



Meeting Record

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

May 17, 2016 | 12:30 p.m. – 4:15 p.m. | Manchester University | Fort Wayne

Facilitator:

John Hill, Office of the Governor

Task Force Members Present:

Senator Jim Merritt, Indiana State Senate
Jane Bisbee for Judge Mary Beth Bonaventura, Indiana Department of Child Services
Senator Jim Arnold, Indiana State Senate
Judge Wendy Davis, Allen Superior Court
Dr. Tim Kelly, Community Health Network
Dan Miller, Indiana Prosecuting Attorneys Council
Dr. Joseph Fox, Anthem, Inc.
Bernard Carter, Lake County Prosecutor
Sheriff John Layton, Marion County Sheriff's Department
Dr. Joan Duwve, Indiana State Department of Health
Kevin Moore for Dr. John Wernert, Indiana Family Social Services Administration

Others Present:

Staff Support to the Task Force

Veronica Schilb, Office of the Governor
Adam Baker, Indiana Criminal Justice Institute
Devon McDonald, Indiana Criminal Justice Institute
Mary Kay Hudson, Indiana Judicial Center
Diane Haver, Indiana Judicial Center

Task Force Members Absent:

Dr. Jerome Adams, Indiana State Department of Health
Chief Michael Diekhoff, Bloomington Police Department
Judge Roger Duvall, Scott Circuit Court
Tony Gillespie, Indiana Minority Health Coalition
Commissioner Bruce Lemmon, Indiana Department of Correction
Justice Mark Massa, Indiana Supreme Court
Representative Wendy McNamara, Indiana House of Representatives
Dr. Charles Miramonti, Indiana University Medicine/Indianapolis EMS
Reverend Rabon Turner, Sr., New Hope Missionary Baptist Church
Superintendent Doug Carter, Indiana State Police
Representative Terry Goodin, Indiana House of Representatives

Meeting Summary:

- Presenters provided an overview of what education and programing efforts are currently in place relative to combating addition and promoting recovery.
- Ms. Seema Verma provided an update on the status of the final report and sought feedback from the Task Force on overall approach to finalizing the report.
- Mr. Hill provided areas of consideration to the Task Force in preparation for future Task Force meetings.

Presentations:

Pharmacist Training and Education on Addiction Tracy Brooks, Manchester University College of Pharmacy

Dr. Tracy Brooks presented to the Task Force on the responsibility of colleges to educate and prepare pharmacy students on the prevention and management of prescription drugs and how the curriculum at Manchester University College of Pharmacy is designed around the topic. As noted in Dr. Brooks' slides, schools of pharmacy should tailor the curriculum to prepare pharmacy students in areas of addiction and substance use disorders. Such curricula would include information on the pharmacology and toxicology of abused substances, the identification, intervention, and treatment of individuals suffering from addiction, the legal and ethical issues that may arise, and information on student assistance for pharmacy students who may suffer from addiction. Manchester currently teaches responsible prescribing practices while educating students on Indiana's controlled substance prescribing laws. Students are also provided an introduction to INSPECT. During the study of INSPECT, Dr. Brooks will pull INSPECT reports and ask the students to identify any areas of concern. One particular pharmacy course at Manchester incorporates nine hours in the area of pain management. Students spend a fair amount of the course studying opiates, such as pain management for both acute and chronic pain, how to take an opiate, which patient populations may be at greater risk of misuse and/or abuse, proper opiate education for patients, and how to prevent adverse effects. Another pharmacy course offered at Manchester examines substance abuse from a therapeutic approach. The course touches on many drugs, such as alcohol, opiates, and benzodiazepines. Students are also taught how to manage special patient populations, such as pregnant women and the evaluation of adolescents facing addiction. This course extends beyond addictive prescription medications and examines the big picture of addiction.

Dr. Brooks noted that the school has a prevention and assistance program for students who may find themselves struggling with substance issues. The school also requires urine drug screens for pharmacy student at the start of each semester. Dr. Brooks concluded by reporting that the Manchester University College of Pharmacy strives to develop professionals who will provide appropriate, supportive and professional care to patients who face addiction.

Dr. Brooks answered questions from the Task Force

Indiana Guidelines for Safe Prescribing in the Emergency Department Brian Tabor and Kaitlyn Boller, Indiana Hospital Association Mike Rinebold, Indiana State Medical Association

Brian Tabor, Kaitlyn Boller, and Mike Rinebold presented to the Task Force on proposed Indiana Guidelines for Opioid Prescribing in the Emergency Department. After review of other state policy and local practice, the guidelines were developed in partnership with the Indiana State Medical Association (ISMA). The guidelines are intended to complement current rules and laws that govern prescribing practices and patient treatment. Hospitals will be encouraged to work within the recommendations.

Mr. Rinebold presented on the recommended guidelines. According to the guidelines, emergency medical clinicians should not replace lost, destroyed, or stolen prescriptions or doses of suboxone, subutex, or methadone. The guidelines also recommend against emergency department professionals prescribing long-acting or controlled-release opioids such as OxyContin, fentanyl patches, and methadone. Additionally, prescriptions for chronic pain should not typically be provided if the patient has recently received a prescription for opioids or other controlled substances (OOCs) from another provider. The guidelines also recommend against the injection form of OOCs. As Slide 24 indicates, an emergency department provider should consider an INSPECT search, exercise caution when the identity

of an individual cannot be verified, and reminds the reader that a prescribing physician has the right to order a drug screen when administering or considering prescribing an OPCS. Additionally, emergency clinicians should limit OPCS prescriptions to less than a five-day supply. The guidelines suggest that patients who frequently visit the emergency department, a coordinated care strategy should be developed, which should include both a treatment plan and referrals for patients with suspected abuse issues. Departments should maintain a current list of pain management providers to provide to emergency department patients in need of follow-up care. Ms. Boller noted that their group aims to finalize the endorsements of the guidelines in order to disseminate and will work together with stakeholders on a safe prescribing campaign.

Discussion on Final Report **Seema Verma, SVC Inc.**

Ms. Seema Verma provided an overview and update to the Task Force on the final report that is currently in production. As noted on slide 33, the purpose of the final report is to document the Task Force process and recommendations, as well as provide a roadmap for the Indiana Commission to Combat Drug Abuse (est. 2016, IC 4-3-25). Ms. Verma noted they are looking for feedback on the structure of the report. She envisions the report capturing the last five to seven years of drug trends in Indiana, with a spot light on the HIV epidemic in Scott County. Then, the report may shift into the three components of the Task Force: enforcement, treatment, and prevention. Relative to each component, the three sections will provide an overview within to include a summary of presentations specific to that component, a summary of the key Task Force discussions that touched on a particular component, and any recommendations and/or updates specific to drug enforcement, treatment, and prevention. It was suggested that the report would also include the personal vignettes that unfolded throughout the series of monthly meetings. Slide 37 lists the potential vignettes that may be highlighted. Ms. Verma noted that they would like for the report to hone in on meeting information and also incorporate national data relative to what is occurring in Indiana. Ms. Verma noted that the next steps are to solicit more suggestions from the Task Force for any future study, roll out the Indiana Commission to Combat Drug Abuse, and decide on the future role of the Task Force. It was noted by a few Task Force members that they would like to look at the report topically.

Indiana Problem-Solving Courts **Mary Kay Hudson, Indiana Judicial Center**

Mary Kay Hudson provided an overview of Indiana Problem-Solving Courts (PSC). By statute, the Indiana Judicial Center provides training and support for PSCs around the state. Ms. Hudson explained that the model is relatively new and allows judges to take an alternative approach to traditional case processing. According to slide 43, the goals of PSCs are to reduce recidivism and system costs, improve access to services and quality of life, and increase public confidence in the courts. In order to achieve such goals, the model is based on the ten key components, as noted on slides 44 and 45. There are various types of PSC models, which include: reentry courts, OVWI courts, domestic violence courts, veterans courts, mental health courts, and family dependency courts. Ms. Hudson noted that the original model began from the drug court model. Now, she explained, drug courts have become common language, yet the original model was revolutionary when first introduced. The model integrates a non-adversarial approach to the criminal justice system. The objective is to link participants to the help they need in order to address any contributing factors that may have led to or resulted in the criminal behavior. PSCs use a team-oriented and treatment-based strategy. Research has indicated that drug courts reduce recidivism and have effects that last up to 14 years post-incarceration. Variably, 78% of drug courts reduce recidivism while 16% have no effect, and six percent were found to have increased recidivism. The National Association of Drug Court Professionals (NADCP) studies drug courts on the national level and has developed guidelines for proper drug court operations. Such practices include those that are

associated with the best outcomes relative to recidivism and cost benefits. Most of the NADCP standards are applicable for each specific model.

The first drug court in Indiana began in 1996. Over the years, Indiana has seen a significant growth in the implementation of PSCs and now has 76 certified PSCs. Slide 53 illustrates the break-down PSCs courts by model and slide 54 illustrates the logistical distribution of PSCs by county. Certified PSCs are guided by IC 33-23-16 and Problem-Solving Court Rules. Ms. Hudson noted that PSCs are lacking on the eastern and northwestern borders of Indiana. Often, the courts are resource-driven, which can pose a challenge to the smaller counties. Ms. Hudson explained that a drug court team will spend approximately four to five hours per week dedicated to each PSC. Therefore, some courts have low enrollment due to lack of judicial time, but not at the fault of lack of interest. Ms. Hudson noted that Indiana has a great opportunity to increase family dependency courts while the model presents a true opportunity to work with a population in need. Additionally, a coordinated approach to research and evaluation could benefit our state. While the implementation of the programs is not simplistic and the courts work with challenging populations after implementation, the reward is high once operations are fueled. Generally, the PSCs courts do not see high-functioning individuals on Medication Assisted Treatment (MAT). In response, Ms. Hudson noted that the forging of a partnership between the Indiana Judicial Center and physicians could have positive impacts in our state. The partnership could serve to develop guidelines and policies relative to MAT, ultimately leading to good care and access to necessary programming.

Conquering the Drug Crisis in the Criminal Justice System **Judge Wendy Davis**

Judge Wendy Davis presented to the Task Force on the ways by which Allen County is working to combat the drug crisis within their jurisdiction's criminal justice system. She noted that much of the criminal population has been released back into the community as a result of the rewrite of the criminal code. While Allen County presents with an abundant amount of programming for the criminal justice population, they still face service gaps that hinder the impact of programming. Stable and sober housing, for example, is a debilitating service gap in Allen County. A number of offenders are waiting for residency at half-way housing. Judge Davis noted that without housing, they cannot properly rehabilitate those in need. In fact, she had a defendant report to her that if she was released from her four-month stay in jail, she would return to the streets and use heroin. Funding, Judge Davis noted, is needed to support and grow transitional housing opportunities.

Judge Davis reported that funding is lacking for Medication Assisted Treatment (MAT). She noted that many offenders could benefit from an MAT injection prior to being released from jail. Additionally, funding is needed for indigent offenders in need of MAT. Judge Davis noted that the HEA 1006-2013 criminal code reform has induced service gaps within their county due to the influx of offenders being released from incarceration. Judge Davis respectfully requested the Task Force to recognize all that Allen County is doing well, such as problem-solving courts, but also requested a focus on the noted service gaps and the continuation of adequate funds for their community supervision efforts.

Heroin and Prescription Drug Prevention **Justin Phillips and Kourtayne Sturgeon, Overdose Lifeline, Inc.**

Ms. Justin Phillips began Overdose Lifeline, Inc. after she lost her twenty-year-old son, Aaron, to a heroin overdose. She shared that when Aaron lost a friend to an overdose, Ms. Phillips' reaction was to combat the dealers. Aaron explained that there would always be another dealer. Ms. Phillips realized the appropriate approach was to attack the stigma that surrounds addiction. In response, she began to talk openly about addiction, did research on Naloxone, and promoted the efforts of first responder overdose reversal kits and Naloxone training for the lay-person.

