



THE ROLE OF SUBSTANCE ABUSE TREATMENT
IN CORRECTIONS

by

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Introduction to the Problem

There are several facets to the problem of substance abuse treatment of offender populations. These facets work together to impede attempts to reduce criminal recidivism and improve our habilitation and rehabilitation of offenders. One facet is the nature of the population itself and the level of its dysfunction. Another is the continuing debate over what issues are primary and how we should treat them. A third is the question of where offenders should be treated, if at all. This brief is designed to explore these issues and to propose a direction for the Department of Corrections future planning in offender substance abuse treatment.

The Population

Iowa Medical Classification Center at Oakdale estimates that 75 - 80% of the prison population has a history of drug and/or alcohol abuse. This percentage is slightly lower in community based corrections.

A 1974 census bureau study of 10,400 state prison inmates found that 39% of robberies, 47% of burglaries, 53% of homicides and 61% of assaults were reported to be committed under the influence of alcohol. The relationship between crime and drugs has been well researched. The findings indicate a direct correlation between the use of mood altering substances and the criminal behavior. It has also been documented that as drug use is reduced, a corresponding reduction in criminal activity occurs. Studies of incarcerated populations reveal histories of alcohol and drug problems that are seven to eight times higher than that of the general population. There is no question that substance abuse is a key issue in offender recidivism.

In addition, there are other complicating factors. These include: the high incidence of a secondary diagnosis such as anti-social personality disorder, learning disabilities, low I.Q.'s, and psychiatric disorders. The resistant manipulative nature of these individuals, the need to respect security issues above therapeutic issues, and the coordination of treatment with other community services release requirements make the treatment of offenders a very complicated proposition.

It is clear, however, that the development of wholistic, effective modalities of treatment coordinated with community support efforts can result in a significant reduction in recidivism, prison population and crime rates. This is true among the offenders known as chronically repeating, predatorial criminals, and lower risk offenders with shorter records who, if they remain abstinent, are less likely to repeat.

Primary Issues

For years, there has been a debate over the effectiveness of substance abuse treatment. Arguments have raged over whether the primary problem was mental illness, behavioral maladaptation, criminality, immorality or a primary disease. Individual groups advocating different types of care

have split into rival camps, fighting over resources, engaging in turf battles, and protecting interests. The bottom line of this discord is that common purpose of these groups is overlooked. Each group wants to help the "patient" abstain from a destructive relationship with substances, change their behavior, and seek support to prevent a return to their destructive lifestyle. But, in order to treat, we must be able to diagnose. These factions are unable to agree on what is wrong with the "patient" and cannot, therefore, get on with effective treatment.

Some treatment organizations have begun to adapt to a solution oriented philosophy. There is no one school of thought or label which can cover every individual afflicted with substance abuse/behavior problems. Many approaches that are valid, with one sort of addict are ineffectual with another. Developing a truly wholistic approach, incorporating different schools of treatment, dictated by individual patient needs, is a solution oriented approach.

In order to do this, we must develop a multi-level continuum of care. This would begin with a comprehensive assessment of problems and needs, resulting in referral to a treatment modality matched to the offenders identified needs. The continuum proposal is more fully examined later in this brief.

Where Should Offenders be Treated?

Arguments are made that institutions are artificial environments where addicts have no access to chemicals, consequently treatment is ineffectual in those settings. On the other hand, there is the likelihood that offenders released untreated from such an institution will abuse substances and re-offend before they have the opportunity to seek treatment in the community. This is another area where discord and confusion among providers is common.

Recent research is optimistic about the success of intensive treatment programs for chemically dependent felons. Other states have implemented statewide substance abuse coordination efforts that yield significantly lower recidivism rates.

Oregon has developed a multi-level continuum of care for the treatment of offenders with substance abuse histories. Offenders classified as substance abusers are assessed and referred to appropriate programs. The different levels used in this program include: alcohol and drug information centers available to the majority of inmates, alcohol and drug classes for the majority of "abusers", Alcoholics and Narcotics Anonymous meetings; residential treatment programs, and the Cornerstone Alcohol and Drug Program. Each program element is tailored to the population it serves. The more intensive the program, the smaller the population served.

The Cornerstone Drug and Alcohol Program has reported substantial reductions in criminality by successfully treating inmates.

Rates of avoiding any arrest, conviction, or
prison time for 3 years after parole for
Cornerstone participants from 1983 through 1985

	<u>No Arrests</u>	<u>No Convictions</u>	<u>No Prison Time</u>
Program Graduates	37%	51%	74%
Non Grads who com- pleted at least 6 months	21%	28%	37%
Non Grads who com- pleted 2-5 months	12%	24%	33%
Non Grads who left before 60 days	8%	11%	15%

The order of success as measured by no arrests, convictions, or prison incarcerations consistently favors time in treatment.

The "Stay'n Out" program in New York has also reported significant reductions in criminality in inmates who have graduated from their program.

The Bureau of Justice Assistance released a monograph in August, 1990 which details the Wisconsin Drug Abuse Treatment Unit. This is an intensive program, specifically designed to treat chronic "predatorial" criminals with long histories of arrests, convictions, and drug addiction. After two years, only 5.9% of their graduates had returned to prison in Wisconsin, compared with 33% of their general population. After 3 years, 12% of graduates returned compared to 37% of the general population. After four years 22.2% of graduates returned versus 41% of the general population. After five years, only 21.6% of graduates returned, compared to 41.5% of the general population.

Other states have also implemented comprehensive treatment strategies within their corrections departments. Some of these include:

Alabama

- Inmate drug screening, addiction assessment, and treatment referral
- Data base for tracking inmate treatment
- Inmate drug education
- Interim treatment prior to intensive treatment (12 step-structured support groups)
- Intensive 8 week residential treatment
- Therapeutic community 6-12 months
- Pre-release transitional services
- Urinalysis in prison, probation, and parole
- Evaluation research

Delaware

- Inmate drug screening, addiction assessment, and treatment referral
- Substance abuse training for corrections staff
- Interim treatment prior to intensive treatment: Prison work program, counseling, substance abuse treatment
- Therapeutic community 9-15 months

Florida

- Inmate drug screening, addiction assessment, and treatment referral
- Training of corrections staff to improve treatment programs and unify treatment efforts.

- Tier I: Inmate drug education 35 - 40 hours of literature distribution, short term counseling, group discussion, education program.
- Tier II: Intensive 8 week residential treatment: individual and group counseling.
- Tier III: Therapeutic community 6-12 months.
- Tier IV: Community based treatment: 10 week program consisting of counseling, NA/AA, education groups.

Evaluation Research

Reduction of recidivism is the goal of correction's substance abuse treatment. It cannot guarantee, however, that the individual will remain abstinent. No accurate statistical method has been found to measure the success of treatment based upon abstinence. This is largely due to the propensity of clients and their associates to minimize the client's drug use. These established programs have, however, shown success in their highest priority, reduction of recidivism.

The state of Iowa has several substance abuse programs in correctional institutions. These range from general education and awareness programs to intensive cognitive or intervention treatment approaches. The T.O.W. program (The Other Way) at Clarinda is one of the intensive programs for alcohol or drug addicted inmates. A five year study of recidivism among program graduates versus general population releasees is now in progress. While not conclusive, as it has not been completed, the initial findings have been very promising.

