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JUDICIAL EDUCATION ON SUBSTANCE ABUSE: PROMOTING AND EXPANDING JUDICIAL AWARENESS AND LEADERSHIP

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FACULTY GUIDE

A project of the American Judges Association and the National Center for State Courts with funding from the State Justice Institute

This curriculum was developed by the National Center for State Courts under a grant from the State Justice Institute (SJI-01-N-210). The points of view expressed do not necessarily represent the official position or policies of the National Center for State Courts, the American Judges Association, or the State Justice Institute.

Acknowledgments

The National Center for State Courts staff wishes to express our appreciation for the many individuals and organizations that helped to bring together this curriculum.

The curriculum would not have come to fruition without the leadership of Judge Terry Eliot and the other members of the American Judges Association Committee on Substance Abuse.

Thank you to the Advisory Committee members for their invaluable expertise and assistance in developing the curriculum. We especially want to thank the committee chair, Judge Bill Schma, for his able direction and inspiration for this effort and committee member Kevin Bowling for his help in crafting the initial curriculum outline and materials.

We sincerely enjoyed having the opportunity to work collaboratively with a number of other organizations that willingly gave their support and time to assist in this effort:

American Probation and Parole Association
Conference of Chief Justices
Conference of State Court Administrators
National Association for Court Management
National Association of Drug Court Professionals
National Association of State Judicial Educators
National Council of Juvenile and Family Court Judges
National Judicial College

Special thanks to the National Association of Drug Court Professionals, the National Council of Juvenile and Family Court Judges and the National Judicial College for contributing materials from their courses to integrate into the curricular materials. In addition, we are appreciative of our contributing substance abuse treatment provider - Bacon Street in Williamsburg, Virginia - for providing their advice and expertise in the field throughout the development of the curriculum.

We also would like to express appreciation to our excellent faculty who presented at the two pilots of the curriculum. Special thanks to Judge Peggy Hora and Judge Karen Freeman-Wilson for the expertise they offered us in refining the curriculum. We are indebted to the treatment experts, Dr. Peter Banys and Stephen Hanson, who provided vast assistance in the development of the materials for Module 2.

Thanks, as well, to our pilot hosts (including the American Judges Association (AJA) and the State of Delaware) and participants (including AJA members and the judges of Delaware) for providing us the opportunity to present the curriculum to you and providing valuable feedback to help us improve our product.

Last, but not least, thank you to Sandra Thurston, Kathy Schwartz, David Tevelin and the State Justice Institute not only for providing the monetary resources to develop the curriculum, but also for providing great guidance and support throughout the process.

Judicial Education on Substance Abuse: Promoting and Expanding Judicial Awareness and Leadership

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JUDICIAL EDUCATION ON SUBSTANCE ABUSE: PROMOTING AND EXPANDING JUDICIAL AWARENESS AND LEADERSHIP

FACULTY GUIDE

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BACKGROUND INFORMATION

About the Project

Courts often become society's first opportunity to identify individuals with substance abuse problems. Every day judges and their staff are confronted by the problems of alcohol and other drug abuse in a variety of cases that appear in our nation's courtrooms. Courts are in a unique position to link these individuals to treatment programs and local drug treatment courts, where available and appropriate. In so doing, courts can contribute to the reduction in demand and use of drugs and help ensure the public's safety. The costs to society in terms of health, safety, and social and economic impact demand full court involvement to identify, confront, and address the abuse of alcohol and other drugs by defendants and other litigants.

In 2001, the National Center for State Courts (NCSC) received funding from the State Justice Institute (SJI), on behalf of the American Judges Association (AJA), to develop, demonstrate, and disseminate an educational curriculum on substance abuse for judges. On behalf of the AJA, the National Center developed a curriculum that is adaptable for various educational contexts at the national, state and local levels and appropriate for judges who deal with substance abuse issues in all types of cases. Through the project, the AJA sought to initiate a strategy to disseminate knowledge and expertise gathered in various disciplines to the judicial community. AJA hopes the curriculum will encourage judges in all types of courts to share current information and work with experts in other disciplines to develop new systemic approaches to address this large and challenging court population.

An advisory committee comprised of representatives from AJA, as the lead organization, and other national organizations (see below) convened twice to assist NCSC staff in curriculum design and provide on-going feedback on the curriculum to ensure it met the needs of the judiciary and judicial educators.

Participating Organizations

American Probation and Parole Association
Conference of Chief Justices
Conference of State Court Administrators
National Association for Court Management
National Association of Drug Court Professionals
National Association of State Judicial Educators
National Council of Juvenile and Family Court Judges
National Judicial College

Additionally, input from addiction treatment specialists was sought to ensure the accuracy and timeliness of information on aspects including pharmacology and treatment modalities. Two pilots of the curriculum with judicial audiences were conducted in the fall of 2002.

We acknowledge that several excellent judicial education curricula exist, dealing with a variety of substance abuse issues, most notably the curricula of the National Judicial College, the National Council of Juvenile and Family Court Judges and the National Drug Court Institute. The intent of this project is not to replace those curricula, but to bring their content to a wider audience of judges and courts.

NOTES TO THE TRAINER

Curriculum Objectives

The objectives of the curriculum are to:

- Generate an awareness of substance abuse issues arising in a variety of cases that appear in the courts
- Identify how the judicial role places judges in a unique position to respond both to the litigants and the community as they struggle with substance abuse issues
- Provide a basic understanding of the nature of substance abuse, addiction and recovery, and treatment modalities
- Assist the judge with the development of strategies and tools for responding (when in the courtroom) to parties with substance abuse problems
- Encourage judges to initiate and engage in an on-going dialogue, with other judges, lawyers, and interested community leaders, regarding the evolving role of the judge in substance abuse issues and problem-solving approaches generally

General Assumptions

Although quantitative and qualitative research has demonstrated the beneficial aspects of therapeutic drug courts and other problem-solving courts, the goal of this program is not to create additional drug courts or problem-solving courts.

The program is intended as a primer on a subject that, hopefully, will encourage judges to seek additional information and instruction on substance abuse and judicial roles.

Overview of Curriculum Components

- Substance Abuse Awareness (approximately 20 minutes) – This module raises awareness regarding the nature, prevalence, and cost of substance abuse and how the judicial role places judges in a position to respond to substance abuse issues to benefit the litigants, the community and the court.

- The Nature of Addiction, Basic Pharmacology and Recovery (approximately 1 hour, 15 minutes) – This module is intended to provide participants with a basic overview of the key concepts of substance abuse and addiction, as well as components of successful recovery and treatment delivery programs.

- Strategies and Tools for the Courtroom (approximately 1 hour, 10 minutes) – This module is designed to assist judges to apply substance abuse and addiction information in their work on the bench.

General Guidelines for Using the Curriculum

Audience

The curriculum is meant to serve as an introductory session for judges who handle all case types. It explores the nature of alcohol and other drug abuse as well as the dynamics of recovery in the court context. We strongly urge that training facilitators conduct a learning needs assessment to determine the general level of knowledge of the prospective participants prior to presenting the curriculum. This information will be critical to faculty in adapting and focusing their presentation of the material.

Venue

The curriculum will be appropriately delivered at state or local judicial conferences. Portions of the curriculum may also be adapted for national judicial conferences or for presentation to other audiences (for instance, Module 1 could be adapted for legislators).

Length

The curriculum, as presented, includes approximately three hours of material (with one 10- to 15-minute break). A preliminary needs assessment conducted among selected state judicial educators, judges, and potential pilot test sites indicated that a half-day (three-hour) presentation would likely be necessary at the outset before it would be possible to obtain a commitment for a full two-day seminar.

The curriculum is comprised of three modules that are purposely designed to be somewhat "elastic" to accommodate user needs. Thus, the curriculum can easily be expanded to a longer program. The three modules are intended to be used in conjunction with each other and will likely have some overlap in presentation (especially depending upon whether the presentation is presented as a half-day, one-day, or two-day program).

Faculty/Presenters

The curriculum is designed for presentation by two knowledgeable experts – a judicial officer and an addiction/treatment specialist (either a doctor or addiction counselor). We encourage training facilitators to select presenters with a strong working knowledge of the covered topics so that they can add their own ideas and experiences to the material. Past experience with facilitation and presentation also will be valuable.

Materials

The content provided in this Faculty Guide is intended as a framework for presenting this material to a judicial audience. The content includes the information considered most important (given a relatively short presentation length) by a group of knowledgeable practitioners (including judges, court administrators, treatment providers, and judicial educators). We encourage you to consider some augmentation to add content specific to your local laws and practices to increase the relevance of this material for specific audiences.

In addition, each participant should receive a notebook of training resources (see Participant Materials section of the curriculum). The amount of resources was kept purposefully small, but once again, augmentation with other resources may be considered. Relevant handouts for participant exercises are included with the content for the respective modules and are referenced in the Faculty Notes.

NOTE: For your convenience, the full Faculty Guide and most Participant Materials have also been provided on the accompanying CD in Adobe Acrobat Reader and/or Microsoft Word document format. If you wish to access the PDF (Acrobat) documents but do not have Adobe Acrobat Readers installed on your computer, a free download of the software is available at http://www.adobe.com/products/acrobat/readstep2.html.

Equipment Needs/Technology Requirements

The presentation slides were developed using PowerPoint (Microsoft Office 2000). The PowerPoint files are included (in the PowerPoint directory) with the curriculum materials on the accompanying CD. The presenter will need access to a laptop with Microsoft PowerPoint (or if PowerPoint is not installed, a PowerPoint Viewer should be installed for viewing PowerPoint presentations), an LCD projector and a screen (large enough for the audience to see clearly).

NOTE: For your convenience, an executable file - PPView.exe – is also included in the PowerPoint directory on the accompanying CD should you need access to a PowerPoint Viewer. Installation directions can be found at the end of the Faculty Guide.

For those who do not have access to an LCD projector, copies of the overhead slides are available for loan from the National Center for State Courts' Library by calling Circulation at 1-800-616-6164.

Due to the colorful nature of the slides, if changes are made and new copies of the slides are printed as handouts, we recommend that you print in "pure black and white" format (a print option for PowerPoint) to ensure clear copies.

Evaluation

Evaluation is an important component of any educational presentation. A sample evaluation form (adapted from the form used by the project staff for the pilot presentations of the curriculum) is included at the end of the introduction. The evaluation form is included for your personal use in obtaining audience assessment of the presentation of this curriculum.

Feedback

Additionally, your feedback regarding your use and presentation of this curriculum is vital to our ongoing efforts to produce quality materials and curriculum appropriate to the issues and audiences in the judicial context. Please complete the enclosed Feedback Form (provided on the CD and at the end of the Faculty Guide) and return to the National Center for State Courts at your earliest convenience. Your input will be utilized to make our efforts more dynamic in the development and refinement of further curriculum, supporting research and materials.

Sample Evaluation Form

Judicial Education on Substance Abuse: Promoting and Expanding Judicial Awareness and Leadership

EVALUATION FORM

INSTRUCTIONS: ***Please complete this form and return it before leaving.*** Your feedback and comments about the content and structure of this educational curriculum will be useful for future trainings. Please be candid; written comments are particularly helpful. Where choices are given, circle the category that best describes your response.

Overall, how would you rate today's program?

1	2	3	4	5
Poor	Fair	Average	Good	Excellent

Did the program meet your expectations?

1	2	3	4	5
Not at all	A Little	Somewhat	Met expectations	Exceeded

How would you rate the overall usefulness of the content of the following segments of the program:

	Not helpful		Somewhat helpful		Very helpful
Module 1: Substance Abuse Awareness					
Content	1	2	3	4	5
Presenter(s)	1	2	3	4	5
Module 2: Addiction 101 – Basic Pharmacology and Recovery					
Content	1	2	3	4	5
Presenter(s)	1	2	3	4	5
Module 3: Strategies for the Courtroom					
Content	1	2	3	4	5
Presenter(s)	1	2	3	4	5

Was the format used for the program the best way to deliver the information and engage participants in the material?

1	2	3	4	5
needed more interaction & discussion		good balance		needed more educational presentation

Which content was most useful for you?

Which content was least useful for you?

How useful did you find the materials in the curriculum support packet?

1	2	3	4	5
Not helpful		Somewhat Helpful		Very Helpful

What other materials would have been helpful to include?

What did you like most about this educational curriculum?

What suggestions can you make for improvements to the content or structure of the curriculum?

How would you categorize your knowledge of substance abuse issues prior to attending today's program?

1	2	3	4	5
No Knowledge	Minimal	Some	Moderate	High

To what extent will you be able to apply what you learned to your work?

1	2	3	4	5
Not at all	A little	Some	Regularly	Extensively

If you feel you will apply what you learned, please provide specific example(s):

Do you feel that a program like this one would be helpful to other judges?
Yes _____ No _____ Why?

Please provide below information regarding your current judicial assignment:

We value your comments and thank you for your cooperation in providing feedback about this educational session.

1

Module 1
Substance Abuse Awareness

Presenter: Judicial officer (with substantial experience in handling substance abuse cases and a working knowledge of substance abuse pharmacological and treatment issues).

Length: The timing for this introductory module will vary from 20 minutes to 1 hour depending upon considerations such as the experience of participants and overall length of the program. The times listed in the faculty notes are based on a 20-minute presentation.

Purpose: This module is intended to raise awareness regarding the nature, prevalence, and cost of substance abuse and how the judicial role places judges in a position to respond to substance abuse issues to benefit the litigants, the community and the court.

Objectives

After completing this module, participants will:

- Recognize the challenges substance abuse brings to litigants' lives and understand the significance of accountability
- Identify the economic impact of substance abuse
- Describe why the judicial role is unique in addressing substance abuse and is indeed part of an effective solution

Instructional methods

Lecture with PowerPoint slides
Individual/small group activities
Facilitated discussion

Participant Handouts

Curriculum and Module 1 Objectives
Module 1 PowerPoint Slides

Faculty Notes

The material presented in this module is intended to provide an overview of the problem of substance abuse. The slides include a significant number of statistics to provide evidence of the problem. **Please note that you are not expected to read every statistic** (this would become very boring and monotonous to the participants). We suggest, instead, that you focus on the high points, moving quickly through the materials and referring participants to the slides for further details.

We also encourage you to insert personal anecdotes from your experiences that will add interest to the material.

Depending on the level of experience of the audience, much of this information may not be new. The pre-training learning assessment will provide insights into the level of expertise of the participants. If the knowledge is high, this opening module can be framed as confirming what participants already know. If additional time is available, you could also pose questions to the audience about their experiences.

Additional Faculty Resource Materials

An excerpted version of the "Mechelle Letter" is provided to read during Slide 5 of Module 1. A full copy of the letter also is included in the faculty materials for reference.

You may also wish to refer to the judicial satisfaction data in the participant materials that shows that judges who are more engaged in these types of court approaches report higher levels of satisfaction with their positions.

In addition to national data on the costs of substance abuse presented in Slide 13, data on individual state spending on substance abuse also is available in: "Shoveling Up: The Impact of Substance Abuse on State Budgets," The National Center on Addiction and Substance Abuse at Columbia University, 2001. State-by-state tables are available at: http://www.casacolumbia.org/usr_doc/statebystate.html

Module 1:
PowerPoint Slides with Faculty Notes

Judicial Education on Substance Abuse

(TIMING: 2 minutes)

Introductions of Faculty

First – let me provide some background:

In 2001, the National Center for State Courts received funding from the State Justice Institute on behalf of the American Judges Association (AJA) to develop an educational curriculum on substance abuse for judges adaptable for various educational contexts at the national, state and local levels and appropriate for judges who deal with substance abuse issues in all types of cases. Various other national organizations also participated in the development of the curriculum. *(Refer to materials for a full list of participating organizations.)*

FACULTY NOTE: Time permitting, you can review specifically the purpose of the curriculum or do a more general overview. (See Faculty Guide for more information.)

The goal of this program is not specifically to create or advocate for more drug courts or other problem-solving courts. Rather, we assume that some methods used in the problem-solving court context can be incorporated within the dockets you hear from day to day. We only have a short time to touch on this material – but several other resources and education programs exist to provide more information – we hope you will want to follow up to learn more.

This curriculum was developed by the National Center for State Courts under a grant from the State Justice Institute (SJI-01-N-210). The points of view expressed do not necessarily represent the official position or policies of the National Center for State Courts, the American Judges Association, or the State Justice Institute.

Why is Substance Abuse Awareness Important to Me As a Judge?

Module 1

(Timing: 2 minutes)

Why is Substance Abuse Awareness Important to You as a Judge?

Courts often become society's first opportunity to identify individuals with substance abuse problems. Every day, judges and their staff are confronted by the problems of alcohol and other drug abuse in a variety of cases that appear in our nation's courtrooms. Courts are in a unique position to intervene in lives affected by substance abuse, and link these individuals to treatment programs, local drug treatment courts, and other support mechanisms where available and appropriate. In so doing, courts can contribute to the reduction in demand and use of drugs and help ensure the public's safety. The costs to society in terms of health, safety, and social and economic impact demand full court involvement to identify, confront, and address the abuse of alcohol and other drugs by defendants and other litigants.

FACULTY NOTE: To make this introduction (and the entire module) more interesting, immediate, and relevant, insert personal stories, examples and anecdotes that address the importance of this issue – how you have seen these cases manifest themselves in your experience.

"The Elephant in the Living Room...."

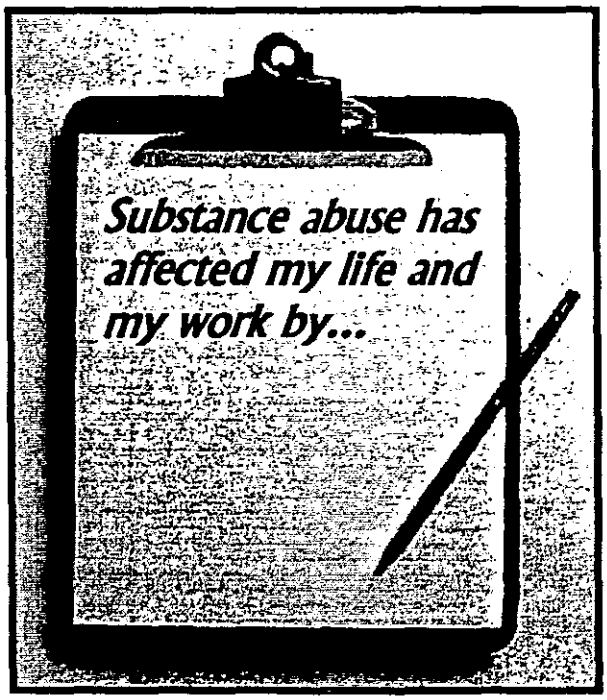
"Substance abuse and addiction is the elephant in the living room of society. Too many citizens deny or ignore its presence.
Abuse and addiction ... are implicated in virtually every domestic problem our nation faces: crime, health cripplers and killers, child abuse and neglect, domestic violence, teen pregnancy, chronic welfare, the rise in learning disabled and conduct disordered children..."

(Timing: 1 minute)

FACULTY NOTE: Read the above quote and add at the end...*"so it not only is the 'elephant in the living room,' but because it is implicated in every domestic problem our nation faces, it invariably becomes the 'ELEPHANT IN THE COURTROOM' too!"*

Source: "Shoveling Up: The Impact of Substance Abuse on State Budgets," The National Center on Addiction and Substance Abuse at Columbia University, 2001.

Take a minute and ask yourself...



(Timing 1 minute for reflection, 3 minutes for feedback)

SLIDE ANIMATION NOTE: Click mouse after slide loads to prompt the "Substance Abuse has..." statement to "write" on the notebook.

Before we get started discussing why you as a judge can develop strategies to more effectively address the substance-abusing population in your courts, take a moment to ask yourself how substance abuse has affected you, either in your personal life or in your work.

Exercise Directions: Faculty should prompt "brainstorming" by participants to list cases other than criminal cases where substance abuse is involved. In the discussion, be sure to mention different types of case contexts (other than just criminal) when a substance abuse issue may be involved, for instance, domestic violence cases, child dependency cases, juvenile delinquency, divorce, bankruptcy, landlord/tenant actions.

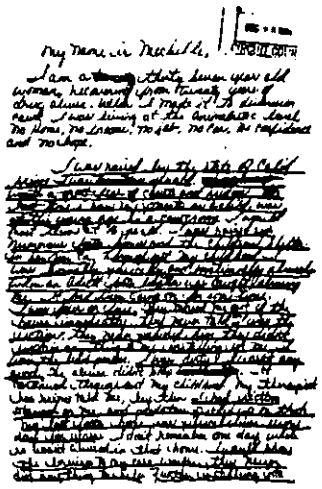
FACULTY NOTE: This exercise seeks to engage the participants in thinking about the impact of substance abuse and begin to dispel the belief that substance abuse issues are only really important to consider in a criminal context.

FACULTY NOTE: Depending on the time available, this exercise can be used in a number of ways – as part of introductions for smaller groups, for table discussions, or just personal reflections.

What it's like in her life, in her own words...

"My name is Mechelle,

I am a thirty seven year old woman, recovering from twenty years of drug abuse. When I made it to court, I was living at the animalistic level – no home, no income, no job, no car, no confidence and no hope...."



(Timing: 3 minutes)

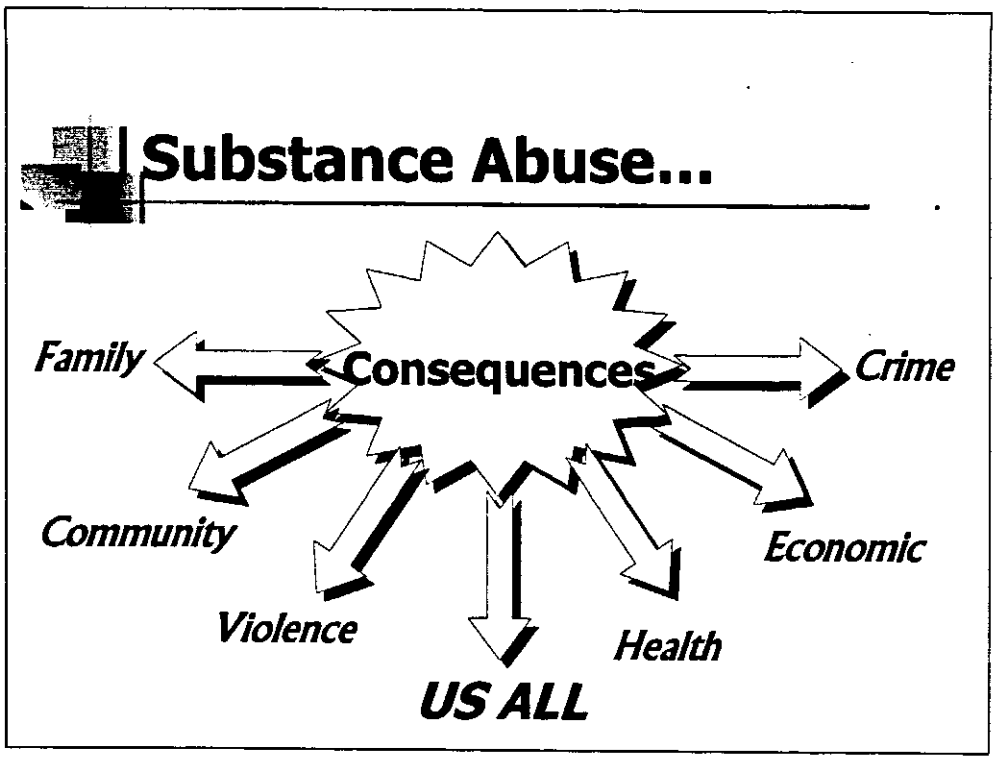
I want to share with you excerpts from an actual letter sent by a litigant regarding her experience with substance abuse and her involvement with the justice system:

EXERCISE: Read excerpts from Mechelle's letter included in Faculty Guide (Module 1 Faculty Resources).

FACULTY NOTE: This is not an exercise requiring class participation through speaking. We want head nods, other silent acknowledgment.

Mechelle's experience is similar to many cases you may have heard or will see and perhaps be able to intervene in. You can hear Mechelle's initial despair and, with greater awareness, understand and identify the factors that precipitated her addiction, and how her interactions with the judicial system had a profound effect on her ability to move toward recovery.

FACULTY NOTE: You can discuss the Module learning objectives, time permitting, or refer participants to materials.

