MIAMI DADE COUNTY ADULT DRUG COURT ENHANCEMENT PROJECT: OPIOID RESPONSE PARTNERSHIP

Advancing & Integrating Specialized Addiction Treatment & Recovery

Judge Jeri B. Cohen
Circuit Court Judge
Miami-Dade Adult & Dependency Drug Courts

Patricia Ares-Romero, MD, FASAM
Chief Medical Officer

National Drug Court Institute Fact Sheet and Recommendations: August 2016

- Opioids were ranked as the primary substance of abuse for 20% of adult urban drug courts and 30% of rural and suburban drug courts
- It is estimated that up to 50% of drug courts do not permit the use of a full array of medication assisted treatments because of ignorance about MAT, lack of access and funding, old notions about "substitution", fear of diversion and resistance from treatment providers
- No research on the effectiveness of MAT among drug court participants, except for positive preliminary findings on vivitrol for alcohol use disorder

Legal Standards for MAT in Courts

- Drug Courts receiving federal funding pursuant to Adult Drug Court Discretionary grants (BJA and SAMHSA), must attest in writing that the Court will not deny eligible candidates access to the program because of the use of FDA approved medications lawfully prescribed for the treatment of SUD
- The program must not require participants to discontinue such medications as a condition of graduating the program
- Courts can only withhold permission to use the medication for misuse, abuse or diversion
- Prohibition does not apply to drug courts not receiving federal dollars

Legal Standards for MAT

- September 2015, New York's governor signed a law to create uniform access to MAT in judicial diversion programs; specifically stated that participation in MAT programs for opioid abuse or dependence can not be a basis for violating a defendant's conditions of release
- Unequivocal intent was to promote the use of MAT in drug courts as well as diversion programs: " While the legislature has the upmost respect for judicial discretion, it is evident that prohibiting the use of methadone and buprenorphine…or requiring its use merely as a 'bridge to abstinence' is contrary to established best practice, and hinders the recovery process.
- Legal Action Center, Medication Assisted Treatment in Drug Court, Recommended Strategies, Center for Court Innovation

Correctional Response

- Most correctional institutions take a punitive approach seeing MAT as replacing one addiction for another
- Funding is a problem
- Practical effects
  - Individuals detox in jail with the use of benzodiazepines
  - Treatment interruption
  - Delay in treatment provision while waiting on a treatment bed in the community
  - Only population with access are pregnant women

Correctional Response

- Use of methadone, buprenorphine and vivitrol is associated with significantly reduced use of unauthorized opioids among probationers and parolees
- Methadone and buprenorphine significantly increase treatment entry and retention among individuals on probation and parole
- Re-arrest rates and reincarceration data is inconsistent, except for naltrexone which has been shown to reduce re-arrest and reincarceration
- Vivitrol is consistently found to increase treatment retention

Correctional Response

- High relapse and overdose rate within 30 days of leaving prison or jail regardless of the amount of time incarcerated
  - Connecticut offers methadone in prison; admission into treatment within one day of release with MAT; lower re-arrest and reincarceration rates for those participating in MAT and counseling; Yale-DOC-DMHAS Partnership show promising preliminary results (Dr Kathleen F. Maurer, Dr. Sherry McKee and Dr. Lindsay Oberleitner DOC and Living Free, New Haven Conn)
  - New York- first in-prison methadone program at Rikers Island started in 1987 and found to reduce recidivism
  - Rhode Island and Vermont-methadone and suboxone
  - Several jails offer vivitrol upon release
  - Significant reduction in recidivism; dramatic reduction in mortality

Brenda Smith v. Aroostook County, United States District Court, District of Maine (DN 1:18-cv-352-NT, March 27, 2019)

- Preliminary injunction granted against Aroostook County and sheriff for refusing to supply suboxone to an individual with OUD who is sentenced to 40 days in jail and who had been taking suboxone for ten years
- Court heard evidence from the prescribing physician that only 5% of his patients stayed sober through counseling alone; more dangerous than ever to use opioids because of fentanyl; risk of overdose among recently incarcerated individuals is higher than among others because of low tolerance in the absence of use

Findings

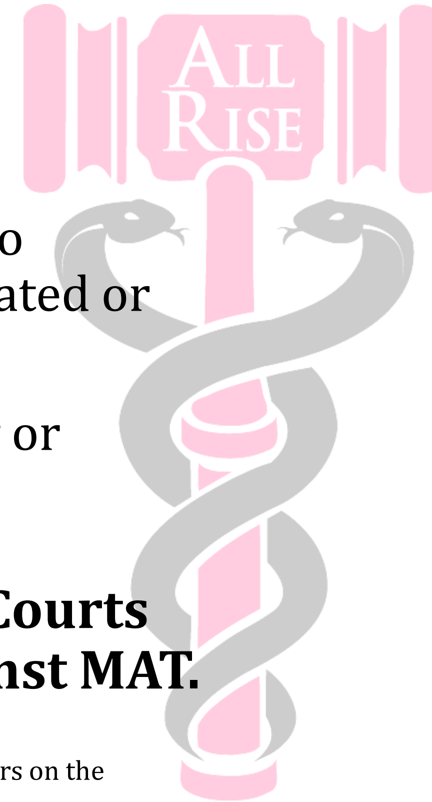
- Treatment with suboxone/methadone associated with 85% decrease in post incarceration mortality
- 75% reduction in in-custody deaths
- Inmates taking MAT in-custody were 7 times more likely to continue treatment/take medication after release
- If jail fears diversion, then alternative reasonable accommodations must be made
- Blanket prohibition has no basis in medicine, rather based on stereotypes and apathy, and is discriminatory and likely violates the ADA
- Growing body of evidence that refusing to provide MAT is medically, ethically and constitutionally unsupportable

The Unequivocal Position of NADCP

In 2010, NADCP issued a unanimous Board resolution directing Drug Courts to:

1. learn the facts about MAT,
2. obtain expert medical consultation,
3. make a fact-sensitive inquiry in each case to determine whether MAT is medically indicated or necessary for the participant, and
4. explain the court's rationale for permitting or disallowing the use of MAT.

The resolution states explicitly that Drug Courts should not have blanket prohibitions against MAT.



National Association of Drug Court Professionals. (2010). Resolution of the Board of Directors on the availability of medically assisted treatment (M.A.T.) for addiction in Drug Courts.

NADCP Standards

Standard I – Target Population

- Provides that candidates for treatment court should not be excluded from participation in the program because they have a legally valid prescription for an addiction or psychiatric medication.

