



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

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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 it 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.

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Super wicked problems

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.

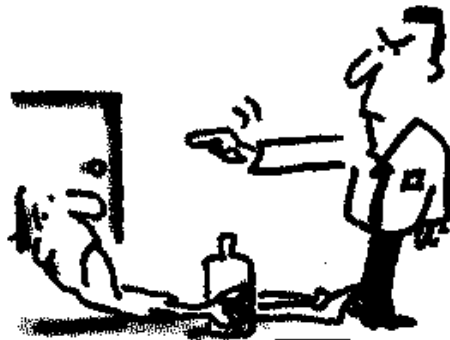
1. Why do we use drugs?
2. Who uses them?
3. What does it mean?
4. Why does it matter?



LIVER



LOVER



LIVELIHOOD



LAW

THE 4 Ls OF ALCOHOL

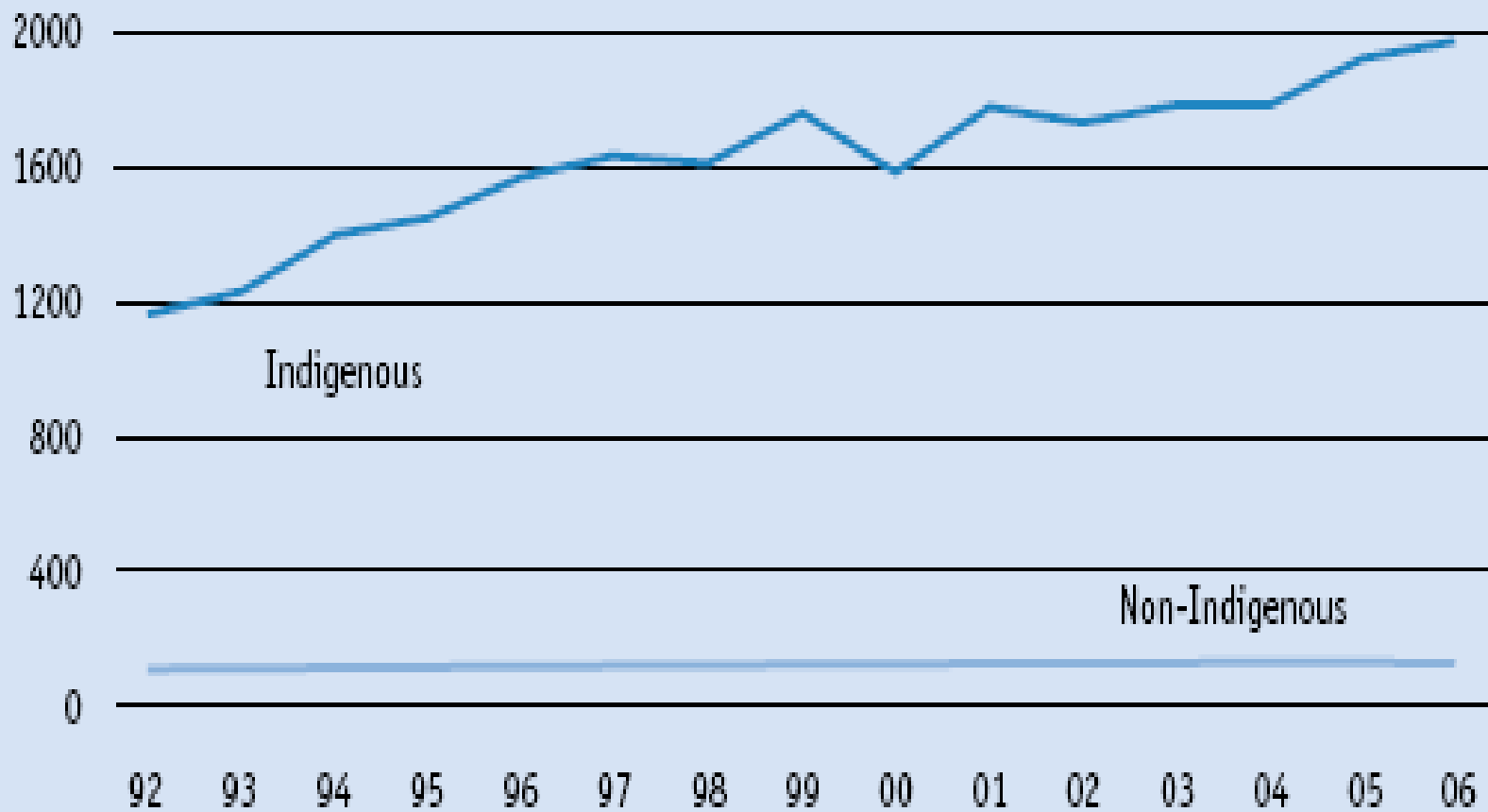


Figure 1: Indigenous and non-Indigenous prisoners, 1992–2006

(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

| Period | Concerns | Responses |
|-----------|--|--|
| 1950s-60s | Alcohol Mid aged males | Medical Model (e.g. Minnesota model) AA Rockbottom 12 step facilitation Confrontation |
| 1970s | Illicits, psychodelics | Inpatient, intensive treatment Therapeutic Communities |
| 1980s | Expanded drug range and age of users | Research Support Brief Intervention and Early Interventions Motivational Interviewing Harm Minimisation Policy (1985) |
| 1990s | Opioids Rise in deaths Polydrug use Gender 'balance' | Pharmacotherapies War on Drugs vs Harm Minimisation |
| 2000s | Amphetamines (meth) Cannabis Alcohol Prescription Opioids | Drug Diversion (from Criminal Justice system to Drug Treatment system) |

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?**

or:

Drug related harm?

