2024 DUI Specialty Dockets Training

Empowering Change and Transforming Lives: Uniting Communities through Specialty Dockets
August 12th - 14th | Williamsburg Virginia
Presentation Slides

August 12, 2024

Trauma, ACES, and Protective Factors to Help Them Move Forward

Keith Cartwright

Developing Treatment Plans for Persons with Co-Occurring Disorders

Dr. Christa Marshall

Lunch and Learn - Polypharmacology of Substance Use: Learning as Hidden Processes

Dr. Brian Kelley

Team Communication

Dr. Christa Marshall

New Virginia Standards and Compliance Process

Olivia Terranova

Liane Hanna

Breakout A: Crisis Management

Dr. Christa Marshall

Breakout B: Testing Tools and Drug Trends

Dominique Delagnes

Breakout C: Identifying Human Trafficking Victims in Specialty Dockets

Meg Kelsey

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Trauma-Responsive Treatment Court Roles and Boundaries, Plus a Quick Peek at the Upcoming National Trauma-Responsive Court Best Practice Standards

Dr. Brian Meyer

A Blueprint for Phases

James Eberspacher

Legal Requirements for Medicated Assisted Treatment in Treatment Courts

Steven Gordon

Is Marijuana Medicine? What We Know and What We Don't Know about Cannabis, THC, and CBD, and How Treatment Courts Can Respond

Dr. Brian Meyer

Breakout A: Best Practices for Addiction Treatment and Recovery in the Context of Gender, Reproduction, and Pregnancy

Dr. Mishka Terplan

Breakout B: Where Did All of Our Clients Go?

James Eberspacher

Breakout C: How We can Identify, Supervise and Stop the High-Risk Impaired Driver

Mark Stodola

August 14, 2024

Recovery Capital

Matthew Ouren

Specialty Dockets DIMS Database

Celin Job

Break

Incentives, Sanctions and Service Adjustments

Matthew Ouren

Cannabis and Cars - Addressing the Challenges of the Marijuana Impaired Driver

Mark Stodola

Trauma, ACEs, and the Protective Factors to Help Move Us Forward.

Specialty Dockets Training, August 12, 2024

What Are Aces?

ADVERSE CHILDHOOD EXPERIENCES INCLUDE:

- 28% Physical Abuse
- 10% Physical Neglect
- 17% Household member who suffered from mental health issues
- 21% Sexual Abuse
- 23% Loss of a parent due to death, divorce, or adandonment
- Emotional Abuse 11%
- Emotional Neglect 15%
- Household member addicted to illegal drugs and/or alcohol 27%
- Household member who was incarcerated 6%
- Witnessing domestic violence against mother 13%

ADVERSE CHILDHOOD EXPERIENCES HAVE BEEN LINKED TO:

Risky Health Behaviors

Chronic Health Conditions

Low Life Potential

Early Death

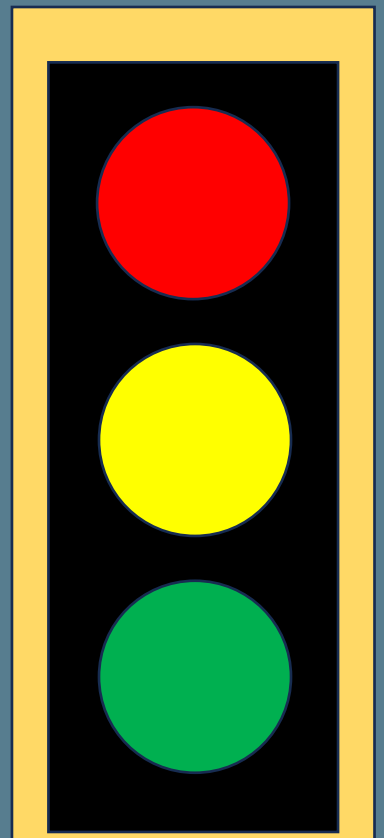
WHAT IMPACT DO ACEs HAVE?

As the number of ACEs increases, so does the risk for negative health outcomes

The More Helpful Question Is:

What Is Trauma?

Trauma Is Not An Event, It's The Stress Of How It's Experienced



TOXIC STRESS

TOLERABLE STRESS

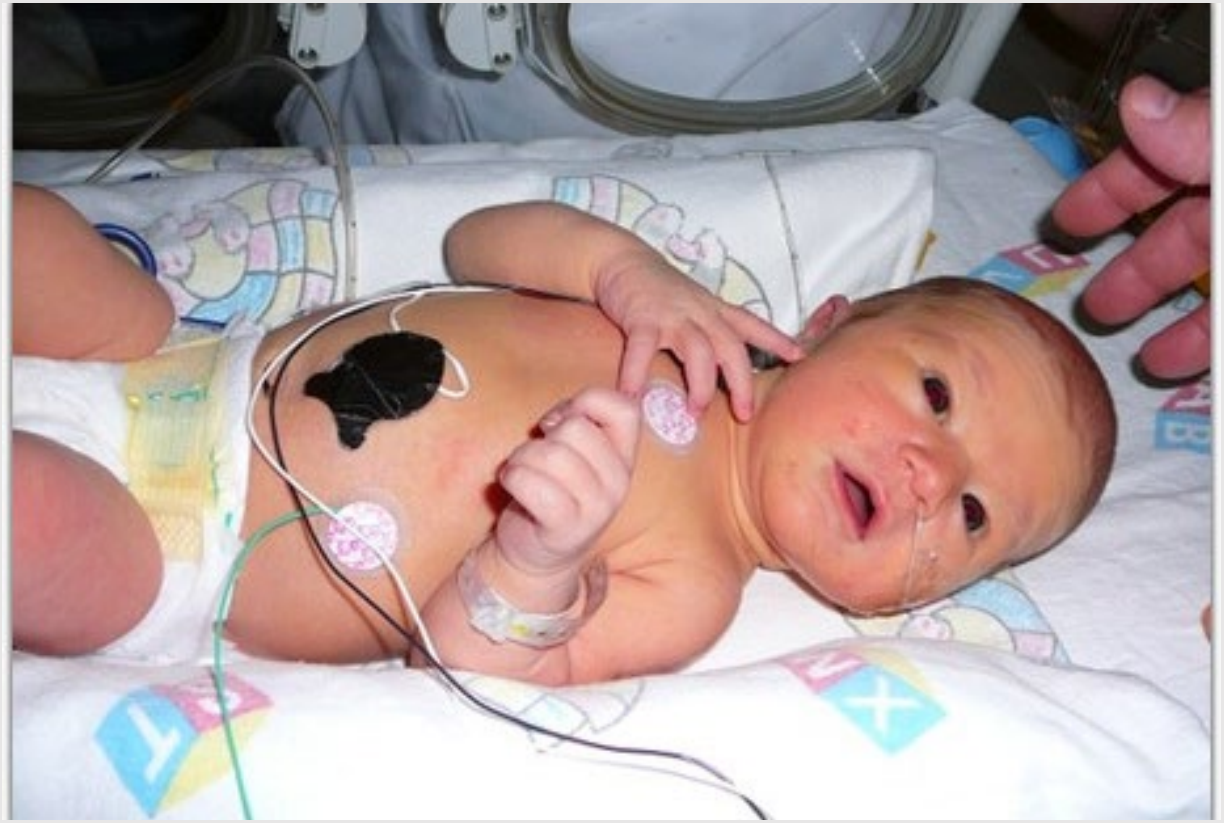
POSITIVE STRESS

TRAUMA

How Resilient We Are Against Tolerable Stress Turning To Trauma Is Largely Determined In Our Childhood.

What is a relationship?

We come into the world looking for someone who is looking for us. ~Dr. Curt Thompson

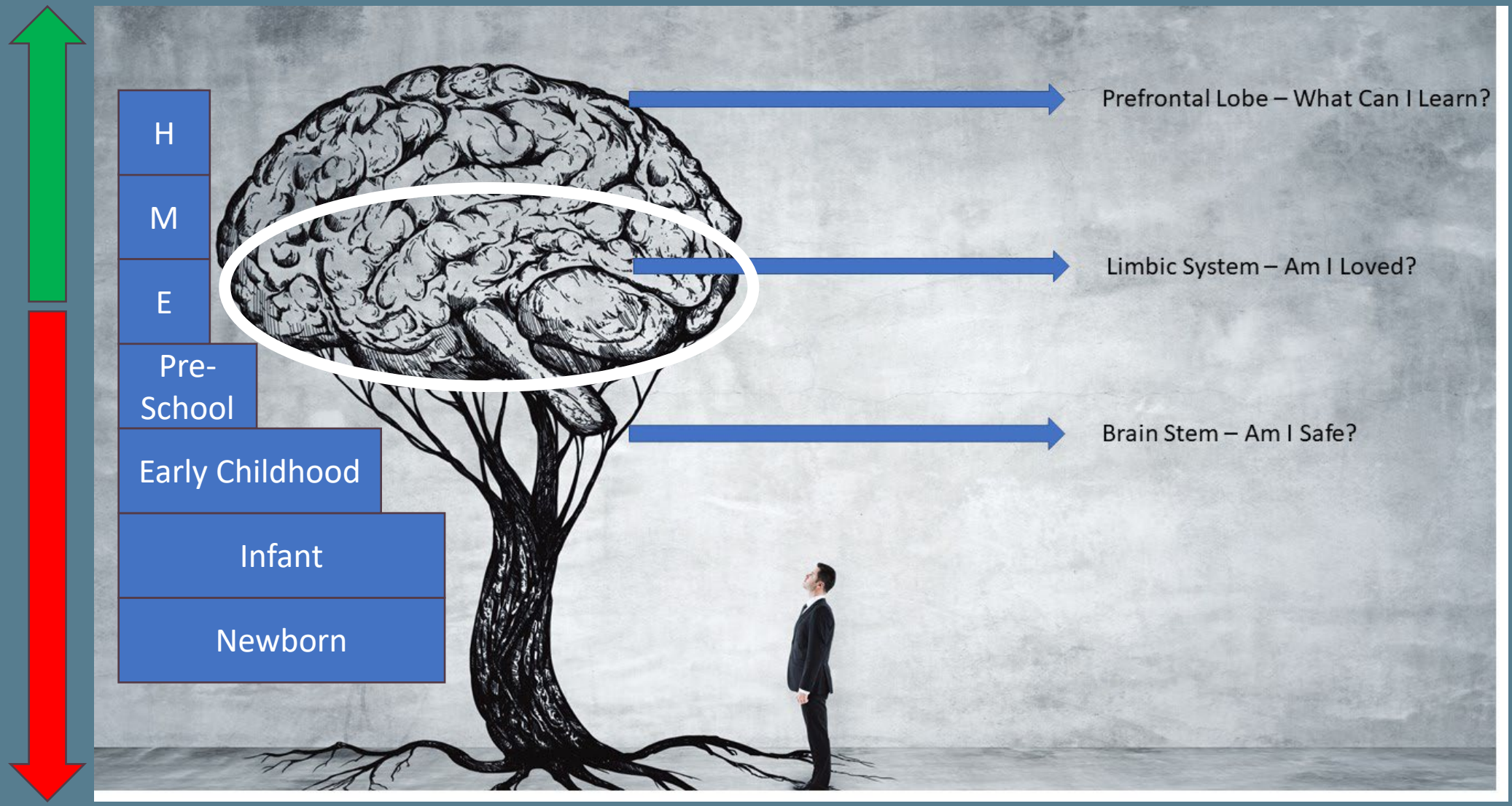


In the earliest seconds of our lives, our survival becomes dependent on human relationships.

~Stephen Porges

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

High Road



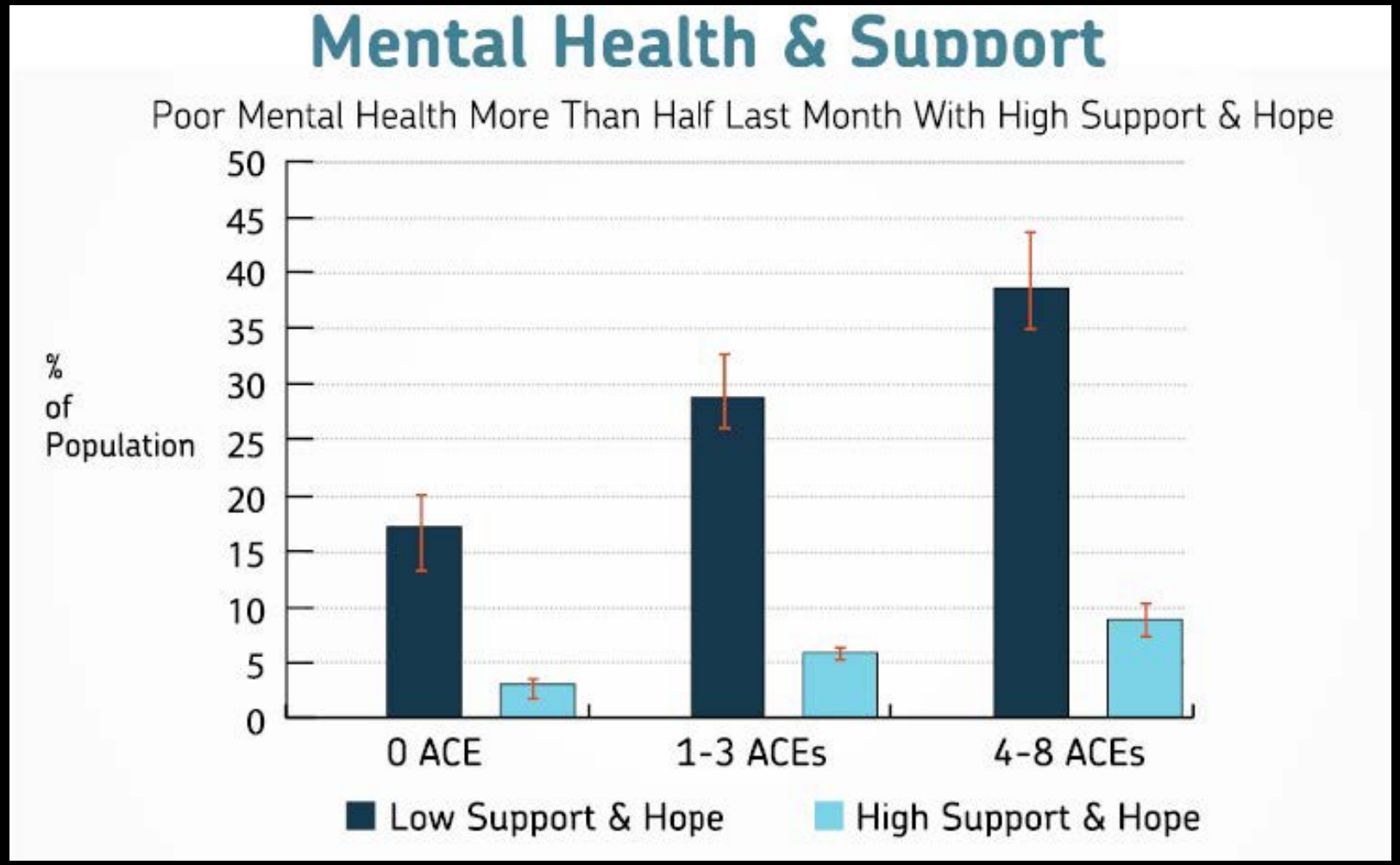
Low Road

What happens when we get stuck in the low road?

Fight	Flight	Freeze	Fawn
Seek safety by confronting perceived threat	Seek safety by escaping from perceived threat	Seek safety by hiding from perceived threat	Seek safety by appeasing perceived threat

The human body is designed to handle about 20 minutes of this FFFF stress at a time……

Mental Health & Support



Relationships are our greatest source of protection AND healing in life.

How do we help someone move from trauma-induced relationship avoidance to healthy bonding and connections?

DEVELOPMENTAL RELATIONSHIPS

The Framework

Developmental relationships are the roots of thriving and resilience for young people, regardless of their background or circumstances. Through these relationships, young people discover who they are, cultivate abilities to shape their own lives, and learn how to engage with and contribute to the world around them. Just as trees rely on a system of roots to support and nourish them, young people need to experience developmental relationships in their families, schools, programs, and communities. However, too many young people miss these opportunities due to bias, prejudice, and systemic exclusion based on their race, ethnicity, income, gender, sexual orientation, abilities, or other differences. Ensuring that every young person experiences the developmental relationships they need is a vital challenge for the 21st century.

The Developmental Relationships Framework was developed by Search Institute, Minneapolis, MN; 800-888-7828; www.searchinstitute.org.

Search INSTITUTE

EXPRESS CARE

Show me that I matter to you.

Be dependable
Be someone I can trust

Be warm
Show me you enjoy being with me

Listen
Really pay attention when we are together

Encourage
Praise me for my efforts and achievements

Believe in me
Make me feel known and valued

CHALLENGE GROWTH

Push me to keep getting better.

Expect my best
Expect me to live up to my potential

Hold me accountable
Insist I take responsibility for my actions

Stretch
Push me to go further

Reflect on failures
Help me learn from mistakes and setbacks

PROVIDE SUPPORT

Help me complete tasks and achieve goals.

Navigate
Guide me through hard situations and systems

Advocate
Stand up for me when I need it

Empower
Build my confidence to take charge of my life

Set boundaries
Put limits in place that keep me on track

SHARE POWER

Treat me with respect and give me a say.

Respect me
Take me seriously and treat me fairly

Collaborate
Work with me to solve problems and reach goals

Include me
Involve me in decisions that affect me

Let me lead
Create opportunities for me to take action and lead

EXPAND POSSIBILITIES

Connect me with people and places that broaden my world.

Inspire
Inspire me to see possibilities for my future

Connect
Introduce me to people who can help me grow

Broaden horizons
Expose me to new ideas, experiences, and places

Express Care

Challenge Growth

Provide Support

Share Power

Expand Possibilities

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Developing Treatment Plans for Persons with Co-Occurring Disorders

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Disclosure

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Disclaimer

Dr. Marshall used to work for the Department of Veterans Affairs. The views expressed in this presentation are solely those of the presenter and do not represent those of the Veterans Health Administration, the Department of Defense, or the United States government. Dr. Marshall has no other conflicts of interest to disclose.

Learning Objectives

Co-occurring disorders present unique challenges to treatment planning. This presentation will focus on adapting treatment plans when the participant:

- 1. Has multiple mental health challenges that may make prioritization of treatment issues challenging.
- 2. Has a mental health disorder that is complicated by a co-occurring substance use disorder.
- 3. Has a mental health disorder that is complicated by the presence of cognitive impairment (e.g., traumatic brain injury, developmental disorder, or other cognitive impairment).

This is topic is **enormous** and is the culmination of most of our graduate school educations! Today is about refreshing **critical thinking, tips, and best-practices**. More often than not there is more than one way to get good results.

A treatment plan is worthless if it is based on a flawed foundation – solid differential diagnosis is paramount!

Dr. Marshalls Top 5 Tips for Differential Diagnosis

- 1: Be certain the client has a full medical examination *before* making a mental health diagnosis.
- 2: Using a model of case conceptualization (like the 5 P's – Presenting, Precipitating, Perpetuating, Predisposing, Protective) to help conceptualize a case is CRITICAL to accurate differential diagnosis.
- 3: For better or worse, because of the way we structure our diagnostic system, comorbidity is the rule rather than the exception.
- 4: Know the distinguishing symptoms/features of diagnoses that have high overlap in presentation.
- 5: If you can't distinguish between diagnoses through clinical interviewing alone, either:
    - know what assessment tools to use to answer your question

    or
    - know what your resources are for assessment referrals.

5 P's Approach to Formulation

Presenting Issues	Statement of the behaviours.
Precipitating Factors	Proximal external and internal factors that triggered the current presenting issue.
Perpetuating Factors	The internal and external factors that maintain the current behaviours.
Predisposing Factors	External and internal factors that increase the person's vulnerability to their current problems.
Protective Factors	The person resilience and strengths & factors that help maintain emotional well-being.

Case Example 1

- 55-year-old female who has no history of mental health episodes referred to outpatient psychotherapy by her PCP:
  - Two acute episode of anxiety (e.g., shortness of breath, difficulty concentrating, shaking) followed by an intense urge to die.
  - The episodes were brief (minutes to hours), and she recovered from it very quickly. When outside of the episodes, she denies any discontent with her life and suicidal thoughts. These episodes terrify her.

Case Formulation

Presenting Problem	See Left
Precipitating Factors	• ?
Perpetuating Factors	• ?
Predisposing Factors	• Diagnosed with diabetes • Currently has uncontrolled blood sugar
Protective Factors	• No previous history of any mental health conditions or suicidality • Reports having a “good life”

Case Example 2

- 22-year-old female presents to an inpatient VA mental health facility:
  - A recent history of sexual assault (w/I past 6 months)
  - Significant mood swings and “catatonia.”
  - On cognitive evaluation is scoring in the mildly impaired range across multiple measures.

Case Formulation

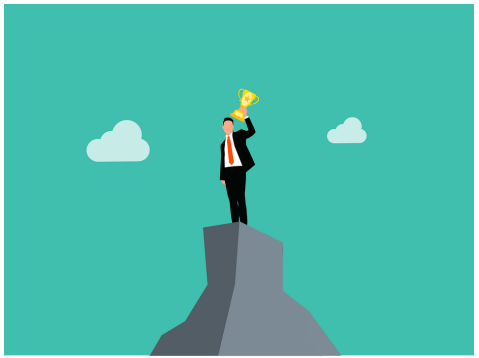
Presenting Problem	See Left
Precipitating Factors	• Sexual assault (?)
Perpetuating Factors	• Decline in self-care and independent functioning • Unable to implement self-regulation strategies
Predisposing Factors	• Not had any treatment for trauma
Protective Factors	• No previous history of any mental health conditions • History of above average academic and intellectual functioning • Access to VA benefits/care • Supportive and engaged family

Building a treatment plan without examining the client’s motivation is like flying a plane with no pilot or map.

What is Motivation?

Motivation includes physical, psychological, and emotional factors that influence whether a person initiates, maintains, or ceases a behavior.

Motivation differs in strength depending on the person and situation.



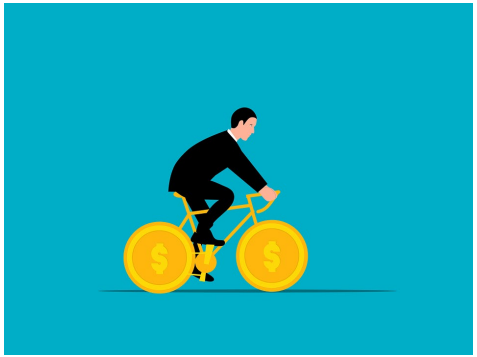


TABLE 9.1
Factors That Motivate Behavior

Factor	Description	Example
Satisfaction of needs	A need is a state of being deficient in biological or social factors. The deficiency motivates the person to engage in behaviors that make up for it (that is, help satisfy the need).	Your job doesn't pay enough money to guarantee that you can pay for housing and food for your family. You take a second job to help pay the bills.
Drive reduction	A drive is an internal psychological state that motivates behaviors that will satisfy a certain need. When the need is satisfied, the drive is reduced.	You feel very cold in your apartment. This feeling creates a drive that motivates you to put on a sweater to satisfy your need for warmth. Once you feel warmed, the drive is reduced.
Optimal level of arousal	Each person has an optimal level of arousal, somewhere from low to high. People are motivated to engage in behaviors that fit with their preferred level of arousal.	You and your partner are an odd couple. Preferring calmness, you stay in and watch movies in the evening. Preferring excitement, your partner goes out to clubs at night.
Pleasure principle	The pleasure principle says that people are motivated to engage in behaviors that make them feel good and to avoid behaviors that cause them pain.	You are completely full after dinner. You order the flourless chocolate cake anyway because you know how good it will taste.
Incentives	Incentives are external factors that motivate behaviors.	Knowing you can win the tennis championship is a good incentive that motivates you to practice hard.

Case Example 3

- 68-year-old African American male Vietnam Veteran presents to VA CBOC with:
  - Posttraumatic stress disorder
  - Hepatitis C
  - Heroin addiction
  - Inability to read

Case Formulation

Presenting Problem	See Left
Precipitating Factors	• Relapse on heroin • Worsening Hep C
Perpetuating Factors	• Poverty • Unsafe neighborhood and living environment • Inability to read
Predisposing Factors	• Age at onset of trauma • Not had any treatment for trauma
Protective Factors	• Access to VA services • Willingness to engage with clinician • Supportive medical staff • A desire to reconnect with his children and grandchildren • Lives within walking distance of community college

Dr. Marshall's Top 4 Tips for Exploring Motivation

1: It is important to know what type of motivating factor is maintaining your client's target behaviors in order to effect change.
2: Motivational Interviewing is appropriate anytime you are asking a client to make difficult change or meeting with resistance against necessary goals.
3: How you feel about the client is a significant predictor of client resistance.
4: If Importance is high but Confidence is low, education, skill building, and practical planning may be necessary before change is realistic.

If you want to learn more:

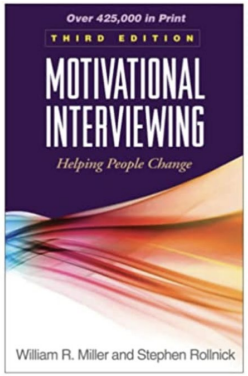
Online Training

Self-paced, 10 hr training
https://motivationalinterviewing.org/self-paced-online-learning-introductory-available-ongoing-basis

MINT
excellence in motivational interviewing

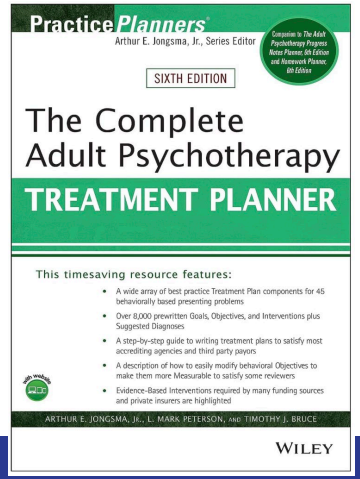
Books

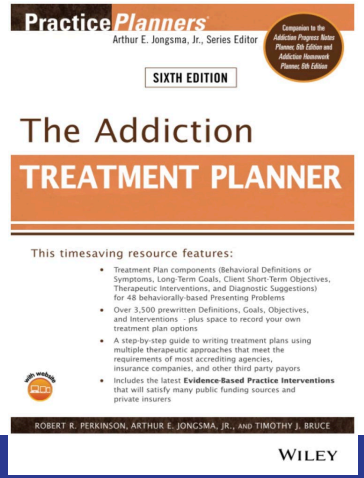
Motivational Interviewing by William Miller and Stephen Rollnick

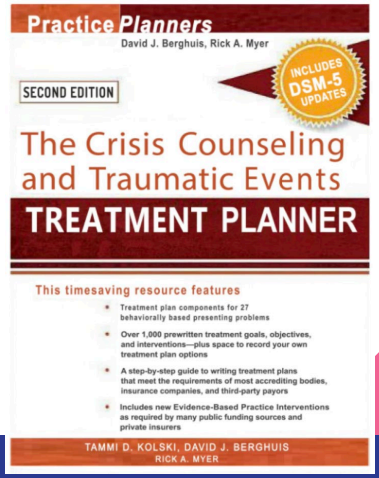


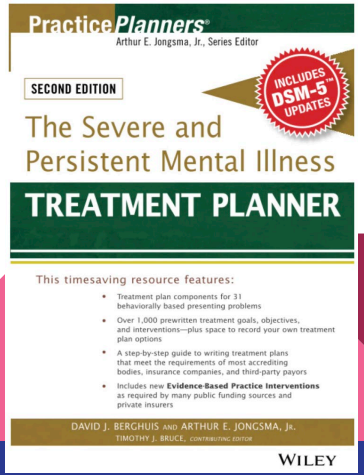
Goal of this talk – Thinking not Formatting

- How certain agencies want you to format your treatment plan will likely vary
- Do make sure your goals are written SMART
  - Specific, measurable, achievable, relevant, time limited
- There are a number of treatment planning guides available that will help you brainstorm or word your treatment plans:





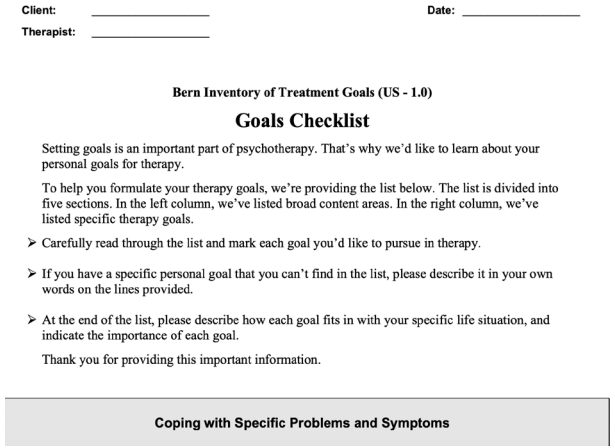




Think critically about what goals you prioritize, and make sure the goals you set make sense for the patient.

Some clients have trouble dreaming of a better life.

- Remember that one of the trauma-related diagnostic criteria in children is “sense of foreshortened future.”
  - Setting treatment goals may be extremely difficult for some clients.
  - Using an imagery exercise or treatment planning inventory may help primes the pump.
    - My favorite treatment planning inventory is the **Bern Inventory of Treatment Goals**



Client: _____ **Date:** _____

Therapist: _____

Bern Inventory of Treatment Goals (US - 1.0)

Goals Checklist

Setting goals is an important part of psychotherapy. That’s why we’d like to learn about your personal goals for therapy.

To help you formulate your therapy goals, we’re providing the list below. The list is divided into five sections. In the left column, we’ve listed broad content areas. In the right column, we’ve listed specific therapy goals.

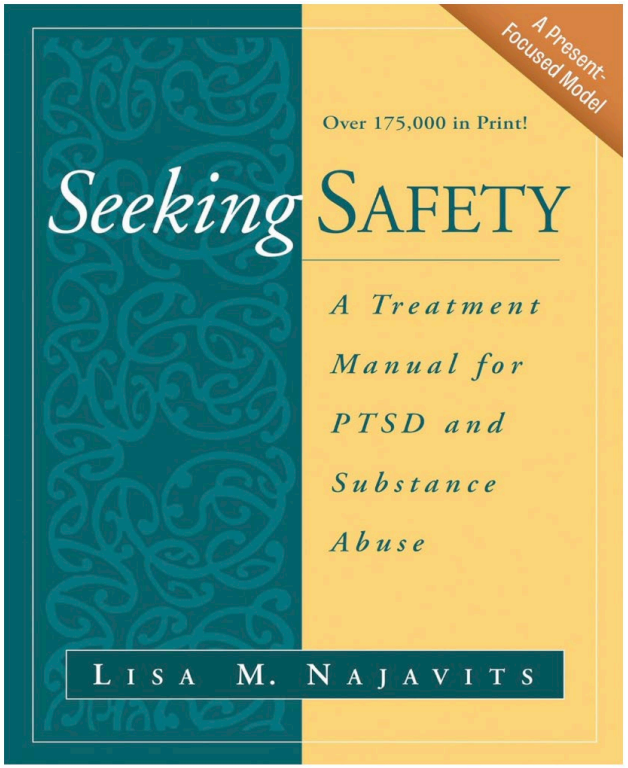
- Carefully read through the list and mark each goal you’d like to pursue in therapy.
- If you have a specific personal goal that you can’t find in the list, please describe it in your own words on the lines provided.
- At the end of the list, please describe how each goal fits in with your specific life situation, and indicate the importance of each goal.

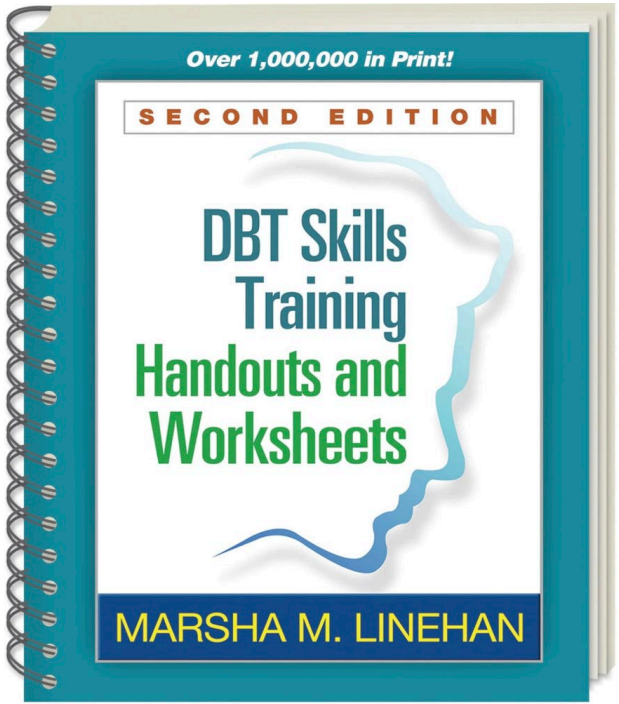
Thank you for providing this important information.

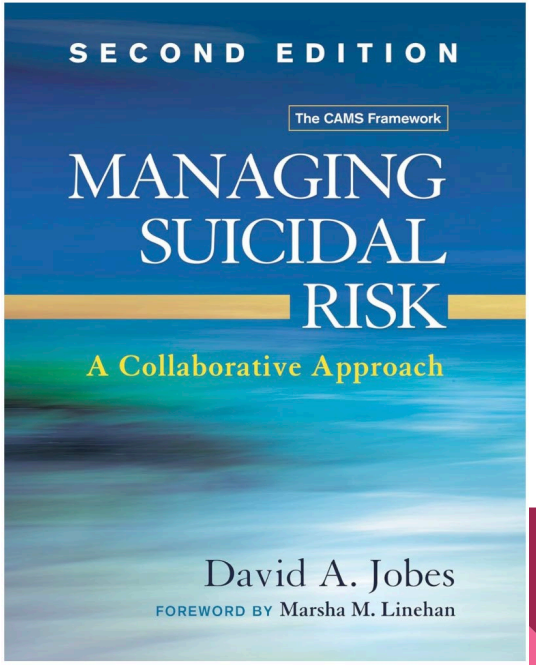
Coping with Specific Problems and Symptoms

Send me an email and I would be happy to forward a pdf copy of this tool.

Treatments for Suicidal Ideation and other High Risk Behavior:







Addressing Treatment-Interfering Behaviors or Barriers.

- Make sure that you are working on your relationship with the client so that YOU are not interfering with their treatment.
- Help them compensate for attention and executive functioning deficits to improve treatment attendance and compliance.
  - Pay attention to section on compensating for brain injury.
- Make sure the client is connected with community resources that will help stabilize their life situation:
  - Housing
  - Food
  - Clothing and laundry
  - Transportation
  - Childcare
  - Healthcare
  - Pain management
  - Sleep hygiene
  - Pharmacological treatment

Where appropriate, use short-term, intermediate, and long-term goals to take a Harm Reduction approach to tasks that the client considers difficult.

Go slow and make room for repetition to allow for the development of confidence in new skills or experiences.

Is your patient capable of what you are asking him or her to do?

Types of Brain Injury

Traumatic (TBI)

Caused by an external force.

Acquired

Results from a specific event.

Developmental/ Organic

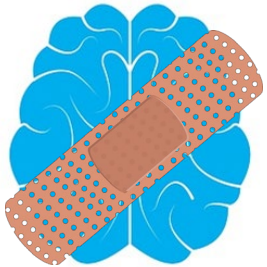
Related to a medical condition or disease.

Issues that can cause brain injury and/or cognitive impairment

- Fetal substance exposure
- Low or borderline IQ
- Arrhythmia
- Head trauma
- Tumors
- Stroke
- Hypoxia/anoxia
- Prolonged substance use
- Infection
- Long-term use of specific medications
- Hypertension
- Blood poisoning
- Prion disease
- Dementia processes
- Huntington’s disease
- Multiple Sclerosis
- Creutzfeldt-Jacob disease
- Normal pressure hydrocephalus
- Pick’s disease
- Wernicke-Korsakoff syndrome
- Late-stage syphilis
- Cancer
- Kidney disease
- Liver disease
- Thyroid disease
- Vitamin B deficiency

Symptoms Associated with Brain Injury

- Headache
- Fatigue
- Nausea
- Depression
- Anxiety
- Irritability
- Emotional Mood Swings
- Aggressive Outbursts
- Low Burstraion Tolerance
- Impulsivity
- Personality Changes
- Decreased Concentration
- Decreased Attention Span
- Decreased Speed of Thinking
- Memory Problems
- Sleep Disturbances
- Sensitivity to Noise or Light
- Tinnitus
- Vision Problems
- Balance Problems
- Unconsciousness lasting minutes to hours
- Coma
- Decline from Previous Level of Functioning



What to do: Fatigue

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

(West et al., 2004)

What to do: Basic communication

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

(West et al., 2004)

What to do: Attention and concentration deficits

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

(West et al., 2004)

What to do: Learning and memory

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

(West et al., 2004)

Example folder

Name:_____

IMPORTANT: Bring to each appearance!

Next Appearance:

_____ _____

_____ _____

_____ _____

Where I will keep my folder:

_____

Important Phone Numbers:

Coordinator (XXX) XXX-XXXX

What to do: Learning and memory

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

(West et al., 2004)

What to do: Planning and organization

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

(West et al., 2004)

What to do: Emotional dysregulation

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

(West et al., 2004)

What to do: Miscellaneous

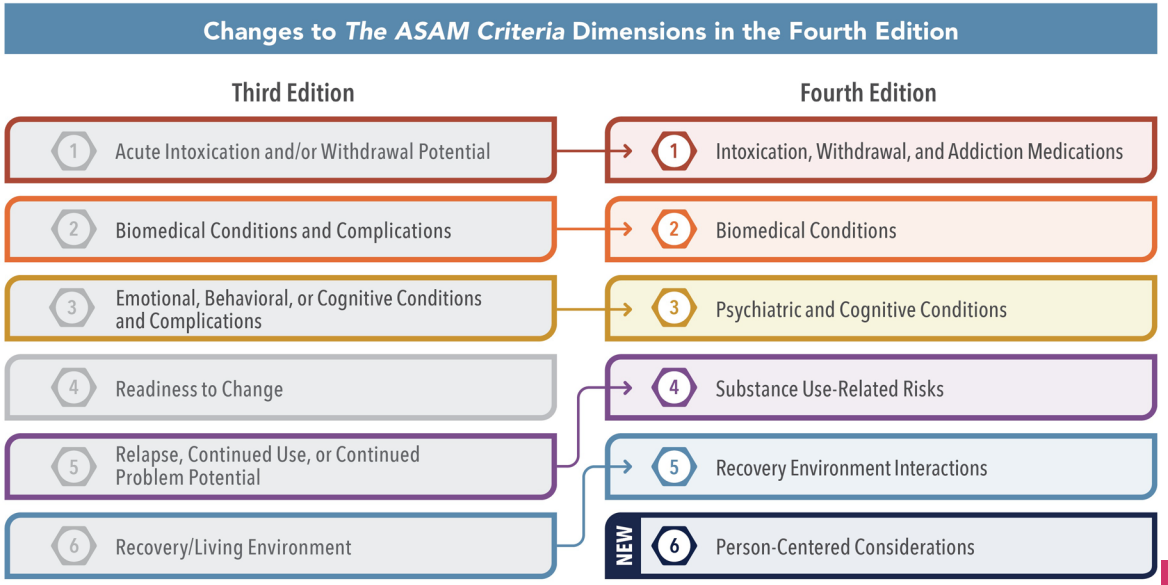
- Be sure that referrals for vocational services or community service are appropriate to the client's level of cognitive ability
  - If you're not sure, consult with the intake specialists at those programs
- If a client does decide to return to work, school, or community involvement, be aware that a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

Possible professional referrals

- Possible mental health referrals:
  - Neuropsychologist (for evaluation)
  - Clinical Psychologist
  - Rehabilitation Psychologist
  - Pain Psychologist
  - Psychiatrist
  - Neuropsychiatrist
  - Brain injury support groups
  - Case Manager

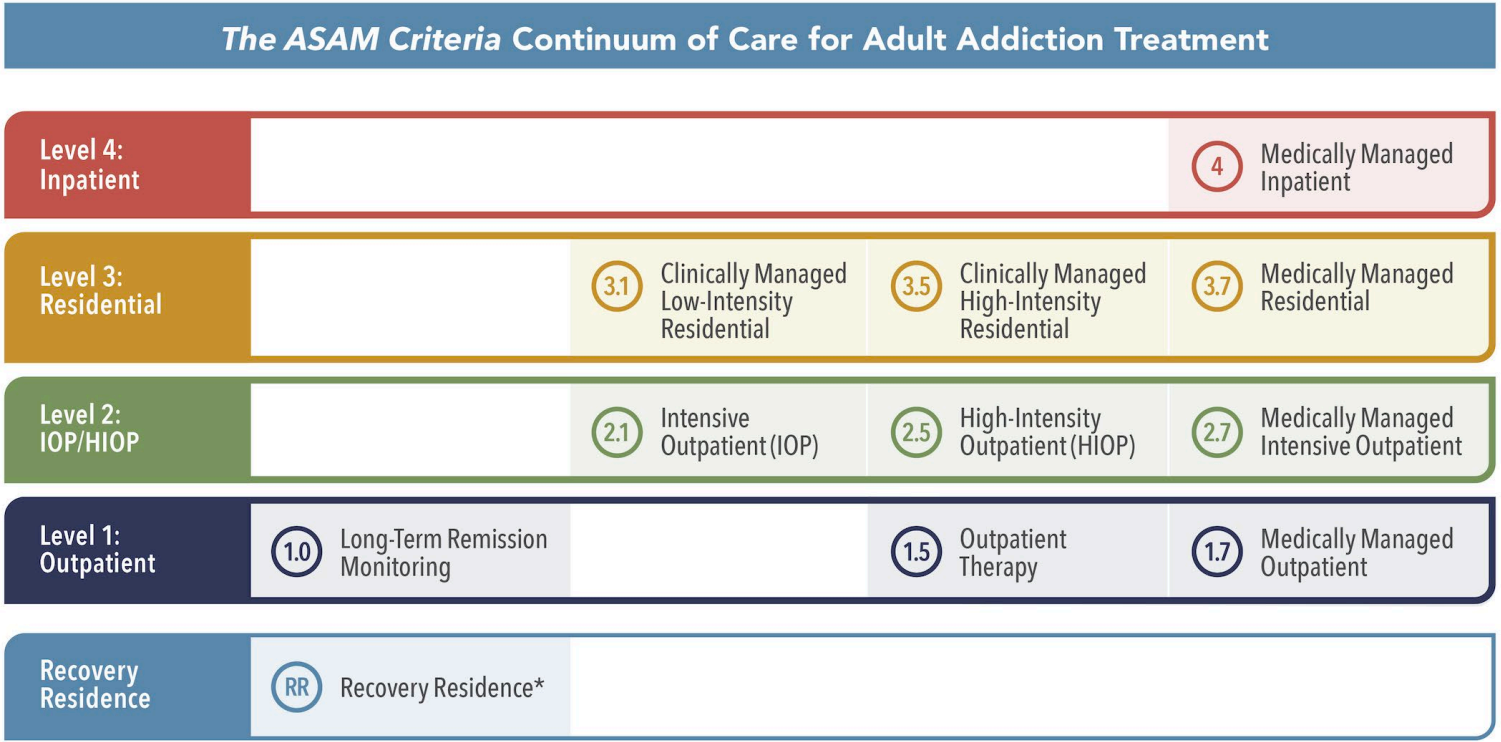
Make sure that for clients dealing with addiction, that you match their level of risk and need with the the appropriate intervention in the continuum of addiction care.

Match Patients with Addiction to the Appropriate Level of Care:



The Fourth Edition reorders the dimensions from the Third Edition. Readiness to change is now considered within each dimension, and the Third Edition Dimensions 5 and 6 were shifted to Dimensions 4 and 5, respectively, in the Fourth Edition. The new Dimension 6: Person-Centered Considerations considers barriers to care (including social determinants of health), patient preferences, and need for motivational enhancement.

Match Patients with Addiction to the Appropriate Level of Care:



Wherever possible, pick EBPs that address multiple problems:

- Motivational Interviewing
- Cognitive Behavioral Therapy
- Dialectical Behavior Therapy
- Seeking Safety
- Acceptance and Commitment Therapy
- Integrated Group Therapy (for bipolar disorder and substance use)
- Assertive Community Treatment (for SPMI)

Monitor, evaluate, and revise your treatment plan.

- Research tells us that monitoring, evaluating, and revising treatment plans significantly improves treatment outcomes.
- However, in practice this is often neglected in many treatment settings.
- Set an appropriate interval to review your client's treatment plan depending on the length of time necessary to achieve goals (several weeks, 3 – 6 months)
    - In more acute settings, treatment goals should be re-evaluated with more frequency
    - Set calendar or treatment software reminders to revise the treatment plan.
    - Revisions may include re-assessing a patient's diagnosis, motivation, or goals as treatment success may reveal new issues to target in treatment.

Tips for Treatment Planning with Complexity and Comorbidity:

1. Your clients may need help dreaming of a better life.
2. Prioritize potentially lethal/extremely high risk behaviors first.
3. Next, work on treatment-interfering behaviors or barriers.
4. Don't make perfection the enemy of progress (i.e., Harm Reduction *is* a valid treatment goal).
5. Be sure you're not asking a fish to fly:
    1. build skills and confidence before asking for intimidating tasks
    2. be sure you are asking for something of which the patient is capable.
6. Match the intensity of the treatment to the level of risk/need.
7. Where available, select evidence-based treatments that address multiple diagnoses/treatment goals.
8. Put processes in place to monitor, evaluate, and revise your treatment plan.

Questions?

Final Thoughts

Thank You!

Evaluation

https://cvent.me/z1nG7z

1. On your compatible phone or tablet, open the built-in camera app.
2. Point the camera at the QR code.
3. Tap the banner that appears on your phone or tablet.
4. Follow the instructions on the screen to complete the evaluation.
5. After completion, you will be provided with a certificate that can be saved and printed.

Christa Marshall

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Polypharmacology of Substance Use: Learning as Hidden Processes

Brian M. Kelley, Ph.D.

Disclosures:

No relevant financial or nonfinancial relationships exist.

We do not receive any finical compensation for any of the resources mentioned in our presentation.

This workshop addresses general legal and ethical principles. It is for educational purposes only. Nothing in this workshop should be understood to provide clinical or medical advice.

Abstract

Drug addiction is far from a passive, static, or random occurrence that affects some individuals and not others. Rather, it is an active, dynamic, and adaptive process initiated and sustained by the individual. While initially a choice, drug use can progressively reduce conscious control over actions and reactions with repeated use. Moreover, the onset of drug use commonly begins during adolescence and often coincides with experiences of trauma and mental health issues.

Many individuals have limited awareness of their evolving patterns of drug use over time, particularly as experimentation can transition to recreational use, self-medication, bingeing, dependence, polysubstance use, and ultimately addiction—this progression is especially notable among adolescents and young adults. Much of the behavior that sustains drug use is learned, often occurring unconsciously without the individual's deliberate recognition. These subconscious processes play a significant role in perpetuating escalating drug use and misuse, particularly in cases involving polysubstance use.

This presentation will delve into how learning processes directly influence the cycle of drug use. Specifically, it will explore the impacts of classical and operant conditioning on substance use, feelings of euphoria, recovery, withdrawal symptoms, and drug-seeking behaviors. Understanding the cycle of addiction and recognizing the individual's role within it are crucial for implementing effective interventions.

Learning Objectives:

Participants in this presentation should achieve the following objectives:

1. Gain a deeper understanding of the intricate and subjective nature of conditioned drug reactions and their influence on relapse.
2. Identify challenges associated with attempting to quit drugs outside of one's daily routine.
3. Propose strategies to mitigate cravings, urges, and withdrawal symptoms among individuals with substance use disorders.
4. Recognize how polysubstance use exacerbates issues related to maladaptive behaviors that perpetuate continued drug use.

Statistical Introduction (Substances):

- 90% of Americans who meet the medical criteria for addiction started smoking, drinking, or using other drugs before age 18.
- One in four Americans who began using any addictive substance before age 18 developed an addiction, compared to 1 in 25 Americans who started using at age 21 or older.
- 75% of all high school students have used addictive substances, including tobacco, alcohol, marijuana, or cocaine; of these, one in five meets the medical criteria for addiction.
- 46% of all high school students currently use addictive substances; of these, one in three meets the medical criteria for addiction.
- 50% of youth have misused a substance at least once (NCDAS, 2021).
- More than 70% of youth have consumed an alcoholic beverage (American Addiction Center, 2024).
- 16.8 (% of youth have smoked cigarettes (NIDA, 2022).
- 43.7% of youth have used marijuana (NCDAS, 2021).
- 14.3% of youth have misused controlled prescription drugs (CDC, 2020).
- 15% of youth have used illegal drugs including cocaine, inhalants, heroin, methamphetamines, hallucinogens, or ecstasy (CDC, 2020).
- 65.1% of youth have used more than one substance.
- Immediate costs per year of teen use include an estimated $68 billion associated with underage drinking and $14 billion in substance-related juvenile justice costs.
- Total costs to federal, state, and local governments of substance use, which has its roots in adolescence, are at least $740 billion per year—over $2000 for every person in America.

Additional statistics are taken from CASA. (2011). Adolescent Substance Use: America's #1 Public Health Problem. The National Center on Addiction and Substance Abuse at Columbia University.

Statistical Introduction (Mental Health):

Lifetime prevalence estimates are as follows:

- Anxiety, 34%
- Mood disorders, 21.4%
- Impulse control disorders, 25%
- Substance use disorders, 16.5%
- Any disorder, 46.4%

The age of onset surrounds the adolescent period

Half of the lifetime cases begin by age 14

Statistics are taken from Harbor Mental Health (2022); Kessler et al. (2005); the National Institute of Mental Health (NIMH Information Resource Center, 2020; 2021); SAMHSA (2023) and Szuhancy & Simon, 2022.

This epidemic is further complicated by the fact that young children have more experience and exposure to a variety of medications, often powerful psychoactive compounds. Nationally, the number of prescription drugs written for psychoactive medication for youth has skyrocketed in the last 15 years. Research on the long-term consequences of such use patterns lags terribly behind. One study found that 1.6 million youth are taking two or more psychiatric medications simultaneously (Merikangas, He, Rapoport, Vitiello, & Olfson, 2013). Most medications are used "off-label," that is, without full FDA approval.

Top prescription drugs for children and adolescents include the following:

- Stimulants like Ritalin (Methylphenidate)
- SSRIs like Prozac (Fluoxetine)
- Antipsychotics like Clozaril (Clozapine)
- Anxiolytics like Valium (Diazepam) or Xanax (Alprazolam)
- Pain relievers like Percocet (Oxycodone) or Demerol (Meperidine)

More Drugs Available, Easier to Access, and Lower Cost

The societal cost of "getting high" becomes higher every day; in other words, people and society pay a big price for substance use problems. However, the actual cost of drugs is getting lower.

Different categories/classes of drugs include:

1. Psychostimulants—cocaine, amphetamine, methylphenidate
2. Tobacco products/nicotine—cigarettes, chewing tobacco, cigars
3. Opioids—heroin, Oxytocin, Percocet, morphine
4. Depressants—alcohol, benzodiazepines, barbiturates
5. Inhalants—nitrous oxide, ethyl ether, toluene
6. Cannabinoids—marijuana
7. Psychedelics—LSD, mescaline, psilocybin
8. Dissociative agents (Arylcyclohexylamines)—PCP, ketamine, dextromethorphan

THE COLORADO SUN

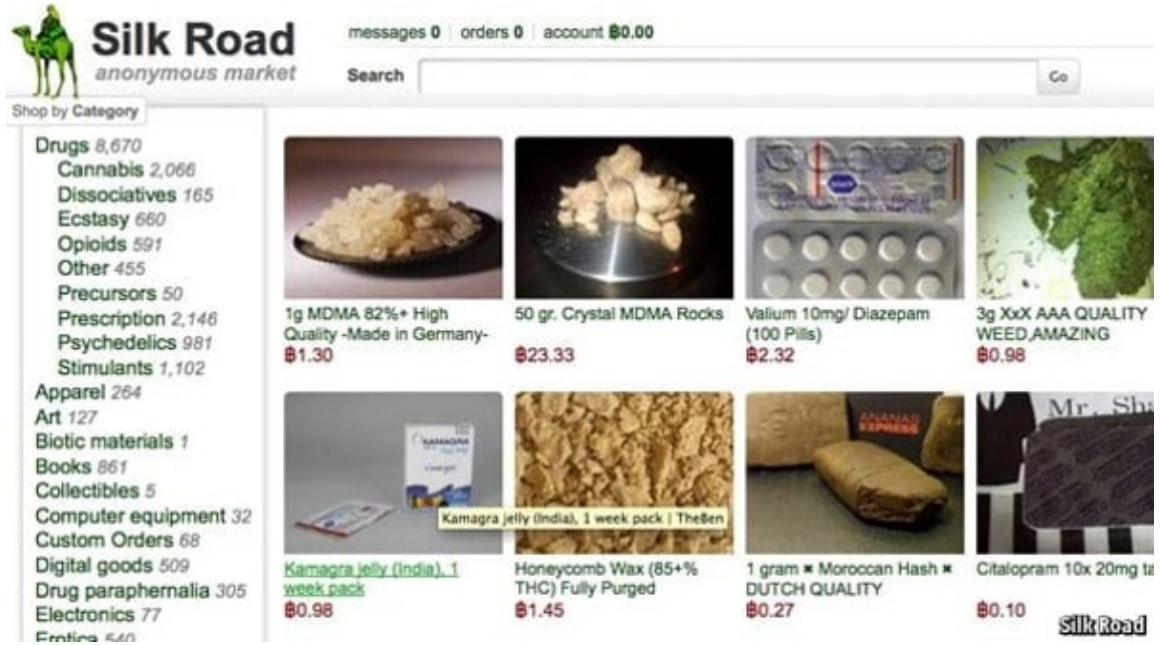
CRIME AND COURTS

Social media apps have made buying illegal drugs about as convenient as ordering pizza, Colorado AG says

Slang, emojis, disappearing messages help dealers move sales from shady, dark alleys to your phone while evading law enforcement

Olivia Prentzel

3:25 PM MST on Mar 8, 2023 Updated 8:21 AM MST on Mar 9, 2023



What Makes a Drug “Bad for You”?

What *Single* Drug-Specific Factor Best Predicts Toxicity

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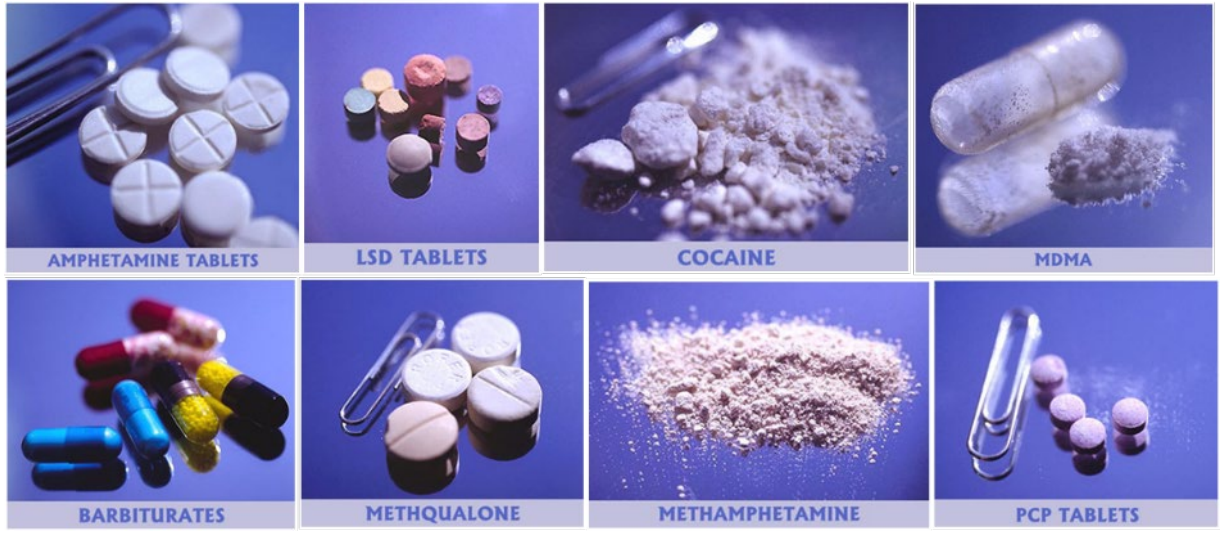

What *Single* Biological-Specific Factor Best Predicts Toxicity

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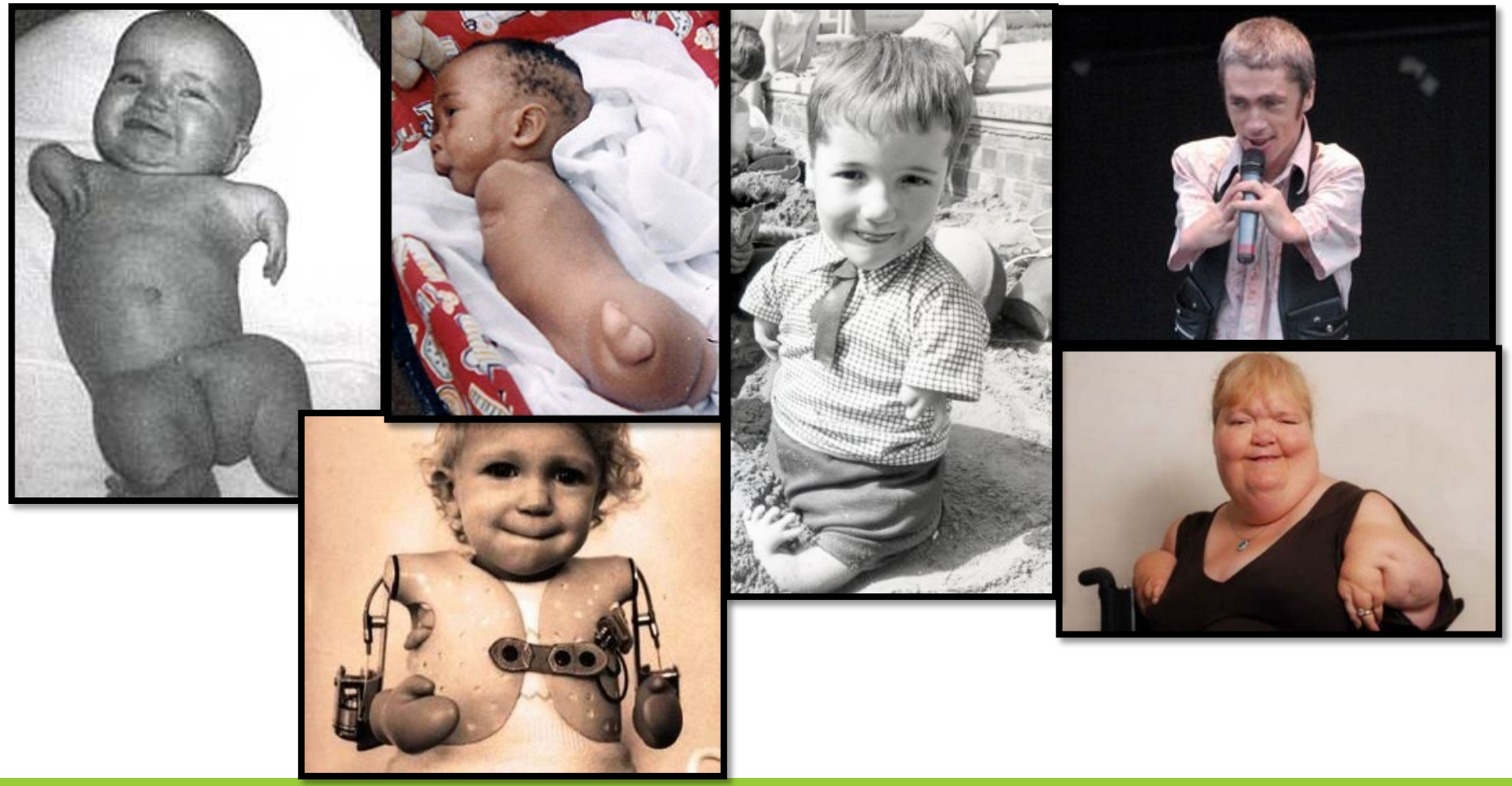
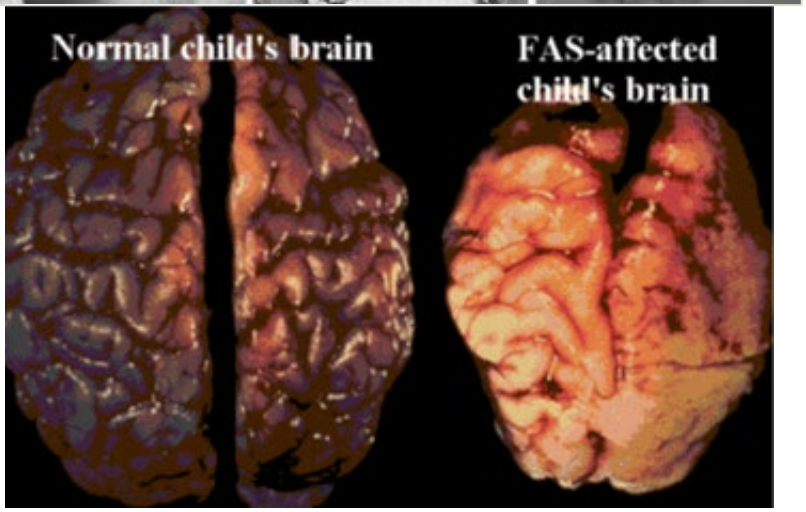
This is a real person, from the *Bodyworks* exhibit

Have you heard of Thalidomide?



Example of Dose and Development: Fetal Alcohol Syndrome



Life-long symptoms include the following:

- Attention deficits
- Memory deficits
- Hyperactivity
- Difficulty with abstract concepts
- Inability to manage money
- Poor problem-solving skills
- Difficulty learning from consequences
- Immature social behavior
- Inappropriately friendly to strangers
- Lack of control over emotions
- Poor impulse control
- Poor judgment

Development is Always Occurring: Risk is Not Equally Distributed Across the Lifespan

Simply stated, the more rapid the biological changes, the higher the risk. The prenatal period is associated with the highest vulnerability followed by the adolescent period.

What is the Most Dangerous, Most Addictive Drug?

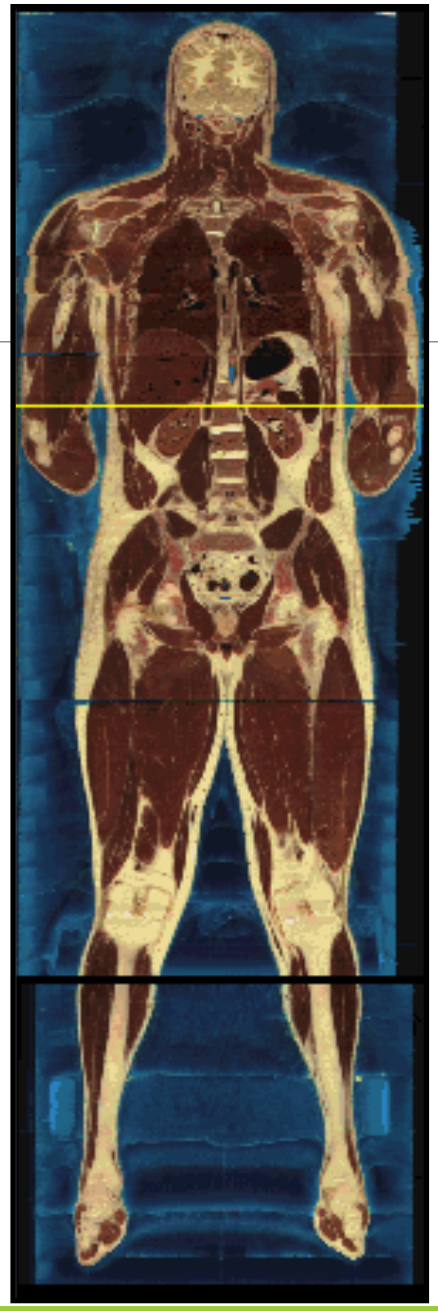
Developmental Processes Start with the Brain

What makes one a grown-up?

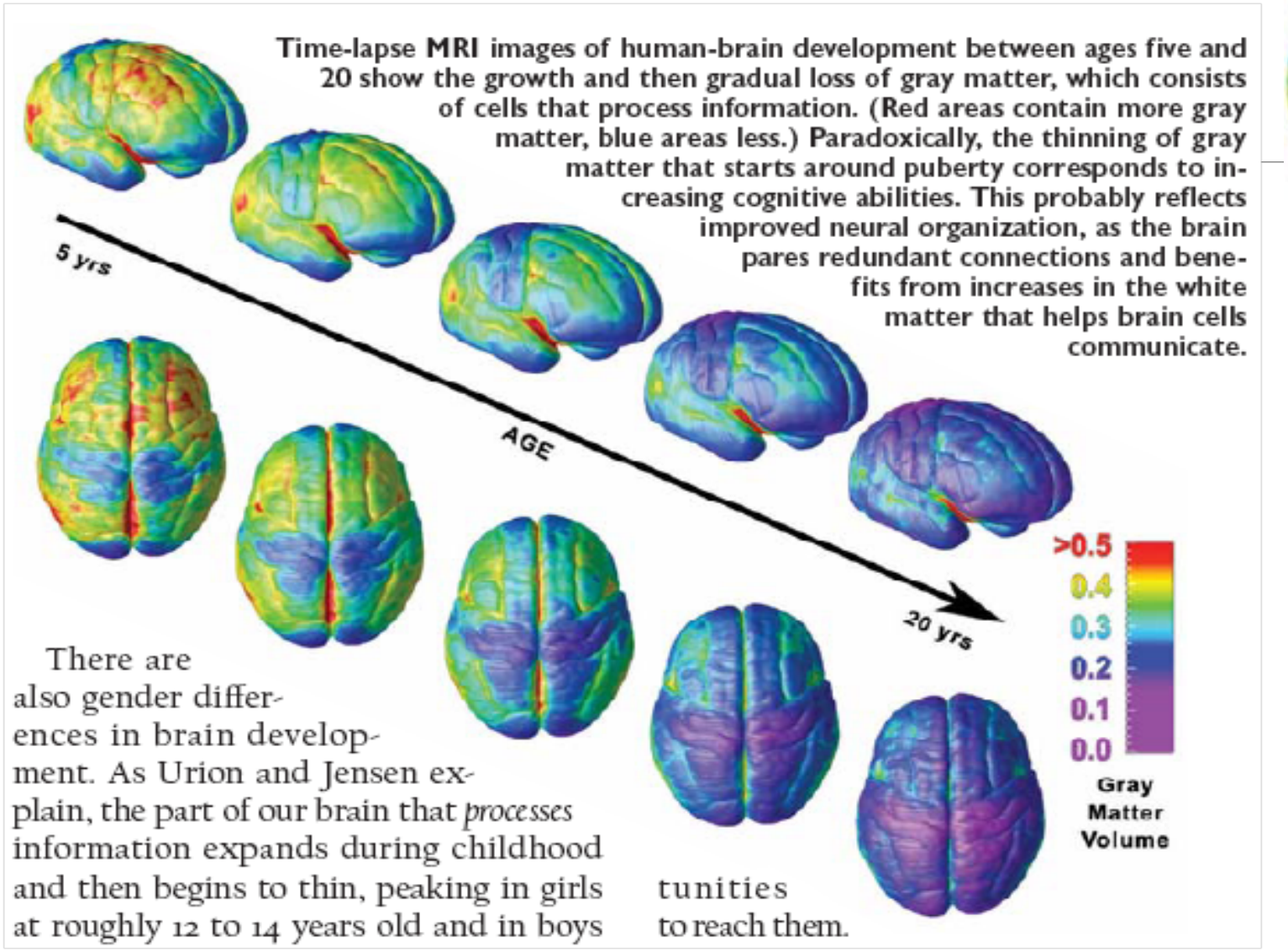
Is it looks, age, or behavior?

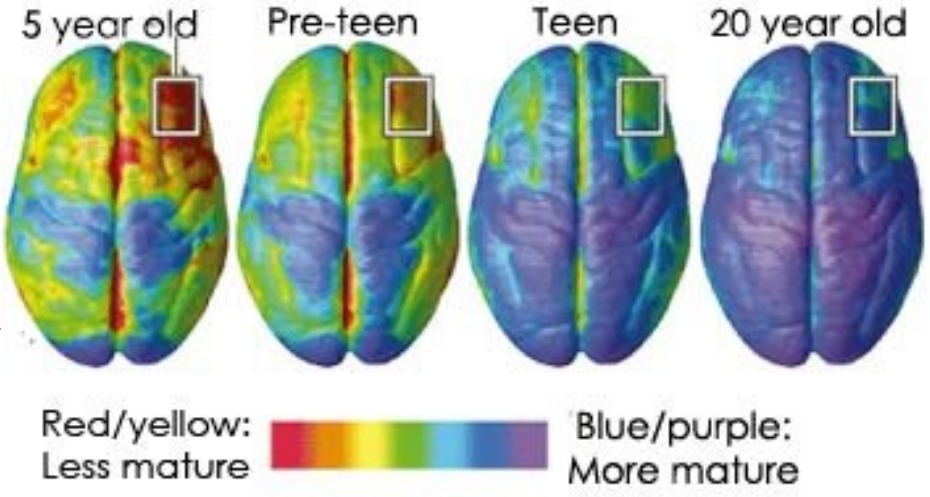
Rapid Physical Growth
Changes in Sleep Patterns
Change in Appetite
Changes in Hormones
Sexual Maturation
Secondary Sexual Characteristics
Motivational Changes
Emotional Changes
Cognitive Improvement
Social Changes
Maturation of Judgment
Self-Regulation Skills

One organ that is responsible for initiating and controlling all of these changes—the BRAIN!



Brain Maturation





The initiation of drug use is the highest among people aged 12 to 18. The average age for the first use of an addictive substance in 2016 was about 18.2 for inhalants, 17.4 for alcohol, 18 for nicotine, and about 19 for illicit drugs (Alcover & Thompson, 2020 ; Lipari, Ahrnsbrak, Pemberton, & Porter, 2017). Initiating substance use during childhood or adolescence increases the risk of developing dependence or substance use disorder (SUD) in the future (SAMHSA, 2014b).

Flint Lead Crises: Did You Hear About it

About a 4-point drop in IQ from lead exposure.

Marijuana and IQ

NIH National Institute on Drug Abuse

1. NSDUH, SAMHSA, 2014; 2. MTF Survey; 3. Meier et al 2012; 4. MTF Survey; Cobb-Clark et al, 2013; Silins et al 2014; Tucker et al 2005; Homel et al, 2014; Volkow et al 2014; Fergusson and Boden 2008; Brooks et al 2013

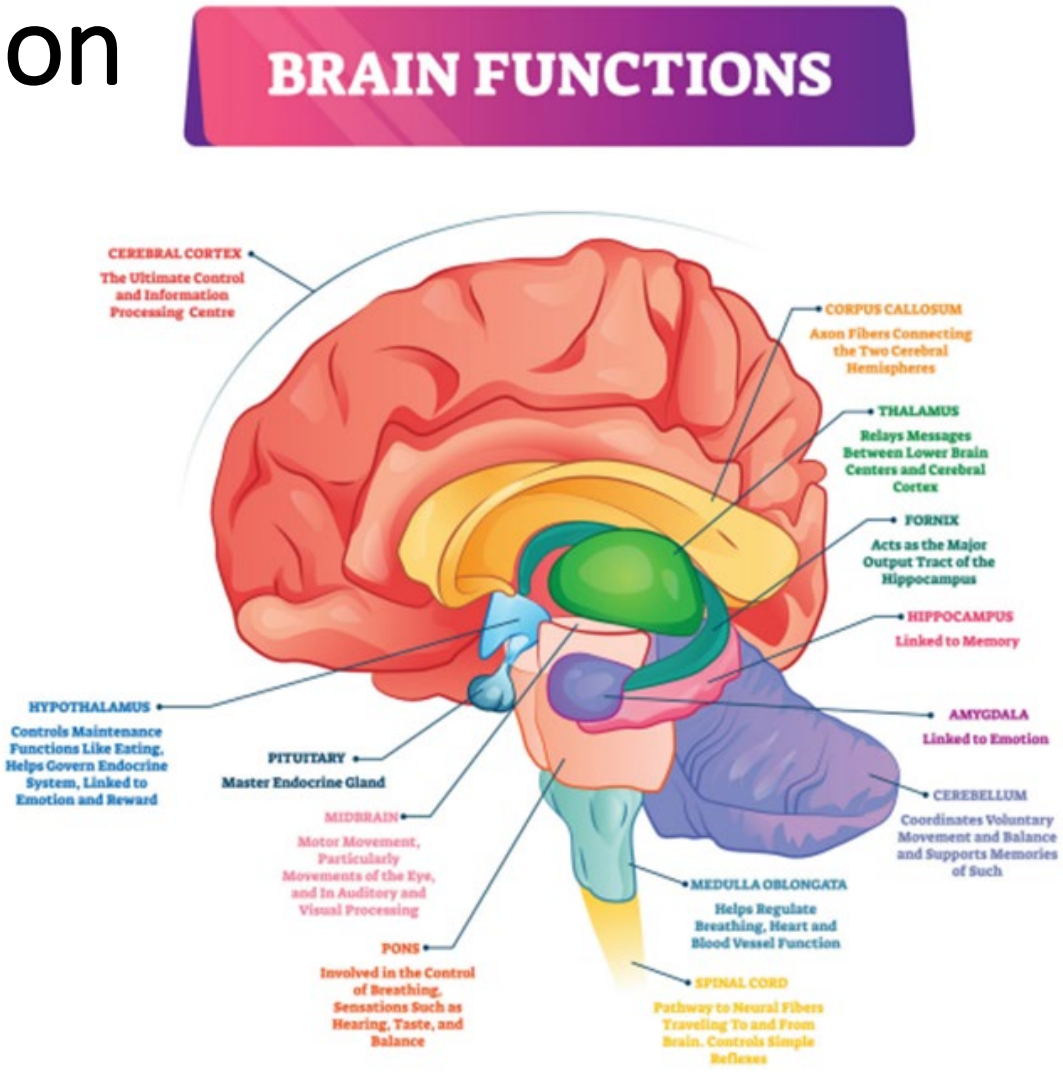
Developmental Brain Dysfunction

Drugs plus rapid development equals a worst-case scenario for brain development as well as complete development.

All abused drugs share common features and result in altered brain development and function. Dysfunction is most significant with reward and thinking.

Now imagine drugs plus development plus mental health issues. And, add to that now, loneliness, overuse of technology, and low educational status.

Furthermore, include multi-generational mental health issues along with poverty.



Developmental Conflict Between Two Brain Systems

People often refer to right brain vs left brain but a more accurate way to think about it is mid-brain (limbic system) vs front-brain (frontal lobe) and to add development in that consideration.

Functions of The Limbic System (Reward System)	Functions of the Frontal Lobe (Executive System)
Energy levels and fatigue	Center of personality
Hunger and eating	Planning
Emotional aspects of smell	Judgment
Thirst	Reasoning
Temperature regulation	Problem-solving/Logical decision making
Hormones (*and all that goes with it*)	Impulse control
Sexual behavior	Control over aggression
Emotional processing	Organization of conscious thoughts
Social processing, emotions of faces	Working memory
Reward/reinforcement/pleasure--Addiction	Control over conscious movement
Emotional aspects of learning and memory	Management of new memories
Anger/Aggression	Connecting actions with consequences
Sensitivity to pain	Attention
Sleep patterns	Cognitive flexibility (multitasking)
Motivation (*the why*)	Goal Persistence/motivation (*the how*)
Examples of Limbic Processes	**Examples of Frontal Lobe Processes**
I want what I want right now	Waiting would be a better option
This drug is really going to help me relax	I am going to feel really bad the next day
More is better right now	It would be healthier to limit myself
I am scared, so I am not going do it	I can overcome my fear and get it done
I am tired, so I am going to skip work	I am tired, but I don't want to miss work
I am mad, and you're going to see how	I am mad but stay calm and under control
You bet I will have another drink (alcohol)	I better not drink more; I have work tomorrow
I have no idea why I just did that	I have planned this activity for days
No worries, I can handle a little right now	Once I start using, it is really hard to stop
I can hang around people using, no problem	I am better off not being around people using
Consequence of Drug Use	**Consequence of Drug Use**
Things are less rewarding	Hard to understand actions and their results
Focus on the immediate benefit of drugs	Ignore the next day or week consequences
Ignore impact on others, me focused	Interferes with delayed gratification

Lots of Opportunity for Neural Dysregulation

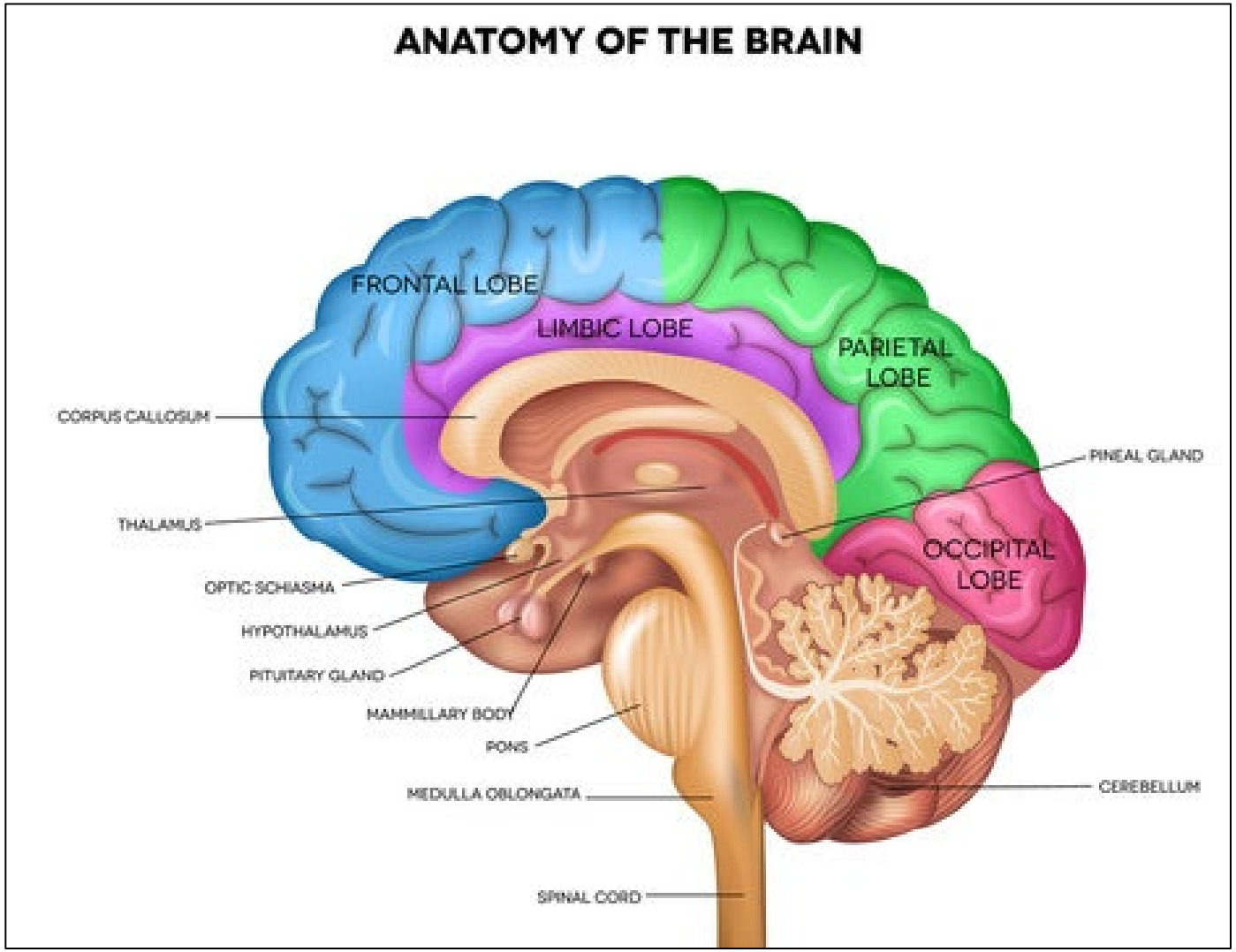
Neurotransmitter	Effect	Location	Functions	Affected by
Acetylcholine	Excitatory	Cortex, spinal cord, neuromuscular junctions, organs activated by the peripheral nervous system (PNS)	Excites or inhibits organs; learning, memory, and movement	Nicotine, some hallucinogens
Adenosine	Inhibitory	Brain, PNS	Sleep, wakefulness, and vasodilation	Caffeine
Anandamide	Inhibitory	Brain, spinal cord, PNS	Regulates the release of other neurotransmitters	Marijuana
Dopamine	Inhibitory	Limbic system, basal ganglia, cerebellum	Movement, emotional behavior, attention, learning, memory, and reward	Cocaine, amphetamine, methamphetamine, Ritalin, Adderall
Endorphins	Inhibitory	Brain, spinal cord	Pain reduction, emotional behavior, eating, learning	Heroin, oxycodone, morphine
Epinephrine	Excitatory	Spinal cord, limbic system, cortex, organs activated by sympathetic nervous	Attention, hunger, energy, arousal, and fight-or-flight response	Cocaine, ephedrine, amphetamines
Gamma-aminobutyric acid (GABA)	Inhibitory	Brain, spinal cord	Primary inhibitory neurotransmitter in the brain. General inhibition, affects arousal and anxiety	Alcohol, barbiturates, benzodiazepines
Glutamate	Excitatory	Brain, spinal cord	Long-term memory, cognitive functioning	Alcohol, PCP, ketamine
Glycine	Inhibitory	Brain, spinal cord	General inhibitory effects	Antiepileptic drugs, some sedatives
Norepinephrine	Both	Spinal cord, cortex, limbic system,	Arousal, eating, emotional behavior, learning, and memory	Cocaine, ephedrine, amphetamines
Serotonin	Inhibitory	Brain, brainstem	Emotional behavior, arousal, sleep	MDMA (Ecstasy), LSD, mescaline, other hallucinogens

Teen Brain Development Occurs in Three Phases:

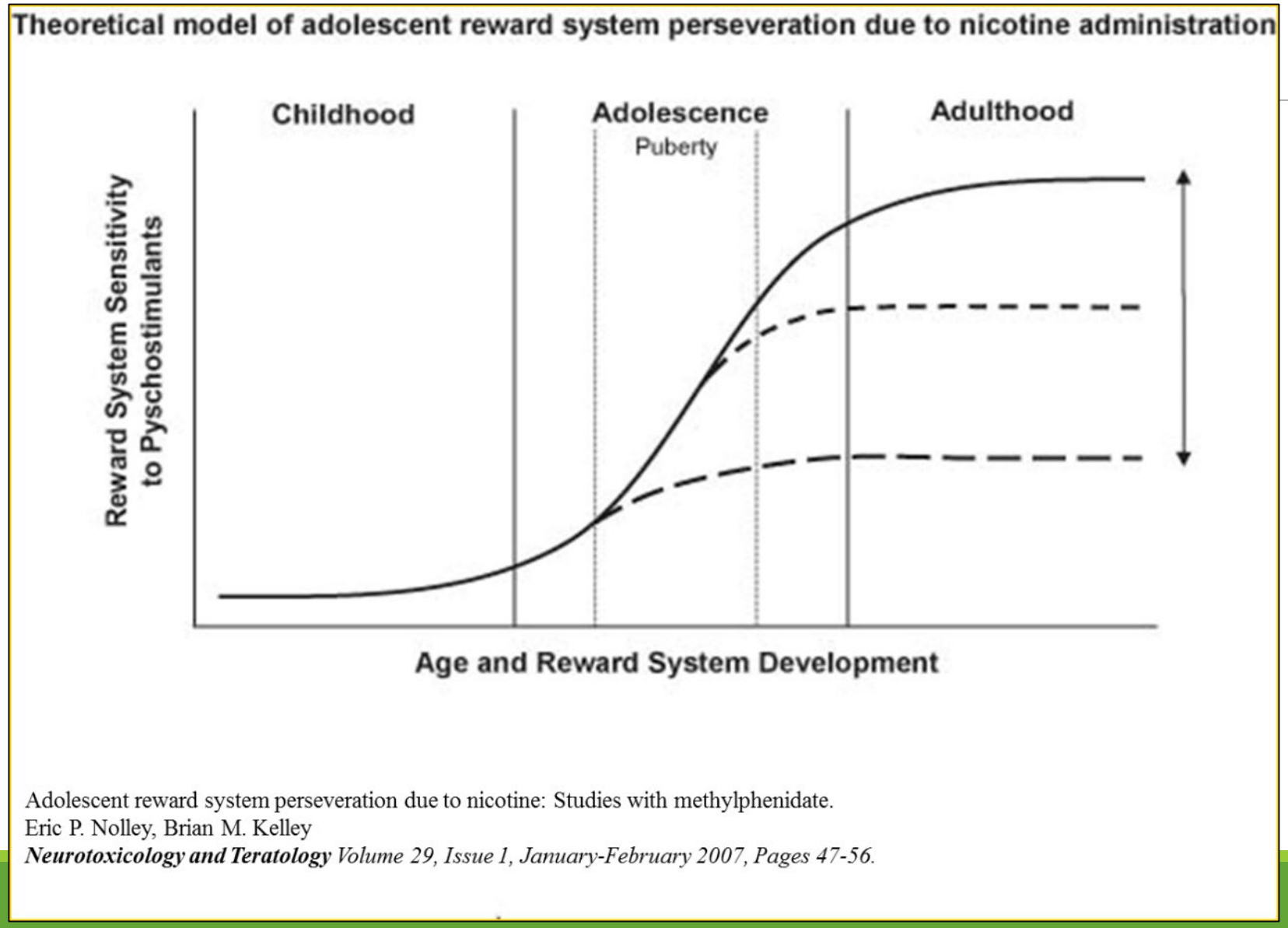
1. **Limbic System (around 11-13)**
   (reward, pleasure, and arousal)

3. **Basal Ganglia (around 19-23)**
   (Connecting the two, so cognition is rewarding)

2. **Frontal Lobe (around 16-18)**
   (Executive Function, cognition, metacognition)



Developmental Model of Drug-Based Brain Dysregulation

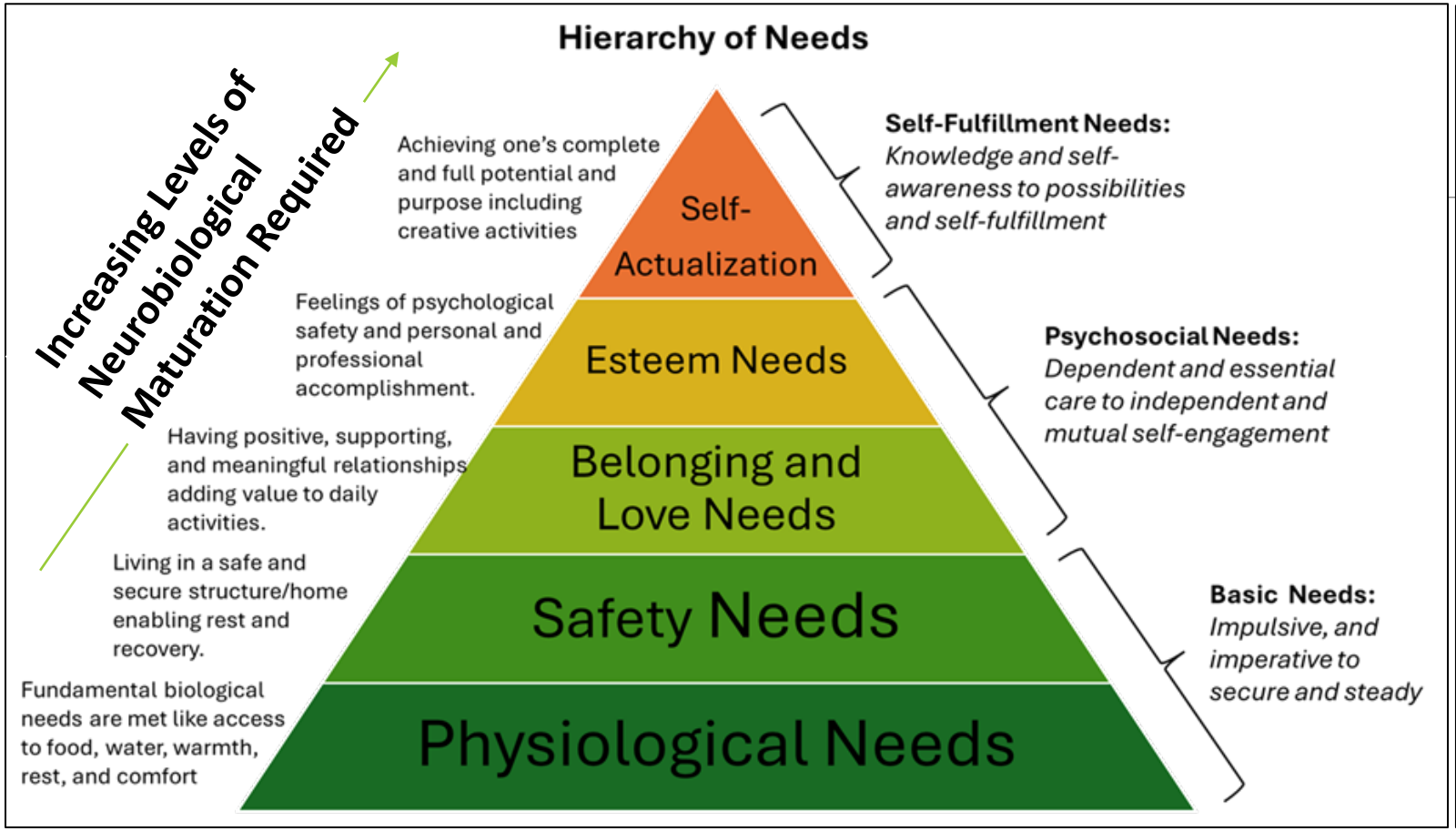


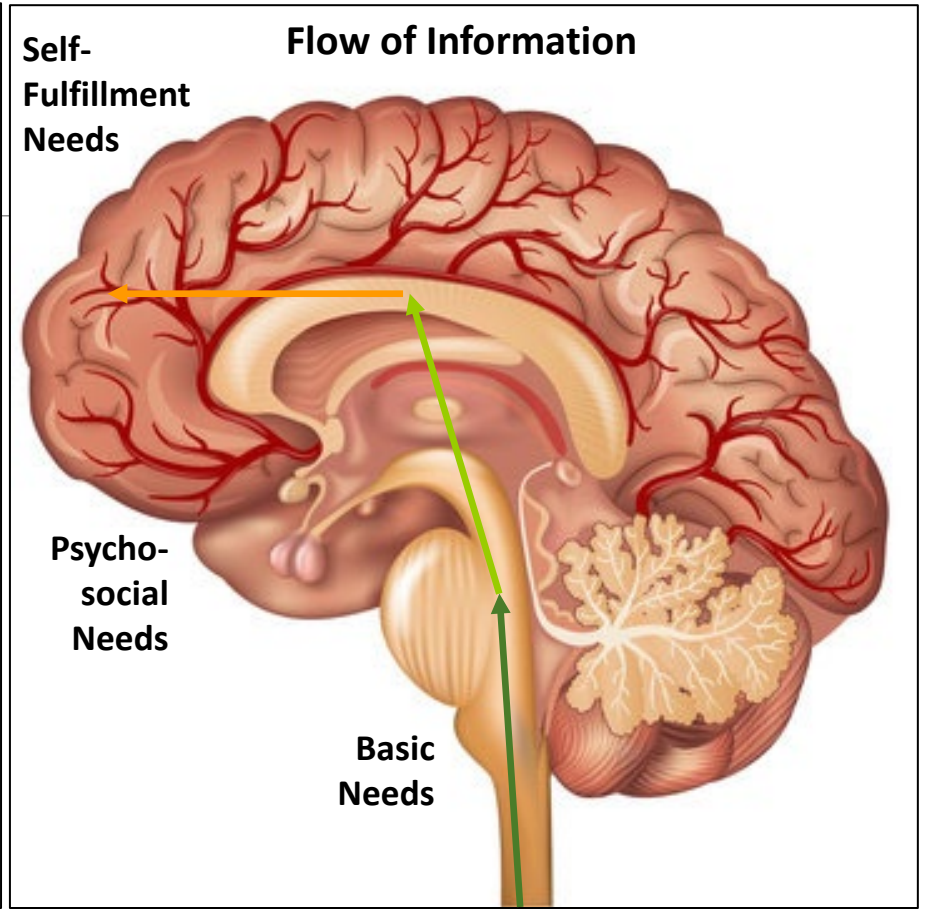
Adolescent reward system perseveration due to nicotine: Studies with methylphenidate.
Eric P. Nolley, Brian M. Kelley
Neurotoxicology and Teratology *Volume 29, Issue 1, January-February 2007, Pages 47-56.*

If this is true, then what does this say about the intellectual ability/maturity of individuals who use substances early in life?

It is difficult to get such individuals to think about the more complex aspects of substance use. Their brain has been developed and trained to focus on immediate biological needs and simple psychosocial needs. This is not to say that higher-level thinking is not possible or occurring, but the default mode network is focused on accessing, using, and recovering from substances.

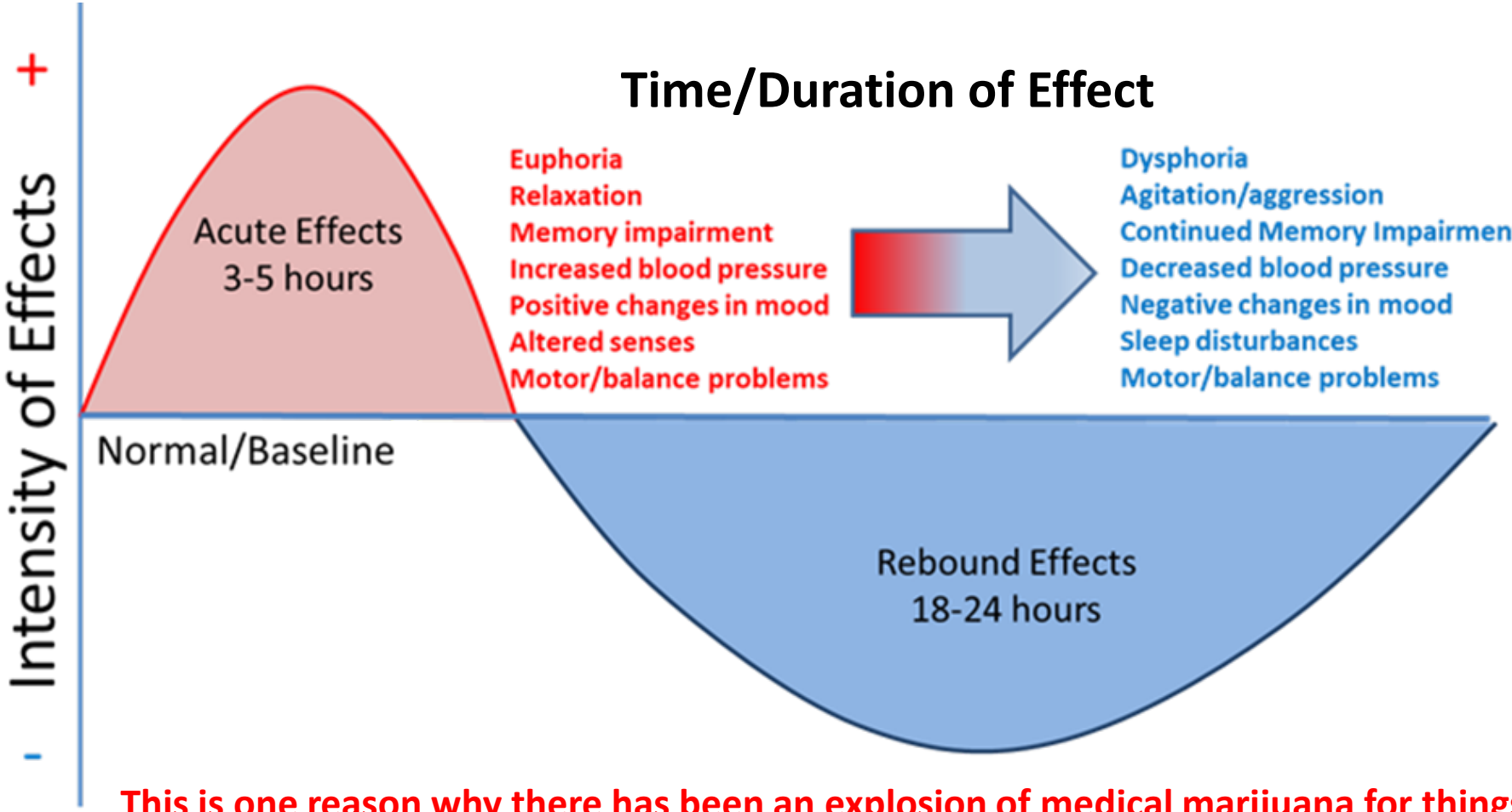
Hierarchy of Needs and Neurobiology





1)The brain processes information in the order noted in the diagram with more basic needs being analyzed first and more complex psychosocial needs analyzed last. Also, the analyses get increasingly complex moving from basic to more complex needs. 2) Each level in the hierarchy requires a more sophisticated area of the brain and it takes a more mature brain to fully appreciate higher levels of need thus there is a neurodevelopmental component to understanding the more complex needs.

Complex Drug Effects Over Time



How often are these considered clinically relevant symptoms independent of substance use?

Repeated use during a critical developmental period can cause the baseline to drop, perhaps permanently.

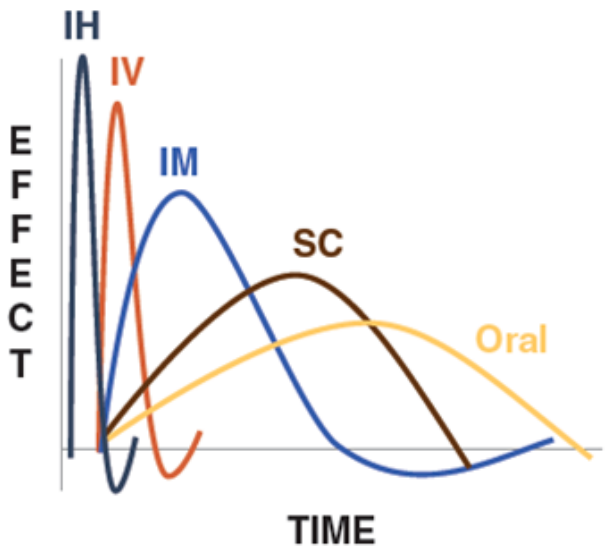
This is one reason why there has been an explosion of medical marijuana for things like anxiety and depression; it is because marijuana is causing anxiety and depression. The rebound effect of marijuana use is dysphoria and anxiety. Withdrawal from opioids also results in anxiety so people take marijuana thinking it will help but generally makes matters worse.

