**Treatment**

*How does one go about treating addiction?*

There isn’t just one way. This is a complex process that might need to be undertaken several times before it works. There are many different types of treatment. One way to subdivide the topic of treatment is to discuss Inpatient treatment as compared to Outpatient treatment. Inpatient treatment usually refers to the patient living in a hospital setting or a residential treatment facility. In this case, the individual is living in the treatment setting full time. How long the person remains in this setting varies greatly; it could be anywhere from two weeks to a year. Inpatient treatment is often co-ed, but sometimes this can be a problem and it may be better to separate the sexes. Often in an inpatient setting there are limited phone privileges. As treatment goes on, patients can earn phone privileges, passes for their family to visit, or even a pass for the patient to visit home for a short period of time.

Outpatient treatment refers to various types of treatment that the recovering individual engages in, but without living/staying in the treatment setting. Outpatient treatment can take many forms. Sometimes this is called community treatment, especially in Europe. An example of outpatient treatment is a Methadone maintenance clinic (discussed later) in which the patient visits the clinic once a day to get a dose of Methadone. Other examples of outpatient treatment include seeing a counselor or clinician for therapy. Group therapy is where there is a group of similar people (e.g. alcoholics) that the recovering patient meets with on a regular basis (e.g. daily or weekly.)

*Is it common for people to relapse (return to drug use) after treatment? What are the causes of relapse?*

Relapse rates range from 40-80% (Heyman, 2013), but many studies would suggest it is closer to 80% than 40% (e.g. Hunt, Barnett, & Branch, 1970). One study of adolescent crack users found that 65.9% had relapsed after one month and 86.4% had relapsed by 3 months after hospital discharge (Lopes-Rosa et al., 2017). Until recently, relapse was considered as a failure. Today, relapse is considered a part of recovery. If it happens, the person just needs to think of it as a mistake and instead of giving up and going back to drug use, he/she should go back to treatment. Factors that have been shown to increase relapse risk for alcoholics include consuming a large amount of alcohol (compared to other alcoholics), not seeing alcohol use as a problem, having less self-efficacy, and reliance on avoidance coping (Moos & Moos, 2006). For all drugs, a major cause of relapse is exposure to the drug or drug priming (de Witt, 1996). Even a sip of alcohol or a puff on a cigarette could lead to relapse. Stress is another major cause of relapse (Ruiling, Lingjiang, & Wei, 2000), especially if the drug was used to cope with stress in the past. Stressors could be major, such as the death of a family member or splitting up with a significant other, or a series of minor stressors, such as a bad day at work. Another cause of relapse is exposure to the environment or people associated with drug use in the past; these are conditioned cues (Khoo, Gibson, Prasad, & McNally, 2017). Just hanging out with former drug-using friends or going back to a setting where the drug was repeatedly used can lead to relapse.

The best way to learn about treatment is to look at the National Institute on Drug Abuse’s Thirteen Principles of Effective Drug Treatment (reproduced from [www.drugabuse.gov/](http://www.drugabuse.gov/) publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment). After some of the principles listed, I have added more information and references.

**Principles of Effective Drug Addiction Treatment**

1. **Addiction is a complex but treatable disease that affects brain function and behavior.**  Drugs of abuse alter the brain’s structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.

Most people who work in treatment settings consider drug addiction to be a disease, although this is still a topic of debate (see Chapter 15 in Buzzed).

1. **No single treatment is appropriate for everyone.**  Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual’s particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

Combining more than one type of treatment is almost always done and it can be very effective. A large scale study assessing community treatments for Alcohol Use Disorder in England found that 58% successfully completed treatment with no re-presentation (no readmittance). The addition of pharmacological treatment to psychosocial intervention increased the likelihood of this outcome by 35%, addition of recovery support by 80%, and addition of both pharmacological intervention and recovery support by 147% (Peacock et al., 2018).

1. **Treatment needs to be readily available.**  Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.

Many treatment programs are private and quite expensive. An example is Bradford Treatment Center in Alabama. There are only a few state-funded inpatient programs in Alabama. In these programs, clients are drug tested on a weekly basis. Waiting lists for state-funded facilities are extremely long - often months.

1. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.**  To be effective, treatment must address the individual’s drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual’s age, gender, ethnicity, and culture.
2. **Remaining in treatment for an adequate period of time is critical.**  The appropriate duration for an individual depends on the type and degree of the patient’s problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

Several studies have shown that treatment outcome improves the longer clients are in treatment (e.g. Gottheil, Sterling, & Weinstein, 1993; McLellen & McKay, 1998; Walker, 2008)

1. **Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug abuse treatment.**   Behavioral therapies vary in their focus and may involve addressing a patient’s motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.

The following are some examples of behavioral therapies.

Behavior Modification

Behavioral therapies are derived from the Psychological principles of Behaviorism and Classical Conditioning. According to Behaviorism, the psychoactive substance (the drug of choice) is considered to be a positive reinforcer because it leads to pleasant feelings and it feels good. In addition to the drug being a positive reinforcer, it is also a negative reinforcer. If someone is feeling the unpleasant effects of withdrawal, and then uses the drug, those unpleasant withdrawal effects will go away. This is negatively reinforcing. It is hard to find other reinforcers to compete with the drug (because it is so reinforcing, being both a positive and negative reinforcer). In order to try to compete with this, some people try Aversion treatment. An example of this is using a drug like Disulfiram (also called Antabuse) to bring about an unpleasant association with alcohol. If a person takes Disulfiram and then later ingests alcohol, the alcohol will make the person nauseous and ill. The problem with this is the person has to be very motivated to avoid alcohol to use this treatment. If the person does not want to experience the negative effects of disulfiram, they simply don’t take it and then he/she can go ahead and drink alcohol without the resulting ill effects. Another part of Behavior Modification as related to addiction is to try to avoid or break associations with people and places that used to be paired with the drug use. This also relates to conditioned cues. If there is a setting where the drug was repeatedly used, the patient can either avoid that setting, or practice going to that setting and NOT ingesting the drug, until that setting no longer brings about drug cravings.

Social Learning Theory

In this treatment, the individual, with the help of a counselor, will examine antecedents of drug use. As a result of this, he/she will identify high risk situations where he/she is likely to use the drug. The patient will learn coping strategies and try to develop alternative reinforcers. He/she will also spend time looking at all the consequences of drug use to try to have a realistic view of how drug use affected his/her life and the lives of others around them.

Cognitive Behavior Therapy

In this treatment, the patient learns to understand his/her cravings for the drug and to develop coping skills to deal with these cravings. The patient learns to recognize situations where he/she is most likely to use the drug, and to avoid those situations if at all possible. This therapy helps the patient cope with problems associated with the use of the substance. Some of the coping strategies include planned delay (wait for a certain period of time before giving in to using the drug), engaging in an alternative activity (calling a counselor/friend/sponsor to help talk him/her out of using), and systematic relaxation techniques. Cognitive Behavior Therapy has been shown to be effective, especially when combined with pharmacological treatment (Becker & Kayo, 2017). Interestingly, because no pharmacological treatments have been shown to be effective for cocaine addiction, Cognitive Behavioral treatment is often used to treat addiction to cocaine (Smokowski & Wodarski, 1998). For alcohol addiction, commonly reported impairments are neurocognitive in nature. Therefore, directly promoting cognitive recovery through cognitive remediation, using knowledge gained from Cognitive Science, could be one way to improve treatment outcomes in people addicted to alcohol (Bates, Buckman, and Nguyen, 2013).

1. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.**  For example, methadone, buprenorphine, and naltrexone (including a new long-acting formulation) are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Acamprosate, disulfiram, and naltrexone are medications approved for treating alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (available as patches, gum, lozenges, or nasal spray) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.

Methadone maintenance is the term used for treatment programs that give individuals frequent (usually daily) Methadone doses to combat opiate addiction. Methadone is a drug that can be taken orally and lasts about 24 hours. It has some actions similar to heroin: it occupies the opioid receptors, relieves pain, and prevents withdrawal. Compared to taking heroin, people taking Methadone show improved health; all indicators of general health improve. Methadone has few or no adverse effects on cognitive or motor function, performance of skilled tasks (such as driving), and no adverse effects on memory. It does not provide the main hedonic effect of heroin, in other words, it doesn’t lead to a rush or a high. The use of Methadone leads to discontinued or greatly reduced use of heroin, for most individuals. Secondary crime is decreased among Methadone users.

