Quality Improvement For Drug Courts:

Evidence-Based Practices

Monograph Series 9
EVALUATING THE EFFECTIVENESS OF ADDICTION TREATMENT:
What Should a Drug Court Team Look for in a Referral Site?

A. Thomas McLellan, Ph.D.
Treatment Research Institute at the University of Pennsylvania

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INTRODUCTION

This review discusses the concepts behind, the clinical goals of, the current structure of, and outcome findings from contemporary addiction treatments. The paper draws on published, randomized controlled trials in peer-reviewed research journals (an indication of scientific rigor) since 1980.

The paper is presented in two parts. Part I discusses the fundamental issues in addiction treatment, its structure, and the basis for what might be called reasonable criteria for effectiveness with drug court-referred participants. Part II summarizes those components of treatment that have shown significant evidence of being effective, especially with court referred participants.

NARRATIVE

PART I - What is “effective treatment” and how can you tell?

What are appropriate goals of addiction treatment?

Many parts of the criminal justice system—and particularly drug courts—refer substance users from their caseloads to community substance abuse treatments as a means of dealing with the “addiction-related” criminal problems. These referrals typically have three rehabilitative goals for the participant that are also relevant to the public health and safety goals of society:

1. Elimination or reduction of alcohol and other drug use. This is the foremost goal of all substance abuse treatments.

2. Improved health and function. Improvements in the medical health and social function of substance abusing participants are clearly important from a societal perspective, but in addition, improvements in these areas are also related to prevention of relapse to substance abuse.

3. Reduction in public health and public safety threats. The commission of personal and property crimes for the purpose of obtaining drugs and the dangerous use of automobiles or equipment under the influence of alcohol are examples of major threats to public safety.

These three goals form the basis for reasonable expectations regarding the “effectiveness of addiction treatment” as it pertains to the drug court situation. Thus, in the review that follows we have used these three outcome domains as the basis for an evaluation of the effectiveness of substance abuse treatment programs and treatment components.

Are These Expectations Reasonable?

Though in many ways, these expectations on the part of drug abuse treatment are sensible, they are difficult to fulfill given the often chronic and complex nature of the substance use related problems presented by drug-involved offenders sent from drug courts. Nonetheless, a review of the now over 1,000 controlled experimental evaluations of drug abuse treatments shows that many components of treatment can reliably produce lasting (six months or longer) changes in one or more of the evaluation domains that are so pertinent to Drug Court function (Hubbard et al., 1989; McLellan et al., 1994; Miller & Hester, 1986).
What is the Standard of Evidence?

As in the courtroom, the research field has levels of evidence with the strongest and most reliable being the randomized controlled trial (RCT). These kinds of experimental studies are a requirement of the Food and Drug Administration, which will not review any new medication or medical device unless there are at least two RCTs by independent, impartial investigators showing significantly better results from the new intervention than from placebo or "treatment as usual" on a relevant outcome indicator. This is a rigorous standard of evidence but one that seems particularly appropriate for the present review given the significant public health and public safety issues at stake in drug court-referred treatment interventions. Thus in the text that follows, the only medications, therapies, and interventions considered are those that have shown positive results in at least two experimental trials.

What is Treatment?

Addiction treatment is typically provided in specialty "treatment programs." These programs may be residential, offering 30 to 60 days of 8 to 10 hour days of rehabilitative care; or may be community centered, outpatient programs that offer 2 to 5 hours of rehabilitative care for 2 to 5 days per week over a 30 to 120 day period.

Regardless of setting or duration, these programs are actually the combination of various therapeutic ingredients or components designed to first overcome denial and to promote recognition and acceptance on the part of the participants that they have a significant addiction problem that they are capable of addressing. Concurrent with this effort, the program attempts to promote acceptance of and preparation for total abstinence from alcohol and other drugs of abuse, which is historically and empirically the best method of assuring sustained rehabilitation. A third clinical goal is assessment of so-called "addiction related" health and social problems that may have led to or resulted from the substance use, but that will have to be addressed if sustained rehabilitation is to be achieved. Finally, responsible clinical programs know that no finite amount of addiction treatment, regardless of the type or intensity or content, is likely to cure addiction. Thus, responsible clinical programs attempt to prepare participants for the inevitable temptations and triggers for return to drug use that they will face following formal care. This final goal is typically achieved by attempting to engage a participant into continuing mutual support for necessary life changes that is offered by Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).

Better programs also prepare the participant's family and friends to help in this process by providing continuing support and monitoring and make attempts to stay in touch with the participant through monthly telephone calls for up to a year following discharge.

How Can This Review Help in the Evaluation of Local Programs?

As should be clear, the program is the basic unit of addiction treatment delivery, but this review cannot provide an evaluation of individual programs. The quality and effectiveness of a program is substantially driven by its personnel, policies, practices, resources, and of course its treatment
components. Unfortunately, most of these aspects of programmatic care are idiosyncratic and subject to continuous change.

The current review does provide a review and summary evaluation of the important treatment components that have shown evidence of effectiveness. Thus the capacity of a local program to provide "evidence-based treatment components" offers one important, but imperfect, indication of that program's quality and potential effectiveness.