Standard V – Substance Use Treatment

- Further directs treatment courts to offer MAT when it is prescribed and monitored by a physician with expertise in addiction psychiatry, addiction medicine, or a related medical specialty.

Standard VI – Complementary Treatment and Social Services

- Treatment courts should offer psychiatric medications for co-occurring mental health disorders when prescribed and monitored by a psychiatrist or other duly trained medical practitioner.

National Association of Drug Court Professionals. (2013). *Adult Drug Court Best Practice Standards (Vol. I)*. Alexandria, VA..
National Association of Drug Court Professionals. (2015). *Adult Drug Court Best Practice Standards (Vol. II)*. Alexandria, VA.

What about Mandating Cessation as a condition of Treatment Court Graduation?

In all cases, MAT must be permitted to be continued for as long as the prescriber determines that the medication is clinically beneficial. Grantees must assure that a treatment court client will not be compelled to no longer use MAT as part of the conditions of the treatment court, if such a mandate is inconsistent with a licensed prescriber's recommendation or valid prescription.

Standard 5: Family Drug Court Guidelines; NADCP and Children and Family Futures

- Treatment court participants receive MAT for SUDs based on an objective determination by a qualified medical provider
- **Individuals on MAT should not be excluded from entering or remaining in FTC or reunifying with children**
- **MAT can help parents achieve stability and focus on other aspects of recovery such as parenting, housing and employment**

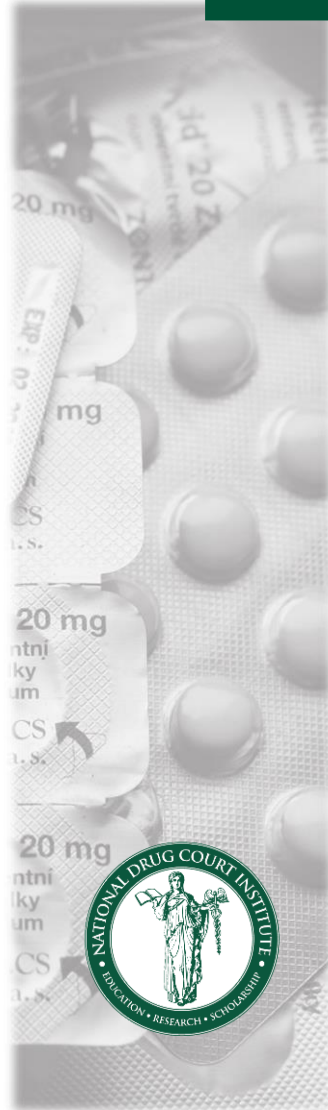
Standard 5

- A study showed that parents with OUD in the dependency system who received MAT had a significantly higher chance of retaining custody of their children than those who did not
- With each additional month of MAT, parents were 10% more likely to retain custody, and a year of MAT increased the likelihood of retaining custody by 120% (Hall MT et.al., Medication Assisted Treatment Improves Child Permanency Outcomes for Opioid Using Families in the Child Welfare System, Journal of Substance Abuse Treatment, 2016 Dec 1; 71:63-7)
- All FTC team members should be trained in the use of MAT

National Judicial Opioid Task Force Standards: Chief Judges and State Court Administrators

- Courts should address opioid epidemic from a public health model
- Courts should encourage their state child welfare agencies to leverage the opportunities of the Family First Prevention Services Act
- Courts should include MAT as one part of a comprehensive treatment plan, in all civil and criminal cases
- Courts should allow the use of MAT for those who wish to participate in specialty courts
- New family treatment courts should be implemented

CHALLENGING BLANKET MAT PROHIBITIONS



Americans with Disabilities Act (ADA)

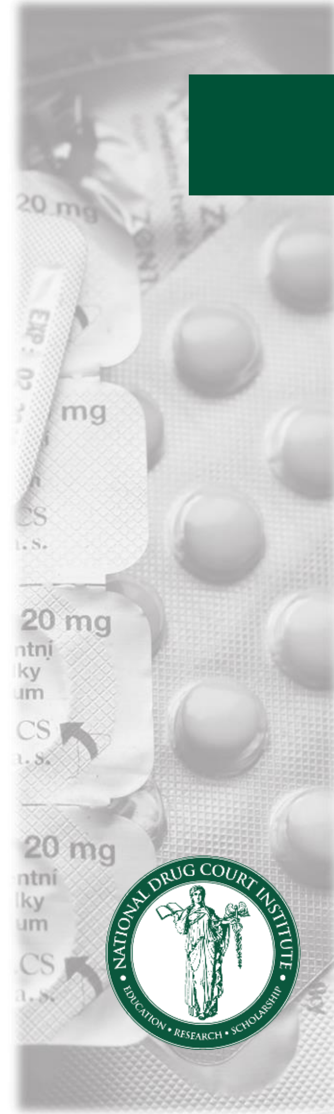
- ✔ Prohibits discrimination by state and local governments (42 U.S.C.A. , sec. 12101ff)(1990); plaintiff need only show that the intentional discrimination was the "but for" cause of the discriminatory action

Rehabilitation Act of 1973 (RA) (29 U.S.C., sec. 701ff)

- ✔ Prohibits discrimination by federally operated or assisted programs
  - *Discovery House, Inc. v. Consol. City of Indianapolis*, 319 F.3d 277, 279 (7th Cir. 2003) ("the ADA and the [Rehabilitation Act] . . . run along the same path and can be treated in the same way").

Due Process protections of 14th Amendment (plaintiff has burden of negating all conceivable rational justifications for the discriminatory act)

8th Amendment-cruel and unusual punishment



SUMMARY OF ADA AND RA

Treatment Court Blanket MAT Prohibitions offend the ADSA & RA because:

1. Treatment court is a program covered by the statutes
2. Treatment court eligible person with opioid substance use disorder has a disability
3. Treatment court eligible persons with opioid substance use disorder do not as a class constitute a substantial risk
4. Blanket denial of MAT is discrimination because of a disability

Findings

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- Inmates taking MAT in-custody were 7 times more likely to continue treatment/take medication after release
- If jail fears diversion, then alternative reasonable accommodations must be made
- Blanket prohibition has no basis in medicine, rather based on stereotypes and apathy, and is discriminatory and likely violates the ADA
- Growing body of evidence that refusing to provide MAT is medically, ethically and constitutionally unsupportable

Blanket Denial of MAT is a Due Process Violation

All judges should:

1. Consider relevant information before making a factual decision,
2. Hear arguments from both sides of a controversy (typically from the defense and prosecution), and
3. Receive evidence from scientific experts, if the subject matter of the controversy is beyond the common knowledge of laypersons.

