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Proceedings developed through:
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June 9, 1999

"Every judge in the Commonwealth should attempt to identify and appropriately respond to the indication of substance abuse by any party appearing before him or her in a court of the commonwealth, where substance abuse is a factor in behavior related to the case. At every stage of the adjudicatory process, courts should provide access to substance abuse information and to referrals for screening, assessment, and treatment for substance abuse."

Supreme Judicial Court Policy Statement
(Adopted March 30, 1995)

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Brown University, Center for Alcohol and Addiction Studies

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APPENDIX

List of Presenters, Facilitators & Participants

Conference Agenda

Agenda

8:30 am	Registration
9:00 am	Welcome and Introduction
9:30 am	Patrice Muchowski, Sc.D. ***Introduction to Substance Abuse***
10:30 am	Break
10:45 am	Workshops—Session I **Workshops 1-8 will be offered during Session I and II. Workshops 9 and 10 will be offered one time only.*
11:45 am	Workshops—Session II
12:45 pm	Lunch (provided)
1:30 pm	Wayne A. Gavryck, M.D. ***Chemical Dependency Treatment: What Should We Expect?***
2:00 pm	Break-Out Sessions *Participants will consider their role in resolving substance abuse issues for individuals and families who appear in court; what responsibility and options they have to address substance abuse when they recognize it; and what they can do differently in their jobs.*
3:15 pm	Break
3:30 pm	Plenary: Break-out reports and Next Steps
4:15 pm	Evaluations and Closing

General Conference Objectives

- To raise awareness regarding the changing approach to substance abuse within the Franklin County court system.
- To familiarize court staff with the issues of substance abuse.
- To encourage participants to understand their role in their everyday work lives in responding to individuals dealing with substance abuse.
- To provide an opportunity for communication, coordination, and collaboration among professionals, in an effort to provide effective substance abuse services to individuals and families appearing before Franklin County courts, in accordance with the Supreme Judicial Court's Policy Statement on Substance Abuse.

PLENARY PRESENTATIONS

Can We Make a Difference?

Presented by:
Patrice M. Muchowski, Sc.D.
Vice President of Clinical Services
AdCare Hospital of Worcester, Inc.

Popular support for drug treatment has diminished. The war on drugs has become a war on the drug user. Significant stereotypes remain which impede alcohol and drug abusing persons from getting the help they need, and, which can work.

Alcohol and drug dependence are bio-behavioral diseases which are often progressive and may even prove to be fatal. These diseases are characterized by impaired control over the use of substances, preoccupation with them, continued use in spite of negative consequences, and thinking distortions most notably: denial.

There are a number of myths about substance abuse. These myths are held by abusers, family members, healthcare providers and society at large. These myths need to be identified and corrected, since myths can promote behaviors which can exacerbate the problem.

Substance abuse treatment is a healthcare specialization. The core components of this treatment can be used to assist the appropriate personnel in making referrals to systems or persons providing effective treatment.

Mandated treatment has a critical role to play and those with leverage to prompt treatment are encouraged to do so. Treatment is available, treatment works, and each of us can make a difference.

Chemical Dependency Treatment: What Should We Expect?

Presented by:
Wayne A. Gavryck, MD
Connecticut River Internists
Advisor, Franklin County Drug Court

The objectives of this presentation were to review current treatment modalities in chemical dependency, discuss the clinical factors that may be important considerations affecting outcomes, and understand what reasonable outcomes we can expect.

1. Addiction as a **chronic** disease vs. being an acute condition
   - Detoxification alone is not treatment.
   - Addicting drugs produce changes in brain pathways that endure long after the person stops taking them.
   - These protracted brain changes produce personal and social difficulties that do not go away after detoxification or even after rehabilitation.
   - Treatment of addiction should be regarded as being long-term, and a "cure" is unlikely.
   - Addictive diseases are often viewed as being self-inflicted and the use of valuable resources for treatment is not viewed with sympathy.
   - In fact addiction has many components that are involuntary, such as:
     - ⇒ heredity
     - ⇒ external factors (family values, peer pressure, price, and availability)
   - After repetitive voluntary drug-taking, the drug user loses the voluntary ability to control its use. The person than becomes addicted to the drug and there is compulsive use; an overwhelming involuntary craving for the drug that perpetuates its use.
   - The transition for drug user to drug addict has been shown in animal experiments to be associated with changes in many of the known brain messengers.
   - Drug addiction is not unlike many other chronic medical illnesses such as diabetes, hypertension and asthma. A "cure" from these illnesses is generally not an expectation. Rates of remission from these illnesses are similar to the rates from diseases of addiction.

