1583

VERA INSTITUTE LIBRARY

Briefing Paper

Briefing No.: 2

February, 1990

Drug Treatment and Alternatives to Incarceration

CASES Briefing Papers are produced as part of the research and development activities at the Center for Alternative Sentencing and Employment Services, 346 Broadway, New York, NY 10013, (212-732-0076).

Janet M. Shute, *Director of Research and Development*

BRIEFING PAPER: Drug Treatment and Alternatives to Incarceration

With unmanageable numbers of drug abusers facing criminal charges in our courts, we are increasingly inclined to send many addicts to treatment rather than jail. The practical and conceptual issues raised by such a policy are complex and require much discussion. This paper provides a framework within which this discussion might proceed by: (i.) addressing some of the treatment questions the literature presents; (ii.) outlining one framework for looking at the range of treatments available; (iii.) exploring the implications of attempting to match clients with appropriate treatments; (iv.) describing the treatment modalities available; (v.) proposing a way of looking at stages of change; and (vi.) raising questions about the impact these issues have on the field of alternatives to incarceration.

I. TREATMENT ISSUES

1. *Does the substance of addiction matter?* What impact does cocaine, heroin or polydrug use have on the methods of treatment? What is the interrelationship between the drug of choice and the attendant social and/or psychological problems, and what impact does that have on choice of treatment?

2. *Can substance abuse be isolated from other social issues?* To what extent are addictions interconnected with other social and psychological disorders, and what are the implications of that for treatment?

3. *What treatment period has the most impact after detoxification?* Heretofore, residential treatment programs have been seen as the phase during which the addict has achieved greatest success; now some theorists (especially Zweben, talking about cocaine dependency[1]) are maintaining that the residential stage is merely a launching platform for the longer-term, even more critical recovery process. Program and patient factors which contribute to retention of patients in treatment are not necessarily those which predict adjustment in the years after leaving treatment.

4. *What constitutes recovery? What role does relapse play?* Relapse and recovery must be defined and the notion of incremental success (or episodic relapse) addressed. Must relapse be looked at as failure, or can it be viewed as part of a more circular learning curve? To what extent are relapse and recovery issues generalizable across categories of substances?

II. FRAME OF REFERENCE

There are many approaches to treatment for addiction problems, ranging, as Marlatt puts it from "chemical aversion to spiritual conversion."

> "Various conflicting theoretical positions have been put forth to explain the etiology of addiction, along with corresponding recommendations for treatment. Some approaches favor a disease model of etiology, whereas others focus more upon acquired psychosocial factors. There is a growing acceptance of a multivariate model of etiology, in which addiction is defined as a 'biopsychosocial' disorder."[2]

Brickman draws an important distinction between the initial *development* (etiology) of an addiction problem and factors associated with *changing* or treating these addictive behaviors. He asks: (1) To what extent is the individual with an addiction problem considered personally responsible for the *development* of the problem? (2) To what extent is the person held responsible for *changing* the problem? To help us understand diverse approaches to how we conceptualize and handle addiction problems, Brickman and his colleagues derived four general models or approaches: the "moral," "compensatory," "medical," and "enlightenment" models.

> "In the first (called the moral model because of past usage of this term) actors are held responsible for both problems and solutions and are believed to need only proper motivation. In the compensatory model, people are seen as not responsible for problems but responsible for solutions, and are believed to need power. In the medical model, individuals are seen as responsible for neither problems nor solutions and are believed to need treatment. In the enlightenment model, actors are seen as responsible for problems but as unable or unwilling to provide solutions, and are believed to need discipline."[3]

Marlatt expands on Brickman's categories further:

> *Moral model:* The temperance movement defined addiction as a moral weakness in character; individuals with this moral weakness were expected to change their behavior through personal effort or enhanced motivation, frequently by the exercise of "willpower." Although this was the predominant approach prior to the rise of the disease model, this model has little support within contemporary professional approaches to addiction treatment. The chief limitation to the moral model is that people who fail to change are made to feel guilty and to blame.
>
> *Medical model:* The medical, or disease, model is the opposite of the moral model. Neither the disease nor the treatment is the patient's responsibility. The disease is caused by uncontrollable biological/genetic factors; treatment is biomedical. The main advantage of the medical model is that it allows people to claim and accept help without being blamed for their weakness.

