# RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

# *Court-Based Overdose Prevention Strategies*

*This project was supported by grant No. 2016-MU-BX-K021 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Point of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice.*

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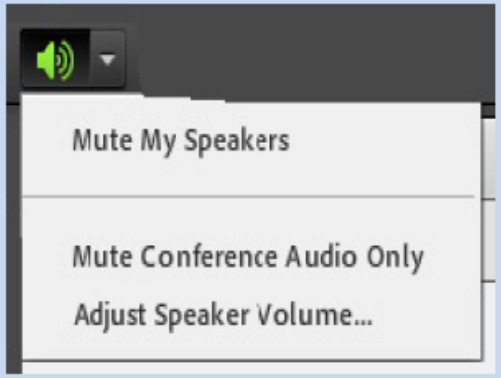


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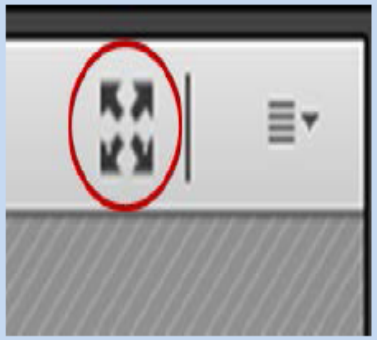
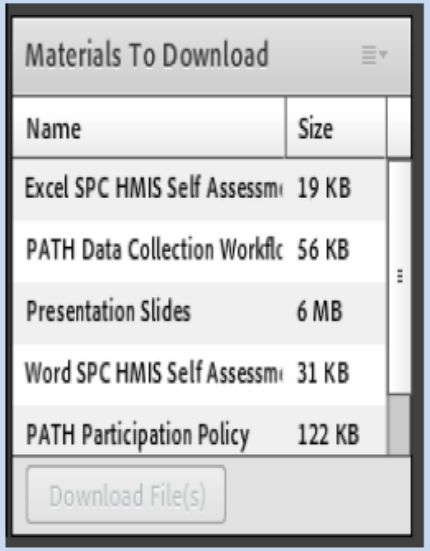


## Presentation materials!

You can download a PDF version of today's presentation and additional resource materials from the "Materials To Download" box.



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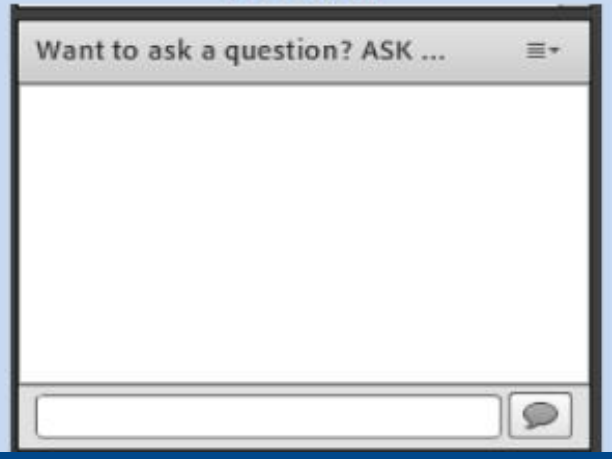
If you have questions for either the presenters or our Technical Support Staff, enter them in the Q&A box.

Our support staff will assist you with your technical issues, and our moderator will present as many questions as possible to the presenter.




## Chat with us!

If you have general comments, please post them in the participant chat box.

# *Court-Based Overdose Prevention Strategies*

**David Lucas MSW, Training & Technical Assistance, Center for Court Innovation**

*In Collaboration with Advocates for Human Potential*

May 6th, 2020

# Center for Court Innovation

The Center for Court Innovation seeks to help create a more effective and humane justice system through:

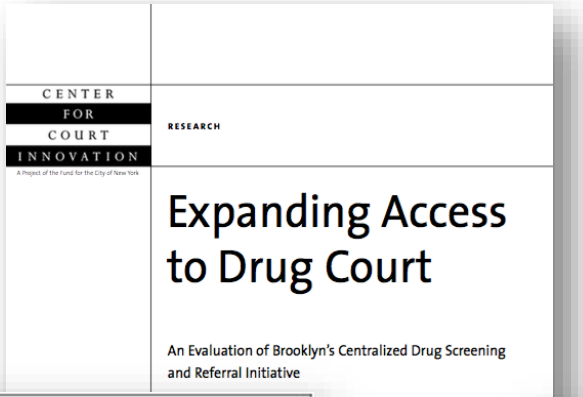
# OPERATING PROJECTS

# Poll 1: Professional Background

**Which of the following best describes your professional background? (Select all that apply)**

- Correctional Officer
- Probation Officer
- Court Professional
- Substance use counsellor
- Mental health counsellor
- Peer Recovery Specialist
- Harm Reduction Worker
- Technical Assistance Provider
- Researcher

# Research


CENTER
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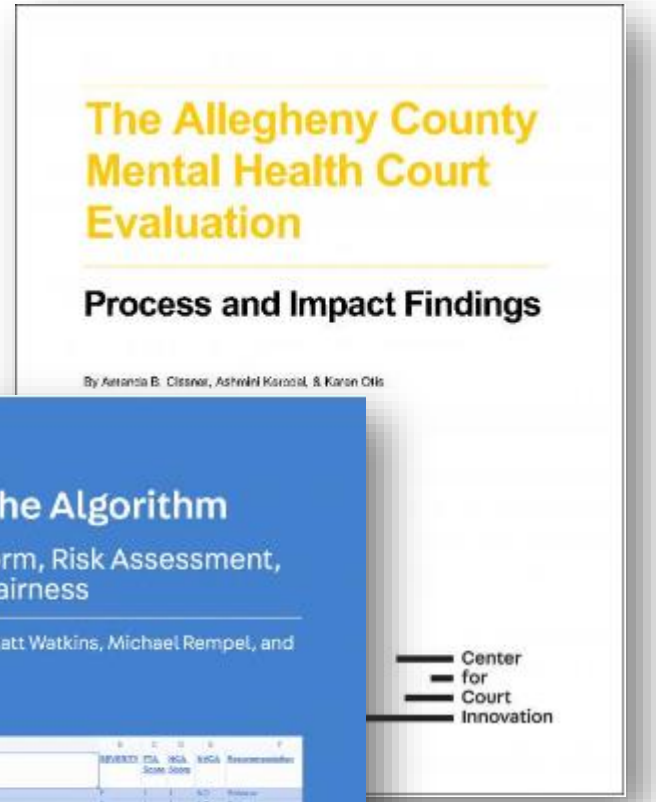
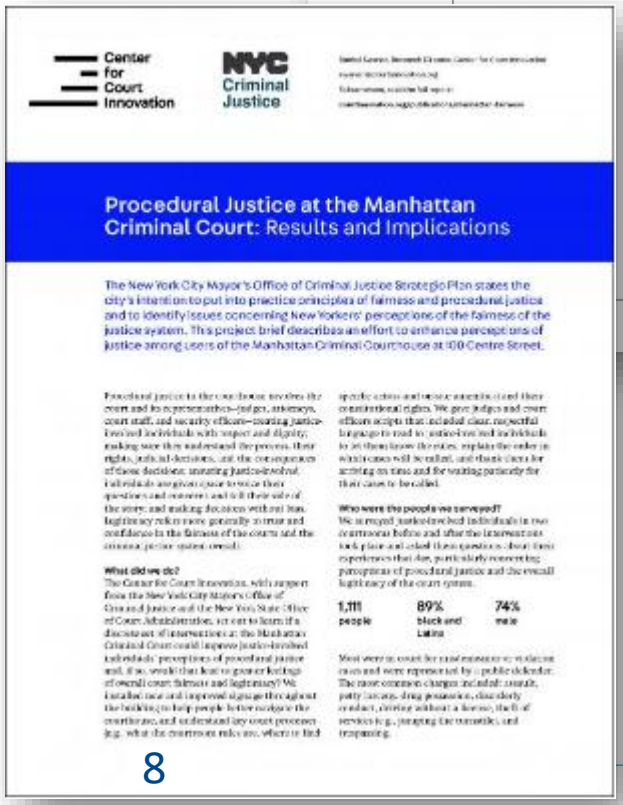
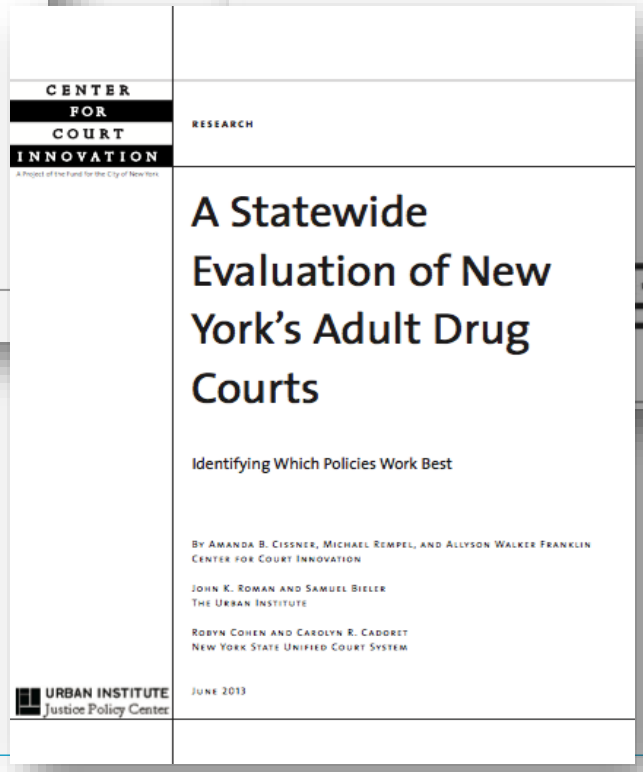
INNOVATION
RESEARCH
Expanding Access to Drug Court
An Evaluation of Brooklyn's Centralized Drug Screening and Referral Initiative