Meyer, W. (2011). Constitutional and Legal Issues in Drug Courts. In D. B. Marlowe & W. G. Meyer (Eds.), *The Drug Court Judicial Benchbook* (pp. 159-180). Alexandria, VA: National Drug Court Institute

The Bottom Line

Under no circumstances may a treatment court judge, other judicial official, correctional supervision officer, or any other staff connected to the identified treatment court deny the use of these medications when made available to the client under the care of a properly authorized physician and pursuant to regulations within an Opioid Treatment Program or through a valid prescription.

NDCI FACT Sheet: Best Practices

- Keep an open mind and learn the FACTS/don't prejudge
- Obtain expert medical consultation about MAT
- Make a fact sensitive inquiry in a case to determine whether MAT is medically indicated and necessary
- Explain the court's rationale if MAT is disallowed for a participant or if a participant is forced to taper
- Under no circumstance should there be a blanket prohibition against MAT as a matter of policy: may be violative of an individuals fundamental constitutional rights, the Americans with Disabilities Act and the Rehabilitation Act
- The Legal Action Center and NADCP

Population Served in Adult Drug Court (ADC)

As of 2016 – ADC had 405 active participants.

- 22% of participants report opioid addiction
- 78.5% below county living wage
- 51.2% below poverty level
- 30% reported Spanish as their primary language spoken.

Situation Before the SAMHSA BJA Grant

- Opioid use surged with clients coming into ADC with OUD not previously seen
- No outpatient MAT services or immediate residential beds; many defendants were homeless and/or from out of town
- MAT only for a fee with licensed doctors; no Medicaid expansion in Florida; Using several providers who required appointments and payment so treatment was not immediate and we lost participants
- Miami Dade County does not have a public methadone clinic
- Individuals not returning to court and getting lost in the system

Situation Before the Opioid Response Grant

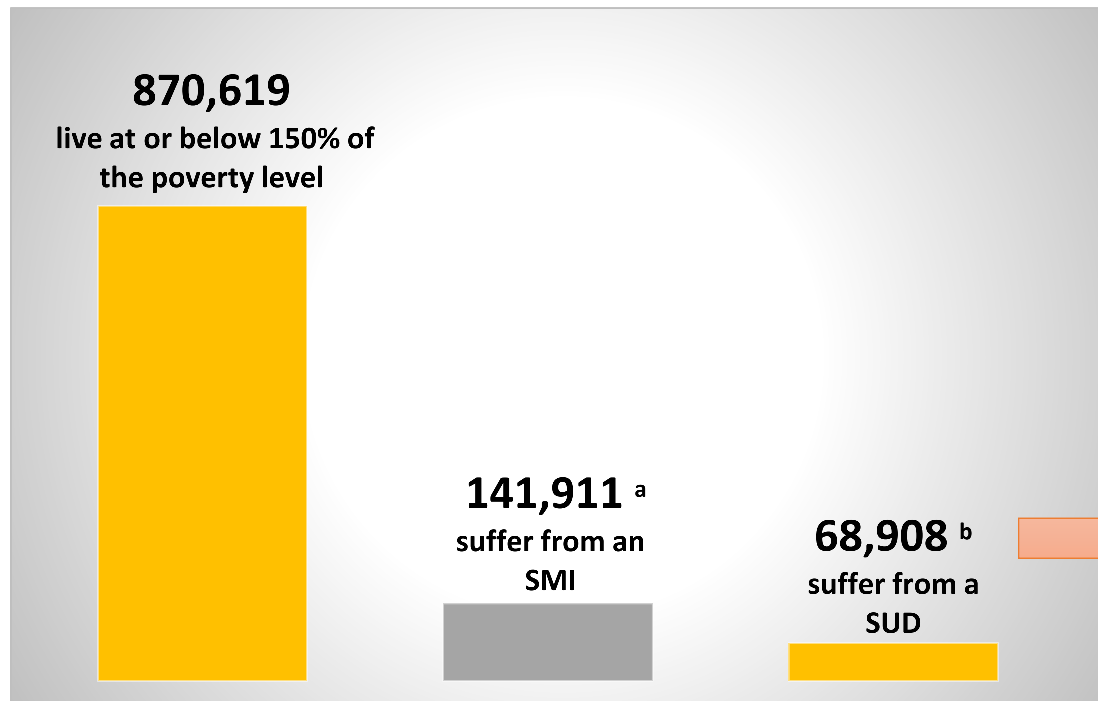
- Once an individual was stabilized with MAT, there was a waiting period for residential treatment placement; few outpatient slots
- Miami has 10 pubic detox beds mostly used for alcohol and benzodiazepine treatment; people waited hours in the emergency room and left
- For those who accessed detox, no follow-up medication and treatment
- The Court did not have a relationship with the public hospitals

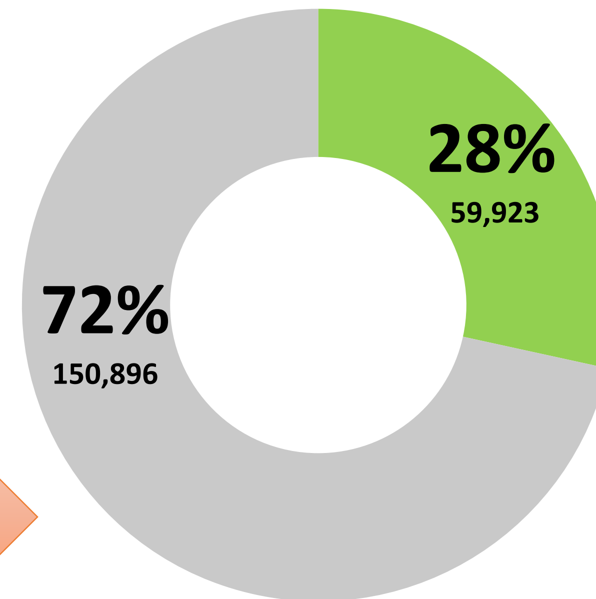
Situation before the Opioid Response Grant

- Lack of family support; resistance and stigma; families are exhausted
- Case managers and other team members were uninformed and reluctant to commit to a MAT protocol
- Treatment, homeless shelters and sober houses and 12 step meetings were hostile to MAT
- Jail was resistant
- Our Entity that manages MHSA was not seeing the surge in opioid use

