

***Judicial Education on Substance Abuse:  
Promoting and Expanding Judicial Awareness and Leadership*** ;

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**Partipant Materials Folder List**

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**Bench Considerations**

**"Judging for the New Millenium"**

**"The Implications of Therapeutic Jurisprudence for Judicial Satisfaction"**

**Tips from Rural Communities**

**Why "No Alcohol" Clause**

Pocket

**Bench Resource List**

**Drugs of Abuse**

**Commonly Abused Drugs**

**Toxicology Drug Testing Tid Bits**

**Drug Testing Resources**

**Possible Alcohol and other Drug Probation Conditions**

**Mental Health/Alcohol and Other Drugs Glossary**

**Principles of Drug Addiction Treatment**

**NIDA Principles of Treatment Slides Handouts**

**Quick Guide to Finding Effective Alcohol and Drug Addiction Treatment**

**The Twelve Steps of Alcoholics Anonymous**

**Alcohol/Drug Webliography**

**Indicators of Co-Occurring Mental Health Disorders**

**Barriers to Treatment for Women**

**Barriers to Treatment for Women with Children**

**CPS Issues for Using Parents**

**"A Check List for County Officials to Assess Jail Conditions for Women"**

**Mental Health Webliography**

**Summary of Treatment Modalities**

Library

National Center for State Courts

300 Newport Ave.

Williamsburg, VA 23185

## *JUDICIAL EDUCATION ON SUBSTANCE ABUSE*

### **BENCH RESOURCE LIST**

The following is a suggested list of materials that would be helpful to a judge in cases involving substance abuse.

1. **Drug Guide** (including traditional names, slang terms, medical uses, duration of effects, possible effects, effects of overdose, withdrawal symptoms). (Examples provided in materials.)
2. **Information on Drug Testing** (including length of time drugs remain in system, possible adulteration substances and myths). (Example and sources provided in materials.)
3. **List of drug conditions of diversion or probation.** (Example provided in materials.)
4. **Glossary of Mental Health/AOD Terms** (provided in materials).
5. **NIDA Handbook – *Principles of Drug Addiction Treatment*** and other information on the elements of effective treatment programs (provided in materials).
6. **Information on 12-step programs**, including the 12 steps (provided in materials), a list of 12-step meetings in neighboring areas of jurisdiction (Findtreatment.org) & attendance verification method (e.g., verification form).
7. **List of useful websites.** (A webliography is provided in materials.)
8. **Personal references found helpful in understanding the recovery process.**

**Other handouts (included in materials) that may be useful:**

- ◆ Indicators of co-occurring mental health disorders
- ◆ Barriers to treatment for women
- ◆ Barriers to treatment for women with children
- ◆ Child protection issues for using parents
- ◆ Jail considerations for women checklist (including drug-addicted pregnant women)
- ◆ Mental health webliography (list of websites related to mental health issues)
- ◆ Summary of treatment modalities

# DRUGS OF ABUSE

Class of Drugs	DRUG	Time in Urine
Sedatives-Hypnotics	ALCOHOL BARBITURATES TRANQUILIZERS (Require Detox)	Max. 12 Hours 3 days 3 days
Opiates	HEROIN METHADONE VICADIN PROPOXYPHENE (Darvon) SYNTHETICS (Dilaudid) (Require Detox)	2-3 Days 2-4 Days 3 Days 3-7 Days  CANNOT BE DETECTED
Stimulants	COCAINE AMPHETAMINES (Including Meth)	2-3 Days 2-4 Days
Hallucinogens	MARIJUANA PCP  LSD MUSHROOMS ECSTACY MDMA	3-27 Days 3-8 Days  ) ) ) ) CANNOT BE DETECTED



## Commonly Abused Drugs

Substance Category and Name	Examples of Commercial and Street Names	DEA Schedule <sup>1</sup> How Administered <sup>2</sup>	Intoxication Effects/Potential Health Consequences
<b><u>Cannabinoids</u></b>			<i>euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination/cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety; panic attacks; tolerance, addiction</i>
hashish	boom, chronic, gangster, hash, hash oil, hemp	I/swallowed, smoked	
marijuana	blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I/swallowed, smoked	
<b><u>Depressants</u></b>			<i>reduced pain and anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration/confusion, fatigue; impaired coordination, memory, judgment; respiratory depression and arrest, addiction</i>
barbiturates	<i>Amytal, Nembutal, Seconal, Phenobarbital; barbs, reds, red birds, phennies, tooies, yellows, yellow jackets</i>	II, III, V/injected, swallowed	<i>Also, for barbiturates—sedation, drowsiness/depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness</i>
benzodiazepines (other than flunitrazepam)	<i>Ativan, Halcion, Librium, Valium, Xanax; candy, downers, sleeping pills, tranks</i>	IV/swallowed	
<u>flunitrazepam</u> ***	<i>Rohypnol; forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies</i>	IV/swallowed, snorted	<i>for benzodiazepines—sedation, drowsiness/dizziness</i>  <i>for flunitrazepam—visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects</i>
<u>GHB</u> ***	<i>gamma-hydroxybutyrate; G, Georgia home boy, grievous bodily harm, liquid ecstasy</i>	under consideration/swallowed	<i>for GHB—drowsiness, nausea/vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death</i>
methaqualone	<i>Quaalude, Sopor, Parest; ludes, mandrex, quad, quay</i>	I/injected, swallowed	<i>for methaqualone—euphoria/depression, poor reflexes, slurred speech, coma</i>

<b>Dissociative Anesthetics</b>			increased heart rate and blood pressure, impaired motor function/memory loss; numbness; nausea/vomiting
ketamine	<i>Ketalar SV</i> ; cat Valiums, K, Special K, vitamin K	III/injected, snorted, smoked	
PCP and analogs	<i>phencyclidine</i> ; angel dust, boat, hog, love boat, peace pill	I, II/injected, swallowed, smoked	Also, for ketamine—at high doses, delirium, depression, respiratory depression and arrest  for PCP and analogs—possible decrease in blood pressure and heart rate, panic, aggression, violence/loss of appetite, depression
<b>Hallucinogens</b>			altered states of perception and feeling; nausea/chronic mental disorders, persisting perception disorder (flashbacks)
LSD	<i>lysergic acid diethylamide</i> ; acid, blotter, boomers, cubes, microdot, yellow sunshines	I/swallowed, absorbed through mouth tissues	
mescaline	buttons, cactus, mesc, peyote	I/swallowed, smoked	Also, for LSD and mescaline—increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors
psilocybin	magic mushroom, purple passion, shrooms	I/swallowed	for psilocybin—nervousness, paranoia
<b>Opioids and Morphine Derivatives</b>			pain relief, euphoria, drowsiness/respiratory depression and arrest, nausea, confusion, constipation, sedation, unconsciousness, coma, tolerance, addiction
codeine	<i>Empirin with Codeine</i> , <i>Fiorinal with Codeine</i> , <i>Robitussin A-C</i> , <i>Tylenol with Codeine</i> ; Captain Cody, Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV/injected, swallowed	
fentanyl	<i>Actiq</i> , <i>Duragesic</i> , <i>Sublimaze</i> ; Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	II/injected, smoked, snorted	Also, for codeine—less analgesia, sedation, and respiratory depression than morphine  for heroin—staggering gait
heroin	<i>diacetylmorphine</i> ; brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I/injected, smoked, snorted	
morphine	<i>Roxanol</i> , <i>Duramorph</i> ; M, Miss Emma, monkey, white stuff	II, III/injected, swallowed, smoked	
opium	<i>laudanum</i> , <i>paregoric</i> ; big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	

<b>Stimulants</b>			
amphetamine	<i>Adderall, Biphedamine, Dexedrine</i> ; bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swallowed, smoked, snorted	<p><i>increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness/rapid or irregular heart beat; reduced appetite, weight loss, heart failure</i></p> <p><i>Also, for amphetamine—rapid breathing; hallucinations/ tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction</i></p>
cocaine	<i>Cocaine hydrochloride</i> ; blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/injected, smoked, snorted	<p><i>for cocaine—increased temperature/chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition</i></p>
MDMA (methylenedioxy-methamphetamine)	<i>DOB, DOM, MDA</i> ; Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I/swallowed	<p><i>for MDMA—mild hallucinogenic effects, increased tactile sensitivity, empathic feelings, hyperthermia/impaired memory and learning</i></p>
methamphetamine	<i>Desoxyn</i> ; chalk, crank, crystal, fire, glass, go fast, ice, meth, speed	II/injected, swallowed, smoked, snorted	<p><i>for methamphetamine—aggression, violence, psychotic behavior/memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction</i></p>
methylphenidate	<i>Ritalin</i> ; JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II/injected, swallowed, snorted	<p><i>for methylphenidate—increase or decrease in blood pressure, psychotic episodes/digestive problems, loss of appetite, weight loss</i></p>
nicotine	bidis, chew, cigars, cigarettes, smokeless tobacco, snuff, spit tobacco	not scheduled/smoked, snorted, taken in snuff and spit tobacco	<p><i>for nicotine—tolerance, addiction; additional effects attributable to tobacco exposure - adverse pregnancy outcomes, chronic lung disease, cardiovascular disease, stroke, cancer</i></p>

<b>Other Compounds</b>			
anabolic steroids	Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise; roids, juice	III/injected, swallowed, applied to skin	no intoxication effects/hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics
inhalants	Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl); laughing gas, poppers, snappers, whippets	not scheduled/inhaled through nose or mouth	stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing/unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death

\*Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Most Schedule V drugs are available over the counter.

\*\*Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.

\*\*\*Associated with sexual assaults.

**SOURCE:** National Institute on Drug Abuse at <http://165.112.78.61/DrugsofAbuse.html>



## TOXICOLOGY DRUG TESTING TID BITS

Drug testing is becoming increasingly sophisticated; however, abusers can still find ways to stay a step ahead of modern technology. There are chemical agents which are known to cause a false positive or false negative drug test result, depending on the type of detection system used. Some foods we consume or common over-the-counter drug remedies used for minor ailments may cause a positive test, which may have adverse employment consequences. If the drug testing results are not taken with care, they can result in troublesome situations. Following are some examples we encounter on a routine basis.

Agent	Test Method	Results*	Cause
Donuts or bagels containing poppy seed fillings (ingested)	EMIT, TLC, FPIA	Positive for Opiates	Contains Morphine
Pseudoephedrine & Ephedrine (ingested)	EMIT assays	False Positive Amphetamines	Cross reactivity
Propionethorphan (ingested)	EMIT assays	False Positive	Dextrophan metabolite
Protargin (Tolectin ingested)	EMIT assays	Invalid results	Interference (high absorb)
Isotrizolam (ingested)	EMIT assays	Invalid results	Interference (high absorb)
Formaldehyde (UrinAid Added)	EMIT II assays	Negative	Interference
Proprietary (Tigan Ingested)	EMIT, FPIA, RIA	Amphetamines False Positive	Cross reactivity
Proprietary (ingested)	GC/MS	False Negative Cocaine	Interference
Proprietary (ingested)	EMIT, FPIA	False Negative	Dilution due to over-hydration
Proprietary (ingested)	EMIT	False Negative	Interference
Proprietary (added)	EMIT, FPIA, RIA	False Negative	Interference
Proprietary (added)	RIA	False Negative – Amph, THC, OP, Cocaine	
Proprietary (added)	EMIT, FPIA	False Negative – THC, Opiates, Cocaine	Interference
Proprietary Drops (added)	EMIT, FPIA	False Negative – THC	Interference
Proprietary Seal Tea (ingested)	EMIT, FPIA, RIA	False Negative – THC	Interference
Proprietary Tea (ingested)	EMIT, FPIA	Positive Cocaine	Contains Cocaine
Proprietary (added)	EMIT	False Negative Benzodiazepines	Interference
Proprietary (added)	EMIT	False Negative	Interference
Proprietary	FPIA, RIA	False Negative – THC, PCP, Benzo	Interference
Drinking Water (drinking before test)	All assays	False Negative – Cocaine	Dilution
Proprietary Additives: Jamaica Me Clean, Lemon Flush, Test Free, Detox, Test Clean, Naturally Clean, Urine Luck, Zydol, Mary Janes' Urine Clean 13	Immunoassays	False Negative  False Negative - THC	Interference

These additives can be detected by measuring pH, specific gravity, and by odor, but it is difficult to catch through simple detection.

Enzyme Multiplied Immunoassay

THC = Thin Layer Chromatography

THC = Cannabinoids

Fluorescence Polarized Immunoassay

GC/MS = Gas Chromatography/Mass Spectroscopy

INFORMATION IS PROVIDED BY GATEWAY RECOVERY SERVICES AND THE PATHOLOGY DEPARTMENT OF BORGESS HOSPITAL, ANN ARBOR, MI

# DRUGS OF ABUSE INFORMATION SHEET

DRUG OF ABUSE	RESULT	DRUGS CAUSING POSITIVE REACTION	DETECTIONS LIMIT	DETECTION TIME AFTER DOSE	COMMENTS
Amine Group	Positive or Negative	Amphetamine, Methamphetamine, Ephedrine, Phenentermine, Mephentermine, Phenylpropanolamine, Pseudoephedrine (decongestant), Phenmetrazine, Isoxsuprine, Diethylpropion, Lebetatol, Isometheptene, Phenetazine, Tranlycypromine, Nyldrine	300 ng/ml	Within 2 hours and up to 48 hours	
Amphetamine/Methamphetamine (Speed/Uppers)	Positive or Negative	Amphetamine, Methamphetamine	1000 ng/ml	Within 2 hours and up to 48 hours	
Barbiturates (Downers/Sedatives)	Positive or Negative	Amobarbital, Aprobarbital, Barbitol, Butabarbital, Butabital, Cyclopentobarbital, Pentobarbital, Phenobarbital, Secobarbital, Talbutal	200 ng/ml	Within 8 hours and up to 10 days	
Benzodiazepines (Anti-anxiety)	Positive or Negative	Alprazolam (Xanax), Bromazepam, Chloridiazeposide (Librium), Cholorazepat, Clobazam, Clonazepam, Delorazepam, Demoxepam, Desalkylflurazepam, Diazepam (Valium), Estazolam, Flurazepam, Flunitrazepam, Halazepam, Lorazepam, Lormetazepam, Medazepam, Nitrazepam, Nordiazepam, Oxazepam, Oxaprozin, Prazepam, Temazepam, Triazolam	200 ng/ml	Within 24 hours and up to 72 hours	
Cocaine (Coke/Crack/Rock/Snow)	Positive or Negative	Cocaine, Benzoyl Ecgonine, Cocaethylene, Ecgonine, Ecgonine Methyl Ester (Benzoyl Ecgonine is the major metabolite of Cocaine)	300 ng/ml	Within 4 hours and up to 72 hours	
Ethanol (Alcohol/Booze/Liquor/Spirits)	Less than 10 mg/dl = Neg. Between 10 and 500 mg/dl = Num. Value		10 mg/dl		
Opiates (Narcotics: Opium/Heroin/Morphine)	Positive or Negative	Codeine, Diacetylmorphine, Dihydrocodeine, Hydromorphone, Hydrocodone, Levorphanol, Meperidine (Demerol), Oxycodone (Percodan)	300 ng/dl	Within 8 hours and up to 72 hours	
Phencyclidine (Angel Dust)	Positive or Negative	Phencyclidine and its metabolites (also PCP analog TCP)	25 ng/ml	Within 48 hours and up to 6 days	
Cannabinoids – THC (Marijuana/Pot/Weed/Grass/Mary Jane)	Less than 50 ng/ml = Neg. Between 50 and 100 ng/ml = Detected Between 100 and 400 ng/ml = Num. Value	Detects major metabolites of Marijuana	50 ng/ml	Within 48 hours and up to 14 days (may be detected for longer periods of time after chronic usage.)	
Propoxyphene (Darvon/Darbocel)	Positive or Negative	Propoxyphene and its metabolite Norproxyphene	300 ng/ml	Within 6 hours and up to 48 hours	

NOTE: CONFIRMATION OF A POSITIVE RESULT BY GC/MS WILL BE SENT TO SKBL LABORATORY UPON REQUEST.

## Resources re: Drug Testing

<http://www.urineluck.com/>

<http://www.cleartest.com/>

<http://www.passyourdrugtest.com/>

<http://www.testclean.com/>

<http://www.thcfree.com/>

<http://www.thewhizzinator.com/>

<http://www.magicvan.com/>

<http://www.wemark.com/zydm.html>

## **POSSIBLE ALCOHOL AND OTHER DRUG PROBATION CONDITIONS<sup>1</sup>**

**Formal/court probation** Supervised OR release

**Jail/prison time** Work furlough, electronic leash, home detention, SWAP (Sheriff's Work Alternative Program) volunteer work

**Mental health** Evaluation, counseling, battered women/PTSD, sexual abuse, grief, parenting classes, take all psychiatric medicine

**Treatment** In-/Out-Patient, clean & sober living, 12-Step (AA, NA, ACOA, Alanon, Alateen, Alatot)

**AOD** No Alcohol or Other Drugs or association with users/abusers or places where it's the primary business

**Ed./Employment** GED/Diploma, employment, job skills training (check TANF resources)

**Search and Seizure** clause (home, person, personal effects, automobile)

**AIDS education** is mandatory. Offer confidential testing for HIV, TB, and/or Hepatitis C

**Registration** as narcotics offender, fines, fees, alcohol assessment, AOD assessment for non-DUI violations

**Medications** Methadone, Wellbutrin, Naltrexone (Revia<sup>TM</sup>), Acamprosate, Nalmefene, Antabuse, Mecamylamine, baclofen

**Urine tests** Determine frequency. No poppy seeds, over-the-counter medications (especially containing ephedra), Vitamin B, health food store "remedies" like Goldenseal or water loading. "Provide a clean, fresh, undiluted, unadulterated, personal urine sample upon request."

Prenatal care, Women, Infants and Children (WIC) and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Civil Addict Program

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<sup>1</sup> This list was created by Judge Peggy Hora, Judge, Alameda County Superior Court, Hayward, CA.



## **MENTAL HEALTH/ALCOHOL AND OTHER DRUGS GLOSSARY<sup>1</sup>**

**Addiction** A chronic, relapsing disease characterized by compulsive drug-seeking and use and by neurochemical and molecular changes in the brain.

**Adrenal glands** Glands located above each kidney that secrete hormones, e.g., adrenaline.

**Affect** A fluctuating change in emotional "weather," as compared to **mood** which is more pervasive and sustained emotional "climate."

**Agonist** An agent that mimics the action of a natural neurotransmitter.

**Amino acids** The building blocks of proteins some of which function as neurotransmitters.

**Analog** A chemical compound that is similar to another drug in its effects but differs slightly in its chemical structure.

**Anhedonia** The inability to experience pleasure.

**Antagonist** An agent that blocks or reverses the actions or effects of another agent.

**Antidepressants** A group of drugs used in treating depressive disorders.

**Anxiety** A strong emotional response of fear and dread accompanied by physical signs such as rapid heartbeat and perspiration.

### **Anxiety Disorders**

- Panic Disorder (unprovoked panic attacks)

- Agoraphobia (generalized irrational fear)

- Social Phobia (irrational fear of embarrassment)

- Specific Phobia (other specific irrational fears)

- Obsessive-Compulsive Disorder (obsessive thoughts and compulsive rituals)

- Generalized Anxiety Disorder (nonspecific anxiety)

- Post-traumatic Stress Disorder (non-acute psychological consequences of previous trauma) and Acute Stress Disorder (acute psychological consequences of previous trauma)

**Attention Deficit Disorder (ADD)** A syndrome usually characterized by serious and persistent difficulties resulting in poor attention span, weak impulse control and hyperactivity in some cases. It is also linked to abnormal dopamine transmission.

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<sup>1</sup> This glossary was developed by Judge Peggy Hora, Alameda County Superior Court, Hayward, CA.

**Buprenorphine** A mixed opiate agonist-antagonist medication for the treatment of heroin addiction.

**Crack** Slang for a smokable form of cocaine.

**Craving** An emotional experience or mental state caused by a neuroadaptive change in the brain after long-term alcohol or other drug use.

**Delusion** A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary.

**Dependence** An adaptive physiological state that occurs with regular drug use and results in a withdrawal syndrome when drug use is stopped; usually occurs with tolerance.

**Depression** A sustained feeling of sadness.

**Detoxification** A process of allowing the body to rid itself of a drug while managing the symptoms of withdrawal; often the first step in a drug treatment program.

**Disorientation** Confusion about the time of day, date, or season (time); where one is (place); or who one is (person).

**Dissociation** A disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment.

**Dopamine** A neurotransmitter present in regions of the brain that regulate movement, emotion, motivation, and the feeling of pleasure. Alcohol, heroin and tobacco elevate levels of dopamine. A new view says it is an aid to learning and may explain why addictive drugs can drive continued use without producing pleasure.

**Elevated** An exaggerated feeling of well-being, or euphoria or elation. A person with elevated mood may describe feeling "high," "ecstatic," "on top of the world," or "up in the clouds."

**Euthymic** Mood in the "normal" range, which implies the absence of depressed or elevated mood.

**Expansive** Lack of restraint in expressing one's feelings, frequently with an overvaluation of one's significance or importance.

**Fentanyl** A medically useful opioid analog that is 50 times more potent than heroin.

**Grandiosity** An inflated appraisal of one's worth, power, knowledge, importance or identity.

**Hallucination** A sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ. Hallucinations may be auditory, gustatory (involving taste, usually unpleasant), mood-congruent or -incongruent, olfactory, somatic, tactile or visual.

**Hallucinogens** A class of drugs such as LSD, PCP, and MDMA ("Ecstasy") which effect serotonin receptors and can cause hallucinations, distort time and space and confuse reality and illusion.

**Levo-alpha-acetyl-methadol (LAAM)** An FDA-approved medication for heroin addiction that patients need to take only three to four times a week.

**Limbic System** Parts of the cerebral cortex, hippocampus, hypothalamus and other brain structures that together function in the expression of emotional behavior.

**Marijuana** The dried leaves from the hemp plant (*cannabis sativa*) whose psychoactive chemical, *tetrahydrocannabinol* (THC), can produce a variety of effects such as uncontrollable laughter, paranoia and memory loss. Marijuana use causes a sharp rise in dopamine levels.

**Methadone** A long-acting synthetic medication shown to be effective in treating heroin addiction.

**Mood** A pervasive and sustained emotion that colors the perception of the world including depression, elation, anger and anxiety.

### **Mood Disorders**

Major Depressive Disorder (major depression without mania)

Bipolar I Disorder (mania with/without major depression)

Bipolar II Disorder (hypomania with major depression)

Cyclothymic Disorder (numerous brief episodes of hypomania and minor depression)

Dysthymic Disorder (prolonged minor depression without mania/hypomania)

**Neuron** A nerve cell.

**Neurotransmitters** Chemicals in the brain allowing neurons to communicate and signal one another. They may be small molecules such as dopamine, serotonin or norepinephrine or larger protein chains called peptides. There are over 100 different neurotransmitters in the brain.

**Opiates** Natural brain chemicals such as endogenous opioids like endorphins or artificial drugs such as heroin or morphine which reduce pain and increase pleasure, relaxation and contentment.



**Panic attacks** Discrete periods of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom.

### **Personality Disorders**

Paranoid Personality Disorder (suspicious, distrustful)

Schizoid Personality Disorder (socially distant, detached)

Schizotypal Personality Disorder (odd, eccentric)

Antisocial Personality Disorder (impulsive, aggressive, manipulative)

Borderline Personality Disorder (impulsive, self-destructive, unstable)

Histrionic Personality Disorder (emotional, dramatic, theatrical)

Narcissistic Personality Disorder (boastful, egotistical, "superiority complex")

Avoidant Personality Disorder (shy, timid, "inferiority complex")

Dependent Personality Disorder (dependent, submissive, clinging)

Obsessive-Compulsive Personality Disorder (perfectionistic, rigid, controlling)

**Pharmacokinetics** The pattern of absorption, distribution, and excretion of a drug over time.

**Phobia** A persistent, irrational fear of a specific object, activity or situation that results in a compelling desire to avoid it. This often leads either to avoidance of the phobic stimulus or to enduring it with dread.