2. Goals of treatment

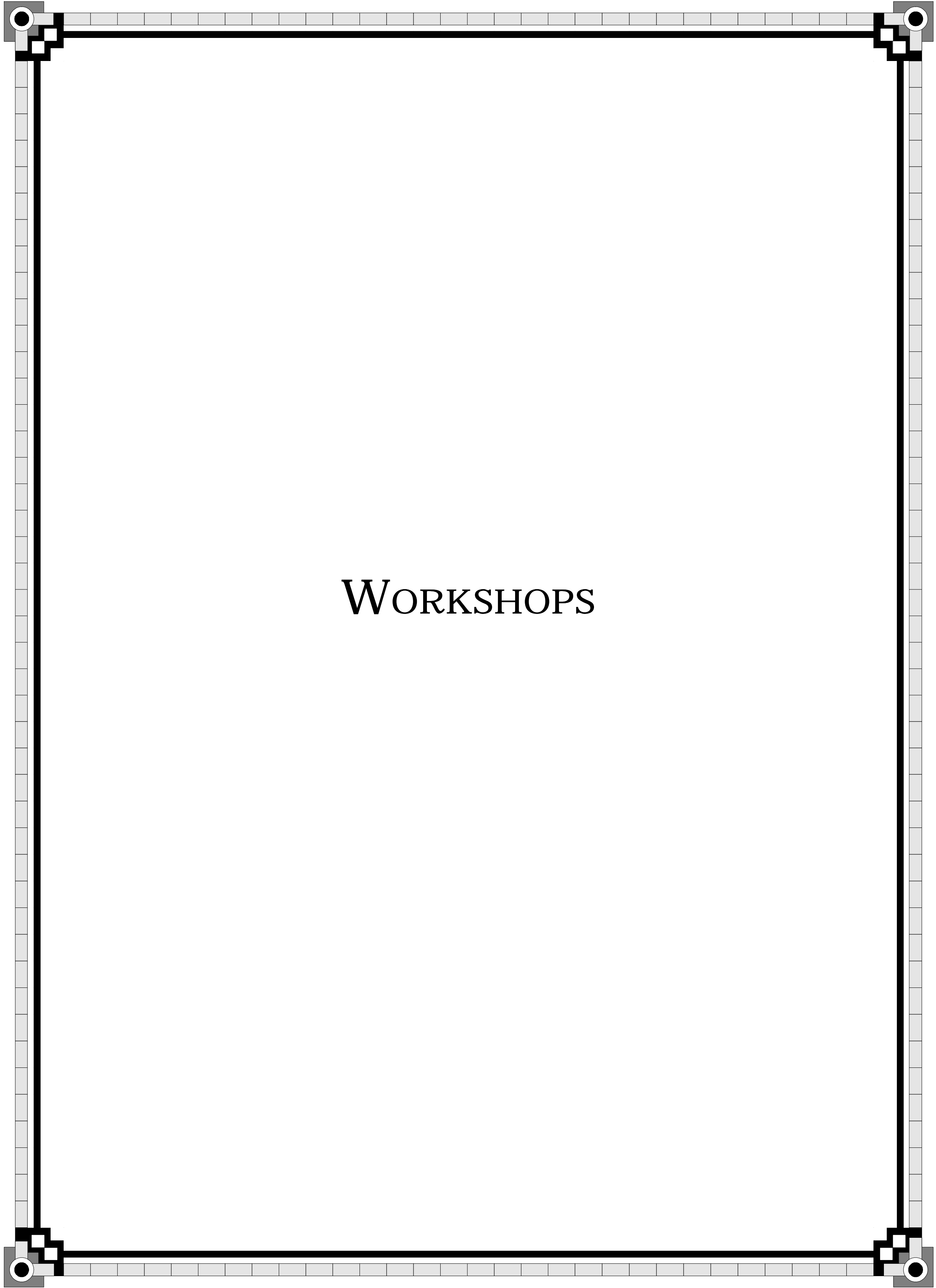
   The goal of contemporary addiction treatment is to provide appropriate initial placement of patients into services of appropriate intensity and to move them from one level of care to another over time, all the while respecting the chronic relapsing and remitting nature of addiction.

   This continuum of care includes preventive, diagnostic and therapeutic services for alcohol or drug

use, abuse and dependence, as well as case finding, emergency services, consultation, withdrawal management, rehabilitation and monitoring services.

3. Facts about treatment as we know them
   - Need to look at outcome measures that do not focus solely on reduced substance use, such as physical and mental health, social function and reductions in public health and safety concerns.
   - Patient characteristics associated with better prognoses:
     - ⇒ low severity of dependence and psychiatric symptoms
     - ⇒ accurate initial assessment, and motivation beyond the pre-contemplative stage
     - ⇒ employed or self-supporting
     - ⇒ having family and social supports for sobriety
   - Factors reliably shown to be associated with improved outcomes:
     - ⇒ staying in, and compliant with treatment longer
     - ⇒ having an individual counselor and more counseling sessions
     - ⇒ receiving proper medications (both anti-craving and psyche medications)
     - ⇒ participating in 12-step programs
     - ⇒ supplemental services for adjunctive medical, psychiatric, and family problems
   - Treatment components and modalities:
     - ⇒ detoxification/medical treatment of withdrawal
     - ⇒ behavioral therapies
     - ⇒ 12-Step programs
     - ⇒ other self-help programs
     - ⇒ pharmacologic therapies

4. National Treatment Improvement Evaluation Study (NTIES)
   - One of the most rigorous studies of Substance Abuse treatment ever conducted.
   - Drug and alcohol use, criminal activity, and employment outcomes were measurably better among individuals who completed their treatment plans, received more intensive treatment and were treated longer.
   - Treatment appears to be cost effective, particularly when compared to incarceration, which is often the alternative. Treatment costs ranged from $1,800 to a high of $6,800 per client, compared to an estimated cost of incarceration of $18,330 annually.