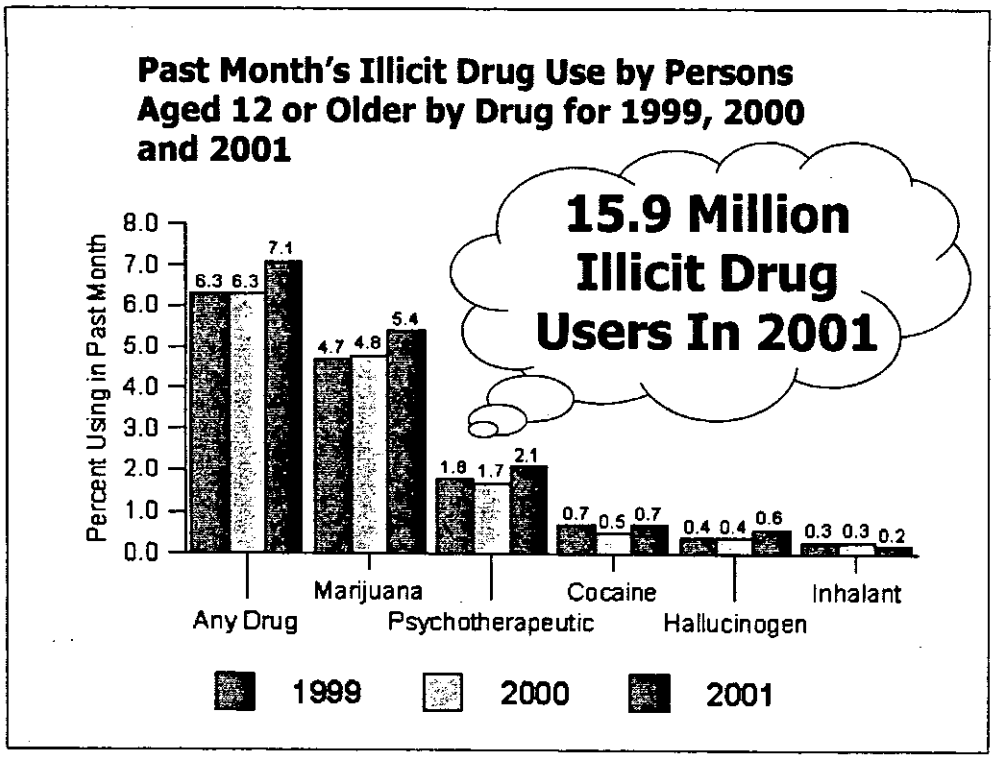


(Timing: 1 minute)

SLIDE ANIMATION NOTE: Once this slide is on screen, mouse click once; the slide will automatically display the various areas of consequences at one-second intervals and then delay by two seconds to end with emphasizing substance abuse consequences affect "us all."

As Mechelle relayed, and lived, so dramatically, substance abuse has incredible consequences – on our families, communities, the economy, heath care, crime and violence – for us all. We are all affected by this epidemic in one way or another.

Source: Graphic concept adapted from Office on National Drug Control Policy, "ONDCP Drug Facts February 2002" Presentation.



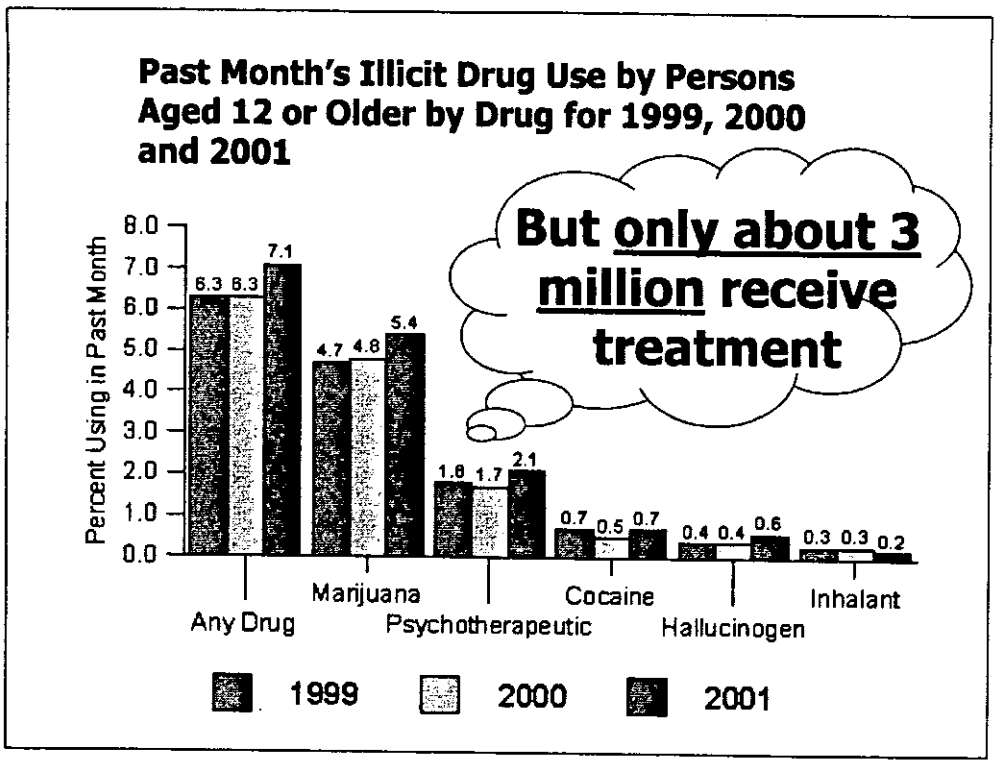
(Timing: 1 minute)

So what do we know about the scope and nature of the substance abuse problem in our country?

Data from the 2001 SAMHSA Household Survey on Drug Abuse indicates the number of users of any illicit drug reported by users in the past month (i.e., relative to the survey period) for 1999, 2000, 2001. In 2001, there were an estimated 15.9 million illicit drug users.

FACULTY NOTE: SAMHSA = Substance Abuse and Mental Health Services Administration

Source: SAMSHA report related graph:
http://www.samhsa.gov/oas/nhsda/2k1nhsda/vol1/CHAPTER2.HTM#fig2.1

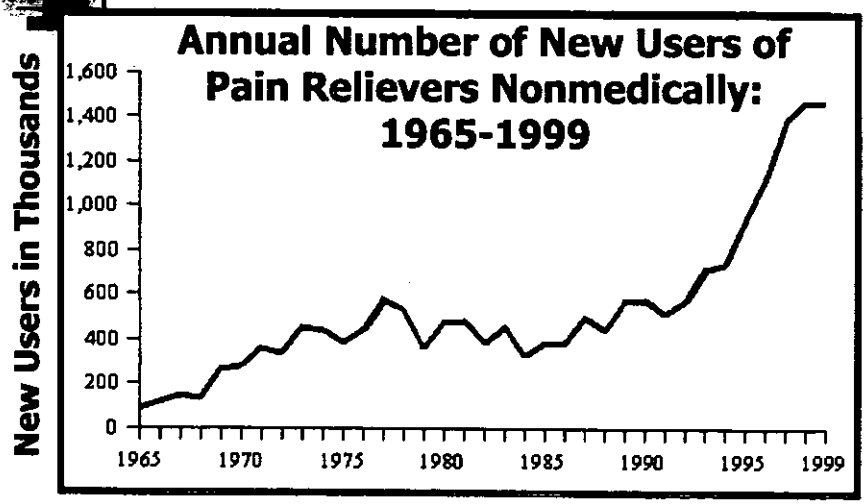


(Continues from Slide 7)

However, other survey findings show that only about 3 million people are currently receiving substance abuse treatment in a given month. As you can see, there is a HUGE gap between treatment needs and those receiving treatment.

FACULTY NOTE: Transition to next slide emphasizing that above numbers only reflect illicit drugs

But It's Not Just "Illegal" Drugs

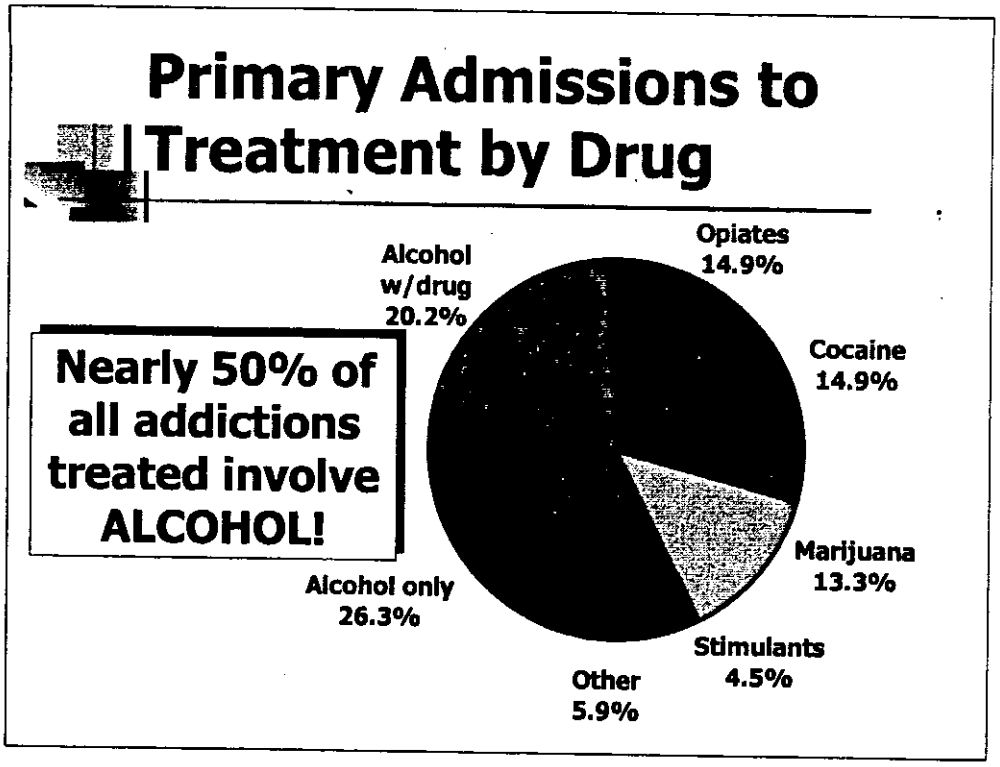


(Timing: .5 minute)

FACULTY NOTE: The data on this slide are intended to emphasize that we are not just referring to illegal drugs or alcohol abusers in this discussion – some substance abusers may be using prescription meds, for instance, and with increasing numbers.

But it's not just "illegal" drugs being "used" or for which treatment may be needed. This slide reflects data regarding the increased use/abuse of pain relievers for non-medical purposes.

Source: SAMHSA, National Household Survey on Drug Abuse, 2000.



(Timing: 1 minute)

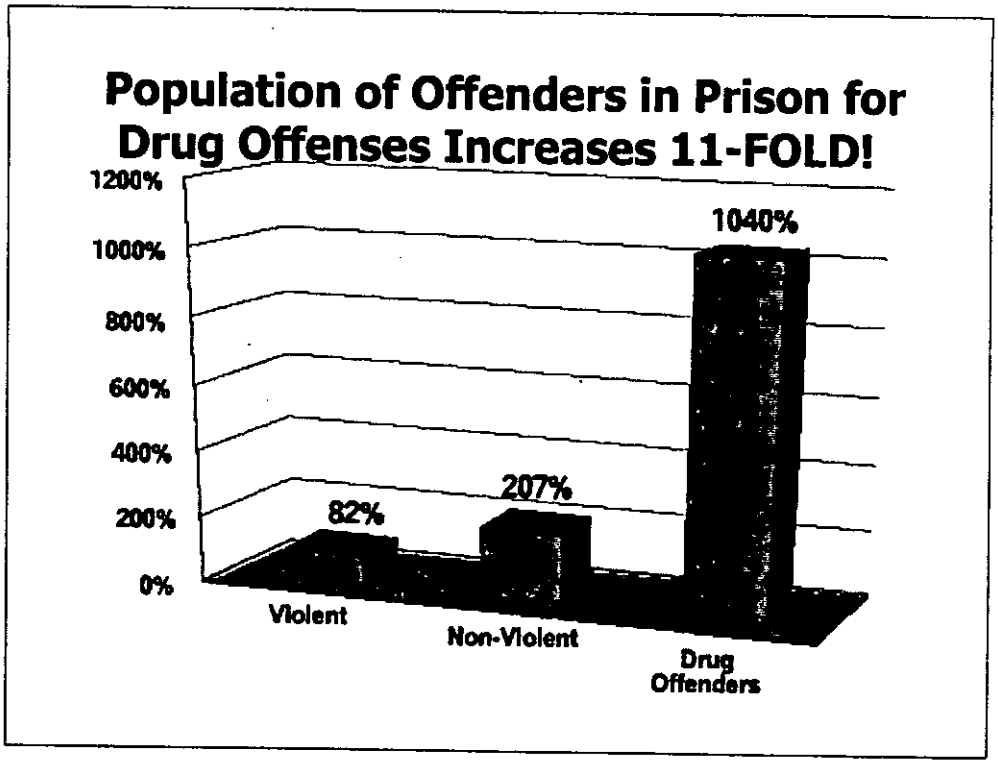
So then, exactly who is being treated and for what? This slide describes the prevalence of drugs used and treatment admissions by type of drug.

FACULTY NOTE: DO NOT read individual statistics – emphasize HIGH percentage of alcohol users. Overview other categories in general.

FACULTY NOTE: To emphasize the amount of alcohol consumed, you can provide this statistic: The top 20% of ALL alcohol consumers DRINK 89% of the ALCOHOL consumed and the TOP 5% CONSUME 42%!

Source: Greenfield, Tom, 60 *Journal of Alcohol Studies* 78 (1999)

Source for Slide: Office on National Drug Control Policy, "ONDCP Drug Facts February 2002" Presentation.

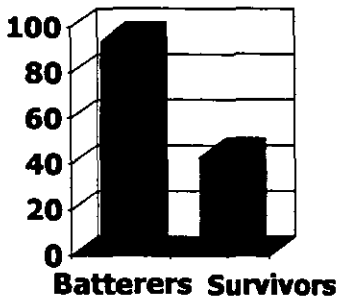


(Timing: .5 minutes)

As the use and dependency on drugs and alcohol increases and the treatment gap looms large, a huge and increasing number of people populating our nation's prisons are there on drug-related offenses. "From 1980-1997, people entering prison for violent offenses doubled, and non-violent offenses tripled, but drug-related offenses increased 11-fold." That's a 1040% increase!

Source: Gililard, Darrel K., *Trends in U.S. Correctional Populations*, 1992. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, 1992, and Murnola, Christopher J. and Beck, Alan. *Trends in U.S. Correctional Populations*, 1997, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics.

FAMILIES & SUBSTANCE ABUSE



■ Percent who tested positive for any alcohol or other drug

Substance abuse is indicated in 81% of reported child abuse and neglect cases

(Timing: 1 minute)

Key: Blue = Any alcohol or other drug.

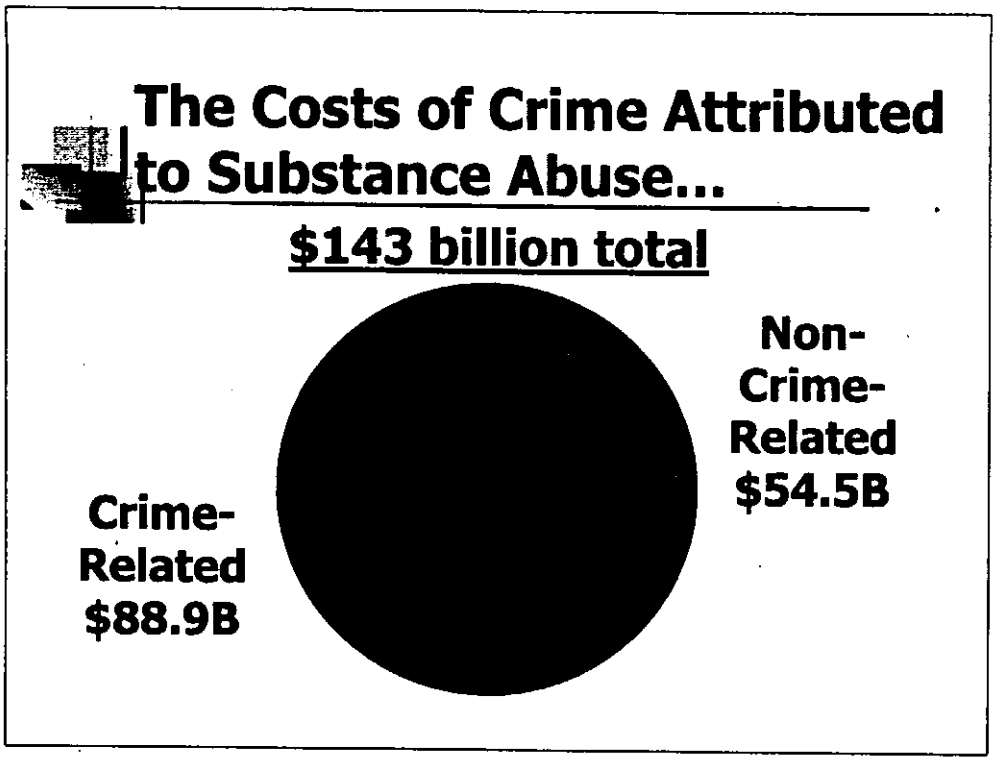
SLIDE ANIMATION NOTE: Slide appears with Batterers/Survivors graph only. Discuss the graph with the information provided directly below...THEN mouse-click to make child abuse and neglect statistic appear after the discussion on the graph.

Offenses involving substance abuse just don't appear on our criminal dockets, however – as witnessed by statistics from the Memphis study that tested both batterers and survivors for drugs. This study demonstrates the strong relationship between domestic violence and substance abuse. Perhaps most interesting is the abuse of substances by BOTH batterers and survivors.

FACULTY NOTE: Click mouse and read "AND substance abuse also has dramatic effects for children - who appear before the court in child abuse and neglect and dependency cases."

Source for chart: Brookoff, Daniel, M.D., "Drug Use and Domestic Violence" NIJ Research in Progress Seminar Series 1996.

Source for child A/N statistic: "The Relationship between Parental Alcohol and Drug Abuse and Child Maltreatment – Study Number 14," http://www.childabuse.com, 2002.

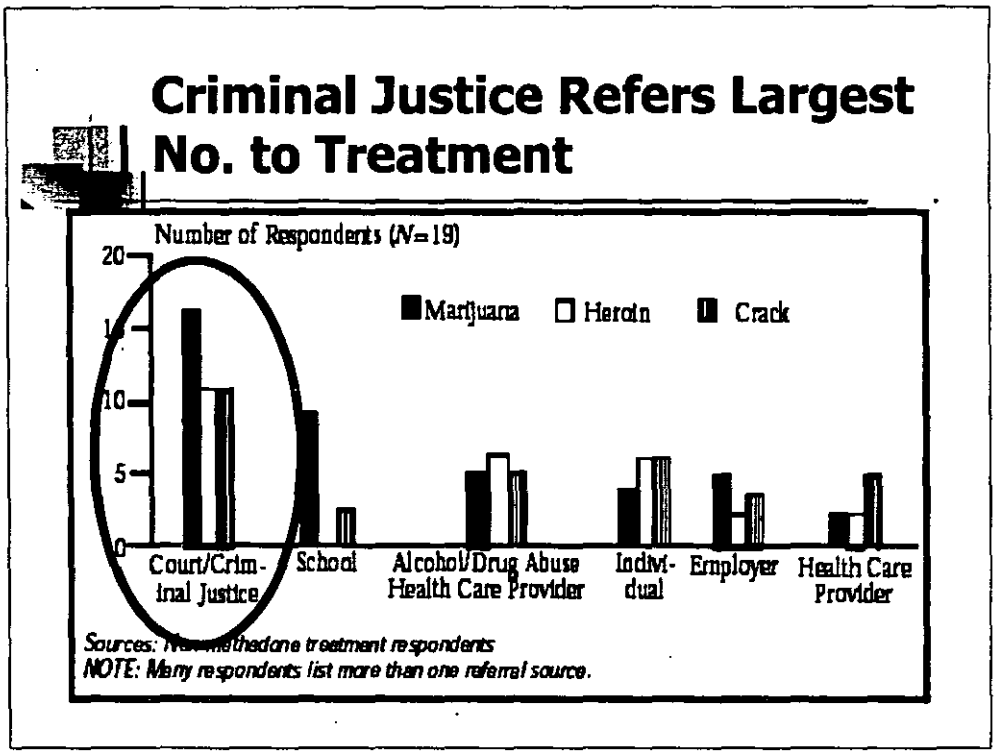


(Timing: .5 minute)

SLIDE ANIMATION NOTE: Slide appears with title and total. Automatically, sections of the pie chart appear; 1 second later, the related dollar amounts appear.

And, all of this has a HUGE economic cost as well. The White House Office of National Drug Control Policy has established cost estimates attributed to substance abuse. It estimates a TOTAL cost of $143 billion, with 62% related to crime-related costs and 38% attributed to non crime-related costs.

Source: Office on National Drug Control Policy, "ONDCP Drug Facts February 2002" Presentation.



(Timing: 1.5 minutes)

Not surprisingly, based on what we've already reviewed about substance abuse and its impact on society and as it presents before our courts, the "Pulse Check" serial study of Trends in Drug Abuse across 21 nationwide sites by the Office of National Drug Control Policy shows that the state court systems are referring a larger number of people to treatment services than other referral sources. However, are the courts making these referrals in meaningful ways that will make a difference in the lives of litigants? **Emphasize the question**: ARE WE DOING IT INTELLIGENTLY AND IN A MEANINGFUL WAY? Do we understand what addiction really is, what works and what doesn't, why litigants behave and respond the way they do, how best to assess the litigant's situation before you, and to make meaningful decisions and craft effective and appropriate orders and sentences based on that knowledge? Not only do these decisions have implications for the immediate case; the public perceptions of how the court system handles these cases has significant implications for the level of public trust and confidence in the judiciary.

FACULTY NOTE: This slide opens with just the graph coming up. With an additional mouse click, the red circle frames the criminal justice data set for emphasis. Coordinate your explanation with the "circling" of the data.

Source: "Pulse Check: Trends in Drug Abuse, April 2002," Office of National Drug Control Policy.

"Using" ⇨ Addiction

Although a person may choose whether or not to initiate the use of psychoactive substances and/or alcohol, drug dependence is an <u>involuntary</u> result.

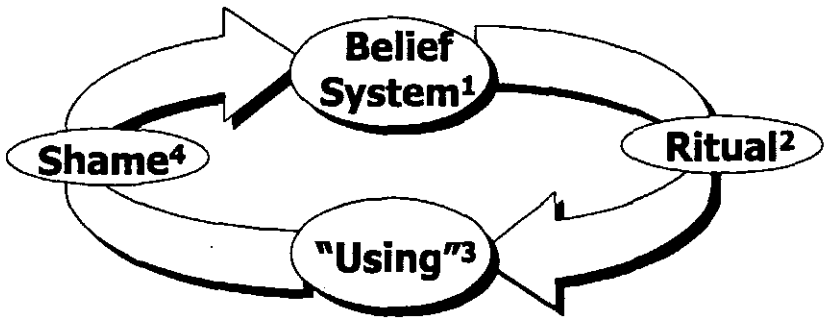
(Timing: 1 minute)

Before we move any farther in the discussion on the nature of addiction, let's be clear that "choosing" to "use" drugs CAN lead to something no one "chooses" or can control – "addiction." USING IS A CHOICE; ADDICTION IS NOT!

FACULTY NOTE: Part of the intention of emphasizing the nature of addiction centers on helping judges to understand why litigants may not be complying with their orders.

Source: Adapted from National Drug Court Institute PowerPoint presentation by Steven Hanson, "Introduction to Addictions/Pharmacology," Feb. 2002.

The "Cycle of Addiction"



- [1]Trigger event/thought occurs
- [2]Routinized behaviors leading to use
- [3]Substance use occurs
- [4]Shame sets in from use

(Timing: 2 minutes)

Addiction, in fact, occurs in a "cycle." The "drug of choice" may change, but the "pattern/cycle" in general does not.

What is important for you to understand about this cycle is that litigants "use" for a variety of reasons – including poor coping skills – they develop a pattern of behaviors that enable and lead to the actual use, and then shame sets in from their behaviors and their use – which starts the cycle all over again.

So, when litigants appear before you, they are NOT trying to **deliberately** "tick you off" by evading your inquiries, lying to you or disregarding any orders from the bench - they are "caught" in a compulsive "cycle" that they cannot stop.

But each time someone intervenes in an addict's life, this compulsive cycle is temporarily challenged and broken, which can bring her/him closer to getting out of denial about the addiction and closer to seeking help. You, in your role as a judge, have a unique opportunity to intervene – sometimes many opportunities – and help "break the cycle" IF you understand the nature of addiction, what it looks like, and why it occurs.

FACULTY NOTE: This cycle of addiction is based on the work of Patrick Carnes and his research on sexual addiction, and has been adapted by professionals in other areas of addiction studies to apply to other forms of addiction.

Slide Source: Graph adapted from the work of Dr. Patrick Carnes, "Out of the Shadows," and Dr. Mark Laser, "Faithful and True," as reproduced at http://www.sarr.org/addicts/the_addiction_cycle.htm

"An encounter with the criminal justice system...

...provides a valuable opportunity to intervene in an individual's life by identifying the clinical needs of substance abusers and then confronting them with the consequences of their own drug and alcohol use."

"Responding to Substance Abuse: The Role We All Play," 1999

(Timing: 1 minute)

As you can see then, we all can play an important role in providing litigants who appear in our courtrooms with an opportunity to move into recovery at a critically important juncture. During the remainder of this presentation, we will be sharing with you more specific information about substance abuse, what it may look like in your courtroom, what substance abusers face in treatment and recovery, and strategies that you can begin to consider to make better, informed decisions when sentencing and crafting orders for these litigants.

