

**Virginia DUI/Specialty Docket Training  
A Call to Action  
August 5-6, 2019  
Hotel Roanoke and Conference Center**

**AGENDA**

**Monday, August 5, 2019**

- |                                |  |
|--------------------------------|--|
| <b>7:30 a.m. – 8:30 a.m.</b>   | <b>Continental Breakfast/Registration</b>  |
| <b>8:30 a.m. – 8:45 a.m.</b>   | <b>Roanoke Welcome</b>   |
| <b>8:45 a.m. – 9:00 a.m.</b>   | <b>Welcome and Remarks</b><br>Hon. Jack “Chip” Hurley, Judge, Tazewell Circuit Court,<br>Vice Chair Virginia Drug Treatment Court Advisory Committee |
| <b>9:00 a.m. – 10:15 a.m.</b>  | <b>Addiction: It’s All in Your Brain</b><br>Victor DeNoble, Ph.D.  |
| <b>10:15 a.m. – 10:30 a.m.</b> | <b>Break</b>   |
| <b>10:30 a.m. – 12:00 p.m.</b> | <b>Boundaries</b><br>Helen Harberts, Retired Criminal Justice Professional   |
| <b>12:00 a.m. – 12:45p.m.</b>  | <b>Lunch</b>   |
| <b>12:45 p.m. – 2:15 p.m.</b>  | <b>Engaging Adolescents with Recoveropoly</b><br>Shannon Garrett, LGSW, LCADC  |
| <b>2:15 p.m. – 2:30 p.m.</b>   | <b>Break</b>   |
| <b>2:30 p.m. – 4:00 p.m.</b>   | <b>Legal Updates</b><br>Helen Harberts, Retired Criminal Justice Professional  |
| <b>5:00 p.m.</b>               | <b>Adjourn</b>   |

Where Treatment and Accountability Meet Justice



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**Tuesday, August 6, 2019**

- 7:30 a.m. – 8:30 a.m.**      **Judges Breakfast – Anatomy of the Opioid Epidemic:**  
By A. Omar Abubaker, DMD, PhD
- 7:30 a.m. – 8:30 a.m.**      **Continental Breakfast/Registration**
- 8:30 a.m. – 10:00 a.m.**    **Myths and Facts of Opioid Epidemic, Keynote Speaker**  
A. Omar Abubaker, DMD, PhD
- 10:00 a.m. – 11:00 a.m.**    **How to Help Families of Addicted Young People**  
Paul Hardy, PhD
- 11:00 a.m. – 11:15 a.m.**    **Break**
- 11:15 a.m. – 12:15 p.m.**    **Military Cultural Competency**  
Leanna Craig, West Regional Director, DVS
- 12:15 p.m. – 1:00 p.m.**      **Lunch**
- 1:00 p.m. – 2:15 p.m.**      **From The Green Cloud: continuing the marijuana debate**  
Paul Hardy, PhD
- 2:15 p.m. – 2:30 p.m.**      **Break**
- 2:30 p.m. – 2:45 p.m.**      **Veteran’s Strategic Plan**  
Monica Christofferson, Senior Program Manager, Technical Assistance
- 2:45 p.m. – 3:15 p.m.**      **Drug Court and Behavioral Health Docket Graduate**  
Bentley and Rex
- 3:15 p.m. – 3:30 p.m.**      **Closing Remarks**

Where Treatment and Accountability Meet Justice



WHAT IS THE  
BIOCHEMICAL BASIS OF  
ADDICTION?

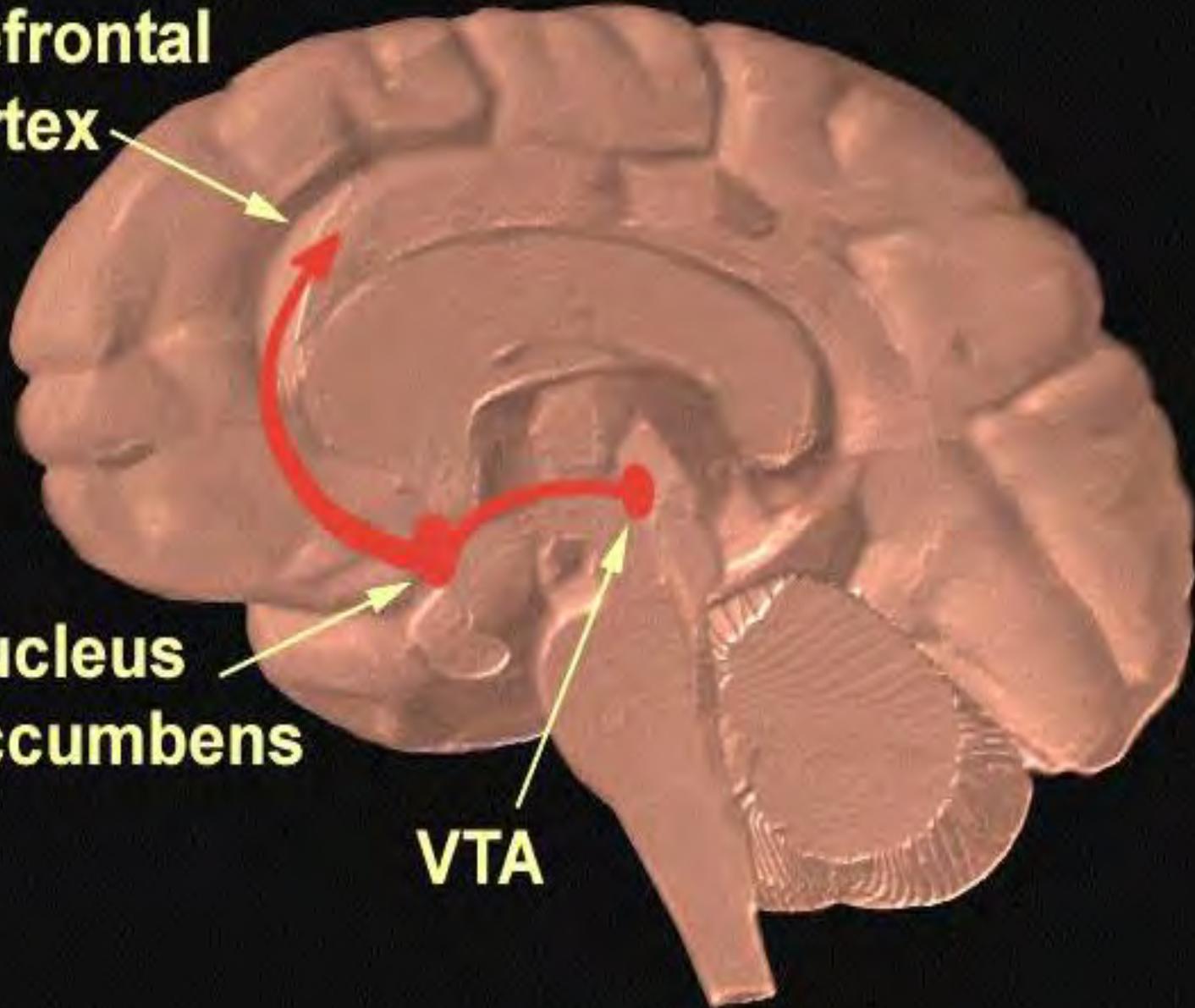


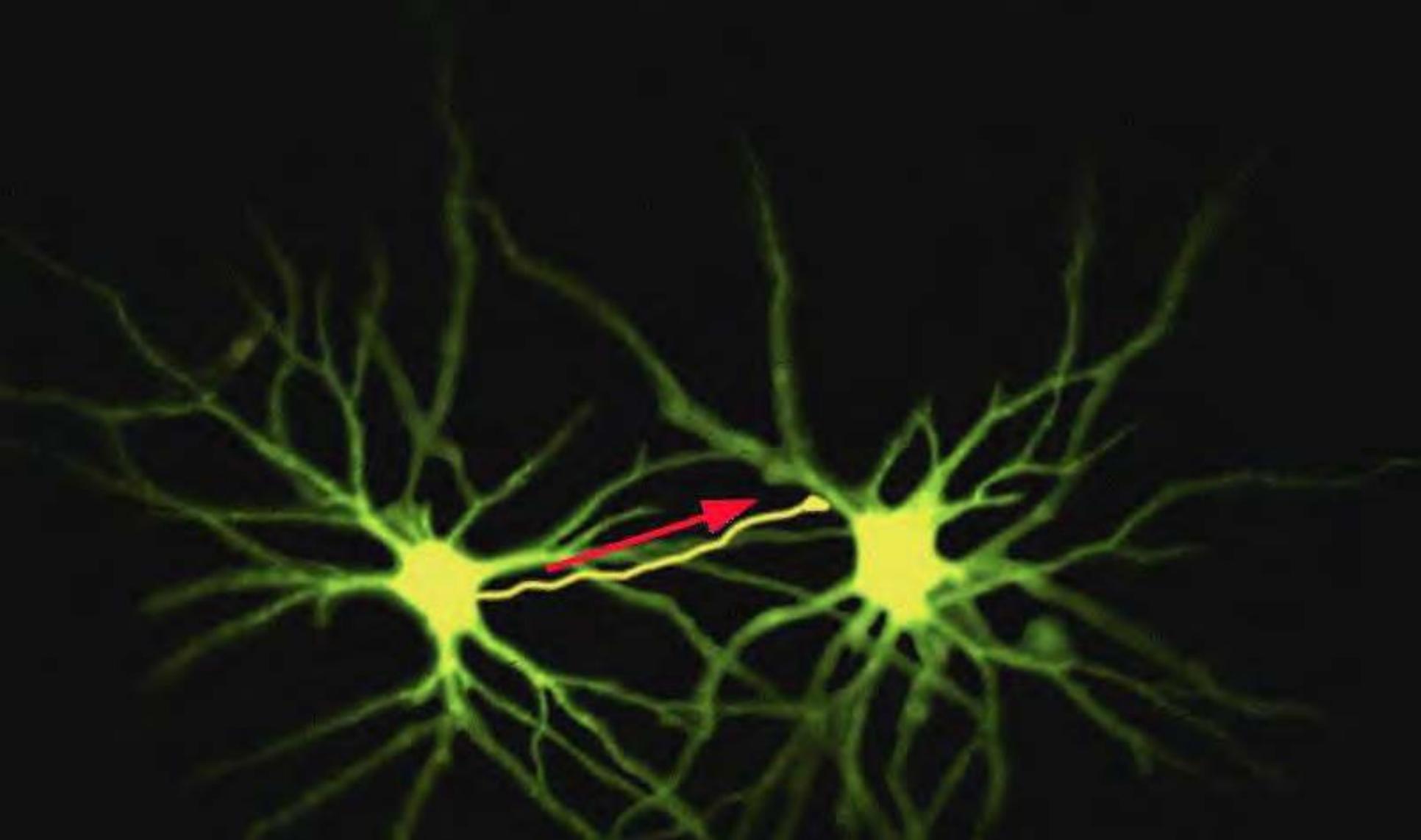
# The Reward Pathway

prefrontal  
cortex

nucleus  
accumbens

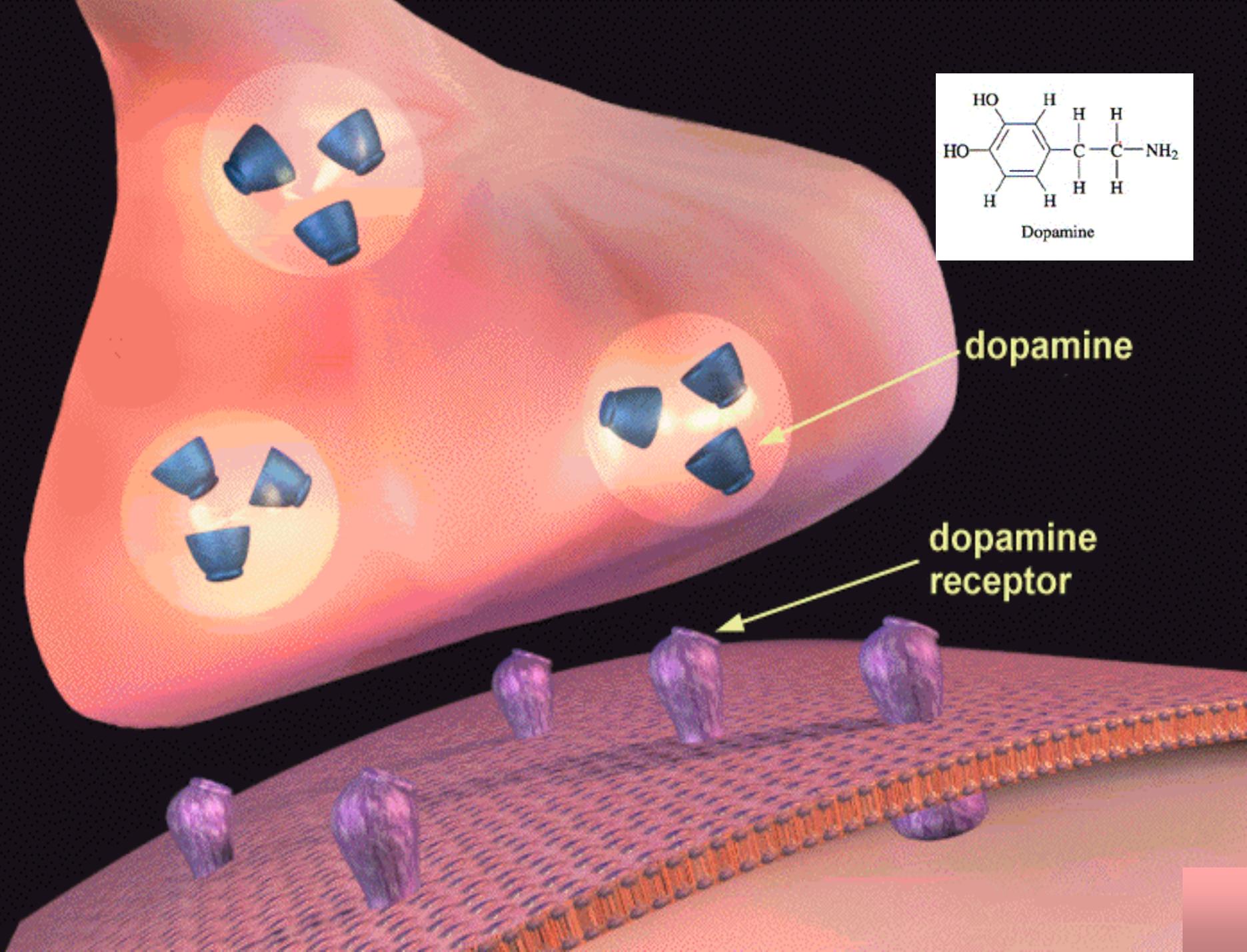
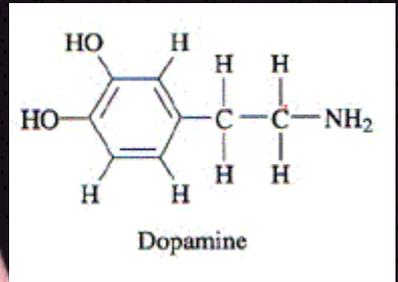
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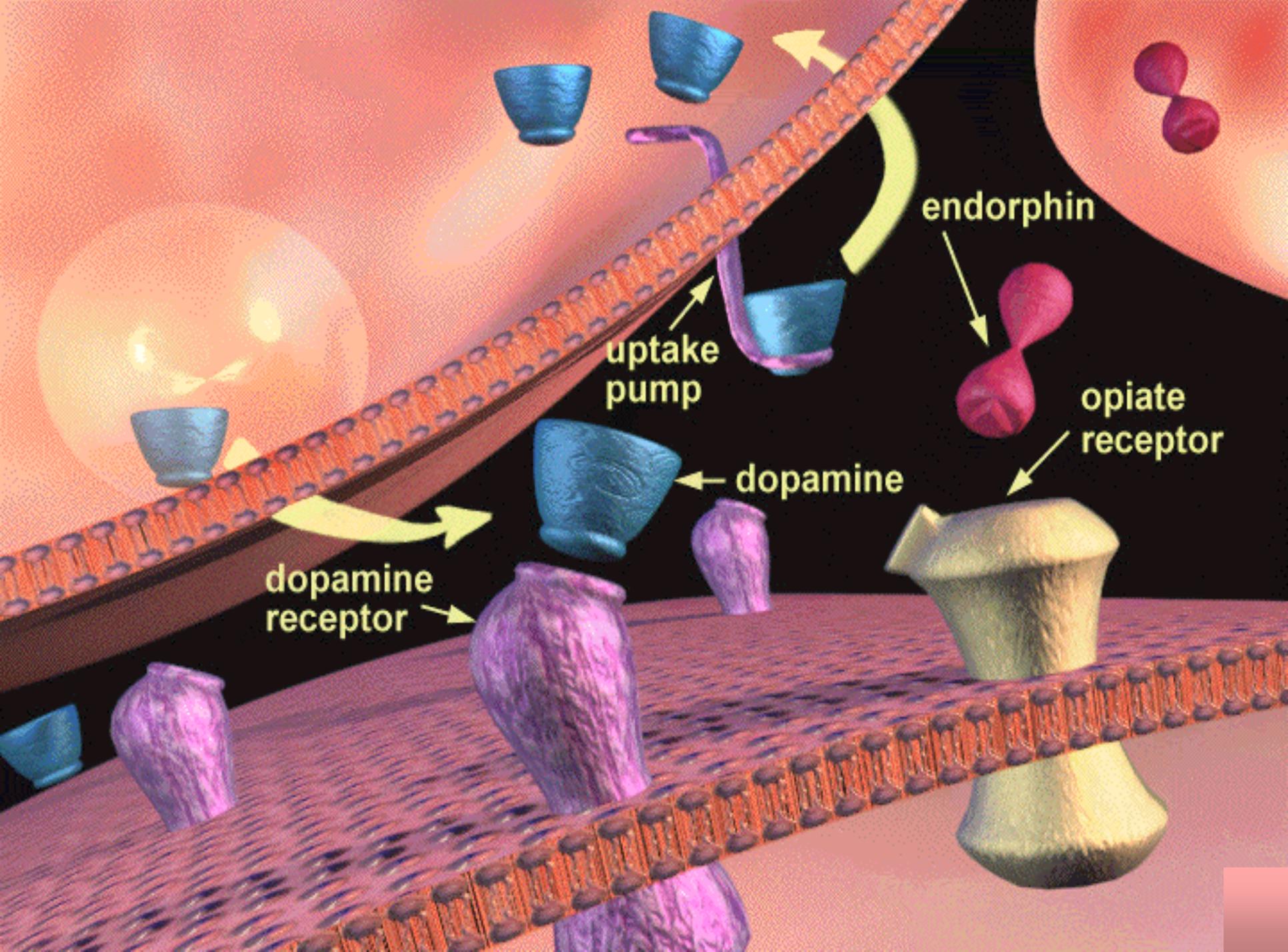


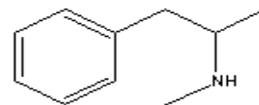


impulse flow



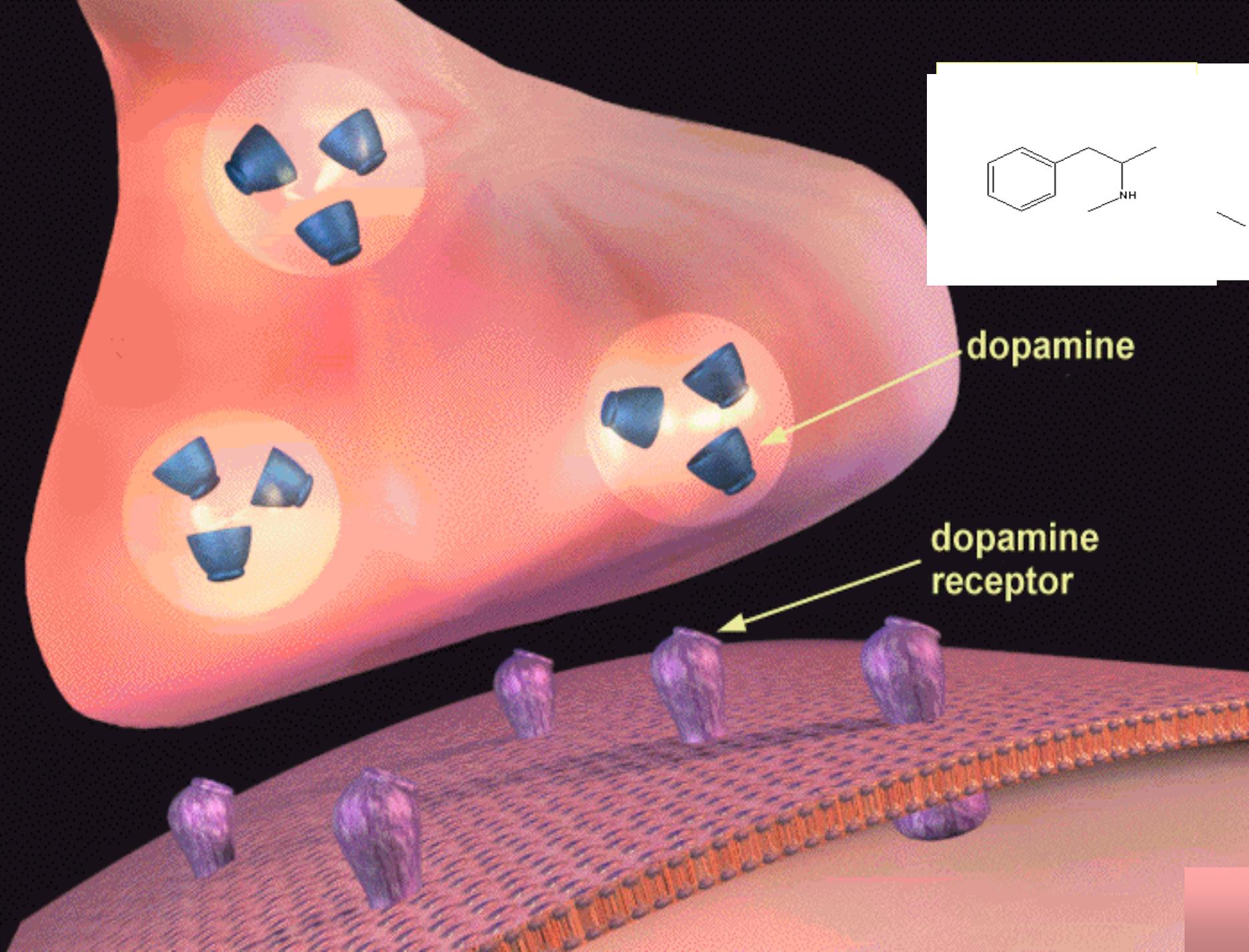




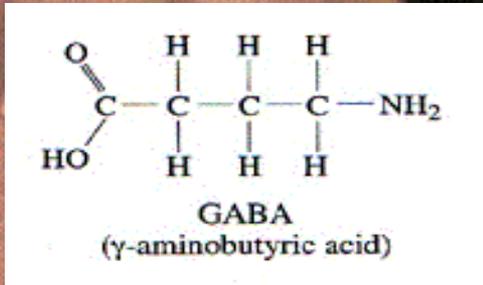
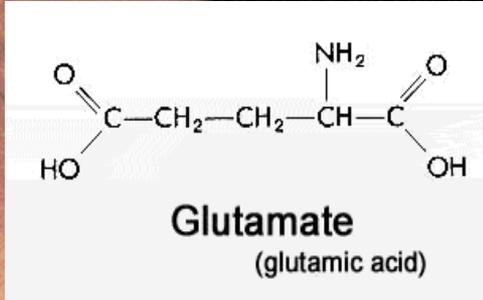
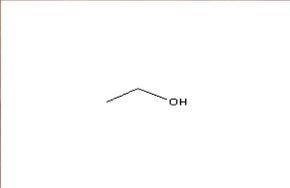
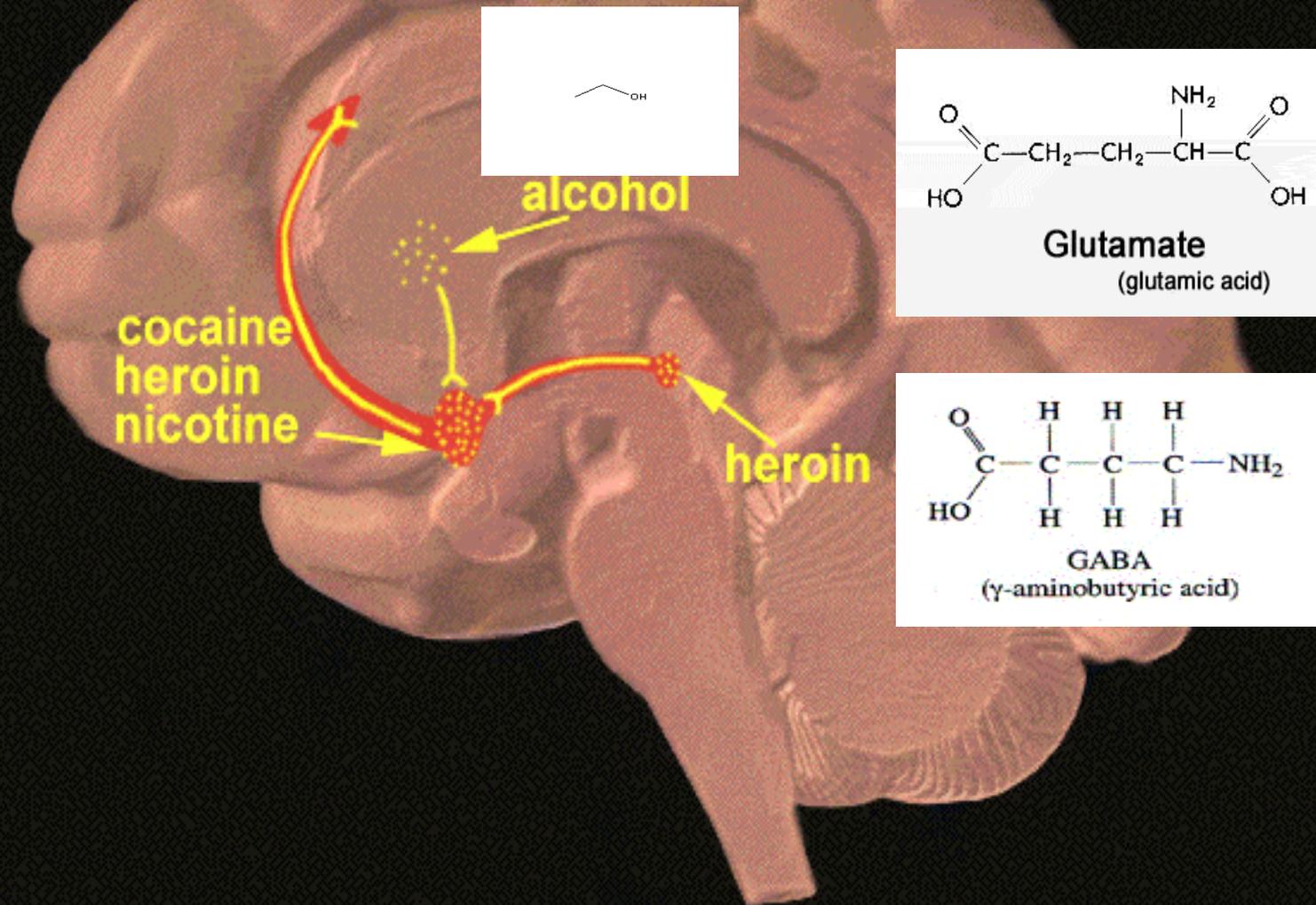


dopamine

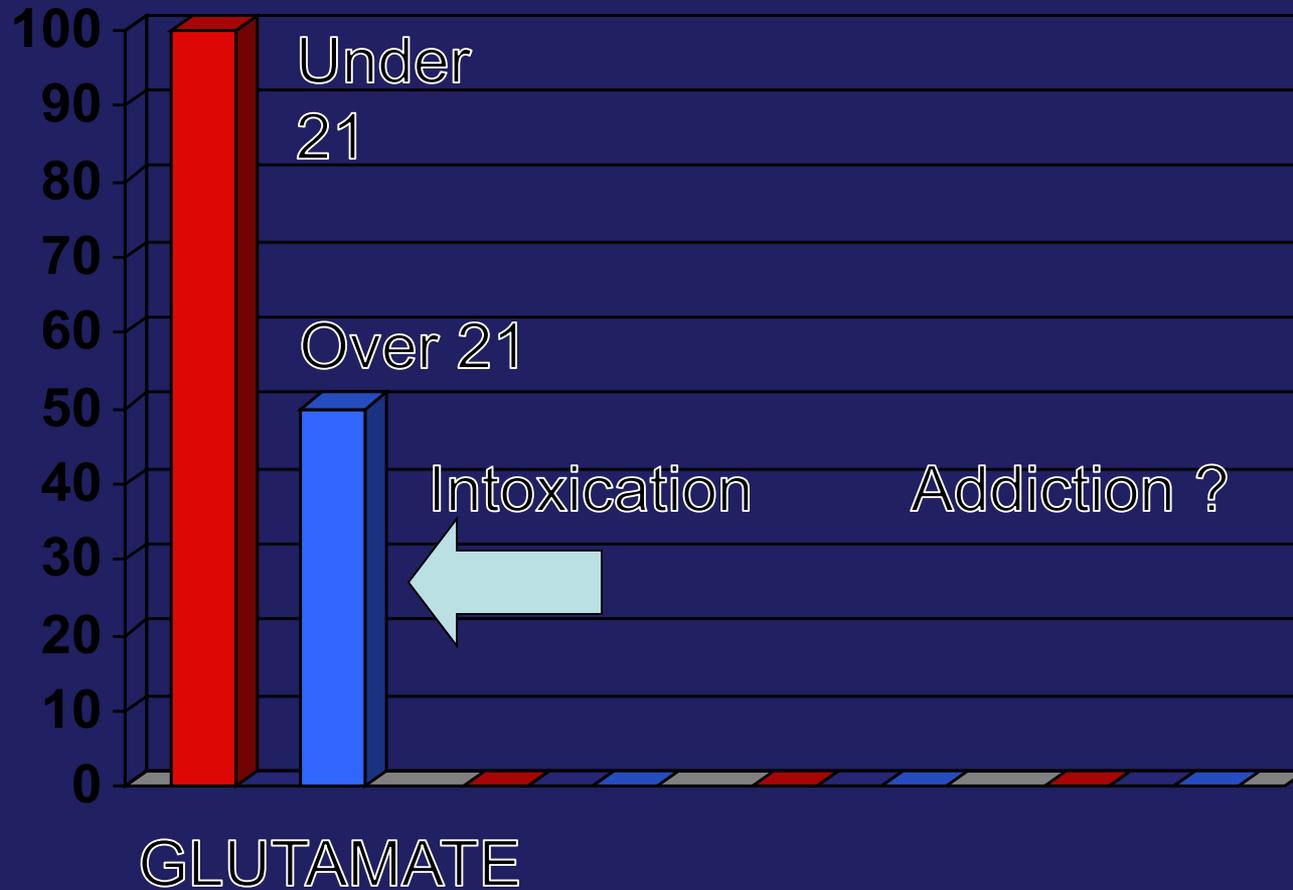
dopamine  
receptor



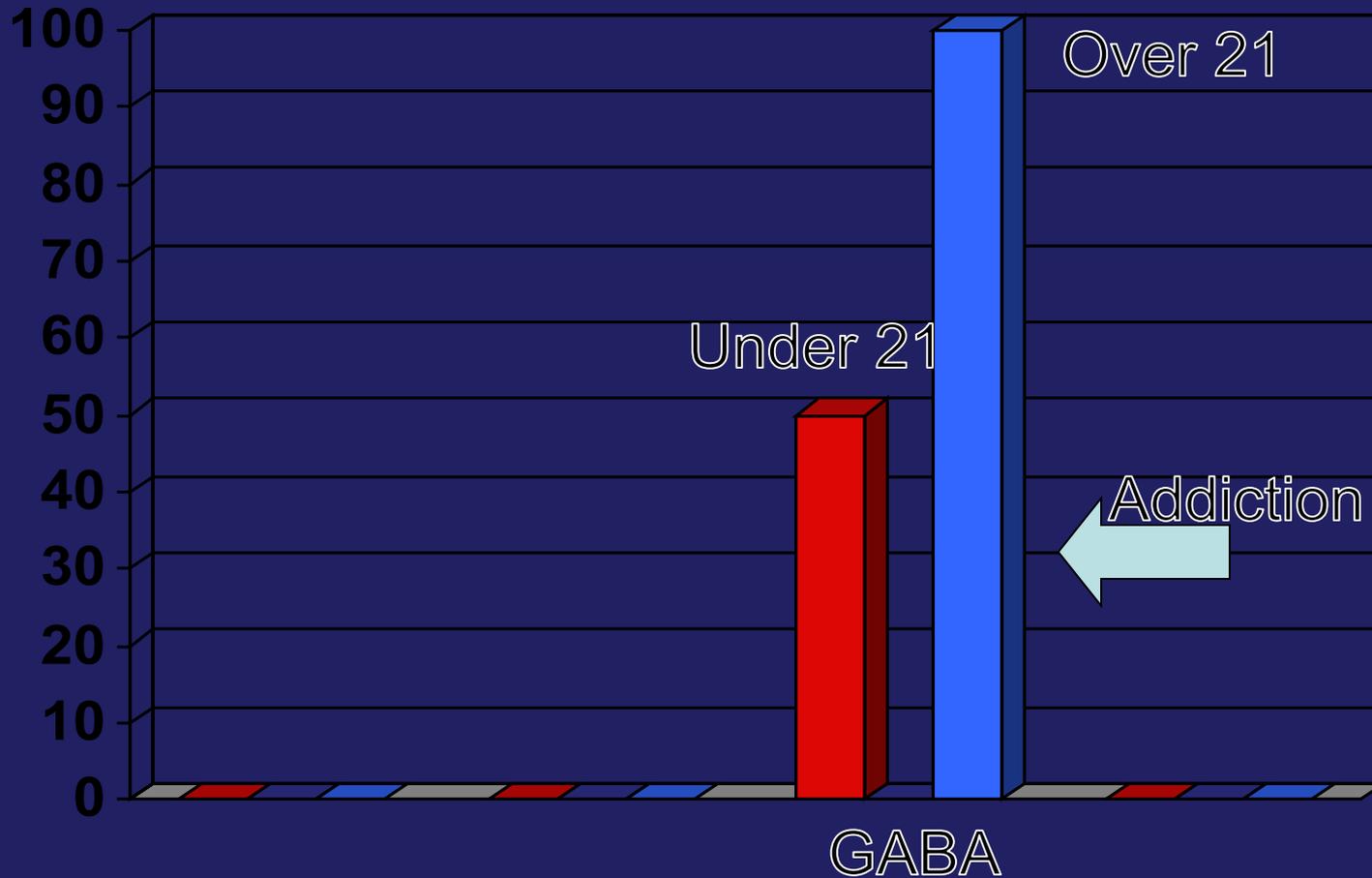
# Activation of the reward pathway by addictive drugs



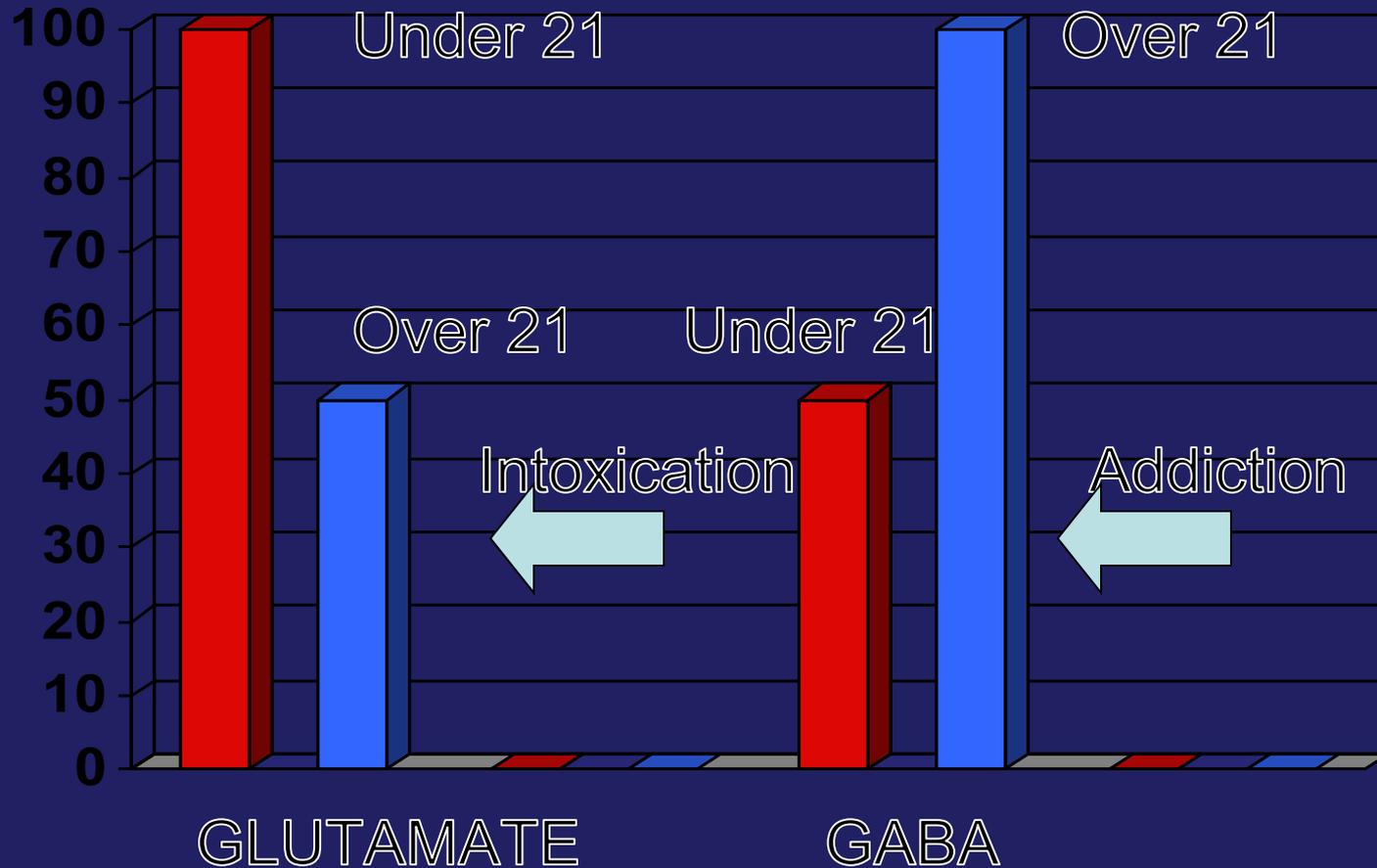
# Biological Basis of Alcohol Addiction



# Biological Basis of Alcohol Addiction



# Biological Basis of Alcohol Addiction





THANK YOU  
Any questions?

# Treatment Court Teams



**Work as a team   Mind your boundaries   Keep your ethics**

Helen Harberts JD   Chico CA  
helenharberts@gmail.com

# Objectives

- Highlight the importance and benefit of working cooperatively with drug court partners
- Identify strategies for developing team relationships
- Learn the pitfalls of boundary problems
- Ethics are NEVER changed.

# Examples:

- As a prosecutor, I cannot:
  - Allow a defendant to suffer a due process violation.
  - Reveal the existence of a search warrant
  - Allow a Brady violation
- As a defense attorney, I cannot:
  - Allow a perpetration of a fraud upon the Court
  - Reveal information subject to privilege.

- As a Judge, I cannot:
  - Defer decisions to the team
  - Conduct ex parte conversations or Court
  - Discuss individual legal matters before me.
  - Ignore the law or Constitution.
- As a treatment provider, I cannot:
  - Reveal information subject to confidentiality laws that are not necessary
  - Ignore safety of others

- As a probation officer, I cannot:
  - Reveal LE activity coming up
  - Ignore public safety mandates incumbent on my profession.
  - Yield my authority to violate probation
- As law enforcement, I cannot:
  - Reveal confidential LE activity.
  - Reveal what I learn in Treatment Court to others.

This isn't that easy, is it?

# Maintaining Boundaries

*Drug Court Professionals  
and Ethics*

## *Is there a problem with...*

- Loaning a current participant money ??
- co-signing a loan on a car for a client?
- Co-signing a mortgage with a client?
- Sleeping with people under your care?
- Having them live with you?
- Hire them to baby sit for you?

# *Professional confusion...*

- Treatment professionals trying to be probation officers
- Probation officers trying to be treatment, when they are not licensed?
- A bench officer who acts as the DA?
- A bench officer who acts as the defense?

*Or a confidentiality AND judgment problem?*

- How about a district attorney who discounts treatment advice because his wife is a nurse and tells him different?

- Agreeing to be a probation officer for clients when probation team members will not serve them.

(District attorney)

- Defense counsel acting as a probation officer-but lacks the authority of the Court.

How about:

- Abuse of power?
- Criminal conduct?

# Gross abuse of power by LE

- <http://www.wsmv.com/story/34654368/woman-admits-relationship-with-deputy-while-inmate> sheriff deputy and drug court participant
- <http://www.wftv.com/news/local/2-volusia-county-deputies-off-job-over-drug-court-sex-scandal/625727529> sheriff deputies and drug court participant

# Two victims

- Appellant befriended drug court participant, J.M. On February 7, 2006, Appellant repeatedly telephoned J.M. and requested that she travel from Custer County to his hotel room in Oklahoma City. J.M. acquiesced when Appellant demanded that she meet him or he would vote for her termination from drug court. When she arrived at the hotel, Appellant provided J.M. with alcohol, engaged in sexual intercourse with her, and performed oral sodomy on her person. Thereafter, Appellant engaged in sexual intercourse with J.M. at her home, at the home of a friend of the Appellant's, at a motel, and at Appellant's home while his wife was on vacation. At Appellant's home, Appellant gave J.M. alcohol, engaged in several instances of intercourse, and performed oral sodomy upon J.M. Appellant and J.M. travelled to Oklahoma City for Drug Court Day at the State Capitol. Appellant repeatedly demanded and engaged in instances of sexual intercourse with J.M. in his hotel room.

- ¶16 During this timeframe, Appellant intervened in J.M.'s urinalysis testing at the Custer County Jail. Appellant instructed his employees to permit J.M. to test in the courthouse bathroom which was nicer than the jail restroom. On at least two separate occasions, Appellant intervened and stopped the jail employees from reporting J.M. for a positive test, took J.M. for a mouth swab test, and had the jail employees discard the positive urinalysis test.
- ¶17 On January 3, 2007, Appellant assisted the drug court compliance officer with an investigation into drug court participant, B.B. Appellant discovered that B.B. was in violation of the Drug Court's rules. He contacted the Drug Court Judge and pursuant to her order took B.B. into custody. The compliance officer assisted and investigated other drug court participants while Appellant drove B.B. to the jail. Through repeated comments on her future, Appellant painted the grim picture of jail, termination from Drug Court, and imprisonment for B.B. Appellant told B.B. that he could save her from prison and make her stay in the jail more comfortable. He pulled off the road near two barns and told B.B. that he would help her if she would help him. Appellant directed B.B. to perform oral sodomy on his person and engaged in sexual intercourse with B.B. The records within the sheriff's department reflected that it took Appellant approximately 44 minutes to transport B.B. the 5 mile distance from her home to the jail.

- ¶8 In May, 2007, J.M. informed Appellant that she could not do it anymore. Appellant informed her: "Well, you know what that means." (Tr. V, 1210, 1453-54). Subsequently, J.M. tested positive on her urinalysis test at the Custer County Jail. She tried to get Appellant to intervene both before and after the test, however, he ignored her requests. J.M. was placed in the Custer County Jail and sanctioned to one year inpatient treatment by the Drug Court. As she left the courtroom, she screamed: "I've effed [sic] the sheriff all this time, you can't do this to me." (Tr. V, 1211, 1490-92).
- ¶9 J.M.'s cousin, C.T., contacted Appellant and informed him that J.M. had DNA evidence proving their sexual relationship. Appellant offered to help C.T.'s brother get out of prison if she would obtain the evidence from J.M. and bring it to him.
- <https://law.justia.com/cases/oklahoma/court-of-appeals-criminal/2010/461458.html>

# JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Friday, December 14, 2012

Former Lincoln County, Missouri, Sheriff's Office Detective  
Sentenced on Sexual Abuse Charges-"Tracker"

2018 UPDATE: multi million dollar judgment, interesting turn on  
who was the responsible party: court, or Sheriff? Respondeat  
Superior?

- MORRISTOWN - A Drug Court participant who admittedly was tipped off to surprise drug screenings and given drug testing kits by a Sussex County Sheriff's officer in exchange for having a sexual relationship with him was given a second chance Wednesday to stay in the program and avoid a prison sentence.

# Drug testing labs....

- Two Arrested for Falsifying Drug Tests in Exchange for Sexual Favors (2017-Texas)

# Judges

- **Former Judge Casey Moreland arrested by FBI on obstruction of justice charges**
- **Ex-judge Casey Moreland accused of taking money from drug court program he started 3/1/18**

## *Ex parte conversations?*

- Between participants and judges?
- Between the DA and participants?

# Codependent Courtrooms???

- Teams or judges who manipulate the system to benefit select clients for personal reasons.
- Teams or judges who “feed “ illness rather than address it.

*Some folks in recovery want to be treatment professionals without training! Ditto lawyers. Ditto probation.*

- "Just because you've had your appendix out doesn't qualify you to take out mine."

"Ethics for Addiction Professionals". Second edition, 1994. LeClair Bissell, M.D., C.A.C.; James E. Royce, S.J., Ph.D.

# Dual relationships

- Drug Court clients present significant challenges to the issue of professional and ethical boundaries.

# Why?

- They are with us longer
- We have a comprehensive look at their entire life
- Part of motivating change is developing a more intense relationship
- We admire their courage and work

# Thus...

- Mind your boundaries and your ethics.
- You may do harm, and you may lose your license, job, or your freedom.
- Team does not mean your ethics change. Period.

*In a drug court model, rather than abandoning their roles, the involved disciplines expand them. The disciplines collaborate on a single mission to create a more effective and efficient system*

# Drug Court Roles (Team concept)

- Judge- delegates some authority to the team. Monitors participant progress. Motivates and engages participants in Court.
- Prosecutor- expands advocacy to include treatment. Recognizes the team. Protects due process & public safety.
- Defense- advocates for successful participation. Participates in and contributes to team efforts to hold participant accountable. Protects client. Raises due process as needed.

- Probation
  - provides monitoring, supervision and case management services
  - provides case related information to all members of the team for purposes other than a revocation
  - in the case management role becomes the bridge to all other team members
- Treatment-both SA and MH
  - Equal place at the table
  - Critical information for team
  - MAT

# Best Practices

- Include law enforcement on the team
- **Train and cross train constantly**
- Follow the research, and follow the Adult Best Practices Volume 1 & 2, as well as the 10 Key Components.
- Read and follow the Judicial Benchbook.

# Respect Boundaries

- You are a member of your profession, not another.
- Mind your ethics and stay out of theirs.
- Respect each other-LISTEN
- It is the strength of the team and the blending of professions that works.

# Each team member operates in three distinct spheres

- Court
  - Staffing
  - Case management, problem solving, and client relations.
- 
- Each function has a separate set of skills
  - Each function still works within the Key Components.

Gotta love Lawyers!

# In the Courtroom

- Protect the record
  - Remember the appeals courts!
- Protect due process
  - This is a COURT, not a program
- Enhance the relationship between the Court and the participant
- Remember the rule of minimization.
- NO FIGHTING !
- The Courtroom is a classroom: every word matters.

# Pre-Court Staffing

- Preparing the execution of the calendar
- FOCUS ON BEHAVIOR MODIFICATION AND THERAPEUTIC RESPONSES.
- This is where you report how you have addressed/solved legal issues.
- “can you live with this for two weeks?”
- Here is where the last minute adjustments happen
- Here is where the last minute details change everything.

# Prep for the Staffing!

## Reports matter.

- Work together to address legal issues up front
- Unless there is a serious legal issue of
  - Constitutional due process dimensions
  - Program integrity
  - Public safety

Counsel's job is to make the law meet the needs of the treatment team.

# Be prepared

- You don't have time to waste
- Settle legal matters before staffing.
- Determine facts up front
- Work out responses consistent with research. All 3 (4) responses should be worked out before Court.
- What are the these responses?

# Understand the other roles

- Lawyers are there for legal reasons. Protect the record. Protect the Constitution. Motivate positively.
- DA's are there to assert public safety concerns (with probation, Court and LE)
- The people who are doing direct services are the ones who know what is going on. **Their recommendations are paramount.**

- Unless public safety or due process is compromised, follow their lead.
- If you can live with the consensus, do so.
- Fighting does not occur in open court.
- Making a record must happen but should happen in a manner consistent with the Court design.
- The worst possible thing? The team is wrong and in two weeks, you can fix it.

A personal story:

“ Because you can argue better  
does not make you right”

# The Bench

- Cannot delegate decisions
- Should be the predominant voice in the room in Court.
- Should spend three minutes with each person...good or bad.
- Should focus on teachable moments.
- Clear patient focus and engagement.
- Should engage and instill hope.

# Supervision

- Is responsible for knowing what is happening outside the court and treatment arenas.
- Home visits are paramount.
- Assessments, and sequential case management based on the assessments.
- Testing results, and working with treatment.
- Delivering MRT.
- Intensive case management, sequenced correctly.
- Constant communication with treatment.

# Treatment

- Must assess, and should provide the team with a diagnosis. And, update.
- Should assess at regular intervals at least every 120 days to measure progress.
- Should provide clinical services in the beginning to assess ability to manage group.
- Should conduct group using manualized treatment with fidelity to the model.
- Should provide information regarding what the participant is working on, and how they are doing.
- Must follow confidentiality standards, but provide sufficient information to help with the message.

# Defense Counsel

- Technically probably the hardest job on the team.
- Must negotiate difficult ethical issues
- Has a duty to the client that is different than all others.
- When the defense is silent, you know you need to pay attention.

# Each profession MUST

- Stay within their ethical mandates.
- There are things that each profession cannot do, team or not.
- Learn that, respect that.
- Help each other out and honor boundaries.

**Protect your clients, protect your court, protect yourself and your profession.**

# MAT: MIND YOUR BOUNDARIES!

- **ARE YOU A MEDICAL DOCTOR?**
- If not, don't make medical decisions regarding medically assisted treatment.
  - It is a CRIME to practice medicine without a license.
  - It will subject you to personal liability.
  - It is professional misconduct
  - It is harmful.

# The magic

Is the team following the research, working together and keeping our eye on the ball.

**The ball= the success of our clients.**

# Ethics in Drug Court:

## *Thorny issues*

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

# Ex parte Communication

- Ex parte communication must be specifically waived or asserted (Model Code Judicial Conduct, Canon 3B(7))
  - Who is present at staffing?
  - Is it ok to attend team meetings w/out client?
  - How many levels of hearsay in staffing?
  - Are 42 CFR waivers executed for everyone present?
- 
- Brown v. State, MD Ct of Appeal 5-18-09

# *Ex parte* staffing

- Permissible to have *ex parte* communications at staffing with appropriate waivers and outside of drug court
- Best practice to inform defense counsel of content and nature of communications
- NY has specific administrative orders permitting such communication

# ABA Rule 2.9(5)

- No ex parte communications except:

(5) A judge may initiate, permit, or consider any ex parte communication when expressly authorized by law to do so.

# ABA Rule 2.9

- Comment [4]

A judge may initiate, permit, or consider ex parte communications ...when serving on therapeutic or problem-solving courts, mental health courts, or drug courts. In this capacity, judges may assume a more interactive role with parties, treatment providers, probation officers, social workers, and others.

# State judicial ethics amendments

- Idaho, Maryland, Montana, Minnesota, New York, Indiana and Arkansas
- Amended their Codes to specifically address and permit *ex parte* communications in problem-solving courts including staffings
- Perhaps a better approach would be amending the Rules of Prof. Resp. for counsel requiring them to be present at staffing and progress reports
- **JUDICIAL ETHICS CHANGES DO NOT CHANGE COUNSEL ETHICAL MANDATES!**

# Out-of-court contact with participants



DTC picnic



Bowling night

# The Judge and Drug Court Participants

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

**Don't do anything more than a  
cameo appearance!**

# Judicial discipline

- *Matter of Blackman*, 591A.2d1339 (N.J. 1991)  
“[J]udges 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)  
Canon 1 and Canon 2 violation to meet individually with probationers.

# Defense counsel



# Defense's duty

- “Duty of representation” of client
- *C.f.*, reasonable diligence and competence in ABA Model Rule 1.3; “devotion and courage” in advocacy in ABA (“Defense Function Guidelines”)
- To competently represent client in DTC must familiarize self with tx, procedures, bases for sanctions or termination, etc. (ABA Model Rule 1.1)

What is the difference between confidentiality laws, evidentiary privileges and ethical duties?

- **Confidentiality laws** are statutes and regulations that prohibit specified disclosures (usually subject to specified exceptions). Improper disclosures of information covered by confidentiality laws can lead to criminal prosecutions and civil lawsuits.
- Unlike confidentiality laws, **evidentiary privileges** generally do not constrain those who choose to disclose information. Instead, privileges protect against compelled disclosure.
- Like confidentiality laws, **ethical duties** prohibit the disclosure of information. Ethical duties, which are ordinarily embodied in professional canon, apply to communications between professionals and those they serve.

# 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.

# Best Practices

- Ensure that DA and Defense Counsel attend staffing and review hearings
- Advocate change in Canons
- Judges: avoid public activities (non-judicial) with participants, except for cameo appearance
- Respect ethical obligations of defense counsel

# Reality Check for Lawyers

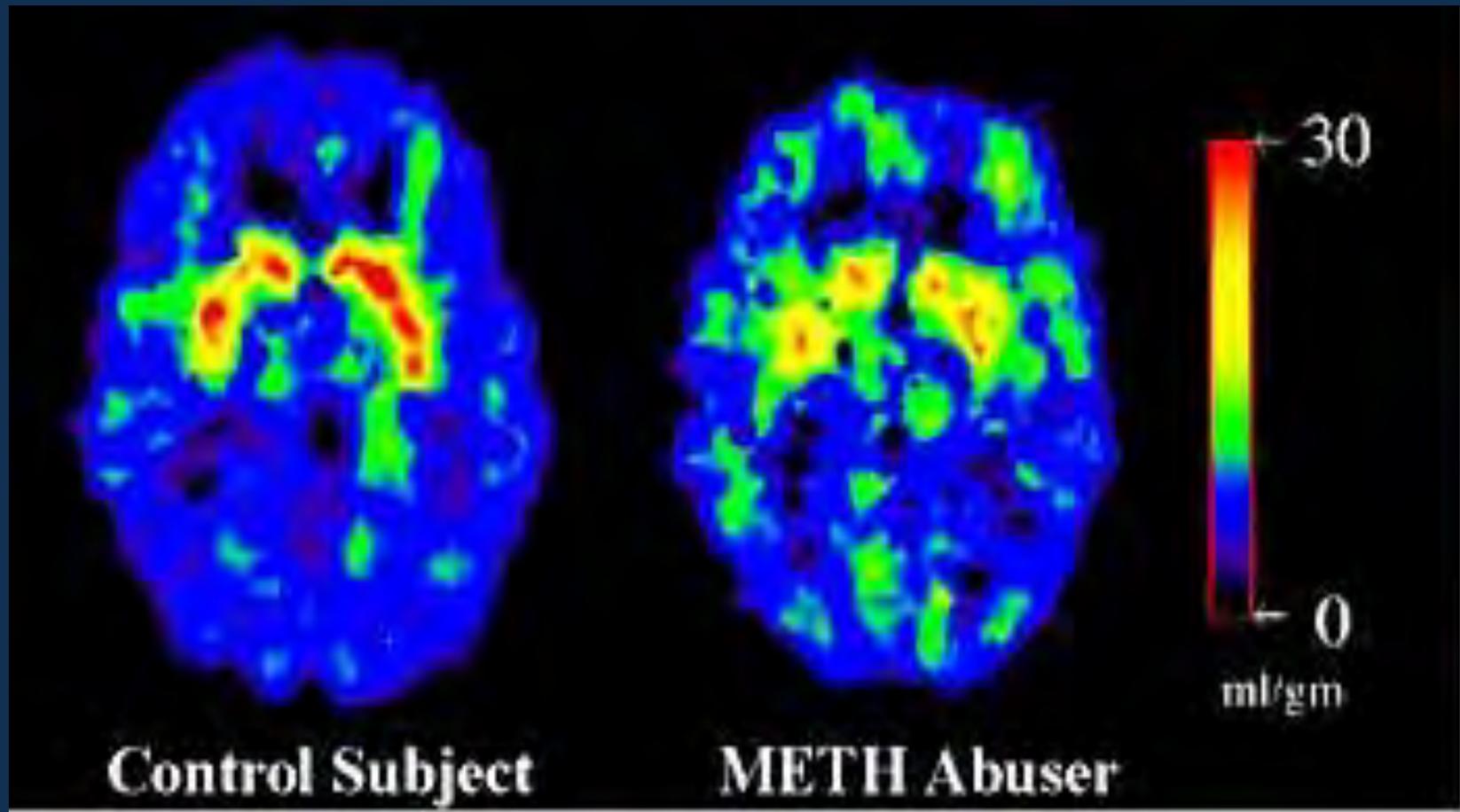
- Counsel can be a great boon to drug courts
- Counsel can be a great impediment
- Our role is NOT limited to the strict application of due process. Our role is to protect the Constitution and maximize outcomes.
- A Pyrrhic Victory is no victory.
- Applying this model to lightweights is no benefit to the public.

# Attorney roles:

1. Protect the Constitution
  2. Maximize outcomes
- Facilitate the treatment team and the plan when it meets #1 and #2
  - Only counsel can find the legal way to get treatment and probation's goals implemented.

Understanding addiction and the psychopharmacology of drugs. Addiction is truly a disease of the brain.

It is treatable.



# Best Practices

- Ensure that DA and Defense Counsel attend staffings and review hearings
- Judges: avoid public activities (non-judicial) with participants, except for cameo appearance
- Respect ethical obligations of defense counsel
- Use evidence based, validated interventions with participants, with fidelity to the model.
  - Screen and treat multiple disorders
  - Address SA, MH, Trauma and Criminal thinking before they leave you.
- Assessment driven decision-making. ONLY. No “gut”.

# Bottom line:

- Ethics never change. Your ethics outside a treatment court are the same within the treatment court. Because you work with a team, does not change your professional ethics.
- It is the existence of a cross trained team that makes the difference in treatment courts, all communicating and working together, doing our own jobs that makes the difference.

Who wins when the team is not  
focused or fights?

The disease

# Practicing Law in Treatment Courts-not so simple anymore

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# Recusal issues

The law is moving!