Behavioral Health Treatment Need in Miami-Dade County

In Miami- Dade County:

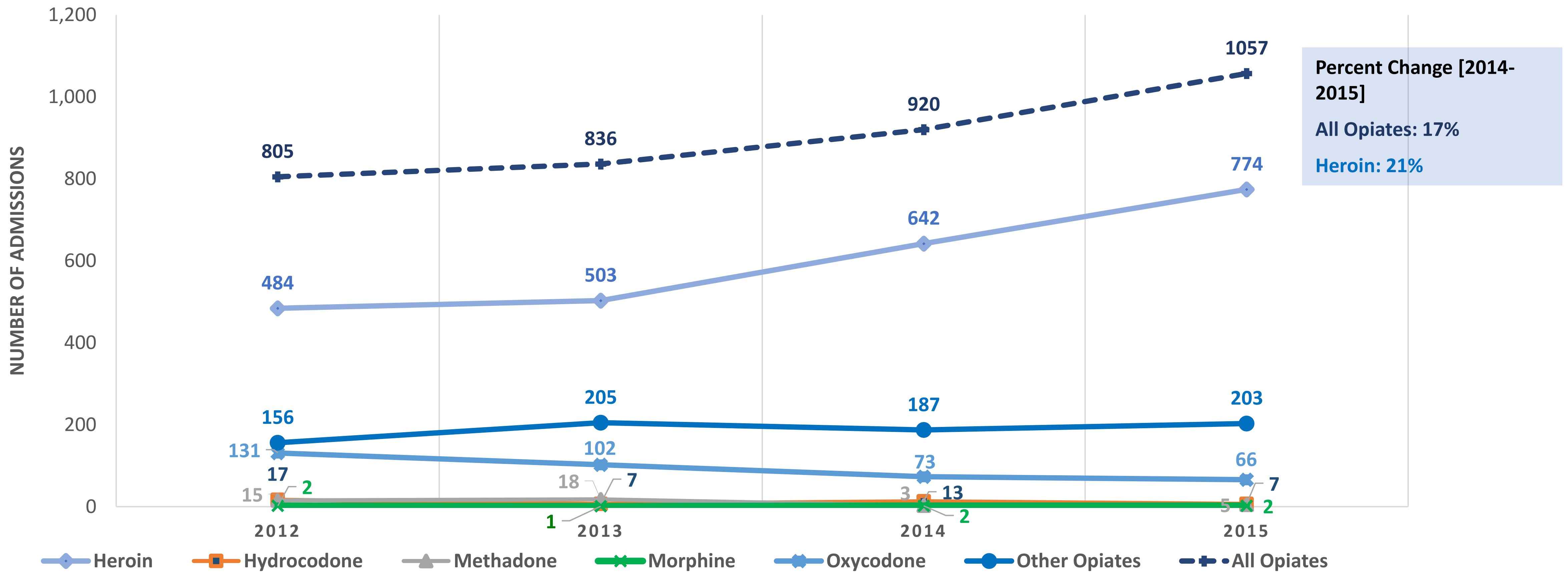




Out of 210,819 who are in need of MH or SA treatment, SFBHN served 28% in FY 15-16, while 72% were still in need.

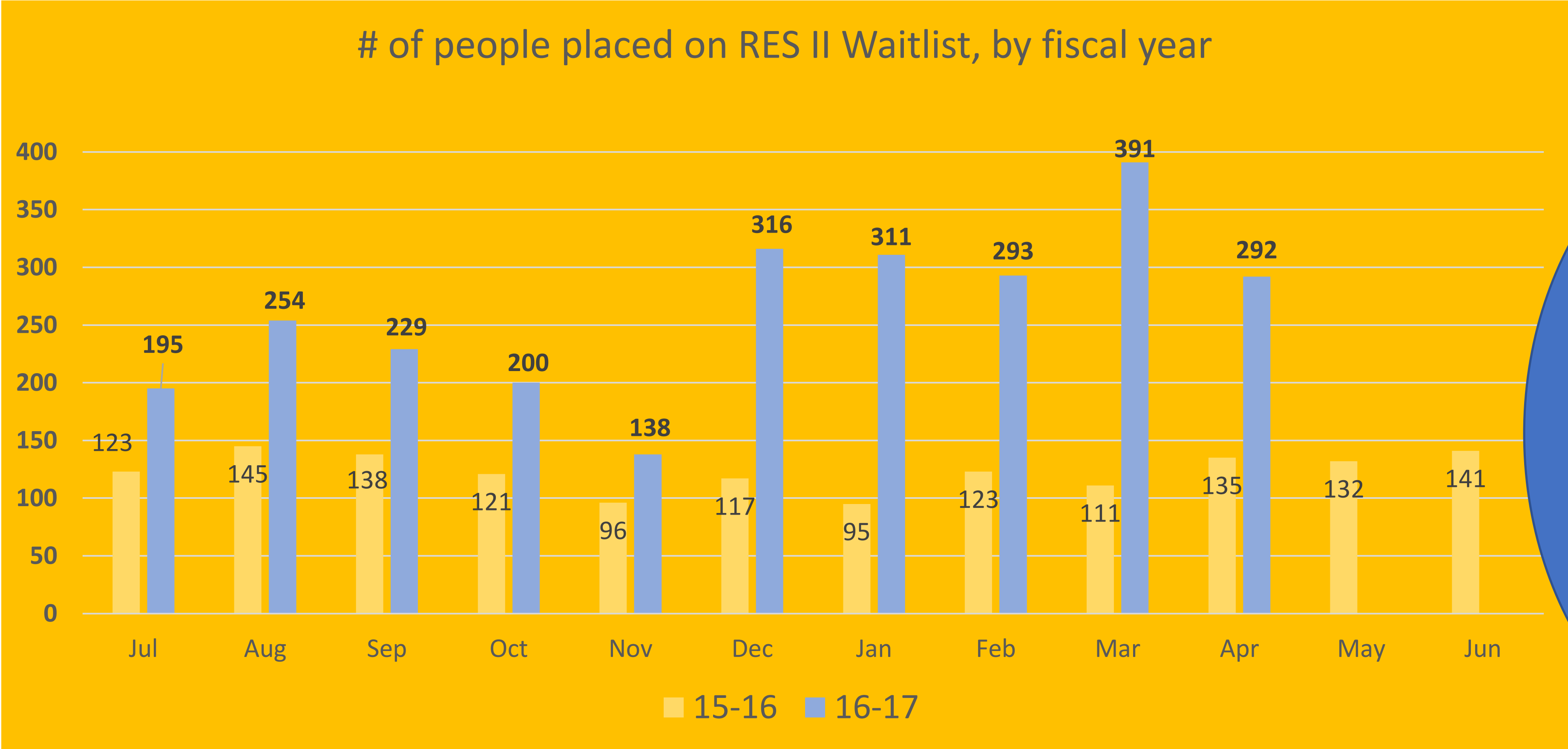
a. Research has indicated that 16.3% of people with low income suffer from a Severe Mental Illness (SMI) [SAMHSA, 2012).
b. 7.8% will meet diagnostic criteria for substance use disorder (SUD) [Surgeon General's Report on Drug and Health, 2016].