Prosecutor-Led Diversion
A National Survey
By Michela Lowry and Ashmini Kerodal


The Allegheny County Mental Health Court Evaluation
Process and Impact Findings
By Amanda B. Cissner, Ashmini Kerodal, & Karen Otis


Center for Court Innovation
NYC Criminal Justice
Procedural Justice at the Manhattan Criminal Court: Results and Implications
The New York City Mayor's Office of Criminal Justice Strategic Plan states the city's intention to put into practice principles of fairness and procedural justice and to identify issues concerning New Yorkers' perceptions of the fairness of the justice system. This project briefly describes an effort to enhance perceptions of justice among users of the Manhattan Criminal Courthouse at 100 Centre Street.
1,111 people
89% black and Latino
74% male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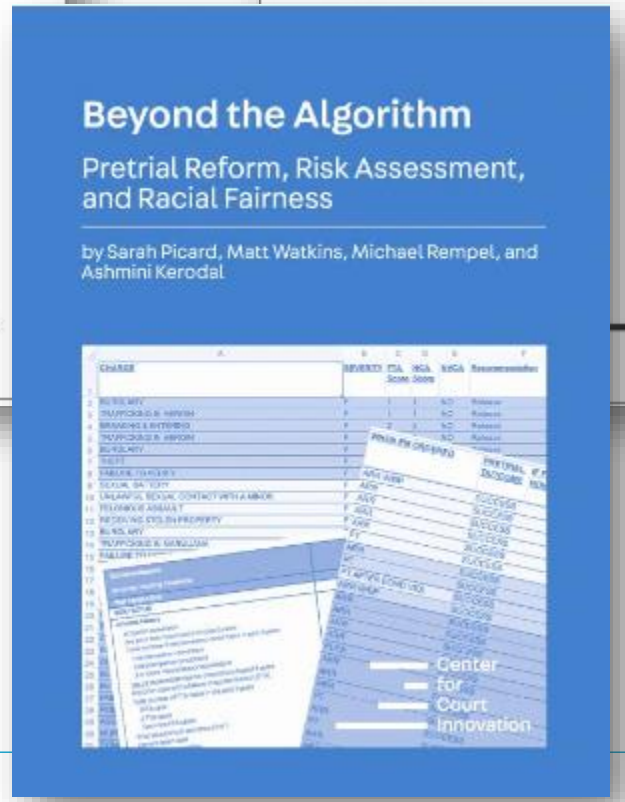
INNOVATION
RESEARCH
A Statewide Evaluation of New York's Adult Drug Courts
Identifying Which Policies Work Best
By Amanda B. Cissner, Michael Rempel, and Allyson Walker Franklin
Center for Court Innovation
John K. Roman and Samuel Bieler
The Urban Institute
Robyn Cohen and Carolyn R. Cadoret
New York State Unified Court System
June 2013
URBAN INSTITUTE
Justice Policy Center


Beyond the Algorithm
Pretrial Reform, Risk Assessment, and Racial Fairness
by Sarah Picard, Matt Watkins, Michael Rempel, and Ashmini Kerodal
Center for Court Innovation

# Statewide Training & Technical Assistance

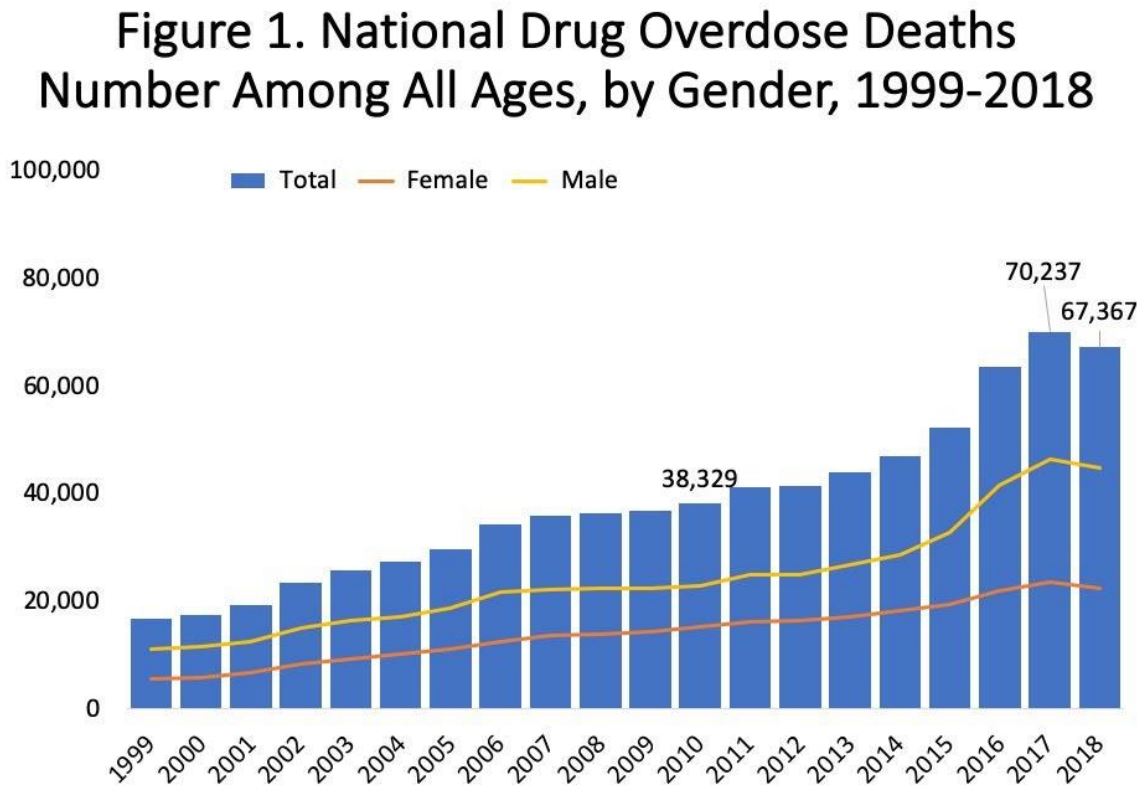
- Coordinating body for statewide problem-solving court administrators
- Statewide strategic planning
- Evidence-based practice implementation
- Statewide training strategy and fidelity reviews
- Innovation through technology
- Peer assessment and peer-facilitated learning
- TreatmentCourts.org Online Learning System
- Publications and webinars
- Treatment court evaluations

# Overview and Objectives

- OD, trends and drivers
- OD, risks and responses
- The impact of COVID-19
- Prevention – existing practices
- OD vs drug court practices
- How can they decrease risk?
- The “Opioid Court” Model

