OPEN NINTH:

CONVERSATIONS BEYOND THE COURTROOM

OPIOIDS, OVERDOSE, AND OUTREACH

EPISODE 79

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HOSTED BY: DONALD A. MYERS, JR.

(Music)

NARRATOR: Welcome to another episode of "Open Ninth: Conversations Beyond the Courtroom" in the Ninth Judicial Circuit Court of Florida.

And now here's your host, Chief Judge Don Myers.

CHIEF JUDGE MYERS: Hello, and welcome to Open Ninth. I'm here today with Keith Raskin, the Vice President of Crisis and Substance Abuse Services at Aspire Health Partners, the Center for Drug-Free Living, Florida's largest behavioral health nonprofit. Keith has also served as the Senior Director of Medication-Assisted Treatment and Detoxification Services. He's been on the frontline of addressing the opioid epidemic for the past six years at Aspire here in Orange County.

Also joining us today is Judge Reginald Whitehead, the Administrative Circuit Judge for Unified Problem-Solving Court Division and a member of the bench at the Ninth Judicial Circuit now for over 25 years. He presides over several special dockets that include our Drug Court Programs in Orange and Osceola County.

The Florida Supreme Court has declared July as Opioid Awareness Month to help bring awareness to the opioid crisis in our community, and I've asked our guests to join us to discuss some of the issues surrounding that crisis.

I'm honored to both -- have you both here. Thank you for joining us.

JUDGE WHITEHEAD: Thank you.

KEITH RASKIN: Thank you.

CHIEF JUDGE MYERS: Keith, let's start with you and get a little bit of background information about opioids and the crisis. What is an opioid?

KEITH RASKIN: Sure. Well, an opioid is basically one of the -- I mean, it -- an opioid can be anything from heroin to oxycodone. So it may be a prescription medication, but it also may be an illegal substance. It is a narcotic.

And heroin, for example, is derived from the -- from a poppy seed plant, same plant that morphine comes from. And so that can be found in many different prescription opiates as well.

CHIEF JUDGE MYERS: So we -- I've heard these categories of natural type of opioids and then the synthetic opioids. So heroin would be a natural form of that. Morphine would be a natural form of that as well?

KEITH RASKIN: That's right. Fentanyl would be a synthetic.

CHIEF JUDGE MYERS: Okay. And the synthetics are drugs that have been developed to serve as pain killers, or are some -- are they all developed for those good purposes, or some -- have some been developed for the purpose of distribution on the streets as illegal drugs?

KEITH RASKIN: Yeah. Sure. That's a good question. Well, fentanyl, for example -- I think that's an important place to go because that is what is causing a great deal of the deaths that we're seeing.

Fentanyl is basically -- was originally used as a medication. And so if you had an in-stage disease such as cancer, maybe stage 4, significant pain issues, you might get a fentanyl patch. That's how most people understood it. But that patch then couldn't continue to be used in other different ways, for example.

What's happened since then is we have people that have basically manufactured this themselves, and drug dealers have basically taken that, made it a part of the medications -- or I'm

sorry, the drugs that they're distributing out on the streets so it's being mixed with heroin and so forth. So it's both; it's a medication and it's also being used illicitly.

CHIEF JUDGE MYERS: So there are reports of opium being used as a painkiller dating back into the 1500s. Morphine was used as a painkiller during the American Civil War in the middle 1800s. Opioids have been around a long time. What happened? Why all of a sudden are we finding -- or talking about a crisis?

KEITH RASKIN: Sure. So I think there are several factors involved there. But one of the primary factors that we -- that a lot of people are pointing to is back in about 2010 there was a crackdown on the pain clinics and so forth, especially in the State of Florida, because we had quite a few of them. And when that got -- had the crackdown, you had a lot of people that were looking to figure out how they were going to get ahold of their opiates.

And you had compounded issues there. You had people that had quite a few opiates in their cabinets. You had still quite a bit of access in the hospitals and so forth for prescriptions, but then you also had a market out there for getting ahold of these on the street. And so you had people that traditionally hadn't gone out looking for opiates on the street, heroin and so on and so forth, that now were turning to that, that really were originally either being treated for a legitimate disease or they were maybe using something illegally or illicitly in that they weren't using their prescriptions properly, but it created a different problem that we hadn't seen before.

CHIEF JUDGE MYERS: So tell us just a little bit -- we're going to talk next about what does the addiction look like in real people. But tell us a little bit about your background so we can understand how it is you have a perspective on that.

KEITH RASKIN: Sure. Sure. My -- I'm technically a licensed mental health counselor. I've been doing this -- working in this field for about 20 years. I've been working at

Aspire Health Partners for about 15 years, working in substance abuse. I was on the treatment side of this for many years and moved into the management side of this and have been an administrator at Aspire Health Partners for about 6 years -- a little bit longer, actually.