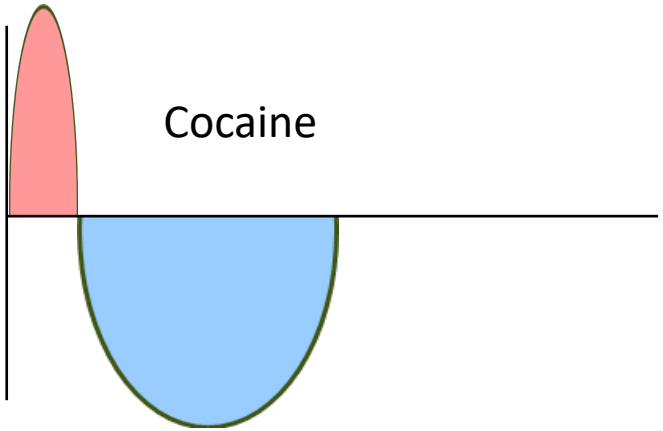
The Impact of Time on Polypharmacology

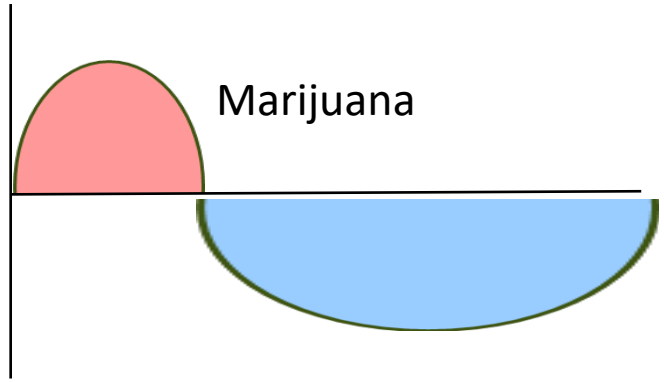
Route and Rate of Administration

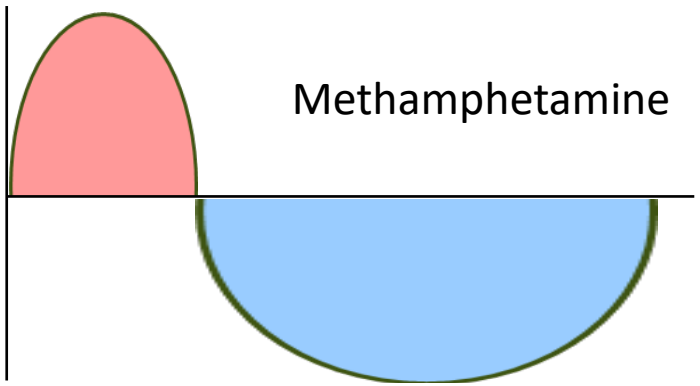
Routes of Drug Administration

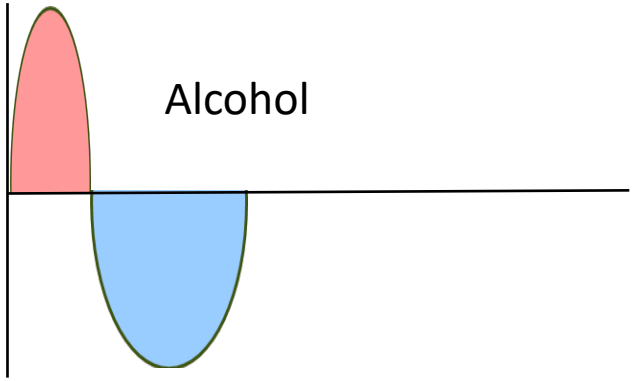
1. Inhalation
2. Intravenous
3. Intramuscular
4. Subcutaneous
5. Sublingual
6. Oral
7. Rectal
8. Topical
9. Others



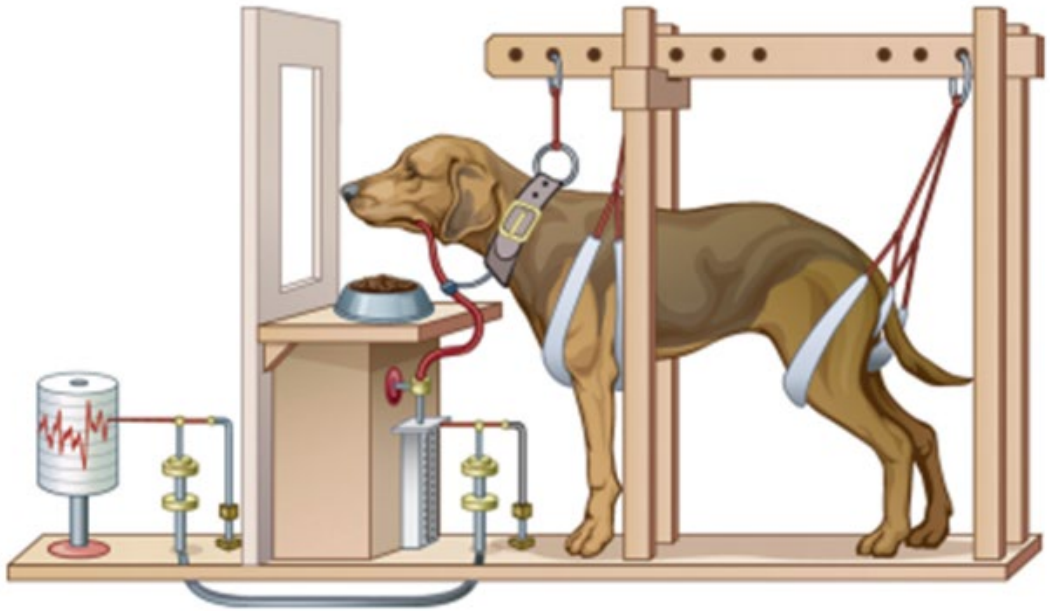






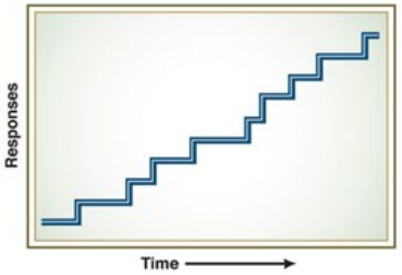


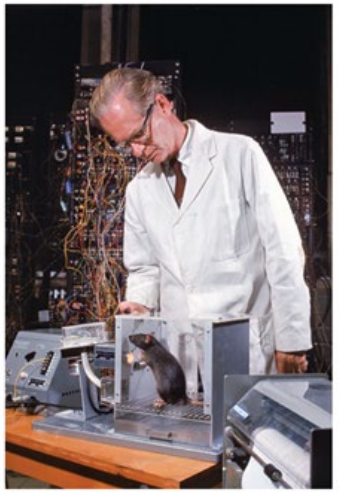
Learning: Classical Conditioning



Perhaps the most well known is classical conditioning. Conditioning, displayed in the research by Ivan Pavlov, is a type of learning based on the formation of new associations between a stimulus and a response (see Figure 5.2_. It has five important components: the **unconditioned stimulus (US)**, **unconditioned response (UR)**, **neutral stimulus**, **conditioned stimulus (CS)**, and **conditioned response (CR)**. In Pavlov's classic experiment, a dog is placed in a harness-like contraption similar to the one shown in Figure 5-1. The apparatus allows food powder to be inserted directly into the dog's mouth or dropped into a dish in front of the dog. The salivation that occurs when food powder is placed in the dog's mouth is an unlearned response and therefore an **UR. The UR is** the automatic, unlearned response an organism gives when the US is presented. The food powder that gives rise to the UR is **US,** which, in the simplest terms, is a stimulus that elicits an automatic, unlearned response.

Learning: Operant Conditioning





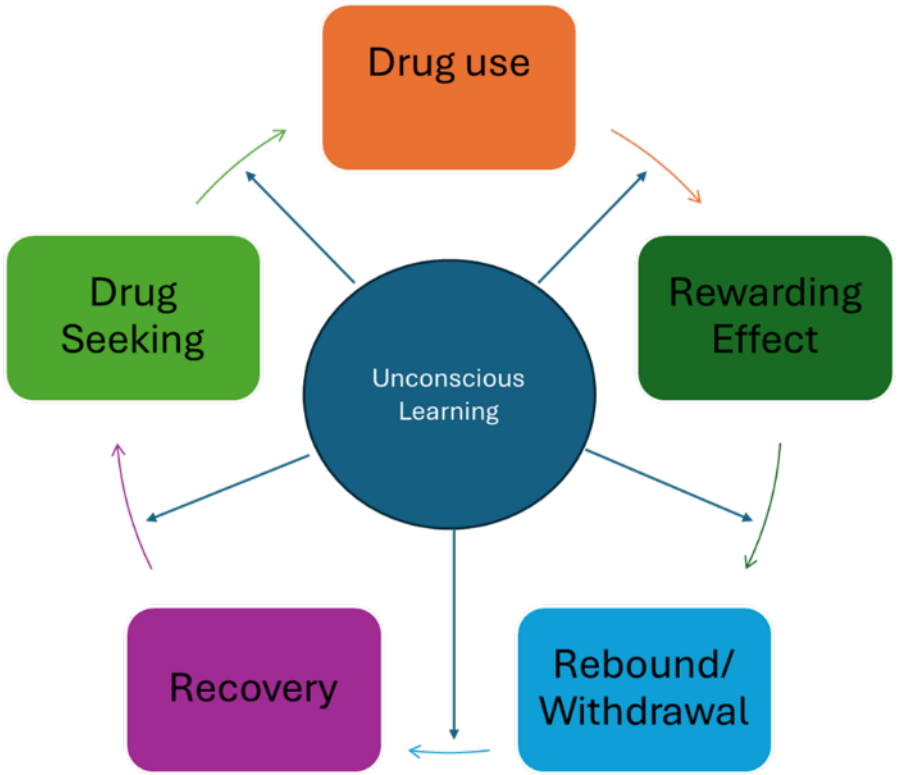
Operant conditioning is a form of learning that is based on the "**law of effect**." The law of effect states that in the presence of a particular stimulus, behaviors that result in a positive experience tend to get remembered or repeated, and behaviors that result in a negative experience tend to be forgotten or avoided. Self-administration of a drug provides one of the clearest examples of the law of effect. Drugs produce immediately pleasurable experiences that can be rapidly associated with stimuli. These stimuli trigger conditioned or learned responses that motivate the person toward repeated drug use. This form of learning is remarkable because the person directs their own behavior but are often unaware of the direct connection between environmental stimuli and learned responses (Tapert et al., 2003). The pleasurable effects of drugs are compounded by the combination of extrinsic and intrinsic reinforcers.

Unconscious Learning Processes Co-occur

Operant and classical conditioning both happen simultaneously, leading toward increased risk for addiction and decreased odds of recovery. Every time a person self-administers a drug, operant conditioning associates the action with its rewarding properties, leading to positive reinforcement. Operant conditioning also incorporates the environment, using stimuli in the environment to serve as indicators. These indicators or environmental cues allow the brain to recognize when the rewarding properties of the drug are available, producing a powerful urge to administer the drug, which can lead to compulsive behavior.

In classical conditioning, the environment also becomes associated with the effects of the drug. It teaches the brain to expect the drug in certain situations. The brain responds by producing effects to counteract the anticipated drug. The symptoms produced by classical conditioning are the same as those produced by withdrawal. The drug can counteract these effects and alleviate them, making the drug even more desirable, thereby strengthening compulsive drug-seeking.

Ironically, when a person alleviates these withdrawal-like symptoms caused by classical conditioning, further operant conditioning occurs. It teaches the brain that relief is available if the person responds to withdrawal symptoms with drug administration, which leads to negative reinforcement (removing the undesirable symptoms). The processes begin to build upon one another, leaving the brain with a complex entanglement of associations pushing the individual toward compulsive drug use. This complex cycle is very difficult to break and usually leaves the person trapped in addiction.



Bring it All Together

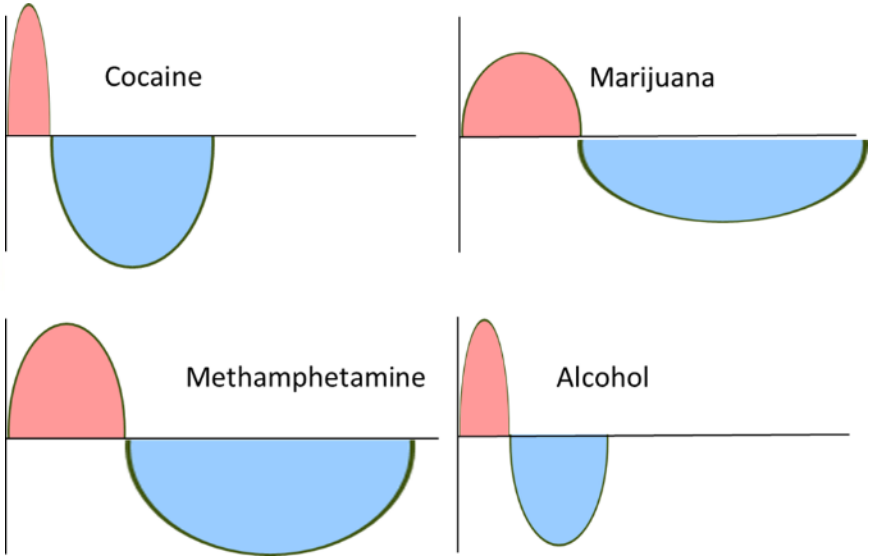
Early and intense use of substances alters neurobiological processes involved in reward and executive function. Such changes interfere with an individual's hierarchy of needs and impair the ability to effectively develop a broader, cohesive worldview.

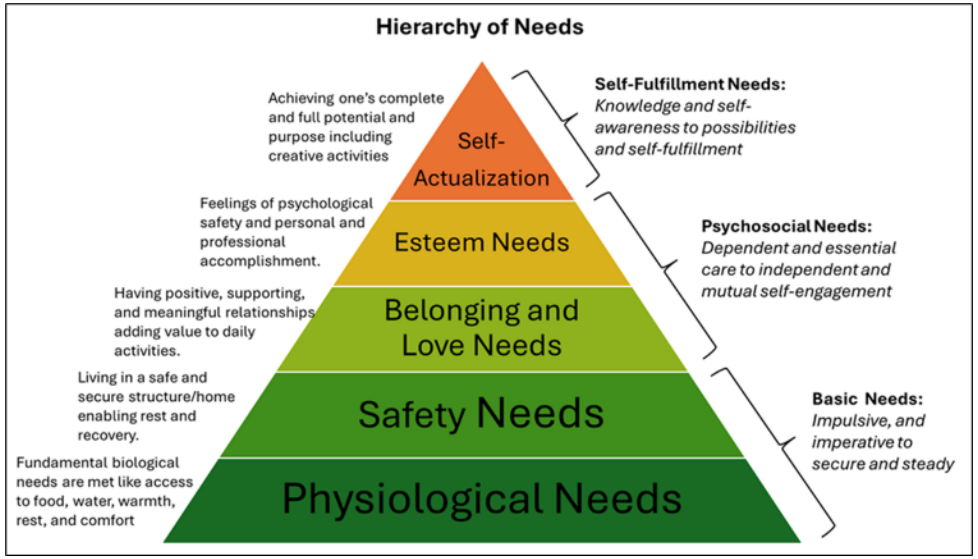
These neurobiological alterations make it harder to understand the already hidden processes involved in withdrawal, craving, and triggers; thereby, creating greater challenges in generating strategies for reducing use.

Reduced understanding of withdrawal, craving, and triggers results in individuals misunderstanding the complex interaction of drugs. Withdrawal is often understood as a new or distinct psychological state/condition like anxiety, depression, ADHD, etc.

The collective and cumulative result is using multiple drugs to moderate the adverse effects of the acute phase and to mitigate the rebound phase. Like using alcohol or marijuana along with cocaine because cocaine often produces anxiety. The learned pattern associated with polydrug use is, while quite complex, generally unconscious.

Changes in Reward and Cognitive Function Driven to Focus on Biological Immediacy

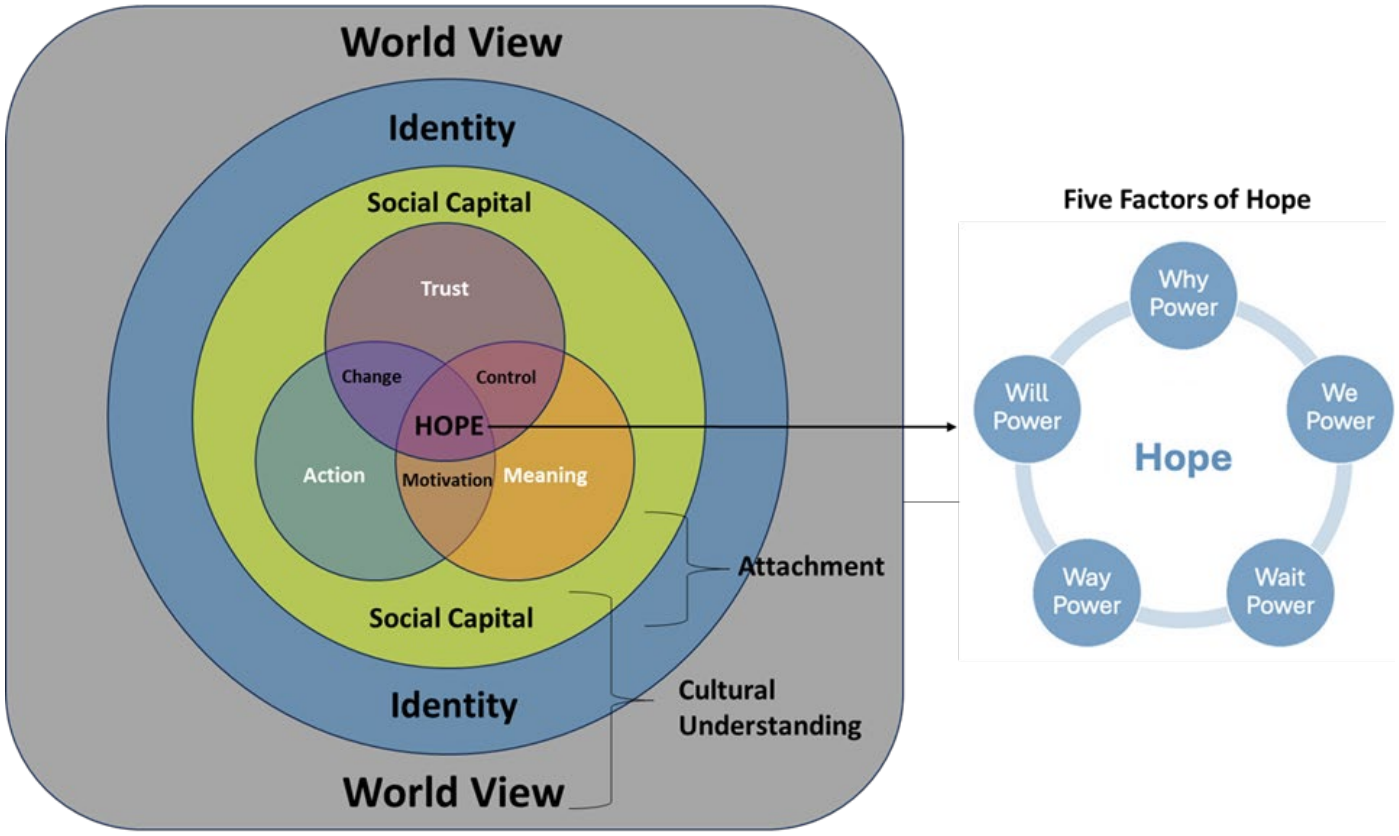




A significant part of treatment involves teaching the client/participant to understand these co-occurring processes and put systems in place to manage triggers. Those with substance use disorder often have a very difficult time managing these challenges on their own. Often, especially early on, they need help managing daily routines to overcome these learned, unconscious processes.

Hope and Social Connections are Vital Signs for Treatment

Are we addressing the correct fundamental, upstream effects?



How have the following impacted your five areas of hope (e.g., why, we, what, way, and will powers).

1. World View—how does your world view inform your definition of and experience around hope?
2. Identity—how does your identity contribute to your definition of and experience around hope?
3. Social Capital—how do your relationships contribute to your definition of and experience around hope?
4. Trust, Meaning, and Action—how do these components contribute to your definition of and experience of hope?
5. Hope—what is your definition of hope and how has it changed across your recovery experience?

Now apply these concepts to specific activities around hope. How is hope captured by the following, especially in your recovery journey.

1. Why Power—why are your working to reduce your addiction?
2. We Power—how are you collaborating with others to reduce your addiction?
3. Wait Power—how you are demonstrating patience and perseverance in your recovery journey?
4. Way Power—how are you putting effort into determining a path toward recovery success.
5. Will Power—how are you working to increase your resilience and resistance in your recovery journey?

Most Important Concepts in Learning and Conditioning in Substance Use Disorder

Concept	Detailed Explanation
Classical Conditioning	This learning process involves pairing a neutral stimulus with a stimulus that naturally evokes a response until the neutral stimulus alone can trigger the response. In substance use disorders (SUDs), environmental cues (such as places, people, or paraphernalia) become associated with substance use, triggering cravings and relapse.
Operant Conditioning	A method of learning that employs rewards and punishments for behavio Substance use often starts and continues because it is reinforced (rewarded) by its effects, such as pleasure or relief from pain, and abstinenc may be punished by withdrawal symptoms and negative emotions.
Positive Reinforcement	Involves increasing the likelihood of a behavior by following it with a rewarding stimulus. Drugs of abuse can act as powerful positive reinforcers by directly stimulating the brain's reward system, leading to repeated use.
Negative Reinforcement	The process of strengthening a behavior by removing or avoiding a negative outcome. In the context of addiction, using substances to alleviate withdrawal symptoms or emotional distress serves as negative reinforcement.
Cue Reactivity	Refers to the psychological and physiological responses to cues (environmental or contextual stimuli) associated with substance use. These cues can trigger intense cravings and relapse, even after long periods of abstinence.

Concept	Detailed Explanation
Cue Reactivity	Refers to the psychological and physiological responses to cues (environmental or contextual stimuli) associated with substance use. These cues can trigger intense cravings and relapse, even after long periods of abstinence.
Extinction and Relapse	Extinction occurs when the conditioned response (e.g., craving) diminishes over time as the conditioned stimulus (e.g., drug paraphernalia) is n longer paired with the unconditioned stimulus (drug effects). However, re lapse can occur due to spontaneous recovery, renewal (returning to the context where the drug was used), or reinstatement (drug effects experienced again).
Habit Formation	Over time, substance use can transition from a goal-directed behavior to a habitual one, largely operating outside conscious awareness and control. This shift is facilitated by changes in the brain regions involved in habitual behavior, making addiction more resistant to change.
Conditioned Compensatory Response	The body's way of preparing for the effects of a substance by eliciting opposite physiological responses to those the drug induces. This can lower the perceived effects of the drug over time, contributing to tolerance and increased consumption.
Social Learning Theory	Suggests that individuals can learn behaviors through observing others, without direct experience. In the context of SUDs, observing substance use by peers or family members can influence attitudes toward drugs and likelihood of initiation.
Sensitization	An increased response to a drug following repeated exposure, opposite to tolerance. Sensitization can contribute to the compulsive nature of drug

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Team Communication

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Disclaimer

Dr. Marshall used to work for the Department of Veterans Affairs. The views expressed in this presentation are solely those of the presenter and do not represent those of the Veterans Health Administration, the Department of Defense, or the United States government. Dr. Marshall has no other conflicts of interest to disclose.

Learning Objectives

Individuals attending this presentation will come away understanding:

1. How setting clear team policies, procedures, and behavioral expectations (i.e., goals) helps a treatment court function.
2. The basic communication skills that are desirable when working within a team setting.
3. How to examine their own personal reactions (i.e., motivation) and how they play a role in team dynamics.

Questions for Reflection and Discussion:

- Why are teams utilized in the workforce?
- Why is team communication important to the functioning of our treatment courts?
- Describe for me the important ways in which team communication takes place in your treatment courts?
- What can happen when we have communication failures?

Critical: Setting Team Expectations and Norms

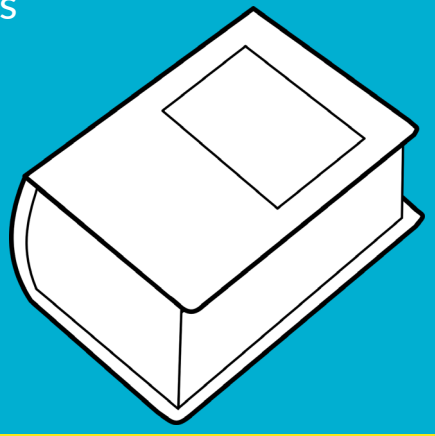
Example: The Worst Group Therapy Experience Ever

Also Known As: Chaos Around a Conference Table

It's Critical: Setting Team Expectations and Norms

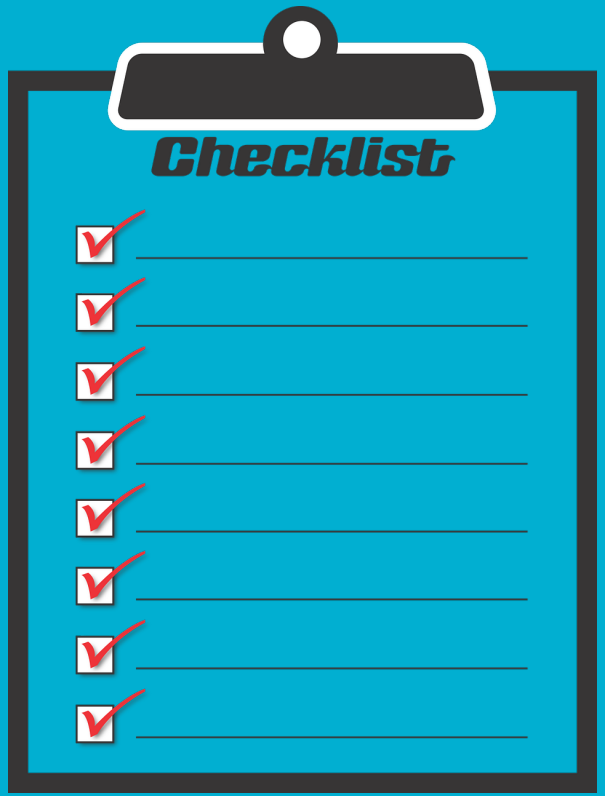
- Best practice is that we have a handbook for treatment court participants to set expectations for them. **But, do you have one for your team members?**
- Given the high levels of turnover, and differences in team culture from one court to another, it is imperative that new team members be brought up to speed quickly. **A handbook is the first step in that process.**
  - Set expectations immediately when a new team members starts
  - Keep expectations realistic
  - Set SMART goals
  - Set expectations to outcome metrics
  - Review employee performance regularly
  - Be open to collaborating on expectations

(Wooll, 2022)



A Handbook Might Include:

- Team culture and values
- Workplace conduct
- Attendance policies
- Dress codes
- Health and safety guidelines
- Performance evaluation processes
- Reporting procedures for grievances or concerns
- How the team views and handles remote work
- Common workplace procedures and instructions



Research on Team Communication: What We Know

- **Definition:** Information sharing verbally or nonverbally (e.g., email) between two or more team members.
- Team communication is necessary for effective team performance (Marks, Zaccaro, & Mathieu, 2000; Warkentin & Beranek, 1999).
  - Communication enhances team performance via facilitating and improving critical team processes such as **coordination** and **strategy formulation** (Marks, Mathieu, & Zaccaro, 2001).
  - Likely also directly relates to team performance because it **distributes critical, task-relevant information** to team members (Salas, Sims, & Burke, 2005).

Research on Team Communication: What We Know

- **Quality** of team communication was found to have a significantly stronger relationship with performance than frequency.
- Authors note, "...too much communication may impart unnecessary noise that mitigates, rather than enhances, performance."
  - Communication quality demonstrates a stronger relationship with performance because it enables team members to gather pertinent information necessary to task completion while minimizing confusion.

(Marlow, S. L., Lacerenza, C. N., Paoletti, J., Salas, E., & Burke, C. S., 2018).

Research on Team Communication: What We Know

- Across team types and functions, team communication ranks incredibly high in terms of determining team performance.
- As team member familiarity increases, team communication becomes even more important for team performance (especially in face-to-face workplaces).
- Information elaboration has the strongest relationship with performance.
  - Degree to which individuals thoroughly elaborate on information they share with team members.
- Followed by knowledge sharing.
  - Extent to which team members share their knowledge or expertise with other team members.

(Marlow, S. L., Lacerenza, C. N., Paoletti, J., Salas, E., & Burke, C. S., 2018).

Types of Communication

1. Leadership communication
2. Upward communication
3. Updates
4. Presentations
5. Meetings
6. Participant and Stakeholder communications
7. Informal interactions

(Cooks-Campbell, 2022)

Why Improve Workplace Communication?

1. Better engagement
2. Increased morale
3. Improved productivity
4. Reduced churn
5. Greater loyalty
6. Better collaboration
7. Fewer workplace conflicts
8. Greater motivation

(Cooks-Campbell, 2022)

Practices for Improving Communication Skills

1. Think it through

- Why are you communicating?
- Who is the receiver, audience, or participant?
- What is your goal or objective?
- What do you want the recipient to do as a result of the communication?
- What format will best accomplish your goal?

(Cooks-Campbell, 2022)

Practices for Improving Communication Skills

2. **Revise and practice**

- **Revise written communication repeatedly for simplicity and ease of understanding**
- **Practice communication, particularly if you feel like it will be tricky or uncomfortable**

(Cooks-Campbell, 2022)

Practices for Improving Communication Skills

3. Seek feedback

Ask a few trusted co-workers and your manager to rate your communication skills. Start by asking them to rate (i.e., on a scale of 1-10) your written and spoken communication separately. Then ask these 3 questions:

- What one thing should I start doing to communicate better with you?
- What one thing should I stop doing in my communications with you?
- What one area or skill should I work on to improve how I communicate in this organization?

(Cooks-Campbell, 2022)

Practices for Improving Communication Skills

4. **Up your conflict management game**

- Soft startup for conversations
  - Tone matters
- Use “I” statements instead of “You” statements
  - “I’m feeling frustrated with the progress on this project.”
  - “I’m concerned about this participants lack of progress in treatment.”
  - “I feel disrespected when team members are not prepared for staffing.”
- Describe what is happening, but avoid judgment
  - “Our implementation of incentives and sanctions is inconsistent.”
  - “Our graduation timelines are much longer than the national average.”
- Be polite and appreciative
- Don’t store things up

(Lisitsa, n.d.)

DEARMAN: A strategy to improve the odds

D - Describe

E - Express

A - Assert

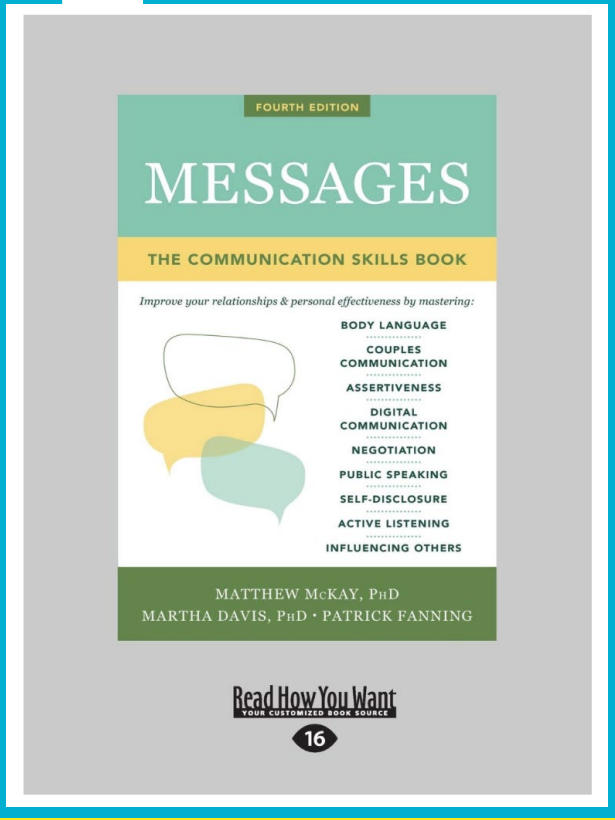
R - Reinforce

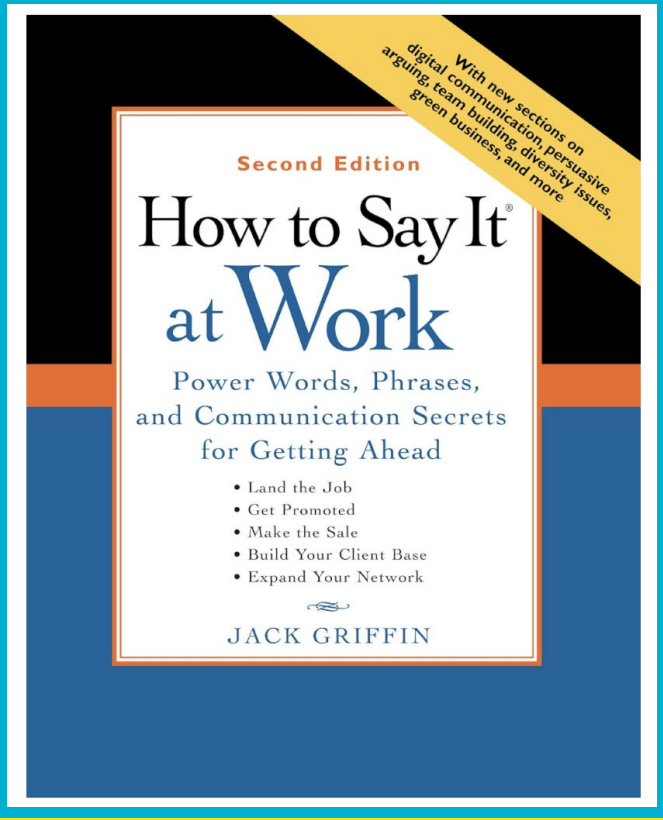
M - Mindful

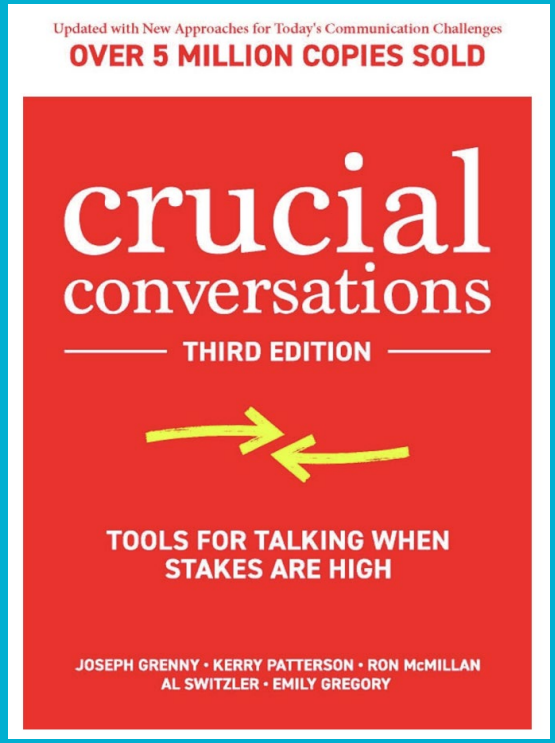
A - Appear Confident

N - Negotiate

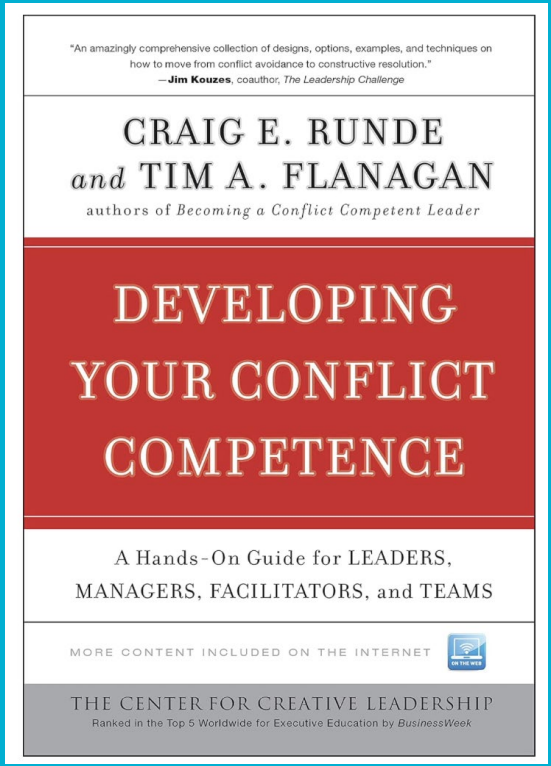
Resources for Better Communication SkillS

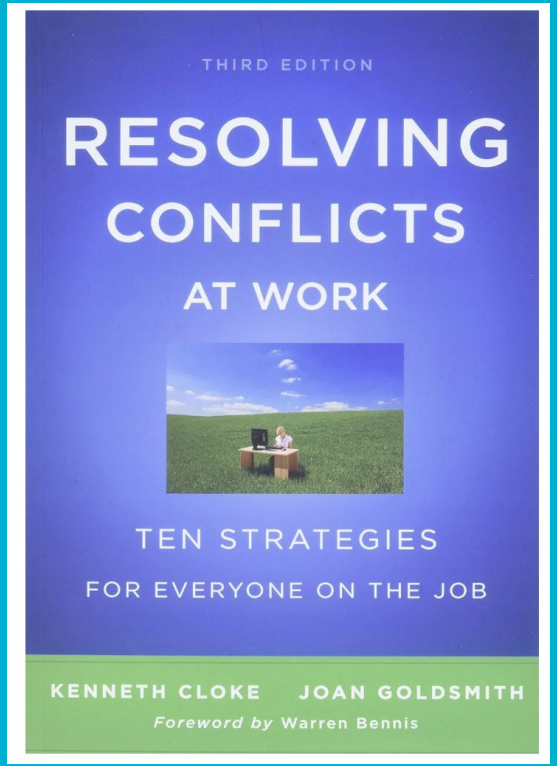






Resources for Better Conflict Management





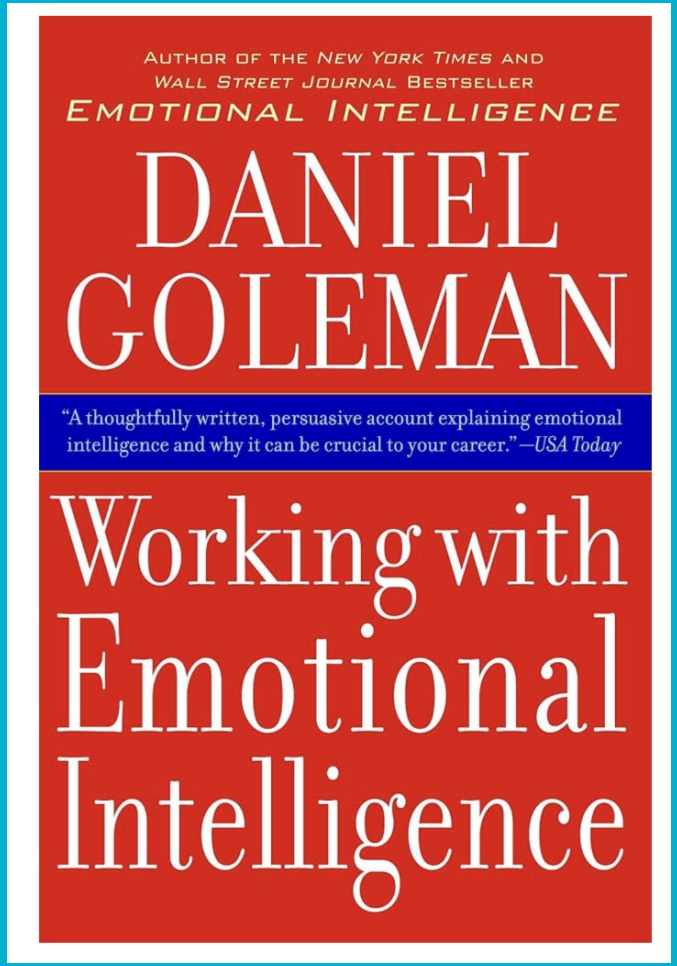
Time for some RADICAL HONESTY!

Questions for Reflection: Personal Characteristics and Team Dynamics

1. How was communication and conflict managed in my family, community, culture?
2. Do I have any strengths or limitations that make communication and conflict management easier or more difficult for me?
3. How well can I anticipate and predict possible causes for confusion and miscommunication, and how good am I at dealing with them upfront?
4. How often do recipients fully understand my messages, emails, or other documents? Do I give enough information and detail?
5. Do I ask questions when I don't understand something, or do I keep it to myself?

Questions for Reflection: Personal Characteristics and Team Dynamics

6. Do people often misunderstand my messages? Am I often surprised that they don't understand what I am saying?
7. Is it easy for me to understand someone else's point of view during a conversation?
8. Do I think about how my responses will be perceived by others, or do I speak without thinking?
9. Can I use communication platforms such as email to quickly and efficiently communicate complex issues?
10. Do I find it difficult to see and read people's body language?
11. Do I struggle to find the right words to convey my message?
12. Do certain types of communication styles or messages make it difficult for me to receive them?


AUTHOR OF THE NEW YORK TIMES AND
WALL STREET JOURNAL BESTSELLER
EMOTIONAL INTELLIGENCE
DANIEL
GOLEMAN
"A thoughtfully written, persuasive account explaining emotional intelligence and why it can be crucial to your career." —USA Today
Working with
Emotional
Intelligence

—You cannot control the people you interact with at work. All you can do is craft and deliver your message in a way that makes you proud of how you conducted yourself.


Questions?
Final Thoughts
Thank You!

Evaluation

https://cvent.me/ANROAR

1. On your compatible phone or tablet, open the built-in camera app.
2. Point the camera at the QR code.
3. Tap the banner that appears on your phone or tablet.
4. Follow the instructions on the screen to complete the evaluation.
5. After completion, you will be provided with a certificate that can be saved and printed.

Christa Marshall

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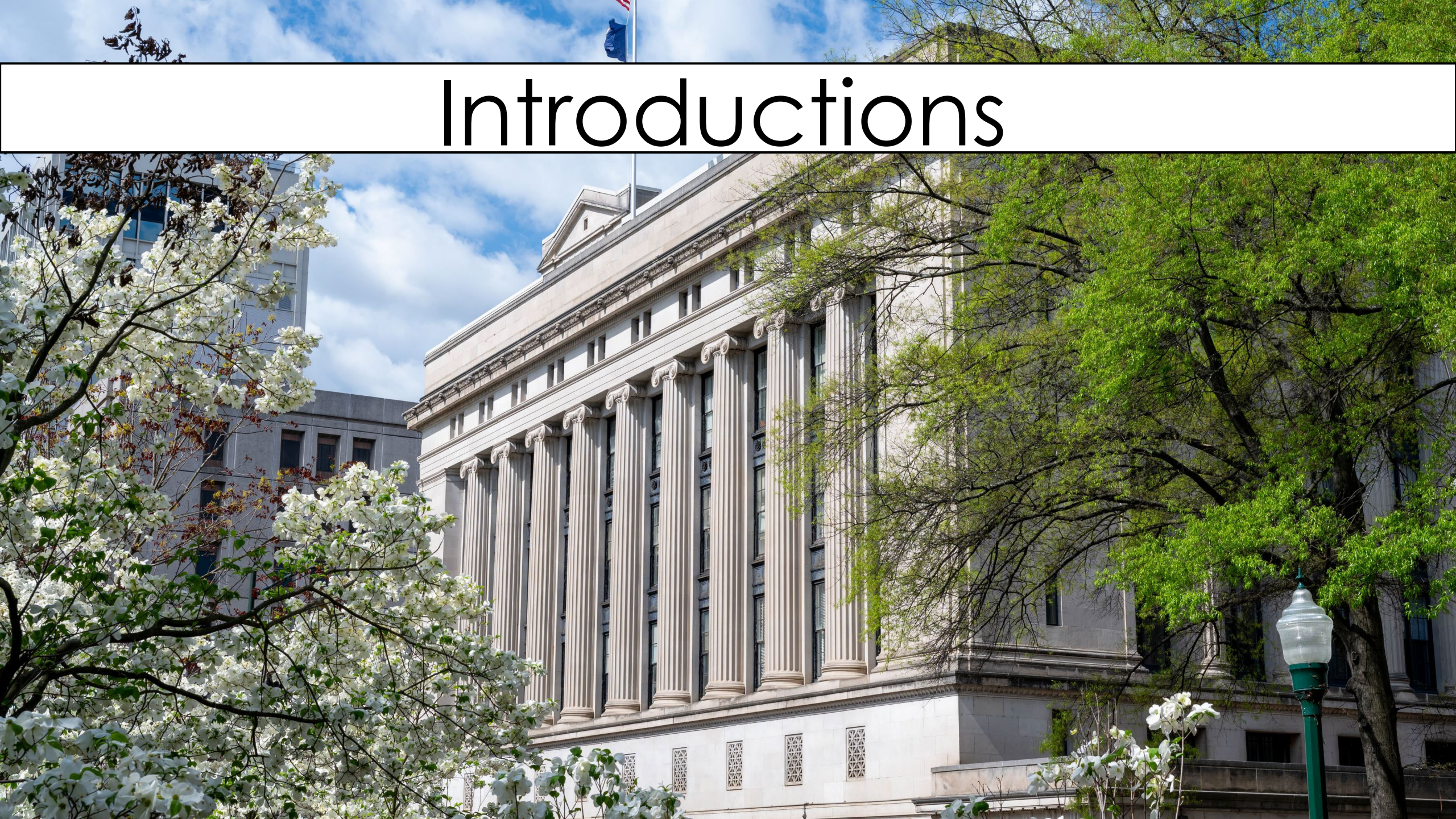
New Virginia Standards and Compliance Process

LIANE HANNA AND OLIVIA TERRANOVA

VIRGINIA SPECIALTY DOCKET COMPLIANCE ANALYSTS

Introductions



Compliance Across the Country

Virginia Recovery Court Standards

"There are and will continue to be differences among individual drug treatment court programs based upon the unique needs and operational environments of the local jurisdictions and the target populations to be served. However, there is also a need for overall uniformity as to basic program components and principles. Therefore, this document is an attempt to outline those fundamental standards and practices to which all adult recovery courts in the Commonwealth of Virginia should subscribe."

–Virginia Recovery Court Standards

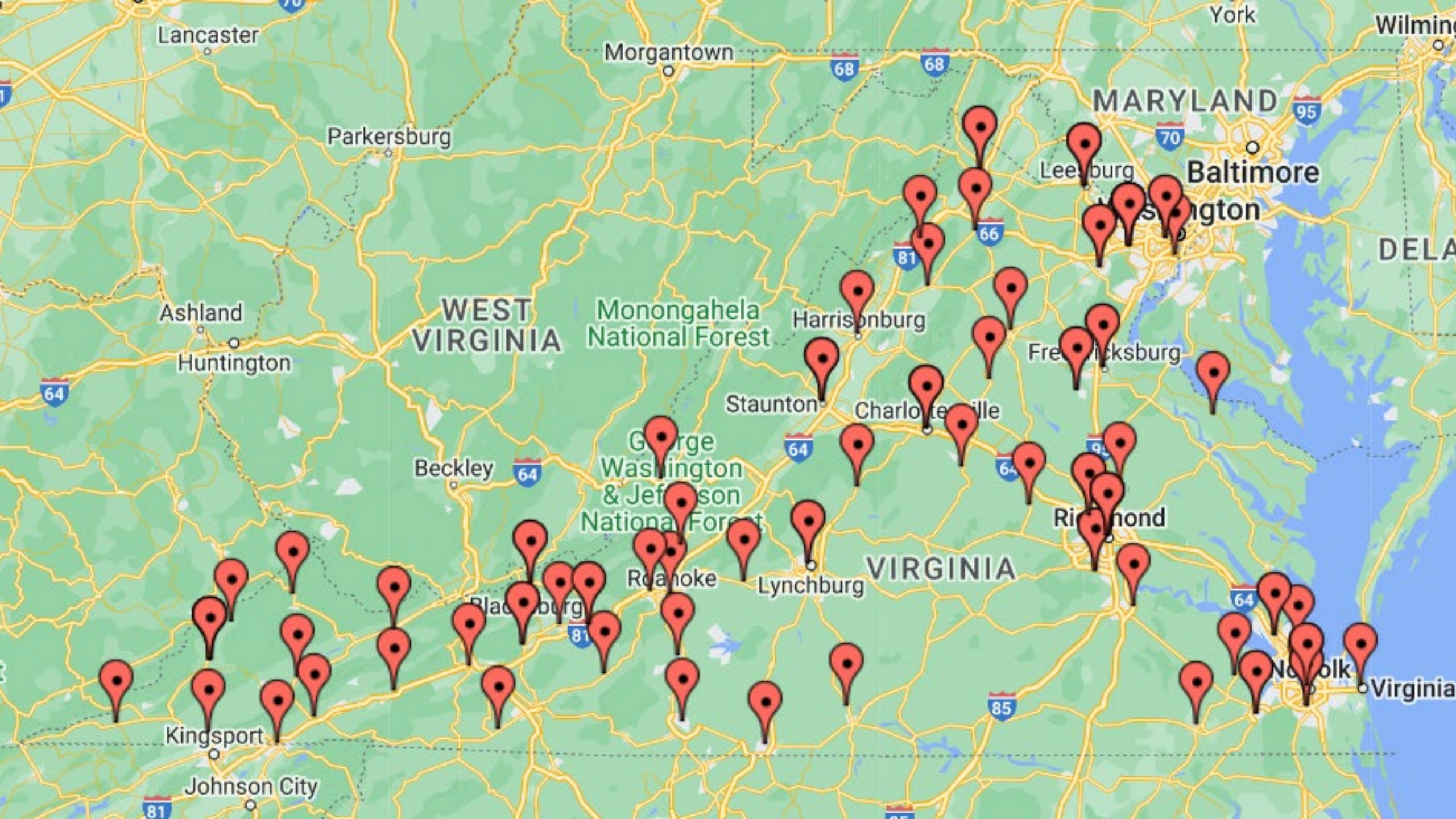
"The second edition of the standards applies to all adult treatment courts, and the term treatment court is used in most instances to reflect this expanded focus. However, terms pertaining to specific treatment court models (e.g., drug court, mental health court) are used when describing findings from studies that focused only on those models."

– **All Rise Best Practice Standards, 2nd Edition**

Virginia Behavioral Health and Veterans Treatment Docket Standards

Highlights of what's different

- Adult Drug Treatment Court Dockets → Recovery Courts
- 28 VA Recovery Courts → 61 VA Recovery Courts
- Substance Abuse Treatment → Substance Use Disorder Treatment
- Goals & Service adjustments
  - Changes to a participant's treatment or supervision


Lancaster
Morgantown
Parkersburg
MARYLAND
Baltimore
Leesburg
Ashland
Huntington
WEST VIRGINIA
Monongahela National Forest
Harrisonburg
Staunton
Charlottesville
Fredericksburg
Beckley
George Washington & Jefferson National Forest
Roanoke
Lynchburg
VIRGINIA
Richmond
Blacksburg
Kingsport
Johnson City
Virginia
York
68
70
95
66
81
64
85

Highlights of what's different

- Adult Drug Treatment Court Dockets → Recovery Courts
- 28 VA Recovery Courts → 61 VA Recovery Courts
- Substance Abuse Treatment → Substance Use Disorder Treatment
- Goals & Service adjustments
  - Changes to a participant's treatment or supervision

Highlights of what's different

GUIDANCE FOR TREATMENT PROVIDERS

GUIDANCE FOR JUDGES

- Minimum of 3 minutes with each participant

Highlights of what's different

- PRE-COURT STAFF MEETINGS
  - All Team members
- JAIL AS A SANCTION
- COST OF TREATMENT: FINES & FEES

Highlights of what's different

- DRUG TESTING
  - 2/WEEK
- MEDICATION FOR ADDICTION TREATMENT AND OTHER PRESCRIBED MEDICATIONS

Introduction to the Virginia Specialty Dockets Compliance Process

THIS IS JUST AN OVERVIEW

WHEN CAN YOU EXPECT TO SEE US?

HOW OFTEN WILL YOU SEE US?

The Process

Specialty Dockets Compliance Process → Compliance Visit Questionnaire → Docket Staffing Observation → Courtroom Observation

Courtroom Observation → Participant Interview Questions → Compliance Summary Report → Recommendations and Action Plan

Self-Assessment

Recovery Court Self-Assessment

This self-assessment has been created using the All Rise (formerly National Association of Drug Court Professionals) Best Practice Standards and Virginia's Recovery Court Standards.

Treatment Court Background

Name/Locality of Recovery Court: Implementation Year:
Current Active Caseload and Current Capacity:
Number of Graduates (Successful completions):
Number of Non-Graduates (Unsuccessful completions):
Most commonly used substance(s) among participants is/are:
Population served (High/low risk, High/low need, separate tracks for risk/need levels):

The tables below provide a list of the Virginia Recovery Court standards. The results of the self-assessment are meant to serve as a starting point for discussion about how you are implementing best practices in your program including what you are doing well and what you would like to improve. As a team, review each standard and determine whether it is a practice that your docket is currently performing.

- Marking the box "⊟" indicates that the treatment court reports performing the practice.
- Leaving the box blank "□" indicates that the treatment court reports not performing the practice.

At the completion of the assessment there will be a place to indicate how many practices your recovery court are implementing that will determine if that standard is:

i. Meeting most practices,
ii. In progress, room for improvement,
iii. Priority area for discussion.

Questions

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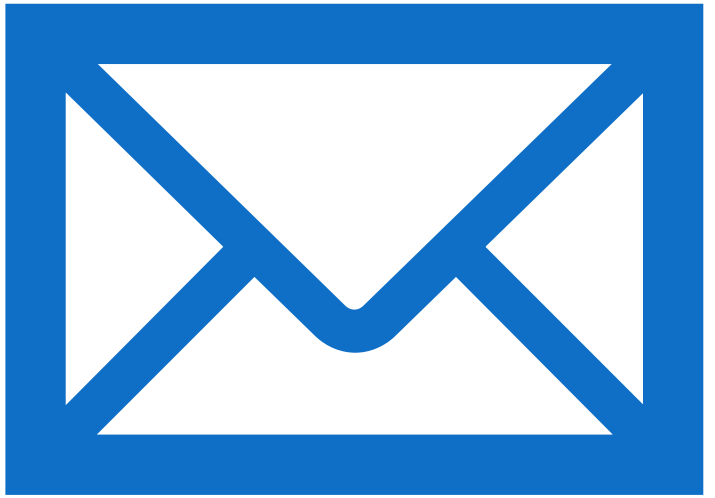

Crisis Management

Christa M. Marshall, Psy.D.
Licensed Clinical Psychologist
Marshall Psychological Services, PLLC
Roberts Wesleyan University, PLLC

Disclosure

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Disclaimer

Dr. Marshall used to work for the Department of Veterans Affairs. The views expressed in this presentation are solely those of the presenter and do not represent those of the Veterans Health Administration, the Department of Defense, or the United States government. Dr. Marshall has no other conflicts of interest to disclose.

Learning Objectives

In this presentation, participants will gain an understanding of:

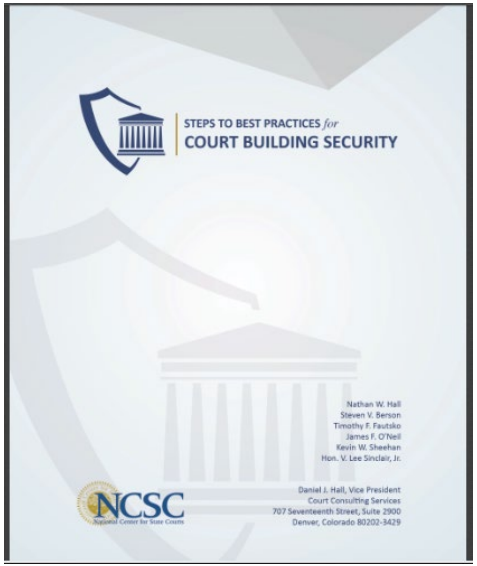
1. Evidence-based practices for managing treatment court participant crises.
2. How to adapt procedures when a crisis is occurring with a staff member.
3. How to help the team and wider community recover from a crisis.

Dealing with a Participant Crisis

The best defense is a good offense…

Address Systemic Safety Concerns

- Trauma-related symptoms may be the result of feeling unsafe with offenders.
- Address practical concerns with practical solutions wherever possible.
- Review best practices for courtroom safety
  - https://cdm16501.contentdm.oclc.org/digital/collection/facilities/id/170
- If your court does not have an emergency management plan, create one.



Warning Signs of Suicide

- Talking about suicide
  - “I’m going to kill myself.”
  - “I wish I were dead.”
  - “I wish that I hadn’t been born.”
- Obtaining the means- buying a gun, getting pills
- Withdrawing from social contact
- Have severe mood swings
- Preoccupation with death, dying, or violence
- Feeling trapped or hopeless
- Increase use of drugs or alcohol
- Doing reckless things- using drugs, self- destructive behaviors, driving recklessly
- Giving away personal belongings or getting affairs in order
- Saying goodbye to people as if they won’t be seen again
- Developing personality changes or being severely anxious or agitated.

(Mayo Clinic Staff, 2018)

Conversations about Suicide and Suicide Rates

- It is a myth that talking about suicide causes a person to have increased suicidal ideations.
- There is no statistically significant data that suggests talking about suicide leads to suicidal ideation.
- Talking about suicide and acknowledging suicidal thoughts may help to:
  - Reduce the stigma
  - Reduce suicidal ideation.
  - Improve mental health in treatment seeking population

(de Beurs et al., 2015; Gould et al., 2005)

How to Talk about Suicide

- Remember, suicidal ideation is not a permanent situation, it is a sign that an individual is suffering and needs treatment.
    - Don’t feel hopeless, but don’t burden yourself with providing treatment. Find a professional that can help.
- Be sensitive, but direct.
- If you fear that a person is in immediate danger
    - Do not leave them alone
    - Call 911

(Mayo Clinic Staff, 2018)

How to Talk about Suicide

Ask questions

- How are you coming with what's been happening in your life?
- Do you ever feel like just giving up?
- Are you thinking about dying?
- Are you thinking about hurting yourself?
- Are you thinking about suicide?
- Have you ever thought about suicide before, or tried to harm yourself before?
- Have you thought about how or when you'd do it?
- Do you have access to weapons or things that can be used as weapons to harm yourself?
- What's causing you to feel so bad?
- What would make you feel better?

(Mayo Clinic Staff, 2018)

How to Talk about Suicide

Offer Support

- National Suicide Prevention Lifeline 1-800-273-8255
- Encourage them to seek treatment from a professional
- Offer to help them find help. Directly ask how you can help them.
- Encourage them to continue to talk to you
- Be respectful, not patronizing or judgemental
- If possible, remove potentially dangerous items from a person's home.

(Mayo Clinic Staff, 2018)

How to Talk about Suicide

Do Not

- Promise to keep someone's suicidal thoughts a secret.
- Dismiss a person's feelings.
- Try to talk them out of their feelings.
- Act shocked.

Don't be patronizing or judgemental

- "Things could be worse."
- "You have everything to live for."

(Mayo Clinic Staff, 2018)

Dealing with an Employee Crisis

How you might know an employee has a crisis:

- changes in people's behaviour or mood or how they interact with colleagues
- changes in their work output, motivation levels and focus
- struggling to make decisions, get organised and find solutions to problems
- appearing tired, anxious or withdrawn and losing interest in activities and tasks they previously enjoyed
- changes in eating habits, appetite and increased smoking and drinking.

(Mind.org)

What To Do When an Employee Discloses a Crisis

- Experts say:
  - Make yourself “tell-able”
  - Thank them for telling you.
  - Listen
  - Tell them you want to support them, but don’t promise unrealistic things.
  - Don’t make it about you.
  - **Maintain confidentiality.**
  - Ask for help from others/Refer them to other resources.
  - Check with your HR or Legal department about requirements.

- Advice for implementing this into practice
  - Be a role model so people feel comfortable reaching out.
  - Be flexible when you can.

(Gallo, A., 2021)

What To Do When an Employee Discloses a Crisis

Changes to how people perform their role:

- Flexible hours or change to start/finish time. For shift workers not working nights or splitting up their days off to break up the working week can also help
- Change of workspace – e.g. quieter, more/ less busy, dividing screens
- Working from home (although it's important to have regular phone catch ups so people remain connected and don't feel isolated)
- Changes to break times
- Provision of quiet rooms
- Return-to-work policies e.g. phased return – reduced hours gradually building up
- Relaxing absence rules and limits for those with disability-related sickness absence
- Agreement to give an employee leave at short notice and time off for appointments related to their mental health, such as therapy and counselling.
- Reallocation of some tasks or changes to people's job description and duties (temporary or permanent).

(Mind.org)

What To Do When an Employee Discloses a Crisis

Extra support:

- Increased supervision or support from manager. For example, some people can take on too much so may need their manager to monitor their workload to prevent this and ensure they're working sensible hours
- Extra training, coaching or mentoring
- Extra help with managing and negotiating workload
- More positive and constructive feedback
- Debriefing sessions after difficult situations
- Mentor or 'buddy' systems (formal or informal)

(Mind.org)

What To Do When an Employee Discloses a Crisis

Extra support:

- Mental health support group or disability network group
- Self-referral to internal support available
- Identifying a ‘safe space’ in the workplace where the person can have some time out, contact their buddy or other sources of support and access self-help
- Provision of self-help information and sharing approaches and adjustments that have proven effective at supporting others
- Encourage people to work on building up their resilience and doing things that support good mental health such as exercise, meditation or eating healthily
- Encourage people to be more aware of their mental state and reflect on what factors affect it in the workplace

(Mind.org)

How to manage an employee’s time off for a crisis:

- be proactive and get involved as early as possible if someone is unwell
- take a person centred approach and be sensitive to the individual’s needs
- be positive, professional and supportive throughout the process
- maintain contact with people throughout their sickness absence.

(Mind.org)

How to manage an employee's time off for a crisis:

- Send a 'get well soon' card as you would with a physical health problem
- Be clear the organization will support people during their absence and reassure them their job will be there when they return
- Maintain regular open and meaningful communication with people – agree together the frequency of contact early on and confirm this in writing
- Take your lead from how people choose to communicate – whether by phone, email, text or face-to-face – and keep checking that the current arrangement is still working for people
- Have an open-door policy so the person can approach you with any concerns
- Ask how people are doing and focus conversations on their well-being

(Mind.org)

How to manage an employee’s time off for a crisis:

- Make it clear people should not rush back to work or push themselves too much
- Staying in touch with friends can support people’s smooth return so encourage work colleagues to keep in touch (if the employee agrees to this)
- Keep people in the loop about important developments at work so they still feel connected
- Regularly communicate with HR/ Occupational Health, act on their recommendations and keep people informed

(Mind.org)

How to manage an employee's time off for a crisis:

- Agree what information they would like shared with colleagues – close colleagues will want to know how they are getting on
- Communicate clearly with the team and ensure they understand the situation. If they have to pick up extra work it's vital this is managed well. There may be uncertainty about if or when their colleague may return. If colleagues feel the person is receiving unfair special treatment this needs to be constructively challenged
- If there are grievances or other concerns raised, work to resolve these as quickly as possible and keep people informed of progress.

(Mind.org)

How to support an employee's return to work:

- Tell people they were missed
- Explain the return-to-work process/ procedures
- Reassure people they are not expected to walk straight back into full time hours or to manage a full-time workload
- Ask the employee how they're feeling
- Use open questions that require more than just a 'yes' or 'no' answer and give people lots of space and time to talk
- Listen and try to empathise with the employee
- Ask if there are any problems at work that might be causing them stress

(Mind.org)

How to support an employee's return to work:

- Ask if there are difficulties outside work that might be contributing to their absence
- Discuss the person's mental health problem and the possible impact on their work
- Discuss possible solutions and ensure you are aware of sources of available support
- Discuss any worries the person has about returning to work, reassure them that this is normal and agree a strategy to address these concerns together
- Try to prepare people for how they may feel on their return and also to think about how they want to manage their return e.g. what they want to say to colleagues
- Understand that despite looking fine, someone may still be unwell.

(Mind.org)

How to support an employee's return to work:

- Meet the individual on their first day back
- Have a plan for the person's first day to ensure they feel included and welcomed (e.g. in lunch plans)
- Explore potential return-to-work adaptations with an open mind
- Explain any recent changes that affect the individual's role, responsibilities and work practices
- Incorporate a phased return to work for the individual, if appropriate
- Make the individual's first few weeks back at work as low-stress as possible
- Involve a 'buddy' – someone they are friends with – to help people reintegrate into the workplace

(Mind.org)

How to support an employee's return to work:

- Promote a positive team spirit and encourage colleagues to make sure the person feels welcome and their return is comfortable
- Colleagues are often unsure if it's ok to ask how people are. Check with the employee who is returning to see how they would like this handled, then communicate this to your team.
- Keep in regular contact with the returning employee and regularly ask how they are
- Ensure there are regular ongoing opportunities to monitor and review what's going well and what's not going well, to make sure the support / adjustments are helping and to tweak these if they aren't quite right.

(Mind.org)

Team Recovery from Crisis

Remember, the best defense is a good offense…

A Mourning Ritual

- Create a time and space for grief
- Collect a one-hour candle and any reminders you may have (pictures, music, etc.)
- Find a quiet place
- Spend one hour thinking of the person you have lost, using the candle as a timer
- You may want to write about them or to them; burn it at the end
- When the candle goes out, mourning time is over

This can be done individually or as a group

Group Acknowledgement

- Avoiding the fact of the death will make it more painful
- Therefore, the team must engage in some discussion about the loss and how it is affecting them
- Each person is given an opportunity to say something
- This is not group therapy
- Rather, it is group mourning, like we do at a person's home when someone dies
- Food is helpful
- It is time-limited

Radical Acceptance

Radical Acceptance is the willingness to experience ourselves and our life as it is. A moment of Radical Acceptance is a moment of genuine freedom.

- Tara Brach, from Radical Acceptance

- The refusal to accept emotional pain is the basis of suffering
- Accepting reality as it is, not as we want it to be
- Neither fighting reality nor avoiding it
- Letting go of the desire to have things as we want them to be transforms suffering into ordinary pain, which is part of life
- Radical acceptance is an active choice that requires an inner commitment

Questions?

Final Thoughts

Thank You!

Christa Marshall

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Evaluation

https://cvent.me/ANRm71

1. On your compatible phone or tablet, open the built-in camera app.
2. Point the camera at the QR code.
3. Tap the banner that appears on your phone or tablet.
4. Follow the instructions on the screen to complete the evaluation.
5. After completion, you will be provided with a certificate that can be saved and printed.

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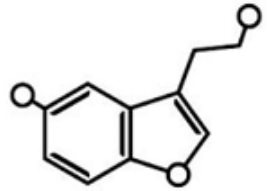
averhealth

- Testing Technology
- Specimen Options
- Results Interpretation
- The Deception of Dilution
- Adulterants

Effective substance use monitoring requires **random, scientifically valid, forensically defensible,** and **timely objective** information, a combination that enables therapeutic intervention and helps Patients to develop coping and refusal skills to new use.

Forensically Defensible
Test results meet Daubert and Frye scientific rules of evidence and supported by case law.



Scientifically Valid
Use proven technology accepted by the scientific community and evaluated by peer-reviewed journals.

Sustained Sobriety
Providing accurate test results that facilitates timely treatment intervention and support recovery.

Timely Objective
Positive or negative results within 48 hours of sample collection enabling timely intervention.

Random
Equal probability to test each day, including weekends and holidays. Not related to treatment, supervision, or court schedules. Notification period is best when limited to 2 to 12 hours.

- Since 1995, Averhealth has helped to reclaim lives, unite families, and strengthen communities by helping people to overcome substance use.
- We do this by integrating technology, people, and science to create and provide the smartest, most innovative solutions for substance use monitoring.
- Today, Averhealth cares for over 550,000 clients nationwide serving more than 2,700 treatment courts and social service programs

Technology: Aversys

- Daily client notification and engagement. Clients check in daily via web, phone or text
- Random selection
- Aversys allows instant access to client information like testing compliance and analytics to help staffing sessions run smoothly

People: Facing Forward

- Work side-by-side with local care team
- Training, Support and Testimony
- Observed Collection Specialization Averhealth staff collect more than one million same gender observed collections annually
- Prosocial client environment

Science: Super Laboratory

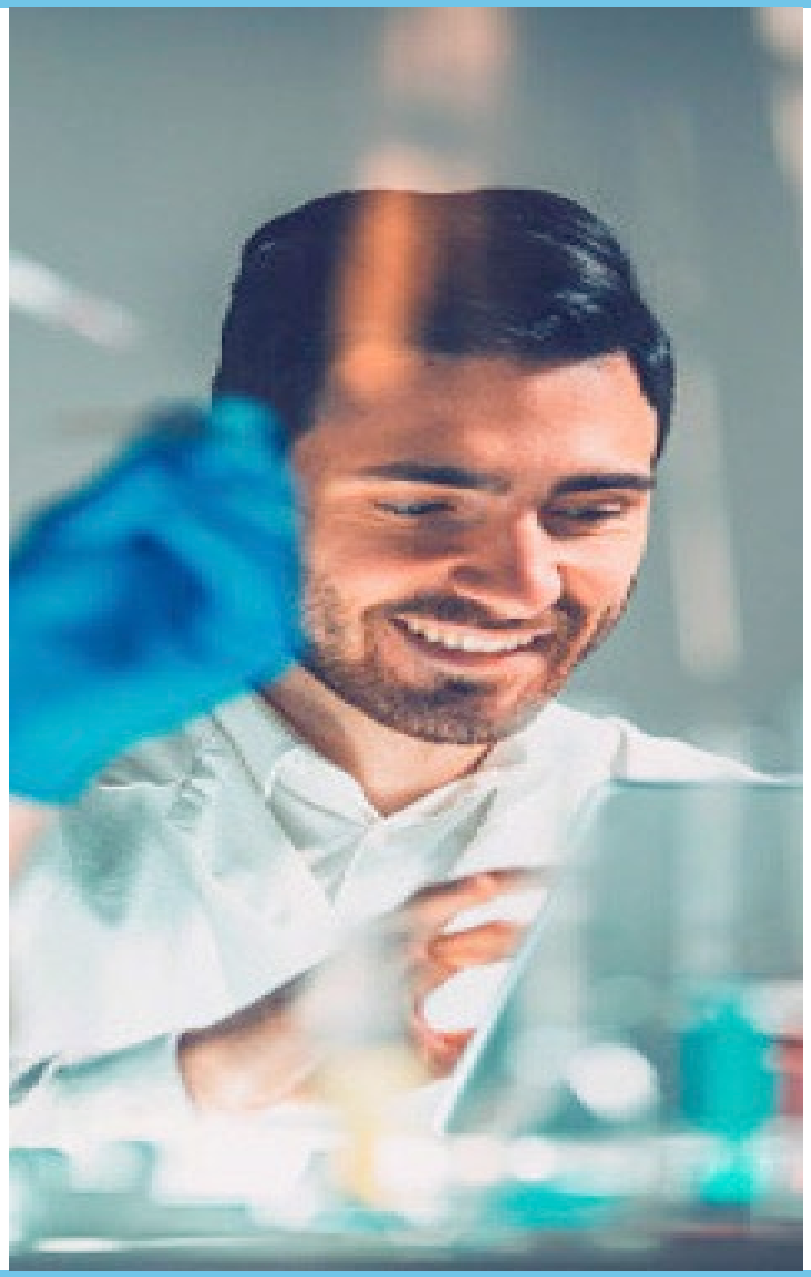
- Nationally Certified with CLIA, CAP-FDT, and DEA Certifications
- Broad Testing Menu. Averhealth tests for more than 1,500 substances including substances designed to avoid detection
- Next Business Day Results

- Averhealth is accredited by CLIA, the College of American Pathologists (CAP-FDT), and the State of New York
- We are subject to comprehensive reviews and certifications by CLIA and the College of American Pathologists (“CAP”) for the CAP Forensic Drug Testing (“CAP-FDT”) certification
- Averhealth is one of only 30 U.S. labs that have achieved CAP-FDT certification

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

CLIA
Clinical Laboratory Improvements Amendments

Testing Technology

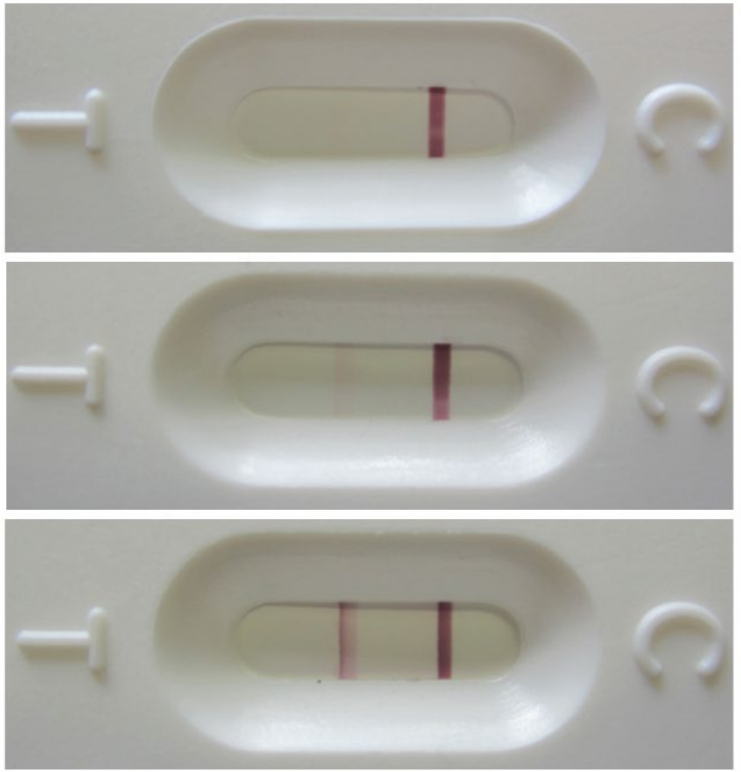


A selection of the optimal testing technology for a given situation must consider:

- **Sensitivity:**
  - Can the test correctly detect the presence of a drug in the specimen?
  - Greater sensitivity increases window of detection and can detect a lower dose.
  - How accurate is your positivity rate?
- **Specificity:**
  - Does the test mistake other substances for the targeted drug (cross reactivity)?
  - How accurate is your negative rate?
- **Substance**: alcohol (Ethanol or EtG), THC, synthetic THC, opiates, cocaine, etc.
- **Specimen Type:** urine, oral fluid, hair, breath, blood, sweat, finger nails, etc.
- **Time:** NADCP Best Practices and Standards maintain that test results should be available within 48 hours of samples collection.
- **Cost**: ranges from about $1 to over $2,000

- Used with just urine or oral fluid
- Qualitative only (positive or negative)

- Threshold 50 to 1000 ng/ml
- Detects classes of drugs, a ‘wide net approach’



Pros

- Results in minutes
- Low Cost
- Just about anyone can administer

Cons

- Variable and Subjective results
  - Variably reactive with drugs within a class
  - Vulnerable to cross reactivity with unrelated substances
- Incapable of distinguishing among specific drugs within a class
- Cannot differentiate new use from residual elimination
- Limited case law
- No proficiency testing
- Fixed test panel
- Yuck factor – urine dip anyone?

- Detects classes of drugs, a ‘wide net approach’
- Used with most specimen types
- Usually qualitative (positive or negative)
- Threshold: 2 to 1000 ng/ml

Pros

- Can establish a custom panel for each client
- Ability to rotate the tests on the panel to cover more drugs
- Established case law
- Distinguish between new and residual elimination

Cons

- Results based on reaction to an antibody
- Drug present below the threshold will be deemed negative
- Cross-reactivity noise (i.e., false positives or unconfirmed positives)
- Many drugs lack antibodies, so no screen is possible

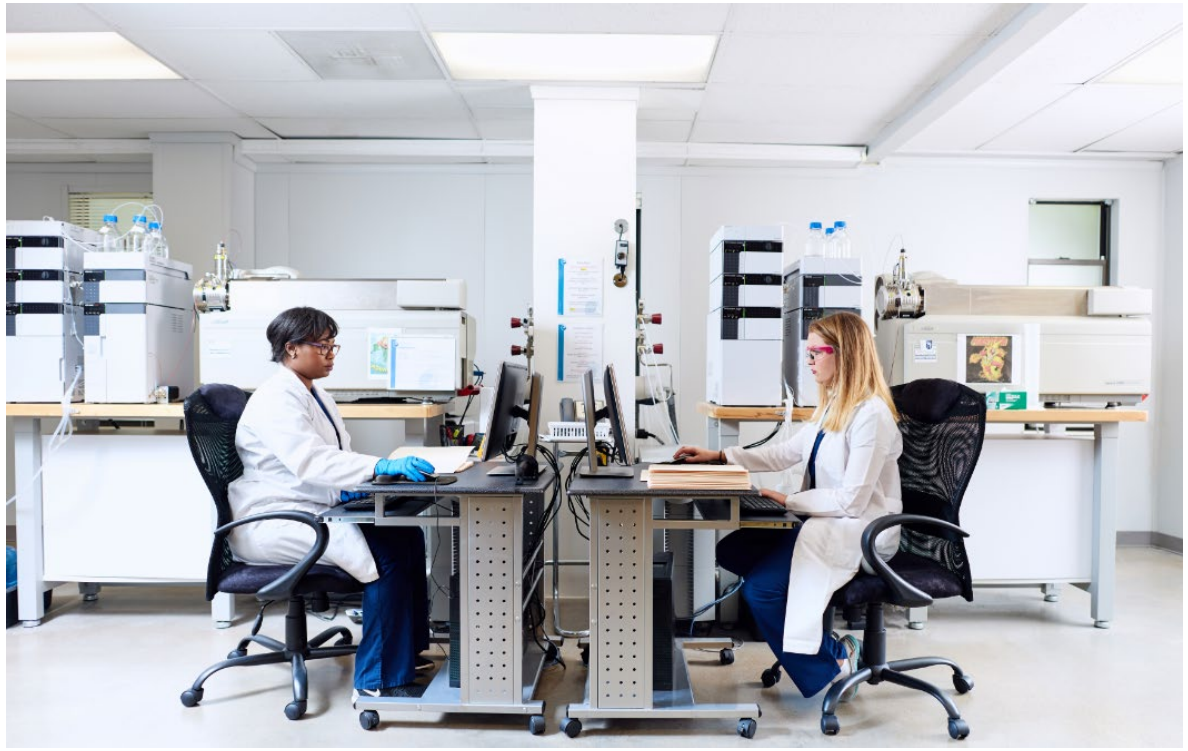
			% of Cutoff			
			75%	100%	125%	
AMP (ng/ml)	0	500	750	1000	1250	1500
(+/-)	0/135	0/135	34/101	75/60	110/25	135/0
BAR (ng/ml)	0	150	225	300	375	450
(+/-)	0/135	0/135	34/101	74/61	102/33	135/0
BUP (ng/ml)	0	5	7.5	10	12.5	15
(+/-)	0/135	0/135	33/102	73/61	101/34	135/0
BZO (ng/ml)	0	150	225	300	375	450
(+/-)	0/135	0/135	29/106	75/60	107/28	135/0
COC 150(ng/ml)	0	75	112.5	150	187.5	225
(+/-)	0/135	0/135	33/102	75/60	105/30	135/0
COC300 (ng/ml)	0	150	225	300	375	450
(+/-)	0/135	0/135	30/105	65/70	96/36	135/0
MDMA (ng/ml)	0	250	375	500	625	750
(+/-)	0/135	0/135	35/100	75/60	95/40	135/0
MET500 (ng/ml)	0	250	375	500	625	750
(+/-)	0/135	0/135	32/103	77/58	99/36	135/0
MET1000 (ng/ml)	0	500	750	1000	1250	1500
(+/-)	0/135	0/135	31/104	77/58	98/37	135/0
MTD (ng/ml)	0	150	225	300	375	450
(+/-)	0/135	0/135	31/104	69/66	95/40	135/0
OPI300 (ng/ml)	0	150	225	300	375	450
(+/-)	0/135	0/135	33/102	70/65	95/40	135/0
OPI2000 (ng/ml)	0	1000	1500	2000	2500	3000
(+/-)	0/135	0/135	37/98	76/59	104/31	135/0
OXY (ng/ml)	0	50	75	100	125	150
(+/-)	0/135	0/135	50/85	86/49	111/24	135/0
PCP (ng/ml)	0	12.5	18.75	25	31.25	37.5
(+/-)	0/135	0/135	26/109	62/73	99/36	135/0
PPX (ng/ml)	0	150	225	300	375	450
(+/-)	0/135	0/135	34/101	77/58	103/32	135/0
TCA (ng/ml)	0	500	750	1000	1250	1500
(+/-)	0/135	0/135	24/111	60/75	99/36	135/0
THC (ng/ml)	0	25	37.5	50	62.5	75
(+/-)	0/135	0/135	27/108	58/77	91/44	135/0

Source: US Diagnostics Pro Screen Drugs of Abuse Cup package insert

- **For common drugs of abuse, instant tests are wrong on about 1 of 4 samples when the substance is within the +/-25% of the Cutoff Level**
- Data based on synthetic samples precisely spiked with a known concentration of substance
- The introduction of cross reactivity noise leads to a higher error rate

Feature	Laboratory	Instant
Urine	✓	✓
Established Case Law	✓	
Definitive Test Results	✓	
New vs. Residual Analysis	✓	
Expansive Test Menu	✓	
Test Panel Flexibility	✓	
Oral Fluid	✓	✓
Hair	✓	
Blood	✓	
Proficiency Testing	✓	
Regulated	✓	

- Detects individual drugs, a ‘targeted approach’
- GC/MS (better) or LC/MS/MS (best)
- Result based on molecular fingerprint of substance
- Quantitative results
- Threshold: <1 to 100 ng/mL



Pros

- Sensitive: detects very small amounts of drug in a sample (<1-10 ng/mL).
- Specific: distinguishes individual drugs and related metabolites.
- State-of-the-art, viewed as “gold standard” for forensic laboratories.
- Objective, quantitative result.
- Can detect virtually any drug (not limited to an antibody) because test results are compared to databases: NIST, reference books, in-house libraries

Cons

- Time: takes longer. Must complete sample preparation before beginning analysis.
- Costs: cost more. Sample prep, consumables, and equipment all cost more than an immunoassay screen.

The required standard is determined by the use of the test result and potential sanction, fine, or punishment.

Laboratory Screen

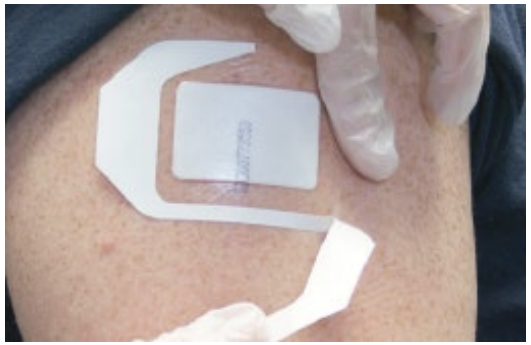
- Increased treatment, essay, juror box, or some other graduated sanction.
- A Patient that self-admits is on the right track to recovery, no confirmation is necessary.
- If a Patient adamantly denies use, then order a confirmation.

Confirmation (LC-MS/MS or GC/MS)

- Jail, prison, loss of driving privileges, or any other loss of liberty.
- Adjudication requires a high degree of certainty and precision.
- Why not use chromatography for every test? (Time & Costs)

Specimen Options

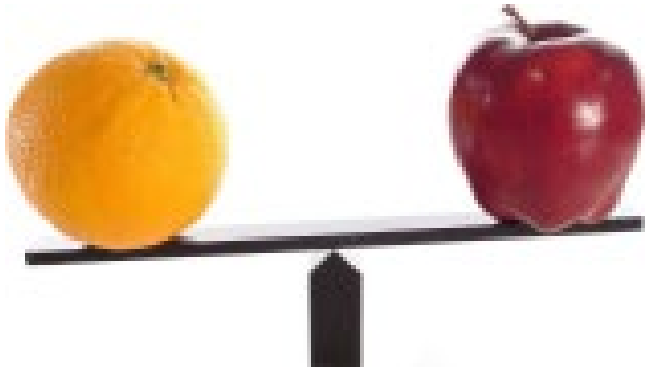
What difference does a biological specimen make to drug test results?



- **Dose** amount substance consumed.
- **Absorption** into the blood stream.
- **Distribution** to organs and tissues.
- **Metabolism** to inactive compounds.
- **Elimination** from the body via urination, sweat, oral fluid, hair, nails.

- **Blood & Breath:** Indicate what is currently in the system & may be affecting function
- **Oral Fluid:** Similar to blood, but capable of detecting fewer drugs
- **Urine:** Indicates prior use
- **Hair:** Historical use

Oral fluid and blood may test negative, while urine and hair test positive.



Comparing specimen types is like comparing apples to oranges, it doesn't work

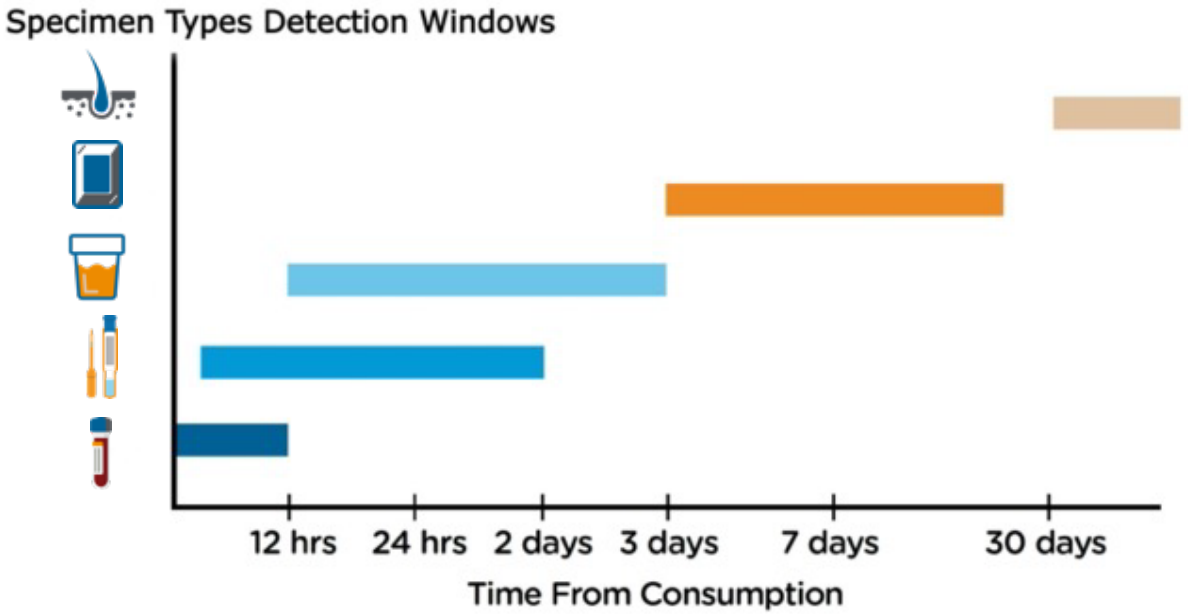
Detection time varies for each specimen time – elimination time matters.

- Blood & Breath: 8 to 12 hours
- Oral fluid: 5 to 48 hours

Drug use is detectible within minutes of consumption

- Urine: 0.5 to 5 days
- Sweat: 5 to 10 days
- Hair: 2 weeks to months

Require multiple doses / uses to produce a positive result



Distribution

- Seconds to Minutes: Smoked drugs appear in blood
- Minutes to Two Hours: Orally ingested drugs in blood and drugs move from blood to oral fluid and (alcohol, inhalants) breath
- About One hour: Drugs appear in urine
- One to Seven Days: Drugs appear in hair

Elimination

- One to Two Days: Drugs most likely cleared from blood or oral fluid
- After Three Days: Most drugs cleared from urine
- After One Week to Several Months: Drugs only found in hair

Specimen	Breadth of Detectable Drugs	Detection Window	Collection Process	Primary Use
Blood	Broad	8 to 12 hours	Invasive	DWI, Post Mortem
Breath	Narrow	8 to 12 hours	Non-Invasive	DWI
Oral Fluid	Moderate	5 to 48 hours	Non-Invasive	Abstinence Monitoring
Urine	Broad	2 to 3 days	Moderately Invasive	Abstinence Monitoring
Sweat	Narrow	5 to 10 days	Non-Invasive	Special Situations, Rural
Hair	Moderate	2 weeks to 3 months	Non-Invasive to Invasive	Child Custody, Rural

Best Use

- Indicates possible or probable impairment.
- What the central nervous system is currently exposed to.
- Commonly used for DUI & Post-Mortem.

Benefits

- Difficult (impossible) to adulterate/substitute.
- Accurate for certain substances within a specified detection window.

Drawbacks

- Short window of detection.
- Limited volume.
- Invasive. Phlebotomist must conduct the collection.
- Noisy specimen (protein, blood cells, lipids).
- Low concentration of drug levels, requires sensitive test.
- Cost.

Best Use

- Currently intoxicated?
- Used independently, does not work well for abstinence monitoring.

Benefits

- Difficult (impossible) to adulterate.
- Immediate results.
- Readily available in virtually unlimited quantities.

Drawbacks

- Limited to ONLY ALCOHOL.
- Short detection window of about 8 to 12 hours.
- Must use a certified collection devise that is appropriately calibrated.
- Technician must be trained on proper collection protocols – this is not a bar game.

- **Best Use**
  - Indicates prior exposure.
  - Does not perfectly correlate with impairment but implies current impairment.
- **Benefits**
  - Less invasive.
  - Does not require gender specific technician to conduct collection.
  - No need to ask recent or residual – Positive = Positive
  - Difficult or impossible to adulterate.
- **Drawbacks**
  - Shorter detection window of 5 to 48 hours.
  - Low detection levels.
  - Higher percentage of Quantity not Sufficient for Confirmation testing due to minimal sample volume.
  - Cost, but technology is improving.

Best Use

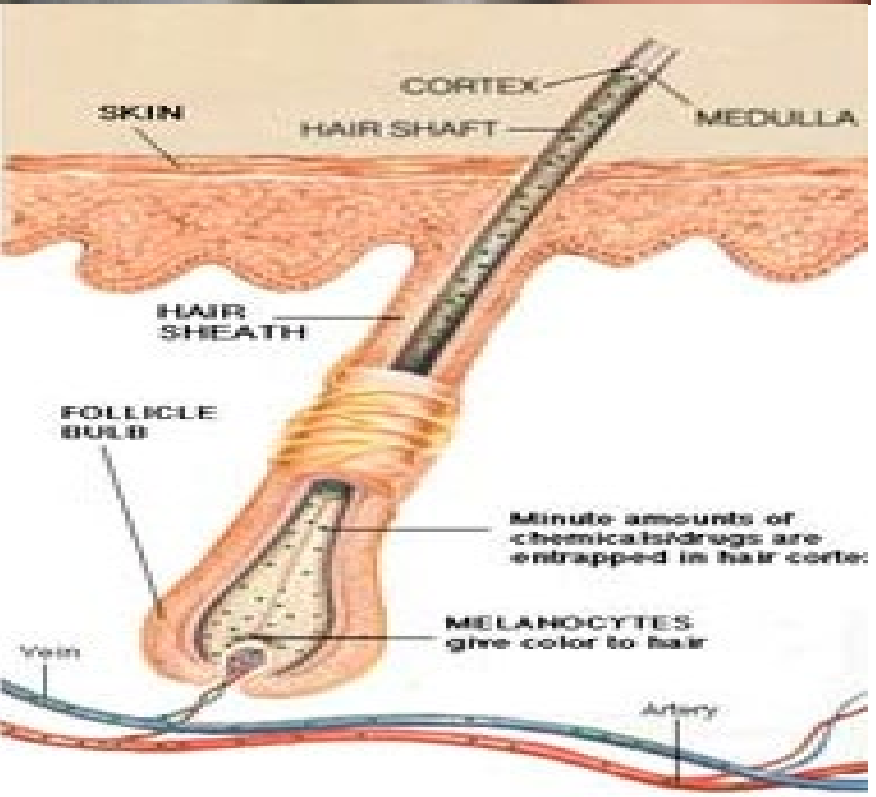
Ideal for abstinence monitoring – frequent, random drug testing

Benefits

- Broadest spectrum of drug tests.
- Lower cost relative to other specimens.
- Small sample volume (30 ml) supports multiple tests.
- Contains high concentration of drugs.
- Detects both recent and past usage.

Drawbacks

- Must follow collection procedures.
- Must conduct validity (dilution) testing.
- Must guard against attempted substitution and adulteration



Best Use

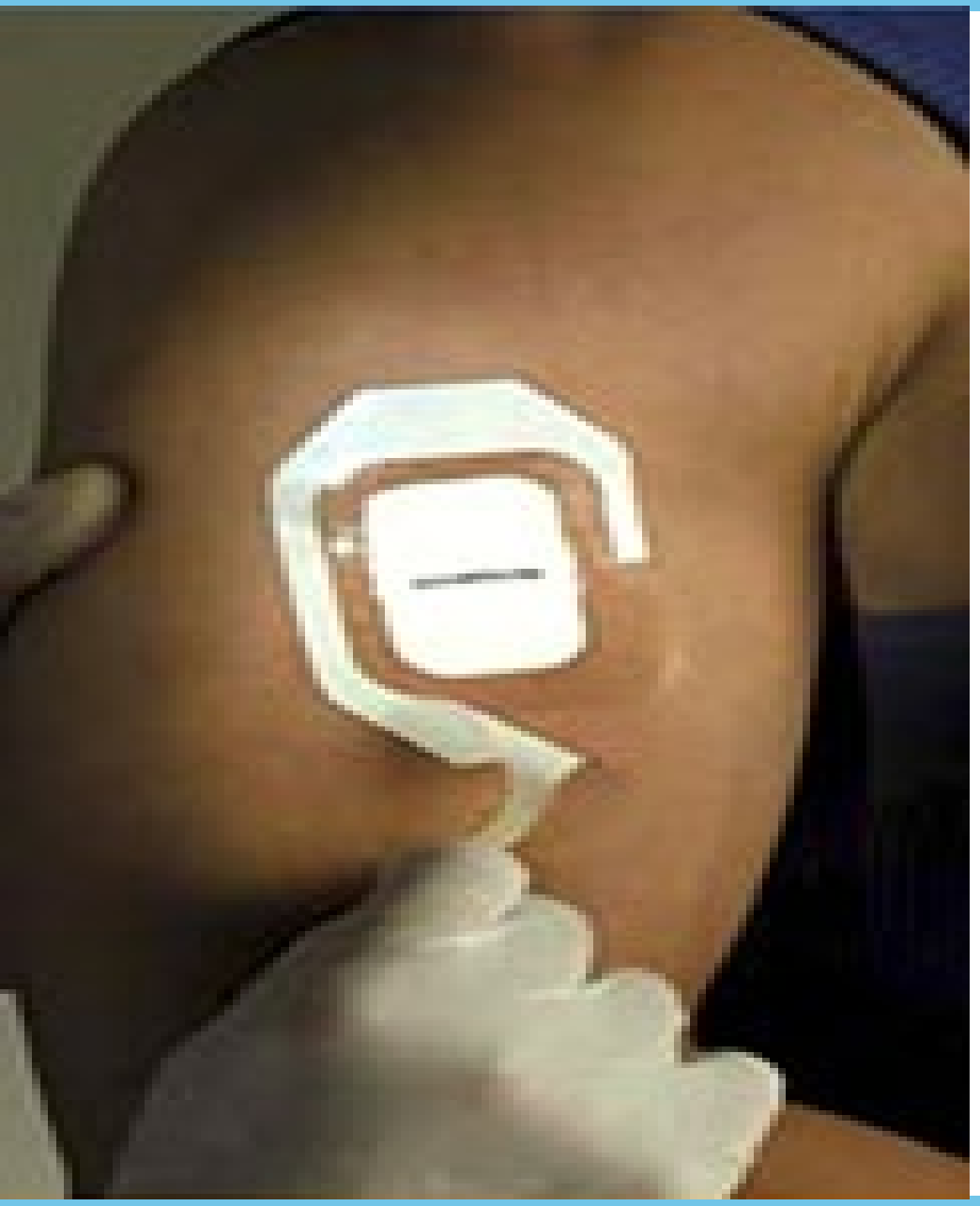
Monitor extended periods of time (employment testing, not abstinence monitoring) or establish a baseline a previous history. Low volume testing.

Benefits

- Long detection window, ranging from ~2 weeks up to ~3 months
- Difficult to adulterate
- Not intrusive, if properly collected

Drawbacks

- Requires an accumulation of use (e.g. 2-5 joints over 3-5 days) delaying relapse identification.
- Lack of head hair…that's ok, any body hair will suffice (extends detection window).
- Hair color, texture and treatments can affect results
- Environmental and occupational exposure



Best Use

Short-term to intermediate monitoring

Benefits

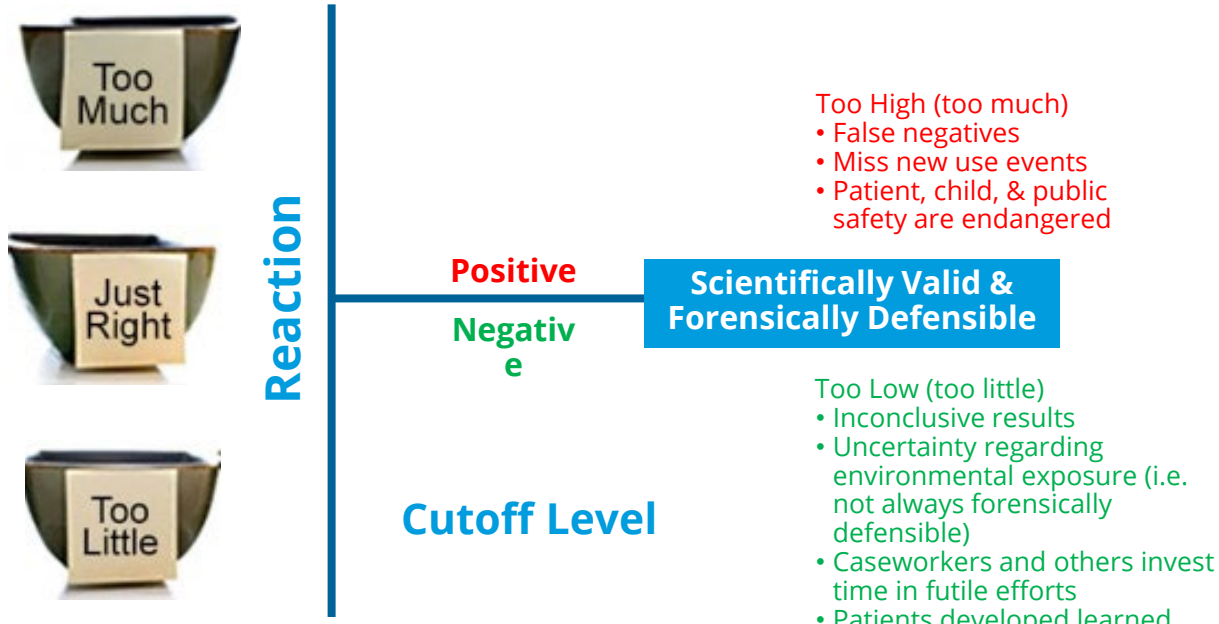
- Non-invasive
- Extended wear (7 to 14 days)

Drawbacks

- Environmental and occupational exposure
- Requires accumulation of drug use for detection
- Extended lead time to identify relapse
- Removal caused by life activities or attempts to circumvent test
- Cost

Results Interpretation

Cutoff levels help to ensure that drug testing is *scientifically valid* and *forensically defensible*.



From a legal perspective, a specimen that produces a reaction just below the cutoff level is as equally negative as a specimen that produces a reaction far below the cutoff level.

- Cutoff levels serve as a safeguard designed to ensure the reliability of testing results.
- Drug tests can be unreliable at detecting the presence (or absence) of drugs at concentrations below the cutoff levels (thresholds).

The Patient is abstaining from drug use or:

- Patient did not use enough to be detected
- Patient is not using frequently enough to be detected
- Detection window has closed
- Drug test is not sensitive enough (i.e., cutoff level is too high)
- Specimen is dilute or tampered
- Patient is using a drug that is not on the test panel

Feasible in the short-term, but prevented by frequent, random testing over time

The Patient used the drug that tested positive

- Most positive results do not measure how much? How intoxicated? How high?
- Positive results generally tell us that the Patient ingested a banned substance or a substance that cross-reacts with a banned substance.
  - Substances that cross-react with banned substances are generally treated as banned substances, unless the Patient obtains approval for such substances.
  - Occasionally, Patients will vehemently deny drug use. Due process mandates that these Patients should have the option of requesting a confirmation test.

Imagine a bowl of M&Ms and Skittles.

- Green M&Ms are strictly prohibited, while green Skittles are permitted.
- Immunoassay screens detects all green candy; both M&Ms and Skittles.
- Immunoassay screens will deem a client that consumes green Skittles as positive for green.
- This is **cross reactivity**, a known limitation of the immunoassay screen methodology.
- Conversely, confirmation testing distinguishes between green M&Ms and green Skittles.

Why bother to screen specimens and not just confirm every sample?

- Time and cost.
- Confirmations are rarely required when high standards are followed and patients abstain from banned substances.
- When a client adamantly denies substance use, request a confirmation prior to punitive intervention.
- Intervention should not be delayed if there is a concern for client or public safety.
- Averhealth recommends a confirmation test when the client denies use and is faced with a loss of liberty.

Denial and manipulation are unfortunately tenants of addiction.

- Fortunately, we do not have to determine the legitimacy of every inventive story.
- Patients who test positive may request a confirmation test.
- A positive drug test, no matter the cause, is in violation of the Patient contract
  - Medication Guide informs Patients of acceptable medications for common symptoms (Acceptable Medications = no patterns of abuse or cross reactivity issues).
  - Everyday substances that can cross-react with the screen (e.g., poppy seeds) so if clients adamantly deny use after a positive result, you can consult with one of our expert toxicologists.

Detection Window

- EtG aids in detecting ingestion for up to two days after light or moderate drinking and up to four days in heavy drinkers.

Screen Cutoff

- 500 mg/mL
    - Research demonstrates that an EtG positive in excess of 500 ng/mL is not associated with everyday products.
- What does it mean if a Patient tests positive for EtG?
    - **Ethyl Gluconuride, EtG**, is a metabolite of alcohol (ethanol) that is used as a marker for consumption of alcoholic beverages.
    - **Ethyl Sulfate, EtS,** is a second metabolite of alcohol (ethanol) that is used in conjunction with EtG as a marker for consumption of alcoholic beverages.