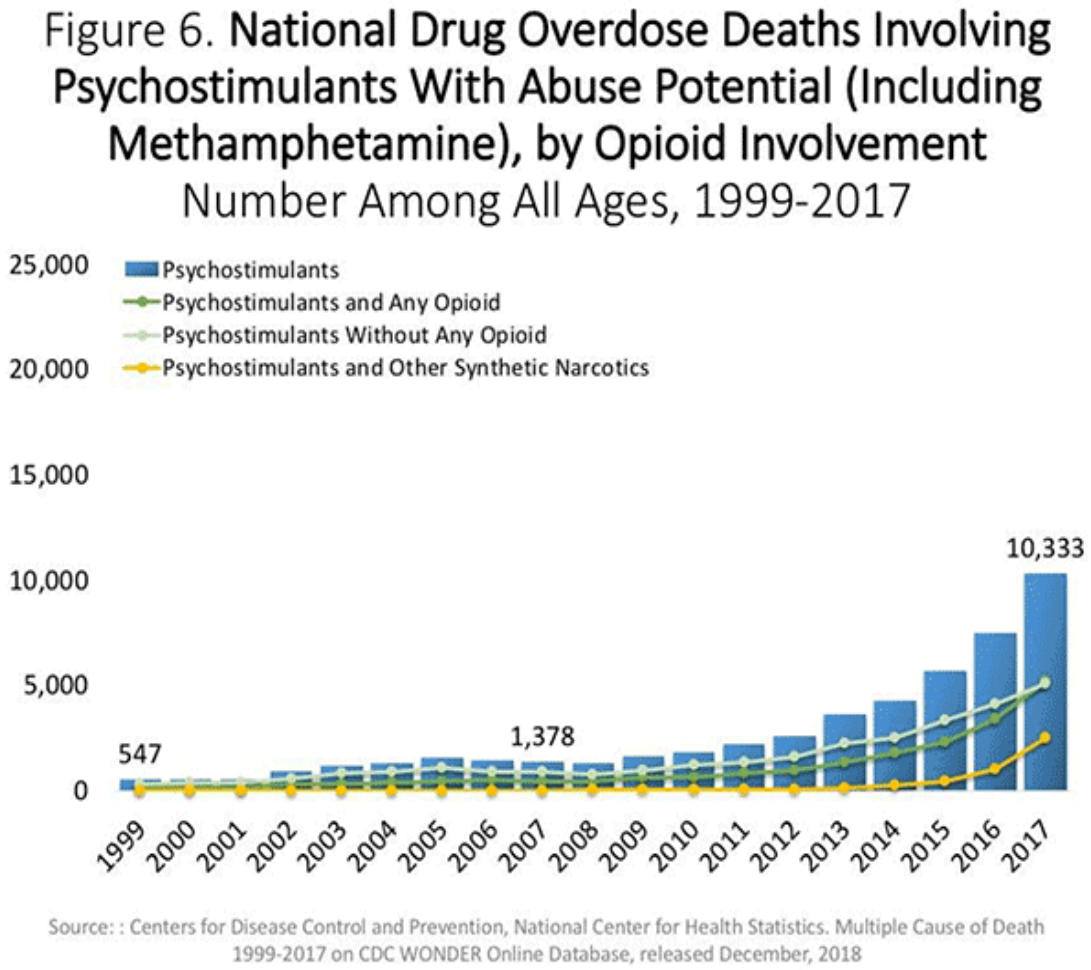
# Overdose trends in the US (1)

- Opioid epidemic (heroin, rx opioids, fentanyl, analogs)
- 67,367 overdose deaths in 2018, two-thirds involving opioids (CDC)
- ~65% of incarcerated have SUDs (NIDA)
- 14% all arrests drug-related (Vera, 2019)
- High rates of CJS-exposure among opioid users (Hayhurst, et al, 2017)
- ~3500+ adult drug courts serving 120,000+ ppl
- Spike in overdoses involving stimulants like meth and cocaine



# Overdose trends in the US (2)

- Sharp increase in of overdoses involving stimulants like meth and cocaine
- In 2017, ~15% of all drug overdose deaths involved meth, and 50 percent of those deaths also involved an opioid
- Sign. regional variability
- Highest rates of use in the west and midwest, along specific distribution corridors
- Curiously, meth-related tx intakes are down
- Meth use is also spiking in the east and northeast, especially in large cities with high rates of homelessness
- Meth OD prevention strategies less robust




https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

# Universal Drivers of Overdose: Macro

- Supply & Demand
- Criminalization
- Overincarceration
- Racial Injustice
- Homelessness
- Healthcare access
- Wage suppression and poverty

- Treatment barriers
- Treatment quality
- Treatment availability
- Treatment costs
- Stigma/discrimination
- Social isolation
- Harm reduction restrictions

https://www.ncbi.nlm.nih.gov/pubmed/31471008
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846593/
https://journals.sagepub.com/doi/full/10.1177/0033354918793627

# Universal Drivers of Overdose: Micro


**Drug**

- The drug itself: what it does and how potent it is
- What it is cut with
- How it is used: smoke, snort, absorbed, swallowed, injected
- Whether it is illegal or legal

**Set**

- Person's unique physiology
- Person's physical health
- Person's mental or emotional state
- Person's cultural identity, culture of origin, sense of belonging
- Expectation of the drug and motivation for using the drug

**Setting**

- Stress in a person's life: social, economic, environmental
- Support in someone's life
- With whom and where a person uses
- Social and cultural attitudes toward the drug meaning

**Drug, Set, and Setting: The Basis for Controlled Intoxicant Use, Norman Zinberg (1986)**
https://www.brianwilliamson.id.au/aod/aodlinks/Drug%20Set%20and%20Setting%20-%20Zinberg%20N.pdf
https://addictionblog.org/treatment/the-drug-set-and-setting-model-of-addiction-an-intro/

# Misinformation as a Driver of Overdose

- **Medications for Opioid Use Disorder (MOUD)**
  - "trading one addiction for another"
  - "big pharma got us into this mess, they can't be trusted"
  - "what about diversion?"
- **Naloxone**
  - "encourages drug use"
  - "encourages riskier drug using practices"
- **Fentanyl**
  - belief that passive airborne exposure causes overdose
  - significant difference between licit and illicit, and analogs


Addiction medications: "Treating Opioid Addiction" (2019) https://www.springer.com/gp/book/9783030162566
Diversion: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6214787/
Fentanyl exposure: https://www.acmt.net/cgi/page.cgi/_zine.html/The_ACMT_Connection/ACMT_Statement_on_Fentanyl_Exposure

# Poll 2: Strategy for Overdose Prevention

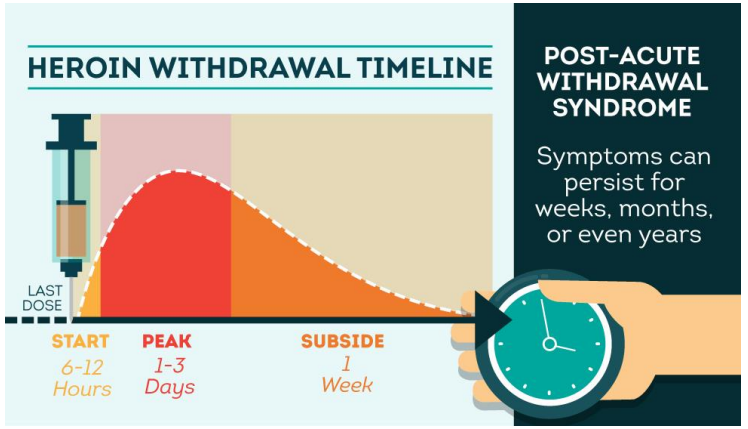
**What do you consider to be the best tool or strategy in overdose prevention?**

- Abstinence-based treatment
- Harm-reduction oriented care
- Public health education
- Safe supply prescribing programs
- Naloxone and syringe service programs
- Medications for Opioid Use Disorder
- Prescription Drug Monitoring
- Supervised Consumption Sites
- Diversion Programs
- Drug Courts

# When are people at highest risk?

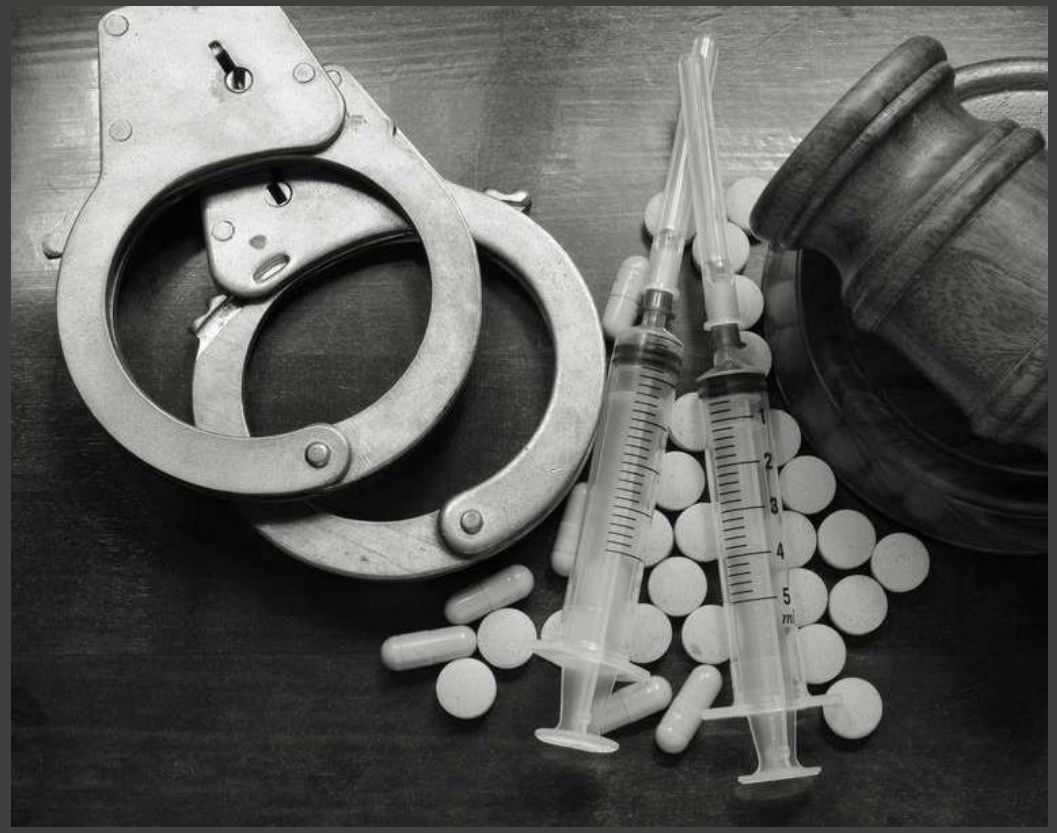
- Forced withdrawal or ‘dopesick’ (also inc. suicidality)
- Re-entry / release from jail/prison (Binswanger, 2007; Joudrey, 2019)
- Release from hospital (Brady, 2015)
- Release from abstinence-based tx (Strang, 2003)
- After a housing eviction (BCSSU, 2019)
- After a destabilizing life event (PTSD)
- Disrupted use of street supply
- Disrupted use of methadone/bupe

