BSAS/BJA Adult Drug Court Grant

# WHERE JUSTICE AND TREATMENT MEET:

## 2st Annual Massachusetts State Drug Court Conference

*Produced by:*
Advocates for Human Potential
for the BSAS/BJA Drug Court Grant

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*In partnership with:*

COMMONWEALTH OF MASSACHUSETTS THE TRIAL COURT

COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

MA Department of Public Health BSAS Bureau of Substance Abuse Services Prevent • Treat • Recover • For Life

Training planned, delivered, and sponsored by the Massachusetts Bureau of Substance Abuse Services Bureau of Justice Assistance Adult Drug Court Discretionary Grant OMB No. 1121-0329 team and conference planning committee composed of Eileen Brigandi, Karen Pressman, Paige Schaffer, Jennifer Parks, BBSAS; Marie Burke, Judge Robert Ziemian, Judge Mary Hogan Sullivan, Victoria Lewis, Shelia Casey, Trial Court; Lisa Braude, DMA, Roberta Leis and Katharine Collet ,conference coordinators and point of contact, AHP

The report was written by Katharine Collet in collaboration with Roberta Leis, consultants for the Drug Court Grant from Advocates for Human Potential.

*Please note additional attachments to this report include: David Mee-Lee and Robert Stutman's PowerPoint presentations.*

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## Drug Court Conference Summary Report

The second annual Massachusetts State Drug Court conference funded by the Bureau of Justice Administration (BJA) Enhancement Grant awarded to the Bureau of Substance Abuse Services (BSAS) (hence forth referred to as the BSAS/BJA Drug Court Grant) was held in partnership with the Trial Court on October 30th at the Marlborough Best Western Hotel.

The conference titled “Where Justice and Treatment Meet” was designed to set the stage for Massachusetts Drug Courts by building on successes and strengthening partnerships, especially between the criminal justice and treatment systems. The conference objectives were to:

1. Discuss the intersection of justice and treatment and their critical roles in Drug Court outcomes;
2. Educate court teams, treatment providers and the recovery community in Drug Court best practices and evidence-based treatment; and
3. Promote peer and expert exchange and support new and existing Drug Courts.

Two-hundred and forty-one participants attended the conference. The participants included judges, probation staff members, court staff members, attorneys, and treatment providers currently involved and interested in Drug, Veterans, and Mental Health Courts.

State leaders from BSAS and the Trial Court set the stage for the event, giving an update on the Opioid Overdose Prevention Taskforce strategic plan, its successes, and relationship to Specialty Courts; an update on the Trial Court strategic plan and commitment to specialty courts; and discussion of the Specialty Court’s success, areas still needing improvement, and need for continued partnerships to ensure that Specialty Courts continue to work and become better.

The morning brought together state and national experts on Drug Courts and addiction to discuss engaging participants in accountable treatment and using research, best practices, and practical knowledge to address common scenarios through a keynote address and panel discussion. The keynote was delivered by Dr. David Mee-Lee, a national expert on the ASAM treatment criteria. Dr. Mee-Lee discussed the levels of care in substance use treatment, and the difference between adherence and compliance to treatment. He focused on how the difference between treatment and compliance relates to the different approaches used by the criminal justice and treatment systems to address behavioral issues and interact with participants, and how these differences can lead to communication challenges between the Drug Courts and the treatment providers. The panel was composed of Dr. Mee-Lee and practitioners from across the state, representing each member of the Drug Court (Judge, Probation Officer, treatment provider, Defense Counsel, Prosecutor, and Drug Court participant). The panel worked through two real life scenarios addressing many of the challenges facing Massachusetts Drug Court team, and practical strategies for addressing these challenges. The topics discussed included,

(1) participant appropriateness based on need and history, (2) use of Medicated Assisted Treatment (MAT), (3) treatment, incentives, and sanctions and best practices, stage of change, and participant's behavior, (4) drug testing, and (5) communication between Drug Court and treatment providers and non-Specialty Court staff. The discussion among the panel members illustrated the diverse viewpoints of the team. The morning ended with a question and answer session, which brought to light a number of very important questions for clarification and further discussion in the day.

A networking lunch allowed participants to meet colleagues from across the state and discuss the morning's presentations and their role and experiences in Drug Court. Lunch was sponsored by the New England Association of Drug Court Professionals.

The afternoon began with a keynote speech from Robert Stutman, outlining the history of drug use and abuse in America. He outlined the rise of drug use and abuse among primarily low-income urban minorities and shift in recent years to suburban youth. He utilized his experiences as a Drug Enforcement Agency (DEA) agent, youth, speaker to adolescents and parents, and CASAColumbia. While he was an engaging speaker, it is important to note that his information sources are not the only ones. The bulk of the afternoon consisted of breakouts by region. In these breakouts, participants were tasked to further discuss the two scenarios presented to the panel and a third new scenario, which in addition to the above topics also included the obligations of team members, especially around disclosure. The breakouts were facilitated by one Drug Court and one treatment representative, and a grant staff note taker documented the conversation.

Evaluations were completed by 70 participants (29%)[1], and indicated that participants were satisfied with conference. Specifically, participants indicated the overall quality of the program was excellent (9.01 out of a possible 10 point rating). On average participants, also indicated that they fell between the strongly agree and agree with the following statements: (1) I learned something at this program that will affect the way I do my job (4.64 out of a possible 5 point rating), (2) If this program were offered again, I would recommend it to a colleague(4.73 out of a possible 5 point rating), (3) The written materials were useful to me(4.24 out of a possible 5 point rating), (4) Interaction with my colleagues contributed significantly to my learning today(4.19 out of a possible 5 point rating), and (5) The objectives were consistent with the purpose/goals of the activity(4.63 out of a possible 5 point rating). The participant's comments suggested that the presentation delivered by Dr. Mee Lee, particularly with respect to adherence versus compliance in treatment, and networking were most the most valuable aspects of the day. (Please see Appendix II: Conference Evaluation Data for more information on participant satisfaction with the conference). Additionally, participants suggested that additional trainings on determining level of care, Medicated Assisted Treatment, and Section 35 would be helpful. It is important to note that the while the number of respondents is low, the evaluation was based off of the Trial Court evaluation, and once that data is analyzed responses from Trial Court employees on the overall conference can be added to this data.

[1] Please note that the Trial Court also conducted a participant evaluation utilizing many of the same questions present in the BJA/BSAS Drug Court evaluation. These have not yet been analyzed, and will be included once the data is received.

This conference was collocated with the New England Association of Drug Court Professionals (NEADCP) annual two day conference, which also focused on exploring the intersection of justice and treatment with 33 sessions to choose from. All individuals invited to Massachusetts Where Justice and Treatment Meet were also invited to the first day of the NEADCP Conference. One hundred and ninety- three people were able to take advantage of this opportunity for further learning. In order to promote and defer the costs of attendance, 170 scholarships were given to interested individuals, with BSAS providing 35, the Trial Court providing 60, the Goldberg Foundation providing 50, the Shaw Foundation providing 30,and the Association for Behavioral Health providing 5. NEADCP Conference participants that filled out the evaluation indicated that they fell between strongly agree and agree that the conference content was interesting (4.75 out of a possible 5 rating) and increased knowledge (4.69 out of a possible 5 rating), and commented that the presentations were excellent.

Given both the incredibly positive verbal feedback received after the conference from participants and state leaders and the results of the evaluations, the conference appeared to meet the objectives, and provide Massachusetts drug court professionals with valuable training that will be used to continue to better the individual drug courts and the relationships between the Criminal Justice and treatment systems.

# WHERE JUSTICE AND TREATMENT MEET

## October 2, 2014

### AGENDA

Co-sponsors:
MA Trial Court and
MA Department of Public Health,
Bureau of Substance Abuse Services

BSAS/BJA Adult Drug Court Grant

| | | LOCATIONS |
|---|---|---|
| 8:00 – 8:45 am | **Registration/Continental Breakfast/Exhibits** | |
| 8:45 – 9:00 am | **Welcome and Introductions** | **Ballroom** |
| | *Honorable Mary Hogan Sullivan,* Presiding Justice, Norfolk County Veterans Treatment Court, Director, Specialty Courts for the District Courts | |
| | *Karen Pressman,* Director of Planning and Development, Bureau of Substance Abuse Services (BSAS), MA Department of Public Health (MDPH) | |
| | *Lydie Ultimo,* MSW, Interim Director, Bureau of Substance Abuse Services (BSAS), MA Department of Public Health (MDPH) | |
| 9:00 – 9:30 am | **Opening Session** | **Ballroom** |
| | *Honorable Paula Carey,* Chief Justice of the MA Trial Court | |
| | *Karen Pressman,* Director of Planning and Development, BSAS, MDPH | |
| | *Harry Spence,* Trial Court Administrator | |
| | *Lydie Ultimo,* MSW, Interim Director, BSAS, MDPH | |
| 9:30 – 10:45 am | **Morning Keynote: "Doing Change or Doing Time–Engaging People in Accountable Treatment"** | **Ballroom** |
| | *David Mee-Lee,* MD, Senior Vice President for the Change Companies and Chief Editor of the Revised Second Edition of the ASAM Criteria | |
| 10:45 – 11:00 am | **Break/Exhibits** | |
| 11:00 am – 12:00 pm | **Experts Perspective on Real Life Drug Court Scenarios** | **Ballroom** |
| | *Moderator: Honorable Robert Ziemian*, Trial Judge, Massachusetts Judiciary | |
| | *Kim Hanton*, Director of Addiction Services, North Suffolk Mental Health Association | |
| | *Judy Lawler*, Probation Officer, Chelsea District Court | |
| | *David Mee-Lee,* MD, Senior Vice President for the Change Companies and Chief Editor of the Revised Second Edition of the ASAM Criteria | |
| | *Mellisa Prefontaine*, Office Manager, Massachusetts Organization for Addiction Recovery | |
| | *Michael Connolly*, Prosecutor, Norfolk County | |
| | *Larry Zalis*, Defense Counsel, Barnstable County | |
| 12:00 – 12:30 pm | **Introduction to Break Out Sessions** | **Ballroom** |
| 12:15 – 1:15 pm | **Networking Lunch/Exhibits** | |
| 1:15 – 2:15 pm | **Afternoon Keynote: "Welcome to America's Worst Drug Epidemic"** | **Ballroom** |
| | *Robert Stutman,* Special Agent in Charge, New York Field Division (Retired), United States Department of Justice, Drug Enforcement Administration | |
| 2:15 – 2:30 pm | **Break/Exhibits** | |
| | • ***Join Together to Strengthen Linkages – Facilitated Regional Breakouts*** | |
| 2:30 – 4:15 pm | **1. All Boston Courts** | **Ballroom – Salon A** |
| 2:30 – 4:15 pm | **2. Chelsea, Lynn, Malden and Cambridge** | **Southborough Room** |
| 2:30 – 4:15 pm | **3. Concord, Lowell, Lawrence, Ayer** | **Ballroom – Salon E** |
| 2:30 – 4:15 pm | **4. Newton, Dedham, Framingham, Quincy** | **Princess Room** |
| 2:30 – 4:15 pm | **5. Dudley, Holyoke, Greenfield, Orange** | **Westborough Room** |
| 2:30 – 4:15 pm | **6. Brockton, Plymouth, Barnstable, New Bedford, Taunton** | **Marlborough Room** |
| 2:30 – 4:15 pm | **7. Juvenile Courts** | **Sterling Room** |
| 4:15 – 4:45 pm | **Close/Evaluations/CE Distribution** | |