Dr. Homer LeMar, Associate Professor at Northwest Missouri State University, reported on the progress of a recidivism study in October, 1990. First year results indicated a 13% rate of return to the correctional system for T.O.W. graduates and 61% rate of return for inmates from Clarinda's general population. The second year yielded a 22% recidivism rate for graduates of the T.O.W. program, however, data on a general population comparison group had not yet been compiled.

There is currently no scientific analysis to support or deny these findings. These statistics deal with raw recidivism over a fixed time period. At this time, research is being developed to control the confounding problems that arise from this type of report.

The Department of Corrections has reached the point in their development of substance abuse treatment that a statewide coordination of programming is imperative.

The remainder of this brief will be devoted to the discussion of solutions to the problems introduced in this section, as well as a proposal of a continuum model for the state of Iowa Department of Corrections.

II

The Disease

In order to discuss the solutions, it is necessary to understand the problems more completely. As the "Disease Concept" of chemical dependency is one of the more controversial and misunderstood approaches to treatment of addiction, we will explore this concept first.

Dr. Stanley Haugland, Medical Director of the Powell Chemical Dependency Center, presents here some historical and theoretical considerations surrounding the disease concept of chemical dependency. He will also introduce and discuss the issue of "Dual Diagnosis". This will be followed by an integration of these concepts into the problems and solutions necessitating this brief.

HISTORICAL CONSIDERATIONS

Stanley Haugland, M.D. *

The idea of addiction to alcohol as a disease was first formulated on this continent by Dr. Benjamin Rush in the early 1800's when he also recognized it as a significant public health problem. His efforts to ameliorate this problem with the help of his medical contemporaries were largely unsuccessful and thus he turned to the clergy for help. The clergy agreed with him that it was a disease, but also believed it was a sin; this crusade against alcohol became known as the temperance movement and lasted for the next 150 years. The temperance movement was a doctor-initiated movement, not a clergy movement as is commonly believed. The disease concept became firmly submerged in the moral sphere, over-shadowed by its being a sin or a crime, in need of salvation and/or punishment. Not until this century have we seen it re-emerge again as a disease.

This re-emergence of the disease concept came about through several significant events. The Alcoholics Anonymous (AA) movement in 1935, gained the support of the American Medical Association in 1956, which resolved to treat it, and the Hughes Act of 1970 (Public Law 96-616) which made it illegal to deny treatment of alcoholism in Hill Burton Hospitals. The Hughes Act was especially important because it created the National Institute of Alcoholism and Alcohol Abuse. This latter act gave a significant boost to research in this field, which previously was not considered to be a bonafide research area. As a result, there now is a growing body of knowledge that undergirds this rapidly emerging field of addictionology.

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THEORETICAL CONSIDERATIONS

Primary Disease Concept Versus Symptom Orientation

It used to be thought that alcoholism was always a symptom of something else - everything including psychic conflicts, depression, job dissatisfaction, marital discord, financial difficulties, and aging. Those trained in this orientation would look for such a cause, treat it, and expect the drinking or drug use to go away. The symptom orientation had serious drawbacks, however, in that it never worked well in practice. Symptom orientation looked for the cause of the fire, while the blaze went unchecked. Furthermore, finding a cause and fixing it rarely, if ever, restores anybody to abstinence. Years of frustration in symptom orientation undoubtedly led many workers in this field to pursue the primary disease concept both in research and in clinical practice.

The primary disease concept holds that chemical dependency is a disease in and of itself, and the disease process is the addictive process that is not yet well understood. We simply do not understand why it is that drugs like alcohol, nicotine, or narcotics (which on first dose or doses make us sick, dizzy, nauseous, or faint) go on to become satisfying, and then finally are addicting in some of us though not in others.

This addictive process is quite likely the same for all ages. Somehow through the use of a psychoactive chemical, perhaps because of an abnormal response, the victim gets "hooked" on the feeling from that chemical, resulting in the desire to use it again and again. Initially, that feeling may have been one of euphoria or relief of dysphoria, or both; in the end, the individual develops a deep-seated need for or a strong dependency on a psychoactive chemical. It is as though a human being has developed a close relationship or a strong bond with a psychoactive chemical, and once this relationship is established, apparently it can never be erased completely. This may, in part, explain why relapse is so common and the addict is rarely able to use any psychoactive substance in a social fashion. This fact has tremendous implications in treatment.

Treatment in the primary disease model means that the addiction/dependency receives first priority and all other things blamed on it are handled secondarily. Treatment in this concept in large measure attempts to redirect that dependency away from psychoactive chemicals and on to other human beings or on to interpersonal relationships. The most important element in recovery is a sustained relationship with a new peer support system that places high priority on abstinence and open and honest relationships with other people. This is exactly what AA attempts to do.

Although the primary disease concept lacks scientific proof, one cannot ignore the success of AA over the years nor the fact that a multitude of treatment centers have adopted the primary disease approach.

THE GENETIC FACTOR IN ADDICTION

(Nature versus Nurture)

Genetics is an important factor in addiction. It has been recognized as such much more since the mid 70's, than it was in the years previous. It used to be thought that alcohol and other drug addiction ran in families because of example "If mom and dad drink or use drugs, what do you expect?"

Dr. Goodwin, Chief of Psychiatry, University of Kansas in the 1970's reported on his research on children of alcoholic parents. Dr. Goodwin studied the offspring of alcoholics in this way:

1. He studied one group of children of alcoholic parents that were raised by those alcoholic parents.
2. He studied another group of children born to alcoholic parents but were adopted in the first 4 to 6 weeks of life and raised by parents who did not drink or use drugs.
3. Then he studied a control group from the general population.

What he found was that, compared to the general population, the sons of alcoholic parents were four times as likely to develop alcoholism if they drank. Furthermore, it didn't matter if they were raised by their alcoholic parents or adopted and raised by parents who never drank. For daughters, the figure approximated three times that of the general population. Since Goodwin's pioneering studies, other "adoptive studies" have confirmed his research. This inherited predisposition, which is a proper term for this phenomenon, is even stronger in subsequent research.

The evidence for a genetic predisposition in addiction has been strengthened further by studying fraternal twins versus identical twins. Identical twins have the same physiology and can be expected to respond to psychoactive chemicals in a similar fashion. The well known result is of course that if one identical twin has alcoholism/drug addiction, the likelihood of the other having it as well approximates 80%. On the other hand, if one fraternal twin has addiction, the chances of the other twin having addiction is close to 27%.

The question that arises then is, what conceivably could be inherited in such a strange illness as addiction? The answer is, two things appear to be under genetic control:

1. Tolerance - alcoholics/addicts have remarkable tolerance for psychoactive drugs in that over time it takes a lot more of whatever is being used to get the same effect. For example, if one could get drunk or high from two to four beers/drinks it always takes an alcoholic more, over time, to achieve the same effect.

