

Drug- and Alcohol-Abusing Offenders and Treatment. In S. M. Barton-Bellessa & J. G. Golson (Eds.), *Encyclopedia of Community Corrections*, Thousand Oaks, CA: Sage Publications (2012).

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Drug- and Alcohol-Abusing Offenders and Treatment

There is a great deal of interest in community corrections as a means of dealing with the problems of the abuse of illegal substances, pharmaceuticals and alcohol. Much has been made of their link to crime and there continues to be some debate about the propriety of treatment vs. punishment, especially for drug offenders. The following examines the relationship between substance use problems and crime, the impact of community treatment, some of the requisites for effective treatment (diagnosis and use-monitoring) and some of the types of treatment available.

The Arrestee Drug Abuse Monitoring Program (ADAM II) samples adult males who are arrested in ten different cities across the United States. Of the arrestees sampled, 31 to 51 percent had used marijuana in the previous 30 days, seventeen to 44 percent tested positive for cocaine and from one to 29 percent tested positive for heroin.

This data underscores the problem of drugs in America, but the data also shows something else. The distribution of the drugs used at the time of arrest varies widely from city to city. Methamphetamine was used by 31 percent of arrestees in Sacramento, California, but was almost unknown in New York. Similarly, while Heroin was used by 18 percent of Chicago arrestees, it was only present for one percent of arrestees in Charlotte, NC. Drug abuse is a real problem, but is not a uniform problem. Drug abuse is often a part of a local culture and economy; it is not a single phenomenon.

Violent crimes accounted for more than 15 percent of the arrests in nine out of the ten ADAM cities and ranged from 17 percent in Atlanta to a high of 31 percent in Chicago. Property crimes accounted for 11 percent of arrests in Washington, DC and 34 percent in New York. Drug related crimes, including simple possession accounted for over 20 percent of crimes in all sites and nearly 50 percent of arrests in Washington and Chicago. A final category, other crimes, made up more than 40 percent of all crimes in six of the ten cities. The other crimes category included violations of community supervision (probation and parole), public order offences, traffic offences (including DUI and DWI), and other minor offenses. It is striking to note that the combined levels of the drug crimes and the other categories account for more than 60 percent of all crimes in nine of the ten reporting cities and more than 75 percent of all arrests in half of the cities sampled. While this does not negate the fact that drug and alcohol use is associated with criminal activity, like broader patterns of criminality, the larger proportion of crimes reported are non-violent.

Although using a different measure (the number of reported arrests, not individuals arrested), FBI drug arrest statistics for 2009 indicate that 18.4 percent of drug arrests were for manufacturing or distribution while 81.6 percent of those arrests were for possession with the total number of drug related arrests estimated at 1,663,582 arrests. Arrests for driving under the influence (drugs or alcohol) were estimated at 1,440,409. As noted in the ADAM report, the bulk of arrestees had been arrested multiple times in the previous year. According to the Bureau of Justice Statistics, in 2008, 19 percent of the victims of violent crime believed that the offender was under the influence of alcohol.

Treatment as an Answer to the Cost of Imprisonment

The PEW Charitable Trust reports that in April 2010, there were more than 1.6 Million Americans in jail or prison. The National Center on Addictions and Substance Abuse at Columbia University (CASA) estimates that the cost of imprisonment for drug offenders on both state and federal levels amounts to 37 billion dollars a

year. Diversion of even ten percent of that population to drug treatment would result in significant savings.

As a policy issue, drug related crime has become a centerpiece of some of the commonsense approaches to the costs of imprisonment and the practical effects of drug treatment. In 2000, California's Proposition 36, by allowing for diversion or treatment for persons whose most serious offense was drug possession, set the tone for correctional treatment for drug offenses across the nation. According to the Campaign for New Drug Policies, in the year after its implementation, prison populations in California dropped by 20 percent, a reduction of 4,000 persons. This led to a spate of similar initiatives across the country that resulted in significant savings from both the long term effects of treatment and the short term savings in the direct costs of imprisonment.

While the move from a punishment regime to a treatment regime has been resisted in some quarters, both the National Institutes on Drug Abuse (NIDA) and CASA agree that there is significant evidence that mandated treatment is as effective as voluntary treatment and that community supervision is as effective in its capacity to reduce recidivism as imprisonment. There is long standing agreement, that mandated treatment keeps people in treatment long enough to have a positive effect on both their substance use problems and the probability that they will return to crime. For persons under community supervision (probation parole, supervised release and pre-trial diversion), drug and alcohol treatment represents a cost effective means of providing a humane and effective measure of correctional control and rehabilitation.