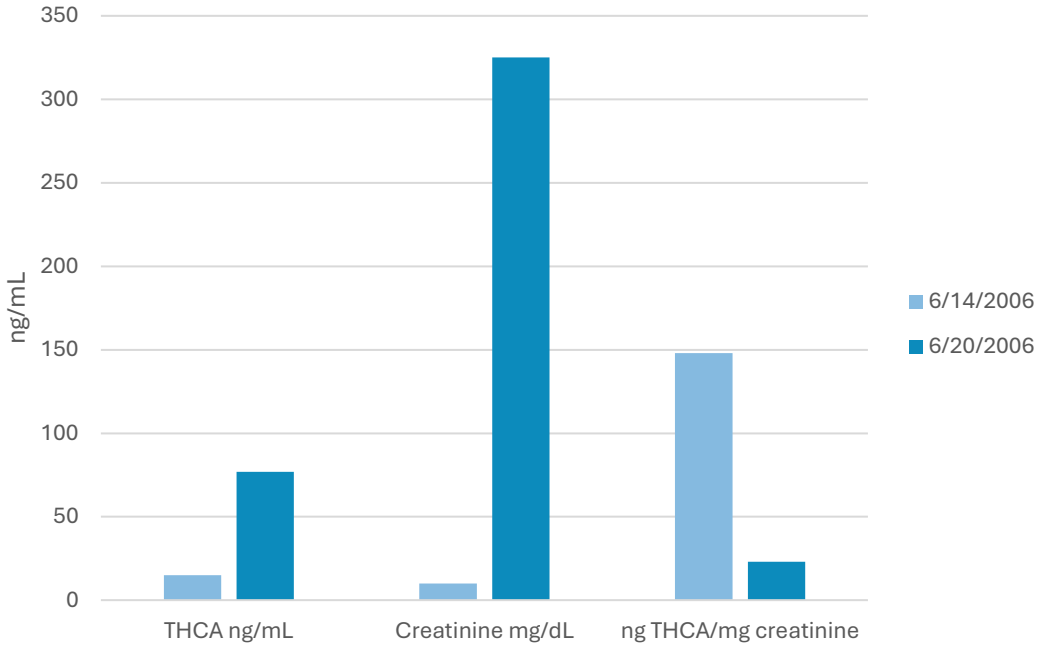
- Popular assumption is that the THC detection window is 30 days or more.
- Assumption is supported by various non-scientific media that indicate the body retains THC for a couple months to 17 years after use.
- Conventional wisdom quandary:
  - Delays intervention (therapeutic or child protection)
  - Delays timely judicial sanction
  - Encourages Patients to deny use

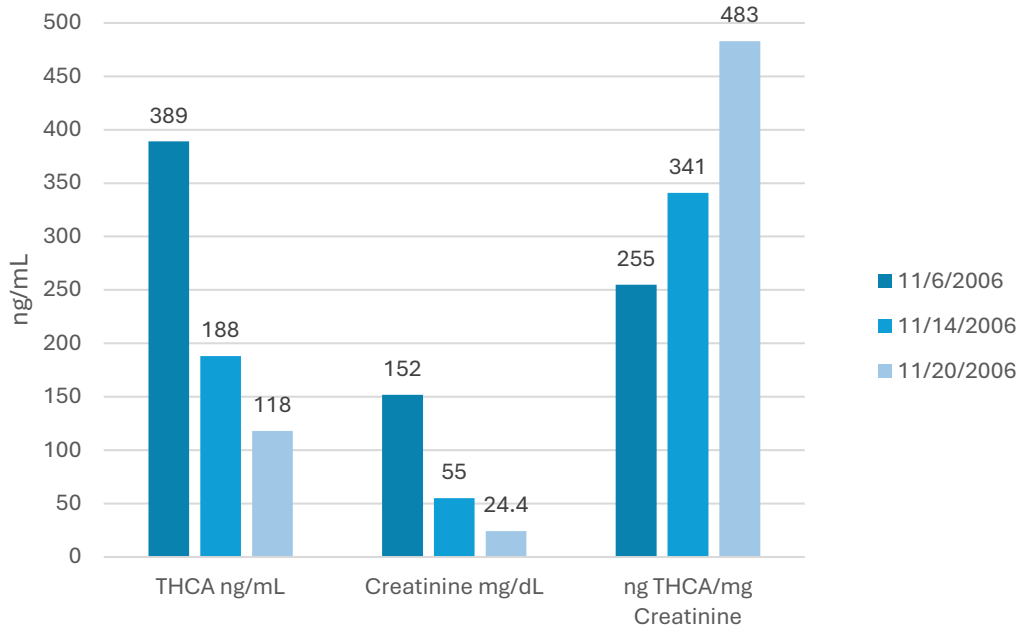
THC detection window is closer to 7 to 25 days & is only an issue when a Patient initially submits to testing.

Cutoff		
Detection Time	**20 ng/ml**	**50 ng/ml**
Occasional Use	Up to 7 days	Up to 3 days
Chronic Use	Up to 25 days	Up to 14 days

HOW TO DISTINGUISH BETWEEN RECENT USE & NON-RECENT THC USE?

- Only an issue when a Patient first submits to testing
- Only an issue for THC
- If simplified approach does not answer the question, call your lab for qualified toxicological support. More in-depth analysis using recent tests results can be done to distinguish between new use and residual elimination.





The Deception of Dilution

- Urine specimen dilution is **the** most common ploys used to avoid the detection of drug (drug and alcohol) use.

- Consuming excess fluid over a short period of time lowers the concentration of detectable drugs in urine, reduces creatinine levels.

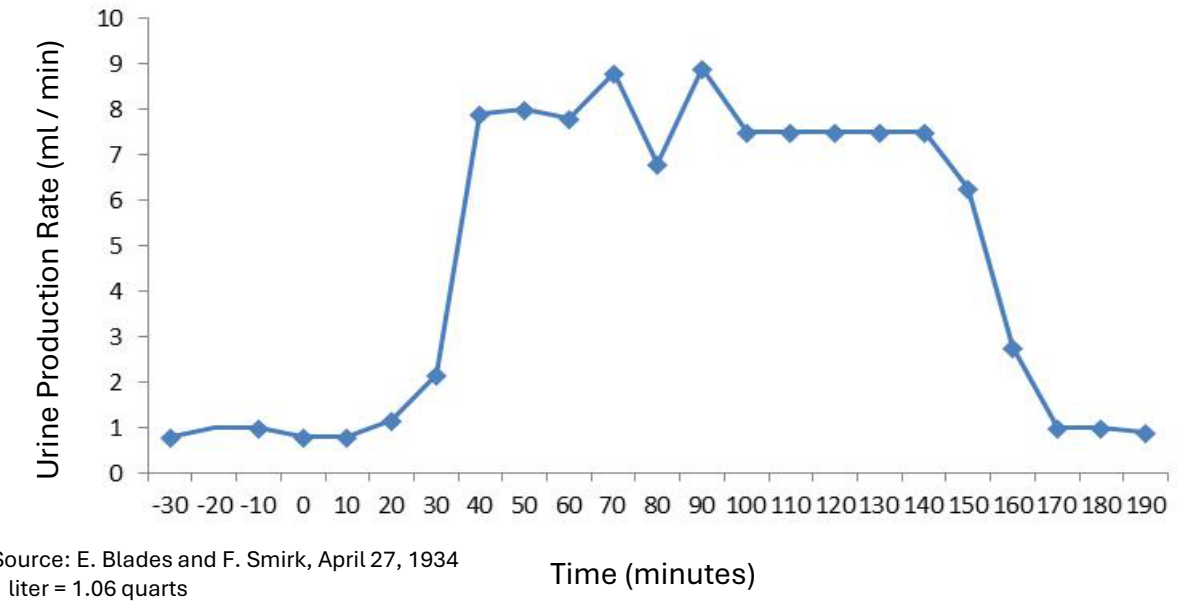
- The combination of a directly observed collection with creatinine testing reduces the Patient's ability to dilute a urine sample.

  - Observation ensures the Patient does not dilute the sample post urination (i.e. adding water to the specimen post collection).
  - Creatinine test detects if the Patient is diluting prior to submitting a urine sample.

We cannot intervene to change a Patient's behavior if we do not know that the Patient has relapsed.

WHAT IS DILUTION (WATER LOADING/FLUSHING)?

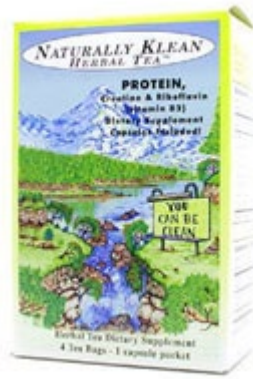
- Water loading / flushing is the rapid consumption of a copious volume of fluid.
  - Rapid consumption = 90 minutes
  - Copious volume = 2-4 quarts (about 2-4 liters)
- Water loading increases the volume of water relative to the volume of detectable drugs, creatinine, and other solids for a period of 2-3 hours…resulting in possible negative drug tests and low creatinine levels.

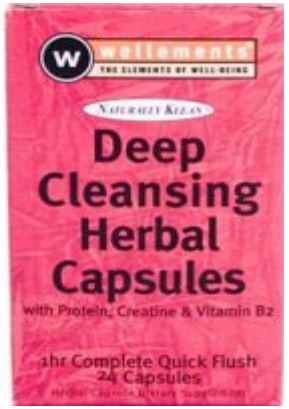


Source: E. Blades and F. Smirk, April 27, 1934
1 liter = 1.06 quarts

Urine production is a function of time and volume. Rapidly consuming 1L of water will cause the urine production rate to sharply increase.

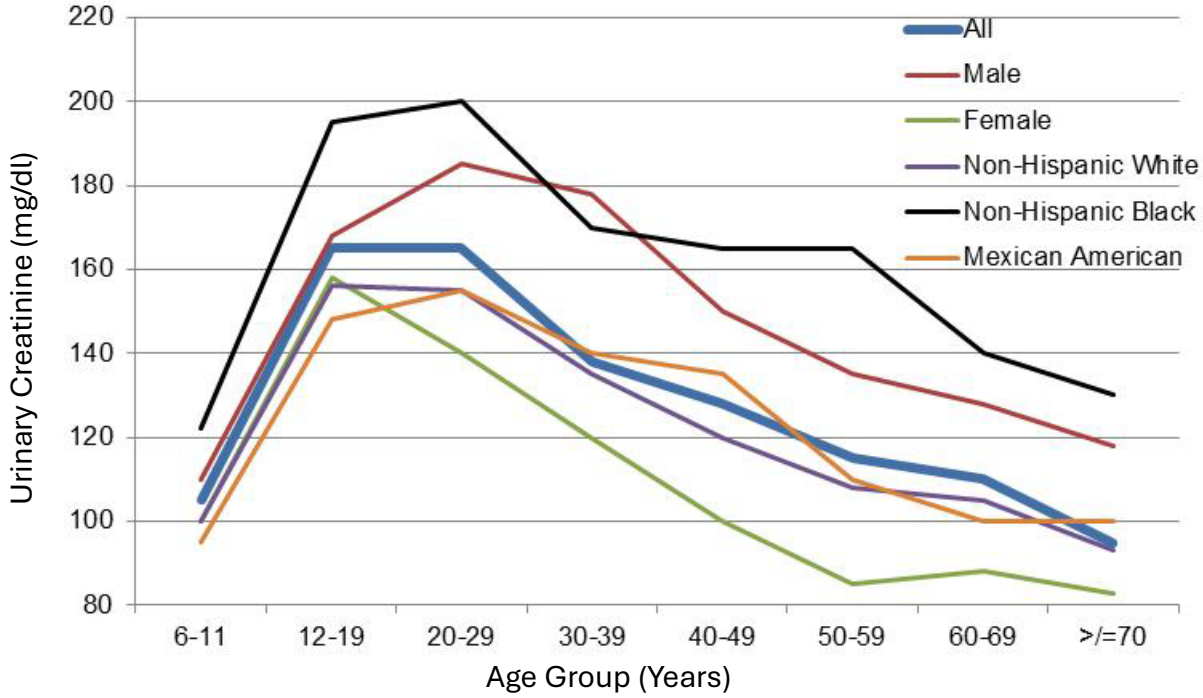
- Consume a large volume of fluid, which results in a drug detection level that is less than the cut-off level and produces a negative test.
- Water is the cheapest and most readily available fluid.
- Other products exist (Gold Seal, Clean'n Clear, Naturally Clean, Test Free, Ultra Klean, etc.), however product directions require the rapid consumption of a copious volume of fluid.
  - There is no evidence to support the ability of such products to eliminate drugs from urine.
  - Patients are instructed to drink a lot of water prior to testing and/or to abstain form drug use for 5 to 7 days prior to the test date.





- Creatinine is a by-product of muscle metabolism that is produced at a relatively constant rate throughout the day.

- Normal Creatinine is about 130 mg/dl –
  "Urinary Creatinine Concentrations in the U.S. Population: Implications for Urinary Biologic Monitoring Measurements", Dana Barr et el, September 23, 2004



Less than 1% of sample population had creatinine level below 20 mg/dl

- Muscle produces a relatively constant amount of creatinine throughout the day.
- Kidneys filter a constant volume of creatinine from blood per unit of time.
- The creatinine excretion rate (CER) for a normal, healthy person can be predicted with a 95% confidence at -2.5% to +1.0% -- *Dr. Joachim H., IX et el, October 22, 2010*

Therefore, urine creatinine levels for a normal, healthy person remain fairly stable:

- Throughout the day (Morning, Afternoon, Evening, Night)
- From Day-to-Day

Muscle Produces Creatinine → **Kidneys Filter Creatinine from Blood** → **Creatinine is ONLY Excreted with Urine**

- **Dilution**, also know as water loading, flushing, over hydrating, etc.

- **Certain Medical Conditions**
  - Rare muscle wasting diseases & some kidney ailments.
  - Patients that always produce a low creatinine level should seek medical treatment.

- **Low creatinine levels are not caused by:**
  - Diabetes (controlled)
  - Exercise
  - High blood pressure
  - Obesity
  - Diet
  - Pregnancy
  - Menstrual Cycle

Denial is common with substance abuse – Patients are expected to deny sample dilution in the same persuasive manner as a positive test result.

It is possible for a Patient's creatinine levels to decline to below 20 mg/dl under extreme condition

……However, multiple creatinine levels below 20 mg/dl are rare and creatinine levels below 10 mg/dl almost always require a concerted dilution effort.

- **Common extreme condition excuses**
  - "I work in the heat and consume a lot of liquids to remain hydrated"…this will cause creatinine levels to increase. The body "knows" to retain excess water for the replenishment of diminished tissue water concentrations and therefore the urine production rate does not increase.
  - "I drink coffee, green tea, etc." – only if the Patient consumes 2 to 4 quarts of such beverage within 90 minutes, equating to more than one Big Gulp every 30 minutes.
  - "I take [drug abc] to manage [condition xyz]" – very few medications will cause a low creatinine level, please check with averhealth if a Patient attributes a low creatinine level to a prescribed or over-the-counter medication.

- **NADCP's Policy:** Urine samples with a less than 20 mg/dl should be considered dilute
- **Common Laboratory Reporting:** Specimens with a creatinine level less than 20 mg/dl are reported as an abnormal specimen

The goal is to encourage positive behavior while preventing destructive behavior.

- A dilute sample does not accurately reflect the recent drug use history of the sample Patient.
- Negative test results from a dilute sample should never be interpreted as no drug use
  - If drugs are present, they are probably not detectable due to dilution.
- Positive test results from a dilute sample are valid
  - The Patient just did not consume enough fluid in a short period of time
    OR
  - The drug concentration is sufficient to remain above the established cut-off level.

Negative dilute test results **DO NOT** provide accurate data regarding a Patient's potential relapse and consequently comprise the treatment court team's ability to affect positive behavior modifications.

HOW TO AVOID DILUTION

- Do not drink excessive amounts of fluids within two hours of providing a sample.

- Limit the amount of fluid you drink to 32 ounces prior to providing a sample.
    - 7-11 Big Gulps contain 32 ounces of fluid
    - McDonald's large drinks contain 32 ounces of fluid
    - Starbuck's Venti size drinks contain 24 ounces of fluid

- Allow your urine to naturally accumulate. The average person naturally creates about one milliliter of urine per minute.

- Drinking excessive amounts of fluid can result in a diluted urine sample.

True or False

1. Creatinine is only excreted through urination.
2. Creatinine levels fluctuate throughout the day and from day-to-day.
3. Drinking a bottle of water (a few cups of coffee, green tea, sports drink, etc.) prior to dropping will cause an abnormally low creatinine level.
4. Exercising or working in the heat and drinking a lot of fluids to remain hydrated will cause an abnormally low creatinine level.
5. Drinking a lot of water (or any other fluid) in a short period of time can cause abnormally low creatinine levels.
6. Rare muscle wasting and kidney diseases can cause abnormally low creatinine levels.
7. Creatinine levels can fluctuate from normal to abnormally low for individuals with rare muscle wasting and kidney diseases.
8. A sample that tests positive, but is dilute, should be viewed as reliable.

True or False

1. Creatinine is only excreted through urination.
   TRUE
2. Creatinine levels fluctuate throughout the day and from day-to-day.
   FALSE
3. Drinking a bottle of water (a few cups of coffee, green tea, sports drink, etc.) prior to dropping will cause an abnormally low creatinine level.
   FALSE
4. Exercising or working in the heat and drinking a lot of fluids to remain hydrated will cause an abnormally low creatinine level.
   FALSE
5. Drinking a lot of water (or any other fluid) in a short period of time can cause abnormally low creatinine levels.
   TRUE
6. Rare muscle wasting and kidney diseases can cause abnormally low creatinine levels.
   TRUE
7. Creatinine levels can fluctuate from normal to abnormally low for individuals with rare muscle wasting and kidney diseases.
   FALSE
8. A sample that tests positive, but is dilute, should be viewed as reliable.
   TRUE

Emerging Drugs

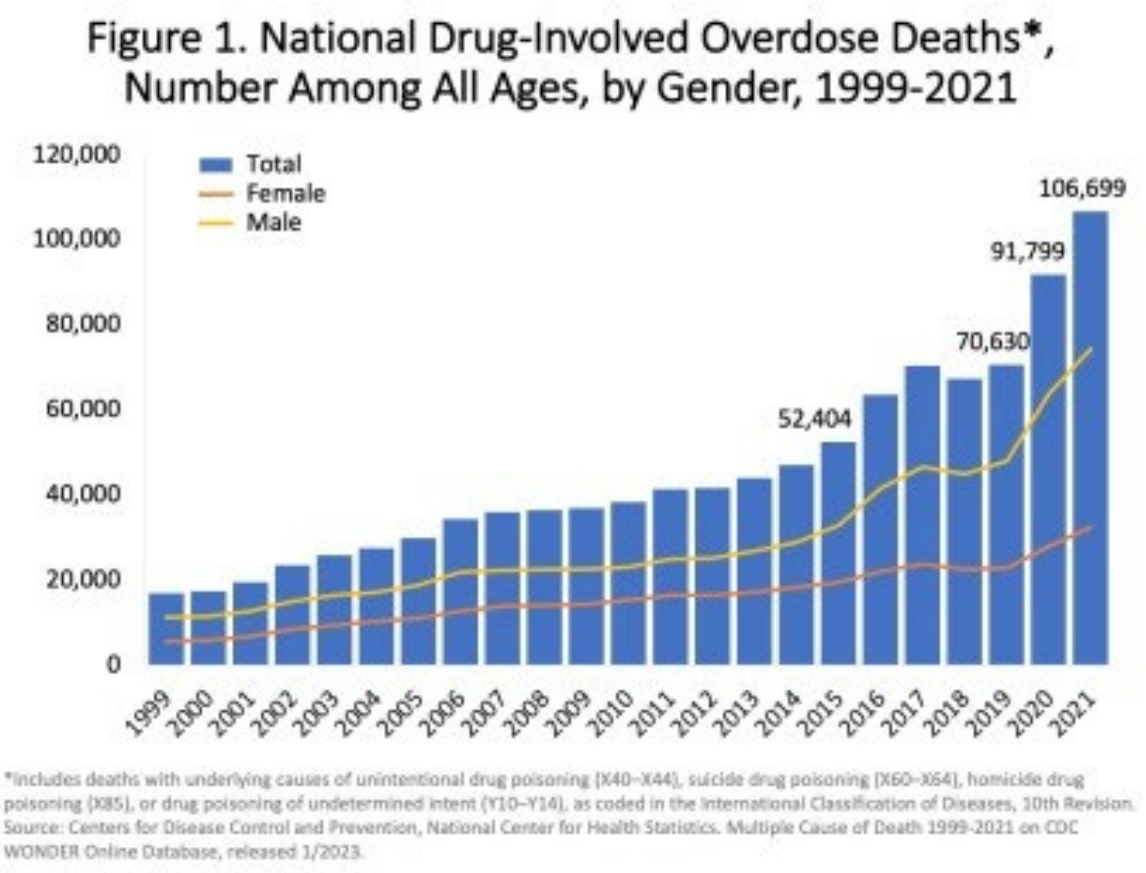
What are the three most commonly used drugs in America in 2023/2024?

- **Alcohol**
  - Past month - 48%
  - Binge drinking past month – 21.7%
- **Tobacco**
  - Past year - 21.2%
  - More than 1 in 5 people smoke cigarettes in **West Virginia**, **Missouri, Wyoming**, **Louisiana** and **Arkansas**.
- **Marijuana**
  - Past year - 13%
  - #3 overall, but #1 most common illicit drug

National Forensic Laboratory Information System-Drug Top-Five Drug Submissions 2023* by IACP Region

Mountain Pacific Region	North Atlantic Region	North Central Region	Southern Region
1. Methamphetamine	1. Cocaine	1. Methamphetamine	1. Methamphetamine
2. Fentanyl	2. Fentanyl	2. Cocaine	2. Cocaine
3. Cocaine	3. Methamphetamine	3. Fentanyl	3. Fentanyl
4. Heroin	4. Xylazine	4. Heroin	4. Heroin
5. Alprazolam	5. Heroin	5. Xylazine	5. Alprazolam

- According to the DEA, "**107,375** people in the United States died of a drug overdose and drug poisonings in a 12-month period ending January 2022. A staggering **67%** of those deaths involved synthetic opioids like **fentanyl**"
- In 2023 the overdose death rate topped 112,000 in a 12-month period for the first time, according to the Centers for Disease Control and Prevention. White House officials say they have "flattened" the upward curve.



- Since 2018, The Center for Forensic Science Research and Education's NPS Discovery program has reported **154** newly discovered NPS in the United States (Figure 1). **NPS opioids** remain the largest subclass (Figure 2).
- In 2023, NPS Discovery reported the discovery of **17** NPS for the first time.

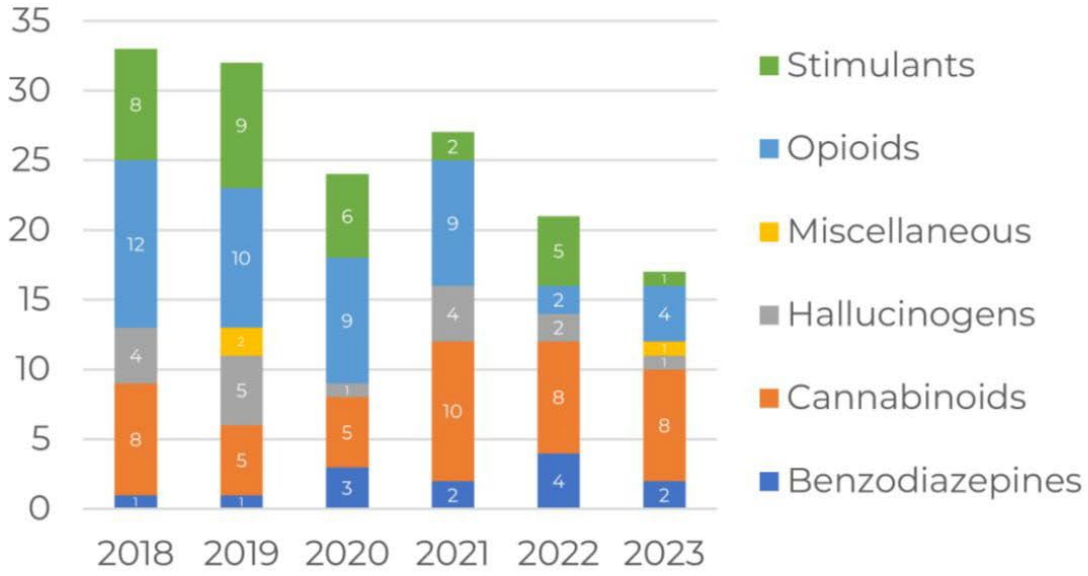


Figure 1: Newly discovered NPS reported for the first time since 2018.

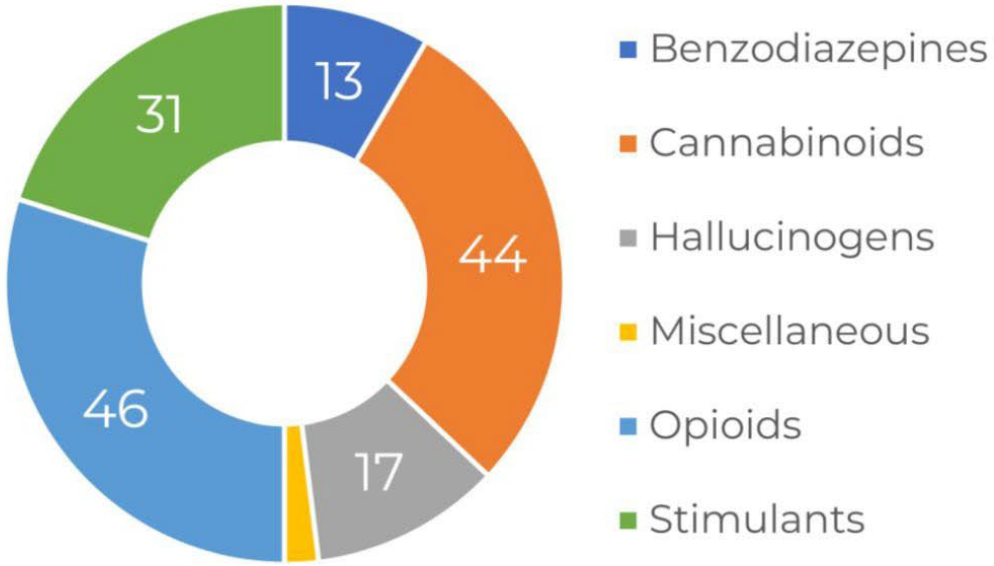


Figure 2: Breakdown by subclass of newly discovered NPS, 2018-2023.

- Since 2018, NPS NPS Discovery has identified **240** NPS in forensic samples (Figure 3).
- **NPS opioids**, **stimulants**, and **cannabinoids** represent the largest subclasses.
- In 2023, **79** total NPS were detected (Figure 4).

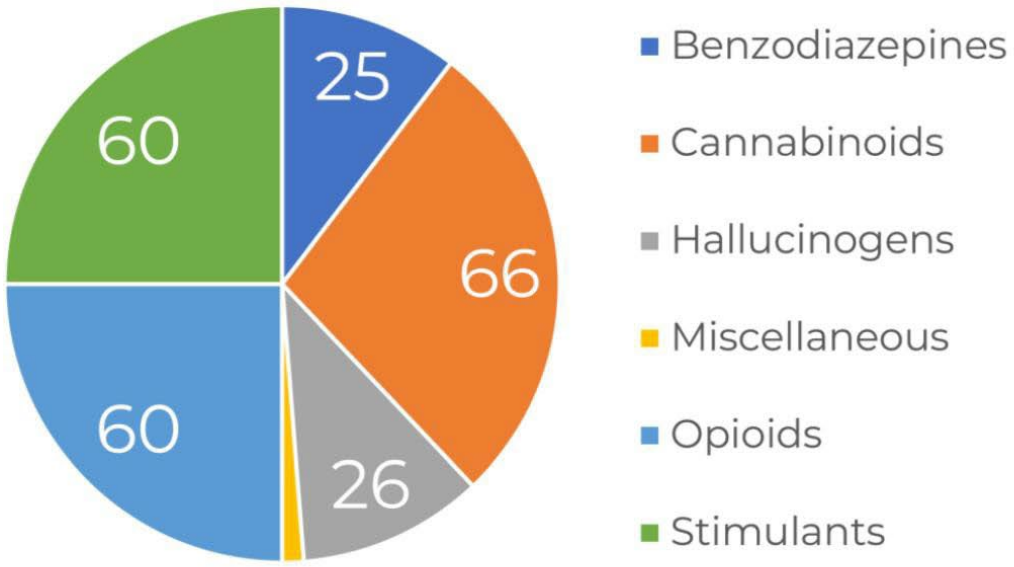


Figure 3: Breakdown by subclass of individual NPS detected, 2018-2023.

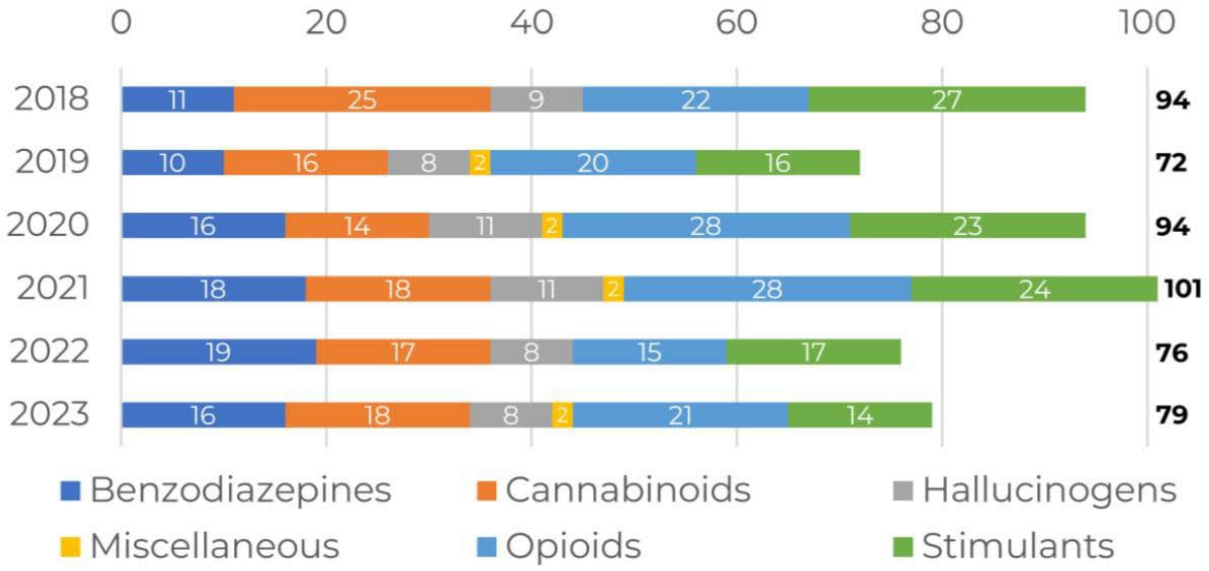
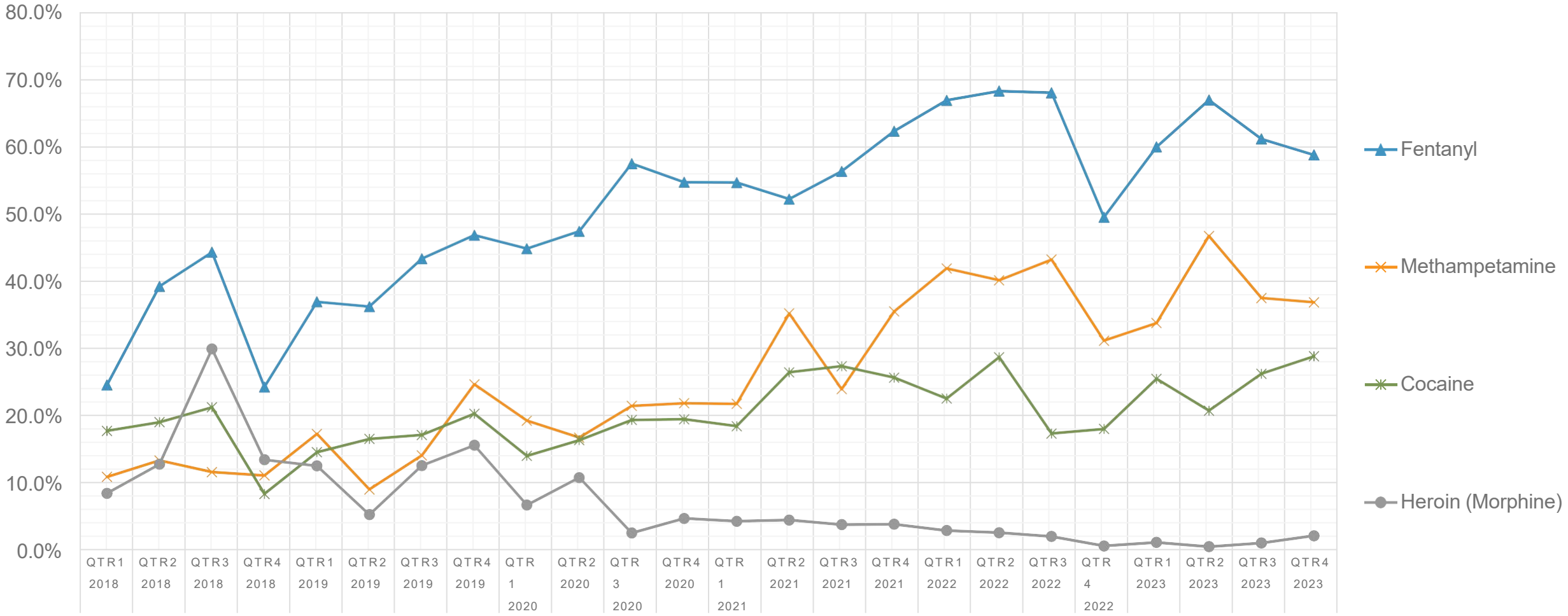


Figure 4: Individual NPS detected each year, cumulative since 2018.

NPS Discovery



- Data **indicates drug seizures** at the U.S.-Mexico border, by pounds seized, are trending down.
    - This good news, at closer look, can be misleading. Seizures of heavier, less-potent drugs like marijuana are down while illicit fentanyl, a drug **100 times more potent** than morphine, are up significantly: 480 percent higher at the southern border in fiscal year (FY) 2023 compared to FY 2020.
- U.S. Customs and Border Protection's (CBP) Border Patrol and Office of Field Operations (OFO) together **seized nearly 549,000 pounds** of illicit drug substances nationwide in FY 2023.
    - Most seizures concerned marijuana (150,000 pounds) and methamphetamine (140,000 pounds), but a notable and growing portion consisted of fentanyl (27,000 pounds). The total number of drug seizures by weight is below previous years: 16 percent below FY 2022, 40 percent below FY 2021, and 50 percent below FY 2020. Overall, this represents a downward trend. Yet, seizures of fentanyl in FY 2023, totaling 27,000 pounds, surpassed fentanyl seizures from the previous three years.
- AMO – Air and Marine Operation

Comparison: Drug Type and Drug Seizures at the Southern Border by Border Patrol and OFO, FYs 2022 and 2023		
Methamphetamine	2022	160,000 lbs.
	2023	121,000 lbs.
Marijuana	2022	85,700 lbs.
	2023	61,200 lbs.
Cocaine	2022	25,200 lbs.
	2023	27,600 lbs.
Fentanyl	2022	14,100 lbs.
	2023	26,700 lbs.
Heroin	2022	1,500 lbs.
	2023	1,200 lbs.
Other Drugs	2022	1,500 lbs.
	2023	2,800 lbs.

Nationwide Fentanyl Seizures by AMO, FY 2020-24	
FY 2023	1,453 lbs.
FY 2022	1,325 lbs.
FY 2021	786 lbs.
FY 2020	558 lbs.

CELEBRITY DEATHS DUE TO SUBSTANCE USE

Prince (2016)
Singer/Songwriter
Fentanyl

Tom Petty (2017)
Singer/Songwriter
Fentanyl and Oxycodone

Mac Miller (2018)
Rapper
Fentanyl, Cocaine, and Alcohol

Juice Wrld (2019)
Rapper
Oxycodone

Tony Hsieh (2020)
Zappos
Ketamine and Nitrous-Oxide

Dwayne Haskins (2022)
Quarterback
Hit by a Truck + Alcohol and Ketamine

Taylor Hawkins (2022)
Foo Fighters Drummer
Opiates, Benzos, TCA, and Alcohol

Matthew Perry (2023)
Actor
Ketamine

Testing Challenges

MANUFACTURING "PROGRESS"

- All major drug classes now have synthetic versions
- Majority started in China
- Purchased over the internet
- Arrive by international mail and "express consignment operations environments" according to the DEA
- Usually see new drugs in Europe first–US about six months later
- Western governments complain to the Chinese government (sometimes at the UN), but clandestine chemists change formulas with ease, and the cycle begins again
- Mexico – faster and cheaper; higher quality and stronger; drug cartel sending fentanyl now that THC is legal in the US
- India is emerging as a source for finished fentanyl powder and fentanyl precursor chemicals

- Pills, powders, liquids seized by law enforcement
- Structure identified by crime lab analytical chemists: LC-MS/MS, GC/MS, FTIR
- Internet sources such as Erowid, Bluelight
- Emergency room admissions provide initial toxicology data
- After standards made – animal studies for pharmacokinetic data
- Very few controlled human studies generally done

Who is using? Waste-water analysis and public urinal studies

Q J Med 2013; 106:147–152
doi:10.1093/qjmed/hcs219 Advance Access Publication 22 November 2012

Analysis of anonymous pooled urine from portable urinals in central London confirms the significant use of novel psychoactive substances

J.R.H. ARCHER[1], P.I. DARGAN[1,2], S. HUDSON[3] and D.M. WOOD[1,2]

1. Authorities crack down on existing drug
2. Clandestine chemists tweak the structure – now considered legal!
3. New drugs found on the street by LE in pill, liquid, or powder form
4. ODs, OWIs, ER admissions
5. News stories, public attention
6. Vendors make reference standards
7. Labs develop tests
8. Research done, scientific data published
9. Legislature controls
10. Back to Step 2

Yeah, but Steps 6-7…how do we figure out what these things even are?

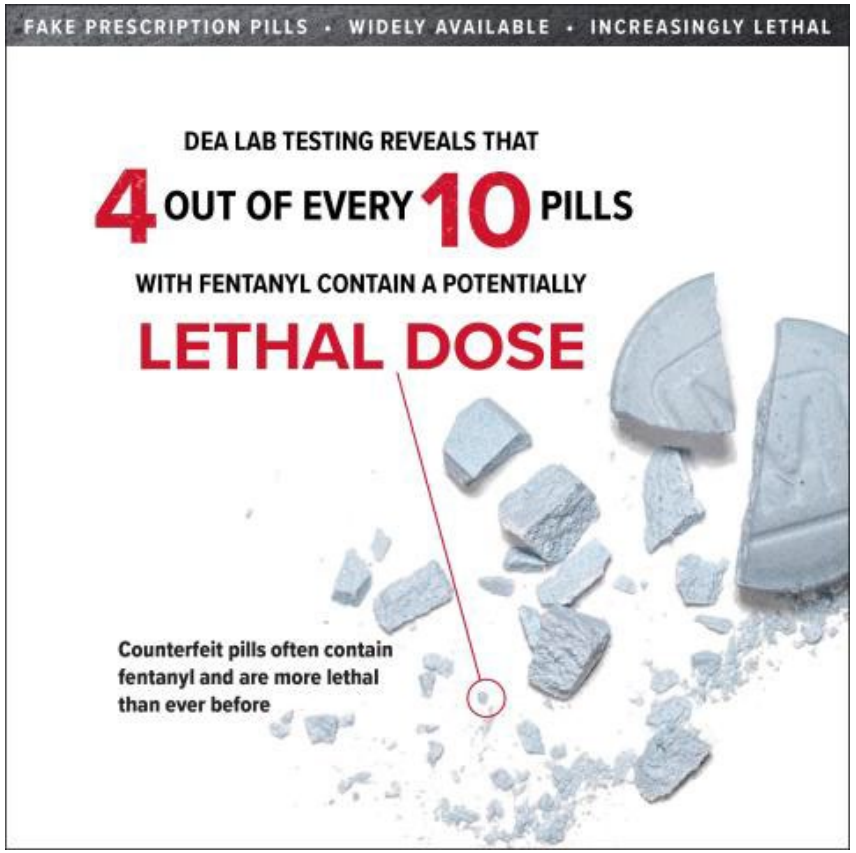
- Initially no reference standards to use for test development
- Metabolism unknown:
    - Compounds may be extensively metabolized. If the reference standard is of the parent drug and the drug is completely converted to metabolites, then you might miss it.
    - Which metabolites? Do some closely related drugs metabolize to the same thing? If we find a metabolite, how do we know which drug it came from?
- Doses usually not known – may be extremely low
- Half-life not usually known – how long can it be detected?
- What do screening panels detect, and at what efficiency?
- What transitions (instrument settings) do we use for LC/MS/MS?

Fentanyl

- Fentanyl is an “opioid” – that acts like an opiate in the body but chemically is not an opiate
  - Used since 1963 as an adjunct to surgery
  - 50 – 100x as potent as morphine
  - Half-life is 3 – 12 hr. – detectable in urine for around 3 days.
- **Oral doses:** 100 – 1600 mcg for breakthrough pain for cancer patients
- **Patches**: 25 – 100 mcg/hr. for 72 hrs., surgical breakthrough pain
- **Injections**: 2 mcg/ml for epidural infusion or 25–100 mcg for IV infusion
- **Nasal spray**: 100 – 400 mcg/spray, up to 800 mcg/day

- Severe respiratory depression, muscle rigidity, seizures, hypotension, coma
- **Fatal Overdoses:**
  - Blood 3 – 28 ng/ml (average 8.3)
  - Urine 5 – 93 ng/ml (average 28)
- Beginning around 2005, we begin to see fentanyl-laced heroin. **Why?**
  - Cheaper to produce than heroin
  - Increases potency, gives more of a kick to heroin
  - Stretches supplies out
- Originally attributed to one lab in Mexico, but it caught on elsewhere

- **Fentanyl:** cheap, potent, and profitable, so dealers use it to make fake pills
- According to DEA, “criminal drug networks are mass-producing fake pills and falsely marketing them as legitimate prescription pills”
- Counterfeit pills are **fake medications with different ingredients than the actual medication**
    - They may contain no active ingredient, the wrong active ingredient, or have the right ingredient but in an incorrect quantity



Authentic Oxycodone
FRONT

Authentic Oxycodone
BACK

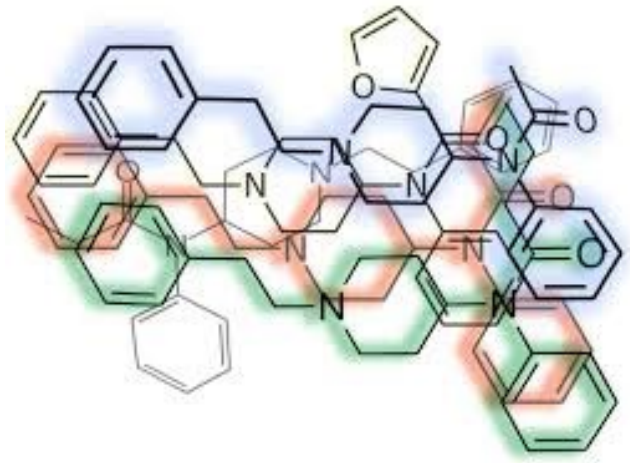
Counterfeit Oxycodone
FRONT

Counterfeit Oxycodone
BACK

Street Names: 30s; 40s; 512s; Beans; Blues; Buttons; Cotton; Greens; Hillbilly Heroin; Kickers; Killers; Muchachas; Mujeres; OC; Oxy; Oxy 80s; Roxy; Roxy Shorts; Whites

"Rainbow fentanyl—fentanyl pills and powder that come in a variety of bright colors, shapes, and sizes—is a deliberate effort by drug traffickers to drive addiction amongst kids and young adults," - DEA Administrator Anne Milgram

- Alphamethylfentanyl
- Acetylfentanyl
- Acrylfentanyl
- Alfentanil
- Benzocarfentanil
- Benzodioxole fentanyl
- Beta-hydroxyfentanyl
- Beta-methylfentanyl
- Butyrfentanyl
- Carfentanil
- Cyclopentanylfentanyl
- Cyclopropylfentanyl
- 4-fluorobutyrlfentanyl
- Furanylfentanyl
- Furanylethylfentanyl
- Methoxyacetylfentanyl
- Octafentanil
- Remifentanyl
- Sufentanil
- Tetrahydrofuranfentanyl
- Thienylfentanyl
- Thiofentanyl



- Trade name Wildnil. Used since 1975 for deer, elk, moose and other large animals
- All pharmacokinetic data are in goats or elands
- Half-life (**in goats**) is 3 – 20 hours
- 60 mg/kg dose gives peak serum 8 ng/ml (**in goats**)
- 169 mg/kg dose gives a peak plasma level of 13 ng/ml (**in elands**)
- Adverse effects: nausea, vomiting, dizziness, drowsiness, bradycardia, respiratory depression, muscle rigidity, coma and death (**in people**)

Elands are really big.

WOULD 10 MG CARFENTANIL SEDATE A T-REX?

SARAH Carfentanil? That's impossible, it would have slept for days!

LUDLOW Something else too, to get it breathing again, maybe we used too much, I don't know. Oh, my God . . .

SARAH You administered an antagonist without knowing the proper dosage?! You put the animal in a narcoleptic state, that thing's a locomotive now! If we don't get it back here - -

Morphine. Carfentanil is mainly just used for sedating rhinos and elephants. A Tyrannosaur and an African Elephant have roughly the same mass, so the dosage used on a T-Rex would be the same as for an Elephant, which would be between 0.5-1.0 mg. Pumping 10 mg of Carfentanil into the T-Rex would be the same as injecting it with about 150,000 mg of Morphine, which is about 10 times the dosage needed to sedate an animal the size of a Tyrannosaur.

Jurassic Park 2: The Lost World

- Suspected in the Moscow theater crisis in October 2002
- 40 to 50 armed Chechen terrorists seized the theater, about 850 people held hostage
- Russian Federal Security Service forces pumped an unnamed chemical into the building's ventilation system, presumably to sedate occupants and allow a rescue operation
- Aerosol exposure – dose cannot be controlled
- Approximately 130 people died due to gas exposure
- One survivor had 0.1 ng/ml urinary norcarfentanil 5 days post-exposure
- Carfentanil and remifentanil found on clothing of another

Alpha MethylFentanyl

- Methylfentanyl, “China White,” was first seen in California in late 1979
- Similar side effects to other Fentanyls
- Possibly **10x** potency of fentanyl (400 – 6000x morphine)

AcetylFentanyl

- Increased use since 2013
- **~ 15x** potency of morphine
- 52 confirmed fatalities involving acetylfentanyl from 2013-2015 (DEA).

Pharmaceutical compounds were developed by Glaxo Smith Kline and Janssen Pharmaceuticals as surgical anesthesia agents:

Alfentanil (Alfenta), c. 1980
- Roughly similar to morphine in potency
- Faster-acting, shorter duration than fentanyl (half-life 1-2 hours)

Sufentanil (Sufenta), c. 1976
- 5 – 10 times as potent as fentanyl, 500 – 800 times as potent as morphine.
- Doses usually low (below 30 mg/kg), given by IV or epidural (patch form in Europe)

Remifentanil (Ultiva), c. 1996
- Very fast-acting – half life 6 – 16 minutes
- Available only in injectable form
- Thought to be used in the Moscow theater crisis

Butyrylfentanyl

- Seen since 2012
- Effects last 1 – 4 hours
- Somnolence, muscle rigidity, respiratory depression, seizures, and coma

Furanylfentanyl

- Seen since 2014
- Effects last 1 – 3 hours
- Toxicity same as Butyrfentanyl

Emerging Concerns

Medetomidine Rapidly Proliferating Across USA — Implicated In Recreational Opioid Drug Supply & Causing Overdose Outbreaks

Medetomidine

- Alpha-2 agonist, in same family of drugs as xylazine and clonidine.
- Synthetically manufactured
- Effects include heightened sedation, analgesia, muscle relaxation, anxiolysis, profound bradycardia, hypotension, hyperglycemia, and hallucinations
- Duration of action is longer than xylazine

Recent mass overdose outbreaks in Philadelphia, Pittsburgh, and Chicago have all been associated with fentanyl or heroin containing medetomidine, as well xylazine and/or others.

5-MeO-DiPT

- "Foxy" or "Foxy Methoxy", is a synthetic psychedelic tryptamine drug, derivative of diisopropyltryptamine (DiPT)

Methallylescaline

- Synthetic analog of mescaline

Bromazolam

- Unscheduled benzodiazepine related to alprazolam

4-HO-MET

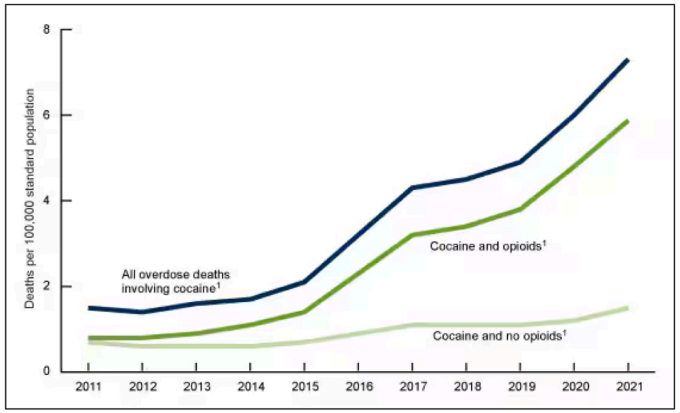
- Metocin, a synthetic tryptamine and psychedelic analog of psilocin

7-OH

- 7-hydroxymitragynine
- Not from Kratom, high potency, synthetically produced, unregulated opioid

- Also known as "moonrock," when smoked, is a popular term for the mixing of heroin or **morphine** with cocaine
- Typically, Cocaine and Heroin, but can include other substances such as: **fentanyl**, amphetamines, opiates, benzodiazepines, or barbiturates
- Cocaine acts as a **stimulant**, raising the pulse, but its effects wear off more quickly than those of heroin, which in turn slow the heart down
- Possible to experience a delayed "**overdose**" (technically, severe respiratory depression)

Figure 1. Age-adjusted rate of drug overdose deaths involving cocaine, by co-involvement of opioids: United States, 2011–2021



[1]Increasing trend from 2011 through 2021 ($p < 0.05$).

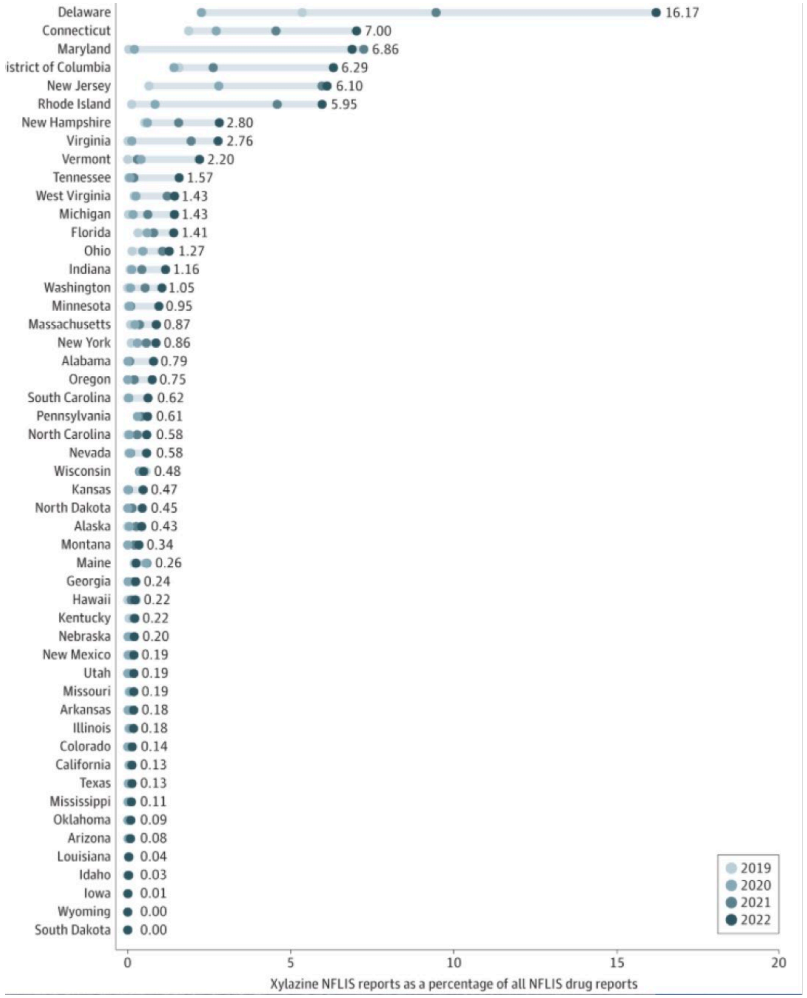
NOTES: Drug overdose deaths involving cocaine were identified using *International Classification of Diseases, 10th Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14, with a multiple cause-of-death code T40.5. Deaths with co-involvement of opioids also had multiple cause-of-death codes T40.0–T40.4 or T40.6. Age-adjusted death rates were calculated using the direct method and the 2000 U.S. standard population. Deaths may involve other drugs in addition to cocaine and opioids. Access data table for Figure 1 .

SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality data file.


FPJ
'ZOMBIE DRUG' HITS AMERICA

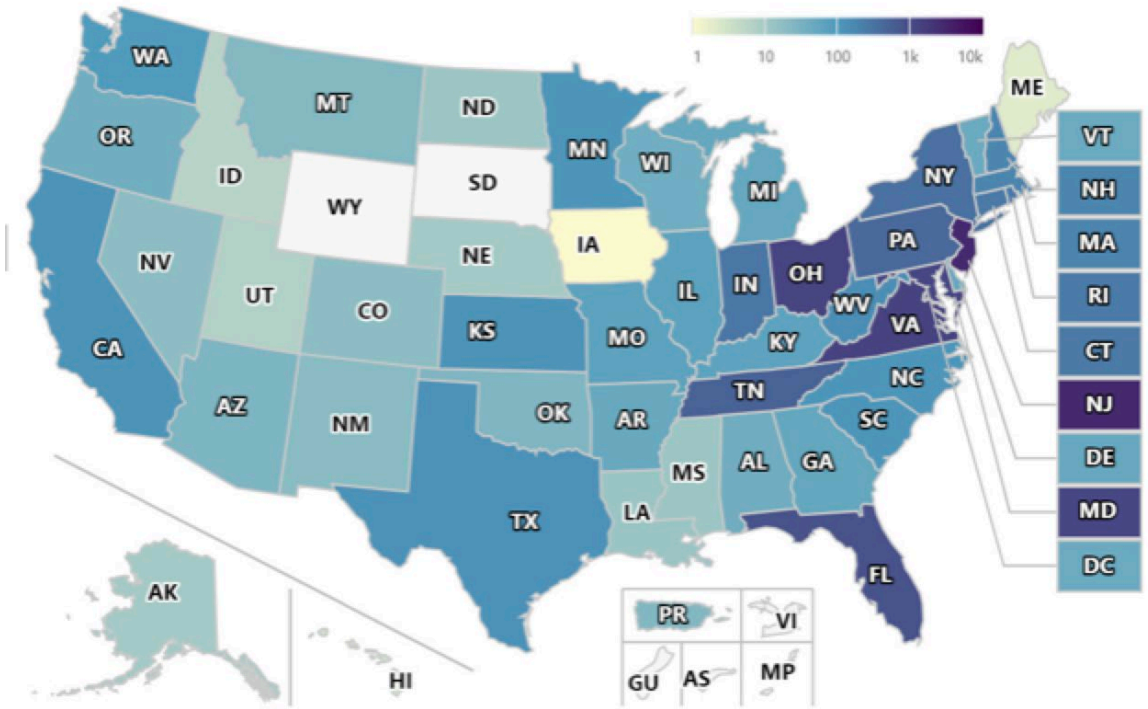
*XYLAZINE (**ZAI**·LUH·ZEEN) "TRANQ"*

- Officials say drug suppliers are lacing the fentanyl and heroin supply with the animal tranquilizer because it is cheap and easy to get
- Xylazine is an unscheduled veterinary drug that's easy to obtain, not illegal, and not subject to strict monitoring
- Causes fast-moving necrotic wounds, mostly on extremities and not necessarily at injection sites
- In 2019, Xylazine had been detected in the drug supply of all but 16 states, and at the end of 2022 it was in all but 3 states.
- Doctors also tell us Narcan won't work to revive a person heavily sedated on "Tranq." Still, they say it should be administered since it's the opioids that are linked to the overdoses
- Averhealth can test via LCMS.



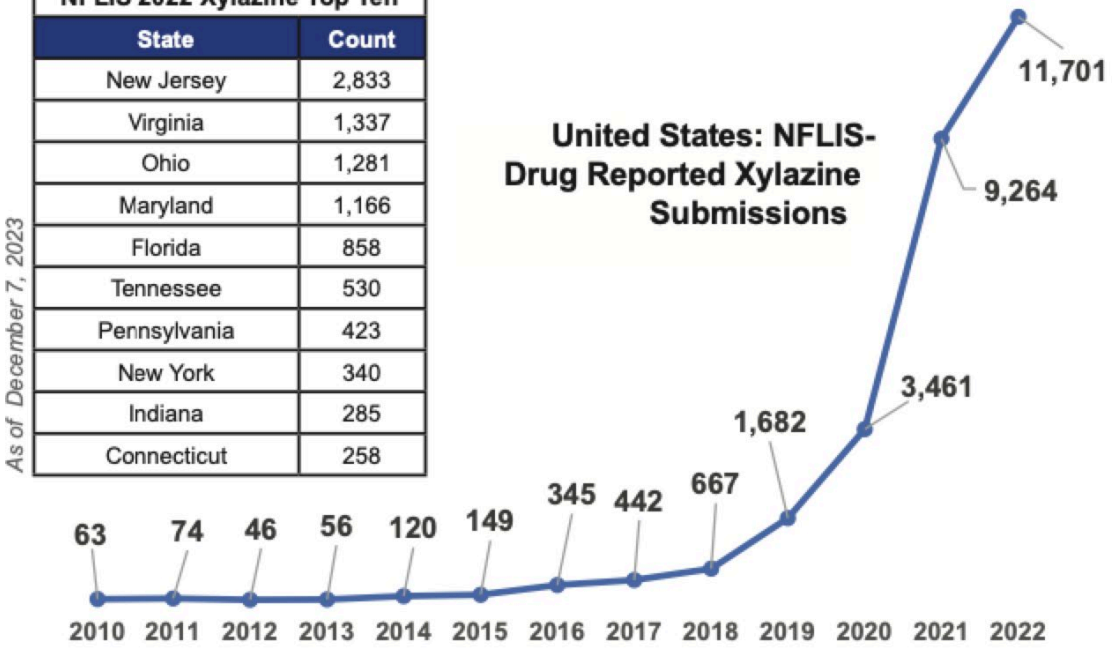
2019-2022 Overdose % by State as a total of all overdose numbers

Etonitazene, isotonitazine, clonitazene, and several additional nitazine analogs are Schedule 1 substances in the US.



NFLIS 2022 Xylazine Top Ten	
State	**Count**
New Jersey	2,833
Virginia	1,337
Ohio	1,281
Maryland	1,166
Florida	858
Tennessee	530
Pennsylvania	423
New York	340
Indiana	285
Connecticut	258

As of December 7, 2023



Source: DEA National Forensic Laboratory Information System (NFLIS-Drug)

ISO: A DEADLY NEW DRUG

- ISO is short for isotonitazine, a deadly synthetic opioid that is 100x to 1000x stronger than morphine and 20x more potent than fentanyl
- ISO was first identified around 2019 in the Midwest but has moved south and towards the eastern seaboard since its discovery
- ISO can present in powder, tablet or solution form and can be snorted, injected and inhaled by smoking or vaporizing
- Similarly to fentanyl, ISO is often mixed into other drugs like heroin or counterfeit Xanax pills, so users don’t know they’re ingesting it
- Narcan can counteract the effects of ISO, but because it is still so new, there is currently no established dosing protocol.
- Averhealth does not have a test, specialty labs only.

*GABAPENTIN (**GA**·BUH·PEN·TN) FUELS OVERDOSE EPIDEMIC*

- Gabapentin is quickly becoming one of the most abused substances in the United States
- Also known as Gaby or Gabby is commonly prescribed for seizures, Restless Leg Syndrome (RLS), and shingles or diabetic nerve pain as well as alcohol withdrawls, sleep disorders, and other medical conditions
- When used in combination with other drugs such as opioids or benzodiazepines, the pair increases the potency and creates a sense of a euphoric high
- Many legitimate drugs such as Gabapentin are being misused due to the perceived ease of access from prescribers

*TIANEPTINE (*TAI·UH·**NEP**·TEEN)

- Developed in the 1960's, with street use in the US since around 2000 due to its opioid-like effects.

- CDC has labeled it an "emerging public health risk"
- Brand names **Stablon**, **Tatinol**, and **Coaxil**

- Street names Zaza, Tianna Red, Neptunes Elixir, Gas station heroin (N.E. is made by Neptune Resources in KC)

- Anti-depressant with some studies showing other uses in asthma, and IBS.

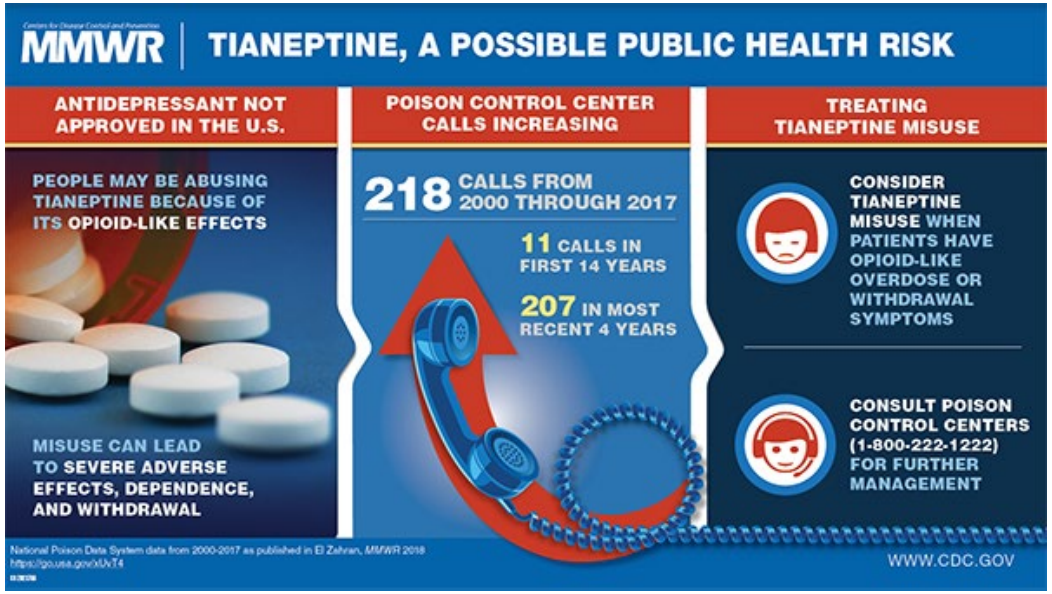
- Most deaths since 2018 involved ingestion of tianeptine with at least one other substance.

- Not a controlled substance yet in the US, but it is banned/schedule II drug in multiple states including AL, GA, FL, IN, KY, MI, MS, OH, & TN.

- Between June and Nov. 2023, there were 20 reported cases of tianeptine causing "severe clinical effects" in New Jersey, as noted in a Feb. 1 alert from the U.S. Centers for Disease Control and Prevention (CDC).

- Detectable in urine for about a day.

- Specialty labs have tests available, but very expensive.



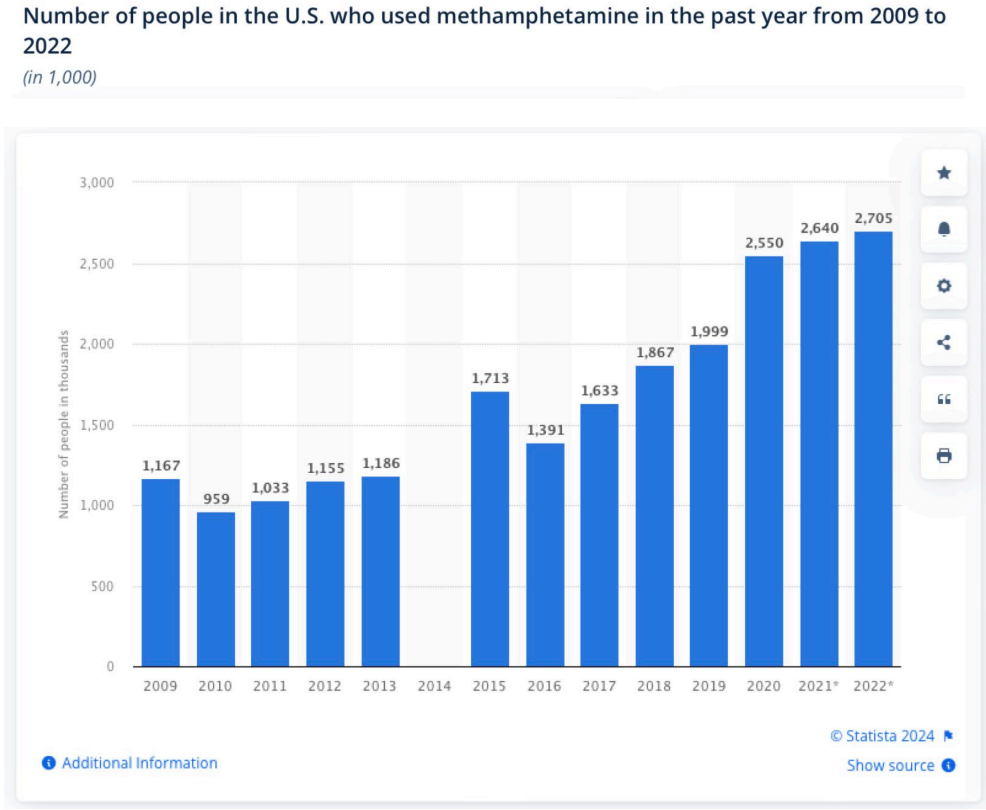
KETAMINE

- Developed in 1962 as an anesthetic for use in animals, approved by the FDA in 1970 for use in humans.
- It is a Schedule III substance under the controlled substance act.
- Being popularized by people like Elon Musk and Matthew Perry.
- Induces feelings of happiness, relaxation, and detachment. Can induce a state of sedation, immobility, relief from pain, and amnesia and is abused for the dissociative sensations and hallucinogenic effects.
- Ketamine has also been used to facilitate sexual assault due to its sedative affects and potential for memory loss.
- The risks associated with using Ketamine include bladder problems, incontinence, mental health problems and fatal overdose. An overdose can cause unconsciousness and dangerously slowed breathing.
- Street names: Cat Tranquilizer, Cat Valium, Jet K, Kit Kat, Purple, Special K, Special La Coke , Super Acid, Super K, Vitamin K
- Is attracting scientific attention as a potential treatment for depression, suicidal thoughts, and pain management.
  - In 2019, the FDA approved a nasal spray called esketamine (Brand name “Spravato”) that’s derived from ketamine for treatment-resistant depression, but only in certain people who also take oral antidepressants and only under strict controls in certified health care settings.
  - The FDA has warned that ketamine and compounded ketamine products aren’t approved to treat any psychiatric disorder. This means that they haven’t been proven to be safe or effective.
  - As of January 2024, there were between 500 and 750 ketamine clinics nationwide as it is legal for doctors to prescribe ketamine for “off label use”.
- Averhealth can screen and confirm.

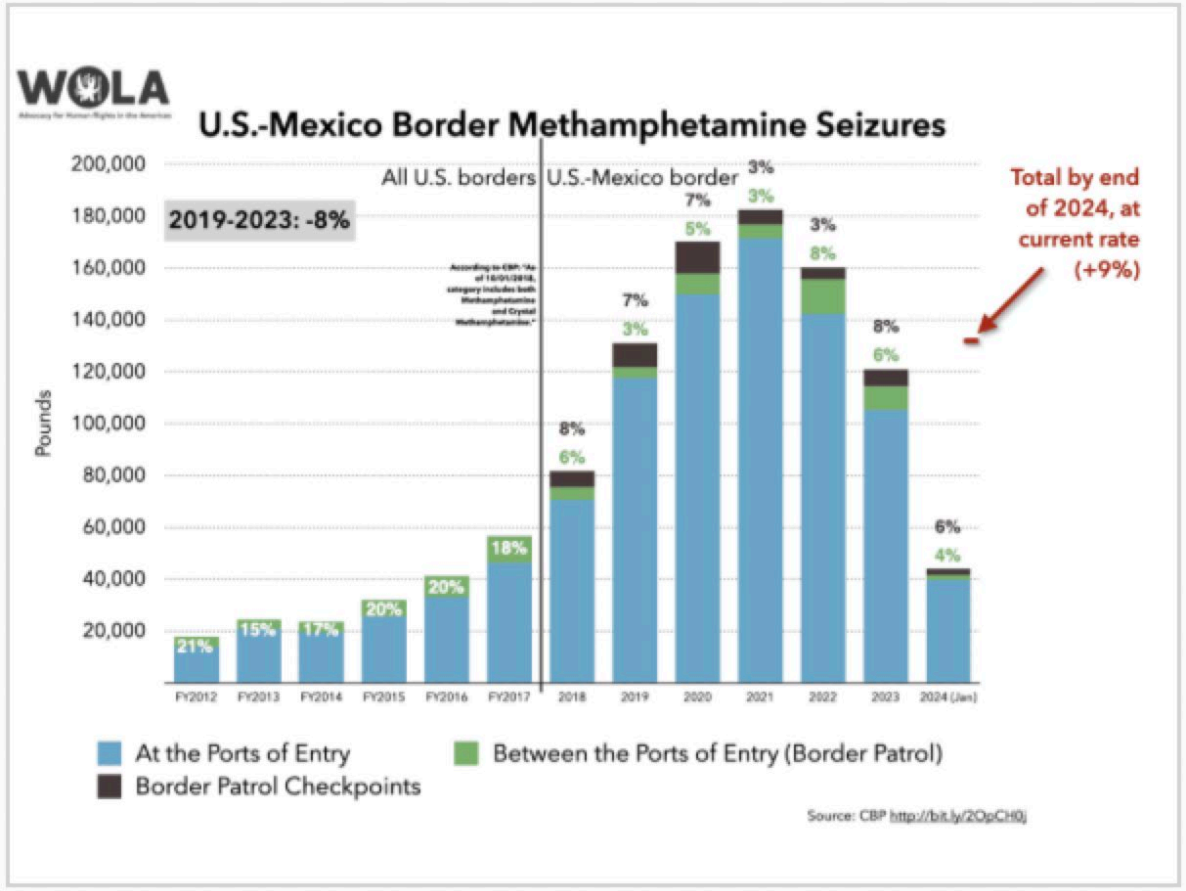
Methamphetamine

- According to the Substance Abuse and Mental Health Administration, **2.6 million Americans** reported using methamphetamines in the last year

- Number of people reporting methamphetamine use continues to rise every year primarily due to the ease of access and affordability.



- On May 7, 2022, the Office of National Drug Control Policy's (ONDCP) revised its plan to "address methamphetamine supply, use, and consequences."
- This 6-pronged plan will address the following: Supply Reduction and Trafficking, Data and Research, Prevention, Harm Reduction, Training and Education, and Treatment.
- There is a downward trend in methamphetamine siezures at the border that began in 2022, but there are worries about an increase in the trend for 2024.



Synthetic and Over-the-Counter Drugs

- Typically, pharmaceutical compounds not for sale in the US
  - Frequently sold in Europe or Asia and may be purchased over the internet
  - Black market rather than clandestine chemists – easier to identify

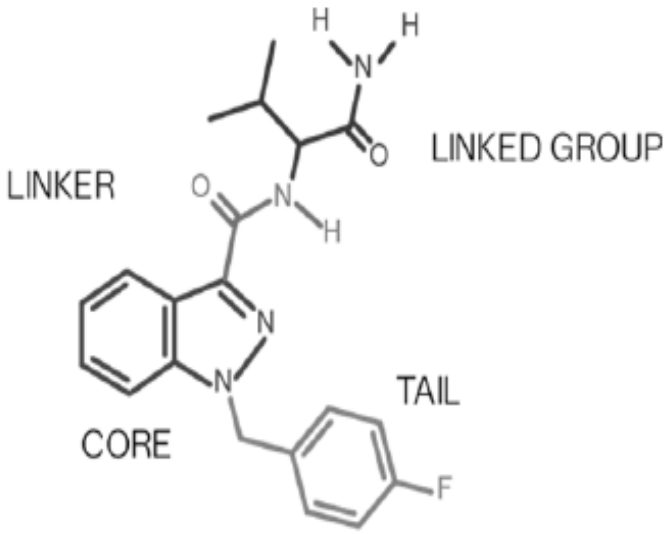
- Around since 2008, increasing in use since about 2015, although not as many as other synthetics:

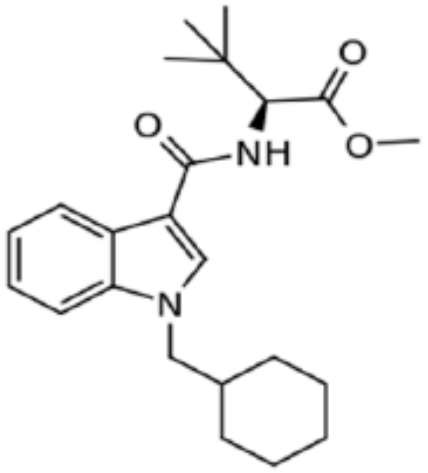
  - Bromazolam
  - Estizolam
  - Phenazepam
  - Halazepam
  - Meclonazepam

- Effects are similar to those of other benzodiazepines (Xanax, Valium, Ativan)

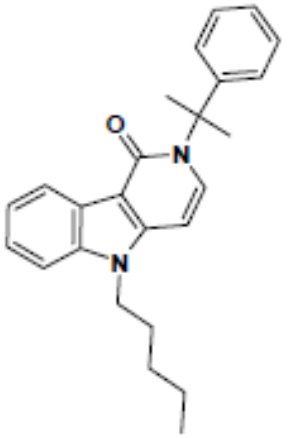
- Pharmacokinetic data typically available

- Since around 2000. First ones called “Spice” or “K2”
- Over 25 different chemical families known, based on chemical structures
- 400 compounds and counting





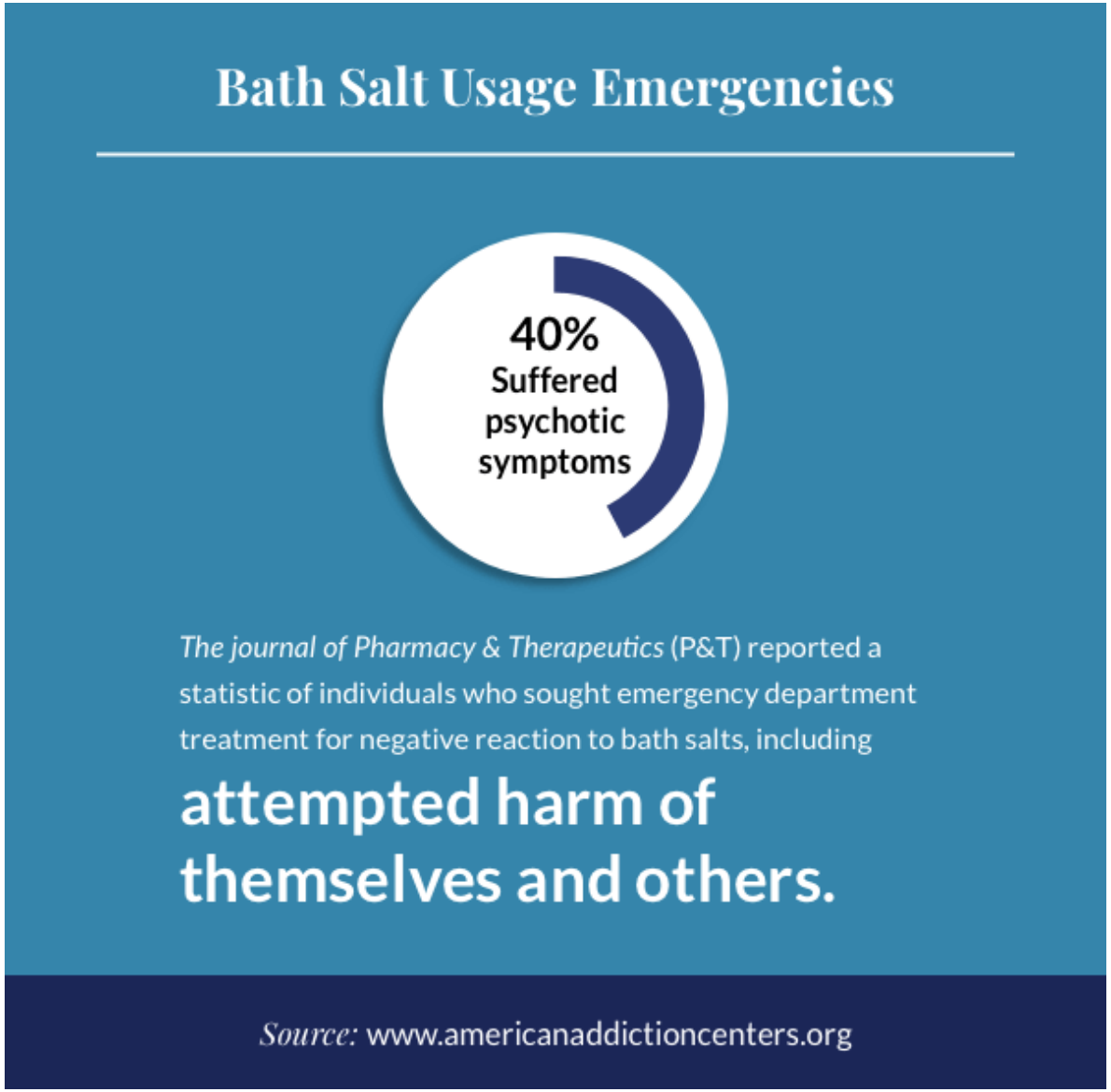
Cumyl-PEGACLONE



- Higher affinity for cannabinoid receptors than cannabis itself:
  - More potent
  - Longer-lasting
  - Prolonged effects

- Some effects cannabis-like, some more typical of stimulants or hallucinogens, including agitation, seizures, hypertension, violent behavior

- **Physical Effects:** extremely high blood pressure (stroke, cardiac arrests reported), dilated pupils, rapid heart rate, kidney failure


Bath Salt Usage Emergencies
40%
Suffered
psychotic
symptoms
The journal of Pharmacy & Therapeutics (P&T) reported a statistic of individuals who sought emergency department treatment for negative reaction to bath salts, including
attempted harm of themselves and others.
Source: www.americanaddictioncenters.org

- Sold as “bath salts”
- Increased use from around 2010
- Several chemical classes (phenethylamines, tryptamines, cathinones, piperazines)

  - Methylenedioxypyrovalerone (MDPV)
  - Flakka (alpha-PVP) – (“zombie drug”)
  - Methylone
  - Pentylone
  - Benzylpiperazine (BZP)
  - TFMPP
  - Mephedrone
  - 2-DPMP (Ivory Wave)
  - 3-methylmethcathinone (3MMC)
  - 4-methylethcathinone (4MEC)
  - Buphedrone
  - Ethylcathinone
  - Dimethyltryptamine (DMT)
  - Alphamethytryptamine (AMT)

- Meant to be **Methamphetamine** or **MDMA** (Ecstasy)–like

- **Stimulant Effects:**

  - Increased alertness
  - Euphoria
  - Agitations
  - Hallucinations
  - Tachycardia
  - Hyperthermia
  - Insomnia
  - Seizures/Tremors

Kratom

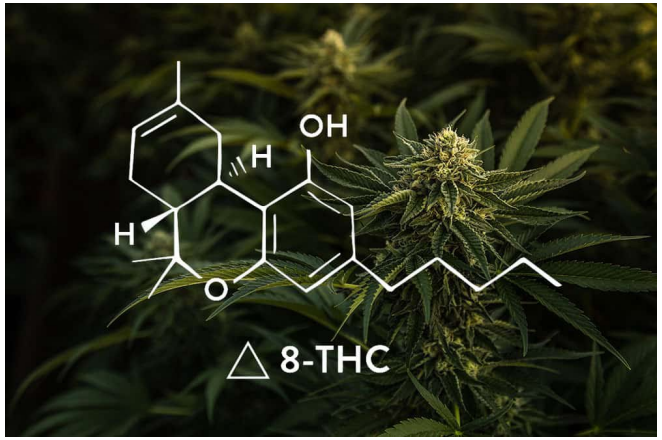
- Kratom, an opioid-like substance with stimulant effects derivative of a Southeast Asian plant, has become an increasingly popular drug in the US over the past two decades

- Kratom's popularity can largely be accredited to its **growing availability in specialty stores and digital markets**

- Often used with CBD

- In 2019, the FDA warned consumers of kratom's addictive properties. While most states lack kratom restrictions, **six states have banned the drug**, and seven more are presently pending restrictive legislation

- Primarily found in states where recreational marijuana is not legal
- Markets towards teens and young adults
- Often found in gas stations and smoke shops
- Found in liquid and vape form
- **Current variants**
  - **Delta 8** *(Averhealth has test)*
  - **Delta 10** *(Averhealth does not test for, very difficult to detect)*
  - **THC 0** *(Averhealth does not test for, specialty labs do)*
  - **HHC** *(Averhealth does not test for, specialty labs do)*



Psychoactive Drugs

A **psychoactive drug**, **psychopharmaceutical**, **psychoactive agent**, or **psychotropic drug**, is a chemical substance that changes functions of the nervous system and results in alterations in perception, mood, consciousness, cognition or behavior.

An assortment of psychoactive drugs, including both street drugs and medications:

- LSD
- Methylphenidate (Ritalin)
- MDMA (ecstasy)
- Peyote (mescaline)
- Psilocybin mushroom (Psilocybe cubensis)

- **8%** of young adults reported using hallucinogens (LSD, MDMA, “shrooms,” PCP, etc.) in the past year

- The **highest percentage ever reported since hallucinogens were first included in the survey in 1988**

- In 2022, 8% of young adults between the ages of 19 to 30 reported past year use of hallucinogens, significantly higher than five years ago (5% in 2017) and 10 years ago (3% in 2012). Types of hallucinogens reported by participants included LSD, MDMA, mescaline, peyote, shrooms or psilocybin, and PCP.

- Adults 35 to 50 doubled from 2% to 4% from 2021 to 2022.

- Suite of drugs used ever-changing
- Pharmacology of most designer drugs not well known
- Many testing challenges
- Laboratories need to continue to update testing panels to cover the synthetic drugs being manufactured in clandestine laboratories
- Make sure you have broad testing panel and rotating in many drugs into your testing panel
- As case managers, if drug testing is suspected based on behavior, test broadly and address behavior


Q&A

Dominique Delagnes
Chief Executive Officer
ddelagnes@averhealth.com

Thank You!

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FREEDOM · HOPE · BELONGING

REGENT UNIVERSITY
CENTER FOR GLOBAL JUSTICE

Virginia Supreme Court Specialty Dockets Training

Understanding the intersectionality of human trafficking and Virginia's Specialty Dockets

TODAY'S INSTRUCTORS

Meg Kelsey, J.D.

Assistant Director

Regent Law School Center for Global Justice

Lisa Kersey, M.H.A.

Executive Director

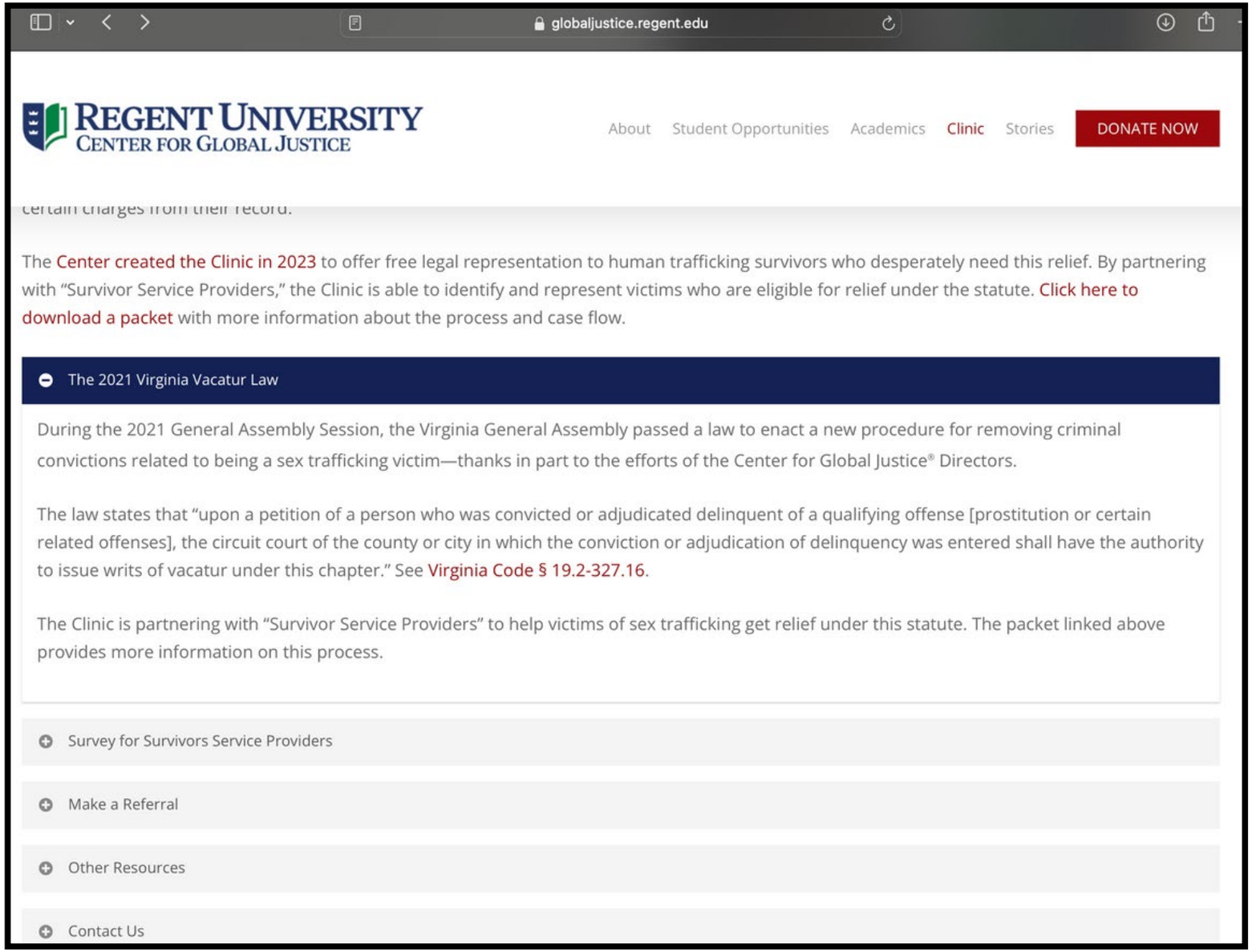
Freekind

REGENT UNIVERSITY
CENTER FOR GLOBAL JUSTICE

Mission

To equip legal advocates who will promote the rule of law and seek justice for the world's downtrodden—the poor, the oppressed, and the enslaved—and to serve and support those already engaged in such advocacy.

In 2023,
the Center for Global Justice launched a clinic to provide pro bono legal assistance to help survivors of human trafficking have their records expunged.



OUR MISSION

Freekind exists to prevent human trafficking in our communities and support survivors on their journey to freedom.

WHAT WE DO

AWARENESS

Speaking engagements and industry-specific training

PREVENTION

Prevention education curricula & programs for middle/ high schools and colleges

RESTORATION

Direct support for adult survivors of human trafficking.

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CREATING OFFRAMPS TO FREEDOM

FOR SURVIVORS OF HUMAN TRAFFFICKING

CRISIS

Jail Program
HelpLine
Victim Identification
Intake Assessment

STABILIZATION

Basic Needs
Restorative Programs
Court Advocacy
Re-entry Planning

TRANSITION

Housing support
Job support
Trauma therapy
Transitional Support

INDEPENDENCE

Permanent housing
Financial stability
Emotional well-being
Healthy relationships

If you don’t know to look for something, you’re never going to see it.

POP QUIZ!

SEX TRAFFICKING

COMMERCIAL SEXUAL EXPLOITATION

PROSTITUTION

WHAT IS HUMAN TRAFFICKING?

The trade of human beings for profit, using force, fraud, or coercion

for the purpose of exploiting them for sex, labor, or both

The A-M-P Model

ACTION

Sex & Labor

Recruiting

Harboring

Transporting

Providing

Obtaining

Sex

Patronizing (ST)

Soliciting (ST)

Advertising (ST)

MEANS

Force

Physical assault, sexual assault, confinement

Fraud

False promises re: work/living conditions, withholding wages

Coercion

Threats of harm, psychological manipulation, confiscation of documents, legal threats, debt bondage

PURPOSE/PROFIT

Sex

Pornography, sex acts, sexual intercourse, residential or commercial brothels

Labor

Domestic servitude, agriculture, begging rings, massage/nail salons, hotels, restaurants, dry cleaning & other service companies

Source: Adapted from model created by NHTRC

VIRGINIA CODE

§ 18.2-348. Aiding prostitution or illicit sexual intercourse, etc.

§ 18.2-355: Taking, detaining, etc., person for prostitution, etc., or consenting thereto; human trafficking.

§ 18.2-356. Receiving money for procuring person; penalties.

§ 18.2-357. Receiving money from earnings of male or female prostitute; penalties.

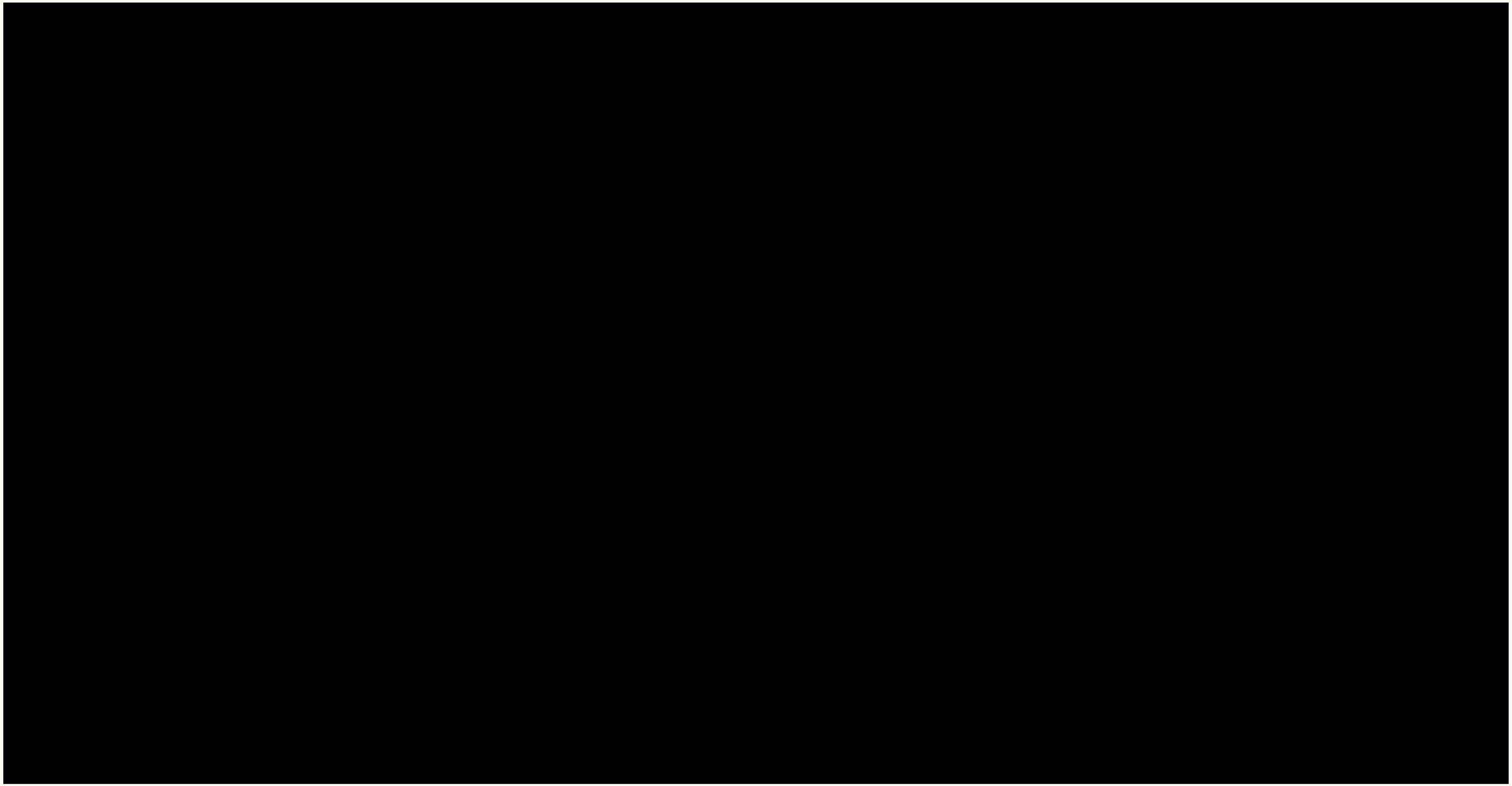
§ 18.2-47. Abduction and kidnapping defined; punishment.

§ 18.2-48. Abduction with intent to extort money or for immoral purpose.

§ 63.2-100. Definitions.
As used in this title, unless the context requires a different meaning:
"Abused or neglected child" means any child less than 18 years of age:

7. Who has been identified as a victim of sex trafficking or severe forms of trafficking as defined in the Trafficking Victim s Protection Act of 2000, 22 U.S.C. § 7102 et seq., and Justice for Victims of Trafficking Act of 2015, 42 U.S.C. § 5101 et seq.

THERE IS NO SUCH THING AS A CHILD PROSTITUTE



Source: Office for Victims of Crime, U.S. Dept of Justice

EXPLOITATION OF VULNERABILITY

Intersections of Human Trafficking

Mental Health

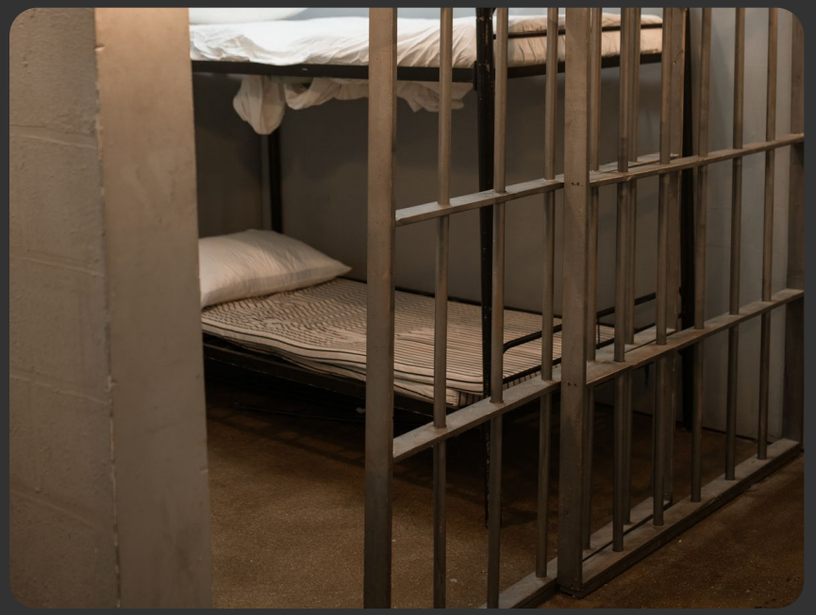
The U.S. National Human Trafficking Hotline Report lists mental health concerns as one of the top five risk factors for human trafficking.

Substance Abuse

According to the State Department, successfully prosecuted cases have proven that the role of substance use disorder in human trafficking is powerful and pervasive.

Veterans

There is a higher prevalence of known risk factors among the veteran population, including homelessness, addiction, suicidal ideation, history of witnessing violence, and difficulty finding work.



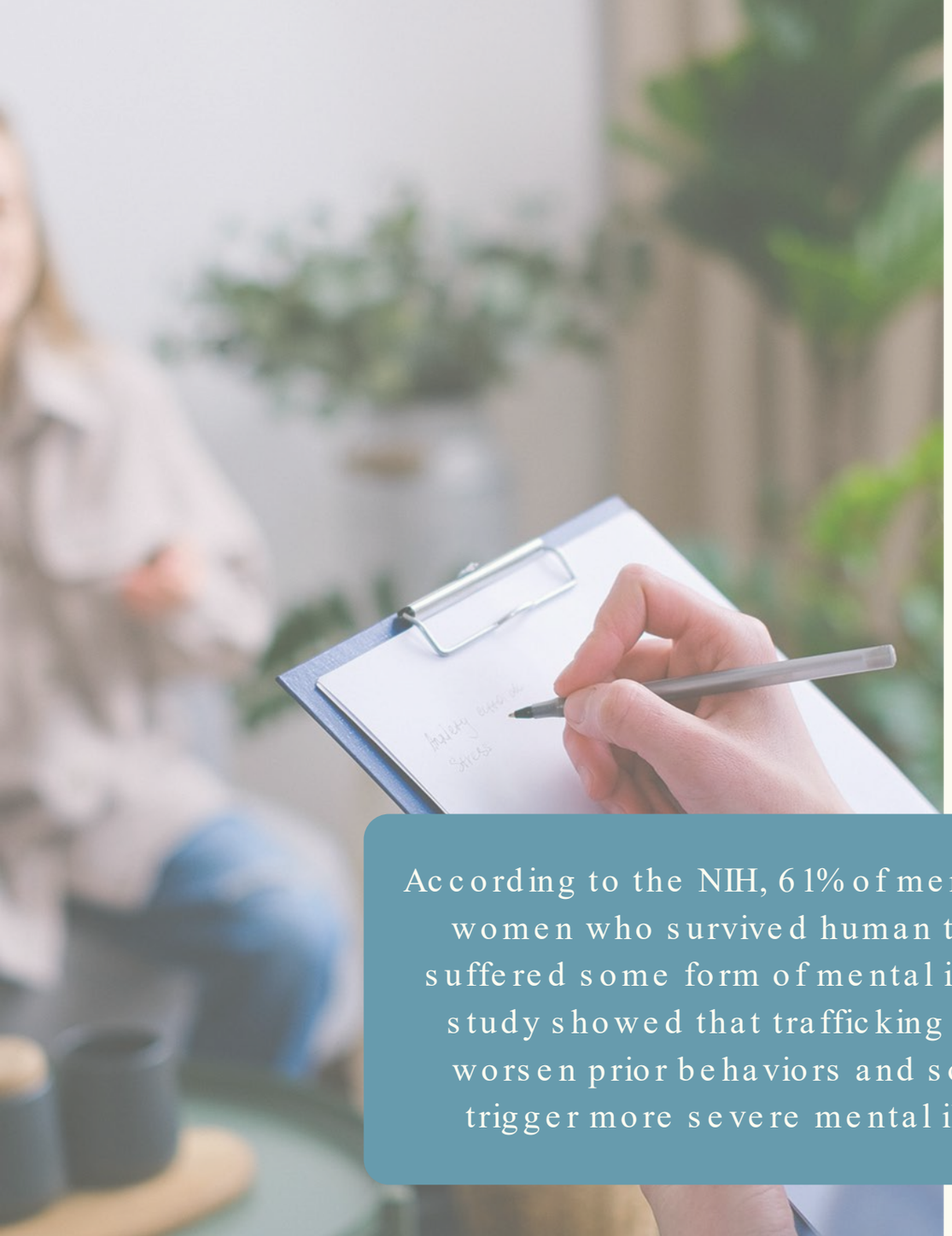
Poor Mental Health as a Risk Factor for Trafficking

Mental health disorders may:

- Limit a person's ability to consent
- Limit a person's ability to assess risk
- Cause some to be more isolated than others, making them more vulnerable to predators
- Increase dependence on others, making them easier to exploit

Mental health factors that contribute to risk:

- Suicidal ideation/attempts
- History of sexual assault/abuse, including DV
- History of emotional and/or physical abuse
- History of neglect, abandonment



According to the NIH, 61% of men and 67% of women who survived human trafficking suffered some form of mental illness. This study showed that trafficking tended to worsen prior behaviors and sometimes trigger more severe mental illnesses.