As far as the relation to the opioid epidemic, I was working in our methadone clinic and was charged with heading up our methadone clinic in treating this as this was starting to come about. And so as we started to realize there was an epidemic, I was there. And we were basically, like everybody else, trying to figure out how we were going to address this.

Since then, we've done quite a bit, and I've been involved in quite a bit surrounding the crisis being part of task force in Orange County. The Orange County Task Force has been one of the more modeled task forces around the country, really, and especially here in the State of Florida, but really looking at how do we do this in the criminal justice system, how do we work better with the hospitals, and then as a treatment facility, what else do we need to be doing.

And a big part of that has been outreach to the community, trying to get the word out about how you get into services, getting NARCAN, naloxone, out there. So my job has really been partly about that, figuring out how to build those systems.

CHIEF JUDGE MYERS: And for our listeners' benefit, we are going to talk a little bit about some of those medications that you've referenced; the NARCAN, the naloxone.

KEITH RASKIN: Naloxone.

CHIEF JUDGE MYERS: Naloxone, thank you, yes.

KEITH RASKIN: That's actually the non-brand name of NARCAN, yes.

CHIEF JUDGE MYERS: Right. As well as the other medications that used -- are used as a part of the treatment, the methadone and those other things that you've referenced. So we'll get into that a little bit.

But in your experience then, what does addiction look like for an individual who perhaps finds themselves having started off with a legitimate medical condition that was extremely painful, prescriptions associated to assist with pain medication; how do we get from that to addiction, and then what does addiction look like?

KEITH RASKIN: Sure. So addiction, when it comes to opiates, looks like addiction to other things. We do know that the disease is progressive and it's chronic, the disease of addiction. And it exists in the brain. And so with regard to opiates, we know that you have natural opiate receptors. When you use an opiate, you are basically causing that to -- you're causing damage to the brain, which is in essence building a need for more because you're changing the structure of the brain, changing the need for the drug. You have natural opiates in your system. But in -- with addiction, in general, addiction is, as I said, progressive. And so basically what you end up with is a disease that has to be managed over a period of time.

With opiates -- with the opiate addiction, we know that the cravings are stronger than some other cravings. We also know that the drugs are more lethal than some other substances. And so when we're looking at this as a progressive disease, it's really important that we care for the person in a more aggressive manner, you might say.

And so in addition to that, we know that the evidence-based practices suggest using medications for that, not simply detoxing -- in fact, newer information is suggesting that detox may not be the best way to go on the first line -- really getting this medication to somebody, evaluating for the medication to make sure it's medically warranted. But SAMHSA and some of the other agencies that kind of oversee this look at this as, you know, what do you need to do to make sure that this person is primed for better success, and really getting somebody on the medications and evaluated is at the front end of that.

CHIEF JUDGE MYERS: So you referenced this idea of detoxification.

KEITH RASKIN: Sure.

CHIEF JUDGE MYERS: So if somebody has used or abused the drug to the point that they have come to a place where they are unable to cope and manage, they may find themselves incarcerated, arrested, or in an Emergency Room type setting.

What is detox; what does that mean?

KEITH RASKIN: Yeah. So detox is going to be basically medically managing the person off of using that substance to the extent that they're safe to go back out on their own. However, very often we need a step-down level of care. In fact, it's always recommended we do some level of step-down. But that level of care could be a relatively higher level of care, meaning it could be a residential program coming out of a detox. Especially when we're talking about these substances, because that is such a strong pull to continue using.

It doesn't take -- it doesn't mean that you've stopped having withdrawals. In fact, withdrawals can take place for months, and some suggest that it could even be years that you're still having cravings. And so that piece needs to be treated. So what you're really doing in a detox is medically managing the person so that they can wean down and they're not craving at the level that they were craving before, but also can come off and work through some of the pain, some of the symptoms that they have as a result of that withdrawal when they first try to come off.

CHIEF JUDGE MYERS: And are there medical consequences of detoxification from opiates?

KEITH RASKIN: Medical consequences being -- if you try to detox on your own, there can be medical consequences. But one of the bigger consequences is that it is very difficult to do

because of the symptoms that you have. And so most people that try to do this on their own, from opiates in particular, find it very difficult to do on their own. So it's very important that they're doing this in a managed way with a doctor, nurses and so forth.

Because the biggest consequence would be that they go back to using. And when you take some time off of it, one of the biggest concerns is when you go back to use you often go pick up exactly what you were using before. And if it's been a few weeks or been a few days even, using what you were using before, you've dropped in your tolerance level which can result in death. And that's very concerning, obviously.

CHIEF JUDGE MYERS: Well -- so that's interesting. I recently read a quote by the Sheriff over here in Seminole County. And what he said was, perhaps the most profound realization that all of us must embrace is the fact that the greatest predictor of whether you will overdose and die is whether you have overdosed and lived.

Does that connect with that idea of tolerance and the idea that you go back to using that same or possibly more amounts?

KEITH RASKIN: It does. It absolutely does. I mean, there's other factors there as well, but certainly that would make sense that that would be one of the greater predictors, for sure.