Addiction?

Infectious diseases?

Social problems?

Associated crime and anti-social
behaviour?

**Beliefs about ‘causes’
drive our preferred
‘cures’
or interventions**

Causes of psychoactive substance use

- **Lack of knowledge about the dangers of psychoactive drugs**
- **Personal problems**
- **Peer pressure**
- **Lack of social skills**
- **Lack of fear of psychoactive drugs**

Cure for the “problem”

- **Education about the effects of psychoactive substance use (often with moralistic or biased information)**
- **Personal development program**
- **Training in resisting peer pressure**
- **Social skills training**
- **Scare tactics**

VALUES AND BELIEFS ABOUT OPIOID ADDICTION AND OPIOID ADDICTION TREATMENT

| CATEGORY | STATEMENT OF POSITION(S) | THE EFFECT ON OPIOID ADDICTION TREATMENT OR ANTIDRUG SOCIAL INTERVENTION |
|---|---|--|
| Values | Everyone should work and contribute to society | Vocational counselling |
| | | Employment as a measure of treatment effectiveness |
| | One should not be dependent on drugs to cope with life's problems | Medication-free treatment |
| | Staying off heroin is more important than being medication free | Methadone or other opioid agonist therapy |
| Belief about the cause of heroin addiction | A moral failing | Narcotics Anonymous |
| | Social deviance or sociopathy | Criminal justice system |
| | Inadequate skills to copy in mainstream society | Long-term therapeutic community |
| | A manifestation of psychiatric disorder | Psychiatric medication, psychotherapy or both |
| | Ignorance about the dangers of heroin | Drug education in the schools |
| Belief about the Pathophysiology of heroin addiction | A temporary biochemical disturbance | Detoxification or short-term methadone maintenance |
| | A permanent biochemical abnormality | Lifetime opioid replacement with methadone or other opioid agonist |
| Belief about the cause of relapse to heron | Most addicts would be less likely to relapse if they knew about the dangers of heroin | Drug education as a component of treatment |
| | Addicts will not use heroin if they cannot feel its reinforcing effects | Blockade of response to heroin by opioid agonist or antagonist |
| | Addicts will not use heroin if they cannot feel its reinforcing effects | Blockade of response to heroin by opioid agonist or antagonist |
| | Craving for heroin is driven in part by a long-term abstinence syndrome that is a manifestation of innate or drug-induced biochemical abnormalities | Prevention of abstinence syndrome with methadone or other opioid agonist |

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)