Poor Mental Health as a Consequence of Trafficking

Common diagnoses among survivors:

- PTSD/CPTSD
- Extreme Anxiety, including paranoia
- Severe Depression, including bipolar
- Dissociative Identity Disorder (DID)
- Psychosis & other SMIs

How survivors may present:

- High level of agitation
- Strong feelings of guilt and shame
- Anger, inability to control emotion
- Flat affect
- Memory loss, inability to recall details, confusion with chronology of events
- Inability to activate executive brain function

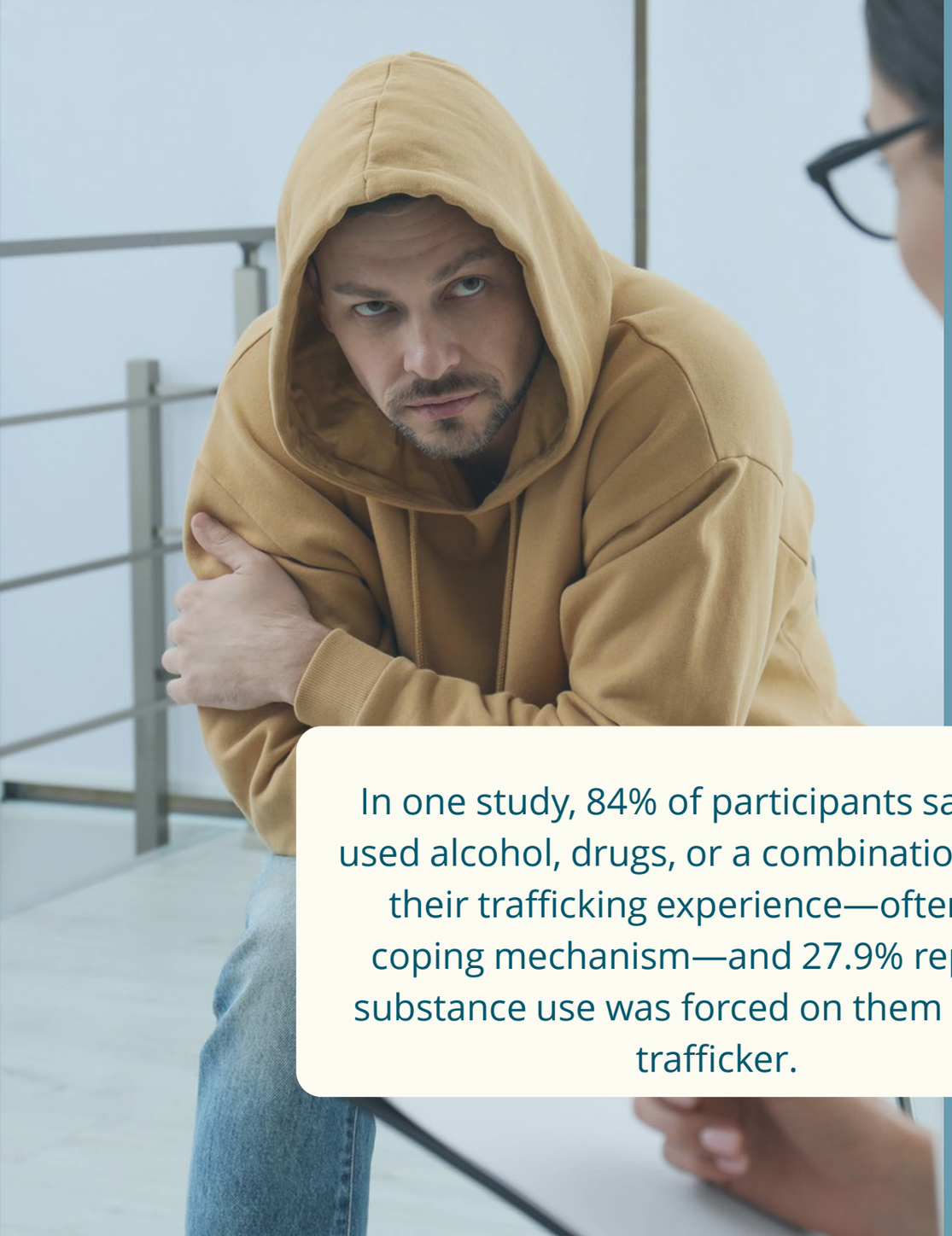
Substance Use as a Risk Factor for Trafficking

- Traffickers often target those already using/buying drugs
- Many people with drug addictions have a history of physical, mental or emotional abuse
- Others become addicted as a result of an illness or injury (e.g. opioid addiction)
- And still others become addicted due to trauma, such as the death of a loved one, high stress work environments, divorce, loss of a child, etc.

*It is important to note that among people with substance use disorders, there are high rates of co-occurring mental illness.

"Exploiting victims' drug dependency and addiction is the most common form of human trafficking we are seeing here in Virginia, and I am grateful to the I-81 Human Trafficking Task Force and the Virginia State Police for bringing this case to justice and providing some relief to these victims."

-Christopher Kavanaugh
U.S. Attorney, Western District of Virginia
(November 2023)



Addiction as a Consequence of Trafficking

- **Control through substance use:** Traffickers often cause substance addiction & use the threat of withdrawal to control victims. It can also be used to decrease the victim's ability to flee.

- **Substance abuse as a coping mechanism:** Some victims of human trafficking may use/abuse substances as a response to their trauma, as a temporary reprieve from the physical & emotional pain, or to help them disassociate to comply with the demands of their trafficker.

In one study, 84% of participants said they used alcohol, drugs, or a combination during their trafficking experience—often as a coping mechanism—and 27.9% reported substance use was forced on them by their trafficker.

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One Survivor's Journey

TO A PLACE OF FREEDOM, HOPE & BELONGING

Veteran status as a Risk Factor for Trafficking

- Prevalence of substance use disorder
- PTSD and other mental health issues
- Prevalence of disabilities
- History of sexual assault, either witnessed or experienced
- Prevalence of homelessness or housing instability
- Difficulty re-integrating into the community, post-service (a sense of belonging, steady employment)
- Gambling or credit card debt

"In 2020, the Veteran's Administration assembled a team to investigate the issue and found that 36% of VA staff had encountered a Veteran who was a victim of human trafficking.

After training, 38% of that staff were able to recognize a past missed opportunity to further assess if a Veteran was being trafficked."

Source: VHA Homeless Programs Office

Key insights for criminal law professionals.

WHAT WE'VE LEARNED

- Most victims do not self-identify as "trafficking victims" -they will, however, answer questions in ways that may indicate they are.
- Criminal charges are only part of the story. Human trafficking is rarely as straight-forward as a history of prostitution offenses.
- Don't underestimate the impact of trauma. It has a complex & profound affect on the body & the brain.
- They frequently have a strong trauma-coerced attachment to their trafficker.
- Anyone can be trafficked, so don't assume it only happens to women and girls.

SO WHERE DO WE GO FROM HERE?

Our shared understanding:

- Survivors of human trafficking are going unidentified and misidentified at multiple points in our criminal justice system.
- Human trafficking has clear and documented intersections with all three specialty dockets in Virginia.
- The criminal records of some trafficking victims can be vacated or expunged under current Virginia law, removing barriers to survivors accessing good jobs and safe, affordable housing.

Our shared goals:

- Reduce harm to trafficking survivors
- Reduce recidivism and incarceration rates
- Decrease associated costs and burden on the criminal justice system
- Increase strength of cases against traffickers

WHAT WE'RE RECOMMENDING

Increasing awareness for all criminal justice professionals and adapting screening procedures to better identify human trafficking victims, so they can:

- Access trauma-responsive restorative care
- Benefit from existing expungement laws, which will remove barriers to jobs and housing
- Empower survivors to consider testifying against their traffickers

WE'RE HERE FOR YOU!

- On site, local training with your entire team to equip with best practices for screening
- Internet accessible resource list for referrals
- Client Referrals:

Contact Freekind to:

-Conduct a thorough screening/intake

-Facilitate access to restorative programs

-Provide transitional support & case mgmt.

Freekind HelpLine: 757-656-1015

Contact Regent's Justice Clinic to

-Review client eligibility for expungement

-Represent eligible clients & assist them with the process

Global Justice Clinic: 757.352.4660

Contact Details

Meg Kelsey

Regent University School of Law
Center for Global Justice Clinic

Website: globaljustice.regent.edu
Clinic Phone: 757.352.4660

Meg's Cell: 757.650.5178
Meg's Email: mkelsey@regent.edu

Lisa Kersey

Freekind

Website: www.freekindva.org
HelpLine: 757-656-1015

Lisa's Cell: 757-651-4380
Lisa's Email: LKersey@freekindva.org

TRAUMA-RESPONSIVE TREATMENT COURT ROLES AND BOUNDARIES*

*Plus a quick peek at the upcoming national Trauma-Responsive Court Best Practice Standards

Brian L. Meyer, Ph.D.
Psychology Program Manager
Central Virginia VA Health Care System
Richmond, VA

August 13, 2024

DISCLAIMER

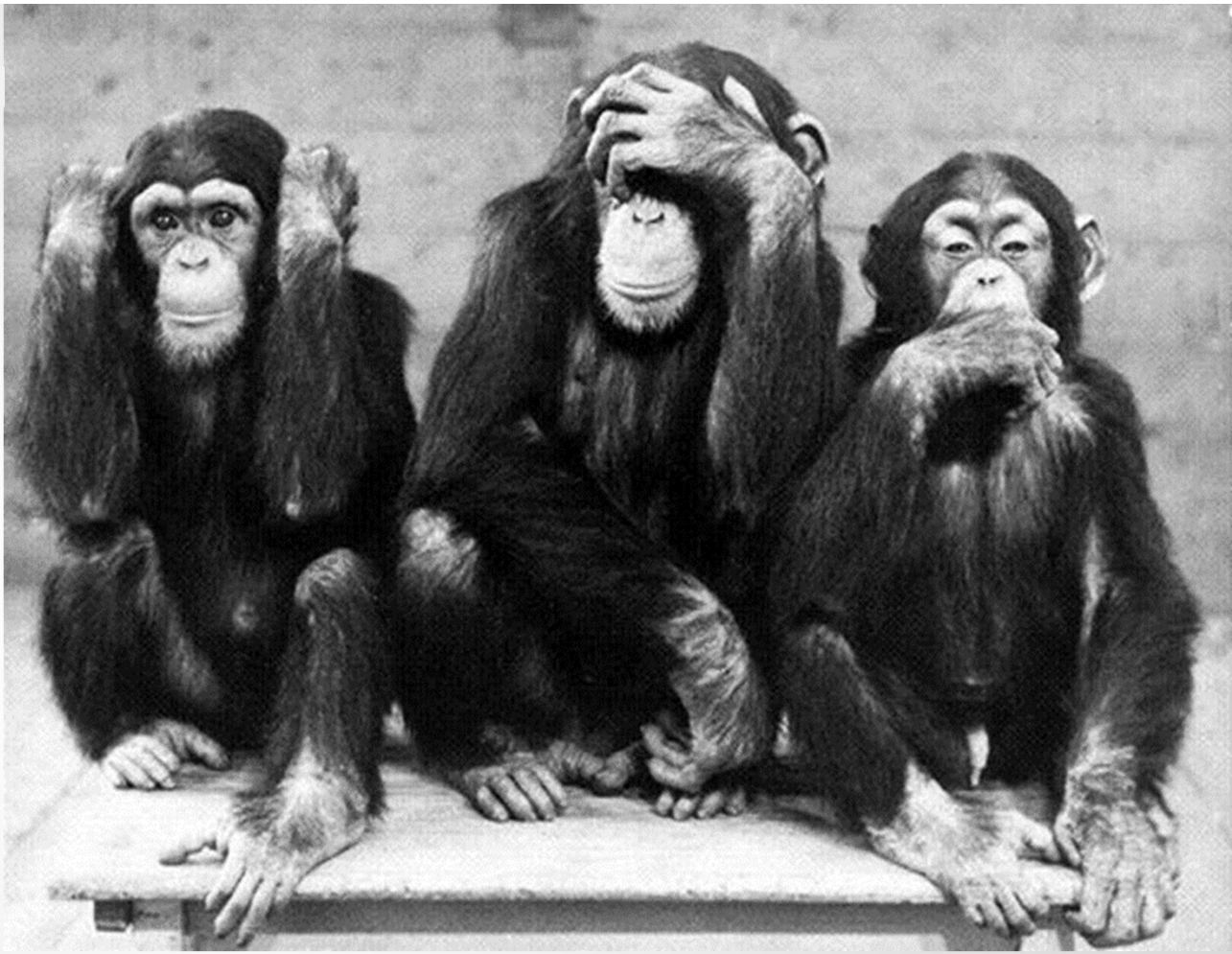
- The opinions expressed during this presentation are those of the presenters, and do not represent the opinions of SAMHSA, the Veterans Administration, or the government of the United States.

ACKNOWLEDGEMENT

- This presentation includes information about trauma-responsive roles for attorneys and probation officers that was developed by Helen Harberts, J.D. It would be much poorer without her contributions.

COPYRIGHT NOTICE

The Way We Were



Hear no Trauma

See no Trauma

Speak no Trauma

CONTINUUM OF TREATMENT COURT TRAUMA RESPONSIVITY

A recent pilot study of trauma-informed judicial education noted that judges felt confidence in their knowledge of trauma afterwards, but uncertainty about what to do with that knowledge (McKinsey et al., 2022)

NOW THAT YOUR COURT IS TRAUMA-INFORMED, WHAT DO YOU ACTUALLY DO?

TRAUMA-RESPONSIVE BOUNDARIES

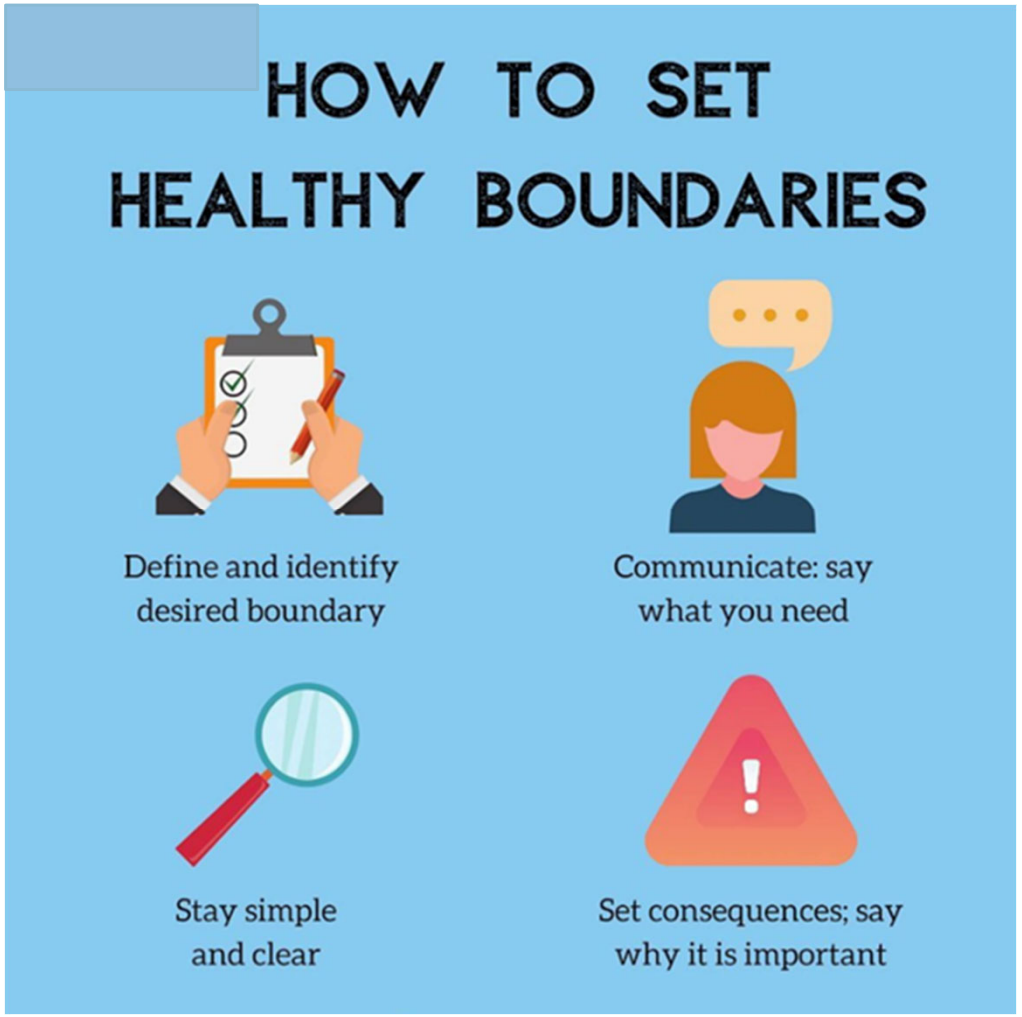
PROBLEM: TRAUMA-RELATED BOUNDARY VIOLATIONS

- Setting up "special" relationships with participants
- Asking others to overshare
- Oversharing about yourself
- Interrupting and/or talking over others when they are speaking
- Not speaking up when others talk over you
- Feeling guilty saying "no"
- Trying to dominate other people
- Allowing other people to dominate you
- Avoiding confrontation
- Feeling guilty taking time for yourself
- Taking responsibility for others
- Subgroups within the treatment team

GUIDELINE: MAINTAIN PROFESSIONAL BOUNDARIES

- Don't share your personal life inside or outside of court
- The traumatic experiences they've had are boundary violations
  - In the course of treatment, they are learning to set boundaries, likely for the first time
  - They don't know how to modulate boundaries based on the setting
- Professional respect declines as personal intimacy increases
- This includes after they graduate
  - No "friending" on social media
  - What happens if they relapse and need to come back?
- Boundaries can't be put back in place
  - They may expect you to treat them differently
  - You can also become split off and treat them differently
- Do not risk harming them again

SETTING HEALTHY BOUNDARIES



GUIDELINE: *NEVER* ASK FOR OR ALLOW THE PARTICIPANT TO SHARE DETAILS OF THEIR TRAUMA IN COURT

1. It violates their boundaries
2. It shames them
3. It can retraumatize them
4. It can trigger other participants
5. It can trigger other members of the treatment team
6. When we prevent the sharing of traumatic details, we decrease secondary traumatization, triggering, compassion fatigue, and burnout.

GUIDELINE: STAY IN YOUR LANE

- In treatment courts, role boundaries blur
- In treatment courts, everyone wants to be a therapist
  - This is a big problem
- Don't tell others how to do their jobs
- Don't try to do the jobs of others

GUIDELINE: RECOGNIZE COMMON BEHAVIORS OF TRAUMATIZED PEOPLE

Fight

- Angry
- Distrustful
- Defiant
- Disrespectful
- Provocative
- Hostile
- Explosive

Flight

- Anxious
- Avoidant
- Panicked
- Delays
- Discomfort with crowds

Freeze

- Frozen
- Unresponsive
- Unable to move
- Dissociates
- Numb

- All of these are due to their neurobiology

GUIDELINE: RESPOND, DON'T REACT, TO COMMON BEHAVIORS OF TRAUMATIZED PEOPLE

Fight

- Take a few minutes outside the courtroom with a team member
- Take some deep breaths
- Meditate

Flight

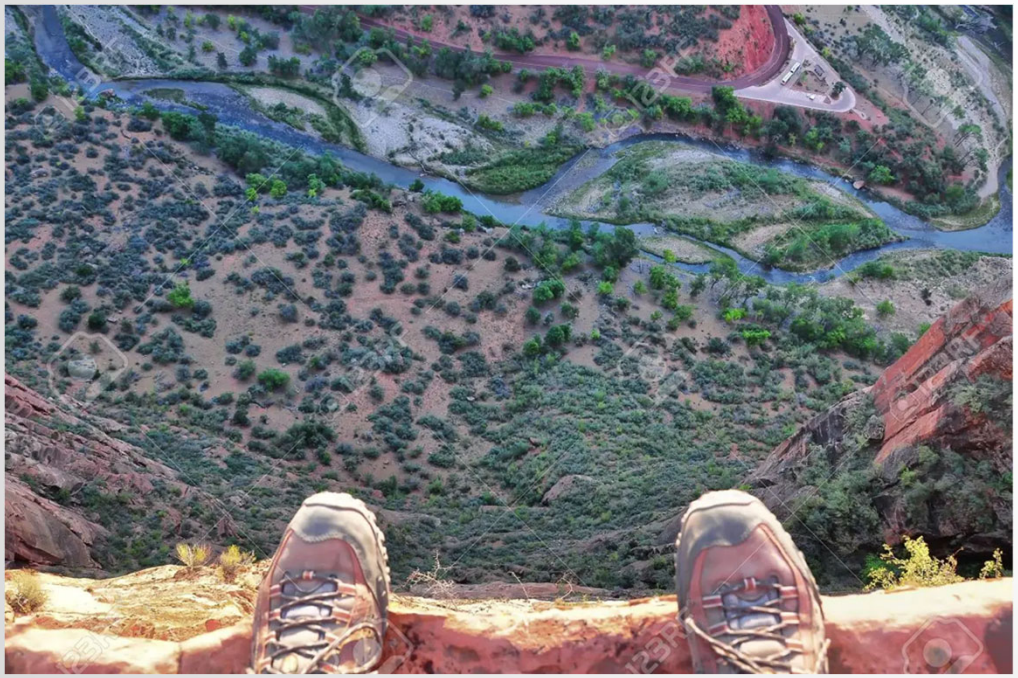
- Take some deep breaths
- Coloring
- Meditate

Freeze

- Grounding
- Squeeze a stress ball
- Chew gum or suck on piece of candy

- Help them understand that their reactions may cause others to react negatively to them

HOW TO RESPOND

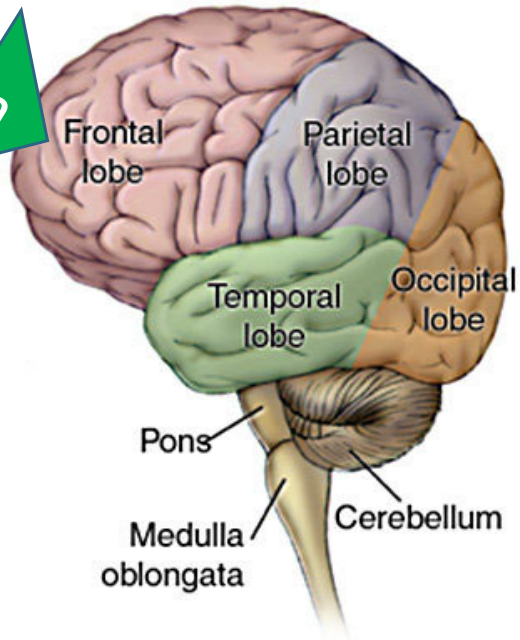


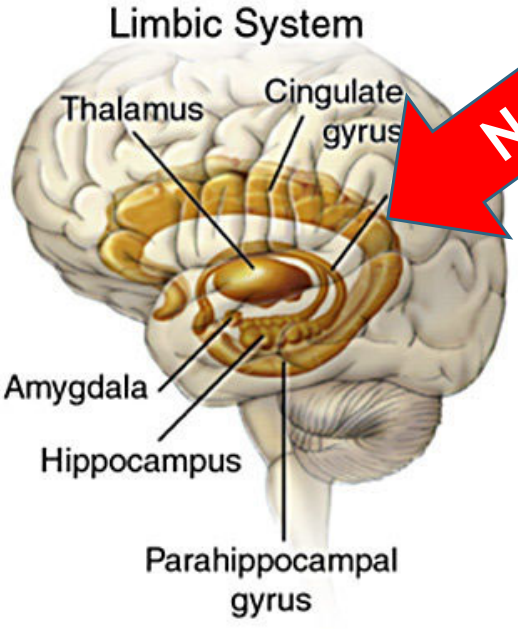
1. Take a mental step back
2. Take a deep breath
3. Think for a moment
4. Give a thoughtful, reasonable response

USE THE RIGHT PART OF THE BRAIN TO DECIDE!

Yes! Reason, information

NO! Step back!

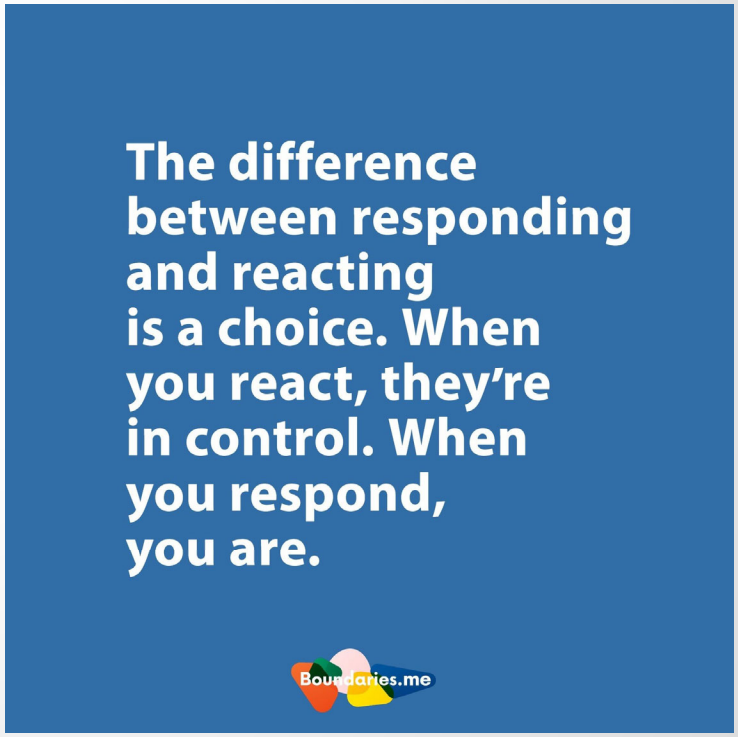




Slide by Helen Harberts, MA, JD

RESPOND, DON'T REACT

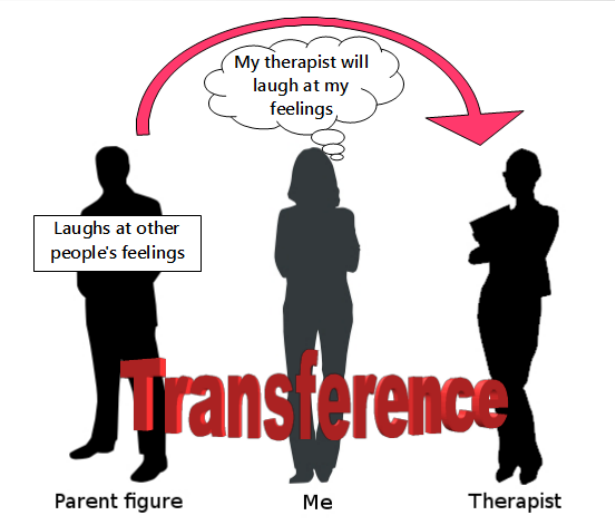
- To hostility with calm and compassion
- To avoidance with invitation and reaching out
- To fear with gentleness
- In other words, *respond with the opposite of what is expected*



GUIDELINE: RECOGNIZE THE TRANSFERENCES OF PARTICIPANTS

Transferences

- People who have been traumatized are likely to have negative experiences of authority
  - Therefore, their most common transferences are negative authority transferences
  - The judge is the most likely member of the team to receive this, but so are prosecuting attorneys
  - Recipients of negative transferences may act against them



- The team needs to discuss how they are being treated by each participant
- Team members are like good parents: they back each other up

GUIDELINE: NO SPLITTING

Recognize

- Splitting occurs when a participant treats one or more people on the team as all good, and one or more as all bad
- Children do this with their parents to get what they want
- It is common in patients with Cluster B personality traits, especially borderline and narcissistic, who try to split the treatment team

Respond

- Label the attempt to split
- Discuss its purpose
- Try not to take it personally (good or bad)
- The person(s) who is/are split off as "good" must support those who are split off as "bad" in front of the participant
- The team must be unified before giving feedback to the participant
- Note that it can be helpful to take advantage of positive relationships that are not pathological

We are the professionals. It is *our* responsibility and our job to practice, model, and teach clear and healthy boundaries.

TRAUMA-RESPONSIVE ROLES ON THE COURT TEAM

THE TRAUMA-RESPONSIVE JUDGE

- Does not use fear to control the courtroom or get someone to feel personally responsible
- Schedules dockets to avoid exposing court participants to unnecessary wait times and traumatic testimony, and avoiding some types of trials before and after treatment court (e.g., murder trials) (McKinsey et al., 2022)
- Creates an environment that is calming, supportive, and not re-traumatizing (McKinsey et al., 2022)
- Watches for signs of trauma in participants and responds accordingly (e.g., sees an agitated participant and has their case heard early)

THE TRAUMA-RESPONSIVE JUDGE

- Steps down from the bench and meets at the same level with everyone
- Takes off their robe when possible
- Maintains transparency and predictability to build trust
- Gives time outs and has the participant return after a cooling off period
- Uses outbursts as teachable moments

THE TRAUMA-RESPONSIVE PROSECUTOR

Prosecution

- Your badge is big and scary
- Your threats and tough talk don't help
- Your smile, and support DOES help
- Your constant message of hope and help is magic
- Engage and instill hope, use your power sparingly and to clear barriers

Slide by Helen Harberts, MA, JD

TRAUMA-RESPONSIVE DEFENSE COUNSEL

Defense

- Be clear and repeat often
- Listen, and share what you can about your client's fears, needs.
- Stop with the legalese and start with easy language….and listen, even when it is not "the point"- it is to them.
- Stay near if they need it, and support.
- Prepare them for "surprises". Caution the team NOT to surprise.

Slide by Helen Harberts, MA, JD

ENGAGE: COURT GREETING BY BOTH COUNSEL

Good Morning! My name is Helen. I'm the prosecutor assigned to this court by the District Attorney. Some of you know me from other courtrooms. (smile) This guy standing next to me is Steve. He is the defense attorney who is assigned here. If you have not met him, you will. He is AMAZING. Like everyone else here: he will help you.

This Courtroom is different than many others. This Court has a team of people and a Judge who have had intensive and specialized training regarding treatment courts and are here to help you succeed. Treatment, probation, the Court staff, the lawyers and the Judge…..all here to help you. If you want to stop using drugs, and to have a different life, THIS IS THE PLACE!

We still have to do some "court stuff" and say "lawyer stuff" now and then, but everything else about this Court is different. The most important thing for you to do is "show up". If you are still using: show up. If you are scared: show up. If you are angry or frustrated: show up. We all know how hard this thing is…but we need you to show up. If you goof: we will help you. But you need to show up.

So: what's the most important thing? SHOW UP. Everything else follows that. Some weeks Steve and I will chat with you about common issues that come up, but today…welcome to our Treatment Court. It's just awesome.

Slide by Helen Harberts, MA, JD

DE-TRAUMATIZE YOUR COURTROOM AND PROCESS

Snarl less, smile more, sell recovery

- Move to gender specific sessions
- Move to seated sessions at tables if you can, so it is less intimidating for trauma survivors
- Nothing sudden
- Place participant in a protected and perceived safe location with “friends” nearby.
- All counsel: court is plenty intimidating….make it less so while still covering your record.

Slide by Helen Harberts, MA, JD

LOOK AT EVERYTHING YOU DO WITH THE END GOAL IN MIND

- I rarely used my field badge as a prosecutor-only at a couple of crime scenes where the officers didn't know me automatically, but I commonly wore it to treatment courts. And I did that with a specific goal in mind. I wanted them to learn that "the badge" is there to help them too. It is a crucial life skill, and I wanted participants not to fear us, but to come to us.
- I used placebo, and engagement. I sold the Court just like I did a set of facts to a jury. Different audience, but same goal. Use your trial skills for engagement. And your smile.

Slide by Helen Harberts, MA, JD

THE TRAUMA-RESPONSIVE TREATMENT PROVIDER

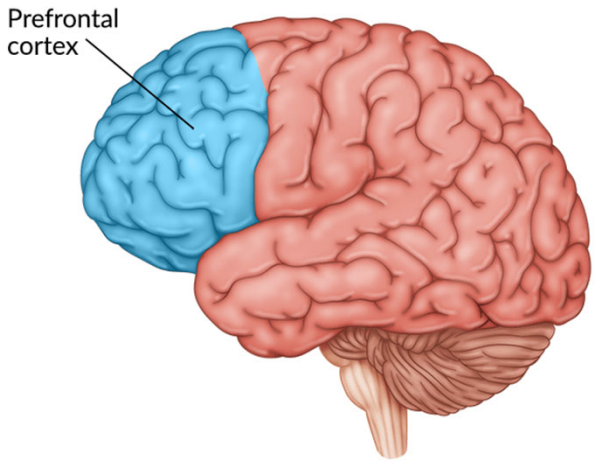
- Understands that the treatment court is a therapeutic entity
- Understands that treatment is the key to reducing recidivism
- Helps explain the role of trauma in the participant's behavior
- Explains the function of lying in trauma and substance abuse
- Explains to everyone the complicated relationship between trauma and substance abuse
- Alerts the court team to unaddressed problems such as Complex PTSD and Race-Based Trauma and Stress

THE TRAUMA-RESPONSIVE TREATMENT PROVIDER

- Pays attention to who is having difficulty each day and recommends adjustments (e.g., allowing agitated participants to go first)
- Calls attention to participant splitting, explains its function, and helps team members present a united front to the participant
- Always asks if all options have been exhausted prior to decisions on jail sanctions and program eviction
- Attends to the potential secondary traumatization of team members
- Encourages team members not to take participant behaviors personally

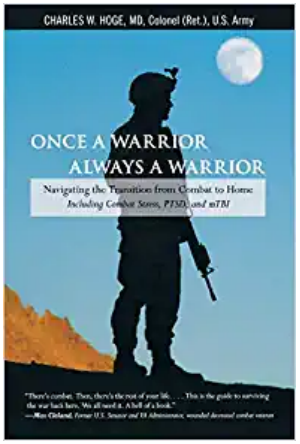
THE TRAUMA-RESPONSIVE TREATMENT PROVIDER RECOMMENDS TRAUMA-INFORMED INTERVENTIONS SUCH AS:

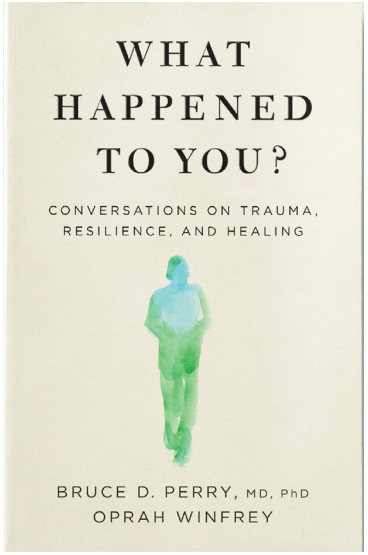
- Having the participant replay the incident/relapse by noticing the trigger, paying attention to their motivations, noticing the consequences, and generating alternative behaviors
- Engage in problem-solving exercises
- Homework that reactivates the prefrontal cortex



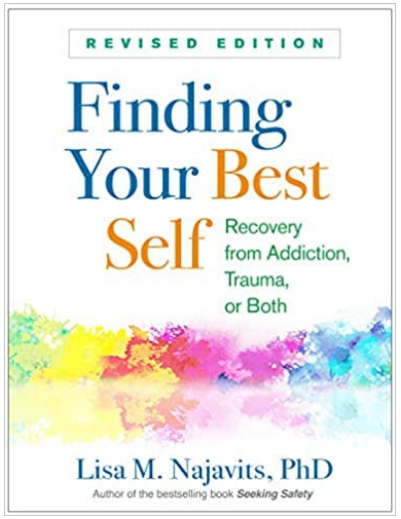
THE TRAUMA-RESPONSIVE TREATMENT PROVIDER RECOMMENDS TRAUMA-INFORMED INTERVENTIONS SUCH AS:

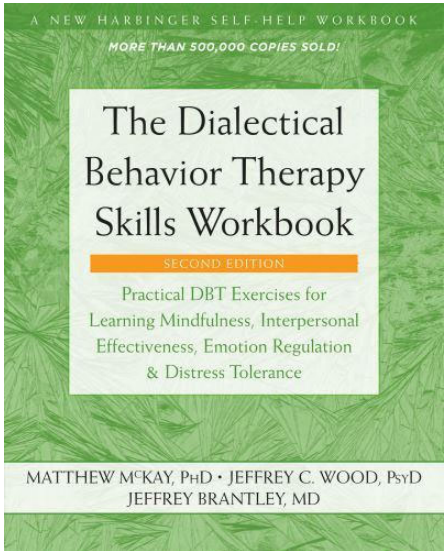
- Using bibliotherapy





- Using workbooks





TRAUMA-RESPONSIVE PROBATION SERVICES: ALTER YOUR APPROACH

- What happened to you? Tell me your story. **Versus: what's wrong with you?**
- Risk-Needs-Responsivity uses strength-based research and this builds into that practice. **Work with protective factors and enhance them.**
- This is not a specific intervention: **it is a way of doing business that improves outcomes.** It is a process of critical thinking specific to each case (Drisko, Grady, & Levinson, 2017)

Slide by Helen Harberts, MA, JD

HOW TO CONDUCT TRAUMA-RESPONSIVE PROBATION SERVICES

- Make the environment feel safe for participants during office and field visits (and you)
- Explain, explain, explain before doing anything when you can, including urine testing.
- Policy and plans in writing for subsequent review after panic subsides
- Recall the mind, in a panic, doesn't recall everything perfectly…or at all.
- Case planning always includes probationer input and helps them control part of their plan.

Slide by Helen Harberts, MA, JD

HOW TO CONDUCT TRAUMA-RESPONSIVE PROBATION SERVICES

- Start with a smile and reassurance.
- Focus on trust and safety. Always focus on dignity, respect and clear communication.
- Use Motivational Interviewing and focus on strengths.
- LOOK for ways to make things less threatening and traumatizing.
- Concurrent treatment and responses that are trauma-focused while addressing co-morbid disorders.

Slide by Helen Harberts, MA, JD

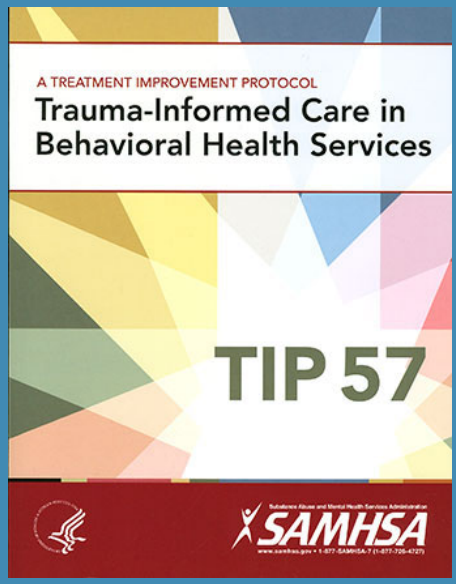
WHY PROVIDE TRAUMA-RESPONSIVE PROBATION SERVICES?

- It is easy to misread behaviors as resistance, or self-destructive (and they may be) but you need to understand that they may also be coping mechanisms to deal with trauma.
- Persons who are suffering from various forms of trauma may react differently that you expect because they need to control situations. Thus, they may trigger an incident, just to control when it happens. If you can avoid that situation via skills, you may avoid having an incident or violation all together and build more coping skills.

Slide by Helen Harberts, MA, JD

- Download and read Tip 57 from SAMHSA
- Focus on how you can build these skills into your work on the team
- Each profession has value, and capacity to help
- Learn to recognize a trauma-based symptom or response as a survival adaptation rather than a simple resistance to the Court or supervision.
- Context, environment, history, culture all impact trauma. Focus on creating a safe environment throughout your Court, and IN your Court.
- Focus on resilience and strengths.

DEVELOP YOUR OWN SKILL SET!



Slide by Helen Harberts, MA, JD

THE TRAUMA-RESPONSIVE COURT COORDINATOR

- Acts as the logical, reasonable representative of the court (prefrontal cortex)
- Keeps the trains running by greasing the wheels with kindness
- Ensures that the treatment provider's messages reach the judge
- Needs to understand and recognize secondary traumatization in team members
- Looks for ways for the participant to have small amounts of control within limits

THE TRAUMA-INFORMED COURT COORDINATOR RECOMMENDS ENVIRONMENTAL CHANGES

Trauma-informed environmental changes such as:

- Adding boxes of tissues
- Softening the lighting
- Eliminating loud, ticking clocks
- Lowering the courtroom temperature
- Reorganizing waiting areas
- Moving the podium to the side wall
- Decreasing the number of signs that say “No”
- Installing multilingual signage

THE TRAUMA-RESPONSIVE TREATMENT TEAM CONSIDERS TRAUMA:

- During team meetings
- While watching a participant's behavior
- While listening to evidence of the participant's behavior
- When engaging with the participant during court sessions
- When engaging with the participant outside of court
- When considering incentives and sanctions
- When delivering incentives and sanctions

A QUICK PEEK AT THE UPCOMING NATIONAL BEST PRACTICE STANDARDS FOR TRAUMA-RESPONSIVE COURTS

THE PROCESS OF DEVELOPING NEW BEST PRACTICE STANDARDS FOR TRAUMA-RESPONSIVE COURTS

- 2015 - The beginnings of an idea
- 2022 – Traction
- 2023 – SAMHSA's GAINS Center convenes an expert panel
  - Joining forces with All Rise (formerly NADCP)
  - Feedback from the field at RISE 23
- 2024 – Rough draft of the standards
  - Multiple sets of commentaries successive drafts
  - Planned publication

Best Practice Standards

THE NEW BEST PRACTICE STANDARDS

I. Governance and leadership – Treatment Court leadership, particularly the judge, must champion a trauma-responsive approach

II. Policy – Policies and practices must be responsive to trauma, including secondary traumatization and triggering of participants and staff

III. Environment – The court's physical environment and language should be modified to increase safety and decrease triggering

IV. Engagement and involvement of supports – Include peers in recovery and family members

THE NEW BEST PRACTICE STANDARDS

V. Cross sector collaboration – both internally on the team and with external agencies, including cross-agency training

VI. Screening, assessment, and treatment – Evidence-based, trauma-focused, and culturally appropriate

VII. Training and workforce development – Both initial and ongoing education in trauma and its manifestations, including historical and vicarious trauma

EXAMPLE OF A STANDARD IN MORE DETAIL

III. Environmental modifications when possible

A. Consider settings outside of the courtroom

B. Non-threatening seating arrangements

C. Decrease environmental triggers (lighting, sound, temperature)

D. Add calming aspects such as warm paint colors, tissues, and multilingual signage

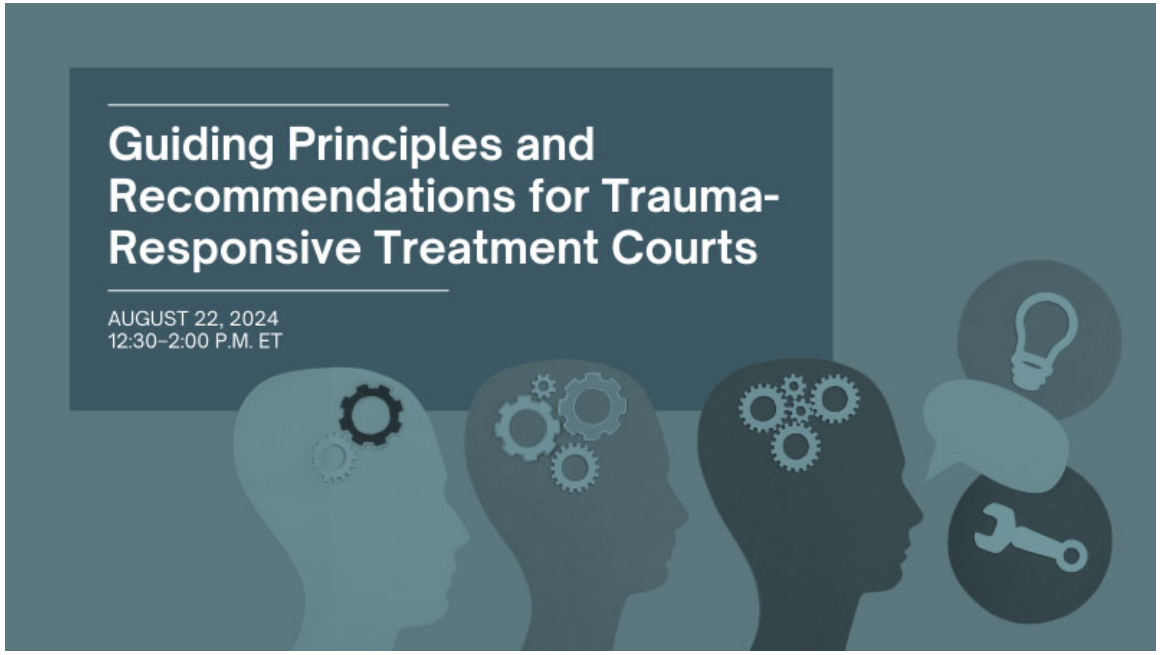
E. Add child care

F. De-escalation training

G. Change court attire (judicial robes, officer uniforms)

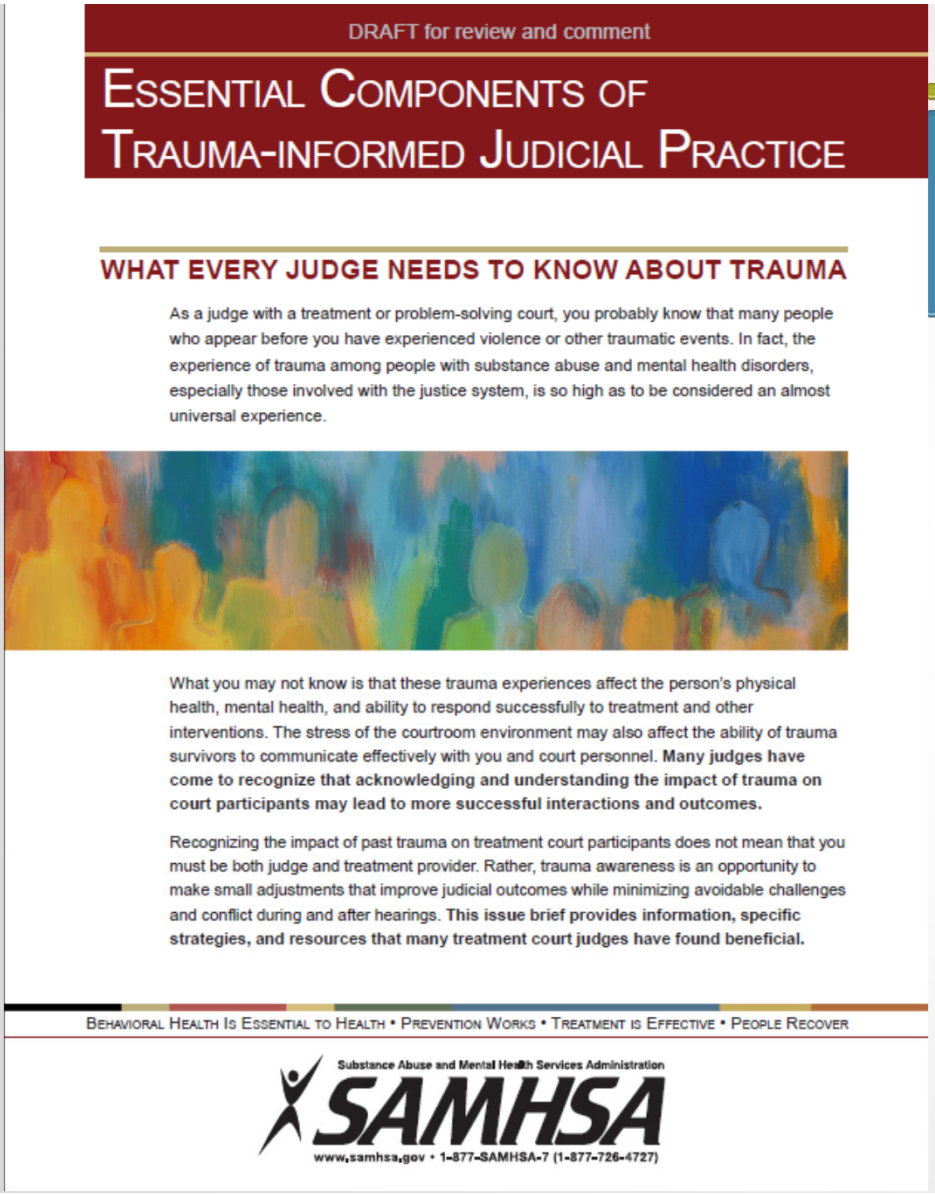
H. Change language to non-stigmatizing, first-person, recovery-oriented language

THURSDAY, AUGUST 22ND: AN EXTENDED PREVIEW



Register at:
https://us06web.zoom.us/webinar/register/WN_MDVrxqDfS0W6B0qUbLEicg#/registration

RESOURCES



DRAFT for review and comment

ESSENTIAL COMPONENTS OF TRAUMA-INFORMED JUDICIAL PRACTICE

WHAT EVERY JUDGE NEEDS TO KNOW ABOUT TRAUMA

As a judge with a treatment or problem-solving court, you probably know that many people who appear before you have experienced violence or other traumatic events. In fact, the experience of trauma among people with substance abuse and mental health disorders, especially those involved with the justice system, is so high as to be considered an almost universal experience.

What you may not know is that these trauma experiences affect the person's physical health, mental health, and ability to respond successfully to treatment and other interventions. The stress of the courtroom environment may also affect the ability of trauma survivors to communicate effectively with you and court personnel. **Many judges have come to recognize that acknowledging and understanding the impact of trauma on court participants may lead to more successful interactions and outcomes.**

Recognizing the impact of past trauma on treatment court participants does not mean that you must be both judge and treatment provider. Rather, trauma awareness is an opportunity to make small adjustments that improve judicial outcomes while minimizing avoidable challenges and conflict during and after hearings. **This issue brief provides information, specific strategies, and resources that many treatment court judges have found beneficial.**

BEHAVIORAL HEALTH IS ESSENTIAL TO HEALTH • PREVENTION WORKS • TREATMENT IS EFFECTIVE • PEOPLE RECOVER

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

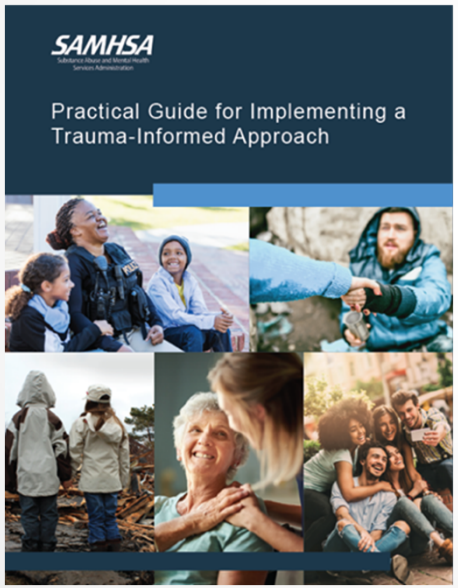
TRAUMA-INFORMED COURTS

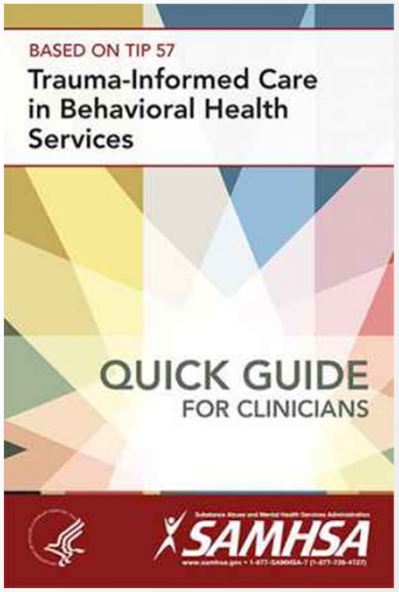
- *Essential Components of Trauma-Informed Judicial Practice*, SAMHSA. Retrieved from http://www.nasmhpd.org/sites/default/files/JudgesEssential_5%201%202013finaldraft.pdf
- McKinsey et al. (2022) *Trauma-Informed Judicial Practice from the Judge's Perspective* https://judicature.duke.edu/articles/trauma-informed-judicial-practice-from-the-judges-perspective/
- Also valuable: *TIP 57: Trauma-Informed Care in Behavioral Health Services*, SAMHSA, available at www.store.samhsa.gov

BOOKS AND WORKBOOKS

- *Once a Warrior, Always a Warrior: Navigating the Transition from Combat to Home* (2010) by Charles Hoge
- *What Happened to You: Conversations on Trauma, Resilience, and Healing* (2021) by Bruce Perry & Oprah Winfrey
- *Finding Your Best Self: Recovery from Addiction, Trauma, or Both* (2019) by Lisa Najavits
- *The Dialectical Behavior Therapy Skills Workbook* (2019) by Matthew McKay, Jeffrey Wood, and Jeffrey Brantley

ADDITIONAL SAMHSA RESOURCES





CONTACT:

Brian L. Meyer, Ph.D.

brianlmeyerphd@gmail.com

DATE

A Blueprint for Phases

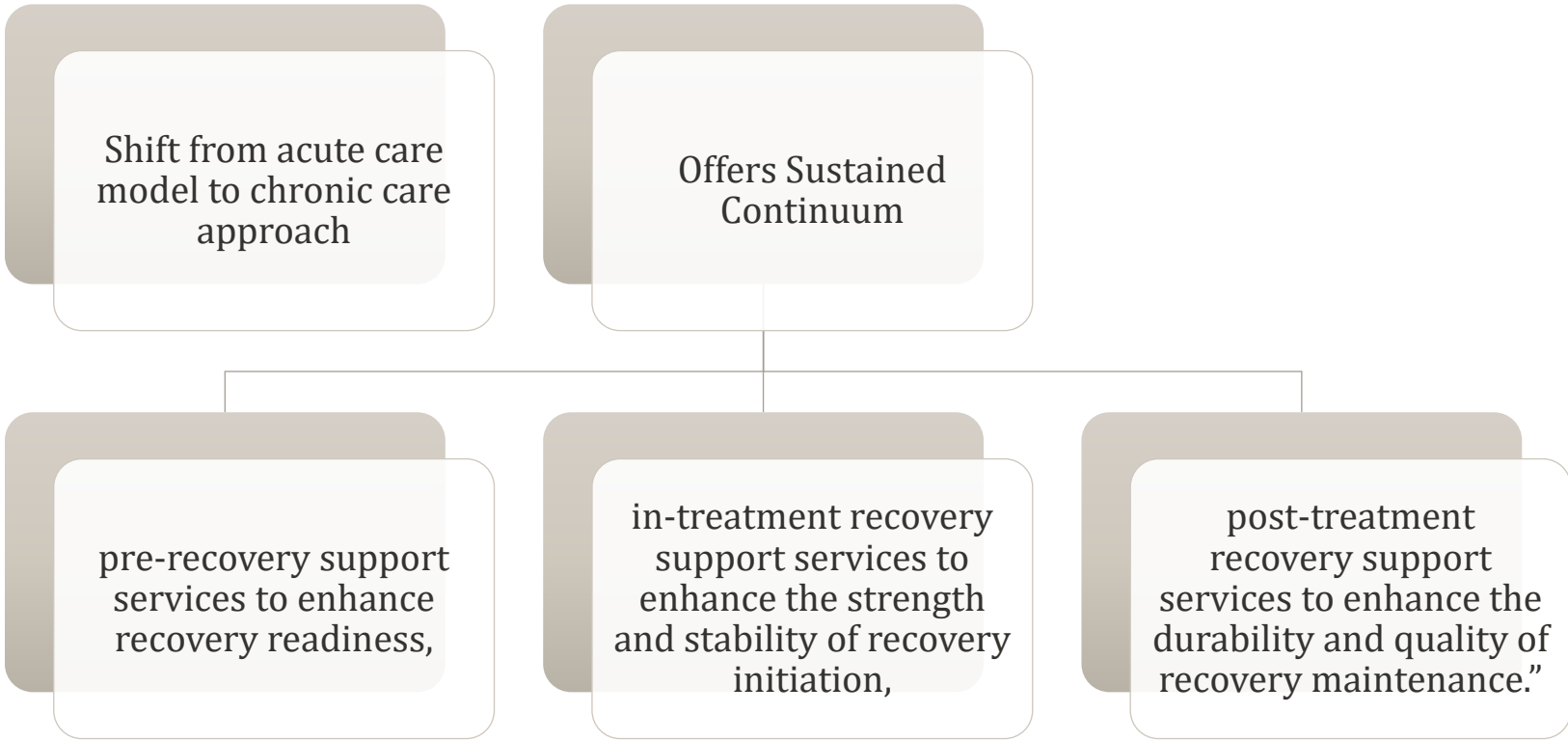
Subtitle

Presenter name, title, change font size to 16pt

Program Phase Focus

- Providing structure, support, and education for participants.
- Helping participants achieve and sustain psychosocial stability and resolve ongoing impediments to service provisions.
- Ensuring participants follow a safe and prosocial daily routine.
- Teaching participants preparatory skills (e.g. time management, personal finances).
- Engaging participants in recovery-supported activities.

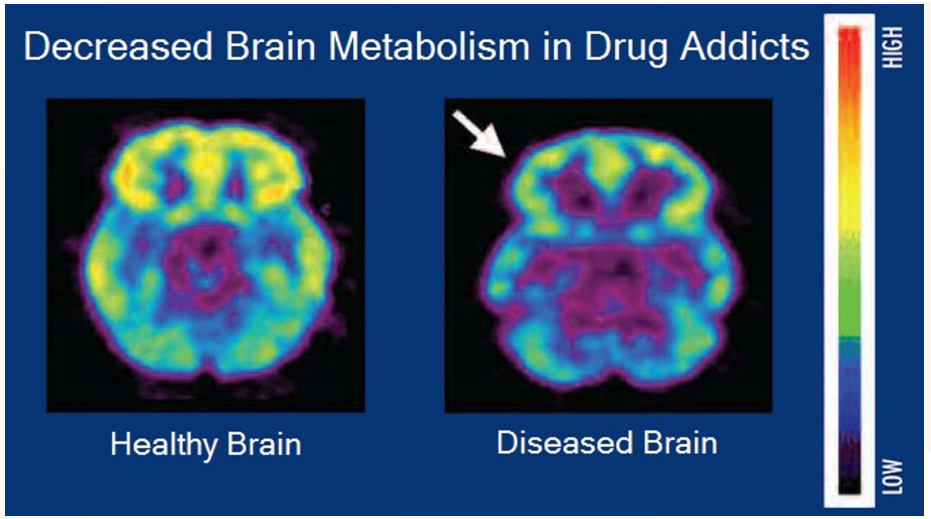
Re - Cap


Shift from acute care model to chronic care approach
Offers Sustained Continuum
pre-recovery support services to enhance recovery readiness,
in-treatment recovery support services to enhance the strength and stability of recovery initiation,
post-treatment recovery support services to enhance the durability and quality of recovery maintenance.”

Why Structure

- Research shows that patients with frontal cortex damage had impaired decision-making abilities.
  https://www.apa.org/monitor/jun01/cogcentral.html

- Cognitive functioning simply refers to our thinking, or mental activity. Drugs and alcohol change how your brain functions and gets worse with extended use.



Drug Use Changes the Brain

- Below are a few points of research in relation to various chronic drug disorders and their effects on cognition. *(Addiction and Cognition by Thomas J. Gould, Ph.D.)*

- cocaine—deficits in cognitive flexibility
- amphetamine—deficits in attention and impulse control
- opioids—deficits in cognitive flexibility
- alcohol—deficits in working memory and attention
- cannabis—deficits in cognitive flexibility and attention
- nicotine—deficits in working memory and declarative learning

Demonstration

What Color is the Word?

- HOUSE
- CAT
- TREE
- HORSE
- BUILDING
- DESK
- TRUCK
- DINNER
- DOG
- CAR
- LAMP
- POOL

What Color is the Word?

- RED
- GREEN
- BLUE
- ORANGE
- PURPLE
- GREEN

- ORANGE
- BLUE
- RED
- PURPLE
- RED
- GREEN

Stroop Test

- The Stroop test can be used to measure a person's selective attention capacity and skills, processing speed, and alongside other tests to evaluate overall executive processing abilities.
- Measures the ability to inhibit dominant responses.
- What dominant responses to participants usually have?
- This is a function of cognitive processing, not motivation.

Two Parts

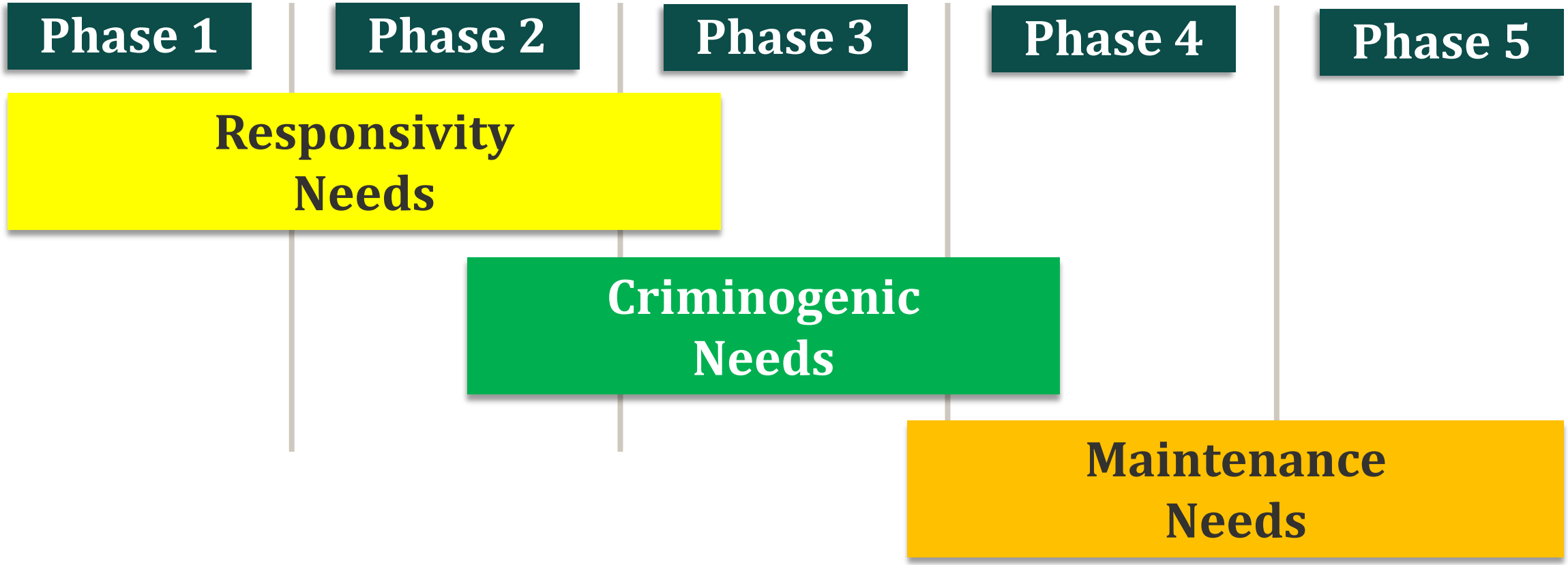
COURT

- Based upon risk levels
- Phases

TREATMENT

- Based on clinical assessment
- Clinical needs
- Levels of care

Timing Matters



Phase 1 – Acute Stabilization and Orientation

- What to focus on
  - Orientation
  - Crisis intervention
  - Develop relationships/alliances with staff
  - Identify/resolve barriers to attendance
  - Ongoing screening and assessment
  - Develop collaborative person-centered treatment/case plans

- Attend court every two weeks for the program's first phase.
  - Some participants will require weekly status hearings
- Random drug and alcohol testing (2 times/wk)
- Comply with supervision
- Weekly office visit
- Monthly home visits
- Curfew (if monitored)
- 30-60 days

Phase 1 – Welcome

- Phase up - Proximal goals have been managed when:
  - Crisis stabilization/no longer acute distress to participant
  - Orientation completed and adequately familiar with program requirements
  - Ongoing comprehensive screening and assessment
  - Collaborated person-centered treatment plan created

Phase 2 – Psychosocial Stabilization

- What to focus on
- Responsivity needs/stabilization needs
  - Lack of secure housing
  - Persistent cravings
  - Withdrawal
  - Anhedonia (lack of pleasure)
  - MH Symptoms
  - Cognitive Impairments

- Attend court every two weeks
- Random drug and alcohol testing (2 times/wk)
- Comply with supervision
- Weekly office visit
- Monthly home visits
- Curfew (if monitored)
- Approximately 90 days

Phase 2: Intensive Support

- Phase up: Psychosocial stability has been achieved
- Stable housing
  - Safe, secure stable housing
- Reliable attendance
  - Attending services (treatment court, supervision, drug and alcohol testing regularly
- Therapeutic alliance
  - Participant has developed a working relationship with at least one team member/staff
- Clinical stability
  - Participant is no longer experiencing debilitating symptoms

Phase 3: Prosocial Habilitation

- What to focus on:
- Criminogenic needs
  - Substance use
  - Peers
  - Problem-solving
  - Impulsivity
  - Antisocial activities

- Attend court monthly (minimum)
- Random drug and alcohol testing (2 times/wk)
- Comply with supervision
- Weekly office visit
- Monthly home visits
- Curfew (if monitored)
- 90-120 days*

Phase 3 – People, Places and Thinking

Phase up: Prosocial habilitation considered managed:

- Prosocial routine
  - Interactions primarily with prosocial persons and activities
- Prosocial skills
  - Completed criminal thinking curriculum and demonstrated skills
- Abstinence efforts
  - Applied efforts to reduce substance use, intermittent intervals of confirmed abstinence

Phase 4: Life Skills

- Early remission achieved
- Clinically stable
- Illiteracy needs
- Vocational/educational needs
- Reduced or eliminated interactions with anti-social or substance using peers a
- Practice prosocial decision making and drug-avoidance skills

- Attend court monthly (minimum)
- Random Drug and alcohol testing (2 times/wk)
- Comply with supervision
- Weekly office visit
- Monthly home visits
- Curfew (if monitored)
- 90-180 days*

Phase 4: Putting it into practice

- Phase up: Life skills considered managed:
- Life skills curriculum
  - Completed a life skills curriculum deemed appropriate and desired by the participant
- Adaptive role – social structure
  - Engaged in adaptive role (school, household management, employment, structured hours)
- Early remission:
  - 90 days without clinical symptoms
- Ability to demonstrate periods of abstinence

Phase 5: Recovery Management

- Involvement in recovery support programs
- Continued care plan
- Achieved early remission
- Participating in peer support groups
- Meeting with peer recovery specialist
- Prosocial support structure
- Attend court monthly or less
- Random drug and alcohol testing (2 times/wk)
- Comply with supervision
- Weekly office visit
- Monthly home visits
- Curfew (if monitored)
- 90 days

Phase 5: Self-Directed Lives/Adherence

- To COMMENCE:

- Recovery management activities:
  - Engaged in peer support
- Continuing care/symptom recurrence prevention plan
  - Attends regular continued care services, if needed or an articulated symptom-recurrence prevention plan
- Restorative justice activity
  - Satisfied reasonable community service, and paid affordable fees
- Abstinence maintenance
    - 90 days abstinent – without requiring perfection!

Phase Demotion

- Demoralizing
- Do not take an incentive away
- What additional support is needed in this phase?
- Gives the wrong message - all or nothing
- Service adjustment does not equal a phase demotion

Critical Questions

List the responsivity needs of your target population you need to address in the first phase:

Stable housing, medical needs, mental health symptoms, cognitive impairments

List how your phase structure addresses criminogenic needs:

Substance use disorders, antisocial cognition, family conflict, and antisocial affiliates

Critical Questions

List how your phase structure addresses maintenance needs.

Job skills, literacy needs, recovery capital, prosocial activities

What is advancement based upon?

- Is it a number of days?
- Is it objective or subjective?
- Does everyone have an equal chance?

Bringing It All Together

CHANCE	CHALLENGE	CHOICE	CHANGE
"If nothing changes, nothing changes"	"If you are going through hell, keep going."	"It always seems impossible until it is done."	"Growth is a willingness to make change"
COURTNEY STEVENS	WINSTON CHURCHILL	NELSON MANDELA	BILL W.

Questions

A Blueprint for Phases

Phases: Key Terms

Proximal, Distal, and Managed Goals

Proximal: goals participants can achieve in the short term and sustain for a reasonable time

Distal: goals that are too difficult for participants to achieve currently and which require service adjustments

Managed: goals that have been achieved and managed for a reasonable time

Clinical Stability

- Not experiencing symptoms that interfere with attending and benefiting from counseling.
- No persistent or severe cravings, withdrawal symptoms, anhedonia, impulsivity/stress reactivity, acute mental health symptoms, or cognitive impairment.

Psychosocial Stability

A participant is psychosocially stable when they have achieved:

- Secure housing
- Reliably attend appointments
- No longer experiencing clinical symptoms that may interfere with the ability to attend or benefit from interventions
- Developed an effective therapeutic or working alliance

Early Remission

- At least 90 days of clinical stability
- Until participants are in early remission…
  - …drug and alcohol testing should not be reduced.
  - …service adjustments are delivered as a response to use.
- Early remission is achieved by the end of the fourth phase of treatment court.

Phases: Importance of Structure

Program Phase Focus

- Providing structure, support, and education for participants.
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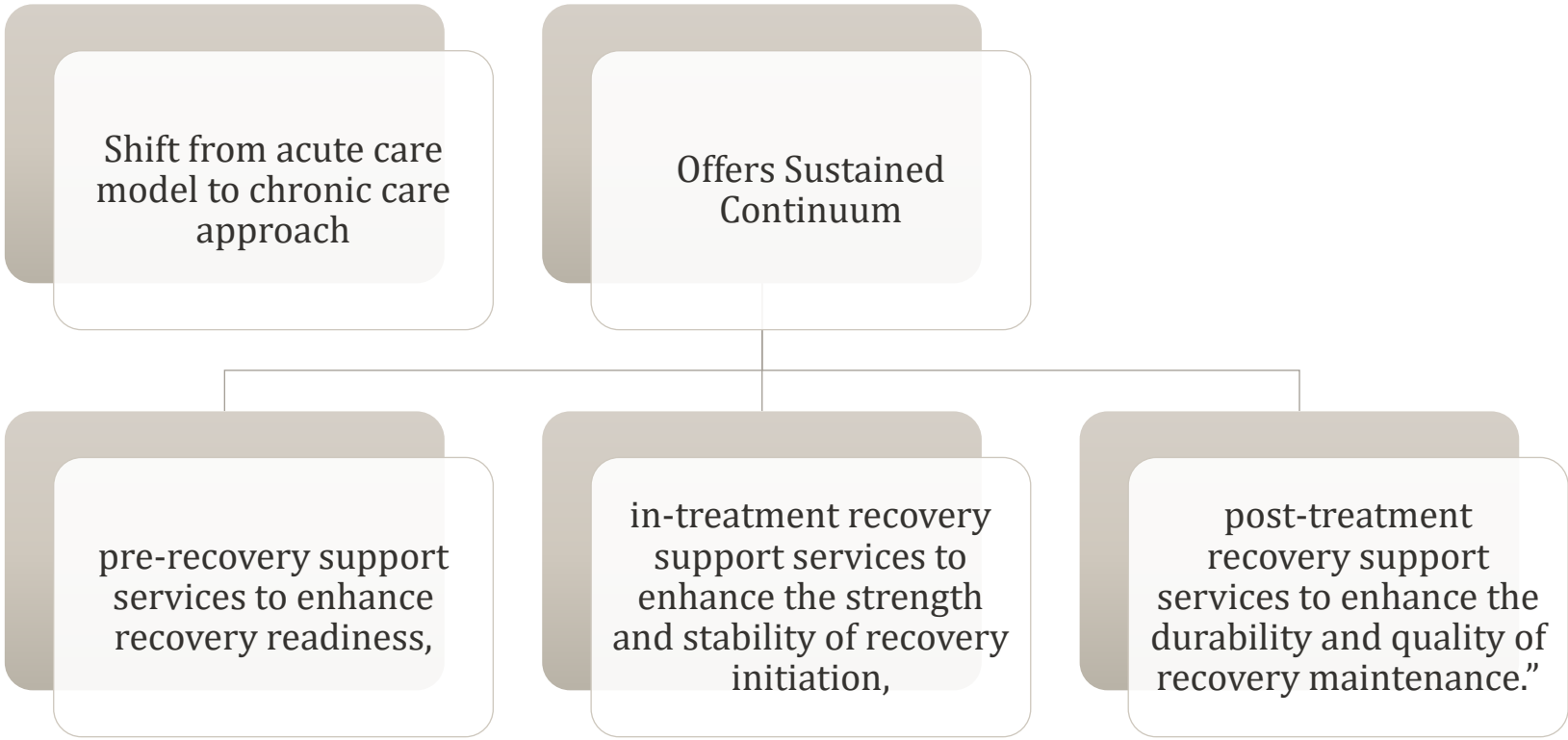
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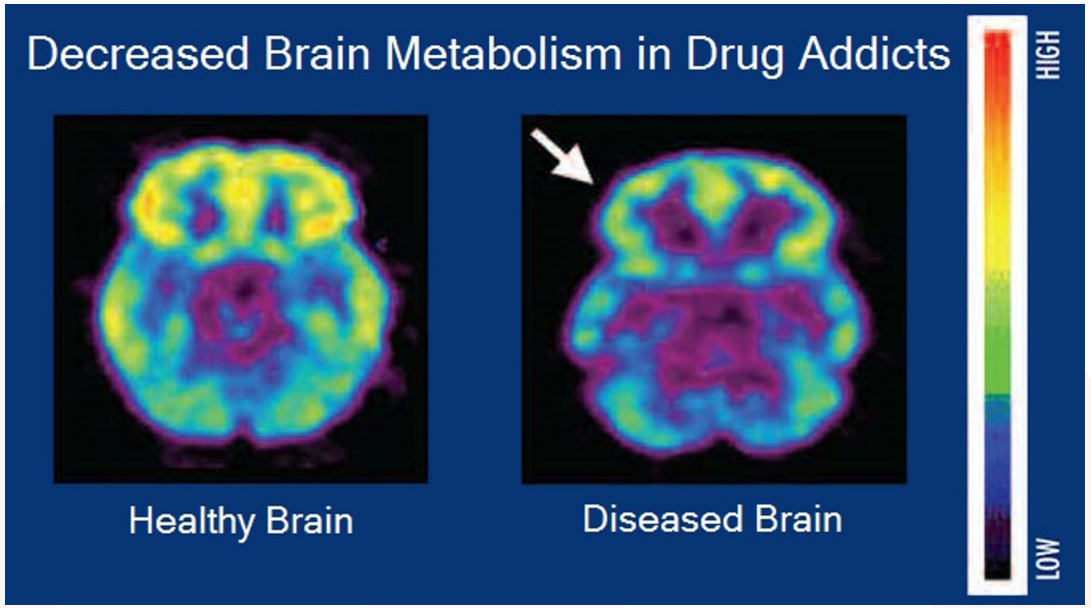
- Research shows that patients with frontal cortex damage had impaired decision-making abilities.

- Cognitive functioning refers to our thinking or mental activity. Drugs and alcohol change how your brain functions and get worse with extended use.



Demonstration

What Color is the Word?

- HOUSE
- CAT
- TREE
- HORSE
- BUILDING
- DESK
- TRUCK
- DINNER
- DOG
- CAR
- LAMP
- POOL

What Color is the Word?

- RED
- GREEN
- BLUE
- ORANGE
- PURPLE
- GREEN

- ORANGE
- BLUE
- RED
- PURPLE
- RED
- GREEN

Stroop Test

- The Stroop test can be used to measure a person's selective attention capacity and skills, processing speed, and alongside other tests to evaluate overall executive processing abilities.
- Measures the ability to inhibit dominant responses.
- What dominant responses to participants usually have?
- This is a function of cognitive processing, not motivation.

Phases: Sequence and Timing

Two Parts

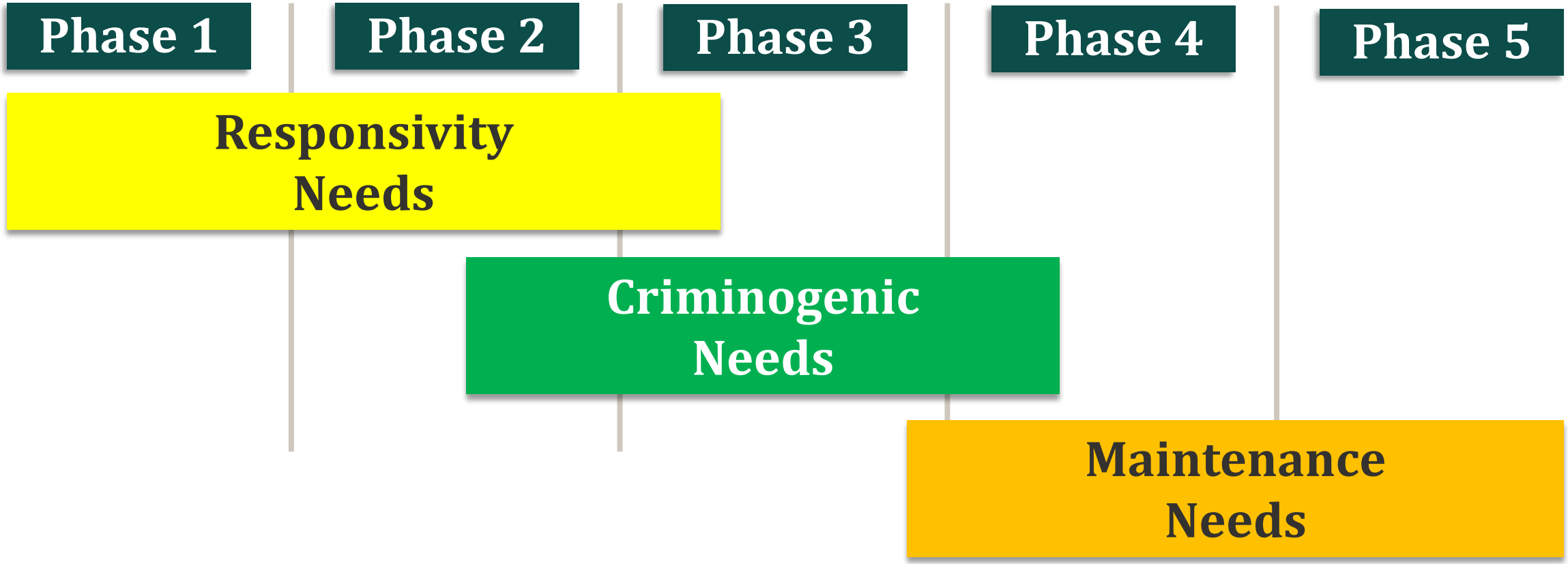
COURT

- Based upon risk levels
- Phases

TREATMENT

- Based on clinical assessment
- Clinical needs
- Levels of care

Timing Matters



Phase 1 – Acute Stabilization and Orientation

Focus of the phase:

- Orientation
- Crisis intervention
- Begin to develop relationships/alliances with staff
- Identify and solve barriers to attendance
- Ongoing screening and assessment
- Develop collaborative, person-centered treatment/case plans

Phase 1 – Acute Stabilization and Orientation

Expectations of the phase:

- Typically brief: 30 – 60 days (early opportunity for success)
- Some participants will require weekly status hearings
- Random drug and alcohol testing (2 times per week)
- Comply with supervision
- Weekly office visit
- Monthly home visits
- Curfew (if monitored)

Phase 2 – Psychosocial Stabilization

Services focus on responsivity needs/stabilization needs:

- Lack of secure housing
- Persistent cravings
- Withdrawal
- Anhedonia (lack of pleasure)
- Mental health symptoms
- Cognitive impairments

Phase 2 – Psychosocial Stabilization

Expectations of the phase:

- Attend court weekly/every other week
- Random drug and alcohol testing (2 times per week)
- Comply with supervision
- Weekly office visit
- Monthly home visits
- Curfew (if monitored)
- Approximately 90-120 days*

Phase 3: Prosocial Habilitation

Services focus on criminogenic needs:

- Substance use
- Peers
- Problem-solving
- Impulsivity
- Antisocial activities

Phase 3: Prosocial Habilitation

Expectations of the phase:

- Attend court every two weeks
- Random drug and alcohol testing (2 times per week)
- Comply with supervision
- Weekly office visit
- Monthly home visits
- Curfew (if monitored)
- Approximately 90 -120 days*

Phase 4: Life Skills

Services focus on maintenance needs:

- Illiteracy needs
- Vocational/educational needs
- Reduced or eliminated interactions with anti-social or substance-using peers
- Practice prosocial decision-making and drug-avoidance skills

Phase 4: Life Skills

Expectations of the phase:

- Attend court monthly (minimum)
- Random drug and alcohol testing (2 times per week)
- Comply with supervision
- Weekly office visit
- Monthly home visits
- Curfew (if monitored)
- Between 90-180 days*

Phase 5: Recovery Management

Services focus on recovery management services:

- Involvement in recovery support programs
- Continued care plan
- Achieved early remission
- Participating in peer support groups
- Meeting with peer recovery specialist
- Prosocial support structure

Phase 5: Recovery Management

Expectations of the phase:

- Attend court monthly or less
- Random drug and alcohol testing (2 times per week)
- Comply with supervision
- Weekly office visit
- Monthly home visits
- Curfew (if monitored)
- Phase length typically 90 days

Program Completion

- Engaged in recovery management activities
- Attends continuing care services
- Has a well-articulated and workable symptom-recurrent prevention plan
- Has satisfied a restorative justice activity
- Demonstrates ability to sustain abstinence, achieved approximately 90 days (without requiring perfection)
- Maintained/reestablished clinical stability

Phases: Progression and Setbacks

Phase 1 – Welcome

Phase up - proximal goals have been managed when:

- Crisis stabilization
  - Emergency & crisis issues have been stabilized &
  - No longer causing acute distress to the participant
- Orientation completed
  - Participant has received clear explanation of policies & procedures
  - Participant is adequately familiar with program requirements
- Comprehensive screening and assessments completed
  - Though they remain ongoing throughout the program
- Collaborated person-centered treatment plan created

Phase 2: Intensive Support

Phase up: Psychosocial stability has been achieved when:

- Stable housing
  - Safe, secure stable housing
- Reliable attendance
  - Attending services (treatment court, supervision, drug and alcohol testing) regularly
- Therapeutic alliance
  - Participant has developed a working relationship with at least one team member/staff
- Clinical stability
  - Participant is no longer experiencing debilitating symptoms

Phase 3 – People, Places and Thinking

Phase up: Prosocial habilitation considered managed when:

- Prosocial routine

  Interactions primarily with prosocial persons and activities

- Prosocial skills

  Completed criminal thinking curriculum and demonstrated skills

- Abstinence efforts

  Applied efforts to reduce substance use, intermittent intervals of confirmed abstinence

Phase 4: Putting it into practice

Phase up: Life skills considered managed when:

- Life skills curriculum

  Completed a life skills curriculum deemed appropriate and desired by the participant

- Adaptive role – social structure

  Engaged in adaptive role (school, household management, employment, structured hours)

- Early remission:

  90 days without clinical symptoms

- Ability to demonstrate periods of abstinence

Phase 5: Self-Directed Lives/Adherence

To Commence:

- Recovery management activities:
  - Engaged in peer support
- Continuing care/symptom recurrence prevention plan
  - Attends regular continued care services, if needed or an articulated symptom-recurrence prevention plan
- Restorative justice activity
  - Satisfied reasonable community service, and paid affordable fees
- Abstinence maintenance
  - 90 days abstinent – without requiring perfection

Phase Demotion

- We do not take an incentive away
  - It is demoralizing
  - Gives the wrong message - all or nothing

- We ask: what additional support is needed in this phase?
- Service adjustment does not equal a phase demotion

Phases: Incorporating Recovery Capital

Critical Questions

List the responsivity needs of your target population you need to address in the first phase:

Stable housing, medical needs, mental health symptoms, cognitive impairments

List how your phase structure addresses criminogenic needs:

Substance use disorders, antisocial cognition, family conflict, and antisocial affiliates

Critical Questions

List how your phase structure addresses maintenance needs.

Job skills, literacy needs, recovery capital, prosocial activities

What is advancement based upon?

- Is it a number of days?
- Is it objective or subjective?
- Does everyone have an equal chance?

Bringing It All Together

CHANCE	CHALLENGE	CHOICE	CHANGE
"If nothing changes, nothing changes"	"If you are going through hell, keep going."	"It always seems impossible until it is done."	"Growth is a willingness to make change"
COURTNEY STEVENS	WINSTON CHURCHILL	NELSON MANDELA	BILL W.

Virginia Specialty Dockets ADA Training

Steven E. Gordon
Assistant United States Attorney
Civil Rights Enforcement Coordinator
USAO Eastern District of Virginia

This Is An Appetizer Presentation: A Course On How The ADA's Many Complex Provisions Apply To State Courts Would Take A Full Day

Educational Objective

Develop an understanding and awareness of the ADA's requirements relating to issues that arise in specialty docket courts, with a focus on the requirement that drug treatment court participants be permitted to take medications that treat substance use disorder.

Overview

- DOJ's Response to the Opioid Epidemic
- Background on the ADA
  - All entities in state and local criminal justice settings, including courts, are covered by the ADA.
  - The ADA covers a broad range of disabilities including addictions/substance use disorders.
- Medications for opioid use disorder
  - Three FDA-approved Medications for opioid use disorder have been proven to be highly effective and to save lives.
  - Most patients with OUD who undergo supervised withdrawal will start using opioids again and won't continue in recommended care.
- The ADA and the Opioid Crisis
  - State drug courts are required to permit drug court participants to take prescribed FDA-approved medications for opioid use disorder.
- Designation of ADA Coordinators
- Potential Collaborators

DOJ's Response to the Opioid Epidemic

- Prevention
- Enforcement
- Treatment

DOJ's Response to the Opioid Epidemic (cont.)

To ensure that people who want to participate in (or have participated in) treatment for Opioid Use Disorder do not face unnecessary and discriminatory barriers to recovery, DOJ is engaging in:

- Outreach
- Technical assistance
- Enforcement under the ADA

Most Important ADA Resource: ADA.gov

Statutory Language

Regulations

Technical Assistance

Settlement Agreements

Archive.ADA.gov

archive.ADA.gov

United States Department of Justice
Civil Rights Division

Information and Technical Assistance on the Americans with Disabilities Act

Search archive.ADA.gov

go

Law / Regulations | Design Standards | Technical Assistance Materials | Enforcement

New on ADA.gov

U.S. v. the Massachusetts Parole Board
Settlement Agreement (posted 11/17/22)

NYC Transit Authority Access-A-Ride Program
Findings Letter (posted 11/17/22)

Fayette County Detention Center
Settlement Agreement (posted 11/17/22)

Contra Costa County Kids at Work
Settlement Agreement (posted 11/17/22)

U.S. v. LA Nail Spa
Settlement Agreement (posted 11/17/22)

Town of Limerick, Maine
Settlement Agreement (posted 11/17/22)

City of Hudson, New York
Settlement Agreement (posted 11/17/22)

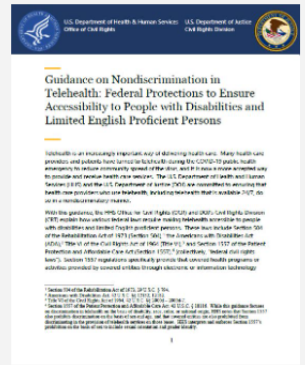
ADA Information Line

The U.S. Department of Justice provides information about the ADA through a toll-free ADA Information Line.
800-514-0301 (voice)
833-610-1264 (TTY)

Introduction to the ADA

File an ADA Complaint on www.ada.gov

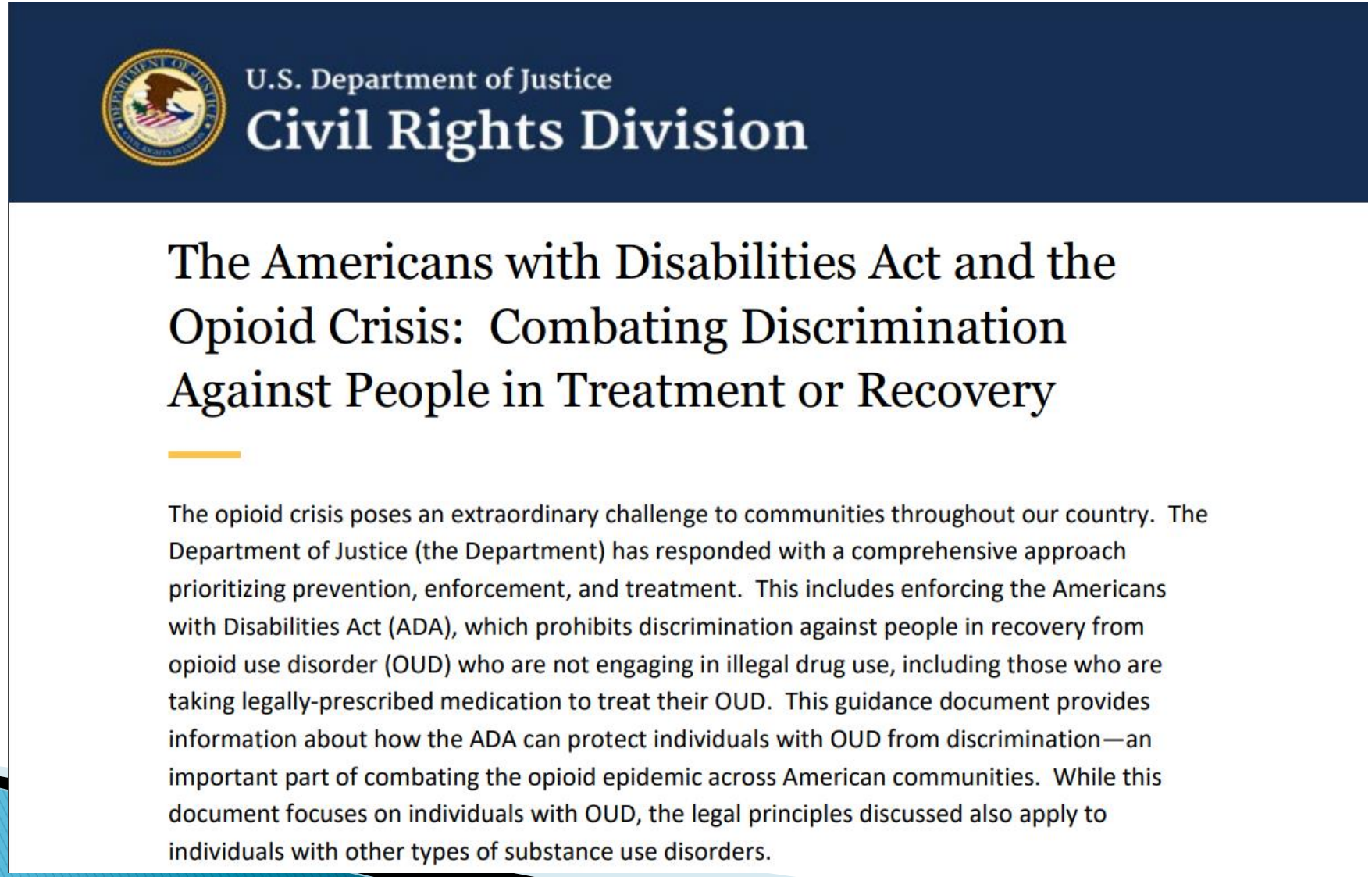
Featured Topic: Guidance on Nondiscrimination in Telehealth



Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons

COVID-19 & the ADA

DOJ Technical Assistance Publication On The Opioid Crisis And The ADA



U.S. Department of Justice
Civil Rights Division

The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery

The opioid crisis poses an extraordinary challenge to communities throughout our country. The Department of Justice (the Department) has responded with a comprehensive approach prioritizing prevention, enforcement, and treatment. This includes enforcing the Americans with Disabilities Act (ADA), which prohibits discrimination against people in recovery from opioid use disorder (OUD) who are not engaging in illegal drug use, including those who are taking legally-prescribed medication to treat their OUD. This guidance document provides information about how the ADA can protect individuals with OUD from discrimination—an important part of combating the opioid epidemic across American communities. While this document focuses on individuals with OUD, the legal principles discussed also apply to individuals with other types of substance use disorders.

What Is Covered by ADA?

The ADA prohibits discrimination and ensures equal opportunities for persons with disabilities in:

- Employment (Title I)
- **State and local government services (Title II)**
- Public accommodations (Title III)
- Telecommunications (Title IV)

The ADA Covers A Broad Range of Public Entities

A "public entity" subject to the ADA's nondiscrimination mandate includes "(A) any State or local government; [and] (B) any department, agency, special purpose district, or other instrumentality of a State or States or local government." 42 U.S.C. § 12131(1).

The section-by-section analysis of the ADA regulations applicable to state and local government entities explains: "[t]itle II coverage, however, is not limited to 'Executive' agencies, but includes activities of the legislative and **judicial branches of State and local governments**."

Title II Covers Public Entities

All state and local governmental entities are covered by Title II, including the following entities operated by state and local governments:

- **State and local courts**
- **Community corrections, including probation, work release and pre-trial services**
- **State and local social service agencies, including the Community Service Board**
- **Regional and local jails**
- **State prisons and correctional facilities**
- **Healthcare providers within correctional facilities**

Public Entities Are Responsible for the ADA Compliance of Their Contractors

"A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability—" discriminate.

Public Entities Are Responsible For Their Contractors' ADA Compliance

"**All governmental activities of public entities are covered, even if they are carried out by contractors**. For example, a State is obligated by title II to ensure that the services, programs, and activities of a State park inn operated under contract by a private entity are in compliance with title II's requirements. The private entity operating the inn would also be subject to the obligations of public accommodations under title III of the Act and the Department's title III regulations at 28 CFR Part 36." Section-by-section analysis of Title II regulations.

ADA Issues Have Arisen In Virginia State Courts

Several years ago, multiple Virginia state court personnel failed to comply with the ADA's effective communication provisions, which resulted in an individual who is deaf being detained for **30 days without a bond hearing because the court failed to obtain a sign language interpreter in a timely manner**. This incident resulted in a settlement agreement with the United States. *See* Settlement Agreement with Entities Of The Commonwealth of Virginia.

Settlement Agreement

SETTLEMENT AGREEMENT AND RELEASE OF CLAIMS

BETWEEN THE UNITED STATES OF AMERICA

AND ENTITIES OF THE COMMONWEALTH OF VIRGINIA

Settlement Provisions Required

- VA S.Ct. Chief Justice to sent a memo to all Chief Judges of Circuit and District Courts requesting the designation of ADA Coordinators in each Judicial Circuit.
- The dissemination of ADA Coordinator's contact information, including the Exec. Sec. of the Supreme Court keeping a list of ADA Coordinators for local courts.
- ADA training for all judges, magistrates and court clerks.
- Information on where to obtain after-hours and non-scheduled interpreters is on the judicial branch's intranet site
- Video remote interpreting is available on demand to all magistrates for after-hours interpreting.

Virginia Court System ADA Coordinator

Americans with Disabilities Act (ADA)

About

The Americans with Disabilities Act (ADA) was enacted to ensure that all qualified individuals with disabilities enjoy the same opportunities that are available to persons without disabilities. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications. Upon request, the Office of the Executive Secretary assists with ADA accommodations for public programs and services of Magistrates, District Court Clerks and Judges, Circuit Court and Appellate Court Judges and Justices, and the Clerks of the Supreme Court of Virginia and the Court of Appeals of Virginia. Circuit Court Clerks, as local Constitutional officers, are responsible for ADA accommodations in their offices.

Contact Information:

- ADA Coordinator - Dr. Renée Fleming Mills
  Office of the Executive Secretary
  100 N. 9th Street
  Richmond, VA 23219
  Phone - (804) 786-6455
  Fax - (804) 786-0109
  E-mail - ADACoordinator@vacourts.gov

S.Ct. of VA Website With List of Court ADA Coordinators

Currently Designated Local ADA Coordinators

District/ Circuit Number	Courts Served	Name of Local ADA Coordinator	Coordinator's Location	Email Contact Information	Additional Contact Information
1	Circuit and District Courts: Chesapeake	Bonnie Coffey Glynis Townsend	Chesapeake General District	bcoffey@vacourts.gov gtownsend@vacourts.gov	757/382-3162
2	Virginia Beach Circuit Court	Dawson Entwisle	Virginia Beach Circuit Court	jentwisl@vbgov.com	757-385-8357
2	Virginia Beach General District Court	Kiwania Dennis	Virginia Beach General District Court	kdennis@vacourts.gov	757/385-8730
3	Circuit, District and J&DR Courts: Portsmouth	Cynthia Morrison	Portsmouth Circuit Court	cmorrison@vacourts.gov	757/393-8671 ext. 5125
4	Circuit and District Courts: Norfolk	Elizabeth Amaya	Norfolk Circuit Court	eamaya@vacourts.gov	757/664/4595

ADA Coordinator

The section-by-section Analysis of the ADA Regulations explain the rationale for the designation of an ADA Coordinator:

"The requirement for designation of a particular employee and dissemination of information about how to locate that employee **helps to ensure that individuals dealing with large agencies are able to easily find a responsible person who is familiar with the requirements of the Act [ADA] and this part [of the ADA regulations] and can communicate those requirements to other individuals in the agency who may be unaware of their responsibilities.**"

United States Attorney's Office Dear Colleague Letter

Dear Colleague Letter Reminding State & Local Government Agencies To Designate An ADA Coordinator

Virginia Drug Treatment Courts

During FY 2023, 60 approved drug treatment court dockets operated in Virginia.

- 51 Adult
- 3 juvenile
- 5 family
- 1 regional DUI

“Drug treatment court dockets incorporate **evidence-based strategies** in a public health approach to accommodate offenders with specific problems and needs that are not or could not be adequately addressed in the traditional court setting, resulting in increased public safety by integrating the criminal justice system with treatment system and community resources.”

Virginia Drug Treatment Court Dockets Fiscal Year 2023 Annual Report.

