Upcoming Webinars

Thursday, May 27, 2021 / 3-5p EDT

Welcome
Chief Justice Kimberly Budd, MA

Evidence-Based Treatment Interventions
Dr. John Brooklyn, University of Vermont Medical Center, VT

Judicial Perspective:
Practical Application for Judges
Judge Kathleen Coffey, MA

Recovery Processes:
Is Recovery Abstinence?
Dr. John Kelly, Harvard School of Medicine, MA

Judicial Perspective:
Practical Application for Judges
Chief Justice Tina Nadeau, NH

Closing Remarks
Chief Justice Gordon MacDonald, NH

REGISTRATION LINK

Session will begin at 3:00 pm

SAVE THE DATE

Thursday, June 17, 2021
3-5p EDT

Closed Question Forums By State
State-specific registration links and information will be announced.

REGIONAL JUDICIAL OPIOID INITIATIVE

National Center for State Courts 50 years 1971-2021

www.ncsc.org/nerjoi

Justice-Involved Individuals with Substance Use Disorders

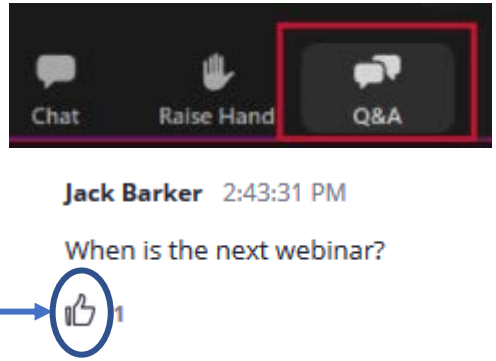
Judicial and Medical Partnership

Judicial Webinar Series

Session will begin at 3:00 pm

NOTE:

- Audio is muted, and the camera is disabled for attendees.
- Chat room allows you to chat with Panelist for technical issues only.
- Q&A is open and allows for upvoting.
- The series will be recorded for later viewing.



REGIONAL JUDICIAL OPIOID INITIATIVE

Sponsored by:

New England Regional Judicial Opioid Initiative and Opioid Response Network

Opioid Response Network STR-TA

Funding for this initiative was made possible (in part) by grant no. 6H79T1080816 from SAMHSA and grant no. 2018-AR-BX-K099 from BJA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S Government.

Agenda & Presenters

Thursday, May 6, 2021 / 3-5p EDT

Welcome
Associate Justice Karen Carroll, VT

Science of Addiction
Dr. Brian Fuehrlein, Yale School of Medicine, CT

Judicial Perspective: Practical Application for Judges
Judge Janet McGuiggan, MA

Co-occurring Disorders and Trauma: What a Judge Needs to Know
Dr. Lisa Callahan, Policy Research Associates

Judicial Perspective: Practical Application for Judges
Chief Justice Paula Carey, MA

Closing Remarks
Chief Justice Richard A. Robinson, CT


Associate Justice Karen Carroll, VT


Dr. Brian Fuehrlein, CT


Honorable Janet J. McGuiggan, MA


Lisa Callahan, Ph.D., PRA


Honorable Paula M. Carey, MA


Chief Justice Richard A. Robinson, CT

Science of Addiction

Denial, Promises and Excuses: Substance Use Disorders

Brian Fuehrlein, MD PhD

5/6/21

Opioid Response Network
STR-TA/SOR-TA

Objectives

- To understand the reward system in the brain and the role it plays in substance use disorders
- To appreciate that substance use disorders are a chronic disease process
- Address misconceptions and how you cannot punish away substance use disorders

Question

A client with an opioid use disorder says “I promise that starting today, I will never use again. When I make a promise, I never break it. I have learned a lesson. I do not need treatment”.

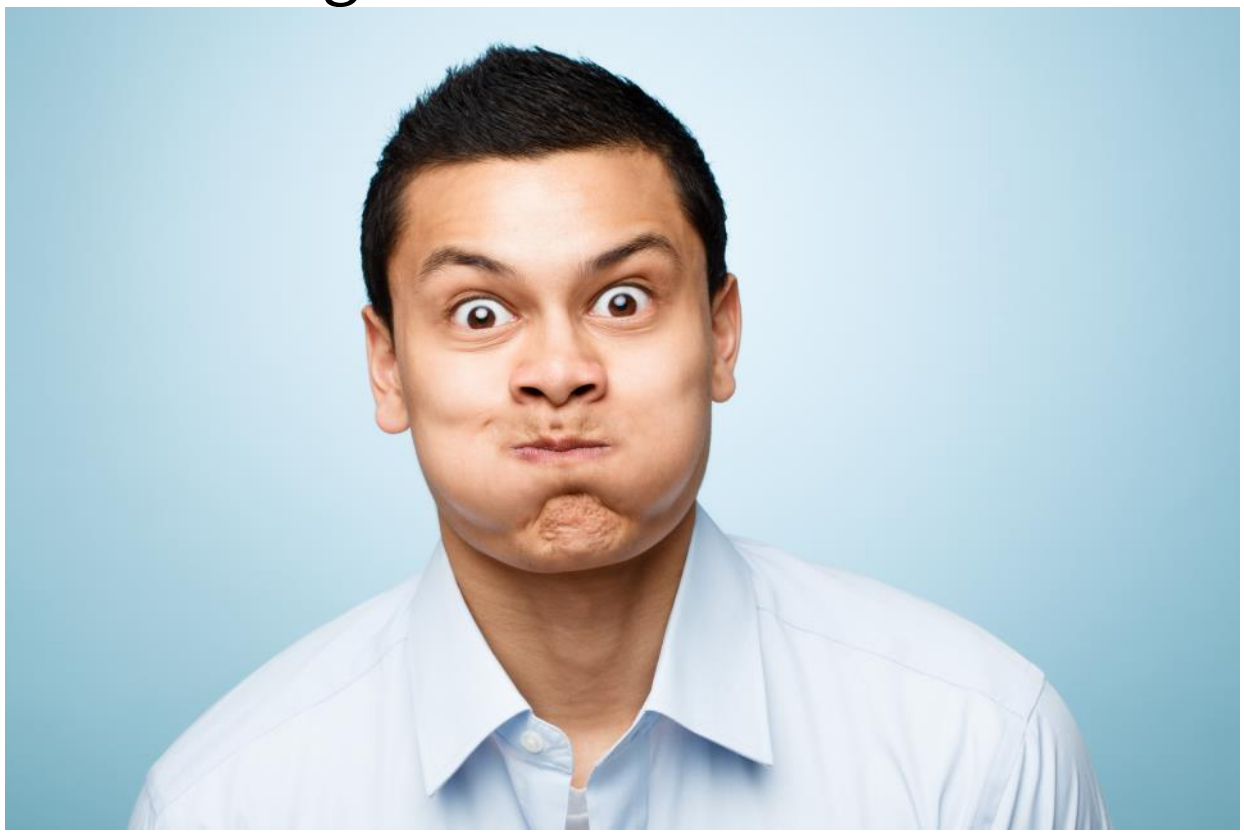
How do you interpret this?