As overdose deaths in Indiana continue to climb, Ms. Phillips continues her efforts to combat first time drug use. She noted that we understand the importance of evidence-based prevention. As quoted by Michael Botticelli with the National Drug Control Policy, “We know that evidence-based prevention efforts are the most effective way to reduce drug use and to support the roughly 90 percent of American youth who do not use illicit drugs.” Ms. Phillips explained that prevention will save Indiana money. The first step in prevention among the youth population is to promote the voices and experiences of youth. Slide 84 introduces an educational program designed for the youth population that informs the viewer on prescription pain medications and heroin. The program targets students in grades 6-12 and is designed to prevent a child’s first drug use. The program has been piloted across five schools in the Indianapolis area, reaching 1900 students. They continue to collect feedback from the schools and students and is under university review for evidence-based validity. The program costs \$1500 per school to implement. The program consists of five key objectives as noted on slide 86. After completion of the program, students are armed with the concept of losing the ability to choose to use, addiction, overdose, “gateway” drugs, and the parallels between opioids/pain pills and heroin.

Task Force Discussion

John Hill noted that it currently costs \$54.41 per day to incarcerate an offender (not to include overhead). The Department of Correction population has been reduced by approximately 1200 offenders since July as they are transitioned into the local jails. Mr. Hill noted that with the disbursements of offenders to the local level, staffing and funding must continue to be prioritized.

Mr. Hill requested that the Task Force consider for the next meeting whether or not to endorse the recommendations of the Indiana Hospital Association and to consider ideas in the area of prevention and service gaps.

Meeting adjourned at 4:15 pm



Meeting Agenda

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

May 17, 2016 | 12:30 p.m. – 4:15 p.m. | Manchester University College of Pharmacy | Fort Wayne

- 12:30 p.m. – 12:35 p.m. Welcome**
John Hill, Co-Chair, Governor's Task Force on Drug Enforcement, Treatment, and Prevention
- 12:35 p.m. – 12:50 p.m. Pharmacist Training and Education on Addiction**
Tracy Brooks, Manchester University College of Pharmacy
- 12:50 p.m. – 1:15 p.m. Indiana Guidelines for Safe Prescribing in the Emergency Department**
Brian Tabor and Kaitlyn Boller, Indiana Hospital Association
Mike Rinebold, Indiana State Medical Association
- 1:15 p.m. – 1:45 p.m. Discussion on Final Report**
- 1:45 p.m. – 2:30 p.m. Overview of Problem-Solving Courts in Indiana**
Mary Kay Hudson, Indiana Judicial Center
- 2:30 p.m. – 3:15 p.m. Conquering the Drug Crisis in the Criminal Justice System**
Judge Wendy Davis, Allen County Superior Court
- 3:15 p.m. – 3:45 p.m. Heroin & Prescription Drug Prevention Education**
Justin Phillips and Kournaye Sturgeon, Overdose Lifeline, Inc.
- 3:45 p.m. – 4:15 p.m. Task Force Discussion**



Speaker Bios

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

► Tracy Brooks, Manchester University College of Pharmacy

Tracy Brooks currently services as the Interim Chair for the Pharmacy Practice Department at the Manchester University College of Pharmacy. In this role, she assists in the management of the Pharmacy Practice Faculty department, in the development of the Doctors of Pharmacy program through teaching, scholarship, and service, and participates on Parkview Health System's Palliative Care Team. Tracy also serves as a clinical pharmacist for Parkview Home Health and Hospice in Fort Wayne, Indiana. She is a member of the American Society of Hospital Pharmacy and the American College of Clinical Pharmacy. Ms. Brooks received her Doctor of Pharmacy from Purdue University.

► Brian Tabor, Indiana Hospital Association

Brian Tabor is Executive Vice President of the Indiana Hospital Association where he oversees all state and federal legislative initiatives and health policy development. Prior to joining IHA in 2008, he worked in various policy roles for the Indiana General Assembly and in government relations for the Indiana Association of REALTORS®. He serves on the governing boards of the Government Affairs Society of Indiana, Covering Kids and Families of Indiana, and the Indiana Health Information Exchange. Brian is native of Connecticut and graduated from Purdue University with a B.A. in Political Science and an M.S. in Agricultural Economics.

► Kaitlyn Boller, Indiana Hospital Association

Kaitlyn Boller is a Patient Safety Analyst/Coordinator at the Indiana Hospital Association where she supports hospital members with quality improvement and patient safety initiatives. Kaitlyn received her B.A. in Political Science from Xavier University and her Masters in Health Administration from the Richard M. Fairbanks School of Public Health at IUPUI.

► Mike Rinebold, Indiana State Medical Association

Mike Rinebold is Director of Government Relations for the Indiana State Medical Association (ISMA). He is the chief advocate for the Association's 8,000 physician members at both the state and federal level.

The Indiana State Medical Association is dedicated to Indiana physicians and the physicians' efforts to provide the best possible health care for their patients. Mike has recently represented the ISMA as a member of the Indiana Prescription Drug Abuse Task Force since its creation in 2012 by serving on the INSPECT and Enforcement subcommittees. In the ever changing landscape of medicine, Mike not only advocates but also educates on key issues including how and where physicians practice as well as access to care for Hoosiers.

Mike has over a decade of service to Indiana as it relates to regulating the practice of medicine. Prior to joining the ISMA in 2008 he served the State of Indiana as the Director for the Medical Licensing Board and also in the Medical Licensing Section of the Office of the Attorney General overseeing the investigations of all health professionals.

Mike is originally from Ohio and a graduate of the University of Mount Union and currently resides in Zionsville with his wife and two sons.

student at Indiana University Purdue University (IUPUI) in Indianapolis, IN and Ryan Sturgeon who works and lives in Austin, Texas.

When seeking an organization to volunteer her time she learned of Overdose Lifeline Inc. naloxone funding efforts. Helping to save lives from prescription pain pills and heroin spoke to her heart as her oldest son Ryan is living with the chronic disease of addiction.

Kournaye was fortunate enough to join the organization and contribute to Overdose Lifeline's "This is (Not) About Drugs" Prescription Pain Medicine (Opioids) and Heroin Prevention Education program. Kournaye is a volunteer, board member and the education program director.



Educating future pharmacists concerning the opioid abuse and misuse epidemic

Tracy L. Brooks, PharmD, BCPS, BCNSP
 Assistant Professor, Pharmacy Practice Manchester
 University College of Pharmacy
 Palliative Care Pharmacist, Parkview Regional Medical Center



Objectives:

- Recognize the role that pharmacy colleges and schools have in preparing student pharmacists concerning the prevention and management of drug related problems.
- Describe how Manchester's curriculum is designed to prepare our pharmacy students for practice
- Briefly tell how the Office of Student Services functions to prevent addiction and substance abuse among students and provides assistance to those suffering from these disorders.



AACP Special Committee on Substance Abuse and Pharmacy Education

Charged the committee to:

- Examine and recommend how pharmacy colleges and schools should prepare all student pharmacists to appropriately assist those who are addicted or affected by others' addiction, and help support addiction recovery with an emphasis on public safety.
- Recommendations on core curricular content and delivery
- Recommendations on prevention and assistance processes within our colleges and schools

AJPE 2010; 74(10) Article 511.



Committee Recommendations

Schools of pharmacy need to assure their curricular outcomes are sufficient to prepare pharmacists to deal with addiction and substance use disorders

- Psychosocial aspects of alcohol and other drug use
- Pharmacology and toxicology of abused substances
- Identification, intervention, and treatment of people with addictive diseases
- Legal/Ethical issues
- Policies to assist student pharmacists with addiction



Manchester Program Outcomes

Work towards improving the health of populations

- Detect health care trends affecting patient populations
- Design an evidence-based disease management program that incorporate outcome indicators, drug tx programs, risk reduction and education programs
- Promote public awareness of diseases
- Be prepared to participate in emergency plans
- Counsel patients on health lifestyles; Certified to adm. Immunizations
- Advocate for policies that increase access to health services and reduce health risks and disparities



Manchester University College of Pharmacy targeted areas in our curriculum

1. Intro to Pharmacy (PHRM 320)

- Explain and apply legal rules relating to controlled substance prescribing and dispensing
- Talk about "responsible prescribing"; educate students about Indiana's controlled substance prescribing law
- Introduce students to INSPECT



2. CNS I (PHRM 451)

- Students receive 9 contact hours on pain management
 - » Acute and Chronic pain management
 - » Comprehensive assessment of pain
 - » Determining which patients may have risk of misuse/abuse
 - » Adverse effect prevention
 - » Opioid Education of patients (including appropriate disposal)
- In Pharmacy Practice Lab (skills labs): practice evaluating actual INSPECT reports



INSPECT

- There are conflicting findings regarding the ability of PDMPs to reduce mortality related to opioid abuse
- PDMPs have been shown to influence the behavior of prescribers, pharmacists and patients
- Studies with pharmacists and PDMPs are very limited - - have been shown to help reduce doctor shopping.

With influence comes power - - Efforts to reduce illegal, nonmedical use of prescribed controlled drugs must be balanced so as not to interfere with appropriate medical use of these medications.



Pharmacist's responsibility

"A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription..... and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law related to controlled substances.



3. CNS II (PHRM 454)

- Drug dependence / Addiction / Tolerance pharmacology (4 hours)
- Policies related to substance abuse. Social aspects of abuse. Non-pharmacological approaches (2 hours)
- Smoking cessation (also taught in non-prescription therapeutics)
- Substance abuse therapeutics (2 hours)



Substance Abuse Therapeutics Objectives:

- List drug MOA, interactions, warnings, and adverse effects for nicotine dependency. Recommend Rx treatment for nicotine dependency
- List the diagnostic criteria for substance use disorders
- Identify s/sx BZDs, ETOH, and opioid withdrawal
- Discuss appropriate pharmacotherapy for dealing with dependence and withdrawal from each type of drug
- Recommend tx options for BZD, ETOH, and opioid dependence
- Outline adv/disadv of buprenorphine and methadone. Counsel patients on appropriate use.
- Manage special patient populations (pregnancy)



4. Toxicology (PHRM 557) – Drugs of Abuse

- Evaluate an adolescent for substance abuse using the CRAFFT tool
- Compare and contrast current safety evidence of traditional cigarettes and e-cigarettes
- Demonstrate how you would discuss with parents the warning signs of inhalant abuse
- Identify easily accessible products that are commonly abused in the community
- Given a case of opioid overdose, recommend the appropriate treatment plan and monitoring parameters.



Prevention and Assistance of substance abuse in student pharmacists

- All students undergo a drug screen prior to the start of each professional year. This is a requirement of our program and sites where we send our students to train.
- Our Student Affairs department has an open door policy to our students. There is also an anonymous e-form where students, staff, and faculty can express concern over another member of the College of Pharmacy – this communication goes directly to Student Services.
- Counseling services are available on site – Danette Till hooks students up with community resources
- Students enter the Pharmacist Recovery Network Program and communicate with the State Board of Pharmacy



Manchester University College of Pharmacy
Mission

Manchester University respects the infinite worth of every individual and graduates persons of ability and conviction who draw upon their education and faith to lead principled, productive, and compassionate lives that improve the human condition.



Conclusion:

Pharmacists clearly have a responsibility to provide appropriate care for patients afflicted with substance abuse and addiction.

In general, society has labeled individuals using illicit drugs with prejudice. Health professionals too often think negatively toward addicts.

We entrust that our pharmacy students will truly deliver appropriate, supportive and professional care to all who struggle with this difficult and often life-destroying problem.





