Savings ↑ 44%

Coordinator attends staffing
Recidivism ↓ 58%
Costs Savings ↑ 41%

Law enforcement attends staffing
Recidivism ↓ 67% Costs Savings ↑ 42%

NPC Research Key Components Study 2008

HEARINGS

Judge, prosecutor, defense attorney, treatment, program coordinator, and probation attends court sessions

Recidivism ↓ 35% Costs Savings ↑ 36%

Treatment attends court sessions

Recidivism ↓ 100% Costs Savings ↑ 81%

Law enforcement attends court sessions

Recidivism ↓ 83% Costs Savings ↑ 64%

Participants have status review sessions every two weeks in first phase

Recidivism ↓ 48% Costs Savings ↑ 23%

NPC Research Key Components Study 2008

JUDICIAL

Judge spends an average of 3 minutes or greater per participant during status review hearings

Recidivism ↓ 153% Costs Savings ↑ 36%

The judge was assigned to Treatment court on a voluntary basis

Recidivism ↓ 84% Costs Savings ↑ 4%

The judge's term is indefinite

Recidivism ↓ 35%

Costs Savings ↑ 17%

NPC Research Key Components Study 2008

Client Selection

Treatment court allows nondrug charges
Recidivism ↓ 95% Costs Savings ↑ 30%

Treatment court that excludes offenders with serious mental health issues
Recidivism ↓ 16% Costs Savings ↓ 50%

The time between arrest and program entry is 50 days or less
Recidivism ↓ 63%

Program caseload is less than 125
Recidivism ↓ 567%
Costs Savings ↑ 35%

Accept high risk/high need offenders
Recidivism ↓ 50%

NPC Research Key Components Study 2008

TREATMENT

Treatment communicates with court via email
Recidivism ↓ 119% Costs Savings ↑ 39%

Treatment court works with two or fewer treatment agencies
Recidivism ↓ 74% Costs Savings ↑ 19%

Treatment court offers gender specific services
Recidivism ↓ 20%

Treatment court has guidelines on frequency of individual treatment sessions a participant receives
Recidivism ↓ 52%

Treatment court offers mental health treatment
Recidivism ↓ 80%
Costs Savings ↑ 12%

NPC Research Key Components Study 2008

Promising Practices Related to Positive Outcomes in Drug Courts

Wraparound Services

Participants need additional support services such as anger management, educational assistance, relapse prevention

Wraparound Services

- Education & Distribution of Overdose Reversal Medication
- Housing Assistance
- Family Therapy
- Trauma Services
- Communication Skills
- Relapse Prevention
- Criminal Thinking Programs
- Clinical Case Management
- Programing to Resolve Interpersonal Conflict
- Medical & Dental Services
- Vocational Intervention

COMMENCEMENT

The minimum length of Treatment court is 12 months or more

Recidivism ↓ 57% Costs Savings ↑ 39%

In order to graduate participants must have a job or be in school

Recidivism ↓ 24% Costs Savings ↑ 83%

In order to graduate participants must have a sober housing environment

Recidivism ↓ 14%

Costs Savings ↑ 48%

NPC Research Key Components Study 2008

Drug Testing

Drug test results are back in 2 days or less

Recidivism ↓ 73% Costs Savings ↑ 68%

In the first phase, drug tests are collected at least 2 times a week

Recidivism ↓ 38% Costs Savings ↑ 61%

Participants are expected to have greater than 90 days clean before graduation

Recidivism ↓ 164%

Costs Savings ↑ 50%

NPC Research Key Components Study 2008

Promising Practices Related to Positive Outcomes in Drug Courts

Responses to Participant Behavior

Require clients to pay program fees

Require clients to complete community service

INCENTIVES & SANCTIONS

Sanctions are imposed immediately after noncompliant behavior

Recidivism ↓ 32% Costs Savings ↑ 100%

Team members given a copy of the guidelines for sanctions

Recidivism ↓ 55%

Costs Savings ↑ 72%

NPC Research Key Components Study 2008

Promising Practices Related to Positive Outcomes in Drug Courts

Training

Staff should participate in training prior program implementation

Judges should receive formal training

All team members receive training ASAP

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TRAINING

All new hires to Treatment courts complete a formal training or orientation

Recidivism ↓ 57%

Costs Savings ↑ 7%

NPC Research Key Components Study 2008

Promising Practices Related to Positive Outcomes in Drug Courts

Data Collection and Monitoring Data

Data maintained electronically

Programs participate in evaluations and use program statistics to make improvements

MONITORING & EVALUATION

EXIT INTERVIEWS

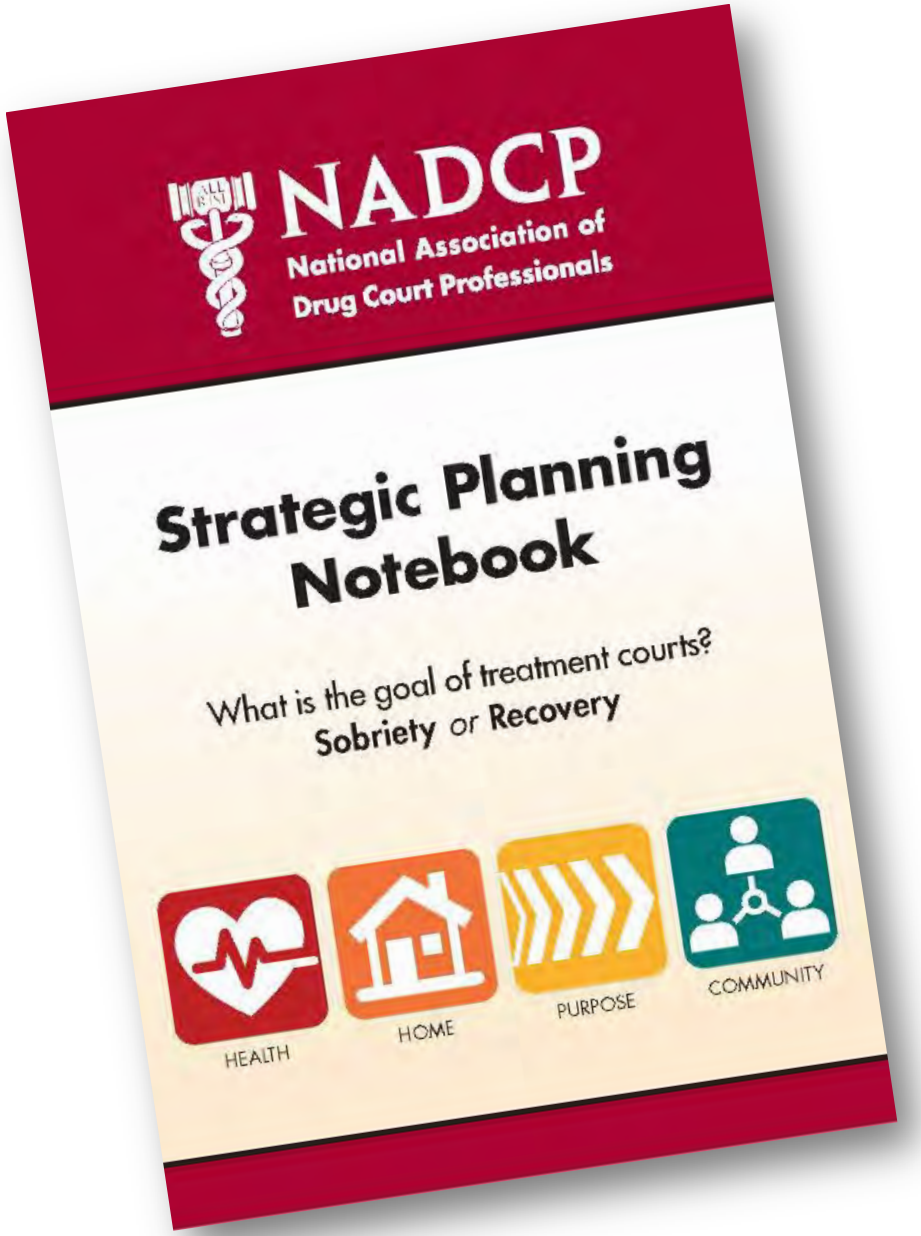
The results of program evaluations have led to modifications in treatment court operations

Recidivism ↓ 85% Costs Savings ↑ 100%

Review of the data and/or regular reporting of program statistics has led to modifications in treatment court operations

Recidivism ↓ 105% Costs Savings ↑ 131%

NPC Research Key Components Study 2008



Strategic Planning Notebook

Connect how the topic relates to recovery

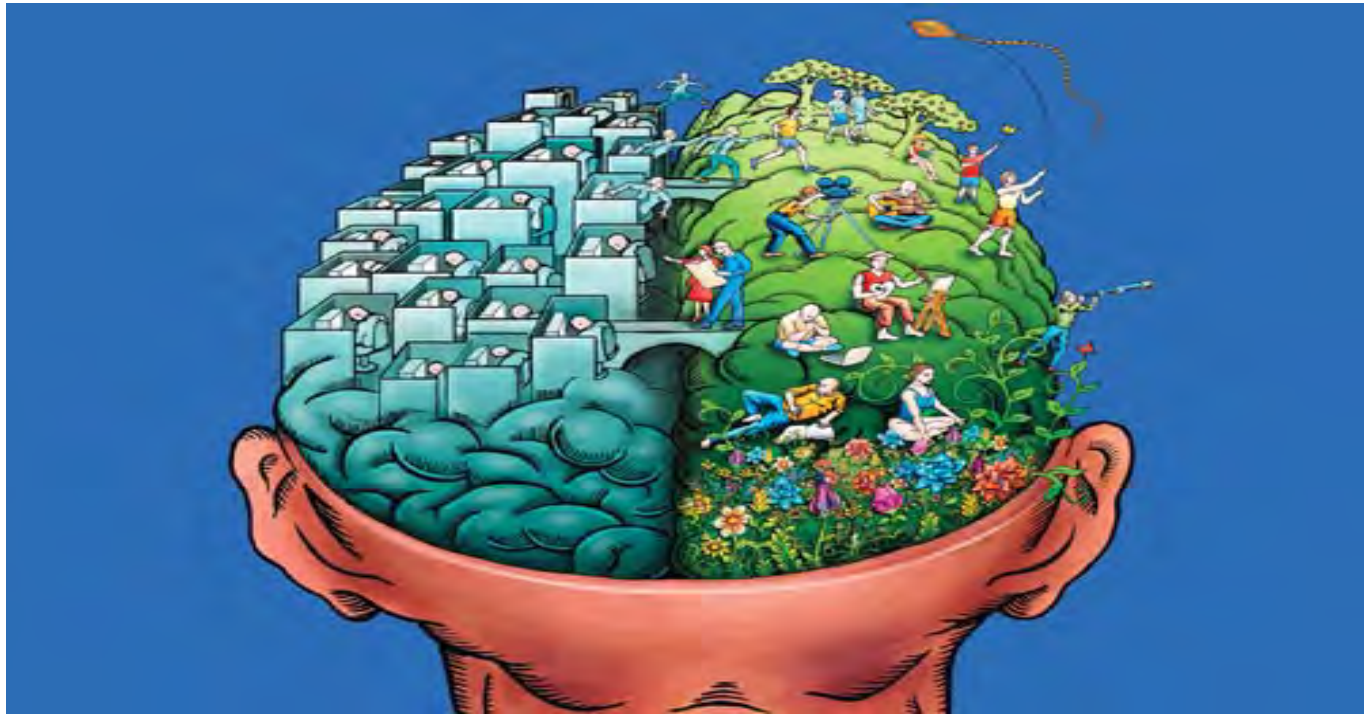
Write down these connections to recovery

Share ideas how to incorporate the topic into your program

May the FORSE be with Us:

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

Impact to Right and Left Hemisphere Talk



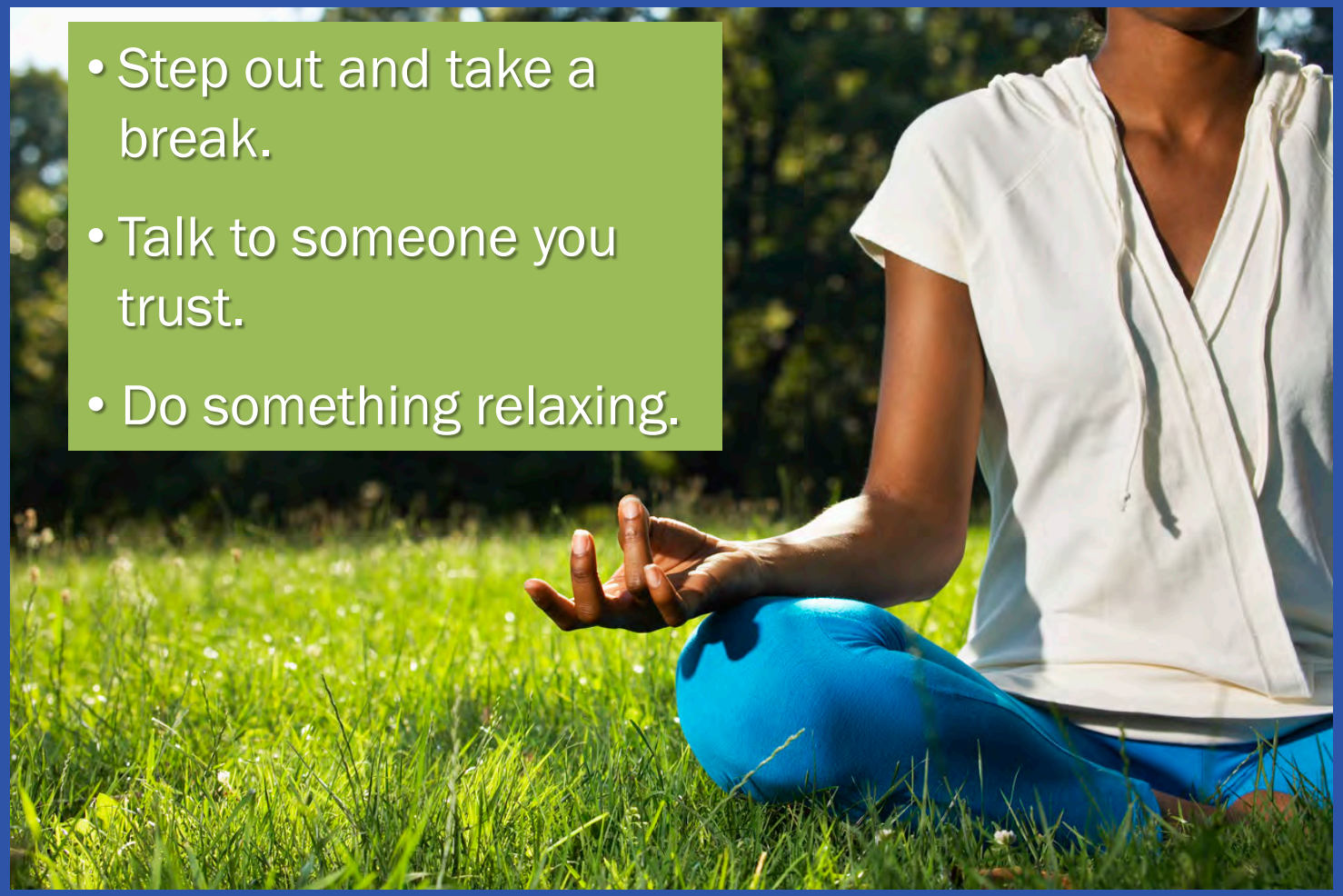
Look at the chart and say the COLOUR not the word

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

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.

Effects of Stress On Your Health
Toxic Stress
Poor Health
TOXIC
TOXIC
TOXIC
TOXIC
TOXIC
TOXIC

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

Mental health
disorders
undetected
Psychiatr
for more fac

Unloved
and
Unwanted

Exposure to Violence in Childhood

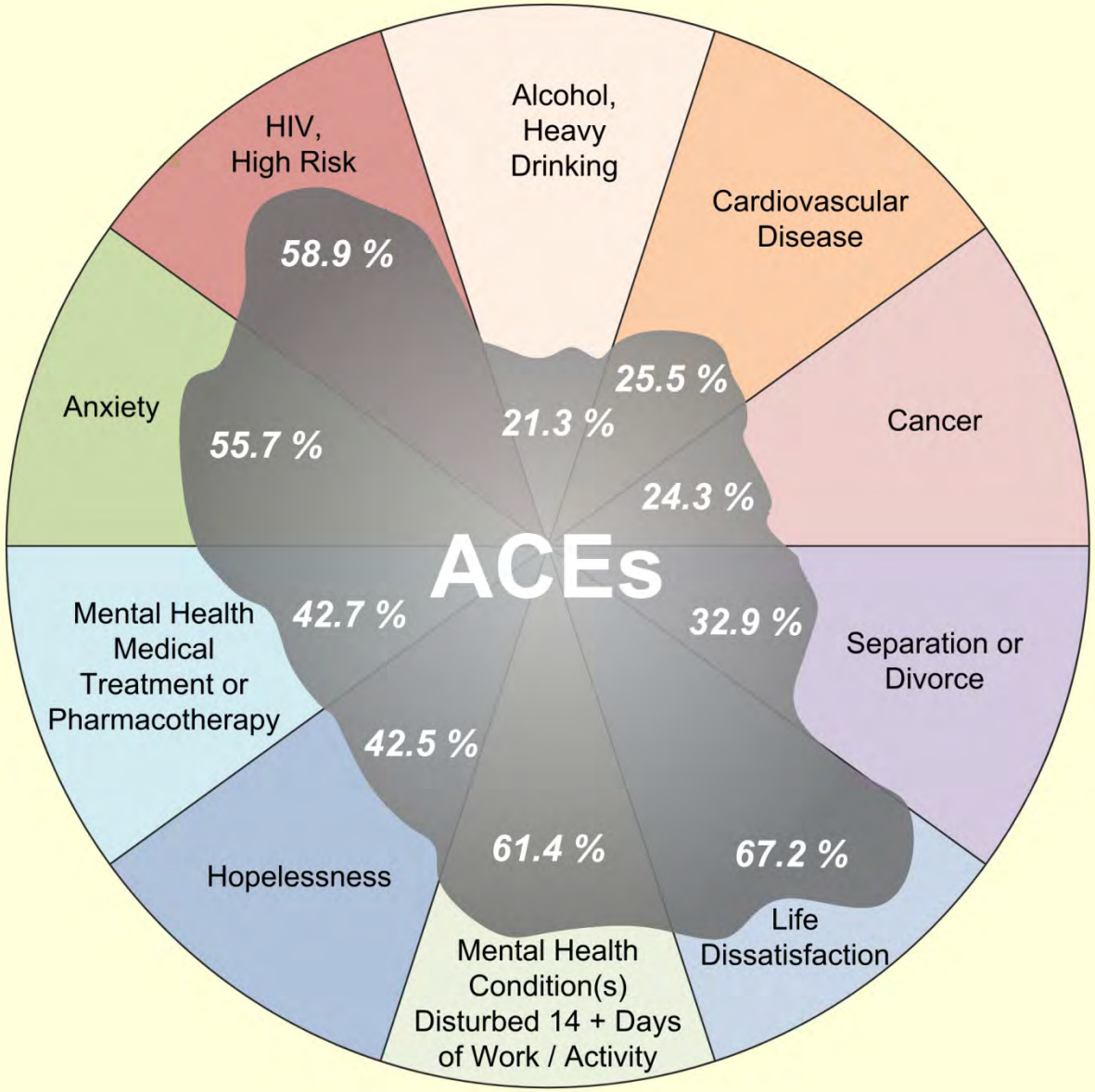
46 million of 76 million children are exposed to violence, crime and abuse each year

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.

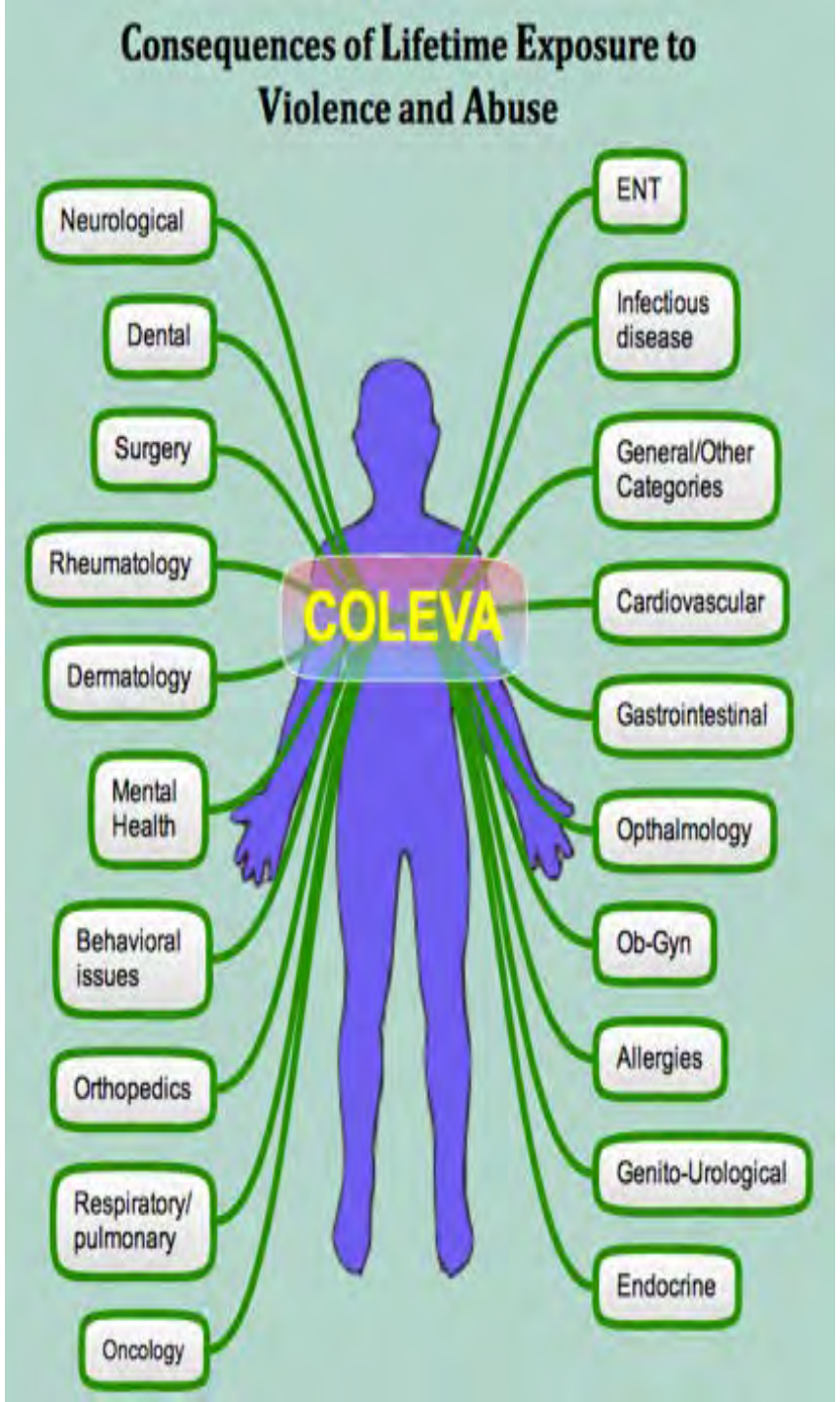
POPULATION ATTRIBUTABLE RISK

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



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

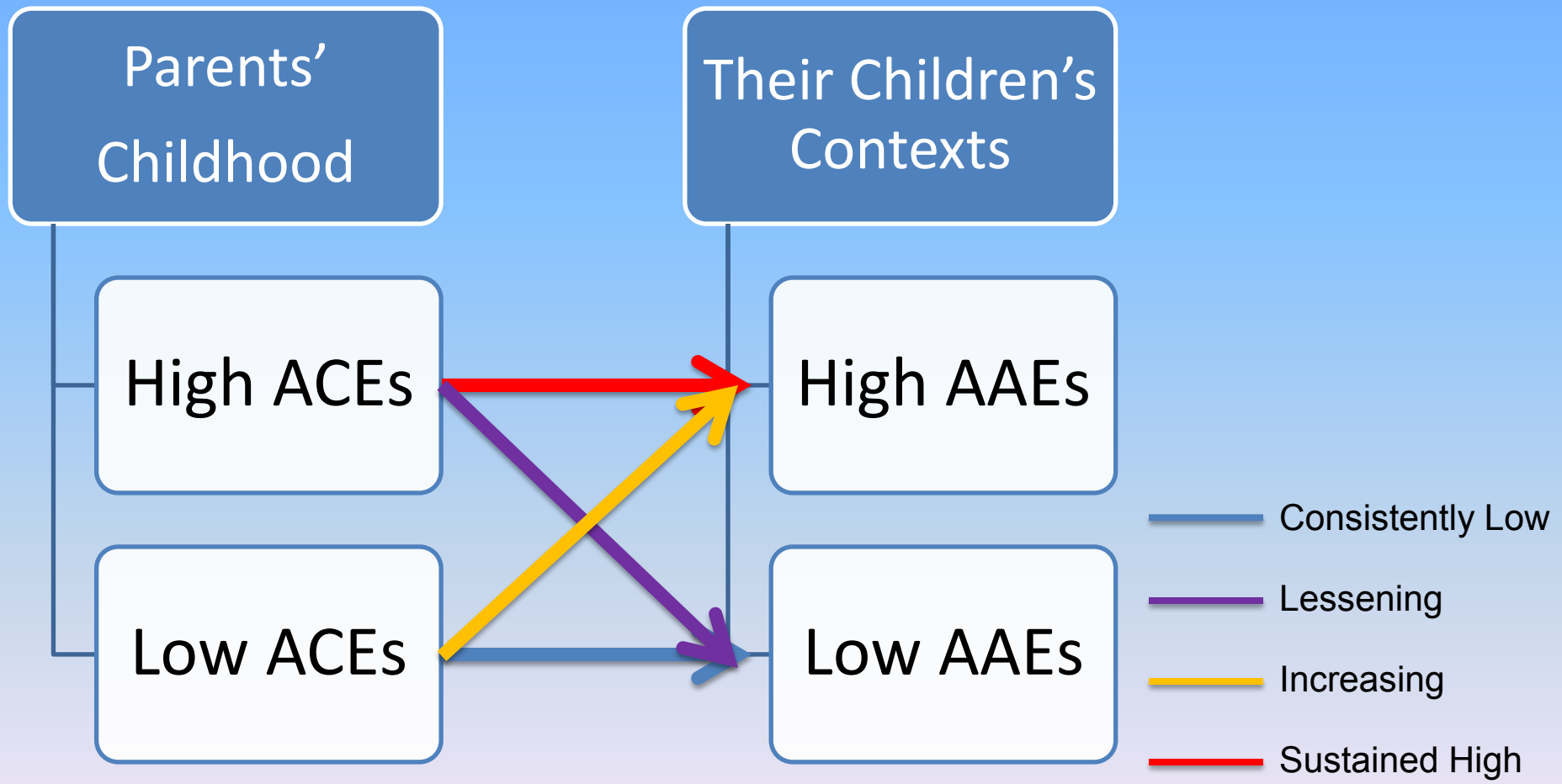
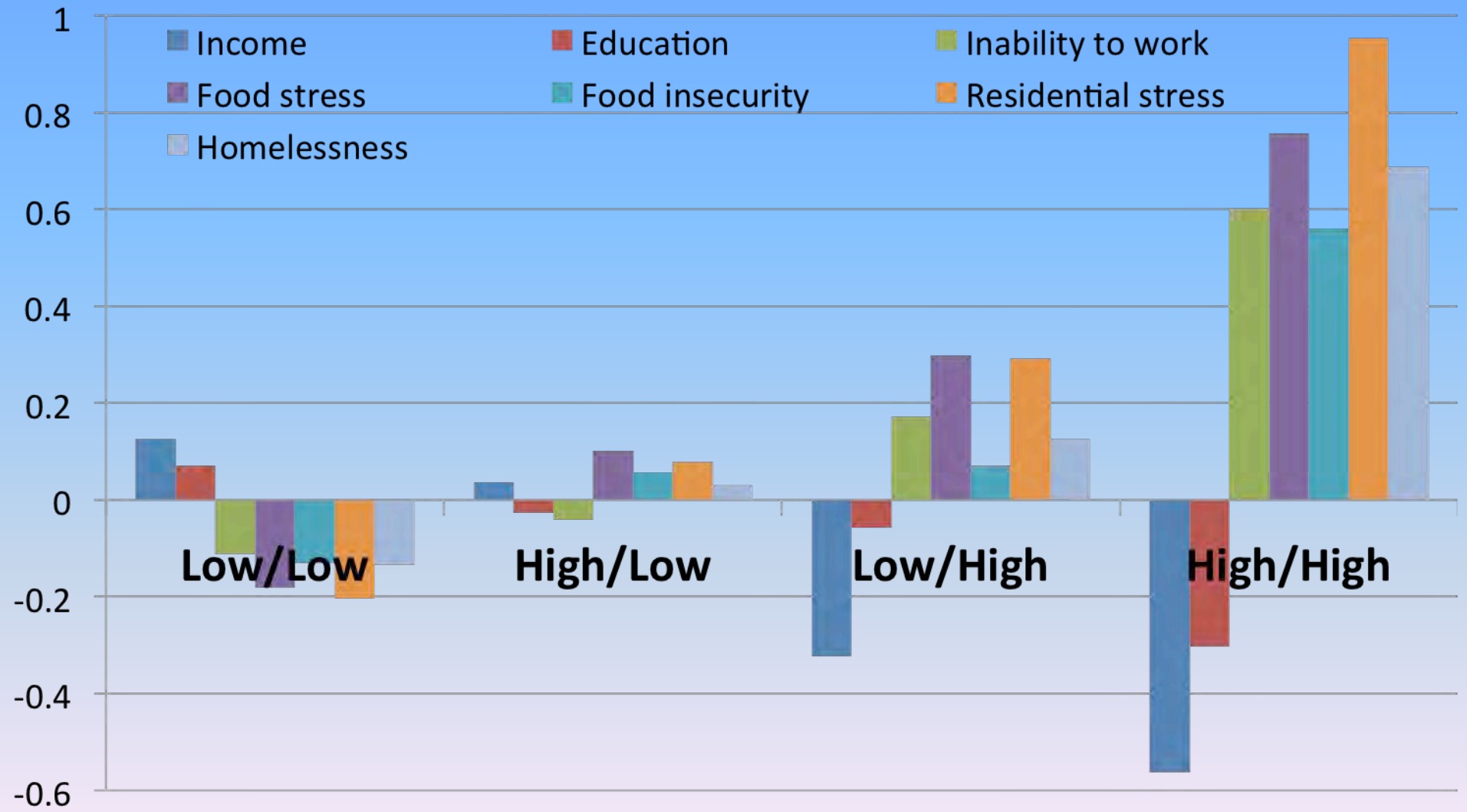
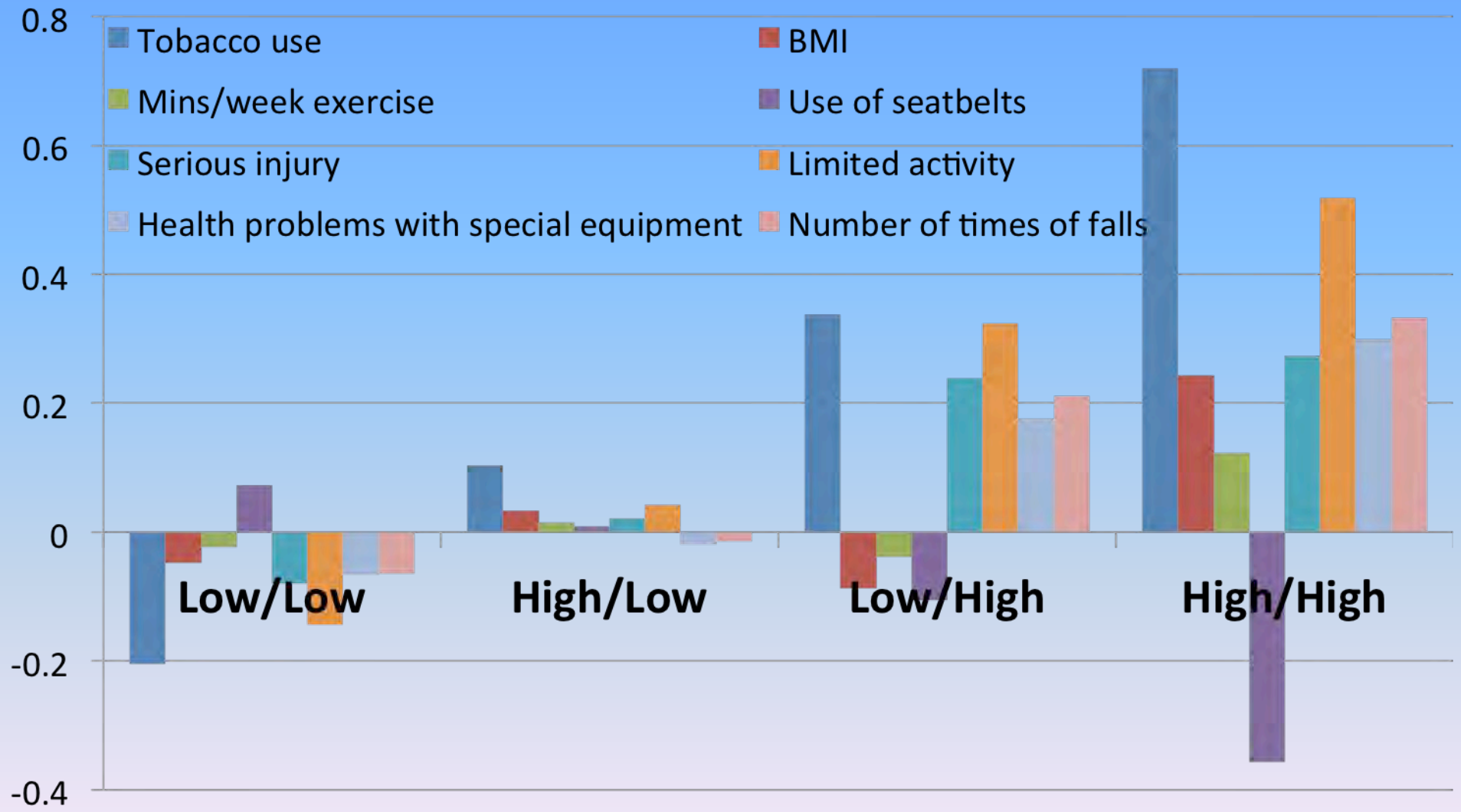


Figure 1. SES and Food/Housing Insecurity by Four Trajectories of Risk Groups



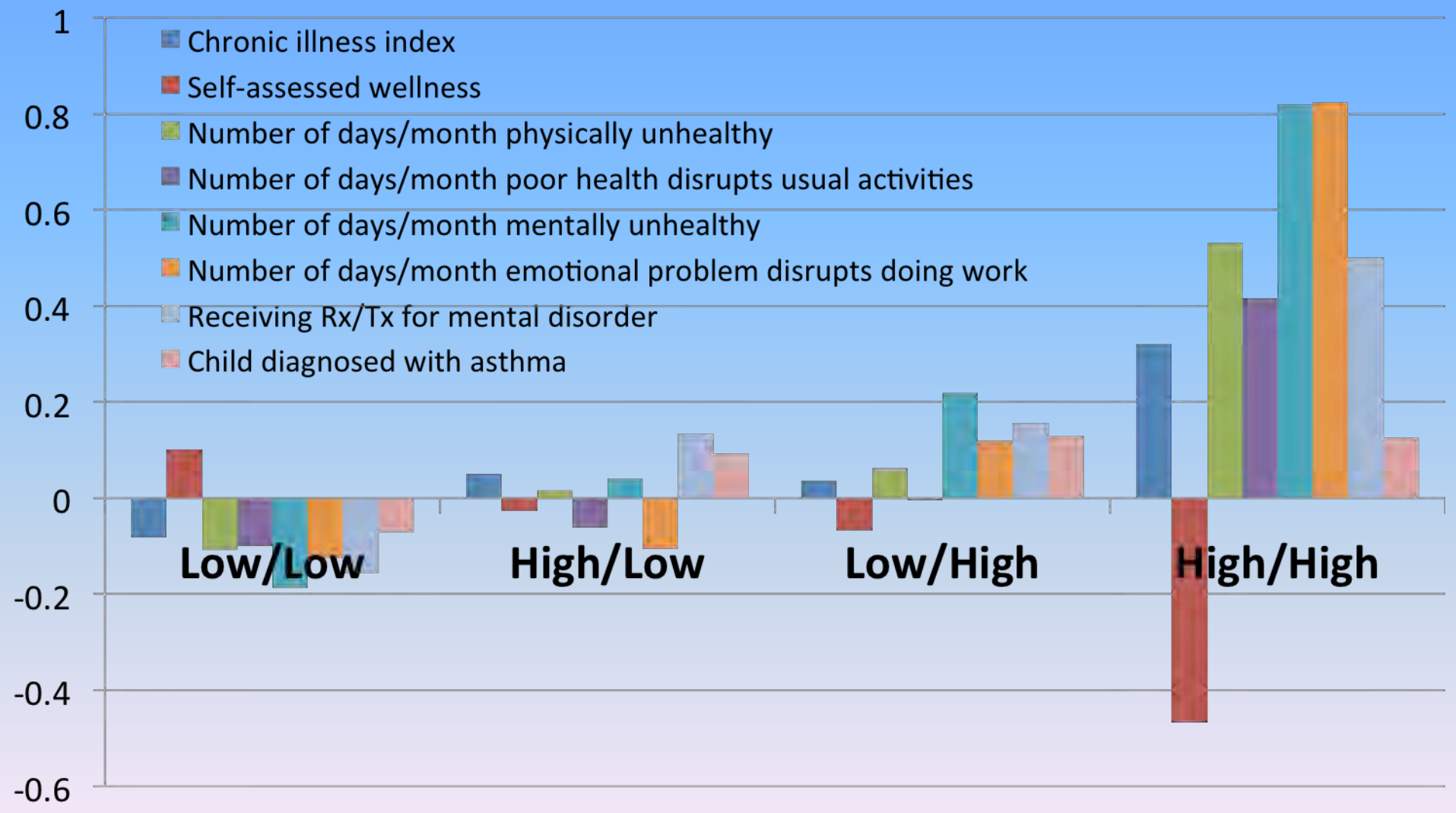
Note: All the indicators are standardized.

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



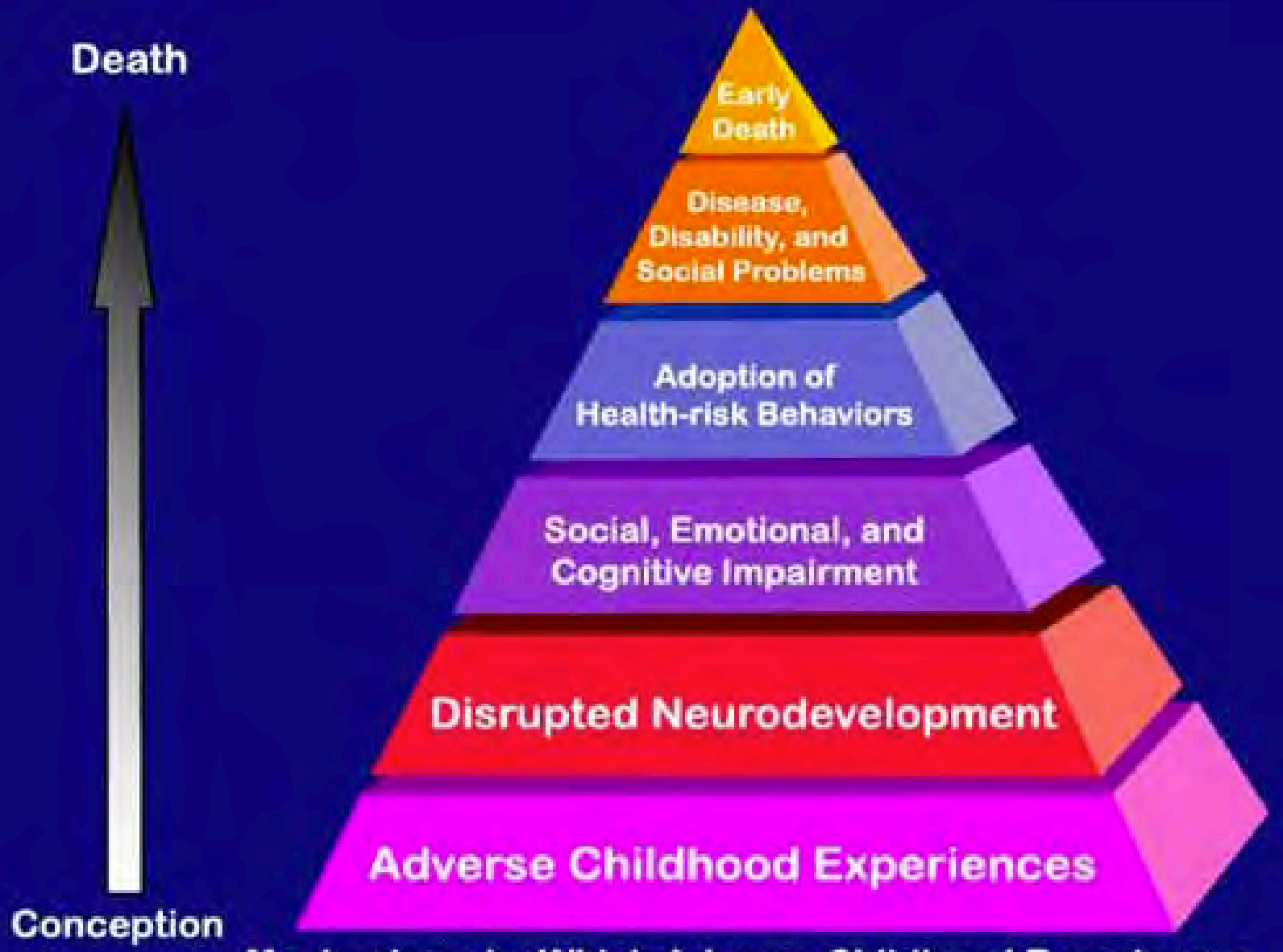
Note: All the indicators are standardized.

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



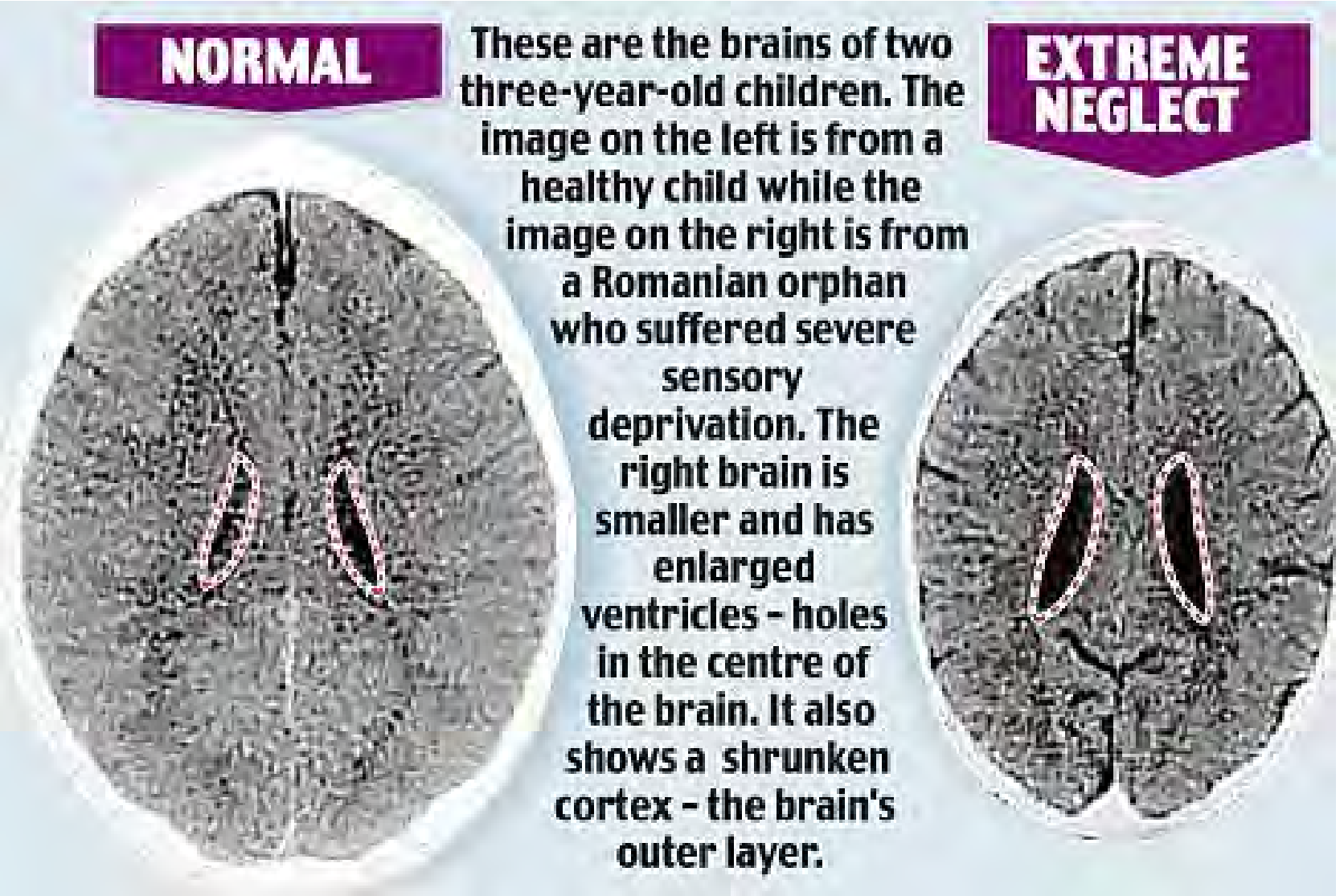
Listening to Our Youth

WHY DOES TRAUMA MATTER?



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

TRAUMA'S IMPACT ON THE BRAIN

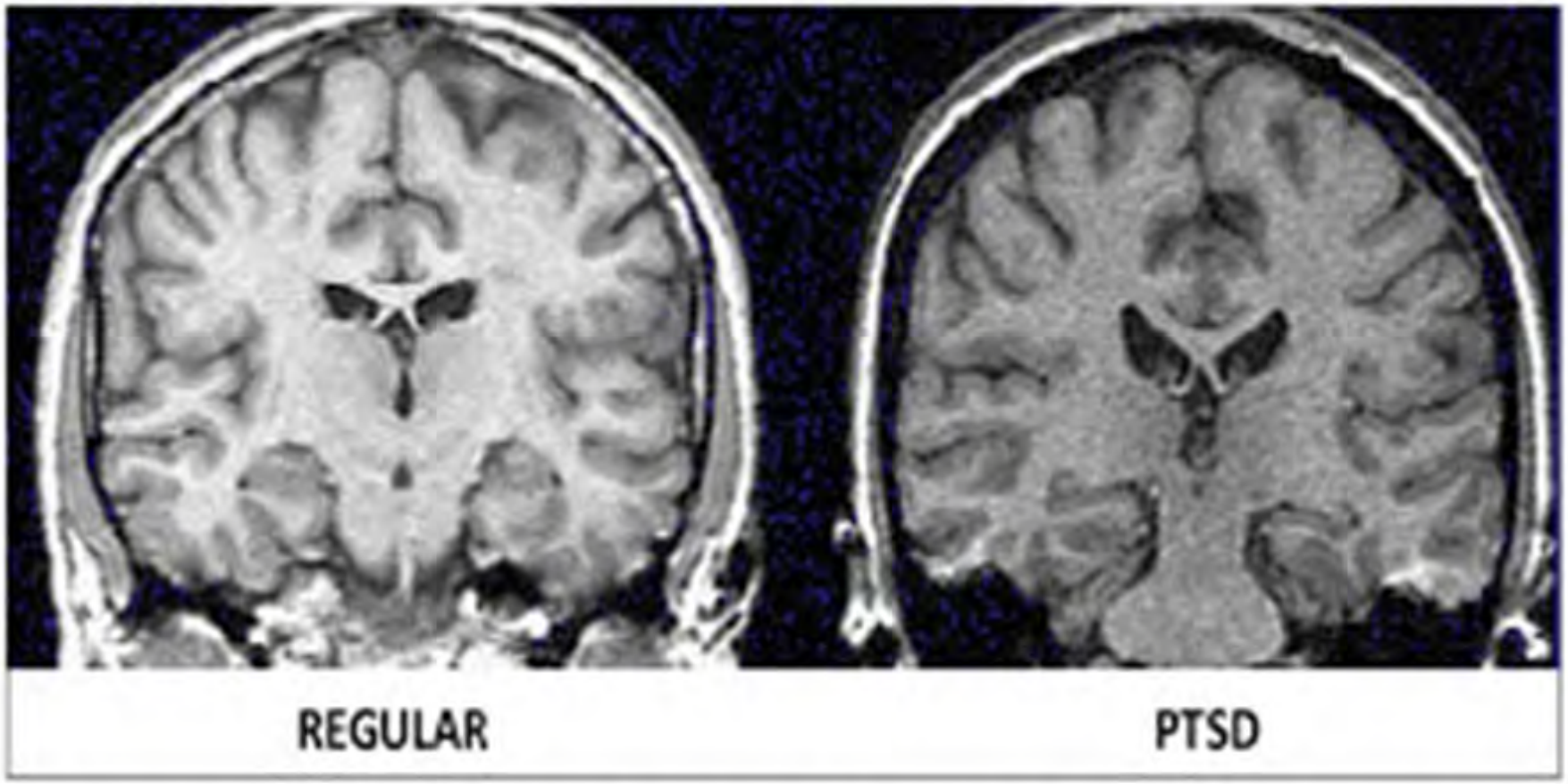

NORMAL
These are the brains of two three-year-old children. The image on the left is from a healthy child while the image on the right is from a Romanian orphan who suffered severe sensory deprivation. The right brain is smaller and has enlarged ventricles - holes in the centre of the brain. It also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

HOW STRESS CHANGES A CHILD'S BRAIN

3-YEAR-OLD CHILDREN

- 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



NOT A SOCIAL OR POLITICAL OPINION.

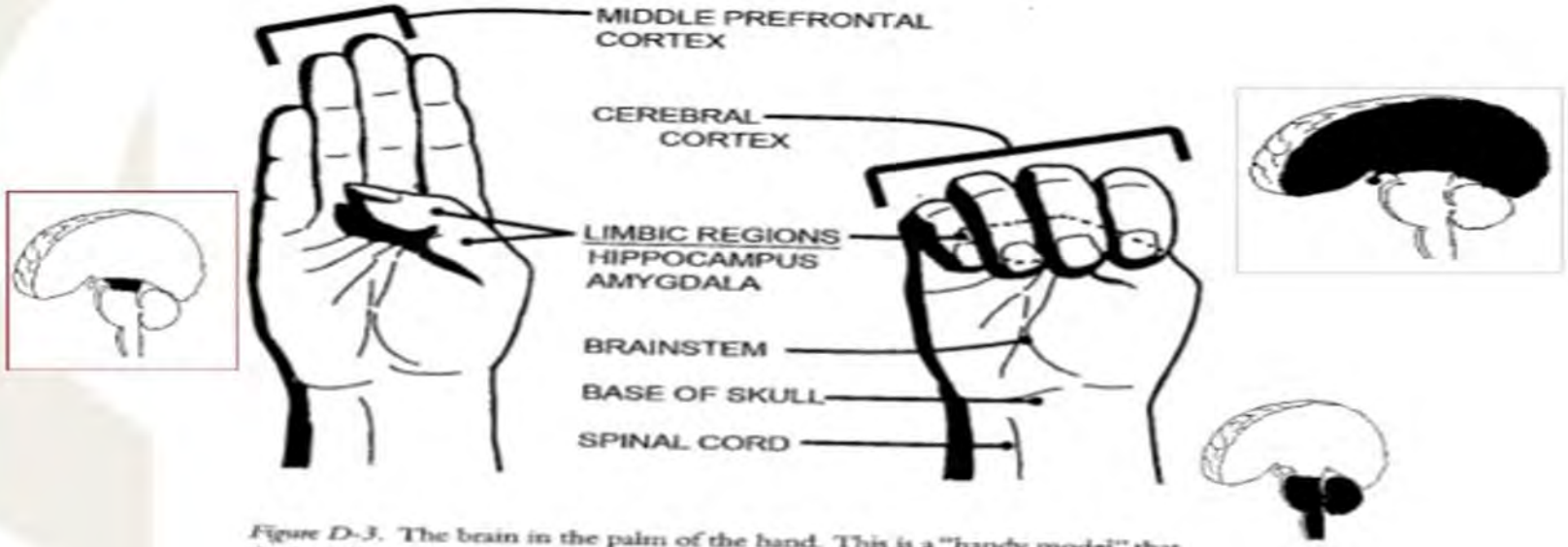
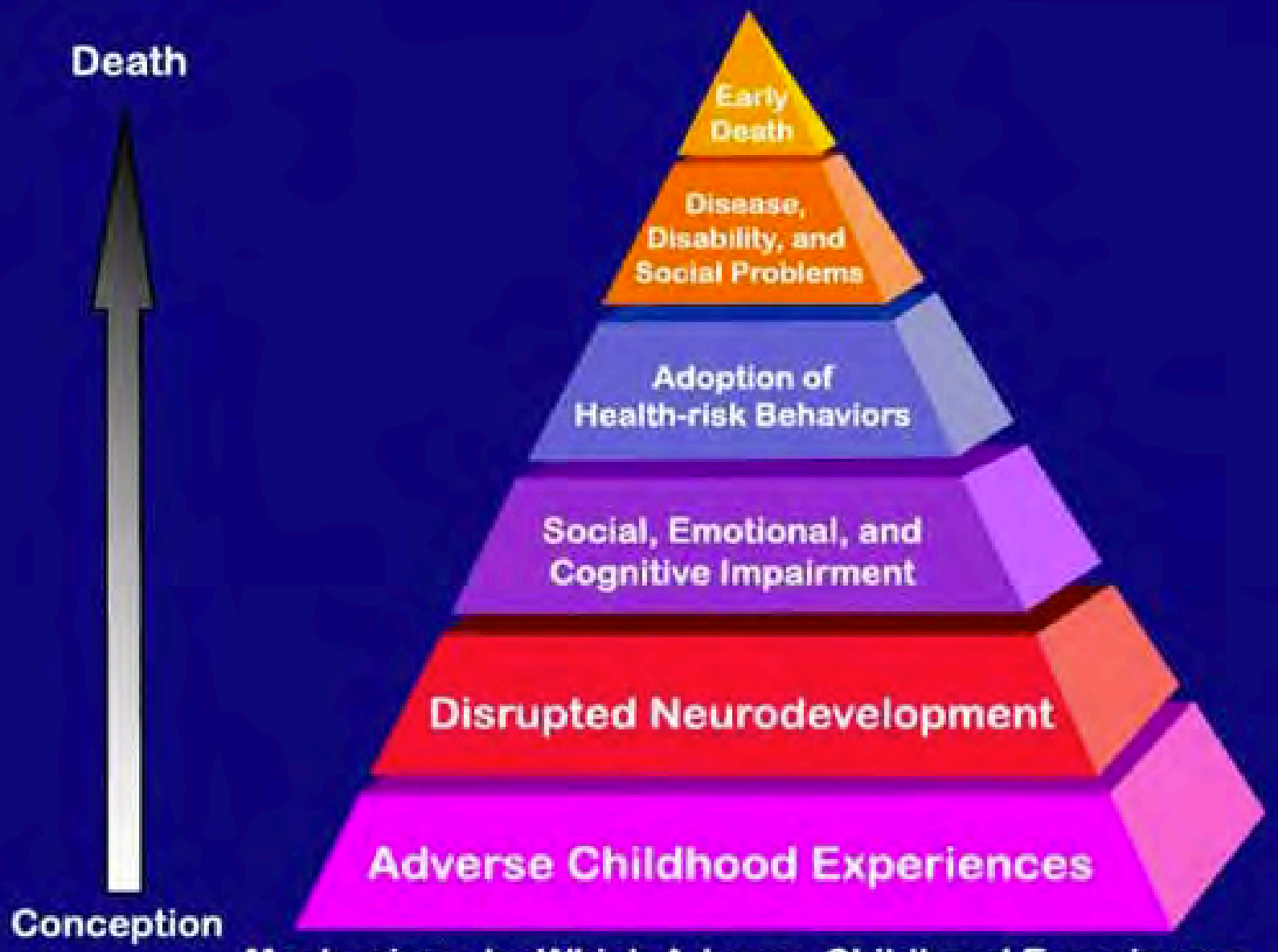


Figure D-3. The brain in the palm of the hand. This is a "handy model" that depicts the major regions of the brain: cerebral cortex in the fingers, limbic area in the thumb, and brainstem in the palm. The spinal cord is represented in the wrist. Please see text for explanation. Copyright © 2012 by Mind 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).