Enlightenment model: Individuals are considered responsible for the origins of the problem, but are not considered capable of changing their behavior on their own. Instead, change is possible only by relinquishing personal control to a "higher power" or collective group entity which can help "enlighten" people as to the true nature of their addiction problem. The various self-help groups (AA, Narcotics Anonymous) and therapeutic communities fall into this category.

Compensatory model: Here people are not considered responsible for the development of the addiction problem (etiology of the problem may involve biological and learning factors that are beyond individual control), but are able to "compensate" for their problem by assuming personal responsibility for changing their behavior. Examples include relapse prevention work and cognitive-behavior therapy, where clients are taught self-management skills and related techniques to bring about a change in their addiction problems.

Marlatt's categorization could be contested (e.g., some would argue that AA would fall into the medical model), but for our purposes this remains a useful construct. It has impact two ways: (1) on our discussion about matching clients to optimal treatment, and (2) on our evaluation of what programs have integrity for our clientele.

III. MATCHING CLIENTS TO TREATMENT:

The literature suggests that individuals with varying needs, characteristics, and drug habits will respond optimally to different kinds of intervention, and that clients should be matched with specific approaches rather than all being treated in the same way. Marlatt writes:

> "Traditional treatment programs provide little if anything in the way of detailed assessment for treatment matching for addiction problems. . . Individual differences in age, gender, ethnic status, personality, cognitive functioning, socioeconomic status, social support, coping skills, and belief systems are too often overlooked or blended together under a single disease entity, or attributed largely to genetic predisposition or the unifying influence of physical dependency."[4]

A better understanding of client motivation and decision-making could be a part of treatment determination; also, treatment contracts with individual patients might form the foundation for reducing relapse.

Is there any wisdom in the field about what kinds of clients would benefit from what kinds of treatment? Selection of one of the four models outlined above would logically dictate the type of therapist or "change agent" who would work with the addicted individual. Professional therapists are more likely to be associated with both the medical model (e.g., physicians, nurses) and the compensatory model (e.g., psychologists, psycho-therapists), whereas paraprofessionals, recovered addicts, and peers are more associated with the enlightenment model. The moral model is more apt to involve a religious group or pastoral counselor.

Attempts to match clients to the four models have already proven interesting. Marlatt observed:

> "...my colleagues and I have found that personal beliefs about the nature of the addiction problem and associated approaches to treatment are important determinants of treatment compliance. In one study (Marlatt, Curry, & Gordon, 1986), smokers were asked to give their own opinions as to whether they thought smoking was primarily a physiological addiction to nicotine (minimum personal responsibility for the development of an addiction) or an acquired "bad habit" that they had learned (maximum personal responsibility). After this assessment of prior beliefs, subjects were randomly assigned to one of two treatment programs that differed in whether smoking was treated as a physical addiction or as a learned maladaptive habit. In assessing initial dropouts from treatment, it was found that subjects who were *mismatched* in treatment assignment (based on their underlying beliefs about the etiology of the problem) were significantly more likely to discontinue treatment than subjects who received a treatment program that was matched with their personal belief system. Further research is clearly needed to determine whether this type of matching has similar results with other types of addiction problems."[5]

Unfortunately, for reasons both pragmatic and theoretical, matching is rarely done. Practically, treatment programs of all kinds are oversubscribed and most drug abusers are placed in whatever program happens to have a slot or a bed available. The system is need-driven. Even if this were not the fact, the notion of matching clients with optimal treatments has research and clinical implications that need extensive further exploration. When one begins to attempt to develop behavioral tests for motivation and to target variables which might predict subjects at high risk for relapse, complex ethical issues are raised - issues around who receives treatment and who does not.

