Mistakes Drug Courts Make and How to Fix Them

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Disclaimer

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

The author has no conflicts of interest to disclose.

WARNING!

You may experience this presentation as provocative....

How Do We Get From

Great

Good

Mistake #1

Expecting the defendant to trust you

Why the Defendant Doesn't Trust You

- Courtrooms are intimidating
- The judge has the power
- The prosecutor is against you
- The defense attorney barely knows you
- The intake clinician may be "the good cop"
- What does the defendant know about collaborative courts, anyway?

Clinical Reasons Why the Defendant Doesn't Trust You

- One of the hallmarks of substance abuse is secrecy
- 60% of people with substance abuse problems have experienced trauma
  - The percentage is probably greater in Drug Courts
  - One of the hallmarks of trauma is distrust of others
  - This is particularly true of those in authority
- Why *should* the defendant tell you his story?

Who Are We Kidding?

Which Court Would You Rather Be In?

What Courts Can Do to Increase Trust

- Have everyone sit on the same level
- Make the table as equal as possible (e.g., square, not rectangular)
- Consider leaving off judicial robes
- Explain how roles are different in a collaborative court
- Practice joint decision making at the table; be a team

What Courts Can Do to Increase Trust

- Openly acknowledge that the defendant might not trust you
  - It tells him that you understand, which is a step in building trust
- Look for openings in which the defendant tells you something about himself, and talk with him about them
- Recognize and acknowledge that trust is built one step at a time
- Practice Motivational Interviewing

Mistake #2

Being trauma-informed is not enough

What Does Being Trauma-Informed Mean?

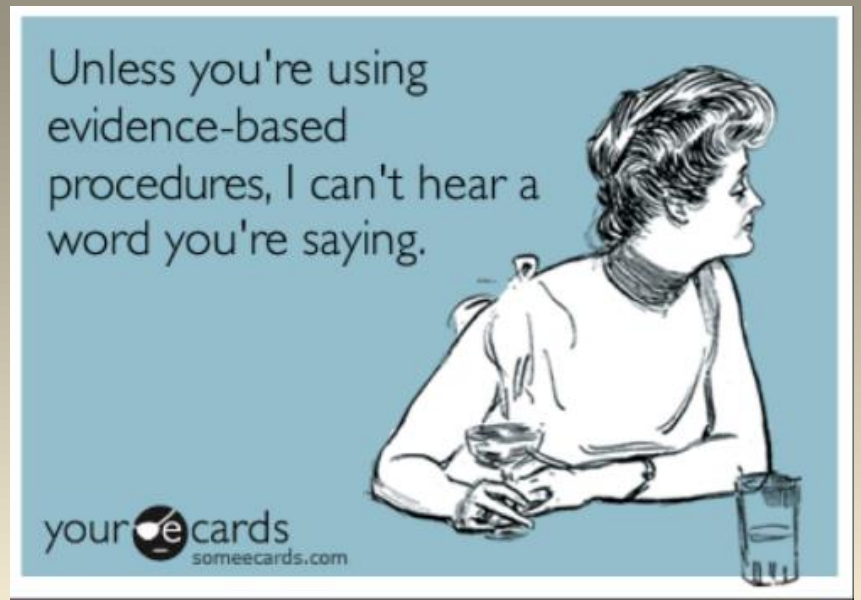
- Being aware of the high frequency of trauma in defendants
  - 60% of people with substance abuse disorders have experienced trauma
  - The rate is probably much higher in judicial settings
- Rates of criminal behavior and violent offenses are much higher in victims of child abuse and neglect (Widom, 1989)
- Rates of child maltreatment are high among drug abusers
  - This is especially true among women, of whom 55-99% have a history of trauma (Najavits et al., 1997)
- Rape victims have far higher rates of drug abuse than those who have not been raped (Kilpatrick et al., 1992)
- 68% of prisoners report childhood abuse, and 23% report multiple forms of abuse (Weeks and Widom, 1998)

What Does Being Trauma-Informed Mean?

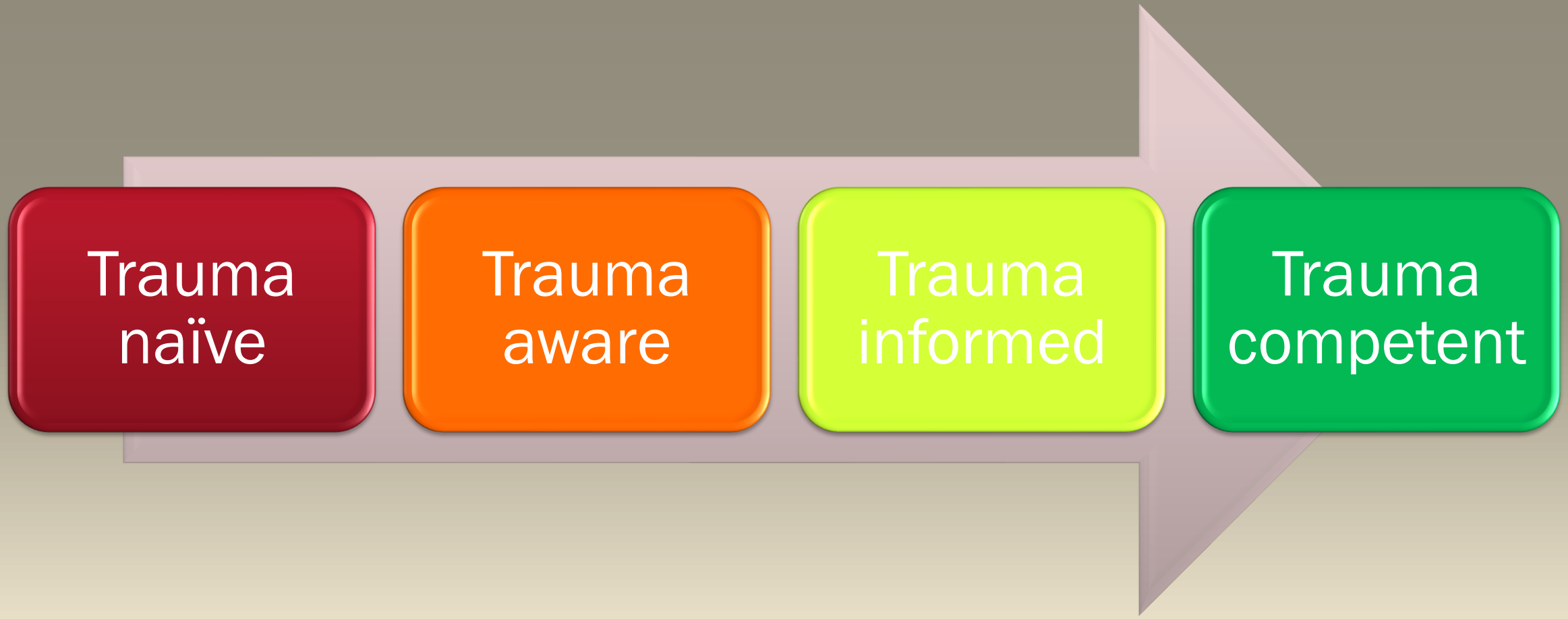
- You understand that there is a link between trauma and substance abuse
- You also understand that, in order for substance abuse to end, trauma also needs to be treated
- Now you are trauma-informed.