Workshops

Recognizing Addiction

Presented by:
Benjamin H. Cluff, MPA, CADAC
Assistant Regional Manager
Department of Public Health
Bureau of Substance Abuse Services

Objectives

Participants:
1. were able to describe elements of a working definition of the addiction process.
2. gained an understanding of factors contributing to a state of abstinence from addictive substances.
3. were able to identify common characteristics experienced by individuals in early recovery from addiction.

A common vocabulary is a necessity in being able to describe and comprehend the phenomena experienced by individuals in the first two years of recovery from active addiction.

An illustration of the progressive nature of active addiction can be provided through a non-medical, functional, "common" vocabulary. This illustration will also provide a foundation for discussing the progressive nature of recovery. Once a foundation has been built, exploration of those periods wherein the progression of addiction and recovery overlap, can begin.

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The DA, Defense Attorney, Judge, Probation Officer, and Police as Enablers

Presented by:
Judge Thomas T. Merrigan, First Justice
Orange District Court
&
Laura Boucher, BS
Deputy Sheriff, Coordinator of Treatment
Franklin County Sheriff's Office

Objectives

Participants:
1. gained a non-defensive understanding of the enabling process.
2. learned to identify strategies to avoid enabling clients.

Enabling - Any behavior or action that assists the addict in the continuation of their addiction.

Enabling can occur either intentionally or unintentionally, and is usually done out of love or misguided concern. The difficulty of watching people in pain, wanting to believe that people are "good", the belief that addiction is caused by something else, or lack of understanding that addiction is a primary illness are all factors for enabling.

There are numerous characteristics of criminal addicts, these may include:

* difficulty in relating to family members
* inability to sustain long-term relationships
* emotional and psychological difficulties
* deficits in educational and vocational skills
* employment problems
* overwhelmed by multiple contacts with criminal justice system
* inability to handle anger and/or stress
* inability to handle social pressures and drug use
* inability to handle high-risk situations conducive to relapse

Developmental Model of Recovery—Six Stages

1. Transition - This stage begins the first time a person experiences a problem related to uncontrolled alcohol or other drug abuse. As the addiction progresses, a series of strategies designed to control use is attempted. This ends with the realization that safe use of alcohol and drugs is no longer possible.

Behavior summary:

- belief that they are "normal" drinkers or drug users
- will attempt periods of controlled use and abstinence
- abstinence is always short lived
- underlying goal—to regain control
- may take years

The major cause of inability to abstain during the transition period is the person's belief that abstinence is unnecessary because there may be a way to control alcohol or other drug use.

Enabling behaviors:

⇒ failure to recognize addiction as primary problem
⇒ giving a "break"
⇒ justifying action as something else i.e. youth, anger, home problems, etc.
⇒ isolated viewpoint
⇒ reinforcement of the control idea

2. Stabilization - During this stage, chemically addicted individuals need to resolve physical withdrawal and other medical problems, learn how to break the psychological conditioning that causes the urge to use alcohol and other drugs, stabilize the crisis that motivated them to seek treatment, and learn to identify and manage symptoms of brain dysfunction.

Behavior summary:

- inability to cope with stress and pressure
- unrelenting obsession
- lack of supportive environment
- may take six weeks to six months

The major cause of inability to maintain abstinence during the stabilization period is the lack of stabilization management skills.

Enabling behaviors:

⇒ treatment is not the crisis
⇒ wrong modality of treatment
⇒ inappropriate sanctions—all or nothing
⇒ belief that treatment is the cure
⇒ lack of knowledge of the recovery process *Pink Cloud* "Boy, you look good!"

3. Early Recovery - The individual establishes a chemical free lifestyle. Addicts need to learn about addiction and recovery.

Behavior summary:

- need to sever drug friends and relationships
- learn to build relationships that support recovery
- develop recovery based values
- replace anti-social values
- lasts approximately one to two years

The primary cause of relapse during the early recovery period is a lack of effective social and recovery skills.

Enabling behaviors:

⇒ compliance vs. surrender
⇒ belief that addict is cured
⇒ not being held accountable for other addictions
⇒ not being held accountable for anti-social values

4. Middle Recovery - This stage is marked by the development of a balanced lifestyle. This is a time of stress, as the addict begins applying basic recovery skills to real life problems.

Behavior summary:

- learn to repair past damage
- re-establish relationships with family
- set new vocational goals
- expand social outlets

The major cause of relapse during the middle recovery period is the stress of life changes.

Enabling behaviors:

⇒ not setting realistic goals for exiting the criminal justice system
⇒ all or nothing sanctioning
⇒ lessening of support

5. Late Recovery - The addict makes changes in ongoing personality issues that interfere with life satisfaction—Self-Actualization.

Behavior summary:

- examine values and goals adopted from parents, culture, and peer groups
- examine unresolved psychological issues—emotional, physical and sexual abuse, and abandonment
- three to five years into recovery

The major cause of relapse during this late phase of recovery is the inability to cope with the stress of unresolved childhood issues or failure to develop a functional personality style.

Enabling behaviors:

⇒ failure to complete conditions of treatment
⇒ inappropriate assessment of treatment needs

6. Maintenance - A lifelong process of continuous growth and development.

Behavior summary:

- coping with adult life transitions
- managing routine life problems, guarding against relapse
- any use of alcohol or other drugs will reactivate the physiological, psychological, and social progression of the disease

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6. *Addiction Resource Guide Glossary of Terms.* http://www.hubplace.com/addictions/glossarv.html

Does Mandatory Treatment Work?