# The debate

- Drug Court Judge knows too much.
- Drug Court Judge knows what is important for sentencing.
- Referral Judge may reduce sentence creating “escape route” and undercut treatment court
- Referral Judge may not distinguish between persons referred.
- Traditional recusal issues
- Defense request for recusal.

# First cases favored recusal

## FIRST CASES FAVORED

- Alexander v. State, 48 P.3d 110, 115 (Okla. Crim. App. 2002)
- Edgar v. K.L., 93 F.3d 256, 259 (7th Cir. 1996) (extra judicial facts)

## TREND

- IN RE DISQUALIFICATION OF BLANCHARD, 2017 Ohio 5543 (Ohio Supreme Court 2017)
- State v. Horne, (Tenn. Court of Criminal Appeals 2017)
- State v. Barraza, P.3d (NM Court of Appeals 2017)
- State v. Watson, No. M2015-00108-CCA-R3-CD., (Tenn: Court of Criminal Appeals 2016)
- State v. McGill, No. M2015-01929-CCA-R3-CD. (Tenn: Court of Criminal Appeals 7/18/2016)
- Plus many more.....

# The basic rules remain the same

- Judges know how to recuse when they have a personal interest or “feeling”.
- If the defendant requests another Judge, get them one. No big deal.

Due Process, equal protection,  
constitutional issues.

So many issues!

BASIC Con. Law stuff

# First Amendment:

- **Religion**

*Ex: **NO** mandatory AA/NA without alternatives being offered as well.*

- This is settled law.
- It does not matter that this is a voluntary program
- This is settled law. Adapt.
- Civil liability may attach for intentional violation. (Sacramento CA, again 8/13)

# So, what to do?

- The law says you cannot force them if they object. You must provide an alternative as well. There are plenty.
- Change your order! *“You must attend AA, NA or other community based self help program, as approved by your probation officer. “*
- *REALITY*: this is very few people and they get over it quickly. Recognize the law, make the new order, enforce the order.
- *COVER YOUR RECORD.*

# Another First Amendment issue:

- **Area and place restrictions:**

*Ex: Do not enter any establishment where ....*

- Valid if narrowly drawn and related to rehabilitation needs of the offender.
- Must have allowances for compelling needs of probationer such as child visitation.
- Should be reasonable in size and duration.

# First Amendment

- **Freedom of association**

*Ex: Do not associate with any person on probation or parole, or any person who uses drugs, except in the context of treatment*

- Valid if narrowly drawn and related to rehabilitation needs of the offender.

# Fourth Amendment

“You are subject to a search of your person, place of residence, vehicle, or any item under your dominion and control any time, day or night, with or without probable cause, or your then and there presence, by any peace or probation officer.”

“You are subject to testing for the presence of banned items and controlled substances for the duration of your participation in the program.”

Get a waiver of electronics and password disclosures.

# Search depends on model

- Post conviction: 4<sup>th</sup> Amendment waivers are valid under Federal law-reduced expectation of privacy Sampson (2006).
- Pre conviction and non-conviction cases, must be individualized findings to apply search on a case by case basis (also true on some local state cases post conviction)
- **Make it a program rule.**

# Electronic devices: sample

You provide specific consent within the meaning of P.C. §1546 to any law enforcement agency seeking information provided by the California Electronic Communication Protection Act. This includes consent to seize and examine call logs, texts and voicemail messages, photographs and emails, contained on any device or cloud or internet connected storage owned, operated, or controlled by you, including but not limited to cell phones, computers, computer hard drives, laptops, gaming consoles, mobile devices, tablets, storage media devices, thumb drives, Micro SD cards, external hard drives, or any other electronic storage devices, by whatever law enforcement agency is seeking the information. You shall also disclose any and all passwords, passcodes, password patterns, fingerprints, or other information required to gain access into any of the aforementioned devices.

# Other bans:

- Alcohol- OK: People v. Beal (CA 1997)
- Articulate why “medical” or recreational marijuana cannot be used on record, and place as a term of probation. (interferes with cognition) (Interferes with motivation)(Except: Arizona )
- Recommendation: authorize FDA approved MAT only.
- Articulate why folks cannot consume any item “not for human consumption”, poppy seeds, or other items that will mess up drug testing.

# Due Process Concerns

- Juveniles have the same rights as adults regarding due process, except for jury.

Program violation: probation-full panoply of rights apply. (PC, counsel, notice, appear, cross exam and witnesses, magistrate, findings)

Changes are coming based on your model!

# Watch out! As the target population changes, so may the rules!!

- Is a sanction a potential loss of a *recognized liberty or property right?*
- Does it invoke the same level of due process as a VOP?
- Certainly if you are a post adjudication probation model. Probably if you are not. Best practice: do it. Adds about 45 seconds to the colloquy.

*What process is due* when defendants potentially suffer a loss to a recognized liberty or property right?

***Q: What is happening?***

- Sanction in program?
- Termination from program?
  
- Different rules may apply depending on the model!
  - DEJ
  - POST CONVICTION

# Due Process

- Procedural protections are due under the 5<sup>th</sup> and 14<sup>th</sup> Amendments when the defendant will potentially suffer a loss to a recognized liberty or property right.
- 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).

**THIS IS ALSO AN ETHICS ISSUE!**

# The question is: what process is due?

## Termination vs. Sanctions

- 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.”)

- **Gross v. State of Maine, Superior Court case # CR-11-4805**  
**(2/26/13)**(drug court procedures relating to **termination** violative of due process and, therefore, unconstitutional. Drug Court participant entitled to: notice of the termination allegations and the evidence against him, right to call and x-examine witnesses, a hearing at which he is present, a neutral magistrate, written factual findings and the right to counsel. Here, the drug court team discussed the termination decision during the termination hearing, without defendant's presence or that of his counsel. That procedure coupled by the fact the Superior Court felt that the drug court judge should have recused, resulted in a finding of constitutional infirmity. Moreover, the appellate court ruled the defendant did not, arguably could not prospectively waive his rights, citing LaPlaca and Staley.

# SANCTIONS ?

- **Brookman v. State, Md: Court of Special Appeals**  
**2017** (Sanctions imposed reversed and remanded for a hearing. Defendants wanted to contest sanctions imposed without a hearing for low creatinine results and failure to appear for a drug test. Court held it was a due process violation to not accord an adversarial hearing, including the right to counsel, the ability to call witnesses and a continuance, if necessary for preparation.)

# Due Process concerns

- Termination is LIKE a VOP hearing in most cases
- Watch your record! Incentives and Sanctions should be noted. Contract analysis does not settle the issue
- States are divided on hearings for non-probation programs. Best practice: follow the VOP procedure.
- Clear majority now moving toward due process.
- *PROSPECTIVE WAIVERS OF RIGHTS IN THIS AREA ARE INVALID!*

# Question:

- Is a sanction a potential loss of a recognized liberty or property right?
- Does it invoke the same level of due process as a VOP?
- Certainly if you are a post adjudication probation model. Probably if you are not. Best practice: do it. Adds about 45 seconds to the colloquy.
- Get the notice of violation on your report forms! Provide due process!

# He waived his rights! NOPE!

- Hendrick v. Knoebel, (SD Indiana 5/10/2017) (“Though we need not rule on Defendants' argument concerning the waiver provision in the DTC Agreement, we note our serious doubts as to its enforceability under Indiana contract law, given the conspicuous lack of parity between the parties, the absence of specificity in the provision's language, the fact that it purports to absolve the DTC's employees of liability for intentionally tortious conduct, and the fact that the DTC Program is an entity of the local government performing a public service. See generally *LaFrenz v. Lake Cty. Fair Bd.*, 360 N.E.2d 605, 608 (Ind. Ct. App. 1977). Moreover, because the provision implicates federal common law by purporting to waive federal statutory and constitutional rights, the likelihood of its enforceability is increasingly remote. Federal courts are rightly skeptical, albeit not uniformly dismissive, of claims that a plaintiff has waived his constitutional rights or has released a defendant from liability for violating them. We "indulge every reasonable presumption against waiver of fundamental constitutional rights," *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938); *Bayo v. Napolitano*, 593 F.3d 495, 503 (7th Cir. 2010), and we acquiesce in a waiver only if it has been "knowing, intelligent, and voluntary." *Schiro v. Landrigan*, 550 U.S. 465, 484 (2007). The lack of specific language in the agreement before us, in conjunction with its prospectivity, not only falls short of eliciting "an intentional relinquishment or abandonment of a known right or privilege," *Patterson v. Illinois*, 487 U.S. 285, 292-93 (1988), but also encourages DTC staffers to violate the DTC participants' constitutional rights, knowing they are acting with impunity. Enforcing such an agreement is inconsistent with the public interest given its potential for abuse and cancellation of the participants' primary means of vindication.”)

# Ouch

Mississippi Commission on Judicial Performance v Thompson 169 So.3d 857  
(5/2015)

**(Drug Court Judge removed from office** for, inter alia, sanctioning individuals to jail without according due process of hearing. 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.)

# Consider this

- Is really about the factual basis or about the factors in mitigation and sanctions?
- What would you prefer if it was you in the client's shoes? Full due process?

# Remember your record!

- You need to document not just the sanctions but the good reviews and incentives in some manner for potential review.
- If someone questions what happened in a couple of years, how will they know *why* you did, what you did?

# Equal Protection issues:

- Poverty-you cannot deny access to indigents. Admission based on ability to pay is a denial of equal protection.
- Discretionary admission criteria must not violate due process (suspect class, semi-suspect class)
- Monitor disparate impacts in admission and program.
- DA may be gatekeeper for admission, and unless constitutional violation, no right to hearing to challenge rejection. *This area is changing rapidly.*

<https://www.ndci.org/resources/law/>

Updated every 6 months

# Best Practice:

- Keep your lawyers involved
- This is how we protect the program, protect the clients, and protect the Constitution.
- It turns out that lawyers also improve outcomes!!!

# Prosecutors

- Attend staffing? Cost savings up 171%
- Attend Court? Recidivism drops 35%

***If your prosecutor is interested in public safety, they should show up***

# Defense Counsel

- Defense attends staffing: Cost savings up 93%
- Defense attorney attends court: Recidivism down 35%

***Defense counsel: necessary***

# Other due process stuff:

- A drug test is a search.
- Some drug tests do not meet Daubert/Kelly/ Frye standards.
- Be sure that the testing meets legal standards for admission in a court of law.
- No information should go to a Judge without notice to counsel. THAT creates the legal nightmare.
  - What if it must be challenged?
  - What if it is not competent evidence?
- Then you buy trouble! Attorneys are there to prevent trouble and facilitate the needs of the treatment team! They protect due process.
- Again, this is a court, not just a program.

# Other stuff

- Open Courtroom? Absolutely (Noelle Bush) (rule of minimization)
- Closed staffing? Yes. (State v. Sykes, 182 Wn2d 168)

# Recent serious trouble spots

- Blanket prohibitions or policies regarding MAT.
  - Pay attention to ADA, RA, 1983 Civil rights claims, 8<sup>th</sup> A issues.
  - Criminal violations for practicing medicine w/o license.
- Lack of due process on hearings for violations and revocations.
- 1983 Civil Rights claims on 1<sup>st</sup> Amendment issues, et alia.  
(Constitutional rights claims) Mandatory damages, no immunity.
- WAIVERS OF RIGHTS as condition of admission.

# 42 USC 1983

## Civil rights proceedings.

- Quasi-immunity for 1983 action extinguished if violates an established constitutional right
- Notice is assumed that requiring AA is a violation of the First Amendment
- Drug court case manager not immune (*Hanas v. Inner City Christian Outreach, Inc.*  
542 F.Supp.2d 683, 701 (E.D. Mich. 2008))

# He waived his rights! NOPE!

- Hendrick v. Knoebel, (SD Indiana 5/10/2017) (“Though we need not rule on Defendants' argument concerning the waiver provision in the DTC Agreement, we note our serious doubts as to its enforceability under Indiana contract law, given the conspicuous lack of parity between the parties, the absence of specificity in the provision's language, the fact that it purports to absolve the DTC's employees of liability for intentionally tortious conduct, and the fact that the DTC Program is an entity of the local government performing a public service. See generally LaFrenz v. Lake Cty. Fair Bd., 360 N.E.2d 605, 608 (Ind. Ct. App. 1977). Moreover, because the provision implicates federal common law by purporting to waive federal statutory and constitutional rights, the likelihood of its enforceability is increasingly remote. Federal courts are rightly skeptical, albeit not uniformly dismissive, of claims that a plaintiff has waived his constitutional rights or has released a defendant from liability for violating them. We “indulge every reasonable presumption against waiver of fundamental constitutional rights,” Johnson v. Zerbst, 304 U.S. 458, 464 (1938); Bayo v. Napolitano, 593 F.3d 495, 503 (7th Cir. 2010), and we acquiesce in a waiver only if it has been “knowing, intelligent, and voluntary.” Schriro v. Landrigan, 550 U.S. 465, 484 (2007). The lack of specific language in the agreement before us, in conjunction with its prospectivity, not only falls short of eliciting “an intentional relinquishment or abandonment of a known right or privilege,” Patterson v. Illinois, 487 U.S. 285, 292-93 (1988), but also encourages DTC staffers to violate the DTC participants' constitutional rights, knowing they are acting with impunity. Enforcing such an agreement is inconsistent with the public interest given its potential for abuse and cancellation of the participants' primary means of vindication.”

Hoffman v Knoebel

US District Court Southern District Indiana

No.4:14-cv-00012-SEB-TAB July 27, 2017

- **It is undisputed that Plaintiffs suffered deprivations of their constitutional due process rights.**
- Judge Jacobi testified that participants never received written warning of the allegations against them before sanctions of jail time were imposed at the status hearings.
- Judge Jacobi never gave a DTC participant an advisement of rights or a re-advisement of rights when any DTC participant was given a sanction. >>>It was not practice to advise a DTC participant of their right to have counsel. >>>no legal counsel was ever appointed prior to a petition to terminate being filed. ...could not recall a time where the judge or anyone else in the courtroom asked a participant if they wanted legal assistance.
- (case decided on other issues, including immunity)

# Equal protection

- Poverty-you cannot deny access to indigents. Admission based on ability to pay is a denial of equal protection.
- Discretionary admission criteria must not violate due process (suspect class, semi-suspect class)
- DA may be gatekeeper for admission, and unless constitutional violation, no right to hearing to challenge rejection.
- Watch your data! Your court should match your jail pop. There is a profound inequity in treatment courts around historically disadvantaged populations. Gender, ethnicity, race, etc.

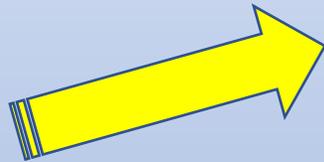
# Protective or Prophylactic Incarceration

- What law or legal theory allows this?
- What about the 8<sup>th</sup> Amendment?
- Violations of probation: watch your record and the length of the hold.
- Pursue civil proceedings if necessary.

Medically Assisted treatment

# MAT: Legal issues abound!

**My  
advice!**



Always start from here:

1. **Are you a medical doctor?**
2. Do you have a license to practice medicine?
3. Do you specialize in addiction medicine?

# Be careful

- Beisel v. Espinosa, Florida, 2017, United States District Court Tampa Division, case No.8:17-cv-51-T-33TBM, pro per misfires, but has instructive language. **[Adult Drug Court allows MAT but local FDC does not-equal protection and discrimination]**
- ADA, Rehabilitation Act of 1973, and some of 42 USC Section 1983 applies to FTC. Some tort claims may also lie.
- Monitor the Legal Action Center, NY NY for updates

## Can we mandate cessation as a condition of Drug Court graduation?

NO- 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.

## 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.

# Challenging Blanket MAT prohibitions:

- The 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.
  - See: *Discovery House, Inc. v. Consol. City of Indianapolis*, 319 F.3d 277, 279 (7<sup>th</sup> Circuit. 2003) (“the ADA and The RA...run along the same path, and can be treated in the same way”).
- Due Process protections of the 14<sup>th</sup> Amendment
  - 1983 Civil Rights violations....
- 8<sup>th</sup> Amendment-cruel and unusual punishment.

# “This drug court isn’t a program under the ADA and RA”

## Wrong.

- Pennsylvania Dep’t of Corrections v. Yesky 524 U.S. 206, 210 (1999) (ADA applies to correctional programs)
- People v. Brathwaite, 11 Misc. 3d 918, 816 N.Y.S. 2<sup>nd</sup> 331 (Crim. Ct., Kings County 2006) (Brooklyn’s alternative sentencing program falls under Title II’s definition of “state service or program.” )
- Evans v. State, 667 S.E. 2d 183, 186 (Ga. App. 2008) (A drug court is a “public entity” under the ADA).

# But they aren't disabled simply because they need MAT!

**WRONG!** Addiction is a disability.

MX Group, Inc. v. City of Covington, 293 F.3d 326, 336 (6<sup>th</sup> Circuit 2002)

*It is well established that drug addiction constitutes and “impairment” under the ADA and that drug addiction necessarily substantially limits major life activities of “employability, **parenting**, and functioning in everyday life”. (emphasis added)*

US v. City of Baltimore, 845 F. Supp. 2<sup>nd</sup> 640 (D. Maryland 2012) Residents of substance abuse facility were individuals with a disability.

# Eligible Participants disqualified due to blanket MAT policy but would be otherwise qualified?

- Thompson v. Davis, 295 F.3d 890, 896 (9<sup>th</sup> Circuit, 2002) Incarcerated individuals who were illegally denied parole because of their disability (drug addiction) sufficiently alleged that there were otherwise qualified for parole.

# MAT users are not a significant risk to health or safety

- New Directions Treatment Services v. City of Reading, 490 F.3d 293, 305 (3<sup>rd</sup> Cir. 2007) (NIMBY case) General statements about heroin users does not establish substantial risk to community. Must establish nature, severity and duration of risk, based on current medical knowledge and best evidence.
- Start, Inc. v Baltimore County, Md. Et alia, 295 F. Supp.2d 569, 577-78 (D.Md. 2003) Risks of diversion and concerns can be mitigated by protocols and administration.
- There are several cases in this area.

# Blanket Denial of MAT access is discrimination because of a disability.

- Disparate treatment
  - Thompson v. Davis, 295 F.3d 890 (9<sup>th</sup> Circuit 2002) denial of parole because of addiction is subject to disparate treatment analysis of ADA.
- Reasonable Accommodation
  - ADA requires reasonable accommodation to avoid discrimination.
- Disparate Impact
  - Title II ADA prohibits eligibility requirements that screen out or tend to screen out individuals with a disability, unless the criteria are essential to the provision of services.

## Watson v. Kentucky, E.D Kentucky, 7/7/15 (F. Supp.2d)

- Watson requires the state court take her off the conditional release terms or remove the “blanket prohibition on her taking suboxone, methadone or any other drugs that she needs to treat her addiction. The state attorney clarified that there was not a Blanket prohibition on MAT, but agreed that “it’s generally the Court’s practice to allow MAT if the doctor will show medical need.”
- Relief denied. Her challenge on federal grounds was denied stating the claim could be handled on the state level.

# Summary:

- Drug Court blanket prohibitions of MAT offend the ADA and RA.
  - Drug Court is a program covered by the statutes
  - Drug Court eligible persons have a disability. (DUI Court too)
  - Drug Court eligible persons do not as a class, constitute a substantial risk
  - Blanket denial of MAT is discrimination because of a disability.

# Due Process and Blanket prohibitions of MAT

*Constitutional due process requires reasonableness or a rational basis for conditions of treatment and supervision of persons on probation or in drug court.*

- Probation terms and conditions should be reasonably related to the crime and the rehabilitative needs of the individual and protection of the community People v. Beaty, 181 Cal.App.4th 644, 105 Cal.Rptr.3d 76 (2010)
- Judge must impose individualized conditions to meet community and individual needs. Commonwealth v. Wilson, 11 A.3d 519 (Pa. Super. 2010).

# Blanket denial of MAT is a due process violation-what about objections?

- All Judges should:
  - Consider relevant information before making a factual decision.
  - Hear arguments from all sides of the controversy and receive evidence from scientific experts, if the subject matter is beyond that of lay person knowledge.

There is a **federal presumption** tied to funding.

- The matter is settled (Presumption) in most instances if: (1) the physician has legal authority to write the prescription, (2) the medication is indicated to treat the patient's illness, (3) the prescription was not obtained fraudulently, and (4) the patient agrees to take the medication as prescribed. If prescribed: Presumption in favor of MAT **Burden of proof is on the objector to show it is inappropriate by preponderance.**

# No federal funding:

- (1) the physician has legal authority to write the prescription, (2) the medication is indicated to treat the patient's illness, (3) the prescription was not obtained fraudulently, and (4) the patient agrees to take the medication as prescribed.
- But the burden is different. The moving party makes a prima facie case, then opposition may introduce evidence of prior abuse of MAT, or MAT deception in treatment.

# GENERAL RULE:

- blanket prohibitions of MAT are a due process violation because they are not rationally (scientifically based).
- They are not reasonable because they are not consistent with individualized sentencing and treatment
- They do not give parties a fair opportunity to present their case, since one alternative is foreclosed.

# 8<sup>th</sup> Amendment-cruel and unusual punishment-growing area

- Correctional officials and health care providers may not act with deliberate indifference to an inmate's **serious medical needs**. Estelle v. Gamble, 429 U.S. 97, 104 (1976); .
- **Deliberate indifference** has both an objective and a subjective element: the inmate must have an objectively serious medical condition, and the defendant must be subjectively aware of and consciously disregard the inmate's medical need. Farmer v. Brennan, 511 U.S. 825, 837 (1994)

# What is a serious medical need?

- Withdrawal symptoms can qualify as a serious medical need. See, e.g., Boren v. Northwestern
- Regional Jail Authority, No. 5:13cv013, 2013 WL 5429421, at \*9 (W.D. Va. Sept. 30, 2013) (alcohol withdrawal states serious medical need); Mayo v.
- County of Albany, 357 F. App'x 339, 341-42 (2d Cir. 2009) (heroin and alcohol withdrawal); Sylvester v. City of Newark, 120 F. App'x 419, 423 (3d Cir.2005) (acute drug withdrawal); Foelker v.
- Outagamie County, 394 F.3d 510, 513 (7th Cir.
- 2005) (methadone withdrawal).

# What is deliberate indifference?

- The failure to provide methadone to an inmate exhibiting symptoms of withdrawal may constitute deliberate indifference to a serious medical need by intentionally ignoring the effects of withdrawal. Foelker v. Outagamie Cnty., 394 F.3d 510, 513 (7th Cir.2005);
- Alvarado v. Westchester County, 22 F. Supp. 3d 208 (SD New York 2014)
- Messina v. Mazzeo, 854 F. Supp. 116, 140 (E.D.N.Y. 1994) (pretrial detainee, whose participation in methadone program was interrupted by arrest, stated deliberate indifference claim against prison doctor who refused to continue methadone treatment).
- See also Mellender v. Dane County, \_\_\_ F. Supp. \_\_\_ (W. D. Wisc. 2006); Norris v. Frame, 585 F.2d 1183, 1188 (3d Cir. 1978)

# Can the Court compel the use of MAT?

- **Question one: are you a physician who is an expert in MAT?**
- That should answer your question.
- The answer is NO.
- Sell v United States 539 U.S. 166 (2003)
  - There are some recent changes for psychotropic meds, but not these.

# What if the prosecution or a party objects?

- Set a hearing, follow guidelines supra.

## Net Message:

- Beware of blanket MAT issues:
- Make a record of denials, or policies
- **Be aware that your “beliefs” are not medicine.**
- Failure to recruit/obtain accessible MAT may be a growing area of liability.

Best practices  
adult best practices standards.

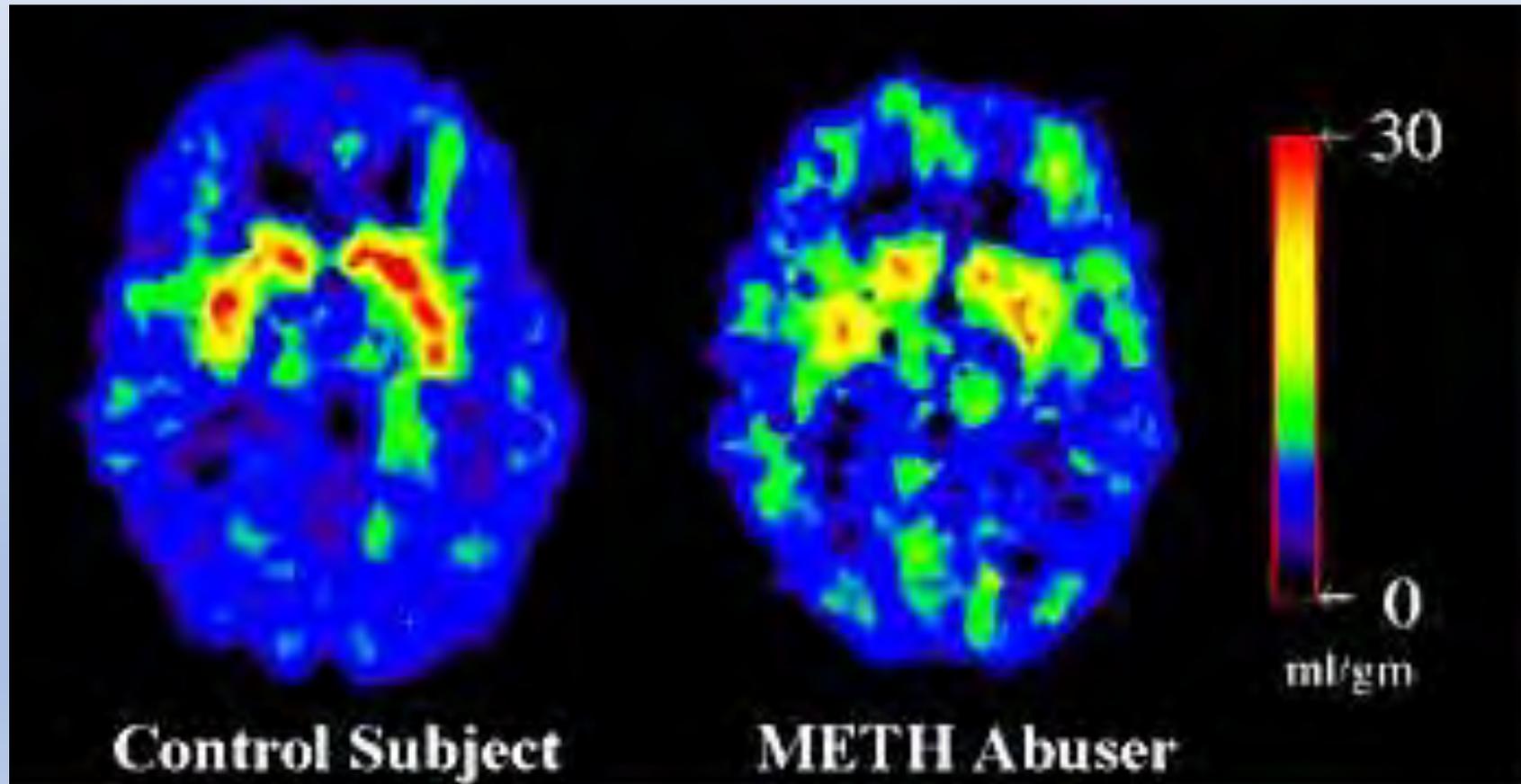
# Best Practices

- Ensure that DA and Defense Counsel attend staffings and review hearings
- Judges/Prosecutors: avoid public activities (non-judicial) with participants, except for cameo appearance
- Respect ethical obligations of defense counsel
- Stay in your lane, and follow the law.

# Best Practices

- Ensure that DA and Defense Counsel attend staffings and review hearings
- Advocate change in Canons and rules of professional responsibility.
- Judges: avoid public activities (non-judicial) with participants, except for cameo appearance
- Respect ethical obligations of defense counsel
- Mind the law and the boundaries!

- Understanding addiction and the psychopharmacology of drugs. Addiction is truly a disease of the brain. It is treatable.



Courts that use jail greater than 6 days have **worse** (higher) recidivism

Percent decrease in recidivism between courts that use differing amounts of jail sanction time



# Attorney roles:

1. Protect the Constitution

2. Maximize outcomes

- Facilitate the treatment team and the plan when it meets #1 and #2
- Only counsel can find the legal way to get treatment and probation's goals implemented.

That look . . .



# So, What's wrong with people?



So, How can I / we help  
facilitate change?



# ABOUT THE AUTHOR

## Dr. Paul A. Hardy

- D. Min. Pastoral Counseling
- Certified Substance Abuse Counselor, VA
- National Master Addictions Counselor

Founded Recovery for Life program in 1998 helping addicts in their areas of addictions, compulsive behaviors and overall struggles with life.

website [www.myrecoveryforlife.com](http://www.myrecoveryforlife.com)



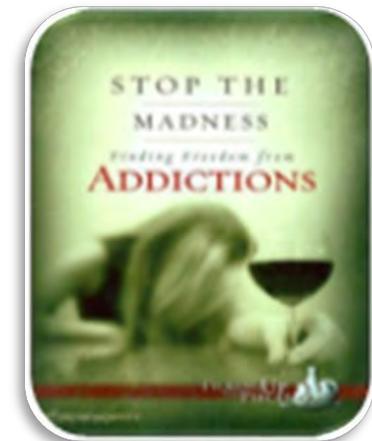
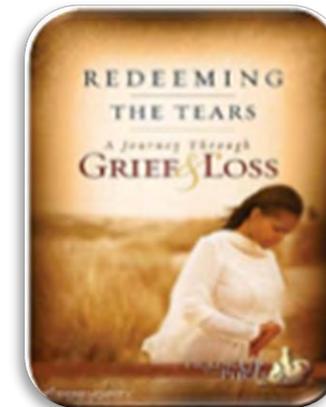
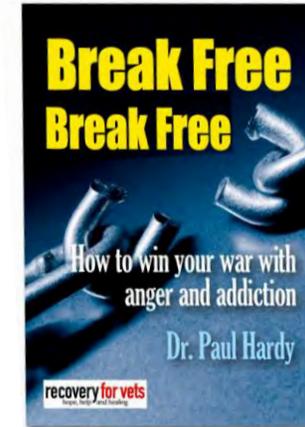
# ABOUT THE AUTHOR

## Dr. Paul A. Hardy

He has self-published numerous books including:

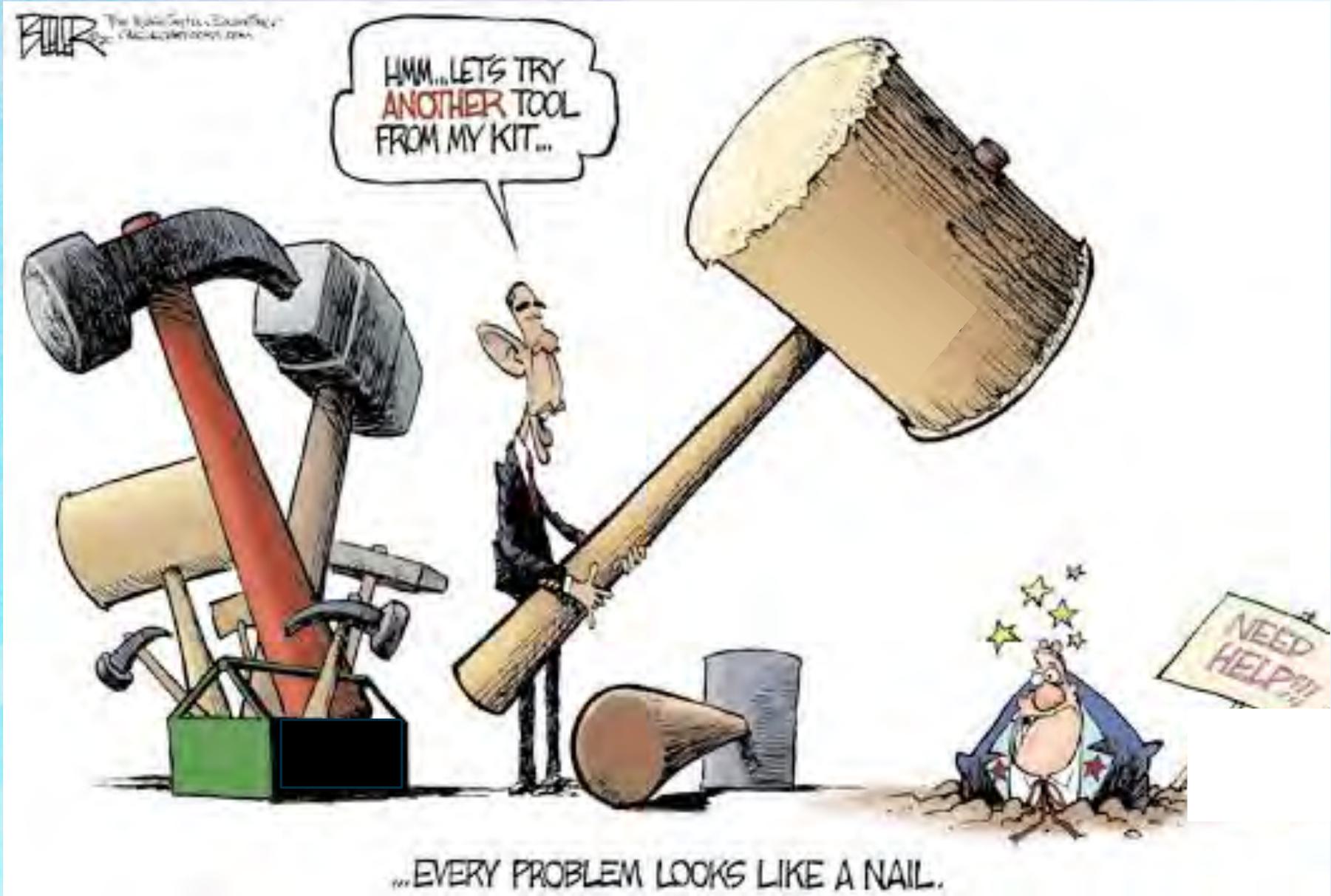
- *Break Free Now*
- *Letting Go, Living Free*
- *Get a Grip*
- *The First 30 Days*
- *Getting it Right*
- *From Darkness to Light*
- *Redeeming the Tears*
- *Stopping the Madness*

Not My Child, Dr. Paul Hardy 2019





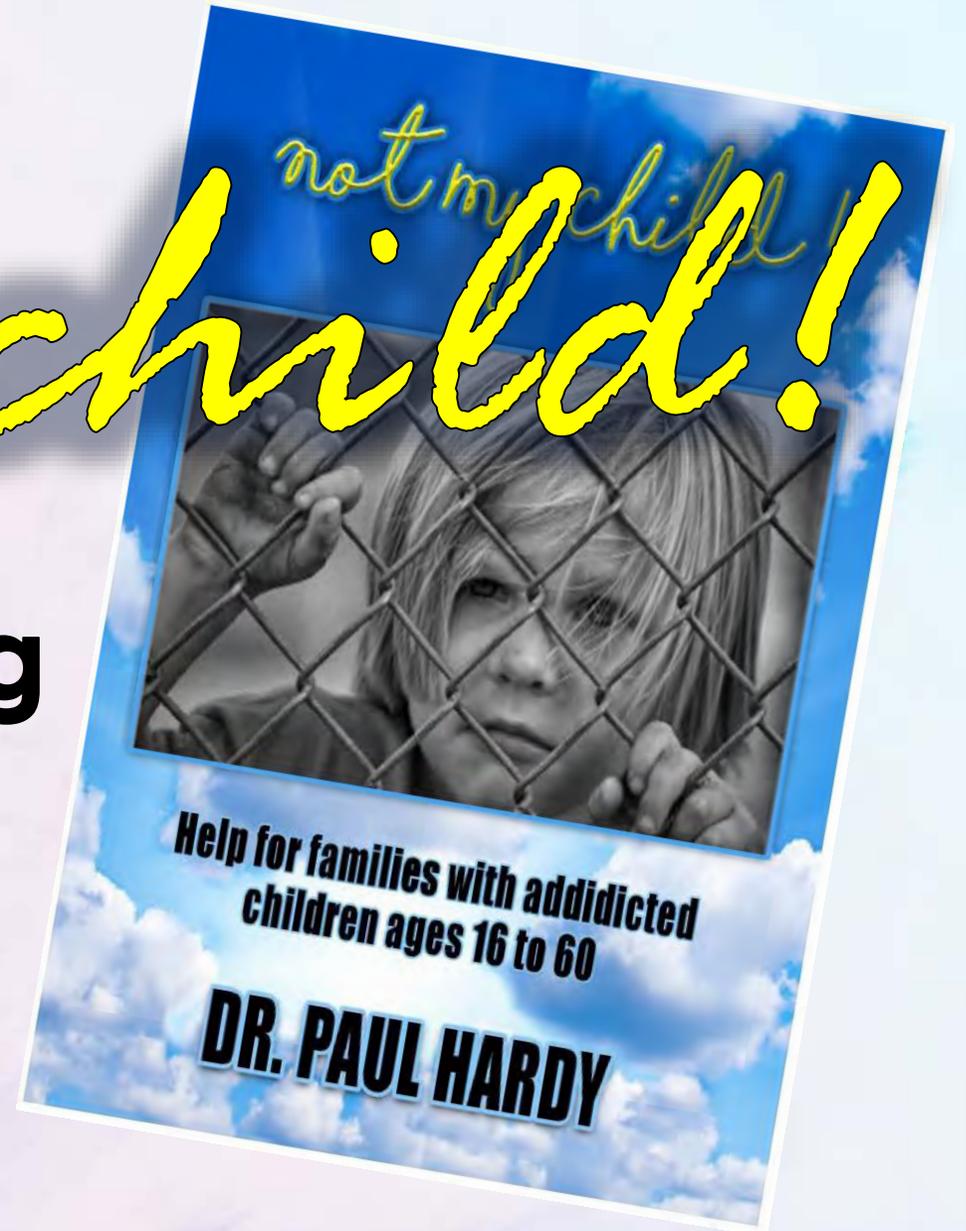
Son, I completed  
all 12 steps for  
**you! They're in**  
your bedroom  
with the clean  
laundry.



...EVERY PROBLEM LOOKS LIKE A NAIL.

*not my child!*

**100 grateful recovering  
addicts said...**





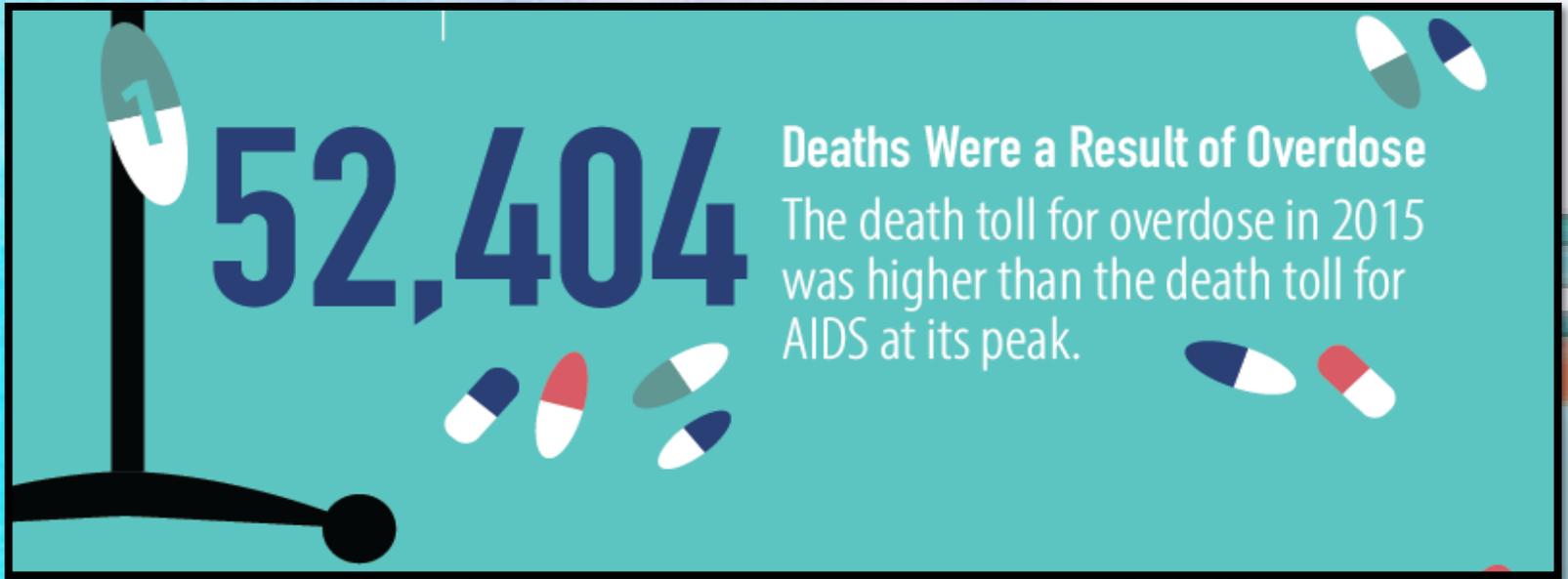
# 8 RECOVERY TOOLS



**TOOL 1. PUROSE:**  
Connect with your own  
motivation to avoid  
burnout. Why do we do  
this?

# NEWS VIDEO

Not My Child, Dr. Paul Hardy 2019

An infographic on a teal background. On the left, a black signpost with a white pill-shaped top containing the number '1' points to the number '52,404'. To the right of the number is the text 'Deaths Were a Result of Overdose' and a paragraph: 'The death toll for overdose in 2015 was higher than the death toll for AIDS at its peak.' Several colorful pills (white with blue, red, and green caps) are scattered around the text.

**1**  
**52,404**

**Deaths Were a Result of Overdose**  
The death toll for overdose in 2015 was higher than the death toll for AIDS at its peak.



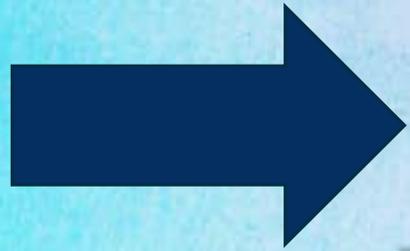
3

# EVERY 19 MINUTES,

**Someone Dies From Drug Abuse**

Experts expect the time between deaths to continue to shrink.





NOT TO  
EXCUSE BUT  
TO LISTEN AND  
UNDERSTAND.

**“I Don’t  
Like People  
Who Take  
Drugs-  
Customs  
Agents,  
For Example”**

ASAM - Addiction is a primary, chronic disease of:

- brain reward
- motivation
- memory (repeated action)
- related circuitry in the brain

Dysfunction in these circuits leads to characteristic:

- biological
- psychological
- social
- spiritual manifestations

This is reflected in an individual  
pathologically pursuing

reward and/or relief

by substance use and other  
behaviors

Like other chronic diseases,  
addiction often involves  
cycles of relapse and  
remission.

Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.



**TOOL 2. ASSESS:**  
Get them to deal with their younger self. “What would you say to a younger you?”

WE ASKED 100 CLIENTS

**“What would you tell a 16-year-old?”**

The adult client has to convince  
the 16-year-old

- “You will go to jail.”
- “It’s all about influences.”
- “Get new friends.”
- “Talk to someone, get a mentor.”
- “Think about the consequences.”

- “Financial hardships on your family.”
- “Learn coping skills.”
- “Get your parents to bribe you.”
- “All new drivers should have interlock.”

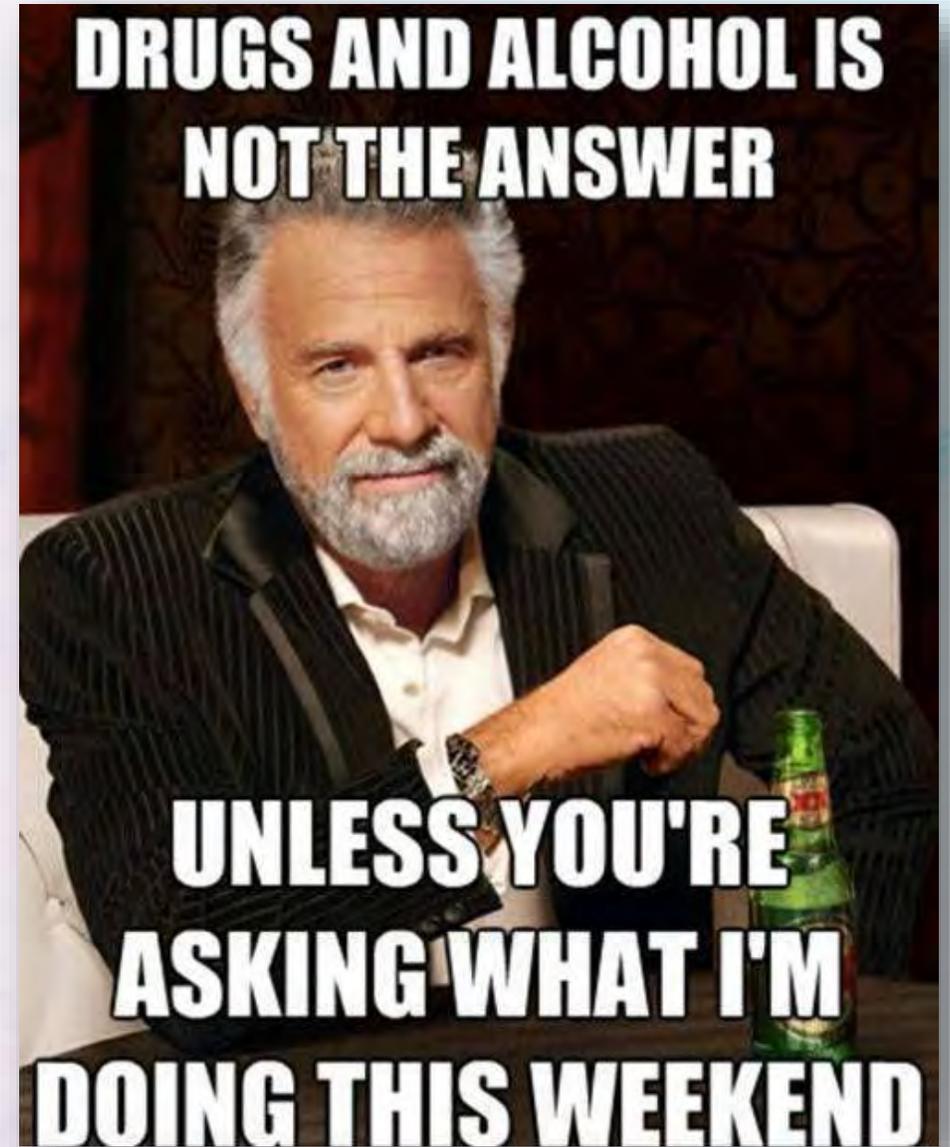
They felt NO person;  
NO experience  
could or would have  
kept them off the  
path of addiction.



Facing the Struggle,  
Think about your  
favorite food

X 10,000

Not My Child, Dr. Paul Hardy 2019



# What's wrong with people?

“We become obsessed with pleasure, feeling good, feeling better, seeking the best high ever!” Dr. Paul



“I just don't want to  
feel miserable.”



**TOOL 3. NORMALIZE:**  
Convince them they are  
not the only one with  
these issues.



What makes a  
really good  
addict?



Lying?

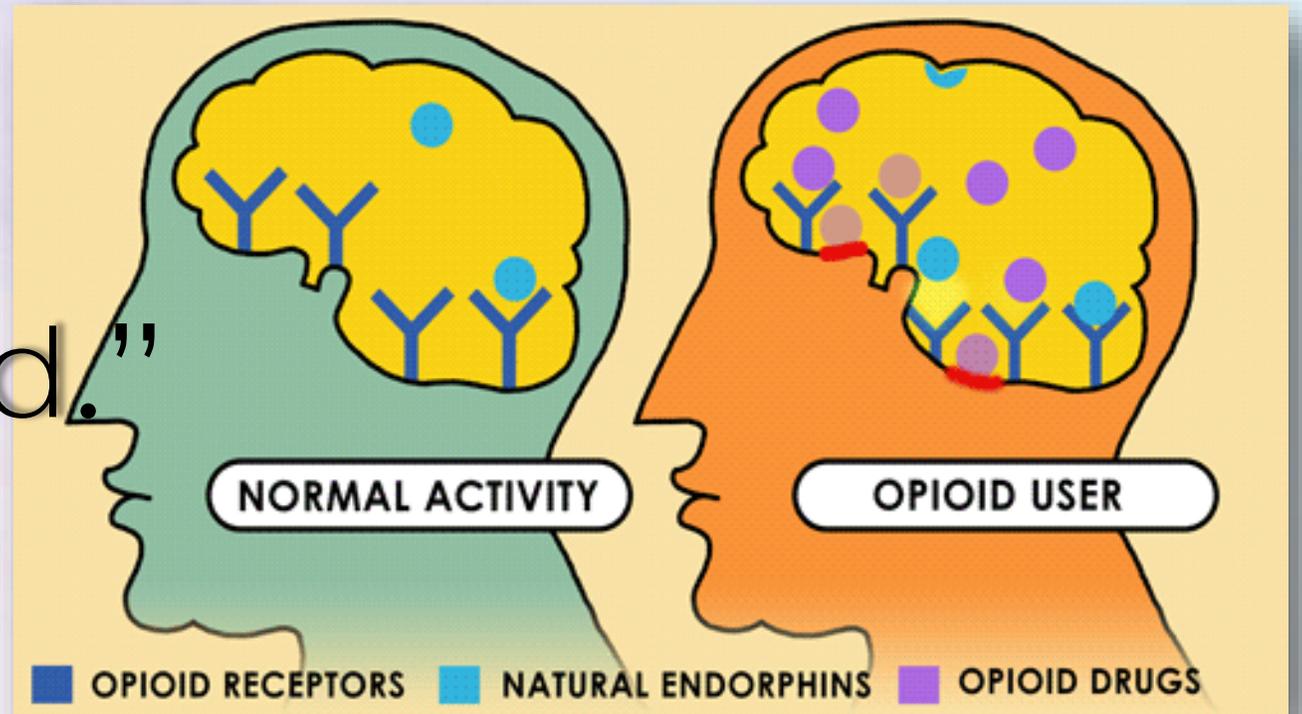
Manipulating?

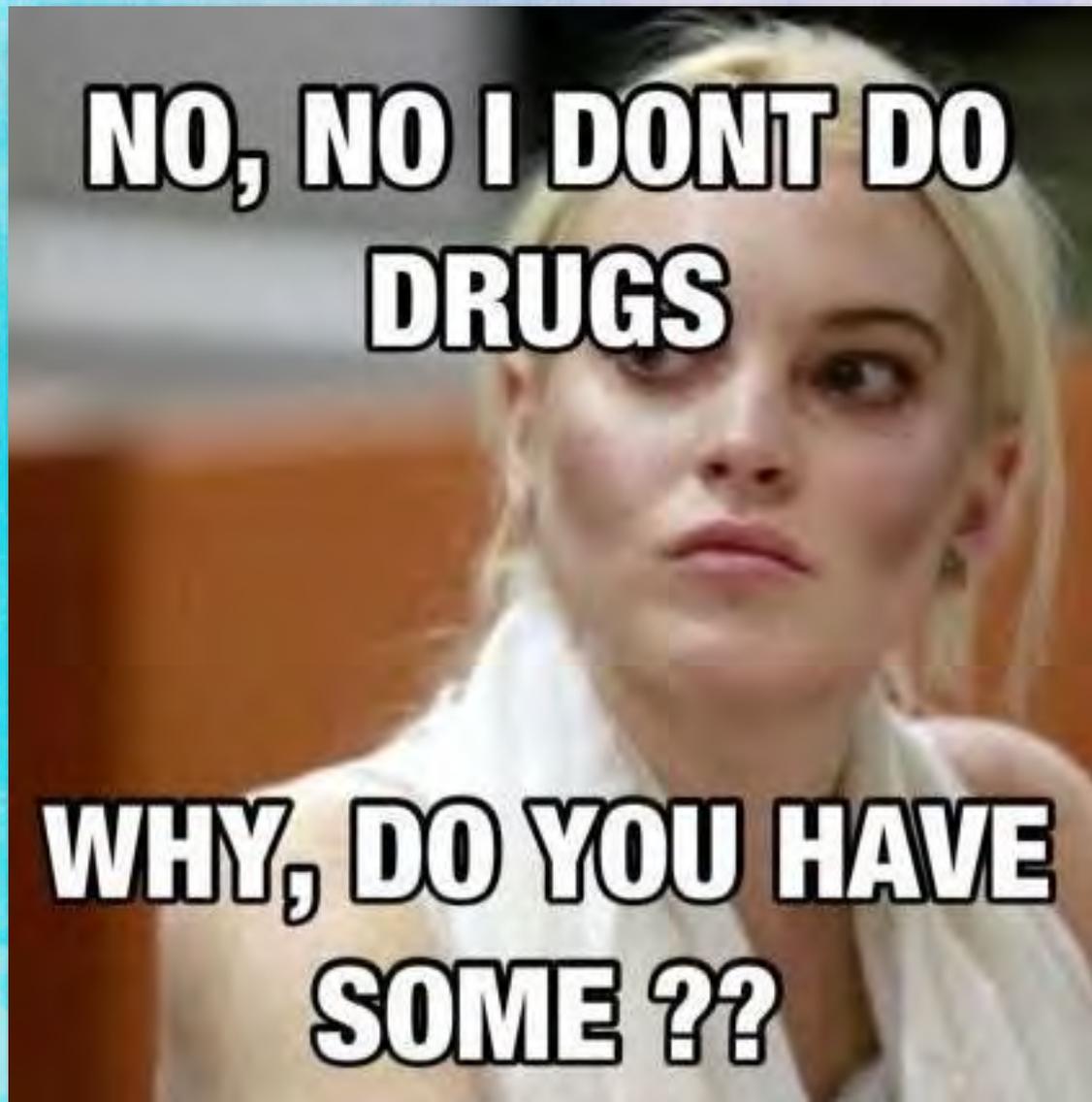
Stealing?

# RISK FACTOR 1

100 grateful recovering addicts said . . .

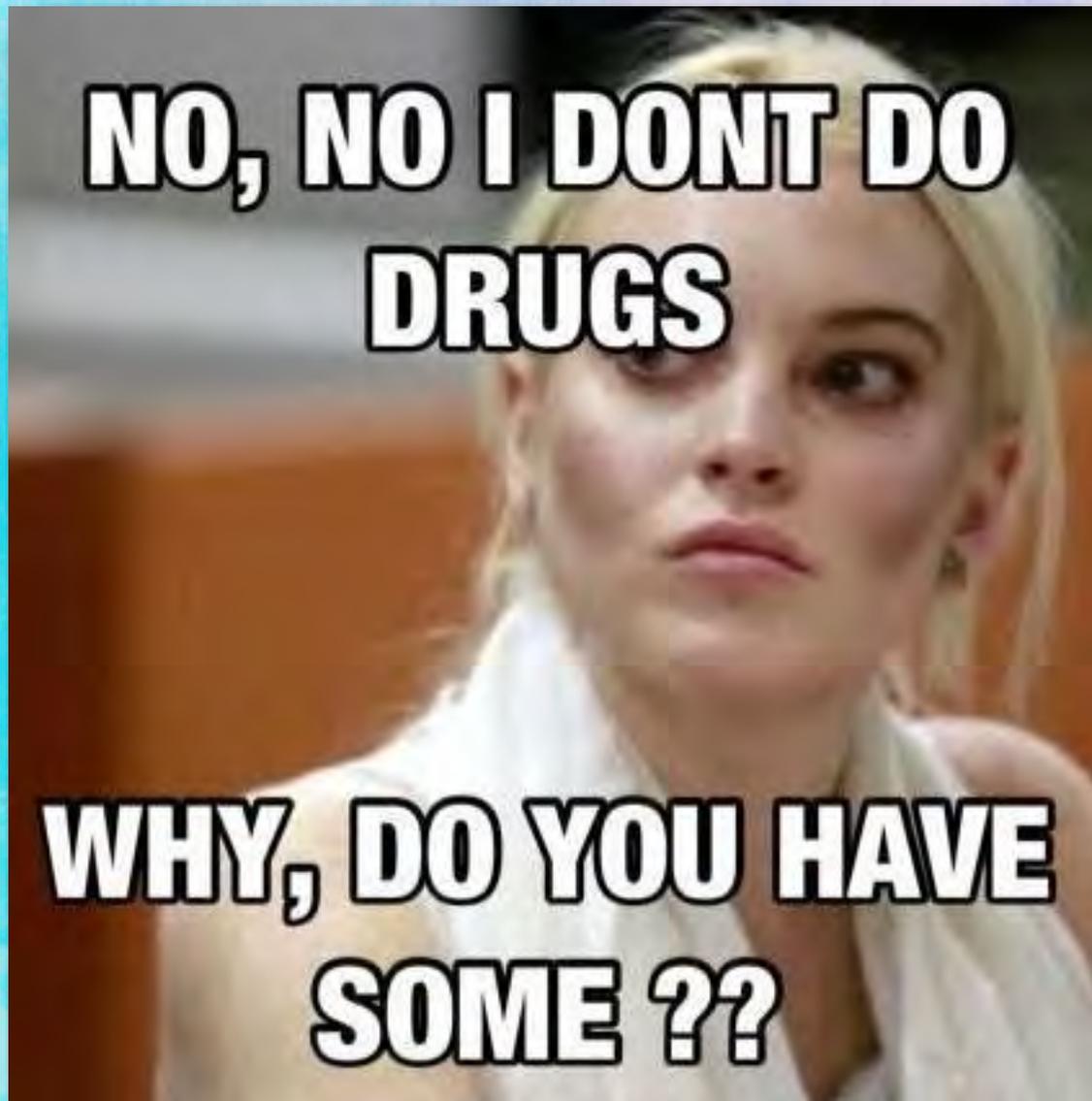
“It seemed like my brain changed.”





