Drug and alcohol addiction in the criminal justice system: the Australian perspective

Ann M Roche

Director
National Centre for Education and Training on Addiction (NCETA)
Flinders University

Drugs, Crime and Their Impact on the Community
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With drugs there is pleasure and death - and everything in between.

The consequences form a spectrum, a continuum, infinite shades of grey.

Drugs in American Society
Eric Goode, 1989
Psychoactive drug use is a ubiquitous thread in human history. …Siegal has argued that the pursuit of intoxication is a fourth basic physiological drive, along with hunger, thirst and sex. (Room, 1991)
Drug use, like many other human behaviours, is complex and multi-factorial in nature.
Drugs and Crime

- Increases/decreases in prevalence and seriousness
- Changing age of onset for both
- Peak age of involvement is increasing (desistance delayed)
- Increased involvement of females
Wicked Problems

"Wicked problem" is a phrase used in social planning to describe a problem that is difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize.

Moreover, because of complex interdependencies, the effort to solve one aspect of a wicked problem may reveal or create other problems.
What are ‘wicked problems’

• No unique “correct” view of the problem;
• Different views of the problem and contradictory solutions;
• Most problems are connected to other problems;
• Data are often uncertain or missing;
• Multiple value conflicts;
• Ideological and cultural constraints;
• Political constraints;
• Economic constraints;
• Often a-logical or illogical or multi-valued thinking;
• Numerous possible intervention points;
• Consequences difficult to imagine;
• Considerable uncertainty, ambiguity;
• Great resistance to change; and,
• Problem solver(s) out of contact with the problems and potential solutions.
Strategies to tackle wicked problems

Wicked problems cannot be tackled by the traditional approach in which problems are defined, analysed and solved in sequential steps. The main reason for this is that there is no clear problem definition of wicked problems. Strategies to cope with wicked problems:

Authoritative
These strategies seek to tame wicked problems by vesting the responsibility for solving the problems in the hands of a few people. The reduction in the number of stakeholders reduces problem complexity, as many competing points of view are eliminated at the start. The disadvantage is that authorities and experts charged with solving the problem may not have an appreciation of all the perspectives needed to tackle the problem.

Competitive
These strategies attempt to solve wicked problems by pitting opposing points of view against each other, requiring parties that hold these views to come up with their preferred solutions. The advantage of this approach is that different solutions can be weighed up against each other and the best one chosen. The disadvantage of this approach is that it creates a confrontational environment in which knowledge sharing is discouraged. Consequently, the parties involved may not have an incentive to come up with their best possible solution.

Collaborative
These strategies aim to engage all stakeholders in order to find the best possible solution for all stakeholders. Typically these approaches involve meetings in which issues and ideas are discussed and a common, agreed approach is formulated. In his 1972 paper, Rittel hints at a collaborative approach; one which attempts, "...to make those people who are being affected into participants of the planning process. They are not merely asked but actively involved in the planning process..." A disadvantage of this approach is that achieving a shared understanding and commitment to solving a wicked problem is a time-consuming process. Research over the last two decades has shown the value of computer assisted argumentation techniques in improving the effectiveness of cross-stakeholder communication. More recently, the technique of dialogue mapping has been used in tackling wicked problems in organizations using a collaborative approach.
Some researchers make a distinction between wicked and super wicked problems. The latter have the following additional characteristics:

- Time is running out.
- No central authority.
- Those seeking to solve the problem are also causing it.

The paradigmatic example of a super wicked problem is global climate change or the environment.
1. Why do we use drugs?
2. Who uses them?
3. What does it mean?
4. Why does it matter?
The 4 Ls of Alcohol

- Liver
- Lover
- Livelihood
- Law
Figure 1: Indigenous and non-Indigenous prisoners, 1992–2006
(rate per 100 000 relevant persons)

Source: Australian Bureau of Statistics, National Prisoner Census 2007
What’s the Problem Constructed to be?

Carol Bacchi

- HARMS?
- RIGHT OR WRONG?
- GOOD OR BAD?
- ADDICTION?
MANY DRUGS, AND PATTERNS OF DRUG USE, CAN CAUSE HARM.

