THERAPY AND PUNISHMENT: NEGOTIATING AUTHORITY IN THE
MANAGEMENT OF DRUG ADDICTION

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Throughout the twentieth century, many behaviors previously considered criminal or immoral were instead defined as medical problems. This process is often referred to as the medicalization of deviance. Like many other behaviors once considered deviant, drug and alcohol abuse has been medicalizing, in a process that accelerated during the latter half of the twentieth century. Despite this movement along the path toward medicalization, drug use, and alcohol use to a lesser extent, are still also sanctioned and managed by the criminal justice system, resulting in a medical-legal-moral hybrid definition of these issues. Today we find instances where these two institutions overlap significantly. At the same time, their mutual involvement in defining and managing drug use is inconsistent.

This research uses a qualitative research design to study how this medical-legal-moral hybrid definition of drug use and addiction is discussed and negotiated by various institutions that label and manage individuals who use drugs. I examined this issue by conducting interviews and observations in Philadelphia’s Drug Treatment Court as well as in two outpatient drug treatment programs. Results indicate that individuals in both settings frame addiction as a “disease,” although the definition is ambiguous and inconsistent. The court and the treatment programs use similar language and methods for assessing substance abuse and how to deal with it. Both also extend the definition of “addiction” to include aspects not directly related to the consumption of drugs or alcohol.
but to the “drug lifestyle” that includes selling drugs. Still, in neither location is a comprehensive, clear definition of “addiction” promoted and used consistently. This ambiguity results in an overlap of therapeutic and punitive methods to handle the individual’s drug usage. In addition, both settings benefit from their interaction and cooperation in managing individuals with substance abuse problems, indicating that rather than moving toward a purely “medical” way of dealing with substance abuse, or placing the issue more firmly in the realm of the criminal justice system, the current mix of moral, criminal and medical methods of labeling and managing substance abuse problems may be more stagnant than the medicalization of deviance thesis suggests.
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CHAPTER 1: ASSESSING THE MEDICALIZATION OF DRUG ADDICTION

Throughout the twentieth century, many behaviors previously considered criminal or immoral were instead defined as medical problems. This process is often referred to as the medicalization of deviance. Like many other behaviors once considered deviant, drug and alcohol abuse has been medicalizing, in a process that accelerated during the latter half of the twentieth century\(^1\). As a result, there appears to be broad public support for the idea that alcoholism and drug addiction are “diseases” or “illnesses.” For instance, a 1987 Gallup poll found that 89% of the American population agreed with the statement “alcoholism is a disease” (cited in Peele 1989). A poll conducted by the Pew Research Center in 2001 found that 52% of Americans believed that drug use should be treated as a disease, compared to 35% who favored treating it as a crime (cited in Lock, Timberlake and Rasinski 2002). In 2006, USA Today and HBO conducted a poll of randomly selected Americans who had an immediate family member with an alcohol or drug addiction. Seventy-six percent of the respondents indicated that “addiction is a disease,” with the vast majority of whom described addiction as both a physical and psychological disease (USA Today 2006). Additionally, alcohol and drug treatment often occur in what would be considered “medicalized” settings (hospitals, clinics), and may involve the prescription of pharmaceutical substances (such as Naltrexone for alcoholism or Methadone for opiate abuse). Many medical insurance plans will cover these treatment episodes, adding to the notion that alcohol and drug problems is a disease.

\(^1\) I reluctantly use the term “abuse” throughout the dissertation to describe the behavior that I refer to, recognizing that the term itself carries a moral condemnation of some sort. However, I am not attempting to confirm or refute the idea that a certain level of substance use constitutes abuse. By abuse, I am referring to...
Despite this movement along the path toward medicalization, drug use, and alcohol use to a lesser extent, are still also sanctioned and managed by the criminal justice system, resulting in a medical-legal-moral hybrid definition of these issues (Conrad 1992). Much drug use is illegal and alcohol use could also involve illegal activity or invoke moral judgments (for instance, driving while intoxicated or women drinking alcohol while pregnant). The existing stigma around drug use (part of which exists because of its legal status) also contributes to a “moral” framework in which society classifies drug users as “bad people.” Additionally, with the development of drug treatment courts, and other programs for offenders with drug or alcohol problems, diagnosing and managing drug use occurs in both the criminal justice system and the drug treatment facility. Today we find instances where these two institutions overlap significantly. At the same time, their mutual involvement in defining and managing drug use is inconsistent. One who is arrested for selling or possessing drugs is sometimes eligible to be sent to a treatment setting rather than jail (through a program such as drug treatment court), or possibly released early from jail to be treated in such a setting. Still, others will spend time in jail for drug-related crimes and receive no substance abuse treatment whatsoever.

This research uses a qualitative research design to study how this medical-legal-moral hybrid definition of drug use and addiction is discussed and negotiated by various institutions that label and manage individuals who use drugs. I examined this issue by conducting interviews and observations in Philadelphia’s Drug Treatment Court as well
as in two outpatient drug treatment programs. Results indicate that individuals in both settings frame addiction as a “disease,” although the definition is ambiguous and inconsistent. The court and the treatment programs use similar language and methods for assessing substance abuse and how to deal with it. Both also extend the definition of “addiction” to include aspects not directly related to the consumption of drugs or alcohol but to the “drug lifestyle” that includes selling drugs. Still, in neither location is a comprehensive, clear definition of “addiction” promoted and used consistently. This ambiguity results in an overlap of therapeutic and punitive methods to handle the individual’s drug usage. That is, in both a criminal justice setting (the court) and a “medicalized” setting (a treatment program), the medical, legal and moral frameworks interact in various ways. In addition, both settings benefit from the interaction and cooperation between the criminal justice system and the treatment establishment in managing individuals with substance abuse problems, indicating that rather than moving toward a purely “medical” way of dealing with substance abuse, or placing the issue more firmly in the realm of the criminal justice system, the current mix of moral, criminal and medical methods of labeling and managing substance abuse problems may be more stagnant than the medicalization of deviance thesis suggests.

The Social Construction of Disease Categories

“A disease is no absolute physical entity but a complex intellectual construct, an amalgam of biological state and social definition” (Rosenberg 1962, 5).

The above quotation is from Charles Rosenberg’s widely influential study, The Cholera Years, in which he documented the various explanations people gave for the
causes of cholera during three epidemics in the 19th century. During the 1832 and 1849 epidemics, the disease was framed in very moralistic terms; those who contracted the disease were seen as sinners, of weak character, and indulgent in vices (Rosenberg 1962). It was a period of time when the status of the medical profession was fairly low, when both doctors and lay people did not view diseases as specific entities outside of the individual, and when there were rudimentary treatments to deal with disease. By the 1866 epidemic, however, the general consensus on how diseases were contracted and how they manifested within the body had changed markedly. By the time the third epidemic occurred, most people believed disease to be an entity that could be distinguished from both the individual sufferer and other diseases. Disease was no longer a judgment from God, but often environmental in origin, and could be isolated and treated. While changes in scientific understanding certainly had a large contribution to this shift in how people thought about disease, they were not the only factors. This shift in thinking about disease reflected broader shifts in society, where people were increasingly separating the spiritual world from the physical one and placing more faith in scientific reasoning.

Rosenberg focused on these cholera epidemics to illustrate how concepts of disease reflect larger social and cultural values. Disease categories are never stagnant; they are constantly being negotiated within the medical establishment, within other institutions in society, and between the medical establishment and other institutions. This is perhaps most evident today when we examine behaviors or events that are currently labeled as “diseases” and are treated medically, although they do not have a clearly understood biological or physical progression. In many of these instances, the concept of
disease in the United States has been expanded to capture many behaviors previously viewed as immoral or criminal. This process, by which a negatively-viewed behavior previously interpreted in religious, legal, or moral terms becomes re-defined and treated as primarily a medical problem has been called the medicalization of deviance (Conrad and Schneider 1980).

The Medicalization Thesis

In this section I will first very briefly describe the concept of medicalization, illustrating some of the important research that initially developed the concept. I will then elaborate on one aspect of medicalization, the medicalization of deviance, paying particular attention to the partial medicalization of drug and alcohol abuse. Finally, I will conclude with a general critique of the conceptualization of the medicalization of deviance and explain how this dissertation contributes to a better understanding of that process because of its micro-sociological focus.

Sociologists do not necessarily agree on a precise definition for the term “medicalization” and its meanings have evolved over time. While current research tends to utilize Conrad and Schneider’s (1980) notion of medicalization, earlier use of the term suggests that it was originally thought of as a much broader concept. One of the first to theorize about the topic, Eliot Freidson (1970), emphasized that medicine was constantly seeking to uncover and control things that it considered socially undesirable. The use of a medical label for a problem gave the medical profession license to control it. Similarly,

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2 The term itself is now often used as a critique of medicalization (i.e., a suggestion of overmedicalization), rather than simply as a neutral term describing the increasing authority of the medical profession in our daily lives.
Irving Zola (1972) saw medicalization as a “process whereby more and more of everyday life has come under medical dominion, influence, and supervision” (495). Renee Fox (1977) elaborated on this idea, citing several social trends that exhibited the increasing medicalization of American society: the increasing technology used in medicine, the increasing political interest in health-related matters, the increasing preoccupation with bioethical issues, the large numbers of young people attempting to enter the medical profession, and the expansion of disease categories to include behaviors or life events not previously viewed as medical in nature. It is this last aspect, the expansion of disease categories to capture deviant behaviors and other life events, that Peter Conrad and Joseph Schneider (1980) focused on when using the term “medicalization” in their classic book *Deviance and Medicalization: From Badness to Sickness*. While I agree with some aspects of their conceptualization of medicalization, in this study I also challenge their notion in several important ways.

Conrad and Schneider (1980) note that a behavior or event can be medicalized on three different levels: (1) on a conceptual level, medical terminology is used to define a problem; (2) at the institutional level, organizations may take a medical approach in treating a problem over which it already had control; and (3) at the interactional level, physicians directly treat the problem as a medical one. In all three levels, medical professionals have different roles, and may not be principally involved in defining or

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3 Conrad first used the term medicalization in a 1975 article and said that it was “defining a behavior as a medical problem or illness and mandating orlicensing the medical profession to provide some type of treatment for it” (12). This initial formulation led to a fuller explanation of the concept in his 1980 work with Schneider.

4 Conrad and Schneider (1980) do not attempt to evaluate whether or not a medical designation is “really” medical, and neither do I. My focus is on understanding how partial medicalization is negotiated and defined on a day-to-day basis in the locations where it is managed institutionally.
treating the problem. In a later article, Conrad (1992) updated the concept of medicalization to include many different processes and outcomes. As a result, he broadly defined medicalization as:

“defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession” (211).

Conrad also suggests that there are degrees of medicalization; the extent of medicalization varies across different behaviors and produces different outcomes. This updated definition leaves open the exact role of the medical profession in defining and treating the newly-defined “medical” issues. This is an important clarification since sometimes the medical profession is not directly involved in the medicalization process. Later, he elaborated on what he called the “shifting engines” of medicalization and emphasized that medicalization in the 21st century is often the outcome of forces such as consumers’ desire for a medical designation, the managed care industry, and changes in biotechnology, such as the increasing power of pharmaceutical companies (Conrad 2007).

Medicalization, in this sense, has been widespread in American society for several reasons. Many see it as part of a larger process of secularization, in that the medical establishment has replaced the role of the church and the law in defining what is “proper” behavior (Freidson 1970, Conrad and Schneider 1980). Although not all medicalized behaviors have advanced in this progression, there has been a tendency to move from sin to crime to illness in categorizing and treating a variety of behaviors (Fox 1977). The
philosophy and ethic of American individualism and an increase in rationality also created a fertile environment for the explanation of behaviors and experiences in medical terms. Western medicine’s attempt to promote more humanitarian solutions to problems was also a powerful force in the medicalization of certain behaviors (Freidson 1989).

While these are all plausible explanations for the medicalization of many behaviors, it is necessary to stress how important the medical profession itself has been in the medicalization process. Medicalization would not have been as widespread without the success of the medical profession in increasing its power and prestige, thereby enforcing its “expertise” over all areas that can be perceived as medical in nature (Starr 1982, Freidson 1989).

Medicine became a dominant and prestigious profession during the twentieth century (Starr 1982). The claimed success of the medical profession in explaining the etiology of and treating infectious diseases gave the profession a powerful position in American society. It was of little surprise, then, that medical professionals attempted to further their jurisdiction into other areas—specifically those that were not previously considered medical issues. As a result, medical practitioners have claimed the authority over not only a person’s physical, but also that person’s psychological and social, well-being. Medicine’s expert control over technologically-advanced procedures and treatments, as well as its increasing use of genetic research to trace the possible causes of certain diseases and behaviors, has fueled further interventions by medical professionals into defining and treating these more contestable areas (Ragoné and Willis 2000, Conrad 2000).
Because of the prestige and power of the medical profession, sociologists often describe the increasing medicalization of American society as a form of social control (Conrad 1992, Freidson 1970, Zola 1972). That is, medicine continues to exert itself into other areas of life in order to legitimize its powerful position in society as well as to be the official gatekeeper of what social behavior will be considered acceptable. Utilizing labeling theory, sociologists show how the more powerful groups in society can label the behaviors of those less powerful as “deviant” even if the less powerful groups do not regard their behavior as illegitimate (Becker 1963). Similarly, medical professionals can label an undesired condition an “illness” and create a new meaning of the issue for both the person who has the affliction as well as for society in general. Talcott Parsons (1951) wrote extensively about medicine as an institution of social control. Having any illness, according to Parsons, is a form of deviance. What the medical establishment defines as disease, then, is always a reflection of what is considered undesirable in society (Armstrong 1987, Conrad and Schneider 1980). In this respect, the medical profession is an institution of social control, since it can legitimate the deviant label inherently attached to illness, through the application of the “sick role” (Parsons 1951). Parsons contended that to be “sick” was to take on a new social role. One of the legitimizing criteria for being able to take on the “sick role” was a general notion by the population that it was not the person’s fault that he/she was sick. However, to sustain that legitimacy, the person must also demonstrate that he/she was trying to get better, such as by visiting a doctor, taking medication, or seeking some other socially approved treatment method. If the person was perceived to be taking responsibility for his/her illness, then he/she would be
granted the sick role status and would not generally receive any moral condemnation for contracting the illness (Parsons 1975).

It is important to note, however, that medicalization is not always a top-down process, where the medical profession imposes its new medical label on a behavior or event without the consent of the general population. Ballard and Elston (2005) argue that the earlier descriptions of medicalization over-emphasized the medical profession’s desire to expand its own dominance and underplayed the benefits of medicine that people perceived. Indeed, there are many instances in which patients themselves demand that a medical label be attached to their condition (Freidson 1989). For example, Vietnam Veterans actively persuaded psychologists to diagnosis them with Post-traumatic Stress Disorder and those suffering from Chronic Fatigue Syndrome sought the medical label to legitimize their illness (Scott 1990, Aronowitz 1992, Mechanic 1995). Some may desire the medical label to help make sense of their problem and to legitimize their “sick role” status. Alcoholics Anonymous, founded in 1935, promoted the idea that alcoholism was a progressive disease, even before the medical establishment had universally agreed that it was a medical problem (Schneider 1978). Many of the subsequent notions about alcoholism as a progressive disease have come from this early definition proposed by Alcoholics Anonymous. These examples show that the medical profession is sometimes only marginally involved in the process of medicalization. When describing medicalization, then, it would be inaccurate to suggest that it is always a result of the increasing desire of medical professionals to exert social control.

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5 A recent event reminded me of this phenomenon when I saw a commercial for a medication to treat fibromyalgia. Part of the marketing of the drug included a reminder to the viewer that fibromyalgia was a “real” condition that could be effectively treated.
Medicalization can have both positive and negative consequences. While it may be viewed as a humanitarian way of dealing with a problem, medicalization incorporates the notion that the source of many social problems lays in the individual, and as a result, depoliticizes the problems (Zola 1972, Conrad and Schneider 1980, Fox 1989). Just as treating the problem as sinful or criminal locates the problem at the individual level, medicalization contributes to the increasing neglect of social, economic, political, or environmental issues that may be related to certain problems. Medicalization may in fact exacerbate this process, since when the problem is perceived to be a medical one, people will most likely grant the authority of dealing with the problem to the medical, or quasi-medical, professional. While the larger community is at least somewhat involved with the criminal justice system, and has worked in the past to change what it views as “unjust” laws, medical professionals have almost uncontested authority in dealing with problems designated as medical (Starr 1982).

The Medicalization of Drug and Alcohol Problems

Labeling somebody “sick” immediately changes his/her role in society (Parsons 1951). One of the consequences of medicalization has been the extension of the sick role to more people and to a broader range of behaviors than in the past (Fox 1989). Drug and alcohol addiction is an example of something that can be considered “medicalized” to an extent. As Conrad (2007) points out, considering something medicalized involves the possibility of one or multiple characteristics. Using his conceptualization, I agree that drug addiction is medicalized at all three levels in various moments: at the conceptual level, medical language is used to describe the problem, at the institutional level, there
are medical facilities designated as drug treatment centers, and at the interactional level, doctors prescribe pharmaceuticals to treat it. As I cited earlier, the public largely considers addiction to be a “disease.” That the latest Diagnostic and Statistical Manual (DSM-IV) outlines several different diagnoses that can be given to alcohol or drug problems (from abuse to dependence) also lends support for the argument that alcohol and drug problems have been medicalized (as mental health disorders). Powerful institutions, like the National Institute on Drug Abuse (NIDA) and the National Institute on Alcoholism and Alcohol Abuse (NIAAA), also strongly support a medical view of addiction, as evidenced by the types of projects they seek and fund. At the institutional level, treatment for addiction occurs in medicalized settings, which involve psychotherapy, counseling and medications. Even self-help groups, like Alcoholics or Narcotics Anonymous, promote the idea that addiction is a “disease.”

The treatment approach to substance abuse may have been a move toward a more sympathetic and less punitive way to deal with the problem (Akers 1992). This medicalization of drug and alcohol problems may have eliminated some of the stigma associated with the behaviors. The large number of self-help groups, where everything from gambling to credit card debt has become an “addiction”, could be evidence that the “addict” label is becoming less stigmatized (Valverde 1998). Whether or not the sick role is fully granted to persons in treatment for substance abuse, however, has not been adequately discussed. For instance, two of the obligations that a person must fulfill in

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6 Some who attend formal treatment programs might also supplement their treatment by attending self-help group meetings outside of the treatment program. Appleton (1995) has suggested that these 12-step programs, since they do incorporate notions of the disease concept into their explanation of addiction are not antithetical to more “medicalized” treatment, but rather should be considered as examples of alternative medicine.
order to be given the sick role status are that he/she first must designate the problem as undesirable and then must also seek treatment for it (Parsons 1951). If a person is court-mandated to attend drug or alcohol treatment, as many in treatment today are, he/she might not fulfill those obligations to be granted the sick role. The person in treatment’s movement into the sick role, then, might depend on the background of the individual and the source of his/her referral into treatment.

While various theories of drug and alcohol addiction continue to exist, the current director of NIDA, Dr. Nora Volkow, a research psychiatrist, has been quite successful in promoting the view that addiction is a “brain disease” to both the medical community and the wider society. Her research uses imaging technology to illustrate how drugs affect certain areas of the brain, causing damage and leading to the user’s inability to control further drug use (NIDA 2008). She indicates that the same effects are produced by a variety of different substances (heroin, cocaine, marijuana), and might even extend to a broader concept of “addiction” that does not just involve illicit drugs or alcohol. For instance, she and her colleagues found similar results in brain images of obese, “pathological” eaters (Volkow 2007). She explained in a 2006 radio program on National Public Radio (“Talk of the Nation”) that this broad notion of addiction could lead to the eventual production of medications that would not be addiction-specific:

“What we’re starting to recognize is that there may be medications…if you’re developing a medication, you don’t necessarily need to address it [as] a medication for cocaine addiction, but rather a medication for addiction, in general. And then you can start to recognize that, indeed, the market could be very large” (NPR 2006).