Source: This quote is taken from conference proceedings of the Substance Abuse Leadership Team in Franklin County, MA. The conference was intended to educate and promote court involvement in substance abuse issues.

Module 1:
Faculty Resources

FACULTY RESOURCE (MODULE 1): MECHELLE'S LETTER EXCERPTS
(To be read for Slide 5)

My name is Mechelle,

I am a 37-year old woman, recovering from 20 years of drug abuse. When I made it to court, I was living at the animalistic level – no home, no income, no job, no car, no confidence and no hope.

I was raised by the state and had a great fear of courts and judges. The last time I saw my parents was as a child in a courtroom. I was raised in numerous foster homes and abused in a number of ways in those homes – physically, sexually, and emotionally. At 16 years old, I was raped by a man who threatened my life – and I got pregnant! I started using drugs immediately after the rape. [Since then, I have been] convicted of 2 felonies, and later picked up for my third felony – retail fraud – and a violation of my probation!

That's how I found out about the drug treatment program -when I went before the Judge and he enrolled me. By the time I'd reached the program, I was contemplating suicide. Treatment gave me the tools I need to stay clean; but I couldn't have done it alone. The program supplied the structure and guidance I needed to get grounded in my recovery.

I know he doesn't like to take credit, but I need to tell you what he has done for me. He helped restore my faith in the system – I no longer fear judges. His genuine kindness and concern was what I'd been looking for all my life. He's also the first positive male role model in my life who didn't abuse me or want something from me. He's shown me there are good men in the world; and the staff women of the program were always there when I was in pain and needed someone to talk me through it.

Without that kind of judge and the program he enrolled me in, those of us chemically dependent continue the cycle of going to jail, getting out and doing the same thing over and over again. I'm very grateful I was fortunate enough to get in. Before that, I didn't even know I had a problem. The denial was sooooo deep – I had a $300-a-day habit; I'm grateful I didn't die from it first!

Today I'm an active member of a 12-Step program that teaches me a new way to live. I no longer have to use, no longer have to cheat or steal. Today I'm a responsible, productive member of society – I have a home, a job, and am going to school. And I have a goal and purpose in life – to help others who suffer from the disease of addiction.

FACULTY NOTE: This is excerpted from an actual letter received by a judge who presides over a drug treatment court. Permission was granted by the judge to use excerpts of this letter in the curriculum.

FACULTY RESOURCE (MODULE 1): MECHELLE'S LETTER FULL VERSION (FOR REFERENCE ONLY – DO NOT READ THIS VERSION)

My name is Mechelle,
I am a thirty seven year old woman, recovering from twenty years of drug abuse. When I made it to diversion court, I was living at the animalistic level, no home, no income, no job, no car, no confidence, and no hope.

I was raised by the state of California since I was two or three years old. I grew up with a great fear of courts and judges. The last time I saw my parents as a child was at this young age in a courtroom. I would meet them at 16 years old. I was raised in numerous foster homes and the Children's Shelter in San Jose, CA. Throughout my childhood, I was sexually, physically, and emotionally abused. When an adult foster brother was caught abusing me, it had been going on for some time. I was four or five. They moved me out of the house immediately. They never told me I was the victim, they never punished him. They didn't explain anything to me, instilling in me, I was the bad person. I was dirty. I wasn't any good. The abuse didn't stop with him. It continued throughout my childhood. My therapist has since told me, by then I had victim stamped on me and predators picked up on that. My last foster home was physical abuse every day for years. I don't remember one day where I wasn't abused in that home. I would show the bruises to my caseworker. They never did anything to help. Further instilling into me I wasn't worth saving or protecting.

I met my biological family when I was sixteen. First my father, I lived with him for about a month, then my Grandmother, then Great Grandfather, from one family member to another each place lasting about a month. By them shipping me from one to another had convinced me I wasn't worth anything. Needless to say, I've had abandonment issues that go back as far as I can remember. Each time I was moved from each home, I was enrolled in a different school, so between the ninth and half of the tenth year in high school – I was enrolled in nine different schools, between San Francisco and Los Angeles.

At sixteen years old I was raped by a man who threatened my life. From this my son was conceived. I had not been sexually active – voluntarily, prior to this. So I had a child before I even had a boyfriend. In my young mind, I was risking more rejection for giving birth to a bi-racial child. I could not tell anyone, except my twin sister, the circumstances behind my pregnancy. I felt so guilty, rape victims do, and I did not trust my family enough to tell them. After the rape, two weeks later I moved from the San Francisco Bay area to Los Angeles where my mother was, because I was afraid I'd run into him again. My first doctor app. was when I was seven months pregnant. That's when my mother found out. The first doctor I saw chewed me out so bad for being sixteen, unmarried and pregnant I left his office cring [sic] and never saw him again. Again deeper instilling I was absolutely no good. I started using drugs immediately after the rape. I don't know how in the world I gave birth to a healthy baby boy. But I thank God, today thank he is healthy! I need to tell you I hold no resentments towards my son for how he was conceived. I tell you this because people tell me, "how could you keep him!" things like this. I have a georgeous [sic], kind, loving, gentle, caring twenty year old young man, whom I love with all my heart. David is currently in Los Angeles County Jail due to the nature of the disease of addiction.

My drug use started with alcohol and pot. Soon progressed to cocaine, LSD, and heroin. I've used percription [sic] drugs, every drug I can think of, I've used. I've overdosed, I've contracted serimal

[sic] hepatitis, I've come very close to death many times and still couldn't stop. I've done many immoral and illegal things to support my habit.

Seven years ago I moved to Michigan to get away from the drugs. I thought that my use would stop there. Of course, it didn't. At that time, I couldn't see I had a problem. I didn't know addiction is a disease. My first five years here in Michigan I went straight down hill. At thirty-two I was convicted of two felonys [sic]. In September of 94 I was picked up for retail fraud – another felony, my third. This was a violation of my probation.

That's how I found out about SADP. I went before Judge XXX and was enrolled. Upon entering treatment, I felt like the lowest piece of trash on the face of the earth. By the time I'd reached the program I was contemplating suicide. I knew an overdose of heroin would be painless. In treatment I learned I have a disease, obsessive and compulsive behavior. That I am not a bad person. Treatment gave me the tools I needed to help me stay clean.

Judge XXX tells me I did it. I got clean, but I couldn't have done it alone. SADP supplied the structure and guidence [sic] I needed to get grounded in my recovery. Anytime I needed anything, they were there. I was living in a using environment, I relapsed at sixty day's clean, and they came the next day and moved me. I was terrified I was going to jail because of my relapse. Remember I told you I have a fear of judges from childhood. Judge XXX was so kind and understanding, he told me he had faith I could do this, that gave me the strength to persevere.

I know he doesn't like to take credit – but I need to tell you what he has done for me. He has helped restore my faith in the system. I no longer have that fear of judges. His genuine kindness and concern was what I'd been looking for all my life. I've told him before, though he's not old enough, he's the father figure I never had. He's also the first positive male role model in my life, who didn't abuse me or want something from me. He's show me there are good men in the world.

The women [staff] of SADP have been great. When I wasn't feeling good, I would call them and whoever was on the other end talked me thru the pain. I can't tell them or thank them enough for what they have done for me.

Without this program, those of us chemically dependent, continue the cycle of going to jail, getting out and doing the same thing all over again. We don't get the help we need. I am so happy to hear there's going to be a SADP program for men. Our prisons are so overcrowded with men that have drug related offenses. This program is what our country needs.

I'm very grateful I was fortunate to get into SADP. Before this I didn't even know I had a problem. The denial was so deep. I'm grateful I didn't have to die with a three hundred dollar a day habit.

Today I am an active member of a Twelve Step program that teaches me a new way to live. I no longer have to use, no longer have to lie, cheat, steal. Today I am a responsible, productive member of society. I have a home, I chair meetings at the women's K-Pep, I used to chair meetings at the treatment center.
I'll be starting school in May. I am employed at XXXX Residential Treatment Center.

Today I have a goal and purpose in life. I help others who suffer from the disease of addiction.

PS. Today I have a little over two years clean. Life is good!

Module 1:
Participant Handouts

JUDICIAL EDUCATION ON SUBSTANCE ABUSE: PROMOTING AND EXPANDING JUDICIAL AWARENESS AND LEADERSHIP

A project of the American Judges Association and the National Center for State Courts with funding from the State Justice Institute.

Courts are often society's first opportunity to identify individuals with substance abuse problems. Every day, judges and their staff are confronted by the problems of alcohol and other drug abuse in a variety of cases that appear in our nation's courtrooms. Courts are in a unique position to link these individuals to treatment programs and local drug treatment courts, where available and appropriate. In so doing, courts can contribute to the reduction in demand and use of drugs and help ensure the public's safety. The costs to society in terms of health, safety, and social and economic impact demand full court involvement to identify, confront, and address the abuse of alcohol and other drugs by defendants and other litigants.

The objectives of the curriculum are to:

- Generate an awareness of substance abuse issues arising in a variety of cases that appear in the courts
- Identify how the judicial role places judges in a unique position to respond both to the litigants and the community as they struggle with substance abuse issues
- Provide a basic understanding of the nature of substance abuse, addiction and recovery, and treatment modalities
- Assist the judge with the development of strategies and tools for responding (when in the courtroom) to parties with substance abuse problems
- Encourage judges to initiate and engage in an on-going dialogue, with other judges, lawyers, and interested community leaders, regarding the evolving role of the judge in substance abuse issues and problem-solving approaches generally

This curriculum was developed under a grant from the State Justice Institute to the National Center for State Courts, on behalf of the American Judges Association. The AJA and NCSC recognized the need to partner with a variety of national organizations in designing this curriculum. Representatives from the following organizations participated in the development of the curriculum:

American Probation and Parole Association
Conference of Chief Justices
Conference of State Court Administrators
National Association for Court Management
National Association of Drug Court Professionals
National Association of State Judicial Educators
National Council of Juvenile and Family Court Judges
National Judicial College

Module 1: Substance Abuse Awareness

This module is intended to raise awareness regarding the nature, prevalence, and cost of substance abuse and how the judicial role places judges in a position to respond to substance abuse issues to benefit the litigants, the community and the court

Objectives

After completing this module, participants will:

- Recognize the challenges substance abuse brings to litigants' lives and understand the significance of accountability
- Identify the economic impact of substance abuse
- Describe why the judicial role is unique in addressing substance abuse and is, indeed, part of a solution

Module 2: The Nature of Addiction, Basic Pharmacology, and Recovery

This module is intended to provide participants with a basic overview of the nature of addiction and substance abuse, as well as the components of successful recovery and treatment delivery programs

Objectives:

After completing this module, participants will be able to:

- Define substance abuse and addiction
- Describe the cycle of addiction
- Examine the pharmacological aspects of substance abuse and the wide breadth of substances abused
- Identify potential substance abuse when it presents in court
- Recognize the different treatment modalities available
- Identify barriers to treatment and recovery
- Recognize the varying treatment needs of special populations (e.g., men vs. women, different ethnic groups, juveniles, persons with alternative sexual orientation, different cultural groups, Native Americans or Alaska Natives, persons with HIV, persons with co-occurring mental disorders)

Module 3: Strategies for the Courtroom

This module is designed to assist judges in developing strategies and tools for responding to substance abuse issues from the bench.

Objectives:

After completing this module, participants will be able to:

- Develop relevant questions a judge can ask from the bench that may elicit information regarding a litigant's use of drugs and alcohol
- Develop strategies to effectively apply substance abuse and addiction information
- Develop a bench resource guide on substance abuse for personal use
- Identify substance abuse resources in the community and strengths and gaps in local substance abuse services

Judicial Education on Substance Abuse

SJI

Why is Substance Abuse Awareness Important to Me As a Judge?

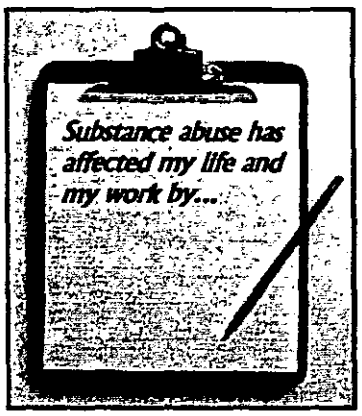
SJI

Module 1

"The Elephant in the Living Room...."

"Substance abuse and addiction is the elephant in the living room of society. Too many citizens deny or ignore its presence.
Abuse and addiction ... are implicated in virtually every domestic problem our nation faces: crime, health crippiers and killers, child abuse and neglect, domestic violence, teen pregnancy, chronic welfare, the rise in learning disabled and conduct disordered children..."

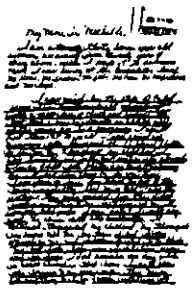
Take a minute and ask yourself...



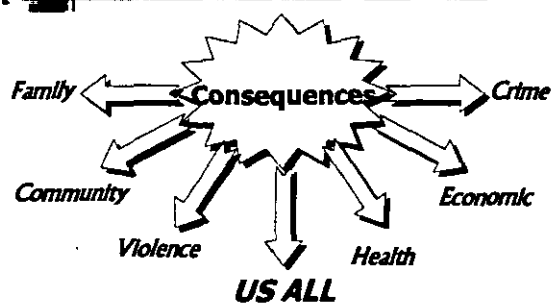
What it's like in her life, in her own words...

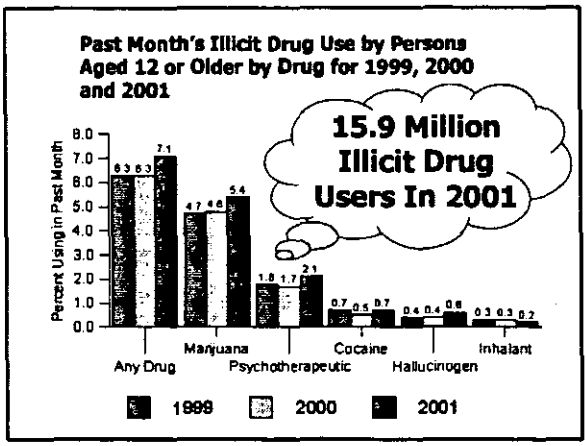
"My name is Mechelle,

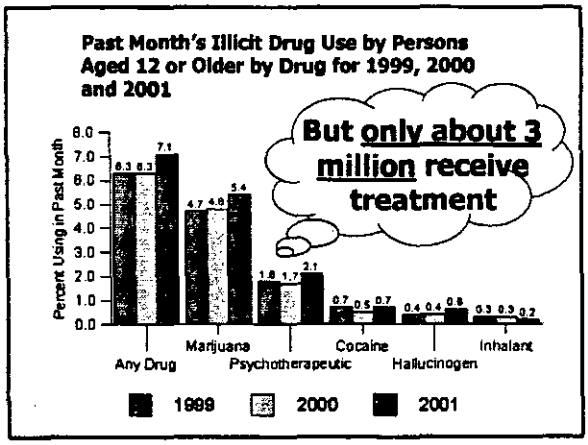
I am a thirty seven year old woman, recovering from twenty years of drug abuse. When I made it to court, I was living at the animalistic level – no home, no income, no job, no car, no confidence and no hope...."

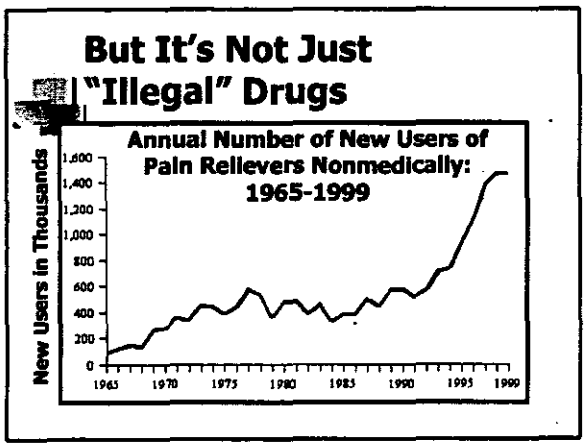


Substance Abuse...

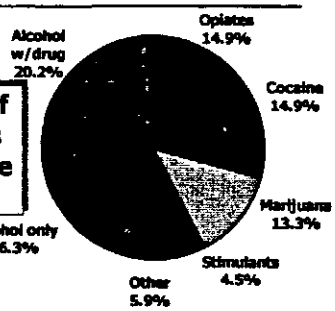



Past Month's Illicit Drug Use by Persons Aged 12 or Older by Drug for 1999, 2000 and 2001
15.9 Million Illicit Drug Users In 2001
Percent Using in Past Month
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
6.3 6.3 7.1
4.7 4.8 5.4
1.8 1.7 2.1
0.7 0.5 0.7
0.4 0.4 0.6
0.3 0.3 0.2
Any Drug
Marijuana
Psychotherapeutic
Cocaine
Hallucinogen
Inhalant
1999
2000
2001


Past Month's Illicit Drug Use by Persons Aged 12 or Older by Drug for 1999, 2000 and 2001
But only about 3 million receive treatment
Percent Using in Past Month
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
6.3 6.3 7.1
4.7 4.8 5.4
1.8 1.7 2.1
0.7 0.5 0.7
0.4 0.4 0.6
0.3 0.3 0.2
Any Drug
Marijuana
Psychotherapeutic
Cocaine
Hallucinogen
Inhalant
1999
2000
2001

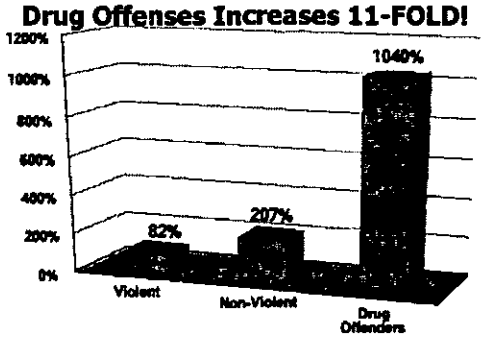

But It's Not Just "Illegal" Drugs
Annual Number of New Users of Pain Relievers Nonmedically: 1965-1999
New Users in Thousands
1,600
1,400
1,200
1,000
800
600
400
200
0
1965
1970
1975
1980
1985
1990
1995
1999

Primary Admissions to Treatment by Drug

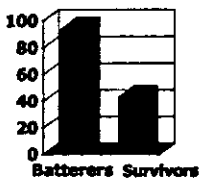


Nearly 50% of all addictions treated involve ALCOHOL!

Population of Offenders in Prison for Drug Offenses Increases 11-FOLD!



FAMILIES & SUBSTANCE ABUSE

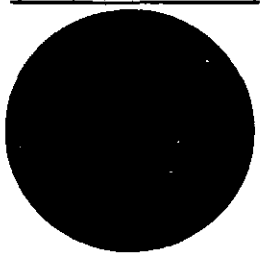


Percent who tested positive for any alcohol or other drug

Substance abuse is indicated in 81% of reported child abuse and neglect cases

The Costs of Crime Attributed to Substance Abuse...

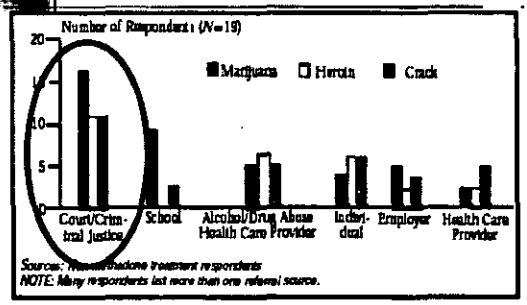
$143 billion total



Non-Crime-Related $54.5B

Crime-Related $88.9B

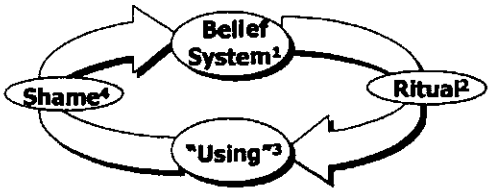
Criminal Justice Refers Largest No. to Treatment



"Using" ⟹ Addiction

Although a person may choose whether or not to initiate the use of psychoactive substances and/or alcohol, drug dependence is an <u>involuntary</u> result.

The "Cycle of Addiction"



- [1]Trigger event/thought occurs
- [2]Routinized behaviors leading to use
- [3]Substance use occurs
- [4]Shame sets in from use

"An encounter with the criminal justice system...

...provides a valuable opportunity to intervene in an individual's life by identifying the clinical needs of substance abusers and then confronting them with the consequences of their own drug and alcohol use."

"Responding to Substance Abuse: The Role We All Play," 1999

2

Module 2
The Nature of Addiction, Basic Pharmacology, and Principles of Recovery

Presenter: Treatment Provider

We strongly urge training coordinators to identify a knowledgeable treatment provider in your local community to present the material in this module. The faculty notes are not intended to support the presentation of this information by a novice.

To identify an appropriate individual, you may wish to contact your state's chapter of the American Society of Addiction Medicine (see list of contacts on-line at http://www.asam.org/) or the National Association of Alcoholism and Drug Abuse Counselors (see list of state contacts on-line at http://naadac.org/affiliates/) for a recommendation of an appropriate expert in your area. The Substance Abuse Mental Health Services Administration (SAMSHA) website also has a Treatment Facility Locator that may provide contacts in your area (www.findtreatment.samsha.gov/facilitylocatordoc.htm)

Length: 1 hour, 15 minutes (this time could vary from 1 hour to 1 day, depending upon considerations such as selection of faculty, experience of participants, and overall length of program)

Purpose: This module is intended to provide participants with a basic overview of the nature of addiction and substance abuse, as well as the components of successful recovery and treatment delivery programs.

Objectives

After completing this module, participants will be able to:

- Define substance abuse and addiction
- Describe the cycle of addiction
- Examine the pharmacological aspects of substance abuse and the wide breadth of substances abused.
- Identify potential substance abuse when it presents in court
- Recognize the different treatment modalities available
- Identify barriers to treatment and recovery
- Recognize the varying treatment needs of special populations (e.g., men vs. women, different ethnic groups, juveniles, persons with alternative sexual orientation, different cultural groups, Native Americans or Alaska Natives, persons with HIV, persons with co-occurring mental disorders)

Instructional Methods

Lecture with PowerPoint Slides

Facilitated Discussion
Possible Individual Activity (see below)

Participant Handouts

Module 2 Objectives (See Module 1 Handouts)
Module 2 PowerPoint Slides
Participant notebook materials also include several items regarding commonly abused drugs, as well as principles of treatment to which the faculty may wish to refer.

Faculty Notes

The expansiveness of the subjects of addiction, treatment and recovery do not permit a completely thorough exploration in this limited context. However, the curriculum suggests the critical education content for a basic education program. You may have additional insights about the material and can adapt the slides to meet your individual presentation needs and style.

The closing slides in Module 2 (see slides on "Commonly Abuse Drugs") are intended to inform judges about the unique characteristics of addiction to specific substances that may have implications for the behavior and accountability of court participants. You may want to consider co-presenting this material with the judicial officer to emphasize these elements. A discussion with audience members about their experiences with court participants under the influence of the various drugs also could be facilitated.

This module includes a large amount of material. Please plan your time carefully.

Additional Faculty Resources

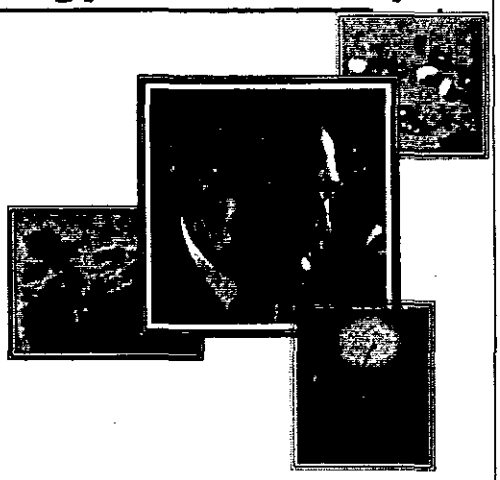
You may wish to consider additional activities to expand this module.

Sample Activity: One suggestion is administering a "drug abuse quiz." A sample quiz is included. You could use this tool (or one you develop yourself) to raise the awareness of participants of some of the myths of substance abuse and treatment.

NOTE: Questions and answers for the "drug abuse quiz" were excerpted from both the ACDE: The American Council for Drug Education's "Drug Awareness Knowledge Quiz" (the full version of their interactive online quiz can be found at http://www.acde.org/youth/quiz.htm), and the "Alcohol and Other Drugs and the Courts" curriculum by Hon. Peggy Fulton Hora, Alameda County Superior Court, Hayward, CA..

Module 2:
PowerPoint Slides with Faculty Notes

Addiction 101: Basic Pharmacology and Recovery



Module 2

SLIDE ANIMATION NOTE: When this slide loads on the screen, after a one-second delay, the collage of drugs and drinking images automatically loads onto the screen one graphic at a time.

This part of the curriculum is intended to provide you with a basic overview of the nature of addiction and substance abuse, as well as some of the components of successful recovery and treatment delivery programs.

FACULTY NOTE: The notes provided on the following slides are not intended to support the presentation of this material by a novice. See the Faculty Guide for suggestions of resources to locate an expert in your area.