Presented by:
Judge Herbert H. Hodos, First Justice
Greenfield District Court
&
Liz Olejnik, MSW
Court Program's Coordinator
Beacon Clinic

Objectives

Participants:

1. explored the definition of "success" in substance abuse treatment, especially in relation to mandated clients.
2. learned how to identify an appropriate client (or defendant) for mandated treatment.

A review of the following studies was conducted to give an overview of recent findings:

1. First national study of substance abuse treatment results
2. Services Research Outcomes Study (SROS), conducted by the Office of Applied Studies of Substance Abuse and Mental Health Services Administration; 5 year study
3. National Treatment Improvement Evaluation Study (NTIES) conducted by the National Opinion Research Center
   - reduces substance use
   - reduces crime
   - treatment rebuilds lives
   - treatment can and does put families back together
   - restores recovering substance abuser to productivity
4. Department of Health and Human Services Survey released results of survey indicating a dramatic rise in drug use among the nation's youth; 12-17 age group
   - up 78% between 1992-1995
   - up 33% between 1994-1995
   - marijuana use up 105% since 1992
   - up 37% between 1994-1995
   - monthly use of LSD and hallucinogens up 183% since 1992
   - up 54% between 1994-1995
   - cocaine use rose 166%

As adolescents move towards addiction, life becomes more centered around "getting high." Substance abuse not only leads to impaired intellectual, academic and social skill development, but actually:

- impairs the ability to learn
- undermines the capacity to concentrate well, retain information
- lowers self-esteem
- takes away choice

Media Influence

* glamorizing drinking
* by 18, kids see 10,000 TV beer commercials
* Serious business goal:
  ⇒ increase percent of users
  ⇒ increase percent of times using

* Michelob ad (10 year span):
  ⇒ "weekends are made for Michelob"
  ⇒ "put a little Michelob in the week"
  ⇒ "the night belongs to Michelob"
  (turns from unwinding to a nightly event)

Step Zero

* can't see they have a problem
* alcoholism is a progressive disease characterized by loss of control
* fear pushes people into denial
  ⇒ won't admit they have a problem
  ⇒ become resentful, angry or defensive when asked about their behavior
  ⇒ the idea of facing reality can be frightening and overwhelming
  ⇒ hard to give it up alone

Excuses

* everybody drinks
* I only drink on weekends
* wine is good for you
* it relaxes me
* it's not a problem
* D.E.N.I.A.L. (don't even know I am lying)

The longer it (the addiction) goes on, the longer it takes for the addict to recognize the nature of their condition.

Intervention is intended for people suspected of experiencing problems with addiction.

Argument for negative consequences of intervention:

* fear
* feeling uncomfortable; may know their families
* labeling the individual, may stigmatize them, interfere with future employment
* experiencing your own denial

These negative consequences are outweighed by the consequences of inaction:

* death
* crime
* use in inappropriate settings
* use with obvious tolerance, withdrawal
* use with negative consequences

Confronting the Client

Why confront clients about their using:

* avoiding confrontation supports denial and resistance
* avoiding confrontation takes away a person's choice of whether or not to enter treatment
* avoiding confrontation wastes valuable time for everyone involved
* people get into treatment only after they are made to REALIZE that they have the disease
* alcoholism is a crisis in a client's life
* people always have the choice of treatment but the catalyst is often outside themselves
  ⇒ jobs
  ⇒ family
  ⇒ children
* an encounter with the criminal justice system provides a valuable opportunity to intervene in an individual's life by identifying the clinical needs of substance users and then confronting them with the consequences of their own drug and alcohol use
* they are given an opportunity to know what's wrong with them

Treatment

* treatment provides substance abusers with a diagnostic assessment and treatment recommendations which are not available under traditional circumstances
* recovery rates are as high for those who go voluntarily as those who go through intervention
* they are given an opportunity to come to terms with their addiction so they can make the profound personal changes necessary to live healthy and productive lives in recovery
* the opportunity to heal in the community
  ⇒ reduces shame, guilt, hopelessness
  ⇒ creates relationship building opportunity provided by the court programs, treatment, AA, and the community as a whole
  ⇒ helps develop a sense of internal accountability
  ⇒ assists in reclaiming a substance-free identity
  ⇒ creates a realization that they too possess an inherent capacity to grow, change, and learn
  ⇒ offers recognition that they can perform in responsible ways (family, jobs, etc.)
  ⇒ leads to the acceptance of the joys and disappointments in life without the need for escape through substance use

Mandatory treatment provides the opportunity for a move from hopelessness, fear, and despair to a renewed vision of life, resulting from freedom from addiction.

Effectiveness of Court-ordered Treatment.

A key premise of these standards is that treatment is effective.[1] Court-mandated substance abuse treatment programs have been convincingly demonstrated to work.[2] Furthermore, research reveals that motivation improves as treatment progresses, and that abusers who are coerced into treatment fare as well as, if not better than, those who enter into treatment voluntarily.[3] In fact, most substance abusers enter treatment not voluntarily, but rather because they are forced by such factors as a family intervention, pressure from a spouse, or the insistence of an employer or co-worker. Voluntary participation is rare, since denial is a symptom of the disease of substance abuse. One goal of treatment is for the substance abuser to recover to the degree that he or she takes responsibility for his of her behavior. Treatment does not always work the first or even the second time, so that relapse should not be a cause for giving up on a substance abuser. In fact, strategies to prevent and address relapse are critical to the effectiveness of treatment. (See Standard XIII with respect to relapse prevention.)