Trauma Informed Treatment ≠ Evidence Based Treatment

- Trauma-informed treatment means that trauma is taken into account when treating substance abuse
  - *Beyond Trauma: A Healing Journey for Women* by Stephanie Covington
- Evidence-based means that research has shown treatment to be effective
  - *Seeking Safety* by Lisa Najavits
- Evidence-based is better



Continuum of Trauma Responsivity



Trauma Competent Courts

- Reconstruct their environments
- Are trauma driven
- Hold regular trauma trainings
- Understand that PTSD is a normal response to an abnormal event
- Are familiar with different trauma presentations
- Refer only to evidence-based treatments for trauma
- Verify that clients are receiving evidence-based treatment
- Have mentors

Becoming Trauma Competent

- Changing the organizational culture
- Changing the question from “What’s wrong with you?” to “What happened to you?”
- See the whole person, not just the problem
- Use SAMHSA’s six principles: safety, trustworthiness, etc.
- Changing your paradigm, e.g., from “You could stop using if you were motivated” to “You need safety, stability, and support to succeed”

Mistake #3

Believing the self-medication hypothesis

Many Reasons Why People with PTSD Use Substances

- To numb their painful feelings (self-medication).
- To try to relax.
- To forget the past.
- To go to sleep.
- To prevent nightmares.
- To cope with physical pain.
- To stop dissociation and flashbacks.
- To feel some pleasure in life.
- To let out their anger.

Many Reasons Why People with PTSD Use Substances

- Peer pressure.
- To socialize with other people and feel accepted.
- Family members drank or used drugs when they were growing up.
- It was common in the military.
- Boredom.
- To get through the day.
- To show people how bad they feel.
- To commit “slow suicide.”

The Truth about Self-Medication

- Only about 1/3 of people start abusing substances after their traumatic experience
- About 1/3 experience trauma and start abusing substances simultaneously
- About 1/3 abuse substances before they experience trauma

Investigate

- Find out when they started using substances and when they first experienced trauma
- Find out what their experience was when they first used substances and in what context
- Ask why they used substances then
- Ask if the reason they use substances now is the same
- Find out for each substance, both those used in the past and those used now

Don’t Get Fooled Again

PTSD ≠

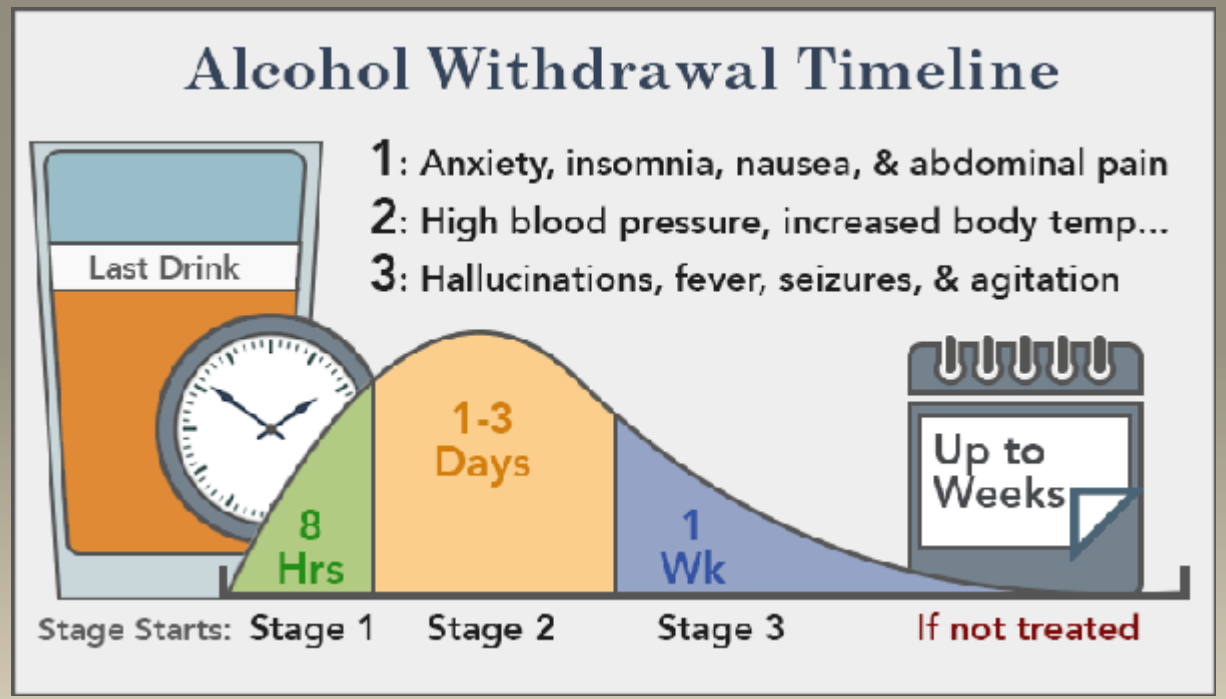
Substance Abuse

- Even when someone begins using substances to cope with traumatic experiences, that does not mean that is why they are using substances now
- People can become substance dependent over time
- Even if treatment significantly decreases their PTSD symptoms, they may not stop abusing substances (Mills et al., 2012)

Mistake #4

Demanding immediate abstinence from traumatized people

Immediate Abstinence from Alcohol May Be Dangerous



- Over time, the central nervous system acclimates to having alcohol in it all of the time
- Sudden withdrawal can lead insomnia, anxiety, headaches, nausea, and vomiting
- It can also result in hallucinations and seizures
- First, do no harm