**Physical dependence** An adaptive physiological state that occurs with regular drug use and results in a withdrawal syndrome when drug use is stopped; usually occurs with tolerance.

**Poly-drug user** An individual who uses more than one drug including alcohol.

**Post Traumatic Stress Disorder (PTSD)** A condition that is caused by repeated traumas and is experienced by combat veterans, prostitutes and battered women.

**Psychosis** Disturbances of perception and thought processes which include schizophrenia and severe mood disorders.

**Receptor** A protein usually found on the surface of a neuron or other cell that recognizes and binds to neurotransmitters or other chemical messengers.

**Rush** A surge of pleasure that rapidly follows administration of some drugs.

## **Schizophrenia & Psychotic Disorders**

### **Schizophrenia**

**Serotonin** A neurotransmitter which excites the motor neurons governing muscle activity, quiets the sensory neurons that mediate hunger and pain, and pacifies neurons in the limbic system. Drugs such as Prozac are "selective serotonin reuptake inhibitors" (SSRIs) and can help with compulsive behaviors, depression and other mood state disorders. "Low serotonin syndrome" includes behavioral characteristics for impulsivity, aggression, violence and antisocial personality disorder. Boys have a lower level of serotonin which may explain why they are more likely than girls to carry through with suicide, become alcoholics/addicts and have ADD.

**Stimulant** Illicit drugs such as cocaine or methamphetamine or a licit drug such as caffeine which cause a buildup of dopamine in the synapse between neurons and intensify feelings of pleasure.

### **Substance-Related Disorders**

Alcohol Dependence (alcoholism)

Amphetamine Dependence (stimulants, speed, uppers, diet pills)

Cannabis Dependence (marijuana, grass, pot, weed, reefer, hashish, bhang, ganja)

Cocaine Dependence (coke, crack, coca leaves)

Hallucinogen Dependence (psychedelics, LSD, mescaline, peyote, psilocybin, DMT)

Inhalant Dependence (sniffing: glue, gasoline, toluene, solvents)

Nicotine Dependence (tobacco)

Opioid Dependence (heroin, methadone, morphine, demerol, percodan, opium, codeine, darvon)

Phencyclidine Dependence (PCP, angel dust)

Sedative Dependence (sleeping pills, barbiturates, seconal, valium, librium, ativan, xanax, quaaludes)

**Synapse** A microscopic gap separating adjacent neurons where neurotransmitter and receptors cluster.

**Syndrome** A grouping of signs and symptoms, based on their frequent co-occurrence, that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection.

**Tolerance** A condition in which higher doses of a drug are required to produce the same effect as during initial use; often is associated with physical dependence.

**Withdrawal** A variety of symptoms that occur after use of an addictive drug is reduced or stopped.

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**PRINCIPLES OF  
DRUG ADDICTION  
TREATMENT**  
A RESEARCH-BASED GUIDE

PRINCIPLES OF  
DRUG ADDICTION  
TREATMENT

A RESEARCH-BASED GUIDE

DAVID L. MUSTASSER, JR.

# PRINCIPLES OF EFFECTIVE TREATMENT

1. **N**O SINGLE TREATMENT IS APPROPRIATE FOR ALL INDIVIDUALS. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
2. **T**REATMENT NEEDS TO BE READILY AVAILABLE. Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.
3. **E**FFECTIVE TREATMENT ATTENDS TO MULTIPLE NEEDS OF THE INDIVIDUAL, NOT JUST HIS OR HER DRUG USE. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.
4. **A**N INDIVIDUAL'S TREATMENT AND SERVICES PLAN MUST BE ASSESSED CONTINUALLY AND MODIFIED AS NECESSARY TO ENSURE THAT THE PLAN MEETS THE PERSON'S CHANGING NEEDS. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.
5. **R**EMAINING IN TREATMENT FOR AN ADEQUATE PERIOD OF TIME IS CRITICAL FOR TREATMENT EFFECTIVENESS. The appropriate duration for an individual depends on his or her problems and needs (see pages 13-51). Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **C**OUNSELING (INDIVIDUAL AND/OR GROUP) AND OTHER BEHAVIORAL THERAPIES ARE CRITICAL COMPONENTS OF EFFECTIVE TREATMENT FOR ADDICTION. In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community. (Pages 37-51 discuss details of different treatment components to accomplish these goals.)
7. **M**EDICATIONS ARE AN IMPORTANT ELEMENT OF TREATMENT FOR MANY PATIENTS, ESPECIALLY WHEN COMBINED WITH COUNSELING AND OTHER BEHAVIORAL THERAPIES. Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.
8. **A**DDICTED OR DRUG-ABUSING INDIVIDUALS WITH COEXISTING MENTAL DISORDERS SHOULD HAVE BOTH DISORDERS TREATED IN AN INTEGRATED WAY. Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.
9. **M**EDICAL DETOXIFICATION IS ONLY THE FIRST STAGE OF ADDICTION TREATMENT AND BY ITSELF DOES LITTLE TO CHANGE LONG-TERM DRUG USE. Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts

achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment (see pages 25-35).

10. **T**REATMENT DOES NOT NEED TO BE VOLUNTARY TO BE EFFECTIVE. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

11. **P**OSSIBLE DRUG USE DURING TREATMENT MUST BE MONITORED CONTINUOUSLY. Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

12. **T**REATMENT PROGRAMS SHOULD PROVIDE ASSESSMENT FOR HIV/AIDS, HEPATITIS B AND C, TUBERCULOSIS AND OTHER INFECTIOUS DISEASES, AND COUNSELING TO HELP PATIENTS MODIFY OR CHANGE BEHAVIORS THAT PLACE THEMSELVES OR OTHERS AT RISK OF INFECTION. Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **R**ECOVERY FROM DRUG ADDICTION CAN BE A LONG-TERM PROCESS AND FREQUENTLY REQUIRES MULTIPLE EPISODES OF TREATMENT. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

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*Three decades of scientific research and clinical practice have yielded a variety of effective approaches to drug addiction treatment.*



## PREFACE

**D**RUG ADDICTION IS A COMPLEX ILLNESS. It is characterized by compulsive, at times uncontrollable drug craving, seeking, and use that persist even in the face of extremely negative consequences. For many people, drug addiction becomes chronic, with relapses possible even after long periods of abstinence.

The path to drug addiction begins with the act of taking drugs. Over time, a person's ability to choose not to take drugs can be compromised. Drug seeking becomes compulsive, in large part as a result of the effects of prolonged drug use on brain functioning and, thus, on behavior.

The compulsion to use drugs can take over the individual's life. Addiction often involves not only compulsive drug taking but also a wide range of dysfunctional behaviors that can interfere with normal functioning in the family, the workplace, and the broader community. Addiction also can place people at increased risk for a wide variety of other illnesses. These illnesses can be brought on by behaviors, such as poor living and health habits, that often accompany life as an addict, or because of toxic effects of the drugs themselves.

Because addiction has so many dimensions and disrupts so many aspects of an individual's life, treatment for this illness is never simple. Drug treatment must help the individual stop using drugs and maintain a drug-free lifestyle, while achieving productive functioning in the family, at work, and in society. Effective drug abuse and addiction treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences.

Three decades of scientific research and clinical practice have yielded a variety of effective approaches to drug addiction treatment. Extensive data document that drug addiction treatment is as effective as are treatments for most other similarly chronic medical conditions. In spite

of scientific evidence that establishes the effectiveness of drug abuse treatment, many people believe that treatment is ineffective. In part, this is because of unrealistic expectations. Many people equate addiction with simply using drugs and therefore expect that addiction should be cured quickly, and if it is not, treatment is a failure. In reality, because addiction is a chronic disorder, the ultimate goal of long-term abstinence often requires sustained and repeated treatment episodes.

Of course, not all drug abuse treatment is equally effective. Research also has revealed a set of overarching principles that characterize the most effective drug abuse and addiction treatments and their implementation.

To share the results of this extensive body of research and foster more widespread use of scientifically based treatment components, the National Institute on Drug Abuse held the National Conference on Drug Addiction Treatment: From Research to Practice in April 1998 and prepared this guide. Pages 3-5 of the guide summarize basic overarching principles that characterize effective treatment. Pages 13-21 elaborate on these principles by providing answers to frequently raised questions, as supported by the available scientific literature. Pages 23-33 describe the types of treatment, and pages 35-47 present examples of scientifically based and tested treatment components.

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*Treatment varies depending on the type of drug and the characteristics of the patient.... The best programs provide a combination of therapies and other services.*

## FREQUENTLY ASKED QUESTIONS

### 1. WHAT IS DRUG ADDICTION TREATMENT?

There are many addictive drugs, and treatments for specific drugs can differ. Treatment also varies depending on the characteristics of the patient.

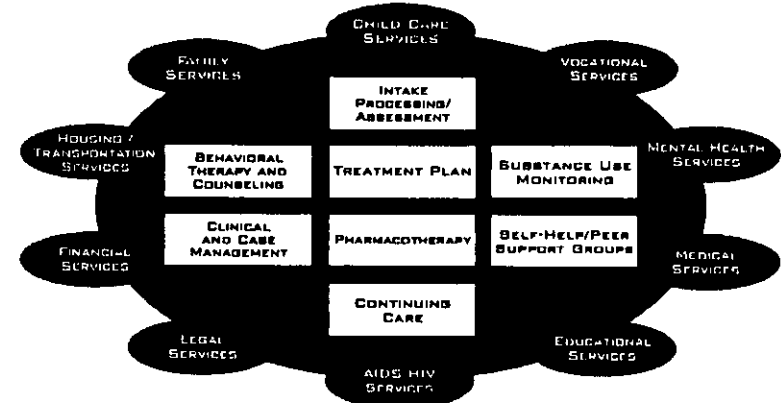
Problems associated with an individual's drug addiction can vary significantly. People who are addicted to drugs come from all walks of life. Many suffer from mental health, occupational, health, or social problems that make their addictive disorders much more difficult to treat. Even if there are few associated problems, the severity of addiction itself ranges widely among people.

A variety of scientifically based approaches to drug addiction treatment exists. Drug addiction treatment can include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination. Behavioral therapies offer people strategies for coping with their drug cravings, teach them ways to avoid drugs and prevent relapse, and help them deal with relapse if it occurs. When a person's drug-related behavior places him or her at higher risk for AIDS or other infectious diseases, behavioral therapies can help to reduce the risk of disease transmission. Case management and referral to other medical, psychological, and social services are crucial components of treatment for many patients. (See pages 23-47 for more detail on types of treatment and treatment components.) The best programs provide a combination of therapies and other services to meet the needs of the individual patient, which are shaped by such issues as age, race, culture, sexual orientation, gender, pregnancy, parenting, housing, and employment, as well as physical and sexual abuse.

**DRUG ADDICTION TREATMENT CAN INCLUDE BEHAVIORAL THERAPY, MEDICATIONS, OR THEIR COMBINATION.**

Treatment medications, such as methadone, LAAM, and naltrexone, are available for individuals addicted to opiates. Nicotine preparations (patches, gum, nasal spray) and bupropion are available for individuals addicted to nicotine.

### Components of Comprehensive Drug Abuse Treatment



*The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.*

Medications, such as antidepressants, mood stabilizers, or neuroleptics, may be critical for treatment success when patients have co-occurring mental disorders, such as depression, anxiety disorder, bipolar disorder, or psychosis.

Treatment can occur in a variety of settings, in many different forms, and for different lengths of time. Because drug addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment often is not sufficient. For many, treatment is a long-term process that involves multiple interventions and attempts at abstinence.

### 2. WHY CAN'T DRUG ADDICTS QUIT ON THEIR OWN?

Nearly all addicted individuals believe in the beginning that they can stop using drugs on their own, and most try to stop without treatment. However, most of these attempts result in failure to achieve long-term abstinence. Research has shown that long-term drug use results in significant changes in brain function that persist long after the individual stops using drugs. These drug-

induced changes in brain function may have many behavioral consequences, including the compulsion to use drugs despite adverse consequences—the defining characteristic of addiction.

**LONG-TERM DRUG USE RESULTS IN SIGNIFICANT CHANGES IN BRAIN FUNCTION THAT PERSIST LONG AFTER THE INDIVIDUAL STOPS USING DRUGS.**

Understanding that addiction has such an important biological component may help explain an individual's difficulty in achieving and maintaining abstinence without treatment. Psychological stress from work or family problems, social cues (such as meeting individuals from one's drug-using past), or the environment (such as encountering streets, objects, or even smells associated with drug use) can interact with biological factors to hinder attainment of sustained abstinence and make relapse more likely. Research studies indicate that even the most severely addicted individuals can participate actively in treatment and that active participation is essential to good outcomes.

**3. HOW EFFECTIVE IS DRUG ADDICTION TREATMENT?**

In addition to stopping drug use, the goal of treatment is to return the individual to productive functioning in the family, workplace, and community. Measures of effectiveness typically include levels of criminal behavior, family functioning, employability, and medical condition. Overall, treatment of addiction is as successful as treatment of other chronic diseases, such as diabetes, hypertension, and asthma.

**TREATMENT OF ADDICTION IS AS SUCCESSFUL AS TREATMENT OF OTHER CHRONIC DISEASES SUCH AS DIABETES, HYPERTENSION, AND ASTHMA.**

According to several studies, drug treatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment. For example, a study

of therapeutic community treatment for drug offenders (see pages 23-33) demonstrated that arrests for violent and nonviolent criminal acts were reduced by 40 percent or more. Methadone treatment has been shown to decrease criminal behavior by as much as 50 percent. Research shows that drug addiction treatment reduces the risk of HIV infection and that interventions to prevent HIV are much less costly than treating HIV-related illnesses. Treatment can improve the prospects for employment, with gains of up to 40 percent after treatment.

Although these effectiveness rates hold in general, individual treatment outcomes depend on the extent and nature of the patient's presenting problems, the appropriateness of the treatment components and related services used to address those problems, and the degree of active engagement of the patient in the treatment process.

**4. HOW LONG DOES DRUG ADDICTION TREATMENT USUALLY LAST?**

Individuals progress through drug addiction treatment at various speeds, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate lengths of treatment. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer often are indicated. For methadone maintenance, 12 months of treatment is the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years.

**GOOD OUTCOMES ARE CONTINGENT ON ADEQUATE LENGTHS OF TREATMENT.**

Many people who enter treatment drop out before receiving all the benefits that treatment can provide. Successful outcomes may require more than one treatment experience. Many addicted individuals have multiple episodes of treatment, often with a cumulative impact.

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## 5. WHAT HELPS PEOPLE STAY IN TREATMENT?

Since successful outcomes often depend upon retaining the person long enough to gain the full benefits of treatment, strategies for keeping an individual in the program are critical. Whether a patient stays in treatment depends on factors associated with both the individual and the program. Individual factors related to engagement and retention include motivation to change drug-using behavior, degree of support from family and friends, and whether there is pressure to stay in treatment from the criminal justice system, child protection services, employers, or the family. Within the program, successful counselors are able to establish a positive, therapeutic relationship with the patient. The counselor should ensure that a treatment plan is established and followed so that the individual knows what to expect during treatment. Medical, psychiatric, and social services should be available.

WHETHER A PATIENT STAYS IN TREATMENT  
DEPENDS ON FACTORS ASSOCIATED WITH  
BOTH THE INDIVIDUAL AND THE PROGRAM.

Since some individual problems (such as serious mental illness, severe cocaine or crack use, and criminal involvement) increase the likelihood of a patient dropping out, intensive treatment with a range of components may be required to retain patients who have these problems. The provider then should ensure a transition to continuing care or "aftercare" following the patient's completion of formal treatment.

## 6. IS THE USE OF MEDICATIONS LIKE METHADONE SIMPLY REPLACING ONE DRUG ADDICTION WITH ANOTHER?

No. As used in maintenance treatment, methadone and LAAM are not heroin substitutes. They are safe and effective medications for opiate addiction that are administered by mouth in regular, fixed doses. Their pharmacological effects are markedly different from those of heroin.

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AS USED IN MAINTENANCE TREATMENT, METHADONE AND LAAM ARE NOT HEROIN SUBSTITUTES.

Injected, snorted, or smoked heroin causes an almost immediate "rush" or brief period of euphoria that wears off very quickly, terminating in a "crash." The individual then experiences an intense craving to use more heroin to stop the crash and reinstate the euphoria. The cycle of euphoria, crash, and craving—repeated several times a day—leads to a cycle of addiction and behavioral disruption. These characteristics of heroin use result from the drug's rapid onset of action and its short duration of action in the brain. An individual who uses heroin multiple times per day subjects his or her brain and body to marked, rapid fluctuations as the opiate effects come and go. These fluctuations can disrupt a number of important bodily functions. Because heroin is illegal, addicted persons often become part of a volatile drug-using street culture characterized by hustling and crimes for profit.

Methadone and LAAM have far more gradual onsets of action than heroin, and as a result, patients stabilized on these medications do not experience any rush. In addition, both medications wear off much more slowly than heroin, so there is no sudden crash, and the brain and body are not exposed to the marked fluctuations seen with heroin use. Maintenance treatment with methadone or LAAM markedly reduces the desire for heroin. If an individual maintained on adequate, regular doses of methadone (once a day) or LAAM (several times per week) tries to take heroin, the euphoric effects of heroin will be significantly blocked. According to research, patients undergoing maintenance treatment do not suffer the medical abnormalities and behavioral destabilization that rapid fluctuations in drug levels cause in heroin addicts.

## 7. WHAT ROLE CAN THE CRIMINAL JUSTICE SYSTEM PLAY IN THE TREATMENT OF DRUG ADDICTION?

Increasingly, research is demonstrating that treatment for drug-addicted offenders during and after incar-

ceration can have a significant beneficial effect upon future drug use, criminal behavior, and social functioning. The case for integrating drug addiction treatment approaches with the criminal justice system is compelling. Combining prison- and community-based treatment for drug-addicted offenders reduces the risk of both recidivism to drug-related criminal behavior and relapse to drug use. For example, a recent study found that prisoners who participated in a therapeutic treatment program in the Delaware State Prison and continued to receive treatment in a work-release program after prison were 70 percent less likely than nonparticipants to return to drug use and incur rearrest (see pages 23-33).

**INDIVIDUALS WHO ENTER TREATMENT UNDER LEGAL PRESSURE HAVE OUTCOMES AS FAVORABLE AS THOSE WHO ENTER TREATMENT VOLUNTARILY.**

The majority of offenders involved with the criminal justice system are not in prison but are under community supervision. For those with known drug problems, drug addiction treatment may be recommended or mandated as a condition of probation. Research has demonstrated that individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.

The criminal justice system refers drug offenders into treatment through a variety of mechanisms, such as diverting nonviolent offenders to treatment, stipulating treatment as a condition of probation or pretrial release, and convening specialized courts that handle cases for offenses involving drugs. Drug courts, another model, are dedicated to drug offender cases. They mandate and arrange for treatment as an alternative to incarceration, actively monitor progress in treatment, and arrange for other services to drug-involved offenders.

The most effective models integrate criminal justice and drug treatment systems and services. Treatment and criminal justice personnel work together on plans and implementation of screening, placement, testing, monitoring, and super-

vision, as well as on the systematic use of sanctions and rewards for drug abusers in the criminal justice system. Treatment for incarcerated drug abusers must include continuing care, monitoring, and supervision after release and during parole.

**8. HOW DOES DRUG ADDICTION TREATMENT HELP REDUCE THE SPREAD OF HIV/AIDS AND OTHER INFECTIOUS DISEASES?**

Many drug addicts, such as heroin or cocaine addicts and particularly injection drug users, are at increased risk for HIV/AIDS as well as other infectious diseases like hepatitis, tuberculosis, and sexually transmitted infections. For these individuals and the community at large, drug addiction treatment is disease prevention.

**DRUG ADDICTION TREATMENT IS DISEASE PREVENTION.**

Drug injectors who do not enter treatment are up to six times more likely to become infected with HIV than injectors who enter and remain in treatment. Drug users who enter and continue in treatment reduce activities that can spread disease, such as sharing injection equipment and engaging in unprotected sexual activity. Participation in treatment also presents opportunities for screening, counseling, and referral for additional services. The best drug abuse treatment programs provide HIV counseling and offer HIV testing to their patients.

**9. WHERE DO 12-STEP OR SELF-HELP PROGRAMS FIT INTO DRUG ADDICTION TREATMENT?**

Self-help groups can complement and extend the effects of professional treatment. The most prominent self-help groups are those affiliated with Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA), all of which are based on the 12-step

model, and Smart Recovery. Most drug addiction treatment programs encourage patients to participate in a self-help group during and after formal treatment.

#### 10. HOW CAN FAMILIES AND FRIENDS MAKE A DIFFERENCE IN THE LIFE OF SOMEONE NEEDING TREATMENT?

Family and friends can play critical roles in motivating individuals with drug problems to enter and stay in treatment. Family therapy is important, especially for adolescents (see pages 35-47). Involvement of a family member in an individual's treatment program can strengthen and extend the benefits of the program.

#### 11. IS DRUG ADDICTION TREATMENT WORTH ITS COST?

Drug addiction treatment is cost-effective in reducing drug use and its associated health and social costs. Treatment is less expensive than alternatives, such as not treating addicts or simply incarcerating addicts. For example, the average cost for 1 full year of methadone maintenance treatment is approximately \$4,700 per patient, whereas 1 full year of imprisonment costs approximately \$18,400 per person.

#### DRUG ADDICTION TREATMENT IS COST-EFFECTIVE IN REDUCING DRUG USE AND ITS ASSOCIATED HEALTH AND SOCIAL COSTS.

According to several conservative estimates, every \$1 invested in addiction treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1. Major savings to the individual and society also come from significant drops in interpersonal conflicts, improvements in workplace productivity, and reductions in drug-related accidents.

*Treatment for drug abuse and addiction is delivered in many different settings, using a variety of behavioral and pharmacological approaches.*

## DRUG ADDICTION TREATMENT IN THE UNITED STATES

Drug addiction is a complex disorder that can involve virtually every aspect of an individual's functioning—in the family, at work, and in the community. Because of addiction's complexity and pervasive consequences, drug addiction treatment typically must involve many components. Some of those components focus directly on the individual's drug use. Others, like employment training, focus on restoring the addicted individual to productive membership in the family and society (see diagram on page 14).

Treatment for drug abuse and addiction is delivered in many different settings, using a variety of behavioral and pharmacological approaches. In the United States, more than 11,000 specialized drug treatment facilities provide rehabilitation, counseling, behavioral therapy, medication, case management, and other types of services to persons with drug use disorders.

Because drug abuse and addiction are major public health problems, a large portion of drug treatment is funded by local, State, and Federal governments. Private and employer-subsidized health plans also may provide coverage for treatment of drug addiction and its medical consequences.

Drug abuse and addiction are treated in specialized treatment facilities and mental health clinics by a variety of providers, including certified drug abuse counselors, physicians, psychologists, nurses, and social workers. Treatment is delivered in outpatient, inpatient, and residential settings. Although specific treatment approaches often are associated with particular treatment settings, a variety of therapeutic interventions or services can be included in any given setting.

### GENERAL CATEGORIES OF TREATMENT PROGRAMS

Research studies on drug addiction treatment have typically classified treatment programs into several general types or modalities, which are described in the following text. Treatment approaches and individual programs continue to evolve, and many programs in existence today do not fit neatly into traditional drug

addiction treatment classifications. Examples of specific research-based treatment components are described on pages 35-47.

**AGONIST MAINTENANCE TREATMENT** for opiate addicts usually is conducted in outpatient settings, often called methadone treatment programs. These programs use a long-acting synthetic opiate medication, usually methadone or LAAM, administered orally for a sustained period at a dosage sufficient to prevent opiate withdrawal, block the effects of illicit opiate use, and decrease opiate craving. Patients stabilized on adequate, sustained dosages of methadone or LAAM can function normally. They can hold jobs, avoid the crime and violence of the street culture, and reduce their exposure to HIV by stopping or decreasing injection drug use and drug-related high-risk sexual behavior.