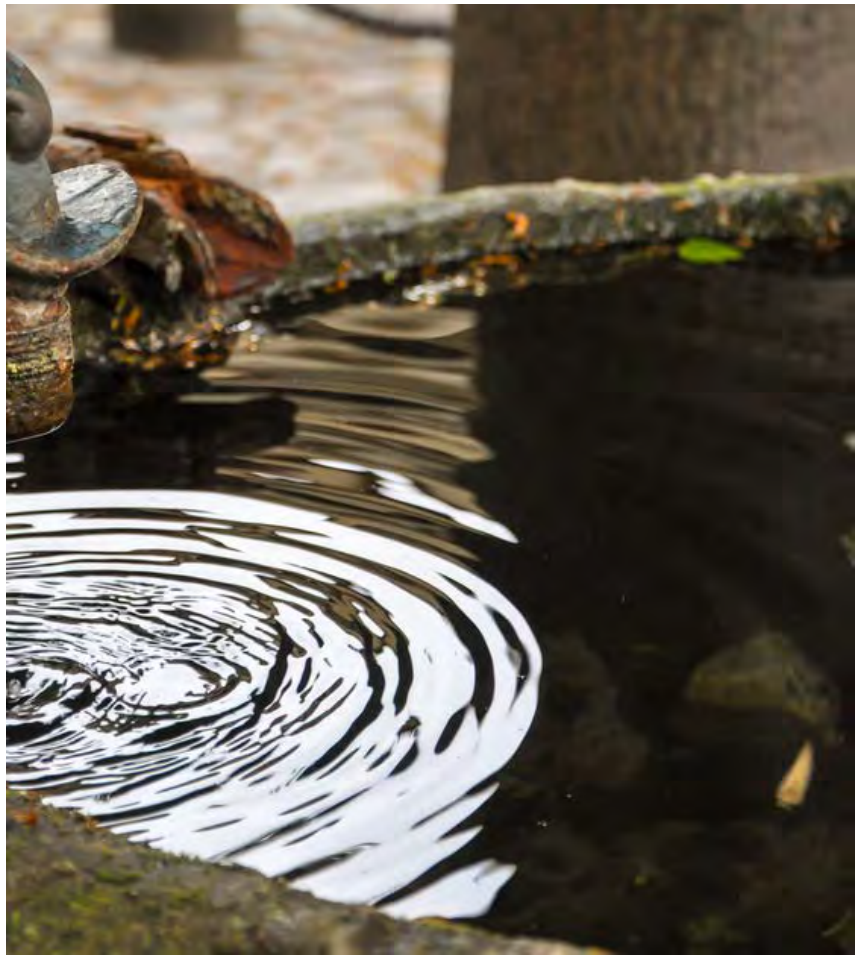


Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

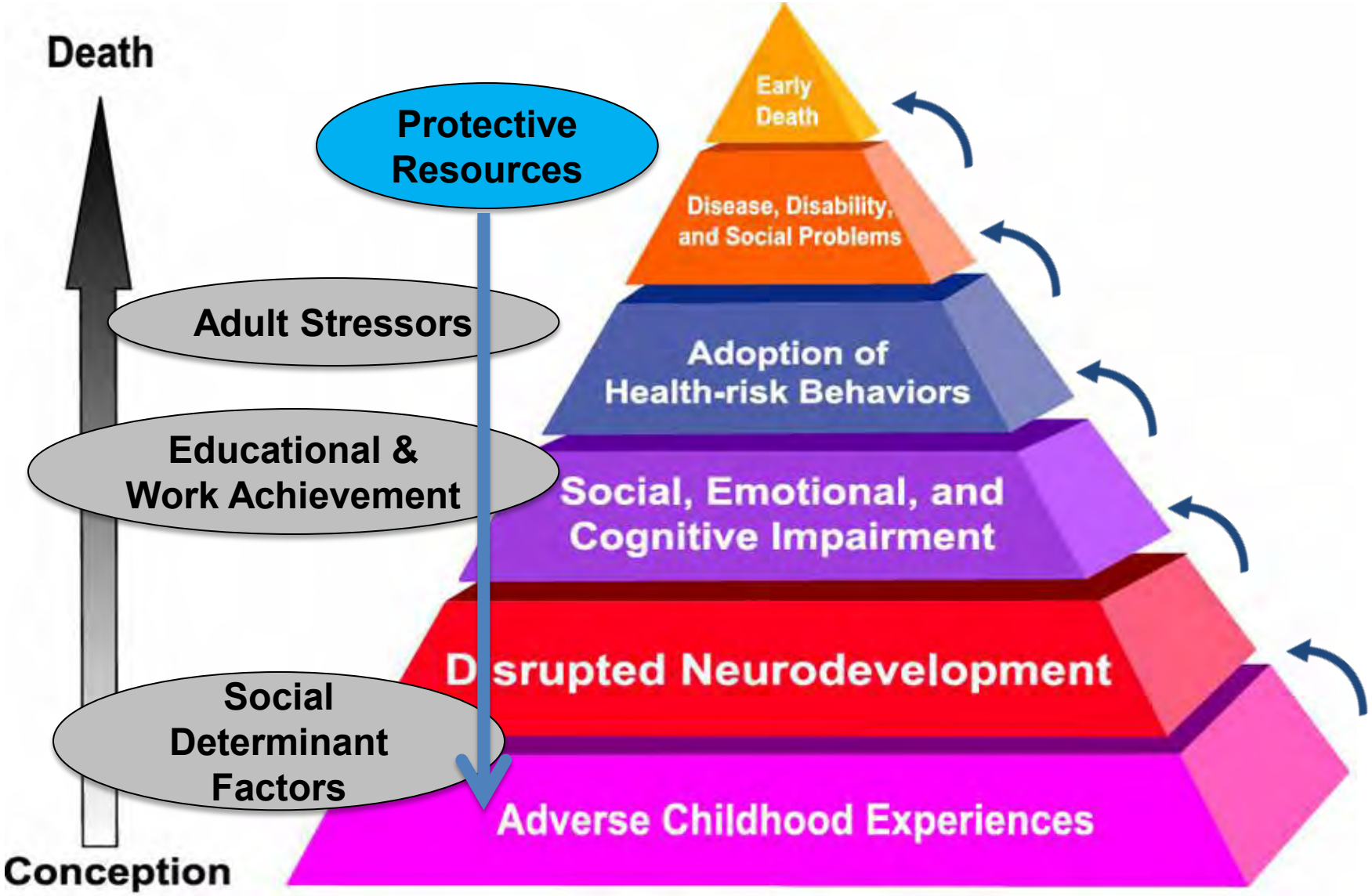
Respond to the need ….

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



Taken from: http://www.cdc.gov/ace/pyramid.htm

Resilience Trumps ACEs

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

Adapted from Blaustein & Kinniburgh (2010) Treating Traumatic Stress in Children and Adolescents

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

Adapted from Blaustein & Kinniburgh (2010) Treating Traumtic Stress in Children and Adolescents

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”

Brené Brown. Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead. Gotham Books, 2012. (287 pages)

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

Brené Brown. Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead. Gotham Books, 2012. (287 pages)

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)

Brené Brown. Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead. Gotham Books, 2012. (287 pages)

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?

Brené Brown. Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead. Gotham Books, 2012. (287 pages)

Resil

www

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

www.Resiliencetrumpsaces.org

Showing Resilient Cards

www.Resiliencetrumpsaces.org

Showing Resilient Cards

www.Resiliencetrumpsaces.org

Show Resilient Cards

www.Resiliencetrumpsaces.org

Resilience Cards

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

www.Resiliencetrumpsaces.org

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

www.Resiliencetrumpsaces.org

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

www.Resiliencetrumpsaces.org

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

www.Resiliencetrumpsaces.org

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

Adverse Childhood Experiences
EMOTIONAL NEGLECT
Adverse Childhood Experiences
CHILD EMOTIONAL ABUSE
Adverse Childhood Experiences
CHILD PHYSICAL ABUSE
Adverse Childhood Experiences
PHYSICAL NEGLECT
Adverse Childhood Experiences
CHILD SEXUAL ABUSE
Adverse Childhood Experiences
DRUG ADDICTED OR
ALCOHOLIC FAMILY MEMBER
Adverse Childhood Experiences
INCARCERATION OF
A FAMILY MEMBER
Adverse Childhood Experiences
MENTALLY ILL, DEPRESSED
OR SUICIDAL FAMILY MEMBER
Adverse Childhood Experiences
LOSS OF A PARENT TO
DEATH OR ABANDONMENT
Adverse Childhood Experiences
WITNESSING DOMESTIC
VIOLENCE AGAINST MOTHER

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

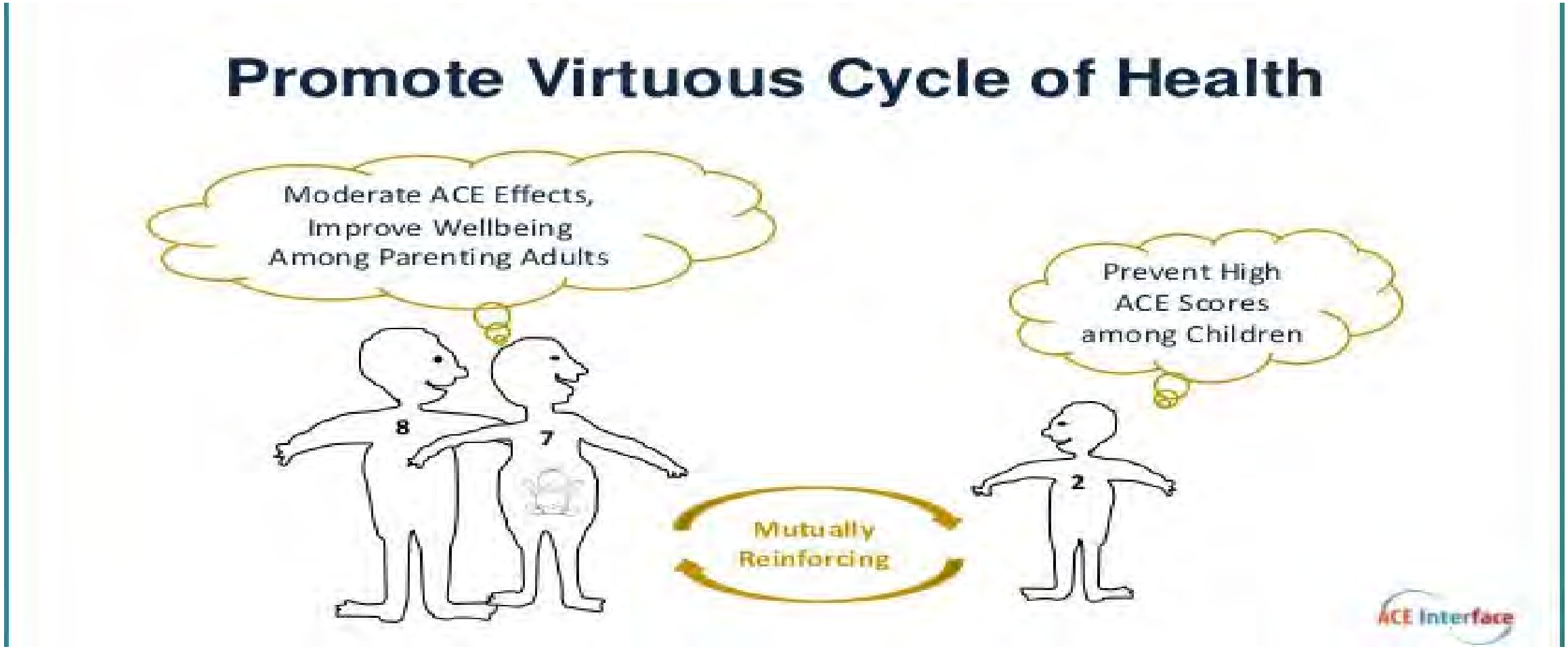
“It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The **credit belongs to the man who is actually in the arena**, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes 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

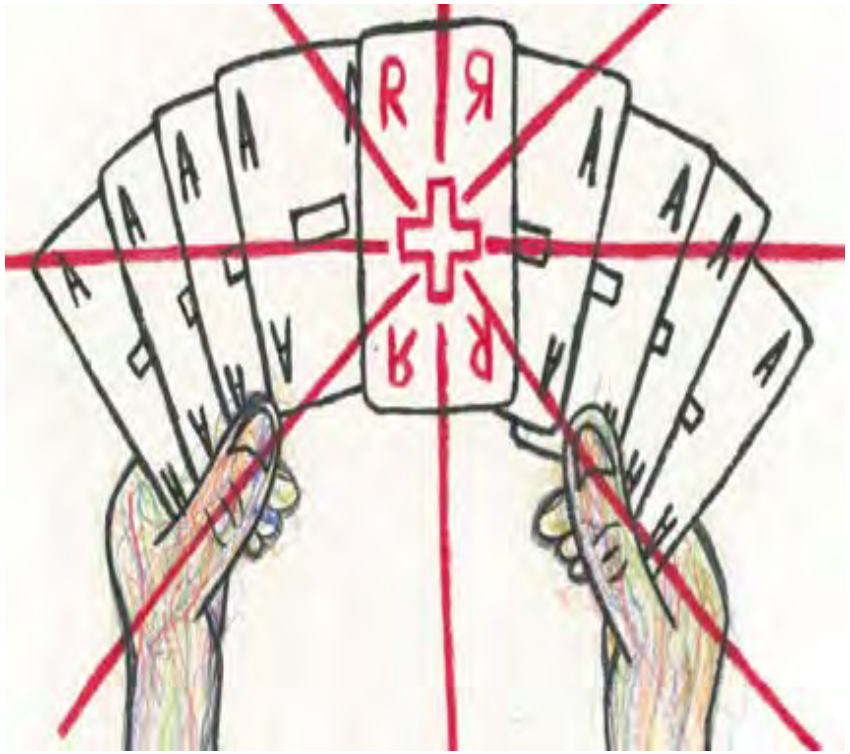


All roads lead to
Resilience
Healthy family
ROAD TO
PARENTAL RESILIENCE
Physical & emotional neglect
ROAD TO
SOCIAL CONNECTIONS
Mentally ill, drug/alcoholic family member
ROAD TO
CONCRETE SUPPORTS
Loss of Parent or Incarcerated Parent
ROAD TO
KNOWLEDGE OF PARENTING & CHILD DEVELOPMENT
Physical, emotional & 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-**E**motional



Children's Resilience Initiative

♥ Resilience TRUMPS ACEs ♠

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

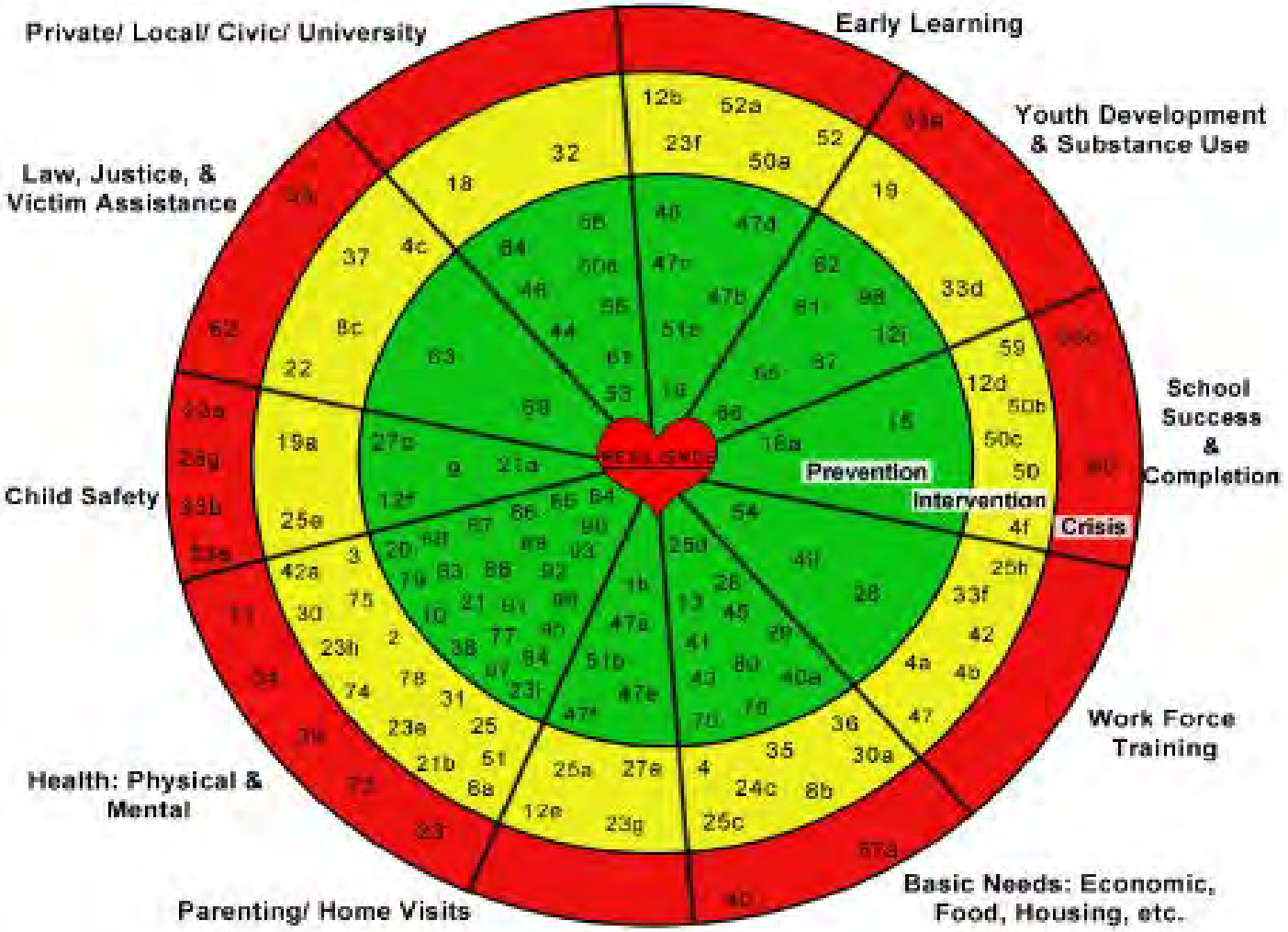
Find us on Facebook

Children's Resilience Initiative - Resilience Trumps ACES

Like

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

Walla Walla organizations that build resilience

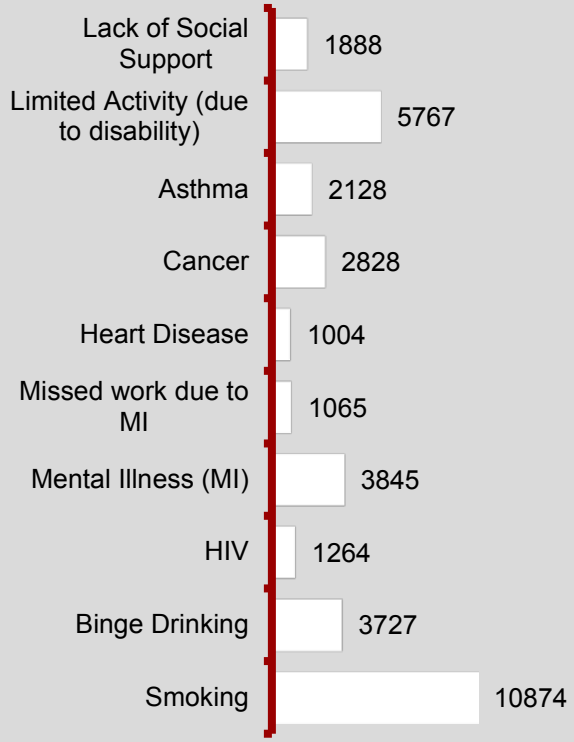


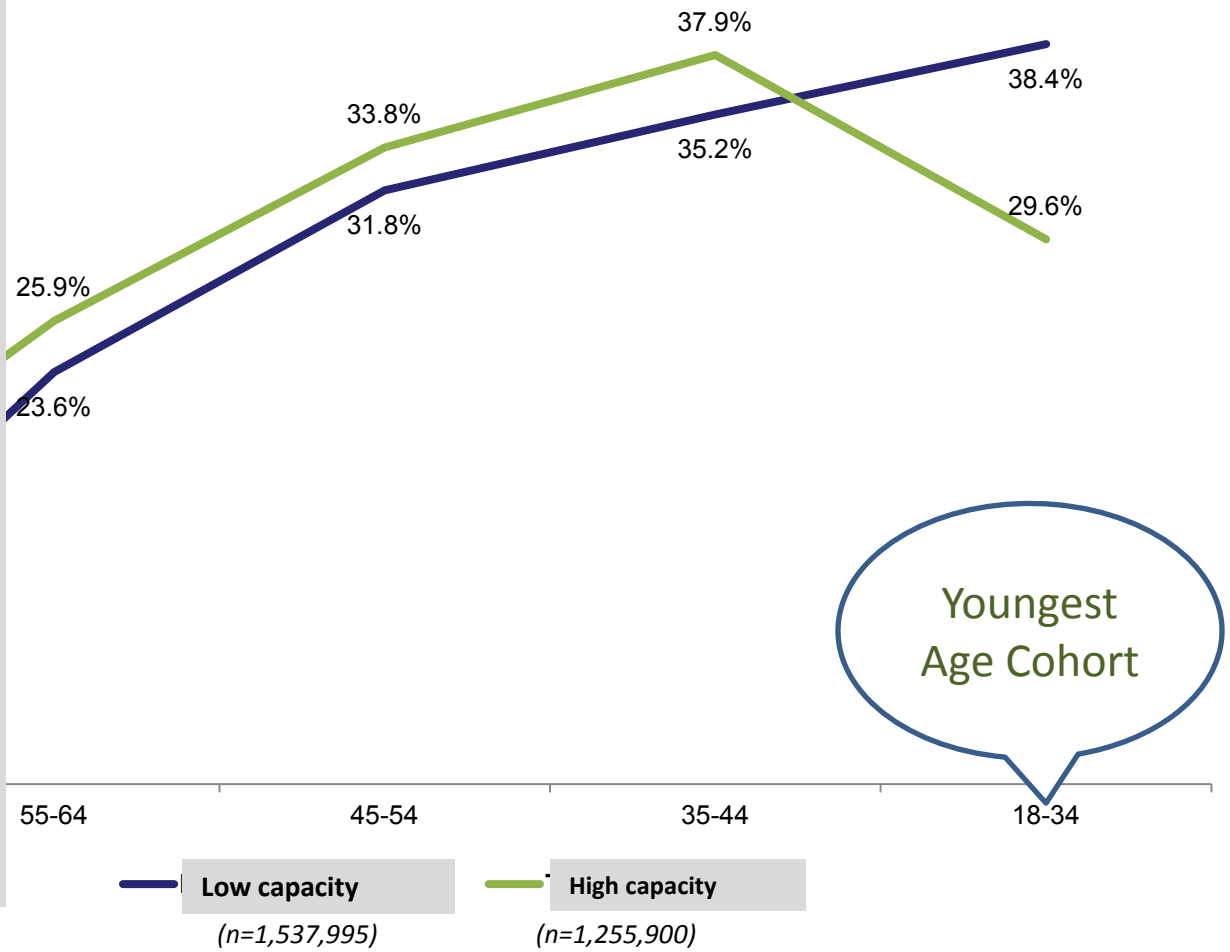
FAMILY • POLICY • COUNCIL
A FAMILY, COMMUNITY & STATE PARTNERSHIP

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

Kansas City
Turn the Page Campaign

By lining up commitments from the community, Turn the Page KC motivates individuals and businesses to tackle issues in its four focus areas:

(1) summer learning,

(2) school attendance,

- EX: chronic absences reduced by 85.7% in some schools who have applied the model

(3) school readiness, and

(4) community engagement.

Since 2011, 3rd grade reading scores have improved city-wide, the number of students attending quality summer programs has quadrupled, and the number of chronically absent students has dropped.

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.

Iowa – Approaching Wellness with ACEs

- New Patient Records for 9 month well exams

NCQA Requirements for a Patient-Centered Medical Home

- Enhance Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Provide Self-Care and Community Support
- Track and Coordinate Care
- Measure and Improve Performance

  www.ncqa.org

Example of Iowa EPSDT Care for Kids Health Maintenance Recommendations for Doctors

- Example of new Patient Form

Trauma in the Health Care Setting

- Injuries
- Illnesses
- Preventive Health Care

Blank Children's Hospital
UnityPoint Health

What Trauma Sounds Like in a Health Care Setting

Blank Children's Hospital
UnityPoint Health

The Patient

- "I thought I was going to die. I was so scared because my mom was not there."
- "Doctors crowded around and stuck stuff on me. They cut my clothes off. I didn't know what was happening"
- "I'm afraid to do many of the things I used to do."
- "Even now some things bring it all back. Some smells – like the smell of metal pipes. I only need one thing to happen and then the day is practically useless."

Source: Center for Pediatric Traumatic Stress, Children's Hospital of Philadelphia

What Trauma Sounds Like in a Health Care Setting

Blank Children's Hospital
UnityPoint Health

The Family

- "I saw my son lying in the street, everyone around him. It was a horrible scene. I thought I was dreaming."
- "We went from taking our child to the family doctor thinking she had the flu, but by the end of the day we were in the PICU and she was covered with needles, tubes and monitors."
- "For a long time, we were so afraid of everything. Afraid he was going to die, afraid he wouldn't have a normal life."

Source: Center for Pediatric Traumatic Stress, Children's Hospital of Philadelphia

What Trauma Sounds Like in a Health Care Setting

Blank Children's Hospital
UnityPoint Health

The Health Care Professional

- "She is the same age as my daughter."
- "The day was absolutely insane. We saw twice the number of patients as normal."
- "I felt so frustrated and wished there was more that we could do."
- "What were they thinking? Why on earth would you not wear a seat belt?"

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

Blank Children's Hospital
UnityPoint Health

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

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UnityPoint Health

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

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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
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VIRGINIA DUI DRUG TREATMENT COURT DOCKETS TRAINING CONFERENCE

The 3 Legged Stool

BALANCING COMMUNITY SUPERVISION, TREATMENT AND TECHNOLOGY TO REDUCE DWI RECIDIVISM

Presenters

Mark Stodola: Probation Fellow, American Probation and Parole Association

Jacquie Sheehey: Director of Marketing and S.M.A.R.T. Mobile Solutions, Smart Start

Learning Objectives

- Identify 3 ways in which alcohol DETECTION technologies can be matched with offender risk
- Understand how assessment tools impact decision making for treatment
- Identify at least 3 strategies to promote effective collaboration among supervision, technology and treatment providers

The Impact Drunk Driving Has On All

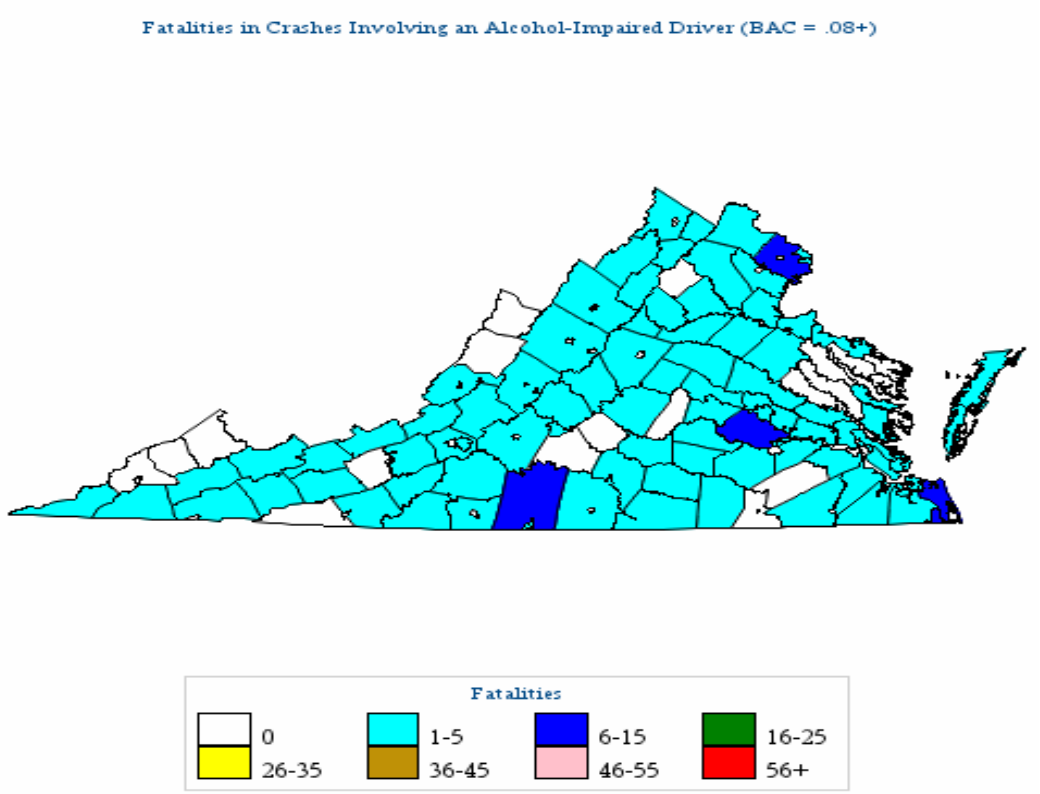
The Realities of Drunk Driving…..

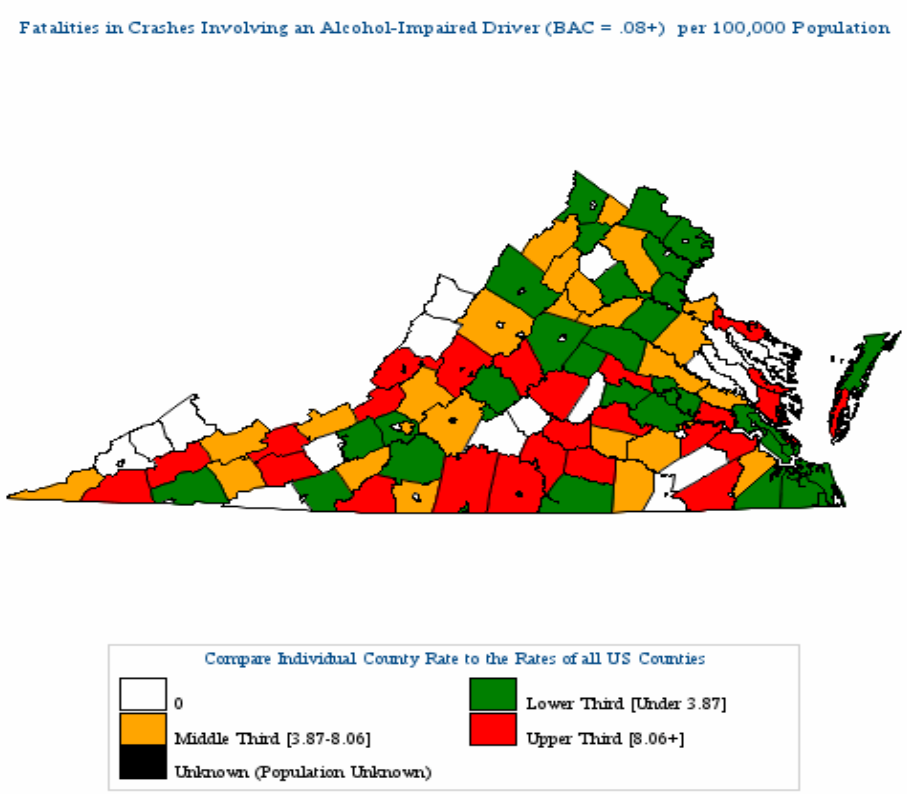
- 2015: 67% of the 10,265 alcohol-impaired driving fatalities had at least one driver with a BAC of .15 g/dL or higher
- 2014-2015: 3.2% increase in alcohol-impaired driving fatalities
- 2015: largest increase in traffic deaths since 1966, and
- 2016: **estimates for the first half of year show an increase of about 10.4%** compared to the number of fatalities in the first half of 2015

Virginia DWI Fatalities

	2011	2012	2013	2014	2015
Alcohol-Impaired Driving Fatalities (BAC=.08+)*	228 (30%)	209 (27%)	263 (36%)	216 (31%)	208 (28%)

Virginia DWI Fatalities by County





Other Virginia Statistics

DWI fatalities represent 28% of all traffic fatalities in Virginia. National average is 29%

3.7% increase in total traffic fatalities from 2014

DWI Arrests- 20,477

Percent of Alcohol-Impaired Driving Fatalities Involving high BAC drivers (.15+)-69.8

4,708,100 individuals under community supervision in 2014

15% of this probation population have been convicted of DWIs

8% of the probation population have been convicted of multiple DWIs

Approximately two thirds of individuals under community supervision are drug or alcohol-involved

Good News!

Americans' roads are safer today as a result of the massive public awareness and enforcement campaigns that begun in the early 1980's

- Alcohol-related traffic fatalities has declined by 1/2 since 1982
- Recidivism rate for drunk drivers declined from 33% to 25% from 1995 to 2011

NHTSA Traffic Safety Facts Research Note (March 2014)

What about the remaining 33%?

What are the unique challenges to supervising the other 1/3 of impaired drivers?

The Three Essential Elements of Effective Supervision

1. **Monitor** supervisee behavior and compliance
2. **Enforce** conditions of supervision
3. **Assist** supervisees to change their behavior

Sentencing the Impaired Driver

"Controlling and preventing drunk driving is complex, requiring a variety of interrelated alcohol and therapeutic activities that are often directed toward the behavioral and cultural attributes of alcohol consumption."

- Michigan DWI/Sobriety Court Ignition Interlock Evaluation Report (2016)

What Works in the Assessment and Supervision of Impaired Drivers?

Major Risk Areas of DWI Recidivism

1. Prior involvement in the justice system specifically related to impaired driving
2. Prior non-DWI involvement in the justice system
3. Prior involvement with alcohol and other drugs (AOD)
4. Mental health and mood adjustment problems
5. Resistance to and non-compliance with current and past involvement in the justice system

Supervision That…

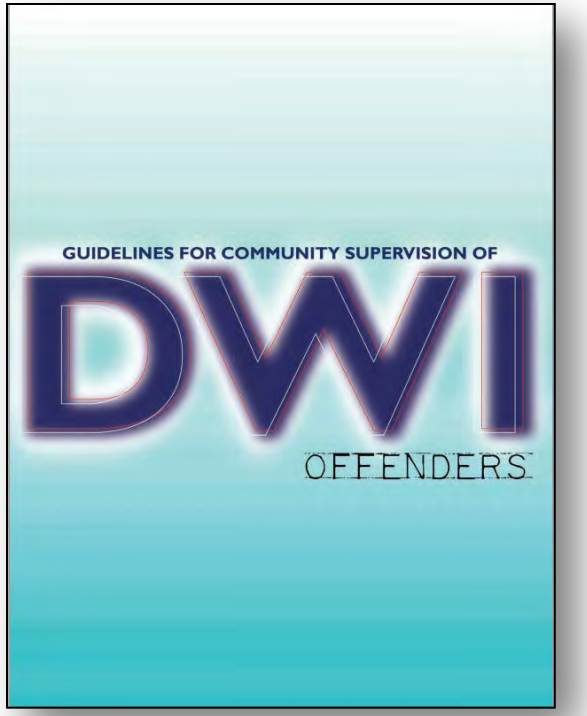
- Places focus on the person, not the charge

- Addresses criminogenic needs
  - The Big Four
  - The Next Four

Assessments

- **ADS** (Alcohol Dependence Scale)
- **ASUDS-R** (Alcohol Substance Use and Driving Survey – Revised)
- **ASI** (Alcohol Severity Index)
- **AUDIT** (Alcohol Use Disorders Identification Test)
- **IDTS** (Inventory Drug-Taking Situations)
- **DAST** (Drug Abuse Screening Test)
- **LSI-R** (Level of Service Inventory-Revised)
- **MAST** (Michigan Alcoholism Screening Test
- **SASSI** (Substance Abuse Subtle Screening Inventory)
- **RIASI** (Research Institute on Addiction Self Inventory
- **IDA** (Impaired Driver Assessment)
- **CARS** (Computerized Assessment and Referral System)

Supervision-What works?



Guideline 4

Where possible, develop partnerships with programs, agencies, and organizations in the community that can enhance and support the supervision and treatment of DWI offenders.

Supervision That Includes Technology

What Do We Know or Need to Know About Technology?

- Alcohol monitoring tools are truly situation-based as to which ones should be in your toolbox
- If we aren't using alcohol monitoring with our clients, how do we know they are staying sober?
- Supervision +Treatment + Tools work with appropriate tools based on risk level of client
- Budgetary constraints play a factor

Consider this . . . .

- How many use alcohol monitoring technology based on risk level?
- Do you have more than one alcohol monitoring tool in your tool box?
- Do you do your own monitoring or do you prefer to have your technology partner do this for you?
- For reporting purposes, do you receive violation notifications in a timely fashion?
- Would you prefer to not have involvement in client testing so you can be more productive each day?

Alcohol Monitoring Technologies

- Continuous Alcohol Monitoring
- Portable Alcohol Monitoring
- Random Alcohol Monitoring

Continuous Alcohol Monitoring

- Automated tests every 30 minutes, 24/7
- Reports only when client downloads via a variety of options
  - Base
  - Wireless Base
  - Direct Connect
  - Ethernet
- Violation notification upon download
- Optional house arrest/RF monitoring in one device
- Passive device
- Cannot remove without tampering

Portable Alcohol Monitoring

- Customized test windows and random tests
- Monitors all risk levels based on number of tests
- Immediate violation notification
- Uploads data after each scheduled test
- Alcohol-specific fuel cell
- User actively engages with device
- Photo verification via facial recognition/detection
- GPS tracking of scheduled tests

Random Alcohol Monitoring

Lab-Based: EtG Testing

- Direct metabolite of alcohol (ethanol)
- Can be detected up to 24-48 hours after ingestion
- Confirm EtG by LC/MS/MS
- Fast results (48 hours - negative; 48-72 hours - positive

Random Alcohol Monitoring

Breathalyzer

- Rapid and precise breath alcohol analysis
- Fuel-cell technology
- Handheld instrument
- Real-time clock
- Roadside or random testing
- Displays BAC reading numerically
- Approved DOT screener

YOU JUST
BLEW $10,000.
Buzzed driving is drunk driving.
buzzeddriving.adcouncil.org
NHTSA

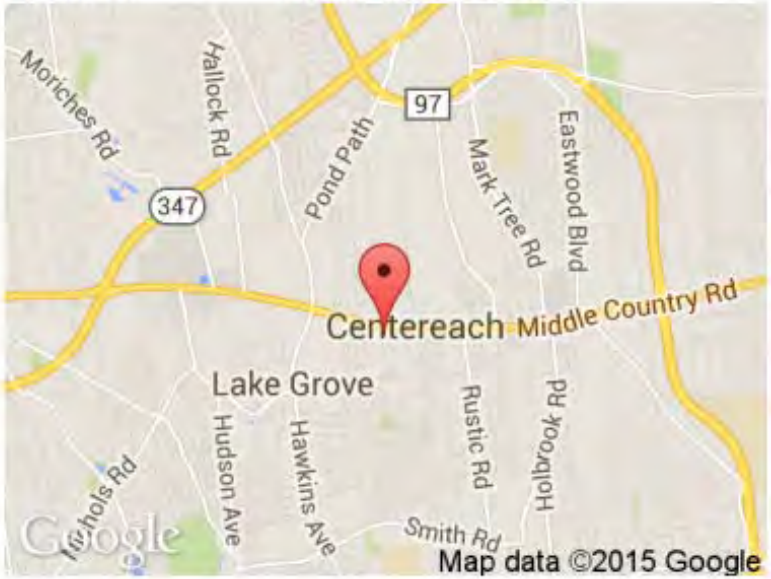
Ignition Interlock

- Fuel-cell technology
- Separates drinking from driving
- Regulatory agencies vary by state
- Fail rates (BAC level) determined by state
- Rolling retests
- Camera technology

Ignition Interlock

- Monthly calibrations
- Monthly downloads of data
- Optional – real-time reporting via modem
- GPS tracking
- Violations/lock-outs
- Terms vary based on state regulations

Client:	Test, Test
Account:	113074150529020912
Event:	Circumvention
Time:	Jul 14, 2015 1:40:22 PM
Location:	40.857506, -73.10347



Map Legend

All-offender

Mandatory for all first offenders with a BAC of .15 or greater (unless if BAC is noted differently)

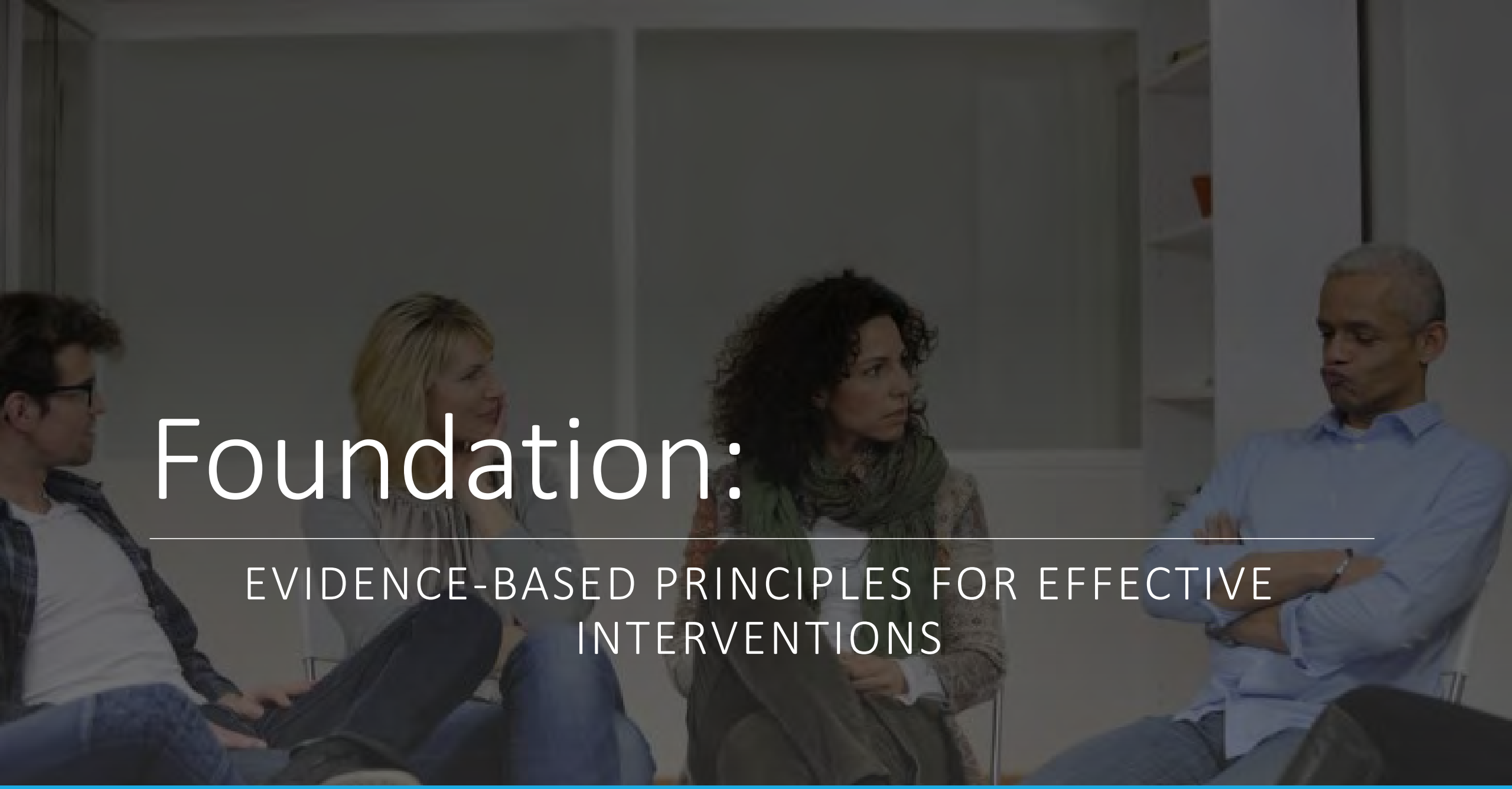
Mandatory for all repeat offenders

Discretionary or optional law

A California pilot program requires interlocks for all convicted DUI offenders in four counties

Noah's Law

- May 19, 2016 – an all-offender interlock law was signed
- October 1, 2016 – Noah's Law went into effect



Foundation:

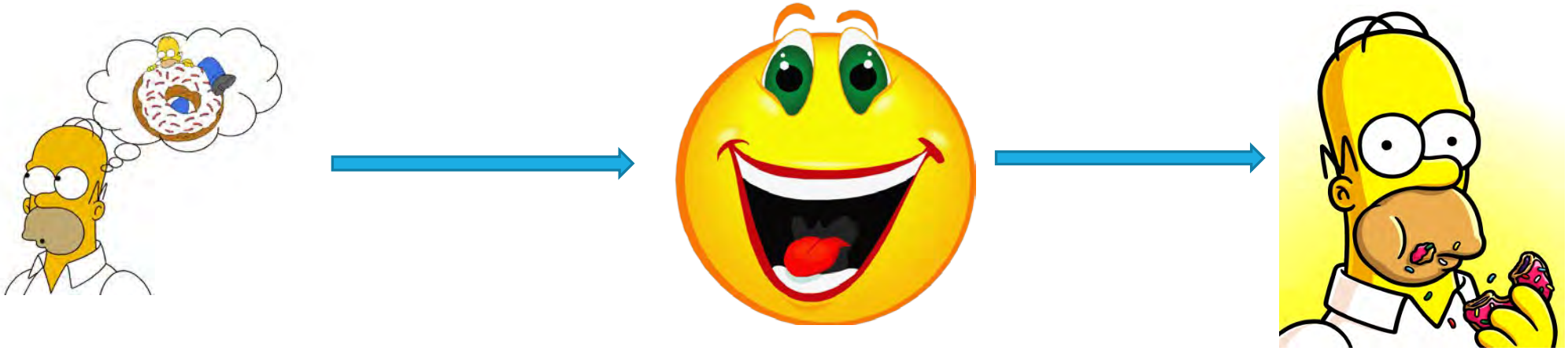
EVIDENCE-BASED PRINCIPLES FOR EFFECTIVE INTERVENTIONS

To Be or Not to Be?

- How do you know if the treatment approach is an EBP model?
- SAMHSA – NREPP
- Treatment is manual-based
  - Specific to a particular intervention
  - Indicate how the intervention should be structured and delivered
  - Include background and theoretical information
- Beware of counterfeits
  - Not every intervention that is manualized is EBP

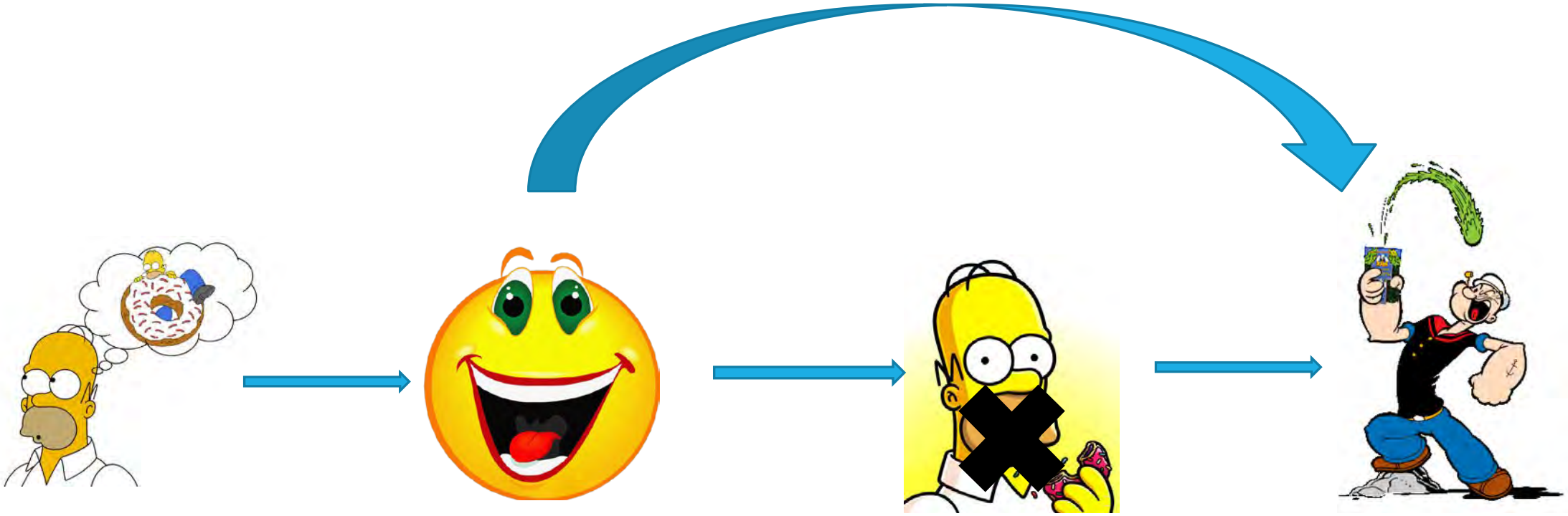
Cognitive Behavioral Therapy (CBT)

Analyzes thoughts, feelings and actions (behavior)



From Good to GREAT!