Immediate Abstinence May Not Be Possible for People Who Have Been Traumatized

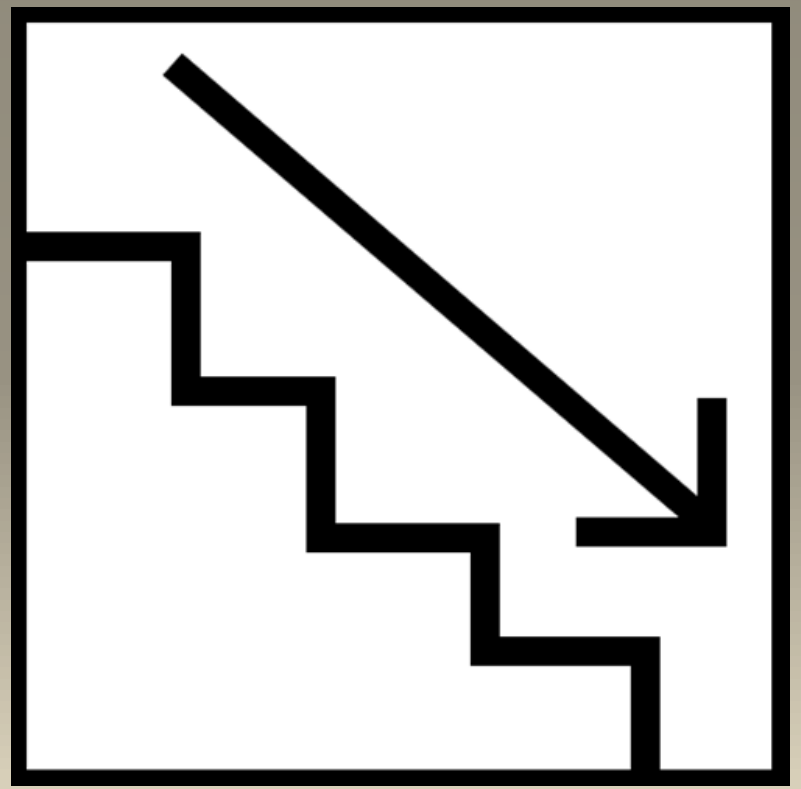
- If they really are using substances to cope with their trauma, immediate abstinence will leave them defenseless
- They will become flooded by all of their trauma-related memories, thoughts, feelings, nightmares, and body experiences
- This will lead to relapse
- This will lead to punishment
  - Punishment can be re-traumatizing
  - It will make them distrust you more

Alternative #1: One at a Time

- When someone abuses multiple substances, it is difficult to give them all up at once
  - Different substances may be used for different purposes
  - Contract to give up the easiest one first
    - This gives them confidence that they can be successful
- This can also be used for safety, such as first stopping driving while using, then stopping going out to use, then stopping use at home

Alternative #2: Warm Turkey

- Contracting to reduce consumption each week until abstinence is achieved
  - e.g., from two cases of beer a day to 18 beers a day, then one case, then 9, 6, 3, 2, 1, and 0
  - Or reducing the number of days per week of usage until there are none



Alternative #3: Try an Experiment

- Contract to try an experiment to go for three days without using
  - Then meet on the fourth day to discuss how it went
  - If successful, renew the experiment
  - If not, try something else

The Goal Is Abstinence

- Methods may be mixed
  - For example, they can cut down one substance at a time, but the last substance (the hardest) may need a warm turkey approach
- Clinicians should monitor the changes
- IMPORTANT: Let them choose the method
  - This empowers them to make the choice, rather than having you make it for them
  - Empowerment is critical for people who have been traumatized
  - It is choice within limits

Mistake #5

Ordering all traumatized people into AA/NA

Traumatized Individuals May Not Like AA/NA

- Reason #1: What is the first step?

Some Traumatized Individuals May Not Like AA/NA

- Reason #1: What is the first step?
  1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
  - Most traumatized people need control
    - Yes, it is a contradiction that they use substances that make them lose control
  - Admitting they are powerless violates their identity

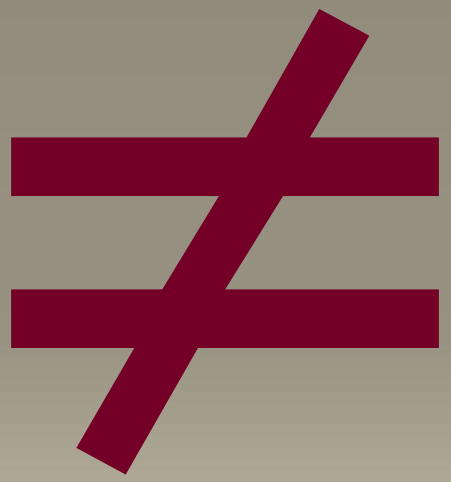
Some Traumatized Individuals May Not Like AA/NA

- Reason #2: What is the third step?

  3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

- Not all traumatized people believe in a higher power
  - They question why God let terrible things happen to them
  - Then they have three choices:
    1. God is good, so I am bad
    2. God is not good
    3. There is no God
- AA and NA depend on faith and trust, which many traumatized people lack

Not All AA or NA Meetings Are Created the Same



- Some are better than others
- It usually depends on the leaders
- Some AA meetings are followed by drinking parties
- Make sure you send them to the *right* meetings

Not All Participants Respond in the Same Way

- More than 40% of participants drop out prematurely from self-help groups (Kelly & Moos, 2003)
- Some people are triggered by hearing stories of others drinking or using drugs
- Make sure your participants are not triggered to drink or use drugs by hearing stories of others drinking and using

Just to Be Clear

- AA and NA have helped millions of people
- This discussion is not meant to stop you from referring to AA and NA
- It is meant to make you think about *which* meetings are helpful to *which* people
  - AA and NA may not be helpful to all traumatized people
- The NADCP Adult Drug Court Best Practice Standards (Volume I, 2013) recommend using Peer Support Groups
  - The Standards do not recommend specific peer support groups

NADCP
National Association of Drug Court Professionals

Alternatives to AA/NA: SMART Recovery

- Self Management and Recovery Training Groups
- Four Point Program
  1. Building and Maintaining Motivation
  2. Coping with Urges
  3. Managing Thoughts, Feelings and Behaviors
  4. Living a Balanced Life
- Allows the use of psychiatric medication
- Does not require belief in God
- Does not require belief that addiction is a disease