Drug courts are thus strongly advised to visit and inspect potential program referral sites regularly. A visual inspection of the physical facility and discussions with clinical staff may be informed by questions regarding the types and variety of "evidence based components" provided, but the visit will provide a much more thorough indication of true quality and effectiveness.

**Part II – What is “Evidence-Based” Treatment?**

**Principles of Effective Treatment**

One way to define effective treatment is to borrow from the scientific principles described in the National Institute on Drug Abuse publication entitled *Principles of Drug Addiction Treatment: A Research-Based Guide*. Examples of these principles of effective care derived from scientific studies include:

- No single treatment is appropriate for all individuals.
- Effective treatment attends to multiple needs of the individual, not just drug use.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
- Medications are an important element of treatment for many patients.

Regular visits by the drug court team to personally inspect the care provided in local programs are a handy and sensible method to get a sense of the quality of treatment provided by programs used as referral sources.

**Evidence-Based Components of Treatment**

Another quick method for getting a sense of the adequacy of potential treatment providers is asking about the nature of the components or ingredients that comprise the treatment regimen at the program. The components or ingredients of treatment, regardless of setting or duration, may be divided into three types: medications, therapies, and services. Here we present a summary discussion of the specific components within each type that have demonstrated effectiveness by the criteria described above.

**Medications**

Medications have developed remarkably over the past five years to the point that a "good treatment program" should have the capacity to assess for and provide medications (see chapter 4). There are now effective medications for the treatment of opiate, alcohol, and nicotine
dependence. Medications for cocaine and marijuana addiction are nearing the marketplace, but are not yet available. There are presently no proven or promising medications for methamphetamine dependence.

An important additional consideration is that at least 50% of any addicted population concurrently experiences significant psychiatric problems such as depression, anxiety, and phobia where the first line treatment of choice is a medication. Psychotropic medications work equally well among addicted participants as they do among those not addicted. Again, "good treatment programs" will have the capacity for professional psychiatric assessment and appropriate medication.

Medications prescribed for reducing alcohol and drug abuse problems may have one or more of several actions including prevention of withdrawal, reduction of postwithdrawal cravings, reducing or completely blocking the pleasurable effects of substances of abuse, and finally punishing re-use of addictive substances by inducing an unpleasant physical effect. Importantly, no medication works with all drugs of abuse, no medication has all the therapeutic effects described, and very few medications work well for even a majority of the population. Reasons for this likely involve specific interactions with genetic qualities of individual metabolism. With this important caution, the following medications have been shown to be effective in the treatment of the designated addiction problems and are currently available for prescription:

- Alcohol - Disulfiram (Antabuse), Naltrexone (Revia or sustained release Vivitrol), Acamprosate (Campral)
- Opiates - Methadone, Buprenorphine (Subutex, Suboxone), Naltrexone (Trexan)
- Cocaine - Disulfiram (Antabuse)

**Treatment Interventions**

There are specific behavioral treatment interventions that also have developed a strong evidence base over the past 5 to 7 years. All the examples cited below have supporting training programs to assure they are applied with fidelity and potency. You will note that many are referred to as "therapies." There is a difference between "counseling" and "therapy." Individual counseling is an important component of addiction treatment and it may be delivered by a range of professionals, even those with little formal training. Counseling focuses upon advice and suggestions for concrete, real world problems in the here and now, such as strategies for how to avoid drug-using friends, how to apply for a job and what to say about an addiction problem, where to obtain drug-free housing, referrals for services and to AA meetings, etc.

Importantly, drug counseling has been shown to be very effective when offered in individual, one-on-one situations. *Group counseling alone has not been shown to be effective* and yet group
counseling is a staple of most addiction programs. Programs that offer only group counseling without any individual counseling should be considered carefully prior to referral.

Therapy should only be delivered by an individual who has had specialized training (but not necessarily a specific degree). Therapies focus on interpersonal and intrapersonal problems with moods, impulse, and relationships. Most evidence-based therapies help participants acquire specific skills rather than just insights or problem recognition. Many can teach useful skills such as relapse prevention, decisional balance, parenting skills, relationship skills, etc., within 24 weekly sessions or less. No therapist can perform all therapies and not all participants are attracted to or respond equally to all therapies. Thus a "good treatment program" should have several therapists trained to proficiency in different evidence-based therapies as well as the capacity to provide individual counseling. What follows are those therapies that have been shown to be effective in the treatment of alcohol, cocaine and opiate addiction problems and that have developed training manuals to assure proficiency.

- Motivational interviewing and motivational enhancement therapy
- Voucher-based reinforcement of drug-free urines
- Cognitive behavioral therapy
- Community reinforcement and family training
- Multisystemic family therapy
- Behavioral couples therapy
- 12-step facilitation therapy

Health and Social Services

Virtually all addicted individuals have one or more concurrent medical, psychiatric, employment, family, and social problems. These problems can seriously complicate the delivery of and benefits from addiction treatment. Thus, "good treatment programs" will have the ability to assess a broad range of potentially complicating health and social problems of their participants and to provide necessary services either on-site or through referral to cooperating community agencies.

Critical Service Needs

Among the most important "addiction related problems"—those that have been shown to affect treatment outcomes—are employment, housing, and psychiatric illness. Thus, these may be among the most critical adjunctive services for addicted populations, although child care, parenting skills training, and services for violence and abuse are particularly important for women participants.