- Post-acute withdrawal syndrome
- Naltrexone (Vivitrol) treatment completion
- Notable change in street supply
- Notable change in MOUD prescription
- Restricted access to Naloxone, sterile supplies
- Experiencing intimate partner violence (Collins, 2020)



# Where do drug courts fit in?

*Drug courts "are designed to provide a more meaningful response to addiction-driven crime by addressing the root of the problem and reducing the likelihood of future offending. If successful, individual offenders receive the treatment they need, and society gains in the form of lower recidivism rates, improved public safety, and lower expenditures for jails or prisons."*



-(Rempel, 2004)
https://www.courtinnovation.org/sites/default/files/documents/CriminalJustice.pdf

# Overdose Prevention: Existing Practices

- Not using alone / social networks
- The use of Naloxone and O2 tanks/bags
- Good Samaritan Laws (limits)
- Prescription Drug Monitoring Program (PDMP)
- Known supply (potency, cut, test strips)
- Safe Supply (medical grade, iOAT)
- Addiction medications (meth, bupe, NXT)
- Low-barrier, client-centered care
- Syringe Exchanges Programs
- Supervised Consumption Sites (underground if in US)
- Police or prosecutor-led diversion programs (LEAD, PAARI)
- Problem-solving courts (drug, opioid, mental health)

# Medications for Opioid Use Disorder (MOUD)

**Methadone:**

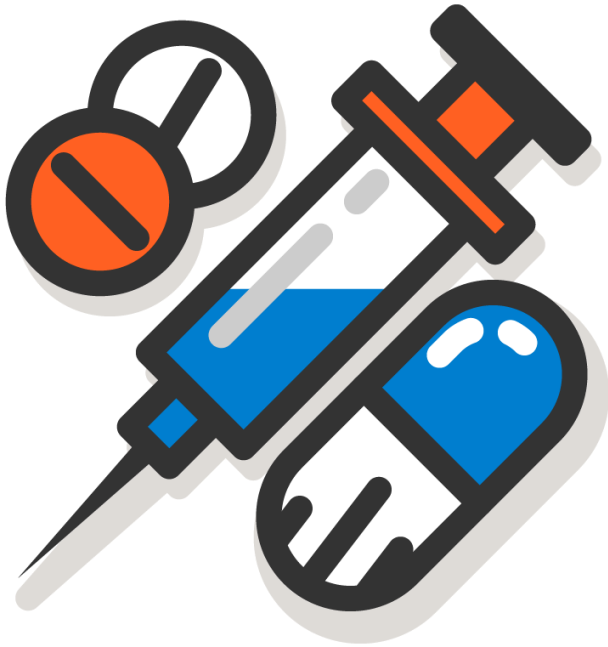
- Full agonist, maintains tolerance
- Some euphoric, painkilling effects
- No ceiling effect
- Diversion potential

**Buprenorphine:**

- Partial agonist, maintains tolerance
- Limited euphoric effects / has a ‘ceiling effect’
- Suboxone formulation contains naloxone
- Less diversion potential

**Naltrexone:**

- Antagonist, does not maintain tolerance
- Blocks the euphoric, painkilling effects of opioids
- Some overdose risk upon treatment completion



“Treating Opioid Addiction” (Kelly, Wakeman, et al, 2019)
https://www.springer.com/gp/book/9783030162566

SAMHSA TIP 63: Medications for Opioid Use Disorder - Full Document (May 2020)

# COVID-19 and MOUD (1)

- Most appts now available by telephone
- Medication delivery systems (curbside delivery, OTP vans, “Capsule”)
- Opioid Treatment Programs have been given COVID guidance for offering take-home MOUD (carries instead of daily visits) 14-28 days
- Some OTPs are suspending urine tests & mandated counseling sessions
- SAMHSA is providing national guidance (and exemption application forms): https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines/covid-19-guidance-otp
- ASAM has some state-level guidance here: https://www.asam.org/advocacy/practice-resources/coronavirus-resources
- DEA re supply chain interruption https://www.dea.gov/press-releases/2020/03/20/deas-response-covid-19

# COVID-19 and MOUD (2)

As of March 20, 2020

SAMHSA
Substance Abuse and Mental Health Services Administration

- Opioid Treatment Program (OTP) Guidance
- SAMHSA recognizes the evolving issues surrounding COVID-19 and the emerging needs OTPs continue to face.
- SAMHSA affirms its commitment to supporting OTPs in any way possible during this time. As such, we are expanding our previous guidance to provide increased flexibility.

FOR ALL STATES

The state may request blanket exceptions for all stable patients in an OTP to receive 28 days of Take-Home doses of the patient's medication for opioid use disorder. The state may request up to 14 days of Take-Home medication for those patients who are less stable but who the OTP believes can safely handle this level of Take-Home medication.

https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf

# Mobile MOUD delivery

**How does it work:**

- Waiving of DEA registration requirements for mobile OTP services
- Vans considered “coincident activity” to usual OTP service
- Will provide much needed access to ppl in rural areas, jails and prisons, and/or recently released
- Limited methadone “courier service” introduced in NYC (Knopf, 2020)

**DEA legislation:**

- “…revisions to the regulations are intended to make maintenance or detoxification treatments more widely available, while ensuring that safeguards are in place to reduce the likelihood of diversion.”
- https://www.govinfo.gov/content/pkg/FR-2020-02-26/pdf/2020-03627.pdf


*Photograph of a van from which buprenorphine is prescribed outside a jail in Baltimore, courtesy of the Behavioral Health Leadership Institute. (More at Filtermag.org)*

# Why do most people divert MOUD?

## Desperation

- dire need to fend off pain, withdrawal

## System Failure

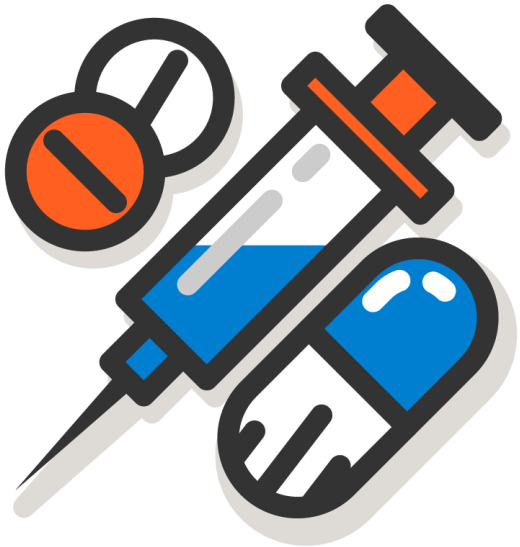
- system barriers in accessing rx medications

## Harm Reduction

- trying to avoid using unpredictable/toxic street supply

## Financial hardship

- selling or trading meds can help meet other basic needs



https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6214787/

# MOUD and Racial Disparities

**Methadone:**

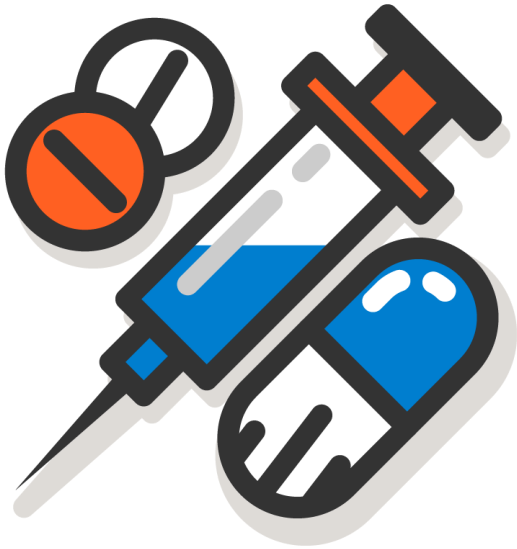
- Highly-regulated and policed
- Clinics often located in dense, urban areas

**Buprenorphine:**

- Family doctor-prescribed / insured
- Office-based / more discreet
- More capacity for take-home / less disruptive

**Naltrexone:**

- Preferred by criminal justice system
- Least amount of personal agency



https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5901978/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3818282/
https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2732871

# What about overdose from crystal meth?

**Causes**

- “overamping”
- mixing (speedball; goofballs)
- lack of sleep, food and hydration

**Signs:**

- chest pain
- high temp, blood pressure
- increased heart rate
- anxiety, paranoia, violence

**Results:**

- stroke
- heart attack

**Treatment**

- No exact MOUD-equivalent
- Limited data re medications that reduce cravings, block effects
- Contingency mgmt.
- Safer practice education
- Stable housing!!