CHIEF JUDGE MYERS: So we talked some about the physical consequences of addiction of this nature. Are there psychological components to it? Is it multifaceted?

KEITH RASKIN: It is, which, you know, also feeds into the stigma that's out there. It's not uncommon to have this as a co-occurring issue related to other mental health issues. Not to say that everybody that has addiction has a mental health issue. But because when you have addiction issues, you're exposed to things that present as possible traumas or inducing trauma.

So, for example, you're putting yourself in more risky situations. A woman that's using heroin is more likely to find themselves in a position that's vulnerable. And because of that, we find that there's quite a bit of risk involved, quite a bit of trauma that may have occurred, and with trauma sometimes comes mental health issues such as PTSD or depression, anxiety, all of those things. That said, it's important that treatment providers are also looking at it from the standpoint of treating the whole person.

And so -- and then you have the issue of the aftermath of the use and how it affects the family. So I mentioned the stigma, there's a lot of stigma about people that are using because it creates a lot of situations where people aren't behaving well. And so sometimes they're engaging with family, the addiction looks like all that matters is me because all I care about is my drug right now. That's an indication of the true disease. And things are falling apart around me but I can't hear you.

The stigma that gets created prevents people sometimes from being able to access treatment, because as the supporting member or family member or whoever that is in the community, you're often interfering with that process saying, you know, just -- I can't put up with this anymore, I don't know what's wrong with you, I don't know why you're doing this, so on and so forth. So it does -- it creates some significant barriers and it has a lot of aftermath. I mean, it really affects all systems.

CHIEF JUDGE MYERS: Collateral damage. Right.

KEITH RASKIN: Absolutely.

CHIEF JUDGE MYERS: So you mentioned an organization, SAMHSA. What is SAMHSA?

KEITH RASKIN: SAMHSA governs basically substance abuse and mental health. But it's one of the guiding agencies government-wise -- Federal Government agencies that pushes out the research, does a lot of the evaluation as to what works. And so when we're looking at what we're doing, we're trying to match it up to evidence-based practice, what's been researched, and they're the ones that often are guiding us in that.

CHIEF JUDGE MYERS: Good. So in your experience and statistically, if you know, does the addiction strike men and women equally?

KEITH RASKIN: Well, traditionally, opiate addiction has been seen more commonly with men. In fact, it was more commonly with -- seen in men that were white and, you know, 20 to 30. What we know is that these statistics are changing significantly. And so now we're seeing, you know, different classes, different -- socioeconomically, different races, different genders all going up. And so we're seeing kids on opiates that wasn't seen before very frequently. We're seeing pregnant women on opiates. We're seeing people that are older and traditionally were using cocaine now using opiates that wouldn't have gone there before. In fact, they'll tell you, it's been like 20 years -- I've been using for 20 years, never thought I'd be using opiates.

And a big part of that is the way that they're incredibly accessible now. In fact, some of the studies that have been done recently -- I saw some statistics up in New England where they found that 10 percent, 9 percent -- don't remember the exact percentage, but the cocaine that was being taken off the streets had fentanyl in it. That's highly concerning. And what we also know is that heroin that people are using and other drugs that people are using on occasion have opiates in them because drug dealers have recognized that this is a lucrative business and this is how they can pull you into it.

CHIEF JUDGE MYERS: Now, I've heard this idea that fentanyl is very inexpensive to produce, relatively.

KEITH RASKIN: It is, that's right.

CHIEF JUDGE MYERS: And that that's one of the reasons it's being introduced into these other drugs to get the same high or perhaps a higher high without the expense. Is that --

KEITH RASKIN: Yeah. My understanding is that heroin and fentanyl are not that different in the amount that it costs to produce it. But the amount that you can make off of it is quite a bit more with fentanyl because it's a lot stronger, so it just follows basic business when you look at it from that perspective.

CHIEF JUDGE MYERS: So we've heard a good number of stories in the media about NARCAN and an emphasis to put NARCAN in the hands of law enforcement and other first responders. What is NARCAN?

KEITH RASKIN: NARCAN is what I was referring to earlier as naloxone. That's the active ingredient in NARCAN. Naloxone is able to reverse the effects of an overdose. It won't do anything if it's not being used for opiates. So if somebody is overdosing for some other reason, NARCAN is not going to do a thing. It's just going to -- you know, it's going to have a zero effect.

So it's incredibly advantageous for people that encounter opiate overdoses or are likely to encounter opiate overdoses to have this in their arsenal. In fact, we've done outreach events in the community to try and get NARCAN into areas where you see a lot of overdoses or hotspots in the area to put NARCAN in the hands of the public because it's no different -- it's very easy to use, in fact. It really just requires the person have a training, but the training isn't that different

than using any other nasal spray. So you basically just have to get it up into the nostril and spray it. This is just one version of it. This is what most people on the street would have.