Addiction Treatment: Assessment and Monitoring

According to NIDA, addictions come in many forms and treatment needs to be tailored to the needs of the client; there is no 'one size fits all' remedy. From the outset, it is important to determine the offender's level of drug or alcohol involvement. It is possible to differentiate between substance users (experimental or recreational users), abusers (persons who have had or risked significant trouble with family, employers, school or the law because of ongoing drug or alcohol use), those who are physically dependent (those who display withdrawal symptoms, use more than they would like, or show an inability to quit) and those who are addicted (those who display the symptoms of dependence along with craving and obsessing about the problem substance or behavior). These basic levels are typically determined by instruments using criteria from the Diagnostic and Statistical Manual of the American Psychiatric Association. For this purpose there are multiple scales and diagnostic services available to Community Corrections Professionals.

Each level of problem calls for a different kind of response. Whether the problem is illegal drugs, prescription drugs, alcohol or multiple substances, diagnosis of the level of the problem is an essential first step towards treating the problem. In the context of community corrections, diagnostic services can be provided by consultants and contract agencies, although some community corrections agencies do in-house assessment.

One of the important considerations for any drug treatment regimen is the accurate monitoring of continuing substance use during treatment. It is impossible to determine whether treatment is being successful, if there is no objective measure. While there multiple ways of determining whether or not an offender assigned to substance abuse treatment is drinking or drugging, the most common way of testing for drugs is urinalysis. Most programs test for the so-called NIDA-5 (Cannabinoids, Cocaine, Amphetamines, Opiates and Phencyclidine). Expanded panels also test for alcohol, barbiturates, ecstasy and others. Ideally, offenders with treatment conditions should submit to random urinalysis on a weekly basis. Random weekly samples mean that on average, the sample is taken weekly but the sample may be taken on any day of the week; the client does not know on which day she will submit the sample. Other tests for substance use include sweat patches, blood testing, hair samples and pupil responses.

Because alcohol is typically out of the system within 24 hours, urinalysis is often replaced with regular breathalyzer tests. According to a 2006 Substance Abuse and Mental Health Services Administration (SAMHSA) advisory, a relatively new urine test for alcohol, ethylgluconuride (EtG), may be used to detect the use of alcohol up to 80 hours after use, but it is insufficiently supported to sustain legal action.

Standard treatments for alcoholism and addiction include long term inpatient, short term inpatient, outpatient, drug courts and any of the above accompanied by pharmacological aids. Pharmacological aids divide into two variants, those that block the effects of the substance and those that punish the use of the substance.

Following assessment an appropriate level of treatment is assigned. There is a wide variety of treatments and supportive modalities. The most familiar approach to drug and alcohol problems is provided by the twelve step movement and is found in Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous and similar groups. Although familiar to almost everyone, these are not treatment modalities, but support groups. In

and of themselves, without the application of a therapeutic regime, their worth is questionable. Nevertheless, NIDA reports that they are widely used to support treatment in the addictions and alcoholism community. Variants of the twelve step model have arisen with specific religious and non-religious orientations (Jewish, Fundamentalist Christian, Rationalist and others).

Inpatient Treatment

During the evolution of the disease model of addiction and alcoholism, the most consistent model of inpatient treatment became a medically assisted detoxification regimen, followed by either a 30-day (short term) or 180-day or longer (long term) inpatient treatment. Because some drugs, including alcohol and benzodiazepines have a potentially life threatening withdrawal syndrome, their treatment is most frequently preceded with a medically assisted withdrawal/detoxification. Other drugs, including cocaine, heroin and methamphetamines, do not have dangerous withdrawal syndromes, but medical assistance may be used to ensure the comfort of the patient and that they complete the process.

After detoxification, inpatient programs begin a regimen of strict discipline, usually incorporating a component of addiction education, an examination of thinking patterns and a cognitive behavioral program designed to identify relapse cues and how to avoid them. Many such programs also include regular attendance at twelve step meetings, often several each day. As part of their bio-psycho-social approach to addictions treatment, such programs also provide employment assistance and family counseling. Both long term and short term treatments typically offer outpatient follow-up programs to provide continuing counseling and support for program graduates. Some provide aftercare at sober houses where graduates can re-enter the community in a supportive environment.

Whether a client is assigned to long term or short term treatment is often determined by the kind of substance they have been using, the length of their involvement with the substance, the length and depth of their involvement in aberrant life styles and the presence of comorbidities; co-occurring diagnoses and problems.

The more complex the defining problems, the longer the addictive pattern, the more likely the client will be in need of long term treatment. NIDA suggests that treatment must be long enough to affect change in the offender. This is often as little as 30 days but rarely longer than 18 months.

Outpatient Treatment

Outpatient programs vary in composition, emphasis and number of sessions. Intensive outpatient treatment often requires multiple group sessions, with individual counseling, employment and family counseling and attendance at twelve-step meetings. Less intensive programming may include groups and individual counseling with other kinds of treatment added as necessary. While there are state-level certifications for alcohol and substance abuse treatment counselors, the quality of services vary widely from program to program.