Clinical Case Management

While the on-site availability of health and social services is optimal, in fact very few community treatment programs, especially outpatient programs, have the personnel and administrative infrastructure necessary to provide even the most critical support services. Because of this, many...
programs have hired and trained clinical case managers whose job it is to assess the needs of the addicted participants and to provide active referral (actually taking a participant, not just calling on their behalf) to appropriate and willing community agencies to assure service linkage. Case management also involves postreferral follow-up to assure compliance with the service delivery plan of the referral agency and in some cases active interventions to prevent or detect early relapses (see chapter 3).

RECOMMENDATIONS

The evidence-based findings summarized here indicate that better outcomes are found in programs that have the capacity to provide or access

a. *individual* drug counseling in addition to group counseling;

b. proper medications (anti-addiction medications and medications for adjunctive psychiatric conditions);

c. supplemental social services for medical, psychiatric, and family problems; and

d. active engagement into 12-step programs or other continuing care regimen following treatment.

Perhaps the most important conclusion to be drawn from this chapter is that, like all other areas of healthcare, addiction treatment also has evidence-based practices derived from the same evaluation designs and methods also used to evaluate pharmacological, educational or medical interventions. Secondly, based on these evaluation methods and standards of evidence, there are several components of addiction treatment that have proven effectiveness, not only in reducing target substance use behaviors, but also in achieving the broader goals of rehabilitation (Hubbard et al., 1989; Institute of Medicine, 1995, 1998; McLellan et al., 1994; McLellan, O’Brien, Lewis, & Kleber, 2000; Miller & Hester, 1986).

At the same time, not all treatments are effective by any standard, and some treatment types and treatment programs are better than others (McLellan et al., 2000). Like the famous adage about politics, all addiction treatment "is local." The ability of a local program to provide many of the evidence-based clinical practices presented here is one good but imperfect indication of true effectiveness of an individual program.

There is no substitute for regular personal inspection and discussion about treatment components (evidence-based practices) with treatment programs that serve as major referral sites for drug court participants. In addition, it is important that drug court judges and case managers monitor attendance of participants at scheduled appointments with community agencies if they are to get the benefits from that referral.
REFERENCES


RELAPSE PREVENTION THERAPY
WITH SUBSTANCE-ABUSING OFFENDERS
An Overview with Recommendations for Drug Courts

G. Alan Marlatt, Ph.D.
George A. Parks, Ph.D.
Addictive Behaviors Research Center, University of Washington

Kathryn A. Kelly, B.A.
FASD Legal Issues Resource Center, University of Washington
INTRODUCTION

Longitudinal studies have repeatedly demonstrated that substance abuse treatment (particularly for 90 days or more) is associated with major reductions in substance use, problems, and costs to society (French et al., 2000, 2002a, 2002b; Hser et al., 2001a; Hoffman, Grella, & Anglin, 2001b; Hubbard et al., 1989; Salome et al., 2003; Sells, 1974; Simpson, Joe, & Roway-Szal, 1997a; Simpson et al., 1997b; Simpson, Joe & Brown, 1997c; Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999). However, postdischarge relapse and eventual readmission are also the norm (Godley, Godley, Dennis, Funk, & Passetti, 2002; Lash, Petersen, O’Connor, & Lehmann, 2001; McKay et al., 1997, 1998). Substance abuse is increasingly seen as similar in course and outcome to chronic health problems such as diabetes, hypertension, and asthma (Donovan 1998; O’Brien & McLellan, 1996). Although the risk for relapse is greatest during the first 3 to 6 months following initiation of abstinence (Hunt, Barnett, & Branch, 1971), recovering substance abusers are still at relatively high risk for 2 years (Moos, Finney, & Cronkite, 1990) and as some risk even after that (Vaillant et al., 1983). In spite of this evidence of chronicity and multiple episodes of care, most substance abuse treatment continues to be characterized as relatively self-encapsulated, serial episodes of acute treatment with postdischarge aftercare typically limited to passive referrals to self-help groups (Dennis, Perl, Huebner, & McLellan, 2000; Godley et al., 2002; McLellan et al., 2000; White, 1996; Etheridge, Hubbard, Anderson, Craddock, & Flynn, 1997).

Concern about these issues has led to new approaches modeled after treatment of other chronic disorders with similar rates of relapse, readmission, and co-occurring problems that complicate treatment. Clients should be urged to participate in some form of lower intensity continuing care, also known as “step-down” care or aftercare, after their initial phase of higher intensity treatment has ended (American Society of Addiction Medicine, 1996; Brownell et al., 1986; Rawson et al., 1991; Washton, 1989). The primary goals of this phase of treatment are to maintain the gains that have been achieved in the initial phase of care and prevent relapses, thereby reducing the likelihood that additional episodes of intensive care will be required. Continuing care is also thought to be important in the treatment of other medical disorders. For example, diabetic, hypertensive, or asthmatic patients are encouraged to comply with medication regimens, attend regular follow-up appointments, and maintain changes in diet and lifestyle to sustain the improvements from their initial phases of care.