“ALL  
ADDICTION  
BECOMES AN  
\_\_\_\_\_”

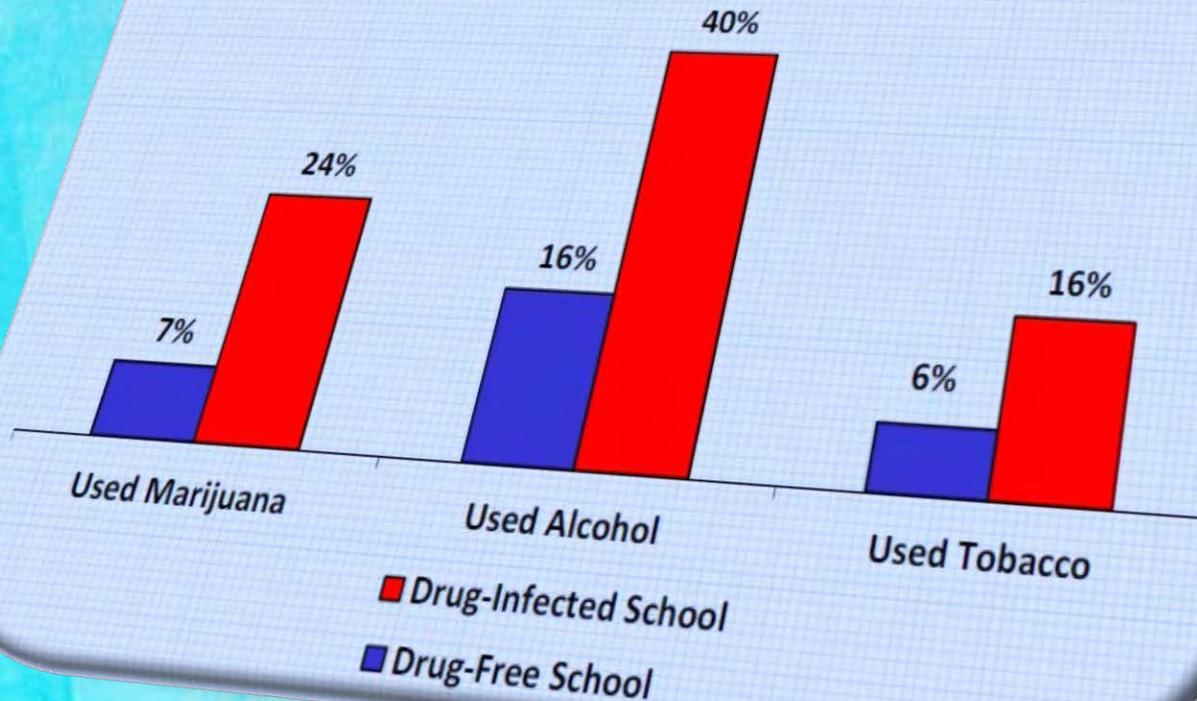
Dr. Paul



“ALL  
ADDICTION  
BECOMES AN  
OBSESSION.”

Dr. Paul

**Teens (Ages 12-17) Who Have Used  
Marijuana, Alcohol, Tobacco**



**RISK FACTOR 2**  
100 grateful  
recovering  
addicts said. . .

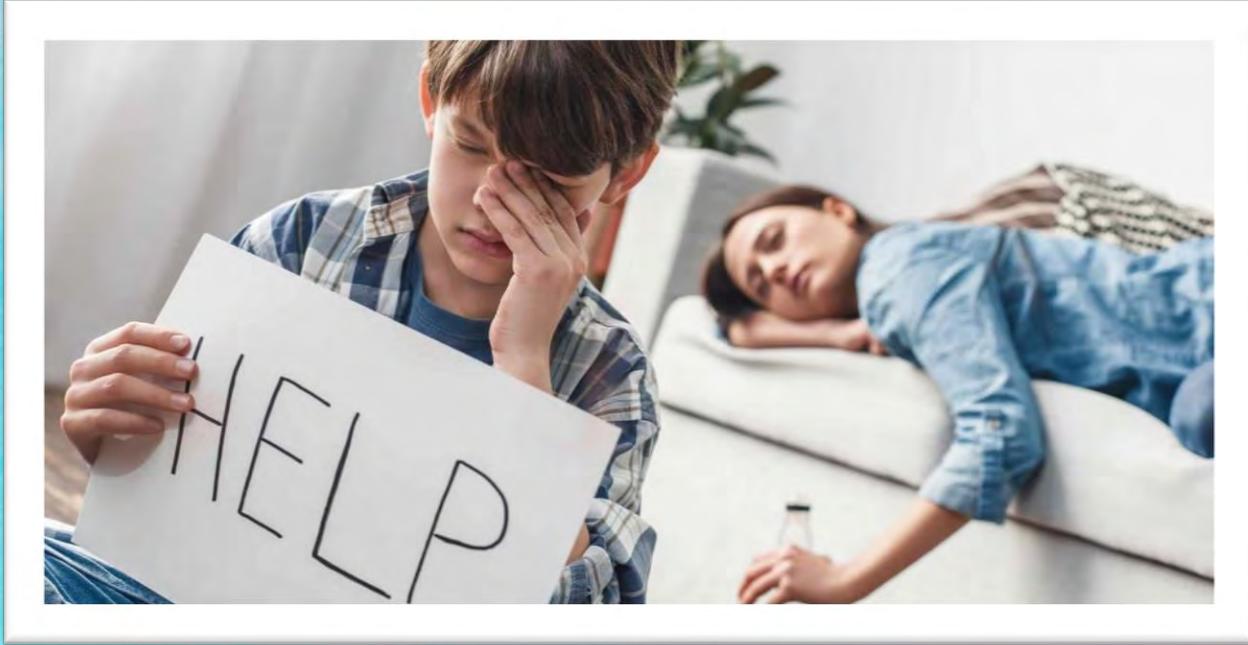
“It was so easy  
to get.”

## RISK FACTOR 3

100 grateful recovering addicts said . . .

“My parents  
were addicted.”





CHILDREN OF ALCOHOLICS

**4 TIMES** MORE



## RISK FACTOR 4

100 grateful recovering addicts said . . .



“I felt  
disconnected.”

- Family disconnect.  
“I never felt like I fit in”
- School disconnect.  
“clothes or lifestyle.”
- Social disconnect.  
“anxiety around people”



“Drugs made me feel like I finally fit in.”

AUSTIN





Substance abuse  
and **“arrested  
development.”**

**“He’s 25 going on  
13.” Dr. Paul**



**I WAS ALWAYS THE  
BLACK SHEEP. THEN I  
STARTED GOING TO  
MEETINGS AND FOUND  
THE REST OF THE HERD.**



## RISK FACTOR 5

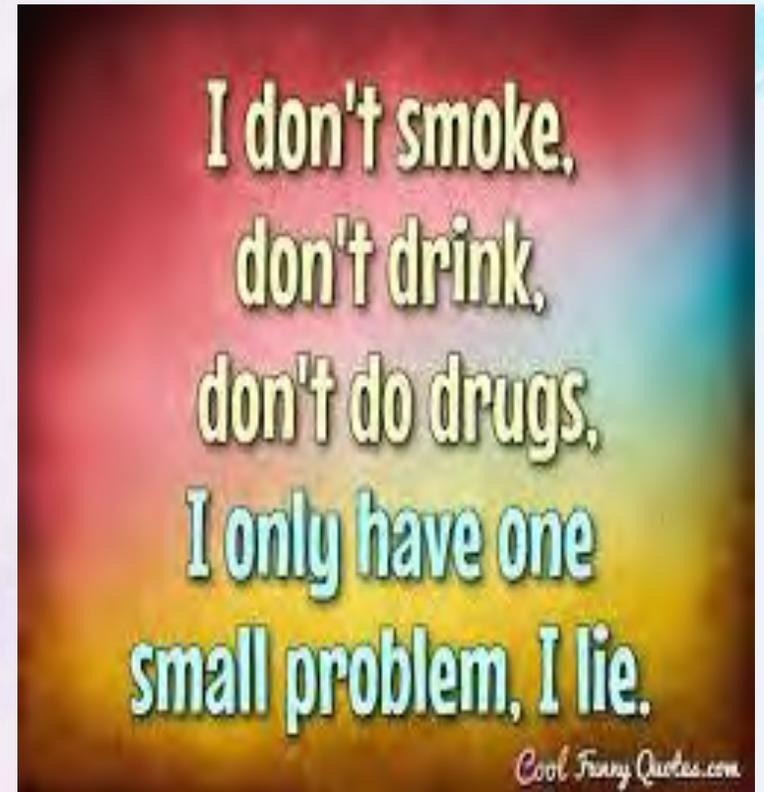
100 grateful recovering addicts said . . .

“I didn’t know what it would do to me until too late. I couldn’t stop.”

## RISK FACTOR 6

100 grateful recovering addicts said . . .

“I have an  
addictive  
personality.”

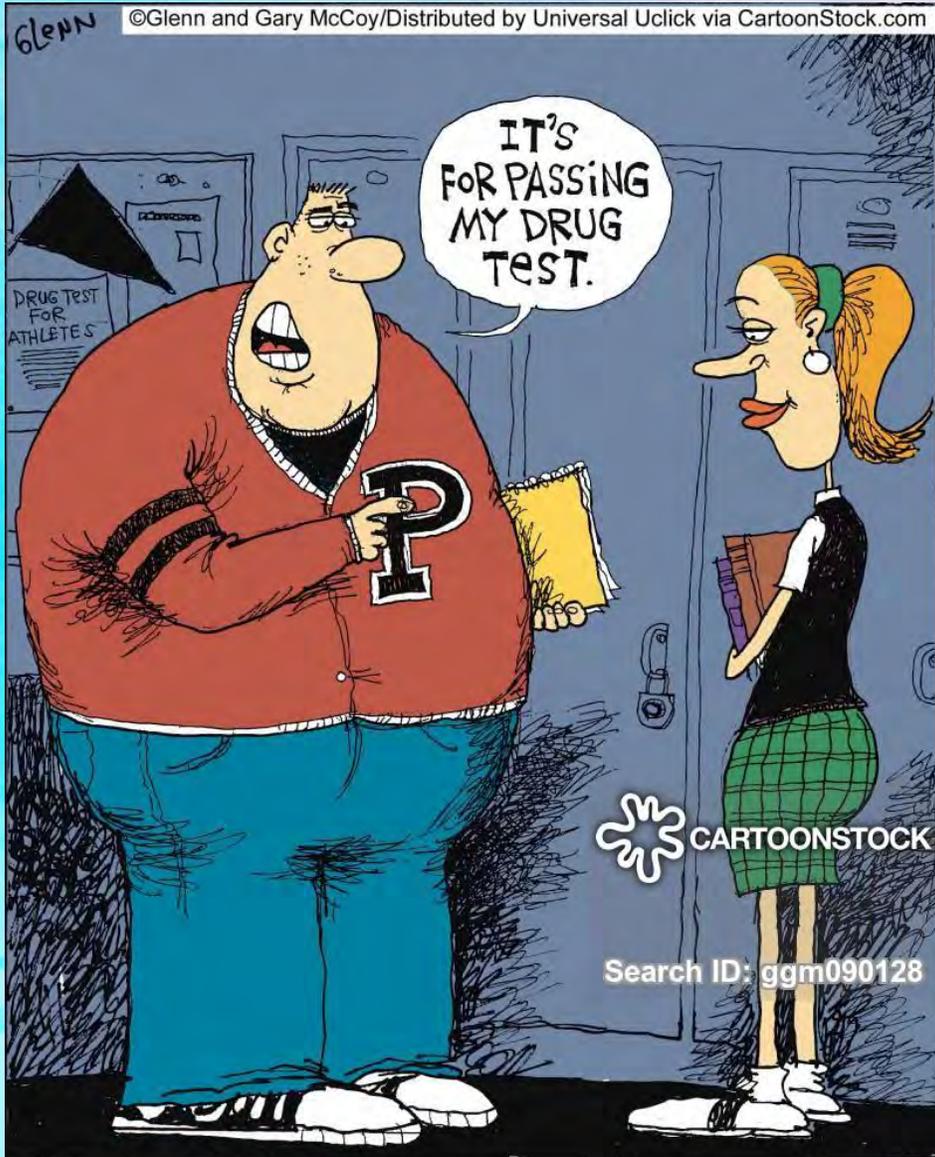


A Catholic Priest, a Jewish  
Priest, and a Baptist Pastor play  
golf . . .

# AUSTIN



Not My Child, Dr. Paul Hardy 2019



Defiant/oppositional personalities come into play. Some people, by nature, refuse to follow laws or norms.

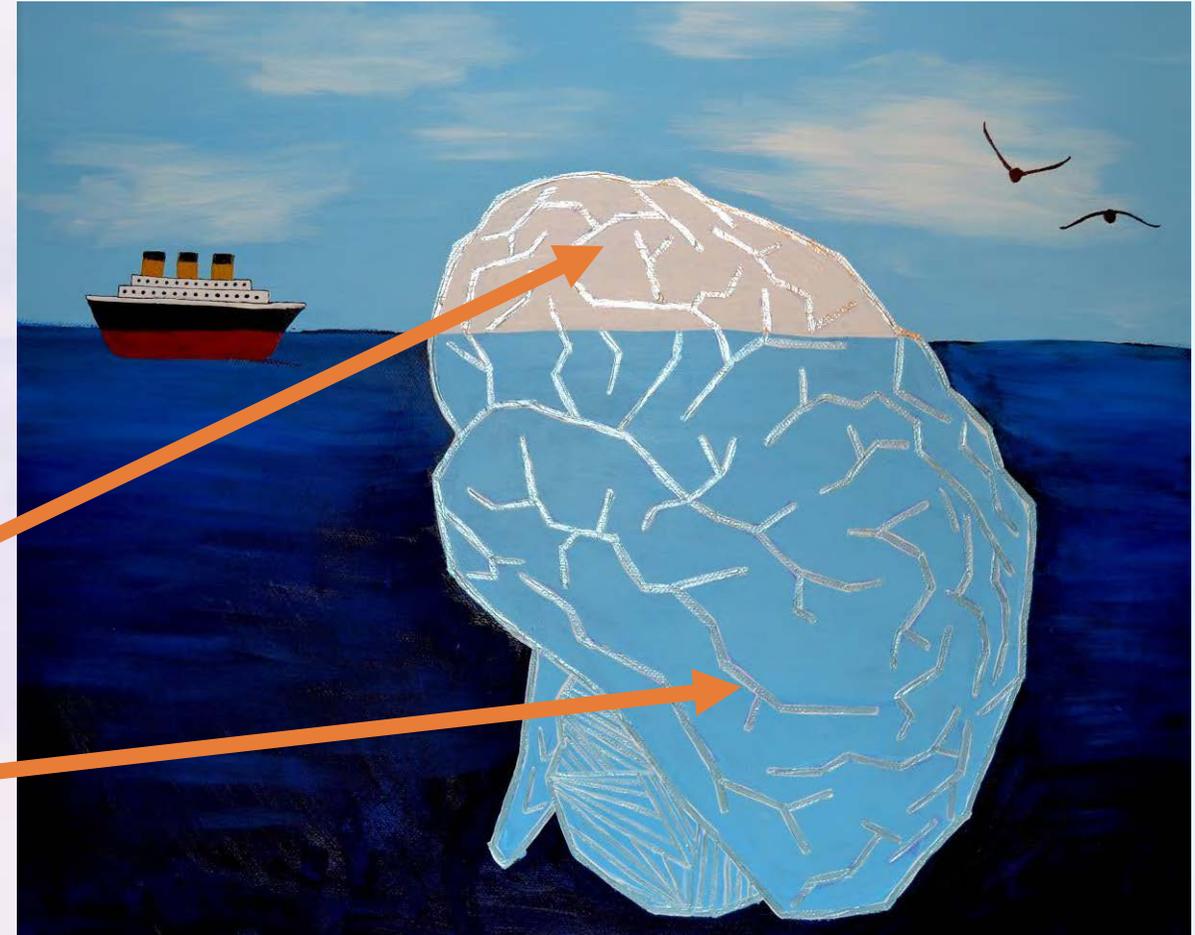


**TOOL 4. DRIVERS:**  
Bring out their emotional  
subconscious drives,  
beliefs

# RISK FACTOR 7

100 grateful  
recovering addicts  
said . . .

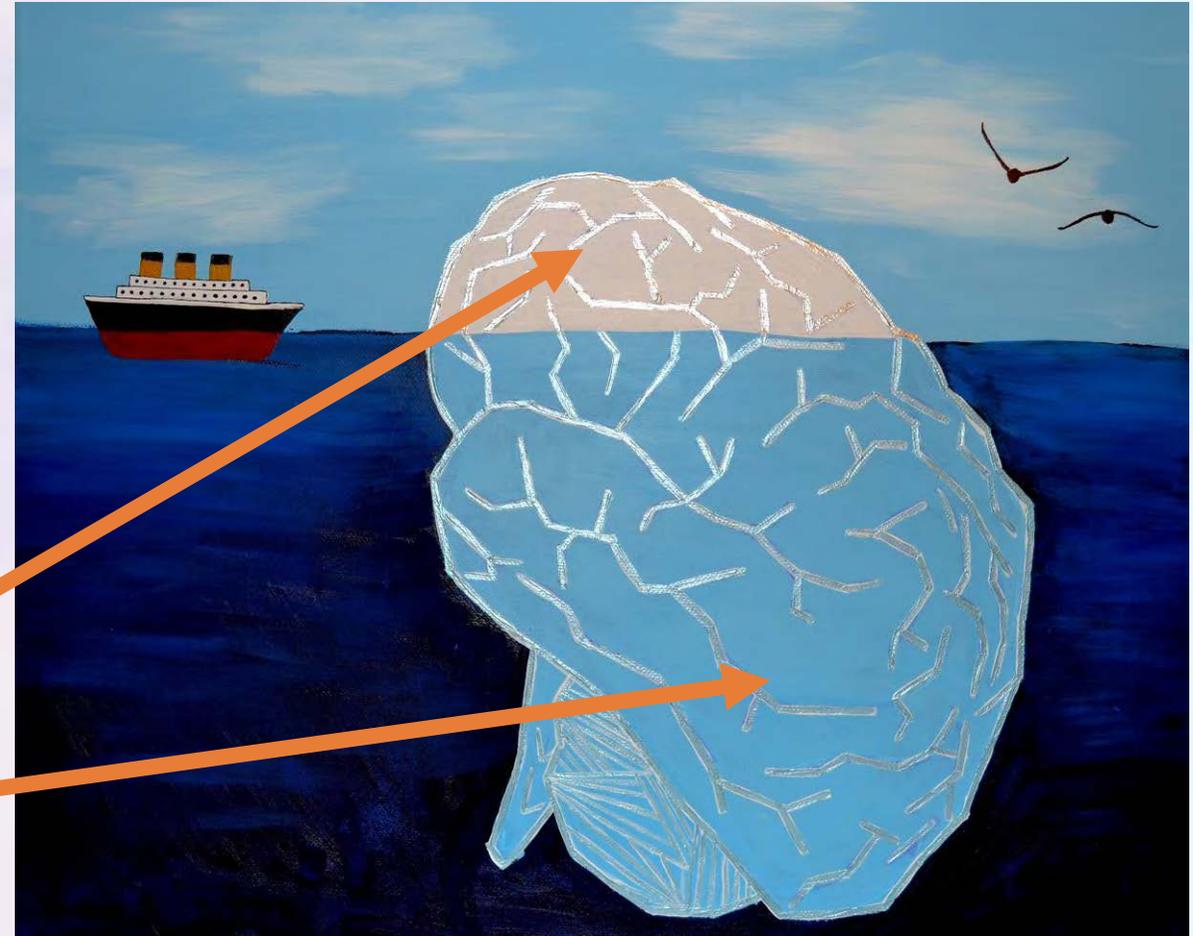
Conscious Mind  
Sub-conscious Mind

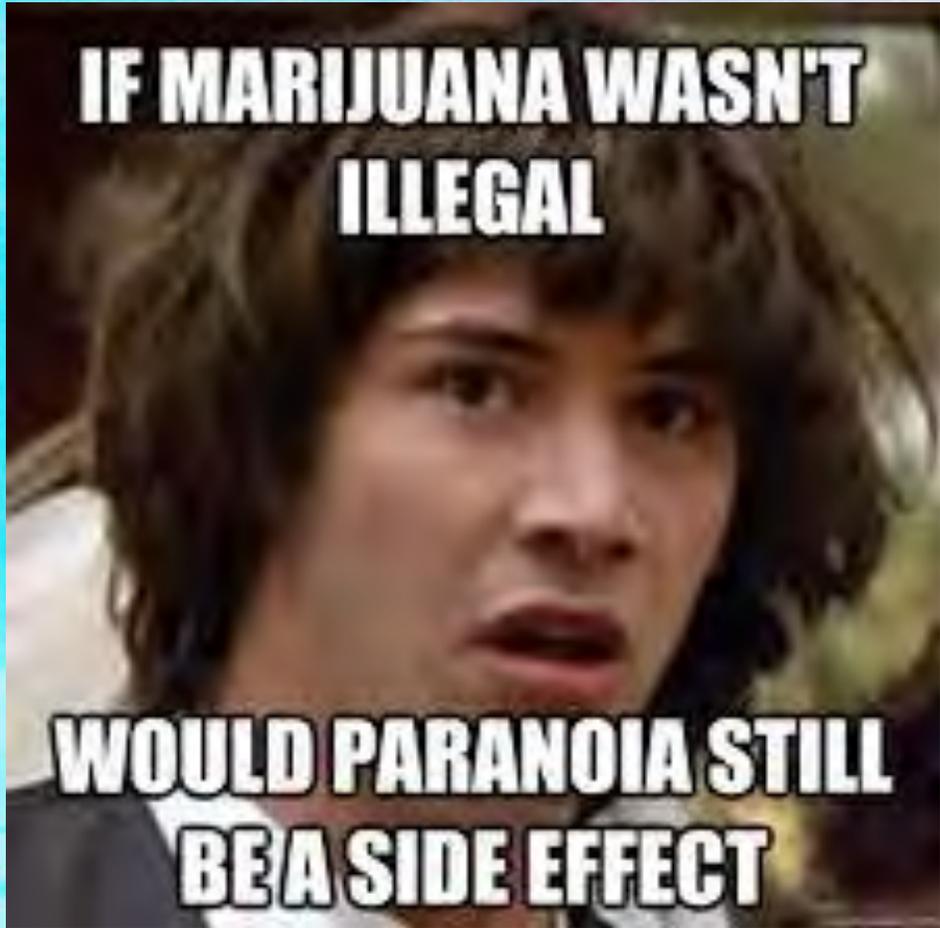


“I was driven by my emotions.”

The subconscious mind must be re-programmed to direct the conscious mind.

EMDR, EFT  
Reframing





# EMOTIONAL DRIVERS

Trying to Solve a problem, insomnia, anxiety, PTSD, pain relief.

Eventually, the chosen solution becomes much worse than the original problem.

Dr. Paul



# EMOTIONAL DRIVERS

To Gain acceptance. Culture still includes the use of substances to gain a status in the group.

# EMOTIONAL DRIVERS

To forget, escape, temporary escape from a harsh reality. Loss or crisis may provoke the desire to escape.

Traumatic memories.

# The Addicted Family

Not My Child, Dr. Paul Hardy 2019

**THE MOMENT HE REALIZED  
HE WAS NOW THE MIDDLE CHILD**





**5. HOPE: Inspire hope.**  
“I have worked with many people like you and they have gotten better.”

# **DRUNK BUS DRIVER**

Not My Child, Dr. Paul Hardy 2019

# THE ADDICTED FAMILY

We know what family members are capable of doing to try to change the addict.

# “THE ADDICTED FAMILY” DYSFUNCTION



# THE ADDICTED USER, VICTIM

“I became addicted.”

“And then it hit me. In was in ‘lala land,’ like I was floating around.”

# THE ADDICTED USER

“I became addicted.”

“Every problem, every stress, every pain in my life suddenly felt absorbed and dissolved.”

# THE ADDICTED USER

“. . . until the high wore off, then I realized my life sucked all over again.

# THE ADDICTED USER

“I went from chasing the high to doing whatever to not get dope sick. I dreaded that more than anything.”

# THE CO-ADDICTED, RESCUER

“I became co-addicted.”

“I became so engulfed in my son’s addiction that I was willing to do anything to help him.”

## THE DRIVEN/RESPONSIBLE

“I became driven and super responsible.”

“To survive, I took on the responsibility for us to get by and deal with dad’s addiction.”

# THE DRIVEN/RESPONSIBLE

“We never knew which ‘dad’ we were going to get. Often I had to get between them or he would have really hurt her.”

# THE CLASS CLOWN, MASCOT

“I became overly emotional.”

I never knew how to act. I really thought if I could just get dad to laugh or connect with me somehow, he would get better.

# THE DARK SIDE, LOST CHILD

“I became dark and self-absorbed.”

“Problems in our family led me to doubt everything. I feel so much pain and anger.”

# THE USER'S FALSE BELIEFS

**BELIEF:** "I can't just get better."

**ANSWER:** "If you do the right things you will."

**BELIEF:** "It's my fate, I was made to be an addict."

**ANSWER:** "You can do better than this."

# THE USER'S FALSE BELIEFS

**BELIEF:** "I don't know what Rock bottom is."

**ANSWER:** "I am your rock bottom."

**BELIEF:** "It's useless to force someone into treatment."

**ANSWER:** "I just want you to get help."

# THE USER'S FALSE BELIEFS

**BELIEF:** “Why try again, the last time didn't work.”

**ANSWER:** “What's different this time?”  
“What are you willing to do?”

Phase 1  
An ASSESSMENT  
An honest discussion with  
boundaries



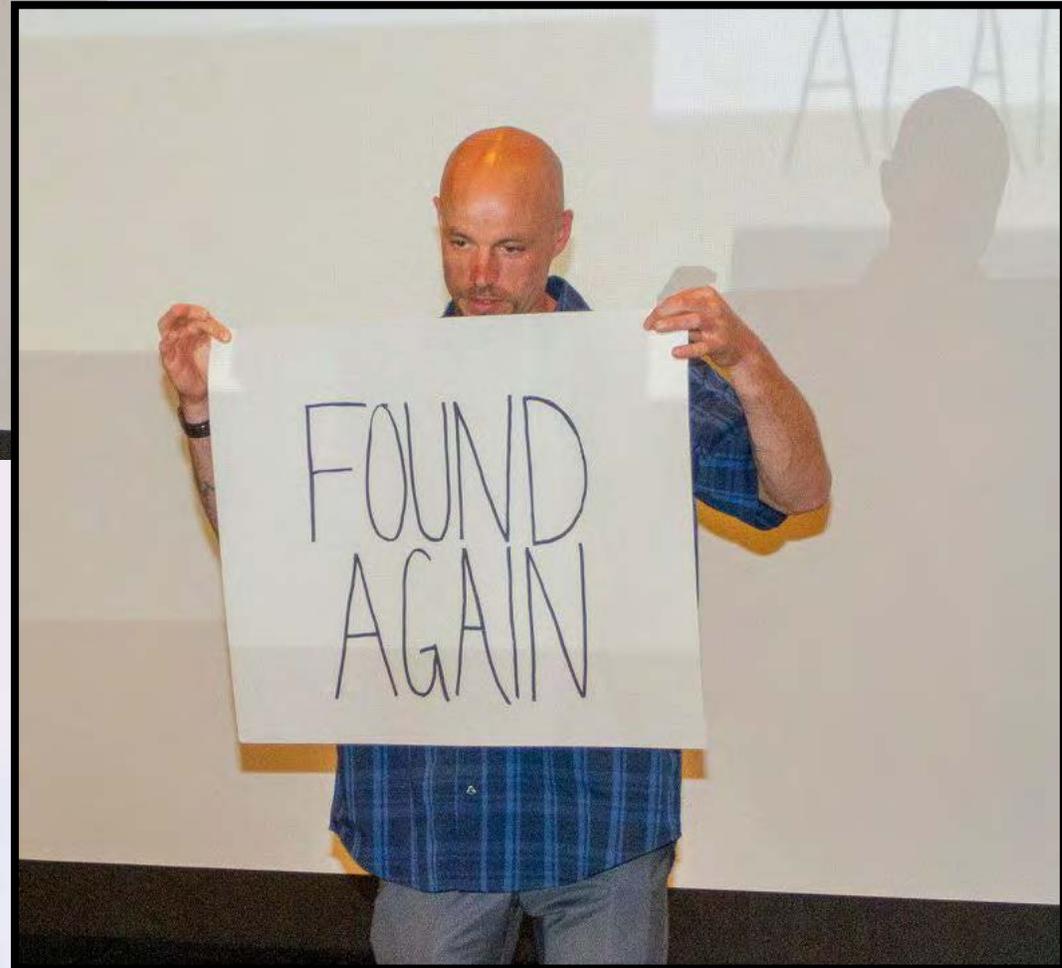
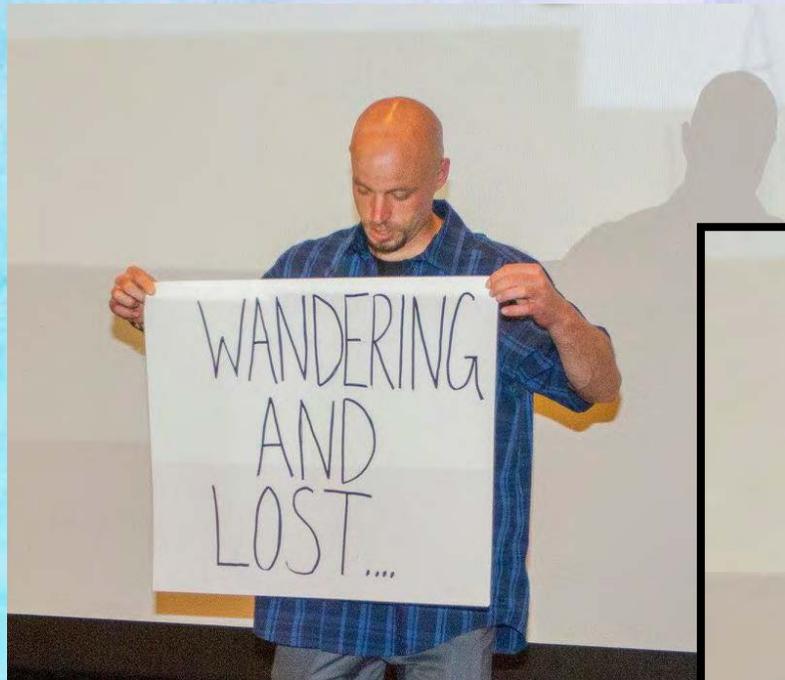
Phase 2  
TREATMENT  
OPTIONS  
An adjustable plan

Phase 3  
OUTSOURCING  
LEVELS OF CARE  
Medical needs  
Willingness  
Finances



JOSH

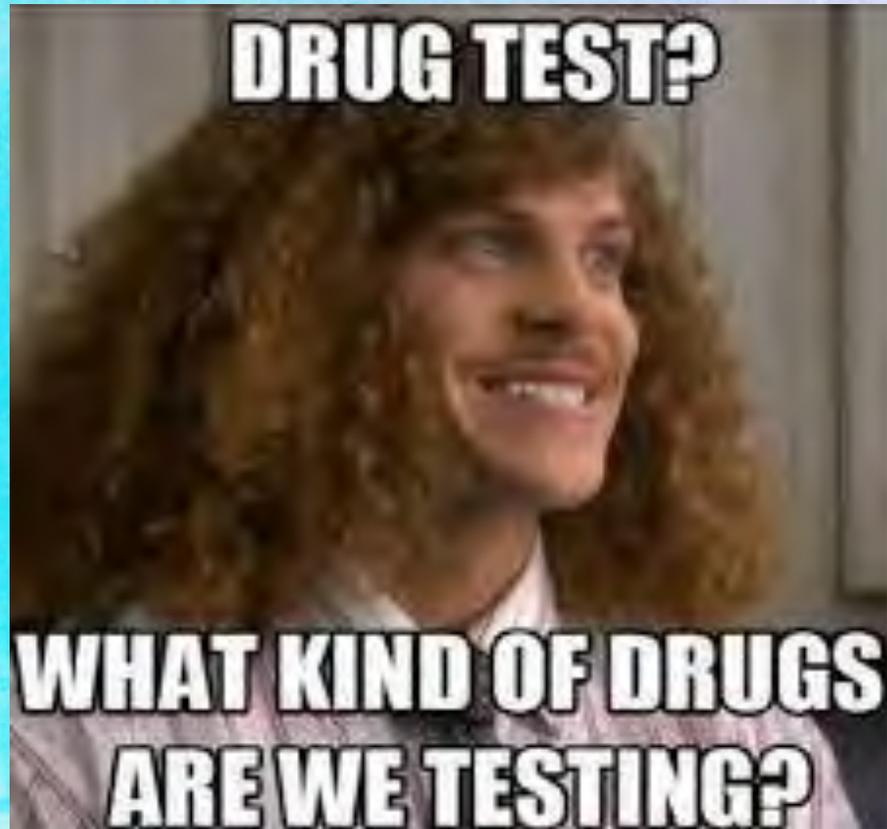
JOSH





## Lessons Parents learned:

- For every privilege, an added responsibility.
- Struggle produces growth.
- Let them fail.
- Let go.



## Lessons Parents learned:

- Change happens because they want it. You can't want it for them.
- They should pay their own way as soon as possible.
- Trust but verify. You keep your sanity with THE DRUG TEST!



**TOOL 6. CONSEQUENCES:**  
Maximize the  
consequences by playing  
out the tape to its logical  
conclusion

Me trying to  
jump over the  
obstacles in my  
life.



# COMMONALITIES

- A drive within their personality and birth order to balance out the family = homeostasis. . . .
- Emotional wounds, trauma may have affect personality

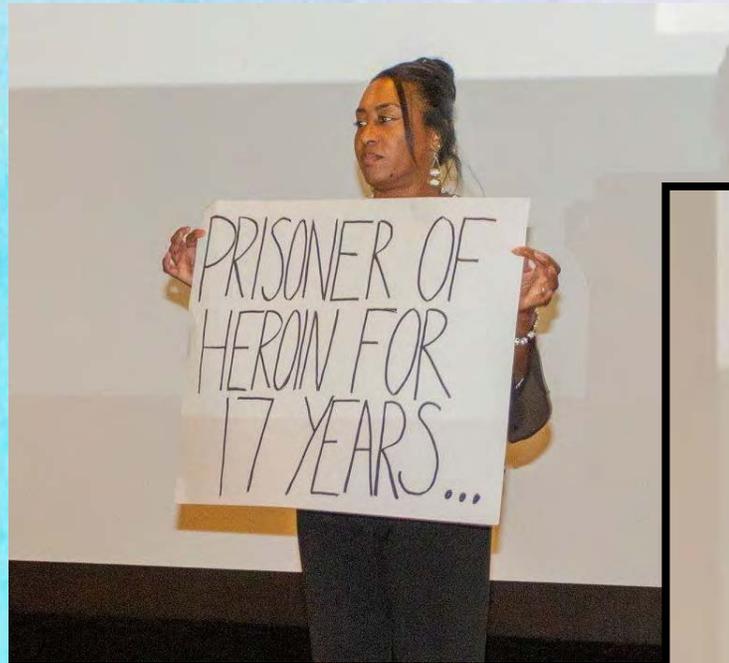
# COMMONALITIES

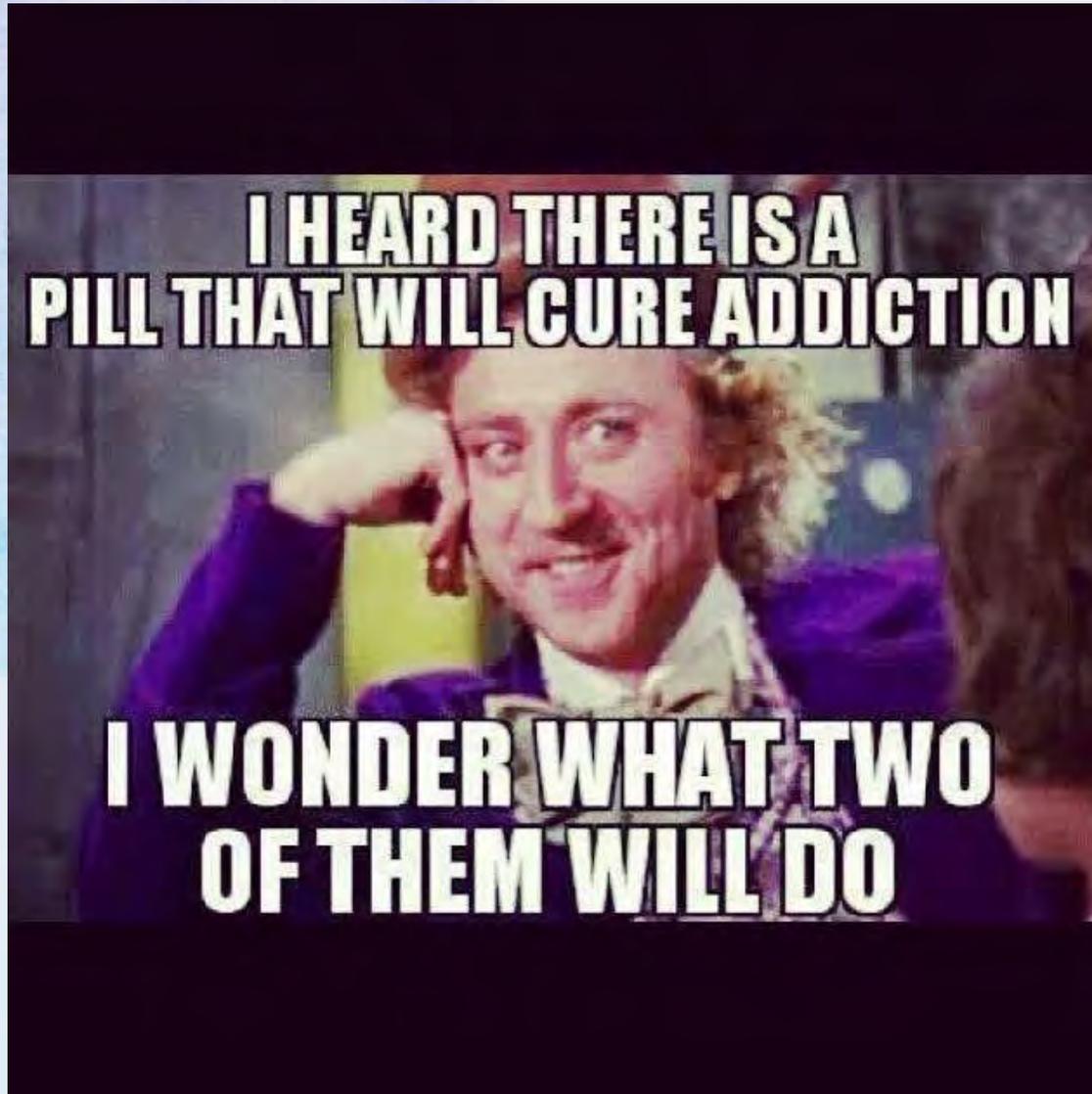
- The seeds of a life-long struggle are planted
- A codependent desire to do more for the addict than the addict will do for themselves

“I have been to rehab of one kind or another over 40 times!” M. still doing well 5 years later

MICHELLE

MICHELLE







## **TOOL 7. SOLUTIONS:** Focus on solutions and resources for each issue

# 100 Grateful Recovering Addicts Said . . .

What do you wish your parents had known?

- How their relationship impacted and fostered my self concept of inadequacy
- How lonely, anxious abandoned and overwhelmed I was from being left in charge.

- My feelings, That they needed to listen to me, and not minimize my emotions
- The effects of their divorce
- that they might have been a part of the problem

# 100 Grateful Recovering Addicts Said. . . What will you do differently?

- Not hang out with wrong people
- Spirituality! Give everything to God, Surrender
- Focus on self-growth/ prioritize self care
- Cultivate healthy relationships
- Forgive self and others



**87% OF PEOPLE CAN'T SEE WHAT'S  
WRONG WITH THIS PICTURE  
CAN YOU???**

*My Quidoo*

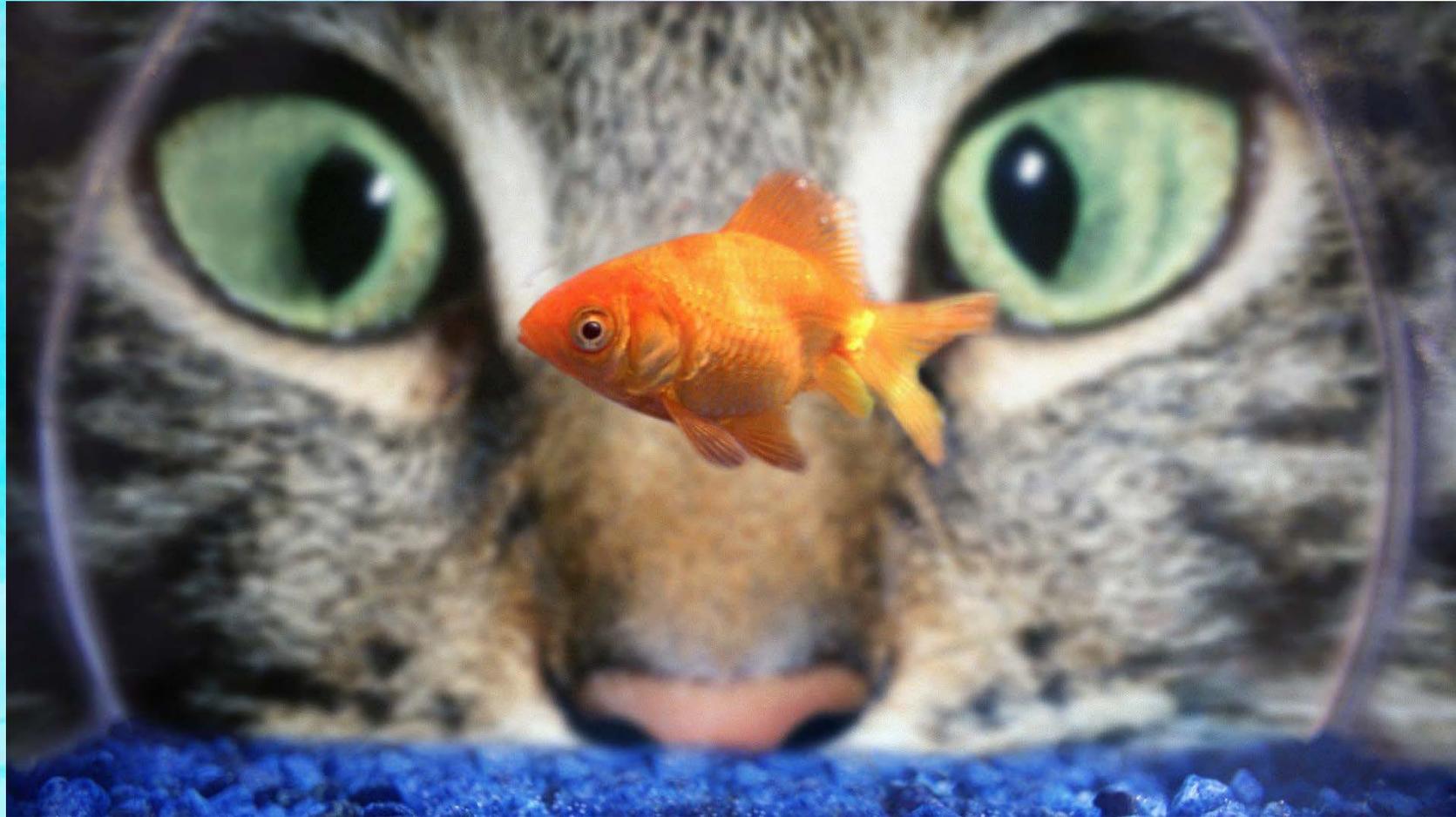
# CONCLUSIONS



- Avoid burnout with self-care
- Balance empathy and gatekeeping
- Employ non-adversarial approaches
- Education, treatment and partnerships
- Prevention is better than being reactive



**TOOL 8. OBSESSION:**  
Teach them to replace  
their obsession with a  
bigger, better obsession.



The person struggling with substance use disorder **MUST** find a bigger, better obsession!

# Questions that work.



1. **What's different** this time?
2. What will become your healthy, new obsession?
3. Who is on your recovery team?

JOHN

JOHN





# recovery **for life**

hope, help and healing



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**National Master Addictions Counselor**

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228 N. Lynnhaven Rd. Suite 118  
Virginia Beach, VA. 23452

p: (757) 456-0093 f: (757) 456-0875  
w: [myrecoveryforlife.com](http://myrecoveryforlife.com)  
e: [doctorpaul56@gmail.com](mailto:doctorpaul56@gmail.com)

JOHN

For more information

[doctorpaul56@gmail.com](mailto:doctorpaul56@gmail.com)

# RESOURCES

<http://youngadultcrisishotline.blogspot.com/>

[youngadultcrisishotline@comcast.net](mailto:youngadultcrisishotline@comcast.net)

<http://www.hopelinks.net/>

["Beautiful Boy," by David Sheff and "Tweak," by Nic Sheff.](#)

National Association of Pretrial Services Agencies ([www.napsa.org](http://www.napsa.org))

National TASC Conference ([www.nationaltasc.org](http://www.nationaltasc.org))

National Drug Court Institute ([www.ndci.org](http://www.ndci.org))

National Association of Drug Court Professionals ([www.nadcp.org](http://www.nadcp.org))

The National GAINS Center (<http://gainscenter.samhsa.gov>)

# RESOURCES

[HBO Addiction. HBO.org](#)

[NOT.org](#)

<http://abcnews.go.com/WN/tough-love-families-dealing-drug-addiction/story?id=9841591>

<http://www.ncadd.org/index.php/for-friends-and-family/signs-and-symptoms>

<http://www.narconon.org/drug-abuse/rules/>

<http://www.hazeldenbettyford.org/articles/when-loved-one-is-addicted>

[14 Rules You Must Never Break When Dealing with an Addict.](#)

[http://www.narconon.org/drug-abuse/rules/.](http://www.narconon.org/drug-abuse/rules/)

# RESOURCES

Schlesinger, S. E (1988). Cognitive-behavioral approaches to family treatment of addictions. In N. Epstein, S. E. Schlesinger, & W. Dryden (Eds.),

Cognitive-behavioral therapy with families (pp. 254-291). New York; Brunncr/Mazel.

Schlesinger, S. E, & Horbeig, L. K. (1988). Taking charge: How families can climb out of the chaos of addiction... and flourish. New York: Fireside Books/Simon and Schuster.

# RESOURCES

<http://foafamilies.org>

[www.CelebrateRecovery.com](http://www.CelebrateRecovery.com)

[Narcotics Anonymous \(N.A.\)](#)

[Cocaine Anonymous \(C.A.\)](#)

[Crystal Meth Anonymous \(C.M.A.\)](#)

[Marijuana Anonymous \(MA\)](#)

[www.myrecoveryforlife.com](http://www.myrecoveryforlife.com)

[www.Nar-anon.org](http://www.Nar-anon.org)

# Key Questions

1. What's wrong with people?
2. How can we help people change?
3. Why are 2/3 of the drugs in the world consumed in America?
4. What would YOU tell a 16 year old?
5. How can craving a favorite food be compared to addiction?
6. What situations often put young people at high risk for substance abuse?
7. Why and how does disconnection interact with addiction?
8. How can the subconscious mind be reprogrammed?
9. Describe how your solution to a problem became worse than the original problem.
10. What is the simplest solution to almost every addiction?



# Military Culture Competency and Transition Awareness

**Working with Servicemembers, Veterans &  
Families**

**Virginia Veteran and Family Support**



# Introductions

Why Is This Important?

How many of you served in the U.S. Military?

How many of you are immediate family members of someone who is or did serve in the U.S. Military?

How many of you have worked with a Servicemember, Veteran or family member in the last 90 days?



# Military Culture Competency

This training provides an overview of military culture to include organizational structure, rank, branches of service, core values, and demographics as well as similarities and differences between the Active and Reserve components, National Guard and Military Family awareness.

It also provides awareness of transition and reintegration needs for veterans and members of the National Guard and Armed Forces Reserves and their Families.



# Learning Objectives

- Describe the military organizational structure, rank, branches of service, core values, and demographics
- Identify differences between the Active and Reserve components and National Guard
- Identify characteristics of military transitions from active duty, deployment and reintegration to civilian life and the challenges that arise
- Identify best practices to enhance behavioral health, treatment options and resources for military servicemember veteran family (SMVF) in community settings
- Identify resources for SMVF, caregivers and providers
- Discuss the prevalence and characteristics of suicide among military service members, and veterans according to Federal and State data sources



# Military Active Duty Population

- 1,429,995 active duty members
- More than half of these are 25 years old or younger
- Approx. 54% are married
- Approx. 42% have children

Approx. 7% are single parents

- 7% of active duty are dual military couples
- Approximately 3 million troops have served in support of OIF/OEF/OND





# Federal Veteran Definition

What is a Veteran?

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



# Our Veteran Population

- 19,998,799 veterans in the U.S.
- 5.1 million are between ages of 25-50
- 5.2 million are between ages of 50-65
- 9.4% of veterans are women
- 7.2 million Gulf War Veterans



Source: National Center for Veterans Analysis and Statistics  
[www.va.gov/vetdata](http://www.va.gov/vetdata)



# Virginia Veterans

Total Veterans	Virginia has approximately 720,000 veterans
Population	Virginia currently has the 8 <sup>th</sup> largest veteran population in the nation, however by 2023, Virginia is projected to be ranked 5th
Young	Virginia ranks 5th in younger veterans (age 17 – 39) 33% of the Virginia veteran population is under the age of 50
Female	Virginia has the largest percentage of women veterans to total veterans, 14% (Nationally, females are 9% of the vet pop)

Source: National Center for Veterans Analysis and Statistics

[www.va.gov/vetdata](http://www.va.gov/vetdata)



## Demographics in the U.S. Military

Deployed around the world, the armed forces are a pillar of U.S. power and influence abroad

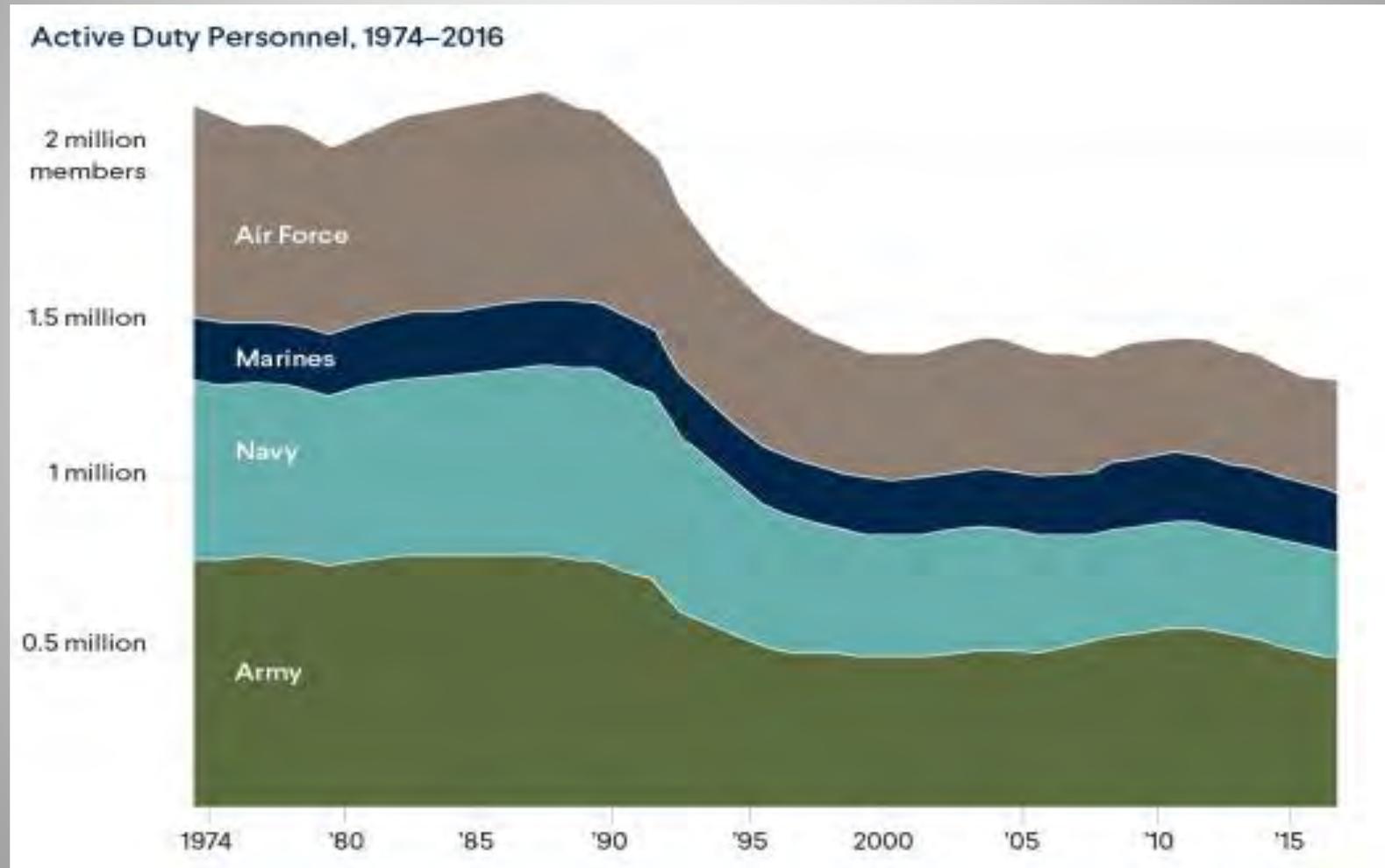
How much does the military resemble U.S. society at large?

1973 - The United States ended the draft for military service, transitioning to the all-volunteer force that exists today

At the time, the active component of the military comprised 2.2 million men and women, that's now under 1.2 million



## Active Duty Personnel 1974 - 2016





## 6 Facts About Diversity in the Military

- The Army remains the largest branch of the U.S. military.
- The active-duty force remains largely male-dominated, but women have made inroads in recent decades
- As the country has become more racially and ethnically diverse, so has the U.S. military
- The active-duty military has grown older in the past 40 years.
- Military officers have considerably higher levels of educational attainment, on average, than enlisted personnel and U.S. adults
- There is much more to the U.S. military than the active-duty force



*“The armed forces pride themselves on being leaders in diversity. In addition to providing equality, diversity gives the military more strength by ensuring that it reflects the very same population it’s called to defend.”*

*\* Dr. David S. Chu Former Undersecretary of Defense for Personnel and Readiness*



# Armed Forces Reserve

Performing duties one weekend per month, plus two weeks of training per year, members of the Reserves and National Guard are considered part-time



# Reserve Components

- 1.5 million in the Reserve Components
- Army, Navy, Air Force, Marine Corps, Coast Guard
- Reserve components are subordinated to the Federal government (four are Dept of Defense and one Dept of Homeland Security)





# Individual Ready Reserve

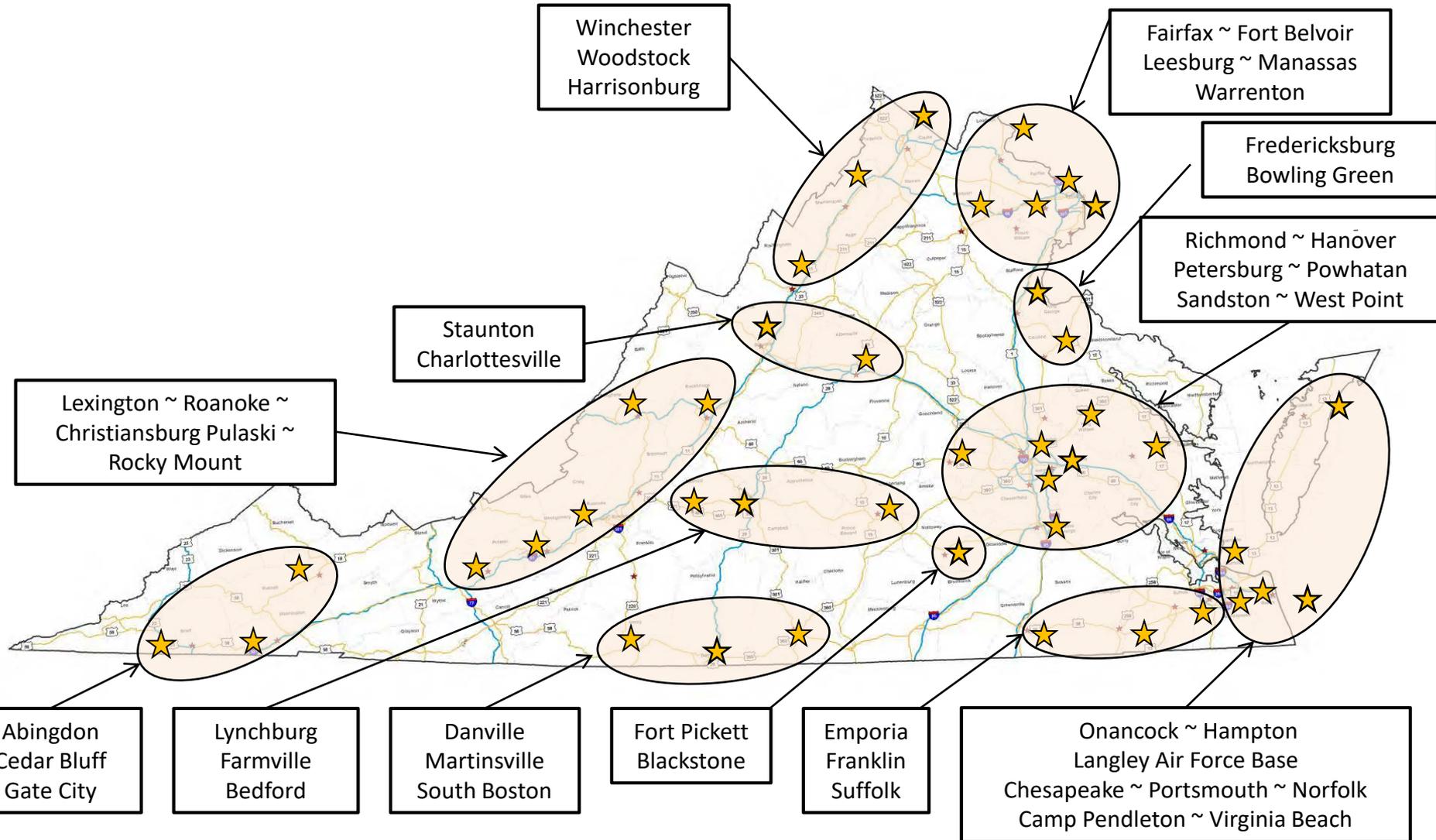
- IRR is a category of the **Ready Reserve** of the Reserve Component of the Armed Forces of the United States.
- Composed of former active duty or **reserve** military personnel
- All members of IRR may be subject to Recall





## Virginia National Guard (Army and Air)

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





# Activation of National Guard

- **Title 10** – President orders National Guard to active duty – can be voluntary or not, total amount of time can not exceed 365 days
- **Title 32** – Ordered by the Governor with the approval of the President – for various purposes including homeland defense, operational activities (airport security, riot control, natural disasters). Funded by the Federal government
- **State Active Duty** - Emergency response, ordered by the Governor





# Military Language

Similar to other cultures, the military (and each subculture within the military) has its own language and terms.

This “language” serves two important purposes:

1. It has a utilitarian function that makes communicating to other service members easier and more efficient
2. It helps to create an identity and sense of belonging for military members (an “us” and “them” so to speak).





