

Effective Treatment for Drug-Involved Offenders

*A Review and Synthesis for
Judges and Court Personnel*

*Developed by Education Development Center, Inc.
with funding from the State Justice Institute*



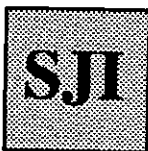
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EFFECTIVE TREATMENT FOR DRUG-INVOLVED OFFENDERS: A REVIEW AND SYNTHESIS FOR JUDGES AND OTHER COURT PERSONNEL

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The Honorable Robert L. Evans, J.D., Detroit Recorder's Court

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*Amy Singer
Project Director
May 1992*

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PREFACE

Numerous studies have found that a substantial proportion of substance abusers—possibly a majority—will not enter or remain in treatment unless some kind of formal pressure is applied. Thus *joint* efforts by the treatment and criminal justice systems are more likely to be effective for reducing drug use and related criminality.¹

Substance use and abuse and the crimes resulting from them command a large commitment from our nation's courts. An overwhelming number of cases brought before the bench relate in some way to alcohol and other drug use, whether they be property crimes committed to pay for drugs, sale or possession of the drugs themselves, or violence associated with the use of drugs. Judges face complicated decisions when confronted with these cases. For example:

- At what points in the adjudicatory process is intervention desirable?
- Does one merely look at the crime committed and sentence accordingly or does one take into account the defendant's substance abuse history?
- If the defendant has entered drug treatment since arraignment, does this change the judge's sentencing decision?
- How can a judge determine which substance-abusing individuals will benefit from treatment?
- If treatment is recommended as part of a probationary sentence, which settings (hospital, residential programs, outpatient facilities) are most effective for rehabilitation? Which offer the most social control?
- What treatment approaches (e.g., psychotherapy, pharmacological treatments) are likely to be effective? Which individuals are likely to benefit from which treatments?
- Is there any proven effectiveness in mandated treatment versus voluntary treatment?
- How can courts monitor treatment to ensure that individuals are adequately assessed, quality services are delivered, and necessary follow-up action is taken in the event of non-compliance?

This benchbook was written to provide a practical guide for judges to help inform their decisions regarding drug-involved offenders. All too often, judges are being asked to make important public safety and treatment choices without a full understanding of pharmacology and drug treatment. Further, they are being

requested to assess likely candidates for treatment, and then, to distinguish the best candidates for specific treatment modalities. Judges are often asked to choose between traditional probation and incarceration without adequate information regarding intermediate sanctions that can offer a broader range of choices. Even when there are choices to be made, judges must know which supervision and monitoring strategies work best (from electronic monitoring to day reporting centers to day fines) and with which kinds of drug-involved offenders. In addition, having a basic knowledge of the dynamics of drug interaction and withdrawal will assist judges in making safer decisions about drug-involved offenders who appear before the court.

We hope that this benchbook provides judges with information that can serve as a helpful foundation for improved decision making with drug-involved offenders. Although much has been written on substance abuse and treatment, there is little available material geared specifically toward judges and court personnel. We recognize that each state has its own case law, every community its own idiosyncratic resources and service delivery system. Nevertheless, we hope that this benchbook will serve as a resource for new and seasoned judges alike as they struggle to understand an enormously complex problem and its consequences for individuals, families, and the community.

How to Use this Benchbook

From the beginning, one of the challenges in writing this benchbook was to determine how we could make it useful for new judges with relatively little or no experience in handling drug-related cases, while at the same time also offering a resource for more seasoned judges.

Because the information needs of judges and court personnel vary, we have designed the benchbook so that each chapter can stand alone. We encourage readers to go to the chapters that pique their interest and meet their needs.

Chapter One: provides an overview of the magnitude of the alcohol and drug problem in the general population and more specifically, among offenders. This chapter describes the impact of the alcohol and drug problem on the courts and other representatives of the criminal justice community as well as many of the related social costs.

Chapter Two: presents descriptions of a variety of drugs and their effects.

Chapter Three: provides information on assessments that may be of special value to probation officers and other court personnel as well as judges. We believe an understanding of the assessment process is key to effective bail and sentencing decisions.

Chapter Four: describes a variety of treatment modalities and discusses their effectiveness.

Chapter Five: provides a context and framework for judicial decision making at the time of sentencing. We outline a variety of dispositional options between traditional probation and incarceration that we hope judges across the country will consider wherever discretion permits.

Chapter Six: highlights supervision and monitoring strategies. It describes not only monitoring and surveillance techniques, but also the importance of aftercare and relapse prevention. We also explore the tension between the likelihood of relapse for alcohol and drug-involved offenders and the court's need to hold individuals accountable for their behavior

Chapter Seven: describes the value of extrajudicial activities. Given the enormous impact of alcohol and drug-involved offenders on the courts, we argue for judicial activism while being mindful of the Code of Judicial Conduct.

Chapter Eight: leaves room for the local jurisdiction to insert substance abuse treatment resources.

Chapter Nine: leaves room to insert local alcohol and drug-related state statutes.

Throughout the benchbook, we have tried to insert useful summary charts and other easy reference materials whenever possible. We have also included selected references and resources, a short history of drug-related policies and legislation, and a brief glossary of terms.

We hope that this benchbook promotes effective judicial decision-making, public safety, and treatment where appropriate for alcohol and drug-involved offenders. We welcome suggestions on how it might be improved.

Endnotes

¹ Christy Visher. (1990). "Incorporating Drug Treatment in Criminal Sanctions." *NIJ Reports*, Summer, No. 221, p. 7. Washington, D.C.: U.S. Department of Justice.

CHAPTER 1: SUBSTANCE ABUSE AND ITS IMPACT

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Chapter 1

SUBSTANCE ABUSE AND ITS IMPACT

Abuse of alcohol and other drugs is a major public health and safety concern for the United States. Public opinion polls reflect the nation's concern regarding such abuse. A 1989 Gallup poll found that the public's fear of drug abuse has surpassed its fear of war and a worsening economy. A January 1990 *Washington Post-ABC* News survey confirmed this finding—40 percent of those surveyed believed that drugs are the most important problem facing America today, followed by poverty and homelessness (9 percent) and the federal budget deficit (5 percent).¹

THE INCIDENCE OF SUBSTANCE ABUSE

The National Institute on Drug Abuse (NIDA) annually conducts the National Household Survey, which reports on the incidence and prevalence of alcohol and drug abuse in the general population. According to this survey, 6.4 percent of the American population (12.9 million individuals) have used an illicit drug, with cocaine leading the list.² NIDA reports that 6.2 million people have used cocaine at least once in the past year, and 10.6 percent of these users consumed the drug once a week or more. Additionally, 5.4 percent of cocaine users took the drug daily or almost daily in 1990.³

Although not an illicit drug, alcohol is responsible for more deaths on an annual basis than all illicit drugs combined.

America's drug problem includes the use of alcohol. Although not an illicit drug, alcohol is responsible for more deaths on an annual basis than all illicit drugs combined. Alcohol is used by 47.3 million Americans on a weekly basis. As many as 10.5 million Americans show signs of alcoholism or alcohol dependence, and another 7.2 million show persistent heavy drinking patterns associated with impaired health and/or social functioning.⁴ People who use drugs frequently use them in combination with alcohol. In a study conducted in 1989, 46 percent of Alcoholics Anonymous (AA) members reported addiction to other drugs in addition to alcohol.⁵

During the years from 1985 to 1990, the number of individuals using cocaine once a month or more decreased 72 percent, from 5.8 million users in 1985, to 2.9 million in 1988, to 1.6 million in 1990. The 1990 Household Survey also found a sharp reduction in the use of any illicit drug, down from 23 million users in 1985, to 12.5 million users in 1988, to 12.9 million users in 1990. Nonetheless, Louis B. Sullivan, secretary of the U.S. Department of Health and Human Services offered this prophetic warning:

These figures must be greeted with guarded optimism. In spite of our individual and national efforts, there are still millions of Americans trapped in the web of addiction, poor health, violence, crime and death. As a result their families and friends confront a living nightmare, and the drug users and drug dealers constitute a severe threat to themselves, their communities and our country.⁶

Indeed, the 1991 Household Survey indicated that the number of Americans using cocaine at least once a month *rose* to an estimated 1.9 million that year, and the number of cocaine-related hospital emergencies reached 25,370—an increase of 30 percent from the previous year.⁷

WHO ARE THE ABUSERS?

Despite the overall reduction in use of illicit drugs from 7.3 percent of the general population in 1988 to 6.4 percent in 1990, there are demographic subgroups with higher rates of use. These subgroups include young adults 18-25 (14.9 percent), African Americans (8.6 percent), individuals residing in large metropolitan areas (7.3 percent), those living in the West (7.3 percent), and the unemployed (14.0 percent).⁸

Too often, the use and abuse of drugs are perceived to be *solely* the problem of specific minority groups, e.g., people living in the inner city or children of abusive parents. Vietnam veterans have also been labeled as “drug burn outs.”⁹ Research confirms, however, that drug use is a far-reaching problem in American society and pervades the lower, middle, and upper classes as well as members of all racial and ethnic groups. To those working in the courts and in treatment settings, it is evident that drug users are not a homogeneous group.

THE LINK BETWEEN DRUG USE AND CRIME

In 1987 the National Institute of Justice started the Drug Use Forecasting (DUF) program. DUF gathers and analyzes information from voluntary anonymous interviews and urine samples of persons arrested for serious crimes in 23 major cities.¹⁰ The goal of this endeavor is to provide a picture of the type and extent of drug use among arrestees. According to DUF's 1990 Annual Report, positive drug rates were detected in urine samples of 30-78 percent of all new arrestees in 1990.¹¹ In 18 of the DUF sites, 50 percent or more new arrestees tested positive for a drug. In that same year, the percentage of all new arrestees testing positive for *two* or more drugs ranged from a low of 4 percent in Omaha, to a high of 46 percent in San Diego. As in 1988 and 1989, cocaine remained the most prevalent drug detected in male and female arrestees in 1990. In 1990, positive rates for cocaine were found in urine samples of 65 percent of all males arrested in Manhattan, 65 percent of all males arrested in Philadelphia, and 48 percent of all

males arrested in Washington, D.C. These rates are two to nine times higher than estimated use in the general population.¹²

Other data indicate that drug use is a pervasive problem among offender populations not only in major cities, but in less urban areas as well. For example, in North Carolina, 1988 estimates by the state's Bureau of Investigation suggest that 80 percent of breaking and enterings and larcenies are committed to support illicit drug habits, and 80 percent of the arrests made per day were drug-related.¹³

From the DUF results, it can be concluded that there is now "overwhelming evidence" linking drug use to criminal activity, with drug abuse by criminal suspects far exceeding the estimated use in the general population.¹⁴ The link "goes well beyond the commission of drug-related crimes such as possession, sale, or manufacture. Drug-abusers are among the most active perpetrators of other criminal acts, and users commit more crimes during periods when they are using drugs frequently than during periods of lesser drug use."¹⁵ According to a Bureau of Justice Assistance Survey:

Drug-abusers are among the most active perpetrators of other criminal acts, and users commit more crimes during periods when they are using drugs frequently than during periods of lesser drug use.

- Nearly 75 percent of jail inmates and 80 percent of state prisoners had used drugs at some point in their lives
- A third of state prisoners and a quarter of convicted jail inmates said they had been under the influence of an illegal drug at the time of their offense¹⁶

The link between drugs and crime is threefold: First, the sale or trafficking of illegal drugs is very profitable. Most illicit drugs are expensive and in great demand. Sellers make a considerable amount of money and are willing to go to great extremes to protect their investment. Second, people addicted to drugs need a lot of money to support their habits. A drug addict may engage in a variety of criminal activities including robbery, shoplifting, burglary, and prostitution in order to obtain money for drugs. The criminal act may be seen by the addict as simply a means to an end—whatever it takes to get the drugs. Third, certain drugs act on the central nervous system in such a way as to increase aggressive or violent behavior in some individuals. Previously nonviolent people may become violent or more aggressive under the influence of drugs such as cocaine or phencyclidine (PCP). We will discuss specifics of drug interaction in more detail in the pharmacology chapter.

Alcohol appears to be a factor in an overwhelming number of violent crimes. In a survey conducted by the National Council on Alcoholism and Drug Dependence, 54 percent of offenders incarcerated for violent crimes such as murder, attempted murder, manslaughter, and rape and other sexual assaults had used alcohol just before the offense.¹⁷

THE IMPACT OF DRUG ABUSE ON THE CRIMINAL JUSTICE SYSTEM

Criminal justice professionals and policymakers are being called upon to confront the overwhelming problems of an increasing number of drug-related crimes, the overburdening of our nation's courts with drug-involved offenders, and prison crowding. Given these circumstances, it is critical to examine the possibilities for collaboration among the courts, other criminal justice practitioners, and drug treatment professionals for the benefit of all systems involved.

The Impact on Law Enforcement

The federal government's law enforcement response to the nation's substance abuse problem has increased significantly over the last two decades. According to the Office of National Drug Control Policy, federal spending on drug control programs has increased from \$1.5 billion in 1981 to an estimated \$10.5 billion in 1991¹⁸ The Institute of Medicine reports that the federal government spent \$2.5 billion on drug enforcement activities in 1988, compared to \$1.76 billion in 1986 and \$36 million in 1969.¹⁹ A 1987 publication entitled *Anti-Drug Law Enforcement Efforts and Their Impacts* estimated that 18.2 percent of total expenditures of state and local governments were devoted to drug-related law enforcement in 1986.²⁰

The Impact on the Courts

The overburdening of our nation's courts with cases of drug-involved offenders has been well-documented in the last decade. One judge aptly put it when he said, "the mouth of the funnel has been enlarged but the size of the neck remains the same."²¹ From 1983 to 1987, the average increase in drug-related state criminal cases in major cities was more than 50 percent.²² According to a report by Patrick A. Langan and John M. Dawson of the Justice Department, "in 1988, about one in three convictions was for drug trafficking or possession. Two years earlier, only one in four concerned drug offenses."²³ From 1980 to 1989, drug cases filed in the U.S. district courts rose by 270 percent.²⁴

Recently, judges from nine of the most populous states held an executive symposium in Philadelphia to discuss the judiciary's response to the drug crisis. Conferees reported:

... the situation is desperate ... the overload causes backlog, the backlog feeds delay, delay along with lack of jail and prison space imperils the right to timely considerations, undermines deterrence and breeds contempt for the law.²⁵

While participating on a panel at the mid-year meeting of the American Judicature Society, Barry Mahoney, senior staff associate at the Institute for Court Management of the National Center for State Courts, spoke of a related problem:

Certainly one of the impacts [of the drug epidemic] is that drug cases are putting terrific pressure on the civil docket and on the dockets of the family/domestic relations courts in terms of reallocating resources. Judges, courtrooms and court staff are handling criminal cases to the detriment of the courts' ability to deal with the rest of their business.²⁶

The Impact on Prisons and Jails

America is spending billions of dollars on corrections "with no end in sight either to the volume of crime, particularly violent crime, or to the numbers of young Americans who commit such crime while under the influence of an increasingly voracious appetite for drugs."²⁷ One in every 46 adults was under some form of correctional supervision in 1989.²⁸ From 1970 to 1988, the rate of incarceration doubled in state and federal institutions.²⁹ As shown in Table 1, in 1990, state and federal inmate populations grew by 8.2 percent, or 58,686, to reach a record total of 771,243.³⁰

Table 1
Change in the State and Federal Prison Populations
1980-1990

Year	Number of Inmates	Annual % Change	Total % Change Since 1980
1980	329,821		
1981	369,930	12.2	12.2
1982	413,806	11.9	25.5
1983	436,855	5.6	32.5
1984	462,002	5.8	40.1
1985	502,507	8.8	52.4
1986	544,972	8.5	65.2
1987	585,084	7.4	77.4
1988	627,588	8.0	91.5
1989	712,557	12.8	116.0
1990	771,243	8.2	133.8

Note: All counts are for December 31 of each year and may reflect revisions of previously reported numbers.

Bureau of Justice Statistics Bulletin

This growth translates into an average *weekly* need for approximately 1,100 additional prison beds.³¹ And by the middle of this decade, the Federal Bureau of Prisons predicts that 70 percent of its inmates will be convicted drug offenders.³²

The American Civil Liberties Union reported that, as of April 1989, 35 states and the District of Columbia faced court orders and/or consent decrees dealing with prison crowding, or the conditions caused by crowding, at one or more of their facilities.³³ In a 1990 report to the president, Attorney General Thornburgh stated:

A cap on the population of an individual prison often requires a wholesale systemwide shift of inmates and resources, including the "back up" of state prisoners in local jails, which aggravates the already severe nationwide shortage of jail space for both federal and state unsentenced prisoners; sometimes, the result is simply to exacerbate overcrowding in other facilities. A cap on an entire system typically requires more extreme measures, ranging from an expansion of supervised probation to emergency early releases.³⁴

... by the middle of this decade, the Federal Bureau of Prisons predicts that 70 percent of its inmates will be convicted drug offenders.

The situation is predicted to get even worse. In 1989, the National Council on Crime and Delinquency (NCCD) forecast that the prison population will grow by 64 percent by 1994. NCCD cites the primary reason for the dramatic increase in prison population as the "war on drugs," which is not only increasing the number of prison admissions but is also increasing the rate of parole revocations.³⁵

The Impact on Probation and Parole

Less tangible, but every bit as troublesome, is the crowding in our nation's probation and parole agencies. As of December 31, 1989, the Bureau of Justice Statistics announced that a record 2,520,479 adults were on federal, state, and local probation, up 5.6 percent in just one year.³⁶ This situation translates into higher caseloads, with overtaxed probation and parole officers having less and less time to spend with the individuals they are required to supervise. Not surprisingly, greater numbers of probationers are "surrendered," only further exacerbating an already crowded prison system.

Victim Losses

The Bureau of Justice Statistics reports that there were 34.1 million crimes committed against American households or individuals twelve or older in 1986 causing personal injury and property damage.³⁷ Of these crimes, an estimated nine million (25 percent of property crime and 15 percent of violent crime) were related to drug abuse. Of these nine million crimes, victim losses have been estimated at \$2.6 billion in stolen property, \$150 million in property damage, \$1.5 billion in lost work time, and \$50 million in medical care.³⁸

Surveys of homicide arrestees reveal that 50 percent test positive for drugs and 16 percent claim to be addicted to substances; 28 percent of inmates convicted of manslaughter were under the influence of an illicit drug at the time of the crime. Twelve percent of this inmate sample claim to use cocaine or heroin daily. It is estimated that 2,900 homicides were drug related in 1985.³⁹

SUBSTANCE ABUSE AND SOCIETY

In addition to its direct impact on crime and the administration of justice, the substance abuse problem in this country has serious consequences for society at large. Each year, substance abuse has the following social, health and economic costs:

- Infants and young children: Among pregnant women, approximately 11 percent used illicit drugs, according to a 1988 hospital survey conducted by the National Association of Perinatal Addiction Research and Education.⁴⁰ Many babies born of drug-using mothers suffer from low birth weights and are at greater risk for a variety of physiological, psychosocial, developmental, and educational problems. The same is true for women who abuse alcohol while pregnant, presenting the risk of giving birth to children with Fetal Alcohol Syndrome. Forty thousand babies are born each year at increased risk due to their mothers' drinking during pregnancy.⁴¹
- A greater incidence of child abuse: Several studies across the country have documented links between substance abuse and neglect, as well as the physical and sexual abuse of children. The U.S. Advisory Board on Child Abuse and Neglect reported that, in a review of over 18,000 child abuse cases handled by the Los Angeles Juvenile Court in 1989, substance abuse was a factor in at least 90 percent of the cases.⁴² A compilation of interviews with 31,000 runaway and homeless youth who received services from shelters across the country revealed the extremely violent nature of the homes from which many of the youth fled. Alcohol or substance abuse on the part of the parent or guardians was a major precipitating or contributing factor in 40 percent of these runaway episodes.⁴³
- The soaring cost of health care: It has been estimated that 25 to 40 percent of all patients in America's hospital beds are being treated for alcoholism or complications caused by alcoholism. *The Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985*, estimated that the direct costs of drug abuse amount to \$2.1 billion. Of this total, three-fifths are for the care of persons in short-stay hospitals with primary and secondary diagnoses of drug abuse.⁴⁴
- AIDS: The increased prevalence of HIV infection among intravenous drug users in the 1980s has had much to do with drug abuse moving to the

forefront of our nation's public health concerns. Drug treatment efforts directed at intravenous drug users are crucial in protecting the user against HIV infection. According to the 1988 Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic, "Intravenous and other drug abuse is a substantial carrier for infection, a major port of entry for the virus in the larger population."⁴⁵ Indeed, 70 percent of the cases in which HIV infection was transmitted through heterosexual activity were traced to sexual relationships with infected drug addict.⁴⁶ James L. Sorensen reports that at the end of the 1980s, 115,786 adults or adolescents in the United States had been diagnosed with AIDS, 21 percent of whom had the "sole risk factor of injection drug use and another 9 percent had both injection drug use and another risk factor for HIV infection."⁴⁷ In addition, the majority of pediatric AIDS cases (58 percent) were directly associated with intravenous drug use.⁴⁸

- Injuries: Almost half of fatally injured drivers and substantial proportions of adult passengers and pedestrians killed in motor-vehicle crashes—as well as in falls, drownings, fires, assaults, and suicides—have [higher than legal] blood alcohol concentrations.⁴⁹
- Workplace costs: The single greatest impact of drugs and alcohol on the US economy is on worker productivity. According to NIDA, 10-23 percent of all estimated workers who use dangerous drugs on the job are late for work three times more often, have 2.5 times as many absences of eight days or more and use three times the normal level of sick benefits as non-abusers.⁵⁰ Rice and her colleagues estimate that in 1985, the losses to potential worker productivity were estimated at \$33.3 billion.⁵¹ Alcoholism alone causes 500 million lost work days per year which translates into more than \$20 billion per year.⁵²

THE COURTS AND TREATMENT

The need for enforcement efforts to combat illicit drug trafficking and use is evident. To date, a large proportion of our federal drug-related dollars have gone towards enforcement activities. There is evidence to indicate, however, that prevention and treatment initiatives provide the best hope for reducing demand for illicit drugs and alcohol. According to Dr. Edward C. Senay:

The most important fact established by the scores of outcome studies conducted in the past 15 years is that drug abuse treatment works. The number and quality of studies carried out demonstrate, as well as can be realistically expected from any set of studies, that positive changes in client functioning occur during and after drug treatment. While there have been programs that have been poorly run and have encountered serious credibility problems, there can be little question that, from a public health and national point of view, many people have been helped by drug treatment.⁵³

Statistics to substantiate Dr. Senay's statement will be detailed later in this benchbook.

Treatment can be cost effective. The National Association of Drug and Alcohol Abuse Directors reports that the estimated cost of drug abuse and its concomitant effects is \$200 billion a year.⁵⁴ Although investing in treatment at the public and private level represents a large financial commitment, it is estimated that successfully treating alcohol problems alone is one-tenth what these problems currently cost our society.⁵⁵ Another study conducted at the behest of NIDA by the Drug Services Research Survey reported that the median total cost per patient for a twelve-month program was \$4,600, although this figure varies greatly depending on treatment modality.⁵⁶ In comparison to the cost of maintaining one inmate in a prison or jail for one year, the cost of drug treatment is remarkably low. For example, in 1990, the state of New York spent \$25,000 per inmate in state prisons, and between \$30,000-\$50,000 per inmate in New York jails.⁵⁷

Although investing in treatment at the public and private level represents a large financial commitment, it is estimated that successfully treating alcohol problems alone is one-tenth what these problems currently cost our society.

In preparing this benchbook, we have come to learn much about drug and alcohol treatment. What we have learned is heartening. Treatment *can* and *does* work. We recognize, though, that when judges evaluate individuals before the court, they must consider a range of factors, not just an individual's drug history or current drug problem. For many who appear before the court, incarceration will be the appropriate and necessary choice; it may also be required as part of mandatory sentencing. Yet, most judges still maintain a great deal of discretion. Often, there is room for drug treatment to play a role in conjunction with other punitive sanctions. Treatment is not antithetical to the criminal justice system, but to the contrary, can be complementary.

The courts have a central role to play in attempting to find solutions to the serious social problem of substance abuse. Families, churches, schools and other institutions are not able to resolve the problem alone. Without a helpful partner who packs some muscle, their efforts to address these complex problems, despite aggressive and valiant efforts, are often ineffective. But judges cannot do it alone either—they must work in concert with the treatment and prevention communities and local education, business, and civic leaders. Whether it is with young children, adolescents, treatment providers, executive branch leaders or others, judges can make a difference in their community by getting involved.

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PHARMACOLOGY

BACKGROUND

Introduction

Because of the tremendous volume of drug-involved offenders who appear before the court, it is useful for judges and other court personnel to be familiar with drug pharmacology—to understand, for example, how alcohol and other drugs may change behavior, to become aware of the effects of drugs on a user's behavior, to make sense of drug testing results.

There are several ways to categorize drugs. The most practical method, and the one we have chosen for this benchbook, is according to their effects on the body's central nervous system, which, in turn, affect the user's behavior. Thus, the classifications we have selected are: *Central Nervous System Stimulants*, *Central Nervous System Depressants*, and *Central Nervous System Disrupters*. These classifications have been further subdivided so that drugs sharing common behavioral effects and withdrawal symptoms are grouped together. The category of *Central Nervous System Stimulants* is subdivided into: amphetamines, including ice; and cocaine, including crack. *Central Nervous System Depressants* is broken down into the subcategories: narcotic analgesics/opiates, alcohol, and sedative hypnotics. *Central Nervous System Disrupters* is divided into the drug categories: psychedelics, cannabis, PCP, and inhalants. Table 2 found at the end of this chapter may be helpful as a quick reference source for judges and others interested in summary information on pharmacology.

Several points must be kept in mind while considering this classification. First, behavioral responses to any given drug vary at different doses. For example, although alcohol is classified as a depressant, at low doses it often causes excitability. Thus, a drug's classification alone does not sufficiently describe its pharmacology, but merely serves as a starting point to compare and contrast drugs and their effects. Second, several drugs may be classified in more than one category. For example, marijuana can be considered either a central nervous system disrupter or a depressant.

This chapter includes discussion of:

- Key definitions and theories of the drug treatment community
- General pharmacology for each major drug group

- Specific pharmacology for the most problematic and/or commonly used drugs within each group, including short-term behavioral and physiological effects, and long-term effects

In classifying and explaining the pharmacology of illicit drugs, we have attempted to present the range of drugs most often associated with abuse. However, some drugs require more attention because their use is more problematic from a criminal justice perspective. Over time, the types of drugs most likely to result in a user's appearance before the court have changed because of a variety of factors, including the drug's availability, cost, and law enforcement priorities. According to the 1989 Drug Use Forecasting (DUF) Report, cocaine was the most prevalent drug found in urine samples of both male and female arrestees in 1988 and 1989. In July 1991, Robert Stutman, the former chief of the Drug Enforcement Agency (DEA) New York office, predicted that we are on the brink of a national heroin epidemic. Stutman asserts that the availability of heroin on the streets is two to three times higher than at any other time in history.¹ Accordingly, we give more emphasis to drugs that are of greater concern to the courts or are more commonly used today.

In describing the pharmacology of each of the major drug groups: *stimulants*, *depressants*, and *disrupters*, we include a discussion of the drugs most commonly abused in each of those categories. This discussion covers the following areas:

- Definition
- Street names
- Routes of administration
- Use patterns
- Major uses, including recreational and medical
- Effects of the drug, including neurological, physiological, and behavioral
- Retention
- Tolerance and withdrawal

Although this chapter is organized by individual drugs, a growing concern for the courts and the treatment community is the increasing use of *poly-substances*. Poly-substance abusers are described by treatment professionals as falling into one of several categories: (1) individuals who will substitute one drug for another drug with similar effects, e.g., some alcoholics will use barbiturates or tranquilizers when alcohol is unavailable; (2) users who will take one drug to counteract another drug's effect, e.g., amphetamine users will often take sedatives or alcohol to "come down" from the amphetamine induced "rush"; (3) individuals who simultaneously use two or more drugs with similar effects in order to intensify the overall effect, often to the point of accidental death. A particularly dangerous example of this poly-substance abuse is the combined use of alcohol with a sedative hypnotic, which can

Over time, the types of drugs most likely to result in a user's appearance before the court have changed because of a variety of factors, including the drug's availability, cost, and law enforcement priorities.

lead to overdose and death; and, (4) those users, often referred to as “junk heads,” who will take any drug or combination of drugs to become intoxicated and avoid withdrawal symptoms. Treatment programs are more likely to be able to manage poly-substance abusers today than in the past; however, medical concerns must be given a great deal of consideration. And it is not uncommon to find a greater degree of psychopathology among poly-substance abusers, suggesting to treatment professionals a multi-faceted approach.

Definitions and Models of Addiction

Professionals attempting to treat addiction do not always agree on exactly what the term means. Is it a disease or a character flaw? Can it be cured or merely controlled? The particular treatment model one chooses may be strongly influenced by how one views the increasingly controversial word “addiction.” Alan G. Marlatt, a well known addictions expert, proposes the following four general models, which build on the work of Philip Brickman:

- **Moral Model:** The moral model of addiction defines the etiology of drug and alcohol problems as moral weaknesses in character. A change in behavior is achievable only through motivation and personal effort. There is little support for this model within the modern drug treatment community.
- **Medical Model:** According to the medical model, neither the disease nor treatment is the patient’s responsibility. Drug addiction is caused by biological or genetic factors. The treatment for addiction is biomedical. The advantage of the medical model is that it allows patients to seek and accept help without blame or guilt. Many modern treatments reflect this approach.
- **Enlightenment Model:** The enlightenment models hold individuals responsible for the origins of their problem, but consider addicts incapable of changing on their own. Change is possible by relinquishing personal control and accepting guidance from a higher power.
- **Compensatory Model:** The compensatory model maintains that individuals are not responsible for the development of addiction, but must assume personal responsibility for changing behavior.²

Models of Drug Consumption

Several models have been proposed regarding the progression of drug use from casual experimentation to addiction. One model of drug consumption, described by the Institute of Medicine, details the use pattern individuals commonly follow as they progress towards addiction.³ Drug consumption is divided into the following stages:

- **Use:** Drug use is experimental, occasional, and often social. One's desire for drugs during this time is controllable and satiable. Drugs may be part of a social activity, but not the sole reason for the social activity occurring. Many individuals stop at this stage, and never advance to increased levels of drug abuse.
- **Abuse:** Drug consumption intensifies and becomes more regular. "Binging on drugs" often characterizes this stage of consumption. Individuals may begin to experience increased negative consequences to their use in this stage. For instance, they may find themselves calling in sick to work more frequently, borrowing money on a more consistent basis, or losing friends due to their treatment of people while under the influence.
- **Dependence:** Dependence describes a state in which one has developed a physical tolerance for a drug. Failure to take the required amount of the drug will result in a painful withdrawal syndrome, the specifics of which vary depending on the particular drug. This state is referred to by addicts as "having a habit." In this state, users need more and more drugs to "get high" and a certain amount of drugs to stave off the withdrawal syndrome, referred to by addicts as "being dope-sick." Some drugs do not create a physical dependence (marijuana, for example) but addicts may describe a psychological dependence on the drug.

A second model describes the road to addiction as a process of social factors, which affect the way one thinks about and uses drugs.⁴ This socialization process follows the following stages:

- **Priming:** the stage in which we learn that alcohol and drugs exist. Rules regarding drugs are learned and vary according to personal experience and environmental factors.
- **Initiation:** the stage at which individuals first try alcohol and drugs. Initiation often takes place within the family.
- **Experimentation:** individuals begin to use alcohol and drugs willingly. They learn the effects of drugs, such as elation or depression. Individuals may try a variety of drugs at this stage to learn their effects.
- **Habitual Use:** this stage is characterized by repeated use of a favored drug. Users believe that drugs can relieve stress, provide excitement, or facilitate social acceptance.
- **Dependency:** users lose control over drug use. They need drugs either psychologically or physically.

The preceding models provide a basic framework for thinking about drug consumption and addiction. Clearly, use patterns vary from individual to individual. Many people never progress from casual or experimental use. Others state

that drug use, for them, was never experimental and that they felt “addicted” to drugs from the very beginning.

Stages of Change

Models are also used to conceptualize how drug and alcohol abusers proceed through stages of change on their way to recovery. The following Stages of Change Model is applicable to drug treatment regardless of treatment modality.⁵ The model is characterized by the following stages:

- Pre-contemplation Stage: this stage describes the period of addiction prior to the consideration of change.
- Contemplation Stage: addicts consider doing something about their drug problem. This stage can continue for a long time.
- Action Stage: addicts make an attempt to find help or treatment. The majority of drug treatment programs are geared toward and address this stage of change.
- Maintenance Stage: individuals attempt to remain drug or alcohol free. This stage has traditionally been neglected by the treatment community.
- Relapse: reverting back to drug use after a period of abstinence.

Under this model, the five stages can occur in any order, taking into account individual differences. Some individuals revert to earlier stages; others continue to move ahead. Relapse is not viewed by treatment professionals as a failure, but as part of the recovery process. In fact, some people prefer to use the term “recovering” to indicate that it is ongoing, and appropriate aftercare measures can help to guide individuals successfully through this process.⁶ For an expanded discussion of relapse prevention and aftercare, see chapter 6.

Understanding Addiction and Dependence

When considering models of addiction, it is helpful to understand the distinction between *addiction* and *dependence*; they are not the same and should not be used interchangeably. Definitions of these terms follow. Other terms commonly used within the drug treatment community and those used throughout this benchbook are included in a glossary in Appendix B.

Addiction: “chronic, compulsive drug use to the extent that a person cannot stop using drugs.” Addiction refers to a behavioral pattern of compulsive drug use, characterized by overwhelming involvement with using and securing the drug. Addiction is also characterized by a strong tendency to relapse after complete withdrawal from a drug. Addiction is the extreme end of the continuum of involvement with a drug. All *addicted*

drug users are drug *dependent*, but not all drug dependent individuals can be considered addicted.⁷

Cross-Dependence: a condition in which one drug can substitute for the effects of another drug with similar chemical characteristics, and can prevent the withdrawal symptoms associated with the use of the other similar drug.⁸

Physical Dependence: often concurrent with addiction, but characterized by a condition in which drug abuse results in the development of physiological tolerance to the drug, followed by physiological withdrawal symptoms during abstinence.⁹

Psychological Dependence: the drug treatment community recognizes that drug use is often pleasurable, affecting mood and psychological well-being as well as creating a physical craving. Thus, psychological dependence is a broad term generally referring to a craving for or compulsion to continue the use of a drug that gives satisfaction or a feeling of well-being. The World Health Organization defines psychological dependence as "a feeling of satisfaction and a psychic drive that requires periodic or continuous administration of the drug to produce a desired effect or to avoid discomfort."¹⁰

DRUGS THAT STIMULATE THE CENTRAL NERVOUS SYSTEM

Drugs that stimulate the body's central nervous system are often referred to as psychomotor stimulants. They act on the central nervous system quite similarly, usually varying only in the intensity and duration of effects produced. Specific drugs discussed in this section include (1) amphetamines, including ice, and (2) cocaine, including crack.

Crack and ice are legally prohibited. Although certain types of amphetamines are still available with a medical prescription, the conditions under which they can be legally prescribed are severely restricted. The widespread illicit use of cocaine, and especially its derivative crack, has reached nearly epidemic proportions in our country's urban centers. Understanding the pharmacology of these drugs should prove especially useful for judges and other court personnel within the criminal justice system.

Amphetamines¹¹

What is an Amphetamine?

The term *amphetamine* is actually a collective term for three closely related drugs: benzedrine ("bennies"), dexedrine, and methedrine ("meth" or "speed"). These substances act as strong stimulants on the central nervous system and the rest of the human body. Although differing slightly in chemical structure, they are so similar in their effects on the body that they can be distinguished from one another only by laboratory analysis. Amphetamines are manufactured in tablet or

capsule form, but can be easily changed into powder or liquid form. Unlike the naturally occurring, psychomotor drug cocaine, amphetamines are wholly derived from synthetic substances.

Street Names

Common street names for amphetamines are uppers, pep pills, bennies, whites, dexies, hearts, speed, meth, crystal, crank, black beauties, copilots, hearts, bumblebees, and footballs.

Routes of Administration

Amphetamines appear in the form of capsules, pills, tablets, white powder, or a rock that resembles a block of paraffin. Amphetamines can be taken orally, sniffed, or diluted and injected into the bloodstream. When amphetamines are taken orally, the rate of absorption is slowed considerably. When amphetamines are given for medicinal purposes, they are always taken orally, because blood levels may be kept fairly constant. When administered by injection or inhalation, absorption occurs more rapidly and the effects of the drug are much more potent. The term "speedball" refers to an injectable combination of amphetamines and heroin that was originated by soldiers stationed in the Far East in the early 1950s. The modern day "speedball" has been expanded to include the combination of any central nervous system stimulant and depressant, typically cocaine and heroin.

Use Patterns

Amphetamine users tend to be those who wish to exert themselves beyond the normal physiological limits, e.g., workers trying to maintain alertness during night shifts, truckers attempting to drive long distances without sleep, students cramming for an exam, athletes attempting to enhance their performances. Many long-term users administer the drug every one to two hours for days without eating or sleeping, to the point of total exhaustion or mental disorientation. These "runs" are followed by a period of withdrawal and separation, which is in turn followed by another "run."

Major Uses

The primary medical uses for amphetamines are restricted today. Amphetamines are used to treat a form of epilepsy associated with "petit mal" seizures. They are also useful in treating certain attention-deficit disorders, such as hyperactivity in children or adults. And because of their strong appetite-suppressant effects, they have been marketed and sold extensively as diet pills. However, tolerance to the appetite-suppressant effects occurs within approximately two

weeks, and dosages must be increased to harmful levels to sustain continued weight loss. Amphetamines are no longer recognized by the medical community as an effective drug for long-term treatment of obesity. Federal regulations now require strict labeling information on all amphetamine-derived preparations.

Amphetamines are used non-medically for a variety of reasons, because they are euphoricants and can improve performance. However, prolonged use of the drug produces agitation and insomnia.

Effects

Effects on the human body vary markedly with amphetamine use, dependent on dosage and duration of use. Effects can be categorized generally as those observed at low-moderate doses (approximately 5-50 milligrams); and those observed at high doses (above 100 milligrams, often administered intravenously).

Neurological

Structurally, amphetamines are closely related to the chemical neurotransmitter norepinephrine in humans. Amphetamines mimic the action of norepinephrine in both the central nervous system and the rest of the body. At high doses, the neurotransmitter dopamine is also activated. These neurotransmitters control areas of the brain that affect blood pressure, heart rate, breathing, and metabolism.

Physiological

All amphetamines induce a significant increase in blood pressure, along with an increase of heart rate, relaxation of bronchial muscles, and a variety of other physiological effects that are symptomatic of drugs that stimulate norepinephrine, including increased blood sugar, increased blood flow to muscles, decreased blood flow to internal organs, dilation of pupils, and increased rate of respiration. In the central nervous system, amphetamines are potent stimulants, producing both brain and behavioral signs of increased alertness and excitement. At low to moderate doses (5-50 milligrams), amphetamines stimulate the respiratory system, and induce slight tremors, restlessness, increased motor activities, insomnia, and agitation. Amphetamines also suppress rapid eye movement sleep, but tolerance to this effect develops, and there is a rapid eye movement rebound during withdrawal from the drug. Low to moderate doses may also produce dryness of the mouth, sweating, headaches, blurred vision, dizziness, and anxiety, with higher doses intensifying these effects. When short-lived, high intensity energy output is desired, such as in an athletic competition, amphetamine use may enhance performance, despite the fact that dexterity and fine motor skills are reduced.

During chronic use of amphetamines in high doses (100 milligrams or more), a more intense pattern of the physiological effects discussed above is induced, partly

because high doses are usually administered intravenously. Other effects arising from prolonged, high dosage use of amphetamines include weight loss, skin sores, ulcers, and various diseases that develop from vitamin deficiencies. As is the case with heroin, the sharing of needles with intravenous use of amphetamines increases the users' risk of contracting the HIV virus. But fatalities directly attributable to the use of amphetamines are rare. Individuals with no built-up tolerance have survived doses of 400-500 milligrams of the drug. Only rarely does high-dose intravenous use result in the lethal rupture of blood vessels or coronary collapse due to the increase in arterial pressure.

... some users experience negative effects of the drug even at low doses.

These effects include increased irritability, restlessness, insomnia, and anxiety. Occasionally, aggressive behavior, hallucinations, and psychosis may occur...

Behavioral

At low to moderate doses, amphetamines improve mood and well-being, increase energy, and induce a sense of exhilaration and clear headedness, while reducing fatigue. Freedom from boredom, mild euphoria, and improved concentration are frequently reported by users. However, some users experience negative effects of the drug even at low doses. These effects include increased irritability, restlessness, insomnia, and anxiety. Occasionally, aggressive behavior, hallucinations, and psychosis may occur, but these symptoms are usually manifested only with higher doses. Depression following the withdrawal of even low doses of amphetamines occurs, but varies in intensity and duration depending on length of use and dosage.