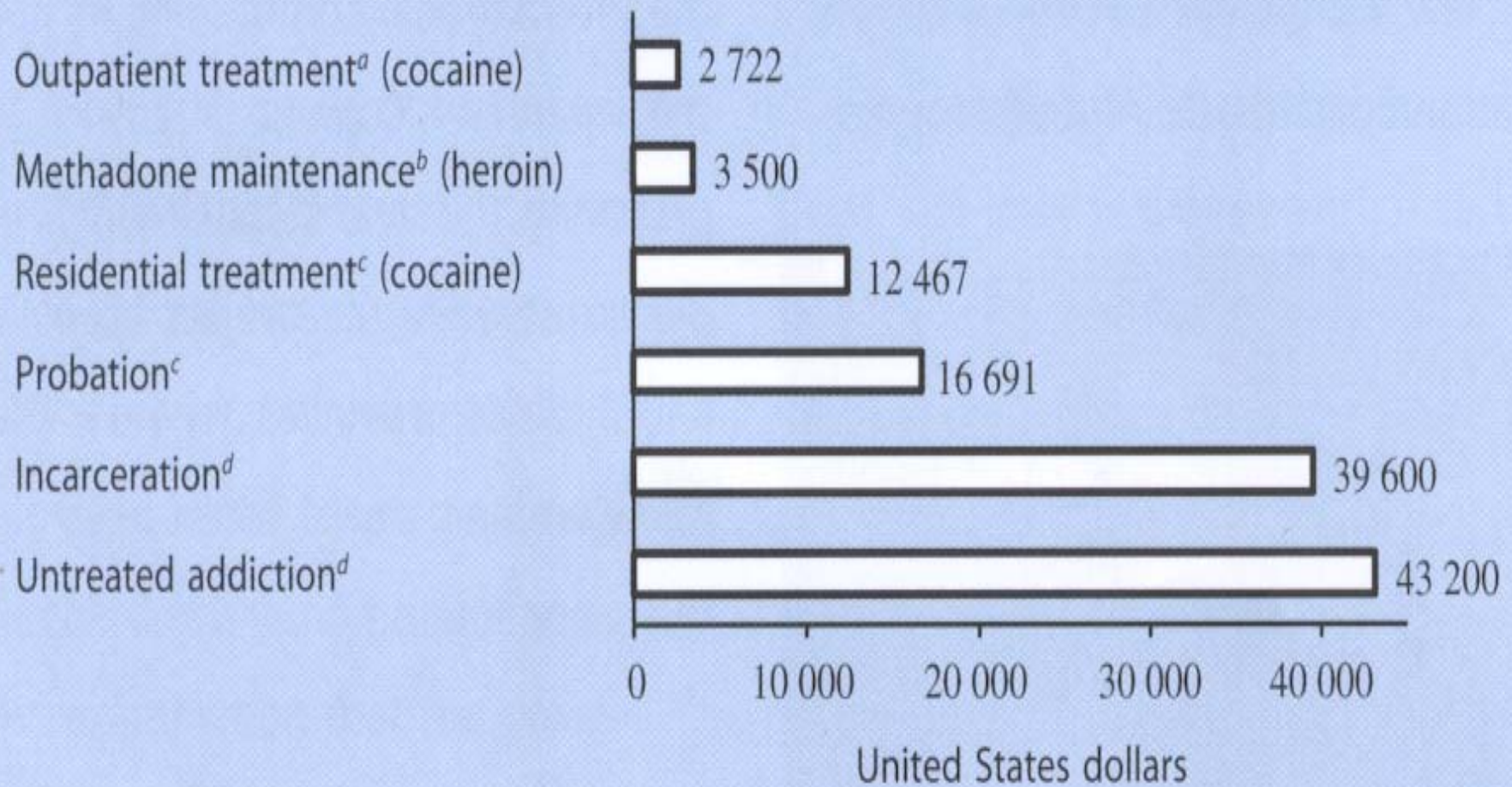
4. Maintenance

(buprenorphine)

5. Aversive therapy

(disulfiram)