## Military Lingo Quiz

“MOS” Occupation Specialty

“Chow” Food or Meal Time

“Squared Away” Taken Care of or Very Professional/Sharp

“In Theater” The Middle East

“Cover” Military Hat or to protect yourself



# Culture of the Military

- Abides by own set of rules and norms (UCMJ)
- Unique set of traditions – service specific
- Own language/Alphabet
- Organized hierarchy/rank structure
- Defined roles (Occupational Specialties)
- Consistency across units/organizations
- Command and Control Model
- Strong work ethic, accountability, personal responsibility
- Stoic, pride in being able to handle adversity
- Clearly-defined career progression





## Core Values

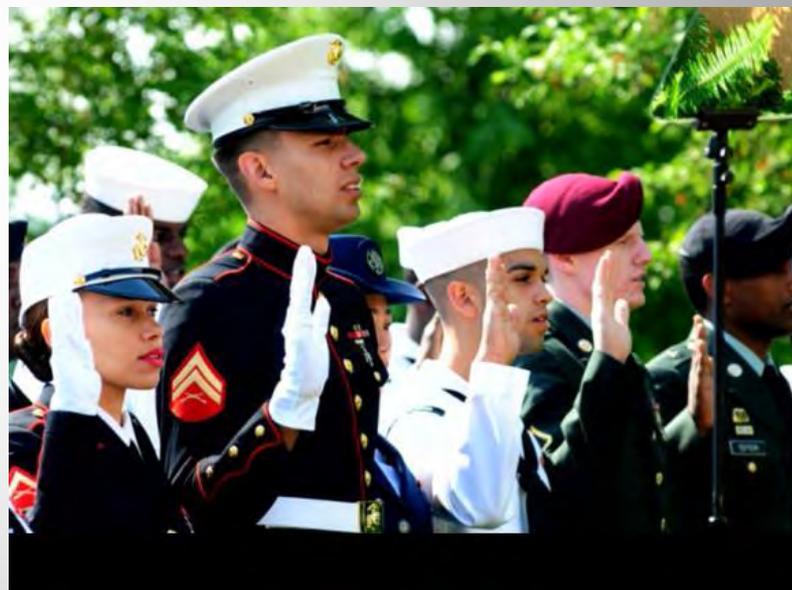
**USN:** *Honor, Courage, Commitment*

**USMC:** *Honor, Courage, Commitment*

**USAF:** *Service Before Self*

**USCG:** *Honor, Respect, and  
Devotion to Duty*

**USA:** *This We'll Defend*



***Duty, Honor, Country***



# Service Ethos



This is my rifle. There are many like it, but this one is mine. It is my life. I must master it as I must master my life. Without me my rifle is useless. Without my rifle, I am useless. I must fire my rifle true. I must shoot straighter than the enemy who is trying to kill me. I must shoot him before he shoots me. I will. My rifle and I know that what counts in war is not the rounds we fire, the noise of our burst, or the smoke we make. We know that it is the hits that count. We will hit.

My rifle is human, even as I am human, because it is my life. Thus, I will learn it as a brother. I will learn its weaknesses, its strengths, its parts, its accessories, its sights and its barrel. I will keep my rifle clean and ready, even as I am clean and ready. We will become part of each other.

Before God I swear this creed. My rifle and I are the defenders of my country. We are the masters of our enemy. We are the saviors of my life.

So be it, until victory is America's and there is no enemy.

## The Soldier's Creed

I am an American Soldier.

I am a Warrior and a member of a team.

I serve the people of the United States and live the Army Values.

**WARRIOR ETHOS**

- I will always place the mission first.*
- I will never accept defeat.*
- I will never quit.*
- I will never leave a fallen comrade.*

I am disciplined, physically and mentally tough, trained and proficient in my Warrior tasks and drills.

I always maintain my arms, my equipment and myself.

I am an expert and I am a professional.

I stand ready to deploy, engage, and destroy the enemies of the United States of America in close combat.

I am a guardian of freedom and the American way of life.

I am an American Soldier.





## Army - Soldier

- **Mission:** To fight and win our nation's wars with sustained land dominance across full-range of military operations
- **Oldest and largest branch; main ground force**
- Built to execute large-scale and long-term ground operations

[www.army.mil](http://www.army.mil)





## Navy - Sailor

- **Mission:** The mission of the Navy is to maintain, train and equip combat-ready Naval forces capable of winning wars, deterring aggression and maintaining freedom of the seas.
- **Second largest branch, main naval force**
- Provides naval security, ensures sea transport and allow for U.S force projection

[www.navy.mil](http://www.navy.mil)





## Air Force - Airman

- **Mission:** To fly, fight and win—in **air**, space and cyberspace. We are America's Airmen
- **Youngest branch**
- Controls air and space operations and is in charge of two-thirds of our nuclear triad

[www.af.mil](http://www.af.mil)





## Marine Corps - Marine

- **Mission:** Marines are trained, organized and equipped for offensive amphibious employment and as a "force in readiness."
- **A rapid deployment amphibious force. (Shorter but more deployments)**
- Particularly skilled in counterinsurgency, small unit tactics (Fallujah, 2004-05)

[www.marines.mil](http://www.marines.mil)





## Coast Guard – Coast Guardsman

- **Mission:** A multi-mission force: protection of U.S. coastlines, waterways and territorial seas, defense readiness, search and rescue, port security, aids to navigation, fisheries patrols, drug interdiction/law enforcement
- The oldest continuing seagoing service in the US and the only military service with arrest authority
- Operates under the Department of Homeland Security but can be transferred to the US Navy by the President in times of war

[www.uscg.mil](http://www.uscg.mil)





# Service Force Population



Since Jun 14,  
1775

**482,264**

Reserve:  
205K

National Guard:  
358K



Since Oct 13,  
1775

**328,162**

Reserve:  
108K



Since Sep 18,  
1947

**310,996**

Reserve:  
71K

National Guard:  
106K



Since Nov 10,  
1775

**328,162**

Reserve:  
108K



Since Aug 4,  
1790

**39,639**

Reserve:  
8,100K



# Rank Structure



## Enlisted

“E”

- An enlisted member is one who has joined the military or "enlisted." A minimum of a high school diploma is required. Paygrades E-1 through E-9

## Non-Commissioned Officer

“NCO”

- An NCO is an enlisted member-rank of **officer** through promotion. NCOs serve as the link between enlisted personnel and commissioned officers. They hold responsibility for training troops to execute missions. Training for NCOs includes leadership, management, specific skills, and combat training. Paygrades E-4/E-5 through E-6/E-9

## Warrant

“W” or “CWO”

- A warrant officer is a highly trained specialist. One must be an enlisted member with several years of experience, be recommended by his or her commander, and pass a selection board to become a warrant officer. Paygrades W1 through W5

## Officer

“O”

- A commissioned officer's primary function is to provide management and leadership in his or her area of responsibility. Requires a bachelor's degree and later, as one progresses through the ranks, a master's degree for promotions. Specific commissioning programs exist (e.g., military academies, Officer Candidate Schools, and Reserve Officer Training Corps [ROTC]). Paygrades O-1 through O-10



<b>Military Rank to Civilian Job Translation</b>	
Officer: O5-O7	CEO, COO, Administrator
Officer: O4	Operations Manager, Vice President
Officer: O1-O3	Project Manager, Director, Supervisor
Commander	Program Manager, Senior Director
Enlisted: Warrant Officer	Senior Technician, Technical Advisor
Enlisted: Senior NCO (E7-E9)	Technical Advisor, Division Supervisor
Enlisted: NCO (E5-E6)	Manager, Foreman, Technical Supervisor
Enlisted: (E1-E4)	Assembler, Specialist, Technician
First Sergeant	Group Supervisor
NCOIC	Supervisor, Senior Technician
Platoon Sergeant	First Line Supervisor



# Normal Stressors of Military Life

## Frequent Moves:

For children: changing schools, loss of friends, new routines

For spouses: job change, periods of un/under-employment, search for new doctors, loss of friends



**Separation Due to Deployments:** spouse becomes single parent, children- loss of parent, uncertainty, worry.

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

**Limited Support System:** separation from extended family, constant loss of friends





## OIF/OEF/OND Conflicts

Operation Iraqi Freedom	Feb. 2003 – Sept. 2010
Operation New Dawn	Sept. 2010 – Dec. 2011
Operation Enduring Freedom	Oct. 2001 – Dec. 2014

- **52,010** U.S. service members wounded in hostile action since the beginning of OIF and over **6,809** service members have been killed in Iraq and Afghanistan
- Approx. **600,000** NG and Reservists have deployed since the beginning of U.S. military operations in Iraq



## Characteristics of OIF/OEF/OND and Differences from Past Conflicts

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



# Additional Stressors of Combat

Combat Stress: transitional period before and after combat deployments

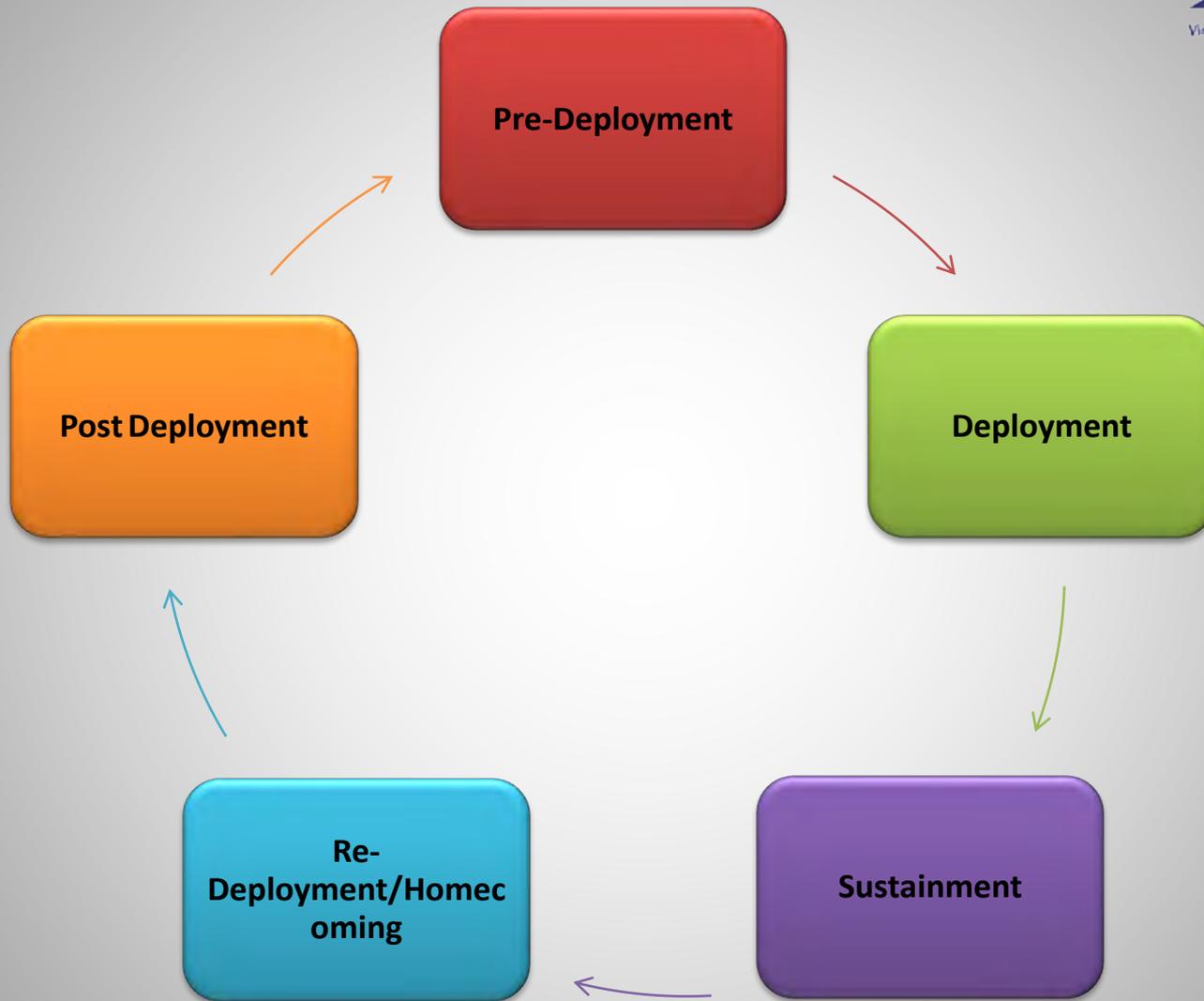
For Guard and Reserves: changes in monthly income, employment concerns, unemployment

Serious Injuries: long lasting impact, some leading to medical discharge

Cycle of Deployment: Pre-deployment, deployment, sustainment, re-deployment, post-deployment



# Emotional Cycle of Deployment





# Everyone is changed by war





# Moving from this....





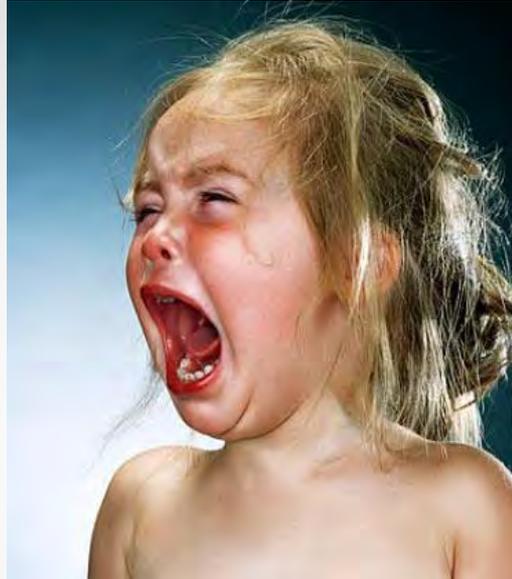








# To This:





# The Process of Transition for Military

- Often more challenging for members of the Guard and Reserves
- Transition Challenges:
  - family life
  - work/work life
  - daily pace and/or routine
  - environmental factors
  - finances





## Stressors of Separation from Military Life

- Finding a new identity
- Forming a new support group
- Choosing a permanent home
- Healthcare
- Employment
- Residual impact of military lifestyle on veteran and family members





# Struggles in Transitioning Combat Veterans

- Loss of identity/purpose (“I was a soldier”)
- Survivors guilt
- The trauma of killing: moral injury
  - A. “I still don’t know” (if he was an insurgent)
  - B. “Knowing” (Who appeared to be threats were killed)
  - C. Collateral damage
- RISKS OF HELP SEEKING





# The Paradox of Coming Home

*“Honeymoon period”: a few hours to a few weeks.*

Changing combat zone responses to appropriate responses in civilian community.

*Reference: Resiliency (previously Battlemind) link for training for mental health providers <https://www.rto.wrair.army.mil/bhr.html>*

# VIDEO

[https://www.youtube.com/watch?v=q\\_zX1uhW4Bw](https://www.youtube.com/watch?v=q_zX1uhW4Bw)



# Readjustment to Family Life

- Difficulty communicating
  - Unsure what to share about their deployment/or can't share at all
  - Lack of sensitivity toward partner
  - Minimizing partner's stressors and challenges

Irritability and anger

Emotional numbing

Intimate partner violence

Intimacy issues

Role changes

Instant marriages prior to deployment



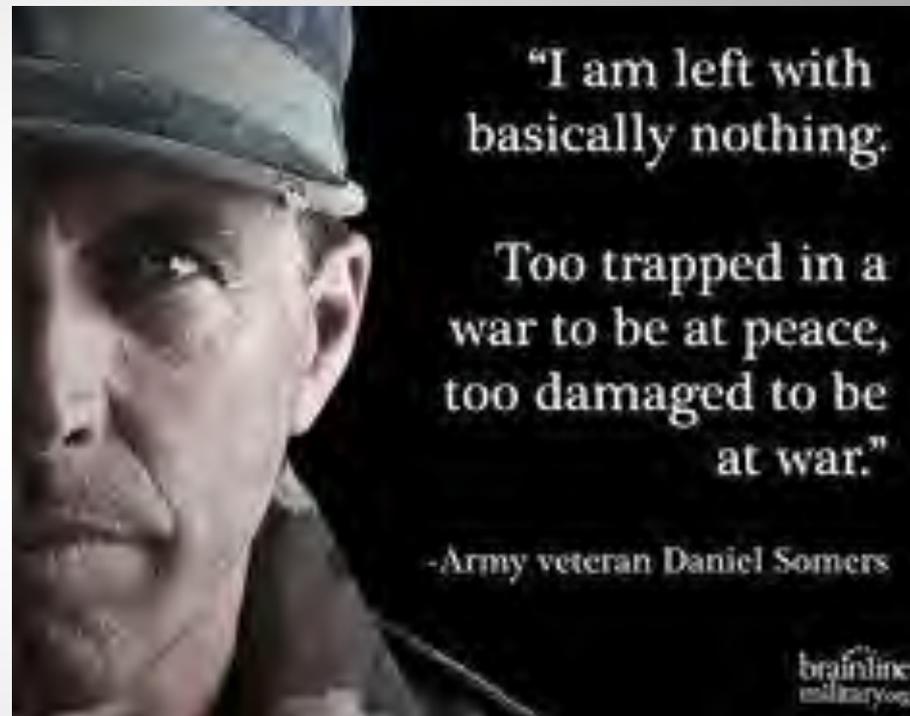
## Common Transition/Adjustment Responses

- Feeling irritable, jumpy or sometimes numb
- Becoming easily annoyed or frustrated
- Feeling disconnected from friends and family
- Experiencing sadness or guilt
- Sleeping too much or too little
- Being uncomfortable with physical or emotional intimacy
- Having intrusive thoughts, flashbacks or nightmares
- Having trouble concentrating or remembering



## Problems which Persist

- PTSD
- TBI
- Anxiety/Depression
- Substance Abuse





## Post Traumatic Stress

- Different from Combat Stress
- Now classified as a “trauma and stressor-related disorder” (DSM V) that occurs after exposure to a traumatic or stressful event



# PTSD

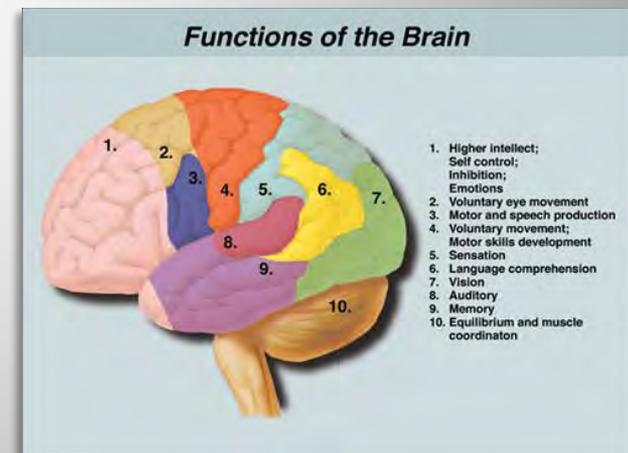
“A Normal Reaction to an  
Abnormal Situation”



# Our Primitive Brain

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

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





## Notable Differences Between Military and most Civilian PTSD

- Trauma reoccurs over months or years (e.g. handling body parts every day, being under fire on a regular basis, repeat deployments)
- Experience is impacted by unit support, command and leadership and national support
- Service members often see themselves as perpetrators



## PTSD by the Numbers

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

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

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

\* *From the National Center for PTSD*



# Treatment for PTSD

**Focus on symptom relief:** Sleep patterns and mood, confronting fears, understanding emotional responses to traumatic events

Treatment will reduce distress associated with memories and quell physiological reactions

## Types of treatment include:

- **Prolonged Exposure Therapy-** processing traumatic memories and thoughts through repetition reduces their power and impact
- **Cognitive Processing Therapy-** examines irrational thought
- **Eye Movement Desensitization Reprocessing (EMDR)**
- **Interpersonal Therapy-** relationship repair
- **Non-traditional therapies** - with or without other clinical treatments



# Traumatic Brain Injury

**TBI is a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain**

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

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

Mild TBI is most prevalent





## Combat Traumatic Brain Injury

- Closed brain injuries – most common
- May not exhibit physical wounds
- Many will not report the incident



# PTSD and Traumatic Brain Injury Symptoms

**IMPACT ON COGNITION AND MEMORY**

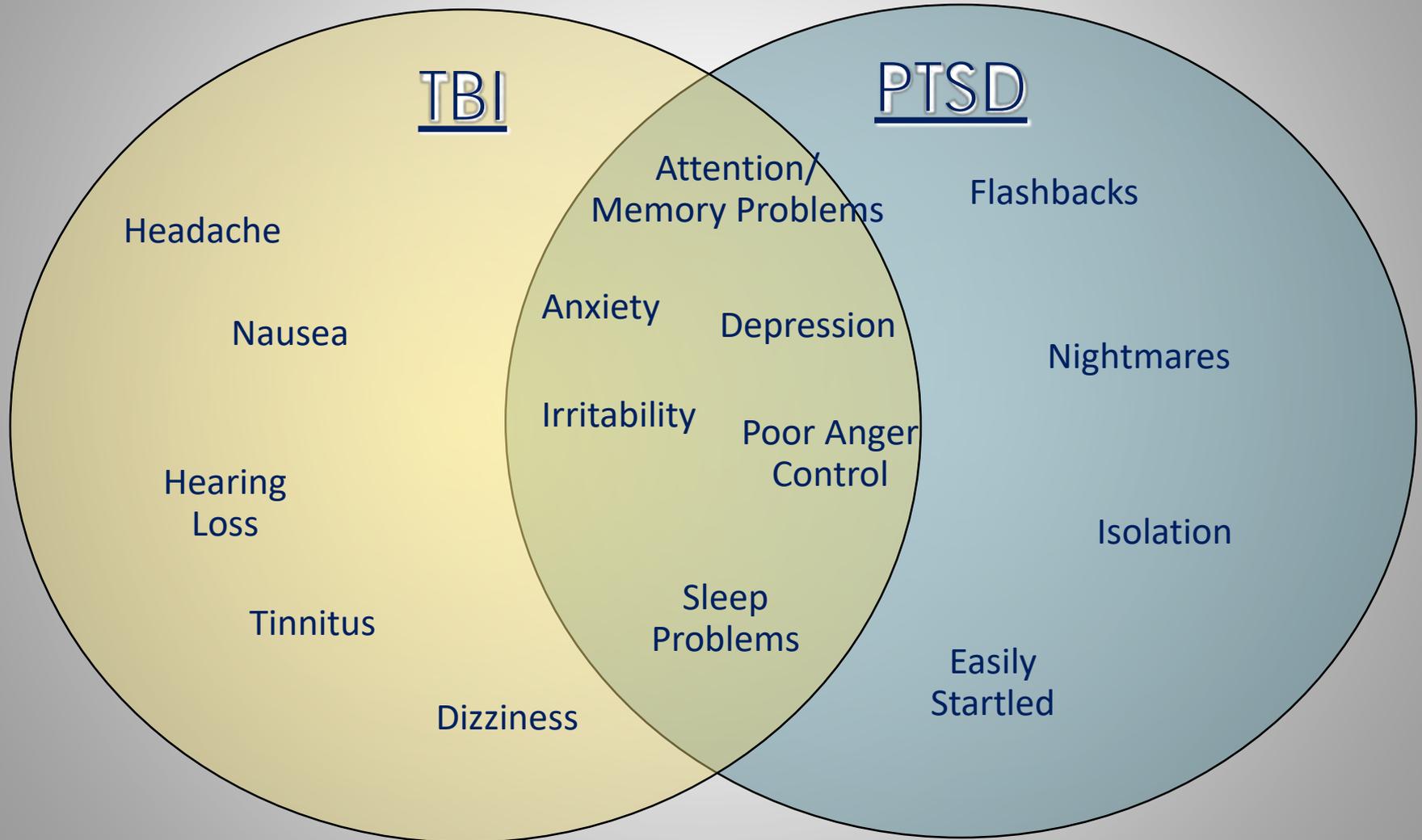
**IMPACT ON EMOTION**

**IMPACT ON BEHAVIOR**





# PTSD/TBI Symptom Overlap





# Common Coping Mechanisms for Veterans with Combat Stress, PTSD and TBI

- Alcohol abuse
- Weapons security or perimeter control at home
- Isolation
- Issues in the home, intimate partner violence
- High adrenaline risk behavior (speeding, etc.)
- Overspending



## Military Sexual Trauma (MST)

- “Sexual assault or repeated, unsolicited, threatening acts of sexual harassment that occurred while a veteran was serving on active duty or active duty for training”
- 1 in 5 female veterans
- 1 in 100 male veterans



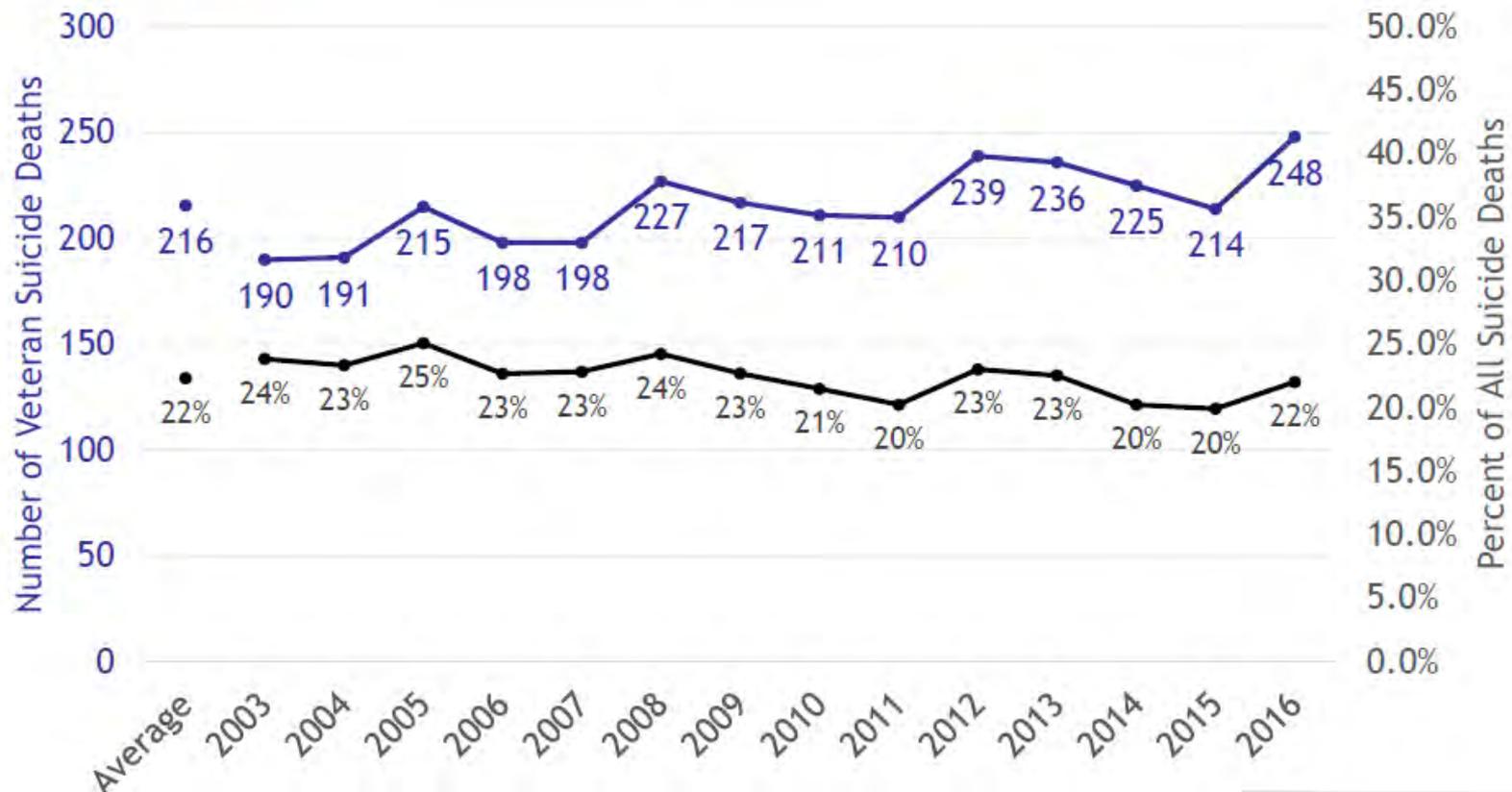


# Suicide and 2016 Virginia Highlights

- Largest increase in veteran suicide deaths since Virginia Violent Death Reporting System (VVDRS) started
- There were 286 violent deaths of veterans in Virginia. 86% were suicide deaths
- Veteran decedents were 3 times more likely to have a Post Traumatic Stress Disorder (PTSD) diagnosis
- Among veterans ages 25-34, 33% of whom had a mental health diagnosis also had PTSD
- Abuse of alcohol alone was twice as frequent among veteran suicide decedents.



# Number of Veteran Suicide Deaths by Year: Virginia





# Suggestions For Working With Veterans

- Connect the service member with other veterans - help them develop a peer support network
- Be Military Culture Competent
- Differentiating between transition and military operational stress and PTSD and where to refer if needed
- Do not share your personal views on war or politics –ACTIVELY listen to the veterans needs
- Focus on transition and ongoing re-integration – structure may be best
- Consider loss of identity/purpose (“I was a Soldier/Marine”)
- Refer to support services/organizations



# Suggestions For Working With Combat Veterans

- Avoid use of diagnostic labeling early on (i.e. “you may have PTSD”)
- Do not say you understand what they have experienced unless you have experienced combat or military yourself
- Involve the veteran’s primary support system
- Long term- recognize importance in discussing grief and survivors guilt and the impact of experiences on the veteran’s spirituality and belief system
- Refer to other professionals as appropriate



# Strengths Resulting From Military Service

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



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



# Resources

DVS--Virginia Veteran and Family Support [www.dvs.virginia.gov](http://www.dvs.virginia.gov)

National Resource Directory [www.nationalresourcedirectory.gov](http://www.nationalresourcedirectory.gov)

Defense Centers of Excellence for

Psychological Health & Traumatic Brain Injury [www.health.mil/dcoe.aspx](http://www.health.mil/dcoe.aspx)

Defense and Veterans Brain Injury Center [www.dvbic.org](http://www.dvbic.org)

Department of Veterans Affairs [www.va.gov](http://www.va.gov)

DoD Disabled Veterans [www.dodvets.com](http://www.dodvets.com)

Vocational Rehab/Employment [www.vetsuccess.gov](http://www.vetsuccess.gov)

Center for Deployment Psychology <http://deploymentpsych.org/military-culture-course-modules>

National Center for PTSD [www.ptsd.va.gov](http://www.ptsd.va.gov)

VetsPrevail <https://www.vetsprevail.org/>



# Questions?

Leanna Craig, Region Director

Virginia Department of Veterans Services  
Virginia Veteran and Family Support

C: 540.556.9112

[Leanna.Craig@dvs.Virginia.gov](mailto:Leanna.Craig@dvs.Virginia.gov)



# **From the Green Cloud**

**marijuana's effect  
on treatment issues**

**Dr. Paul Hardy  
CSAC, NMAC**

**Rarely has there been such a divide between science and public opinion as there is with medicinal and recreational use of marijuana.**

**What public perception changes have we noticed in Virginia concerning marijuana since states began legalizing it in 2012?**



**Students and our society tend to  
“rank” substances by  
seriousness**

**Heroin**



**Students tend to “rank”  
substances by seriousness**

**Heroin  
Meth**



**Students tend to “rank”  
substances by seriousness**

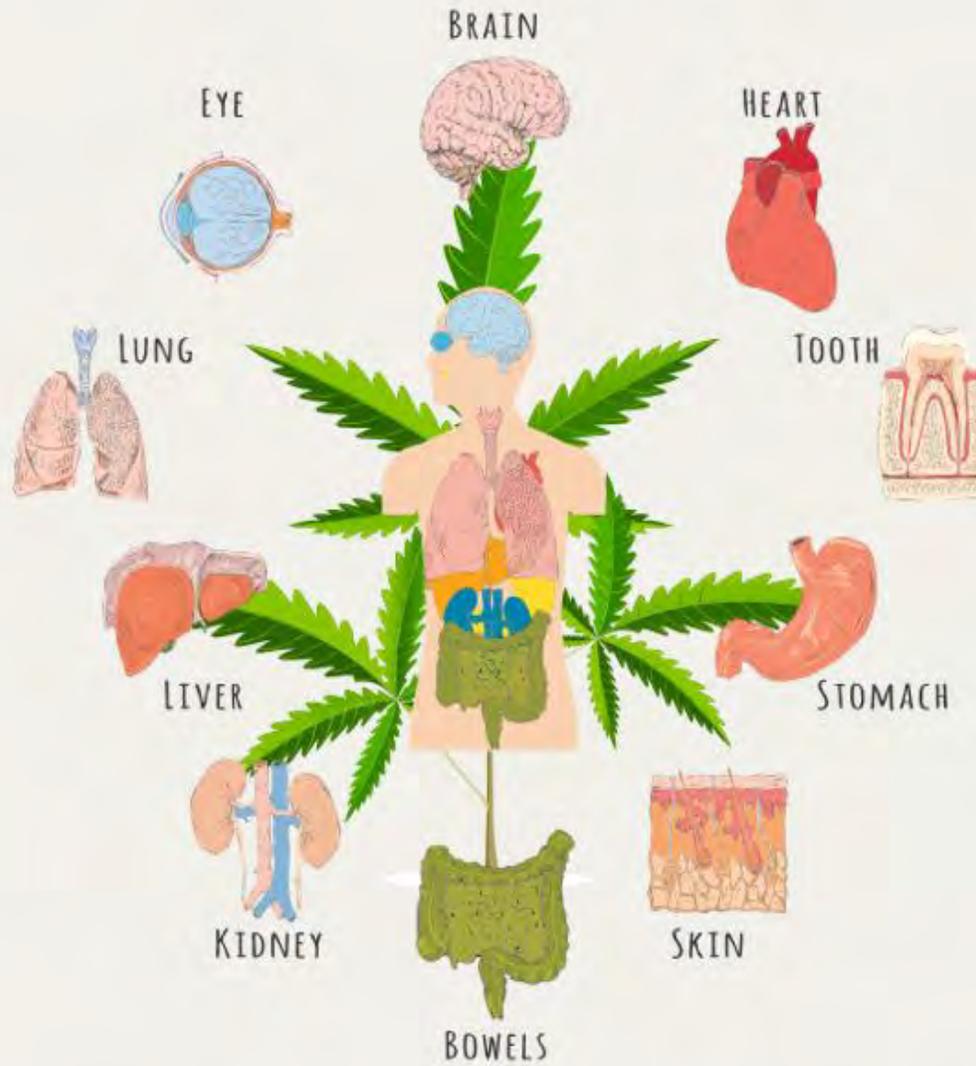
**Heroin  
Meth  
Cocaine**



**Students tend to “rank”  
substances by seriousness**

**Heroin**  
**Meth**  
**Cocaine**  
**Marijuana**

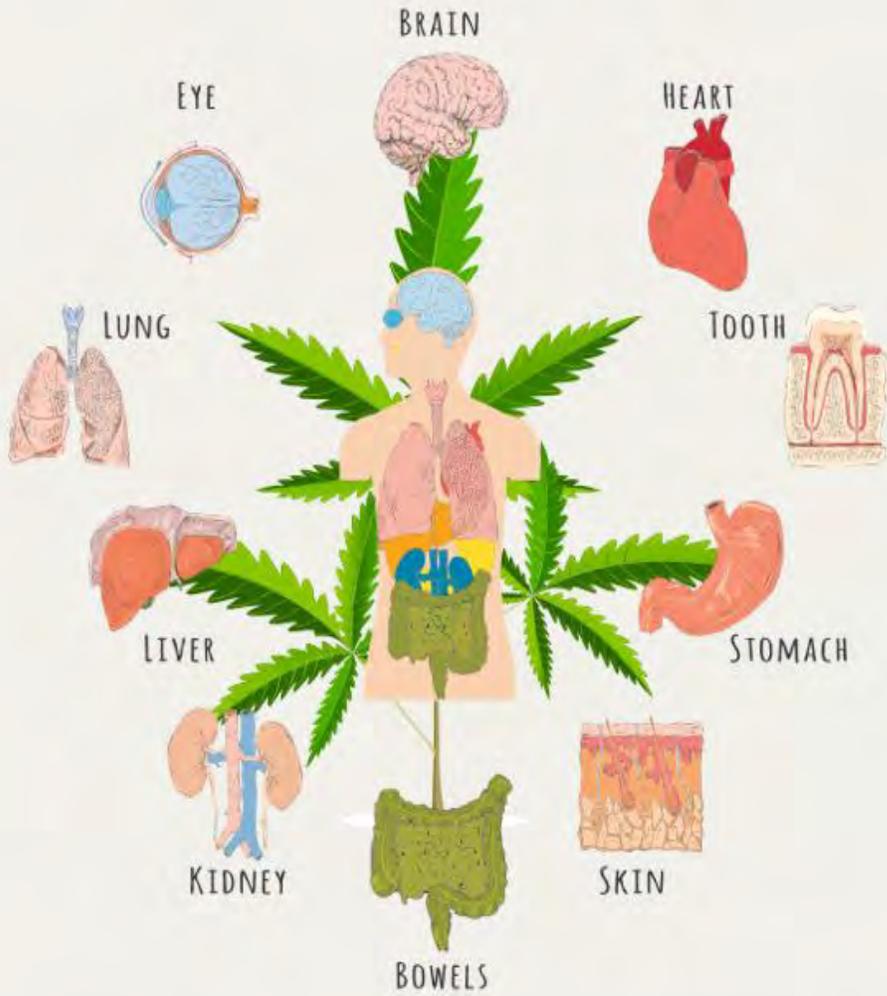




# ENDOCANNABINOID SYSTEM

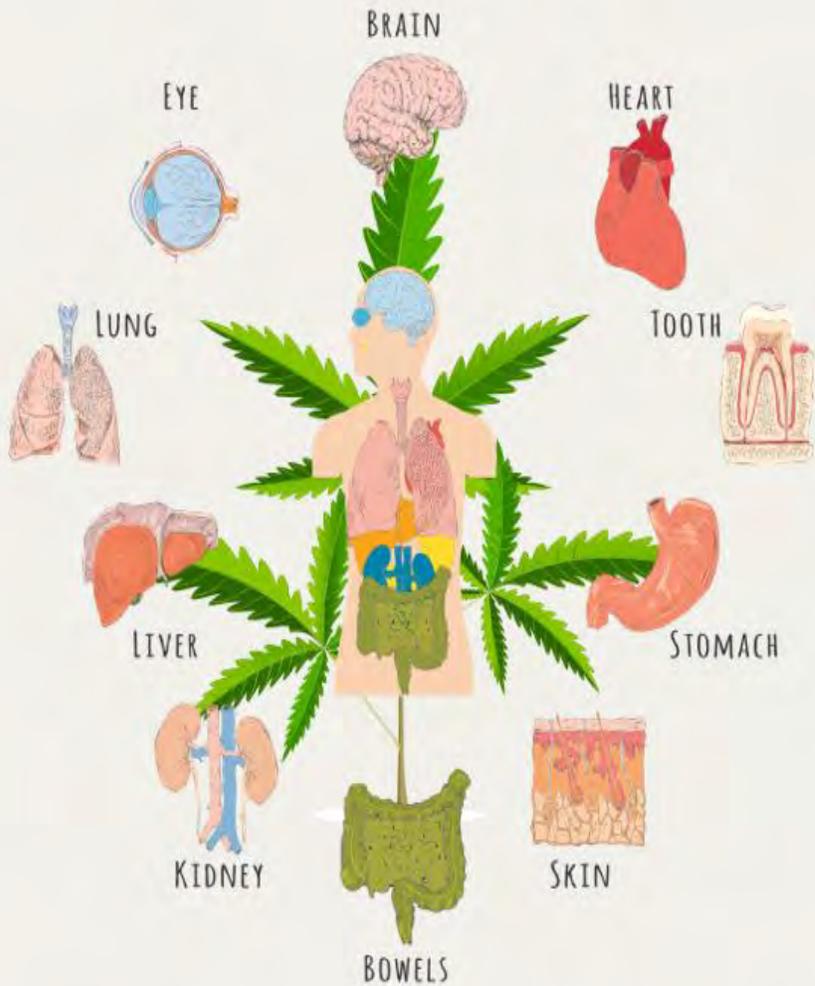


<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3303140/>

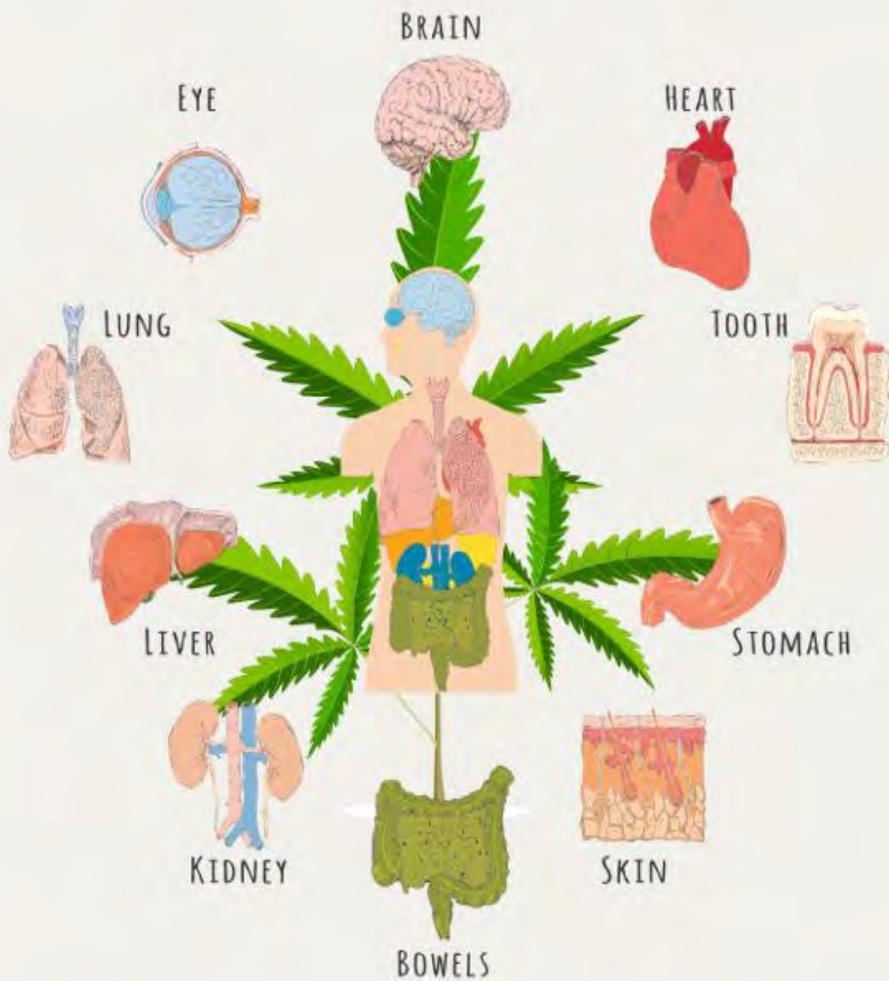


# WHAT IS THE ENDOCANNABINOID SYSTEM?

In 1964, researchers in Israel discovered the therapeutically active substances in cannabis that have come to be called cannabinoids and isolated the most popular and possibly effective cannabinoid, THC (tetrahydrocannabinol). More than 20 years later, in 1988, researchers identified the human body's endocannabinoid system.



Endocannabinoids are the special molecules naturally produced in the human body that are closely related to proper functioning of the immune system and nervous system and that are mimicked by the cannabinoids found in the cannabis plant. Cannabinoids contained in cannabis, referred to as phytocannabinoids, simply imitate endocannabinoids. Cannabinoids fit perfectly into specialized receptors found throughout the nervous and immune systems, serving to enhance, or improve upon, the body's own ability to maintain homeostasis (balance) and health.



# THE ROLE OF RECEPTORS

Research since the discovery of the endocannabinoid system has led to the identification of specialized receptors in the body. Knowledge of these receptors, called CB1 and CB2, has greatly enhanced the overall knowledge of how cannabinoids synergistically interact with other cannabinoids and endocannabinoids to produce sometimes profound medical effects. An understanding of these receptors also allows for the production of synthetic cannabinoids and specialized extracts that best take advantage of the function of these receptors.

**I DON'T KNOW WHAT  
HAPPENED TO YOUR WEED**



**BY THE WAY, YOU'RE  
OUT OF PRINGLES**

weed memes

**Why is a roach clip  
called a "roach  
clip?"**

**Because pot holder  
was already taken**

# **Marijuana is addicting**

## **true or false?**

National Institute on Drug Abuse. Drug Facts: Marijuana; 2012. Available at: [http://www.drugabuse.gov/sites/default/files/marijuana\\_0\\_0.pdf](http://www.drugabuse.gov/sites/default/files/marijuana_0_0.pdf)

**cannabis dependence  
disorder affects around  
1 in 10 users.**

<https://www.leafscience.com/2017/10/06/is-marijuana-addictive/>

**Cannabis use disorder,  
“continued use despite clinically  
significant impairment, ranging  
from mild to severe,” **DSM-5****

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5. Arlington, VA: American Psychiatric Publishing.

<https://www.leafscience.com/2017/10/06/is-marijuana-addictive/>

**everyone who uses cannabis  
will become addicted.**

**true or false**

<https://www.leafscience.com/2017/10/06/is-marijuana-addictive/>

**marijuana effects perception  
and judgment and is  
associated with low  
achievement.**

**true or false**

Drugs.com. (2015). Marijuana.

**for most teens who enter  
treatment, marijuana is the  
main or only drug they use.**

**true or false?**

Room, R. et al. (2010). Cannabis Policy: Moving Beyond  
Stalemate. Oxford, UK: Oxford University Press.

**Teens who identify other  
drugs as their primary drug  
of choice often say they use  
marijuana too.**

**true or false?**

Washington State Tobacco, Alcohol and Other Drug Trends  
Report, (2012).

**Marijuana addiction is more common among teens than adults because their brains are still developing and vulnerable.**

**true or false?**

Partnership Attitude Tracking Study (PATs) Sponsored by MetLife Foundation.; 2012. Available at: <http://www.drugfree.org/wp-content/uploads/2013/04/PATS-2012-FULL-REPORT2.pdf>.

**Some teens make the mistake of believing that marijuana can help reduce issues with ADHD or anxiety, and improve their focus in school without issues.**

**true or false?**

Casey BJ, Jones RM, Hare TA. The adolescent brain. Ann. N. Y. Acad. Sci. 2008;1124:111–126.

**adolescents who use  
marijuana can have serious  
resulting issues**

**true or false?**

Casey BJ, Jones RM, Hare TA. The adolescent brain. *Ann. N. Y. Acad. Sci.* 2008;1124:111–126.

**I JUST SAVED 100% ON STRESS**



**BY SWITCHING TO CANNABIS**

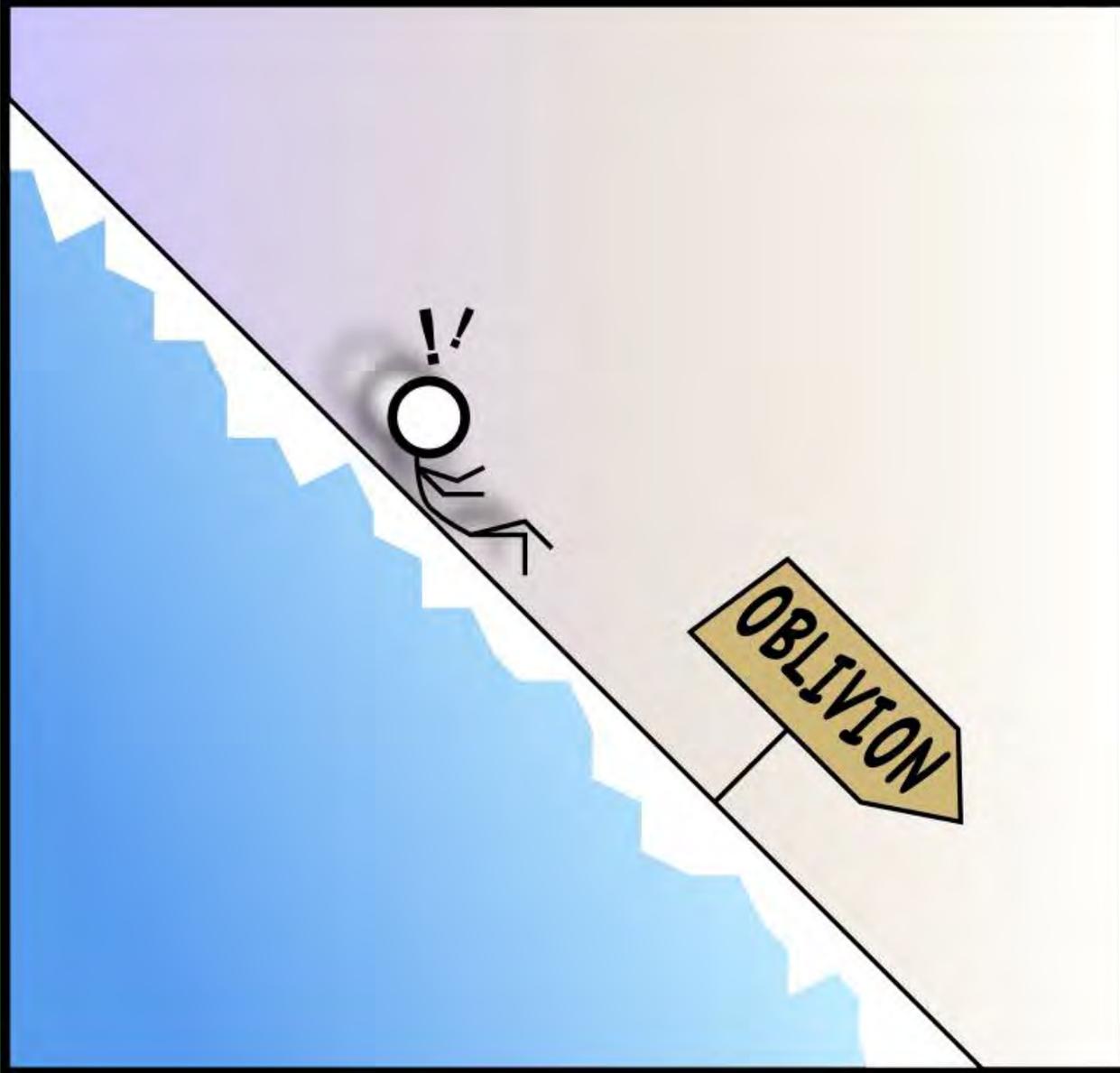
# **THE SLIPPERY SLOPE**

**you like how  
it makes you  
feel**

# **THE SLIPPERY SLOPE**

**- you keep using it**



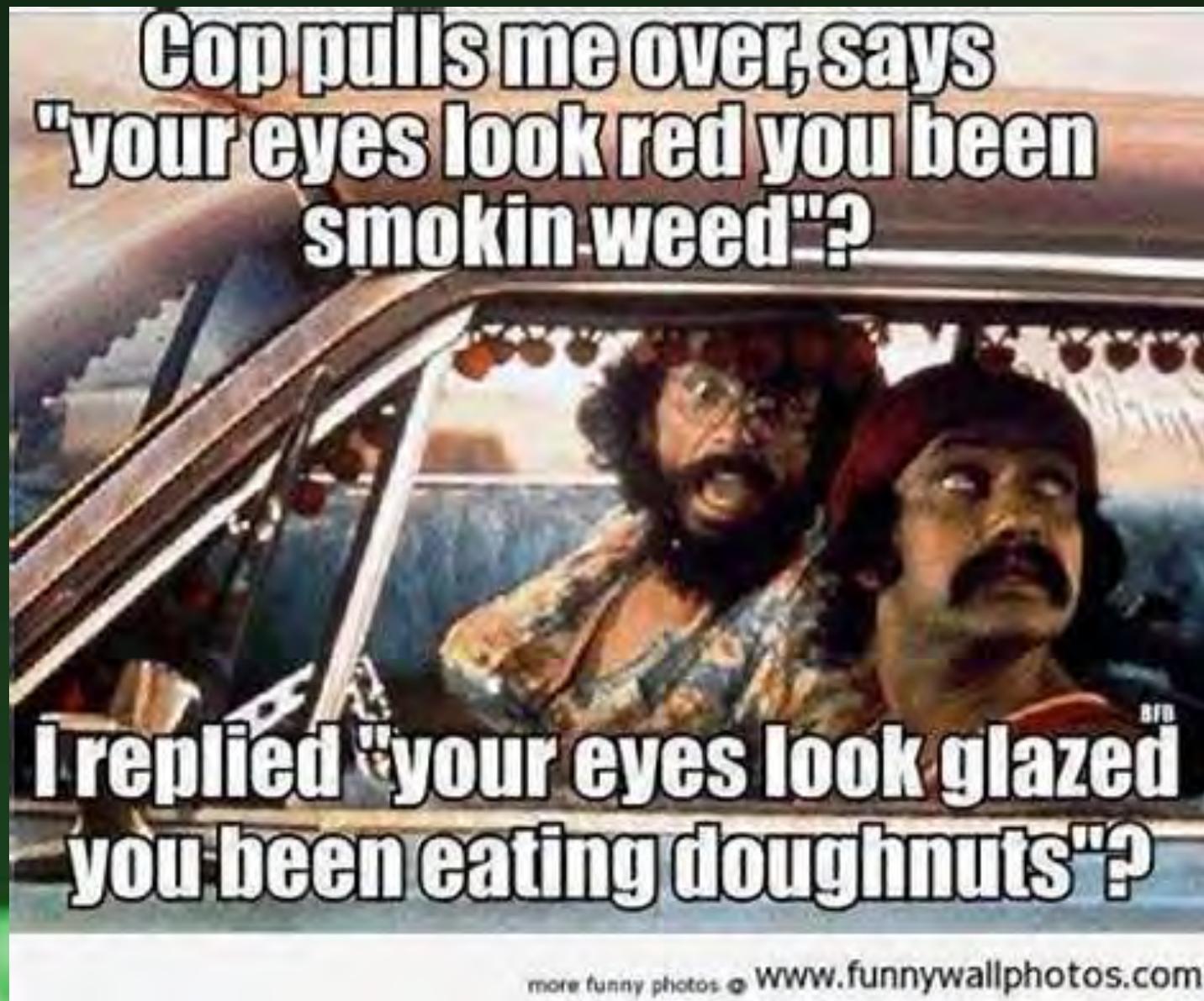


# THE SLIPPERY SLOPE

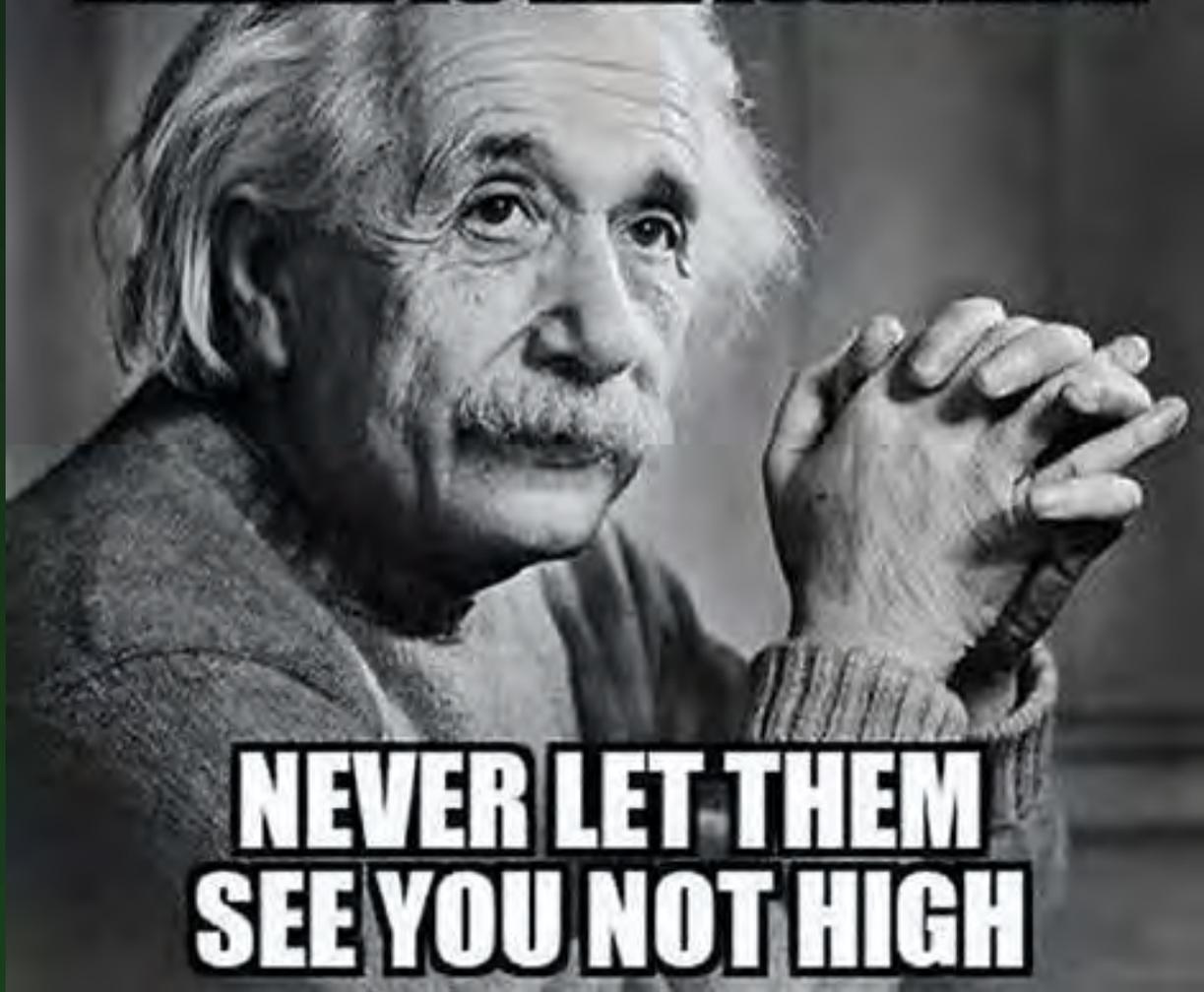
you think you  
can stop any  
time

# THE SLIPPERY SLOPE

- the longer  
you use, the  
harder it is to  
stop



**IF YOU DON'T WANT PEOPLE TO  
BE ABLE TO TELL YOUR HIGH**



**NEVER LET THEM  
SEE YOU NOT HIGH**

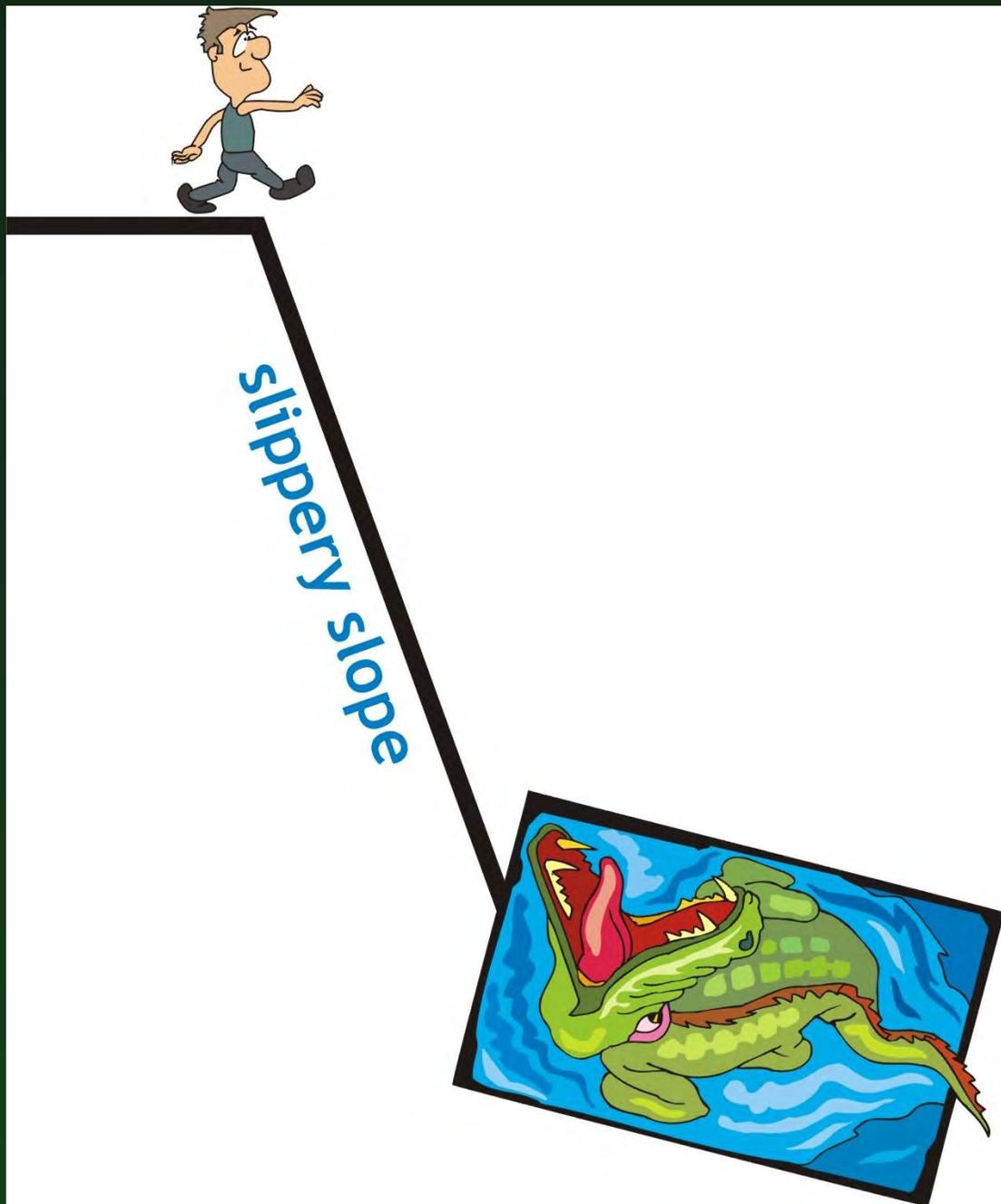
# **THE SLIPPERY SLOPE**

**it starts  
changing  
your brain**

# **THE SLIPPERY SLOPE**

**you crave it**





# THE SLIPPERY SLOPE

it takes over  
your life!