## Appendix II: Conference Evaluation Data

As part conference participants were asked to complete an evaluation describing their satisfaction with (1) overall the program, (2) Dr. David Mee Lee's presentation on accountable treatment in Drug Courts, (3) a practitioner's panel on Drug Court Scenarios, (4) Robert Stutman's presentation on the history of the drug epidemic, and (5) the regional breakout sessions. The evaluations were based on comments and participants ratings of the programming. The overall quality of the program utilized a ten point scale allowing participants to determine the quality of the program, with the following categorizations: 1 - 2 poor, 3 - 4 fair, 5 – 6 neutral, 7 – 8 very good, and 9 – 10 excellent. The remainder of the evaluation utilized a five point scale allowing participants to determine their satisfaction or dissatisfaction, with the following categorizations: (1) strongly disagree, (2) disagree, (3) neither agree nor disagree, (4) agree, and (5) strongly agree. In addition to this evaluation, one note taker was assigned to each of the breakout sessions to document the discussion among participants. Across the breakout sessions, participants had conversations about the barriers and need for communication between treatment providers and the court system. The general conclusion was that both sides wanted to work better together, but did not know where to start. Additionally, breakouts noted the need for better drug testing. The atmosphere was reported to be engaged and welcoming by note takers.

### The overall evaluation

| Average Participant Rating of the Overall Conference | |
|---|---|
| Question | Average Rating (5 point scale) |
| How would you rate the quality of this program overall? | 9.02 (10 point scale) |
| I learned something today that will affect the way I do my job. | 4.64 |
| If this program were offered again, I would recommend it to a colleague. | 4.73 |
| The written materials will be useful to me. | 4.24 |
| Interaction with my colleagues contributed significantly to my learning today. | 4.19 |
| Objectives were consistent with the purpose/goals of the activity. | 4.63 |

### Comments

1. Very informative and interesting. (4)
2. Very informative on a topic with which I had zero knowledge/familiarity.
3. Peer group was terrific!
4. Very good content- in some areas could have been more relevant.
5. Timeframes, lunch, food service were excellent.
6. Really liked Dr. Mee-Lee and the presenter from the DEA.
7. The only reason I gave 3's is because I'm already quite knowledgeable about this subject.
8. Best seminar attended in past ten years.
9. Excellent panels, workshop, and speakers. (3)
10. Break out session with J. Lawler was great.

### Most Helpful

Question: What was most helpful about this program?

1. Discussion of concerns about local providers.
2. Learning non-correctional perspectives.
3. David Mee Lee – treatment versus compliance, and rethinking and individual and group treatment. (4)
4. It was all extremely helpful.
5. DEA agent was great- stats great. Landscaping of drugs and use and changes in history.
6. Cutting edge.
7. Learning what should be the focus of individuals who are coping with addiction.
8. Great recent information.
9. Poor case study, as it applies to a recovery program.
10. Muting other people.
11. The information presented.
12. Judge Borders.
13. Great speakers. (2)
14. Very informative.
15. Everything.
16. Informative.
17. Just a better understanding of what the drug courts are doing.
18. The program discussing the barriers we create to keep clients out of drug court.
19. Dialogue between courts/treatment and emphasis on teamwork (6)
20. The group discussions.
21. Great presentations.

### Places for Improvement

Question: How could we improve upon this program?

1. Change case study.
2. No suggestions. (3)
3. Include frontline treaters, grass-roots clinicians, multicultural (ethnic) panelists.
4. Involve more judges.
5. Peer leadership.
6. Monthly regional drug court meetings.
7. It was beyond better than I expected.
8. Written or electronic availability of information.[2]
9. Have more time for Dr. Mee Lee and Robert Stutman. (2)
10. Have more drug court practitioners in the room.
11. Continue to offer this program.
12. Stress 12 step.
13. Smaller discussion groups.
14. More structure to breakouts.

### Additional Trainings

Question: Please provide any suggestions that you might have for additional judicial education topics presented at this training or any other topic.

[2] Due to this suggestion, AdCare sent out all of the training material to the participants and grant leadership.

1. Bring back trauma next year (good to have a break this year).
2. Determine how a recovery home impacts drug court- both plusses and minuses.
3. Examination of referral process to drug court, evaluation of participation, compassion of outcome of drug court as probation.
4. Mock drug courts.
5. Lab screening expert.
6. Updated publication listing latest means of abuse, methods, drug names and indications.
7. Section 35 would be an excellent topic for a training.
8. More info for judicial ed regarding assessments and determining appropriate level of care rather than underlying assumption that treatment court equals residential treatment.
9. Peer intervention.
10. Explanation of insurance rules and guidelines.
11. The effects of integrated care on drug court.
12. More on MAT and women; families and MAT and drug court.
13. Fix drug testing.

Question: Please provide any suggestions that you might have for additional substance use disorder education topics presented at this training or any other topic.

1. Perhaps a special focus on youth.
2. Dual diagnosis treatment.
3. More about prevention "workbook" on current trends in abuse and treatment milieus.
4. How to deal with Post Acute Withdrawal Symptoms.
5. Motivational Interviewing (Motivational Enhancement training).
6. A complete ASAM training, so folks understand who truly meets criteria for residential treatment.
7. Discuss in greater detail the Section 35 process- challenges and solutions.
8. Overdose prevention.

## Keynote Presentation:

| **Average Participant Rating of "Doing Change of Doing Time: Engaging in Accountable Treatment" David Mee Lee** | |
|---|---|
| Questions | Average Rating (5 point scale) |
| I learned something at this presentation that will affect the way I do my job. | 4.81 |
| The presentation addressed my questions of concerns on this topic. | 4.72 |

Question: Please indicate two things you learned from this session.

Answer Themes: The difference between treatment and adherence and the need to put this into practice in both Drug Courts and treatment facilities.

1. Treatment is different than compliance. Basics of ASAM criteria.
2. To use Motivational Interviewing technique. Work with client to plan treatment.
3. Refreshing for a new perspective on defining successful treatment.
4. The 5 steps on the CHANGE spiral. Compliance and adherence definitions and uses for both.

5. You want people to adhere, not to comply. Treat clients as individuals.
6. "Testing (lab results) not to catch you." "Adherence versus compliance" language measures a lot!
7. I need to concentrate on adherence to treatment, not compliance. Hold treatment providers accountable/adjust treatment as needed.
8. How desperate we need places to help addiction. How scary the numbers are of children addicted.
9. Need for treatment- not blame.
10. Treatment needs to be held accountable. Compliance versus adherence.
11. Dr. Mee-Lee was awesome. What a great message. Treatment engagement versus compliance. Appreciated his understanding of effective therapeutic alliance.
12. "Sustained talk." Changing treatment plan versus sanctions.
13. He was great. If you don't feel you have an addiction, then relapse prevention is not the treatment to choose. It's not resistance, it's discord per MET.
14. "Resistance" and "adherence".
15. Overall, excellent. I've heard him before- nothing new, but always right on target!
16. Excellent.
17. Concerns from judges about Sec. 35 and that two new drug courts are opening.
18. Compliance versus adherence. Sustain talk. Excellent speaker. Would love for him to come back.
19. Problems facing drug courts to which my program impacts- both positively and negatively.
20. The balance between compliance versus adherence. Verbatim versus therapeutic justice.
21. Not to use certain terms. Treat person where they are.
22. Distinction between compliance versus adherence. Key components of assessment/treatment planning.
23. What works for one client doesn't work for others. Compliance/adherence.
24. Great update on Motivational Interviewing techniques.
25. This was excellent- straightforward and very, very helpful. Difference between compliance/adherence. Role of sanctions.
26. Concept of compliance versus adherence. Use of sanctions.
27. Having a therapeutic alliance. Engaging client as the participant.
28. The challenge of getting the treatment right. Compliance versus adherence.
29. Needs for beds.
30. "Matching horses and courses" in treatment. The strong references on psychotherapy. (I heard his webinar previously. He is FANTASTIC!)

| **Average Participant Rating of "Welcome to America's Worst Drug Epidemic" Robert Stutman** | |
|---|---|
| Questions | Average Rating (5 point scale) |
| I learned something at this presentation that will affect the way I do my job. | 4.49 |
| The presentation addressed my questions of concerns on this topic. | 4.33 |

Question: Please indicate two things you learned from this session.

Answer Themes: The historical and current context of drugs of use and abuse, and how this affects and is related to methods of use and abuse and drug use and abuse among youth.

1. It was eye-opening regarding the use of oxycontin. The review of drugs of abuse was informative.
2. He kept the audience's attention. A great speaker. Crack made woman= to men in drug addiction. Only 37% of overdoses are from heroin. FYI- a little outdated on how he sees addiction professionals.
3. Information on young people's use; information on oxycontin. Great storyteller.
4. Don't like to hear stats always. Too many numbers.
5. Age of impact.
6. How crack changed the country and that it finalized drug addiction.
7. Great.
8. Juvenile drugs of choice. Statistics.
9. Huffing is a major issue for teens. Oxys are crushed and not swallowed whole. Presentation did not take multicultural audience into account when generalizing experiences.
10. Drug statistics and youth drug use.
11. Great info.
12. Tell the kids you're going to like drugs, not "you're gonna die".
13. Excellent presentation.
14. This presentation enlightened me. It provided important updates, presented a picture that was clear. It offered resource info.
15. Huffing is a gateway between alcohol and heavy drug use. Overdose has increased by ¾ over past ten years.
16. The intent of drug use.
17. Excellent. Wow.
18. Statistics of epidemic. Differences in drug use/landscape in US.
19. Numbers are important.
20. Huffing and age of addiction.
21. Youth are abusing substances at a young age; what our youth are abusing.
22. Having two teenagers, I found the presentation to be very informative and interesting. Statistics were unbelievable. Great speaker.
23. 90% of drug addicts are one by age 21; before crack, 70% of addicts were men. Now 50/50 trending towards women.
24. Prescription drugs are our worst enemies. Friends are introducing kids to drugs.
25. The summarization of addiction. Overdose is leading cause of accidental death.
26. Age of onset and correlation with dependence.
27. Statistics were astonishing. Differences in drug use today.
28. Awesome presenter. Wonderful up-to-date info and a realistic presentation.
29. "Resistance" is a two-way problem.