She also mentioned, however, that the pharmaceutical companies were not actively researching and developing such medications. She cites the stigmatization of drug
addiction as one possible reason, recognizing that people might be reluctant to take such drugs and therefore would not produce a profit for the pharmaceutical company. This apparent lack of interest by pharmaceutical companies to develop medications to treat “addiction” also has implications for the medicalization process, since Conrad (2007) argues that pharmaceutical companies are one of the chief mechanisms that drive further medicalization.

Still, Volkow has been very successful in the transmission and acceptance of the “brain disease” concept. One example of her success in promoting this theory of addiction was a 2007 Senate Bill introduced by Senator Joe Biden (D-DE) called the “Recognizing Addiction as a Disease Act” that would change the name of NIDA to the National Institute on Diseases of Addiction and change NIAAA to the National Institute on Alcohol Disorders and Health. The co-sponsors of the bill argued that the name change was necessary to reflect the “reality” that “addiction is a neurobiological disease” (Szalavitz 2007). Their framing of addiction and comments about the name change were almost identical to published statements by Volkow found on NIDA’s website.

Problems with the Medicalization of Deviance Thesis

Despite the movement toward further medicalization of drug addiction, the criminal justice system still has a very crucial role in the management of those who use drugs. During the 20th century, while the “disease” view of addiction became more widely accepted, there was also the increasing criminalization of drug use, with harsher penalties attached to drug-related crimes. The “War on Drugs,” since its official
beginning in 1971, has led to additional funding for both drug treatment and the 
incarceration of those arrested for drug-related offenses. During the 1980s, in the height 
of the United States’ “War on Drugs,” it was estimated that 1.2 million suspected drug 
offenders were arrested each year, most often for simple possession or petty sale 
(Wisotsky 1992). Drugs are often involved in other types of offenses. In 2004, 18% of 
federal prisoners indicated that they committed their current offense to get drugs (Bureau 
of Justice Statistics 2004). The 2003 survey conducted by the Arrestee Drug Abuse 
Monitoring Program found that 74% of those sampled tested positive for drugs and/or 
alcohol within 48 hours of their arrest (Zhang 2003). Currently, the way we deal with 
drug abuse combines elements of medicalized treatment and criminal penalties. 
Depending on the crime, a person might be sent to treatment rather than to prison. 
However, many are still incarcerated for problems related to drug use. Some of those 
who are sentenced to jail might leave early to attend drug treatment programs. As a 
result, there are no real clear indications as to when the problem is a criminal one and 
when it is a medical one or why it is often handled as both. Thus, there is much more 
institutional overlap between the criminal justice system and the medicalized treatment 
establishment than the medicalization thesis suggests.

Existing research on the partial medicalization of drug and alcohol problems tends 
to concentrate on the macro-level factors that have either promoted or stalled the 
medicalization process (Conrad 2000, Conrad and Schneider 1980, May 2001, Appleton 
1995). This body of research often implies that the medical-moral-legal hybrid definition 
would play out differently in different realms. That is, in the courts, drug abuse would be

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7 As of May 3, 2008, the bill was still in committee.
considered a legal problem, by some religious groups it would be considered a moral problem, and in substance abuse treatment settings it would be considered a medical problem. Yet, Peyrot (1984) has argued that these different aspects (legal, moral, medical) can intertwine in the same setting. For instance, in some prisons, inmates who were convicted of a drug-related crime might undergo substance abuse treatment (possibly in individual counseling or group therapy). In this setting, then, a person would be receiving mixed messages- that the problem is not really his/her fault, but that he/she is still going to be legally punished for the “illness.” It would be reasonable to assume, then, that in all contexts this hybrid definition would need to be negotiated. One would most likely not simply subscribe to one component of the definition in one realm and another component once he/she enters a new realm. For instance, we would not expect that somebody who had spent time in jail for purchasing heroin, but who is currently receiving methadone for heroin addiction in a treatment program, simply replaced a criminal framework with a medical one without some negotiation within himself/herself and between himself/herself and the treatment facility.

This could be further emphasized by the fact that sometimes treatment providers are resistant to a more medicalized view of drug and alcohol problems. The utility of pharmacological treatments, such as methadone or naltrexone, has been debated heavily not just among medical professionals, but among treatment providers and those in treatment as well (Volpicelli and Szalavitz 2000, Rychtarik et al. 2000). Inherent to this debate is the idea that pharmaceuticals might replace one drug addiction with another. Even if the drugs are considered to be non-addictive, there is still often resistance to using them in treatment. The regulations around the prescription and distribution of
pharmacological treatments are also very extensive. The idea that addiction might be a moral choice creeps into these debates about whether or not pharmaceuticals should be used to treat alcohol and drug problems (Volpicelli and Szalavitz 2000). If addiction is perceived to be a matter of self-control, then those who still abuse drugs and alcohol are perceived to have a character weakness or a moral or spiritual problem. From this perspective, using medications to alleviate craving or withdrawal would be seen as cheating or making the process of overcoming drugs and alcohol too “easy.”

Another shortcoming of the literature that describes the medicalization of deviance process is that it often treats the situation as either-or, that is, the research describes the transition of how the behavior went from being labeled as “deviant” to it being considered a medical problem. These descriptions often overlook the idea that medicalization needs to be viewed instead as a continuum and that certain behaviors even if medicalized to some extent could still retain characteristics of deviant behaviors. Even studies that recognize that “partial” medicalization occurs tend to understate the ongoing negotiation of competing frameworks and definitions that must occur on a daily basis among those “treating” the problem.

Even those who recognize that the degree of medicalization is a continuum often minimize the complexity of the issue. Conrad (1992), in trying to emphasize that there are degrees of medicalization, categorizes some behaviors as having been almost completely medicalized (such as alcoholism or schizophrenia), while others have only been minimally medicalized (such as sexual addiction). Opiate addiction, according to

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8 Rosenberg (2006) offers a similar critique of the medicalization thesis, arguing that Conrad’s notion, even updated, is overly simplistic.
Conrad and Schneider (1980), is categorized as a behavior that was medicalized in the beginning, then became criminalized, and was later “re-medicalized” to an extent with the development and funding of methadone maintenance treatment. While this might be accurate in describing some major shifts in dealing with people who use opiates (such as heroin or morphine), it would be incomplete to simply attach the label “medicalized” or “criminalized” to different time periods. If we want to understand exactly what it means for something to be considered a “medical” problem or a “disease” then we need to have a more nuanced understanding of how such terminology gets used and what exactly “treatment” looks like. Even though something is considered a “disease,” it might still retain aspects of the hybrid definition, even in the treatment realm.

In attempting to clarify the concept, Conrad (1992) is still implying that the process of medicalization has a beginning and an end. His example of sexual addiction is used to illustrate the stages of medicalization, suggesting that either this problem is in an early stage and will eventually become fully medicalized (and thus become accepted by the society at large as a medical problem) or that it will not progress along the continuum and instead start to move towards becoming demedicalized. This study challenges this notion that the process of the medicalization of deviance has a beginning and an end. By studying a problem that has been partially medicalized (drug and alcohol abuse), I illustrate that the medicalization of deviant behaviors is an on-going process that involves the continuous negotiation and renegotiation of the medical label with other competing conceptual frameworks that still exist. I also demonstrate that the current medical-legal-moral hybrid conceptualization of drug addiction could be a permanent state because of the cooperation among the institutions in each part of that designation.
One of the most significant problems with Conrad’s conceptualization of medicalization that this dissertation addresses is the continuing importance of responsibility for an individual whose behavior has been “medicalized” to some extent. Conrad (2007) says:

“One social implication of increased medical social control is that more forms of behavior are no longer deemed the responsibility of the individual. That is, when the cause is seen as biological and subject to ‘medical excuse,’ the individual is no longer considered responsible for the behavior. The social response moves from being punitive to being therapeutic... While in many cases (as with alcoholism or drug addiction) this may be a more humane approach, it also extends the range of behaviors for which people are no longer considered responsible” (152).

Results from my observations and interviews in drug treatment programs and the drug treatment court challenge this assertion. Rather than the therapeutic replacing the punitive, I will show that we actually have an overlap of the two in both philosophy and institutional practice. Responsibility plays a continuingly important role while a person is in drug treatment, whether or not he/she was referred from the criminal justice system. Because the person had to initially ingest what society classifies as a dangerous and illicit substance, the person, even when labeled “sick,” is never able to shed his/her own responsibility for their “disease.” In many ways, this allows the criminal justice system and the treatment establishments to co-exist and even cooperate since both then view the person in treatment as responsible for their current predicament and for moving beyond it.

Another related shortcoming of the existing literature on medicalization is that it tends to focus on macro-level processes and minimizes or ignores the micro-level factors that contribute to the medicalization process. For instance, those who discuss the process
of medicalization often focus on the social and political institutions, or social movements, that contributed to the new medical definition for the behavior. Researchers often trace the development of “claims-making” activities, such as medical “experts” publishing about the issue in journals and framing the debate about the definition of the issue (Epstein 1996). Indeed, “moral entrepreneurs” are important in the medicalization of an event or behavior (Becker 1963). This body of research is useful for understanding how a problem gets redefined as a medical issue in a broad, general sense. However, there is very little research on the micro-level processes that operate within the treatment or court setting, where the definition and management of “addiction” must be continuously negotiated among the multiple conceptualizations that exist. Thus, it is not really understood how a medicalized definition is negotiated with other views of the problem while in settings that label and manage drug addicts. One exception is Rossol (2001) who, by using a symbolic interactionist perspective, focused on how gambling problems get defined as medical problems in Gamblers’ Anonymous meetings. Such research on the medicalization of deviance, however, is quite rare. As a result, it is not fully understood to what extent other problems, such as substance abuse, are medicalized conceptually at the level of treatment and how “medicalized” the treatment actually is. For instance, a behavior such as drug or alcohol addiction still has moral and criminal implications. Acceptance of a medicalized view of addiction might not be so clear-cut at the level of treatment, even if most Americans believe that it is a medical problem in a general sense. This dissertation will attempt to contribute to a more nuanced understanding of the medicalization process by showing how macro-level views of a problem translate to the micro-level in both drug treatment and criminal justice settings.
While drug and alcohol problems are often conceptualized as “diseases” and this characterization is the result of a movement toward medicalization, this dissertation explores what exactly a “medicalized” definition of addiction means in the organizations that label and manage addicts.

Plan of the Dissertation

The arrangement of the dissertation chapters is as follows. In chapter two, I examine the history of drug policy in the United States, with particular attention to the 1970s forward, after the birth of the “War on Drugs” in 1971. Drug policy has consistently overlapped two dimensions of managing drugs – treatment and law enforcement. Only by understanding the evolution of that policy do we fully understand the current relationship between treatment programs and the criminal justice system and how this relationship relates to broader conceptualizations of drug problems. In chapter three, I present the treatment landscape in Philadelphia and describe criminal justice initiatives that include drug treatment. I also discuss my methodology in that chapter. Chapters four, five, and six present my main findings and analysis. Chapter four is devoted to Philadelphia’s drug treatment court program and how addiction gets framed and managed in that setting. In chapter five, I illustrate the same issues around the labeling and management of addiction in two different drug treatment programs. In chapter six, I expand on the ambiguity of the addiction label in these settings and introduce the concept of therapeutic punishment, a term I use to describe the overlap of therapy and punishment in all of these settings. Finally, in chapter seven, I revisit my original research questions and synthesize my main findings in an effort to expand our
understanding of how the medicalization of deviance process works on a day-to-day basis. I also discuss the broader implications of this research and its limitations.
CHAPTER 2:
THE WAR ON DRUGS AND THE TREATMENT OF ADDICTION

This chapter will provide background on various drug policies enacted by the United States government as well as on the history of addiction treatment in the United States. While historians, physicians and sociologists have written about these two topics, there has been very little analysis of the relationship between the two. Close examination of drug-related policies, especially since the official beginning of the “War on Drugs” in 1971, reveals that there is a significant overlap between the funding of addiction treatment in the United States and the expansion of criminal sanctions for drug offenses. This chapter will briefly describe important drug-related legislation with particular attention to 1970 onward, the beginning of the official “war on drugs.” The war on drugs was also the birth of dedicated federal funding for drug/alcohol treatment in the United States and the institutionalization of funding for fighting drug-related crime. Drug treatment, therefore, has largely continued because of the criminal focus on drugs. This is particularly important because it directly affects the philosophy of drug treatment, especially as more individuals are entering treatment through the criminal justice system.

The chapter will also describe various approaches to the treatment of alcohol and drug addiction, and how these approaches developed over time. Emphasis in this area will also be on the past forty years, where we see an explosion in the number of treatment programs in the United States and the development of more “medicalized” treatment modalities, such as methadone maintenance treatment for opiate addicts. In the same time period, while drug arrests increased dramatically, overall drug use significantly declined. The chapter will also provide a discussion of criminal justice initiatives that have
incorporated addiction treatment, concentrating on the same time period. The result of these programs and the government’s promotion of the benefits of “coerced treatment” is that today the largest category of people in treatment are those who have been referred by the criminal justice system.

U.S. Drug Policy: Balancing Punishment and Treatment

While drug use has been regarded as something that has been practiced in all societies throughout recorded history, public and legal response to drug use has been anything but consistent. This section will provide an overview of the legal responses to the use of drugs in the United States, starting with the earliest legislation that criminalized drug use. This early legislation is important for understanding subsequent drug policy, but most of this section will explore the various presidential administration’s policies around the “War on Drugs” – a war that was officially launched in 1971 by President Richard Nixon and continues today.

Early Responses

The first federal legislation that criminalized the possession of certain drugs was the Harrison Narcotic Act, passed in 1914. Because the federal government has limited powers regarding the criminalization of behavior, the Act was written in a language that resulted in a tax being imposed on the importers and distributors of narcotics, defined as opiates and cocaine (Spillane and McAllister 2003, Sharp 1994). The Act required

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9 Concern over narcotics use increased considerably in the final thirty years of the 19th century. There had been growing concern over opiate use, because of the large number of people using these drugs and also because the drug was increasingly tied to “undesirable” ethnic groups, particularly Chinese immigrants who had arrived in large numbers in the mid-19th century (Musto 1999). Before this federal legislation was
medical practitioners, manufacturers and importers of narcotics to register with the United States government, obtain a license, pay a small fee and maintain paperwork on all transactions; those in possession of these drugs, who were not registered, were in violation of the law (Davenport-Hines 2002, Spillane and McAllister 2003). The focus was largely on physicians and pharmacists because they were known to be prescribing these drugs for “maintenance purposes” (that is, so opiate addicts would not experience withdrawal) (Sharp 1994). The effect of the Act was to criminalize narcotic possession and use except for what was narrowly defined as medical purposes.

Several Supreme Court cases clarified the extent to which the Harrison Act applied (Faupel et al 2004, Sharp 1994). One case in 1916 (U.S. v. Jin Fuey Moy) resulted in the Court ruling that it was criminal to be in possession of narcotics unless they were prescribed by a registered physician. Another case, Webb et al. v. U.S. (1919), addressed whether it was legal for physicians to prescribe opiates to addicts for “maintenance” purposes. While the physician, Dr. Webb, who had been prescribing narcotics to addicts, argued that he could do so under provisions of the Harrison Act, the court ruled that such uses were not explicitly medical and therefore were not permissible. However, this decision was essentially overturned in Lindner v. U.S. (1925), where the Court modified its previous stance on the prescription of opiates for maintenance purposes, and argued that in small amounts it could be legal. This decision was particularly notable because the Court wrote that those addicted to narcotics were “diseased and proper subjects for medical treatment” (Faupel et al 2004). This position created, several cities had already passed anti-opium ordinances, the first being San Francisco (Davenport-Hines 2002).
was advanced further in the 1962 case of *Robinson v. California*, which struck down a California statute that made it a misdemeanor to “addicted to the use of narcotics” (Faupel et al 2004). The Supreme Court ruled that the status of being an addict could not be considered criminal, since it would violate the Eighth Amendment’s protection against cruel and unusual punishment. Thus, possession of an illicit substance was still illegal, but the status of being a “user” or “abuser” was not itself a crime.

Shortly after the passage of the Harrison Narcotic Act, the Eighteenth Amendment to the Constitution was ratified, prohibiting the manufacture and sale of alcoholic beverages. The National Prohibition Act (also known as the Volstead Act), passed in 1920 and cleared the way for the practical implementation of Prohibition (Faupel et al 2004). The 18th Amendment remained in effect until 1933, with several states continuing their ban on alcohol after the federal ban was lifted (Brecher 1972). While Prohibition is largely regarded as a policy failure by social scientists and historians, it did result in a significant decline in the consumption of alcohol (Lender and Martin 1987). Not surprisingly, with the ban on alcohol use, the consumption of marijuana, which was legal at the time, had increased in visibility, with the development of “tea pads” – marijuana smoking establishments – in major cities in the United States (Brecher 1972).

The increase in marijuana consumption soon became a topic of concern to the federal government. Drug law-enforcement was institutionalized in 1930 with the creation of the Federal Bureau of Narcotics, which operated within the Treasury Department (Sharp 1994). The first head of this agency was Harry J. Anslinger, who
served as U.S. commissioner of narcotics until 1962\textsuperscript{10}. Anslinger served as a “moral entrepreneur” of sorts against the use of drugs, helping to create and pass anti-drug legislation, while also facilitating the public’s increasing intolerance of drugs (Becker 1963, Sharp 1994). Several highly punitive drug laws passed during his tenure, most significant being the Marihuana Tax Act of 1937, which in effect criminalized marijuana. He used racist and sensationalized propaganda that argued that marijuana was a highly dangerous, violence-invoking drug, associated with Mexican immigrants and African-American jazz musicians (Sharp 1994, Musto 1999). The Act received little opposition from Congress and was quickly passed. The Harrison Act and the Marihuana Tax Act, in addition to creating a new class of “illicit” drugs, also helped to create a new subculture that centered on acquiring and using these drugs (Lindesmith 1965, Becker 1963).

Two other significant drug laws, passed during Anslinger’s tenure, increased the legal sanctions associated with drug possession. The Boggs Act, passed in 1951, increased penalties for drug law violations and established uniform penalties for both narcotics and marijuana violations (Sharp 1994). The Boggs Act also mandated a minimum sentence of two years for first-time possession of narcotics (Massing 1998). The Narcotics Control Act of 1956 increased the penalties enacted by the Boggs Act and created mandatory minimum sentences for drug offenses\textsuperscript{11}. It also allowed for the sale of heroin to minors to be punishable by death (Massing 1998). Both pieces of legislation were effectively used as political weapons by members of Congress who had higher political aspirations and wanted to position themselves as tough on crime (Sharp 1994).

\textsuperscript{10} He was essentially the first “drug czar” in the United States, although that title would not be used until 1989.
These early responses to drug use were largely punitive in nature, and did not focus much on the treatment or rehabilitation of those with drug problems. Drug treatment itself was practically non-existent, with the exception of Federal Public Health Service Hospitals, commonly known as “narcotic farms,” which were established in the 1930s (Campbell 2006). These institutions were essentially medium security prisons that offered detoxification, psychotherapy, and vocational counseling to federal prisoners who could be sent there rather than to an ordinary federal penitentiary (Inciardi and Martin 1993). Research on addiction also occurred at these facilities (Campbell 2006). These institutions, one in Lexington, KY and the other Fort Worth, TX, would serve as the first attempt at prison-based drug treatment. The Lexington facility operated until 1973, when it was turned back into a prison (Acker 2002).