A. Since he is confident and motivated, treatment is not necessary.

B. Since he has an opioid use disorder, we should recommend treatment.

Analogy

- Breath holding exercise



Reward System Basics

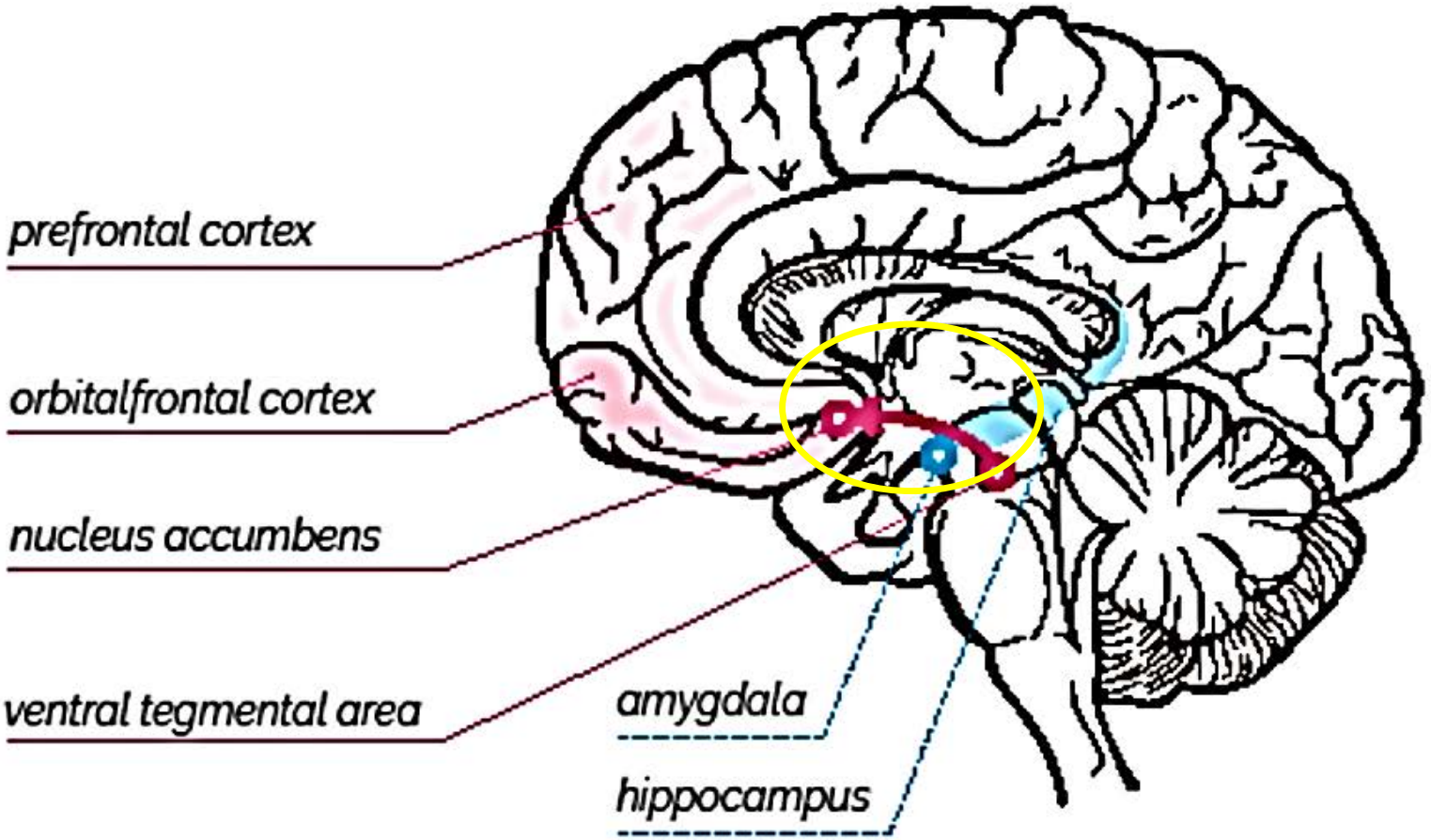


Image from Fuehrlein and Ross, Biological Psychiatry

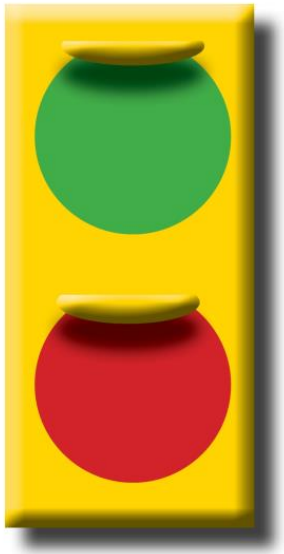
Reward System Basics

- Biologically and evolutionary, the primary purpose of life is to survive and pass on genetics
- The reward system is designed to reinforce eating, drinking water, sexual activity, and raising offspring
- These are activities designed for survival and procreation, which are the most important things to the organism and the species
- For lower level organisms, the reward system is critical to survival and drives daily activity

Basic Review

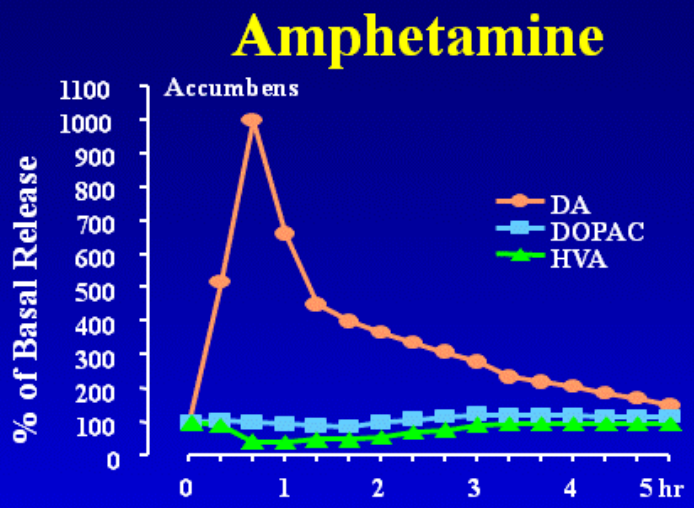
- Reward system – Reinforce primitive behaviors designed

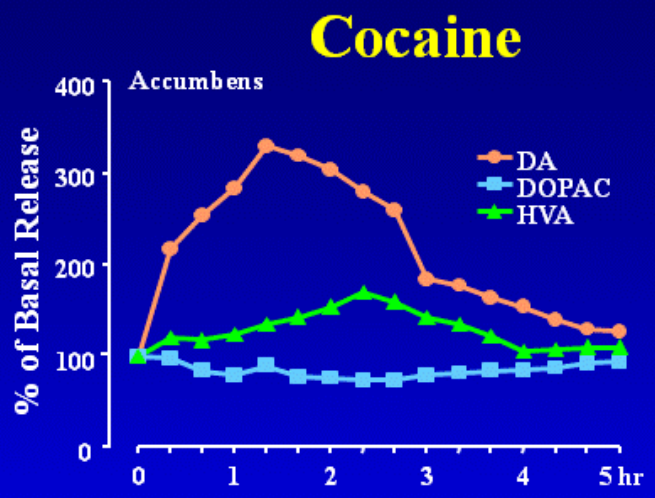
  for survival of person and species

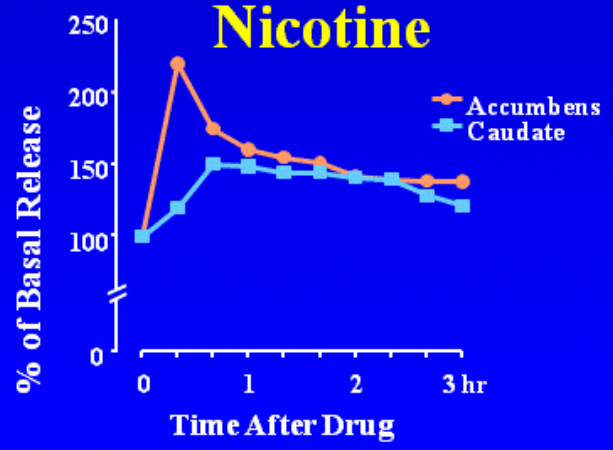


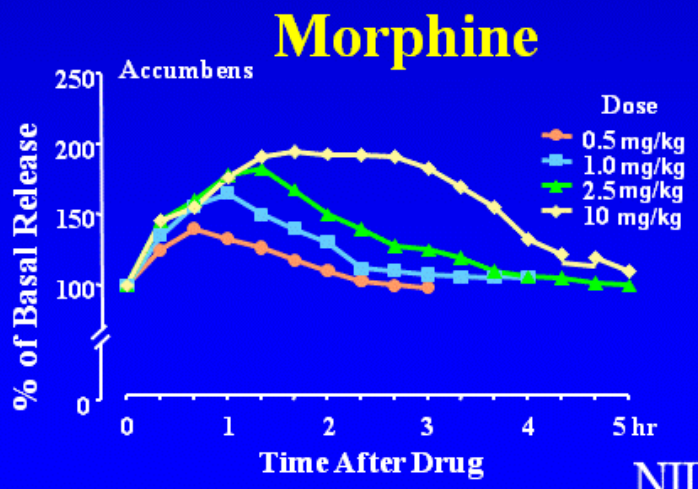
- “GO” → Dopaminergic reward system
- “STOP” → Cortex
- “STOP and GO” Extended Amygdala
- Cortex – Higher executive planning and long-term goals
- Extended Amygdala – emotional importance and fear of withdrawal