But when you spray it, it basically can pull the opiates off the receptor, therefore releasing the effects of the overdose and gives you a period of time to get the person to the Emergency Room. Without that, they can overdose and die because the brain is telling them to stop breathing, continues to slow them down. When the NARCAN pulls that opiate -- or cleans that opiate receptor off, the person comes awake, sometimes relatively violently, but it gives you time to get the emergency personnel there, if they're not already there and the ones that are administrating it, and get them to the hospital.

CHIEF JUDGE MYERS: So just to kind of wrap around this a little bit, what's the scope of the crisis in the State of Florida versus the nation, and in our community in particular compared with the rest of the state?

KEITH RASKIN: Yeah. So nationwide, my understanding is that we've had 2017 -- in 2017, the statistic was about I believe in the neighborhood of 72,000 overdose deaths. With opiates, it was more than half of those deaths. So we -- and I -- just to give some perspective on that, in our clinic, in our detox, it used to be that opiates was one of the more uncommon things that we would see in a detox. Now it is about 90 percent of what we see in our detox. Doesn't mean that there aren't other substances there, but it's very often in the drug screen we're doing in the clinics.

Thirty thousand of those -- approximately, nationwide of those overdose deaths are fentanyl related. So that tells you what's actually killing people when it comes to these overdoses. That's only the overdose deaths.

Now, if we were to talk about overdoses in general or just use in general, the numbers are astronomical. The State of Florida follows the exact same pattern. Orange County, same pattern; there's no difference here. So when we're looking at the numbers here, it looks just like that, you know, proportionally.

CHIEF JUDGE MYERS: So we've seen this rise, obviously, dramatically over the last 10 years. I think I read a statistic that this is anticipated to continue to increase through 2025 even, so we're not on a downward trend by any means. We haven't addressed the problem to the point where it's even going to level off.

KEITH RASKIN: Absolutely. That's exactly what we're seeing.

CHIEF JUDGE MYERS: So, Judge Whitehead, let's talk a little bit about where opioids intersect with the law and with the courts. Tell me your experiences -- so tell us a little bit, I guess, about what you do in the Problem Solving Courts generally, and then we'll focus in a little bit down onto the Opioid Drug Court issues.

JUDGE WHITEHEAD: The Problem Solving Court, it all started with Drug Court. I started doing Drug Court in Osceola County in 1990 -- '99, and we went from Drug Court to Mental Health Court, Veterans Treatment Court, Problem -- Court. We also have a Juvenile Drug Court, which we now have a Dependency Drug Court too.

And over the years, you've seen some of the same problems that you just talked about here today; you see them evolve. We didn't see the opioid addiction. Every once in a while, even in Drug Court, I'll say 10 years ago, we may have three or four people on heroin. Now, all of a sudden, out of 150 people, I may have 80 people with an opioid addiction. And we decided that we needed to start an Opioid Court too, because of the fact that dealing with that addiction is different than a normal addiction. You really need to get some input from treatment, the

detoxification process -- this is very educational to me too, just understanding now why we do certain things in court.

And over the course of time, we've seen the difficulty we had. Because the opioid addiction, it's not one of those where you think, okay, they're in a program now so they should be okay. That was our struggle, getting individuals that were incarcerated to get to treatment. And not only to get to treatment, to get to detox and then staying on them with the treatment plan. Everybody had their own individual treatment plan.

That required more work, but it also required education from the standpoint of the bench, the lawyers, and also the case managers and even treatment too, just understanding how we can all work together and come up with a solution. And that's what we do. It's almost like you can't come up with a set plan. You have to kind of work over the course of time. We meet every two or three months, say, okay, now, that wasn't working; let's see what else we can do now.

And that's a little different, because we like -- in the legal process, we like to set rules and laws and stick them there and make them work and kind of force people to do that. Well, you can't do that with this addiction. You have to try to feel what's going to work. And if it doesn't work this time, we'll come back and come up with something else.

CHIEF JUDGE MYERS: So the idea behind Problem Solving Courts, and Drug Courts in particular, is a recognition that the traditional methods of sentencing and consequences for behavior weren't effective?

JUDGE WHITEHEAD: Oh, yeah, I should -- I forgot about that when I started thinking about some of the things you were saying. What Problem Solving Court is really designed to do is to give you more time to give individual attention to individuals. The average judge will see a person on a criminal case two or three times. And during those two times -- two

or three times, the longest time may be the sentencing process. And they really don't get to know the individual. They don't know that individual's problems.

In all the Problem Solving Courts, I will see that individual at least twice a month. Sometimes, if it's an opioid addiction, I'll bring them in every month -- every week. And I will get -- have a staff of people, treatment, case managers, probation officers, giving me input as to their progress. I will know where they're living in this community, I know whether they're working or not, and then it gives me some kind of way of getting to really know this individual. And that's what -- Problem Solving Court is there to solve some of their problems. We don't solve the problem, but we provide the support that if they really work hard at it and they try, they can solve the problems themselves.