With higher doses of amphetamines, the euphoric effects are increased. When the drug is injected, users report a feeling of intense euphoria called a "rush" or a "flash," often described in sexual terms. This effect, however, is offset by the manic paranoia that is induced following a "binge" or "run" of intravenous amphetamine use and is caused by excessive levels of norepinephrine, the activation of dopamine, and chronic lack of sleep and food. One of the most serious consequences of high dose intravenous use of amphetamines is a stimulant-induced psychosis that is characterized by confused and disorganized behavior, compulsive repetition of meaningless acts called "punding," irritability, fear, suspicion, hallucinations, and delusion.

Retention

When amphetamines are taken orally by very active people, peak blood levels are reached in about thirty minutes, but maximum concentration for sedentary people may take up to three hours after ingestion. Amphetamines cross the blood/brain barrier and are concentrated in the spleen, kidneys, liver, lungs, and brain. *Amphetamines can be detected in urine from two to four days after first administration. This window of detection is dependent upon the user's rate of metabolism and amount of the drug administered.*¹²

Tolerance and Withdrawal

Tolerance to the effects of amphetamines develops at different rates and to different degrees. Tolerance to the appetite-suppressing effects develops after approximately two weeks. The mood-elevating effects of amphetamines are subject to tolerance, but not to the same extent as the appetite-suppressing effects. Tolerance to sleep-suppressing effects does not occur.¹³

Both a psychological and a physiological dependence on amphetamines occurs after prolonged use. Withdrawal from amphetamines produces increased appetite, fatigue, irritability, prolonged sleep, and depression, sometimes leading to suicide.¹⁴ During withdrawal from the drug, sleep may last several days. Upon awakening, the user is extremely hungry, lethargic, and depressed.¹⁵

ICE (METHAMPHETAMINE HYDROCHLORIDE)

Ice is the street name for the drug *methamphetamine hydrochloride*, a type of amphetamine which commonly appears in solid form. The street term for the drug is derived from its appearance; after the manufacturing process, ice is formed into a clear, crystal-shaped solid that looks like glass. The color of ice ranges from transparent with a slight yellowish cast to translucent milky white, or a pure white, resembling rock candy.¹⁶ Unlike cocaine, which is derived from a natural source, ice is produced in a laboratory. While crack produces a "high" lasting approximately five to twenty minutes, the euphoria induced by ice lasts from two to eight hours depending on the potency of dosage.¹⁷ Most of the production of ice takes place in labs in Korea, Taiwan, and Singapore. Because of its proximity to the U.S. mainland, Hawaii is the primary source for ice in this country. Although the use of ice in the continental United States is relatively low, it has reached nearly epidemic proportions in Hawaii, paralleling the crack problem in several major United States cities.¹⁸

Methamphetamine, the first significant amphetamine derivative, was first synthesized in 1919 by a Japanese chemist. It was widely used in the 1930s, prescribed by doctors for a variety of ailments, including depression, sleep disorders, and obesity. Shortly after this, alarming side effects from the drug, such as strokes, heart attacks, pulmonary edema, comas, and deaths were reported, and the drug became listed as a controlled substance in the United States.¹⁹ After World War II, its use became prevalent in Japan for individuals trying to increase their productivity and extend their working hours. Today, ice is the number one drug of abuse in Japan.²⁰

During 1988, 629 illicit methamphetamine laboratories were seized by law-enforcement authorities in the United States. This represented a 600 percent increase in seven years.²¹ Despite this alarming statistic, there remains little evidence of any widespread availability or distribution of the drug in the continental United States.²²

Street Names

Common street names for methamphetamine hydrochloride are ice, crystals, glass, and "batu" in Hawaii.²³

Routes of Administration

Powdered methamphetamine can be snorted or injected. Ice is always smoked, because the fumes of the drug reach the brain much more quickly. Ice is smoked in a glass pipe called a "bong," which differs in design from a crack pipe. Whereas coke pipes have two sections, one that holds the drug and another that cools it, ice pipes have only one section where the drug is heated. There are no coolers or screens on the pipe. The pipe has a hole in the top leading to the main chamber and a vent hole, called a "carb" on the street, between the ice compartment and the mouthpiece. The user covers the vent hole with a finger and heats the ice until it is burned into a gas. Ice users often have telltale burn marks on their fingers from covering the carb hole as the drug is smoked. Clear ice is water-based and burns quickly, leaving a milky-white residue in the bowl. Yellow ice is oil-based and burns more slowly, leaving a brown or black residue. Ice is odorless when smoked.²⁴ A single "hit" comes in a penny-sized plastic bag called a paper, which is a little less than one-tenth of a gram and costs approximately \$50.²⁵ Ice may also come in glass vials. The high induced by smoking ice lasts anywhere from eight to twenty-four hours, depending on potency and amount.²⁶ When allowed to cool, ice reverts to its solid crystal form, allowing it to be reused and easily transported.

Use Patterns

Generally, people use ice for the same reasons they take other amphetamines: to achieve a "high," to gain extra energy, to fight fatigue in order to work or study, or to lose weight.

Major Uses

When the serious side effects of methamphetamine were revealed, use of the drug was discontinued by the medical community, and ice became listed as a controlled substance in the United States. Currently, the drug is used only illegally for recreational purposes.²⁷

Effects

Neurological

Ice acts similarly to the other amphetamines, as a stimulant on the central nervous system.

Physiological

Physiological symptoms of ice use include rapid heart and respiratory rate, increased body temperature, hoarse voice from burning the throat during inhalation, dilated pupils, loss of appetite with accompanying weight loss, and insomnia. Prolonged use can cause fatal lung and kidney disorders. Overdose of ice can induce convulsions and cardiac arrest.²⁸

Behavioral

The initial behavioral effects of ice are increased alertness, feelings of increased energy, feelings of well-being or euphoria, and excitation. However, feelings ranging from mild anxiety to paranoia, and hallucinations are also reported by users. An increase in violence and aggression can occur. Users often experience mild to severe depression once the drug wears off.²⁹

Retention

*Ice can be detected in urine up to seventy-two hours after administration.*³⁰

Tolerance and Withdrawal

Prolonged use of ice can lead to a high degree of tolerance to the drug's euphoria-producing effects, causing individuals to use greater quantities of the drug, which in turn leads to more severe insomnia, anxiety, paranoia, and the accompanying depression that follows when the effects of the drug wear off.³¹

Withdrawal symptoms from ice include depression, fatigue, irritability, tremors, insomnia, anxiety, irregular heartbeat, dry mouth, nausea, vomiting, and cramps. Less frequent symptoms of withdrawal from ice include convulsions, coma, and in rare instances, death.³²

... feelings ranging from mild anxiety to paranoia, and hallucinations are also reported by [ice] users. An increase in violence and aggression can occur.

Cocaine

What is Cocaine?³³

Cocaine is the major psychoactive ingredient extracted from the leaves of the coca plant. It consists of white, odorless crystals or crystalline powder derived from a paste made from the crushed leaves. Most of the cocaine sold in the United States today has been altered to increase the quantity of the drug for the seller's profit. Substances commonly used to increase quantity include sugar, talc, and local anesthetics such as lidocaine. Purity of street cocaine varies from a low of 15 percent to a high of 95 percent.

Street Names

Common street names for cocaine are coke, Big C, C, snow, snowbird, lady, nose candy, blow, toot, leaf, flake, freeze, happy dust, Peruvian lady, and white girl.

Routes of Administration

While cocaine can be absorbed through the digestive-system, it is absorbed so slowly that the effects may be missed. Potency is increased several-fold when cocaine is injected, sniffed, smoked, or inhaled. Snorting or sniffing cocaine powder through the nose has been the most common route of administration, until the recent introduction of crack, a smokable form of cocaine. Typically cocaine powder is finely chopped with a razor blade on a hard, flat surface and then arranged into thin lines. A line of cocaine is then snorted through a rolled bill, straw or "coke spoon." The inhaled cocaine penetrates the mucous membranes of the nasal lining, enters the bloodstream, and is circulated to the brain within several minutes of administration. One line provides the user with twenty to forty minutes of stimulation, described as mild euphoria. A minority of cocaine users rub cocaine on their gums, palates, or underside of their tongues, or have the powder blown from a straw onto the back of their throats.

Intravenous injection of a cocaine solution usually induces an initial rush or "flash" of euphoria, which is intense, but short-lived. A new extremely dangerous method of absorption called "freebasing" has surfaced in the last decade. This is a chemical process whereby cocaine is changed into a smokable and more potent substance called "base" or "freebase." This method involves treating the cocaine powder with a strong alkali and ether. The cocaine is then smoked in a water pipe or sprinkled on a tobacco or marijuana cigarette. This produces a sudden, intense high, often leading to an equally intense "crash." Both freebasing and intravenous injection of cocaine lead to quicker and more direct absorption of the drug, and therefore provide a more immediate and intense high. Both, however, increase the possibility of toxic reactions, including convulsions, irregular heartbeat, and cessation of breathing. Freebasing also carries with it the danger of explosion-based burns during production.

The combined use of cocaine with depressant drugs is a growing practice, especially among long-term compulsive users. Sometimes a mixture of cocaine and heroin is taken, referred to as a "speedball." This mixture cuts the effects of the stimulant, reducing nervousness, and excitability and lessening the intensity of the cocaine crash. Speedballing, however, often increases the risks of drug dependency and toxic overdoses.

Use Patterns

Cocaine, one of the most effective euphorants ever discovered, has become an “in” drug among all income and age groups. Portrayed as the “caviar of drugs,” cocaine holds an appeal that is partially pharmacological and partially symbolic. In many circles, cocaine is an emblem of wealth and status.

Cocaine users can be roughly divided into five categories:

- Social Users: the most common category of users, use the drug in social settings, as a recreational activity only.
- Routine Users: use cocaine to cope with what they feel are unbearable situations. Typically, they do not use cocaine for recreation, and they do not feel the euphoric effects.
- Performance Users: use cocaine to enhance their self-confidence and alleviate feelings of low self-worth.
- Boredom/Stress Relief Users: use cocaine to numb feelings of emptiness, and in some cases, to induce feelings of sexual excitement and connectedness with others.
- Addicted Users: develop slowly from users in the previous categories. They use the drug every hour or more, and prefer it to food, water, and sexual satisfaction.³⁴

These categories are not exclusive, since many users exhibit characteristics of several types of user profiles. In almost every category of cocaine use, there is a tendency to use concurrently other drugs, such as marijuana, tranquilizers, heroin, and the most common, alcohol. Cocaine addicts use other drugs to maintain a high between cocaine doses, to relieve the depression and fatigue that accompany the cocaine crash, or to reduce the nervousness and anxiety cocaine tends to induce.³⁵

Major Uses

Cocaine is used primarily as a “recreational drug” although it also has limited medical use. It is a valuable anesthesia for nose, throat, larynx, and lower respiratory surgery, because it acts as a pain reliever and causes blood vessels to narrow, reducing bleeding during surgery.³⁶ Since the development of anesthetics that are non-addicting, however, it is less commonly used. At one time, cocaine was used extensively in eye surgery, but it is no longer used, since the discovery that cocaine has a tendency to ulcerate the cornea.³⁷

Until recently, another therapeutic use of cocaine was in the “Brompton cocktail”—a solution of cocaine, methadone or morphine, and alcohol used for the relief of pain in terminally ill patients. This mixture was especially popular in English hospices, because it controlled pain without causing stupors or unconsciousness in patients. However, most hospices now use a combination of mor-

Cocaine addicts use other drugs to maintain a high between cocaine doses, to relieve the depression and fatigue that accompany the cocaine crash, or to reduce the nervousness and anxiety cocaine tends to induce.

phine and alcohol.³⁸ Because cocaine mimics certain psychotic states more closely than does any other drug, excluding amphetamines, it is sometimes used to study psychosis for medical research.³⁹

Effects

Neurological

Cocaine stimulates the body's central nervous system, affecting both the cortex and the brainstem.⁴⁰

Physiological

Cocaine also increases heart rate, blood pressure, respiration, and body temperature.⁴¹ It relaxes the muscles of bronchial airways and constricts blood vessels of the nose, making breathing easier. When the drug wears off, bronchial muscles contract and blood vessels relax, causing nasal stuffiness and bleeding of the nasal membranes in regular users. If use continues, the perforation of the nasal septum may eventually occur.⁴² Cocaine increases motor activity, but this becomes less and less coordinated as the dose is increased and the brainstem affected.⁴³ Dilation of the pupils, as well as a rise in the rate of metabolism, may also occur.⁴⁴ Cocaine suppresses rapid eye movement sleep and causes a rebound in such sleep when users come down from a cocaine high.⁴⁵ Prolonged use often results in malnutrition, since cocaine inhibits appetite. Chronic abusers often lose weight and suffer from vitamin deficiencies as well.⁴⁶ Because cocaine passes the placental barrier quite easily, babies born to mothers who use cocaine during pregnancy often suffer from birth defects, developmental delays, and symptoms of withdrawal.⁴⁷ Ingestion of the drug can cause lung damage, blood clots, burns, tremors, chest pain, vomiting, convulsions, stroke, heart attacks, and deaths caused by respiratory collapse. If users survive the first three hours of a cocaine overdose, they are likely to recover, but if respiratory failure has occurred for an extended period of time, users may suffer from varying degrees of brain damage.⁴⁸

Behavioral

The stimulating, euphoric effects of the drug are dependent on the dose, purity, user's mindset, psychosocial setting, and route of administration. Recreational users report feelings of exhilaration, well-being, energy, sensation of clear thoughts and perceptions, reduction of fatigue, euphoria, increased mental alertness, sociability, decrease in hunger, relief from or indifference to pain, feelings of great strength, and delusions of grandeur.⁴⁹ The cocaine rush is nearly always described in sexual terms, akin to the intense feeling of an orgasm.⁵⁰ These feelings in recreational users last twenty to thirty minutes and are followed by a mild depression or come-down.⁵¹ Long-term or chronic users may miss the drug's euphoric effects, but suffer from the effects of a more intense come-down or "crash,"

symptoms of which may include restlessness, irritability, mood swings, anxiety, hostile behavior, tiredness, and an overwhelming desire for more cocaine.⁵² Chronic use may result in paranoia, psychosis, and hallucinations of touch, sight, taste, or smell; an example of these is the perception that insects, known as “coke bugs,” or snakes are crawling beneath the skin.⁵³

Retention

Cocaine crosses the blood/brain barrier and is concentrated in the spleen, kidneys, and brain. It is metabolized by the liver and excreted in urine. *Cocaine can be detected in urine twelve to seventy-two hours after first administration.*⁵⁴

Tolerance and Withdrawal

Chronic cocaine users may develop tolerance to such effects as appetite suppression, heart and blood pressure changes, and euphoria. Prolonged use can have the opposite result, however, making the brain more sensitive to cocaine’s effects. Called “kindling,” this effect can make the brain so sensitive that even low doses of cocaine may cause seizures and sudden death.⁵⁵ The inhibiting of rapid eye movement sleep does not diminish with prolonged use, and the occurrences of psychotic behavior become more frequent with prolonged use.⁵⁶

While a number of cocaine users can maintain a recreational habit, cocaine often produces the compulsive “coke” addict.⁵⁷

Since even a single dose of the drug is usually followed by a period of depression and lethargy, withdrawal after a lengthy period of high dosage use is followed by a profound physical and emotional depression, similar to that of amphetamine withdrawal.⁵⁸

... even a single dose of [cocaine] is usually followed by a period of depression and lethargy ...

CRACK

Crack cocaine is a powerful cocaine derivative, produced by converting cocaine hydrochloride into a chemical base by heating it with ammonia or baking soda and water. After this cooked substance hardens, it is placed in molds and cut into chips or “rocks.” This conversion process is safer, easier, and cheaper than the conversion process for making freebase. Crack is off-white in color and resembles hard shavings similar to slivers of soap or chips of cracked paint. The name “crack” describes the sound made when the drug is smoked. Crack rocks sell for approximately \$5 to \$10 on the street. Most typically, crack is sold in small plastic vials containing one, two, or three rocks.⁵⁹

In 1985, crack emerged on the streets of New York and Los Angeles, dramatically changing the drug scene in the United States. By the end of the 1980s the use of crack had reached epidemic proportions in the United States.⁶⁰

Street Names

Common street names for crack are rock, eight-balls, track, boulders, dime, dime rock, Rox, yeaho, Roxanne, caine, bump, eye-opener, and pony.⁶¹

Routes of Administration

Crack rocks are typically sold in small vials, but may also be sold in folding paper or tin foil. Crack is smoked in a pipe, sprinkled into a tobacco cigarette, or mixed with marijuana. Street crack is sometimes laced with amphetamines or adulterated with compounds, such as "B-12," benzoyl, or other fillers. Because the drug is inhaled, crack is quickly absorbed through the lungs into the bloodstream.

Use Patterns

Because crack is available for as little as \$5 to \$10, the drug is affordable to many new users, including women, high school students, and even younger children.⁶² Once addicted to crack, many people turn to stealing, dealing, and prostitution to support their habit.⁶³ Many users take crack with a combination of other drugs. Some crack users use heroin, marijuana, or depressants, such as alcohol and valium, in order to ease the intensity of the post-crack depression.⁶⁴ The popularity of crack has spawned a large, unregulated market whose high profits have attracted a new generation of individual sellers, as well as organizations. Circulating salespeople who also use crack are referred to as "touters." Street sales are made by low-level retail dealers who may or may not use crack; they are known in drug circles as "runners," "rollers," or "beepermen."⁶⁵ Drug-related violence has increased sharply with the growth of the crack market. By 1989, there were an average of 3,600 crack arrests per month in New York City.⁶⁶ Forty percent of all cocaine abusers are crack users.⁶⁷ Of these crack users, one-fourth will stop using crack on their own with the help of family, clergy, or self-help groups; one-half will enter traditional treatment programs at some point during their addiction; and one-fourth will not be able to stop using crack regardless of attempts to get treatment. These chronic abusers are often involved in criminal activity, and many are mentally ill.⁶⁸

Major Uses

There are no known medical uses for crack. Crack is a highly addictive "recreational" drug.

Effects

Neurological

Crack is absorbed into the brain in a matter of seconds.⁶⁹ In the brain, crack stimulates the neurotransmitter dopamine which controls mood, producing an intense euphoria. But crack also prevents the return of the neurotransmitter for reuse in the nerve cells, which results in depression and leads to an intense craving for more of the drug in order to replenish the chemical transmitters of the brain.⁷⁰

Crack interferes with the functioning of the central nervous system. It can cause brain seizures and strokes. Crack users are six and one-half times more likely to suffer a stroke than non-drug users.⁷¹ Other neurological consequences, such as loss of consciousness, may also occur with the use of crack.⁷²

Physiological

In the body, crack produces the same physiological effects as cocaine. Smoking crack produces increased pulse rate and blood pressure, loss of appetite, and dilated pupils.⁷³ Crack may produce sensory system disorders, such as motor and visual problems. Using crack may lead to a variety of pulmonary disorders, such as hoarseness and chest congestion characterized by the coughing up of black sputum. Lung disease is such a common affliction of chronic crack smokers that it is referred to as "crack lung."⁷⁴

Excessive doses of crack may cause seizures or death due to respiratory failure, cerebral hemorrhage, or heart failure. The symptoms of crack overdose are extreme physical agitation, increase in body temperature, hallucinations, and convulsions.⁷⁵

Behavioral

Crack produces a short intense feeling of euphoria followed by several minutes of a pleasant high, which is quickly followed by a severe "hangover" characterized by deep depression, irritability, occasional feelings of paranoia, and an overwhelming craving for more crack. It is this withdrawal hangover, *not* the euphoric high, that makes crack so addictive.⁷⁶ Crack users report feelings of increased alertness, excitation, euphoria, and insomnia. During prolonged use, individuals may become confused, anxious, depressed, short-tempered, and suspicious. They may have difficulty concentrating and suffer from memory loss. Some users become aggressive and experience panic attacks. Anxiety, restlessness, and extreme irritability may indicate the onset of a toxic psychosis, characterized by tactile hallucinations, similar to those of paranoid schizophrenia.⁷⁷

Crack has become a significant factor in the transmission of sexually transmitted diseases, including AIDS. Although there is no conclusive evidence linking crack use and AIDS, crack use promotes high-risk sexual behavior, such as engaging in sexual relations with numerous partners in a "crack house." Some users exchange sex for crack, and cocaine and crack users are as likely to test positive for HIV infection as intravenous drug users.⁷⁸

Retention

Crack crosses the placental barrier in pregnant women easily. Babies born to mothers who use crack during pregnancy may suffer immediate and long-term physical and emotional effects. These “crack” babies may begin life in a painful state of withdrawal and may be developmentally delayed or impaired.⁷⁹ *It appears that crack has the same window of detection period as cocaine—it can be detected in urine twelve to seventy-two hours after first administration, however, research is limited.*⁸⁰

Crack is considered one of the most addictive substances ever known.

Tolerance and Withdrawal

Crack is considered one of the most addictive substances ever known. Because of the intensity of the come-down depression of crack, the drug has the potential for extraordinary psychic dependency. Recurrent users must resort to larger doses at shorter intervals in order to achieve the same euphoric effects and avoid withdrawal. Severe cravings for crack may last months after recovery from addiction. Withdrawal from crack, although rarely life-threatening, is marked by severe depression, irritability, sleepiness, apathy, anxiety, and sometimes disorientation.⁸¹

Currently there is no state-of-the-art treatment method for crack addicts. Most drug treatment programs are designed for opiate and alcohol abusers. Drug treatment researchers are currently investigating new strategies for crack addicts. Drug treatment researcher Richard Rawson has identified five stages of recovery for cocaine and crack abusers.⁸²

- **Withdrawal:** This stage lasting approximately two weeks, is marked by addicts' initial abstinence from crack or cocaine.
- **“Honeymoon” stage:** This occurs between the third and seventh week of abstinence from the drug and is characterized by the patients' belief that they are cured of the addiction. Energy levels are high, and the patients report a general rosy outlook on life.
- **“The wall”:** This stage lasts approximately two months and marks a major hurdle in recovery. Often patients experience strong cravings for crack, are depressed and anxious, can't concentrate, and lose interest in sex.
- **The fourth stage of recovery:** This occurs approximately four months after withdrawal. Depression and anxiety are eased, as addicts' lives begin to return to normal and intense drug cravings subside.
- **The fifth stage of recovery:** This occurs approximately six months after initial abstinence from the drug and is characterized by the acquiring of lifestyle, coping, and balancing skills by recovering addicts.

DRUGS THAT DEPRESS THE CENTRAL NERVOUS SYSTEM

Drugs that depress the body's central nervous system vary greatly with regard to medicinal and recreational purposes and severity of withdrawal symptoms. Specific drugs discussed in this section include (1) narcotic analgesics/opiates, including heroin and methadone, (2) alcohol, and (3) sedative hypnotics. The legality of these drugs reflects our society's attitudes. Heroin is prohibited by law for any purposes, methadone is legally available within a federally approved treatment program, and for the treatment of chronic pain, and sedative hypnotics are legal only by medical prescription. Alcohol, in contrast, is culturally acceptable and legally available to any individual above the age of twenty-one. However, withdrawal from severe alcohol addiction may lead to death, whereas withdrawal from even the most chronic heroin addiction is seldom life-threatening.

Narcotic Analgesics/Opiates⁸³

What is an Opiate?

The term *opiate* refers to any natural or synthetic narcotic drug that exerts actions upon the body similar to those induced by morphine—the major pain-relieving agent obtained from the opium poppy. This family of drugs is also frequently referred to as narcotic analgesics or narcotics. A narcotic analgesic is a drug that induces sleep and produces a loss of sensitivity to pain as well. The terms “narcotics” and “opiates” are used interchangeably to refer to the same family of drugs. However, the term “narcotic” is often used inappropriately or incorrectly to refer to the habit-forming property of any drug. This common misuse of the term makes it difficult to use it with any degree of accuracy. When referring to this family of drugs, we will use the term “opiates” in order to avoid confusion.

Opiates may be further classified into three categories: natural opiates, including opium, morphine, codeine, and thebaine; semi-synthetic opiates, including heroin, hydromorphone, thebaine derivatives, and etorphine, which are all produced by modifying the chemicals found in opium; and synthetic opiates, including Demerol, methadone, and Darvon, which are made entirely in a laboratory. Enkephalins and endorphins, which are produced in the human body and in the bodies of most vertebrates, have been described as “natural internal” opiates because of their parallel effects.

Opium is the sun-dried milky extract from the seed pods of the poppy *Papaver somniferum*. Known as the “mother drug,” opium contains a variety of ingredients, including morphine and codeine. The bulk of the ingredients of opium, however, consists of resins, oils, sugars, and proteins that account for more than 75 percent

of the weight of opium. Morphine makes up approximately 10 percent of opium, and codeine amounts to only .05 percent of opium extract.

The pharmacological effects of synthetic opiates are nearly identical to those of opium, but the chemical structures differ. Perhaps the best known synthetic opiate is Demerol, which is similar to morphine but shorter acting. Numorphan and Dilaudid are six to ten times more potent than morphine. Other synthetic opiates are Levo-Dromoran, Talwin, Narphen, Stadol, Nubain, Darvon, Sublimaze, and Sufenta.

To varying degrees, these drugs are all analgesics, reducing pain in non-addicts, but they are poor substitutes for morphine and heroin in addicts. One synthetic, most commonly called methadone, is used successfully to treat heroin addicts. It has the advantages of being longer acting than morphine, is able to be efficiently administered orally, and does not produce an increased tolerance to its effects, as is the case with heroin. From methadone, chemists have derived another synthetic drug for treating heroin addicts, named 1-alpha-acetylmethadol or LAAM. LAAM, although not used as commonly as methadone, has the advantage of providing analgesic effects from forty-eight to seventy-two hours, which is much longer than methadone's effects, which last approximately twenty-four to thirty-six hours. According to certain users, however, LAAM is not as successful at blocking withdrawal symptoms within the first twelve hours of administration. In addition, many recovering opiate addicts prefer the daily dose *and* the daily contact of peer and professional support that methadone clinics offer.

Routes of Administration

The opiates are administered orally, injected into the bloodstream, muscles, or under the skin, or inhaled. Generally, absorption from the gastrointestinal route is slower and less complete than inhalation or injection. The blood levels of the drug that are reached after a given dose is administered orally are less than half of that reached when the drug is injected. Opiates may be injected by a subcutaneous or "skin popping" route or through intravenous injection known as "main-lining." Opiates achieve significant levels in the blood within seconds to minutes of intravenous injection. The opiates reach all body tissue.

Major Uses

The major medical use of opiates is relief of pain. Since the addictive properties of the drugs are relatively high, scientists have been working for decades on synthetic versions that have the same pain-relieving effects without the addictive qualities. These attempts have met with varying rates of success. Opiates' other prominent uses include the control of coughing through suppression of the cough reflex, the control of diarrhea through contraction of the intestinal muscles, and the relief of pulmonary distress due to cardiac insufficiencies.

Opiates have been used in their various forms for centuries. In this country, heroin is the most commonly used opiate for "recreational" purposes. Like the other opiates, it is reported by its users to produce feelings of calm, peacefulness, and total relief from physical and emotional pain. A more detailed account of the subjective effects of opium is offered under the subtitle "Heroin."

Effects

The opiates produce a complex mixture of effects on the neurological, central nervous, gastrointestinal, and respiratory systems of humans.

Neurological

Opiate receptors have been found in the brains of most vertebrates, and there appear to be at least three types of opiate receptors in the human brain. These receptors are activated to reduce pain when the body is under extreme stress or physical pain. In 1981, medical researcher Eric J. Simon isolated six naturally occurring opiates, which activate the brain's receptors by binding to them, causing the reduction in pain. He called these naturally occurring opiates "endorphins." It is now generally believed that all opiates work in a similar way to reduce painful sensations. Opiates also reduce the impact of the adverse emotions associated with pain.

Physiological

Opium, in all except natural internal forms, can produce nausea, which may lead to vomiting during the first few times of administration. This is caused by the stimulation of the area of the brain that detects impurities in the blood. However, opiates also depress this center and nausea and/or vomiting is alleviated with subsequent administrations of the drug.

Opiates cause constriction of the pupils of the eye. Opiates have little effect on the heart, but lower blood pressure somewhat by dilating the peripheral blood vessels, which causes flushing of the face and neck, and perspiration. Opiates do not decrease the overall action of the stomach and intestines, but they do appear to disrupt the coordination of digestive activity so that food passes very slowly through the digestive system, leading to constipation or cessation of diarrhea. Opiates also interfere with urination by causing the bladder sphincter to contract. Opiate use decreases the sex hormones in both sexes, and it is thought to be responsible for the difficulties in maintaining erections and generally reduced sex drive reported by male users. Opiates also account for diminished fertility in male and female users. Heavy use may even cause the atrophy of secondary sex characteristics in males and the cessation of menstruation in females. The most serious physiological effect of the opiates, however, is depression of the respiratory system, often leading to death.

Behavioral

Regular opium users report feelings of euphoria, well-being, peacefulness, contentment, sleepiness, or conversely, feelings of boundless energy and excitement. First-time users, however, may experience irritability, anxiety, and general discomfort. Many of the effects of the drug depend on the setting and the pre-existing emotions of the user. It is safe to say, however, that those addicted to the drug experience some form of pleasurable sensation, whether it be ecstasy or merely the cessation of discomfort or pain they normally experience in their drug-free state. Opiates at high doses induce a drowsy, trancelike state or "nod," during which users often see visions or have vivid daydreams. While opium often causes sleepiness, high doses cause insomnia. When users do sleep, they exhibit increased muscular tension and a marked decrease in rapid eye movement sleep. Overdoses of opiates produce a comatose state marked by pinpoint pupils and severe depression of breathing, which often leads to death. Some opiates lower the seizure threshold and may cause convulsions at high doses, although this is rare.

As tolerance to the drug [opiates] increases, users experience more negative mood states and aggressive impulses.

Retention

Most opiates are bound to blood proteins and are concentrated in the lungs, liver and spleen. Both heroin and codeine are metabolized into morphine, and then further metabolized and excreted by the kidneys. Ninety percent of morphine is eliminated within twenty-four hours of administration. *Opiates may be detected in urine from two to four days following administration.*⁸⁴

Tolerance and Withdrawal

Perhaps the most significant feature of all the opiates is the rapidity and extent of tolerance regular users experience. As tolerance to the drug increases, users experience more negative mood states and aggressive impulses. Tolerance to opiates varies with different physiological responses, dosages, and frequencies of administration. Tolerance to respiratory depression, analgesic, sedative, and euphoric effects usually develops, but tolerance to pupil constriction and constipation does not. With intermittent use, little tolerance develops, but with regular use, such tolerance develops that extremely large amounts of the drug must be administered simply to avoid discomfort. If individuals have developed a tolerance to one of the opiates, they will exhibit a tolerance to all the other natural or synthetic opiates, but not to alcohol or any other sedative hypnotic drug.⁸⁵

Although there is much disagreement among the experts regarding the severity of opiate withdrawal, all agree that, unlike alcohol or barbiturate withdrawal, opiate withdrawal is seldom life-threatening. Symptoms of opiate withdrawal include restlessness, cravings for the drug, sweating, anxiety, fever, chills, nausea, vomiting, increased heart and respiratory rate, elevated blood pressure and body temperature, muscle cramps, insomnia, diarrhea, and general aches and pains.

Most opiate addicts are physically recovered within seven to ten days of total abstinence from the drug.⁸⁶

HEROIN⁸⁷

Heroin is a semisynthetic opioid made by treating morphine with acetic anhydride to produce diacetylmorphine. Heroin was first introduced in 1898 as a cough suppressant. Pure heroin appears as a powder, ranging in color from white to dark brown, depending on the amount of impurities it contains from the manufacturing process or on the presence of additives. It may also appear in liquid form, with the consistency of tar.⁸⁸

Street Names

Some common street names for heroin are smack, horse, brown sugar, junk, mud, Big H, tootsie roll, and black tar.⁸⁹

Routes of Administration

Heroin is either inhaled through the nasal passages, smoked, or injected via a needle and syringe directly into the bloodstream or under the skin. Injection is the most cost-effective way for the user to administer heroin, because much of the drug when smoked or inhaled is exhaled and wasted. Heroin is seldom eaten, due to the slowness and incompleteness of absorption from the digestive system. When first administered intravenously, heroin achieves significant levels in the brain within seconds to minutes of the injection. Unlike morphine, heroin bypasses the brain/blood barrier easily, and it is this property that makes it so potent when compared to morphine. This rapid rate of absorption is often experienced as an intensely pleasurable "rush" by heroin users, who may need to continue to use higher and higher doses of the drug to regain this experience, since tolerance to the effects of heroin happens quite rapidly for regular users. Peak brain effects of heroin are reached within fifteen minutes to one hour after absorption in the blood, and generally heroin's effects diminish within three to six hours after administration.

Use Patterns

First exposure to heroin is usually motivated by curiosity or peer pressure. It is almost always introduced by a friend or family member. It is not known how many people exposed to heroin become addicts, but it is known that many people are able to maintain what is called an "ice cream habit" or "chipping" in which heroin is taken occasionally and only when the drug opportunities are available. The initial experience with heroin is usually unpleasant, accompanied by nausea, vomiting,

and sometimes lethargy or disorientation. Subsequent use is required to experience the heroin "rush" and attendant ecstasy reported by regular users.

Heroin use is most common among males in large metropolitan areas, but as with other addictions, there is no single personality profile among users. Marie Nyswander, one of the founders of the methadone maintenance modality, said she could detect no single "type" among her patients: "their range of personality characteristics is as varied as in any other group of the same number of individuals."⁹⁰ There does appear to be some "maturing out" of heroin use among users in their thirties or forties, but the longer people have used heroin, the less chance there is that they will eventually "grow out" of their addiction.⁹¹

Major Uses

There are no specific medical uses for heroin in the United States.

Effects

Neurological

Heroin, like the other opiates, produces analgesic effects similar to those of endorphins by several mechanisms. It blocks incoming sensory information from areas of the spinal cord that normally transmit the perception of dull, burning pain. When the body undergoes pain and/or stress, the area of the brain rich in opiate receptors is activated and reduces the sensation of pain. It is believed that opiates, similar to endorphins, produce analgesic effects by stimulating these opiate receptors in the brain. Opiates also reduce the impact of the adverse emotion associated with pain. Thus heroin, like the other opiates, acts as a strong painkiller, and it does so without impairing the user's vision, hearing, touch, or pressure sense. It alters the *perception* of the painful stimulus, not the pain itself, and it appears to alter the awareness of painful emotional conditions, as well as physical ones.

Physiological

When heroin is first administered, one of its most notable effects is nausea leading to vomiting. But opiates also depress this vomiting center, so that nausea and vomiting are seen only after the first few administrations of the drug, and with continuing doses these symptoms decrease.

Heroin causes constriction of the pupils of the eye, and chronic users, like other opium users, often have pinpoint pupils. Heroin acts similarly to the other opiates on the human digestive system so that food passes very slowly through the digestive system, producing constipation, from which most heroin users suffer at some time. Heroin, like other opiates, also interferes with urination. It decreases the sex hormones in both sexes, and it is thought to be responsible for difficulties in maintaining erections in male users and a generally reduced sex drive in both male

and female users. Heroin use accounts for diminished fertility in both male and female users. More toxic than any of these negative physiological effects, however, is the depression of the respiratory system, which can occur during heroin use, as well as with use of other opiates. Also, heroin is sometimes cut with toxic agents. When death results from heroin overdose, it is almost always caused by either toxic agents within the drug or respiratory collapse.

Behavioral

Regular heroin users report feelings of euphoria and well-being. Increased sensitivity in hearing and vision and an inability to judge the passage of time and space are other sensations often reported by users. Opiates at high doses induce a drowsy, trance-like state or "nod" during which users often see visions or have "dreams," more like vivid daydreams than the hallucinations produced by drugs such as LSD.

While heroin often causes sleepiness, high doses of heroin actually cause insomnia. When users do sleep, they exhibit increased muscular tension and a marked decrease in rapid eye movement sleep. Heroin, as well as other opiates, may cause convulsions at high doses. An overdose of heroin results in a comatose state marked by pinpoint pupils and severe depression of breathing which often leads to death.

As tolerance to the drug increases, physical activity and social interaction decrease, while negative mood swings and aggressive behavior increase.

Retention

Most opiates, including heroin, are bound to blood proteins and are concentrated in the lungs, liver, and spleen. All opiates readily pass through the placental barrier into the fetus of a pregnant woman. Heroin, unlike other opiates, passes into the user's brain with little difficulty. Both heroin and codeine are metabolized into morphine, and then further metabolized and eventually excreted by the kidneys. Ninety percent of morphine is eliminated within twenty-four hours of administration. *Heroin can be detected in urine from two to four days after first administration.*⁹²

Tolerance and Withdrawal

As with other opiates, heroin is notable for the rapidity and extent of tolerance to its effects. As tolerance to the drug increases, physical activity and social interaction decrease, while negative mood swings and aggressive behavior increase. Tolerance to opiates varies with varied physiological responses, dosages, and frequency of administration. Tolerance to respiratory depression, as well as analgesic, euphoric, and sedative effects can develop, but tolerance to pupil constriction and constipating effects does not usually develop. With intermittent use, little tolerance develops, but with regular use tolerance to heroin grows to the point where much

... although there is disagreement regarding severity, most experts agree that heroin withdrawal, unlike alcohol or barbiturate withdrawal, is seldom life-threatening.

larger amounts may have to be administered in order to reach euphoria or to simply prevent withdrawal. Cross-tolerance also develops, so that individuals who become tolerant to one opiate will exhibit tolerance to all other natural or synthetic opiates, but will not develop a tolerance to alcohol or barbiturates, as the large number of deaths from the combined effects of opiates and depressants can attest.

Symptoms of withdrawal from heroin include restlessness, cravings for the drug, sweating, extreme anxiety, fever, chills, nausea, vomiting, increased respiratory and heart rate, elevated blood pressure and body temperature, muscle cramps, insomnia, diarrhea, and general aches and pains. And although there is disagreement regarding severity, most experts agree that heroin withdrawal, unlike alcohol or barbiturate withdrawal, is seldom life-threatening. Heroin withdrawal proceeds in predictable stages, beginning six to twelve hours after the last administration of the drug, peaking at thirty-six to seventy-two hours. Most addicts are physically recovered within a week to ten days of initial withdrawal.

METHADONE

Methadone hydrochloride is a synthetic opiate, first synthesized by German chemists during World War II. Unlike opiates such as heroin or morphine, which are derived from sources of natural origin, synthetic opiates are produced entirely within a laboratory. Chemically, methadone bears little resemblance to morphine, but it has nearly identical pharmacological properties and behavioral effects. It was first introduced in the United States as an analgesic, equal in potency to morphine. Methadone became widely used in the 1960s after two physicians, Vincent Dole and Marie Nyswander pioneered a methadone maintenance program for the treatment of opiate dependency. Methadone is widely used in the treatment of opiate dependency, and for this purpose it is legal in the United States. Because methadone is used as a form of addiction treatment, it will be discussed more thoroughly in chapter 4, "Treatment for Drug-Involved Offenders."

Street Names

Common street names for methadone are dollies, done and biscuits. Commercial names include Dolophine, Methadose, and Amidone.⁹³

Routes of Administration

Methadone is primarily taken orally in a liquid solution under the supervision of treatment professionals. It can also be injected. When injected intravenously, it produces a "rush" similar to that of injected heroin. When used in a treatment setting, methadone is rarely administered by injection.⁹⁴

Use Patterns

Opiate-dependent individuals in methadone maintenance treatment use methadone in singular twenty-four hour doses as part of a medically supervised program, which usually includes other treatment approaches such as individual, group, and family counseling, behavioral modification strategies, and/or twelve step programs. Methadone is occasionally misused for recreational purposes and is sometimes sold on the street.

Major Uses

Methadone is used medically in the controlled withdrawal or maintenance of opiate-dependent individuals. Orally administered in daily doses, methadone is substituted for addicts' usual injection of heroin or other opiate narcotic. Depending on the type of program or patient preference, methadone may or may not be gradually withdrawn. When used in the proper dosage, methadone eliminates opiate withdrawal symptoms, reducing cravings for additional opium. Withdrawal symptoms from methadone itself last longer than those from heroin, but they are also much less acute. Methadone maintenance programs allow patients to move toward conventional patterns of living and improved social functioning. Because methadone is administered orally, it reduces the risk of HIV infection from shared needles.

Effects

There is a significant difference between the initial effects of methadone in people who have never or rarely used an opiate and in opiate-dependent individuals. Although individuals who have never used an opiate may feel the analgesic and euphoric effects of methadone, in opiate-dependent individuals these effects are blocked; hence methadone's effectiveness in the treatment of opiate addiction.⁹⁴

Neurological

Methadone, like heroin and other opiate-based drugs, is a central nervous system depressant. It mimics the action of the naturally occurring opiate receptors in the brain.⁹⁶ When injected, methadone readily crosses the brain/blood barrier, producing the familiar opiate "rush" reported by users. However, when the drug is ingested orally, blood levels remain constant for approximately twenty-four hours, and the effect produced is slow, steady, and barely perceptible by opiate-dependent individuals.⁹⁷

Physiological

Methadone has relatively few physiological effects. Users report an increase in perspiration, fatigue, and constipation as common side effects.