Effects of Drugs on Dopamine Release









Di Chiara and Imperato, PNAS, 1988

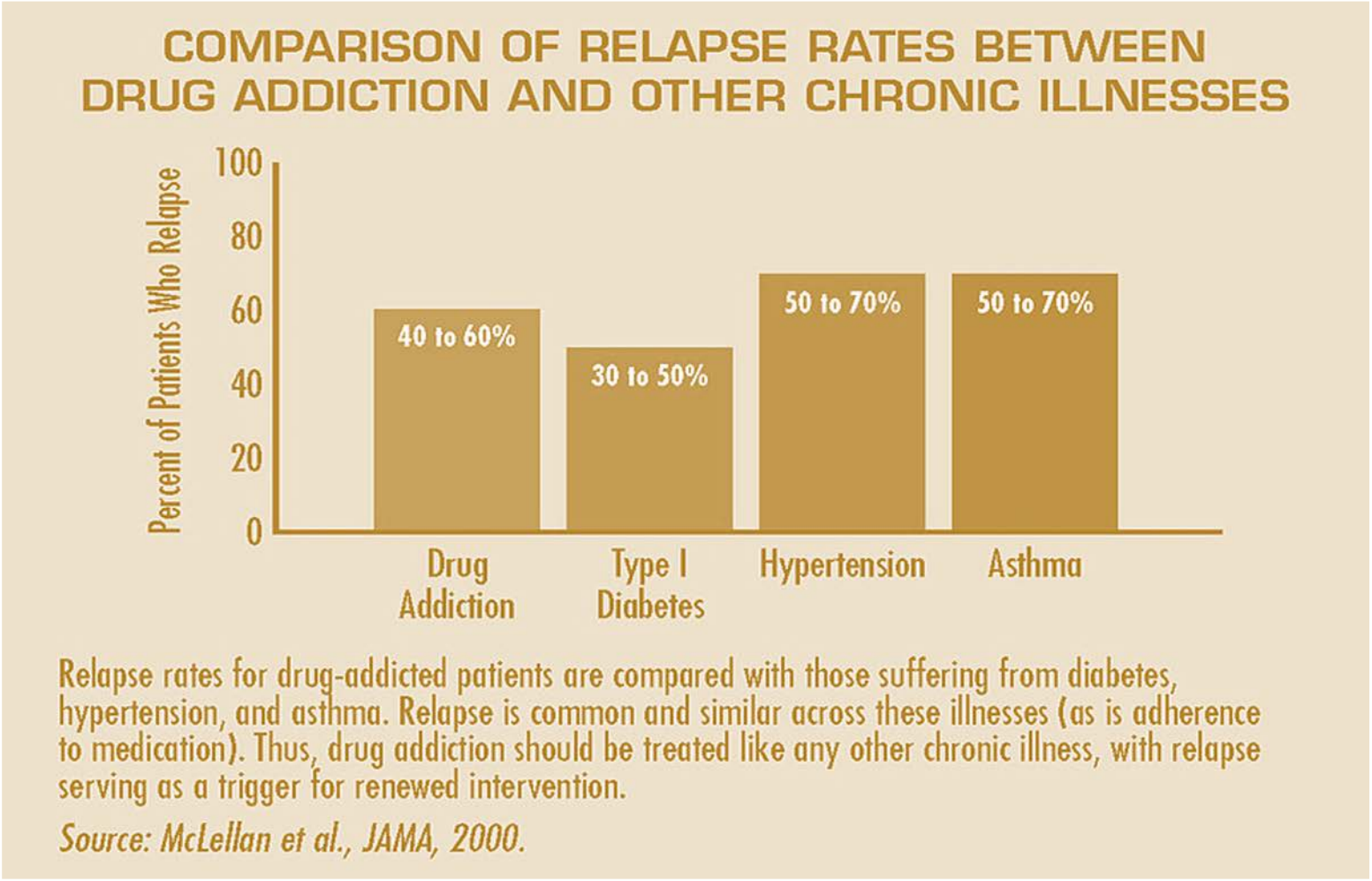
NIDA

That must be critical for survival!

Sure that felt good, but we should not do that again…dangerous stuff…

Whatever I choose I'm doing it above all else

Relapse Rates and Chronic Diseases



What happens with chronic exposure?

Activate Reward Pathway → Substance gets less rewarding in time → Craving for substance increases

Drug induced	• hard to stop once you begin
Cue induced	• people, places, things
Stress induced	• positive and negative stress

Denial

- Substance use disorders often viewed as “cunning and baffling”
- The reward system looks for ways to convince the cortex to continue use

- Denial is a defense mechanism; it defends the substance use disorder and helps it to continue
- There is little motivation to change when the behavior is not believed to be a problem, hence the substance use disorder is protected

Promises

- Promises help the patient to continue their disorder by denying a need for treatment or other interventions
- As with denial, this is usually not the patient “lying” but a symptom of the disease process, which the patient truly believes
- Broken promises destroy relationships and families and make it very difficult to regain trust

Excuses

- Excuses to relapse are triggers for the patient, but perceived as excuses to others
- Sometimes triggers are negative (stressful event, rainy day), other times they are positive (happy events, sunny day)
- Patients with a substance use disorders often create excuses to enable the disorder to continue
- At times, the excuse is legitimate, i.e., spouse tragically dies and patient relapses after 5 years of sobriety

Return to Use

- Return to use happens before the patient actually uses
  - Often changes in thinking or behavior that occur prior to the use of the substance
  - A time for clinicians to potentially intervene and hopefully prevent the use of the substance
- This is a part of the disease process and common
  - Addiction is a chronic, relapsing disease of the brain
  - Does not indicate a failure of treatment or moral failing of the patient
  - A time to assess treatment needs
  - Most often can be a learning experience when approached properly

Choice

- Think about someone with an opioid use disorder slowly and methodically destroying everything that was ever important.

Question

A client reports drinking only 1-2 drinks per day and does not understand why everyone thinks this is a problem.

How do you interpret this?

A. 1-2 drinks is a safe amount and is thus not concerning.

B. We need more information about the drinks.

Standard Drinks

- **12 oz regular beer (5% alcohol)**
  - Light beer contains slightly less alcohol (4.2%)
  - Malt beverages contain approximately 7% alcohol
- **5 oz of table wine (12% alcohol)**
- **1.5 oz of 80 proof spirits (40% alcohol)**
- **Remember 60 as an easy way to figure out drink size and percent**

Some Other Terms

- Nip = common airplane bottle = 50 ml = 1.7 oz = slightly more than 1 standard drink
- Pint = 375ml = 12.7 oz = 8.5 standard drinks
- Fifth = fifth of a gallon = 750 ml = 25.4 oz = 17 standard drinks
- Handle = approximately half gallon = 1.75 L = 59 oz = 39.3 standard drinks

Question

A client with an opioid use disorder says “I have tried NA in the past and listening to all of those stories makes me want to use”.

How do you interpret this?

A. NA is not for them.

B. We should have a further discussion about their experience to make a more informed decision about whether NA could still help them.

Alcoholics/Narcotics Anonymous

- The recovery program
  - Meetings (90 in 90)
  - Sponsorship
  - Step work
  - Commitments

Treatment

- Problematic behavior is a symptom of the illness
- While punishment is often necessary, punishment is not a treatment for substance use disorders
- Treatment should be part of the equation

Working with communities to address the opioid crisis.

- SAMHSA's State Targeted Response Technical Assistance (STR-TA) and State Opioid Response Technical Assistance (SOR-TA) grants created the *Opioid Response Network* to assist states, individuals and other organizations by providing the resources and technical assistance they need locally to address the opioid crisis .
- Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

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Working with communities to address the opioid crisis.

- The Opioid Response Network (ORN) provides local, experienced consultants in prevention, treatment and recovery to communities and organizations to help address this opioid crisis.
- The ORN accepts requests for education and training.
- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.

Contact the Opioid Response Network

- To ask questions or submit a request for technical assistance:
  - Visit www.OpioidResponseNetwork.org
  - Email orn@aaap.org
  - Call 401-270-5900

Trauma, Co-Occurring Disorder, & the Courts

Lisa Callahan, PhD
Policy Research Associates, Inc
May 6, 2021

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Opioid Response Network
STR-TA/SOR-TA

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What is trauma and why is it a focus across so many systems?

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Emergence of trauma as an issue

- Science
  - Adolescent brain development
  - Observable impact of trauma on adults
- Professional experiences being studied & reported
- Money
  - Costs to many systems – justice, medical, behavioral health, employment, social services, family, military, etc.
- Politics
  - “Raise the age”
  - Trauma experiences in other populations (e.g. soldiers)

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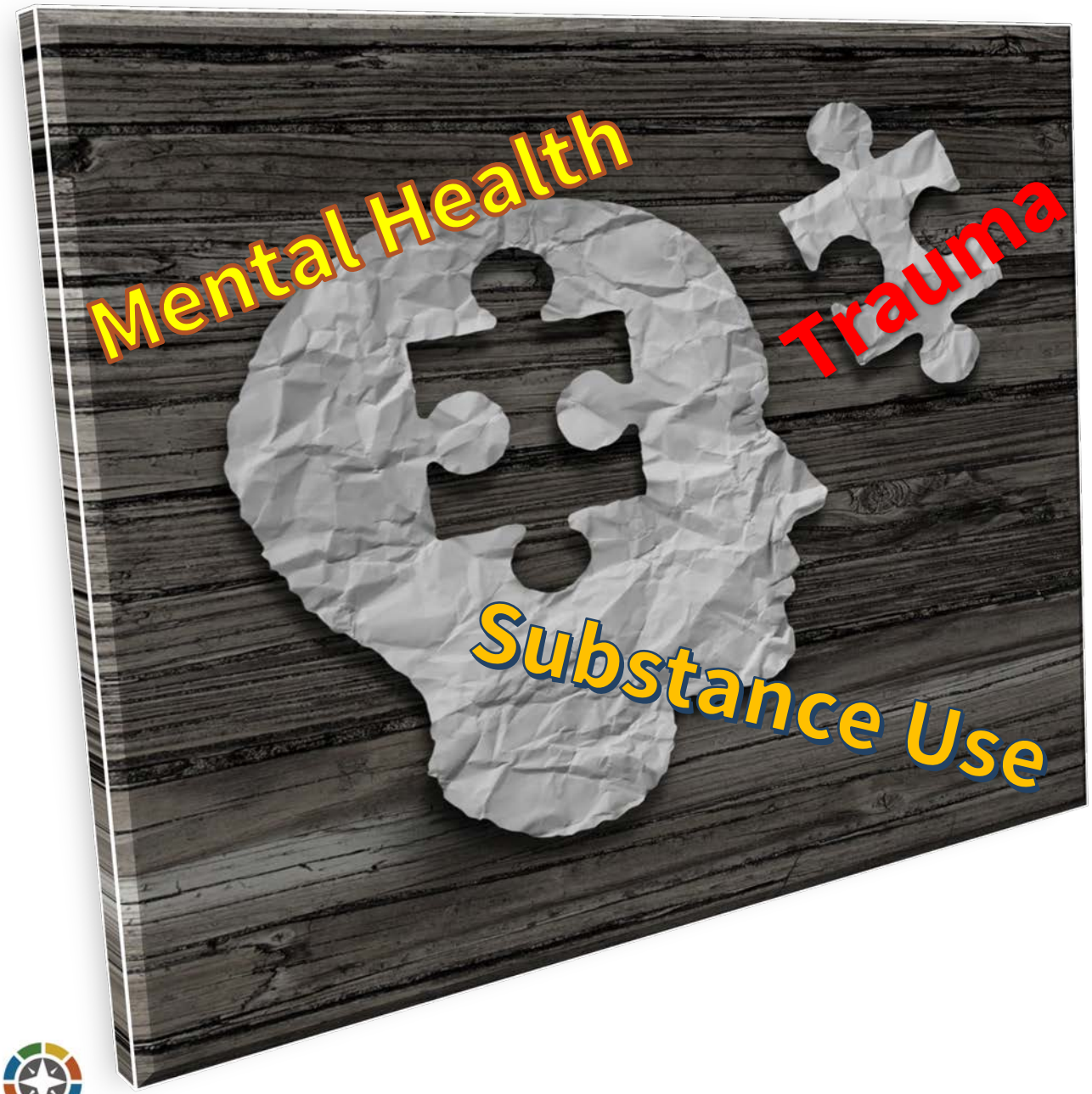
What's in it for me?