While the 1960s were relatively quiet in terms of drug legislation and public concern over drug use, drugs would become a major issue again in the 1970s. The focus on law-enforcement tactics would continue to dominate during this period. However, there was also a significant increase in the attention given to drug treatment issues during this time. Table 1 summarizes major legislation and funding for drug control for each Presidential administration since the beginning of the war on drugs. I will summarize some of the major legislation from each presidential administration and discuss the share of the drug control budget going toward treatment and law enforcement. As the table shows, over time the total drug control budget increased dramatically. While I did not adjust the budget figures to reflect inflation, the total budget today would be more than

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11 The Controlled Substances Act of 1970 lifted mandatory minimum sentences for drug offences. Mandatory minimums were then reinstated during the Reagan Administration.
twice the amount it was in 1970 (adjusted for 2007 dollars). As we shall see in the next section, the beginning of the “War on Drugs” resulted in a continued push forward for harsh penalties associated with drug use but it also resulted in large amounts of federal money going toward drug treatment for the first time. This would also mark the beginning of the debate on how to best deal with the “drug problem” – by devoting more resources toward “supply-side” (i.e., law enforcement) tactics, or those that focus on the “demand-side” (i.e., treatment and prevention).

The Beginning of the “War on Drugs”

Richard Nixon campaigned heavily on a platform of law and order in 1968 (Sharp 1994). When he took office, there was not a very high level of public concern about drugs, although that changed through the early years of his Presidency (see Figure 1). As analysts have argued, public concern about drugs is often the aftermath of political rhetoric and legislation, rather than the cause of it (Sharp 1994). That appears to be the case in the early 1970s, with very low public concern over drugs before 1970, the year that the federal government passed the Controlled Substances Act, which proved to be the cornerstone of drug policy for the rest of the 20th century. As Figure 1 shows, in 1970, only 3% of Americans named “drugs” as the most important problem facing the country.

After the passing of the Controlled Substances Act, and the official launch of the “war on drugs” in 1971, we see a dramatic increase in concern about drugs, with 20% naming it the most important problem in 1973. The full name of the 1970 Controlled Substances Act is the Comprehensive Drug Abuse Prevention and Control Act. The Act essentially incorporated all changes in drug laws that had occurred since the Harrison Act
Table 1. Presidential Timeline of Drug Control Legislation and Funding, 1970-2007

<table>
<thead>
<tr>
<th>President and Term</th>
<th>Major Policy/Legislation</th>
<th>Drug Control Budget (range for various years; actual dollars)</th>
<th>% of budget going toward treatment (beginning - end)</th>
<th>% of budget going toward law enforcement (beginning - end)</th>
</tr>
</thead>
<tbody>
<tr>
<td>George H. Bush (1989-1992)</td>
<td>1988 - Omnibus Drug Abuse Act</td>
<td>$6.6 – 11.9 billion</td>
<td>17% - 18%</td>
<td>65% - 60%</td>
</tr>
<tr>
<td>George W. Bush (2001-present)</td>
<td>2002 – Reducing Americans' Vulnerability to Ecstasy Act (the RAVE Act)</td>
<td>$10.8 – 13.8 billion</td>
<td>22% - 18%</td>
<td>54% - 65%</td>
</tr>
</tbody>
</table>

*I could only find figures for 1977 and 1978.
was passed, therefore making it the defining legislation for current drug law policy (Faupel et.al. 2004). Several of these changes are important as they involved the legal consequences of drug possession (through The Boggs Act of 1951), and also introduced the possibility of court-mandated drug treatment (through The Narcotic Addict Rehabilitation Act of 1966)\(^\text{13}\).

Title II of The Controlled Substances Act also placed illicit substances into one of five categories, or “schedules,” according to the medical utility and the potential abuse of the drug (Spillane and McAllister 2003). Each schedule is subject to different levels of regulation, with lower-numbered schedules related to higher regulation. This

\(^{12}\) In years where the question is asked more than once, I recorded the highest number reported during the year.

\(^{13}\) The Narcotic Addict Rehabilitation Act gave courts the authority to order drug treatment as an alternative to prison sentences.
categorization of controlled substance continues today, with much controversy around the placement of drugs into certain categories\textsuperscript{14}.

The Controlled Substances Act was also remarkable because it included $124 million in funding for drug treatment and drug education programs (Sharp 1994). Still, the significance of the legislation had more to do with the criminal justice side of the policy. While the Act reduced federal penalties for possession and distribution of marijuana, it also created mandatory minimum sentences of ten years and a maximum fine of $100,000 for first-time drug traffickers (Sharp 1994). Penalties for second-time offenders were even harsher. It also established new funding for drug-law enforcement - $220 million over a three-year period (Sharp 1994). Another law passed in 1970, the Organized Crime Control Act, further strengthened the law enforcement side of drug policy. Title IX of that Act, called the Racketeer Influenced and Corrupt Organizations (RICO) statute, granted law enforcement the power to seize property that was acquired through organized criminal activity (Sharp 1994). It also instituted severe penalties for drug law violators.

Nixon continued to focus on the “drug problem” in 1971 by creating a new drug control agency – the Office of Drug Abuse Law Enforcement (ODALE). This agency was under direct control of the president and focused primarily on arresting street-level drug dealers (Davenport-Hines 2002). While there were several other government agencies focused on drug control at the time, ODALE was created to circumvent the bureaucracy of those institutions. In 1973, the ODALE merged with the existing Bureau

\textsuperscript{14} For instance, especially among proponents of the use of marijuana for medicinal purposes, there is much controversy around the labeling of marijuana as a Schedule I drug, a categorization that only includes drugs that are defined as having no recognized medical utility.
of Narcotics and Dangerous Drugs (formerly the FBN) to form the Drug Enforcement Administration (DEA) (Sharp 1994).

On June 17, 1971, Nixon declared drug abuse “public enemy number one in the United States” and that to fight this enemy, “it is necessary to wage a new, all-out offensive” (Massing 1998, p.112). This is recognized as the official start of the war on drugs. Nixon requested $155 million in new funds, of which $105 would go for treating and rehabilitating drug abusers (Massing 1998). While the exact funding would differ from his request, this was the only time since the war on drugs began that more money went toward treatment and prevention than toward law enforcement. In 1972, the amount of federal funding for treatment and prevention efforts doubled that for law enforcement (Sharp 1994).

In 1972, by passing the Drug Abuse Office and Treatment Act, Congress permitted Nixon to create another distinct agency that focused on treatment and prevention issues - the Special Action Office for Drug Abuse Prevention (SAODAP) (Sharp 1994). SAODAP was created to help coordinate the various agencies that were involved in drug treatment in one capacity or another, such as the Veterans Administration, the Office of Economic Opportunity and the National Institute on Mental Health. SAODAP had the power to oversee the drug treatment programs that were operating through these organizations and direct funding to those that seemed to be the most promising (Sharp 1994). It was through SAODAP that funding for methadone maintenance treatment became a central focus of the Nixon Administration. Later in this chapter I will explore the evolution of methadone maintenance therapy, but it is important to note that this treatment modality would unlikely be as prevalent today if it had not
been for the increased funding that the Nixon Administration put toward its implementation nationally in the early 1970s. The SAODAP was institutionalized in 1972 through the Drug Abuse Office and Treatment Act.

This new policy on drugs, one that focused heavily on treatment, was related to Nixon’s campaign promise of lowering crime. Several advisors in his administration had investigated the impact of methadone maintenance treatment on crime rates in large cities, like Washington D.C. (Massing 1998). They noticed dramatic declines in crime rates after the expansion of methadone maintenance programs. Nixon wanted to demonstrate that he reduced crime, as he had promised, before the 1972 election and his staff convinced him that this program could be the answer (Sharp 1994).

Nixon easily won re-election in 1972, and shortly after it became obvious that drugs were no longer a central concern of the administration (Sharp 1994). The federal budget for drug treatment and rehabilitation declined in 1973, while funding for drug-law enforcement increased. This shift in policy priorities has led some to conclude that Nixon’s focus on treatment was only an attempt to reduce crime in time for re-election and that he was actually philosophically opposed to large amounts of federal dollars going toward treatment and prevention (Sharp 1994). Not surprisingly, after the political rhetoric and legislative action declines, we also see a significant decline in public concern over drugs after 1973 (see Figure 1). By 1974, concern about drugs went back to the same low level (3%) that it was in 1970, despite the increase in use itself through the 1970s (Gfroerer and Brodsky 1992).
Drug Policy before Reagan

The fluctuation between supply-side approaches to drug control and demand-side ones continued through the 1970s. Also, the high level of drug use during the 1970s begins declining by the end of the decade and continued to significantly decline through the end of the century (see Figure 2). While funding for drug control continued to increase during the Ford and Carter Administrations, the supply and demand sides of the budget were similar in proportion, although there began a decline in the proportion of funding going toward treatment. The Ford Administration’s approach to drug control was primarily based on attempts to eradicate poppy production in Mexico, due to the influx of heroin into the United States (Massing 1998). The most significant piece of drug legislation that passed during his tenure was the Drug Abuse Treatment and Control Amendments in 1974 which essentially just strengthened Nixon’s legislation. While a government report indicated that the priority should be on drug treatment, by 1976, federal spending on drug-law enforcement for the first time surpassed the amount spent on treatment and prevention (Massing 1998).

During this time, there was also considerably more attention paid to marijuana use. Jimmy Carter actually ran for office on a platform of decriminalizing marijuana, and by that time several states had already decriminalized it to varying extents (Sharp 1994). A large grassroots movement of parents against decriminalization, however, ended the possibility that the federal government would decriminalize marijuana (Massing 1998). For the most part, drugs were not mentioned as significant issues by politicians in the late 1970s; tactics of drug control continued more as part of the existing routine of various
programs (Sharp 1994). Carter increased funding for drug prevention and education programs through the Alcohol and Drug Abuse Education Amendments in 1978. This legislation also authorized employee assistance programs. As Figure 1 shows, concern about drugs remained very low through the end of the 1970s. Drugs would re-emerge as a significant political issue, however, during the 1980s, and as a result we see a dramatic increase in the number of Americans who were concerned about drugs in the late 1980s.

**Drug Policy in the 1980s and 1990s: Investing in Incarcerating**

Drug policy issues again became a priority after President Ronald Reagan took office. A series of laws that were enacted under his administration indicated a shift back toward more repressive drug policies. For instance, in 1984, Congress passed the Sentencing Reform Act, which re-established mandatory minimum sentences for those
convicted of drug offenses (Faupel et al. 2004, Sharp 1994). This legislation also increased penalties for drug-law offenders and gave judges the power to deny a defendant pretrial release (Sharp 1994). Two years later, the Anti-Drug Abuse Act of 1986 was passed which, among other things, further increased the penalties for drug-trafficking offenses. It also institutionalized the discrepancy in the penalties for crack cocaine versus powder cocaine. Under this Act, a person convicted of possessing five grams of crack cocaine was given the same penalty (five years) as someone convicted of possessing 500 grams of powder cocaine (Musto 1999). This difference in mandatory minimum sentences (known still today as the controversial “100-to-1” discrepancy) was the product of intense fear of the psychoactive effects of crack cocaine, which at the time were believed to be much stronger than powder cocaine and could provoke extremely violent behavior (Davenport-Hines 2002). Years of research would dispel the myth that there were substantial differences between the two substances, although the sentencing disparity continues today. The 1986 legislation did also increase funds for treatment and education for the first time in more than a decade, although the amount was insignificant compared to the funding for law enforcement tactics. In real dollars, the 1986 federal budget for drug treatment was barely one-fifth the amount it was in 1973 (Massing 1998). There would be no return to the budgets of the 1970s, with the larger proportion of funds going toward treatment and prevention. In fact, federal funding for drug control through the 1980s would see the share going toward law enforcement programs never falling below 70%, and at times rising as high as 83% (see Table 1).

15 It is difficult to ignore the racial implications of such a policy. Crack cocaine use in the 1980s was largely concentrated in poor, urban areas and more often used by racial minorities, while the typical powder cocaine user was wealthier and white (Musto 1999).
As demonstrated by his support of these laws, Reagan took a very “supply-side” approach to fighting the war on drugs. Although he spoke of “demand-side” tactics, they were largely symbolic and did not include significant funding nor a detailed strategy about how they would be implemented (Sharp 1994). A good example is Nancy Reagan’s “Just Say No” campaign, which was a moral statement on the weakness of those who become drug addicts rather than any real campaign to prevent drug abuse. These tactics were apparently successful at arousing public concern over drugs, since drugs again became an important national issue during the mid-1980s (see Figure 1). At the same time, the proportion of the drug control budget going toward treatment sunk to an all-time low of 8% by the end of Reagan’s term.

The Anti-Drug Abuse Act was passed again in 1988, and provisions were added that increased penalties associated with drug abuse violations in other ways. For instance, the Act reinstated the death penalty for major drug traffickers and expanded the right of the government to seize the assets of those who were arrested for drug-related offenses. This legislation also institutionalized the administration’s “zero-tolerance” policy of aggressive enforcement by the Coast Guard and U.S. Customs of laws against illegal drug possession, even in small amounts (Sharp 1994). It also created a cabinet-level official whose job it would be to coordinate federal drug-control policy, informally named the “drug czar” (Sharp 1994). The drug czar headed the new office of National Drug Control Policy and advised the president on organizational and budget matters involving drug enforcement agencies. The first “drug czar” was William Bennett; he was appointed by the newly-elected George Bush and confirmed by the Senate in March 1989. Not surprisingly, Bennett’s approach to fighting the drug war focused heavily on
the law enforcement side; he was even quoted as saying that treatment was a form of “coddling” (Massing 1998, 195).

The 1988 Act, along with the legislation of 1984 and 1986, profoundly affected the criminal justice system, by creating tremendous prison and jail overcrowding. Figure 3 shows the dramatic increase in arrests for drug abuse violations since 1980\textsuperscript{16}. Figure 4 shows the increase in the number of people serving prison sentences for drug-related offenses (mostly due to possession and/or sales). More aggressive arrest policies in the second half of the 1980s also led to the large increases in the number of incarcerations (Reuter 1992). Couple the increase in arrests with harsher penalties and longer sentences of incarceration enacted through the 1980s, and the result is a substantial increase in the overall prison population during the same time. These increases are also due to Congress requiring states to impose severe penalties for drug-related offenses on their own, or face possible withholding of federal highway funds (Reuter 1992).

George Bush announced his drug strategy during a televised address in September 1989\textsuperscript{17}. Public concern over drugs was at a new high that year, with 27% of Americans indicating that “drugs” was the nation’s most important problem. Bush’s drug control strategy recommended increasing the number of drug arrests and expanding the nation’s prison system. In that speech, he specifically said, “We need more prisons, more jails, more courts, more prosecutors” (Sharp 1994, 60). He proposed an increase in federal

\textsuperscript{16} According to the Uniform Crime Reports issued by the FBI, drug abuse violations are defined as “State and/or local offenses relating to the unlawful possession, sale, use, growing, manufacturing, and making of narcotic drugs including opium or cocaine and their derivatives, marijuana, synthetic narcotics, and dangerous nonnarcotic drugs such as barbiturates” (Bureau of Justice Statistics 2006).

\textsuperscript{17} This was the speech where Bush held up a bag of crack cocaine that he said was purchased in the public park across from the White House. A Washington Post columnist would publish a story two weeks later
Figure 3. Number of Arrests for Drug Abuse Violations, 1980-2004.

Source: FBI, Uniform Crime Reports, Crime in the United States

Figure 4. Number of Persons in State Correctional Facilities for Drug Offenses, 1980-2004

Source: FBI, Uniform Crime Reports, Crime in the United States

revealing that the supposed “purchase” was actually a set-up by Drug Enforcement officials, who took four weeks to orchestrate the event by luring a drug dealer to the area.
drug spending, including $1.6 billion for the federal prison system. He did also increase money for treatment; still, only 17-18% of the budget went toward treatment and prevention programs (Massing 1998). While this was certainly an improvement over the Reagan years, it was still quite low compared to the proportions in the 1970s.

The war on drugs continued through the 1990s. When Bill Clinton took office in 1993, he appointed Dr. Lee Brown to the drug czar position. Brown wanted to increase funds for treatment in order to eliminate waiting lists (Massing 1998). Clinton’s 1994 drug control strategy incorporated this goal with a proposed increase in funding for treatment of 14.3% and a proposed decrease in funding for drug interdiction efforts. His announcement of the strategy at a prison-based drug treatment program was particularly symbolic of what would prove to be the new approach to expanding treatment (that is, through the criminal justice system). However, there was a broader concern for new survey results showing an increase in marijuana use among high school students, the first increase in fourteen years (Massing 1998). Clinton’s treatment initiative was cut as a result, and a subsequent budget had a smaller proportion of dollars going toward treatment and prevention – a comparable proportion as the final year of the Bush Administration (Massing 1998). Clinton continued the trend toward increasing punishments for drug offenders. For instance, the 1994 Violent Crime Control and Law Enforcement Act tripled the maximum penalties for using children to distribute drugs near a school or playground. Clinton’s well-known “Welfare Reform Act” (the Personal Responsibility and Work Reauthorization Act) restricted government benefits, like housing benefits and cash assistance, for those who were convicted of drug offenses.
General Barry McCaffery replaced Lee Brown as drug czar in 1996 after Brown’s resignation and drug policy quickly moved to military efforts of demand-side policies, such as attempts to destroy coca production in Columbia (known as Plan Colombia)\textsuperscript{18}. There was a small increase in funding for treatment, but it was a rather trivial sum; most cities in the United States still had long waiting lists for drug treatment (Massing 1998).

The Current Drug Strategy

George W. Bush issued his first National Drug Control Strategy in February 2002, which linked the drug war with the current “War on Terror.” In the introduction to the 2002 drug control strategy, he indicated that “Our fight against illegal drug use is a fight for our children’s future, for struggling democracies, and against terrorism” (ONDCP 2002). He described drug profits as a way that terrorists are funded. To introduce this link between drugs and terrorism, the White House funded television ads that promoted the connection. One such ad first ran during the 2002 Superbowl and asked “Where do terrorists get their money?” The ad then responded, “If you buy drugs, some of it might come from you.” While anti-drug rhetoric has historically used foreign threats in its campaigns, such as the anti-Mexican sentiment around the Marihuana Tax Act, Bush’s attempt to link the War on Drugs with the War on Terror appears to be the first time that such explicit references were included in the written drug control strategy.

The 2002 strategy focused on three areas: prevention (primarily through school-based programs), treatment (which focuses extensively on the importance of “coerced” treatment and prison-based treatment programs, and “disrupting the market” (aimed at law enforcement and international drug eradication efforts). While the largest of those

\textsuperscript{18} The coca plant is used to manufacture cocaine.
three sections, seven pages, was devoted to explaining treatment approaches, the largest overall budget item was domestic law enforcement, which in Fiscal Year 2002, comprised over 50% of total spending for federal drug control. Looking at the spending priorities from a “supply/demand” perspective shows that about 67% of the budget went toward “supply-side” tactics, like law enforcement and interdiction, while only 33% went toward “demand-side” tactics, like treatment and prevention (ONDCP 2002). Bush also signed the Reducing Americans’ Vulnerability to Ecstasy Act (known as “the RAVE Act”) in 2002, which increased the penalties for those who operated establishments where people consumed drugs. Because the original legislation was aimed at “crack houses” and other places where people went exclusively to buy and use drugs, this Act was controversial because it targeted legitimate establishments, like night clubs, and could be interpreted to include things like bottled water and glow sticks as drug paraphernalia. The law probably passed easily because of the reported increase in high school ecstasy use between 1999 and 2001 (according to the annual Monitoring the Future Survey).

The 2006 National Drug Control Strategy focuses on the same three topics as the 2002 strategy, although a much larger proportion (24 pages) of the report is used to explain the third approach, “Disrupting the Market” (ONDCP 2006). The explanation of prevention programs is six pages; the section on treatment is only five pages. In addition, the only explicit treatment programs named in the report are Drug Courts, which are not what many would classify as treatment programs per se, but rather a criminal justice

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19 The budget reports also indicate that the total amount of funding for the treatment and prevention programs includes funding for research, thus making the actual amount of money going toward these
initiative that includes treatment with frequent court supervision. This appears to be an attempt to merge the “supply” and “demand” sides of funding, especially if these drug courts are funded through the “treatment” portion of the budget. The overall proportion on spending for treatment also decreased through Bush’s second term; it comprised 18% in the 2007 budget.