Indiana Guidelines for Opioid Prescribing in the Emergency Department

Governor's Task Force on Drug Enforcement, Treatment, and Prevention
May 17, 2016



Introduction to the Guidelines 

- *Developed in partnership with ISMA and coordinated with other stakeholders*
 - Reviewed other states' policies and local practices
- *Hospitals are encouraged to align current policies with recommendations*
 - Facility Action Checklist is available
- *Still in draft form but finalizing now*



IHAconnect.org

Introduction to the Guidelines 

- *Intended to complement pre-existing chronic pain management rules and other laws governing prescribing practices or patient treatment*
 - Guidelines provide a general approach but do not supersede clinical judgment of prescribers
 - Best practices for treatment of pain in acute settings outside of the ED are being developed

IHAconnect.org

Emergency Medical Clinicians 

- *Emergency medical clinicians should not routinely provide:*
 - Replacement prescriptions for lost, destroyed or stolen OPCS
 - Replacement doses of Suboxone, Subutex or Methadone for patients seeking addiction treatment
 - Long-acting or controlled-release opioids (OxyContin, fentanyl patches and methodone)

IHAconnect.org

Patient Assessment for Appropriate Prescribing 

- *Patient's presenting symptoms, overall condition, clinical examination and risk for addiction are the basis of determining the appropriateness of prescribing OPCS*
 - Prescriptions for chronic pain should not typically be provided if it is known that the patient has either previously presented with the same problem or recently received a prescription for OPCS from another provider
 - Doses of OPCS for routine chronic pain or acute exacerbations of chronic pain should not typically be given in injection form

IHAconnect.org

Patient Assessment for Appropriate Prescribing Cont'd 

- *Patient's presenting symptoms, overall condition, clinical examination and risk for addiction are the basis of determining the appropriateness of prescribing OPCS*
 - IV Demerol (Meperidine) for acute or chronic pain is discouraged
 - Providers should consider risk factors for respiratory depression when prescribing to patients currently taking benzodiazepines and/or other OPCS

IHAconnect.org

Considerations for ED Clinician 

- *When an ED provider is considering prescribing or administering OPCS, the emergency clinician:*
 - Should consider a search of INSPECT
 - Should exercise caution in situations in which the identity of the individual cannot be verified
 - Has the right to perform a drug screening

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Optimize Health Outcomes by Minimizing Supply



- *Except in rare circumstances, emergency clinicians should limit ED prescriptions for OPCS to no more than a five-day supply*
 - Continued pain needs referral to the PCP or appropriate specialist for evaluation

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Consider Alternatives Before Prescribing



- *Prior to making a final determination regarding whether a patient will be provided a prescription for OPCS, the clinician may consider the following options:*
 - Contact the patient's routine provider who usually prescribes their OPCS
 - Request a consultation from their hospital's palliative or pain service or an appropriate sub-specialty service
 - Perform case review or case management for patients who frequently visit emergency/acute care facilities with pain-related complaints
 - Request medical and prescription records from other hospitals, provider offices, etc.

IHAconnect.org

Coordinate Care



- *The ED facility should coordinate the care of patients who frequently visit the ED to establish a patient-specific policy/treatment plan, which should include treatment referrals for patients with suspected prescription drug abuse problems*

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Identify Pain Management Services



- *Emergency/acute care facilities should maintain an updated list of clinics that provide primary care and/or pain management services for patients, as needed*

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Provide Guidelines to Patients



- *Following the medical screening, emergency/acute care facilities should consider providing a patient handout that reflects the above guidelines and clearly states the facility position regarding the prescribing of OPCS*

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Next Steps



- *Finalize endorsements of guidelines and disseminate*
- *Work with stakeholders on a "Safe Prescribing" campaign*
- *Resume work on other acute prescribing guidelines with stakeholders*

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State of Indiana Governor's Task Force on Drug Enforcement, Treatment, and Prevention *Final Report Update*

Seema Verma, MPH
SVC, Inc.

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Purpose

- The purpose of this final report is to document the Task Force process and recommendations, as well as provide a roadmap for the Indiana Commission to Combat Drug Abuse, established in 2016 by Senate Bill 271 (Pub. L. 7).

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Overview of Indiana SUD Issue

- Overall Trends in Drug Use in Indiana (e.g., overdose deaths, lab submissions, opioid access)
- Methamphetamine Production in Indiana (e.g., seizures, associated fatalities/injuries, pharmacy loss/robberies)
- Associated Public Health Impact (e.g., infant morbidity/mortality, hospital admissions, drug use among pregnant women)
- Associated Public Cost (e.g., HIP substance use disorder utilization, hospital admissions)
- Spotlight on Scott County HIV Epidemic (e.g., trends in diagnoses, HIV incidence, incidence of drug use)

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Three Components

- Report will consist of three sections addressing the following components:
 - Enforcement, Treatment, and Prevention
- Each report section will provide an overview of:
 - Status of Each Component in Indiana
 - Summary of Task Force Presentations and Identified Best Practices
 - Summary of Key Task Force Discussions
 - Task Force Recommendations and an Update on Current Status (i.e., progress to date)

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Personal Stories/Vignettes

- To emphasize the personal nature of substance abuse, and to highlight the work of those impacted by substance and fighting against the epidemic, the final report will incorporate small impressionistic scenes focusing on a particular event or individual.



Note: Example vignette taken from Maryland SUD report.

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Potential IN Task Force Meeting Vignettes

- Justin Phillips (Lifeline/Aaron Phillips story)
- Sean O'Daniel (INSPECT/prescribing guidelines)
- IEMS story about naloxone administration—officer, EMS, or victim
- Rodrigo Garcia (healthcare providers w/addictions)
- Joan Moon (vivitrol access)
- Jamie Williams (trauma therapy recommendation)
- Ben Gonzalez (vivitrol/MAT access)
- Jill Gonzalez (naloxone saved life)
- Cynthia Stone (family support groups)
- Linda Ostewig (family support)
- Karen Andre (methamphetamine addiction)
- Janice Walker (neonatal abstinence syndrome)
- Sandy Jeffers (Pathways recovery service/treatment model)
- Kathleen Bates (Indiana Coalition on Prevention and Treatment)

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Next Steps

- Suggestions for Future Study
- Indiana Commission to Combat Drug Abuse
- Future role of the Task Force

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Outline Review/Discussion (handout)

• GOVERNOR'S •
TASK FORCE
on Drug Enforcement,
Treatment & Prevention

Indiana Problem-Solving Courts

Mary Kay Hudson, Director of Court Services
Indiana Judicial Center
mk.hudson@court.in.gov

Problem-Solving Court: Defined

The term "problem-solving court" generally refers to an alternative approach to traditional case processing that focuses on outcomes related to victims, offenders, and society
(Center for Court Innovation, 2001).

Problem-Solving Court Goals

- Reduce recidivism & system costs
- Improve access to services and quality of life
- Increase public confidence in the courts

10 Key Components

- Key Component #1 Integrate alcohol and other drug (AOD) treatment services with criminal justice
- Key Component #2 Non-adversarial approach
- Key Component #3 Early identification and admission
- Key Component #4 Access to continuum of AOD treatment
- Key Component #5 Frequent AOD testing

10 Key Components, BJA, 1997

- Key Component #6 Rapid responses to participants' compliance
- Key Component #7 Ongoing judicial interaction
- Key Component #8 Monitoring and evaluation
- Key Component #9 Interdisciplinary education
- Key Component #10 Partnerships

Types of Problem-Solving Courts

- Adult criminal
 - Reentry
 - OWI
 - Domestic violence
 - Mental health
 - Veterans
- Juvenile delinquency
- Family dependency (CHINS)

All models are based upon the 10 key components

Do Drug Courts Work?

What We Already Know:

- Drug courts reduce recidivism
- Effects last up to 14 year post-participation
- Average reduction is 18 percent
- Some reductions up to 60 percent

Variable Effect Sizes...

- 78 percent reduce recidivism
- 16 percent have no effect
- 6 percent increase recidivism

Research Question...

What practices distinguish an effective drug court from one that causes harm?

NADCP Adult Drug Court Best Practice Standards

- Guide adult drug court operations
- List practices associated with best outcomes – recidivism and cost benefits
- Most standards applicable across models

<http://www.nadcp.org/Standards>

Best Practice Areas

- Targeting and Eligibility
- Historically disadvantaged groups
- Role of the judge
- Incentives, sanctions, therapeutic adjustments
- Substance abuse treatment
- Complementary services
- Drug testing
- Team membership and roles
- Caseloads
- Monitoring and evaluation

Indiana Problem-Solving Courts

- First drug court 1996
- 76 certified programs – about 2000 participants
- Guided by IC 33-23-16 & PSC Rules
- Indiana Judicial Center provides training, technical assistance and certification – incorporates research and best practices

Types of PSC in Indiana

- Drug courts – adult and juvenile (37 adult, 4 juvenile)
- Reentry courts (9)
- Mental health courts (3)
- Family drug courts (CHINS) (6)
- Veterans courts (16)
- Domestic violence court (1)

<http://www.in.gov/judiciary/pscourts/files/pscourts-psc-directory.pdf>

Indiana Certified Problem-Solving Courts



Policy Recommendations

- Increase the number and capacity of all models – regional approach; promote family dependency/CHINS expansion
- Expand training opportunities
- Develop a coordinated approach to research and evaluation – process, outcome and cost benefit
- Promote fidelity to the model

For additional information...

- National Association of Drug Court Professionals www.nadcp.org
- Center for Court Innovation www.courtinnovation.org
- Children and Family Futures www.cffutures.org

Questions?

• GOVERNOR'S •
TASK FORCE
on Drug Enforcement,
Treatment & Prevention



**2016
CRIMINAL
JUSTICE
PROJECTS**

ALLEN COUNTY, IN

**How is Allen County
combating the drug crisis
with the Criminal Justice
System?**

Aligning Supervision Programs & Initiatives

- Allen County Community Corrections
- Reentry Court
- Restoration Court (Mental Health)
- Allen County Adult Probation
- HOPE Probation
- Criminal Division Services
- Drug Court Program (DCP)
- Alcohol Countermeasures Program (ACP)
- Pretrial Services (PTS)
- Joint Veterans Court
- Allen County Pretrial Pilot Project

We have positioned ourselves for the best utilization of state funding

ACCC & ACAP Collaboration Plan

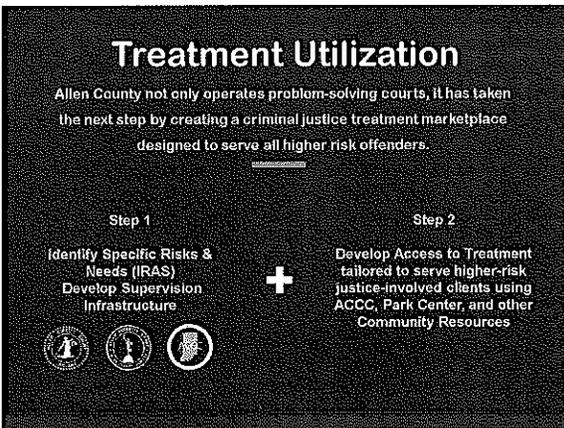
- Negotiate Service Contracts
- Cost Reductions
- Uniform Case Planning
- Development of Treatment Program
- Collaborate on Problem-Solving Court Workgroups
- Community Assessment Screening Team (C.A.S.T.)
- Develop Training to enhance evidence-based practices

Utilization of HEA1006 IDOC Funding Availability

	Allen County Community Corrections	Allen County Probation Department
2015-2016	<p>\$170,500</p> <p>Hiring staff for expansion of Home Detention and Electronic Monitoring Level of Supervision</p>	<p>\$113,900</p> <p>Hiring two (2) full time staff Computer software upgrades for case planning</p>
2016-2017	<p>\$534,900</p> <p>Support Staff for Financial Services GPS Equipment Supervision Personnel & Equipment</p>	<p>\$205,400</p> <p>Funding 3 FT PO positions at \$35,000 ea. Salary Increase</p>

Funding afforded the following:

Allen County Community Corrections	Allen County Probation Department
<p>(FY2015-2016)</p> <ul style="list-style-type: none"> 1 Home Detention Officer 1 Communications Technician 	<p>(FY2015-2016)</p> <ul style="list-style-type: none"> 2 FT PO Positions
<p>(FY 2016-2017)</p> <ul style="list-style-type: none"> 1 Finance Deputy Position 1 Home Detention Officer Position Vehicle Supplies/Maintenance GPS Equipment Purchase & Leasing / Insurance & Maintenance costs 1 Vehicle 5 Computers 5 Desks 2 Printers 	<p>(FY 2016-2017)</p> <ul style="list-style-type: none"> 3 FT PO positions Salary adjustments for 2 Po positions funded in FY15-16 Drug testing supplies Travel/Training Office Equipment & Operational Supplies



REMAINING SERVICE GAPS

ALLEN COUNTY, IN

Service Gaps: Housing



Allen County maintains great outpatient treatment services and community-based criminal justice supervision services, but so often we need stable and sober housing to best support and continue treatment & supervision services.