## Panel Discussion:

| Average Participant Rating of "Welcome to America's Worst Drug Epidemic" Robert Stutman | |
|---|---|
| Questions | Average Rating (5 point scale) |
| I learned something at this presentation that will affect the way I do my job. | 4.18 |
| The presentation addressed my questions of concerns on this topic. | 4.14 |

Question: Please indicate two things you learned from this session.

Answer Themes: The different perspectives between the treatment and justice systems and how this affects perception, treatment planning and reassessment, and use and acceptance of MAT. As well as the need, discuss these topics more openly to ensure the participant is successful.

1. MAT is important for some with drug court. Sanctions need to be fair.
2. A bit rambling. Not as focused as I would have liked.
3. How everyone needs to collaborate for drug courts to work. That deterrence doesn't necessarily work.
4. Providers need to be more upfront about their programs and not hold court, probation (drug courts) hostage. Express what it is they need to improve- their services.
5. Seeing all different perspectives between the legal system and treatment.
6. Different aspects of drug court. Creative suggestions from other drug courts.
7. Great scenarios. The facilitator really was able to provide depth to the questions and refine them to make the conversations rich.
8. Pregnant women who are incarcerated get methadone.
9. That it is helpful to have a conversation about MAT with all types of disciplines in the room. Pregnant women with history of opioid addiction are being given methadone when incarcerated.
10. The complexity of the treatment options and the range of specialty courts.
11. Found that this was less helpful. I feel like breakout groups among colleagues in the same region would have been more helpful.
12. Split between treatment and justice.
13. A "time out" can be an excellent therapeutic opportunity to weigh one's options.
14. Changes in discharge are something others are thinking about.
15. Excellent.
16. Time outs. Need to find alternatives. Treatment needs to be readdressed when it's not working. Have to be able to assist offender to help them and what works for them.
17. Will visit a drug court within thirty days to determine how our program can improve both support and understanding.
18. Some things need to change about treatment. Everyone needs to be on the right page in treatment versus court.
19. Need for individual-based treatment plan versus cookie cutter treatment plan. Use of MAT's may be underrated.
20. Helpful discussion.
21. You cannot mandate abstinence. The longer in residential, better chances of recovery.

## Regional Breakouts:

| Average Participant Rating of "Welcome to America's Worst Drug Epidemic" Robert Stutman | | | | | | | |
|---|---|---|---|---|---|---|---|
| Questions | Average Rating (5 point scale) | | | | | | |
| | Boston | Chelsea, Lynn, Malden & Cambridge | Concord, Lowell, Lawrence & Ayer | Newton, Dedham, Framingham & Quincy | Dudley, Holyoke, Greenfield & Orange | Brockton, Plymouth & Barnstable | Juvenile |
| I learned something at this presentation that will affect the way I do my job. | 5.00 | 4.75 | NR | 3.90 | 4.33 | 4.09 | 5.00 |
| The presentation addressed my questions of concerns on this topic. | 5.00 | 4.75 | NR | 3.89 | 3.67 | 4.00 | 5.00 |

### Boston

Question: Please indicate 2 things that you learned from this breakout.

No Comments

Atmosphere: Good discussion by all participants.

### Chelsea, Lynn, Malden & Cambridge

Question: Please indicate 2 things that you learned from this breakout.

1. Frustration with insurance and drug testing.
2. Insurance/urines.

Atmosphere: Calmly worked through the cases as a group and wound up talking about drug testing and lack of residential treatment.

### Concord, Lowell, Lawrence & Ayer

Question: Please indicate 2 things that you learned from this breakout.

No Comments.

No breakout, all went to Robert Stutman afternoon session.

### Newton, Dedham, Framingham & Quincy

Question: Please indicate 2 things that you learned from this breakout.

1. A nice presentation/new knowledge.
2. Many different types of people work and are involved in the drug court.
3. Collaboration is key and abundant; defense attorneys make my hair hurt.
4. Actual drug court procedures. Varied components of the process.

Atmosphere: The courts grouped amongst themselves, splitting into teams that performed similar functions for discussion. While they agreed to disagree, every group admitted that they want to do what is in the best interest of participants.

### Dudley, Holyoke, Greenfield & Orange

Question: Please indicate 2 things that you learned from this breakout.

1. How the actual individual drug courts work.

Atmosphere: Welcoming

### Brockton, Plymouth & Barnstable

Question: Please indicate 2 things that you learned from this breakout.

1. New drug courts opening- interested in learning from others.
2. Helpful discussion.
3. Courts and programs can be beneficial.
4. Drug court concerns and needs from providers.

Atmosphere: Positive and collegial, but some participants may have been holding back.

### Juvenile Courts

Question: Please indicate 2 things that you learned from this breakout.

1. Fabulous session.

Atmosphere: Attentive and engaged.

## Appendix IV: Keynote Speaker Presentations

# Doing Change or Doing Time: Engaging People in Accountable Change

David Mee-Lee, M.D. Davis, CA
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October 2, 2014 Best Western Royal Plaza Hotel, Marlborough, MA

## A. Understanding Motivation and "Resistance"

### 1. From Pathology to Participant

- Resistance is often perceived as pathology within the person, rather than an interactive process; or even a phenomenon induced and produced by the clinician
- "Resistance" may be as much a problem with knowledge, skills and attitudes of clinicians as it is a "patient" problem

As a first step to moving from pathology to participant, consider our attitudes and values about resistance.

### 2. Changing the Concept of Resistance

(Miller, William R; Rollnick, Stephen (2013): "Motivational Interviewing - Helping People Change" Third Edition, New York, NY. Guilford Press.)

- In the Glossary on page 412: "Resistance – A term previously used in Motivational Interviewing, now deconstructed into its components: sustain talk and discord."

So if you start deleting "resistance" from your clinical vocabulary and focus on "sustain talk" and "discord," you are now in a better position to attract a person into recovery than responding to them as a resistant, non-compliant person in denial.

What is "sustain talk"?

- It is "the client's own motivations and verbalizations favoring the status quo." (p. 197). The person is not interested in changing anything; I am OK with keeping things the way they are – status quo, sustain what I have already got or where I already am.
- "There is nothing inherently pathological or oppositional about sustain talk. It is simply one side of the ambivalence. Listen to an ambivalent person and you are likely to hear both change talk and sustain talk intermingled." (p. 197). "Well maybe I have a drug problem and should do something about it if I don't want to be arrested again." (Change talk). "But it really isn't as bad as they say, they're just overacting." (Sustain talk).

What is "discord"?

- "If we subtract sustain talk from what we previously called resistance, what is left? The remainder …more resembles disagreement, not being "on the same wavelength," talking at cross-purposes, or a disturbance in the relationship. This phenomenon we decided to call discord." (p. 197).
- "You can experience discord, for example, when a client is arguing with you, interrupting you, ignoring, or discounting you." (p. 197).

"Sustain talk is about the target behavior or change" – drinking or drugging, over-eating, gambling etc. "Discord is about you or more precisely about your relationship with the client – signals of discord in your working alliance." – Are you on the same page as your client? Are you more interested in abstinence and recovery than they are? Are you doing more work than them about going to AA or taking medication?

## B. **Natural Change and Self-Change**

(DiClemente CC (2006): "Natural Change and the Troublesome Use of Substances – A Life-Course Perspective" in "Rethinking Substance Abuse: What the Science Shows, and What We Should Do about It" Ed. William R Miller and Kathleen M. Carroll. Guildford Press, New York, NY. pp 91; 95.)

The Transtheoretical Model (TTM) illuminates the process of natural recovery and the process of change involved in treatment-assisted change. But "treatment is an adjunct to self-change rather than the other way around." "The perspective that takes natural change seriously…shifts the focus from an overemphasis on interventions and treatments and gives increased emphasis to the individual substance abuser, his and her developmental status, his and her values and experiences, the nature of the substance abuse and its connection with associated problems, and his or her stage of change." (DiClemente, 2006)

### 1. What Works in Treatment - The Empirical Evidence

(a) Extra-therapeutic and/or Client Factors (87%)

(b) Treatment (13%):

- 60% due to "Alliance" (8%/13%)
- 30% due to "Allegiance" Factors (4%/13%)
- 8% due to model and technique (1%/13%)

(Wampold, B. (2001). *The Great Psychotherapy Debate*. New York: Lawrence Erlbaum.
Miller, S.D., Mee-Lee, D., & Plum, B. (2005). Making Treatment Count. In J. Lebow (ed.). *Handbook of Clinical Family Therapy. New York: Wiley).*

### 2. Definitions of Compliance and Adherence

Webster's Dictionary defines "**comply**" as follows: to act in accordance with another's wishes, or with rules and regulations. It defines "**adhere**": to cling, cleave (to be steadfast, hold fast), stick fast.

## C. **Assessing Readiness to Change**

* Transtheoretical Model of Change (Prochaska and DiClemente):

Pre-contemplation: not yet considering the possibility of change although others are aware of a problem; active resistance to change; seldom appear for treatment without coercion; could benefit from non-threatening information and information to raise awareness of a possible "problem" and possibilities for change.

Contemplation: ambivalent, undecided, vacillating between whether he/she really has a "problem" or needs to change; wants to change, but this desire exists simultaneously with resistance to it; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

Preparation: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

Action: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out and regression in readiness to change.

Maintenance: sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.

Relapse and Recycling: expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action; comprehensive, multidimensional assessment to explore all reasons for relapse.

Termination: this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

* Readiness to Change - not ready, unsure, ready, trying, (doing what works): Motivational interviewing (Miller and Rollnick)

## D. **Engaging the Client as Participant**

### Developing the Treatment Contract

| | **Client** | **Clinical Assessment** | **Treatment Plan** |
|---|---|---|---|
| What? | What does client want? | What does client need? | What is the Tx contract? |
| Why? | Why now?<br>What's the level of commitment? | Why? What reasons are revealed by the assessment data? | Is it linked to what client wants? |
| How? | How will s/he get there? | How will you get him/her to accept the plan? | Does client buy into the link? |
| Where? | Where will s/he do this? | Where is the appropriate setting for treatment?<br>What is indicated by the placement criteria? | Referral to level of care |
| When? | When will this happen?<br>How quickly?<br>How badly does s/he want it? | When? How soon?<br>What are realistic expectations?<br>What are milestones in the process? | What is the degree of urgency?<br>What is the process?<br>What are the expectations of the referral? |

## H. **The Coerced Client and Working with Referral Sources**

The mandated client can often present as hostile and resistant because they are at "action" for staying out of jail; keeping their driver's license; saving their job or marriage; or getting their children back. In working with referral agencies whether that be a judge, probation officer, child protective services, a spouse, employer or employee assistance professional, the goal is to use the leverage of the referral source to hold the client accountable to an assessment and follow through with the treatment plan.