Behavioral

Methadone's effectiveness in the treatment of opiate addiction is caused by the fact that, when the correct dosage is administered in a twenty-four hour period, none of the usual euphoric effects of opium are experienced, and the usual withdrawal symptoms are blocked. Thus, the craving for more opium is greatly reduced, if not eliminated.⁹⁸

Retention

Ten to thirty percent of methadone is eliminated in urine unchanged. The majority of methadone is metabolized within the liver. *Methadone can be detected in urine up to seventy-two hours after administration.*⁹⁹

Tolerance and Withdrawal

Methadone at therapeutic doses reduces withdrawal symptoms and cravings for opiates.

Withdrawal symptoms from methadone itself occur and are generally more prolonged than symptoms from other types of opiate withdrawal, but they are also much less severe and debilitating.

Alcohol

What is Alcohol?

The term *alcohol* is used to describe the chemical compound ethyl alcohol. It is one of several compounds in the "alcohol family." Ethyl alcohol is a thin, colorless fluid with a mild aromatic odor and pungent taste. It is capable of being mixed with water in all proportions, and is diffusible through human body membranes. Ethyl alcohol is the essential ingredient in the beverage alcohol. The ethyl alcohol contained in beverages is derived from certain grains and fruits in a process called *fermentation*. In this process, yeast cells act on the naturally occurring sugar in grain or fruit juices. The yeast cells convert the sugar to carbon dioxide and alcohol.

Because of its high level of toxicity, pure alcohol is rarely consumed. Alcohol is almost always taken in the form of an alcoholic beverage: wine, beer, or distilled spirits. Wine is produced from the fermented juices of grapes or other fruits and has a typical alcohol content of 10 to 14 percent by volume. Beer is derived from cereal grains such as barley, rye, corn, or wheat in a process called brewing, which converts the starch found in cereal broth to a fermentable sugar. Beer contains 3 1/2 to 6 percent alcohol by volume. Whiskey, vodka, gin, rum, tequila, and brandy are types of distilled spirits made from the fermented mixtures of cereal, grains, plant, or fruits, which are heated in a *still*. Distilled spirits have a relatively

high alcohol content, ranging from 40 to 50 percent by volume. This percentage is indicated by the term *proof* appearing on a bottle. Proof is twice the percentage of alcohol by volume.

Street Names

Common street names for alcohol are booze, hooch, juice, brew, and sauce.

Routes of Administration

Alcohol is almost always taken orally in liquid form.

Use Patterns

Currently, alcohol is our most socially accepted “recreational” drug. Although a licit substance, it has the potential to be abused, particularly by those who abuse other substances. Not all alcoholics abuse other drugs, but a significant portion of drug abusers also abuse alcohol.

Americans spend nearly \$31 billion per year on alcohol consumption. Between \$117 and \$120 billion is spent yearly on the problems associated with alcohol abuse. These costs are accrued from death-related expenses, reduced productivity in the workforce, lost employment, medical illnesses, motor vehicle accidents, crime, welfare, incarceration, and treatment and rehabilitation.¹⁰⁰

Sixty-five to sixty-eight percent of Americans drink, and there exists much cultural ambivalence regarding the use and abuse of alcohol.¹⁰¹ Coupled with this general ambivalence concerning the use of alcohol is much confusion in our society regarding the nature of alcoholism. Although more people have come to accept the “medical model” of alcohol addiction, in which alcoholism is viewed as a disease that can be treated, if not cured, many people still regard alcoholics as lacking willpower, character, or moral standards.¹⁰²

The seriousness of the alcohol problem in this country is indicated by the fact that one-tenth of the drinking population consumes one-half of all alcoholic beverages sold.¹⁰³ The level of alcohol consumption is higher among men and younger adults than among women and senior citizens, but recently the levels of drinking among younger women have been rising. In general, drinking levels are higher among men and women under the age of fifty, with higher educational, social, and professional status. Drinkers tend to fall within the range of four categories: social drinkers; episodic excessive or “binge” drinkers; progressive, excessive drinkers; and chronic alcoholics. These drinking categories are not necessarily progressive steps toward alcoholism, nor are they discrete categories, since several styles of drinking may appear in an individual drinker.¹⁰⁴

Not all alcoholics abuse other drugs, but a significant portion of drug abusers also abuse alcohol.

Major Uses

Alcohol appears in many prescription and non-prescription medications, but it is currently not used alone for any medical purposes. Some studies have indicated that a small daily consumption of alcohol may inhibit certain heart diseases, but this has not been totally accepted by the medical community.

Alcohol has been used for centuries for recreational and ceremonial purposes.

Effects

Neurological

Alcohol depresses the central nervous system. The degree of alcohol's depressant effects on the central nervous system depends on the concentration of alcohol in the bloodstream. Most individuals can maintain a relatively low blood/alcohol concentration by taking one drink (the equivalent of one-third ounce of pure ethyl alcohol) per one and one-half hour, since alcohol is metabolized within the body approximately at this rate.¹⁰⁵ With this blood/alcohol concentration, an individual will experience only mild effects, such as the slight heightening of existing moods and a small amount of impairment of mental functioning. More substantial mental impairment occurs when blood/alcohol concentration ranges from .03 percent to .10 percent. In this range, mental inefficiency, feelings of relaxation, mild euphoria, and sedation are usually experienced. With a blood/alcohol concentration between .10 percent and .15 percent, 65 percent of drinkers will display definite signs of mental impairment. The precise mechanism of brain impairment is not completely understood. It is thought that the higher brain centers of the cerebral cortex which control judgement are depressed first, followed by paralysis of the lower centers of the brain, including the medulla, which results in poor coordination, confusion, disorientation, stupor, coma, and finally death.¹⁰⁶

Physiological

Once alcohol is ingested orally, the process of absorption begins. Alcohol requires no digestion, passing readily through the walls of the gastrointestinal tract, where tiny blood vessels absorb it. One-fifth of alcohol is absorbed in the stomach, and the major site of alcohol absorption is the small intestine. A number of factors influence rapidity of absorption, including concentration of alcohol, amount of alcohol, rate of consumption, amount of food in the stomach, body weight, body chemistry, emotions, and the amount of tolerance to alcohol an individual has built up. After being absorbed through the capillary walls of blood vessels in the intestines, alcohol is circulated to all parts of the body. Eventually it is distributed evenly in the body's fluids and cells, achieving a concentration proportionate to the water content and blood supply of organs and tissues. Alcohol continues this dilution process in the body. Regardless of original alcohol concentration, blood/alcohol levels rarely exceed .60 percent, and at this level nearly all drinkers would

be dead. The moderate drinker's blood/alcohol level is generally a few hundredths of 1 percent.¹⁰⁷

The physiological effects of alcohol are numerous and vary according to blood/alcohol concentration. At low levels of blood/alcohol concentration, slight impairment of fine motor skills occurs, along with an increase in reaction time, slight loss of muscle control, and slightly slurred speech. At .09 to .15 percent blood/alcohol concentration, vision and hearing abilities are reduced, performance of all motor skills becomes more difficult, and speech becomes noticeably slurred. From .20 to .30 percent blood/alcohol concentration, body movements can be made only with assistance, and there is difficulty in standing and staying awake, as well as in responding to any stimuli. At .40 percent blood/alcohol concentration, a dangerously high level, almost complete anesthesia is experienced; depressed reflexes and unconsciousness or coma are likely. Between .50 to .60 percent blood/alcohol concentration, deep coma or death is most likely to occur, although death from respiratory depression may occur at much lower levels of blood/alcohol concentration.¹⁰⁸

Behavioral

Behavioral effects of alcohol consumption follow the same pattern of increasing severity as do neurological and physiological effects, depending on blood/alcohol concentrations. At very low levels of blood/alcohol concentration (.01 to .03 percent) very slight feelings of relaxation and slight exhilaration occur. At .06 percent, mild sedation and exaggeration of existing emotions occur. At .09 percent blood/alcohol concentration, inhibitions and self-restraint are lessened, and judgment is clouded. From .10 to .15 percent, major impairment of mental functioning is exhibited, irresponsible behavior is likely, and feelings of euphoria have been reported. From .20 to .30 percent blood/alcohol concentration, mental confusion and a minimum of perception and comprehension are experienced. From .40 to .60 percent, all reactions to stimuli are suspended, as coma or death are induced at this level.¹⁰⁹

Retention

Approximately 95 percent of alcohol ingested is metabolized before excretion. Metabolism generally takes place in the liver, where alcohol is converted to carbon dioxide and water. The small amount of alcohol that is not metabolized is excreted unchanged in the urine and through the lungs. Alcohol passes the placental barrier in pregnant women easily, and children born of alcoholic mothers may experience withdrawal symptoms at birth and a pattern of birth defects known as "fetal alcohol syndrome."¹¹⁰

Alcohol can be detected in urine from two to fourteen hours after first ingestion.¹¹¹ More commonly, however, law enforcement and criminal justice personnel test for the

presence of alcohol with a breathalyzer or by testing the concentration of alcohol in the blood.

Tolerance and Withdrawal

The development of tolerance to the physical and psychological effects of alcohol depends upon the amount and duration of alcohol ingestion. Moderate drinkers develop little or no tolerance to the effects of alcohol. Chronic alcoholics exhibit a marked tolerance. The physical dependence that develops in chronic alcoholics results in a period of intense hyperexcitability during alcohol withdrawal. This withdrawal can lead to convulsions and even death when not medically supervised. As alcohol becomes metabolized more rapidly in the liver, neurons in the brain become more tolerant to the presence of the drug and larger doses must be administered to achieve the same physiological and psychological effects.¹¹²

... [alcohol] withdrawal can lead to convulsions and even death when not medically supervised.

Sedative Hypnotics¹¹³

What are Sedative Hypnotics?

The term *sedative hypnotics* refers to a group of drugs with diverse chemical structures sharing the common effect of depressing the central nervous system. Drugs included in this group can be further broken down into the categories of: (1) barbiturates, (2) non-barbiturate hypnotics, and (3) anti-anxiety agents. When administered, drugs in each of these categories diminish awareness of the environment, spontaneity, and physical activity. Higher doses produce drowsiness, lethargy, and even unconsciousness.

Major kinds of barbiturates include Amytal, Seconal, and Nembutal. Of approximately fifty derivatives of barbituric acid once marketed for medical use, fewer than fifteen are in common use today. Barbiturates are still prescribed for conditions requiring the depression of the central nervous system. Small doses of barbiturates calm nervous individuals; larger doses induce sleep. The major types of non-barbiturate hypnotics include glutethimide (Doriden), methypyrlyon (Noludar), ethchlorynol (Placidyl), and methaqualone (Quaalude, Sopor). These drugs were first introduced in the United States as a less toxic, less dependency-producing substitute for barbiturates. Unfortunately, neither of these characteristics proved accurate. It was not until the discovery of anti-anxiety agents called benzodiazepines, which include Librium, Xanax, and Valium, that the medical community found a truly less toxic barbiturate substitute. These drugs are structurally unrelated to barbiturates but closely resemble them in their effects.

They are considered a first choice by the medical community when an anti-anxiety, sedative, or hypnotic action is required, because they are generally considered effective, safe, and less lethal than the other forms of sedative-hypnotics if overdose occurs. However, their ability to be less dependency-producing remains scientifically unsubstantiated. Also, the additive effects of combining benzodiazepines *and* alcohol can lead to serious depression of the respiratory system and reduced visual and motor skills. They also should not be used during pregnancy, especially in the first trimester when damage to the developing fetus due to drug use is most likely to occur. Diazepam (Valium) and chlordiazepoxide are two of the most widely prescribed drugs in the United States. More than 45 million prescriptions for Valium are filled each year.¹¹⁴

All sedative hypnotics produce similar effects on the body, differing only in speed and duration of action. Consequently, sedative hypnotics can be classified in four groups according to their speed and duration of action: long, intermediate, short, and ultra-short acting. Long-acting sedative hypnotics (eight to twelve hours) are usually administered to treat anxiety and epilepsy. Intermediate- and short-acting sedative hypnotics (one to eight hours) are usually used as aids to sleep, and ultra-short acting sedative hypnotics (thirty minutes to five hours) are administered intravenously as anesthetics.

Street Names

Common street names for sedative hypnotics are downers, blues, blue heavens, yellow jackets, reds, red birds, red devils, dolls, goof balls, and King Kong pills.

Routes of Administration

Sedative hypnotics are usually administered orally, except when used as anesthetics where rapid effects are necessary. Intravenous administration of sedative hypnotics is rarely attempted except by medical professionals in hospital settings, since fatality can easily result from overdose.

Use Patterns

Use patterns usually follow one of two types. In one pattern, the users initially obtain their sedative hypnotic through a prescription for the treatment of a diagnosed medical ailment. Users then continue to take the drug after the prescribed period, in approximately the same dosage.

The frequency of this pattern is made possible by the fact that the legal use of sedative hypnotics prescribed by physicians as sleeping pills is widespread. Five to fifteen percent of the population take sleeping pills occasionally, and one to three percent use them frequently.¹¹⁵ The addictive capability of sedative hypnotics is

illustrated by the fact that a large number of patients continue to use them for extended periods, even though tolerance to the sleep-inducing effects of the drugs develops rapidly. The use of sedative hypnotics in hospitals and residences for the elderly is also considered high.¹¹⁶

In the second pattern of use, the sedative hypnotics are initially obtained illegally and taken in high doses. Street use differs from the first pattern in that the drugs are taken in higher doses and in binges, rather than in regular, low-dose intervals. Taken this way, sedative hypnotics are often used as an alcohol substitute or in combination with alcohol to increase the depressant effects, often resulting inadvertently in fatality.

Major Uses

Sedative hypnotics are used medically for the treatment of numerous disorders, including relief from anxiety, insomnia, as an aid for alcohol detoxification, for the prevention of epileptic seizures, as a pre-anesthetic sedative, or as an agent to induce anesthesia. Compounds containing barbiturates have been employed in the treatment of more than seventy-five different disorders, ranging from arthritis to bedwetting.¹¹⁷ In recent years, however, their use has been declining, since they have a low therapeutic index, have caused many accidental fatalities, and have been used for suicides. The safer benzodiazepines have replaced the extensive use of barbiturates. However, all sedative hypnotics have addictive capabilities.

Sedative hypnotics are used "recreationally," often in combination with alcohol to increase their depressant effects.

Effects

Neurological

The sedative hypnotics depress activity of the brain. In normal doses, they act as selective depressants of certain pathways within the brain that produce wakefulness. Resulting depressed behavior occurs when the arousal center of the brain is depressed. This depression of chemical neurotransmitters within the brain appears to account for the various stages of behavioral depression.¹¹⁸ These progress from disinhibition to relief from anxiety, to sedation, hypnosis, general anesthesia, coma, and finally, death.¹¹⁹

Physiological

Sedative hypnotics produce slight decreases in blood pressure, heart rate, and respiration, as well as loss of fine and large motor coordination. Time spent in rapid eye movement sleep is greatly reduced; consequently dreaming is suppressed. Symptoms of drowsiness or hangover may follow the use of sedative hypnotics. Subtle alterations of judgment, motor skills, and behavior may persist for hours or

days until the compound is eliminated; this pattern is quite similar to that of an alcohol-induced hangover. The depressant effect on the respiratory system can result in death if a substantial amount of the drug is administered. Sedative hypnotics appear to have no significant effect on the gastrointestinal tract, kidneys, or other organs, until toxic doses are reached.

Behavioral

Behavioral effects of sedative hypnotics are similar to those observed during alcohol intoxication. Behavioral disinhibition and relief from anxiety may result in mild euphoria. Occasionally, users may react by withdrawing, becoming depressed, or alternatively becoming aggressive and violent. The user's mental state and social environment prior to taking the drug can affect whether the person will experience mild euphoria or depression.

Retention

Sedative hypnotics are readily absorbed in the bloodstream after administration and are well distributed in most body tissues. Short- and intermediate-acting sedative hypnotics penetrate the blood/brain barrier easily, while long-acting ones do so with less facility. With the exception of barbitol, which is excreted unchanged, most sedative hypnotics are metabolized in several ways before excretion, primarily through the liver. *Detection of sedative hypnotics in urine depends on the duration of action: short-acting sedative hypnotics can be detected in urine within twenty-four hours of administration, intermediate-acting sedative hypnotics have a window of detection from forty-eight to seventy-two hours, and long-acting sedative hypnotics can be detected in urine more than a week after administration.*¹²⁰

It is generally only after unusually high levels of the drug [sedative hypnotics] are reached, or after abrupt discontinuation at lower levels, that removal leads to serious withdrawal symptoms.

Tolerance and Withdrawal

Use of sedative hypnotics on a regular basis produces two types of tolerance: (1) the liver will metabolize the drug more quickly, and (2) neurons will become more adaptive to the presence of sedative hypnotics in the brain. Therefore, a higher dose will be needed to both maintain a given level of drug in the body and to achieve the same behavioral effects. Tolerance to depression of the respiratory system does *not* occur; consequently, the risk of fatality increases when higher doses are administered.¹²¹

Physical dependence on sedative hypnotics is similar to the physical dependence produced by opiate narcotics, but the dose required to induce dependence is much higher than the dose required to induce sleep. It is generally only after unusually high levels of the drug are reached, or after abrupt discontinuation at lower levels, that removal leads to serious withdrawal symptoms. Rebound in rapid eye movement sleep is a common withdrawal symptom. Withdrawal from sedative

... drugs that disrupt the body's central nervous system produce a much wider and often dissimilar variety of effects, including depression, stimulation of vital functions, disruptions in perception, distortions of reality, and hallucinations.

hypnotics differs from opiate withdrawal in that it may lead to life-threatening convulsions. Withdrawal symptoms may also include hallucination, restlessness, and disorientation associated with withdrawal convulsions. According to the national Drug Abuse Warning Network (DAWN), sponsored by the National Institute on Drug Abuse (NIDA), approximately 16 percent of all emergency room admissions for drug abuse in the three-year period from July 1984 to December 1987 were for the abuse of sedative hypnotics, a percentage which was higher than all other drug-related admissions.¹²²

Psychological dependence on sedative hypnotics is likely to occur when they are used compulsively. Many individuals who use sedative hypnotics become psychologically dependent on them.

DRUGS THAT DISRUPT THE CENTRAL NERVOUS SYSTEM

Unlike drugs that primarily depress or stimulate the body's central nervous system and vital functions, drugs that disrupt the body's central nervous system produce a much wider and often dissimilar variety of effects, including depression, stimulation of vital functions, disruptions in perception, distortions of reality, and hallucinations. Specific drugs contained in this section include (1) psychedelics, including LSD, psilocybin (mushrooms), dimethyltryptamine (DMT), and mescaline, (2) cannabis, (3) phencyclidine (PCP), and (4) inhalants. The majority of these drugs can not be obtained legally. Marijuana, although illegal for recreational purposes, is legal in certain jurisdictions for limited medical purposes. Inhalants, although legal, are not intended to be used for recreational purposes.¹²³

Psychedelics

What is a Psychedelic?

Hallucinogens, or *psychedelic drugs*, include organic and synthetic agents that induce visual, auditory, and tactile hallucinations. A hallucination is usually thought of as an altered or distorted perception of reality. Hallucinogens also disrupt cognition and perception, a symptom sometimes associated with psychotic behavior. Researchers suggest that there is a problem in distinguishing this class of drug from others. Many drugs taken at high doses will result in hallucinations due to toxic psychosis, or drug poisoning. The distinction between hallucinogens and other drugs, then, is that this class of drugs causes hallucinations at non-toxic levels.

Psychedelics, particularly LSD, reached their peak of popularity in the 1960s. The use of psychedelics has decreased significantly with the onset of the cocaine/

crack epidemic.¹²⁴ However, hallucinogens are still widely abused in the United States. The 1990 National Household Survey on Drug Abuse (NIDA) estimates that 15 million people, or 7.6 percent of the American population over the age of twelve, have tried and/or used psychedelics at some point in their lives.¹²⁵ In 1990, 1.1 percent of the population, or 2.2 million Americans over the age of twelve used psychedelics.¹²⁶

Routes of Administration

The majority of hallucinogens are taken orally, in the form of pills, tablets, and capsules. Occasionally users inject LSD, but most use "blotter acid," paper that has been soaked with the drug and chewed.

Major Uses

There are no therapeutic or medical uses for psychedelics. Psychedelics are purely a recreational class of drug used to experience distortion of the senses.

Effects

Psychedelics vary widely in chemical structure and produce a wide variety of behavioral effects. There are, however, various common physiological and behavioral effects that follow ingestion of all psychedelics. The following sections include more detailed descriptions of specific hallucinogens, including LSD, mescaline, psilocybin (mushrooms) and DMT.

Neurological

Like the central nervous system stimulators cocaine and amphetamines, some psychedelics, such as mescaline, act on the neurotransmitter norepinephrine (NE) in humans. However, while amphetamines and cocaine produce more behavioral stimulation, the psychedelics in this group produce more hallucinogenic stimulation in the brain. Some psychedelics, such as LSD, psilocybin (mushrooms), and DMT, activate the chemical neurotransmitter serotonin in the part of the brain affecting sensory perception.

Physiological

The most common physiological effects of hallucinogens include increased heart rate, rise in body temperature, and dilated pupils.

Behavioral

Impaired task performance, loss of attention, and time distortion are among the various behavioral effects induced by hallucinogens. Long-term effects may in-

clude permanently impaired judgment, toxic psychosis, depression, and genetic damage in some cases. There is also a risk of flashbacks for frequent users.

Retention

The retention of psychedelics within the body varies widely from drug to drug. Generally, psychedelics pass through the system in seventy-two to ninety-six hours. *Psychedelics may be detected in urine from 24 to 120 hours after administration, depending on the type of psychedelic, the user's rate of metabolism, and the amount of drug ingested.*¹²⁷

Tolerance and Withdrawal

Tolerance in humans develops rapidly to the effects of LSD, psilocybin, DMT, and mescaline. If LSD is taken repeatedly, its effects disappear within two to three days, and an increased amount of the drug will have no effect. However, this tolerance dissipates rapidly, and sensitivity will return within a week.

No withdrawal symptoms associated with the psychedelics have been found.

LSD (LYSERGIC ACID DIETHYLAMIDE)

LSD is the abbreviation of the German expression for *lysergic acid diethylamide*. It is derived from the ergot fungus, which is found on rye, or from lysergic acid amide, found in morning glory seeds. LSD, the most powerful of the psychedelics, is estimated to be 100 times more potent than psilocybin and 4,000 times more potent than mescaline in its ability to produce altered states of consciousness. Because it is so powerful, LSD is generally ingested in extremely small quantities called micrograms or "mikes." The LSD sold on the street may contain a variety of adulterants, including strychnine or methamphetamine (speed).

Street Names

Common names for LSD include acid, California sunshine, microdot, cube acid, blotter acid, purple haze, orange sunshine, domes, and barrels.

Routes of Administration

LSD is generally taken orally in pill or tablet form.

Use Patterns

Unlike drugs such as cocaine or crack, hallucinogens are not used continually. The use of drugs such as LSD tends to be sporadic and episodic, due to users' quick

tolerance to the drugs' effects and the extreme disorienting effects users experience while under the influence of the hallucinogen, rendering them incapable of normal functioning. LSD is often taken in binges or "runs."

Major Uses

There are no therapeutic uses for LSD. It is purely a "recreational" drug.

Effects

Neurological

LSD is structurally similar to the chemical neurotransmitter serotonin in the brain, which affects sensory perceptions. Its neurological effects are characterized by heightened awareness and visual hallucinations.

Physiological

Common physiological effects include nausea, chills, dilated pupils, increased heart rate and blood pressure, hot and cold flashes, loss of appetite, insomnia, and dizziness.

Behavioral

Common behavioral effects include visual hallucinations; emotional changes, including mood swings; time distortion; panic attacks; and flashbacks. Subjective effects reported by users include keen vision and hearing, enhanced creativity, and perceptions involving God, the devil, birth, death, and reincarnation.

LSD is not a toxic agent, and there are no reported deaths due to overdose of LSD. In addition, LSD does not seem to produce long-term psychotic behavior, as has been reported with frequent use of some of the other central nervous system drugs, such as PCP.

In 1967, at the height of LSD use, there was some scientific evidence indicating that LSD caused birth defects and cancer. However, these findings have never been proven or replicated. One well-regarded drug researcher notes that there has been a torrent of research on the topic, but we do not appear to be much further ahead of where we were in 1967.¹²⁸

One disturbing long-term effect of hallucinogens in general, and LSD in particular, is the tendency of users to experience flashbacks. During a flashback, individuals briefly experience the effects of LSD long after taking the drug. Similarly, people who have used LSD may experience the *trailing phenomena*, "in which objects appear to move in a jerky, discontinuous vision as though being illuminated by stroboscopic light."¹²⁹ People who have used LSD only once in their lifetime may experience flashbacks or the trailing phenomena. However, flashbacks diminish over time with longer periods between flashbacks and dimin-

Common behavioral effects include visual hallucinations; emotional changes, including mood swings; time distortion; panic attacks; and flashbacks.

ishing duration of each one. Flashbacks and the trailing phenomena are often triggered by stress.

Retention

Effects of LSD begin thirty to ninety minutes following ingestion, and last eight to twelve hours. Peak effects occur two to three hours following ingestion. LSD is metabolized in the liver, and thus can be detected in the bile and feces. *LSD is detectable in urine up to 24 hours after ingestion. Metabolites of LSD may be found up to 124 hours after ingestion.*¹³⁰

Tolerance and Withdrawal

Tolerance to the effects of LSD develops very quickly. If taken repeatedly, LSD becomes completely ineffective within two or three days. However, tolerance to LSD disappears quickly and sensitivity reappears within a week. No withdrawal symptoms associated with LSD have been documented.

PSILOCYBIN (MUSHROOMS)

In 1958, Albert Hofmann, the discoverer of LSD, isolated two hallucinogenic substances from the naturally occurring psilocybe mushroom, *psilocybin* and *psilocin*.¹³¹ The chemical structure of psilocybin closely resembles that of the psychedelic drugs LSD, DMT, and the chemical neurotransmitter serotonin in the human brain.¹³² When eaten, psilocybe mushrooms affect human cognition and perception in ways similar to LSD. Great variation exists in potency among the approximate fifteen different species of psilocybin mushrooms, and significant differences in potency exist between mushrooms within the same species, as well. The usual oral dose of *Psilocybe semilanceata* (*Liberty Caps*) ranges from ten to forty mushrooms, while the usual dose of *Psilocybe cyanescens* may be only two to five mushrooms. Unfortunately, there are also extremely toxic species of mushrooms that are not psychoactive, yet closely resemble the psilocybin mushroom. For centuries, psilocybin mushrooms have been used in religious and sacramental ceremonies throughout Central America.

Like LSD, psilocybin mushrooms were used extensively by the counterculture of the 1960s. Because they required more work to obtain and were less potent, mushrooms were never as popular as LSD. Mushroom use decreased in the 1970s, paralleling the decline of LSD. There now appears to be somewhat of a resurgence in the popularity of psilocybin use, since mushrooms can be found all over North America and have the added attraction of being considered "natural."

Street Names

Common street names for psilocybin mushrooms are magic mushrooms and Mexican mushrooms.

Routes of Administration

In order for psilocybin to produce its psychedelic effects, it must first be changed into psilocyn in the body, prior to entering the brain. One to five grams of dried mushrooms are ingested orally. Occasionally synthetic psilocybin is made in the form of white powder and is ingested in a dose of between twenty to sixty milligrams. In rare instances psilocybin is injected. The effects of psilocybin mushrooms can be felt within one half hour of oral administration and last between three to six hours.

Use Patterns

Tolerance to the hallucinogenic effects of psilocybin mushrooms, like other psychedelic drugs, occurs rapidly (within two to three days), and therefore the mushrooms are rarely used continuously, but are eaten sporadically to achieve their psychedelic effects. Unlike the other classes of drugs, psychedelic drugs do not tend to be used increasingly by most users. The ingestion of psilocybin mushroom usually decreases or stops completely as users "mature out" of the experience.

Major Uses

There are no known medical uses for psilocybin mushrooms. They are used sacramentally by certain religious groups in Central America and have been used recreationally for centuries.

Effects

As a hallucinogen, psilocybin mushrooms are 100 times less potent than LSD, but their effects are qualitatively the same if dosage adjustments are made. Psilocybin mushrooms are also more potent and less toxic than mescaline. When they are ingested orally, their effects may be experienced within thirty minutes.

Neurological

As with LSD, psilocybin mushrooms are known as "serotonin psychedelics" because of their structural resemblance to the neurotransmitter serotonin in the brain, where it is involved in the regulation of body temperature, sleep, and sensory perception. However, the hypothesis that the psychedelic effects induced by psilocybin are due to an action on serotonin neurons in the brain has not yet been conclusively proven.

Physiological

The changes that occur in the central nervous system when psilocybin mushrooms are ingested affect individuals' sensory perception, sense of time, emotions, moods, and mental processes. Mushrooms can produce very strong visual distortions and vivid hallucinations.

Behavioral

Behavioral effects in humans are closely related to levels of psilocin in the brain. Low doses of psilocin (four to five milligrams) produce a pleasant experience marked by relaxation. Higher doses (up to fifteen milligrams) induce perceptual alterations and hallucinations. Users report a heightened awareness of sensory input or a "flood of sensations" while taking the drug. Especially vivid imagery is often reported, along with an enhanced sense of clarity; a perception of the environment as beautiful, novel, or harmonious; and the commingling of the senses or "synesthesia" in which sounds are "seen," and visuals are "heard."

Retention

Once administered, psilocybin is converted into psilocin in the body. Twenty-five percent of the drug is excreted unchanged, mostly in urine. Five percent is metabolized. What happens to the remaining seventy percent of the drug once in the body is scientifically unknown. No data were available regarding detectability.

Tolerance and Withdrawal

Tolerance to the effects of psilocybin develops rapidly, within two to four days of continuous use. Because of the rapidity of tolerance, physical dependence on the drug does not tend to occur. Although possible, physical dependence on psilocybin mushrooms is extremely rare. There is cross-tolerance between psilocybin, LSD, and mescaline.

No withdrawal symptoms to psilocybin mushrooms have been discovered.

DIMETHYLTRYPTAMINE (DMT)

DMT is a very powerful, fast-acting drug. Administered in either powder or liquid form, it induces short-acting psychotic effects. DMT is a derivative of certain South and Central American shrubs. It is easily synthesized and was first produced in 1931. As a hallucinogen, it is much less potent than LSD. DMT is the active principal ingredient of various South American snuffs, such as *cohoba*, a snuff prepared from beans of the *Piptadenia peregrina*, and *yopo*, a similar product originating in the West Indies. The hallucinations and mental confusion that accompany inhalation of these powders are caused by the presence of DMT and

the drug *bufotenine* contained in the snuffs. DMT can be found in several other plants. Most of the forty-five to sixty species of the tree genus *Virola* found in the jungles of South and Central America contain it in their bark. The drug is used by Indians of the Amazon and Orinoco rivers. Just after the turn of the century, the German anthropologist Koch-Grunberg recorded that the bark of the virola was being prepared by a witch doctor of the Yekwana Indians. The witch doctor stripped the bark, pounded it, and then boiled it in water, until all the water had boiled off. The remaining sediment was then toasted over a fire and chopped into a powder. This powder was then snorted. This snuff is recognized by many names; the most common is *yankee* in Colombia and *parica* in Brazil.

Street Names

Because of its short duration of action—between one to two hours, DMT is commonly called by the street name of businessman's LSD.

Routes of Administration

DMT is not absorbed into the bloodstream when administered orally; consequently it is usually inhaled in powder or smoke form. Usually DMT is combined with tobacco, parsley, or marijuana. Occasionally, DMT is ground into a fine powder and sniffed, eaten, or prepared as a solution for injection. One of the most unique aspects of DMT is its nearly instantaneous impact upon the user. The psychedelic effects of the drug begin and reach peak intensity ten minutes after it is smoked, and last between thirty minutes to one hour. After this, visual and time sense distortions subside rapidly.

Use Patterns

DMT is used medically for the treatment of various diseases by South and Central American Indians and for religious ceremonies.

Major Uses

In the United States, DMT is used solely for "recreational" purposes.

Effects

Neurological

Like LSD and psilocybin, DMT closely resembles and alters the activity of the chemical neurotransmitter serotonin in the brain.

Physiological

When taken in combination with various foods and liquids, DMT may produce life-threatening changes in blood pressure. DMT use can also result in severe headaches, brain hemorrhage, and, in extreme cases, death. Individuals who use DMT must avoid certain aged and fermented foods, such as pickled herring, fermented sausages, salami, pepperoni, sharp or aged cheeses, yogurt, sour cream, beef and chicken livers, beer, wine, cola, chocolate, and raisins, among other foods.¹³³

Behavioral

DMT use can result in severe headaches, brain hemorrhage, and, in extreme cases, death.

DMT produces behavioral effects similar to those of LSD, but of shorter duration. The psychedelic properties of DMT result primarily from alterations in visual perception. Euphoria and behavioral excitability are also reported by users.

Retention

DMT is absorbed in blood only by inhalation. *It can be detected in urine up to twenty-four hours after administration.*

Tolerance and Withdrawal

Little information is available regarding the development of tolerance or dependence on DMT, but it is generally believed to exhibit the same qualities as LSD.

MESCALINE

Mescaline is the active ingredient in the peyote cactus, native to the deserts of Mexico and the southwestern United States. Peyote is a small, spineless cactus, which has a thick tubular root. It has been used for centuries in Mexico. Like the psilocybin mushroom and morning glory seeds, the peyote was a sacred plant for the Aztecs.¹³⁴ A typical hallucinogenic dose of mescaline (approximate 200 milligram) is 4,000 times *less* potent than the average dose of LSD.¹³⁵

The first European account of peyote use in Mexico was a description of Aztec use by the Spanish in the seventeenth century. There is archeological evidence that peyote has been used for at least eight thousand years. The Spanish used it as a medicine and to foresee the future. Eventually, the Spanish government concluded that peyote usage was satanic and made vigorous efforts to eliminate its worship. The government succeeded, however, only in driving it into remote areas, where it has vigorously survived.

In 1919, the chemical structure of mescaline was determined, and the drug was first synthesized. Mescaline was used as a hallucinogen in the 1960s in this country. Like psilocybin, however, it was not as easy to manufacture as LSD and

was less potent. It therefore did not achieve the popularity that LSD enjoyed during those years. Currently, mescaline is the only psychedelic agent that has been sanctioned by the United States government for limited religious use.

Street Names

Common street names for mescaline are mesc, buttons, and cactus.

Routes of Administration

To prepare mescaline, the top part of the peyote cactus is cut into thick slices and set in the sun to dry. These slices shrivel into brown disks, called mescal buttons. The buttons are ingested orally, sucked, or chewed until they disintegrate. Mescal buttons have a nauseating odor and bitter taste. They may also be prepared into cakes, tablets, or a water-soluble powder, which may be eaten or injected. During a peyote ceremony, an Indian may consume as many as twelve buttons.

Use Patterns

Mexican Indians have been using mescaline in ceremonies for centuries. Indians of the United States have known about the effects of the peyote plant for many years, but it was not until the end of the last century that they began using it extensively. They built a new religious ceremony around it, which incorporated elements of their own religious beliefs and Christianity into a new religion, known as the Native American Church. This church has spread from Mexico to Canada and has indicated that it has 250,000 members. By an act of United States Congress in 1970, the use of mescaline for sacramental purposes of the Native American Church was made legal.

Major Uses

There are no known medical uses for mescaline. It continues to be used by Mexican and North American Indians for religious purposes. Mescaline is also used for "recreational" purposes.

Effects

Neurological

Mescaline is a central nervous system disrupter. It reacts similarly to the chemical neurotransmitter norepinephrine in the brain. Norepinephrine controls moods and temperature in the body, among other functions.

Physiological

Mescaline is absorbed readily from the digestive system. The first effects of the drug are nausea, vomiting, tremors, and lack of coordination. These are followed by a period of psychedelic effects similar to those produced by LSD, which may last several hours. Large doses of the drug produce effects similar to the fight/flight syndrome of the central nervous system, including dilation of pupils and increased blood pressure, heart rate, and body temperature. Mescaline is not considered toxic, even in high doses.

Behavioral

Mescaline induces altered sensory perceptions, including visual distortions consisting of brightly colored lights and geometric designs similar to those induced by LSD. Unlike LSD, however, mescaline produces less cognitive confusion, and more insight is retained. Large doses of the drug produce behavioral arousal and excited mental states similar to those induced by amphetamines.

Retention

Mescaline is rapidly and completely absorbed within the body. Peak concentration in the brain is usually achieved within thirty to ninety minutes. The effects of a single dose last approximately twelve hours. *Mescaline can be detected in urine up to forty-eight hours after administration.*¹³⁶

Tolerance and Withdrawal

Tolerance to the psychedelic effects of mescaline develops rapidly (within three days) of continuous use. Cross-tolerance with LSD and psilocybin also exists. No physical dependence or withdrawal symptoms from mescaline use appear to occur.

Cannabis (Marijuana)

What is Cannabis (Marijuana)?

Cannabis sativa, or marijuana, was given its name and classification by Linnaeus in 1753. Prior to its formal classification, marijuana and its derivatives were grown and cultivated for thousands of years for its fibers, oils, and seeds. It has been speculated that cannabis might be man's oldest source of fiber.

Cannabis is neither a hallucinogen nor a sedative, as it possesses properties of both types of drugs. This drug classification is inclusive of every part of the Indian hemp plant. Although there are many varieties of the cannabis plant, all types can be distinguished by their distinctive leaves, which grow in groups of five and are usually long and slender, with serrated edges.

The active ingredient in cannabis is *delta-9-tetrahydrocannabinol (delta-9-THC)*, commonly referred to as THC. However, there is an entire category of drugs called cannabinoids that are found exclusively in the hemp plant. Currently, more than eighty different cannabinoids have been identified.

Street Names

Marijuana and its derivatives hashish and hashish oil, from the resin of the marijuana plant, possess a variety of street names, including pot, reefer, weed, grass, hash, tea, kif, and maryjane.

Routes of Administration

Marijuana is most frequently used by smoking dried leaves and flowers of the hemp plant. A less common method of drug intake includes eating plant parts, usually by mixing them in cakes, breads, and brownies. Although eating marijuana provides a slower effect, baking the hemp plant alters the chemistry of cannabis, thus providing a stronger, more potent physiological effect. Additionally, hashish and hashish oil can be brewed into a potent tea.

Use Patterns

Many researchers consider heavy use to be at least once a day, or at least five marijuana cigarettes, called joints, a week. Medium use is at least three joints a week, and light use is once a month or less.

Major Uses

Cannabis is used for both medical and recreational purposes. Medically, cannabis has been successful in treating glaucoma. THC, the active ingredient in cannabis, is used to reduce the nausea and vomiting often associated with the side effects of chemotherapy.

Effects

Neurological

THC is a difficult compound to classify. At low to moderate doses, THC acts on the central nervous system as a mild sedative-hypnotic, like alcohol. Higher doses of THC, however, may produce euphoria, hallucinations, and heightened awareness similar to those produced by psychedelics. The structure of THC does not resemble that of any known chemical transmitter in the brain, and its mechanism of action is currently unknown.¹³⁷

Marijuana users report a subjective effect of increased sensory acuity. . . . The most common behavioral effects of marijuana use are time distortion and deficit in short-term memory.

Physiological

The most common physiological effect of marijuana is bloodshot eyes, producing a "stoned" appearance. Other common effects include a dry mouth, extreme thirst, and an intense feeling of hunger, which is strongest three hours after inhalation. An increase in heart rate, in some individuals up to 160 beats per minute, and fluctuations in blood pressure and body temperature are also associated with marijuana use. Marijuana causes drowsiness and increased sleep time; however, large doses often interfere with the normal sleep cycle, causing insomnia and restlessness.

Behavioral

Marijuana users report a subjective effect of increased sensory acuity. Testing of sensory thresholds, however, shows only a decrease in visual, auditory, and tactile sensitivity. Marijuana causes a decrease in pain sensitivity, which proves its analgesic properties.

The most common behavioral effects of marijuana use are time distortion and deficit in short-term memory. Users often lose the ability to retain and coordinate information. It is not unusual, for example, for people under the influence of cannabis to start a sentence and then stop halfway through because they forgot what they started to say. Likewise, cannabis tends to shorten the attention span of users and makes them more easily distracted. Mood swings from euphoria to dreaminess are characteristic. There is generally a pleasant feeling of joy and well-being, of getting "high." However, users sometimes report the occurrence of "freak-outs," or panic attacks that arise from hallucinations, paranoia, and perceptual distortion.

There are several long-term, harmful effects of frequent marijuana use. Similar to tobacco smoke, marijuana smoke carries carbon monoxide and tars. Cannabis contains 50 percent more tar than tobacco and 70 percent more benzopyrene, a carcinogen. Because marijuana smokers tend to inhale deeply and hold the smoke in their lungs, it is estimated that one joint yields five times the amount of benzopyrene as one cigarette. Thus, smoking as few as two or three joints a day may carry the same risk of lung cancer as smoking one pack a day.

Retention

When marijuana is smoked, major physiological effects occur within two to three minutes of inhalation. Peak effects usually occur ten to twenty minutes after inhalation, and last from ninety minutes to two hours. When marijuana is eaten, effects occur within thirty to sixty minutes of ingestion. Peak occurs two to three hours after eating.