Costs of drug abuse treatment in the USA per person, per year

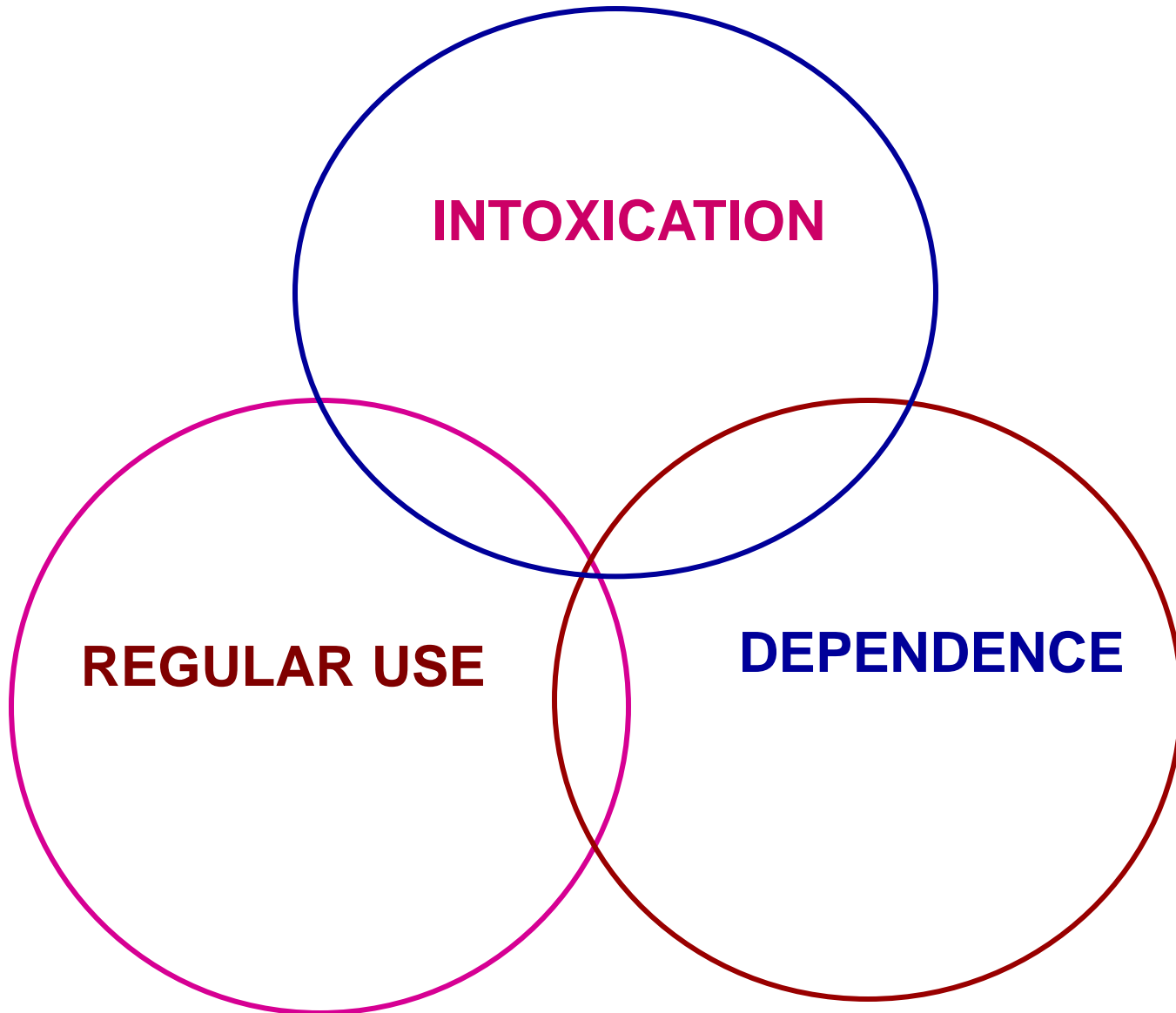


**SOME HARMS
ARE ACUTE AND TRANSIENT
IN NATURE**

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 !**

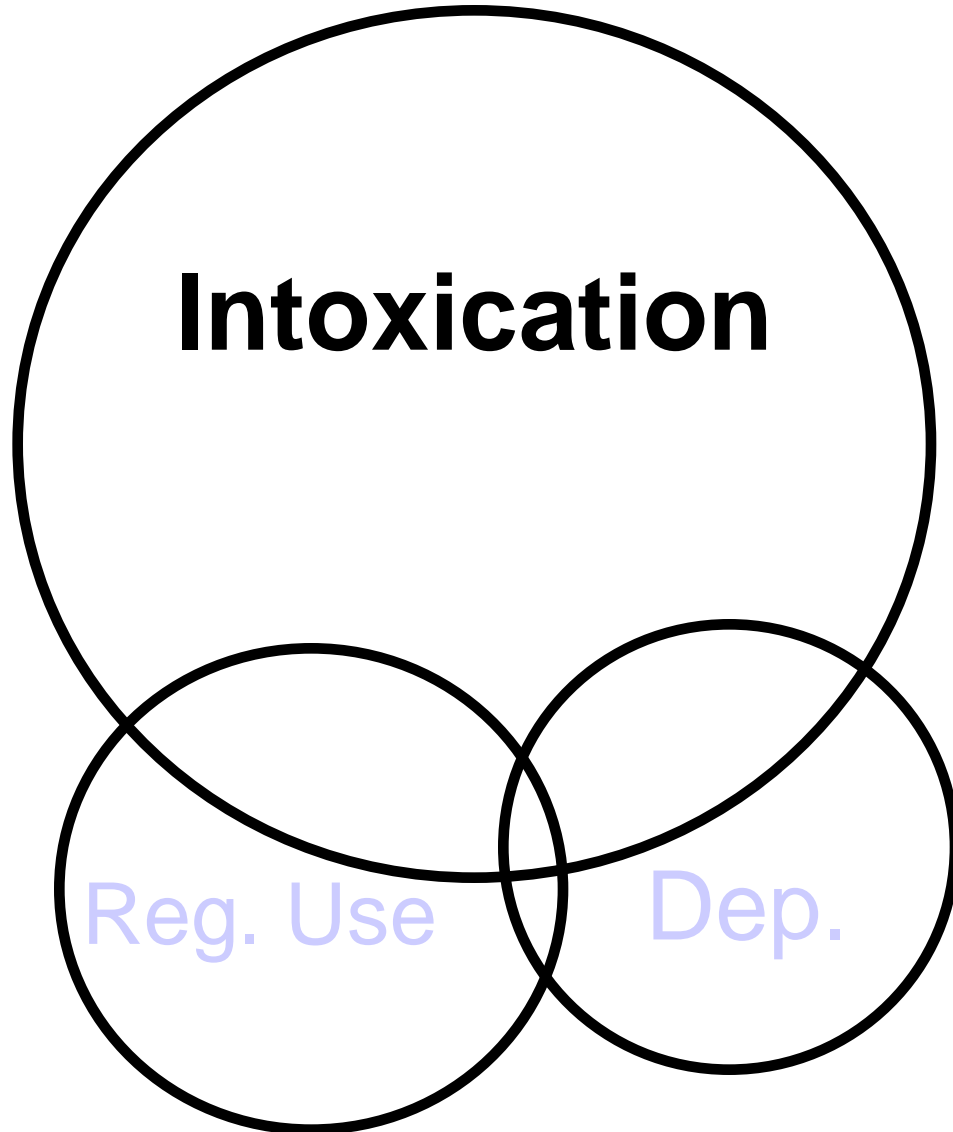


INTOXICATION

REGULAR USE