Find someone who stares at you  
the same way Rihanna stares at  
weed



**How do you know when  
you have smoked  
enough pot?**

**Answer: When you start  
looking around for the  
directions on how to use  
the lighter.**

**... there is still a great deal of research to be done concerning the effects of marijuana on the health of humans; widespread marijuana use has only become prevalent in this country within the last three decades...**

[https://cyber.harvard.edu/evidence99/marijuana/Health\\_1.html](https://cyber.harvard.edu/evidence99/marijuana/Health_1.html)

**it would be fallacious to conclude that because the chemicals in marijuana have been found to present fewer dangers than some very harmful substances, the medical or recreational use of marijuana is perfectly safe.**

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5. Arlington, VA: American Psychiatric Publishing.

**The most potent argument against the use of marijuana to treat medical disorders is that marijuana may cause the acceleration or aggravation of the very disorders it is being used to treat.**

# Possible Issues

**Anxiety, Depression**

**A permanent decrease in  
IQ with prolonged use**

**Damage to bronchial passages**

**Decreased ability to fight fungi, etc.**

**Hallucinations, Paranoia**

**Donald P. Tashkin, M.D., "Effects of Marijuana on the Lung and Its Immune Defenses,"**

**The very thing we choose to be  
a solution can often create a  
greater problem than the one  
we are trying to solve. Dr. Paul**

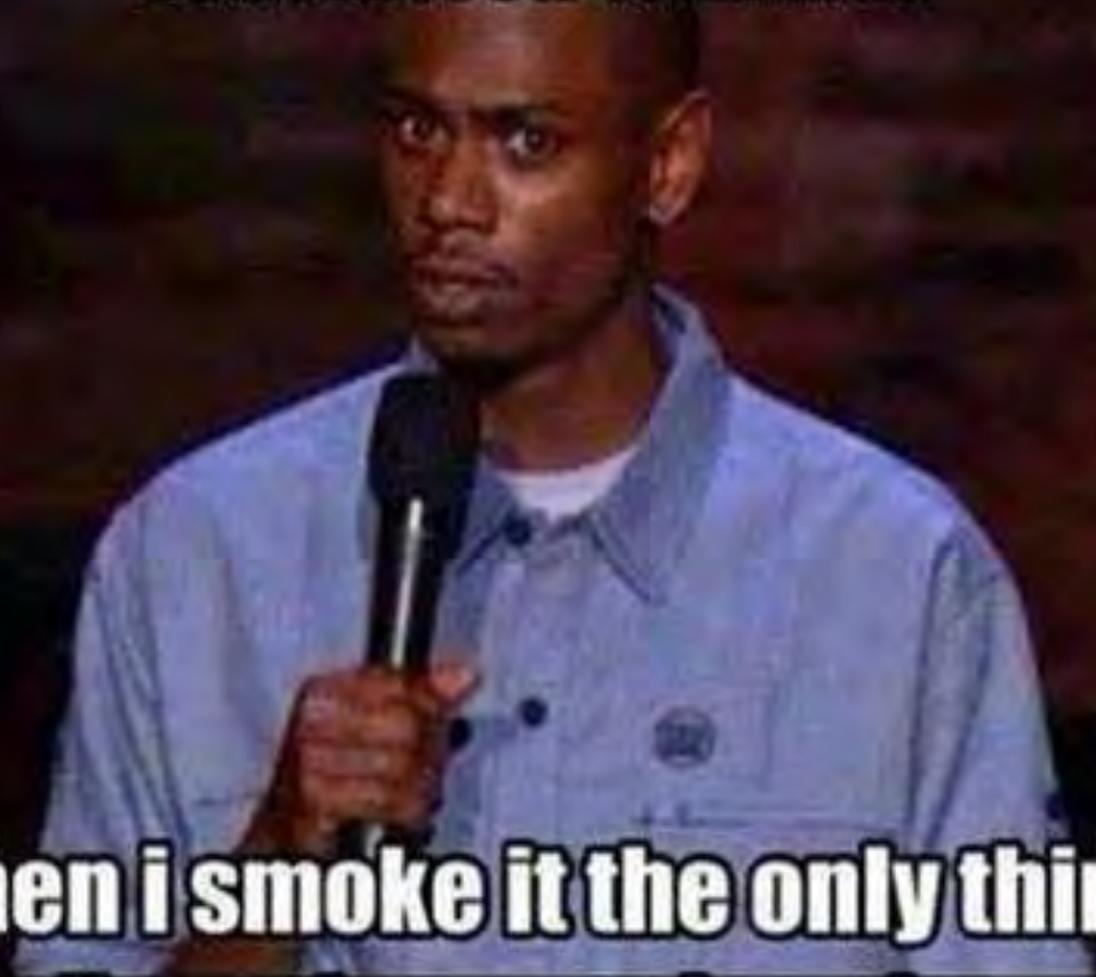


# **CULTURAL ANXIETY**

**Do you see any patterns  
that explain why people  
are so anxious today?**



**I don't understand why weed is still  
considered criminal.**

A man with a serious expression, wearing a light blue button-down shirt, is holding a black microphone. He is looking slightly to the left of the camera. The background is dark and out of focus.

**when i smoke it the only thing  
i'm a threat to is cake.**

# Signs of marijuana use disorder



**□ Tolerance.** smoking  
more to produce the  
same effects  
“I don't know how  
much I smoke.”

[https://www.addictions.com/marijuana/10  
-common-marijuana-addiction-symptoms/](https://www.addictions.com/marijuana/10-common-marijuana-addiction-symptoms/)



**□ Withdrawal symptoms.** Upset stomach, anxiety or depression, the body has developed physical dependence.

<https://www.addictions.com/marijuana/10-common-marijuana-addiction-symptoms/>



**The National Institute on  
Drug Abuse explains that  
users may experience  
any of the following  
when **ending use**:  
Grouchiness,  
Sleeplessness,  
Anxiety, Cravings**



**□ Escalating,  
Smoking more** than  
intended. “I will only  
smoke one joint and then  
I wind up smoking more  
than I intended.

[https://www.addictions.com/marijuana/10-  
common-marijuana-addiction-symptoms/](https://www.addictions.com/marijuana/10-common-marijuana-addiction-symptoms/)



**□ Control:**  
**Inability to control**  
**or cut back. Trying to**  
**cut back but still using**  
**more than anticipated**

<https://www.addictions.com/marijuana/10-common-marijuana-addiction-symptoms/>



**□ Time & Cost:  
Spending too  
much time or  
money.**

<https://www.addictions.com/marijuana/10-common-marijuana-addiction-symptoms/>





**1974**

**Oz = \$40**

**2019**

**Oz = \$400**



**□ Activities:**  
**Reduced activities,**  
Participating less in  
**activities once enjoyed.**  
**(sports, hobbies, etc.)**

<https://www.addictions.com/marijuana/10-common-marijuana-addiction-symptoms/>



**□ Stress: Using pot to relieve stress and becoming dependent on it for relaxation. Smoking to cope with stress is a dependency.**

<https://www.addictions.com/marijuana/10-common-marijuana-addiction-symptoms/>



**□ Consequences:  
Smoking despite  
known consequences.  
legal, social, financial,  
relational**

<https://www.addictions.com/marijuana/10-common-marijuana-addiction-symptoms/>



# ARRESTED:

Treatment, early intervention, and education need to be **available and accessible.**

## ADOLESCENT SUBSTANCE ABUSE SKILL BUILDING PROGRAM

*Program only costs \$25 per session*



**recovery for life**  
hope, help and healing

[www.myrecoveryforlife.com](http://www.myrecoveryforlife.com)

**Saturdays at 1:00pm**

**For More Information Call 757-456-0093**

Recovery for Life Treatment Center

Yorktown Commerce Center

228 N. Lynnhaven Rd. Suite 118

Va. Beach, VA 23452

**We all have that**



**One friend**

**What  
concerns are  
there  
regarding  
legalization?**

# **FEARS...**

**It will might lead to other  
substances**

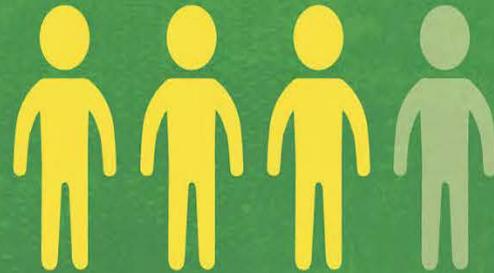
**It might spin out of control**

**How much is too much?**

# TEEN SUBSTANCE USE TODAY

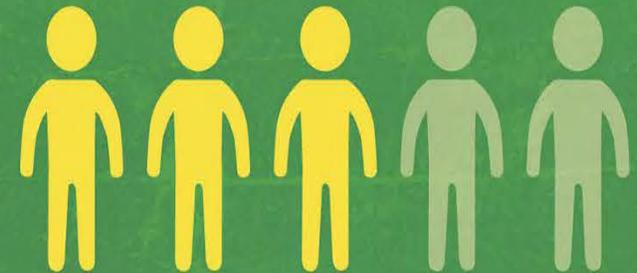
**76%** of teens agree that with legalization, teenagers may be more likely to experiment with marijuana

**76%**



**Nearly 3 out of 4** teens believe that having easier access to marijuana may accelerate teenagers in trying other drugs

**3 out of 5** teens agree that teenagers who use marijuana are more likely to try heroin



rosecrance

[www.Rosecrance.org](http://www.Rosecrance.org)

*Based on a recent online survey of 400 U.S. teenagers ages 13-17 conducted by Wakefield Research and commissioned by Rosecrance*

# **Mental Health**

**Problems linked**

**Becoming  
dependent**

**General  
life problems**



**Relationship and  
home conflicts**

**Leaving home  
early**

**Difficulty with  
memory and  
learning**



**Dropping out  
from study or  
work**



**Financial  
difficulties**



**Can medical marijuana  
legalization decrease  
prescription opioid  
dependence??**



*How do you know  
you're a  
pothead?.....When the  
last thing you studied  
for was a urine test*

# **From The Green Cloud**

---

**Effects of Legalized  
Marijuana on  
Communities**

# Report 2015, WA & OR

- Adolescent use increased between 2012 and 2014
  - 1% for sixth-graders
  - 27% for 12<sup>th</sup> graders

Washington State. 2015.

- **Use among adults was found to be highest 18 to 24**
- **Up to 21% of WA** adults in this age range reported use in 2014

- Arrests for any drug or narcotic decreased 17% between 2012 and 2013
- Incidents involving marijuana decreased by more than half between 2012 and 2013

- Possession charges decreased from 5,133 in 2012 to 1,918 in 2014
- Marijuana-related non-prison convictions decreased from 502 in 2011 to 13 in 2014

# Oregon. 2016

- **Key Findings: Many young people and adults in Oregon use marijuana**
  - **Nearly 50% of 11<sup>th</sup>-graders who drive and currently use marijuana reported driving within 3 hours of using marijuana in the past month**

Oregon. 2016

**48% of Oregon adults** report to having ever used marijuana

**11% of adults** currently report use, 14% men and 8% women

# Oregon, Contd

- Youth Impact

- In 2015, 67% of 11<sup>th</sup>-graders who reported using said they got marijuana from a friend
  - 17% gave money to someone else to get it
  - 16% got it at a party
  - 7% got it from an older sibling
  - 7% from an OMMP (Oregon medical marijuana patient) cardholder/caregiver

# Oregon, contd

## Youth Impact

Of students surveyed about driving after using marijuana, 5% of female students and 7% of male students who reported that they drove, also reported driving within 3 hours of use.

# Oregon

**Education is important!**

**Nearly half of the 11<sup>th</sup>-graders currently using marijuana that drive a car report that they drove within three hours of using marijuana in the last month**

**Is using marijuana or CBD as a  
MAT for clients detoxing or  
abstaining from harder drugs  
(heroin or meth) a reasonable  
treatment consideration?**





**6 Ways  
Cannabis  
Helps  
Mental  
Health With  
Dr. Michele  
Ross**

<https://cannabis.net/blog/medical/6-ways-cannabis-helps-mental-health>

**1. Your endocannabinoid system:**  
the largest neurotransmitter system in your body regulates every other neurotransmitter, including serotonin, dopamine, norepinephrine, and GABA.

-> "How this complex system of receptors, ligands, and enzymes is integrated in helping to regulate fundamental processes, is nowadays **still under investigation.**

**Traditional treatments for depression target serotonin, treatments for anxiety target GABA, and treatments for ADHD target dopamine. Many of us are anxious, depressed, and unfocused. **Why take 3 drugs when cannabis could treat the root of the problem?****

<https://cannabis.net/blog/medical/6-ways-cannabis-helps-mental-health>

**2. The endocannabinoid system helps you forget. If you have PTSD or depression, you can't forget traumatic events or silence that critic in your head telling you you're not good enough.**

**This is because you suffer from  
endocannabinoid deficiency.  
Using cannabis restores  
endocannabinoid system  
function and **helps you let go.****

**3. If you have chronic pain, you're likely depressed. Instead of getting an opiate prescription and a prescription for Prozac, why not use a medication that treats both symptoms?**

**4. What's better for mental health, THC or CBD? In some patients, THC can worsen anxiety or even trigger a psychotic episode, especially when taken in high doses, stressful situations, or in a patient that has schizophrenia.**

**5. Treating mental health with cannabis** is more than just about the cannabinoids, like THC or CBD. Terpenes like linalool, limonene, and beta-caryophyllene all have medicinal benefits too, such as reducing anxiety.

**6. Worried about the psychoactive effects of cannabis...aka my kids or my boss can't find out I'm high?**

**Eating a low-dose of THC, such as a 2.5mg of THC, is a great alternative to a Xanax. It's an effective dose to reduce anxiety or relieve stress, but not high enough dose to feel out of it.**

**Finally, by eating your THC instead of smoking it, you won't smell like pot and no one will have to know your secret.**

# Family Dynamics and Marijuana



*Looking at the family system is imperative in addressing addiction. If the family system does not change, the same dysfunctional pattern will make the addict at risk for a relapse or another dysfunctional behavior.*

*- R. Fields (Drugs in Perspective)*

# Effective Treatment Interventions

- **Motivational Enhancement Therapy**
- **Brief Strategic Family Therapy**
- **Cognitive-Behavioral Therapy**

# Effective Treatment Interventions

Treatments proving most effective involve multifaceted approach:

1. Abstinence-based incentives
2. Parent-directed behavioral contact
3. Individualized CBT



# CBD vs THC



# How Are CBD and THC Related?

- CBD and THC are both natural compounds that are found in plants that belong to the **Cannabis genus**
- CBD and THC both interact with the endocannabinoid system, but they create very different effects

<https://www.healthline.com/health/cbd-vs-thc>

# How Are CBD and THC Related

- Both have the same molecular structure;  $C_{21}H_{30}O_2$ . Their arrangements are slightly different
- Both are very similar to the body's natural endocannabinoids

<https://www.healthline.com/health/cbd-vs-thc>

# Where Does CBD Come From?

- CBD is primarily extracted from hemp plants
- CBD extract can be used as oils, tinctures, edibles, and more



# What Does CBD Do?

- While THC is the main **psychoactive** compound in marijuana that creates the 'high' sensation, **CBD is not psychoactive**

<https://www.healthline.com/health/cbd-vs-thc>

- Both have roles in pain, stress, sleep, immune function, and more
- CBD and THC both bind with cannabinoid 1 (CB1) receptors, but very differently.

<https://www.healthline.com/health/cbd-vs-thc>

- THC binds tightly to produce the 'high' sense of euphoria
- CBD has a very weak bind to CB1 and can actually interfere with THC binding, dampening the psychoactive effects of THC

<https://www.healthline.com/health/cbd-vs-thc>

# The Medical Effects of CBD

- CBD and THC share many medical benefits
  - Many use CBD for
    - Seizures                      Inflammation                      Pain
    - Psychosis or mental disorders
    - Inflammatory bowel disease
    - Nausea    Migraines
    - Depression    Anxiety

<https://www.healthline.com/health/cbd-vs-thc>

# Side Effects of CBD vs THC

- **CBD: Large amounts of CBD can be well tolerated**
  - Research suggests that any side effects that are experienced with CBD are probably the result of interactions from other medications being taken
- **THC can cause :**
  - Increased heart rate, Coordination problems
  - Dry mouth, Red eyes
  - Slower reaction times, Memory loss

<https://www.healthline.com/health/cbd-vs-thc>

# THC in CBD

- Because THC and CBD are both found in the cannabis plant, both marijuana and hemp plants produce each substance.
- Marijuana has much higher THC content than hemp, and hemp has a much higher CBD content than marijuana.
- **The average marijuana strain contains about 12% THC.**
- **CBD extracts can not contain more than 0.3% THC to be legally sold as CBD in the United States.**

**How will expanding medical  
legalization affect mental  
health professionals and legal  
issues?**



# **Therapeutic Implications**

**does the nature of addiction  
contradict the use of marijuana in  
addiction treatment?**



# **Therapeutic Implications**

**You are addicted to drugs if you can't stop taking it even if you really want to.**

# Therapeutic Implications

- 1. Marijuana potentially produces substance use disorder. Families need to be educated.**

# Therapeutic Implications

**ACTION:** **dialogue** - physical reasons to stop using. Teach parents to express a no use attitude.

**Children whose parents have  
a positive attitude toward  
marijuana use are **five times**  
more likely to use marijuana  
by 8th grade**

Risk and Protective Factors for Your Marijuana Use: Preliminary Findings, (2013). Hong, G., Becker, L. Presented July 10, 2013 at the What Works Youth Marijuana Symposium.

**Start early! Start Earlier!**

**Since teenagers who use  
marijuana often start by age 14**



# Therapeutic Implications

**2. It is against the law for people under 21, and should be.**

# Therapeutic Implications

**ACTION:** **present cases** of legal and employment/professional issues.

**How has treatment changed  
in the local area since 2012?  
More or less patients with  
use disorders since other  
states legalized?**



# Therapeutic Implications

3. **Marijuana use** gets in the way of saying YES to other exciting opportunities in life.

# Therapeutic Implications

**ACTION:** **motivate** toward better alternatives.



**Help your clients and teach  
parents to **role play** ways to say  
no to marijuana and other drugs.**

Risk and Protective Factors for Your Marijuana Use: Preliminary Findings, (2013). Hong, G.,  
Becker, L. Presented July 10, 2013 at the What Works Youth Marijuana Symposium.

# Therapeutic Implications

4. In therapy, it makes it more difficult for clients to **focus**. Have you ever tried to work with a client who had just used?

# Therapeutic Implications

**ACTION: Set professional boundaries.**



# Therapeutic Implications

5. There are **driving while impaired** and **possession (legal) issues.**

# Therapeutic Implications

**ACTION: List and educate**  
**about legal consequences.**

# Therapeutic Implications

**6. There are financial reasons not to use marijuana.**

# Therapeutic Implications

**ACTION:** List financial expenses for using.

# CONCLUSION:

**There is much work to be done, and it is early to conclude about marijuana and/or CBD use.**

# **CONCLUSION:**

**Substance abuse education  
must start earlier!**



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# Virginia Veterans Treatment Court Statewide Strategic Planning Project



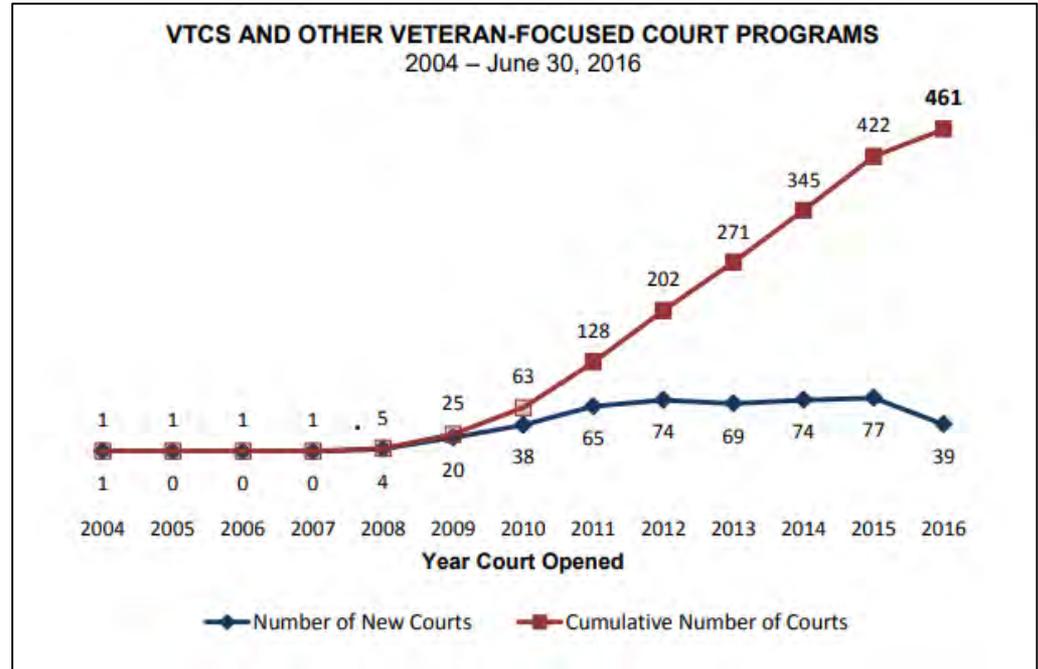
Center  
for  
Court  
Innovation

# Project Overview

- Two year statewide strategic planning process with \$200,00 of grant awarded funds for year two
- BJA-funded initiative, including four other states: Maine, Ohio, Pennsylvania, and California
- Strategic planning

# National Veterans Treatment Court Landscape

- Approx. 200,000 veterans in jails and prisons nationwide (BJS)
- Veterans Treatment Court model is proliferating across the nation, approx. 500 VTCs operational
- Increase in funding for VTCs from BJA:
  - \$6,000,000 in FY16 v. \$22,000,000 in FY19

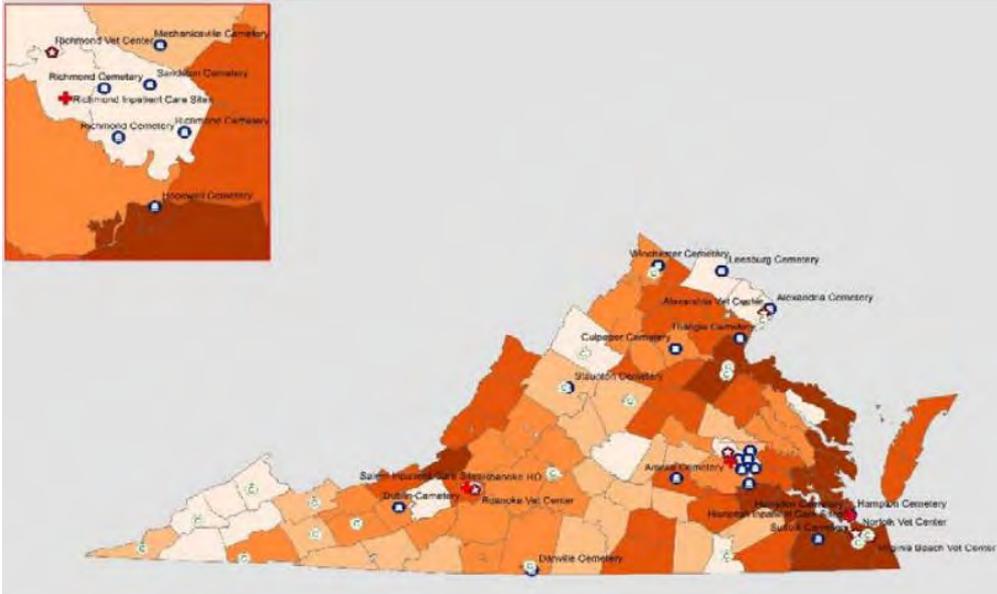
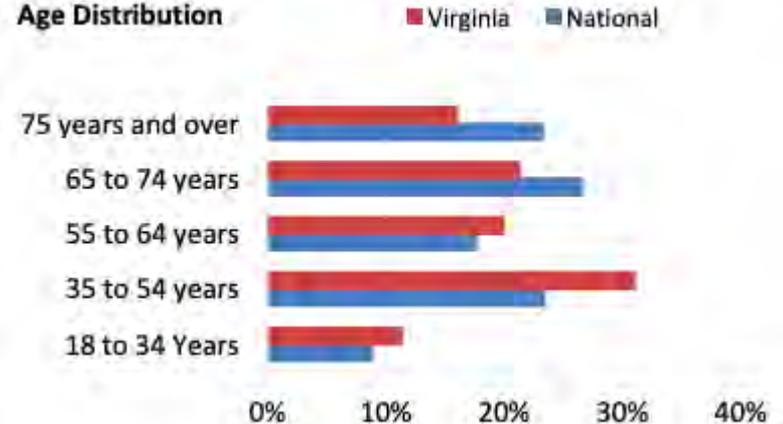


Source: U.S. Department of Veterans Affairs

# Virginia Veterans Landscape

- Virginia ranks #8 for total veterans population (725,028)
- 14% of veterans are women, higher than national average

## Age Distribution





# Background: 10 Key Components to Veterans Treatment Courts

**Key Component #1:** VTCs integrate alcohol, drug treatment, and mental health services with justice case processing.

**Key Component #2:** Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights

**Key Component #3:** Eligible participants are identified early and promptly placed in the VTC program

**Key Component #4:** VTCs provide access to a continuum of alcohol, drug, mental health and other related treatment and rehabilitation services

**Key Component #5:** Abstinence is monitored by frequent alcohol and other drug testing

# Background: 10 Key Components to Veterans Treatment Courts

**Key Component # 6:** A coordinated strategy governs VTC responses to participants' compliance

**Key Component# 7:** Ongoing judicial interaction with each Veteran is essential

**Key Component # 8:** Monitoring and evaluation measure the achievement of program goals and gauge effectiveness

**Key Component # 9:** Continuing interdisciplinary education promotes effective Veterans Treatment Court planning, implementation, and operations

**Key Component # 10:** Forging partnerships among VTC, Veterans Administration, public agencies, and community-based organizations generates local support and enhances Veteran Treatment Court effectiveness

# National Trends

Early Identification

Target population & eligibility

Veteran peer mentors

Training: Treatment teams & the community

Resources

# National Veterans Treatment Court Landscape

- Nationwide challenges:
  - Devoted court resources
  - Mentors
  - Early identification
  - Case management
- More VTC research and evaluations needed

<b>MENTOR COMPONENT</b>	
Mentor Program is under development	9.5%
Mentor Program is operational	68.8%
Average number of mentors	8 mentors
Most common coordinator of operational programs	
Volunteer Mentor Coordinator	58.7%
Treatment Court Coordinator	15.6%
Paid Mentor Coordinator	12.1%

<b>VETERAN/MILITARY</b>	
<u>Only Accepts</u>	
Veterans with military related mental health conditions <sup>1</sup>	20.2%
Combat Veterans	5.6%
OEF/OIF/OND Veterans	2.2%
<u>Allows</u>	
Active Duty Military	71.3%
Reserve/Guard	66.8%
VA Health Care ineligible Veterans	67.5%

# Needs Assessment Findings

Lack of consistency in eligibility criteria

Incentive to participate

Target population

Training

Veterans specific programming

Recovery support services

Veteran Peer Mentors

Implementation of new dockets

# Virginia's Goals and Objectives

Goal 1: Accurately account for all veterans in the criminal justice system in Virginia

Goal 2: Increase enrollment in veterans treatment dockets

Goal 3: Provide training and education about veterans treatment dockets and how to create one in a new jurisdiction

Goal 4: Ensure all veterans treatment docket teams have received adequate training in best practices for VTCs, treatment, veterans-specific issues, and military culture.

# Virginia's Goals and Objectives

Goal 5: All veterans treatment dockets have a mentor program with a mentor coordinator, and age and gender appropriate mentors for all participants

Goal 6: Ensure all justice-involved veterans have appropriate and timely wrap-around services

Goal 7: Assess the need for implementation of veterans dockets



Central East (HHS Region 3)

PTTC

Prevention Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

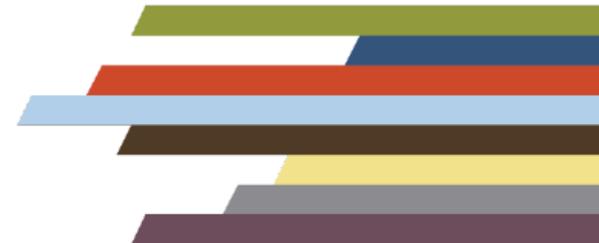
# RECOVEROPOLY

## A Game of Recovery and Relapse

Shannon Garrett, LMSW, LCADC

*Consultant, The Danya Institute*

8-5-2019



# Central East Region

## HHS REGION 3

Delaware

District of Columbia

Maryland

Pennsylvania

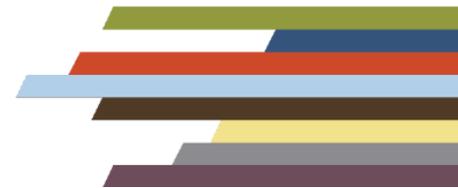
Virginia

West Virginia

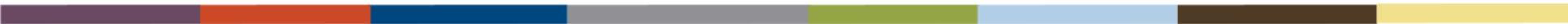


Central East (HHS Region 3)

PTTC



# PTTC Mission

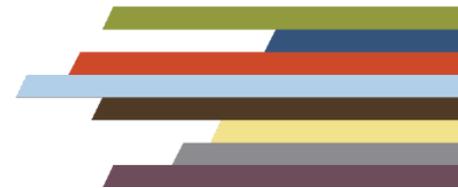


To Strengthen **the Capacity of the Workforce to Deliver Evidence-Based Prevention Strategies and Facilitate Opportunities for Preventionists to Pursue New Collaboration Opportunities, which include Developing Prevention Partnerships and Alliances**



Central East (HHS Region 3)

PTTC



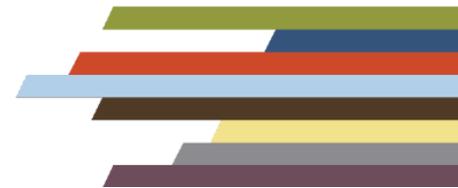
# Central East PTTC Specialty Area

Engaging and Collaborating with Primary Care Providers for Substance Use Prevention



Central East (HHS Region 3)

PTTC



# Other Resources in Region 3



Central East (HHS Region 3)

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ATTC

Addiction Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration



Central East (HHS Region 3)

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MHTTC

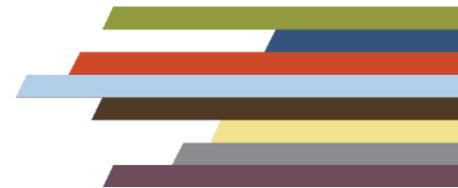
Mental Health Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration



Central East (HHS Region 3)

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PTTC



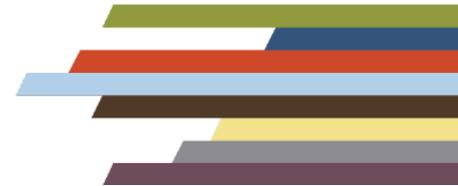
# Evaluation

***Your feedback is important!***

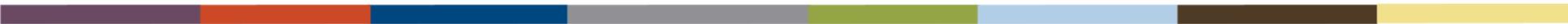


Central East (HHS Region 3)

PTTC



# Presenter Contact



**Shannon Garrett, LMSW, LCADC**

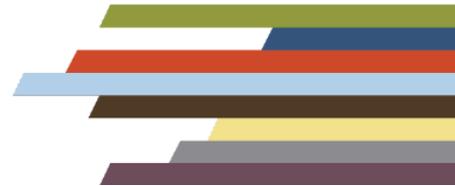
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Central East (HHS Region 3)

PTTC



# How to Contact the PTTC



Central East (HHS Region 3)

PTTC

Prevention Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration

*a program managed by*

THE DANYA INSTITUTE

[www.pttcnetwork.org/centraleast](http://www.pttcnetwork.org/centraleast)

Deborah Nixon-Hughes

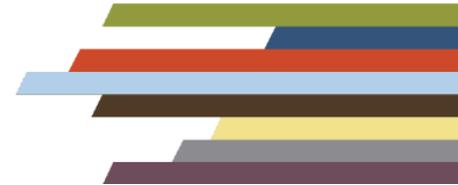
[dhughes@danyainstitute.org](mailto:dhughes@danyainstitute.org)

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Central East (HHS Region 3)

PTTC



# Recoveropoly

## A Game of Recovery and Relapse

Shannon Garrett, LMSW, LCADC  
Consultant, The Danya Institute

8-5-19

# Engagement is Crucial to Treatment

- Motivational Interviewing
- Motivational Incentives
- Stages Of Change
- Experiential Activities
- DBT (Mindfulness)
- CBT (Teaching Coping Skills)
- Having some fun

# Co-Occurring Disorders

- Substance Use Disorder
- Mental Health Disorder
- Medical Disorder
- Family Stressors
- Legal Involvement
- Education and Work Disruption
- Negative Social Relationships
- Spiritual Emptiness

# Integration of Treatment

- SUD Programs
- MH Therapists, Psychiatrists
- Primary Care Providers
- Family Members
- Parole, Probation, Drug Court
- Teachers, Employers
- Strong Peer Support Systems
- Spiritual and or Religious Fulfillment
- 12-Step Fellowships

# RECOVEROPOLY

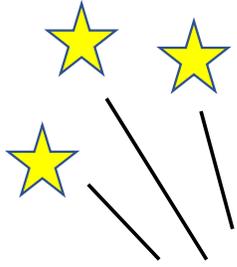
- This experiential activity is my attempt to pull together
  - Engagement Techniques
  - Co-Occurring Disorders
  - Integration of Treatment Providers
  - And some old-fashioned fun that doesn't have a screen.

# **THE MIRACLE OF RECOVERY STARTS HERE**

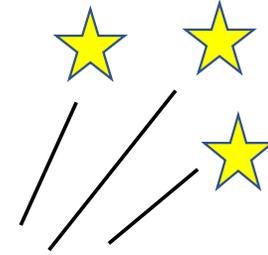
**THE JOURNEY OF RECOVERY  
OFTEN TIMES BEGINS WITH  
INPATIENT TREATMENT**

**THERE IS NO SHAME IN  
RELAPSE. GET HONEST AND  
RETURN TO TREATMENT.**

**ROLL THE DICE  
AND ENTER EARLY RECOVERY**



**IF YOU DON'T HAVE A SPONSOR  
YOU CAN ASK FOR ONE NOW.**



# **CELEBRATION**

**YOU ATTEND A 12 STEP MEETING WHERE  
YOUR SPONSOR IS CELEBRATING  
10 YEARS CLEAN**

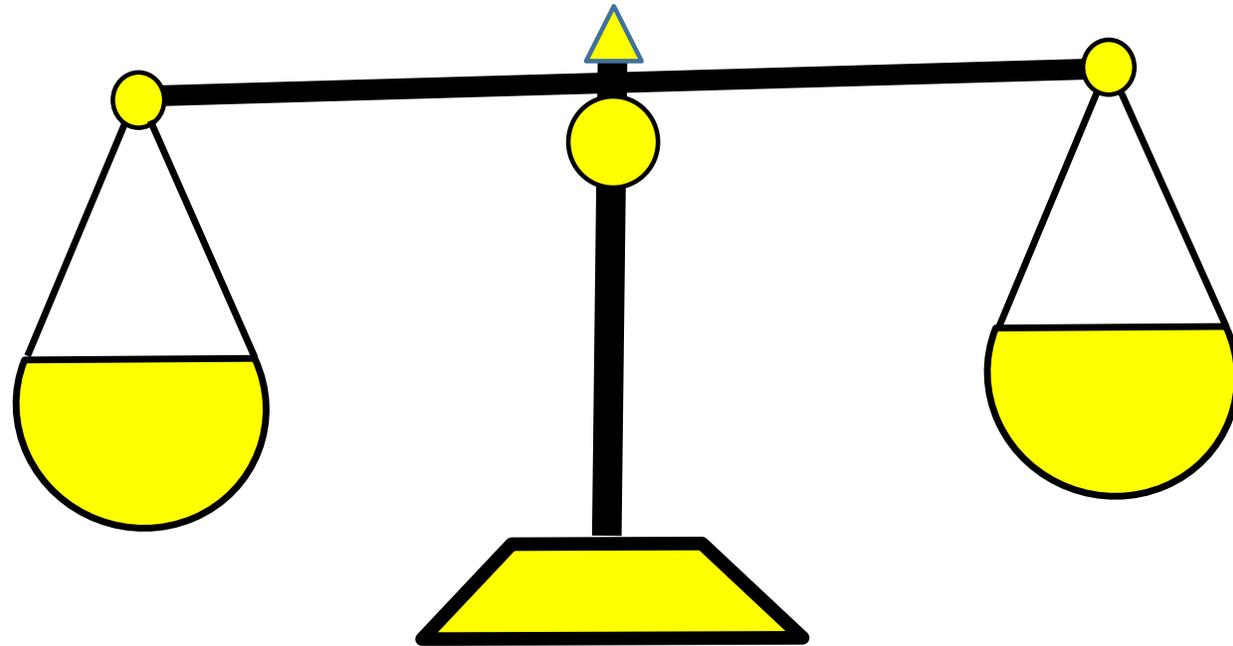
**PICK UP 60 DAYS CLEAN**

# OUTPATIENT COUNSELING

**YOU ATTEND OUTPATIENT COUNSELING AT  
AUSTIN ADDICTION AND MENTAL HEALTH CENTER  
YOU MEET POSITIVE PEERS IN RECOVERY**

**PICK UP A POSITIVE PEER CARD  
AND USE IT TO MAKE BETTER  
DECISIONS IN RECOVERY.**

# ACCEPTANCE



## DRAW AN ACCEPTANCE CARD

# FAMILY COUNSELING

IF YOU ROLL AN  
ODD NUMBER  
YOU HAVE BEEN  
ARGUING AND  
FIGHTING  
WITH YOUR FAMILY  
AGAIN.  
THEY DON'T TRUST YOU.

**LOSE A TURN**

IF YOU ROLL AN  
EVEN NUMBER  
YOU HAVE BEEN  
WORKING  
ON COMMUNICATION  
SKILLS WITH YOUR  
FAMILY AND  
ESTABLISHING TRUST.

TAKE AN EXTRA  
TURN

A signpost with three signs and a light switch. The signpost is a vertical black line with several horizontal bars. The top sign is grey with blue text. The middle sign is grey with black text. The bottom sign is dark blue with white text. To the left of the signpost is a light switch with a blue double-headed arrow.

**GO TO JAIL**

**RECOVERY IS ABOUT MAKING CHANGES  
IN YOUR BEHAVIOR.  
WHAT CHANGES DO YOU STILL NEED TO MAKE?**

**PAY 30 DAYS TO GET OUT OF JAIL or  
USE GET OUT OF JAIL FREE CARD or  
ROLL DOUBLES TO GET OUT or  
GET OUT AFTER TWO TURNS IN JAIL**

# BACK TO SCHOOL

COMPLETING AN EDUCATION IN  
HIGH SCHOOL, COLLEGE OR TRADE  
SCHOOL; GIVES YOU THE KNOWLEDGE  
TO EMPOWER YOUR NEW FOUND  
FREEDOM IN RECOVERY.

$$\frac{2(a+b)}{(a+b)^2(b-a)}$$

DRAW AN  
ACCEPTANCE CARD  
CHOOSE TO KEEP IT OR GIVE IT  
AWAY

$$E=mc^2$$

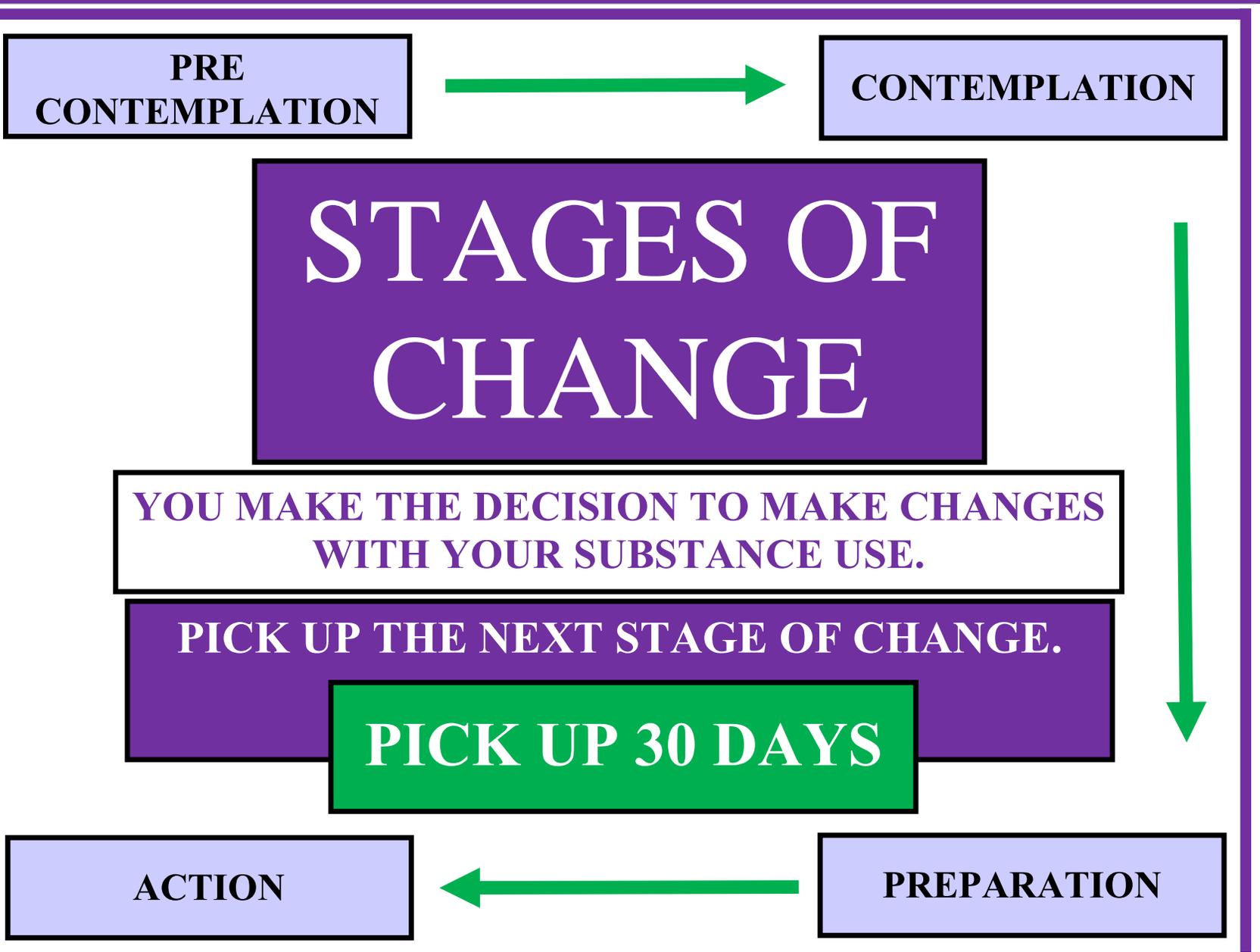
**PICK UP  
A BUG  
AND  
LOSE A  
TURN**



**YOU  
DECIDED TO  
HAVE SEX  
WITHOUT  
USING SOME  
TYPE OF  
PROTECTION**

**GET RID OF THE BUG BY VISITING THE MEDICAL  
CLINIC. IF YOU OCCUPY THE SAME SPACE AS ANOTHER  
PLAYER AT THE END OF A TURN, GIVE THEM A BUG.**

(Recoveropoly does not endorse pre-marital sexual relationships or unprotected sex.)



# TRIGGER SITUATION

**Shorty Ra Ra and Rhonda Woo Woo stop you on the street. They heard you been in rehab and wanna get you high to celebrate you gettin out. That bud smells good!**

## **Roll an Odd Number**

You do not try to avoid them or use a refusal skill.

### **RELAPSE**

Return to start and lose all days clean.

## **Roll an Even Number**

You try to avoid them and use refusal skills.

### **GOOD JOB MANAGING TRIGGERS**

Take another turn.



# SLIPPERY SLOPE



**YOU BEEN HANGING OUT WITH  
THOSE OLD USING FRIENDS AGAIN!**

**PICK UP A  
USING FRIEND CARD**

**OLD USING FRIENDS ENDANGER YOUR RECOVERY, WHILE YOU  
HAVE A USING FRIEND CARD, ROLL ONLY ONE DIE. GET RID OF A  
USING FRIEND CARD BY ATTENDING 12 STEP MEETINGS.**

# **MEDICAL CLINIC**

**YOU ATTEND YEARLY MEDICAL  
CHECK UPS AND TAKE GOOD  
CARE OF YOUR HEALTH.**

**YOUR BODY THANKS YOU  
TAKE ANOTHER TURN.**

**YOU GET TREATED FOR STD'S  
GET RID OF ALL YOUR BUG CARDS.**

# **VIOLATION OF PAROLE AND PROBATION**

**YOU'VE BEEN PRACTICING THE SAME  
ILLEGAL BEHAVIORS EXPECTING  
DIFFERENT RESULTS.**

**GO DIRECTLY TO JAIL**

**KEEP  
COMING  
BACK**

# **12 STEP RECOVERY MEETING**

**ONE  
DAY AT  
A TIME**

**YOU ATTEND 12 STEP MEETINGS ON A REGULAR BASIS**

## **PICK UP 30 DAYS**

**SAY GOODBYE TO AN OLD USING FRIEND**

**“God grant me the serenity to accept the things I cannot change  
the courage to change the things I can  
and the wisdom to know the difference.”**

# **MENTAL HEALTH**

**YOU MEET WITH YOUR PSYCHIATRIST  
AND THERAPIST REGULARLY. YOU  
ACCURATELY REPORT THE SIDE EFFECTS  
AND BENEFITS OF MEDICATION.**

**FOR TAKING CARE OF YOUR  
MENTAL HEALTH  
TAKE AN EXTRA TURN**

# TRIGGER SITUATION

A group of friends from work have invited you to come out drinking with them. You decide to test out your new recovery and just watch the rest of them drink. “I’ll just have a coke”

## Roll an Odd Number

You do not try to avoid them or use a refusal skill.

**RELAPSE**

Return to start and lose all days clean.

## Roll an Even Number

You try to avoid them and use refusal skills.

**GOOD JOB MANAGING TRIGGERS**

Take another turn.



**HIGHER  
POWER**

**PICK UP A HIGHER POWER  
CARD AND USE IT TO  
PREVENT A RELAPSE**

# Cards in the Game

Sponsor Card

Positive Peer Card

Acceptance Card

Stages of Change Cards

Get out of Jail Free Card

Bug Card

Using Friend Card

Higher Power Card

# How to Win

- Get 1 year in Recovery by collecting 30-day tokens.
- Progress through Stages of Change to Action.
- Avoid Relapse.

# LET'S PLAY

## AUDIENCE PARTICIPATION

WHEN ANYONE PICKS UP 30 DAYS

- APPLAUSE (and some cheering if you're feelin it)

IF A TEAM RELAPSES

- Shout out some encouragement.

Thank you all for doing what you do  
to make a difference!

## Evaluations Please

Shannon Garrett, LMSW, LCADC

Program Director

Austin Addiction and Mental health Center

Frederick, Maryland

Shanbo85@aol.com

2019 DUI/ SPECIALITY DOCKET TRAINING REGISTRATION

Where Treatment and Accountability Meet Justice



# The Opioid Epidemic: My Story, Our Journey, and Where to Go From Here

A. Omar Abubaker, DMD, PhD, Professor, Chair  
Department of Oral and Maxillofacial Surgery  
Virginia Commonwealth University

August 6, 2019

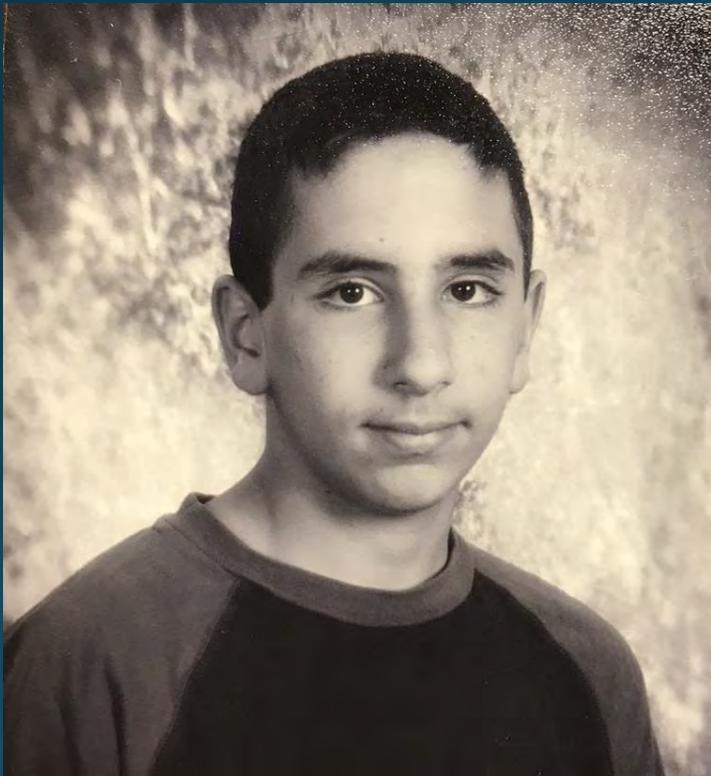
# The Opioid Epidemic: My Story, Our Journey, and Where to Go From Here

- My Story: Personal
- Our Journey: What we have learned and what we have not
- Where to go from here

# The Opioid Epidemic: My Story

# Disclosure and disclaimer

I am just a dad...