Patients stabilized on opiate agonists can engage more readily in counseling and other behavioral interventions essential to recovery and rehabilitation. The best, most effective opiate agonist maintenance programs include individual and/or group counseling, as well as provision of, or referral to, other needed medical, psychological, and social services.

PATIENTS STABILIZED ON ADEQUATE  
SUSTAINED DOSAGES OF METHADONE  
OR LAAM CAN FUNCTION NORMALLY.

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**NARCOTIC ANTAGONIST TREATMENT USING NALTREXONE** for opiate addicts usually is conducted in outpatient settings although initiation of the medication often begins after medical detoxification in a residential setting. Naltrexone is a long-acting synthetic opiate antagonist with few side effects that is taken orally either daily or three times a week for a sustained period of time. Individuals must be medically detoxified and opiate-free for several days before naltrexone can be taken to prevent precipitating an opiate abstinence syndrome. When used this way, all the effects of self-administered opiates, including euphoria, are completely blocked. The theory behind this treatment is that the repeated lack of the desired opiate effects, as well as the perceived futility of using the opiate, will gradually over time result in breaking the habit of opiate addiction. Naltrexone itself has no subjective effects or potential for abuse and is not addicting. Patient noncompliance is a common problem. Therefore,

a favorable treatment outcome requires that there also be a positive therapeutic relationship, effective counseling or therapy, and careful monitoring of medication compliance.

**PATIENTS STABILIZED ON NALTREXONE CAN HOLD JOBS, AVOID CRIME AND VIOLENCE, AND REDUCE THEIR EXPOSURE TO HIV.**

Many experienced clinicians have found naltrexone most useful for highly motivated, recently detoxified patients who desire total abstinence because of external circumstances, including impaired professionals, parolees, probationers, and prisoners in work-release status. Patients stabilized on naltrexone can function normally. They can hold jobs, avoid the crime and violence of the street culture, and reduce their exposure to HIV by stopping injection drug use and drug-related high-risk sexual behavior.

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**OUTPATIENT DRUG-FREE TREATMENT** varies in the types and intensity of services offered. Such treatment costs less than residential or inpatient treatment and often is more suitable for individuals who are employed or who have extensive social supports. Low-intensity programs may offer little more than drug education and admonition. Other outpatient models, such as intensive day treatment, can be comparable to residential programs in services and effectiveness, depending on the individual patient's characteristics and needs. In many outpatient programs, group counseling is emphasized. Some outpatient programs are designed to treat patients who have medical or mental health problems in addition to their drug disorder.

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**LONG-TERM RESIDENTIAL TREATMENT** provides care 24 hours per day, generally in nonhospital settings. The best-known residential treatment model is the therapeutic community (TC), but residential treatment may also employ other models, such as cognitive-behavioral therapy.

TCs are residential programs with planned lengths of stay of 6 to 12 months. TCs focus on the "resocialization" of the individual and use the program's entire "community," including other residents, staff, and the social context, as active components of treatment. Addiction is viewed in the context of an individual's social and psychological deficits, and treatment focuses on developing personal accountability and responsibility and socially productive lives. Treatment is highly structured and can at times be confrontational, with activities designed to help residents examine damaging beliefs, self-concepts, and patterns of behavior and to adopt new, more harmonious and constructive ways to interact with others. Many TCs are quite comprehensive and can include employment training and other support services on site.

**THERAPEUTIC COMMUNITIES FOCUS ON THE "RESOCIALIZATION" OF THE INDIVIDUAL AND USE THE PROGRAM'S ENTIRE "COMMUNITY" AS ACTIVE COMPONENTS OF TREATMENT.**

Compared with patients in other forms of drug treatment, the typical TC resident has more severe problems, with more co-occurring mental health problems and more criminal involvement. Research shows that TCs can be modified to treat individuals with special needs, including adolescents, women, those with severe mental disorders, and individuals in the criminal justice system (see page 31).

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SHORT-TERM RESIDENTIAL PROGRAMS provide intensive but relatively brief residential treatment based on a modified 12-step approach. These programs were originally designed to treat alcohol problems, but during the cocaine epidemic of the mid-1980's, many began to treat illicit drug abuse and addiction. The original

residential treatment model consisted of a 3 to 6 week hospital-based inpatient treatment phase followed by extended outpatient therapy and participation in a self-help group, such as Alcoholics Anonymous. Reduced health care coverage for substance abuse treatment has resulted in a diminished number of these programs, and the average length of stay under managed care review is much shorter than in early programs.

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MEDICAL DETOXIFICATION is a process whereby individuals are systematically withdrawn from addicting drugs in an inpatient or outpatient setting, typically under the care of a physician. Detoxification is sometimes called a distinct treatment modality but is more appropriately considered a precursor of treatment, because it is designed to treat the acute physiological effects of stopping drug use. Medications are available for detoxification from opiates, nicotine, benzodiazepines, alcohol, barbiturates, and other sedatives. In some cases, particularly for the last three types of drugs, detoxification may be a medical necessity, and untreated withdrawal may be medically dangerous or even fatal.

DETOXIFICATION IS A PRECURSOR OF TREATMENT.

Detoxification is not designed to address the psychological, social, and behavioral problems associated with addiction

and therefore does not typically produce lasting behavioral changes necessary for recovery. Detoxification is most useful when it incorporates formal processes of assessment and referral to subsequent drug addiction treatment.

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TREATING CRIMINAL JUSTICE-INVOLVED DRUG ABUSERS AND ADDICTS

Research has shown that combining criminal justice sanctions with drug treatment can be effective in decreasing drug use and related crime. Individuals under legal coercion tend to stay in treatment for a longer period of time and do as well as or better than others not under legal pressure. Often, drug abusers come into contact with the criminal justice system earlier than other health or social systems, and intervention by the criminal justice system to engage the individual in treatment may help interrupt and shorten a career of drug use. Treatment for the criminal justice-involved drug abuser or drug addict may be delivered prior to, during, after, or in lieu of incarceration.

COMBINING CRIMINAL JUSTICE SANCTIONS WITH DRUG TREATMENT CAN BE EFFECTIVE IN DECREASING DRUG USE AND RELATED CRIME.

PRISON-BASED TREATMENT PROGRAMS.

Offenders with drug disorders may encounter a number of treatment options while incarcerated, including didactic drug education classes, self-help programs, and treatment based on therapeutic community or residential milieu therapy models. The TC model has been studied extensively and can be quite effective in reducing drug use and recidivism to criminal behavior. Those in treatment should be segregated from the general prison population, so that

the "prison culture" does not overwhelm progress toward recovery. As might be expected, treatment gains can be lost if inmates are returned to the general prison population after treatment. Research shows that relapse to drug use and recidivism to crime are significantly lower if the drug offender continues treatment after returning to the community.

COMMUNITY-BASED TREATMENT FOR CRIMINAL JUSTICE POPULATIONS. A number of criminal justice alternatives to incarceration have been tried with offenders who have drug disorders, including limited diversion programs, pretrial release conditional on entry into treatment, and conditional probation with sanctions. The drug court is a promising approach. Drug courts mandate and arrange for drug addiction treatment, actively monitor progress in treatment, and arrange for other services to drug-involved offenders. Federal support for planning, implementation, and enhancement of drug courts is provided under the U.S. Department of Justice Drug Courts Program Office.

As a well-studied example, the Treatment Accountability and Safer Communities (TASC) program provides an alternative to incarceration by addressing the multiple needs of drug-addicted offenders in a community-based setting. TASC programs typically include counseling, medical care, parenting instruction, family counseling, school and job training, and legal and employment services. The key features of TASC include (1) coordination of criminal justice and drug treatment; (2) early identification, assessment, and referral of drug-involved offenders; (3) monitoring offenders through drug testing; and (4) use of legal sanctions as inducements to remain in treatment.

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*Each approach to drug treatment is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society.*

## SCIENTIFICALLY BASED APPROACHES TO DRUG ADDICTION TREATMENT

This section presents several examples of treatment approaches and components that have been developed and tested for efficacy through research supported by the National Institute on Drug Abuse (NIDA). Each approach is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society. The approaches are to be used to supplement or enhance—not replace—existing treatment programs.

This section is not a complete list of efficacious, scientifically based treatment approaches. Additional approaches are under development as part of NIDA's continuing support of treatment research.

**RELAPSE PREVENTION**, a cognitive-behavioral therapy, was developed for the treatment of problem drinking and adapted later for cocaine addicts. Cognitive-behavioral strategies are based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Individuals learn to identify and correct problematic behaviors. Relapse prevention encompasses several cognitive-behavioral strategies that facilitate abstinence as well as provide help for people who experience relapse.

The relapse prevention approach to the treatment of cocaine addiction consists of a collection of strategies intended to enhance self-control. Specific techniques include exploring the positive and negative consequences of continued use, self-monitoring to recognize drug cravings early on and to identify high-risk situations for use, and developing strategies for coping with and avoiding high-risk situations and the desire to use. A central element of this treatment is anticipating the problems patients are likely to meet and helping them develop effective coping strategies.

Research indicates that the skills individuals learn through relapse prevention therapy remain after the completion of treatment. In one study, most people receiving this cognitive-behavioral approach maintained the gains they made in treatment throughout the year following treatment.

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**SUPPORTIVE-EXPRESSIVE PSYCHOTHERAPY** is a time-limited, focused psychotherapy that has been adapted for heroin- and cocaine-addicted individuals. The therapy has two main components:

- Supportive techniques to help patients feel comfortable in discussing their personal experiences.
- Expressive techniques to help patients identify and work through interpersonal relationship issues.

Special attention is paid to the role of drugs in relation to problem feelings and behaviors, and how problems may be solved without recourse to drugs.

The efficacy of individual supportive-expressive psychotherapy has been tested with patients in methadone maintenance treatment who had psychiatric problems. In a comparison with patients receiving only drug counseling, both groups fared similarly with regard to opiate use, but the supportive-expressive psychotherapy group had lower cocaine use and required less methadone. Also, the patients who received supportive-expressive psychotherapy maintained many of the gains they had made. In an earlier study, supportive-expressive psychotherapy, when added to drug counseling, improved outcomes for opiate addicts in methadone treatment with moderately severe psychiatric problems.

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INDIVIDUALIZED DRUG COUNSELING focuses directly on reducing or stopping the addict's illicit drug use. It also addresses related areas of impaired functioning—such as employment status, illegal activity, family/social relations—as well as the content and structure of the patient's recovery program. Through its emphasis on short-term behavioral goals, individualized drug counseling helps the patient develop coping strategies and tools for abstaining from drug use and then maintaining abstinence. The addiction counselor encourages 12-step participation and makes referrals for needed supplemental medical, psychiatric, employment, and other services. Individuals are encouraged to attend sessions one or two times per week.

In a study that compared opiate addicts receiving only methadone to those receiving methadone coupled with counseling, individuals who received only methadone showed minimal improvement in reducing opiate use. The addition of counseling produced significantly more improvement. The addition of onsite medical/psychiatric, employment, and family services further improved outcomes.

In another study with cocaine addicts, individualized drug counseling, together with group drug counseling, was quite effective in reducing cocaine use. Thus, it appears that this approach has great utility with both heroin and cocaine addicts in outpatient treatment.

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### MOTIVATIONAL ENHANCEMENT

THERAPY is a client-centered counseling approach for initiating behavior change by helping clients to resolve ambivalence about engaging in treatment and stopping drug use. This approach employs strategies to evoke rapid and internally motivated change in the client, rather than guiding the client stepwise through the recovery process. This therapy consists of an initial assessment battery session, followed by two to four individual treatment sessions with a therapist. The first treatment session focuses on providing feedback generated from the initial assessment battery to stimulate discussion regarding personal substance use and to elicit self-motivational statements. Motivational interviewing principles are used to strengthen motivation and build a plan for change. Coping strategies for high-risk

situations are suggested and discussed with the client. In subsequent sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change or sustained abstinence. Clients are sometimes encouraged to bring a significant other to sessions. This approach has been used successfully with alcoholics and with marijuana-dependent individuals.

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**BEHAVIORAL THERAPY FOR ADOLESCENTS** incorporates the principle that unwanted behavior can be changed by clear demonstration of the desired behavior and consistent reward of incremental steps toward achieving it. Therapeutic activities include fulfilling specific assignments, rehearsing desired behaviors, and recording and reviewing progress, with praise and privileges given for meeting assigned goals. Urine samples are collected regularly to monitor drug use. The therapy aims to equip the patient to gain three types of control:

**Stimulus Control** helps patients avoid situations associated with drug use and learn to spend more time in activities incompatible with drug use.

**Urge Control** helps patients recognize and change thoughts, feelings, and plans that lead to drug use.

**Social Control** involves family members and other people important in helping patients avoid drugs. A parent or significant other attends treatment sessions when possible and assists with therapy assignments and reinforcing desired behavior.

According to research studies, this therapy helps adolescents become drug free and increases their ability to remain drug free after treatment ends. Adolescents also show improvement in several other areas—employment/school attendance, family relationships, depression, institutionalization, and alcohol use. Such favorable results are attributed largely to including family members in therapy and rewarding drug abstinence as verified by urinalysis.

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**MULTIDIMENSIONAL FAMILY THERAPY (MDFT) FOR ADOLESCENTS** is an outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (that is, individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings. Treatment includes individual and family sessions held



In the clinic, in the home, or with family members at the family court, school, or other community locations.

During individual sessions, the therapist and adolescent work on important developmental tasks, such as developing decisionmaking, negotiation, and problem-solving skills. Teenagers acquire skills in communicating their thoughts and feelings to deal better with life stressors, and vocational skills. Parallel sessions are held with family members. Parents examine their particular parenting style, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their child.

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MULTISYSTEMIC THERAPY (MST) addresses the factors associated with serious antisocial behavior in children and adolescents who abuse drugs. These factors include characteristics of the adolescent (for example, favorable attitudes toward drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward drug use), school (dropout, poor performance), and neighborhood (criminal subculture). By participating in intense treatment in natural environments (homes, schools, and neighborhood settings) most youths and families complete a full course of treatment. MST significantly reduces adolescent drug use during treatment and for at least 6 months after treatment. Reduced numbers of incarcerations and out-of-home placements of

juveniles offset the cost of providing this intensive service and maintaining the clinicians' low caseloads.

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COMBINED BEHAVIORAL AND NICOTINE REPLACEMENT THERAPY FOR NICOTINE ADDICTION consists of two main components:

- The transdermal nicotine patch or nicotine gum reduces symptoms of withdrawal, producing better initial abstinence.
- The behavioral component concurrently provides support and reinforcement of coping skills, yielding better long-term outcomes.

Through behavioral skills training, patients learn to avoid high-risk situations for smoking relapse early on and later to plan strategies to cope with such situations. Patients practice skills in treatment, social, and work settings. They learn other coping techniques, such as cigarette refusal skills, assertiveness, and time management. The combined treatment is based on the rationale that behavioral and

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COMMUNITY REINFORCEMENT  
APPROACH (CRA) PLUS VOUCHERS is an  
intensive 24-week outpatient therapy for treatment of  
cocaine addiction. The treatment goals are twofold:

- To achieve cocaine abstinence long enough for patients to learn new life skills that will help sustain abstinence.
- To reduce alcohol consumption for patients whose drinking is associated with cocaine use.

Patients attend one or two individual counseling sessions per week, where they focus on improving family relations, learning a variety of skills to minimize drug use, receiving vocational counseling, and developing new recreational activities and social networks. Those who also abuse alcohol receive clinic-monitored disulfiram (Antabuse) therapy. Patients submit urine samples two or three times each week and receive vouchers for cocaine-negative samples. The value of the vouchers increases with consecutive clean samples. Patients may exchange vouchers for retail goods that are consistent with a cocaine-free lifestyle.

This approach facilitates patients' engagement in treatment and systematically aids them in gaining substantial periods of cocaine abstinence. The approach has been tested in urban and rural areas and used successfully in outpatient detoxification of opiate-addicted adults and with inner-city methadone maintenance patients who have high rates of intravenous cocaine abuse.

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VOUCHER-BASED REINFORCEMENT  
THERAPY IN METHADONE MAINTENANCE  
TREATMENT helps patients achieve and maintain  
abstinence from illegal drugs by providing them with a  
voucher each time they provide a drug-free urine sample.  
The voucher has monetary value and can be exchanged  
for goods and services consistent with the goals of treat-  
ment. Initially, the voucher values are low, but their value  
increases with the number of consecutive drug-free urine  
specimens the individual provides. Cocaine- or heroin-  
positive urine specimens reset the value of the vouchers  
to the initial low value. The contingency of escalating  
incentives is designed specifically to reinforce periods of  
sustained drug abstinence.

Studies show that patients receiving vouchers for drug-free urine samples achieved significantly more weeks of abstinence and significantly more weeks of sustained abstinence than patients who were given vouchers independent of urinalysis results. In another study, urinalyses positive for heroin decreased significantly when the voucher program was started and increased significantly when the program was stopped.

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**DAY TREATMENT WITH ABSTINENCE CONTINGENCIES AND VOUCHERS** was developed to treat homeless crack addicts. For the first 2 months, participants must spend 5.5 hours daily in the program, which provides lunch and transportation to and from shelters. Interventions include individual assessment and goal setting, individual and group counseling, multiple psychoeducational groups (for example, didactic groups on community resources, housing, cocaine, and HIV/AIDS prevention; establishing and reviewing personal rehabilitation goals; relapse prevention; weekend planning), and patient-governed community meetings during which patients review contract goals and provide support and encouragement to each other. Individual counseling occurs once a week, and group therapy sessions are held three times a week. After 2 months of day treatment and at least 2 weeks of abstinence, participants graduate to a 4-month

work component that pays wages that can be used to rent inexpensive, drug-free housing. A voucher system also rewards drug-free related social and recreational activities.

This innovative day treatment was compared with treatment consisting of twice-weekly individual counseling and 12-step groups, medical examinations and treatment, and referral to community resources for housing and vocational services. Innovative day treatment followed by work and housing dependent upon drug abstinence had a more positive effect on alcohol use, cocaine use, and days homeless.

#### *References:*

Milby, J.B.; Schumacher, J.E.; Raczynski, J.M.; Caldwell, E.; Engle, M.; Michael, M.; and Carr, J. Sufficient conditions for effective treatment of substance abusing homeless. *Drug & Alcohol Dependence* 43: 39-47, 1996.

Milby, J.B.; Schumacher, J.E.; McNamara, C.; Wallace, D.; McGill, T.; Stange, D.; and Michael, M. Abstinence contingent housing enhances day treatment for homeless cocaine abusers. *National Institute on Drug Abuse Research Monograph Series 174, Problems of Drug Dependence: Proceedings of the 58th Annual Scientific Meeting. The College on Problems of Drug Dependence, Inc., 1996.*

**THE MATRIX MODEL** provides a framework for engaging stimulant abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction.

The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and

the patient is realistic and direct but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is a critical element for patient retention.

Treatment materials draw heavily on other tested treatment approaches. Thus, this approach includes elements pertaining to the areas of relapse prevention, family and group therapies, drug education, and self-help participation. Detailed treatment manuals contain work sheets for individual sessions; other components include family educational groups, early recovery skills groups, relapse prevention groups, conjoint sessions, urine tests, 12-step programs, relapse analysis, and social support groups.

A number of projects have demonstrated that participants treated with the Matrix model demonstrate statistically significant reductions in drug and alcohol use, improvements in psychological indicators, and reduced risky sexual behaviors associated with HIV transmission. These reports, along with evidence suggesting comparable treatment response for methamphetamine users and cocaine users and demonstrated efficacy in enhancing naltrexone treatment of opiate addicts, provide a body of empirical support for the use of the model.

#### *References:*

Huber, A.; Ling, W.; Shoptaw, S.; Gulati, V.; Brethen, P.; and Rawson, R. Integrating treatments for methamphetamine abuse: A psychosocial perspective. *Journal of Addictive Diseases* 16: 41-50, 1997.

Rawson, R.; Shoptaw, S.; Obert, J.L.; McCann, M.; Hasson, A.; Marinelli-Casey, P.; Brethen, P.; and Ling, W. An intensive outpatient approach for cocaine abuse: The Matrix model. *Journal of Substance Abuse Treatment* 12(2): 117-127, 1995.

## RESOURCES

### GENERAL INQUIRIES: NIDA PUBLIC INFORMATION OFFICE 301-443-1124

Inquiries about NIDA's treatment research activities:  
Division of Clinical and Services Research, 301-443-0107  
(for questions regarding behavioral therapies) or  
301-443-4060 (for questions regarding access to treatment,  
organization and management, and cost effectiveness);  
and, Medications Development Division, 301-443-6173  
(for questions regarding medications development).

WEBSITE: <http://www.nida.nih.gov>

### CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT)

CSAT, a part of the Substance Abuse and Mental Health Services Administration, is responsible for supporting treatment services through block grants and developing knowledge about effective drug treatment, disseminating the findings to the field, and promoting their adoption. CSAT also operates the National Treatment Referral 24-hour Hotline (1-800-662-HELP) which offers information and referral to people seeking treatment programs and other assistance. CSAT publications are available through the National Clearinghouse on Alcohol and Drug Information (1-800-729-6686). Additional information about CSAT can be found on their website at [www.samhsa.gov/csat](http://www.samhsa.gov/csat).

### SELECTED NIDA EDUCATIONAL RESOURCES ON DRUG ADDICTION TREATMENT

The following are available from the National Clearinghouse on Alcohol and Drug Information (NCADI), the National Technical Information Service (NTIS), or the Government Printing Office (GPO). To order, refer to the NCADI (1-800-729-6686), NTIS (1-800-553-6847), or GPO (202-512-1800) number provided with the resource description.

### MANUALS AND CLINICAL REPORTS

**Measuring and Improving Cost, Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs (1999).** Offers substance abuse treatment program managers tools with which to calculate the costs of their programs and investigate the relationship between those costs and treatment outcomes. NCADI # BKD340. Available online at <http://www.nida.nih.gov>

**An Overview of Prison and Community-Based Drug Abuse Treatment (1999).** Summarizes substantive research on prison and community-based drug abuse treatment from the last 25 years and highlights how public health research can help inform public policies across systems. In press.

**A Cognitive-Behavioral Approach: Treating Cocaine Addiction (1998).** This is the first in NIDA's "Therapy Manuals for Drug Addiction" series. Describes cognitive-behavioral therapy, a short-term focused approach to helping cocaine-addicted individuals become abstinent from cocaine and other drugs. NCADI # BKD254. Available online at <http://www.nida.nih.gov>.

**A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction (1998).** This is the second in NIDA's "Therapy Manuals for Drug Addiction" series. This treatment integrates a community reinforcement approach with an incentive program that uses vouchers. NCADI # BKD255. Available online at <http://www.nida.nih.gov>.

**An Individual Drug Counseling Approach to Treat Cocaine Addiction: The Collaborative Cocaine Treatment Study Model (1999).** This is the third in NIDA's "Therapy Manuals for Drug Addiction" series. Describes specific cognitive-behavioral models that can be implemented in a wide range of differing drug abuse treatment settings. NCADI # BKD337. Available online at <http://www.nida.nih.gov>.

**Mental Health Assessment and Diagnosis of Substance Abusers: Clinical Report Series (1994).** Provides detailed descriptions of psychiatric disorders that can occur among drug-abusing clients. NCADI # BKD148.

**Relapse Prevention: Clinical Report Series (1994).** Discusses several major issues to relapse prevention. Provides an overview of factors and experiences that can lead to relapse. Reviews general strategies for preventing relapses, and describes four specific approaches in detail. Outlines administrative issues related to implementing a relapse prevention program. NCADI # BKD147.

**Addiction Severity Index Package (1993).** Provides a structured clinical interview designed to collect information about substance use and functioning in life areas from adult clients seeking drug abuse treatment. Includes a handbook for program administrators, a resource manual, two videotapes, and a training facilitator's manual. NTIS # AVA19615VNB2KUS. \$52.95.