Because it is stored in fat tissue, marijuana is retained for a longer duration than most of the drugs that disrupt the central nervous system. *THC in the urine of*

*casual marijuana users may be detected from two to seven days after administration. For chronic users the window of detection may be much longer, ranging from three to four weeks.*¹³⁸

Tolerance and Withdrawal

There is little evidence that users become either physiologically or psychologically tolerant of marijuana. After discontinuation of the drug, users may experience inner "unrest," reduced appetite, hot flashes and sweating, irritability, insomnia, and restlessness.

Marijuana has been cited for providing a "stepping stone" on the route to the use of other drugs, typically heroin. Some studies show that almost all heroin users at one time used marijuana, and, the more that people use marijuana, the more likely it is that they use other drugs as well. In 1982, the National Survey of Drug Abuse found that those who use marijuana often drink alcohol simultaneously. This evidence, while illustrating a correlation between marijuana and other drugs, is not strong enough to support the theory that marijuana use "causes" progression to other drugs. At the core of the "stepping stone" theory is the hypothesis that users develop tolerance and become bored with the effects of "mild" drugs and escalate to more powerful drugs. However, marijuana users neither develop a physiological tolerance nor give up marijuana when they begin to take other drugs, but tend to use other drugs in conjunction with marijuana.

Phencyclidine (PCP)

What is Phencyclidine (PCP)?

Developed in the 1950s as a surgical anesthetic, *phencyclidine (PCP)* was introduced into the medical community under the trade name *Sernyl*. In 1965, the drug was taken off the market because of its unpleasant side effects, one of which was visual hallucinations. PCP appears in a wide variety of forms and colors. In its original state, it is a white crystalline powder that has a bitter taste. It is often mixed with dyes, dissolved in water, or cut with adulterants and contaminants. It is sold in the form of multicolored powders or gummy substances, which have been processed into tablets or capsules. Modifications of the basic PCP manufacturing process have produced a number of chemically similar compounds referred to as analogues. Included in this group are PCC, PCE, PHP, TCP and the anesthetic ketamine. All have been sold illicitly on the street as "PCP." PCP was originally classified as a depressant by the federal government, but because of its dissociative qualities, has been considered as a psychedelic by many drug treatment professionals. Because PCP can exhibit stimulant, depressant, and psychedelic properties depending on dosage, its specific pharmacological classification has not been

agreed upon by the scientific community. PCP can be considered a “dissociative anesthetic,” because while under its influence, medical patients often had their eyes open, yet felt dissociated from all bodily sensations and their environment.¹³⁹

PCP first appeared on the illegal drug scene in 1965, but it did not receive much attention until it appeared as the “PeaCe Pill” in 1967 in San Francisco’s “hippie” community and as “hog” in New York City’s subculture in 1968. Touted as being more potent than marijuana, but less disorienting than LSD, PCP gained in popularity, but was soon associated with very unpleasant side effects. It soon disappeared from the marketplace, but resurfaced in the guise of other illicit drugs, such as THC, LSD, and other psychedelics.¹⁴⁰

PCP gained notoriety as the drug menace of the late 1970s and early 1980s. In 1977 the National Institute on Drug Abuse initiated a nationwide campaign to inform the public of the hazards of PCP.¹⁴¹ However, more recently, the Drug Use Forecasting (DUF) Annual Report of 1990 reported that PCP use among arrestees was limited to a few sites. The highest percentage of positive testing for PCP in males was found in Chicago (15 percent) and for females in San Jose (13 percent). Fewer than 10 percent of arrestees in the remaining DUF sites were found to be positive for PCP.¹⁴²

Street Names

Common street names for PCP are angel dust, embalming fluid, rocket fuel, loveboat, lovely, hog, super grass, and killer weed.¹⁴³

Routes of Administration

PCP can be smoked, inhaled, sniffed, eaten, or injected intravenously. It is most commonly put into cigarettes and smoked. Sometimes PCP is placed in parsley, marijuana, or other leaf mixtures and smoked. Less frequently, liquid PCP is ingested with juice or alcoholic beverages, or injected intravenously, usually two to three times per day for prolonged periods of time.

Use Patterns

Many individuals use PCP in conjunction with alcohol and marijuana at parties to intensify the high. Others value its psychedelic properties more. In the recent past, because of its bad street reputation, PCP was often misrepresented and sold as THC, marijuana, mescaline, LSD, amphetamines, and even cocaine.

Major Uses

Once used as an anesthetic, PCP is no longer used by the medical community. PCP is now illegal and only used illicitly for “recreational” purposes.

Effects

The pharmacological effects of PCP depend on the route of administration and dosage. The subjective effects of the drug vary widely from one PCP user to the next. The behavioral effects of this drug may be of special concern to the courts because of the drug's capacity to increase aggressiveness and violent behavior.

Neurological

The action of PCP on the brain remains a mystery to the scientific community. PCP does not appear to have a specific effect on any of the receptor sites for any neurotransmitter. It does alter the levels of some transmitters. It appears to stimulate sigma receptors in the brain. The location and function of sigma receptors are currently unknown, but scientists have theorized that they play a role in the mental illness, schizophrenia.¹⁴⁴

The behavioral effects of this drug may be of special concern to the courts because of the drug's capacity to increase aggressiveness and violent behavior.

Physiological

PCP use elevates heart rate and blood pressure while depressing the central nervous system. Increased salivation, sweating, repetitive movements, and muscle rigidity may also occur while a person is under the influence of PCP. Speech is often blocked. Large doses may produce convulsions, coma, heart and lung failure, or ruptured blood vessels in the brain.

Behavioral

When PCP is eaten, it produces a high lasting five to eight hours. When it is smoked or snorted the effects last from three to five hours. Small doses (five milligrams or less) lead to a drunken state or euphoria, accompanied by a numbness of the extremities. Users often appear "stoned," with a staggering gait and slurred speech. Users report a temporary feeling of detachment from their surroundings. Feelings of strength, power, and invulnerability may accompany this detachment.

In moderate doses (five to ten milligrams), analgesia and anesthesia are induced. Moderate PCP users often cannot tell when they have been seriously hurt. A psychic state similar to that induced by sensory isolation is produced. Disorganized thoughts, drowsiness, hostility, and bizarre behavior have been reported.

In large doses (ten milligrams or more), analgesia and anesthesia are more pronounced. Severe depression, violent behavior, paranoia, and visual and audio hallucinations may occur, as may stupor, coma, or convulsions.¹⁴⁵

Retention

PCP is entirely metabolized and excreted in urine. *Traces of PCP may be detected in urine up to seven days after administration.*¹⁴⁶

Tolerance and Withdrawal

Tolerance develops to the effects of PCP. Users frequently need only a small amount of the drug to experience the behavioral effects of the drug at first, but within two to six weeks, they need much more PCP to attain the desired effects.

Research with nonhuman subjects has shown that there may be some withdrawal symptoms after continual use of PCP, but no systematic study of withdrawal from PCP in humans has been undertaken.¹⁴⁷

Inhalants

What are Inhalants?

Inhalants consist of a diverse group of compounds manufactured for adult purchase, and produced, distributed, and sold for legal purposes. They include various commercial products used as cleaners, cosmetics, paint solvents, glues, motor fuels, and aerosol sprays. When inhaled, however, these chemicals produce vapors that alter the senses. Inhalants produce a more rapid high than does drinking alcohol or ingesting other drugs. Effects subside after one or two hours, and the hangover from inhalants is reported as less unpleasant than that of alcohol. Many users consider inhalants more reliably intoxicating than marijuana.

Inhalants can be classified into three major groups: (1) commercial solvents, including toluene, xylene, benzene, naphtha, acetone, and carbon tetrachloride found in commercial products such as airplane glue, paint thinner, gasoline, cleaning fluids, nail polish remover, cigarette lighter fluid, and typewriter correction fluid; (2) aerosols, which are the suspended particles contained in the gas of many household sprays, including cooking sprays, glass chillers, spray paints, hair sprays, and freon, which is used in refrigerators and air conditioners; and, (3) anesthetics, such as chloroform, ether, halothane, nitrous oxide, and cyclopropane.¹⁴⁸

Street Names

Common street names for inhalants are laughing gas, whippets, poppers, snappers, rush, bolt, bullet, locker room, and climax.

Routes of Administration

These substances are always inhaled. Often users employ efficient ways of containing the vapors, for example, placing glue in a bag to better confine the vapors and increase their intensity.¹⁴⁹

Use Patterns

Inhalants are often the very first psychoactive agents that people use for recreational purposes. Because of their low cost and easy availability, they tend to be used by the young who may have limited access to other drugs. More young males than females use inhalants. Recently, however, increasing numbers of male and female adults have used inhalants for an inexpensive, fast, "high." Nitrogen oxide or "laughing gas" has become a popular intoxicant for high school and college students, as well as young professionals. Other types of inhalants are found in commonly used household items and motor fuels.

Major Uses

Several inhalants are currently used for medical purposes. Nitrous oxide is used as an anesthetic. Amyl nitrite plays a large medical role in the treatment of heart patients. This inhalant relieves the suffocation effect and associated fear commonly experienced in the heart condition, angina pectoris.

Effects

Neurological

Inhalants tend to depress the central nervous system. Amyl nitrite dilates the arteries of the brain, inducing a feeling of lightheadedness and a flushed appearance.

Physiological

The use of inhalants can induce headaches, nausea, dizziness, slurred speech, shakiness, uncoordination, double vision, muscle spasms, flushing, hypotension, chest pains and palpitations, weight loss, and cough.

Fatalities can occur from inhalant use. Certain inhalants are extremely poisonous. High concentrations of inhalants can cause suffocation by displacement of oxygen in the lungs or by depression of the central nervous system to the point that breathing stops. Sudden death by cardiac arrest may occur when an inhalant is used while the individual is engaged in strenuous activity. Long-term use may induce hepatitis and brain hemorrhage. Repeated inhaling of concentrated vapors over time may permanently damage the nervous system, lungs, and liver.

Behavioral

The behavioral effects of inhalant use include: feelings of euphoria, the blotting out of unpleasant sensations, and a dreamlike "high" similar to alcohol intoxication. At low doses, users experience a relaxed, lightheaded, giddy feeling, followed by feelings of excitement and exhilaration, accompanied by a reduction in inhibi-

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tions. At higher doses, users experience distorted perceptions, extreme confusion, and hallucinations. Eventually they experience a complete numbing of the senses, and with continued use, suffer unconsciousness.

Retention

Inhalants reach peak concentration levels within fifteen to thirty minutes of administration, are rapidly metabolized in the body, and are nearly undetectable in urine.¹⁵⁰

Tolerance and Withdrawal

Tolerance to the intoxicating effects of inhalants can develop with regular use, but physical dependence has not been established by medical researchers. Inhalants appear to have few withdrawal symptoms.

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TABLE 2**DRUGS OF ABUSE**

Stimulants	Name	Medical Uses	Appearance	Routes of Administration	Possible Effects	Duration of Effects	Effects of Overdose	Withdrawal	Approximate Detection Time in Urine *
	Amphetamines	weight control, treatment of attention deficit disorder, treatment of petit mal seizures, and narcolepsy	tablets, capsules, pills, white powder or rock resembling paraffin	taken orally, diluted and injected intravenously, inhaled	dry mouth, dilated pupils, dizziness, headaches, loss of appetite, insomnia, restlessness, irritability, chills, sweating, tremors, blurred vision, skin sores, increased alertness, excitation, euphoria, ulcers, increased pulse rate and blood pressure, sensory hallucinations	2 - 4 hours	agitation, increase in body temperature, stimulant-induced psychosis, possible death by lethal rupture of blood vessels, or coronary collapse (in high-dose intravenous users)	increased appetite, irritability, long periods of sleep, apathy, disorientation, depression	2 - 4 days after administration depending on user's rate of metabolism and the amount taken
	ICE	none	clear, crystal-shaped solid resembling glass; color ranges from transparent to milky or pure white resembling rock candy	smoked	dilated pupils, increased energy and sense of well being, feelings of euphoria, mild anxiety, loss of appetite, insomnia, increased body temperature, increased heart and respiratory rate, increased aggression, hallucinations, and paranoia	2 - 8 hours	convulsions, fatal lung and kidney disorders, and cardiac arrest	dry mouth, fatigue, nausea, anxiety, irritability, mild to severe depression, tremors, irregular heartbeat, convulsions, coma	up to 3 days after administration

* These are general guidelines only. Detection times vary, depending on analytic methods used, the user's physical condition, metabolism of the drug, fluid intake, and method and frequency of drug use.

TABLE 2**DRUGS OF ABUSE (cont'd.)**

Stimulants	Name	Medical Uses	Appearance	Routes of Administration	Possible Effects	Duration of Effects	Effects of Overdose	Withdrawal	Approximate Detection Time in Urine.*
	Cocaine	vasoconstrictor, anesthetic for ear, nose, and throat surgery, intubation	white crystalline powder often diluted with other ingredients such as talc	inhaled through nasal passages, injected, smoked	decreased appetite, weight loss, elevated body temperature, heart rate, and blood pressure, increase in motor activities and rate of metabolism, dilation of pupils, suppression of REM sleep, perforation of nasal septum, euphoria, increased energy and alertness, relief of pain, delusions of grandeur, increased sexual desire, blood clots, lung damage, tremors, chest pains	1 - 2 hours	convulsions, seizures, respiratory collapse, stroke, heart attacks, brain damage	drug craving, restlessness, irritability, mood swings, anxiety, fatigue, lethargy, depression	12 hours - 3 days after administration
	Crack	none	light brown or beige pellets or crystalline rocks that resemble coagulated soap or shavings of cracked paint; then packaged in small plastic vials	smoked in a pipe, or sprinkled on tobacco or marijuana cigarette	similar to those of cocaine, but due to high concentration of drug and the rapidity with which it reaches the brain, provides more potent stimulant effects, more disorganizing effects on emotion, cognition, and behavior	5 - 20 minutes	loss of consciousness, respiratory failure, brain seizures, stroke, heart failure	drug cravings, sleepiness, irritability, apathy, anxiety, disorientation, depression, and paranoia	12 hours - 3 days after administration

* These are general guidelines only. Detection times vary, depending on analytic methods used, the user's physical condition, metabolism of the drug, fluid intake, and method and frequency of drug use.

TABLE 2
DRUGS OF ABUSE (cont'd.)

Depressants	Name	Medical Uses	Appearance	Routes of Administration	Possible Effects	Duration of Effects	Effects of Overdose	Withdrawal	Approximate Detection Time in Urine *
	Heroin	none	powder ranging in color from white to dark brown; liquid resembling tar	injected, inhaled through nasal passages, smoked	constriction of pupils, nausea, constipation, drowsiness, decrease in sex hormones, diminished fertility, alleviation of pain, increased sensitivity of hearing and vision, feelings of euphoria, drowsy trance-like state, vivid daydreams	3 - 6 hours	pinpoint pupils, convulsions, depression of respiratory system, coma	sweating, chills, fever, muscle cramps, diarrhea, nausea, vomiting, increased respiratory rate, restlessness, insomnia, cravings for more heroin, anxiety	2 - 4 days after administration
	Methadone	controlled withdrawal or maintenance of opiate-dependent individuals in treatment settings, analgesic for chronic pain	white crystalline powder, tablets, liquid	taken orally in liquid solution under medial supervision; injected	sweating, fatigue, constipation, analgesic, blocks opiate withdrawal symptoms, feelings of euphoria only in individuals who have never used opiates before, no euphoric effects in opiate-dependent individuals	8 - 18 hours when used as an analgesic 24 - 36 hours when used for withdrawal or maintenance of opiate-dependent individuals	similar to heroin	similar to the withdrawal effects of heroin, but more prolonged and less intense	up to 3 days after administration

* These are general guidelines only. Detection times vary, depending on analytic methods used, the user's physical condition, metabolism of the drug, fluid intake, and method and frequency of drug use.

TABLE 2
DRUGS OF ABUSE (cont'd.)

Depressants	Name	Medical Uses	Appearance	Routes of Administration	Possible Effects	Duration of Effects	Effects of Overdose	Withdrawal	Approximate Detection Time in Urine *
	Alcohol	sedation, digestive aid, to decrease uterine contractions	thin, colorless fluid derived from grains and fruits	taken orally in liquid form	impaired mental functioning, poor coordination, impaired vision and hearing, slurred speech, sedation, relaxation, heightened moods, lowered inhibitions, euphoria, clouded judgment, disorientation	2 - 8 hours (widely variable)	depression of respiratory system, coma, death	intense hyperactivity, coma, death may occur if not medically supervised	up to 14 hours, however, detection period depends on amount consumed; more commonly, however, law enforcement personnel test for alcohol with a breathalyzer or blood test, rather than a urine test
Depressants	Sedative Hypnotics	treat anxiety, aid to sleep, treat epilepsy, anesthetic in surgery, aid in alcohol detoxification	pills, tablets, capsules, liquids	taken orally, through intravenous injection when used as an anesthetic	decreased physical activity, lethargy, decreased REM sleep, loss of fine and large motor skills, decreased blood pressure and heart rate, general anesthesia, sedation, decreased environmental awareness, lowered inhibitions, relief from anxiety, mild euphoric feelings, depression	<i>Ultra-short acting:</i> 30 min. - 5 hours <i>Short-intermediate acting:</i> 1 - 8 hours <i>Long-acting:</i> 8 - 12 hours	unconsciousness, depression of respiratory system, coma, death	restlessness, disorientation, rebound in REM sleep, hallucinations, life-threatening convulsions	<i>Short-acting:</i> up to 24 hours after administration <i>Intermediate-acting:</i> 2 - 3 days after administration <i>Long-acting:</i> more than 1 week after administration

* These are general guidelines only. Detection times vary, depending on analytic methods used, the user's physical condition, metabolism of the drug, fluid intake, and method and frequency of drug use.

TABLE 2**DRUGS OF ABUSE (cont'd.)**

Disrupters	Name	Medical Uses	Appearance	Routes of Administration	Possible Effects	Duration of Effects	Effects of Overdose	Withdrawal	Approximate Detection Time in Urine.*
	LSD (Lysergic Acid Diethylamide)	none	pills, tablets, sheets of blotter paper	taken orally, licked off blotter paper	dilated pupils, increased body temperature, impaired task performance, chills, nausea, mild dizziness, loss of appetite, insomnia, mood swings, heightened awareness, increased hearing and visual sensitivity, time distortions, panic attacks, hallucinations, flashbacks	8 - 12 hours	longer, more intense "trips," psychosis	withdrawal symptoms not reported	up to 24 hours after administration
	Psilocybin (Mushrooms)	none	dried mushrooms, capsules, tablets	taken orally	similar to LSD, but much less potent, relaxation, mood swings, time distortion, co-mingling of senses, hallucinations	3 - 6 hours	same as LSD	withdrawal symptoms not reported	no available data
	Dimethyl-tryptamine (DMT)	treatment of various diseases by South and Central American Indians	powder or liquid form, derived from certain South and Central American shrubs	smoked, inhaled, injected	similar to LSD but less potent: severe headaches, life-threatening changes in blood pressure, excitation, euphoria, short-acting psychotic effects	1 - 2 hours	brain hemorrhage, death	withdrawal symptoms not reported	up to 24 hours after administration

* These are general guidelines only. Detection times vary, depending on analytic methods used, the user's physical condition, metabolism of the drug, fluid intake, and method and frequency of drug use.

TABLE 2

DRUGS OF ABUSE (cont'd.)

Disruptors	Name	Medical Uses	Appearance	Routes of Administration	Possible Effects	Duration of Effects	Effects of Overdose	Withdrawal	Approximate Detection Time in Urine *
	Mescaline	none	brown disks resembling buttons; tablets, liquid; active ingredient in the peyote cactus	taken orally, sucked, chewed, injected	similar to LSD but much less potent: dilated pupils, increased body temperature, nausea, vomiting, tremors, increased heart rate, blood pressure, euphoria, visual hallucinations	8 - 12 hours	same as LSD	withdrawal symptoms not reported	up to 48 hours after administration
	Cannabis (Marijuana)	treatment of glaucoma, cancer chemotherapy anti-nauseant, anti-convulsant, treatment for asthma	dried parsley mixed with stems and/or seeds	smoked, taken orally	bloodshot eyes, dry mouth, extreme hunger and thirst, mild sedative, analgesic, increased blood pressure and heart rate, lung damage, increased sensitivity to sensory perception, mood swings, decreased attention span, decrease in short-term memory, time distortion, euphoria, hallucinations, panic attacks, paranoia	Smoked: 1 1/2 - 2 hours Taken orally: 2 - 3 hours	fatigue, paranoia, possible psychosis	discontinuation of use may cause restlessness, reduced appetite, hot flashes, sweating, irritability, insomnia	For casual users: 2 - 7 days after administration For chronic users: up to 3 - 4 weeks

* These are general guidelines only. Detection times vary, depending on analytic methods used, the user's physical condition, metabolism of the drug, fluid intake, and method and frequency of drug use.

TABLE 2
DRUGS OF ABUSE (cont'd.)

Disrupters	Name	Medical Uses	Appearance	Routes of Administration	Possible Effects	Duration of Effects	Effects of Overdose	Withdrawal	Approximate Detection Time in Urine *
	Phencyclidine (PCP)	none	variety of forms and colors; original state: white, crystalline powder with bitter taste; sold in forms of multi-colored powders, tablets, capsules	smoked, inhaled, taken orally, injected intravenously	sweating, repetitive movement, muscle rigidity, numbness of extremities, slurred or blocked speech, increased heart rate and blood pressure, depressed central nervous system, feelings of invulnerability, analgesic, euphoria, increased aggression and violent behavior, visual and audio hallucinations	<i>Smoked, inhaled:</i> 3 - 5 hours <i>Taken orally:</i> 5 - 8 hours	convulsions, coma, heart and lung failure, ruptured blood vessels in brain	no systematic study has been undertaken	up to 8 days after administration
Disrupters	Inhalants	anesthetic in surgery, treatment of angina pectoris	diverse group of compounds including various commercial products used as cleaners, cosmetics, paint solvents, glues, motor fuels, aerosol sprays	vapors inhaled	flushing, weight loss, headaches, nausea, lack of coordination, tremors, slurred speech, double vision, muscle spasms, chest pains, heart palpitations, dilated arteries in brain, relaxation, light-headedness, euphoria, hallucinations	30 min. - 2 hours	unconsciousness, death through depression of respiratory system, cardiac arrest or brain hemorrhage	withdrawal symptoms not reported	nearly undetectable in urine

* These are general guidelines only. Detection times vary, depending on analytic methods used, the user's physical condition, metabolism of the drug, fluid intake, and method and frequency of drug use.

ASSESSMENT

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Chapter 3

ASSESSMENT

According to Judge Michael Brennan Getty of the Circuit Court of Chicago, "... the primary difficulty for the court is to identify acceptable candidates [for treatment-oriented dispositions].¹ ... In the last analysis, the judge presiding over criminal cases must decide who are the best candidates for alternative sentencing.²

In this chapter, we will discuss considerations regarding substance abuse assessments as well as specific assessment instruments. Assessments are intended to help *inform* judicial decisions; they are not intended to *replace* them or to make a decision for a judge.³ Yet, most judges want some guidance as they make decisions regarding such questions as:

- Who can benefit from treatment and at which intervention points?
- What type of treatment and supervision is most appropriate?
- How can a substance abuse assessment report be properly evaluated?
- Who is unlikely to respond to any kind of treatment at all?
- How can the need for treatment and social control be balanced?

Assessment is a diagnostic process that provides information to identify the needs of offenders who are substance abusers, ascertain what risk they pose to the community, and recommend treatment options, bearing in mind the resources of a particular community.⁴ The correct identification of an offender's problems is key to determining effective supervision and treatment models.⁵ In recent years the process of assessment itself has become increasingly formalized, with an emphasis on "more uniform, reliable and valid methods of assessment."⁶ As more standardized assessment processes have been developed, the use of substance abuse assessment has become increasingly legitimized within the judicial system.

OBJECTIVES OF ASSESSMENT

A judge can expect a good assessment process to meet the following four primary objectives:

- To determine if and to what degree the offender is using drugs: It is important to identify those individuals before the court who are substance abusers, whether or not the specific charges facing the person are drug-related.

Further, it is necessary to understand the role substance abuse plays in the person's criminal activities.

- To establish the degree of risk to the community because of the offender's substance abuse: Many more treatment options are available to people in the community than to those who are incarcerated. For that and other reasons, judges must balance the potential therapeutic benefit to a person remaining at liberty with any potential risk to public safety. The Report of the National Task Force on Correctional Substance Abuse Strategies suggests that:

the assessment of risk is especially critical for [those] who must make recommendations to the judiciary regarding disposition. The degree of perceived risk will be reflected in the intensity of supervision and monitoring recommended, as well as in the type of treatment that is both appropriate for the offender and consistent with public safety.⁷

- To ascertain the offender's amenability to treatment: Studies indicate that substance abusing offenders with certain profiles are more amenable to treatment than those who exhibit other characteristics.⁸ For example, offenders who are cooperative and truthful in the assessment process are more likely to be rehabilitated than those who are hostile. One objective of an assessment is to determine to what degree treatment is likely to result in a favorable outcome for an offender.
- To determine if and what treatment is appropriate: A wide range of treatment and supervision strategies are available for substance abusers, although, in many areas, not all options exist or are accessible. An assessment will suggest which type of supervision and/or "treatment program best fits the drug abuse and programmatic needs of each offender." Given that there "will always be a lack of resources for drug abusing offenders . . . it is paramount that these resources be put to the best possible use."⁹

WHEN SHOULD AN ASSESSMENT BE DONE?

Offenders should be evaluated "at the earliest stage and throughout their involvement with the correctional system."¹⁰ Treatment Alternatives to Street Crime (TASC), a national organization that works with substance abusers within the justice system, suggests that the assessment process begin "at the earliest point possible in the justice continuum."¹¹ The following list includes intervention points at which an assessment can be initiated and additional evaluation and follow-up/undertaken.

- Deferred prosecution
- Arraignment
- Pretrial

- Pre-sentencing
- Sentencing
- Probation
- Parole
- Revocation hearings¹²

... sequential assessing allows for quick and relatively inexpensive screening, and ensures that the most involved and expensive assessment tools are reserved for those whose circumstances are most complex.

The sooner a judge has information about an offender's substance abuse and related risk to the community, the earlier in the offender's journey through the court process can meaningful treatment begin. For example, an immediate assessment can be done to aid a judge in making a decision about bail. Assessments done at such an early stage, under severe time constraints, are necessarily faster and less complete than longer, more comprehensive evaluations that might be done for sentencing purposes. In the short time frame that exists for making a bail decision, there is the option of urine testing and administering a quick psychometric instrument (these will be discussed later in the chapter). The results of these tests, coupled with information about the nature of the immediate alleged offense and any past convictions, will provide a judge with concrete information about community risk and the severity of the substance abuse.

Dan Beto, the highly respected chief probation officer of the Brazos County (Texas) Community Supervision and Corrections Department, points out that a good assessment process also must be sequential, allowing for additional information to be gathered as needed.¹³ In such a multi-step process, when a preliminary screening gives an indication that there may indeed be a substance abuse problem, the next stage of the assessment will delve more deeply into the nature of the problem and other contributing factors. This concept of sequential assessing allows for quick and relatively inexpensive screening, and ensures that the most involved and expensive assessment tools are reserved for those whose circumstances are most complex.

Assessment data and recommendations should follow clients as they move through the correctional system. Thus, the pre-sentence investigator must provide assessment information to others responsible for the offender at other stages.¹⁴ To be most effective, assessments must be updated periodically. Reassessments are useful for monitoring the progress an offender is making in treatment and for yielding information about the effectiveness of specific treatment interventions.¹⁵

WHO DOES ASSESSMENTS?

Four categories of people conduct substance abuse assessments.

- Employees of the court might be subdivided into two groups: those who supervise general caseloads and may have no special training or certification to

perform assessments and those who work only with substance abusers and have specialized training in their assessment.¹⁶ There are distinct advantages to using an individual from within the court system who has expertise in the field of drug abuse. Such an officer will "be equally sensitive and responsive to the mandates" of the court and the problems and needs of the offender.¹⁷

- Treatment agencies often are used on a contract basis to conduct substance abuse assessments for the court. If substance abuse is their specialty, a certain degree of expertise is guaranteed. Drawbacks to using a community treatment agency, however, are high cost and the lack of adequate linkages between the agency and the court.¹⁸ There may also be a bias toward steering the offender to that particular program. It is especially important to be wary of "for-profit" treatment centers, which may have empty beds they want to fill.¹⁹ Agencies that specialize in substance abuse often have on their staffs paraprofessionals who are former addicts. There are some advantages to using these individuals in conducting drug use assessments, in that they may be particularly good at breaking through the denial that is so common among drug users.
- Independent assessment agencies appear to offer a very promising approach. Such an agency has as its major function the provision of assessment services, not the direct provision of treatment. One well-known example of such an assessment organization is Treatment Alternatives to Street Crime (TASC).²⁰ TASC, specializing in drug-involved offenders, is neutral in that it is not aligned either with the court or with a specific treatment program. Thus, TASC functions as "an objective and effective bridge between two separate institutions: the justice system and the treatment community."²¹
- Mental health professionals, such as psychologists or psychiatrists, occasionally present evaluations to the court. These evaluations, however, may have less value, because the average mental health professional or physician, although legally qualified to give an opinion in most jurisdictions, is probably (with rare exceptions) poorly qualified to give an opinion on the "likelihood to be rehabilitated" question, rarely having experience in long-term treatment of either addicts or alcoholics.²²

Assessments may be done by individuals from a variety of disciplines. Although certain states have licensing requirements set by statute, there is also a movement under way to develop national certification standards. Such standards could ensure, regardless of discipline, that individuals have satisfied the training and experience requirements necessary to be considered as qualified health care providers in the addictive disorders.²³

It is important for judges to question the background of the individual who has done the assessment. A psychologist may have a broader view of the potential problems of an offender, yet have a different perspective from that of a substance abuse counselor with many years of experience working directly in drug and alcohol programs. Both may be capable of preparing excellent assessments as long as they are not restricted to a narrow ideology. Although there has been some tension in the field regarding who is most suited to do evaluations, it is likely that as the field of credentialing evolves, the strengths and weaknesses of those conducting assessments will be better understood.

CONTENT OF AN ASSESSMENT

A comprehensive assessment should contain most, if not all, of the following elements, while a preliminary or speedy assessment might contain only one or two components or perhaps items selected from one or more components. The section of this chapter entitled "Selecting Assessment Tools" will discuss specific factors to consider when ordering an assessment for a particular set of circumstances.

- **Criminal Record:** "Among other things, a criminal history is a record of individual behaviors. The information in a criminal record can provide valuable information about the nature and extent of an offender's drug use."²⁴ It is useful to note whether there is a background of illegal involvement with drugs, such as possession of drugs or drug paraphernalia. The record may also reveal criminal behavior that frequently corresponds with drug use, such as assault and disorderly conduct, burglary, and other lucrative crimes.²⁵ In addition, a criminal history provides data about involvement in violent crimes that must be considered when weighing potential risk to the community if the offender is not incarcerated.
- **Current Drug Use:** A basic and important means of obtaining information about an offender's current drug use is through urine testing. The major strength of drug testing is its usefulness in determining the type and amount of a drug used. Urinalysis can be done very quickly, an important consideration given the time pressures faced by most judges. While different types of drug tests have different degrees of reliability, overall, drug testing is still considered to be the most reliable indicator of drug use.²⁶ Accurate data about current drug use are critically important for a judge who must make a decision that affects public safety. Drug testing can be done onsite or offsite through a contract with a laboratory that is equipped to handle forensic samples. Onsite testing procedures allow for almost immediate detection of the presence of drugs.²⁷

Another good source of information about an arrestee's drug use is observational reports from arresting officers and other police or jail personnel. Such information is available to a judge on an immediate basis.

- **Drug History:** In addition to drug testing, information about the history and patterns of an offender's drug use will help determine the extent of the problem. Scales have been developed to measure the severity of drug use. Such scales generally include the following variables:
 - Drug(s) used
 - First use including age at first use and type of drug first used
 - Development of use including changes in amount and frequency, duration of use, and periods of abstinence
 - Patterns of use including routes of administration, combinations, and substitutes
 - Most recent use including amount, frequency, and duration²⁸

Self-reports about drug use by the offenders may yield some information. However, it must be noted that although drug users in treatment have been found to accurately report on their drug use, arrestees cannot be relied on to do the same.²⁹ Often, arrestees will minimize their drug or alcohol use. They will, for example, tell a probation officer that they occasionally have one beer too many at home on the weekends or that they sometimes smoke a joint or two. But self-reports provided to the courts will rarely reveal the full extent of a user's problem. Therefore, drug testing is highly desirable.

- **Medical History:** A physical examination, along with a complete medical history, is an important part of an assessment when there is sufficient time to do this. Numerous medical conditions are associated with alcohol and drug abuse. They may result from acute or chronic effects of the drugs themselves, from complications related to the use of dirty needles, and/or chronic irritation to the site of drug administration. Other conditions may relate to the hazardous life-style of drug users, such as injuries, or sexually transmitted disease from prostitution.³⁰
- **Psychological Status:** Assessment includes an evaluation of the offender's mental status and a review of past mental health history. A brief mental status exam would include: orientation to person, time and place; ability to concentrate on the interview process; and appropriateness of the responses.³¹

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In reviewing the mental health history, it is important to note any past suicide attempts, inpatient and outpatient treatment, and use of psychoactive medications. Further, it is helpful to learn if there have been any indications of clinical depression, sociopathic behavior, or acute or chronic mental illness.

- **Social and Environmental Circumstances:** This part of the assessment focuses on the offender's living arrangements, and family and community factors. In addition to determining the stability of an offender's housing status, it would evaluate the family and friendship support systems available. Included in this would be a review of the involvement of family and friends in both drug use and criminal activities.

Family history is also germane here. In addition to looking at past substance abuse and criminality by parents and other family members, it may be helpful to identify any abuse or neglect in the offender's background.³²

- **Educational and Occupational Background:** Information about an offender's education and work history will help establish an understanding of past levels of functioning. Substance abusers who have solid work backgrounds are more likely to return to appropriate social functioning than those who do not.³³ Information to be gathered would include the following:
 - Highest grade completed and, if applicable, reason for leaving school
 - Adjustment problems and, if applicable, learning disabilities
 - Number and types of jobs held
 - Job skills, training
 - Attitudes towards work
 - Military service³⁴
- **HIV Status:** Intravenous drug use is the fastest growing route of transmission for HIV; therefore, the National Task Force on Correctional Substance Abuse Strategies recommends that "HIV risk assessment should be a routine part of all assessments conducted with all substance abusing populations."³⁵ This risk assessment must be entirely voluntary, and any testing for HIV infection must be done only after the individual has given fully informed consent. An HIV risk assessment will indicate which individuals might benefit from HIV testing, and suggest how to target HIV education and treatment services.³⁶ There is evidence that "criminal justice detainees are a receptive audience for education, prevention and treatment programs."³⁷ If an offender chooses to be tested, the test must be accompanied with counseling about HIV and AIDS, and must include safeguards regarding confidentiality.³⁸

ASSESSMENT METHODS

The process of conducting an assessment involves several steps. Initially, arrestees who are possible substance abusers must be identified. To determine likely candidates for a substance abuse assessment, one could look at the circum-

stances of this and past arrests and any information about past drug treatment.³⁹ Observational accounts from police, probation officers, and other officials are also good leads as to who might be a candidate for an assessment. Offenders may also disclose their own substance abuse, and urine tests provide key information regarding the presence of drugs in the body. All of this information should be gathered at the earliest possible opportunity—most often this occurs at arraignment.

Testing

Psychometric test instruments, administered verbally or in writing, are designed to measure such factors as severity of drug abuse, criminal drug abuse patterns, and amenability to treatment. They may also be used to match a person to a certain type of treatment.⁴⁰

Self-administered test instruments include questionnaires and check lists, some of which may be scored by computer. Staff administering these tools do not need special training or education. A disadvantage, however, is that they require relatively high levels of client skill such as literacy, consequential thinking, and introspection. Self-administered assessments may not be tailored for different cultural and demographic groups. These instruments also rely heavily on client willingness to disclose sensitive information.⁴¹ Self-administered instruments are “most useful in voluntary versus court ordered situations. . . .”⁴² There will be more discussion of specific test instruments later in this chapter.

Interviewing

It is often helpful to conduct an interview with the offender and to interview “others who may provide reliable input.”⁴³ There are two basic approaches to conducting interviews for the purpose of assessment. One is the scripted interview format, the other is the guided, structured interview.⁴⁴

Scripted interviews use predetermined structured questions asked in a precise order. One advantage of this format over a written questionnaire is that respondents have more leeway in answering than simple yeses and nos (yet less leeway than in a structured, guided interview).⁴⁵ Other pluses are that scripted interviews do not demand literacy skills of the respondent. The training needed by staff administering them is predominantly in documenting and scoring techniques.⁴⁶

One disadvantage of scripted interviews is that interviewers are not permitted to probe the responses.⁴⁷ The questions also may not be tailored for different populations, and they make little accommodation for different cognitive or emotional states.⁴⁸

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The *structured, guided* method of conducting interviews “usually follows some basic diagnostic criteria and guidelines but relies entirely on the interviewer to select pertinent questions, make observations, and interpret results.”⁴⁹ The advantages of this format are that the interviewer can adjust questions to accommodate individual cognitive and emotional styles and a variety of cultural and demographic factors. The added interaction between the interviewer and the respondent may also elicit additional disclosures on the part of the respondent.⁵⁰ Structured, guided interviews are most useful with heterogeneous populations and nonvoluntary referrals.⁵¹

The disadvantages of guided interviews are that they must be given by staff who are proficient in assessment and interview methods.⁵² Interviewer skill and cultural biases may affect results, and the interview process is often time-consuming and costly.⁵³

Interviewing Collateral Sources

As part of the process of obtaining as complete a picture as possible about an offender’s substance abuse and level of personal and social functioning, it is often useful, when time allows, to interview other “collateral sources.”⁵⁴ Obtaining information from other sources is particularly useful when an offender denies or minimizes the level of drug abuse.⁵⁵ Other individuals who know the offender well, such as family members, employers, teachers, treatment providers, and medical professionals may be able to provide reliable information; it is important to question sources in such a way that they will provide descriptive responses rather than opinions as to whether or not someone has been using drugs.⁵⁶ Collateral information should include descriptions of the offender’s drug-related behavior, including abrupt changes in personality or appearance. Releases from the offender should be obtained. In some instances, a request to the judge will be made for an order compelling the offender or others to make this information available.

One caveat when gauging the value of the information given by other informants is that many substance abusers go to great lengths to conceal their drug activities. Therefore, the collateral sources may not be able to give a true picture as to the extent of the offender’s drug use.

TYPES OF ASSESSMENT TOOLS

Many tools or instruments are available to assess offenders who abuse substances. Some of these tools will be discussed in this chapter and are summarized in Table 3 at the end of the chapter. They range from simple, quick, and inexpensive screening mechanisms to comprehensive, lengthy, and expensive evaluations. Many

are in computerized formats, which permit objective scoring and analysis. Regardless of the simplicity or complexity of the assessment, it is crucial that it "provides [a] uniformity and fairness in the decision-making process."⁵⁷

Some assessment instruments are privately developed, others are developed by local correctional agencies, and still others are developed by federal agencies.⁵⁸ Proprietary instruments, while typically of high quality, generally are too expensive for use by public agencies. Instruments developed by federal agencies are considered more reliable for use in a wide variety of settings than those developed by local agencies. Most locally designed instruments tend to be narrowly focused and program-specific. Since drug-involved offenders are not a homogenous group in regard to their substance abuse patterns and needs, no one model of assessment is appropriate to all offenders.⁵⁹

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SELECTING ASSESSMENT TOOLS

The accumulated experience with the process of assessing substance abusers suggests "that there is no one right way of doing a substance abuse assessment."⁶⁰ Further, "it should be understood that no one tool is sufficient, in and of itself, to accomplish an accurate assessment."⁶¹

The findings from an assessment tool are most reliable if that tool is designed to evaluate people with characteristics similar to those on whom it is actually being used. For example, instruments developed for use with highly educated people are probably inappropriate for those with poor literacy skills, and one designed for adolescents may not work with older people.⁶²

Questions that a judge might ask about the appropriateness of an instrument are:

- Was this assessment instrument tested on a population similar to the population on which it is now going to be used?
- Are any distinct emotional or cognitive skills necessary on the part of the offender who is being assessed with this instrument?
- Does the literacy level of the instrument correspond to that of those being assessed?
- Are the expectations about self-disclosure reasonable in the setting and under the circumstances?⁶³
- Can this instrument be administered in the time frame that is available to the court?

Judges also need to consider whether an assessment tool fulfills legal requirements for accountability.⁶⁴ Relevant factors to consider include the objectivity of an instrument and the skill level and authority of the assessor.⁶⁵

The first six assessment tools we describe can be administered by trained probation officers or other court personnel. Most of the instruments described gather information to be considered primarily at the time of sentencing. However, the first tool described is oriented specifically towards bail considerations. Many of the assessment instruments can be re-administered in part or in whole at other stages in the process, such as a revocation hearing, if an individual's status needed to be re-evaluated. Although each instrument can be used alone, it is possible to combine the use of two or more instruments to generate more comprehensive data.