# Adam's Story...



**1993**



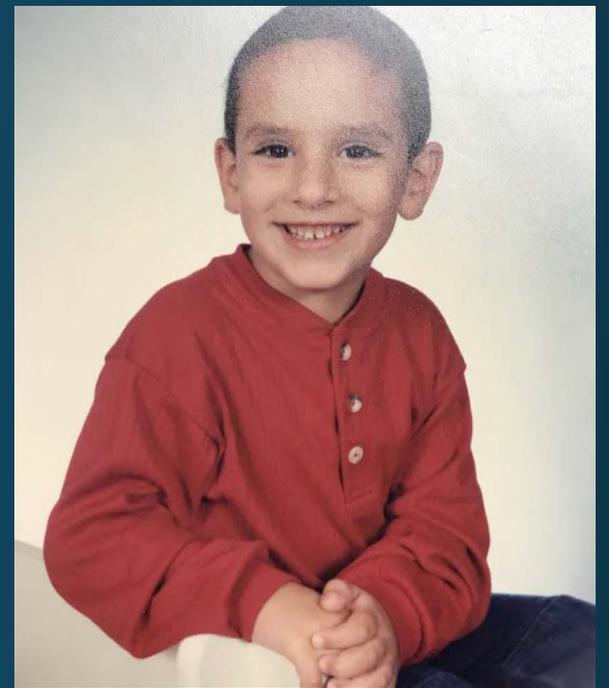
**2013**



**2014**

# Who is Adam?

- Adam the child, loving and always cared about others
- Not as good at soccer but has high social skills....
- Struggled with hidden anxiety, and with ADD



# Who is Adam?



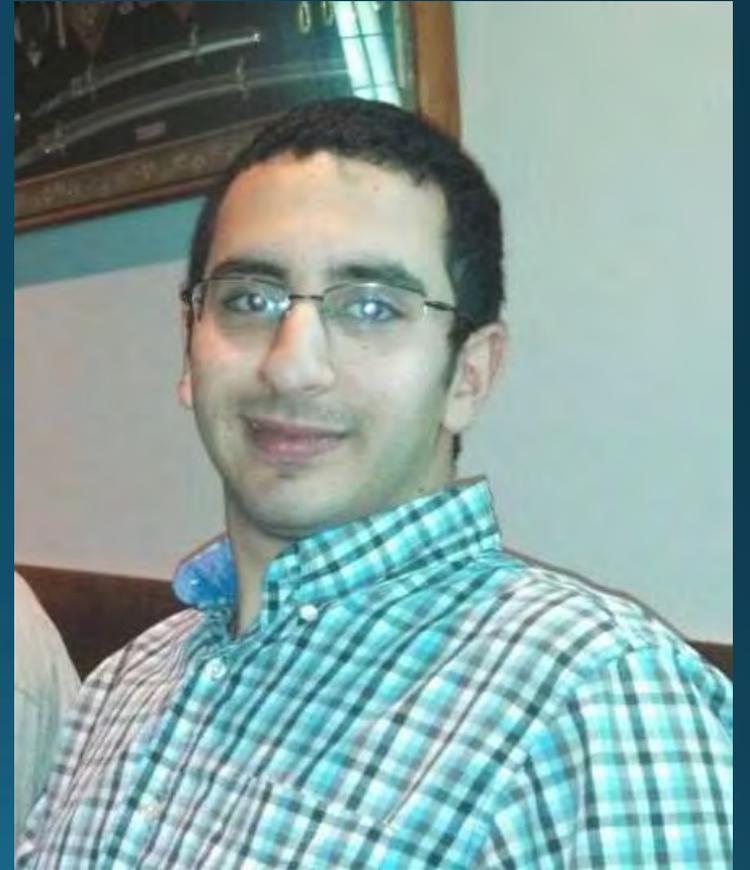
The ROTC



The Firefighter

# Who is Adam?

- Adam the adult in Recovery
- Adam in his death



**WHY ME ?**

**GOD**



# The Opioid Epidemic: My Journey

# My Journey: August 2015-May 2016



King's College London



THE UNIVERSITY OF ADELAIDE



*In recognition of the successful completion of the required course of study, the presidents of the below-named universities,  
by virtue of the authority vested by said universities, hereby confer upon*

**Abubaker Omar Abubaker**

*the degree of*

**Post-Baccalaureate Graduate Certificate in Addiction Studies**

*With all the rights, honors, distinctions and privileges thereto appertaining.*

*In testimony whereof we have caused the signatures of the duly authorized university officials  
to be hereunto affixed on this 24th day of December, in the year 2016.*

The Duke of Wellington  
Chairman of the College Council  
King's College London

Prof. Abubaker Omar Abubaker  
AC CSC RAN (PhD)  
University of Adelaide

John A. Lake Jr.  
Rector of the Board of Visitors  
Virginia Commonwealth University

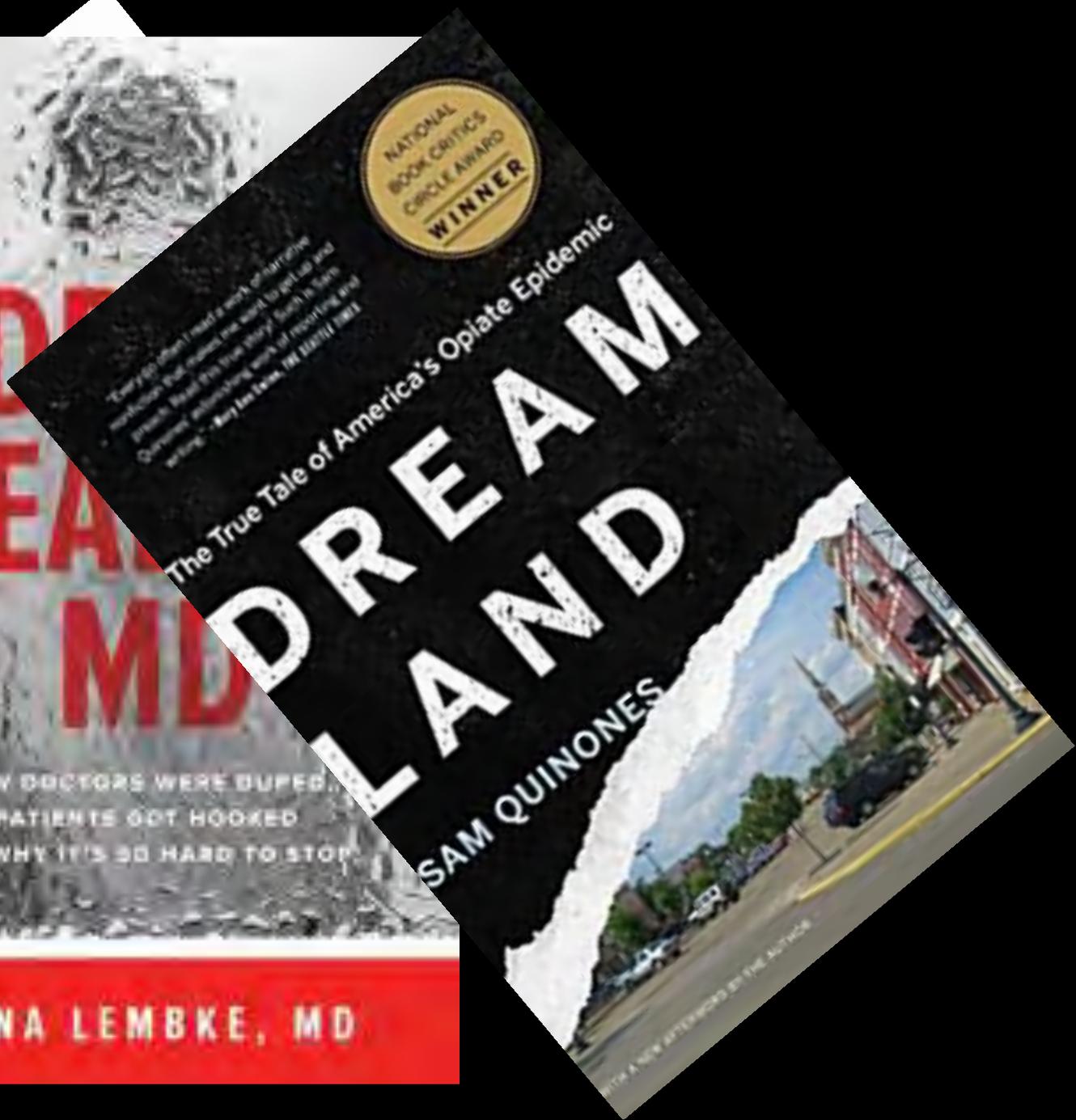
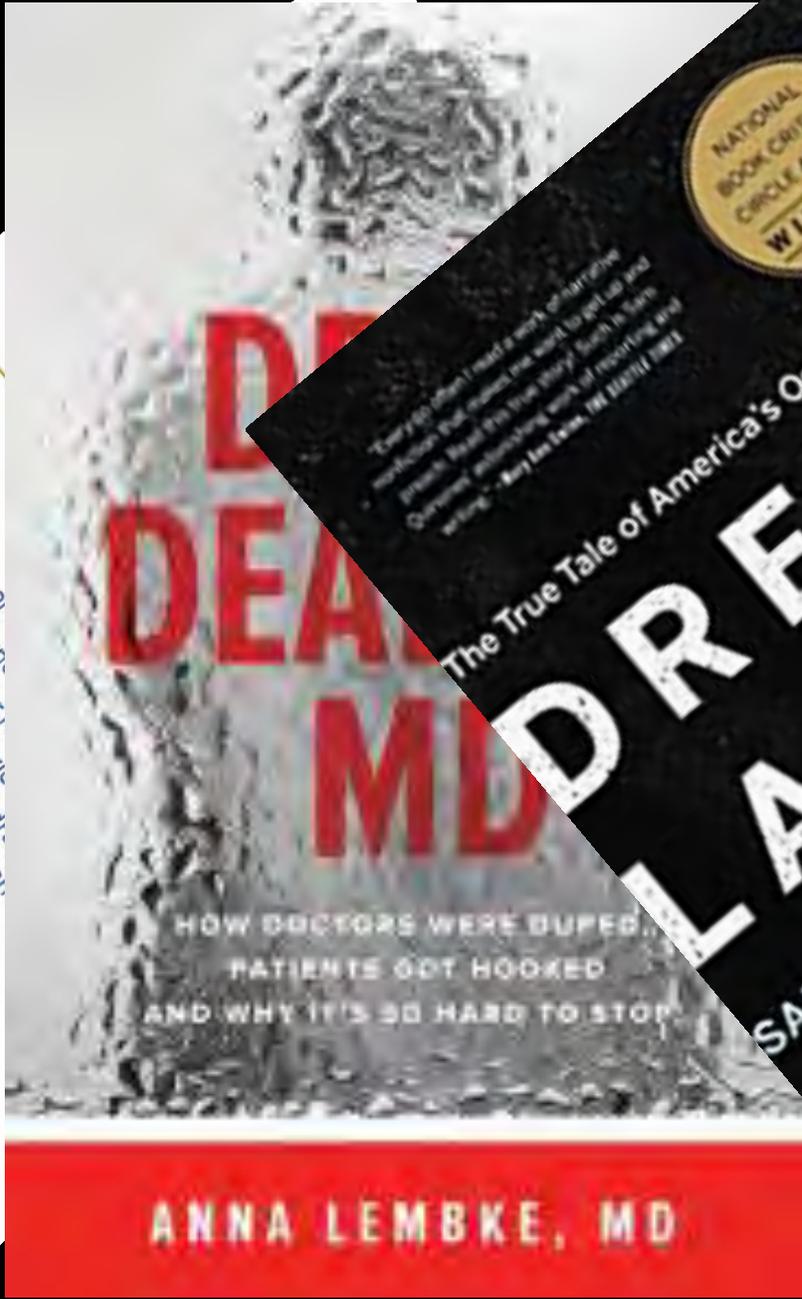
Professor Edward Byrne AC  
President and Principal  
King's College London

Professor William Bollinger  
Vice-Chancellor and President  
University of Adelaide

Michael Ross  
President  
Virginia Commonwealth University



Governor  
Governor  
Governor  
Congressman Patrick  
Professor Bertha Mad  
Florida Attorney General Pat



# My Journey Into the Darkness

'My Son died of a disease that preventable and we do not prevent it, treatable and we do not treat it, and undeniable but we continue to deny it'

**Gary Mendell, Founder and CEO, Shatter Proof Foundation**



**... make a difference ...as small as it may  
be but it can add up**

# Proper Prescribing Protocol At VCU Oral and Facial Surgery Department

Assessment of  
the expected  
severity of post-  
operative pain

Assessment of  
the risk of  
exposure to  
opioids

# Proper Prescribing Protocol At VCU Oral and Facial Surgery Department

**-Mild**

**-Moderate**

**-Severe**

**-Low**

**-Moderate**

**-High**

# Toolkit for Effective Management of Postoperative Acute Dental Pain

Preoperative discussion of the goals of postoperative pain management

- Multimodal pain therapy
- Pharmacological management
- Adjunct modalities of pain control

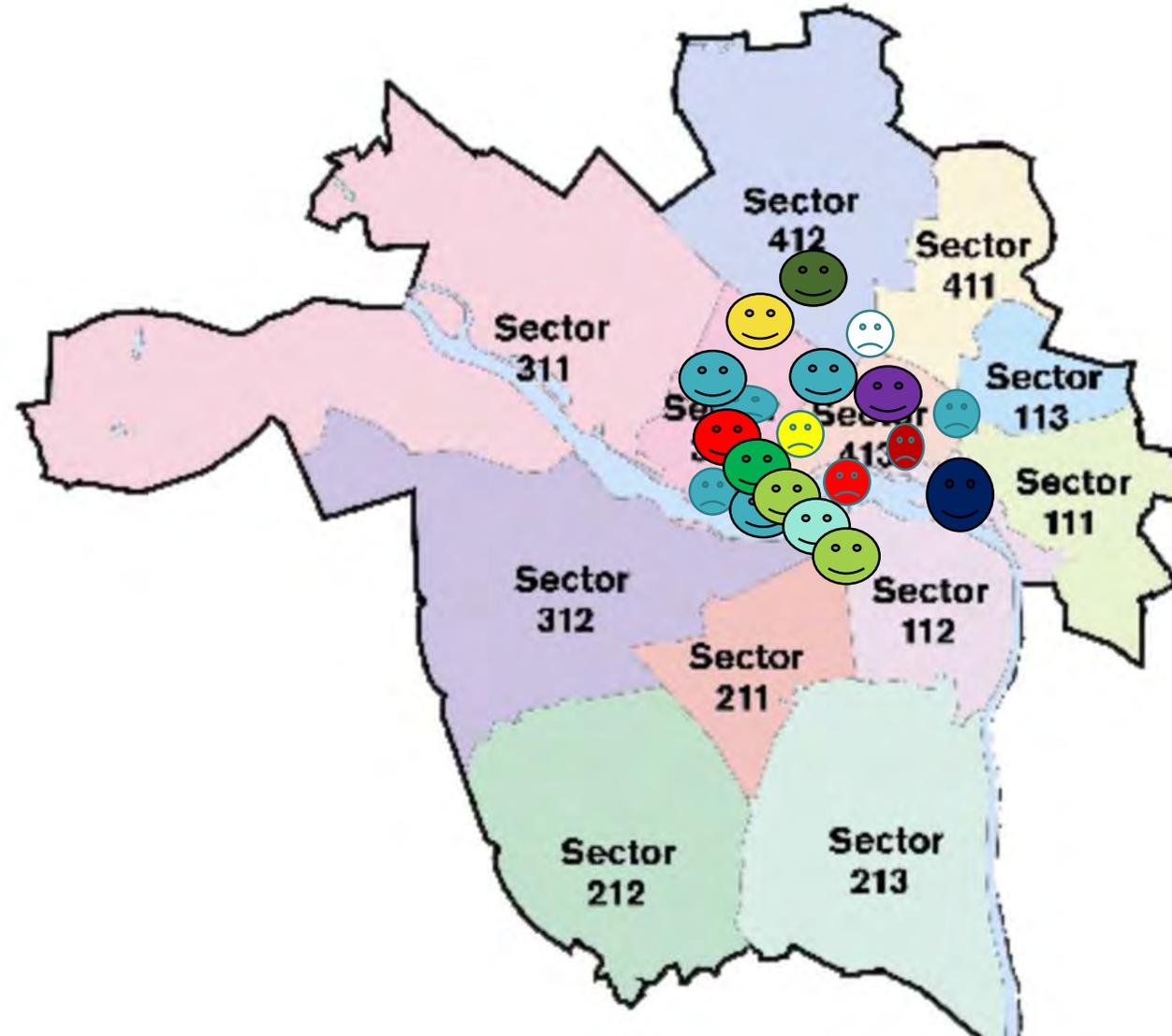
# Results of of Dental Pain Management Protocol and Education At VCU School of Dentistry

VCU Oral and Maxillofacial	17.31	26043	VCU Oral	57841	45.03%
2013	25.85	5457	2013	9560	57.08%
2014	17.40	5443	2014	9370	58.09%
2015	16.10	5436	2015	10913	49.81%
2016	15.46	5232	2016	11818	44.27%
2017	11.09	3544	2017	11748	30.17%
2018	7.98	931	2018	4432	21.01%

# Results of of Dental Pain Management Protocol and Education At VCU School of Dentistry

<b>VCU Oral and Maxillofacial</b>	<b>16.42</b>	<b>28134</b>
2013	26.01	5335
2014	17.43	5341
2015	16.12	5355
2016	15.47	5151
2017	11.09	3481
2018	7.60	2238
2019	6.88	1233

# A Journey in Darkness







# **The Opioid Epidemic: Our Journey And What We Have Learned**

***Tens of Thousands Die,  
Hundreds of Thousands Families Suffer  
And No Family Is Safe,  
Including Yours.....***



**THE PRESIDENT'S COMMISSION  
ON COMBATING DRUG  
ADDICTION AND THE OPIOID  
CRISIS**

**Roster of Commissioners**

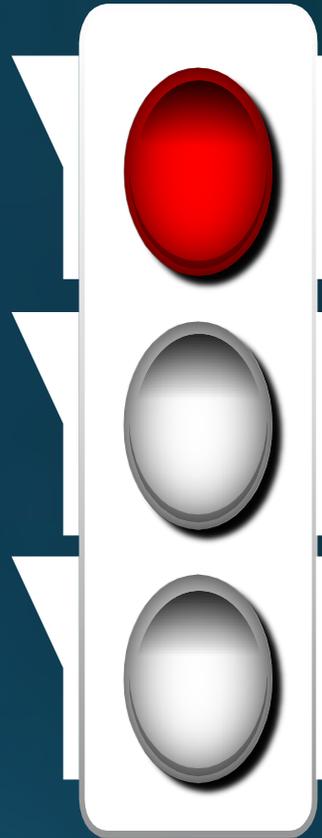
- Governor Chris Christie, Chairman
- Governor Charlie Baker
- Governor Roy Cooper
- Congressman Patrick J. Kennedy
- Professor Bertha Madras, Ph.D.
- Florida Attorney General Pam Bondi



# A WARNING!!

“Every American should be awakened to this simple fact: if this scourge has not found you or your family yet, without bold action by everyone, it soon will.”\*

*\*The PRESIDENT'S Opioid Commission report*





of Americans say they know someone who has  
**died from a Rx painkiller overdose**

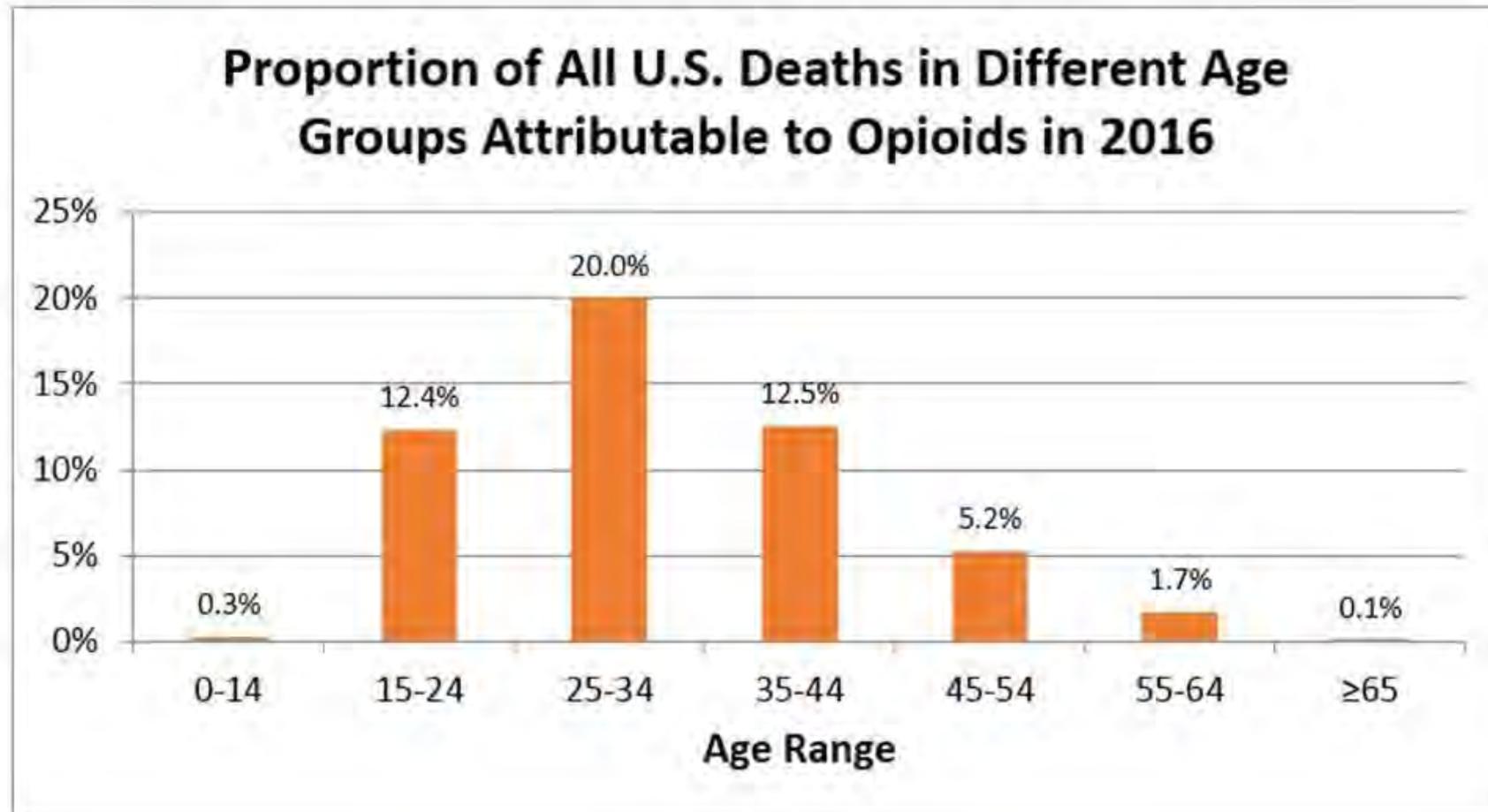
**13%** say it's an **acquaintance**

**8%** say it's a **close friend**

**6%** say it's a **family member**

# Opioid epidemic is deadlier than the Vietnam War in '68, study says

By Keith Humphreys June 7



**HEALTH**

# No Family Is Safe From This Epidemic

As an admiral I helped run the most powerful military on Earth, but I couldn't save my son from the scourge of opioid addiction.

**JAMES WINNEFELD** NOV 29, 2017

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# In one night, she lost two sons to opioids. She's on a mission to spare others that unfathomable pain

By MEGAN THIELKING [@meggophone](#) / AUGUST 15, 2017



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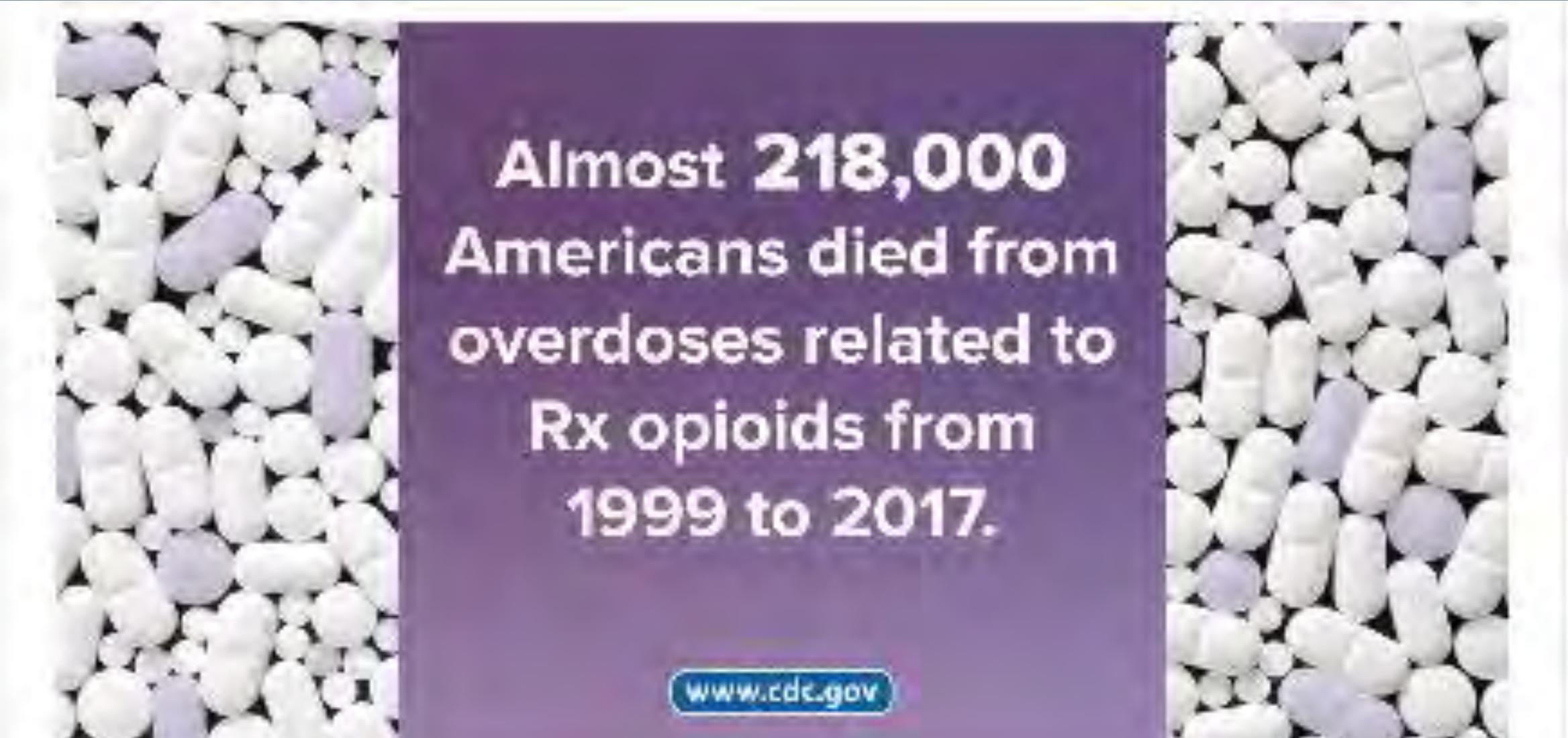


PARENTS

One family loses two sons to opioid epidemic: It's 'overwhelming'

# Massachusetts Mom Loses Third Son to Drug Overdose



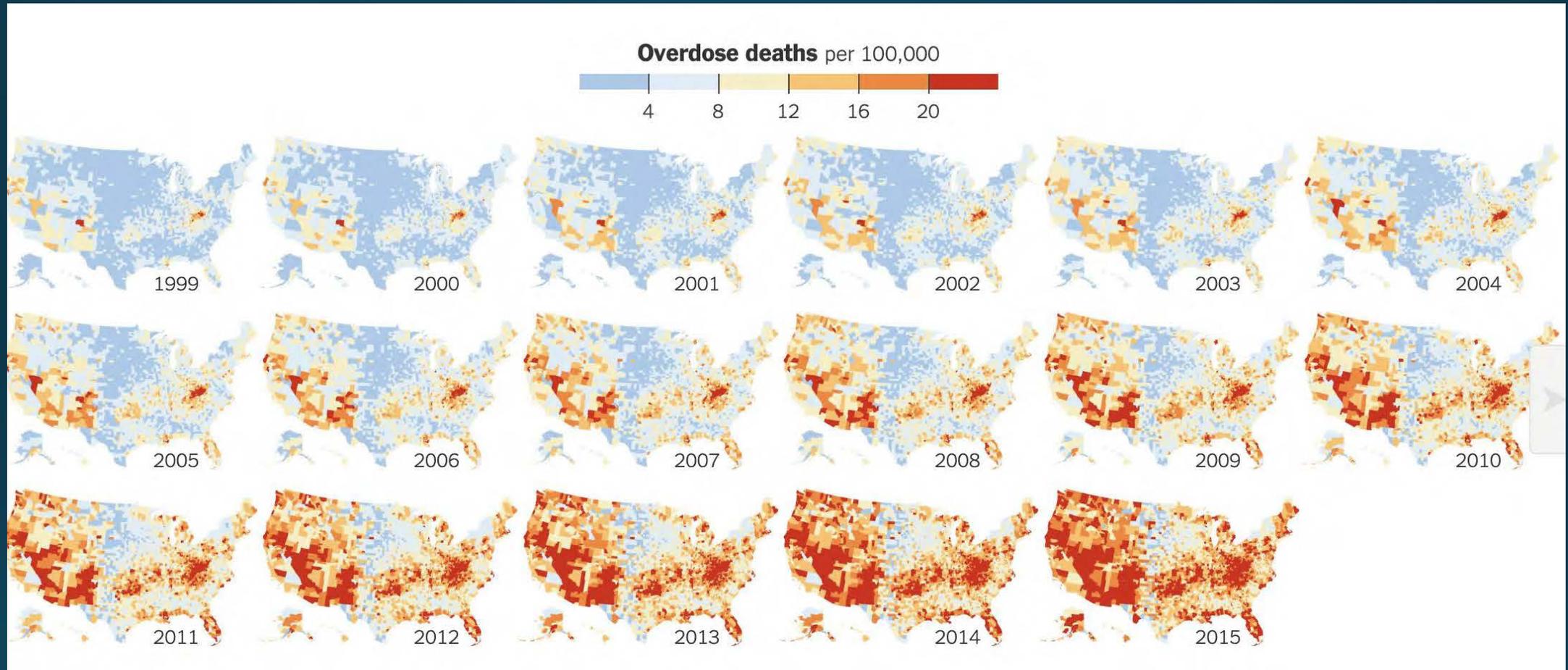


**Almost 218,000**  
Americans died from  
overdoses related to  
Rx opioids from  
1999 to 2017.

[www.cdc.gov](http://www.cdc.gov)

**By 2025, the yearly overdose deaths is projected to be nearly 82,000 Americans**

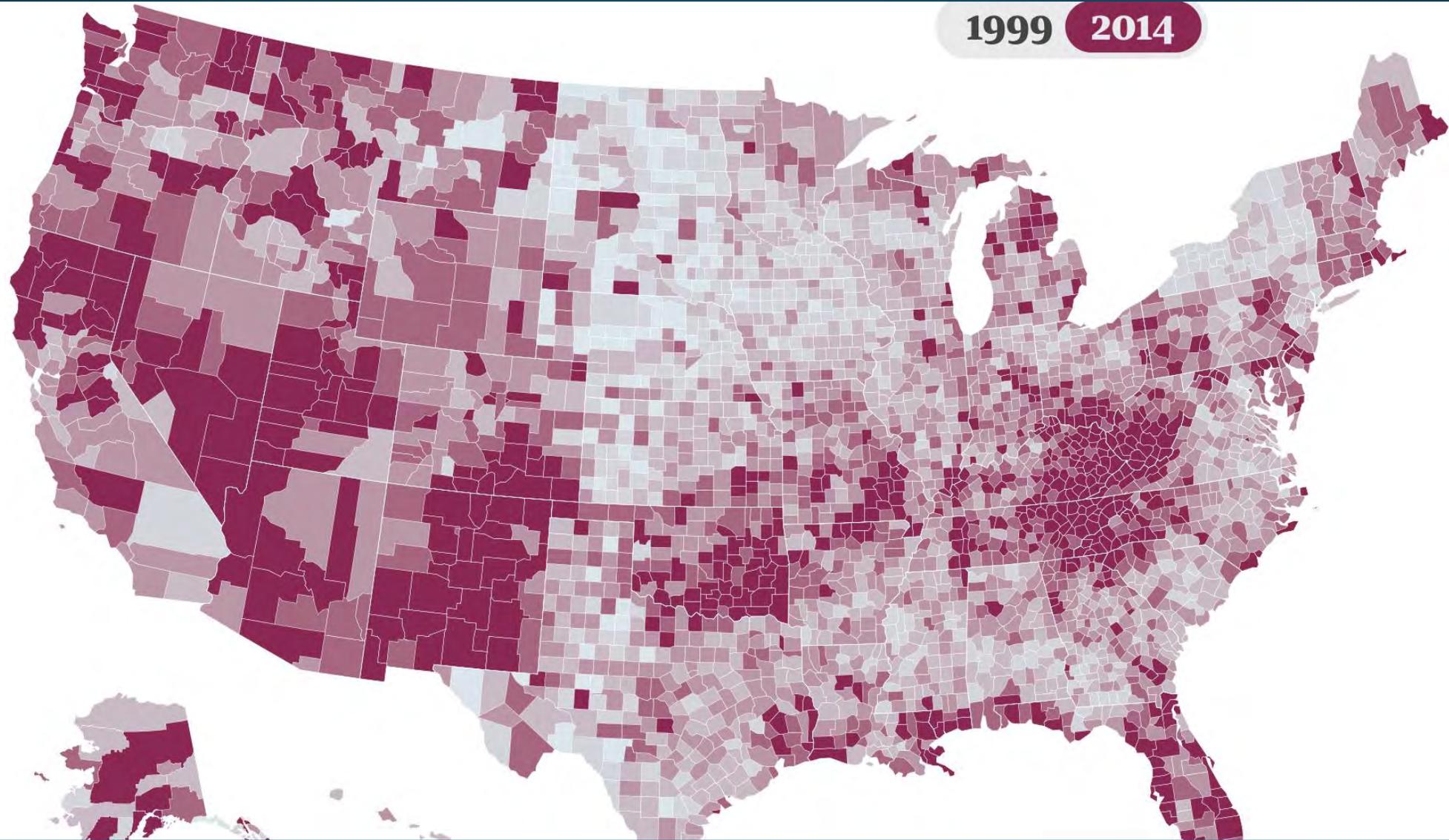
# The Numbers



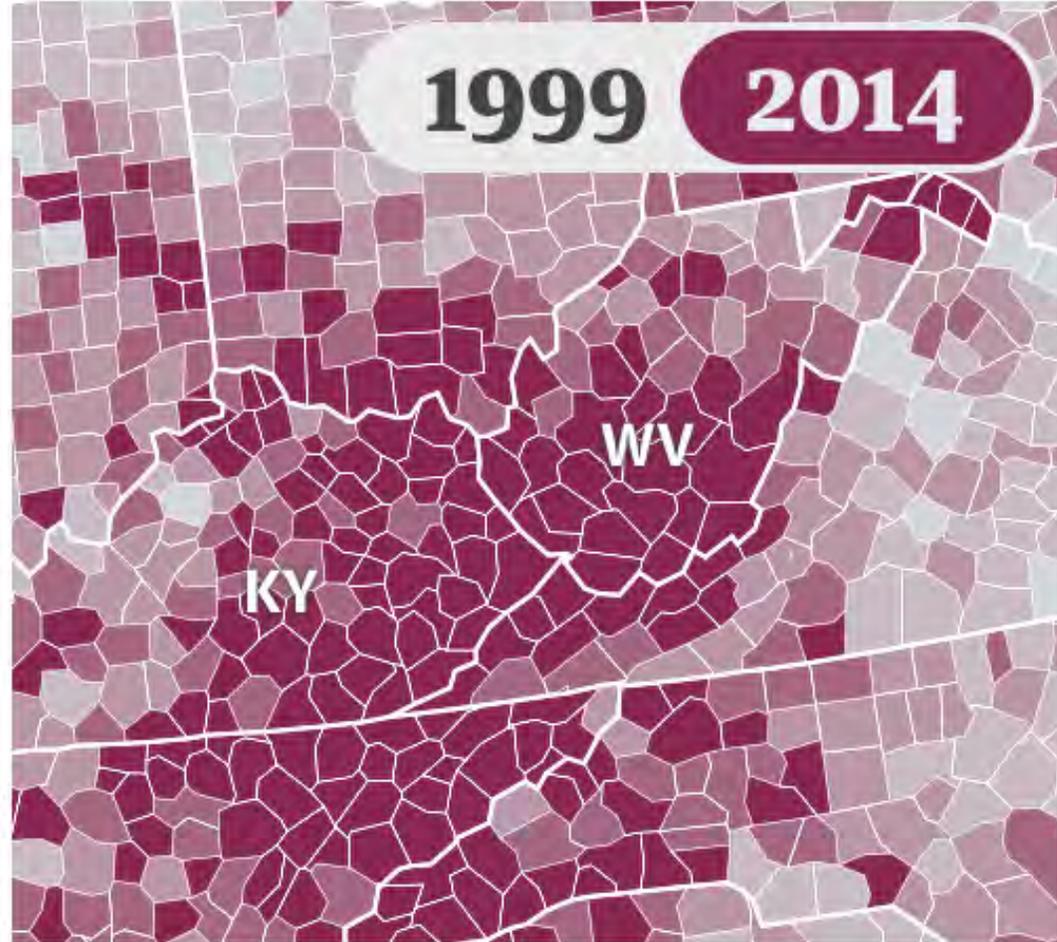
**1999- 2015**

**Overdose deaths more than tripled across the US**

1999 2014



# Central Appalachia



Deaths per 100,000 residents - by state

**1022  
ADAY**



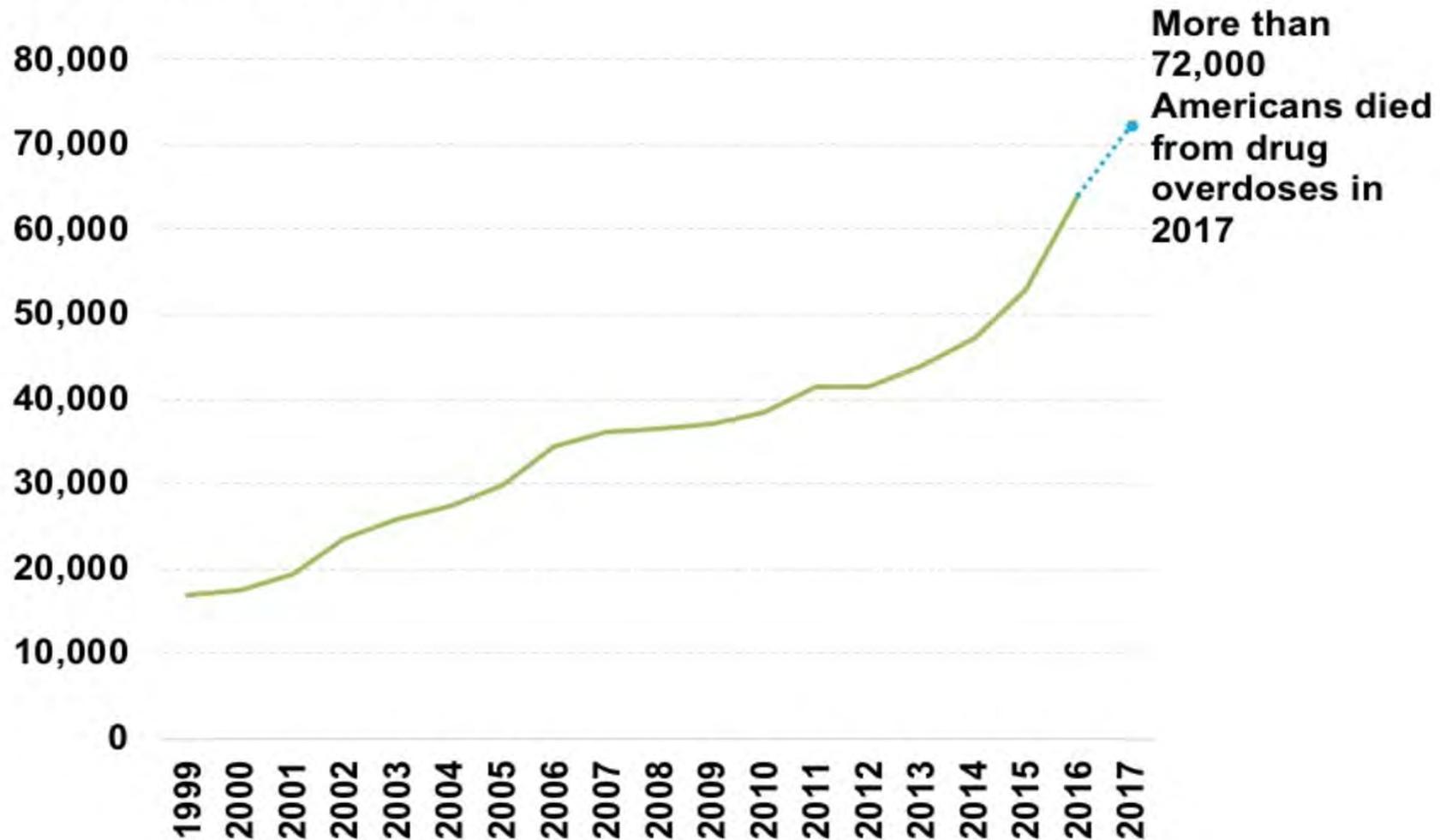
**When alcohol related deaths are factored in, the number is 433**

# Casualties of Drug Overdose in the US, in Perspectives

Every day: 192 casualties



## Total U.S. Drug Deaths



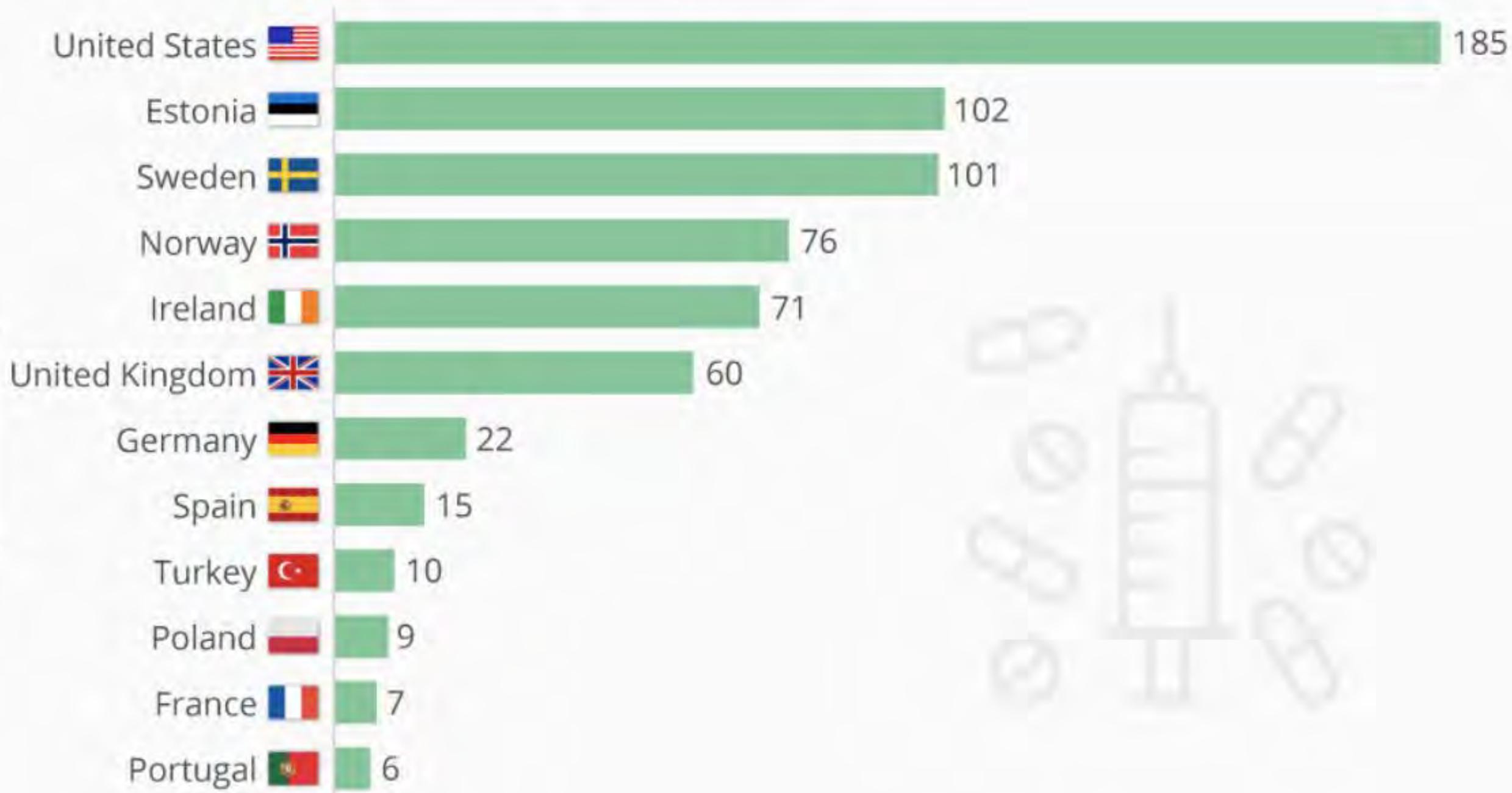
6 times higher than in 1999

# US 2017 Casualties in Perspectives



**NRG Stadium, Houston**

# Drug-induced deaths per million of the population



**(Unintentionally) doctors'/dentists' role in the opioid epidemic is greater than what many of us would like to think**

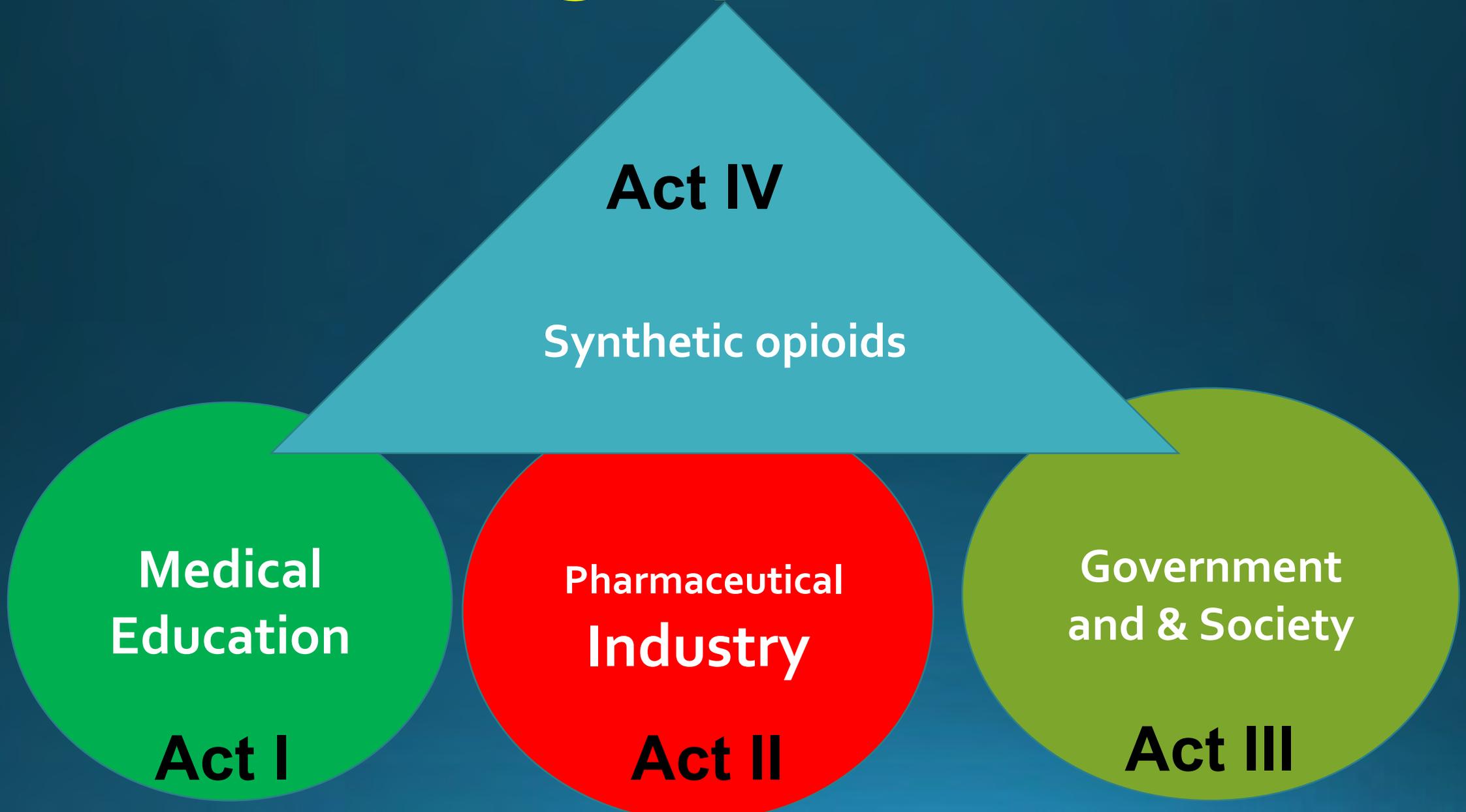
# The Opioid Epidemic: How Did We Get There?

A tragedy of four  
acts: Doctors  
played the first  
act



A journey of three  
waves: Doctors  
drove the first wave

# The Tragedy of Four Acts



# Inadequate Medical Education

```
graph LR; A[Inadequate Medical Education] --> B[Understanding addiction]; A --> C[Pain Management]; A --> D[Opioid Prescribing]; A --> E[Screening for high risk patients];
```

**Understanding  
addiction**

**Pain  
Management**

**Opioid  
Prescribing**

**Screening for  
high risk  
patients**

# The Journey to The Opioid Epidemic: Three Waves

**First Wave (1999-2010): Prescription Medications**

**Second Wave (2010-....): Heroin**

**Third Wave (2014-.....):  
Synthetic Opioids/Mixtures**

# The Opioid Epidemic: How Did We Get There?

Pain  
management

Adults

Substance Use Disorder

Pain  
management

Adolescence

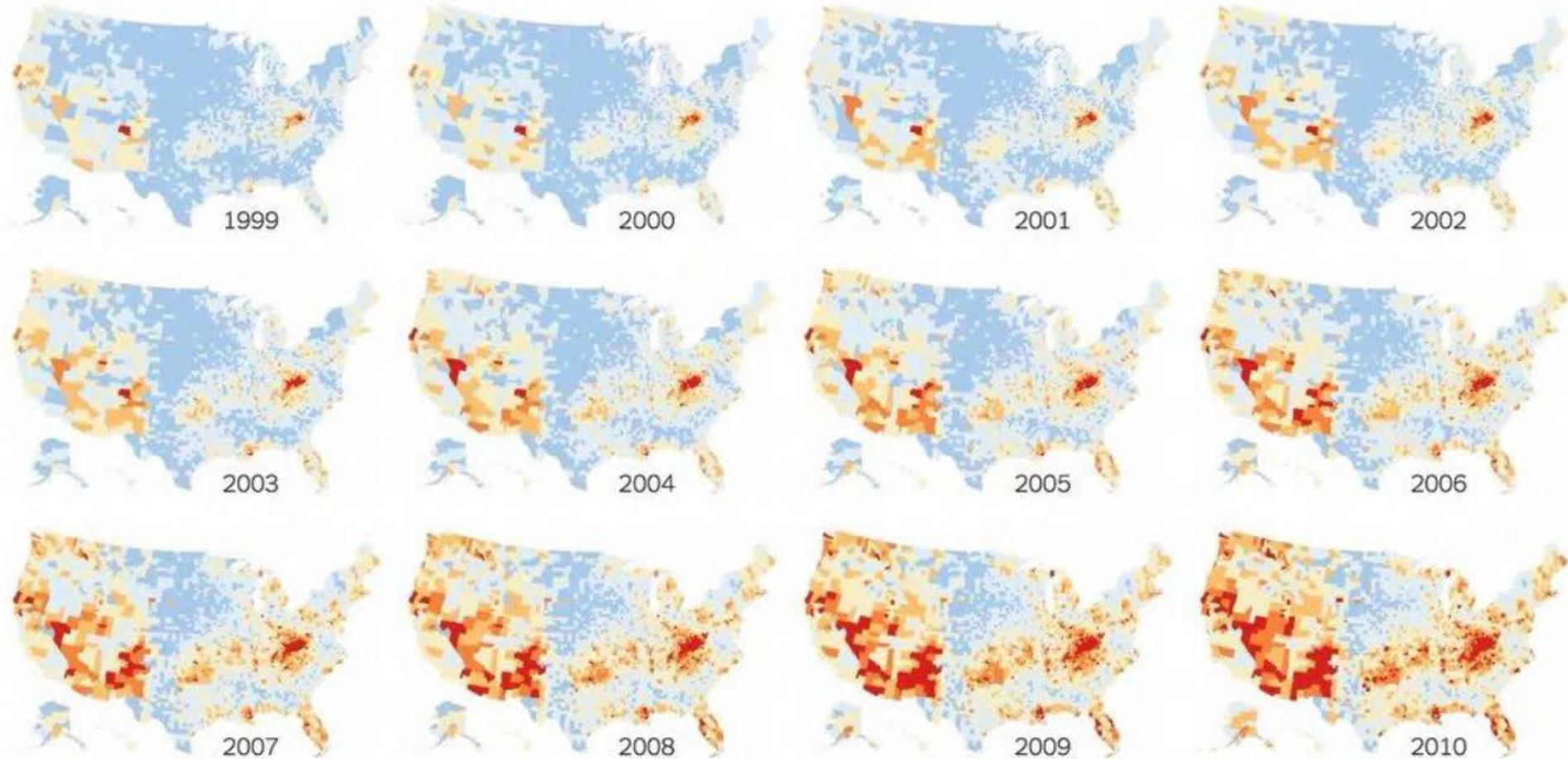
Substance Use Disorder

Experimentation!!

Adolescence

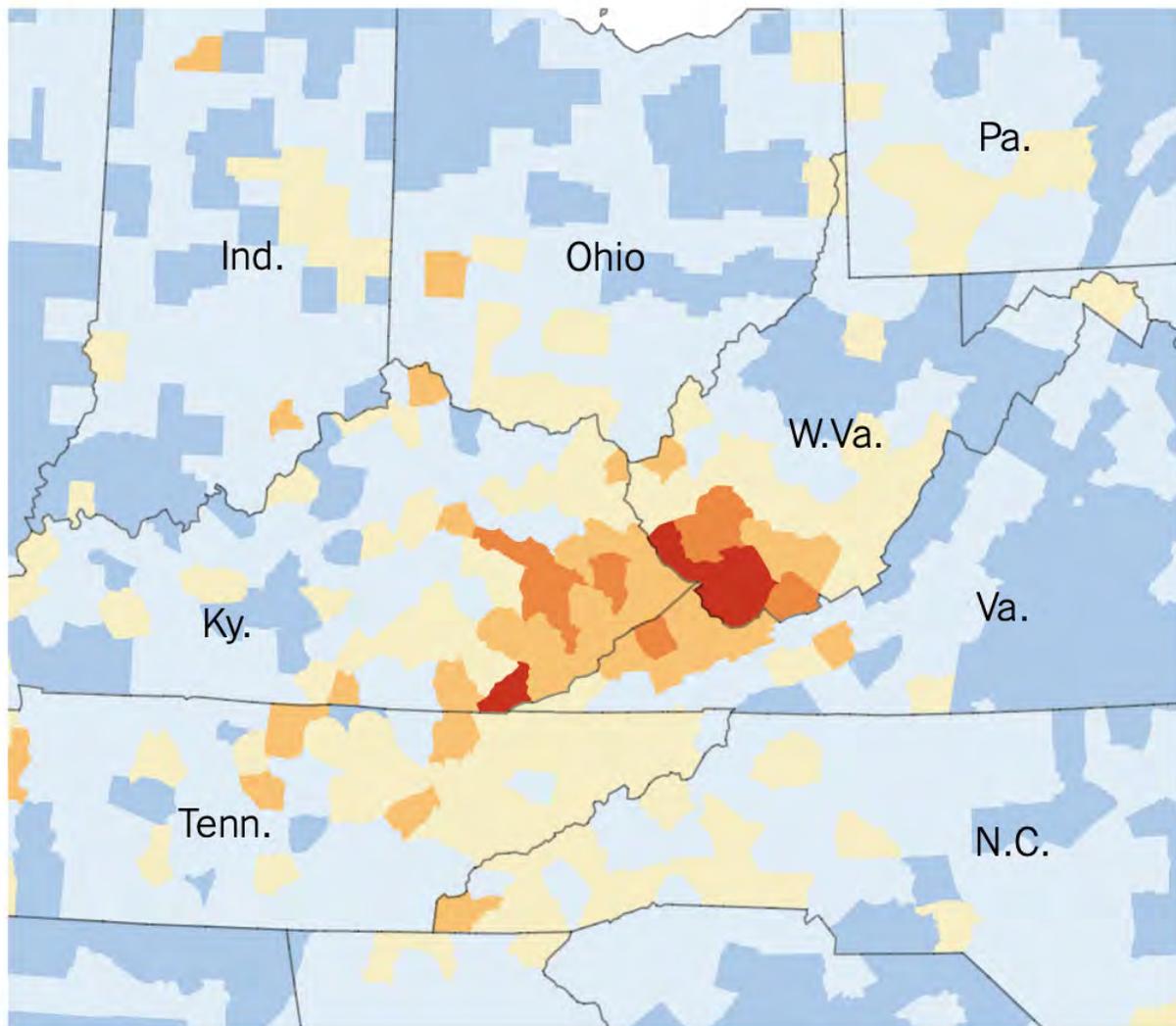
Substance Use Disorder

# The First Wave Starting 1999 to 2010

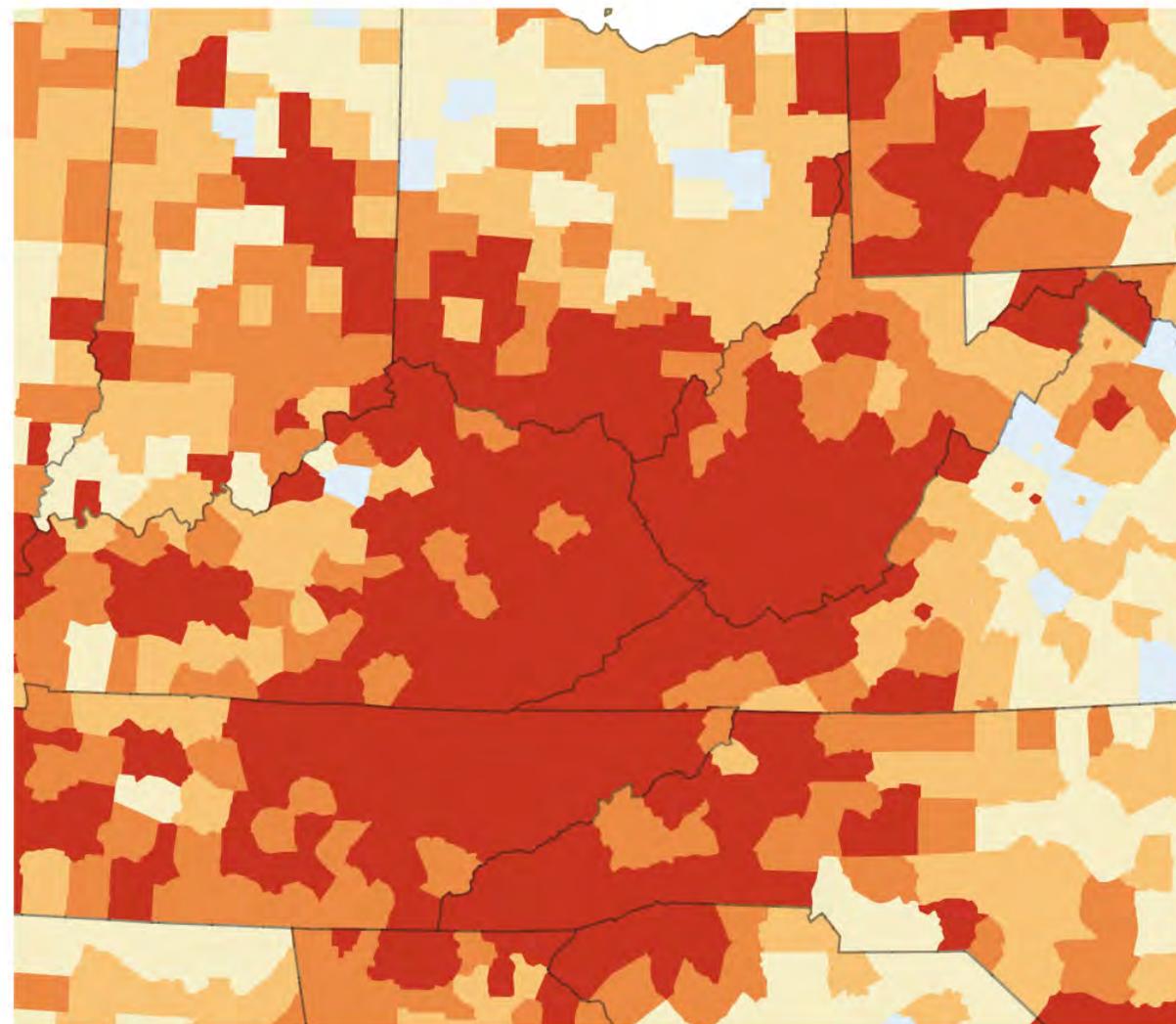


**Rapid increases in overdose deaths from prescription medications**

## Workplace injuries may drive rising addiction in Appalachia.



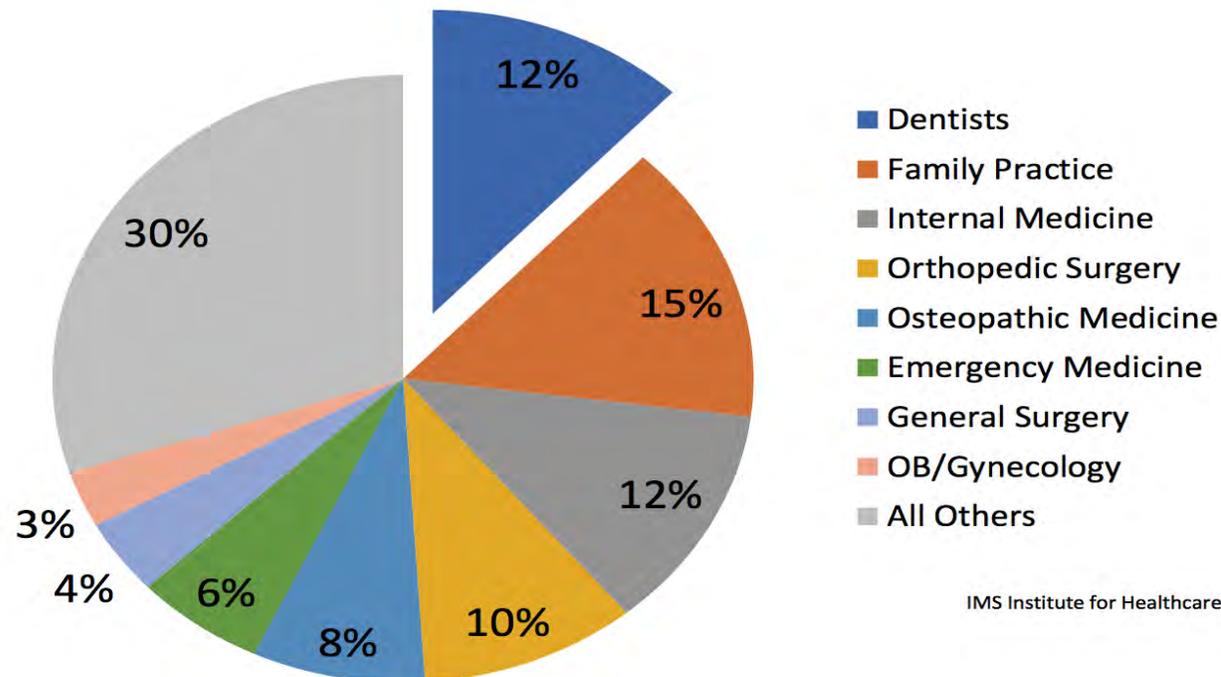
1999



2015

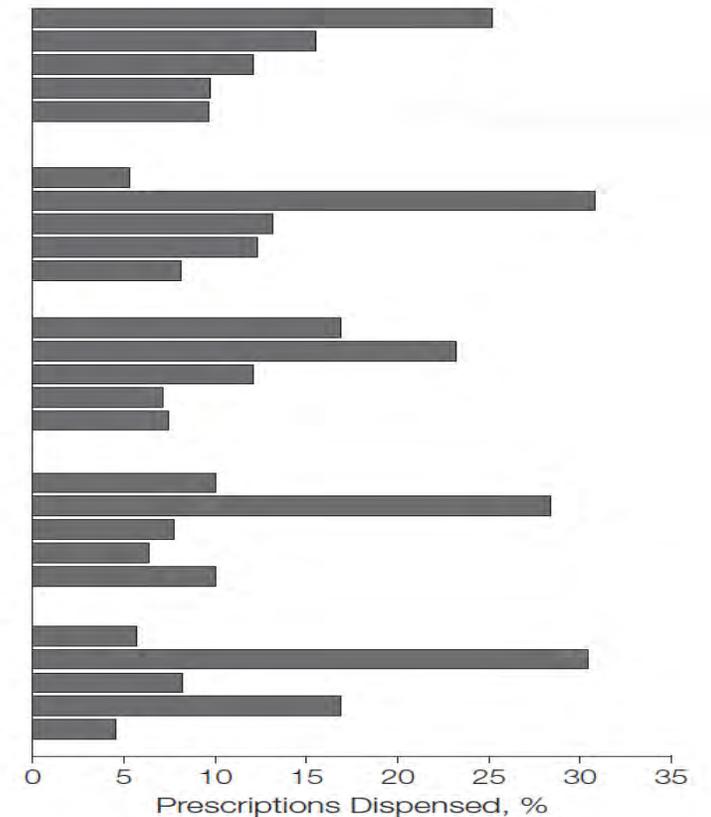
# Dentists “Disproportionate” Share of Opioids Prescribing

Prescribers of Immediate Release Opioids



IMS Institute for Healthcare Informatics

- Age 0-9 y
  - ENT physicians
  - Pediatricians
  - Dentists
  - GP/FM/DO
  - Emergency medicine
- Age 10-19 y
  - Pediatricians
  - Dentists
  - GP/FM/DO
  - Emergency medicine
  - Orthopedic surgery
- Age 20-29 y
  - Dentists
  - GP/FM/DO
  - Emergency medicine
  - IM
  - OB/GYN
- Age 30-39 y
  - Dentists
  - GP/FM/DO
  - Emergency medicine
  - Orthopedic surgery
  - IM
- Age ≥40 y
  - Dentists
  - GP/FM/DO
  - Orthopedic surgery
  - IM
  - Anesthesiology



# Opioid Prescribing Patterns of Dentists (OMFS)

Approximately 92%  
of wisdom teeth  
patients are opioid-  
naïve patients



Most patients are  
prescribed an  
average quantity of  
20 opioids tablets

# What I Learned

Opioids Analgesics ARE NOT Safe  
For Everybody



# Use of Opioids for Acute Pain

Opioids use to treat acute pain can lead to “long-term” use which increases with the length of the *initial prescription*

# The CDC on Use of Opioids for Acute Pain..2016

**The likelihood of long-term use increases sharply after the third and fifth days of taking an opioid prescription**

# Risk Factors for Opioid Use Disorders in Adult Postsurgical Patients

History of substance use and abuse



Use of “sedative hypnotics”



Any chronic physical malady/chronic pain



Younger age/older age



Family history of SUD

# Overprescribing Painkillers Contributed to The Opioid Epidemic



100 Million Prescription Opioids Go Unused Each Year  
Following Wisdom Teeth Removal

# Association of Opioid Prescriptions From Dental Clinicians for US Adolescents and Young Adults With Subsequent Opioid Use and Abuse

**Almost 7% of the exposed group received another opioid prescription within a year, compared to 0.1% of non-exposed group.**

# Addiction to Opioid

## Painkillers Is "Precursor" to Heroin Addiction

4 out of 5 Heroin Users



Previously Misused Prescription Pain Medications

Source: White House Office of National Drug Control Policy

**94%** of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were **"far more expensive and harder to obtain."**

Source: Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA Psychiatry*. 2014

**Where Are We Now?**

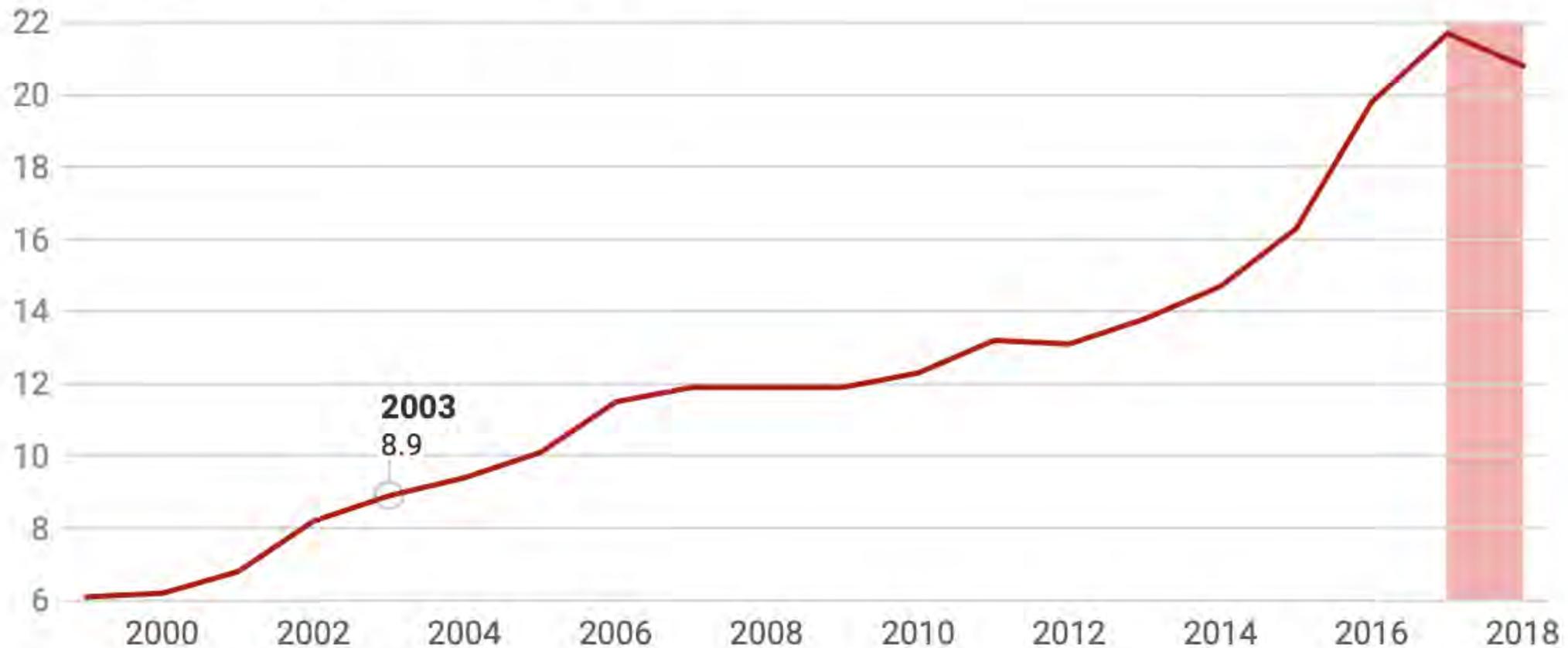
**Have A long Way To Go.....**

# Prevention of Prescription Opioid Misuse and Projected Overdose Deaths in the United States

- Targeting prescription opioid misuse may have only a modest effect, ( 3.0% to 5.3% decrease in opioid overdose deaths).
- Multipronged approach additional policy interventions are urgently needed to change the course of the epidemic.