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[1]"[D]rug and alcohol dependence are treatable medical illnesses." A. Thomas McClellan, Charles P. O'Brien, Norman Hoffman, and Herbert D. Kleber, *Is Drug Dependence A Treatable Medical Illness*: *A Review of Recent Research,* supported by grants from the Department of Veterans Affairs, National Institute on Drug Abuse, and Robert Wood Johnson Foundation. p. 30, 1998.

[2]See for example, Corbett & Petersilia, "A Review of Research for Practitioners," *Federal Probation,* vol. 58, no.l, March 1994.

[3]Singer, Amy. *Effective Treatment for Drug-involved Offenders: A Review and Synthesis for Judges and Other Court Personnel,* produced by Education Development Center, Inc., 55 Chapel St., Newton, MA 02160, p 144 (May 1992).

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4. Treatment Improvement Protocol (TIP) Series, #12 (1998). *Combining Substance Abuse Treatment with Intermediate Sanctions for Adults in the Criminal Justice System.*
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Women, Violence, and Substance Abuse

Presented by:
Joan Featherman, EdD
The Survivor's Project

Objectives

Participants:

1. gained an understanding of the effects of sexual abuse and domestic violence on individual functioning and family dynamics.
2. gained an understanding of the role of substance abuse in coping with the effects of violence.
3. learned strategies for maximizing their effectiveness in their work with women with histories of trauma and substance abuse.

This workshop explored the interacting effects of substance abuse, child sexual abuse, and domestic violence in the lives of women who come in contact with the judicial system. The two stated goals were:

1. to promote institutional change by adopting a more trauma informed perspective and
2. to help staff make the most productive use of their interactions with substance abusing female trauma survivors; to facilitate recovery rather than to re-traumatize.

Participants were presented with common myths and assumptions about substance abusing women, with concrete differences in patterns of female substance abusers compared with male substance abusers, and also with some widely accepted aspects of substance abuse treatment which are contraindicated for female trauma survivors due to a potential for re-traumatization.

Participants learned about how dissociation and other coping strategies may present in their work settings. Discussion of coping strategies focused on the role which substance abuse may play in coping with child sexual abuse and domestic violence. Concrete strategies were suggested which recognize the trauma-related role of commonly misunderstood behaviors seen in the work setting. These suggestions included the importance of explicitly validating the need for safety and control, pulling for strength and resilience rather than pathology, and assuming that the woman can make positive choices for herself with regard to treatment options and resources.

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Trends in Treatment: Resources for Recovery

Presented by:
John H. Elliott, MA
Project Coordinator
Franklin County Court & Community
Substance Abuse Intervention Project

Objectives

Participants:
1. learned what community and professional resources are available.
2. gained an understanding of what is new in treatment.
3. learned that recovery is a process, not a single event.

The first part of the session was an overview of the existing service delivery system for substance abuse services, with an emphasis placed on Franklin County. We discussed the range of inpatient and outpatient treatment modalities, and the self help programs. We also discussed how to determine when each type of treatment may be appropriate.

The next part of the program was dedicated to new developments in the treatment field. This included new and specialized treatment for the court population (i.e. Drug Courts). We also discussed innovations in specialized treatment for juveniles (Strengths Based Intervention and Treatment).

The last part of the workshop was exposing the participants to the concept of recovery as a process, not an event. Using a model (developed by Gorski, et al), we examined the stages of recovery and discussed the changes taking place for all affected individuals.

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Recovery vs. Abstinence: The Journey Through Recovery

Presented by:
Michael H. Donahoe, M.Ed., CAS

Objectives

Participants:

1. discussed the attitude changes that are essential for recovery from addiction.
2. explored the three spiritual principles — honesty, openness, and willingness — as they apply to a 12-step recovery program.
3. gained an enhanced understanding of spirituality.

The familiarization of participants with attitude changes found in the 12-steps of Alcoholics Anonymous and its use in a recovery process of time, was the primary goal of this workshop. The secondary goal was to enhance understanding of the “Spiritual Experience” (as depicted in the book “Alcoholics Anonymous”, appendices II) by introducing the necessity of the three basic, spiritual principles—honesty, openness, and willingness in order to effect long term sobriety and a new way of life.

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Is There Such a Thing as Adolescent Addiction?

Presented by:
Ellen Brower-Gately, LMHC
Franklin/Hampshire Juvenile Court Clinic
Tri-County Youth Programs
&
Doug Grote, LicSW, CADAC
Beacon Clinic
&
John Jones, Caseworker II
Department of Youth Services

Objectives

Participants:

1. learned that developmental issues may make substance use harder to address in adolescents than in adults.
2. learned that any substance use in teens may involve participation in illegal activities leading to greater involvement in a socially problematic sub-culture.
3. addressed factors affecting the risk of substance use (family circumstances, history of childhood abuse, etc.)

This workshop was designed to give participants maximum input into their learning process. Workshop facilitators oriented members to this expectation at the beginning of the session. Facilitators offered a brief presentation covering fundamentals of adolescent substance use and then opened the workshop for questions from participants and further discussion.