This curriculum was developed by the National Center for State Courts under a grant from the State Justice Institute (SJI-01-N-210). The points of view expressed do not necessarily represent the official position or policies of the National Center for State Courts, the American Judges Association, or the State Justice Institute.

Addiction is a Complex Illness

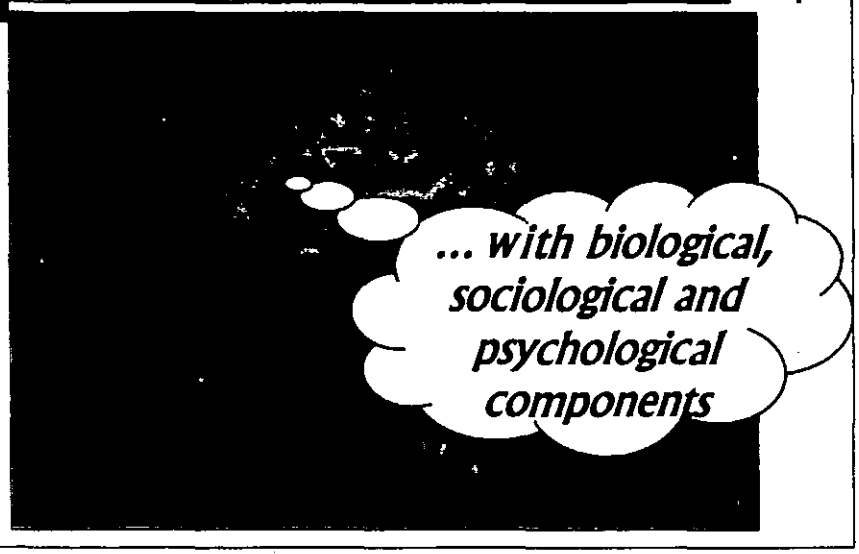


Image Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 1: "The Brain & the Actions of Cocaine, Opiates, and Marijuana"
http://www.nida.nih.gov/pubs/teaching/Teaching2.html

Nature of Addiction

- Loss of control
- Harmful Consequences
- Continued Use Despite Consequences

"That is not one of the seven habits of highly effective people."

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Three "C's" of Addiction

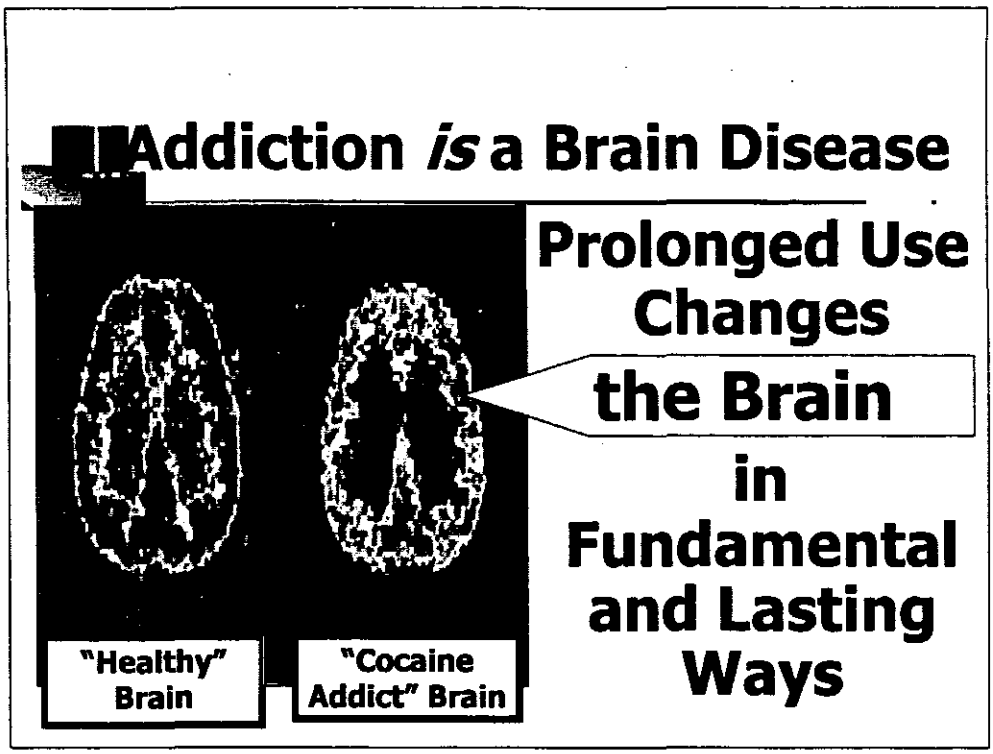
- **Control**
  - Early social/recreational use
  - Eventual loss of control
  - Cognitive distortions ("denial")
- **Compulsion**
  - Drug-seeking activities
  - Continued use despite adverse consequences
- **Chronicity**
  - Natural history of multiple relapses preceding stable recovery
  - Possible relapse after years of sobriety

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Addiction Risk Factors

- Genetics
- Young Age of Onset
- Childhood Trauma (violent, sexual)
- Learning Disorders (ADD/ADHD)
- Mental Illness
  - Depression
  - Bipolar Disorder
  - Psychosis

Slide Source: "Alcohol and Other Drugs and the Courts" curriculum, Judge Peggy Fulton Hora, Alameda County Superior Court, Hayward, CA *and* Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.



*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word**)*

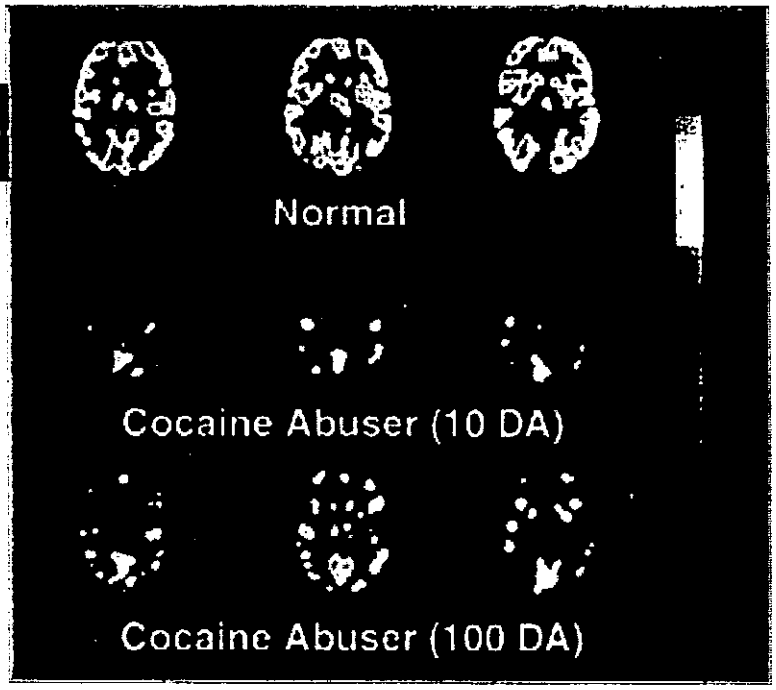
Positron emission tomography (PET) scan of a person on cocaine

Cocaine has other actions in the brain in addition to activating reward. Scientists can now see how cocaine actually affects brain function in people. The PET scan allows us to see how the brain uses glucose; glucose provides energy to each neuron so it can perform work. The scans show where the cocaine interferes with the brain's use of glucose - or its metabolic activity. The left scan is taken from a normal, awake person. The red color shows the highest level of glucose utilization (yellow represents less utilization and blue shows the least). The right scan is taken from a cocaine abuser on cocaine. It shows that the brain cannot use glucose nearly as effectively – point out the loss of red compared to the left scan. There are many areas of the brain that have reduced metabolic activity. The continued reduction in the neurons' ability to use glucose (energy) results in disruption of many brain functions.

Image Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 5: "Bringing the Power of Science to Bear on Drug Abuse and Addiction"
http://www.nida.nih.gov/pubs/teaching/Teaching5/Teaching3.html

Slide Source: Steve Hanson, MSEd Director, John L. Norris ATC New York State Office of Alcoholism and Substance Abuse Services

Instructions Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 2: "The Brain & the Actions of Cocaine, Opiates, and Marijuana"
http://www.nida.nih.gov/pubs/teaching/Teaching4.html



*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word)***

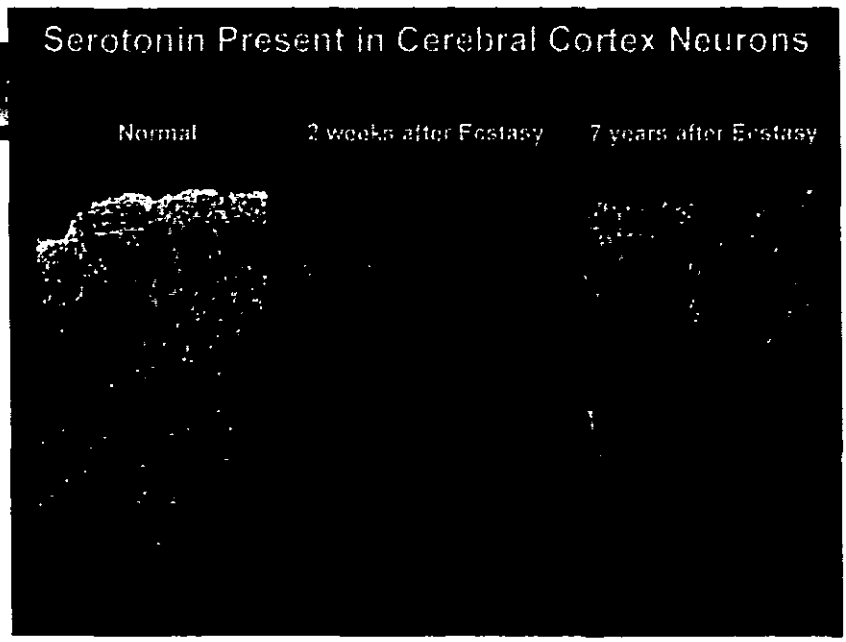
Long-term effects of drug abuse. This PET scan shows us that once addicted to a drug like cocaine, the brain is affected for a long, long time. In other words, once addicted, the brain is literally changed. Let's see how...

In this slide, the level of brain function is indicated in yellow. The top row shows a normal-functioning brain without drugs. You can see a lot of brain activity. In other words, there is a lot of yellow color.

The middle row shows a cocaine addict's brain after 10 days without any cocaine use at all. What is happening here? **[Pause for response.]** *Less yellow* means *less normal activity* occurring in the brain - even after the cocaine abuser has abstained from the drug for 10 days.

The third row shows the same addict's brain after 100 days without any cocaine. We can see a little more yellow, so there is some improvement - more brain activity - at this point. But the addict's brain is *still* not back to a normal level of functioning... more than 3 months later. Scientists are concerned that there may be areas in the brain that never fully recover from drug abuse and addiction.

Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 5: "Bringing the Power of Science to Bear on Drug Abuse and Addiction"
http://www.nida.nih.gov/pubs/teaching/Teaching5/Teaching3.html



*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word)***

When people use Ecstasy repeatedly or long-term, there are changes in their brain chemistry that suggest that the serotonin neurons might be damaged. The major clues are that serotonin itself and its metabolites (remind students that serotonin that is taken back up into the terminal is metabolized by enzymes) are diminished throughout the brain. However, the best neurochemical evidence that we have so far in humans is that the density of serotonin transporters that are located on the terminals is reduced as well. This is illustrated in this slide.

Long-term Effects in Monkeys

The loss of serotonin transporters and decrease in serotonin suggest that the serotonin neurons are damaged (animal studies have revealed that this is the case). A very important experiment was performed in monkeys to determine if Ecstasy can actually damage neurons. Monkeys were given Ecstasy twice a day for 4 days (control monkeys were given saline). One group of monkeys' brains were removed 2 weeks later for analysis and another group of monkeys lived for an additional 7 years before their brains were removed. Scientists examined the brains for the presence of serotonin. This slide shows the presence of serotonin in neurons of the neocortex from 3 typical monkeys. On the left, the monkey who did not receive any Ecstasy had a lot of serotonin (in pink) in the neocortex. Two weeks after a monkey received Ecstasy, most of the serotonin was gone (point to the middle panel), suggesting that the serotonin neuron terminals were destroyed (there was no destruction of the serotonin cell bodies arising back in the brainstem). Point to the right hand panel and show students that this damage appeared to be long-term because 7 years later there was some recovery, but it was not complete (in fact, the pattern of regrowth of serotonin terminals was abnormal—point out one of the areas where the pink lines are running sideways). Scientists found similar changes in limbic areas of the brain such as the hippocampus and amygdala. The monkey experiments are an important reminder that humans may suffer the same fate, although this still remains to be demonstrated. It's difficult to do this same kind of experiment in humans because it requires removing pieces of the brain to look for the loss of the serotonin neurons.

Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 4: "The Neurobiology of Ecstasy (MDMA)" http://www.nida.nih.gov/pubs/teaching/Teaching4/Teaching4.html

Image courtesy of Dr. GA Ricaurte, Johns Hopkins University School of Medicine.

How Drugs Work

- Interact with neurochemistry

⇨ Results:

- Feel Good – Euphoria/reward
- Feel Better – Reduce negative feelings

Slide Source: Steve Hanson, MSEd, Director, John L. Norris ATC, New York State Office of Alcoholism and Substance Abuse Services

Dopamine Spells REWARD

SLIDE ANIMATION NOTE: Slide initially loads without wording on the image. At approximately one-second intervals, the words "release," "activate," and "recycle" appear onscreen. You may wish to coordinate a brief introductory overview explanation with the animation and then expand on the explanation after the slide is complete.

FACULTY NOTE: (from NIDA teaching instructions – ***you may use this narrative text as a guide, but it does not need to be repeated word for word)***

Explain that drugs concentrate in areas of the brain that are rich in dopamine synapses. Review dopamine transmission in the nucleus accumbens. Point to dopamine in the synapse and to dopamine bound to dopamine receptors and to uptake pumps on the terminal.

When drugs (cocaine is the drug in this example) are present in the synapse, they (represented in turquoise) bind to the uptake pumps and prevent them from removing dopamine from the synapse. This results in more dopamine in the synapse, and more dopamine receptors are activated. This causes many changes inside the cell that lead to abnormal firing patterns.

As a result, there are increased impulses leaving the nucleus accumbens to activate the reward system. With continued use of drugs (cocaine), the body relies on the drug to maintain rewarding feelings. The person is no longer able to feel the positive reinforcement or pleasurable feelings of natural rewards.

Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 1: "The Brain & the Actions of Cocaine, Opiates, and Marijuana

http://www.nida.nih.gov/pubs/teaching/Teaching4.html

Natural Rewards

- Food
- Sex
- Excitement
- Comfort

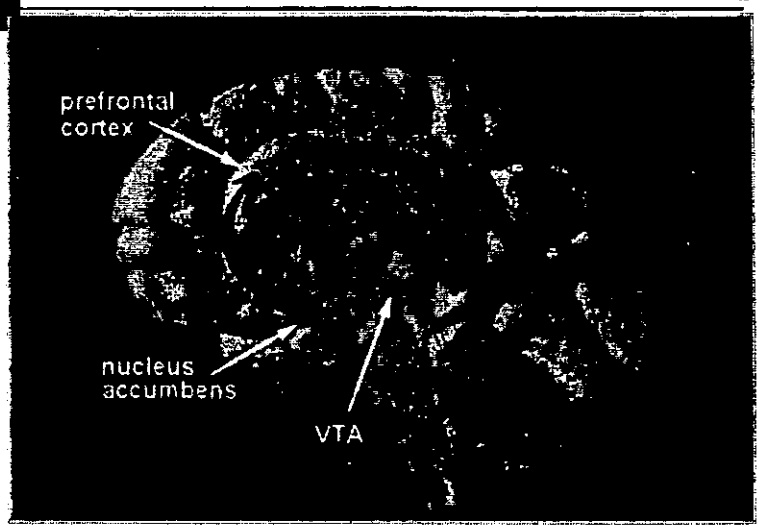
*FACULTY NOTE: (from NIDA teaching instructions - **you may use this narrative text as a guide, but it does not need to be repeated word for word)***

Natural rewards such as food, water, sex and nurturing allow the organism to feel pleasure when eating, drinking, procreating and being nurtured. Such pleasurable feelings reinforce the behavior so that it will be repeated. Each of these behaviors is required for the survival of the species. Remind your audience that there is a pathway in the brain that is responsible for rewarding behaviors.

Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 2: "The Neurobiology of Drug Addiction"

http://www.nida.nih.gov/Teaching2/Teaching3.html

Brain Reward Pathways



*FACULTY NOTE: (from NIDA teaching instructions - **you may use this narrative text as a guide, but it does not need to be repeated word for word)***

Tell your audience that this is a view of the brain cut down the middle. An important part of the reward pathway is shown, and the major structures are highlighted: the ventral tegmental area (VTA), the nucleus accumbens and the prefrontal cortex. The VTA is connected to both the nucleus accumbens and the prefrontal cortex via this pathway and sends information to these structures via its neurons. The neurons of the VTA contain the neurotransmitter dopamine, which is released in the nucleus accumbens and in the prefrontal cortex (point to each of these structures). Reiterate that this pathway is activated by a rewarding stimulus. [Note: the pathway shown here is not the only pathway activated by rewards; other structures are involved too, but only this part of the pathway is shown for simplicity.]

Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 2: "The Neurobiology of Drug Addiction" http://www.nida.nih.gov/Teaching2/Teaching3.html

Activation of Reward

*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word)***

Summary: addictive drugs activate the reward system via increasing dopamine neurotransmission.

In this slide, the reward pathway is shown along with several drugs that have addictive potential. Just as heroin (morphine) and cocaine activate the reward pathway in the VTA and nucleus accumbens, other drugs such as nicotine and alcohol activate this pathway as well, although sometimes indirectly (point to the globus pallidus, an area activated by alcohol that connects to the reward pathway). While each drug has a different mechanism of action, each drug increases the activity of the reward pathway by increasing dopamine transmission. Because of the way our brains are designed, and because these drugs activate this particular brain pathway for reward, they have the ability to be abused. Thus, addiction is truly a disease of the brain. As scientists learn more about this disease, they may help to find an effective treatment strategy for the recovering addict.

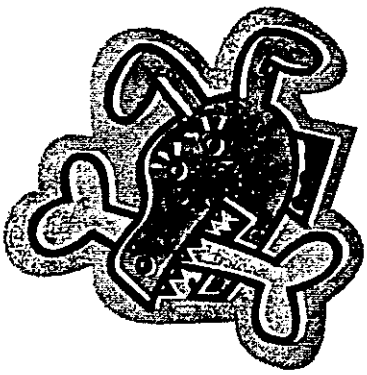
Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 2: "The Neurobiology of Drug Addiction" http://www.nida.nih.gov/Teaching2/Teaching5.html

Behavior Pathways

- Rewarding behaviors can become routine
- "Subconscious" control of the behavior
- Difficult to extinguish behaviors because people are <u>not always aware</u> when they are initiated
- Resistant to change

Slide Source: Steve Hanson, MSEd, Director, John L. Norris ATC, New York State Office of Alcoholism and Substance Abuse Services

Addiction = Dog with a Bone



- It never wants to let go.
- It bugs you until it gets what you want.
- It never forgets when/where it is used to getting its bone.
- It thinks it's going to get a bone anytime I do anything that reminds it of the bone.

FACULTY NOTE: This metaphor worked with a group of patients. They can imagine the dog and its persistence. Metaphors of treatment being like dog obedience school are there if you want them.

Slide Source: Steve Hanson, MSEd, Director, John L. Norris ATC, New York State Office of Alcoholism and Substance Abuse Services

How Long Does the Brain Remember?

Amygdala not lit up

Amygdala activated

Front of Brain

Back of B

Nature Video

Cocaine Video

*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word)***

The memory of drugs - just the *mention* of items associated with drug use may cause an addict to "crave" or desire drugs. This PET scan is part of a scientific study that compared recovering addicts, who had stopped using cocaine, with people who had no history of cocaine use to determine what parts of the brain are activated when drugs are craved.

Brain scans were performed while subjects watched two videos. The first video, a nondrug presentation, showed nature images - mountains, rivers, animals, flowers, trees. The second video showed cocaine and drug paraphernalia, such as pipes, needles, matches, and other items familiar to addicts.

The yellow area on the upper part of the second image is the amygdala **(a-mig-duh-luh)**, a part of the brain's limbic system, which is critical for memory and responsible for evoking emotions. For an addict, when a drug craving occurs, the amygdala becomes active, and a craving for cocaine is triggered.

This craving demands the drug *immediately*. Rational thoughts are dismissed by the uncontrollable desire for drugs. At this point, a basic change has occurred in the brain. This *changed brain* makes it almost impossible for drug addicts to stay drug-free without professional help.

Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 5: "Bringing the Power of Science to Bear on Drug Abuse and Addiction"
http://www.nida.nih.gov/pubs/teaching/Teaching5/Teaching4.html

Cognitive Deficits

- Memory problems – short-term loss
- Impaired abstraction
- Perseveration using failed problem-solving strategies
- Loss of impulse control
- Similar performance to those with brain damage

Slide Source: Steve Hanson, MSEd, Director, John L. Norris ATC, New York State Office of Alcoholism and Substance Abuse Services *and* Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Common Characteristics of Addicts

- Unemployment
- Multiple criminal justice contacts
- Difficulty coping with stress or anger
- Highly influenced by social peer group
- Difficulty handling high-risk relapse situations

Slide Source: "Responding to Substance Abuse: The Role We All Play," The Substance Abuse Leadership Team (SALT) of the Franklin County Courts Conference, SAMSHA Grant No. 4U98 T100 846 *and* Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Common Characteristics...

- Emotional and psychological immaturity
- Difficulty relating to family
- Difficulty sustaining long-term relationships
- Educational and vocational deficits

Violence

- Alcohol disinhibits aggressivity
- Stimulants produce dose-dependent paranoia
- Opiate-seeking, but not opiates, produces violence

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Who needs treatment?

13 to 16 million Americans need treatment for alcohol and/or other drug abuse in any year

BUT...

Only 3 million receive care

Slide Source: "Changing the Conversation," Improving Substance Abuse Treatment: The National Treatment Plan Initiative, DHHS Pub. No. (SMA)00-3480 (2000) http://www.natxplan.org/news/vol2.pdf

Matching Treatment to Individual's Needs

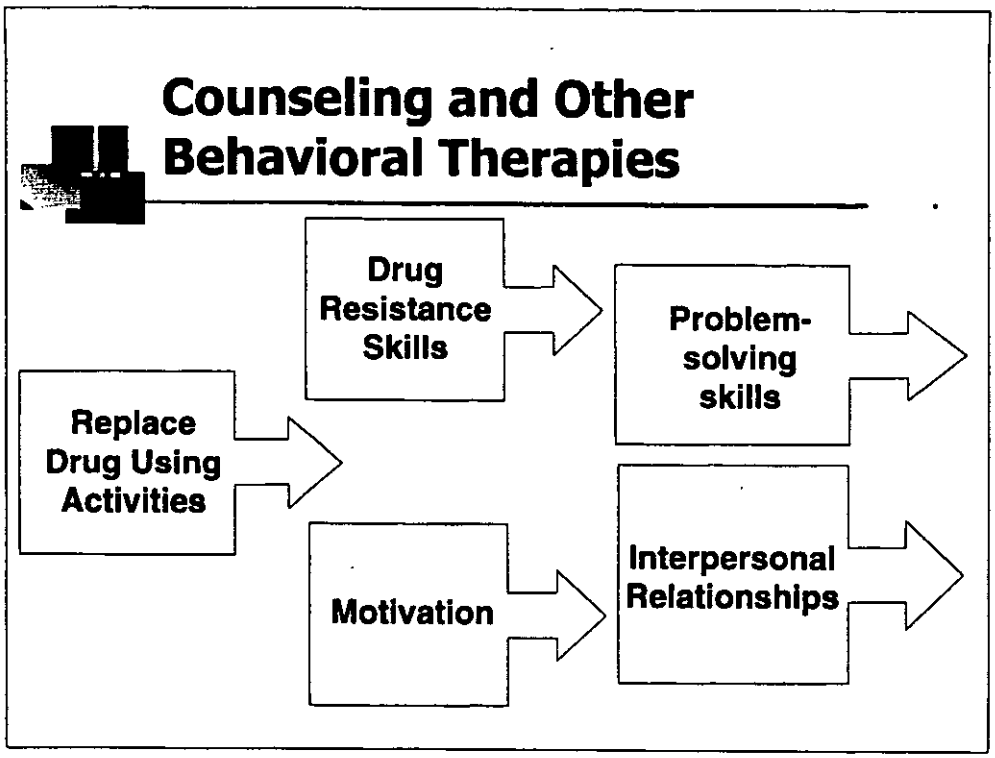
- No single treatment is appropriate for all individuals
- Effective treatment attends to multiple needs of the individual, not just his/her drug use
- Treatment must address medical, psychological, social, vocational, and legal problems

*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word**)*

No single treatment is appropriate for all individuals. Matching treatment setting, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

Effective treatment attends to multiple needs of the individual, not just his or her drug use. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

Image Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 3: "Understanding Substance Abuse and Addiction: What Science Says" http://www.nida.nih.gov/pubs/teaching/Teaching3/Teaching4.html



*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word**)*

Counseling and Other Behavioral Therapies

Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction. In therapy, patients address motivational issues, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

Image Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 3: "Understanding Substance Abuse and Addiction: What Science Says" http://www.nida.nih.gov/pubs/teaching/Teaching3/Teaching4.html

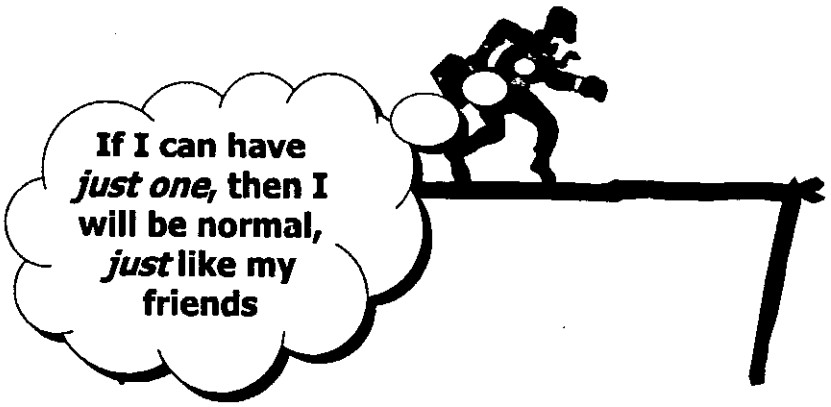
Abstinence

- Strictly speaking, abstinence is developed, not recovered
- It is an abnormal condition, signifying an internal defect (disease)
- Addicts want to be "normal," that is, using drugs in control

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Self-Control

- Addicts seek control, not abstinence



SLIDE ANIMATION NOTE: Slide initially loads without "callout" stating, "If I can have...." After a one-second interval, callout automatically loads.