There are some disadvantages of Methadone Maintenance. Many would argue that you are replacing one addiction with another (exchanging heroin for Methadone). Some individuals can never stop using Methadone. In fact, Methadone *Reduction* treatment, where the individual is given less and less Methadone over time, as opposed to Methadone Maintenance, often doesn’t work and may even lead to the individual going back to heroin (Gossop, 2015). Some individuals use Methadone and continue using heroin and other drugs (especially alcohol). Finally, most neighborhoods are not willing to have a Methadone Maintenance clinic in the area. This is sometimes referred to as NIMBY or Not in my Backyard.

A longitudinal study of the effectiveness of treatments for heroin addiction in Italy (Salamina et al., 2010) reported that Methadone maintenance therapy was more effective than therapeutic community (explained later) and abstinence-oriented therapies. If psychotherapy was combined with the given therapy, this increased retention. For methadone maintenance, the dosage was very important. Those given 60 mg methadone or more daily had the best retention. The lower the dose, the more risk of dropping out of therapy. Methadone Maintenance was associated with lower mortality during treatment and after treatment. A follow up study of more than 1000 drug users in the UK found that Methadone maintenance was a better treatment that Methadone reduction. The more rapidly heroin was reduced, the worse the heroin use outcomes. In addition, researchers found that 2/3 of patients in the reduction group in actuality were not reduced on dosage over time (Gossop, 2015).

Another medication that is used for opiate addiction is Suboxone. This is the trade name for Buprenorphine, which has both opiate agonist and opiate antagonist properties. It is safer than Methadone, because a person can’t overdose on it. It can be taken for chronic pain and it can also be used to transition from Methadone to no drug. If Suboxone dosage is reduced, it doesn’t trigger withdrawal symptoms (which is the case with Methadone).

A drug to combat opiate overdoses, Naloxone or Narcan, has received a lot of attention lately. This drug will occupy the opiate receptors and knock out the heroin or morphine or whatever opiate drug was occupying the receptors. It will cause the person to wake up and start breathing again. The drawback is that it only lasts 30-90 minutes. At that point if enough of the original drug is in the system, the person could still be at risk of an overdose. It used to be that only hospitals had access to this drug. Now, opiate users can be given free Naloxone kits and trained on its use. It can be injected or given as a nasal spray. Drug stores like Walgreens and CVS have Naloxone and will sell it or give it free in some cases. Doctors can prescribe it. Given the opiate crisis we are in, this is a really good thing.

An individual who is trying to quit smoking has a lot of options these days. There is a nicotine patch, a 24 hour transdermal delivery of nicotine. There are also nicotine lozenges which can be used for a short burst of nicotine to help with cravings. Nicotine gum can be used for the same purpose as the lozenges, and many report it tastes better. Vaping is quite popular, and it actually is a bit safer than smoking nicotine, in terms of effects on the lungs and cancer risk.

Disulferam (mentioned earlier) is used to help people abstain from alcohol use. It blocks one of the enzymes in the body, aldehyde dehydrogenase, resulting in nausea, flushing, and palpitations when alcohol is ingested. Drugs that are reported to reduce cravings for alcohol are naltrexone (an opiate antagonist) and acamprosate (Jonas, Amick, Feltner, Bobashev, Thomas, & Wines, 2014). Extended release Naltrexone reduces alcohol cravings and use during and after treatment. One study reported a significant reduction of the patients’ craving from baseline to week 3 following the initial dose. In addition, lower levels of alcohol use were reported at 30 and 60 days post medication cessation (Crevecoeur-MacPhail, Cousins, Denering, Kim, & Rawson, 2018).

1. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.**  A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person’s changing needs.
2. **Many drug-addicted individuals also have other mental disorders.**  Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.

This is commonly reported. For instance, see Luccini, 2007; Volkow, 2001). It is best to treat drug addiction and mental disorders simultaneously.

1. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.**  Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and can, for some, pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.