NARRATIVE

Addictive Behaviors and Relapse Prevention Therapy

Relapse Prevention Therapy (RPT) is a cognitive-behavioral approach to the treatment of addictive behaviors that specifically focuses on the nature of the relapse process and suggests coping strategies useful in maintaining behavior change initiated during drug treatment or while incarcerated in an institution (Marlatt & Donovan, 2005; Parks, Marlatt, & Anderson, 2003). RPT is based on the idea that engaging in addictive behaviors helps people “feel good” (enhanced pleasure) or to “feel better” (self-medication of physical or emotional pain) as long as the intoxicating effects of the drug last.
RPT views addictive behaviors from a biopsychosocial point of view. Biologically, psychoactive chemicals affect brain function and narrow a person’s ability to experience pleasure other than from a drug high. Psychologically, addictive behaviors result in distorted thinking including denial and rationalization as well as preoccupation with acquiring and using drugs. Finally, socially, addictive behaviors can cause interpersonal conflicts with family, friends, fellow workers, and association with those who use and sell drugs can result in criminal activity. Over time, the cycle of drug highs and drug withdrawal leads to tolerance, dependency, and numerous drug-related harms such as physical disease, financial losses, relationship problems, and conflict with the law. Unfortunately, a person’s alcohol or drug habit not only becomes their main source of pleasure and relief from pain, but also their characteristic means of coping with life in general.

A Cognitive-Behavioral Model of the Relapse Process

RPT is based on a Cognitive-Behavioral Model of Relapse Prevention developed by Alan Marlatt and his colleagues designed to help substance-abusing clients 1) prevent relapse by coping more effectively with high-risk scenarios and 2) manage relapse by coping with lapses before they escalate into a full-blown relapse (Marlatt & Donovan, 2005). Relapse Prevention Therapy begins by assessing a client’s unique risk factors, which increase his or her vulnerability to relapse. In RPT, these high-risk scenarios are defined as any internal state or external circumstance in which it is difficult for a client to avoid using alcohol or other drugs. Three of the most common high-risk scenarios are social pressure, negative emotions, and interpersonal conflict.

When faced with a high-risk scenario, a client’s ability to use effective coping strategies to respond successfully to risky people, places, thoughts, feelings, or things reduces the probability of a lapse and allows the client to prevent a relapse from developing by never allowing it to start (See “Relapse Prevention” path on Figure 1). Ineffective coping decreases a client’s motivation and self-efficacy. The client may begin to think there is no use trying to resist temptation and that he or she is just not able to cope with the high-risk scenarios without using drugs (low self-efficacy). Getting drunk or high begins to sound good as positive outcome expectancies for substance use start to grow and reasons not to use fall prey to denial and rationalization (See lower path of Figure 1).

Failure to cope with high-risk scenarios combined with a belief that alcohol or drug use will fix the problem may result in a lapse or a single instance or episode of use that may or may not lead to relapse. Whether a lapse becomes a relapse depends on the person’s emotional and cognitive reactions following the use of a substance. The Abstinence Violation Effect (AVE) consisting of black and white (dichotomous) thinking (e.g. “What’s the use, I may as well continue since I’m...”)

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dirty anyway.”) and attributing the cause of the lapse to personal flaws (e.g. “I guess I’m just a hopeless drunk and might as well admit it.”) will increase the likelihood that a person will go on using after a slip (see lower path of Figure 1). However, relapse management, including damage control measures, which allow the individual to quit early and escape the high-risk scenarios, is always another option and may lead to a prolaplace and getting back on track.

The RPT model views a lapse as a Fork in the Road, one path leading to full-blown relapse and the other path leading to Relapse Management through damage control and a return to abstinence with a recommitment to sobriety and recovery (See “Relapse Management” line on Figure 1). This analysis of the crisis created by a lapse is consistent with the view of the maintenance stage of habit change as a time when mistakes are expected and can be overcome with renewed effort. As the old adage goes, “We can learn much from our mistakes.” Seen in this way, a lapse is a crisis involving both the danger of full-blown relapse but also the opportunity for learning to avoid a future relapse. In drug court clients, a lapse may also involve criminal conduct or harm to victims and therefore may need to be managed from both therapeutic and correctional perspectives involving various types of sanctions. Lapse should be assessed and debriefed by both treatment and drug court personnel and then responded to in a way that balances sanctions and increased treatment.

Figure 1. A Cognitive-Behavioral Model of Relapse: Immediate Determinants

Relapse Set-Ups

In many, perhaps even most, of the relapse episodes we have studied in our research or worked with in offender supervision or clinical practice, the first lapse a client experiences is preceded by internal states or external circumstances the client was not expecting and/or was generally unprepared to cope with effectively. Often, clients report finding themselves in rapidly escalating high-risk scenarios with which they could not deal effectively and so reverted to their familiar
habit of substance use. When we later debrief and analyze a lapse or relapse episode with the client, the lapse or subsequent relapse often appears to be the last link in a chain of events that preceded the client’s exposure to the high-risk scenario itself, beginning with an unbalanced lifestyle leading to a desire for indulgence and craving that were transformed by distorted thinking into decisions that led to exposure to that particular high-risk scenario where a lapse or relapse eventually occurred (See Figure 2). It seems as if, perhaps unknowingly, even paradoxically, some clients set themselves up for relapse and, when in drug court, set themselves up for criminal recidivism too.