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Self Help

- Complements and extends treatment efforts
- Most commonly used models include 12-Step (AA, NA) and Smart Recovery
- Most treatment programs encourage self-help participation during/after treatment

*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word**)*

Self-help groups can complement and extend the effects of professional drug addiction treatment. The most prominent self-help groups are those affiliated with Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA), all of which are based on the 12-step model and Smart Recovery. Most drug addiction treatment programs encourage patients to participate in a self-help group during and after formal treatment.

Slide Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 3: "Understanding Substance Abuse and Addiction: What Science Says" http://www.nida.nih.gov/pubs/teaching/Teaching3/Teaching5.html

12-Step Groups

- Myths
  - Only AA can treat alcoholics
  - Only a recovering individual can treat an addict
  - 12-step groups are intolerant of prescription medication
  - Groups are more effective than individuals because of confrontation

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

12-Step Groups

- Facts
  - Available 7 days/week, 24 hrs/day
  - Work well with professionals
  - Primary treatment modality is fellowship (identification)
  - Safety and acceptance predominate over confrontation
  - Offer a safe environment to develop intimacy

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Medical Detoxification

Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.

- High post-detoxification relapse rates
- Not a cure!
- A preparatory intervention for further care

*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word or word**)*

Medical Detoxification

Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. However, medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

Slide Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 3: "Understanding Substance Abuse and Addiction: What Science Says" http://www.nida.nih.gov/pubs/teaching/Teaching3/Teaching4.html *and* Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Medications

Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

- Alcohol: Naltrexone, Disulfiram, Acamprosate, Odansetron
- Opiates: Naltrexone, Methadone, LAAM, Buprenorphine
- Nicotine: Nicotine replacement (gum, patches, spray), bupropion
- Stimulants: [None to date]

*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word**)*

Medications for Drug Addiction

Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring addiction to alcohol. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.

Slide Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 3: "Understanding Substance Abuse and Addiction: What Science Says" http://www.nida.nih.gov/pubs/teaching/Teaching3/Teaching5.html *and* Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Public Health

- Drug treatment is disease prevention
- HIV infection in injecting drug users
- >90% injection drug users are infected with Hepatitis C virus

*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word**)*

HIV/AIDS, Hepatitis and Other Infectious Diseases

Drug injectors who do not enter treatment are up to six times more likely to become infected with HIV than injectors who enter and remain in treatment. Drug users who enter and continue in treatment reduce activities that can spread disease, such as sharing injection equipment and engaging in unprotected sexual activity. Participation in treatment also presents opportunities for screening, counseling, and referral for additional services. The best drug abuse treatment programs provide HIV counseling and offer HIV testing to their patients.

Slide Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 3: "Understanding Substance Abuse and Addiction: What Science Says" http://www.nida.nih.gov/pubs/teaching/Teaching3/Teaching5.html *and* Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

How Long Should Treatment Last ?

Tx

- Depends on patient problems/needs
- Less than 90 days is of limited or no effectiveness for residential/outpatient setting
- A minimum of 12 months is required for methadone maintenance
- Longer treatment is often indicated

*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word)***

Individuals progress through drug addiction treatment at various speeds, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate lengths of treatment. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer often are indicated. For methadone maintenance, 12 months of treatment is the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years.

Slide Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 3: "Understanding Substance Abuse and Addiction: What Science Says" http://www.nida.nih.gov/pubs/teaching/Teaching3/Teaching4.html

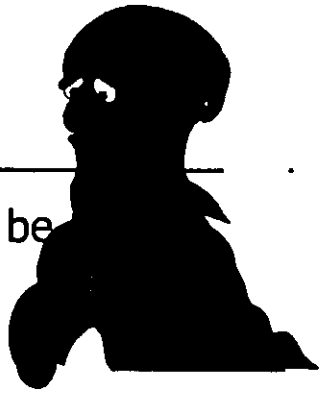
Compliance & Chronicity

Chronic Illness	Medication Compliance	Relapse within 1 year
Diabetes	<60%	30-50%
Hypertension	<40%	50-70%
Asthma	<40%	50-70%
Diet or Behavioral Changes	<30%	

McLellan AT, Lewis DC, O'Brien CP, Kleber HD;
Drug Dependence, A Chronic Medical Illness, JAMA, Oct 4, 2000

Slide Provided by: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Coercion



Treatment does not need to be voluntary to be effective.

- Court-Ordered Probation
- Family Pressure
- Employer Sanctions
- Medical Consequences

*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word)***

Treatment does not need to be voluntary to be effective. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions. Individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.

Slide Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 3: "Understanding Substance Abuse and Addiction: What Science Says" http://www.nida.nih.gov/pubs/teaching/Teaching3/Teaching5.html *and* Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

"Costly" or "Cost-Effective"

- **Expensive Incarceration: Treatment is less expensive than not treating or incarceration (1 year of methadone maintenance = $3,900 vs. $25,900 for imprisonment)**
- **1:7 Rule: Every $1 invested in treatment = up to $7 in reduced crime-related costs**
- **Health Offset: Savings can be > 1:12 when health care costs are included**
- **Reduced interpersonal conflicts**
- **Improved workplace productivity**
- **Fewer drug-related accidents**

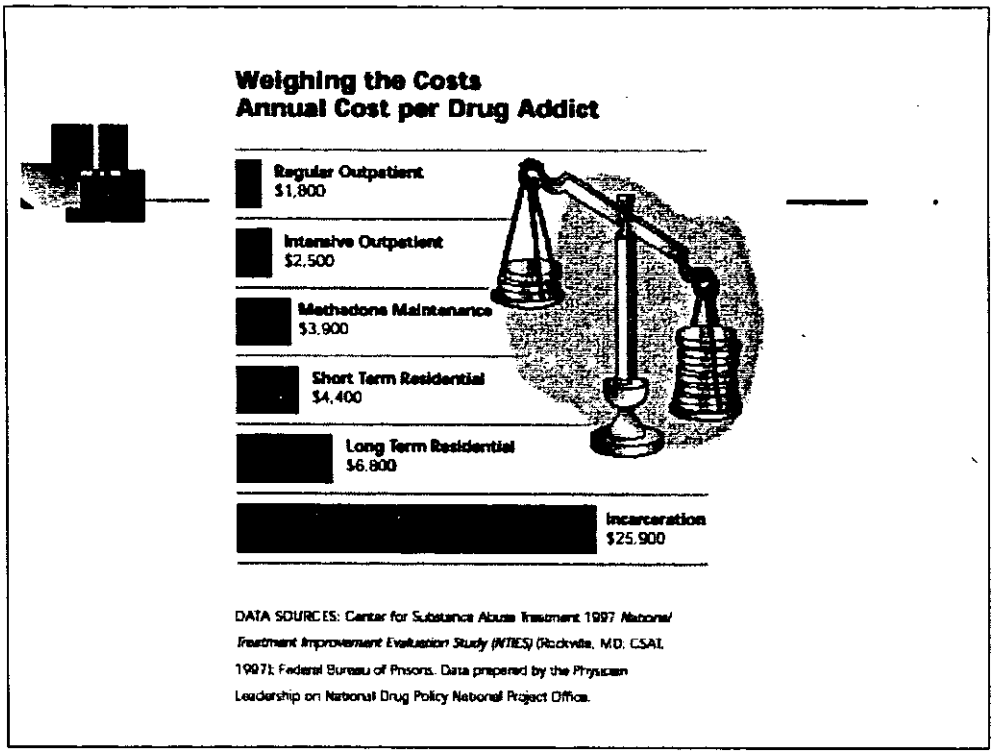
*FACULTY NOTE: (from NIDA teaching instructions – **you may use this narrative text as a guide, but it does not need to be repeated word for word**)*

Cost Effectiveness of Drug Treatment

Drug addiction treatment is cost-effective in reducing drug use and its associated health and social costs. Treatment is less expensive than alternatives, such as not treating or simply incarcerating addicts. For example, the average cost for 1 full year of methadone maintenance treatment averages between $4,000 and $5,000 per patient, whereas 1 full year of imprisonment costs approximately $20,000 or more per person.

According to several conservative estimates, every $1 invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1. Major savings to the individual and society also come from significant drops in interpersonal conflicts, improvements in workplace productivity, and reductions in drug-related accidents.

Slide Source: National Institute on Drug Abuse (NIDA) Teaching Packet No. 3: "Understanding Substance Abuse and Addiction: What Science Says" http://www.nida.nih.gov/pubs/teaching/Teaching3/Teaching5.html



Slide Sources: Center for Substance Abuse Treatment, 1997 *National Treatment Improvement Evaluation Study (NTIES)* (Rockville, MD: CSAT, 1997); Federal Bureau of Prisons. Data prepared by the Physician Leadership on National Drug Policy National Project Office.

What is Recovered in Recovery ?

- Abstinence
- Sense of Responsibility
- Range of Emotions
- Intimacy

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Phases of Recovery

Clinical Model Developed by Peter Banys, M.D.
VA Medical Center and
University of California at San Francisco

- Crisis
- Abstinence
- Sobriety
- Recovery

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Compounding Issues in Recovery

- Socio-economic
- Single parent
- Ethnic
- Matriarch/ Patriarch
- Gender
- Religion
- Treatment
- Co-dependency
- Employment
- Domestic violence
- Living situation
- Extended family

Slide Source: John N. Marr, MS, Presentation on "Basic Pharmacology – Addiction: Fact versus Fiction" for the National Drug Court Institute.

Dual-Diagnosis

- Mood Disorder+: For those with mood disorders, 24-40% have a co-occurring substance abuse disorder
- Alcoholism+: 65% of females and 44% of male alcoholics have co-occurring mental health disorder(s)
  - THE MAJOR ONE = DEPRESSION
    19% of female alcoholics, 4x the rate for men
- Addiction+: 30-59% of women in treatment have PTSD, 2-3 times the rate for men
- Prescriptions: 1:7 women >64 years old takes medication for a mental health disorder

Slide Source: "Alcohol and Other Drugs and the Courts" curriculum, Judge Peggy Fulton Hora, Alameda County Superior Court, Hayward, CA.

Treatment Effectiveness

- Drug dependent people who participate in drug treatment
  - Decrease drug use
  - Decrease criminal activity
  - Increase employment
  - Improve their social and intrapersonal functioning
  - Improve their physical health
- Drug use and criminal activity decrease for virtually all who enter treatment, with increasingly better results the longer they stay in treatment.

Slide Source: Office on National Drug Control Policy, "ONDCP Drug Facts February 2002" Presentation.

But...For How Long?

- One Year After Treatment
  - Drug selling fell by nearly 80%
  - Illegal activity decreased by 60%
  - Arrests down by more than 60%
  - Trading sex for money or drugs down by nearly 60%
  - Illicit drug use decreased by 50%
  - Homelessness dropped by 43% and receipt of welfare by 11%
  - Employment increased by 20%

Slide Source: Office on National Drug Control Policy, "ONDCP Drug Facts February 2002" Presentation.

How Long...?

- Five Years After Treatment
  - Users of *any* illicit drugs reduced by 21%
    - **Cocaine users by 45%**
    - **Marijuana users by 28%**
    - **Crack users by 17%**
    - **Heroin users by 14%**

Slide Source: Office on National Drug Control Policy, "ONDCP Drug Facts February 2002" Presentation.

How Long...?

- Five Years After Treatment (continued)
  - Numbers engaging in illegal activity significantly reduced
    - **56% fewer stealing cars**
    - **38% fewer breaking and entering**
    - **38% fewer injecting drugs**
    - **30% fewer selling drugs**
    - **34% fewer homeless**
    - **23% fewer victimizing others**

Slide Source: Office on National Drug Control Policy, "ONDCP Drug Facts February 2002" Presentation.

Myths of Addiction Treatment

- Myth of Self-Medication
  - Treating just the "underlying" disorders tends not to work
  - Depression doesn't make you drink
  - BUT drugs do make you feel good (however, less and less over time)

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
  - Weakness or will power has little to do with becoming addicted
  - Educated, strong people succumb to the best drugs in the world

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
- Myth of Holding One's Liquor
  - The "Wooden Leg" Syndrome predicts alcoholism, not immunity to alcoholism

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
- Myth of Holding One's Liquor
- Myth of Detoxification
  - Getting sober is easy
  - Staying that way is incredibly difficult

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
- Myth of Holding One's Liquor
- Myth of Detoxification
- Myth of Brain Reversibility
  - Addiction produces permanent neurotransmitter and chemical changes
  - "Kindling" increases risk of permanent paranoia and hallucinations (from alcohol and stimulants)

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Facts of Addiction Treatment

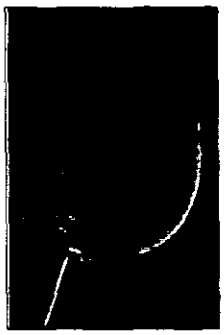
- Addiction is a brain disease
- Chronic, "cancerous" disorders require multiple strategies and multiple episodes of intervention
- Treatment works in the long run
- Treatment is cost-effective

Slide Source: Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Commonly Abused Drugs:

Alcohol

Class of Drug:
Sedatives-Hypnotics



Related Issues:

- ✓Detoxification
- ✓Fetal Alcohol Syndrome (FAS)
- ✓Loss of Judgment
- ✓Suicide/Homicide
- ✓DWI/DUI Concerns
- ✓Poly-drug Use
- ✓Legality Issues

FACULTY NOTE: The intention of the "related issues" on this and the following slides is to identify unique characteristics of addiction to particular drugs (including behavior while using, when stopped using, or special considerations with treatment) that have particular implications for the behavior and accountability expectations of court participants addicted to these drugs. The issues raise considerations for the issuance of orders by the court and the judicial process.

The following are some ideas about how to relate the issues to the judicial process or special issues about which judges should be aware:

Detoxification - Alcohol withdrawal is severe and can be life threatening. Supervision during detox is recommended.

Fetal Alcohol Syndrome (FAS) – If a court participant is pregnant, there is special concern for the unborn child.

Loss of Judgment – Alcoholics exhibit significant loss of judgment, particularly when using. Judges need to consider this element of the addiction in crafting orders.

Suicide/Homicide Rates with Intoxication – The higher prevalence of aggression, as well as suicide attempts, should be considered.

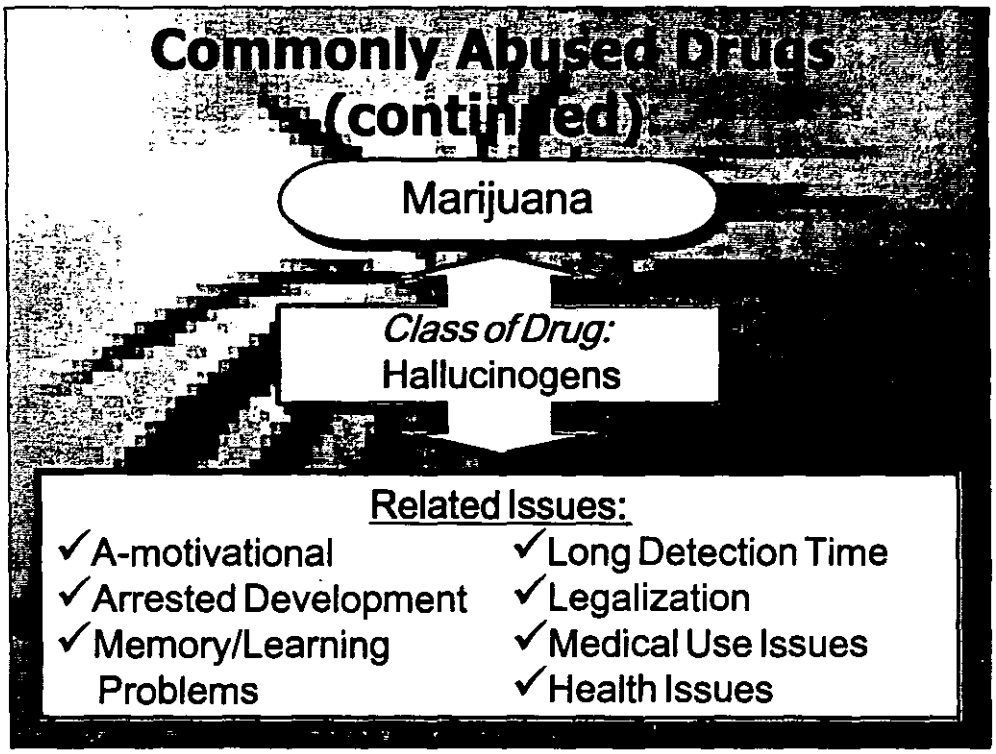
DWI and DUI concerns – The public safety hazards associated with alcohol abuse are significant.

Poly-drug Use – Alcohol is often abused in conjunction with other substances (you can refer back to the slide in Module 1 (Slide 10) that shows that 20.2% of addicts admitted to treatment were abusing alcohol AND another drug.

Legality Issues – Our society tends to normalize excessive drinking because alcohol is a legal substance. Therefore, many will underplay the significance of the problem of alcoholism.

Medications Available – In terms of treatment options, medications to assist in treating alcoholism are available (e.g., Antabuse and Naltrexone).

Source: Adapted from John N. Marr, MS, Presentation on "Basic Pharmacology – Addiction: Fact versus Fiction" for the National Drug Court Institute.



FACULTY NOTE: Higher potency today than in the 60s – considered 10x stronger or more.

A-motivational syndrome –Counterproductive to compliance/knocks out drive and ambition.

Arrested development – Abusers are likely to have low emotional maturity – the drug causes the user's emotional maturity to stop developing (generally considered as of time in terms of chronological age when they began "using") so even though the court participant is 30, he or she may be acting as though he or she is 17.

Memory/Learning Problems – These effects will make it difficult for participants to remember compliance issues (such as attending group sessions).

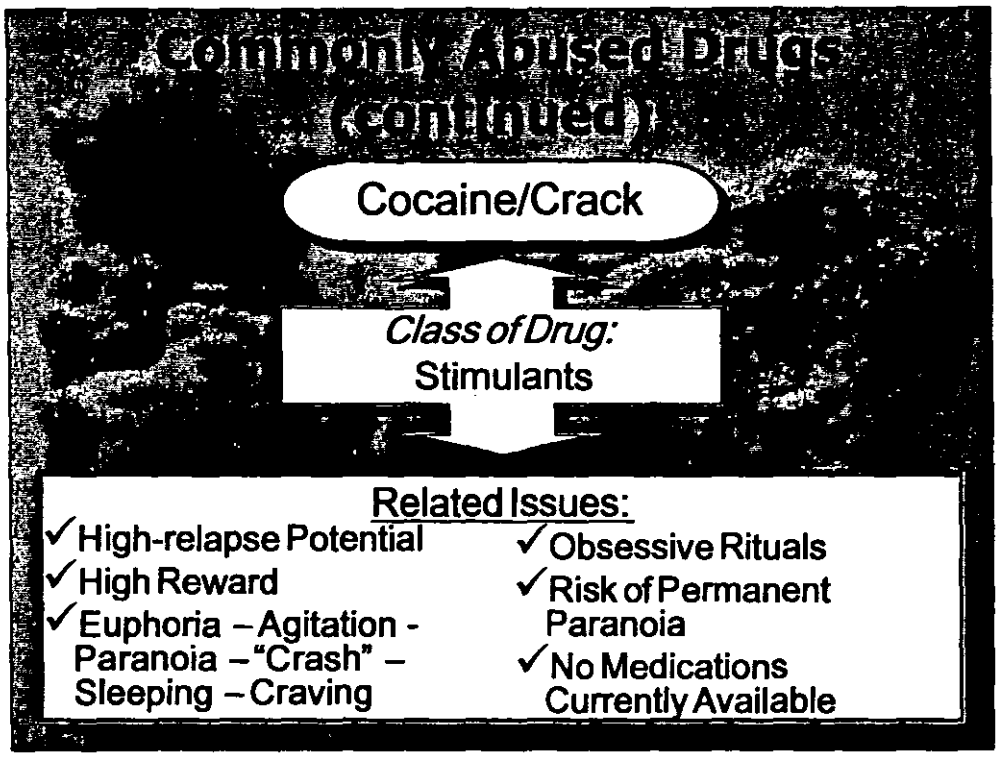
Long detection time in urine – Although many alteration methods are available to "fake" a clean urine screen, alternative testing – such as hair testing – can also be used because marijuana has a long half-life in the body.

Legalization – The push to legalize marijuana may undermine compliance issues.

Medical Use Issues – Although claims about the medical uses of marijuana are prevalent, its only medically confirmed uses are for cancer chemotherapy nausea and AIDS Wasting Syndrome anorexia.

Health Issues – Marijuana joints are highly carcinogenic (they have 5-7 Times more tar than cigarettes).

Source: Adapted from John N. Marr, MS, Presentation on "Basic Pharmacology – Addiction: Fact versus Fiction" for the National Drug Court Institute.



FACULTY NOTE:

High-relapse potential – You should never be surprised by relapse, it is to be expected, especially early in treatment.

High Reward – Part of the relapse issue is the significant stimulation of the brain reward zones when using cocaine. (Rats will do work - press levers - for cocaine until they die of exhaustion.)

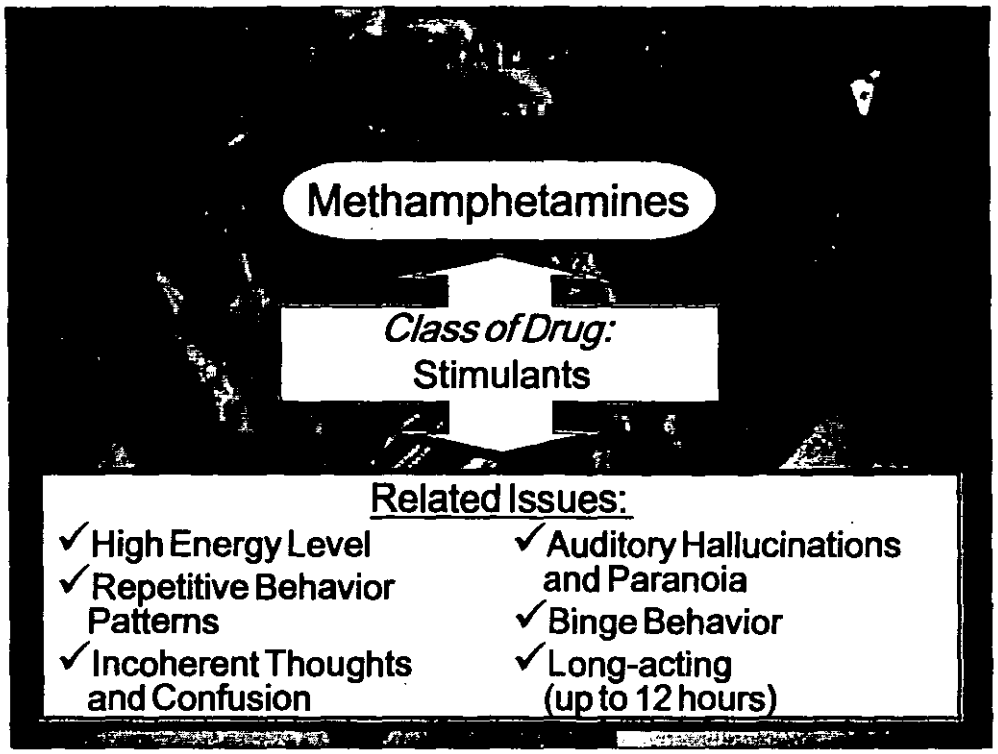
Euphoria - Agitation – Paranoia - "Crash" – Sleep – Craving – Progression of use

Obsessive Rituals – Cocaine addiction is characterized by rituals that trigger use (e.g., getting money from an ATM, seeing white powder). Finding a means to break the triggers is critical to treatment.