Three main approaches to outpatient drug and alcohol treatment have been developed and subjected to significant testing by the federal government and are increasingly used throughout the country. All were manualized and subject to significant testing during and since the Project Match study of the effect of treatment matching on drinking behaviors in alcoholism. In the time since their original publication, all three have been applied to all manner of substance abuse treatment beyond alcohol. These treatments are twelve step facilitation therapy, motivational enhancement therapy, and cognitive behavioral therapy.

Twelve step facilitation therapy seeks to engage the client in the philosophy and discipline of the twelve step community. It focuses on encouraging the client to take responsibility for their problems, to surrender to a higher power and to build a substance abuse free lifestyle. The program has had success with alcoholics and has been used with opiate, cocaine and methamphetamine addicts.

Motivational Enhancement Therapy has found a great deal of application and validation both within and outside of addiction treatment. It grows directly from the Stages of Change model that came to public attention with the publication of Prochaska, Norcross and diClementi's *Changing for Good*. The Stages of Change model outlines a series of stages through which any change or decision process must pass and identifies specific means for passing from precontemplation (roughly equivalent to denial) to completion in which the change has been completed and is relatively self-maintaining.

Motivational Enhancement Therapy begins with diagnosis and problem description and works with the offender to identify treatment outcomes. A central part of the approach attempts to have the client understand the inconsistencies between their own behavior and their stated outcomes. MET has been shown to be most effective in creating and maintaining the motivation to enter and complete treatment. Combined with cognitive

approaches it has been very effective with alcohol and marijuana.

Cognitive Behavioral therapy has already been described and has become one of the most commonly used approaches to drug treatment. It includes addiction education, an examination of thinking patterns and a cognitive behavioral program designed to identify relapse cues and how to avoid them. It is useful across the range of substance abuse disorders and is often combined with other approaches.

Drug Courts

Drug Courts are a significant source of effective community treatment for drug impacted offenders of all varieties. They combine the impact of lower caseloads, immediate reinforcement for compliance and punishments for non-compliance with intense treatment and case management.

Participants are typically enrolled in intensive outpatient treatment accompanied by regular, often weekly (at the outset) reports to the Court. In those sessions their progress, including urinalysis results, is reported to the Court by both community corrections officers and drug treatment providers. In the context of those meetings, the Court has the authority to impose intermediate sanctions (including short-term imprisonment), relieve or increase reporting requirements and provide positive reinforcement and encouragement. As the sessions are played out in open court, there is also a strong element of community reinforcement and social learning. Assignment to drug courts is made as part of the sentencing process.

Pharmacological Interventions

Pharmacological interventions are used in conjunction with therapy, to block the action of addictive drugs, partially block and partially mimic their action or to cause discomfort when the problem substance is used. Methadone was the first chemical treatment to be approved by the FDA for the treatment of opioid addiction and was cited as the treatment of choice for heroin addiction by the AMA. Methadone blocks the euphoric effects of heroin, morphine and other opioids, while preventing withdrawal symptoms. In combination with counseling, it is held to be very effective in reducing the cravings and relapses that are characteristic of opioid addiction.

Buprenorphine is a drug that partially replaces the action of opioids and partially blocks their actions. It is relatively safe and has been approved for prescription by physicians. In otherwise well-motivated opioid addicts, for whom intensive treatment would be unproductive, it provides a positive alternative. Its efficacy, as with other treatments is enhanced by adequate counseling or therapy.

Naltrexone prevents the action of opioids completely. Unlike the other two drugs mentioned, that partially mimic the action of opioids, naltrexone completely blocks their action. Its impact on the nervous system is such that it has been used to eliminate the inebriant effects of alcohol and marijuana as well as heroin and morphine. It is most effective when combined with an adequate counseling regimen.

Two other drugs have been specifically designated for use with alcohol. Acamprosate is prescribed to mollify the symptoms of withdrawal from alcohol and has a positive effect on continuing abstinence.

Disulfiram (Antabuse) has been in use for the treatment of alcoholism for many years. Unlike the other pharmacological agents listed, its effects focus not on the neurology of addiction but alcohol metabolism. By interfering with the processing of alcohol and its by-products, by allowing their accumulation in the body, persons who drink alcohol while taking disulfiram can become violently ill after only one drink. It is used to discourage drinking and to prevent drinking in high risk situations.

See Also: Addiction-Specific Support Groups, Case Management, Community Corrections as an Alternative to Imprisonment, Counseling, Drug Courts, Drug Testing In Community Corrections, Economic Costs of Community Corrections (Cost-Savings of Community Corrections), Motivational Interviewing, Recidivism , Reducing Prison Populations, Specialized Caseload Models, Therapeutic Communities

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