Criminal justice professionals such as judges, probation and parole officers untrained in addiction and mental health run the risk of thinking that mental health and addiction issues can be addressed from a criminal justice model. They can see mandated treatment for addiction and mental health problems as a criminal justice intervention e.g., mandate the client to a particular level of care of addiction treatment for a fixed length of stay as if ordering an offender to jail for a jail term of three months.

Unfortunately, clinicians and programs often enable such criminal justice thinking by blurring the boundaries between "doing time" and "doing treatment". Clinicians say that they cannot provide individualized treatment since they have to comply with court orders for a particular program and level of care and length of stay. For everyone involved with mandated clients and think this way, the 3 C's are important:

**3 C's**

- Consequences – It is within criminal justice's mission to ensure that offenders take the consequences of their illegal behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the offender and the public is best served by providing treatment rather than punishment, then clinicians provide treatment not custody and incarceration. The obligation of clinicians is to ensure a person adheres to treatment; not to enforce consequences and compliance with court orders.

- Compliance – The offender is required to act in accordance with the court's orders; rules and regulations. Criminal justice personnel should expect compliance. But clinicians are providing treatment where the focus is not on compliance to court orders. The focus is on whether there is a disorder needing treatment; and if there is, the expectation is for adherence to treatment, not compliance with "doing time" in a treatment place.

- Control –The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public. While control is appropriate for the courts, clinicians and treatment programs are focused on collaborative treatment and attracting people into recovery. The only time clinicians are required to control a client is if they are in imminent danger of harm to self or others. Otherwise, as soon as that imminent danger is stabilized, treatment resumes collaboration and client empowerment, not consequences, compliance and control.

The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms of the law or the workplace to carry out mandates determined for reasons other than clinical.

Thus, working with referral sources and engaging the identified client into treatment involves all of the principles and concepts above to meet both the referral source and the client wherever they are at; to join them in a common purpose relevant to their particular needs and reason for presenting for care now at this point in time. The issues span the following:

- Common purpose and mission – public safety; safety for children; similar outcome goals
- Common language of assessment of stage of change – models of stages of change
- Consensus philosophy of addressing readiness to change – meeting clients where they are at; solution-focused; motivational enhancement
- Consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create incentives for change and provide supports to allow change
- Communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change ; keep our collective eyes on the prize "No one succeeds unless we all succeed!"

## Carl

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Marijuana Use Disorder, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms, but then he really doesn't think he has a problem and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister.

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but denies use. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

Yolanda, Carl's 24 y.o. sister, has custody of Carl following his mother's death from a car accident eighteen months ago. She is single, employed by the telephone company as a secretary, and has a three y.o. daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana and crack which Carl says he is holding for a friend.

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## DVD SET - "MOTIVATIONAL INTERVIEWING"

Motivational Interviewing authors, Miller, Moyers and Rollnick have developed a two-part DVD set. It provides descriptions and demonstrations of the new four-process method of Motivational Interviewing. Watch a video explaining what resources are now available from The Change Companies with the new edition of Motivational Interviewing just published.
http://www.changecompanies.net/motivational_interviewing.php
To order: The Change Companies at 888-889-8866. www.changecompanies.net.

## ELearning or DVD Set - "HELPING PEOPLE CHANGE"

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1. The Therapeutic Alliance – Pre-Test Questions and a discussion of answers; Enhancing Self-Change and Forging the Alliance - Disc 1 of a Five Part Series Workshop
2. Understanding and Assessing Stages of Change – Discussion of Compliance versus Adherence; Explanation of Stages of Change Models (12-Step model; Transtheoretical Model of Change; Miller and Rollnick) - Disc 2 of a Five Part Series Workshop
3. Motivational Interviewing and Ambivalence – Principles of Motivational Interviewing; Spirit of Motivational Interviewing; Working with Ambivalence - Disc 3 of a Five Part Series Workshop
4. Establishing the Treatment Contract; Role Play – What, Why, How, Where and When to establish the Treatment Contract; and a role play with a "17 year old young man" to illustrate this technique - Disc 4 of a Five Part Series Workshop
5. Stages of Change; Implications for Treatment Planning – Stage of Change and the Therapist's Tasks; discussion of Relapse Policies; Using Treatment Tracks to match Stage of Change; discussion of Mandated Clients and relationship to the criminal justice system - Disc 5 of a Five Part Series Workshop

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# America's Worst Drug Epidemic


Robert M. Stutman

# PRESENTED BY:

Robert M. Stutman
The Stutman Group

Former Special Agent in Charge,
U.S. Drug Enforcement Administration

# Do you know these drugs?

- OC'S
- ROXIE'S
- HUGGING
- PHARMING
- SALVIA
- K2/SPICE
- FRUIT SALAD
- BACKPACKING

# Two Drugs Have Changed Our Culture

- LSD
- Crack


# LEADING CAUSE OF DEATH BY ACCIDENT

- *For the first time in history, automobile accidents are the second leading cause of death by accident in the United States. The Centers for Disease Control announced that in 2010 (the most recent year for which we have statistics):*

- *THE LEADING CAUSE OF DEATH BY ACCIDENT WAS DRUG OVERDOSE (APPROXIMATELY 39,000 DIED)*

- *APPROXIMATELY 23,000 OF THOSE DEATHS CAUSED BY PHARMACEUTIAL DRUGS (ALMOST 60%)*

- *THE LEADING CAUSE OF DRUG OVERDOSE WAS **PHARMACEUTICAL DRUGS.***

# *IN OTHER WORDS…*

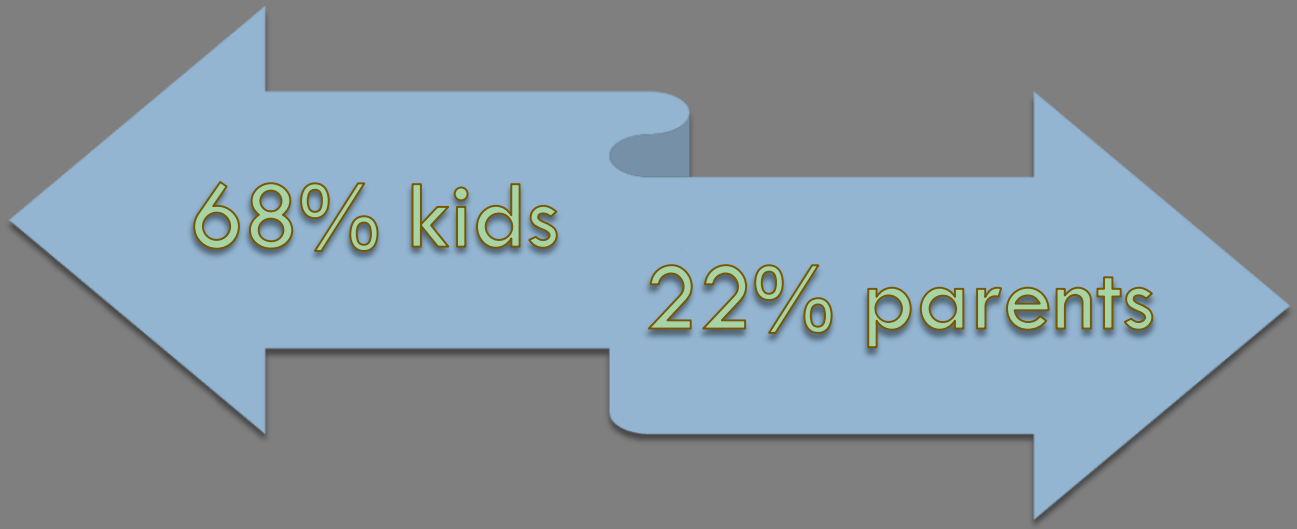
- *WE COULD COMPLETELY CLOSE THE BORDERS IN THE US*
- *WE COULD STOP ALL USE OF HEROIN, CRACK, METH & COCAINE.*
- *YET – WE WOULD ONLY DECREASE DRUG OVERDOSES BY 40%*

# *WE HAVE A HUGE NATIONAL DEBATE OVER GUN VIOLENCE IN THE UNITED STATES – AS WE SHOULD!*

- *On average, 87 people die every day due to gun violence in the United States – one person every 17 minutes.*
- *On average, 100 people die from drug overdose every day in the United States – approximately one person every 19 minutes.*
  - *Where is the uproar over this? At the very least, where is the national conversation?*

# Columbia University Drug Study

- 68% of *high school graduates* said that drugs played a major role in their lives.
- 22% of *parents* said that drugs played a major role in their children's lives.



# 71% of high school students describe their school as drug infested.

Imagine if that was ASBESTOS.



# What's happening in college?

50% of college students binge drink (approximately 6 drinks in two hours) and/or abuse drugs monthly.

# 50 %

They don't just get drunk every month, they get drunk and/or use drugs.

# College Headline

- 23% of all college students would be diagnosed as fully alcohol or drug dependent.
- This is 3x the national average.

# What are the practical effects of college binge drinking and drug use?

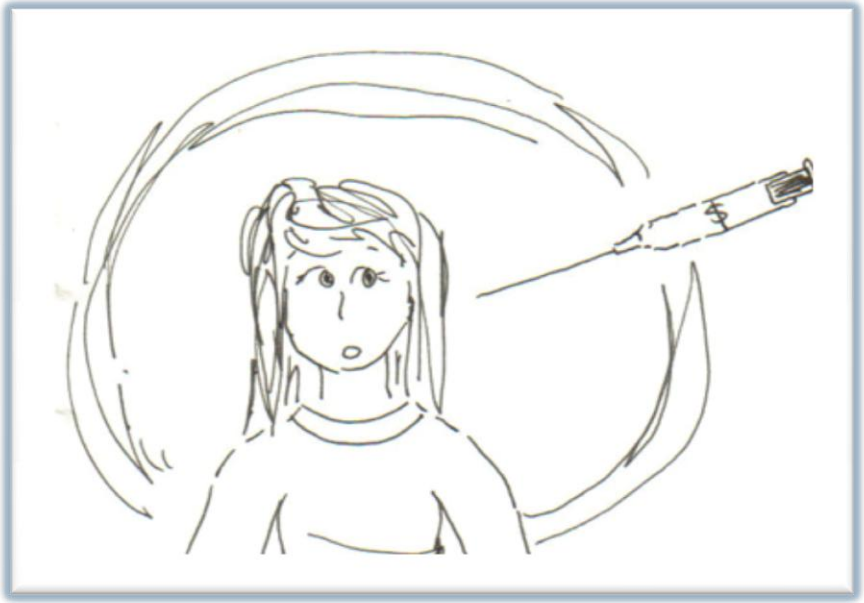
# We all remember Virginia Tech

- Approximately 32 students killed in one day
- On average 2600 students are injured daily on college campuses because of the effects of alcohol/drugs.
- 1,644 female college students are sexually assaulted daily primarily due to the effects of alcohol/drugs.
- 5-6 college students die daily on college campuses due to the effects of alcohol/drugs.