**Program Evaluation Package (1993).** A practical resource for treatment program administrators and key staff. Includes an overview and case study manual, a guide for evaluation, a resource guide, and a pamphlet. NTIS # 95-167268. \$44.00.

**Relapse Prevention Package (1993).** Examines two effective relapse prevention models, the Recovery Training and Self-Help (RTSH) program and the Cue Extinction model. NTIS # 95-167250. \$62.00.

#### RESEARCH MONOGRAPHS

**Beyond the Therapeutic Alliance: Keeping the Drug-Dependent Individual in Treatment (Research Monograph 165) (1997).** Reviews current treatment research on the best ways to retain patients in drug abuse treatment. NTIS # 97-181606. \$47; GPO # 017-024-01608-0. \$17. Available online at <http://www.nida.nih.gov>.

**Treatment of Drug-Exposed Women and Children: Advances in Research Methodology (Research Monograph 166) (1997).** Presents experiences, products, and procedures of NIDA-supported Treatment Research Demonstration Program projects. NCADI # M166; NTIS # 96-179106. \$49; GPO # 017-01592-0. \$13. Available online at <http://www.nida.nih.gov>.

**Treatment of Drug-Dependent Individuals With Comorbid Mental Disorders (Research Monograph 172) (1997).** Promotes effective treatment by reporting state-of-the-art treatment research on individuals with comorbid mental and addictive disorders and research on HIV-related issues among people with comorbid conditions. NCADI # M172; NTIS # 97-181580. \$38; GPO # 017-024-01605. \$9.

**Medications Development for the Treatment of Cocaine Dependence: Issues in Clinical Efficacy Trials (Research Monograph 175) (1998).** A state-of-the-art handbook for clinical investigators, pharmaceutical scientists, and treatment researchers. NCADI # M175.

#### VIDEOS

**Adolescent Treatment Approaches (1991).** Emphasizes the importance of pinpointing and addressing individual problem areas, such as sexual abuse, peer pressure, and family involvement in treatment. Running time: 25 min. NCADI # VHS40. \$12.50.

**NIDA Technology Transfer Series: Assessment (1991).** Shows how to use a number of diagnostic instruments as well as how to assess the implementation and effectiveness of the plan during various phases of the patient's treatment. Running time: 22 min. NCADI # VHS38. \$12.50.

**Drug Abuse Treatment in Prison: A New Way Out (1995).** Portrays two comprehensive drug abuse treatment approaches that have been effective with men and women in State and Federal Prisons. Running time: 23 min. NCADI # VHS72. \$12.50.

**Dual Diagnosis (1993).** Focuses on the problem of mental illness in drug-abusing and drug-addicted populations, and examines various approaches useful for treating dual-diagnosed clients. Running time: 27 min. NCADI # VHS58. \$12.50.

**LAAM: Another Option for Maintenance Treatment of Opiate Addiction (1995).** Shows how LAAM can be used to meet the opiate treatment needs of individual clients from the provider and patient perspectives. Running time: 16 min. NCADI # VHS73. \$12.50.

**Methadone: Where We Are (1993).** Examines issues such as the use and effectiveness of methadone as a treatment, biological effects of methadone, the role of the counselor in treatment, and societal attitudes toward methadone treatment and patients. Running time: 24 min. NCADI # VHS59. \$12.50.

**Relapse Prevention (1991).** Helps practitioners understand the common phenomenon of relapse to drug use among patients in treatment. Running time: 24 min. NCADI # VHS37. \$12.50.

**Treatment Issues for Women (1991).** Assists treatment counselors help female patients to explore relationships with their children, with men, and with other women. Running time: 22 min. NCADI # VHS39. \$12.50.

**Treatment Solutions (1999).** Describes the latest developments in treatment research and emphasizes the benefits of drug abuse treatment, not only to the patient, but also to the greater community. Running time: 19 min. NCADI # DD110. \$12.50.

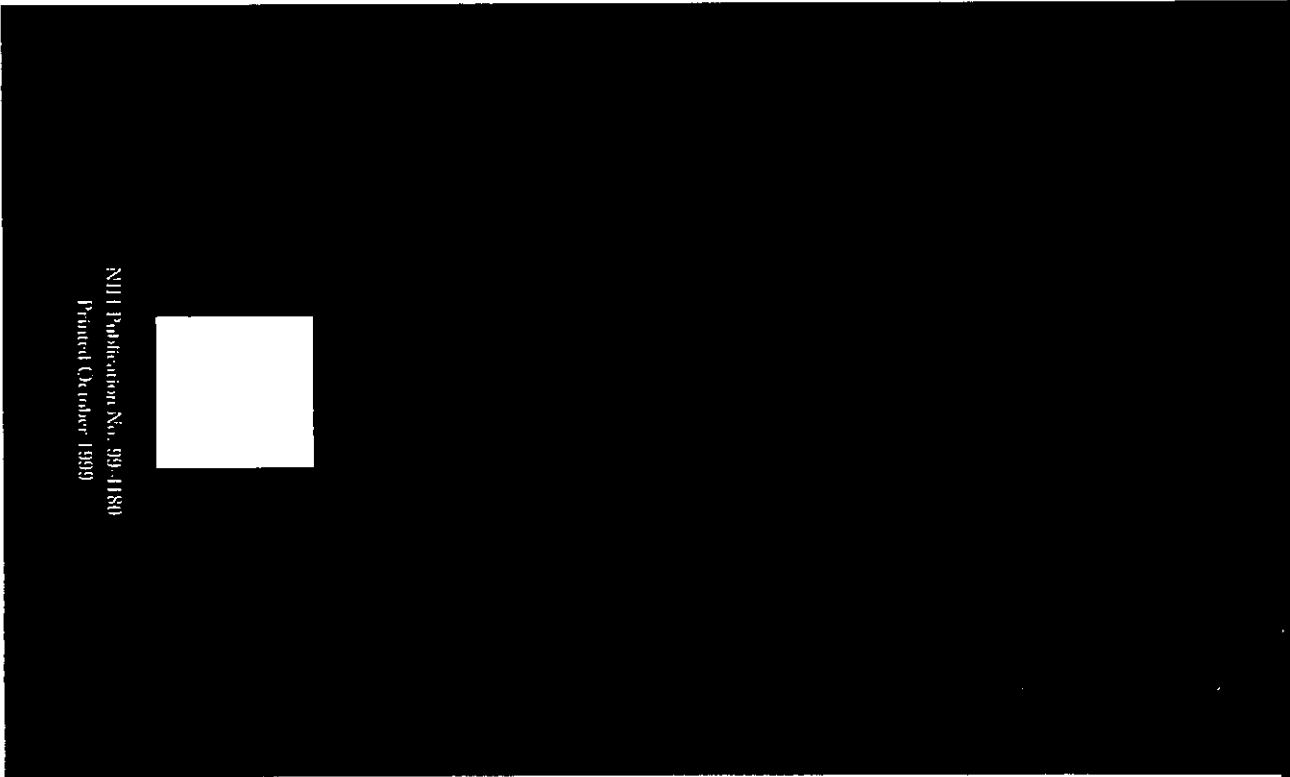
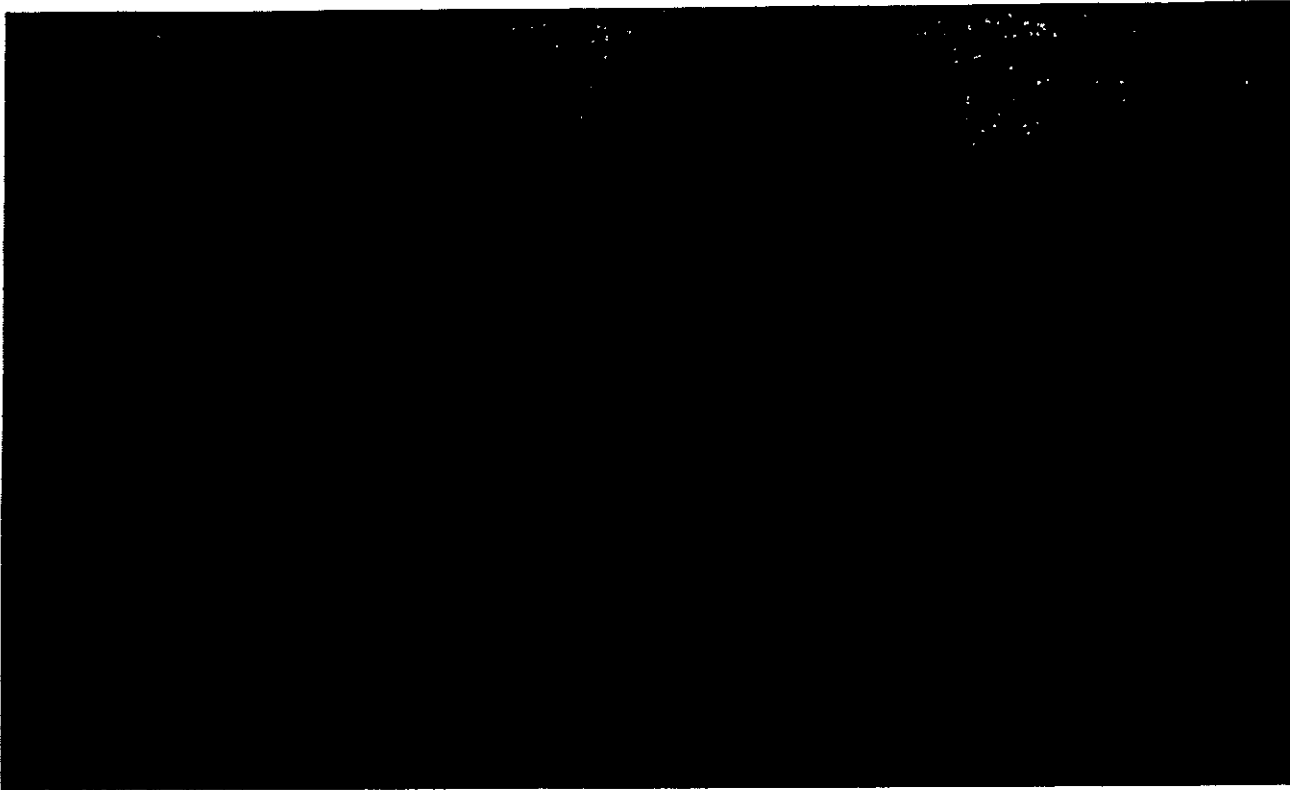
**Program Evaluation Package (1993).** A practical resource for treatment program administrators and key staff. Includes an overview and case study manual, a guide for evaluation, a resource guide, and a pamphlet. NTIS # 95-167268. \$44.

**Relapse Prevention Package (1993).** Examines two effective relapse prevention models, the Recovery Training and Self-Help (RTSH) program and the Cue Extinction model. NTIS # 95-167250. \$62.

#### OTHER FEDERAL RESOURCES

**THE NATIONAL CLEARINGHOUSE FOR ALCOHOL AND DRUG INFORMATION (NCADI).** NIDA publications and treatment materials along with publications from other Federal agencies are available from this information source. Staff provide assistance in English and Spanish, and have TDD capability. Phone: 1-800-729-6686. Website: <http://www.health.org>.

**THE NATIONAL INSTITUTE OF JUSTICE (NIJ).** As the research agency of the Department of Justice, NIJ supports research, evaluation, and demonstration programs relating to drug abuse in the contexts of crime and the criminal justice system. For information, including a wealth of publications, contact the National Criminal Justice Reference Service by telephone (1-800-851-3420 or 1-301-519-5500) or on the World Wide Web (<http://www.ojp.usdoj.gov/nij>).




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Printed October 1999











## NIDA: Principles

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## NIDA Principles of Treatment



1. Treatment Matching	8. Dual-Diagnosis Treatment
2. Availability	9. Medical Detoxification
3. Domains of Care	10. Coercion
4. Individualization	11. Monitoring
5. Retention	12. High-Risk Behaviors
6. Psycho-Social Treatment	13. Recidivism
7. Medications	

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## 1. Treatment Matching



**No single treatment is appropriate for all individuals.**

- Patient-Oriented, not Program-Oriented, Interventions

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## 2. Availability

**Treatment needs to be readily available.**

- Treatment motivation may be fleeting, and reducing barriers to immediate access is essential.

TX

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## 3. Domains of Care

**Effective treatment attends to multiple needs of the individual, not just his or her drug use.**

- McLellan et al. have identified 7 domains in the Addiction Severity Index (ASI)
- ASI Domains: Alcohol, Drugs, Medical, Psychological, Family, Employment, Legal.
- BPSS Model: Bio-Psycho-Social-Spiritual

TX

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## 4. Individualization

**An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.**

- Treatment should not be one-size-fits-all.

TX

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## 5. Retention

Tx

Remaining in treatment for an adequate period of time is critical for treatment effectiveness.

- Dropout Intervention and F/U
- Good retention predicts good outcomes.

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## 6. Psycho-Social Treatment

Tx

Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.

- Twelve-Step Programs (AA) and Twelve-Step Facilitation (TSF)
- Cognitive-Behavioral-Therapies (CBT)
- Group and Individual Counseling/Psychotherapy

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## 7. Medications

Tx

Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

- Alcohol: Naltrexone, Disulfiram, Acamprosate, Ondansetron
- Opiates: Naltrexone, Methadone, LAAM, Buprenorphine
- Nicotine: Nicotine replacement (gum, patches, spray), bupropion
- Stimulants: [None to date]

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8. Dual-Diagnosis Treatment

Tx

Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.

- Depression, Suicidality
- Psychoses, Paranoia
- Violence, Domestic Abuse

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9. Medical Detoxification

Tx

Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.

- High post-detoxification relapse rates
- Not a definitive intervention, a preparatory intervention for further care

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10. Coercion

Tx

Treatment does not need to be voluntary to be effective.

- Court-Ordered Probation
- Family or Employer Sanctions
- Medical Consequences & Physician Advice

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## 11. Monitoring Tx

Possible drug use during treatment must be monitored continuously. Lapses to drug use can occur during treatment.

- Randomization
- Frequency
- Feedback

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## 12. High-Risk Behaviors Tx

Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.

- High Risk Sexual Behavior
- Needle-Sharing Behaviors
- Environmental Exposure Risks

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## 13. Recidivism Tx

Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

- Relapses Precede Stable Recovery
- Natural History of Alcoholism (Vaillant)
- "Doing Research"
- Harm-Reduction Approaches

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## **A Quick Guide to Finding Effective Alcohol and Drug Addiction Treatment**

If you or someone you care for is dependent on alcohol or drugs and needs treatment, it is important to know that no single treatment approach is appropriate for all individuals. Finding the right treatment program involves careful consideration of such things as the setting, length of care, philosophical approach and your or your loved one's needs.

**Here are 12 questions to consider when selecting a treatment program:**

1. Does the program accept your insurance? If not, will they work with you on a payment plan or find other means of support for you?
2. Is the program run by state-accredited, licensed and/or trained professionals?
3. Is the facility clean, organized and well-run?
4. Does the program encompass the full range of needs of the individual (medical: including infectious diseases; psychological: including co-occurring mental illness; social; vocational; legal; etc.)?
5. Does the treatment program also address sexual orientation and physical disabilities as well as provide age, gender and culturally appropriate treatment services?
6. Is long-term aftercare support and/or guidance encouraged, provided and maintained?
7. Is there ongoing assessment of an individual's treatment plan to ensure it meets changing needs?
8. Does the program employ strategies to engage and keep individuals in longer-term treatment, increasing the likelihood of success?
9. Does the program offer counseling (individual or group) and other behavioral therapies to enhance the individual's ability to function in the family/community?
10. Does the program offer medication as part of the treatment regimen, if appropriate?
11. Is there ongoing monitoring of possible relapse to help guide patients back to abstinence?
12. Are services or referrals offered to family members to ensure they understand addiction and the recovery process to help them support the recovering individual?

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) provides a toll-free, 24-hour treatment referral service to help you locate treatment options near you. For a referral to a treatment center or support group in your area, call:

**1-800-662-HELP**

1-800-487-4889 (TDD) • 1-877-767-8432 (Spanish) • <http://findtreatment.samhsa.gov>  
DHHS Publication No. (SMA) 02-3616 • NCADI Publication No. PHD877



# The Twelve Steps of Alcoholics Anonymous

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**T**he relative success of the A.A. program seems to be due to the fact that an alcoholic who no longer drinks has an exceptional faculty for "reaching" and helping an uncontrolled drinker.

In simplest form, the A.A. program operates when a recovered alcoholic passes along the story of his or her own problem drinking, describes the sobriety he or she has found in A.A., and invites the newcomer to join the informal Fellowship.

The heart of the suggested program of personal recovery is contained in Twelve Steps describing the experience of the earliest members of the Society:

- 1. We admitted we were powerless over alcohol - that our lives had become unmanageable.*
- 2. Came to believe that a Power greater than ourselves could restore us to sanity.*
- 3. Made a decision to turn our will and our lives over to the care of God as we understood Him.*
- 4. Made a searching and fearless moral inventory of ourselves.*
- 5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.*
- 6. Were entirely ready to have God remove all these defects of character.*
- 7. Humbly asked Him to remove our shortcomings.*
- 8. Made a list of all persons we had harmed, and became willing to make amends to them all.*
- 9. Made direct amends to such people wherever possible, except when to do so would injure them or others.*
- 10. Continued to take personal inventory and when we were wrong promptly admitted it.*
- 11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.*
- 12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.*

Newcomers are not asked to accept or follow these Twelve Steps in their entirety if they feel unwilling or unable to do so.

They will usually be asked to keep an open mind, to attend meetings at which recovered alcoholics describe their personal experiences in achieving sobriety, and to read A.A. literature describing and interpreting the A.A. program.

A.A. members will usually emphasize to newcomers that only problem drinkers themselves, individually, can determine whether or not they are in fact alcoholics.

At the same time, it will be pointed out that all available medical testimony indicates that alcoholism is a progressive illness, that it cannot be cured in the ordinary sense of the term, but that it can be arrested through total abstinence from alcohol in any form.

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# **ALCOHOL/DRUG WEBLIOGRAPHY**

Prepared by Hon. Peggy Fulton Hora

- **12 Life in Recovery**  
[www.12stepmag.com](http://www.12stepmag.com)  
A new 12-Step magazine

**AA World Services**  
[www.alcoholics-anonymous.org](http://www.alcoholics-anonymous.org)  
Home page of AA General Services Office

**Addiction Treatment Forum**  
<http://www.atforum.com/>  
Home page of Addiction Treatment Forum

**Al-Anon and Alateen**  
[www.al-anon.alateen.org](http://www.al-anon.alateen.org)  
Alcoholics recovery program

**Alcohol and Drug Services**  
<http://www.adsyes.com/>  
Home page of Alcohol and Drug Services

**Alcohol Doctor**  
[www.Alcoholmd.com](http://www.Alcoholmd.com)  
Provides online medical information (education and services) about alcoholism

**Alcohol Policies Project, Center for Science in the Public Interest**  
[www.cspinet.org](http://www.cspinet.org)  
Home page of Center for Science in Public Interest which promotes health through education of the public regarding nutrition and alcohol.

**Alcohol-Related Injury and Violence Literature Database**  
[www.andornot.com/trauma](http://www.andornot.com/trauma)  
Contains bibliographic references to publications about alcoholism

**American Academy of Addiction Psychiatry**  
[www.aaap.org](http://www.aaap.org)  
Information on the field of Addiction Psychiatry

**American Council on Alcoholism**  
[www.aca-usa.org](http://www.aca-usa.org)  
A public education group about alcoholism  
**American Council for Drug Education**  
[www.acde.org](http://www.acde.org)

Substance abuse prevention and education agency

**American Foundation for Addiction Research (AFAR)**

[www.addictionresearch.com](http://www.addictionresearch.com)

AFAR is dedicated to fostering scientific research, understanding and disseminating the knowledge of the causes and nature of addictive disorders.

**American Medical Association**

[www.ama-assn.org](http://www.ama-assn.org)

Home page for the AMA

**American University Justice Programs, Drug Court Clearinghouse**

<http://www.american.edu/justice/aboutdrugcourts.html>

The Clearinghouse and Technical Assistance Project (DCCTAP) assists justice system officials and professionals in addressing issues relating to drug court programs in their jurisdictions.

**Anonymous One**

<http://www.anonymousone.com/main.htm>

"A recovery resource like no other"

**Anonymously Yours Bookstore**

<http://ay12steps.com/>

Recovery bookstore and gift shop

**Arrestee Drug Abuse Monitoring (ADAM) Program**

<http://www.adam-nij.net/>

Program tracks trends in the prevalence and types of drug use among booked arrestees in urban areas

**Australian Drug Courts**

<http://www.aic.gov.au/>

Home page of the Australian Institute of Criminology

**Bill Nye the Science Guy (Episode 34--The Brain)**

<http://www.billnye.com/core.html?flashtarget=core.html&noflashtarget=noflash.html>

Bill Nye the Science Guy home page providing a link to Episode 34--The Brain.  
(Episode Guides, Life Science, Humans, The Brain.)

**Brainplace**

<http://www.brainplace.com/bp/default.asp>

All you ever wanted to know about the brain

**Bureau of Justice Assistance (BJA)**

[www.ojp.usdoj.gov/BJA](http://www.ojp.usdoj.gov/BJA)

Part of the U.S. government, BJA provides leadership and assistance in support of local criminal justice strategies to achieve safe communities

**Bureau of Justice Statistics (BJS)**

<http://www.ojp.usdoj.gov/bjs/>

Part of the U.S. government, BJS provides criminal justice statistics

**California Association of Drug Court Professionals (CADCP)**

[www.cadcp.org](http://www.cadcp.org)

Home page of CADCP, a voluntary state organization for drug court professionals

**California Department of Alcohol and Drug Programs**

[www.adp.state.ca.us](http://www.adp.state.ca.us)

Home page of California Department of Alcohol and Drug Programs

**California Drug Court Project**

[www.courtinfo.ca.gov/programs/drugcourts/](http://www.courtinfo.ca.gov/programs/drugcourts/)

Home page of California Drug Court Project located in the Administrative Office of the Courts

**California Narcotic Officers' Assn./Calif. Dept. of Justice**

[www.stopdrugs.org](http://www.stopdrugs.org)

Information on illegal drugs from narcotics officers.

**California Society of Addiction Medicine**

<http://www.csam-asam.org/>

Home page of physicians dedicated to improving treatment of alcoholism and other addictions.

**California Women's Commission on Addictions**

<http://www.cf1.org/CWCA/launch.htm>

CWCA is a statewide grassroots organization dedicated to the reduction, prevention of, and recovery from, alcohol and other drug related problems among women, their families and their communities.

**Canadian Centre on Substance Abuse**

<http://ccsa.ca>

A non-profit organization working to minimize the harm associated with the use of alcohol, tobacco and other drugs.

**Centre for Addiction and Mental Health (Canada)**

<http://www.camh.net/>

A public hospital providing care for people with mental health and addiction problems, a research facility, an education and training institute, and a community based organization providing health promotion and prevention services across the province of Ontario, Canada.

**Center for Disease Control and Prevention (CDC)**

[www.cdc.gov](http://www.cdc.gov)

Home page for CDC

**Center for Substance Abuse Prevention**

<http://www.samhsa.gov/centers/csap/csap.html>

Home page of Substance Abuse Prevention a division of Substance Abuse, part of the Substance Abuse and Mental Health Services Administration (SAMHSA)

**Center for Substance Abuse Research, University of Maryland**

[www.cesar.umd.edu](http://www.cesar.umd.edu)

Home page of Center for Substance Abuse University of Maryland

**Center for Substance Abuse Treatment (CSAT)**

[www.samhsa.gov/csap](http://www.samhsa.gov/csap)

Home page for CSAT a division of SAMHSA

**CSAT Technical Assistance Publications (TAPs)**

<http://www.treatment.org/Taps/>

Home page for Treatment Improvement Exchange TAP information

**CSAT Treatment Improvement Protocols (TIPs)**

<http://www.treatment.org/Externals/tips.html>

Home page for Treatment Improvement Exchange TIP information

**Child Welfare League of America**

[www.cwla.org](http://www.cwla.org)

Home page for Child Welfare League of America

**Children of Alcoholics Foundation**

[www.coaf.org](http://www.coaf.org)

National non-profit that provides a range of educational materials and services on parental substance abuse.