Cognitive distortions such as denial and rationalization make it easier to set up one’s own relapse episode without having to take personal responsibility. Not only can a client deny having held any intent to resume alcohol or other drug use, but that client can also minimize or discount the severity of the long-range negative consequences of personal choices and actions. The process of relapse is often begun by a number of covert antecedents that through a chain of events and Apparently Irrelevant Decisions (AIDs) lead a client toward a high-risk scenario. When cognitive distortions mask true intent, clients can deny any responsibility following a relapse or recidivism event, saying, “This is not what I expected or wanted to happen and it really isn’t my fault.”

Figure 2. Relapse Set-Ups: Covert Antecedents of Relapse Scenarios

Evidence Supporting the Efficacy of Relapse Prevention Therapy

Carroll (1996) conducted a review of the efficacy of Relapse Prevention Therapy as a substance abuse treatment. Incorporating studies of RPT for smoking, alcohol, marijuana, and cocaine
addiction, Carroll concluded that RPT was more effective than no-treatment control groups and equally effective as other active treatments. Based on the qualitative results from Carroll, Irvin and colleagues conducted a meta-analysis on the efficacy of RPT techniques in the improvement of substance abuse and psychosocial outcomes (Irvin, Bowers, Dunn, & Wang, 1999). Overall treatment effects demonstrated that RPT was a successful intervention for reducing substance use and improving psychosocial adjustment. RPT was equally effective across different treatment modalities, including individual, group, and marital treatment delivery.

Marlatt’s cognitive-behavioral model of relapse prevention has also been used as the foundation for several empirically supported correctional programs for substance abusing offenders typically delivered in jails, in prisons and in the community (Pelissier et al., 2000; Peters, Kearns, Murrin, Dolente, & May, 1993; Porporino, Robinson, Millson & Weekes, 2002). A recent meta-analytic review of the use of RPT in correctional programs reported that when RPT components are added to an offender change program, the rehabilitation program has a greater impact on reducing recidivism. More RP components associated with greater efficacy (Dowden, Antonowicz & Andrews, 2003).

**Relapse Prevention Therapy in Special Populations**

When applying Relapse Prevention Therapy with offenders in treatment for substance abuse problems, intervention techniques may need to be adapted for special populations and their unique needs and learning styles. Special populations include both young and elderly offenders, women in treatment (also women with children at-risk for brain damage due to alcohol or other drug exposure), offenders with co-occurring mental health and addiction problems, different ethnic groups (e.g., Native Americans, African Americans, Hispanics), and those with multiple addictive behavior problems (e.g., drug use and gambling).

One drug court special population that clearly requires specially adapted techniques of Relapse Prevention Therapy is individuals who have been exposed to alcohol in utero. Fetal Alcohol Spectrum Disorder (FASD) is the prevailing term describing all birth defects associated with this exposure. The organic brain damage associated with FASD causes a range of serious cognitive and behavioral problems. The incidence/prevalence of FASD is approximately 1 in 100 births (Sampson et al, 1997). This disability is seen with fair frequency in drug court. Streissguth and colleagues (1996, 2004) found in their study for the Centers for Disease Control that 30% of adolescents and adults with FASD have drug or alcohol abuse problems.

The value to drug court of identifying those defendants who may be cognitively disabled, is to provide the most effective approach to achieve and maintain abstinence. These individuals generally have average or borderline I.Q. scores but have far more difficulty in managing their lives than those with the same I.Q. who are not brain damaged. In King County Drug Court (Washington State), court personnel are using a referral check sheet to identify those who may be disabled by prenatal alcohol exposure. This check sheet can be found in the Legal Issues section of the Fetal Alcohol and Drug Unit Web site: [http://depts.washington.edu/fadu/legalissues/](http://depts.washington.edu/fadu/legalissues/)

Some elements of traditional Relapse Prevention Therapy are unlikely to be effective for individuals with FASD, although the disability caused by FASD varies significantly. Individuals with this
disability often will lack the degree of self-awareness and maturity needed to understand why particular scenarios entail a high risk of triggering a relapse or to be able to master an abstract and complex coping strategy. Several alternative approaches seem more effective for preventing relapse by individuals with FASD.

Treatment should include identifying the scenarios likely to pose a high risk of relapse and offer simple, concrete corresponding rules (e.g. “Don’t go to the Dew Drop Inn or hang out with Danny Drug Dealer”) that are taught to clients through repetition. Written copies of those rules, limited in number and in easily understood language, may be useful. Regarding both rules and role-playing, repetition and continuing reinforcement is key. Since those with FASD generally respond well to the authority of the court, the judge can play a significant role in providing ongoing positive reinforcement of Relapse Prevention goals.

RECOMMENDATIONS

In order to encourage the utilization of research-based best practices in the area of Relapse Prevention Therapy (RPT) the following recommendations including many useful suggestions by Kushner (2007) are offered:

1. Drug courts should recognize the chronic, relapsing nature of substance use disorders. Evidence from both community-based and correctional drug treatment programs strongly suggests that drug courts should institute long-term continuity of care including structured aftercare services for as long as the court’s mandate permits to more effectively reduce relapse and recidivism.