# ARE WE WINNING THE DRUG WAR?

# Between 1992-2007

- Overall drug use has declined by more than 5%
- The number of drug overdoses has *quadrupled*



The number of drug addicts have doubled

19 million drug addicts are age 12 and over.

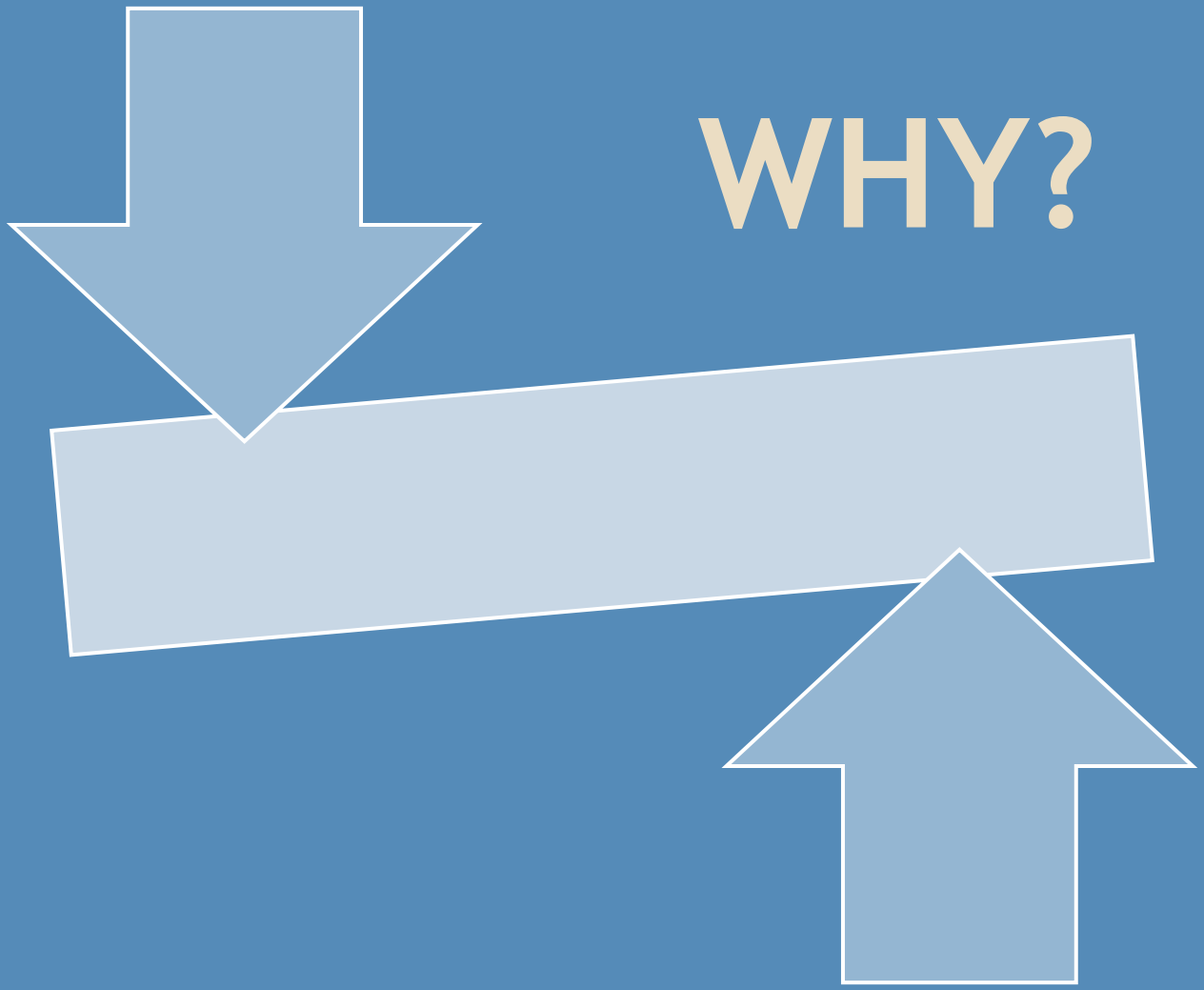
# Understand The Importance Of Those Figures. The Paradigm Has Changed

The paradigm used to be:

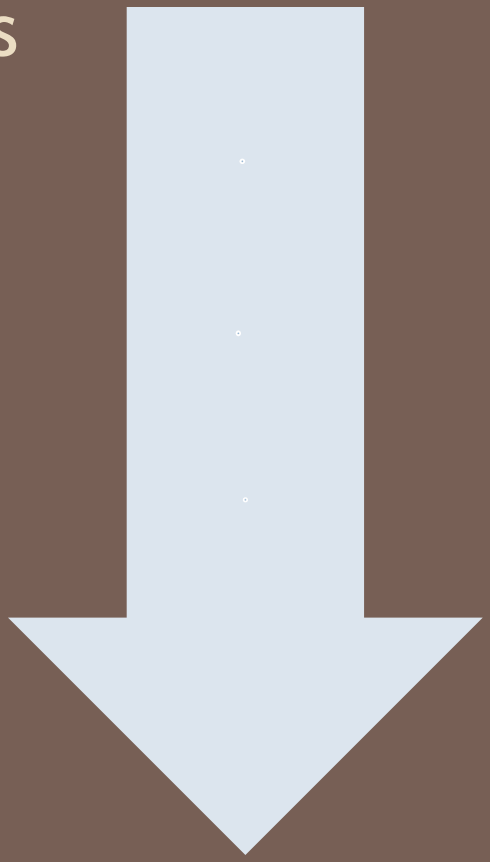
- *Drug Use Goes Up --- Drug Addiction Goes Up*
- *Drug Use Goes Down – Drug Addiction Goes Down*

***That is no longer the case…***

# WHY?



**1968:**
16 years of age.



**2007:**
12.5 years of age.

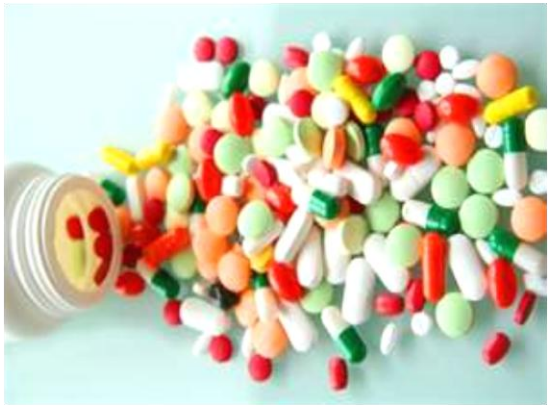
# Age of first use.

# AT RISK

- At What Grade Are Children Most At Risk for First Trying Recreational Alcohol?


# TODAY'S DRUGS

- When we did drugs like Grass, PCP, DMT, Mescaline….
  - ALMOST NO ONE DIED
- TODAY – THERE IS NO ROOM FOR ERROR!



# Old Drugs

# Alcohol

- 12% of adult regular drinkers are alcoholics
- 26% of teen regular drinkers are alcoholics
- 40% of young adults who start drinking at age 15 or below will become alcoholics in their adult lives

# Cocaine/Methamphetamines

- Extremely addicting.
- Cocaine and methamphetamines are now internally, essentially, the same drug. Extremely addicting.

# Heroin

A white suburban adolescent drug of choice.


# Why is heroin a white suburban drug of choice?

- The purity of heroin has gone from an average of 5% to 50% purity in the United States within the past ten years.
- This means that almost no new users ever touch a needle; users smoke or snort the drug.

# HEROIN

- We are becoming a heroin abusing society again…
- Gee – what a shock!!!

# HEROIN

- **We don't have a new heroin problem, we have an opioid problem that morphed into a heroin problem.**
- **The majority of new heroin users started with pharmaceutical opioids which they got for free or inexpensively from friends or medicine chests.**
- **When they had to pay for opioids on the street, they found that heroin is 60% cheaper.**


YR 2000: AFGHANISTAN = 4%

YR 2011: AFGHANISTAN = ***95%***

# MARIHUANA

Should we legalize marijuana?

- Medical
- Recreational

We have had peer review studies for a period of time indicating that long-term use of marijuana effects the brain.

# MARIHUANA

- HOWEVER,
- in an important new study…
- It appears that even ***occasional*** marijuana use effects the brain.
- The Journal of Neuroscience

http://www.drugfree.org/join-together/drugs/occasional-marijuana-use-may-change-structure-of-young-peoples-brains-study?utm_source=Join%20Together%20Daily&utm_campaign=e339a2eae0-JT_Daily_News_Is_Google

# MARIHUANA

The marihuana our kids are smoking today is not your mother's grass.

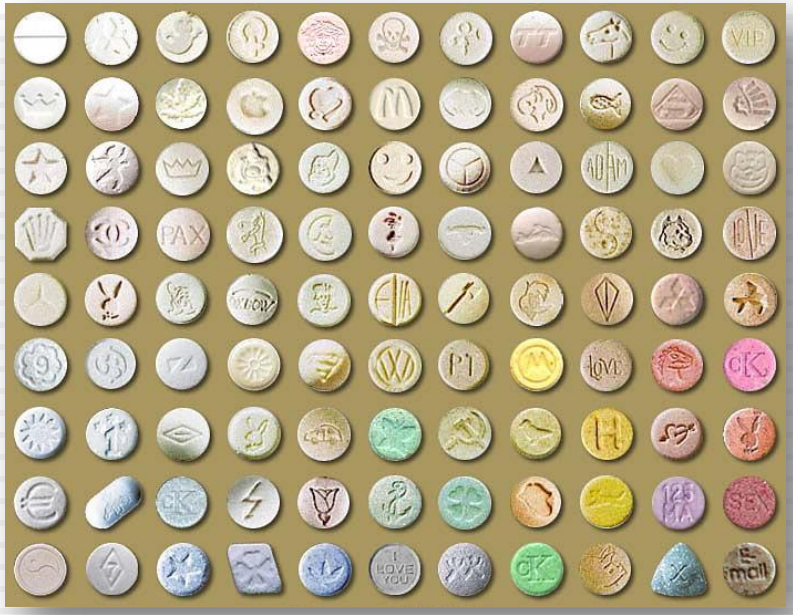
# New Drugs

# Salvia

- Salvia divornum first cousin of “purple sage”.
- Legal and an extremely strong and short acting hallucinogen.

