2015

Drug Treatment Court: The Power of Understanding Addiction

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FAMILY MEDICINE PROJECT

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Problem Identification

- The Drug Treatment Court in Burlington is one of about 3000 drug treatment courts nationwide. They were developed as an "alternate sentencing court", a method of restorative justice that would allow people who had multiple criminal charges related to substance abuse to overcome their addiction, have their criminal charges dismissed, and pursue a fuller life. This is provided as an alternative to strict punishment without treatment of addiction which often results in a revolving door between drugs and prison.
- The program consists of 3 phases lasting 9-18 months with twice weekly urine drug screens throughout. Successful graduates from the program would have at least 8 months worth of urine-proven abstinence, no criminal activity, and following a well-developed plan for employment or educational pursuits.
- As part of this program, many participants attend an Intensive Outpatient Program (IOP) taught by Bob Wolford, the Coordinator for Criminal Justice Programs at Howard Center. Bob noted that understanding the science behind addiction can be very empowering to people struggling with addiction and that is what inspired this project.

Public Health Considerations

- "In 2007-2008, Vermont ranked first among all states in several drug-use categories among persons age 12-17: past-month illicit drug use; past-year marijuana use; and past-month marijuana use. Vermont also ranked first in the Nation for past-year cocaine use among young adults age 18-25." Source: National Survey on Drug Use and Health (NSDUH), 2007-2008.
- "Approximately 12 percent of Vermont residents reported past-month use of illegal drugs; the national average was 8 percent. The rate of drug-induced deaths in Vermont is below the national average." Source: National Survey on Drug Use and Health (NSDUH), 2007-2008.
- "Opiates, including prescription drugs, are the most commonly cited drugs among primary drug treatment admissions in Vermont." Source: National Survey on Drug Use and Health (NSDUH), 2007-2008.
- Substance abuse in Vermont is a public health crisis and the connection between substance abuse and criminal activity to support the addiction is well established. From a public health perspective, this court is exactly the sort of initiative we should be advocating for. Instead of punishing the criminal manifestations of disease (addiction), we should be treating the root cause. This is not only better for the individual in providing them the tools to successfully overcome their addiction, but it results in less crime, less incarceration, and increased public safety.

Community Perspective

- Bob Wolford LICSW is Coordinator of Criminal Justice Programs at Howard Center and was my mentor for this project. Here are some highlights from my interview with him:

Q: If drug courts are so effective, why aren't they more popular?

Bob: "Not everyone uses the same lens to look at addiction, and that is where the problem lies. Lots of people still view addiction as a lifestyle choice instead of as a disease."

Q: Running this sort of a court is expensive. Do you think its realistic to spread this model?

Bob: "On average, it costs 42k/year to incarcerate a man in Vermont, about 70k/year to incarcerate a woman. It costs 65k/year to hire a case worker, including benefits package. That case worker could provide services for 20-22 people, saving hundreds of thousands in prison costs."

Q: What is something you think the drug treatment court could do better?

Bob: "Based on my experience, sometimes I think that we're not patient enough. Most courts try to get people through within 18 months, 24 months at the most. I'm not sure that's enough time for some people. We don't have enough Medication Assisted Treatment available and that is a big hurdle as well."

Community Perspective

- I also interviewed one of the participants in the program who preferred to remain anonymous. Here are the highlights from my interview with her:

Q: Tell me about your story, what lead you to participate in this program?

A: "About 10 years ago, I slipped in the bathtub and broke my tailbone. My doctor prescribed me some Percocet and Vicodin for the pain and gave me enough refills to last 5 months. While I was taking the medicines, I didn't think anything was wrong; my pain was gone and I felt good. But when the refills ran out, I started to feel really sick. That was the first time I felt something might be wrong. I worked as a pharmacy tech and eventually I was stealing medications to try to make myself feel better. I got in trouble at work and things really started to go down hill."

Q: Did your doctor ever discuss the risk of addiction when they prescribed the medications?

A: "No. I don't think that's something they did back then. Now I know that was way too much pain medications for me and that I was actually getting high off it and not just relieving the pain. But that was my first experience with a narcotic, I thought that was normal."