*Summary*

Examining the history of drug policy in the United States since 1970 reveals that the federal government has consistently favored moralistic and punitive approaches to controlling drug use. While the initial strategy of the Nixon Administration focused heavily on funding drug treatment programs (primarily methadone maintenance) as a way to decrease drug use and overall crime, almost all subsequent policy increased the sanctions associated with drug use and funded law enforcement or international eradication programs (like Plan Colombia). The next section also demonstrates that what focus the government did have on treatment in the 1990s onward was one in which treatment was very much tied to law enforcement, rather than being an alternative approach to handling drug problems.

The History of Addiction Treatment: Frameworks and Modalities

This section provides an overview of the evolution of the drug treatment industry in the United States. First I will provide a brief history of early methods of treatment and the origins of Alcoholics Anonymous, since that organization played a large role in the

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programs considerably less. There is no such inclusion of “research” funding associated with the law enforcement and interdiction tactics.
development of modern-day treatment facilities and continues to have a significant role in the treatment of addictions today. I will then discuss the development and expansion of methadone maintenance therapy for opiate addiction, as well as the explosion in the drug treatment industry that occurred largely as a result of the expansion of methadone maintenance treatment and the increased funding from the federal government for treatment programs during the 1970s.

**Early Forms of Treatment**

Alcohol consumption was much higher in the United States during the 18th and 19th centuries than it is today (Tracy and Acker 2004). Other drug use, what we would consider “illicit” drugs, was relatively low. While the number of people who drank alcohol on a regular basis was high, there was still little tolerance for drunkenness, and Americans soon began to distinguish between “good” drinking and “bad” drinking (White 2004). Benjamin Rush, a Philadelphia physician, was a prominent figure concerned with excessive drinking in the 18th century. In 1785 he published *An Inquiry into the Effects of Ardent Spirits Upon the Human Body and Mind*, which was the first widely-distributed pamphlet describing his proposed disease concept of alcoholism. This pamphlet also became an inspiration to the growing temperance movement; since Rush believed that anybody who consumed enough alcohol could develop the “odious disease” of drunkenness, the temperance movement used it as evidence that all alcohol use should be eradicated (Rush 1785, Musto 2002). Rush himself did not advocate for total abstinence from alcoholic beverages, however, and even praised the benefits of

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20 He does not actually use the term alcoholism, but instead refers to “drunkenness” as an ailment (Rush 1785).
“brewed” beverages, such as beer and wine, that he differentiated from “distilled” alcohol.

In 1840 a group of self-described “drunkards” formed the Washingtonian Society, an abstinence society named after George Washington (Lemanski 2001). The group had meetings where fellow drunkards testified about the evils of alcohol, recounting the damage it had done to their life and the benefits of living a life free of alcohol. They also established some of the nation’s first “inebriate homes,” institutions designed to reform the drunkard in “non-punitive” settings (Tracy 2005). This group’s membership exploded soon after they formed; an estimated 600,000 members joined the movement between 1840 and 1845 (Tracy 2005). The movement folded quickly, and by 1847 was almost completely inactive (Lemanski 2001, White 1998).

Some of the methods of the Washingtonians continued on in other temperance societies, such as the post-Civil War “gospel” temperance movement, which used prayer meetings and public confessionals to rouse support (Chavigny 2004). These groups were explicitly evangelical and religious, advocating the idea that drinking and drunkenness were sins; only God’s grace could save the drunkard. In major cities, temperance groups opened their own inebriate homes (Chavigny 2004). During this time there was also a growing promotion of a disease concept of alcoholism, named “inebriety,” by various physicians. These physicians also advocated for separate treatment for alcoholics, in institutions similar to the existing inebriate homes. While these types of institutions were more resistant to the overtly religious nature of the homes run by temperance organizations, they were hardly purely “medical” in their focus, and did advocate for
certain treatments of the patient’s “spirit” as well (Tracy 2005). There was a growth in these institutions, both public and private, through 1920. Once Prohibition passed, however, most advocates felt that the final solution to the problem had been reached, and most of these institutions closed soon after (Tracy 2005).

The Institutionalization of Alcoholics Anonymous and the Disease Concept

Treatment for alcoholism and drug addiction in distinct settings would not become widespread again until the 1970s, due to an increase in federal funding for such programs. After prohibition, the primary method of treating addiction became Alcoholics Anonymous (A.A.), founded in 1935 by two “reformed” alcoholics – Bill Wilson and Dr. Bob Smith. They based the now well-known “twelve steps” of A.A. on the tenets of a similar movement, the Oxford Group, which was popular in the 1920s and which A.A. was affiliated with until 1937 (White 1998). While A.A. borrowed the overarching Christian framework from the Oxford Group, they also incorporated the resistance toward organized religion, per se, and focused on spiritualism rather than specific religious teachings (Lemanski 2001). In addition, they emphasized that alcoholism was a “disease” over which the individual had no control, although the initial use of the disease concept appears to have been more metaphorical than based on any advancements in scientific and medical knowledge.

Alcoholics Anonymous proved to be a fast-growing movement. In its first four years, A.A. grew to about 100 members (Lemanski 2001). After the publication of the “Big Book” of A.A., Alcoholics Anonymous, in 1939, membership increased dramatically. A 1941 year-end report placed total membership at 8000 and the early

\[21\] With few exceptions, most alcoholics at this time had been placed in jails or insane asylums.
1950s saw membership approach 100,000 (White 1998). In the 1950s, the A.A. model expanded into several other “12 step” groups, such as Al-Anon (for families of Alcoholics) and Narcotics Anonymous (for drug addicts). By the year 2000, A.A. boasted that it had 1.16 million members in the United States, and over 2 million worldwide (Lemanski 2001).

As membership in A.A. continued to grow throughout the second-half of the 20th century, its principles were also folded into the dominant model of addiction treatment that emerged in the 1940s and 1950s: The Minnesota Model. This model was first applied in two small treatment programs in Minnesota in the late 1940s, including Hazelden, a well-known treatment facility that continues to operate today (White 1998). The approach to treatment emphasized the components of A.A., including the twelve steps, along with the disease concept of alcoholism that was developed by E.M. Jellinek, through his work at the Yale Center on Alcohol Studies (Lemanski 2001).

Jellinek’s research on the causes and treatment of alcoholism became widely accepted through the 1950s and culminated in the 1960 publication of his book, *The Disease Concept of Alcoholism*. In this book, he defined alcoholism as “any use of alcoholic beverages that causes any damage to the individual or society or both” (Jellinek 1960, 35). He proposed five “species” of alcoholism, which he identified as alpha, beta, delta, gamma, and epsilon; however, he only considered gamma and delta varieties to be true illnesses. These forms were characterized by increased physical and psychological tolerance to alcohol, the presence of withdrawal symptoms with discontinued drinking, and the inability to abstain from alcohol (i.e., loss of control) (Jellinek 1960). The other “species” he identified involved periodic phases of heavy drinking without major
physical or psychological complications. This became the dominant “disease model” of alcoholism, and was officially endorsed by the World Health Organization in 1951 and by the American Medical Association in 1956 (Faupel et al. 2004). This acceptance of alcoholism as a disease led to an expansion of the alcohol treatment industry, with treatment now operating in distinct institutions; treatment included detoxification procedures that further incorporated a medical view of treating alcohol addiction. At the same time, treatment also incorporated the philosophy of Alcoholics Anonymous, which also embraced this disease view of alcoholism.

The relationship between the disease view of alcoholism and the principles of Alcoholics Anonymous was codified by the creation of the National Committee for Education on Alcoholism in 1944, by Jellinek and A.A. member Marty Mann (White 1998). The two founders of A.A. were listed as advisors in the early formation of the institution. This organization would eventually become the National Council on Alcoholism and Drug Dependence (NCADD), whose current mission is to “fight the stigma and the disease of alcoholism and other drug addictions” (NCADD website 2008). By the 1970s, this organization had close ties with the treatment industry, Alcoholics Anonymous, and the federal government.

In 1970, Congress passed the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (also known as “the Hughes Act,” named after the Senator, an active A.A. member, who sponsored the bill) (Lemanski 2001). The bill established the National Institute on Alcohol Abuse and Alcoholism (NIAAA), which provided a large amount of federal money for treatment programs. NIAAA also contracted with NCADD, resulting in 75% of NCADD’s budget coming from the federal
government (Lemanski 2001). Around this same time, major insurers, such as Blue Cross and Aetna, began to add coverage for alcoholism treatment to their plans (Lemanski 2001). This coupling of federal dollars to support treatment programs, along with the expansion of insurance coverage, resulted in an explosion of addiction treatment facilities; one estimate supposed that the number of treatment facilities at least quadrupled between 1970 and 1990 (Lemanski 2001). The vast majority of these facilities included 12-step components in their treatment programs, a practice that continues today. In a 2004 survey of publicly funded drug and alcohol treatment programs nationwide, about 60% of the programs’ administrators reported that the 12-step model “best characterized” their program, while another substantial proportion indicated that the 12-step model was incorporated as one of several emphases. In addition, more than 64% of the programs required patients to attend 12-step meetings during the course of treatment (Roman and Johnson 2004). Because of the hegemonic status that Alcoholics Anonymous has for treating drug and alcohol problems, it is difficult to find a treatment program in the United States today that does not incorporate twelve-step philosophy, despite research that suggests that it is not a very effective treatment modality (Lemanski 2001).

The Development of Methadone Maintenance

The 1960s saw major developments in the treatment of drug addiction, although development of treatment programs that utilized these new methods did not immediately follow. In the late 1960s there were virtually no institutions to treat drug addiction, besides the “narcotics farms” that were described earlier, which operated more like prisons (Massing 1998). The other major form of treatment occurred in “therapeutic
communities” which were programs that utilized A.A. principles and abusive, confrontational “therapy” in military-style boot-camp settings (Lemanski 2001).

In the 1960s, the use of methadone was being studied, largely through the experiments of Dr. Vincent Dole and Dr. Marie Nyswander in New York City (Massing 1998). They experimented with different drugs, first heroin and morphine, in an attempt to control the withdrawal symptoms and craving associated with heroin addiction among Harlem addicts. They eventually found that a large dose of methadone, a synthetic opiate, administered daily, was the most effective at eliminating withdrawal symptoms while still allowing the individual to function normally (Massing 1998). The researchers were also convinced by this discovery that addiction was a permanent condition that required daily doses of methadone indefinitely, which is what led to the name of the technique – methadone maintenance.

After this discovery, methadone maintenance as a form of treatment for drug addiction became more widespread but also clashed considerably with those who supported therapeutic communities for treating drug problems (Massing 1998). Therapeutic communities viewed methadone as a “crutch,” while advocates of methadone maintenance therapy perceived therapeutic communities as “virtual penal colonies” (Massing 1998, 89). Methadone treatment would prove to win that battle and become a dominant method for treating heroin addiction, although the debate around whether it is merely substituting one addiction with another would continue, as it does today.

One of the most prominent researchers and advocates for methadone maintenance therapy was Dr. Jerome Jaffe, a psychiatrist at the University of Chicago who himself
secured state funding to open 15 treatment facilities in the Chicago area, serving more than 900 people at a given time (Massing 1998). Jaffe was also diligent about keeping records of what happened to patients during and after treatment, and consistently employed new methods to improve treatment. He also conducted research on the spread of heroin addiction in Chicago; when his field teams identified “mini-epidemics” in certain areas, outreach teams would go and recruit addicts to treatment programs (Massing 1998, 95).

Nixon Administration advisors involved with the drug issue became interested in Jaffe’s work. They were impressed by the research that showed methadone maintenance therapy had significant and immediate results - decreased use of heroin, reduced unemployment, and, most interesting to them, a reduction in criminal activity (Massing 1998). One of Nixon’s advisors, Dr. Robert DuPont, set up a pilot version of Jaffe’s Chicago system in Washington, D.C. in 1969, called the Narcotics Treatment Administration. They monitored the program, which had more than 2000 treatment slots in the city, to see if crime went down (Massing 1998). Crime statistics released for 1970 showed a decline in crime in D.C. by 5.2%, the first decline in years. More importantly, most of the reduction in crime occurred after the program had become fully operational (Massing 1998). This was enough evidence for the Nixon Administration to create the Special Action Office for Drug Abuse Prevention (SAODAP) in 1971, and appoint Jerome Jaffe to be its head. As illustrated earlier in this chapter, the Nixon Administration would provide substantial amounts of federal money for drug treatment programs, mostly methadone treatment, through the early 1970s. With the institutionalization of federal agencies, like the National Institute on Drug Abuse (NIDA) in 1974, federal funding for
drug treatment would become a regular budget item. The establishment of NIAAA and NIDA created a national system of addiction treatment (White 1998).

_Treatment Options Today_

As this section discussed, most publicly funded treatment programs today incorporate twelve-step approaches. In addition, methadone maintenance continues to be a widespread method of treating opiate addiction. While other options exist, these two modalities, in outpatient programs, dominate the treatment landscape. While the 1970s saw increasing numbers of treatment programs that were predominantly inpatient facilities, research in the 1990s did not support the claim that inpatient treatment was more effective than outpatient. As a result, insurance companies and federal programs like Medicaid cut back their coverage of inpatient treatment episodes (Lemanski 2001). The result was a huge shift to outpatient treatment, with a resulting expansion during the 1990s in the number of facilities offering this type of treatment. This trend continues today, where fewer than 25% of publicly funded treatment facilities are dedicated to only inpatient treatment (Roman and Johnson 2004).

The Two Converge: Treating Addiction through the Criminal Justice System

Untreated substance abusing offenders are more likely to relapse to drug abuse and return to criminal behavior. This can bring about re-arrest and reincarceration, jeopardizing public health and public safety and taxing criminal justice system resources. Treatment offers the best alternative for interrupting the drug abuse/criminal justice cycle for offenders with drug abuse problems (from National Institute on Drug Abuse Publication, “Principles of Drug Abuse Treatment for Criminal Justice Populations” 2006).
The dramatic increase in the number of arrests for drug-related offenses through the 1980s and 1990s and the subsequent increasingly high number of persons incarcerated for those offenses was discussed earlier in this chapter (see Figures 3 and 4). This explosion in the prison population, as well as the crowded caseload of the criminal court system, resulted in the development of several criminal justice initiatives aimed at incorporating treatment for drug problems (White 1998). The programs we have today are very much an extension of earlier programs, especially those that were first implemented during the 1970s. This section will describe the most prominent of those initiatives that have included drug treatment as a significant component of how to deal with those arrested for drug-related offenses.

The 1960s and 1970s saw a significant linking of addiction treatment with the criminal justice system (Faupel et al. 2004). The 1962 Supreme Court decision, *Robinson v. United States*, in addition to overturning a state law that prosecuted those who consumed drugs, included a lesser-known provision that permitted a state to establish compulsory treatment for narcotic addiction, with penal sanctions for failure to comply with treatment (Inciardi and McBride 1991). California had already instituted its own “Civil Addict Program” in 1961 that involved the involuntary commitment of narcotic addicts for treatment. The 1966 Narcotic Addict Rehabilitation Act (NARA) permitted treatment to be used as an alternative to jail at the federal level. Most of these programs involved sending offenders to the “narcotic farms” described earlier, or versions of therapeutic communities with their harsh re-socialization tactics (Faupel et al 2004).

The 1970 Controlled Substances Act described earlier also authorized the diversion of primarily non-violent, first-time drug-related offenders from the criminal
justice system into addiction treatment programs (Inciardi and McBride 1991). This program became institutionalized in 1972 with the creation of the Treatment Alternatives to Street Crime (TASC) program, which was created by the Special Action Office for Drug Abuse Prevention (SAODAP) and operated under the Law Enforcement Assistance Administration (LEAA). By this time, there was an increase in community-based treatment programs, and the TASC program diverted drug-involved offenders into those programs. The first TASC programs became operational in Wilmington, Delaware and Philadelphia by the end of 1972 (Inciardi and McBride 1991). Nixon linked treatment with his drug control strategy because of the reduction in crime that researchers noted for those who participated in treatment.

The TASC program was based on three assumptions: that problems of drug abuse and addiction affect significant portions of the population, especially in metropolitan areas; that along with drug addiction comes a cycle of crime, arrest, incarceration, release, and often continued drug use; and that there are opportunities for the introduction of treatment alternatives to street crime because of the frequent contact between the addict and the criminal justice system (Inciardi and McBride 1991). The program also gave credit to two prevailing sociological theories of crime in the 1970s: labeling theory and social learning theory. Proponents of labeling theory argue that when a person is labeled a criminal, they develop a criminal identity that leads to further criminal behavior. Labeling theorists contend that reintegration programs are better deterrents for future crime than incarceration. Social learning theorists argue that everything about criminal behavior is learned, so that if you incarcerate an individual, he/she will learn further criminal behaviors and attitudes from those in prison. By initially focusing on pre-
trial diversion for first-time offenders, the TASC program was attempting to avoid the label of “criminal” being used and also to avoid the socializing of less serious offenders into more serious ones through incarceration (Inciardi and McBride 1991).

Initially, TASC programs, and treatment resources in general, were almost exclusively aimed at those who used heroin (Inciardi and McBride 1991). This was likely due to the number of offenders who had reported using heroin and the generally higher use of heroin in the 1970s compared to today. The focus on heroin specifically in these programs was problematic, however, since most first-time offenders were marijuana users. However, marijuana-users generally refused to participate in a diversion program like TASC because they would likely not face harsh sanctions through the criminal justice system (most likely, they would be given probation if they plea bargained). TASC thus broadened its definition to include all drug-involved offenders and by 1977 the program’s clients were equally divided between pretrial diversion and post-trial sentencing (Inciardi and McBride 1991).

The TASC program expanded rapidly. By 1978, 73 projects in 24 states were being funded; the number of TASC programs increased to 178 by 1991 (Nolan 2001). TASC significantly increased the proportion of those in treatment who had criminal records (Inciardi and McBride 1991). While federal funding was completely withdrawn from TASC in 1982, due to the elimination of the LEAA, it did have some of that funding restored in 1984 through block grants for programs aimed at drug-related crime. However, with no over-seeing organization in place, TASC programs would evolve in different ways in different settings. By the late 1980s, many of the TASC programs surveyed did not fit the original TASC model and the kinds of services emphasized
varied across programs (Inciardi and McBride 1991). TASC continues today as a broadly defined program that links offenders to drug treatment and provides case management services.

The TASC program allowed defendants to go into treatment as an alternative to incarceration or as a condition of probation or parole. The other way that treatment is incorporated into the criminal justice system is through prison-based treatment programs, which were first seen with the creation of “narcotic farms” in the 1930s. The 1986 Anti-Drug Abuse Act included millions of dollars for substance abuse treatment, of which a large proportion was directed at prison-based programs (Wexler 1994). Such programs expanded through the 1990s; a 1997 SAMHSA survey indicated that 40% of all correctional facilities nationwide had some sort of onsite substance abuse treatment, including detoxification, individual or group counseling, or pharmaceutical treatment (SAMHSA 2000). A more recent study found that the most prevalent services offered in prisons are group counseling (Taxman et al. 2006). About 20% of prisons offer treatment programs that are isolated from the rest of the prison population, and function as a 24-hour treatment environment. Many prison-based programs are modified therapeutic community programs; they aim to change the whole lifestyle of the inmate, including elimination of antisocial behavior and the development of pro-social attitudes in addition to abstinence from drugs (Welsh and Zajac 2004).

TASC was also a precursor to the current drug court movement, which began in the late 1980s. Many components of the drug court program are similar to those of TASC, including the original rationale of each – that of alleviating the justice system from the large number of low-level drug offenders (Nolan 2001). With the strict laws
passed in the 1950s, drug-related arrests and incarceration had increased considerably; that increase was even more dramatic in the 1980s. The two programs were also similar in that both offered that the client’s criminal record could be expunged after successfully completing the program. One of the major differences between TASC and drug courts is that with a drug court program, the court is much more involved during the treatment process and monitors the client’s progress on a monthly basis (Nolan 2001)\textsuperscript{22}.