# ECSTASY

- Short and long-term effects.



# Effects of Ecstasy

- Short term:
- "Everybody loves everybody"
- Serotonin levels in the brain rise significantly
- Rise in body temperature

- Long term:
- Night terrors
- Significant short and long term memory deprivation
- In a study published in 2011, it was proven that ecstasy destroys brain cells in the area that controls memory (hippocampus). In other words, in mimics Alzheimer's disease in adolescence.

# KETAMINE

- Special K
- Dissociative high
- Near death experience

# STATISTICS

- *For the first time ever non heroin opiate addiction surpassed heroin or cocaine as the leading cause of drug treatment admission in the U.S.*

  *Cesar Fax July 30, 2012 Vol. 21, Issue 30*

- *ER reports from Prescription drugs doubled in 5 years to average 101,000 per month, 50,000 from opioids stable for illicit drugs.*

  *Cesar Fax July 23, 2012*

- *One person dies every 19 minutes from prescription drug abuse in the United States according to Centers for Disease Control and Prevention*

# The Two Most Widely Abused Prescription Drugs

## ADDERALL


## RITALIN

# WHY?

*BECAUSE THEY ARE PHARMACEUTICAL GRADE COCAINE OR METHAMPHETAMINE*



There are as many new users of prescription drugs as there are of marihuana ages 12-17 years.


# PRESCRIPTION DRUGS

# OPIOIDS ARE *DIFFERENT*

- Kids never swallow *Extended-Release Opioids* in pill form
- They *Parachute*
- Meaning they crush and snort or swallow crushed opioid pills in a tissue


# EXTENDED-RELEASE OPIOIDS

- Instead of being introduced into the system over 8 hours
- It gets introduced into the system in **8 SECONDS**
  - HITS THEM LIKE A FREIGHT TRAIN!

When I ask kids why they use extended release opioids.

"IT CAME FROM A DOCTOR – IT'S SAFE"

# CAN YOU PICK OUT AN EXTENDED RELEASE OPIOID DRUG ADDICT?

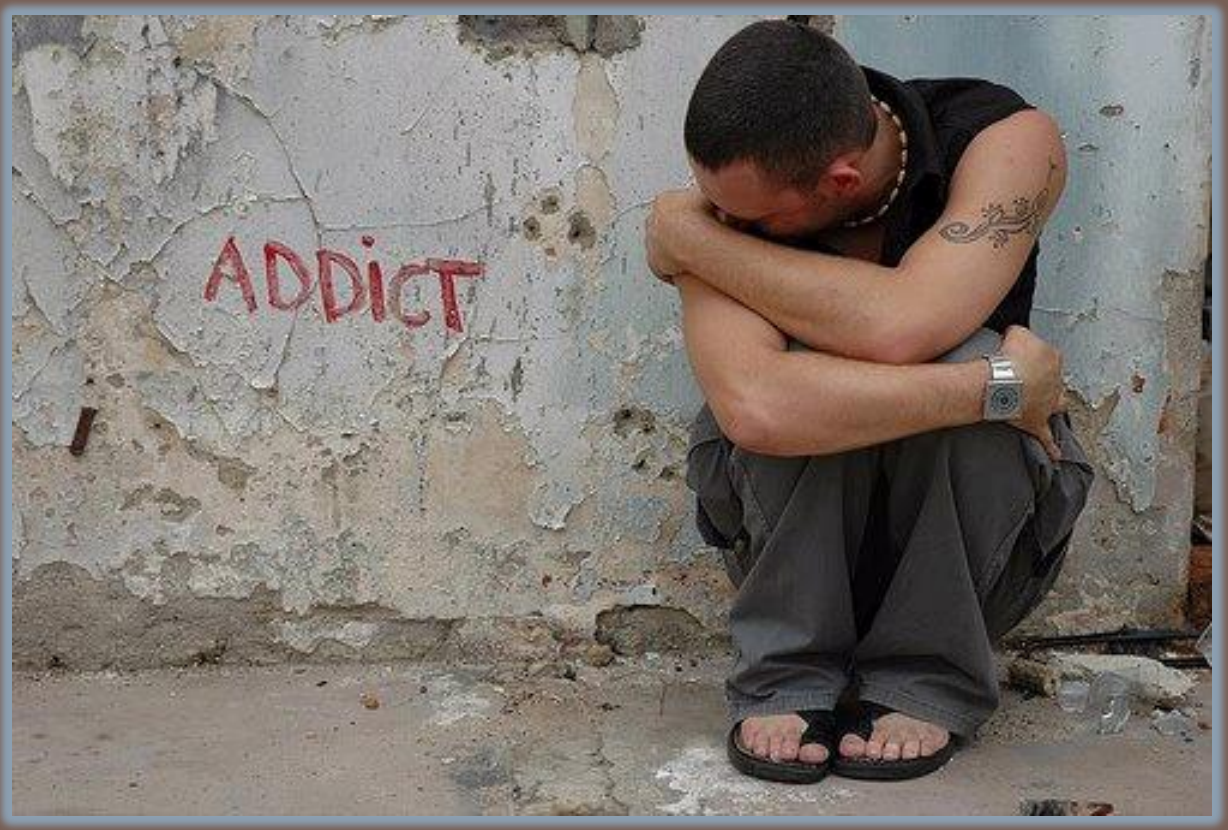
After 40 years of experience I can pick out a heroin addict, cocaine addict and regular marijuana user, but I cannot pick out an extended release opioid drug addict. For those of you who think you can, think again….

RUSH LIMBAUGH

# Extended Release Opioids

- The Killer Drug in the United States
- "It's Like Being Held in My Mother's Arms"
  -high school student

The Picture of Extended Release Opioids in the New Millennium




# WHO ARE THE DRUG ADDICTS IN THE UNITED STATES?

# ETHNICITY

- Can you identify a drug addict by the color of his or her skin?
- Yes. The majority are white.

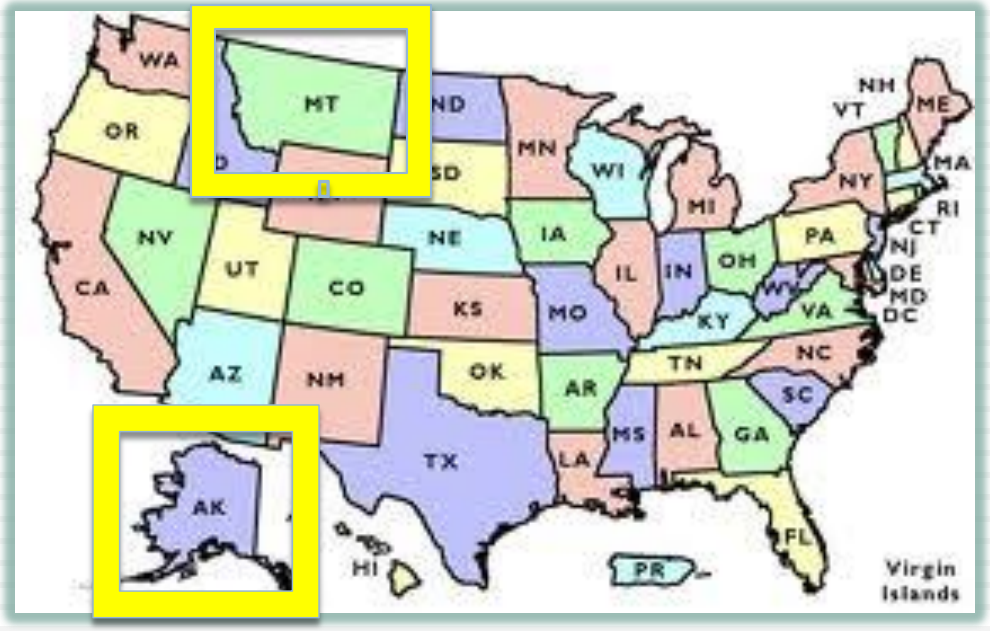
# NEW STUDY

- In the past year, a major study has proven that per capita, more white high school students abuse drugs than African American or Latino students.

  *Archives of General Psychiatry*

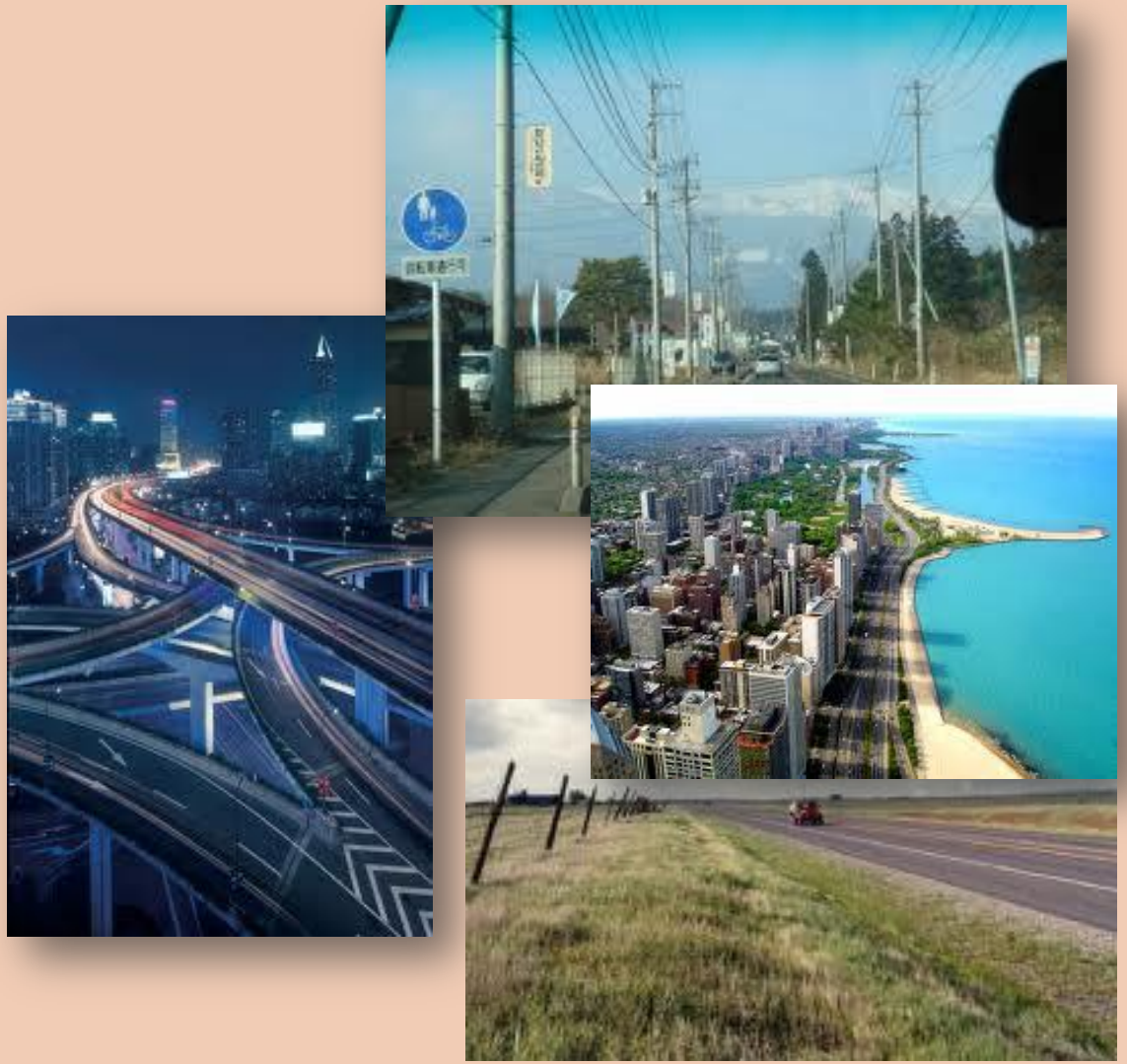
- Is that what you thought?