One of the phrases I like to use is, the reason you have this addiction is either people, places or things. Now, you know which one you're getting the drugs from, so you have to make some changes in your life. But you also know we have to have support; you cannot do it by yourself. You need family support, and sometimes you need professional support. And that's what Problem Solving Court is really about.

CHIEF JUDGE MYERS: So you talked about seeing folks in these specialized dockets multiple times a month.

JUDGE WHITEHEAD: Um-hum.

CHIEF JUDGE MYERS: What's the length of time that you might work with somebody in that court system?

JUDGE WHITEHEAD: Well, you'd think that in -- the natural assumption by a lot of people in the community is that, okay, you're in a Drug Court or a Problem Solving Court now so you can get your act together. But it's an addiction, especially with opioids, and it takes time.

Because even if you go to detox and you do residential and then you go back into the environment where you can get the drugs at, there's that temptation as you indicated and that urge for -- the craving for that drug. So it varies, I guess, to say.

The program typically, if you do -- in most of the Problem Solving Courts, if you do everything you're supposed to do, and diligent in going to treatment and going through the different phases, it usually takes about a year to go through that process, on average. That's the average length of time it would take.

CHIEF JUDGE MYERS: Keith?

KEITH RASKIN: Yeah. I was going to add to that, because the one-year mark actually correlates with the stages of change, and that's what guides substance abuse treatment in many areas. And so what that is, is it's sort of a breakdown of the different stages of somebody who is going through addiction treatment. And the final stage of change, being maintenance, is where you would be in the six-month to one-year period, meaning that you have had significant time not using anything, therefore the brain has been able to heal. Because we know that the decision-making center of the brain is what's highly affected and no longer working properly when you're using. So you need some time for that to heal. So that six months to a year period allows them to start making better decisions.

And so to Judge Whitehead's point, that makes sense why that would be the time needed. Because you are going to have relapse. As this is a progressive disease, you're going to have times where somebody picks up and uses. But the goal would be to have those times be shorter and shorter to where we're not having them anymore. And, you know, not unlike other types of diseases it's, you know, kind of like when you're getting treatment for cancer, for example, and you get chemo, you may have to go back for treatment again. It makes sense to be under a

doctor's care during that time as well. You're not just -- you know, hey, call me if you need something. It's -- usually you're being -- you're coming back and being rescreened and checked and so forth.

JUDGE WHITEHEAD: Even when we do graduations from various Problem Solving Courts, one of the things that we'll talk about to that individual is that, look, what you learned here is -- you learned all the tools; we've given you the tool chest and the tool kit to help yourself now, so don't put that tool kit on a shelf and forget about it; you need to keep practicing those things.

Because like, you know, in aftercare, you're giving them maintenance and tools that will help them survive as they are, because they're on their own now. They're not on probation any longer, they're not under the court's supervision. And many times we'll see an applicant -- we'll have an individual who will go back and relapse. And some of that relapse will be that, I was afraid that I was losing my support system so I intentionally did that so that I could stay here a little longer. And some folks we have to push out because we have to encourage them that, you can't just stay in this situation forever. You're going to have to go out there and exist without the support -- well, not so much without the support, without -- with the tools that you need to have, but not in the court system.

CHIEF JUDGE MYERS: Right. So, Judge Whitehead, you're -- are you a licensed mental health counselor?

JUDGE WHITEHEAD: I feel like it sometimes because I -- not -- no, I'm not a licensed mental health counselor, but you do a lot of -- little bit of everything in this process. You -- I listen, I support. Even sometimes -- it may not have anything to do with the addiction, but just what we try to do in our Problem Solving Court is not just always talk about sanctions.

We give individuals incentives. You know, if you have 35 days of being clean and free, we give you a round of applause, a Way To Go certificate, and we recognize you. We move people up in dockets. We like to focus on the positive things.

Sometimes I will -- and that's why we have staffings after -- before each session so that they kind of -- this is my cheat-sheet to give me all the information I need to make me look good, but it's not so much making me look good as it is when that individual comes up, I heard you got a new job, and how do you like your job. Well, now we're just having a conversation and you can see that individual light up like, well, these people care. And one thing I've learned consistently, if people find out that individuals around them care about what they do, they try harder and they make that effort.

A lot of times, like you said, the mental health aspect of it is depression because nobody cares, nobody's concerned about me, I don't have that support. Well, now you see you have individuals supporting you in roles that you don't normally expect them to be supporting you. We have prosecutors that are congratulating them on cases. Their attorneys come back after they put them into the programs and encourage them to continue to do well. So with that support, individuals try harder.

CHIEF JUDGE MYERS: So you rattled off a list earlier of all the different people that participate in the Drug Court Program. You've got case managers. You have counselors?

JUDGE WHITEHEAD: That's correct. The treatment -- we call them treatment -- the counselors come. And I think it's important that we all know -- I've visited treatment facilities because I need to understand what everybody's doing and their roles. And we do have case managers, we have a probation officer that's usually there. And it's a probation officer that's assigned to all of the Problem Solving Courts, so it's not a variety of probation officers, so they

understand how the process works. They understand that when an individual has a positive drug test and on probation, it's not an automatic violation of probation; we're going to immediately address that in court.