Funding is needed to support and grow good transitional housing opportunities.

2016 ACCC Housing & Referral Statistics

The following statistics demonstrate the number of offenders referred for supervision with ACCC who were found ineligible due to unsuitable housing, so far in 2016.

Found Ineligible	January	February	March	April
	26	16	94	70

Figures represent Referrals for HD Suspended & Executed Supervision Component & Reentry Program

Service Gaps: Medication Assisted Treatment

Allen County has identified that medically assisted treatment for justice-involved persons is a current service gap.

- Access to prescription drug monitoring systems
- Vivitrol Therapy Pretrial Release Protocol

Funding is needed to support and grow these types of projects for indigent offenders.

Service Gaps: Medication Assisted Treatment

Allen County private providers coming together with Allen County Health Commissioner Deb McMahon to attempt to utilize the private providers/hospitals with medically assisted treatment program – outpatient

Service Gaps: Medication Assisted Treatment

Current feasibility study with Indiana Criminal Justice Institute and local sheriff for Vivitrol Therapy Pretrial Release Protocol.

Barriers include funding, navigators, legal liability issues.

Service Gaps: Navigators

Necessitating the need for Navigators, similar in function to the medical community.

Need for local navigator services for Sheriff in the jails and for criminal justice providers to utilize.

Summary:

We all know that drug abuse leads many into the criminal justice system.

Creative and comprehensive community supervision services coupled with treatment services is our best tool.

Summary:

Allen County positioned itself to take advantage of services and funding available.

But, 1006 reform taxing our systems and have brought even more to light the service gaps we've discussed today.

Would ask the Governor and Task Force to recognize all we are doing right – but also focus attention on these service gaps.

Recommendations

Please fund housing availability

Please support new initiatives like MAT

Continue funding adequately our community supervision services

THANK YOU

For your time & attention

Hon. Wendy Davis
Judge
Allen Superior Court
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* GOVERNOR'S *
TASK FORCE
on Drug Enforcement,
Treatment & Prevention



Overdose Lifeline, Inc.

Overdose Lifeline, Inc. works with NPO's IIGMA dedicated to helping individuals, families, and communities affected by the disease of addiction, provided the attention and care required of a chronic disease.

overdose-lifeline.org

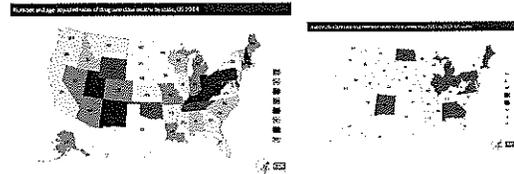


We're here to help

- Working with law enforcement, government, and communities to advance the laws and resources available
- Prevention Education
- Harm Reduction
 - First responder naloxone overdose reversal kits and training
 - Naloxone distribution and training for the individual and family
- Providing education on the chronic disease of addiction and prevention and recovery information and resources
- Support group and events



CDC 2014: Overdose Deaths



Response to the opioid and heroin epidemic



REDUCE
Overdose rates

- Expand the use of and access to Naloxone - overdose reversal drug
- First responders and individuals



REVERSE
Overdose

- First responders and individuals



PREVENT
People from starting

- Youth education - prevent the first use
- Family education - risk factors and prevention for their family



Why prevention?

"We know that evidence-based prevention efforts are the most effective way to reduce drug use and to support the roughly 90 percent of American youth who do not use illicit drugs. This Administration will continue to expand community-based efforts to prevent drug use, pursue 'smart on crime' approaches to drug enforcement, increase access to treatment, work to reduce overdose deaths, and support the millions of Americans in recovery."

Michael Botticelli, Director of National Drug Control Policy



Why prevention?

In total, alcohol, tobacco and illicit drug use exacts more than \$700 billion annually in costs related to crime, lost work productivity and health care. For every \$1 invested into prevention and early treatment programs, up to \$10 can be saved in costs related to substance use disorders.

-- ASAM (American Society of Addiction Medicine)



Overdose Lifeline, Inc.



Prescription Pain Medicine (Opioids) and Heroin Prevention Education Program

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About the education program

An efficacy-based, turn-key program complete with materials, support and train-the-trainer component

- Targeting students grades 6 – 12, adaptable for other groups
- Designed to prevent the first use
- Flexible, fits to classroom and assembly/convocation settings
- Built for 45-minute time block, can expand for longer time periods
- Currently undergoing evidence-based review with IUPUI



Education program objectives/outcomes

After completing the lesson, students will know and understand

1. Drug use can lead to heroin use, addiction, overdose, and death
2. The risks of heroin and prescription pain drug misuse
3. The impact of heroin, drugs and alcohol on the user and the user's family and friends
4. Alternatives to using heroin, drugs, and alcohol
5. The many ways to ask for help and available information and resources



Educational program pilot period

January – May 2015, Overdose Lifeline, Inc. partnered with Indianapolis Metro Police Department (IMPD) to deliver the Education and Prevention program across 5 Indianapolis area high schools, reaching more than 1900 students.

- Collecting feedback from educators, students, Students Against Destructive Decisions (SADD)
- Modifying the program based upon pilot experience



Program data & evidence-based study

The "This is (Not) About Drugs" educational program is currently undergoing evidence-based review with Indiana University - Purdue University with classroom observations/surveying launching in Fall 2016. In the interim the student worksheet data analysis shows program produced **significant attitudinal changes** in the student audience.

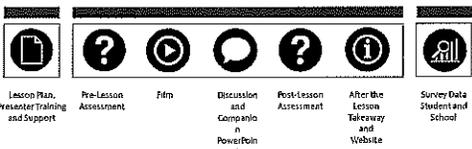
Summary:

246 students were given the pre test prior to the training and were again measured using the same test after receiving the training (post test). For the pre test a mean score of 15.5 was found and for the post test a mean score of 21.4 was found, indicating an average improvement in the scoring of 5.9.



Educational program package

The lesson plan and program materials are mapped to the program objectives and designed to provide the student with the opportunity to learn through a guided and practical exercise – deepening the students understanding and retention.



 Film: This is (Not) About Drugs



Most important message

- Prescription Pain Pills = Heroin, they are Opioids.
- They are highly addictive. When you use opioids and heroin you lose your ability to choose.
- You can become addicted and you can overdose with just 1 use, with the 2nd, the 3rd, etc.
- Heroin and prescription pills are rarely the starting point - First is marijuana, alcohol and other drugs.



Feedback

South Vermillion High School Principal Don Harman believes the work of Overdose Lifeline is vital, "I would encourage every high school principal to contact them and have them speak to your student body. To me, that right there - every high school and I hate to say this, some middle schools - that message needs to get out there."

"The best kind of drug case is the case that we don't have because somebody makes the choice to not use. And if people, young people especially, that may not have had a lot of information about narcotics - specifically heroin and addiction - if they have more information, then it will increase the possibility that they're going to make good decisions, not bad decisions."

-- Brent Eaton, Hancock County Prosecutor

"Indiana Students Against Destructive Decisions (SADD) sees the unique value in this educational program, as Overdose Lifeline works with law enforcement to deliver a message that must be shared with young people in the Indianapolis area. Programs like this have great potential to create positive change in our communities."

-- Jamie Vickers, State Coordinator Indiana SADD

"I appreciate Overdose Lifeline, Inc. for coming out to our high school to present this lesson on heroin prevention. Heroin use has become an epidemic in our state and it's vital that our young people become aware of what could potentially happen to them if they experiment with heroin or opioids." -- Jeff Wright, Indiana High School, Health Teacher



Students "what did you learn"

"Don't do any kind of drugs because you will probably end up somewhere where you never thought you would be."

"I learned that no matter how confident you are that you won't get addicted to a drug after taking one dose, you can easily come addicted and it's not within your control. Even trying drugs that aren't as powerful, will lead to more dangerous drugs that can severely effect your life."

"I learned that people normally do other drugs before doing heroin or prescription pain medicine, it is sort of like a ladder."

"Prescription drugs and heroin are the same type of drug and are equally dangerous. Both are opioids, and both have the potential to end your life."

"I learned that drugs can really mess up someone's life. More than anyone thinks in the first place, but listening to someone describe how hard it was to get through hit me in ways that are indescribable."

"I learned that drugs are never the right path to go down and that you should always stay away from them. Always keep good positive people in your life to make you a better person so you don't go down the wrong path."

"That practically any drug out there could really screw up your plans for life. If I want to do big things, I can't let something stupid like a little pill effect my grades, my goals, and my friendships/relationships."



With prescription pain medicine and heroin addiction rising across the nation and with overdose as the leading cause of death of our youth, it is critical that we help our youth through awareness and knowledge.

"This is (Not) About Drugs" - An opioid educational program designed to prevent first use and save young Hoosier lives.

Seeking funding and support to deliver the "This is (Not) About Drugs" prevention education program to 150+ Indiana schools.



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Thank you

Justin Phillips, 317-828-6883, justin@overdose-lifeline.org
Kourtayne Sturgeon, 317-409-7256, education@overdose-lifeline.org

overdose-lifeline.com/education





Indiana Guidelines *for* Opioid Prescribing *in the* Emergency Department

The Indiana Hospital Association and the Indiana State Medical Association, in coordination with other stakeholders, have developed guidelines for safe and appropriate prescribing practices for managing pain in the emergency department (ED).

More information on the ongoing efforts across the state can be found at:

[Governor's Task Force on Drug Enforcement, Treatment and Prevention](#)

[Attorney General's Prescription Drug Abuse Prevention Task Force](#)

[Indiana State Medical Association – Controlled Substance Prescribing](#)

[Indiana Board of Pharmacy Prescription Drug Monitoring Program \(INSPECT\)](#)

In creating these guidelines, policies adopted in other states were reviewed along with practices developed by hospitals within Indiana.

It is recommended that hospitals review their current practices on the use and prescribing of opioids and other controlled substances in the ED and, if necessary, take action to align current policies with the recommended guidelines. To assist in that review, a Facility Action Checklist is included with these guidelines.

The Indiana Guidelines for Opioid Prescribing in the Emergency Department do not supplant or supersede the clinical judgment of prescribers. All individuals who present to the ED are required to be provided an appropriate medical screening examination to determine if an emergency medical condition exists. These guidelines are intended to provide a general approach to prescribing opioids and other controlled substances in the ED and are intended to complement the Indiana Chronic Pain Management Rules and any other laws governing prescribing practices or patient treatment.

Additionally, IHA and ISMA plan to develop best practices and guidelines addressing the treatment of pain in other hospital settings outside of the ED.