2. Drug courts should model case management and treatment services after strategies utilized in long-term care for other chronic diseases such as diabetes, asthma, and cancer including periodic post-discharge monitoring, re-intervention as needed, and long-term recovery management. This approach is consistent with evidence that suggests stable recovery from substance use disorders is likely to involve multiple treatment episodes over a protracted period of time.

3. Drug courts should urge treatment providers to use principles of evidence-based RPT in their services at all levels care including early intervention, outpatient treatment, intensive outpatient treatment, day treatment, and residential care.

4. Drug courts should encourage treatment providers to tailor their RPT services to address the needs of special subpopulations of participants including young and elderly offenders, women, offenders with co-occurring disorders, offenders with cognitive disabilities and those from different ethnic groups. In addition, all drug court personnel should receive training to enhance their effectiveness in working therapeutically with these special populations.

5. Drug courts should encourage treatment providers to offer integrated RPT services to participants with co-occurring substance use and mental disorders since the research evidence shows that an integrated approach is more effective than parallel or sequential treatment that fragments service delivery.
6. Drug courts should require systematic, comprehensive and formalized Relapse Prevention Plans (RPP) to assist drug court participants to remain abstinent from drugs. RPPs are an essential component to effective RPT. Early identification of problems through monitoring of the RPP will allow the drug court team to intervene in a timely and appropriate way and should improve long-term outcomes.

7. Drug courts should ensure that the judge, case managers, the participant, and the entire drug court team continually monitor the effectiveness of the RPP that is currently in place. When there is evidence of problems in maintaining sobriety or complying with the RPP, the drug court team should require participants to make changes in the RPP including a return to treatment or an increase in the level of care of an ongoing treatment.

8. Drug courts should ensure that RPPs should contain, at a minimum, the following components:

   - Identifying and managing relapse warning signs,
   - Understanding the "cues" that trigger craving and managing craving and urges,
   - Identifying, disputing and replacing patterns of thinking that increase relapse risk,
   - Anticipating high-risk relapse scenarios and developing effective coping skills,
   - Identifying and learning to manage negative emotional states,
   - Identifying and coping with social pressure to use,
   - Learning ‘damage control’ to interrupt lapses early in the process and return to treatment,
   - Improving interpersonal relationships and developing a recovery support system,
   - Developing employment and financial management skills, and
   - Creating a more balanced lifestyle.

9. Drug courts should provide legislative, administrative, and funding bodies with information and supporting statistics to demonstrate the value of increased financial support for aftercare services including Relapse Prevention Therapy, breath testing for alcohol, urinalysis for the presence of drugs, contingency management to encourage abstinence from drugs, post-discharge monitoring, reintervention as needed, and ongoing, long-term recovery management.
REFERENCES


GENDER-RESPONSIVE DRUG TREATMENT SERVICES FOR WOMEN:
A Summary of Current Research and Recommendations for Drug Court Programs

Christine Grella, Ph.D.
UCLA Integrated Substance Abuse Programs
INTRODUCTION

In the past 20 years, new funding and policy initiatives have increased the availability of substance abuse treatment services developed specifically for women, thus enabling researchers and evaluators to study gender-specific treatment processes and outcomes (Blumenthal, 1998; Greenfield, et al., 2007). Traditionally, men have been more likely than women to access substance abuse treatment through the criminal justice system; however, women substance abusers are increasingly entering into the criminal justice system and consequently being referred to treatment under court supervision (Grella & Greenwell, 2004). Drug courts can build upon this body of research on the treatment needs, processes, and outcomes of women in order to improve the likelihood of successful treatment and drug court outcomes.

NARRATIVE

Profile of Women Offenders with Substance Abuse Problems

Women offenders typically have complex treatment/service needs given their multiple problems and the barriers they often face to obtaining needed services (Alemagno, 2001; Freudenberg, Wilets, Greene, & Richie, 1998). Women offenders often present to treatment with co-occurring substance abuse and mental health problems, limited employment skills and work history, and repeated prior interactions with the criminal justice system (Greenfield & Snell, 1999; Grella & Greenwell, in press; Messina, Burdon, & Pendergast, 2003; Owen & Bloom, 1995; Teplin, Abram, & McClelland, 1996). Considerable research has shown that most women offenders with substance abuse problems have been exposed to abuse, trauma, or violence as children and/or as adults (Browne, Miller, & Maguin, 1999; Green, Miranda, Daroowalla, & Siddique, 2005; Greene, Haney, & Hurtado, 2000; Grella, Stein, & Greenwell, 2005; Zlotnick, 1997). Many, if not most, women substance abusers who enter into the criminal justice system have been separated from their children, either through informal arrangements with other family members or because their children have been put into foster care by the child welfare system (Bogart, Stevens, Hill, & Estrada, 2005; Grella & Greenwell, 2006; Goldberg, Lex, Mello, Mendelson, & Bower, 1996). Many women substance abusers have physical health problems that stem from the consequences of substance abuse and associated unhealthy and risky behaviors, which are further compounded by their lack of access to or utilization of health care services (Messina & Grella, 2006; Staton, Leukefeld, & Logan, 2001). Moreover, women offenders tend to have more severe family and social problems; have higher rates of co-occurring mental disorders, particularly mood and anxiety disorders; and are less likely to have viable work skills or employment history, as compared with males (Langan & Pelissier, 2001; Pelissier & Jones, 2005; Sacks, 2004; Weitzel et al., 2007). Hence, in recent years there has been increasing attention to designing treatment interventions that address the clinical and service needs of women offenders, as distinct from their male counterparts.