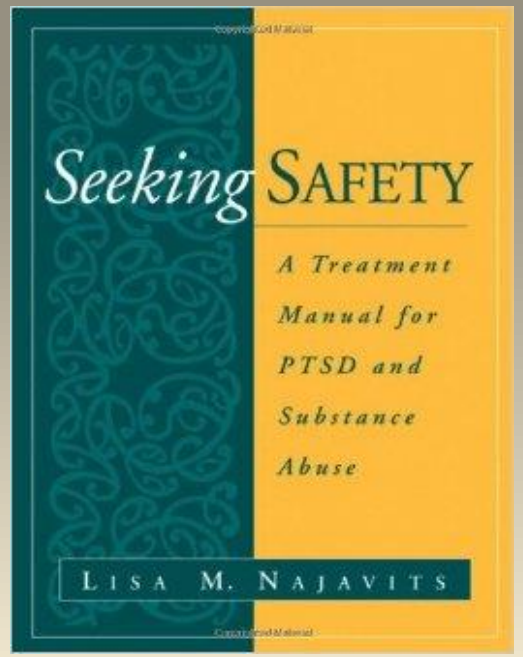
SMART Recovery

- A cognitive-behavioral approach to substance abuse
- Focuses on empowerment and self-reliance
- Uses empirically-supported treatment strategies
- Research shows it is effective (e.g., Hester et al., 2013)
- Provides tools and techniques
- Worksheets
- Web courses
- In person and online meetings
- Online resources

SMART Recovery®
Self Management and Recovery Training

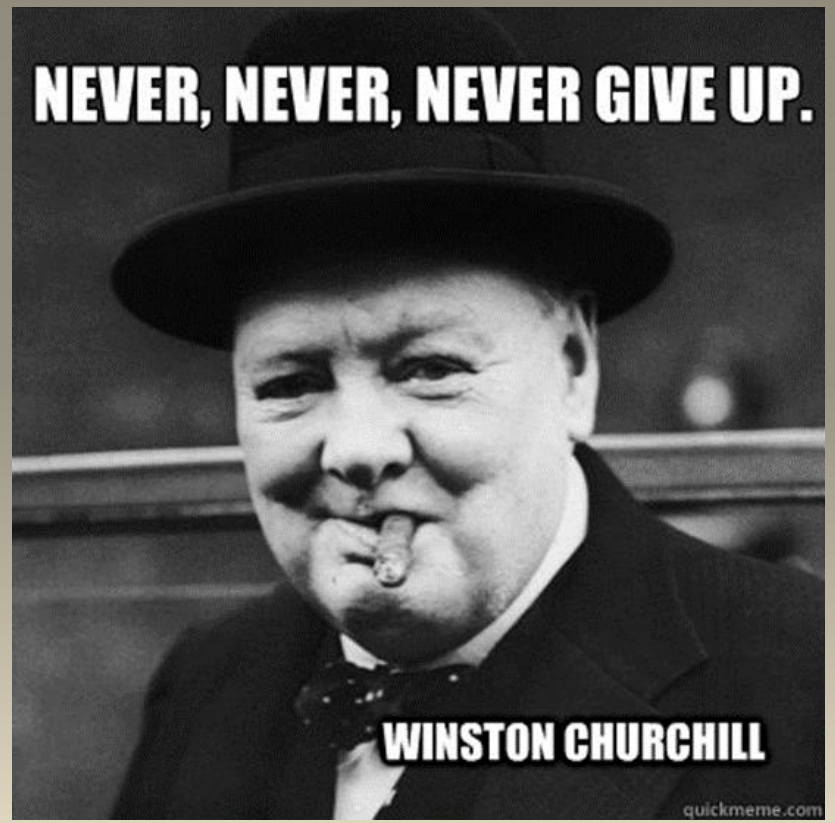
Alternatives to AA/NA: Seeking Safety

- An integrated treatment for PTSD and Substance Abuse
- Combines psychoeducational and psychodynamic treatment
- 25 lessons on topics that overlap between PTSD and Substance Abuse
  - Safety Skills
  - Grounding
  - Anger
  - Boundaries
  - Self-care
  - Honesty
  - Compassion



Seeking Safety

- Can be provided by professionals or paraprofessionals
- 6 randomized controlled trials and 3 controlled studies
- Seeking Safety has shown positive results across all studies (Najavits & Hien, 2013)
- Seeking Safety is the only evidence-based treatment for PTSD and Substance Abuse



Mistake #6

Referring to residential treatment as the answer to substance abuse

Residential Treatment May Not Be the Answer

- Reviews of the outcomes of residential treatment for substance abuse (and co-occurring disorders) are mixed and not definitive (cf. Brunette et al., 2004)
- For example, one review (Finney et al., 2006) found that, out of 14 studies of inpatient vs. outpatient alcohol treatment:
  - Five found residential treatment to be more effective
  - Two found day treatment to be more effective
  - Seven found no difference

Residential Treatment May Not Be the Answer

- Residential treatment is far more expensive
- Longer programs are not better
  - A study of 28 residential treatment programs for substance abuse (Harris et al., 2011) found that participants in programs with ALOS 15-30 days and 31-45 days showed significantly *greater* decreases in alcohol use than participants in programs with ALOS > 90 days
  - Moreover, the shorter programs also had participants who started with more severe alcohol abuse
  - There were no differences in drug abuse between longer and shorter programs

Factors to Consider When Referring to Residential vs. Outpatient Programs

- Has Intensive Outpatient Programming been tried?
  - If not, try IOP first
- What outcome research proves the effectiveness of the program?
  - The research must include follow-up data
    - Otherwise residential programming will show abstinence at discharge
    - That is not an indication of effectiveness: it's just a result of containment
  - The true measure of effectiveness is whether abstinence lasts *past* discharge
    - Require a minimum of 6 month follow-up data
- How intensive is Intensive Outpatient Programming?
  - At least 9 hours per week are needed

Factors to Consider When Referring to Residential vs. Outpatient Programs

- Is the defendant able to quit without being removed from their environment?
  - If not, then consider residential treatment
  - But then the defendant must move to another environment after discharge
- Does the defendant have already existing supports in the community?
  - If so, IOP may be more effective
- Does the residential program have community reintegration programming?
  - If not, it may not be effective