NATURE, SEVERITY AND EXTENT OF HARMs CAN VARY SUBSTANTIALLY.
## Historical Overview

<table>
<thead>
<tr>
<th>Period</th>
<th>Concerns</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950s-60s</td>
<td>Alcohol Mid aged males</td>
<td>Medical Model (e.g. Minnesota model) AA Rockbottom 12 step facilitation Confrontation</td>
</tr>
<tr>
<td>1970s</td>
<td>Illicits, psychodelics</td>
<td>Inpatient, intensive treatment Therapeutic Communities</td>
</tr>
<tr>
<td>1980s</td>
<td>Expanded drug range and age of users</td>
<td>Research Support Brief Intervention and Early Interventions Motivational Interviewing Harm Minimisation Policy (1985)</td>
</tr>
<tr>
<td>1990s</td>
<td>Opioids Rise in deaths Polydrug use Gender ‘balance’</td>
<td>Pharmacotherapies War on Drugs vs Harm Minimisation</td>
</tr>
<tr>
<td>2000s</td>
<td>Amphetamines (meth) Cannabis Alcohol Prescription Opioids</td>
<td>Drug Diversion (from Criminal Justice system to Drug Treatment system)</td>
</tr>
</tbody>
</table>
It is important to be clear about our purposes, and our intended end goals.

Goals may vary:
- for different drugs
- in different contexts, and
- for different ages of the user
What are we trying to prevent?
Preventing What?

- Psychoactive substance abuse?
- Regular psychoactive substance use?
- Any use?
- Use of a particular drug?
Drug related harm?
Addiction?
Infectious diseases?
Social problems?
Associated crime and anti-social behaviour?
Beliefs about ‘causes’ drive our preferred ‘cures’ or interventions
<table>
<thead>
<tr>
<th>Causes of psychoactive substance use</th>
<th>Cure for the “problem”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of knowledge about the dangers of psychoactive drugs</td>
<td>• Education about the effects of psychoactive substance use (often with moralistic or biased information)</td>
</tr>
<tr>
<td>• Personal problems</td>
<td>• Personal development program</td>
</tr>
<tr>
<td>• Peer pressure</td>
<td>• Training in resisting peer pressure</td>
</tr>
<tr>
<td>• Lack of social skills</td>
<td>• Social skills training</td>
</tr>
<tr>
<td>• Lack of fear of psychoactive drugs</td>
<td>• Scare tactics</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>STATEMENT OF POSITION(S)</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Values</td>
<td>Everyone should work and contribute to society</td>
</tr>
<tr>
<td></td>
<td>One should not be dependent on drugs to cope with life's problems</td>
</tr>
<tr>
<td></td>
<td>Staying off heroin is more important than being medication free</td>
</tr>
<tr>
<td>Belief about the cause of heroin addiction</td>
<td>A moral failing</td>
</tr>
<tr>
<td></td>
<td>Social deviance or sociopathy</td>
</tr>
<tr>
<td></td>
<td>Inadequate skills to copy in mainstream society</td>
</tr>
<tr>
<td></td>
<td>A manifestation of psychiatric disorder</td>
</tr>
<tr>
<td></td>
<td>Ignorance about the dangers of heroin</td>
</tr>
<tr>
<td>Belief about the Pathophysiology of heroin addiction</td>
<td>A temporary biochemical disturbance</td>
</tr>
<tr>
<td></td>
<td>A permanent biochemical abnormality</td>
</tr>
<tr>
<td>Belief about the cause of relapse to heroin</td>
<td>Most addicts would be less likely to relapse if they knew about the dangers of heroin</td>
</tr>
<tr>
<td></td>
<td>Addicts will not use heroin if they cannot feel its reinforcing effects</td>
</tr>
<tr>
<td></td>
<td>Addicts will not use heroin if they cannot feel its reinforcing effects</td>
</tr>
<tr>
<td></td>
<td>Craving for heroin is driven in part by a long-term abstinence syndrome that is a manifestation of innate or drug-induced biochemical abnormalities</td>
</tr>
</tbody>
</table>
Pharmacotherapies
(non-exhaustive examples for function and agents)