**CoDependents Anonymous**

[www.codependents.org](http://www.codependents.org)

Self-help 12 step organization to develop healthy relations

**Community Anti-Drug Coalitions of America (CADCA)**

<http://www.cadca.org/>

CADCA is a membership organization of over 5,000 anti-drug coalitions.

**Community Tool Box**

<http://ctb.lsi.ukans.edu/tools/tools.htm>

How to do the different tasks necessary for community health and development

**Cornell University Medical College**

[www.med.cornell.edu/neuro/](http://www.med.cornell.edu/neuro/)

Neuroscience web page of Cornell Medical College

**Dads and Mad Moms Against Drug Dealers**

<http://www.dammadd.org/mission.asp>

DAMMADD will pay citizens a cash reward for any tip that leads to the arrest and successful conviction of a drug dealer.

**Dana Alliance for Brain Initiatives**

[www.dana.org/brainweb](http://www.dana.org/brainweb)

Information on the brain relating to various conditions

**Debtors Anonymous**

[www.debtorsanonymous.org](http://www.debtorsanonymous.org)

A fellowship of men and women who share a common desire to help others to recover from compulsive debting.

**Drug Court Planning Initiative**

<http://dcpi.ncjrs.org/index.html>

Home page for the Drug Court Planning Initiative, sponsored by the Bureau of Justice Assistance

**Drug Court Technology**

[www.drugcourtech.org](http://www.drugcourtech.org)

Home page for Drug Court Technology

**Drug Enforcement Administration**

[www.usdoj.gov/dea](http://www.usdoj.gov/dea)

Home page for the DEA, U.S. Department of Justice

**Drug Strategies**

[www.drugstrategies.org](http://www.drugstrategies.org)

Non-profit research institution that promotes alternative approaches to the nation's drug problem

**DSM IV**

<http://www.behavenet.com/capsules/disorders/d4class.htm>  
Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition

**Dual Diagnosis Anonymous**

<http://www.swiftsite.com/mft/dda120.htm>  
A 12-step program for people with co-occurring mental health disorders

**Dual Recovery Anonymous**

<http://draonline.org/>  
An independent, twelve step, self-help organization for people with a dual diagnosis

**Femina Women's Resources**

[www.femina.com/](http://www.femina.com/)(use search engine, "addiction")  
A search engine that deals with women.

**Gam-Anon**

[www.gam-anon.org](http://www.gam-anon.org)  
Assistance with problem gambling

**Gamblers Anonymous**

[www.gamblersanonymous.org](http://www.gamblersanonymous.org)  
Self help 12 step group for compulsive gamblers

**Gateway Recovery Center**

<http://gatewayrecovery.org/main.htm>  
A Montana treatment program with an excellent website

**GHB Information**

<http://www.projectghb.org/>  
Information on the drug GHB

**Hazelden**

[www.hazelden.org](http://www.hazelden.org)  
Publisher of books on recovery

**Healthy Nations Initiative**

<http://www.uchsc.edu/>  
University of Colorado Health Science Center

**Higher Education Center for Alcohol and Other Drug Prevention**

<http://www.edc.org/hec/>  
U.S. Department of Education website for drug and alcohol prevention

**Indian Health Services**

<http://www.ihs.gov/MedicalPrograms/Alcohol/index.asp>

The Federal Health Program for American Indians and Alaska Natives.

**Indiana Prevention Resource Center**

[www.drugs.indiana.edu](http://www.drugs.indiana.edu)

Indiana clearinghouse for prevention technical assistance and information about alcohol, tobacco, and other drugs.

**Institute on Behavioral Research**

[www.ibr.tcu.edu](http://www.ibr.tcu.edu)

To evaluate and improve the effectiveness of programs for reducing drug abuse and related problems.

**Johnson Institute Foundation**

<http://www.johnsoninstitute.com/html/history.html>

Improving the public's understanding of addiction as a treatable illness.

**Join Together Online**

<http://www.jointogether.org>

Information website on reducing substance abuse and gun violence.

**Miami Coalition for a Safe and Drug-Free Community**

[www.miamicoalition.org](http://www.miamicoalition.org)

Miami-Dade Co. community strategy site related to social issues

**Legal Action Center**

[www.lac.org](http://www.lac.org)

LAC fights discrimination against people with histories of addiction, AIDS, and criminal records and advocates for sound public policies in these areas.

**LifeRing Recovery**

<http://www.unhooked.com/>

A secular, 12-Step recovery program

**Living Cyber**

[www.livingcyber.org](http://www.livingcyber.org)

AA on line with chat rooms

**Manisses Communication Group, Inc.**

[www.manisses.com](http://www.manisses.com)

Mission to provide essential information to decision makers and service providers in mental health and addiction.



**MedWeb**

<http://www.medweb.emory.edu/MedWeb/>

Emory University Med Web

MedWeb is a catalog of biomedical and health related web sites maintained by Emory University.

**Methamphetamine Campaign**

<http://www.stopdrugs.org/methcrisis.html>

Information on methamphetamine

**Methamphetamine Treatment Project (MTP)**

[www.methamphetamine.org](http://www.methamphetamine.org)

MTP is a multi-site initiative to study the treatment of methamphetamine dependence.

**Metropolitan Atlanta Council on Alcohol and Drugs**

[www.macad.org](http://www.macad.org)

The Council on Alcohol and Drugs is a substance abuse prevention and education agency

**Miami Drug Court**

[www.miamidrugcourt.com](http://www.miamidrugcourt.com)

Home page of the country's first drug court

**Monitoring the Future Study, University of Michigan**

[www.isr.umich.edu/src/mtf/](http://www.isr.umich.edu/src/mtf/)

Monitoring the Future is an ongoing study of the behaviors, attitudes, and values of American secondary school students, college students, and young adults.

**Mothers Against Drunk Driving**

[www.madd.org](http://www.madd.org)

A non-profit organization that focuses on the effects of drunk driving and underage drinking and supporting those who are victims of those crimes.

**Narcotics Anonymous**

[www.na.org](http://www.na.org)

Self help 12 Step site for addicts

**National Addiction Technology Transfer Centers**

<http://www.nattc.org/>

A nationwide, multi-disciplinary resource that draws upon the knowledge, experience and latest work of recognized experts in the field of addiction

**National Association of Addiction Treatment Providers**

[www.naatp.org](http://www.naatp.org)

Represents almost 200 not-for-profit and for-profit treatment providers

**National Advocates for Pregnant Women**

<http://advocatesforpregnantwomen.org/>

Advocates for the rights of pregnant women and their children; protects pregnant women from being punished for their pregnancies

**National Association of Alcoholism and Drug Abuse Counselors (NAADAC)**

[www.naadac.org](http://www.naadac.org)

NAADAC's mission is to lead, unify and empower addiction focused professionals to achieve excellence through education, advocacy, knowledge, and standards of practice, ethics, professional development and research.

**National Association of Drug Court Professionals (NADCP)**

[www.nadcp.org](http://www.nadcp.org)

NADCP is a voluntary membership organization that promotes and advocates for drug courts and providing for collection and dissemination of information, technical assistance, and mutual support to association members.

**National Association for Children of Alcoholics**

<http://www.nacoa.net/>

Our mission is to advocate for all children and families affected by alcoholism and other drug dependencies.

**National Association of State Alcohol and Drug Abuse Directors (NASADAD)**

[www.nasadad.org](http://www.nasadad.org)

NASADAD's purpose is to foster and support the development of effective alcohol and other drug abuse prevention and treatment programs throughout every State.

**National Center for State Courts (NCSC)**

<http://www.ncsconline.org/>

The National Center is an independent, nonprofit organization dedicated to the improvement of justice.

**National Center on Addiction and Substance Abuse at Columbia University (CASA)**

[www.casacolumbia.org](http://www.casacolumbia.org)

Inform Americans of the economic and social costs of substance abuse and its impact on their lives.

**National Clearinghouse for Alcohol and Drug Information (NCADI)**

<http://www.health.org>

NCADI is the world's largest resource for current information and materials concerning substance abuse.

**National Clearinghouse for Alcohol and Drug Information  
Culture and Prevention: Putting Down Roots**

<http://www.health.org/features/multicultural/>

Providing culturally and linguistically appropriate materials and resources to prevent or reduce substance abuse.

**National Council for Community Behavioral Healthcare**

[www.nccbh.org](http://www.nccbh.org)

Trade association of mental health and substance abuse providers

**National Council of Juvenile and Family Court Judges (NCJFCJ)**

<http://www.ncjfcj.unr.edu/>

NCJFCJ is dedicated to serving the nation's children and families by improving the courts of juvenile and family jurisdictions.

**National Council on Alcoholism and Drug Dependence (NCADD)**

[www.ncadd.org](http://www.ncadd.org)

NCADD advocates prevention, intervention and treatment through offices in New York and Washington, and a nationwide network of affiliates.

**National Commission Against Drunk Driving**

<http://www.ncadd.com/>

Commission to reduce impaired driving and its tragic consequences by uniting public and private sector organizations and other concerned individuals who share this common purpose.

**National Criminal Justice Reference Service (NCJRS)**

<http://www.ncjrs.org/>

NCJRS is a federally sponsored information clearinghouse for people around the country and the world involved with research, policy, and practice related to criminal and juvenile justice and drug control.

**National Drug Court Institute (NDCI)**

[www.NDCI.org](http://www.NDCI.org)

Promoting education, research and scholarship for drug court and other court-based intervention programs.

**National Evaluation Data Services**

<http://neds.calib.com/>

To increase scientifically-based analyses that answer vital questions in the substance abuse treatment field.

**National Families in Action**

<http://www.nationalfamilies.org/>

Its mission is to help families and communities prevent drug use among children by promoting policies based on science.

**The National GAINS Center for People with Co-Occurring  
Disorders in the Justice System (GAINS)**

<http://www.gainsctr.com/>

Information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system.

**National Health Information Center**

<http://www.health.gov/nhic/>

NHIC puts health professionals and consumers who have health questions in touch with those organizations that are best able to provide answers.

**National Household Survey on Drug Abuse**

<http://www.samhsa.gov/oas/p0000016.htm>

SAMHSA's National Household Survey on Drug Abuse is the primary source of information on the prevalence, patterns, and consequences of drug and alcohol use and abuse in the U.S.

**National Institute on Alcohol Abuse and Alcoholism**

[www.niaaa.nih.gov](http://www.niaaa.nih.gov)

NIAAA supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems.

**National Institute on Drug Abuse (NIDA)**

[www.nida.nih.gov](http://www.nida.nih.gov)

NIDA's mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction.

**NIDA Club Drugs**

[www.clubdrugs.org](http://www.clubdrugs.org)

Information on drugs used by young adults at all-night dance parties.

**NIDA Marijuana**

<http://www.marijuana-info.org/>

Resources regarding marijuana use, its effects and treatment.

**NIDA Steroids**

[www.steroidabuse.org](http://www.steroidabuse.org)

Information on steroids and their effects

**National Institutes of Health**

<http://www.nih.gov>

NIH sponsors research to help prevent, detect, diagnose, and treat disease and disability, from the rarest genetic disorder to the common cold.

**National Institute of Justice**

[www.ojp.usdoj.gov/nij](http://www.ojp.usdoj.gov/nij)

NIJ is the research and development agency of the U.S. Department of Justice and is the only federal agency solely dedicated to researching crime control and justice issues.

**National Inhalants Prevention Coalition**

[www.inhalants.org](http://www.inhalants.org)

NIPC is a public-private effort to promote awareness and recognition of the under publicized problem of inhalant use.

**National Judicial College (NJC)**

<http://www.judges.org/>

NJC provides educational opportunities for judges on a variety of topics, including substance abuse.

**National Library of Medicine (Medline)**

[www.ncbi.nlm.nih.gov](http://www.ncbi.nlm.nih.gov)

National Center for Biotechnology Information (NCBI) creates public databases, conducts research in computational biology, develops software tools for analyzing genome data, and disseminates biomedical information.

**National Mental Health Association (NMHA)**

[www.nmha.org](http://www.nmha.org)

NMHA is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness.

**National Organization on Fetal Alcohol Syndrome**

<http://www.nofas.org/>

Information on Fetal Alcohol Syndrome

**National Youth Anti-Drug Media Campaign**

<http://www.theantidrug.com/index.html>

A multi-lingual, prevention website

**Neuroscience for Kids**

<http://faculty.washington.edu/chudler/neurok.html>

Neuroscience for Kids is for all students and teachers who would like to learn more about the nervous system.

**Neurosciences on the Internet**

[www.neuroguide.com](http://www.neuroguide.com)

A searchable and browsable index of neuroscience resources available on the Internet

**The Other Bar**

[www.otherbar.org](http://www.otherbar.org)

The Other Bar is a network of volunteer lawyers and judges who deal with alcoholism and chemical dependency on a personal and absolutely confidential basis by providing on-going assistance and support.

**Overeaters Anonymous**

[www.overeatersanonymous.org](http://www.overeatersanonymous.org)

Self help 12 Step site for compulsive overeaters

**Pacific Southwest Addiction Technology Transfer Center (PSATTC)**

[www.attc.ucsd.edu](http://www.attc.ucsd.edu)

PSATTC at the University of California, San Diego, (UCSD) assists service systems and institutions develop capacities for addressing substance use disorders within populations they serve.

**Pain and Chemical Dependency**

<http://www.painandchemicaldependency.org/>

Site for a series of conferences on pain and chemical dependency

**Partners for Substance Abuse Prevention**

<http://www.samhsa.gov/preventionpartners/>

A virtual meeting place for those involved in substance abuse prevention

**Partnership for a Drug-Free America**

[www.drugfreeamerica.org](http://www.drugfreeamerica.org)

The Partnership For A Drug-Free America is a non-profit coalition of professionals from the communications industry, whose mission is to help teens reject substance abuse.

**Physicians' Leadership on National Drug Policy**

[www.plndp.org](http://www.plndp.org)

Physicians organization that produced videos "Addiction and Addiction Treatment," and "Health, Addiction Treatment, and the Criminal Justice System."

**Quitnet (Stop Smoking)**

[www.quitnet.org](http://www.quitnet.org)

Information on how to quit smoking.

**Research Institute on Addiction (RIA)**

[www.ria.org](http://www.ria.org)

RIA is a research center of the University at Buffalo, The State University of New York, and a national leader in the study of alcohol and substance abuse issues.

**Robert Woods Johnson Foundation**

[www.rwjf.org/main.html](http://www.rwjf.org/main.html)

RWJF was established as a national philanthropy in 1972 and today it is the largest US foundation devoted to improving the health and health care of all Americans.

**S-Anon International Family Groups**

[www.sanon.org](http://www.sanon.org)

Self help 12 step group for people affected by someone's sex addicted behavior

**Safe and Drug Free Schools Program**

[www.ed.gov/offices/OESE/SDFS](http://www.ed.gov/offices/OESE/SDFS)

Federal government's primary vehicle for reducing drug, alcohol and tobacco use, and violence, through education and prevention activities in our nation's schools.

**San Francisco Medical Society**

[www.sfms.org](http://www.sfms.org)

The San Francisco Medical Society is a non-profit organization consisting of over 1500 physician members and fifteen staff members that advocate for the interests of San Francisco physicians and their patients in the interest of public health.

**Sex Addicts Anonymous**

[www.saa-recovery.org](http://www.saa-recovery.org)

Self help 12 Step program for sex addicts

**Sex and Love Addicts Anonymous**

[www.slaafws.org](http://www.slaafws.org)

Self help 12 step program for sex/love addicts

**Sexaholics Anonymous**

[www.sa.org](http://www.sa.org)

Self help 12 step program for sexaholics

**Sexual Compulsives Anonymous**

[www.sca-recovery.org](http://www.sca-recovery.org)

Self help 12 Step program for sex compulsives

**Smoke-Free Families**

<http://www.smokefreefamilies.org/>

A national program working to identify and disseminate evidence-based approaches to improving smoking cessation rates during pregnancy.

**The Smokers Quitline**

[www.quitnet.org](http://www.quitnet.org)

Information on how to quit smoking.

**Sober Dykes**

<http://www.soberdykes.org/index.html>

Recovery page for lesbians

**Society for Neuroscience**

[www.sfn.org](http://www.sfn.org)

World's largest organization of scientists and physicians dedicated to understanding the brain, spinal cord and peripheral nervous system.

**Society for Neuroscience Brain Briefings**

[www.sfn.org/briefings](http://www.sfn.org/briefings)

Information on neuroscience to the lay audience.

**Students Against Destructive Decisions (SADD)**

[www.saddonline.com](http://www.saddonline.com)

To provide students with the best prevention and intervention tools possible to deal with the issues of underage drinking, drunk driving, drug abuse and other destructive decisions.

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

[www.samhsa.gov](http://www.samhsa.gov)

SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

**SAMHSA FAS Prevention**

<http://prevention.samhsa.gov/faspartners/>

Fetal Alcohol Syndrome prevention materials

**SAMHSA Prevention On Line**

<http://www.samhsa.gov/centers/clearinghouse/clearinghouses.html>

SAMHSA information clearinghouses links.

**SAMHSA Prevention Pathway**

<http://www.samhsa.gov/preventionpathways/>

Information on prevention programs, program implementation, evaluation technical assistance, online courses, and a wealth of other prevention resources.



**SAMHSA Substance Abuse and Mental Health Statistics**

[www.drugabusestatistics.samhsa.gov](http://www.drugabusestatistics.samhsa.gov)

Provides the latest national data on alcohol, tobacco, and drug abuse.

**SAMHSA Substance Abuse Treatment Locator**

<http://findtreatment.samhsa.gov/>

Find the right drug abuse treatment program or alcohol abuse treatment program

**Sober Housing**

<http://www.soberhouses.com/>

A national directory of sober housing

**Substance Abuse and Mental Health Data Archive**

[www.icpsr.umich.edu/SAMHDA](http://www.icpsr.umich.edu/SAMHDA)

Access to substance abuse and mental health research data

**Treatment Alternatives for Safe Communities (TASC)**

[www.tasc-il.org](http://www.tasc-il.org)

TASC is a not-for-profit Illinois agency that specializes in social service delivery and technology.

**United Nations Office for Drug Control and Crime Prevention (UNDCP)**

<http://www.undcp.or.at/index.html>

UNDCP educates the world about the dangers of drug abuse.

**University of California, Los Angeles Integrated Substance Abuse Program (ISAP)**

<http://www.uclaisap.org/>

ISAP coordinates substance abuse research and treatment under authority of the UCLA Neuropsychiatric Institute & Hospital (NPI&H).

**Web of Addictions**

<http://www.well.com/user/woa>

The Web of Addictions is dedicated to providing accurate information about alcohol and other drug addictions.

**Wheeler Center on Neurobiology and Addiction**

[www.ucsf.edu/cnba/index.html](http://www.ucsf.edu/cnba/index.html)

The Wheeler Center for the Neurobiology of Addiction has brought together core faculty in cellular, molecular and systems neurosciences to explore and identify the neural circuits, molecular targets and biochemical actions that help drugs of abuse take command of the brain.

**White House Office of National Drug Control Policy (ONDCP)**

[www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov)

The principal purpose of ONDCP is to establish policies, priorities, and objectives for the Nation's drug control program.

**Wisconsin Clearinghouse for Prevention Resources**

[www.uhs.wisc.edu/wch/](http://www.uhs.wisc.edu/wch/)

Develops, produces and disseminates educational materials, offers prevention services, and provides information throughout Wisconsin.

**Wisconsin/Michigan State Brain Collections**

<http://www.neurophys.wisc.edu/www/neurosci.html>

Links to other Neuroscience Resource websites.

**Women in Recovery**

[www.womeninrecovery.com](http://www.womeninrecovery.com)

Home page of a residential recovery home for women

**Women for Sobriety, Inc.**

[www.womenforsobriety.org](http://www.womenforsobriety.org)

A non-profit organization dedicated to helping women overcome alcoholism and other addictions.

## INDICATORS OF CO-OCCURRING MENTAL HEALTH DISORDERS

- A history of unstable relationships, divorce, and/or cutoffs.
- A history of being underemployed or consistently unemployed in spite of talent, education, and ability, and often an inexplicable but consistent difficulty in finishing things no matter how enthusiastically started.
- Frequent changes of residence, sometimes across the country, with the hope of "starting over."
- A past with many unresolved and profound resentments about how unfairly one has been treated, a "victim" stance with a lack of accountability or responsibility for one's own actions, creating the undesired result.
- Inability to succeed at a task or goal in spite of repeated efforts and adequate information.
- A habit of resistance and questioning when an authority figure – manager, supervisor, spouse, parent, judge, police or probation officer gives directions to be followed.
- Periods of having "the blues" without an obvious medical or emotional reason.
- Self-destructive thoughts and/or actions like starving, overeating, overspending, causing meaningless but repetitive and harmful arguments with loved ones, cutting or hurting oneself, or drinking or using drug or sex to damaging excess.
- Frequent trips to emergency rooms, arrests for driving under the influence or for other drug-related charges or any ongoing pattern of painful drama in one's life is often indicative of the negative consequences of an untreated dual disorder.
- Difficulty falling asleep or staying asleep accompanied by frequent insomnia in the early morning hours.
- Fatigue and exhaustion in the morning and unwillingness to face the day.
- Troubling and seemingly unresolvable problems returning again and again to one's thoughts, as if they had a life of their own.
- Periods of euphoria, feeling powerful and capable of anything imaginable, any grand scheme, no matter how unrealistic, along with high energy and little need for sleep.
- A joylessness to life with little reason for laughter, a sense that things are just "gray" and will always be that way, no matter how hard I try, no matter what I do.
- Inability to feel genuine satisfaction with oneself and one's accomplishments despite praise or adulation from others.
- Saying things one believes are meant to be funny, but which are deeply hurtful or anger producing in others – with accompanying losses and loneliness always.
- Difficulty understanding the impact of one's behavior on others, a sense of nothing "being real."

## BARRIERS TO TREATMENT FOR WOMEN<sup>1</sup>

- Alcoholic women experience significantly higher incidents of domestic violence. "Making the Link: Domestic Violence & Alcohol and Other Drugs," Center for Substance Abuse Prevention (CSAP) (Spring 1995).
- "Dual diagnosis" (the co-occurrence of a major psychiatric disorder with drug dependency) is more prevalent in women than men (65% vs. 44%). "Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs," DHHS Pub.No.(SMA) 94-3006.
- Battered women are at increased risk of attempting suicide, abusing alcohol and other drugs, depression and abusing their own children. "Making the Link....," *supra*.
- "Cold turkey" withdrawal of a pregnant woman from depressants (alcohol, heroin, Valium, etc.) must be medically supervised to avoid miscarriage and compromising the woman's health. "Pregnant, Substance-Using Women," TIP #2 DHHS Pub.No.(SMA) 93-1988; See also: Hora & Becker, "Judicial Considerations in Sentencing Pregnant Substance Users," 35 *Judges' Journal* 3 (Spring 1996).
- At least 70% of women drug users were sexually abused by the age of 16. "Women & Drug Abuse," NIDA NIH Pub.No. 94-3732.
- More than 70% of AIDS cases among women are related to IV drug use or sex with a man who uses. "Practical Approaches..." *supra*.
- Drug treatment is the most important element in successful family maintenance or unification. Senate Office of Research, "California's Drug-Exposed Babies" (1990).
- Most publicly-funded drug treatment centers do not have child care and only 11.5% of all treatment programs provide child care. Congressional Caucus for Women's Issues, GAO, "Drug Exposed Infants: A Generation at Risk" (1990).
- Women fear loss of dependent children if they seek substance abuse treatment. "Alcohol and Women," NIAAA (Oct. 1990); "Women and Drug Abuse," NIDA, NIH Pub.No. 94-3732 (1994).
- 21.5 million women smoke; 4.5 million abuse alcohol/are alcoholic; 3.5 million misuse prescription drugs; 3.1 million use illicit drugs. National Center on Addiction and Substance Abuse, Columbia University (June 1996).
- A predominance of male patients and staff is a barrier. "Men and Women in Drug Abuse Treatment Relapse at Different Rates and for Different Reasons," 13 *NIDA Notes* (1998).
- The social stigma for women addicts is greater. *Id.*
- Women are more likely than men to complete drug treatment. Wallen, Jacqueline, Ph.D., M.S.W., "Researcher/Sex Issues," in *Drug Addiction Research and the Health of Women*, Executive Summary, Nat'l. Inst. On Drug Abuse, (NIH 98-4289) (May 1998).