Analyzes thoughts, feelings, actions (behavior), learn new skills



Medication-Assisted Treatment (MAT)

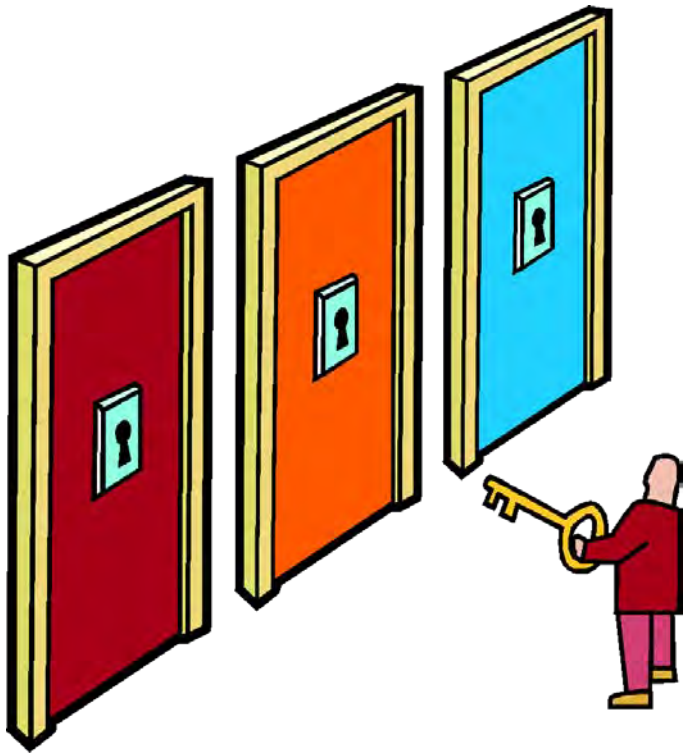
- Best when complimented with counseling and other behavioral therapies
- Provides relief from withdrawal symptoms
- Prevent drugs from working (antagonist)
- Reduce cravings
- Provide replacement chemicals (agonist)
- Provide aversive reactions

Types of MAT

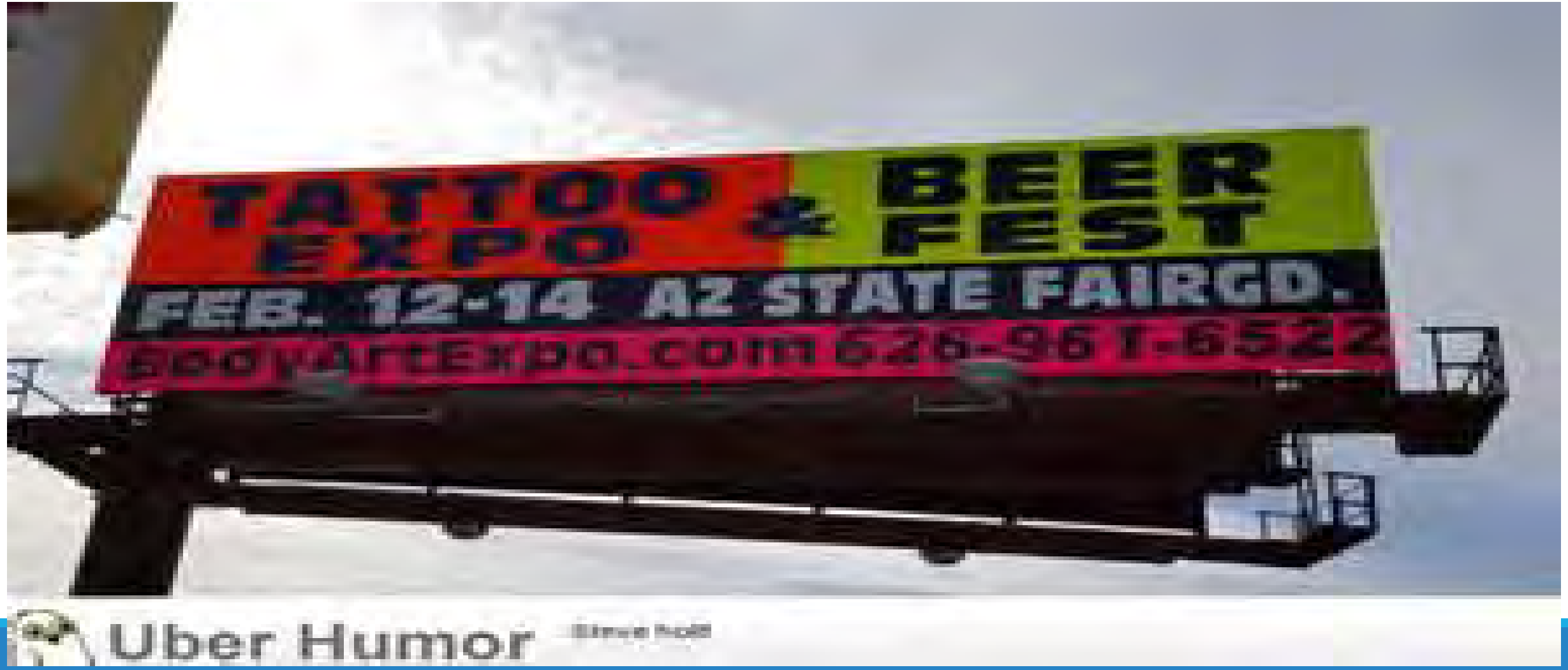
- **Naltrexone/Vivitrol** – interrupts actions of alcohol
- **Acamprosate** – reduces alcohol cravings
- **Disulfiram/Antabuse** – produces adverse reactions with alcohol use

AA or N/A?

- Voluntary
- Coerced
- Options



So What Could Possibly Go Wrong?



What Treatment and Alcohol Technology Vendors Need to Know About Community Supervision

- Blended caseloads mean lack of DWI expertise
- DWI cases one of many…
- Time constraints
- Don’t know what I don’t know
- Develop a department S.M.E.
- Have a seat at the table
- What would you add to the list?

What Community Supervision and Treatment Needs to Know About Alcohol Technology

- Match technologies to risk and behaviors of client
- Technology is worthless if you don’t monitor the results
- Immediate violation notifications allow you to impose sanctions and change behavior
- Client accountability is enforced when the responsibility is on the client
- Partnerships with vendors are critical
- What would you add to the list?

What Community Supervision and Technology Providers Need to Know About Treatment

- Treatment should be based on results of assessment
- Client confidentiality
- Effective Case/Treatment Plan - Lack of information from community supervision hampers treatment success
- Not all treatment is alike
- DWI convictions don’t always mean DWI treatment
- Alcohol technology without treatment shows limited results
- What would you add to the list?

Questions
Answers

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MY STORY

Leroy Robinson

MY PAST

- Family background
- I sold before I used
- I got shot
- I got shot…again!
- Paralysis
- Impact on family

TURNING POINTS

- “The handshake”
- I became homeless
- Drug Court Team support
- Peer support
- Community connections

TODAY…

- Giving back to community
- Reconnected with my children
- Restored my dignity/faith
- Career
- Licensed driver with new car

THE FUTURE…

- Peer Recovery Support Specialist
- College
- Limitless…"The Best is Yet to Come!"

QUESTIONS?

Trauma, Drama, Drinking & Drugging: A Look at Co-Occurring Clients

Christa M. Marshall, Psy.D.

SOME SLIDES CREATED BY BRIAN MEYER, PH.D.

8/7/2017

DISCLAIMER

Dr. Marshall used to work for the Department of Veterans Affairs. The views expressed in this presentation are solely those of the presenter and do not represent those of the Veterans Health Administration, the Department of Defense, or the United States government.

The author has no financial conflicts of interest to disclose.

Agenda

- Posttraumatic stress disorder (PTSD) and substance abuse
- Mental health, traumatic brain injury (TBI), and substance abuse
- The role of chronic pain and substance abuse
- Some basic strategies, tips, and resources for court professionals

PTSD AND SUBSTANCE ABUSE

- Not all trauma leads to PTSD

  Depending on the study, the type of trauma, and the group studied, 3%-58% get PTSD
- More men (61%) than women (51%) experience a trauma at some point in their lives, but women experience PTSD at twice the rate of men (10% vs. 5%)

(Kessler et al., 1995; Tolin and Foa, 2006)

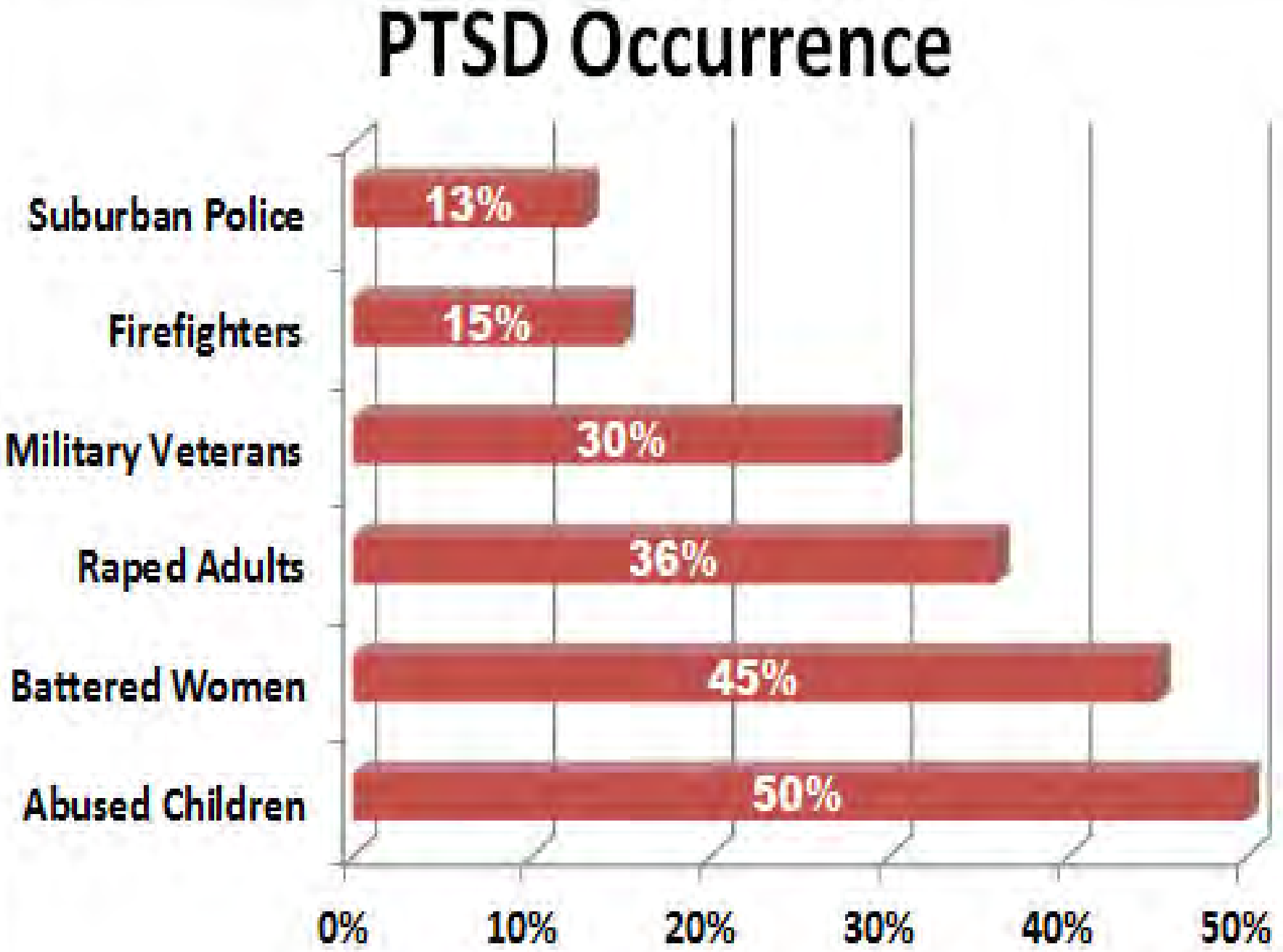
PTSD AND SUBSTANCE ABUSE

- About 7 – 8 of people meet criteria for PTSD at some point in their life
- 50 – 66 % of individuals diagnosed with PTSD also suffer from addiction
- Those with PTSD are about 2 to 4 times more likely to struggle with substance abuse than peers without PTSD

(McCauley, Kileen, Gros, Brady, & Back, 2012)

PTSD AND SUBSTANCE ABUSE

- Combat and war-zone trauma
- Rape
- Child physical abuse
- Child sexual abuse
- Domestic violence
- Environmental trauma
- Torture
- Being held hostage
- Genocide
- Cultural trauma
- Accidents
- Natural disasters
- Fires


PTSD Occurrence
Suburban Police
13%
Firefighters
15%
Military Veterans
30%
Raped Adults
36%
Battered Women
45%
Abused Children
50%
0%
10%
20%
30%
40%
50%

PTSD AND DSM-5

PTSD is characterized by:

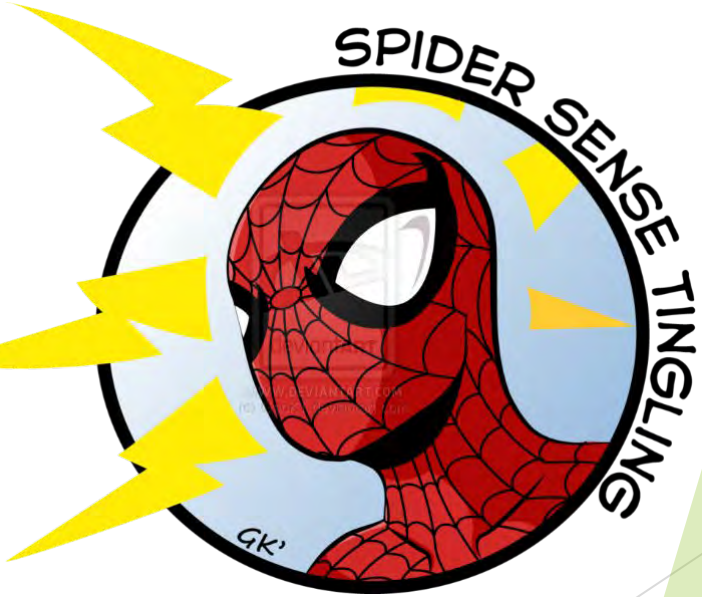
- Exposure to a severe life-threatening event
- Repetitive re-experiencing of the event
- Avoidance of stimuli associated with trauma
- Negative moods and cognitions
- Increased arousal

The PTSD Experience

- Nerves on edge
- Jumpy
- Can't sleep
- Nightmares
- Irritable all the time
- Explosive outbursts
- Wants to be left alone
- Depressed
- Can't stand crowds
- Heart races/sweats

The PTSD Experience

- Hates New Year's Eve and July 4th
- Secretive
- Distrusts others
- Sees world as dangerous
- Constantly watching for danger
- Hates lines
- Overwhelmed by stimulation
- Feels responsible for trauma

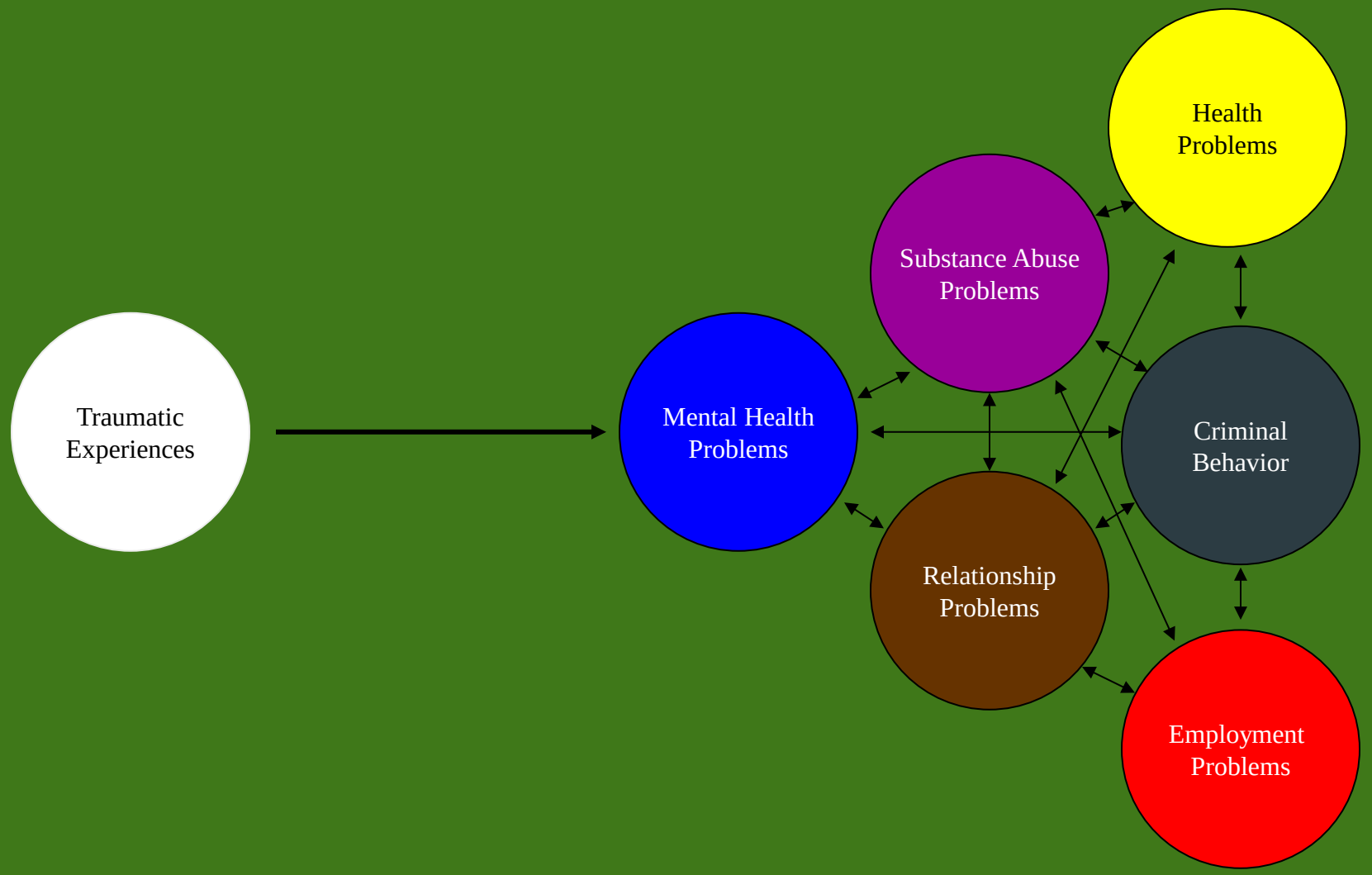


The PTSD Experience

Copes by:

- Cutting off relationships
- Isolating
- Taking risks
- Self-harming behaviors
- Using drugs and alcohol

THE CATALYZING EFFECT OF TRAUMA



Court Professional Tip: Resources for more education on PTSD

- *Trauma and Recovery* (1993), Judith Herman
- *The Body Keeps the Score* (2015), Bessel van der Kolk
- *Handbook of PTSD* by Matthew Friedman, Terence Keane, and Patricia Resick
- *The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms, 2nd ed.* (2013), Mary Beth Williams and Soili Poijula

Court Professional Tip: Resources for more education on PTSD

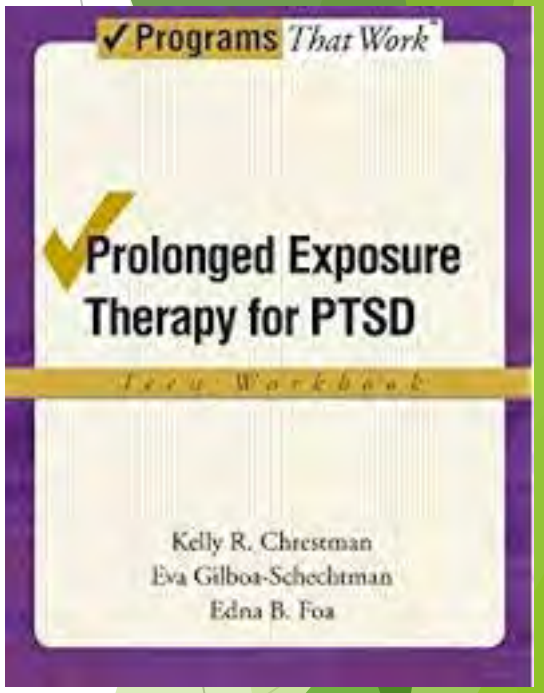
- National Center for PTSD: www.ptsd.va.gov
- International Society for Traumatic Stress Studies: www.istss.org
- International Society for the Study of Trauma and Dissociation: www.isst-d.org

Court Professional Tip: Resources for more education on Veterans with PTSD

- *Once a Warrior--Always a Warrior: Navigating the Transition from Combat to Home--Including Combat Stress, PTSD, and mTBI* (2010), Charles Hoge
- *After the War Zone: A Practical Guide for Returning Troops and Their Families* (2008), Matthew Friedman and Laurie Slone
  - Free podcast available at https://itunes.apple.com/eg/podcast/returning-from-the-war-zone/id657517343

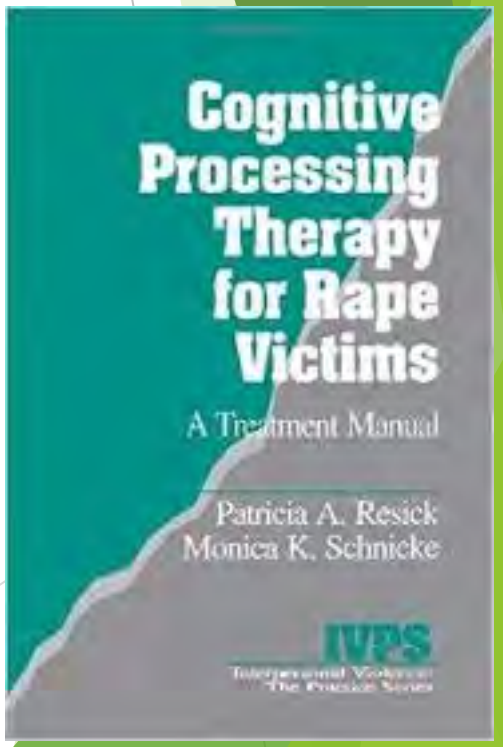
Court Professional Tip: Resources for more education on Prolonged Exposure for PTSD

- *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences Therapist Guide* (2007), Edna Foa, Elizabeth Hembree and Barbara Olaslov Rothbaum
- *Reclaiming Your Life from a Traumatic Experience: A Prolonged Exposure Treatment Program Workbook* (2007), Barbara Rothbaum, Edna Foa and Elizabeth Hembree
- http://vaww.collage.research.med.va.gov/collage/E_behav/PE



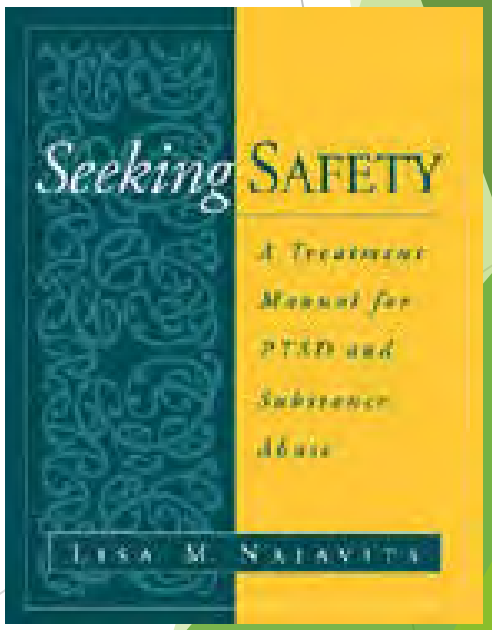
Court Professional Tip: Resources for more education on Cognitive Processing Therapy for PTSD

- *Cognitive Processing Therapy for Rape Victims: A Treatment Manual* (1993), Patricia Resick and Monica Schnicke
- http://vaww.collage.research.med.va.gov/collage/CPT



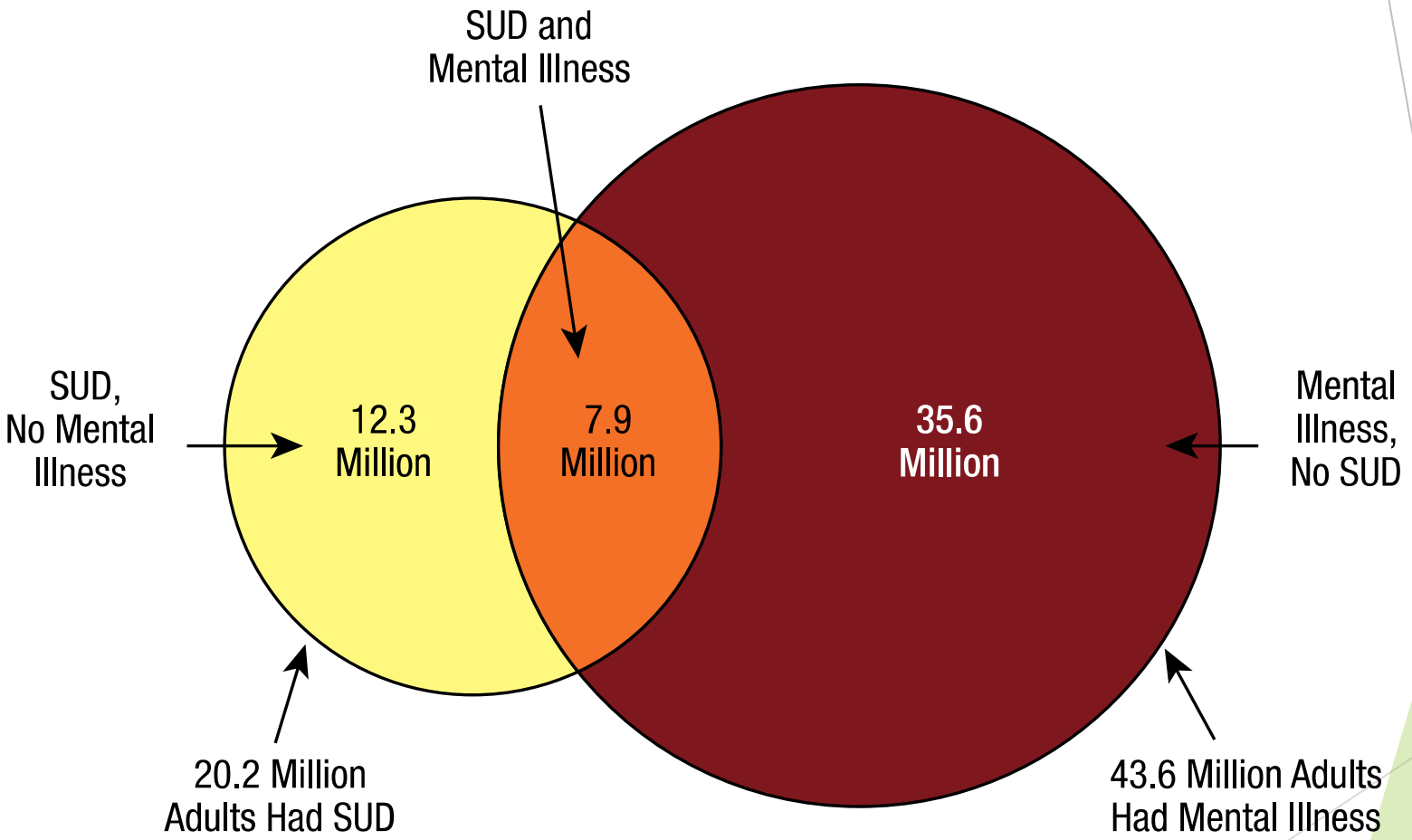
Court Professional Tip: Resources for more education on PTSD and SUD Treatment

- Seeking Safety: a group specifically designed for individuals dealing with both PTSD and substance abuse
  - Very structured – designed to provide significant education and coping skills
  - Flexible length of group intervention
  - http://www.treatment-innovations.org/seeking-safety.html



MENTAL HEALTH, TBI, AND SUBSTANCE ABUSE

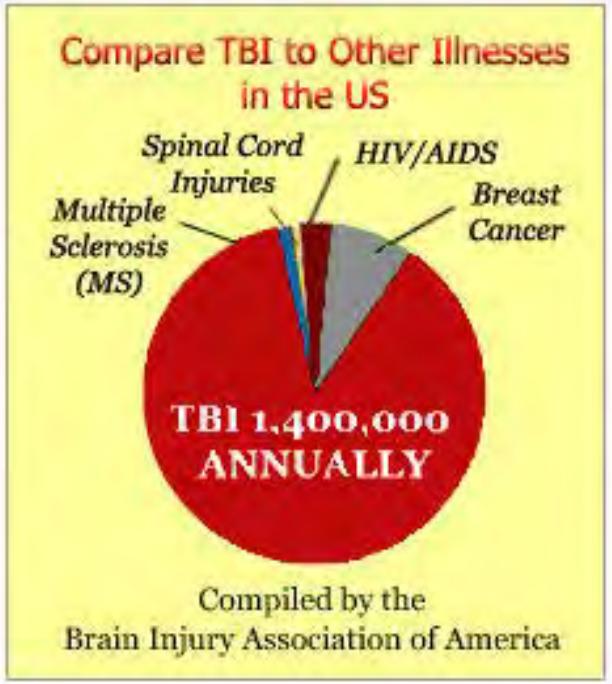
Figure 48. Past Year Substance Use Disorders and Mental Illness among Adults Aged 18 or Older: 2014

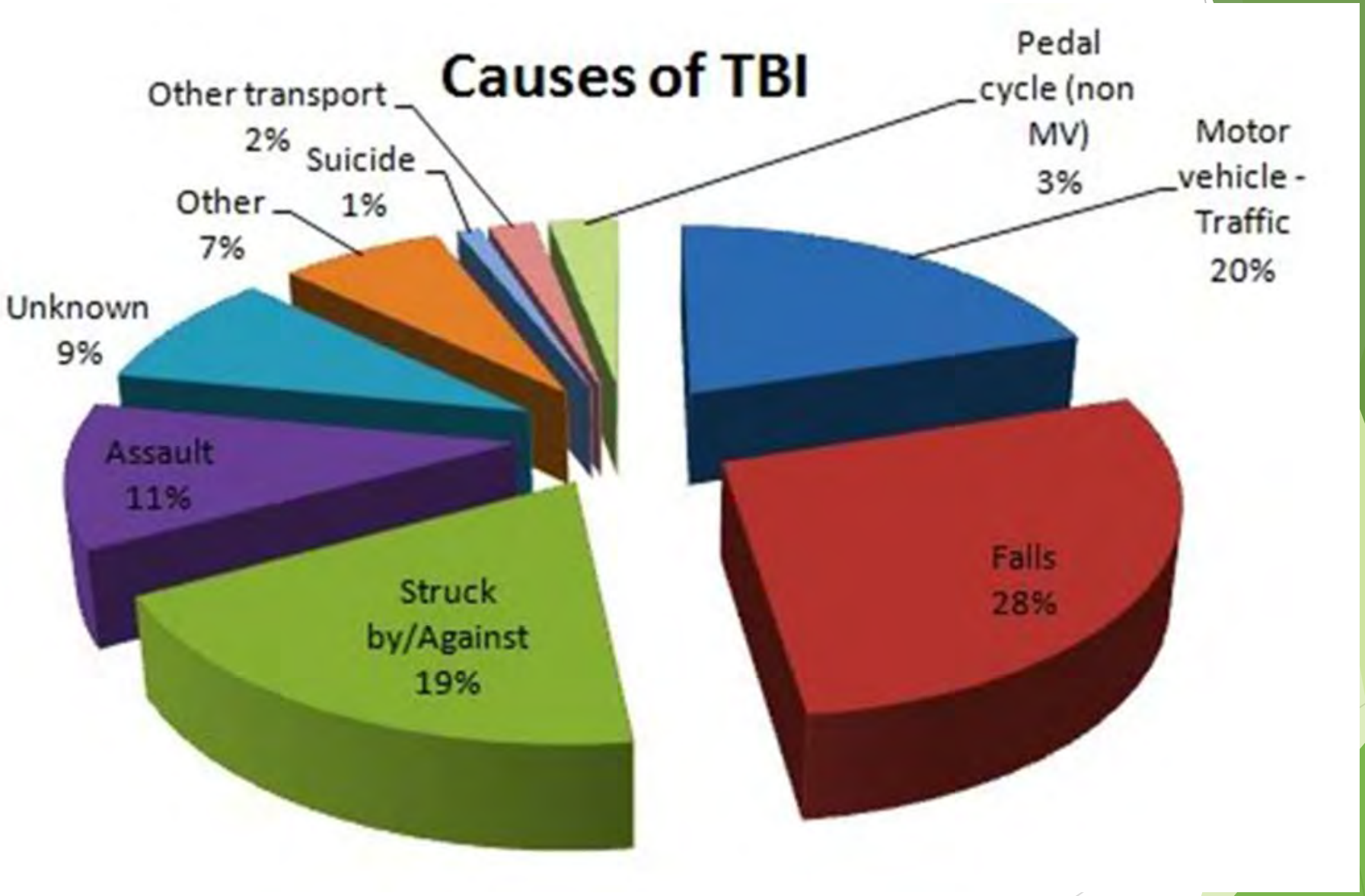


(Center for Behavioral Health Statistics and Quality, 2015)

MENTAL HEALTH, TBI, AND SUBSTANCE ABUSE

- TBI occurs when a blow or jolt to the head or a penetrating head injury disrupts the function of the brain (CDC, 2005)
- Most mild TBIs resolve within six months
- Effects of TBI are often *cumulative*





National Center for Injury Prevention and Control, CDC

Traumatic Brain Injury Classification

Severity	GCS	LOC	PTA
Mild	13–15	< 30 min.	<24 hrs.
Moderate	9–12	30 min. – 24 hrs.	24 hrs. - 7days
Severe	3–8	>24 hrs.	>7 days

GCS = Glasgow Coma Scale
LOC = Loss of Consciousness
PTA = Post-Traumatic Amnesia

American Congress of Rehabilitation

BEHAVIORAL PROBLEMS OF TBI

Behavioral problems of people with traumatic brain injury (TBI) complicate recovery. The list of behavioral dysfunction ranges from emotionally labile (mood swings), depression, and hyperactivity to aggression, sexual inappropriateness, and elopement (running away). Even lack of activity, or lack of initiation, can be a behavioral problem. In addition, psychological reactions to traumatic brain injury as well as predisposition to psychiatric abnormalities can be factors in behavioral complications. The locus of the traumatic brain injury is the key predictor of behavioral problems, as shown in the following diagram.

FRONTAL LOBE
(behind the forehead)

An injury to this part of the brain can cause changes in emotional control, initiation, motivation , and inhibition. Intolerance for frustration and easily provoked aggressive behavior are typical. Promiscuity and lethargy may also result. An injury to the frontal lobe can lead to the inability to plan a sequence of complex movements needed to complete multi-stepped tasks (such as making coffee).

CEREBRAL CORTEX
(gray matter)

The cerebral cortex is the layer of cells on the outer surface of the cerebral lobes. A diffuse impact injury, such as with a motor vehicle accident, where the head is subjected to rapid and forceful movements, can impair the brains ability to process emotions and behavior.

PARIETAL LOBE
(near the back and top of the head)

The parietal lobe is specialized for processing body information. Damage to the parietal lobe impairs the ability to identify objects by touch, increases clumsiness and neglect on the side of the body opposite the damage and creates an inability to draw and follow maps and describe how to get somewhere.

TEMPORAL LOBE
(side of head above ears)

Aggression resulting from temporal lobe damage is typically unprovoked and very abrupt. Damage here causes both long-term and short term memory loss and difficulty in new learning, affecting a person's ability to relearn appropriate behavior. Right lobe damage can cause persistent talking .

OCCIPITAL LOBE
(located at the posterior end of the cortex)

The occipital lobe's main function is vision. Damage to this area causes degrees of blindness, difficulty with locating objects in environment, identifying colors, produces hallucinations, inability to recognize words or to recognize the movement of an object and difficulties with reading and writing.

LIMBIC SYSTEM
(deep inside the brain)

Damage to this area, distorts emotions and physical desires and leads to difficulty with organization/perception of the environment and problems with balance and movement. Damage can also cause decreased vital capacity in breathing, important for speech.

CEREBELLUM
(base of skull)

Injury to the cerebellum can result in the loss of ability to coordinate fine movement, loss of ability to walk, and the inability to reach out and grab objects.

Betty Clooney Foundation for Persons with Brain Injury
4439 ½ E. Village Road
Long Beach, CA 90808
562-938-9005
www.bcftbi.org info@bcftbi.org

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MENTAL HEALTH, TBI, AND SUBSTANCE ABUSE

- Individuals with mental health and substance use disorders are at a higher risk of sustaining a TBI
- Individuals with a TBI are also at greater risk for developing substance use and mental health conditions
- TBI is a risk factor for legal involvement and also represents a significant barrier to successful substance abuse and mental health treatment

Prevalence

- 102 moderate to severe TBI patients examined at 3, 6, and 12 months post-injury
- Gave participants the Structure Clinical Interview for DSM-IV (SCID)
  - Also gave a "proxy informant" the same interview
- Before injury:
  - 29.4% met criteria for multiple mental health conditions
  - 25.3% met criteria for one mental health condition
  - Odds were about 50% that if you had a mood disorder you also had an anxiety disorder (and vice versa)

(Gould, Ponsford, Johnston, & Schonberger, 2011)

Prevalence

- Post-injury
  - 61% met criteria for one or more psychiatric disorders (statistically significant higher levels of diagnosis)
    - 37.3% met criteria for multiple mental health conditions
    - 23.5% met criteria for one mental health condition
  - Mood and anxiety disorders are most prevalent diagnoses
    - Major depressive disorder and PTSD (also unspecified anxiety)
    - Odds are about 70% that if you have depression you also have anxiety (and vice versa)
- 74% of individuals who had a pre-injury psychiatric diagnosis experience post-injury diagnosis
  - 45% of patients without a history of psychiatric illness went on to develop one after injury

(Gould, Ponsford, Johnston, & Schonberger, 2011)

Prevalence

- What about substance use?
  - Most doctors recommend a period of abstinence of about one year after injury
    - Risk of second TBI
    - Lowers threshold for seizures
    - Greater family involvement right after injury
  - Most longer-term research indicates that substance use can be a significant problem for individuals suffering from TBI

(Gould, Ponsford, Johnston, & Schonberger, 2011)

Table 2. *Frequency of psychiatric disorder compared with the general population* ($\alpha = 0.01$)

Disorder category Diagnosis	Lifetime pre-injury disorders					12-Month post-injury disorders				
	n	%	Population rate (%)	χ^2	*p*	*n*	%	Population rate (%)	χ^2	*p*
Any disorder	54	52.9				62	60.8			
Recalculated rate of any disorder[a]	42	41.2	45.1		N.S.	38	37.3	19.5	20.36	0.001
Mood disorder	24	23.5				43	42.2			
Recalculated rate of mood disorder[b]	17	16.7	12.6		N.S.	32	31.4	5.5	132.35	0.001
MDD	14	13.7	10.9		N.S.	30	29.4	4.2	159.66	0.001
Dysthymic disorder	4	3.9	1.5		N.S.	1	1.0	1.0		N.S.
Bipolar disorder	0	0.0	1.5		N.S.	2	2.0	1.1		N.S.
Depressive disorder NOS	7	6.9	–			20	19.6	–		
Mood disorder NOS	1	1.0	–			1	1.0	–		
Anxiety disorder	22	21.6				45	44.1			
Recalculated rate of anxiety disorder[c]	12	11.8	17.8		N.S.	16	15.7	11.1		N.S.
Social phobia	8	7.8	7.8		N.S.	3	2.9	4.2		N.S.
PTSD	2	2.0	5.8		N.S.	13	12.7	3.6	24.26	0.001
Panic disorder with/without agoraphobia	2	2.0	3.3		N.S.	2	2.0	1.8		N.S.
Agoraphobia without panic disorder	0	0.0	1.4		N.S.	0	0.0	0.6		N.S.
OCD	0	0.0	4.1		N.S.	1	1.0	3.1		N.S.
GAD	1	1.0	5.1		N.S.	2	2.0	1.7		N.S.
Anxiety disorder NOS	6	5.9	–			36	35.3	–		
Specific phobia	6	5.9	–			7	6.9	–		
Substance-induced anxiety disorder	1	1.0	–			1	1.0	–		
Acute stress disorder	0	0.0	–			1	1.0	–		

(Gould, Ponsford, Johnston, & Schonberger, 2011)

Table 2. *Frequency of psychiatric disorder compared with the general population* ($\alpha = 0.01$)

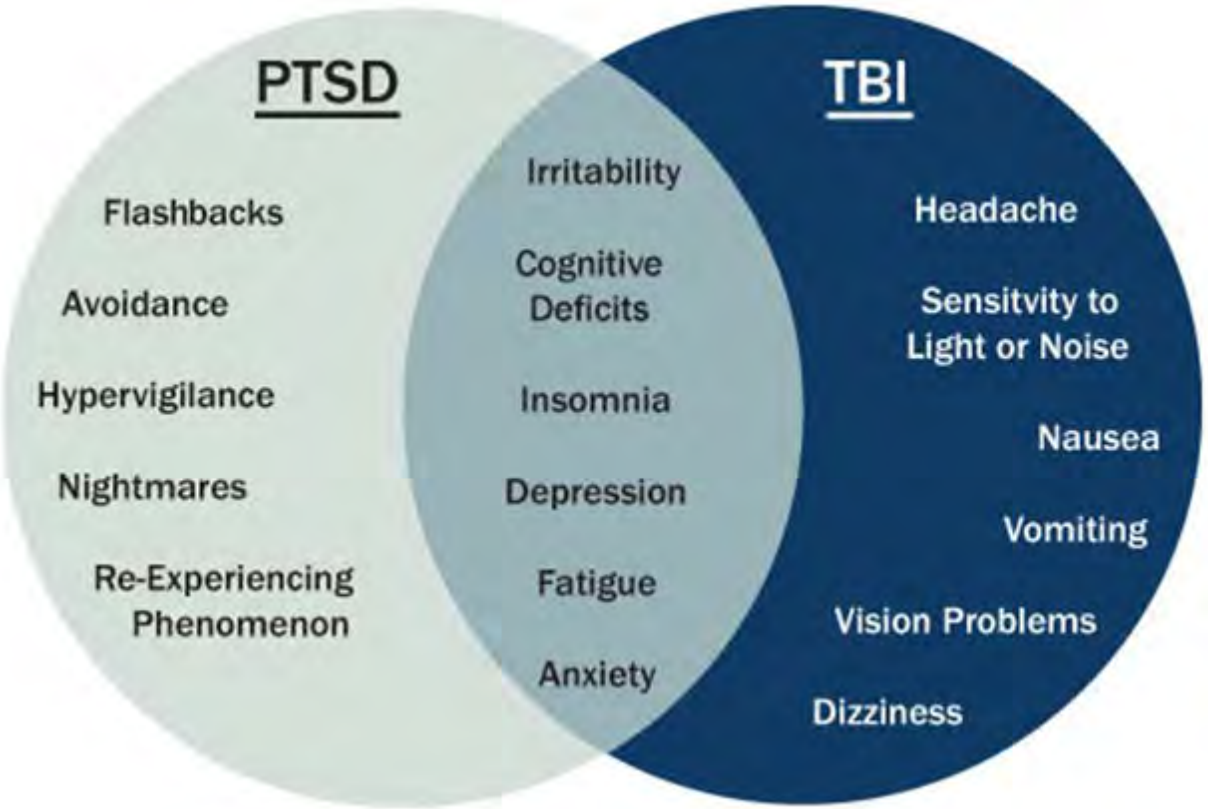
Disorder category Diagnosis	Lifetime pre-injury disorders *n*	%	Population rate (%)	χ^2	*p*	12-Month post-injury disorders *n*	%	Population rate (%)	χ^2	*p*
Substance use disorder	35	34.3	31.9		N.S.	12	11.8	8.65		N.S.
Alcohol abuse	16	15.7	23.8		N.S.	4	3.9	5.0		N.S.
Alcohol dependence	12	11.8	5.5	7.893	0.005	2	2.0	2.4		N.S.
Drug abuse	1	1.0	6.8		N.S.	4	3.9	1.5		N.S.
Drug dependence	4	3.9	4.6		N.S.	2	2.0	1.2		N.S.
Adjustment disorders	8	7.8	2.0–8.0[d]			5	5.0	2.0–8.0[d]		
With depressed mood	5	4.9	–			2	2.0	–		
With anxious mood	0	0.0	–			1	1.0	–		
With mixed anxious and depressed mood	3	2.9	–			2	2.0	–		
Psychotic disorders	4	3.9	–			2	2.0	0.4–0.7[e]		
Schizophrenia	1	1.0	0.4[f]			1	1.0	–		
Substance-induced psychotic disorder	3	2.9	–			1	1.0	–		
Eating disorders	5	5.0	–			3	3.0	0.5[g]		
Anorexia nervosa	2	2.0	1.9[h]			1	1.0	<0.1[g]		
Bulimia nervosa	1	1.0	2.9[h]			1	1.0	0.4[g]		
Eating disorder NOS	2	2.0	5.3[h]			1	1.0	–		
Somatoform disorders	0	0.0	0.2–2.0[i]			0	0.0	5.7–16.6[j]		

(Gould, Ponsford, Johnston, & Schonberger, 2011)

Co-Occurrence of PTSD and mTBI

- PTSD occurs more in mild TBI than in moderate or severe TBI
  - Post-traumatic amnesia may have a protective effect (Vasterling et al., 2009)
- Increased level of brain injury *within* mTBI increases likelihood of developing PTSD (Kennedy et al., 2007)
  - 27% of those with concussions developed PTSD
  - 44% of those with loss of consciousness developed PTSD

Overlapping PTSD and TBI symptoms



Possible professional referrals

- Neuropsychologist
  - Psychologist who is trained in assessing mental health conditions, as well as evaluating cognitive functioning through:
    - a clinical interview
    - neuropsychological testing
    - write a detailed report with recommendations
    - provide verbal and written feedback to the client
  - Obtaining a copy of the clinician's report can help court professionals:
    - Understand a client's diagnosis
    - Set appropriate expectations regarding ability to be compliant
    - Appropriately adapt court proceeding to meet client's abilities

Court Professional Tip: Know what types of professionals can help

- Speech therapy
- Physical therapy
- Occupational therapy
- Cognitive rehabilitation
  - Restoration
  - Substitution
  - Environmental restructuring
- Psychotherapy focused on adjustment
- No medications have been approved to treat the cognitive deficits associated with TBIs

Mindfulness-based stress reduction, PTSD, and mTBI

- Mindfulness-Based Stress Reduction (MBSR) consists of eight 2.5 hour sessions of mindfulness meditation and gentle yoga (Kabat-Zinn, 1990)
- MBSR decreased mental fatigue and improved processing speed in people with mTBIs (Johansson et al., 2012)
  - Some anxiety and depression scores also declined
- MBSR improved attention and decreased PTSD symptoms in a pilot study of Veterans with mTBI and PTSD (Cole et al., 2015)

Wellness Approaches can help

- Mindfulness meditation
- Yoga
- Tai Chi
- Qi Gong
- Acupuncture

Court Professional Tip: TBI and Fatigue

- Prolonged effort (e.g., “trying harder”) does not usually result in better performance
- Schedule meetings or tasks at the time of day during which the client is most alert and functional
- May impact ability to drive to sessions
  - Consider videoconferencing to avoid missed court dates
  - Make cancelation/rescheduling policy very clear
  - Encourage clients to identify backup drivers
- If you have an individual with slow cognitive processing (due to fatigue or other factors):
  - consider scheduling extra time
  - break up large amounts of information into more frequent sessions

(West et al., 2004)

Court Professional Tip: TBI and basic communication

- Check for understanding frequently during a conversation
  - Avoid "yes/no" responses by asking **for a return demonstration**
- Speak clearly, slowly, while facing the client and at a reasonable volume
  - Avoid chewing gum, talking over loud noises
- Provide the client with feedback regarding their communication
  - E.g., too loud, too soft, too fast, tangential

(West et al., 2004)

Court Professional Tip: TBI and attention

- Minimize auditory and visual distractions
  - Proper lighting, minimize noise (e.g., white noise machines), minimize number or participants in court room
- Breaks can increase cognitive performance (depends on length of meetings)
- Stress and anxiety can decrease concentration. If you see signs of anxiety(e.g., fidgeting, sweating, stuttering):
  - Encourage taking a deep breath
  - Offer a short recess if appropriate
  - If you know they are in counseling, ask if the client has been taught any strategies to manage anxiety
- Maximize the client's attention by addressing one issue at a time to completion (i.e., avoid multitasking)

(West et al., 2004)

Court Professional Tip: TBI and learning and memory

- Consider providing all clients with a distinctive looking folder with basic paperwork, court requirements, and referral resources
  - Provide visual cues that they client should bring the folder to each session
  - Provide space for writing down court dates
  - Provide important contact information on the folder itself
  - If you have the funds, provide a basic calendar
  - If you have any particularly difficult procedures or vendors they need to interact with, provide checklists or explicit instructions on how to complete tasks
  - Provide any maps that may be necessary
  - Provide some blank paper and a pen inside for clients to take down notes

(West et al., 2004)

Example folder

Name:_____

IMPORTANT: Bring to each appearance!

Next Appearance:

_____ _____

_____ _____

_____ _____

Where I will keep my folder:

_____

Important Phone Numbers:

Coordinator (XXX) XXX-XXXX

Court Professional Tip: TBI and learning and memory

- Remind or assist the clients in setting alarms on cell phone (if possible)
  - Court appearances
  - Medical, mental health, therapy, or community resource appointments
  - Set an alarm the day before reminding them:
    - Help facilitate planning, rides etc.
  - Set an alarm the day of the appointment with enough time to travel to appointment in a timely way
- Repeat yourself – and ask for a return demonstration.

(West et al., 2004)

Court Professional Tip: TBI and planning/organization

- If you are asking the client to do something new or particularly difficult:
  - Ask them to narrate the steps involved
  - Help refine their thinking (i.e., make suggestions)
  - Provide additional resources if necessary
  - Write it down, draw pictures, use audio

(West et al., 2004)

Court Professional Tip: TBI and emotional regulation

- To reduce anxiety and agitation explain unusual procedures or activities in advance.
  - Reassurance along with modulating voice tone and speed will also increase relaxation
- Whenever appropriate, encourage participation in recovery from the patient's family
  - Allow helpful family members to attend sessions with the client
    - This is especially important for clients who are not able to read or write well
  - Consider holding joint education nights with local brain injury organizations for family members of clients to help educate them about brain injury, treatment, and community resources

(West et al., 2004)

Court Professional Tip: TBI and miscellaneous

- Be sure that referrals for vocational services or community service are appropriate to the client's level of cognitive ability
  - If you're not sure, consult with the intake specialists at those programs
- If a client does decide to return to work, school, or community involvement, be aware that a *gradual* return to these activities might be clinically indicated
  - Consider a referral to a disability rights advocate or case manager to help the individual appropriately request accommodations
- Be aware of the client's ability to drive (and under what conditions)

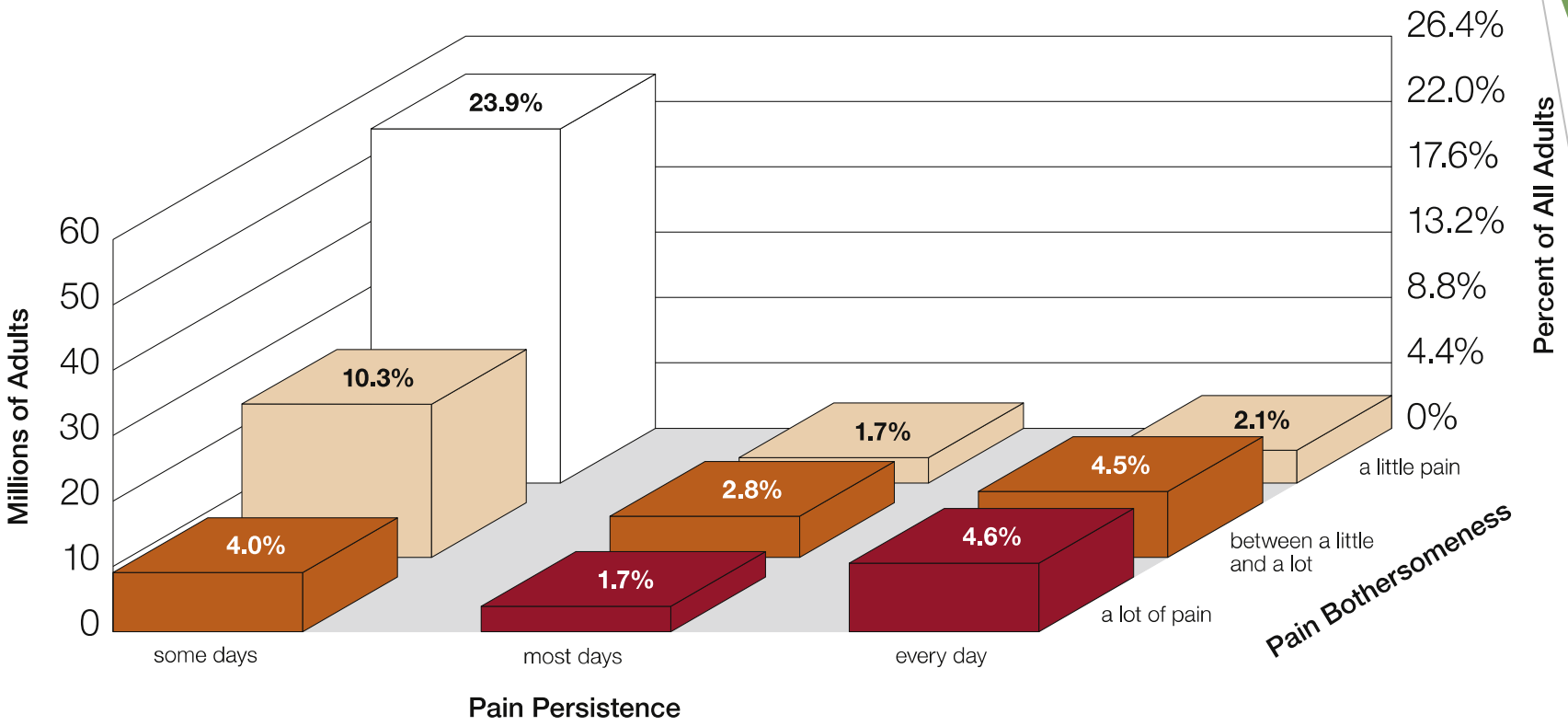
Possible professional referrals

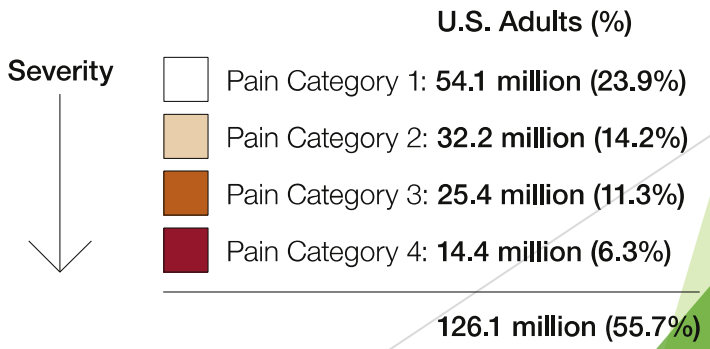
- Possible mental health referrals:
  - Clinical Psychologist
  - Rehabilitation Psychologist
  - Pain Psychologist
  - Psychiatrist
  - Neuropsychiatrist
  - Brain injury support groups
  - Case Manager

Chronic pain: Scope of the problem

- National Health Interview Survey – 2012
  - 8,781 adults; pain scale rating 1(low) to 4(high)
  - Estimate 126.1 million adults report some pain in the previous 3 months
  - 14.4 million (6.4%) level 4 pain
  - 25.4 million (11.3%) level 3 pain
  - More likely to have worse health status, use more healthcare, and be diagnosed with a disability

(Nahin, 2015)


Millions of Adults
60
50
40
30
20
10
0
26.4%
22.0%
17.6%
13.2%
8.8%
4.4%
0%
Percent of All Adults
23.9%
10.3%
4.0%
1.7%
2.8%
1.7%
2.1%
4.5%
4.6%
some days
most days
every day
Pain Persistence
a little pain
between a little and a lot
a lot of pain
Pain Bothersomeness


U.S. Adults (%)
Severity
Pain Category 1: 54.1 million (23.9%)
Pain Category 2: 32.2 million (14.2%)
Pain Category 3: 25.4 million (11.3%)
Pain Category 4: 14.4 million (6.3%)
126.1 million (55.7%)

(Nahin, 2015)

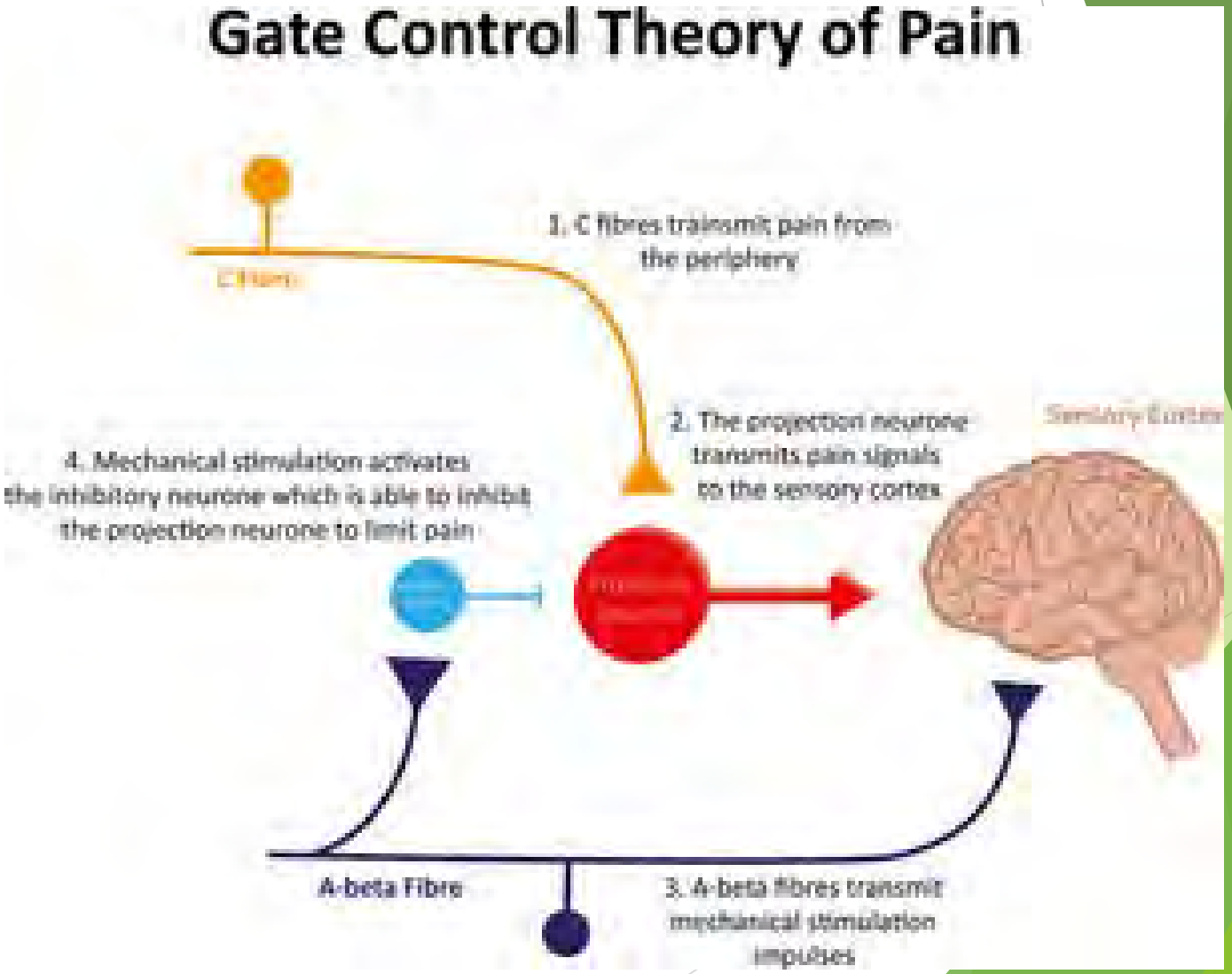
Opioid Addiction Crisis

- In 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills.
- Four in five new heroin users started out misusing prescription painkillers.
- 2014: 94% of people in treatment for opioid addiction chose to use heroin because prescription opioids were "far more expensive and harder to obtain."
- The prescribing rates for prescription opioids among adolescents and young adults nearly doubled from 1994 to 2007.