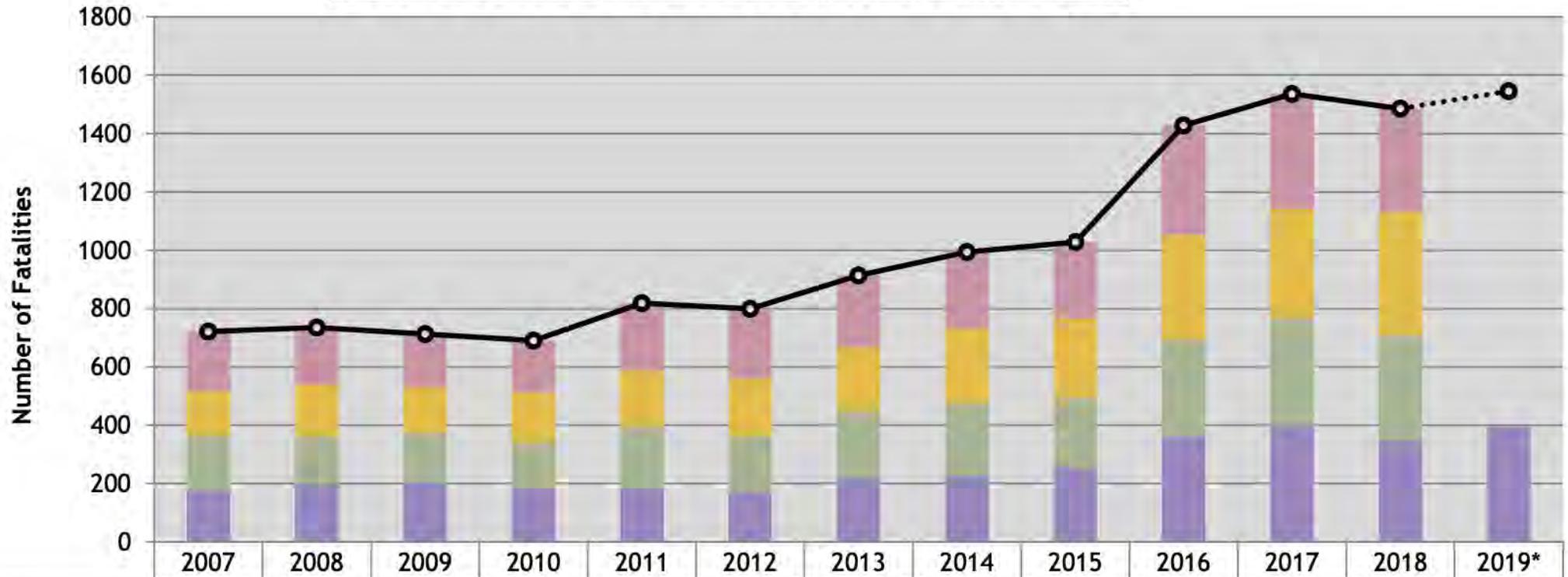
# Drug overdose deaths in the U.S. dropped in 2018 for only the second time in two decades

deaths per 100,000 people (age-adjusted)



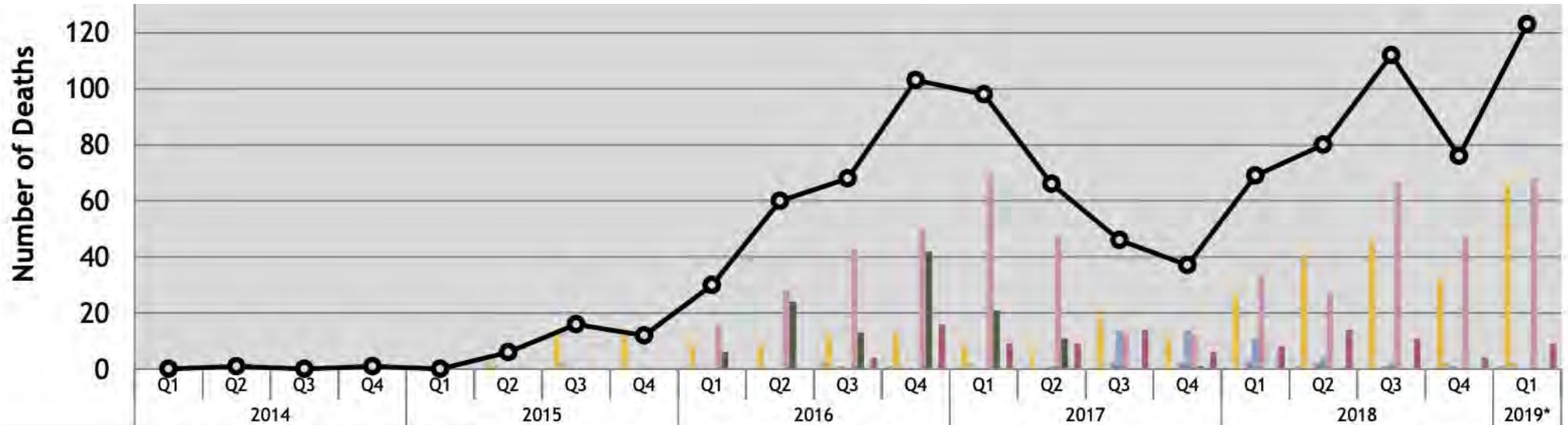
*\*data for 2018 are for the second quarter of the year*

Chart: Elijah Wolfson for TIME • Source: U.S. National Center for Health Statistics • [Get the data](#)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	205	195	183	179	232	240	248	263	262	375	393	354	
Q3	152	180	157	170	191	199	217	257	270	359	375	423	
Q2	188	162	172	159	215	190	230	246	243	332	371	363	
Q1	176	198	201	182	181	170	219	228	253	362	397	346	395
Total Fatalities	721	735	713	690	819	799	914	994	1028	1428	1536	1486	1546

# FENTANYL ANALOGS



	2014				2015				2016				2017				2018				2019*
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
3-Methyl Fentanyl	0	0	0	0	0	0	0	0	0	0	3	1	0	0	0	0	0	1	0	0	1
Acetyl Fentanyl	0	1	0	1	0	5	14	12	8	8	12	13	8	6	18	11	27	40	46	32	66
Butyryl Fentanyl	0	0	0	0	0	1	2	0	0	0	0	0	2	0	0	0	0	0	0	2	2
Carfentanil	0	0	0	0	0	0	0	0	0	0	1	0	0	0	2	2	3	2	1	1	0
Cyclopropyl Fentanyl	0	0	0	0	0	0	0	0	0	0	0	0	0	1	14	14	11	4	2	0	0
Despropionyl Fentanyl**	0	0	0	0	0	0	0	0	16	28	43	50	70	47	13	12	33	27	67	47	68
Furanyl Fentanyl	0	0	0	0	0	0	0	0	6	24	13	42	21	11	0	1	0	0	0	0	0
Methoxyacetyl Fentanyl	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	2	3	0	0	0	2
Para-Fluoroisobutyryl Fentanyl***	0	0	0	0	0	0	0	0	0	0	4	16	9	9	14	6	8	14	11	4	9
<b>Total Fentanyl Analog Fatalities</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>6</b>	<b>16</b>	<b>12</b>	<b>30</b>	<b>60</b>	<b>68</b>	<b>103</b>	<b>98</b>	<b>66</b>	<b>46</b>	<b>37</b>	<b>69</b>	<b>80</b>	<b>112</b>	<b>76</b>	<b>123</b>

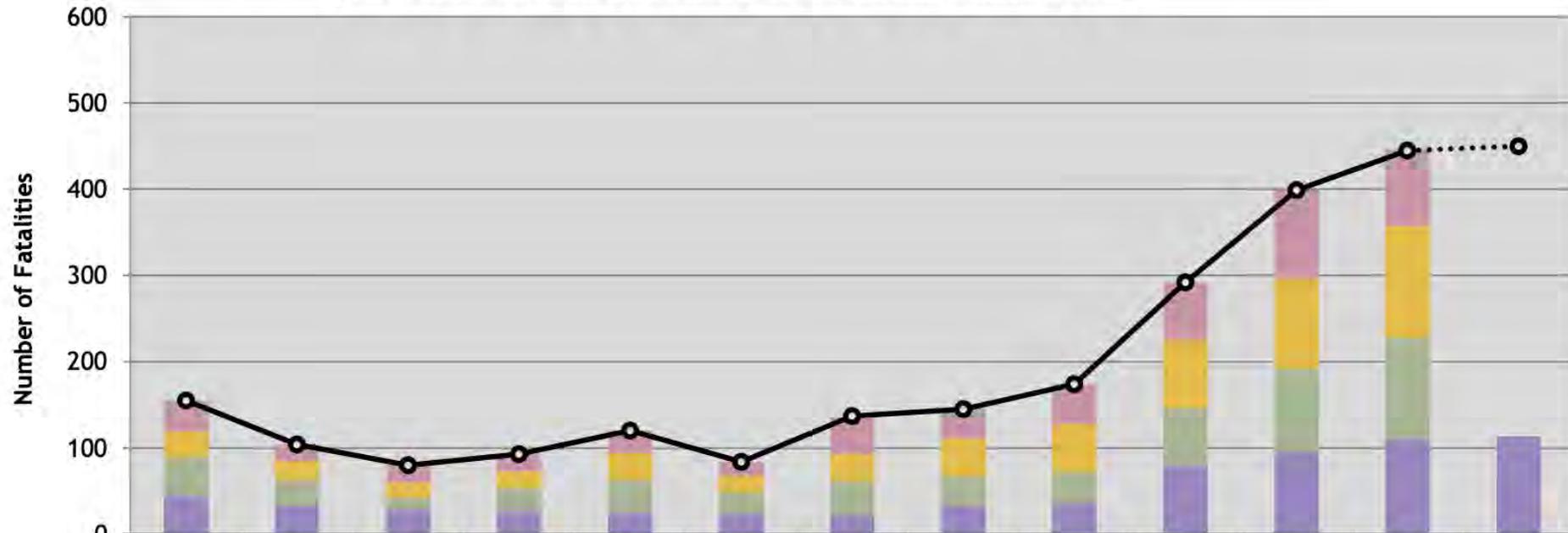
<sup>1</sup> Each fentanyl analog is tallied by each time it caused or contributed to death (analyzed from either toxicology or the cause of death statement) and therefore the total number of analogs will far exceed the actual number of fatalities

<sup>2</sup> Despropionyl fentanyl is a major metabolite of furanyl fentanyl. Therefore, numbers presented in the 'despropionyl fentanyl' category control for furanyl fentanyl (despropionyl deaths without furanyl fentanyl).

<sup>3</sup> In certain cases, specialized testing through an outside laboratory is needed for toxicology testing. In this laboratory, their testing for para-fluoroisobutyryl fentanyl and para-fluorobutyryl fentanyl cannot distinguish between the two analogs and therefore in this analysis, the two drugs are grouped together under 'para-fluoroisobutyryl fentanyl'

# COCAINE

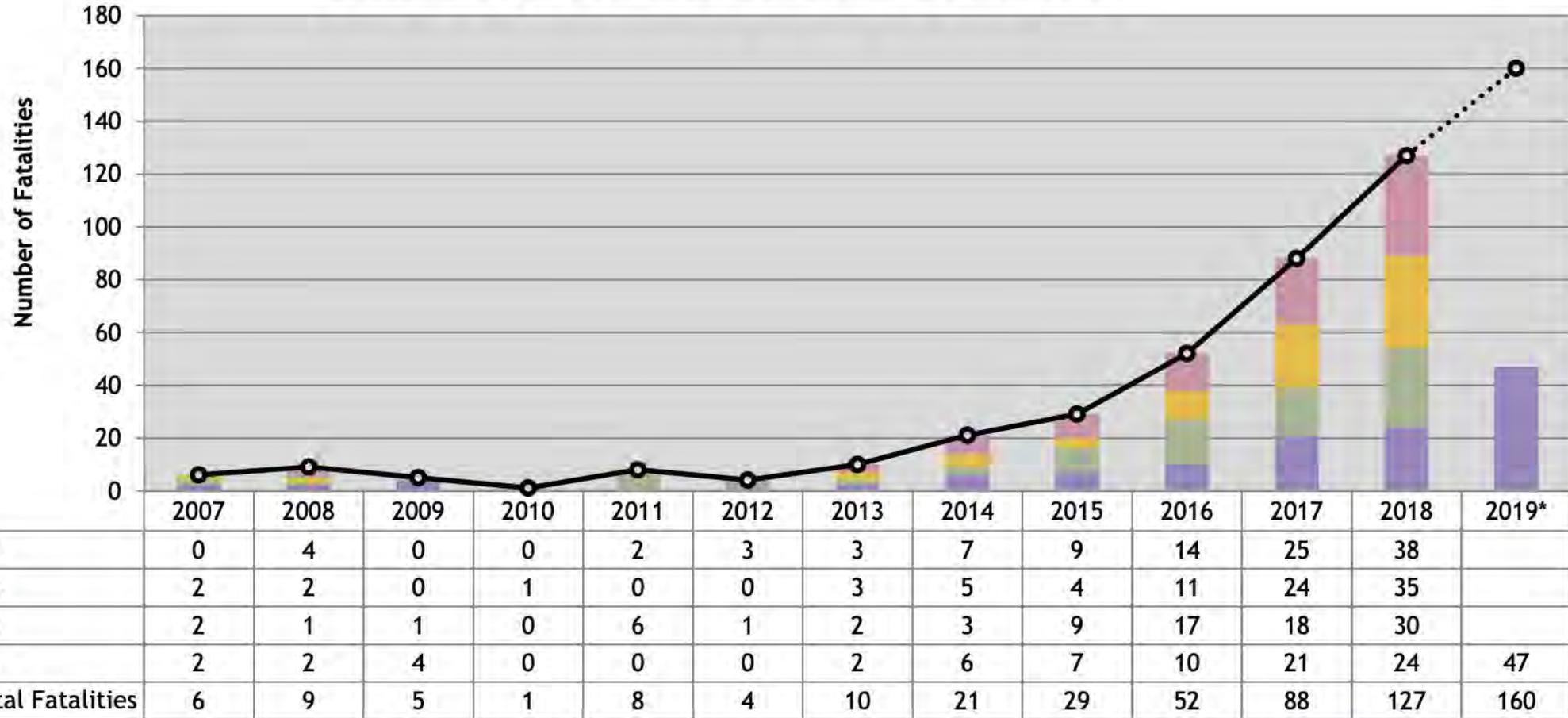
Total Number of Fatal Cocaine Overdoses by Quarter and Year of Death, 2007-2019\*  
 (Data for 2019 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	36	19	20	20	26	16	44	34	46	67	103	88	
Q3	30	22	18	19	31	20	31	44	56	79	104	130	
Q2	44	30	14	27	38	24	40	34	36	66	96	118	
Q1	45	33	28	27	25	24	22	33	36	80	96	110	113
—●— Total Fatalities	155	104	80	93	120	84	137	145	174	292	399	445	450

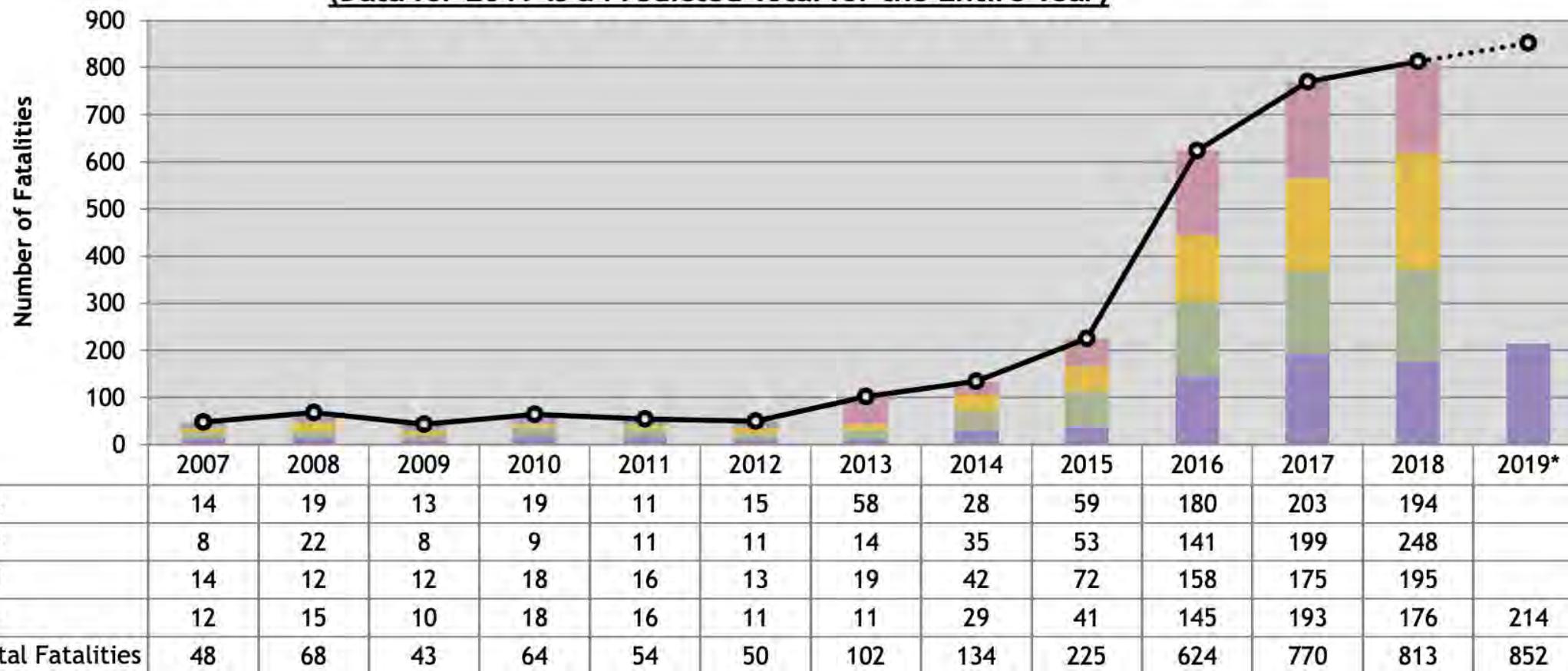
# METHAMPHETAMINE

(Data for 2019 is a predicted total for the entire year)



# FENTANYL

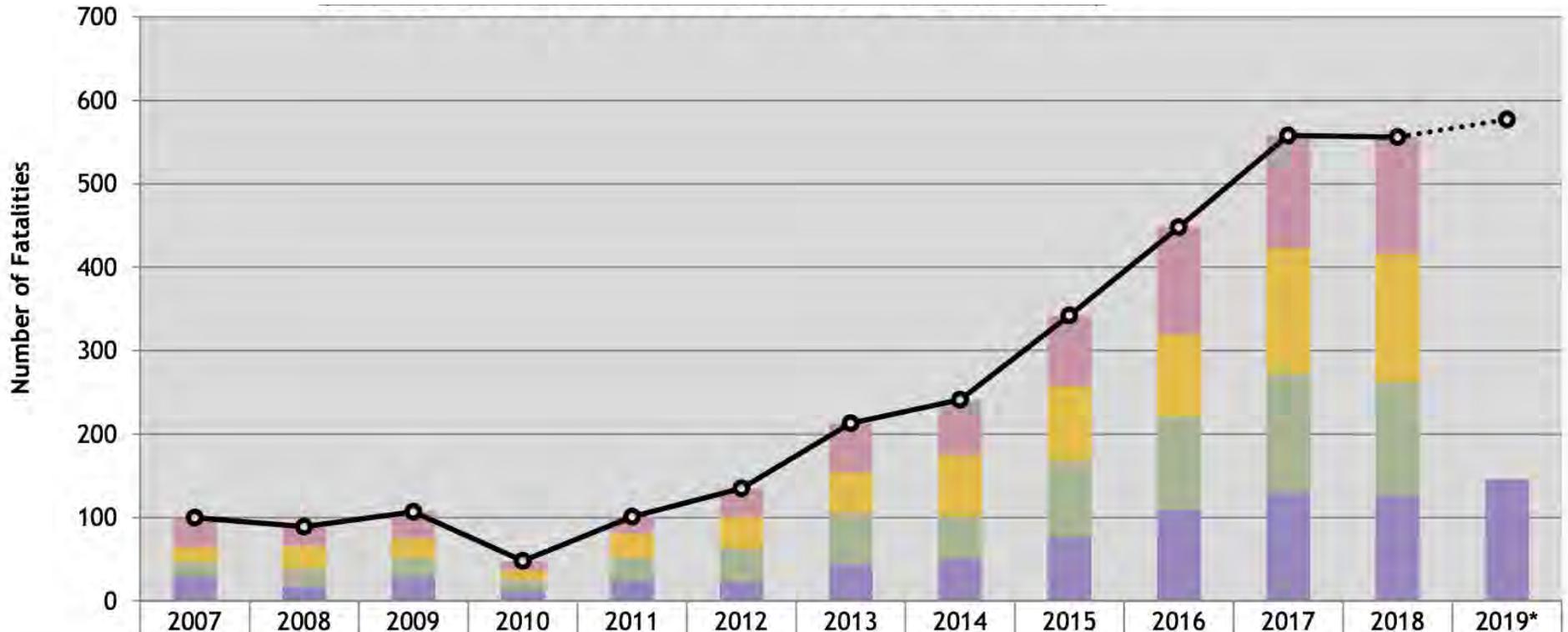
Total Number of Fatal Fentanyl Overdoses by Quarter and Year of Death, 2007-2019\*  
 (Data for 2019 is a Predicted Total for the Entire Year)



<sup>1</sup> Historically, fentanyl has been categorized as a prescription opioid because it is mass produced by pharmaceutical companies. However, law enforcement investigations and toxicology results have demonstrated that several recent fentanyl seizures have **not** been pharmaceutically produced, but illicitly produced. This illicit form of fentanyl is produced by international drug traffickers who import the drug into the United States and often, mix it into heroin being sold. This illicitly produced fentanyl has been the biggest contributor to the significant increase in the number of fatal opioid overdoses in Virginia.

<sup>2</sup> Illicit and pharmaceutically produced fatal fentanyl overdoses are represented in this analysis. This includes all different types of fentanyl analogs (acetyl fentanyl, furanyl fentanyl, etc.)

# HEROIN

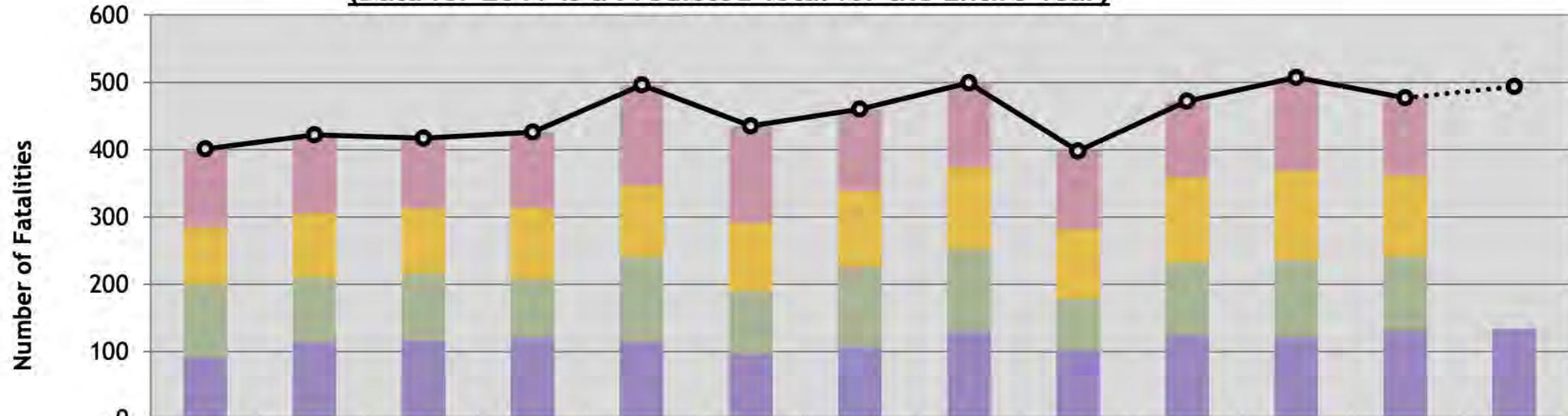


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	35	23	32	11	20	34	59	66	84	129	135	140	
Q3	18	27	23	11	29	38	48	74	90	98	151	154	
Q2	17	22	24	14	27	40	62	51	92	111	142	135	
Q1	30	17	28	12	25	23	44	50	76	110	130	127	146
● Total Fatalities	100	89	107	48	101	135	213	241	342	448	558	556	577

# PRESCRIPTION OPIOIDS (EXCLUDING FENTANYL)

Total Number of Fatal Prescription Opioid Overdoses (Excluding Fentanyl) by Quarter and Year of Death, 2007-2019\*

(Data for 2019 is a Predicted Total for the Entire Year)

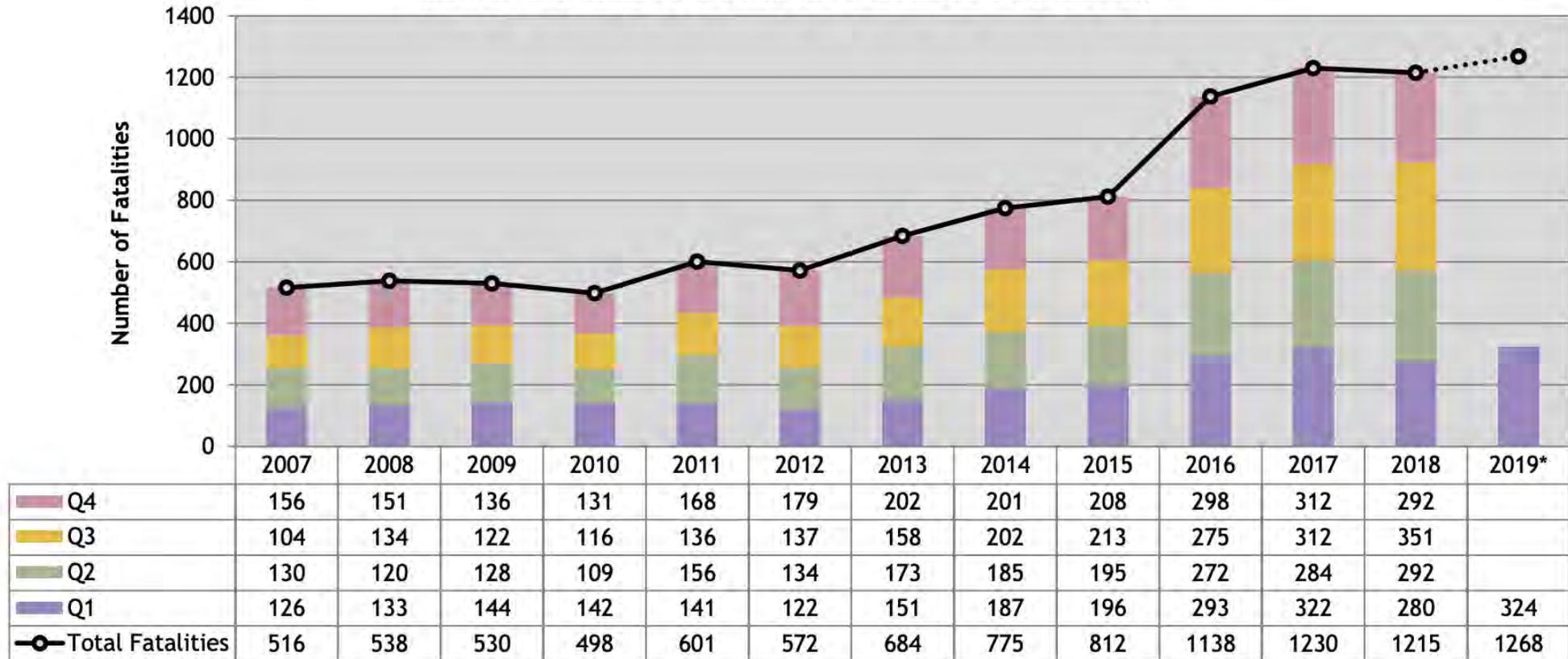


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	116	116	104	112	149	144	121	125	116	113	138	115	
Q3	86	96	97	107	106	101	113	122	104	127	133	121	
Q2	107	96	100	86	126	93	119	122	77	107	115	110	
Q1	92	114	116	121	115	97	107	130	101	125	121	131	134
Total Fatalities	401	422	417	426	496	435	460	499	398	472	507	477	494

<sup>1</sup> 'Prescription Opioids (excluding fentanyl)' calculates all deaths in which one or more prescription opioids caused or contributed to death, but excludes fentanyl from the **required list** of prescription opioid drugs used to calculate the numbers. However, given that some of these deaths have multiple drugs on board, some deaths may have fentanyl in addition to other prescription opioids, and are therefore counted in the total number. Analysis must be done this way because by excluding all deaths in which fentanyl caused or contributed to death, the calculation would also exclude other prescription opioid deaths (oxycodone, methadone, etc.) from the analysis and would thereby undercount the actual number of fatalities due to these true prescription opioids.

# ALL OPIOIDS

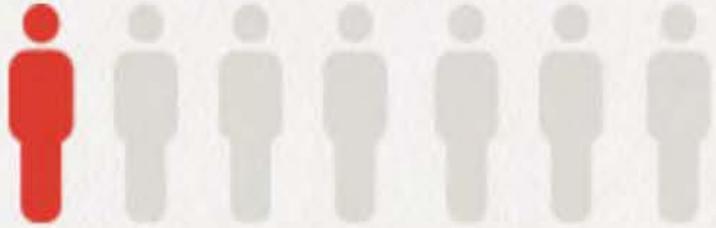
**Total Number of Fatal Opioid Overdoses by Quarter and Year of Death, 2007-2019\***  
 (Data for 2019 is a Predicted Total for the Entire Year)



<sup>1</sup> 'All Opioids' include all versions of fentanyl, heroin, prescription opioids, U-47700, and opioids unspecified

<sup>2</sup> 'Opioids Unspecified' are a small category of deaths in which the determination of heroin and/or one or more prescription opioids cannot be made due to specific circumstances of the death. Most commonly, these circumstances are a result of death several days after an overdose, in which the OCME cannot test for toxicology because the substances have been metabolized out of the decedent's system.

<sup>3</sup> Fatal opioid numbers have changed slightly from past reports due to the removal of fentanyl from the category of prescription opioids, as well as the addition of buprenorphine, levorphanol, meperidine, pentazocine, propoxyphene, and tapentadol added to the list of prescription opioids.



**40 Million**  
**or >1 in 7**

**AGES 12 AND OLDER HAVE  
A SUBSTANCE PROBLEM...**

**...THIS IS MORE THAN THE  
NUMBER OF AMERICANS WITH:**



**HEART CONDITIONS**  
**(27 Million)**



**DIABETES**  
**(26 Million)**



**CANCER**  
**(19 Million)**

**Only 11% are getting the help they need.**

# 45% of inmates

---

in local jails and state prisons simultaneously grapple with a substance use and psychological disorder.

# The Real Harm In Numbers



**23.5 million Are in recovery**

# Types of Substance Use Disorders

- ✓ Alcohol Use Disorder
- ✓ Tobacco Use Disorder
- ✓ Stimulant Use Disorder
- ✓ Hallucinogen Use Disorder
- ✓ Opioid Use Disorder
- ✓ Sedative Use Disorder
- ✓ Marijuana Use Disorder

Substances that students have tried  
*at least once* before the age of 18:



91% Alcohol



40% Tobacco



47% Marijuana



18% Prescription  
Drugs



5% Illicit  
Substances

## TOP 3 SUBSTANCES USED BY COLLEGE STUDENTS IN 2016

78.9%



ALCOHOL

39.3%



MARIJUANA

9.9%



ADDERALL

# Where Do We Go From Here?

**Answer the most important  
question**

# We are still struggling with the central question

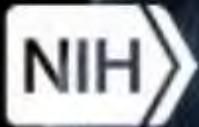


# Is Addiction A Choice or a Disease



“In all my years as a physician, I have never, ever met an addicted person who wanted to be an addict.”

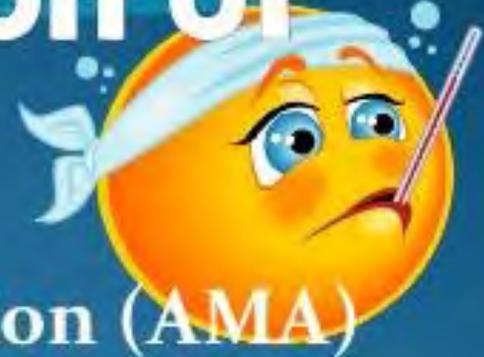
- Dr. Nora Volkow  
NIDA Director



National Institute  
on Drug Abuse

[DrugAbuse.gov](http://DrugAbuse.gov)

# Medical Recognition of the Disease



1956 – The American Medical Association (AMA) formally recognized the disease concept of alcoholism/addiction

June 1988 – The American Society of Addiction Medicine (ASAM) was admitted to AMA House of Delegates as a voting member

2000 – The AMA added “addiction medicine” to its list of designated specialties

# Surgeon General Vivek Murthy: Addiction Is A Chronic Brain Disease, Not A Moral Failing

The way forward includes needle exchanges and calling addiction what it is: a medical condition.



By Erin Schumaker



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LIFESTYLE**

We're basically your best

# The Choice Argument: Addiction Is Not Disease

Diabetes is a disease and diabetic can not choose to not be diabetic

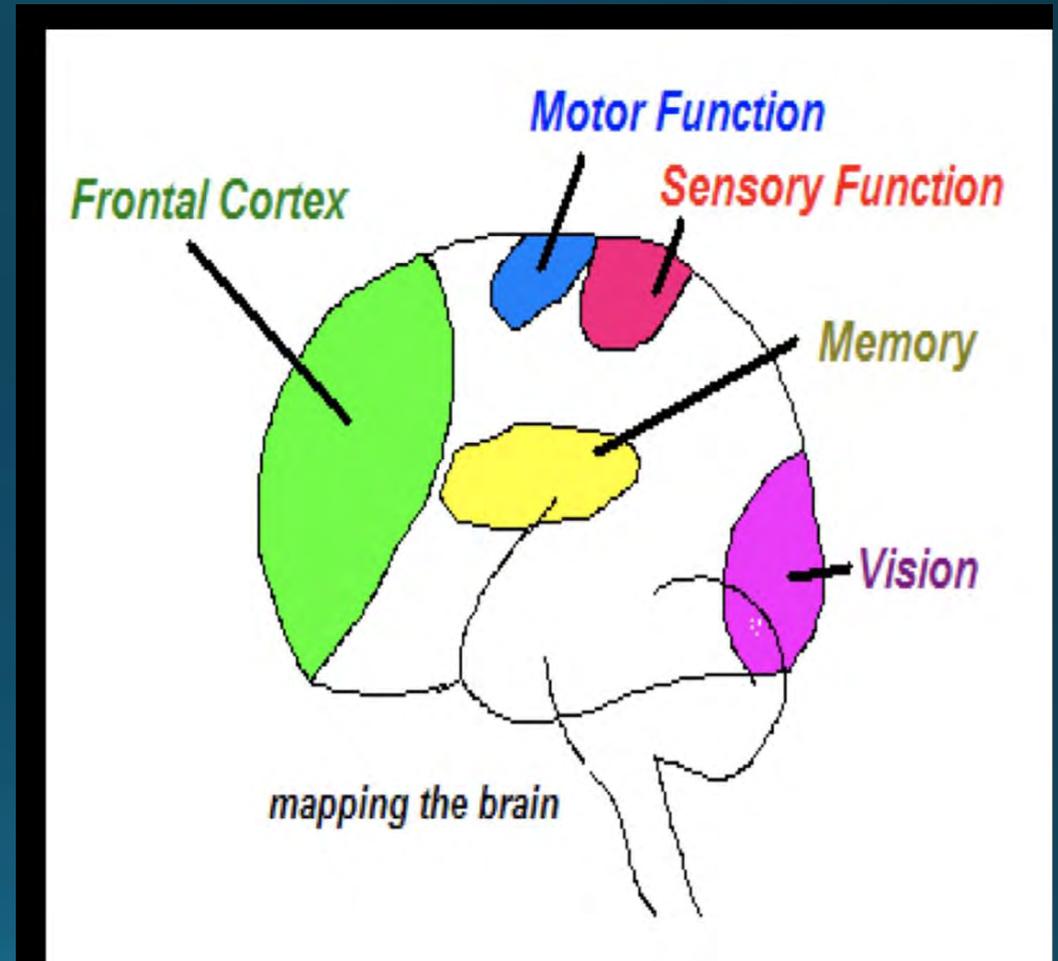
The frontal lobe controls choices, morality, and spirituality, ...

Addict can choose to use or not use drugs

Therefore, addiction is not a disease

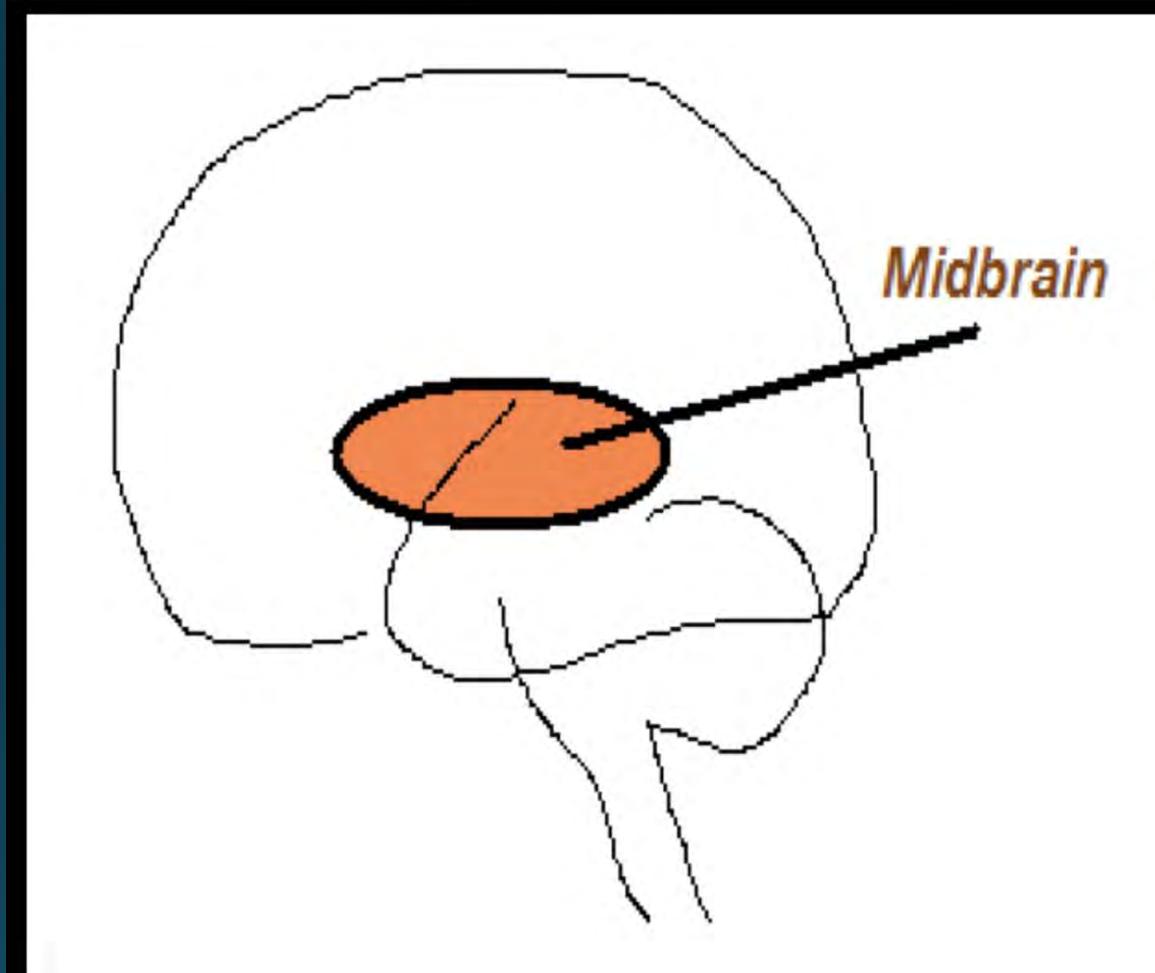
# Frontal Cortex : Choice

- Personality
- Love,
- Emotional meaning
- Morality,
- Decency,
- Responsibility,
- Spirituality
- conscious



**Problem: Frontal Cortex is Not Where Drugs Work**

# Addiction: The Disease Arguments



**Midbrain: It Is Where  
Drugs Work**

**Survival:**

- Food
- Sex
- Drugs

**Handles the next thirty seconds**

# In Addiction

In the midst of  
survival panic

+

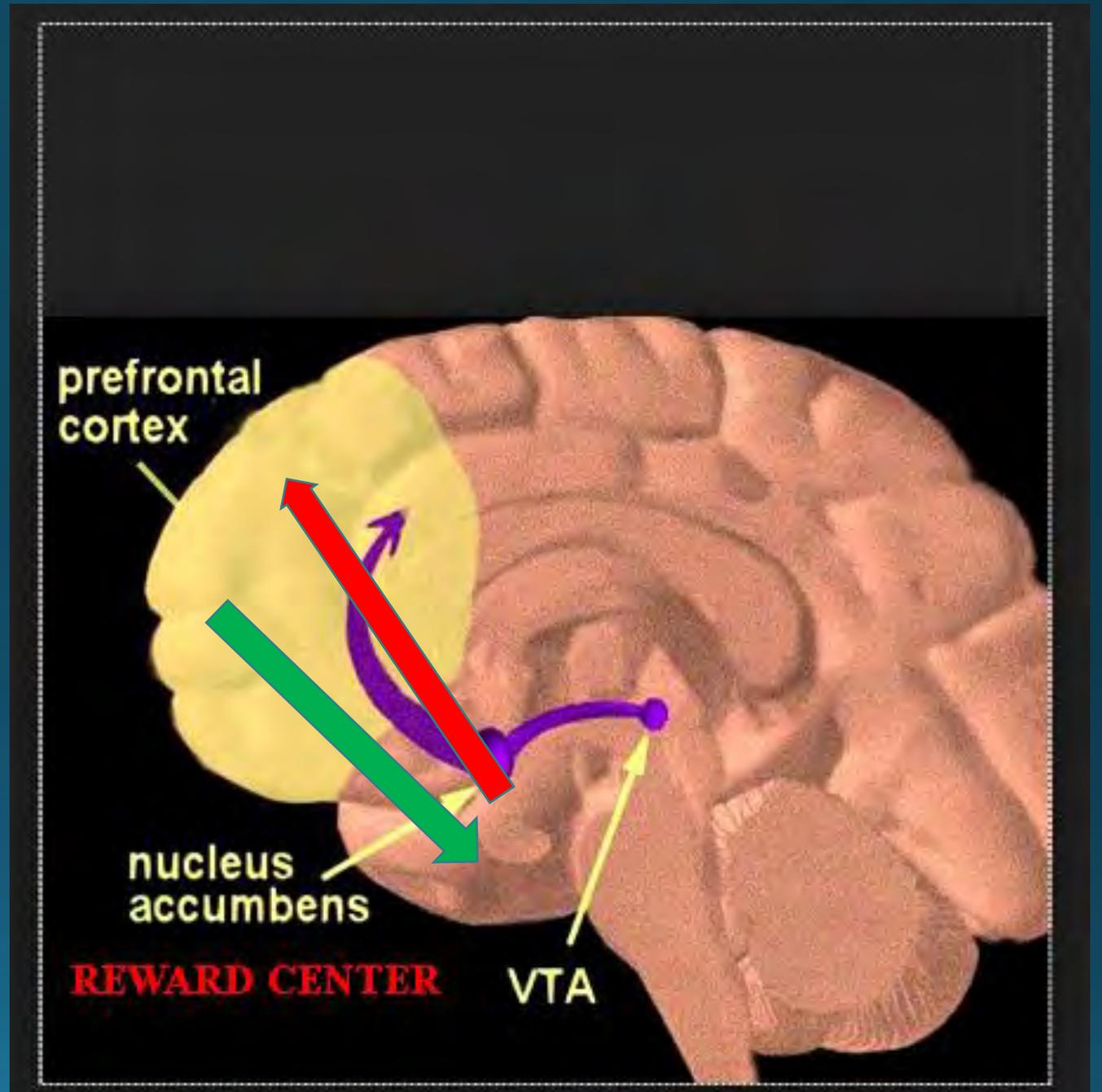
The midbrain  
reigns



Forebrain and  
conscious  
thought become  
constricted  
(inaccessible)



The midbrain  
reigns



# What Happens If We Call Addiction a Disease?

**Addicts are patients**

A large, light green downward-pointing arrow connects the first box to the second box.

**Addicts have the same rights as all patients**

A large, light green downward-pointing arrow connects the second box to the third box.

**Stigma associated with the disease disappears and addicts would not be stigmatized for their disease**

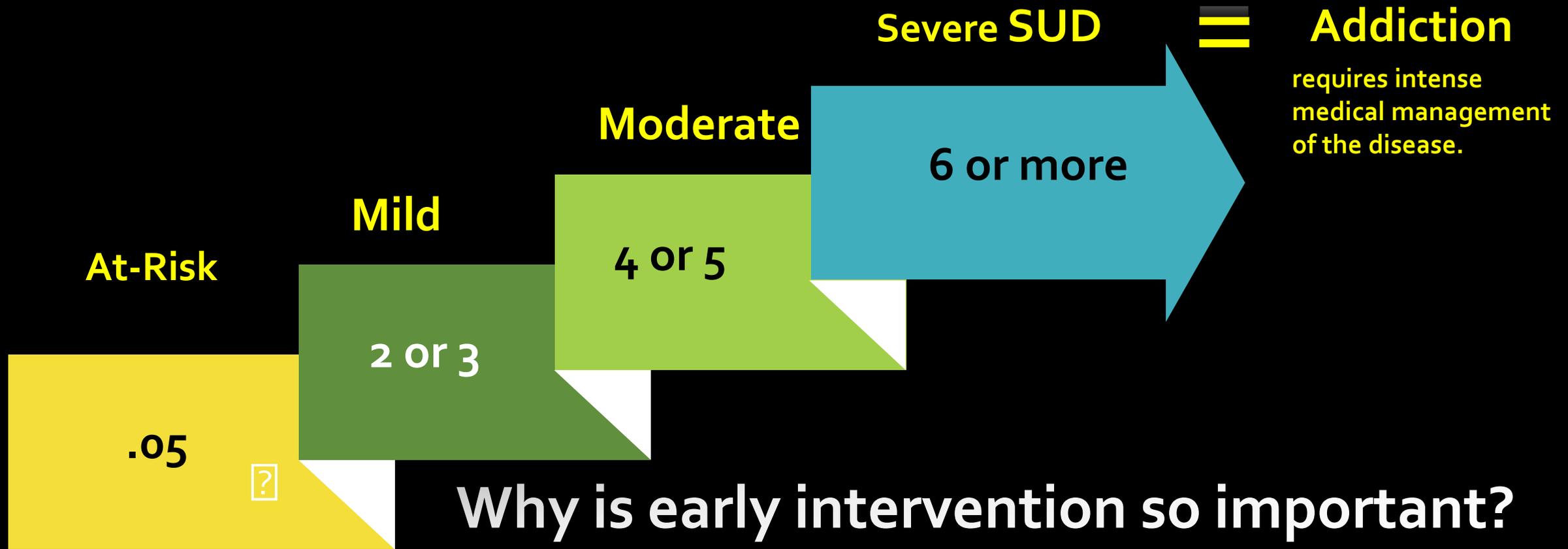
# Criteria for a Substance Use Disorder

- 1. Hazardous use**
- 2. Social or interpersonal problems related to the use**
- 3. Neglected major roles to use (work, school, etc)**
- 4. Withdrawal**
- 5. Tolerance**

# Criteria for a Substance Use Disorder

- 6. Used larger amounts/longer**
- 7. Repeated attempts to control use or quit**
- 8. Much time spent using**
- 9. Physical or psychological problems related to use**
- 10. Activities given up to use**
- 11. Craving**

# Severity Levels of Substance Use Disorder

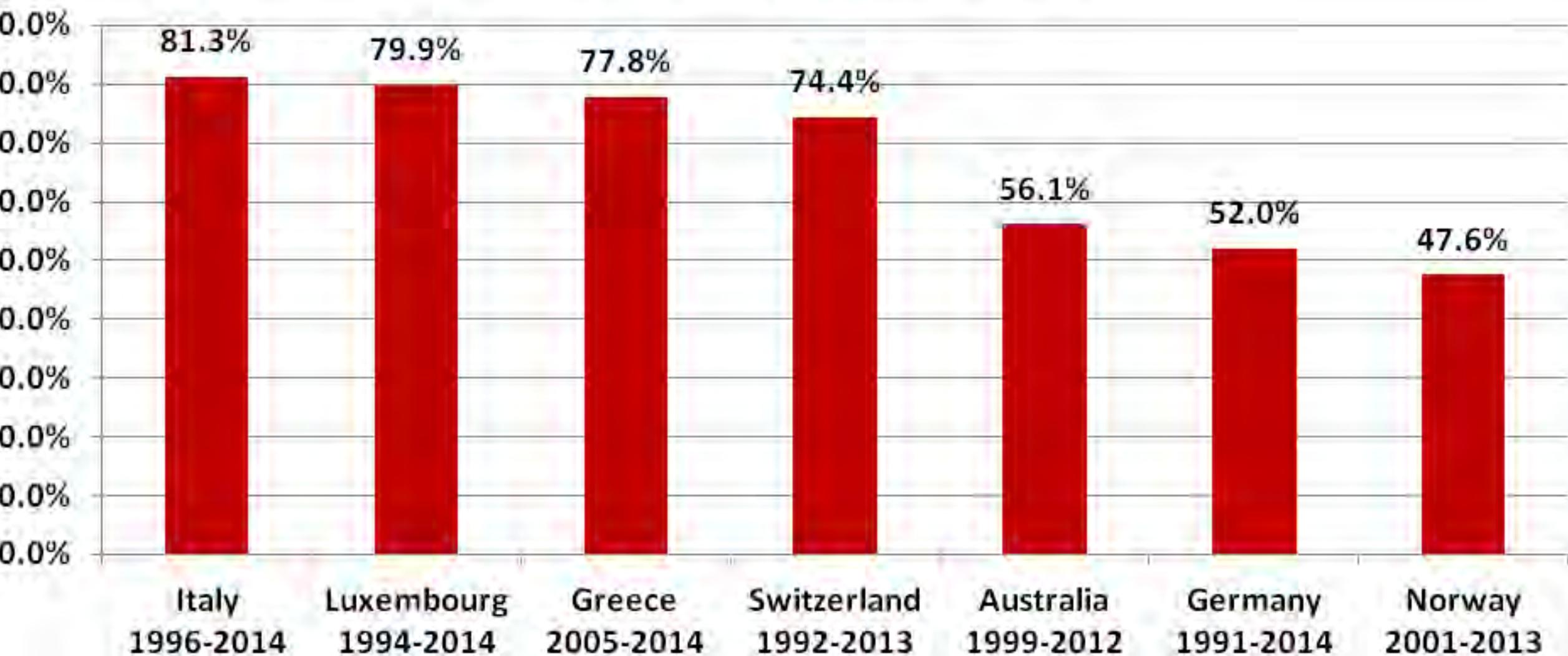


Because like cancer and other health conditions, it worsens over time

# So What If....

- Addiction is treated like a disease with individualized treatment with follow up with each patient?
  - We had evidence-based prevention services in every school and community?
  - We had robust recovery services for every American in recovery?
  - Treated addiction in our healthcare system instead of in criminal justice system, shackling our patients with criminal histories?
- Jessica Hulsey Nickle, Addiction Policy Form**

# Figure 1. Percentage by which drug deaths were reduced in 7 countries



# Possible Factors for Success

- 1 Extremely good access to opioid substitution therapy (OST)
- 2 Drug consumption rooms (DCRs)
- 3 Heroin assisted treatment (HAT)
- 4 Housing first initiatives
- 5 Take home naloxone (THN)

# Together, We Can Solve This Our Way!



# Can We?



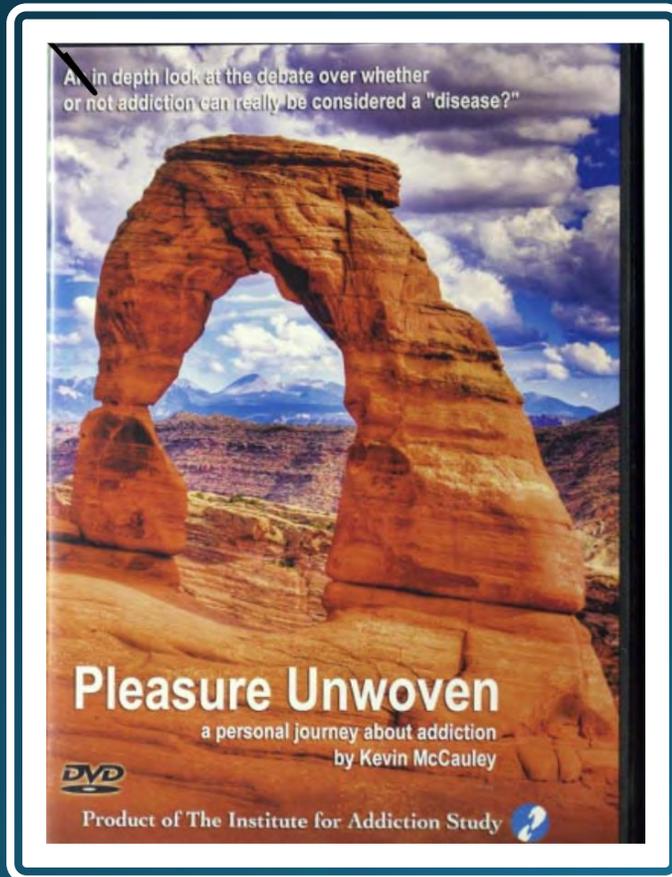
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=



# “Is Addiction A Disease or A Choice? Is Recovery Possible”



## Dr. Kevin McCauley – Pleasure Unwoven



Kevin McCauley, is a qualified medical doctor and he focuses the important question about addiction: “Is it really a “disease?” This video essay, filmed in high-definition and recipient of NAATP’s Michael Q. Ford Journalism Award 2010, presents the arguments for and against this question. Reviewing all the latest research about addiction along the way. Uses the spectacular landscape of Utah’s State and National

Parks to describe the brain areas involved in addiction, turns complex neuroscientific concepts into easy-to-understand visual images that will help people in recovery feel better understood, and their families and friends feel hope that recovery is possible.

recovery

**Thank you for your attention!**

Any Questions or  
Comments?