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<sup>1</sup> Created by Judge Peggy Hora, Alameda County Superior Court, Hayward, CA.



## **BARRIERS TO TREATMENT FOR WOMEN WITH CHILDREN\***

- Loss of income and inability to pay for treatment
- Stigma, particularly for drug dependent mothers
- Lack of child care. Only 12.9% of publicly funded treatment facilities offer child care. When women can take their children to treatment, there is improved retention and treatment success.
- Fear of losing custody. More than half (58% in 1995) of AOD directors and CPS directors report a positive drug test was grounds for reporting a pregnant woman to a state agency compared to 12% in 1992.
- Fear of prosecution. Fewer than 1/2 (45%) of state AOD and CPS directors reported criminal prosecution of drug using women in their state compared to 71% in 1995.
- Suppression of violence including rape, incest and domestic violence can trigger relapse and is a critical issue that must be addressed in treatment. Recovery can be too painful for some women.

\*"Steps to Success. Helping Women with Alcohol and Drug Problems Move from Welfare to Work," Legal Action Center (May 1999) at 14.

# **CPS ISSUES FOR USING PARENTS<sup>1</sup>**

- Prenatal care is the #1 factor for a healthy birth outcome
- 70% of child abuse/neglect cases based on AOD abuse
- Children in alcohol-abusing families are 3.6 times more likely to be victims of maltreatment
- Children who are abused may be more likely to become AOD abusers as adults
  - #1 barrier to treatment for women is child care (11.5% programs provide child care)
  - Alcohol is present in >50% of DV cases
  - Alcoholic women experience > violence, verbal and physical
  - 1.4 million child abuse/neglect cases in '86;  
3.2 million in '97
  - 520,000 children in foster care in '98 vs. 340,000 in '88 at a cost of \$1.2 billion
- In California, 25% of foster children have been in place more than 5 years and 105,000 children are living in out-of-home care
- 80% of welfare agencies report substance abuse and poverty as their top two problems
- 3% of SAMHSA's budget goes to gender-specific programs
- Federal \$ for AOD treatment targeting pregnant/postpartum women & children is 10% that provided in 1995
- SAMHSA funding designed for women has dropped 38% since 1994
  - \$1 in treatment saves \$7 in other costs

## **CSAT study showed after treatment:**

2/3 women not using AOD, 86% children with mother,  
<10% involved with criminal justice system

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<sup>1</sup> Prepared by Judge Peggy Hora, Alameda County Superior Court, Hayward, California.

# A CHECK LIST FOR COUNTY OFFICIALS TO ASSESS JAIL CONDITIONS FOR WOMEN

## DEVELOPED BY:

Judge Peggy Hora  
Municipal Court of California  
County of Alameda

## ASSOCIATION WITH CEWAER:

Assemblywoman Dede Alpert  
CEWAER President

Dr. Karpiw, Ph.D.  
CEWAER Executive Director

April 1995

Public policy paper from the  
non-profit corporation  
California Elected Women's  
Association for Education  
and Research

## Overview

The prison and jail population in this state has exploded in recent years, and with that comes problems of overcrowding, understaffing and a lack of understanding of the needs of the new generation of prisoners. Prison and jail officials are just beginning to recognize the distinct needs of female inmates and how they differ from those of their male counterparts.

This issue was a topic of considerable debate at the 1994 Supervisors' Retreat sponsored by CEWAER, the California Elected Women's Association for Education and Research. Discussion began as an offshoot of the supervisors' review of the just-released CEWAER policy paper, *Women and Substance Abuse*, co-authored by Municipal Court Judge Peggy Hora and Laurie Drabble, Executive Director of the California Women's Commission on Alcohol and Drug Dependencies. This policy paper underscored the need for adequate substance abuse prevention and treatment options for women, who are sometimes inappropriately treated or underserved.

Concern for how substance-abusing women, including substance-abusing pregnant and parenting women, are treated expanded to an analysis of how all women are treated in jail. The supervisors determined that, in most counties, no rigorous evaluation had ever been conducted to ensure that county jails provide basic health and safety conditions for incarcerated women.

As a result of this discussion, Judge Peggy Hora developed the following check list to assist county officials in analyzing jail conditions for women, including substance-abusing and pregnant and parenting women.

This check list can be used to guide an informal discussion or evaluation with jail officials or it can be used to structure a public hearing and organize staff and public testimony. Whatever approach you decide to take, CEWAER hopes this public policy tool will help ensure that basic health and safety conditions are provided in your county jail.



# DOES YOUR COUNTY PROVIDE ADEQUATE JAIL CONDITIONS FOR WOMEN?

## CONSIDER THE FOLLOWING:

### PREGNANCY

- ☐ What prenatal care is available to pregnant women in your county jail?
- ☐ Are pregnant women housed on the bottom bunk?
- ☐ What exercise is available for pregnant women?
- ☐ Are extra fluids, sufficient time to eat and dietary supplements (such as those available through WIC — the Women, Infants and Children Nutrition Program) offered to pregnant, incarcerated women?
- ☐ What are the conditions, including necessary transportation, for OB/GYN visits, childbirth and delivery? Are there special considerations for "high risk" pregnancies?
- ☐ Are pregnant women or women in delivery handcuffed, shackled or hobbled?
- ☐ What is your county's in-custody miscarriage rate; and how does it compare to the general population, locally and statewide?
- ☐ Is immediate, reliable pregnancy testing and abortion information available at intake?
- ☐ Does your county post information regarding inmates' abortion rights as required by Penal Code Section 3406?

### PARENTING

- ☐ How is "bonding" between infant and parent accomplished after an inmate delivers?
- ☐ Are there contact visits, parenting classes and/or a Teaching and Loving Kids (TALK) program for parents and children?
- ☐ Are parents provided information about their children, including Child Protective Services (CPS) status, when they are incarcerated? Is there a cooperative agreement between the jail and CPS to gather this information?
- ☐ Do parents have access to their children's foster parents by phone?
- ☐ What provisions are made for parents to attend juvenile court proceedings affecting their children?

### ALCOHOL AND OTHER DRUG ISSUES

- ☐ What are the provisions for medically supervised drug withdrawal or methadone maintenance for inmates, including pregnant women?
- ☐ Is there in-custody alcohol or other drug treatment (such as Deciding, Educating, Understanding, Counseling and Education — DEUCE) available for women?

Is there transitional or "half way" housing available to women who wish drug treatment?

Are 12-Step programs (such as Alcoholics Anonymous, Narcotics Anonymous, Adult Children of Alcoholics and/or Al-Anon) available at least three times a week?

## OTHER HEALTH/SAFETY ISSUES

Is confidential and/or anonymous HIV testing available to inmates?

Is comprehensive education on HIV available that specifically addresses prevention information for women?

Is transportation provided to women who are released from custody after dark?

Is extra clothing furnished to women during their menstrual periods?

## EDUCATION

Are skills or job training programs equally available to women and men? Is training in "non-traditional" jobs encouraged?

Are literacy or English as a Second Language (ESL) classes available?

Are GED classes available?

## OTHER

Are alternatives to incarceration programs (such as work furlough, work in lieu of confinement or weekend work) equally available to women and men?

Are judges, defense lawyers and prosecutors aware of the programs available to women that are alternatives to incarceration?

## ABOUT THE AUTHORS

Judge Peggy Hora was elected to the Municipal Court of Alameda County in 1984. She has served as that court's presiding judge and as president of California-Nevada Women Judges. Judge Hora has studied and lectured extensively on alcohol and other drug abuse and the courts, emphasizing the special needs of women offenders and perinatal substance abuse.

## ABOUT CEWAER

CEWAER is a non-profit, non-partisan association that provides public policy research, skills training, educational workshops and networking opportunities for women leaders. Founded in 1974, CEWAER is the oldest and largest association of its kind in the nation. Our membership includes elected women serving at all levels of government. The association also values its members in the corporate, business and academic communities.

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## **Mental Health Webliography**

Prepared by Hon. Peggy Fulton Hora, Alameda County Superior Court, Hayward, CA

### **American Academy of Child and Adolescent Psychiatry**

[www.aacap.org](http://www.aacap.org)

A public service offering information about developmental, behavioral, and mental disorders which affect children and adolescents.

### **American Psychiatric Association**

[www.psych.org](http://www.psych.org)

Home page of the American Psychiatric Association, a medical society specializing in the diagnosis and treatment of mental and emotional illnesses and substance abuse disorders.

### **American Psychological Association**

<http://helping.apa.org>

A comprehensive help center designed to help psychologists, students, and the general public access mental health information and services.

### **Anxiety Disorders Association of America**

[www.adaa.org](http://www.adaa.org)

Home page of the Anxiety Disorders Association of America, a non-profit organization that promotes the prevention and cure of anxiety disorders.

### **Centre for Addiction and Mental Health**

[www.camh.net](http://www.camh.net)

The Centre for Addiction and Mental Health is a public hospital providing direct patient care for people with mental health and addiction problems.

### **Consumer Organization and Networking Technical Assistance Center**

[www.contac.org](http://www.contac.org)

A national technical assistance center which serves as a resource center promoting self-help, recovery, and empowerment.

### **Depression and Related Affective Disorders Association (DRADA)**

[www.med.jhu.edu/drada/index.html](http://www.med.jhu.edu/drada/index.html)

A web site offering information on depressive illness and manic-depressive illness.

**Dual Diagnosis Website**

<http://users.erols.com/ksciacca/>

This site is designed to provide information and resources for service providers, consumers, and family members who are seeking assistance and/or education in the field of dual diagnosis.

**Freedom From Fear (Anxiety disorders)**

[www.freedomfromfear.org](http://www.freedomfromfear.org)

A national not-for-profit mental health association offering aid and counsel to those who suffer from anxiety and depressive illness.

**Internet Mental Health Diagnosis**

[www.mentalhealth.com/fr.71.html](http://www.mentalhealth.com/fr.71.html)

Online diagnosis of the 37 most common mental disorders.

**Mental Health Infosource**

[www.mhsource.com](http://www.mhsource.com)

Home page of Mental Health Infosource, offering information and educational resources for primary care and mental health professionals.

**Mental Help Net**

[www.mentalhelp.net](http://www.mentalhelp.net)

Home page of Mental Help Net, a non-profit company offering a comprehensive source of online mental health information, news, and resources.

**National Alliance for the Mentally Ill**

[www.nami.org](http://www.nami.org)

A grassroots organization of consumers, families, and friends of people with severe mental illnesses.

**National Empowerment Center, Inc.**

[www.power2u.org](http://www.power2u.org)

This web site is filled with practical information for those who have been labeled with a mental illness.

**National Mental Health Association**

[www.nmha.org](http://www.nmha.org)

Home page of the National Mental Health Association, a nonprofit organization addressing all aspects of mental health and mental illness.

**National Mental Health Consumers' Self-Help Clearinghouse**

[www.mhselfhelp.org](http://www.mhselfhelp.org)

A consumer-run national technical assistance center serving the mental health consumer movement.

**National Mental Health Services Knowledge Exchange Network (KEN)**

[www.mentalhealth.org](http://www.mentalhealth.org)

The Center for Mental Health Services (CMHS) Knowledge Exchange Network (KEN) provides information about mental health.

**Obsessive Compulsive Foundation**

<http://ocfoundation.org/>

Home page of the Obsessive-Compulsive Foundation, a not-for-profit organization of people with obsessive compulsive disorders and related disorders.

**Practitioner Resources in Substance Abuse & Co-Occurring Disorders**

[www.athealth.com/Practitioner/](http://www.athealth.com/Practitioner/)

Provides information and services for mental health practitioners and those they serve

**Schizophrenia Wellness Center**

[http://www.medscape.com/pages/editorial/resourcecenters/public/schizophrenia/r  
c-schizophrenia.ov](http://www.medscape.com/pages/editorial/resourcecenters/public/schizophrenia/rc-schizophrenia.ov)

The latest psychiatric and medical news on Schizophrenia

# **Treatment Protocol Effectiveness Study: Summary of Treatment Modalities**

## **TREATMENT MODALITIES**

### **1. Therapeutic Communities (TC)**

Therapeutic communities (TCs) are intensive, long-term, residential treatment facilities. They attempt to provide an environment that allows clients to develop both socially and psychologically through a combination of personal counseling and life skills courses. As clients progress through the program they are given more responsibilities as well as more freedom, the ultimate goal being complete self-sufficiency and a drug free lifestyle. TCs are recommended for hardcore drug users who have failed other forms of drug abuse treatment.

### **2. Pharmacological Treatment**

Pharmacological treatment is typically a long-term treatment in which the addict is maintained with medications. Dependencies are treated with medication that either replaces the illicit drug or blocks its actions. **Methadone**, for example, is an effective substitute for heroin, morphine, codeine, and other opiate derivatives. It does not produce euphoria or sedation, but it does effectively suppress the withdrawal symptoms such as agitation, sleep disturbance and mild depression. **Naltrexone** blocks the effects of opioids such as heroin and is also effective with alcohol. It is more effective among highly motivated patients who have greater social supports.

Other pharmacological treatments include **Buprenorphine**, which is designed to reduce craving, enhance treatment retention, and block the effect of illicit opioids, and **LAAM** (a long-acting opiod maintenance compound), which also suppresses withdrawal symptoms and requires weekly, rather than daily maintenance are showing increasing popularity and significant success rates.

### **3. Outpatient Drug Free Treatment**

Outpatient drug free treatment includes a range of protocols, from highly professional psychotherapy to informal peer discussions. Counseling services vary considerably and include individual, group, or family counseling, peer group support; vocational therapy; marital therapy; and cognitive therapy. The ideal goal of outpatient drug free treatment is abstinence from drug use, but reduced drug use is commonly viewed as more realistic.

### **4. Inpatient Treatment**

Inpatient treatment refers to the treatment of drug dependence in a hospital and includes medical supervision of detoxification. The primary goal of inpatient drug-free treatment is to help the patient achieve and maintain a drug-free lifestyle. There are various inpatient treatment programs that are proven to have encouraging success rates, including therapy based programs, 12-step programs, and multimodality programs. Finding the right programs for the client's individual circumstances is critical for the long-term effectiveness.

# **Treatment Protocol Effectiveness Study:**

## **Summary of Treatment Modalities**

**Therapy based programs** tend to serve older or middle-class patients rather than adolescents whose drug use has not yet developed or patients who have a specific psychiatric problem in addition to drug use. These psychiatric programs typically require a 4 to 12 week stay. It usually begins with detoxification and is followed by a variety of services including individual, group, and family therapy, education, and training in behavioral techniques such as relaxation and exercise.

**Twelve-step programs** are based on a model of total abstinence. Patients work on at least the first four steps of the AA model while in the treatment program, with progression through the remaining eight steps expected through subsequent involvement with AA or NA. Twelve-step treatment is reportedly more effective for middle-age participants than for those in other age groups.

**Multimodality programs** offer a variety of services including inpatient treatment, medical care, outpatient brief treatment, vocational training, educational enhancement for adolescents, family therapy, adult or adolescent TCs, methadone maintenance, group psychotherapy, individual psychotherapy, drug education, and stress-coping techniques. In-patient treatment is generally required at some point in the multimodal treatment process, and because few programs provide childcare services, foster care may be the only option for who require inpatient treatment. Many women avoid treatment for fear they will be unable to regain custody of their children after completing treatment. Pregnant women may risk criminal charges for drug use during pregnancy and also often refrain from seeking treatment

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Treatment Protocol Effectiveness Study, Executive Office of the President, Office of National Drug Control Policy, Barry R. McCaffrey, Director, March 1996.  
<http://www.whitehousedrugpolicy.gov/treat/trmtprot.html>



## JUDICIAL EDUCATION ON SUBSTANCE ABUSE

### BENCH CONSIDERATIONS\*

*The following is a list of issues that judges may want to consider related to parties. (These are some lifestyle traits that may show an inclination toward addiction and may give the judge clues about underlying substance abuse issues.)*

#### A. Introduction/Background

1. What grade did the litigant complete in school?
2. Is the litigant currently employed? When was he/she last employed?
3. Does the litigant own or rent a home? If not, with whom does he/she live?
4. Does the litigant have children? If yes, do they live with the litigant? If no, with whom do they live? Does the litigant have custody?
5. How old are the children? If they are school age, do they attend school?
6. Are his/her children involved with child protective services or the juvenile court system in any way?
7. Does the litigant have any significant debts/owe people money?

#### B. Substance Abuse

1. Has the litigant, his/her significant other, or child(ren) used alcohol or drugs (including marijuana) during the past six months?
2. Has the litigant, significant other, or child(ren) been treated in an inpatient, outpatient, or other counseling program during the past six months?
3. If yes, is the litigant, significant other, or child(ren) suffering from an addiction to drugs or alcohol?
4. If the litigant has not been involved in treatment, would he/she be amenable to or like a referral to a treatment program?
5. Is the litigant taking any known medications presently?

\* This list of considerations was developed by the National Center for State Courts under a grant from the State Justice Institute (SJI-01-N-210). The points of view expressed do not necessarily represent the official position or policies of the National Center for State Courts, the American Judges Association, or the State Justice Institute.

# Judging for the New Millennium

William Schma

Quickly complete this sentence: "The role of the law in society is \_\_\_\_\_." If you might "to heal," close this journal and go to your next. You won't find much of what you haven't thought about. Anyone else, read on to explore an emerging role for courts and judges in the new millennium. The topic of this special issue of *Court Review* is "Therapeutic Jurisprudence," or TJ, as it is commonly known. No definition of TJ captures it fully. The author offers the following definition as best capturing the essence of TJ: "the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects."<sup>1</sup> It is a study of the role of law as a healing agent, and it offers fresh insights into the role of law in society and those who practice it.

TJ can be thought of as a "lens" through which to view regulations and actions as well as the roles and behavior of all actors—legislators, lawyers, judges, administrators. It may be used to identify the potential effects of proposed legal arrangements on therapeutic outcomes. It is useful to inform and shape policies and procedures in the law and the legal process. TJ posits that, when appropriate, the law apply an ethic of care to those affected.

TJ does not "trump" other considerations or override important societal values such as due process or the freedoms of speech and press. It suggests, rather, that mental and physical health aspects of law should be examined to inform us of potential success in achieving proposed goals. It proposes to consider visible negative psychological effects of a proposal may cause unwittingly. It doesn't necessarily dominate, but

rather informs and in so doing provides insight and effective results. Such considerations enter into the mix to balance when considering a law, or a legal decision, or course of legal action.

It is important for judges to practice TJ because—like it or not—the law does have therapeutic and anti-therapeutic consequences. This is empirical fact. Consider the following situations; they are familiar to judges.

In busy dockets, it is common for judges to accept "no contest" or *nolo contendere* pleas in sex offense cases in lieu of a guilty plea. TJ will not dictate whether a judge should do this or not. It will, rather, ask the judge to consider the therapeutic effects that may follow as a consequence of such a plea. They may be considerable, because in the case of sex offenders a *nolo* plea may reinforce a process of denial that will frustrate the offender's rehabilitation. If the offender does not have to admit the crime to the judge, he or she may more easily deny it later to a probation officer or sex abuse counselor. Anti-therapeutic consequences such as frustration of rehabilitation and return to abusive behavior may result from the judge's acceptance of the plea. Ironically, this process would be started by the judge—the very person society most expects to promote the rule of law.

The same may be said of criminal cases involving an addiction to alcohol or other drugs. The biggest hurdle that an addict or alcoholic usually must overcome is denial. It is difficult to admit affliction with an uncontrollable disease, especially one to which our society has attached moral overtones. Nevertheless, those experienced with recovery know that this admission is critical. If, for whatever reason, a judge accepts a *nolo* plea in such a case and does not require

the defendant to confront his or her addiction openly, the judge misses a critical "therapeutic moment." Moreover, as in the case with sex offenders, the judge may have set in motion a course of denial that will virtually guarantee the failure of subsequent rehabilitation efforts and the eventual return of the offender to the system.

Consider this final example: the role of apology in tort law. Practitioners familiar with medical malpractice cases know that many plaintiffs only want an apology from their health care provider for the adverse outcome they experienced. A lawsuit is the furthest action on their mind. And for negligent care providers, an apology for a regrettable mistake would be a therapeutic event. Unfortunately, some professional insurance practices prohibit an insured from having any contact with a patient who may file a claim. There is a good reason for this from the standpoint of the insured and the insurer: a non-privileged admission could end up in court as a *coup de grace*. The anti-therapeutic result, however, can be that the patient is deprived of what the patient may want most, and the health care provider cannot take necessary steps to cleanse his or her mind and return to productive work. Moreover, because the provider is forced by the law into a position of denial, the likelihood of reoccurrence increases.

TJ first identifies these anti-therapeutic elements that might otherwise go unexplored. Next, it asks whether an action could be taken to avoid them without "trumping" the established legal principles involved. It proposes such action and methods to evaluate it. TJ is, therefore, not merely a speculative exercise, but rather action-oriented. It seeks tangible results.

Permit me to describe some personal

**Footnotes**  
Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCHOL., PUB. POL. AND LAW 193, 196 (1995).

experience I have had in each of these areas to demonstrate how TJ applies. For more than five years I have refused to routinely accept *nolo* pleas in felony sexual abuse cases. Once my practice became known among local lawyers, no defendant has refused to go forward with a guilty plea. The attorneys prepare their clients for this in advance if they are in my court. (This suggests, of course, the significant role lawyers play to prepare clients for therapeutic or anti-therapeutic court experiences, but that is a separate topic I leave for another day.) Moreover, since then I have never had a sexual abuser appear at sentence and deny to me that he or she committed the crime. Nor have I received a single letter from a family member denying that the defendant was capable of such an act. These were routine when I accepted *nolo* pleas. As a result, at sentencing, I can confront defendants much more effectively with the reality of their behavior and the wrongfulness of their conduct. This result is also more therapeutic for victims of such crimes.

Beginning in 1992, I presided over a drug treatment court in my community. A drug court diverts certain non-violent, substance-abusing criminal defendants from the traditional adversarial criminal justice system into treatment and rehabilitation. Since then, more than 800 adult felony offenders addicted to alcohol or other drugs have been enrolled in this program. Fifty-five percent of women and 64% of men remain engaged in their recovery while they are in the program. The recidivism rate of participants is less than 15%. For graduates, it is less than 2%. This drug court and more than 400 others across the country apply TJ principles to criminal justice.

Recently in my court, I have experimented in medical malpractice cases

with what I call "good faith conferences." As part of the settlement of two cases, one involving a death, a meeting was held between the interested parties, including the plaintiff or the family of the deceased and the physician-defendant. Attorneys were present at both conferences. One was held in my presence; the other occurred in the office of a neutral, experienced personal injury attorney. All participants agreed that anything said could not be used for any purpose. During these conferences, each side was permitted to speak about the feelings they had experienced because of the perceived malpractice and the lawsuit. The physicians explained why they had done what they had believed to have been medically appropriate in the circumstance, yet apologized to the family or plaintiff. Patients and their families expressed frustration and anger over everything from the physician's attitude to the care administered. The results have been mixed. However, the attorneys involved—all experienced in medical malpractice—and I agree that this method of dispute resolution meets significant litigant needs and is worth further refinement. But for the Therapeutic Jurisprudence movement, this project may never have occurred.