If drug addiction was simply a matter of an individual being physically dependent on a drug, it would be very easy to treat. Once the individual had been detoxified and successfully gotten the drug out of his/her system, without experiencing severe withdrawal effects, he/she would be cured! That is obviously not the case. There are psychological, social, and environmental aspects to drug addiction, in addition to what it does physically.

1. **Treatment does not need to be voluntary to be effective.**  Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.

Does treatment have to be voluntary to be effective? No! Coerced addiction treatment with alternative consequences (such as incarceration, loss of job, losing custody of a child, etc.) can be just as effective, or even more effective, as voluntary treatment (Miller & Flaherty, 2000). In the workplace, treatment leads to lower absenteeism, results in less turnover, fewer medical claims, and better productivity. In criminal populations, coerced treatment results in reduced criminal activity, improved psychosocial status, and increased retention in treatment. It also improved posttreatment outcomes. Among those arrested for drunk driving, coerced treatment resulted in fewer subsequent arrests for DUI. A comprehensive review found “No studies reported negative findings regarding having ‘consequences’ for refusal of addiction treatment. In reality, consequences such as loss of benefits or incarceration appeared to motivate clients/patients to accept addiction treatment”. (Miller & Flaherty, 2000, p. 14).

One example of this type of program is Drug Court or TASK (Treatment Alternatives for Safer Communities). We have one of these programs here in Jefferson County. The individual charged with a drug-related crime may be given this as an alternative to jail time. The program combines case management and therapeutic interventions with judicial oversight and accountability. The goals include: reducing recidivism, improving public safety, and keeping the defendant as a contributing member of society. The individual must go through intensive treatment and drug education. The individual has to stay drug free, has to go to treatment of some kind, and may have to get a job in order to escape conviction. The individual is tested regularly for the presence of drugs in the system. Benefits of drug court include staying out of jail, being drug-free, and having charges dismissed upon successful completion of the program. After a period of time, the defendant could apply for expungement of the criminal record of the arrest and criminal charges.

1. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.**  Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual’s treatment plan to better meet his or her needs.

Weekly drug testing is quite common in many different treatment programs.

1. **Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.**   Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Substance abuse treatment facilities should provide onsite, rapid HIV testing rather than referrals to offsite testing—research shows that doing so increases the likelihood that patients will be tested and receive their test results. Treatment providers should also inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations, and help link them to HIV treatment if they test positive.

*But Treatment is Expensive. Is it worth it?*

Addiction treatment has been shown to be cost-effective in several studies (e.g. Becker & Kayo, 2017). A California study found that $1.00 of treatment costs saved at least $7.00 in other medical and social costs. Criminal activity also decreased after treatment (Schildhaus, Gerstein, Dugoni, Brittingham, & Cerbone, 2000). Treatment can also result in lower posttreatment health care costs for treated alcoholics, even including treatment costs, compared to a non-treated group (Holder & Blose, 1992). Treatment resulted in a reduction of crimes committed such as shoplifting and drug selling and these reductions were maintained 5 years later – reduced to one fourth the intake levels (Gossop, 2015). A U.K. study found that for every pound spend on treatment, there was a return of more than 3 pounds in terms of cost savings associated with reduced victim costs of crime and reduced demands upon the criminal justice system (Gossop, 2015).

Treatment works! A study of crack cocaine and /or heroin users showed that 71% of heroin users were abstinent or reliably improved after 6 months of treatment, for crack cocaine users, it was 65% abstinent or reliably improved, and for users of both drugs, 65%. The percentage of people whose use was unchanged was 26% for heroin, 33% for crack, and 33% for both (Marsden et al., 2009).

*What are some different treatment models that haven’t already been discussed?*

Therapeutic Community

This is a unique type of treatment where the individual lives with others who have gone through, or are currently going through, treatment. This group of people serves as a surrogate family and communal support group. An example is Delancey Street Foundation in San Francisco, CA. The program pays for itself and does not accept any state or government funding. Treatment is regimented, and the individuals go through specific stages in a specific order. The living and work environments are run by ex-addicts. There is an arduous screening process and not everyone gets in. This makes it hard to evaluate success rates. One study found that there was a significant reduction of relapse risk in individuals that participated in a peer-support community (Boisvert, Martin, Grosek, & Clarie, 2008).