And that's one of the things where court comes in at. We try to have immediate consequences. In other words, you test positive today, they notice me and we set you on the docket within a week so we can address that. Because what I've found is if we don't -- wait, and they know they have court in two weeks, they'll just use three or four times and we'll just have that one sanction. But if we can get that problem addressed -- well, what happened; there was a death in the family, whatever -- and we can talk about it a little bit, that mental health part comes in.

And prosecutors are important too, because they make the decision. And we have one individual that's the prosecutor assigned to all Problem Solving Courts, and that particular prosecutor reviews all the cases so we have consistency in the type of cases that we're bringing in. Because we always have to look -- from a prosecution standpoint, they don't want to bring someone in that may have a, say, delivery of cocaine and it looks like they may be a drug dealer. But he has to make that decision, is this a person that's a person that was selling drugs to support his habit. And he may not know all of it until he gets the evaluation back from treatment, they may tell him that.

And so we have consistency there instead of having, say, 50 prosecutors deciding these are the cases to come to Drug Court. We have one prosecutor that's reviewing those cases and he understands the need and he also understands addiction and everything because he came from a background of Drug Court too. So that helps us too. So it's not just that they are being

prosecutors. They may be the gatekeeper to a certain extent, but it's also an encouragement to them to see people that are successful in the program too.

CHIEF JUDGE MYERS: Okay. So is there anything unique about the Problem Solving Court docket as it relates to the opioid cases? Do you handle those just as a part of the larger group of cases or are they handled separately, and why?

JUDGE WHITEHEAD: Initially, we -- they were together, all the cases. But we just weren't having the success that we thought we needed to have with our opioid cases. And we started realizing that most of them need to be in detox. And you go from detox to residential care. And during that time -- normally, when you have positive drug tests when you initially come in in the regular Drug Court process, you sanction each positive test. But with opioids, we decided we needed to give them some time to get in treatment and get adjusted to treatment.

A lot of times it's a residential treatment and you've got rules and regulations there. But just getting them there and getting them stabilized, because of the withdrawals and everything, we had to kind of slowly deal with them and let them go to treatment for a while before we brought them to court and start addressing some of the things that we need to do -- that we would normally do.

And also we had -- it's trial and error. We had to learn. We have -- I won't call it a staff -- we have a quarterly team meeting where we meet because some of the things we're doing aren't working in Opioid Court right now and maybe there's something more we can do to help this individual. And so we kind of change the rules as we go, and we're still feeling our way through because this is something that, like I said, it's an individual process.

And you have to have some -- in my opinion, I know we haven't gotten to this yet, but I think you need some type of medication to assist you with your addiction. This isn't one of

those where you can just go cold turkey. And for all the reasons that you've been explaining to us, you have to have some type of medication assistance and you have to go to detox before you can get to that point.

CHIEF JUDGE MYERS: So that's probably a good time to transition and talk a little bit about some of the treatment options that are available for the individual who is -- who suffers from an addiction or use problem. What's the big picture of the treatment regimen?

KEITH RASKIN: Sure. Sure. There's many different ways to do that and there's different levels of care. And so that's evaluated depending on the point of entry. And so to Judge Whitehead's point, you know, evidence-based -- for opiate addiction, evidence-based treatment is medication-assisted treatment, or at least the evaluation of whether or not that's appropriate for this individual.

And so that's important, I think, to note simply because, as Judge Whitehead mentioned, you can't just do the same-old same-old. It doesn't work, so you just bang your head against the wall trying to do basic talk-therapy with somebody who actually needs a medication to help heal the brain so that we don't continue that cycle.

But the full continuum of care includes everything from a detoxification, which would be a three to seven-day stay in a detoxification unit, not dissimilar from an Emergency Room or hospital where you're medically managed to come off of that medication, then you would step down either into a residential program depending on the level of use, the factors at home, how often have we seen you, is this the first time or the second time, did a physician make the decision that a professional certification was needed because the level of use was at the level of potential death and overdose. All of those factors play into whether or not we determine the person needs to go to a residential level of care.

In the traditional Drug Court model that we use, if residential is not needed, everybody is stepping at least into the intensive outpatient model, which means you're going to get nine hours of treatment services every week on top of the medication, if that's what's advised. Those nine hours aren't just pulled out of a hat. That's what intensive outpatient studies have backed up, this is what that should be, that's a level of care. And so you're getting group counseling, you're getting individual counseling, you're getting your drug screens and that medication. So it's quite a bit.

Then if you're successful in that, you might drop to a standard outpatient level of care, which is going to be maybe one group or one individual during the week. It's very much geared towards where you're at. So as you work through the stages of change, let's say you get to the maintenance stage, you might drop to fewer services.

