TESTIMONY FOR THE U.S. SENTENCING COMMISSION:
TREATMENT AS AN ALTERNATIVE TO INCARCERATION FOR OFFENDERS WITH SUBSTANCE USE DISORDERS

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To the Commission, I thank you for the opportunity to submit this testimony. My hope is that it contributes to your deliberations and ultimately your recommendations.
My theme for this testimony centers on my belief that treatment for persons with Substance Use Disorders (SUD) works and recovery is possible. This belief does not extend singularly, one-to-one, to every addicted individual. However, it does include a number of offenders for whom addiction underpins their criminal acts. While the acts themselves are not excusable, it is prudent to look at the catalyst in an effort to diminish its effect. Accomplishing this task could reduce the potential for recidivism. Therefore I lend my support for treatment of SUD's as an alternative to incarceration.

At its core, addiction typified by obsession, compulsion, denial, loss of control and continued use despite adverse consequences. Addictive substances are considered psychoactive in that their primary impact is in the brain. These substances work in that they have a designated place in the brain to call home. Further, they alter the normal functioning of the central nervous system. Therefore, a person diagnosed with a SUD essentially has a brain disease. Psychoactive drugs cannot create sensations or feelings that do not have a natural counterpart in the brain system. This disease brings with it a variety of Biopsychosocial implications. The notion of a user of psychoactive substances having a "high jacked brain", centers on their continued use of a psychoactive substance and precipitating a loss of executive brain function leading to diminished logic, disregarding of consequences and ultimately poor decision making. Poor decision making is often the case when a crime is committed. An appropriate treatment response addresses the Biopsychosocial basis of addiction.

From a general biological perspective there are many aspects which relate ultimately to behavior. As the user moves toward more chronic use a tolerance is produced. There is a need for more of the substance to achieve the euphoric effect experienced at earlier levels of use. Using more of the substance and stopping its use could precipitate withdrawal. Withdrawal is the body's attempt to rebalance itself after cessation of prolonged use of a psychoactive drug. At some point the use of the substance is centered more on maintenance than euphoria. The primary objective at this juncture is the avoidance of withdrawal. There is a tendency to do what it takes to obtain the substance and relieve the discomfort. The instrumental strategies employed could range from lying to an employer because of a hangover to committing a crime to obtain funds to purchase illicit drugs.

The psychological status of persons with SUD's impacts behavior. It is well documented that a number of persons presenting for treatment of their SUD have a co-occurring mental health disorder. Based on best practices in the treatment of SUD's, for individuals with a SUD, a co-

occurring disorder is the expectation rather than the exception. Many offenders with SUD's experience an extraordinarily harsh existence. As such many of them might experience a variety of psychiatric symptoms. Their condition, relative to their lifestyle, might never be diagnosed and treated. What then are the ramifications? Clearly, there is the potential for addicts to use substances medicinally to ameliorate symptoms of an underlying mental health disorder. Cessation of the substance use could exacerbate the symptoms. In turn, exacerbation of the symptoms could become the trigger leading to cravings and a return to substance use. For offenders in this category dual concerns exist. Persons diagnosed with a mental health disorder often are prescribed psychotropic medication(s) designed to reduce the symptoms of the disorder. Should they use psychoactive substances while on the medication(s), the therapeutic benefit is often not met. Additionally, persons with co-occurring disorders are known to have issues with medication dosing compliance. For a variety of reasons they do not take the medication(s). The behavior of persons who are experiencing emotional instability along with craving and compulsions is often both irrational, impulsive. Again, the commission of a crime or continuation of a criminal lifestyle could occur as a result.

The nature of irrationality and impulsiveness with SUD's also plays out in the social context. At the most basic level the addicted individual begins to form an attachment to the substance and diminish their social attachment, which includes family, friends and society as a whole. This is the area in which the boundaries of the social contract are weakened. It boils down to an issue of development of a counterproductive relationship. The more intense the relationship to the substance, the less important a relationship to self, others and community. Broken families, chronic health issues and crime are some of the byproducts of the relationship. The notion of a maladaptive relationship to self reflects my testimony to this Commission on November 14, 2006. Many recovering offenders have moved toward embracing the social contract as members of the community. They do not reflect the person they were in active addiction.