5/16/2016

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Indiana Guidelines *for* Opioid Prescribing *in the* Emergency Department

5. Prior to making a final determination regarding whether a patient will be provided a prescription for opioids and other controlled substances, the emergency clinician may consider the following options:
 - a) *Contact the patient's routine provider who usually prescribes their opioids and other controlled substances.*
 - b) *Request a consultation from their hospital's palliative or pain service (if available) or an appropriate sub-specialty service.*
 - c) *Perform case review or case management for patients who frequently visit the emergency/acute care facilities with pain-related complaints.*
 - d) *Request medical and prescription records from other hospitals, provider's offices, etc.*
6. The ED facility should coordinate the care of patients who frequently visit the ED to establish a patient-specific policy/treatment plan, which should include treatment referrals for patients with suspected prescription drug abuse problems.
7. Emergency/acute care facilities should maintain an updated list of clinics that provide primary care and/or pain management services for patients, as needed.
8. Following the medical screening, emergency/acute care facilities should consider providing a patient handout that reflects the above guidelines and clearly states the facility position regarding the prescribing of opioids and other controlled substances.

NOTE: It is recommended that these guidelines not be posted in the ED waiting rooms or treatment areas. CMS has expressed concern that the posting of signs and/or distribution of brochures in an ED emphasizing that certain types of pain medications will not be prescribed may place a hospital at risk of noncompliance with the Emergency Medical Treatment and Labor Act (EMTALA).

5/16/2016

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NADCP
National Association of
Drug Court Professionals

need to **Know**

What Have We Learned from the Multisite Adult Drug Court Evaluation? Implications for Practice and Policy

The Multisite Adult Drug Court Evaluation

By Shelli B. Rossman, M.A., and Janine M. Zweig, Ph.D.

May 2012

In 2011, the National Institute of Justice (NIJ) and a team of researchers from The Urban Institute's Justice Policy Center, RTI International, and the Center for Court Innovation completed a five-year longitudinal process, impact and cost evaluation of adult Drug Courts. The Multisite Adult Drug Court Evaluation (MADCE) compared the services and outcomes in twenty-three adult Drug Courts from seven regions in the U.S. against those of six comparison sites in four regions. The comparison sites administered diverse programs for drug-involved offenders, including Treatment Alternatives for Safer Communities (TASC), Breaking the Cycle (BTC), and standard court-referred, probation-monitored treatment. Offender-level data were obtained from 1,157 Drug Court participants and 627 comparison offenders who were carefully matched to the Drug Court participants on a range of variables that influenced outcomes. The study was designed to answer three basic questions:

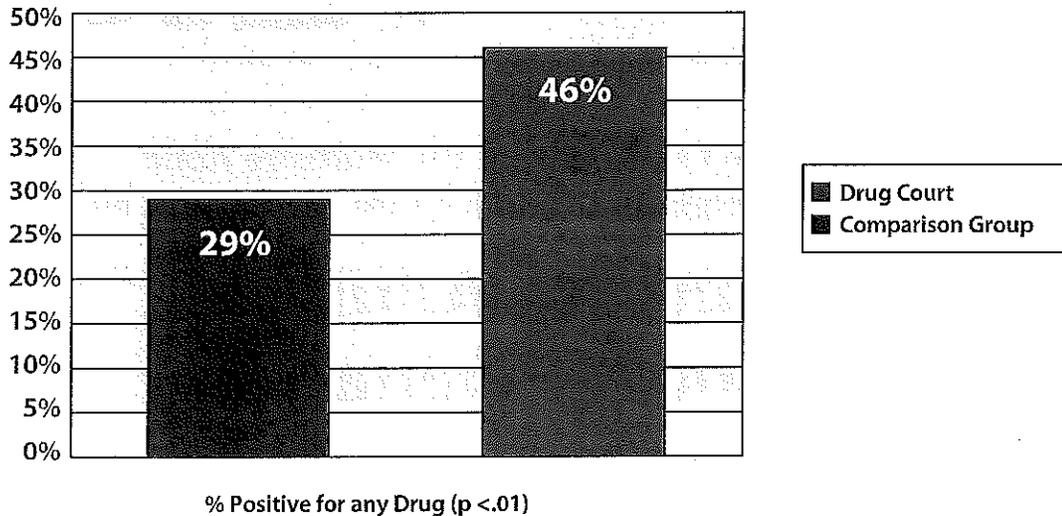
Do Drug Courts Work?

Drug Court participants and matched comparison group members were compared on key outcomes, including self-reported drug use, oral fluids drug test results, self-reported criminal behaviors, official criminal recidivism records, and psychosocial outcomes.

For Whom Do Drug Courts Work Best?

Analyses examined the extent to which the Drug Courts affected subgroups of offenders characterized by demographic variables, primary drug of abuse, criminal history, violence history, and associated mental health problems.

Figure 1. Oral Swab Drug Test Results at 18 Months



How Do Drug Courts Work?

The study identified which policies and practices in the Drug Courts might predict better outcomes. In addition, the study examined participants' perceptions of the programs to determine whether those perceptions influenced outcomes.

MADCE Findings

The key findings from the MADCE supported many of the expectations upon which best practices in the Drug Court field are currently based; however, they also revealed some unexpected results that may challenge some of those practices.

Drug Court participants were significantly less likely than the matched comparison offenders to relapse to drug use, and those who did relapse used drugs significantly less.

Effectiveness of Drug Courts

Drug Court participants were significantly less likely than the matched comparison offenders to relapse to drug use, and those who did relapse used drugs

significantly less. Figure 1 compares the rates of positive oral swab drug tests at eighteen months.

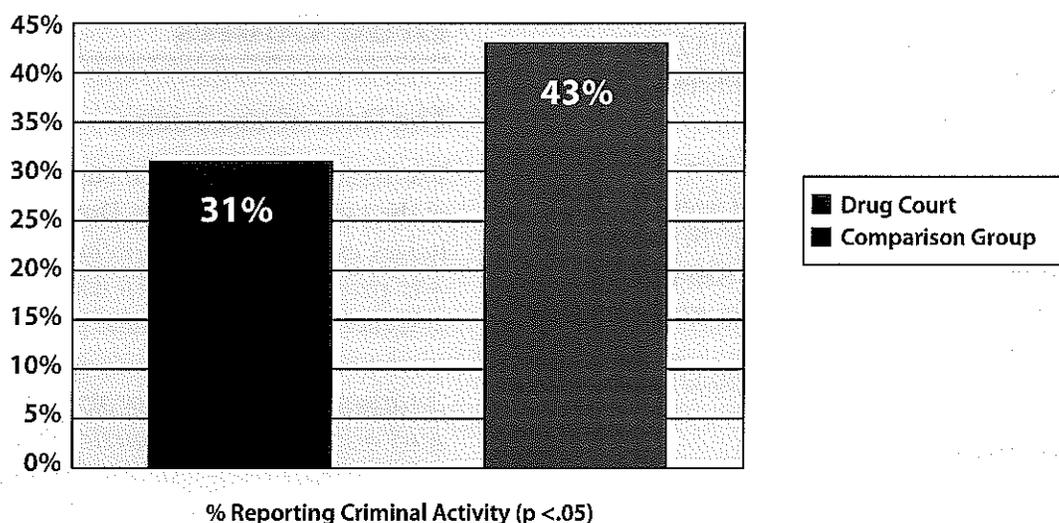
Drug Court participants reported committing significantly fewer criminal acts than the comparison group after participating in the program. Figure 2 compares the percentages of participants who reported engaging in any criminal activity at eighteen months.

Drug Court participants reported significantly less family conflict than the comparison offenders at eighteen months. Drug Court participants were also more likely than the comparison offenders to be enrolled in school at six months.

Drug Court participants reaped psychosocial benefits in areas of their lives other than drug use and criminal behavior. Drug Court participants reported significantly less family conflict than the comparison offenders at eighteen months. Drug Court participants were also more likely than the comparison offenders to be enrolled in school at six months and needed less assistance with employment, educational services, or financial issues at eighteen months.

THE MULTISITE ADULT DRUG COURT EVALUATION

Figure 2. Criminal Activity in the 6 Months Before the 18-Month Survey



Target Population

Drug Court reduced drug use equivalently for most subgroups of participants, regardless of their primary drug of choice, past criminal history, or associated mental health problems. Little empirical justification exists for denying admission to Drug Court based on an offender's clinical presentation or criminal history.

Participants with violence histories reduced substance use just as much in Drug Court as those without violence histories and reduced criminal activity even more. Thus, prohibitions contained in state and federal statutes against admitting violent offenders into Drug Courts may not be justified on the grounds of effectiveness or cost.

Participants with violence histories reduced substance use just as much in Drug Court as those without violence histories and reduced criminal activity even more.

The largest cost benefits were achieved by reducing serious offending on the part of a relatively small subset of the Drug Court participants. On average, the Drug Courts returned net economic benefits to their local communities of approximately \$2 for every \$1 invested; however, this did not represent a statistically significant improvement

over the comparison programs. The absence of statistical significance may have been influenced by the nature of the target populations. Many of the Drug Courts in the MADCE reduced low-level criminal offenses that are typically not associated with high incarceration or victimization costs. This suggests Drug Courts will need to target more serious offenders to reap significant cost benefits for their communities.

Best Policies

The most effective Drug Courts had the following policies or characteristics:

- *Greater leverage over their participants.* The participants were made aware of the alternative sentences they faced if they failed the program and were in regular contact with program personnel and the judge.
- *Greater predictability of sanctions.* The programs had a written schedule of sanctions for infractions that they shared with participants and staff. However, the teams retained discretion to overrule the sanctions if there were good reasons to do so.
- *Consistent point of entry.* The more effective Drug Courts maintained one point of entry into the program, either at preadjudication or postadjudication, but not both.

- *Positive judicial attributes.* The more effective Drug Courts had judges whose interactions with the participants were respectful, fair, attentive, enthusiastic, consistent, predictable, caring, and knowledgeable.

The most effective Drug Courts had greater leverage over participants, greater predictability of sanctions, consistent point of entry, and positive judicial attributes.

Best Practices

The most effective Drug Courts provided the following services:

- More frequent judicial status hearings (at least twice per month)
- Higher and more consistent levels of praise from the judge
- More frequent urine drug testing (at least twice per week)
- More frequent clinical case management sessions (at least once per week)
- A minimum of thirty-five days of formal drug-abuse treatment services

Participants' Perceptions of the Judge

The primary mechanism by which the Drug Courts reduced substance use and crime was through the participants' perceptions of and attitudes toward the judge. Significantly better outcomes were achieved by participants who rated the judge as being knowledgeable about their cases and who reported that the judge knew them by name, encouraged them to succeed, emphasized the importance of drug and alcohol treatment, was not intimidating or unapproachable, gave them a chance to tell their side of the story, and treated them fairly and with respect.

Recommendations to Drug Courts

The Role of the Judge

The results of the MADCE support the centrality of the judge in influencing Drug Court outcomes. Judges exert considerable influence and authority over participants, and when used strategically, this influence can elicit substantial positive change.

Judges exert considerable influence and authority over participants, and when used strategically, this influence can elicit substantial positive change.

- *Train judges on best practices regarding judicial behavior.* Judges do not necessarily have the innate traits that elicit the most positive outcomes from participants, and thus may benefit from training in best practices for judicial behavior. New Drug Court judges should participate in team and judicial-specific training to acquire the knowledge and skills of an effective Drug Court judge.
- *Hold frequent judicial status hearings.* Twice per month is the minimum frequency for status hearings that the MADCE found effective. Most of the effective Drug Courts in the MADCE held status hearings four times per month.

Most of the effective Drug Courts in the MADCE held status hearings four times per month.