(American Society of Addiction Medicine, 2016)

The Gate Control Theory of Pain

- Melczak and Wall (1960's)
- Scottish terriers
- First theory to suggest that psychological, social, and environmental factors can influence pain
- Competing signals (e.g., heat, cold, massage, vibration) can inhibit the pain signal
- Well-researched - lots of physiological evidence to support the gate control theory of pain



Integrated Approach to Pain Management

- What would an integrated pain management plan look like?
- Depends on:
  - what has already been tried?
  - the type and location of pain
  - number of comorbid medical conditions
  - physical proximity to treatment centers
  - goals regarding quality of life
  - availability of basic resources
  - patient's support system
  - readiness of patient to be an active participant

Integrated Approach to Pain Management – The Team

- Patient
- Support system (family members, friends, neighbors)
- Physician
- Nurse
- Psychologists
- Physical therapists
- Pharmacists
- Social workers
- Peer support
- Occupational therapists
- Vocational counselors
- Nutritionist
- Recreational therapist
- Clerical Staff

Alternatives to Opioid Medications

- Medications
  - Non-steroidal anti-inflammatory drugs (NSAIDS) – ibuprofen
    - Kidney problems, blood clots, ulcers
  - Anticonvulsants – Gabapentin (Neurontin)
    - Good for nerve pain
    - Drowsiness, weight gain, may be contraindicated in those with kidney stones and glaucoma
  - Muscle Relaxers
    - Drowsiness
  - Antidepressants
    - tricyclic antidepressants – amitriptyline, imipramine, and clomipramine effective at treating neuropathic pain; can use lower doses than for depression
    - Cymbalta musculoskeletal pain
  - Topical medication – lidocaine and capsaicin

Medical Interventions and Equipment

- Radiofrequency Ablation – target a particular nerve
  - Still considered experimental and not covered by insurance
- Steroid injections for joint pain
- Epidural
- Trigger point injections
- Botox Injections
- Surgically implanted neurostimulators
  - Usually does not relieve all of the pain
  - Considered successful when pain is reduced by 50%
- Transcutaneous Electrical Nerve Stimulation (TENS) Unit

Physical Activity

- Exercise
  - Decrease all-or-nothing thinking
  - Slowly increase over time
  - “Motion is lotion”
  - Weight loss
  - Improve mood – endogenous opioids
- Physical Therapy
  - Often time limited
  - “Use it or lose it”
  - Compliance with home exercise program key
  - Often a place for psychologists to co-treat

Massage Therapy

Massage Therapy

- 153 Veterans with advanced stage illness in a palliative care program

Table 2. Short-Term Change in Symptom Scores in all Patients on First Day of Massage.

Symptoms	N	Mean ± SD	Median[b] IQR	95% CI of the mean	Adjusted Change[c]	95% CI of Adj Change
Pain intensity	115	1.65 ± 2.14	2, 2	(1.26, 2.05)	2.10	(1.76, 2.44)
Pain unpleasantness	103	2.10 ± 2.61	2, 4	(1.59, 2.61)	2.49	(2.07, 2.91)
Anxiety	100	1.52 ± 2.38	0, 2	(1.05, 1.99)	2.08	(1.75, 2.41)
Shortness of breath	100	0.87 ± 1.80	0, 1.5	(.51, 1.23)	1.16	(0.89, 1.43)
Relax	100	2.92 ± 2.61	3, 4	(2.40, 3.44)	3.11	(2.74, 3.47)
Peace	91	1.80 ± 2.42	1, 3	(1.30, 2.31)	2.54	(2.18, 2.90)

Abbreviations: CI, confidence interval; IQR, interquartile range; SD, standard deviation.
[a]All changes are calculated so that large positive values correspond to large improvement in symptom.
Note: IQR is calculated as 75th percentile minus 25th percentile.
[b]For every symptom, a one-sided sign test for median change scores being greater than 0 gave a *P* value <.001; *P* value < .0083 corresponds to evidence for a significant short-term improvement, adjusting for multiple comparisons.
[c]Expected mean short-term change for patients at observed mean values of baseline symptom scores, adjusting for baseline values of the symptom scores.

(Mitchinson, Fletcher, Kim, Montagnini, & Hinshaw, 2014)

Massage Therapy

- Yes, but how did it make them feel?
- “I feel better than I have in a long time; that was beautiful.”
- ‘‘I’m in heaven. No offense to God, but this is the only time I’m in heaven.’’
- ‘‘a little better than a piece of warm apple pie and a cup of coffee’’ and admitted, ‘‘I’d be lying if I said I didn’t like it.’’

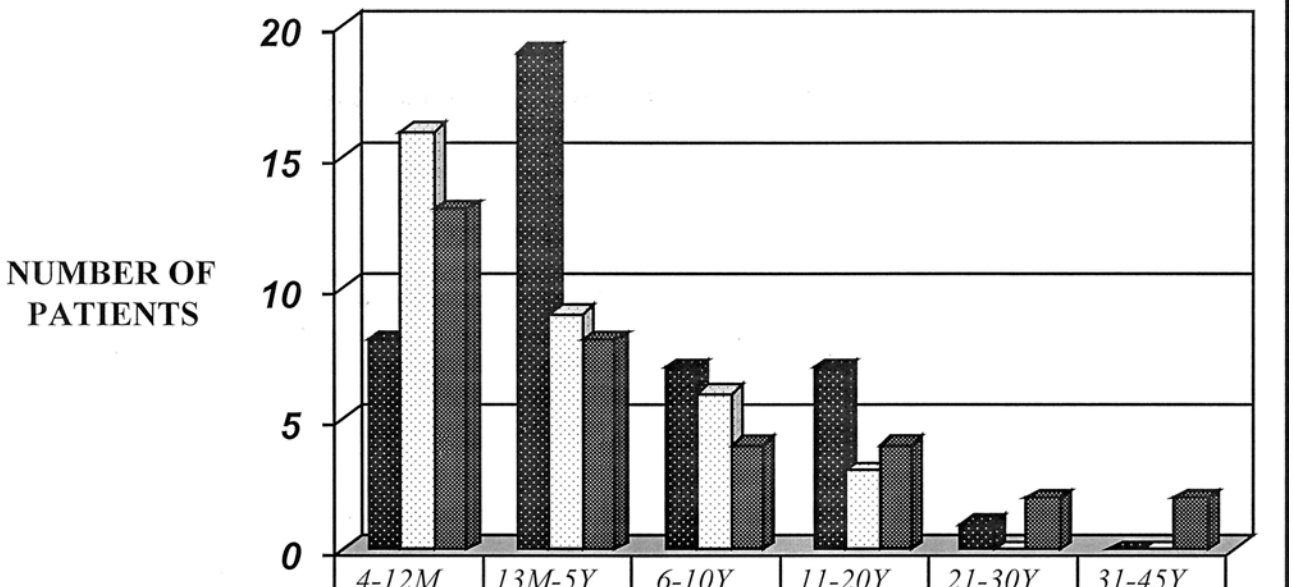
- Drawbacks - time-intensive, costly, effects have limited duration

(Mitchinson, Fletcher, Kim, Montagnini, & Hinshaw, 2014)

Chiropractic Manipulation

- Spinal adjustment is said to improve the alignment, motion, and function of a vertebral joint.
- Used to treat: back pain, headaches, neck pain, arthritis, blood pressure, prevent surgery
- Insurance may only cover part of the cost of chiropractic adjustment
  - Often times the initial exam and x-rays are not covered
  - May only have a limited number of sessions covered

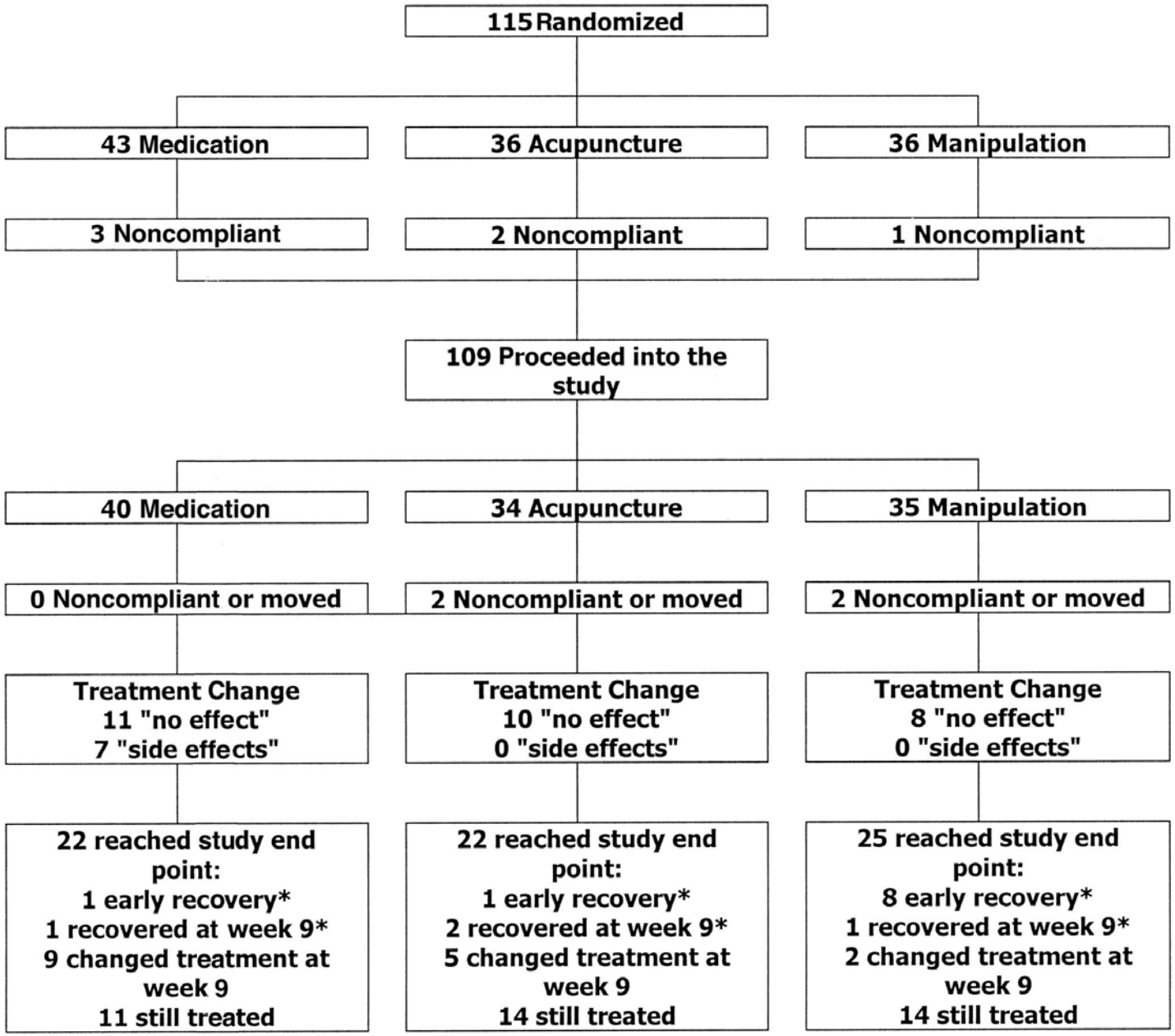
Comparison of Medication, Acupuncture, and Chiropractic Adjustment for Chronic Pain



	4-12M	13M-5Y	6-10Y	11-20Y	21-30Y	31-45Y
MEDICINE	8	19	7	7	1	0
ACUPUNCTURE	16	9	6	3	0	0
MANIPULATION	13	8	4	4	2	2

Figure 3. Duration of spinal pain symptoms.

(Giles & Muller, 2003)

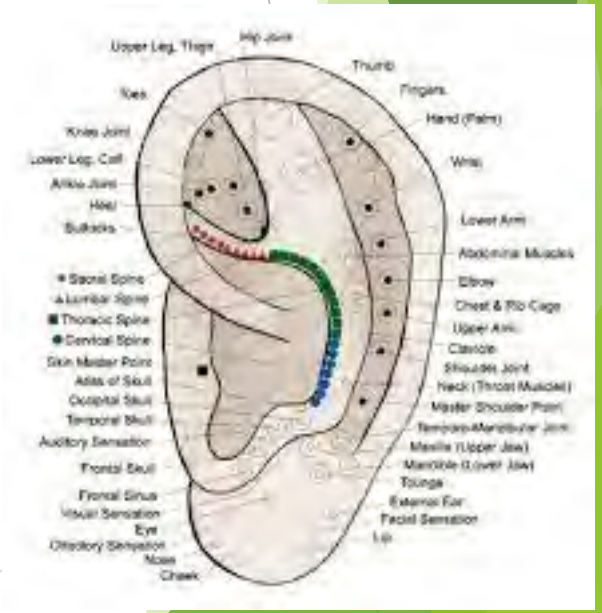


- Study found that chiropractic adjustment was better at reducing subjective and objective measures of pain than acupuncture and medication.
- Highest number of asymptomatic patients was found in the adjustment group.

(Giles & Muller, 2003)

Acupuncture

- Auricular acupuncture– ear acupuncture
- Dosage – single session vs multiple sessions
- Needles removed vs. indwelling needles
- Outcome Research (Asher et al. 2010):
  - Large-scale meta-analysis of 17 studies
  - Compared auricular therapy to sham, standard medical care, or control
  - Acute pain, chronic pain, perioperative pain
    - Average decrease in pain score was 1.56 standard deviations greater than control group
  - Decreased consumption of analgesics



(Asher et al., 2010)

Psychotherapies

- Hypnosis
- Mindfulness-based Stress Reduction
- Cognitive Behavioral Therapy for Chronic Pain
- Acceptance and Commitment Therapy
- Biofeedback
- Cognitive Behavioral Therapy for Insomnia

Psychotherapy

- Hypnosis
  - Been around for 200 years
  - Treating clinician makes suggestions changes in experience of perceptions, sensations, thoughts, and behavior
  - Weight loss, tobacco cessation, alcohol cessation, pain

Psychotherapy

- Mindfulness-based Stress Reduction
  - Intensive training in mindfulness meditation and application for coping with stress, illness, and pain
  - Paying attention, on purpose, moment-to-moment in a way that is nonjudgmental and nonreactive
  - MINDFUL BREATHING EXERCISE
  - Examination of 133 chronic pain patients with a variety of chronic pain conditions
  - Chronic back/neck pain or who had two or more comorbid pain conditions experienced the largest average improvement in pain severity and functional limitations
  - Lesser improvements were found in patients with fibromyalgia, arthritis, and chronic headache/migraine

(Rosenzweig, Greeson, Reibel, Green, Jasser, & Beasley, 2010)

Psychotherapy

- Cognitive Behavioral Therapy for Chronic Pain
- Psychological Factors
  - Pain cognitions
  - Catastrophizing
  - Hurt vs. harm
  - Negative affect
  - Answer-seeking
  - Pain self-efficacy

(Murphy, McKellar, Raffa, Clark, Kerns, & Karlin, n.d.)

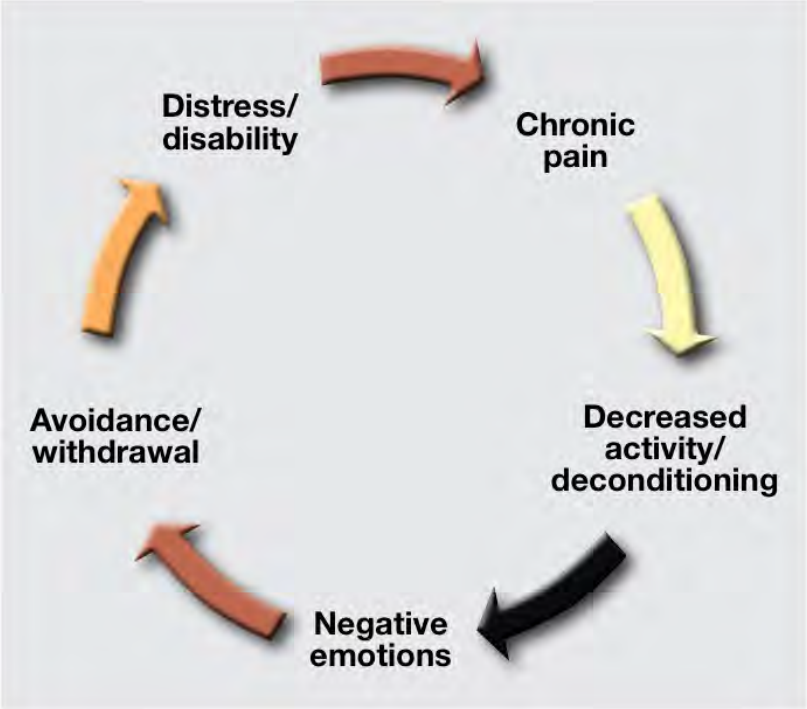
Psychotherapy

- Cognitive Behavioral Therapy for Chronic Pain
- Behavioral Factors
  - Guarding
  - Resting/under-activity
  - Over-activity
  - Pacing
  - Relaxation training
- Social
  - Solicitous significant other
  - Punishing

(Murphy, McKellar, Raffa, Clark, Kerns, & Karlin, n.d.)

Psychotherapy

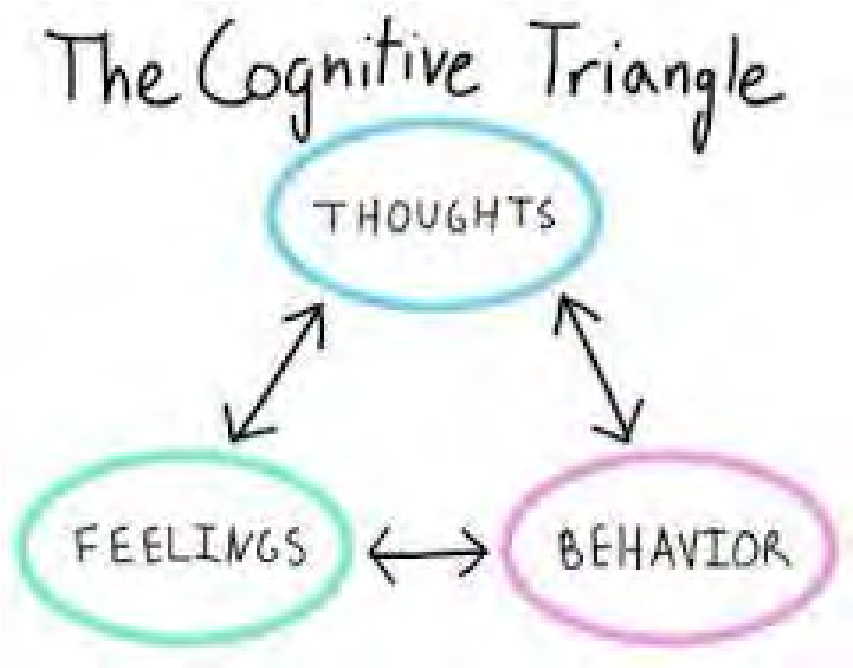
- Chronic Pain Cycle



(Murphy, McKellar, Raffa, Clark, Kerns, & Karlin, n.d.)

Psychotherapy

- Cognitive Behavioral Therapy for Chronic Pain



CBT for Chronic Pain

Session 1: Interview and Assessment .....
Session 2: Treatment Orientation.....
Session 3: Assessment Feedback and Goal Setting ...
Session 4: Exercise and Pacing.....
Session 5: Relaxation Training .....
Session 6: Pleasant Activities 1 .....
Session 7: Pleasant Activities 2 .....
Session 8: Cognitive Coping 1 .....
Session 9: Cognitive Coping 2 .....
Session 10: Sleep .....
Session 11: Discharge Planning.....
Session 12: Booster Session .....

(Murphy, McKellar, Raffa, Clark, Kerns, & Karlin, n.d.)

CBT for Chronic Pain Outcomes

- Been examined for 30 years
- Meta-analysis (Hoffman, Papas, Chatkoff, & Kerns, 2007)
  - Examined 22 studies
  - Found support for CBT-CP as part of a multidisciplinary treatment approach and as a stand-alone intervention
  - Compared to control, CBT-CP participants showed improvement in pain intensity, pain-related interference, health-related quality of life, and depression
- Can be done in group and individual modalities

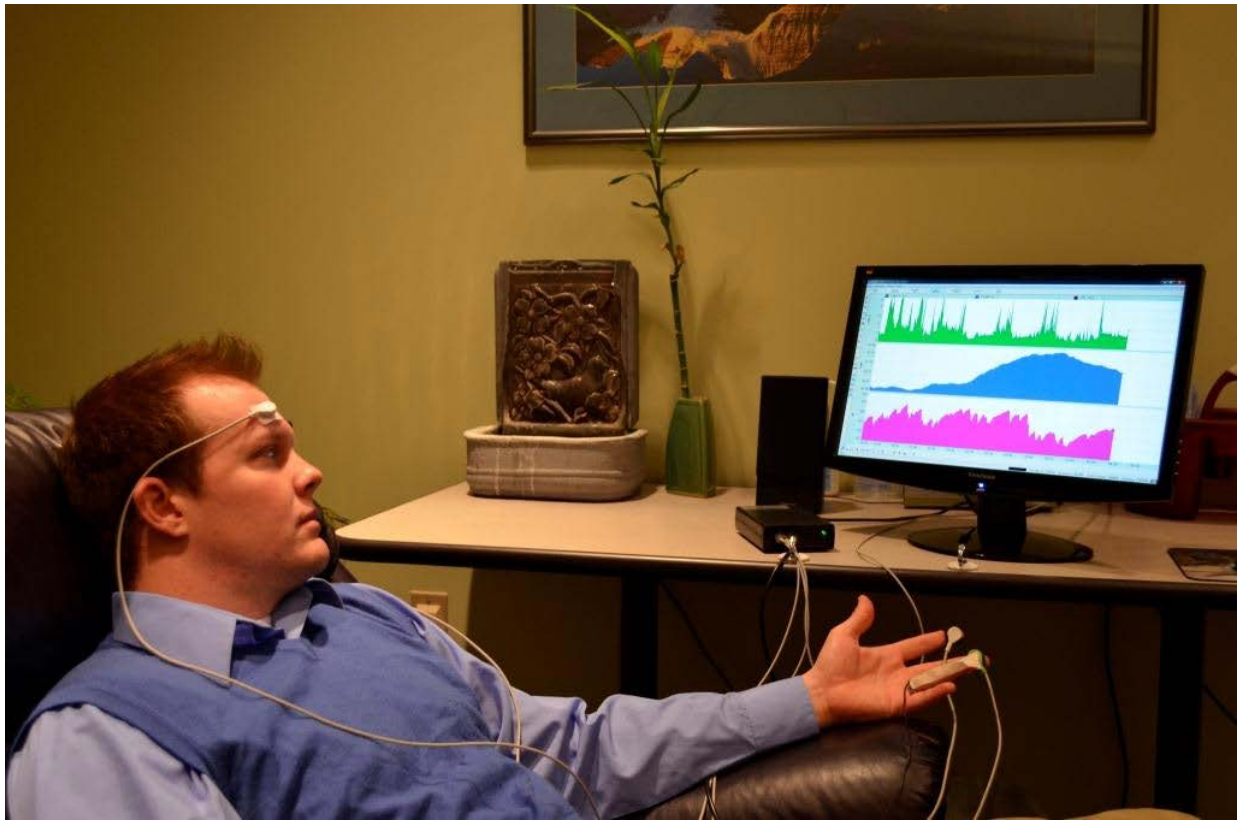
Psychotherapy

- Acceptance and Commitment Therapy
  - Uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility
  - Use metaphor to help people change their relationship with their thoughts
    - Piece of paper metaphor
  - Committing themselves to value-based behavior despite pain and other mental health concerns
  - Large body of research suggesting it is helpful with a number of conditions – PTSD, depression, chronic pain

Psychotherapy

- Biofeedback
  - Electronic monitoring of automatic process used to train a patient to acquire voluntary control
  - Types
    - Electromyography (EMG) – muscle tension
    - Thermal – skin temperature
    - Neurofeedback (EEG) – brain wave activity
  - 8 – 20 sessions (depending on the condition)
  - Assign home practice
  - Typically helps with conditions impacted by stress

Biofeedback



The Role of Insomnia

- 50-80% of chronic pain patients also have ongoing sleep problems (Cheatle et al., 2016)
- Chronic pain impacts sleep, and poor sleep impacts chronic pain
- Insomnia frequently "takes on a life of its own"
  - Treating chronic pain does not necessarily impact sleep
  - But treating sleep frequently does improve chronic pain!
- Cognitive Behavioral Therapy for Insomnia
  - Stimulus-control
  - Sleep Restriction
  - Cognitive Restructuring
- Get underlying medical problems under control – sleep apnea

Parting thoughts for court professionals

- A co-occurring disorders treatment plan is multifaceted as there is more than one problem to address
- Know what kind of providers may be available in your community to treat specialized problems
- Know what evidence-based therapies are available, and ask if your referrals sources are using them to treat your clients
- Find treatment providers in your community and make a personal connection
  - Your personal recommendation to clients will go a long way!
- Look for programs and practitioners that provide education to family and friends
  - Stop the enabling and punishing
- See if there is anything you can do to improve communication
  - E.g., get copies of the provider Release of Information for clients to fill out when at court appointments

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From Brain Science to Public Health: Addiction as Disease

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Associate Director Addiction Medicine
Virginia Commonwealth University
Addiction Medicine Consultant
Virginia Medicaid (DMAS)

Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

Anne Case[1] and Angus Deaton[1]

15078–15083 | PNAS | December 8, 2015 | vol. 112 | no. 49

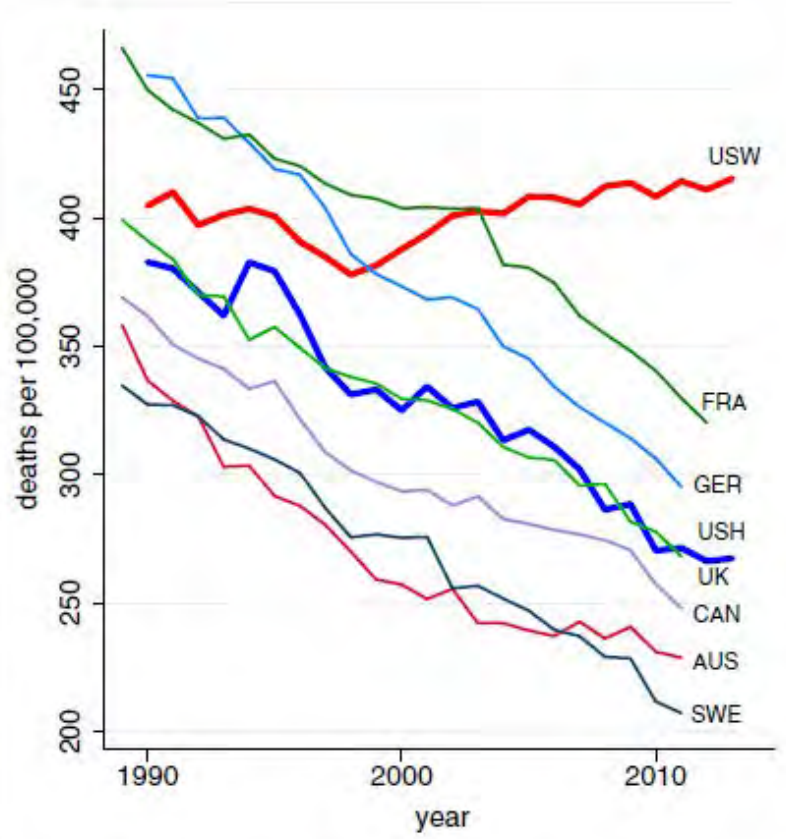


Fig. 1. All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

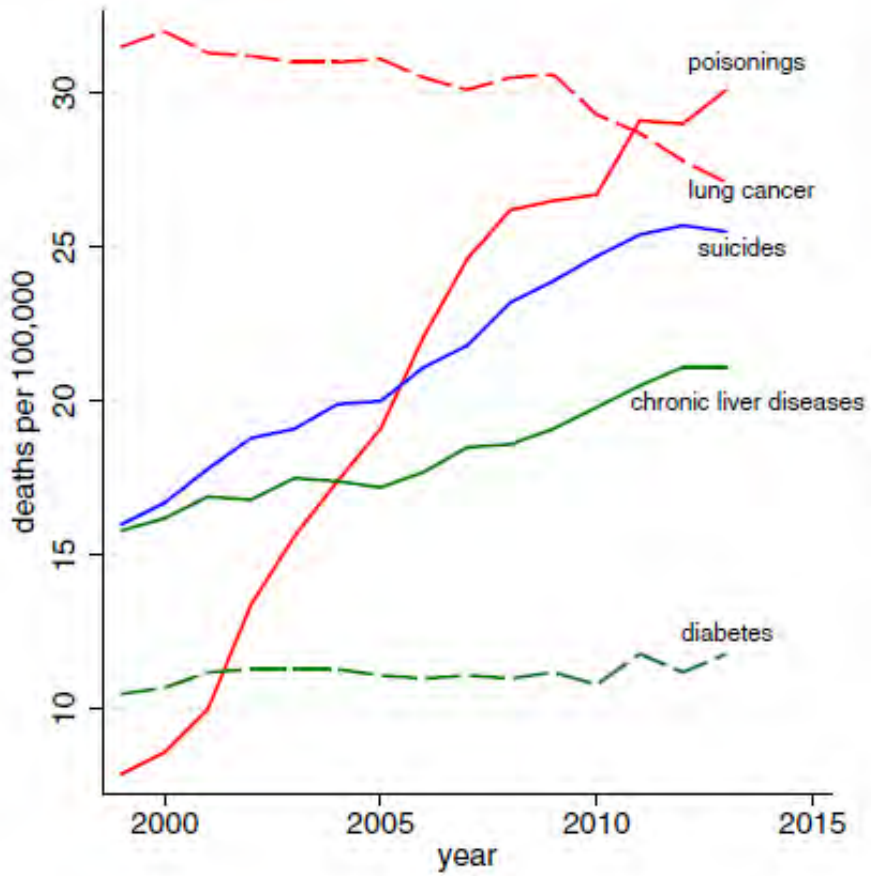
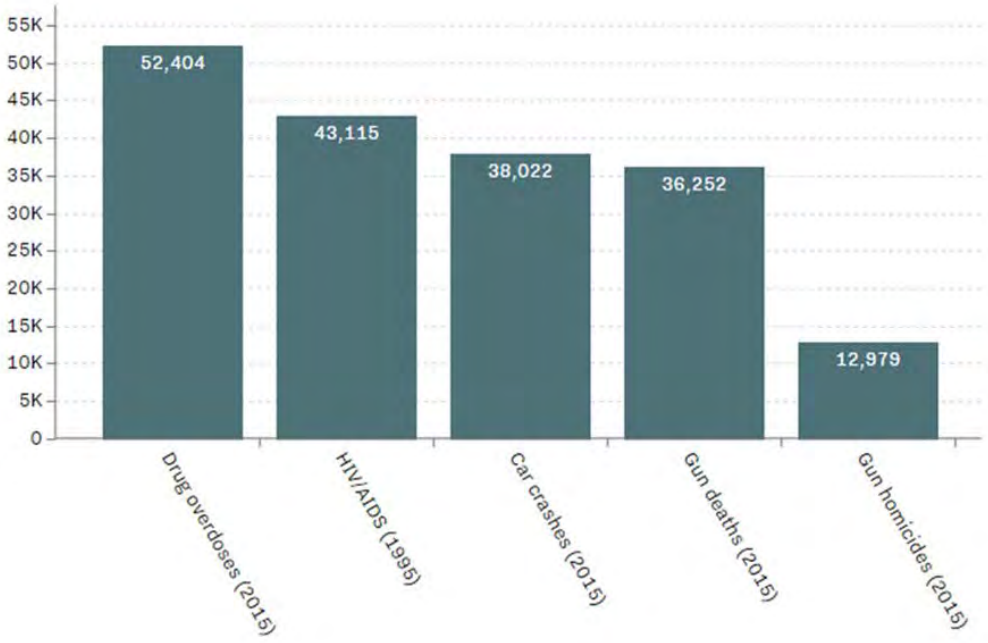


Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.

Drug overdoses killed more people in 2015 than HIV/AIDS at its 1995 peak

Total deaths in America by cause and year



Source: Centers for Disease Control and Prevention

Vox

TheUpshot

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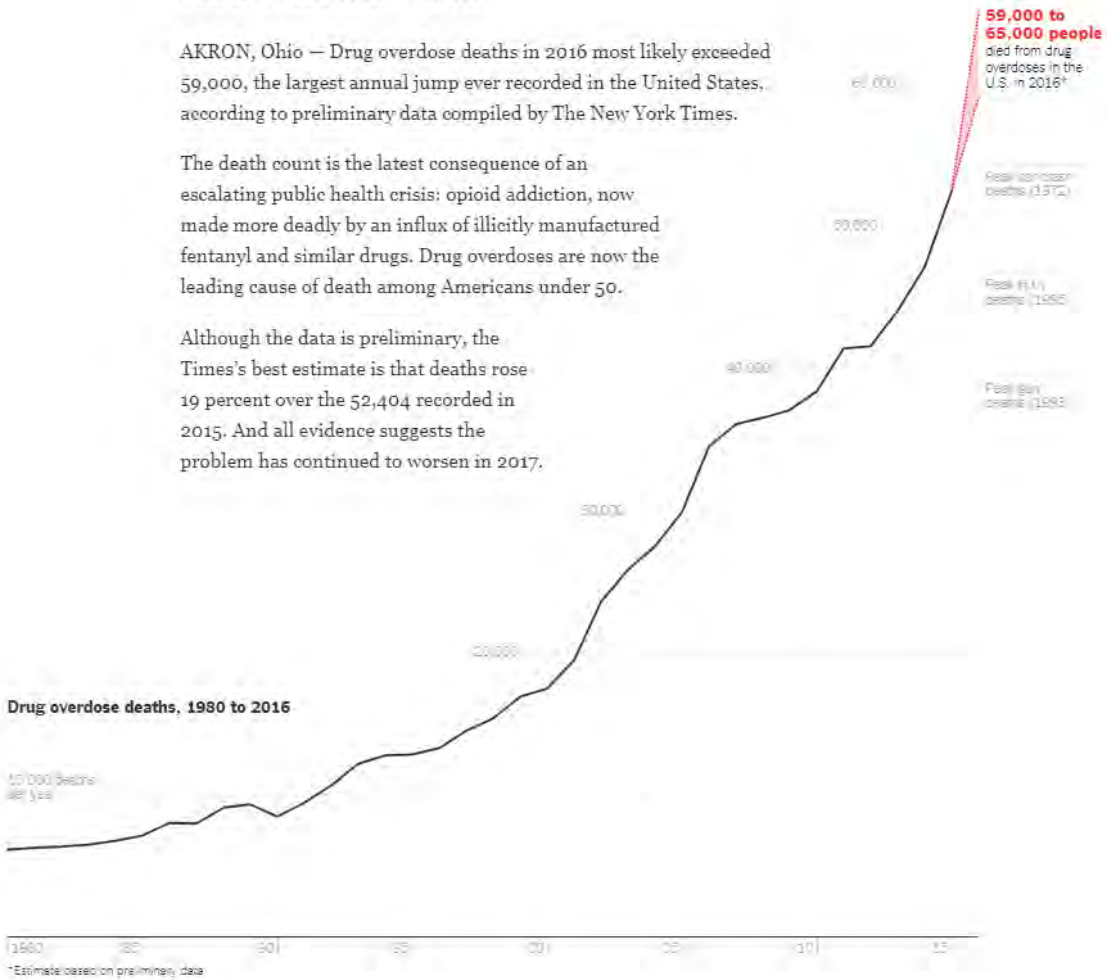
Drug Deaths in America Are Rising Faster Than Ever

By JOSH KATZ JUNE 5, 2017

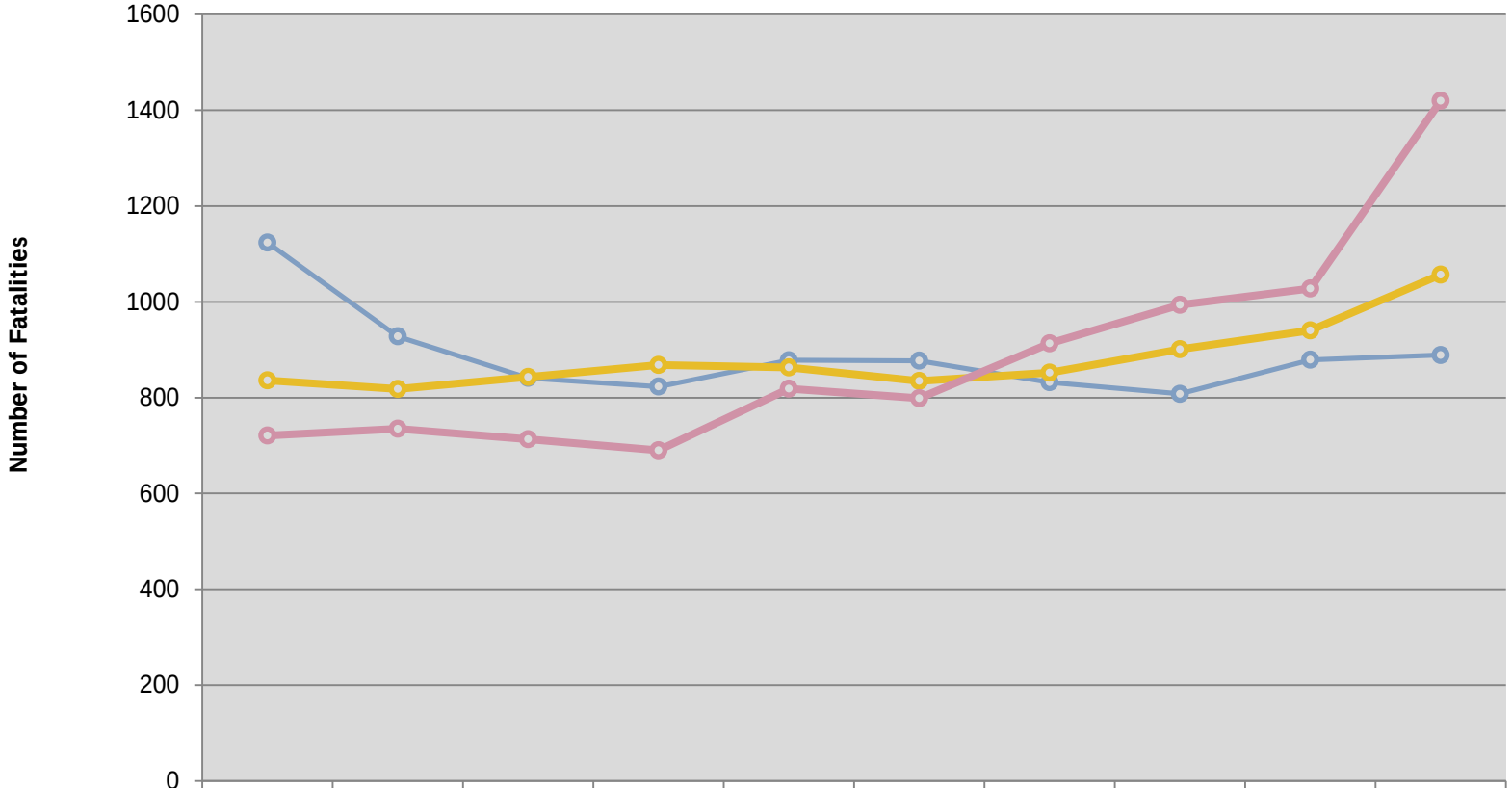
AKRON, Ohio — Drug overdose deaths in 2016 most likely exceeded 59,000, the largest annual jump ever recorded in the United States, according to preliminary data compiled by The New York Times.

The death count is the latest consequence of an escalating public health crisis: opioid addiction, now made more deadly by an influx of illicitly manufactured fentanyl and similar drugs. Drug overdoses are now the leading cause of death among Americans under 50.

Although the data is preliminary, the Times's best estimate is that deaths rose 19 percent over the 52,404 recorded in 2015. And all evidence suggests the problem has continued to worsen in 2017.



TOP 3 METHODS OF UNNATURAL DEATH

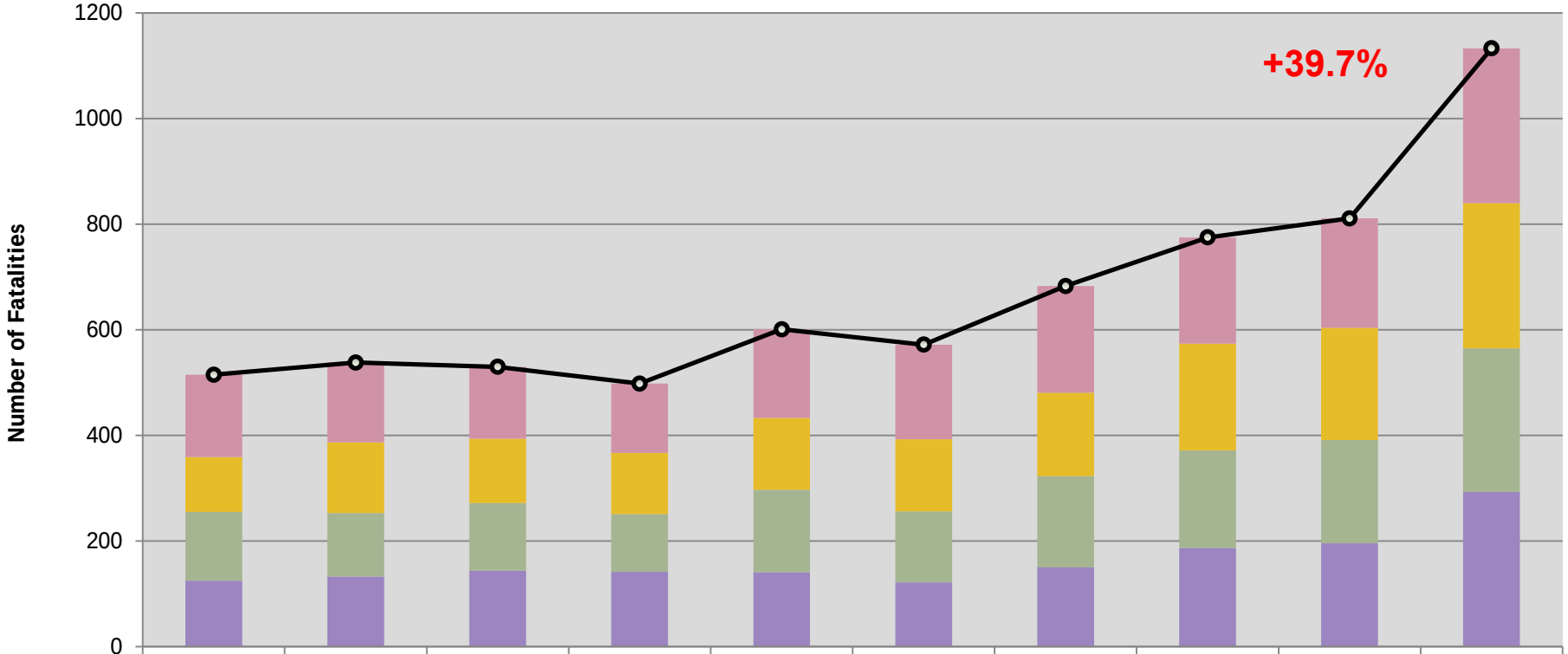


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
Motor Vehicle Related	1124	928	841	823	878	877	832	808	879	889
Gun Related	836	818	843	868	863	835	852	901	940	1057
Fatal Drug Overdose	721	735	713	690	819	799	913	994	1028	1420

[1] Top 3 methods of death (motor vehicles, guns, and drugs) include all manners of death (accident, homicide, suicide, and undetermined)

ALL OPIOIDS

Total Number of Fatal Opioid Overdoses by Quarter and Year of Death, 2007-2016



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
Q4	156	151	136	131	168	179	202	201	207	293
Q3	104	134	122	116	136	137	158	202	213	275
Q2	130	120	128	109	156	134	173	185	195	272
Q1	125	133	144	142	141	122	150	187	196	293
Total Fatalities	515	538	530	498	601	572	683	775	811	1133

http://www.vdh.virginia.gov/data/opioid-overdose/

VA Opioid Addiction Indicators | Information

Virginia Opioid Addiction Indicators

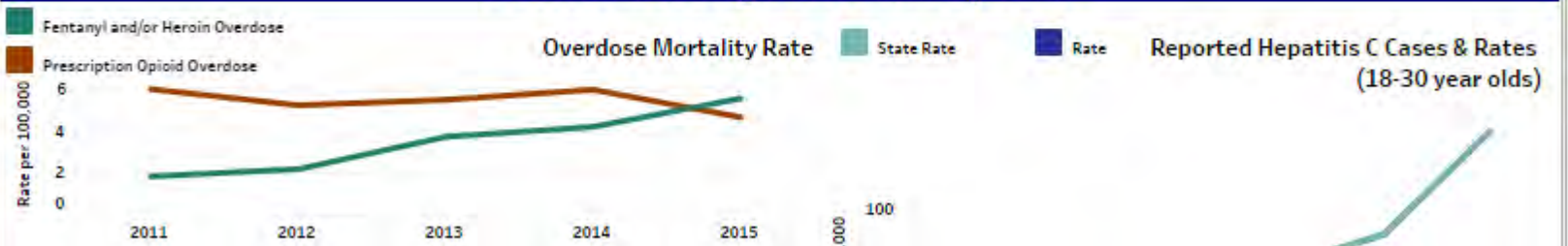
Year 2015 | Geographic Grouping VDH Health Region | Select Detail (All)

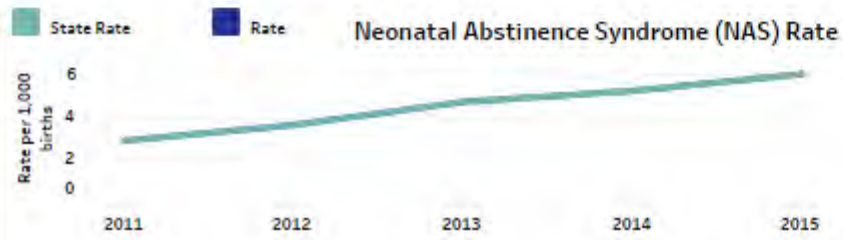
2015 Virginia State Summary

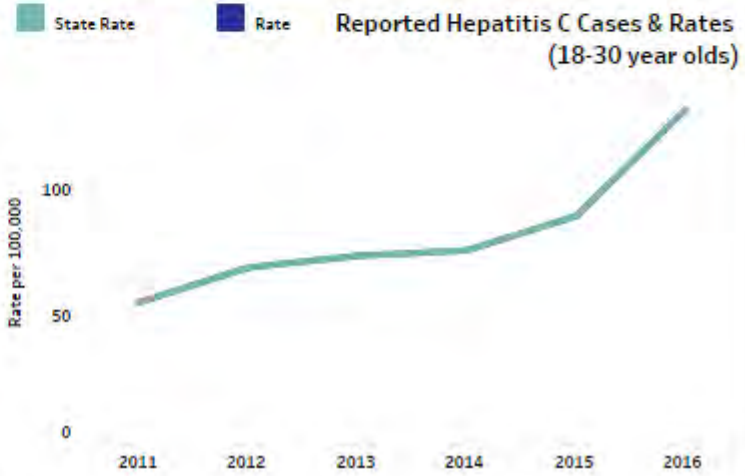
Fentanyl and/or Heroin Overdose	Prescription Opioid Overdose	ED Heroin Overdose	ED Opioid Overdose	EMS Narcan	Reported Hepatitis C (18-30 year olds)	Diagnosed HIV
Deaths	Deaths	Visits	Visits	Administrations	New Cases	New Cases
471	398	800	7,326	2,858	1,382	969
Mortality Rate	Mortality Rate	Visit Rate	Visit Rate	Administration Rate	New Case Rate	New Case Rate
5.6	4.7	9.5	87.4	33.9	89.7	11.6

Rates are calculated as per 100,000 Virginia residents, except for Neonatal Abstinence Syndrome (NAS), which is calculated as per 1,000 live births.