Addiction is a chronic disease. In many cases this can be reversed if the disease process is arrested and the addiction moves into remission. For many offenders the appropriate intervention for the treatment of their SUD is treatment, not incarceration. It is important to note that stopping substance use is not the end, but rather the beginning. To embrace this concept it is important to understand what treatment is. In this context treatment is an organized system of care which relies on assessments to determine offender needs, treatment plans that address these particular needs, an environment conducive to change and the use of evidence based practice. There is a broad base of knowledge that applies to all persons with SUD's. Nonetheless, offenders with an SUD have needs in one or more of the following areas as delineated by the Addiction Severity Index (ASI):

1. Medical status
2. Employment and support
3. Alcohol & drug use
4. Legal status
5. Family/social status
6. Psychiatric status

There are many types or modalities of treatment. For each of them, an appropriate course of care is responsive to the deficiencies in each of these areas. The obvious goal is to reduce the deficiencies in any are indentified as needing corrective interventions. The operational goal, regardless of modality is four-fold. The first is to educate the offender in all aspects of the disease process and broad aspects of recovery. The second is to provide an environment conducive to developing insight. The strategy is to help the offender make the argument for change. This argument cannot be made by anyone other than the offender in treatment. If other sources had potent enough an argument, it is hard to envision the offender being in his or her current predicament. The third is to guide the offender toward the development of recovery resources. Broadly speaking, persons in recovery learn recovery in the company of recovering people. They don't learn from people engaged in substance use and criminal activities. The fourth centers on the importance of personal responsibility. A person in treatment is encouraged to accept sole responsibility for the maintenance of their sobriety.

The ability to accept personal responsibility requires a significant change in thinking and behavior. My intent is not to paint support of treatment for offenders with a broad brush. However, I believe that many offenders, with SUD's are not cognitively structured to make decisions in their or societies best interest. An example is the perplexing scenario of an offender on parole who knows that one of the conditions for continued freedom, and possible parole violation, are urinalysis results free of illicit substances. Yet, the urine assays come back with levels indicating substance use. An inherent mechanism required for survival of the species is the quest for freedom, caution and the will to survive. Addiction is a brain disease with Biopsychosocial implications which disrupts this mechanism.

There are people who commit offenses who would not have done so if their brains executive function was working. These are the offenders that treatment for their SUD is beneficial. Treatment begins when the offender meets the criteria for eligibility for diversion. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol #44" More than half of those in the criminal justice system who complete treatment programs and participate in aftercare do not commit new crimes. Most prisoners, who serve mandatory sentences, but get no treatment, commit new crimes and start using drugs or alcohol soon after release. "
The starting point is a comprehensive assessment. Again, a comprehensive assessment which includes a structured interview, elements of the ASI and mental health screening is important. Additionally, utilization of the Patient Placement Criteria (PPC) set forth by the American Society of Addiction Medicine (ASAM) is a good tool to determine the level of care required to address the needs of the offender.

My summation centers on the spirit of the National Institute of Drug Abuse (NIDA) pamphlet on "Principles of Drug Abuse Treatment for Criminal Justice Populations." Persons with SUD's suffer brain changers which preclude an appreciation of consequences. Treatment for their SUD's works as long as it occurs on a continuum with enough time to produce lasting change. Change from this perspective centers on cognitive restructuring leading toward pro-social behaviors. Provided this occurs, recovery is possible. The treatment environment serves as a "living lab' where new ways of thinking can incubate. Within this environment the offender can make the

argument for change, for up to this point no other power or authority has been able to make it for them. Treatments for offenders require the collaboration of a variety of community resources and multidisciplinary case management. This integrated approach addresses the variety of needs offenders bring with them as they enter treatment. Many of these needs are discovered after they have begun the therapeutic process.

The cost of an untreated SUD is enormous. It negatively impacts the very fabric of our communities. The impact of positive psychosocial change improves our communities beyond measure. Thomas Edison said "Our greatest weakness lies in giving up. The most certain way to succeed is always to try just one more time." Our science says that we can help the offender with an SUD. Let's not give upon them. Again, I thank the Commission for allowing me to present this testimony in favor of providing treatment as an alternative to treatment to offenders with Substance Use Disorders.

Resources

To obtain TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System*, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Ask for NCADI No. BKD526

The National Institute on Drug Abuse (NIDA) is part of the National Institutes of Health (NIH) , a component of the U.S. Department of Health and Human Services. The pamphlet can be obtained at http:// www.drugabuse.gov/PODAT_CJ

American Society for Addiction Medicine, Patient Placement Criteria, 2nd Edition Revised.