IV. DRUG TREATMENT MODALITIES:

At the moment, there is no systematic determination of who receives what kind of treatment. What are the primary methods of drug treatment? Drug treatment can involve pharmacologic treatment or drug-free treatment. The best known programs fall into the following categories:

Chemical modalities: These include:

For opiates[6]:

> *Methadone detoxification (DT)* - A treatment procedure using methadone or any of its derivatives administered in decreasing doses, over a period of time not to exceed 21 days, for the purpose of detoxification from opiates, and other rehabilitation.
>
> *Methadone maintenance (MM)* - A treatment procedure using methadone or any of its derivatives administered over a period of time in excess of 21 days, to relieve withdrawal symptoms, reduce craving and permit normal functioning so that, in combination with rehabilitation services, patients can develop productive

life styles. Some opioid-dependent patients, particularly those with severe psychological problems, do significantly better in a methadone maintenance program than in the confrontational milieu of a therapeutic community. To what degree the better outcome is related to the pharmacological effects of methadone or the less demanding treatment environment is not yet clear.[7] Many clients can lead stable lives while on methadone; however, methadone is a drug in and of itself. Also, few methadone maintenance clinics offer supplementary counseling or support services.

Methadone to abstinence (MTA) - A treatment procedure using methadone administered for a period exceeding 21 days, as part of a planned course of treatment involving reduction in dosage to the point of abstinence followed by drug-free treatment.

For cocaine, the following groups of pharmacologic agents are currently under investigation[8]:

Tricyclic antidepressants - These include desipramine and imipramine which have been considered of potential value due to their ability to block the re-uptake of norepinephrine, a neurotransmitter depleted by chronic cocaine use.

Dopamine agonists - These include bromocriptine and amantadine and have been assessed for their ability to stimulate dopamine depleted by chronic cocaine use. Preliminary studies on these drugs have suggested that they produce an attenuation of depression and craving for cocaine that characterizes the early stages of cocaine withdrawal.

Amino Acids - These have been suggested as a potentially useful pharmacologic tool for treating cocaine withdrawal since they are the precursors of several neurotransmitters depleted by cocaine.

The chaotic circumstances that most addicts are in at the time of treatment initiation makes it extremely difficult to accurately assess the value of a specific therapeutic intervention. For example, a medication that might reduce cocaine craving will not provide assistance with the social disorganization, family disruption, financial stress and other emotional obstacles which the addict is faced with in the first few days of abstinence. It is very possible that a useful pharmacologic approach may be dismissed as not useful because its effects are overwhelmed by non-pharmacologic issues. Some strategies may be useful at later stages than they have been tried heretofore.

Drug-free treatment is a modality that does not include any chemical agent or medication as the primary part of the drug treatment. Although there are a range of non-pharmacologic strategies for treating addicts - e.g., Outward Bound and wilderness programs; acupuncture to relieve cocaine craving; psychotherapy - there are two basic types of programs:

Drug-free residential communities, or therapeutic communities (TCs) - TCs focus on maintaining a drug-free existence. Chemical detoxification is a condition of entry, not a goal of treatment. The TC can be distinguished from other major drug treatment modalities in two fundamental ways. First, the primary "therapist" and teacher in the TC is the community itself, consisting of peers and staff who are role models of successful personal change. Second, the TC offers a systematic approach to achieving its main rehabilitative objective, which is to change the negative patterns of behavior, thinking, and feeling that predispose drug use. The problem is the person, not the drug. Addiction is a symptom, not the essence of the disorder. Physiological dependency is seen as secondary to the wide range of circumstances which influence and then gain control over an individual's drug use behavior.

TCs can deal with a variety of drug patterns, for they perceive that the chemical abused is of less importance than its meaning to the user. DeLeon observes:

> "Rather than drug use patterns, individuals are distinguished along dimensions of psychological dysfunction and social deficits. A considerable number of clients have never acquired conventional lifestyles. Vocational and educational deficits are marked; middle-class, mainstream values are either missing or unpursuable. Most often, these clients emerge from a socially disadvantaged sector where drug abuse is more a social response than a psychological disturbance. Their TC residential experience can be termed 'habilitation' - the development of a socially productive, conventional lifestyle for the first time in their lives. In clients from more advantaged backgrounds, drug abuse is more directly expressive of psychopathology, personality disturbance, or existential malaise. In referring to these clients, the word 'rehabilitation' is more suitable because it emphasizes a return to a lifestyle previously lived, known, and perhaps rejected."[9]

Nevertheless, substance abusers in the TCs share important similarities. Either as cause or consequence of their drug abuse, all reveal features of personality disturbance and impeded social function. Thus, all residents in the TC follow the same regime and progress through the same stages. TCs believe that a lifestyle change can occur only in a social context. Negative patterns, attitudes, and roles were not acquired in isolation, nor can they be changed in isolation.