These are not radical concepts; they are mainstream. They do give a fresh perspective on honored principles of the legal profession. Abraham Lincoln advised lawyers (and presumably judges): "Discourage litigation. Persuade your neighbor to compromise wherever you can. . . . As a peace-maker, the lawyer has a superior opportunity of being a good man."<sup>2</sup> Roscoe Pound spoke of "sociological jurisprudence," arguing that law must look to the relationship between itself and the social effects it creates.<sup>3</sup> Oliver Wendell Holmes

said "the life of the law has not logic; it has been experience," and noted that the practical necessities, times have always shaped the rules and the legal practices of a given age.

At a presentation to the annual meeting of the National Association for Court Management in 1996, the need to become "more therapeutic" in our courts was described as one of the top issues facing the courts in the future. In 1996, in a cover story in the *American Bar Association Journal* entitled, "Lawyer Turns Peacemaker," the author noted public dissatisfaction with the justice system and argued for the need to apply a more therapeutic approach to litigation so that the parties' feelings of anger, resentment, or rejection would give way to a healing process.<sup>6</sup>

Recently, David Rottman and Pamela Casey, staff members of the National Center for State Courts and frequent authors on this topic, observed that courts are moving towards a "problem-solving" orientation to their responsibilities and forming problem-solving partnerships to address more effectively complex social problems that have come to dominate their dockets in recent years.<sup>7</sup> The Commission on Trial Court Performance Standards also raised the level of court consciousness on these matters through its Trial Court Performance Standards. Standard 3.1 states: "The trial court takes appropriate responsibility for the enforcement of its orders. No court should be unaware or unresponsive to realities that cause orders to be ignored."<sup>8</sup> And Standard 4.5 states:

The trial court anticipates new conditions and emergent events and adjusts its operations as necessary. Effective trial courts are responsive to emergent public

2. Abraham Lincoln, in *QUOTE IT! MEMORABLE LEGAL QUOTATIONS*, 429-430 (Eugene Gerhart, ed. 1987).
3. Roscoe Pound, *The Scope and Purpose of Sociological Jurisprudence*, 25 *HARV. L. REV.* 140 (1912).
4. Oliver Wendell Holmes, in *THE SOCIOLOGY OF LAW* 4 (James Simon, ed. 1968).
5. Francis Gavin and James Thomas, *The Top Ten Issues Facing State Courts in 1996 and What You Can Do About Them*, Workshop at Eleventh Annual Conference, National Association for Court Management, Albuquerque, New Mexico, July 18, 1996.
6. Richard Reuben, *The Lawyer Turns Peacemaker*, 82 *A.B.A. J.*,

August 1996 at 54.

7. David Rottman & Pamela Casey, *A New Role for Courts?*, *INST. JUST. J.*, July 1999 at 12.
8. *TRIAL COURT PERFORMANCE STANDARDS WITH COMMENTARY* (Bureau of Justice Assistance, 1997). For more information on the Trial Court Performance Standards, see Pamela Casey, *Dealing with the Optimal Court Performance: The Trial Court Performance Standards*, *COURT REVIEW*, Winter 1998 at 24 [available on the Web at <http://aja.ncsc.dni.us/courtrev/cr35-4/CR35-4Casey.pdf> (visited March 26, 2000)].

ues such as drug abuse, child spousal abuse, AIDS, drunken driving, child support enforcement, crime and public safety, consumer rights, gender bias, and the more efficient use of fewer resources. A trial court that moves liberately in response to emergent issues is a stabilizing force in society and acts consistently with the role of maintaining the rule of law.<sup>9</sup>

There is already significant judicial leadership in this movement. Judith S. Chief Judge of New York, wrote recently about the emergence of what she called "hands-on courts." She made several useful observations:

In these new courts, judges are active participants in a problem-solving process. . . . What's so different about this approach? First is the court's belief that we can and should play a role in trying to solve the problems that are piling our caseloads. Second is the belief that outcomes—not just process and precedents—matter.<sup>10</sup>

In a speech at the Holocaust Museum in 1997, Justice Richard J. Goldstone of the Constitutional Court in South Africa described this same role this way: "One of the tasks of justice in the context of deterrence, of retribution. But too infrequently, justice looked at as a form of heal-

ing."<sup>11</sup> That healing role is at the heart of TJ, as noted by Michael D. Zimmerman, a member of the Utah Supreme Court and its former chief justice.<sup>12</sup> He called for "involved judging" in which "judges and courts assume a stronger administrative, protective, or rehabilitative role toward those appearing before them, that they become more involved in what some have termed 'therapeutic jurisprudence.'"<sup>13</sup> He recognized that this was a "new cultural reality" for most judges.<sup>14</sup> Yet he pointed out that it will not go away, and, unless we craft our own response, it will be thrust upon us by society.<sup>15</sup>

TJ acknowledges that the healing roots of the legal profession can be in tension with our highly developed adversarial system and with our emphasis on process. As David Wexler, co-founder with Bruce Winick of the school of TJ, has pointed out, the adversarial nature of our system has legitimate and crucial value for critical thinking. However, the legal system suffers from a culture of adversarial representation and relationships, in which argument rises to the level of a privileged status.<sup>16</sup> This can obscure many important societal values that the legal system need not and should not ignore, such as outcome, social harmony, and the ethic of care. TJ is receiving attention precisely because it requires that we recognize such values, balance them with others, and make choices. Practitioners are discovering

that TJ strikes a resonant chord in the legal system and community for beneficial and sensible outcomes of problems that come to light in legal trappings.

Judges must take the lead and assume appropriate responsibility for these issues. If we do not, as Justice Zimmerman observed, they may be resolved without us.<sup>17</sup> More important, we will have failed in our responsibility as leaders. We will reap the resulting public disaffection with us and the system we supervise. We'll deserve it.



William G. Schma was appointed as a Kalamazoo County (Mich.) Circuit Court Judge in 1987. He was elected in 1988 and re-elected in 1990 and 1996. He has lectured, published articles and

law reviews, and made presentations on substance abuse and criminal justice, drug treatment courts, and Therapeutic Jurisprudence. Judge Schma has presided over the Kalamazoo County Substance Abuse Diversion Program, a diversion program for felony substance abusers. He is a founding member of the National Association of Drug Court Professionals, and he is past president of the Michigan Association of Drug Court Professionals.

FEDERAL COURT PERFORMANCE STANDARDS WITH COMMENTARY, *supra* note 8, at 20.

Judith S. Kaye, *Making the Case for Hands On Courts*, NEWSWEEK, Oct. 11, 1999, at 13 [available on the Web at [http://www.newsweek.com/nw-srv/printed/us/dept/my/my0115\\_1.htm](http://www.newsweek.com/nw-srv/printed/us/dept/my/my0115_1.htm) (last visited March 26, 2000)].

Richard Goldstone, speech given at the Holocaust Museum, Washington, D.C. (Jan. 27, 1997).

Michael Zimmerman, *A New Approach to Court Reform*, 82

JUDICATURE 108 (1998).

13. *Id.* at 109.

14. *Id.* at 109-10.

15. *Id.* at 110.

16. David Wexler, *Therapeutic Jurisprudence and the Culture of Critique*, 10 J. CONTEMP LEGAL ISSUES 263 (1999).

17. Zimmerman, *supra* note 12, at 110 ("We can choose to be the agents of innovation, or the subjects of innovation.").

## Court Review thanks

- David Rottman for assisting with the editing chores for this special issue
- David Wexler and Bruce Winick for helping to identify potential authors for this issue and otherwise lending their encouragement
- Lynn Grimes for helping coordinate all of the people and paper involved in this issue

# The Implications of Therapeutic Jurisprudence for Judicial Satisfaction

Deborah J. Chase and Peggy Fulton Hora

## "Drug court judges get to color outside the lines."<sup>1</sup>

Therapeutic jurisprudence has been posited as the jurisprudential underpinning of the burgeoning drug treatment court movement and drug treatment courts as therapeutic jurisprudence in action.<sup>2</sup> Therapeutic jurisprudence is the study of the extent to which substantive rules, legal procedures, the roles of lawyers and judges produce therapeutic or therapeutic consequences for individuals involved in the legal process.<sup>3</sup>

Drug treatment courts are an alternative to traditional case processing in which judges supervise the treatment and recovery of alcoholics/addicts and where the adversarial system is out of place. Drug treatment courts use a team approach among the judge, prosecutor, defense counsel, treatment provider, probation officer, drug treatment court coordinator, and community policing officer where the "focus is on the participant's recovery and law-abiding behavior—not on the merits of the pending case."<sup>4</sup> If, however, a drug treatment court participant is not able to comply with the rigors of the drug treatment court program, that individual is returned to the traditional criminal justice system for further processing of his or her case. Drug treatment courts can be either pre- or post-plea and, thus, either court may impose sentence, including jail or prison time, or try the case if there is a program failure.

By shifting the main focus in selected alcohol and other drug cases from legal to therapeutic concerns, the roles of the drug treatment court professionals shift as well. This does not mean that legal concerns, such as due process, are trumped by therapeutic ones. Rather, it means that the therapeutic value of non-adversarial case processing—where the focus is on treatment and recovery—is recognized and utilized. This shift in role appears to benefit staff as well as litigants. Specifically, judges

who work therapeutically seem to experience increased job satisfaction.

For the prosecution, police, and probation, the focus shifts from arrest and conviction to treatment and recovery. Underlying this shift in focus is the belief that it will result in a reduction of criminal behavior, a savings in incarceration costs, and both tangible and intangible benefits to the community, the individual, and the individual's family.<sup>5</sup> The defense attorney, after analyzing the legal issues and clarifying all options for the client, shifts focus from minimizing a client's exposure to criminal sanctions to ensuring that the addicted client stays in treatment and recovery.<sup>6</sup> Police officers who are involved in drug treatment courts through community policing efforts see their role change from a "You call, we haul, that's all" role in drug cases to more of a community monitoring and direct participant encouragement role. Many drug treatment court participants have asked that their arresting officer be present at their graduation and they credit the officer with literally saving their lives.

Finally, the judge goes from being a detached, neutral arbiter to the central figure in the team, which is focused on the participants' sobriety and accountability. Sanctions for program failures are not primarily for punishment; rather, sanctions are tools for program compliance to enhance treatment and recovery. Sanctions provide the external structure needed until participants can develop their own internal structure to be able to maintain sobriety. The judge's personal knowledge of a participant's background, reasons for use, living situation, physical and mental health, family, employment, parenting skills, and other matters is unequalled in the criminal system. The judge is both a cheerleader and stern parent, encouraging and rewarding compliance, as well as attending to lapses. Through weekly, fortnightly, then monthly mandatory court appearances, the judge sees the incredible changes a participant makes. The judge watches as the participant gets a GED, gains employment, recovers children from Child Protective Services, gets off wel-

### Footnotes

- Remark overheard at a national drug court conference.  
Peggy Fulton Hora & William G. Schma, *Therapeutic Jurisprudence*, 82 JUDICATURE 9 (1998); and Peggy Fulton Hora et al., *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime*, 74 NOTRE DAME L. REV. 439 (1999).  
See David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and*

Research, 45 U. MIAMI L. REV. 979 (1991).

4. DRUG COURTS PROGRAM OFFICE, U.S. DEP'T OF JUSTICE, *DEFINING DRUG COURTS: THE KEY COMPONENTS* 6 (1997).
5. DRUG STRATEGIES, *CUTTING CRIME: DRUG COURTS IN ACTION* (1997); See generally, Steven Belenko, *Research on Drug Courts: A Critical Review*, 1 NAT'L DRUG CT. INST. REV. 1 (1998).
6. See Videotape: *Drug Treatment Courts: The Defense Perspective* (The Rutter Group, 1994), in which Michael Judge, Public Defender of Los Angeles, explains the defense role.

fare, kicks out an abusive boyfriend, gains independence and confidence, and, finally, graduates from the program.

The judge cannot help but be changed by this process. Consequently, the hypothesis for this article stemmed from two judges known to the judicial co-author, who discovered their own alcoholism after becoming drug treatment court judges. She also noticed her own attitudes, job satisfaction, and happiness in court being affected by her assignment as a drug treatment court judge. Personal observation makes it clear that the drug treatment court not only can have a therapeutic effect on the recovering participant but also on the other criminal justice players in the courtroom as well.

## THE JUDICIARY

The positive effect of a particular judicial assignment on the judge is not a topic that has received much research attention. In a 1980 study of American trial judges, the perception of their work environment was not found to be related to whether they were sitting on specialized calendars or master calendars.<sup>7</sup> However, in a 1981 survey, judges complained of job stress arising from lack of control over what type of cases they were given.<sup>8</sup> In another 1982 study, 422 juvenile court judges in West Germany were surveyed to assess their attitudes toward social assistance and the administration of justice. The highest job satisfaction was found in the judges who endorsed and practiced with a social science and educational orientation in their work, interacted well with service providers, approved of specialized judicial training, and were involved in community work outside the court.<sup>9</sup> In the 1980 study of American judges, it was found that judges who work long hours, are involved in community relations, and are involved in bar activities are more likely to be satisfied with their environment.<sup>10</sup>

Job stress is the more common focus of research on judicial satisfaction.<sup>11</sup> Job stress in judges is commonly associated with social isolation,<sup>12</sup> feeling disliked by others, lack of interest and understanding, and not feeling appreciated.<sup>13</sup> They also suffer from lack of feedback, a heavy caseload volume, and lack of control over what cases they get.<sup>14</sup> Additionally, frustration with their lack of ability to be helpful to litigants seems to contribute to judicial stress.

Judges express dismay when, due to large caseloads, they have to "process" people, because they have so little time to listen. In such circumstances, there can be a tendency for them

to withdraw empathy and respect for the litigants.<sup>15</sup> The sense of judicial stress is frequently observed in family law judges, for example. Judicial officers in family law see experience high stress, frustration, feelings of helplessness, and burnout.<sup>16</sup>

In contrast, however, many of the factors related to job stress are not as commonly observed in drug treatment court judges. It is proposed that the therapeutic effects of drug treatment courts carry over to the judicial officers and other court workers in increased job satisfaction and possibly overall mental health. Drug treatment court judges and others have stopped smoking, stopped drinking alcohol, realized their own alcoholism, gone on diets, and exercised more. Many expressed a sense of pride in a job well done and a brighter outlook since taking the drug treatment court assignment. Feelings had not heretofore been experienced in their previous careers.

Family law court judicial officers work with a court process that is quite different from that of the drug treatment court. Although originally conceptualized to be therapeutic orientation,<sup>17</sup> family law courts, due to increased caseloads, fragmentation of issues, have not broadly employed therapeutic principles.<sup>18</sup> The National Center for State Courts has estimated that family law is the largest and fastest growing segment of state courts' civil caseloads.<sup>19</sup> Legal issues related to family law enter the court system in many different ways. Cases of child abuse and/or neglect are heard in criminal court and/or juvenile dependency court. Juvenile delinquency matters are heard in the juvenile court. Cases concerning the guardianship of children are heard in probate court. Divorce, paternity, and delinquent attorney child support cases may be heard in family court. Requests for civil domestic violence restraining orders may be heard in civil domestic violence courts. If there have been criminal charges, those cases are heard in criminal court. As there is movement toward court reform for family law, to date only eleven states have implemented unified family law systems to address these issues.<sup>20</sup>

California has not implemented a therapeutic unified family law system. Cases related to families are still fragmented among multiple departments in the overwhelming majority of California counties. According to California Superior Court Judge Donna Petre, "Each of these departments has no knowledge of the decisions of the other, even if the deci-

7. JOHN PAUL RYAN, ET AL., AMERICAN TRIAL JUDGES 160 (1980).

8. Issiah M. Zimmerman, *Stress-What It Does to Judges and How It Can Be Lessened*, JUDGES J., Summer, 1981, at 4.

9. R. Pommerening, *Self-Image of German Juvenile Judges*, 65 MONATSSCHRIFT FÜR KUNSTLOGIE UND STRAFRECHTSREFORM 193 (1982).

10. RYAN, ET AL., *supra* note 7.

11. Pommerening, *supra* note 9; Tracy Eells & Robert C. Showalter, *Work Related Stress in American Judges*, 22 BULL. OF AM. ACAD. OF PSYCHIATRY & L. 71 (1994); Joy Rogers, et al., *The Occupational Stress of Judges*, 36 CANADIAN J. OF PSYCHIATRY 317 (1991).

12. Eells & Showalter, *supra* note 11; Rogers et al., *supra* note 11. See also Issiah M. Zimmerman, *Isolation in the Judicial Career*, COURT REVIEW, Winter 2000 at 4.

13. Eells & Showalter, *supra* note 11.

14. Zimmerman, *supra* note 8.

15. Zimmerman, *supra* note 8.

16. Jeffrey A. Kuhn, *A Seven-Year Lesson on Unified Family Courts: What We Have Learned Since the 1990 National Family Law Symposium*, 32 FAM. L.Q. 67, 75-93 (1998).

17. Herma Hill Kay, *A Family Court: The California Proposal*, 56 CALIF. L. REV. 1205, 1205-1248 (1968).

18. Barbara A. Babb, *America's Family Law Adjudicatory Systems*, 32 FAM. L.Q. 31, 37-50 (1998); Catherine Ross, *The Failure of Fragmentation: The Promise of a System of Unified Family Law*, 32 FAM. L.Q. 3, 6-14 (1998).

19. Ross, *supra* note 18, at 6.

20. The states are Delaware, the District of Columbia, Hawaii, New Jersey, Rhode Island, South Carolina, Florida, Massachusetts, New York, Vermont, and Washington. See Babb, *supra* note 18.

the same family and its children. The larger the court, the more the problem is compounded. In large courts, each of the departments may not be just in separate courts, but in different facilities miles away from one another with no technological contact."<sup>21</sup> The lack of a holistic approach by the court in the family law litigants sets it in stark contrast to the approach taken by the drug treatment courts.

## RESEARCH

The authors conducted an informal opinion survey of court professionals, including judicial officers, to compare the opinion in drug treatment courts to those in family law courts. It was hypothesized that the differences in judicial satisfaction observed between drug treatment court and family law court judicial officers might be related to the differences between the operation of a court when incorporating the principles of therapeutic jurisprudence<sup>22</sup> and the operation of a court that functions in a more traditional manner. Such differences were expected to be expressed through significantly different attitudes in the following areas:

The drug treatment court judicial officers were expected to feel more strongly that the role of the court includes providing help to the litigants in solving the problems that brought them there.

The drug treatment court judicial officers were expected to hold a more positive view of the individuals who appeared before them.

The drug treatment court judicial officers were expected to feel more strongly that their assignments had a personally positive emotional effect on them.

The drug treatment court judicial officers were expected to report a greater increase in personal insights and motivation for healthy change as a result of their assignment.

## THE SURVEY

Participants were given a set of 25 questions with answers on a five-point scale in which the respondent was to rate each answer from (1) "Very Untrue" to (5) "Very True." The questions were identical for both groups. Questionnaires were distributed to attendees at a January 1999 California conference of drug court professionals; through the California Association of Drug Court Professionals' newsletter in the spring of 1999; and at the National Association of Drug Court Professionals' conference in the fall of 1999. Family law professionals were surveyed at the California Family Support Council's annual training conference in February 1999. There were participants from most of California's counties who were asked to take questionnaires back home and distribute them to judges, attorneys, mediators,

family law facilitators, and others, and to return them by mail. In the summer of 1999, judges attending an advanced family law course in California were surveyed and a direct mail campaign to judicial officers in both assignments was completed in the winter of 1999. Responses from the drug treatment court professionals came from across the country. Responses from the family law court professionals came from within California. The California family law court professionals who responded to this survey were selected from the part of California's fragmented system that handles cases of divorce, legal separation, annulment, paternity, child support, and, in some cases, private guardianships and domestic violence restraining orders.<sup>23</sup> These family law court professionals have not had the benefit of a statewide court strategy that applies the principles of therapeutic jurisprudence to the family law courtroom.

## THE PARTICIPANTS

There were a total of 194 judicial officers who responded to the survey: 98 from the family law courts and 96 from the drug treatment courts. One hundred twenty-three non-judicial officers responded; 68 from the drug treatment courts and 55 from the family law courts.

Overall, the judicial officers<sup>24</sup> responding were 67% male and 33% female. They ranged in age from 35 years to 75 years with a mean age of 52 years. The drug treatment court judicial officers were 72% male and 28% female. The family law court judicial officers were 63% male and 37% female.

The judicial officers' professional tenures ranged from 1 year to 50 years, with an overall average of 14 years. The time in their current assignments ranged from 3 months to 19 years, with an average of 4 years. The female judicial officers were slightly younger, on average, and had been in the profession for less time. This was true for both the drug treatment court and the family law court groups.

## THE ROLE OF THE COURT

The judicial officers were asked to respond to several statements meant to reflect their perception of the court's role. A statistical test called an analysis of the variance (ANOVA) was conducted between the responses of drug treatment court and family law court judicial officers.<sup>25</sup>

The first statement was, "I believe that part of our job is to help the litigants/defendants work to solve the problems that brought them to our courts." Although the drug treatment court group was slightly stronger in this belief (average=4.57) than the family law court group (average=4.53), this difference was not statistically significant. Both groups, however, were strong in their positive responses to this inquiry. Overall, the

Hon. Donna Petre, *Unified Family Court: A California Proposal*, 1 J. OF THE CENTER FOR CHILDREN & THE CTS. 161 (1999).

Hora & Schma, *supra* note 2.

This survey did not seek respondents from the juvenile court or criminal courts, which deal with cases of child abuse or neglect, delinquency, or domestic violence.

Both judges and subordinate judicial officers, such as commissioners and referees, responded to this survey.

The statistical size of these differences is represented by the F-val-

ues, which are set out in the footnotes. These differences are considered statistically significant if they are not likely to have occurred by chance. In social science research, the point at which the results are considered not to have occurred by chance is referred to as the probability value or p-value, and is commonly set at a minimum level of p=.05. The p=.05 value indicates that there is only a 5% probability that the observed effect has occurred by chance. Likewise, a value of p=.01 indicates probability of 1% that the effect occurred by chance and a value of p=.001 indicates

judicial officers answered this question in the affirmative 88% of the time.<sup>26</sup>

The second statement was, "I feel like the court I work in is helpful to the litigants/defendants who appear there." Both groups of judges also felt that their courts were helpful to the people who appeared there before them; however, the drug treatment court judicial officers scored significantly higher (average=4.35) than the family law court judicial officers (average =4.09) on this question.<sup>27</sup>

In response to the statement "I have seen the litigants/defendants make significant improvement in their lives," there was also a significant difference between the drug treatment court group (average=4.58) and the family law court group (average=3.71).<sup>28</sup> While 92% of the drug treatment court judicial officers reported seeing improvement in those appearing before them, only 56% of the family law court judicial officers responded similarly. The non-judicial personnel from the drug treatment court also responded significantly more often that they believe their courts are helpful and witness improvement in the litigants.

A drug treatment courtroom clerk had this to say:

I am part of the solution. Before Drug Court there was a feeling that there were a lot more probation violations and offenders and I would feel, 'Here they are again. They're back.' I feel confident that I won't see graduates [from the Drug Treatment Court] again and the caseload will be less. I am in touch with the community with Drug Court and I know the faces and names of the defendants who are actually smiling and happy.

**TABLE NO. 1  
WITNESS OF LITIGANT IMPROVEMENT  
(N=183\*)**

(answers)	No (1,2)	Sometimes (3)	Yes (4,5)
<b>Drug Treatment Court (n=87)</b>	0	8%	92%
<b>Family Law Court (n=96)</b>	4%	40%	56%

\* 11 missing responses

Working relationships among the personnel in the courtroom were also addressed. Both the drug treatment court and family law court judicial officers perceived that their courtrooms worked in a teamlike fashion. However, there is a difference in the way the non-judicial professionals view their

courtroom relationships. The drug treatment court professionals indicated that there was more teamwork in their courtroom than did the family law court professionals.<sup>29</sup>

Both the drug treatment court and family law court judicial officers felt respected by their co-workers. There was, however, a difference between the responses of each court's non-judicial professionals: the drug treatment court group felt significantly more respect from their co-workers than the family law court group.<sup>30</sup>

#### ATTITUDE TOWARD LITIGANTS/DEFENDANTS

The next set of statements dealt with the respondents' attitudes toward the litigants. There were significant differences between the drug treatment court judicial officers and the family law court judicial officers in every question about their attitudes toward those appearing in their courtrooms.