Alcoholics Anonymous and 12 Steps Programs

Alcoholics Anonymous (AA) was the first 12 Step Program. Started by Bill Wilson and Bob Smith in 1935 the general idea was that alcoholics could regularly meet with other alcoholics to help each other keep from drinking. Many people attend an AA meeting every day in the early stages of recovery. AA is an international organization that holds many meetings a day in various locations (usually in churches.)

Advantages of AA are the ease of finding a meeting and the anonymous nature of the organization (the organization does not identify its members by name and does not keep records of members or attendees of meetings.) New members are assigned a sponsor, someone who has not used the drug for a long period of time and who is willing to help the new member if he/she is wanting to use the drug. These sponsors increase the chances of success. Some disadvantages of AA are that because it is anonymous, statistics are usually not available to determine the success rates of members. Another disadvantage is that this tends to be a very religious/spiritual program; individuals who are not religious/spiritual may be uncomfortable with this type of treatment. A final disadvantage is that some AA programs discourage use of any drugs during treatment, even drugs that will decrease the cravings for the substance.

The 12 Steps of Alcoholics Anonymous

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

Alcoholics Anonymous has been incredibly influential, and the 12 steps have been modified to be used in treatment for several different addictions (e.g. cocaine, heroin, and even gambling). An old movie, *When a Man Loves a Woman,* is a realistic look at alcoholism and how it affects a family. At the end of the movie, the main character does a talk for a “Speaker Meeting” at A.A. In a speaker meeting, an alcoholic will tell his or her story.

**Birmingham’s Drug Court – Some Notes and Observations**

The Birmingham Drug Court meets Thursday afternoons at 1:30 at the Mel Bailey Criminal Justice Center (801 Richard Arrington Jr. Blvd N) on the 3rd floor. I went to observe one afternoon. Judge Shanta Owens was presiding. I was impressed with the Judge and the Case workers. They really seemed motivated by what was in the best interests of the people in this program.

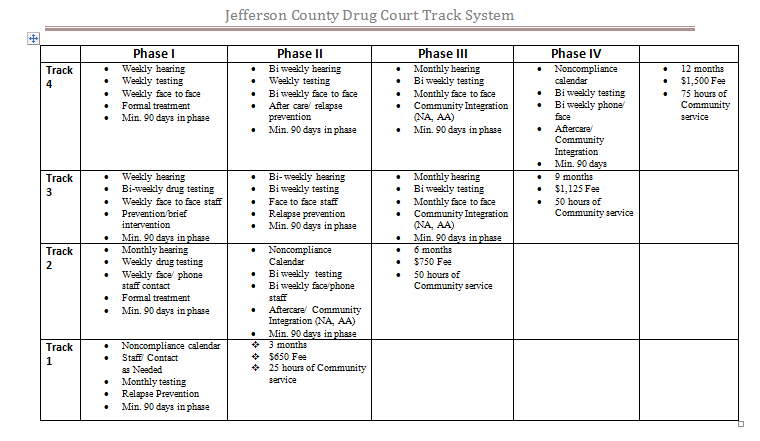
Drug court started out with the Judge congratulating compliant individuals. There were 15, but some had already left. Compliant individuals were given pink tickets (but the color changes daily and the tickets had to be turned in before a person left.) Then the Judge met with a group of individuals that had blue tickets; these folks still needed to pay fees or complete their hours of community service in order to graduate. Next, the Judge met with the people that had not passed their most recent drug test. In most cases, but not all, after having a discussion with these people and their case workers, she gave them another chance and did not send them to jail. I thought it was very interesting that this Judge did not appear to send people to prison for just using marijuana. In fact she said “I think marijuana is a poor reason to go to jail.” One person failed a suboxone test but she contested it; she was retested and it came up negative (clean). One person failed a drug test but then had 3 negative (clean) tests. The Judge let him go. Many folks were encouraged to maintain more contact with their case worker. Many of the defendants cited transportation problems as the reason why they missed a test. The best I could tell, when they are released from jail but haven’t graduated from the program yet, they call a number every morning and get a color. If the color is red (for instance) that means they have to come in and get drug tested. They are supposed to come in that day for a test no matter what. Some of the folks were assigned an essay to complete before they meet with the Judge again (in the next session of drug court). All the people mentioned above were in civilian clothes, although some of them had their wrists shackled.