Drug-free outpatient settings (DF) - Most outpatient programs provide an integrated approach to services, providing, among other things, substance abuse counseling, a health unit, vocational training and/or referral, and recreation.

Matrix Center: One of the most interesting models of outpatient treatment for cocaine users was established by The Matrix Center in 1983. The treatment model developed, called the neurobehavioral model, has structured information and strategies derived from clinical research on addiction into a viable treatment program.[10] This evolved from both an understanding of the biochemistry of cocaine addiction and a behavioral analysis of types of problems encountered by cocaine users as they proceed through a period of cocaine abstinence.

The neurobehavioral model is an initial attempt to structure information, support and encouragement across a series of stages that are experienced by cocaine users as they progress through the first 6 months of recovery. This model attempts to sequence strategies in a way that will correspond to a timetable of problem emergence during cocaine recovery.

Over the period of a year, this model sees five stages of recovery:

(1) 0- 15 days post-cocaine	-	Withdrawal
(2) 16- 45 days post-cocaine	-	Honeymoon (reduced craving)
(3) 46-120 days post-cocaine	-	The Wall (relapse vulnerability)
(4) 121-180 days post-cocaine	-	Adjustment
(5) 181 + days post-cocaine	-	Resolution (completion of the intensive six-month program)

Behavioral, cognitive, emotional, and relationship categories are addressed appropriate to each of these stages. Primary to the process is the use of individual sessions with a professional therapist; group dynamics are secondary. A sample of the session topics include: rating withdrawal symptoms; teaching thought-stopping procedures; presenting time-scheduling techniques; dealing with drug-using friends; monitoring personal behavior change; reviewing nutrition and exercise habits; dealing with "The Wall"; examining control issues; exploring emotional responses to recovery; learning introspection techniques; and integrating skills learned in treatment into lifestyle changes.

V. STAGES OF CHANGE:

Before concluding consideration of treatment modalities, it is useful to consider a recent conceptual advance in the field of addictions treatment: the notion that individuals proceed through a series of relatively discrete stages in the change process. First is the "precontemplation" stage, which characterizes the ongoing addiction pattern prior to any active consideration of change. Next comes the "contemplation" stage, also called the "motivation and commitment" stage, in which the individual considers doing something about the problem. The next stage is the "action" stage, in which the individual makes an active attempt to change, either on his/her own or by seeking outside help. Most addiction treatment programs are geared toward the action stage. The final stage, often neglected because of our usual focus on the action stage, is the "maintenance" stage, perhaps the most crucial. As has been noted in much research, most of the "variance" in treatment outcome in the addictions field can be accounted for by events that occur after the completion of a formal treatment program.[11]

The "stages of change" model is applicable to addiction treatment regardless of the treatment modality during the action phase. Different matching strategies can be employed with each stage in the change process; indeed, matching is particularly critical in the maintenance stage.

Stages of change: Relapse and recovery: A similar model might be useful in looking at relapse and recovery as parts of the maintenance stage. As Brownell observes, there are two common definitions in Webster's Dictionary of relapse: (1) "a recurrence of symptoms of a disease after a period of improvement" (an outcome definition) ; and (2) "the act or instance of backsliding, worsening, or subsiding" (a process definition). Brownell and Marlatt suggest that, instead of seeing a relapse as an end state, as a failure, we look at it as a process and break it down into *lapse* and *relapse*:

> "A lapse is a single event, a reemergence of a previous habit, which may or may not lead to the state of relapse. When a slip or mistake is defined as a lapse, it implies that corrective action can be taken, not that control is lost completely. . . The individual's *response* to these lapses determines whether relapse has occurred. . . A model might include the time prior to a lapse, the lapse itself and the period in which the person does or does not relapse. . . on a circular rather than linear model of change. Linear models have stages that occur in a specific sequence, with relapse occurring at the last stage. A circular model shows relapse leading back to an earlier stage from which an individual may make another attempt to change. . . A person who relapses may be acquiring information about his or her weaknesses and may learn ways to prevent lapses in the future."[12]

Lapses seem to be more commonly associated with situational or social factors; relapses occur during negative emotional states or highly stressful events.