It's important to note that the medication-assisted treatment alone is evidence-based, as I've mentioned. And that model only has a one time a week meeting with a therapist, and it's proven to be effective. So the medication has also been proven to be the most important component of that.

So getting somebody to be on the medication is more than half the battle. Then having them meet with a therapist during that week is important. But a big part of what they're doing is trying to make sure that you're showing up for your medication.

JUDGE WHITEHEAD: I think that it's an important thing to let everyone know, especially from a judicial standpoint, I can't order anyone to take this medication. And I tell them that I can't -- I'm not a doctor. I can't order you to take medication. It's your body and you have to make that decision. However, treatment has recommended that this is what you need. So if you're going to stay -- be able to stay in this program, you're going to have to be

able to take that medication. I can't -- I'm not going to penalize you, I don't punish you by -- but we have to follow their recommendation because it's not just a recommendation from a counselor, you've seen a doctor.

And because you have to really monitor this situation because we're losing people, even in our programs. We still lose individuals. I mean, lose in deaths. More so than I've ever seen. That's why it's so serious.

And I think about the cases of people that aren't getting any treatment that I know -- I hear about it in the news all the time. It's almost like a regular thing. If you look at the paper, that you're seeing someone dying from heroin overdose or opioid overdose. So it's important that we understand what's going on in treatment. Just like treatment can understand how we -- and that's one of the things I've -- how the courthouse actually works.

But in our staffings, treatment is learning how to be more candid but also not reveal things that may be something that from a medical standpoint they don't need to tell us. But they tell us all the important information we need to know, hopefully to help this individual get better.

CHIEF JUDGE MYERS: So we talked about treatment programs that includes some counseling as well as a medication-assisted treatment program in conjunction with that for the highest effectiveness. I've also heard discussions about peer support.

KEITH RASKIN: Peer support, yeah. And that is sort of -- it's newer in terms of treatment programs looking at -- and I wouldn't say it's new completely. It's been around. But it's being looked at now as a very integral part of this process.

Now, the way a lot of these programs are funded is through State and Federal funding. And that is still -- you know, everybody is still getting their head around the idea that somebody who comes from the side of this problem as somebody who's suffered from the disease might

actually be beneficial to somebody -- is new. But what we see is that people are starting to gravitate around that now. And so new funding has started to come in now, saying, hey, we want to do this.

Now, there's regulations as to how to get somebody certified as a peer, which is not easy to do. And so there's some hoops that need to be worked through on that side. But peers are very beneficial from the standpoint of helping somebody stay in treatment.

And so very often somebody who's been through it, you know, walk the walk, can talk the talk. And so somebody who has -- is going through it sometimes is benefitted from talking to somebody who's been there before.

CHIEF JUDGE MYERS: Okay.

JUDGE WHITEHEAD: I will notice -- even in court, when I'm doing hearings, I have a hundred people in the courtroom, I will see some of the individuals that are -- I'm not saying older but just a little wiser and more mature, they will encourage others as they're coming up to the podium. I'll see them in the background talking to them. And I can see them and I always -- I let them know, I say, you always been encouraging other people. And he'll say, that's why -- somebody encouraged me. So that was a big motivation. So it really works.

And like you said, we have Federal funding for it. And even with the Federal funding, they don't have anything set -- they're still trying to feel their way as to what works. And every once in a while they'll bring an evaluator down to our program that goes around the country. And I think it's very beneficial because now they share with us ideas from other areas and they learn things from us that that they can take to other places too.

CHIEF JUDGE MYERS: You know, it's difficult to drive down the street without seeing those signs on temporary stands advertising everything from cell phone plans to timeshare buybacks to selling your home for a great price.

I was driving down the street recently and saw a sign that said, need Suboxone, and had a telephone number on it. What is that about?

KEITH RASKIN: Yeah. Well, that's -- that isn't -- first let me say that's not our treatment provider that's doing that. But that -- I can't tell you exactly what that sign is, but I can tell you that --

JUDGE WHITEHEAD: I'd be leery of that sign, there.

KEITH RASKIN: I'd be leery of it as well. And we -- when we've seen it before, I can tell you I've called them before to find out what's being set up. And it's very often a situation that somebody is basically just bringing people in quickly to get them started on the medication. And all these other things that we're talking about, the supports, aren't there.

It's also geared at people that can pay. And we know that most of the people that we're serving in these clinics don't have the resources. They often don't have insurance. They often don't have a whole lot of money to their name. Even if they did before, they've lost much of it because of the use. And so it's really catering to a small portion of people. And, you know, I'd be leery of those signs as well.

CHIEF JUDGE MYERS: We can't take a deep dive into it today, it's something I'd actually love to come back and talk with you further about, but the medication lists; the methadone, the buprenorphine, the Suboxone --

JUDGE WHITEHEAD: Vivitrol.

CHIEF JUDGE MYERS: -- Vivitrol; what's the point of those medications? How do they assist in the treatment protocol?