# geography




- states with highest rates of addiction

# geography



Urban vs suburban/rural high schools

# PRIVATE SCHOOLS VS. PUBLIC SCHOOLS

- High school athletics

- INTELLIGENCE/NOT MY KID

# JOHN JUNG

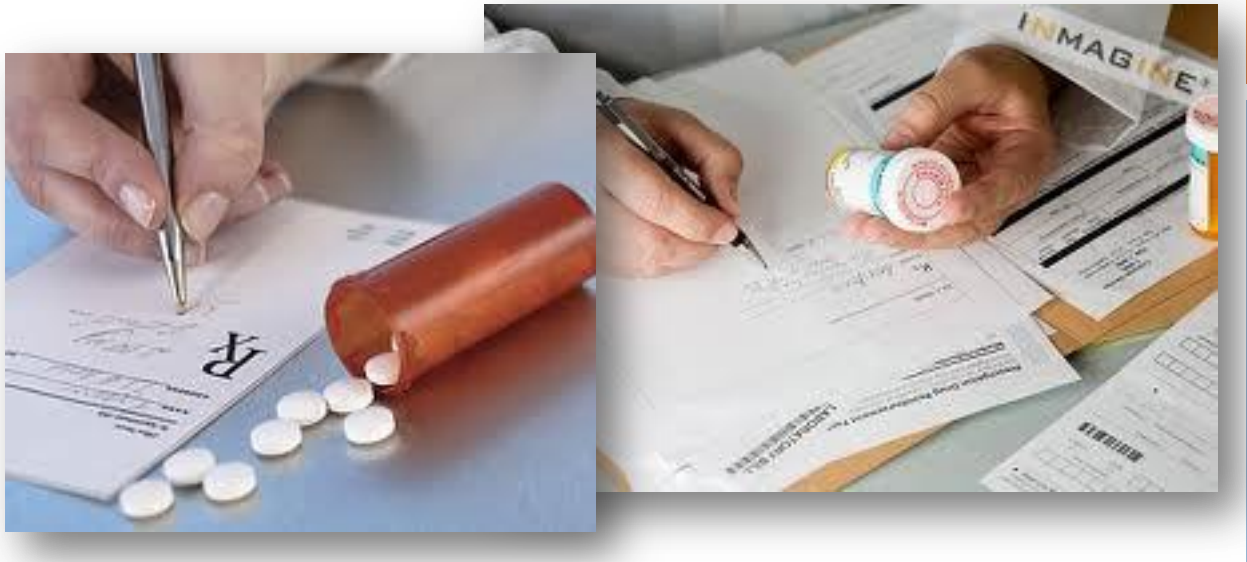
- No. 5 in his class at University of Wisconsin
- M.D. graduate of U-Penn in May 2006 – Top 10% of class
- MBA from Wharton in May 2006
- August 26, 2006 died from adverse effects of cocaine

HTTP://WWW.DRUGFREE.ORG/MEMORIALS/JOHN_JUNG#
HTTP://WWW.JOHNWJUNGMEMORIAL.ORG/

# Prescription Drugs

- Heavy opioid abusers get almost 40% of their drugs directly from a physician.
- Occasional opioid abusers get the majority of their drugs from medicine chests or their friends.

# PRESCRIPTION DRUGS



Physicians in the United States prescribe more opioids per capita than any other country in the world.

The number two country is Denmark, and they prescribe 50% of what we prescribe.
The National Center on Addiction and Substance Abuse
At Columbia University (CASA)

# For Every Doctor Visit in the U.S. …

Approximately 20% result in a prescription for opioids.

*Archives of Internal Medicine*

# Journal of the American Medical Association

- A recent JAMA publication found *hydrocodone* to be the drug of choice for *9th graders* experimenting with drugs-over marijuana.
- Allen Burton, MD. Dr. Burton is the Chair, Department of Pain Medicine, at MD Anderson Cancer Center, Texas

# Prescription Drugs

Best estimate, on average in the United States, a traumatic pain patient uses about *6* opioids tablets that are prescribed to them.

The average prescription for opioids in the United States is *60* pills.

Internal Department of Justice, Study for Federal Prosecution

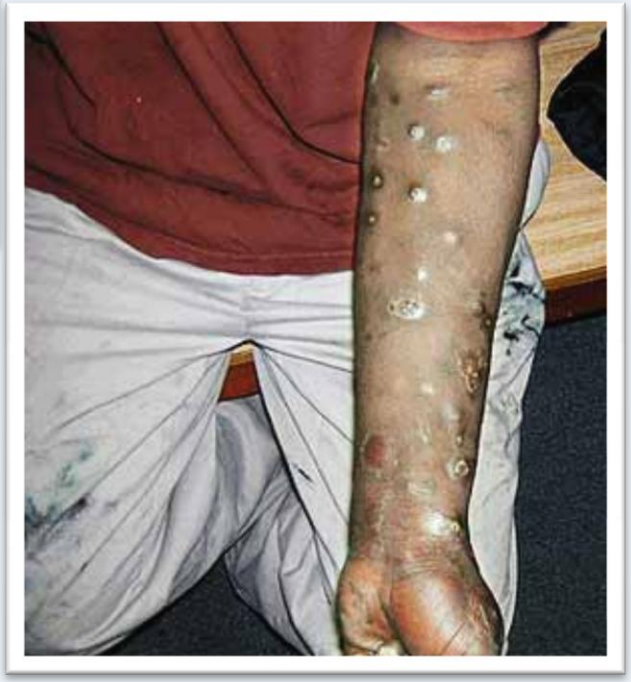
**“The data supporting long-term use of opiates for pain, other than cancer pain, is scant to nonexistent.**

**These are dangerous drugs.**

**They’re not proven to have long-term benefit for non-cancer pain, and they’re being used to the detriment to hundreds of thousands of people in this country.”**

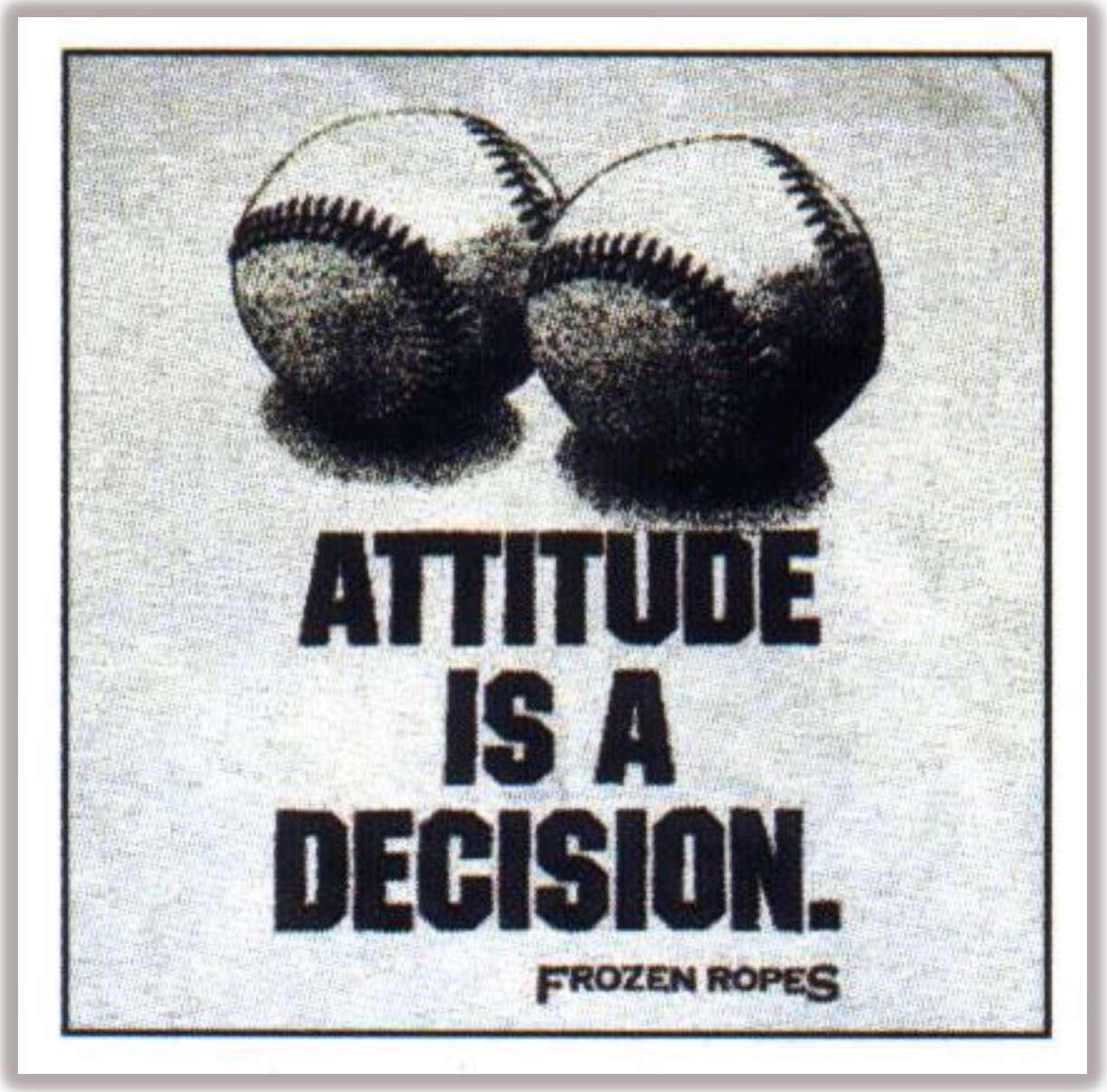
Dr. Tom Frieden, Director of the Centers for Disease Control