These programs have institutionalized the relationship between drug treatment and the criminal justice system. The first part of this chapter illustrated the parallel trend of increased funding for treatment and law enforcement. The most recent drug control strategy names drug courts as a form of treatment. Reviewing these developments, it appears that supply side tactics (like law enforcement) and demand side tactics (like drug treatment) have converged in fighting the war on drugs. The result is that there has been a substantial increase in the number of people in treatment who are referred from the criminal justice system. A national report of treatment admissions, produced by SAMHSA, shows that 36% of all admissions in 2004 were court-mandated, the largest referral category (see Table 2). Looking at specific drugs that clients were in treatment for, the majority of those in treatment for marijuana problems (57%) were referred from the criminal justice system. Those in treatment for alcohol problems also had a high proportion that had been court-mandated to treatment (42%). This is likely because treatment has been incorporated more into probation sentences for driving while intoxicated and marijuana possession cases.

\textsuperscript{22} Drug courts will be discussed in more detail in the next chapter.
This trend will likely continue unless laws against drug offenses or law enforcement practices are relaxed. California voters approved of a ballot initiative in 2000, the Substance Abuse and Crime Prevention Act (Proposition 36), which permanently changed state law to allow first and second-time nonviolent, simple drug possession offenders the opportunity to receive substance abuse treatment rather than incarceration. Only a handful of states, however, have passed similar legislation that automatically diverts cases from the criminal justice system. The next chapter will focus on Philadelphia and the current treatment landscape there.

Table 2. Admissions into a Treatment Program by Primary Substance of Abuse and Referral Source, 2004

<table>
<thead>
<tr>
<th>Source of Referral to Treatment</th>
<th>Primary Substance of Abuse</th>
<th>Total (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Admissions</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Criminal Justice System</td>
<td>36%</td>
<td>42%</td>
</tr>
<tr>
<td>Individual</td>
<td>34%</td>
<td>29%</td>
</tr>
<tr>
<td>Substance Abuse/Health Care Provider</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>Work/School</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
<td>9%</td>
</tr>
</tbody>
</table>

SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS).
CHAPTER 3: 
DRUG AND ALCOHOL TREATMENT IN PHILADELPHIA

The previous chapter explored the complex history of the growth of addiction treatment in the context of increasing criminalization of drug use and more punitive methods for addressing drug-related crimes. The current chapter provides an organizational landscape for the arrangement of “medicalized” alcohol and drug treatment in Philadelphia and the various programs that intertwine drug treatment with the criminal justice system. The project’s methodology is also discussed. The similarity between states in the methods of accrediting and administering drug treatment programs and the various ways that the criminal justice system incorporates drug treatment indicates that, while this dissertation focuses on locations in Philadelphia, the results may have some application to other urban areas in the United States.

The Distribution of Treatment Programs in Philadelphia

In Philadelphia, the Coordinating Office for Drug and Alcohol Abuse Problems (CODAAP), under the Department of Public Health, has administered the city’s state-licensed drug and alcohol treatment programs since 1973. According to a list published on their website, in 2006 there were eighty-eight licensed drug treatment programs in Philadelphia, providing services to over 17,000 Philadelphians annually (CODAAP 2007). CODAAP also coordinates drug treatment for various criminal justice initiatives, such as the Forensic Intensive Recovery Program, which diverts prisoners, parolees, and those on probation into treatment programs. While there are many other drug and alcohol treatment programs and support groups present in the city (from church-sponsored
lectures to “recovery houses” to Alcoholics Anonymous meetings), this chapter focuses on those that are licensed and monitored by the Commonwealth of Pennsylvania, because only these programs are recognized as legitimate treatment facilities whose services will be reimbursed by the state (or private insurance companies). For this reason, these facilities arguably house the most “medicalized” drug and alcohol treatment programs in that they meet the criteria set by the Commonwealth for licensing, have certain established methods of treatment in common that are shared with other accredited programs nationwide, and are the only settings permitted by federal law to administer methadone.

The various treatment facilities in Philadelphia offer a variety of services, including outpatient care, inpatient residential care, and methadone maintenance. The Pennsylvania Client Placement Criteria for Adults (PCPC) are a set of guidelines, produced by Pennsylvania’s Department of Health, designed to provide a basis for determining the most appropriate type of treatment for individuals with drug and alcohol problems. An individual seeking or being referred to treatment is required to be evaluated by a clinician at the treatment facility using these criteria, which were updated in a second edition published in 1999. Based on the individual’s responses to a number of questions in six different areas, the clinician determines the severity of the individual’s problem and recommends a particular level of care. The six dimensions include the severity or possibility of withdrawal symptoms, biomedical conditions and

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23 The Pennsylvania Bureau of Drug and Alcohol Licensing, under the Department of Health, inspects and licenses drug treatment programs. Accreditation requirements are extensive, and include specific obligations for staffing, client-counselor ratio (in outpatient programs, not to exceed 35 clients per counselor), the minimum educational attainment of counselors and supervisors, and training programs. Programs are inspected every year to ensure that they are complying with the standards for licensing.
complications, emotional/behavioral conditions and complications, treatment acceptance/resistance, potential for relapse, and the individual’s social environment. An individual with more severe problems in these six areas will be recommended for a more intensive level of care. In general, those with the possibility of severe withdrawal will be placed in a detoxification program, regardless of the severity of problems in the other areas. The assessed severity of problems in the other areas will determine the appropriate level of care in a treatment program that does not include detoxification.

The PCPC outlines nine possible levels of care. Facilities employing each of these levels of care can be found in Philadelphia. The use of pharmacological treatments (i.e., methadone) would not be considered a separate level of care but may be an additional treatment offered in certain programs. Below is a brief summary of the nine specified levels of care, ordered from least to most intensive, and their prevalence in Philadelphia. Each level of care represents a possible treatment “program” within one of the 88 treatment facilities. Table 3 shows the prevalence of the various program types in Philadelphia. This table was produced using a printed list of CODAAP programs obtained in 2004 and was updated with information from CODAAP’s website in 2007. While there are only 88 discrete treatment facilities, multiple levels of care can be found within many of the facilities, resulting in an estimated 207 different treatment programs managed by this office.

Many individuals involved in Philadelphia’s treatment system will participate in one or more of these programs through the course of his/her treatment episode. For

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24 Most, if not all, treatment facilities do not place much importance on the actual drug used in assessing the severity of the individual’s problem or in determining the proper course of treatment for the individual.
instance, somebody who completes an inpatient program will often continue treatment in the same or a different facility at the outpatient level. Similarly, those participating in an intensive outpatient treatment program (Level 1B) might also be living in a Halfway-House (Level 2B), and are therefore participating in two levels of care simultaneously. Several of these facilities have programs designed for specific populations, such as pregnant women or Spanish-speakers.

Table 3. Summary of Alcohol and Drug Treatment Programs in Philadelphia by Level of Care Offered, 2007

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Type</th>
<th># Programs</th>
<th>% of Facilities offering type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>Outpatient</td>
<td>65</td>
<td>74%</td>
</tr>
<tr>
<td>1B</td>
<td>Intensive Outpatient</td>
<td>40</td>
<td>45%</td>
</tr>
<tr>
<td>2A</td>
<td>Partial Hospitalization</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>2B</td>
<td>Halfway House</td>
<td>6</td>
<td>7%</td>
</tr>
<tr>
<td>3A</td>
<td>Medically Monitored Detoxification</td>
<td>13</td>
<td>15%</td>
</tr>
<tr>
<td>3B</td>
<td>Short-term Residential</td>
<td>23</td>
<td>26%</td>
</tr>
<tr>
<td>3C</td>
<td>Long-term Residential</td>
<td>33</td>
<td>38%</td>
</tr>
<tr>
<td>4A</td>
<td>Inpatient Detoxification</td>
<td>14</td>
<td>16%</td>
</tr>
<tr>
<td>4B</td>
<td>Inpatient Residential</td>
<td>10</td>
<td>11%</td>
</tr>
<tr>
<td><strong>TOTAL Programs</strong></td>
<td></td>
<td><strong>207</strong></td>
<td></td>
</tr>
</tbody>
</table>

| Total Number of Facilities | 88                      |
| % of Facilities that Include Methadone Maintenance Treatment | 14%                     |

Source: Coordinating Office of Drug Abuse Programs, Philadelphia.
Level 1A – Outpatient

An outpatient treatment program is an organized, non-residential program that provides psychotherapy at regularly scheduled sessions for, at most, five hours each week. Additional individual or group therapy may be included in this type of program, as determined by the treatment program. The criteria that must be met for an individual to be placed in an outpatient treatment program include minimal to no risk of “severe withdrawal syndrome,” a willingness to cooperate with the treatment staff, and a relatively stable social environment that offers emotional support for the individual seeking treatment. Of the 88 treatment facilities in Philadelphia, 65 (74%) offer outpatient therapy as a treatment option. It is the most frequently found type of treatment, possibly because of Pennsylvania Department of Health policy that any state-licensed drug and alcohol treatment facility can offer outpatient treatment. Thus, facilities that offer more intensive levels of care, such as inpatient and/or detoxification, are permitted to also offer outpatient treatment without meeting any additional licensing requirements.

The large number of outpatient substance abuse treatment programs also reflects a trend in general medical care toward more outpatient services rather than inpatient care. For substance abuse treatment, the trend in the past fifteen years has been toward more outpatient types of treatment, largely due to the high costs of inpatient care (Volpicelli and Szalavitz 2000). Because of the high costs, insurance companies will often limit the number of days a person can remain in inpatient treatment. Even if the program recommends 28 days of inpatient treatment, an insurance carrier might only reimburse 7-

geared toward a specific drug or drugs that a person used.

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10 days, resulting in a person participating in a shorter program or being forced to pay for the remaining days in treatment out of pocket. Insurance companies are more likely to cover outpatient treatment for longer periods of time. Researchers report that in national samples there were not significant differences in outcomes between those who had completed outpatient versus those who had completed inpatient treatment (for example, Miller and Hester 1986; Cummings 1991), yet outpatient treatment was far more cost-effective (Mojtabai and Zivin 2003).

**Level 1B – Intensive Outpatient**

Intensive outpatient treatment is also a non-residential type of program that provides structured individual psychotherapy and, often, group therapy sessions. While group therapy sessions are not required by CODAAP, they are commonplace in intensive outpatient programs in Philadelphia. At this level of care, an individual is required to receive at least 5 hours of treatment (but less than 10), at least 3 days a week. The main criteria that determines an individual’s placement into intensive outpatient rather than ordinary outpatient treatment is that those placed in intensive outpatient often have slightly more serious emotional problems and are determined to lack an understanding of the severity of their alcohol and drug problems. Of the 88 treatment facilities in Philadelphia, 40 (45%) offer an intensive outpatient treatment program. Each of the facilities in Philadelphia that offers an intensive outpatient treatment program also offers a non-intensive outpatient treatment program (Level 1A), where many people continue treatment after completing an intensive outpatient program. That is, after he/she completes the requirements for an intensive outpatient program, he/she will often “step down” to once a week individual therapy sessions with a therapist at the same facility.
Level 2A – Partial Hospitalization

While this level of care is found in non-residential programs, it is a more intensive type of treatment than the previously discussed outpatient types of programs. In a partial hospitalization program, the individual attends regularly scheduled treatment sessions at least 3 days per week for a minimum of 10 hours each week. Individual and group therapy sessions are each required twice a week. While an individual must have minimal to no risk of severe withdrawal to meet the criteria placing him/her in this level of care, he/she is evaluated to have more severe problems in the other five qualifying dimensions. The individual might have co-existing biomedical problems, have more serious emotional and behavioral problems, be more resistant to treatment, and lack a structured support system. While the person entering treatment has more severe problems in these dimensions, the problems are not so severe that they require a more intensive level of care (such as an inpatient program). There are currently three partial hospitalization programs in Philadelphia.

Level 2B – Halfway House

This level of care is characterized as a community-based residential treatment and rehabilitation facility, where individuals live in what is supposed to be a “home-like” atmosphere, often called a “Recovery House.” Individuals entering this type of treatment are required to have already had some experience in another type of drug and alcohol treatment or to be currently undergoing treatment elsewhere. Halfway Houses are live-in/work-out environments, where the typical length of stay is three to six months. While the individual must have minimal to no risk of severe withdrawal, the individual does meet the criteria requiring a more structured, residential treatment setting. Those criteria
might include a high risk for relapse, a very poor social environment and a lack of a social support system (i.e., friends and/or family members supportive of the individual’s treatment attempt). There are six half-way house programs in Philadelphia managed by CODAAP; these programs are separate for men and women. There are many other “recovery houses” in Philadelphia that are unregulated and unlicensed.

*Level 3A – Medically Monitored Inpatient Detoxification*

This level of care involves treatment in a residential facility that provides a 24-hour professionally directed evaluation and detoxification. Detoxification is “the process whereby a drug- or alcohol-intoxicated or dependent client is assisted through the period of time required to eliminate the presence of the intoxicating substance (by metabolic or other means) and any other dependency factors while keeping the physiological and psychological risk to the client at a minimum” (PCPC Manual 1999: 51). Treatment is conducted in a licensed drug and alcohol non-hospital detoxification unit. The main criteria that must be met for this level of care is that the individual has a risk of severe withdrawal syndrome that can be managed in this setting, but does not require the full resources of an acute care general hospital or a medically managed intensive inpatient treatment system. Individuals are strongly encouraged to participate in a more formal treatment program after the detoxification process, since detoxification is the only form of treatment a person is receiving at this level of care. Thirteen treatment facilities, or 15%, in Philadelphia offer a program of this level of care.

*Level 3B – Medically Monitored Short Term Residential*

This type of treatment consists of 24-hour evaluation, care and treatment, by professionals who are not necessarily primary care medical staff (doctors or nurses). The
individual seeking treatment will often be referred to this type of care if he/she has moderate impairment in social, occupational, or school functioning. Both individual and group therapy are required in this type of treatment. While the person who meets the criteria for this level of care shows no signs of withdrawal, he/she often has sufficient biomedical problems, serious emotional problems, a lack of understanding of the severity of his/her alcohol or drug problem, and an inability to control drug or alcohol use in his/her current social environment. In Philadelphia, there are 23 facilities (26%) that offer this type of treatment.

**Level 3C – Medically Monitored Long Term Residential**

This type of treatment is a residential program with 24-hour evaluation, care and treatment. Individual therapy is required in this setting. These programs serve clients with “chronic deficits in social, educational, and economic skills, impaired personality and interpersonal skills, and significant drug-abusing histories which often include criminal lifestyles and subcultures” (PCPC Manual 1999: 68). The criteria that must be met to place someone into this level of care includes a lack of social responsibility, past or current criminal behavior, dysfunctional relationships with family members, resistance to alcohol and drug treatment, a lack of a supportive social environment and a high potential for relapse. The existence and severity of these characteristics are determined by the clinician at the initial meeting with the person entering treatment. In Philadelphia, there are 33 facilities (38%) that offer this level of care.

**Level 4A – Medically Managed Inpatient Detoxification**

This level of care differs from Level 3A (Medically Monitored Inpatient Detoxification) in that the treatment takes place in an acute care setting. Individuals
seeking treatment with very severe withdrawal problems that require primary medical and nursing facilities are recommended for this level of care. Treatment occurs in a 24-hour medically directed setting where full resources of a hospital facility are available. Such programs often are found in acute care general hospitals, acute care psychiatric hospitals or an appropriately licensed chemical dependency specialty hospital with an acute care medical and nursing staff and emergency and life-support equipment. In these settings there is also the possibility of conjoint treatment for biomedical and/or emotional conditions. Individuals are often encouraged to engage in a longer-term treatment program after this detoxification program. There are fourteen treatment facilities (16%) that offer this level of care in the Philadelphia area.

**Level 4B – Medically Managed Inpatient Residential**

This level of care provides 24-hour medically directed evaluation and treatment for individuals with drug and alcohol problems who also have coexisting biomedical, psychological and/or behavioral conditions that require frequent care. Facilities that offer this type of treatment need to have, at minimum, 24-hour nursing care, 24-hour access to specialized and intensive medical care, and 24-hour access to physician care. Individual and group therapy sessions are also mandated. This is the most intensive treatment setting of all nine levels of care. Individuals often participate in this type of treatment program and then enter a less intensive program (i.e., halfway house, intensive outpatient or outpatient) at the end of the inpatient program. In the Philadelphia area, there are 10 treatment facilities (11%) that offer medically managed inpatient residential treatment.
Pharmacological Treatments

While there are nine levels of care for drug and alcohol treatment programs, as established by Pennsylvania’s Department of Health, some treatment programs utilize pharmacological treatments while others do not. Pharmacological treatments involve the prescription and distribution of pharmaceutical substances (such as methadone, LAAM, and naltrexone), most often for opiate users, but occasionally for other drugs, including alcohol. Most treatment programs that offer pharmacological treatments will also require patients to participate in individual and/or group therapy. However, an individual can receive a substance like methadone daily for many years and eventually not receive any other forms of treatment from the program on a regular basis.

Methadone is by far the most common pharmacological treatment for opiate use in Philadelphia, and in the rest of the United States (West, O’Neal, and Graham 2000). For an individual to be considered appropriate for pharmacological treatment, he/she must be 18 years or older, have been addicted to opiates for over one year (per federal regulations), and have a history of unsuccessful responses to non-pharmacological treatments. Methadone must be prescribed by a licensed physician and can only be administered by a treatment program (not by a pharmacy for take-home use). Individuals who receive methadone from a program may eventually receive take-home bottles of the prescribed dosage, requiring the individual to visit the clinic two or three days a week rather than daily. However, he/she will always have to visit the clinic to receive the prescribed medicine, even if reduced to once a week. Only twelve of the treatment facilities in Philadelphia offer pharmacological treatment in addition to the other treatments associated with the level of care of the program.
While methadone is the most common pharmacological treatment for opiate abuse, other prescription medications have been approved and are used on a smaller scale. These medications use the drug buprenorphine rather than methadone and are the first pharmacological treatments for opiate abuse that can be prescribed in a doctor’s office, rather than administered by a drug treatment program, per the Drug Abuse Treatment Act of 2000\textsuperscript{25}. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) website, there are currently 44 doctors in Philadelphia who are licensed to prescribe buprenorphine medications. However, because of restrictions as to which doctors can prescribe these medications (to qualify, doctors must receive a Drug Enforcement Agency identification number), and the high costs associated with the medications, they are not yet used on a widespread basis. Doctors who prescribe buprenorphine medications are also restricted by the number of patients that they are permitted to treat by federal regulations\textsuperscript{26}. A 2003 survey of doctors who were eligible to prescribe buprenorphine medications revealed significant barriers to the use of buprenorphine, including the lack of insurance coverage for the drug, difficulty accessing the medication in local pharmacies, and federal regulations about the number of patients who can be treated by each doctor. Even though these medications may not be offered on a widespread basis yet, they do challenge the existing drug treatment model by placing treatment for opiate addiction solely into a patient-doctor relationship.

\textsuperscript{25} Currently only two prescription drugs containing Buprenorphine - Subutex and Suboxone - have been approved by the Food and Drug Administration.

\textsuperscript{26} During the initial year after application for a license to prescribe these medications, physicians may only have a maximum of 30 patients that are currently prescribed the medication. After the initial year, a physician may prescribe the medication to 100 patients each year.
The Distribution of People in Treatment

The Coordinating Office of Drug and Alcohol Abuse Programs (CODAAP) estimates that it provides substance abuse treatment to approximately 17,000 Philadelphia residents each year. While I was unable to obtain data from that office regarding what types of treatment programs were the most populated, a review of national and state-level data reveal that people who receive substance abuse treatment most commonly do so in outpatient programs.

A 2006 national survey of the American population by SAMHSA revealed that approximately 4 million people in the United States participated in some type of substance abuse treatment in the previous year. Figure 5 shows the locations of the most prevalent named places for treatment. As the chart shows, more people received treatment in an outpatient facility than in any other location. More so, among those who attended treatment programs, almost twice as many went to outpatient care rather than inpatient (2.7 million people vs 1.6 million).