Relapse prevention: One of the fastest emerging techniques to preclude relapse in substance abuse is relapse prevention, which is becoming increasingly important as a tool for ongoing maintenance programs. Relapse prevention incorporates a variety of behavioral, cognitive, educational, and self-control techniques aimed at reducing the potential for relapse and at enhancing self-efficacy (a person's belief that he or she can respond effectively to a situation by using learned behavioral skills). As Marlatt points out:

> "Relapse may be a response to a host of variables, including but not restricted to such factors as environmental and personal stress, lack of adequate coping skills, insufficient social support, motivational deficits, and so on. A detailed assessment of such factors may lead to the development of a relapse prevention plan. . . that can be employed regardless of the type of intervention used in the action stage. Variables predictive of relapse include ratings of self-efficacy, or perceived ability to cope with specific high-risk situations; degree of social support; and occurrence of stressful life events and/or 'daily hassles'."[13]

Criticizing the medical model's emphasis on physiological causation, Marlatt focuses on the situational and psychological factors which determine relapse, claiming that the most frequent determinants of relapse are (a) negative emotional states, (b) direct or indirect social pressure, and (c) interpersonal conflict. These three primary high-risk situations are associated with almost three-quarters of all the relapses reported. Other findings show that "relapse follows a painful emotional state (40%), failure to enter arranged after-care treatment (37%), and encounters with conditioned environmental stimuli (34%); 85% involve multideterminants. As Wallace puts it: ". . . the initial period of attempted abstinence is wrought with peril for psychologically vulnerable patients who face challenging environmental stimuli."[14]

Marlatt suggests, in line with the stages of change model, that certain skills be practiced during the action stage: specifically, (a) decision-making, (b) cognitive restructuring, (c) coping skills, and (4) cue elimination. Areas of intervention for the maintenance phase include: (a) continued monitoring, (b) social support, and (c) general life-style change, including such activities as meditation and exercise.[15]

Issues of "recovery": How does this notion of stages of change impact on our definition of "success" or "recovery? Is abstinence the measure, or are short-term changes in lifestyle and longer periods of time between relapses considered successes? How do we account for the interplay of psychological, environmental, and physiological factors as we evaluate progress? Some researchers and clinicians define recovery as total abstinence, whereas others accept some limited substance use. Some feel that recovery involves freedom from the influence of substances; others feel that recovery is complete when drug abuse and related behavior are no longer problematic in the individual's life. Alcoholics Anonymous claims an alcoholic never actually recovers and is always at risk for relapse.[16]

The national Drug Abuse Reporting Program (DARP), in 1973, suggested that three other evaluative criteria are important: (1) client motivation; (2) successful matching of clients with counselors; and (3) length of time in treatment (at least 90 days).[17]

VI. ALTERNATIVES-TO-INCARCERATION ISSUES

This paper does not attempt to address or evaluate the above conceptual issues in depth, but rather to provide a framework within which treatment issues can be discussed as they relate to the criminal justice field, in particular, alternatives to incarceration. There are a number of questions which need to be grappled with before program decisions can be made, including:

1. *What are we trying to achieve with drug treatment?* Are we trying to achieve long-term recovery from addiction? If so, and if the literature is correct that that implies focusing on the "maintenance" stage, can alternatives have any appreciable impact on the problem, or can those kinds of services best be provided by aftercare centers which specialize in techniques of relapse prevention and contingency contracting? Are we trying to encourage short-term prevention or long-term reduction of crime? How does that influence the way we look at residential programs and the length of time spent in them? Is length of program to be dictated by treatment concerns or by jail displacement concerns? Do we need to be concerned with a program which has punitive elements, or are we truly interested in providing programs that motivate addicts to recovery, however defined? Our goals will strongly influence our approach.