The first statement was, "I believe that the litigants/defendants are really trying hard to solve their problems and improve their lives." The drug treatment court judicial officers seemed more convinced that the individuals in their courts were working hard to solve their problems, while the family law court judicial officers did not express this view. Neither group of judicial officers ranked remarkably high in their view of litigant motivation; however, the drug treatment court responses were significantly higher (average=3.79) than the family law court responses (average=3.08) in this respect.<sup>31</sup> Fifty-seven percent of the drug treatment court group believed that the litigants were genuinely working to solve their problems. Another 35% of this group expressed the belief that the litigants are making an effort at least some of the time. No drug treatment court respondents thought that the litigants completely lacked motivation to address their problems. Comparatively, only 18% of the family law court respondents felt that the litigants were working to make progress; 74% reported that they saw this motivation in litigants at least some of the time; and 8% reported that litigants were simply not trying at all.

**TABLE NO. 2  
LITIGANT MOTIVATION  
(N=184\*)**

(answers)	No (1,2)	Sometimes (3)	Yes (4,5)
<b>Drug Treatment Court (n=89)</b>	0	43%	57%
<b>Family Law Court (n=95)</b>	8%	74%	18%

\* 10 missing responses

.1% probability of a chance occurrence. Statistically, a significant difference is important because it allows a mathematical inference that the differences found between these particular drug treatment court and family law court respondents would be present in a larger population of similar participants.

26. The percentage figures for survey responses were calculated as follows: responses of 1 and 2 were coded as "NO"; responses of 3

were coded as "SOMETIMES"; responses of 4 and 5 were coded as "YES."

27. F= 4.94      p=.03  
28. F= 64.69      p=.0001  
29. F= 4.85      p=.03  
30. F= 3.84      p=.05  
31. F= 51.98      p=.0001



The second statement was, "I believe that the litigants/defendants have a good chance for improvement if they are given help by the court." The drug treatment court judicial officers were significantly more hopeful (average=4.27) than the family law court judges (average=3.68) that the litigants in their rooms could make significant improvements if provided some help from the court.<sup>32</sup> The drug treatment court expressed hope for the litigants' prospects for improvement 84% of the time while the family law court group reported such hopefulness only 54% of the time. All of the drug treatment court judicial officers had at least some hope for the litigants; however, 3% of family law court judicial officers saw no hope at all for improvement in their litigants.

**TABLE NO. 3  
HOPE FOR LITIGANT  
(N=185\*)**

	No (1,2)	Sometimes (3)	Yes (4,5)
Drug Treatment Court (n=89)	0	16%	84%
Family Law Court (n=96)	3%	43%	54%

\* 10 missing responses

The next statement was, "I feel I am respected by the litigants/defendants." The drug treatment court judicial officers (average=4.45) felt significantly more respected by the individuals who appear in front of them than the family law court judicial officers (average=3.89).<sup>33</sup> Ninety-two percent of the drug treatment court group reported that they felt respected by the litigants while only 72% of the family law court group felt respected by litigants.

**TABLE NO. 4  
RESPECTED BY LITIGANTS  
(N=184\*)**

	No (1,2)	Sometimes (3)	Yes (4,5)
Drug Treatment Court (n=88)	0	8%	92%
Family Law Court (n=96)	1%	27%	72%

\* 16 missing responses

The most significant difference between the two groups was their responses to the statement, "I feel that the litigants/defendants are grateful for the help our court is providing to them." The drug treatment court group perceived gratitude from the litigants far more frequently (average=4.21)

than did the family law court group (average=3.34).<sup>34</sup> The drug treatment court judicial officers perceived the litigants as grateful for the help that they had received from the court 81% of the time. In the family law court group, only 33% felt that the litigants were grateful for help received from the court.

**TABLE NO. 5  
LITIGANT GRATITUDE  
(N=184\*)**

	No (1,2)	Sometimes (3)	Yes (4,5)
Drug Treatment Court (n=88)	1%	18%	81%
Family Law Court (n=96)	4%	63%	33%

\* 10 missing responses

Additional differences were found in the responses to the statement, "I admire the litigant/defendants for their efforts in trying to change their lives for the better." The drug treatment court judicial officers were significantly more admiring (average=4.37) than the family law court judicial officers (average=3.69) of efforts made by the litigant/defendants to change their lives for the better.<sup>35</sup> Of the drug treatment court group, 86% expressed admiration for the litigants. In the family law court group, only 55% reported that they admired the litigants for their efforts. The non-judicial drug treatment court professionals were also significantly more likely than those in the family law court group to admire the litigant/defendants for their efforts to change their lives for the better.<sup>36</sup> One drug treatment court judge added the comment: "I have a great respect for what our participants accomplish; I don't even have the ability to stay on a diet."

**TABLE NO. 6  
ADMIRE LITIGANTS' EFFORTS  
(N=178\*)**

	No (1,2)	Sometimes (3)	Yes (4,5)
Drug Treatment Court (n=83)	0	14%	86%
Family Law Court (n=95)	7%	38%	55%

\* 16 missing responses

#### POSITIVE EFFECT OF JUDICIAL ASSIGNMENT

Other statements were included to elicit responses pertaining to personal beliefs about being influenced by one's court assignment. Significantly more drug treatment court judicial officers enjoyed talking with family and friends about their work,<sup>37</sup> were

F= 28.12 p=.0001  
F= 33.68 p=.0001  
F= 70.57 p=.0001

35. F= 30.46 p=.0001  
36. F= 11.9 p=.001  
37. F= 40.66 p=.0001

happier in their assignments,<sup>38</sup> and felt more pride in their work<sup>39</sup> than those from the family law court. Drug treatment court judicial officers were slightly less likely than family law court judicial officers to think they might want to transfer to another assignment; however, neither group exhibited much motivation to change assignments. Nevertheless, drug treatment court judicial officers were significantly more likely (average=4.48) than family law court judicial officers (average=3.76) to feel that they had been positively affected by their judicial assignments.<sup>40</sup> Ninety-one percent of judicial officers in the drug treatment court group reported feeling that their assignment had affected them in a positive way emotionally. Family law court judicial officers felt this way only 64% of the time.

A California drug treatment court judge said:

[I]t's a passion and working with passion is more energizing and worthwhile. . . . I have become more honest and direct in my dealings with others and myself which is a tremendous growth. One reason is that you cannot ask others to be honest without being honest yourself. . . .

[W]orking with a team has increased my skills in that area. My leadership skills have sharpened. Best of all, I am a happier person because I believe that what we are doing in our DTC is making a difference.

Another California drug treatment court judge said she would have left the bench had it not been for Drug Treatment Court:

My involvement with drug court is the most meaningful contribution I have made in my life other than raising my children. . . . I would have quit this job without drug court. I love my job because of drug court. Drug court gives meaning in my life; I am part of a solution rather than part of the problem

**TABLE NO. 7**  
**AFFECTED POSITIVELY BY ASSIGNMENT**  
(N=177\*)

(answers)	No (1,2)	Sometimes (3)	Yes (4,5)
<b>Drug Treatment Court (n=82)</b>	1%	8%	91%
<b>Family Law Court (n=95)</b>	11%	25%	64%

\* 17 missing responses

38. F= 10.01 p=.002  
39. F= 6.1 p=.01  
40. F= 31.70 p=.0001  
41. r = .56 p=.0001  
42. r = .49 p=.0001  
43. r = .44 p=.0001  
44. r = .34 p=.0007  
45. r = .33 p=.0009  
46. r = .30 p=.003  
47. r = .52 p=.0001

## FACTORS MOST ASSOCIATED WITH POSITIVE AFFECT JUDICIAL ASSIGNMENT

In drug treatment courts the three answers most highly related to the feeling that the "judicial assignment was beneficial" were: (1) "litigants are grateful for the help they received";<sup>41</sup> (2) "witnessing the litigants improve";<sup>42</sup> and (3) "hope for litigant improvement."<sup>43</sup> For the family law court judicial officers the order was: (1) "belief that the court is helpful";<sup>44</sup> (2) "feeling of admiration for the efforts of the litigants";<sup>45</sup> and (3) "feeling that the litigants were grateful for the help they received."<sup>46</sup> Overall, it was found that the most common predictor of positive emotional effect was the perception by the judicial officers that "litigants are grateful for the help they are given by the court."

## INCREASED INSIGHT AND MOTIVATION FOR HEALTHY CHANGE

The final set of statements were designed to measure insight and motivation for healthy change. Thirty-seven percent of drug treatment court judicial officers indicated that they had learned a lot about domestic violence from working in their assignment and 95% had reported learning a lot about alcoholism/addiction. Of the family law court judicial officers, 70% reported learning a lot about domestic violence and 80% reported learning about substance abuse. Given the correlation between substance abuse by both the perpetrator and the victim in domestic violence cases, it appears that more training is to be done in this area.<sup>48</sup>

Twenty percent of both family law court and drug treatment court judicial officers responded that they had gained insight into their own personal problems. Overall, the drug treatment court professionals (both judicial and non-judicial) more frequently than the family law court professionals (both judicial and non-judicial) have discovered their own addiction during their court assignments,<sup>49</sup> have stopped drinking or using other substances,<sup>50</sup> or have stopped smoking.<sup>51</sup> These differences were more pronounced in the non-judicial professionals than in the judicial officers. However, the drug treatment court judicial officers were still significantly more likely to have stopped drinking or using other substances than the family law court judicial officers.<sup>52</sup> There was no significant difference between the drug treatment court and family law court groups with regard to diet and exercise.

## DISCUSSION

All groups of judicial officers agreed that part of their job was to help those appearing before them solve the problems that brought them to court. Likewise, both groups felt that

48. Using self-reports of substance abuse from assailants and victims, one study found that nearly all of the assailants (94%) and almost half of the victims (43%) used alcohol or other drugs in the hours prior to the assault. See Daniel Brookoff, Drug Use in Domestic Violence (unpublished National Institute of Justice Research in Progress Seminar Series) (1996).

49. F= 7.21 p=.008  
50. F= 10.96 p=.001  
51. F=4.53 p=.04  
52. F= 3.97 p=.05

ts were helpful to the litigants. However, the drug treatment court group was far more likely to report actually getting witness changes for the better in their litigants. For this group, seeing the litigants improve was highly correlated with rating their judicial assignment as positive. The drug treatment courts commonly use frequent reviews as part of the therapeutic strategy. This allows the judicial officers to see the litigants on an ordered, routine basis and view their progress. Such is not the case in most family law courts. For the most part, the first time the family law court judicial officers have contact with a litigant is when something has gone wrong. The opportunity to see the effect of the court on the litigants provides the drug treatment court judicial officers with positive feedback about their work and may serve to relieve stress.<sup>53</sup>

The greatest difference between the drug treatment court and family law court judicial officers was in their attitude toward litigants. The drug treatment court judicial officers expressed a far more positive attitude toward those appearing before them. They were more likely to believe that the litigants are actually trying to solve their problems and had a good chance for improvement if given some help from the court. They felt more respected by the litigants, were more likely to believe that the litigants were grateful for the help they received in the court, and were more likely to admire the litigants for their efforts.

Perception of litigant gratitude was the most important over-predictor of feeling positively about the judicial assignment. This suggests that recognition by the litigants of the help they have received is an important part of the helping process and that the effect on both judicial officer and litigant is dependent on the relationship between them. It has been a principle in the drug treatment court literature that the therapeutic effect on the litigant is dependent on the relationship that develops with the judicial officer. Interestingly, this survey suggests that the judicial officers' satisfaction in their work also is a product of the relationship with the litigant. The greatest difference between these two groups of judicial officers is in the perception of litigant gratitude. The family law court group scored remarkably low in this category. Perhaps predictably, the drug treatment court respondents were far more likely than those in the family law court group to report that their assignments had affected them positively.

## CONCLUSION

As a final observation, it must be stated that the enthusiasm for drug treatment court professionals for their work is not only infectious but is almost unheard of in a profession which experiences a high degree of "burnout" and job dissatisfaction.<sup>54</sup> Still, therapeutic jurisprudence is a relatively young field, and much research remains to be done.<sup>55</sup> For example, there are other factors affecting judicial satisfac-

tion that differentiate drug treatment courts and family law courts and seem to exist independently from the application of therapeutic jurisprudence. The family law court is a civil court in which the two parties are emotionally involved in an inability to resolve their differences. The emotional dynamics of the adversarial system in a criminal court is different when one of the parties is the state. Another difference is that litigants are entitled to attorneys in the criminal court; in family law court, however, the litigants frequently appear pro se. It has also been suggested that family law litigants appear less sympathetic because their actions are often harmful to others, such as in domestic violence or contested custody cases. Of course, drug treatment court defendants, while being basically harmful to themselves, do inflict injury on others as well. Another difference is that the drug treatment court assignment is usually self-selected by judicial officers. For the most part, this is not true for the family law judicial officers. Family law courts are routinely understaffed, underfunded, and are not high-ranking in the judicial status hierarchy. Consequently, family law judicial assignments are frequently entry-level positions of short duration, usually held by those who are younger and have less experience.<sup>56</sup>

Future research is needed to assess the significance of these and other factors in relation to the questions we have posed herein. It would be helpful, for example, to survey a group of family law court judicial officers who are actually working in therapeutic courts, either in the increasing number of therapeutic civil domestic violence courts or from a jurisdiction that employs a unified family court system. Likewise, it would be informative to survey a group of criminal court judicial officers that work in a traditional criminal justice setting.

The study of judicial satisfaction is important because it can be used as an indicator of the efficacy of the court. This research suggests that if, indeed, the work of the court is beneficial to the litigants, this success will express itself in the attitudes of judges and other court professionals with regard to their own job satisfaction. If the work of the court results in fewer criminal cases or fewer protracted family law litigations, both litigants and the court benefit. If stress reduction and job satisfaction result in improved mental and physical health for judges, such benefits are both personal and systemic. Moreover, the ambiance in a courtroom where the judge is happy and satisfied provides an atmosphere in which the litigants are more likely to be comfortable and perform at their maximum. Recognition of the relationship between a judge's perception of litigant gratitude and his or her own job satisfaction shows that judges, too, remain social and human, even while on the bench. It is also believed that the therapeutic effects of these new types of courts, which employ the social sciences and are orientated to problem solving, not only will continue to have beneficial effects on the litigants and court personnel, but also will result in an increased quality of justice for all.

Zimmerman, *supra* note 8.

See generally, the work of Susan Daicoff, Associate Professor of Law, Capital University Law School, Columbus, Ohio, on lawyer job satisfaction, mental health, and alcoholism/addiction at <http://users.law.capital.edu/sdaicoff> (last visited April 1, 2000). See also, Isaiah Zimmerman, *supra* notes 8 and 12; and Isaiah

Zimmerman, *Dealing With Professional Stress: Insights for Judges*, 31 THE BOSTON B.J. Nov./Dec. 1987, at 39.

55. Professor David Wexler first used the term in 1987 in a paper delivered to the National Institute of Mental Health. The concept began to appear frequently in law literature only in the early 1990s. Hora et al., *supra* note 2.

56. Ross, *supra* note 18.



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Editor's note: The survey instrument used in the research reported in this article is reprinted in its entirety at page 20.

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# APPENDIX

## DRUG COURT PROFESSIONALS SURVEY

TITLE: \_\_\_\_\_      \_\_\_\_\_ MALE      \_\_\_\_\_ FEMALE      AGE: \_\_\_\_\_

\_\_\_\_\_ years spent in your profession      Time in your current assignment \_\_\_\_\_

This is part of a study about working in the court. Your answers to the following items are anonymous; please do not put your name on this questionnaire. Please answer each question using the 1 to 5 response scale indicated below.

	Very untrue of me OR strongly disagree	Not true of me OR disagree	Sometimes true and sometimes not true OR undecided	True of me OR agree	Very true of me OR strongly agree
I believe that part of our job is to help the litigants/defendants work to solve the problems that brought them to our court.	1	2	3	4	5
I feel like the court I work in is helpful to the litigants/defendants who appear there.	1	2	3	4	5
I have seen litigants/defendants make significant improvement in their lives.	1	2	3	4	5
I believe that the litigants/defendants are really trying to solve their problems and improve their lives.	1	2	3	4	5
I believe that the litigants/defendants have a good chance for improvement if they are given some help from the court.	1	2	3	4	5
I feel that the judge and other members of our court staff work together as a team.	1	2	3	4	5
The judge in our court often talks to staff about the cases.	1	2	3	4	5
I feel respected by the other members of my court's staff, including the judge.	1	2	3	4	5
I feel that I am respected by the litigants/defendants.	1	2	3	4	5
I feel that the litigants/defendants are grateful for the help our court is providing to them.	1	2	3	4	5
I admire the litigants/defendants for their efforts in trying to change their lives for the better.	1	2	3	4	5
I feel I have been affected in a positive way emotionally by my work in this assignment.	1	2	3	4	5
I enjoy discussing my work with family and friends.	1	2	3	4	5
I feel proud of what I am doing at work.	1	2	3	4	5
I feel happier in this assignment than I have in others I have had.	1	2	3	4	5
I think I would rather go to another assignment or job.	1	2	3	4	5
As a result of this assignment I have learned a lot about domestic violence.	1	2	3	4	5
As a result of this assignment I have learned a lot about alcoholism and drug addiction.	1	2	3	4	5
As a result of this assignment I feel I have gained some insight into personal problems I have been struggling with.	1	2	3	4	5
Since I have been working in this court:					
a. my relationship with my significant other has improved.	1	2	3	4	5
b. I have discovered I was an alcoholic/addict.	1	2	3	4	5
c. I have stopped drinking or using other substances.	1	2	3	4	5
d. I have stopped smoking.	1	2	3	4	5
e. I have been trying to eat a healthier diet.	1	2	3	4	5
f. I have been trying to exercise more.	1	2	3	4	5



## **TIPS FROM RURAL COMMUNITIES**

### **Providing Substance Abuse Services**

- Extended hours; evening and day track (Sharp)
- Pool resources from community agencies (Sharp, Ettlinger)
- Use parole officers to apply immediate sanctions (Sharp)
- MOUs with community agencies should assure responsibility for aftercare (Bartels)
- Use family preservation units to counsel in-home (Anderson)
- Collaborate with community health nurses (Anderson)
- Understand that participants will rely on informal supports (family, community) rather than government agencies (Bushy)
- Most substance abuse-mental health counselors will be in regional hospitals. Locate activities there. (Bushy)
- Offer services in multi-function building to diminish inroads on confidentiality. (Bushy)
- Empower participants to counsel each other & carry on program by themselves. (Ettlinger)
- Brief interventions can be effective: mail, telephone, 1 to 3 counseling sessions (Miller)
- Integrate counseling into health screenings, pastoral care. (Miller)
- Take-out methadone is important service to rural clients, but requires tracking (Murphy)
- Use data-crunching programs as catalyst for interventions; data derived from screening instruments (Puskar)
- On-line therapy can provide daily motivational counseling, peer support and high confidentiality. (Alemi)

### **Providing Other Services to Rural Clients**

- Develop a client benefit fund to cover emergencies (Sharp)
- Three meals a day offered at treatment clinic (Sharp)
- Empower participants to provide child care, meals, etc. for each other (Ettlinger)
- Permit on-line therapy computers to be used for other tasks (Alemi)

## Court Process

- Off-site court (e.g. at regional hospital where treatment services are provided)
- Night court, to accommodate day laborers
- In far away areas, closer court from adjoining jurisdiction may hear case.
- Drug court calendar can combine 3 populations: criminal, family, juvenile – with judicial response appropriate to each.
- Some resources can be shared (e.g. same group counseling for adults in criminal and family cases)
- Core resources can be supplemented to meet particular needs (e.g. social workers as case managers for family cases; probation officers for adults in criminal system).

## Training

- Offer intensive training to new professionals in exchange for 2-3 year commitment to program (Anderson)
- On-line courses for providers cuts down on isolation, offers support (Bushy)
- For brief counseling methods, train health care professionals who will be performing medical screening; and train clergy. (Miller)

## Fundraising and Evaluation

- As a first step in fundraising, develop data on needs (Sharp)
- Evaluators should be part of treatment team. (Sharp)
- Benchmarking is a multi-court evaluation that does not identify a court, but allows each court to see how it is doing as against both itself and other courts. (Alemi)

## Common Barriers to Provision of Services in Rural Areas

- Attitudes: family takes care of its own; work before treatment; suspicion of government (Bushy)
- Lack of transportation (Bushy)
- Lack of telephones (Bushy)
- Bad Weather (Bushy)
- Seasonal labor demands (Bushy)
- Tolerance for drinking (Sohm)



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## WHY A "NO ALCOHOL" CLAUSE NEEDS TO BE IN ALL DRUG TREATMENT COURT CONTRACTS

Hon. Peggy Fulton Hora, Alameda County Superior Court

Understanding that not all defendants who are eligible for a drug treatment court are addicts or alcoholics, drug treatment courts use the medical model for their treatment modality. In fact, some eligible defendants would never be arrested again even without a diversion program. They are either experimenters or thrill-seekers for whom the arrest experience alone will have been enough to stop the drug-using behavior. Since we don't have a system that distinguishes between those persons and alcoholics/addicts, they will all be treated as if they have the disease of addiction.

Assuming that is the case, the hallmark of addiction is a loss of control and continued use despite adverse consequences. It, therefore, makes no sense to tell an addict to use alcohol (or any other drug) in *moderation*; they cannot do anything relating to brain chemistry in moderation. The brain makes no distinction between alcohol and other drugs which may be illegal. All drugs, including alcohol, work on the biochemistry of the brain. Moreover, the incidence of polydrug use (including different illicit drugs as well as alcohol) is rampant. For instance, the 1996 Drug Use Forecasting (DUF) report shows in Los Angeles, 20% of men and 24% of women who tested positive for any drug other than alcohol at the time of arrest tested positive for two or more illicit drugs of abuse. In San Diego it was 31% of males and 25% of females and in San Jose the figures were 15% and 23%, respectively. In another study, 19% of male alcoholics and 31% of female alcoholics were polydrug users. Sixty-six percent of drug treatment courts in a recent survey reported their participants having moderate to severe alcoholism and approximately 60% of programs test for alcohol as well as other drugs.<sup>1</sup>

People who are addicted to drugs of abuse, including alcohol, have markedly changed the biochemistry of the brains so that if they do not use, they experience a feeling of dysphoria (the exact opposite of euphoria). They feel really, really bad. It takes up to a year to begin to cope with this feeling that is present when the addict/alcoholic is free from drugs of abuse. Alcoholics never regain a level of dopamine equal to that of "normal" persons. Cocaine addicts may have physical reactions such as a rise in pulse rate, respiration, blood pressure and pupil dilation for as long as ten years after sobriety when they see paraphernalia such as a crack pipe. In short, alcohol and other drugs **injure sobriety**.

The reason it is important to prohibit the use of any drugs, including alcohol, during the recovery process is so that alcoholics/addicts can learn to deal with their normal, sober state – to have "uninjured sobriety." Any chemical alteration of the brain, including "drinking in moderation" (although there is no such thing for an alcoholic/addict), further injures his or her sobriety. Whether a person started using drugs because they were genetically predisposed, because of a childhood trauma such as sexual abuse, or because of a dual diagnosis (the co-occurrence of a major mental disorder with addiction), they must work through those issues to stay clean and sober. So, for instance, a woman who was repeatedly sexually abused by her father and started using drugs of abuse to mask the pain of being an incest survivor, will start to experience the trauma again when she becomes sober. She needs to be counseled through this issue so that she will not begin using again. Alcohol will not benefit this process.. Recognizing that a "no alcohol" ban is overly inclusive, it is nonetheless necessary in contracts with a drug treatment population so that they may regain their sobriety and continue their recovery.

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<sup>1</sup> Cooper, Caroline S., 1997 *Drug court Survey report: Executive Summary*, American University Drug court Clearinghouse and Technical Assistance Project (1997) at 4-5.

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