1. Reduce craving
   (bupropion, acamprosate, naltrexone: alc/nic/her)

2. Detoxification
   (clonidine, naltrexone, diazepam)

3. Substitution
   (NRT, methadone, LAAM, dexamphetamine)

4. Maintenance
   (buprenorphine)

5. Aversive therapy
   (disulfiram)
Costs of drug abuse treatment in the USA per person, per year

- Outpatient treatment\(^a\) (cocaine): $2,722
- Methadone maintenance\(^b\) (heroin): $3,500
- Residential treatment\(^c\) (cocaine): $12,467
- Probation\(^c\): $16,691
- Incarceration\(^d\): $39,600
- Untreated addiction\(^d\): $43,200

United States dollars
SOME HARMS
ARE ACUTE AND TRANSIENT
IN NATURE
OTHERS ARE LONGER TERM AND MAY INVOLVE CHRONIC PROBLEMS SUCH AS:

- DEPENDENCE

- BRAIN DAMAGE

- PERMANENT ORGAN DAMAGE
  (LIVER DISEASE, HEP C, PERIPHERAL NEUROPATHY)
NOT ALL DRUGS INVOLVE DEPENDENCE OR ADDICTION!
Types of Problems
YOUTH

Intoxication

Reg. Use

Dep.
Intoxication
Violence
Motor vehicle accidents
Hangover
O/Dose
Property Offences
Although they restricted themselves to one drink at lunch time, Alan and Roger found they were not at their most productive in the afternoons.
Types of Problems
Older People (Users)

- Regular Use
- Intox
- Dep
Types of Problems

- Intoxication
  - Regular Use
    - Vein damage
    - Infections
    - Organ Disease
    - Relationships
    - Financial
Types of Problems
Clinical Samples

Intox

Dependence

Regular Use
Types of Problems

- Intoxication
- Regular Use
- Dependence
  - Withdrawal
  - Craving
  - Obsessive Compulsion
  - X Control
- Craving
- Obsessive Compulsion
- Control
DEPENDENCE

- EXISTS IN VARYING DEGREES

- IS USUALLY A LONG TERM PHEMOMENON

- IT TAKES A LONG TIME TO RESOLVE

- MULTIPLE ATTEMPTS ARE OFTEN REQUIRED

- RELAPSE IS NOT ONLY COMMON, IT IS USUAL
THE BEST THING YOU CAN DO IS GIVE UP SMOKING, DRINKING AND FRIED FOOD

WHAT'S THE SECOND BEST?
Long-term drug use can result in significant changes in brain function that persist long after the individual stops using that drug.
A person makes a voluntary decision to use a drug and continues to use it until the repeated drug exposures change the brain's structure and functioning.

As a result of these changes, the individual's scope for voluntary acts becomes severely restricted, particularly with respect to drug use.

He or she now exhibits the essential features of addiction - compulsive, nearly irresistible drug craving, seeking, and use.
The environment is critically important because re-exposure to environmental cues can elicit tremendous craving and relapse long after the individual stops using drugs.
voluntary decisions, external influences, and brain changes all contribute to drug addiction
SOME DRUGS DO NOT HAVE A RECOGNISED DEPENDENCE SYNDROME

(e.g. ECSTASY)
You don’t have to be addicted to experience harms from drugs

(e.g. overdose can, and does, occur among non-addicted heroin users)
Conversely;
you can be addicted to some substances and experience minimum harms!
Behaviour Change

• Changing any behaviour can be difficult where it is:
  - well established,
  - reinforced and
  - involves a degree of compulsion or habituation.
“I’m not asking you to change your spots. I’m just asking you to take out the garbage.”
## Treatment Success


<table>
<thead>
<tr>
<th>Dependence</th>
<th>Success rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>50 (40-70)</td>
</tr>
<tr>
<td>Opioid</td>
<td>60 (50-80)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>55 (50-60)</td>
</tr>
<tr>
<td>Nicotine</td>
<td>30 (20-40)</td>
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</tbody>
</table>