Although it's true that a majority of teens experiment with drugs, it is actually less than ten percent (10%) who become regular users and/or dependant. Most teens appearing before the court fit into this category. Teen substance users are at higher risk for court involvement because all drug use and underage drinking requires participation in illegal activities. Moreover, drug use implies an acceptance of the drug sub-culture and may require involvement in the related illegal behaviors needed to access substances and the money needed to pay for them.

It is impossible for users not to be affected by their drug use. Repeated drug use alters brain chemistry - in some cases permanently. Some individuals from troubled backgrounds are particularly vulnerable to these changes, especially those with family histories of alcoholism, depression, attention deficit disorders and other mental illnesses. The bio-chemical and emotional changes associated with child abuse and neglect can also contribute to ongoing substance abuse.

Once involved with substances, adolescents are less likely to stop spontaneously. Some of the reasons for this are as follows:

1. Adolescents are physiologically resilient. The reduced physical consequences for substance use makes it less likely

that an adolescent will cut down or cease using because it makes them feel bad.
2. Adolescents typically live in the here and now and are rarely interested in any long-term consequences. This means that it may take many years of repeated problems before each individual connects their drug use to its consequences.
3. Many of these adolescents come from families that are using substances themselves and/or live in a community with a high acceptance level for substance use.
4. Our culture overtly supports the use of substances by adults to alter their brain chemistry for pleasure, recreation, or coping with distress while assuming that these adults can control their use. Adolescents, more than adults, lack the maturity and strength to recognize the difference between an escape, however brief, from stressors and a cure for them.

Some adolescents will stop abusing substances as they mature. Other adolescents will continue with increasing substance abuse problems into adulthood. Predicting which adolescents will stop and which will continue is a complicated and inexact science. Because of this, any substance use by adolescents should be addressed. Substance use by court involved youth, who are at higher risk, should not be tolerated.

It is easier to address substance use in adolescents if they are not currently using substances. Courts and court personnel can function as an external structure to require an adolescent to stop using substances long enough so that their problems can be addressed by applying negative consequences for ongoing use.

Addressing adolescent substance use within the mental health system may be difficult in this day of managed care, as insurance companies are frequently unwilling to pay for repeated treatments - citing a lack of "medical necessity." Their refusal to pay for long term residential care has lead to the closing of adolescent care facilities in Western MA - meaning that resources are dwindling.

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Gambling: The Connection to Substance Abuse

Presented by:
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Objectives

Participants:
1. gained a general knowledge of the signs and symptoms of problem gambling.
2. became familiar with the resources in Western MA that help compulsive gamblers.

Compulsive gambling is an addiction; typically following a progressive, deteriorating course and often leading to impairment of functioning in all areas of the gambler's life. In other words, compulsive gambling is very much like addictions to alcohol and other drugs in terms of its development and in terms of its destructive potential. Substance abusers are about eight times more likely to have gambling problems than the general population. Compulsive gamblers are also, about five times more likely to have substance abuse problems. By recognizing, and responding effectively to, the signs of gambling problems in substance abusing clients, service providers enhance the clients' chances of recovering from all their addictions.

Gambling problems can develop along with (and coexist with) substance abuse problems. When this is the case, the gambling—if unaddressed—will undermine efforts to treat the substance abuse. Gambling problems can also develop after sobriety is established. In these cases the likelihood of relapse of the chemical addiction is increased.

While there are few resources to help compulsive gamblers, there are some accessible to residents of Western MA. These include Gamblers Anonymous, Gam-Anon, and several outpatient treatment programs. Directing a client in need to any of these could be one of the most useful interventions a service provider can make.

References

1. Custer, R.L. & Milt, H. (1985). *When Luck Runs Out: Help for Compulsive Gamblers and Their Families.* NY: Warner.
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3. Gamblers Anonymous (1989). A New Beginning. LA: The GA Publishing Co.
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Drug Testing: Technology and Goals

Presented by:
Alan Coley, BS
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Objectives

Participants:
1. were introduced to the concepts of illicit drug detection and of legitimate medication interactions.
2. gained an understanding of how urinalysis can become an integral part of client supervision and behavior change.

Methods of detection for drug abuse in urine were discussed from a technical standpoint. General analytical terminology such as sensitivity and specificity, and their relation to methodologies was reviewed. Drug classification, effects on the body, metabolism and excretion were also covered.

The "lecture" emphasized validity of drug abuse results. Validity of results are dependent on methodology, cross-reactivity, cut-off levels, and use of adulterants during collection. A Zero-Tolerance program using semi-quantitative results was also reviewed.

References

1. Aegis Analytical Labs, LA.
2. Michael Lehrer, Ph.D., Long Island Jewish Medical Center.
3. Ed O'Connor, Ph.D., American Association for Clinical Chemistry.
4. Alan Wu, Ph.D., Hartford Hospital.
5. Mike Carey, Champaign County Court Services, Urbane IL.

Drug Court

Presented by:
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&
Christopher Donelan, MPA
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&
Suzanne Breen-Nelson, BA
Franklin County Substance Abuse Intervention Project

Objectives

Participants:
1. gained specific knowledge of daily operations, requirements, and expectations of the Franklin County Substance Abuse Intervention Project (The Drug Court) in Greenfield and Orange.
2. gained a broader knowledge of other operative Drug Courts throughout the country.

Maureen Frazier presented an overview of Drug Court history and the rationale leading to the establishment of the first Drug Court ten years ago in Miami.