DEPENDENCE

Types of Problems YOUTH



Intoxication

Violence

Motor vehicle accidents

Hangover

O/Dose

Property Offences



Community Amenity

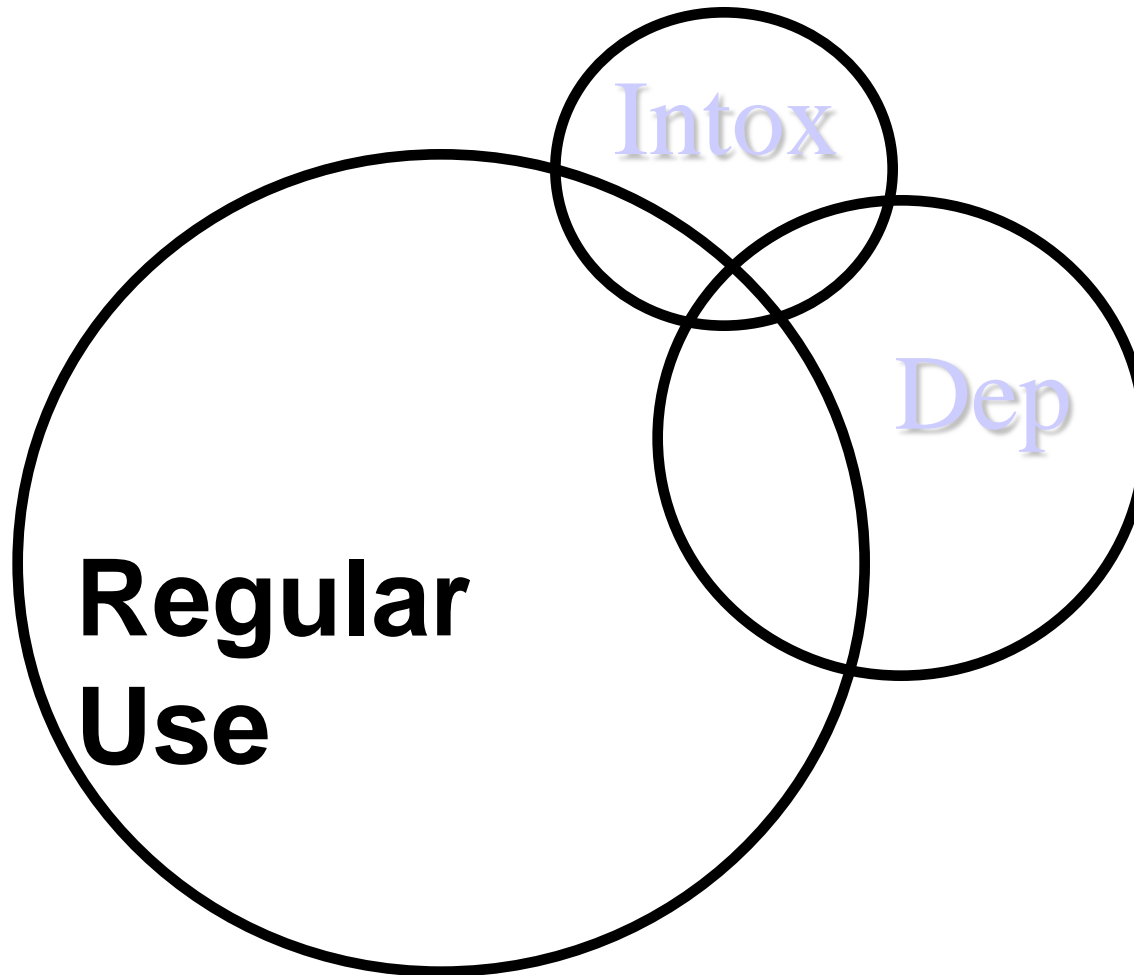


Good Vibrations, Feb '08



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)