Number of SA Admissions that reported Opiates as Primary Drug of Choice: Breakdown by Type (SFBHN) [2012-2015]



Source: SFBHN Consumer Data

Number of people placed on ASA Residential Level II Waitlist, by FY



FY 15-16: 1477 people placed on the waitlist

FYTD 16-17 (Jul-Apr.): 2619 people placed on the waitlist

Note: There has been a **117%** increase in the number of people placed on the waitlist between Jul-Apr. as compared to last year during the same period

Source: SFBHN RES II Waitlist

SFBHN Waitlist Data – IV Drug Users

FYTD 15-16

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 15-16 # of people on Waitlist	123	145	138	121	96	117	95	123	111	135	132	141
FY 15-16 # of IV Drug Users on Waitlist	12	8	15	16	11	12	8	12	6	21	14	18

FYTD 16-17

Heroin

Number of Heroin Related-Deaths in Florida: 2000 to 2016*

Number of Occurrences

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2 X 1stH 2016
Deaths	208	271	250	230	150	109	78	93	119	95	48	57	108	199	447	779	868*

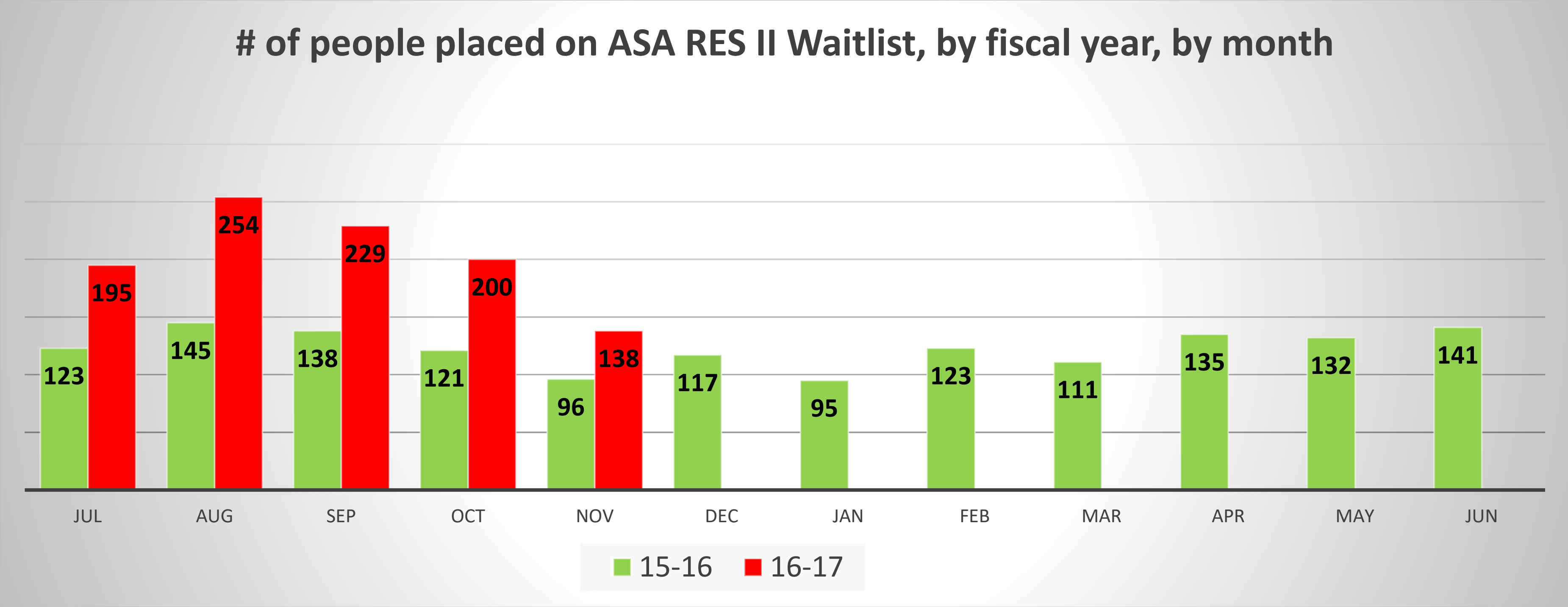
* Projected Increase based on 2 X 1st Half of 2016

Source: Florida Medical Examiners Commission Reports

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
FYTD 16-17 # of IV Drug Users on Waitlist	22	24	36	33	21	33	35	37	41	44

Legend: FYTD 16-17 # of people on Waitlist; FYTD 16-17 # of IV Drug Users on Waitlist

Number of people placed on ASA Residential Level II Waitlist, by FY



FY 15-16: 1477 people placed on the waitlist

FYTD 16-17 (Jul-Nov): 1016 people placed on the waitlist

Note: There has been a **63%** increase in the number of people placed on the waitlist between Jul-Nov. as compared to last year during the same period

Cost to the system – breakdown for IV Drug Users

Service Type Needed	Dollar Amount Needed
ASA Residential Level II Beds Needed	$ 1,814,215
Outpatient Services Needed	$ 4,307,076
Medication Assisted Treatment Needed	$ 63,574
TOTAL FUNDING NEEDED	**$ 6,184, 865**

Opioid Response Partnership Grant

- The Opioid Response Partnership was a targeted attempt to meet the needs of individuals with OUD who were unable to access services in a timely manner and consequently, were dying before accessing care; 6 deaths in one year
- U.S. Department of Justice, Bureau of Justice Assistance: $400,000 award beginning October 1, 2016 through September 30, 2019
- U..S Department of Health and Human Services/SAMHSA grant $975,000 over 3 years beginning September 30,2016 and ending September 29, 2019

Disclaimer

- The opinions, findings, and conclusions or recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the U.S. Department of Justice, the U.S. Department of Health and Human Services, or grant-making components.