Of interest is the fact that some individuals appear to be protected from becoming addicts because of INTOLERANCE. Some people, the majority of orientals, seem to be protected from becoming addicted

because of this intolerance. If they drink more than a small amount, say one or two drinks, they get an uncomfortable skin flush, headaches, and nausea and vomiting which has been called the "oriental syndrome." Scientists have demonstrated that this reaction is identical to the alcohol - Antabuse reaction. So, some individuals appear to have a built-in protection against becoming addicted to alcohol because of intolerance and this most assuredly is genetic in origin.

2. An abnormal response to alcohol or other psychoactive chemicals which makes one more susceptible to addiction is thought to be an inherited characteristic. All of us are familiar with the wide variation individuals have in response to chemicals used. A small amount of a sedative can make an individual very sleepy and yet in another individual doesn't seem to be affected at all. This same phenomenon may very well be at work in early addiction. Late addiction is easy to understand because that almost always is "relief use." What is meant by an abnormal response is that where one individual without this tendency "feels good" after taking a drink or a drug an individual with this inherited tendency, feels "extra good" after using alcohol or the drug. Anything that makes an individual feel good is apt to be repeated. This is called positive reinforcement in psychological language and is behind all of our habits. The better something makes us feel, the more likely it is to be repeated.

This extra good feeling, which is mediated by the neurotransmitters in our brain, leads then to the situation where an individual wants to re-experience that good feeling or in some cases of early addiction, get rid of a bad feeling. In any instance, the end result is a deep-seated drive to use again, like a hunger or thirst that, once there, cannot be erased. We have not had any success in teaching an individual how to use "socially".

Of course, environment or parental example also plays a role, but has never adequately explained this strong family tendency for addiction. This is especially shown when children of addicts have been adopted out the first few weeks of life and raised by parents that never use but still become addicts. This is further evidence that a disease process is at work. No one ever intends to become an addict, that we know of, and this is especially true in families. If mom or dad are practicing addicts, the children as they grow up, often times state, "I will never drink or use like my mom or dad," but then they do.

The disease concept has gained strength through the evidence of this inherited tendency and from the fact that no one ever intended to become an addict. Finally, the disease concept gains further credence from the fact that after treatment it is common for individuals to state that they do not intend to use but if they do use it will be different this time. When they do use again the same addictive pattern reasserts itself.

An addict needs to take the first drink, joint, or pill, but that does not explain addiction. Although no one ever intended to become an addict and therefore can't be blamed for becoming an addict, this doesn't mean that an individual is not in large measure responsible for their recovery. Much the same as a diabetic can remain well if they exercise discipline in

regards to their diet and the taking of insulin or other medications, so it is, the addict can be well if they exercise discipline in not using and by learning how to redirect that need for chemicals onto human beings or interpersonal relationships. This is the essence of addiction and this is the essence of recovery. Rarely does an addict get well by themselves.

"Probably the most important element in recovery is a sustained relationship with a new peer group whose goals are abstinence and more open and honest relationships with people" (Vernelle Fox, M.D.). This is the goal then in the treatment of addiction whether or not nature or nurture or some combination thereof is the cause. If someone has been addicted for many months or years, the ultimate cause really matters little. Treating the addiction and subsequently the related problems takes first priority.

ADDICTION VERSUS DEPENDENCY

Although addiction and dependency are frequently used interchangeably, they do not always mean the same thing. Addiction implies loss of control, exemplified by unpredictable use. That is, once use has begun, it is never certain when and if it can be ceased. Further, addiction implies increasing tolerance. More and more of the drug is needed or desired for the same effect. Dependency, as in chemical dependency, usually means the same as addiction.

There is another meaning that we are not concerned with here. Some patients are dependent upon insulin, cortisone, digitalis, or other drugs that are not mood altering. Individuals can become dependent on aspirin but do not abuse it. The term chemical dependency as used in addiction always implies mood-altering drugs, such as alcohol, anti-anxiety agents, sedative hypnotics, narcotic analgesics, or amphetamines. Chemical dependency further includes illicit drugs such as marijuana, cocaine, heroin, and LSD.

DUAL DIAGNOSIS

This is a term that has become popular this past decade among those in the helping and healing arts, for example, psychiatrists, psychologists, counselors, and those who work in addiction. The reason, of course, is that it is quite common for people with addiction to also have a major or significant mental health illness and vice versa.

1. Some patients' latent mental health problems or illnesses may become manifest with the taking of psychoactive chemicals.
2. People with mental health illnesses "stumble on" to the fact that drugs such as alcohol helps them feel more normal or comfortable. This appears to be acceptable initially, but, this is not so once addiction is established.

Now, the patient has two illnesses that must be addressed e.g., mental health and addiction. If one gets treated and the other is ignored, the risk of failure is greatly increased. It is axiomatic that if one

diagnosis is ignored in a dual diagnosis patient, the chances of failure are greatly increased so much that to ignore it or overlook it, increases one's vulnerability to malpractice.

Sometimes it is impossible to know which came first, the depression or the alcohol use. This goes for the other illnesses as well. Sometimes psychoactive chemicals will mask an underlying mental illness as well as aggravate it. An individual who has used drugs and alcohol since youth and may have never learned how to solve the ordinary problems of daily living thus appearing retarded or mentally deficient.

Some of the more common dual diagnosis patients include bi-polar affective disorder plus the addiction to alcohol, schizophrenia and the use of LSD and all other sorts of psychoactive chemicals, personality disorders such as an anti-social personality and any and all other psychoactive chemicals. This last is the most common type of dual diagnosis experienced in corrections.

Sometimes it is impossible to know which came first, the mental condition or the use of drugs/alcohol. Also, it is a well known fact that alcohol is a depressing drug. This may account for the tremendous increase in suicide among practicing alcoholics. We know for a fact that for every 100 depressed alcoholics admitted to a treatment center, that in 85% of those admitted, their depression will subside within one to three weeks, whereas 15% continue to be severely depressed and deserve, and indeed need, additional assistance.

Evaluation/treatment may vary depending on who sees the patient first. Is this a mental health worker or social worker or a counselor? If one is from a mental health background, that approach is likely to receive highest priority, whereas if one is from addictionology, then the drug or alcohol use will be considered paramount.

Almost all would agree it is not possible to know in every case which came first and indeed may not be that important. Rather the greatest emphasis must be given to the alcohol and drug use, and concurrently, the mental health problem must be addressed. The mental health issues may be addressed at a later date if detoxification or other factors necessitate it. It is rare, indeed, for any individual to recover from a mental health problem if drinking and drug use continue unabated.

III

TREATMENT VS. INCARCERATION

Criminality (anti-social personality disorder) and substance abuse are a dual diagnosis, like any other. The majority of the convicted population is considered to have anti-social personality disorders. Iowa Methodist Medical Center estimates that 80% or more carry this diagnosis. Seventy-five to 80% of these are also considered substance abusers. If you simply treat the substance abuse problem by detoxifying the individuals and educating them on why not to do this in the future, you are left with an individual who continues to think and act without regard to the societal and personal boundaries of the world around him. The continued criminal behavior will result in arrest and reincarceration. If you treat the anti-social personality disorder attempting to change distorted/dysfunctional thought and behavior patterns by identifying them, setting limits (motivating change), and practicing new behaviors, but ignore the substance abuse problem, you will again fail. The inmate, upon release, almost immediately returns to substance abuse, resulting in-out-of control behavior. This leads to dishonesty, paranoia, and criminal thought/behavior.