Figure 2: Drug Treatment Court Dockets within the Virginia Judicial System

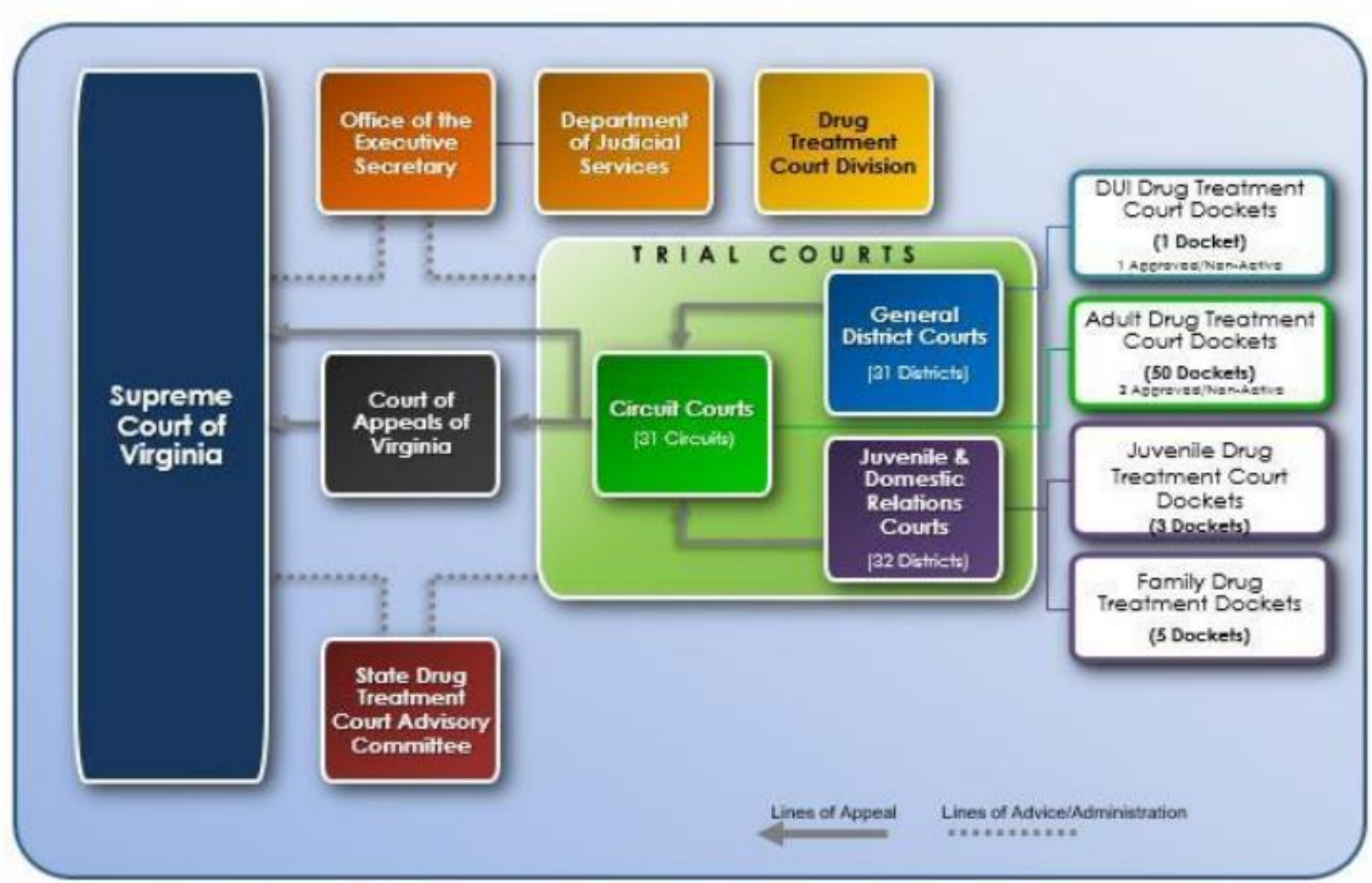


Figure 5. Approved Adult Drug Treatment Court Dockets in Virginia, FY 2023

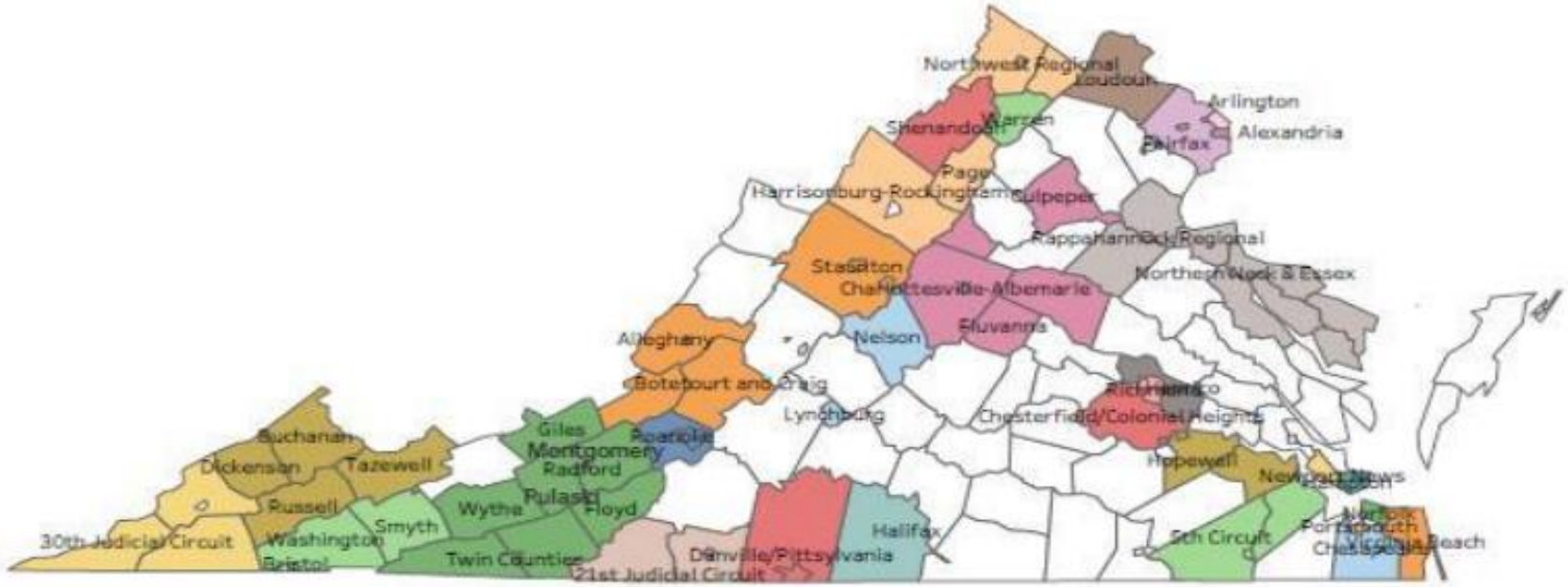


Figure 6. Number of Adult Drug Treatment Court Docket Participants by Fiscal Year, 2016-202

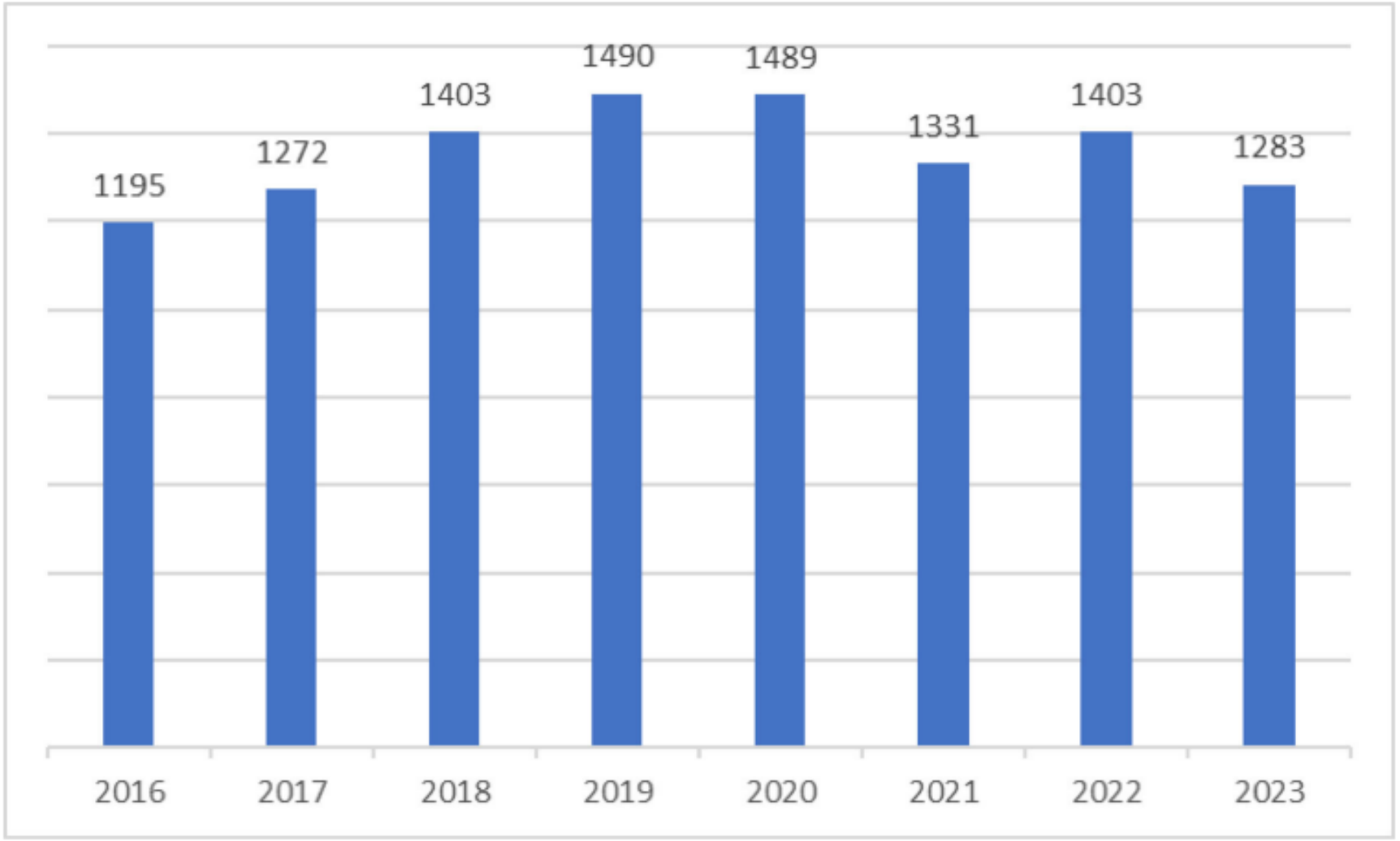
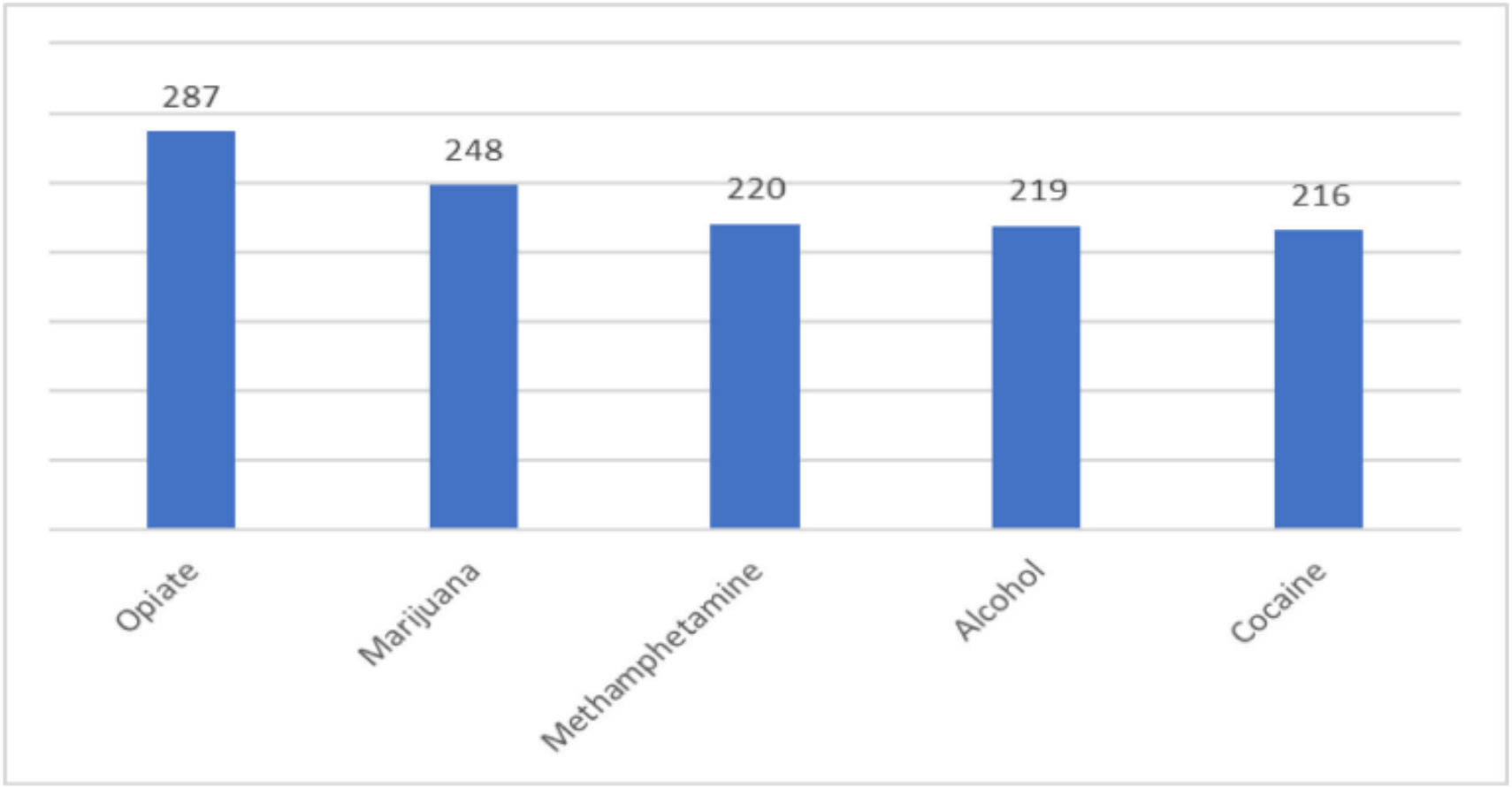


Figure 7. Drugs Most Frequently Used by Adult Drug Treatment Court Docket Participants, FY 2023



Note: Figure 7 should be interpreted with caution. Data are based on self-reported drug use. Participants may report using more than one substance or may choose to not disclose previous drug use.

Examples of Discrimination Under the ADA

- Failing to afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is equal to that afforded others.

- Using eligibility criteria that screening out or tend to screen out people with disabilities from programs or services.

- Using a method of administration of a program that results in discrimination against people with disabilities.

Individualized Assessment Are Key Because One Size Solutions Do Not Fit All

Equity-Based Verses Equality Based Solutions

EQUALITY:
Everyone gets the same – regardless if it's needed or right for them.

EQUITY:
Everyone gets what they need – understanding the barriers, circumstances, and conditions.

Actions required by the ADA are **not** special privileges, but instead measures that ensure accessibility and equity.

The ADA Applies To Many Different Types of Disabilities

Definition of Disability

- A physical or mental impairment that substantially limits one or more major life activities.
- A record of such an impairment.
- Being regarded as having such an impairment.

42 U.S.C. § 12102; 28 C.F.R. § 36.105 (see the revised definition of disability adopted after ADA Amendments Act of 2008).

"Physical or mental impairment includes . . . Drug addiction and alcoholism." 28 C.F.R. § 35.108(b)(2).

The ADA and the Opioid Crisis

Substance use disorder (SUD) in the United States: (48.7 million people aged 12 or older (or 17.3%)) (Substance Abuse and Mental Health Services Administration ("SAMSHA")).

Studies show that approximately 20 percent of incarcerated individuals in the United States have OUD.

Discrimination Under the ADA Not Limited to Affirmative Animus

"The ADA . . . Specifically prohibits discrimination against [individuals with disabilities], not just based on invidious 'affirmative animus,' but also based on thoughtlessness, apathy, and **stereotypes** about disabled persons." Guckenburg v. Boston University, 974 F.Supp. 106 (D.Ma. 1997).

U.S. Surgeon General Murthy's Report

SUD, including OUD, is a chronic disease.

SUD/OUD are not a moral failing.

U.S. Surgeon General Murthy's Report

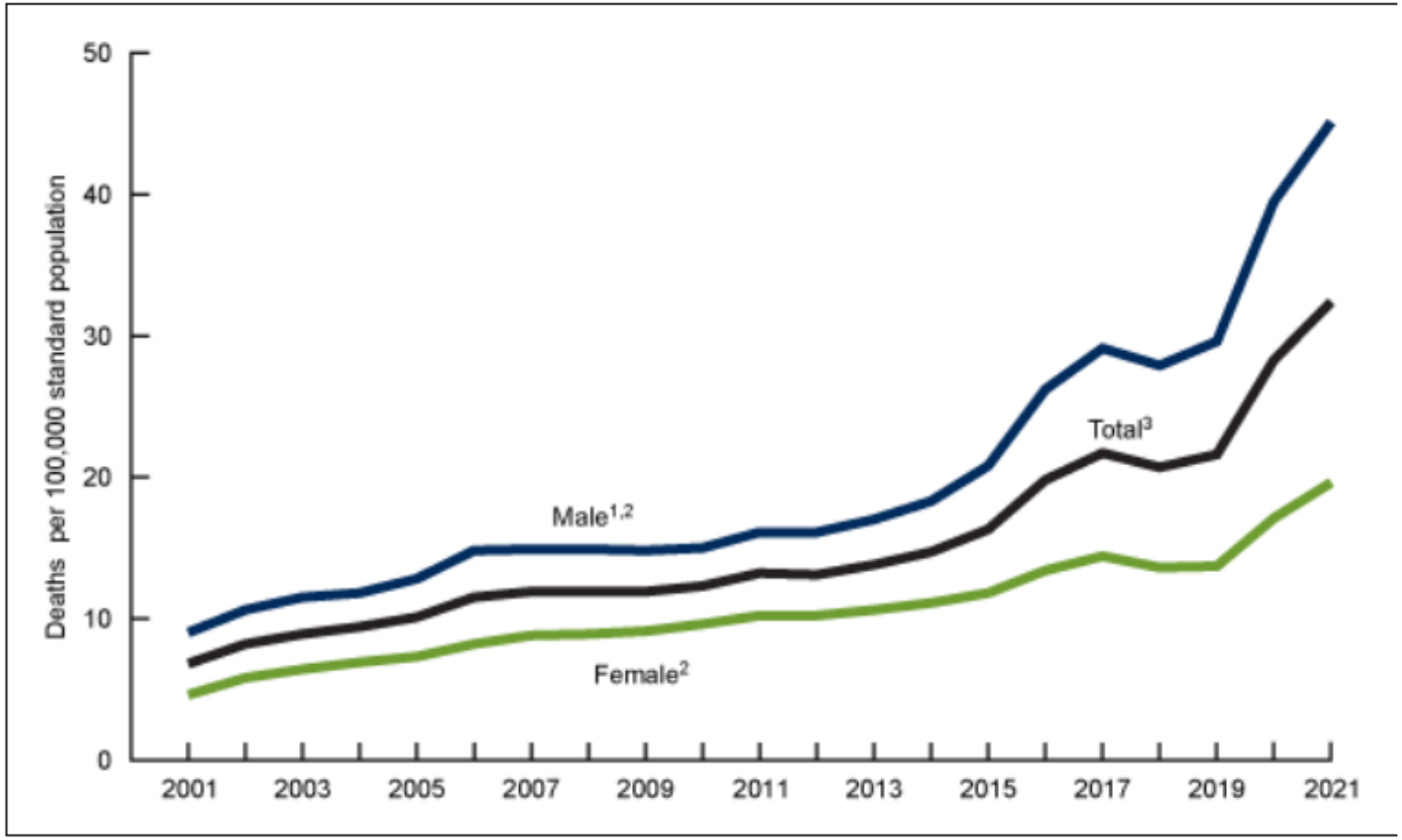
"For far too long, too many in our country have viewed addiction as a moral failing. This unfortunate stigma has created an added burden of shame that has made people with substance use disorders less likely to come forward and seek help. It has also made it more challenging to marshal the necessary investments in prevention and treatment. We must help everyone see that addiction is not a character flaw – it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer."

CDC Statistics On Overdose Deaths

In 2023, nearly 108,000 people died of a drug overdose, with 75% of those deaths involving an opioid. The overall rise in overdose deaths in the last 20 years is largely attributable to the proliferation in the drug supply of illicit fentanyl, a highly potent synthetic opioid.

Overdose Deaths Have Dramatically Increased In The Last Two Decades

Figure 1. Age-adjusted rate of drug overdose deaths, by sex: United States, 2001–2021



Substance Use Disorder in Virginia

Virginia Department of Health's Statistics from 2022:

- 2,490 drug overdose deaths in Virginia
- 79 percent of overdose deaths in Virginia involved opioids: fentanyl, fentanyl analogs, and tramadol.
- 22,398 drug overdose emergency department visits among Virginians

OUD is a Disability

OUD substantially limits major life activities, such as caring for oneself, learning, concentrating, thinking, and communicating. 42 U.S.C. § 12102(2)(A); 28 C.F.R. § 35.108(c)(1)(i).

OUD also limits the operation of major bodily functions, such as neurological and brain functions. 42 U.S.C. § 12102(2)(B); 28 C.F.R. § 35.108(c)(1)(ii).

The determination of whether an impairment substantially limits a major life activity is made without regard to the effect that ameliorating measures—including medication—may have on the impairment. 42 U.S.C. § 12102(4)(E)(i); 28 C.F.R. § 35.108(d)(1)(viii).

FDA-Approved Medications that Treat OUD

Methadone

Buprenorphine (Suboxone)

Naltrexone

There Is Broad Consensus That Medications Are Necessary To Treat OUD

The Substance Abuse and Mental Health Services Administration ("SAMHSA") has comprehensively detailed the broad and well-established consensus in the medical and scientific communities that these medications are necessary for the effective treatment of many individuals with OUD.

SAMHSA, Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder (2021), https://perma.cc/CT4T-CHZZ

How MOUDs Work

According to SAMHSA, all three medications, when appropriately administered to patients for whom they are clinically indicated, can improve patients' health and wellness by:

- Normalizing brain chemistry and body functions without the negative and euphoric effects of the illicit opioid;
- Blunting or blocking the euphoric effects of illicit opioids;
- Reducing or eliminating cravings to use opioids; and,
- For methadone and buprenorphine (suboxone), reducing or eliminating withdrawal symptoms.

These medications are safe to use for months, years, or even a lifetime.

How MOUDs Work

According to the U.S. National Institute on Drug Abuse (NIDA), methadone and buprenorphine help diminish the effects of physical dependency on opioids, such as withdrawal symptoms and cravings, by activating the same opioid receptors in the brain targeted by prescription or illicit opioids without producing euphoria.

Naltrexone, meanwhile, treats OUD by blocking opioid receptors and thereby preventing any opioid from producing rewarding effects such as euphoria or pain relief.

When taken as prescribed, these medications are safe and effective.

MOUDs Are Not Interchangeable

While all three OUD medications can be effective for certain individuals with OUD, they are not interchangeable; they have different pharmacological properties that elicit different responses from different patients. See SAMHSA, TIP 63, at 3-10.

A medical provider's decision about which OUD medication is appropriate for a particular patient will depend on an individualized assessment of the patient's medical, psychiatric, and substance use histories, their current level of physical dependence on opioids, their prior responses to medication, their occupation, their pregnancy status, and their treatment preferences. *Id*.

Some Patients Will Need MOUDs As A Maintenance Treatment

How long a patient receives OUD medication is also tailored to the needs of each patient and, in some cases, treatment can be indefinite. The best results "occur when a patient receives medication for as long as it provides a benefit," an approach known as "maintenance treatment." TIP 63, at 1-8.

Denial of MOUDs Causes Great Harm

The medical and scientific evidence summarized in SAMHSA's TIP 63 makes clear that if a court categorically denies access to even one of the three FDA-approved OUD medications without individually assessing the medical needs of those to whom it is denying access, it will prevent many people with OUD from accessing the only medication that will effectively treat their disability.

If a court orders an individual to abstain from an FDA-approved OUD medications, and instead requires all individuals with OUD to go through medically supervised withdrawal, it inflicts even greater harm. It not only denies those with OUD access to the most effective, evidence-backed treatments available; it increases the likelihood that they will overdose.

Myths, Fears, and Stereotypes About MOUDs

- MOUD substitutes one addiction for another
- MOUD is inferior to quitting
- MOUD patients sell their drugs
- MOUD is dangerous

Reality

According to SAMHSA, MOUDs have been shown to:

- Give people the time and ability to make necessary life changes associated with long-term remission and recovery
- Minimize cravings and withdrawal symptoms
- Allowing people to better manage other aspects of their life, such as parenting, attending school, or working, and
- Provide a much better chance of patients discontinuing illicit opioid use over the long term.

Reality

According to SAMHSA, medication assisted treatment has been shown to:

- Improve patient survival;
- Increase retention in treatment programs;
- Decrease illicit opiate use and criminal activity;
- Increase patients' ability to gain and maintain employment; and
- Improve birth outcomes among pregnant people with opioid use disorder ("OUD").

Reality

“Medications for opioid use disorder are safe and effective. They help sustain recovery and prevent overdose deaths,”

“Failing to use safe and lifesaving medications is devastating for people denied evidence-based care. What's more, it perpetuates opioid use disorder, prolongs the overdose crisis, and exacerbates health disparities in communities across the country.”

Nora Volkow, M.D., Director of the National Institute on Drug Abuse.

Post-release opioid-related overdose mortality is the leading cause of death among people released from jails or prisons.

A seminal study in the United States demonstrated that after controlling for demographic factors, individuals released from prison in Washington State had 129 times greater risk of drug overdose in the first 2 weeks post-release relative to the general population. The majority of these overdoses involved opioids.

MOUDs Reduce The Risk Of Overdose Deaths

MOUDs can significantly reduce the risk of overdose death; a recent study showed that people with OUD were 82% less likely to die of an overdose when they were receiving MOUD than when they were not.

Rhode Island Case Study On MOUDs

- Unified prison and jail system
- Implemented opioid screening and treatment in 2016.
- Incoming inmates are screened to determine if they have OUD.
- Inmates who were taking MOUDs upon intake were permitted to continue.
- Inmates with OUD who were not taking MOUDs upon intake were given access to MOUDs.
- Offers all three FDA-approved forms of MOUD.
- Links individuals to MOUD in the community after release (warm hand-off).

Rhode Island Case Study On MOUDs

- Assessed post-release mortality.
- 61% reduction in post-release deaths.
- 12% statewide reduction in opioid overdose deaths.

ADA Requirements

Title II of the ADA prohibits public entities, including state courts, from discriminating based on disability in the provision of their "services, programs, or activities." 42 U.S.C. §§ 12131(1)(A)-(B), 12132.

ADA Requirements

When a court categorically limits a party's access to medications used to treat OUD, without a qualified medical professional individually assessing whether they may be medically necessary to treat specific individuals with OUD, the court denies those individuals an equal opportunity to benefit from its services and violates the ADA.

ADA Requirements

Decisions about access to medical treatment that rests on stereotypes about individuals with disabilities rather than "an individualized inquiry into the patient's condition" will likely be considered discriminatory.

Withholding a medication used to treat addiction without "an individualized inquiry into the patient's condition" will likely be considered discriminatory.

The ADA Covers

Mandating people onto specific forms of medication as a matter of *policy*.

Mandating people off a specific form of medication in drug court.

Mandating people onto a specific form of medication as a condition of parole.

The ADA Covers

Maintenance on treatment that has already begun prior to an individual being part of the criminal justice system.

In corrections facilities, not medically assessing intakes to be induced onto MOUD as a matter of policy, even though other medical conditions, such as hypertension, are evaluated.

Discontinuing people on treatment *because* they are illegally using other drugs.

ADA/OUD Enforcement Activities

- Private lawsuits have become very frequent. Federal courts have been unanimous, upholding access to medication.
- DOJ has initiated compliance reviews and investigations.
- The Office of Justice Programs, which provides federal grants to entities in criminal justice settings, has initiated compliance reviews on grant recipients, as compliance is often a condition of funding.

Smith v. Aroostook County

Smith v. Aroostook County, 376 F.Supp.3d 146 (D.Me. 2019) *aff'd* 922 F.3d 41 (1st Cir. 2019) (granting a preliminary injunction under the ADA when a county jail had a blanket policy of prohibiting inmates from taking Medication Assisted Treatments during incarceration); *accord: Pesce v. Coppinger*, 355 F.Supp.3d 35 (D.Ma. 2018).

Medically Supervised Withdrawal Likely Violates The ADA

The court in the *Aroostock County* case held that a jail's general policy of putting individuals through medically supervised withdrawal rather than providing them with OUD medication likely violated the ADA. *Id.* at 158-161

DOJ Investigation of the Pennsylvania Unified Judicial System

Example of DOJ ADA Enforcement Against State Courts Related to MOUD

DOJ Issued A Letter of Finding in the ADA Investigation of the Unified Courts of Pennsylvania

Example of DOJ ADA Enforcement Against State Courts Related to MOUD

Some state courts in Pennsylvania were prohibiting or limiting the use of medication to treat OUD by individuals who are under court supervision.

One state court judge issued an administrative order requiring all individuals under the court's supervision to be "completely clean of any opiate based treatment medication" within 30 days of being sentenced.

Threat of Jail For Failure To Discontinue Taking MOUD

A probation officer wrote to a complainant who was being treated with physician-prescribed buprenorphine that she had 30-days to stop taking her prescribed OUD medication or should would be considered to be in violation of her probation and sent to jail.

A probation officer wrote to a second complainant who was also being treat with physician-prescribed buprenorphine that she must stop using MOUD or she would be removed from a diversion program meant to keep first time offenders out of jail.

Threat To Remove From Mental Health Court Program

The Allegheny (PA) County Court of Common Pleas' Mental Health Court required court approval for OUD medication, but cautioned that exceptions to their prohibition "are made only on rare occasions" and that "[i]f a regularly prescribing physician feels that a client needs to be on any prohibited prescription continuously to sustain a certain quality of life, then the client may not be acceptable to participate in the Mental Health Court Program."

Directing Parties To Use A Particular MOUD

The Blair (PA) County Court of Common Pleas prohibited participants in its treatment courts who have OUD from taking any OUD medication other than Vivitrol (i.e., naltrexone). It does not allow the use of other commonly prescribed medications such as methadone or buprenorphine.

DOJ's Finding

"By requiring Complainants . . . to wean off of their prescribed OUD medication, the Jefferson and Northumberland County Courts of Common Pleas **discriminated against the Complainants on the basis of disability and denied them an equal opportunity to benefit from UJS services, programs, or activities**. 42 U.S.C. § 12132; 28 C.F.R. §§ 35.130(a), (b)(1). The bans and limitations imposed on OUD medication by other county treatment courts strongly suggest that those UJS component courts have similarly discriminated and continue to discriminate against other individuals with OUD who were or currently are under court supervision. Discriminating against a person because that person takes medication to treat a disability constitutes discrimination on the basis of disability."

DOJ's Finding

"In requiring the Complainants and others to stop using buprenorphine, the Jefferson and Northumberland County Courts and other UJS component courts also violate the ADA by **imposing an eligibility criterion that screens out or tends to screen out individuals with OUD**, such as the Complainants, from fully and equally enjoying the courts' programs, when the criterion is not necessary for the provision of those programs. 28 C.F.R. § 35.130(b)(8)."

DOJ's Finding

"[T]he bans and limitations on use of OUD medication imposed by the Jefferson and Northumberland County Courts, and by other UJS treatment courts, for individuals under court supervision constitute discriminatory methods of administration that violate Title II of the ADA. These bans and limitations subject qualified individuals with OUD to discrimination and impair or defeat accomplishment of the objectives of the UJS programs in which these individuals participate. 28 U.S.C. § 35.130(b)(3)."

DOJ reached a Settlement Agreement with the Pennsylvania Court System That Includes A Very Informative Policy Document That Provides A Roadmap For ADA Compliance

Administrative Office of Pennsylvania Courts Will Recommend and Encourage All Judicial Districts to Adopt an Addendum To Their ADA policies

Exhibit 1 (Addendum ADA Policy in Judicial Districts)

It is the policy of this judicial district to prohibit discrimination against all individuals—including those with substance use disorder—in accessing or participating in judicial proceedings or other Court services, programs, or activities.

The United States Department of Justice maintains that blanket or *per se* bans barring or otherwise limiting persons under court supervision (including pretrial probation and release, post-conviction probation and parole, and Problem-Solving Courts—including Adult, Juvenile, or Family Drug Court; DUI Court, Adult or Juvenile Mental Health Court; veterans Treatment Court; Domestic Violence Court) from accessing physician-prescribed medications and treatment is a violation of the Americans with Disabilities Act (ADA).

It is the policy of this judicial district to conform to the position of the United States Department of Justice in the following respects.

Key Provisions Of The UJS New ADA Policy

Prohibits judges from limited an individual's use of medications that they have been lawfully prescribed to treat SUD.

Prescription decisions are to made only by a licensed prescriber on an individualized basis.

Key Provisions Of The UJS New ADA Policy

Judges and others in the court system will not express a preference for or mandate one medication over another.

Admission to the drug court program will not be conditioned upon discontinuing or weaning off of prescribed medications.

Judges and others may not rely upon a party's prior illicit use of medications for SUD as a ground for prohibiting current use of a prescribed medication.

Other Settlement Provisions

The Settlement agreement required the UJS to provide ADA training, including about MOUD and disability discrimination to:

All UJS judges handling criminal matters

Probation and treatment court coordinators

Example of DOJ Enforcement Action: ADA/MOUD Case Involving A Jail

Settlement Agreement with Allegheny County, Pennsylvania

Allegheny County Jail ("ACJ") refused to provide an inmate with methadone, an FDA approved medication for OUD, even though he was receiving it from a licensed provider prior to his incarceration.

The Allegheny County settlement agreement (paragraph 13) requires ACJ to:

Evaluate inmates for OUD at the outset of their incarceration to determine if MOUDs would be appropriate, including those who were not previously taking MOUDs.

Provide inmates with access to the FDA-approved medications to treat OUD, including both individuals who are taking MOUDs when incarcerated and those who were not taking MOUDs, but would benefit from them.

(More on next slide)

The Allegheny County settlement agreement (paragraph 13) requires ACJ to (continued from last slide)

Maintain an individual taking a particular medication to treat OUD unless a qualified medical provider concludes that the medication is no longer medically appropriate.

Not use incentives, rewards, or punishments to encourage or discourage individuals from receiving any particular medication to treat OUD while they are in ACJ's custody and control.

Learn More About DOJ's Position on ADA/MOUDs

DOJ's Statement of Interest in Strictland v. Delaware County

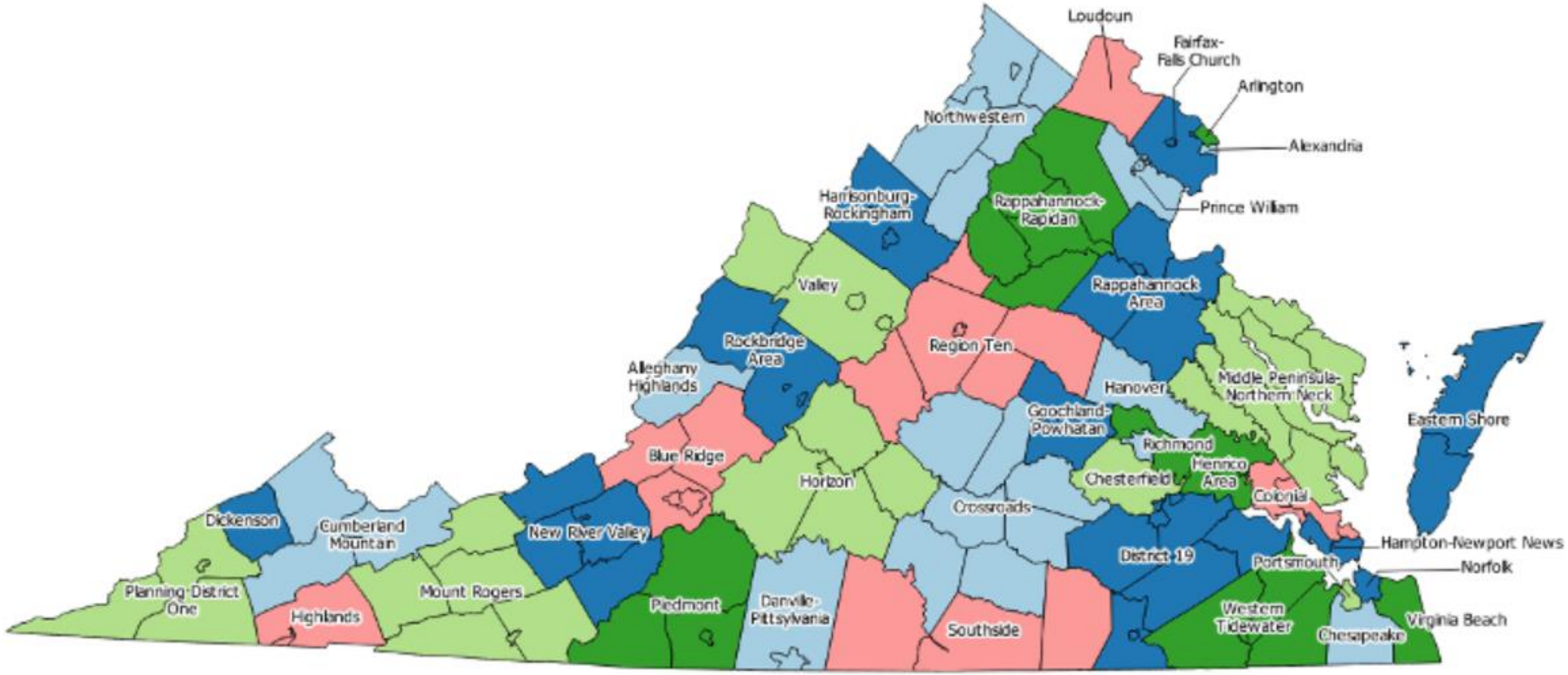
Potential Collaborators

Virginia Community Service Boards

CSB's Responsibilities

- CSBs function as the **single points of entry** into publicly funded **mental health, developmental, and substance use disorder services**, defined in § 37.2-100 of the Code of Virginia (Code).
- CSBs are **service providers**, directly and through contracts with other providers.
- CSBs serve as **advocates** for individuals who are receiving or are in need of services.
- CSBs act as **community educators**, **organizers**, and **planners**.
- All 40 CSBs offer MOUD services.

CSB Coverage Map



Virginia Opioid Abatement Authority

What is the OAA?

The Opioid Abatement Authority is an independent body, the purpose of which is to abate and remediate the opioid epidemic in the Commonwealth through financial support from the Fund, in the form of grants, donations, or other assistance, for efforts to treat, prevent, and reduce opioid use disorder and the misuse of opioids in the Commonwealth.

Fairfax County Sheriff's Department – Trailblazer on Using MOUDs (Nuts & Bolts)

Jail-based Addiction Recovery Program Continues at Release through Community Partnerships

"In the Fairfax County Adult Detention Center, our goal is to assist incarcerated men and women leading up to their release from the jail and set them up to successfully reintegrate into the community."

Sahana Karpoor, LCSW, Behavioral Health/MAT Program Manager
Fairfax County Sheriff's Office

October 25, 2022

In the operation of its Adult Detention Center (ADC), the Fairfax County Sheriff's Office offers Medication for Addiction Treatment (MAT) for inmates with opioid use disorder (OUD). OUD is a chronic but treatable health condition similar to diabetes, heart disease or asthma. With the MAT program, the Sheriff's Office has not only made it a priority to offer evidenced-based treatment for individuals with OUD while they are incarcerated but also to ensure wraparound reentry recovery supports at release.

In FY 2022, the Sheriff's Office had 805 inmates engaged in MAT services.

As these incarcerated men and women prepare to leave the ADC, the Sheriff's Office – in partnership with the jail-based Community Services Board (CSB) team and the Chris Atwood Foundation (CAF) – links them with recovery housing, 12-step programs such as Narcotics Anonymous, wellness programs, and a MAT provider in the community.

To increase the chances for success on the challenging path to recovery, the Sheriff's Office gives participants bridge doses of OUD medications to cover them until they are able to connect with a community provider. Additionally, participants are given a free cell phone with a fixed number of minutes and the capability for the CSB Addiction Medicine Clinic (AMC) to add more minutes. This cell phone helps them connect with community-based recovery supports. The Sheriff's Office reentry program recognizes transportation as one of the challenges for continued success and immediately sets up transportation to a MAT clinic and recovery housing, as needed. Before participants leave the jail, the reentry coordinator also can assist them with obtaining legal identification and starting the Medicaid application/eligibility process.

Nurse prepares to give an inmate a dose of medication while deputy watches.

Chesterfield Sheriff's Department

CHESTERFIELD COUNTY

New medication-assisted opioid treatment program launches in Chesterfield County Jail

by: Tannock Blair
Posted: May 16, 2022 / 04:28 PM EDT
Updated: May 16, 2022 / 04:28 PM EDT

(U.S. Attorneys Office for Utah via AP)

Recovery Behind the Walls Group

Hosted by the correctional facilities that offer MOUDs.

Started in May 2022.

February 2024: 40 jails participate.

My Contact Information

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Is Marijuana Medicine?
What We Know and What We Don't about Cannabis, THC, and CBD, and How Treatment Courts Can Respond

Brian L. Meyer, Ph.D.
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August 13, 2024

Disclaimer

The views expressed in this presentation are solely those of the presenter and do not represent those of the Veterans Health Administration or the United States government.

The presenter has no conflicts of interest to disclose.

None of the material in this presentation should be taken as legal advice. It is a clinical and scientific approach to the problems that legalized “medical” uses of marijuana present. Courts must follow their state laws, which vary enormously from state to state.

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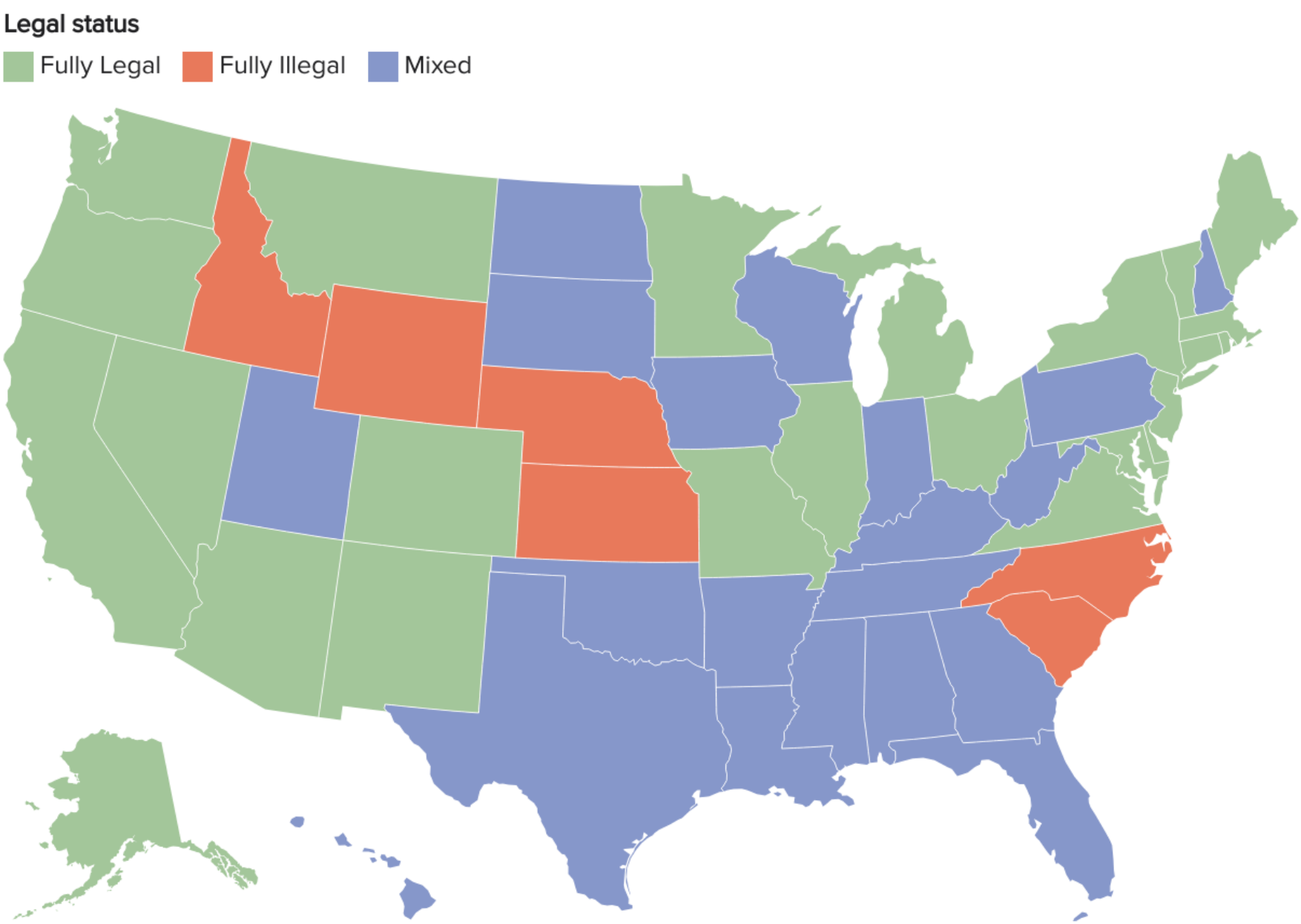
CANNABIS USE IN THE U.S.

Legality of Marijuana

- Illegal at federal level
- 24 states plus Washington DC have legalized recreational marijuana
- 38 states have legalized medical marijuana
  - 29 include PTSD
  - 33 include pain
  - 3 include TBI

States in Which Marijuana Is Legal



Note: Data as of April 19, 2024.

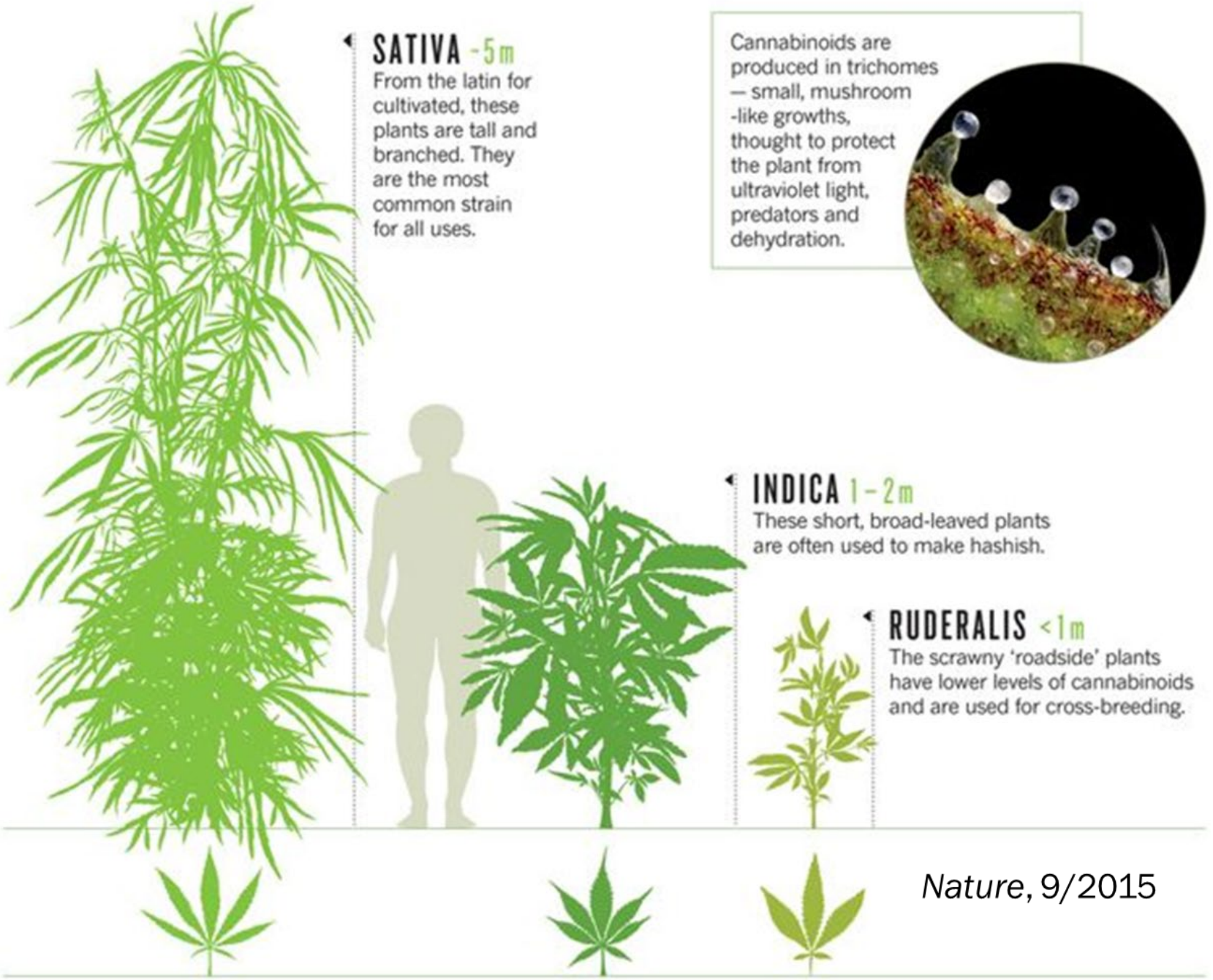
Map: Taylor Johnston / CBS News • Source: DISA Global Solutions

Medical Marijuana in Virginia

- In order to qualify for medical cannabis in Virginia, you must be a Virginia resident and have a condition that an eligible medical practitioner has determined will benefit from the use of cannabis
- The medical practitioner must issue a written certification for medical cannabis

WHAT IS MARIJUANA?

Species of Cannabis



Despite many claims otherwise, there is little to no research indicating that ingestion of different species results in different effects.

Different Types of Marijuana?

- **Hemp** is a strain of cannabis sativa with less than 0.3% THC content
- **Sinsemilla** is a strain of cannabis sativa in which female plants are kept seedless to produce high THC content
- Potency of marijuana varies from crop to crop and even plant to plant

Beware the power of testimonials!

Types of Cannabinoids

Phytocannabinoids are compounds produced by the cannabis plant (e.g., THC, CBD, CBN)

Endocannabinoids are neurotransmitters produced naturally in the body

- They play roles in cognition, emotion, and memory

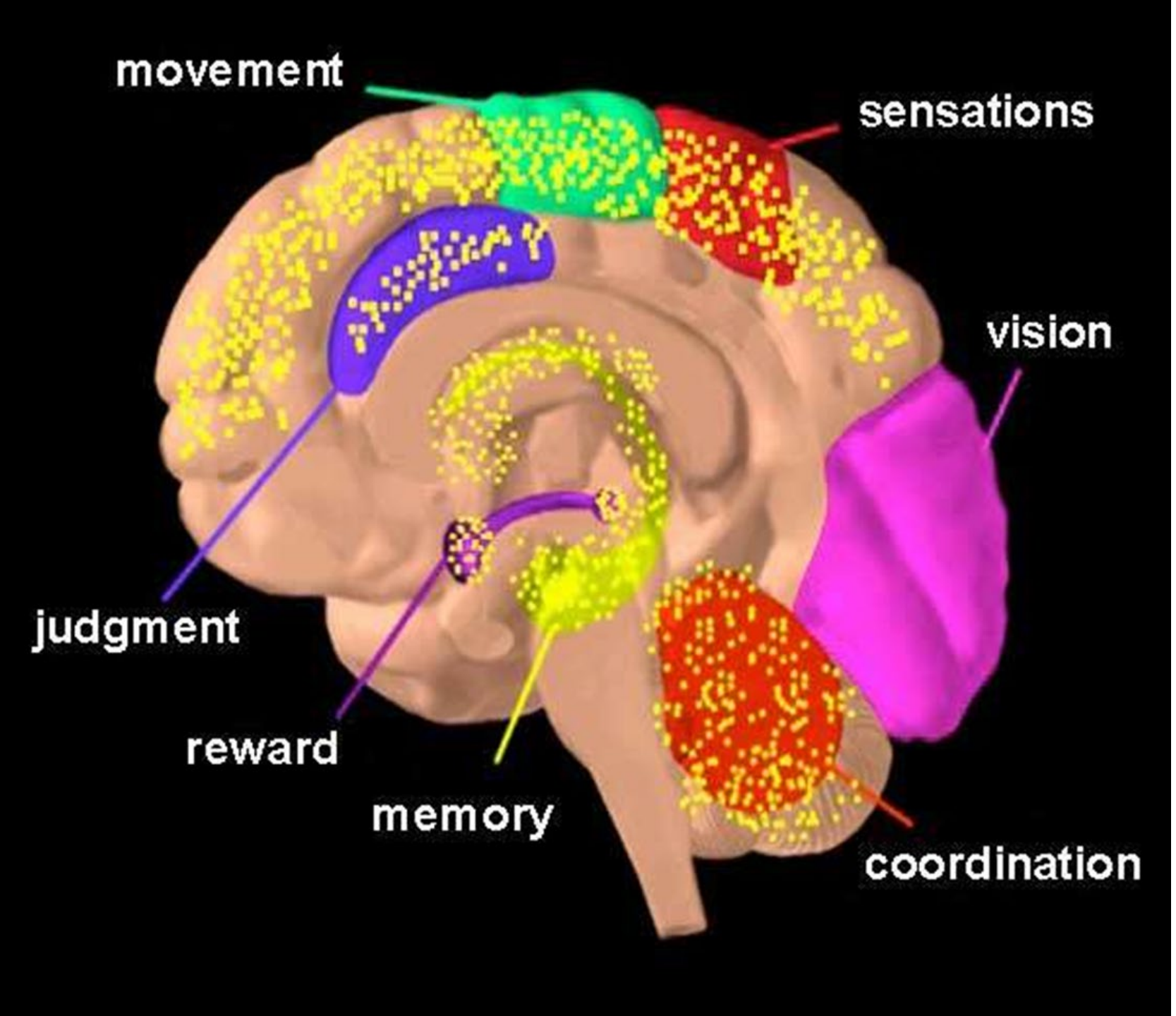
Pharmaceutical cannabinoids are synthetic analogs produced in a lab or pharmaceutically prepared as a whole plant extract

- Marinol (dronabinol), Nabilone
- Nabiximols, Epidiolex

Synthetic cannabinoids are man-made chemicals sprayed on dried plants or sold as liquids (e.g., k2, spice)

Herkenhamet al., 1990; Mechoulam& Parker, 2013; Moreira & Lutz, 2008; WHO, 2016

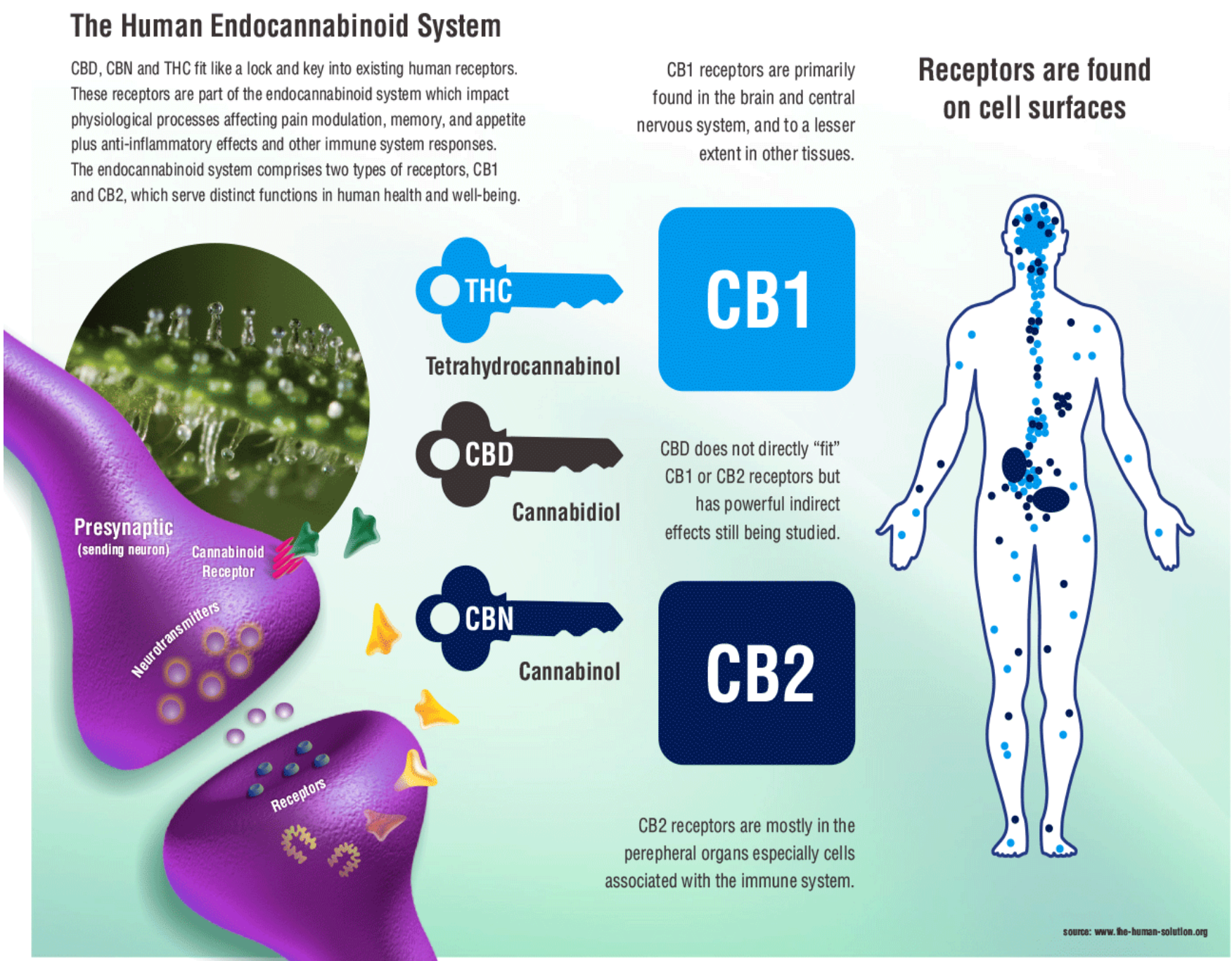
THE EFFECTS OF MARIJUANA



THC Receptors in the Brain

Volkow, NIDA 2014

There are at least 113 identified cannabinoids in a cannabis plant. We know very little about most of them, and less about how they affect the human brain and body.



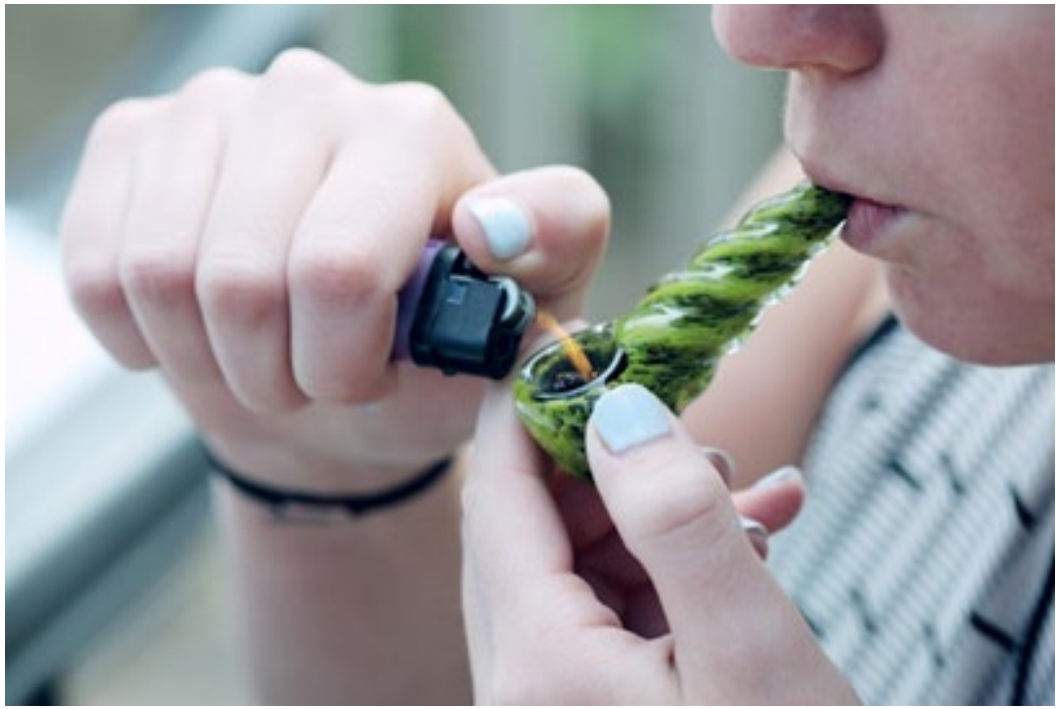
Short-Term Effects of Marijuana

- Mild euphoria, “High”, “buzz”
- Appetite stimulation, “munchies”
- Altered senses (for example, seeing brighter colors)
- Altered sense of time
- Changes in mood from euphoria to anxiety and panic
- Impaired body movement
- Difficulty with thinking and problem-solving
- Impaired memory
- Hallucinations (when taken in high doses)
- Delusions (when taken in high doses)
- Psychosis (risk is highest with regular use of high potency marijuana)

NIDA, 2019

Short-Term Effects of Marijuana Vary Depending on:

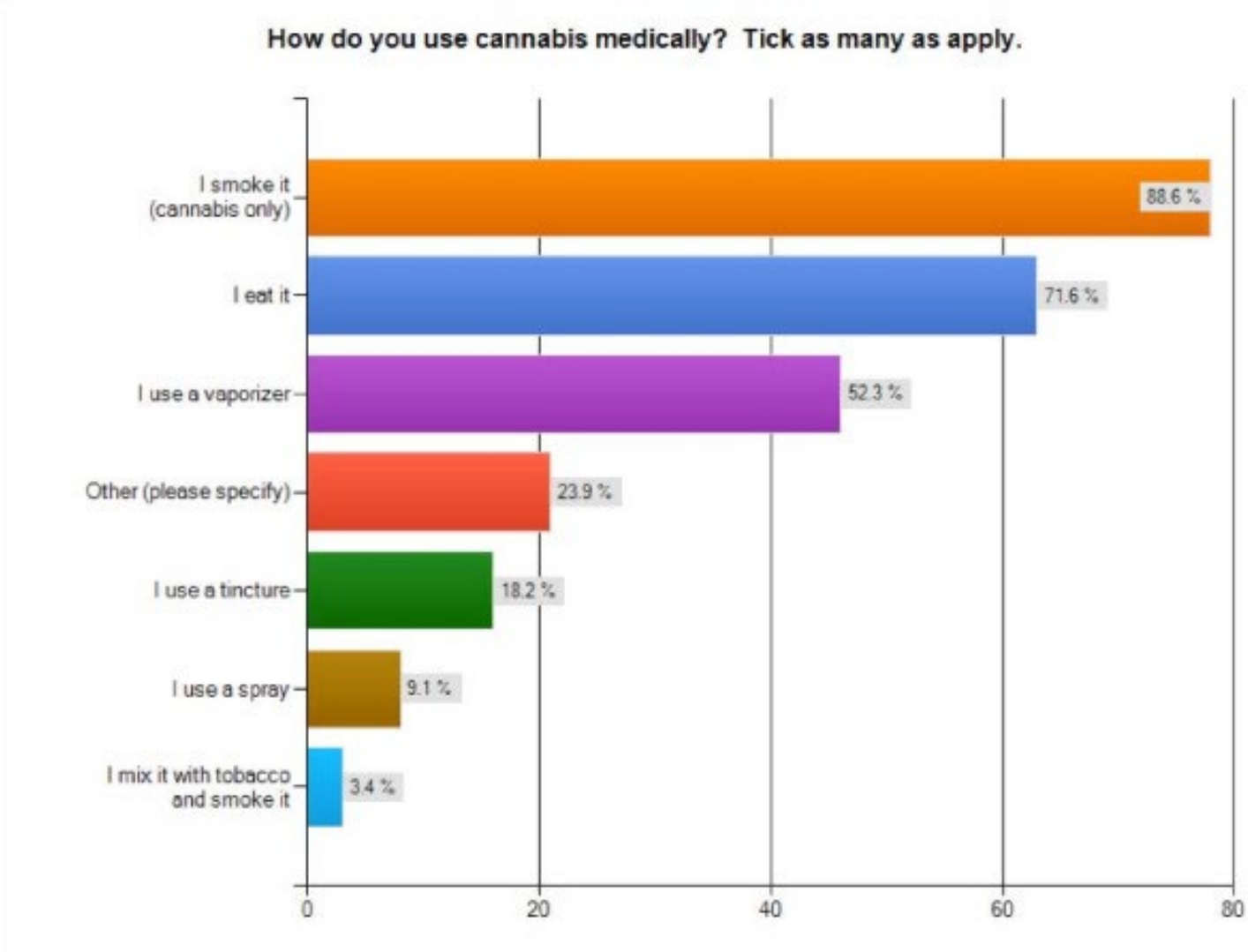
- Proportions and concentration of cannabinoids
- Route of administration
- Dose and quantity consumed
- Frequency of use
- Gender
- Genetic vulnerability
- History of use/prior experience
- Mood state
- Environment/context of use
- Concurrent drug use



Crippaet al., 2009; WHO, 2016

slide information by Browne, 2019

Routes of Cannabis Administration



Lucas, 2012

Some Proposed Medical Uses of Marijuana

- May help with inflammation such as in inflammatory bowel disease (Nagarkatti et al., 2009)
- Decreases nausea
- Stimulates appetite
- Anticonvulsant effect
- May help movement disorders
- Decreases eye pressure in glaucoma
- Analgesic effects

The use of medical marijuana for a wide range of disorders is inconsistent with the science supporting its effectiveness.

Andrew Monte, Richard Zane, & Kennon Heard, 2015

ARE THERE POSSIBLE MENTAL HEALTH USES FOR MARIJUANA?

There is no current scientific evidence that marijuana is in any way beneficial for the treatment of any psychiatric disorder. In contrast, current evidence supports, at minimum, a strong association of cannabis use with the onset of psychiatric disorders. Adolescents are particularly vulnerable to harm, given the effects of cannabis on neurological development.

American Psychiatric Association, 2013

The Relationship between Marijuana and Anxiety Is Complex

- Cannabis causes acute anxiety in 20-30% of users after smoking it (Thomas, 1996)
  - This is especially true at high doses and in drug-naïve people Manzanare et al., 2004)
- Frequent users have higher anxiety levels than non-users (Crippa et al., 1998)
- The probability of mood or anxiety disorders in users with dependence doubles (Agosti, Nunes, & Levin, 2002)
- Cannabis dependence is also related to panic attacks (Zvolensky et al., 2006)
- Long-term users report a reduction in anxiety (Hathaway, 2003)

Does Marijuana Treat PTSD?

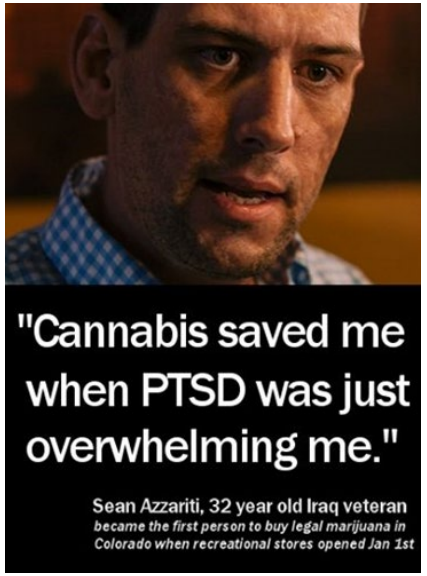
There is no current scientific evidence that *the cannabis plant* is an effective treatment for PTSD. What we have:

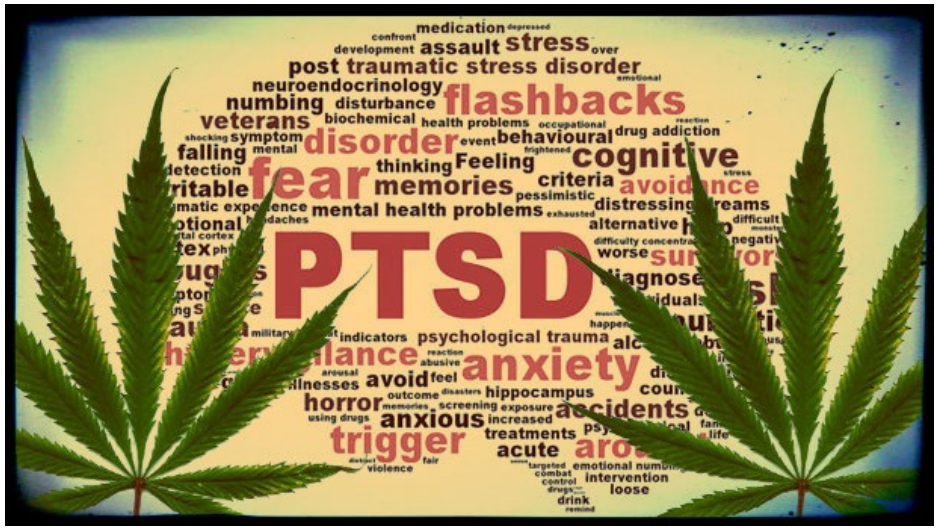
- Anecdotal evidence from cannabis users that drug helps with PTSD
- Preclinical studies testing a specific pharmaceutical cannabinoid
- Few studies of pharmaceutical cannabinoids in humans
- Case studies
- No randomized controlled trials studying the cannabis plant
- Long term effects are largely unknown

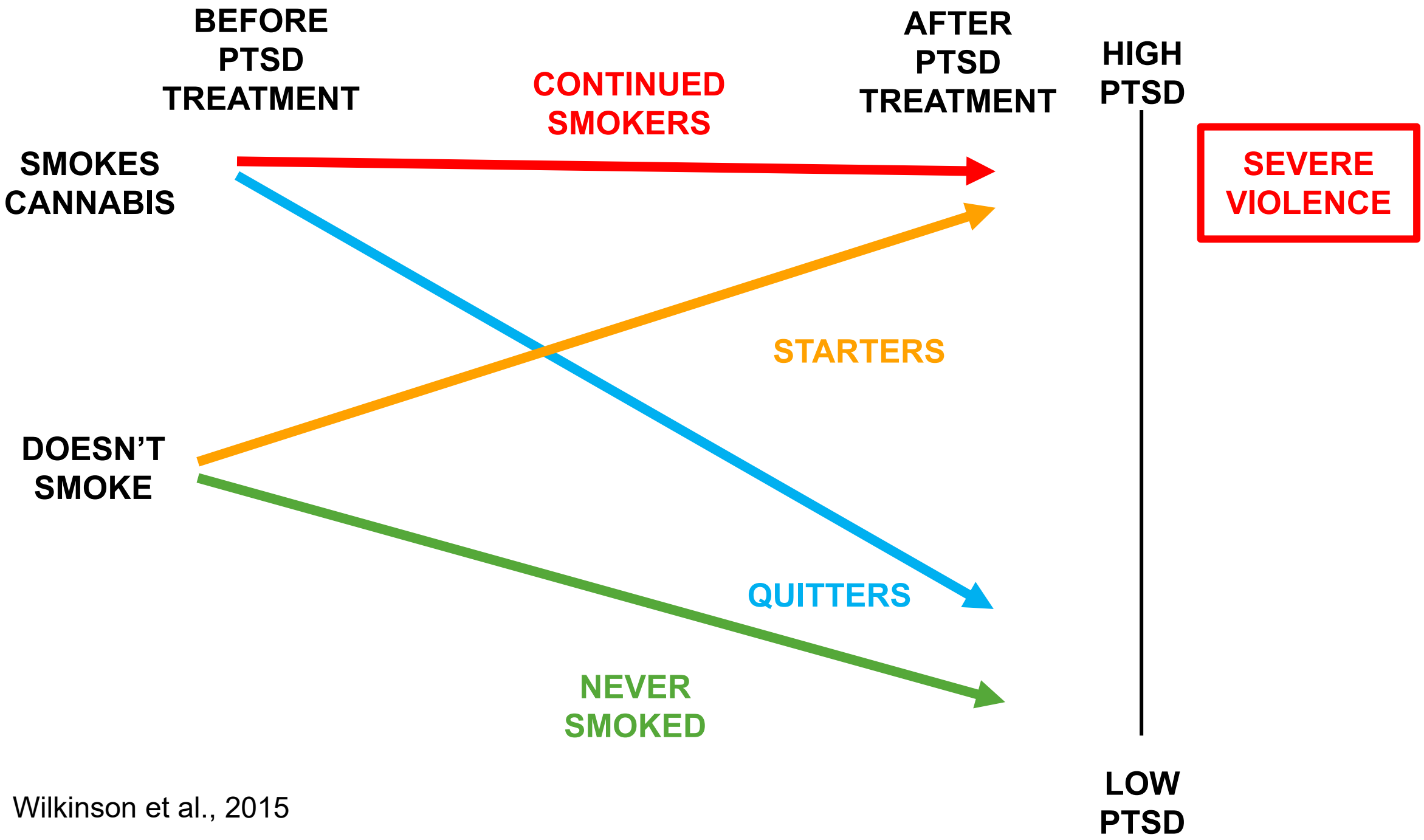
Browne, 2019

Does Marijuana Treat PTSD?

- Many people with PTSD claim that marijuana is the only thing that helps their PTSD
  - Some Veterans are lobbying Congress to allow the VA to prescribe medical marijuana
- There is no research evidence for this claim
  - The first two studies shows that marijuana makes PTSD *worse*
  - One found that cannabis use <u>prolonged</u> PTSD symptoms (Bonn-Miller et al., 2011)







Wilkinson et al., 2015

Does Marijuana Reduce the Incidence of Opioid Use Disorder?

- This hypothesis is based on the idea that marijuana may substitute as a treatment for pain, thus reducing the need for opioids
- The effects of cannabis and cannabinoids on chronic noncancer pain are small to none, and the likelihood of harm is moderate to high (Hauser et al., 2019; Stockings et al., 2018)
- Sativex, a pharmaceutical mix of THC and CBD not available in the U.S., has failed Phase III clinical trials in reducing cancer pain (Fallon et al., 2015)

Does Marijuana Reduce the Incidence of Opioid Use Disorder?

- Cannabis use is associated with opioid misuse (Reisfield et al., 2009)
- Cannabis use increases the risk of developing nonmedical prescription opioid use and Opioid Use Disorder (Olfson et al., 2018)

Meta-analyses…do not strongly support the use of cannabinoids for chronic pain nor do prospective studies demonstrate significant cannabinoid-mediated opioid sparing effects.

Babalonis & Walsh, 2019

Does Marijuana Decrease Opioid Deaths?

- Some people have argued that marijuana can be used to decrease opioid deaths
- A 2014 study (Bachhuber et al., 2014) of the years 1999-2010 found that there were 25% fewer opioid overdose deaths in states with medical marijuana laws compared to those without
  - This was trumpeted by the marijuana industry
- However, a 2019 follow-up study (Shover et al., 2019) found that this was true only for the years 1999-2010
  - It found that, when the analysis was extended to 2017, there were 23% *more* opioid overdose deaths in states with medical marijuana laws

To Be Fair, There Are Problems in Marijuana Research

- The federal government has limited research on marijuana
- All marijuana used for federally-approved research came from one 12 acre farm at the University of Mississippi (now there are two)
  - It is one strain
  - It is less potent than most marijuana available today
  - Often there are more approved studies than marijuana available
- Many studies have been done with pharmaceutical THC or CBD, not the cannabis plant

Therefore, most research that has been conducted is not generalizable

IS MARIJUANA MEDICINE?

What Do You Get When You Buy Marijuana Products?

We don't know

- A study of 84 CBD products made by 31 companies sold online (Bonn-Miller et al., 2013) found:
  - Only 26 were accurately labeled
    36 underestimated the amount of CBD
    22 overestimated the amount of CBD
  - THC was detected in 18 samples
  - Cannabidiolic acid was found in 13 samples
  - Cannabigerol was found in 2 samples

What Do You Get When You Buy Edible Marijuana?

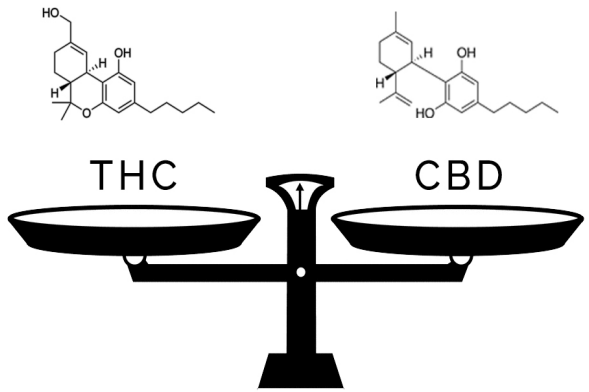
16-26% of patients using medical marijuana consume edibles (Grella et al., 2014; Walsh et al., 2013)

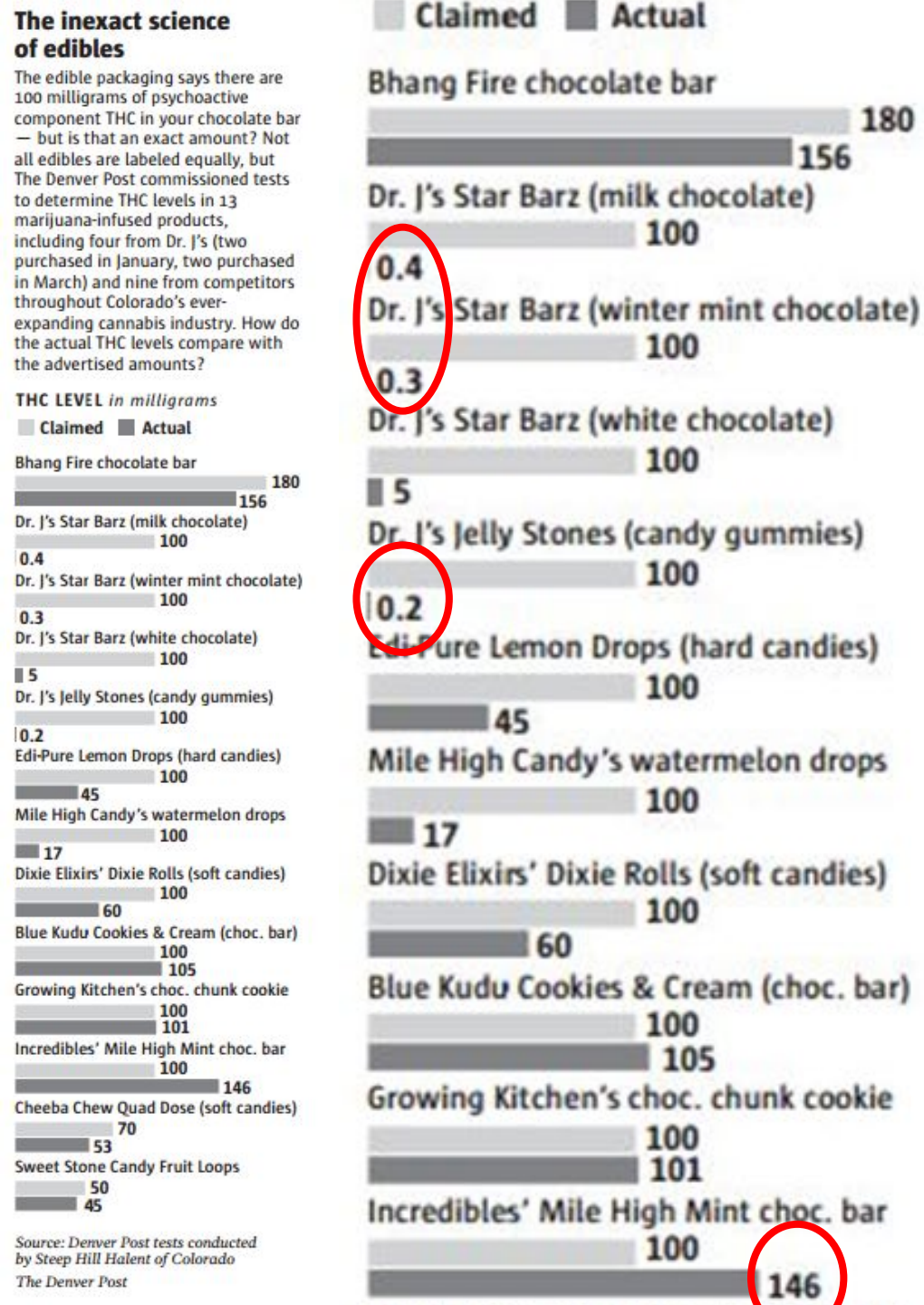
We don't know

- A study of 75 edible products from 47 brands sold in California and Washington (Vandrey et al., 2015) found that:
  - 13 were accurately labeled for THC
    17 were underlabeled for THC
    40 were overlabeled for THC
  - 44 had detectable levels of CBD
    Only 13 had CBD labeled
    4 were underlabeled for CBD
    9 were overlabeled for CBD
  - Other cannabinoids were found

The Ratio of CBD:THC May Matter

- THC and CBD have inverse quantities in a cannabis plant
  - The more THC there is, the less CBD there is
- There is more CBD in stems and more THC in leaves and flowers
- CBD can inhibit some of the psychoactive effects of THC (Russo & McPartland, 2003)
- One study suggests a ratio of 1:1 may be optimal (Vermersch, 2011)
  - This is the ratio in Sativex





Effects of Edibles

- Inconsistent dosing: An examination in the Denver Post (3/9/14) of 10 edibles claiming to contain 100 mg. of THC found that the actual amounts varied from <1mg. To 146 mg.
- The delayed effects of ingestion may cause some people to ingest more of the product

Problems in Determining What People Get When They Use Cannabis

- Different subtypes of cannabis
- Unknown concentrations of THC, CBD, and other cannabinoids in individual plants
- Differing ratios of THC:CBD
- Differing methods of ingestion can increase percentage of THC ingested
- Inaccurate labeling
- Lack of information about dosages
- Lack of research

Is Marijuana Medicine?

- According to the federal Food and Drug Administration (FDA), a drug is defined as:
  - A substance recognized by an official pharmacopoeia or formulary.
  - A substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.
  - A substance (other than food) intended to affect the structure or any function of the body.
  - A substance intended for use as a component of a medicine but not a device or a component, part or accessory of a device.
- FDA considers drug products to be pharmaceutical equivalents if they meet these three criteria:
  - They contain the same active ingredient(s)
  - They are of the same dosage form and route of administration
  - They are identical in strength or concentration

FDA, 2019

Is Marijuana Medicine?

- All FDA-approved medicines have clearly-defined and measurable ingredients that are consistent from one dose to the next
- Cannabis plants contain hundreds of chemical compounds that vary from plant to plant
- Medicine from a pharmacy provides information on:
  - Brand/manufacturer
  - Drug strength
  - Directions for administration
  - Indications for use (that have been proven by research)
  - Reactions/side effects
- Marijuana is not a single entity

Is There Medical Use for Marijuana?

- Evidence for some medical value of some components
  - CBD and seizure disorder (Dravet's syndrome and Lennox-Gastaut syndrome)
  - THC products for wasting illnesses and appetite production

- Medications must have undergone substantial research to answer critical questions before getting to market and widespread use in humans:
    - Isolation of single components; manufacture processes
    - Delivery mechanism
    - Pharmacokinetics/pharmacodynamics
    - Dose-response relationships (e.g.: doubling a dose may or may not double the effect)
    - Therapeutic range
    - Adverse events: what are they and how best to avoid/address should they occur?
  - These types of studies would be difficult for marijuana because there are so many components

Summary of Recent Meta-analysis of Cannabinoid Effects on Mental Health Problems

- 83 studies from 40 randomized controlled trials
- N=3,067

There is scarce evidence to suggest that cannabinoids improve depressive disorders and symptoms, anxiety disorders, attention-deficit hyperactivity disorder, Tourette syndrome, post-traumatic stress disorder, or psychosis. There is very low quality evidence that pharmaceutical THC (with or without CBD) leads to a small improvement in symptoms of anxiety among individuals with other medical conditions. There remains insufficient evidence to provide guidance on the uses of cannabinoids for treating mental disorders within a regulatory framework.

Black et al., *The Lancet,* 10/28/19

Conditions that Qualify for the Texas Compassionate Use Program That Allows Low THC Cannabis (<0.5%) to be Swallowed

- Amyotrophic Lateral Sclerosis
- Autism
- Epilepsy
- Multiple Sclerosis
- Seizure Disorders
- Spasticity
- Terminal Cancer

- Incurable neurodegenerative diseases
  - Muscular Dystrophy
  - Vascular dementia
  - Huntington’s Disease
  - Alzheimer’s Disease
  - Prion Diseases
  - Chronic Traumatic Encephalopathy
  - Lewy Body Dementia
  - Parkinson's Disease
  - Maple Syrup Urine Disease
  - And dozens of other rare diseases

Which Conditions That Qualify for the Texas CUP Are Proven to Respond to Cannabis?

- Multiple Sclerosis
- Two rare childhood seizure disorders: Dravet's Syndrome and Lennox-Gastaut Syndrome
- Spasticity

- Note: we do not know if any of these respond to low-THC cannabis

IF MARIJUANA IS MEDICAL, DOES IT HAVE SIDE EFFECTS?

Effects on Major Organ Systems

Respiratory

- Many of the same mutagens and carcinogens in nicotine are found in marijuana smoke
- Impact on lung function and respiratory cancer is being studied

Immunologic

- Evidence of immunosuppression due to impact on CB2 receptor
- Observed increase in mortality of HIV positive patients with cannabinoid abuse
- Increased incidence of viral infections

Cardiovascular

- Increases heart rate and produces orthostatic hypotension
- May impact platelet function and play a role in atherogenesis

Information from Ilene Robeck

Effects on Major Organ Systems

Liver

- **Daily** cannabinoid use is associated with liver steatosis that can lead to fibrosis

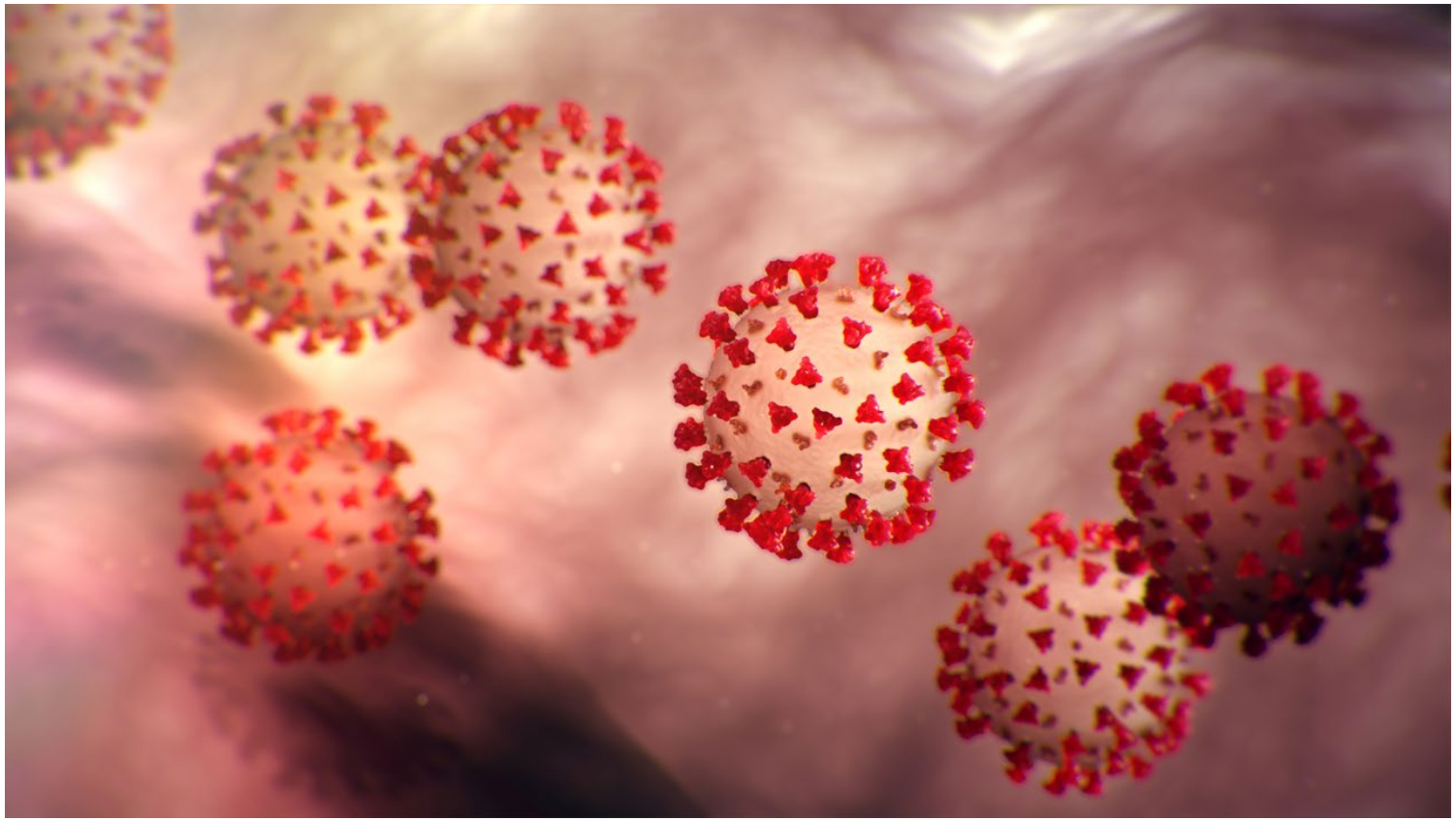
Endocrine

- Inhibition of Pituitary Luteinizing hormone, Prolactin, and Growth Hormone
- Induction of ACTH and Corticosterone Secretion

Information from Ilene Robeck

Vulnerability to COVID-19: A Side Effect of Use

- A recent study (Wang et al., 2021) found that cannabis smokers with CUD were 3X as likely to develop COVID-19 as non-smokers



Cannabis and Fertility

- Cannabis decreases sperm count, seminal fluid, and causes abnormal sperm behavior (Burkman et al., 2019)
- It decreases sperm motility
- Cannabis causes changes in DNA of sperm (Kollins et al., 2018)
- Marijuana may delay or prevent ovulation
- Marijuana use during pregnancy may lead to low birth weight, developmental delays, and behavioral problems

Neonatal Effects of Exposure to Cannabis In Utero

Laboratory exposure to THC and other cannabinoids leads to the formation of functionally impaired neurons. (Miranda et al., 2020)

- Vasoconstriction, which reduces blood supply and oxygenation, which can lead to hypoxia and possible ischemic injury (Thompson et al., 2009)
- Low birth weight babies
- Mild withdrawal symptoms at birth
- Increased newborn morbidity, especially susceptibility to illness (Metz et al., 2017)
- Increased NICU admissions (Warshak et al., 2015)

Recent Research on Prenatal Exposure to Cannabis In Children

- Longitudinal Adolescent Brain and Cognitive Development Study of 11,489 9-11 year-olds (Paul et al., 2020)
- Fetal exposure to cannabis after knowledge of pregnancy related to lower birth weight, total intracranial volume, and white matter volume
- Exposure both before and after knowledge of pregnancy related to lower cognition, lower grey matter, BMI, and sleep problems
  - They were also related to psychopathology, including psychotic-like experiences, depression, anxiety, thought problems, social problems, and problems in attention, impulsivity, internalizing behaviors, and externalizing behaviors
- A 20 year study of birth outcomes (Hines et al, 2021) found that both maternal and paternal use of cannabis increased the likelihood of pre-term birth 6 X

Effects of Prenatal Exposure to Cannabis

In Children

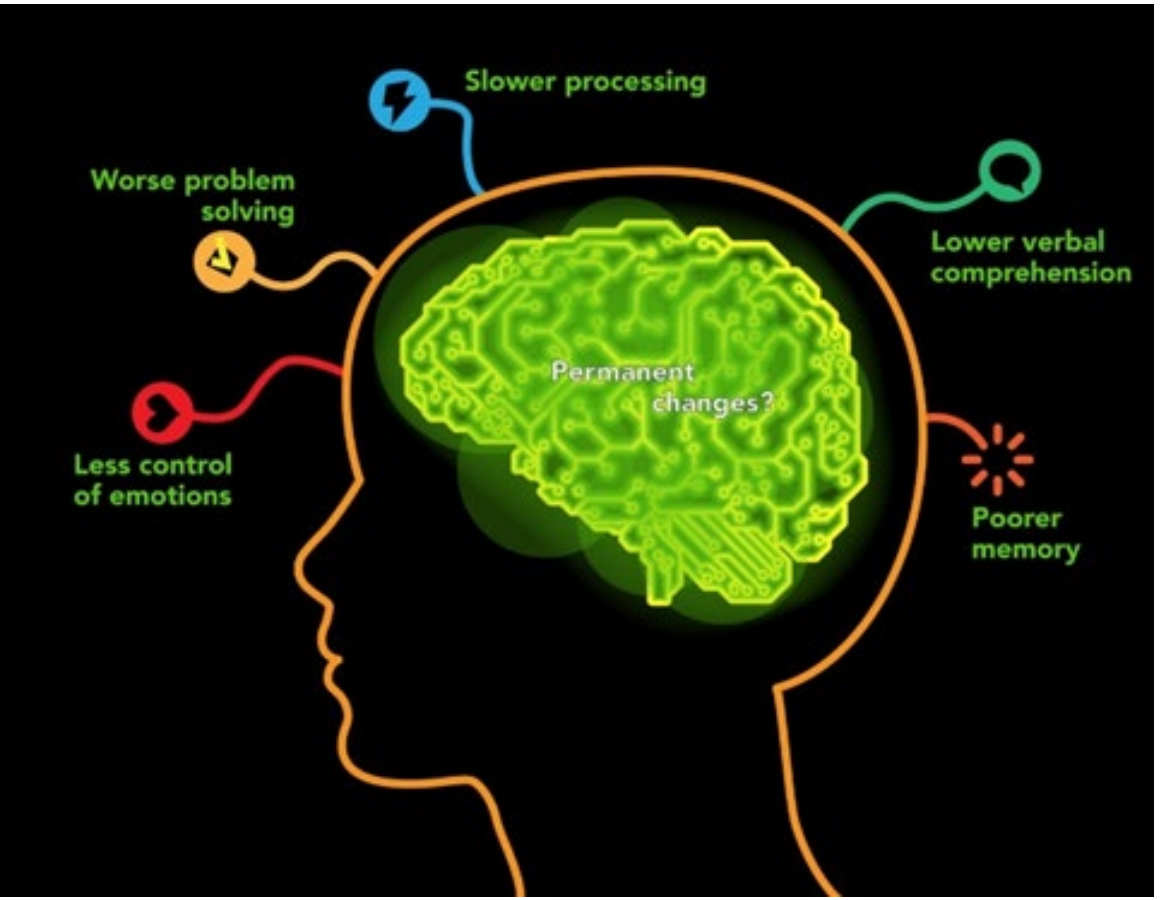
- Poorer school achievement, especially in reading and spelling
- Poorer problem-solving
- Impaired attention
- Deficit in memory
- Learning disabilities
- Impaired planning
- Increased impulsivity
- Hyperactivity
- Depressive symptoms

In Adolescents

- Decreased working memory
- Impaired executive function
- 2X risk of tobacco and marijuana use, starting earlier
- Delinquent behaviors
- Increased risk for psychiatric disorders

Goldschmidt et al., 2004;
Minnes et al., 2011;
Smith et al., 2004

Acute Cognitive Effects



- Decline in verbal fluency
- Decline in memory recall
- Changes in sensory perception
- Slower reaction time, including driving
- Decreased attention span
- Decreased accuracy in assessing time and distance
- Slower ability to shift sets
- Decreased psychomotor coordination
- Decreased problem solving
- Declines in academic performance

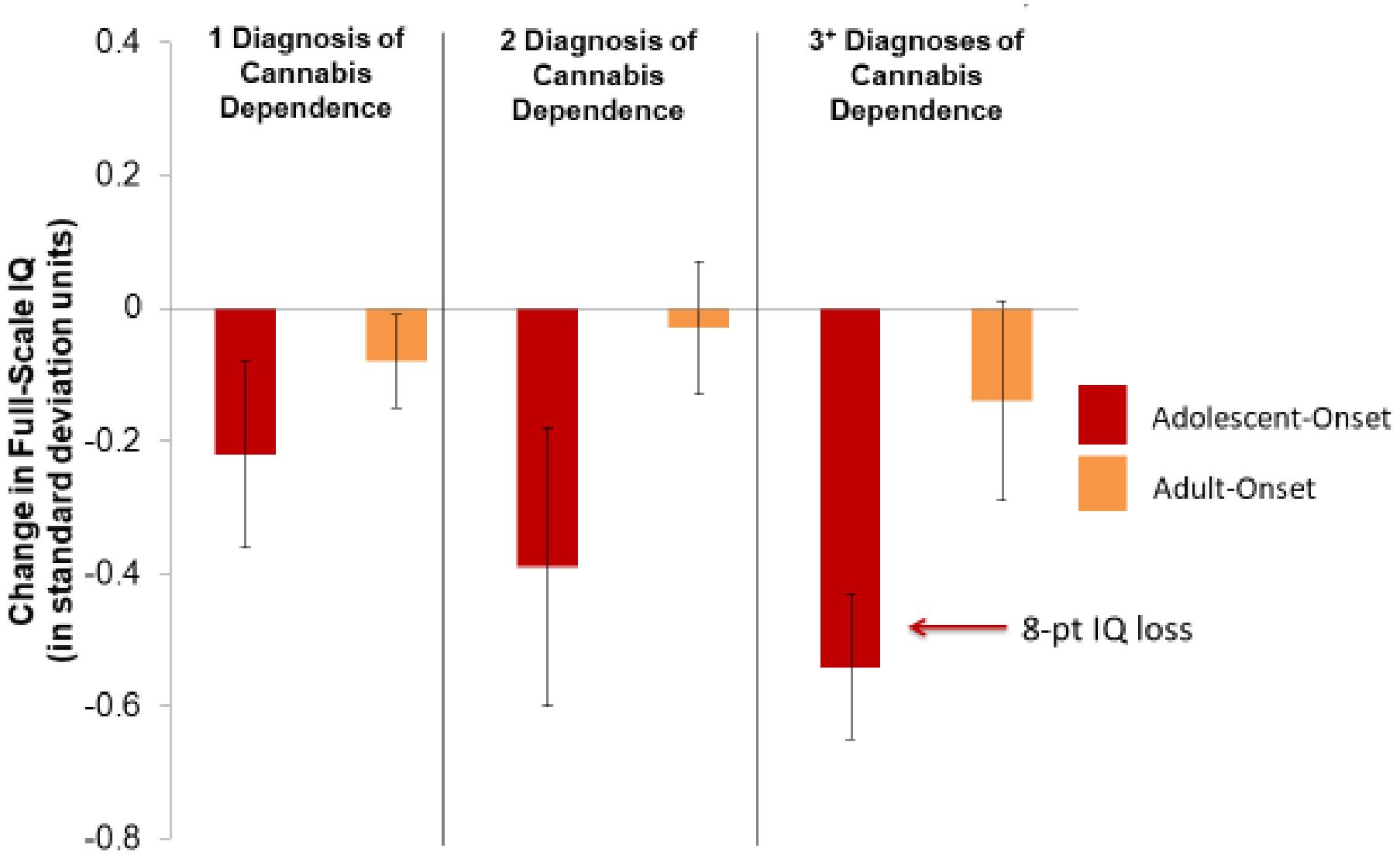
Even Small Amounts of Cannabis Can Change the Teenage Brain

- 14 year-olds with 1-2 instances of cannabis use (Orr et al., 2019)
- Several regions of the brain had increased grey matter volume compared to matched controls
- Perceptual reasoning was worse
- Use was associated with future generalized anxiety symptoms

Adolescent Onset of Cannabis Use Results in IQ Decline

Longer persistence of use led to greater impairment.

IQ did not rebound after cannabis use stopped.



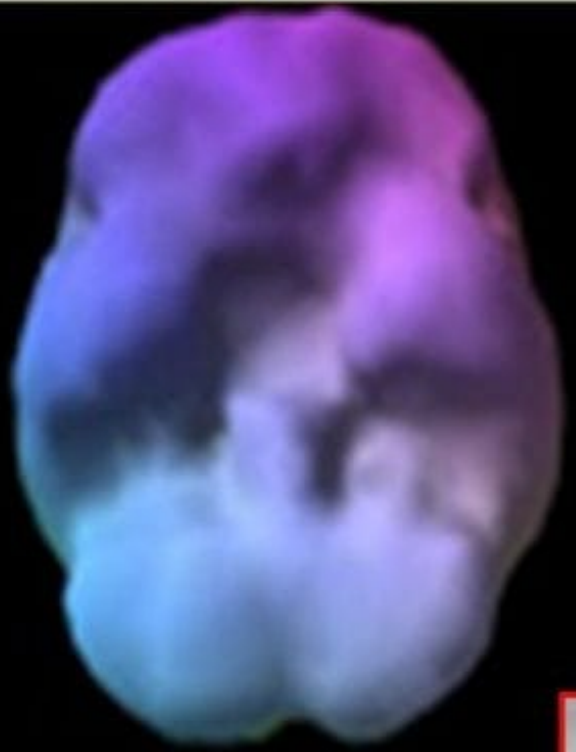
Adolescent cannabis exposure is associated with greater decrease In IQ

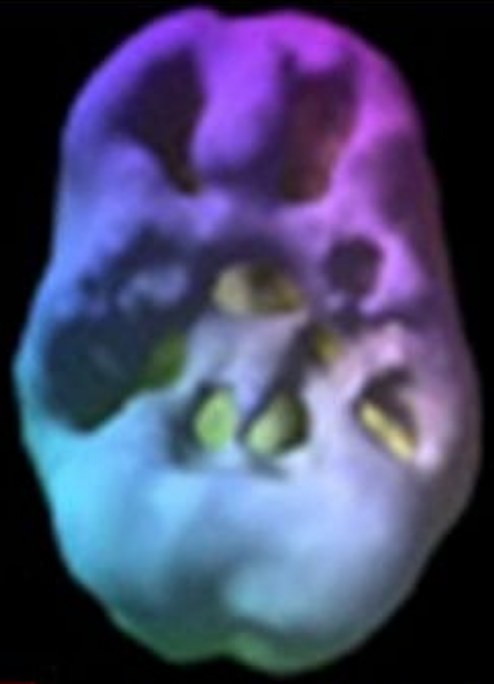
Meier et al., 2012

OPTIMAL?