Risk of permanent paranoia – You should be aware of a risk among former cocaine abusers of a permanent "kindling" of paranoia and hallucinations even after use has stopped.

No medications are currently available – although tests are being conducted on some new meds.

Source: Adapted from John N. Marr, MS, Presentation on "Basic Pharmacology – Addiction: Fact versus Fiction" for the National Drug Court Institute. Also content from Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.



FACULTY NOTE:

Like long-lasting cocaine, methamphetamines destroys certain nerve tissue and are more debilitating to the brain than cocaine – it's man-made - common terms: speed, meth, chalk, ice, crystal

High energy level – Even small doses can lead to increased wakefulness, physical activity and decreased appetite.

Repetitive behavior patterns – These are similar to compulsive disorders, such as picking at skin/pulling out hair.

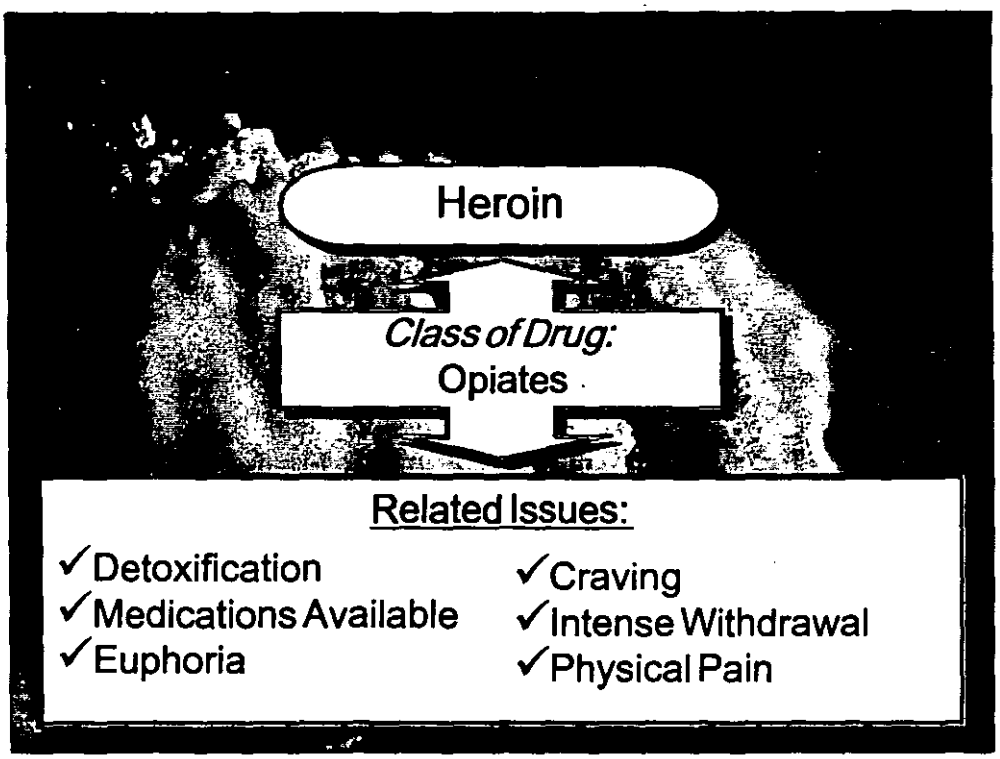
Incoherent thoughts/Confusion

Auditory hallucinations/paranoia – In extreme cases, the paranoia can result in homicidal and suicidal thoughts (also common: formication – delusions of parasites or insects on skin).

Binge behavior – Because pleasurable effects disappear even before the drug concentration in the blood falls significantly, users try to maintain the high by binging on the drug.

Long-acting (up to 12 hours): Because it is so long-lasting, it is harder to control effects.

Source: Adapted from John N. Marr, MS, Presentation on "Basic Pharmacology – Addiction: Fact versus Fiction" for the National Drug Court Institute.



FACULTY NOTE:

New production (in South America) with high purity and potency.

More recently a smokeable form has been created.

Detoxification - It has limited long-term efficacy because of the strong psychological AND physical addiction.

Medications available – Methodone maintenance is more effective for most users (not psychologically, but it seems to work better).

Euphoria – initial surge of euphoria ("rush") immediately after injection; enters brain very rapidly, so particularly addictive. After rush, period of drowsiness (several hours).

Craving – This will affect relapse and ability to comply with treatment.

Intense withdrawal – This can occur within just a few hours of the last time the drug is taken, and peak 2-4 days after last use.

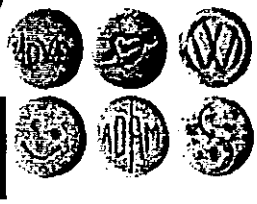
Physical pain – Opiates are unlike other drugs in that withdrawal is accompanied by great physical pain.

Source: Adapted from John N. Marr, MS, Presentation on "Basic Pharmacology – Addiction: Fact versus Fiction" for the National Drug Court Institute.

Commonly Abused Drugs (continued):

"New Drugs"

Club Drugs
Prescription Drugs



- ✓Popular with Youth and Young Adults
- ✓Significant Health Risks: Neuron Destruction with Ecstasy
- ✓Users Believe They Know How to Reduce the Risks – WRONG!
- ✓Availability Increasing

FACULTY NOTE:

Types: Ecstasy (MDMA); GHB (Gamma Hydroxy Butyrate); Rohypnol (related to Valium)

Source: Adapted from John N. Marr, MS, Presentation on "Basic Pharmacology – Addiction: Fact versus Fiction" for the National Drug Court Institute. Also content from Peter Banys, M.D., Assoc. Clinical Prof. of Psychiatry, University of California at San Francisco, VA Medical Center, San Francisco.

Module 2:
Faculty Resources

DRUG AWARENESS KNOWLEDGE QUIZ

Do you know what drugs people are using today and what those drugs can do? Test yourself and find out what you know. You may be surprised by some of the answers!

1. The most commonly abused drug in the U.S. is:
   - ❑ Marijuana
   - ❑ Alcohol
   - ❑ Cocaine
   - ❑ Heroin

2. More people die each year in the U.S. as a result of:
   - ❑ Alcohol
   - ❑ Tobacco
   - ❑ Heroin
   - ❑ Cocaine

3. About 1/3 of alcoholics have a co-existing mental health disorder.
   - ❑ True
   - ❑ False

4. Marijuana is much stronger today than it was 10 years ago.
   - ❑ True
   - ❑ False

5. The number one risk factor for alcoholism is childhood sexual abuse.
   - ❑ True
   - ❑ False

6. The high from a typical dose of crack lasts:
   - ❑ 1 hour
   - ❑ 30 minutes
   - ❑ 5 minutes

7. Physiological responses to drugs and paraphernalia may occur as long as 10 years after the person stops using.
   - ❑ True
   - ❑ False

ANSWERS TO THE DRUG AWARENESS QUIZ

Here are the answers to the seven questions asked on the Drug Awareness Knowledge Quiz.

1. The most commonly abused drug in the U.S. is:
   Alcohol

2. More people die each year in the U.S. as a result of:
   Tobacco

3. **FALSE** Fully 65% of women alcoholics and 44% of men have the dual diagnosis of alcoholism and a co-existing mental disorder such as clinical depression, phobic disorder, or panic disorder.

4. **TRUE** Marijuana is much stronger today than it was 10 years ago.

5. **FALSE** The number one risk factor for alcoholism is genetics. About 80% of alcoholics have an alcoholic family member. Identical twins have a 74% concordance with alcoholism compared to 32% of fraternal twins.

6. The high from a typical dose of crack lasts:
   5 minutes

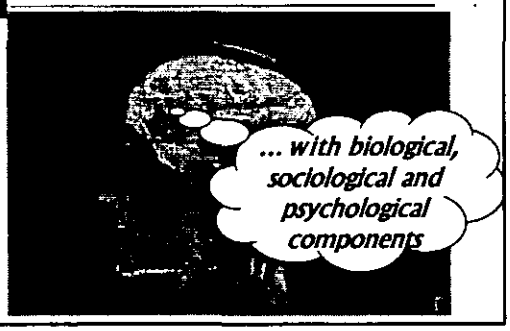
7. **TRUE** Physiological symptoms from viewing a "crack" pipe, passing one's old dealer or seeing drugs can elevate respiration, heart rate and dilate pupils even after 10 years of abstinence.

Module 2:
Participant Handouts

Addiction 101:
Basic Pharmacology and Recovery

Module 2

Addiction is a Complex Illness



Nature of Addiction

- Loss of control
- Harmful Consequences
- Continued Use Despite Consequences

"That is not one of the seven habits of highly effective people."

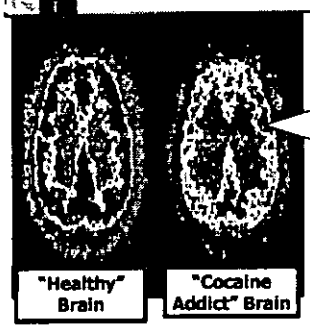
Three "C's" of Addiction

- **Control**
  - Early social/recreational use
  - Eventual loss of control
  - Cognitive distortions ("denial")
- **Compulsion**
  - Drug-seeking activities
  - Continued use despite adverse consequences
- **Chronicity**
  - Natural history of multiple relapses preceding stable recovery
  - Possible relapse after years of sobriety

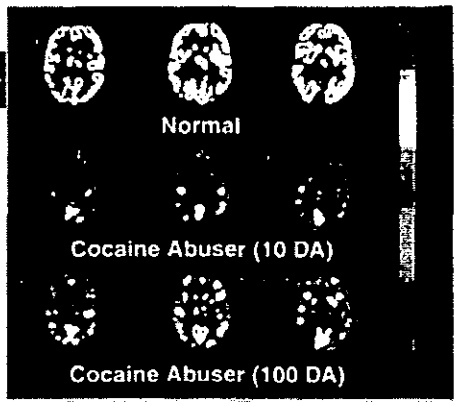
Addiction Risk Factors

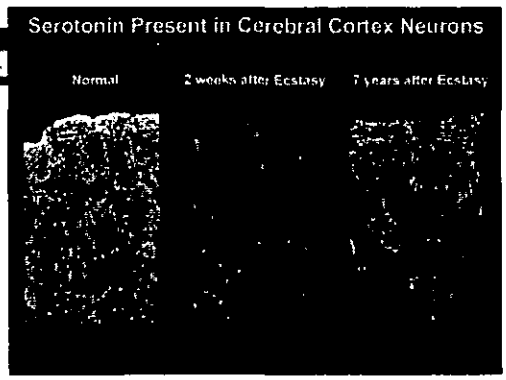
- Genetics
- Young Age of Onset
- Childhood Trauma (violent, sexual)
- Learning Disorders (ADD/ADHD)
- Mental Illness
  - Depression
  - Bipolar Disorder
  - Psychosis

Addiction *is* a Brain Disease



Prolonged Use Changes the Brain in Fundamental and Lasting Ways





How Drugs Work

- Interact with neurochemistry

⇨ Results:

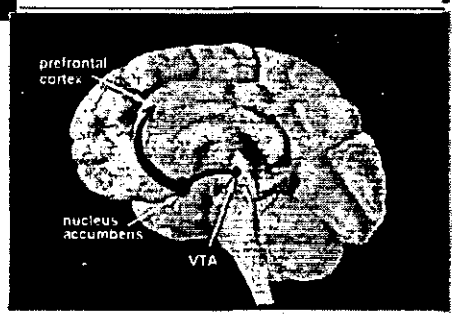
- Feel Good – Euphoria/reward
- Feel Better – Reduce negative feelings

Dopamine Spells REWARD

Natural Rewards

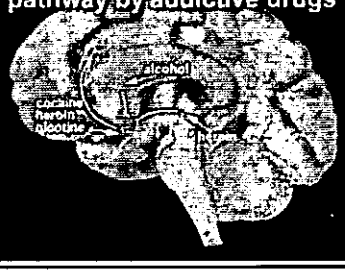
- Food
- Sex
- Excitement
- Comfort

Brain Reward Pathways



Activation of Reward

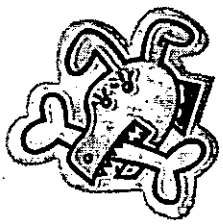
Activation of the reward pathway by addictive drugs



Behavior Pathways

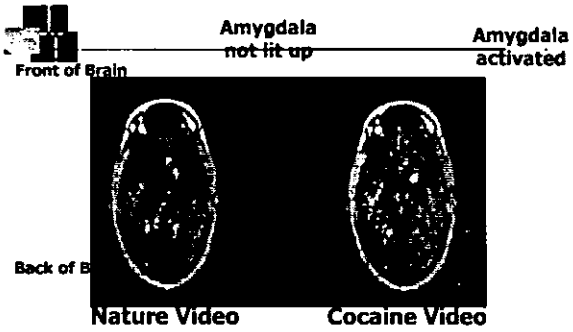
- Rewarding behaviors can become routine
- "Subconscious" control of the behavior
- Difficult to extinguish behaviors because people are <u>not always aware</u> when they are initiated
- Resistant to change

Addiction = Dog with a Bone



- It never wants to let go.
- It bugs you until it gets what you want.
- It never forgets when/where it is used to getting its bone.
- It thinks it's going to get a bone anytime I do anything that reminds it of the bone.

How Long Does the Brain Remember?



Cognitive Deficits

- Memory problems – short-term loss
- Impaired abstraction
- Perseveration using failed problem-solving strategies
- Loss of impulse control
- Similar performance to those with brain damage

Common Characteristics of Addicts

- Unemployment
- Multiple criminal justice contacts
- Difficulty coping with stress or anger
- Highly influenced by social peer group
- Difficulty handling high-risk relapse situations

Common Characteristics...

- Emotional and psychological immaturity
- Difficulty relating to family
- Difficulty sustaining long-term relationships
- Educational and vocational deficits

Violence

- Alcohol disinhibits aggressivity
- Stimulants produce dose-dependent paranoia
- Opiate-seeking, but not opiates, produces violence

Who needs treatment?

13 to 16 million Americans need treatment for alcohol and/or other drug abuse in any year

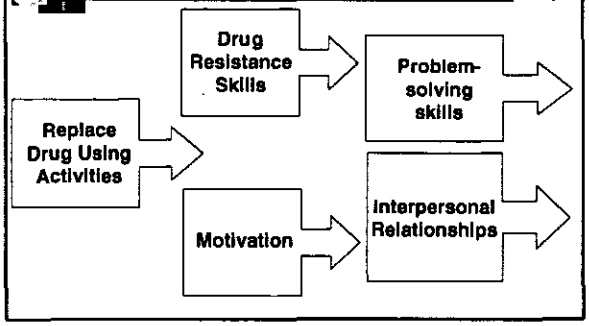
BUT...

Only 3 million receive care

Matching Treatment to Individual's Needs

- No single treatment is appropriate for all individuals
- Effective treatment attends to multiple needs of the individual, not just his/her drug use
- Treatment must address medical, psychological, social, vocational, and legal problems

Counseling and Other Behavioral Therapies

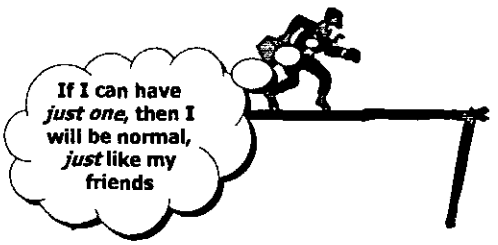


Abstinence

- Strictly speaking, abstinence is developed, not recovered
- It is an abnormal condition, signifying an internal defect (disease)
- Addicts want to be "normal," that is, using drugs in control

Self-Control

- Addicts seek control, not abstinence



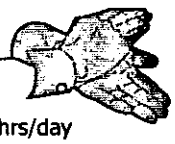
Self Help

- Complements and extends treatment efforts
- Most commonly used models include 12-Step (AA, NA) and Smart Recovery
- Most treatment programs encourage self-help participation during/after treatment

12-Step Groups

- Myths
  - Only AA can treat alcoholics
  - Only a recovering individual can treat an addict
  - 12-step groups are intolerant of prescription medication
  - Groups are more effective than individuals because of confrontation

12-Step Groups



- Facts
  - Available 7 days/week, 24 hrs/day
  - Work well with professionals
  - Primary treatment modality is fellowship (identification)
  - Safety and acceptance predominate over confrontation
  - Offer a safe environment to develop intimacy

Medical Detoxification

Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.

- High post-detoxification relapse rates
- Not a cure!
- A preparatory intervention for further care

Medications

Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

Alcohol:	Naltrexone, Disulfiram, Acamprosate, Odansetron
Opiates:	Naltrexone, Methadone, LAAM, Buprenorphine
Nicotine:	Nicotine replacement (gum, patches, spray), bupropion
Stimulants:	[None to date]

Public Health

- Drug treatment is disease prevention
- HIV infection in injecting drug users
- >90% injection drug users are infected with Hepatitis C virus

How Long Should Treatment Last ?

Tx

- Depends on patient problems/needs
- Less than 90 days is of limited or no effectiveness for residential/outpatient setting
- A minimum of 12 months is required for methadone maintenance
- Longer treatment is often indicated

Compliance & Chronicity

Chronic Illness	Medication Compliance	Relapse within 1 year
Diabetes	<60%	30-50%
Hypertension	<40%	50-70%
Asthma	<40%	50-70%
Diet or Behavioral Changes	<30%	

McLellan AT, Lewis DC, O'Brien CP, Kleber HD;
Drug Dependence, A Chronic Medical Illness, JAMA, Oct 4, 2000

Coercion

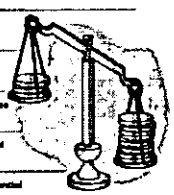
Treatment does not need to be voluntary to be effective.

- Court-Ordered Probation
- Family Pressure
- Employer Sanctions
- Medical Consequences

"Costly" or "Cost-Effective"

- **Expensive Incarceration: Treatment is less expensive than not treating or incarceration (1 year of methadone maintenance = $3,900 vs. $25,900 for imprisonment)**
- **1:7 Rule: Every $1 invested in treatment = up to $7 in reduced crime-related costs**
- **Health Offset: Savings can be > 1:12 when health care costs are included**
- **Reduced interpersonal conflicts**
- **Improved workplace productivity**
- **Fewer drug-related accidents**

Weighing the Costs
Annual Cost per Drug Addict



Regular Outpatient $1,400

Intensive Outpatient $2,400

Methadone Maintenance $3,900

Short Term Residential $4,400

Long Term Residential $9,900

Incarceration $25,900

DATA SOURCES: Center for Substance Abuse Treatment 1997 National Treatment Improvement Evaluation Study (NTIES) (Available: WO CSAT 1997); Federal Bureau of Prisons. Data compiled by the Physician Leadership on National Drug Policy National Report (1996)

What is Recovered in Recovery ?

- Abstinence
- Sense of Responsibility
- Range of Emotions
- Intimacy

Phases of Recovery

Clinical Model Developed by Peter Banys, M.D.
VA Medical Center and
University of California at San Francisco

- Crisis
- Abstinence
- Sobriety
- Recovery

Compounding Issues in Recovery

- Socio-economic
- Single parent
- Ethnic
- Matriarch/ Patriarch
- Gender
- Religion
- Treatment
- Co-dependency
- Employment
- Domestic violence
- Living situation
- Extended family

Dual-Diagnosis

- Mood Disorder+: For those with mood disorders, 24-40% have a co-occurring substance abuse disorder
- Alcoholism+: 65% of females and 44% of male alcoholics have co-occurring mental health disorder(s)
  - THE MAJOR ONE = DEPRESSION
    19% of female alcoholics, 4x the rate for men
- Addiction+: 30-59% of women in treatment have PTSD, 2-3 times the rate for men
- Prescriptions: 1:7 women >64 years old takes medication for a mental health disorder

Treatment Effectiveness

- Drug dependent people who participate in drug treatment
  - Decrease drug use
  - Decrease criminal activity
  - Increase employment
  - Improve their social and intrapersonal functioning
  - Improve their physical health
- Drug use and criminal activity decrease for virtually all who enter treatment, with increasingly better results the longer they stay in treatment.

But...For How Long?

- One Year After Treatment
  - Drug selling fell by nearly 80%
  - Illegal activity decreased by 60%
  - Arrests down by more than 60%
  - Trading sex for money or drugs down by nearly 60%
  - Illicit drug use decreased by 50%
  - Homelessness dropped by 43% and receipt of welfare by 11%
  - Employment increased by 20%

How Long...?

- Five Years After Treatment
  - Users of *any* illicit drugs reduced by 21%
    - **Cocaine users by 45%**
    - **Marijuana users by 28%**
    - **Crack users by 17%**
    - **Heroin users by 14%**

How Long...?

- Five Years After Treatment (continued)
  - Numbers engaging in illegal activity significantly reduced
    - **56% fewer stealing cars**
    - **38% fewer breaking and entering**
    - **38% fewer injecting drugs**
    - **30% fewer selling drugs**
    - **34% fewer homeless**
    - **23% fewer victimizing others**

Myths of Addiction Treatment

- Myth of Self-Medication
  - Treating just the "underlying" disorders tends not to work
  - Depression doesn't make you drink
  - BUT drugs do make you feel good (however, less and less over time)

Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
  - Weakness or will power has little to do with becoming addicted
  - Educated, strong people succumb to the best drugs in the world

Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
- Myth of Holding One's Liquor
  - The "Wooden Leg" Syndrome predicts alcoholism, not immunity to alcoholism

Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
- Myth of Holding One's Liquor
- Myth of Detoxification
  - Getting sober is easy
  - Staying that way is incredibly difficult

Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
- Myth of Holding One's Liquor
- Myth of Detoxification
- Myth of Brain Reversibility
  - Addiction produces permanent neurotransmitter and chemical changes
  - "Kindling" increases risk of permanent paranoia and hallucinations (from alcohol and stimulants)

Facts of Addiction Treatment

- Addiction is a brain disease
- Chronic, "cancerous" disorders require multiple strategies and multiple episodes of intervention
- Treatment works in the long run
- Treatment is cost-effective

Commonly Abused Drugs:

Alcohol

Class of Drug:
Sedatives-Hypnotics

Related Issues:

- ✓Detoxification
- ✓Fetal Alcohol Syndrome (FAS)
- ✓Loss of Judgment
- ✓Suicide/Homicide
- ✓DWI/DUI Concerns
- ✓Poly-drug Use
- ✓Legality Issues

Commonly Abused Drugs (continued):

Marijuana

Class of Drug:
Hallucinogens

Related Issues:

- ✓ A-motivational
- ✓ Arrested Development
- ✓ Memory/Learning Problems
- ✓ Long Detection Time
- ✓ Legalization
- ✓ Medical Use Issues
- ✓ Health Issues

Commonly Abused Drugs (continued):

Cocaine/Crack

Class of Drug:
Stimulants

Related Issues:

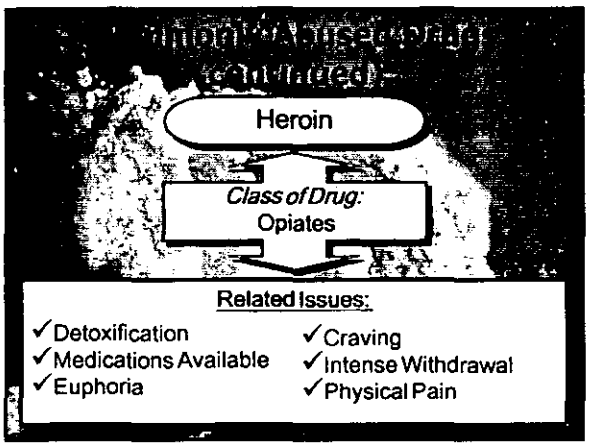
- ✓ High-relapse Potential
- ✓ High Reward
- ✓ Euphoria – Agitation - Paranoia – "Crash" – Sleeping – Craving
- ✓ Obsessive Rituals
- ✓ Risk of Permanent Paranoia
- ✓ No Medications Currently Available

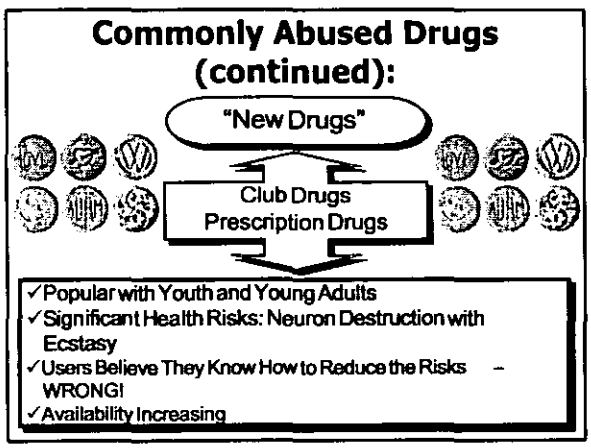
Methamphetamines

Class of Drug:
Stimulants

Related Issues:

- ✓ High Energy Level
- ✓ Repetitive Behavior Patterns
- ✓ Incoherent Thoughts and Confusion
- ✓ Auditory Hallucinations and Paranoia
- ✓ Binge Behavior
- ✓ Long-acting (up to 12 hours)


Heroin
Class of Drug:
Opiates
Related Issues:
✓Detoxification
✓Medications Available
✓Euphoria
✓Craving
✓Intense Withdrawal
✓Physical Pain


Commonly Abused Drugs (continued):
"New Drugs"
Club Drugs
Prescription Drugs
✓Popular with Youth and Young Adults
✓Significant Health Risks: Neuron Destruction with Ecstasy
✓Users Believe They Know How to Reduce the Risks – WRONG!
✓Availability Increasing

3

Module 3
Strategies and Tools for the Courtroom

Presenter: Judicial Officer (with possible assistance from Treatment Provider)

Length: 1 hour, 10 minutes (this time could vary from 1 hour to 3 hours depending on the small group activities)

Purpose: This module is designed to assist judges to apply substance abuse and addiction information in their work on the bench.