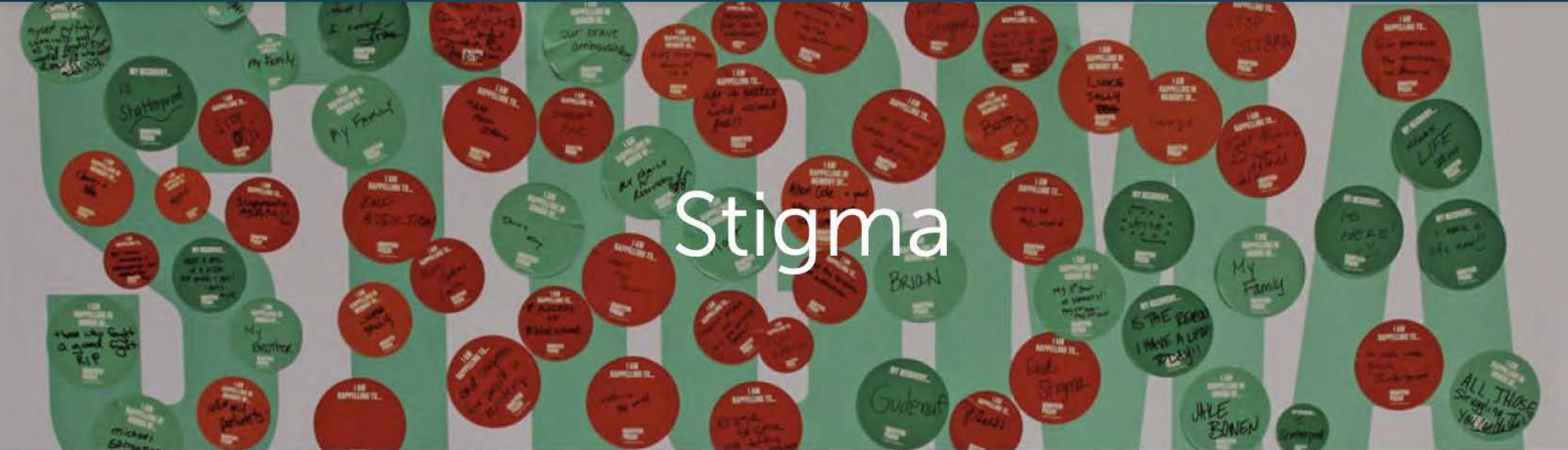
***Abubaker@VCU.edu***



the disease argument

# Parents, Educators, Clinicians And Citizens Responsibilities

- This issue is an American issue.....and to fix it is an American duty,
- After September 11<sup>th</sup>, our President and our nation banded together to use every tool at our disposal to prevent any further American deaths.
- We must act boldly to stop this epidemic: We (EVERYBODY) need to take bold steps and we can not afford to wait ...



# Stigma

Science has proven that substance use disorder is a chronic brain disease that can be managed with medical treatment. **It is NOT a moral failing or a character flaw.**



# Stop Talking 'Dirty': Clinicians, Language, and Quality of Care for the Leading Cause of Preventable Death in the United States

A patient with diabetes has “an elevated glucose” level. A patient with cardiovascular disease has “a positive exercise tolerance test” result. A clinician *within* the health care setting addresses the results. An “addict” is not “clean”—he has been “abusing” drugs and has a “dirty” urine sample. Someone *outside* the system that cares for all other health conditions addresses the results. In the worst case, the drug use is addressed by incarceration.

On December 9, 2013, the first ever national drug policy reform summit was held at the White House. A major thrust

despite harmful consequences. Yet, despite evidence of a strong causal role for genetics and impairment in inhibitory control, stigma is alive and well. Research is now revealing that one contributory factor to the perpetuation of stigma may be the type of language we use.

Use of the more medically and scientifically accurate “substance use disorder” terminology is linked to a public health approach that captures the medical malfunction inherent in addiction. Use of this term may decrease stigma and increase help-seeking. In contrast, tough, punitive,

*John F. Kelly, PhD, Sarah E. Wakeman, MD, Richard Saitz, MD, Massachusetts General Hospital and Harvard Medical School Boston Massachusetts General Hospital Boston Boston University Medical Center Boston, Mass*

# The Case



ADDICTION IS

A DISEASE

VS

ADDICTION

IS A CHOICE



**THE PRESIDENT'S COMMISSION  
ON COMBATING DRUG  
ADDICTION AND THE OPIOID  
CRISIS**

**Roster of Commissioners**

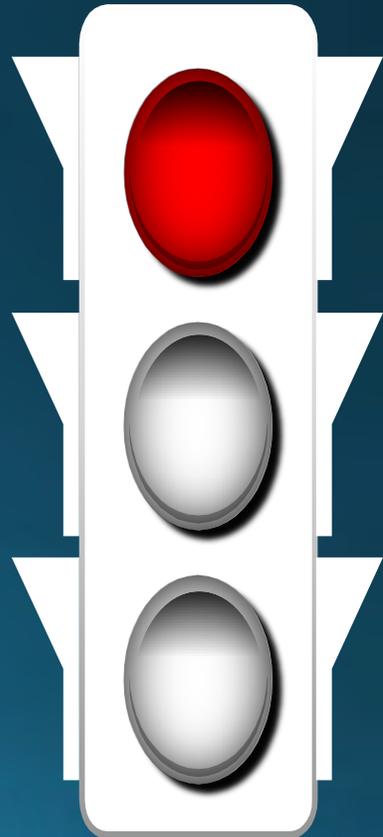
- Governor Chris Christie, Chairman
- Governor Charlie Baker
- Governor Roy Cooper
- Congressman Patrick J. Kennedy
- Professor Bertha Madras, Ph.D.
- Florida Attorney General Pam Bondi



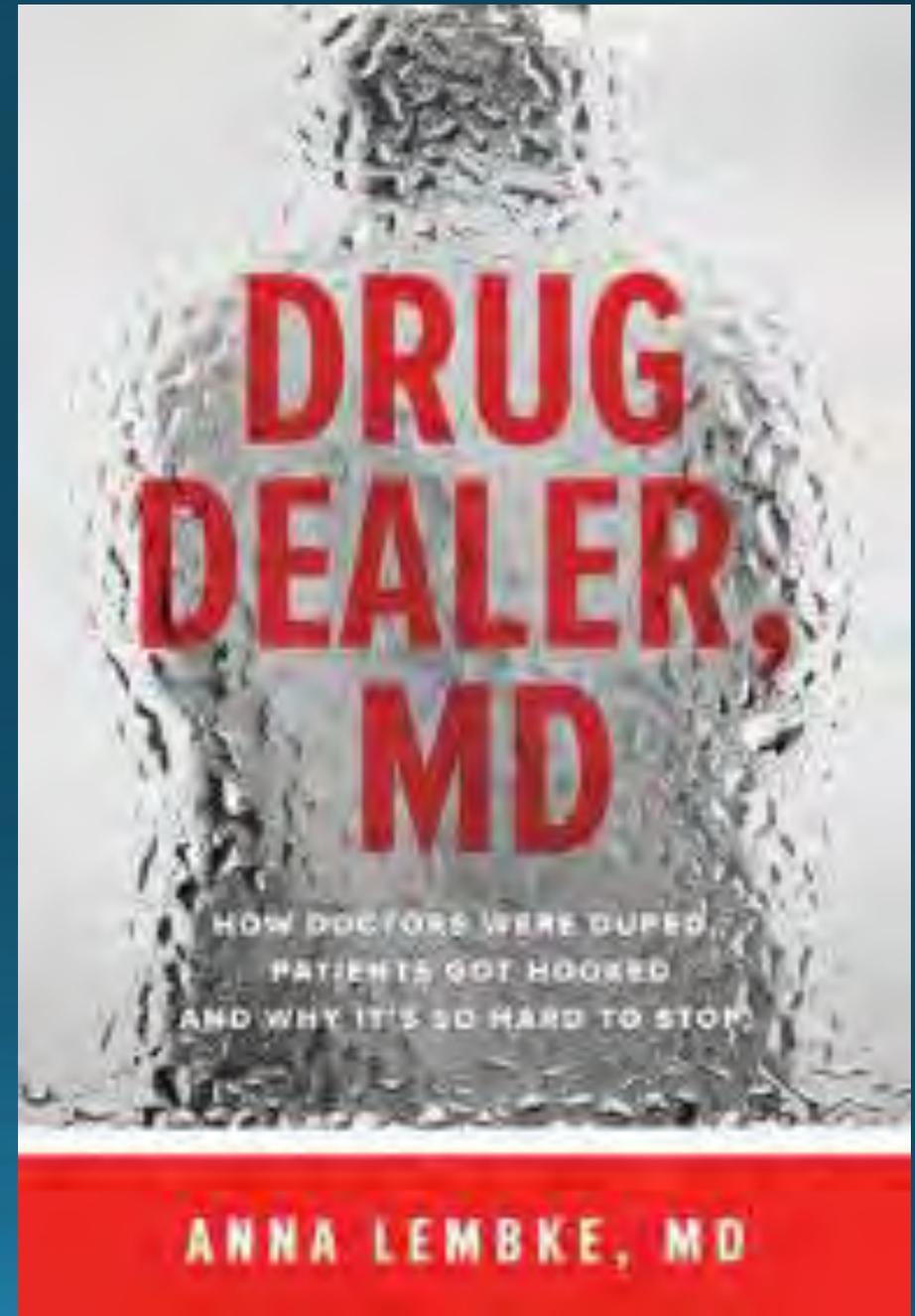
# A WARNING!!

“Every American should be awakened to this simple fact: if this scourge has not found you or your family yet, without bold action by everyone, it soon will.”\*

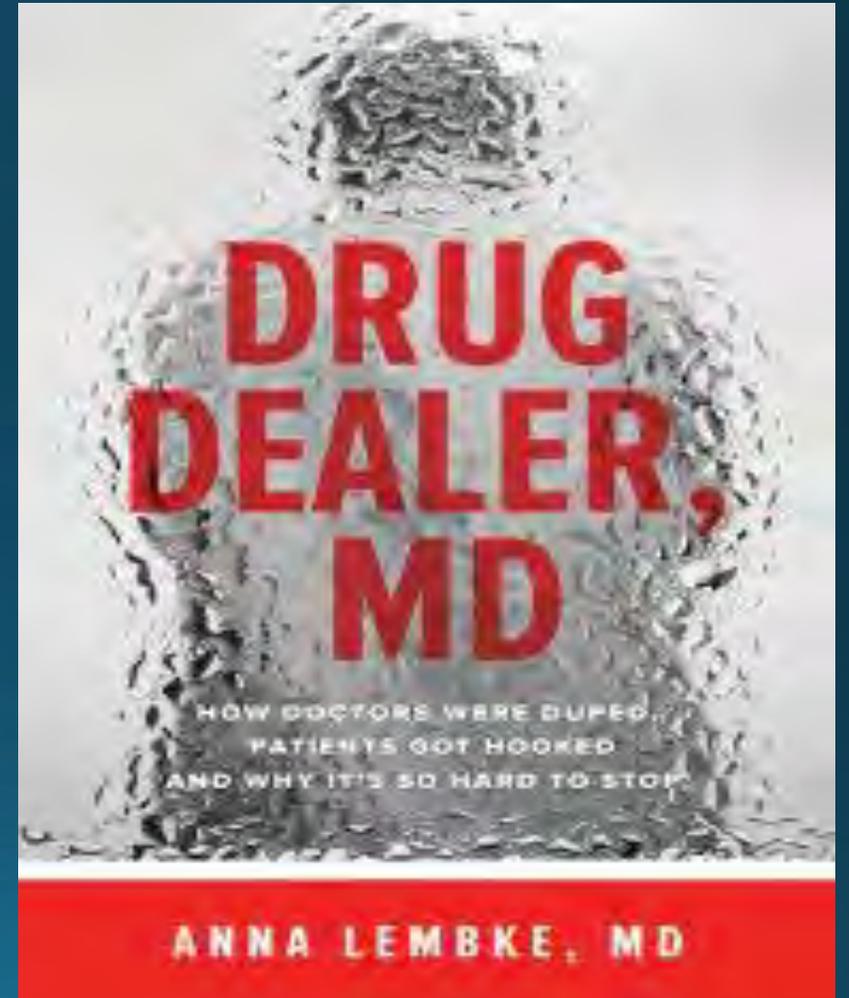
*\*The PRESIDENT'S Opioid Commission report*



**“Medicine must once and for all embrace addiction as a disease, not because science argues for it, but because it is practical to do so.”**



**“As long as the system continues to ostracize patients with addiction, . . . , the prescription drug epidemic will continue, as will the suffering of millions of people with untreated addiction.”**





# HOW STIGMA IMPACTS RECOVERY



## STIGMA CAN...

**REDUCE** WILLINGNESS TO SEEK PROFESSIONAL HELP

**CAUSE** RELUCTANCE TO ATTEND TREATMENT

**LIMIT** ACCESS TO HEALTHCARE, HOUSING, AND EMPLOYMENT

**DIMINISH** SELF-ESTEEM

**EXACERBATE** DEPRESSION

**AFFECT** PERSONAL RELATIONSHIPS AT A TIME THEY'RE NEEDED MOST

# What can we do?

1. Language Matters – use appropriate language
2. Show compassion to those struggling
3. Educate and raise awareness

# Language Matters

Say This	Not That
Substance Use Disorder	<del>Substance Abuse</del>
Individual with a Substance Use Disorder	<del>Addict, Junkie,</del> <del>Drug abuser, Druggie</del>
In recovery	<del>Clean; Staying clean</del>
Has a Substance Use Disorder	<del>Drug Habit</del>
Positive drug test; Currently using substances	<del>Dirty drug test</del>

# EFFECTIVE WAYS TO COMBAT STIGMA

**LEARN** ABOUT ADDICTION

POLITELY **CORRECT** MISCONCEPTIONS

**SEEK** AND SHARE RESOURCES

**OFFER** COMPASSIONATE SUPPORT

**LISTEN** WHILE WITHHOLDING  
JUDGMENT

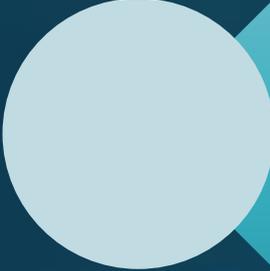
**TREAT** PEOPLE WITH RESPECT

**REPLACE** NEGATIVE ATTITUDES WITH  
EVIDENCE-BASED FACTS

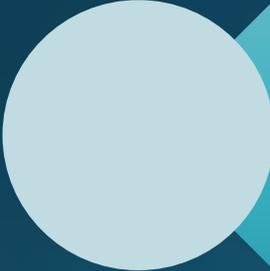
**SHARE** YOUR OWN STORIES OF STIGMA



# Preoperative Discussion of Postop Pain



Set goals for pain control



Review the risks / possible side effects of prescribed medications



Discuss modes of disposal of the unused opioid medications

# Strategies for Pharmacologic Management of Postop Dental Pain

NSAID as the primary agents for managing post-operative pain.

Combining two analgesic agents

Opioids analgesics be reserved for only severe pain

# Strategies Towards Opioid- Reducing/Opioid –Free Pain Management

**Clinician  
Education**

**Better patient  
Assessment**

**Discuss with the  
patient plans for  
pain management**

# Goals Towards Opioid-Reducing/Opioid – Free Pain Management

Non-opioid first line of treatment

Lowest dose/ for shortest duration opioid regimen

Adjunct modalities of pain control

Be kind in dealing with patients with SUD:  
Words Matter.

“ We can never forget that the faces of substance use disorders are real people. How we respond to this crisis is a moral test for America. Are we a nation willing to take on an epidemic that is causing great human suffering and economic loss? Are we able to live up to that most fundamental obligation we have as human beings: to care for one another? ”

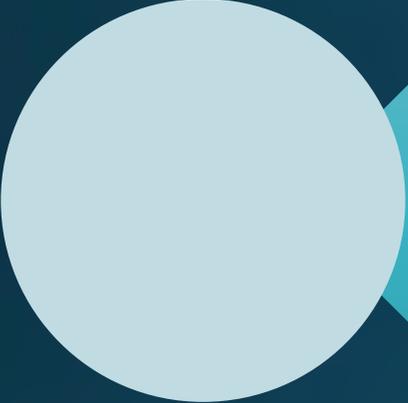
**Vivek H. Murthy, M.D., M.B.A.**

Vice Admiral, U.S. Public Health Service

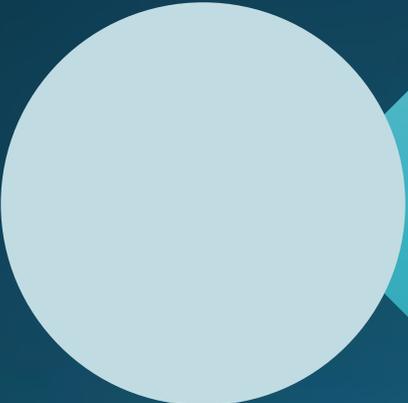
Former Surgeon General



# Best Tasks of Addiction Treatment



Tools to Manage Stress and decrease craving



Find the thing that is more emotionally meaningful than the drug to displace the drug

# Punishment won't stop drug use because drug is survival

The Survival imperative is at a level of the unconscious

Survival

Kids

Freedom

Health

Marriage

Job

**What if we took**  
**punishment out of the treatment**

**(Is there a group of addicts we don't punish?)**

# ***PILOTS!***



***Kevin McCauley, M.D.***

***Sober Living By The Sea, Newport Beach, CA***

***(949) 439-1949***

***kevintmccauley@hotmail.com***

# **Treatment Outcome Variance in Pilots Treated for Alcoholism:**

**“The United States Navy enjoys a 95-97% return to flying status rate in its pilots treated for alcoholism.”**

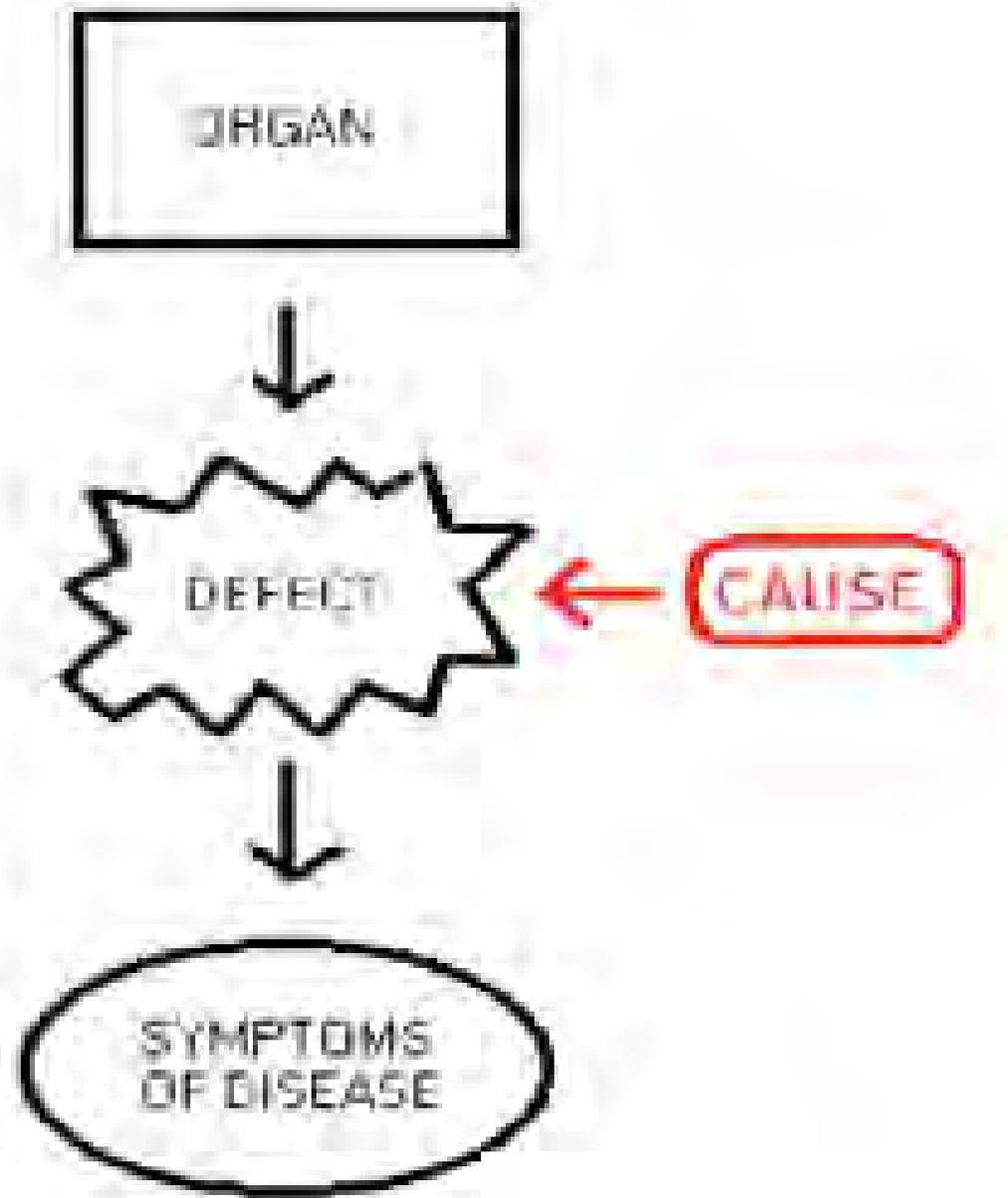
**- Joseph A. Pursch, M.D.**

**“Since the inception of its impaired pilot program in conjunction with the FAA and ALPA EAPs, UAL has an 87% return to flight status rate in pilots treated for alcohol problems.”**

**- Stanley Mohler, M.D.**

# The Disease Model

(a CAUSAL model)



# The Opioid Epidemic: A New Approach For Dentists

1. How accurately do we understand dental pain?
2. Are opioid analgesics safe for managing pain?
3. How effective are non-opioid analgesics?
4. How much opioid analgesics is needed?
5. Where do we go from here?

**It's not that the addict doesn't  
have "values" . . .**

**It's that in the midst of survival panic  
the addict cannot draw upon those values  
to guide their behavior . . .**

**The midbrain now reigns . . .**

**And conscious thought becomes constricted.**

<https://www.addictionpolicy.org/what-is-addiction>

<http://fox8.com/2014/02/10/heroin-hits-home-robbys-story/>

# Questions?

**References available on request**

**Please contact:**

**Kevin McCauley, M.D.**

**Sober Living By The Sea, Newport Beach, CA**

**(949) 439-1949**

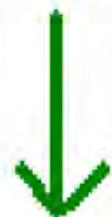
**kevintmccauley@hotmail.com**

**Please also see: [www.addictiondoctor.com](http://www.addictiondoctor.com)**

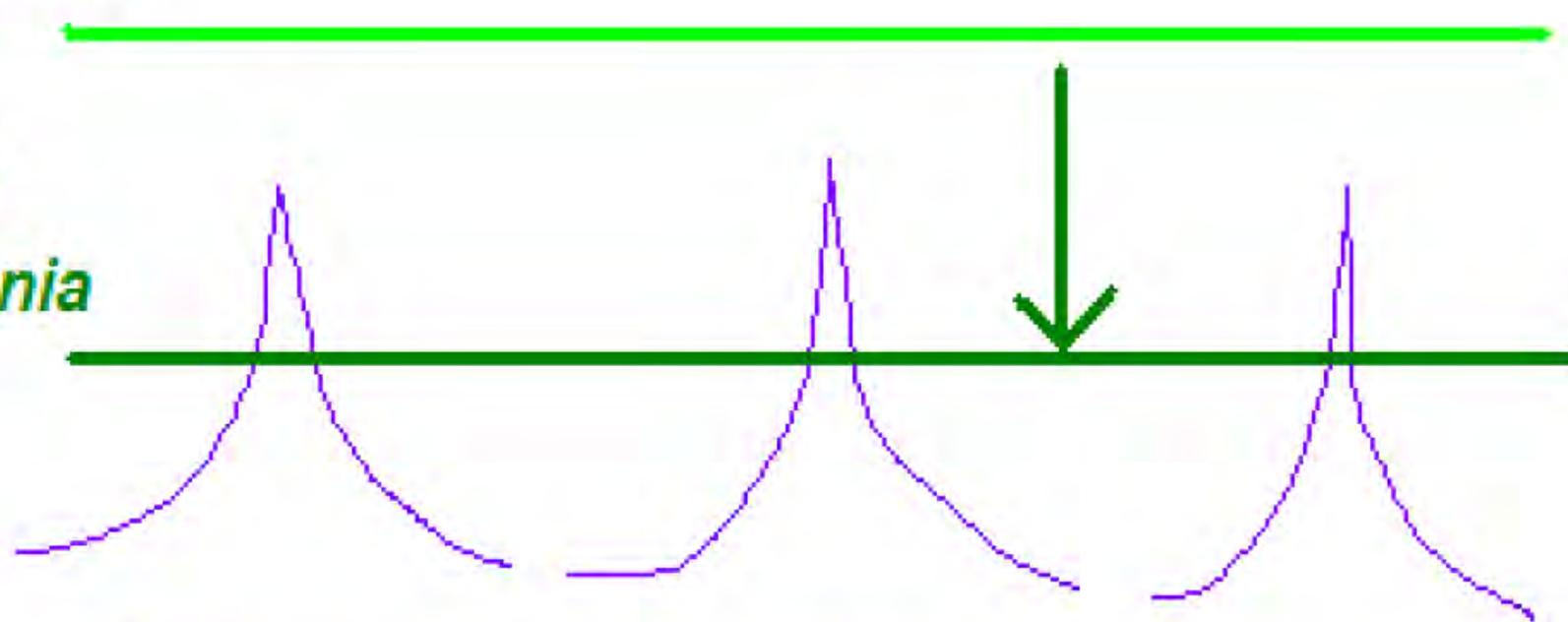
# Then . . .

1.

*Anhedonia*



*Hedonia*



*Disneyland*

*Job Promotion*

*Kid does well in  
school*

### Box. Case study questions.

---

#### CASE QUESTIONS

**Case 1** Patient A has a history of drug-seeking behavior. MassPAT\* data for the past 12 months show the following:

No. of controlled medication prescriptions filled: 151

No. of opioid prescriptions filled: 97

No. of unique prescribers for all scheduled medications: 53

No. of pharmacies used: 27

Given this scenario, what is your impression of the patient's drug-seeking behavior?

**Case 2** Because of major trauma, patient B has undergone extensive facial reconstruction surgery. As a result, she sees an orofacial pain specialist. She is seeing you for the placement of a dental implant, which in your opinion will require a short course of oxycodone and acetaminophen in the first 2 postoperative days. Her MassPAT data show the following:

No. of controlled medication prescriptions filled: 2

No. of opioid prescriptions filled: 20

No. of unique prescribers for all scheduled medications: 2

No. of pharmacies used: 2

Given this scenario, what is your impression of the patient's drug-seeking behavior?

**Case 3** A 33-year-old health care worker with jaw pain recently moved from a neighboring state. The dentist was suspicious of her symptoms and her stated need for opioids. In the past 6 months, she has had 18 prescriptions (16 for opioids, 2 for benzodiazepines) written by 18 prescribers, 15 of whom were dentists practicing within a few miles of each other in a metropolitan area. The patient filled the prescriptions at 10 pharmacies. A check of the MassPAT data from the neighboring state demonstrated the same pattern of dentist shopping.

With this scenario, the dentist should (indicate all that apply)

Prescribe the requested opioid, and appoint the patient for definitive evaluation later.

Perform a full history and clinical evaluation, and offer appropriate treatment.

Dismiss the patient from the practice.

Call the other providers and primary care physician to discuss options.

Discuss concerns of opioid misuse directly with the patient and offer counseling options.

Inform law enforcement agencies.

---

\* MassPAT: Massachusetts Prescription Awareness Tool.

“ We can never forget that the faces of substance use disorders are real people. How we respond to this crisis is a moral test for America. Are we a nation willing to take on an epidemic that is causing great human suffering and economic loss? Are we able to live up to that most fundamental obligation we have as human beings: to care for one another? ”

**Vivek H. Murthy, M.D., M.B.A.**

Vice Admiral, U.S. Public Health Service

Former Surgeon General



# The Four Painful Facts About Addiction

- Addiction is a disease that afflicts more than 22 million Americans every day
- The majority of those addicted—nearly 9 out of 10—began experimenting with substances before their 18th birthdays, while their brains were still developing
- Research exists that could have saved Brian and countless others like him but But is not being implemented throughout communities and healthcare system.
- For every major disease in this country, there is one well-funded national organization—but not for addiction.

# Duration of Opioid Use is a Predictor of Misuse

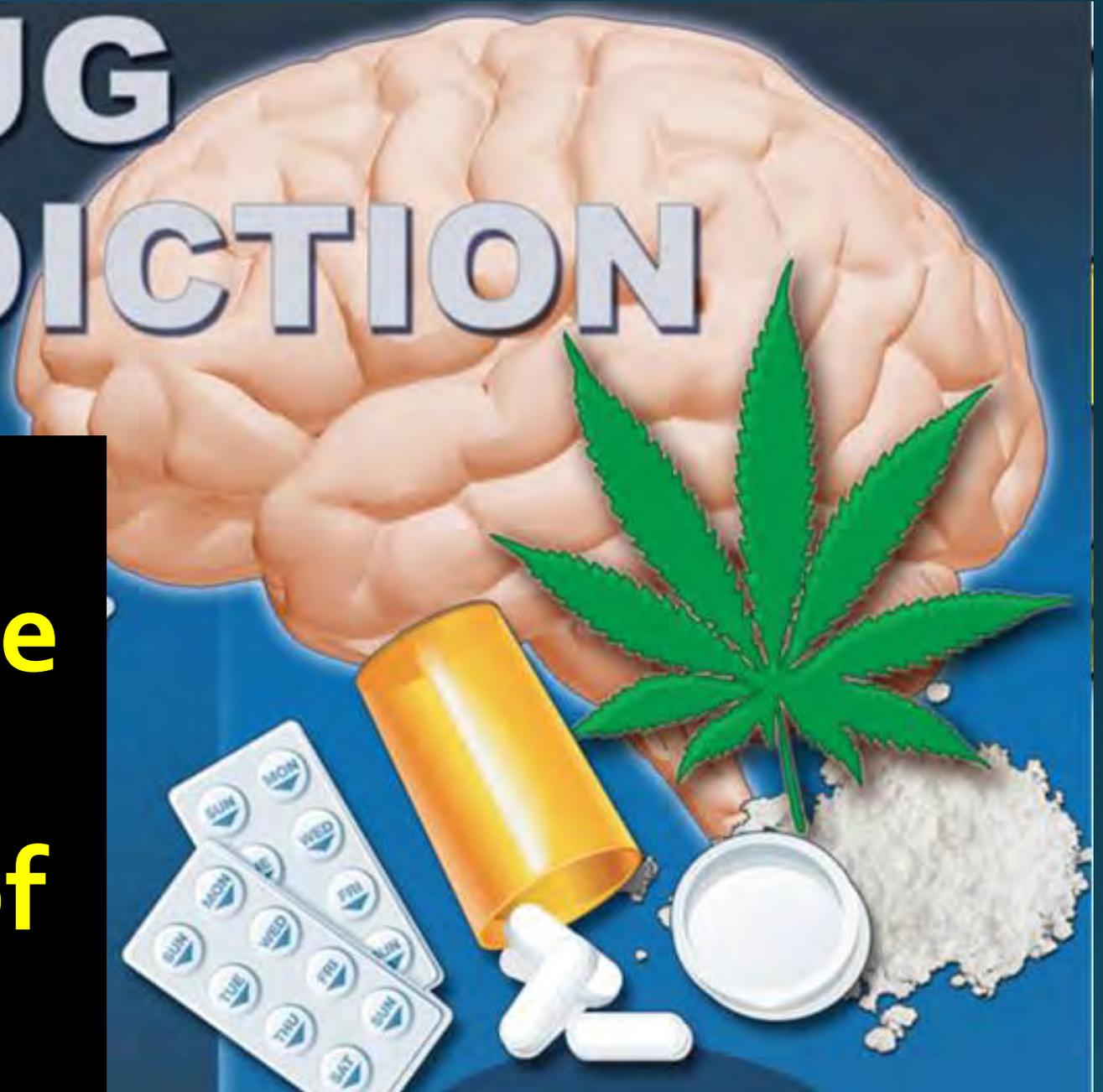
**Highest among 15-24 year of age group**

**Each refill for additional week of opioid use is associated with adjusted increase rate of misuse of 44%**

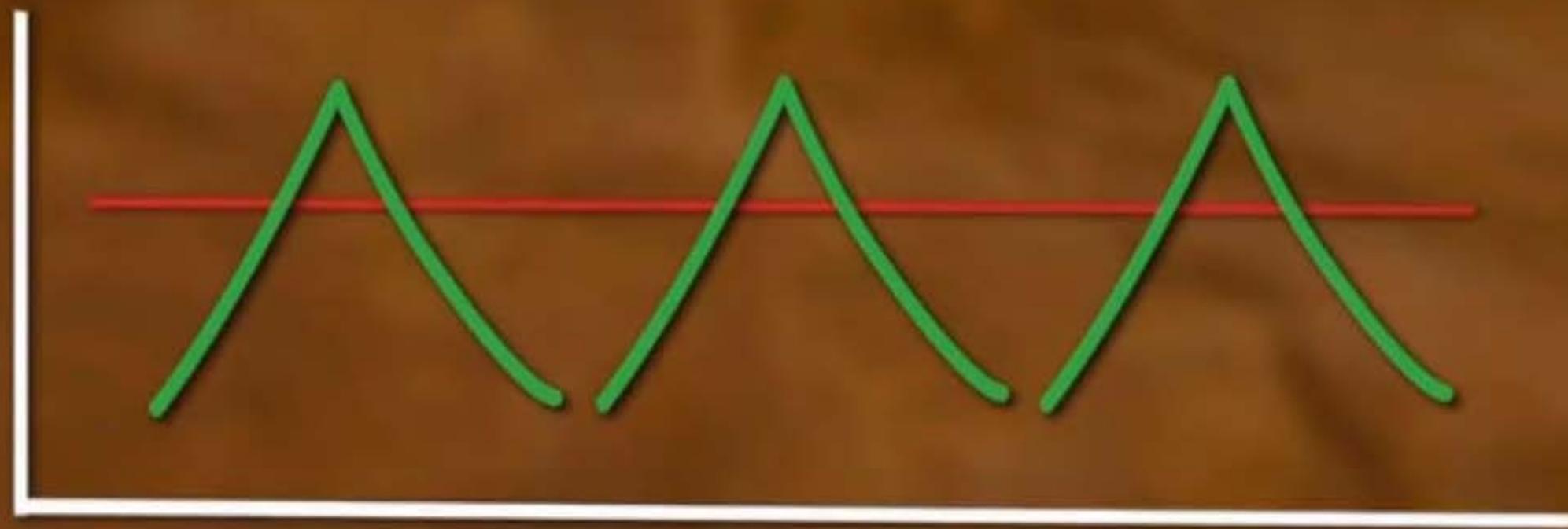
**Duration of opioid use is the strongest predictor of misuse**

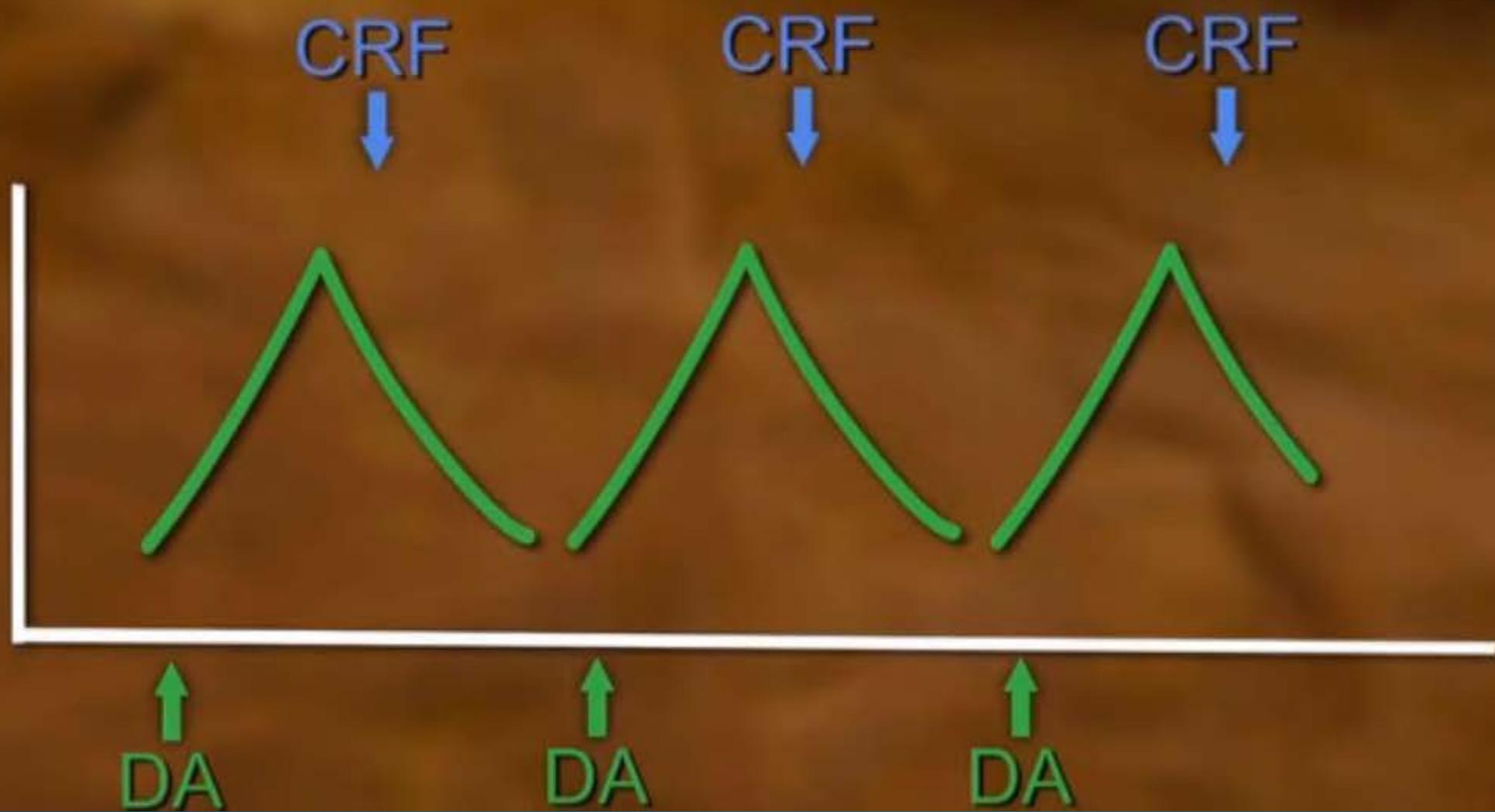
# DRUG ADDICTION

Addiction is not what most people think. It is a chronic disease of the brain.



# Hedonic Set Point





# Hedonic Set Point



Anhedonia: Pleasure death

# The Case

## **Disease** against **Choice**

1. Opening Statement
2. Confessions
3. Evidence
4. Testimonies
5. Exhibit
6. Closing Statement

# Addiction: Common Definition

**A chronic, neurobiological disease with psychosocial, genetic, and environmental factors prompting its development with the patient show one or more of certain behaviors**



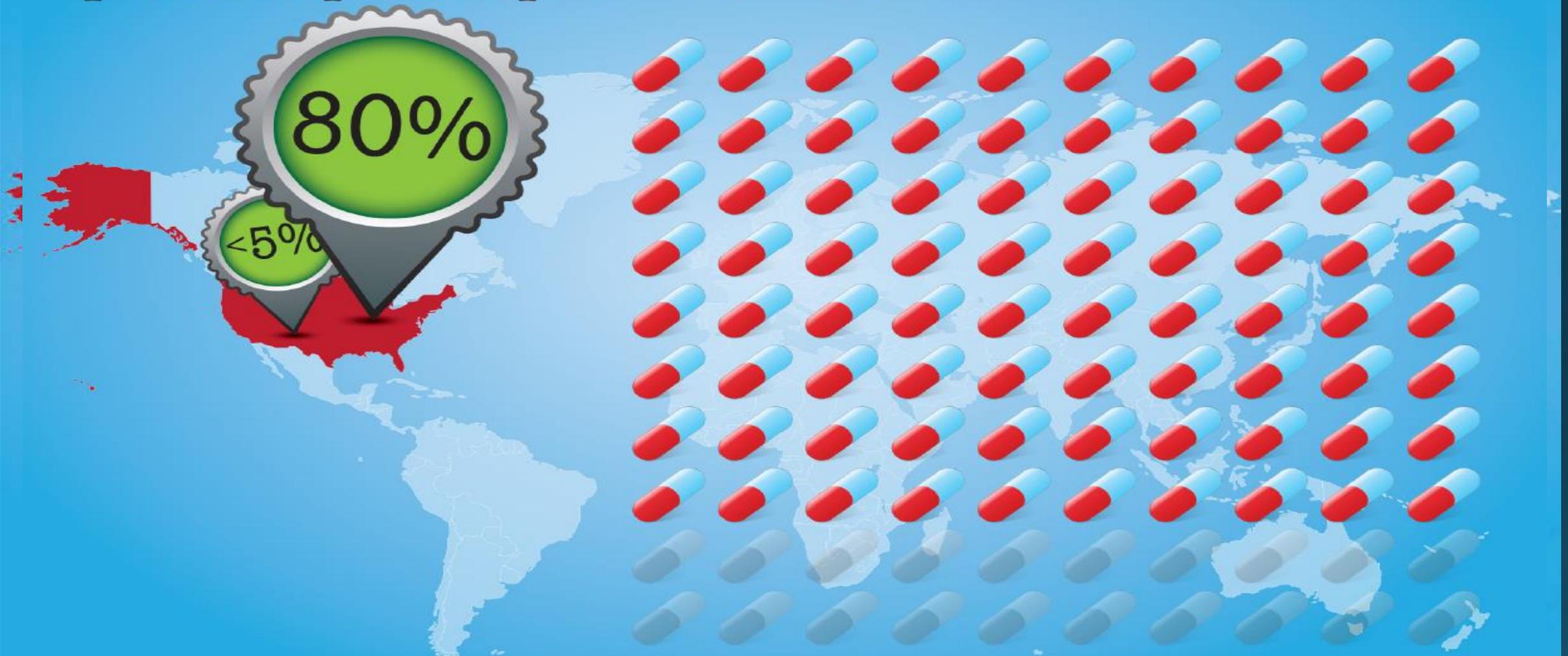
# Doctors ` Role



"The prescription overdose epidemic is doctor-driven. It can be reversed in part by doctor's actions. **Prescription opioid overdose deaths can be prevented by improving prescribing practices.** We can protect people from becoming addicted to opioids and clinicians are key to helping to reverse the epidemic."

**Thomas R. Frieden, MD, MPH**  
**Director of the CDC (Centers for**

And yet, we consume 80% of the world's prescription painkillers.



# The First Wave Starting 199-2010

100 Million Prescription Opioids Go Unused Each Year Following Wisdom Teeth Removal

*Surplus of Prescription Painkillers May Contribute to Opioid Epidemic; Study Suggests Drug Disposal Kiosks in Pharmacies and Small Financial Incentives Could Help*

September 22, 2016



24% of American  
high school students  
are taking  
prescription  
pills  
for recreational purposes

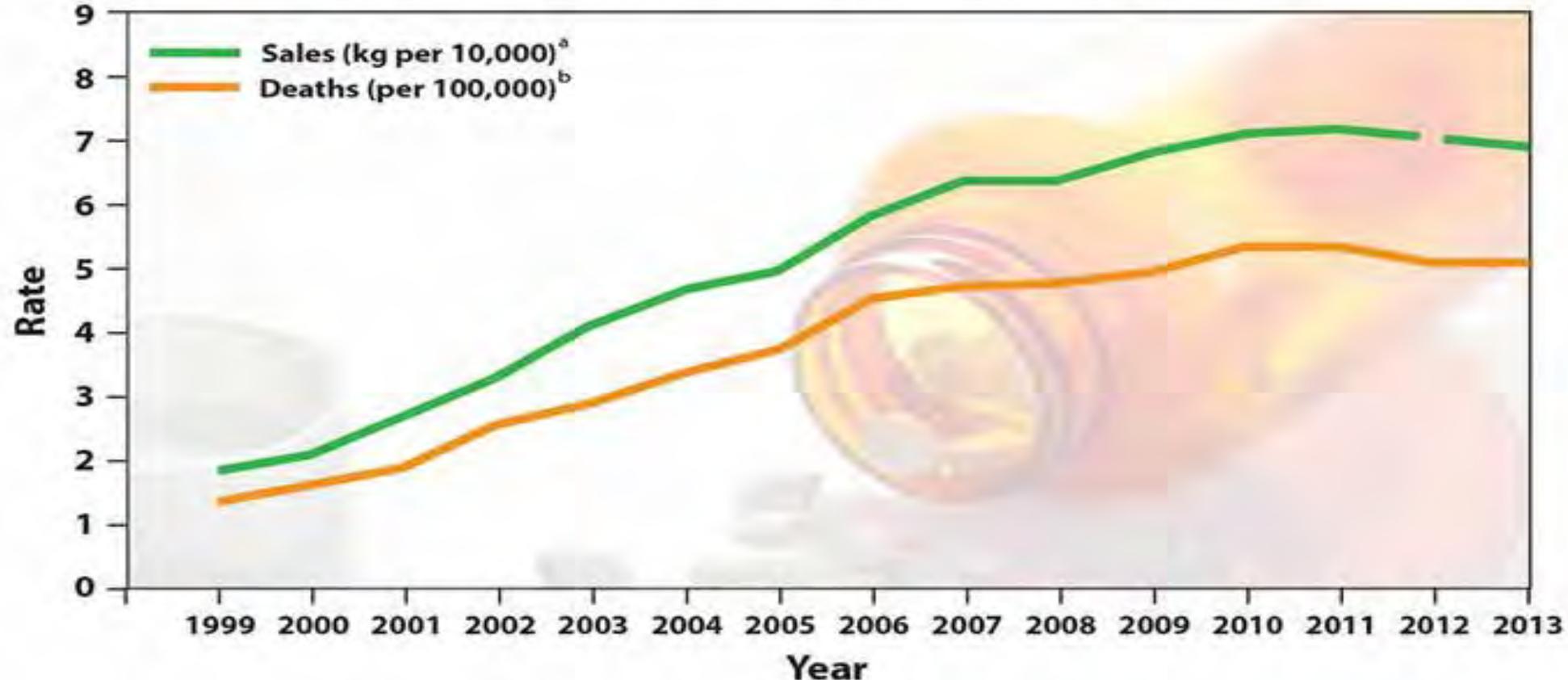
**Two-thirds of teens who abused pain relievers in the past year say they got them from family and friends.**



This includes getting them in their own homes from medicine cabinets and the kitchen counter. Grandparents' homes are especially vulnerable.

# The First Wave Starting 1999-2010

Prescription Painkiller Sales and Deaths

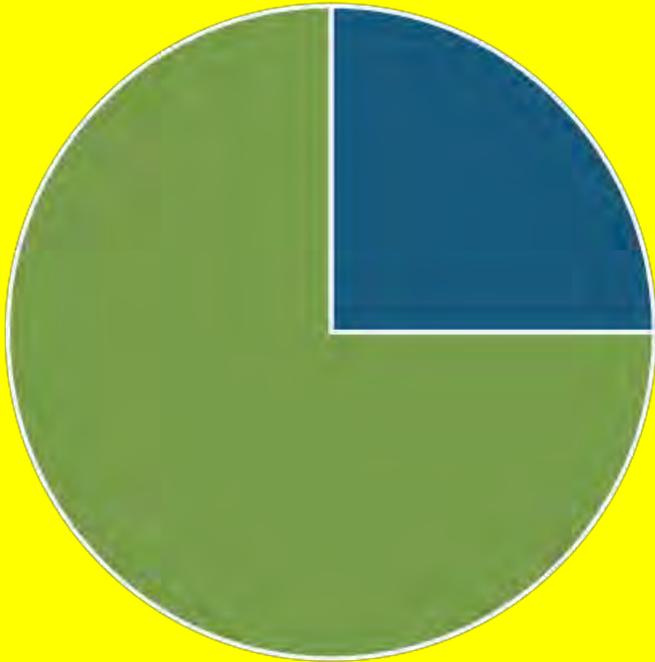


Increased prescribing of opioids and increased overdose deaths from prescription opioids

[http://www.fatherhugs.com/uploads/2/8/5/5/2855395/disease\\_modelrevisedjpk.pdf](http://www.fatherhugs.com/uploads/2/8/5/5/2855395/disease_modelrevisedjpk.pdf)

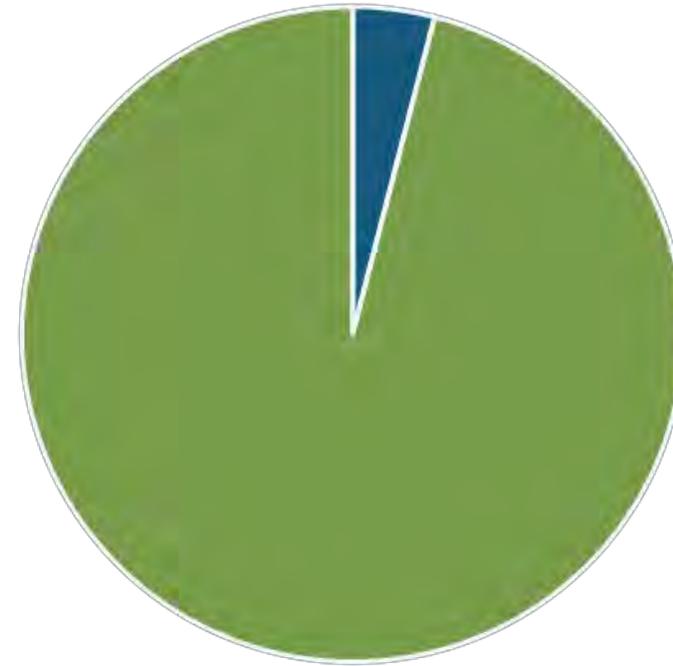
# Age Matters

Under 18



**1 in 4 who began using any addictive substance before age 18 developed a SUD**

Over 21



**1 in 25 who started using at age 21 or older developed a SUD.**

# What Does It Mean that Addiction Is A Disease To Us (Dentists and Educators?)

- Addiction has parity
- As an educator and a parent, a plea !!!

*Guest Editorial*

---

## **Bringing the Opioid Epidemic Home to Dental Education**

A. Omar Abubaker

# What Does It Mean that Addiction Is a Disease To Us (Dentists and Educators?)

- We have to learn about addiction
- We have to teach just like other diseases
- We screen our patients for high risk patients for addiction
- Refer patients whom we identify at risk
- Treat those affected with dignity and compassion:  
Words Matter

⇒ VCU Oral and Maxillofacial	16.42	28,134
⇒ 2013	26.01	5,335
D	30.61	2,930
F	20.43	795
P	20.00	1
R	20.40	1,609
⇒ 2014	17.43	5,341
D	16.15	3,048
F	19.97	833
P	20.00	2
R	18.64	1,458
⇒ 2015	16.12	5,355
D	15.05	3,043
F	17.84	585
P	13.00	7
R	17.44	1,720
⇒ 2016	15.47	5,151
D	14.67	2,682
F	17.10	731
P	10.00	1
R	16.03	1,737
⇒ 2017	11.09	3,481
D	10.89	1,431
F	11.63	539
P	10.75	4
R	11.09	1,507
⇒ 2018	7.60	2,238
D	7.07	436
F	7.45	388
P	4.00	1
R	7.81	1,413
⇒ 2019	6.88	1,233
D	5.75	159
F	6.48	148
R	7.14	926



# SHATTER PROOF™

**Fixing the broken  
treatment system  
starts now**

Shatterproof is  
transforming addiction  
treatment in America.  
Stay tuned for updates

"Dad, 300 years ago, they burned women on stakes in Salem, Massachusetts because they thought they were witches. Later they learned they weren't and stopped. Someday, people will realize that I am not a bad person. That I have a disease and I am trying my hardest."



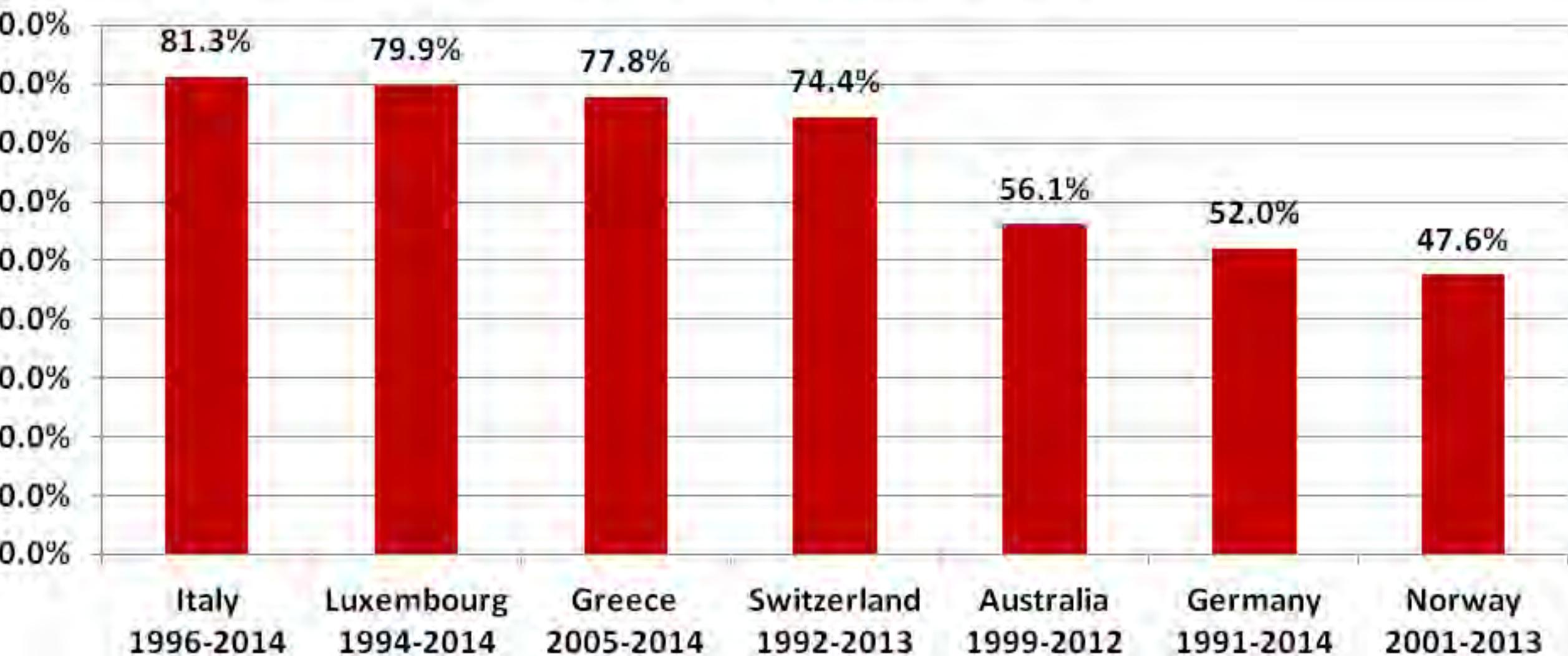
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**'Brian died of a disease that preventable and we do not prevent it, treatable and we do not treat it, and undeniable but we continue to deny it'**

**Gary Mendell, Founder and CEO**



# Figure 1. Percentage by which drug deaths were reduced in 7 countries



# Possible Factors for Success

- 1 Extremely good access to opioid substitution therapy (OST)
- 2 Drug consumption rooms (DCRs)
- 3 Heroin assisted treatment (HAT)
- 4 Housing first initiatives
- 5 Take home naloxone (THN)