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Opioid Response Partnership – Goals & Objectives

1. Expanded case management services to focus on the opioid population in drug court

2. Improved immediate access to opioid use disorder treatment and services facilitating stabilization and rehabilitation by :

- streamlining system of referral and follow-up for detox and treatment between the Adult Drug Court, Jackson Outpatient MAT program, South Florida Behavioral Health Network and other community providers;
- Providing residential and outpatient detox, treatment and referrals for social services through community providers;
- Meeting the needs of pregnant women
- Moving people out of the jails

Initial Engagement in the Program

- Court drug tests defendants and significant others at first court hearing; reviews the charges
- Court takes an extensive family history of drug usage, mental health issues and trauma;
- Services are set up on demand
- Family engagement is highly encouraged
- A case manager is assigned
- Assessment is scheduled
- A subsequent hearing is set within 2-3 days or the next day if necessary

Assessment

The participants are scheduled, once arraigned to obtain an in-depth assessment

The assessment includes:

- Mental health screening form to assess mental health
- ACE (Adverse Childhood Events) to assess for trauma
- TCUDS-V (Texas Christian University Drug Screening) to assess for severity of drug use
- RANT (Risk and Needs Assessment) to determine the risks and needs of each participant
- Treatment is immediate

Facility Overview

Jackson Behavioral Health Hospital provides a full continuum of care for children, adolescents, adults and seniors. We offer individual, couples, family, and group therapies. Whether inpatient or outpatient, from treatment through discharge, all services are supportive, and safe environment. At Jackson Behavioral Health Hospital, we are committed to meeting the needs of each patient at each stage of treatment.

TEAM MEMBERS:
Patricia Ares-Romero, M.D., FASAM
Chief Medical Officer
Stephen McLeod-Bryant, M.D.
Addiction Fellows and Residents
Medical Students
Tamala Russell-Reed, APRN
Tania Torres, APRN
Lavonia McCoy, LPN
Jorge Larrea, MHS
Romy Perez, LCSW
Clara Lora Ospina, PsyD
Psychology Intern
Peer Specialist

Jackson
HEALTH SYSTEM

Jackson Behavioral Health MAT Clinic

- Immediate comprehensive behavioral health services
  - Withdrawal Management
  - MAT Maintenance
  - Complete Psychiatric Evaluation
  - Individual and Group Therapy
  - Medical Assessment and Treatment – Family practice ARNP
  - University of Miami Medical partners
  - LCSW, therapist and patient navigator participate in court staffing weekly for ORP clients

- Nursing station and Mental Health Specialist area

- Reception and waiting area

MAT Protocol / Work flow

- Patients are referred from the Miami-Dade Drug Court
- Warm greeting & welcome by staff
- Urine toxicology screen and vital signs of the patient taken by Licensed Practical Nurse (LPN)
- Laboratory studies are drawn by LPN
- History and Physical Exam completed by our Family Practice - ARNP
- Psychiatric evaluation is provided by one of our psychiatrist
- Opioid Use Disorder medication determined by physician in conjunction with the patient.
    - Suboxone/Subutex
    - Naltrexone/Vivitrol
    - System relief

Medication Assisted Treatment (MAT) Medical Protocol

An evidence-based practice that utilizes medications in combination with behavioral therapies for the treatment of substance use disorders. I

MAT with buprenorphine for opioid use disorder consists of three phases:

Stage 1: Induction Phase (duration approximately 1 week)

- Goal is to find the minimum dose of buprenorphine at which the patient experiences optimal results with minimal symptoms of withdrawal

Stage 2: Stabilization Phase

- Dosage adjustments and frequent contact with patient during early stabilization
- Once stable dose is reached and monthly toxicology tests free of illicit opioids, physician determines less frequent visits are acceptable

Stage 3: Maintenance Phase

- Patient is on buprenorphine for a indefinite period of time – 24 months

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Miracles made daily.

Suboxone

- Initial dose of Suboxone / buprenorphine received in clinic, patient is observed
- Patient is introduced to the therapist and scheduled for the same day or following day
- Treatment goal is 3 weekly visits to our clinic
- Patient is only given enough medication unit the next visit.
- Patient is also given Narcan Kit on initial visit with education
- Urine drug screen prior to medication and every visit *

SUBOXONE sublingual tablets, including generic equivalents
One 2 mg/0.5 mg buprenorphine/naloxone sublingual tablet
One 8 mg/2 mg buprenorphine/naloxone sublingual tablet
12 mg/3 mg buprenorphine/naloxone taken as: • One 8 mg/2 mg sublingual buprenorphine/naloxone tablet AND • Two 2 mg/0.5 mg sublingual buprenorphine/naloxone tablets
16 mg/4 mg buprenorphine/naloxone taken as: • Two 8 mg/2 mg sublingual buprenorphine/naloxone tablets

Treatment Modalities

- Medication management
- Therapeutic interventions [patient specific]
    - Cognitive Behavioral Therapy
    - Trauma centered treatment
    - Motivational enhancement/interviewing
    - Family therapy
    - Addiction groups
    - Psychosocial support
    - Recovery oriented care
    - Case management

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Goals of Treatment

- Increase the retention rate of patients in treatment
- Increase the length of time participants are able to maintain sobriety
- Act as a bridge of treatment to Inpatient rehabilitation treatment when needed
- Increase the number of participants completing treatment programs
- Decrease the rate of new arrests and convictions while enrolled in the program
- Decrease the number of participants incarcerated in the 12 months following program

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World Health Organizations (WHO's) Principles of good care for chronic disease

- Develop a treatment partnership with the patients
- Focus on the patients' concerns and priorities
- Support patient self-management of illness
- Organize a proactive follow-up
- Work as a clinical team
- Ensure continuity of care

Key Insights

- Most patients began their OUD with prescription opioids and escalated to illegal drug use [Oxycodone and Heroine].
- Significant percentage of patients are tired of using opioids but have been unable to stop.
- Trauma history is common
- Hepatitis C
- Mood disorders both previously diagnosed and undiagnosed.
- Education on OUD treatment has been challenging for families and patients.
- Better outcomes with strong engaged family support.

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Key findings

Components of successful MAT programs

Counseling and other services are essential

- Require counseling and wrap-around services from a licensed treatment provider in addition to medication management
- Treatment must be on demand
- Medications often continue after completion of treatment and treatment court
- Frequent court appearance
- Frequent urine testing and strip counting
- Engage the family

Team's endorsement of MAT is the goal, not a prerequisite.