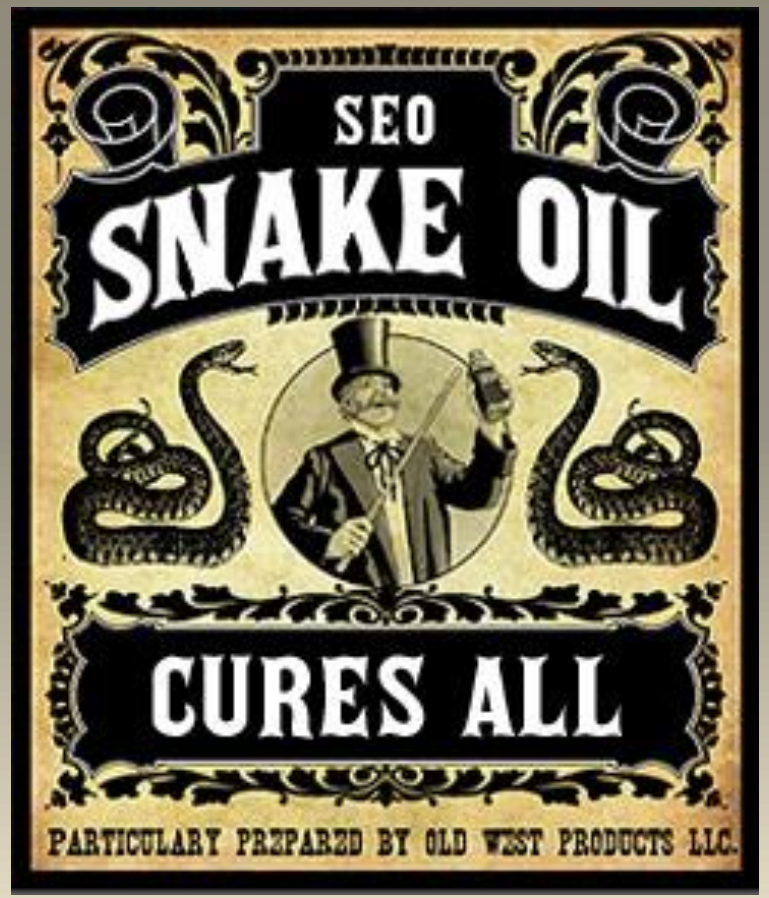
Factors to Consider When Referring to Residential vs. Outpatient Programs

- Do they use evidence-based treatments?
  - Find out which ones, and what is the evidence for them?
- Do they have dual diagnosis programming, and is it evidence-based?
  - If not, that increases the risk of relapse
- Is job skills training part of the program?
  - If not, then success is less likely
- Are homeless services part of the program?
  - If not, then success is less likely

Mistake #7

Not ordering evidence-based treatments and verifying that clients are receiving them

Beware of Snake Oil



- There is a large gap between what we know works in substance abuse treatment and what is practiced in the field (Miller et al., 2006)
- Many commonly used treatments have not been subjected to much research
- Be careful about the power of testimonial

Use What Has Been Proven to Work

In a famous study, Miller and Wilbourne (*Addiction,* 2002) compared the evidence of 361 controlled studies of treatments for Alcohol Use Disorders:

Least Effective

- Educational lectures, films, groups
- General alcohol counseling
- Psychotherapy
- Confrontational counseling
- Relaxation training
- Standard treatment
- Video self-confrontation
- Alcoholics Anonymous
- Milieu therapy
- Antidepressant, non-SSRI
- Metronidazole (anti-bacterial medication)

Most Effective

- Brief intervention
- Motivational Enhancement
- GABA agonist (sedatives, anxiolytics)
- Opiate agonist (Naltrexone, Naloxone)
- Social skills training
- Community reinforcement
- Behavior contracting
- Behavioral marital therapy
- Case management
- Self monitoring
- Cognitive therapy

Trust, but Verify

- How do you know when a program is using the treatment it says it is?
- Verify
  - Have the program show you the materials they are using and the studies behind them
  - If there is a manual, ask both the therapist and the client what lesson/skills they are working on

Mistake #8

Not paying attention to pain

Chronic Pain and Substance Abuse

- Pain is often used as a justification for substance abuse (Jarcho et al., 2012; Joy et al., 1999)
- Patients in substance abuse treatment show higher levels of pain than the general population (Sheu et al., 2008; Mertens et al., 2003)
- Patients in pain treatment have higher levels of substance abuse than the general population (Atkinson et al, 1991)
- Among methadone maintenance patients, 61-80% have moderate to severe pain (Barry et al., 2009; Jamison, 2000; Rosenblum et al., 2003)