We must remember when treating individuals with dysfunctional personalities that they are much more comfortable with their dysfunction than they will be with the new life we advocate for them. It will be a long time before mainstream behavior is more comfortable or attractive than dysfunctional behavior.

There is a tendency to over-generalize the treatment of chemical dependency, to stereotype it. Many individuals see the treatment of chemical dependency as a "primary disease", in direct conflict with the rehabilitation of criminal thought and behavior. They believe that calling the problem a disease frees the inmate of responsibility for their actions. The opposite philosophy can also be found in practice (e.g. to punish, or incarcerate is wrong, since these people are "sick", not "bad").

These goals are not in conflict with one another. As the two diagnoses work together to tear the individual's life down, the two treatments should work together to restore or initiate sane living.

The first step in treatment of substance abuse is the advocacy of total abstinence from all mood altering substances. Next is to identify distorted thought patterns which protect the patient from dealing with the realities of the problems he/she is causing through their chemical usage. Behaviors which need to be changed must be confronted, the motivation the individual has to change his/her lifestyle must be explored. There may be a sincere desire to stop the emotional pain of their addiction. Very often however, it is a desire to prevent the loss of a marriage, a job, or even severe physical difficulties.

The next step is to change the environment to support behavior changes. After practicing new behaviors long enough (this is individualized based on the extent of dysfunction), the patient becomes comfortable with the

changes and the new behavior is now their actual coping behavior. Then a continuum of care is necessary for ongoing support of appropriate coping behaviors to prevent reversion to quicker, easier coping behaviors which are destructive to their recovery.

Treatment of criminality consists of enforced behavior change, through incarceration, probation, or other sanction. Intensive group examination of the individual's distorted thinking and subsequent behavior patterns, group or peer confrontation and pressure to change these, and group support for new thought and behavior patterns are the steps in this treatment process. This is followed by supervision after release to ensure the behavior stays changed.

MODEL

Treatment of
Substance Abuse:

Abstinence --- Identification of Distorted Thought --- Behavior Change
--- Environment Change --- Continuum of Support

Treatment of
Criminality:

Identification of Distorted Thought --- Behavior Change --- Environment
Change --- Monitoring

Essentially, these two treatments are trying to accomplish the same end, through very similar means.

While the disease concept discusses "powerlessness" over chemicals, the intent of this is not absolution of responsibility. "Powerlessness" applies to the addicted individual's inability to control chemical consumption once they start. Their addiction is a widely accepted medical fact. By treating an individual's chemical dependency, we empower them with many alternatives. Using chemicals or other destructive behaviors no longer has to be their coping behavior structure. Choosing not to use these alternatives is where the responsibility lies with the addicted individual. He/she accepts "powerlessness" to motivate ongoing abstinence. The intent is not for them to blame their hurting of others on it. Accepting powerlessness, instead, means accepting the need to become accountable.

Setting limits, to whatever degree needed, is very much a part of becoming accountable for oneself. Incarceration, probation, parole and residential living are all forms of limit setting for individuals not capable of doing it for themselves. Advocating substance abuse treatment, the disease concept, powerlessness, etc. is therefore not a call to discard criminal rehabilitation. It is a call to treat all aspects of the inmate's problems. Substance abuse feeds into criminality but does not entirely create it in all cases. Criminality feeds into substance abuse, but is not entirely responsible for it in all cases. Both of these "primary" issues must be addressed in order to affect any lasting change.

The Emergence of Multi-Diagnosis

Things are different today. Clients in treatment for chemical dependency, whether it be public, private, correctional, or other are a different breed than was seen 10 years ago, or even as recently as five years ago. No longer are a majority of cases singularly problematic due to chemical dependency. While the diagnosis of chemical dependency is still very much a "primary disease" in that it creates its own symptoms, this diagnosis is now, more often than not, coupled with one or several other organic or personality dysfunctions. The reasons for this are too complicated and numerous to completely explore in this manuscript. However, a brief overview of some of the dynamics is necessary.

One of the dynamics possibly contributing to the increase in dysfunction is the continuing trend in American culture away from supportive nuclear family systems, religious cultural belief and involvement, and the increase in combined or extended families. Strong cultural ties or guidelines serve to unite people in support of one another, holding dysfunction and substance abuse in check. According to Bell and Evans, "Socially disruptive drinking occurs only in secular settings; when alcoholic beverages are used in sacred or religious contexts, they seldom produce socially disruptive drunken comportment, unless such behavior is considered appropriate to the religious worship. Where opportunities for group or community recreation are few and alcoholic beverages are available, alcohol consumption will become a major form of recreational activity in a community.

Alcohol and other substance abuse is often related to family dysfunction. Substance abuse is becoming increasingly identified as a right of passage marking adulthood, and children desiring independence are turning to substance abuse as their declaration of individuality. The increase in family dysfunction, either in parents, children or both, sometimes leads to an increase in neglect, physical, sexual or psychological abuse.

An individual suffering from post traumatic stress disorder, related to abuse, war experience or other traumatic experience, has special needs in treatment. They are often unable to focus on their chemical use problem because of their inability to focus emotionally. They also have significant difficulties with abstinence as this often leads to re-emergence of post traumatic stress symptomatology.

Another issue which is changing the nature of our clientele is the popularity of crack cocaine and methamphetamine. Addiction to crack cocaine seems to intensify certain behavioral symptoms of addiction. These addicts tend to be extremely narcissistic, lacking in remorse, less aware of personal or societal boundaries, and severely lacking in impulse control. The craving for crack can be so demanding that the user will resort to theft, deceit and violence to procure more of the drug. Crack is considered the most addictive derivative of cocaine and the side effects of irritability and hyperactivity are believed to be more serious for crack users than cocaine users because of crack's more destructive effects on brain neurotransmitters. Many of these dynamics are the same in crystal methamphetamine users. However, this drug leads to more intensive mood swings and subsequently often results in more violence in the addict's behaviors.

In the past, the disease concept, intervention based treatment was developed to address primary alcoholism. It dealt foremost with chronic alcoholism which led to deterioration of job, family, physical, emotional, social, and sometimes legal life areas. Often there could be family support for recovery. The patient would work through his/her interference in the life of others, re-establish communication with family members, and leave treatment to a continuum of care in AA or other aftercare.

Instead of this kind of patient, today we are treating substance abusers with:

Anti-social Personalities	Borderline Personalities
Bi-Polar Affective Disorders	Extensive Abuse Histories
Schizophrenia	Illiteracy
Depression	and/or incompatible
Mental Retardation	cultural differences
Learning Disabilities	Severe Poverty

Usually some combination of the above.

In most cases, we are now habilitating as opposed to rehabilitating individuals. We cannot ask people to re-assert behaviors they've never displayed or seen in their role models. Unfortunately, in most cases, treatment centers are using a treatment modality that is still geared to treat the chronic alcoholic who simply needs rehabilitation.