Characteristics of Gender-Responsive Treatment Programs

Specialized substance abuse treatment services and programs for women generally focus on the psychosocial profile of substance-abusing women and their need for comprehensive services, particularly in regard to pregnancy and parenting, physical and mental health problems,
employment and housing, and history of trauma and victimization. Moreover, substance abuse treatment for women usually employs “empowerment” and supportive approaches to treatment, rather than confrontational approaches that were originally developed for male clients (Brown, Sanchez, Zweben, & Aly, 1996; Hodgins, el-Guebaly, & Addington, 1997; Strauss & Falkin, 2000). Some research suggests that women may be more responsive to treatment within women-only treatment facilities or groups, because they feel less intimidated or concerned about being stigmatized in such settings, because of a desire to obtain services specific to their needs (e.g., for pregnancy or parenting), or because they seek shelter from intimate partner violence (Dahlgren & Willander, 1989; Green, 2006; Jessup, Humphreys, Brindis, & Lee, 2003). These emergent treatment approaches have been characterized as “gender-sensitive” or “gender-responsive” (Bloom, Owen, & Covington, 2003; Luthar & Walsh, 1995). Yet, according to national survey data, fewer than half of the substance abuse treatment programs in the U.S. that accept women clients offer services or groups specifically for female clients (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006).

A growing literature has examined the characteristics of those substance abuse treatment programs that do provide services for women. These programs typically provide a wider range of services designed to meet women’s specific treatment needs (Grella, Polinsky, Hser, & Perry, 1999; Uziel-Miller & Lyons, 2000). Some studies have shown that women who receive treatment in specialized treatment programs generally have more severe problems, greater needs, and fewer resources compared with women in mixed-gender programs (Copeland, Hall, Didcott, & Buiggs, 1993; Reed & Leibson, 1981). Yet, despite their more severe problem profile, several studies have shown that women treated in women-only programs are more likely to complete treatment compared with women who receive treatment in mixed-gender treatment programs (Grella, 1999; Niv & Hser, 2007). Similarly, in a study using a national treatment sample, pregnant and parenting women who were treated in residential programs in which there were higher proportions of other such women had longer stays in treatment; longer stays, in turn, were positively associated with higher rates of posttreatment abstinence (Grella, Joshi, & Hser, 2000).

Outcomes of Gender-Responsive Treatment Programs

Research on gender-responsive treatment has shown that substance abuse treatment services that address women’s needs have promising results. Several studies have demonstrated that women have higher rates of treatment completion and better outcomes when residential treatment programs have live-in accommodations for children (Hughes, Coletti, Neri, & Urmann, 1995; Stevens & Patton, 1998; Szuster, Rich, Chung, & Bisconer, 1996; Wobie, Eyler, Conlon, Clarke, & Behnke, 1997); when outpatient treatment includes the provision of family therapy (Zlotnick, Franchino, St Claire, Cox, & St John, 1996), individual counseling (Volpicelli, Markman,
Monterosso, Filing, & O’Brien, 2000), and family services (Wingfield & Klempner, 2000); and when treatment includes comprehensive supportive services, such as case management, pregnancy-related services, parenting training/classes, childcare, vocational training, and aftercare (Brindis, Berkowitz, Clayson, & Lamb, 1997; Camp & Finkelstein, 1997; Howell, Heiser, & Harrington, 1999; Lanehart, Clark, Bollings, Haradon, & Scrivner, 1996; Strantz & Welch, 1995; Weisdorf, Parran, Graham, & Snyder, 1999). In addition, studies have shown that women in substance abuse treatment who receive more health and social services report better outcomes and greater satisfaction with treatment (Sanders, Trinh, & Sherman, 1998), particularly when services are matched with the patients’ needs (Marsh, D’Aunno, & Smith, 2000; Smith & Marsh, 2002). A review of 38 studies showed that the following treatment elements were associated with better outcomes among women: child care, prenatal care, women-only admissions, supplemental services and workshops on women-focused topics, mental health services, and comprehensive programming (Ashley, Marsden, & Brady, 2003). Among these elements, the provision of child care appears to be one of the most important factors in increasing the retention of women in treatment (Brady & Ashley, 2005). Overall, the accumulated research findings demonstrate the benefits of substance abuse treatment services that are specifically designed to meet women’s needs and support the use of gender-specific or gender-responsive treatment services (Orwin, Francisco, & Bernichon, 2001).

**Evidence-Based Treatment Approaches for Women Substance Abusers**

In the past few years, a greater emphasis has been placed on incorporating treatment approaches that have received empirical support from scientific research on treatment effectiveness and outcomes. Several treatment approaches have emerged as the primary evidence-based treatment practices within the field of addictions treatment. These include: relapse prevention, motivational interventions, contingency management, and trauma-informed interventions. These treatment approaches have either been modified, or have the potential to be, in order to address the specific treatment needs of women. These are briefly described below.