- *Choose Drug Court judges carefully.* Not all judges may be suited to the Drug Court model in terms of their personality and attitudes toward offenders and the judicial relationship. Drug Courts may best be served if administrators assign judges to the Drug Court docket who are committed to the problem-solving court model and are interested in serving in this role.

THE MULTISITE ADULT DRUG COURT EVALUATION

- *Give them time*—judges may need time to develop effective approaches to the Drug Court bench. Rotating judges on and off the Drug Court bench will likely decrease not only the judges' abilities to successfully implement their roles, but also the overall success of the Drug Court program.
- *Monitor participant satisfaction.* Drug Courts should continuously monitor participants' attitudes about the judge. If a judge elicits widespread negative responses from the participants, corrective action may be indicated.
- *Avoid suitability determinations.* Drug Court teams are not very successful at predicting who will succeed in their program. Therefore, they should avoid allowing entry only to offenders they believe will be better suited to the services.

Rotating judges on and off the Drug Court bench will likely decrease not only the judges' abilities to successfully implement their roles, but also the overall success of the Drug Court program

Drug Court Eligibility

An important finding emerging from the MADCE is that Drug Courts appear equally effective in reducing crime and drug use among a wide range of offenders; however, their cost-effectiveness may be reduced by focusing on low-risk participants. Therefore, Drug Courts should consider broadening their eligibility requirements to reach higher-risk offenders.

Drug Courts should consider broadening their eligibility requirements to reach higher-risk offenders.

- *Consider removing eligibility restrictions based on the offender's drug of choice, criminal history, or co-occurring mental health disorders.* There is no empirical basis for many of these eligibility restrictions currently being imposed in Drug Courts.
- *Consider including violent offenders with substance use diagnoses.* The MADCE findings revealed that many violent offenders in Drug Court programs reduced drug use as much as other participants and reduced their criminal behaviors even more.

Sanctions Policies and Practices

The most effective Drug Courts in the MADCE had a coordinated sanctioning strategy, yet exercised flexibility in its implementation in a way that mattered considerably to the participants. Perhaps the participants perceived this flexibility as being more fair because it took individual circumstances into account. This suggests Drug Courts should distribute a written schedule of sanctions to its staff and participants, yet maintain flexibility when applying it. In this way, participants will be forewarned about the potential sanctions for noncompliance and will expect more severe sanctions with repeated infractions. Equally important, however, the Drug Court team should allow for individual circumstances that might warrant a less severe reaction from the court.

There is no empirical basis for many of these eligibility restrictions currently being imposed in Drug Courts.

Leverage

Participants fared better in the Drug Courts when they understood what specific alternative sentences would be if they failed the program and if they maintained regular contact with Drug Court staff and the judge. This provides a further rationale for Drug Courts to target higher-risk populations who face a realistic prospect of jail or prison time if they are terminated. In addition, all team members in the Drug Court should make a concerted effort to periodically remind participants about the potential consequences of termination. Finally, participants should sign entry contracts clearly acknowledging the potential consequences of failure and the presumptive alternative sentence if they do not graduate from the program.

Drug Courts should distribute a written schedule of sanctions to its staff and participants, yet maintain flexibility when applying it.

Case Management

Many Drug Courts rely predominantly on group-based counseling services for treatment. However, the MADCE results underscored the importance of individual case-management sessions as well. Given the myriad challenges faced by addicted offenders, once-weekly individual contacts might not be sufficient. Whether or not the primary case manager is a court staff member or treatment provider, participants are likely to have better outcomes if they meet with the case manager more than once per week, at least during the first phase of treatment.

Participants are likely to have better outcomes if they meet with the case manager more than once per week, at least during the first phase of treatment

Drug Testing

Continuous monitoring of alcohol and other drug abstinence is critical to the success of Drug Courts. Drug tests should be performed frequently, certainly more than once per week during the initial phase of the program. Drug tests not only assist program staff to monitor program compliance, but also communicate to participants that they are being closely watched, perhaps increasing perceptions of court leverage.

Treatment

Providing substance abuse treatment is integral to the Drug Court model. Drug Courts that offer

treatments of short duration may not allow participants sufficient time to tackle their substance use problems and alter their attitudes and behaviors accordingly. Treatment must be of sufficient length and dosage to achieve sustained success.

Drug Courts work, so ensure provisions are made to fund their continued existence.

Recommendations to Policy Makers

With good cause, policy makers have consistently funded Drug Court programs across the country for two decades, and the number of programs has grown exponentially during that time. But what do the MADCE findings mean for policy makers in the future?

Drug Courts work, so ensure provisions are made to fund their continued existence. The research evidence clearly establishes the effectiveness and potential cost-effectiveness of Drug Courts. Government agencies should continue to spend resources funding Drug Court programs. They should sponsor training and technical assistance to encourage the implementation of evidence-based practices and to ensure Drug Courts target the most appropriate offender populations for their programs.

Encourage Drug Courts to include more serious offenders in their programs. Drug Courts achieve higher reductions in recidivism and greater cost savings when they treat high-risk, prison-bound populations. As a condition of public sponsorship, federal funders and local policy makers should require Drug Courts to expand their eligibility criteria to include more serious offenders.

(Continued on page 8)



NADCP

**National Association of
Drug Court Professionals**

About NADCP

It takes innovation, teamwork and strong judicial leadership to achieve success when addressing drug-using offenders in a community. That's why since 1994 the National Association of Drug Court Professionals (NADCP) has worked tirelessly at the national, state and local level to create and enhance Drug Courts, which use a combination of accountability and treatment to compel and support drug-using offenders to change their lives.

Now an international movement, Drug Courts are the shining example of what works in the justice system. Today, there are over 2,500 Drug Courts operating in the U.S., and another thirteen countries have implemented the model. Drug Courts are widely applied to adult criminal cases, juvenile delinquency and truancy cases, and family court cases involving parents at risk of losing custody of their children due to substance abuse.

Drug Court improves communities by successfully getting offenders clean and sober and stopping drug-related crime, reuniting broken families, intervening with juveniles before they embark on a debilitating life of addiction and crime, and reducing impaired driving.

In the 20 years since the first Drug Court was founded in Miami/Dade County, Florida, more research has been published on the effects of Drug Courts than on virtually all other criminal justice programs combined. The scientific community has put Drug Courts under a microscope and concluded that Drug Courts significantly reduce drug abuse and crime and do so at far less expense than any other justice strategy.

Such success has empowered NADCP to champion new generations of the Drug Court model. These include Veterans Treatment Courts, Reentry Courts, and Mental Health Courts, among others. Veterans Treatment Courts, for example, link critical services and provide the structure needed for veterans who are involved in the justice system due to substance abuse or mental illness to resume life after combat. Reentry Courts assist individuals leaving our nation's jails and prisons to succeed on probation or parole and avoid a recurrence of drug abuse and crime. And Mental Health Courts monitor those with mental illness who find their way into the justice system, many times only because of their illness.

Today, the award-winning NADCP is the premier national membership, training, and advocacy organization for the Drug Court model, representing over 27,000 multi-disciplinary justice professionals and community leaders. NADCP hosts the largest annual training conference on drugs and crime in the nation and provides 130 training and technical assistance events each year through its professional service branches, the **National Drug Court Institute**, the **National Center for DWI Courts** and **Justice for Vets: The National Veterans Treatment Court Clearinghouse**. NADCP publishes numerous scholastic and practitioner publications critical to the growth and fidelity of the Drug Court model and works tirelessly in the media, on Capitol Hill, and in state legislatures to improve the response of the American justice system to substance-abusing and mentally ill offenders through policy, legislation, and appropriations.

(Continued from page 6)

Drug Courts achieve higher reductions in recidivism and greater cost savings when they treat high-risk, prison-bound populations.

Develop best practice standards to guide Drug Court operations. Now is the time to develop and codify standards of practice for Drug Courts. The field has matured sufficiently and has amassed enough evidence-based information to achieve substantial

reductions in crime and drug use, but only when the programs adhere to the lessons of research and maintain fidelity to the model.

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need to **Know**

Research Update on Family Drug Courts

By Douglas B. Marlowe, J.D., Ph.D. and Shannon M. Carey, Ph.D.

May 2012

Between 60% and 80% of substantiated child abuse and neglect cases involve substance abuse by a custodial parent or guardian (Young et al., 2007). Continued substance abuse by a custodial parent is associated with longer out-of-home placements for dependent children and higher rates of child revictimization and terminations of parental rights (TPR) (Brook & McDonald, 2009; Connell et al., 2007; Smith et al., 2007). Parents who complete substance abuse treatment are significantly more likely to be reunified with their children, and their children spend considerably fewer days in out-of-home foster care (Green et al., 2007; Smith, 2003). Unfortunately, more than 60% of parents in dependency cases do not comply adequately with substance abuse treatment conditions and more than 80% fail to complete treatment (Oliveros & Kaufman, 2011; Rittner & Dozier, 2000; U.S. Government Accountability Office, 1998).

Family Drug Courts (FDCs)¹ were created to address the poor outcomes derived from traditional family reunification programs for substance-abusing parents. The first FDC was established in 1995 in Reno, Nevada; now well over 300 programs operate throughout the United States (Huddleston & Marlowe, 2011). These specialized civil dockets were adapted from the adult criminal Drug Court model (adult Drug Courts) (Wheeler & Fox, 2006). As in adult Drug Courts, substance abuse

treatment and case management services form the core of the intervention; however, FDCs emphasize coordinating these functions with those of child protective services. In addition, participants must attend frequent status hearings in court during which the judge reviews their progress and may administer gradually escalating sanctions for infractions and rewards for accomplishments. Unlike adult Drug Courts, where the ultimate incentive for the participant

¹ These programs are variously referred to as Family Drug Treatment Courts, Family Treatment Drug Courts, Family Dependency Treatment Courts, and Family Treatment Courts.

might be the avoidance of a criminal record or incarceration, in FDC the principal incentive for the participant is family reunification, and a potential consequence of failure may be TPR or long-term foster care for the dependent children.²

Continued substance abuse by a custodial parent is associated with longer out-of-home placements for dependent children and higher rates of child revictimization and terminations of parental rights.

The child welfare system also reaps benefits from FDCs. Dependency courts are required by statute to make reasonable efforts towards family reunification and to reach permanency decisions within a specified time period of approximately twelve to eighteen months.³ By allowing for more efficient case processing and providing a wider range of needed treatment services, FDCs assist the courts to meet these statutory obligations.

FDC is among the most effective programs for improving substance abuse treatment initiation and completion in child welfare populations.

Effectiveness

A number of methodologically sound impact evaluations have been completed within the past several years, revealing significantly better outcomes in FDC as compared to traditional family reunification services (Green et al., 2009; Marlowe, 2011). A recent review of the research literature concluded that FDC is among the most effective programs for improving substance abuse treatment initiation and completion in child welfare populations (Oliveros & Kaufman, 2011).

Table 1 (see end of article) summarizes outcome evaluations that had acceptable methodological rigor. Where multiple studies were conducted on the same program, the most recent or comprehensive evaluation is presented. These evaluations included comparison samples of parents or guardians in dependency proceedings who were identified as having a substance abuse problem and who would have been eligible for FDC but did not participate. The participants for the contemporary comparison samples were recruited during the same time period as for the FDC and were typically drawn from adjacent counties or had been placed on a wait list because of insufficient slots in the FDC program. Participants for the historical comparison samples were recruited from the same jurisdictions as the FDC participants during an earlier period before the FDC was established. In most of the evaluations, the researchers matched the FDC and comparison groups on variables, such as parental substance abuse history and child welfare history, that were significantly correlated with outcomes or statistically controlled for differences on these variables in the outcome analyses (See Table 1).

Treatment completion rates were 20 to 30 percentage points higher for the FDC participants than for the comparison participants.