# Availability



# absence of immediate harmful effects

# ATTITUDE

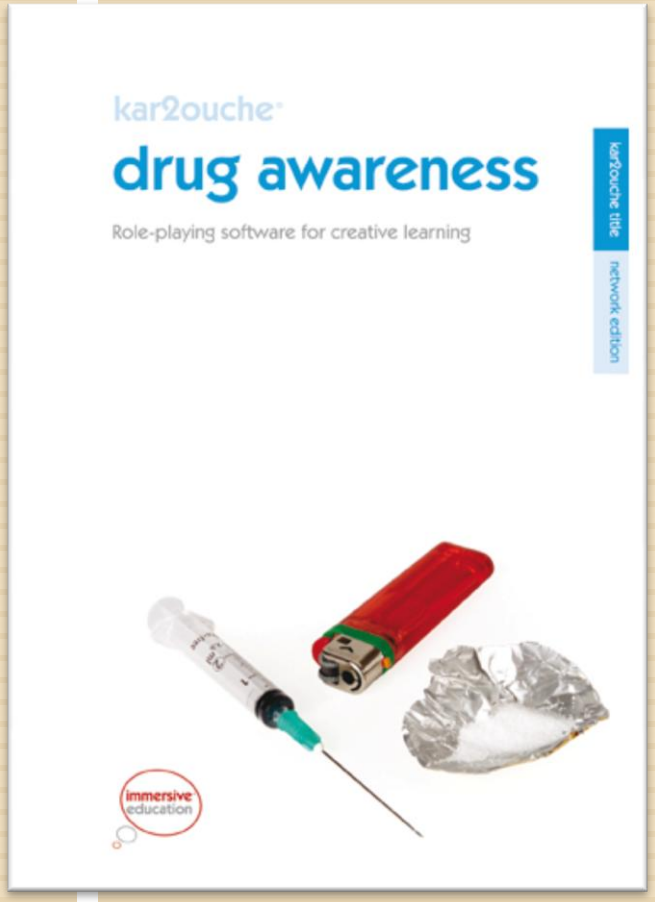


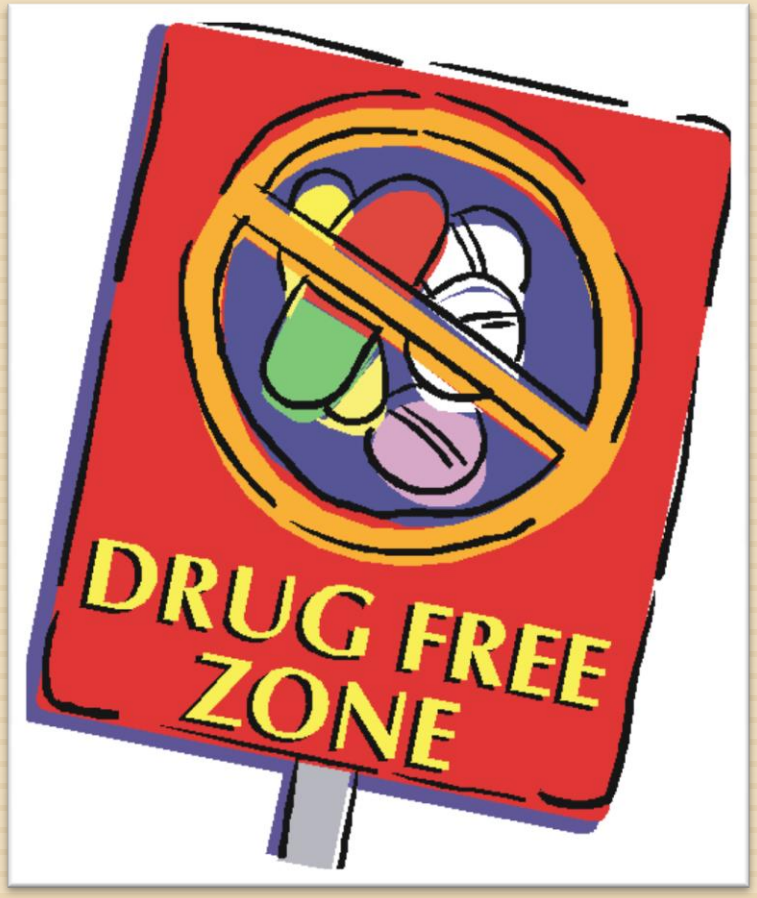
# WHAT CAN WE DO?

# We must be honest with our kids…




"I love you. I know you love me. The only thing you ever told me about drugs is that they would kill me if I did them. I did, and they didn't so I never believed anything you said after that."




School systems must institute scientifically validated school education programs.

- There is a well known drug education program that has been studied in 19 major peer review scientific journals…

- 18 of the 19 said that the program was of no long term use or worthless…

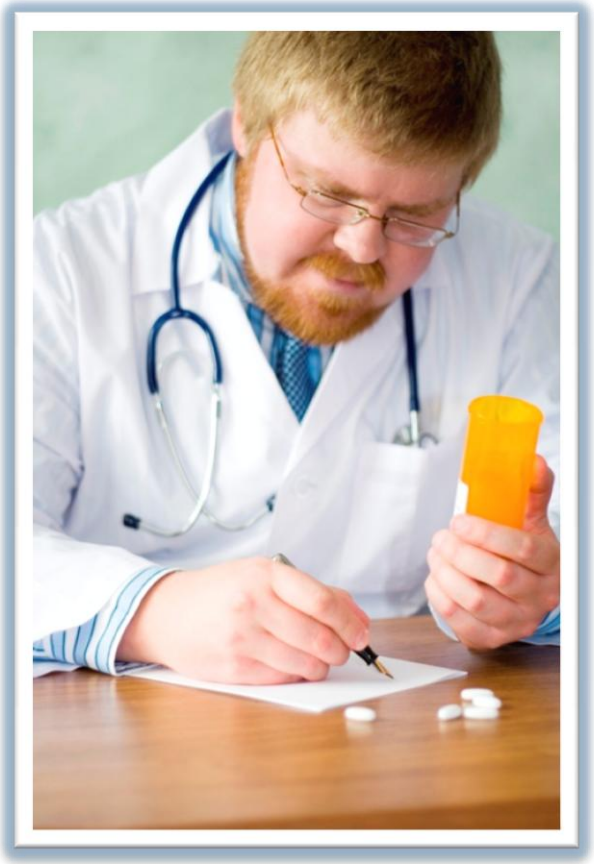
- The US Department of Education notified every school system in the US that the program had no long term value.

# That program is DARE.



Clergy - often the first line of defense for families must be trained in how to deal with this issue.

# Physicians must be better trained and understand what their opioid prescriptions may be doing to their community.



- We must stop using jails as warehouses.
- It will not work.
- In the past 15 years the number of arrests for drugs has gone up by 100% and drug addiction has gone up by 100%.
- Does this sound like a rational program?


# THE CRIMINAL JUSTICE SYSTEM

# THREE MOST ACCURATE PREDICTORS OF SUBSTANCE ABUSE AMONGST CHILDREN.

- Age of first use.
- The gateway drug…

  **tobacco**
- The most important predictor of substance abuse:
- The higher the number the better.
- The maximum number seven.
- **The number of times a week you have dinner with your children.**

# WHY I DO THIS.


Kenny

# 2 OVERDOSES IN 1986

The most moving presentation I've ever heard about drugs in America was six sentences long, less than a year ago.

The following are the six sentences…

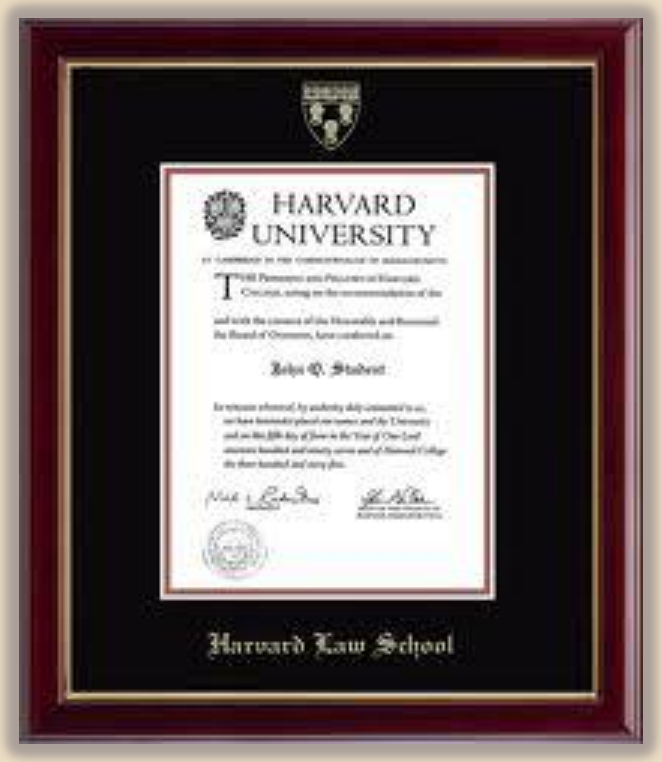
"My name is Holly Hennesy and I live in Palm Beach, Florida.

# Sentence #1:

# "This is my son Jason when he graduated Brown university in 2001"

## Sentence #2:

# "THIS IS MY SON'S HARVARD LAW DEGREE IN 2005"




## SENTENCE #3:

# "This is my son's MBA from the University of Chicago in 2008"


## Sentence #4:

# "This is my son Jason's drug of choice in 2009"


## Sentence #5:

# "This is my son Jason in 2011 thanks to OxyContin"

# If you want to learn more about substance abuse in the United States:

- go to www.thestutmangroup.com and click on the "links" section
- read "How to Raise a Drug-Free Kid" by Joseph Califano Jr.
- read *High Society* by Joseph Califano Jr.
- see the most accurate film on drugs; Traffic with Michael Douglas and Catherine Zeta-Jones