*success defined as greater than 50% reduction in Addiction Severity Index

Some medical conditions:
compliance and relapse (<12 months)

op.cit. Lancet

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Compliance &amp; relapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Medication regimen</td>
</tr>
<tr>
<td></td>
<td>&lt;50%</td>
</tr>
<tr>
<td></td>
<td>Diet &amp; foot care</td>
</tr>
<tr>
<td></td>
<td>&lt;30%</td>
</tr>
<tr>
<td></td>
<td>Relapse</td>
</tr>
<tr>
<td></td>
<td>30-50%</td>
</tr>
<tr>
<td>High BP</td>
<td>Medication regimen</td>
</tr>
<tr>
<td></td>
<td>&lt;30%</td>
</tr>
<tr>
<td></td>
<td>Diet</td>
</tr>
<tr>
<td></td>
<td>&lt;30%</td>
</tr>
<tr>
<td></td>
<td>Relapse</td>
</tr>
<tr>
<td></td>
<td>50-60%</td>
</tr>
<tr>
<td>Asthma</td>
<td>Medication regimen</td>
</tr>
<tr>
<td></td>
<td>&lt;30%</td>
</tr>
<tr>
<td></td>
<td>Relapse</td>
</tr>
<tr>
<td></td>
<td>60-80%</td>
</tr>
</tbody>
</table>
Types of Drug Users

Enormous variability and range from:

- Experimenters
- Social users
- Regular heavy users
- Dependent users
Motivation to Use Drugs Among Young People

1. Risk-takers/pleasure seekers
2. Socially disconnected
3. Self-medicators
Considered rejectors
Cocooned rejector
Ambivalent neutrals
Risk controllers
Thrill seekers/ Careful curious
Reality–swappers
• FUN
• FORGET
• FUNCTIONAL
INCENTIVE

→  PLEASURE
→  PAIN
→  PURPOSE

CONSEQUENCE
PREDISPOSE

PRECIPITATE

PERPETUATE
• ACCESS / AVAILABILITY
• OPPORTUNITY
• INCENTIVE / MOTIVATION
Social influence plays a primary role in the initiation of use,

Psychological factors may play a more important role in the maintenance of drug use.
Many factors can either increase or decrease the likelihood of making the initial voluntary decision to use drugs. They include:

- the quality of parenting one receives, and
- whether or not one has undiagnosed or untreated mental illness,
- or is exposed to a good prevention/intervention program.
• DRUG USE IS SOCIAL

• OCCURS IN A SOCIAL CONTEXT

• NEEDS TO BE ADDRESSED IN TERMS OF SOCIAL, POLITICAL AND ECONOMIC CONTEXT
Social and economic circumstances,

Cultural imperatives,

Individual behaviours,

Political decision making
We need to simultaneously:

1. Lower people’s vulnerability
2. Minimise harms associated with use
3. Prevent progression to dependence
4. Treat addicts
5. Address access and availability
Conditioned and Anticipatory Responses
... preventive action on drug problems can never be imposed on society and culture.

All such action, if it is to have any chance of success (and avoid likelihood of harm), has to be based on a sensitive willingness to listen, and understand.

Prevention is then an invitation to change, rather than an edict, and the invitation will be accepted only if it is sensible.

(Edwards 1980, p. 232)
RISK FACTORS

- Low grade point average
- Lack of religiosity
- Psychopathology
- Deviance
- Sensation seeking
- Early alcohol use
- Poor relationship with parents
- Perceived peer drug use
- Perceived adult drug use
PROTECTIVE FACTORS

• Parental affection
• Parental interest
• Parental time spent with children
• Attitudes of parents towards their children
• Consistency in disciplinary actions by both parents
• OTHER PROTECTIVE FACTORS