As previously discussed, treating substance abuse without treating anti-social thoughts and behaviors is ineffective. It is equally ineffective to treat someone for substance abuse who is functionally illiterate or learning disabled, and unable to grasp the concepts discussed. It is ineffective to treat someone who is not able to make more than minimum wage, send them out to raise a family with no resources, but expect them to be happy enough to remain sober, especially if they have the option of dealing drugs and making a thousand dollars a day.

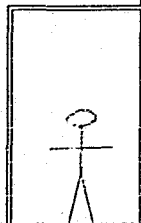
In order to habilitate, we must approach all dysfunction wholistically. Treatment planning should address identified problems in many areas, not just substance abuse.

SHARED SYMPTOMOLOGY

_____ Inconsistent parenting -----	----- Inconsistent work habits -----
_____ Inability to maintain relationships -----	----- Irregular eating and sleeping -----
_____ Compulsive _____	_____ Impulsive _____
----- DRINKING AND/OR USING CHEMICALS -----	
----- Isolation _____	_____ Defensive _____
_____ Unmotivated to change _____	_____ Apathetic _____
_____ Dissatisfaction with life _____	_____ Self-pity _____
_____ Narcissistic _____	_____ Unreasonable resentments _____
----- Obsession with using chemicals "normally" -----	_____ Conscious lying _____
_____ Feels omniscient _____	_____ Easily angered _____
_____ Distortion _____	_____ Denial _____
_____ Crime -----	_____ Violence -----
----- Financial responsibility -----	_____ Depression -----
	_____ Loneliness -----
	_____ Confusion -----
	_____ Loss of self-confidence -----

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_____ Usually present
 ----- Sometimes present



ANTISOCIAL PERSONALITY DISORDER



CHEMICAL DEPENDENCY

There is an old saying, "If you make a drunken horse thief stop drinking, what you have is a sober horse thief." Looking at the above graphic, it is fairly easy to conceptualize that simply removing the symptom of alcohol and drug abuse, leaves you with an extremely dysfunctional individual. This is only the example of the anti-social personality with substance abuse. A wholistic approach addressing each of the thought and behavior problems (or other diagnoses) identified in an individual case is necessary. It matches treatment to the individual.

It is this wholistic approach which necessitates a coordinated continuum of care capable of addressing inmate treatment within appropriate security guidelines.

IV

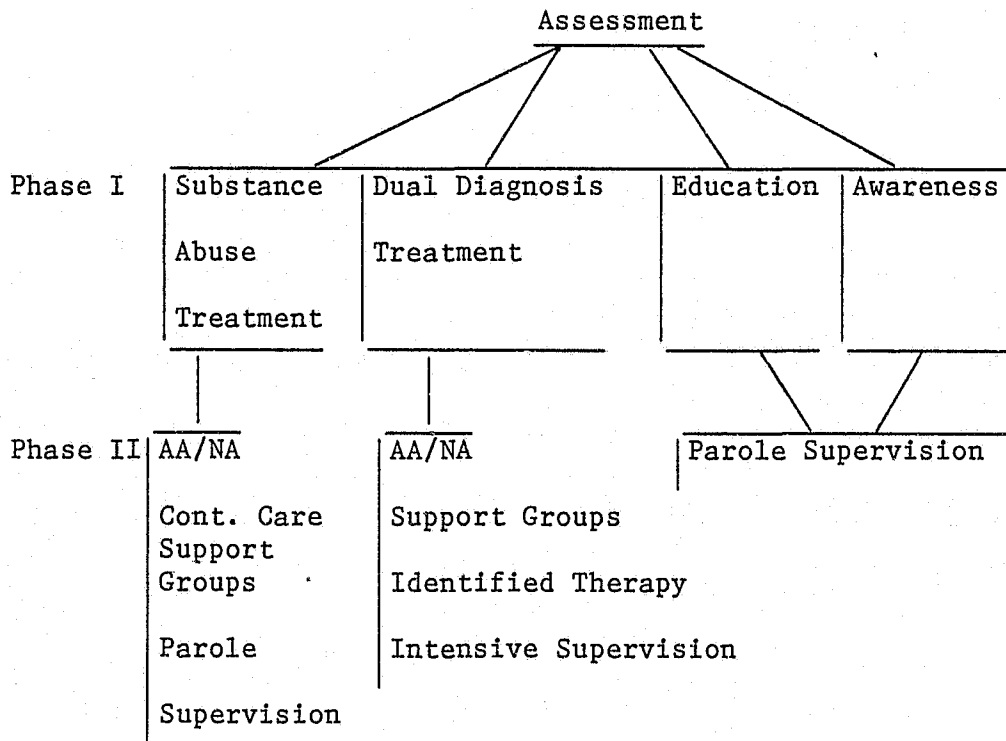
Continuum of Care

The popular theories of treating chemical dependency are usually those which center around a "quick fix", a short term treatment requiring little to no effort or growth on the part of the client. Aversion therapy and alternative drug maintenance programs are examples of these. People do not wish to acknowledge the depth of dysfunction associated with chemical dependency, or the wholesale lifestyle changes which are necessary to recover from it. "Quick fixes" are therefore attractive. Also, the nature of addiction demands short term gratification, whereas wholistic recovery is a long term, if not life long, process.

Unfortunately, "quick fixes", despite their popularity, are not effective in addressing the whole problem. They once again focus on the need to change only the actual drug use behavior, leaving all other unhealthy organic or personality factors to lead to relapse.

A continuum of care is a multi-faceted process addressing the many problems presented by our polydiagnosis clientele. It would begin with a unified assessment process. The client would then be referred to one of several available options for treatment. Following successful completion of initial treatment, they would be referred for continuing care to continue support for behavior and environment changes. Continuing care is the second phase of recovery. It is a long term phase and it is essential to ongoing recovery.

Example
CONTINUUM MODEL



An important key to the success of this model is the ability of the inmate to move both directions in the system. That is to say, if inappropriate behavior, total lack of progress, or security issues require it, the inmate could return to a higher degree of structure. This potential must be real for the model to work. If limits are set, but inconsistently carried out, this will only serve to undermine the credibility of the process.

Phase I

Assessment

This is the key to multidisciplinary treatment planning. This process must examine all aspects of the individual in order to identify all needs which must be addressed or accounted for in treatment. It includes a comprehensive psycho-social substance abuse history; a battery of psychological testing and interviews to provide a complete psychological profile, intelligence functioning, and literacy skills; and physical examination and testing. The resulting information will differentiate among four major divisions in the population. Individuals who:

1. Have abused substances but are not addicted, are essentially pro-social, do not have extensive criminal history, and are not likely to re-offend.
2. Are chronically addicted to chemicals. They're essentially pro-social and not likely to re-offend if they remain abstinent from mood altering substances.
3. Are anti-social with little remorse about their crimes. Are resistant to help and do not see themselves in need of changing. Are chronically addicted to chemicals. Are expected to re-offend.
4. Have some other psychological disorder (organic or personality). Are chronically addicted to chemicals. Are likely to re-offend.

This assessment would only be administered to those individuals who were flagged as substance abusers in classification and whose sentence would make assessment at the point of classification worthwhile.