Healthy Brain

Marijuana Brain





16 yr. old daily user

Amen Clinics

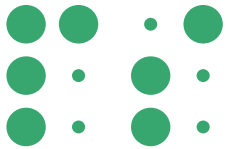
Early Initiators Have Worse Outcomes

- Study of the NSDUH results from 2015-2018 (Volkow et al., 2021) indicates:
  - 15.4% of adolescents had used cannabis and 51.5% of 18-25 y.o. had used cannabis
  - Adolescent initiators were more likely to develop Cannabis Use Disorder than young adult initiators
- A longitudinal 20 year Australian study of adolescent vs. young adult initiators (Chan et al., 2021) found that early initiators of cannabis use were more likely to use illicit drugs, to become high-risk alcohol drinkers, to smoke daily, and less likely to be in a relationship

Long-Term Effects

Impaired memory

Decreased attention



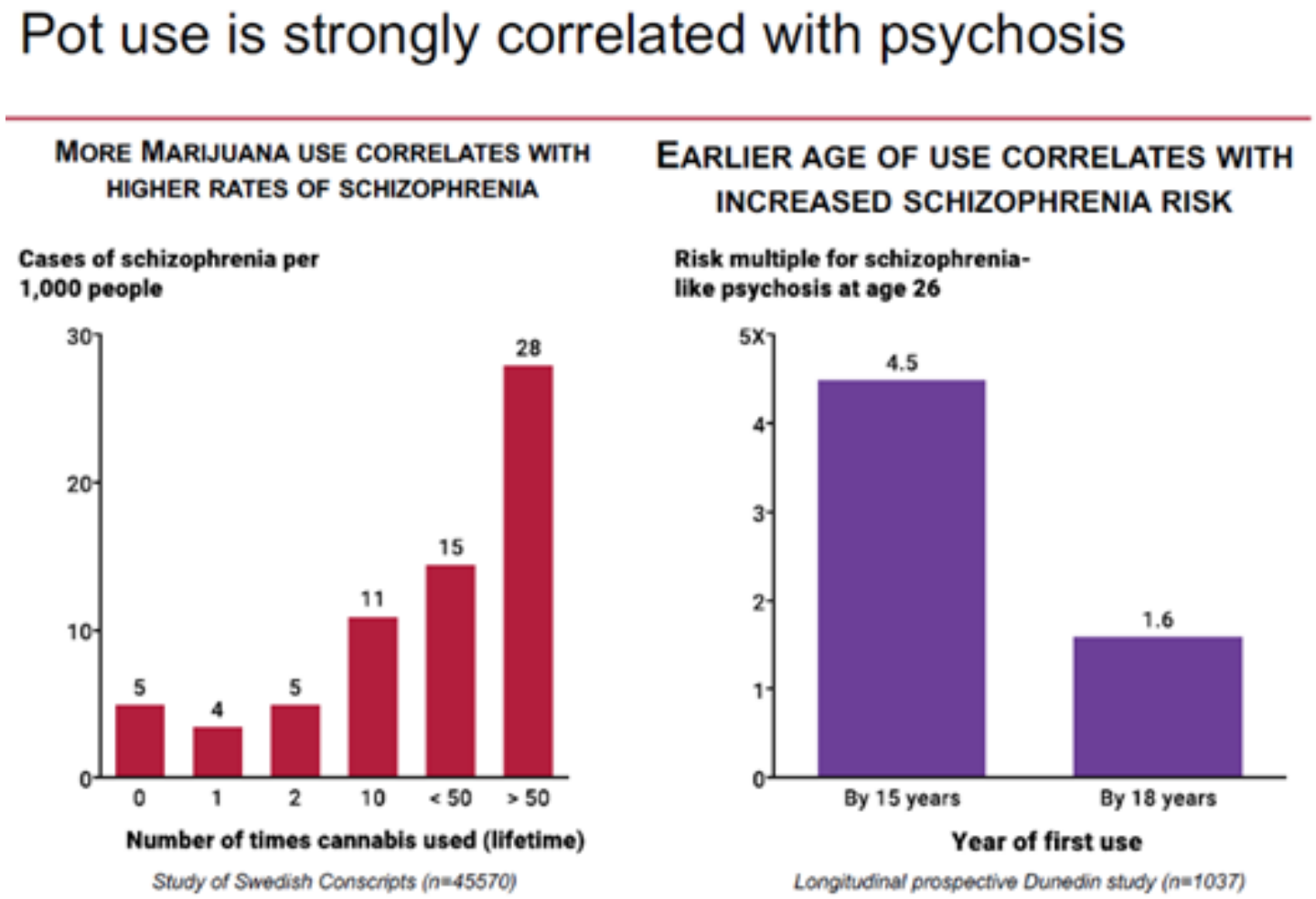
Impaired learning ability

Slowed information processing

Decreased motivation

- These all worsen with increasing usage
- These all worsen when usage begins in childhood or adolescence

Mental Health Effects of THC



- Increased paranoia
- Can trigger psychosis, including schizophrenia (Andreasson et al., 1987; Arseneault, 2002)
- Paranoid psychotic disorder in adulthood (D'Souza et al., 2016)
- Increased panic
- Increased anxiety disorders
- Increase depressive disorders

We know almost nothing about marijuana with > 16% THC content

Cannabis Use Continues to be Associated with Mental Health Problems

- Adults with depression have twice the likelihood of using cannabis compared to those without depression (Gorfinkel, Stohl, & Hasin, 2020)
  - The likelihood increased over the previous decade
- Cannabis Use Disorder (CUD) is associated with increased risks for self-harm, overall mortality, and death by unintentional overdose and homicide (Fontanella et al., 2021)
- Among Veterans, CUD is associated with increased risks for a history of suicide attempts, self-harm, and current suicidal ideation (Kimbrel et al., 2018)
- The proportion of schizophrenia cases associated with CUD has increased 3-4 X over two decades (Hjorthoj et al., 2021)

Other Problems Associated with Marijuana

- Anxiety
- Agitation
- Impaired judgment
- Apathy (Cannabis Amotivational Syndrome)
- Cannabis Hyperemesis Syndrome
- Impaired balance and coordination
- Unemployment
- Legal problems
- Motor vehicle accidents (Washington Post, June, 2017)

Drug Interactions

CNS Depressants

- Alcohol
- Benzodiazepines
  - Alprazolam
  - Clonazepam
  - Lorazepam
- Benzodiazepine-like
  - Zolpidem
  - Eszopiclone
- Muscle relaxants
- Opioids

Stimulants

- Amphetamines
- Cocaine

Anticholinergics

- Antihistamines

Some Antidepressants

- Tricyclic
  - Amitriptyline
- Serotoninergic
  - Fluoxetine

Northern New England Poison Center

1-800-222-1222
www.nnepc.org

Cannabis Can Be Addictive

- Regular cannabis users can develop tolerance, cravings, and withdrawal symptoms
- 10-20% become dependent on cannabis (Volkow et al., 2016)
  - 9% dependence for adult starters
  - 17% dependence for teenage starters
  - 25-50% for daily users
- Psychological dependence is also possible

Brain Aging

- The largest known study of brain aging (Amen et al., 2018)
  - 62,454 SPECT tomography scans of 30,000 brains from individuals 9 months-105 years
  - Studied 128 different brain regions
- It examined disorders that aged the brain
  - Schizophrenia was #1
  - Cannabis abuse was #2, aging the brain an average of 2.8 years
  - This was more than Bipolar Disorder, ADHD, or Alcohol Abuse
  - Cannabis aged the brain almost 5 times more than Alcohol Abuse

The cannabis abuse finding was especially important, as our culture is starting to see marijuana as an innocuous substance. This study should give us pause about it.

Daniel Amen

What Happened in Colorado after Medical Legalization

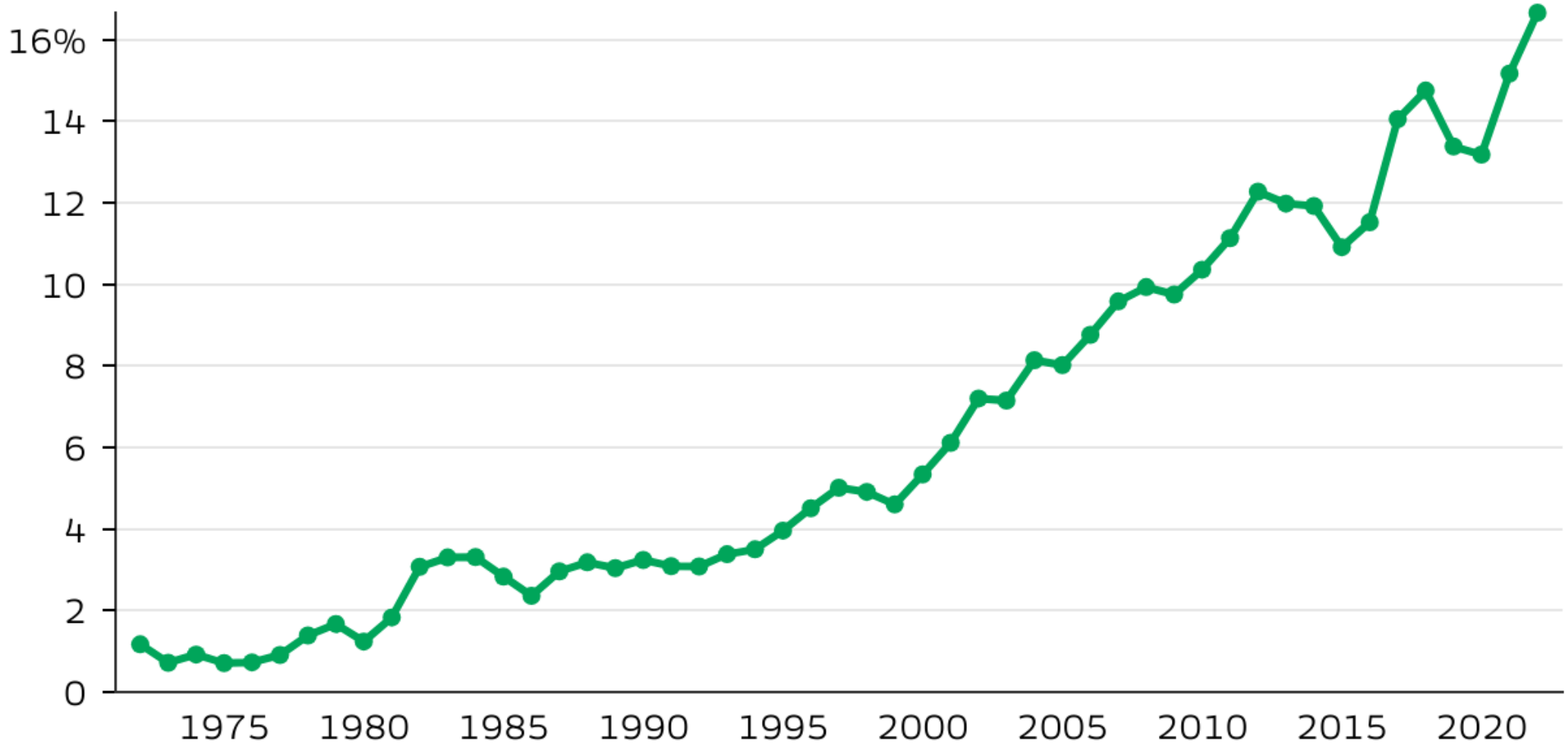
- An increase in ED visits for marijuana-associated illnesses
- An increases of marijuana-related burns, including some over 70% of the body and requiring as many as 21 skin grafts
- A doubling of Cannabis emesis syndrome, which involves cyclic vomiting, severe abdominal pain, and sweating
- Unintentional marijuana ingestion by children, sometimes requiring admission to pediatric intensive care
  - This is increased by edibles that are appealing to children
  - Childproof packaging is no longer childproof after opening
- Dosages that bring on delirium in adults can cause respiratory arrest in children
- Marijuana's involvement in fatal crashes doubled from 10% to 20% from 2013-2016 (Denver Post, 8/25/17)

Monte et al., 2014

CANNABINOIDS

Today's cannabis is a lot stronger than its predecessors

Cannabis available today contains more than 10 times as much **THC**, on average, than it did in the 1970s



SOURCE: NIDA POTENCY MONITORING PROGRAM, UNIVERSITY OF MISSISSIPPI

This Is Not Your Father's Cannabis

- A study of 38,681 samples of cannabis from 1995-2014 (Elsohly et al., 2016)
- The THC potency rose from an average of 4% in 1995 to 12% in 2014
- CBD content fell from an average of 0.28% to <0.15%
- The ratio of THC to CBD changed from 14:1 to 80:1
- Some extracts are above 50% THC

THC vs. CBD

THC

- Psychoactive
- Get high/euphoric
- Illegal
- Proven to help:
  - Decrease nausea
- Alleged to help many problems
- Relaxing/drowsy
- Can trigger paranoid psychosis
- Can increase anxiety
- Damages memory
- Apathy

CBD

- Not psychoactive
- No high
- Legal
- Proven to help:
  - Decrease childhood epileptic seizures
- Alleged to help many problems, including pain and anxiety
- Minimal side effects

The Potential Promise of CBD

Anti-Anxiety

- Studies of laboratory animals and of people suggest that CBD may have anxiolytic properties (Fusar-Poli et al., 2009)

Anti-Pain

- Some small studies show that CBD may have analgesic properties
- This is true at low doses
- Higher doses do not bring more pain relief (Wilsey et al., 2013)
- Two studies show that CBD may be helpful in decreasing spasticity and its pain in people with Multiple Sclerosis

Proven Medical Uses of Cannabinoids

THC

- To decrease nausea and vomiting
  - Wasting Syndrome
  - Cancer patients receiving chemotherapy
- Possibly for spasticity in Multiple Sclerosis

CBD

- For rare childhood forms of epilepsy
  - Dravet syndrome
  - Lennox-Gastaut syndrome
- Possibly for anxiety
- Possibly for some forms of pain

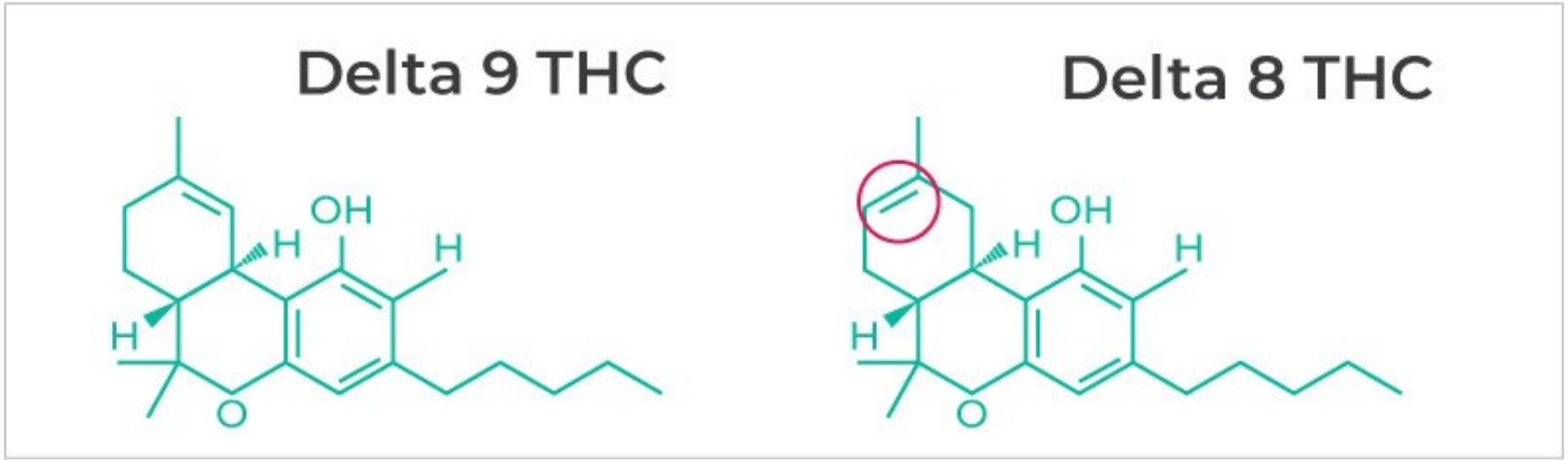
That's all

Summary

- Synthetic THC has been shown to increase appetite and decrease nausea
- Synthetic CBD has been shown to decrease seizures
- Mixed results of THC/CBD combination
- Some small N studies and animal model studies show possibility of that CBD may help chronic pain and/or anxiety
- Few blinded RCTs, the gold standard of research
- No studies show that cannabis leaves, oils, waxes, creams, edibles, or other forms of ingestion result in effective treatment of any problem
- Research in the past 5 years has not proven any additional medical uses for cannabis or cannabinoids
  - It has shown that there are significant negative cardiovascular effects, up to and including death
  - New study of 4 million electronic health records over 20 years found that > 116,000 patients who smoked cannabis daily had head and neck cancers, which was 3-5X greater than the normal rate (Gallagher et al., 2024)

A New Cannabinoid: Delta-8 THC

- THC usually refers to the Delta-9 THC isomer
- Delta-8 THC is one of 113 cannabinoids in the cannabis plant
  - It is less potent than Delta-9 THC: marketed as “diet weed” or “weed light”
  - It is not currently illegal under federal law, and can be transported over state lines
  - It can be sold by businesses that sell hemp, not just regulated dispensaries
- Made by mixing CBD with acid (battery acid, pool chemicals, vinegar, etc.)
- Sold in smoke shops and gas stations



WHAT CAN TREATMENT COURTS DO?

Treatment Courts Must:

- Be familiar with the laws of your state
- Be aware of the rapidly-changing nature of the science of cannabis and cannabinoids
- Take into account how marijuana can impact treatment (e.g., for PTSD)
  - This includes interactions with medications taken

Cannabis Interferes with Treatment

- Cannabis interferes with new learning and with the formation of memories
  - This makes it more difficult to learn new behaviors
- Cannabis interferes with treatment for PTSD
- Cannabis worsens Opioid Use Disorders
- Cannabis is associated with increased severity of Drug Use Disorders

If cannabis interferes with treatment, and you are working in a treatment court, how can you provide treatment that works?

What Can You Tell Participants?

- Those that claim it is legal: “So is alcohol, and we don’t allow alcohol consumption in Treatment Court.”
- Those who claim it is their right: “You do not have a legal right to participate in treatment court.”
- Those who claim it is medicine: “There are many medicines that we do not allow in treatment courts: opioids, benzodiazepines, stimulants, and others. All have the potential for abuse and addiction, which cannabis also does.”
- You may have to change your acceptance criteria when you screen potential participants.

Treatment Court Options

Always follow state law!

- Hold to the principle of total abstinence
- Allow the use of already-approved synthetic medicines like Marinol, Nabilone, Sativex, and Epidiolex, but only for on-label uses
- Decline to allow the use of any unproven substance or formulation (leaves, vaping, waxes, oils, creams, etc.)
- Decline to allow any alternative method of ingestion other than taking a pill composed of a synthetic cannabinoid
- Hold participants responsible for any THC showing up in their urine or blood
- Allow participants to use CBD products, holding them responsible if any THC shows up in their urine or blood

WHAT WILL YOUR COURT DECIDE TO DO?

BASE IT ON THE LAW AND THE SCIENCE.

QUESTIONS?

Contact:
Brian L. Meyer, Ph.D.
brianlmeyerphd@gmail.com

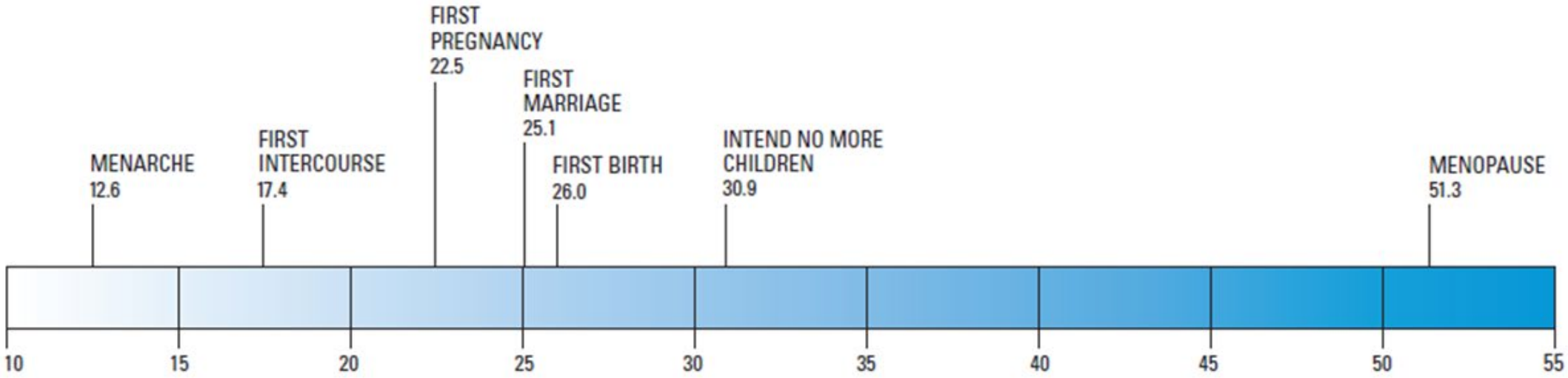
Best Practices for Addiction Treatment and Recovery in the Context of Gender, Reproduction, and Pregnancy

Mishka Terplan MD MPH FACOG DFASAM

Medical Director and Senior Research Scientist
Friends Research Institute
Adjunct Faculty and Substance Use Warmline Clinician
University of California, San Francisco

FIGURE 1.1

The typical woman spends five years pregnant, postpartum or trying to get pregnant and 30 years trying to avoid pregnancy.



Median age at which event occurs*

Note *Age by which half of women have experienced event.
Source Reference 6.

Sex and Gender Differences in Substance Use, Misuse and Addiction

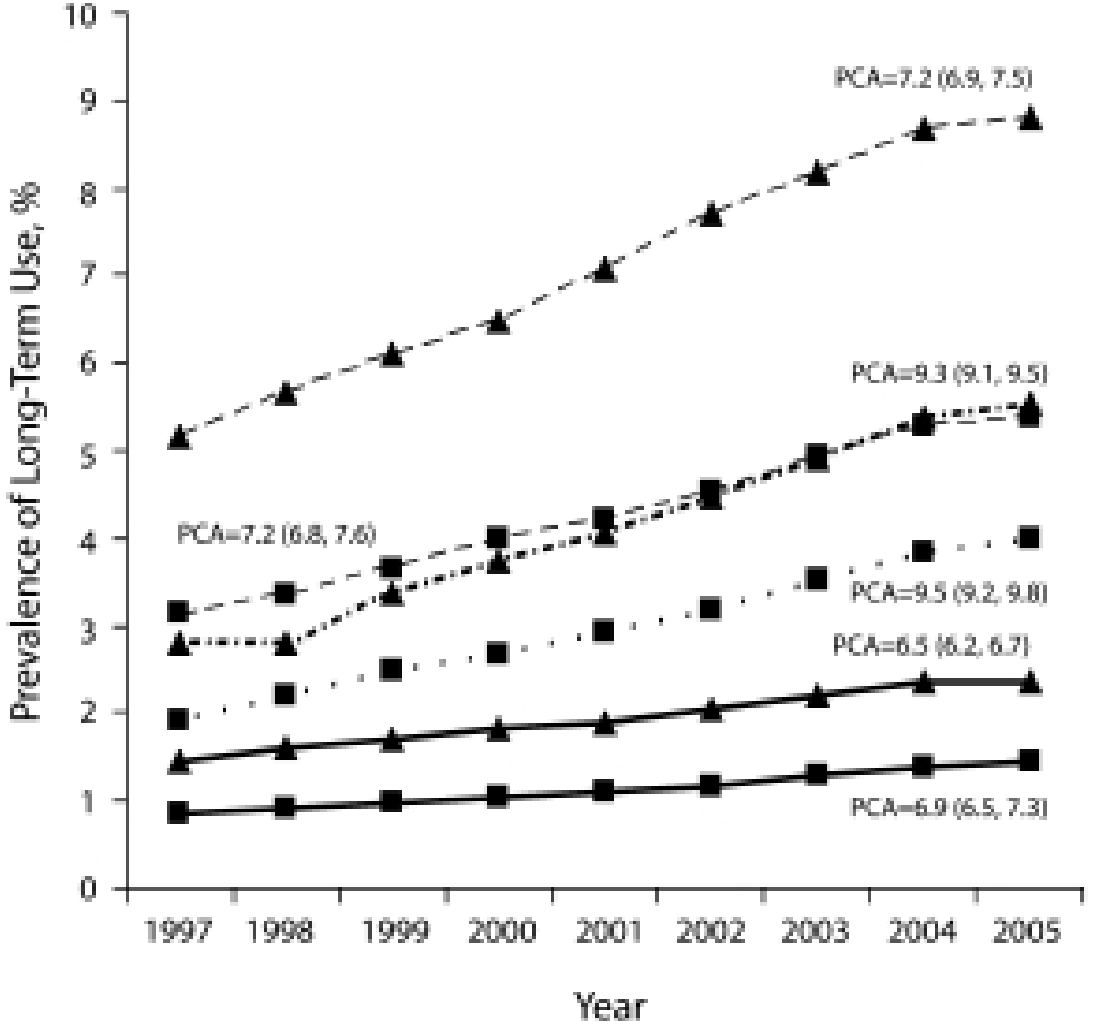
Behavioral Health Burden

Diagnosis	Percent Reporting	
	Female	Male
Serious Psychological Distress (past month)	**6.0%**	**4.1%**
Any Mental Illness (past year)	**26.2%**	**17.3%**
Serious Mental Illness (past year)	**5.0%**	**3.0%**
Major Depressive Episode (past year)	**8.5%**	**4.7%**

Prescription Medication

Past Year	Male	Female
Prescription psychotherapeutic drugs	40.9%	47.8%
Opioid Analgesic	33.9%	38.8%
Tranquilizers	11.3%	17.9%
Sedatives	5.6%	8.2%
Stimulants	6.5%	6.3%

a

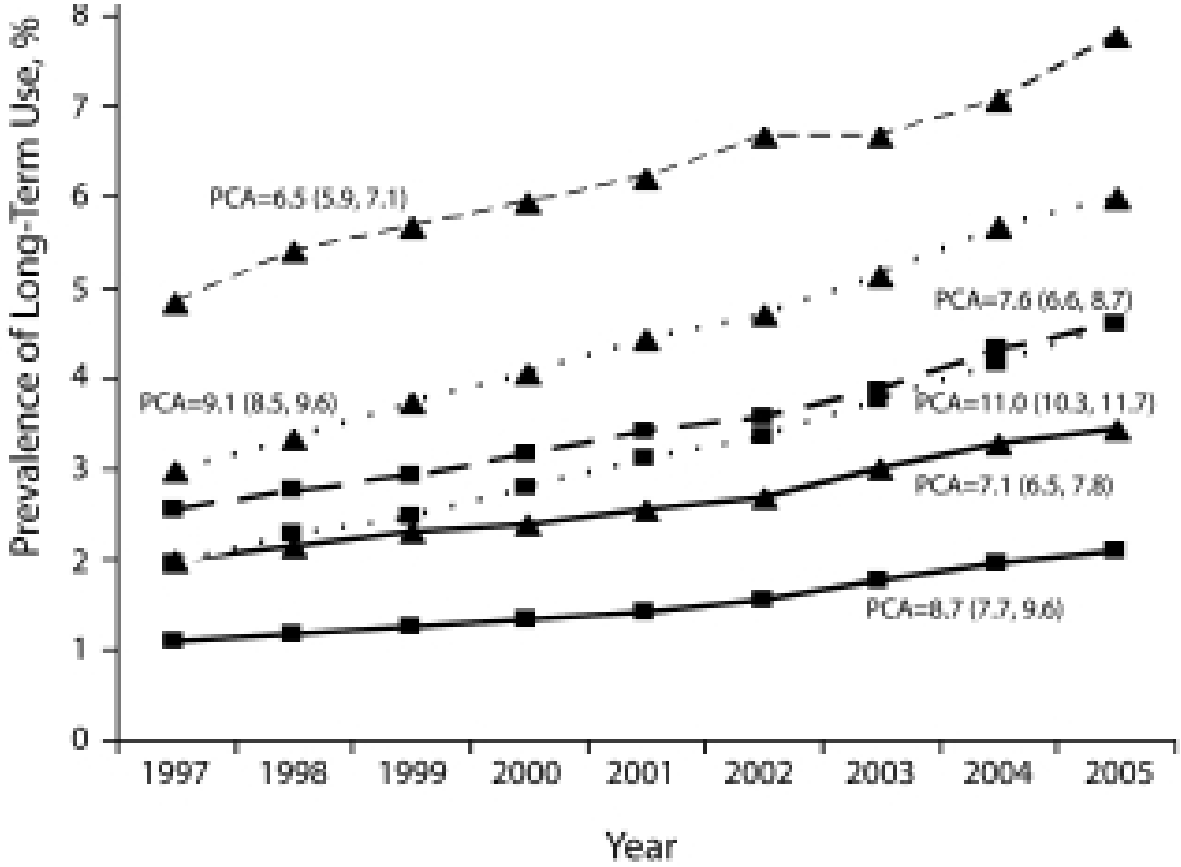


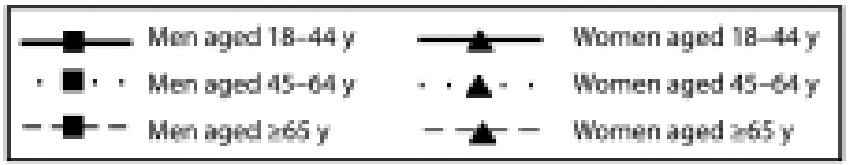
b

Age and Gender Trends in Long-Term Opioid Analgesic Use for Noncancer Pain

December 2010, Vol 100, No. 12 | American Journal of Public Health

Cynthia I. Campbell, PhD, MPH, Constance Weisner, DrPH, Linda LeResche, ScD, G. Thomas Ray, MBA, Kathleen Saunders, JD, Mark D. Sullivan, MD, PhD, Caleb J. Banta-Green, PhD, MSW, MPH, Joseph O. Merrill, MD, MPH, Michael J. Silverberg, PhD, MPH, Denise Boudreau, PhD, Derek D. Satre, PhD, and Michael Von Korff, ScD





Gender Differences in Opioid Continuation

- Compared to Men, Women use opioids:
  - to deal with negative emotions
  - to relax, reduce stress, focus attention, increase confidence
  - to loose weight, increase energy
  - more likely to mix opioids with other sedatives – co-ingestion – risk factor for mortality

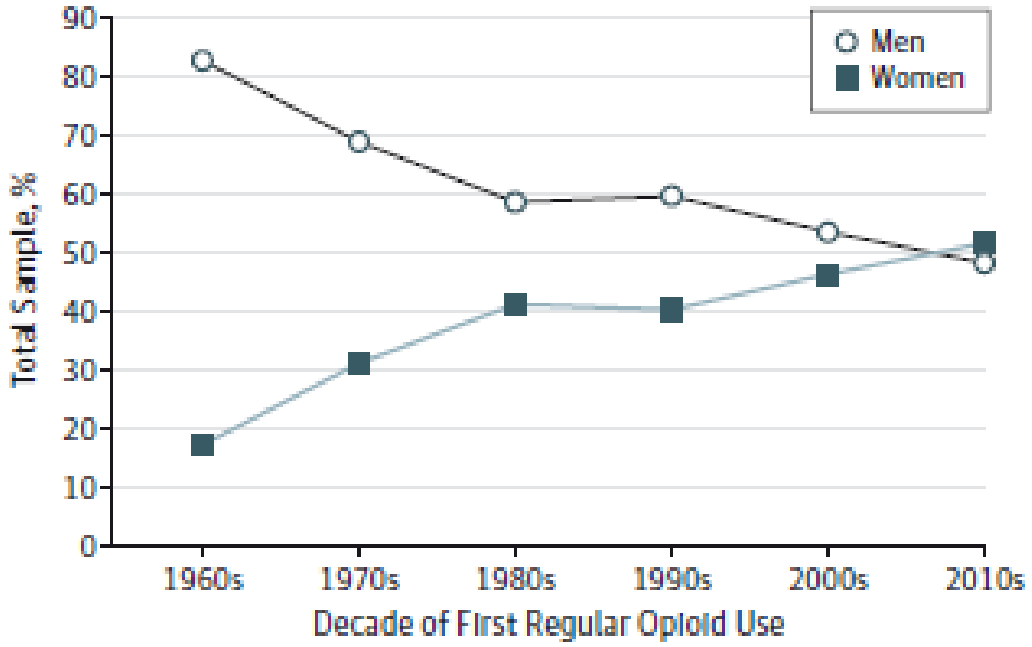
Original Investigation

The Changing Face of Heroin Use in the United States
A Retrospective Analysis of the Past 50 Years

Theodore J. Cicero, PhD; Matthew S. Ellis, MPE; Hilary L. Surratt, PhD; Steven P. Kurtz, PhD

JAMA Psychiatry. 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366
Published online May 28, 2014.

Figure 2. Sex Distribution of Respondents Expressed as Percentage of the Total Sample



Short Communication

Addictive Behaviors 74 (2017) 63–66

Increased use of heroin as an initiating opioid of abuse

Theodore J. Cicero*, Matthew S. Ellis, Zachary A. Kasper

Washington University in St. Louis, Department of Psychiatry, Campus Box 8134, 660 S. Euclid Avenue, St. Louis, MO 63110, United States

Table 1
Characteristics of heroin vs. prescription opioid initiates, 2005–2015.

	Initiate Cohort, No. (%)		
	Heroin (n = 631)	Prescription opioid (n = 5254)	Sig.[a]
Age at survey completion (SE)	27.0 (0.28)	28.9 (0.11)	< 0.001[b]
Gender			0.82
Male	299 (47.8%)	2519 (48.3%)	
Female	327 (52.2%)	2701 (51.7%)	
Ethnicity			0.01
White	479 (78.0%)	4262 (82.2%)	
Non-white	135 (22.0%)	922 (17.8%)	
Urbanicity of residence			0.01
Urban	280 (51.6%)	2095 (46.1%)	
Suburban/rural	263 (48.4%)	2454 (53.9%)	
Highest completed education			< 0.001[b]
Some college or more	204 (32.7%)	2141 (41.0%)	
Education lower than college	409 (65.5%)	2994 (57.3%)	
None	11 (1.8%)	90 (1.7%)	

Sex/Gender Difference: Telescoping

- Telescoping:
  - Substance use in women progresses more quickly to addiction and to the onset of medical problems and disorders
  - Women tend to enter treatment at later stage of addiction

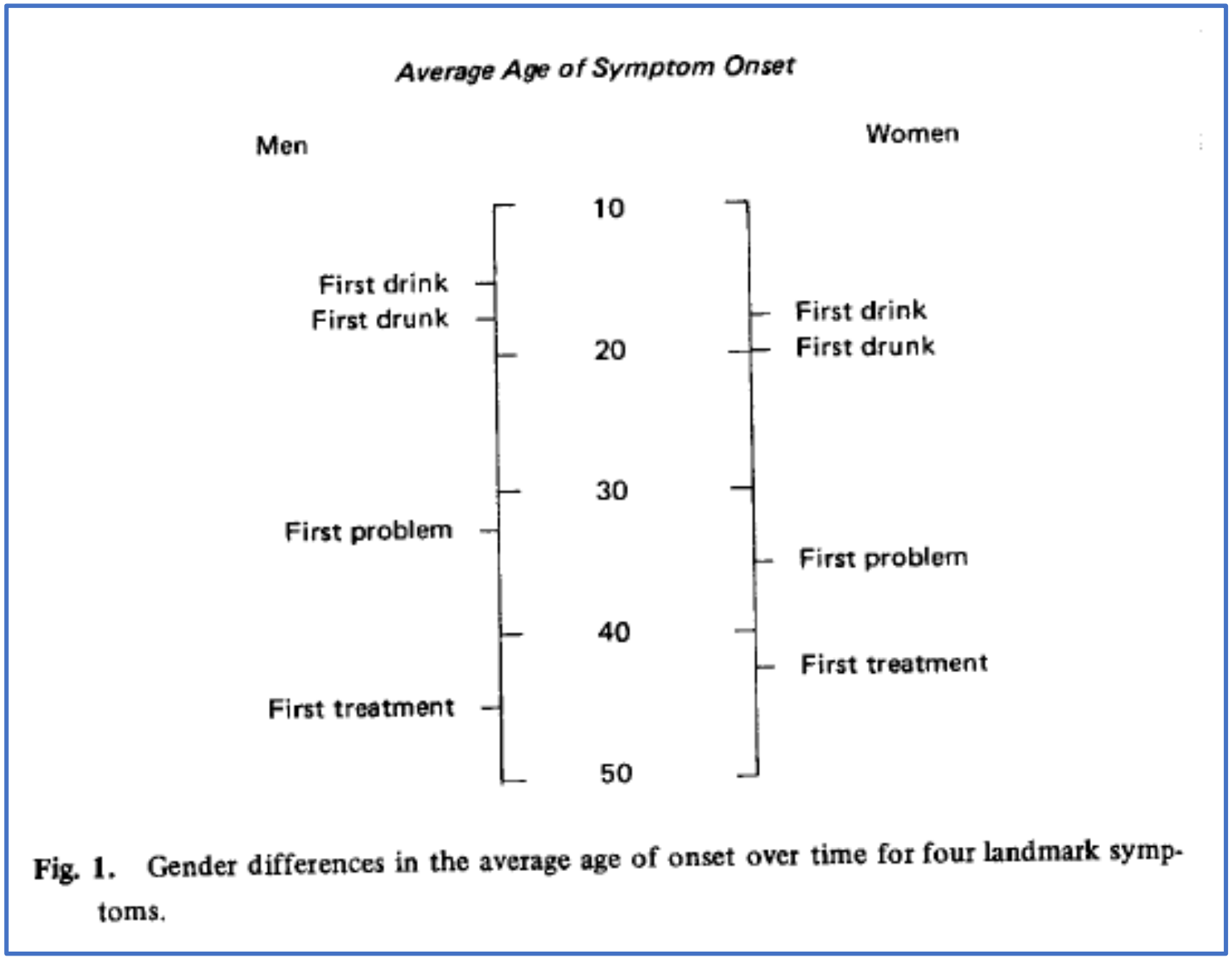


Fig. 1. Gender differences in the average age of onset over time for four landmark symptoms.

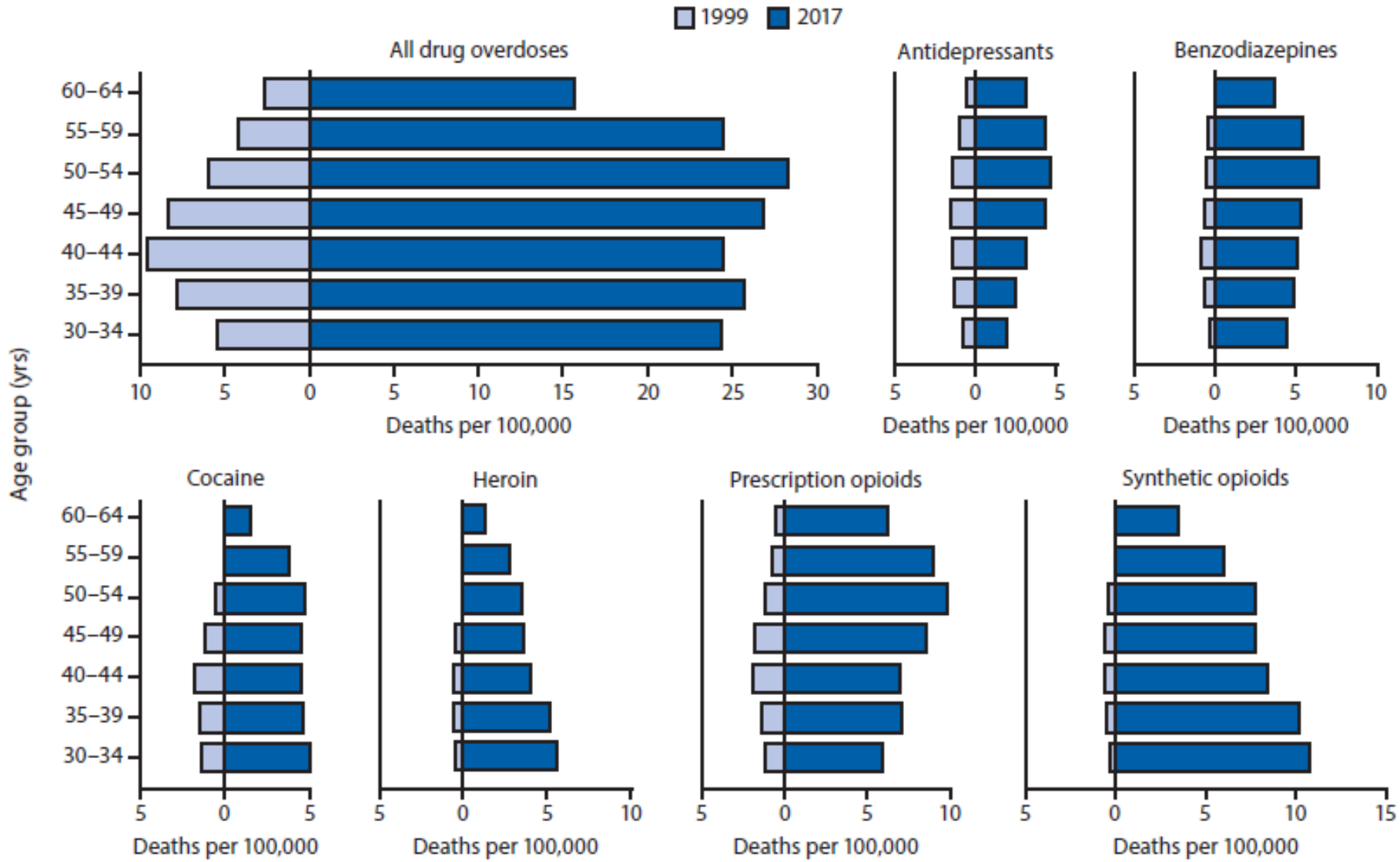
"Telescoping of alcoholism in women alcoholics", *Int J Addict*, 1989

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 68 / No. 1
January 11, 2019

Drug Overdose Deaths Among Women Aged 30–64 Years — United States, 1999–2017

Jacob P. VanHouten, MD, PhD[1]; Rose A. Rudd, MSPH[2]; Michael F. Ballesteros, PhD[1]; Karin A. Mack, PhD[1]

FIGURE 2. Drug overdose deaths (unadjusted) per 100,000 women aged 30–64 years, by age group and involved drug or drug class — National Vital Statistics System (NVSS), 1999* and 2017[†,§]



Mertens et al. Addict Sci Clin Pract (2015) 10:26
DOI 10.1186/s13722-015-0047-0

ADDICTION SCIENCE & CLINICAL PRACTICE

RESEARCH Open Access

Physician versus non-physician delivery of alcohol screening, brief intervention and referral to treatment in adult primary care: the ADVISe cluster randomized controlled implementation trial

Jennifer R. Mertens[1*], Felicia W. Chi[2], Constance M. Weisner[2,3], Derek D. Satre[2,3], Thekla B. Ross[2], Steve Allen[2], David Pating[4], Cynthia I. Campbell[2], Yun Wendy Lu[2] and Stacy A. Sterling[2]

Abstract

Background: Unhealthy alcohol use is a major contributor to the global burden of disease and injury. The US Preventive Services Task Force has recommended alcohol screening and intervention in general medical settings since 2004. Yet less than one in six US adults report health care professionals discussing alcohol with them. Little is known about methods for increasing implementation; different staffing models may be related to implementation effectiveness. This implementation trial compared delivery of alcohol screening, brief intervention and referral to specialty treatment (SBIRT) by physicians versus non-physician providers receiving training, technical assistance, and feedback reports.

Methods: The study was a cluster randomized implementation trial (ADVISe [Alcohol Drinking as a Vital Sign]). Within a private, integrated health care system, 54 adult primary care clinics were stratified by medical center and randomly assigned in blocked groups of three to SBIRT by physicians (PCP arm) versus non-physician providers and medical assistants (NPP and MA arm), versus usual care (Control arm). NIH-recommended screening questions were added to the electronic health record (EHR) to facilitate SBIRT. We examined screening and brief intervention and referral rates by arm. We also examined patient-, physician-, and system-level factors affecting screening rates and, among those who screened positive, rates of brief intervention and referral to treatment.

Results: Screening rates were highest in the NPP and MA arm (51 %); followed by the PCP arm (9 %) and the Control arm (3.5 %). Screening increased over the 12 months after training in the NPP and MA arm but remained stable in the PCP arm. The PCP arm had higher brief intervention and referral rates (44 %) among patients screening positive than either the NPP and MA arm (3.4 %) or the Control arm (2.7 %). Higher ratio of MAs to physicians was related to higher screening rates in the NPP and MA arm and longer appointment times to screening and intervention rates in the PCP arm.

Conclusion: Findings suggest that time frames longer than 12 months may be required for full SBIRT implementation. Screening by MAs with intervention and referral by physicians as needed can be a feasible model for increasing the implementation of this critical and under-utilized preventive health service within currently predominant primary care models.

640,000 adult patients

Women less likely to be screened:

- PCP arm OR=0.78 (0.75, 0.82)
- Non MD OR=0.82 (0.77, 0.87)

Among those screened, women less likely to receive BI/RT

- PCP arm OR=0.60 (0.48, 0.76)
- Non MD OR=0.62 (0.51, 0.77)

Manuel and Lee *Substance Abuse Treatment, Prevention, and Policy* (2017) 12:28
DOI 10.1186/s13011-017-0114-5

Substance Abuse Treatment, Prevention, and Policy

RESEARCH Open Access

Gender differences in discharge dispositions of emergency department visits involving drug misuse and abuse—2004-2011

Jennifer I. Manuel[1*] and Jane Lee[2]

Table 1 Characteristics of ED Visits Involving Drug Misuse or Abuse, DAWN 2004–2011

	Total (N = 14,245,776)	Men (n = 8,203,524; 57.6%)	Women (n = 6,042,252; 42.4%)	Men vs. Women[a]		
	Weighted %	Weighted %	Weighted %	Unadjusted OR	95% CI	p
Age (years)						
18–20	12.0	12.3	11.5	1.08	1.01–1.15	0.022
21–34	34.6	35.2	33.8	1.06	1.02–1.10	0.005
35–54	42.1	42.3	41.9	1.02	0.98–1.05	0.318
55 or older	11.4	10.3	12.8	0.78	0.74–0.82	<.001
Race/Ethnicity						
Non-Hispanic White	63.0	59.3	68.2	0.68	0.63–0.73	<.001
Non-Hispanic Black	24.0	25.6	21.7	1.24	1.14–1.35	<.001
Hispanic	11.6	13.8	8.5	1.71	1.59–1.84	<.001
Other	1.4	1.3	1.6	0.87	0.77–0.97	0.016
Drug Misuse or Abuse Category						
Alcohol only	8.7	8.6	8.9	0.97	0.89–1.05	0.433
Prescription Drugs only	30.8	23.8	40.3	0.46	0.44–0.49	<.001
Illicit Drugs only	30.4	34.2	25.2	1.54	1.48–1.61	<.001
Illicit Drugs w/ Alcohol	14.2	17.8	9.4	2.10	1.97–2.24	<.001
Prescription Drugs w/ Alcohol	6.3	5.7	7.1	0.78	0.73–0.84	<.001
Illicit Drugs w/ Prescription Drugs	6.9	6.9	6.9	0.99	0.93–1.06	0.805
Illicit Drugs w/ Prescription Drugs & Alcohol	2.7	3.0	2.2	1.34	1.23–1.47	<.001
Discharge Disposition						
Discharged Home	51.7	50.4	53.4	0.89	0.84–0.93	<.001
Released to Police/Jail	3.3	4.3	2.0	2.25	2.03–2.49	<.001
Referral to Outpatient Detox/Drug Treatment	5.1	5.5	4.4	1.27	1.15–1.42	<.001
Inpatient Detox/Psychiatric Hospital Admission	9.0	9.7	8.2	1.2	1.07–1.35	0.002
General Hospital Admission	20.1	19.1	21.5	0.86	0.81–0.91	<.001
Transferred to Another Facility	8.8	8.8	8.7	1.01	0.92–1.10	0.847
Left Against Medical Advice	2.1	2.3	1.8	1.25	1.12–1.38	<.001

Notes: The table reports weighted frequencies and percentages
[a]Unadjusted logistic regression models of sample characteristics and discharge dispositions as a function of gender. Odds ratio (OR) estimates were tested using design-based t-statistics with 1433 degrees of freedom

Original Research

Association of Patient Sex and Pregnancy Status With Naloxone Administration During Emergency Department Visits

Lauren A. Forbes, MPH, Joseph K. Canner, MHS, Lorraine Milio, MD, Torre Halscott, MD, MS, and Arthur Jason Vaught, MD

Table 2. Primary and Secondary Outcomes for Reproductive-Aged Nonpregnant Women Compared With Men and Pregnant Women Compared With Nonpregnant Women With Opioid Overdose–Related Emergency Department Visits

	Men (n=443,714)	Nonpregnant Women (n=304,364)	Pregnant Women (n=25,056)	Nonpregnant Women vs Men		Pregnant Women vs Nonpregnant Women	
				OR (95% CI)	aOR (95% CI)*	OR (95% CI)	aOR (95% CI)*
Naloxone administration	9,303 (2.10)	5,186 (1.70)	69 (0.27)	0.81 (0.78–0.84)	0.86 (0.83–0.89)	0.16 (0.13–0.20)	0.16 (0.13–0.21)
Subsequent facility admission	120,611 (27.18)	91,972 (30.22)	10,136 (40.5)	1.16 (1.15–1.17)	1.04 (1.03–1.06)	1.57 (1.53–1.61)	2.04 (2.00–2.10)
Mortality	13,289 (2.99)	6,734 (2.21)	102 (0.41)	0.73 (0.71–0.75)	0.71 (0.69–0.73)	0.18 (0.15–0.22)	0.28 (0.23–0.35)

FOCUS ON OPIOID OVERDOSE

PREHOSPITAL EMERGENCY CARE 2016;20:220–225

USE OF NALOXONE BY EMERGENCY MEDICAL SERVICES DURING OPIOID DRUG OVERDOSE RESUSCITATION EFFORTS

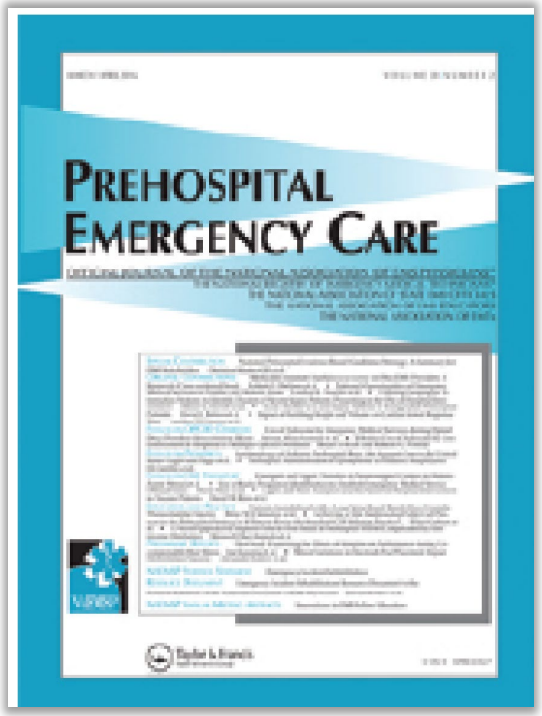
Steven Allan Sumner, MD, Melissa C. Mercado-Crespo, PhD, M. Bridget Spelke, Leonard Paulozzi, MD, David E. Sugerman, MD, Susan D. Hillis, PhD, Christina Stanley, MD

TABLE 1. Administration of naloxone during emergency medical services resuscitation attempts by patient and scene characteristics of individuals deceased due to opioid overdose ($N = 124$)

		Naloxone administered		Naloxone not administered		
		n	%	*n*	%	*p*-value
Heroin present on toxicology at death	Yes ($N = 60$)	45	75.0	15	25.0	0.04
	No ($N = 64$)	37	57.8	27	42.2	
Age (in years)	Younger than 30 ($N = 30$)	26	86.7	4	13.3	< 0.01
	30 to 50 ($N = 52$)	34	65.4	18	34.6	
	Older than 50 ($N = 42$)	22	52.4	20	47.6	
Gender	Male ($N = 89$)	66	74.2	23	25.8	<0.01
	Female ($N = 35$)	16	45.7	19	54.3	

TABLE 2. Association of patient and scene characteristics with no administration of naloxone during emergency medical services resuscitation attempts among individuals deceased due to an opioid overdose ($N = 124$)

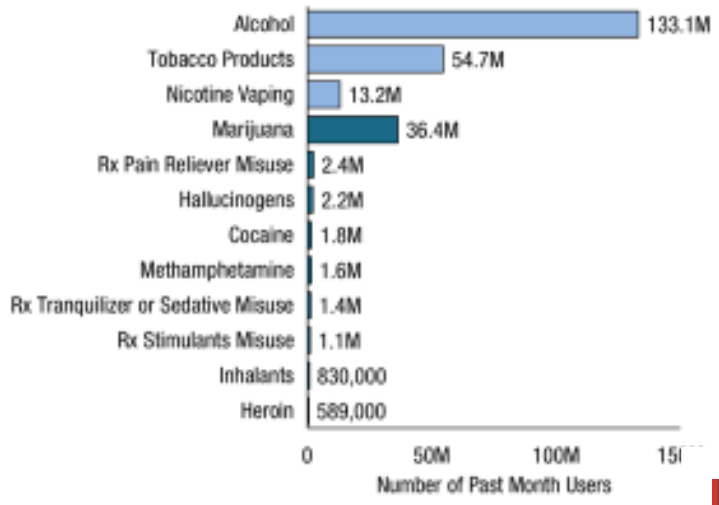
		Unadjusted			Adjusted[a]		
		OR	95% CI	*p*-value	OR	95% CI	*p*-value
Age (in years)	Younger than 30 ($N = 30$)	1 (ref)	–	–	1 (ref)	–	–
	30 to 50 ($N = 52$)	3.4	1.0–11.4	0.04	3.2	0.9–11.3	0.07
	Older than 50 ($N = 42$)	5.9	1.8–19.9	<0.01	4.8	1.3–17.4	0.02
Gender	Male ($N = 89$)	1 (ref)	–	–	1 (ref)	–	–
	Female ($N = 35$)	3.4	1.5–7.7	<0.01	2.9	1.2–7.0	0.02



Why would a pregnant person use drugs?

FFR1.1

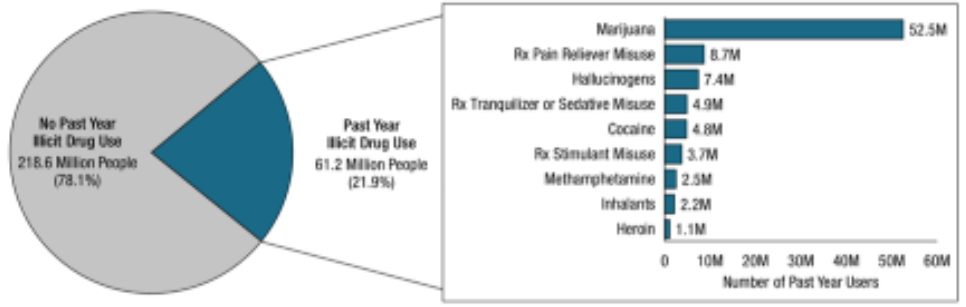
Past Month Substance Use: Among People Aged 12 or Older; 2021



Rx = prescription.
Note: The estimated numbers of current users of different substances are not mutually exclusive because people could have used month

FFR1.14

Past Year Illicit Drug Use: Among People Aged 12 or Older; 2021



Rx = prescription.
Note: The estimated numbers of past year users of different illicit drugs are not mutually exclusive because people could have used more than one type of illicit drug in the past year.

SAMHS

Not everyone who uses drugs becomes addicted

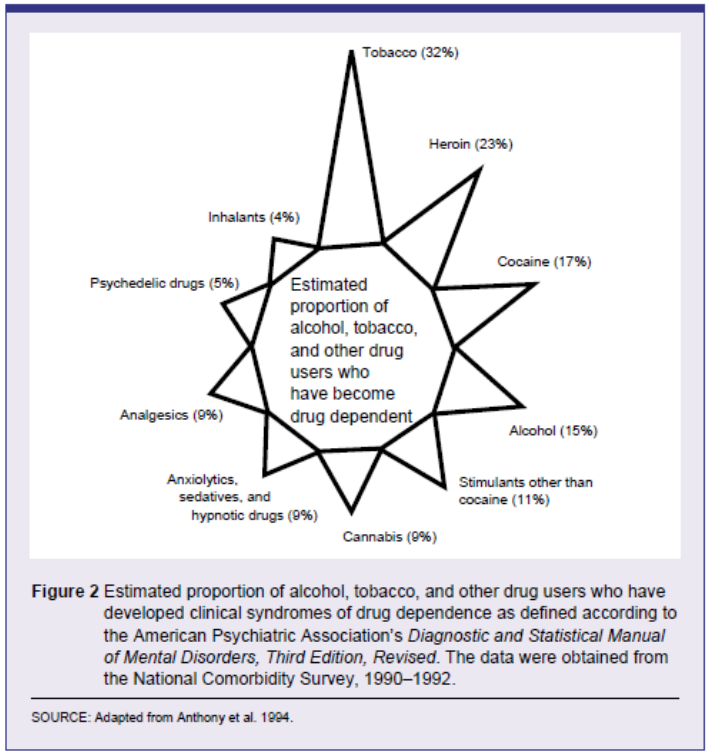
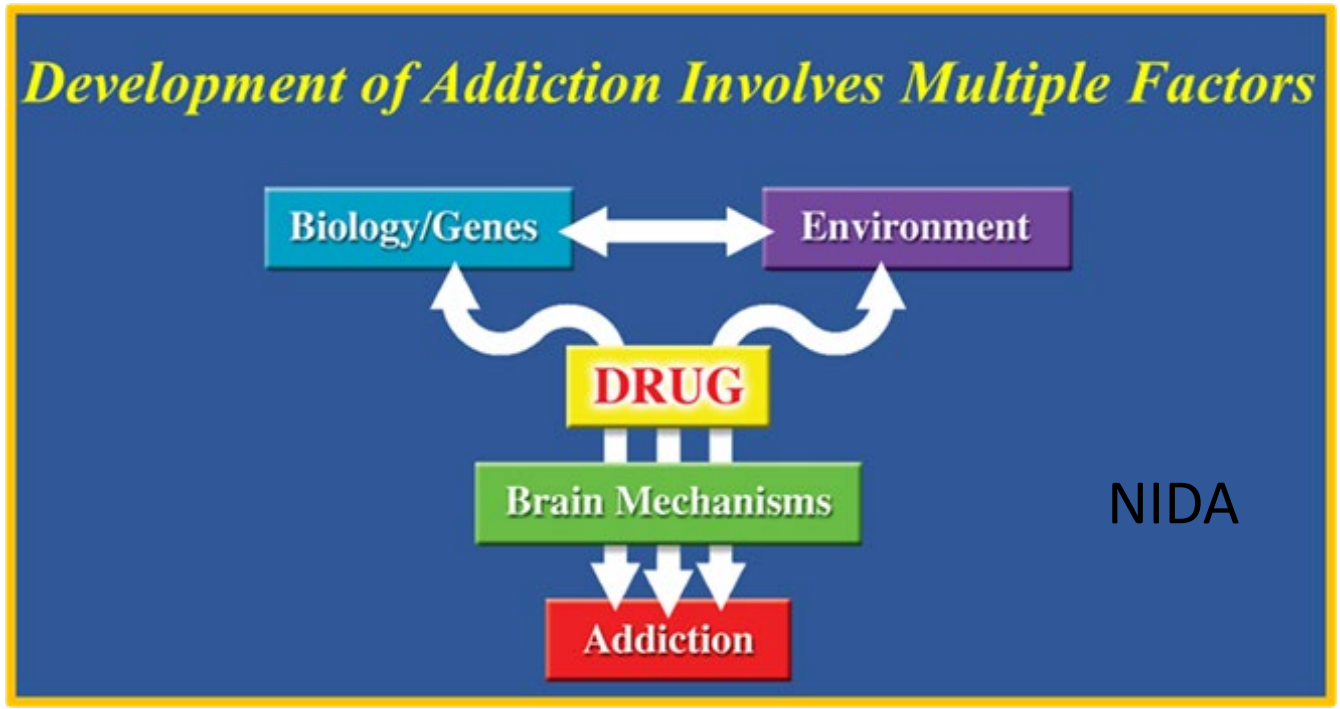


Figure 2 Estimated proportion of alcohol, tobacco, and other drug users who have developed clinical syndromes of drug dependence as defined according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised*. The data were obtained from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

SOURCE: Adapted from Anthony et al. 1994.



NIDA

What is Addiction?

Definition:

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

DSM-5 Substance Use Disorders

1. Tolerance[2]

2. Withdrawal[2]

Loss of Control

3. Larger amounts and/or

4. Unsuccessful efforts to cut down

5. Increased time spent obtaining, using or recovering

6. Craving/Compulsion

Use Despite Negative Consequences

7. Role failure, work, home, school

8. Social, interpersonal problems

9. Activities given up

10. Hazardous use

11. Physical or psychological harm

Addiction: A Brain-centered Condition Whose Visible Symptoms are Behaviors

[1] Mild (2-3), moderate (4-5), severe (≥6)

[2] Not valid if opioid taken as prescribed

APA. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.)

Addiction as Chronic Disease: Treatment Works

Drug Dependence, a Chronic Medical Illness

Implications for Treatment, Insurance, and Outcomes Evaluation

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

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

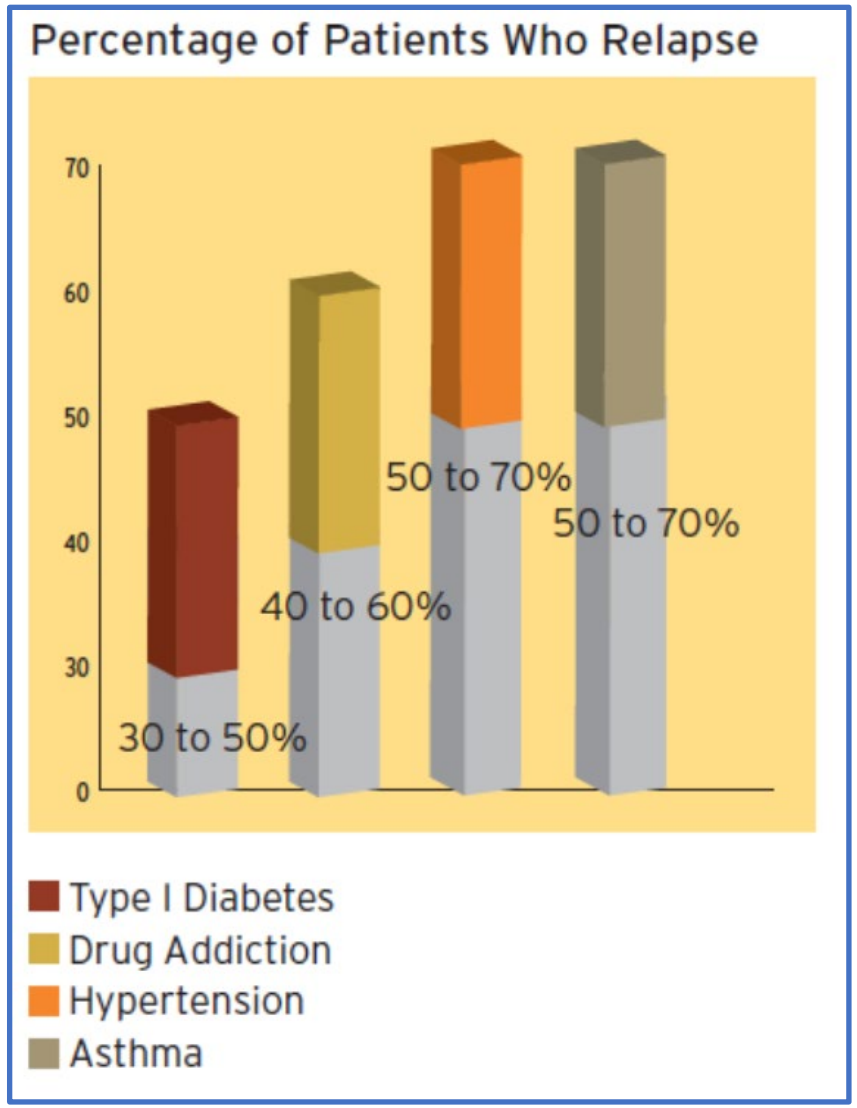
JAMA. 2000;284:1689-1695 www.jama.com

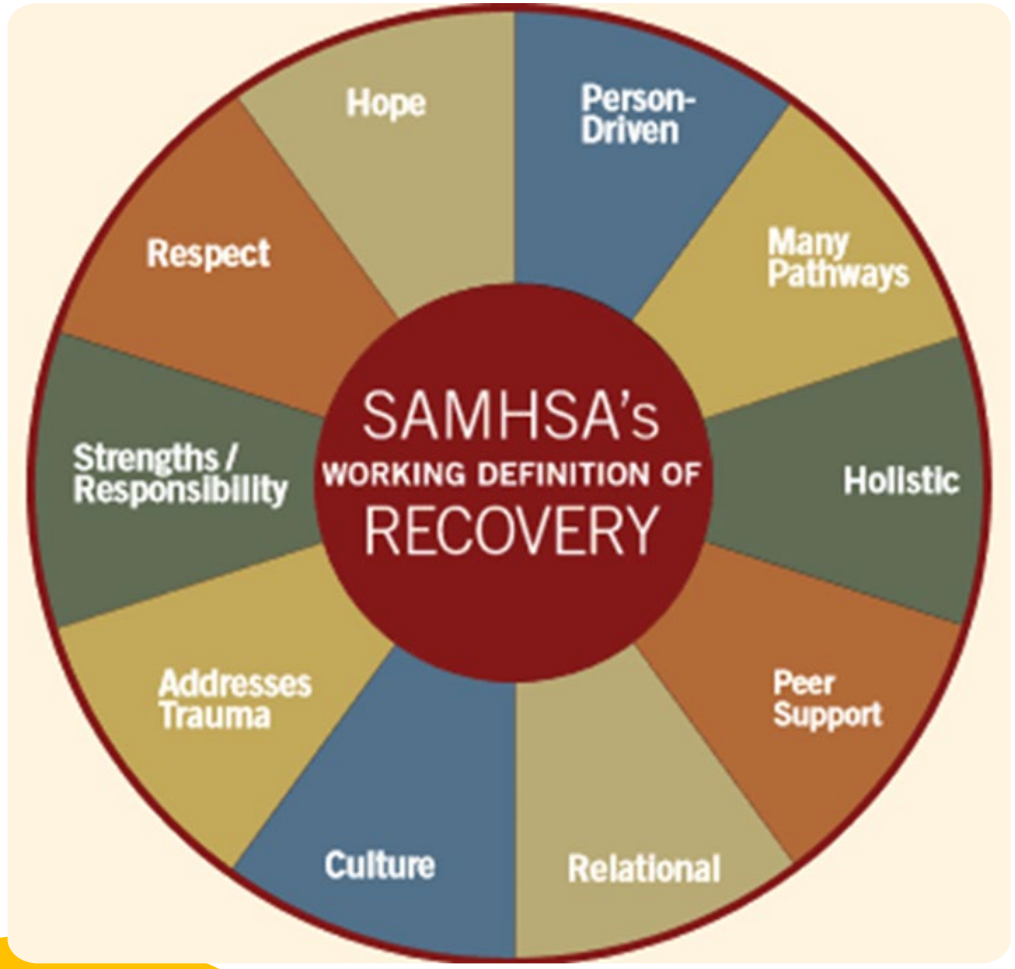
MANY EXPENSIVE AND DISturbing social problems can be traced directly to drug dependence. Recent studies[1-4] estimated that drug dependence costs the United States approximately $67 billion annually in crime, lost work productivity, foster care, and other social problems.[2-4] These expensive effects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

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

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

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



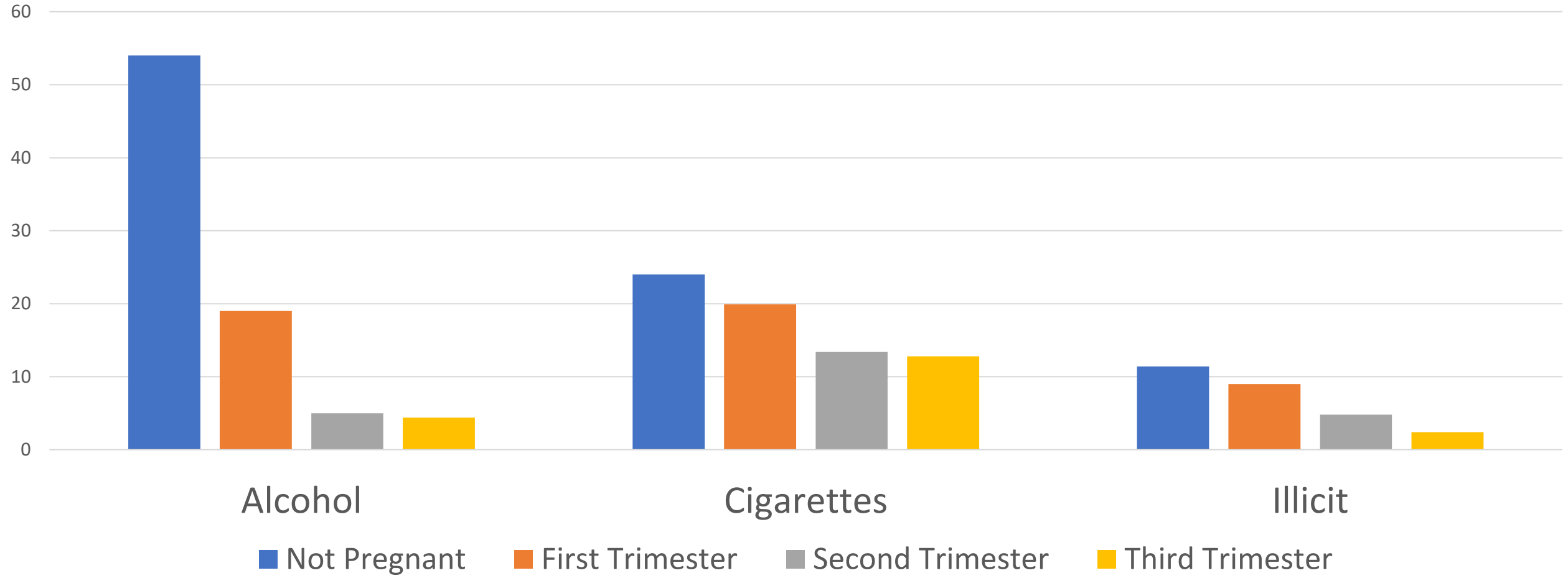


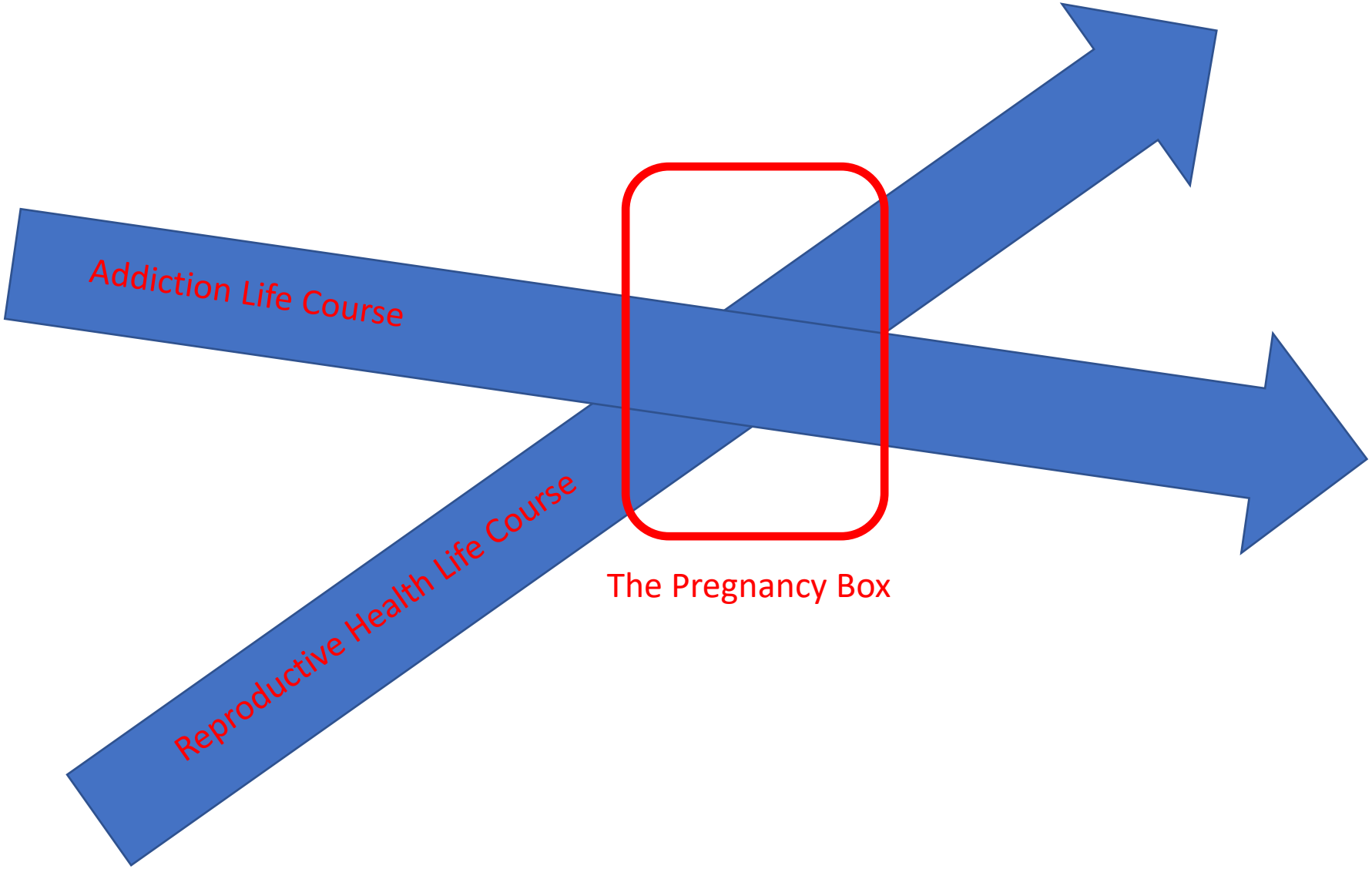
Recovery is the Goal of Treatment

Recovery: “a dynamic process of self-directed action, it is the movement toward wellness, rather than any single outcome state... “recovery” [is] a process rather than an outcome. Abstinence, as one of many outcomes that may or may not fully occur across multiple domains of individual wellness, is thus a potential product of the process of recovery.”

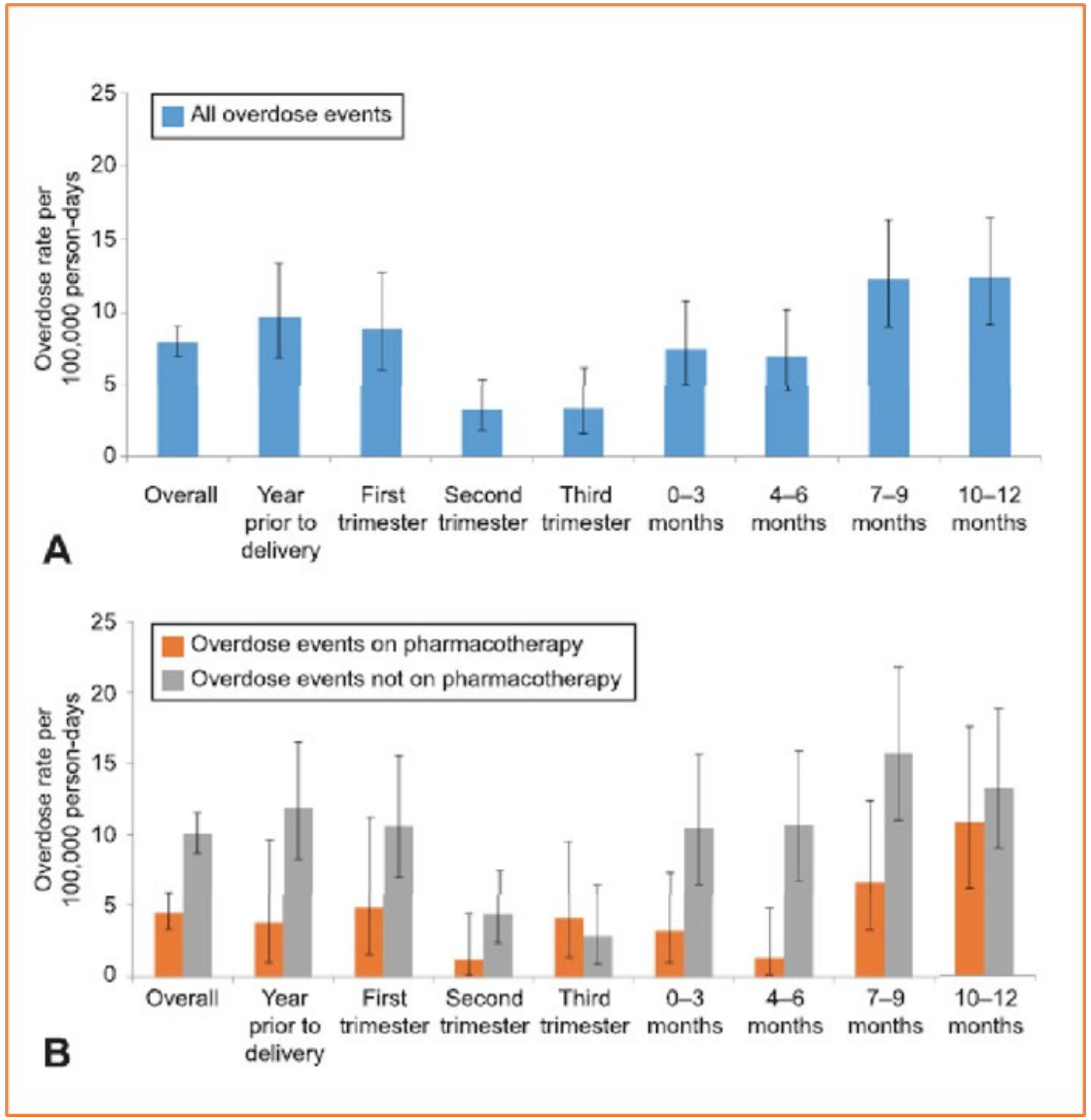
Ashford, Robert D., et al. "Defining and operationalizing the phenomena of recovery: a working definition from the recovery science research collaborative." Addiction Research & Theory27.3 (2019): 179-188.

What happens when people who use drugs get pregnant?




Addiction Life Course
Reproductive Health Life Course
The Pregnancy Box

Postpartum and Maternal Death from Overdose



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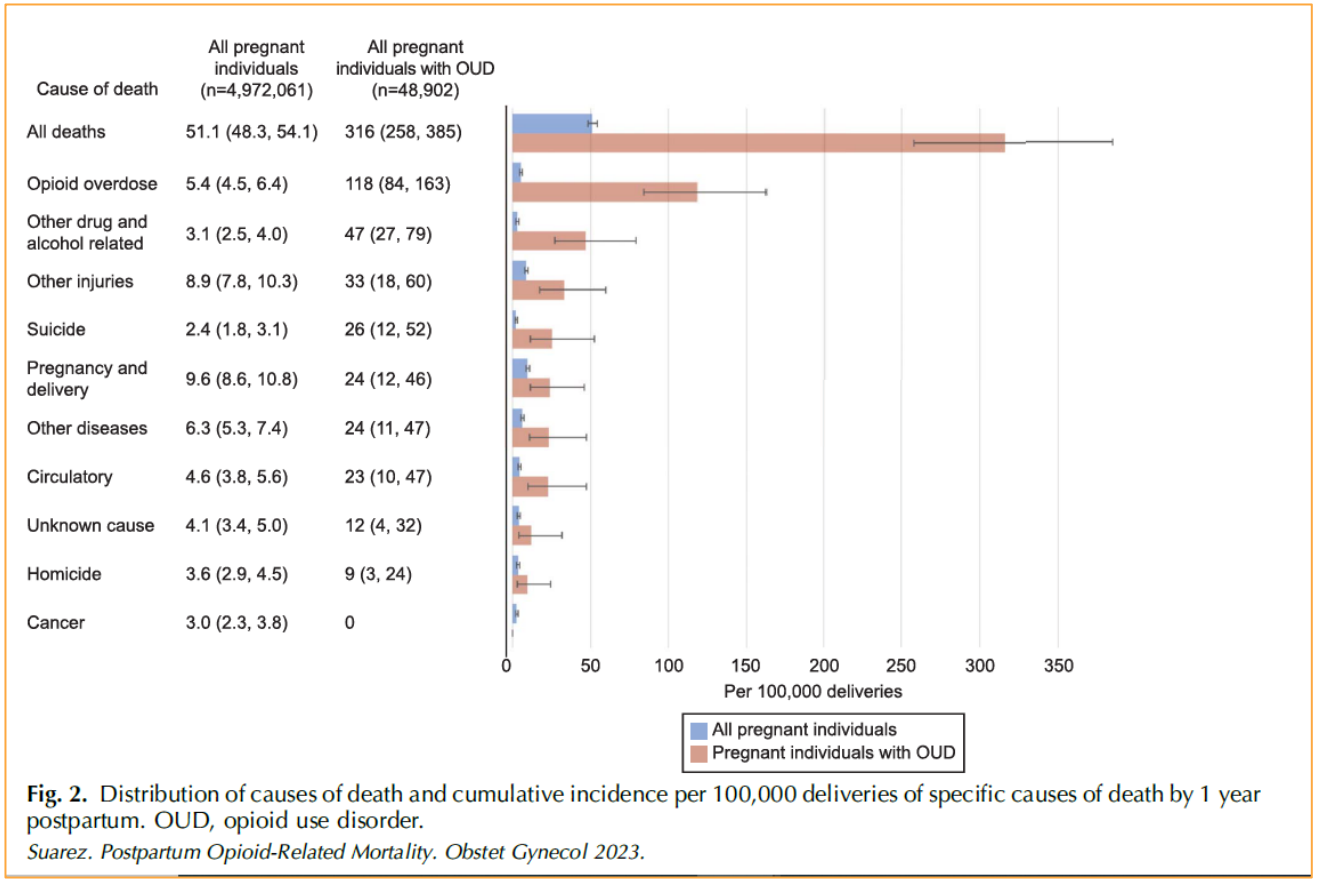


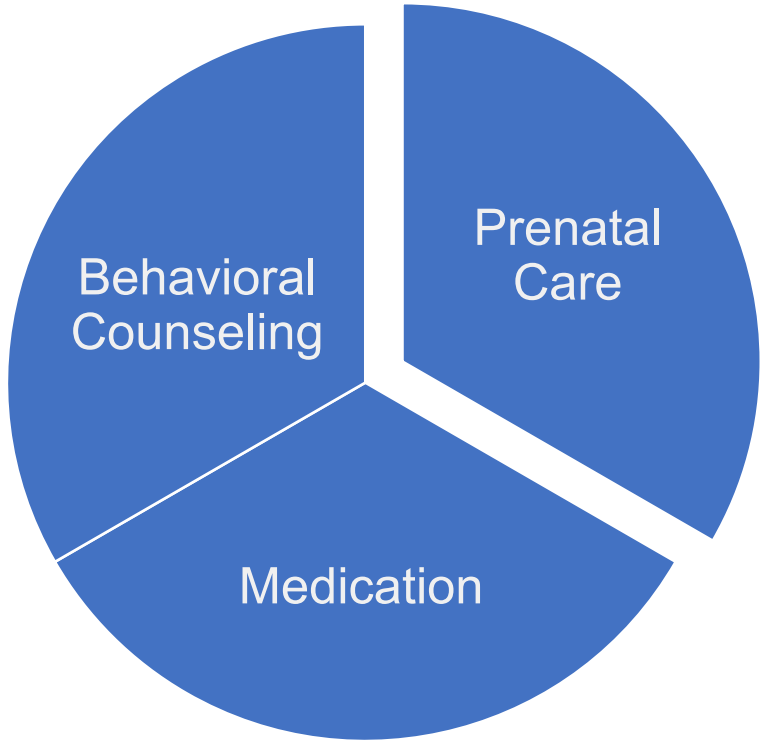
Cause of death	All pregnant individuals (n=4,972,061)	All pregnant individuals with OUD (n=48,902)
All deaths	51.1 (48.3, 54.1)	316 (258, 385)
Opioid overdose	5.4 (4.5, 6.4)	118 (84, 163)
Other drug and alcohol related	3.1 (2.5, 4.0)	47 (27, 79)
Other injuries	8.9 (7.8, 10.3)	33 (18, 60)
Suicide	2.4 (1.8, 3.1)	26 (12, 52)
Pregnancy and delivery	9.6 (8.6, 10.8)	24 (12, 46)
Other diseases	6.3 (5.3, 7.4)	24 (11, 47)
Circulatory	4.6 (3.8, 5.6)	23 (10, 47)
Unknown cause	4.1 (3.4, 5.0)	12 (4, 32)
Homicide	3.6 (2.9, 4.5)	9 (3, 24)
Cancer	3.0 (2.3, 3.8)	0

Fig. 2. Distribution of causes of death and cumulative incidence per 100,000 deliveries of specific causes of death by 1 year postpartum. OUD, opioid use disorder.

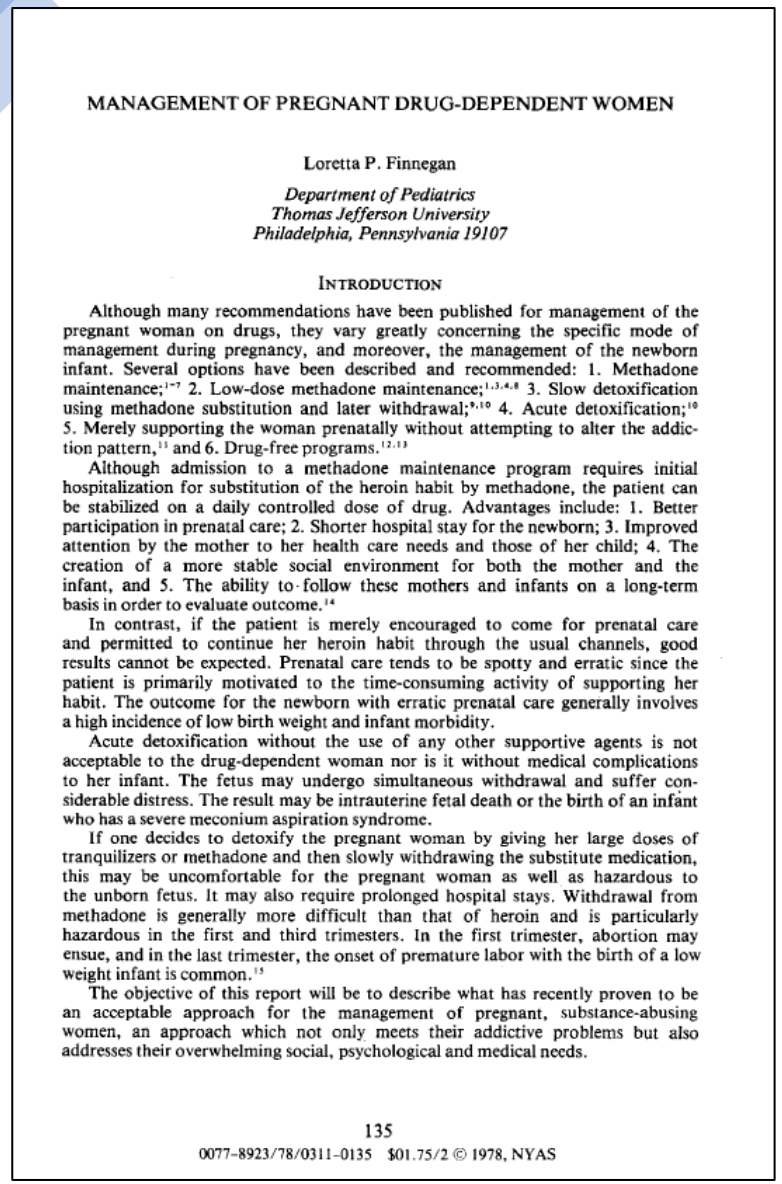
Suarez. Postpartum Opioid-Related Mortality. Obstet Gynecol 2023.

Treatment

"Gold Standard" is integration: Comprehensive, Co-located Service Delivery



- SUD Services:
  Full range of person centered, culturally and linguistically effective, non-punitive, evidence informed SUD (not just OUD) services, including as needed (but not limited to):CBT, MI, Contingency Management
- Assessment for equitable access to and outcomes from these services



MANAGEMENT OF PREGNANT DRUG-DEPENDENT WOMEN

Loretta P. Finnegan

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INTRODUCTION

Although many recommendations have been published for management of the pregnant woman on drugs, they vary greatly concerning the specific mode of management during pregnancy, and moreover, the management of the newborn infant. Several options have been described and recommended: 1. Methadone maintenance;[1-7] 2. Low-dose methadone maintenance;[1,3,4,8] 3. Slow detoxification using methadone substitution and later withdrawal;[9,10] 4. Acute detoxification;[10] 5. Merely supporting the woman prenatally without attempting to alter the addiction pattern,[11] and 6. Drug-free programs.[12,13]

Although admission to a methadone maintenance program requires initial hospitalization for substitution of the heroin habit by methadone, the patient can be stabilized on a daily controlled dose of drug. Advantages include: 1. Better participation in prenatal care; 2. Shorter hospital stay for the newborn; 3. Improved attention by the mother to her health care needs and those of her child; 4. The creation of a more stable social environment for both the mother and the infant, and 5. The ability to follow these mothers and infants on a long-term basis in order to evaluate outcome.[14]

In contrast, if the patient is merely encouraged to come for prenatal care and permitted to continue her heroin habit through the usual channels, good results cannot be expected. Prenatal care tends to be spotty and erratic since the patient is primarily motivated to the time-consuming activity of supporting her habit. The outcome for the newborn with erratic prenatal care generally involves a high incidence of low birth weight and infant morbidity.

Acute detoxification without the use of any other supportive agents is not acceptable to the drug-dependent woman nor is it without medical complications to her infant. The fetus may undergo simultaneous withdrawal and suffer considerable distress. The result may be intrauterine fetal death or the birth of an infant who has a severe meconium aspiration syndrome.

If one decides to detoxify the pregnant woman by giving her large doses of tranquilizers or methadone and then slowly withdrawing the substitute medication, this may be uncomfortable for the pregnant woman as well as hazardous to the unborn fetus. It may also require prolonged hospital stays. Withdrawal from methadone is generally more difficult than that of heroin and is particularly hazardous in the first and third trimesters. In the first trimester, abortion may ensue, and in the last trimester, the onset of premature labor with the birth of a low weight infant is common.[15]

The objective of this report will be to describe what has recently proven to be an acceptable approach for the management of pregnant, substance-abusing women, an approach which not only meets their addictive problems but also addresses their overwhelming social, psychological and medical needs.

0077-8923/78/0311-0135 $01.75/2

	Obstetrical Complications	LBW
Untreated OUD – No PNC	36.9%	47.7%
Methadone – No PNC	32.1%	35.5%
Methadone - + PNC	33.7%	19.7%
No SUD – No PNC	32.3%	19.4%
No SUD - + PNC	32.0%	13.9%

Matern Child Health J (2017) 21:893–902
DOI 10.1007/s10995-016-2190-y

The Prevalence and Impact of Substance Use Disorder and Treatment on Maternal Obstetric Experiences and Birth Outcomes Among Singleton Deliveries in Massachusetts

Milton Kotelchuck[1] · Erika R. Cheng[2] · Candice Belanoff[3] · Howard J. Cabral[3] · Hermik Babakhanlou-Chase[4] · Taletha M. Derrington[5] · Hafsatou Diop[6] · Stephen R. Evans[3] · Judith Bernstein[3]

Core Principle of PNC:

Optimize maternal health via chronic disease management

	No Addiction	Treated Addiction	Untreated Addiction
Preterm Birth	8.7%	10.1%	19.0%
Low Birthweight	5.5%	7.8%	18.0
Fetal Death	0.4%	0.5%	0.8%
Neonatal Mortality	0.4%	0.4%	1.2%
Post Neonatal Mortality	0.05%	0.03%	0.1%

Addiction: From Reward Seeking to Relief Seeking

Heroin Addiction—A Metabolic Disease

Vincent P. Dole, MD, and Marie E. Nyswander, MD, New York

THE METHADONE Maintenance Research Program[1-3] began three years ago with pharmacological studies conducted on the metabolic ward of the Rockefeller University Hospital. Only six addict patients were treated during the first year, but the results of this work were sufficiently impressive to justify a trial of maintenance treatment of heroin addicts admitted to open medical wards of general hospitals in the city.

Methadone therapy was started in low dosage (10 to 20 mg/day in divided portions) and increased slowly over a period of four to six weeks to avoid narcotic effects. After the patients had reached the stabilization level (80 to 120 mg/day) it was possible to maintain them with a single, daily, oral ration, without further increase in dose. At the end of the six weeks of hospitalization the patients were discharged to outpatient clinics where they received their daily

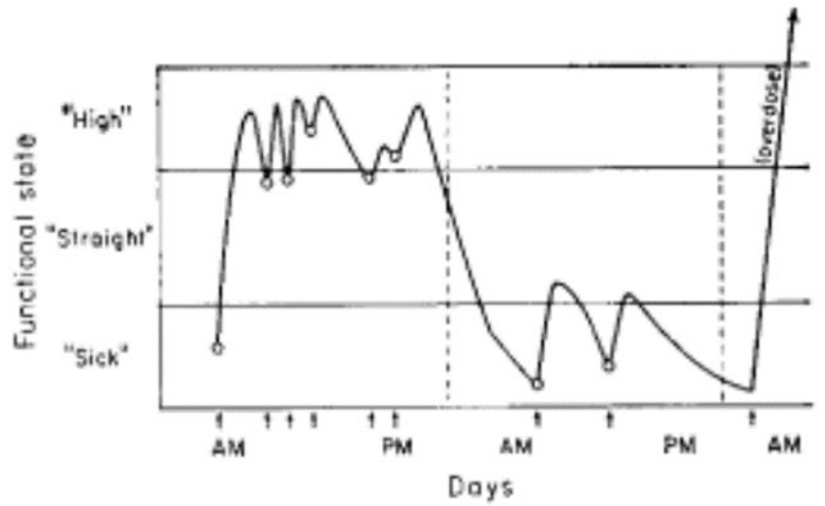

Fig 1.—Diagrammatic summary of functional state of typical "mainline" heroin user. *Arrows* show the repetitive injection of heroin in uncertain dose, usually 10 to 30 mg but sometimes much more. Note that addict is hardly ever in a state of normal function ("straight").

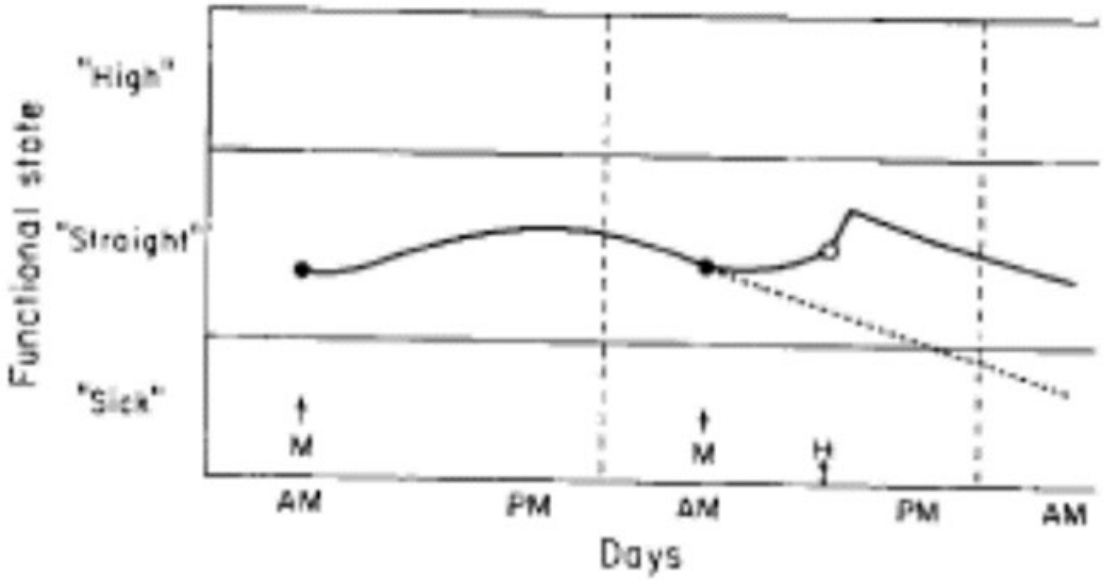

Fig 2.—Stabilization of patient in state of normal function by blockade treatment. A single, daily, oral dose of methadone prevents him from feeling symptoms of abstinence ("sick") or euphoria ("high"), even if he takes a shot of heroin. *Dotted line* indicates course if methadone is omitted.

SAMHSA Clinical Guide Recommendations

- Medically supervised withdrawal is not recommended during pregnancy
- Buprenorphine and methadone are the safest medications for managing OUD during pregnancy
- Transitioning from methadone to buprenorphine or from buprenorphine to methadone during pregnancy is not recommended

Most People Receive no Treatment in Pregnancy

Table 3
Past year substance use disorder treatment receipt among reproductive age women in need of treatment.

Substance use disorder diagnosis	Total[a]	Not pregnant nor parenting	Pregnant[†]			Parenting	P values[‡]
			1st trimester	2nd trimester	3rd trimester		
Any past year substance use disorder	9.3% (8.4–10.2)	8.8% (7.7–9.8)	12.8% (8.7–16.9)			9.9% (8.5–11.4)	0.063
treatment need[§]			12.5% (7.3–17.7)	9.4% (4.7–14.0)	18.7% (5.5–32.0)		0.246
Alcohol use disorder	7.4% (6.6–8.3)	6.8% (5.9–7.7)	11.8% (7.2–16.5)			8.2% (6.6–9.9)	0.021
			11.7% (5.8–17.6)	9.0% (3.3–14.7)	16.2% (2.6–29.9)		0.505
Illicit drug use disorder[‖]	17.1% (15.5–18.7)	17.0% (14.8–19.2)	21.8% (13.9–29.6)			16.5% (13.7–19.3)	0.439
			26.0% (15.1–36.8)	13.2% (5.1–21.3)	29.2% (8.5–49.9)		0.187
Opioid use disorder[¶]	23.6% (18.9–28.2)	31.1% (27.0–35.1)	34.7% (20.7–48.7)			23.6% (18.9–28.2)	0.033
			54.2% (30.2–78.1)	20.0% (3.5–36.5)	31.1% (0.0–63.7)		0.152

Martin, 2020, DAD

Racial Inequities in Medications for OUD

Table 2. Adjusted and Unadjusted Odds Ratios for Use of Medication and Type of Medication for Pregnant Women With Opioid Use Disorder

Variable	Odds ratio (95% CI)		Pseudo-R^2	
	Unadjusted	Adjusted[a]	Full model	Model without race/ethnicity
Any treatment use			0.09	0.06
Medication vs no medication				
White non-Hispanic	1 [Reference]	1 [Reference]		
Black non-Hispanic	0.39 (0.30-0.51)	0.37 (0.28-0.49)		
Hispanic	0.44 (0.36-0.53)	0.42 (0.35-0.52)		
Consistency of treatment use			0.09	0.06
Consistent use vs no medication				
White non-Hispanic	1 [Reference]	1 [Reference]		
Black non-Hispanic	0.26 (0.18-0.37)	0.24 (0.17-0.35)		
Hispanic	0.36 (0.28-0.46)	0.34 (0.27-0.44)		
Consistent vs inconsistent treatment use				
White non-Hispanic	1 [Reference]	1 [Reference]		
Black non-Hispanic	0.44 (0.30-0.66)	0.44 (0.30-0.65)		
Hispanic	0.65 (0.50-0.85)	0.64 (0.48-0.83)		
Type of medication			0.12	0.09
Buprenorphine (alone) vs methadone (any)				
White non-Hispanic	1 [Reference]	1 [Reference]		
Black non-Hispanic	0.53 (0.36-0.79)	0.60 (0.40-0.90)		
Hispanic	0.68 (0.52-0.90)	0.77 (0.58-1.01)		
Buprenorphine vs none				
White non-Hispanic	1 [Reference]	1 [Reference]		
Black non-Hispanic	0.27 (0.19-0.39)	0.28 (0.19-0.40)		
Hispanic	0.36 (0.28-0.46)	0.37 (0.29-0.47)		

JAMA Network Open. 2020;3(5):e205734. doi:10.1001/jamanetworkopen.2020.5734

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Racial inequity in methadone dose at delivery in pregnant women with opioid use disorder

Emily W. Rosenthal [a,*], Vanessa L. Short [b], Yuri Cruz [c], Cecily Barber [b], Jason K. Baxter [b], Diane J. Abatemarco [b], Amanda R. Roman [b], Dennis J. Hand [b,d]

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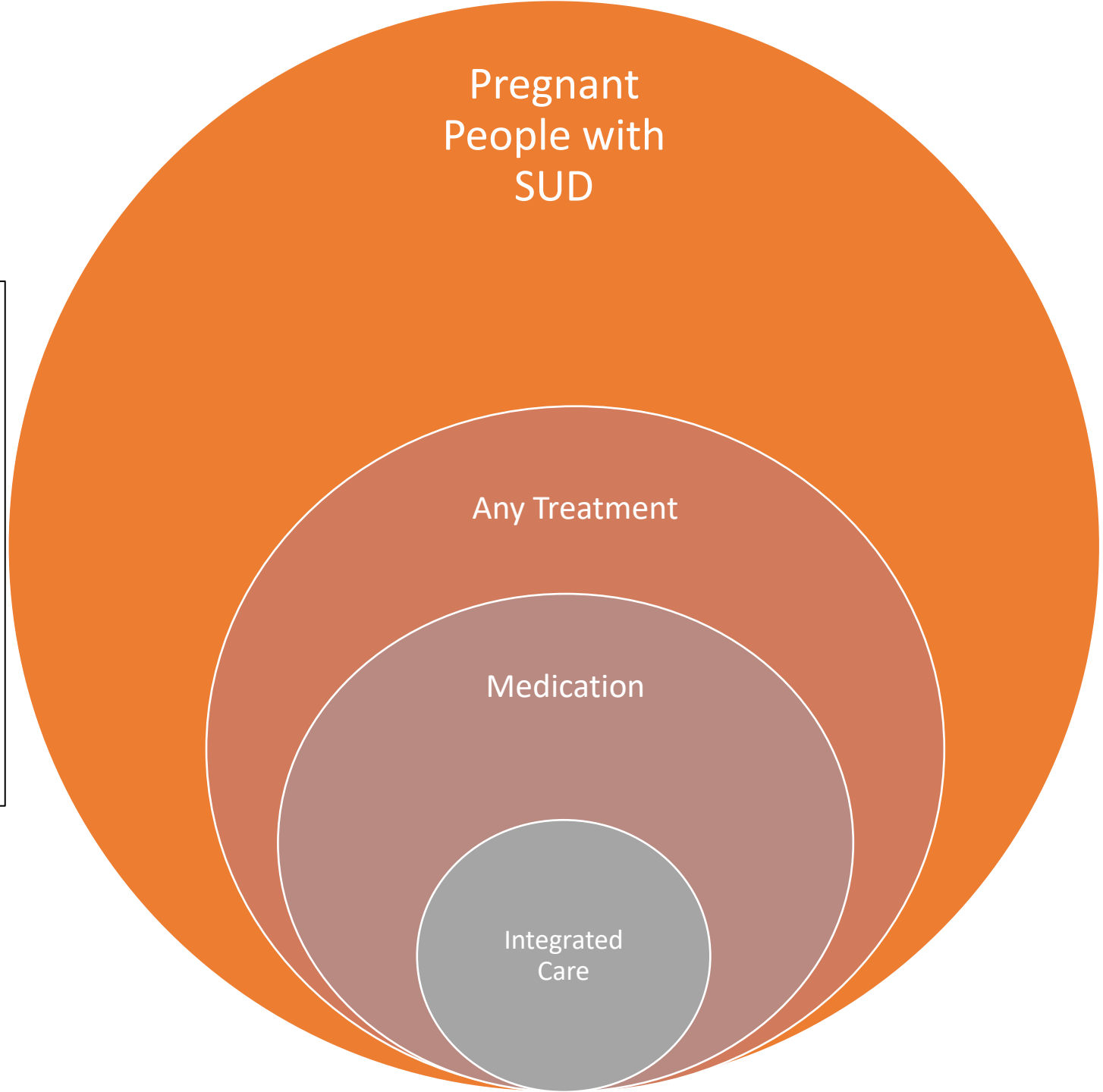
	White NH	Black NH	Hispanic
Methadone Dose	144.9	97.5	129.8

Comprehensive treatment and medication are rare and unavailable for most pregnant people with SUD



From the Comprehensive Child Development Act to CAPTA (Child Abuse Prevention Treatment Act):

PRESIDENT VETOES CHILD CARE PLAN AS IRRESPONSIBLE

He Terms Bill Unworkable and Voices Fear It Would Weaken Role of Family

DEC 1 0 1971

PERKINS PLEDGES FIGHT

But Overriding of Nixon's Step Is Doubted—Javits May Seek Compromise

NYTimes

By JACK ROSENTHAL

Special to The New York Times

WASHINGTON, Dec. 9—In a stinging message, President Nixon vetoed today a Congressionally initiated bill to establish a national system of comprehensive child development and day care.