• Commitment to school
• Quality of relationship with parents and interactions with peers
• Conformity and participation in deviant activities
• Health and psychological functioning
<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Protective factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community</strong></td>
<td></td>
</tr>
<tr>
<td>• Perceived drug availability</td>
<td>• Encouragement &amp; reward for involvement</td>
</tr>
<tr>
<td>• Favourable drug use norms</td>
<td>• Opportunity for community involvement</td>
</tr>
<tr>
<td>• Community transitions &amp; mobility</td>
<td></td>
</tr>
<tr>
<td>• Community disorganisation</td>
<td></td>
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<tr>
<td><strong>School</strong></td>
<td></td>
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<tr>
<td>• Academic failure</td>
<td>• Opportunities and rewards for school involvement</td>
</tr>
<tr>
<td>• Low school commitment</td>
<td></td>
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<tr>
<td><strong>Family</strong></td>
<td></td>
</tr>
<tr>
<td>• Family conflict</td>
<td>• Family attachment</td>
</tr>
<tr>
<td>• Poor discipline</td>
<td>• Opportunities and rewards for family involvement</td>
</tr>
<tr>
<td>• History of antisocial behaviour</td>
<td></td>
</tr>
<tr>
<td>• Poor management</td>
<td></td>
</tr>
<tr>
<td>• Favourable parental views on</td>
<td></td>
</tr>
<tr>
<td>drugs and antisocial behaviour</td>
<td></td>
</tr>
<tr>
<td><strong>Peer individual</strong></td>
<td></td>
</tr>
<tr>
<td>• Attitudes to drug use</td>
<td>• Social skills</td>
</tr>
<tr>
<td>• Friends’ drug use</td>
<td>• Belief in the moral order</td>
</tr>
<tr>
<td>• Perceived risks associated</td>
<td></td>
</tr>
<tr>
<td>• Sensation seeking</td>
<td></td>
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<tr>
<td>• Attitudes to antisocial</td>
<td></td>
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<tr>
<td>• Rebelliousness</td>
<td></td>
</tr>
<tr>
<td>behaviour</td>
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</table>
Anything I want to do is illegal,
fattening, or causes cancer in mice
### Determinants of Social Order

<table>
<thead>
<tr>
<th>THE STATE</th>
<th>THE MARKET</th>
<th>THE COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Politics</td>
<td>Economics</td>
<td>Culture</td>
</tr>
<tr>
<td>Democracy</td>
<td>Global interdependence &amp; free market forces</td>
<td>Post-modernisation &amp; transnational homogenisation</td>
</tr>
</tbody>
</table>
1. What function does the view expressed serve for the authors?

2. What does it do for addicted individuals?

3. What impact does it have on society as a whole?

4. How well does it make sense out of the research data?

5. How well does it conform to your personal observations and experiences?

6. If everybody in the world held this view, what would our world be like?

(Stanton Peele, 1988)
1. YP stay in education longer
2. Sexual intercourse experienced earlier and earlier ages (42% years 10-12 had had sexual intercourse (2002)
3. More unsupervised time
4. Different experience of ‘family’ : 1 in 6 families in 2006 were single-parent families vs 1 in 17 in 1970’s
6. 3 M’s deferred (Marriage, Mortgage, Maternity)
7. Live at home longer (KIPPERS)
8. Have more expendable income
9. Different views about work/life balance
10. Leisure and recreation a greater priority and we live in an increasingly individualised and socially disconnected world
“We see the world as we are, not as it is.”

a saying from the Talmud
“....as much as 90% of the mistakes of thinking are mistakes of perception”.

deBono, 1999:278-9
Hierarchy of Barriers

1. Lack of awareness
2. Lack of familiarity
3. Lack of agreement
4. Lack of self-efficacy
5. Lack of outcome expectancy
6. Inertia of previous practice
7. External barriers to implementation (eg guidelines characteristics, patient barriers, environmental barriers such as nowhere to refer)

Good judgement comes from experience.

Experience?

That comes from bad judgement.
It oversimplifies the facts to say that drug abuse is voluntary at first and subsequently becomes involuntary.

There are voluntary and involuntary components to every stage of the process - from the initial decision to take a drug through addiction and treatment to abstinence.