

EXECUTIVE SUMMARY

PURPOSE

The purpose of the memorandum is to provide information that will lead to an understanding of the need that exists in correctional populations for the treatment of alcohol and drug use disorders.

REVIEW OF THE PROBLEMS

- Alcohol is the most used and abused drug in the nation
- Worldwide 5 percent of all deaths of young people between the age of 15 and 24 years were attributed to alcohol use and globally 140 million people are suffering from alcohol dependence
- The National Institute of Alcoholism and Alcohol Abuse estimates that 18 million people in the US have an alcohol use disorder.
- 100,000 Americans die of alcohol-related causes each year, making alcohol the third leading contributor to mortality related to lifestyle (tobacco is first and diet and activity patterns are second)
- Over 1 million American are heroin users and need treatment
- 36 million Americans abuse prescription drugs, mostly narcotics and benzodiazepines
- It is estimated that 60-80% of the offenders in jail, prison, probation or parole had drugs or alcohol involvement when the crime was committed.
- The cost to the nation is around \$185 billion per year in healthcare, lost wages and productivity

PRESENT SITUATION

There is no organized treatment with any standards, protocols or algorithms for the treatment of addictive disorders. Most programs utilize the 12-Step Model of recovery and eschew the use of any medications. The only exception to the use of medication is in the treatment of heroin addiction.

MEDICAL MODEL OF ADDICTION

Addictive disorders can be succinctly described as a disorder of the pleasure system of the brain. As such it is a 'brain disease' involving specific regions of the brain modulated by specific biochemicals called neurotransmitters. Neuroscience has further revealed that the pleasure activity is channeled through a common pathway leading to the acceptance of the 'gateway theory'. Any pleasure producing activity enters the brain through the same gateway by initially activating the same neurotransmitter and then cascading to other regions of the brain. Cravings, triggered by internal or external cues are part of the common gateway.

MEDICATIONS IN THE TREATMENT OF ADDICTIVE DISEASES

The history of medications in the treatment of addictive diseases is one of incredible ignorance and unrealistic expectation. The majority of the drugs that appeared to work spectacularly in the early stages of treatment ended up making the patients even more addicted to the 'antidotes'. Some of these drugs included morphine, heroin, LSD and benzodiazepines.

These and other similar drugs that give a patient a false sense of relief from the effects of the addictive drug are often powerfully addicting themselves. They are termed 'psychoactive' because of the propensity to cause a 'high' and behave similarly to addictive drugs. The clinical advantage of using psychoactive drugs is that the patients do not have to be detoxified, little or no training is required to administer them and the patients will remain in 'treatment' because any interruption will lead to withdrawal and intense discomfort.

The severe problems encountered in weaning patients off methadone convinced many researchers that psychoactive medications have a limited role in maintenance treatment. After a brief period of detoxification with psychoactive drugs the patients should be switched to non-psychoactive drugs during which they would receive relapse prevention therapy and ultimately return to society.

The criterion established to develop a non-psychoactive medication was quite rigorous yet scientists were able to identify naltrexone as the drug that met every one of the requirements. There were high hopes and expectations that the first non-psychoactive medication with impeccable profile of safety and efficacy would be a critical weapon in the treatment of addictions to opioids. The intrinsic characteristics of naltrexone required that patients be first detoxed from opioids before starting the medication. Additionally, patients taking naltrexone soon realized that they could discontinue taking the drug and experience no withdrawal or other symptoms.

The perceived difficulty in using naltrexone was labeled “does not work”. However it is used to treat motivated patients like physicians, pharmacists, airline pilots, etc. who faced a loss of license if the drug use was not curbed.

In 1994 naltrexone was approved as the first anti-craving medication for the treatment of alcoholism. It was also the first drug that worked inside the brain to attenuate cravings. The effects of naltrexone were radically different than Antabuse which was often seen as a punishment and did nothing to curb cravings. This time around the opposition to the use of naltrexone came from the AA groups like the Hazelden Foundations and the Betty Ford Institute. The opposition was rooted in the belief that alcoholism was a disease of the spirit and only the intervention of a higher power can help.