The proposal, he said, was characterized by "fiscal irresponsibility, administrative unworkability and family-weakening implications."

The President said that he objected to committing, without wide national debate, "the vast moral authority of the national Government to the side of communal approaches to child-rearing over against the family-centered approach."

The veto message, which had been expected, was unusually strong in its language. Mr. Nixon also criticized two other measures included in the same legislation—renewal of the Office of Economic Opportunity, the Federal antipoverty agency, and the spinning off of the Federal legal services program as an independent corporation.

Excerpts from veto message are printed on Page 22.

Congress Reacts Quickly

The veto brought quick, sharp reaction from Congress. "We'll fight it all the way," said Representative Carl D. Perkins, Democrat of Kentucky, chairman of the House Education and Labor Committee.

It was extremely doubtful, however, that Congress could muster enough votes to override the veto. While the Senate passed the measure by a 63-to-17 vote last week, the House vote on Tuesday was only 210 to 186.

Senator Jacob K. Javits, Republican of New York, co-sponsor of the bill, expressed disappointment and said that if the veto was not overridden he would seek a quick compromise bill. Senator Walter F. Mondale, Democrat of Minnesota, the other Senate co-sponsor, said that the veto was "a cruel blow to children and working parents."

The child development proposal had attracted unusually broad support from labor, religious, women's liberation and public interest groups. They and Congressional advocates argued that it was a necessary response to a change in society as large numbers of mothers have gone to work.

Ronald L. Ziegler, the White House press secretary, told reporters that the President was not opposed to day care. Mr. Nixon's opposition, rather, is to the particular program set out in the bill, Mr. Ziegler said.

However, in his message, Mr. Nixon said:

"Neither the immediate need nor the desirability of a national child development program of this character has been demonstrated."

The President called attention to other Administration proposals concerning child development. He cited particularly the $750-million day care component of his welfare reform plan. This is to provide service to welfare mothers who would go to work under the Administration's plan.

Repeatedly in the message, Mr. Nixon raised strong reservations about the principle of child development.

"We cannot and will not ignore the challenge to do more for America's children in their all-important early years," the message said.

Asks Measured Response

"But our response to this challenge must be a measured, evolutionary, painstakingly considered one, consciously designed to cement the family in its rightful position as the keystone of our civilization.

"Good public policy requires that we enhance rather than diminish both parental authority and parental involvement with children."

The Congressional proposal called for a broad system ranging from nutrition aids for pregnant mothers to after-school programs for teen-agers.

The plan would have cost $2-billion in its first full year of operation. It would have operated through Federal grants to communities of down to 5,000 population that applied for funds and gave assurance of high standards of quality.

The Congressional proposal, Mr. Nixon said, would create "a new army of bureaucrats" without answering where qualified personnel would come from and without justifying costs that he estimated could reach $20-billion a year.

Two Other Segments Scored

The President also applied sharp language to two other components of the bill, which began last winter as simply a two-year extension of O.E.O.

As to the extension of the poverty agency, Mr. Nixon criticized mandatory funding levels set by Congress for 15 programs. Such earmarking "is genuinely reactionary legislation," he said, most importantly because it restricts the amount of funds available for innovations.

The earmarking would mean, he said, that "O.E.O. would rapidly degenerate into just another ossified bureaucracy."

The President said that he would have vetoed this proposal even if it had come to him separately.

The final component of the bill, the proposal to create an independent national legal services corporation, was supported in principle by the Administration. But once again Mr. Nixon said that the restrictions that Congress imposed in the final bill were "an affront to the principle of accountability to the American people as a whole."

Mr. Nixon expressed strong objections to the machinery for choosing this corporation's board. Six of the members would be appointed by the President, and the 11 others would be chosen by him from lists provided by professional groups.

The universal aim of the corporation proposal was to insulate the controversial poverty law program from political pressures. But Mr. Nixon said today "It would be better to have no legal services corporation than one so irresponsibly structured."

Continued on Page 22, Column 1

FACTSHEET

August 2017

About CAPTA: A Legislative History

The key federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted on January 31, 1974 (P.L. 93-247). This act has been amended several times and was last reauthorized on December 20, 2010, by the CAPTA Reauthorization Act of 2010 (P.L. 111-320). Most recently, certain provisions of the act were amended on May 29, 2015, by the Justice for Victims of Trafficking Act of 2015 (P.L. 114-22) and on July 22, 2016, by the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198).

CAPTA provides federal funding and guidance to states in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations, including Indian tribes and tribal organizations, for demonstration programs and projects. Additionally, CAPTA identifies the federal role in supporting research, evaluation, technical assistance, and data collection activities; establishes the Office on Child Abuse and Neglect; and establishes a national clearinghouse of information relating to child abuse and neglect.[1] CAPTA also sets forth a federal definition of child abuse and neglect. In 2015, the federal definitions of "child abuse and neglect" and "sexual abuse" were expanded by the Justice for Victims of Trafficking Act to include a child who is identified as a victim of sex trafficking or severe forms of trafficking in persons.

The complete text of the law (U.S. Code title 42, chapter 67) can be downloaded from the Cornell University Legal Information Institute website at https://www.law.cornell.edu/uscode/text/42/chapter-67. The text of CAPTA as amended, including the Adoption Opportunities program and Abandoned Infants Assistance Act, as amended, is available on the Children's Bureau website at https://www.acf.hhs.gov/cb/resource/capta2016.

[1] This clearinghouse operates as Child Welfare Information Gateway.

Child Welfare Information Gateway

Children's Bureau/ACYF/ACF/HHS
800.394.3366 | Email: info@childwelfare.gov | https://www.childwelfare.gov

Children's Bureau

“If I Wasn’t Poor, I Wouldn’t Be Unfit”

The Family Separation Crisis in the US Child Welfare System

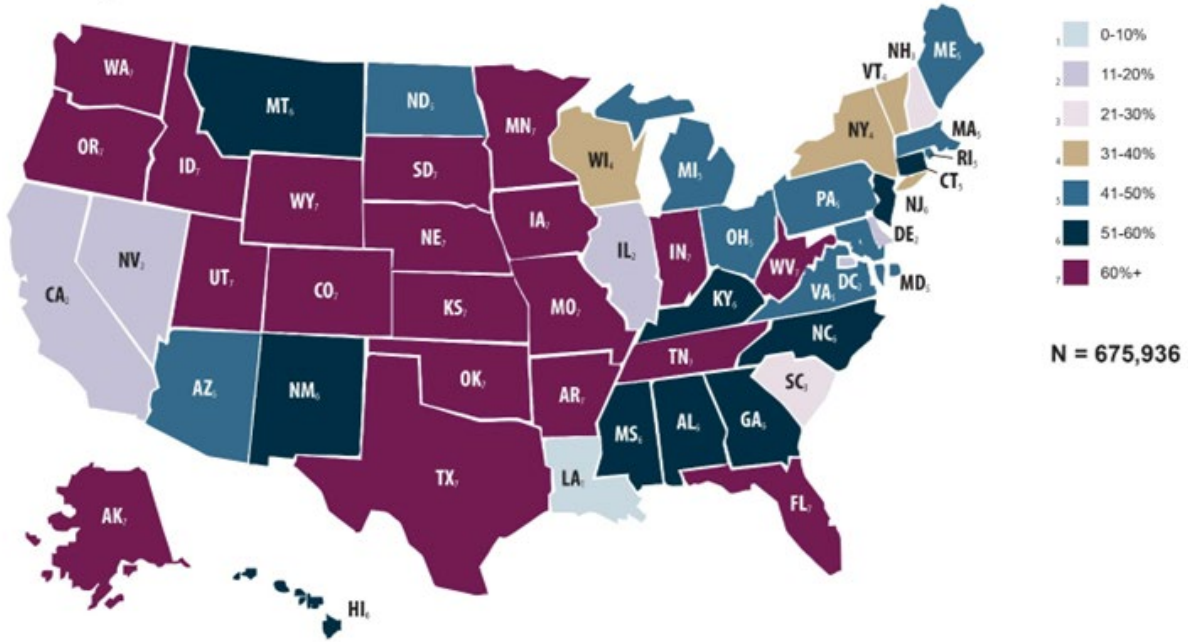
HUMAN RIGHTS WATCH

ACLU

Percent of Children Removed with Parental Alcohol or Drug Abuse as an Identified Condition of Removal by Age, 2019

Under Age 1

National Average 50.7%



N = 675,936

“Test and Report” Provider Culpability

- Most child welfare reports (<1yr) originate from medical professionals during birthing hospitalization
- Health Professional Reporting increased 400% in past decade
- Driven by (misuse of) urine drug testing
- Compounds racial inequities

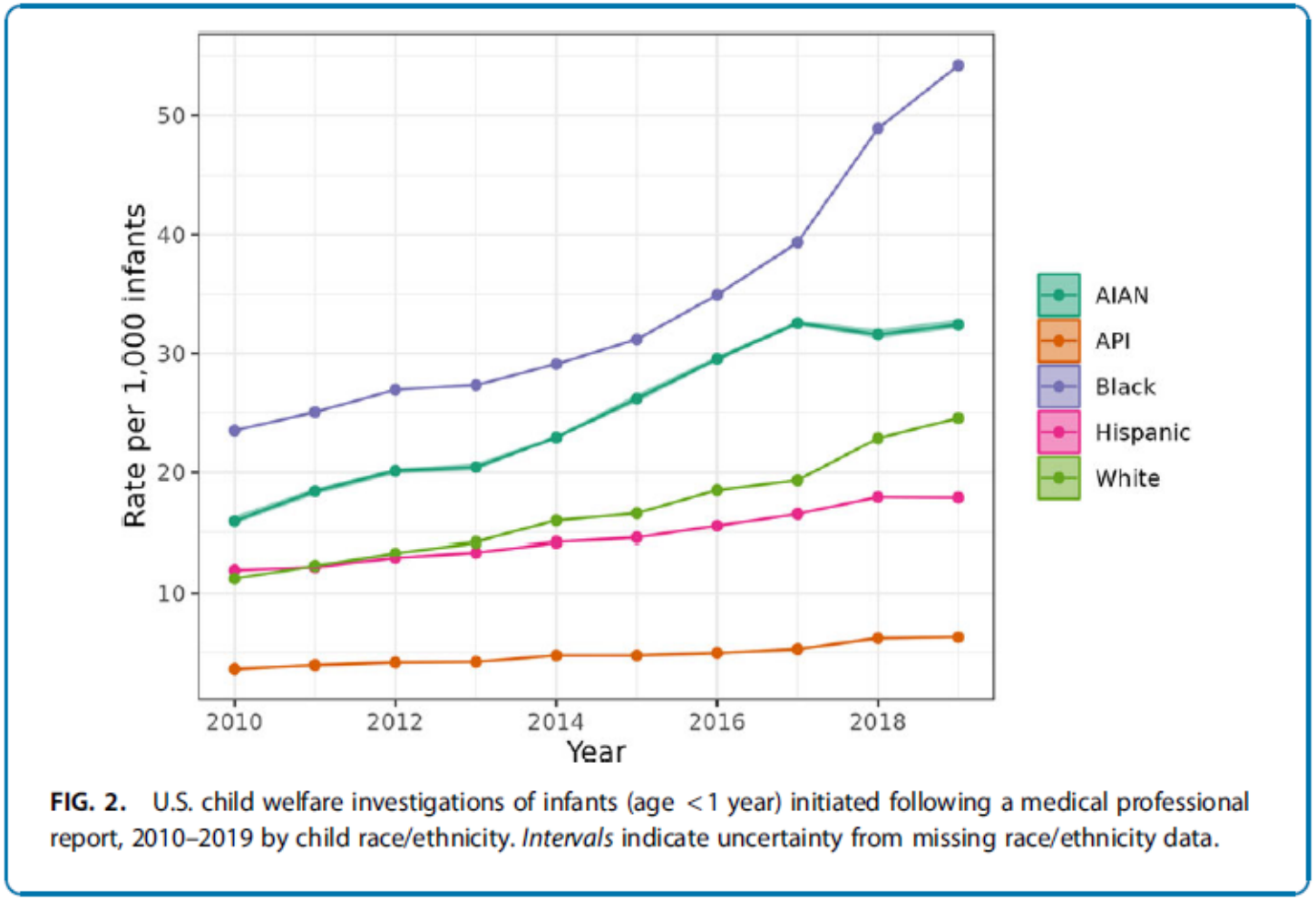


FIG. 2. U.S. child welfare investigations of infants (age < 1 year) initiated following a medical professional report, 2010–2019 by child race/ethnicity. *Intervals* indicate uncertainty from missing race/ethnicity data.

HHS 2020 https://www.childwelfare.gov/pubs/factsheets/cpswork/; Edwards F et al, *Health Equity*, 2023; AAP 2015 https://pediatrics.aappublications.org/content/135/5/948

The fetus does not know if the exposure is prescribed, used as directed or misused, legal or illegal, natural or synthetic

Provider Assumptions:
Social/Legal Distinctions = Biological/Public Health

Known Teratogens: ACE-Inhibitors, Alcohol, Carbamazepine, Diethylstilbetrol (DES), Isotretinoin, Phenytoin, Tobacco, Valproic Acid (partial list)

Alcohol use during pregnancy can lead to lifelong effects.

Up to 1 in 20 US school children may have FASDs.

People with FASDs can experience a mix of the following problems:

Physical issues

- low birth weight and growth
- problems with heart, kidneys, and other organs
- damage to parts of the brain

Which leads to...

Behavioral and intellectual disabilities

- learning disabilities and low IQ
- hyperactivity
- difficulty with attention
- poor ability to communicate in social situations
- poor reasoning and judgment skills

These can lead to...

Lifelong issues with

- school and social skills
- living independently
- mental health
- substance use
- keeping a job
- trouble with the law

FASD United, the National Voice on FASD

fasdunited.org

“Crack Babies”: A Cautionary Tale

Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Besharov

LAST WEEK in this city, Greater Southeast Community Hospital released a 7-week-old baby to her homeless, drug-addicted mother even though the child was at severe risk of pulmonary arrest. The hospital's explanation: "Because [the mother] demanded that the baby be released."

The hospital provided the mother with an apnea monitor to warn her if the baby stopped breathing while asleep, and trained her in CPR. But on the very first night, the mother went out drinking and left the child at a friend's house—without the monitor. Within seven hours, the baby was dead. Like Dooney Waters, the 6-year-old living in his mother's drug den, whose shocking story was reported in The Washington Post last week, this child was all but abandoned by the authorities.

Washington Post 1989

The New York Times

Schools Trying to Cope With 'Crack Babies'

By Priscilla van Tassel
Jan. 5, 1992

JANE STEIN, a 29-year veteran of elementary school teaching, is seeing a different breed of pupils in her kindergarten class these days at the Joyce Kilmer School in Trenton.

"Their attention span is much shorter," she said. "It's very difficult for them to sit still for a long period of time. I guess you'd call it itchiness. They plain can't pay attention."

“The kids are coming to us damaged.”

COCAINE USE IN PREGNANCY

IRA J. CHASNOFF, M.D., WILLIAM J. BURNS, PH.D., SIDNEY H. SCHNOLL, M.D., PH.D., AND KAYREEN A. BURNS, PH.D.

Abstract With the increasing use of cocaine in the United States, there has been growing concern regarding its effects on the fetuses and neonates of pregnant cocaine abusers. Twenty-three cocaine-using women enrolled in a comprehensive perinatal-addiction program were divided into two groups: those using cocaine only and those using cocaine plus narcotics. These two groups were compared with a group of women who had used narcotics in the past and were maintained on methadone during pregnancy, and with a group of drug-free women. All four groups were similar in maternal age, socioeconomic status, number of pregnancies, and cigarette, marijuana, and alcohol use. Their medical histories indicated that the cocaine-using women had a significantly higher rate of spontaneous abortion than the women in the other two groups. In the pregnancies under study, four cocaine-using women had onset of labor with abruptio placentae immediately after intravenous self-injection of cocaine. Neonatal gestational age, birth weight, length, and head circumference were not affected by cocaine use. However, the Brazelton Neonatal Behavioral Assessment Scale revealed that infants exposed to cocaine had significant depression of interactive behavior and a poor organizational response to environmental stimuli (state organization).

These preliminary observations suggest that cocaine influences the outcome of pregnancy as well as the neurologic behavior of the newborn, but a full assessment will require a larger number of pregnancies and longer follow-up. (N Engl J Med 1985; 313:666-9.)

WITH the increasing use of cocaine in the United States, there has been a growing interest in the potential medical complications of cocaine use, including its effects on pregnancy, the fetus, and the neonate. In conjunction with the increased use of cocaine in the general population, the number of cocaine-using pregnant women presenting to the Perinatal Addiction Project of Northwestern Memorial Hospital has escalated dramatically, providing an opportunity to evaluate the effects of cocaine on pregnancy and the newborn.

From the Departments of Pediatrics, Psychiatry and Behavioral Sciences, and Pharmacology, Northwestern University Medical School, and Northwestern Memorial Hospital, Chicago.

Address reprint requests to Dr. Chasnoff at Northwestern Memorial Hospital, Chemical Dependence Program, Institute of Psychiatry, 320 E. Huron St., Chicago, IL 60611.

METHODS

From January 1983 to September 1984, 23 infants were born to cocaine-using women enrolled in the Perinatal Addiction Project of Northwestern Memorial Hospital's Institute of Psychiatry and Prentice Women's Hospital and Maternity Center. During this period, every woman referred to the program for cocaine use during pregnancy was enrolled by the second trimester of pregnancy and was involved in an intensive program that included prenatal care and treatment for chemical dependence. Four women who were referred to the program but refused to be enrolled for treatment were lost to follow-up. None of the women who accepted treatment dropped out of the study. Twice-weekly maternal urine samples were obtained on a regular basis to screen for the use of illicit drugs (opiates, amphetamines, barbiturates, benzodiazepines, propoxyphene, cocaine, or phencyclidine). Alcohol breath tests were performed at the discretion of the patient's counselor to check for alcohol use. In order to evaluate the specific effects of cocaine on pregnancy and the newborn, the cocaine-using women were divided into two groups on the basis of concurrent use or nonuse of narcotics and were compared with two control groups. One control group was

First description of cocaine outcomes

N=23

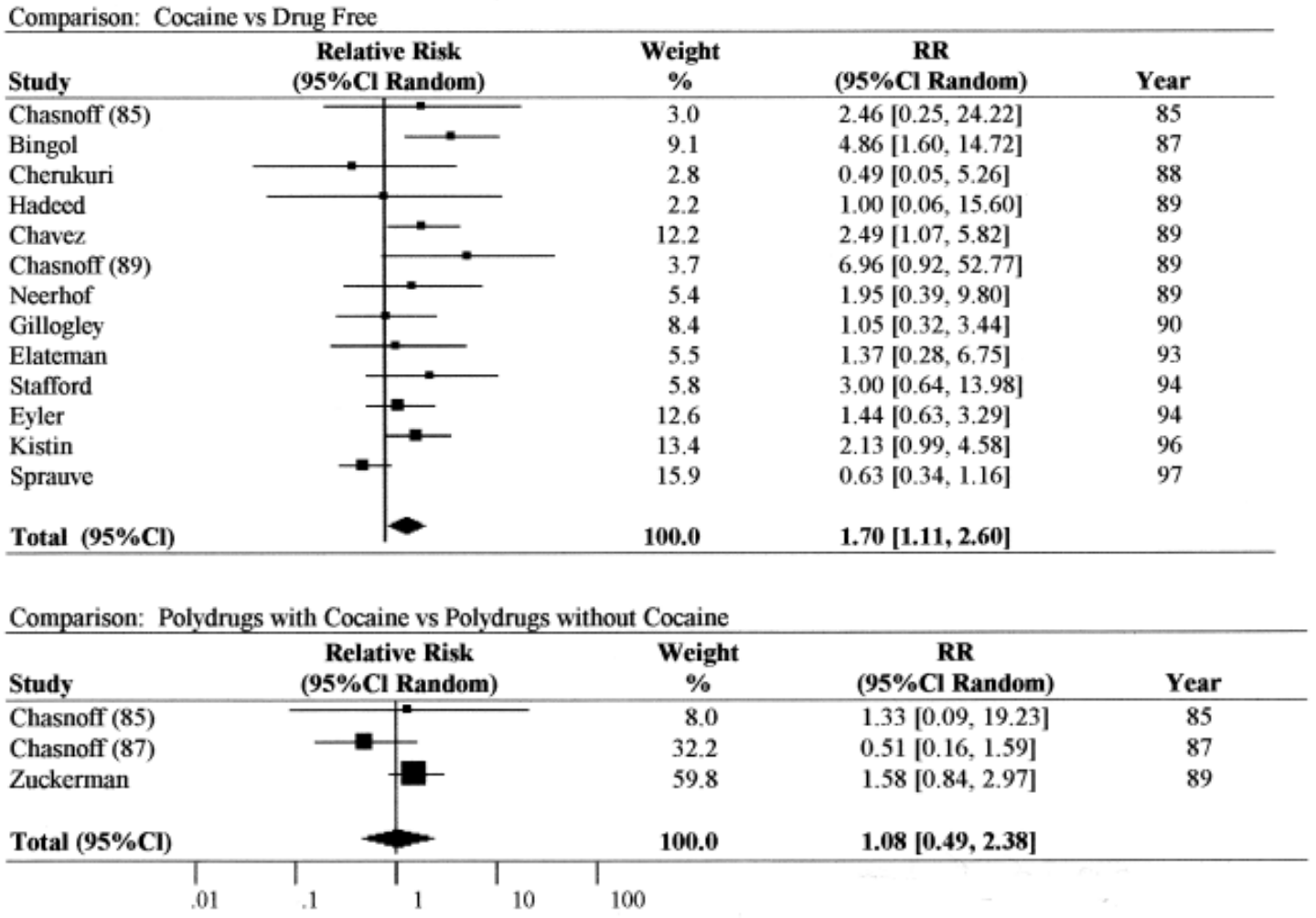
4 abruptions

Lower scores on Brazelton Neonatal Behavioral Assessment Scale

Fetal effects of cocaine: An updated meta-analysis

Addis et al *Reproductive Toxicology* 2001

- Search MEDLINE and EMBASE
- 1/89 – 12/97
- 516 articles reviewed
- 36 included in analysis
- 35,000 women of whom 4200 were cocaine exposed
- Inclusion criteria
  - Exposure – any cocaine
  - Case-control or cohort with comparison group
  - Blinded reviewing



Comparison: Cocaine vs Drug Free

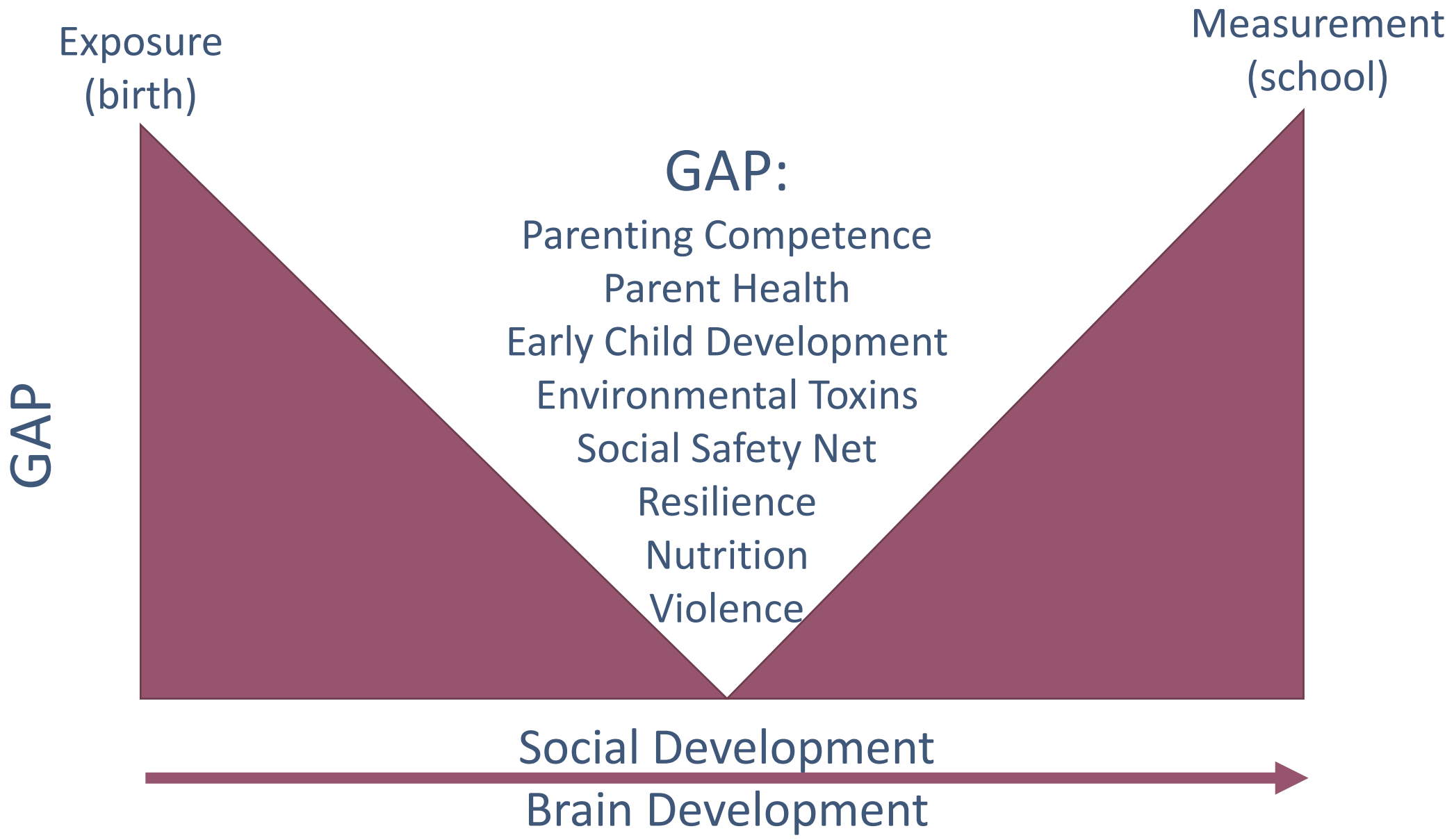
Study	Relative Risk (95%CI Random)	Weight %	RR (95%CI Random)	Year
Chasnoff (85)		3.0	2.46 [0.25, 24.22]	85
Bingol		9.1	4.86 [1.60, 14.72]	87
Cherukuri		2.8	0.49 [0.05, 5.26]	88
Hadeed		2.2	1.00 [0.06, 15.60]	89
Chavez		12.2	2.49 [1.07, 5.82]	89
Chasnoff (89)		3.7	6.96 [0.92, 52.77]	89
Neerhof		5.4	1.95 [0.39, 9.80]	89
Gillogley		8.4	1.05 [0.32, 3.44]	90
Elateman		5.5	1.37 [0.28, 6.75]	93
Stafford		5.8	3.00 [0.64, 13.98]	94
Eyler		12.6	1.44 [0.63, 3.29]	94
Kistin		13.4	2.13 [0.99, 4.58]	96
Sprauve		15.9	0.63 [0.34, 1.16]	97
Total (95%CI)		**100.0**	**1.70 [1.11, 2.60]**	

Comparison: Polydrugs with Cocaine vs Polydrugs without Cocaine

Study	Relative Risk (95%CI Random)	Weight %	RR (95%CI Random)	Year
Chasnoff (85)		8.0	1.33 [0.09, 19.23]	85
Chasnoff (87)		32.2	0.51 [0.16, 1.59]	87
Zuckerman		59.8	1.58 [0.84, 2.97]	89
Total (95%CI)		**100.0**	**1.08 [0.49, 2.38]**	

.01 .1 1 10 100

Fig. 1. Major Malformations


Exposure
(birth)
Measurement
(school)
GAP:
Parenting Competence
Parent Health
Early Child Development
Environmental Toxins
Social Safety Net
Resilience
Nutrition
Violence
GAP
Social Development
Brain Development

Measurement and Context

Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol. 85, No. 6
doi:10.1007/s11524-008-9315-6

Illicit Drug Use and Adverse Birth Outcomes: Is It Drugs or Context?

Ashley H. Schempf and Donna M. Strobino

ABSTRACT *Prenatal drug use is commonly associated with adverse birth outcomes, yet no studies have controlled for a comprehensive set of associated social, psychosocial, behavioral, and biomedical risk factors. We examined the degree to which adverse birth outcomes associated with drug use are due to the drugs versus surrounding factors. Data are from a clinical sample of low-income women who delivered at Johns Hopkins Hospital between 1995 and 1996 (n=808). Use of marijuana, cocaine, and opiates was determined by self-report, medical record, and urine toxicology screens at delivery. Information on various social, psychosocial, behavioral, and biomedical risk factors was gathered from a postpartum interview or the medical record. Multivariable regression models of birth outcomes (continuous birth weight and low birth weight ([LBW] <2,500 g)) were used to assess the effect of drug use independent of associated factors. In unadjusted results, all types of drug use were related to birth weight decrements and increased odds of LBW. However, only the effect of cocaine on continuous birth weight remained significant after adjusting for all associated factors (−142 g, p=0.05). No drug was significantly related to LBW in fully adjusted models. About 70% of the unadjusted effect of cocaine use on continuous birth weight was explained by surrounding psychosocial and behavioral factors, particularly smoking and stress. Most of the unadjusted effects of opiate use were explained by smoking and lack of early prenatal care. Thus, prevention efforts that aim to improve newborn health must also address the surrounding context in which drug use frequently occurs.*

KEYWORDS *Illicit drugs, Psychosocial factors, Pregnancy, Birth weight, Low birth weight*

TABLE 3 Linear regression results of birth weight and drug use

	Marijuana coefficient (95%CI)	Cocaine coefficient (95%CI)	Opiates coefficient (95%CI)	Heavy smoking 10+ cigarettes per day coefficient (95%CI)	Heavy drinking daily/weekly coefficient (95%CI)
Unadjusted	−250.0 (−384.0, −116.0)***	−475.1 (−584.6, −367.7)***	−462.3 (−582.0, −342.5)***	−543.8 (−674.3, −413.3)***	−438.3 (−629.1, −247.5)***
Adjusted for other drug use	−0.2 (−140.6, 140.2)	−219.7 (−369.4, −70.0)**	−165.1 (−324.6, −5.5)*	−307.7 (−470.1, −145.3)***	−120.5 (−319.8, 78.8)
Social factors	12.7 (−127.6, 152.9)	−225.0 (−377.4, −72.8)*	−170.2 (−330.3, −10.1)*	−278.8 (−445.1, −112.6)**	−83.7 (−284.6, 117.1)
Social and psychosocial factors	7.7 (−131.5, 146.9)	−187.2 (−339.0, −35.5)*	−162.1 (−321.0, −3.1)*	−232.2 (−398.2, −66.2)**	−68.1 (−267.7, 131.5)
Social, psychosocial, and behavioral factors	10.1 (−128.2, 148.5)	−171.3 (−322.5, −20.1)*	−129.9 (−289.2, 29.5)	−225.9 (−391.0, −60.8)**	−46.3 (−245.3, 152.6)
Social, psychosocial, behavioral, and biomedical factors	−24.6 (−155.8, 106.5)	−142.0 (−285.8, 1.8)	−85.6 (−237.7, 66.4)	−158.2 (−315.9, −0.5)*	−30.6 (−219.4, 158.2)

Social factors include maternal age, money for necessities, and housing. Psychosocial factors include stress and pregnancy locus of control. Behavioral factors include early prenatal care. Biomedical factors include hypertensive disorders, other medical risk factors, prepregnancy weight, and net weight gain.

*$p<0.05$; **$p<0.01$; ***$p<0.001$

Substance Use in Pregnancy and Subsequent Child Maltreatment: Where is the Evidence?

- Substance-exposed infants have increased likelihood of child welfare involvement
- No strong evidence of substantiated maltreatment
- Overall literature is of poor methodological quality

Review Article

Child Maltreatment
1-26

DOI: 10.1177/1077559521990116
journals.sagepub.com/home/cmx
SAGE

Prenatal Substance Exposure and Child Maltreatment: A Systematic Review

Anna E. Austin[1,2], Caitlin Gest[1], Alexandra Atkeson[1], Molly C. Berkoff[3], Henry T. Puls[4], and Meghan E. Shanahan[1,2]

Abstract

State and federal policies regarding substance use in pregnancy, specifically whether a notification to child protective services is required, continue to evolve. To inform practice, policy, and future research, we sought to synthesize and critically evaluate the existing literature regarding the association of prenatal substance exposure with child maltreatment. We conducted a comprehensive electronic search of PubMed, Web of Science, PsycInfo, CHINAL, Social Work Abstracts, Sociological Abstracts, and Social Services Abstracts. We identified 30 studies that examined the association of exposure to any/multiple substances, cocaine, alcohol, opioids, marijuana, and amphetamine/methamphetamine with child maltreatment. Overall, results indicated that substance exposed infants have an increased likelihood of child protective services involvement, maternal self-reported risk of maltreatment behaviors, hospitalizations and clinic visits for suspected maltreatment, and adolescent retrospective self-report of maltreatment compared to unexposed infants. While study results suggest an association of prenatal substance exposure with child maltreatment, there are several methodological considerations that have implications for results and interpretation, including definitions of prenatal substance exposure and maltreatment, study populations used, and potential unmeasured confounding. As each may bias study results, careful interpretation and further research are warranted to appropriately inform programs and policy.

Keywords

child maltreatment, infants, substance abuse

Table III. Foundational principles for the clinical definition of opioid withdrawal in the neonate

1. Substance use disorder is a disease requiring compassionate, ethical, equitable, and evidence-based care.
2. The maternal–neonate dyad is the appropriate subject of care; this definition is intended to identify clinical and supportive care needs of the dyad; shared interests should be prioritized.
3. A diagnosis of NAS or NOWS does not imply harm, nor should it be used to assess child social welfare risk or status. It should not be used to prosecute or punish the mother or as evidence to remove a neonate from parental custody.
4. Environmental factors, family influences, and social structures strongly influence neonatal outcome and should be recognized.

THE JOURNAL OF PEDIATRICS • www.jpeds.com ORIGINAL ARTICLES

Standardizing the Clinical Definition of Opioid Withdrawal in the Neonate

Shahla M. Jilani, MD[1,*], Hendrée E. Jones, PhD[2,3,*], Matthew Grossman, MD[4], Lauren M. Jansson, MD[5], Mishka Terplan, MD, MPH[6], Laura J. Faherty, MD, MPH, MSHP[7,8], Dmitry Khodyakov, PhD, MA[7], Stephen W. Patrick, MD, MPH, MS[9], and Jonathan M. Davis, MD[10]

Objective To standardize the clinical definition of opioid withdrawal in neonates to address challenges in clinical care, quality improvement, research, and public policy for this patient population.
Study design Between October and December 2020, we conducted 2 modified-Delphi panels using ExpertLens, a virtual platform for performing iterative expert engagement panels. Twenty clinical experts specializing in care for the substance-exposed mother–neonate dyad explored the necessity of key evidence-based clinical elements in defining opioid withdrawal in the neonate leading to a diagnosis of neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS). Expert consensus was assessed using descriptive statistics, the RAND/UCLA Appropriateness Method, and thematic analysis of participants' comments.
Results Expert panels concluded the following were required for diagnosis: in utero exposure (known by history, not necessarily by toxicology testing) to opioids with or without the presence of other psychotropic substances, and the presence of at least two of the most common clinical signs characteristic of withdrawal (excessive crying, fragmented sleep, tremors, increased muscle tone, gastrointestinal dysfunction).
Conclusions Results indicate that both a known history of in utero opioid exposure and a distinct set of withdrawal signs are necessary to standardize a definition of neonatal withdrawal. Implementation of a standardized

Birth is not Safe for People who use Drugs and Discrimination is a Patient Safety Issue

"Equating a positive toxicology test with child abuse or neglect is scientifically inaccurate and inappropriate, and can lead to an unnecessarily punitive approach, which harms clinician-patient trust and persons' engagement with healthcare services."

ASAM Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People, 10, 2022

"The laws, regulations, and policies that require health care practitioners and human service workers to respond to substance use and substance use disorder in a primarily punitive way, require health care providers to function as agents of law enforcement."

ACOG, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period: Statement of Policy, 11, 2020*

Pregnancy and Addiction: Mutual Mistrust

Provider

- Mistrust (often) misplaced
- Rooted in discrimination and prejudice
- Consequences of misplaced trust are minor

Patient

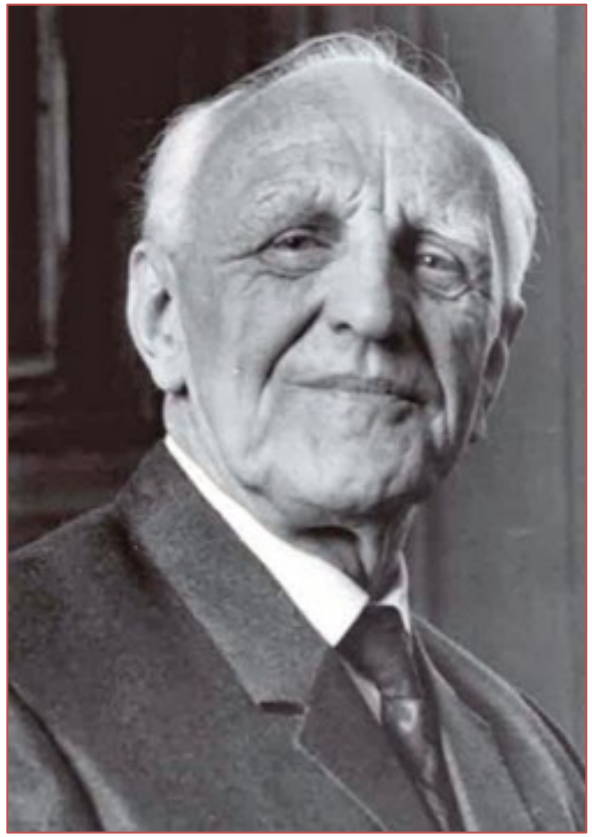
- Mistrust warranted by people who experience oppression
- Legitimate: historic memory and everyday discrimination
- Consequences of misplaced trust are severe

Power Differential
Risk/Vulnerability Different
Responsibility for Overcoming Mistrust Rests with Providers

Center on the Dyad

"There is no such thing as a baby … If you set out to describe a baby, you will find you are describing a baby and someone. A baby can not exist alone, but is essentially part of a relationship"

(D.W. Winnicott 1966)



Conclusion: Do Less Harm

- Evidence-Based: Grounded in Science
  - Harms of illicit substances exaggerated; Effects of licit substances minimized
  - Overstate the importance of intrauterine exposure; Neglect the role of the care-giving environment
- Person-Centered: Ethical and Grounded in Human Rights
  - Reproductive Health as a Human Right - Right to determine whether and when to become pregnant, and right to raise children in safe and sustainable environments
  - Support autonomy and maternal subjectivity in decision making surrounding pregnancy
  - Remain attuned to the unique demands we place on pregnant and parenting people, their bodies and their minds

Thank You mterplan@friendsresearch.org

Doingrightbybirth.org

CLINICIAN CONSULTATION CENTER
National rapid response for HIV management and bloodborne pathogen exposures.

Substance Use Warmline
Peer-to-Peer Consultation and Decision Support
10 am – 6 pm EST Monday - Friday
855-300-3595

Free and confidential consultation for clinicians from the Clinician Consultation Center at San Francisco General Hospital focusing on substance use in primary care

All Rise
Impaired
Driving Solutions

Where Did Our Clients Go?

Increasing interest, support, and enrollment in your impaired driving treatment court

Question of the Session

What is an impaired driving treatment court?

Explore

- Is your Treatment Court at capacity in terms of number of client the team and providers can serve?
- How was this number originally calculated/determined?
- What do you believe may be barriers to entry?
- How might your phase structure deter program entry?
- Why bother?

Why the lack of support?

Where's the love?

Impaired driving treatment courts are a proven model

Why is there a lack of support?

Not going to happen

- Public safety concerns
- Skepticism and ignorance
- Competing interests and interventions
- Outright opposition

Public Safety Concerns

Impaired driving is arguably the most dangerous behavior in our communities

Skepticism and Ignorance

- Mistrust of the research
- Unaware of the research
- Unaware of the model
- Belief that impaired drivers can be served by other treatment court models

Competing Interests and Interventions

SYSTEM RESPONSES TEND TO BE ON ONE END OF THE SPECTRUM OR THE OTHER

ALSO FILLED WITH INTERVENTIONS THAT ARE ARBITRARY AND NON-PRESCRIPTIVE

Outright Opposition

For years, critics of treatment courts have found reasons – some justifiable – to be in opposition.

How do we overcome these barriers to gain support?

Standards Primer

Standard I: Target Population

I. Target Population

A. Objective Eligibility and Exclusion Criteria

- **No subjective criteria or personal impressions (suitability)**
  - Motivation for change
  - Complex needs
  - Attitude
  - Optimism about recovery

I. Target Population

B. Proactive Recruitment

- Rapid enrollment
- Educate stakeholders
- Post information in strategic locations
- Offer immediate pre-plea services
- Ideal scenario: universal screening

I. Target Population

C. High-Risk and High-Need Participants

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

I. Target Population

C. High-Risk and High-Need Participants

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

Do Not Mix High Risk and Low Risk Participants!!

I. Target Population

E. Criminal History Considerations

- Drug sales are **not categorically excluded**
- Violent crimes are **not categorically excluded**

Standard II: Equity and Inclusion

II. Equity and Inclusion

A. Staff Diversity

- Team reasonably reflects the pool of potential participants
- Outreach and recruitment efforts
- Counselors/peer specialists with similar characteristics

II. Equity and Inclusion

B. Staff Training

- All team members are trained to :
  - define key performance indicators of cultural equity in their program
  - record requisite data
  - identify cultural disparities in program operations and outcomes
  - implement corrective measures

II. Equity and Inclusion

C. Equity Monitoring

- Teams "continually monitor" the following for evidence of disparities:
  - referral rates
  - admission rates
  - completion rates
  - service provision
- Teams meet annually to review data and take corrective measures

II. Equity and Inclusion

D. Cultural Outreach

- Team makes proactive efforts to recruit individuals from underserved cultural groups
- Independent evaluators conduct surveys with potential participants
- Team reviews findings and makes adjustments to recruitment practices

II. Equity and Inclusion

H. Fines, Fees, and Costs

- Disparate impact
- Imposed only for persons who can meet the obligations
- Imposed at amounts that are unlikely to impose undue stress/impede treatment progress

Do your homework

Understand the Data

STARTING A PROGRAM?

- Determine need by looking at arrest, conviction, and probation data
- What interventions are currently used?
- Are they successful or unsuccessful at making an impact?

HAVE AN EXISTING PROGRAM?

- Are we collecting, analyzing, and reporting data?
- Have we conducted outreach?
- Who are our supporters/detractors?

Know Your Community

Who has been affected by impaired driving?

Have impaired driving incidents been in the news lately?

What is the general response to impaired driving?

Who are the stakeholders that need to be at the table?

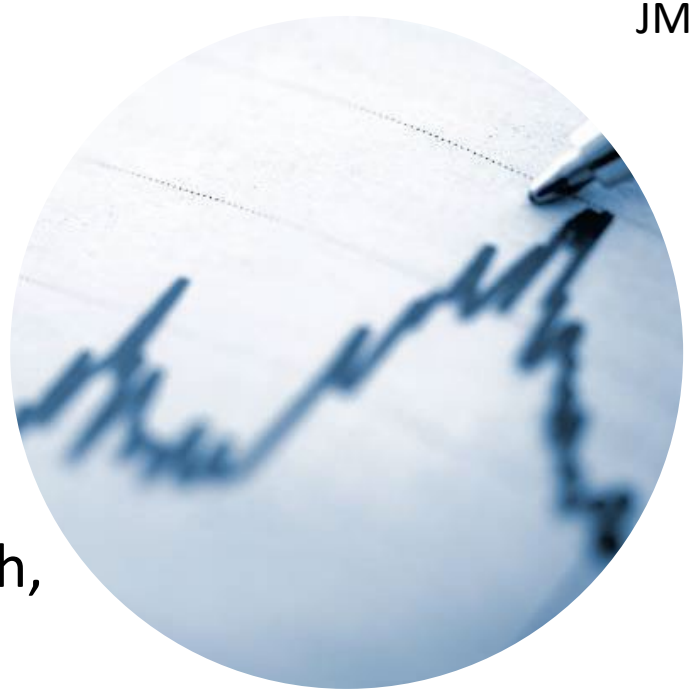
What is our best outreach approach?

Increasing Program Enrollment

Common Barriers to Enrollment

- Eligibility criteria are not well defined or are too narrow
- Key partners who refer to the treatment court are not bought into the treatment court
- Key partners who refer to the treatment court do not have a clear idea of treatment court eligibility
- Key partners who refer to the treatment court do not have a system in place for identifying potential participants
- Potential participants do not have a positive impression of the treatment court

Risk and Need Eligibility



Standard I

Target Population is High-Risk and High-Need Participants

High Risk = likely to be rearrested or fail on standard probation

High Need = serious and persistent substance use, mental health, or trauma disorder and other significant treatment or social service needs, such as traumatic brain injury, insecure housing, or compulsive gambling

- Validated Assessments: For criminogenic risk and clinical needs
- Individuals should not be disqualified from participation because of co-occurring mental health or medical conditions or because they have been legally prescribed psychotropic or addiction medication.
- Eligibility and exclusion criteria should be objective, and specified in writing

Getting Buy-In

- You'll need buy-in on your eligibility criteria from your partners, particularly if you have people who are not supportive of treatment courts
- Reach out to all your potential referral sources (prosecutor, probation, defense bar, other judges, etc.) to sell them on your program
- Provide fact sheets on the purpose of treatment court and any data you have on treatment court success
- If you don't have any data from your own program, use data from other state or national sources (https://allrise.org/about/treatment-courts/)
- Make sure potential referral sources have your written eligibility criteria and work with them to develop a process for how they will screen individuals for referral in their organization

Getting Buy-In Examples

Prosecutor

- Show prosecutor the treatment court success data
- Work with prosecutor to develop the legal eligibility
- Provide **written** legal screening criteria for quick review and referral

In a CA court - When individuals at first appearance were put on the first available treatment court calendar (within 7 days) warrants decreased by 50% and enrollment and retention increased.*

*Ensure that defense attorney available to talk before treatment court appearance and prosecutor agree on limited immunity (anything they discuss cannot be used against them or charged as a new crime)

Getting Buy-In Examples

Prosecutor

Portland's rocket docket – DA's Office had a deputy DA assigned to review cases as they came in for potential treatment court eligibility before arraignment

Defense attorney attended arraignments and explained the program – given immunity

Participants entered treatment court within 3 days

Buffalo's opioid court – Jail screened everyone right after booking, anyone with risk of overdose sent to court same day

Cut death rate in half

Getting Buy-In

Probation

- Coordinator sent an email to probation – you know that guy on your caseload that's driving you crazy and is like having an ongoing root canal? Those are the people we specialize in. Send them on over!

Defense Attorneys

- Reach out to the defense bar – provide fact sheets
- If your treatment court has the ability to expunge charges upon successful completion, that can be a huge selling point. What about decreasing or waiving jail time, or the length of time on probation?
    - How many defense attorneys win cases with clients who have possession charges or have committed crimes due to their drug use? Getting clients to graduation and case expungement is a win!

Who else needs to buy-in?

Potential Participants!

- Your referral sources (including current and former participants) not only need to buy in, they need to have a message that makes your treatment court sound like a great option
- Enter Social Marketing

View the program from a participant perspective

"All we hear about at the beginning are 'rules, rules, rules,' but no mention of benefits." - participant

The message:

"So, there's this drug court program. It's really hard. You have to go to treatment several days a week. And you should feel privileged to get that treatment.

You have to stop using. They will drug test you several days a week, and you have to go see a probation officer and case manager regularly too.

You also have to go to court twice a month and talk to the judge. If you miss an appointment or screw up, they'll put you in jail.

If you work really hard at it, you might graduate and then you might get time off your jail sentence or time off probation. If you fail, you'll have to serve your sentence. So, what do you think? Ready to try it?"

Strategy: Use social marketing principles and techniques to understand the perspective of potential participants and to enhance their access and retention in your program.

- **Product** enhancements
- A **price** which reflects benefits > costs *(What's in it for them?)*
- **Promotional** messages
- A **place** or environment which supports the behavioral changes

How do we Enhance our products?

Learn More About Your Participants:

Conduct exit interviews

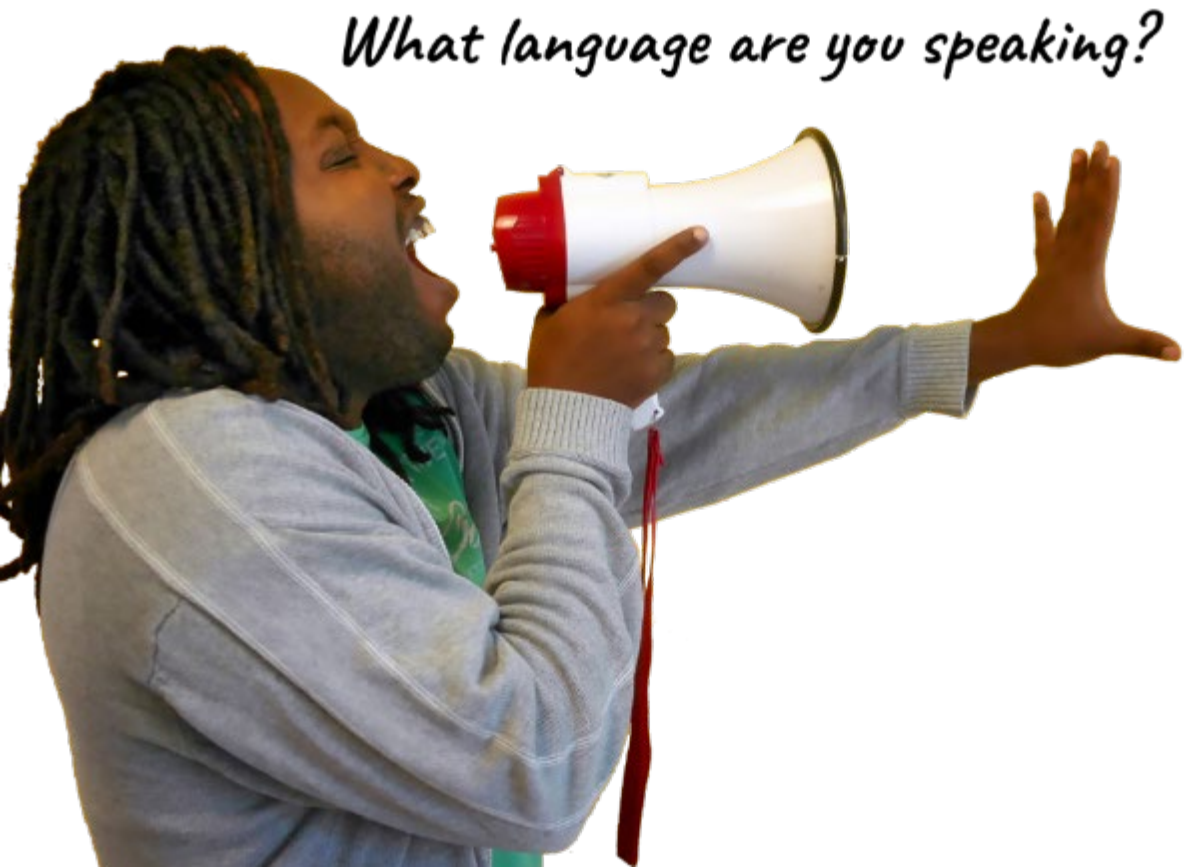
- TCI exit interview form - https://allrise.org/sample-documents/sample-document-exit-interview/

Conduct focus groups with current participants

Form a community advisory group

- Toolkit - https://allrise.org/publications/equity-and-inclusion-toolkit/

Promotion – The Message



Think of your promotional message not as what you put into it, but as what the consumer takes out of it.
(Reeves, 1961)

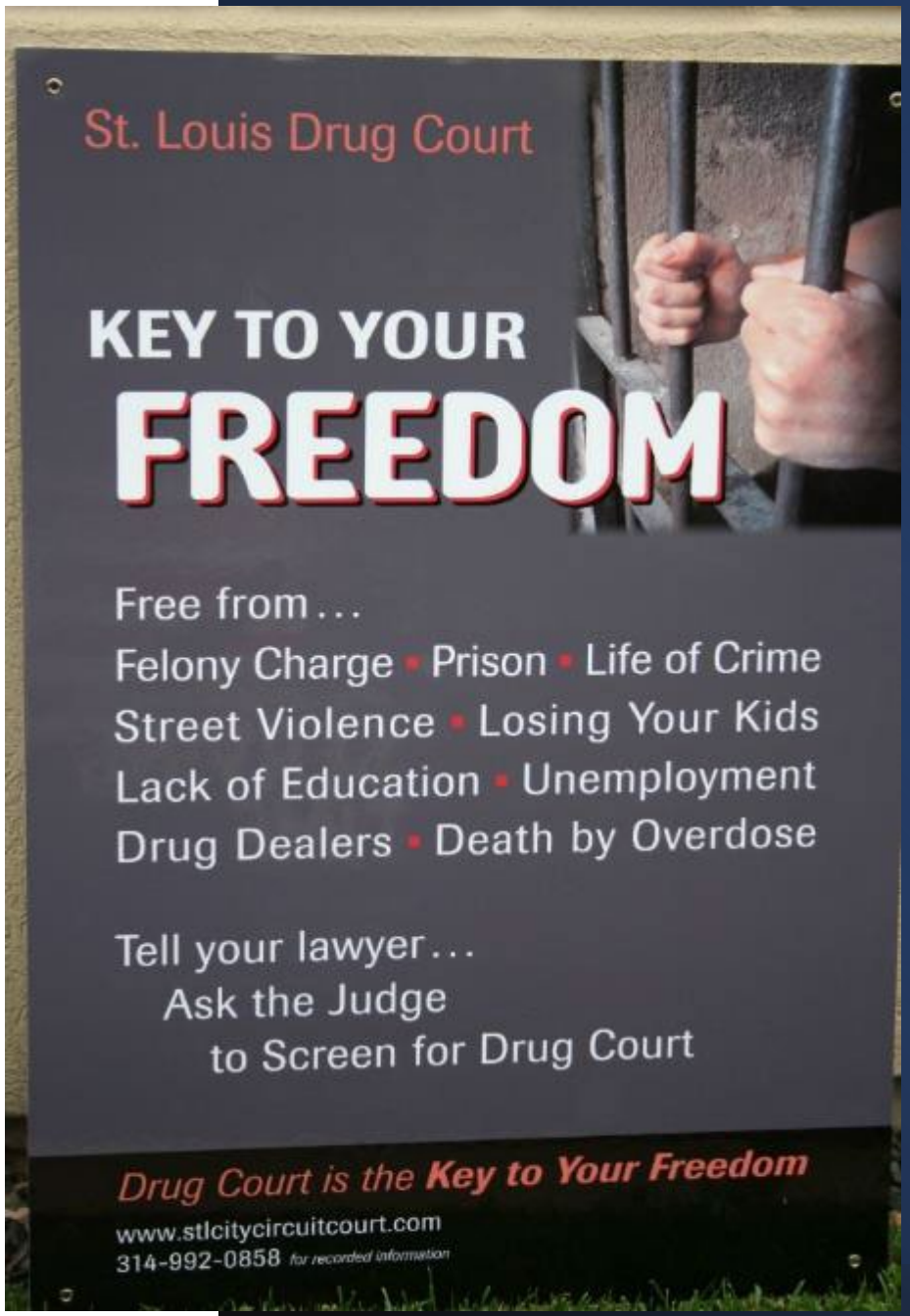
We tell them about the benefits of the program, but they don't seem to hear us. (staff communication)

Making Enhancements to Promotional Materials

Examples:

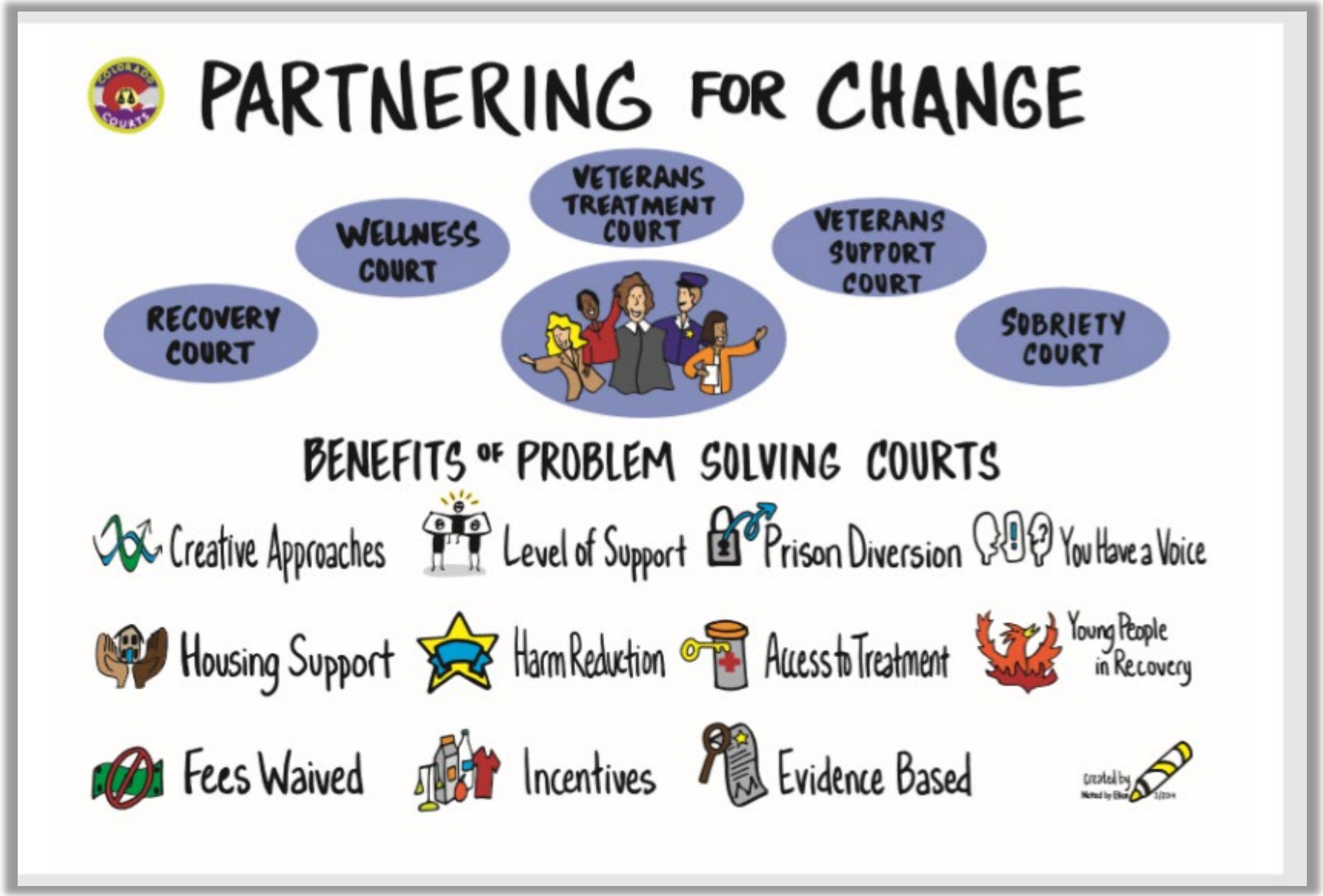
Use the ‘inmate grapevine’

- Educate jail staff about benefits of program
- Create benefits brochure to distribute at jail
- Display posters
- Have program staff meet with incarcerated individuals



Using Social Marketing to Enhance your Program Message

Colorado 18th Judicial District



All Rise E&I Brochure

JM

COURT PERSONALIZATION NOTE:

NADCP can provide images from our archive, or you can use your own images. Images should display diversity reflecting the community you serve.

What's next?

If you are interested in learning more or would like to give treatment court a shot, talk to your lawyer and let them know. You can also reach out to our program coordinator at [CONTACT INFO HERE].

COURT PERSONALIZATION NOTE:

Use this area on the back cover to add your court logo and primary contact email, phone number or website.

FOLD

Is Treatment Court Right for You?

The decision to enter treatment court is not an easy one, and we understand that you have a lot to consider right now. We encourage you to get as much information as possible. We are available to answer any questions you may have.

COURT PERSONALIZATION NOTE:

Use this area on the front cover to add your court logo and primary contact email, phone number or website.

All Rise E&I Brochure

JM

What is Treatment Court?

Treatment court is for people who are in the justice system because of a substance use or mental health disorder. We want to keep you out of jail because we believe you have value and belong in your community. **Our goal is to provide you with the treatment, structure, and support you need to change your life.**

Treatment court is very different from traditional court because a skilled team works together to provide you with the support you need.

In treatment court, our goal is to:

- Keep you out of jail.
- Clear your record of the case that brought you here.
- Help you find work
- Help find you a place to live if you need it
- Help get you back to school if that is what you want
- Help you have a better relationship with your family

What do we ask of you?

You may have heard that treatment court is a challenge. For some, this may be true. But all we ask of you is that you show up, try, and be honest.

We understand the nature of addiction. You may stumble along the way. That is ok. If you are honest and you show up for your appointments, we will do everything we can to get you back on track.

FOLD

How it works?

Our program is divided into X phases. As you progress in treatment, you will move up in phase towards your graduation.

Phase 1: Description

Phase 2: Description

Phase 3: Description

Phase 4: Description

Phase 5: Description

COURT PERSONALIZATION NOTE:

Add descriptions of phases. Keep these short and positive, focusing on the benefits of each phase and the benchmark for advancing.

"I had heard of drug court but wasn't really sure what is was. When I started I was really nervous but the team helped me understand that they were there to support me. And they were! Any time I needed something I knew I could ask. I graduated last year and know have a job and my own house. This program works!"

– JACK T.

COURT PERSONALIZATION NOTE:

Include 3-4 short testimonials from graduates. They should emphasize being skeptical at first but ultimately finding the program helpful. Ensure diversity in testimonials.

"Drug court isn't easy. But that's ok. They help you with everything and understand if you mess up. They just want to see you try your hardest. And treatment was only part of what they did. Before I graduated drug court they helped me get my GED. Now they are helping me apply to college!"

– JUANITA L.

Increasing Retention

Common barriers to retention

- Lack of engagement
- Lack of appropriate RNR
  - Services don’t match individual participant needs
  - Services aren’t responsive to participant differences
- Lack of incentives and appropriate use of behavior modification tools

Retention starts with Engagement

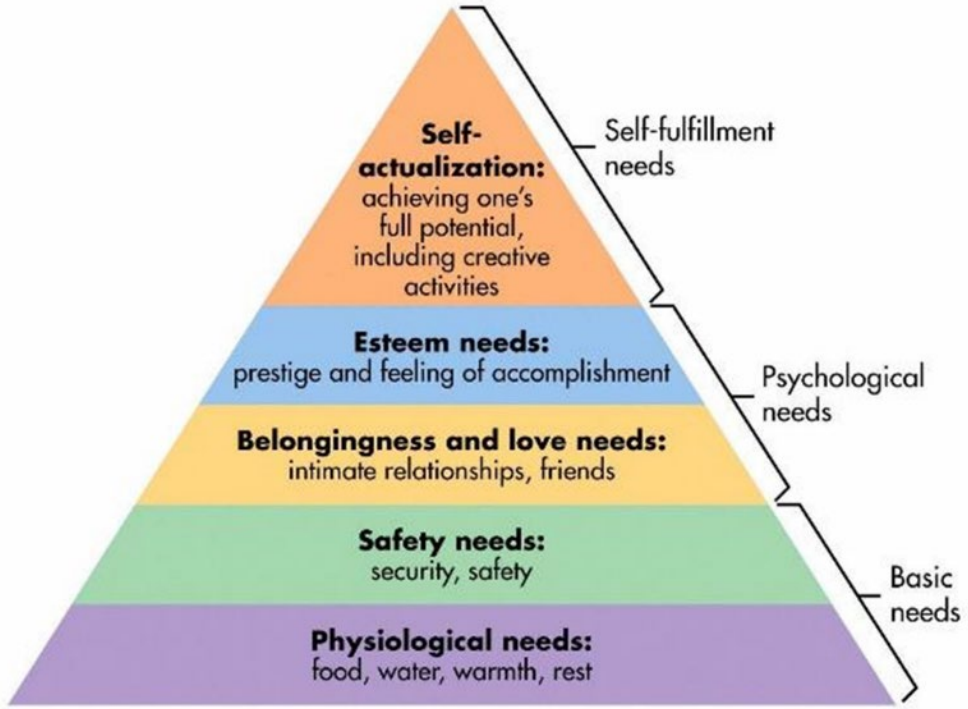
Engagement starts with human connection

HUMAN CONNECTION LEADS TO ENGAGEMENT AND BEHAVIOR CHANGE

- Research recognizes the importance of belonging and human connection as a basic human need and as something necessary for success

Definition of Connection: "The energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgement; and when they derive sustenance and strength from a relationship." – Brene Brown, The Gifts of Imperfection

Maslow's Hierarchy of Needs



HUMAN CONNECTION & BEHAVIOR CHANGE

We are neurologically wired for connection

In brain imaging studies **Perceived Social Isolation** was associated with changes in connectivity between and within different portions of the brain associated with:

- Diminished **executive function**
- Decreased ability to **sustain attention** which impacts **working memory, executive control,** and **maintaining task sets**
- Hypervigilance to **social threat** and diminished **impulse control**

Layden et al., 2016

Use Risk-Need-Responsivity Principles

MODEL AS A GUIDE TO BEST PRACTICES

Risk

WHO

Match the intensity of the individual's intervention to their risk of reoffending

Deliver more intense intervention to higher-**risk** offenders

Need

WHAT

Target criminogenic needs: antisocial behaviors and attitudes, SUD, and criminogenic peers

Target criminogenic **needs** to reduce risk of recidivism

Responsivity

HOW

Tailor the intervention to the learning style, motivation, culture, demographics, and abilities of the offender

Address the issues that affect **responsivity**

Manage the Message

What is an impaired driving treatment court?

ATTRISE

Impaired Driving Solutions

Thank You

How We can Identify, Supervise and Stop the High-Risk Impaired Driver

Mark Stodola

Probation Fellow

American Probation and Parole Association

OBJECTIVES

- Identify the factors that have influenced the increase in impaired driving fatalities
- Identify research-based strategies that are effective in the supervision of impaired drivers
- Identify drug/alcohol testing strategies to maximize client accountability
- Identify the characteristics and profiles of impaired drivers and the criminogenic risk factors that increase their likelihood of recidivating

STATE OF DUI IN AMERICA

Where we are Today ……..

Impaired Driving by The Numbers

- In 2019, there were 1,024,508 drivers arrested for DUI.
- An alcohol-impaired driving fatality occurs every **48 minutes**.
- In 2022, there were **13,524** alcohol-related traffic fatalities.
  - **This is a 14% increase over 2020**
- In 2018, the most frequently recorded BAC among drinking drivers in fatal crashes was **.16**
- **127 million** drunk driving episodes occurred in 2021.

Table 1. Fatalities in Alcohol-Impaired-Driving Traffic Crashes, by Role, 2021

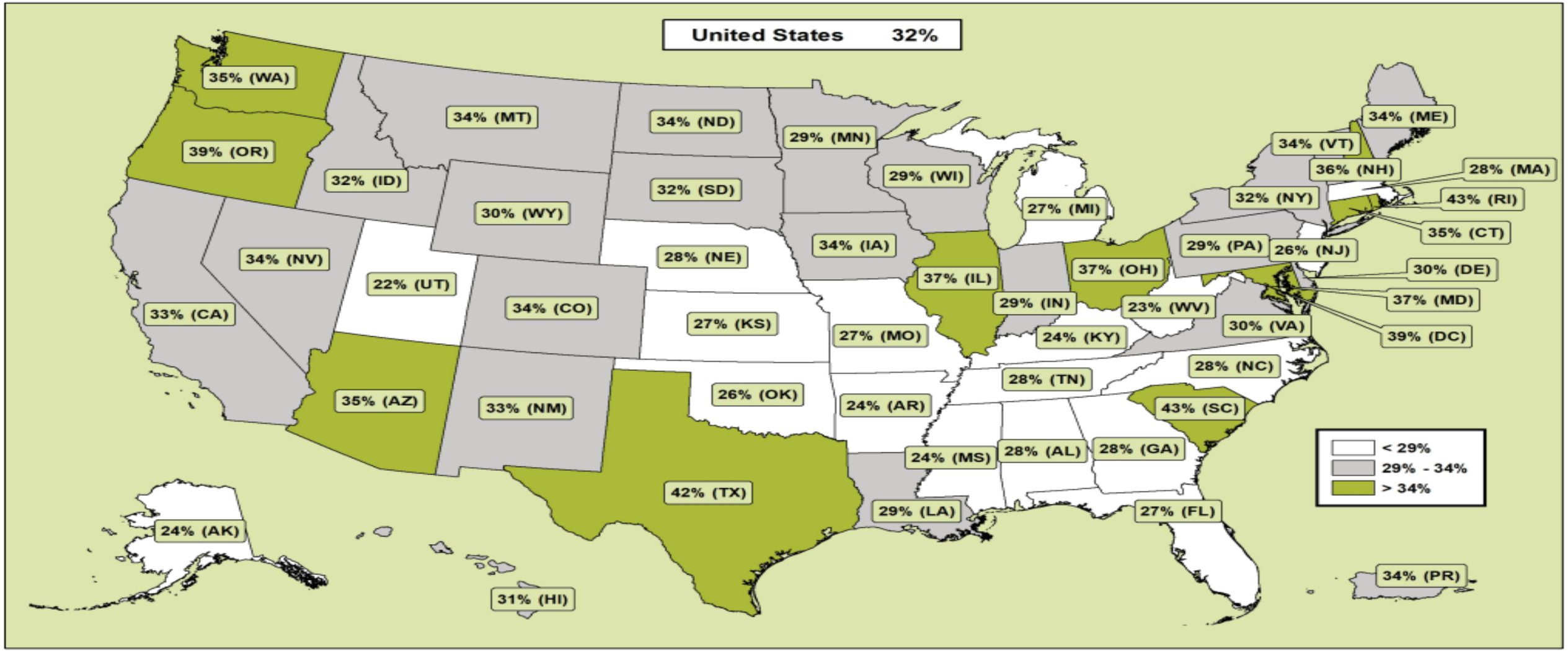
Role	Number	Percent
Alcohol-Impaired Drivers	8,089	60%
Passengers Riding With Alcohol-Impaired Drivers	1,603	12%
Subtotal	**9,692**	**72%**
Occupants of Other Vehicles	2,085	16%
Nonoccupants (pedestrians/pedalcyclists/other)	1,607	12%
Total Alcohol-Impaired-Driving Fatalities	**13,384**	**100%**

Source: FARS 2021 ARF

Notes: Percentages may not add up to 100 percent due to individual rounding. NHTSA estimates BACs when alcohol test results are

Alcohol-Impaired-Driving Fatalities as a Percentage of Total Fatalities 2022

Figure 8. Percentages of Alcohol-Impaired-Driving Traffic Fatalities, by State, 2022



Source: FARS 2022 ARF
Notes: Puerto Rico is not included in the U.S. percentage. NHTSA estimates BACs when alcohol test results are unknown.

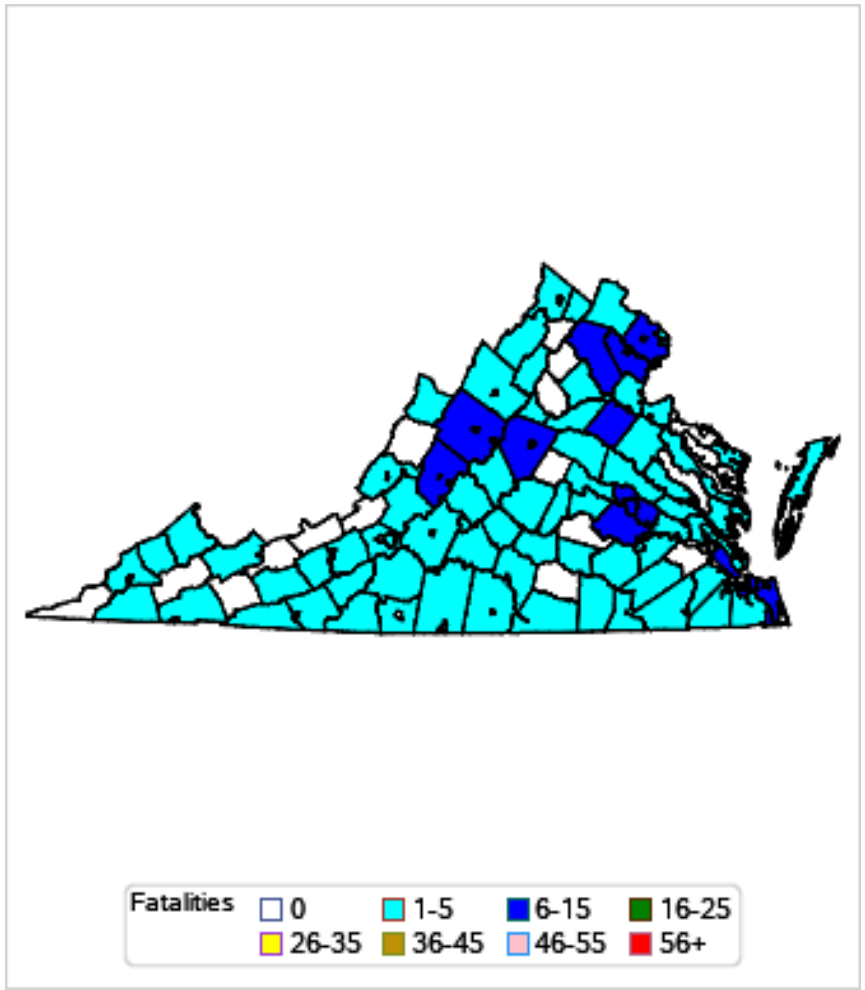
Virginia DWI Arrests

	2018	2019	2020	2021	2022
Impaired Driving Arrests (BAC=.08+)*	21,481	21,114	17,042	16,907	17,328

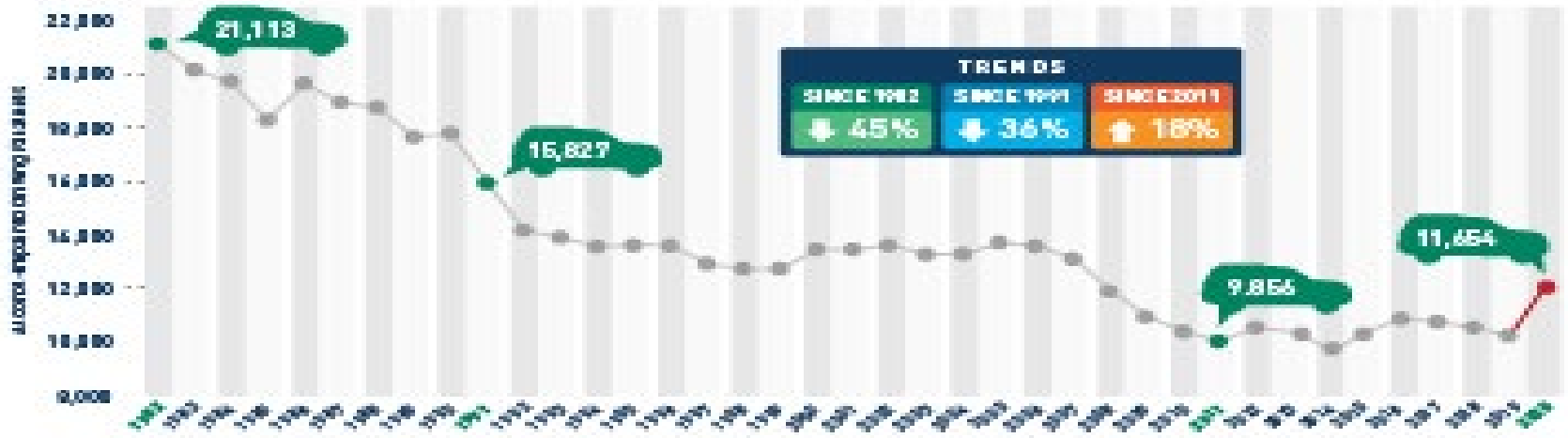
Virginia DWI Fatalities

	2018	2019	2020	2021	2022
Alcohol-Impaired Driving Fatalities (BAC=.08+)*	245	237	282	285	298
	30%	29%	33%	29%	30%

Fatalities in Crashes Involving an Alcohol-Impaired Driver (BAC = .08+) by County for 2022



Drunk Driving Deaths Increased 14% in 2020



Together, we can end impaired driving, and it will take everyone and effective and proven solutions.

Why have we made progress?

- **Passage of laws to target multiple facets of the problem**
- **Sustained and high visibility enforcement efforts**
- **Identifying the countermeasures that work; evaluation and strengthening of programs**
- **Targeting high-risk offenders**
- **Assessment and treatment**
- **Public education and awareness**
- **Changing societal norms**

Good News!!!

Two Thirds of DWI Offenders self correct!

Unique challenges when supervising the third that don’t…

With impaired drivers, don’t assume!

The drunk driver before you could actually be a polysubstance user.

IMPAIRED DRIVERS:
NOT THE USUAL SUSPECTS

Impaired Driver Profiles

- Predominantly male (70-80%)
- Between the ages of 20-45; majority between ages 20-30
- Employed/educated at a higher rate than other offenders
- High-BAC levels (.15>)
- Often drink more per occasion and consume more alcohol than the general population; majority are binge drinkers
- Often have SUDs
- Have personality and psychosocial factors that increase risk of offending: irritability, aggression, thrill-seeking, impulsiveness, external locus of control (blaming others), anti-authoritarian attitudes

High-Risk Impaired Drivers…
Who ARE These People?

Repeat Impaired Drivers

- Overwhelmingly male (90%); ages 20-45
- More often single, separated, or divorced
- Tend to have lower levels of education/income and higher levels of unemployment compared to first offenders
- More likely to have BACs exceeding .20 or refuse to provide a chemical sample
- Age of onset of drinking, family history, and alcohol misuse are risk factors

Repeat Impaired Drivers

- Likely to have cognitive impairments (executive cognitive functioning) due to long-term alcohol dependence
- More likely to have a higher disregard for authority and show greater indications of anti-social personality characteristics
- May result in lack of motivation which can affect willingness to engage in treatment

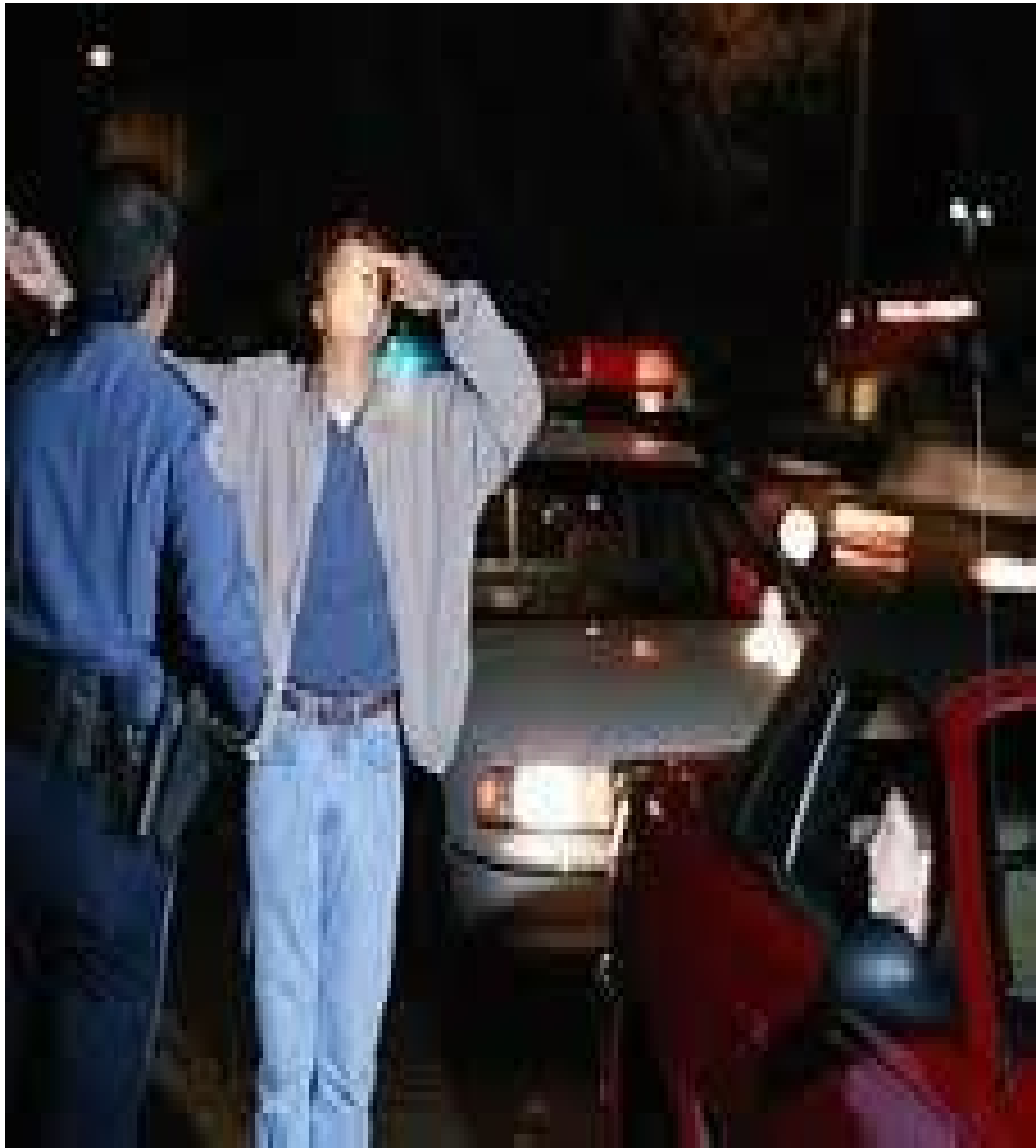
Sentencing To Reduce Recidivism:
What Doesn't Work

- Fines & jail alone
- Traditional probation
- Community service
- License suspension
- Victim impact panels

When the other guy says he can do the job for a lot cheaper

Traditional impaired driving enforcement

- **DUI is the *ONLY* crime where the investigation stops after obtaining a minimum amount of evidence.**
- Current protocols prevent drug testing once a suspect registers an illegal BAC.
- Implications:
  - » Hinders the ability to measure the true magnitude of the drug-impaired driving problem.
  - » Many DUI arrests are inaccurately attributed to alcohol alone.



With impaired drivers, don’t assume!

The drunk driver before you could actually be a polysubstance user.

SCREENING & ASSESSMENT

Who is most likely to recidivate?

Do you assess for risk and needs with impaired drivers?

Do your assessment tools tell you what you need to know?

Limitations of instruments

- Majority of instruments are not designed for or validated among DUI offender population.
- Using traditional assessments, DUI offenders are **commonly identified as low risk due to a lack of criminogenic factors.**
- DUI offenders often have unique needs and are resistant to change on account of limited insight.
- Recognition that specialized instruments should be created to accurately assess risk and needs of impaired drivers.

Impaired Driving Assessment (IDA)

Major Risk Areas of DUI Recidivism

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

ASSESSMENT IS ONGOING & DYNAMIC

Testing-Supervision That Includes Technology

Testing considerations

- Test for both alcohol and drugs
- Broad testing panel
- Mix up your protocol
- Are there ways to capture synthetic drugs?
- Pay attention to technological advances
- Resources

Evidence-based Treatment

- How do you know if the treatment approach is an EBP model?
- Treatment approach, dosage, and frequency decisions should be made by a trained professional and driven by clinical assessment.
- Treatment should be manual-based:
  - Specific to a particular intervention.
  - Indicates how the intervention should be structured and delivered.
  - Includes background and theoretical information.
- Beware of counterfeits - not every intervention that is manualized is an example of evidence-based practice
- IOP VS. residential treatment

So What Could Possibly Go Wrong?

Don’t live in a silo!!

Individualize justice

- Understand that there is more to the offending than just driving drunk.
- Avoid judgments and focus on the individual; there is no one-size-fits-all model for supervision and treatment.
- Respect for the individual coupled with accountability.
- Utilize a comprehensive approach that addresses individual risk factors and treatment needs.

Focus on the behavior – it's more than just drug use!


QUESTIONS?

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Recovery Capital

Matthew Ouren, All Rise project director

Recovery

SAMHSA – "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Recovery Research Institute – "The process of improved physical, psychological, social well-being and health after having suffered from substance-related conditions."

Group Activity

BEFORE

What are some participants' characteristics when they enter the VTC program?

VS

AFTER

*What are the characteristics for these same participants when they leave the VTC program? **

* Or, perhaps more importantly, what do you think they may want to see within themselves?

Distinction

TREATMENT

- In-patient services
- Detox
- Group Session
- Individual Counseling
- Medication

RECOVERY

- Choice
- Personal
- Value
- Thrive
- Medication

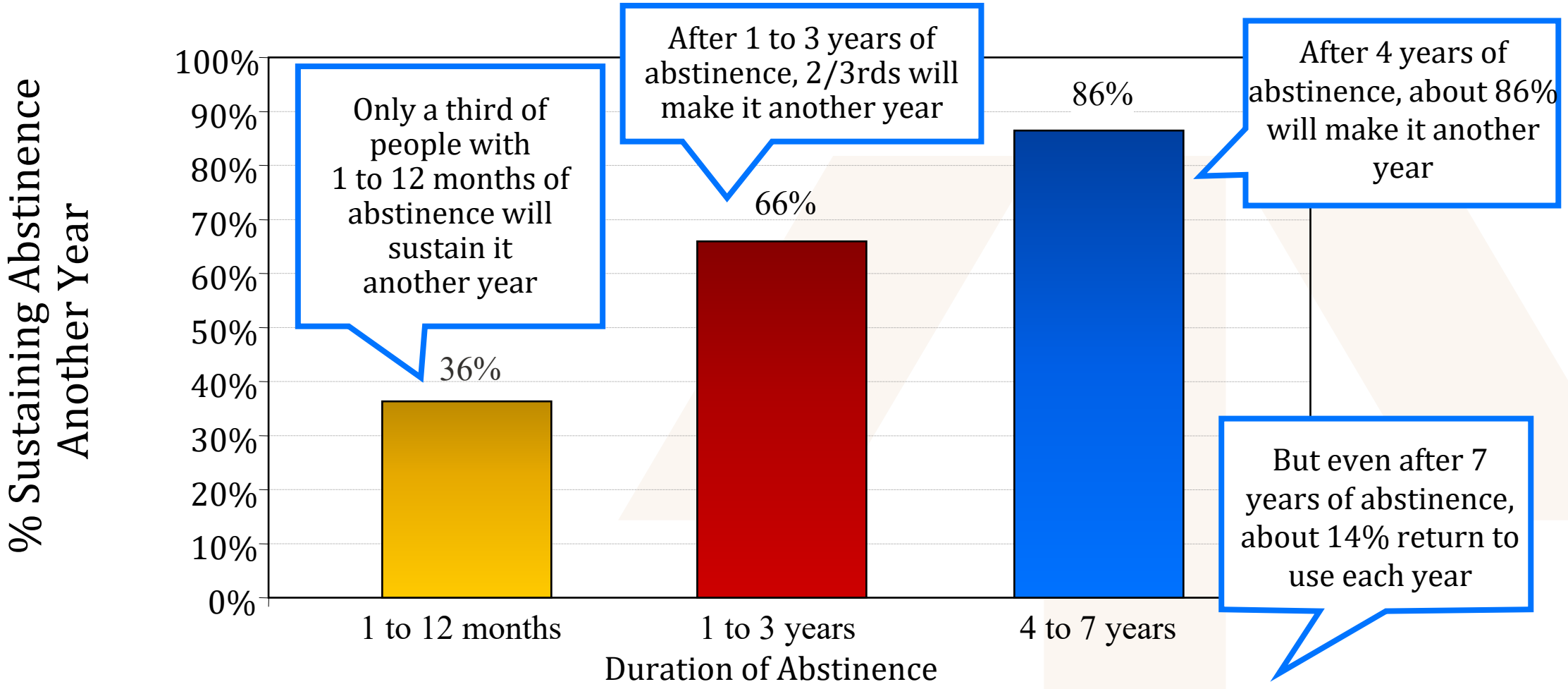
Common Themes?

There are common themes across these definitions. The process of recovery is not just about abstinence.

Recovery **INCLUDES**

- Empowerment
- Well-being
- Quality of life
- Connectedness

Likelihood of Sustaining Abstinence Grows Over Time



Source: Dennis, Foss & Scott (2007)

Recovery Capital

Recovery Capital is the tangible and intangible assets participants gather during the recovery process and draw on to sustain their long-term recovery.

(Granfield & Cloud, 1999; White & Cloud, 2008)

Current Research Findings

- An emerging field of study.
- Those who complete treatment have higher levels of recovery capital.
- Those in rural areas specifically benefit from focused efforts on building social and personal capital.
- Peer recovery support services delivered by community recovery organizations (n-23459) resulted in statistically significant changes in recovery capital.
- The number of contacts and completed goals were predictive of increases in post scores.
- **A 2016 study found that treatment court clients had "restricted recovery capital portfolios" (n=34).**

The Throughline Between Recovery Capital and Complementary Services (Standard VI)

Physical (financial)	Personal	Social or family	Community	Cultural
• Health-Risk Prevention • Housing Assistance • Medical and Dental Care	• Intrinsic assets and abilities • Vocational, Educational, and Life Skills Counseling	• Network of relationships that support recovery • Defined Family Counseling • Significant Other Counseling	• Neighborhood resources and support • Social Integration • Shared Resources • Peer Accountability	• Cultural Values and Norms • Religious and Spiritual Influences • Cultural Competence in treatment

Physical (financial) Capital

- Personal safety
- Stable housing
- Healthy nutrition
- Access to healthcare
- Mental health
- Finances
- Reliable transportation

Physical Capital

- I have a safe place to live.
- I have reliable transportation to take me where I need to go.
- I have access to healthy, nutritious food.
- I have access to financial assistance.
- I have access to treatment to address my mental health.

Personal + Human Capital

Life Skills

Household Management

- ✓ Effective Problem Solving
- ✓ Self-Efficacy

Vocational Education

Educate Prospective Employers

- ✓ Accommodations

Other Services

Motivational Counseling

- ✓ Manualized Treatment i.e., CBT

Personal + Human Capital

- I have a clearer sense of my values and live them more fully today.
- I am learning and growing in areas of interest.
- I routinely engage in physical activity that I can do to strengthen my body, increase flexibility, and build endurance.
- I have financial resources to provide for myself (and my family).

Social Capital

- Family
- Friends
- Supportive social relationships that are centered around recovery
- Relational connections

Social Capital

- I have an intimate partner who is supportive of my recovery.
- I have sober friends that I enjoy spending time with.
- I have meaningful relationships with my family of origin (biological family.)
- I get the emotional support I need from other people.
- I actively reach out to friends to stay connected (e.g., phone, text, email).

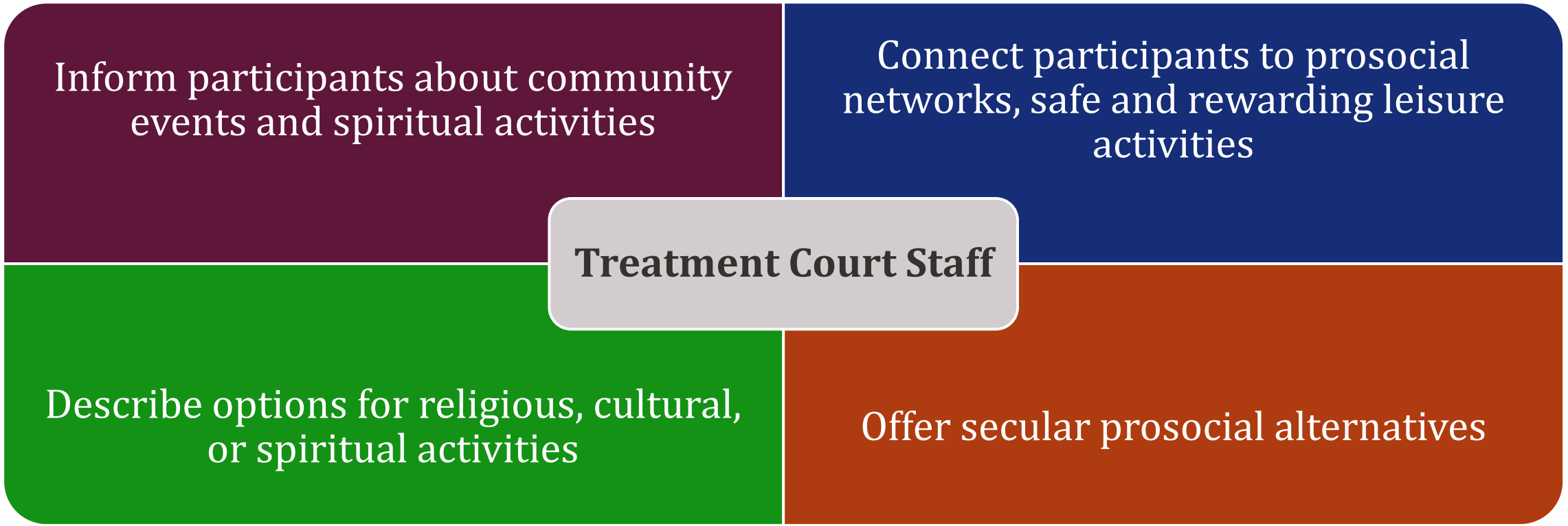
Community Capital

- Neighborhood resources
- Pro-social networks
- Secular Alternatives
- Rewarding leisure activities
- Self-esteem
- Supports life satisfaction

Community Capital

- I routinely collaborate with a peer who supports my recovery (someone also in recovery, coach, mentor, or sponsor).
- I regularly attend recovery group meetings (in-person, online).
- I maintain healthy boundaries in my recovery community (e.g., emotional, material, physical, sexual, spiritual).
- I participate in a work-related training program or educational program.
- I get help from substance use recovery professionals (e.g., counselors, therapists, recovery coaches, and professional peer support).

Cultural Recovery Capital



So, what does the team need?

Step By Step

Assessment of Individual Recovery Capital

Mapping of Community Resources

Case Planning and Staffing

Phase Realignment

STEP 1 – ASSESSMENT OF RECOVERY CAPITAL

Assessment of Recovery Capital

(Groshkova et al., 2013)

Instructions for participants. Please tick if you agree with any of the following statements.

1. Having a sense of purpose in life is important to my recovery journey
2. I am able to concentrate when I need to
3. I am actively involved in leisure and sport activities
4. I am coping with the stresses in my life
5. I am currently completely sober
6. I am free from worries about money
7. I am actively engaged in efforts to improve myself (training, education and/or self-awareness
8. I am happy dealing with a range of professional people
9. I am happy with my personal life
10. I am making good progress on my recovery journey
11. I am proud of my home
12. I am proud of the community I live in and feel a part of it
13. I am satisfied with my involvement with my family
14. I cope well with everyday tasks
15. I do not let other people down
16. I am free of threat or harm when I am at home
17. I am happy with my appearance
18. I engage in activities and events that support my recovery
19. I eat regularly and have a balanced diet
20. I engage in activities that I find enjoyable and fulfilling
21. I feel physically well enough to work
22. I feel safe and protected where I live
23. I feel that I am in control of my substance use
24. I feel that I am free to shape my own destiny
25. I get lots of support from friends
26. I get the emotional help and support I need from my family
27. I have a special person that I can share my joys and sorrows with
28. I have access to opportunities for career development (job opportunities, volunteering or apprenticeships)
29. I have enough energy to complete the tasks I set myself
30. I have had no 'near things' about relapsing

BARC-10

ID/Name			Date:			
	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1. There are more important things to me in life than using substances	1	2	3	4	5	6
2. In general I am happy with my life	1	2	3	4	5	6
3. I have enough energy to complete the tasks I set for myself	1	2	3	4	5	6
4. I am proud of the community I live in and feel a part of it	1	2	3	4	5	6
5. I get lots of support from friends	1	2	3	4	5	6
6. I regard my if as challenging and fulfilling without the need for using drugs or alcohol	1	2	3	4	5	6
7. My living space has helped to drive my recovery journey	1	2	3	4	5	6
8. I take full responsibility for my actions	1	2	3	4	5	6
9. I am happy dealing with a range of professional people	1	2	3	4	5	6
10. I am making good progress on my recovery journey	1	2	3	4	5	6
add columns		+		+		+		+		+	
TOTAL						

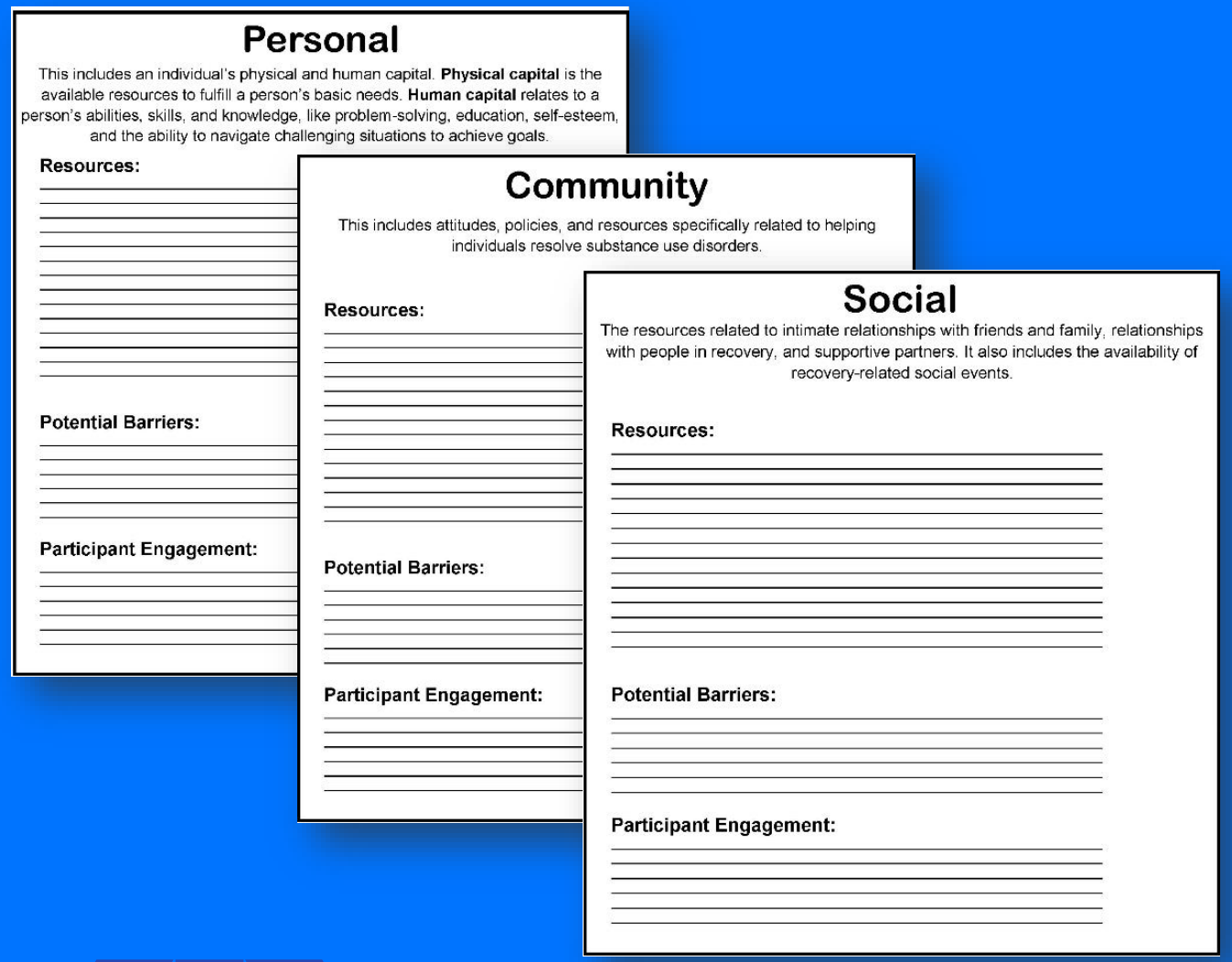
*Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card

Recovery Capital Scale

Place a number by each statement that best summarizes your situation.