KEITH RASKIN: Sure. They work differently to -- in some respects. The methadone and buprenorphine work very similarly. Vivitrol, or oral naltrexone -- oral naltrexone has basically -- basically is the generic version of Vivitrol, although Vivitrol is an injectable that lasts for quite a bit.

But without getting into all the details of them, they work differently but the outcome is the same, which is it basically results in you not wanting to use or not being able to get high. In the case of Vivitrol, you're actually blocking the effects. So if I do use and I'm on Vivitrol or oral naltrexone, I'm not going to feel it, which is a big component of this.

Because basically if I do go out and use -- and sometimes people are using not so much because of the -- always the craving, sometimes it's because it's what I always do. And so if I've been doing that every time I run into my, you know, stressor or trigger, I might go use. But I find out I don't get high, then I know it's a waste of money. It's a waste of money and, you know, it kind of teaches me that this isn't worth it.

We do find that sometimes somebody will test positive for something and you go, what are you doing. But the reality is, that is different that methadone or buprenorphine in that you still can get high with those but your cravings go down significantly and you're generally stabilized on those at a very low dose and so you don't need to keep going up and up on methadone or buprenorphine the same as you would if you're using illicit substances.

CHIEF JUDGE MYERS: And the methadone and buprenorphine are opioids, is that right?

KEITH RASKIN: They are opioids, yes, they are.

CHIEF JUDGE MYERS: Okay. So one of the criticisms you hear about this idea of treating an opioid disorder with simply supplying a different opioid, how would you respond to that?

KEITH RASKIN: Yeah. Well -- and I'm not a doctor, so I can tell you how our doctors have explained it to me. And it's not dissimilar from what I just mentioned to you, which is that the -- if you're using heroin, for example, you're going to build a tolerance to that and you're going to need more and more and more of it.

If you get to a certain level of methadone, as a doctor that's overseeing you and seeing you on a regular basis, I can determine that this is exactly where you need to be. Sometimes at a very low dose, relatively speaking. And you're no longer going to have your cravings at this dose and you're going to be able to function. And eventually we'll be able to taper you down. Can't do that with heroin; you're going to keep going up and up.

So yes, it's an opiate, but it operates differently, so --

CHIEF JUDGE MYERS: Let's wrap up and talk a little bit about your thoughts about where all of this heads over the course of the next 10 years.

KEITH RASKIN: Sure.

CHIEF JUDGE MYERS: What do you see happening?

KEITH RASKIN: Sure. Well, I can tell you that the need is certainly needing to focused on the treatment aspects as we've been discussing here. It's for every two dollars spent in the treatment side, you're saving ten dollars in jails and in courts and in your hospitals. That's significant. You know, it's really looking at how we're devoting our resources. If we do that -- and the good thing is a lot of people are talking about this, you know, just like here today. This is a different thing than we've experienced before.

There's more deaths related to this annually than breast cancer, than gun violence. That's astounding. And so I think the attention on this should have a positive effect in the long run. But in the short term, it's not getting better right now so we want to make sure that people don't -- aren't confused by that.

One of the areas that we need to figure out how to help get out there is not just what the problem is but where do you go, how do you get into treatment. And too often, you know, you watch the news reports and nothing is said about this is where you go to get the treatment. It's all about, you know, the person that died or the overdoses or sometimes the first responder that was exposed to fentanyl and the statistics and how horrible they are, but you're not seeing anything about where do you go. That's important.

CHIEF JUDGE MYERS: And Judge Whitehead, in the court system, what do you see in the next couple of years?

JUDGE WHITEHEAD: Well, I hope that we can continue to have conversations like this because it's very educational to people before they get to the court system, possibly. And hopefully that will help them understand where to go, what to do with this problem. It's going to change the way we do things in court.

And sometimes as veteran judges, new judges, we all get stuck in the same old routine, in the same old way of doing things, and we can't do that. We need to educate our judges more that they understand, their prosecutors, their defense lawyers, all of the staff, probation -- we need to understand that this is a different situation here and we have to handle it differently.

And I think it would help us address other addiction issues too, with other types of illegal drugs also. So it's something that we have to spend more time, we all have to get educated and learn more by going to seminars.

I'm going to a drug court conference in two weeks -- the National Drug Court Conference in D.C. You meet people from around the country that are having the same problems. It's the same everywhere. And we could come up with more creative ideas about how to address it. So I think that it's good to have a national -- well, a month of Drug Awareness, but we've got to carry it on to each month, almost every day.

CHIEF JUDGE MYERS: That's wonderful. Well, this has been a fascinating conversation, gentlemen.

Mr. Raskin, thank you.

Judge Whitehead, thank you very much.

Great conversation about the intersection between our courts and the opioid crisis, something that it sounds like it's going to be with us for some time to come. And I imagine we'll have an opportunity to come back and have another conversation. So thank you.

KEITH RASKIN: Thank you.

JUDGE WHITEHEAD: Thank you.

(Music)