Objectives

After completing this module, participants will be able to:

- Develop relevant questions a judge can ask from the bench that may elicit information regarding a litigant's use of drugs and alcohol
- Develop strategies to effectively apply substance abuse and addiction information
- Develop a bench resource guide on substance abuse for personal use
- Identify substance abuse resources in the community and strengths and gaps in local substance abuse services

Instructional Methods

Lecture with PowerPoint Slides
Facilitated Discussion
Scenarios with Small Group Discussion

Participant Handouts

Module 3 Objectives (See Module 1 Handouts)
Module 3 PowerPoint Slides
Personal Action Plan (Print on colored paper for easier reference by faculty)
Scenarios (Print on colored paper for easier reference by faculty)

Faculty Notes

At the end of this module, individuals will be asked to complete a "personal action plan" identifying some things they will do as a result of attending this program. You should consider drawing participants' attention to the action plan guide in the materials during this module.

This module includes a small group exercise and discussion of a series of scenarios (covering aspects of substance abuse in different judicial contexts). Please read and study the scenarios as well as the additional notes on the PowerPoint slides to be prepared to facilitate the discussion among participants.

A critical concept that you should convey through this module is the importance of information gathering in making informed judicial decisions. Some judges may be very hesitant about asking the types of questions from the bench that are outlined in these materials (although

many judges regularly do ask these types of questions). Stress to the participants that this is information that they should have – not necessarily how they should obtain that information. In obtaining information, the concept of coordinating and collaborating with other entities (such as probation, service providers, etc.) also is appropriate to emphasize. You may wish to examine the concept of collaboration as you discuss the bench considerations and the scenarios.

Judicial access to useful resources is another concept that you should convey through this module. We recommend in the materials that participants consider developing a bench book on substance abuse that they can use for reference. Some suggested materials to incorporate into the bench book are included in the participant materials. Judges also should be encouraged to seek out resources in their own communities (for instance, times and locations of 12-step meetings, lists of local treatment providers).

Remember to have participants complete the evaluation form prior to the end of the session.

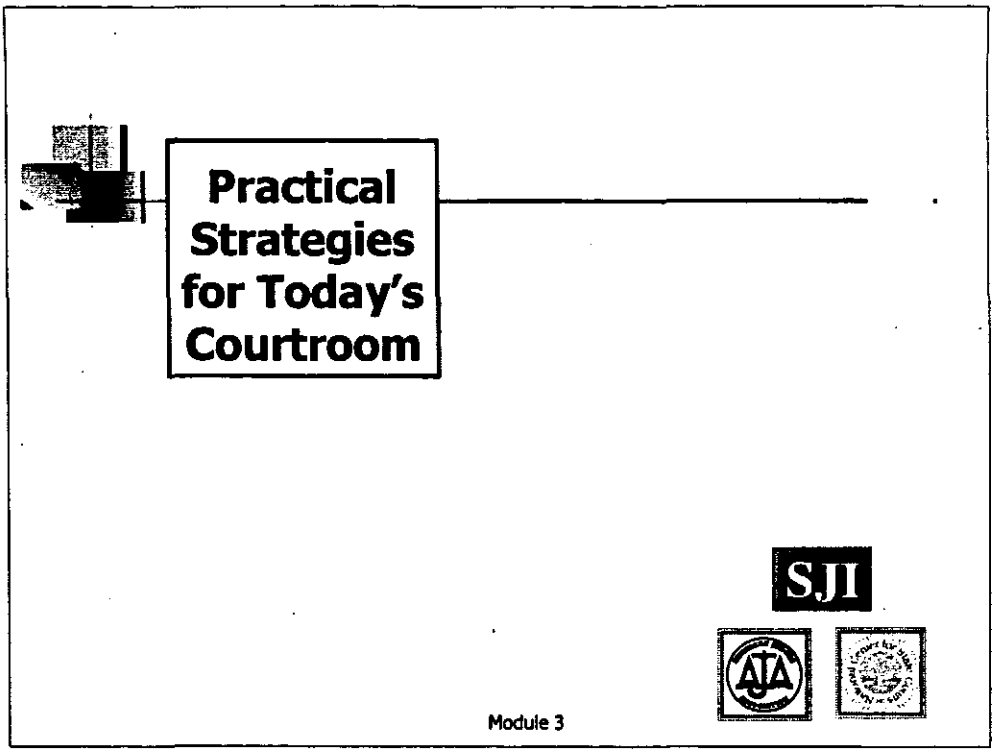
Additional Faculty Resources

Some judges may be uncomfortable with some of the judicial activities suggested in this module. Resources exist that support these activities, however, to which you may wish to refer.

Reference is made in the presentation to the Trial Court Performance Standards. Faculty unfamiliar with the Standards may wish to view the full document on-line at http://www.ncsconline.org/D_Research/TCPS/index.html.

The Conference of Chief Justices and the Conference of State Court Administrators drafted a joint resolution in support of problem-solving court approaches (attached) that encourages the judiciary to examine the applicability of practices in drug treatment courts and other problem-solving court models to the work of courts generally.

Module 3:
PowerPoint Slides with Faculty Notes



(TIMING: 2 minutes)

The previous two segments have provided you with information on the impact of drugs and alcohol on society and a short course on pharmacology and treatment considerations. Now let's think about how to apply this information to your work on the bench. How do you solicit information from those appearing before you regarding their drug/alcohol use? What testing should you require? How do we/you interpret results? What treatment programs are available, and how do you monitor attendance or establish that as a condition?

One goal in this session is to begin to develop a bench book or resource guide you could refer to when substance abuse issues arise during a case. There are resources in the handout materials, as well as on the following slides, that I'd like to offer for your consideration. Following that, I'd like to ask you to work through some scenarios in your table group to (1) answer the issues raised and (2) draw out or share the various ways that you might handle these situations from the bench.

One last note: This section is intended to be participatory, so please ask questions, raise issues, and share your techniques as we go through this issues. After all, you are the ones who do this on a daily basis, and it is your experience in applying this information that may be extremely helpful to others.

FACULTY NOTE – It would be ideal for you to engage other faculty as well, as the participants in discussions during this section. The goal of Module 3 is to get participants to apply their understanding of Modules 1 and 2 in a court setting. One model for doing that is to engage in a dialogue. If participants don't answer the questions, draw in the other faculty to highlight what the slides or lesson are attempting to draw out.

At the end of this module, individuals will be asked to complete a "personal action plan" identifying some things they will do as a result of attending this program. You should consider drawing participants' attention to the action plan guide in the materials for referral during this discussion.

This curriculum was developed by the National Center for State Courts under a grant from the State Justice Institute (SJI-01-N-210). The points of view expressed do not necessarily represent the official position or policies of the National Center for State Courts, the American Judges Association, or the State Justice Institute.

Bench Considerations

A. *Introduction/Background*

1. What grade did the litigant complete in school?
2. Is the litigant currently employed? When was he/she last employed?
3. Does the litigant own or rent a home? If not, with whom does he/she live?
4. Does the litigant have children? If yes, do they live with the litigant? If no, with whom do they live? Does the litigant have custody?

(TIMING: 5-8 minutes)

FACULTY NOTE: You will need to progress through 3 slides during this exercise. Pace transitions as appropriate for the audience.

First, can I see a show of hands by those of you who have developed a list of questions you ask prior to sentencing or establishing conditions for release, visitation, etc? What do you think about asking questions which may be helpful in assessing the situation? These may be questions that you ask yourself from the bench or that you seek from court service officers or others who screen litigants in your courtroom. All of these issues, however, may shed light on a litigant's involvement with alcohol and other drugs and thus will help you in crafting appropriate and effective sentences – including probation and other orders.

FACULTY NOTE: Some judges may be very hesitant about asking these types of questions from the bench themselves (although many judges regularly do ask these types of questions). Stress to the participants that this is information that they should have – not necessarily how they should obtain that information. The purpose is to get the judge to be an effective information gatherer. A number of different people may be able to solicit this information. Encourage collaboration with others in the system as a means to get more accurate information.

ACTIVITY – Review possible bench questions/considerations, adding additional information as needed, to provide the substance abuse context for particular items (keying to risk factors, etc). This list may need to be adjusted depending on the audience, for instance to better fit a juvenile/family context. Refer to your pre-training learning assessment to determine if alterations are necessary.

Bench Considerations (continued)...

5. How old are the children? If they are school age, do they attend school?
6. Are his/her children involved with child protective services or the juvenile court system in any way?
7. Does the litigant have any significant debts/owe people money?

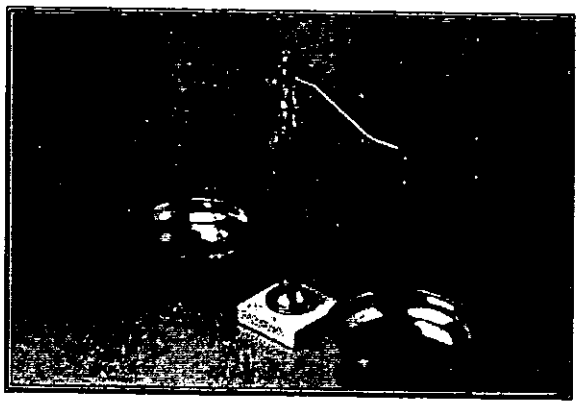
B. *Substance Abuse*

1. Has the litigant, his/her significant other, or child(ren) used alcohol or drugs (including marijuana) during the past six months?

Bench Considerations (continued)...

2. Has the litigant, significant other, or child(ren) been treated in an inpatient, outpatient, or other counseling program during the past six months?
3. If yes, is the litigant, significant other, or child(ren) suffering from an addiction to drugs or alcohol?
4. If the litigant has not been involved in treatment, would he/she be amenable to, or like a referral to, a treatment program?
5. Is the litigant taking any known medications presently?

"Weighing" the Court Performance Standards



Against Substance Abuse...

(Timing: .5 minutes)

One of the tools you have in support of greater court involvement with substance abusers in the courtroom is the Trial Court Performance Standards. The Standards, developed in the early 1990s by the National Center for State Courts with funding from the Bureau of Justice Assistance, provide support to the role of the court in this area.

Standards...

- **Standard 3.5 Responsibility for Enforcement**: The Trial Court takes appropriate responsibility for the enforcement of its orders.
- **Standard 4.5 Response to Change**: The Trial Court anticipates new conditions and emergent events and adjusts its operations as necessary.

(Timing: 2 minutes)

Two standards are particularly relevant to the role of judges and the court in cases involving substance abuse, and referrals to treatment and other services.

The commentary for Standard 3.5, Responsibility for Enforcement, states that no court should be unaware of, or unresponsive to, realities that cause its orders to be ignored. This standard applies to the court's responsibility to ensure that orders to treatment are actually carried out. It is not enough to order the treatment without determining whether the litigant ever actually attended the program. Doing so, ultimately, may diminish public trust and confidence in the courts. Take a moment to consider how you take responsibility for the enforcement of the orders in your court.

Standard 4.5, Response to Change, also applies to these cases. The commentary states effective trial courts are responsive to emergent public issues such as drug abuse... A trial court that moves deliberately in response to emergent issues is a stabilizing force in society and acts consistently with its role of maintaining the rule of law.

Possible Conditions of Orders

- Formal/court probation
- Jail/prison time
- Mental health
- Treatment (in/out)
- AOD – No alcohol or other drugs
- Urine tests
- Education/ employment
- Search/seizure clause
- AIDS education
- Registration
- Medications
- Health (e.g., prenatal care)

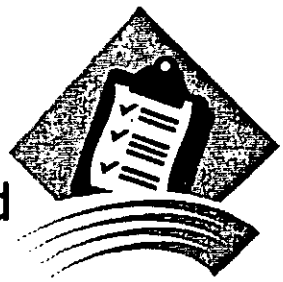
(TIMING: 8 minutes)

FACULTY NOTE: Instructors should pose these or similar questions to the audience to generate discussions regarding appropriate conditions for differing situations and the resulting orders from the bench. Emphasize that these conditions can apply to probation or other types of court orders (permanency plans, bail conditions, etc.)

When establishing conditions, whether for probation, visitations, bail or conditional release, are the following ones that you routinely consider as part of your order? How does the pharmacology and treatment information we just reviewed impact what conditions you would set for those appearing before you? Do you have information on appropriate services and providers in your community where you can refer litigants (clients) that address special needs related to various substances, living situations, etc.?

Conditions should be ...

- Realistic
- Relevant
- Research-supported



(TIMING: 1 minute)

When establishing conditions, whether for probation, permanency plans, bail, or conditional release, remember your conditions should meet this test: they should be realistic, relevant and research-supported.

For example, to simply order abstinence is probably not a realistic condition for someone with a crack cocaine addiction. It would not be relevant to require someone to travel 15 miles to treatment if he/she does not have a car, possess a valid license, or have access to adequate public transportation. And it would not be supported by research to order methadone treatment for anything other than heroin addiction.

Further, orders should recognize the unique qualities of each litigant.

Special Issues: Child Dependency

- Adoption and Safe Families Act (ASFA) time requirements for permanency
- What is the best interest of the children involved in the matter before you?
- Special issues regarding parenting skills
- Coordination with other jurisdictions
- Compliance with standards in Indian Child Welfare Act (ICWA) where Native American children/families are involved

(TIMING: 2 minutes)

When establishing conditions - whether for probation, visitations, bail or conditional release - in matters involving children, participants should be made aware of the Adoption and Safe Families Act time requirements for permanent placements. Other special concerns include considering the best interest of the child and special attention to evaluating the parenting skills of the litigant. Another important issue is that of coordination with other jurisdictions, particularly to avoid the issuance of conflicting orders. In addition, where Native American children/families are involved, placement considerations should comply with standards in the Indian Child Welfare Act (ICWA).

FACULTY NOTE: Faculty should research applicable requirements for the jurisdiction in which they are presenting this curriculum.

AA and the First Amendment

Griffin v. Coughlin, 88 N.Y.2d 674, 673 N.E.2d 98, 649 N.Y.S.2d 903 (1996), cert. denied, 519 U.S. 1054, 117 S. Ct. 681, 136 L. Ed. 2d 607 (1997).

Warner v. Orange County Dep't of Probation, 173 F.3d 120 (2d Cir.), cert. denied, 528 U.S. 1003, 120 S. Ct. 495, 145 L. Ed. 2d 382 (1999).

(Timing: 1 Minute)

One cautionary note about ordering litigants to 12-step programs: federal judges have found that ordering Alcoholics Anonymous (AA) specifically is illegal, but ordering a 12-step program generally is not.

FACULTY NOTE: This slide provides citations for the case law on this issue. We recommend that you read the cases themselves for a more thorough understanding of the cases, in case the participants have additional questions.

To summarize: Griffin held it violates the Establishment Clause of the First Amendment to deprive petitioner of eligibility for expanded family visitation program for refusing to participate in drug/alcohol program that required mandatory attendance in religious-oriented practices. Warner held that probation is liable for damages for "establishment" of religion by requiring AA.

Other Cases: O'Conner v. State of Cal. 855 F.Supp 303 (C.D. Calif. 1994) (No 1st Amendment violation where probationer given choice between AA and secular program)

See also: Honeymar, Michael G., Jr., "Alcoholics Anonymous as a Condition of Drunk Driving Probation: When Does it Amount to Establishment of Religion?," 97 Columbia Law Review 437 (1997)

Verifying 12-Step Meeting Attendance

- Have attendance cards signed by the meeting secretary (usually people don't "secretary" more than once a week) or have them stamped with a distinctive (and hard-to-duplicate) stamp
- Check where and when they say they're going against your county's list of meetings
- Ask for their 30-, 90-, etc. day "chips"

(TIMING: 2 minutes) with next slide

So, now that we know you can order a 12-step program (as long as it is not specifically AA), how do you monitor or verify attendance at 12-step meetings? Do these suggestions cover methods used by you or court services personnel reporting to you?

FACULTY NOTE: More information on 12-step programs is included in the participant materials.

Verifying 12-Step Meeting Attendance (cont'd)

- Keep the 12 steps on the bench, ask what step they're on and quiz them
- Ask whether they're working through the steps with a sponsor and a workbook
- Make them choose a "home meeting"
- Ask whether they're doing service
- Ask if they're talking in meetings

Drug Testing

- What kind of test to order
- Defenses and myths
- Adulteration issues
- Monitoring/countermeasures

(Timing: 4 minutes)

Drug testing is something that courts routinely set as a condition of court orders. The purpose of testing, however, is not to catch litigants using, but to determine if a particular mode of treatment appears to be working. Judges should not just order testing; they should be familiar with the testing alternatives and how to interpret results. One important reminder, however: testing is not foolproof.

Various types of tests are available, including urine, blood, sweat, hair, saliva, and breath, each with their own advantages and disadvantages.

You should also be aware of the common testing defenses and myths, such as passive inhalation, poppy seeds, drug cross-reaction, hemp oil, intimate contact – some are legitimate, most are not.

Litigants also will likely try a variety of adulteration methods (some of which actually work). Examples include addition (using water, common household products, or commercial products), physiological methods (such as water loading), and substitution (including using commercial or a friend's urine or other fluids). Some unique delivery systems are also on the market (check out www.thewizzinator.com). A list of drug testing websites is included in the participant materials.

To avoid these problems, courts should consider the use of a variety of counter-measures. Limit water consumption pre-test, define a diluted sample, institute structured collection methods, and utilize analytical detection measures. Randomization is key – the person being tested cannot know the window.

FACULTY NOTE: You may consider involving the treatment provider in this discussion, particularly the likelihood of various defenses/myths being true.

Group Discussion

- Scenarios
  - Charlie and Mary
  - Theresa
  - Alice
  - Clifford

(Timing: 15 minutes for discussions, 10 minutes for reporting back)

Now it's time to test your understanding of today's session through some scenarios developed to focus on various types of cases where you may encounter substance abuse issues. The scenarios include:

Scenario 1: "Charlie and Mary" - domestic violence case
Scenario 2: "Theresa" - child dependency case
Scenario 3: "Alice" - DUI case
Scenario 4: "Clifford" - probation violation

Exercise Instructions: Break the participants into groups of approximately 5-6 people each, with each assigned to discuss one of the four scenarios for up to 15 minutes. Participants should review the scenario facts to themselves, and then discuss in their small groups the possible substance abuse issues (risk factors, actions that suggest underlying substance abuse problems) and the questions outlined at the end of the scenario. Suggest that within each group the participants might want to discuss what else they would need to learn about the litigant to set an appropriate condition or referral from the bench. Who else would they involve in the case? Can they have some investigative work done prior to making a decision or as part of the decision? By whom? Have one member of the group take notes to report back to the large group (as time permits).

If time is more limited, then eliminate reporting by each group and instead ask for responses from the audience as the scenarios are discussed.

FACULTY NOTE – At the end of the group discussion, the faculty should recap the critical points in each of the scenarios – use the previous slides on probation considerations, 12-step meeting verification and testing to support the points. You are especially encouraged to discuss or draw out collaborative ways judges are interacting with other agencies, within as well as outside the justice system, to address substance abuse issues. If no participants highlight this, the faculty should raise the issue specifically.

Essentials in a "Bench Resource Guide"

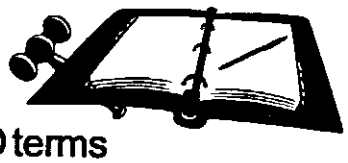
1. Drug guide (slang terms, traditional names, medical uses, duration of effects, possible effects, signs of overdose, withdrawal symptoms)
2. Information on drug testing (including length of time drugs remain in system, possible adulteration methods and myths)
3. List of drug conditions for diversion or probation

(TIMING: 4 minutes with next 2 slides)

As we have gone through this discussion, you may have been developing your own list of resources that would be useful to have at your fingertips on the bench. Through talking with other judges, we developed a list of resources you may want to consider. The list is not exhaustive, but it will be a starting point in developing a bench resource that is useful to you! Many of these items are included in your materials. Others you will need to seek out in your own communities.

FACULTY NOTE: Mention the various bench resources on the list and fill in any anecdotes about how you have found that information to be useful.

"Bench Resource Guide (cont'd)..."

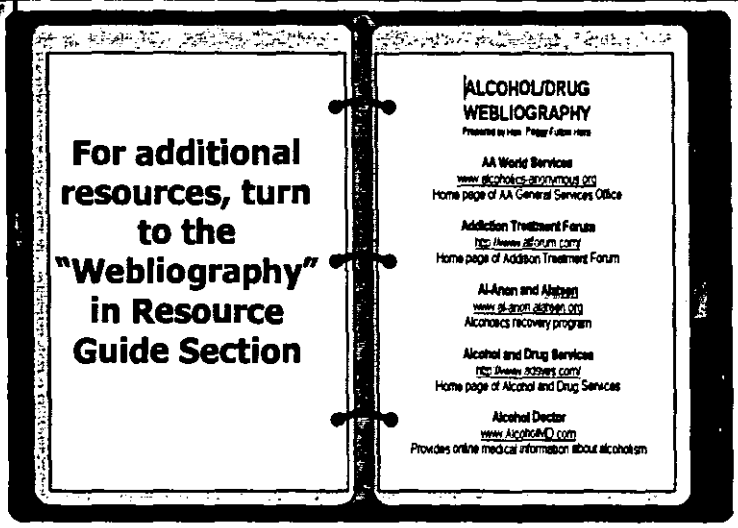


4. Glossary of mental health/AOD terms
5. NIDA Handbook – *Principles of Drug Addiction Treatment* and other information on elements of effective treatment
6. Information on 12 -step programs, including meetings (in neighboring areas of jurisdiction) and attendance verification method/form

"Bench Resource Guide (cont'd)..."

7. List of useful websites
8. Personal references/resources found helpful in understanding the recovery process.

Other Resources Available to You

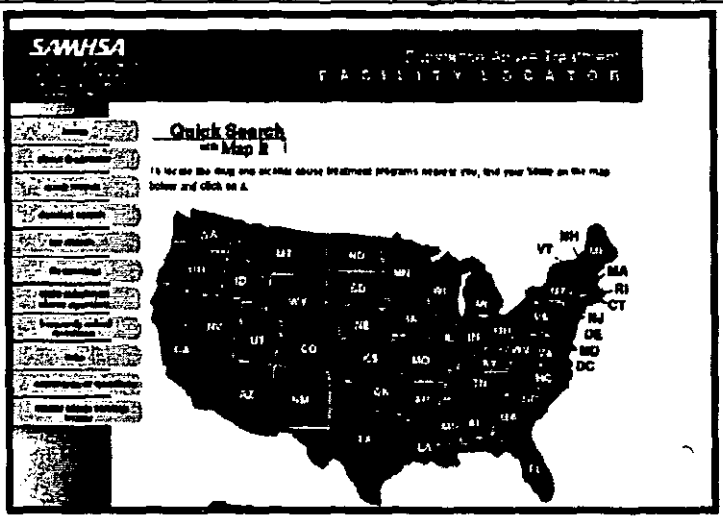


SLIDE ANIMATION NOTE: Slide loads onscreen as blank pages initially. At one-second intervals, automatically, the left page loads first, and then the right "Webliography" page loads.

There are many websites that provide valuable information on these topics – your resources also include a webliography developed by a judge with up-to-date links to resources on the Web.

Locate treatment facilities nationwide

http://www.findtreatment.samhsa.gov/facilitylocatordoc.htm



SLIDE ANIMATION NOTE: Slide initially loads onscreen with image and slide title only. After a one-second interval, the website address automatically loads onto the screen.

One website may be particularly helpful - the Find Treatment site maintained by SAMHSA, especially if you aren't already familiar with treatment resources in your community.

Educational Opportunities

- The National Judicial College
  1 (800) 25-JUDGE www.judges.org
- Natl Council of Juvenile & Family Court Judges
  (775) 784-6012 www.ncjfcj.unr.edu
- Natl Association of Drug Court Professionals/ Natl Drug Court Institute
  1 (877) 507-3229 www.nadcp.org

We have just touched the tip of the iceberg – other national education organizations have more extensive training programs that cover this material – and much more. Please get in touch with one of them if you would like to pursue this information further.