**Reversal**

- There is no “Naloxone” equivalent for crystal meth

# COVID-19 and Substance Use Disorders

- Compromised immune systems (Hep C, HIV, diabetes)
- Poor respiratory, cardiovascular, or pulmonary health (COPD, asthma)
- Opioid Use Disorder (slows breathing; restricts oxygen)
- Stimulant Use Disorder (constricts blood vessels; hypertension)
- Alcohol Use Disorder (withdrawal, delirium tremens)
- Long-time smokers especially high risk (lung or heart disease)
- Involuntary withdrawal from painkillers/benzos due to reduced access
- Cognitive deficits (not having risk/mitigation literacy)
- Chronic pain, injury, mobility or physical impairment

https://www.drugabuse.gov/related-topics/covid-19-resources

# Resources

## Harm Reduction and Overdose Prevention Resources for PWUD

- Vital Strategies: Resources for Drug Use and COVID-19 Risk Reduction
- Harm Reduction Coalition: Guidance for People Who Use Drugs
- Yale Program in Addiction Medicine, Guidance for People Who Use Substances on COVID-19
- HAMS: Harm Reduction for Alcohol
- Never Use Alone (overdose prevention hotline)
- Harm reduction guidance/COVID-19 outbreak (French/Spanish)
- National Institute on Drug Abuse COVID-19
- NEXTDristro (mail-out naloxone, HR supplies)
- Stimulant Use Harm Reduction Tip Sheet

# Drugs Courts and Overdose Prevention

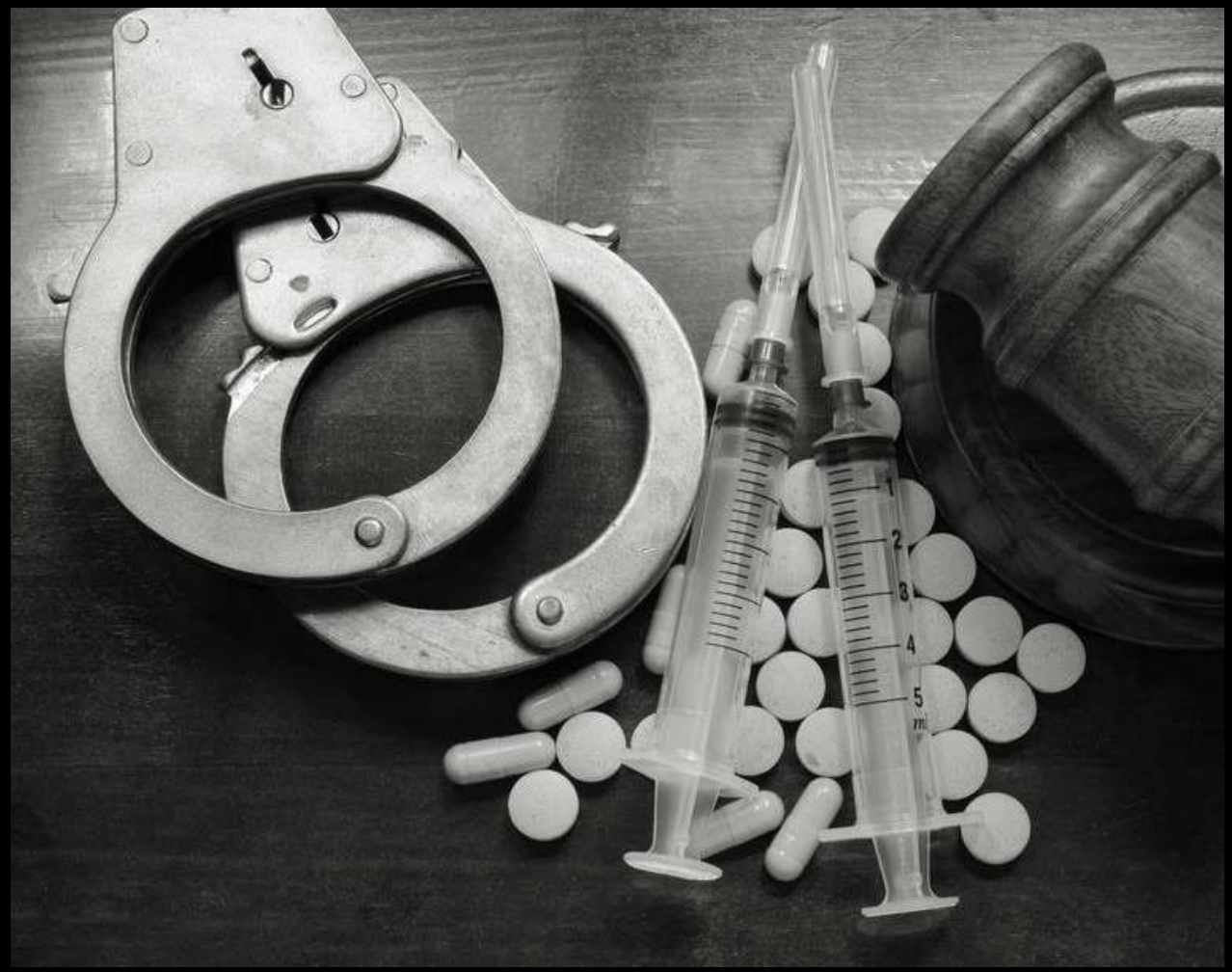


Photo from TheFix.com

# Drug court practices vs. OD risk

- **Target Population (NADCP Best Practice Standard I)**
  - -best outcomes with high-risk/high-need pop
  - -avoid net-widening by offering alt. track w/ lighter touch
  - -tailor services; be sure to not over-treat/supervise
- **Time to entry (Standard I)**
  - -often delayed …should be days, not weeks or months
  - -change in drug tolerance must be addressed upon jail release
- **Assessment (Standard I)**
  - -need a detailed picture of a person's OD history
  - -harm reduction strategies engaged at the earliest stage possible

https://ndcrc.org/wp-content/uploads/2019/01/Adult-Drug-Court-Best-Practice-Standards-Volume-2-Text-Revision-December-2018.pdf

# Drug court practices vs. OD risk

- **Incentives, Sanctions, and Therapeutic Adjustments (Standard IV)**
  - -underuse of therapeutic response
  - -overuse of jail sanctions
- **Phase Advancement (Standard IV)**
  - -tendency to take “first bed available”
  - -MOUD-related barriers
- **SUD Treatment (Standard V)**
  - -restrictions, program fit (e.g., smoking, phone use, visits)
  - -MOUD attitudes  (accepted but discouraged?)
  - -discharge / safety planning re OD risk

https://ndcrc.org/wp-content/uploads/2019/01/Adult-Drug-Court-Best-Practice-Standards-Volume-2-Text-Revision-December-2018.pdf

# Drug court practices vs. OD risk

- **Complementary Services (Standard VI)**

  -should include syringe services programs where indicated

  -clear and consistent attitudes re naloxone

- **Drug Testing (Standard VII)**

  -how are test results taken up

  -program responses to disputed tests

- **Data Collection (Standard X)**

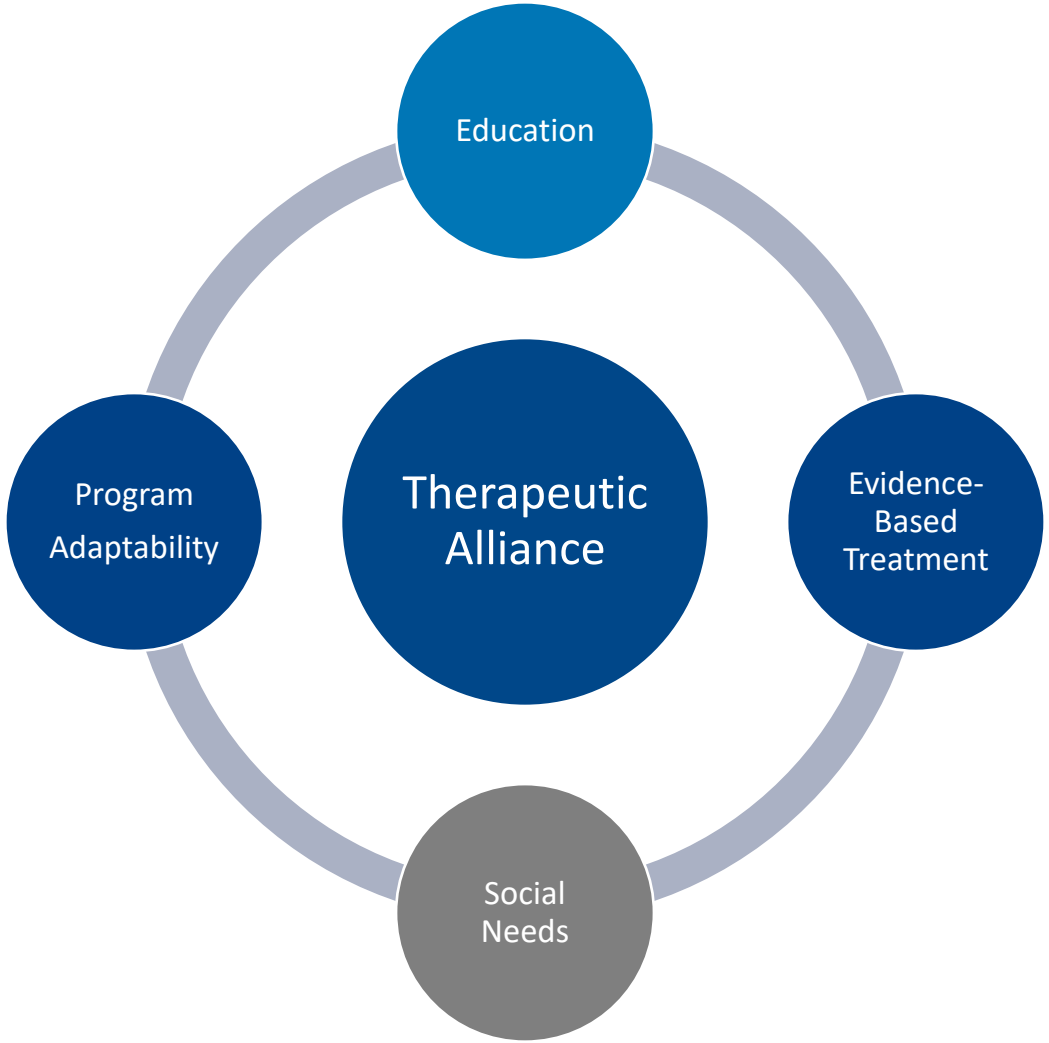
  -collect detailed info on client overdose, fatal and non