2. *What is our response to relapse?* Can we encourage program models of treatment which allow relapse as part of their structure? What constitutes relapse in treatment populations? If treatment is for a particular substance abuse problem, how are we to consider such issues as controlled or occasional use, substitution, and continuation of use of another, perhaps lesser, substance which may also constitute abuse? Will the system or the public accept a treatment model which allows relapse - which does not automatically assign blame to a participant and return him/her to jail after relapse, but instead sees relapse as part of a recovery cycle? Or is the political reality such that we can only adopt a model which blames and further punishes the participant for failure? These issues have major implications when discussing jail displacement.

3. *Do the social conditions within which ATI participants live virtually preclude successful drug treatment?* If relapse prevention is predicated on the belief that stress is a major determinant of relapse, is it possible that our clients - with their multiple dependencies, history of polydrug use, lack of housing, education and employment - are experiencing stress to such a degree that we must adapt our views of success and recovery when we look at their ongoing behavior? Are the stresses so great that we will be unable to address the needs of our participants? Enrolling offenders in programs which are unrealistic for them, and thus subjecting them to the possibility of being resentenced to heavier sentences for program violations or relapse, also has profound implications for jail displacement - and for the offenders.

Prevailing over all of these are the questions: Why has criminal justice policy recently focused on drug treatment? What are sentencing judges hoping to accomplish by finding alternatives which also accomplish drug treatment? All of this merits exploration.

ENDNOTES

1. Frye, Robert V., Ed., Journal of Psychoactive Drugs: A Multidisciplinary Forum, "The Therapeutic Community: The Third Decade, Vol. 18, No. 3. July-September 1986, p. 195.

2. Marlatt, G. Alan, "Matching Clients to Treatment: Treatment Models and Stages of Change," Assessment of Addictive Behaviors, ed. by Dennis M. Donovan & G. A. Marlatt, Guilford Press, New York City, 1988.

3. Brickman, P., Rabinowitz, V., Karuza, J., Coates, D., Cohn, E., & Kidder, L., "Models of Helping and Coping," American Psychologist, 37, pp. 368-84, 1982.

4. Marlatt, pp. 481-82.

5. Marlatt, p. 478.

6. "Directory of Substance Abuse Programs in New York State," State of New York Division of Substance Abuse Services, p. iii, November 1986.

7. Jaffe, Jerome H., "Evaluating Drug Abuse Treatment: A Comment on the State of the Art," Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects, NIDA Research Monograph 51, 1984.

8. Rawson, Richard A., Obert, J., McCann, M.J., & Smith, D.P., "Psychological Approaches for the Treatment of Cocaine Dependence: A Neurobehavioral Approach," Matrix Institute on Addictions, Beverly Hills, California.

9. DeLeon, George, "The Therapeutic Community and Behavioral Science," Learning Factors in Substance Abuse, NIDA Research Monograph 84, 1988.

10. Rawson.

11. Marlatt, pp. 479-82.

12. Brownell, Kelly, Marlatt, G. A., Lichtenstein, E., & Wilson, G. T., "Understanding and Preventing Relapse," American Psychologist, July 1986, p. 766.

13. Marlatt, pp. 478-80.

14. Wallace, Barbara C., "Psychological and Environmental Determinants of Relapse in Crack Cocaine Smokers," Journal of Substance Abuse Treatment, Vol. 6, pp. 95-106, 1989.

15. Brownell, pp. 765-782.

16. Leukefeld, Carl G., & Tims, F. M., "Relapse and Recovery in Drug Abuse: Research and Practice," The International Journal of the Addictions, 24 (3), pp. 189-201, 1989.

17. Simpson, Dwayne D., "National Treatment System Evaluation Based on the Drug Abuse Reporting Program (DARP) Followup Research," Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects, ed. by Tims, Frank M. & J. P. Ludford, NIDA Research Monograph 51, pp. 29-41, 1984.