- MAT program can succeed even if some team members aren't convinced MAT is effective if they agree: treatment decisions are made by clinicians.
- Courts that had buy in from the whole team had a more positive view of their programs.
- Do not send opioid addicted individuals to programs that do not support MAT

Challenges

- Boundaries with clients
- Necessity for intensive follow-up
- Failing to show up for appointments
- Need to wait 24-30 hours before starting medication (policy change to allow a take home dose to get started with follow-up the next day)
- Precipitated withdrawal
- Diversion of suboxone/ strip counting and reports to the court
- Challenges with corrections

Challenges

- The clinic staff was not accustomed to dealing with severe substance abuse cases with a criminal court population
- There is only one location for the clinic, thereby, creating transportation problems
- Drug testing: Per hospital protocol, participants sign in with actual appointment dates/times which does not allow for flexibility with drug testing

Challenges in the Community

- Lack of knowledge regarding MAT in residential programs. Participants are still being told that it is a “drug” and he/she is not truly in recovery while on MAT
- Programs are hesitant to allow the participants to leave to clinic appointments and return with medication.
- NA and sober living houses will not allow individuals using medication
- Financial limitations

Expansion of MAT in the Community

- Managing Entity has allocated money to all residential and out-patient treatment facilities to provide buprenorphine and vivitrol
- State entity is also funding vivitrol
- Massive education campaign in Miami Dade has educated treatment providers about the science and efficacy of MAT; still work to be done; working with sober houses
- Judges and court staff are being educated statewide through the STR grant
- Developed a relationship with the private methadone provider

Expansion of MAT in the Community

- Narcan is being dispensed by all law enforcement and the JMH clinic
- The Dade State Attorney has allowed the expansion of Drug Court to moderately violent offenders and probationers; judges, state attorneys and defense bar are being trained to identify opioid addicted individuals and refer
- Child Welfare is working with the criminal court to identify unsafe children
- JMH and the Court are working with the jail to develop MAT protocol for those in jail

Next Steps

- Education & Capacity building for other court personnel and providers regarding MAT and the ORP
- Expand MAT services (separate from ORP funding) to dependency court and other client populations not court involved
- Develop a warm hand-off with the Emergency Room
- Ongoing partnership with law enforcement and other stakeholders (Opioid Task Force)
- Sustainability planning and funding diversification

Adult Drug Court: Opioid Response Partnership Expansion Project (ORP-E)

- Expands the scope of the Opioid Response Partnership (ORP) by providing over the lifetime of the project (2019-2024), outpatient medically-assisted treatment (MAT) and mental health services to over 200 adult drug court participants with a primary substance use disorder (SUD), including opioids and or alcohol, plus a co-occurring mental health diagnosis.
- Under this partnership with Jackson Behavioral Health (JBH) and Miami-Dade Adult Drug Court (ADC), participants will receive comprehensive case management, stabilization or detoxification, MAT and mental health counseling as needed
- MAT program expanded into the jail; protocol being developed

Florida Courts: Opioid Initiative

- Circuit Champions Identification: chief judge selects judge and court staff who agree to become subject matter experts
- Circuit Champion Self-Study: podcasts, selected articles and knowledge from local experts; participate in facilitated statewide calls creating a community for shared learning
- Opioid Awareness Month: with the support of the chief justice through a proclamation, courts launch an awareness campaign focused on educating criminal and family court judges; weekly resources are emailed and champions coordinate a circuit wide event with experts

Opioid Initiative

- Training Needs Assessment: Using knowledge acquired from the awareness month, local champions prepare a needs assessment along with local court teams
- Circuit Champions Conference Attendance: AATOD in Orlando 2019
- Regional Trainings: Informed by needs assessment, and using the developed expertise of the champions, OSCA coordinates five regional trainings beginning in January 2020

ORP Client Overview

- 205 clients enrolled between Jan 2017-August 2019
- 142 clients discharged
- 63 current clients
- While enrolled, clients receive comprehensive services including:
  - MAT and SUD treatment
  - Mental health treatment
  - Medical/dental care
  - Housing and Employment support
  - Couples/Family therapy and Parenting services
  - Education services

Client Demographics (n = 205)

- 70.2% of ORP clients (n = 144) are males
- Ages range from 18 years to 64 years (Mean = 31.1 years)
- 96% are employed
  - 50% of those employed are working full time
- Race/Ethnicity
  - 48.8% are White and Hispanic
  - 44.4% White Non-Hispanic
  - 5.9% Black/African American (1 person is Black + Hispanic)
  - 1.0% Asian

Past 30-DAY Drug Use (Self-reported at intake)

- 20.8% of clients report alcohol use
- 45.2% of clients (n = 88) reported illegal drug use
- Of the 88 clients:
  - 50.0% reported past 30-day marijuana use
  - 40.9% reported past 30-day cocaine use (Injection, Nasal, Smoking)
  - 39.7% reported past 30-day Heroin use
  - 18.2% reported Fentanyl Use
  - 11.6% reported past 30-day Percocet
  - 10.2% reported past 30-day Oxy use
- 34.1% of those reporting past 30 day drug use reported injecting drugs

Co-occurring disorders and support

- 55.1% had dual-diagnosis (reported symptoms of anxiety and depression common)
- 34.1% reported lifetime experience of violence or trauma
- 34.6% reported being homeless
- 21.5% have children out of their custody
- 81.2% reported having family support

Discharged clients (n = 142)

- More than half were discharged successfully (53.2%)
- Reasons for unsuccessful discharge include:
  - 45% left on their own against staff advice
  - 35% out on AC for more than 90 days
  - 10% discharged due to non-participation
  - 8% discharged due to rule violation or other offense
  - 1 person was transferred to another facility due to health reasons
  - 3 people died

Treatment Episodes

A treatment episode is defined as the period of treatment between admission and discharge from a facility. If the participant transitioned from residential to outpatient successfully, that is considered to be the same treatment episode.