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The D.C. Pretrial Risk Assessment Program is geared specifically to assessing the risks of flight and community safety.⁶⁶ Urine testing is done on all arrestees; additional information about those who show positive results is gathered through an interview conducted by court staff who are educated at the bachelor's degree level and have received training in using the instrument. While the process of gathering and verifying information is time-consuming, once the information has been collected, it takes only minutes to use the instrument to determine the level of risk. For defendants who are rated with a medium or high risk, the instrument suggests specific release conditions that reduce the risk to acceptable levels.⁶⁷ Often the conditions include regular urine testing. Few assessment programs are geared towards informing arraignment decisions; the D.C. Pretrial Risk Assessment Program is noteworthy because it can be administered within a short time frame and is widely accepted by judges.

Drug Offender Profile Evaluation/Referral Strategies (DOPERS) consists of a scripted twenty-five minute face-to-face interview with the offender.⁶⁸ DOPERS was developed by the Texas Adult Probation Commission to explore the relationship between the offender's substance abuse and criminal activities, in order to recommend an appropriate treatment and supervision plan.⁶⁹ The Texas Department of Criminal Justice provides two and one-half days of training for probation officers or other court personnel who will administer this instrument. One drawback of the DOPERS is that scoring is complicated, but efforts are underway to simplify it.⁷⁰

The Offender Profile Index (OPI), developed by the National Association of State Alcohol and Drug Abuse Directors, is designed to use objective, easily available information to recommend one of five specific types of drug treatment programs. The OPI is a face-to-face interview that requires about thirty minutes. It is geared specifically for use both pre- and post-sentencing.⁷¹ It is also one of the few instruments to assess HIV risk.⁷²

Client Management Classification (CMC) "provides a structured way for staff to immediately evaluate offenders and to quickly develop supervision strategies based on specific offender types."⁷³ Administration is through a forty-five minute scripted interview with the client. One drawback of the CMC is that limited data about drug use are collected; it is therefore commonly used in conjunction with at

least one other instrument. For example, it is one of four components of the Wisconsin Uniform Substance Abuse Screening Battery, which we describe below. Developed by the Wisconsin Department of Corrections, it is currently being used by many state and county agencies. It is recommended that five days of training precede its use.⁷⁴

The Substance Abuse Questionnaire (SAQ) is a computerized instrument, which contains 151 items designed for adult chemical dependency screening.⁷⁵ This is one of the instruments that the Brazos County Community Supervision and Corrections Department is using after field-testing several other instruments. It is a proprietary instrument that consists of a questionnaire that is self-administered either with pencil and answer sheet or on a computer screen. It can be completed in twenty-five minutes and scored by computer within five minutes.⁷⁶ A short interview is also required. The SAQ is available in English and Spanish versions.

The Addiction Severity Index (ASI), perhaps the most widely used assessment instrument, is a multidimensional tool that "assumes that addiction must be evaluated within the context of treatment problems that may have contributed to or resulted from alcohol or drug use."⁷⁷ It gathers objective data and provides a subjective estimate of the severity of the person's problem in seven specific areas. The ASI is administered in a highly structured interview with the offender.⁷⁸ Among its disadvantages are its lengthiness, the need for a clinician to interpret its results and the absence of recommendations for treatment.⁷⁹ There is conflicting information about the reliability of the ASI with nonvoluntary populations. On one hand, it is acknowledged as one of the few proven instruments. However, it has not been "proven" with offender populations because it has not been used extensively in correctional settings. The appropriateness of its use with nonvoluntary clients is currently being examined.⁸⁰

TASC has developed an instrument, simply known as the TASC, Inc. Evaluation, to determine an offender's needs, motivation for treatment, and type of treatment needed. It consists of a guided interview that may take up to two hours, and should be conducted by a trained clinician.⁸¹ Because the TASC Evaluation generates substantial information on which to base a clinically sound referral for treatment, judges have found it useful.

The Short Michigan Alcohol Screening Test (SMAST) is a thirteen-item questionnaire exploring a person's drinking habits, history, and alcohol-related problems.⁸² This instrument requires a seventh grade reading level on the part of respondents; no specific skills are needed for either administration or interpretation. The SMAST was developed from the original Michigan Alcoholism Screening Test (MAST) to remedy some problems associated with it. The SMAST has proven to have a high degree of reliability with Latino individuals, but is useful with all populations.⁸³

Assessment tools are most useful when they are actually administered to populations similar to those for whom they were designed and on whom they were tested.

An excellent and very comprehensive (but also time-consuming and more costly) approach to assessment is to utilize a battery of instruments, such as the Wisconsin Uniform Substance Abuse Screening Battery. This uniform set of instruments was developed in Wisconsin to evaluate all persons entering its correctional system.⁸⁴ It is currently used in all institutional intakes and is being introduced in probation intakes. It combines identification, classification, and treatment assessment instruments with personality profiles and measurements of specific offender needs.⁸⁵ This battery is composed of four different instruments:

- The Alcohol Dependence Scale, a self-reported review of alcohol involvement
- The Offender Drug Use History, which takes ten minutes to score
- The Client Management Classification Interview, a forty-five-minute structured interview
- The Megargee offender typology, derived from the Minnesota Multiphasic Personality Inventory⁸⁶

One advantage of the Uniform Substance Abuse Battery is that it elicits extensive information through which client characteristics and problems can be quickly determined. This system of assessments has made significant strides in matching offenders to appropriate interventions, and it provides sound data that can move with the offender through the entire correctional system. The Wisconsin strategy not only provides comprehensive data regarding offender treatment needs, but also determines the need for specific programs.⁸⁷

CONSIDERATIONS FOR SPECIAL POPULATIONS

The term "special populations" refers to groups that require special considerations in terms of their substance abuse, for example, people with psychiatric disorders, mentally retarded offenders, minorities and women. Assessment tools are most useful when they are actually administered to populations similar to those for whom they were designed and on whom they were tested. Some instruments have been shown to work poorly with certain groups; the Addiction Severity Index, for example, is not highly useful for women and non-opiate-using offenders.⁸⁸

Offenders With Psychiatric Disorders

A 1990 study published in the *Journal of the American Medical Association* found that people who abuse alcohol or drugs are much more likely than non-abusers to suffer from pre-existing mental disorders, such as manic depression, anxiety, and schizophrenia.⁸⁹ When assessing dually diagnosed individuals, it is important to learn if their mental status allows them to participate fully in the assessment

process. It is also important to note whether an offender is taking prescribed psychoactive medications, or conversely, is not taking medications that have been deemed necessary.

Mentally Retarded Offenders

Special considerations relate to assessing offenders who are mentally retarded or of borderline intelligence. Primarily, it is necessary to use assessment instruments that do not presuppose a high level of literacy and to administer the assessments in a manner that is clear and understandable.

Linguistic and Cultural Minorities

It is well understood that drug abuse has a particularly devastating effect on minority communities. One consequence is that the high crime rates and violence associated with substance abuse lead to disproportionately high levels of involvement with the judicial system.

It is important to understand, however, that minority groups are not homogenous. While many have in common the experience of racism and poverty, a variety of cultural factors must be taken into account. For example, within the traditional Hispanic culture, drug use among women is prohibited.⁹⁰ This contributes to reported low use of drugs among less acculturated Hispanic women, and to the presence of few Hispanic women in treatment programs. Further, in the Hispanic culture, problems are traditionally dealt with within the family. And for Hispanic men, the "cultural value of machismo" makes it difficult for them to admit that they are not in control and need help.

When assessing Hispanic offenders, it is necessary both to consider these relevant cultural factors, and to make provisions for translation or interviewing in Spanish, if indicated. There are clearly advantages to using bilingual, bicultural staff to conduct assessments.

In conducting assessments of other minority populations, such as African-Americans, Native Americans, or members of recent immigrant groups, it is similarly imperative to be sensitive to pertinent cultural norms and linguistic considerations. When conducting an assessment of a person who has failed at previous treatment attempts, it is important to explore whether the treatment programs were culturally appropriate for the person; inappropriate treatment may have a bearing on the person's lack of success.

When conducting an assessment of a person who has failed at previous treatment attempts, it is important to explore whether the treatment programs were culturally appropriate . . .

Women Offenders

Women are a special population in terms of substance abuse because they are underserved in drug treatment programs.⁹¹ Studies indicate that a number of barriers impede women from entering or successfully completing treatment programs.

Barriers to treatment entry include:

- Lack of economic resources
- Child-related responsibilities
- Lack of women-oriented services
- Less sensitive referral network
- Stigma and stereotyping

Barriers to successful completion of treatment include:

- Low self-esteem
- Too many other responsibilities
- Insensitivity and sexual harassment
- Lack of assertiveness and skills
- Unresolved sexuality issues, often related to prior sexual abuse or assaults⁹²

The most useful assessments of women offenders will emphasize the overall context of the women's lives in addition to their substance abuse. The areas of health, housing, and childcare seem to be most important.⁹³

SUMMARY

Assessments can be useful tools for judges who must decide whether an offender could benefit from substance abuse treatment. Given the Drug Use Forecasting results we have described earlier, an argument could be made that an assessment should be considered even when a substance abuse problem is not obviously apparent. A good assessment will also suggest what kind of treatment an offender needs and how much risk the offender poses to the community. Of special interest to many judges, who face severe time constraints, are assessment instruments that can be administered and analyzed quickly. It is important, however, to remember that assessment is not a one-time event, but is a process that can be useful at many points in the judicial, corrections, and treatment systems. No one assessment instrument is correct for all situations, but with many instruments to choose from, a judge is likely to find at least one, or a combination, that will meet a particular set of needs.

... assessment is not a one-time event, but is a process that can be useful at many points in the judicial, corrections, and treatment systems.

Endnotes

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- ¹⁴ U.S. Department of Justice, National Institute of Corrections. *Intervening With Substance Abusing Offenders*, p. 23.
- ¹⁵ Ibid., pp. 23-24.
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TABLE 3**ASSESSMENT INSTRUMENTS**

Instrument	Target Population	Purpose	Information Gathered	Application/ Time Requirements	Administration Training Requirements	Validity/ Reliability	Utility and Restrictions	Comments	Contact
Addiction Severity Index	Drug-involved adult population	Assesses drug problem and level of treatment needed	General demographic information, medical history, drug abuse use, employment, support status, legal status/history, family/social relationships, psychiatric status and subjective confidence and severity rating	Assessment applied in a face-to-face interview with client/offender. Takes 60-90 minutes to complete.	ASI literature suggests assessment be administered by a trained technician at an M.S.W. level or equivalent. Training manual and video are available and either training package must be followed by mock interviews under supervision. Also available in PC diskette which calculates composite scores. Interpretation of scores by trained clinician takes up to 15 minutes.	Studies have demonstrated high reliability and validity.	The ASI has undergone significant evaluation and is one of the few "proven instruments." It collects both objective and subjective information. The ASI has primarily been tested on adult, opiate-dependent males, but has been successfully transferred to female populations. Not recommended for juveniles.	Often used in a clinical setting. Not always applied by M.S.W. or equivalent; yet confidence level remains high. Some modifications have been made to provide for applications in Department of Corrections.	Dr. Thomas McLellan Veterans Administration Medical Center University and Woodland Avenue, Philadelphia, PA 19104 (215) 823-5809
Client Management Classification (CMC)	Adult probation, parole, and institutional population	Determines appropriate supervision strategies and human service needs. Includes an offender classification system.	Combines objective and subjective information including: attitudes toward offense; offense history; school; occupational attainment; family and interpersonal relationships; future plans, socio-demographics; criminal justice history; general appearance/ attitudes and interviewed assessment. Info analyzed to determine offender needs risk and needs and level of management supervision strategies.	Face-to-face interview with offender, takes about 45 minutes.	Requires five-day training session through Wisc. Department of Corrections. Manual and template are provided in session. Scoring results in categorical segments with specific goals, services, treatment, and worker/ offender relationships included.	CMC has been evaluated with an overall reliability of 90%. The evaluative results of the CMC by its users are quite positive.	The CMC integrates service needs factors into a meaningful classification system that provides detailed guidelines on supervision and services. Info collected on drug use is limited. This info is only highlighted if offender has divulged a history of drug-related offenses.	The CMC is used in the Wisconsin Department of Corrections as part of an overall screening battery consisting of 4 separate assessments. The Offender Drug Use History, Alcohol Dependency Scale and Megargee Offender typology derived from the Minnesota Multi-phasic Personality Inventory (MMPI) are all used in conjunction with the CMC.	Gary Arling Box 7925 Madison, WI 53707 (608) 266-7499

TABLE 3

ASSESSMENT INSTRUMENTS (cont'd.)

Instrument	Target Population	Purpose	Information Gathered	Application/ Time Requirements	Administration Training Requirements	Validity/ Reliability	Utility and Restrictions	Comments	Contact
D.C. Pretrial Risk Assessment	Pretrial Arrestees	Assesses risk of flight and community safety.	Uses data from pretrial interview including criminal history, residences, employment, and drug use. All information is validated.	Considerable time is taken gathering data and verifying information received from the client. Once the information is collected, the instrument takes minutes to employ to determine the arrestee's risk.	D.C. Pretrial Services has a six-week training program for its officers. Staff employing the Risk Assessment are bachelor's level, with some criminal justice experience or education.	Based on a significant body of pretrial experience and research with over a year's research in putting the fiscal instrument together. This instrument is accepted by judges and has been embraced by other pretrial agencies.	The D.C. pretrial instrument is an objective assessment. Initially judges hesitated in using it because instrument does not recommend financial release.	Virginia's pretrial service agency will be employing these instruments shortly. D.C. pretrial staff will be training Virginia's staff.	Jay Carver D.C. Pretrial Services 400 F Street, N.W. Washington, D.C. 20001 (202) 727-2911
Drug Offender Profile Evaluation/ Referral Strategies (DOPERS)	Suspected drug-involved probationers	Determines specific probation supervision and treatment recommendations.	The DOPERS combines objective and subjective information in the examination as to how the offender's drug use and criminal activity are related. Items assessed include: drug use, drug use and criminal behavior, consequences of drug use, prior treatment, probationer's "reality," and officer's impressions.	Face-to-face interview with offender, takes about 25 minutes.	Requires 2-1/2-day training session through Texas Department of Criminal Justice. Training focuses on instrument using videos, interview techniques, and 4 drug offender profiles which determine strategies/treatment.	In final stages of validity assessment. A simplified scoring procedure is anticipated.	The DOPERS instrument elicits extensive drug use information upon which a recommendation is based. Each drug offender profile provides the case manager with strategies to employ and assists in focusing on which is the overriding factor: criminality or drug-using behavior. Scoring is complicated, but it is hoped the current validation process will greatly simplify that procedure.	The instrument is used primarily to focus on illicit drug use, although alcohol use can be considered. It is specific to drug use and criminal behavior as it relates to that drug use, so it should be used as part of an overall assessment process. This instrument is not copyrighted; there is no cost for a sample copy.	Nancy Powell Bartlett, Texas Department of Criminal Justice, Community Justice Assistance Division, 8100 Cameron Rd., Bldg. B, Suite 600 Austin, TX 78753 (512) 834-8188

TABLE 3
ASSESSMENT INSTRUMENTS (cont'd.)

Instrument	Target Population	Purpose	Information Gathered	Application/ Time Requirements	Administration Training Requirements	Validity/ Reliability	Utility and Restrictions	Comments	Contact
Offender Profile Index (OPI)	Suspected drug-involved defendants/offenders, primarily pre- and post-sentence.	Determines specific drug intervention disposition for the criminal justice decision-maker.	This wholly objective instrument combines info on the offender's drug use history with stake in conformity as measured by: demographics, family support, education, current school and employment, household responsibility, criminal record, psychological and previous drug treatment info. The outcome is a numerical score that leads to 5 specific drug intervention strategies: drug-testing, out-patient, intensive out-patient, short-term residential, or long-term residential treatment.	The OPI is a face-to-face interview that may be completed in about 30 minutes.	The OPI can be administered by any trained professional with basic interviewing skills. Staff should review OPI Manual for scoring and probing techniques. Mock interviews are recommended. The assessment is essentially self-scoring, a numerical score corresponds with recommendation.	The OPI has had limited application, but has face validity and is based directly on an existing body of research. The OPI has been accepted as practically useful by judges, probation officers, treatment personnel, and TASC programs in demonstration settings. Process and impact evaluations are under way that may result in minor modifications.	The OPI provides extensive info on drug use patterns and behaviors, provides a specific, objective numerical score, and recommends a specific drug intervention. It has had limited applications to date and is not reliable for juvenile or incarcerated populations. Additionally, the OPI is drug-driven and does not focus heavily on alcohol use.	Drug testing in combination with self-reported drug data contributes to reliability. The OPI is being tested so it is not currently available for distribution. It is anticipated that it will be available later in 1992 and will be in the public domain.	Dr. Duane McBride Department of Behavioral Science Andrews University Berrien Springs, MI 49102 (616) 471-3576
Substance Abuse Questionnaire (SAQ)	Adult probationers	Assesses risk and needs and presents treatment recommendations.	Measures alcohol and drug use, aggressiveness, resistance, stress level, coping abilities, and truthfulness.	Computerized self-administered instrument that can be completed in 25 minutes.	A comprehensive orientation and operating guide is available.	Demonstrated reliability and validity.	Requires IBM or IBM-compatible computer.	Available in English and Spanish. Copyrighted material sold on computer diskettes.	Herman Lindeman 3008 N. Third St. Suite 303 Phoenix, AZ 85021 (602) 234-2888

TABLE 3**ASSESSMENT INSTRUMENTS (cont'd.)**

Instrument	Target Population	Purpose	Information Gathered	Application/ Time Requirements	Administration Training Requirements	Validity/ Reliability	Utility and Restrictions	Comments	Contact
Short Michigan Alcohol Screening Test (SMAST)	Individuals suspected of alcohol abuse regardless of legal status.	Identifies alcohol problem.	Thirteen-item questionnaire centered around individual's drinking habits, history, and alcohol-related problems.	Yes or No answers to 13 questions. Should take no more than 15 minutes to complete.	Test requires 7th grade reading level. No other specific skills are necessary for either administration or interpretation.	The SMAST was developed from the original Michigan Alcohol Screening Test (MAST). Evaluation data indicated that, unlike the MAST, it does not tend toward false positives and is an effective diagnostic instrument. Has proven to have a high degree of readability with Latino populations, but is useful with all populations.	Very quick and easy to identify alcohol problems. Makes no recommendation once problem is identified.		
TASC, Inc. Illinois	Drug-involved defendant/offender populations through post-disposition.	Assesses need, motivation, and level of treatment.	Assessment info includes generic demographic info, criminal justice involvement, treatment history, psycho-social info, treatment readiness, and specific and subjective treatment and auxiliary service needs.	Face-to-face interview with offender, takes 90-120 minutes for completion. Verification of info includes: review of rap sheet, previous treatment records, collateral contacts, and a supervisory review of assessment and other records.	Best when performed by a trained clinician for outcome recommendation. Training involves familiarity with form, mock interviews, observation of interview process, and supervised interview. Requires familiarity with services and resources available in jurisdiction.	This assessment instrument has been used for over a decade on male and female adult offenders throughout the state of Illinois. The information and recommendations are relied upon by judges, probation, and treatment professionals.	This instrument generates a reasonable amount of data upon which a clinically sound referral decision may be reached. In addition, it probes client insights into their drug problems and perceived need for rehabilitation as a measure of motivation. No instrument validation has been conducted.	The material is copyrighted.	Melody Heaps, Eve Weinberg, TASC, Inc. 1500 N. Halstead Chicago, IL 60622 (312) 787-0208

This information is adapted primarily from the U.S. Department of Justice *Drug-Offender Assessment Monograph*.

TREATMENT

CHAPTER 4: TREATMENT FOR DRUG-INVOLVED OFFENDERS

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TREATMENT FOR DRUG-INVOLVED OFFENDERS

For many who work within the criminal justice system, the practical objective of drug-abuse treatment is to end drug consumption and other criminal activity, with the secondary goals being to change lifestyle and personal values, increase job skills, and improve individual and public health, specifically in the face of the AIDS epidemic. According to the Institute of Medicine, "the standard of success is whether behavior during and after treatment is appreciably better than what would probably occur in the absence of treatment."¹

Criminal justice practitioners and researchers generally acknowledge the fact that some treatment is better than no treatment and that, in general, treatment works. Whether treatment achieves the specific goals of the criminal justice system may be more difficult to answer. Given that system's struggle with issues of prison crowding and the burdening of our courts with drug-related cases, referring individuals to community-based treatment programs as part of pretrial diversion or as a condition of probation may be appropriate in certain situations. In light of the strong relationship between drugs and crime cited earlier, many drug treatment professionals would urge that compulsory treatment be adopted more widely as a technique for reducing criminal activity. The following questions summarize some of the more commonly posed concerns:

- Is treatment a good investment for the criminal justice system? Do the benefits of treatment justify the costs?
- What constitutes *effective* treatment for drug-involved offenders?
- Is the public safety jeopardized when treatment in the community is offered as an alternative to incarceration?
- What type of treatment works best for what types of clients/offenders?
- Are there treatment variables or abuser characteristics that serve as clues to whether treatment will be successful?
- Is it possible to prevent relapse among former drug and alcohol users?

In this chapter, we will address the above concerns. We begin with a review of the various types of treatment available, along with findings regarding their effectiveness. We also discuss general findings regarding treatment effectiveness that apply to all treatment modalities.

We should point out, however, that it is difficult to measure the long-term effectiveness of drug treatment. For example, drug abusers often have multiple

treatment experiences, and it becomes virtually impossible to distinguish the effects of one specific treatment experience from another.² It is also hard to make comparisons across different treatment modalities given the variety of goals, purposes, and measures of effectiveness. Nor do clients within these programs possess comparable baseline levels of measures such as frequency and severity of drug use, criminality, and employment.³ In addition, evaluating the comparative effects of different treatment modalities is difficult because researchers and treatment providers rarely assign clients to treatment randomly. Further, few drug treatment studies have a “no-treatment” control group, since it is generally considered unethical to deny patients, for research purposes, access to treatment. Treatment outcome is also heavily dependent on appropriate matching of treatment with the offender’s specific cultural background and environment. Finally, the nature of an individual’s addiction career can confound the results of drug treatment studies. Periods of remission within one’s addiction career, sometimes termed “maturing out,” tend to last longer as one gets older. Thus, it is difficult to determine what behaviors are caused by the natural maturation process, and what behaviors may be related to drug treatment.⁴

TREATMENT MODALITIES AND THEIR EFFECTIVENESS

Multiple approaches and settings fall under the rubric of drug and alcohol treatment. Clearly, there is a range of *philosophies* and *approaches* within the treatment community—from methadone maintenance to a “twelve-step” abstinence model. Treatment *settings* may be outpatient, inpatient, residential, or day treatment (a combination of outpatient and residential treatment where clients may spend a large part of the day in structured activities, but do not live in the facility). Treatment *facilities* include hospitals, clinics, prisons, half-way houses, mental health centers, and group homes. Different programs may include (or require) a combination of *modalities*: individual psychotherapy, group therapy, family therapy, vocational training, and living-skills training. The *staffing* at drug treatment centers varies as well: some programs rely exclusively on trained professional staff, whereas other programs may use recovering drug addicts.

Given the broad spectrum of existing approaches, there are innumerable ways to classify drug treatment programs, and it is often difficult to divide them into separate categories. With the above caveat in mind, we will discuss the significant features of the treatment categories listed below.

- Detoxification
- Methadone Maintenance and Other Pharmacological Treatments
- Residential Treatment
- Outpatient Programs

- Self-Help Groups
- Acupuncture

The goals of detoxification are mainly to reduce or suppress withdrawal symptoms in a supervised, safe setting.

DETOXIFICATION

Detoxification is not considered a modality in and of itself and the data regarding its effectiveness must be considered within the context of its limited goals. The goals of detoxification are mainly to reduce or suppress withdrawal symptoms in a supervised, safe setting. Because of its short duration and lack of comprehensive treatment program, detoxification alone is not associated with long-term improvement. Researchers have consistently found "no effects from detoxification that are discernibly superior to those achieved by untreated withdrawal in terms of reducing subsequent drug-taking behavior and especially relapse and dependence."⁵ Despite this discouraging news, detoxification does provide an opportunity for drug-treatment professionals to recruit clients into subsequent treatment. In fact, detoxification from drugs or alcohol is often a prerequisite for admission to other treatment programs. According to the Institute of Medicine, "success at recruitment may well be a more critical outcome for detoxification programs than the conventional primary goals of comfort and suppressing withdrawal symptoms."⁶

Alcohol Detoxification

Alcohol detoxification functions as a method of crisis intervention and possibly as the beginning of more extensive treatment. The medical intervention detoxification provides is often necessary to manage the withdrawal symptoms caused by abstinence from alcohol. These range from mild anxiety and physical stress to severe withdrawal symptoms known as delirium tremens (the DTs). Without medical intervention, alcohol detoxification is extremely dangerous and life-threatening, unlike withdrawal from many other drugs.⁷

Hospitalization for detoxification is recommended for patients who display moderate to severe withdrawal symptoms or other medical complications such as seizures. There have been recent efforts to detoxify patients without hospitalization. In these cases, detoxification may take place on an outpatient basis or in a nonmedical detoxification center. Residence in any detoxification facility may last from two days to two weeks.

Since alcohol withdrawal can lead to life-threatening seizures, anti-anxiety medications such as Librium, Valium, Tranxene, and Serax are often used to ease or prevent withdrawal symptoms such as hallucinations, disorientation, and seizures.⁸

These drugs have similar chemical properties to those of alcohol and can be given in decreased amounts until the person is safely detoxified. These drugs do not *treat* alcoholism, they are not used alone as maintenance drugs, and they have few benefits if used without any complementary treatment. They merely make withdrawal from addiction to alcohol safer. Such safety concerns should be considered, however, when an alcoholic offender is held on a pretrial basis or when a period of incarceration is imposed. The health consequences related to withdrawal must be properly managed under medical supervision.

Drug Detoxification

Drug detoxification is often a hospital-based, medically, and therapeutically supervised withdrawal from drug use to abstinence over a short period of time, ranging from five to twenty-one days. Drug detoxification is seldom effective by itself for bringing about recovery from dependence, and like alcohol detoxification, it is not considered a treatment modality in and of itself, but rather a gateway to other treatment modalities.

Different types of drugs will produce different withdrawal symptoms. Therefore, detoxification methods will vary depending on the drug used. To determine the type of withdrawal symptoms caused by a drug, one should consider the characteristic effects of the drug and then reverse them. Thus, withdrawal from depressants will produce hyperactivity, while withdrawal from stimulants will produce depression.⁹

For many, drug detoxification starts with an emergency room admission for a drug overdose. For criminal justice clients, detoxification may occur *de facto* in the local jail or in a police lockup, sometimes with medical supervision, but not always.

Symptomatic treatment is used to lessen withdrawal discomfort. Drugs used for symptomatic treatment are prescribed to address only the side effects of withdrawal, not the withdrawal itself. For example, clonidine is an anti-hypertensive drug that has been successful in reducing symptoms of opiate withdrawal and reducing the craving for opiates. Lithium has been used to decrease cocaine craving.¹⁰

Most medical detoxification includes drug substitution and/or symptomatic treatment. Drug substitutes, such as methadone for opiate addicts and Librium for alcoholics, will be described under the heading Pharmacological Treatments. Drug substitutes are chemically similar to certain illicit drugs and are effective in controlling the rate and severity of withdrawal.¹¹ When methadone is used in a detoxification setting, however, it is used for only a short period of time, not to exceed thirty days.

Some clients use methadone to detoxify from their opiate addiction on an outpatient basis, rather than staying in a long-term maintenance program. In fact, many methadone maintenance programs offer a detoxification component as part of their program. Clients receive methadone in reduced amounts until they have comfortably reduced or eliminated their narcotic dependence. Although some methadone clients are able to reduce their dose of methadone to the point of abstinence, others remain on it indefinitely. Many of the clients who have been maintained on methadone for years contend that they would go back to illegal narcotics if they were to detoxify from methadone. Most of the clients on methadone maintenance, in fact, have had numerous failed detoxes scattered throughout their histories.

Detoxification is a critical period for many patients, because of their poor physical condition and vulnerable emotional state. It may prevent serious medical consequences and it may result in an addict's willingness to consider treatment. Hospital personnel (nurses, doctors, social workers) who are knowledgeable about addiction may be helpful in discussing future options with the patient.

METHADONE MAINTENANCE AND OTHER PHARMACOLOGICAL TREATMENTS

Generally, pharmacological treatments are those in which a chemical agent is used to treat and reduce the use of illicit drugs. Of these pharmacological treatments, only methadone maintenance is considered a treatment modality in and of itself. The other pharmacological treatments are considered adjuncts to other treatment modalities. There are several types of pharmacological treatments: (1) drug substitutes such as methadone; (2) antidipsotropic drugs such as Antabuse, given to cause an unpleasant physical reaction should the drug be ingested; (3) antagonist drugs such as naltrexone given to block the effects of opiates or cocaine within the brain; (4) agonist-antagonist drugs such as buprenorphine, which combine the effects of drug substitutes with the blockade effects of the antagonist drugs; and, (5) psychotropic drugs such as lithium, desipramine, and other tranquilizers, which are used to control withdrawal, cravings, depression, or other symptoms of drug abuse.

Drug Substitutes (Methadone Maintenance)

The most common pharmacological approach, methadone maintenance, is used as treatment for opiate addiction, particularly heroin. Drug users recommended to methadone maintenance programs are most often those with long histories of abuse and prolonged opiate dependence. The great majority of clients use signifi-

cant amounts of heroin and other substances and engage in criminal activity to support their habit.¹²

According to the Institute of Medicine, the primary goal of methadone maintenance is to reduce drug consumption and other criminal activity, while improving psychological well-being and social functioning. Methadone maintenance combines regular counseling and daily medication with methadone (a long-acting narcotic analgesic), which takes effect gradually and wears off slowly within a twenty-four to thirty-six hour period. This property makes it possible for clients to reach a stable, noneuphoric state, "without the psychophysiological cues that precipitate opiate craving."¹³ Methadone maintenance is also effective in preventing symptoms of heroin withdrawal, which although not life-threatening like alcohol withdrawal, are very uncomfortable and are often considered intolerable for the addict.¹⁴ The individual stabilization dose of methadone depends upon the addict's level of tolerance, but is usually between 30-100 milligrams.

Methadone maintenance programs are usually administered on an outpatient basis, with daily visits to a clinic to receive methadone doses under medical supervision. Methadone maintenance technically refers to a planned treatment duration of 180 days or longer. Following several months of compliance with clinic requirements and a clean drug-testing record, under the provisions of many clinics, a client may be allowed to visit the clinic less often than once a day, self-administering one or more doses on a take-home basis. This privilege is revoked if the client fails to comply with program regulations or if a test for drug use comes back with a positive result.

All methadone maintenance programs, under federal regulation by the U.S. Department of Health and Human Services (1989), must be administered "in conjunction with provision of appropriate social and medical services."¹⁵ Thus, all programs provide some supportive services; however, they vary in the level and quality of counseling and other rehabilitative services they offer. Some mandate extensive psychotherapy and AIDS education, while others provide little more than the methadone itself. These variations in services provided reflect a two-sided view of the etiology of drug abuse. Programs in which the basic treatment philosophy is derived from the medical model consider drug abuse as a medical problem which can be treated chemically. Given this orientation, psychotherapy and other counseling are considered secondary, and abstinence is not the principal goal of treatment. In these programs, it is believed that it is the methadone itself which will address and treat the narcotic addiction and dependence. Programs in which the basic treatment philosophy is "psychotherapeutic" contend that although methadone may alleviate physiological craving for narcotics and withdrawal symptoms, it does nothing to address and treat the reasons for addiction, and the feelings and fears associated with the transition to a drug-free life. These programs often make compliance with therapy a requirement for those who wish to continue with a methadone maintenance program.

Methadone maintenance combines regular counseling and daily medication with methadone . . . which takes effect gradually and wears off slowly within a twenty-four to thirty-six hour period.

In general, studies on the effectiveness of methadone maintenance reveal that most individuals experience significant reductions in illicit narcotic use and crime, as well as improvements in employment status, during the period they are maintained on methadone.¹⁶ Dropout rates for methadone maintenance programs tend to be lower than those of other modalities. In fact, a large number of methadone clients stay in treatment for three or more years.

Studies over time have demonstrated that methadone can be an effective way to treat addiction for drug-involved offenders, preventing both relapse and recidivism. A landmark study conducted by Vincent Dole and Herman Joseph followed the progress of 1,413 patients in methadone treatment programs in New York during the years of 1966-1967 and 1972. Of these patients:

- Forty percent remained in continuous treatment and the rest had been discharged one or more times.
- A dramatic decline in drug use and an improvement in social functioning were seen in the 40 percent of patients who had remained in continuous treatment from the time of original admission. Within this group, after approximately seventy-two months in treatment, the incidence of *serious* opiate use (greater than twice per week) had fallen from a pretreatment level of 100 percent to 1 percent.
- The arrest rate for *any* crime had fallen from 90 percent to 5 percent. Favorable treatment outcome was associated with time in treatment, absence of behavioral problems, and employment.
- Of the remaining 60 percent of methadone maintenance patients who were discharged, only 20 percent were discharged in "good standing" (no serious opiate use), and of this percentage only one-third were successfully detoxed without relapse.¹⁷

Methadone treatment can also have an effect on stemming the spread of AIDS among intravenous drug users. Sharing dirty needles is a leading cause of transmission of the HIV virus. Many state-funded programs are being encouraged or mandated to incorporate AIDS education into their clinics, along with hiring AIDS coordinators or AIDS specialists to refer and consult with clients and staff members. Because of its demonstrated success in reducing heroin consumption and associated criminal behaviors, and its utility in the fight against AIDS, methadone maintenance may be a useful treatment option for heroin-involved offenders. Yet methadone maintenance is not without controversy. One important concern associated with methadone maintenance is the abuse of substances other than narcotics by some clients. While many individuals experience a reduction or elimination of illicit narcotic use while in treatment, this same reduction is not seen with non-heroin drug use and alcohol consumption. In recent years, the use of cocaine among methadone clients has increased sharply.¹⁸ There is also some

concern that clients are "switching" their addiction from an illegal narcotic to a legal one.

The Institute of Medicine maintains:

... these controversies and reservations are neither trivial nor in themselves compelling. Methadone is an opiate, but consumption of a stable, clinically appropriate oral methadone dose is not behaviorally or subjectively intoxicating and does not impair functioning in clinically detectable ways. Toxic side effects are rare, and the general health of clients improves dramatically as compared to their health status while on heroin.¹⁹

Antidipsotropic Drugs (Antabuse)²⁰

Antidipsotropic drugs are drugs that, when taken in conjunction with certain substances, cause violent physical reactions. The behavioral principle behind this type of treatment is that drug abusers will associate the violent reaction with the drug they are abusing and stop taking it. The most commonly used antidipsotropic drug is Antabuse, which is used for the treatment of alcohol abuse. Antabuse produces a marked physical reaction when ingested with alcohol, including labored breathing, nausea, vomiting, sweating, weakness, and vertigo. Intensity and duration of the reaction vary from individual to individual. In addition, Antabuse *alone* may cause side effects, such as headaches and erectile difficulties in males. Also, Antabuse is excreted very slowly from the body. Thus, the possibility of a reaction upon the ingestion of alcohol remains for four to five days following the last dose. This particular treatment demonstrates how difficult it can be to treat addiction, as well as the lengths people are willing to go to try to help themselves. Individuals are actually willing to take voluntarily an antidipsotropic drug that will make them violently ill should they drink. Some alcoholics know intellectually that they will die if they do not stop drinking, but it takes *feeling* as if they are going to die, after ingesting both alcohol and Antabuse, to get them to stop.

The success of Antabuse treatment depends largely on the willingness of the client to use it as directed. Studies show that the abstinence rates among subjects who are given placebos, but think they are taking Antabuse, are comparable to the abstinence rates of subjects actually given Antabuse. Antabuse may be most beneficial as an adjunctive treatment or as a temporary aid for those motivated to stop drinking. Those who are compulsive, older, socially stable, and motivated seem to do better on Antabuse, while those who are depressed or have sociopathic tendencies do not fare as well. *Given the role of motivation in the successful use of Antabuse, mandatory prescription of this drug to alcohol-abusing offenders is unlikely to be effective or safe.*

Antagonist Drugs (Naltrexone)

Antagonist drugs, such as naltrexone, inhibit the euphoric effect of opiates within the brain. When trexan is taken prior to heroin use, the user does not experience a "high." Unlike Antabuse, it produces no unpleasant side effects. Naltrexone is primarily used to prevent relapse among highly motivated heroin addicts. Researchers such as Rawson and Tennant advocate using naltrexone to fight urges and cravings during periods of abstinence to help the client experience a completely drug-free state.²¹ There is a beneficial behavioral reinforcement for heroin addicts who take naltrexone. If individuals relapse under the influence of naltrexone and do not get high, in essence, they have spent their money on heroin "for nothing." After a time, this negative reinforcement helps to extend periods of abstinence.

Agonist-Antagonist Drugs (Buprenorphine)

Ten years ago, investigators at the National Institute of Drug Addiction Research Center conducted clinical studies of the opioid analgesic, buprenorphine, and concluded that it could have value in treating opioid drug abuse. Buprenorphine is an opioid mixed agonist-antagonist, meaning that it provides in one compound the desirable features of both methadone and naltrexone. It combines the patient acceptability and cross-tolerance of methadone with the narcotic blockade and lack of physical dependence of naltrexone. Buprenorphine is still in an early experimental stage, but its success in treatment looks promising, and NIDA is vigorously pursuing its development.²² Many patients being treated for narcotic abuse use cocaine, as well. A preliminary study of 138 opioid addicts treated with methadone, naltrexone, or buprenorphine found that both naltrexone and buprenorphine were much more successful in blocking the euphoric effects of the combination of cocaine and opiates. These medications may be useful in treating "speedball" abusers.

Psychotropic Drugs

Psychotropic drugs are used often to treat patients with psychiatric disorders. For example, someone diagnosed with an anxiety disorder may be treated with Xanax, Valium, or other drugs from the benzodiazepine family. Other drugs may be prescribed for depression, panic disorder, or schizophrenia. When an individual has a history of substance abuse in addition to a psychiatric disorder (referred to as dual diagnosis), the issues can become quite complicated for treatment professionals and the criminal justice system.

The use of psychotropic drugs for drug addicts is surrounded by debate because of the potential for abuse of certain drugs and because of the ambiguity of a treatment message that prohibits some drug use and sanctions others.²³ In addition, there are often problems regarding diagnosis. If a patient is withdrawing from a drug, these symptoms may be confused as psychiatric symptoms, or they may mask real psychopathological symptoms. A drug addict who needs psychotropic drugs to control a condition such as schizophrenia may be less likely to take this medicine if it does not produce a drug "high."

Dr. Herbert Kleber, the former deputy director for demand reduction in the Office of National Drug Control Policy reports that 87 percent of addicts have had some psychiatric disorder during their lifetimes. Depression is the most common diagnosis, followed by anti-social personality disorder, schizophrenia, and anxiety.²⁴ It was discovered quite by chance that a drug called desipramine, which is used primarily to treat depression, may also be useful in helping cocaine addicts achieve and maintain abstinence, at least for a short time. Desipramine is reported to decrease the positive effects of cocaine and reduce the craving.²⁵

Considering the relative frequency of potentially treatable psychiatric disorders and the problems (such as failure to continue in treatment and unsuccessful treatment) presented when psychiatric disorders remain undiagnosed, Dr. Kleber recommends a psychiatric assessment for those who fail to respond to conventional treatment approaches. For many of those with a psychiatric disorder, he favors the use of psychotropic drugs.²⁶

[In therapeutic communities] the primary therapist and teacher is the community itself, usually consisting of trained staff, former addicts, and peers who role-model successful personal change.

RESIDENTIAL TREATMENT

Drug-free residential communities focus on achieving and maintaining a drug-free existence. We have chosen to differentiate between residential therapeutic communities and other hospital-based residential programs.

Therapeutic Communities

Therapeutic communities (TCs) can be distinguished from other modalities in three ways. First, TCs operate on a "total immersion" view of treatment, requiring a twenty-four hour residential setting and comprehensive rehabilitative services. These services include, but are not limited to, individual and group therapy, recreation, drug education about "the disease of addiction," vocational counseling, and other family, legal, medical, and social services. Second, the primary therapist and teacher is the community itself, usually consisting of trained staff, former addicts, and peers who role-model successful personal change.²⁷ Third, TCs subscribe to the belief that the problem is the person, not the drug. Drug dependence is considered a symptom, not the essence of the disorder. Physiologi-

cal dependence is seen as secondary to a broad range of circumstances, which predispose a person to drug use and ultimately influence drug use behavior.²⁸ This perspective shapes the operation, staffing, and organization of the community. Extensive work is done on changing attitudes and “getting honest” to help prevent relapse. And although drug addiction may be considered a symptom of a greater root problem, it is taken seriously by all—to continue to drink and take drugs *will* lead to someone’s continued downfall and, ultimately, to death.