Q: Do you think it would have helped if your doctor discussed that with you?

A: "I'm not sure, that's really hard to say. I think it might have. Maybe I would have seen the warning signs earlier or found help earlier."

Intervention and Methodology

- After much discussion with Bob Wolford, we decided that the most effective intervention that I would be able to provide would be an educational session during his Intensive Outpatient Program(IOP).
- The IOP consists of three weekly sessions of three hours each.
- The goal of the IOP is to help participants develop the skills needed for long-term success in their rehabilitation.
- We decided that the topic of my presentation would be the neurophysiology of opioid dependence and withdrawal.
- I delivered my presentation on 11/18/2015 and structured it as an interactive "chalk talk". Participants were encouraged to share their own insights into how these substances affected them. The presentation was about 45 minutes long and was attended by 10 people.

Results/Feedback

- I collected feedback verbally after the presentation. Here were some recurring comments:
- "Understanding the science behind [opioids] is really empowering!" This was the most repeated feedback, shared by multiple participants.
- Several participants shared strong sentiments about physicians:

"They're happy to prescribe you pain meds but when you develop an addiction because they prescribed you too much, they want nothing to do with you?!"

"I definitely didn't feel comfortable talking to my doctor about my addiction."

- In response to my saying that withdrawal symptoms typically last two weeks or less and methadone withdrawal being longer but not as severe as heroin withdrawal, several strong sentiments were shared:

"The book is wrong. Withdrawal lasts much longer than two weeks and withdrawing from Methadone or Buprenorphine is just as bad as withdrawing from heroin. When I stopped Buprenorphine I had physical symptoms of withdrawal for at least a month!"

"Of course they have to say withdrawing from Methadone is not as bad – they prescribe it!"

Evaluation of effectiveness and limitations

- Judging by the feedback I received, the presentation appears to have been effective in explaining the basic neurophysiology behind opioid dependence and withdrawal. Of course my ability to evaluate that is limited by the fact that people may not have wanted to share more negative feedback with me directly.
- The presentation was also effective in helping me develop an understanding of addiction and withdrawal that is informed by real people and real experiences, not just medical articles. When participants who had actually experienced addiction and withdrawal disagreed with what I had read, it made me think more deeply and more critically about the things I had learned.
- One limitation of the project is that I am simply not an expert in these topics and only did my best in trying to read and prepare for this presentation. Perhaps a presentation by a specialist with deeper knowledge and experience would be more effective.
- Since the participants in the IOP are constantly rotating, it would be effective to repeat this type of presentation every 6 months or so to the new cohort.

Recommendations for future interventions/projects

- A quantitative study of the number of "defendants" who are eligible for Drug Treatment Court, the number that actually enroll, the number who complete the program and what those people go on to do would be very powerful. Such a study could really help put some numbers on the good that this program does.
- A presentation on preventative health as related to substance abuse would be really helpful. This could cover topics from HIV and Endocarditis to Cirrhosis and Megaloblastic Anemia.
- A survey of the attitude of judges and lawyers towards the Drug Treatment Program would also be valuable. Several of the participants in this program, particularly the Judge, mentioned that many in the criminal justice community view the program with hostility or disdain and this has been a barrier to growing the program. Perhaps a survey of lawyers and judges could help explain the source of these feelings and how to best address them.

References

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- Loimer N, Hoffmann P, Chaudhry H. Ultrashort noninvasive opiate detoxification. Am J Psychiatry 1993; 150:839
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Interview Consent Form

- **Thank you for agreeing to be interviewed. This project is a requirement for the Family Medicine clerkship. It will be stored on the Dana Library ScholarWorks website. Your name will be attached to your interview and you may be cited directly or indirectly in subsequent unpublished or published work. The interviewer affirms that he/she has explained the nature and purpose of this project. The interviewee affirms that he/she has consented to this interview. Yes __X__ / No _____**

Bob Wolford, LICSW explicitly agreed to be named and included in this project. The second interviewee chose to remain anonymous and was mentioned as such in the slide where her interview was discussed.