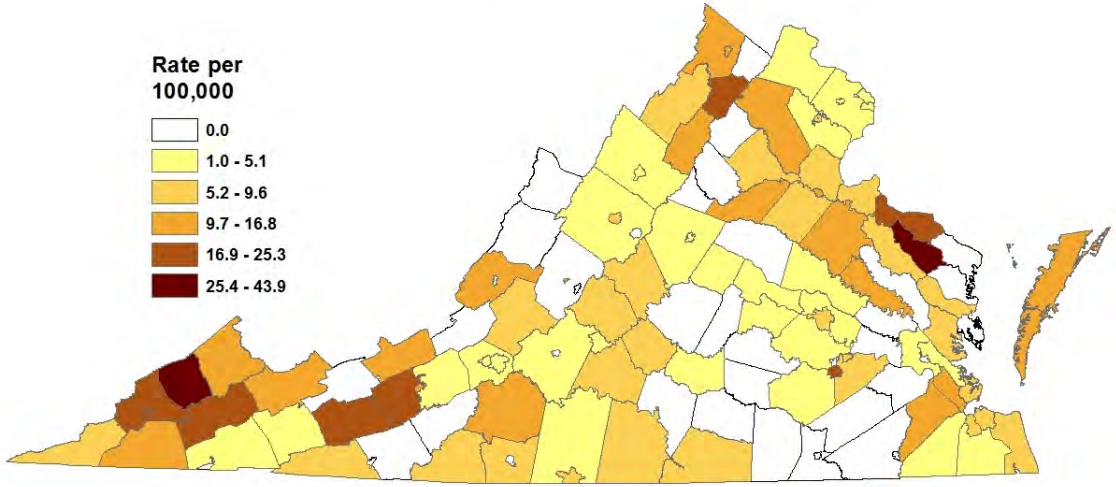
VDH Health Region Trends by Year



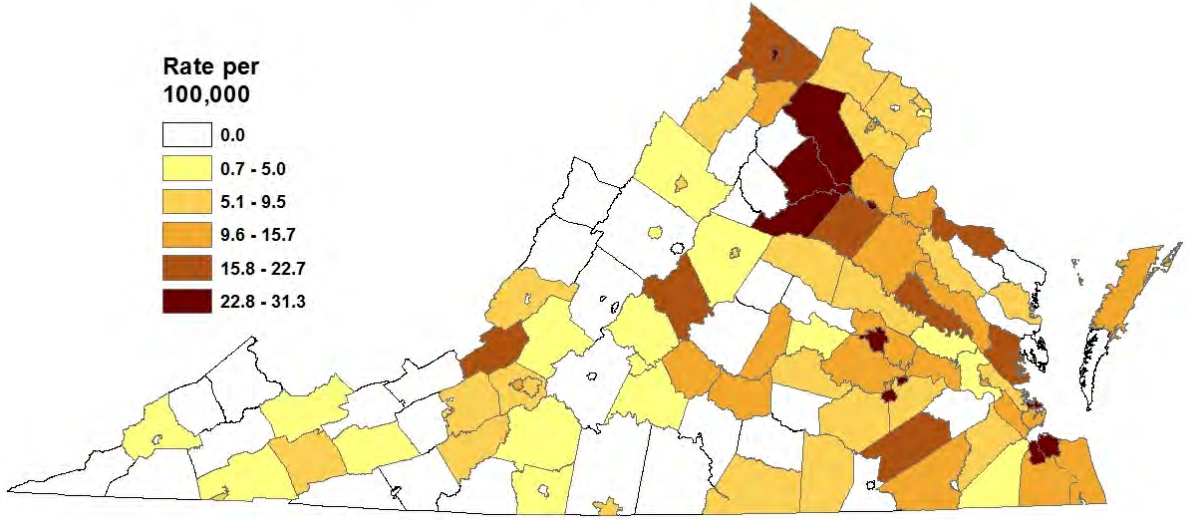




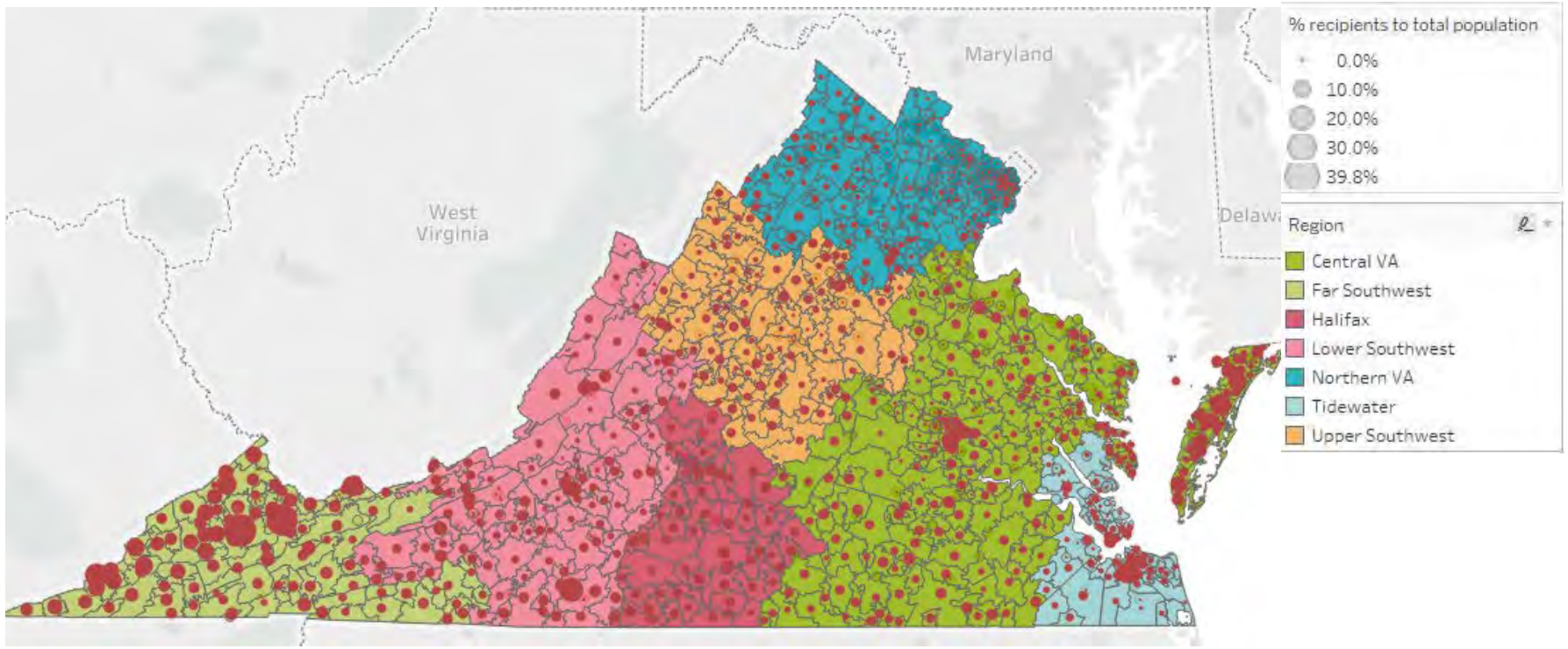
Rate of Fatal Prescription Opioid (Excluding Fentanyl) Overdoses by Locality of Overdose, 2016



Rate of Fatal Fentanyl (Rx, Illicit, and Analogs) and/or Heroin Overdoses by Locality of Overdose, 2016



Communities Impacted by Addiction



Source: Department of Medical Assistance Services – claims/encounter data (November 3, 2016) and 2010 U.S. Census Bureau Population.
Circles % of Medicaid recipients whose claims/encounter data included an addiction related diagnosis respective to the total population in that zip code.

ARTS Addiction and Recovery Treatment Services

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

Opioids: A Public Health Crisis

- All VA institutions, public and private, needed to respond

Virginia's Medicaid Program Key Facts

1 Million +

Virginians covered by Medicaid/CHIP

1 in 8

Virginians rely on Medicaid

2 in 3

Residents in nursing facilities supported by Medicaid - Primary payer for LTSS

50%

Medicaid beneficiaries are children

62%

Long-Term Services & Supports spending is in the community

1 in 3

Births covered in Virginia

Behavioral Health

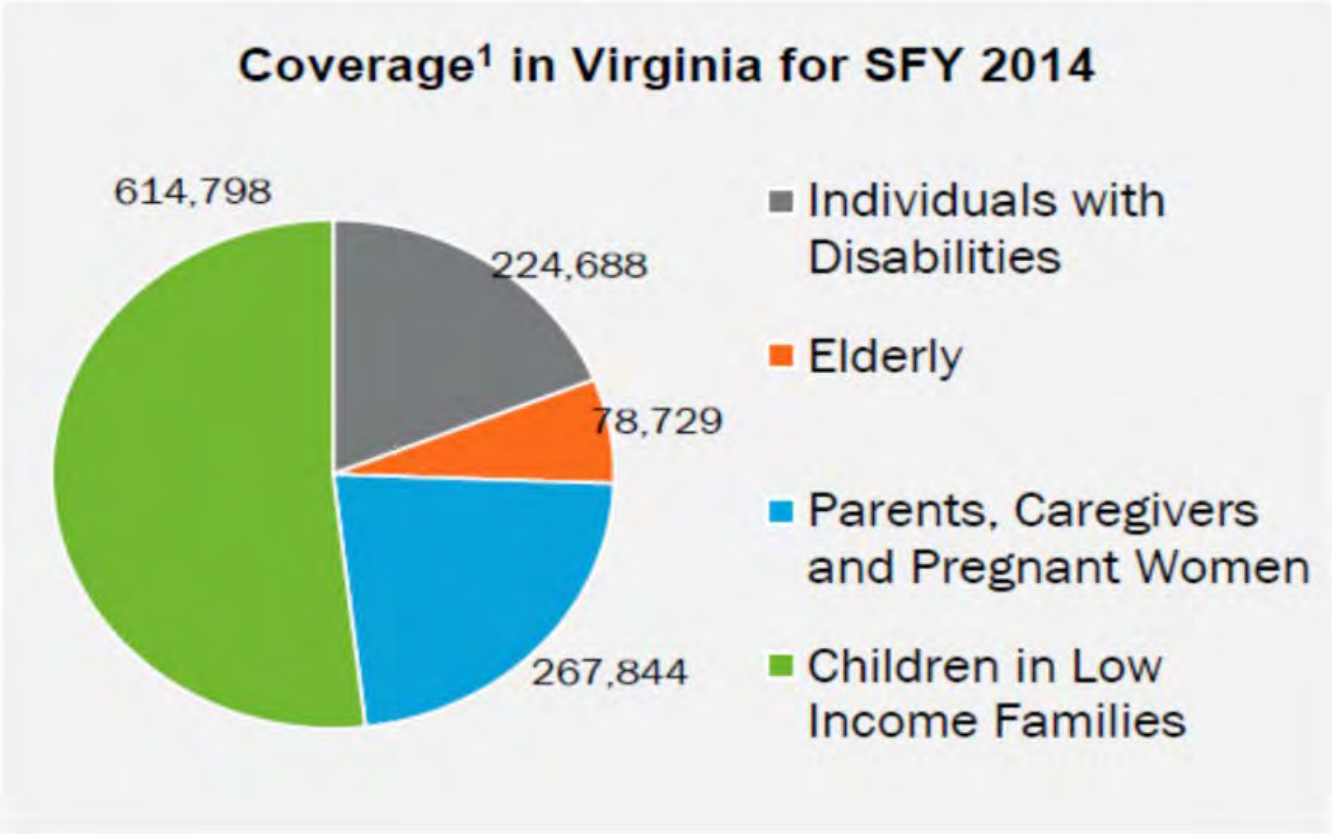
Medicaid is primary payer for services

ARTS Addiction and Recovery Treatment Services

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

Overview: Virginia Medicaid

Virginia's Medicaid population breakdown



Medicaid coverage is primarily available to Virginians who are children in low-income families, pregnant women, elderly, individuals with disabilities and parents meeting specific income thresholds.

ARTS Addiction and Recovery Treatment Services

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

Addiction Brain Science

Not everyone who uses drugs becomes addicted

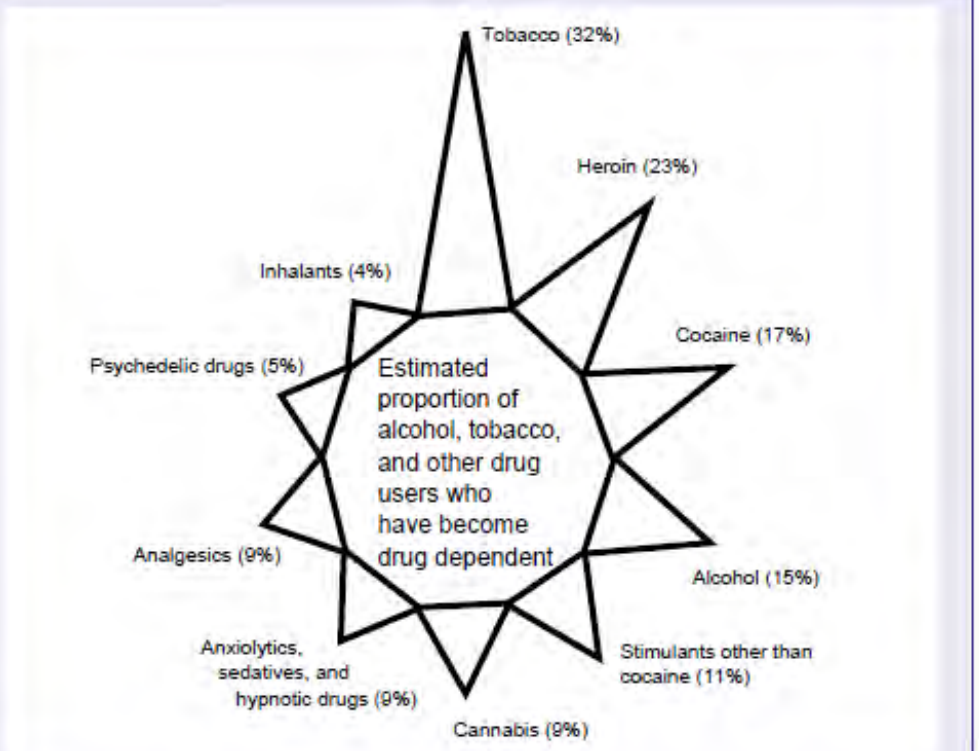


Figure 2 Estimated proportion of alcohol, tobacco, and other drug users who have developed clinical syndromes of drug dependence as defined according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised*. The data were obtained from the National Comorbidity Survey, 1990–1992.

SOURCE: Adapted from Anthony et al. 1994.

Experimental and Clinical Psychopharmacology
1994, Vol. 2, No. 3, 244–268

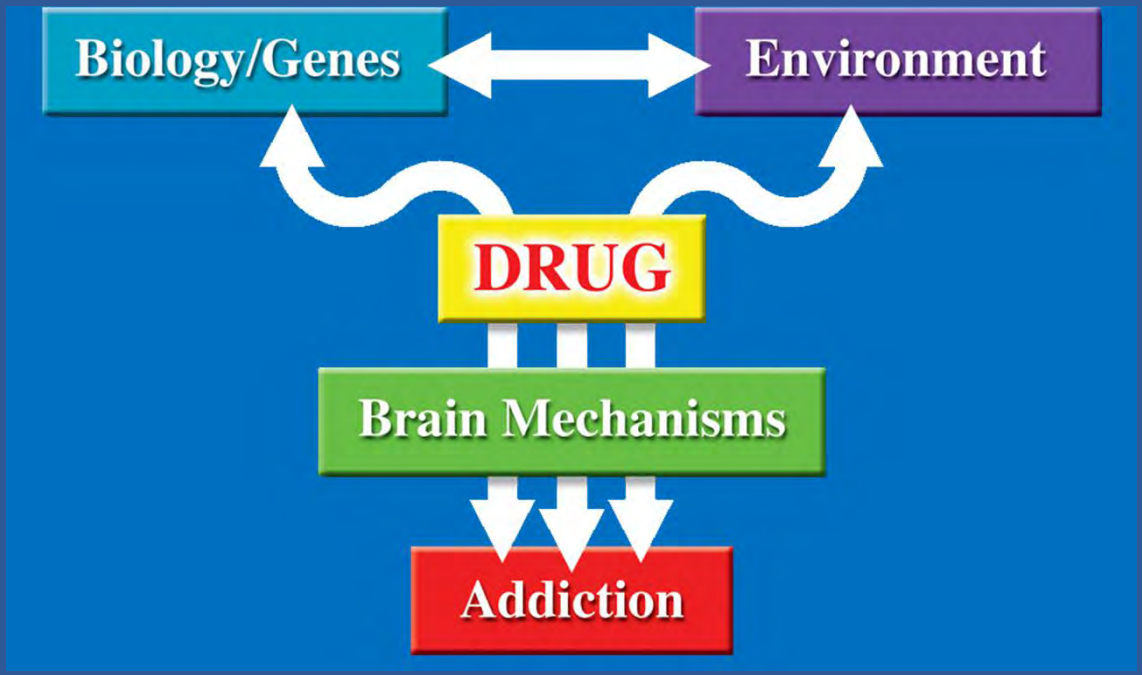
In the public domain

Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances, and Inhalants: Basic Findings From the National Comorbidity Survey

James C. Anthony, Lynn A. Warner, and Ronald C. Kessler

Why do some people become addicted and not others?

- Genetic
- Home environment/neighborhood
- Age of onset
- Psychiatric co-morbidities – Trauma
  - Childhood sexual and/or physical abuse (>60% of individuals w addiction)
  - PTSD (c 50% of individuals w PTSD lifetime addiction)
- Violence – history/current violent relationship



What is Addiction?

Addiction: Brain-Centered Disease
Whose visible symptoms are behaviors

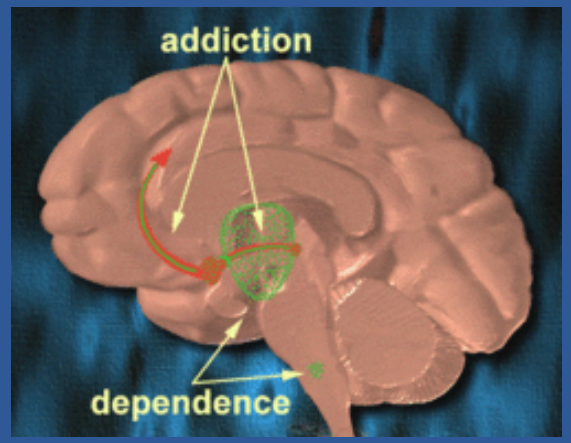
What is Addiction?

Addiction: Brain-Centered Disease
Whose visible symptoms are behaviors

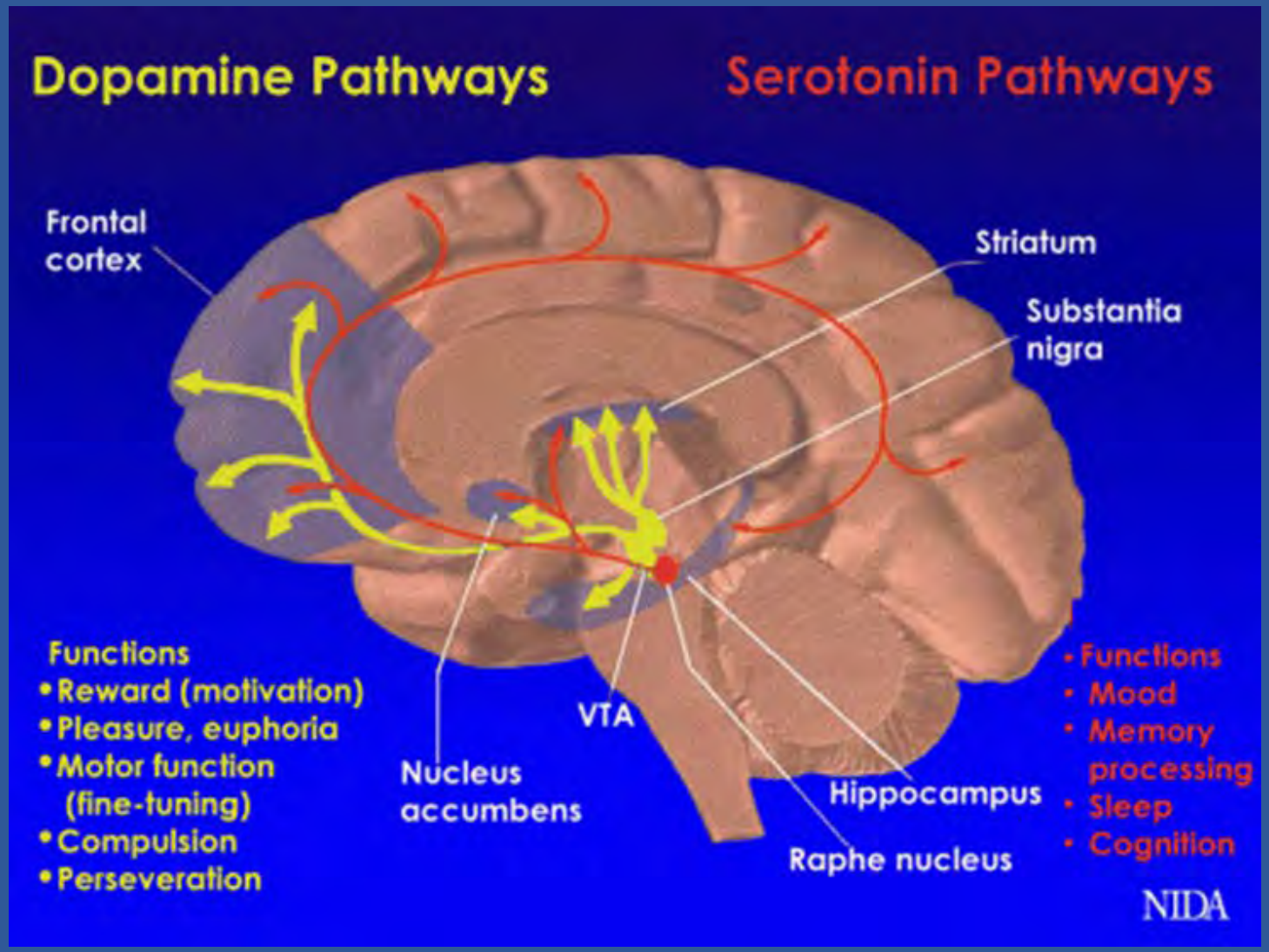
Most Salient Symptom:
Continued use despite adverse consequences

Addiction vs Dependence/Tolerance

- Physical dependence/tolerance is not addiction
  - Addiction is a brain disease that affects behaviour
  - Dependence is an expected adaptation of the body to a specific substrate so that in the absence of that substrate a withdrawal syndrome develops
  - Tolerance is pharmacologic principle where reaction to specific concentration of drug is reduced with repeated use
  - Affect different parts of the brain
- Many medications cause either tolerance or dependence or both (SSRIs, HTN medication)
  - Everyone taking enough opioid continuously for longer than a week

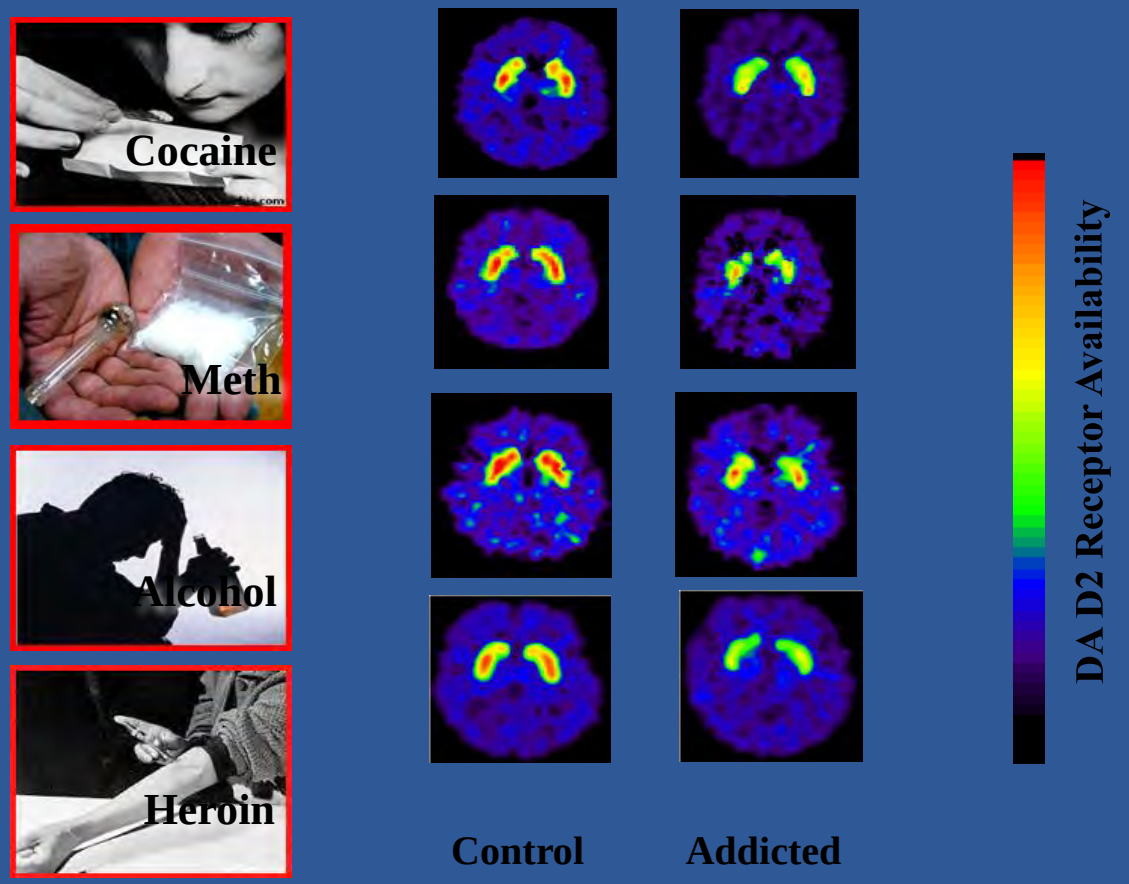


Dopamine and the “Hijacked Brain” Hypothesis



Functionally…

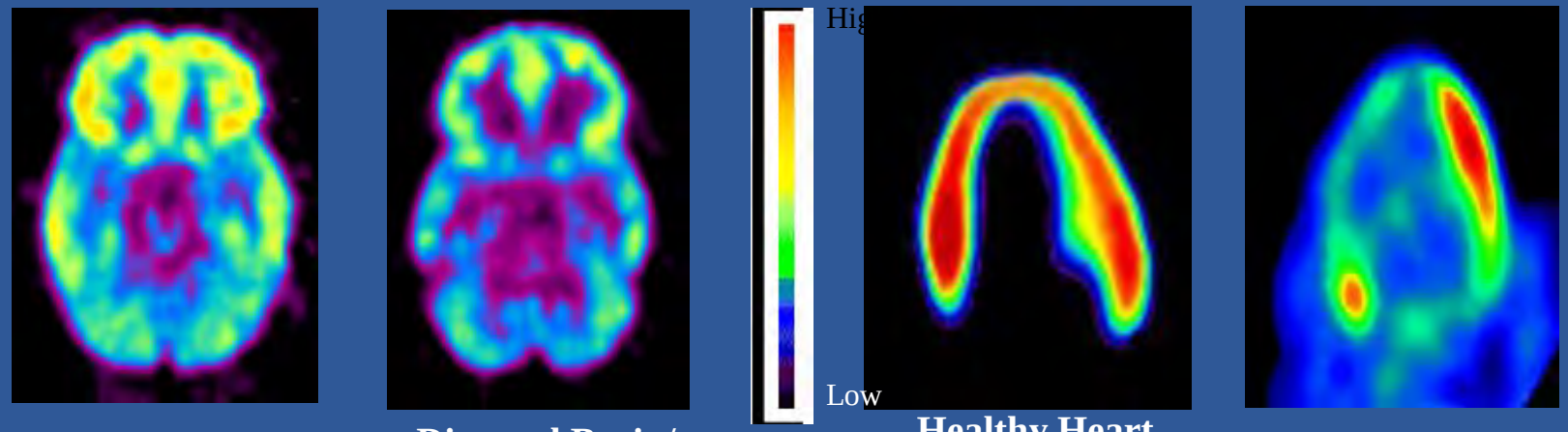
Dopamine D2 Receptors are Decreased by Addiction



Addiction Changes Biology

Decreased Brain Metabolism in *Drug User*

Decreased Heart Metabolism in *Heart Disease Patient*



Diseased Brain/ Cocaine User

Healthy Heart

Diseased Heart

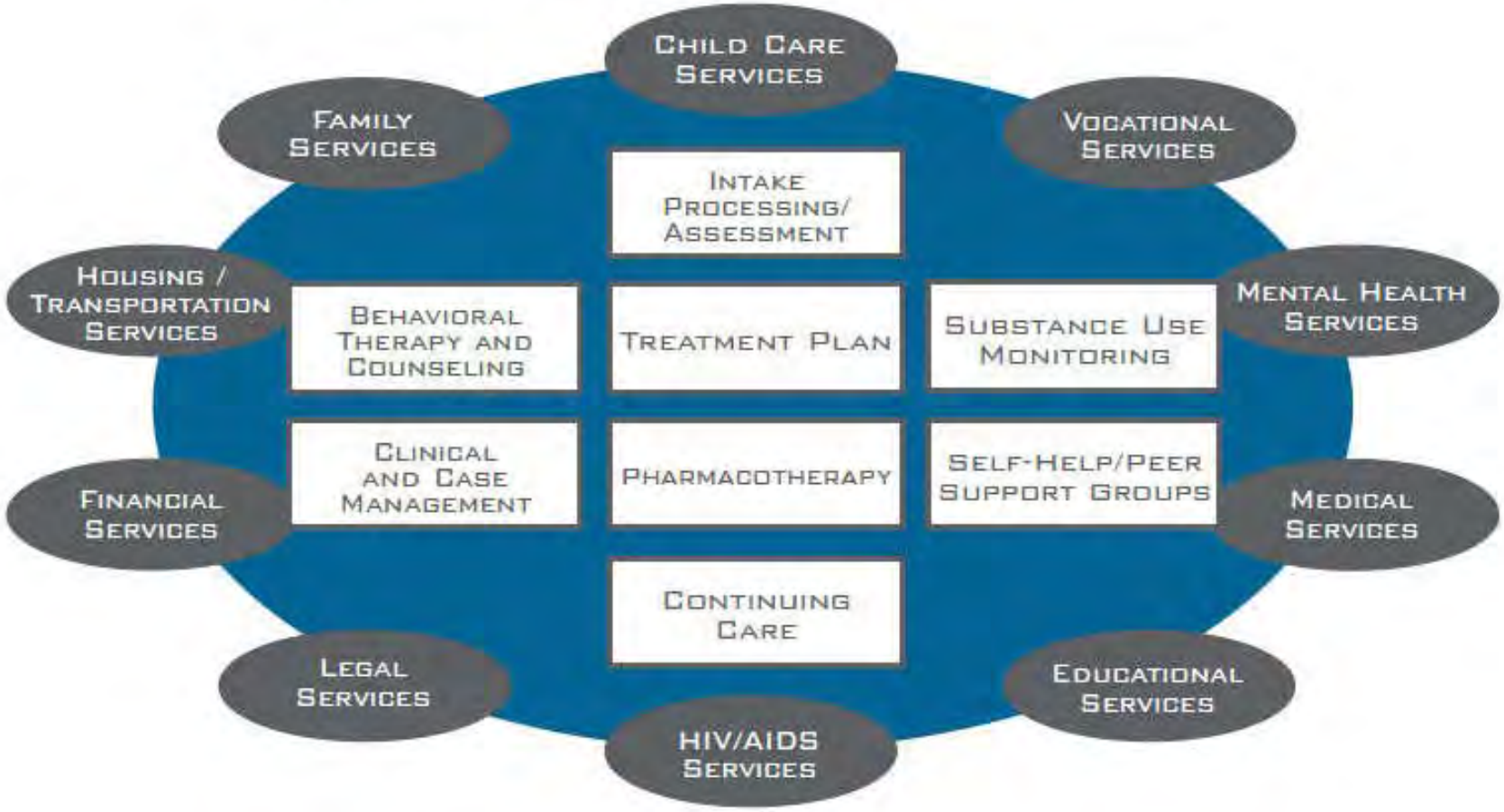
Research supported by NIDA addresses all of these components of addiction.

NIDA

If left untreated, addiction lasts a lifetime

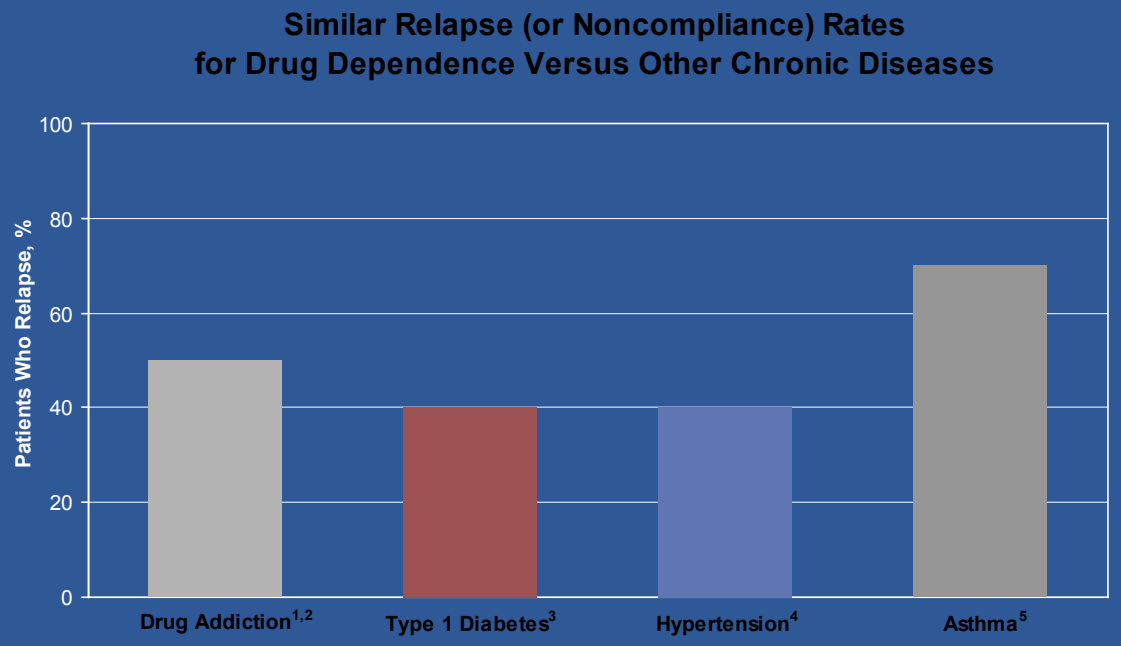
- The natural history of addiction:
  - Relationship failure
  - Parenting failure
  - Inability to function in workforce
  - Incarceration
  - Homelessness
  - Untreated medical and psychiatric co-morbidities
  - HIV HCV acquisition and transmission
  - Overdose
  - Death

What is Treatment?



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

How effective is treatment?



Drug Dependence, a Chronic Medical Illness

Implications for Treatment, Insurance, and Outcomes Evaluation

A. Thomas McLellan, PhD
David C. Lewis, MD
Charles P. O'Brien, MD, PhD
Herbert D. Kleber, MD

The effects of drug dependence on social systems has helped shape the generally held view that drug dependence is primarily a social problem, not a health problem. In turn, medical approaches to prevention and treatment are lacking. We examined evidence that drug (including alcohol) dependence is a chronic medical illness. A literature review compared the diagnoses, heritability, etiology (genetic and environmental factors), pathophysiology, and response to treatments (adherence and relapse) of drug dependence vs type 2 diabetes mellitus, hypertension, and asthma. Genetic heritability, personal choice, and environmental factors are comparably involved in the etiology and course of all of these disorders. Drug dependence produces significant and lasting changes in brain chemistry and function. Effective medications are available for treating nicotine, alcohol, and opiate dependence but not stimulant or marijuana dependence. Medication adherence and relapse rates are similar across these illnesses. Drug dependence generally has been treated as if it were an acute illness. Review results suggest that long-term care strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated, and evaluated like other chronic illnesses.

JAMA. 2000;284:1689-1695 www.jama.com

Many expensive and disturbing social problems can be traced directly to drug dependence. Recent studies[1-4] estimated that drug dependence costs the United States approximately $67 billion annually in crime, lost work productivity, foster care, and other social problems.[2-4] These expensive effects of drugs on all social systems have been important in shaping the public view that drug dependence is primarily a social problem that requires interdiction and law enforcement rather than a health problem that requires prevention and treatment.

This view is apparently shared by many physicians. Few medical schools or residency programs have an adequate required course in addiction. Most physicians fail to screen for alcohol or drug dependence during routine examinations.[5] Many health professionals view such screening efforts as a waste of time. A survey[6] of general practice physicians and nurses indicated that most believed no available medical or health care interventions would be "appropriate or effective in treating addiction." In fact, 40% to 60% of patients treated for alcohol or other drug dependence return to active substance use within a year following treatment discharge.[7-9] One implication is that these disappointing results confirm the suspicion that drug dependence is not a medical illness and thus is not significantly affected by health care interventions. Another possibility is that current treatment strategies and outcome expectations view drug dependence as a curable, acute condition. If drug dependence is more like a chronic illness, the appropriate standards for treatment and outcome expectations would be found among other chronic illnesses.

To explore this possibility, we undertook a literature review comparing drug dependence with 3 chronic illnesses: type 2 diabetes mellitus, hypertension, and asthma. These examples were selected because they have been well studied and are widely believed to have effective treatments, although they are not yet curable. Our review searched all English-language medical and health journals in MEDLINE from 1980 to the present using the following key words: *heritability*, *pathophysiology*, *diagnosis*, *course*, *treatment*, *compliance*, *ad-*

Author Affiliations: The Treatment Research Institute, Philadelphia, Pa (Dr McLellan); The Penn/VA Center for Studies of Addiction at the Veterans Affairs Medical Center and the University of Pennsylvania, Philadelphia (Drs McLellan and O'Brien); The Brown University Center for Alcohol and Addiction Studies, Providence, RI (Dr Lewis); and The National Center on Addiction and Substance Abuse at Columbia University, New York, NY (Dr Kleber).
Corresponding Author and Reprints: A. Thomas McLellan, PhD, The Treatment Research Institute, 150 S Independence Mall W, Suite 600, Philadelphia, PA 19106-3475 (e-mail: tmclellan@tresearch.org).

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Graph adapted from Caron Foundation. http://www.caron.org/pdfs/RelapseRecovery-2003.pdf., 2. Hoffman NG, Miller NS. *Psychiatr Ann.* 1992;22(8):402-408. 3. Graber AL et al. *Diabetes Care*. 1992;15(11):1477-1483., 4. Clark LT. *Am Heart J*. 1991;121(2 pt 2):644-669., 5Dekker FW et al. *Eur Respir J*. 1993;6(6):886-890.

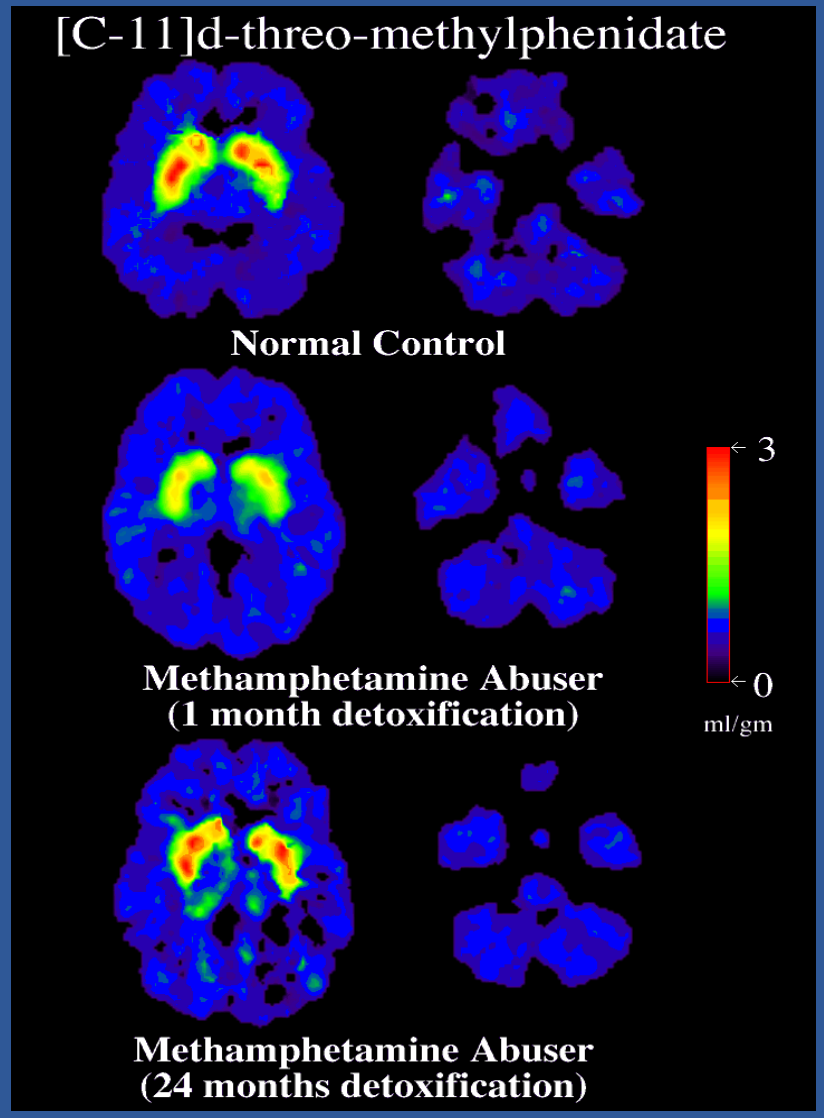
What is the Goal of Treatment?

- **Recovery**
  - Protracted Abstinence
  - Restored Functioning
  - (Re)Integration into family, community, society

Recovery Leads to Return of Normal Brain Structure and Function

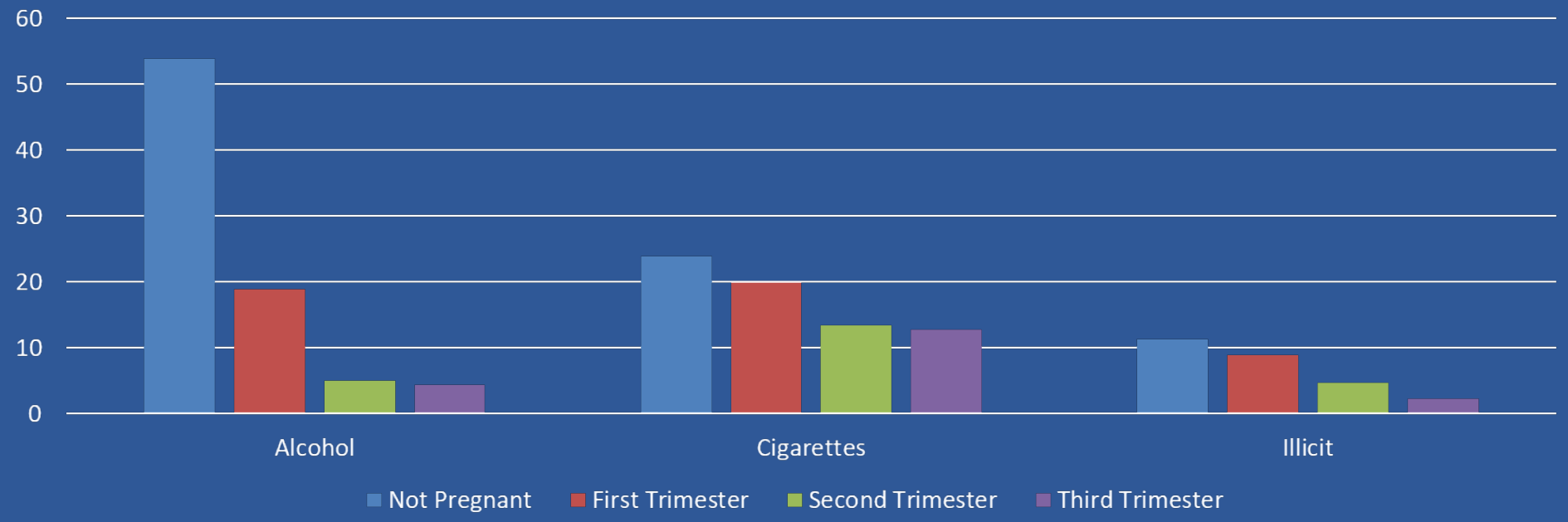
DAT Recovery with prolonged abstinence from methamphetamine

Volkow et al., J. Neuroscience, 2001.



Pregnancy

What happens when women who use drugs get pregnant?



National Survey Drug Use and Health 2013/2014
Past Month Use Data

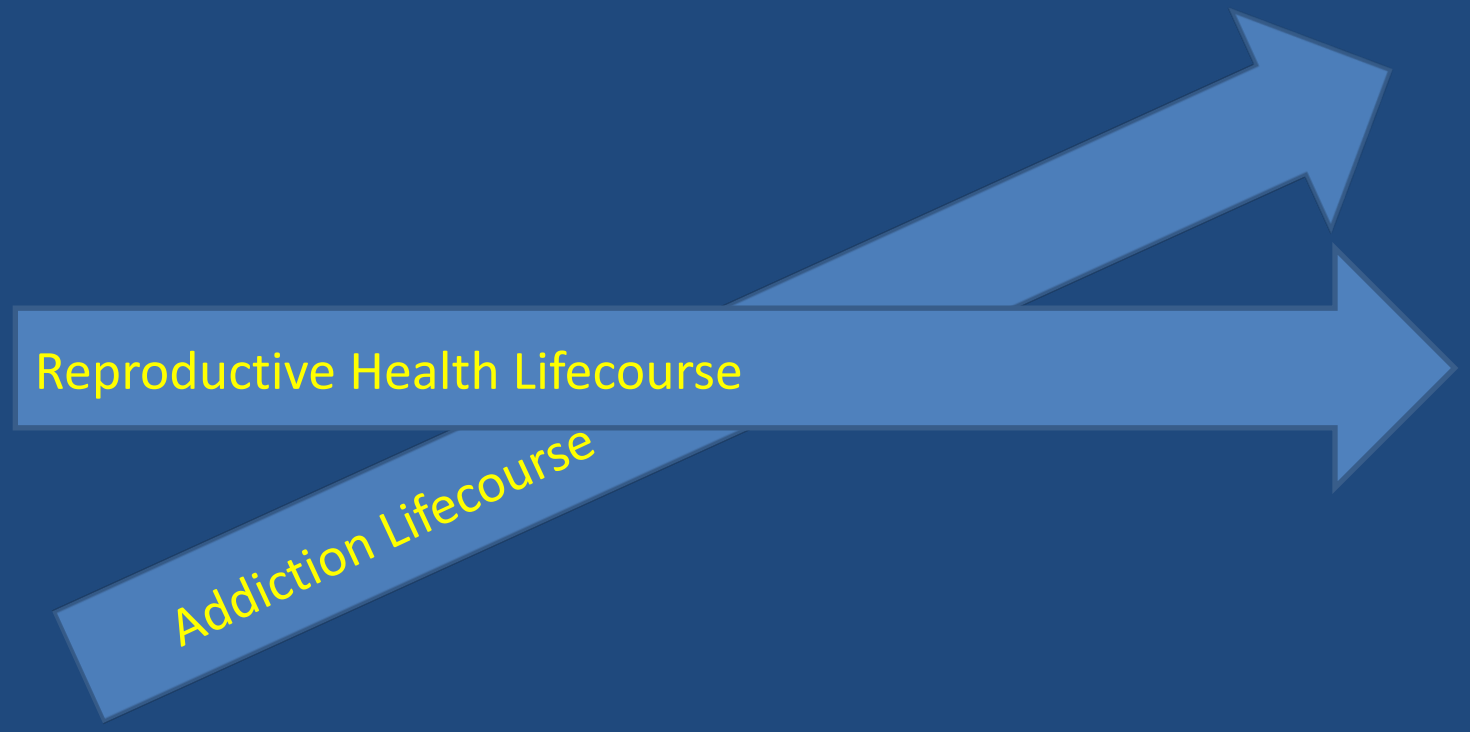
All pregnant women are motivated to maximize their health and that of their baby-to-be

Those who can’t quit or cut back – have a substance use disorder

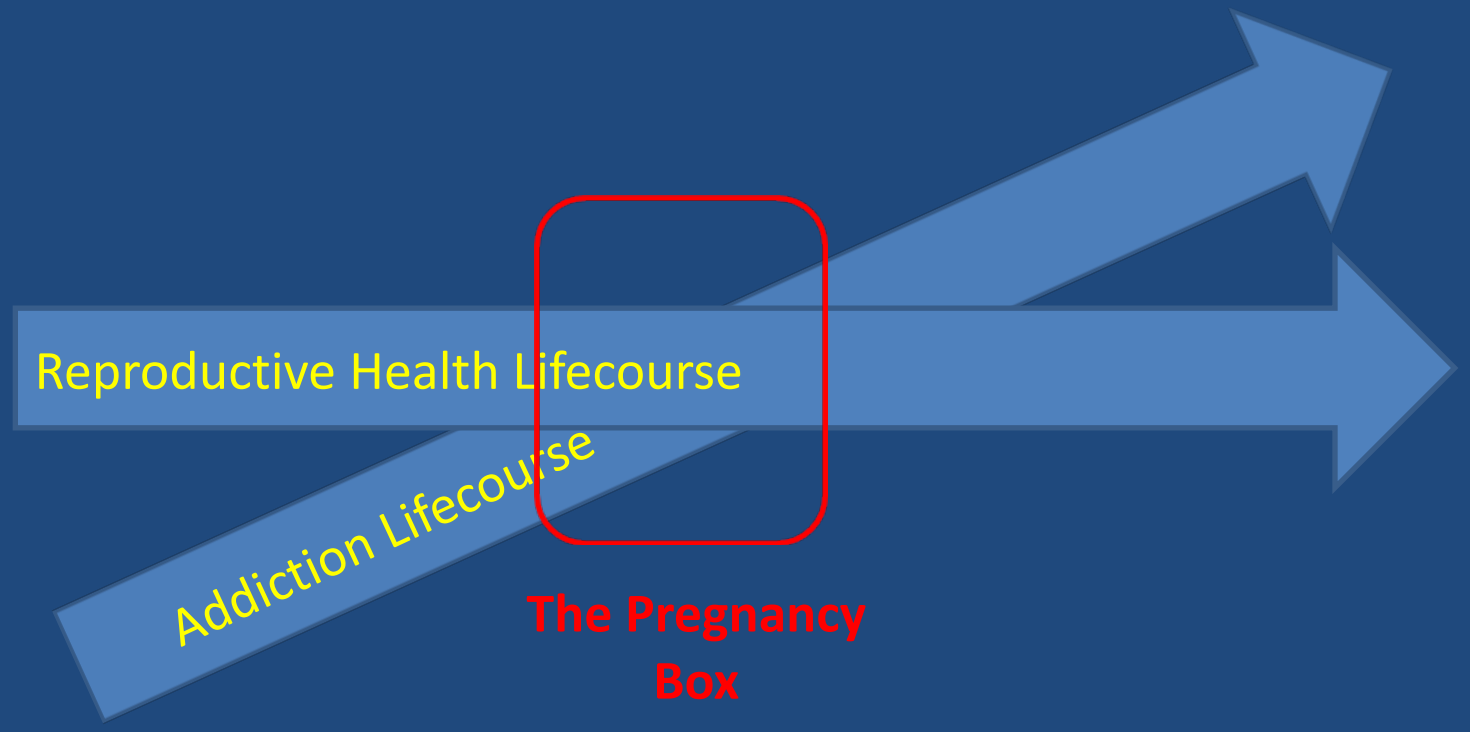
Continued use in pregnancy is pathognomonic for addiction

Women with SUD in Pregnancy

Women with SUD in Pregnancy



Women with SUD in Pregnancy



Women with SUD in pregnancy

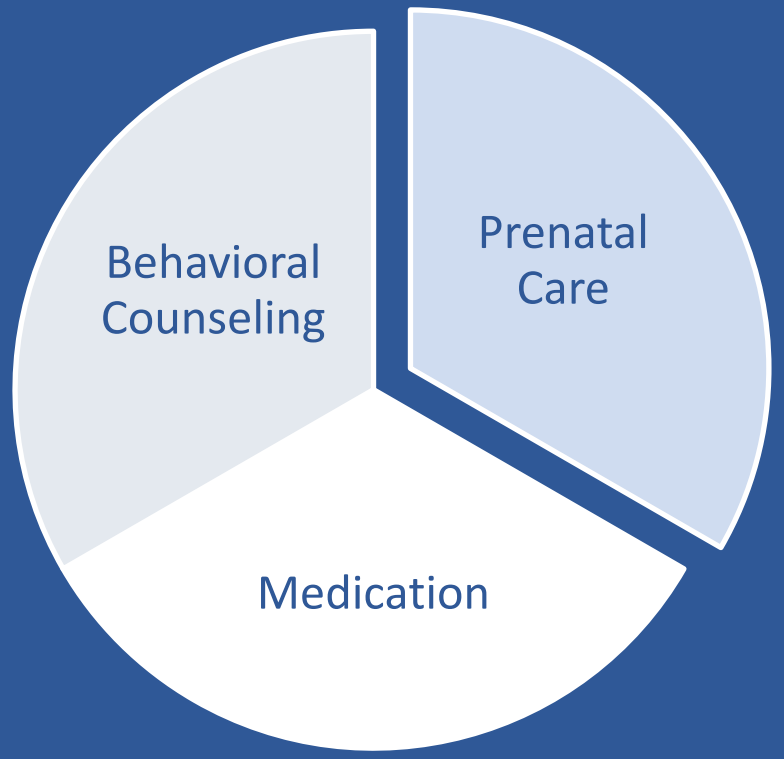
- Mental Health
  - Two thirds co-occurring mental health disorders (Benningfield 2010)
    - Past 30 days: Mood disorder (50%), Anxiety (40%), PTSD (16%)
  - Childhood trauma: 50-90% physical or sexual abuse (Cormier 2000)
  - 60-80% past year intimate partner violence (Engstrom 2012, Tuten 2004)
    - Chronic pain worse in IPV survivors (Wuest 2008)

Women with SUD in pregnancy

- Reproductive Health
  - Unplanned pregnancy: 80% (Heil 2012)
  - Low rates of contraception (Terplan 2015)
  - Higher rates of HIV
- Other substance use
  - High rates of smoking (>90%)
- Nutritional other medical needs
- Social functioning
  - Inadequate social supports
  - 67% their parents used drugs (Finnegan 1991)
  - Unpredictable parenting models
  - Children – childcare needs

- Pregnant women with SUD have unique set of needs across multiple domains – domains that affect both obstetric health and outcomes and addiction treatment
- Care needs to address those needs

“Gold Standard” - Integration



Comprehensive co-located service delivery

Comprehensive Care (Prenatal Care + SUD Treatment) Works

Table IV. Incidence (%) labor and delivery complications

Variable	Addicts (No. = 72)	Clinic controls (No. = 36)	High-risk controls (No. = 36)	Combined controls (No. = 72)
Laceration	19.4	16.7	36.1	26.4
Breech presentation	2.8	2.7	0	1.4
Forceps, other than outlet and low	8.3	2.7	0	1.4
External version	0	5.6	0	2.8
Precipitate birth	1.4	0	0	0
Cord complications	8.3	11.1	11.1	11.1
Contracted or abnormal pelvis	0	2.8	0	1.4
Premature labor	5.6	2.7	5.6	4.2
Meconium	23.6	19.4	11.1	15.2
Other complications	6.9	5.5	0	2.8
Respiration established with catheter and/or forced O_2	31.9	36.1	19.4	27.8

- Methadone treatment during pregnancy + comprehensive prenatal care reduced OB risk to a comparable level of “non-addicted” women of similar socio-medical circumstances

Strauss et al., *AJOG,* 1974

Integrated Treatment Works

- Kaiser Early Start – Behavioral Health embedded in Prenatal Care Clinics
  - Birth outcomes among Early Start moms were same as non-drug-using women (Goler 2008)
  - Cost effective – net cost benefit of $6 million (50,000 individuals) (Goler 2012)
  - Early Start expanded to all Kaiser NoCal OB clinics

What Level of Care?