SAMHSA also surveyed treatment programs nationally to collect information about those admitted to treatment. They surveyed enough facilities that state-level data could be analyzed. Figure 6 shows the number of admissions into alcohol and drug treatment programs in Pennsylvania for select years between 1992 and 2006. The chart indicates that treatment admissions increased over the fourteen year period. While the population overall also did increase, the size of the increase in admissions is still significant despite the increase in the population size. For instance, in 1992, the number of treatment admissions reflects about 0.3% of Pennsylvania’s population; in 2006, treatment admissions were 0.6%. Most of the increase seems to have occurred through
the 1990s, with a much smaller increase between 2000 and 2006\textsuperscript{27}. This may reflect larger increases in federal dollars going toward treatment programs in the 1990s, as was revealed in President Clinton’s drug control strategy (chapter 2). While the drug control budget continued to grow under George Bush, the increases toward treatment and prevention programs were more modest compared to increases in law enforcement and interdiction efforts.

\textsuperscript{27} This is only an approximation because the data reflect treatment admissions, not individuals who entered treatment. A person might have multiple treatment episodes in a given year; each admission would be counted separately. Therefore, these estimates are probably slightly higher than the actual proportions in the population.
Philadelphia in Context

Because the treatment programs administered by CODAPP in Philadelphia must meet state licensing regulations, the types of programs and the services offered are similar throughout Pennsylvania. Looking at the distribution of treatment programs statewide, Philadelphia resembles the entire state in the types of programs available. For instance, a 2006 survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), revealed that 77% of treatment facilities statewide offer outpatient care, which is similar to the 74% of Philadelphia’s treatment facilities. Other levels of care statewide had similar proportions to those in Philadelphia. Although these licensing requirements vary by state, there is also evidence that the treatment realm in Philadelphia has some known similarities with substance abuse treatment across the nation. A 2005 survey by SAMHSA finds that 81% of substance abuse treatment
facilities nationwide offer outpatient care, making it the most popular form of substance abuse treatment. In Philadelphia, 74% of treatment facilities offer outpatient treatment, making it the most common form of treatment found in Philadelphia as well. Other levels of care had similar distributions nationwide as they do in Philadelphia. One distinction worth noting between Philadelphia’s treatment facilities and those nationwide is the proportion that offer methadone or buprenorphine for opiate addiction. While 14% of Philadelphia’s treatment facilities offer methadone as part of treatment, only 8% of all facilities nationwide do. This difference could be due to differences in the percentage of people seeking treatment primarily for heroin abuse in Pennsylvania (21%) compared to nationwide (14%). Overall, however, it appears that the treatment landscape in Philadelphia is similar to the rest of Pennsylvania and the United States. While it is not possible to claim with certainty that specific programs in Philadelphia will be similar in operation to other treatment programs nationwide, we could expect there to be similarities between Philadelphia and the United States as a whole, since the organization of Philadelphia’s treatment facilities largely reflects the organization of treatment facilities nationwide.

The number of people participating in the various treatment programs across Pennsylvania also reflects this pattern of organization. Table 4 shows the distribution of clients in treatment on March 31, 2006 by treatment type. The data were obtained by a survey administered to Pennsylvania treatment facilities. The response rate of the survey was 96.5%. While it only captures the number of people in treatment programs at one particular moment in time, it is useful for understanding the distribution by treatment
type, since we would not expect that proportion to fluctuate, even if the total number of clients did.

Table 4. Clients in Treatment in Pennsylvania on March 31, 2006 by Program Type

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>% of All Clients in Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Outpatient (Level 1A)</td>
<td>41.7%</td>
</tr>
<tr>
<td>Intensive Outpatient (Level 1B)</td>
<td>14.5%</td>
</tr>
<tr>
<td>Partial Hospitalization (Level 2A)</td>
<td>1.7%</td>
</tr>
<tr>
<td>Detoxification (Level 3A)</td>
<td>1.0%</td>
</tr>
<tr>
<td>Short Term Residential (Level 3B)</td>
<td>4.2%</td>
</tr>
<tr>
<td>Long Term Residential (Levels 3C)</td>
<td>5.4%</td>
</tr>
<tr>
<td>Inpatient Detoxification (Level 4A)</td>
<td>0.3%</td>
</tr>
<tr>
<td>Inpatient Residential (Level 4B)</td>
<td>0.8%</td>
</tr>
<tr>
<td>Methadone</td>
<td>30.5%</td>
</tr>
<tr>
<td><strong>Total (44,349)</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: National Survey of Substance Abuse Treatment Services, conducted by SAMHSA, 2006

The vast majority of people in treatment (86.7%) were in outpatient programs (including methadone treatment since that most often takes place in outpatient programs). A large number of admissions were receiving methadone treatment (30%), despite the relatively small number of facilities that prescribe the substance. This data does not reflect new treatment admissions for a given year, but rather a census of how many people are in treatment at a given moment in time. Because many clients who take methadone do so for much longer than a typical outpatient treatment episode, the percentage in the table of those in a methadone program could be a bit misleading. More importantly, this survey
reveals that the distribution of clients across different treatment types in Pennsylvania largely reflects the distribution of the programs themselves. Outpatient treatment is by far the most common type of treatment offered and treats the most people each year.

Drug Treatment and the Criminal Justice System

CODAAP also manages several programs in Philadelphia that intertwine the criminal justice system and alcohol/drug treatment services in various ways. This section will briefly describe those programs, with particular emphasis on Philadelphia’s Drug Treatment Court because of the intensity of the relationship between the criminal justice system and drug/alcohol treatment found within this program. The Philadelphia Health Management Corporation (PHMC), a non-profit public health organization, determines the level of care for individuals referred into these programs, authorizes payment for services from funding agencies, and provides case management services. The stated goal of all of the court-related treatment initiatives is “to enhance community safety by reducing criminal recidivism due to substance abuse and mental illness through the provision of behavioral health treatment and related services under criminal justice supervision as an alternative to incarceration” (PHMC 2007). As was discussed in Chapter 2, TASC (Treatment Alternatives to Street Crime) was the first widespread program to directly link the criminal justice system with the treatment establishment and was in many ways a precursor to the current set-up of programs that intertwine these two institutions.
The Forensic Intensive Recovery (FIR) Program offers eligible criminal offenders the opportunity to participate in drug/alcohol treatment as a condition of their probation. The program was implemented in 1993 in response to a 1991 federal decree that required the City of Philadelphia to provide a minimum of 250 drug/alcohol treatment slots for individuals currently in prison. The Defenders Association of Philadelphia refers clients it deems eligible for the program. These clients are then evaluated by PHMC for the appropriate level of care and referred to a community-based substance abuse treatment program. Specialized treatment programs are available for individuals with both substance abuse and mental health problems.

In addition to participating in drug/alcohol treatment, the FIR program participant will be assigned a case manager, who will meet frequently with the program participant and assess his/her progress. Initially, a housing coordinator will also assess whether the individual must live in a Recovery House. This assessment is made based on the current living situation and whether or not the coordinator evaluates the living environment as clinically appropriate. The program participant will also be in regular contact with his/her parole officer, who will monitor the client’s progress both directly and by communicating with the client’s case manager. Clients who leave treatment or who fail to attend treatment as ordered by the court will be sanctioned and possibly re-incarcerated. If a client is arrested for a crime during his/her participation in the program, then he/she will be dismissed from the FIR program.
Intermediate Punishment and Parole Program

Philadelphia’s Intermediate Punishment and Parole (IPP) Program offers drug/alcohol treatment and community service to non-violent offenders in lieu of incarceration. This program has been operating in Philadelphia since 1995 and requires an initial evaluation screening, conducted by PHMC, similar to the FIR program. Those who qualify for the program will attend community-based substance abuse treatment and complete a court-determined amount of community service. The program participant’s progress is monitored by a case manager and additional services, like vocational training, are offered. The types of offenses that qualify for this program tend to be less serious than those in either the FIR or the Drug Treatment Court Program.

Drug Treatment Court

Philadelphia’s Drug Treatment Court is part of a network of approximately 1700 such courts nationwide. The first drug treatment court originated in Miami in 1989; Philadelphia’s was established in 1997. As of April 2007, there were 1699 drug courts operating in the United States, with an additional 349 in planning phases (Office of National Drug Control Policy 2007). The growth of drug courts has been rapid and expansive. Drug courts can be found in all fifty states, the District of Columbia, and Puerto Rico.

These courts were created to deal with the increasing number of arrestees with substance abuse problems and the resulting crowding of prisons from the increased incarceration of individuals found guilty of drug-related offenses since the 1980s. Between 1989 and 1999, approximately 350 drug courts were implemented and evaluated. Studies of these courts generally agree that participants in a drug treatment
court have lower re-arrest rates compared with similar offenders not in a drug court program, although the rates fluctuate considerably by study (BJA Drug Court Clearinghouse Project 2006). The general acceptance of the idea that drug court programs have positive outcomes and save money compared to incarceration has facilitated the rapid growth in their numbers in the past several years. While the majority of drug court programs are for adults, there are also juvenile drug court programs, which were first implemented in 1995.

While the program specifications vary from court to court, there are several characteristics in common among the various drug treatment court programs. The U.S. Department of Justice, in collaboration with the National Association of Drug Court Professionals, published ten “key components” for defining drug courts in 2004. These components include the integration of alcohol and drug treatment services with case processing, the promotion of abstinence through frequent alcohol and drug testing, identifying eligible participants early, using a non-adversarial approach, ongoing judicial interaction with each participant, and close monitoring of the participant’s progress in achieving set goals. Eligibility criteria and specific program components, such as what types of treatment are offered, differ depending on the program.

Philadelphia’s Drug Treatment Court began in 1997 and was the first drug court in Pennsylvania. In a recent Philadelphia Inquirer article, the presiding judge of Philadelphia’s Drug Court reported that 1357 people have graduated from the program through May 2007 (Herbert and Shaw, 2007). Currently, a maximum of about 400 individuals participate in the program at any one time because of budget limitations. Philadelphia’s Drug Treatment Court has an annual operating budget of $1.5 million,
from state funding and federal and local grants according to another Philadelphia Inquirer article (Stoiber, 2005).

To be eligible for the Philadelphia program, an individual cannot have been arrested for a violent offense, is evaluated as having a drug and/or alcohol problem, and cannot have more than two prior, non-violent convictions (from “Philadelphia Treatment Court” brochure). Cases deemed as eligible are referred to treatment court from the District Attorney’s office. From the cases that meet the loose criteria listed above, Philadelphia’s program almost exclusively selects only first-time drug felony offenders for the option of entering the drug court program. Therefore, the majority of individuals currently involved in Philadelphia’s drug treatment court have been arrested for drug possession and intent to deliver and/or conspiracy.

Philadelphia’s program is a “pre-trial” court, meaning that individuals who meet the conditions for eligibility are identified at arraignment and sent to the court program for an orientation session. At that session, each defendant meets with the Public Defender assigned to treatment court (or a private attorney if they choose). The lawyer explains the treatment court program to the client, evaluates the individual’s case with him/her, and either recommends or does not recommend the program for that particular client. If the client decides to enter the treatment court program, then he/she enters a plea of guilty or “no contest” and starts community-based substance abuse treatment very soon after.

There are five phases of Philadelphia’s treatment court program. The first four must be completed in order to graduate; when the fifth phase is complete, the individual’s case is expunged. Throughout the program, the client is expected to remain drug and alcohol free (as monitored by frequent tests), to attend treatment sessions, and to work on
other goals once the treatment episode is over, such as getting a job or completing a GED. All of these program requirements are closely monitored by the drug court “team” – the judge, the public defender, the assistant district attorney, the client’s case manager, and the client’s therapist. Throughout the drug court program, a client must appear in court once a month, where his/her progress will be reviewed by the court team. If he/she is complying with the program requirements, then he/she will receive public encouragement from the judge and will also receive various rewards along the way. For instance, to complete phase one of the program, the client must fulfill all of the intake requirements for the court program and the designated treatment program, attend treatment as scheduled, be drug-free for thirty days, and not be convicted of any new crimes. At the completion of each phase, clients are recognized by the court team with applause and often receive a certificate or gift, such as a hat or a key chain. If a person breaks a rule or expectation of the court program, then he/she is sanctioned publicly by the judge. Sanctions vary from having to write an essay (usually a punishment when somebody occasionally relapses) to spending a weekend in jail (for missed court sessions, frequent drug use, or other more serious violations as assessed by the court team). Repeat sanctions and general program noncompliance results in termination from the program.

The program is designed to be completed in one year, although most participants take longer. On average, a person who graduates takes between 14 and 15 months to complete the program (Goldkamp, Weiland and Moore 2001). If a person successfully completes the program, and remains arrest-free for the year following completion, the person’s record is expunged. However, a person is foregoing the right to a trial and is entering a plea of no contest (essentially guilty) when entering the program. Therefore, if
a person does not succeed in the program, he or she will go directly to jail without a trial. The Judge of Philadelphia’s Drug Treatment Court program refers to this set-up as the “carrot and the stick”: the carrot is that if the person successfully completes the program, then the case is dismissed and one year later expunged; the stick is that if the person does not successfully complete the program, then he or she is going to jail for a determined amount of time based on the offense without any trial or opportunity to appeal.

Philadelphia’s Drug Treatment Court boasts a 77% graduation rate, according to the judge who presides over the court, along with 91% remaining conviction free in their first year following completion of the program (Herbert and Shaw 2007). A report published in 2001 evaluated Philadelphia’s drug treatment court between 1998 and 2000 (see Goldkamp, Weiland, and Moore 2001). This report revealed a number of characteristics of the treatment court participants28. For instance, 58% of participants were African-American, 28% were Hispanic and 13% were white. The median age of participants was 23 years and 83% of participants were male. Ninety-six percent were charged with a drug felony. The most common drug that participants reported using in the thirty days prior to beginning the program was marijuana (58%) followed by alcohol (41%). Seventy-three percent of participants were recommended to outpatient or intensive outpatient programs, with residential treatment being recommended for about 26% of participants.

28 While there has not been a more recent published report to describe participant characteristics, my own observations of the court during 2005 and 2006 suggest that these characteristics have remained rather consistent over time.
Research Methods

This dissertation uses qualitative methods to examine how drug problems are characterized and managed in institutions that label individuals as drug “addicts.” My primary research questions are (1) how is drug addiction conceptualized and managed in a criminal justice setting? and (2) how is drug addiction conceptualized and managed in a treatment setting? In order to respond to these questions, I conducted interviews and observations in two institutions that label individuals as “addicts”: a Drug Treatment Court program and an outpatient drug treatment facility (which housed a methadone program and an intensive outpatient program). My research project seeks to examine how the “addict” label is created and promoted within these two institutions and how those in these institutions negotiate competing definitions of that label (i.e., drug addiction as a criminal problem vs. a moral problem vs. a medical problem vs. a social problem vs. a spiritual problem, etc.). While the rigor involved in quantitative research is the application of structured questionnaires and statistical tools, the rigor in qualitative research is found in the “principled development of strategy to suit the scenario being studied” (Holliday 2002: 8). The data primarily come from observations at group therapy sessions in the drug treatment facility and observations of court proceedings at Philadelphia’s Drug Treatment Court. I also conducted open-ended interviews with participants and employees in these two sites. Data collection occurred from June 2005 to May 2007. Any available documents related to these facilities were also collected and analyzed. In order to explore the meanings of addiction in these two institutions, these qualitative methods seemed most appropriate.
Site Selection

Since my project is qualitative, I was limited in the number of programs I would be able to include in my dissertation, due to the time I would have to spend at each observing and conducting interviews. I initially planned to include five different treatment programs in my research design (with at least one having some clients from the criminal justice system). However, after my dissertation proposal was approved, data collection was initially halted for several months as I awaited approval from Temple University’s Institutional Review Board (IRB). During that time, I learned about Philadelphia’s Drug Treatment Court and sat in on several court sessions out of curiosity. As I learned more about the focus and structure of the court program, I consulted my advisor about including it as one of my sites for research. She quickly agreed that it would be a good site to explore my research questions, and the rest of my committee concurred. Philadelphia’s Treatment Court then became one of the major sites where I would conduct research.

Due to the length of time I was going to spend in the drug court program, it became apparent that I would have to decrease the total number of sites that I had initially planned on including in my dissertation. Since the treatment court program incorporated outpatient treatment as part of the program, and it is the most prevalent form of treatment, I decided that I would focus the remaining part of my research on outpatient treatment programs. As I had initially planned, I also wanted to include a methadone maintenance program. As the first part of this chapter revealed, most of the people who go through drug treatment do so in an outpatient setting and there are more outpatient programs in Philadelphia than any other treatment type. A substantial number of people are also
enrolled in methadone maintenance treatment, making it the most popular type of treatment for opiate abuse.

I reviewed the list of programs in Philadelphia from the Coordinating Office of Drug and Alcohol Abuse Programs (CODAAP). I wanted to select programs that served as broad a population as possible, in terms of substance of abuse, and were not limited to special populations (i.e., pregnant women or Spanish-speakers) so that the program might be more generalizable to other programs in the city. I also wanted to ensure that the programs included clients from the various criminal justice initiatives. I contacted 15 of the remaining programs (based on location accessibility) and asked them to send me brochures describing their facility and programs. I also asked them questions over the phone about the general structure of their programs and the inclusion of clients from the criminal justice system. I received information in the mail from eleven of the programs. The programs’ brochures and my telephone conversations suggested that they were all quite similar in their approach to treatment, including individual counseling, group therapy sessions, use of twelve step methods, and, in some programs, methadone maintenance. From that list I chose a facility that housed two separate treatment programs, one an outpatient methadone program and the other an intensive outpatient program. I chose the programs because they were under the same organizational management, a teaching hospital, and thought it would be useful for my research questions to analyze two different treatment modalities that operate within the same organization (so that differences by treatment modality were not likely a result of the organization itself). The facility also met my other criteria: one of the programs was a methadone maintenance program and the intensive outpatient program included clients
referred from all of the various criminal justice initiatives in Philadelphia that incorporate drug treatment. Because the programs are affiliated with a teaching hospital, I had to submit my proposal and questionnaires to their IRB for approval. While this delayed my data collection at the sites, in the end it proved to be beneficial to the project. Those working in the programs seemed to view my project as more legitimate because I could show them the approval from their own IRB as well as Temple’s.

While it is not possible to generalize my findings from these two programs to others in the city, the licensing requirements by the state, as well as the program-level components that must exist to be labeled a certain type of treatment program (i.e., Intensive Outpatient – Level 1B), suggest that there are likely some similarities in these programs with others that offer the same treatment type. From my brief survey of other outpatient programs (through brochures and telephone conversations), it appeared that there was little variation in the general structure of the programs across the city. With several exceptions, all of the programs are located in poorer residential neighborhoods in the city, which suggests that the population of individuals in treatment at the programs I chose would also likely be similar by class to those in other programs. Many of the programs were also in predominantly African American neighborhoods.

*Treatment Court*

I observed Philadelphia’s Drug Treatment Court program for six months. Court sessions were two days a week, every Tuesday and Wednesday. On Tuesdays, court proceedings were mostly occupied with the public defender meeting eligible participants, explaining the program, and enrolling those who wanted to enter the program. Wednesday’s sessions were typically filled with the monthly visits of program
participants, as well as a graduation ceremony once a month. During these observations, I sat in the back of the courtroom where the program participants also sat. I took brief notes during the court proceedings and wrote more detailed fieldnotes afterward. Throughout my time in treatment court, I probably observed about 150 program participants and about 14 different court staff.

I approached every employee of the court program that had direct contact with clients inside and outside of the courtroom for an interview. Those who agreed to be interviewed included the assistant public defender, the evaluator who is in charge of new participants’ initial assessment, the case management supervisor, and the coordinator of Philadelphia’s “model courts” (which include family court and community court in addition to drug treatment court). Since it was difficult to talk to these people while in the courtroom, I contacted them by mail or telephone to seek an interview. I interviewed all of them in their respective offices. The two most-involved individuals who either declined or ignored my request for an interview were the judge and the assistant district attorney. One of the case managers that I observed also ignored my letter and telephone messages seeking an interview. However, during the time I was observing the court sessions, I heard an interview with the presiding judge of the Treatment Court on the local station of National Public Radio. I transcribed verbatim this one hour-long interview and included it in my analysis.