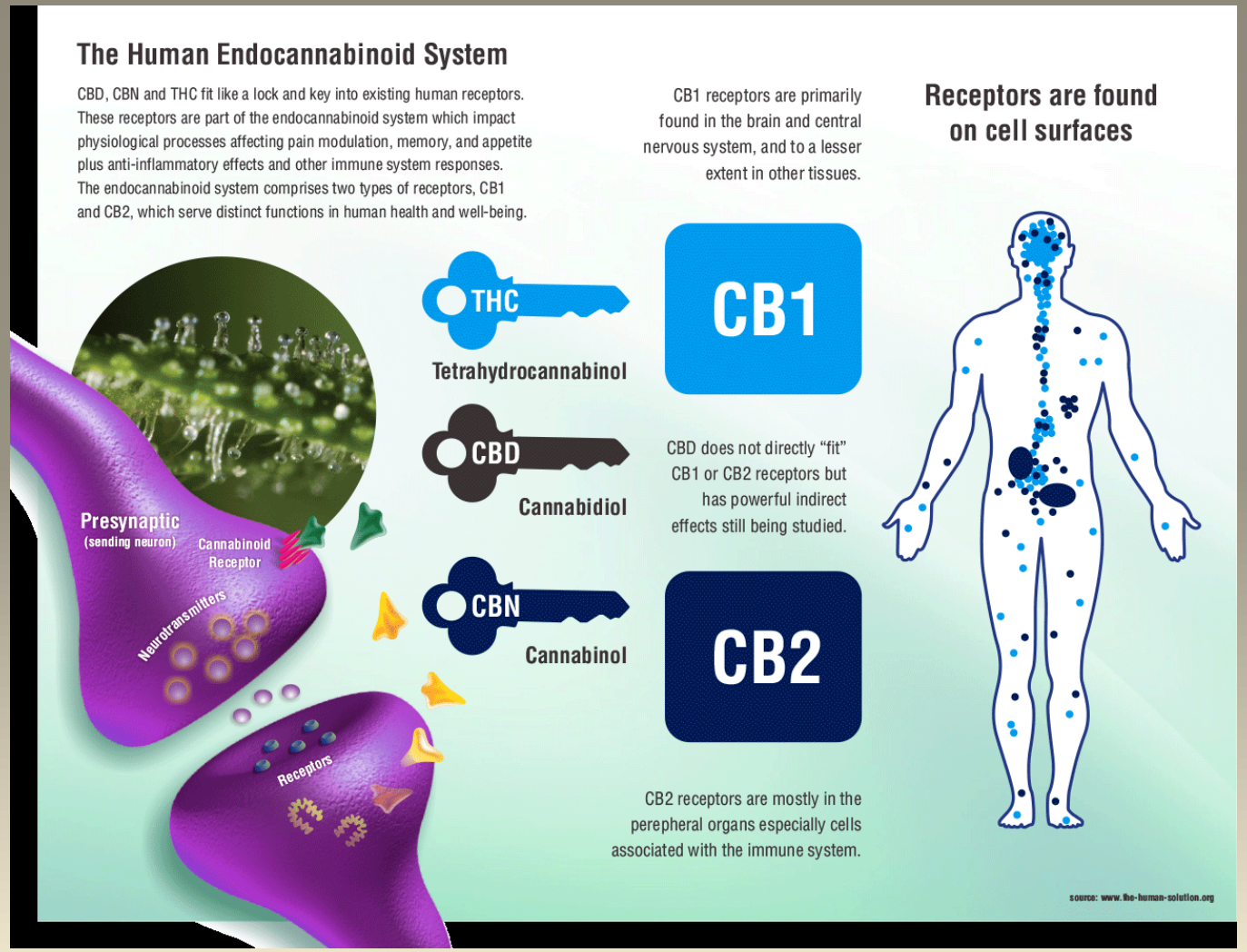
Alcohol and Pain

- 73% of patients seeking substance abuse treatment who identify alcohol as their drug of choice report moderate to severe pain (Larson et al., 2007)
- 43% of older problem drinkers report moderate to severe pain in the past month, compared to 30% of non-problem drinkers (Brennan et al., 2005)
- 25% of treatment-seeking pain patients report heavy drinking (Kim et al., 2013; Lawton & Simpson, 2009)
- Men endorse drinking to cope with pain (Brennan et al., 2005: Riley et al., 2002)
- Excessive drinking predicts chronic pain severity (Castillo et al., 2006)

Chronic Pain and Opioid Abuse

- From 1999-2011, consumption of hydrocodone more that doubled and consumption of oxycodone increased nearly 500% (Jones et al., 2014)
- By 2010, enough opioid pain relievers were sold to medicate every adult in the US with the equivalent of 5 mg. of Hydrocodone every 4 hours for a month
- 4/5 of current heroin abusers report that their abuse began with opioid pain relievers (Muhuri et al, 2013)

Chronic Pain and Cannabis



- The endocannabinoid system modulates pain in the body (Guindon & Hohman, 2009)
- Therefore, cannabis use may decrease pain

What Can Courts Do?

- Pain must be assessed during clinical intakes
  - Type, location, intensity, frequency, chronicity, functional impact
- Refer to non-drug pain treatment
  - Medical options (surgery, TENS units, blocking or burning nerves, etc.)
  - Topical medications (Lidocaine, analgesic creams, Capsaicin, etc.)
  - Physical therapies (PT, OT, hydrotherapy, heat, cold, massage, etc.)
  - Integrative health approaches (acupuncture, yoga, Mindfulness Meditation, etc.)
  - Psychological therapies (CBT for Pain, Mindfulness-Based Stress Reduction, etc.)

Mistake #9

Not paying attention to insomnia

Substance Abuse and Insomnia

- Substance Abuse can create sleep disorders
  - Every stimulant abuse worsens insomnia: cocaine, caffeine, nicotine, ADHD medications, etc.
  - 28% of people with insomnia use alcohol to sleep
    - Drinking results in waking up 2½ - 3 hours later to urinate
    - Alcohol disrupts the sequence and duration of sleep states
    - Alcohol consumed within 1-6 hours of bedtime disrupts the 2nd half of sleep (NIH, 1998)
    - Drinking results in a decrease in total sleep time

Substance Abuse and Insomnia

- Opioids cause both sedation and wakefulness (De Andres & Caballero, 1989)
  - Veterans with chronic pain who were prescribed opioids are more likely to report sleep disruption than those who did not take opioids (Morasco et al., 2014)
  - Heroin causes alternation between oversleeping due to sedation and severe sleeplessness
    - It also results in poor sleep quality
- Marijuana decreases slow wave sleep and REM sleep
  - It also decreases sleep quality

High Co-Morbidity of Insomnia

- Insomnia is one of 20 characteristics of PTSD
  - It frequently continues even after PTSD is successfully treated
- Insomnia has a bidirectional relationship with depression
  - 85% of depressed people have insomnia
- Pain is the #1 medical cause of insomnia
  - Of those with chronic pain, 65% have insomnia
  - People with insomnia have higher pain sensitivity (Sivertsen et al., 2015)

What Can Courts Do?

- Insomnia must be assessed during clinical intakes
  - Type, onset, duration, functional impact
  - Check for sleep apnea
    - 50% of Veterans with PTSD have sleep apnea
    - Many people with chronic pain who take opioids also have sleep apnea
- Refer to insomnia treatment
  - Avoid sedative and hypnotic medications, as they are addictive
  - Use non-addictive medications like Trazodone and Remeron
  - Refer to Cognitive Behavioral Therapy for Insomnia

CBT-I for Insomnia

- Cognitive-Behavioral Therapy for Insomnia (Perlis et al., 2008)
  - 6 session treatment
  - Psychoeducation about sleep and what interferes with it
  - Sleep restriction
  - Stress management
  - Cognitive restructuring
  - Relapse prevention