  -follow local overdose trends closely (zip codes, spikes, drug alerts)

  -overdose fatality review and Sequential Intercept Model

  https://ndcrc.org/wp-content/uploads/2019/01/Adult-Drug-Court-Best-Practice-Standards-Volume-I-Text-Revision-December-2018.pdf

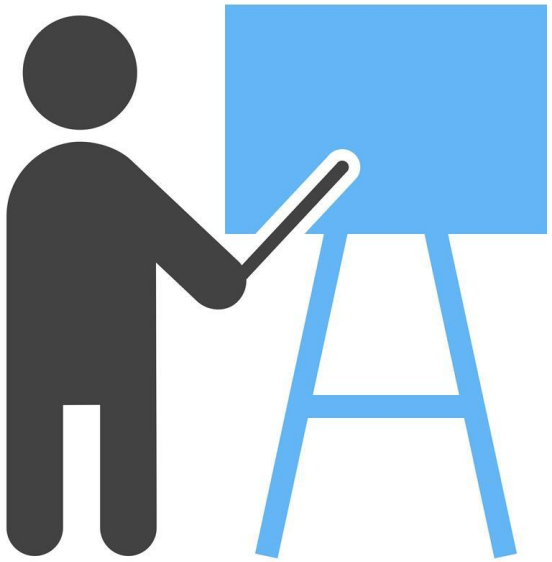
# What can drug courts do to decrease risk?



# What can drug courts do to decrease risk?

## EDUCATION

- Provide drug, set and setting psycho-education
- Provide drug-specific and poly-use risks and strategies
- Offer Naloxone training and accessibility
- Explain Good Samaritan Laws, and limits
- Teach the basics of MOUD - how do they work?
- Advise on detoxes that accommodate MOUD
- Offer info on STI transmission, prevention and treatment
- Make available Syringe Exchange Program locations
- Provide clients with drug supply alerts if available
- Remind of Three Ns …Never Use Alone, Naloxone, K(n)ow the supply



# Poll 3: Reducing Overdose Risk

**What do you think is the most important thing drug courts should do to reduce overdose risk:**

- Address long wait times
- Improve access to MOUD
- Improve access to varied treatment
- Provide harm reduction education
- Enhance peer recovery integration
- Stop sanctioning for drug use
- End the use jail sanctions
- Better address social needs

# What can drug courts do to decrease risk?

## EVIDENCE-BASED TREATMENT

- Accept and plan for recurrences of use (MI, Stages of Change)
- Permit and ensure access to all 3 FDA-approved medications
- Screen for OD risk factors (OD history, IDU, homelessness, stigma, trauma)
- Assess client need for MOUD; link to provider w/ warm handoff
- Partner with several trusted OTPs/MOUD providers
- Defer to medical experts regarding dosage, take-homes and tapering
- Ensure partner treatment agencies are providing trauma-informed care
- Identify MOUD-friendly mutual aid options when needed (online)
- Evaluate and address racial and ethnic disparities in MOUD access

# What can drug courts do to decrease risk?

## SOCIAL NEEDS

- Practice ‘Housing First’ model (McKenna, 2003)
- Practice ‘Medication First’ model
- Provide health insurance and ID support
- Safety plan to address food and/or income instability
- Safety plan to address intimate partner violence
- Safety plan to address sex work-related risks
- Support educational and vocational goals (‘recovery capital’)
- Leverage the skills and experience of peer recovery specialists
- Ensure that a client’s support networks are varied

# What can drug courts do to decrease risk?

## PROGRAM ADAPTABILITY

- Reflect on abstinence-based culture (shame, secrecy)
- Ask how relapse/violation of abstinence is responded to?
- Develop non-custodial sanctions for all in-program violations
- Consider MOUD/Naloxone costs against program fees
- Consider phase advancement requirements vs MOUD regimen
- Value all pathways equally – including those involving MOUD
- Address OD risk/MOUD needs upon release from custody, hospital
- Acknowledge all proactive health choices, even if they involves using

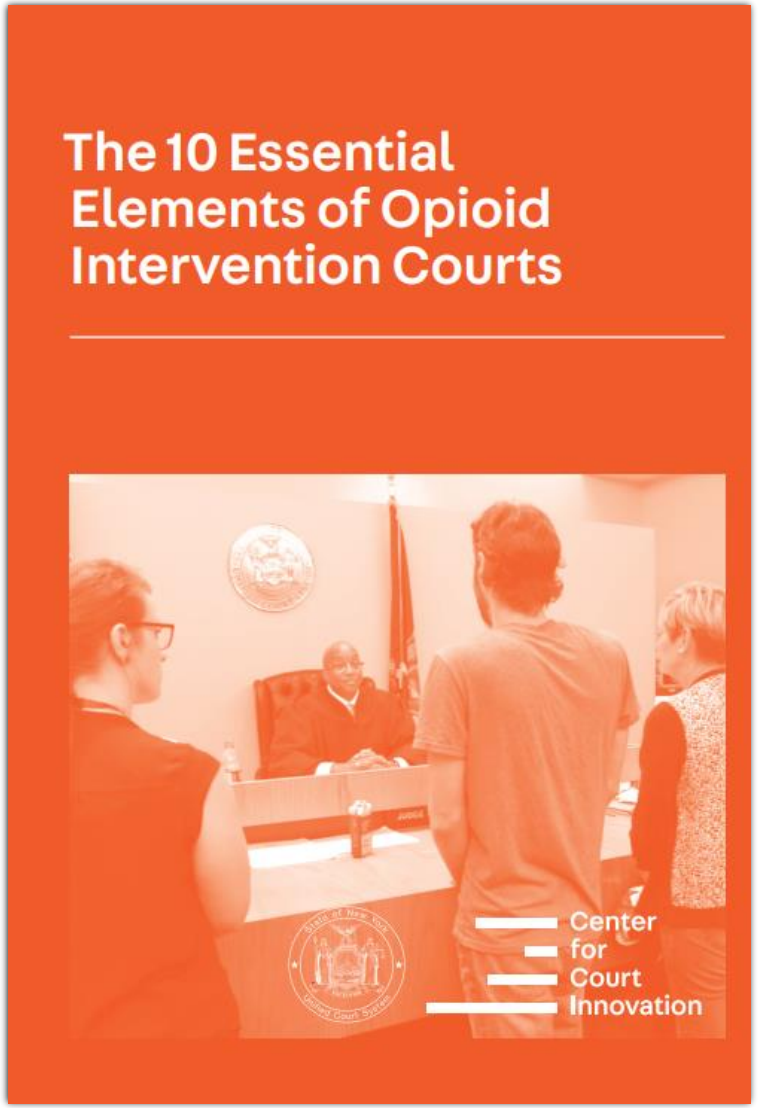
# What can drug courts do to decrease risk?

## THERAPEUTIC ALLIANCE

- Meets clients where they are (accept and respect ambivalence)
- Assumes trauma hx (primary, secondary, intergeneration, institutional)
- Alliance can be more important than tx modality (Horvath, Fluckiger)
- Collaborative goal-setting, empathy, affirmation (Wampold, 2015)
- Person-first, scientific, destigmatizing language (Rashford, 2019)
- Harm reduction conversations are open, honest, and non-judgmental
- Proactive health choices are a sign of hope

# Opioid Intervention Courts: Background

- Opioid epidemic (heroin, rx opioids, illicit fentanyl)
- 70,200 OD deaths in 2017, two-thirds involving opioids
- Buffalo sees OD deaths climb 7 cons. years
- The ‘Buffalo Opioid Court’ opens in 2017
- Opioid Court model begins to spread nationwide



# Opioid Intervention Courts: The Model

- Opioid intervention courts are rapid response programs that use immediate screening and treatment engagement, intensive judicial monitoring, and recovery support services to prevent opioid overdose and save lives.