I also interviewed four clients who were going through the court program and one who had completed the program and returned to be a guest speaker at a graduation. The four clients who were enrolled in the court program were also in treatment at one of the programs included in my sample. Our interviews took place at the treatment program.
approached the treatment court graduate on the day he spoke and we arranged an interview that took place in his home.

Each interview that I conducted lasted between one and two hours and was tape recorded, with the exception of the case manager supervisor, who would only answer my questions via typed responses. The in-person interviews were semi-structured with open-ended questions that were slightly tailored for each interviewee depending on his/her position in the treatment court. See Appendixes A and B for examples of questionnaires. Each interview was transcribed verbatim.

Southside and Westview Treatment Programs

I also completed observations at a treatment facility that housed two distinct drug treatment programs. The treatment facility was affiliated with a major hospital in Philadelphia and operates in total four drug/alcohol programs across the city. The two programs that I observed and recruited interviewees from were housed in the same building on different floors, and had separate staff, separate billing procedures, and operated mostly independent from one another. This site was chosen because it exemplified some of the more “medicalized” characteristics of drug and alcohol treatment: its hospital affiliation and its ability to dispense methadone on site.

The first program I observed was an outpatient methadone maintenance program (Level 1A), which was given the fictional name “Southside Clinic.” At this program, I observed a group therapy session for three months that met twice a week. Every group member signed a consent form granting me permission to observe the group sessions. However, in order to not be intrusive, I never tape-recorded sessions and only wrote detailed fieldnotes after the group meeting was over. At a given time, this group would
usually have between eight and ten members. Two different counselors were in charge of the group, each running it on alternate days. Throughout the course of my observing, I encountered approximately 25 different people participating in the group. All of the people in this group session were new to the Southside program, with the exception of one member who had been a patient at the clinic for several years. Most were seeking treatment for heroin abuse, with several indicating that prescription opiates (i.e., oxycodone) was their drug of choice. Several cited poly-substance abuse problems (most often using benzodiazepines and/or cocaine along with heroin). Participants were expected to attend these group therapy sessions for two to four weeks and then enter the intensive outpatient program. All of the group members were also receiving daily doses of methadone.

The other program I observed was an intensive outpatient program (Level 1B) that I assigned the pseudonym “Westview.” One of the defining features of intensive outpatient versus ordinary outpatient is the inclusion of multiple hours of group therapy each week. There were four different groups at Westview. I observed two of these groups; each group met three times a week. In total, I observed these groups for four months. Both groups were designed explicitly for individuals who were not receiving methadone as part of treatment. These groups included those who were self-referred to treatment as well as those referred from the criminal justice system (i.e., Drug Treatment Court, FIR). Approximately half of the group members were referred from the criminal justice system (according to the program coordinator). A group session would typically have between seven and ten members and last two and a half hours. Throughout the
course of my observations, I encountered about 30 different people participating in both groups.

I also conducted face-to-face, open-ended interviews with group participants and several people working in each program (Southside and Westview). I approached every counselor that I encountered in these group sessions for an interview; all of them consented (4). I also asked to interview the clinical/program supervisors in each program who both agreed. In the programs, I approached clients and asked to interview them after a group session. I would attempt to schedule the interview for that day or for the time immediately following the next group session, since clients were more likely to participate if they did not have to make a separate trip to the facility for the interview. My selection of group members to approach for an individual interview was rather unscientific. In general, I tried to include a broad range of client characteristics, in order to get the most diverse group of interviewees. Therefore, if after one session I approached a male to interview, the next session I would first approach a female. I alternated my interview requests also by race (when possible) and how long someone was in treatment. At the Southside Clinic, I interviewed eight participants from the group. At the Westview clinic, I also interviewed eight group participants, four of whom were affiliated with a program that intertwined substance abuse treatment with the criminal justice system (such as FIR or drug treatment court). These interviews were tape-recorded and transcribed verbatim. Each interview lasted between one and two hours.
The next three chapters discuss my major findings\textsuperscript{29}. In chapter four, I turn to the treatment court setting to discuss the ways in which addiction gets defined and used in that program. Chapter five focuses on the Southside and Westview programs and ambiguities around their use of the addiction label. Chapter six examines further these ambiguities around the addiction label in both programs.

\textsuperscript{29}Most of the analysis comes from the observations in each setting and the interviews with those working in the court and treatment programs. I had initially planned on including an additional chapter on the clients’ perspectives, but ultimately decided to focus on the organizational aspects of the programs. In the end, I think that it makes a more coherent dissertation, although I do plan on returning to those interviews and writing a separate paper based on them. Initial analysis of those interviews was presented in 2006 at the annual meeting of the American Sociological Association.
CHAPTER 4:
PHILADELPHIA’S DRUG TREATMENT COURT AS BOTH A LEGAL AND MEDICAL AUTHORITY

Judge Gallo\textsuperscript{30}, a white, bearded man of approximately 65 years, sits at the courtroom bench in front of a large green banner that reads “Philadelphia Drug Treatment Court” in gold letters. On the banner is also a picture - the traditional “scales of justice,” with the addition of the doctors’ symbol of two snakes around a staff, prominent in the center post. The judge gives a brief introduction to a group of six individuals who have just entered a plea of “no contest” to their charges of possession with intent to deliver a controlled substance in exchange for acceptance into Philadelphia’s drug treatment court program\textsuperscript{31}:

\textit{Judge Gallo}: To be in this program, we assume you have a problem with drugs and/or alcohol. If not, you shouldn’t be here... If you’re here to quote ‘beat your case,’ you’re not in the right place. The primary reason for you to be in this program has to be that you recognize that you have a problem and you want to do something about it... The truth is, if you don’t have a drug or alcohol problem, you’ll fail. There’s too much expected of you... You all know the expression, it’s just the tip of the iceberg? Well, if you understand that expression, then you get the point of this court. Because only 10\% of an iceberg is visible above the water. Well, the 10\% above is the substance abuse. And the 90\% below is the reason for it. If you have other problems, you need to recognize it. And we’ll get you help... You might have low self esteem, depression, anger, mental health issues. You can get treatment but you need to own up... It takes at least one year to complete this program... You’ll come here about once a month. You’ll stand there right in the middle. You’ll have your case manager on one side, and the treatment provider on the other. You know the Clint Eastwood movie, \textit{The Good the Bad and the Ugly}? Well, we decide which you are... I’m going to give you six words to memorize.

\textsuperscript{30} All names of persons have been changed.
\textsuperscript{31} I felt it was inappropriate to use quotation marks unless the statement was recorded verbatim by a tape recorder. Therefore, excerpts from my fieldnotes do not contain quotation marks since the dialogue was recorded from memory soon after an observation. All face-to-face interviews I completed were tape-recorded and transcribed verbatim, however, so quotation marks are used around statements from those interviews. Judge Gallo’s remarks in quotation marks come from a recorded broadcast of a radio program on which the judge was interviewed.
If you memorize these six words, and abide by them, you’ll get through. There are three positive words, and three negative ones. So first, the positive ones. Honesty. You have to be honest with the court and everyone else. There can’t be any denial. Next, be committed to doing this. It will take a year of your life, so you need to be committed. Third, be responsible. Maybe no one ever held you responsible for anything. Here, we’ll hold you accountable. Ok, now the three negative: [says slowly] people, places and things. The vast majority of people fail the program because of these reasons. You can no longer after today be around people, places or things. If you do, you’ll fail… I’ll leave you with a visual aid. There are four doors in this courtroom. One is behind me, so that doesn’t count. So that leaves you with three. The two doors behind you, that’s where you come in and out, come and go as you please. The door to your left, that door goes to jail. So at the end, you will either go through one of those doors behind you, with a diploma under your arm, or you’ll go through this side door and go to jail. It’s up to you. Remember those six words: honesty, commitment, responsibility, people, places and things. Back door graduate, side door terminate. [from fieldnotes]

The judge exits the courtroom as the court coordinator gives each of the individuals an appointment to meet with the court evaluator who will assign him/her to a specific drug treatment facility. These individuals are now official “clients” of Philadelphia’s Drug Treatment Court Program32.

While there are other criminal justice initiatives that implement drug and alcohol treatment, Philadelphia’s Drug Treatment Court Program, as well as drug courts in general, appears to be the most-heavily supervised of these initiatives, combining elements of the criminal justice system with an emphasis on treating the “disease” of addiction. Supervision occurs at both the treatment and the criminal justice levels and these two institutions interact consistently throughout an individual’s movement through the drug court program. At the program-level, negotiating these two sometimes-opposing

32 All of the court staff, as well as the handbook of the treatment court, always referred to the participants of the treatment court program as “clients.” I use the same label throughout this chapter for continuity, but I do discuss in a later chapter the significance of the labels used for the individuals in both the treatment court and the drug treatment programs.
perspectives on drug use can be difficult. As the training manual of the 2007 conference of the National Association of Drug Court Professionals (NADCP) reads, “Drug courts strike a balance between ‘hugging a thug’ and ‘locking them up and throwing away the key.’” This chapter explores how a “medicalized” concept of addiction (as in, a disease that needs to be treated) is articulated and reinforced within a criminal justice setting. The analysis is based on observations of Philadelphia’s Drug Treatment Court and interviews conducted with the court staff and several “clients” participating in the program. I also examined documents related to the annual conference of the NADCP to understand how this organization of drug court professionals defines addiction issues and how to manage them in the court setting. Just as Judge Gallo’s introduction to the program emphasizes issues of treatment as well as the necessity of being responsible and accountable, there is an overlap of medical and legal emphases throughout the program articulated by all of those involved. It is difficult to distinguish which components of the program rely on the client’s acceptance of a disease model of addiction and which are related to the client’s compliance with the other steps necessary to complete the program, such as getting a job or further education. The end result is a rather ambiguous overlap of the medical, the legal, and the moral in both a philosophical approach to managing drug problems and the practical application of services from both the criminal justice system and the treatment program. Despite the apparent contradiction of combining treatment with punishment, this incorporation of treatment for addiction into a criminal justice initiative, and heavily

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33 As described in Chapter 3, I completed six months of observations at Philadelphia’s Drug Treatment Court program. I also interviewed the Assistant Public Defender, Case Manager supervisor, the court evaluator, the manager of specialty courts, and two clients associated with the program. While the judge declined to be interviewed by me, I was able to secure a transcript of an hour-long interview he did on a local radio program. This interview occurred during the same time period of my observations.
monitoring it, serves the interests of the court program and further legitimizes the criminal justice system’s role in managing drug-related issues.

Overview of Philadelphia’s Drug Treatment Court Program

Drug Treatment Courts (also referred to as “drug courts”) first came into existence in Miami, Florida in 1989; Philadelphia’s Drug Treatment Court program was established in 1997. Today, more than 1500 drug courts operate around the country and similar programs can also be found internationally. The number of drug courts nationwide has increased dramatically, especially since the mid-1990s (see Figure 7). The further medicalization of drug and alcohol abuse, and the public’s subsequent acceptance of drug addiction as a disease that should be treated, are possible reasons for this legal shift in dealing with substance-using offenders (for example, Conrad and Schneider, 1980). Indeed, there is evidence to suggest that Americans do not think that drug addiction should be heavily penalized. A 2001 poll conducted by the Pew Research Center found that 52% of Americans believed that drug use should be treated as a disease, compared to 35% who favored treating it as a crime. In a 2004 national survey, 81% of people said they would be more likely to vote for a candidate for Congress who favored reducing spending on the war on drugs and reallocating the money toward drug prevention, education, treatment, and recovery programs (Center for Health and Justice at TASC 2007).

However, most research on drug courts emphasizes structural reasons for their development. Most scholars of drug courts will cite the exploding rates of incarceration and the crowded legal system, largely due to the 1980s “War on Drugs”, and subsequent
harsher sentencing policies, as the structural impetus for the development of drug courts (Olson et al., 2001). Still, there has been little analysis examining how the “medical” and the “criminal” interact in such a setting, and the ways in which these different perspectives co-exist.

Figure 7. Number of Drug Courts in the United States, 1989-2006

The presiding judge of Philadelphia’s Drug Treatment Court, Judge Gallo, cites mostly structural reasons for why the program was initiated:

Judge Gallo: “It was very frustrating because the same people were coming back for the same reasons. Some, unfortunately, for more serious offenses. So the opportunity was presented to me [in 1995], ‘Do you want to try something different?’ And, I was approached to consider starting a drug court. Quite frankly, I didn’t know what they were talking about.” [from a radio interview]
While he mentions being unaware of drug court programs at the time, he says that substance abuse appeared to be the “underlying problem” for most of the offenders he was encountering. At the same time, however, he does not agree that the solution would be to increase the number of alcohol/drug treatment programs and access to them, or to incorporate drug/alcohol treatment into prison or probation:

*Judge Gallo*: “What you could do obviously is place them on probation and hopefully they would get some treatment… But the problem was, there wasn’t really someone in place to monitor what they do… This program… they come before me, we review everything they do…we hold them accountable for what they need to do.” [from radio interview]

Access to high-quality treatment is not enough to curb the problem, according to Judge Gallo. The court system still needs to be active in the supervision and monitoring of clients as they go through treatment. One implication of this emphasis is that the client might not be responsible enough on his/her own to get “better” and that one of the court’s functions is to ensure that the client follows a treatment plan.

Thus, the court program uses a “carrot and stick” model of justice as the judge explains during a radio interview:

*Judge Gallo*: “There are statistics out there…that will tell you most voluntary treatment does not work. What works is coerced treatment…So you need the carrot and stick…The carrot is this: you’re arrested for selling drugs in Philadelphia, it’s a felony offense, many people are facing 5-10 years as a maximum sentence. What we’re gonna do is give you all the treatment you need, all the ancillary services you need, and then at the end of this, if you graduate, your plea is withdrawn and your case is dismissed with prejudice. I mean it’s over forever…And then a year later, if you’re arrest-free and drug-free, we’re gonna expunge your record; it’s gonna be erased. Now that’s that carrot. The stick is this: if you don’t complete the program, you are going to jail, and the only question is how long… You now have a convicted felony, but secondly, you still have not addressed your substance abuse problem.” [from radio interview]
The judge emphasizes the need for coerced treatment and the “stick” to ensure compliance with the program. At the same time, he mentions that failing the program also means that the person will still have a substance abuse problem, a serious issue that the judge associates with the criminal activity.

This interaction between a medical view of addiction (a problem that needs to be clinically treated) operating within a criminal justice framework (a crime that should be punished) is rather easily framed by the judge: the court evaluates them as needing treatment, the court sends them to treatment, the court makes sure that they are compliant with the treatment plan they are given, and the court sanctions them if they are not compliant. There is no ambiguity about the court’s role, at least according to the judge; while they do not provide the treatment services, they determine what the treatment will be and whether or not the client is compliant with that treatment plan. In reality, there is much more ambiguity over what is considered “treatment” and what is not, and, as a result, over what should be done regarding issues of non-compliance and what is viewed as client irresponsibility.

The Stage, the Actors, and the Script

In *The Presentation of Self in Everyday Life* (1959), Erving Goffman uses a “micro-sociological” perspective, viewing interactions as “performances,” where an individual constructs identity through his/her presentation of self, his/her interaction with others and the setting in which those interactions occur. This theoretical perspective is useful when examining Philadelphia’s Drug Treatment Court Program and the action that takes place in the courtroom. James Nolan (2001), in his analysis of several drug courts
in the United States, uses Goffman’s notions of social interaction to describe the drug court setting and the changing roles of the court staff within it. He illustrates that the judge, public defender, and district attorney shed the typical adversarial roles associated with the criminal court and instead work cooperatively on each client’s case (Nolan, 2001). I also employ Goffman’s perspective, but in an attempt to illustrate how the main players in the court create an appearance of unity despite underlying conflict that exists due to the overlap of medical and criminal justice perspectives operating in the same program. This conflict is not a direct result of the changing social roles within the courtroom, that is, a move toward less adversarial relationships among the courtroom participants. Instead, I argue that conflict emerges mainly because of clashing views (those of medical and criminal) about how to deal with a client who faces possible expulsion from the program. In most cases, the public defender will argue that the client’s addiction problem is the underlying cause of his/her breach in compliance with program rules, and subsequently needs more intensive treatment. Arguing against that analysis, the assistant district attorney will most likely advocate that the judge hold the client criminally responsible for his/her actions (or lack of) and attempt to convince the judge that the client should go to prison. In situations where the client’s drug problem does not appear to be a major issue (he or she is compliant with treatment, is following the court procedures as instructed, or possibly does not have a very serious problem), little conflict emerges. In this section I will first explain the court procedures and how people enter the drug court program. By examining each of these processes, it becomes clear that the “medicalized” notions of addiction get tangled up with the legal realm in every stage in the program. Then, I will focus on issues of conflict in the courtroom and how this
conflict is a result of the overlap of the medical, moral and criminal perspectives that exist.

Figure 8 summarizes the steps to entering the drug treatment court program. All phases, except for the clinical evaluation, are organizationally managed by the criminal justice system. While the clinical evaluator is employed by the Philadelphia Health Management Corporation (a non-profit, public health organization that contracts with the city), he only conducts evaluations with individuals who have been referred to his office from the criminal justice system. At the conclusion of officially entering the program (a plea of “no contest” is recorded), the client is scheduled to begin whatever alcohol/drug treatment program he/she has been assigned. The Department of Public Health pays for treatment services, through the office of the Coordinating Office of Drug and Alcohol Abuse Programs (CODAAP).

Eligibility criteria for drug court programs vary by court; for a person to be eligible for Philadelphia’s drug treatment court program, the offense that he/she was arrested for must be non-violent and he/she cannot have more than two prior convictions or juvenile adjudications. While any offender who claims to have a drug/alcohol problem who meets the above criteria is technically eligible to participate in the program, the District Attorney’s office targets individuals with first-time felony drug charges (mainly possession with intent to deliver) for entry into the program. As a result of this effort, almost all (96%) of the treatment court participants are facing a drug felony charge, according to an evaluation of the program through the year 2000 (Goldkamp et

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34 While the criteria that the offense is “non-violent” must always be met, the District Attorney’s office exercises some flexibility when determining who is eligible for the program based on prior criminal record, according to the assistant Public Defender assigned to the Treatment Court.
Figure 8. Entering Philadelphia’s Treatment Court Program.

- Person is Arrested
- District Attorney Flags Case as Targeted Offense
- Client Goes to Treatment Court Session
- Client Meets with Public Defender – First Time
- Client is Evaluated for drug problem
- Client Returns to Treatment Court – Meets with Public Defender again
- Client Enters Plea and Begins Treatment Court Program
- Client Rejects Program OR Client Found to be Not Eligible
al., 2001). That same report also indicated that the racial breakdown of participants was 58% black, 28% Hispanic and 13% white, which is far different from the racial breakdown of the city of Philadelphia (43% black, 8% Hispanic, and 45% white, according to the 2000 Census), although may reflect the disproportionately higher arrest rate for drug-related crimes among minorities\textsuperscript{35}. The median age at the start of the program was 23 years and participants were almost exclusively male (83%). My own observations, while far less scientific, would conclude that these demographic factors were similar during the year that I observed (2005-2006)\textsuperscript{36}.

What the individual was arrested for and his/her criminal history, then, are used to initially determine eligibility; drug use or abuse is not a primary consideration despite drug treatment being such an important focus of the court program. Since the District Attorney’s office targets drug felony cases and there are currently only enough resources to handle approximately 400 cases a year, most individuals who qualify for the program never have the option of entering the program. In addition, most eligible participants are probably not aware of the program. Some of these cases do find their way into the program – perhaps the individual’s lawyer knows about the program or the case gets sent to the Public Defender’s office and the attorneys decide to refer the case to the treatment

\textsuperscript{35} A recent report by the Sentencing Project found that drug arrests for African Americans increased at three times the rate for whites in large cities between 1980 and 2003, while usage rates are quite similar for the two groups (King 2008).