Being trauma informed…..

- increases safety
  - practice universal precautions
- promotes recovery & public health
  - interrupt coping/survival behavior patterns
- reduces recidivism
  - prevent deeper end justice involvement
  - engage families
- acknowledges trauma in "clients" as well as professionals
- reduces the burden on individuals, families, & society



Missing piece

SAMHSA'S Definition of Trauma

- Individual trauma results from an **event**, series of events, or a set of circumstances that is **experienced** by an individual as physically or emotionally harmful or threatening and that has lasting adverse **effects** on the individual's functioning and physical, social, emotional, or spiritual well-being.

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DSM-5: Trauma & Stress or Related Disorders

1. Persistent mood disturbances/cognitive symptoms – negative thoughts, mistrust, memory lapses
2. Hypervigilance/hyperarousal – constant symptoms rather than triggered
3. Re-experiencing – flashbacks, nightmares, bad memories
4. Avoidance – avoiding certain places, people, & situations that trigger bad memories

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Examples of Traumatic Events Children & Adults Experience

- Intentional trauma – abuse, bullying, rape, violence in community, exposure to violence
- Unintentional trauma – sudden death or illness of loved one, serious injuries/illness, separation from care giver/family, family disruption
- Other types – historical trauma, community trauma, poverty, homelessness, vicarious trauma, racism, ethnic cleansing, war

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What is Co-occurring Disorder or Co-morbidity?

Co-occurring Disorder (Comorbidity)

- Co-existence of both a mental health disorder and a substance use disorder
- Common risk factors contribute to both
  - Genetics
  - Environmental factors such as stress
  - Trauma, including epigenetic transmission
  - Each is a risk factor for the other

Source: www.nimh.gov/health/topics/substance-use-and-mental-health/

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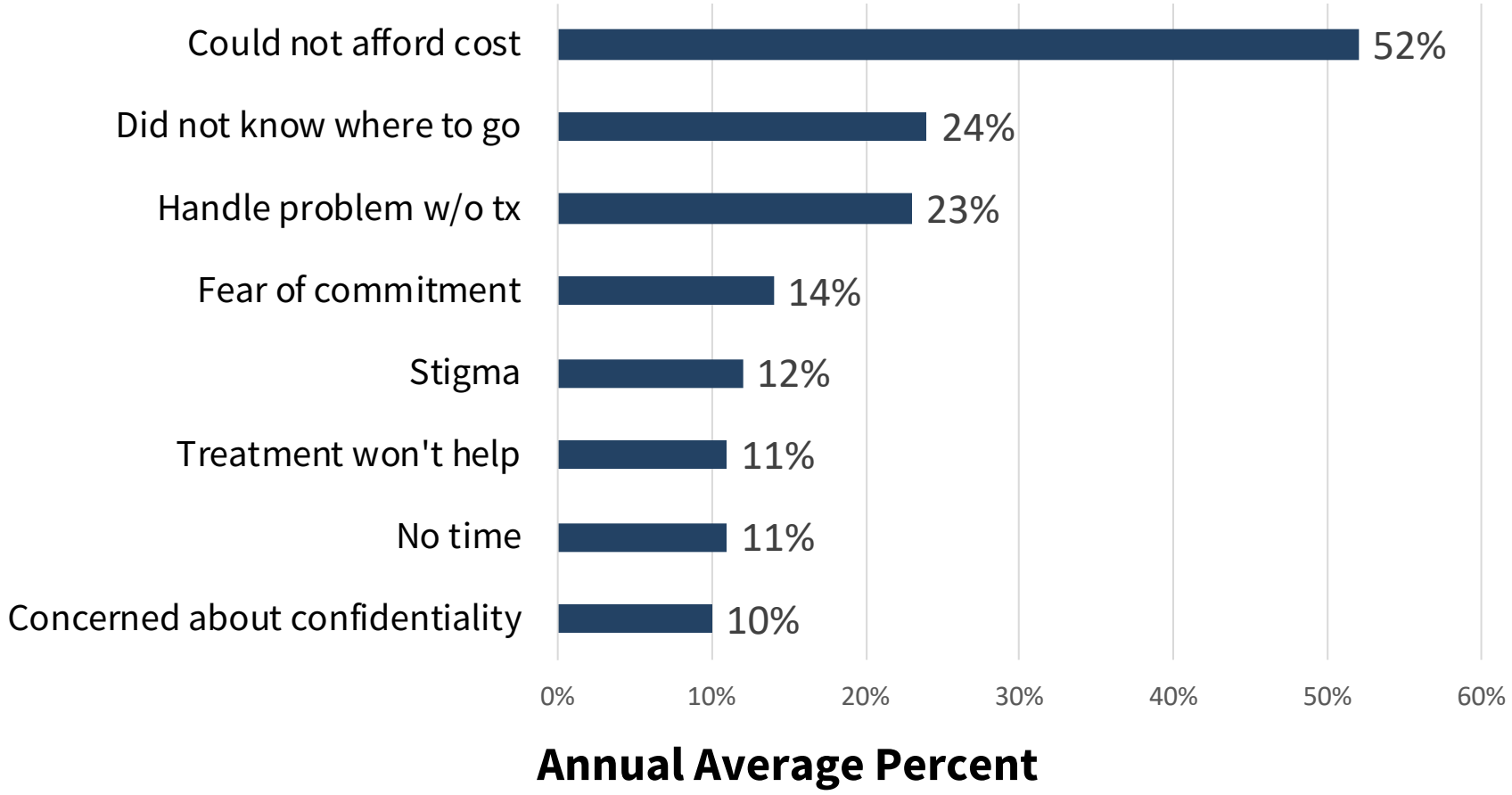
Prevalence of Co-occurring Disorder (COD)

- 7.7 million adults in the U.S. have COD
  - Of the 20.3 million adults with SUD, 38% have mental illness
  - Of the 42 million adults with mental illness, 18% have SUD
- Treatment
  - 53% received neither SUD or MH treatment
  - 35% MH treatment only
  - 4% received SUD treatment only
  - 9% received both