	Total number of clients	% Successful	% Chose MAT
1 ADC Treatment Episode	144	52.8%	35.4%
2 or more ADC Treatment Episodes	61	47.5%	73.8%
On Probation	12	66.7%	41.7%
Spent more than 1 day in jail prior to ADC	145	54.5%	46.9%
0-1 relapses	120	60.0%	36.7%
2 or more relapses	80	41.3%	62.5%

***People who chose MAT had more treatment episodes and more relapses*

Overall Predictors of Success

- Being on MAT, having children out of custody, and having trauma were not related to overall success.
- People with family support were more likely to be successful.
- Those with dual-diagnoses, females, and homeless individuals were less likely to be successful

	SUCCESSFUL (N = 105)	UNSUCCESSFUL (N = 100)
MAT	44.7%	49.0%
Children out of custody	21.9%	19.0%
Trauma	39.4%	37.6%
Family Support	89.4%	72.0%
Dual Diagnosis	53.8%	67.1%
Female	22.8%	37.0%
Homeless	39.4%	57.5%

Predictors of Overall Success

Successful individuals spent more than 13 months in ADC

- Large effect size (Cohen's *d* = .86)

Successful people had fewer relapses (less than 2)

- Small effect size (Cohen's *d* = .21)

Spending more time in the division prior to enrolling in ADC was associated with being successful (people who were in jail for longer)

- Medium effect size (Cohen's *d* = .46)

Overview of Individuals on MAT

96 individuals chose to receive Medication Assisted Treatment (MAT)

79.1% Suboxone
14.6% Vivitrol
3% Naltrexone
3% Methadone

39.6% Homeless

25% have children out of their custody

38.3% have a dual diagnosis

37.5% have trauma history

Being on MAT does not predict success. Who chooses MAT?

Individuals selecting MAT had more relapses (2.5 compared with 1.4)

- Medium effect (Cohen's *d* = .60)

Individuals selecting MAT were slightly older (32 years old compared with 30.5 years)

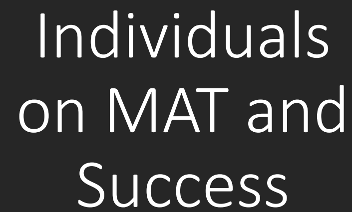
- Small effect (Cohen's *d* = .12)

Trauma, homelessness, family support, jail time, being on probation, or having dual-diagnoses) were not related to MAT selection

MAT and Success

- Individuals who were successful with MAT had fewer relapses, were in ADC more than one year, had more treatment episodes, and were older.

	Successful on MAT (n = 47)	**Not Successful on MAT (49)**
Average Number of Relapses	80% had 2 or fewer relapses	80% had 3 or more relapses
Average Months involved in Drug Court	75% were in for more than 12 months (average = 14 months)	75% were in for 12 months or less (average = 12 months)
Average Number of ADC Treatment Episodes	57% had 0-1 treatment episode 43% had 2 or more treatment episodes	62% had 0-1 treatment episode 38% had 2 or more treatment episodes
Age	32.5 years old	30.4 years old



Being on MAT lessens disparities in overall success

When looking ONLY at those on MAT

- There are no more differences in success based on
- gender
- homelessness
- having a dual-diagnosis
- having family support

For individuals with trauma who chose MAT, 66.7% were successful

- 58% of those with trauma who did NOT choose MAT were successful

MAT and Success – A Summary of 205 Clients

	Yes MAT	**No MAT**	**TOTAL**
Successful	49.0% (n = 47)	53.2% (n = 58)	105 Individuals were Successful
Unsuccessful	51.0% (n = 49)	46.8% (n = 51)	100 Individuals were Unsuccessful
TOTAL	96 Individuals chose MAT	105 Individuals chose NO MAT	

Miami Child Welfare Integration

Treatment in collaboration with the child welfare Community Based Care lead agency and dependency case management agency partners

Increase safety and reduce risk of children in the child welfare system whose parents have a substance abuse disorder by developing in-home safety plans

Reduce the number of out-of-home placements;

Reduce the time a child remains in child welfare system; and

Reduce rates of re-entry into child welfare system.

BEHAVIORAL HEALTH INTEGRATION

Department of Children & Families (DCF) hired an Opioid Behavioral Health Consultant to consult with Child Protective Investigators in the hubs and as active participants in the field;

- DCF hired recovery oriented system of care specialists (peers) working closely with treatment facilities providing MAT services;
- Out-patient services are being enhanced
  - Additional funds for engagement and OP
  - Staffed with FERS specialist (life coach-peer) to assist in navigating systems (CW, treatment, CM)
  - Statewide and local education on opioid addiction and MAT funded by the Managing Entity and STR money

Dependency Case Plans

- Make sure Case Plan includes counseling and ability to obtain MAT
- Develop strong relationships with treatment providers
- The provision of MAT is a **REASONABE EFFORT**

Disposition

Does the child need to be placed in the custody of DCF?
Is DCF's permanency plan appropriate?
Is DCF making reasonable efforts to achieve that plan?

What is known about prognosis for opioid use/addiction? What is known about treatment? What is known about the capacity of opioid abusers to enter and stay in recovery? What is known about relapses?

- Evidence exists that shows Medication Assisted Treatment (MAT) is very effective for opioid use disorders. These medications such as buprenorphine (e.g., Suboxone, Subutex) and methadone are not heroin/opioid substitutes. They are prescribed or administered under monitored, controlled conditions and are safe and effective for treating opioid addiction when used as directed by relieving withdrawal symptoms and/or reducing cravings.
- Most individuals receiving MAT also need counseling to address underlying problems that contribute to drug use such as trauma, other mental health conditions, and unhealthy relationships and violence.
- Appropriate medication for opioid use disorders should not have adverse effects on intelligence, mental capability, or employability. If a person on MAT appears "high" it is likely that they are also using other substances.

What case specific information does the judge need to know?

- Does the case plan include evidence-based treatment that the parent can access?
- Does the case plan identify, and address concrete supports the parent needs to engage in treatment?
- Does the case plan identify other substances the parent is abusing? Are these adequately addressed?
- Does the case plan identify any co-occurring disorders/issues (e.g. mental health, domestic violence, chronic physical health problems)? Are these adequately addressed?
- Have children under age 3 been referred for a Part C (IDEA) evaluation?
- Are child developmental delays being addressed?
- Does the case plan include an evidence-based parenting program as part of or in addition to drug treatment?
- If neglect or drug exposure was significant, has the child-parent relationship been evaluated and is there a treatment plan to improve that relationship?

Dependency Drug Court

- 40% of DDC clients have an opioid use disorder or alcohol use disorder
  - 27% opioids
  - 13% alcohol
- Use of Medication Assisted Treatment (MAT) - (Suboxone, Naltrexone, Vivitrol, etc.)
  - 72% On Medication Assisted Treatment
  - **24%   Not on Medication Assisted Treatment**

Dependency Drug Court

- Of the 24% not using MAT:
    - 80% opioid use disorder
        - All assessed for MAT eligibility, but declined
    - 20% alcohol use disorder
        - Ineligible due to medical concerns