- By helping to stabilize individuals who are at immediate risk of overdose death, opioid courts offer support to individuals in crisis and set participants on the path to long-term recovery and a better quality of life.

# The ‘Opioid Court’ Model: Ten Essential Elements

1. Broad legal eligibility criteria
2. Immediate screening for risk of overdose
3. Informed consent after consultation with defense counsel
4. Suspension of prosecution or expedited plea
5. Rapid clinical assessment and treatment engagement
6. Recovery support services
7. Frequent judicial supervision and compliance monitoring
8. Intensive case management
9. Program completion and continuing care
10. Performance evaluation and program improvement

# 10 Essential Elements Roundtable: Contributors

- Medical and behavioral health experts
- Judges, prosecutors, defense attorneys
- Treatment providers
- NPC Research
- Center for Court Innovation
- New York State Office of Court Administration
- Bureau of Justice Assistance

# Opioid Intervention Courts: Replication

- Opioid intervention courts need not be identical.
- Each court will inevitably reflect local conditions, resources, and constraints.
- All opioid intervention courts should, however, strive to incorporate most of the 10 essential elements.

# Opioid Intervention Courts: Contributors

- Buffalo Opioid Court (NY)
- ROCS Strategy (TN)
- Cumberland County OIC (PA)
- Gila County Opioid Court (AZ)
- Brown County Heroin Court (WI)
- Staten Island HOPE Program (NY)
- Bronx, Manhattan OAR Court (NY)

# For More Information

https://www.courtinnovation.org/publications

- The 10 Essential Elements of Opioid Intervention Courts
- Court Responses to the Opioid Epidemic: Happening Now

COURT RESPONSES TO THE OPIOID EPIDEMIC: HAPPENING NOW

Heroin, prescription pain relievers, and synthetic opioids like fentanyl have contributed to a national epidemic. More than 70,200 Americans died from drug overdose in 2017, and more than two-thirds of these deaths involved opioids. Overdose deaths have increased by double-digit percentages each year since 2014.

This epidemic poses special challenges for the justice system. Opioid-related arrests have spiked. Police, probation officers, and court staff are being trained to administer overdose reversal medication. Jails are overseeing the detoxification of incarcerated opioid users. In the face of these pressures, justice officials across the country are working to develop new, more effective responses to opioid-related crime.

For decades, drug courts have been the leading model serving court-involved individuals with opioid use disorders, and they continue to play a central and irreplaceable role in combating the opioid crisis. Drug courts alone, however, are not enough. New justice system approaches are needed to prevent overdose deaths through immediate access to evidence-based treatment—including medication-assisted treatment—and wraparound supports.

This document provides a snapshot of some of the strategies being used by courts and justice system practitioners around the country to prevent overdose deaths and save lives.

OPIOID INTERVENTION COURTS

1. BUFFALO OPIOID INTERVENTION COURT

Buffalo
New York

Overdose deaths in the state of New York have been steadily climbing for seven consecutive years and exceed the national average, in large part due to the arrival of illicit fentanyl. In response, New York's Unified Court System, a pioneer in the treatment court field for decades, developed the country's first opioid intervention court in Buffalo in 2016.

Created with the explicit goal of saving lives, the Buffalo Opioid Court relies on day-of-arrest intervention, evidence-based treatment, daily judicial supervision, and wrap-around services to prevent overdose death. Prior to arraignment, court staff go to the jail and interview defendants, using a brief survey developed by the court, to identify those at risk of opioid overdose. Those at risk for overdose receive a brief bio-psycho-social screening, which is administered immediately following arraignment by an onsite team of treatment professionals and case coordinators. Based on the results, each consenting individual is transported to an appropriate treatment provider, where most begin medication-assisted treatment with buprenorphine, methadone, or naltrexone. The process of initial interview, arraignment, bio-psycho-social screening, and transfer to treatment is completed within 24 hours of arrest.

Once connected with a treatment provider, the participant receives a comprehensive clinical assessment and an individualized treatment plan. Opioid intervention court staff provide daily case management for

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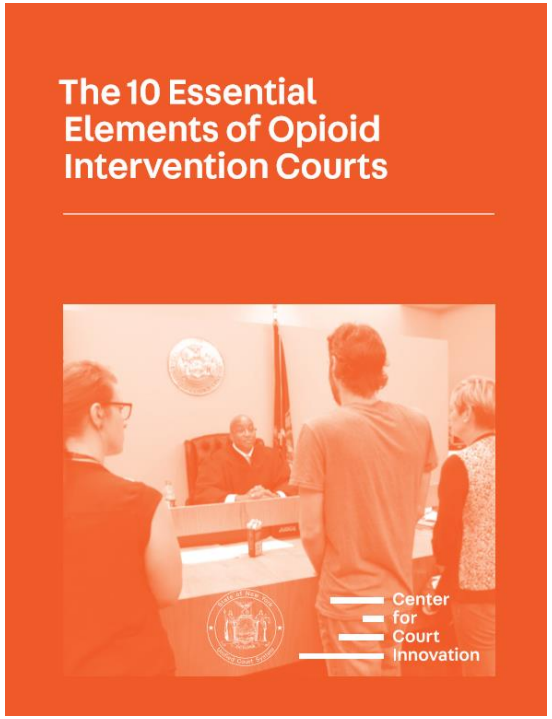
For more information about the opioid epidemic and available training and technical assistance, contact Aaron Arnold, Director of Technical Assistance, at arnolda@courtinnovation.org.




Bureau of Justice Assistance
U.S. Department of Justice

Center for Court Innovation

# Thank you!

dlucas@nycourts.gov

**David Lucas, MSW**

Training & Technical Assistance, Center for Court Innovation

*In Collaboration with Advocates for Human Potential*

# Questions?

**Type your questions in the Q&A box on your screen.**

# Certificate of Attendance

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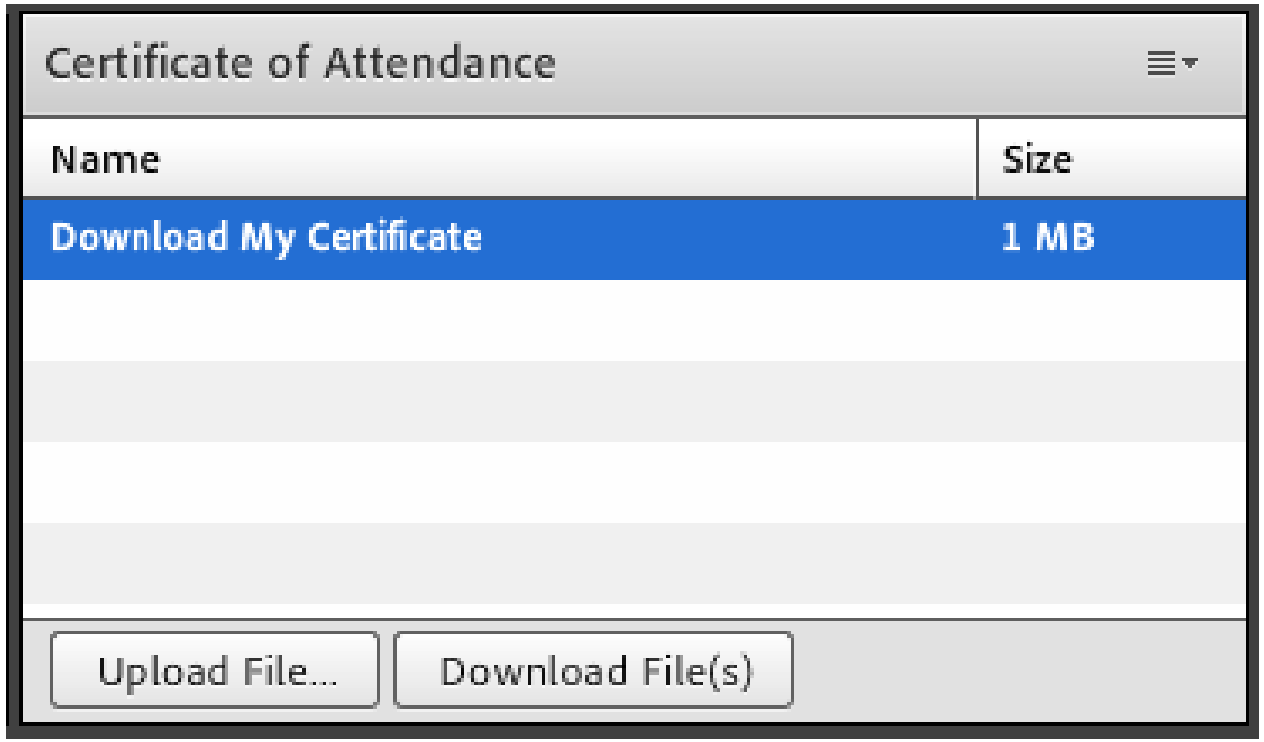