The assessment, if it meets Iowa licensure standards, could be accepted by the Iowa Division of Substance Abuse as the intake psycho-social history and assessment. This would significantly reduce the duplication of assessment which occurs when working with corrections case loads.

Once the assessment process yields the necessary information, this can aid classification in determining which institution is most appropriate for placement in order for the inmate to continue into treatment as their sentence draws to a close. This could possibly reduce the need for transferring inmates to facilitate treatment. It would not, however, always be possible to put the inmate in the recommended institution, depending upon the risk assessment and sentence.

Finally, the assessment could be maintained electronically to facilitate timely transferral of necessary information to the treatment centers at the time of admissions.

Treatment

In a continuum of care, there would be separate modalities with varying levels of intensity and alternative components. As 75 - 80% of the prison population is identified with some alcohol or drug behavior history, all institutions could feasibly present a substance abuse awareness program. As not all of that 75 - 80% require an intervention type of treatment, we can then prioritize our resources to the individuals in need.

There are arguments that we should spend the majority of our resources on those who are least resistant, and most likely to change because they have the best chance of recovery. There are also arguments that we should focus resources on those who are most anti-social and least likely to change. This is because they are the most dangerous, the chronic repeaters, and need more intensive help if they are to accomplish anything.

In a continuum of care, we have the opportunity to disperse resources as they are demanded by needs. Those who are addicted, but most likely to change would benefit from fewer hours of treatment, in a less structured environment. Those who are least likely to change and presently higher security risk, but have the most needs could be treated in a long term treatment modality combining interventionist treatment for substance abuse and behavioral correction treatment such as that developed by Yochelson and Samenow. This would be a dual diagnosis treatment center. Still another modality would address substance abuse coupled with organic disorders such as schizophrenia, or manic depression.

Something misleading about a discussion of "treatment" is that this word is equated with counseling or therapy. Treatment, however, does not equal therapy. Multi-disciplinary treatment happens on many levels. These include education, vocational training or rehabilitation, medical treatment, hygiene training, and development of social skills. Each step which enhances the coping skills of the client, increases the likelihood that he/she will succeed in changing their behavior.

Recommended modalities of treatment for corrections fall into five categories. They include: 1. Substance abuse awareness programs for the majority of inmates, 2. Outpatient treatment for chemical dependency, 3. Inpatient treatment for chemical dependency, 4. Long term residential treatment for anti-social behavior and chemical dependency, and 5. Long term treatment for chemical dependency and organic psychiatric disorders.

There will be those whose sentence is too short to facilitate treatment in the institution. In these cases, a close relationship with community based corrections and community treatment services is necessary. In such cases, the individual's treatment in the community should be a condition of their parole. In monitoring an individual expected to seek treatment in the community, contact should be initiated by their parole officer before they leave treatment.

Phase II

Continuing Care

Assessment and treatment are high profile. In most institutions, public and private, they are the focus of resources and attention. There are many reasons for this. Treatment is a costly, intensive undertaking and therefore controversial. The nature of delivery of treatment services demands close monitoring to assure quality. Treatment is also a time of crisis and growth for the individual and their family. Unfortunately, these factors often take the focus off of continuing care. Treatment equals about 5% of recovery. Ninety-five percent of recovery occurs after treatment in continuing care. The most important element in recovery is a sustained relationship with a new peer support system that places a high priority on abstinence and open, honest relationships with others.

A continuum of care needs a balance of resources between Phases I and II of recovery. This is so the client has immediate and continuing care, so that the client understands that continuing care is as important, if not more important than treatment. This balanced approach also assures the quality of continuing care that is required for comprehensive recovery.

Again, each case is individualized. Each person has different needs. Some will simply need parole supervision, active involvement in Alcoholics Anonymous or Narcotics Anonymous (AA/NA), and a structured, facilitated continuing care support group. Others may need the above as well as intensive supervision, with a significant amount of structure in order to succeed. There is evidence that some individuals function best in a recovery population halfway house before attempting sobriety on the streets. Still others may need one to one therapy, medical or other individual issues addressed.

Developing strong Phase I services without emphasizing Phase II is reverting to the "quick fix" mentality. Closing existing gaps between institutions and community based corrections, working closely with the parole board to ensure coordination, and nurturing our Phase II resources in the community are a priority task in developing an effective coordinated continuum of care.

There is some concern that putting resources into institutions for treatment is "front-loading" and that institutions are a "sterile" environment where inmates have limited access to mood altering chemicals. Therefore, treatment in institutions is less effective and resources should be placed at the "back end" of the spectrum, in the community.

Removing addicts from their environment and placing them in artificial communities for the purpose of treatment has long been, and is still the main approach to treatment for substance abuse in the community. The majority of individuals treated in institutions have already been treated in the community, but treatment is a process, not a product.

In a continuum, there is not a front or a back of the system. There can, however, and should be an entrance and an exit. You can enter at any point on the continuum. You can exit either due to success or failure.

Receiving services within the continuum, as long as you remain appropriate according to progress and security, should be dictated by needs. Admitting an inmate to this continuum while in an institution is an excellent opportunity to treat, support, and monitor an extremely high risk group, that has historically slipped through the cracks.

PROBLEMS

Resistance and Relapse

Resistance

Among critics, there is a pervasive sentiment that treatment in institutions can't be successful because inmates are being forced into it. The belief is that in order for an individual to recover, they have to want to recover for themselves and that resistance on the part of offenders perpetuates failure. Finally, many critics believe that offender populations aren't like populations in public or private treatment centers where the patients are "voluntary" and want sobriety. Resistance in substance abuse treatment is not, however, peculiar to offender populations.

With any chronic illness, the patient experiences a realization process. This is described by some as a grief process including denial, anger, bargaining, depression and acceptance. These are the emotional/behavioral defenses that humans use to protect themselves from harsh realities. This process is as prevalent in chemical dependency as it is in cancer or diabetes.

The beginning of the addiction process is an incredibly powerful bonding experience between the addicted individual and their substances of abuse. Individuals find relief and release through substance use, the likes of which they've never experienced through any other means. Further, they experience virtually no consequences at first. The remainder of their addictive career is spent trying to recapture those first moments of substance related "freedom" without associated consequences. Their relationship with chemicals becomes increasingly important in their life. It becomes more important than family, spouse, children, work, the law, and their own values, morals, and physical health. As the importance of chemicals surpasses the importance of these other factors in the addicted person's life, they begin to get messages that there is something wrong. They experience consequences. The combination of physical tolerance to chemicals and the awareness of the problem in those around the addicted, ensures that they will never be able to recapture that initial simple freedom in substance use without consequences.

Unfortunately, it is the delusion of every abnormal substance user, that they will somehow, someday, be able to use again like a "normal" person. To use without hurting themselves or others. This is denial. Denial is supported by distorted thinking. Thinking that is incapable of seeing their substance use as primarily responsible for consequences. They distort. They blame others. If their spouse would get off their back..., if their boss wouldn't put so much pressure on them..., if the police hadn't been following them..., they wouldn't have all the problems they have. The important distinction is that they believe these things to be facts. It is not simple dishonesty, they now believe their justification.