The parents or guardians in FDC programs were more likely than the comparison participants to complete substance abuse treatment in all but one of the evaluations and these differences were statistically significant in all but two of the evaluations. In most instances, treatment completion rates were 20 to 30 percentage points higher for the FDC participants than for the comparison participants. Although not reported in the table, parents in the FDCs were also significantly more likely to enroll in substance abuse

² Some FDCs apply a hybrid model that consolidates criminal and civil dependency cases for individuals charged with a drug offense who also have children in the dependency system.

³ Adoption and Safe Families Act of 1997, PL. 105-89.

RESEARCH UPDATE ON FAMILY DRUG COURTS

treatment, entered treatment sooner, and remained in treatment longer than the comparison parents in most of the evaluations. As was noted earlier, dependency courts are required to make reasonable efforts towards family reunification and achieve permanency within a specified time. Increasing parental entry into and engagement with treatment directly furthers these statutory goals.

Family reunification rates were higher for the FDCs in all but one of the evaluations and were significantly higher in all but three of the evaluations. In most instances, family reunification rates were approximately 20 to 40 percentage points higher for the FDC programs than for the comparison groups. The relatively few instances in which the differences were not statistically significant were typically attributable to insufficient sample sizes.

Family reunification rates were approximately 20 to 40 percentage points higher for the FDC programs than for the comparison groups.

The children of the FDC participants also spent significantly less time in out-of-home placements in the majority of the evaluations, typically averaging fewer months in foster care. Approximately half of the evaluations examined new dependency petitions or reentries to the child welfare system following family reunification; however, those that did typically tracked the samples for only a relatively brief period of twelve months post-reunification. Because returns to child protective services usually occur after a few years, new dependency petitions during the first twelve months were infrequent in most conditions and did not differ appreciably between the FDC and comparison groups. One noteworthy exception is the evaluation of the Sacramento Dependency Drug Court, which examined child welfare outcomes after sixty months. That study reported a lower rate of new substantiated allegations of child maltreatment for the FDC participants (17% vs. 23%); however, differences in reentry rates to foster care were small (21% vs. 24%) (Boles & Young, 2011).

The children of the FDC participants also spent significantly less time in out-of-home placements in the majority of the evaluations, typically averaging fewer months in foster care.

Two evaluations (Carey et al., 2010a, 2010b) also tracked and examined new criminal arrests. Both studies reported substantially lower arrest rates for the FDC participants as compared to the comparison groups (40% vs. 63% and 54% vs. 67%, respectively). These findings are important because although FDC proceedings are civil in nature, participants frequently have concurrent involvement with the criminal justice system. Reducing criminal recidivism might, therefore, be an important value-added benefit of FDC programs.

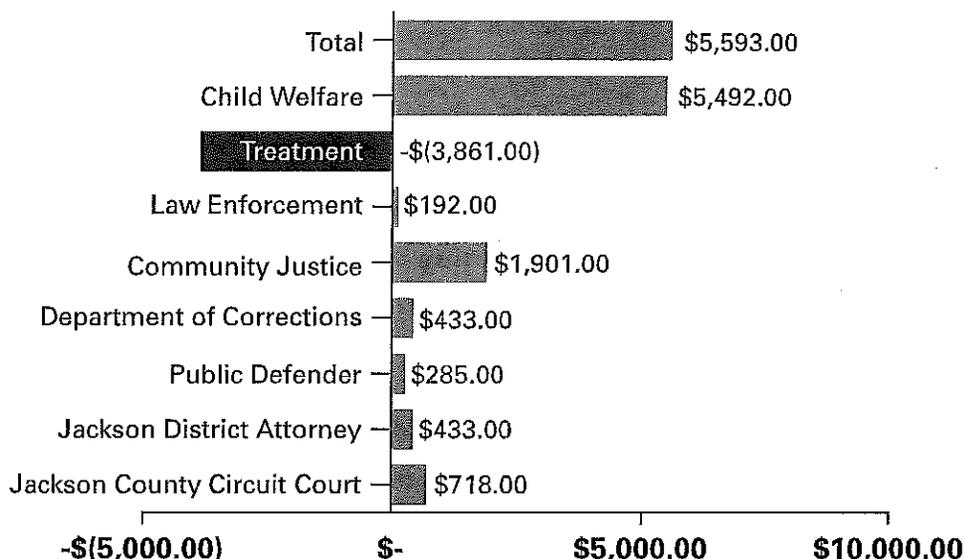
Cost-Effectiveness

Several evaluations reported cost savings for FDC resulting from a reduced reliance on out-of-home child placements. Estimated savings from the reduced use of foster care were approximately \$10,000 per child in Maine (Zeller et al., 2007), \$15,000 in Montana (Roche, 2005), \$13,000 in Oregon (Carey et al., 2010b), and £4,000 (\$6,420) in London (Harwin et al., 2011).

Several evaluations reported cost savings for FDC resulting from a reduced reliance on out-of-home child placements.

Three evaluations included cost-effectiveness analyses that took into account a wider range of up-front expenditures and financial benefits of the programs and yielded estimates of the average net cost savings per family (Burrus et al., 2008; Carey et al., 2010a, 2010b). These studies employed a cost-to-taxpayer approach that treated participants' interactions with publicly funded agencies as transactions in which public resources were consumed and societal costs incurred. *Program costs* were those associated with providing services to participants. For example, when parents or guardians appear in court for status hearings or are tested for drugs, resources such as judge time, defense attorney time, court facilities,

Figure 1. Average Cost Savings Per Participant Realized by each Agency in the Jackson County Community Family Court. Adapted with permission from Carey and colleagues. (2010a).



and urine test cups are consumed. *Outcome costs* were those associated with participants' subsequent interactions with outside agencies, such as the child welfare system and criminal justice system. *Cost savings* were determined by calculating the program and outcome costs for the FDC and contrasting those figures with comparison group costs.

Program costs for the FDCs ranged from approximately \$7,000 to \$14,000 per family.

The program costs for the FDCs ranged from approximately \$7,000 to \$14,000 per family, depending on the range and intensity of services that were offered. The majority of the program costs were attributable to substance abuse treatment. Not surprisingly, programs that provided services for both the dependent children and their parents had the highest treatment costs.

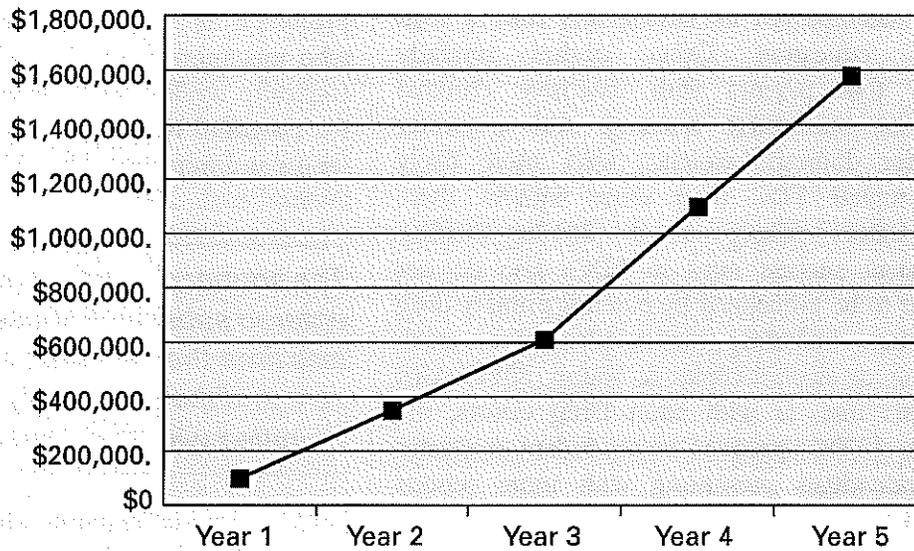
Outcome costs were substantially lower in all three studies for the FDC participants than for the comparison groups. This was primarily due to the decreased use of child welfare resources by the children (e.g., less time in foster care) and decreased use of criminal justice resources by the parents (e.g., fewer rearrests and less time in jail or on probation). Taking into account both the investment costs of the programs and the value of the outcomes that were produced, the average net cost savings from the FDCs ranged from approximately \$5,000 to \$13,000 per family.

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Figure 1 presents detailed cost information from one of the evaluations performed in Jackson County, Oregon. Nearly every agency involved in the FDC realized some cost savings, although the magnitude of the savings varied considerably.

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Figure 2. Total Cost Savings Over Five Years for the Marion County Fostering Attachment Treatment Court. Adapted with permission from Carey and colleagues. (2010b).



The child welfare system realized the largest cost savings as a result of reduced use of foster care. Community corrections followed in cost savings as a result of parents spending less time on probation or in jail. Notably, the treatment program was the only agency that did not reap net dollar benefits. This was because the parents in the FDC program participated significantly more in treatment than did the non-FDC participants. As was intended, the FDC significantly increased parents' use of substance abuse treatment services and as a result decreased their use of other publicly funded services, such as those of child welfare, community corrections, and the courts.

The child welfare system realized the largest cost savings as a result of reduced use of foster care.

Importantly, the total cost savings that may accrue to a community from a FDC accumulate as participants maintain improvements over time and more participants enter the program. Figure 2 depicts the total cost savings

that accrued from a FDC in Marion County, OR, over a five-year period (Carey et al. 2010b). The total taxpayer cost savings increased approximately ten fold over the five years.

The total taxpayer cost savings increased approximately ten fold over the five years.

Target Population

In the criminal context, adult Drug Courts have been found to be equivalently effective for participants regardless of their primary drug of choice, associated mental health problems, or criminal history (Carey et al., 2012; Zweig et al., 2012). In fact, evidence suggests adult Drug Courts are more effective for participants who are high risk and seriously addicted to drugs or alcohol (Marlowe, 2009). Similar findings are emerging for FDC programs. A four-site national study of FDCs (Worcel et al., 2007) found that few participant characteristics predicted better outcomes, suggesting the programs

tended to be equally effective for a wide range of participants. In fact, marginally better outcomes ($p = .08$) were reported for mothers with co-occurring mental health problems and other demographic risk factors, such as being unemployed or having less than a high school education. Other studies similarly found that parents with extensive criminal histories, inadequate housing, and a greater risk for domestic violence were more likely to complete FDC than those without these risk factors (Carey et al. 2010a, 2010b). Treatment success rates in FDCs also do not appear to be influenced by parents' primary drug of abuse, including methamphetamine, crack cocaine, or alcohol (Boles & Young, 2011). This suggests that, as with adult Drug Courts, the effects of FDC appear to be equivalent or greater for individuals presenting with more serious histories.

Parents with extensive criminal histories, inadequate housing, and a greater risk for domestic violence were more likely to complete FDC than those without these risk factors

Best Practices

In the criminal court context, a good deal of research has identified the best practices within adult Drug Courts that are associated with better outcomes (Carey et al., 2012; Zweig et al., 2012). Although research in FDCs is just beginning to catch up to this level of sophistication, comparable findings are beginning to emerge suggesting that many lessons learned about best practices in adult Drug Courts are also applicable to FDCs.

Time to Treatment Entry. The sooner parents or guardians entered substance abuse treatment, the less time their children spent in foster care and the more likely they were to be reunified with their families (Green et al., 2007).

Many lessons learned about best practices in adult Drug Courts are also applicable to FDCs.

Frequency of Counseling Sessions. Participants who met more frequently with their counselors (typically weekly for at least the first phase of the program) remained in treatment significantly longer and were more likely to complete treatment (Worcel et al., 2007).

The sooner parents or guardians entered substance abuse treatment, the less time their children spent in foster care and the more likely they were to be reunified with their families.