- Residential Services vs Outpatient
  - Residential services (over)utilized historically

The Impact of Substance Abuse Treatment Modality on Birth Weight and Health Care Expenditures

2001

Marilyn Daley , Milton Argeriou , Dennis McCarty , James J. Callahan , Donald S. Shepard & Carol N. Williams

- More care=heavier infants
  - Residential 190 gm, $17,211
- Most cost-efficient – outpatient
  - 139 gram increase in weight, investment of $1,788

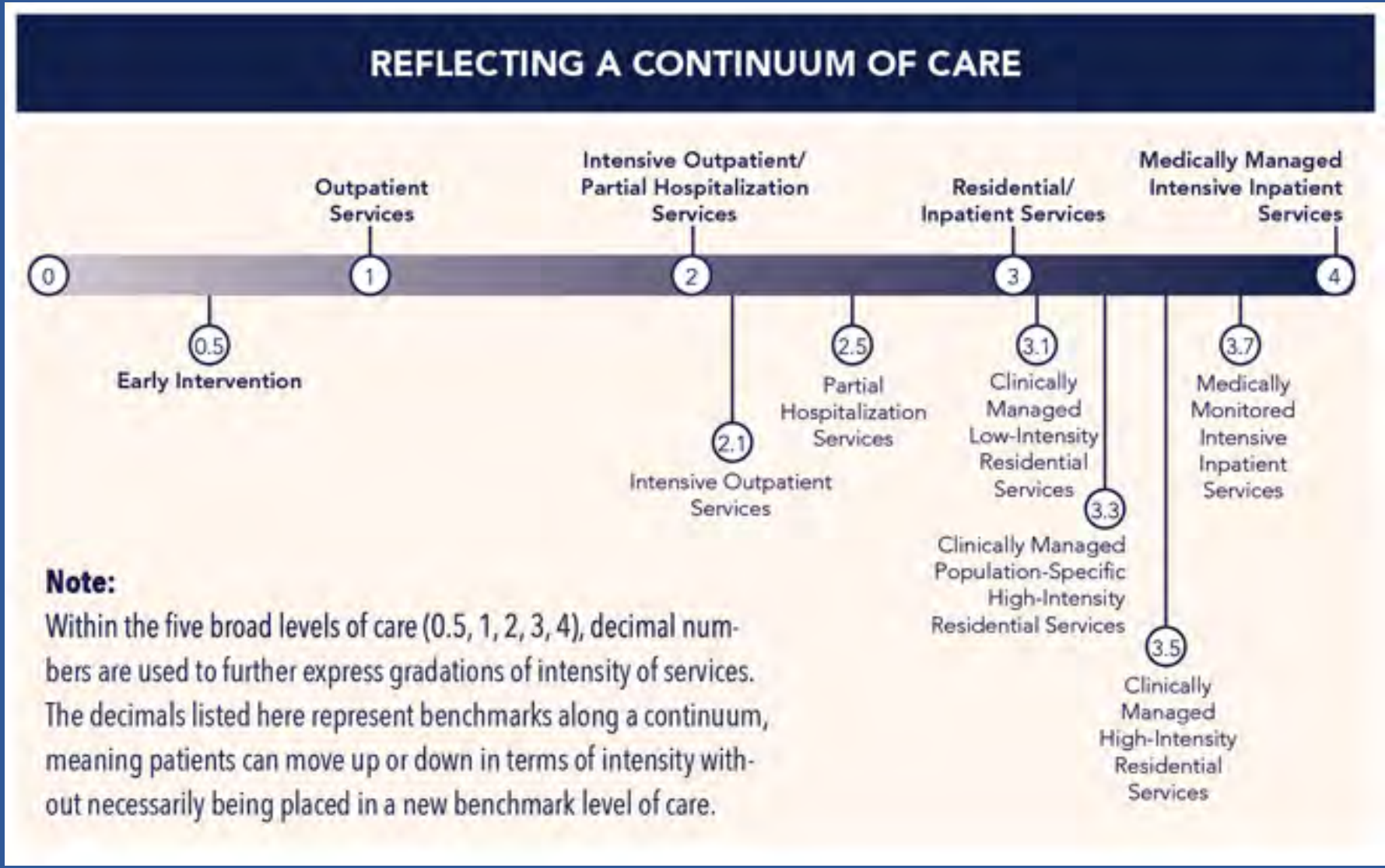
TABLE 5
Summary of Costs and Effectiveness: Infant Birth Weight and Total Health Care and Substance Abuse Expenditures for 445 Pregnant Women and Their Infants

Cost and Effectiveness	Detoxification Only N=170	Methadone Only N=56	Residential Only N=63	Outpatient Only N=79	Residential &Outpatient N=77	Total N=445
Total health care costs	$15,573	$23,530	$29,445	$17,068	$32,884	$21,799
Infant birth weight	2864 G	2955 G	2963 G	3026 G	3072 G	2954 G

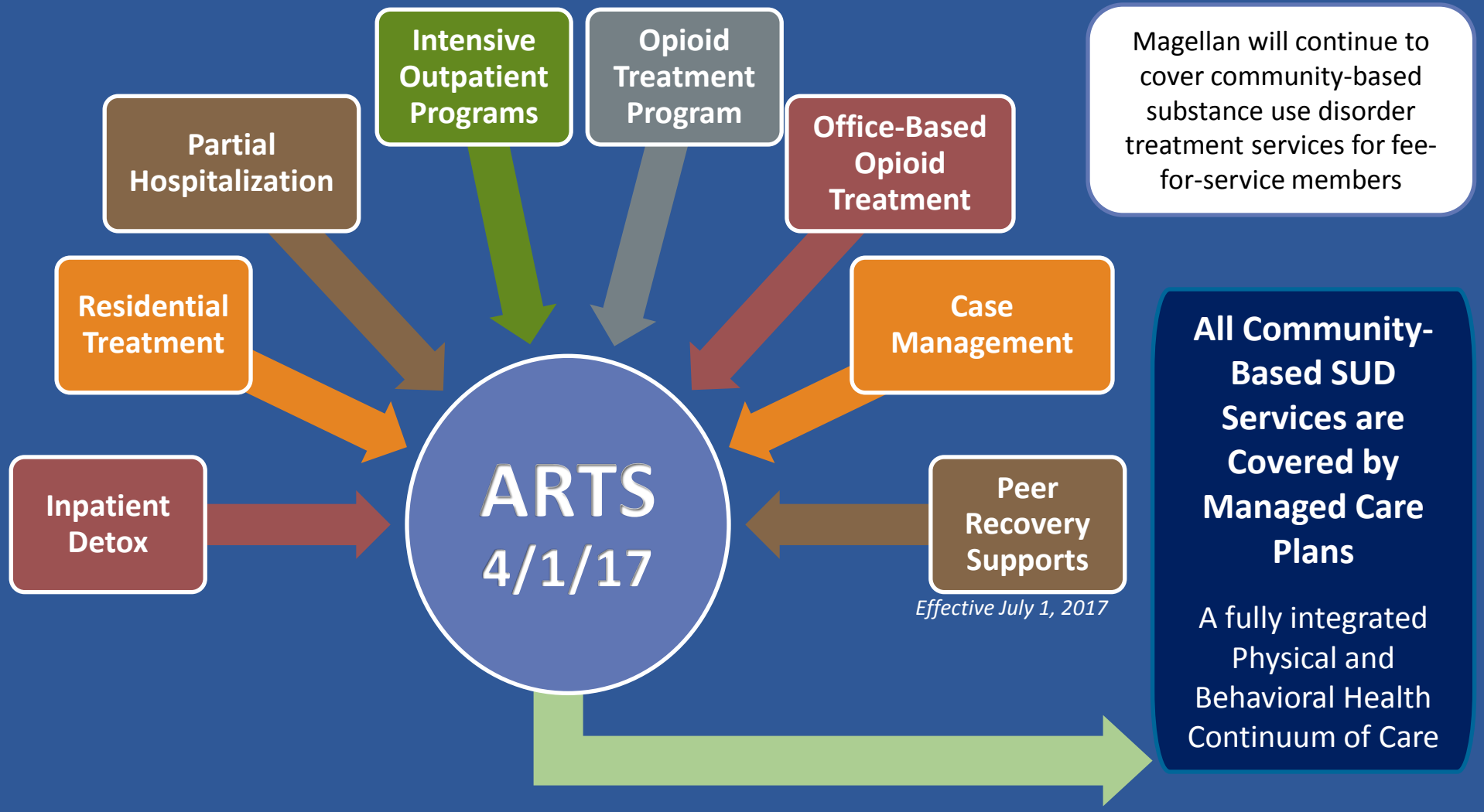
Residential Treatment Example

- 27 yo G2 P1 remanded into residential treatment at 16 wks for cocaine and cannabis use disorder. She had stable housing and decent community support for her recovery. After several weeks treatment residential provider deemed her ready to step down level of care – outpatient care available – MCO viewed continued residential not clinically justified – declined further payment - but court order stated that she would return to jail if engaged in anything but residential treatment.

ASAM Continuum of Care



Transforming the Delivery System for Community-Based SUD Services



Magellan will continue to cover community-based substance use disorder treatment services for fee-for-service members

All Community-Based SUD Services are Covered by Managed Care Plans

A fully integrated Physical and Behavioral Health Continuum of Care

Virginia Medicaid Addiction and Recovery Treatment Services (ARTS) Benefit

- Residential Services, what CMS allows:
  - 30 Day average across the system
  - 90 Day max

- What I tell providers:
  - Discharge planning starts day 1
  - Goal of treatment = Recovery
  - Recovery is in the community

How to utilize treatment (ARTS) to realize recovery

- Consider other non-residential levels of care
  - Partial Hospitalization
- Goal of treatment = Recovery
  - Based in the community
- Consider housing needs uncoupled from addiction treatment

Recommendations

- Treatment recommendations
  - Should not be Level of Care specific and
  - Should allow for patient to progress through treatment as clinically indicated
- Due to ARTS – we have greater system of care in VA
  - Hence more than residential treatment options for pregnant women

Preliminary Increases in Addiction Providers Due to ARTS

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS	% Increase in Providers
Inpatient Detox (ASAM 4.0)	Unknown	103	NEW
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	78	↑ 1850%
Partial Hospitalization Program (ASAM 2.5)	0	13	NEW
Intensive Outpatient Program (ASAM 2.1)	49	72	↑ 47%
Opioid Treatment Program	6	29	↑ 383%
Office-Based Opioid Treatment Provider	0	55	NEW

ARTS Addiction and Recovery Treatment Services

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

Recommendations

- I am happy to be involved – especially on the front end
- Please reach out to me if needed
- Mishka.Terplan@vcuhealth.org

Treatment for Opioid Use Disorder in Pregnancy

- Standard of care: Medication Assisted Treatment plus behavioral counseling
  - Methadone or Buprenorphine
- Benefits
  - Stable intrauterine environment (no cyclic withdrawal)
  - Increased maternal weight gain
  - Increased newborn birth weight and gestational age
  - Increase prenatal care adherence
  - Decrease in (illicit) drug use - reduction of HIV/HCV acquisition and transmission
  - Decrease risk of overdose
  - Other supportive services

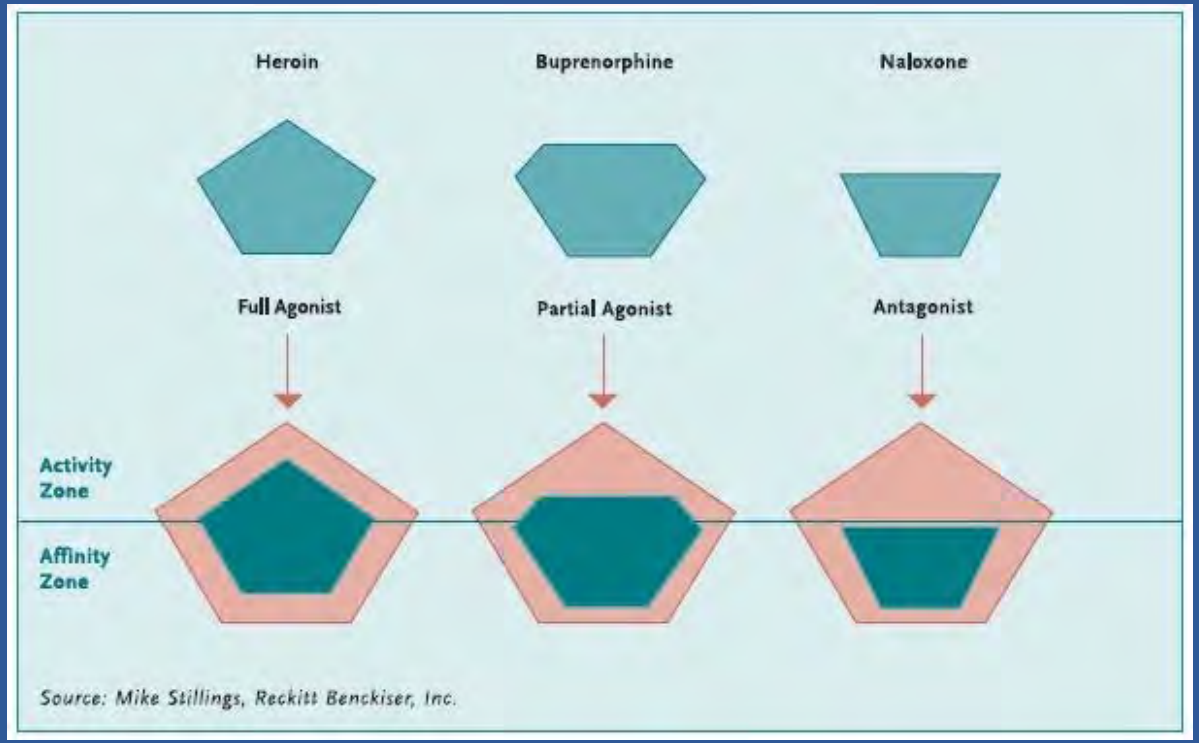
Treatment of Opioid Use Disorder in Pregnancy

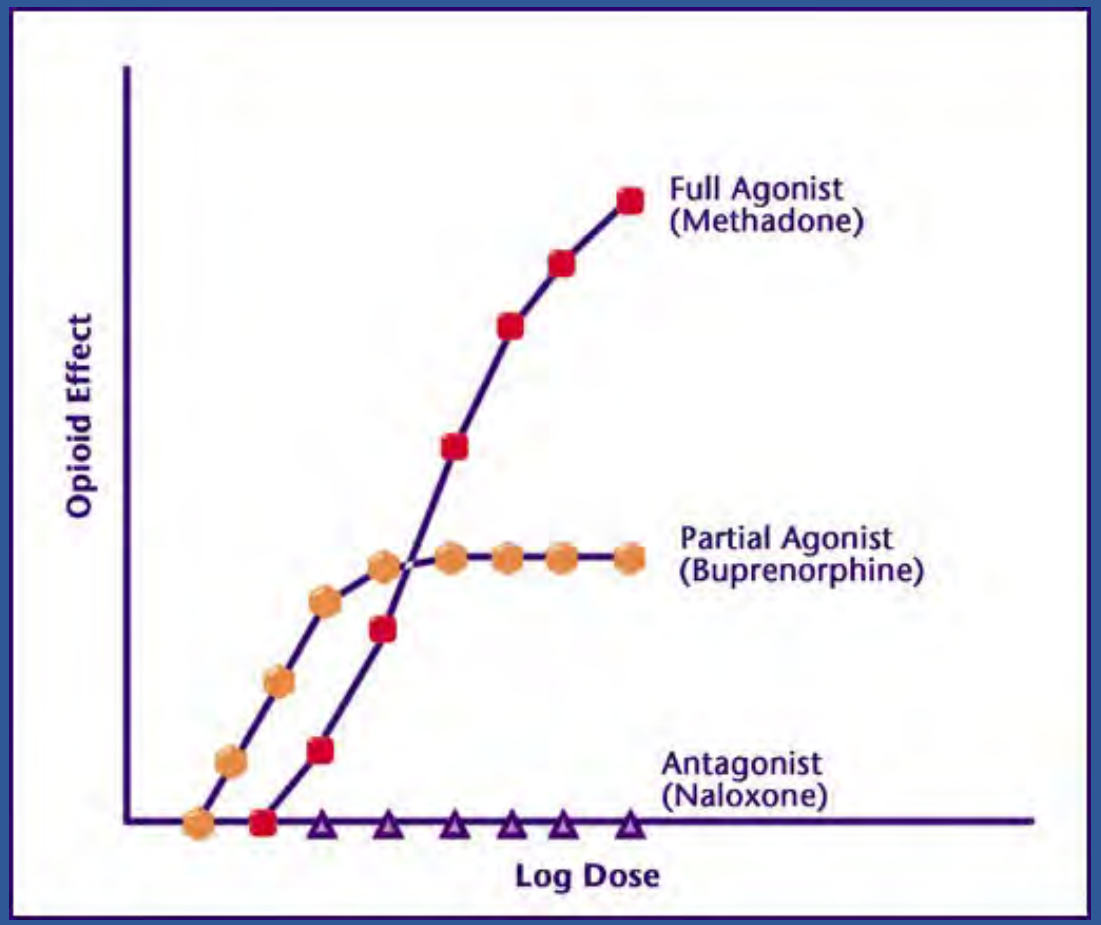
- "Because it is crucial that pregnant women engage in treatment for their addictions, OTPs should **give priority to admitting pregnant patients at any point during pregnancy** and providing them with all necessary care, including adequate dosing strategies as well as referrals for prenatal and follow-up postpartum services." *Federal Guidelines for Opioid Treatment Programs, 2015*
- Pregnant women – don't need to meet DSM criteria for use disorder to receive MAT (TIP 43)

Treatment of Opioid Addiction in Pregnancy: Medication and Behavioral Counseling

- MAT supported by:
  - CDC
  - WHO
  - SAMHSA
  - BOP
  - NCCHC
  - ACOG
  - ASAM
  - AAP
  - AAFP
  - Federal Guidelines for Opioid Treatment 2015
  - (partial list)
- MAT not supported by:

Opioid receptor activation





Pharmacotherapy

- Methadone
  - Since 1960s
  - Can only be dispensed from an OTP: daily doses followed by take homes
- Buprenorphine
  - Since 2002 – first office-based medication approved under DATA2000
  - Need special waiver to prescribe (x number) – NP/PA/MD/DO
- Naltrexone
  - Oral – injection – no special waiver or location needed for utilization

Methadone vs Buprenorphine in Pregnancy

Methadone

- May have better treatment retention
- No risk precipitating withdrawal
- Patients with more severe opioid use disorder

Buprenorphine

- Probably less severe NAS
- Reduced risk of overdose during induction
- Reduced risk of overdose if children exposed to medication

Putting it all together

- All pregnant women manifest motivation to maximize their health during pregnancy
- Most women stop or decrease use in pregnancy - Those that can’t have a SUD
- Engagement in care improves outcomes
- Pregnant women with SUDs have unique set of needs
- Care needs to be compassionate and non-judgmental, comprehensive and appropriate to level of care

Addiction as a chronic disease – in context

- We know how to treat addiction
- We know a little less about how to prevent addiction

- We don’t know how to cure addiction

- Disease severity may change over time – risk of symptom recurrence is always present
- Goal – lifelong management – support recovery

Thank You

- Mishka Terplan
- Follow me on Twitter @do_less_harm
- Mishka.Terplan@vcuhealth.org

Resources

- ASAM National practice guidelines
  - https://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg/complete-guideline
- PCSS-MAT
  - pccsmat.org

Resources

ORIGINAL RESEARCH

OPEN

American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

Kyle Kampman, MD and Margaret Jarvis, MD, FASAM

The Centers for Disease Control have recently described opioid use and resultant deaths as an epidemic. At this point in time, treating this disease well with medication requires skill and time that are not generally available to primary care doctors in most practice models. Suboptimal treatment has likely contributed to expansion of the epidemic and concerns for unethical practices. At the same time, access to competent treatment is profoundly restricted because few physicians are willing and able to provide it. This "Practice Guideline" was developed to assist in the evaluation and treatment of opioid use disorder, and in the hope that, using this tool, more

committee. Recommendations included in the guidelin
a broad range of topics, starting with the initial evalu
patient, the selection of medications, the use of all t
medications for opioid use disorder, combining psych
ment with medications, the treatment of special populat
use of naloxone for the treatment of opioid overdose. To
further research were noted.

(*J Addict Med* 2015;9: 1–10)

AMERICAN SOCIETY OF ADDICTION MEDICINE
FOUNDED 1954
ASAM

ASAM
THE NATIONAL PRACTICE GUIDELINE
For the Use of Medications in the Treatment of Addiction Involving Opioid Use

The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

Consultants:
Chinazo Cunningham, MD, MS
Associate Chief, Division of General Internal Medicine
Director, General Internal Medicine Fellowship Program
Director, Diversity Affairs, Dept. of Medicine
Professor of Medicine
Albert Einstein College of Medicine/Montefiore Medical Center

Marc Fishman, MD
Medical Director, Maryland Treatment Centers, and
Assistant Professor, Johns Hopkins University Department of Psychiatry

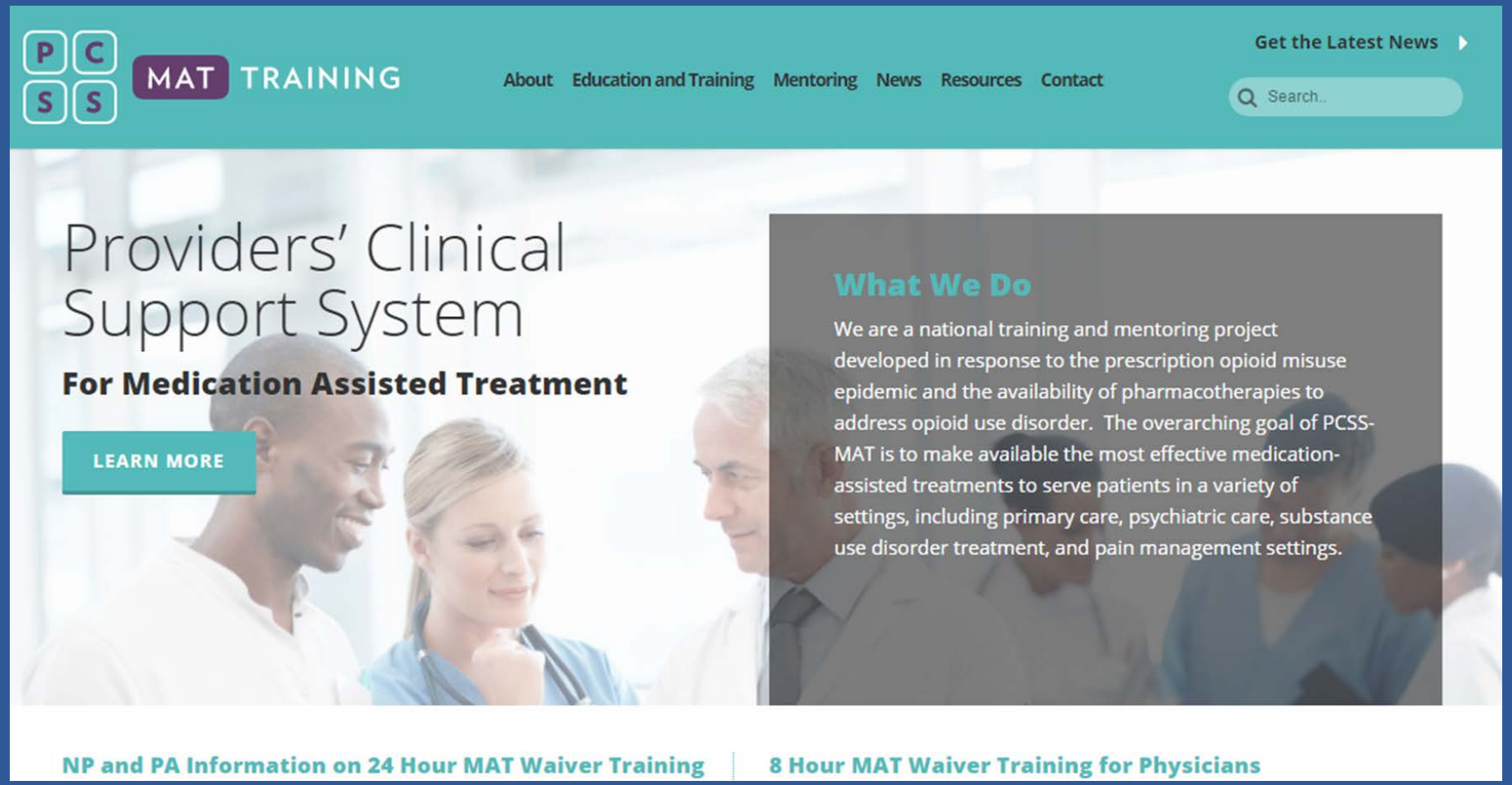
NOT FOR DISTRIBUTION

Key Points

Diagnosis

Treatment

Resources


PCSS
MAT TRAINING
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Mentoring
News
Resources
Contact
Get the Latest News
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Providers' Clinical Support System
For Medication Assisted Treatment
LEARN MORE
What We Do
We are a national training and mentoring project developed in response to the prescription opioid misuse epidemic and the availability of pharmacotherapies to address opioid use disorder. The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, substance use disorder treatment, and pain management settings.
NP and PA Information on 24 Hour MAT Waiver Training
8 Hour MAT Waiver Training for Physicians

Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009

Robert P. Schwartz, MD, Jan Gryczynski, PhD, Kevin E. O'Grady, PhD, Joshua M. Sharfstein, MD, Gregory Warren, MA, MBA, Yngvild Olsen, MD, Shannon G. Mitchell, PhD, and Jerome H. Jaffe, MD

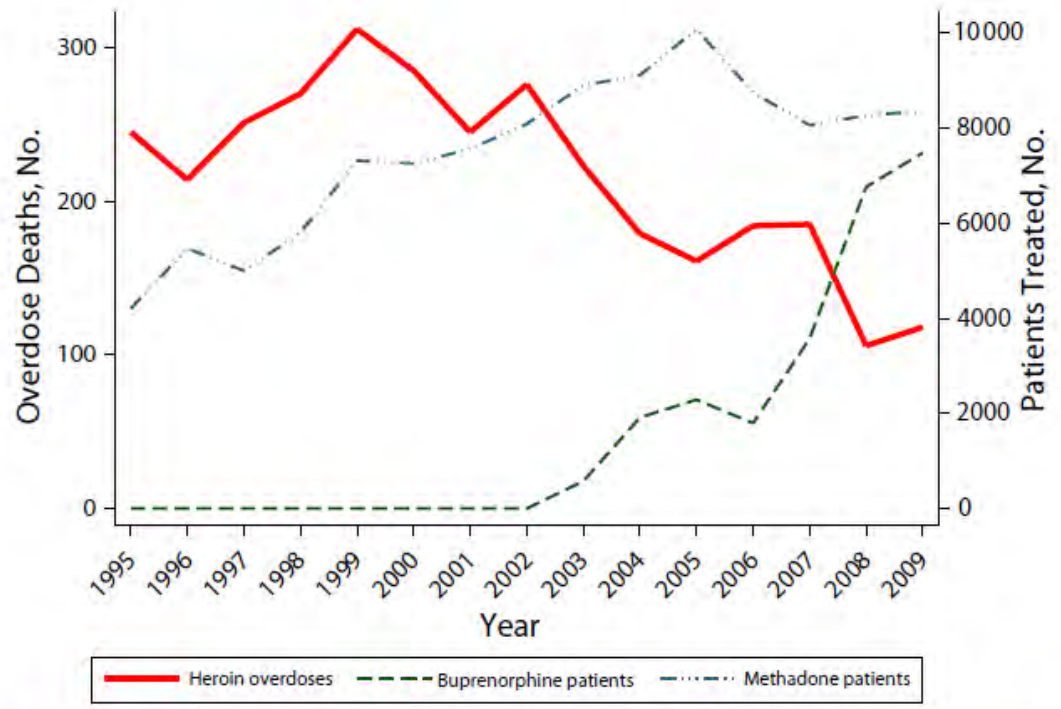


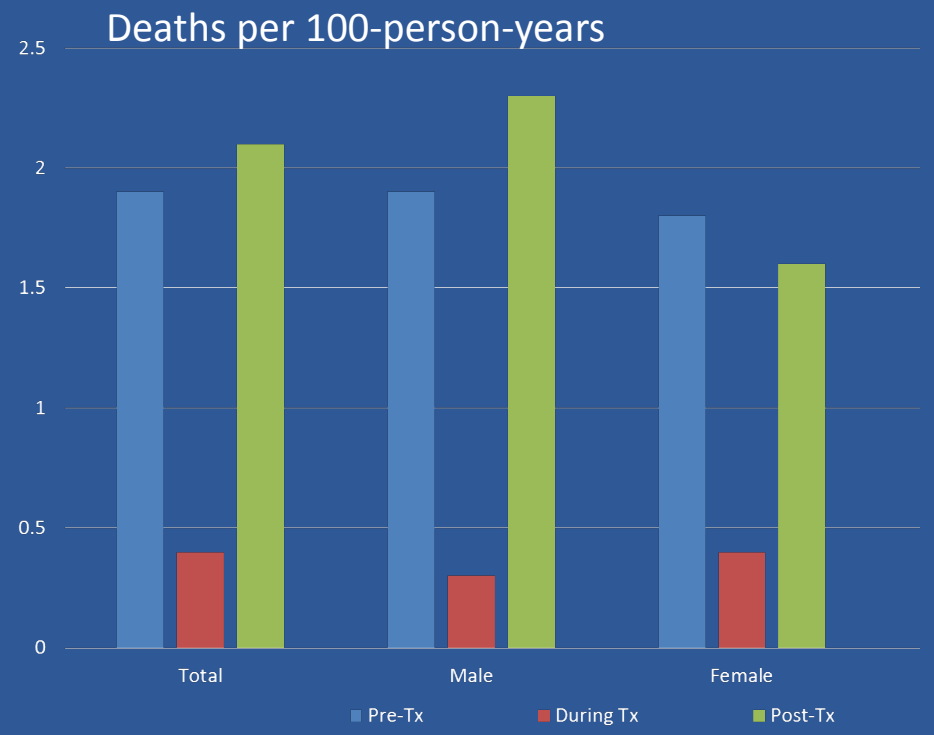
FIGURE 1—Heroin overdose deaths and opioid agonist treatment: Baltimore, MD, 1995–2009.

Mortality prior to, during and after opioid maintenance treatment (OMT): A national prospective cross-registry study

Thomas Clausen *, Katinka Anchersen, Helge Waal

University of Oslo, Medical Faculty, Institute of Psychiatry, SERAF – National Centre for Addiction Research, Oslo, Norway

Received 13 August 2007; received in revised form 6 November 2007; accepted 6 November 2007
Available online 21 December 2007



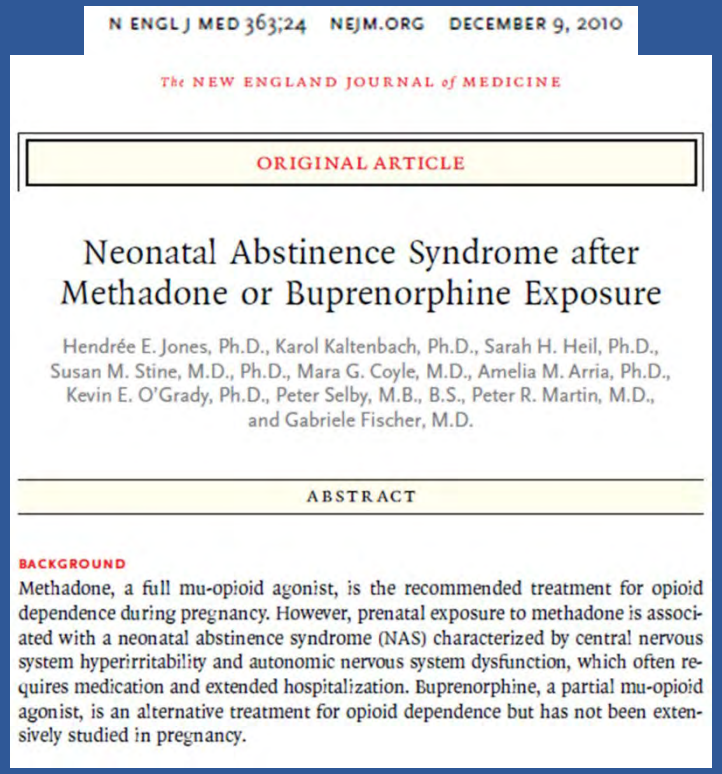
Opioid Use Disorder Criteria

- Taking the opioid in larger amounts and for longer than intended
- Wanting to cut down or quit but not being able to do it
- Spending a lot of time obtaining the opioid
- Craving or a strong desire to use opioids
- Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- Stopping or reducing important social, occupational, or recreational activities due to opioid use
- Recurrent use of opioids in physically hazardous situations
- Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
- *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount.
- *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal

- *(Does not apply when used appropriately under medical supervision)

Which Medication?

- Methadone standard of care since 1970s
- Buprenorphine studied since 2002
- What about naltrexone?



N ENGL J MED 363;24 NEJM.ORG DECEMBER 9, 2010

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure

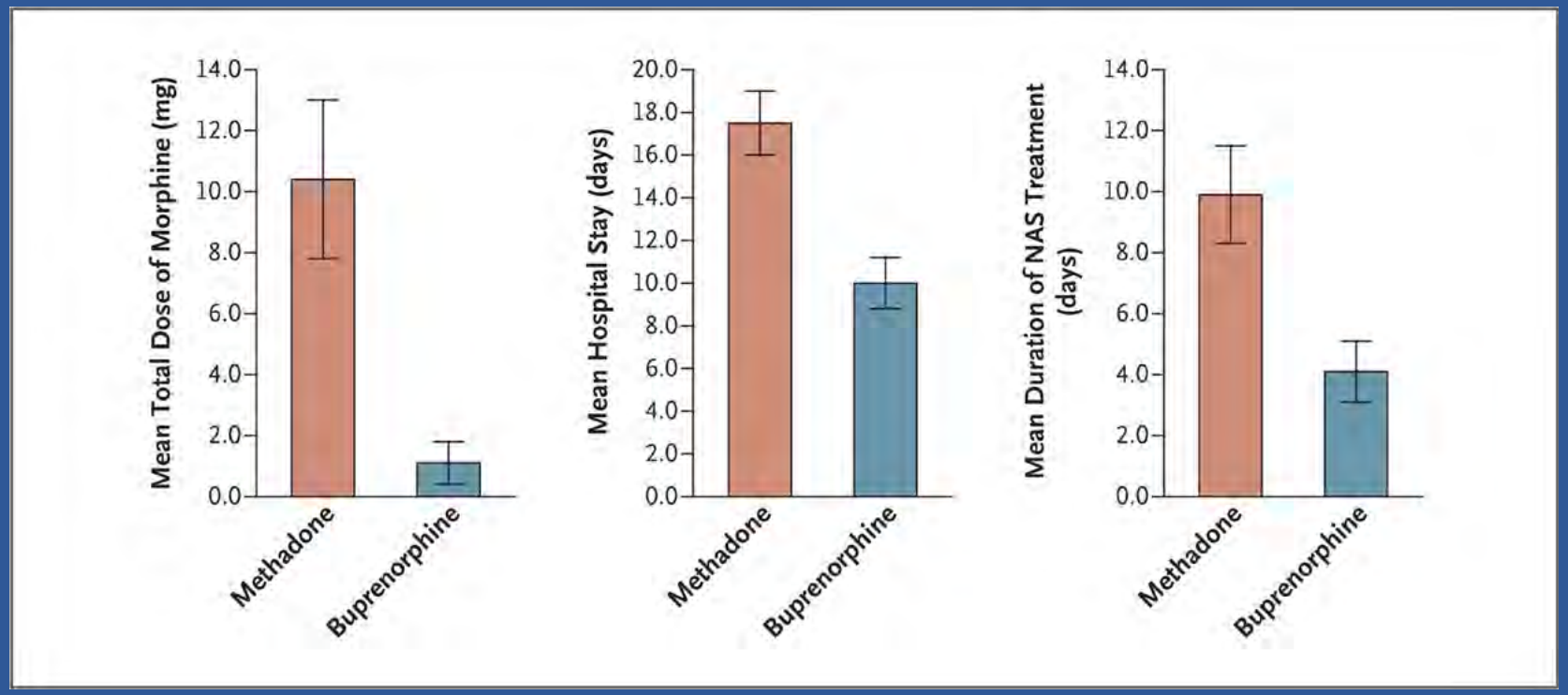
Hendrée E. Jones, Ph.D., Karol Kaltenbach, Ph.D., Sarah H. Heil, Ph.D., Susan M. Stine, M.D., Ph.D., Mara G. Coyle, M.D., Amelia M. Arria, Ph.D., Kevin E. O'Grady, Ph.D., Peter Selby, M.B., B.S., Peter R. Martin, M.D., and Gabriele Fischer, M.D.

ABSTRACT

BACKGROUND

Methadone, a full mu-opioid agonist, is the recommended treatment for opioid dependence during pregnancy. However, prenatal exposure to methadone is associated with a neonatal abstinence syndrome (NAS) characterized by central nervous system hyperirritability and autonomic nervous system dysfunction, which often requires medication and extended hospitalization. Buprenorphine, a partial mu-opioid agonist, is an alternative treatment for opioid dependence but has not been extensively studied in pregnancy.

Mean Neonatal Morphine Dose, Length of Neonatal Hospital Stay, and Duration of Treatment for Neonatal Abstinence Syndrome.



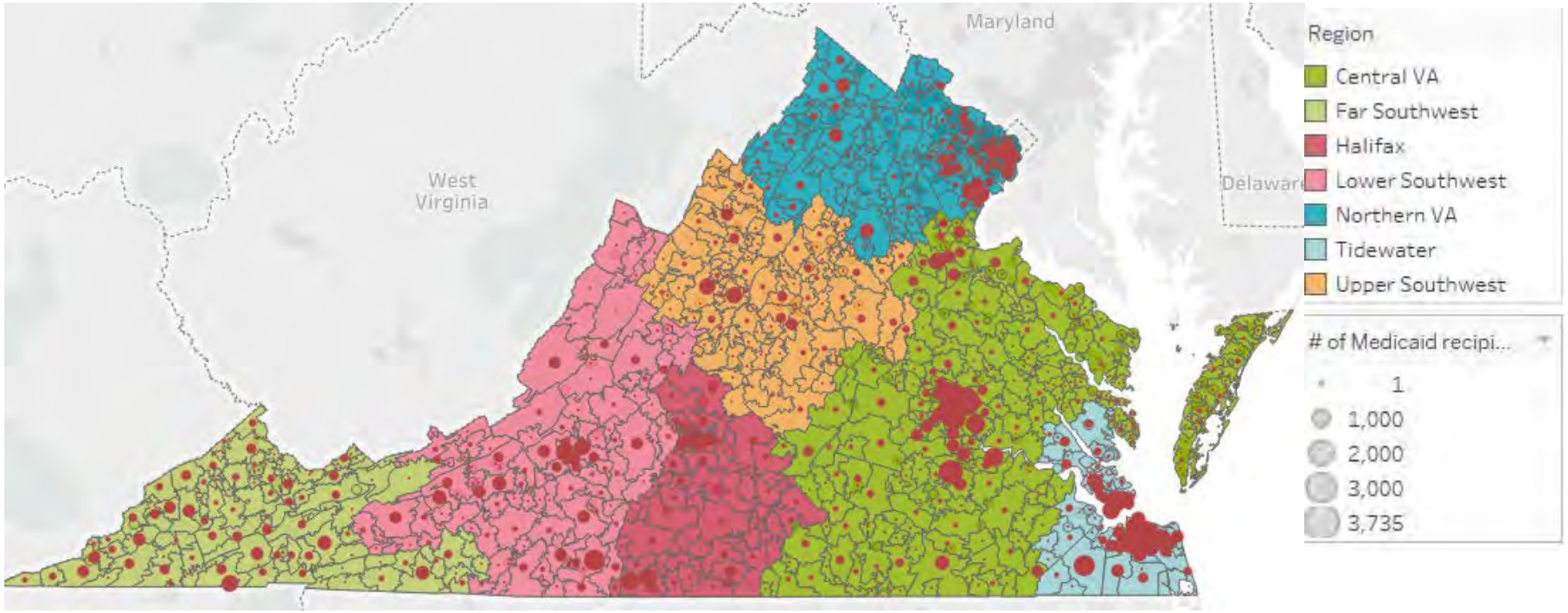
The NEW ENGLAND JOURNAL of MEDICINE

Jones HE et al. N Engl J Med 2010;363:2320-2331.

MOTHER Study: Secondary Outcomes

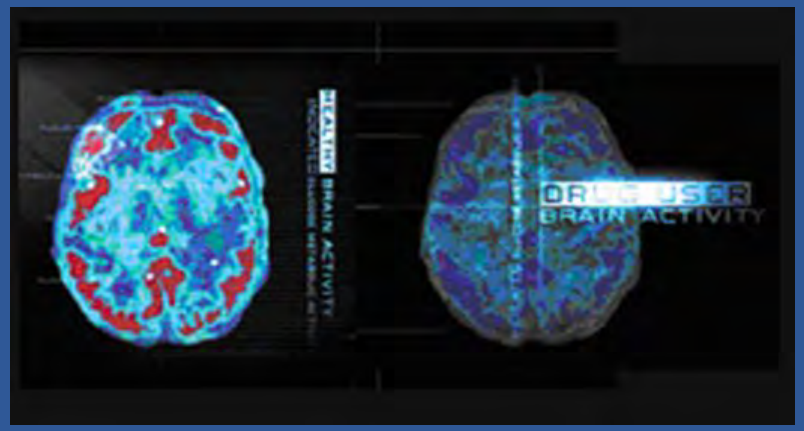
- Maternal outcomes similar in the 2 study conditions (N=131)
  - Low rates of illicit drug use during pregnancy and at delivery
- Clinically meaningful attrition rate in buprenorphine condition (18% in methadone arm vs 33% in buprenorphine arm)

Medicaid Members with Substance Use Disorder Diagnosis



Source: Department of Medical Assistance Services – claims/encounter data (November 3, 2016).
Circles # of Medicaid recipients whose claims/encounter data included an addiction related diagnosis.

What is Addiction?
Addiction is A Brain Disease



NIDA

- Characterized by:
  - Compulsive Behavior
  - Continued use despite negative consequences
  - Persistent changes in the brain’s structure and function

What Level of Care?

- Not all residential services are the same
- "Specialty" Residential

Substance Abuse, Vol. 23, No. 1, March 2002 (© 2002)

Benefit–Cost Analysis of Addiction Treatment in Arkansas: Specialty and Standard Residential Programs for Pregnant and Parenting Women

Michael T. French, PhD,[1,2,5] Kathryn E. McCollister, PhD,[1] John Cacciola, PhD,[3] Jack Durell, MD,[3] and Raymond L. Stephens[4]

	Cost	Benefit-Cost
Specialty Residential	$8035	$17,144
Standard Residential	$1467	$8090

What happens when women who use drugs get pregnant?

Substance	Abstinence Pregnancy	Abstinence Postpartum
Alcohol	92%	45%
Cigarettes	47%	20%
Illicit Drugs	79%	9%

NSDUH 2012/13 Past Month

ASAM LOC Placement	Setting
4 Medically Managed Intensive Inpatient	• Acute Care General Hospital - Inpatient Detox in Medical Beds
3.7 Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)	• Inpatient Psychiatric Unit • Freestanding Psychiatric Hospital • Community-Based Facility
3.5 Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent) **3.3** Clinically Managed Population-Specific High-Intensity Residential Services (Adults)	• Community-Based Facility Licensed for SA Residential Treatment Services • Specialty Unit in a Health Care Facility
3.1 Clinically Managed Low-Intensity Residential Services	• Mental Health and Substance Abuse Group Home • Supervised Living Services for Adults
2.5 Partial Hospitalization Services **2.1** Intensive Outpatient Services	• Licensed Program at a Health Care Facility or Community Provider
1 Outpatient Services	• Outpatient Services
0.5 Early Intervention	• Emergency Departments, Primary Care Clinics, FQHCs, CSBs, Health Departments, Pharmacies, etc.
Opioid Treatment Program (OTP)	• Public and Private Methadone Clinics
Office-Based Opioid Treatment (OBOT)	• CSBs, FQHCs, Outpatient Clinics, Physician's Offices

Being a Legal Eagle:
Confidentiality, Ethical and Constitutional Requirements

National Drug Court Institute
Judge William G. Meyer (ret.)
Senior Judicial Fellow

Presented by
Judge Margaret Spencer (ret.)

Refresher/Crash Course

- Confidentiality/HIPAA
- Ethics
  - Ex Parte Communications
  - Judge/Participant Contact Outside Courtroom
  - Defense Function
- Limited Constitutional Issues

42 CFR, Part 2-Summary

- ✓ **Is it a program-AOD fed assistance?**
- ✓ **Is it patient identifying information?**

General Rule:

Patient Identifying Information cannot be disclosed

42 USC §290dd-2 and 42 CFR Part 2

- Applicability
  - Federally assisted alcohol and drug programs that provide diagnosis, treatment or referral for treatment
- Information covered
  - Substance abuse patient records, and information that identifies a person as an alcohol or drug abuser
  - Disclosure of this information is prohibited without obtaining the written consent of the individual, a court order, or unless pursuant to limited circumstances involving medical emergencies, audit/evaluation activities, and research

HIPAA

Contrary to myth, HIPAA covered entities do not include the courts, court personnel, accrediting agencies like JCAHO and law enforcement personnel including police or probation officers.

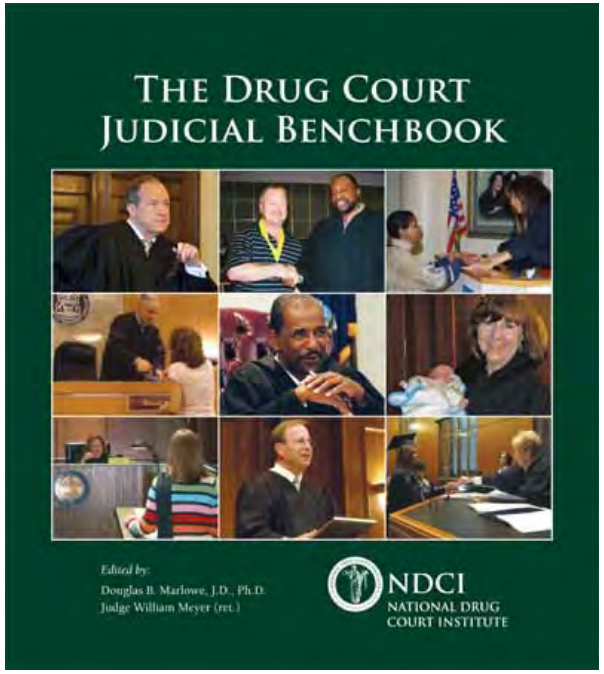
GAINS CENTER, "Dispelling the Myths…" Feb. 2007

HIPAA [privacy rule 45 CFR Parts 160 and 164]

  - Treatment providers cannot disclose patient identifying information relating to health services or payment for health services; the patient must receive notice and may consent to disclosure
- Intended to provide secure sharing of sensitive health information among providers
- Covered entity? drug court treatment providers are covered entities; assume HIPAA applies to drug courts

SAMPLE FORMS

- Court Order allowing treatment provider to release information
  - And
- Participant Consent Form allowing release of confidential information
- Pages 193 - 194



Confidentiality & Open Courtroom

The provisions of 42 CFR 2.35 and the need for open courtrooms required denial of motion to close proceedings. *Florida v. Noelle Bush*, Florida Circuit Court (Oct. 2002)

What about staffing – Open?

State v. Sykes, 339 P. 3d 972 (Wash. 12/18/14) (Adult drug courts are philosophically, functionally, and intentionally different from ordinary criminal courts. Based on their unique characteristics, we hold that adult drug court staff meetings are not subject to the open courts provision of article I, section 10 of the Washington State Constitution. Whether adult drug court staff meetings are presumptively open or closed is left to the discretion of the individual drug courts.)

What about Defendant's right to be at every critical stage of proceeding—staffing too?

A defendant's right to be present at a proceeding is required "whenever his presence has a relation, reasonably substantial, to the fullness of his opportunity to defend against the charge.'" However, this right is not absolute. ….Just as closed staffings are critical to the success of drug court in the context of public trial rights, the presence of the defendant at staffings would frustrate the collaborative purpose of drug court. *State v. LeClech*, Washington Court of Appeals, NOT SELECTED (6/15/15)

Best Practices

- Assume Confidentiality Laws apply
- Designate someone on the team to be Confidentiality Compliance Officer
- Provide CCO with resources
- Your Consents should cover HIPAA, open courtroom and voluntariness, with acknowledgement of representation.
- Follow the rule of minimization
- Obtain an Administrative Judicial Order for HIPAA
- Update your Releases regularly
- Document your privacy policies

Ethics in Drug Courts: Thorny Issues

1. *Ex Parte* Communications and Staffing
2. Judicial Fraternization/Impartiality
3. Role of the Defense Counsel

Ex Parte Communications

Several States including Oklahoma, Minnesota, Montana, New York, Indiana, Idaho, Arkansas and Colorado have amended their Canons of Judicial Conduct to address the ex parte communication issue facing problem solving courts.

A judge may initiate, permit, or consider ex parte communications expressly authorized by law or by consent of the parties, including when serving on therapeutic or problem-solving courts such as many mental health courts, drug courts, and truancy courts. In this capacity, judges may assume a more interactive role with the parties, treatment providers, probation officers, social workers, and others. Comment Canon 2.9

VIRGINIA ?

- Canon 3 (B)(7)(A) – shall not initiate, permit or consider ex parte communications except for emergencies
- Any ex parte communications must be shared with the drug team during staffing
- Judge must avoid initiating extrajudicial factual inquiries about participants

The Judge & Drug Court Participant

Judge attended group activities, softball games, bowling night, holiday party, spring picnic, Disneyland trip, with drug court participants.

DISCIPLINED

Matter of Blackman, 591 A.2d 1339 (N.J. 1991)

Judge Blackman argued that his attendance was an innocent mistake; he had no improper motive and had been friends with the Defendant for many years. The court was unpersuaded and stated: "The lesson is that a judge who attends a public or social event will be perceived as endorsing or supporting not only the event itself but also persons associated with the event."

In re Jones, 581 N.W.2d 876 (Neb. 1998)

Judge met individually with probationers. The judge justified a portion of his conduct on his sincere concern for the welfare of addicts and their progress. The Nebraska Supreme Court was unpersuaded and found that Jones' conduct constituted a violation of Canon 1 (uphold integrity and Independence of Judiciary) and Canon 2 in that Jones failed to act in a manner that promotes public confidence in the integrity and impartiality of the judiciary.

Judicial Impartiality

- What's permitted
  - Cameo appearances
  - Appearances with the prosecutor and defense counsel
  - Encouraging and supporting drug court pro-social activities
- What's not permitted
  - Meeting individually with a participant
  - Attending a participant's birthday party

  Why: Canons 1 and 2 of the ABA Canons of Judicial Conduct
- Query-Would participation cast reasonable doubt on the judge's ability to act impartially or threaten public confidence in the integrity of the judiciary?

Judicial Independence

- Judicial delegation of decision making? NO
- The final decision
- Judge's responsibility – exercise independent judgment
  - Consider recommendations from drug court team
  - Make a preliminary judicial decision
  - That may be modified after "in court" communication with a participant
  - NOTE: the majority "vote" from the team? NO

Respect Role of Defense

National Legal Aid and Defender Association:

Nothing in the problem solving court policies or procedures should compromise counsel's ethical responsibility to…challenge evidence or findings and the right to recommend alternative treatments or sanctions.