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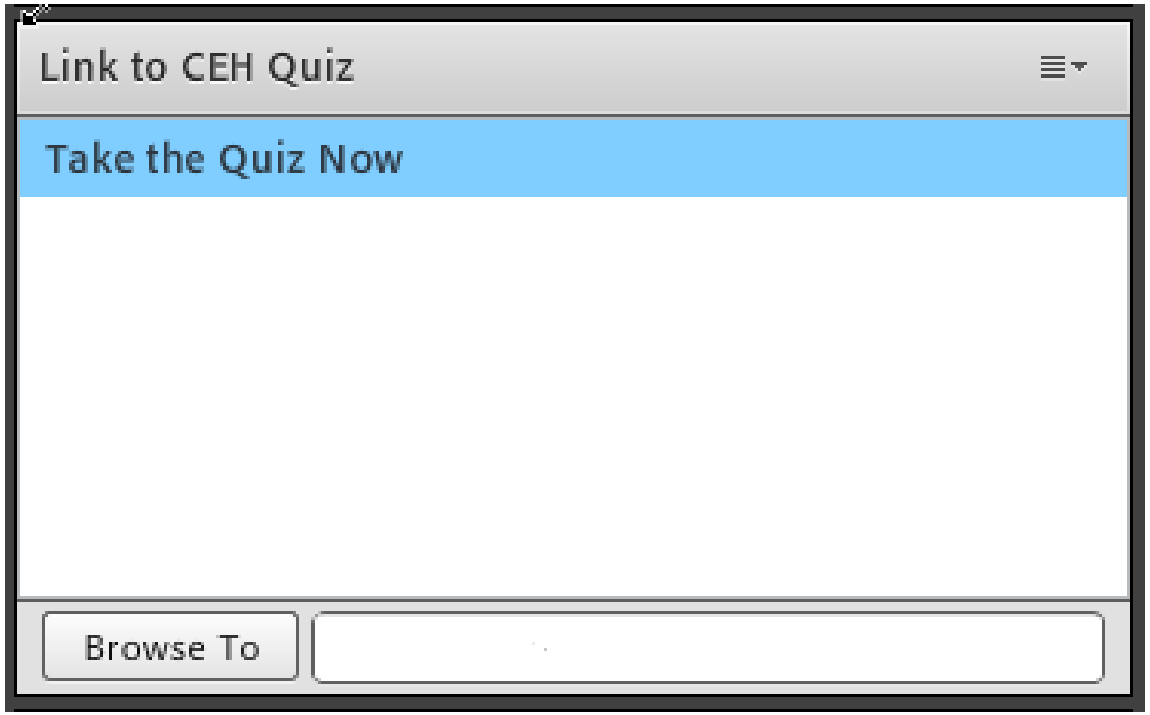

For more information on RSAT training and technical assistance please visit:

http://www.rsat-tta.com/Home

Stephen Keller
RSAT TTA Coordinator

skeller@ahpnet.com

*Additional resources can be found in the following slides*

# 5 ways to adjust program culture to reduce OD risk:

1. Return to first principles of ‘do no harm’ and ‘meet people where they are.’
2. Remember that becoming abstinent quickly does not guarantee stability or safety.
3. Respond to a client disclosure about planned use with non-judgment and acceptance. This will provide a foundation for a longer discussion about safety and other options.
4. Strengthen therapeutic alliances by adjusting recovery processes to a pace the client feels safe with.
5. Celebrate and incentivize program engagement, especially when a client is still struggling with use. Achievements like:

    -consistent program attendance

    -active group participation

    -gaining new insights

    -pursuing new vocational or recreational endeavors

    -being a supportive peer to other clients

    -taking steps to improve general health or stability

    -meeting family obligations

    -acquiring no new criminal charges

    -staying connected with the program despite new challenges or hardships

# What other practical steps can drug courts start taking right away?

- Ensure that all drug court team members are trained on the basics of Opioid Use Disorder and the FDA-approved medications that treat it.
- Make best efforts to provide swift (same day) linkages to MOUD medications upon release from custody, where indicated.
- Partner with multiple, trusted MOUD providers and allow participants to work with a provider of their choosing.
- Provide overdose-reversal training and ensure low-barrier Naloxone access for all staff and participants.
- Provide participants with education about overdose risk, safer practices, blood-borne virus transmission, testing and available treatments.
- Screen for fentanyl (and analogs) in routine drug testing and discuss results with participants.
- Inform participants about local Good Samaritan Laws (and important limits to protection).

# What other practical steps can drug courts start taking right away? (cont…)

- Offer participants with credible alerts when drug-checking information becomes available.
- Reduce or suspend the payment of drug court program fees if a participant is incurring MOUD costs.
- Partner with withdrawal management services that accommodate MOUD.
- Develop non-custodial sanctions for all drug court-specific violations like missed groups, disputed toxicology, or recurrence of use.
- Provide meaningful MOUD support, education, and naloxone upon release from custody, hospital, inpatient treatment or withdrawal management (“detox”).
- Defer to addiction medicine experts regarding the use of MOUD, tapering, length of treatment and dose.
- Do not encourage or mandate participants to abstinence-only treatment if they are using or considering using MOUD.
- Value all pathways to recovery - including those involving MOUD - equally.

# Opioid Court Essential Elements
# #1: Broad Legal Eligibility

- Opioid intervention courts should accept the broadest range of charges possible, ideally including felony and misdemeanor charges.
- Eligibility should rest primarily on the defendant’s clinical needs, rather than the crime charged
- Federally funded programs are not permitted to accept violent offenders

# Opioid Court Essential Elements
# #2: Immediate Screening for Risk of Overdose

- Use a specialized screening tool to identify individuals who are at high risk of overdose, ideally within hours of arrest
- Screening administered by court staff, pretrial services, or another partner agency should be universal and immediate
- Information obtained through screening must be protected in accordance with federal and state confidentiality laws and professional ethics
- Information should be shared only with defense counsel until defense counsel consents to broader release

# Opioid Court Essential Elements
# #3: Informed Consent after Consultation with Defense Counsel

- Every person who screens positive for risk of overdose and who also meets legal eligibility criteria should be offered the opportunity to enter after consultation with defense counsel
- Defense counsel should be on hand to advise clients as immediately as possible after overdose screening
- Defendants who agree to participate should have their cases transferred without delay

# Opioid Court Essential Elements
# #4: Suspension of prosecution or expedited plea

- Suspend prosecution of the case for the duration of the program, allowing the participant, the court, and the treatment providers to focus on clinical stabilization, or
- Expedite the plea process and facilitate the rapid resolution of the legal case so that treatment inception is not delayed by legal procedures

# Opioid Court Essential Elements
# #5: Rapid Clinical Assessment and Treatment Engagement

- Defendants should receive a comprehensive clinical assessment and rapidly engage in evidence-based treatment services ideally within 24 hours of arrest
- Medication-Assisted Treatment should be offered to all participants as medically appropriate, following informed consent, and ideally within 24 hours of arrest
- Treatment plans should be developed in partnership with the participant and should consider participant’s unique mental and physical health, trauma, and other needs

# Opioid Court Essential Elements
# #6: Recovery Support Services

**Opioid courts should**

- Offer participants a broad range of evidence-based recovery support including secular alternatives
- Utilize peer recovery advocates to help participants engage in the program
- Assist participants with medical needs, trauma-related care, housing, transportation, and where available, partner with family support navigators who can help address the impact of opioids on the entire family

# Opioid Court Essential Elements
# #7: Frequent Judicial Supervision and Compliance Monitoring

**Opioid courts should**

- Require participants to return to court frequently for supervision and monitoring to replace daily drug seeking behavior
- Use evidence-based techniques, like motivational interviewing, to engage participants in strengths-based conversations about their progress
- Require participants to undergo frequent, random drug testing using evidence-based drug testing protocols
- Avoid imposing punitive sanctions for positive drug tests and work with treatment partners to adjust the participant’s treatment plan to achieve clinical stabilization

# Opioid Court Essential Elements
# #8: Intensive Case Management

- Case managers employed by the opioid intervention court or a partner agency should help to ensure and prioritize necessary treatment and recovery supportive services
- Case managers act as liaisons between the court, supervision agencies, and service providers to coordinate the ordering and timing for services

# Opioid Court Essential Elements
# #9: Program Completion and Continuing Care

**Opioid courts should**

- Require participants to complete a minimum of 90 days of treatment and supervision to achieve stabilization and lay a foundation for longer-term treatment
- Eligible participants should be assessed for possible enrollment in longer-term programs, like a drug court, mental health court, or veterans treatment court
- Where a legal case can be resolved at the conclusion of the 90-day stabilization period, participants should be offered continuing care planning

# Opioid Court Essential Elements
# #10: Performance Evaluation and Program Improvement

- Opioid courts should collect data around clearly-defined, participant-level performance measures
- Courts should meet at least annually as a team to analyze data, ideally with the help of a qualified research partner, to identify service gaps and make program improvements