Next, Judge Owens met with people that had been in jail for a day or more. These people were in a prison uniform and had their wrists and ankles shacked. One woman was kicked out of the program because the Judge did not think she was serious. She was sentenced to 2 years in jail. The best I could tell, these folks were in jail because they had repeatedly failed to show up for drug tests and the Judge had to issue one or more warrants for their arrest. If she had had to issue a warrant more than once, she seemed less likely to let them go. One man was sentenced to 14 days in county jail because he hadn’t done his community service. One person was sentenced to one night in jail for missing 2 drug tests. She said the ratio is usually one night in jail for missing one drug test. One noncompliant individual was sentenced to 18 months in jail.

Some other observations: There was a large age range of defendants. The youngest was 18 and the oldest was 55. Although most of the people in the program were African American, there were also a couple Hispanic individuals (5%) and several White individuals (20-30%). The male/female ratio was about 2/3 male and 1/3 female. Several folks in the program had kids.

The following are some questions I asked Judge Owens and her answers.

1. Is there a standard amount of fees and hours community service, or does the amount depend on the individual?  **Our fees depend on which Track a participant falls within.  Every client is given an assessment upon entry into the Program.  Based upon this assessment, the track is determined.  We have Tracks 1-4, with 4 being the “High Risk, High Need” offenders and Track 1 being “Low Risk, Low Need” offenders.  Track 1 fees are the cheapest and Track 4 fees are the most expensive.  Every participant has to perform 50 hours of community service, unless there is a medical issue or a disability that is noted.  If a client is on disability, his/her fees are drastically reduced.**
2. What is ASAM?  is it a type of assessment?  **Yes, it is an assessment to determine what level of treatment is needed for the client.  It gives us a roadmap to determine if the client should be released to outpatient or inpatient treatment.**
3. How often does drug court meet?  Is it most every Thursday?  **We meet every Thursday, except the 1st Thursday of the month.  I take the Drug Court Pleas (for new clients) in the morning at 9:00 a.m. and the Sanctions Docket (the one you observed) is held at 1:30 p.m.**
4. What is a MAT appointment?  **Medication Assisted Treatment.  Many clients are unable to refrain from drug use on their own and have to have other forms of medication to assist them in their sobriety.  We are huge proponents of MAT, and the National Standards support this train of thought.  Ex:  Vivitrol, Suboxone, Methadone are all forms of MAT.  If a client is a participant of TASC and engaged in treatment, we provide MAT for many of the clients.**



**An Outpatient Treatment Program in Alabama – Health Connect America**

This organization is a private, outpatient program. They take Medicaid and Blue Cross Blue Shield. Some people self-pay. The cost of one session is usually $25. This group offers the following services: an intensive outpatient program for adolescents 13-18, an aftercare/outpatient group for adolescents 13-18, an outpatient group for adults (18+), in-home counseling services and mental health counseling services for families, adults, adolescents, and children. Peer support and targeted case managers are used. As long as the individual passes the drug tests, he/she can keep coming to group. If a person fails one drug test but stops and admits it, he she will be able to participate. But if more than one drug test is failed, he/she will most likely be refused treatment. If a person cannot make it through the intensive outpatient program, he/she will be referred to an inpatient facility. The counselor I spoke to said that they do a substance abuse assessment (ASAM) and a Universal assessment to determine if other problems (mental disorders) are present. She said that a lot of time is spent teaching people some basic life skills. She also said that a lot of time is spent helping people deal with feeling intense emotions. She said she thinks of the drug use as a filter that keeps the individual from experiencing intense emotions, and when that filter is no longer present, it is often hard to deal with strong feelings. She said that opiate use is very common in Alabama. She said this organization will work with the Fritz Clinic. The Fritz clinic supplies Suboxone and Naltrexone to people with Opiate use disorder. She said that her organization didn’t like the results (or lack of results) people got with Methadone. She said that most clinics that give Methadone don’t seem to try to reduce the dosage over time.

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