Thus begins the development of a complicated structure of defense mechanisms, all of which are geared to protect the addicted person from having to consciously admit and accept that the root of their problems is their substance use. These defenses are numerous, but they include justifying, minimizing, evading, silence, threats, and sarcasm. The types of defenses used depend largely on the individual's personality. Before an addicted individual can move on to the acceptance of their chemical dependency, this structure of defenses must be disassembled. This requires intervention.

Intervention comes in many forms, only one of which is legal pressure. A large number of patients admitted to treatment centers are there to save a marriage, a job, to satisfy their physician, or several other possibilities. It is rare that once the boss, spouse or doctor have intervened, that the addict is now suddenly wanting sobriety. Remember, their substance use is now a closer, more trustworthy friend than any of the above. It is always there for them, and always yields the release, the feeling they expect. So even though they enter treatment without legal consequences hanging over their head, they do not want to be there, nor do they want to be sober. A telephone survey of a private treatment center in Des Moines on December 4, 1990 indicated that 2 individuals were in treatment voluntarily and 21 were in treatment due to some kind of external force, only 2 of which were legal interventions.

The task of making the connection between the addict's use and their problems is the job of the treatment center. Treatment modalities must therefore be developed to break through defenses if the addict is ever to move out of denial and into the acceptance/recovery process. Resistance to treatment is by no means a dynamic peculiar to offender populations. Nor is it an insurmountable obstacle to successful recovery from chemical dependency. If resistance could not be overcome, this approach to treatment would have been discarded years ago. This is not to pretend that offenders do not have special needs. On the contrary, this is simply further evidence of the need to develop treatment specific to the more intensive needs of offenders.

Relapse

Because offender populations are at such high risk for relapse, it is important to discuss some of these dynamics. Again it is argued that because offenders are high risk for relapse, it is not worth putting resources into treating them. These issues will be addressed in two ways. First, there are several myths about relapse that must be dispelled. Second, relapse is an opportunity to pinpoint the specific issues which have not been treated or need further attention.

Myths

-It is a myth that relapse is a "slip". It is a process, not an event. Each addictive personality has a map of behaviors which, if the behaviors are resumed, will lead to the resumption of chemical use. It is predictable and preventable.

-It is a myth that relapse is a failure, something to be ashamed of and therefore to keep hidden. Every addicted individual whether sober 20 years or 20 days can expect to experience some of their benchmark relapse behaviors. The question is what do they do about it when they recognize the behaviors as relapse symptoms? Do they seek help, or do they return to the denial/distortion process discussed earlier.

-It is a myth that relapse is an event over which the chronic relapser has no power. Whatever the circumstances, the individual has hope of recovery. Some may take more effort, support, and structure than others.

-It is a myth that anyone having a period of abstinence and resuming chemical use has relapsed. Abstinence does not equal recovery. In order for someone to relapse, they must first have made some progress. This means behavior change. When they begin to change their behaviors and experience relief from these symptoms (see graphic-Chapter 3), they have begun a process of recovery. Once this process has begun, something must happen to trigger reversion to relapse behaviors. Someone who is simply "dry" for a period of time but changes no behavior, is still in the active addiction dynamic. They have never experienced progress, recovery, relief and will not respond to a relapse modality of treatment.

Why is relapse an opportunity? Chronic relapsers are lacking coping skills in one or more areas of their life. It may be interpersonal conflict or social pressure to use, negative emotional states, or urges and temptations to use. Some are external, and relate to other people while others are internal, relating to how they perceive their life. When a crisis or turning point occurs in one of these areas, the relapse cycle is set in motion. It may be the end of a relationship, the death of a loved one, or receiving a promotion. Celebration is just as often the instigator of the relapse cycle as pain, because the relapser has no comfortable practiced new behaviors to cope with happiness and self affirmation.

When this crisis occurs, the addict reverts to what he/she knows, what they're comfortable with, and what has always gotten them through in the past. They return to addictive behavior. This may be with or without chemical use. Either way, they are in a relapse dynamic that, without intervention, will lead to resumption of chemical use.

This affords us the opportunity to examine the individual's relapse process, identify the high risk areas of their life, and tailor programs to help the individual develop coping behaviors that are not self-destructive. This is the opportunity to find solutions for a baffling portion of the substance abuse population. This population is not hopeless, nor are they too far gone to prioritize resources for them.

VI

CONCLUSIONS

Criminal recidivism is a growing problem in corrections. Prison overcrowding has reached all time highs in the state of Iowa in 1990.

Individuals with established patterns of both drug abuse and criminality have been shown to have increases in criminality which correspond to increases in substance abuse. Individuals with a reduction in substance abuse have a corresponding reduction in criminality. It is time for a proactive, coordinated approach to intensive treatment of substance abusing offenders.

It is clearly documented that intensive substance abuse treatment is successful in reducing criminal recidivism. It is also clear that education alone, when not part of pre-treatment groups or intensive treatment, has virtually no impact on continued drug use. Thus, the development of a comprehensive continuum of care is recommended. An in depth, centralized assessment process and multiple tiers of treatment intensity, coupled with a direct bridge to community support systems, comprise this continuum. The implementation of this process will reduce criminal recidivism in substance abusing offenders, aid in reducing prison populations, and set a precedent for proactive approaches to treatment of offenders in the community.

In recent years the Department of Corrections has made significant strides toward addressing substance abuse. The support of the Governor's office and Legislature has been integral to this process of development.

In the future, some further commitment of resources will be needed to accomplish this transition. Many of our effective programs for addressing substance abuse exist primarily on grant funding. These grants are intended to start programs, but are not available to maintain them. "The Other Way" program at Clarinda is nearing the end of available grant funds and will need a legislative appropriation to continue after Fiscal Year 1992. The T.A.S.C. (Treatment Alternatives to Street Crimes) program exists on a grant and will have these funds available for only a few more years. In addition, the establishment of a continuum process would need fiscal support in the way of: 1. Adjustment of present allotments for expenditures and 2. New appropriations for program implementation.

Reality is that substance abuse will be an ongoing problem for years to come. The sooner we apply proven approaches, the better our chances are of stopping the rapid increase of substance abuse related crime and criminal recidivism in our state.

G L O S S A R Y

Abstinence: Cessation of use of a psychoactive substance previously abused, or on which the user has developed drug dependence.

Abuse Potential: The property of a substance that, by its physiological or psychological effects, or both, increases the likelihood of an individual's abusing or becoming dependent on that substance.

(Drug) Addict: A person who is physically dependent on one or more psychoactive substances, whose long-term use has produced tolerance, who has lost control over his intake, and would manifest withdrawal phenomena if discontinuance were to occur.

(Drug) Addiction: A chronic disorder characterized by the compulsive use of a substance resulting in physical, psychological, or social harm to the user and continued use despite that harm.

Alcohol Abuse: Use of ethyl alcohol in a quantity and with a frequency that causes the individual significant physiological, psychological, or sociological distress or impairment.

Alcohol Addiction: Physiological and psychological dependence on alcohol.