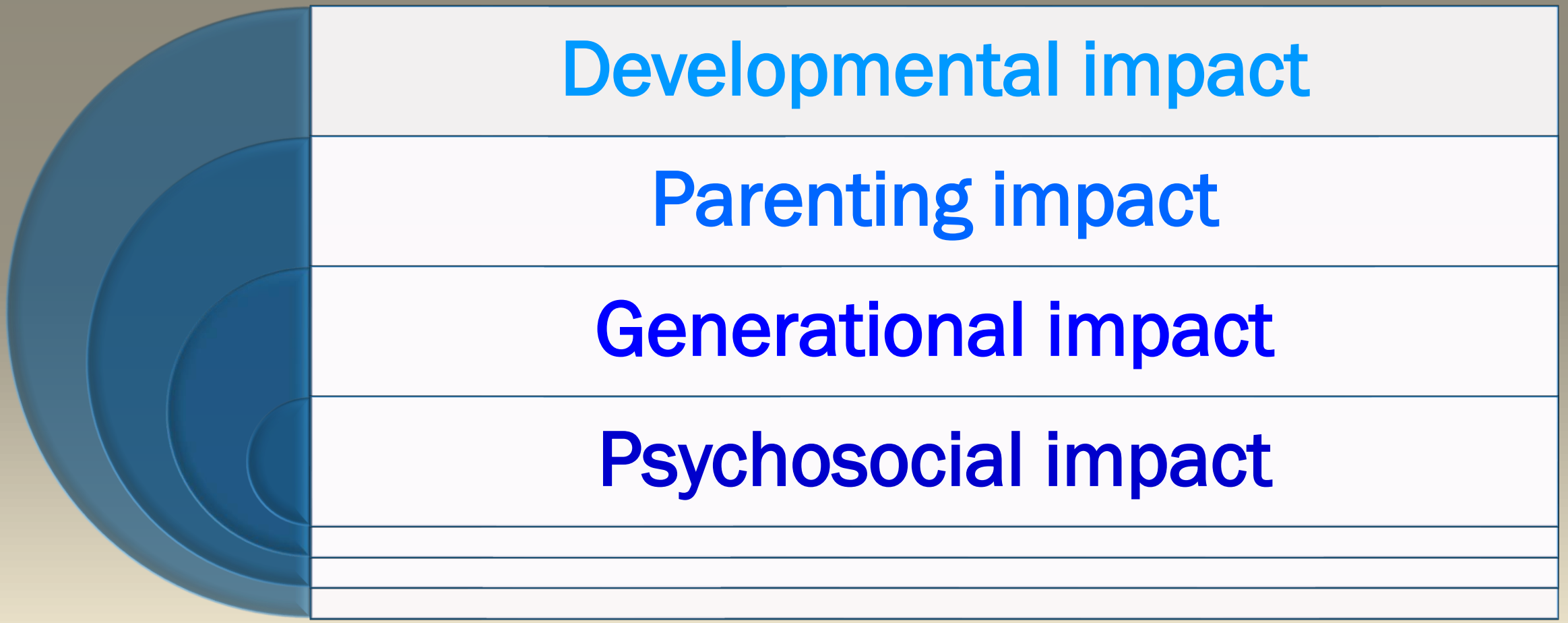
Mistake #10

Leaving out families

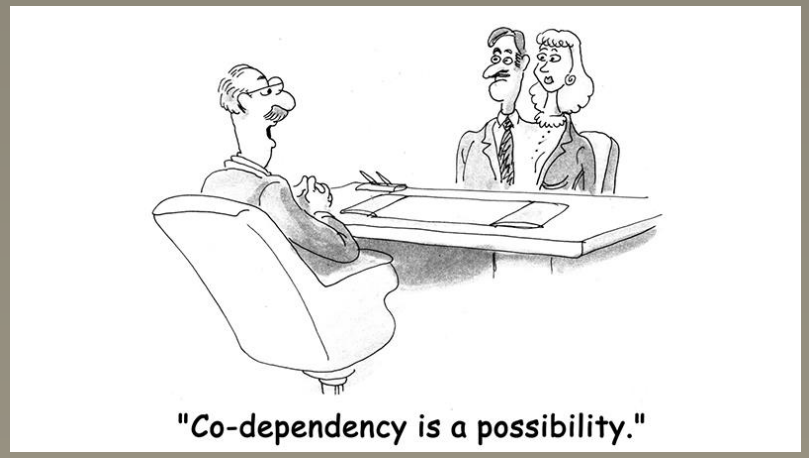
Families and Drug Courts

- No one recovers alone
- Recovery occurs in the context of families
- 60-75% of adult court participants have at least one minor child
- Courts hold parents responsible for their parenting
  - Parenting classes improve Drug Court outcomes
  - Drug courts providing parenting classes show a 65% reduction in recidivism and 52% greater cost savings compared to those without (Carey et al., 2012)

Addiction Is a Family Disease



Families Affect Substance Abuse in Many Ways



- Family members may be models
- Family stress contributes to substance abuse
  - Children, too!
- Spouses/partners may also abuse substances
- Spouses/partners may be enabling and co-dependent
- Families are often the greatest source of supports for the substance abuser
- Therefore, family involvement can be critical to ensure the lasting success of abstinence and treatment
  - It can also be preventative for children

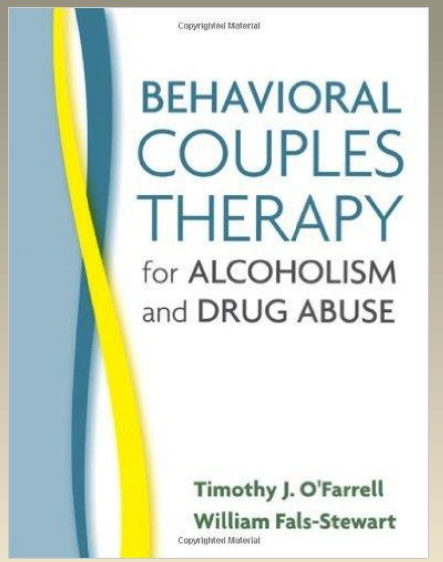
How to Involve Families

- Make ways for team members to talk with family members
- Ask family members to provide history
- Assess family functioning
- Conduct home visits
- Involve family members in treatment
- Develop a coordinated, cross-system approach to address needs of parents and youth

Behavioral Couples Therapy for Alcoholism and Drug Abuse

- 12-20 joint couples sessions
- Uses a Recovery Contract that involves both members of the couple in a daily ritual to reward abstinence
- Improves the relationship by
  - Increasing positive activities (catch your partner doing something nice, etc.)
  - Teaching communication skills (listening skills, negotiating, etc.)
- Compared to individual treatment, BCT:
  - Produces greater abstinence
  - Improves relationship functioning
  - Decreases domestic violence
  - Decreases problems of the couple's children

O'Farrell & Fals-Stewart, 2006



Mistake #11

Not using trained mentors

Most Courts Do Not Use Trained Mentors

- Veterans Treatment Courts do
- AA and NA models use Sponsors
- The Behavioral Health treatment world is now using certified Peer Support Specialists
  - This includes the Veterans Health Administration
- People who have been through it make good
  - Role models
  - Listeners
  - Teachers