FUTURE MEDICATIONS IN THE TREATMENT OF ADDICTIVE DISORDERS

The difficulty in weaning patients off addictive drugs like opioids, benzodiazepines, etc. has led to the development of medications that have no addiction liability. The development of such medications was further facilitated by the progress made in understanding the complex interaction between neurotransmitters and receptors. The newer medications that have either been approved or close to approval are highly effective with zero abuse potential. These drugs include:

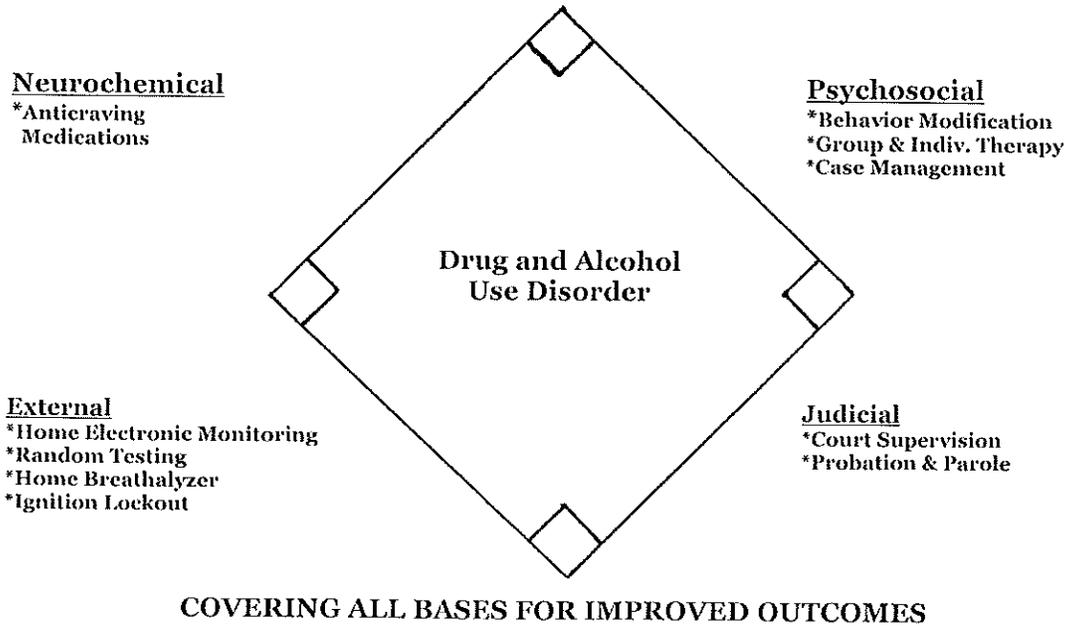
- Acamprosate
- Buprenorphine (low abuse potential)
- Nalmefene
- Ondansetron
- Topiramide
- Naltrexone

Unfortunately the competencies and skills required to use these non-psychoactive medications do not exist and there is little or no interest to learn more about these drugs.

THE ARCC PHILOSOPHY OF TREATMENT

Addictive disorders are primary, chronic and progressive medical diseases that have a strong behavioral component. Successful treatment is predicated on integrating medications and behavioral therapies to achieve the desired outcomes. Patients are required to be on maintenance medications for periods ranging 3-6 months and sometimes longer for behavioral modification to be effective. Only non-psychoactive medications have a meaningful role as maintenance medications. The treatment of other preexisting conditions like depression, PTSD should be treated concomitantly.

THE ARCC MODEL™ FOR THE TREATMENT OF ADDICTIVE DISORDERS



ARCC has field-tested the integrated program in a wide spectrum of patients and situations and the results have been consistently good. The field-tested programs include:

- Drug Courts
- Professional Groups
- Homeless Shelters
- General Population

THE FUTURE OF THE TREATMENT OF ADDICTIVE DISORDERS

Where we are

Treatment does not work

Medications have no role

Where we want to be

Integrated treatment works

Medications are critical for improved outcomes

More punishments

Integrated treatment is more effective than punishment

Drug Courts

Therapeutic Courts

High Recidivism

Reduced Recidivism

THE APPLICABILITY OF THE ARCC PROGRAM IN THE CORRECTIONAL SETTING

The pendulum has swung away from incarceration towards treatment. The severe budgetary crisis is forcing states to close prisons and release nonviolent drug and alcohol offenders early. The high rates of recidivism caused mainly due to alcohol and drug use when released on probation and parole is placing a higher burden on medical services. States and courts are looking for innovative programs that have high success rates. The ARCC program meets this requirement.

Successful outcome for clients in the correctional settings are contingent on the right blend of sanctions and incentives. The ARCC model encompasses all aspects necessary for successful outcome.

ARCC PRINCIPLES OF TREATMENT OF ADDICTIVE DISORDERS

- Medications are a critical element in the biopsychosocial treatment of addictive disorders
- Non-psychoactive medications should be the first line drugs used before switching to psychoactive drugs
- Treatment should be initiated during incarceration and continued during the parole/probation phase
- Address psychosocial issues as part of behavioral modification
- Concurrent treatment of co-existing mental illness
- Address quality of life and community integration like jobs, housing and family issues
- Treatment should be of sufficient duration – six months or longer
- Recovery is a long-term process and may involve multiple episodes of treatment. Non-psychoactive medications are critical for relapse prevention
- Right combination of sanctions and incentives to achieve desired outcomes