ABA Standards

Defense Function

The basic duty defense counsel owes to the administration of justice and as an officer of the court is to serve as the accused's counselor and advocate with courage and devotion and to render effective, quality representation. ABA Model Rule 1.2; ("Defense Function Guidelines")

To competently represent client in DTC must familiarize self with treatment, procedures, bases for sanctions or termination, etc. (ABA Model Rule 1.1)

Smith v. State

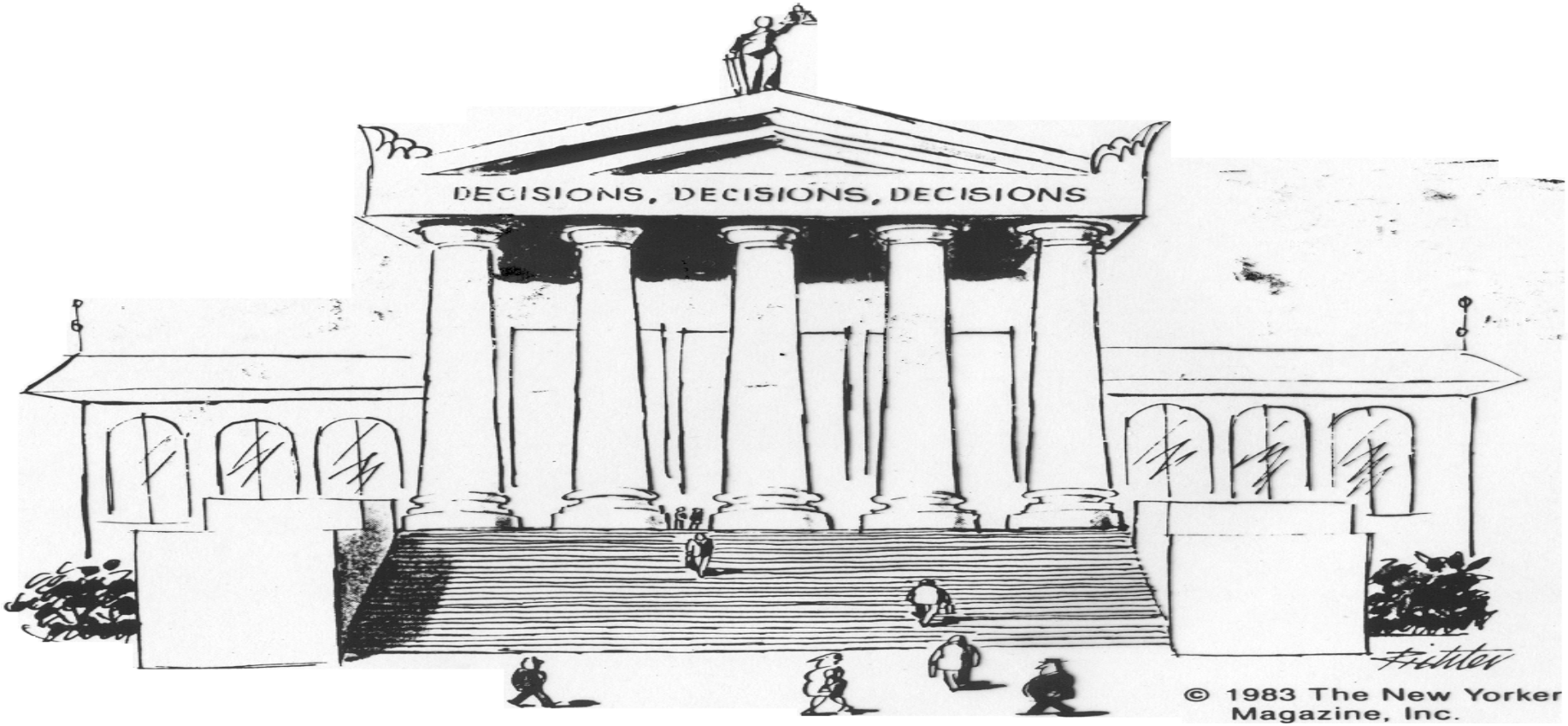
FLORIDA Ct. App. 4th Dist. 3/19/03

It is essential that lawyers educate themselves as to the availability, requirements, and appropriateness of drug court programs. Only then can they effectively advise their clients. It is equally important for the institutions that educate future lawyers, as well as those that educate the other disciplines that play vital roles in the drug court process, to incorporate drug courts into their curricula. For lawyers to do otherwise is for them to become legal dinosaurs. To ignore the need to learn about the drug court process is to ignore the evolution of the justice system. The sooner the Bar educates itself, the issue raised in this case will become extinct.

Best Practices

- Ensure that DA and Defense Counsel attend staffings and review hearings
- Where CJC permit *ex parte*-insure disclosure to opponent
- Judges avoid public activities (non-judicial) with participants, except for cameo appearance
- Respect Ethical Obligations of Defense Counsel

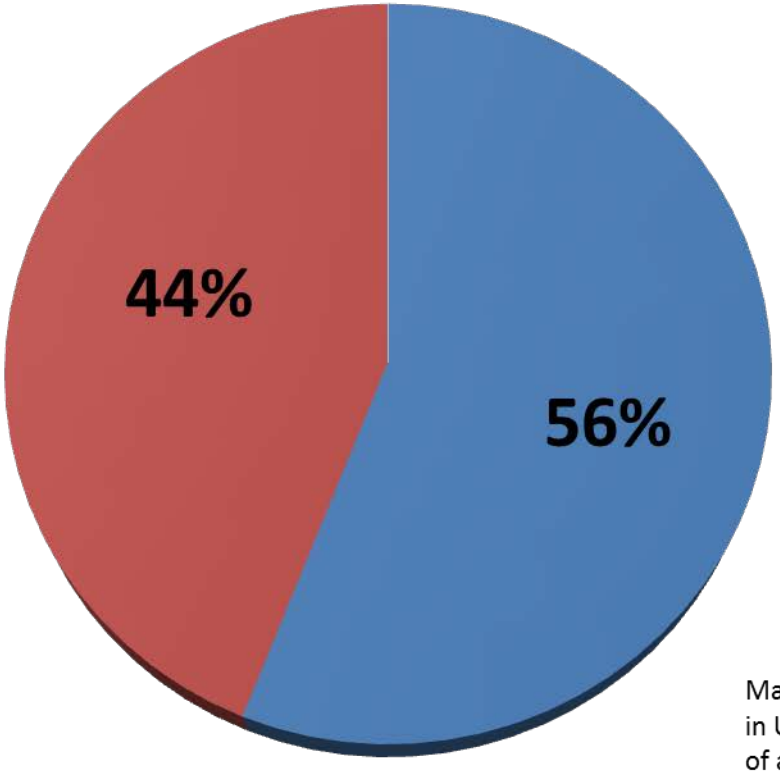
Constitutional Issues in Drug and other Problem-Solving Courts



Can a Drug Court prohibit MAT, such as methadone, because it substitutes one addiction for another?

NO!

Prevalence of MAT Use in Drug Courts



D/C MAT

D/C no MAT

Matusow, *et al* (2013). Medication assisted treatment in U.S. Drug Courts: Results from a nationwide survey of availability, barriers and attitudes. *Journal of Substance Abuse Treatment*, *44*, 473-480.

The Unequivocal Position of NDCI

Inclusion of MAT as part of opioid abuse treatment in drug courts is recommended by the NDCI as well as the National Association of State Alcohol and Drug Abuse Directors

NDCI Drug Court Practitioner Fact Sheets. Alexandria, VA: National Drug Court Institute; 2002. *Methadone and other pharmacotherapeutic interventions in the treatment of opioid dependence:* National Association of Drug Court Professionals. (2010). *Resolution of the Board of Directors on the availability of medically assisted treatment (M.A.T.) for addiction in Drug Courts; National Association of Drug Court Professionals. (2013 &2015). Adult Drug Court Best Practice Standards (Vol. I & II-Standards I, V & VI). Alexandria, VA..*

When, if ever, can the Drug Court say No & Still Keep Federal Funding?

Medications available by prescription must be permitted, **unless** the judge determines the existence of one of the following conditions :

1. The client is **not** receiving those medications as part of treatment for a diagnosed substance use disorder;

2. A licensed clinician, acting within their scope of practice, has **not** examined the client and determined that the medication is an appropriate treatment for their substance use disorder

3. The medication was **not** appropriately authorized through prescription by a licensed prescriber

The Bottom Line

Under no circumstances may a drug court judge, other judicial official, correctional supervision officer, or any other staff connected to the identified drug court deny the use of these medications when made available to the client under the care of a properly authorized physician and pursuant to regulations within an Opioid Treatment Program or through a valid prescription.

What about mandating cessation as a condition of Drug Court graduation?

In all cases, MAT must be permitted to be continued for as long as the prescriber determines that the medication is clinically beneficial. Grantees must assure that a drug court client will not be compelled to no longer use MAT as part of the conditions of the drug court, if such a mandate is inconsistent with a licensed prescriber's recommendation or valid prescription.

Challenging Blanket MAT Prohibitions

- Americans with Disabilities Act (ADA)

  Prohibits discrimination by state and local governments

- Rehabilitation Act of 1973 (RA)

  Prohibits discrimination by federally operated or assisted programs

Discovery House, Inc. v. Consol. City of Indianapolis, 319 F.3d 277, 279 (7th Cir. 2003) ("the ADA and the [Rehabilitation Act] . . . run along the same path and can be treated in the same way").

- Due Process protections of 14th Amendment

- 8th Amendment-cruel and unusual punishment

Can your Drug Court refer participants to twelve step fellowship programs like AA/NA?

Yes, under certain circumstances.

FIRST AMENDMENT

- Working the twelve steps requires:

➢ **Confess to God "the nature of our wrongs" (Step 5)**

➢ **Appeal to God to "remove our short comings" (Step 7)**

➢ **By "prayer and meditation" to make "contact" with God to achieve the "knowledge of his will" (Step 11).**

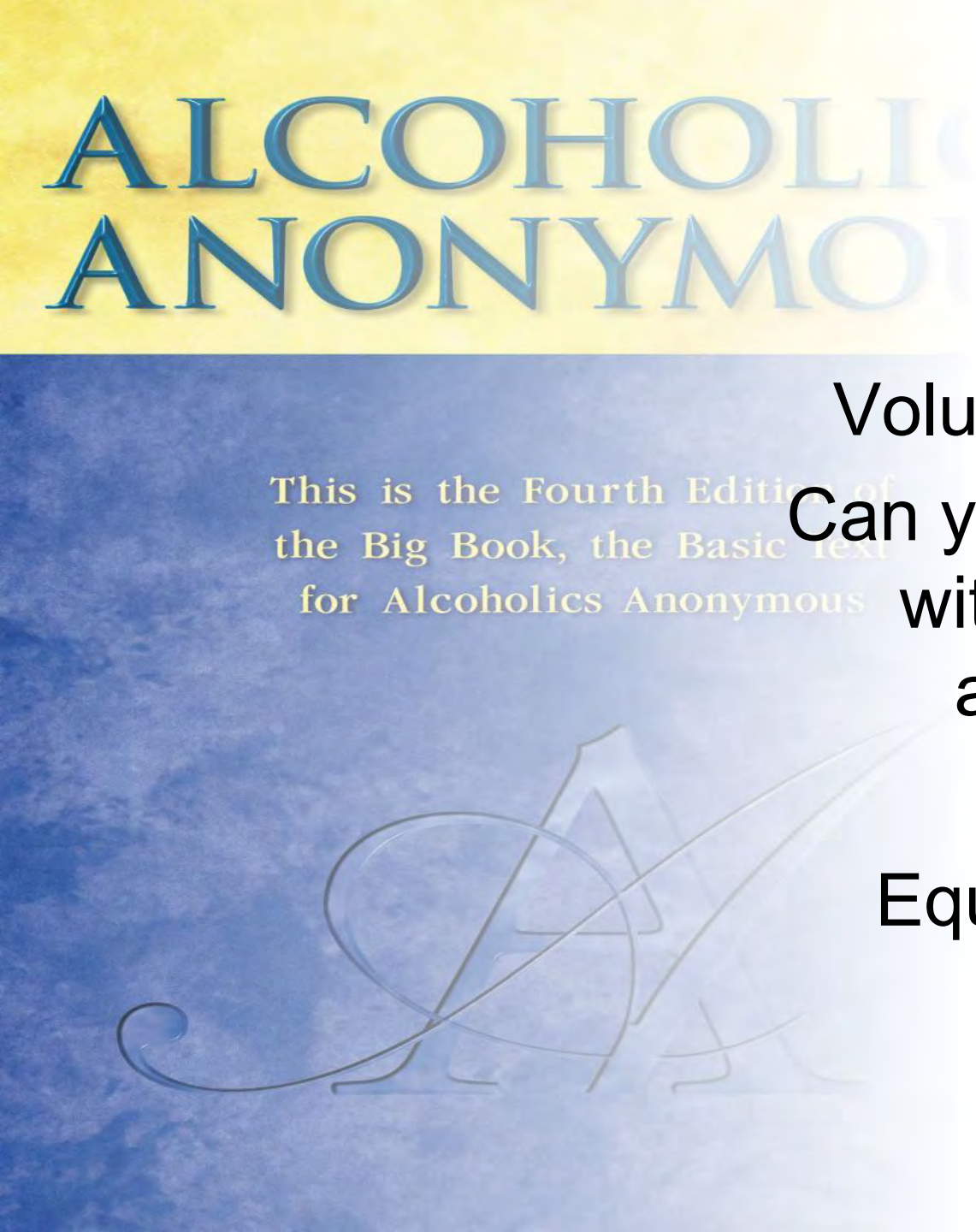
FIRST AMENDMENT

- *Kerr v. Ferry*, 95 F.3d 472, 479-80 (7th Cir. 1996) (prison violated Establishment Clause by requiring attendance at Narcotics Anonymous meetings which used "God" in its treatment approach);

- *Griffin v. Coughlin*, 88 N.Y. 2d 674 (1996) cert. denied 519 U.S. 1054 (1997) (conditioning desirable privilege – family visitation – on prisoner's participation in program that incorporated Alcoholics Anonymous doctrine was unconstitutional as violation of the Establishment Clause);

- *Inouye v. Kemna*, 504 F.3d 705 (9th Cir. 9-7-2007, amended on 10/3/07)(Parole officer lost qualified immunity by forcing AA on Buddhist)

- *Hanas v. Inter City Christian Outreach*, 542 F. Supp. 2d 683 (E.D. Mich. 2/29/08) (Drug Court program manager and drug court consultant held liable for actions related to referral to faith based program, where they knew of participant's objections while in the program and when the program denied the participant the opportunity to practice his chosen faith –Catholicism)).



Voluntary program:

Can you mandate AA without secular alternative?

Equal Protection Violation

Not all is lost

- *O'Conner v. California*, 855 F. Supp. 303, 308 (C. D. Calif.) (no Establishment Clause violation where DUI probationer had choice over program, including self-help programs that are not premised on monotheistic deity)

- *In Re Restraint of Garcia*, 24 P.3d 1091 (Wash. App. 2001) (same)

- *Americans United v. Prison Fellowship*,509 F.3d 406 (8th Cir. 12/3/07) (state supported non-coercive, non-rewarding faith based program unconstitutional First Amend. establishment clause violation, where alternative not available)

- LifeRing Recovery http://lifering.org/
- Rational Recovery https://rational.org
- Secular Organizations for Sobriety http://www.sossobriety.org/

Online alternatives ?

- LifeRing Recovery http://lifering.org/
- Rational Recovery https://rational.org
- Secular Organizations for Sobriety

http://www.sossobriety.org/

First Amendment and Area Restrictions

Who uses place and area restrictions?

Reasonable when narrowly drawn:

1) **Whether the defendant has a compelling need to go through/to the area;**

2) **A mechanism for supervised entry into the area;**

3) **The geographic size of the area restricted, and**

4) **The relatedness between the restriction and the rehabilitation needs of the offender.**

See *People v. Rizzo*, 362 Ill. App. 3d 444 (2005).

Association Restrictions

Watch who you hang out with

Not necessarily know that they are druggies or felons, look at what associates are doing and where they are

Malone v. State, 2012 Ark. App. 280, (2012); State v. Allen, 370 S.C. 88, 634 S.E.2d 653 (2006); Jones v. State, 41 P.3d 1247 (Wyo. 2001) (persons of disreputable character); State v. Hearn, 128 P.3d 139 (Wash. App. 2006) (prohibition against associating with drug users or dealers constitutional); Commonwealth v. LaPointe, 759 N.E.2d 294 (Mass. 2001).

Search Waiver

***Sampson v. California*, 547 U.S. 843 (2006)**

- In parole case, mandatory search waiver constitutional and totally suspicionless search is upheld. No need to have a finding of reasonableness, but the search cannot be for harassment.
- Probationers and parolees, who are subject to a clearly disclosed search condition of parole or probation, <u>have greatly diminished expectations of privacy</u> such that warrantless searches survived Fourth Amendment scrutiny.

Due Process

- Procedural protections are due under the due process clause when the defendant will **potentially suffer** a loss to a **recognized liberty or property right** under the 14th Amendment.
- If due process applies, the question remains what process is due.

Fuentes v. Shevin, 407 U.S. 67 (1972).

Morrissey v. Brewer, 408 U.S. 471 (1972).

Due Process

- Revocation=Termination
- *People v. Anderson,* 833 N.E.2d 390 (Ill. App. 2005); *State v. Cassill-Skilton*, 122 Wash. App. 652 (Wash. App. 2004); *Hagar v. State*, 990 P.2d 894 (Ok. 1999). *In Re Miguel*, 63 P.3d 1065, 1074 (Ariz. App. 2003) (juvenile).

Due Process

What is required?

- P/C determination
- Written Notice
- Right to Appear
- Cross-examine and call witnesses
- Independent magistrate
- Written findings-reasons

Gagnon v. Scarpelli, 411 U.S. 778, 781-782 (1973). (probation)

- Right to Counsel—state mandate

Weight of Authority

- **HARRIS v. COMMONWEALTH,** 279 Va. 541 (2010)
  Consequently, because Harris had no opportunity to participate in the termination decision, when deciding whether to revoke Harris' liberty and impose the terms of the plea agreement deprived Harris of the opportunity to be heard regarding the propriety of the revocation of his liberty interest.

- **GOSHA v. STATE, Gosha v. State, 927 N.E.2d 942 (Ind. Ct. App. 2010)**
  In termination from drug court, due process rights include:
  written notice of the claimed violations, disclosure of the evidence against him, an opportunity to be heard and present evidence, the right to confront and cross-examine witnesses, and a neutral and detached hearing body

- **HUNT v. COMMONWEALTH, 326 S.W.3d 437 (Ky. 2010)** summary probation revocation proceeding when defendant sentenced to probation with drug court as a condition of probation, where no evidence presented, but simple conclusory statements made and counsel appointed immediately prior to hearing violated due process)

- **State v. Shambley**, 281 Neb. 317 (2011) (Drug court program participants are entitled to the same due process protections as persons facing termination of parole or probation.)

Pre-Allegation Waiver of Hearing

- Neal v. State, 2016 Ark. 287 (Ark. Sup. Ct. 6/30/16) (Citing *LaPlaca* and *Staley, infra* , Ark. Sup. Ct. holds: "[T]he right to minimum due process before a defendant can be expelled from a drug-court program is so fundamental that it cannot be waived by the defendant in advance of the allegations prompting the removal from the program.")

- State v. LaPlaca**,** 27 A.3d 719 (New Hampshire 2011) (Even where program manual provided: "Any violation of the terms and conditions of the [Program] shall result in the imposition of sanctions, without hearing, by the court as deemed fair and appropriate, consistent with statutory authority and the descriptions as outlined in the [Program] policy manual. The defendant waives any right(s) to any and all hearings. Termination of participation in the [Program] shall result in the imposition of the suspended prison sentences and fines without hearing. The defendant shall affirmatively waive any and all rights to a hearing", waiver pre-notice of allegations was not enforceable.
- Court relied upon Staley v. State, 851 So.2d 805 (Fla. Dist. Ct. App. 2003) Failure to provide the participant a pre termination hearing was a violation of due process in the context of removal from drug court and imposition of a suspended sentence.) See also Gross v. State of Maine, Superior Court case # CR-11-4805 (2/26/13

- People v. Freeman not selected Calif. Ct Appeals 4th Dist. 2nd Div. 1/23/12—*contra, without discussion.*

Due Process & Judicial Impartiality

TEST:

U.S. v. Ayala, 289 F.3d 16, 27 (1st Cir. 2002) (would the facts, as asserted, lead an objective reasonable observer to question the judge's impartiality)

Alexander v. State, 48 P. 3d 110 (Okla. 2002)

- Requiring the District Court to act as Drug Court team member, evaluator, monitor and final adjudicator in a termination proceeding could compromise the impartiality of a district court judge assigned the responsibility of administering a Drug Court participant's program.
- Therefore, in the future, if an application to terminate a Drug Court participant is filed, and the defendant objects to the Drug Court team judge hearing the matter by filing a Motion to Recuse, the defendant's application for recusal should be granted

What is the trend on recusal?

Recusal Not Required

1. *State v. Belyea, 160 N.H. 298, 999 A.2d 1080 (N.H. 2010)*
2. *Mary Ford v. Kentucky, (Ky. Appellate April 30, 2010)*
3. *Grayson v. Kentucky*, No. 2011-CA-000399-MR. Court of Appeals of Kentucky UNPUBLISHED (June 29, 2012)
4. *Arizona v. Tatlow*, No. 1 CA-CR 11-0593, Court of Appeals of Arizona, Division One, Department C. (December 4, 2012)
5. *Arizona v. Perez Cano,* No. 1 CA-CR 11-0473 Court of Appeals of Arizona (September 20, 2012) UNPUBLISHED
6. *State v. Rogers,* 170 P. 3d 881 (Idaho 2007)
7. *State v. McGill*, No. M2015-01929-CCA-R3-CD. (Tenn: Court of Criminal Appeals 7/18/2016) (rejecting *Stewart*)

Recusal Required

1. Minnesota v. Cleary, No. A15-1493 (Court of Appeals of Minnesota July 5, 2016.) (When the sole basis for revoking probation is a probationer's termination from drug court and the drug court judge participated in the drug court team's decision to terminate the probationer from drug court, a probationer is entitled to have a judge other than the drug court judge preside over the probation revocation hearing, because of the appearance of lack of impartiality)

2. State v. Stewart, W2009-00980-CCA-R3-CD (Tenn. Crim. App. 8-18-2010)(not selected for publication)

Do infractions involving jail as a potential sanction require a hearing, when the participant denies the factual basis?

Yes!

Due Process and Sanctions

Hearing vs. nonhearing—If the drug court participant does not admit the violation and denies the factual basis of the alleged non compliance and jail is a possible sanction, ask yourself:

1. Will the defendant **potentially** suffer a loss to a **recognized liberty** or property right at the sanctioning hearing?
2. If the answer to 1. is yes, the due process clause is implicated.
3. Because due process is implicated, the issue becomes, **what type of hearing** is participant entitled to.

Gagnon v. Scarpelli, 411 U.S. 778, 781-782 (1973);Wolff v. McDonnell, 418 U.S. 539, 557 (1974) overruled on other grounds *Sandlin v. Conner*, 515 U.S. 472 (1995) *In Re Miguel*, 63 P.3d 1065, 1074 (Ariz. App. 2003). (juvenile entitled to hearing).

Key Component #2

Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

NICELY v. COMMONWEALTH, 2007-CA-002109-MR (Ky. App. 4-24-2009)

Under these circumstances, if a *sentencing court chooses to find a defendant in contempt for violating conditions of probation as opposed to revoking or modifying the conditions of probation, the defendant must be afforded certain due process rights, including a hearing*. *Pace*, *supra* at 395.

STATE v. STEWART, (Tenn. Crim. App. 8-18-2010) (NSOP)

- Having reviewed the record, we are additionally troubled by the four or five occasions where the defendant in this case was "sanctioned" to significant jail time by the drug court team during the two years he participated in the program.

- Leaving aside (as we must) **the obvious due process concerns attendant to any additional deprivation of the defendant's liberty that has been imposed through a collaborative, non-adversarial, and at times *ex parte* process rather than through a traditional adversarial evidentiary hearing, there is considerable tension between this outcome and the general guidelines under which drug courts should operate**. The drug court program explicitly recognizes that alcohol and drug addiction "is a chronic, relapsing condition," that "many participants [will] exhibit a pattern of positive urine tests," and expressly contemplates that many participants will experience periods of relapse "[e]ven after a period of sustained abstinence."

Mississippi Commission on Judicial Performance v. Thompson, ____Miss. ___, (Miss Supreme Court 5/21/2015)

(Judge Thompson's conduct of depriving participants in drug court of their due-process rights when he signed orders of contempt without the persons being properly notified of the charge of contempt or a right to a hearing, and by conducting "hearings" immediately after "staffing meetings" without adequate time for the persons to have proper counsel or evidence presented, violated Canons 1, 2A, 3B(1), 3B(2), 3B(4), 3B(8), and constitutes willful misconduct in office and conduct prejudicial to the administration of justice. Result: Judge removed from office)

Sanction Hearing

Taylor v. State, CR-15-0354 (Ala. Crim. App. 9/9/16)
Sanctioning hearing using hearsay not due process violation.
Concurrence: I realize that developing specific procedures for handling drug-court sanctions can be an arduous task — especially given the dearth of case law in this State addressing drug-court programs. I would encourage other drug-court judges in this State either to use or to develop a drug-court-sanction procedure similar to the one outlined in this Court's opinion (i.e.: provision of a hearing). I would also recommend to other drug-court professionals that they take advantage of the vast training resources and educational opportunities available through the National Association of Drug Court Professionals.

Is it permissible to place an addicted drug court participant in jail, while you are awaiting a placement bed to become available?

NO! - unless due process requirements are met.

She is an addict and, if I release her, she will OD

Robinson v. California, 370 U.S. 660 (1962)[1], The Eighth Amendment of the Constitution was interpreted to prohibit criminalization of particular conduct—status as an addict, as contrasted with prohibiting the use of a particular form of punishment for a crime.

Preventive Detention

Hoffman v. Jacobi (S.D. Ind., 9/29/2015)

(Magistrate Judge recommends class certification on 42 USC §1983 damages and injunctive relief suit against Drug Court Judge and team for incarcerating participants for lengthy periods of time, while awaiting placement in drug treatment facilities. Plaintiffs allege that the decision to hold them in jail pending placement was made without counsel, hearing, consideration of bond, or other rights of due process) (Injunctive relief moot-Court Closed—Judge forced to Resign 4/22/16)

Preventive Detention

Kansas v. Hendricks, 521 U.S. 346, (1997) (upholding the preventive detention of sexual predators because the detention was preceded by an adversarial hearing that afforded the individual robust procedural protections, including the right to state funded counsel, the right to present and cross-examine witnesses, and the right to an annual case review to determine if detention was still warranted). *Kansas v. Crane,* 534 U.S. 407, 415 (2002) (holding that a state law authorizing the civil commitment of sex offenders was unconstitutional because it did not require an adversarial hearing as to whether the offender lacked control over the dangerous behavior).

Civil Commitment

O'Conner v. Donaldson 422 US 563 (1975) (cannot fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different)

Addington v. Texas 441 US 418 (1979) (clear and convincing evidence)

Best Practices

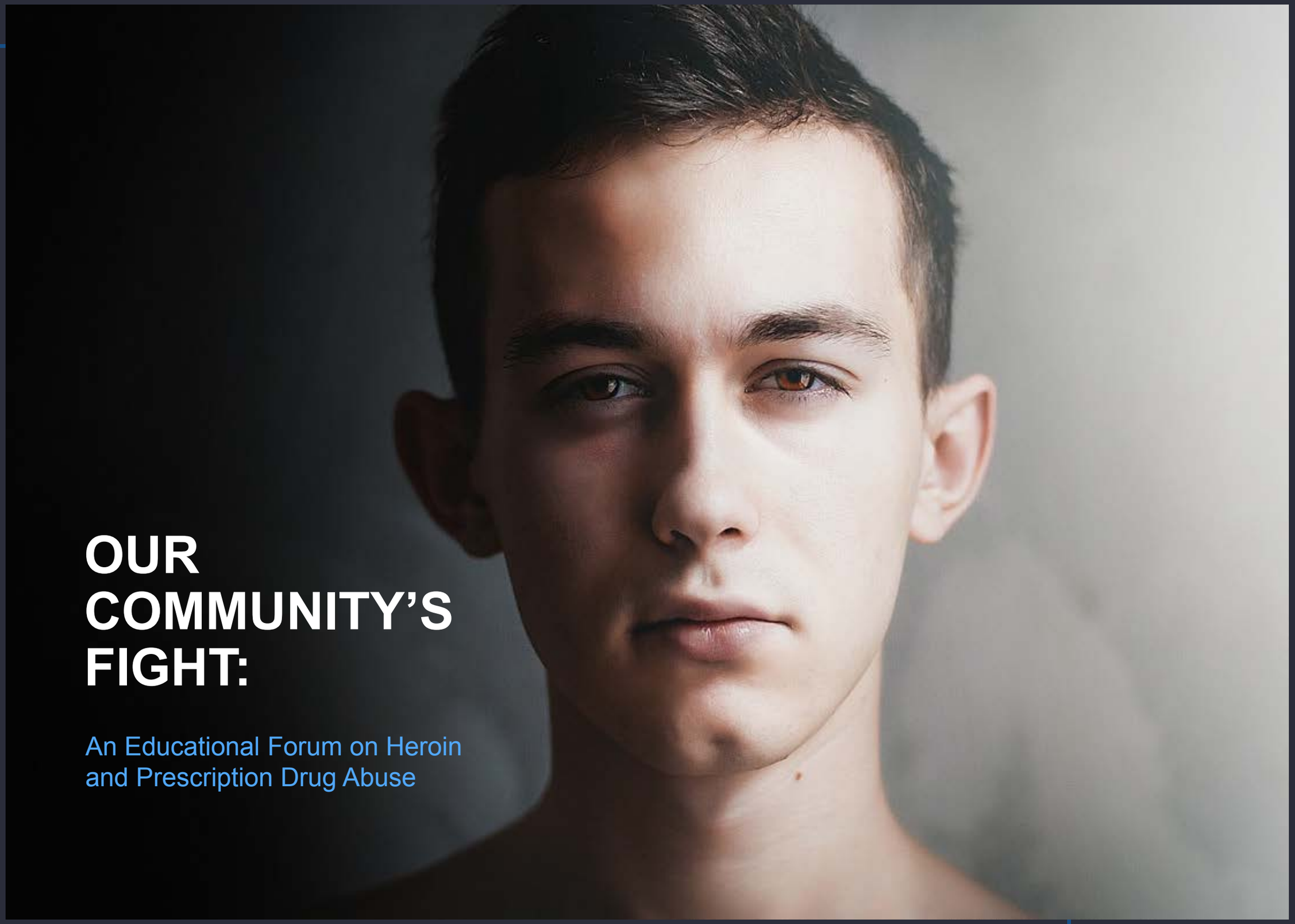
- Provide a secular alternative to AA and written consent
- Place and Area restrictions rationally related to rehabilitation
- Written, knowing 4th Amend. waiver
- Provide DP protections at termination hearing
- If participant denies factual basis and jail possible sanction, provide DP protections at Sanctions hearing
- Provide equal access to drug court participation to all
- Consider whether Defendant can recuse Judge for revocation, or written waiver
- Insure participant knows what (s)he getting into (Boykin advisement)—no staffing access
- Use MAT, when clinically indicated and appropriately prescribed
- Do not use preventive detention

Resources

- LEGAL ACTION CENTER, "Confidentiality and Communication", (LAC 2012)
- NDCI, "Ethical Considerations for Judges and Attorneys in Drug Court" (May 2001)
- NDCI, "Federal Confidentiality Laws and How They Affect Drug Court Practitioners" (2001)
- NDCI, "Critical Issues for Defense Attorneys in Drug Court" (2003)
- GAINS CENTER, "Dispelling the Myths…" Feb. 2007
- Chapters in Judicial Manual (2017) on Ethics, Confidentiality &Legal Issues—Chapters 7,8 &9
- NDCI

  http://www.ndci.org/law

The end



OUR COMMUNITY'S FIGHT:

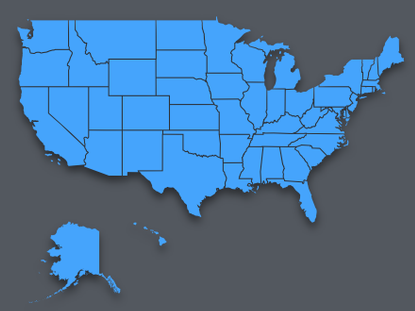
An Educational Forum on Heroin and Prescription Drug Abuse

John Robert "Bobby" Baylis

Born: August 26, 1986
Left us: June 6, 2015

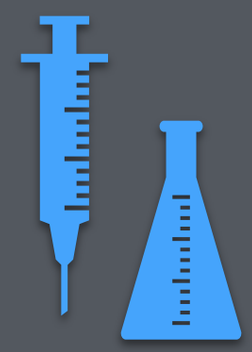
My Son's Story

DISCUSSION TOPICS



THE RISE OF OPIOIDS

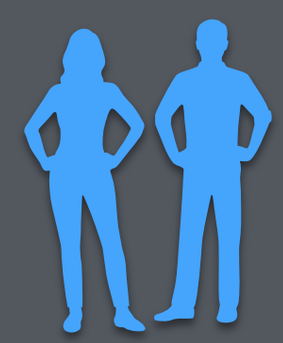
THE PATH OF A MONSTER



HEROIN & FENTANYL

IDENTIFIERS

OVERDOSES

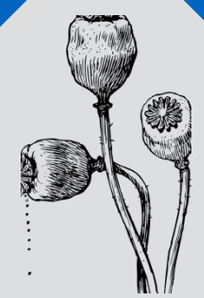


COMMUNITY DENIAL

KEY DEFINITIONS

OPIOIDS

(Prescription drugs)
"Man made" painkillers: Hydrocodone, Oxycodone, Percocet, etc.



OPIATES

"Natural" pain relievers derived from the poppy plant: Heroin.

SYNTHETICS

"Man made" nonprescripti on drugs: Fentanyl.

HOW DID WE GET HERE?

Why are we in this fight?

1990s

OVERPRESCRIBING OF PAINKILLERS

DECRIMINALIZATION OF MARIJUANA DECREASES CARTEL PROFITS 40%

1999-2008

OVERDOSE RATES SOAR AS SALES INCREASE

15,000 Americans die from opioid overdoses

2010

254 MILLION OPIOID PRESCRIPTIONS FILLED IN THE U.S.

2014

OPIUM PRODUCTION IN MEXICO INCREASES 50%

Supplies the appetite of America's epidemic

2015

***52,404* AMERICANS DIE BY OVERDOSE**

33,091 Opioid deaths
12,989 Heroin deaths

HAVE YOU EVER USED AN OPIOID PRESCRIBED BY A DOCTOR?

- ANYONE IS PRONE TO THE BRAIN DISEASE OF ADDICTION.

- PEOPLE ADDICTED TO Rx OPIOIDS ARE 40x MORE LIKELY TO BECOME ADDICTED TO HEROIN.

ARE UNUSED Rx MEDICATIONS HOUSED IN YOUR MEDICINE CABINET?

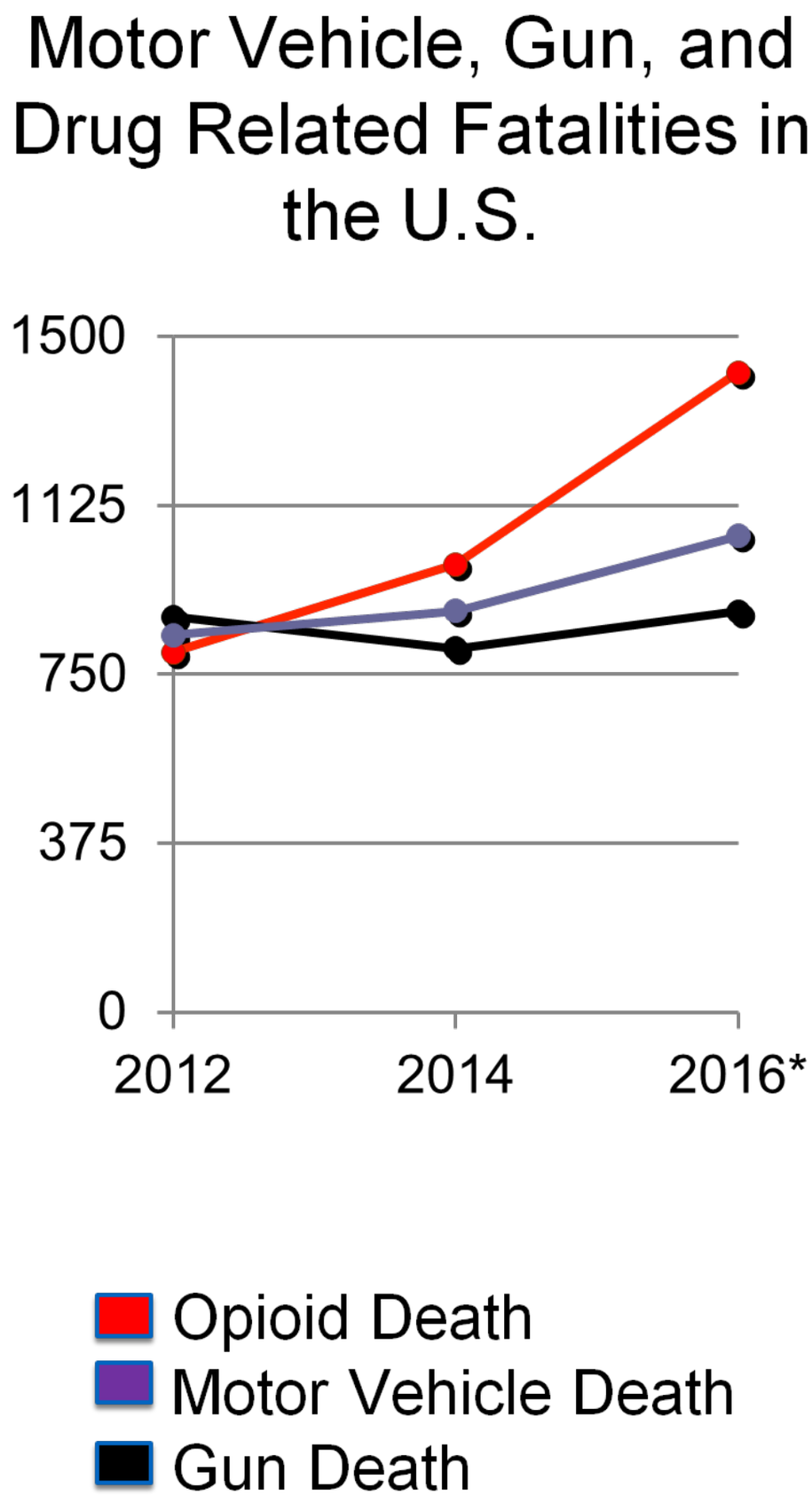
- 42% OF TEENS THAT HAVE ABUSED Rx DRUGS OBTAINED THEM FROM THEIR PARENT'S MEDICINE CABINETS.

WHO COMES INTO YOUR HOME?

By

2015

OPIOID DEATHS SURPASSED MOTOR VEHICLE AND GUN DEATHS



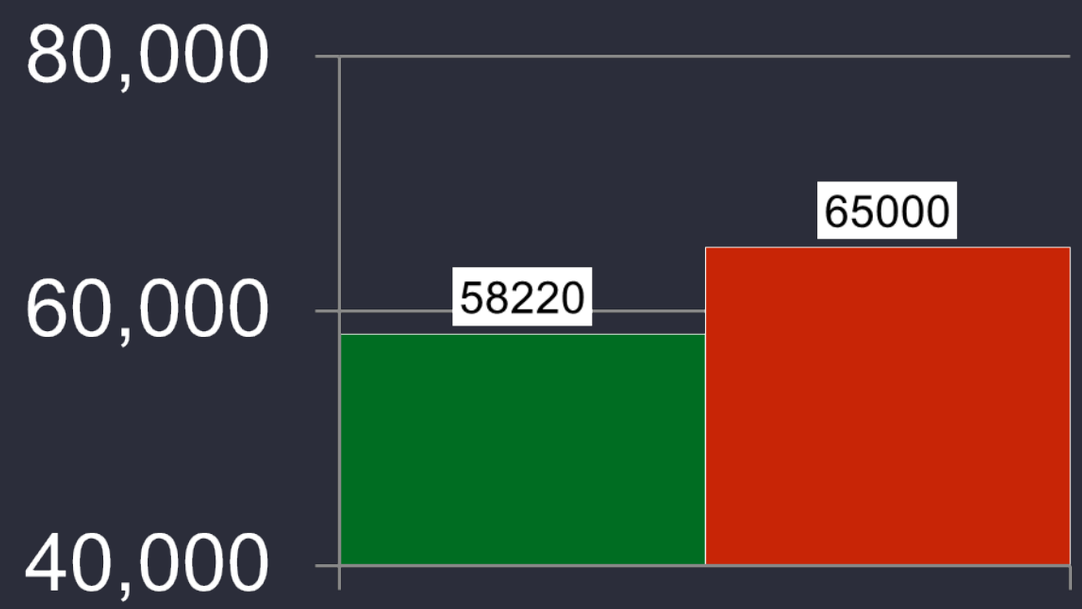
By

2016

OPIOID DEATH PROJECTIONS SURPASS CASUALTIES OF THE VIETNAM WAR

Source: NY Times, archives.gov, iCasualties.org

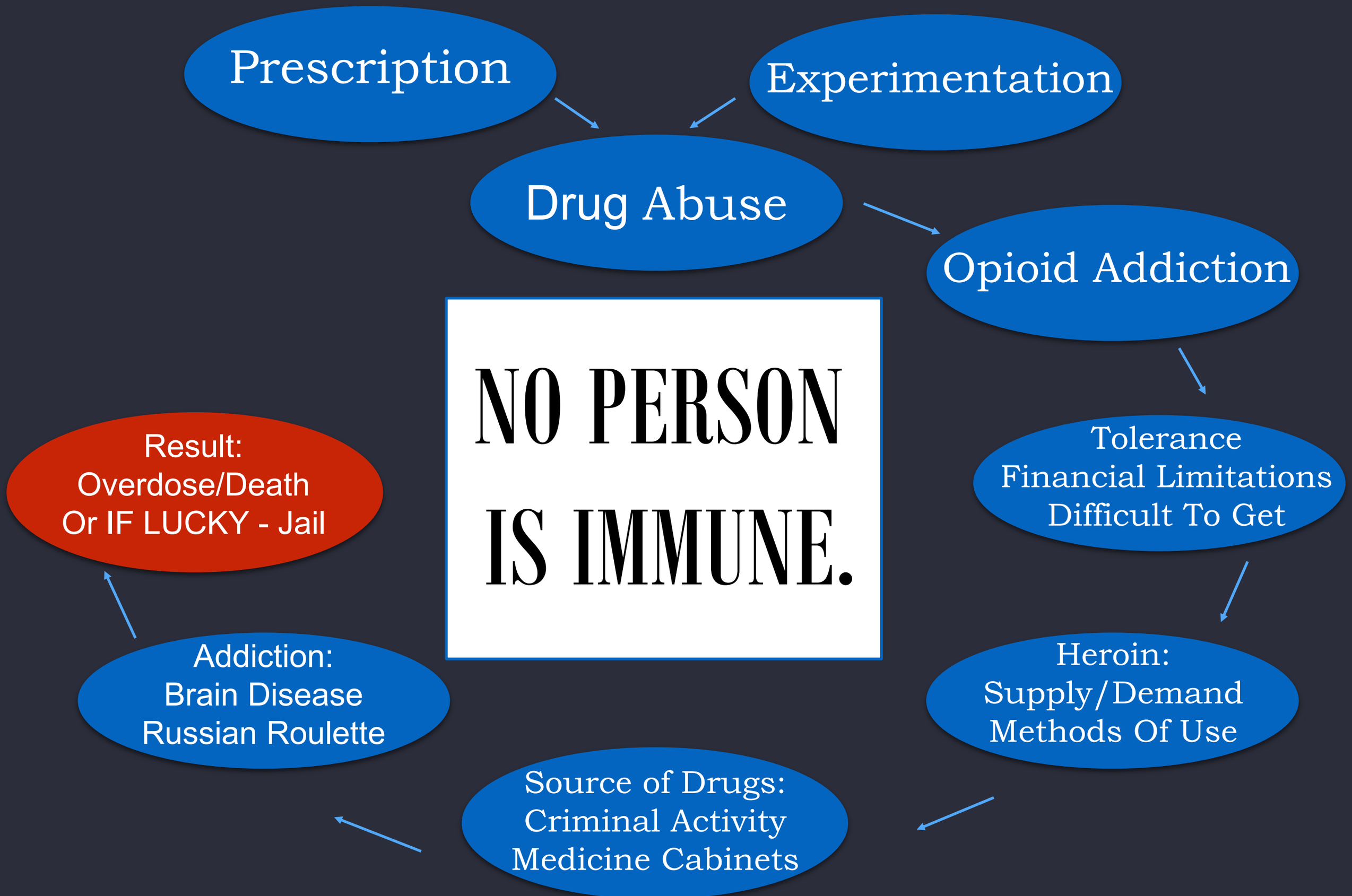
2016 Opioid Death Projections Compared to Casualties of Vietnam War



Opioid Deaths
Vietnam War Casualties

- Americans represent only 5% of the world's population.
- Americans consume 80% of the global Oxycodone supply and 99% of the global Hydrocodone supply.
- The U.S. uses 2/3 of the world's illegal drugs.

THE PATH OF A MONSTER



HEROIN

Myth	Fact
Less addictive when smoked or snorted.	Risk of HIV/Hepatitis is lessened when not using needles, but every method of use is highly addictive.
Heroin users are older.	Average user is 21 yrs old, and the age continues to fall.
You become addicted with a single use.	Addiction is a process, and varies among people.
Heroin is an "inner city problem".	False. Heroin has reached suburbia as well. Growing number of users are middle class and wealthy.

HEROIN
(OPIATE)

- No medical use.
- Typically seen as a grey, or black, powder.
- White in its purest form.
- Black, sticky variety known as "Mexican black tar".

- 448 deaths in VA 2016

FENTANYL
(SYNTHETIC)

- Produced by "street chemists"
- 30 different analogs available.
- Just 2mg dose lethal for average adult male.
- Frequently disguised as Rx pills.

- 618 deaths in VA 2016

METHODS OF USE

- Over 80% of heroin users who inject the drug do so with a partner, and yet 80% of overdose victims are found alone by first responders.

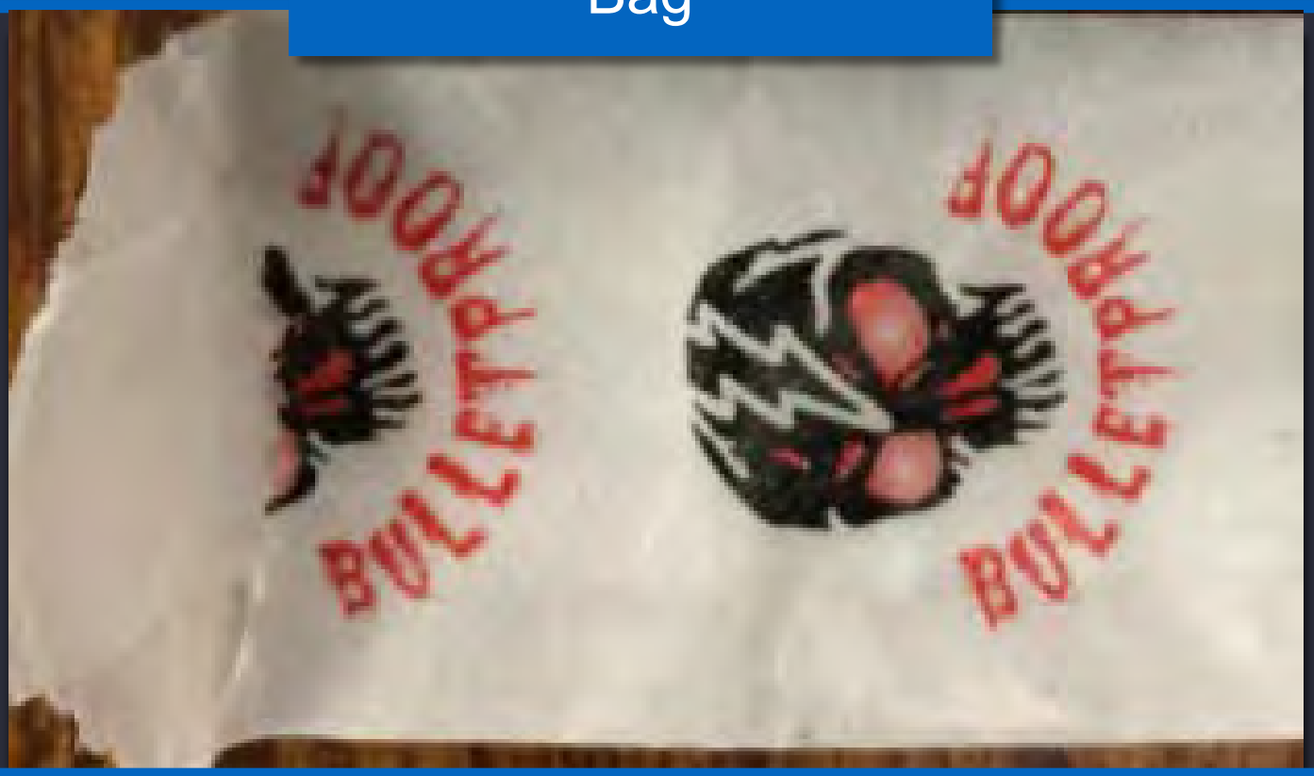
Smoking

Snorting

Shooting

STREET PACKAGING

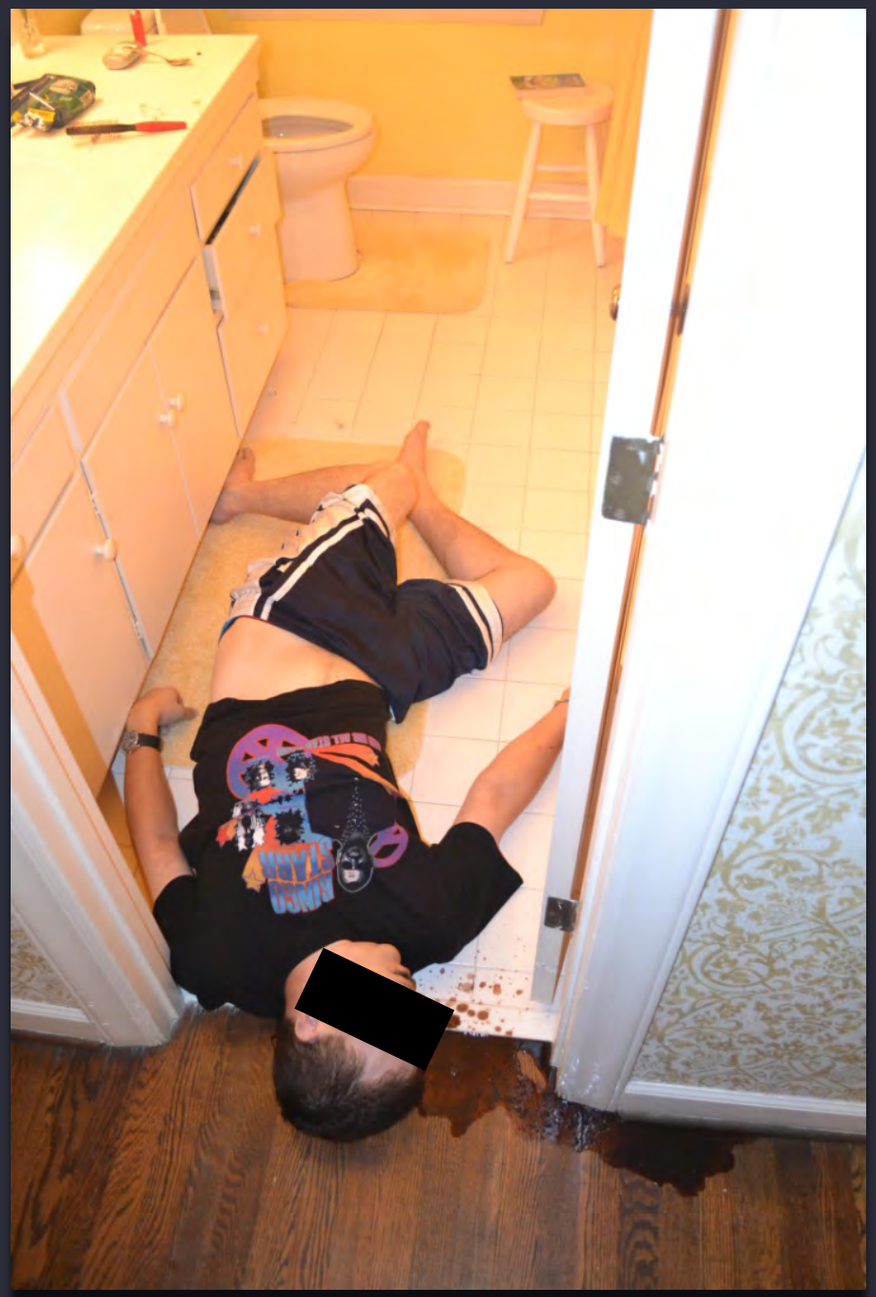
Bag

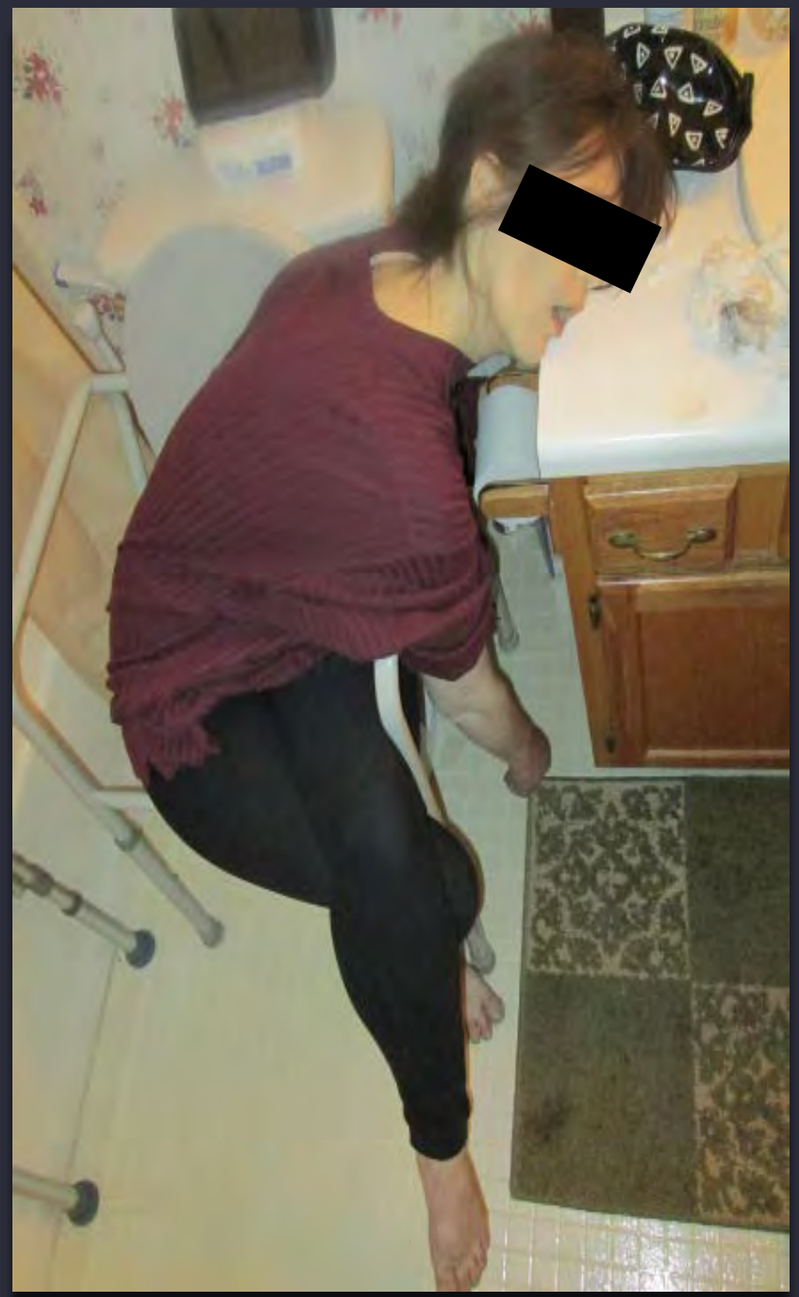


Bundles

-Marketing for dealers
-Identifiers for police

ALL TOO OFTEN THIS IS THE RESULT





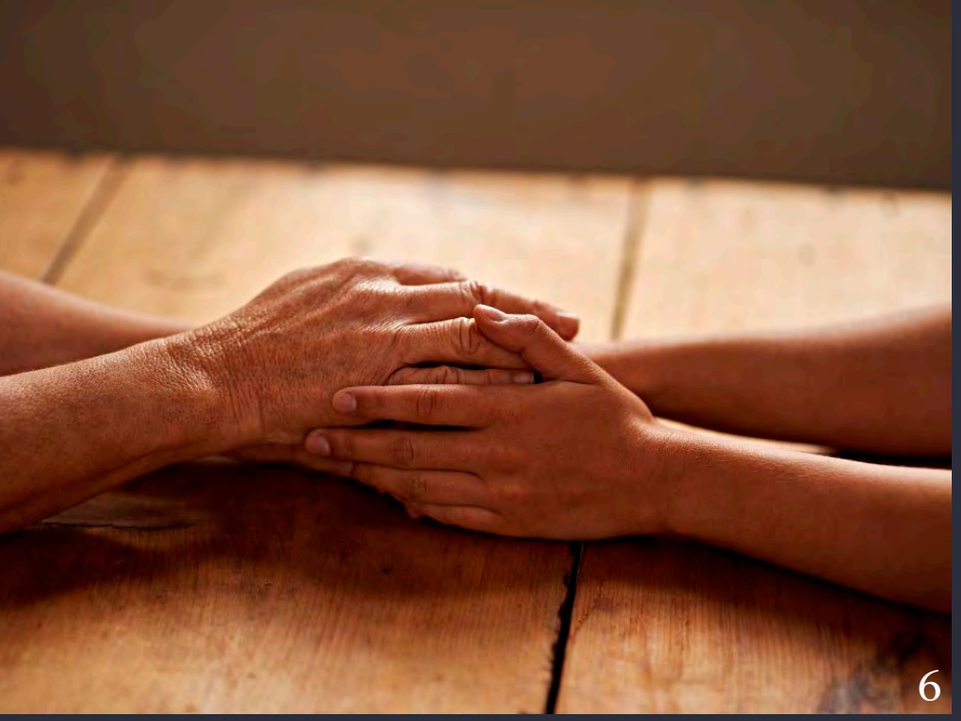
THE FACES OF HEROIN?