TCs generally function as an “aftercare” option, rather than as a “first stop” for drug-involved offenders. The recovery process within therapeutic communities is shaped by several assumptions. Client *motivation* is crucial to recovery and is often dependent upon pressure to change. Thus, clients will not change unless they (1) desire to change, (2) feel internal pressure such as guilt or disgust, or (3) receive external pressure such as mandatory treatment as a condition of probation. Rehabilitation involves an *interaction* between the client and the community. The community achieves this by: exerting pressure on the individual to make it through the program (if you can do this, you can do anything; we won’t let you fail); caring (we care about you and want you to live; you will only live if you stay clean); role modeling (if we can do this, so can you) and, understanding (we know how tough it is, but it is worth all the effort). *Social learning* must occur if recovery is to progress. Learning within a therapeutic community is participatory; clients “learn by doing,” and they receive constant feedback on their attitude and performance. TCs are explicit in identifying right and wrong behaviors for which rewards and punishments exist. Members progress through a residential program in clearly demarcated stages. Each succeeding stage carries more responsibility and personal freedom than the previous one. All TC members are assigned to work duties and are responsible for the maintenance and upkeep of the facility.²⁹

TCs attract a wide variety of drug abusers, although they originally attracted large numbers of narcotic addicts. Today, the majority of the TC client population are non-narcotic abusers. According to George DeLeon and Mitchell S. Rosenthal, leading researchers and proponents of TCs, “this modality has responded to the changing trend in drug use patterns, treating clients with drug problems of varying severity, different life-styles, and various social, economic and ethnic backgrounds.”³⁰

Research reveals that, despite differing social and ethnic backgrounds, TC clients display a considerable amount of psychosocial dysfunction. Typically, IQ scores of clients are in the dull-normal range, socialization is poor, and depression and anxiety levels are extremely high. Among adult admissions, two-thirds have been arrested, and approximately 35 percent have prior drug treatment histories and are not amenable to other forms of treatment.³¹ DeLeon and Rosenthal conclude that:

The psychological profiles reveal drug abuse as the prominent element in a picture that mirrors features of both psychiatric and criminal populations. For example, the character disorder characteristics and poor self-concept of delinquent and repeated

offenders are present, along with the dysphoria and confused thinking of emotionally unstable or psychiatric populations. These profiles vary little across age, sex, race, primary drug, or admission year and are not significantly different from drug abusers in other treatment modalities. Thus, the drug abusers who come to the TC do not appear to be sick, as do patients in mental hospitals, nor are they simply hard-core criminal types, but they do reveal a considerable degree of psychological disability.³²

In the last decade, TCs have diversified their services and adopted more flexible standards. Cost, availability, and insurance reimbursement issues have led to three different approaches to therapeutic communities.

- The Traditional Therapeutic Community is a long-term program lasting an average of fifteen months. This model is considered most appropriate with hard-core drug users involved in criminal activities, although today it is being used less often because of its high cost. DeLeon and Rosenthal describe the traditional TC philosophy as follows:

Fundamental to the TC concept is the necessity for a total twenty-four hour community impact to modify permanently lifelong destructive patterns of behavior. The basic goal is to effect a complete change in lifestyle: abstinence from drugs, elimination of anti-social (criminal) behavior, development of employable skills, self reliance, and personal honesty.³³

- The Modified Therapeutic Community lasts an average of six to nine months. This model has more limited goals than a traditional TC, including attaining a drug free state and acquiring practical living skills. This model is considered appropriate for addicts who have minimal social support. It is less costly than the traditional TC and allows for a greater number of offenders to participate because of the reduced length of stay.
- The Short Term Therapeutic Community lasts an average of three to six months and places little emphasis on resocialization. Its primary goal is to help the addict attain a drug-free existence. This model is considered appropriate for individuals with a stable social and family environment.³⁴

Most evaluations of TCs indicate that they are both cost-effective and cost-beneficial when compared with prisons.³⁵ More recently, Harwood and colleagues examined the benefits of drug treatment in terms of crime-related behavior. Analyzing the Treatment Outcome Prospective Study (TOPS) database, they found that TCs virtually pay for themselves, because of reduced criminal activity while the client is in treatment, as compared with pre- or post-treatment criminal activity.

As indicated by the Drug Abuse Reporting Program (DARP) and other studies, therapeutic communities (TCs) are comparatively effective in reducing illicit drug use and crime and increasing employment status. The therapeutic community approach has been found to have some advantages over other modalities in that treatment effects generally are more lasting and clients report greater satisfaction with treatment.

... TCs virtually pay for themselves, because of reduced criminal activity while the client is in treatment, as compared with pre- or post-treatment criminal activity.

Some treatment professionals advise that drug-involved women offenders may not do well in TCs . . . The confrontational approach might be too intense and therefore counterproductive.

Nevertheless, studies consistently reveal that the dropout rate for TCs is higher than in many other types of treatment programs. DARP found that while only 26 percent of methadone maintenance clients dropped out of treatment within the first ninety days, 52 percent of clients in therapeutic communities did so.³⁶ In a study of seven TC programs, it was found that drop out rates are highest within the first thirty days of treatment (30-40 percent); this rate declines as the length of time in treatment increases.³⁷ In fact, the most consistent predictor of treatment success is the length of time in treatment. For those who remain in treatment, outcome studies generally report significant declines in drug use and criminality, and increases in pro-social behavior. Studies of psychological adjustment for clients in TCs show significantly improved psychological scores at follow-up.³⁸

Because of the intensity of treatment in TCs, aftercare is critical to sustain treatment improvements. Many TC clients are transitioned to half-way houses or referred to outpatient treatment and self-help groups.

No "typical" client profile has emerged that predicts length of stay in a therapeutic community or successful treatment outcomes. Research suggests, however, that less severe criminal activity is correlated with longer retention. Similarly, lower lifetime criminality has been correlated with better treatment outcomes.³⁹ Higher levels of education and lower levels of drug and alcohol consumption are also related to more positive treatment outcomes.⁴⁰ Taken together, these findings indicate that therapeutic communities hold promise for those who are involved in both substance abuse and crime.

Therapeutic communities may not be an appropriate treatment for individuals with severe psychopathology. A comparative study looked at the outcomes of three groups of methadone maintenance and TC clients classified as having either low, medium, or high levels of psychiatric problems. Low- and medium-severity clients showed improvement under both treatment conditions. With high-severity clients in therapeutic communities, longer treatment duration showed worsening across all measures. The use of confrontation and the prohibition of psychotropic drugs, although less common today than several years ago, may be counterproductive for clients with severe psychiatric problems.⁴¹ Some treatment professionals advise that drug-involved women offenders may not do well in TCs for similar reasons. Many of these women are highly dependent and have low levels of self-esteem. The confrontational approach might be too intense and therefore counterproductive.

Therapeutic communities originated from the narcotic addiction treatment tradition; however, non-opiate addicts, including cocaine abusers, are being increasingly referred to therapeutic communities. Currently, there is little empirical data on TCs' effectiveness with non-opiate users.⁴²

Hospital-based Programs

Hospital-based programs offer a combination of medically supervised detoxification and a structured day, which includes supportive psychotherapy, group therapy, and Alcoholics/Narcotics Anonymous meetings. Many hospital-based programs are located in private, for-profit hospitals and are used by those of middle to upper socioeconomic status. In other words, one must be able to pay a certain amount of money to attend these programs or have the appropriate insurance coverage. Some programs have slots available for uninsured patients, but patients often are placed on a waiting list until an "uninsured bed" becomes available.

These programs generally last between twenty-one and twenty-eight days. This setting is often chosen by employed people who have a problem with drugs or alcohol and may have been told that treatment is required in order for them to keep their jobs. Attending a hospital-based program shows their employer that they are trying to address their addiction, while it avoids a prolonged absence from work. These programs are usually run by psychiatrists, psychologists, and health professionals who employ a variety of clinical approaches, including traditional group, individual, and family therapy. Programs often include training in relaxation, exercise, and coping skills. Special psychiatric attention is given to those addicts who have serious mental illness in addition to their drug problem.⁴³ These programs themselves tell their patients that they are not "cured" after a stay in their hospital. Aftercare plans often include recommendations for outpatient counseling and attendance at AA/NA meetings. These are only recommendations, however; if clients do not follow through on using outside supports, they often wind up back in the hospital for another period of detoxification.

Hospital-based programs, to date, have not been subject to much review. Most of these programs are not government funded, and thus, are not subject to government reviews and evaluations.⁴⁴ Individual programs may vary considerably, and appropriate research should be conducted before considering a referral and placement in one of them.

OUTPATIENT PROGRAMS

Outpatient programs include a wide variety of treatment approaches, which may or may not have significant features in common. Perhaps this variation is caused by the wide variety of drug abusers served by outpatient programs, including young clients with no record of drug abuse, criminal justice referrals, and clients who have completed other types of treatment.

Outpatient programs range from drop-in rap sessions to highly structured programs, and vary in staffing requirements, treatment philosophies, and goals. Among the services provided are individual and group therapy, family counseling,

vocational and educational training, legal counseling, and referral services.⁴⁵ Generally, outpatient programs provide for one to two visits per week, with an average duration of six months.⁴⁶

Many outpatient programs focus on resocializing clients. "Change-oriented" programs generally provide young abusers with life-skills training to enable them to lead a drug-free life. "Adaptive" programs focus on the immediate needs of the client and incorporate strategies to reduce the client's need for drugs as a vehicle for coping with stress. Adaptive programs do not operate on the assumption that the addict will live a drug-free life following treatment.⁴⁷

Many judges consider outpatient programs to be a low intervention approach, appropriate for the low-risk offender. Although outpatient treatment accounts for almost 50 percent of clients in treatment, generalized evaluations of programs within this modality are difficult given the wide variety of therapies and approaches involved.⁴⁸ According to the Drug Abuse Reporting Program (DARP), as long as outpatient programs can retain offenders in treatment for at least three months, these programs have demonstrated that they can be as effective as other modalities.

TOPS data reveal that only half of the clients in outpatient programs received a primary diagnosis of drug abuse. Thus, therapy in outpatient programs generally focuses on other problems, including depression. According to TOPS, three quarters of outpatient program clients were in need of psychological services.⁴⁹

SELF-HELP GROUPS

Self-help groups are consumer- and peer-oriented groups in which the client and helper are helped concurrently. The self-help movement has grown tremendously in the past two decades; currently there are an estimated 500,000 groups nationwide addressing a multitude of issues, including drug abuse, eating disorders, and gambling. Self-help groups operate in a multitude of settings, including churches, other community facilities, and prisons.

Self-help groups strive to reduce the client's feeling of isolation and dysfunction by infusing their work with a "you are not alone" belief. There is an emphasis on empowering the individual through peer and spiritual guidance. Sessions or group meetings often consist of exchanging ideas on effective ways of handling problems and obstacles to maintaining behavior change.

Alcoholics Anonymous (AA), perhaps the best-known of all self-help efforts, currently boasts of more than one million members nationwide. AA describes itself as a voluntary, self-run group with no political or religious affiliation. AA advocates the disease model of alcoholism, and stresses that alcoholism is an incurable condition which, if left untreated, will lead to death. AA offers an alternative to, or a complement for, other types of drug treatment, including psychotherapy and medical intervention. Membership is free, voluntary, and can last a lifetime.

AA is well-known for setting forth the Twelve Traditions and Twelve Steps of its purpose, organization and rules, around which other self-help groups, such as Narcotics Anonymous (NA), AlAnon (for families of alcoholics), and AlAteen (for adolescent drinkers), have organized themselves. Steps 1-3 entail admission of powerlessness over alcohol and other drugs and commitment to a higher spiritual power. Steps 4-9 involve assessment of character defects and other guilt provoking behaviors and a restructuring of damaged relationships and self. Steps 10-12 require a continuing commitment to the other steps and to spread the message of AA to others.⁵⁰ Alcoholics strive to maintain abstinence through a lifetime of following the Twelve Steps.

In recent years, the AA organization has come under some attack for its reliance on a "higher power," its stance that alcoholism is incurable, and its belief that alcoholics are helpless against the disease. Those who have difficulty with the AA tradition maintain that "AA simply substitutes one kind of dependency for another," that is, dependence on a lifetime of meetings and spiritual guidance.⁵¹ In response to these criticisms, organizations such as Rational Recovery and Women for Sobriety have formed self-help groups with a decidedly different ethos. Central to their belief system is taking personal responsibility for one's actions, relying on oneself rather than a higher power. Even these organizations acknowledge that "part of AA's attraction is the release from accountability implied by the appeal to higher forces. Calling drinking a disease instead of a personal failing also seems to help some people."⁵²

Self-help groups were traditionally modelled after Alcoholics Anonymous and the Twelve Step philosophy. By its very nature, AA and similar programs are difficult to evaluate. Although reported correlations between AA attendance and abstinence are common, establishing a causal link between recovery and AA meeting attendance is difficult. To date, only a few studies have been conducted on the efficacy of AA, largely because of its philosophical disinclination to undergo scientific study. None has revealed strong empirical evidence that AA is an effective treatment.⁵³ However, "the weight of clinical and observational evidence along with some research data support the conclusion that self-help groups appear to be essential in facilitating recoveries in a number of substance abusers."⁵⁴

There is some controversy regarding mandatory AA or NA attendance for the criminal justice population. Many self-help proponents maintain that mandatory attendance is not effective because "wanting to change" is critical for recovery, according to the AA program philosophy. Others point out that many drug-involved offenders are in need of individualized services, which AA and other Twelve Step programs do not provide.⁵⁵ But there are other self-help proponents who believe that court-mandated referral to AA or NA can be helpful, and they are willing to act as monitors or liaisons to the court. The governing board of Alcoholics Anonymous addresses this question directly:

... "the weight of clinical and observational evidence along with some research data support the conclusion that self-help groups appear to be essential in facilitating recoveries in a number of substance abusers."

All of us sober in AA know to get well we really had to want it for ourselves—eventually, if not at first. We could not stay sober just because we were “required” to or for somebody else.

Yet, in every real sense, every single AA member is at first “sentenced” to AA—if not by the court, then by employer, family, friends, doctor, or counselor, or by his or her own inner suffering. We would not come to AA until we had to, in some way.

So in AA we are not concerned about who or what first sends the alcoholic to us, or how. Our responsibility is to show AA as such an attractive way of life that all newcomers who need it soon want it . . .

In most cases, the group secretary is happy to sign or initial a slip furnished by the court saying so and so was at the such and such meeting on a particular date.⁵⁶

Many judges and probation officers feel court-ordered AA or NA is not appropriate for an initial referral. Yet, there is a great deal of support for AA or NA for aftercare, particularly if attendance begins during a residential program and then continues as individuals transition to less restrictive settings. Many judges and treatment professionals believe that there is no better way to sustain recovery than a self-help group.

ACUPUNCTURE

Acupuncture has been used to treat a variety of illnesses and ailments in the Far East for many centuries. Although the practice is widespread in other parts of the world, its acceptance as a legitimate medical intervention in the United States has been limited. However, like chiropractic medicine or healing through the use of visual imagery, it is increasingly accepted, as those who have experienced this form of treatment share their beneficial experiences with others. Many factors have propelled the acupuncture boom, including more open-mindedness towards Eastern medicine. The principal reason for the growing acceptance of acupuncture is its success, when used in conjunction with conventional treatment, in treating drug addiction.⁵⁷

For the last fifteen years, acupuncture has been used to treat addictive disorders. It was first used with alcoholics and has since been used with other drug users. Today, acupuncture is most commonly used to help drug users detoxify, because it helps reduce withdrawal symptoms and lessens the craving for drugs. It is almost always administered along with counseling, including NA, AA, and AIDS education classes. The largest program in the United States is located at Lincoln Hospital in the South Bronx in New York. Approximately 280 patients are seen each day. Two of the most significant advantages of this programs are its low cost

and the fact that there are no waiting lists. Seventy-five percent of the patients are court-referred, yet regardless of the referral source, ability to pay, or record of past treatment failures, no one is turned away.⁵⁸

The process of acupuncture detox involves placing needles just under the skin, usually on the external portion of the ear. Whether the needle insertion stimulates the body's own pain-killing hormones, the endorphines, to produce feelings of calm and euphoria or whether it is the belief or wish that this *old/new* form of treatment will have a helpful impact, drug users are motivated to attend acupuncture detox programs. In the process, their day develops some structure and they may see other program participants in much the same way that AA attendees see members of their groups—as people who share a common problem—so that there is less of a sense of alienation. They may also talk to a counselor who links them to an employer or helps them find housing. Although this assistance may not deal directly with the drug problem, helping users manage some of their underlying day-to-day problems may produce important benefits.

Michael Smith, the medical director of the Substance Abuse Division of the Department of Psychiatry of Lincoln Hospital suggests a number of reasons for the success of his acupuncture detox program. The following is summarized from his written testimony to the House of Select Committee on Narcotics:

- (1) Patients learn to have confidence in daily acupuncture visits and the relief that consistently occurs. Acupuncture is a treatment for craving and fear as well as withdrawal symptoms. Acupuncture acts physiologically by enhancing the patient's own balancing mechanisms.
- (2) The struggle for sobriety is "one day at a time." By testing urines on a daily basis, providing daily acupuncture, and encouraging brief daily counseling sessions—we are functioning in the same rhythm as the patient's struggle for recovery.
- (3) Clinical staff makes a primary alliance with the criminal justice referral agency *and* with the client. This process of dual alliance with the client and the disciplinary agency is the basis for successful work. There is a lack of contradictory messages, a lack of excuses, and an abundance of interest in their daily struggle to be drug-free.
- (4) The counseling process emphasizes a non-judgmental, non-invasive, supportive approach. The firm challenge of sobriety is established, but the treatment relationship is quite flexible and open-ended. On some days patients may want to ventilate their feelings; at other times they may want to just say "hello" and receive the acupuncture treatment.
- (5) Frequent urine testing provides an objective non-personalized measure of success that can be accepted equally by all parties.
- (6) The fear and shame associated with impending incarceration or removal of a child is certainly an important factor in any success. In the chemical dependency field, it is considered beneficial for a prospective patient to face a fearful concrete reality.
- (7) "There is no such thing as a hopeless case" is another basic principle. . . . (no) prospective patients (are screened out) as "poorly motivated" or "unsuitable" as is frequently done in regard to criminal justice referrals. All referrals are accepted . . ."⁵⁹

Treatment of non-narcotic addiction, including cocaine and polydrug use, is a more recent development within the treatment community.

One of the most highly-regarded studies on the effectiveness of acupuncture was conducted by three researchers at the University of Minnesota Medical School. They studied acupuncture treatment given to alcoholics; their findings may not necessarily apply to users of other drugs. They found that significant treatment effects continued at the end of a six-month period for those who received real acupuncture. By comparison, the control group, whose members received "sham" acupuncture, in which needles were put near but not directly on specified acupuncture sites, expressed a moderate to strong desire to drink and had more than double the number of drinking episodes and admissions to detoxification centers.⁶⁰

Clearly, the research in this area is very preliminary and limited. It will be important to evaluate the treatment effectiveness of acupuncture programs, since many more have recently opened around the country. Although low cost is an important motivator for policymakers deciding on the types of treatment programs to fund, most judges will await further research or will prefer to see firsthand how well these programs work.

COMPARATIVE FINDINGS ON TREATMENT EFFECTIVENESS

Until recently, drug treatment services and research on their effectiveness in the United States have focused heavily on narcotic addiction. The most extensive research on the efficacy of narcotic drug treatment have been two multi-site, federally funded studies of publicly supported programs: the Drug Abuse Reporting Program (DARP) and the Treatment Outcome Prospective Study (TOPS). Both studies, described below, have demonstrated the effectiveness of drug treatment for drug-involved offenders. Treatment of non-narcotic addiction, including cocaine and polydrug use, is a more recent development within the treatment community. To date, there have been no large-scale studies on the efficacy of drug treatment for cocaine and crack addicts. Unfortunately, for judges sitting on the bench today, research on the efficacy of treatment for cocaine and other non-opiate abusers is just now underway. Given the drug treatment community's past focus on opiate addiction, Cross and colleagues note that:

... it is unclear to what degree one can generalize to treatment of those who abuse cocaine, amphetamines, sedatives, hypnotics and other drugs. Again, opiates differ from cocaine and other drugs chemically, but there are commonalities in patterns of abuse, associated problems, and treatment methods. Also, there appears to be significant polydrug abuse in opiate-abusing populations.⁶¹

Drug Abuse Reporting Program (DARP)

The Drug Abuse Reporting Program, established in 1969 as a national treatment system evaluation project, was the first comprehensive nationally-based evaluation of drug abuse treatment effectiveness.⁶² This evaluation was conducted by the Institute of Behavior Research of Texas Christian University. DARP examined admission records of more than 44,000 clients in fifty-two NIDA-supported agencies during the early years of community-based treatment between 1969-1974.⁶³ Opiate addicts accounted for the vast majority of the sample; only 14 percent of the sample represented non-opiate drug users.⁶⁴ The effectiveness of four major types of drug treatment (methadone maintenance, therapeutic communities, outpatient programs and detoxification) was analyzed. The treatments were compared with each other and with non-treatment.⁶⁵

The most significant finding of the DARP study was that all four treatment modalities were of limited value when treatment lasted ninety days or less. When treatment lasted for more than ninety days, the effectiveness of methadone maintenance, therapeutic communities, and outpatient programs, improved in direct proportion to the amount of time spent in treatment. In contrast, detoxification showed no substantial favorable outcomes when compared to non-treatment. Another significant finding was that the most consistent predictor of treatment effectiveness, aside from treatment duration, was the criminal history of the client before and during treatment. Higher rates of pre-treatment arrests and incarcerations coincided with poorer post-treatment outcomes, such as higher rates of criminal activity, drug use, and unemployment.⁶⁶

In 1974, the first series of DARP post-treatment research evaluations was initiated. A total of 6,402 clients were selected from thirty-four treatment programs for follow-up interviews approximately six years after first admission to a DARP treatment program.⁶⁷

A sample of 697 opiate addicts was chosen for a second wave of DARP follow-up interviews beginning in 1982, approximately twelve years after first admission to treatment.⁶⁸ Analysis of the follow-up data confirmed that drug treatment was associated with favorable outcomes in the three major modalities of treatment: methadone maintenance, therapeutic communities and outpatient drug-free programs. Specifically, 61 percent of male addicts in the three DARP treatment programs were abstinent from opiate drugs for one or more years prior to the follow-up interview. Only 21 percent of male opiate addicts continued their drug use throughout the follow-up period.⁶⁹ The second major finding of the follow-up data was that there was no significant difference in outcomes among the three major modalities.⁷⁰

A separate analysis of the *non-opiate* addicts in the DARP group was also conducted. Overall, favorable treatment outcomes were consistent with those of the opiate-addicted clients: 44 percent of non-opiate addicts obtained highly

When treatment lasted for more than ninety days, the effectiveness of methadone maintenance, therapeutic communities, and outpatient programs, improved in direct proportion to the amount of time spent in treatment.

favorable outcomes and 29 percent obtained moderately favorable outcomes as defined by the study. However, for this group of clients, outpatient programs appeared to have a treatment advantage over therapeutic communities. This finding should be viewed with caution, though, since non-opiate addicts in therapeutic communities were relatively rare and were much younger than the opiate-addicted clients in the therapeutic communities. These communities may have been more oriented to the older, opiate clients, and may have neglected the younger non-opiate addicted clients to some extent.⁷¹ With the exception of research on alcohol, there is little research on the effectiveness of non-opiate drug treatment, although several studies are now under way to evaluate treatment effectiveness for non-opiate drug addicts.

Treatment Outcome Prospective Study (TOPS)

The TOPS project consisted of an in-treatment study and a follow-up study. The in-treatment study included a sample of 11,750 individuals admitted to drug treatment programs in ten United States cities from 1979 to 1981. Follow-up studies were conducted for the 1979, 1980, and 1981 cohorts.⁷²

The TOPS project was designed to provide nationally-based information regarding client behavior before, during, and after treatment. The study's measures included clients' alcohol consumption, criminal activity, drug use, mental health, and economic productivity. Treatment modalities included for study were (1) methadone maintenance, (2) residential programs, and (3) outpatient programs.⁷³

Pre-treatment and in-treatment data from the TOPS study revealed that:

- Clients under legal pressure to undergo treatment did as well or better than those who sought treatment on their own.
- Outpatient programs had the poorest retention rates. Twenty-one percent of the clients dropped out within a week and 36 percent within four weeks.
- More than 40 percent of all drug treatment clients reported some illegal activity in the year before treatment; more than 70 percent of these clients reported that they stopped illegal activity during treatment.
- Methadone maintenance clients were the least likely to drop out of treatment.
- Half of the methadone maintenance clients were unemployed before treatment and most remained unemployed while in treatment.
- A high level of depression exists among drug addicts seeking treatment. Approximately half of all methadone maintenance clients reported severe depression in the year prior to entering treatment.⁷⁴

TOPS client follow-up data indicate the following:

- There was a reduction in the use of clients' primary drug in all treatment modalities.
- Reports of illegal activity decreased after treatment in all modalities. The largest change in criminal activity, however, occurred with residential clients.
- Clients in all modalities reported a significant decrease in depression following treatment.

Consistent Findings on Treatment Effectiveness

Several important findings from the research and literature regarding drug treatment effectiveness deserve highlighting. Although many of these findings seem self-evident, the implications for judicial decision-making are significant. The following holds true for all treatment modalities:

- There are large variations of effectiveness within modalities and programs, largely due to differences in staff, including variations in staffing ratios, clinical competence, and experience.⁷⁵
- Individuals under legal pressure to undergo treatment do as well or better than those who seek treatment on their own.⁷⁶
- Length of time in treatment is related to treatment outcome. Generally, the more time spent in treatment, the better the treatment outcome.⁷⁷
- Individuals with a history of extensive criminal activity tend to have poorer treatment outcomes.⁷⁸
- Frequency of drug use and criminal behavior decrease during treatment.⁷⁹
- Individuals with a severe psychopathology tend to have poorer treatment outcomes.⁸⁰
- Individuals with greater ties to conventional society tend to have more favorable outcomes.⁸¹

Many drug treatment and criminal justice professionals believe that the central issue regarding drug treatment is not whether it works, but what type of treatment works best for what type of clients/offenders.

TREATMENT-CLIENT MATCHING

Many drug treatment and criminal justice professionals believe that the central issue regarding drug treatment is not *whether* it works, but *what type of treatment works best for what type of clients/offenders*. Among the most important factors to consider when assigning individuals to treatment and supervision are the type, extent, and severity of their criminal activity. Assessments may provide important information on an offender's need for and amenability to treatment. For example, often career criminals become involved with the criminal justice system at a young

age. Conventional treatment efforts are less likely to succeed with this group. As drug treatment and criminal justice professionals suggest, breaking the drug-crime cycle for these offenders requires a drug treatment program which alters both drug use *and* behavioral patterns.⁸² Narcotic addicts who were involved in crime *prior* to their addiction require different treatment strategies from those whose criminal behavior began with their drug use. The former tend to continue their criminal activity during periods of abstinence. In contrast, narcotic addicts whose criminal activity started *during* their addiction career show drastic declines in criminal activity during periods of recovery.⁸³ The Bureau of Justice Assistance maintains that:

... while intervention aimed at eliminating narcotic addiction and thus eliminating crime would be an unrealistic objective for most individuals with pre-addiction criminal involvement, it might be a reasonable one for the majority of addicts with no serious pre-addiction crime.⁸⁴

Many treatment professionals believe that these patterns apply to non-opiate users as well as opiate users.

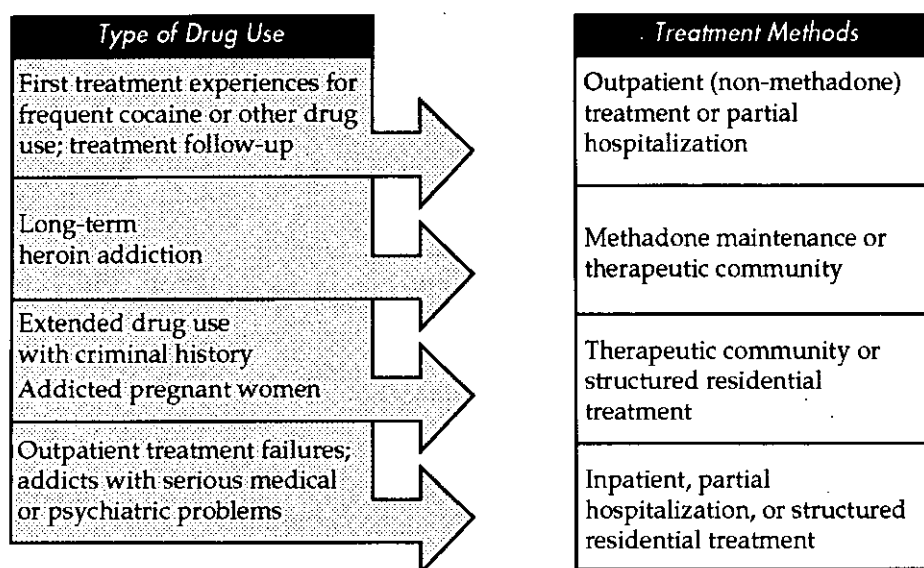
While there are no tried-and-true rules or guidelines regarding patient matching, there are factors to consider when referring clients to treatment. The following factors have been suggested by Dr. Herbert Kleber, the former Deputy Director for Demand Reduction in the Office of National Drug Control Policy.⁸⁵

- **Type of drug(s) used.** With the increased prevalence of polydrug use, multiple addictions must be addressed. For example, in recent years, the drug-treatment community has seen an increase in cocaine use among methadone maintenance clients. Given these problems, programs that address only one dependency are likely to fail. Familiarity with the breadth of local treatment programs is crucial.
- **Presence and severity of psychological problems.** Drug abusers with psychiatric disorders may respond differently to treatment approaches than do those without such disorders. Therapeutic communities are often counterproductive for clients with severe psychopathology.
- **Rehabilitation vs. habilitation.** For treatment clients who possess vocational skills and/or interpersonal skills, stopping drug use may produce a substantial improvement in overall functioning. Individuals whose drug use and criminal activity increase when they are unemployed tend to benefit from programs that provide vocational counseling. It is important to consider programs that not only help the individual *find* employment, but also help the individual *maintain* employment. However, for clients who began using drugs at an early age and do not possess work or social skills, additional aid beyond stopping drug use may be necessary. In this instance, therapeutic communities may be the most appropriate treatment because they provide more comprehensive services.

- **Lifestyle changes.** Drug-using friends and family members often contribute to client relapse. Moving out of drug-using neighborhoods and reducing or severing relationships with drug-using associates are associated with more successful treatment outcomes. It is important to choose a treatment program that helps clients avoid contact with drug-users. This is often achieved through helping the clients plan leisure time and cope with the anxiety associated with achieving and maintaining a drug-free existence. Participation in a tightly scheduled day reporting center should be considered.
- **Family involvement.** Much of the literature points to the effectiveness of family involvement in the rehabilitation process. Likewise, the number of treatment programs using family therapy is increasing. An important point to consider when referring a client to treatment is the program staff's effectiveness in obtaining and maintaining the help of family members. Involving an offender's family in treatment (either without the offender, in AL-ANON or AL-A-TEEN, or together in another treatment program) may be helpful.
- **Client motivation.** Treatment programs need to maintain client motivation by encouraging and facilitating positive vocational, interpersonal, and economic gains as well as positive family interaction.
- **Program structure.** The lifestyles of many addicts are chaotic and unstable, as reflected in irregular sleeping and eating patterns. Treatment programs should provide the client with a consistent structure and time schedule to aid them in adjusting to the "real" world.

The Office of National Drug Control Policy suggests the following model:

Matching Drug Use to Treatment Methods



Source: ONDCP, 1990

Several predictors related to client success in treatment have been identified by Miller and Hester. Although their literature review was based primarily on studies of alcohol abusers, it has relevance for those who abuse other substances as well.⁸⁶ Five of the most salient characteristics are listed below. They should be considered as a judge selects the most appropriate form of treatment and supervision.

Research indicates that clients with high self-esteem benefit from group therapy, while clients with low self-esteem respond less favorably to group therapy and may actually do better without it.

- Problem severity. In some studies, more severe pre-treatment alcohol use was correlated with better treatment outcome if the client was given intensive treatment. Less severe drinkers had better outcomes when given less intensive treatment and tended to become moderate drinkers rather than completely abstinent. In terms of psychological impairment, it was found that clients with high levels of psychiatric impairment generally responded poorly to treatment compared to clients with low levels of psychological impairment.
- Neuropsychological status. Similar to psychiatric problems, high severity neuropsychological problems are associated with poorer treatment outcomes. Special conditions of mental health counseling along with drug treatment may be advisable.
- Self-esteem. Research indicates that clients with high self-esteem benefit from group therapy, while clients with low self-esteem respond less favorably to group therapy and may actually do better without it.
- Social stability. In general, clients with greater social stability tend to have more successful treatment episodes. Furthermore, research indicates that unmarried clients respond more favorably in a community treatment model that provides a broad range of services.
- Other life problems. Treatment that targets specific problems has been associated with better outcomes than all-purpose treatment that provides a standard set of interventions for all clients. Specific interventions include social skills and vocational training, assertiveness and relaxation training, and the prescription of lithium for depressed clients.

A 1983 study on treatment matching for both alcohol- and drug-dependent clients had interesting implications regarding treatment effectiveness. The study sample included 130 alcohol-dependent and 256 drug-dependent clients. Based on hypotheses generated in a previous study, some patients were matched to treatment, while others were not specifically treated in their optimally predicted programs. Criteria for matching clients to specific treatments included medical, employment, legal, family and psychiatric factors. Two major findings resulted from this study. First, even without matching treatment assignments, substance abuse rehabilitation was effective. Second, effectiveness of treatment was enhanced by matching patients to the most appropriate programs.⁸⁷

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CHAPTER 5: SENTENCING

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SENTENCING

There is no single arrow that judges may draw at the time of sentencing. Judges must stock the quiver with a broad range of options—options that go beyond the “in or out” decision or traditional probation versus incarceration.¹

In this chapter, we will discuss the “sentencing landscape” or current climate in which judges must make their decisions. We begin with a brief discussion of sentencing issues, including mandatory sentencing, sentencing guidelines, and the use and value of discretion. We will also discuss the efficacy of mandatory treatment and compulsory supervision. Later in this section, we will detail specific sentencing options that judges, probation officers, and others may wish to consider.

BACKGROUND

In the past few years, the federal government and many states have passed tougher sentencing laws that rely more heavily on incarceration for drug-involved offenders. Yet, while the public and many political leaders call for a more punitive approach, diminishing fiscal resources conflict with the demand for more prison beds.² Furthermore, research shows that incarceration and other punitive measures *alone* have not eradicated the drug problem. Research also suggests that “...retention in drug abuse treatment is the most powerful variable associated with changing drug abuse and related behaviors, including alcohol abuse and arrests.”³ With the increase in drug abuse among criminal offenders and the crowding of our prisons, it seems clear that incarcerating all drug-involved offenders is not the answer to the drug epidemic.

It is thus not surprising that sentencing, particularly of drug-involved offenders, is continually under review and subject to frequent revision. As a result, the number of individuals being referred to community-based programs as alternatives to incarceration or as a special condition of probation or parole is growing steadily. The Institute of Medicine estimates that half or more of those admitted to community-based in-patient and out-patient treatment are on probation or parole at the time of admission.⁴ And, increasing support has developed for the design of more creative “intermediate sanctions” or “intermediate punishments.”

Across jurisdictions, however, laws and sentencing guidelines vary greatly. For example, within the new federal sentencing guidelines, there is a policy statement

that reflects the view that drug dependence and alcohol abuse should not be considered as mitigating factors at the time of sentencing. It states:

Drug dependence or alcohol abuse is *not* a reason for imposing a sentence below the guidelines. Substance abuse is highly correlated to an increased propensity to commit crime. Due to this increased risk, it is highly recommended that a defendant who is incarcerated also be sentenced to supervised release with a requirement that the defendant participate in an appropriate substance abuse program. If participation in a substance abuse program is required, the length of supervised release should take into account the length of time necessary for the supervisory body to judge the success of the program.

This provision would also apply in cases where the defendant received a sentence of probation. The substance abuse treatment condition is strongly recommended and the length of probation should be adjusted accordingly. Failure to comply would normally result in revocation of probation.⁵

Some states, such as Michigan, have passed tougher drug and alcohol-related laws. In fact, Michigan's tough mandatory sentence for drug possession was recently upheld by the U.S. Supreme Court. In this test case, a Michigan man with no previous criminal record or history of violence received a mandatory sentence of life with no possibility of parole following conviction for possession of 672.5 grams of pure cocaine. Of this sentence, Justice Scalia said, "Severe, mandatory penalties may be cruel, but they are not unusual in the constitutional sense, having been employed in various forms throughout our nation's history."⁶

Other states are exploring whether to create sentencing commissions to investigate major sentencing revisions. Many of these states are reacting specifically to the passage of mandatory drug laws, which have led to dramatic increases in state prison populations. Of equal concern is the fact that some of the first-time drug-involved offenders are receiving extremely lengthy sentences (such as the one received by the Michigan man), considered by many to be disproportionate to the sentences of other offenders, including those who commit acts of violence. Accordingly, some state policymakers, bar associations, and judicial working groups are asking that legislators restore some of the discretion that was taken away with the passage of mandatory minimum drug sale and possession laws.

In most state jurisdictions, judges still possess a great deal of discretion when sentencing drug-involved offenders. Where this discretion remains, sentencing decisions can become even more agonizing. On the one hand, there is public outcry for toughness, while on the other hand, a judge may be facing a pregnant, substance-abusing, single mother with young children at home or a young man with a history of mental health problems in addition to his drug and alcohol problem.

As part of the Crime Control Act of 1984, Congress created the United States Sentencing Commission. The commission described the following overarching sentencing goals:

On the one hand, there is public outcry for toughness, while on the other hand, a judge may be facing a pregnant, substance-abusing, single mother with young children at home . . .

- (1) to reflect the seriousness of the offense, to promote respect for the law, and to provide just punishment for the offense
- (2) to afford adequate deterrence to criminal conduct
- (3) to protect the public from further crimes of the defendant
- (4) to provide the defendant with needed educational or vocational training, medical care, or other correctional treatment in the most effective manner

... the existence of a drug or alcohol problem should not immunize one from being held accountable at the time of sentencing. ... public safety considerations must come first.

How can those sentencing goals be applied to drug-involved offenders? Judge Robert Evans of the Recorder Court in Detroit asserts that the existence of a drug or alcohol problem should not immunize one from being held accountable at the time of sentencing. He advocates that public safety considerations must come first. Only after public safety considerations are met can judges consider how best to maximize the available treatment and supervisory options. Not surprisingly, many offenders with serious criminal records tend to avoid drug-abuse treatment unless they think their willingness to participate in treatment may offset a lengthy period of incarceration. Thus, at a minimum, programs with strict supervision and monitoring are recommended for offenders with a record of frequent and serious criminal activity.⁷ And certain offenders, regardless of how much they may need treatment, may simply be too dangerous to remain in the community. The best choice for these individuals will be incarceration with drug treatment provided inside prison walls and follow-up treatment on their release to the community. When a judge determines that prison is not appropriate (or required by law), then a range of community-based intermediate sanctions should be considered, most of which include special conditions of mandatory substance abuse treatment.

INTERMEDIATE SANCTIONS

A wide array of alternatives or intermediate sanctions are currently being used. Although this may seem to contradict efforts to pass tougher laws, this concurrent trend reflects the views expressed by authors Norval Morris and Michael Tonry in *Between Prison and Probation: Intermediate Punishments in a Rational Sentencing System*:

We are both too lenient and too severe; too lenient with many on probation who should be subject to tighter controls in the community, and too severe with many in prison and jail who would present no serious threat to community safety if they were under control in the community.⁸

Whatever the motivation, greater numbers of policymakers and judicial leaders now recognize that it is impossible simply to build our way out of the prison crowding problem. In a recent article in the *Judges Journal*, Daniel J. Freed, director of the Criminal Sentencing Program at Yale and Barry Mahoney, senior associate at the Institute for Court Management of the National Center for State Courts wrote:

We believe that there are a large number of cases in which monetary sanctions and community punishments, sometimes coupled with a brief custodial component, can be at least as effective as straight imprisonment in attaining the goals of sentencing.⁹

They also state:

In our view, prison and jail overcrowding (and the cost consequences of the overcrowding) are excellent reasons for considering sentencing alternatives, but they are not the most important reasons. A more powerful rationale is that options other than incarceration are capable of achieving the legitimate objectives of sentencing in a very large number of cases that currently end up with the offender in prison or jail.¹⁰

These sanctions can be more than an add-on to probation; they take the public safety into account, they consider the rehabilitative needs of the offender, and they give priority to prison space for violent and repeat offenders. They are proving successful in regard to reducing the total expenditure for corrections while providing drug treatment, supervision, and allowing for victim restitution. They range from dispositions that affect an offender's financial assets to those that affect an individual's liberty. Some require that the offender give something back to the community—either through restitution or community service. Others focus on combining treatment with accountability, such as day treatment programs with regular urine testing. These options are not mutually exclusive. They may include a short period of incarceration (such as confinement in a shock incarceration program) or the threat of imprisonment. But their continued success requires that:

- Intermediate punishments be rigorously enforced; they should not, as is too often the present case, be ordered absent adequate enforcement resources.
- Breaches of conditions of intermediate punishments must be taken seriously by the supervising authority and, in appropriate cases, by the sentencing judge, if these punishments are to become credible sanctions.¹¹

Intermediate sanctions may also be used in combination with the following:

- Intermittent imprisonment—a specified number of weekends in jail, or a commitment to jail subject to daytime release for employment;
- The “split sentence,” in which a prison term of several years is imposed, and then split so that most of the prison term is suspended after a brief period of “shock incarceration”;
- The “reverse split sentence,” in which a prison term is imposed and then split so that the initial months or years are immediately suspended on conditions laid down by the court, with the sentence to be reconsidered if the conditions are met; and
- The two-part sentence, in which a prison term is imposed and carried out, subject to early reevaluation to determine whether the prisoner qualifies for intensive probation . . .¹²

Freed and Mahoney suggest that:

... alternative sentencing [intermediate sanctions] be advanced as a way to enrich the sentencing process, reduce its excessive dependence on prisons, and accord greater weight to sentencing goals other than incapacitation, without excluding the possibility of custody as a component of some intermediate sanctions.¹³

... research has determined that those who enter treatment under some form of coercion are likely to do at least as well as—sometimes better than—those who enter voluntarily.