Types of Problems

Intoxication

Regular Use

Vein damage

Infections

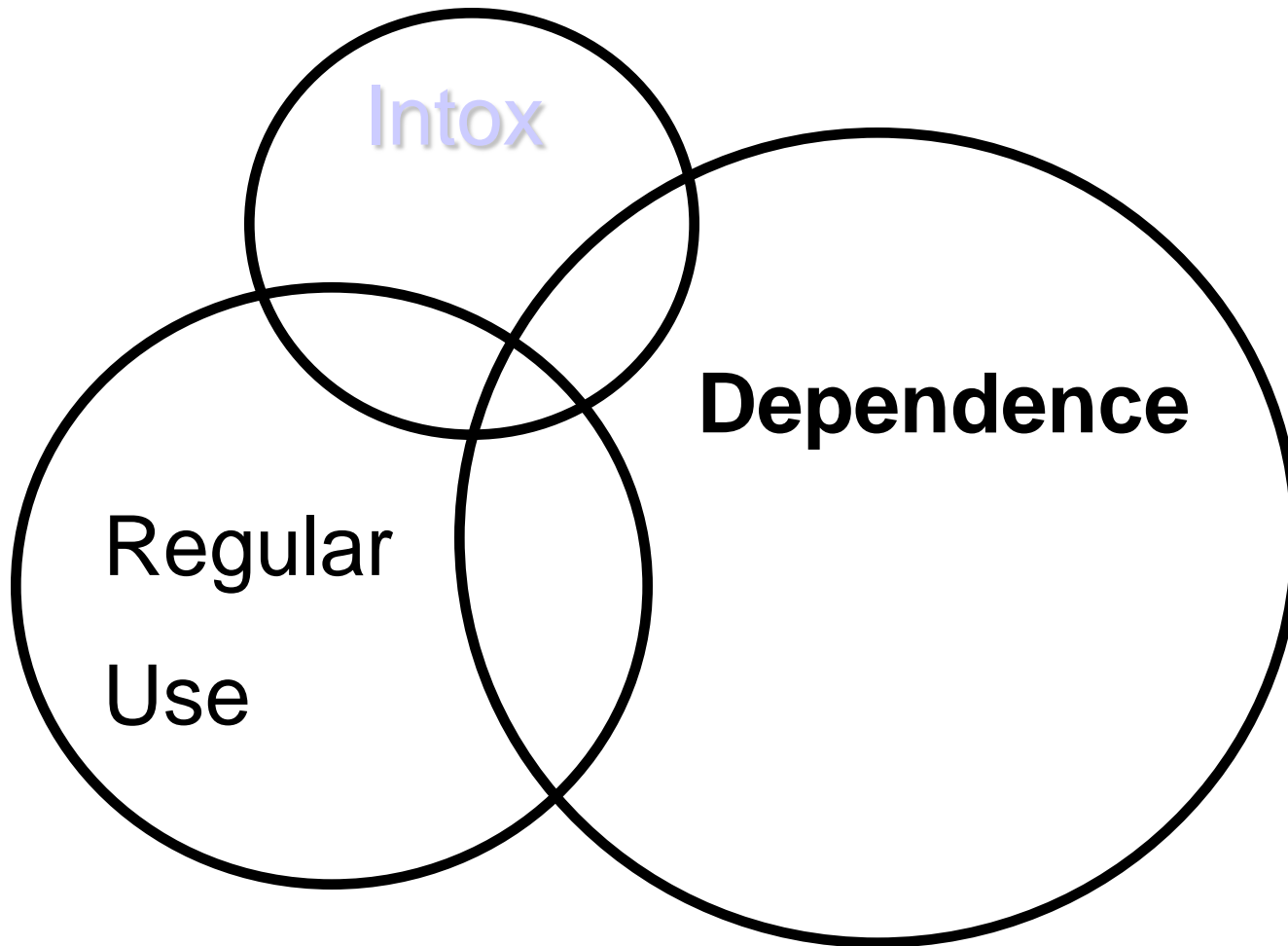
Organ Disease

Relationships

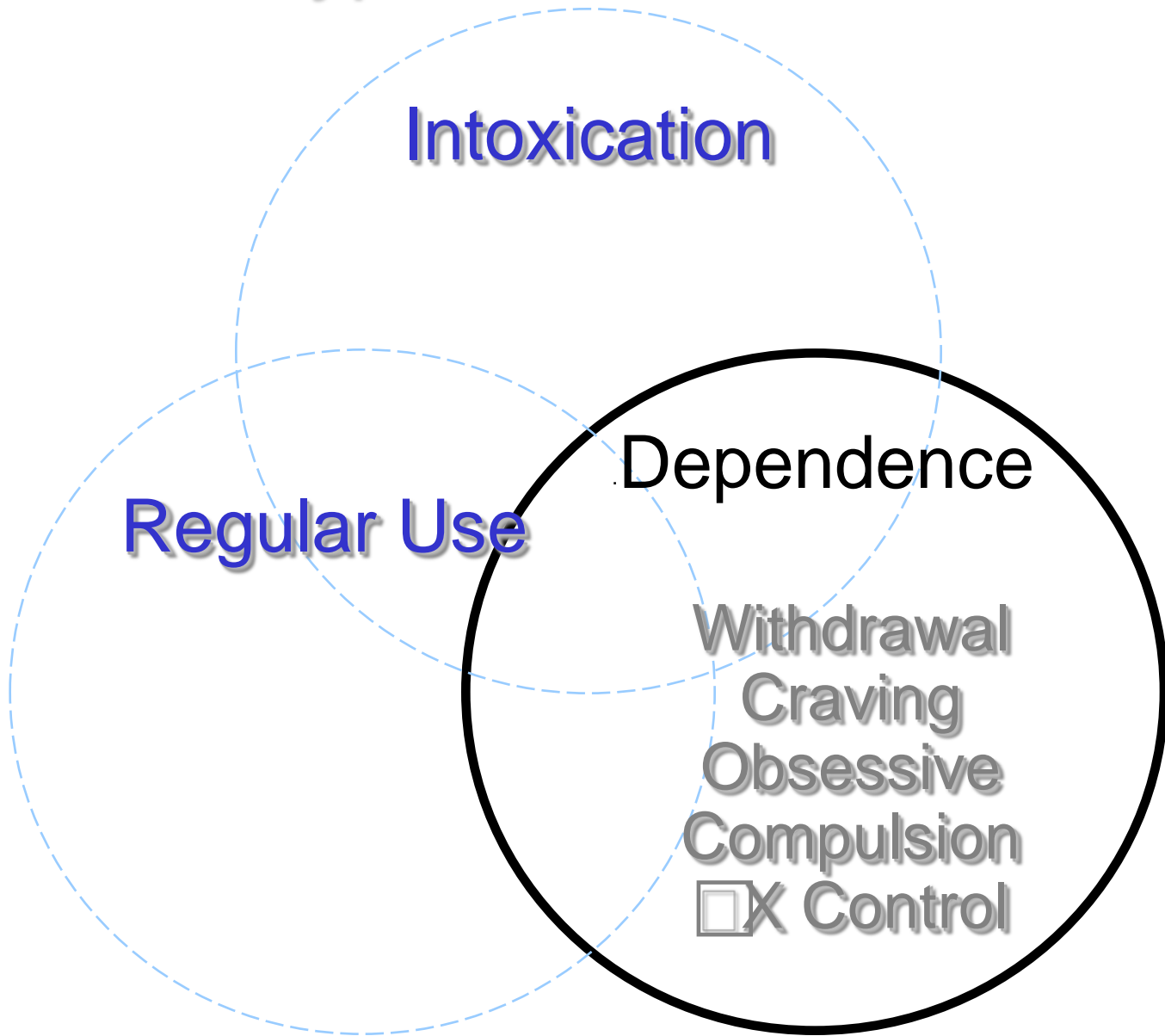
Financial

Types of Problems

Clinical Samples



Types of Problems

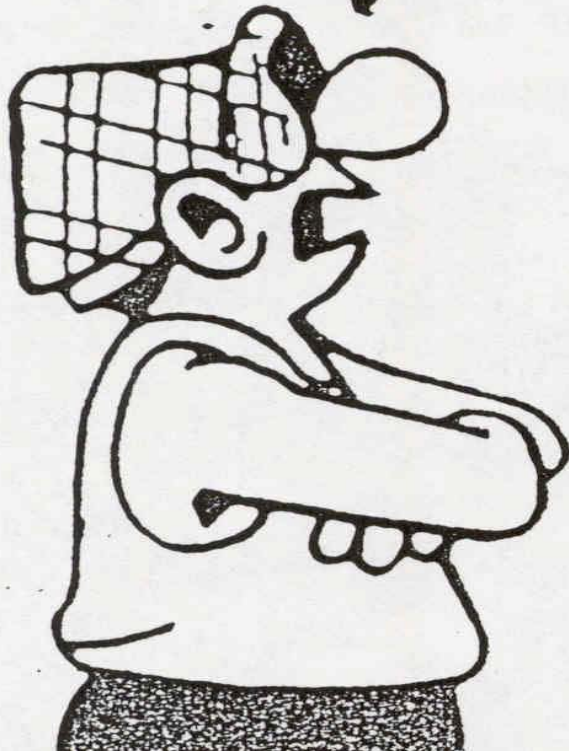


DEPENDENCE

- EXISTS IN VARYING DEGREES**
- IS USUALLY A LONG TERM PHENOMENON**
- 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 IS 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;