The REAL faces of Heroin.

THE TRUTH ABOUT NARCAN

WE ARE SAVING LIVES...BUT WE ARE FAILING TO STOP OVERDOSES.

The ENABLING argument??



PARENTAL & COMMUNITY DENIAL

- Addiction or a crime?
- Culture and stigma must change
- At risk behavior:

  - unrestricted cell phone and internet use

  - gateway drug use

What are we going to do about it?

We will talk to every

-Church

-School

-Organization

to empower them with knowledge.

ROANOKE VALLEY EFFORTS

EDUCATION/PREVENTION

- Law Enforcement Summit
- Heroin Task Force
  -LEOs, CAs, Treatment professionals, family/addicts.
- Community Forums
- Schools
- Churches
- Press Conference/ PSA

- Drug take-back
- Youth Alcohol & Drug Abuse Prevention Project (YADAPP)
- Family Day Dinner
- Town Hall Meetings
- Collaborative Projects

TREATMENT RESOURCES

- Detoxification Programs
- Residential Treatment Programs (Short & Long Term)
- Intensive Outpatient Programs
- Mental Health Services
- Aftercare/Support Groups

* NOT ENOUGH SPACE AVAILABLE*

Roanoke
HOPE Initiative

PROSECUTION

- Bond
- Drug Court
- ALPHA

PROSECUTION DECISIONS

- Nonviolent crimes
  - -Larcenies
  - -Possession
- Violent crimes
- Probation violations

THE PATH TO HEROIN ADDICTION THROUGH OPIOID USE IS EASILY FOUND.

WE MUST STOP THEM FROM REACHING HEROIN.

THE TIME FOR PREVENTION IS NOW.

This is our community.

We are in this together!

- Culture Change
- Stigma Change
- Thinking Outside the Box

We must adapt to this ever-changing epidemic.

CONTACT INFORMATION

(540) 375.3041

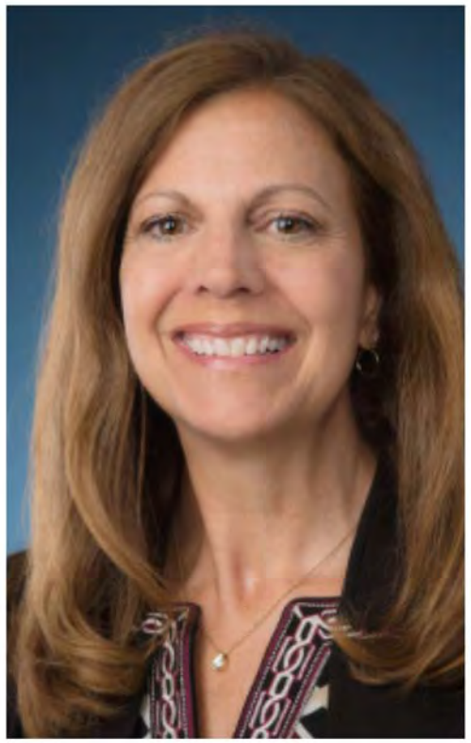
tbowers@salemva.gov

Thomas E. Bowers

Salem, VA Commonwealth's Attorney

BRADLEY FREE CLINIC
...We Care

Roanoke HOPE Valley



(540) 344-5156

janine@bradleyfreeclinic.com

Janine Underwood
Executive Director,
Bradley Free Clinic

prevention council OF ROANOKE COUNTY

CCoVA
Community Coalitions of Virginia
Partnering for Healthy Communities Across the State

(540) 353-5682

nhans@pc4y.org

Nancy Hans

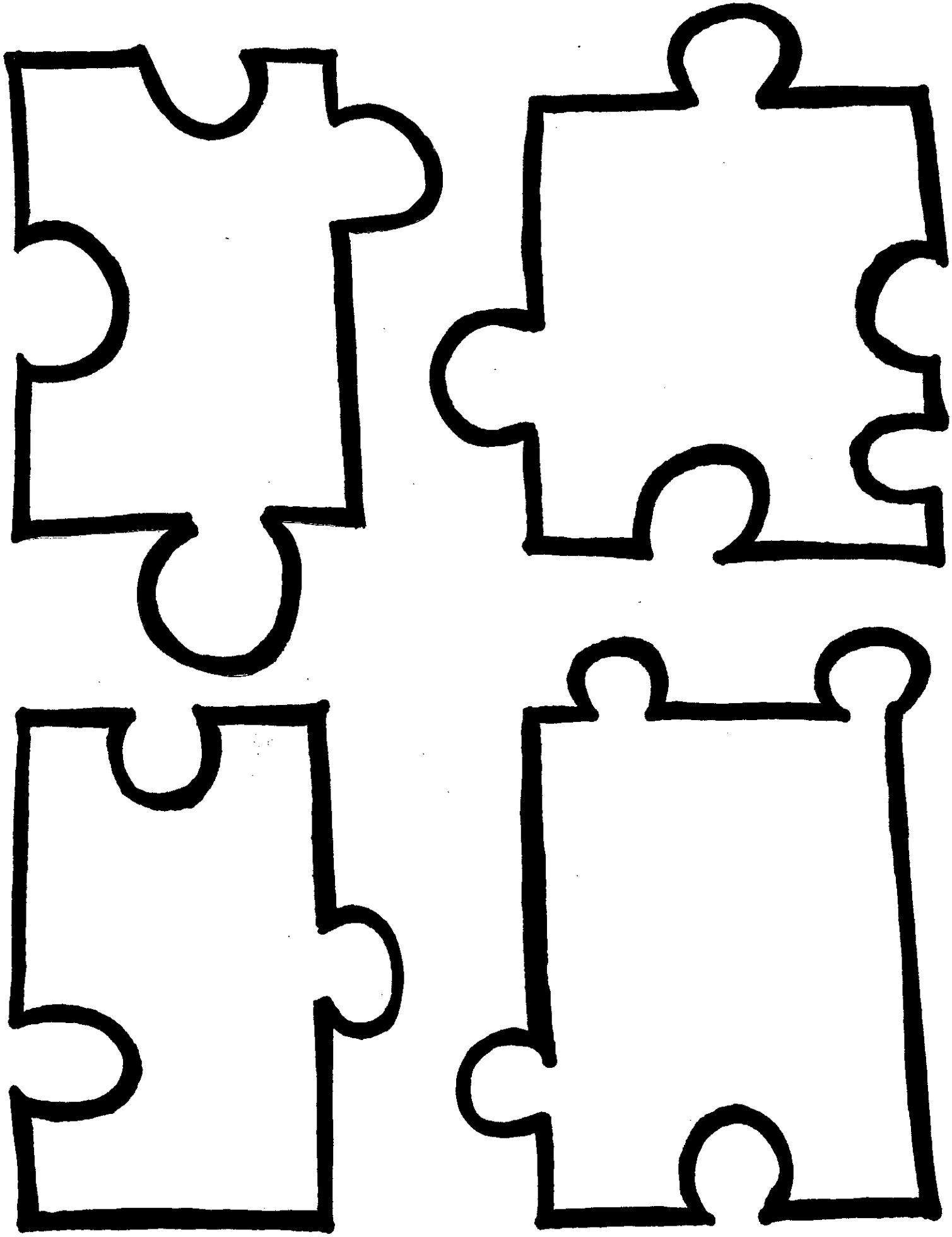
Executive Director,
Prevention Council of Roanoke County
Chair, Community Coalitions of VA

RESOURCES

1. https://www.shutterstock.com/video/gallery/Burlingham-401095
2. http://atlaslasvegas.com
3. http://drug-rehab-4u.blogspot.com/2011/04/smoking-heroin-gateway-to-heroin.html
4. http://alamy.com/stock-photo-young-woman-snorting-cocaine
5. http://www.mentalhealthportland.org/heroin-abuse-shooting-up-in-southwest-washington/
6. http://www.prevention.com/mind-body/leaning-how-to-forgive/slide/5
7. http://bradleyfreeclinic.com/
8. http://roanokeprevention.org/
9. http://storiesmagic.wordpress.com/2015/08/09/confession-of-a-teenager-epi-6

- Lopez, German. (2017) Drug Overdoses Killed More Than Vietnam War. *Vox*. Retrieved on (18 July 2017) http://www.vox.com/policy-andpolitics/2017/7/7/159925488/opioid-epidemic-deaths-2016

Lying	Negative Attitude	Stealing	Cheating
Verbal Abuse	Hurting Others	Authority Problem	Trust
Disrespect	Deception	Gossiping	Hold A Grudge



When it’s okay to not know...

Cultural Competency

Culture

the behaviors and beliefs characteristic of a particular social, ethnic, or age group

Dictionary.com

Co mpet en c y

the quality of being competent; adequacy; possession of required skill, knowledge, qualification, or capacity

Dictionary.com

Google

Cultural Humility

All Videos News Images Shopping More Settings Tools

About 2,090,000 results (0.66 seconds)

Cultural humility is the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of **cultural** identity that are most important to the [person]."

Cultural humility - Wikipedia
https://en.wikipedia.org/wiki/Cultural_humility

About this result Feedback

Cultural Competency vs. Cultural Humility

Humility

the quality or condition of being humble; modest opinion or estimate of one's own importance, rank, etc.

Dictionary.com

Cultural Humility

Cultural Humility

"ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]"

Experience Shapes Culture

Domestic Violence

"Domestic violence is the **willful** intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a **systematic pattern** of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, psychological violence, and emotional abuse."

www.NCADV.org/learn-more/what-is-domestic-violence

8,000,000

The number of paid days each year that are missed from work by domestic violence victims

$4,100,000,000

The health-related costs of domestic violence each year - (Centers for Disease Control & Prevention)

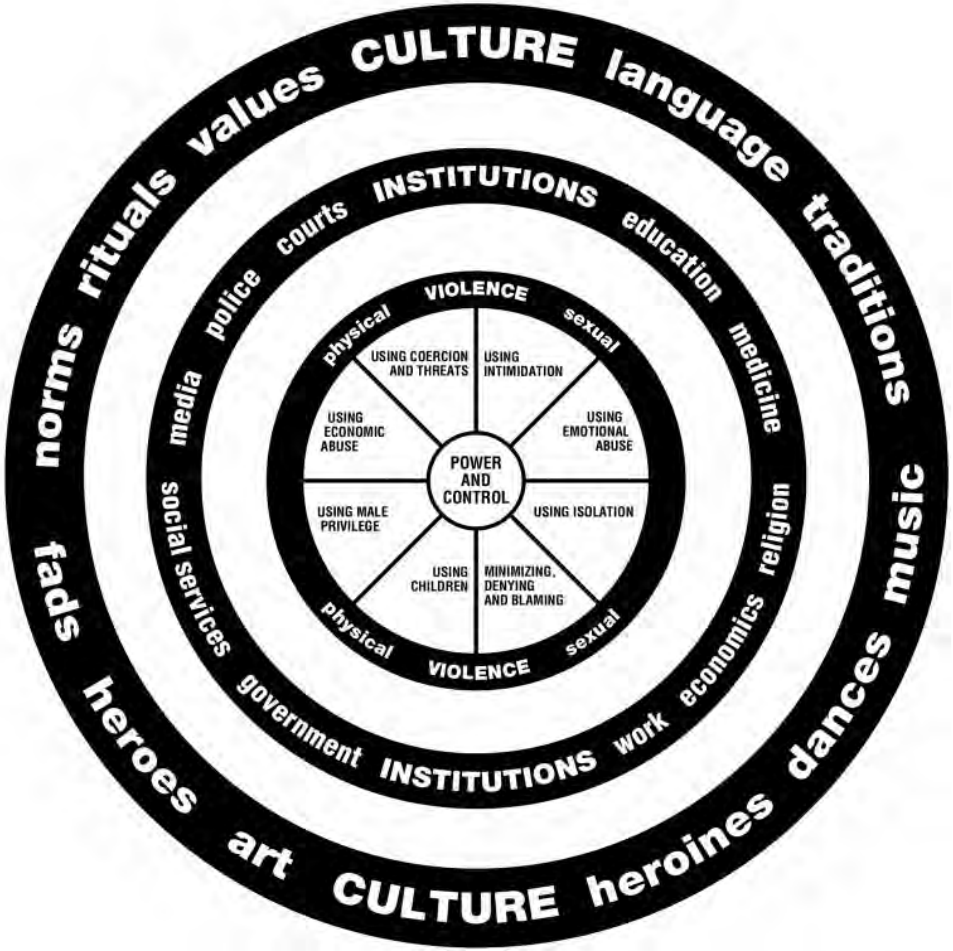
20 people in the U.S. are abused every minute

National Coalition Against Domestic Violence

1 in 5 women in the u.s. Is raped during her lifetime

www.cdc.gov

PHYSICAL VIOLENCE SEXUAL
USING COERCION AND THREATS
Making and/or carrying out threats to do something to hurt her • threatening to leave her, to commit suicide, to report her to welfare • making her drop charges • making her do illegal things.
USING INTIMIDATION
Making her afraid by using looks, actions, gestures • smashing things • destroying her property • abusing pets • displaying weapons.
USING ECONOMIC ABUSE
Preventing her from getting or keeping a job • making her ask for money • giving her an allowance • taking her money • not letting her know about or have access to family income.
USING EMOTIONAL ABUSE
Putting her down • making her feel bad about herself • calling her names • making her think she's crazy • playing mind games • humiliating her • making her feel guilty.
POWER AND CONTROL
USING MALE PRIVILEGE
Treating her like a servant • making all the big decisions • acting like the "master of the castle" • being the one to define men's and women's roles
USING ISOLATION
Controlling what she does, who she sees and talks to, what she reads, where she goes • limiting her outside involvement • using jealousy to justify actions.
USING CHILDREN
Making her feel guilty about the children • using the children to relay messages • using visitation to harass her • threatening to take the children away.
MINIMIZING, DENYING AND BLAMING
Making light of the abuse and not taking her concerns about it seriously • saying the abuse didn't happen • shifting responsibility for abusive behavior • saying she caused it.
PHYSICAL VIOLENCE SEXUAL



DOMESTIC ABUSE INTERVENTION PROGRAMS
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.theduluthmodel.org

INTERSECTIONS OF SUBSTANCE USE/ABUSE

50% of men entering Sub. Abuse treatment have battered in the past year

25%-50% of women getting services for DV have Sub. Abuse problems

55%-99% of women who have Sub. Abuse issues have been a victim of DV at some point in their lives

Common misunderstandings about domestic violence

"He only hits me when he's drinking"

"But I want to see my kids and she is a good Mom"

Legal & social history of Domestic violence

ESTABLISHED HISTORY

ROMAN SOCIETY- A WOMAN WAS PROPERTY OF HUSBAND

ENGLISH COMMON LAW-"RULE OF THUMB"

1870's- A "FEW" STATES BANNED A MAN'S RIGHT TO BEAT HIS FAMILY

THE PAST 50 YEARS..

1950's & 1960's- Civil rights movements/anti-war movements.

1970's- Women's liberation, women's health, & anti-rape movements.

1990's- **3 times** more animal shelters in the U.S. than there were shelters for battered women.

1994- Violence Against Women's Act

THE PAST 20 YEARS...

2005- The Protection of Women from Domestic Violence Act- "any act, conduct, omission or commission that harms or injures has the potential to, will be considered domestic violence by the law."

National Domestic Violence Hotline has received over 3 million calls since 1996.

VAWA trains over 50,000 law enforcement officers, prosecutors, & Judges annually.

“

Violence against women = Human rights abuse

Domestic abuse ≠ Private Matter = Public Problem!

“To deny people their human rights is to challenge their very humanity”- *Nelson Mandela*

INTERSECTIONS OF DOMESTIC VIOLENCE GLOBALLY

on individuals, health systems, & society

Psychological/ Emotional/ Medical/ Mental & Financial impacts on women & families

Batterers cost nations' fortunes in terms of law enforcement, health care, lost labor & decreased progression of development

Traumataic effects on children who witness the violence (increased tendencies toward suicide, drugs, and violence)

The lack of sobriety, either in victims or abusers, increases the chances of further violence to the victims.

The Paradox

The lack of victim safety threatens the sobriety of the victim & the abuser.

Obstacles to arrest & prosecution-

Criminal Justice Institute

1. "Abuse was difficult to prove..."
2. "Our jails are already overcrowded & he won't be locked up very long anyway."
3. "He's well-respected in the community, he couldn't have done what she said."
4. "She doesn't seem too sure to me... She'll probably change her mind anyway."
5. "She called the Commonwealth's office and said she wanted to drop the charges."
6. "They were both drunk and high.. who knows what actually happened?"

Experience Shapes worldview

Sexual Assault

refers to sexual contact or behavior that occurs without explicit consent of the victim.

Some forms of sexual assault include:

- Attempted rape
- Fondling or unwanted sexual touching
- Forcing a victim to perform sexual acts, such as oral sex or penetrating the perpetrator's body
- Penetration of the victim's body, also known as rape

Sexual assault can take many different forms, but one thing remains the same: it's never the victim's fault.

Sexual Violence: Consequences

Research has found that women who have experienced sexual violence during adulthood are more likely than other women to use and abuse substances, including alcohol, illicit drugs and prescription drugs

WHY??

Wanting to feel better

Trying to numb or escape the pain

Fear that family or friends won’t understand

Confusion or self-consciousness about the experience

Lacking an effective support system or care

Debr a

“It made me feel like drugs were the only way out. I was looking for love in all the wrong places.”

Sexual violence is fundamentally about power: the power someone else has to hurt the victim, and the loss of power (over body, identity, and environment) experienced by the victim.

Experience Shapes worldview

Adverse Childhood Experience

“ACE Study”

Prevalence of ACEs by Category for CDC-Kaiser ACE Study Participants by Sex, Waves 1 and 2.

ACE Category	Women	Men	Total
	Percent (N = 9,367)	Percent (N = 7,970)	Percent (N = 17,337)
ABUSE			
Emotional Abuse	13.1%	7.6%	10.6%
Physical Abuse	27%	29.9%	28.3%
Sexual Abuse	24.7%	16%	20.7%
HOUSEHOLD CHALLENGES			
Mother Treated Violently	13.7%	11.5%	12.7%
Household Substance Abuse	29.5%	23.8%	26.9%
Household Mental Illness	23.3%	14.8%	19.4%
Parental Separation or Divorce	24.5%	21.8%	23.3%
Incarcerated Household Member	5.2%	4.1%	4.7%
NEGLECT			
Emotional Neglect[3]	16.7%	12.4%	14.8%
Physical Neglect[3]	9.2%	10.7%	9.9%

Note: [3]Collected during Wave 2 only (N=8,629). Research papers that use Wave 1 and/or Wave 2 data may contain slightly different prevalence estimates.

ACE Score Prevalence for CDC-Kaiser ACE Study Participants by Sex, Waves 1 and 2.

Number of Adverse Childhood Experiences (ACE Score)	Women	Men	Total
	Percent(N = 9,367)	Percent (N = 7,970)	Percent (N = 17,337)
0	34.5%	38.0%	36.1%
1	24.5%	27.9%	26.0%
2	15.5%	16.4%	15.9%
3	10.3%	8.5%	9.5%
4 or more	15.2%	9.2%	12.5%

Note: Research papers that use Wave 1 and/or Wave 2 data may contain slightly different prevalence estimates.

Source: Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016.

Experience Shapes worldview

Po v er t y

- Marginality
- Helplessness
- Dependency
- Inferiority

Marginality

- Not fitting in
- Competing for basic needs
- Perceptions of being oppressed by those in power or authority

Helplessness

- Feelings of not being able to compete
- Feelings of inadequacy are pervasive
- Fatalism

Dependency

- Dependency
- “Life owes me”
- Opportunism
- Minimal efforts to attain greater gains

Inferiority

Contributing Factors:

- Low self-esteem
- Existential Angst
- No sense of personal or family history

Psychological Trauma and Substance Abuse

Maintaining Humility

- Life-long Learning & Critical Self-Reflection
- Recognize and Challenge Power imbalances
- Institutional accountability

We can never be Culturally Competent, but we can operate with Humility

“The fact that we are here and that I speak these words is an attempt to break that silence and bridge some of those differences between us, for it is not difference which immobilizes us, but silence. And there are so many silences to be broken.”

- Audre Lorde

Thanks!

Warren Rodgers, Jr.
Southside Survivor Response Center, Inc.
www.SSRCenter.org
wrodgers@SSRCenter.org
(276) 403 - 4084

Traumatic Experience

Socially, it's Easier to understand Traumatic Response from combat veterans.

Physiological response to trauma

Combat Veterans

Shifting the Lens: Alternative Approaches in Drug Treatment Courts

CHRISTA M. MARSHALL, PSY.D.

08/08/2017

- Dr. Marshall has no financial conflicts to disclose.

- Questions for the group:
  - What is your community's impression of MAT?
  - How many of your courts are using MAT?

Addiction to Opioids is Prevalent and Lethal

- 20.5 million Americans 12 or older had a substance use disorder in 2015
  - 2 million involving prescription pain relievers
  - 591,000 had a substance use disorder involving heroin
- Four in five new heroin users started out misusing prescription painkillers.
- Drug overdose is the leading cause of accidental death in the U.S. in 2015
  - 52,404 lethal drug overdoses
  - 20,101 overdose deaths related to prescription pain relievers
  - 12,990 overdose deaths related to heroin

(Center for Behavioral Statistics and Quality, 2015; Jones 2013)

Heroin Withdrawal Symptoms

STAGE 1
Up to 8 hours after last dose

Drug cravings

Moodiness

STAGE 2
8 to 24 hours after last dose

Stomach cramps

Upper body secretions

Restlessness

STAGE 3
Up to 3 days after last dose

Diarrhea

Fever / Chills

Muscle spasms

Nausea / Vomiting

Cardiovascular problems

Source: Kosten TR, O'Connor PG. Management of drug and alcohol withdrawal. New England Journal of Medicine, 2003; 348:1786.

Symptoms of Opioid Withdrawal

Early Withdrawal Symptoms

These usually start within 6-12 hours for short-acting opiates, and they start within 30 hours for longer-acting ones:

- Tearing up
- Muscle aches
- Agitation
- Trouble falling and staying asleep
- Excessive yawning
- Anxiety
- Nose running
- Sweats
- Racing heart
- Hypertension
- Fever

Late Withdrawal Symptoms

These peak within 72 hours and usually last a week or so:

- Nausea and vomiting
- Diarrhea
- Goosebumps
- Stomach cramps
- Depression
- Drug cravings

(American Addiction Centers, 2017)

Medication Assisted Treatment

- FDA approved medications to treat opioid, alcohol, and stimulant use disorders
  - Goals - to use medication to:
    - normalize brain chemistry
    - relieve withdrawal symptoms and psychological cravings
    - block euphoric effects of substances
    - normalize bodily functions without substances
  - MAT requires conjoint behavior therapy and education in addition to medication
- Combining MAT with anxiety medication, especially benzodiazepines (e.g., Xanax, valium) can be fatal.

(SAMHSA, 2015)

Phases of MAT

1. Acute
2. Rehabilitative
3. Supportive-care
4. Medical maintenance
5. Tapering (optional)
6. Continuing-care

*Not a linear model – relapse is part of recovery

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- Acute (Detox or admission to comprehensive MAT)
  - Medication to minimizes sedation and other undesirable side effects
  - Assessing the safety and adequacy of each dose after administration
  - Rapidly but safely increasing dosage to suppress withdrawal symptoms and cravings
  - Referrals for co-occurring disorders and medical, social, legal, family, and other problems associated with opioid addiction
  - Develop alternative strategies for coping with cravings or compulsions to abuse substances

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- Rehabilitation Phase Main Goal: Deal with current major life problems so that patient can address bigger life goals (e.g., education, employment, reconciliation with family)
  - Increase participation in constructive activities (employment, education, vocational training, child rearing)
  - Medication administration more flexible to allow for participation in activities
  - Participate in support groups, as long as they support MAT (e.g., faith based, 12-step)
  - Develop skills to cope with triggers
  - Focus on getting the body healthy
  - Build social support system
  - Address legal problems
  - Address mental health problems

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- Supportive-care phase (typically lasts 2 - 3 years; estimate)
  - Decreased frequency of visits to OTP clinics
  - Abstinence from alcohol and illicit drugs
  - Medical conditions stable
  - Stable source of income
  - Family relationships/support system stable
  - Legal issues have been resolved

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- Medical Maintenance
  - 2-years of treatment and compliance necessary to receive full 30-day supply of methadone
  - Clinic continues to make dosage adjustments as needed
  - Random drug testing and medication recall (prevents medication diversion)
  - Important to celebrate accomplishments and treat this as a legitimate recovery option

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- Tapering
  - Medically supervised withdrawal
  - A number of medical, psychological, and social factors should be considered before deciding on tapering
  - Should increase supportive services during this time
  - Therapy for 3 – 12 months focusing on coping and relapse prevention

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- Continuing-care (after Tapering)
  - Continued f/u care with physicians
  - Continued participation in recovery and support groups
  - Continued contact with mental health and case management professionals, although at longer intervals

(Center for Substance Abuse Treatment, 2005)

Medication Assisted Treatment

- Benefits of treatment:
  - Improve patient survival
  - Increase retention in treatment
  - Decrease illicit opiate use and other criminal activity among people with substance use disorders
  - Increase patients' ability to gain and maintain employment
  - Improve birth outcomes among women who have substance use disorders and are pregnant
  - Decreased potential for relapse decreases likelihood of contracting HIV or Hepatitis

(SAMHSA, 2015)

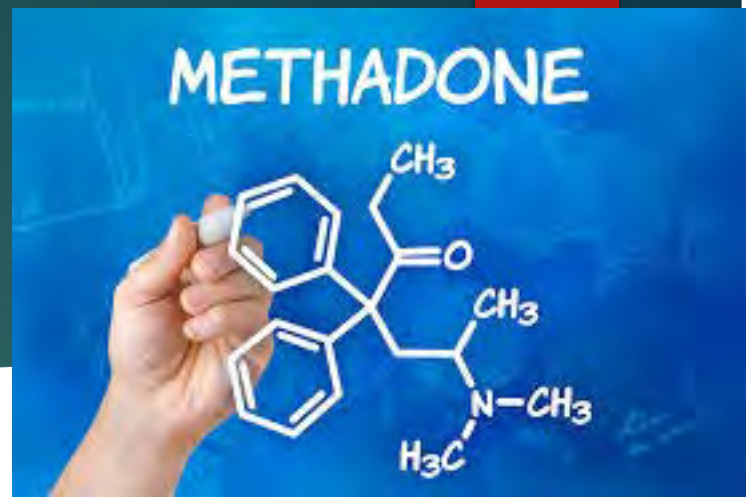
Goals of Opioid Replacement Therapy

1. Eliminate opioid withdrawal symptoms throughout the 24-h following administration
2. Abolish cravings or urges to use other opioids
3. Establish adequate tolerance to preclude euphoria caused by use of illicit opioids
4. Eradicate use of illicit opioids as demonstrated by self-report and urine toxicology testing
5. Minimize side effects so that the patient does not experience any intoxication and can function normally

(Buchholz & Saxon, 2016)

Happy, Healthy, Productive!

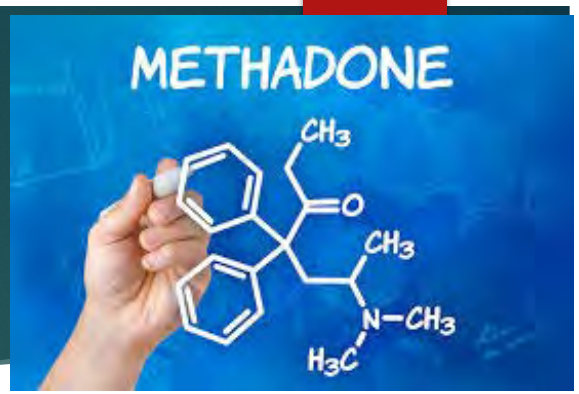
Methadone



- Requirements for participation
  - One year documented opioid use disorder
  - This can be waived for patients who are pregnant, recently released from incarceration, or had previous treatment in last 2 year
- Available in tablet, rapidly dissolving wafer, and liquid.
  - Early in treatment must present daily, but eventually may get doses in week-long supply.
  - Can be significant drug interactions – especially with other CNS depressants (e.g., alcohol, benzodiazepines)

(Buchholz & Saxon, 2016)

Methadone

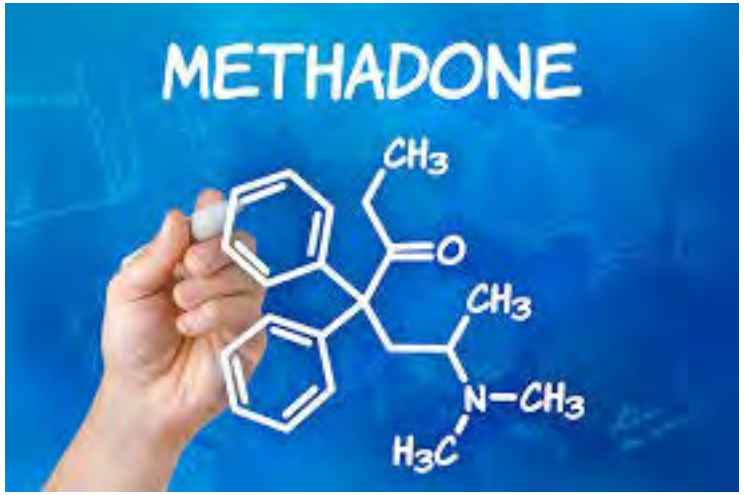


- Side effects include: pupillary constriction, constipation, sedation, respiratory depression, QT interval prolongation, increased sensitivity to pain, tolerance
- Initial dosage: 5 – 30mg
- Clinical trials show that methadone maintenance doses of 80–100 mg per day have advantages over lower doses in reducing illicit opioid use and retaining patients in treatment (Strain, Bigelow, Lievson, & Stilzer, 1999).
- Maintenance doses are typically from 80mg – 120mg (although individual patients vary considerably from this depending on a number of factors)

(Buchholz & Saxon, 2016)

Methadone

- Not typically a good option for pain management – analgesic effects last 6 hours
- Some clinics split the dose for pain management purposes – but evidence to back up this practice minimal (Dunn, Brooner, & Clark, 2014).

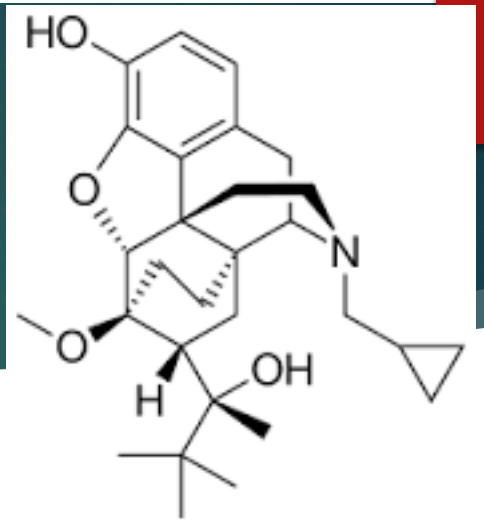


(Buchholz & Saxon, 2016)

Methadone Outcomes

- 11 clinical trials involving 1,969 people, methadone improved treatment retention and reduced heroin use compared with nonmedication treatment (Mattick, Breen, Kimber, & Davoli, 2009)
- If all eligible offenders offered methadone treatment, 3.3 million nondrug crimes could be averted (Bhati, Roman, & Chaln, 2008)
- Every dollar spent on ongoing methadone treatment yields almost $38 in benefits through reduced crime, better health, and gainful employment (Zarkin, Dunlap, Hicks, & Mamo, 2004)

Buprenorphine

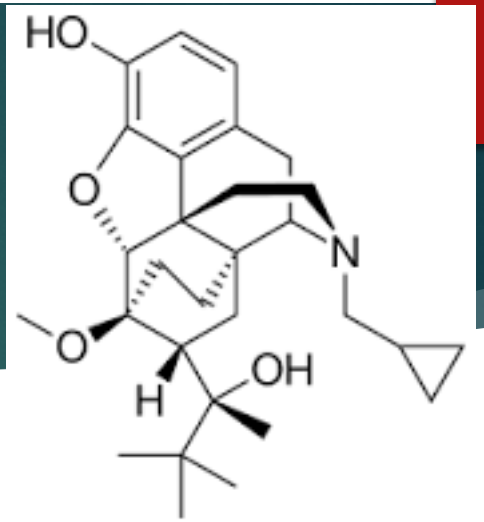


Brand Names: Suboxone, Buprenex, Butrans

- Better safety profile than methadone.
  - Partial opioid agonist with a ceiling effect: higher doses do not necessarily lead to increasing activity
  - Less risk of respiratory depression and overdose
  - Fewer drug-drug interactions
  - Less impact on cardiac functioning

(Buchholz & Saxon, 2016)

Buprenorphine



- Methods of delivery

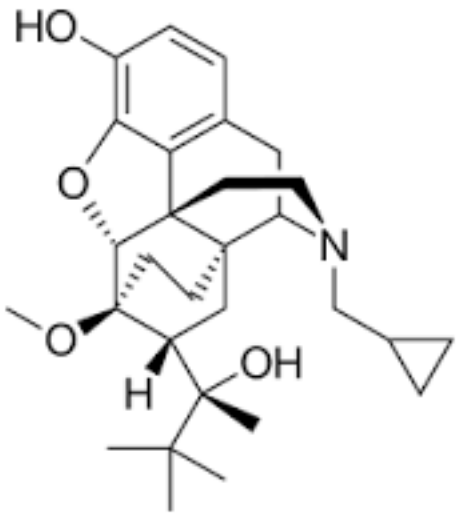
1. buprenorphine sublingual tablets
2. buprenorphine/naloxone sublingual tablets
3. buprenorphine/naloxone sublingual film
4. buprenorphine/naloxone buccal film
5. buprenorphine IM/IV (mainly used for acute pain)
6. buprenorphine transdermal patch (approved for use in management of pain)

- Notice the use of naloxone combination – prevents misuse as activated when injected

(Buchholz & Saxon, 2016)

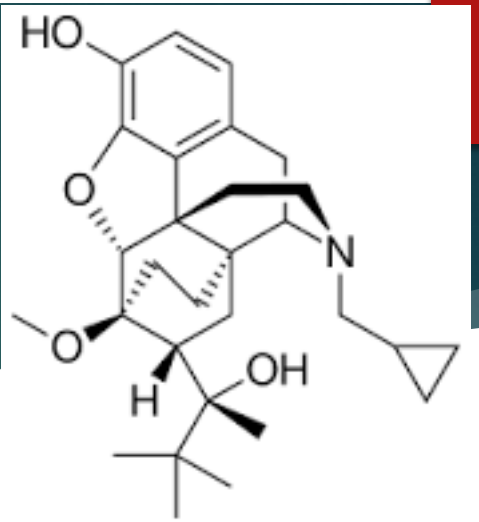
Buprenorphine

- Side effects: constipation, nausea, sweating, headaches, elevated liver enzymes, tolerance
- Risk of precipitated opioid withdrawal
  - Need to have abstained from opioids long enough to display moderate opioid withdrawal on Clinical Opiate Withdrawal Scale
  - Initial dose of buprenorphine 2 -4 mg
  - Subsequent doses may be between 2 – 32mg
  - Finding a stable dose may take days or weeks



(Buchholz & Saxon, 2016)

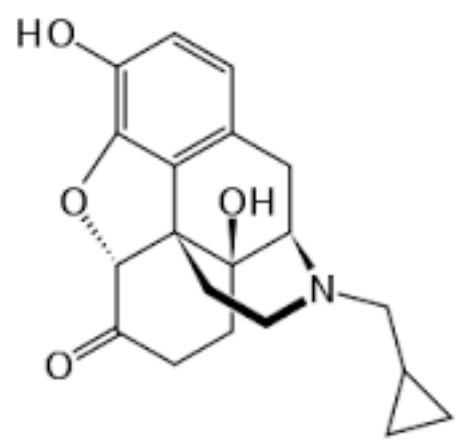
Buprenorphine



- More effective than placebo
- As effective as *moderate* doses of methadone
- Unlikely to be as effective as *higher* doses of methadone
- May not be the treatment of choice for patients with higher levels of physical dependence

(Center for Substance Abuse Treatment, n.d.; Veilleux, Colvin, Anderson, York, & Heinz, 2010).

Naltrexone – Opioids and Alcohol



Brand Names: Revia, Vivitrol

- Oral medication and injectable
  - 50mg oral pills, 380 mg monthly injectable
- Highly effective opioid antagonist – blocks receptors (no high)
- Can produce withdrawal in individuals who have not been abstinent for 7 – 10 days.
- No narcotic effects – when someone stops taking this there are no withdrawal symptoms
- 50 mg blocks opioids for 24 hours
- Side Effects: nausea, vomiting, anxiety, nervousness, insomnia, headache, joint or muscle pain, and fatigue
- In criminal justice, multisite study, those who received 6 months of naltrexone injections had significantly fewer positive urine tests for opioids and lower recidivism than those who did not receive treatment (Coviello et al., 2012)

(Center for Substance Abuse Treatment, 2005)

Side Effects of Opioid Replacement Therapy

Whole Body Effects

- Weakness, loss of energy (asthenia)
- Back pain, chills
- Fluid accumulation (edema)
- Hot flashes
- Flu syndrome and malaise
- Weight gain

Gastrointestinal Effects

- Constipation
- Dry mouth
- Nausea and vomiting
- Abdominal pain

Musculoskeletal Effects

- Joint pain (arthralgia)
- Muscle pain (myalgia)

Nervous System Effects

- Abnormal dreams
- Anxiety
- Decreased sex drive
- Depression
- Euphoria
- Headache
- Decreased sensitivity to tactile stimulation (hypesthesia)
- Insomnia
- Nervousness
- Somnolence

Respiratory Effects

- Cough
- Rhinitis
- Yawning

Cardiac Effects

- Electrocardiogram changes (possible QT prolongation with high doses of methadone)
- Postural hypotension
- Slowed heart rate (bradycardia)

Hepatic Effects

- Abnormal liver function tests

Endocrine Effects

- Hyperprolactinemia
- Absence of menstrual periods (amenorrhea)

Skin and Appendage Effects

- Sweating
- Rash

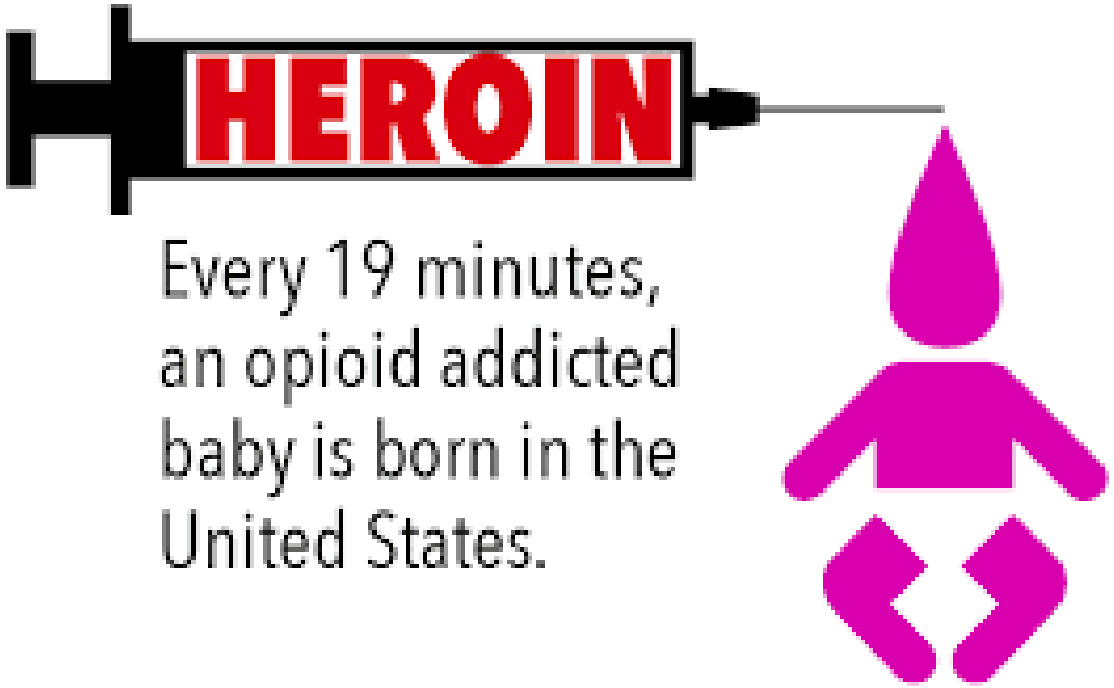
Special Sensory Effects

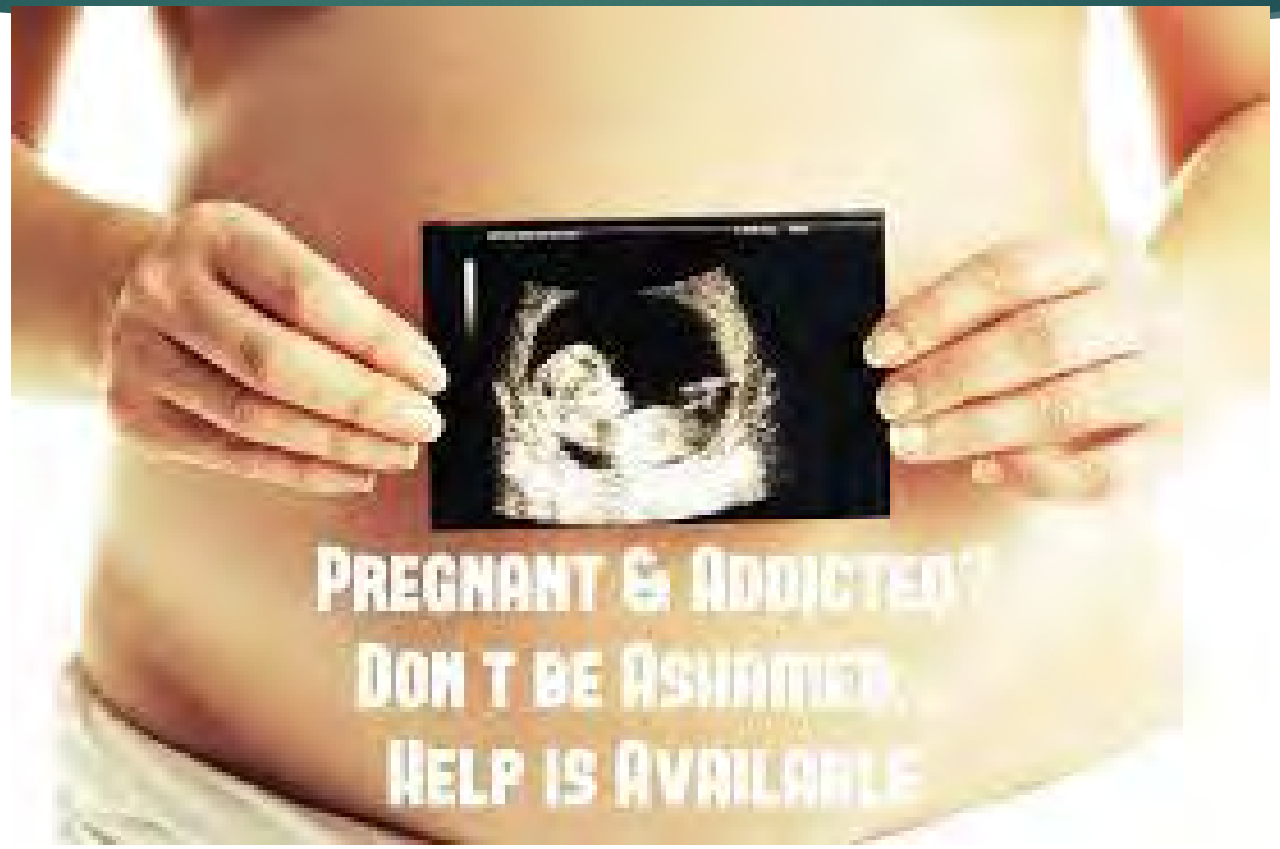
- Blurred vision

Urogenital Effects

- Difficult ejaculation
- Impotence

(Center for Substance Abuse Treatment, 2005)


HEROIN
Every 19 minutes, an opioid addicted baby is born in the United States.


PREGNANT & ADDICTED?
DON T BE ASHAMED.
HELP IS AVAILABLE

MAT in Pregnant Women

- Pregnant opioid users especially marginalized
- Because opioid use causes cessation of periods, may interpret this as infertility
- Avoiding MAT in pregnant women increased risk of infections, STIs, HCV and HIV
- May interpret early signs of pregnancy as opioid withdrawal and increase opioid use
- Inducing even mild opioid withdrawal can cause premature labor and adverse effects on the fetus

(Center for Substance Abuse Treatment, 2005)

MAT in Pregnant Women

- Because MAT normalizes endocrine functioning, women need to be counseled about possibility of becoming pregnant
- When on methadone, as pregnancy progresses may need to increase dosage due to increased blood volume
- Decreases fetal death rate
- Increases birth weight
- Avoid use of Naloxone whenever possible – can induce acute opioid withdrawal in the fetus
- Women can breastfeed on methadone (assuming no other health complications)

(Center for Substance Abuse Treatment, 2005)

Neonatal Abstinence Syndrome (NAS)

- Infants exposed to opioids during gestation:
  - Hyperactivity of CNS and ANS
  - Changes in gastrointestinal tract and respiratory system
  - Uncoordinated/frantic sucking and feeding difficulties
  - Withdrawal symptoms – minutes up to 2 weeks (usually 72 hours)
    - May be treated with medications until eventual tapering
    - Can make baby's behavior more difficult to tolerate
    - Can impact bonding

(Center for Substance Abuse Treatment, 2005)

MAT and Parenting

- In a recent study of 596 parents abusing opioids in Child Welfare System
  - 9.2% receiving MAT
  - Increased months of MAT increased odds of parents maintaining custody of their children

(Martin, Wilfong, Huebner, Posze, & Willauer, 2016).

Prevalence of Alcohol Use Disorders

- 10-20% of patients seen in primary care and hospital settings have a diagnosable alcohol use disorder
- 2013 18 million people met criteria, but only 1.4 million got treatment
- MAT very underused in alcohol use disorders despite being a recommendation for patients suffering from moderate to severe alcohol use disorders
  - **Mild:** The presence of 2 to 3 symptoms
  - **Moderate:** The presence of 4 to 5 symptoms
  - **Severe:** The presence of 6 or more symptoms

(SAMHSA & NIAAA, 2015)

Criteria for Alcohol Use Disorder

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- **Alcohol is often taken in larger amounts or over a longer period than was intended.**
- **There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.**
- **A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.**
- **Craving, or a strong desire or urge to use alcohol.**
- **Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.**
- **Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.**

(American Psychiatric Association, 2013)

Criteria for Alcohol Use Disorder

- Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
- Recurrent alcohol use in situations in which it is physically hazardous.
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of alcohol to achieve intoxication or de sired effect.
  - A markedly diminished effect with continued use of the same amount of alcohol.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for alcohol
  - Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

(American Psychiatric Association, 2013)

Disulfiram

- Brand Name: Antabuse
- For patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may have best chance
  - Must have already gone through alcohol withdrawal
  - Ideally, willingness to take under supervision of family member or treatment program
- Daily administration: 500 mg first 1 – 2 weeks; maintenance 125mg – 500mg
- Causes nausea-vomiting, flushing, and heart palpitations to create deterrent to drinking
  - If high levels of alcohol are in the system, the symptoms can be much more severe
- Contraindicated for
  - severe myocardial disease or coronary occlusion, psychoses, pregnancy, high levels of impulsivity, suicidality

(SAMHSA & NIAAA, 2015)

Acamprosate

- Brand name: Campral
- Indicated for maintenance of abstinence from alcohol for those who are abstinent at treatment initiation
  - Counters imbalance between glutamatergic and GABAergic system in chronic alcohol abuse and withdrawal
- Administered 3 times per day; 666mg per dose
- Avoid in patients with kidney problems
- Not for use in pregnancy

(SAMHSA & NIAAA, 2015)

***Naltrexone – Opioids and Alcohol

Brand Names: Revia, Vivitrol

- Oral medication and injectable
  - 50mg oral pills, 380 mg monthly injectable
- Highly effective opioid antagonist – blocks receptors (no high)
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- No narcotic effects – when someone stops taking this there are no withdrawal symptoms
- 50 mg blocks opioids for 24 hours
- Side Effects: nausea, vomiting, anxiety, nervousness, insomnia, headache, joint or muscle pain, and fatigue

(Center for Substance Abuse Treatment, 2005)

Stimulant Addiction

- Combination of naltrexone and buprenorphine is being used to treat cocaine addiction for some.
  - reducing overall drug cravings and managing withdrawal symptoms

(SAMHSA, 2015)

Increasing MAT in Drug Courts

- Examine reasons that MAT is not being used (e.g., lack of knowledge, long-standing community beliefs about MAT, bureaucratic issues, potential cost)
- Learn more about the actions and benefits of MAT from the Center for Substance Abuse Treatment, state ASAM chapters, state Opioid Treatment Authorities, and the American Association for the Treatment of Opioid Dependence (see)
- Identify local providers of MAT
- Contact local OTP directors and discuss the effectiveness of MAT

Increasing MAT in Drug Courts

- Develop relationships providers/facilities that offer integrated substance use disorders and mental health treatment
- Consult regularly with treatment professionals; use their expertise to set the best course for each drug court participant
- Identify local physicians who can prescribe buprenorphine and extended-release injectable naltrexone and who are willing to coordinate such care with drug court staff
- Work with local substance abuse coalitions to educate the community and change attitudes about the treatment of opioid dependence, to increase understanding of MAT and change drug court policies

(SAMHSA, 2014)

Resources

American Association for the Treatment of Opioid Dependence
http://www.aatod.org

American Society of Addiction Medicine

http://www.asam.org

Behavioral Health Treatment Services Locator

http:// ndtreatment.samhsa.gov

Buprenorphine Physician and Treatment Program Locator
http://buprenorphine.samhsa.gov/bwns_locator

Medication-Assisted Treatment for Substance Use Disorders
http://www.dpt.samhsa.gov

National Alliance for Medication Assisted Recovery

http://www.methadone.org

National Alliance of Advocates for Buprenorphine Treatment
http://www.naabt.org

National Commission on Correctional Health Care

http://www.ncchc.org

National Drug Court Institute

http://www.ndci.org

Opioid Treatment Program Directory

http://dpt2.samhsa.gov/treatment

State Opioid Treatment Authorities

http://dpt2.samhsa.gov/regulations/smalist.aspx

(SAMHSA, 2014)

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Roanoke Drug Court graduates 23rd class

By Sara Machi |
Posted: Tue 11:25 PM, Aug 08, 2017
Updated: Tue 11:27 PM, Aug 08, 2017

ROANOKE, Va. (WDBJ) The 23rd class of Roanoke Drug Court graduated today at a ceremony in Hotel Roanoke.

One of the fourteen participant's, Stormy Barbour, says it's been a lot of hard work since she started in December 2014, but it's worth it for her 13-month-old son Connor.

"It's not at all easy. It's very hard, and you've got to be 100% dedicated to it or it doesn't work," stated Barbour.

Salem Commonwealth's Attorney, Tom Bowers stated, "As a CA you see a losses. You see death. You see overdoses. And to come today and see 14 people who have a new chance at life, it's very exciting"

Roanoke had the first drug court in the state, and they hope to graduate another class in December.