5. Strongly Agree
4. Agree
3. Sometimes
2. Disagree
1. Strongly Disagree

___ I have the financial resources to provide for myself and my family.
___ I have personal transportation or access to public transportation.
___ I live in a home and neighborhood that is safe and secure.
___ I live in an environment free from alcohol and other drugs.
___ I have an intimate partner supportive of my recovery process.
___ I have family members who are supportive of my recovery process.
___ I have friends who are supportive of my recovery process.
___ I have people close to me (intimate partner, family members, or friends) who are also in recovery.
___ I have a stable job that I enjoy and that provides for my basic necessities.
___ I have an education or work environment that is conducive to my long-term recovery.
___ I continue to participate in a continuing care program of an addiction treatment program, (e.g., groups, alumni association meetings, etc.)
___ I have a professional assistance program that is monitoring and supporting my recovery process.
___ I have a primary care physician who attends to my health problems.
___ I am now in reasonably good health.
___ I have an active plan to manage any lingering or potential health problems.
___ I am on prescribed medication that minimizes my cravings for alcohol and other drugs.
___ I have insurance that will allow me to receive help for major health problems.



RECOVERY CAPITAL STAFFING QUESTIONS

Which recovery capitol domain is the participant working on this week?

What is the participant's need they are addressing?

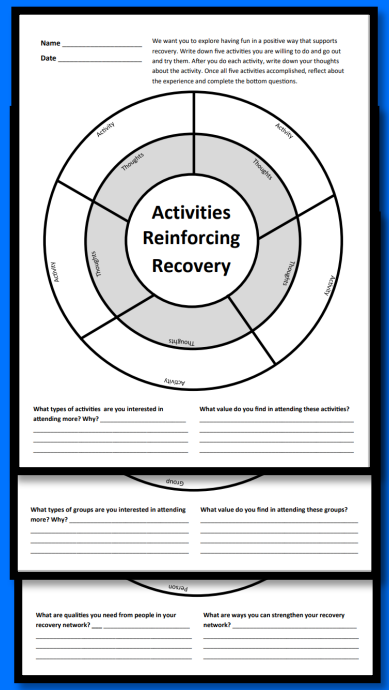
Are there any barriers they are experiencing?

How can the team help?

CHECKLIST

- **What** is the need?
- **Which** resource best meets the need?
- **What** barriers exist to access resource?
- **How** will you get the participant to engage in the resource?

Resources


Name _____
Date _____

We want you to explore having fun in a positive way that supports recovery. Write down five activities you are willing to do and go out and try them. After you do each activity, write down your thoughts about the activity. Once all five activities accomplished, reflect about the experience and complete the bottom questions.

Activities Reinforcing Recovery

Activity / Thoughts / Activity / Thoughts / Activity / Thoughts / Activity / Thoughts / Activity / Thoughts

What types of activities are you interested in attending more? Why? _____

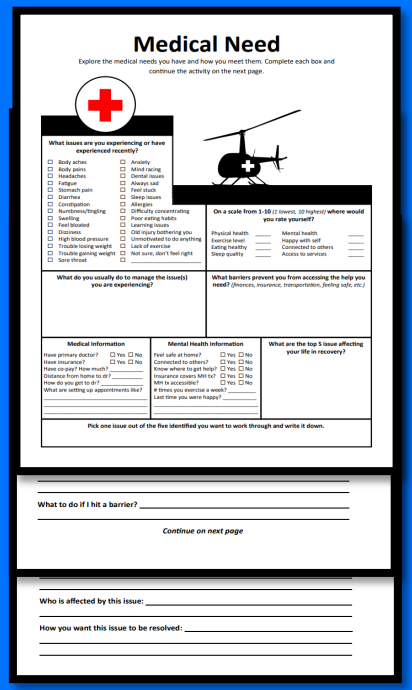
What value do you find in attending these activities?

What types of groups are you interested in attending more? Why? _____

What value do you find in attending these groups?

What are qualities you need from people in your recovery network? _____

What are ways you can strengthen your recovery network? _____


Medical Need

Explore the medical needs you have and how you meet them. Complete each box and continue the activity on the next page.

What issues are you experiencing or have experienced recently?

Body aches, Body pains, Headaches, Fatigue, Stomach pain, Diarrhea, Constipation, Numbness/tingling, Swelling, Feel bloated, Dizziness, High blood pressure, Trouble losing weight, Trouble gaining weight, Sore throat, Anxiety, Mind racing, Dental issues, Always sad, Feel stuck, Sleep issues, Allergies, Difficulty concentrating, Poor eating habits, Learning issues, Old injury bothering you, Unmotivated to do anything, Lack of exercise, Not sure, don't feel right

On a scale from 1-10 (1 lowest, 10 highest) where would you rate yourself?

Physical health, Exercise level, Eating healthy, Sleep quality, Mental health, Happy with self, Connected to others, Access to services

What do you usually do to manage the issue(s) you are experiencing?

What barriers prevent you from accessing the help you need? (finances, insurance, transportation, feeling safe, etc.)

Medical Information: Have primary doctor? Have insurance? Have co-pay? How much? Distance from home to dr? How do you get to dr? What are setting up appointments like?

Mental Health Information: Feel safe at home? Connected to others? Know where to get help? Insurance covers MH tx? MH tx accessible? # times you exercise a week? Last time you were happy?

What are the top 5 issue affecting your life in recovery?

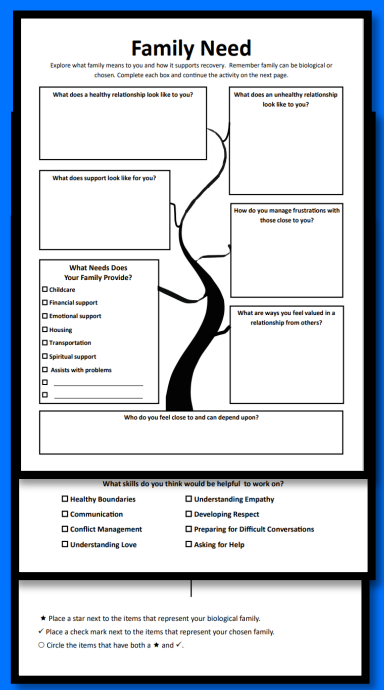
Pick one issue out of the five identified you want to work through and write it.

What to do if I hit a barrier? _____

Continue on next page

Who is affected by this issue: _____

How you want this issue to be resolved: _____


Family Need

Explore what family means to you and how it supports recovery. Remember family can be biological or chosen. Complete each box and continue the activity on the next page.

What does a healthy relationship look like to you?

What does an unhealthy relationship look like to you?

What does support look like for you?

How do you manage frustrations with those close to you?

What Needs Does Your Family Provide?

Childcare, Financial support, Emotional support, Housing, Transportation, Spiritual support, Assists with problems

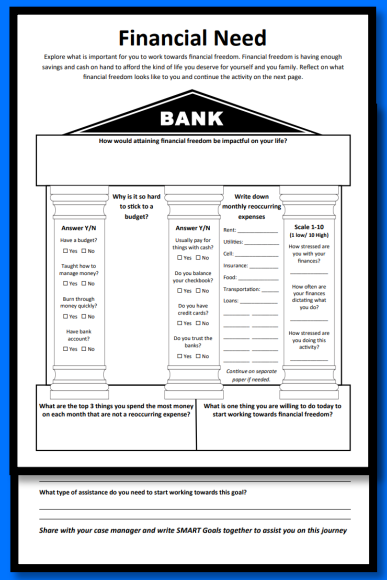
What are ways you feel valued in a relationship from others?

Who do you feel close to and can depend upon?

What skills do you think would be helpful to work on?

Healthy Boundaries, Communication, Conflict Management, Understanding Love, Understanding Empathy, Developing Respect, Preparing for Difficult Conversations, Asking for Help

★ Place a star next to the items that represent your biological family.
✓ Place a check mark next to the items that represent your chosen family.
○ Circle the items that have both a ★ and ✓.


Financial Need

Explore what is important for you to work towards financial freedom. Financial freedom is having enough savings and cash on hand to afford the kind of life you deserve for yourself and you family. Reflect on what financial freedom looks like to you and continue the activity on the next page.

BANK

How would attaining financial freedom be impactful on your life?

Why is it so hard to stick to a budget?

Answer Y/N: Have a budget? Taught how to manage money? Burn through money quickly? Have bank account?

Answer Y/N: Usually pay for things with cash? Do you balance your checkbook? Do you have credit cards? Do you trust the bank?

Write down monthly reoccurring expenses: Rent, Utilities, Cell, Insurance, Food, Transportation, Loans

Scale 1-10 (1 low/ 10 High): How stressed are you with your finances? How often are your finances dictating what you do? How stressed are you doing this activity?

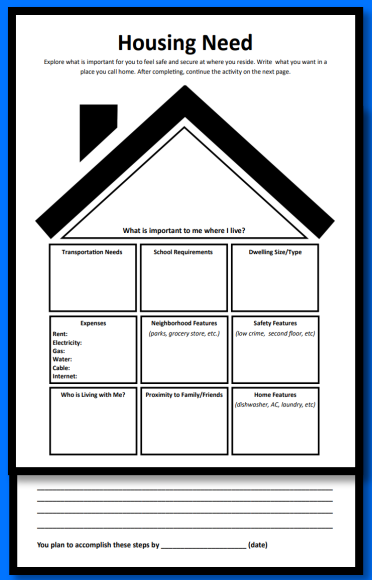
Continue on separate paper if needed.

What are the top 3 things you spend the most money on each month that are not a reoccurring expense?

What is one thing you are willing to do today to start working towards financial freedom?

What type of assistance do you need to start working towards this goal?

Share with your case manager and write SMART Goals together to assist you on this journey


Housing Need

Explore what is important for you to feel safe and secure at where you reside. Write what you want in a place you call home. After completing, continue the activity on the next page.

What is important to me where I live?

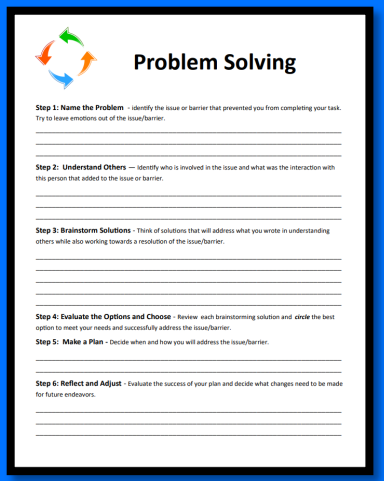
Transportation Needs, School Requirements, Dwelling Size/Type

Expenses: Rent: Electricity: Gas: Water: Cable: Internet:

Neighborhood Features (parks, grocery store, etc.), Safety Features (low crime, second floor, etc)

Who is Living with Me?, Proximity to Family/Friends, Home Features (dishwasher, AC, laundry, etc)

You plan to accomplish these steps by _____ (date)


Problem Solving

Step 1: Name the Problem - identify the issue or barrier that prevented you from completing your task. Try to leave emotions out of the issue/barrier.

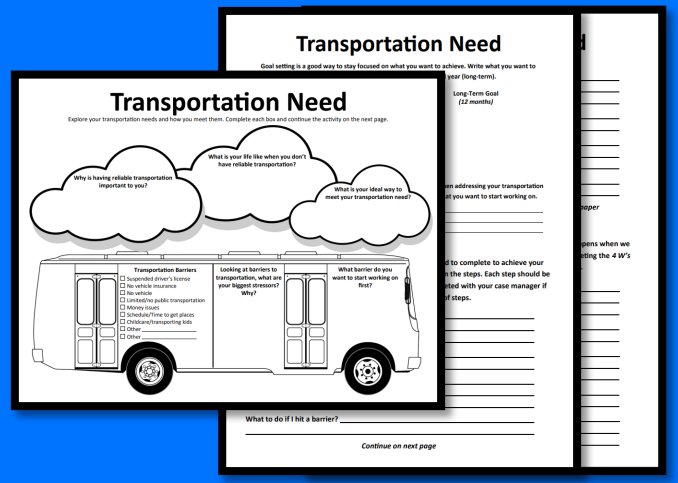
Step 2: Understand Others — Identify who is involved in the issue and what was the interaction with this person that added to the issue or barrier.

Step 3: Brainstorm Solutions - Think of solutions that will address what you wrote in understanding others while also working towards a resolution of the issue/barrier.

Step 4: Evaluate the Options and Choose - Review each brainstorming solution and *circle* the best option to meet your needs and successfully address the issue/barrier.

Step 5: Make a Plan - Decide when and how you will address the issue/barrier.

Step 6: Reflect and Adjust - Evaluate the success of your plan and decide what changes need to be made for future endeavors.


Transportation Need

Explore your transportation needs and how you meet them. Complete each box and continue the activity on the next page.

Why is having reliable transportation important to you?

What is your life like when you don't have reliable transportation?

What is your ideal way to meet your transportation need?

Transportation Barriers: Suspended driver's license, No vehicle insurance, No vehicle, Limited/no public transportation, Money issues, Schedule/Time to get places, Childcare/transporting kids, Other, Other

Looking at barriers to transportation, what are your biggest stressors? Why?

What barrier do you want to start working on first?

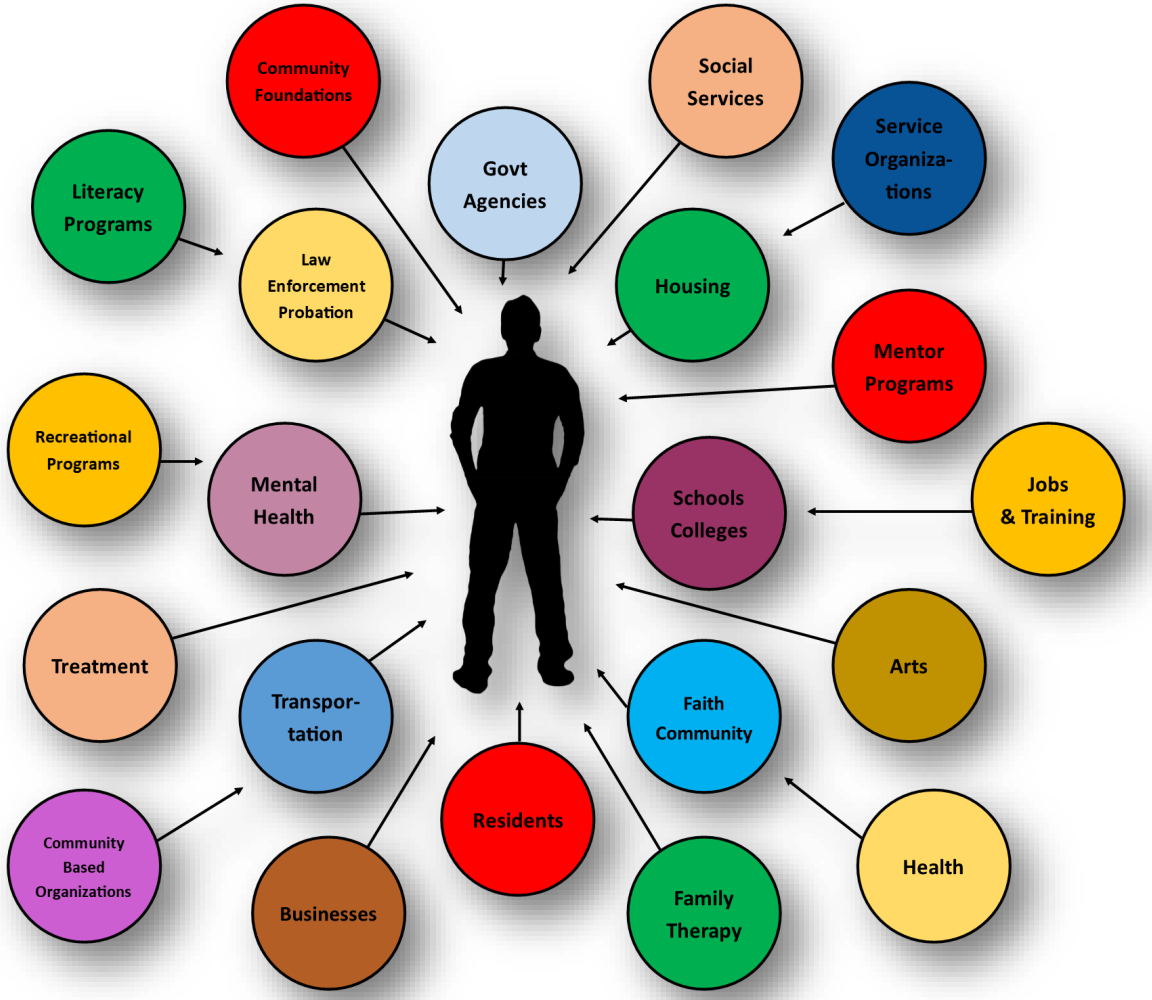
What to do if I hit a barrier? _____

Continue on next page

Long-Term Goal (12 months)

https://allrise.org/publications/recovery-capital-worksheets/

Step 2 – Community Mapping



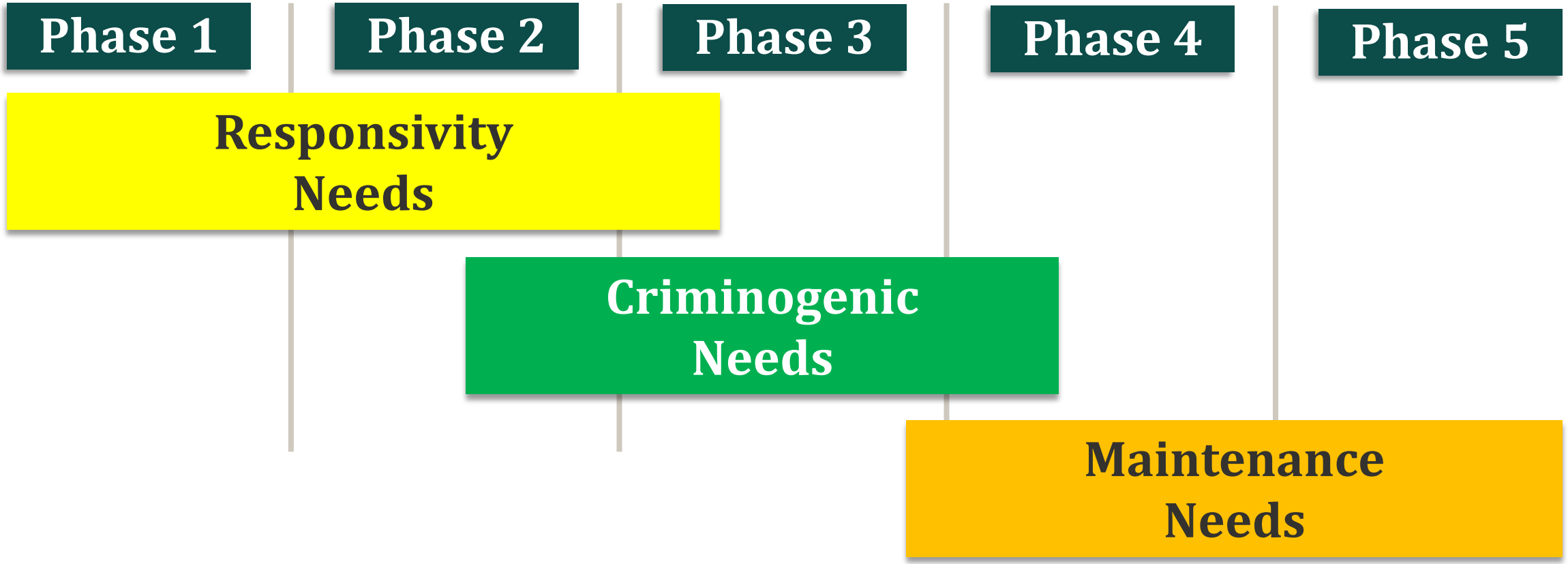
Step 3 - Case Planning and Staffing

- Risk/Need/Responsivity
- Coordinate with treatment plan
- Court responses should consider elements of recovery capital & long-term recovery management

Step 4 - Program Phase Focus

- Providing structure, support, and education for participants.
- Helping participants achieve and sustain psychosocial stability and resolve ongoing impediments to service provisions.
- Ensuring participants follow a safe and prosocial daily routine.
- Teaching participants preparatory skills (e.g. time management, personal finances.)
- Engaging participants in recovery-supported activities

Timing Matters



In summary

- To maximize client outcomes, we must think beyond the treatment court's “temporary” structure.
- The treatment court is well positioned to assist clients by creating meaningful pathways of connectedness that last long after the court team has finished their work and support.
- For those that can make it to 7 years, their likelihood of relapse is less than 14%.
- Shift from thinking about what the treatment court “managed” to what the court assisted the client in adding to their lives.

Matthew Ouren

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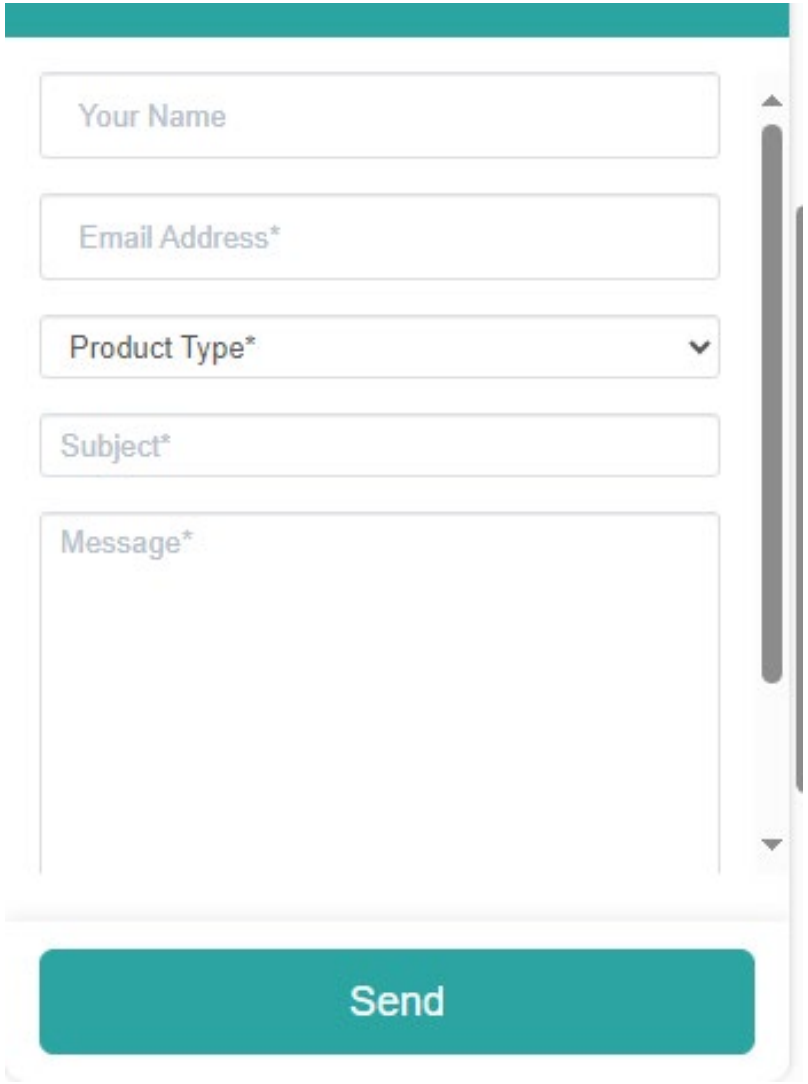
SPECIALTY DOCKETS DIMS DATABASE (SDDD)

WHY ARE WE CHANGING TO A NEW DATABASE ?

To cater the need of growing number of Specialty dockets in Virginia

To simplify user experience

Easier analytics



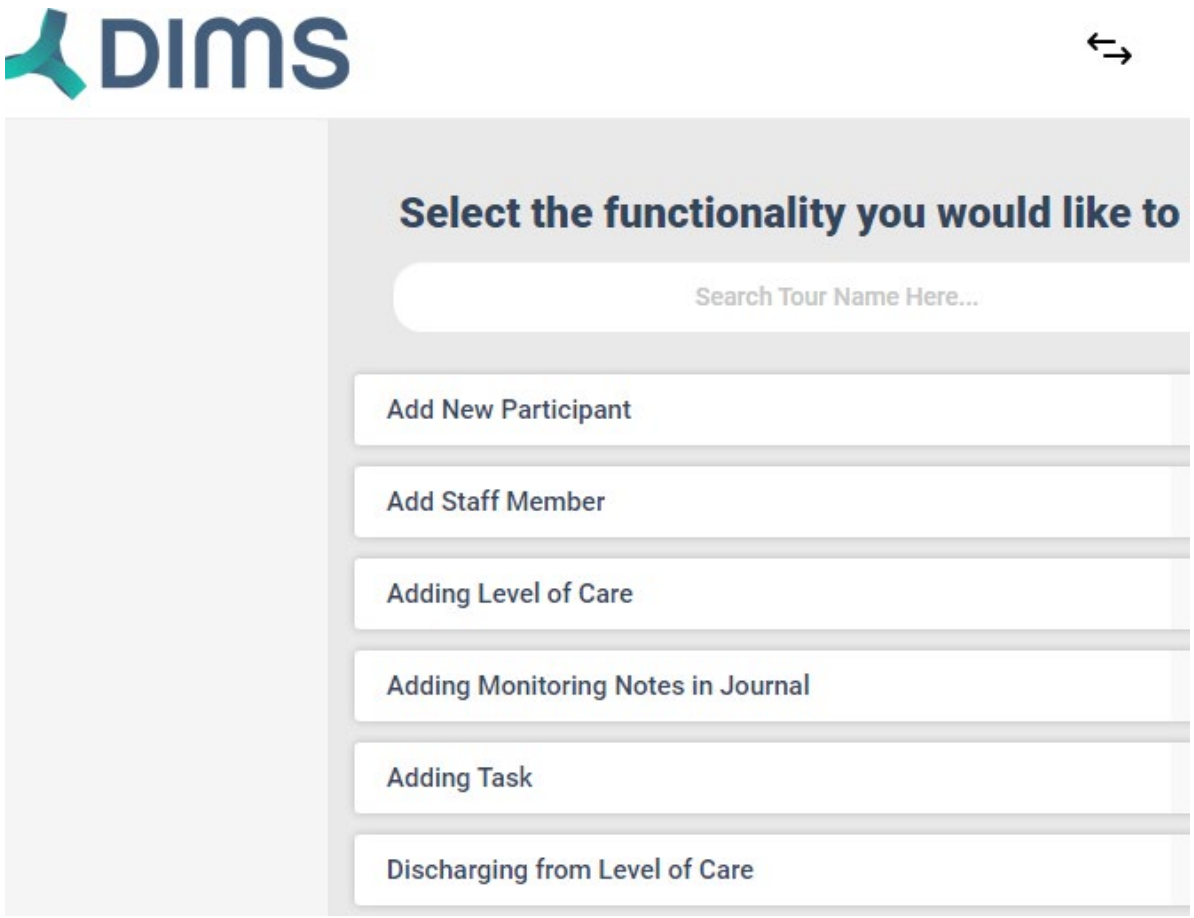
- **Does not require VPN**
- **Chat help on system**

- **DIMS tours**

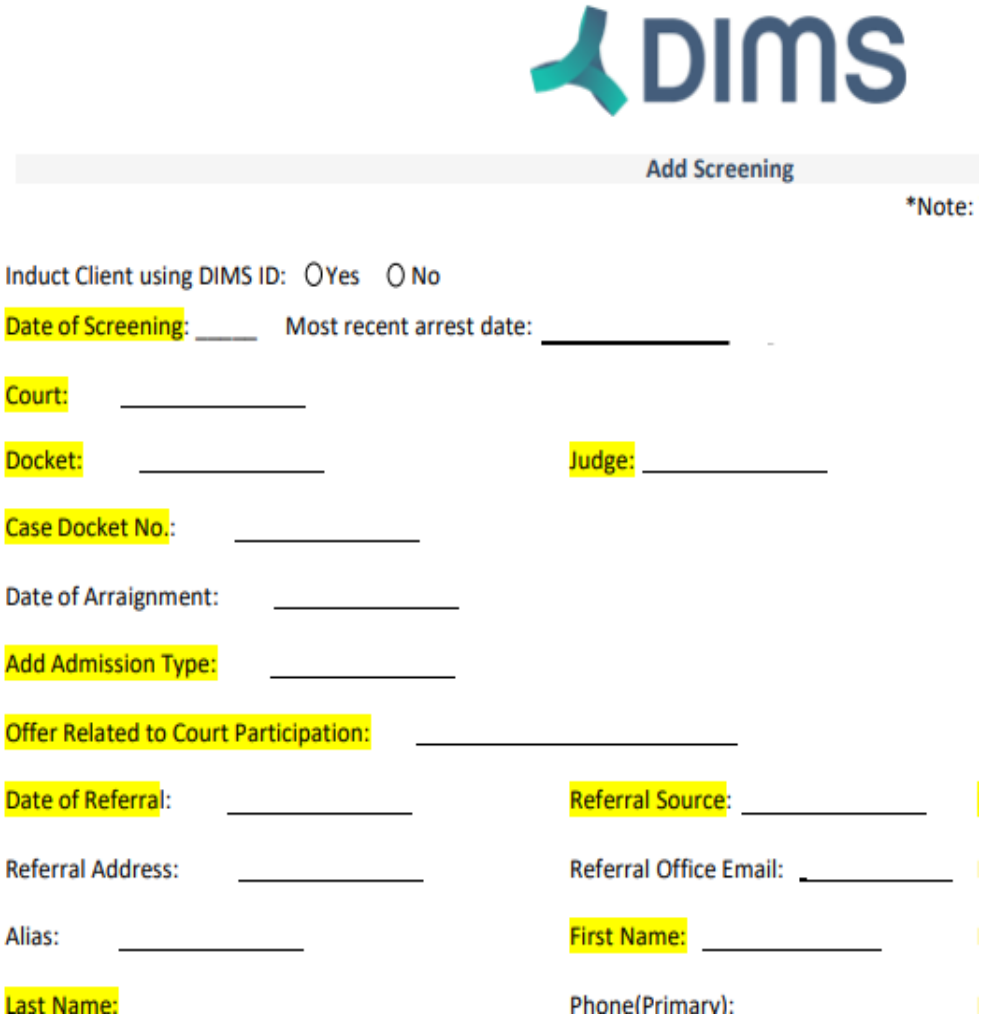
  Pprovide user guidance

- **DIMS Wikki**

  - **Provides user manual**



- **Printable Initial Screening Forms**
- **Staff calendar available**
- **Display of discharged and paused participants in a different tab on the home page**



- Non-compliance in treatment
- Tasks overdue
- Drug test no show
- Drug test positive
- Birthday of participants

Alerts are generated automatically and manually

Provide users a high-level view of their respective dockets.

Reporting period can be selected as per the user's choice.

Court performance analytics can be produced in a click.

Staffing report easily generated.

Reports are downloadable and can be shared using secured password.

Visual presentation of the participants data is available from screening to discharge.

Producing analytics /reports are easy

What remains the same

Coordinators serve as the local quality assurance

All users need to complete the SD user access form.

SDDD team are the database administrator.

Training

Initial training from DIMS

Individual training from Specialty Dockets

Pilot and group 1 and group 2 and 3 training were conducted in July and last week Feedback wazs collected.

Go-live by Mid-September

Timeline

Play video

For additional Questions or further assistance please contact Celin Job at cjob@vacourts.gov

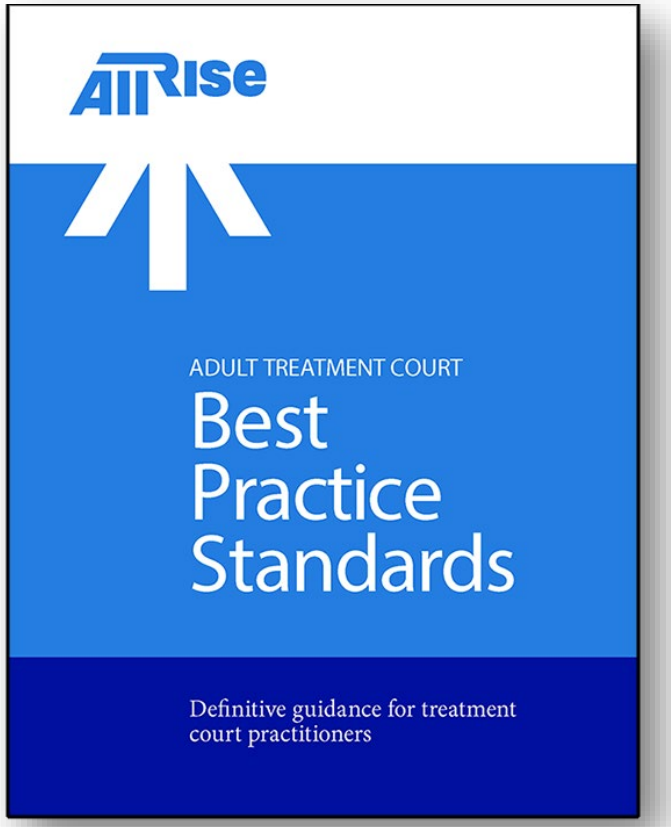
Incentives, Sanctions, Service Adjustments

Matthew Ouren, project director

The Background

- Based on scientific theories and research that date back to the beginning of the 20th Century.
- Our response (or lack of response) to participant behavior will make the behavior more or less likely to reoccur.
- Contemporary studies applying behavioral learning science to criminal justice populations, including treatment courts, have led to research-based principles.
- Behavior Science and Addiction Science

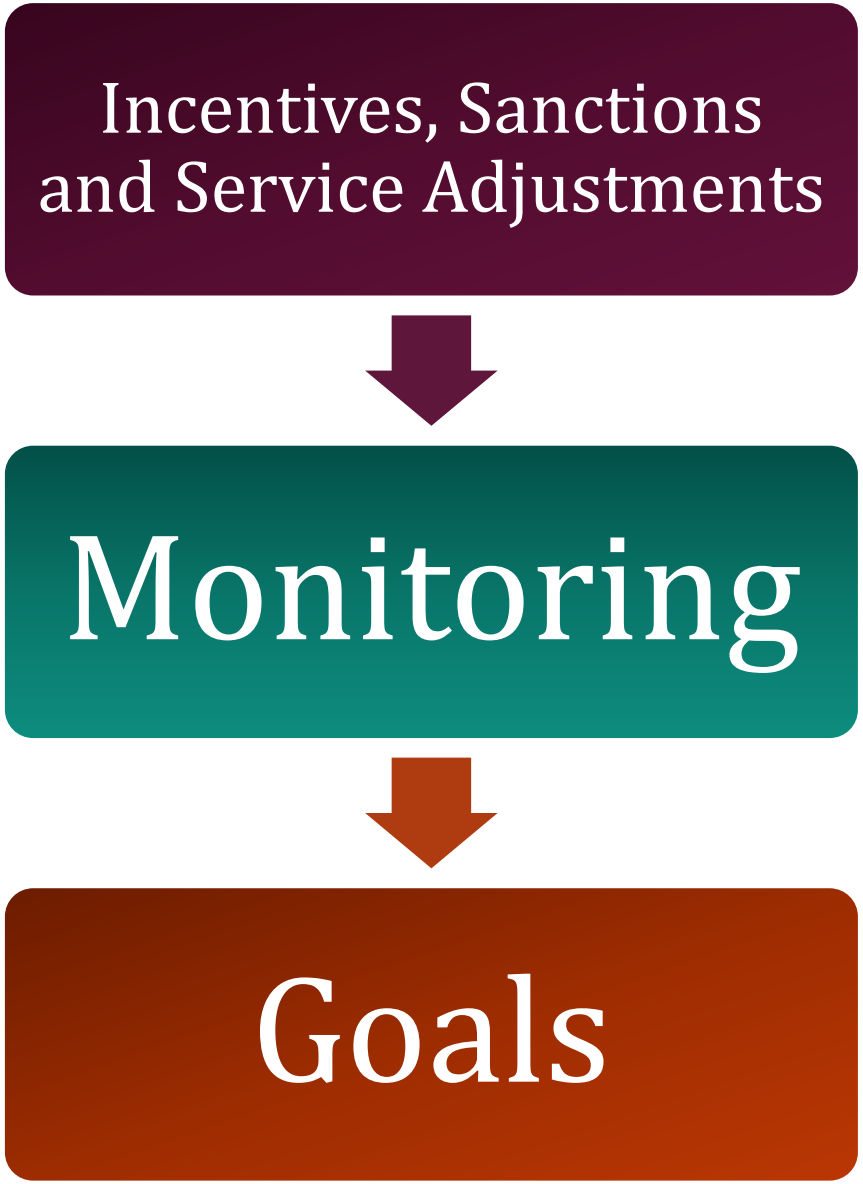
Adult Treatment Court Best Practice Standards



- Standard IV- Incentives, Sanctions, and Service Adjustments
- AllRise.org

The Basics First

Understanding goals and appropriate monitoring will set your team up to select the best responses to behavior.



Target Population

High-Risk

- Significant risk of committing a new crime – high recidivism.
- Difficulty in less intensive dispositions, such as probation.
- Have a moderate to severe substance use disorder.

High-Need

- Compulsive substance use
- Serious and persistent mental health or trauma issues
- Other significant treatment or social service needs.

See Standard I. Target Population

Proximal Goals

- Can be met in the short term and sustained for a reasonable period.
- Not necessarily easy, but it can be accomplished.
- The court uses incentives and sanctions to address compliance or non-compliance of proximal goals.

Truthfulness

Delivering a Valid Drug Test

Attendance

Admit

Proximal Goals (cont.)

Attendance is often a proximal goal –

- Participants can attend sessions, such as court, treatment, and supervision appointments.
- Participants can deliver valid drug or alcohol test specimens.
- NOT meeting these requirements is often willful or reflects inattention to one's responsibilities.

Truthfulness is a proximal goal –

- Dishonesty about missing a counseling session is a proximal infraction, **whereas** denying that they have a problem or need counseling is distal.

Distal Goals

- Not easily achievable without help.
- Intermittent achievement but not sustainable.
- Service adjustments are needed to accomplish these goals.

Adaptive Life Skills

Responding to Treatment

Attitude Change

Problem-Solving Skills

Distal Goals (cont.)

- Starting and succeeding at a job
- GED
- Remaining abstinent from drugs and alcohol
- Support groups

Managed Goals

Conditions that participants have met and sustained for a significant period.

Not required to perform goals perfectly, but well enough to satisfy program expectations.

Once a goal is considered managed, it is appropriate to reduce the magnitude of the incentive.

Managed Goals (cont.)

Example:

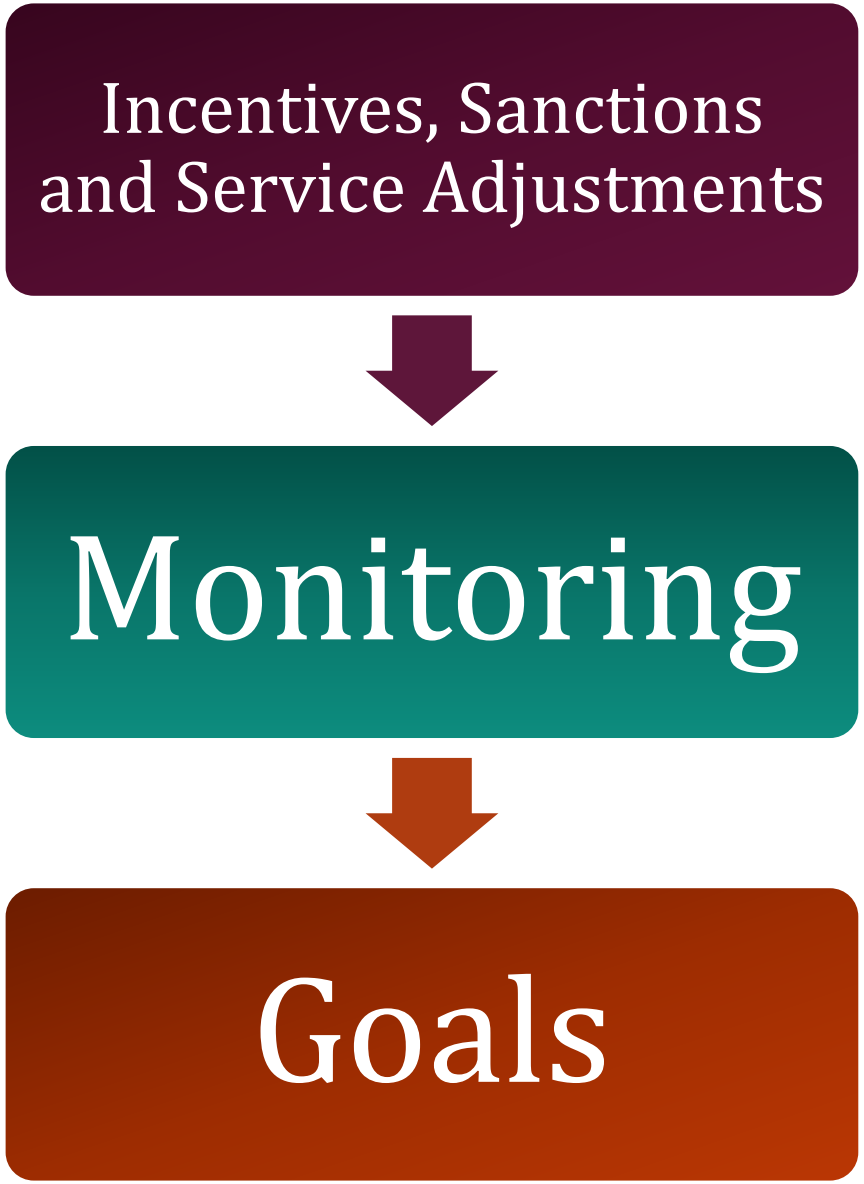
- Participants have attended scheduled group counseling sessions for several weeks, so group attendance can likely be considered managed, even if the person is not contributing actively to the group.

Activity: ID behaviors as either proximal or distal for a new, Phase I Participant

• Attendance	• Proximal
• Truthfulness	• Proximal
• Responding to treatment	• Distal
Abstinence from drug(s)	• Distal
• Get tested (UA)	• Proximal
• Motivation for change	• Distal
• Take care of family and or dependents	• Distal
• Get job	• Distal

Reliable and Timely Monitoring

Critical for effective behavior modification



Most Influential Factors

CERTAINTY

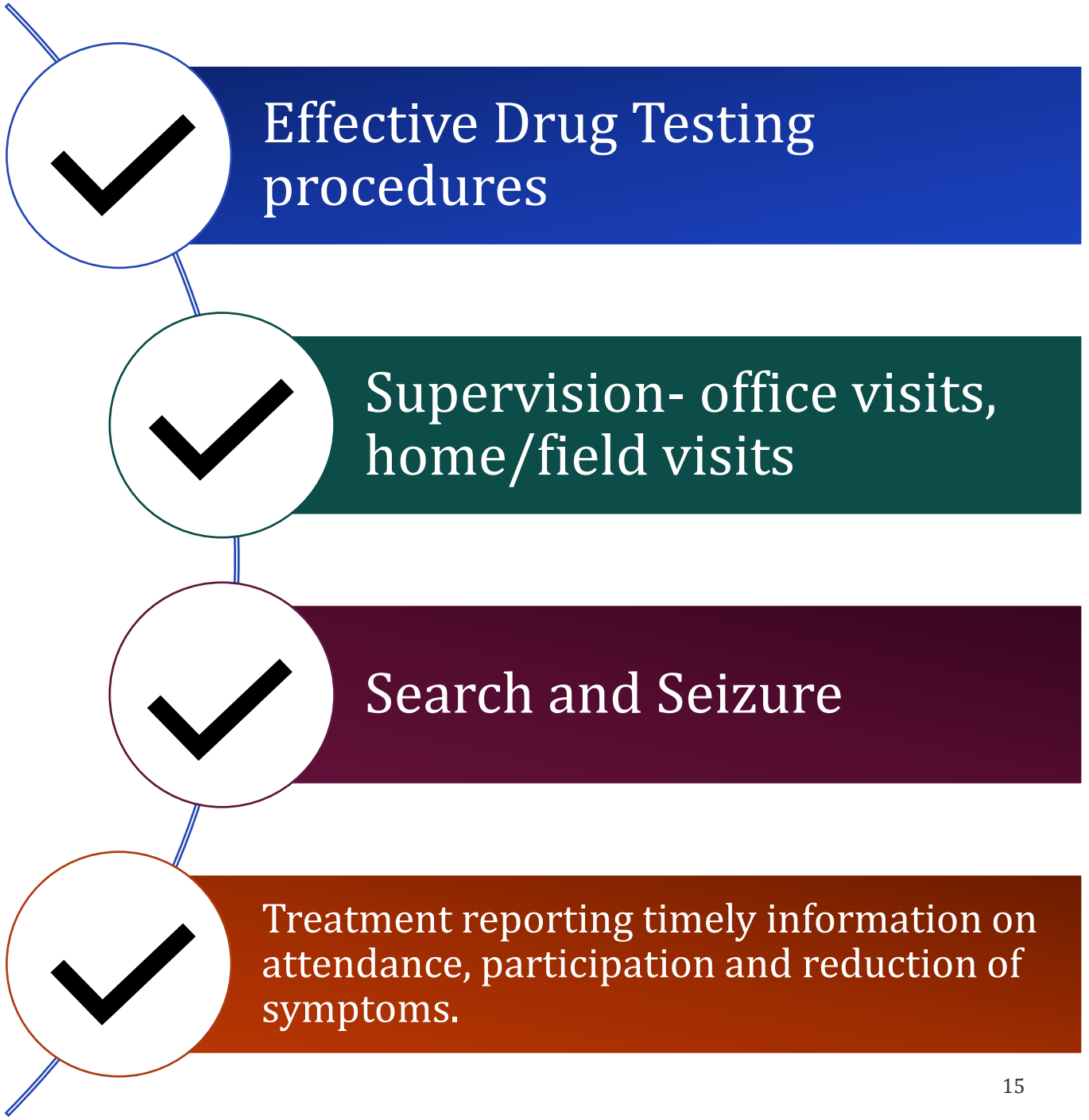
- Ratio of incentives to achievements or sanctions to infractions.
- The larger the ratio, the better the effects

CELERITY

- Time between an achievement or infraction and the delivery of the response.
- Associated with the behavior

Participant Monitoring

The whole team needs to participate in this. All information is required to determine a response.

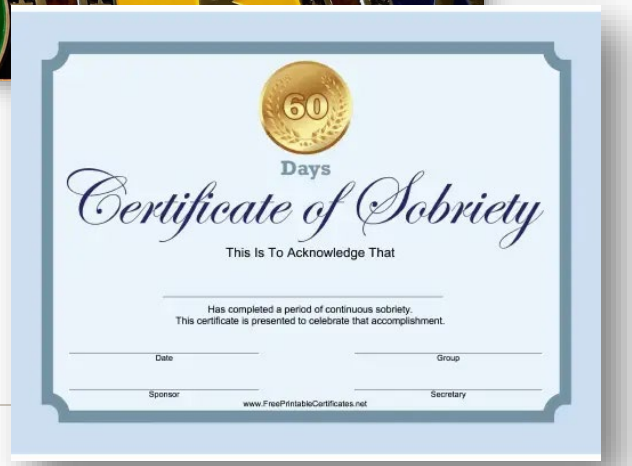


Incentives

- Verbal Praise
- Public Recognition
- Symbolic Tokens
- Tangible Prizes
- Point System
- Fishbowl Drawings
- Financial Waivers
- Reduced Non-Service Obligations

Symbolic Tokens

- The judge can present the token/award during the promotion ceremony.
- A different token for each phase:
  - ✓ Ph. 1 Courage
  - ✓ Ph. 2 Strength
  - ✓ Ph. 3 Focus
  - ✓ Ph. 4 Adapt
  - ✓ Ph. 5 Commitment
- Certificate of sobriety/phase advancement.



Point System/Fishbowl

- VTC Punch Card
- VTC Cash
- Drawings

Reduced Non-service Obligations and Financial Waivers

- Reduction in community service hours.
- Reduced court-ordered financial obligations.
- Fast pass – move to the front of the line at testing our court.

VTC Fast Pass (testing/court)

Reduced CSW

Court Fees

Service Adjustments

- The participants **want** incentives, and they do **not want** sanctions, but they **need** service adjustments.
- Infractions of distal goals receive service adjustments until participants have developed the skills and resources needed to accomplish these goals. (the goals become proximal)

Supervision Adjustments

- Status hearing
- Sessions with community supervision officers
- Drug/alcohol testing
- Home visits

CONTACT

Use core correctional practices and motivational interviewing to bring insight and skills-building

HOME FIELD

Identify potential safety threats in the participant's social environment and early signs of impending symptom recurrence

Supervision Adjustment

INPUT FROM TEAM "EXPERTS" - REDUCED ONLY ONCE THE PARTICIPANT HAS PSYCHOSOCIAL STABILITY

- ✓ Stable housing
- ✓ Reliable attendance
- ✓ Therapeutic alliance
- ✓ Clinical stability

Treatment Adjustments

- Considerable clinical expertise is required to assess participants' treatment needs, refer them to appropriate services, and adjust the services if they are insufficient or no longer required.
- Under no circumstance should non-clinically trained treatment court team members impose, deny, or alter treatment services if such decisions are not based on clinical recommendations of qualified professionals.

Treatment Adjustments

- If a participant is attending but is not improving, the treatment should be adjusted to better serve the person's needs and preferences.
- If a participant disagrees with staff about recommended treatment options, treatment professionals should make every effort to reach an acceptable agreement with the participant for a regimen that:
  - Has a reasonable chance of therapeutic success
  - Places the fewest burdens on the participant
  - Unlikely to jeopardize the participant's welfare or public safety

Learning Assignments

- Delivered as a service adjustment to help participants avoid distal infractions
- Learning assignments should never be framed as a punish but as an opportunity to improve one's adaptive functioning
- Learning assignments are delivered to help participants understand their condition, identify their risk factors for symptoms or infractions, and develop better problem-solving skills.

Learning Assignment Examples

Activity Log

Cognitive Behavioral Therapy (CBT)

Essay Assignment

Journaling Assignment

Life Skills Assignment

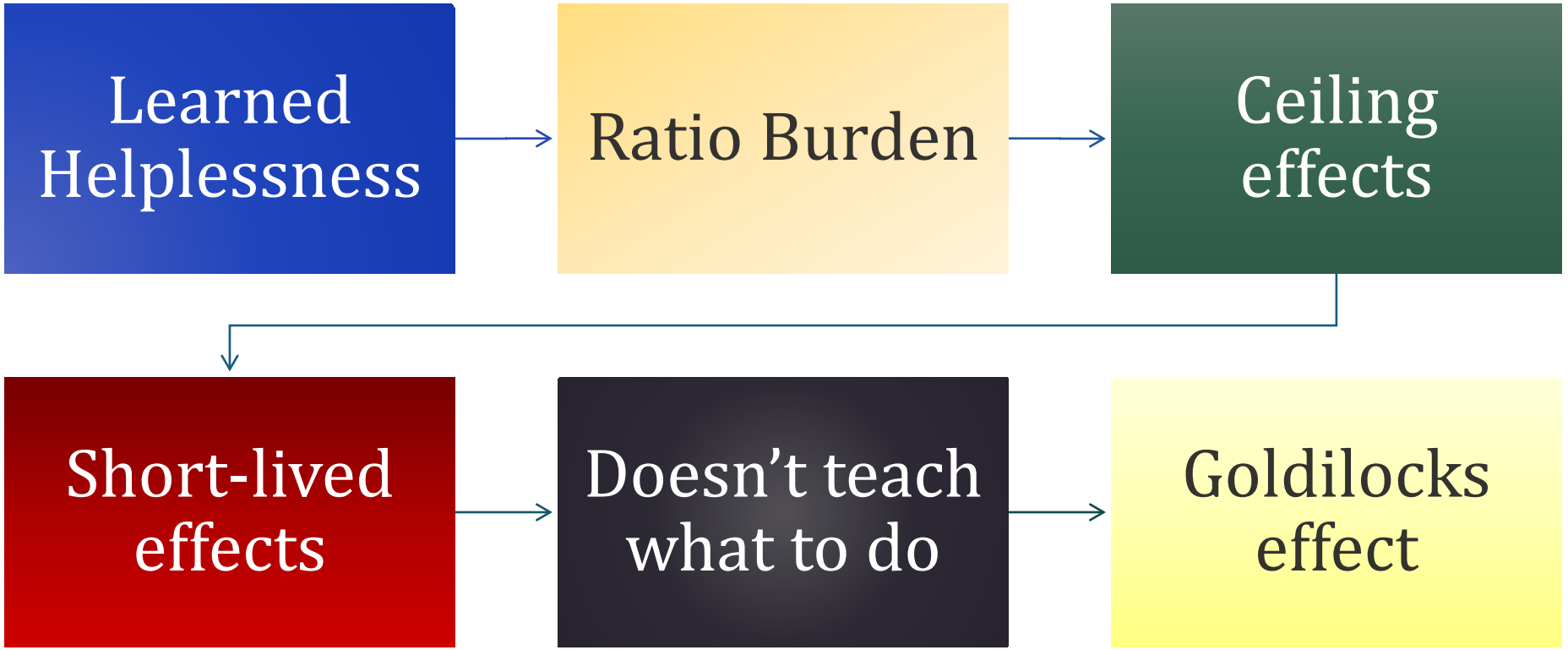
Sanctions

Level	Type of Sanction
Low	Verbal warnings
Moderate	Courtroom Observations
Moderate	Instructive Community Service
Moderate	Curfew
Moderate	Travel or Association Restrictions
Moderate	Electronic Surveillance
High	Team Round Table
High	Day Reporting
High	Home Detention
High	Jail Detention

Jail Sanctions

- Used primarily for proximal behaviors only after numerous lesser sanctions have been attempted and failed unless immediate risk to public safety exists.
- Not for distal goal infractions.
- Brief, pre-defined time period (No more than 3 to 6 days or less)
- Not in the first 30 – 60 days of treatment court
- Not for treatment.
- Nor for overdose prevention.
- Not for preventive detention.

Negative Side Effects to Sanctions

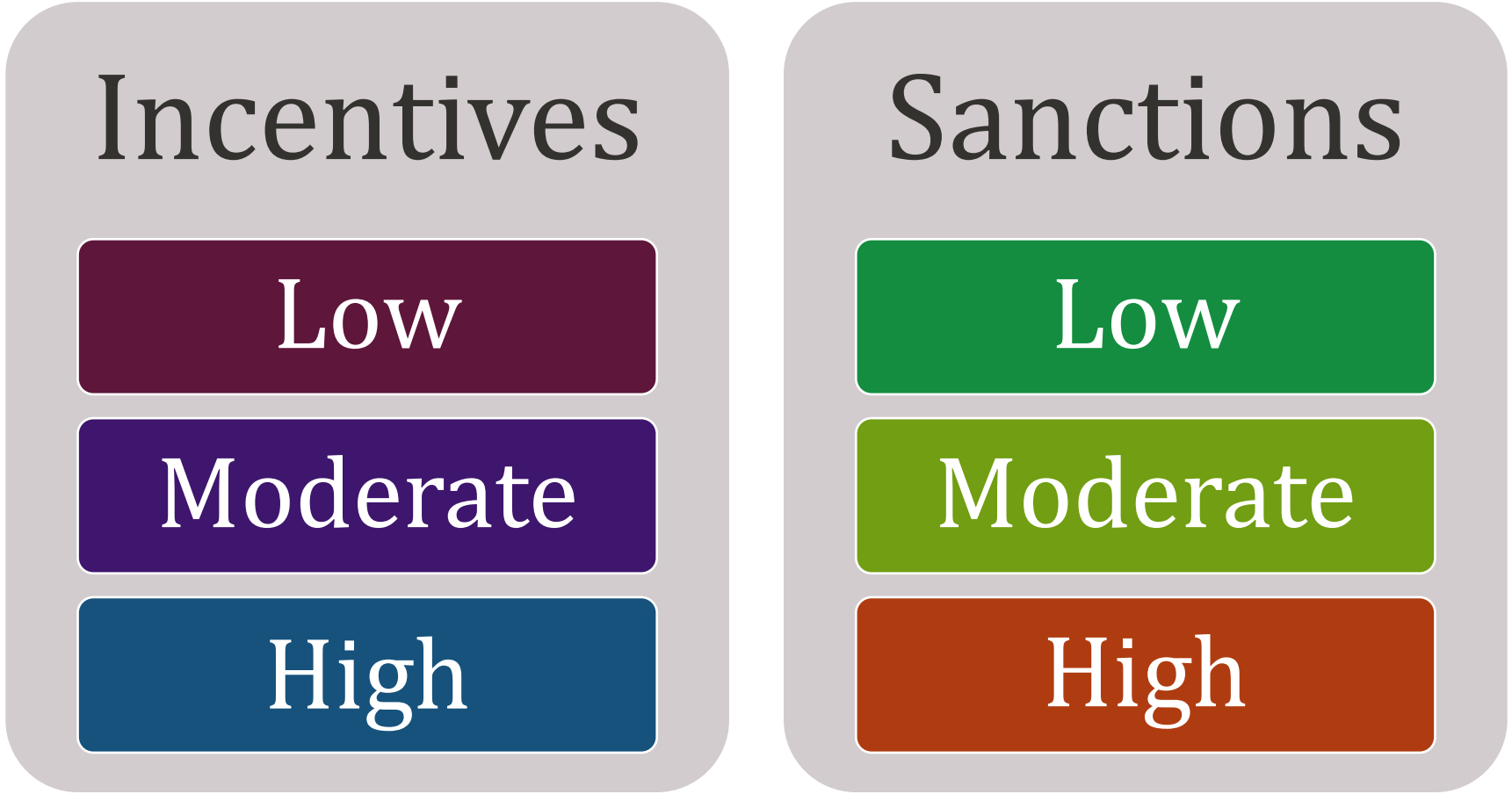


A word of caution and considerations to think about

RESPONSIVITY FACTORS:

- Participants with serious and persistent mental health disorders or lacking reliable transportation may not be able to attend counseling sessions or other services reliably.
- Do not demote a phase. Respond to the behavior and move forward

Guideline or "Menu"



Reference Guide for Standard IV: Incentives, Sanctions, and Service Adjustments

https://allrise.org/publications/incentives-and-sanctions-list/

Choosing Responses – Proximal Infraction

- 1st –2nd—Verbal warning reminding about program P&P concerning avoidable infractions. Emphasize staff taking these seriously, explain why they are taken seriously, and deliver a clear warning of what will happen if the infractions happen again.
- Then, move on to moderate-magnitude sanctions
- After four to five undeterred proximal infractions, serve as a broad guideline for considering a high-magnitude sanction. Staff judgment is required, and caution with jail sanctions for persons with trauma history or severe mental health or substance use disorders.

Choosing Responses – Distal Infraction

- Response with a service adjustment, not a sanction.
- If attending treatment and not getting better, adjust services.
- Reevaluate to identify potential obstacles such as language barrier, co-occurring mental health disorders, trauma history, culturally related barriers or stress reactions.
- If services not available that are needed should not be sanctioned or sentenced more harshly for not responding to inadequate care.

Abstinence should not be considered a proximal goal until participants with a compulsive substance use disorder have achieved early remission (at least 90 days of clinical stability).

American Psychiatric Association [APA], 2022

Clinically Stable

No longer experiencing clinical symptoms:

- Withdrawal
- Persistent substance cravings
- Anhedonia (an ability to experience pleasure naturally)
- Executive dysfunction
- Acute mental health symptoms

Choosing Responses – Managed Goal Infractions

- Remember, not perfectly or with ease, should be taken seriously but should not lead to an overreaction.
- Effort to understand what happened and what is needed to quickly get the person back on track.

How We Decide

Staffing Framework

Who	**are they in terms of risk and need?**
Where	are they in the program (phase)?
Why	did this happen (circumstances)?
Which	behaviors are we responding to? proximal, distal, or managed
What	is the response choice/magnitude?
How	do we deliver and explain the response

Procedural Fairness

- Advance notice (with flexibility)
- Opportunity to be heard (required if facing loss of liberty or property)
- Equivalent responses for equivalent conduct
- Respect and dignity
- Clear rationale
- Punish the act, not the person
- Expressed optimism and therapeutic motives

Thank You

Karen Cowgill

PROJECT DIRECTOR, ALLRISE

Cannabis and Cars-Addressing the Challenges of the Marijuana Impaired Driver

Mark Stodola
APPA Probation Fellow

Overview

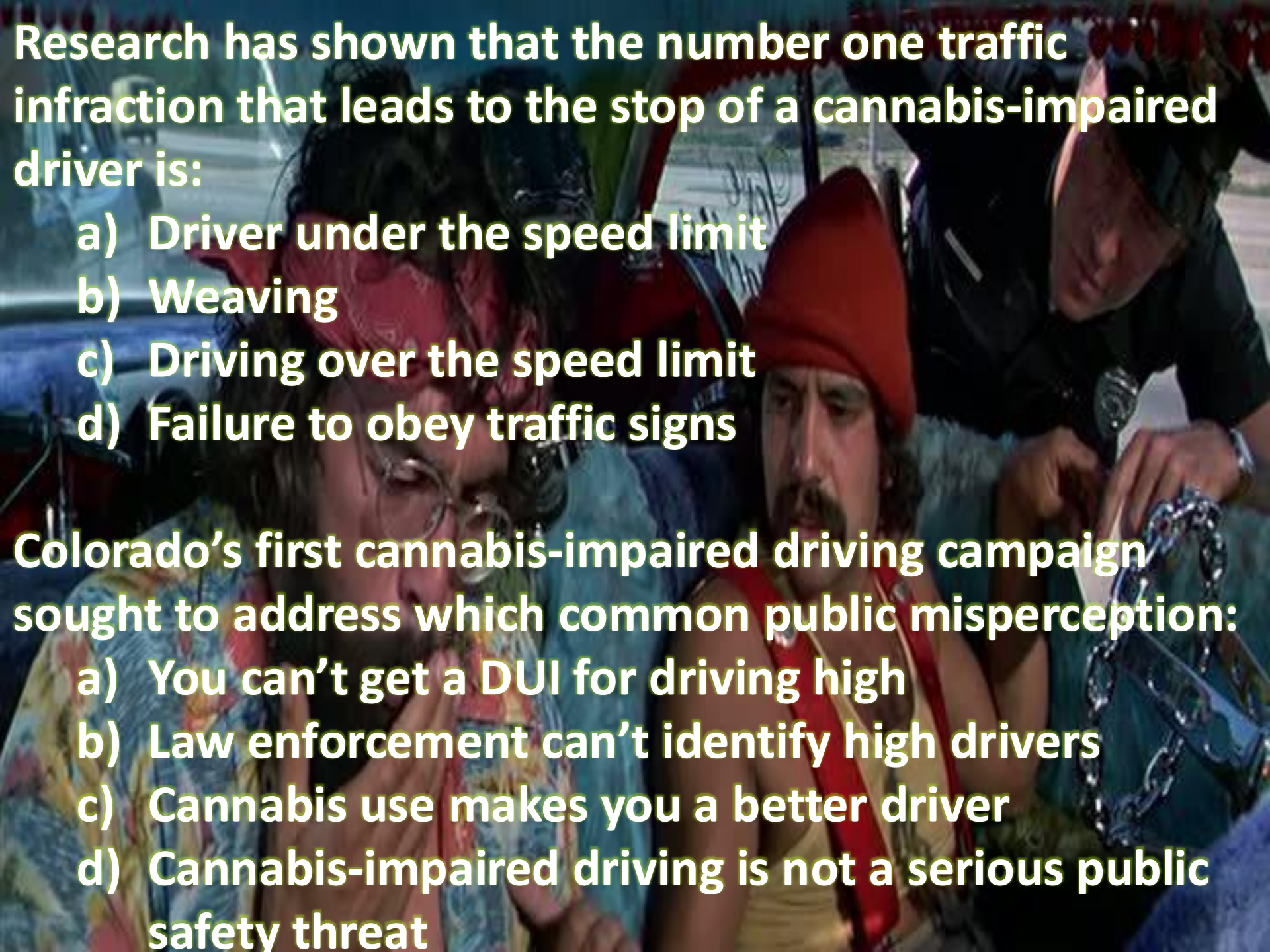
- State of DUI in America
- Magnitude of the DUID problem
- Marijuana-impaired driving
- Complexities and challenges:
  - Policy
  - Enforcement
  - Testing
- Supervision solutions/ recommendations

Cannabis is the most frequently detected drug in the systems of:

a. Fatally-injured drivers
b. Surviving drivers
c. Drivers arrested for DUI
d. All of the above

Research shows a sharp increase in DUI's in those state that legalize recreational MJ

a. True
b. False



Research has shown that the number one traffic infraction that leads to the stop of a cannabis-impaired driver is:

a) Driver under the speed limit
b) Weaving
c) Driving over the speed limit
d) Failure to obey traffic signs

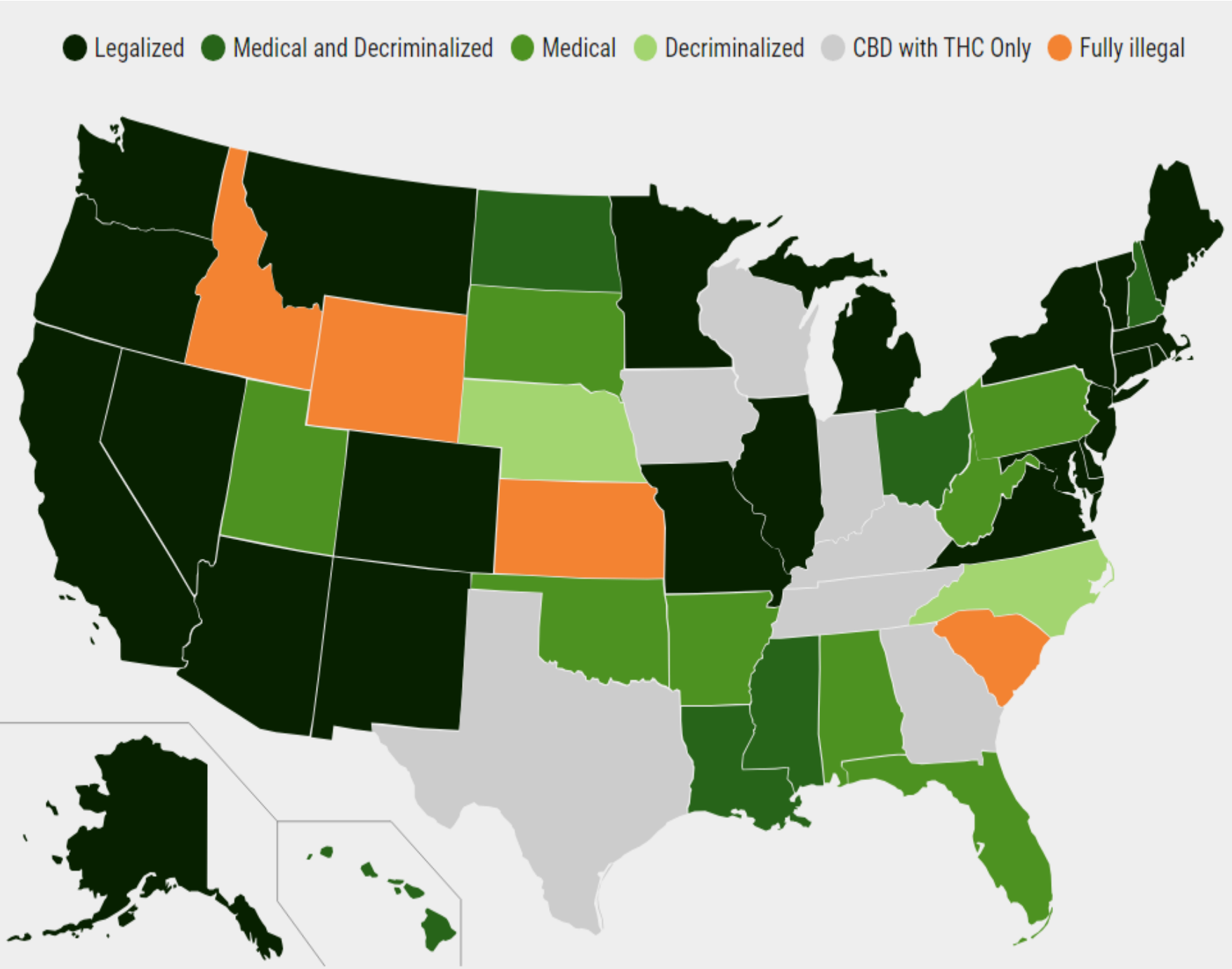
Colorado's first cannabis-impaired driving campaign sought to address which common public misperception:

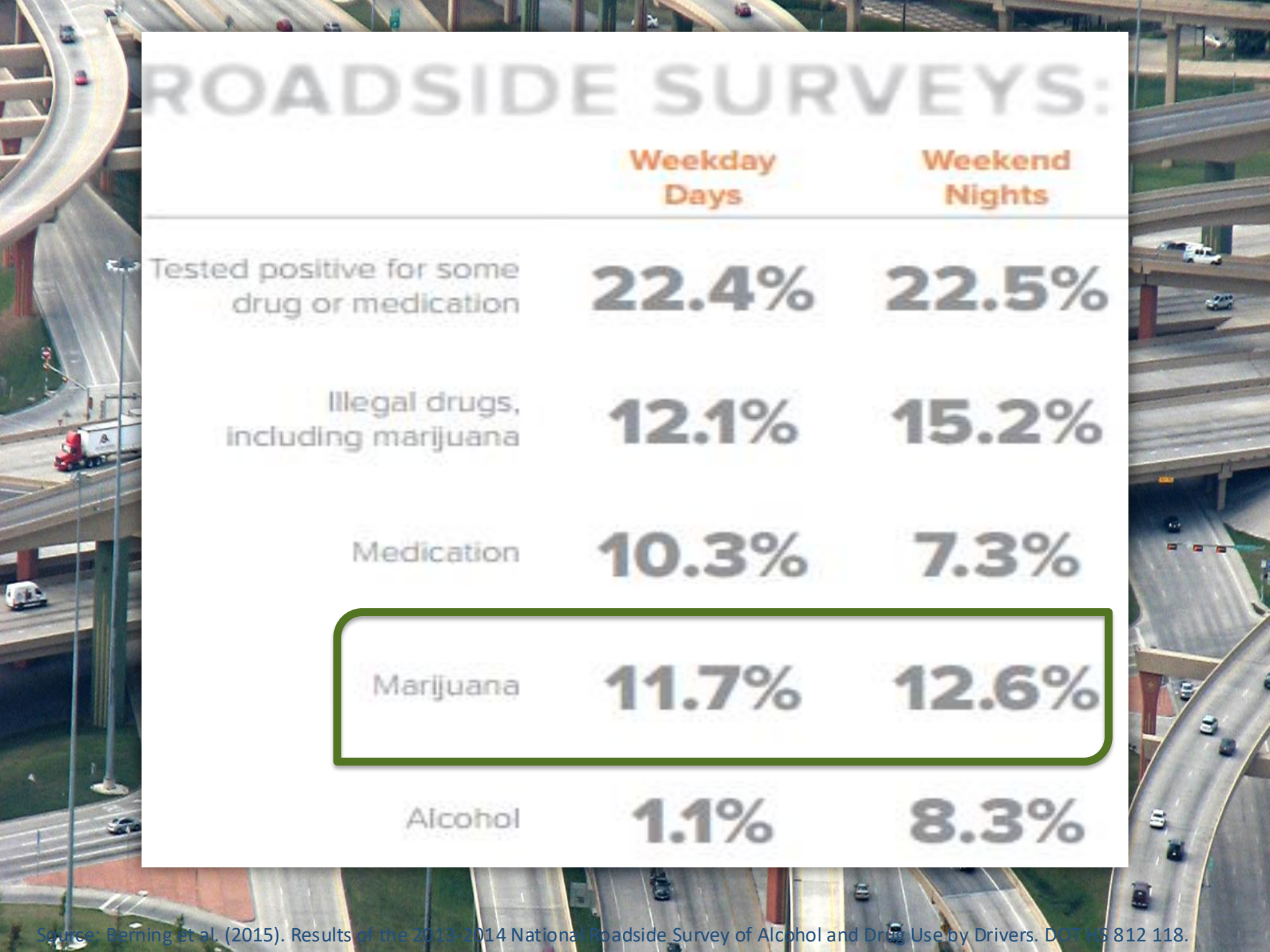
a) You can't get a DUI for driving high
b) Law enforcement can't identify high drivers
c) Cannabis use makes you a better driver
d) Cannabis-impaired driving is not a serious public safety threat

Impaired Driving by The Numbers

- In 2019, there were 1,024,508 drivers arrested for DUI.
- An alcohol-impaired driving fatality occurs every **48 minutes**.
- In 2022, there were **13,524** alcohol-related traffic fatalities.
  - **This is a 14% increase over 2020**
- In 2018, the most frequently recorded BAC among drinking drivers in fatal crashes was **.16**
- **127 million** drunk driving episodes occurred in 2021.

DRUG-IMPAIRED DRIVING


Legalized
Medical and Decriminalized
Medical
Decriminalized
CBD with THC Only
Fully illegal



ROADSIDE SURVEYS:

	Weekday Days	Weekend Nights
Tested positive for some drug or medication	22.4%	22.5%
Illegal drugs, including marijuana	12.1%	15.2%
Medication	10.3%	7.3%
Marijuana	11.7%	12.6%
Alcohol	1.1%	8.3%

Source: Berning et al. (2015). Results of the 2013-2014 National Roadside Survey of Alcohol and Drug Use by Drivers. DOT HS 812 118.

MJ Challenges

- **MJ related impairment is now 2nd to alcohol in impaired driving stats**
- **MJ has a very short detection window**
- **Inconsistency of States, IE- adopting certain concentrations versus zero tolerance.**

And if that wasn't enough….

- One third of MJ users consume on a daily basis.
- 78% of Americans have access to legal marijuana
- 20% of MJ users account for 80% of product consumption.
- MJ prices have dropped by 50%

Toxicology Issues

- About half of the Toxicology Labs test for drugs if an individual has .10 BAC or higher……
- No clear evidence that MJ alone causes an increase in crashes

MJ and Other Drugs

Research—Other Drugs

- Medical/Recreational MJ reduces opioid use, no effect on ODs or deaths
- Medical/Recreational MJ reduces opioid prescriptions
- Medical/Recreational MJ increases combined alcohol/MJ use
- Medical/Recreational MJ no effect on alcohol sales
- Medical/Recreational MJ ? effect on other drugs

The challenge of polysubstance use

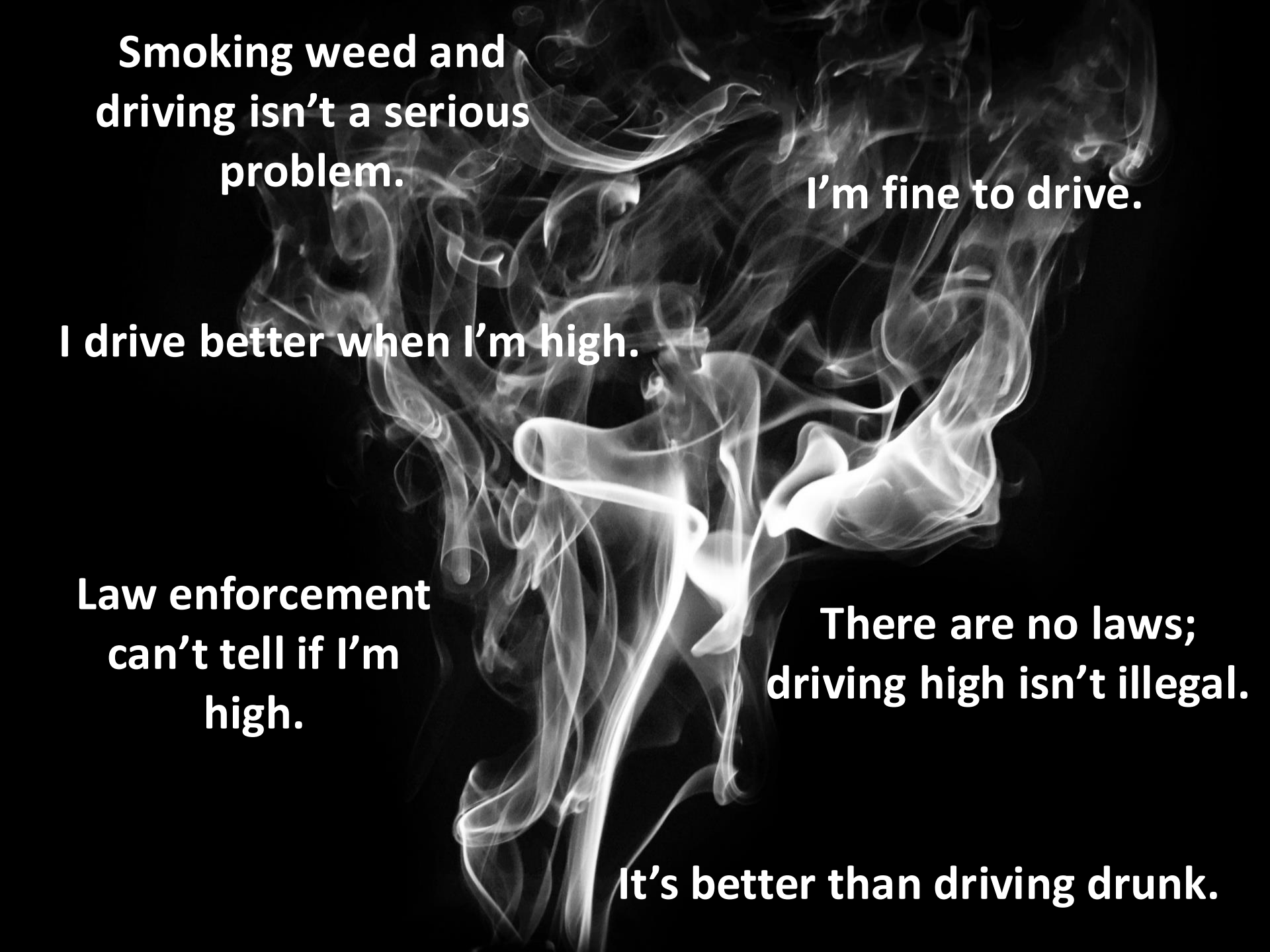
DUID crash risk

TABLE 3. CRASH RISK ASSOCIATED WITH DRUG USE IN EUROPEAN STUDIES

Risk level	Relative risk	Drug category
Slightly increased risk	1-3	marijuana
Medium increased risk	2-10	benzodiazepines cocaine opiods
Highly increased risk	5-30	amphetamines multiple drugs
Extremely increased risk	20-200	alcohol together with drugs

Shulze et al., 2012; Griffiths, 2014

PUBLIC AWARENESS & PERCEPTIONS


Smoking weed and driving isn't a serious problem.
I'm fine to drive.
I drive better when I'm high.
Law enforcement can't tell if I'm high.
There are no laws; driving high isn't illegal.
It's better than driving drunk.


Sabina
HOLISTIC HEALTH
DOES MEDICAL MARIJUANA CURE EVERYTHING?

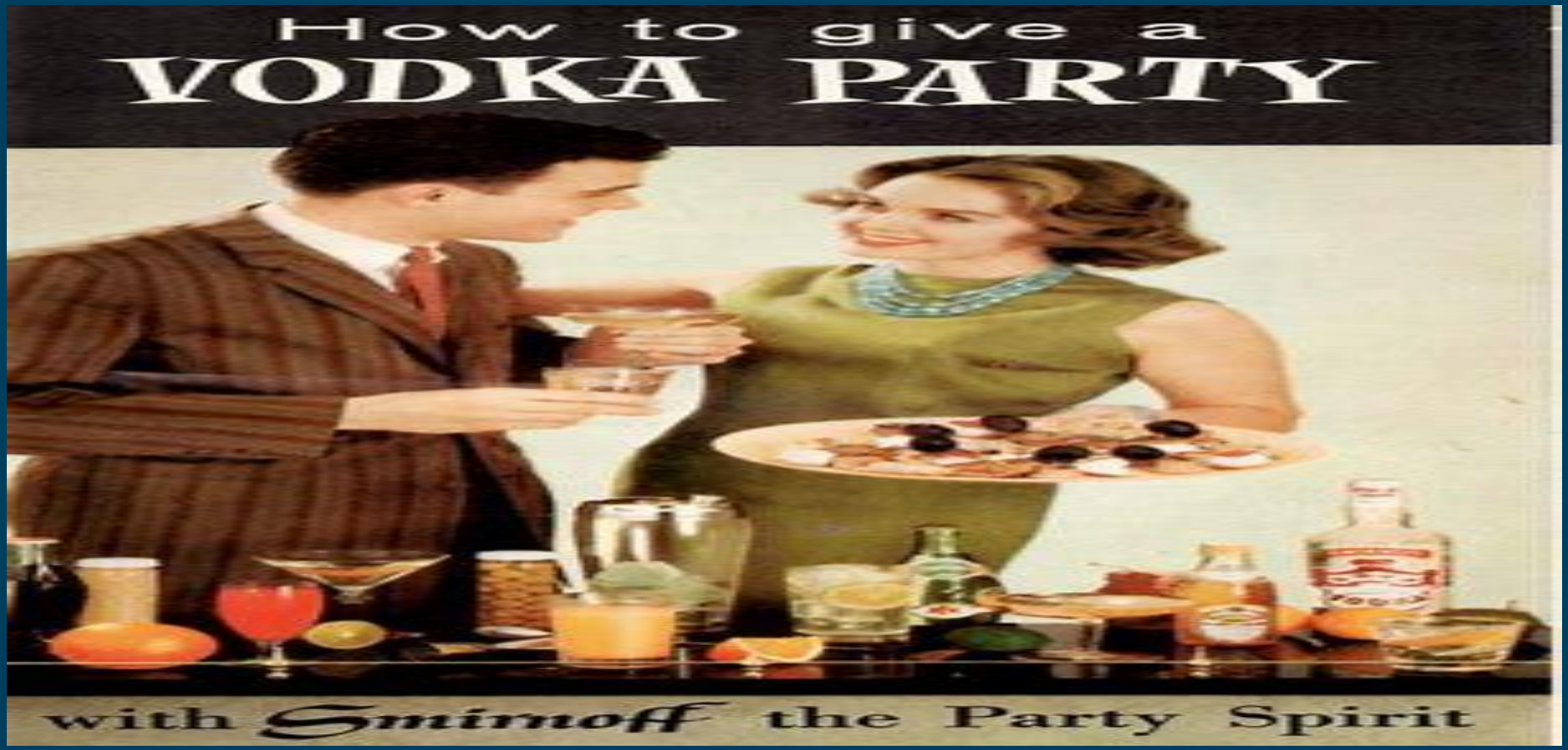

NEWS 9
CAN CANNABIS CURE COVID-19?


How can a person get the fastest relief for migranes using cannabis?

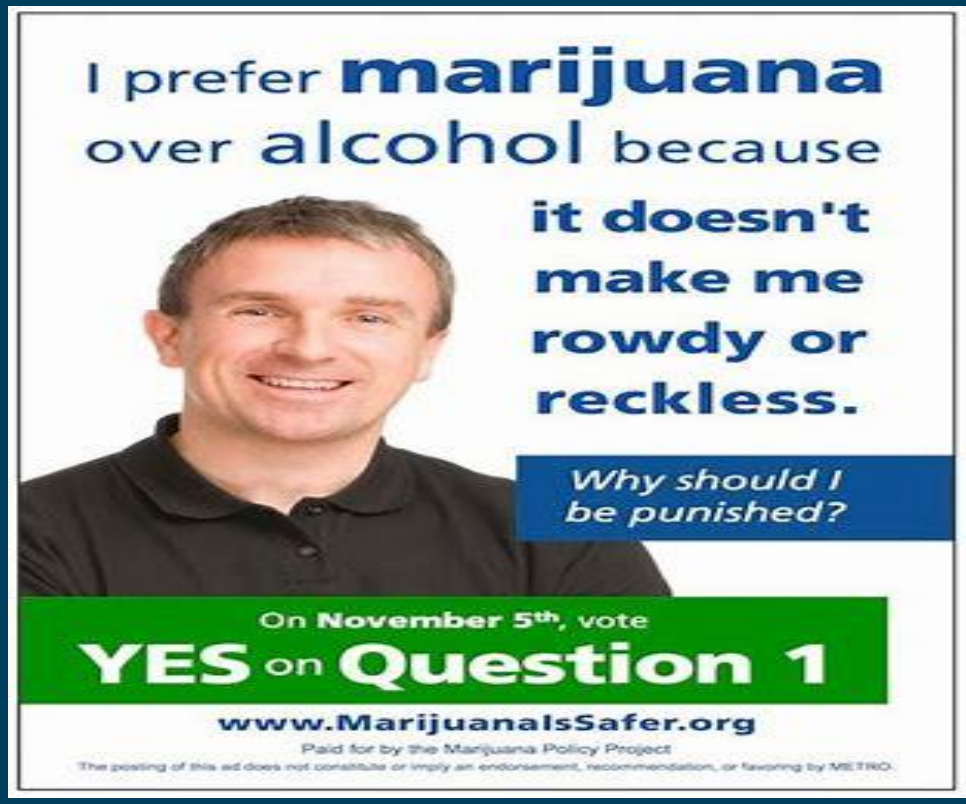

MARIJUANA AND SCHIZOPHRENIA


Marijuana &
Your Metabolism

Where we were with alcohol in the 70's.....



Is Where we are with marijuana today



EFFECTS OF DRUGS ON DRIVING

Signs of cannabis impairment

Eyelid tremors

Lowered temperature

Slow, deliberate speech

Odor of marijuana

Side-to-side, front-to-back, circular sway

Dilated pupils, bloodshot, watery eyes

Rebound dilation

Increased B/P (New users)
May be lowered for experienced users

Increased pulse rate

Body/Leg tremors

Other indicators:

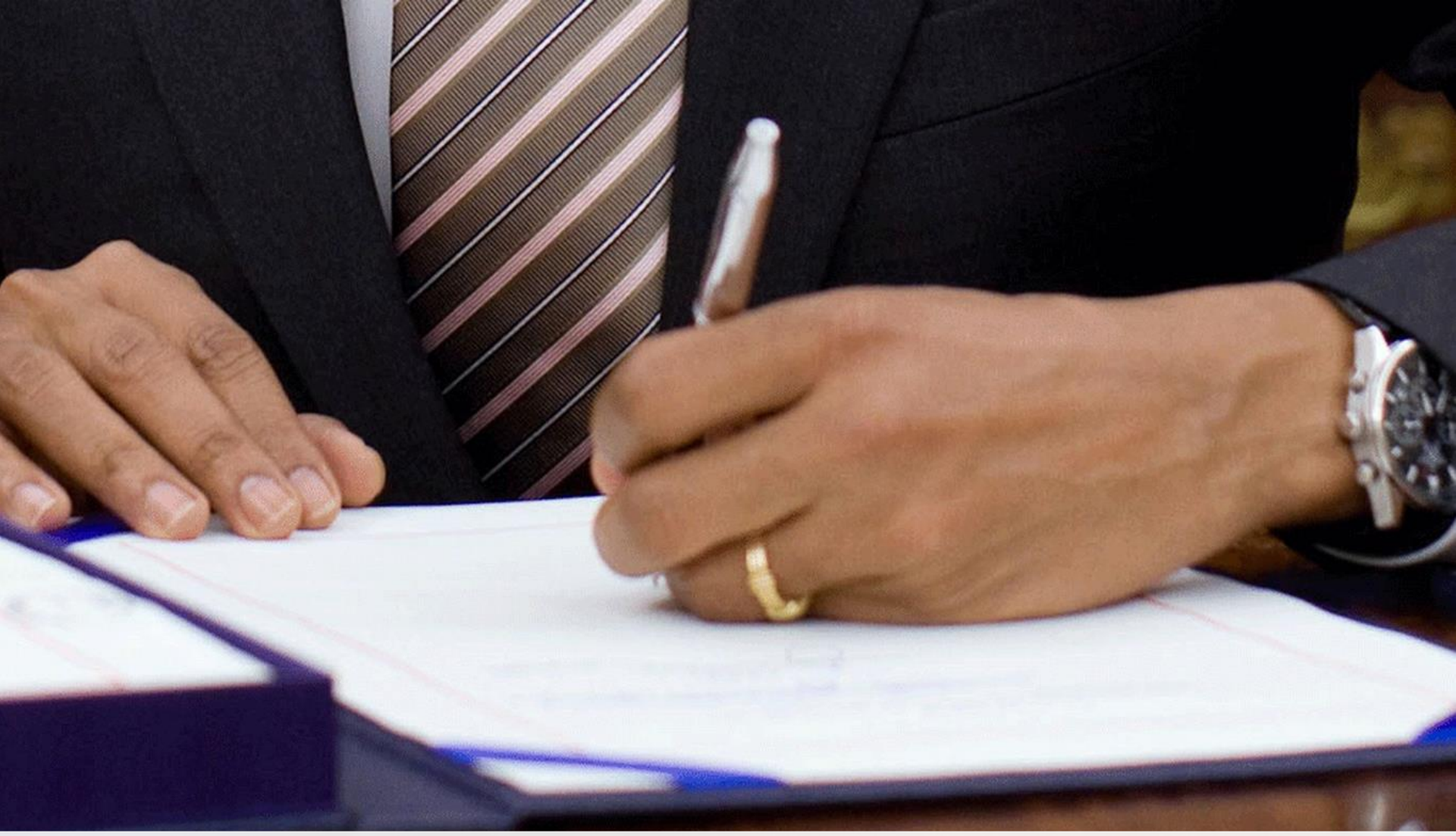
- Relaxed inhibitions
- Sharpened sense of humor
- Difficulty with concentration
- Disorientation
- Short-term memory problems
- Fatigue, Lethargic
- Altered time and space perception

Image source: Chuck Hayes, 2016.

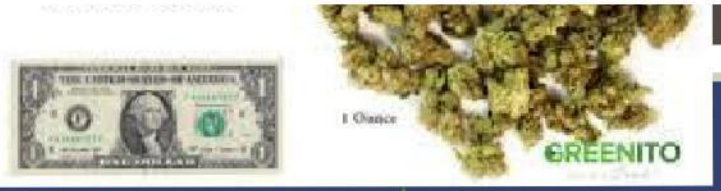
Cannabis and driving

- Poor attention to tasks
- Time and distance perception
- Slower braking/reaction time
- Poor speed maintenance
- Poor lane tracking/more steering corrections
- Drivers impaired by marijuana may compensate by driving slower and increasing following distance
- Level of impairment increases with dose

Sources: Compton and Berning, 2015; Hartman and Huestis, 2013; Kelly-Baker, 2014.



DRUG-IMPAIRED DRIVING POLICY ……AND CHALLENGES



1 OUNCE

60 JOINTS

DRUG POLICY RESEARCH CENTER

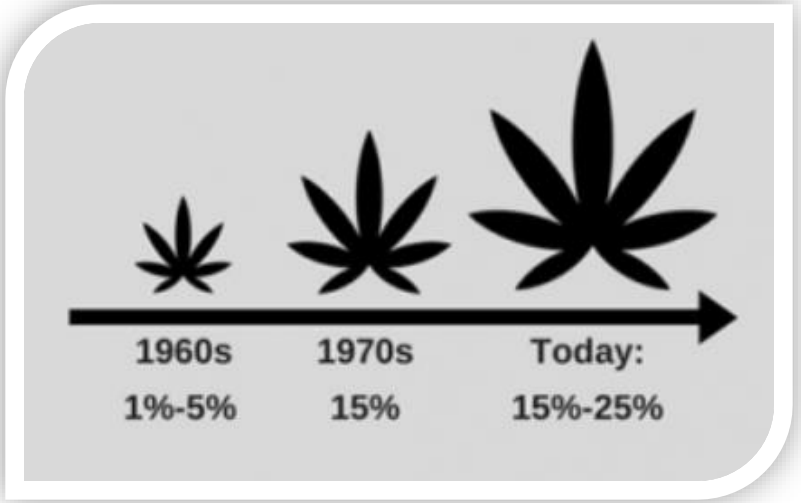

“Cannabis Plant”

Business has changed since 2012…

Designer dispensaries


21+
TUMBLEWEED
EXPRESS DRIVE-THRU
ENTER
TODAY

And so has the product…



Presence vs. Impairment

- **Relationship between a drug's presence in the body and its impairing effects is complex and not well understood.**
- **Presence of a drug ≠ impairment**
  - Some drugs/metabolites may remain in the body for days or weeks after initial impairment has dissipated.
  - Individuals differ considerably in the rate of absorption, distribution, and elimination of drugs.
  - Some people are more sensitive to the effects of drugs, particularly first-time or infrequent users.
  - Wide ranges of drug concentrations in different individuals produce similar levels of impairment in experimental situations.

Presence vs. Impairment: Marijuana

- Marijuana metabolites can remain in the body for 30+ days.
- THC concentrations fall to about 60% of their peak within 15 minutes after smoking; 20% of their peak 30 minutes after smoking; while impairment can last 2-4 hours.
- There is no DUID equivalent to .08 BAC.
  - It is currently impossible to define DUID impairment with an illegal limit as drug concentration levels cannot be reliably equated with a specific degree of driver impairment.

Drug-Impaired Driving

GHSA RESPONSIBILITY.ORG

NOT RECOMMENDED: Impaired Driving Per Se Laws for Marijuana or Opioids

	Alcohol 	Marijuana/Opioids 
Drivers know impairing effects?	✓ Drivers can plan with "standard drinks"	⊘ Dose response is difficult to predict, varies significantly
Correlation with impairment?	✓ Presence = impairment	⊘ Presence ≠ impairment
Measurable at typical time of blood draw?	✓ Dissipates gradually	⊘ Dissipates rapidly


“There is no BAC for THC”

Other Strains of Cannabis

- CBD-Pure CBD oil will not show up in testing and won't make you high
- Delta 8-is legal in most states and is an analog of THC though it has lower potency and can (but often isn't) be detected in testing
- Delta 10-Legal allegedly gives you more energy
- THC-O Legal- is a stronger analog of delta 9 THC. It takes longer to kick in but produces effects that are roughly three times as strong as conventional THC.
- Rick Simpson Oil-Very high level of THC

Method of ingestion matters!

Cannabis Ingestion Methods

Inhaling - Pulmonary

Oral - Digestive


Sharpie
Permanent Marker


INDVR


PUFFIT™ 2

Trans mucosal – sublingual, intranasal, rectal, ocular

Transdermal

CANNABIS CONCENTRATES

CRUMBLE
Dried oil with a honey-comb like consistency

BADDER/BUDDER
Concentrates whipped under heat to create a cake-batter like texture

SHATTER
A translucent, brittle, & often golden to amber colored concentrate made with a solvent

DISTILLATE
Refined cannabinoid oil that is typically free of taste, smell & flavor. It is the base of most edibles and vape cartridges

CRYSTALLINE
Isolated cannabinoids in their pure crystal structure

DRY SIFT
Ground cannabis filtered with screens leaving behind complete trichome glands. The end-product is also referred to as kief

ROSIN
End product of cannabis flower being squeezed under heat and pressure

BUBBLE HASH
Uses water, ice, and mesh screens to pull out whole trichomes into a paste-like consistency

Edibles


No More of These...
mr.Dankbar
KRONDIKE
DOPEST
DANKIES
1000mg of THC
pot tarts
Wildberry
3X STRENGTH
Reefers
CUP
Health


pot tarts
DEA


BLUE DREAM CAKE POP
CAKE POP


McJuana?


nugtella
Hazelnut spread with
Medical Marijuana


Twixed
Munchy Way
Reese
KeefKat
Buddahfinger
OEO
CRUNCH
DEA

EDIBLES DOSING CHART

THC CONTENT PER DOSE	WHAT TO EXPECT	WHO'S IT FOR?
1 - 2.5 mg THC	• Mild relief of pain, stress, anxiety, and other symptoms • Improved focus and creativity	• First-time consumers • Microdosers
2.5 - 15 mg THC	• Stronger symptom relief • Euphoria • May impair coordination and alter perception	• Patients with persistent problems • Restless sleepers • Social butterflies
15 - 30 mg THC	• Strong euphoria or unwanted effects in unaccustomed consumers • May impair coordination and alter perception	• Well-seasoned consumers • Medical patients with developed tolerances • Experienced consumers seeking to sustain sleep
30 - 50 mg THC	• Very strong euphoria in unaccustomed consumers • Likely to impair coordination and alter perception	• Consumers who have poor GI absorption of cannabinoids • People with significant tolerance to THC
50 - 100 mg THC	• Can cause extreme side effects such as rapid heart rate, nausea, and pain • Highly likely to impair coordination and alter perception	• For experienced THC individuals only • Patients with cancer, inflammatory disorders, or conditions that necessitate high doses

Always begin at the lowest recommended dose. Gradually increase by 1 or 2mg per dose, if necessary, to find your optimal dose. For more information go to Healer programs: ***www.healer.com/programs***

HEALER

Leafly

Stoner Things

COLORADO EDIBLES GET A NEW LOOK

10 mg THC serving

INHALING
— smoking or vaping —

Cannabis smoke or vapour delivers THC, the chemical that gets you high, into your lungs where it passes directly into your bloodstream and then your brain.

You will feel the effects from **seconds to a few minutes** of inhaling.

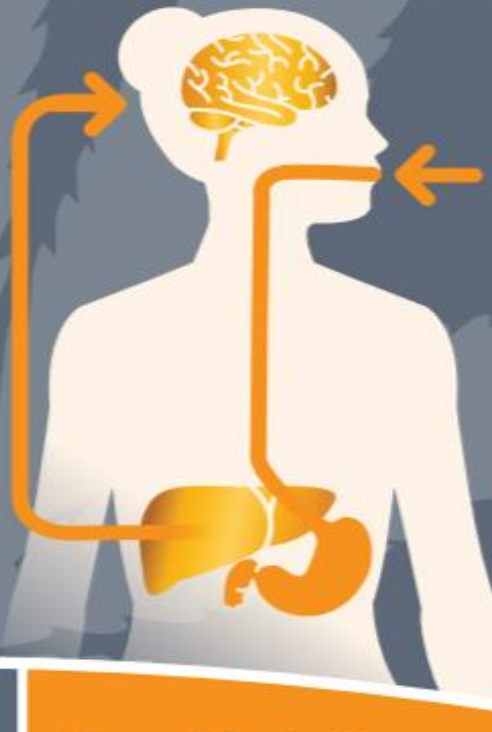
Full effects can peak within **30 minutes**.

START OF EFFECTS

PEAK EFFECTS

INGESTING
— eating or drinking —

Edible cannabis travels first to your stomach then to your liver before getting into your bloodstream and brain. The liver converts THC into a stronger form and this combined with the THC from the original product adds to the intensity of the high.



You will feel effects within **30 minutes to 2 hours** of ingesting.

Full effects can peak **within 4 hours**.

CONSUMING CAN CAUSE CRASHING.

It takes up to two hours for an edible to affect you.
Don't be behind the wheel when your high hits.

IF YOU'RE HIGH, DON'T DRIVE.

DRIVE HIGH GET A DUI

CDOT COLORADO Department of Transportation

CO COLORADO MOVING TOWARDS ZERO DEATHS

What about this scenario?

Tobacco or THC?

Officers need more tools

- Not all officers receive specialized training.
- Availability of DREs is limited.
- Polysubstance impaired driving is becoming increasingly common.
- Drugs metabolize quickly.
- Warrants take time.

What does the problem look like in your state?

- **Assess your state's drugged driving issues**
  - What drugs are you most commonly seeing (fatal crashes, arrested drivers)?
  - Are there regional differences?
  - Are there high-risk segments of the population?
- **Collect baseline data**
  - Test more drivers for drugs
  - Track DUID and DUI separately in crash, arrest, and court data for better analysis

What tools are available?

- Assessment
- Supervision
- Technology
- Testing

Do you assess for risk and needs with impaired drivers?

Do your assessment tools tell you what you need to know?

Approximately 25% of individuals arrested and 30% of individuals convicted of DUI are repeat offenders.

Contact with the criminal justice system in and of itself, does not deter at least 1/4 of all offenders.

Assessments should drive decision-making

- Using traditional assessment tools, DUI/DUID offenders are commonly identified as low risk due to a lack of criminogenic factors.
- DUI/DUID offenders often have unique needs and are resistant to change on account of limited insight into their behavior.
- Specialized instruments should be used to accurately assess risk and needs of impaired drivers.
- Validated risk and needs assessment instruments are available – some specific to DUI population (e.g., IDA; CARS).

With impaired drivers, don't assume!

The drunk driver before you could actually be a polysubstance user.

PROS | CONS


Where do we place these people?


DWI offenders engage in behavior that is dangerous and frequently causes serious injury or fatalities.

Focus on the behavior – it's more than just drug use!


QUESTIONS?

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