Suzanne Nelson presented the weekly schedule of the Franklin County Drug Court program and the basic requirements, expectations, and goals of the Drug Court participants.

Christopher Donelan presented the probationary implications of screening, assessment, terminations, and graduations of Drug Court participants. He also described various sanctions imposed upon participants.

References

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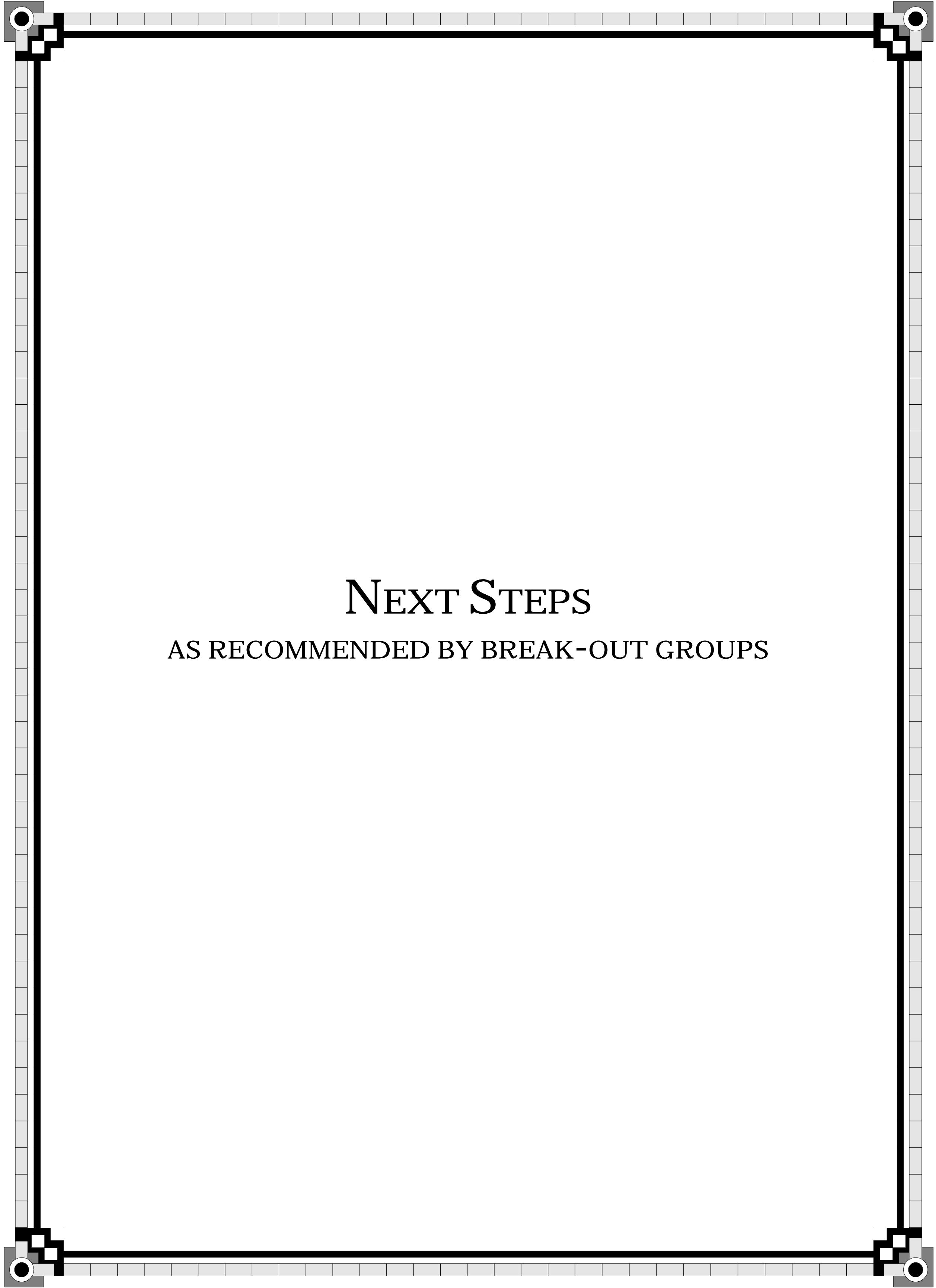

Next Steps

as recommended by break-out groups

Next Step recommendations
by break-out groups

After lunch, conference participants broke into role-specific groups, i.e. probation officers, clerical, security/court officers, etc. Eleven groups met in separate rooms with a trained facilitator. The task of each group was to discuss the following questions in relation to their specific job responsibilities.

1. In your work, how do you identify instances of substance abuse? If face-to-face, what questions do you ask?
2. How do you decide if it's appropriate for you to address the substance abuse issue?
3. If it is appropriate, how and when do you address it? What steps do you take?
4. What concerns do you have about responding to an indication of substance abuse?

To add a sense of immediacy to their discussion, a talented and versatile local actor entered each break-out room in turn — at unspecified moments — playing the character of a rather difficult individual under the influence who might be encountered by the courthouse staff. For several minutes, he proceeded to enact a highly realistic scenario that was appropriate to each group without coming out of character before he exited.