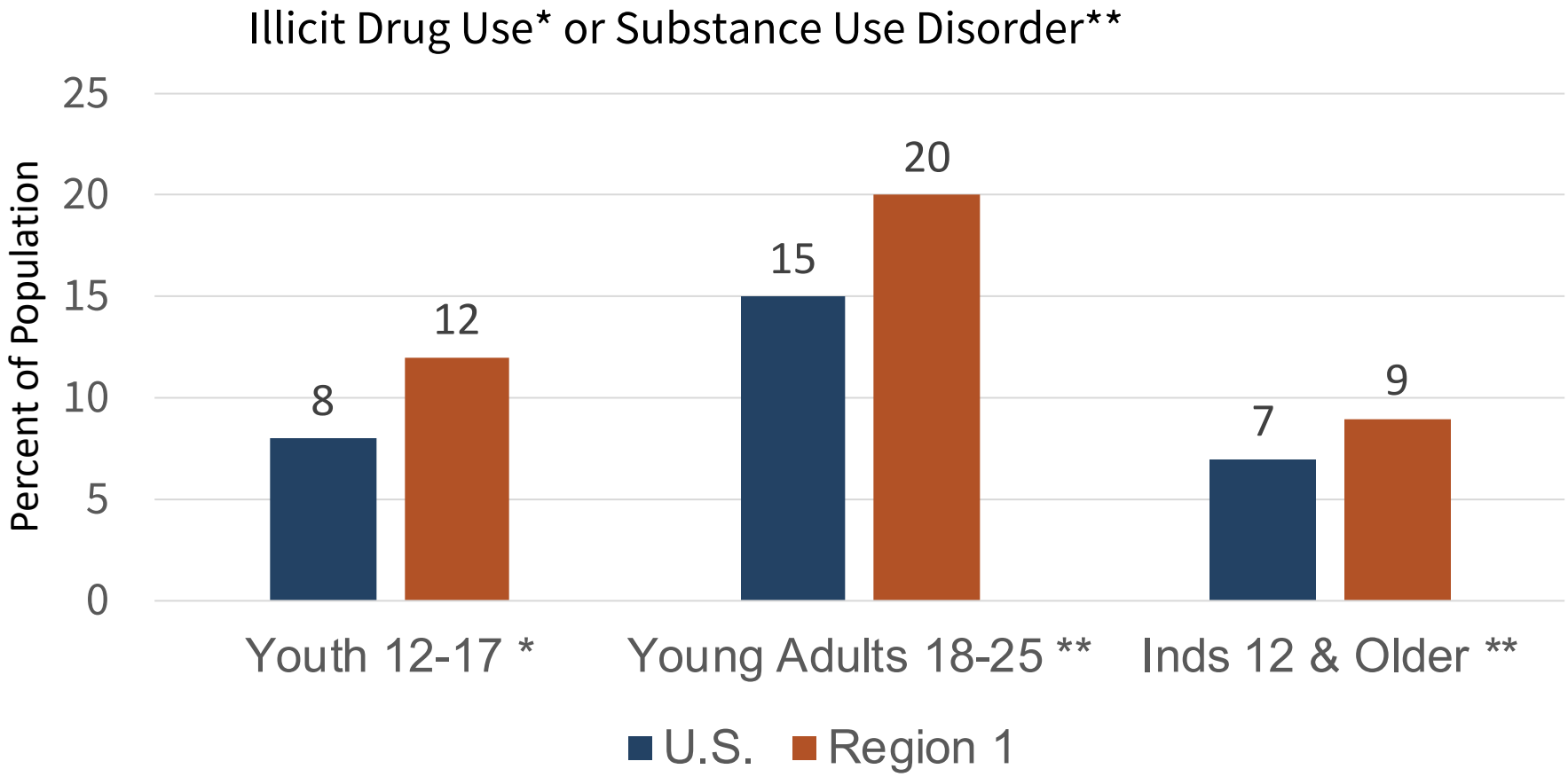
Source: Han et al., 2017

Barriers to Treatment for Adults with COD

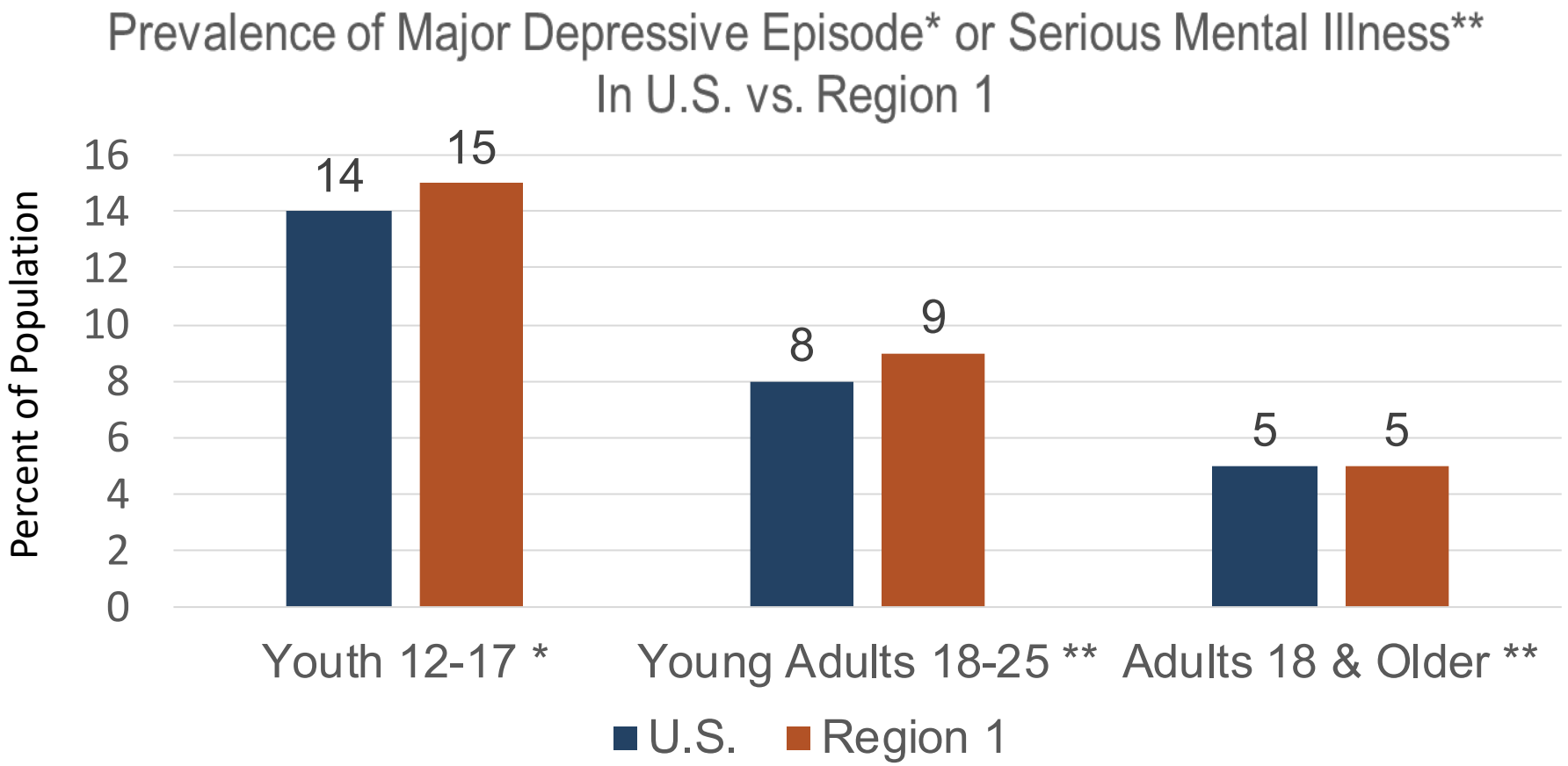


Source: Han et al., 2017

Annual Prevalence of Substance Use Disorder in U.S. v. Region 1, New England



Annual Prevalence of Major Mental Health Disorder in U.S. v. Region 1



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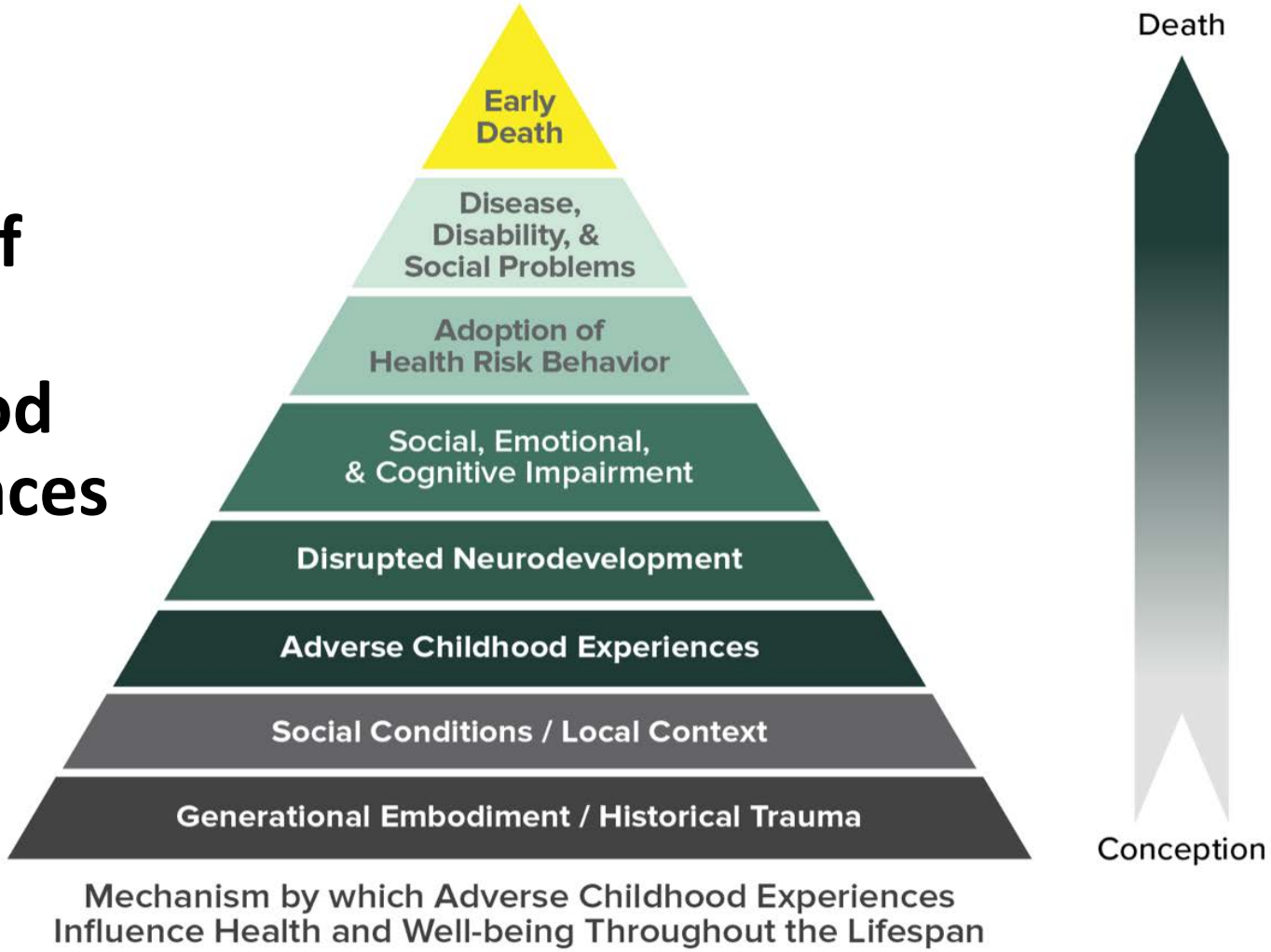
The Impact of Early Experiences with Trauma