Alcohol Dependence: Chronic loss of control over the consumption of alcoholic beverages, despite obvious psychological or physical harm to the person. Increasing amounts are required over time, and abrupt discontinuance may precipitate a withdrawal syndrome. Following abstinence, relapse is frequent.

Alcoholic: Person who has experienced physical, psychological, social, or occupational impairment as a consequence of habitual, excessive consumption of alcohol.

Alcoholics Anonymous: An international, nonprofessional organization of alcohol-dependent persons devoted to the achievement and maintenance of sobriety of its members through self-help and mutual support.

Alcoholism: A chronic, progressive, and potentially fatal biogenetic and psychosocial disease characterized by tolerance and physical dependence manifested by a loss of control, as well as diverse personality changes and social consequences.

* **Antabuse:** A brand of Disulfiram, a deterrent therapy, taken orally, which stops the normal metabolism of alcohol resulting in the build-up of a toxic substance (Acetaldehyde) causing distressful symptoms (i.e. nausea, vomiting, headache, flushing, chest pain, rapid heart rate and loss of blood pressure). It is inexpensive and effective in small doses (250mg per day). It is used in addition to some other form of therapy and not considered to be efficacious in and of itself. It is particularly of value for extremely impulsive individuals. Antabuse should only be used with informed consent. (PDR 1991)

* Antisocial Personality Disorder: (DSMIIIR 301.70, 1987) "People with this disorder tend to be irritable, and aggressive and tend to get repeatedly into physical fights... including spouse-or child beating... they generally have no remorse about the effects of their behavior on others; they may even feel justified in having hurt or mistreated others..."

Blackout: Acute anterograde amnesia with no formation of long-term memory loss during which there is no recall for activities, resulting from the ingestion of alcohol and other drugs.

Cannabis Dependence: The psychological need for a routine pattern of cannabis use to the point where social-occupational functioning is impaired to some degree.

Chemical Dependency: Generic term relating to psychological or physical dependency, or both, on an exogenous substance.

Chronic Alcoholism: An obsolete term that should be abandoned. Synonymous with "alcoholism.": The contrasting term "acute alcoholism" is now rarely used, and means only severe intoxication by alcohol.

* Criminality: Refers to antisocial personality disorder.

Cross-dependence: The ability of one drug to suppress the manifestations of physical dependence produced by another and to maintain the physically dependent state.

Cross-tolerance: Tolerance, originally produced by long-term administration of one drug, which is manifested toward a second drug that has not been administered previously (e.g., tolerance to alcohol is accompanied by cross-tolerance to volatile anesthetics or barbiturates).

(Drug) Dependence: A generic term that relates to physical or psychological dependence, or both. It is characteristic for each pharmacological class of psychoactive drugs. Impaired control over drug-taking behavior is implied.

Detoxification: A process of withdrawing a person from an addictive substance in a safe and effective manner.

Disease Concept: Recognition that chemical dependency is a chronic, progressive, and potentially fatal biogenetic and psychosocial disease characterized by tolerance and physical dependence manifested by a loss of control, as well as diverse personality changes and social consequences.

Drug Abuse: Any use of drugs that causes physical, psychological, economic, legal, or social harm to the individual user or to others affected by the drug user's behavior.

Drug Free: Ongoing disassociation from the use of any psychoactive substance.

Drug Intoxication: Changes in physiological functioning, psychological functioning, mood states, or cognitive processes, or all of these, as a

consequence of excessive consumption of a drug; usually disruptive.

Drug Misuse: Any use of a drug that varies from a socially or medically accepted use.

Enabling Behavior: Any action by another person or an institution that intentionally or unintentionally has the effect of facilitating the continuation of abuse or dependence.

Familial Alcoholism: Pattern of alcoholism occurring in more than one generation within a family, due to either genetic or environmental factors.

Family Intervention: Specific form of intervention involving family members of alcohol and drug addicts designed to benefit the target patient as well as family constellation.

Impaired Physician: A physician whose clinical conduct does not meet accepted standards of practice and that is secondary to alcohol-drug use, or psychiatric illness, or physical illness, or all three.

Intervention: Act of interceding in behalf of an individual who is abusing, or is dependent on, one or more psychoactive drugs, with the aim of overcoming denial, interrupting drug-taking behavior, or inducing the individual to seek and initiate treatment.

Loss of Control: The inability to limit the use of substances via an internal locus of control.

Maintenance: A form of therapeutic intervention applied to opiate addicts, and consisting of the oral administration of a substitute opiate drug to minimize the reinforcement of drug taking and prevent a withdrawal reaction, while permitting rehabilitation to be achieved.

Overdose: The inadvertent or deliberate consumption of a much larger dose than that habitually used by the individual in question, and resulting in serious toxic reactions or death.

Physical Dependence: A physiological state of adaptation to a drug or alcohol, usually characterized by the development of tolerance to drug effects and the emergence of a withdrawal syndrome during prolonged abstinence.

Polydrug Abuse: Concomitant use of two or more psychoactive substances in quantities and with frequencies that cause the individual significant physiological, psychological, or sociological distress or impairment.

Prevention: Social, economic, legal, or individual psychological measures aimed at minimizing the use of potentially addicting substances, or lowering the dependence risk in susceptible individuals.

Primary Prevention: Attempts to reduce the incidence of new cases (or problems) in a general population.

Problem Drinking: (1) Drinking patterns that have resulted in serious disturbances of health, work, social adjustment, or other areas of functioning. (2) A pattern of alcohol consumption that does not satisfy all the criteria of alcoholism, but that is characterized by sufficiently large intake to have generated problems of health or social functioning.

Psychological Dependence: The emotional state of craving a drug either for its positive effect or to avoid negative effects associated with its absence.

Recovering Alcoholic: An alcoholic who is successfully abstaining; to emphasize the concept that no one is ever cured, and that recovery must be continuously worked at.

Recover: A process of overcoming both physiological and psychological dependence on a drug or alcohol.

Rehabilitation: The restoration of an optimum state of health by medical, psychological, social, and peer group support for a chemically dependent person and his significant others.

Relapse: Recurrence of alcohol- or drug-dependent behavior in an individual who has previously achieved and maintained abstinence for a significant time beyond the period of detoxification.

Sobriety: Generally refers to the state of complete abstinence from alcohol and other drugs of abuse in conjunction with a satisfactory quality of life.

Substance Abuse: The use of psychoactive substance in a manner detrimental to the individual or society but not meeting criteria for substance or drug dependence.

Tolerance: Physiological adaptation to the effect of drugs, so as to diminish effects with constant dosages or to maintain the intensity and duration of effects through increased dosage.

Treatment: Application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive, or health injuring; or to restore appropriate levels of physical, psychological, or social functioning.

Withdrawal: Cessation of drug or alcohol use by an individual in whom dependence is established.

Withdrawal Syndrome: The onset of a predictable constellation of signs and symptoms involving altered activity of the central nervous system after the abrupt discontinuation of, or rapid decrease in, dosage of a drug.

All terms except those marked * are extracted from: Rinaldi, R.C., Steindler, E.M., Wilford, B.B., Goodwin, D., Clarification and Standardization of Substance Abuse Terminology, JAMA, 259(4) pp. 555-557, 1988.

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