For example, he interrupted the group of judges and clerk/magistrates by entering as a drunken, late-arriving attorney, asking those in the room for help locating his client. Not only did they respond instantly and proactively to the sudden challenge of interacting with the man, but their high level of animation continued after his departure as they carried on their exploration of realistic options for responding to cases in which substance abuse is a factor.

The actor, Court Dorsey, prepared for his role by talking with current court personnel about the kind of real-life scenarios that take place in the Greenfield and Orange courthouses. Afterwards, many court staff said they found Mr. Dorsey's portrayals extremely convincing and that his involvement had enriched their break-out session discussions.

Judicial Administration Team

Facilitator: Julie Mazo

NEXT STEPS
A. Judicial Administration Team will develop uniform policies.
B. Determine how each department will handle interventions; limitations on authority; in-office and inter-office dialogues; encourage over- (rather than under-) reporting.
C. Examine Orange policies.
D. How to deal with attorneys known as substance abusers.

Probation Officers—"A"

Facilitator: Ariel Brugger

NEXT STEPS
A. Look into expansion of clinical services, more treatment options, availability of counselors and group sessions.
B. Prepare to deal with issues that may evolve after a period of sobriety has been established. Mental health issues, counseling issues, etc., often come to surface after sobriety has been established.
C. Look at discovering more proactive approaches to dealing with substance abusers - this would replace current reactive policy, feeling of constantly putting out fires.

Probation Officers—"B"

Facilitator: Greg Hessel

NEXT STEPS
A. Training for each court on how to respond as a group in that court.
   1. Each court should have a standard policy as to how you will respond to an intoxicated individual.
   2. The court officers have a mandate in their policy not to take an intoxicated individual into custody.
B. Chief Court Officer should have a training for court employees as to their mandates and how they can work together effectively for safe work conditions.
C. Judges need to be more supportive to probation - respect probation officer's recommendations. Sanctions should be imposed more frequently.
D. There should be more communication and networking amongst all courts and agencies.

Clerical Personnel—"A"

Facilitator: AnnMarie Meltzer

NEXT STEPS
A. A contact person, on-site, who is trained to identify substance abuse.
B. More education to address related issues - CardioPulmonary Resucitation, Tuberculosis, Hepatitis and other diseases.
C. More education on issues of: identification, prevention, and treatment.
D. Expand each workshop presented on June 9 into a half-day in-depth session.

Clerical Personnel—"B"

Facilitator: Kate Stevens

NEXT STEPS
A. As "counter people," outside of security officers, we are the first in line. We need to be ready to very carefully identify if someone appears under the influence of a substance to determine the safety of all involved - determine the security of our own and then react.
B. "The Drill" - a knowledge of the chain of command and everyone else's role, so as not to interfere with another person's role.
C. Continuing education for staff and public - what's available. SALT team to exchange experiences.

Clerical Personnel—"C"

Facilitator: Bill O'Riordan

NEXT STEPS
A. Training in what clerical staff should do to handle these situations.
B. Have a specific court individual available at all times during court hours to assess a person's condition.
   1. someone trained in substance abuse
   2. could be anyone in court environment
   3. all court hours should be covered - lunches, vacations, sick leave, etc.
   4. could one person cover three courts in Greenfield?
   5. courts should know who designated person is
C. Develop a protocol to handle these situations. Currently, there is an unspoken protocol based on experiences in the court environment.

Security Personnel

Facilitator: Ann Hare

NEXT STEPS

A. Guidelines established for all Franklin County courts of how and when to intervene.
B. Training - dealing with substance abusers for security and court officers. Some medical training to identify real situation such as withdrawals vs. faking.
C. Ongoing updates and better communication between court personnel.

D.A.'s Office

Facilitator: Mary Ellen Shea

NEXT STEPS

A. More resources to send people to at all stages of substance abuse - perhaps a central resource person.
   1. person, group or network to plug into
   2. need to know who to make the referrals to
   3. more resources for kids' pre-substance abuse problems - after school programs, self-esteem programs, preventive resources
B. Open lines of non-confrontational, communication.
C. Training for attorneys, advocates, all staff.

Human Service Professionals—"A"

Facilitator: Cate Woolner

NEXT STEPS

A. Continue working to erase the shame and taboos associated with substance abuse - increase abilities and comfort level in confronting issues.
B. Have more forums/workshops like this where we can talk openly about our fears/biases, etc.
C. Continue to support the collaboration that this conference was inspired by.
D. Continue our individual work, find support to keep addressing our own histories.
E. Create a list of resources - treatment, police, etc. - to give to all providers; or have a central resource to call that is current - to provide some information about procedures followed by other treatment agencies.

Human Service Professionals—"B"

Facilitators: Roy Schwartz & Pam Walker

NEXT STEPS

A. Cease keeping the silence
B. Training
   1. how to ask questions, what to ask
   2. become more comfortable asking questions and discussing substance abuse
   3. how to handle denial
   4. who to refer to
   5. services available
   6. networking
C. Department of Transitional Assistance (Welfare) and Department of Employment and Training
   1. concerns about getting permission, encouragement, and mandate from above to address substance abuse
   2. include notification to clients that they will be asked about substance abuse
   3. include substance abuse questions as part of intake procedure

Community Members

Facilitators: Lucinda Brown & George Roix

NEXT STEPS

A. Have more role plays to get practice with interventions.
B. Check into availability of alcohol and method for intervening on the job.
C. Learn more about substance abuse in general.

Appendix

APPENDIX

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