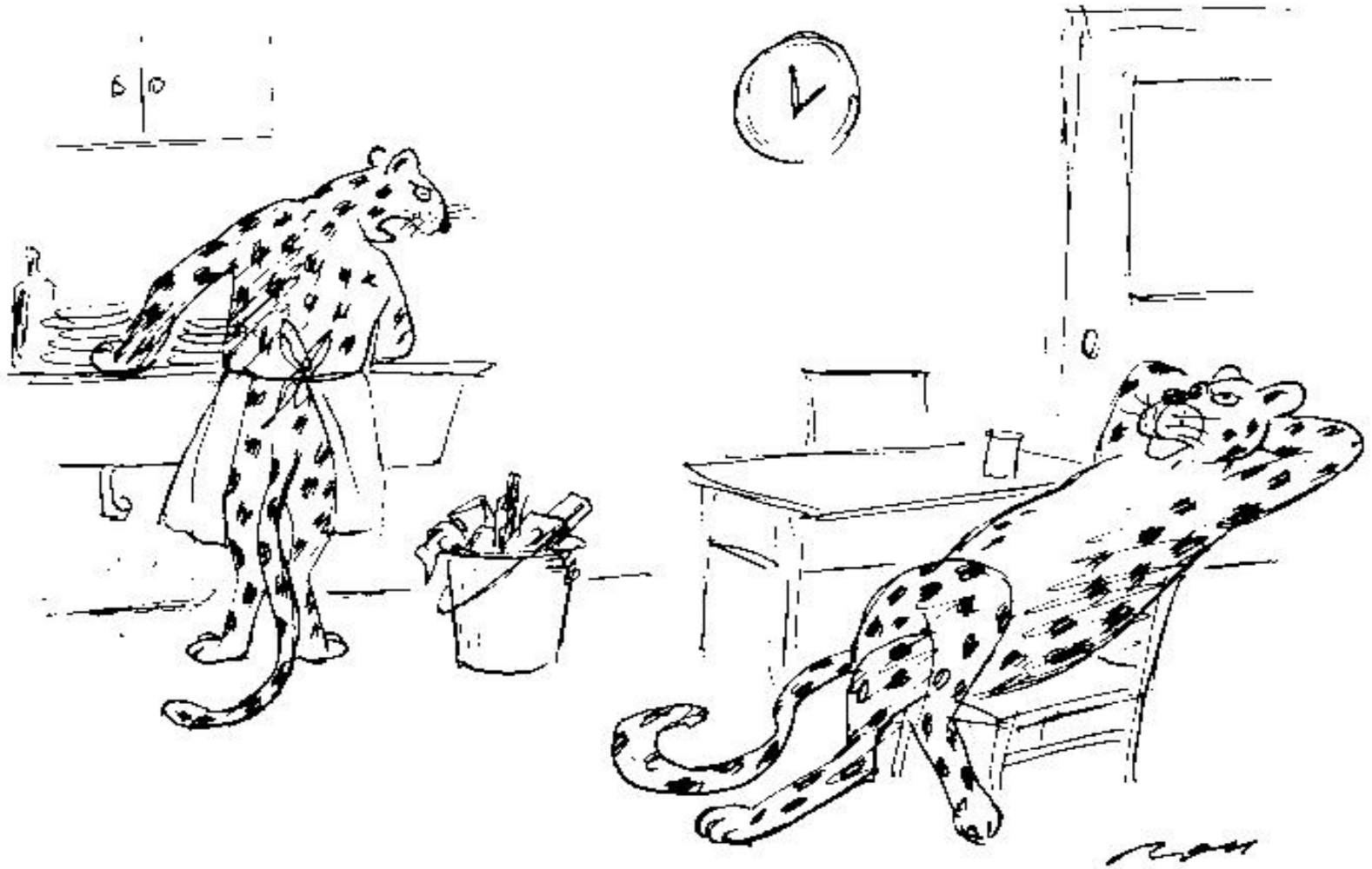
you can be addicted to some
substances and experience
minimum harms!



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

O'Brien CP, McLellan AT *Lancet* 347:237-240:1996.

| Dependence | Success rate |
|------------|--------------|
| Alcohol | 50 (40-70) |
| Opioid | 60 (50-80) |
| Cocaine | 55 (50-60) |
| Nicotine | 30 (20-40) |

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

Centre for Addiction and Mental Health. Managing Alcohol, Tobacco and Other Drug Problems:
A Pocket Guide for Physicians and Nurses. Draft May 17, 2001 ed. Toronto: University of Toronto;
2001.