It should be noted here that drug and alcohol treatment and criminal justice supervision strategies are not mutually exclusive. Some probation departments include highly trained probation officers who have become drug-treatment specialists. Many of the larger probation departments actually run residential programs and offer a continuum of services including NA and AA meetings. Likewise, many treatment programs are willing to monitor a drug-involved offender's behavior by taking urine samples, verifying attendance, and complying with any other special condition that the court imposes. Treatment programs that report incidents of non-compliance provide the feedback that the court needs to enhance the safety of the community and promote the principles of accountability. Because of the overlap between the treatment and criminal justice systems, it is important for judges and others to know the capacity and expertise of their local public and private agencies.

In the following sections, we describe intermediate sanctions that may be used in combination with a variety of sentences. These intermediate sanctions are only a starting point; there is a great deal of room for thoughtful innovation in this field.

MANDATORY DRUG TREATMENT

Mandatory drug treatment is usually used in conjunction with other sanctions; it is a key element at the judge's disposal. We presume that courts will order drug users to participate in treatment. It should be noted that research has determined that those who enter treatment under some form of coercion are likely to do at least as well as—sometimes better than—those who enter voluntarily.¹⁴ Simply put, offenders may be more willing to comply with treatment requirements—and for longer periods of time—because they do not want to be sent to prison for failure to comply. Treatment Outcome Prospective Study (TOPS) data indicate that individuals referred by the criminal justice system often stay in treatment longer, and Drug Abuse Reporting Program (DARP) subjects reported that complying with the conditions of probation and parole, and avoiding legal problems were important incentives for remaining in treatment.¹⁵

The notion that supervision by the criminal justice system is effective in keeping drug-involved offenders away from drugs is certainly not new. A study of almost 5,000 opiate abusers conducted in 1943 found that individuals on parole and probation had higher abstinence rates than patients who received treatment voluntarily. A twenty-year follow-up study of addicts admitted to a federal prison in

Lexington, Kentucky, revealed that compulsory parole supervision was the single most significant factor in determining abstinence among 100 narcotic addicts.¹⁶

Perhaps the best testimony to the effectiveness of treatment accomplished by compulsory supervision is the California Civil Addict Program (CAP), which began in 1961. CAP referred drug-dependent criminal offenders to compulsory treatment under court order. CAP's program of mandatory, outpatient treatment, accompanied by close supervision (including weekly urine testing and weekly meetings with parole officers), was associated with significant reductions in criminal activity, unemployment rates, and narcotic drug use among participants.¹⁷ Components of CAP can be found in a variety of intermediate sanctions, including several models of intensive supervision programs. Today, mandatory substance abuse treatment programs might also include attendance at AA or NA meetings, as well as participation in mandatory AIDS education classes.

One dilemma regarding mandatory treatment, however, is that all too often probation department practices or other criminal justice practices are unable to adequately ensure drug-involved offenders' entry, length of stay, and success in treatment programs.¹⁸ Building bridges between the courts and drug treatment programs is a necessary step toward ensuring the success of mandatory treatment.

INTENSIVE SUPERVISION PROGRAMS

Intermediate sanctions include a variety of intensive supervision programs. According to the Office of National Drug Control Policy, intensive supervision programs (ISPs) are one of the few sanctions that promise to *both* punish and rehabilitate drug-involved offenders.¹⁹ ISPs can generally be described as either jail/prison "diversion" programs or probation/parole "enhancement" programs.²⁰ Presently, all fifty states have some kind of intensive supervision program in place, and some of those programs focus specifically on drug-involved offenders. The objectives are to:

- Provide a cost-effective community option for offenders who would otherwise be incarcerated
- Administer sanctions appropriate to the seriousness of the offense
- Promote public safety by providing surveillance and risk-control strategies indicated by the risk and needs of the offender
- Increase the availability of treatment resources to meet offender needs
- Promote a crime-free lifestyle by requiring ISP offenders to be employed, perform community service, make restitution and remain substance-free²¹

Early recidivism studies reflect lower recidivism rates for offenders in ISPs than for those under traditional probation. These promising results have encouraged

policymakers to expand ISP for drug-involved offenders.²² Earlier versions of ISPs focused primarily on reduced caseloads and treatment-focused contacts. Today, programs are more likely to emphasize control and offender accountability. Now, nearly all ISPs require some combination of the following elements:

- House arrest
- Frequent reporting and contact
- Curfew
- Unannounced home visits
- Random drug testing
- Community service
- Victim restitution
- Fees to help offset the cost of supervision
- Electronic monitoring
- Involvement in substance abuse programs²³

Many of these ISP components will be described in detail later in this chapter.

According to a recently conducted RAND study on ISPs for drug-involved offenders,

... these conditions impose a greater risk of detection and revocation than routine probation or parole does ... offenders will recognize this and be deterred from future crime (i.e., recidivism)—thus lessening the risk to the community ... treatment (coupled with counseling and employment) may rehabilitate offenders—which has long-term benefits for society.²⁴

No “model” ISP has been developed; rather local communities adapt these programs to local needs, with wide variations in reporting protocols, caseload size, required number of face-to-face contacts, and so forth.

Today, it is generally agreed that a program cannot consider itself truly intensive unless there is at least weekly face-to-face contact with the offender, with additional weekly collateral contacts. Most ISPs begin the supervision at this level or higher for all offenders. Many programs require several contacts per week during the initial phase of ISP and then reduce the intensity of supervision over time based on offender compliance and progress. Length of stay in intensive supervision is typically six to twelve months. Most programs discharge offenders to regular probation or parole supervision.²⁵

The RAND Corporation has studied ISP programs for drug-involved offenders in Seattle, Washington; Des Moines, Iowa; Santa Fe, New Mexico; Atlanta, Macon, and Waycross, Georgia; and Winchester, Virginia. These communities all participated in training, were able to receive ongoing technical assistance, and agreed to participate in an independent evaluation by RAND. They can serve as valuable resources to other communities wishing to start up or adapt their intensive supervision programs.²⁶

The RAND study found that even though all seven sites differed greatly from one another, there were consistent results with regard to recidivism. In this study, they found that recidivism rates were not reduced for participants. This was the case even though participants had more supervisory and treatment-oriented contracts than did traditional probationers.²⁷ It has been suggested, however, that these sites emphasized control and deterrence rather than treatment. And the treatment was limited to out-patient services and rarely offered more than a few hours of group counseling.

RAND also studied three ISP sites in California: Contra Costa, Los Angeles, and Ventura. In this study, greater participation in counseling, employment, restitution activities, and community service were associated with lower levels of recidivism (both technical violations and new arrests).²⁸ These conflicting results may be related to the differing risk characteristics of offenders in the respective types of programs.²⁹ This suggests that further study is required.

The authors of the RAND study also concluded that ISPs helped to rehabilitate the system.

In the long run, such intermediate sanctions escalate the costs of crime to the offender, and help restore the principle of just deserts to the criminal justice system. And, bridging the middle ground with intermediate sanctions should eventually enhance the deterrent effectiveness of the sentencing system as a whole.³⁰

Shock Incarceration Programs

Starting in 1983, shock incarceration programs have opened in fifteen jurisdictions in nine states. They typically involve a relatively short period of incarceration for youthful offenders. These young offenders are confronted with rigid discipline and strenuous physical exercise, the goals being to deter them from criminal behavior and to build self esteem. Some of the programs are reminiscent of boot camps, with tough-minded staff, military drills, and strict schedules. Because many of these offenders are being incarcerated for the first time and have not been exposed to a traditional prison with more experienced inmates, these programs are considered safer and more orderly than other more traditional prison settings. The strict discipline and full daily schedules also help in this regard.

Most of the programs require these young offenders to volunteer for participation. The incentive for many is a significantly reduced period of incarceration, often provided through an early parole. The reasons for establishing programs of this sort are threefold:

- To reduce prison overcrowding by adding to total bed capacity.
- To reduce recidivism by diverting young offenders into a well disciplined environment. This includes building up the self esteem of offenders, assisting

in personal growth by exposing offenders to a very challenging experience and helping them succeed, and providing a deterrent to future criminality.

- To respond to a public demand for a quick, “get-tough” answer to crime.

Across the country, offenders may enter these programs immediately following conviction and sentencing as an additional condition of their probationary sentence. They may also enter the program after being sentenced to a correctional facility and subsequently classified by correctional staff. If an immediate reduction in prison overcrowding is the primary goal of shock incarceration, then it should be reserved for those whose offense would customarily have resulted in a period of incarceration, not those who would otherwise be on probation.

Many criminal justice professionals maintain a healthy skepticism—they recognize that it will take more than push-ups and running laps to alter the behavior patterns of young offenders, especially those with drug problems.

The day-to-day costs of operating shock incarceration programs are comparable to those in a traditional low- to medium-security prison. However, since a program participant receives a shorter sentence, a bed is “turned over” more frequently during a fixed time thereby reducing overall costs. These cost savings occur only if the participants are those who would have otherwise been incarcerated for longer periods of time.

There are still no conclusive data on recidivism rates for graduates of shock incarceration programs. Many criminal justice professionals maintain a healthy skepticism—they recognize that it will take more than push-ups and running laps to alter the behavior patterns of young offenders, especially those with drug problems. The National Institute of Justice has prepared *Shock Incarceration: An Overview of Existing Programs*, which provides a history of the development of these programs and raises important issues, but does not provide evaluation results.

Day Reporting Centers

The first day reporting center in the United States was established in Springfield, Massachusetts and was modeled after centers operating in Great Britain. Day Reporting Centers (DRCS) typically allow offenders to reside at home, but they vary from traditional house arrest programs by requiring adherence to an intensive prescribed schedule of supervisory and treatment contacts.

The goals of day reporting centers are to reduce overcrowding and provide a supervised transition from a life in conflict with the law, to one as a contributing member of the community. This is achieved by (1) restricting activities through strict supervision by requiring multiple contacts, including frequent and random drug testing and daily itineraries; (2) penalties/sanctions to stress accountability through restitution, curfews, payment of fines, and community service; and, (3) rehabilitation to provide offenders with the support and means to address their complex needs related to substance abuse, education, counseling, and employment.

Programs vary with regard to the frequency of client check-ins, frequency of drug testing, range of admissions (sentenced, pre-trial, or both), and participation of female offenders. Yet commonalities are generally found in offense exclusions (e.g., no sex offenders), termination criteria (e.g., three "dirty" urines and you are remanded), drug testing, and client notification. Many proponents of the DRC model believe face-to-face contacts and the establishment of a relationship between offenders and their "supervisory authority" are far more likely to keep offenders from getting re-involved with drugs and crime than the "robo-technology" of electronic monitors. An NIJ Issues and Practices report, entitled *Day Reporting Centers for Criminal Offenders: A Descriptive Analysis of Existing Programs*, provides a description of the development of day reporting programs and may be useful for those who are considering starting a program.

House Arrest/Electronic Monitoring

Home confinement or "house arrest" programs are in place in thirty-three states and the District of Columbia. House arrest can be implemented alone, as part of a probation term, or as a follow-up to a prison, jail, or pre-trial detention. Most offenders are required to stay in their own homes. Some may leave to follow a pre-approved itinerary that permits them to go to work, medical appointments, school, or counseling. In many states, house arrest programs have been administered successfully with or without surveillance-enhancing technology.³¹ Although research suggests that the electronic monitoring devices are not a critical component to ensure compliance with house arrest, their use is becoming more popular. The monitoring equipment can be divided into two types: continuous signaling devices that constantly monitor the presence of an offender at a particular location (active devices), and programmed contact devices that contact offenders periodically to verify their presence (passive devices).³²

Perry Johnson, a corrections consultant in Michigan cautions that electronic monitoring is not for everyone. He writes:

It is most appropriate as an adjunct to the conventional halfway house for placement of offenders (either probationers or inmates) who have obtained employment and have been drug-free. Those who are unwilling or unable to comply with program restrictions, people out of control because of serious psychological problems, and the very dangerous simply must be confined.

On the other hand, situational offenders and others with a law-abiding orientation do not require this level of supervision. Traditional probation with appropriate probation cases works just fine, thank you. But for a significant segment of the offender group, a program that insists that they work, remain drug-free, and stay home during high-risk leisure hours should reduce public risk to an acceptable level.³³

Community Service Orders

Standing alone or as one of several special conditions of probation, the use of community service orders can be very effective. Such punishments are applicable to the indigent and to the wealthy, to celebrities and the unknown; they have much to contribute provided, as is the case for other intermediate punishments, that they are vigorously supervised and enforced.³⁴ The list is limited only by the imagination of the sentencing judge and the availability of some supervision to ensure that the offender fulfills the terms of the sentence.³⁵ Not only are offenders afforded an opportunity to enhance their self-esteem by giving something back to the community, but local hospitals, schools, and charities also benefit directly. It is important that the number of community service hours ordered by the judge is realistic for both the offender and the community agency. Community service orders should be constructed to enable and encourage compliance. Two well-regarded authors suggest the following criteria by which a community service program should be evaluated:

It is important that the number of community service hours ordered by the judge is realistic for both the offender and the community agency.

Community service orders should be constructed to enable and encourage compliance.

Advantages:

- The value of the services it provides
- The jail and prison costs saved
- The improved sentencing capacity of the courts
- The sense of self-worth and self-confidence in their working and earning capacity that it gives to offenders

Disadvantages:

- The cost of the program itself
- The crimes that would have been prevented by sentences that otherwise would have been imposed
- The displacement of free labor
- The possible excessive widening of the net of social control

Debt or credit in doubt:

- The recidivism rate³⁶

Certainly community service orders are not appropriate for major drug sellers or for offenders with histories of violence. But, for certain "less serious" offenders, community service orders can be especially effective if they are imposed along with other supervisory conditions.

FINANCIAL SANCTIONS

Restitution

This sanction perhaps requires the least explanation, because in most jurisdictions it is routinely imposed. The offender is required to “pay back” the victims for their losses to try to make the victims “whole.” According to Richard Lawrence, assistant professor of criminal justice at St. Cloud University in Minnesota:

Restitution is generally intended to have a rehabilitative effect on the offender, in addition to benefitting the victim and/or the victim’s family. Because restitution is related to the damage incurred, the hope has been that it will be perceived as more just by offenders, giving them a clearer sense of accomplishment and “paying for the crime.” Offenders completing restitution are likely to get a more positive response from the victim and the community than if they were sent to prison. It is hoped that restitution will benefit offenders by not severing community ties (an inevitable result of prison incarceration), while serving as a reminder that they must pay for their wrongdoing.³⁷

Restitution is ordered to reimburse victims for economic losses, and includes property repair or replacement, medical expenses, lost wages, deductible amounts required for insurance coverage, and in some instances, the cost of counseling. Orders that include a payment schedule are most useful. Bringing offenders back into court periodically for failure to adhere to their payment schedule should be considered; otherwise many offenders do not make payments until their probationary term is about to expire—leaving the victim without any compensation in the interim. National studies have revealed that the overwhelming majority of offenders will comply with their restitution orders if they are allowed to pay in installments and monitored by probation or program staff. This holds true regardless of the offense, the offender’s past record, or whether or not the offender is employed at the time of disposition.³⁸

In at least five states (Alabama, Mississippi, Nevada, South Carolina, and Texas) there are “restitution centers,” also known as community release centers that have become instrumental in the collection of restitution. Offenders are generally ordered to reside at the center for 90 to 180 days. They are released for employment, community service, or both. Offenders then surrender their paycheck to the center to meet restitution and other court-ordered financial obligations.³⁹ Other jurisdictions including Phoenix, Arizona, have combined restitution collection with some form of intensive supervision. During weekly visits, probationers are required to sign their paychecks over to the probation department. Another check is issued to the offender, minus the amount used for victim restitution.⁴⁰

Day Fines

The Vera Institute of Justice in New York City has carefully studied the use of the “day-fine” system as an intermediate sanction. Sally Hillsman, director of research at Vera reports:

The advantages of the fine as a criminal sanction are well recognized: it is unmistakably punitive and deterrent in its aim; it is sufficiently flexible to reflect the seriousness of the offense and the level of the offender’s resources; it can be coupled with other noncustodial sanctions when multiple sentencing goals are sought; it does not further undermine the offender’s ties to family and community; it is relatively inexpensive to administer, relying primarily on existing agencies and procedures; and it can be financially self-sustaining and provide revenue for related social purposes such as victim compensation.⁴¹

RESTRUCTURING THE CRIMINAL FINE FOR BROADER USE

The following is adapted from a handout on day fines that Judy Green, the director of court programs at the Vera Institute of Justice, prepared for a bench retreat in Delaware.

Research on the criminal fine has served to highlight a sharp contrast between the way criminal fines are traditionally used in American sentencing practice (either as a low-level sanction for petty crime, or as an add-on to other “primary” penalties) and the way they are used in western Europe, where the criminal fine is the primary non-custodial penalty, systematically imposed across a broad range of common criminal offenses.

This contrast is particularly puzzling, given the many advantages the fine offers as an intermediate penalty. The fine has an unmistakably punitive impact on offenders, and research has documented its deterrent effect. The sanction fits comfortably within penalty systems that stress offender accountability—when fined, offenders quite literally are made to pay their debt to society. Moreover, fines can be flexibly scaled to cover a broad range of offense severity, while at the same time they can be calibrated to fit each individual offender’s ability to pay.

Research suggests that the apparent underutilization of fines in America may stem from the rigidity of the fixed-sum fining system, whereby the fine is simply imposed as a flat dollar amount in each case. This approach tends to result in courts having informal tariff systems or “going rates” for specific offenses. Given the large number of low-income offenders sentenced daily in our state court systems, these flat dollar fine amounts tend to cluster at the bottom of the legislated ranges, thus, in turn, restricting the use of fine sentences to the least serious categories of offenses.

To craft a remedy to this problem, the Vera Institute has been working in close collaboration with the bench and bar to demonstrate the utility of the day fine, to permit judges to quickly and systematically adjust a fine amount *both* to the severity of offenders’ crimes *and* to their economic circumstances.

The day fine system rests upon a simple two-step process in setting fine amounts. First, the court sentences offenders to a certain number of day fine units (e.g., 15, 90, 200 units), according to the gravity of the offense, but without regard to offenders' means. Then the value of each unit is set at a share of the offender's daily income (hence the name, *day fine*), and the total fine amount is determined by simple multiplication. This easy procedure assures routine imposition of equitable fine sentences, the punitive impact of which is in proportion to the crime.

ADAPTING THE DAY FINE SYSTEM TO AMERICAN PRACTICE

The primary goal of the Staten Island Economic Sanctions Project has been to demonstrate the feasibility of replacing the fixed-sum fine method with a day fine system, and to measure the impact of this reform. The central components of the day fine plan which resulted from this collaboration include (1) a system of sentencing benchmarks (numerical guidelines) which proposed a specific number of day fine units for each criminal offense within the full range of penal law misdemeanor and violation conviction charges common to cases disposed in this court; (2) a system for collecting the necessary means information for all units in dollars for a particular offender; and (3) a microcomputer-based information system which automates and records collection and enforcement activities.

Preliminary results indicate that the day fine system in Staten Island provides an attractive, workable method for restructuring the criminal fine to make it a more useful and more equitable sentence.

In Phoenix, Arizona, the Maricopa County Superior Court day fines planning committee designed a test of the applicability of the day fine concept in both felony and misdemeanor cases to accomplish two specific reforms:

- To create a mechanism for equitable consideration of an offender's means in determining the *total* amount of an appropriate monetary sanction package, which might include a fine, a probation service fee, a victim compensation fund assessment, and restitution.
- To enable judges to impose such a penalty in lieu of probation in cases where the offender is not in need of either a specific specialized service or structured supervision.

The Phoenix experiment has just begun. It has been structured so that the collection of "FARE supervision" orders (as the sanction is called) will be handled by the adult probation department. This effort should help to increase fairness while reducing the probation department's caseload, and improving the court's ability to collect the complex array of monetary penalties, fees and assessments authorized (and in some instances mandated) by Arizona law in criminal case dispositions.⁴²

Jurisdictions utilizing day fines report that many of the implementation obstacles that they anticipated did not occur. Vera is willing to provide technical assistance to those jurisdictions interested in adapting a day fine program for local use. For more information on day fines, see the excellent monograph available from the National Institute of Justice entitled *The Practices and Attitudes of Trial Court Judges Regarding Fines as a Criminal Sanction*.⁴³

Denial of Federal Benefits

The Anti-Drug Abuse Act of 1988 includes provisions that allow for the denial of selected federal benefits available from the federal government to those convicted of drug trafficking or possession. (Certain states require the passage of legislation to allow for denial by state court judges—the National Drug Prosecution Center has prepared model legislation.) The government's purpose in enacting this legislation was to "punish drug offenders who might not otherwise receive a meaningful and tailored punishment . . . to send out a message that there are consequences for drug use and trafficking."⁴⁴

Certain benefits are exempted, such as health, welfare, disability, and social security benefits. In addition, the law provides for the restoration of federal benefits following the successful completion of a drug treatment program. In November 1989, federal sentencing guidelines were amended to include the denial of federal benefits as an option available to judges sentencing persons convicted in the federal court.

The following questions and answers may provide further guidance to judges and others who consider this sanction to be an effective tool. The questions are excerpted from a U.S. Department of Justice Fact Sheet.⁴⁵

What is an offense under this Act?

There are two categories of offenses affected by this statute. The first concerns drug trafficking, which is defined as conviction for any state or federal offense consisting of the distribution of controlled substances. The second concerns possession and is defined as conviction of any state or federal offense involving the possession of a controlled substance.

What are the main benefits that can be denied?

Contracts, grants, loans, fellowships, and licenses are all deniable benefits. Student loans and grants are a major deniable benefit, but not the only one. Federal aircraft and maritime licenses and the right to contract with the federal government are all important benefits that can be denied.

Must all benefits be denied?

Courts have the option of denying all federal benefits or only selected benefits.

Are there any other exclusions to the denial of benefits?

There are a number of benefits that have been specifically exempted from the denial process by statute. These include veterans benefits, benefits related to long-term drug treatment, and earned benefits that are earned by financial contributions or services such as social security, and other retirement benefits.

How long can benefits be denied?

The length of the denial depends upon the crime and the decision of the court. Drug traffickers can be denied benefits for up to five years for a first offense, up to ten years for a second offense, and permanently for a third offense. Persons convicted of possession can be ineligible for benefits for up to one year for a first offense, and up to five years for subsequent offenses.

What happens if a drug offender enters treatment and is rehabilitated?

If an offender who is denied federal benefits enters and successfully completes a long-term drug rehabilitation program and is rehabilitated under criteria established by the Department of Health and Human Services, the court can suspend the denial of benefits.

Can the denial of a benefit be suspended?

The sentence of a denial of federal benefits can be suspended by the court upon rehabilitation of the offender or for other reasons at the discretion of the court.

Does the denial of federal benefits have an impact on other laws or regulations?

The denial of federal benefits by a court is an option that can be imposed in addition to other penalties.

How does the denial process work?

The denial of federal benefits is a sentence pronounced by a state or federal judge as a result of conviction for trafficking or possessing of drugs. When denial of benefits is part of the sentence, the Department of Justice is notified by the sentencing court and the name of the individual who is denied benefits is published in the *Lists of Parties Excluded from Federal Procurement and Nonprocurement Programs*, which is maintained by the General Services Administration (GSA) and generally known as the "Debarment List."

What are federal agencies' responsibilities under this program?

Prior to making an award or conferring a benefit on an individual, agencies are required to consult the Debarment List to be sure that the individual is not ineligible for benefits.

How does an agency know which have been denied?

The Debarment List contains codes that indicate if all benefits have been denied or if the denial is limited only to some benefits. If the denial is partial, agencies must contact the Department of Justice clearinghouse, which maintains a complete listing of the benefits denied to each individual covered under the program. Agencies will be advised immediately of the status of the individual over the telephone with a memorandum of record provided to the requesting agency.

How long does the denial remain in effect?

The period of denial will vary depending on nature of the crime and the desire of the court. The Debarment List will contain an expiration date for the period of denial.

Where can I get forms or more detailed information on this program?

Detailed information can be obtained from the Department of Justice, Office of Justice Programs, Denial of Federal Benefits Project, 633 Indiana Ave. NW, Washington, DC 20531. The project's telephone number is (202) 307-0630.⁴⁶

OTHER SANCTIONS

Revocation of Driver's and Professional Licenses

... certain states are considering whether to institute a drug education program similar to that used in driving under the influence cases, where, upon completion of the program, the period of suspension could be reduced.

Several states have passed legislation providing for the revocation or suspension of a driver's license upon conviction for a violation of controlled substance laws. The intent of these laws is to provide a deterrent that would reduce the demand for drugs. Although similar laws have applied to drunk drivers for years, this parallel legislation is less common today, but the situation is likely to change. Failure to mandate a six-month suspension of driving privileges for convicted drug offenders by October 1, 1993 results in a 5 percent reduction of a state's allotment of federal highway funds. The reduction increases to 10 percent on October 1, 1995.⁴⁷

In some jurisdictions, implementation of these statutes has raised day-to-day operational challenges. For example, a range or specific period of time for suspension must be developed, along with criteria describing which factors increase or decrease the period of suspension. Also, certain states are considering whether to institute a drug education program similar to that used in driving under the influence cases, where, upon completion of the program, the period of suspension could be reduced.

Other states have found that those convicted of possession of very small amounts of a controlled substance have frequently received lenient dispositions, such as a continuance without a finding. Some members of the criminal justice community fear that if the period of suspension is very lengthy, drug-involved defendants would not offer guilty pleas and would backlog the system with relatively minor cases.

For some state judges, license suspension may provide yet another dispositional option. Depending upon the individual defendants and their work or school status, the geography of the community, the local transportation system, and other social and economic factors, license suspension may be an effective deterrent for certain drug-involved individuals.

In at least seven states, professional licenses may also be suspended or revoked upon conviction for a drug offense. The right to practice law or medicine, teach, or practice a trade is terminated or suspended upon conviction of a drug offense. Reinstatement is conditioned on successful rehabilitation or completion of a drug treatment program.⁴⁸

User Fees

In many jurisdictions across the country, offenders are being required to pay a variety of user fees, which may include the cost or partial cost of probation or parole supervision, or the cost of alcohol or other drug treatment. According to a recent *Corrections Compendium* survey, offenders in twenty-eight states are now charged probation supervision fees.⁴⁹ Many probation officers believe such a fee alters offenders' views of their supervision and treatment and makes them value what they must pay for. Others view such fees as a way for corrections and treatment staff to offset their program costs, although some states have had operational problems in managing the collections. An excellent report prepared for the Department of Justice by Dale Parent of ABT Associates, Inc. entitled *Recovering Correctional Costs Through Offender Fees* provides a thorough analysis of this topic.⁵⁰

A New Jersey statute assesses each individual convicted of a drug offense, or placed on probation for a drug offense, a fee ranging from \$500 to \$3,000. The money is used to fund alcohol and drug treatment programs. Since its adoption, the law has been responsible for the collection of nine to ten million dollars annually. The premise underlying this provision is that the offenders causing the problem are the members of society most appropriate for funding education and treatment.⁵¹

The range of sanctions that are offered in a jurisdiction will work well only if they are added in a thoughtful fashion, with consideration for their impact on the system at all levels.

SUMMARY

This list of sentencing options is only a starting point. The range of sanctions that are offered in a jurisdiction will work well only if they are added in a thoughtful fashion, with consideration for their impact on the system at all levels. They must have a clear rationale, one which can be clearly articulated and understood by judges, offenders, victims, and the public.

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CHAPTER 6: SUPERVISION AND MONITORING STRATEGIES

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SUPERVISION AND MONITORING STRATEGIES

Expectations regarding behavior and the consequences of non-compliance must be clearly articulated.

Judges and court personnel recognize that for any community-based, intermediate sanction to be effective, it must satisfy public safety concerns while meeting the rehabilitative needs of the offender. For safety concerns to be satisfied, proscribed escalating sanctions must be in place for failure to comply with conditions set at the time of sentencing. Monitoring and accountability are essential to protect the community *and* to support drug-involved offenders in their efforts to comply with the order(s) of the court. If there are failures, they must be dealt with swiftly and fairly, preferably prior to the revocation stage. If that is not possible, the judge and other court personnel must be prepared to send a message to the offender.

Several of the most successful supervision strategies include:

- At the outset, matching offenders with supervision, control, and treatment programs appropriate to their assessed needs and perceived risks.¹ With drug-involved offenders, this undoubtedly includes regular, consistent meetings with treatment and supervisory contacts.
- Aftercare or a relapse prevention approach that ensures that drug treatment continues and becomes intertwined with an offender's schedule.
- Urine testing.

Perhaps not a strategy by itself is the use of court appearances, including revocation hearings that can serve to "wake up" offenders, before their behaviors spiral downward.

SUPERVISION, CONTROL, AND TREATMENT

Regardless of whether the supervising authority is a probation officer, counselor, or clinician, a clear and consistent message must be conveyed to offenders about their use of drugs and alcohol. Expectations regarding behavior and the consequences of non-compliance must be clearly articulated. It is not uncommon for drug-involved offenders to push the boundaries of their supervision to test which behaviors will or will not be tolerated. Thus, the "orientation" to probation is a critical intervention point; it presents an opportunity to make the probationary rules and sanctions clear right from the start.² A monitoring strategy that is able to adapt to changes in the risk/need equation is equally important.

In the report of the National Task Force on Correctional Substance Abuse Strategies, Gerald Vigdal of the Wisconsin Department of Corrections cautions that:

... overprogramming and underprogramming of substance-abuse offenders can also yield negative results. Excessive programming for a specific offender can cause the offender to drop out of treatment as well as waste limited treatment resources. Insufficient programming may allow the offender to complete the treatment without receiving sufficient intervention for real change.³

Probation departments that build on assessment information and use a variety of supervision strategies that adapt to the needs of the offender will be most effective. Some larger departments may be able to have probation officers handle specialized caseloads including the Intensive Supervision Programs (ISPs) we described earlier. Other departments may rely in some measure on new technology, such as electronic monitors, that can augment other supervision activities. Smaller departments may need to rely on the strength of the relationship that develops between the probation officer and the probationer. Whatever the capacity, the drug-involved offender needs to know the rules—there should be incentives for good behaviors and sanctions for non-compliance.

Several model programs have targeted supervision strategies with drug-involved offenders. Some of the most highly regarded include:

- Fast Track in Chicago, Illinois, which is court-based and managed by Circuit Court Judge Michael Getty. This is a prescriptive program, with a specially designed protocol for nonviolent, drug-involved offenders. After an assessment, individuals follow a regimen that includes treatment, drug testing, and regular appointments. Failure to comply with this regimen results in individuals being subjected to an increasing series of penalties in an effort to hold them accountable for their actions.
- TASC, the largest scale, best known, and most successful court referral program, which was established in 1972 as Treatment Alternatives to Street Crime (TASC). Originally organized to serve opiate addicts, TASC quickly became a common vehicle for diverting lesser drug offenders to drug treatment in order to avoid “clogging” the system with minor drug offenses. TASC programs provide pretrial screening to assess suitability for community-based treatment. When individuals are deemed appropriate for treatment (and the prosecutor and court agree), they may enter a community-based treatment program.

Data are available that compare TASC referral with other referral programs. Generally, retention rates for TASC-referred clients were an average of seven weeks longer for residential programs and six weeks longer for outpatient programs than the retention rates for all other clients. As indicated earlier, longer treatment stays are generally correlated with more positive treatment outcomes.⁴

Other programs worthy of further consideration include:

- The Coos County (Oregon) Drop Program, initiated by the local district attorney
- The Serious Targeted Offender Program (STOP), which operates statewide in Florida
- A Substance Abuse Program for Probationers (ASAPP) in San Diego, California
- Do Drugs, Do Time in Maricopa County, Arizona
- The HAAS Pilot Program in Oregon, which is a cooperative effort of the circuit court, the Department of Community Corrections/Program Services Division, the district attorney's office, and the sheriff's office

All programs clearly communicate their goals to drug-involved offenders—they also communicate and work cooperatively with local drug treatment and enforcement agencies. In a June 1991 report by the National Institute of Corrections entitled *Intervening With Substance Abusing Offenders: A Framework for Action*, there is an excellent appendix of exemplary programs that have been established to deal with substance abuse offenders. The appendix is called "Strategy and Briefs," and it thoroughly describes fourteen worthy programs. For those desiring more information on program models, we would highly recommend ordering this publication from the National Institute of Corrections at (303) 939-8877.

THE IMPORTANCE OF AFTERCARE AND RELAPSE PREVENTION ACTIVITIES

There is general consensus that aftercare and relapse prevention activities can play an important role in maintaining crime-free behavior among drug-involved offenders. The primary goal of aftercare is to prevent a return to drug use; it is based on the premise that continuing assistance and support can reduce subsequent treatment risks often associated with relapse. These activities should begin well before drug-involved offenders are released from their structured environments, whether that be prisons or therapeutic communities.⁵ If, for example, drug-involved offenders receive a "split sentence" and are first assigned to a boot camp or a therapeutic community, it is very important that the drug treatment continue after release, throughout the tenure of the probationary term. Likewise, when offenders go through a detox program, they should be referred for follow-up treatment if the goal is to help them remain drug-free. Without appropriate aftercare in the community, the vast majority of serious drug-involved offenders are likely to re-offend. Many report feeling overwhelmed by the transition from a highly structured environment to one within the community that demands that offenders plan activities, relearn skills to interact in personal relationships, and

manage household problems and finances. Efforts to address these stresses and break the cycle of drug use among offenders in the community appear likely to reduce the criminal activity of these individuals, and to lessen the problem of overcrowding in local, state, and federal correctional facilities.⁶

The results of a 1986 study conducted by James B. Eaglin document the importance of aftercare. One thousand probationers and parolees participated in a federally-funded aftercare program. Eaglin found that while a high percentage of the offenders had at least one positive urine test during the study period, most clients had no arrests or parole violations, and 60 percent had gained employment.⁷

A number of aftercare and relapse prevention strategies have been developed. They draw from a variety of approaches and attempt to offset many of the post-treatment factors that contribute to relapse. Several are listed below.

- **Family Factors.** The family often plays a role in maintaining drug-abusing behavior. Conversely, family support following treatment is a strong predictor of post-treatment success for both drug and alcohol abusers. Thus, positive interactions between treated drug abusers and their families is crucial for treatment success. This may involve the family entering treatment to understand how one family member's addiction has an impact on the entire family system.

Social Support Approaches can be helpful in providing services to the family, new social support networks such as self-help groups, and links with community volunteers and human service professionals.

- **Peer Factors.** The social network of friends with whom former drug addicts interact following treatment is also an important factor contributing to the likelihood of relapse. Relapse to drug or alcohol use often occurs when there is social pressure to use drugs. There is evidence that those who continue to use drugs post-treatment have friends and associates who also use drugs.

Social Support Approaches, as well as Residential Strategies, have been used successfully to provide new social networks for recovering addicts. Half-way houses and "sober houses" are also utilized in the alcohol treatment and criminal justice fields.

- **Isolation.** Social isolation following treatment is associated with relapse to alcohol and drug abuse.

Social Support Approaches and Activities-focused Strategies that strive to involve the client in organized activities such as community service, religious groups, sports teams, volunteer work, and social activities have helped clients with the problems associated with isolation.

- **Lack of Involvement in Productive Roles.** There is evidence that former addicts who do not become involved in productive roles (school, employment) following treatment are at high risk of returning to drug or alcohol use.

... family support following treatment is a strong predictor of post-treatment success for both drug and alcohol abusers.

Vocational Strategies that assist former drug and alcohol users in finding employment, job skills training programs, and support work programs, which emphasize graduated responsibilities and wages specific to certain ability levels, can help recovering addicts become involved in productive societal roles, build self-esteem, and attain financial independence.

- **Lack of Involvement in Active Leisure/Recreational Activities.** Research on post-treatment outcomes has shown a positive relationship between involvement in recreational and leisure activities (sports, hobbies, crafts, volunteer work, reading) and reduced post-treatment alcohol and drug use.

Activities-focused Strategies, as well as Social Support Approaches can provide structure and support and reduce the likelihood of relapse.

- **Negative Emotional States.** Substance abuse researchers maintain that post-treatment depression increases the likelihood that a former addict will return to drug or alcohol use following treatment.

Skills-Training Programs including stress and coping workshops, living skills, problem-solving, decision-making and assertiveness training, as well as any or all of the previously mentioned relapse prevention approaches can combat depressive emotional states in the recovering addict.

- **Physical Symptoms.** Some former addicts tend to use drugs as a form of self-medication. Allergies, back pain, headaches, and insomnia are among the physical symptoms related to a return to drug use.

Advocacy Strategies can help former addicts gain access to needed services through medical, legal, and community advocacy efforts.⁸

Howard J. Shaffer, chief psychologist at the North Charles Institute for the Addictions, believes, like many other professionals in the drug treatment community, that much can be learned about relapse prevention from drug users who have succeeded in quitting on their own. The responses of drug-involved offenders validated many of the approaches described above, but they also spoke of learning and then avoiding the triggers that led to their return to drugs in the past. Users said they knew there were certain social situations to avoid, certain corners to stay away from—for some, staying away from a girlfriend or avoiding a particular buddy at work was essential. Once users learn what their triggers are, they can choose to avoid situations where relapse is more likely to occur. This strategy parallels one of Weight Watchers, which cautions its members to learn what their “red light” foods are and to stay away from them. A thoughtful relapse prevention strategy builds on such behavior modification principles. Today, many programs help drug users learn this relapse prevention technique and try to promote alternative activities that can offer positive reinforcement for a drug-free lifestyle.

URINE TESTING

Urine testing has been a clinical component of drug treatment programs since the 1960s, but tests were often expensive and inaccurate. New urine testing methods have substantially reduced costs, improved accuracy, and permitted urine testing to be conducted on-site by trained criminal justice personnel, for example in a courthouse or parole reporting center.⁹

The President's 1991 National Drug Control Strategy promotes drug testing through urinalysis as a priority for identifying and monitoring the drug-involved offender and urges all fifty states to establish offender drug testing.¹⁰ Today, the goals of drug testing may include identification, assessment, deterrence, surveillance, and treatment.¹¹ Some argue that drug testing has a therapeutic benefit, because it not only detects and confirms drug use, but it also helps break through the denial.¹² It can also be used to support abstinence and provide for positive reinforcement. There are, however, substantial differences of opinion regarding the value of urine testing as a deterrent to continued drug use, and studies regarding its effectiveness are limited. Its use as a monitoring tool is more widely accepted; an increasing number of probation departments are using urine monitoring. Testing urine to monitor a pre-trial population is more controversial. However, "with the availability of drug testing, judges are more likely to release the drug-using offender to the community since drug testing of released offenders is an effective means of monitoring drug use and reducing criminal risk."¹³

Practically speaking, most jurisdictions cannot afford to conduct blood, hair, or saliva analysis or the more elaborate Gas Chromatography/Mass Spectrometry (GC/MS), whether these tests are done by probation or a treatment provider. They are more likely to use a process known as immunoassay of which there are two types: radio-immunoassay and enzyme immunoassay. The latter method is more commonly used by community corrections agencies to screen samples, with GC/MS done only as needed to confirm a positive result. The chromatography methods are more conclusive in their findings, but their complexity and costs render this technique unrealistic as a screening process.¹⁴

The American Probation and Parole Association (APPA), in its monograph on drug testing guidelines and practices writes:

A "clinically approved" confirmation is a second test by an alternate chemical method to positively identify a drug or metabolite and is carried out on presumptive positives from initial screens. Written admissions of drug use and other testing protocols may be used by an agency in place of the second alternate chemical method. The basic question regarding the issue is whether to confirm or not and, if so, under what conditions. If testing is to be conducted only to make confrontations, then the initial testing methodology should be sufficient. However, *if testing is to be conducted as part of a scheme of progressive sanctions which lead to revocation proceeding, then a more thorough approach to confirmations should be considered* (emphasis added).