Lifelong Effects of Adverse Childhood Experiences ~ACEs~



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Source: cdc.gov

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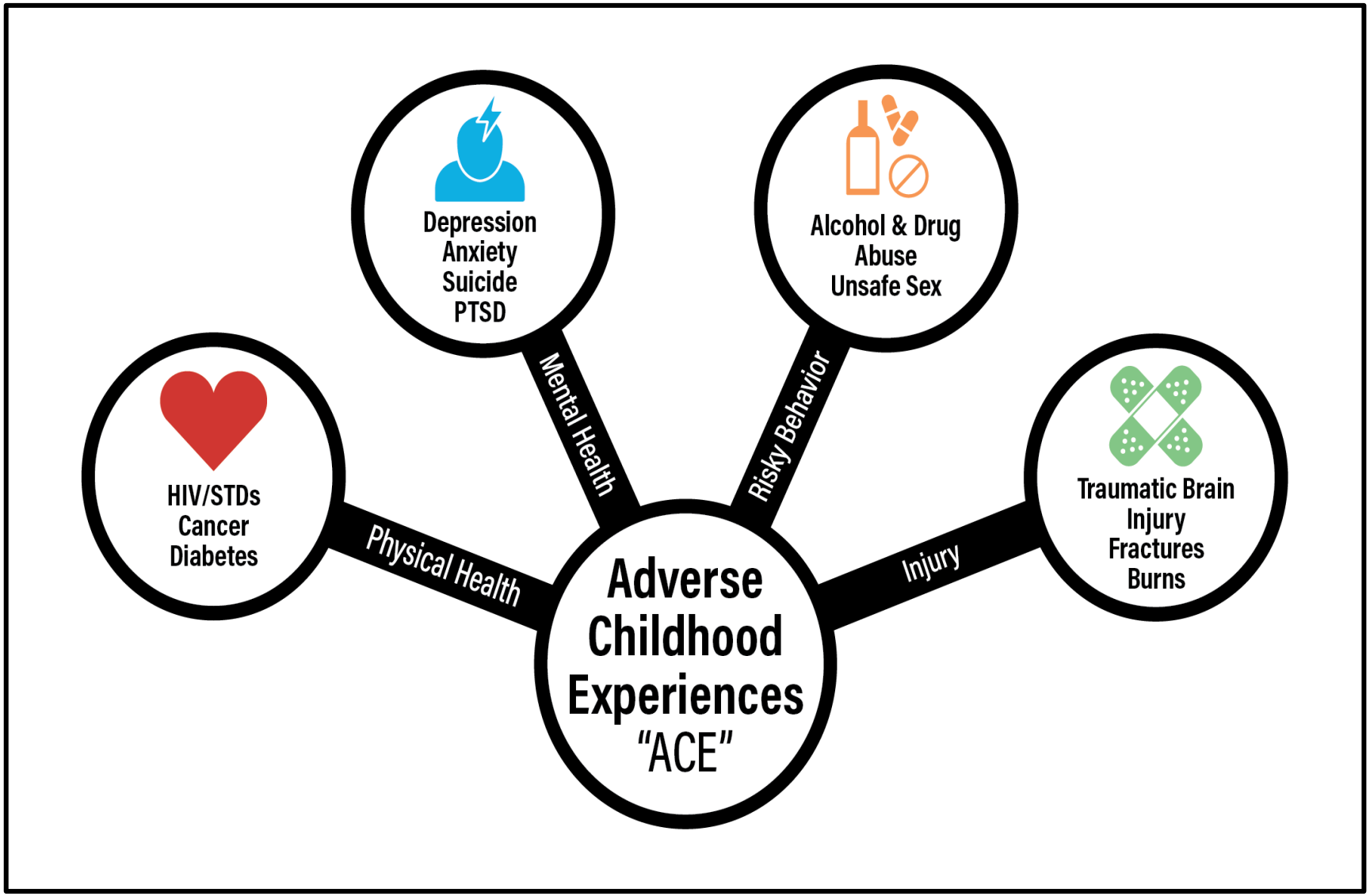
Depression
Anxiety
Suicide
PTSD
Alcohol & Drug
Abuse
Unsafe Sex
HIV/STDs
Cancer
Diabetes
Traumatic Brain
Injury
Fractures
Burns
Mental Health
Risky Behavior
Physical Health
Injury
Adverse
Childhood
Experiences
"ACE"

Physical Health & Trauma

ACE studies* demonstrate that childhood trauma <u>significantly</u> increases the risk of:

- Cigarette smoking[1]
- Suicidal behavior[1,2]
- Difficulty controlling anger[3]
- Memory impairment[4]
- Sexuality issues[3]
- Heart disease[5]
- Headaches[6]
- Adolescent pregnancy[7]
- Obesity[3]
- Lung disease[8]
- Cancer[5,8]
- Premature death[9]

Sources:

1 Feletti et al., 1998
2 Thompson et al., 2018
3 Anda et al., 2006
4 Edwards et al., 2001
5 Hughes et al., 2017
6 Anda et al., 2010
7 Hills et al., 2010
8 Brown et al., 2010
9 Brown et al., 2009

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Substance Use/Mental Health & Trauma

- Suicidality [1]
- Alcohol misuse [2,3]
- Witnessing/perpetrating IPV [2,4,5]
- Lower scores on MH measures [6]
- Depression [1]
- Co-occurring disorder [2]
- Psychotropic med prescriptions [7]
- Anxiety [2]
- Hallucinations [8]
- Antisocial personality disorder [9]
- Substance Use Disorder [1,3]

Sources:

1 Felitti et al., 1998
2 Anda et al., 2006
3 Hughes et al., 2017
4 Dube et al., 2002
5 Whitfield et al., 2003
6 Edwards et al., 2003
7 Anda et al., 2007
8 Whitfield et al., 2003
9 DeLisi et al., 2019

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Mental Health/Criminal/Behavioral Issues & Trauma

As exposure to childhood risk factors* increases, so do:

- depression & anxiety in adulthood
- criminal arrests in adulthood
- education attainment declines after 1 risk factor*

* Risk factors: child abuse/neglect, parental divorce, parental arrest, sibling arrest, parental substance use, sibling substance use, single-parent home, deceased parent, 5+ children in home, homelessness, removal from home, HH $ stress

Source: Horan & Widom 2015

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Expanding Definitions of Adversity

- ACES include 10 items

- Broadening the Focus – Additional items:
  - Low SES → lower physical health score
  - High peer victimization → higher distress symptoms
  - High peer social isolation → higher distress symptoms
  - High exposure to community violence → higher distress symptoms

The "Toxic Triad"

- Exposure to Parental Domestic Violence → maltreatment, social & behavioral problems, depression, anxiety, lower social skills, violent & risky delinquency, adult abuse, negative health behaviors
- Parental Addiction → maltreatment, lower academic achievement, substance abuse, aggression, criminal behavior, depression, psychopathology
- Parental Mental Illness → maltreatment, mood disorders, internalizing & externalizing, depression, substance abuse

Source: Fuller-Thompson, Sawyer, & Agbeyaka, 2019

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Toxic Triad in CJ Populations

	HH IPV -> Mother	HH Sub Use	HH MI/ Suicide
US Adult Population[1]	13%	27%	19%
Adult COD Court[2]	83%	45%	37%
Juvenile COD Court[3]	24%	43%	44%
Boys in State Detention[4]	81%	24%	8%
Girls in State Detention[4]	84%	30%	12%

** HH= Household
**MI= Mental Illness
**IPV= Intimate Partner Violence

Sources:
1 Feletti et al., 1998; 2 IL Tx Ct; 3 Callahan et al., 2014; 4 Fox et al., 2015

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Childhood Trauma's Long Term Effects

- Childhood & adult psychopathology – risk of ADHD, depression, anxiety, personality disorders [1]
- Cognitive, social, & emotional competencies [2]
- Increased risk of chronic illnesses [3]
- Overall higher risk of physical & psychological problems
- Childhood trauma "sets the stage" for chronic and severe SUD
- Individuals with SUD report high levels of childhood victimization [4]
- Early childhood trauma may alter normal neurological development, expose them to poor learning environments, & affect cognitive development [5]

Sources:

[1] Cummings et al., 2012; [2] Enoch, 2011; [3] Dong et al., 2004; [4] Enoch et al., 2010; [5] Najavitz et al., 2017

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Connecting Mental Illness, Substance Use, and Trauma

Major Research Connecting Trauma with SUD

- Strongest link is between PTSD (DSM-5 Mental Disorder) and SUD
- PTSD ⟺ SUD increases vulnerability[1]
  - Diagnosis of PTSD in adults increased risk of SUD 3-5 years later[2]
  - Diagnosis of anxiety in adolescents increased risk of AUD[4] years later[3]
  - Highest rates of COD in combat and sexual assault survivors[4]
  - PTSD ⟺ SUD is found across all age groups[1]

Sources:

[1] Najavitz et al., 2017; [2] Chilcoat & Breslau, 1998; [3] Wolitshy-Taylor et al., 2012; [4] Bailey & Stewart, 2014

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How are trauma and SUD/COD connected?

3 hypotheses explaining high rates of trauma & SUD:

1. Self medication

   – substance use reduces painful emotions associated with trauma

2. Substance-induced

   – SUD increases the risk of PTSD, exacerbating symptoms of trauma

3. Shared vulnerabilities

   – other factors common to both PTSD and SUD/COD contribute to both

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Behavior = Coping & Survival

- Hopelessness (indifference)
- Aggression (self & others)
- Hypervigilance (distrustful)
- In the moment, unfocused (no goals)
- Resentful (holds grudges)

When the brain is stressed – a person cannot think, plan, or execute.