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

op.cit. *Lancet*

| Disorder | Compliance & relapse | |
|-----------------|---------------------------------|--------|
| Diabetes | Medication regimen | <50% |
| | Diet & foot care | <30% |
| | Relapse | 30-50% |
| High BP | Medication regimen | <30% |
| | Diet | <30% |
| | Relapse | 50-60% |
| Asthma | Medication regimen | <30% |
| | Relapse | 60-80% |

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

CONSEQUENCE

| | | |
|---|-----------------|---|
| → | PLEASURE | → |
| → | PAIN | → |
| → | PURPOSE | → |

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

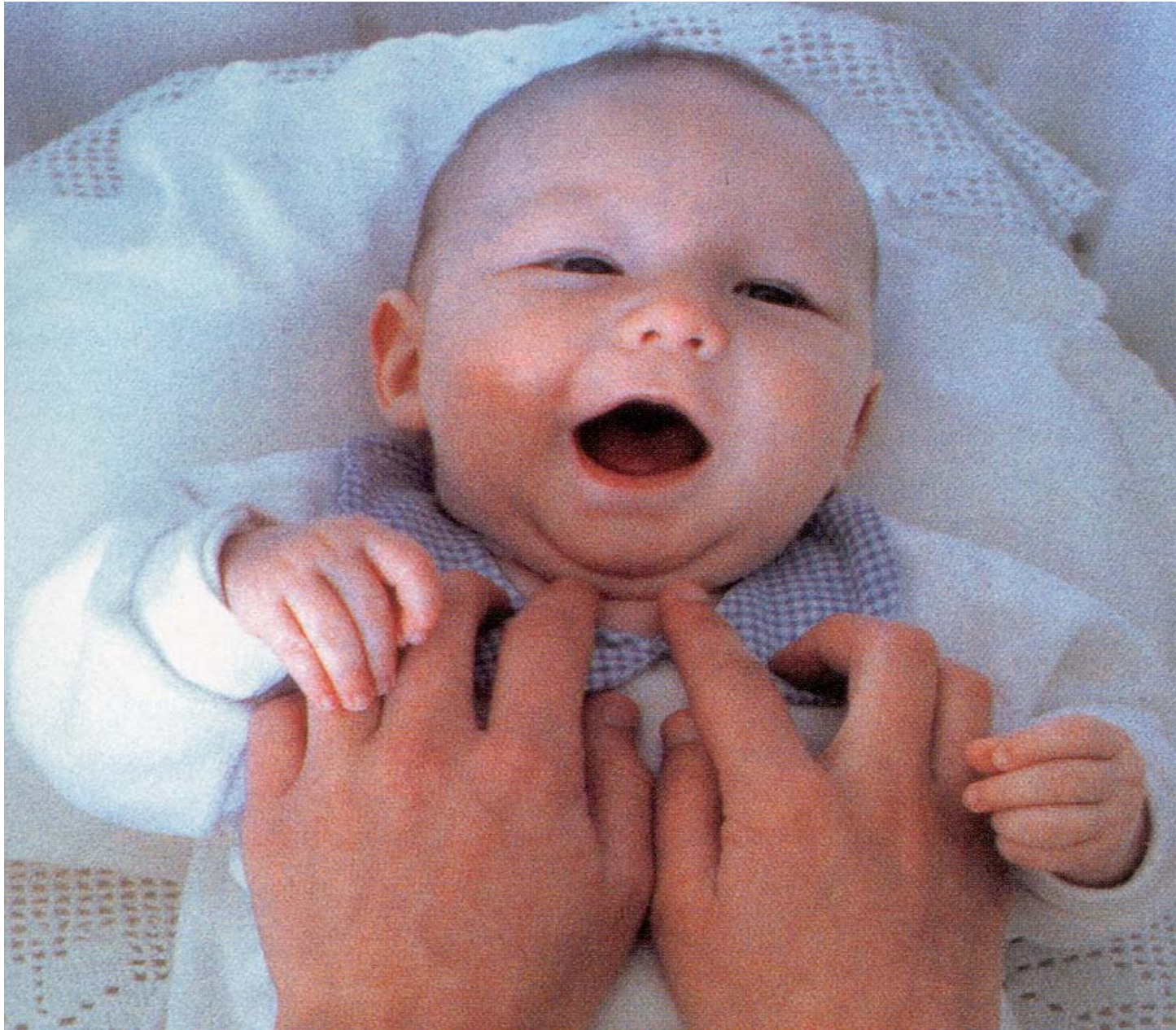
We need to simultaneously:

1. Lower people's vulnerability
2. Minimise harms associated with use
3. Prevent progression to dependence
4. Treat addicts
5. Address access and availability

END of EARTH 2
HOUGHTON 4



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

Risk and protective factors by prevalence

Risk factors

Protective factors

Community

- Perceived drug availability
- Favourable drug use norms
- Community transitions & mobility
- Community disorganisation

- Encouragement & reward for involvement
- Opportunity for community involvement

School

- Academic failure
- Low school commitment

- Opportunities and rewards for school involvement

Family

- Family conflict
- Poor discipline
- History of antisocial behaviour
- Poor management
- Favourable parental views on drugs and antisocial behaviour

- Family attachment
- Opportunities and rewards for family involvement

Peer individual

- Attitudes to drug use
- Friends' drug use
- Perceived risks associated with drug use
- Sensation seeking
- Attitudes to antisocial behaviour
- Rebelliousness

- Social skills
- Belief in the moral order

Anything I want to do is

illegal,

fattening, or

causes cancer in mice



Determinants of Social Order

| THE STATE | THE MARKET | THE COMMUNITY |
|-----------|---|---|
| Politics | Economics | Culture |
| Democracy | Global interdependence & free market forces | Post-modernisation & transnational homogenisation |

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
5. Get married later (21/23 yrs, 1970 – 28/30 yrs, 2005)
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)

Source: "Why don't physicians follow practice guidelines? Cabana et al JAMA, 282;15:1999

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.