Courts Need Their Own Trained Mentors

- 36 states now have training programs for Peer Support Specialists
- NAMI also has a Peer-To-Peer training program
- Peer Support Specialists:
  - Are available
  - Help develop a Personal Recovery Plan
    - This is a life plan that may include substance abuse treatment, stable housing, vocational skill development, education goals, health care, and well-being
  - Teach new skills
  - Help monitor progress
  - Model effective coping techniques
  - Support self-advocacy

Mistake #12

Using derogatory language

Problems in Commonly Used Language

- Language can be definitional
  - For example, “addict” means you are defined by your addiction
- Language can create stigma
  - For example, “dirty urine” means you are a dirty person
- Language can create a life sentence
  - For example, “personality disorder” means a permanent condition
- Language can create false causes
  - For example, “You could stop if you wanted to.”
  - This example also makes a brain disease into a moral failing
- Language can be shaming
  - For example, “You are a drunk.”

Changing Your Language

Harmful	Helpful
• "Defendant"	• Use their name
• "Addict"	• Person with an addiction
• "Your urine drug screen was dirty."	• "Your urine showed the presence of drugs."
• "Your urine drug screen was clean."	• "Your urine did not show the presence of drugs."
• "You could stop drinking if you wanted to."	• "We want to help you obtain safety, stability, and support so that you can succeed."

Changing Your Language

Harmful	Helpful
• “You are a drunk.”	• “You were intoxicated.”
• “You have a Borderline Personality Disorder.”	• “You have frequent difficulty regulating your emotions.”
• “You should know better.”	• “These are our expectations.”
• “You violated your contract.”	• “You did not meet the terms of your contract.”
• “Compliance/noncompliance”	• “Adherence/nonadherence”

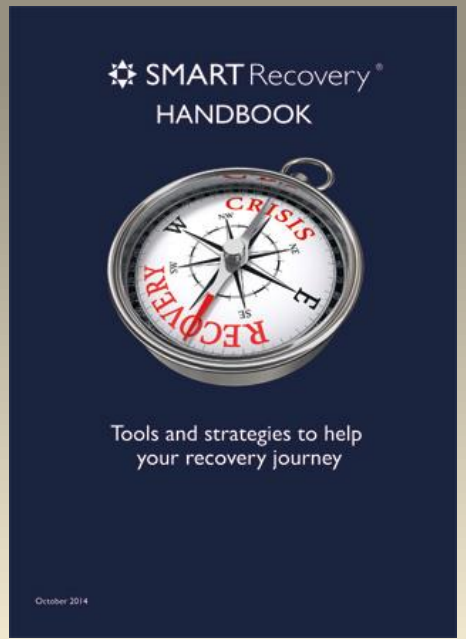
References

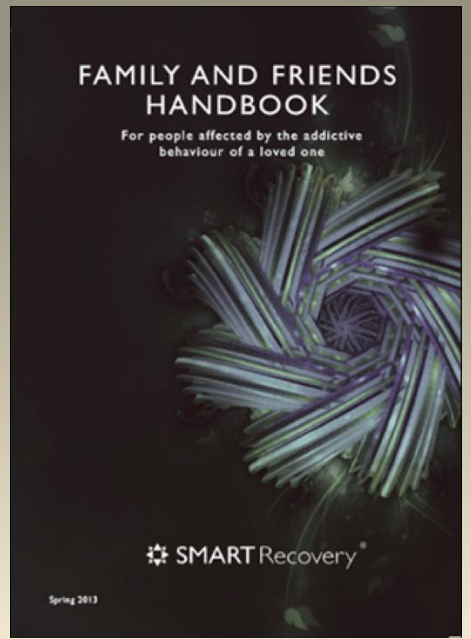
Trauma Competent Courts

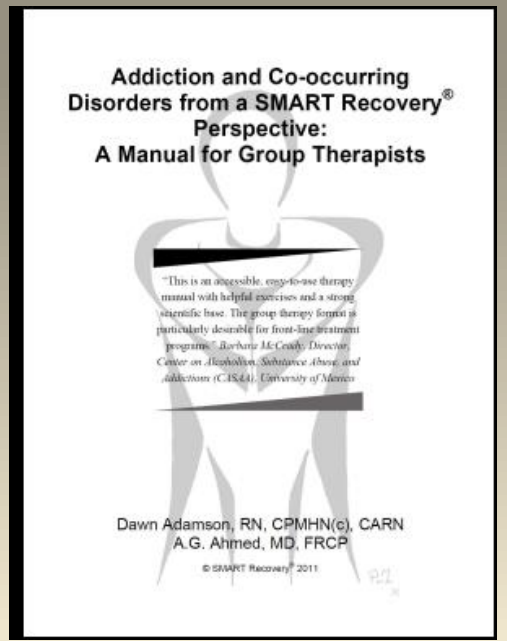
- *Essential Components of Trauma-Informed Judicial Practice,* SAMHSA. Retrieved from http://www.nasmhpd.org/sites/default/files/JudgesEssential_5%201%202013finaldraft.pdf
- Also valuable: *TIP 57: Trauma-Informed Care in Behavioral Health Services,* SAMHSA, available at www.store.samhsa.gov.

SMART Recovery

- www.smartrecovery.org
- http://smartrecoverytraining.org/moodle/
- http://www.smartrecovery.org/community/#.Vims8GtRI2Y







SMART Recovery App

Seeking Safety

- *Seeking Safety* (2002), Lisa Najavits
- *8 Keys to Trauma and Addiction Recovery* (2015), Lisa Najavits
- http://www.treatment-innovations.org/seeking-safety.html

Cognitive-Behavioral Therapy for Pain

- *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach Therapist Guide* by John Otis
- *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach Workbook* by John Otis

Cognitive-Behavioral Therapy for Insomnia

- *Cognitive Behavioral Treatment of Insomnia: A Session-by-Session Guide* (2008), by Michael L. Perlis, Carla Jungquist, Michael Smith, and Donn Posner
- *Overcoming Insomnia: A Cognitive-Behavioral Therapy Approach Workbook* (2008), by Jack Edinger and Colleen Carney

Family Involvement

- *Behavioral Couples Therapy for Alcoholism and Drug Abuse*, by Timothy O'Farrell and William Fals-Stewart
- Children and Family Futures www.cffutures.org
- National Center on Substance Abuse and Child Welfare www.ncsacw.samhsa.gov

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