Action Plan

- List three items (facts, strategies, information) that were new to you and that you will share with others
- List sources of information on substance abuse treatment that you would like to investigate, or encourage your support staff to acquire information about, in your community
- List three ways you would like to enhance your judicial work in the area of substance abuse

(Timing: 3 minutes)

We hope that this presentation has provided you with some valuable new ideas about effectively addressing the litigants in your courtroom who have substance abuse problems. Now, we want to provide you with a chance to make some plans for how you will use this information when you return to your jurisdiction. If you have not done so already, please take a few minutes to complete your "personal action plan."

FACULTY NOTE: You may wish to photocopy the Action Plan on colored paper for easy reference.

EVALUATION & FEEDBACK

Please take a few minutes to complete the evaluation form to provide insights on how we can improve this presentation in the future.

Module 3:
Faculty Resources

FACULTY RESOURCE (MODULE 3): TRIAL COURT PERFORMANCE STANDARDS

NOTE: Could also be used as a participant handout

TRIAL COURT PERFORMANCE STANDARDS

The full text of the standards with commentary is available on-line at:
http://www.ncsconline.org/D_Research/TCPS/index.html

Standard 3.5: Responsibility for Enforcement
The trial court takes appropriate responsibility for the enforcement of its orders.

Commentary. Courts should not direct that certain actions be taken or be prohibited and then allow those bound by their orders to honor them more in the breach than in the observance. Standard 3.5 encourages a trial court to ensure that its orders are enforced. The integrity of the dispute resolution process is reflected in the degree to which parties adhere to awards and settlements arising out of them. Noncompliance may indicate miscommunication, misunderstanding, misrepresentation, or lack of respect for or confidence in the courts.

Obviously, a trial court cannot assume responsibility for the enforcement of all of its decisions and orders. Court responsibility for enforcement and compliance varies from jurisdiction to jurisdiction, program to program, case to case, and event to event. It is common and proper in some civil matters for a trial court to remain passive with respect to judgment satisfaction until called on to enforce the judgment. Nevertheless, no court should be unaware of or unresponsive to realities that cause its orders to be ignored. For example, patterns of systematic failures to pay child support and to fulfill interim criminal sentences are contrary to the purpose of the courts, undermine the rule of law, and diminish public trust and confidence in the courts. Monitoring and enforcing proper procedures and interim orders while cases are pending are within the scope of this standard.

Standard 3.5 applies also to those circumstances when a court relies upon administrative and quasi-judicial processes to screen and divert cases by using differentiated case management strategies and alternative dispute resolution. Noncompliance remains an issue when the trial court sponsors such programs or is involved in ratifying the decisions that arise out of them.

Standard 4.5: Response to Change

The trial court anticipates new conditions and emergent events and adjusts its operations as necessary.

Commentary. Effective trial courts are responsive to emergent public issues such as drug abuse, child and spousal abuse, AIDS, drunken driving, child support enforcement, crime and public safety, consumer rights, gender bias, and the more efficient use of fewer resources. Standard 4.5 requires trial courts to recognize and respond appropriately to such public issues. A trial court that moves deliberately in response to emergent issues is a stabilizing force in society and acts consistently with its role of maintaining the rule of law.

Courts can support, tolerate, or resist societal pressures for change. In matters for which the trial court may have no direct responsibility but nonetheless may help identify problems and shape solutions, the trial court takes appropriate actions to inform responsible individuals, groups, or entities about the effects of these matters on the judiciary and about possible solutions.

CONFERENCE OF CHIEF JUSTICES
CONFERENCE OF STATE COURT ADMINISTRATORS

CCJ Resolution 22
COSCA Resolution 4

In Support of Problem-Solving Courts

WHEREAS, the Conference of Chief Justices and the Conference of State Court Administrators appointed a Joint Task Force to consider the policy and administrative implications of the courts and special calendars that utilize the principles of therapeutic jurisprudence and to advance strategies, policies and recommendations on the future of these courts; and

WHEREAS, these courts and special calendars have been referred to by various names, including problem-solving, accountability, behavioral justice, therapeutic, problem oriented, collaborative justice, outcome oriented and constructive intervention courts; and

WHEREAS, the findings of the Joint Task Force include the following:

- The public and other branches of government are looking to courts to address certain complex social issues and problems, such as recidivism, that they feel are not most effectively addressed by the traditional legal process;
- A set of procedures and processes are required to address these issues and problems that are distinct from traditional civil and criminal adjudication;
- A focus on remedies is required to address these issues and problems in addition to the determination of fact and issues of law;
- The unique nature of the procedures and processes encourages the establishment of dedicated court calendars;
- There has been a rapid proliferation of drug courts and calendars throughout most of the various states;
- There is now evidence of broad community and political support and increasing state and local government funding for these initiatives;
- There are principles and methods grounded in therapeutic jurisprudence, including integration of treatment services with judicial case processing, ongoing judicial intervention, close monitoring of and immediate response to behavior, multidisciplinary involvement, and collaboration with community-based and government organizations. These principles and methods are now being employed in these newly arising courts and calendars, and they advance the application of the trial court performance standards and the public trust and confidence initiative; and
- Well-functioning drug courts represent the best practice of these principles and methods;

NOW, THEREFORE, BE IT RESOLVED that the Conference of Chief Justices and the Conference of State Court Administrators hereby agree to:

1. Call these new courts and calendars "Problem-Solving Courts," recognizing that courts have always been involved in attempting to resolve disputes and problems in society, but understanding that the collaborative nature of these new efforts deserves recognition.

2. Take steps, nationally and locally, to expand and better integrate the principles and methods of well-functioning drug courts into ongoing court operations.

3. Advance the careful study and evaluation of the principles and methods employed in problem-solving courts and their application to other significant issues facing state courts.

4. Encourage, where appropriate, the broad integration over the next decade of the principles and methods employed in the problem-solving courts into the administration of justice to improve court processes and outcomes while preserving the rule of law, enhancing judicial effectiveness, and meeting the needs and expectations of litigants, victims and the community.

5. Support national and local education and training on the principles and methods employed in problem-solving courts and on collaboration with other community and government agencies and organizations.

6. Advocate for the resources necessary to advance and apply the principles and methods of problem-solving courts in the general court systems of the various states.

7. Establish a National Agenda consistent with this resolution that includes the following actions:

   a. Request that the CCJ/COSCA Government Affairs Committee work with the Department of Health and Human Services to direct treatment funds to the state courts.

   b. Request that the National Center for State Courts initiate with other organizations and associations a collaborative process to develop principles and methods for other types of courts and calendars similar to the *10 Key Drug Court Components*, published by the Drug Courts Program Office, which define effective drug courts.

   c. Encourage the National Center for State Courts Best Practices Institute to examine the principles and methods of these problem-solving courts.

   d. Convene a national conference or regional conferences to educate the Conference of Chief Justices and Conference of State Court Administrators and, if appropriate, other policy leaders on the issues raised by the growing problem-solving court movement.

   e. Continue a Task Force to oversee and advise on the implementation of this resolution, suggest action steps, and model the collaborative process by including other associations and interested groups.

Adopted as Proposed by the Task Force on Therapeutic Justice of the Conference of Chief Justices in Rapid City, South Dakota at the 52nd Annual Meeting on August 3, 2000.

Module 3:
Participant Handouts

JUDICIAL EDUCATION ON SUBSTANCE ABUSE: PROMOTING AND EXPANDING JUDICIAL AWARENESS AND LEADERSHIP

PERSONAL ACTION PLAN

Consider the information presented during today's session and how you can incorporate it into your work when you return to your jurisdiction

List three items (facts, strategies, information) about which you heard in the program that were new to you and that you will share with others when you return home:

1.

2.

3.

List sources of information on substance abuse treatment that you would like to investigate, or encourage your support staff to acquire information about, in your community when you return home:

List three ways you would like to enhance your judicial work in the area of substance abuse:

1.

2.

3.

CHARLIE & MARY

by Hon. Peggy Fulton Hora, Alameda Co. Superior Court, CA

After a whirlwind romance, Charlie and Mary eloped to Las Vegas three years ago. Charlie has always been jealous throughout their relationship and complains about Mary's family and friends. She has gradually withdrawn from them to placate Charlie and because she grows frustrated hearing her mother call Charlie "that alcoholic bum." Charlie pays all the bills, controls the checkbook and gives Mary a household allowance. They have one car, Charlie's, and he drives her shopping or she takes the bus.

After Mary became pregnant last year and became focused on the impending birth, Charlie began to feel left out and started to brood and withdraw. After one weekend of heavy drinking, he grabbed Mary's arm very hard and accused her of having an affair with her Ob/Gyn. Mary was more frightened than hurt and agreed to switch to a woman doctor. That evening Charlie brought Mary flowers, apologized and said his jealousy was based on the depth of his love for her.

After their daughter, Charlene, was born, Charlie began complaining about Mary's housekeeping, her cooking and her unavailability to him. She was always "too tired" to spend time with him, and he began to resent the baby. Charlie became more verbally abusive to Mary as the months wore on. He was drinking a six-pack each weeknight and a case on weekends.

Charlene, who is now 18 months old, fell one afternoon and cut her forehead. Mary got a ride to the hospital from her neighbor, Sam. When Charlie got home from work and found Mary gone he was furious. He drank until he heard a car outside. He saw Sam dropping Mary off in front of the house and rushed outside in a rage. He pulled Mary out of the car and roughly removed Charlene from the car seat. Charlene began to cry and, while trying to comfort her daughter, Mary was kicked in the back by Charlie. The neighbor, Sam, attempted to intervene, and Charlie punched him in the mouth.

Charlie has been charged with battery on Sam, domestic assault on Mary and child endangerment. Mary is seeking a civil protective order for herself and her child and is asking that Charlie receive counseling for his drinking, as she believes this is the cause of his violence.

Discussion Questions:

What are the different courts that might see this case? How many different court orders might be issued by different judges? Which order has priority? Any prerequisites to modifying a "no contact" restraining order? Are there prerequisites placed on Charlie? On Mary?

What, if anything, should Mary's doctor have done when she "dropped out" of prenatal treatment? What obligations, if any, do physicians have to report domestic violence? Had Mary been badly injured by Charlie during either incident so as to require a visit to the ER, would the physician's obligations be any different?

Should you dispel Mary's belief that alcohol "causes" Charlie's violence? If so, how, and who should dispel it? What type of counseling, if any, does Charlie need? If he is court-ordered to counseling for violence and AOD abuse, which should come first? What type of counseling, if any,

would you order for Mary and Charlene? What is the effect, if any, on children who witness family violence? Should Mary be prosecuted for child endangerment because she didn't leave Charlie?

Is Charlie an alcoholic? How do we know? How will the judge find out? What should the judge do?

THERESA

by Hon. Patricia Bresee, San Mateo, CA

Theresa, age 20, has once again been arrested for possession of methamphetamine (meth). This is her second arrest as an adult and came as a result of a "bust" of a house in which Theresa and her 3-year-old son, Marcus, appeared to be living. Also in the house were Brandon, Theresa's current boyfriend, who is the alleged father of her unborn child (due in three months); Brandon's brother, Hans; Hans's girlfriend, Lisa; and Lisa's three children. Substantial quantities of meth were seized, as well as some drug paraphernalia and $1,200 in $20 bills. Theresa denies involvement in any selling but acknowledges that she smokes marijuana and snorts meth on occasion. Three bindles of meth were found in her purse. The children were removed and turned over to the county welfare department, and petitions on each of them to make them dependents of the court have been filed in juvenile court.

Theresa has a history of runaways as a teen and was declared a ward of the juvenile court herself as a result of a sustained petition alleging possession of marijuana for sale. She was placed in a series of group homes and was terminated from juvenile probation when she turned 18.

DISCUSS:

1. **How do you solve a problem like Theresa's?**
2. **What other information do you need?**
3. **What collateral issues should be investigated?**

ASSIGNMENT:

Assume Theresa has entered a nolo plea. Prepare recommendations, including the amount of jail time, if any, you wish to have the judge impose. What conditions will you impose on Theresa if the petition is sustained? What do you suggest her reunification plan look like? Does your perspective change if you are the CPS worker, probation officer, or judge? In what way?

ALICE

by Hon. Peggy Fulton Hora, Alameda Co. Superior Court, CA

Alice, 26, is before you for sentencing after being found guilty of driving under the influence of cocaine. This is her first contact with the criminal justice system. The test taken at the time of the incident showed a blood alcohol level of .04 as well as a metabolite for cocaine.

At trial, testimony revealed that the officer's attention was drawn to Alice's car when it swerved dramatically on the freeway. The officer further testified that, after the stop and during the investigation, Alice's partner, Mark, who was a passenger in the car, blurted out that he had hit her while she was driving and that's why the car swerved. Mark was so intoxicated that the officer arrested him for being drunk in public, but not for hitting Alice since the officer could see no marks on her and Alice refused to make a citizen's arrest.

At the sentencing hearing, the district attorney recommends "a standard, first-time disposition." Defense counsel agrees with the recommendation. **As the treatment provider, what is your recommendation? If you were the judge, do you accept the "standard first"?**

Same facts, except Mark says she turned around to hit the kids in the back seat and that's why she swerved. **Any different result?**

Same facts, except Alice has a prior conviction for child endangerment based upon her refusal to leave Mark, whom the children have witnessed beating her. **Any different result? What if the child endangerment was based on Alice leaving the children home alone at night and in a filthy condition? What if the prior was for battery on another woman? For another AOD offense?**

Any different result if the charge involved marijuana (at a low level commensurate with claims of one-time use the previous day) vs. cocaine (at a level indicative of recent use and likely impairment)? Why?

What else do you want to know?

CLIFFORD

by Hon. Peggy Fulton Hora, Alameda Co. Superior Court, CA, and John Marr, MS, Las Vegas, NV

Clifford is 32 years old and an assistant manager in a department store at the local mall. His father was an alcoholic who was abusive to the family. His mother tried her best, albeit unsuccessfully, to shield her children from her husband. Clifford has one sister from whom he is estranged. Clifford married young and had one child, whom he sees sporadically. He has been divorced for nine years but has a live-in girlfriend, Athena, who works as a bartender at the trendy new cigar bar in town.

Clifford pled "no contest" to his second DUI about six months ago. His BAC was .14. Your jurisdiction requires formal probation for this offense in addition to fines, penalties, DUI school, license suspension, test conditions, and a no-alcohol clause.

A petition to revoke Clifford's probation has been filed based on his failure, on two occasions, to report and test as directed by the probation officer. Clifford appears in court and tells you he missed the tests because of inventory and a hideous work schedule.

What penalty, if any, do you impose for Clifford's missed tests?

Clifford is back on a second petition. The PO tested him because he appeared at the probation office extremely hyper, fidgety, and exhibiting the symptoms of a bad "cold." The "On Track" presumptive urine test was negative, but the PO, based on his suspicions, sent the sample to the lab. A GC/MS test showed positive for a cocaine metabolite and THC. Clifford admits snorting a little cocaine Athena brought home to improve their sex life.

What penalty, if any, do you impose if Clifford admits cocaine use?

What do you do about the unadmitted marijuana use?

Instead, Clifford tells you that the test was positive because he had been to the dentist that day and Lidocaine was used during the dental procedures. You know that Lidocaine does not test positive on the GC/MS.

What penalty, if any, do you impose for lying?

Assume instead, that prior to the observed test by the PO, Clifford is caught trying to pour urine from a concealed bottle into the test cup.

Any different result?

Practical Strategies for Today's Courtroom

SJI

Module 3

Bench Considerations

A. *Introduction/Background*

1. What grade did the litigant complete in school?
2. Is the litigant currently employed? When was he/she last employed?
3. Does the litigant own or rent a home? If not, with whom does he/she live?
4. Does the litigant have children? If yes, do they live with the litigant? If no, with whom do they live? Does the litigant have custody?

Bench Considerations (continued)...

5. How old are the children? If they are school age, do they attend school?
6. Are his/her children involved with child protective services or the juvenile court system in any way?
7. Does the litigant have any significant debts/owe people money?

B. *Substance Abuse*

1. Has the litigant, his/her significant other, or child(ren) used alcohol or drugs (including marijuana) during the past six months?

Bench Considerations (continued)...

2. Has the litigant, significant other, or child(ren) been treated in an inpatient, outpatient, or other counseling program during the past six months?
3. If yes, is the litigant, significant other, or child(ren) suffering from an addiction to drugs or alcohol?
4. If the litigant has not been involved in treatment, would he/she be amenable to, or like a referral to, a treatment program?
5. Is the litigant taking any known medications presently?

"Weighing" the Court Performance Standards

Against Substance Abuse...

Standards...

- **Standard 3.5 Responsibility for Enforcement:** The Trial Court takes appropriate responsibility for the enforcement of its orders.
- **Standard 4.5 Response to Change:** The Trial Court anticipates new conditions and emergent events and adjusts its operations as necessary.

Possible Conditions of Orders

- Formal/court probation
- Jail/prison time
- Mental health
- Treatment (in/out)
- AOD – No alcohol or other drugs
- Urine tests
- Education/ employment
- Search/seizure clause
- AIDS education
- Registration
- Medications
- Health (e.g., prenatal care)

Conditions should be ...

- Realistic
- Relevant
- Research-supported

Special Issues: Child Dependency

- Adoption and Safe Families Act (ASFA) time requirements for permanency
- What is the best interest of the children involved in the matter before you?
- Special issues regarding parenting skills
- Coordination with other jurisdictions
- Compliance with standards in Indian Child Welfare Act (ICWA) where Native American children/families are involved

AA and the First Amendment

Griffin v. Coughlin, 88 N.Y.2d 674, 673 N.E.2d 98, 649 N.Y.S.2d 903 (1996), cert. denied, 519 U.S. 1054, 117 S. Ct. 681, 136 L. Ed. 2d 607 (1997).

Warner v. Orange County Dep't of Probation, 173 F.3d 120 (2d Cir.), cert. denied, 528 U.S. 1003, 120 S. Ct. 495, 145 L. Ed. 2d 382 (1999).

Verifying 12-Step Meeting Attendance

- Have attendance cards signed by the meeting secretary (usually people don't "secretary" more than once a week) or have them stamped with a distinctive (and hard-to-duplicate) stamp
- Check where and when they say they're going against your county's list of meetings
- Ask for their 30-, 90-, etc. day "chips"

Verifying 12-Step Meeting Attendance (cont'd)

- Keep the 12 steps on the bench, ask what step they're on and quiz them
- Ask whether they're working through the steps with a sponsor and a workbook
- Make them choose a "home meeting"
- Ask whether they're doing service
- Ask if they're talking in meetings

Drug Testing

- What kind of test to order
- Defenses and myths
- Adulteration issues
- Monitoring/countermeasures

Group Discussion

- Scenarios
  - Charlie and Mary
  - Theresa
  - Alice
  - Clifford

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"Bench Resource Guide (cont'd)..."

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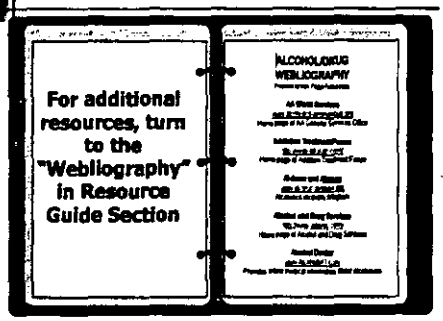
"Bench Resource Guide (cont'd)..."

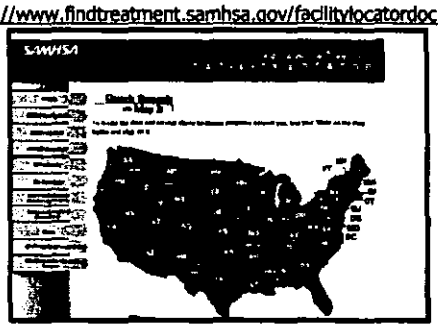
7. List of useful websites
8. Personal references/resources found helpful in understanding the recovery process.

Other Resources Available to You



Locate treatment facilities nationwide

http://www.findtreatment.samhsa.gov/facilitylocatordoc.htm



Educational Opportunities

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  1 (800) 25-JUDGE www.judges.org
- Natl Council of Juvenile & Family Court Judges
  (775) 784-6012 www.ncjfcj.unr.edu
- Natl Association of Drug Court Professionals/ Natl Drug Court Institute
  1 (877) 507-3229 www.nadcp.org

Action Plan

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EVALUATION & FEEDBACK

4

NCSC Feedback Form

Judicial Education on Substance Abuse: Promoting and Expanding Judicial Awareness and Leadership

NCSC Feedback Form

Please complete the following form after presenting the curriculum and return to:

Denise O. Dancy
Research Division
National Center for State Courts
P.O. Box 8798
Williamsburg, VA 23187-8798

Email to: ddancy@ncsc.dni.us or fax at: 757-564-2127.

1. To what type of audience did you present this curriculum (i.e., judges, court staff, probation officers, etc.)?

2. In what context was the curriculum presented (i.e., conference, staff training, CLE, etc.)?

3. What module or modules did you use? What kind of presenter(s) did you use (i.e., expertise in what field – judicial officer, treatment provider, addiction physician, etc.)?

4. If you used the full curriculum, did you expand on the curriculum or use in its 3-hour, 3-module format? If you did expand on it, how, and in what module(s)? What additional materials, information, or presenters did you incorporate into your expanded version?

5. What did you find most useful in the curriculum/particular module(s)? In the CD or other accompanying materials?

6. What did you find least useful in the curriculum/particular module(s)? In the CD or other accompanying materials?

7. Other comments or suggestions:

PowerPoint Viewer Installation Instructions

PowerPoint Viewer 97 for PowerPoint 97, 2000, and 2002 Users

This download is for users who don't have Microsoft PowerPoint®; it allows them to view PowerPoint 95, 97, 2000, and 2002 presentations.

The PowerPoint Viewer 97 allows people who use PowerPoint to share their presentations with people who do not have PowerPoint installed on their computers. When you post presentations on the Internet, you can include the PowerPoint Viewer to expand your online audience to people who might not have PowerPoint, or to those with different versions. You can use this viewer to view files created in both PowerPoint for Windows® and PowerPoint for the Macintosh.

Notes

- You can view and print presentations, but you cannot edit them in the PowerPoint Viewer.
- The PowerPoint Viewer supports all PowerPoint 97 and PowerPoint 95 features.
- Some PowerPoint 2000 and 2002 features are not supported by the viewer:
    - Picture bullets
    - Automatic numbering
    - Animated GIF pictures
    - Microsoft Visual Basic® for Applications (VBA) controls
    - ActiveX® controls are not supported by the viewer

FEATURES

- Provides full fidelity display of PowerPoint 95 and PowerPoint 97 files, including the animations, graphics effects, action settings, hyperlinks, and custom shows.
- Opens presentations saved in PowerPoint for Windows 2.0 or later and PowerPoint for Macintosh 3.0 or later.
- Supports printing of PowerPoint presentations.
- Allows printing and password protection for kiosk-style slide shows.
- In addition to running as a stand-alone application, the PowerPoint Viewer 97 is optimized for displaying PowerPoint presentations inside Microsoft Internet Explorer 3.x and above.
- PowerPoint presentations can be displayed within Netscape Navigator 2.x or higher.

SYSTEM REQUIREMENTS

- A personal computer with a 486 or higher processor
- Microsoft Windows 95, 98, or 2000 operating system, or Microsoft Windows NT Workstation operating system 3.51 (with Service Pack 5.x or later) or 4.0, or Microsoft Windows ME
- 7 MB of hard disk space (9 MB free for installation only)
- VGA or higher-resolution video adapter
- Microsoft Mouse or compatible pointing device

Total Download Size = 2826 kb
Total Download Time = 17 mins @ 28.8k

TO INSTALL THIS DOWNLOAD:

1. You may want to print this page to use as a reference when you are offline.
2. Download the file from Tools on the Web by clicking the **Download Now!** at the top left of this page and following the instructions in the dialog boxes.
3. Close any Windows-based programs that are running.
4. Double-click the **Ppview97.exe** program file on your hard disk to start the setup program.
5. Follow the instructions on the screen to complete the installation.

INSTRUCTIONS FOR USE:

On the **Start** menu, point to **Programs**, and then click **Microsoft PowerPoint Viewer 97**. The viewer will start and allow you to choose a PowerPoint file to view.

TO REMOVE THIS DOWNLOAD:

1. On the **Start** menu, point to **Settings**, and then choose **Control Panel**. Double-click **Add/Remove Programs**.
2. In the list of programs on the **Install/Uninstall tab**, find **Microsoft PowerPoint Viewer 97** and highlight it. Click **Add/Remove**.
3. In the **Microsoft PowerPoint Viewer 97 Setup** dialog box, click **Remove All**.
4. Confirm that you are certain you want to uninstall this software by clicking **Yes**.
5. Click **Restart Windows** or **Exit Setup** in the dialog box.

FOR SUPPORT OF THIS DOWNLOAD:

If you are experiencing problems with this download or the Office Tools on the Web site, please review our Support Page for assistance.

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