Several options are available to those agencies that need to confirm initial results. The requirements within probation and parole jurisdictions vary from state to state. Some

Today, the goals of drug testing may include identification, assessment, deterrence, surveillance, and treatment.

courts or parole boards will require confirmations, while others will not. If confirmation is required, then the agency will have to determine if the results are worth the cost.¹⁵

The APPA recommends that initial full screening results should be used to assist in developing an appropriate level for supervision. They suggest:

The frequency of screening should be based on the offender's drug use history and the offender's potential criminal effect on the community. If the offender is found to have a positive specimen, then, after confrontation, more frequent random screening should be conducted. Positive results used in conjunction with other evidence may be used to determine the frequency of screening.¹⁶

With regard to drug testing protocols, APPA advises that probation agencies determine for each offender whether the collection of specimens will be scheduled, random, or a combination of both.¹⁷ It is also suggested that creative monitoring strategies be used, including the collection of samples during field visits to the home, job site, or school.¹⁸

The advantages to random collections include the following:

- Offenders are required to provide a specimen on notice
- Offenders have reduced ability to schedule their drug use so as to avoid detection
- The rate of specimen collection averages can be lowered, allowing for considerable cost reductions

Random collection of specimens, to be most effective, requires the use of a computer, because monitoring the tests can be difficult. Without computers, patterns of collection could be discerned by offenders, while various offenders or groups of offenders may be either overtested or undertested.¹⁹

Random collection generally requires a selection process that ensures that each person in the given population has an equal chance of being selected.

The advantages to scheduled collections include the following:

- Scheduled collections are less confusing to offenders than are unscheduled collections
- Offenders receive specific dates and times to provide specimens for testing
- Scheduled collections are easier for staff to organize and maintain

The most serious weakness of scheduled collections is that offenders may also schedule their drug use in order to escape detection. Effective monitoring of offenders using this method would require specimens to be collected three times a week.²⁰

In the *National Narcotic Intervention Program: Participant's Manual*, suggestions regarding when random sampling should be conducted are offered. The recommendations are predicated on the assumption that there is evidence to justify mandatory participation in a drug monitoring program.²¹ The authors suggest random sampling at the following times:

- a. Initially, upon being released to probation or parole, offenders should be tested. When potential drug abuse is indicated, drug screening should be an integral part of the assessment portion of the offender's orientation to supervision.
- b. As soon as possible after a missed appointment, offenders should be tested. Offenders will try to avoid detection after consuming illicit drugs by creating convenient excuses for missing scheduled appointments with their supervising officer. This buys offenders valuable drug retention time. If they can put off seeing their officer for a few days they may be able to void a clean urine sample if asked to submit a specimen. Therefore, officers, if their intention is to confirm this suspicion, should make every effort to obtain a specimen within twenty-four hours of the missed appointment.
- c. As soon as possible after commission of a new offense, offenders should be tested. If possible, obtain a sample within twenty-four to thirty-six hours after a new arrest. This may require cooperation with local law enforcement agencies, or having people report after release from bail. If urinalysis results indicate that offenders were under the influence of drugs (particularly if it is their drug of choice) at the time of arrest, this may motivate them to seek treatment or learn from the experience.
- d. As soon as possible after their payday, offenders should be tested. Payday can be a time to celebrate, for drug offenders like anyone else. Drug offenders may choose to celebrate by getting high. If supervising officers request a urine sample and it is found to be positive, they should have constructive intervention strategies in mind to confront the offender.
- e. At the time of an unannounced field visit, offenders should be tested. If the intent of the drug monitoring program is to screen on a random basis, an unannounced visit is one of the best times to do it. Urine samples may be randomly collected during office visits, but offenders are aware that any time they go for an office visit they may be requested to provide a specimen.²²

The Bureau of Justice Assistance published a monograph in July 1991, entitled, *American Probation and Parole Association's Drug Testing Guidelines and Practices for Adult Probation and Parole Agencies*. This comprehensive report draws on the expertise of those who specialize in the field of drug testing and community corrections. It addresses a variety of practical implementation issues, including such matters as what "cutoff" levels the courts should use when determining whether a drug screen reflects a positive or negative result (they suggest following National Institute of Drug Abuse (NIDA) guidelines). It also analyzes critical legal questions and includes a compilation of case law in its appendix. It is an extremely valuable resource for courts that are trying to establish programs and protocols in this area.

REVOCATION HEARINGS

In many communities, especially those with serious prison overcrowding problems and court-imposed population caps, probationers and others recognize that there are few consequences for technical probation violations, including drug use. Because the local correctional facilities have limited capacity to admit anyone new without releasing someone else, probationers could assume that little would happen as a result of "minor" infractions. Unless a new crime were committed, many probationers believed they could glide through the tenure of their probationary sentence with few consequences for misbehavior.

*... judges would benefit
... by having a broad
array of "consequences"
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hearings.*

However, as probation has evolved and become more punitive (more urine testing, higher fines, electronic monitoring, etc.), it is becoming more common for offenders to find themselves back before the court for failure to comply with the conditions of probation. This presents several complicated choices for the court. Just as judges would benefit from having a broad range of sentencing options at the time of disposition, so, too would they benefit by having a broad array of "consequences" to impose at revocation hearings. Andrew Klein, a widely respected chief probation officer in Quincy, Massachusetts, writes:

If judges find themselves "wandering in deserts of uncharted discretion"²³ when it comes to sentencing, the task is even more challenging when it comes to sentencing defendants who have been given the opportunity of a probationary sentence and failed. Probation violations, unlike crimes, do not have established "going rates," widely agreed-upon determinations of seriousness within the criminal justice community. Worse, judges are not required to study or take account of the positive behavior and contributions probationers may have made, even while failing other areas of their probation. The result is all too often an "all or nothing" system of sentencing for probation violators that, on the one hand, ignores behavior warranting punishment and, on the other, severely punishes behavior that isn't all that awful.²⁴

Judge Albert L. Kramer, the presiding justice in Quincy, Massachusetts and a leader in the sentencing reform arena, recommends the practice of "tourniquet sentencing."²⁵ He argues that the sanction for noncompliance should be both proportional to the extent of the noncompliance *and* progressive. Of tourniquet sentencing, Judge Kramer says:

It will increase if the defendant fails to respond to the initial tightening of the tourniquet. It is particularly well suited for sentencing a probation violator. If a probationer's violation does not demand immediate and long-term incarceration, incremental and progressive punishment may allow the court to enforce ultimately its probationary orders without countenancing repeated technical violations. As a result, without unduly compromising public safety, the court can increase the odds that the victim will get repaid in full, the community receive the benefit of the defendant's labor, and the probationer deal with the behavioral problems or addictions that encourage his criminal behavior. Strategically imposed small but increasing doses of jail after the first few probation violations may prevent the necessity for a more substantial dose at a later time.²⁶

As a supervision strategy, it is essential to bring offenders back into court to *turn up the heat* when necessary. Judge Michael Getty believes the formality of court proceedings may serve to impress offenders with the gravity of their offenses, and it may remind them that the court is cognizant of a problem situation.²⁷ To complement the messages drug-involved offenders receive regarding accountability and responsibility, the court and treatment programs must actually work together as a team, something akin to being co-therapists.

Given the relapsing nature of addiction, each jurisdiction will need to determine how many “slips” it will tolerate. Some courts will remand a drug-involved offender to jail for a few days for one positive urine test. Others will issue warnings and will offer more intensive supervision and treatment. Each jurisdiction will need to assess how much relapsing behavior it can tolerate, if any. There is no easy answer. But whatever the decisions, the court must not equivocate and must continue in its mission to provide swift and fair justice.

Endnotes

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- ¹⁶ Ibid., p. 30.
- ¹⁷ Ibid., p. 33
- ¹⁸ American Probation and Parole Association. *National Narcotic Intervention Program*, p. V-16.
- ¹⁹ U.S. Department of Justice, Bureau of Justice Assistance. *American Probation and Parole Association's Drug Testing Guidelines and Practices for Adult Probation and Parole Agencies*, p. 35.
- ²⁰ Ibid., p. 33.
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CHAPTER 7: BEYOND THE BENCH: JUDICIAL ACTIVITY OUTSIDE THE COURTROOM

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BEYOND THE BENCH: JUDICIAL ACTIVITY OUTSIDE THE COURTROOM

Community involvement is not necessarily incompatible with a judge's role.

... of equal salience is the need for the judiciary to shoulder a fair share in planning for the good health, indeed the rejuvenation, of a criminal justice system faced with a flood of drug cases. At a time when court dockets are clogged, jails overcrowded, judges, police, prosecutors, defenders and probation officers overworked and disillusioned, treatment facilities and prisons bursting, streets unsafe, and the public frightened, new plans and assertive action are needed.¹

Judges have an opportunity to respond to the drug crisis outside as well as inside the courtroom by serving as educators of the public and leaders of the community. Such involvement is likely to benefit both the courts and the community. Judges have much to offer as respected legal authorities who can demystify the criminal justice system and explain its limitations to the public. At a time of overwhelming demand on the criminal justice system caused by drug offenses and drug-related cases, increased public awareness of the court's role may be key in maintaining the credibility of the system. Community involvement is not necessarily incompatible with a judge's role. Judges across the country have served as community leaders initiating reforms in the area of drug abuse, without compromising their impartiality.

WHY GET INVOLVED?

The traditional role of a judge has been that of an adjudicator of disputes, one who works in a world removed from political and social conflicts. That limited role is becoming increasingly untenable as cases involving serious social problems, such as drug abuse, overwhelm the courts' dockets.²

Judges around the country report an explosion of cases involving the sale and possession of drugs as well as crimes committed because of drug abuse.³ One judicial conference report, cited earlier, described a "desperate" situation in which:

... overload causes backlog, the backlog feeds delay, delay, along with lack of jail and prison space imperils rights to timely consideration, undermines deterrence, and breeds contempt for the law.⁴

In many courts, resources originally allocated to civil and family or domestic cases have been diverted to criminal cases, in an attempt to meet the demand for judicial resources in drug-related cases. Judges are increasingly concerned about this reallocation and the resulting diminishing of access to the civil justice system.⁵

The public is not likely to be sympathetic to the problems facing the courts. Studies have indicated that there is widespread public ignorance of the powers and functions of the courts and that courts themselves are blamed for delays or the acquittal of criminal defendants.⁶

Responding to these challenges, which threaten the functioning of the courts and the credibility of the judicial system itself, judges around the country have determined that they can no longer remain passive observers and have begun to take a more active role outside the courtroom. These judges have grappled with the question of the propriety of becoming involved in social policy issues.⁷ To meet their ethical obligations to uphold the independence of the judiciary, judges must avoid involvement in political matters.⁸ And certainly there are ethical limitations for the "activist judge." Steven Lubet, professor of law at Northwestern University writes:

It is both unnecessary and undesirable to isolate judges from the society in which they live. Although the Code of Judicial Conduct provides a solid basis for the regulation of nonjudicial activities, there are still areas that require examination.⁹...There appears to be no case law which defines the sort of civic or charitable activity which might reflect adversely on a judge's impartiality.¹⁰

Consider for example, a simple but tough problem. Should a judge who is on the board of directors (or even the advisory committee) of a local, non-profit drug treatment program hear individual cases seeking placement in, or termination from, that program? Questions such as this raise very serious ethical considerations. However, it is generally agreed that there are appropriate roles for judges to play in the community in addressing social problems, notwithstanding these ethical limitations.¹¹ In fact, the Code of Judicial Conduct (which was recently revised and adopted on August 7, 1990) encourages judges to participate in nonpartisan activities, such as teaching, public speaking, or testifying at public hearings and making recommendations to public and private grant-making agencies on projects concerning the law, the legal system, or the administration of justice.¹² Canon 4A, 4B, and 4C provide additional guidance in the areas of extrajudicial activities.

By becoming involved in such activities, judges will be able to increase the awareness of legislators, government officials, and the community of the impact of the drug crisis in their courtrooms. Courts have a responsibility not only to seek sufficient monies for the efficient and effective operation of judicial branch service, but also to participate vigorously in planning for system-wide initiative and progress in the war on drugs.¹³ Judges, in turn, may learn more about the causes and treatment of substance abuse and can apply this new knowledge when deciding cases involving substance abuse.

... judges around the country have determined that they can no longer remain passive observers and have begun to take a more active role outside the courtroom.

WHAT JUDGES CAN OFFER

Judges have much to offer as they move outside the courtroom into a more socially active role. As experts on the law and as administrators of the criminal justice system, they have a unique vantage point. They know what protections the U.S. Constitution affords defendants and how particular statutes require judges to act in cases involving drugs. They understand the day-to-day functioning of the system. They can spot the logjams. They can see where new resources are essential, how existing resources could be better coordinated, how information could be shared, where training is needed, and where community support is needed. They can also explain the sentencing process and argue for the need for and the benefits of intermediate sanctions as alternatives to traditional incarceration.

Because of the authority inherent in their role as impartial adjudicators, judges are likely to be effective community leaders. As one judge noted:

... generally speaking, judges are believed to be people who are above the fray. They don't have any turf to protect, there are no hidden agendas. That gives the advantage of being able to bring people together who do have turf to protect and to get a consensus as to what is to be done. And not only to get a consensus as to what is to be done, but to get something done.¹⁴

Many thoughtful suggestions have been made about opportunities for judicial outreach in the community. One chief justice, known for his persuasiveness and sense of humor, described the importance of getting judges out to talk with the animal kingdom—the elks and the lions—and then after a proper pause, added chambers of commerce and other community agencies to his list.¹⁵ These opportunities fall into four general categories: public education, coordination of efforts, brokering resources, and monitoring the quality of drug treatment programs.

Public Education

According to several recent surveys, the public is generally unaware of what judges do.¹⁶ What information the public does have tends to be obtained from the news and TV shows rather than from direct contact with judges or the courts.¹⁷ Judges, together with local bar associations, can work to change public perception of the courts by educating the public about the Constitution, criminal statutes, and the operation of the criminal justice process from arrest through incarceration and release.

SCHOOLS

Schools provide an ideal setting for judges to educate the public. Ideas for educational opportunities in the schools include:

- Speaking to students at all levels
- Assisting schools in developing special curricula for students concerning drugs and the law
- Assisting schools in developing programs for student participation in mock trials or debates on drugs and the law
- Establishing programs for students to volunteer in the courts or in court-run programs¹⁸

LEGISLATIVE HEARINGS

Judges have opportunities to educate the public, as well as lawmakers, when testifying at legislative hearings before committees concerned with pending legislation or investigating particular issues. Such testimony can provide valuable feedback to legislators and policymakers on particular statutes or programs.¹⁹ For example, such hearings might give judges the opportunity to describe unintended results, such as the court backlog caused by particular anti-drug abuse legislation. Also, if up-to-date data are maintained on the number of drug-involved cases and the impact those cases have on the courts, powerful resource allocation plans can be put forth.

THE MEDIA

Judges have additional opportunities to educate the public through the media. Judges can write articles for publication in newspapers, appear on TV or radio talk shows, or work with local cable TV stations to develop special programs on the law. Judges can invite the media to attend events, such as speeches or seminars, that are part of judicial outreach programs. Courts can prepare educational materials for the media that explain court proceedings or programs, including relevant statistical information.²⁰

PUBLICATIONS

Judges can also produce educational materials for public distribution, such as pamphlets on the courts. These pamphlets could be produced in collaboration with community groups or local social service agencies. Topics could include the availability of counseling and drug treatment services, as well as explanations of how drug crimes are prosecuted and, if relevant, how mandatory sentencing laws operate.²¹

Coordination

Another key role for judges is that of coordinator. As neutral, respected authorities, judges are ideal candidates to coordinate various existing efforts to deal with drug issues. As one judge describes such an effort:

... it was a way to get all the players in the system working together in a cooperative, coordinated way. On this task force, which was under the umbrella of the county, we have the federal people—U.S. Attorney, DEA, FBI, federal probation, and so forth—and we have the county people—the DA, the public defender, the county drug abuse office, the treatment people, the medical profession, the superintendent of schools, the superior court, and the municipal court.²²

As neutral, respected authorities, judges are ideal candidates to coordinate various existing efforts to deal with drug issues.

Coordination efforts can result in significant benefits for all participants. Such efforts might include:

- The establishment of an anti-drug task force of all local professionals currently involved in anti-drug activities to foster cooperation, sharing of resources, and engage in joint problem-solving
- The establishment of an anti-drug task force of community volunteers to assist in public education and anti-drug campaigns and to volunteer in substance abuse treatment programs
- Joint training of judges, judicial staff, law enforcement personnel, prosecutors, public defenders, and parole officers on issues of drug abuse including information on how treatment works, how referrals are made, and recovery timeframes²³
- The sharing of criminal justice information among various criminal justice agencies, to the extent permitted by law²⁴
- The development, together with community groups, treatment providers, and government officials, of new treatment programs and a guide to local treatment resources²⁵
- The joint discussion and coordination of all proposed reforms to the criminal justice system by members of the local anti-drug task force
- The appointment of a liaison for the courts to improve communication among the legislative, executive, and judicial branches²⁶

Brokering Resources

If asked, most communities would describe the resources they have available to treat drug offenders as inadequate. In fact, there are many communities that have virtually no resources to treat drug-involved offenders. Some small jurisdictions have been able, with shoestring budgets, to establish educational programs for drunk drivers. These programs, however, are limited and have little to offer to

offenders with other substance abuse problems. In such communities, judges have had success marshalling support from a variety of funding sources, by persuading both public and private funders of the importance of establishing substance abuse treatment programs.

Below are some examples of the difference judicial involvement can make in local communities.

Several years ago, in Bedford, Indiana, a judge played a lead role in developing a TASC program for the Lawrence Circuit Court. This judge worked cooperatively with the director of TASC in Washington, D.C. and also sought local support. Years later, although the judge no longer sits in this same court, the TASC program is still operational.

In Cambridge, Massachusetts, a small, but effective, drug treatment program was on state government's cut list, in part, because it had few advocates fighting for its continuation (unlike programs for the mentally ill or mentally retarded that are well supported by family members). The presiding justice of the Cambridge District Court was able to articulate to policymakers and state budget bureau staff why it was so essential to continue the program.

Would the Indiana program have been launched without help from the judge? Maybe. Would the Cambridge drug treatment program have had its funding restored without judicial intervention? Perhaps. But it certainly can be argued that because judges know the resource needs of their courts, they can make the case as effectively as anyone else. Some would argue that given the enormity of the drug problem affecting our communities, judges have an obligation to speak out for adequate drug-treatment resources. Their neutrality enables them to assess the needs for drug treatment options within their community better than other individuals who may have a vested interest in one particular segment of the system.

The Office of Justice Programs, in a draft Program Brief entitled *Adjudication of Drug Offenders*, goes one step further and argues that adding new programs is not enough.

... simply adding a program without carefully linking it with the rest of the system, may have minimal impact. Similarly, policy changes in one agency will have repercussions throughout the system. ... Most criminal justice systems operate on a delicate balance of policy and practical considerations which are applied to decisions made during each stage of the criminal justice process, from initial arrest to final disposition.²⁷

Because judges view the criminal justice process from arraignment through sentencing (and sometimes beyond), they are well suited to ensure that new and ongoing programs *and* policies match the needs of those whom the court is intended to serve.

Monitoring the Quality of Local Programs

Judges and other court personnel can play an important role not only in brokering drug treatment resources for offenders but also in monitoring the quality

A site visit can give judges or court personnel such as probation officers important firsthand information about the quality of a program.

of these resources on an ongoing basis. Quality assurance is key to the efficient use of scarce treatment dollars. Drug treatment programs that are inappropriate or ineffective are a waste of valuable resources. Because of their continuing involvement with offenders and treatment programs, judges and their staff are in a good position to assess the efficacy of these programs over time. This assessment can be made: (1) on the basis of written information provided to the court by the program; (2) through contact with program staff during court appearances; (3) through visits to program sites; and, (4) through communications with current clients and program alumni. Although not all of the feedback from offenders will seem reliable, taken in its full context, this information can offer some helpful insights into how programs are managed.

Careful review of materials provided by the programs can help assure that judges are referring offenders to programs specifically designed to meet the needs of these offenders. In reviewing this information, judges should ask:

- What is the program's philosophy and is it well articulated to clients and the court? Does it target a particular group? Are program goals realistic or does the program promise to be all things to all offenders?
- Can the program be expected to deliver the results promised, e.g., no relapses, no future arrests?
- Are program treatment methods well defined? Is treatment according to methods generally accepted by experts in the field? Are treatment methods experimental?
- How does the program measure results? Are there milestones built into the treatment plan so that a drug-involved offender's progress can be assessed? Are these results acceptable to the court? Do outcomes include job placement and other social adjustment factors as well as drug abstinence?²⁸

Court appearances by program staff afford judges with additional program assessment opportunities. Judges can gauge program performance by noting the progress of offenders in particular programs. These court appearances can provide a forum for ongoing communication between the court and the program. Judges can reiterate their general expectations for treatment while program staff can help the court evaluate progress in a particular case. Ideally, such discussions should be open and frank and include discussion of failures; for example, whether relapse in a particular case is normal or caused by a more serious problem or whether an offender's failure in a program is caused by criminal behavior or by a violation of program rules.²⁹

A site visit can give judges or court personnel such as probation officers important firsthand information about the quality of a program. Observations of staff interacting with clients may reveal the adequacy of staff skill and training in managing and treating offenders referred by the courts. Observations can also

reveal whether treatment guidelines are being followed and whether the program is being implemented in a manner consistent with representations made to the court.

In one state, a court visit to a treatment program in a state correctional facility revealed that, contrary to widespread belief, almost no treatment was being provided at the facility. This revelation was an important factor in reform of that particular state's substance abuse programs for offenders. In another state, a tour of an alcohol-treatment program affirmed for the visiting judges that the program was professionally administered, and that the treatment staff were topnotch. They learned of the low recidivism rate of program graduates and were encouraged that this program had much to offer criminal justice referrals.

Judges are in a unique position to address the problems of drug abuse. From their vantage point, they observe the entire operation of the criminal justice system and the progress of offenders through that system. They may be the first to spot communication breakdowns or system failures or to identify resource needs. They can play key roles in convening task forces to address these problems, in advocating for new resources, and in monitoring the quality of existing resources. Their knowledge of the law and the respect they are accorded by the community make judges ideal educators of the public about the legal issues involved in drug abuse cases. In light of their special status, judges should consider becoming involved in community activities and contributing their valuable insights to the efforts to confront the drug crisis.

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- ³ Ibid.
- ⁴ Ibid.
- ⁵ Ibid.
- ⁶ The Bureau of Justice Assistance Block Grant Program. "A Fair Share for the Courts," pp. 8-1-8-2.
- ⁷ State of New Jersey Administrative Office of the Courts. *The Judicial Response to the Drug Crisis*, p. 14; Davis et al., p. 316.
- ⁸ American Bar Association. (1990). *Code of Judicial Conduct*, Canon 5.
- ⁹ Steven Lubet. (1985). "Participation by Judges in Civic and Charitable Activities: What are the Limits?" *Judicature*, (August-September), Vol. 69, No. 2, p. 68.
- ¹⁰ Ibid., p. 75.
- ¹¹ State of New Jersey Administrative Office of the Courts. *The Judicial Response to the Drug Crisis*, p. 14.
- ¹² American Bar Association. (1990). *Code of Judicial Conduct*, Canon 4B.
- ¹³ The Bureau of Justice Assistance Block Grant Program. "A Fair Share For The Courts," p. 2-2.
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- ¹⁵ Remarks made by Chief Justice Paul Liacos, March 6, 1991.
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- ²⁰ Hodson, pp. 8-6-8-10.
- ²¹ Ibid., p. 8-14.
- ²² Davis et al., p. 317.
- ²³ Ronald I. Weiner. (1990). *Evaluation Report*. Report prepared for Drugs and the Judicial Response Drug Awareness Seminar for Judges in the Metropolitan Washington Region, (Jan. 26-27), p. 10. State Justice Institute grant #SJI-90-11K-E-012. Washington, D.C.: Clinical & Forensic Associates; Supreme Court of New Jersey. (1990). *Discussion Paper for the 1990 Judicial Conference on Drugs and the Courts*, p. 32. Secaucus, N.J.: 1990 Judicial Conference.
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LOCAL TREATMENT
RESOURCES

CHAPTER 8: LOCAL SUBSTANCE ABUSE TREATMENT RESOURCES



Chapter 8

**LOCAL SUBSTANCE ABUSE
TREATMENT RESOURCES**

**LOCAL SUBSTANCE ABUSE TREATMENT RESOURCES
ARE TO BE INSERTED BY THE LOCAL JURISDICTION.**

CHAPTER 9: STATE STATUTES



Chapter 9

STATE STATUTES

**RELEVANT STATE STATUTES ARE TO BE INSERTED BY
THE LOCAL JURISDICTION.**

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CLEARINGHOUSES AND OTHER RESOURCES

1. **Alcoholics Anonymous**
General Service Office, Inc.
Box 459, Grand Central Station
New York, N.Y. 10163
(212) 870-3400
2. **The Drugs and Crime Data Center & Clearinghouse**
1600 Research Boulevard
Rockville, Md. 20850
(800) 666-3332
3. **Narcotic and Drug Research Institute, Inc.**
11 Beach Street
New York, N.Y. 10013
(212) 966-8700
4. **National Association of State Alcohol & Drug Abuse Directors**
444 North Capital Street, NW, Suite 642
Washington, D.C. 20001
(202) 783-6868
5. **National Clearinghouse for Alcohol & Drug Information**
P.O. Box 2345
Rockville, Md. 20852
(800) 729-6686
(301) 468-2600 (Local calls)
6. **National Institute on Drug Abuse (NIDA)**
U.S. Department of Health and Human Services
Parklawn Building
5600 Fishers Lane
Rockville, Md. 20857
(800) 638-2045
7. **National Institute of Drug Abuse (NIDA), Drug Information and Treatment Referral Hotline**
1-(800) 662-HELP (4357)
8. **Office for Treatment Improvement**
(301) 443-6549
9. **Bureau of Justice Assistance Clearinghouse**
P.O. Box 6000
Rockville, Md. 20850
(800) 688-4252

10. **National Consortium for Treatment Alternatives to Street Crime Programs (TASC)**
444 North Capital Street NW
Suite 642
Washington, D.C. 20001
(202) 783-6868
11. **Bureau of Justice Statistics Clearinghouse**
P.O. Box 6000
Rockville, Md. 20850
(800) 732-3277
12. **Juvenile Justice Clearinghouse**
P.O. Box 6000
1600 Research Boulevard
Rockville, Md. 20850
(800) 638-8736
13. **National Institute of Justice/National Criminal Justice Reference Service**
P.O. Box 6000
Rockville, Md. 20850
(800) 851-3420
14. **Pre-trial Services Resource Center**
1325 G. Street, NW, Suite 620
Washington, D.C. 20005
(202) 638-3080
15. **State Justice Institute**
1650 King Street
Suite 600
Alexandria, Va. 22314
(703) 684-6100
16. **National Center for State Courts**
1110 North Glebe
Arlington, Va.
(703) 841-0200
17. **National AIDS Information Clearinghouse**
P.O. Box 6003
Rockville, Md. 20850
(800) 458-5231
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(800) 342-2437

APPENDIX A: HISTORY OF DRUG-RELATED POLICIES AND LEGISLATION



Appendix A

HISTORY OF DRUG-RELATED POLICIES AND LEGISLATION

Because of the complex and constantly changing nature of the substance abuse problem in the United States, the formulation of policy and legislation has always responded to shifts in public emphasis and concern. Three ideological models for thinking about drug use, the libertarian, medical, and criminal justice models, have shaped our approach to the problem.¹

LIBERTARIAN MODEL

Before the Civil War, a libertarian approach to drug use prevailed in the United States. Drugs such as opium were cheap, available, and legally unrestricted. This approach was a reflection of the burden of governing a new nation and its inherent Jeffersonian ideals, rather than an acceptance or positive view of drugs. American constitutionalism prescribed a limited role for the federal government, and at the time the government's attention was concentrated on the few matters where it could have a certain impact. A lack of interest in the impact of drug use in American society was the predominant reality for much of the nineteenth century.

It was not until the middle to late 1800s, when the country's concern with the alcohol problem grew, that the libertarian model began to lose ground. At this time, libertarian ideas were also responding to several political shifts. The spread of industrialization, the growing military power, and the immigration of unprecedented numbers of Asians and eastern and southern Europeans from 1880-1920 were remaking the country Jeffersonians had initially fashioned. The libertarian ideal of minimalist government was bending to the pressures of a increasingly diverse population with multiple needs.

The libertarian model was further weakened by technological advances. Modern chemists were developing morphine and cocaine, and the hyperdermic needle was invented. New, more concentrated drugs were being produced, and the number of people using drugs for purely recreational purposes was growing. These users were often stereotyped in racial terms, but, in reality, drug use cut across racial, ethnic, and economic backgrounds. The libertarian model gave way as pressure for government action against the drug problem rose. Early legislation attempted to discourage opium smoking by outlawing opium dens and levying high taxes on imports of opium prepared for smoking. In 1906, the federal

government passed legislation that required manufacturers to list all ingredients including narcotics on medicinal labels.

MEDICAL MODEL

... [medical model] adherents believe that drug addiction is a disease that responds to treatment, and is not caused by moral laxity or a lack of "willpower"...

The medical model was adopted in the late 1800s, as physicians began to realize that a significant number of citizens, mostly "respectable" middle-class women were addicted to powdered morphine and opiates. Opiates were central to nineteenth century medicine. Many middle-class people, particularly women, were prescribed opiates for a variety of ailments, and "nervous" disorders, and as routine "tonics." The promotion and frequent prescription of opiates resulted in abuse and addiction. From their observations, physicians formulated a medical model of drug use, namely, that independent of any moral sanctions, individuals display addiction withdrawal syndrome after they have used drugs for a considerable period of time. This is also referred to as the "disease model" of drug addiction. Its adherents believe that drug addiction is a disease that responds to treatment, and is not caused by moral laxity or a lack of "willpower" on the part of the user.

CRIMINAL JUSTICE MODEL

With the rise of rapidly expanding urban centers in the late nineteenth and early twentieth centuries, however, more attention was being focused on the use of drugs by the lower classes, and on the link between crime and drugs. This eventually led to the criminal justice model of drug use. Adherents to this model were more concerned with the criminal offenses and irresponsibility of drug users than with the common addiction and withdrawal syndromes offenders shared with non-criminal users. Under this model, drug use was fundamentally immoral, ruinous behavior, and users needed to be punished, rather than treated. Police, courts, and prisons were and are the mainstay for controlling the drug problem under this model.

The Harrison Narcotic Act of 1914 sought to straddle the medical and the criminal justice models. It strove to limit the prescription and distribution of narcotics, but skirted the question of indefinite drug prescription for an addict's personal use. However, in 1919 a Supreme Court decision established the legality of prosecuting addicts, in addition to those physicians who prescribed drugs to patients to support personal habits. With this legislation, the criminal justice model came into the forefront of drug policy formation. With the prohibitionist 1920s, the medical model continued to be set back. During this period, addicts were sought, prosecuted, and jailed in unprecedented numbers.

The drug problem declined during WW II and the Depression. However, heroin began to appear on America's streets in the late 1940s. The 1950s and early 1960s brought a new wave of drug problems despite increased criminal sanctions for drug-involved offenders. Dismayed by the escalation of drug-involved offenses despite increased criminal sanctions, a series of government and private panels began to reevaluate the national commitment to a nearly exclusive criminal justice approach to combating the drug problem. The push for a national drug treatment movement began in America's federal prisons. Prisons in Lexington, Kentucky, and Fort Worth, Texas, incarcerated drug-dependent offenders *and* provided in-prison treatment programs. Although the benefits of these programs proved elusive, these facilities provided the backdrop for research on drug treatment and for a public-tier, community-based treatment initiative.

NARCOTIC ADDICTION REHABILITATION ACT (NARA)

The first major federal acknowledgment of the reemergence of the medical perspective occurred in 1966 with the Narcotic Addiction Rehabilitation Act (NARA). This legislation authorized the community-based treatment of addicts following their release from incarceration. This act provided the needed link between criminal justice and health care communities by establishing the Division of Narcotic Addiction and Drug Abuse of the National Institute of Mental Health. In 1973, this branch of the National Institute of Mental Health (NIMH) became the National Institute on Drug Abuse (NIDA).²

New treatment approaches, namely therapeutic communities and methadone maintenance programs, which were exclusively based on the medical model, together with President Nixon's "war on crime," provided the backdrop for a large public-tier treatment effort. Nixon's "war on crime" clearly recognized the link between drugs and crime. This campaign's goal was to remove drug-dependent criminals from the street and America's prisons and to provide rehabilitation in light of growing evidence that many crimes were committed to support drug habits.³

TREATMENT ALTERNATIVES TO STREET CRIME

A subsequent federal initiative that acknowledged the link between drugs and crime commenced in 1972, during the Nixon administration, with the establishment of the Treatment Alternatives to Street Crime (TASC).⁴ TASC programs are in operation today and serve essentially as a "diversion" mechanism to identify and refer drug-involved offenders to treatment. They identify, assess, and refer appro-

The 1986 Anti-Drug Abuse Act reflected America's concern regarding the rise of drug abuse, particularly cocaine.

appropriate drug offenders who have committed non-violent crimes to community-based substance abuse treatment as an alternative or supplement to existing justice system sanctions. TASC is now operating in more than 125 communities.⁵ Federal funding eroded for drug treatment between 1975 and 1986. The rise of drug-related crime dramatically increased during this time period and continues to grow. This time period also saw an increase in privately-funded drug treatment facilities, often hospital-based, serving an addict population whose private insurance provides coverage for services.⁶ Since 1986, the primary focus of the federal government has been based on the criminal justice model of law "enforcement and interdiction."⁷ This focus was apparent throughout the Reagan administration's "war on drugs." The 1986 Anti-Drug Abuse Act reflected America's concern regarding the rise of drug abuse, particularly cocaine. Federal funds were allocated primarily for enforcement and prevention, rather than for treatment.

1988 ANTI-DRUG ABUSE ACT

Given the unprecedented rise in drug-related homicides, the public's concern regarding the AIDS epidemic, and the emergence of the crack epidemic, the 1988 Anti-Drug Abuse Act and the 1989 emergency supplement helped once again to balance the division of funds between enforcement, prevention and treatment. The 1988 Act is emphatic in calling for programs that improve drug control technology, including pre-trial testing programs, and programs that provide for the identification, assessment, referral to treatment, and case management and monitoring of drug-dependent offenders.⁸ The 1988 act also established a new Office of National Drug Control Policy and the nation's first high-level "drug czar."⁹ The first National Drug Strategy document published in September 1989 sweepingly rejects libertarian ideas and argues for tougher criminal sanctions. It takes a criminal justice/medical approach, calling for state and local governments to expedite the adjudication of drug offenders, maintain the safety of the communities, and meet the needs of drug-dependent criminals.¹⁰ In line with the overall stress on stronger criminal sanctions, this document argues for the greater effectiveness of mandatory drug treatment compared to the effectiveness of voluntary treatment. The second document released in January 1990 is more encompassing in its analysis of treatment programs, but continues the major criminal justice emphasis of the first document.¹¹

Endnotes

- ¹ The following discussion of all three models is drawn primarily from: Institute of Medicine. (1990). In Dean R. Gerstein and Henrick J. Harwood (eds.). *Treating Drug Problems*, Vol. 1., pp. 3, 40-52. Washington, D.C.: National Academy Press.
- ² Carl G. Leukefeld. (1985). "The Clinical Connection: Drugs and Crime." *The International Journal of the Addictions*, Vol. 20, Nos. 6&7, p. 1052.
- ³ Institute of Medicine. *Treating Drug Problems*, p. 51.
- ⁴ Carl G. Leukefeld, p. 1053.
- ⁵ U.S. Department of Justice. Bureau of Justice Assistance. (1988). *Treatment Alternatives to Street Crime, TASC Programs*, January, p. 3. Washington, D.C.
- ⁶ Institute of Medicine. *Treating Drug Problems*, p. 53.
- ⁷ Ibid., p. 55.
- ⁸ John J. Robinson and Arthur J. Lurigio. (1990). "Responding to Overcrowding and Offender Drug Use: How About a Community Approach?" *Perspectives*, (Fall), p. 24. Lexington, Ky.: American Probation and Parole Association.
- ⁹ Institute of Medicine. *Treating Drug Problems*. p. 55.
- ¹⁰ John J. Robinson and Arthur J. Lurigio, p. 24.
- ¹¹ Institute of Medicine. *Treating Drug Problems*, p. 56.



APPENDIX B: GLOSSARY



Appendix B

GLOSSARY

Absorption: passage of chemical compounds, such as minerals, nutrients, or drugs through membranes of the body.

Abstinence: a deliberate effort to refrain from taking psychoactive drugs. Usually, though not always, implies being physiologically drug-free. Taking psychoactive drugs under medical supervision does not violate abstinence.

Analgesic: a drug taken to reduce or eliminate pain.

Chipping: the casual or sporadic use of a narcotic which does not result in addiction.

Chromatography: a procedure used to isolate or identify substances contained in a mixture by allowing the mixture to flow over or around a medium that will change color if the target substances are present.

Chronic: a condition or practice marked by long duration or frequent recurrences, often used in opposition to "acute," in describing a condition or practice.

Confirmation Test: a second test used to validate a positive reading from a previous screening test. Confirmation tests are more reliable and more expensive than screening tests.

Controlled Substances: psychoactive plants and chemicals designated in the Federal Controlled Substances Act as approved for medical use only or disapproved for any purpose.

Cross Tolerance: a condition that develops when tolerance to one drug results in tolerance to a chemically similar drug.

Depressants: drugs that reduce the activity of the nervous system. Alcohol, barbiturates, and narcotics are examples.

Detoxify: to recover from the effects of a toxin on the system. Also considered the first step in breaking an addiction to a substance.

Endogenous Drugs: drugs that are in a usable form as found in nature.

Enzyme Immunoassay: the procedure of attaching an enzyme tag to a particular drug to identify it in urinalysis.

Excretion: elimination of drugs from the body. As they are primarily excreted by the kidneys, most illicit drugs can be detected in the urine of the user. They are also excreted by the lungs, the skin, and the intestine.

False Negative: test results show that drugs are not present in the urine, when in reality the person is using drugs.

False Positive: test results show that drugs are present in the urine, when in reality the person is not using drugs.

Freebase: smokable cocaine.

Full Drug Screen: testing a specimen to determine the presence of any and all drugs.

Hallucinogens: drugs that disrupt the central nervous system and produce a variety of perception and mood changes. LSD, DMT, mescaline, and magic mushrooms are examples.

High: an altered state of consciousness marked by euphoria, feelings of lightness, self-transcendence, and energy; not necessarily drug-related.

Intravenous: relating to the injection of a substance directly into the bloodstream.

Mainline: to inject a drug intravenously.

Mass Spectrometry: a detection device usually used in conjunction with a gas chromatograph (GC/MS) that specifically identifies the constituents of complex fluid mixtures.

Narcotics: a class of depressant drugs derived from opium or chemically related to opium.

Neurochemical: chemical substances involved in the transmission of information by the nerves.

OD: drug overdose.

Partial Drug Screen: testing a specimen to determine the presence of a specific drug or category of drugs.

Polydrug Use: the consumption of more than one drug at the same time, to alter or enhance their effects.

Potency: a term used to compare the relative strengths of two or more drugs; the more potent the drug, the less that is required to induce a given effect.

Psychosis: loss of ability to distinguish one's own thoughts and perceptions from reality.

Recovery: the process of replacing behavior associated with drug use with more productive activities and behavior. Abstinence is often associated with recovery.

Relapse Prevention: an increasingly popular technique designed to prevent recurrence of active drug use. It incorporates a wide variety of behavioral, cognitive, education, and skill-building techniques aimed at reducing the potential for relapse.

Route of Administration: method by which a drug is taken or introduced into the body. Common routes of administration for most illicit drugs include intravenous injection, oral ingestion, intranasal (sniffing) and inhalation (smoking).

Sedative-Hypnotics: a class of depressants.

Semisynthetic Drugs: drugs created by altering materials found in nature.

Screening Test: an initial test that is used to detect drugs of abuse in urine. Screening tests are less expensive and not as accurate as confirmation.

Skin-Popping: the practice of injecting drugs under the skin rather than intravenously or into a muscle. Most frequently done with heroin.

Sniff: to inhale the fumes of certain glues or solvents to alter perception.

Speedball: injecting the combination of a stimulant and a depressant, usually cocaine and heroin.

Steroids: a large family of pharmaceutical drugs related to the adrenal hormone cortisone.

Stimulants: drugs that increase the activity of the nervous system. Caffeine, cocaine, and amphetamines are examples.

Synthetic Drugs: drugs created in a laboratory out of materials not found in nature.

Thin-Layer Chromatography (TLC): a chromatographic procedure used to identify drugs of abuse in urine using a thin layer of material such as silicon as a carrier. The separated substances are dyed, and the resultant color and migration patterns are used to identify the drugs in question.

Tolerance: a decrease in the response to a particular drug that occurs with its continued use. One must either accept this weaker response or administer increasing doses of the drug to achieve the effect once achieved with a lower dose. Although the rate at which one develops tolerance varies widely among different drugs and from person to person, the phenomenon occurs with nearly every drug.

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