Length of Time in Treatment. The more days parents or guardians attended substance abuse treatment, the more likely they were to be reunified with their children (Green et al., 2007). One evaluation in Montana reported that, particularly for parents who were abusing methamphetamine, attending at least fifteen months of substance abuse treatment increased the likelihood of success by 63% (Roche, 2005).

Completion of Treatment. A consistent finding across multiple sites is that completion of substance abuse treatment is associated with significantly fewer days in foster care for dependent children and a greater likelihood of family reunification (Green et al., 2007; Worcel et al., 2007). A statewide study in Maine found that parents who completed substance abuse treatment were five times more likely to be reunified with their children (Zeller et al., 2007).

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Family Treatment Model. Contrary to many beliefs, most family-based treatments are *not* evidence-based. The only family interventions that have shown consistent evidence of success are those that (a) provide outreach to participants in their homes or community, (b) teach parents or guardians to be more consistent and effective supervisors of their children, and (c) enhance positive communication skills among family members (Child Welfare Information Gateway, 2012; Fixsen et al., 2010; Liddle, 2004). Examples of counseling packages that incorporate these principles include multisystemic therapy and multidimensional family therapy. Both of these treatments, with some modifications, have been shown in controlled experiments to significantly improve outcomes in FDC (Dakof et al., 2009; Dakof et al., 2010), Juvenile Drug Court (Henggeler et al., 2006; Schaeffer et al., 2010), and the child welfare system (Oliveros & Kaufman, 2011; Swenson et al., 2009). These studies demonstrate that FDCs should apply manualized, structured, evidence-based family treatments and offer outreach services, where needed, in participants' homes or communities of origin.

Parents who completed substance abuse treatment were five times more likely to be reunified with their children.

Relationship with Counselor. Participants who reported a more positive therapeutic relationship with their counselors were more likely to complete treatment (Worcel et al., 2007).

FDCs should apply manualized, structured, evidence-based family treatments and offer outreach services, where needed, in participants' homes or communities of origin.

Relationship with Judge. Participants in FDC focus groups indicate they perceived their interactions with the judge to be especially critical to their success in the program. Specifically, being treated with respect by the judge and

being empowered by the judge to engage actively in their own recovery were believed to produce greater achievements (Somervell et al. 2005; Worcel et al., 2007). More research is needed to establish whether these perceptions are, in fact, associated with better outcomes in FDC; however, comparable studies in adult Drug Courts confirmed that a participant's positive perceptions of the judge were a predictor of significantly greater reductions in substance abuse and crime (Zweig et al., 2012). It seems reasonable to anticipate that similar findings may emerge in FDC as well.

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Drug Testing. Participants who were subjected to more frequent urine drug screens remained in treatment longer and were more likely to complete treatment (Worcel et al., 2007).

Parenting Classes. Adult Drug Courts that provided parenting classes had 65% greater reductions in criminal recidivism and 52% greater cost savings than Drug Courts that did not provide parenting classes (Carey et al., 2012). Although these analyses were conducted in the criminal court system as opposed to in FDCs, they often included parents who were involved in collateral dependency proceedings.

At least a dozen methodologically defensible evaluations conducted in eight U.S. states and London by independent scientific teams offer convincing evidence that FDCs produce clinically meaningful benefits and better outcomes than traditional family reunification services for substance-abusing parents.

(Continued on page 10)

Table 1. Summary of Methodologically Acceptable Evaluations of Family Drug Courts

Citation	Location(s)	Research Design	Sample Sizes (N's) ^a	Follow-Up Interval	Guardian Treatment Completion
Ashford (2004)	Pima County, AZ	Contemporary non-matched comparison	FDTC: 33; Comparison: 45	12 mos. post-entry	48% vs. 31%
Boles & Young (2011)	Sacramento, CA	Historical non-matched comparison	FDTC: 4,858; Comparison: 173	12 to 60 mos. post-entry	66% vs. 57% ^b
Bruns et al. (2011)	King County, WA	Contemporary matched comparison	FDTC: 76; Comparison: 182	12 to 42 mos. post-entry	62% vs. 29% ^{**}
Burrus et al. (2008)	Baltimore, MD	Historical matched comparison	FDTC: 200; Comparison: 200	16 mos. post-petition	64% vs. 36% ^{**}
Carey et al. (2010a)	Jackson County, OR	Contemporary and historical matched comparison	FDTC: 329; Comparison: 340	12 to 48 mos. post-entry	73% vs. 44% ^{***}
Carey et al. (2010b)	Marion County, OR	Contemporary and historical matched comparison	FDTC: 39; Comparison: 49	12 to 24 mos. post-entry	59% vs. 33% [*]
Harwin et al. (2011)	London, England	Contemporary non-matched comparison	FDTC: 55; Comparison: 31	6 to 12 mos. post-entry	N.R.
Worcel et al. (2007)	Santa Clara, CA	Contemporary matched comparison	FDTC: 100; Comparison: 370	24 mos. post-entry	69% vs. 32% ^{***}
"	Suffolk, NY	Contemporary matched comparison	FDTC: 117; Comparison: 239	24 mos. post-entry	61% vs. 32% ^{***}
"	Washoe, NV	Contemporary matched comparison	FDTC: 84; Comparison: 127	24 mos. post-entry	62% vs. 37% ^{**}
"	San Diego, CA	Contemporary matched comparison	FDTC: 438 ^d ; Comparison: 388	24 mos. post-entry	31% vs. 40%
Zeller et al. (2007)	Belfast, Augusta & Lewiston, ME	Contemporary and historical non-matched comparisons	FDTC: 49; Comparisons: 38 & 55	12 mos. post-exit	55% vs. 23% [*] & 34%

^ap < .05; ^bp < .01; ^cp < .001; ^dp-value not reported. TPR = Termination of parental rights. CPS = Child protective services. N.R. = not reported.

^aN's may reflect multiple children per family and in some instances multiple guardians per family. N's may be smaller in some comparisons due to missing or incomplete data.

^bIncludes participants who left treatment before completion but made satisfactory progress.

^cReflects new substantiated allegations of child maltreatment but not necessarily new petition or reentry to foster care.

^dIncludes 334 participants who received court-ordered case management and recovery support services outside of the traditional FDTC context.

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Child Time in Out-of-Home Care	Family Reunification	TPR	New CPS Petition After Reunification	Guardian Criminal Arrests	Avg. Cost Savings Per Family
N.R.	52% vs. 30%	N.R.	N.R.	N.R.	N.R.
352 vs. 369 days	45% vs. 27%***	N.R.	17% vs. 23%†°	N.R.	N.R.
481 vs. 689 days***	41% vs. 24%***	N.R.	N.R.	N.R.	N.R.
252 vs. 346 days**	70% vs. 45%**	N.R.	N.R.	N.R.	\$5,022
307 vs. 407 days*	51% vs. 45%*	13% vs. 20%*	N.R.	40% vs. 63%**	\$5,593
211 vs. 383 days**	80% vs. 40%**	8% vs. 35%**	N.R.	54% vs. 67%†	\$13,104
153 vs. 348 days†	39% vs. 21%†	N.R.	N.R.	N.R.	N.R.
437 vs. 504 days**	76% vs. 44%***	11% vs. 34%	2% vs. 6%	N.R.	N.R.
312 vs. 310 days	57% vs. 55%	8% vs. 11%	5% vs. 0%*	N.R.	N.R.
301 vs. 466 days***	91% vs. 45%***	3% vs. 34%**	2% vs. 2%	N.R.	N.R.
477 vs. 477 days	56% vs. 45%*	24% vs. 28%	7% vs. 9%	N.R.	N.R.
589 vs. 688 & 647 days	21% vs. 25% & 28%	27% vs. 29% & 31%	7% vs. 7% & 9%	N.R.	N.R.

(Continued from page 7)

Clearly, more research is needed to identify other best practices and evidence-based practices that can optimize their effectiveness and cost-effectiveness in FDCs.⁴ If the history of adult Drug Courts is any indication, research on FDCs is likely to pick up pace as the programs increase in numbers across the country and scientists take notice of the promising results.

Conclusion

In the short span of approximately seven years, FDC has emerged as one of the most promising models for improving treatment retention and family reunification rates in the child welfare system (cf. Green et al., 2009; Oliveros & Kaufman, 2011). At least a dozen methodologically defensible evaluations conducted in eight U.S. states and London by independent scientific teams offer convincing evidence that FDCs produce clinically meaningful benefits and better outcomes than traditional family reunification services for substance-abusing parents. These positive benefits do not appear to be limited to low-severity or uncomplicated cases and indeed may be larger for parents presenting with more serious clinical histories and other negative risk factors for failure in standard treatment programs. Finally, evaluators are beginning to uncover the specific practices within FDCs that can optimize their outcomes and cost-benefits for taxpayers.

These promising findings clearly justify additional efforts to expand and enhance FDC programs. Ignoring the positive results and continuing to invest public dollars in programs that have not been tested or that have been discredited is unjustifiable. Research is clear that FDC programs outperform the traditional child welfare and dependency court systems in terms of protecting vulnerable children and rehabilitating and reuniting dysfunctional families. The most rational and humane course of action to protect dependent children is to build upon the firm foundation of success that is emerging from FDC.

⁴ Evidence-based practices that have been identified in substance abuse treatment programs and child welfare settings other than FDC can be found at <http://www.oasas.ny.gov/prevention/nrepp.cfm> and <http://www.cebc4cw.org/topic/substance-abuse-treatment-adult/>.

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NADCP

National Association of
Drug Court Professionals

About NADCP

It takes innovation, teamwork and strong judicial leadership to achieve success when addressing drug-using offenders in a community. That's why since 1994 the National Association of Drug Court Professionals (NADCP) has worked tirelessly at the national, state and local level to create and enhance Drug Courts, which use a combination of accountability and treatment to compel and support drug-using offenders to change their lives.

Now an international movement, Drug Courts are the shining example of what works in the justice system. Today, there are over 2,500 Drug Courts operating in the U.S., and another thirteen countries have implemented the model. Drug Courts are widely applied to adult criminal cases, juvenile delinquency and truancy cases, and family court cases involving parents at risk of losing custody of their children due to substance abuse.

Drug Court improves communities by successfully getting offenders clean and sober and stopping drug-related crime, reuniting broken families, intervening with juveniles before they embark on a debilitating life of addiction and crime, and reducing impaired driving.

In the 20 years since the first Drug Court was founded in Miami/Dade County, Florida, more research has been published on the effects of Drug Courts than on virtually all other criminal justice programs combined. The scientific community has put Drug Courts under a microscope and concluded that Drug Courts significantly reduce drug abuse and crime and do so at far less expense than any other justice strategy.

Such success has empowered NADCP to champion new generations of the Drug Court model. These include Veterans Treatment Courts, Reentry Courts, and Mental Health Courts, among others. Veterans Treatment Courts, for example, link critical services and provide the structure needed for veterans who are involved in the justice system due to substance abuse or mental illness to resume life after combat. Reentry Courts assist individuals leaving our nation's jails and prisons to succeed on probation or parole and avoid a recurrence of drug abuse and crime. And Mental Health Courts monitor those with mental illness who find their way into the justice system, many times only because of their illness.

Today, the award-winning NADCP is the premier national membership, training, and advocacy organization for the Drug Court model, representing over 27,000 multi-disciplinary justice professionals and community leaders. NADCP hosts the largest annual training conference on drugs and crime in the nation and provides 130 training and technical assistance events each year through its professional service branches, the **National Drug Court Institute**, the **National Center for DWI Courts** and **Justice for Vets: The National Veterans Treatment Court Clearinghouse**. NADCP publishes numerous scholastic and practitioner publications critical to the growth and fidelity of the Drug Court model and works tirelessly in the media, on Capitol Hill, and in state legislatures to improve the response of the American justice system to substance-abusing and mentally ill offenders through policy, legislation, and appropriations.

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