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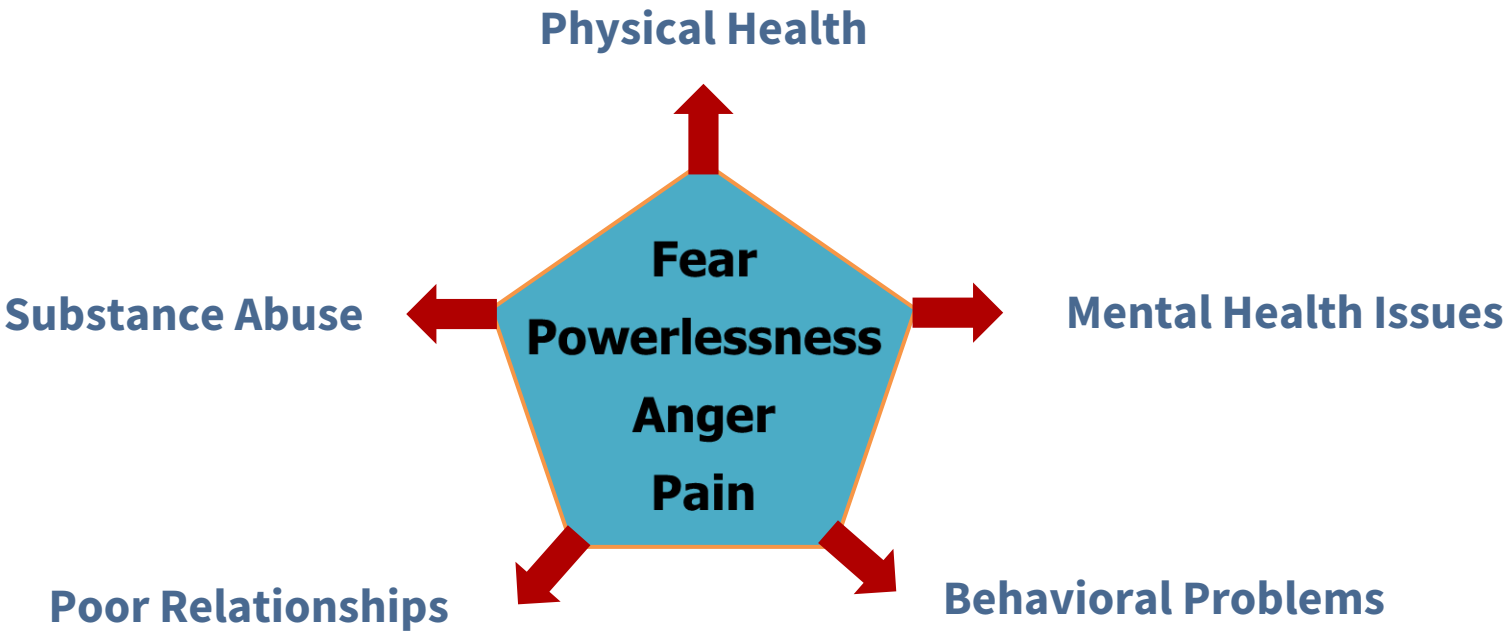
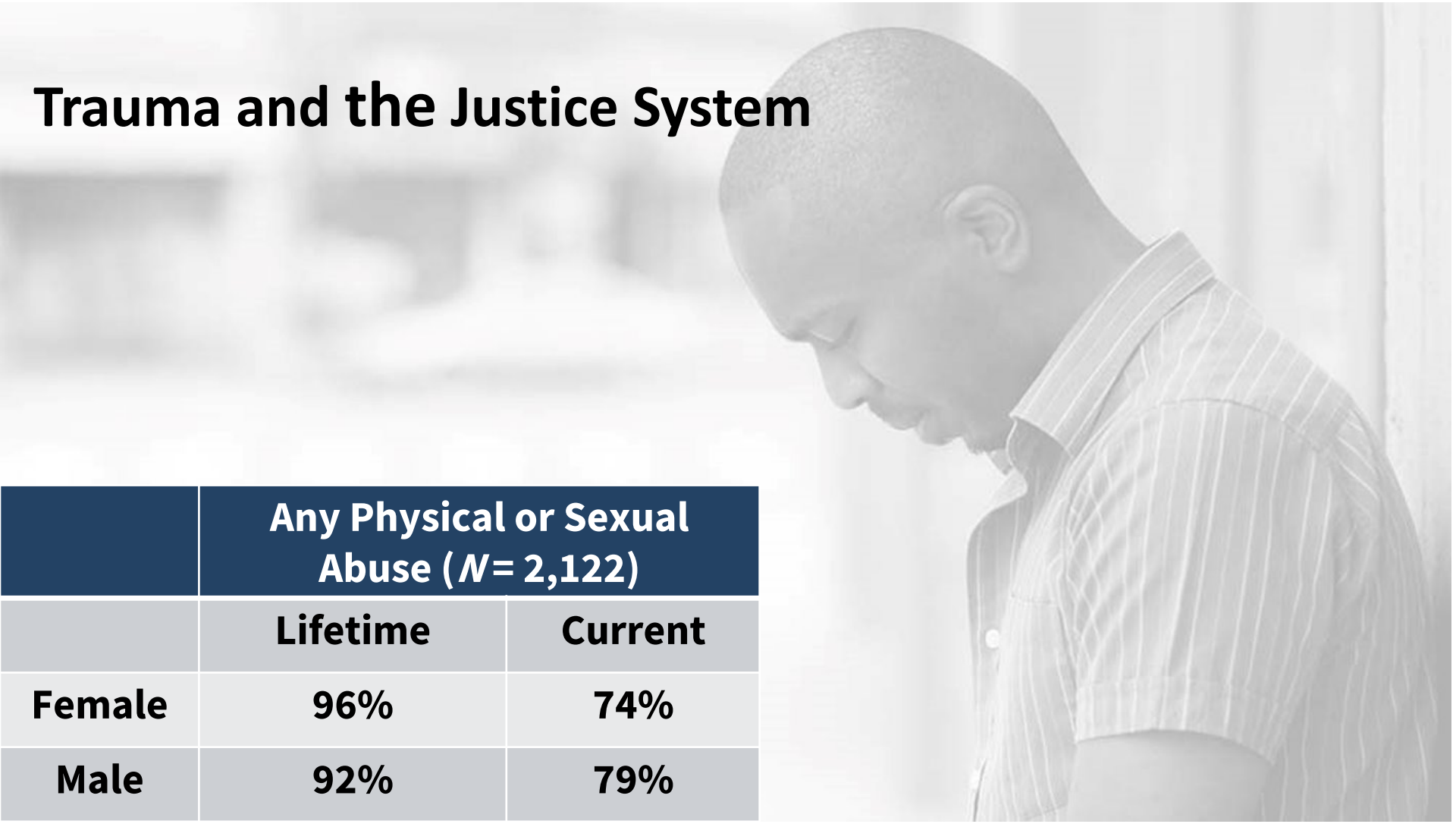
Long-term Effects of Trauma



Trauma and the Justice System



	Any Physical or Sexual Abuse (*N* = 2,122)	
	Lifetime	Current
Female	96%	74%
Male	92%	79%

Becoming Trauma-Informed in the Courtroom (& Beyond)

SAMHSA's Trauma-informed Approach

1. Realize the prevalence of trauma & why a trauma-informed approach is important

2. Recognize how trauma affects all individuals in an organization, program, system, & workforce

3. Respond effectively & with compassion

4. Resist Re-traumatization

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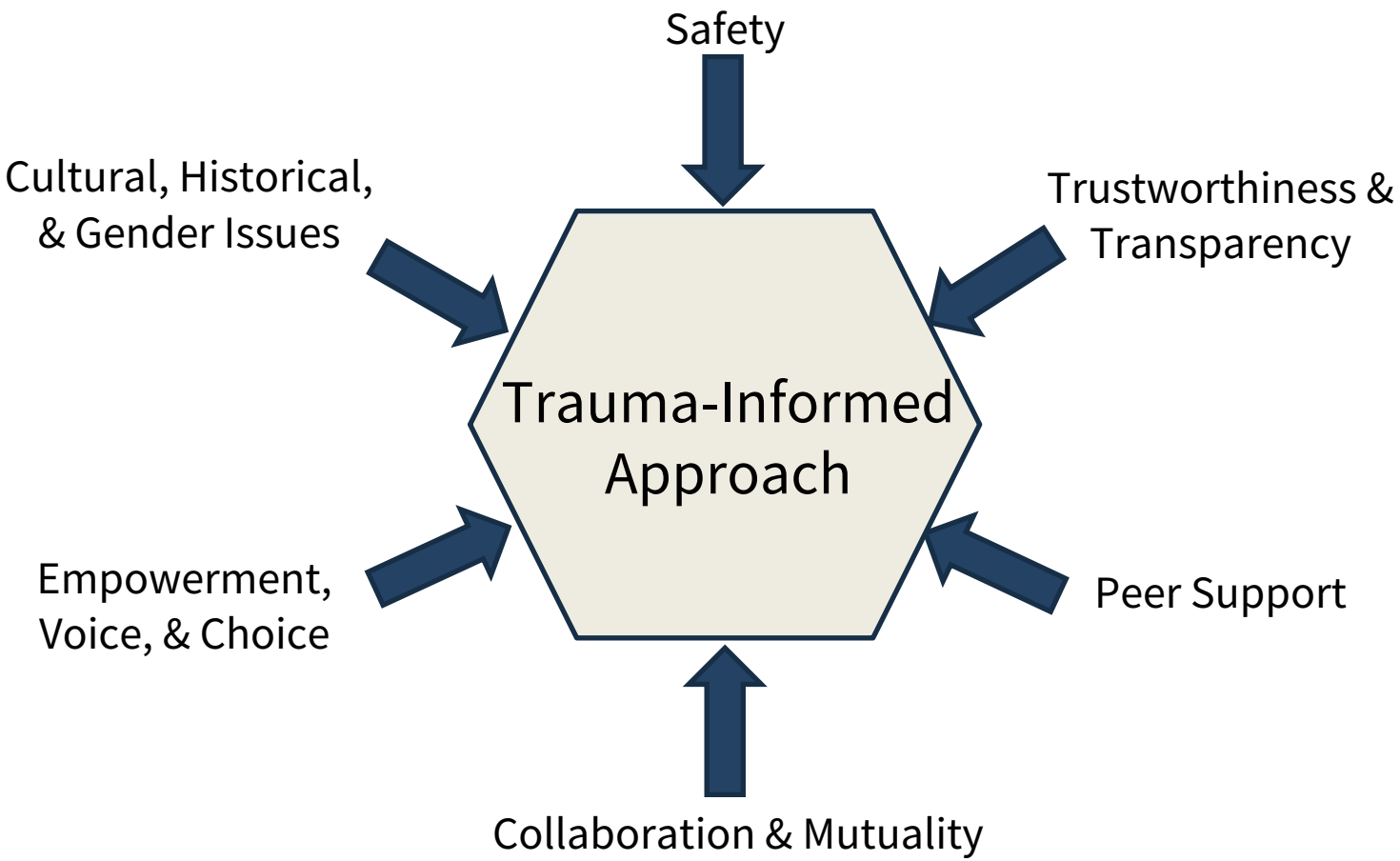
Principles of a Trauma-Informed Approach



What is trauma-informed practice?