*Relapse Prevention*

Relapse prevention approaches focus on teaching clients to recognize “cues” or “triggers” for substance use and strategies for avoiding relapse in those situations. Research has shown that different factors are associated with relapse to substance use following treatment for men and women. For males, these include living alone, positive affect, and social pressures, whereas for females, relapse has been associated with not living with one’s children, being depressed, having a stressful marriage, and being pressured to use by their sexual partners (Rubin, Stout, & Longabaugh, 1996; Saunders, Baily, Phillips, & Allsop, 1993; Walitzer & Dearing, 2006; Zywiak, et al., 2006).

*Motivational Interventions*

Motivational interventions use therapeutic strategies to increase the individual’s awareness of their substance abuse problems and to engage their commitment to behavior change. This approach can build upon the issues that are central to motivating women to address their substance abuse problems, particularly related to their identity, self-esteem, health, and relationships with children, other family members, and friends. Yet few studies have actually
looked at gender differences in motivational approaches (Vasilaki, Hosier, & cox, 2006). In one example, a brief motivational intervention was used to address alcohol use among pregnant women in primary health care settings; information on the health effects of alcohol use during pregnancy was provided, with the aim of motivating women based on their desire to protect the health of their child (Handmaker, Miller, & Manicke, 1999).

Contingency Management
Contingency management approaches employ a schedule of rewards to strengthen the practice of desired behaviors (e.g., abstinence). These rewards may be small gifts, cash, or vouchers, which can be accumulated based on the duration of abstinence attained, as well as reversed upon a relapse. These approaches have been successfully used in smoking reduction programs for pregnant women who are in treatment for drug abuse (Donatelle, et al., 2004). One creative approach to contingency management utilized a community outreach program that solicited donations of personal hygiene or household items from local merchants and businesses that were then used to stock an on-site “store” from which women could choose their “prizes” upon attaining certain thresholds of abstinence (Amass & Kamien, 2004).

Trauma-Informed Interventions
Several interventions have been developed to incorporate treatment for prior trauma exposure within the context of substance abuse treatment; these treatment approaches are referred to as “trauma informed” (McHugo, et al., 2005). Examples of these approaches include: Seeking Safety, which integrates cognitive behavioral strategies with group psychotherapy to address both PTSD and substance abuse disorders (Najavits, 2002); Beyond Trauma, a curriculum that was developed specifically for women offenders and employs “relational theory” to build upon the importance of relationships in women’s emotional wellbeing (Covington, 2003); and the Trauma Recovery and Empowerment Model, which uses group therapy to promote recovery skills and social functioning (Fallot & Harris, 2002).

RECOMMENDATIONS
Based on the accumulated clinical and treatment outcome research on treatment for women with substance abuse problems, there are several recommendations for treatment of women within a drug court context. These include:

1. Drug courts should refer women to treatment programs that are either focused exclusively on women clients or that provide services specifically tailored for women’s needs. Of primary importance is referring women with young children to residential programs that have certified child care programs and bed capacity for their children, or to outpatient programs that have access to child care programming while the mother is in treatment. It is essential that programs provide a supportive and safe environment for women and their children, in which women can address the issues that uniquely impact their recovery.

2. Because of the generally high prevalence of co-occurring mental and substance abuse disorders among women offenders, drug courts should make sure that mental health screening and assessment occurs for all women and, when indicated, that mental health treatment is integrated with addiction treatment. Provision of integrated treatment at a single
site is preferable, including individual and group counseling, access to medications with medication management, and psychosocial support groups. Optimal programs include those in which staff have been specifically trained in “best practices” for treating individuals with co-occurring disorders.

3. Because of the high rates of trauma exposure among this population, drug courts should ensure that treatment programs screen women for their history of trauma and the ongoing effects of exposure to trauma, violence, and victimization, including posttraumatic stress disorder. Integrated treatment approaches should be used to address these issues within the context of substance abuse treatment. Use of empirically supported trauma-focused treatment approaches enhances the likelihood that these approaches will be effective.

4. Because of the generally low levels of work skills and employment history among women offenders, drug courts should assure that treatment programs provide services that address their need for education and employment skills. These can include screening and assessment of need for literacy education; pre-vocational services; preparation for job search (including resume development, computer literacy, interview preparation); and job referrals.

5. Because of the high likelihood that women offenders will enter drug court with parenting-related issues, drug courts should ensure that parenting-related needs are assessed, and, if appropriate that treatment is coordinated with child welfare services. These can include case conferencing with social workers, family reunification services, parenting education and skills training, and supervised visitation with children living with other caretakers.

6. Drug courts should refer women to treatment programs that screen for health problems commonly found among female substance abusers, including infectious diseases (HIV, HCV, other sexually transmitted diseases), untreated chronic health problems (e.g., hypertension, diabetes), and reproductive-related problems or needs.

7. Whenever possible, drug courts should utilize treatment programs that incorporate evidence-based treatment approaches, such as those covered in this monograph (i.e., case management, cognitive behavioral therapies, relapse prevention, pharmacotherapy, contingency management), and that these approaches are modified, as appropriate, to increase their relevance and application to women’s specific treatment needs.
REFERENCES