- Incorporating an understanding of trauma into your routine courtroom practice
  - What is trauma?
  - What is vicarious or secondary trauma?
- Assuring your clients/defendants/families have access to trauma-informed interventions
  - What evidence-based trauma services exist in your community?
- Focusing on how services are delivered by partner organizations
  - Are my partner agencies trauma-informed?

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Incorporating Trauma-informed Practice Into Your Courtroom

- Identifying trauma
- Adjusting the relationships among parties
  - Respect, Information, Safety, Choice (RISC)
- Adapting strategies
  - Authority is not based on power, it's based on trust
- Preventing vicarious trauma
  - Workplace culture – expectations, caseload, etc.

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Guidelines for Implementing a Trauma-Informed Approach in Your Court/CJS

- Governance & Leadership
- Policy
- Physical Environment
- Engagement & Involvement
- Screening, Assessment, & Treatment Services
- Cross-sector Collaboration
- Training & Workforce Development
- Progress Monitoring & Quality Assurance
- Financing
- Evaluation

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What does it mean to provide leadership on the subject of trauma-informed courts?

- Be the champion for a trauma-informed approach
- Support and invest in implementing a trauma-informed approach
- Identify a point of responsibility for the work
- Include peers/persons with lived experience

Are your polices, practices, and procedures trauma-informed?

- Analyze your courtroom policies to determine if they are trauma-informed
- Develop written policies, practices, and procedures that establish a trauma-informed approach as essential to your courtroom and larger community
- "Hard wire" trauma-informed policies, procedures, and practices into your courtroom and community

Is your court environment sensitive to trauma?

- Do people feel safe in your courtroom? Are they safe?
- Are there physical changes you can make to improve the safety?
- Are rules and practices flexible or rigid?
- Is privacy and confidentiality a priority?

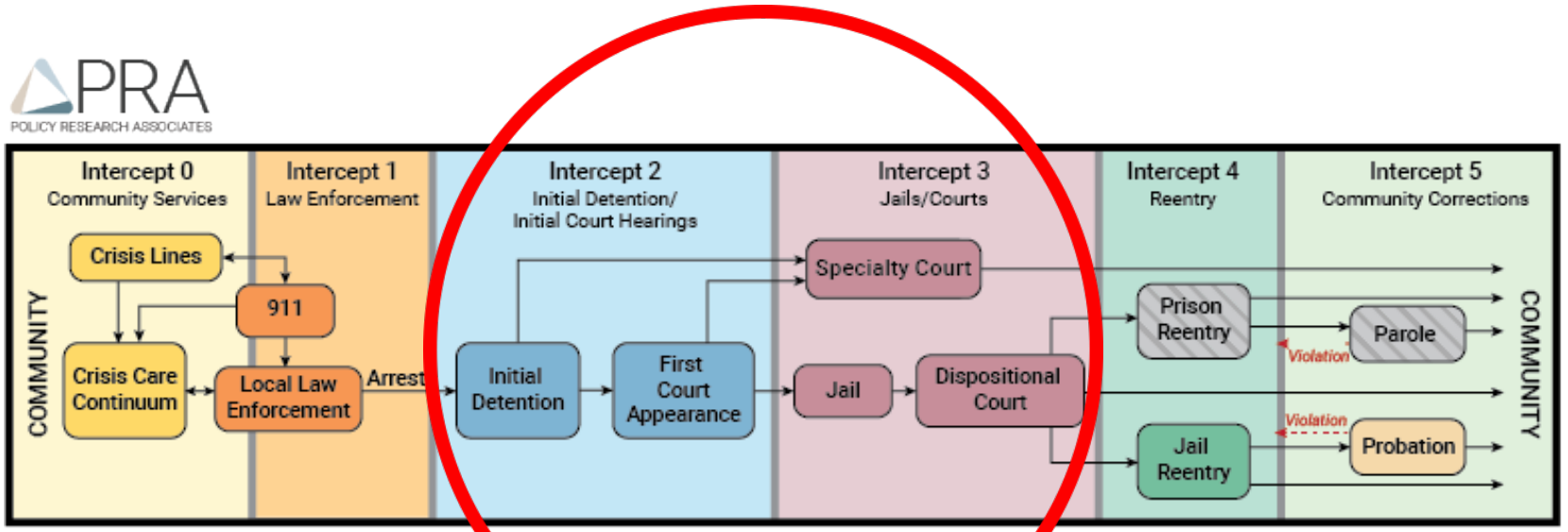
How do you engage and involve others to foster trauma-informed practices in your courtroom?

- Include people in recovery, people receiving services, family members, and trauma survivors - ASK
- Program design, implementation, service delivery, quality assurance, cultural competence, access to peer support, workforce development, & evaluation.

Can you do this alone?

- Where is your treatment provider community with regard to trauma-informed, trauma-sensitive practices?
- Are other parts of your justice system trauma-informed?
- Who are the champions in other organizations?
- Where are the gaps? Strengths?

Sequential Intercept Model (SIM)



Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law, 35*(5-6), 380-395. https://doi.org/10.1002/bsl.2300

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Questions to Consider in Your Court

- What do we hope to gain by being a trauma-informed court?
- Is my courtroom set up in a trauma-informed way?
- How can we alter the courtroom set up to be more trauma-informed?
- Do defendants, families, victims, witnesses, and staff feel safe?
- Can people in my court hear what the judge and other key officials are saying? Do we speak clearly?
- Do court staff show respect toward people in court?
- Do we explain court procedures to people in the courtroom?
- What policies and procedures need to be altered to be more trauma-informed?

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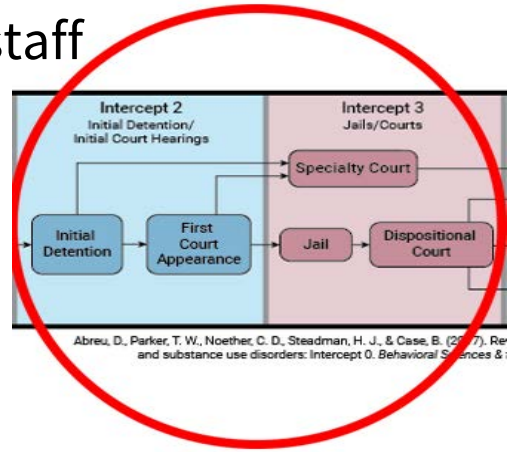
Consequences Courts May Consider

- Continuity of Care
- Employment/Ban the Box
- Housing
- Voting
- Driver's License/ Identification
- Entitlements - SSI/SSDI
- Medical Insurance
- Child Care
- Fees and Fines

Trauma-informed Adaptations & Programs at Intercepts 2/3

- Screening & assessment for trauma/other issues -> placement
- Integration of peers & navigators at every step
- Diversion as the assumption, not the exception
- Awareness of impact of suspension of entitlements based on length of jail term
- Awareness of impact of costs of incarceration
- Continuity of care – medications and providers
- In-reach of community-based behavioral health professionals
- Specialized dockets
- Recovery courts
- Focus on wellness of staff
- Training for staff



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What are some “quick fixes”?

- Habits
- Policies
- Environment
- Training

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Until the lion has his own storyteller, tales of the hunt will always favor the hunter.

-African proverb

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Contact Information

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THANK YOU!

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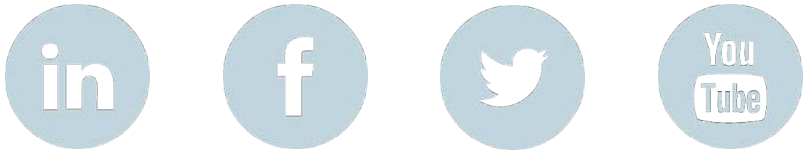
Creating positive social change through technical assistance, research, and training for people who are disadvantaged.



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Upcoming Webinars

Thursday, May 27, 2021 / 3-5p EDT

Welcome
Chief Justice Kimberly Budd, MA

Evidence-Based Treatment Interventions
Dr. John Brooklyn, University of Vermont Medical Center, VT

Judicial Perspective:
Practical Application for Judges
Judge Kathleen Coffey, MA

Recovery Processes:
Is Recovery Abstinence?
Dr. John Kelly, Harvard School of Medicine, MA

Judicial Perspective:
Practical Application for Judges
Chief Justice Tina Nadeau, NH

Closing Remarks
Chief Justice Gordon MacDonald, NH

REGISTRATION LINK

SAVE THE DATE

Thursday, June 17, 2021
3-5p EDT

Closed Question Forums By State
State-specific registration links and information will be announced.

REGIONAL JUDICIAL OPIOID INITIATIVE

National Center for State Courts 50 years 1971-2021