\textsuperscript{36} In contrast, the court staff members were almost exclusively white and female. The judge, the assistant district attorney, the assistant public defender, the court coordinator, and the support staff for both the assistant district attorney and public defender were all white. All but the judge and one of the assistant DA’s paralegals were female. The only racial diversity seemed to be in the position of case manager. There appeared to be about 8 or 9 different case managers. One was an African American male who looked to be in his late 40s, one was a Hispanic woman who appeared to be in her mid-40s (she would also translate for Spanish-speaking clients); the remaining case managers appeared to be young (mostly in their 20s), white men and women.
court program. However, almost all of the cases that end up in treatment court are from that targeted group of drug sales cases that the District Attorney’s office processes\(^{37}\).

Once a client has been referred to Philadelphia’s treatment court program, he/she will visit the court on a Tuesday for an initial introduction to the program. He/she will also meet with the Assistant Public Defender, who, according to her own estimate, represents about 70% of all participants in the program. During this initial visit, the potential participants will first be addressed by the Assistant Public Defender, Liz:

\[\text{Assistant Public Defender} \text{ [standing in front of a group of approximately 10 individuals sitting in the gallery]: Good morning everyone. My name is Liz and I’m from the District Attorney’s office. I will be representing most of you. When you are arrested, the first thing you have is a preliminary hearing. This is where your case is brought before a judge. The police officer is there and he explains what you were arrested for. The judge then decides if there is enough evidence to have a trial. Then you have a trial where you defend your case. This here is neither of those things. This is a treatment program (motions hand to green banner above judge’s bench). The program lasts a year. You are here because your case was randomly selected based on the charge. You have a choice of whether you want to complete this program. If you complete the program, then your record is wiped clean. There are two requirements for you to be on this program. One is that you are a drug user and you want treatment. The treatment you will get will last about a year. The second is that you plead no contest. What that means is that you forego any preliminary hearing and any opportunity to defend yourself. If you are successful in the program, then no plea is ever officially entered in your record, and your record is wiped completely clean of the crime. If you fail, the plea is entered, you don’t get a trial, and you go directly to jail. This is a purely voluntary program. You do not have to participate if you don’t want to. [from fieldnotes]}\]

These possible participants were likely arrested about two weeks prior to this initial day in the courtroom and referred directly from the District Attorney’s office\(^{38}\). After the

\(^{37}\) Goldkamp et al. (2001) estimated that about half of all eligible cases do not get referred to Treatment Court.

\(^{38}\) The small number of cases that are referred to Treatment Court through another mechanism (i.e., a personal lawyer) would not attend this initial session and would proceed directly to meeting with the court evaluator.
assistant public defender (Liz) gives this introduction, she meets with each client individually to assess whether or not they want to consider the program. If the client decides to consider the program, then he/she is given an appointment to meet with the court evaluator who will assess the person’s drug problem. In this first meeting, Liz only gives each client a brief overview of the program because she likely does not yet have full discovery and therefore does not know all of the details of the case and cannot offer other legal options to the client. That she refers to the court program as a “treatment program” reflects her perspective on addiction and its placement in the court. While in a typical courtroom the public defender would “defend” his/her client from the charges he/she faces, the public defender in the treatment court mostly “defends” the client’s addiction from those who push for more punitive methods. Her case tends to rely on research on the causes and consequences of addiction and she often argues that the client should not be held as responsible for his/her actions because of his/her “disease.”

At this point, most clients appear to be eligible for the program based on the charges against them and prior criminal record. The court evaluator then assesses the severity of the individual’s drug/alcohol problem. If the client reports that he/she has an alcohol or drug problem (by his/her own admission), then he/she is deemed to be clinically eligible for the program. In this sense, just about any drug use is seen as a problem in need of treatment. In an interview, the court’s evaluator, Patrick, mentions that there are few clients who would not be eligible for the program based on the evaluation he does with them:

*Patrick:* “Really the only way that they’re going to become ineligible for the program *clinically* is if their mental health rules them out. Because
there are some levels of mental health that we are just not capable enough
to deal with.” [from interview]

Specifically, Patrick mentions several serious mental health conditions, like
schizophrenia or other un-medicated disorders that could prohibit someone from entering
the program. He also reveals that the primary means of determining the appropriate level
of treatment for a person is through a subjective questionnaire that asks questions about
how often a person uses drugs and what types of drugs he/she uses. Urine drug tests
might confirm or deny a person’s report of use, but for the most part, the person’s own
admission of his/her problem is the primary method for determining what the extent of
his/her drug problem is. Thus, if a client uses *any* drugs, and states that he/she considers
the use to be a problem, then he/she will be deemed to need treatment. The evaluator
mentions that he might also place a person into a higher level of care if he wants to add
more structure to that person’s life:

*Patrick:* “If you’re 28 and unemployed playing Playstation all day,
chances are you’re lit while you’re doing it, you know what I mean? And
also if you’re not *about* anything, then I’m gonna put you in treatment.
I’m gonna make you about something. So a situation like that, I might put
him in intensive outpatient just for a more healthier engagement… More
time in treatment is more access to making clients want more of
themselves, you know what I mean? To want an education, or *want* a
better job or to *want* to do job training, anything like that.” [from
interview]

The level of care, then, is not necessarily determined by the severity of the person’s drug
problem, but the perceived severity of other problems, like unemployment, under-
education or criminal history. This also helps to explain why some of those areas also
become “medicalized” by the court and the treatment programs, as I will illustrate later in
the chapter.
Like a well-rehearsed play, the monthly appearance of a client in the courtroom followed a regular pattern with a memorized script. The client would stand before the judge in between his case manager and his counselor or treatment provider, both of whom would summarize the report. The judge would then ask the client “How are you doing?” and often congratulate the client on having a “good report” or let him/her know that he/she was “doing well.” From these interactions, “doing well” meant that the client was attending all scheduled treatment sessions, had no positive urine drug screens, and was meeting with his/her case manager. In addition, if the client had been in the program for a significant length of time, then “doing well” meant that he/she was also working or pursuing some educational goal, such as studying for the GED exam. The judge smiled and seemed genuinely pleased when clients were doing well, and would often then joke with them and ask about family members. The judge also used these clients to emphasize to the rest of the court room what “you’re supposed to do.” These interactions would only take a minute or two, and were by far the most common type of interaction found during Wednesday’s sessions. Among the Wednesday sessions I observed, about 80% of clients followed this pattern and were deemed to be “doing well” and received no sanction. The actual rate of sanctions, however, is higher because the court also met on Tuesdays, but primarily for two other reasons: introducing new clients to the program and reviewing the most serious cases facing possible expulsion from the program.

“Doing well” also meant successfully progressing through the five phases of the treatment court program. Completion of the first four phases results in graduation from the program; the fifth phase is to remain drug-free and conviction-free during the 12 months post-graduation in order to have the client’s record expunged. Phase one is
measured during the first 30 days of the program. During that time, the client must complete all of the necessary steps to enter the program, attend treatment sessions and meetings with his/her case manager as scheduled, have no new convictions, and remain drug-free for thirty days. Phase two is completed at the end of the next three months, as long as the client is drug-free for 90 days, attends treatment and case manager sessions as scheduled, has had no new arrests or convictions, and has had no more than two sanctions from the court. Phase three occurs after an additional four months of attending sessions and treatment, no new convictions, and being drug-free for 120 days. In addition, the client is supposed to pay all court fines and costs at this point, although most cases I witnessed were permitted to pay those costs up to the day before graduation. Phase four requires another four months of proper attendance, no new convictions, and being drug-free for 120 days. Completing phase four resulted in graduation from the program. When a client completed each phase, the Judge recognized it during his/her monthly court appearance and everyone in the courtroom would applaud. Small gifts were also often given to the client when he/she completed a phase, such as a framed certificate, a hat, or a key chain.

The culmination of the four phases of the drug treatment court program was a graduation ceremony and subsequent dismissal of the charge that made the client initially eligible for the program. On the last Wednesday of each month, the clients who had met the criteria to complete phase four during the previous few weeks would participate in the graduation event. Past graduates were often invited as guest speakers, and at one graduation ceremony, I witnessed several members of the Pennsylvania State Legislature, including Speaker of the House Dennis O’Brien, observing the event. Spirits were often
very high at this event, especially among the court staff, who would enthusiastically congratulate clients, take their photos, and meet their family members. The judge would read each graduate’s name and summarize his/her course in the program, including what level of treatment was undergone, whether he/she was working or going to school, and other accomplishments that the judge deemed worth mentioning. The client would then receive a framed graduation “diploma” and address the crowd. Many speeches by the clients were short, sometimes a quick “thank you” to the court or even a curt “I did what I had to do, now I’m outta here” type of remark. About half of the graduates would refer to a speech that they had written (at monthly appearances leading up to graduation, the judge would frequently ask the client if his/her “speech was ready”).

The graduate would occasionally get quite emotional while addressing the crowd. These emotional speeches were often referred to by the court staff as further evidence that the treatment court program was successful at accomplishing its goals, even though most speeches were not emotional nor particularly long.

*Patrick* (evaluator): “I’ll tell you, I came in here with a little bit of a bias…You know, I don’t know if it’s a bias, but there’s not enough money for drug and alcohol [treatment] these days. So my attitude was, if you think I’m going to waste my money on dealers that are trying to beat a case, you’re out of your mind. There are too many people dying out there for some little 18 year-old who got caught hustling three nick bags to take the money for treatment so that he doesn’t have a felony on his record…And then after making a couple of the graduations, boy, that will really open your mind up…Guys talkin’, ‘Look, you know, I found a wife, I support my children now, I pay child support now, I have a job, I realize that kinda nonsense…blunt existence is not anything I’m about.’ You know, *those* can be really moving. I mean, that’s where this program excels, is taking not even really a spark of desire and absolutely turning it into something. I mean, to this day, the graduations, I still can’t believe those…” [from interview]
Judge Gallo: “I mean I had one young lady, um, she sang a song to me. And that was her speech, this song. And then you have others that come up and say, another young lady, that her mother never knew her sober after she was 12 years old. And her mother died like three months ago and missed her graduation and then she holds up her diploma and says ‘Mom, this is for you.’ I mean I could go on and on with the stories.” [from radio interview]

The first quote above demonstrates that Patrick, the court evaluator, initially had doubts about the program’s focus and the resources used for the group that the District Attorney’s office targeted for participation (drug sellers). Perceiving a transformation by the clients, however, convinces him that those who are targeted do benefit from the program and therefore he does not have any uncertainty regarding whether or not drug sellers are actually drug “addicts.” Similarly, the judge recounts emotional graduation speeches as evidence of people who “turn their life around” because of treatment court. The court staff offer these events as evidence that the program is the right way to handle these cases; it was likely intentional that the only time state legislators (who must approve state funding) visited the court was on a graduation day.

A defining feature of the drug court program is the non-adversarial nature of the whole court experience. Others who have studied drug treatment courts (and subsequent court programs based on this model) emphasize this as a main difference between traditional courts and the drug treatment courts (Nolan 2001). In a traditional court, the public defender would typically represent the client against accusations made by the assistant district attorney with the judge acting as a mediator. In the drug treatment court, the public defender, district attorney and judge are most often working together in discussing a particular client and evaluating his/her progress in the program. Rarely do these roles become adversarial on the floor of the courtroom. This apparent
cooperativeness also reinforces the idea to the client that everybody is in agreement about the goals of the program and that having a clinical component (treatment for addiction) in a criminal justice setting does not produce ambiguity about roles within the program. Everybody enforces the clinical aspects of the program (compliance with treatment), just as they all enforce the criminal justice aspects (compliance with the law).

Sometimes conflict would occur among the courtroom actors. One way that those who work in the treatment court, the “court team,” create a balance between the medical and the criminal justice perspectives that are sometimes in conflict is through successful manipulation of the “backstage” and “frontstage” settings in the courtroom (Goffman, 1959). While the frontstage is the courtroom floor where cases are publicly presented, the backstage consists of the various actors discussing clients who are violating some rule of the program. During these “backstage” meetings, which often take place in the judge’s chambers before the afternoon court session, “problem cases” would get discussed and most often sanctions would be determined before the court sessions began. Interestingly, the client would not be present at those meetings. Participants in this process would describe how there would often be disagreement in the “backstage” meetings. Here, the treatment court evaluator discusses those backstage meetings:

Patrick: “Instead of getting into this huge thing at the bar of the court, the holds are addressed before court with the DA, the PD, the Judge, the case manager and Ashley, the supervisor. So when it does come to the bar of the court, it’s almost like it’s scripted already. Like, earlier on, we discussed, blah, blah…and sanctions are usually decided back there. Cause the argument that takes place back there, nobody needs to see at the bar of the court, certainly not the client.” [from interview]

As Patrick illustrates, conflict might occur at those meetings, over what is an appropriate sanction, or whether or not the client should be terminated from the program, but when it
is time for the client to appear before the judge, and for the team to put on their “frontstage” performance, the team creates the appearance of unity.

At other times, disagreement between the court team would occur in public, on the courtroom floor. These situations, which were rare, would most often involve the public defender arguing for leniency in sanctioning due to an unaddressed need for treatment. The assistant district attorney, in those times of conflict, would most often argue against any leniency and advocate for harsher punishment, regardless of the “clinical” case that the public defender was making. The judge would most often also dismiss issues of treatment and instead emphasize the client’s lack of responsibility and accountability. Here is one such example from a hearing in court:

Assistant. D.A.: Your Honor, you know this case well. The client began the program in March of 2004. And she doesn’t even have a phase 1 certificate yet. She had to spend a week in jail. She went AWOL, relapsed. In September of 2004 she was sentenced to a jury box…three days jail in October 2004. Tested positive for opiates and cocaine. November 2004, 3 days in jail. Was discharged from Recovery House for breaking rules…Your Honor said it was her last chance…We request that she be terminated from the program.

Public Defender: Your Honor, the client has one ARD for K and I [lesser sentence for possession charge]. She’s only 24 years old and she doesn’t have a substantial criminal record. What she does have is an addiction. She’s been using opiates for most of her adult life. Her problem in the program has primarily been with relapsing. At Presbyterian, there was some report of behavioral problems. The court ordered a psychiatric because it was felt that the client might be a dual-diagnosis. It’s known that 60% of women addicts have a dually diagnosed mental health problem. The psychiatric didn’t occur. It was finally done by [treatment facility], where she was diagnosed with a Mood Disorder and Bipolar Disorder. She was still not diagnosed with a dual-diagnosis problem because she’s on methadone. The Dual diagnosis should have been identified earlier. It was the responsibility of the court to follow through with the order given, and for some reason it wasn’t. Her behavioral problems at the programs is an indication of her dual diagnosis. I am asking the court for another chance because of this late diagnosis.
Judge [addresses public defender]: Ms. Peterson, tell me. What, if any, responsibility does she bear? What you’re telling me is it’s collectively all our fault. What’s her responsibility? Second, you asked for all those things. You’re the one. You can’t have it both ways. Third, as far as being on methadone, we can’t make a program specifically for her nor any other individual in this program.

Public Defender: Judge, I missed this too. I didn’t push for the psych [evaluation]. What’s Shauna’s responsibility? To be honest with what’s going on with her. I don’t know if someone can diagnose themselves. A lot of our clients give into impulse and they don’t know why. She’s found out and now she needs to deal with it.

Judge: But she’s not even trying! I don’t see any basis for letting her continue.

Public Defender: Will the court hear from her?

Judge: Sure, go ahead.

Client (crying): I don’t think I deserve another chance… Nobody has any reason to believe me, including my mother who is present here. But, I’m just tired of using.

Judge (angry): What are you doing about it? Now you’re tired because you’re going to jail?

Client: No. I’m tired of everything. The lifestyle…

Judge: I hear this all the time. ‘I’m an addict. I need help. But I won’t stop using and I won’t go to treatment’…

Client: I had a hard time at some of the programs… I didn’t get along with the counselors. I don’t know what else to say.

Judge: I don’t see any effort…The court finds you guilty of possession of oxycontin with intent to deliver. Guilty of conspiracy. November 15th, back here for sentencing.

In this situation, the public defender uses research on addiction, as well as a personal appeal by the client, to elicit support for the notion that this client needs more treatment and should be allowed to stay in the program. The judge, however, does not give her another chance because he perceives her as irresponsible, regardless of her diagnosis or addiction. The judge and the district attorney do not dispute the evidence that she has an addiction problem, but such a diagnosis does not diminish the client’s level of responsibility in any way.
The Importance of Addiction in the Structure of the Program

The participant’s handbook for Philadelphia’s Drug Treatment Court Program indicates that the program is “unique because it represents a much closer working union between treatment and the criminal justice system than is traditionally seen in the criminal courts.” Indeed, as articulated both by court documents and interviews with the court staff, the client’s addiction problem is of prime importance in the drug treatment court program. At the same time, however, this “union” between the legal and the medical institutions is not without ambiguity in theory and practice. In this section, I will outline how the “disease of addiction” is articulated and emphasized in the program and describe how this notion is also enforced by the various members of the court staff. The importance of the client’s drug/alcohol problems and the necessary treatment for these problems is articulated throughout the duration of the program. Because this emphasis takes place most often in the courtroom setting and is articulated by the court staff, it becomes difficult to disentangle the “treatment” part of the program from the other components. It also contributes to ambiguity of whose authority (medical or legal) it is to evaluate the extent of addiction and provide treatment, since the court staff play such a large role in both the clinical and the legal aspects of the program.

Go Directly to Treatment

One of the ways that treatment for addiction is articulated as a major goal of the program is through the enforcement of attending treatment sessions. The importance of attendance is pressed upon the clients at their initial meeting with the court evaluator, even before they have officially entered the program:
Patrick: “Treatment becomes the trump card when you join treatment court. I let them know, once you sign that dotted line at the bottom, not only are you signing away all your rights and fair legal proceedings, a trial by jury and all of that, you know, but you are letting us know that you now clearly understand that while you are in treatment court, drug and alcohol treatment’s now the most important thing in your life. And if you can’t make that statement, don’t sign that paper.” [from interview]

The level of care that the evaluator assigns can be restricted by what gets approved for public funding, just as in any other treatment setting. Using the evaluation criteria, a structured interview called the “Addiction Severity Index,” Patrick ends up referring the majority of clients to intensive outpatient treatment (IOP), followed by ordinary outpatient treatment. Very few clients get referred to more intense levels of care, such as partial hospitalization or inpatient. Some of this is likely due to funding restrictions, as Patrick articulates here when referring to issues with opiate users:

Patrick: “The days of innumerable detoxes are certainly gone… If someone has a couple of in-patients under their belt and I want in-patient, there’s a very good chance that they’re not gonna get it. They’ll say, ‘Look, this isn’t cost effective; they’re not serious. They’re just gonna have to stick this through at IOP.’” [from interview]

There are ways of getting around funding restrictions that Patrick mentions. Here he refers to a situation that occurred with an opiate user who was initially approved for outpatient methadone maintenance although Patrick sought a higher level of care:

Patrick: “I’ll tell them, go to the clinic. Stay clean, but if you can’t, go to the clinic and give these urines. Because if you go to the clinic and keep droppin’ hot urines for other things, then we can make a case. ‘Look, she has a certain level of commitment now, she attends the clinic regularly…She’s doing her part, but she is no match for this addiction and [she needs] more intensive treatment.’” [from interview]

Patrick said that he would almost always receive the requested increase in level of care in the above situation. Interestingly, it appears that for alcohol/drug treatment, the lowest
level of care is first tried and if not successful, then a higher level of care is pursued. Similarly, if a client has had inpatient treatment before (it was probably deemed clinically necessary), and is in need of the same treatment again, that initial “failure” excludes him/her from another inpatient treatment episode.

The importance of treatment sessions is also emphasized in the court, especially during the client’s monthly appearance before the judge. How many sessions the client attended is reported, and if he/she missed any, the judge will determine if it was an excused absence. If the missed session is deemed to be an unexcused absence, then the client is sanctioned. Even if the client is working, the judge views that as no excuse for missing treatment sessions, as is shown here in the courtroom:

Judge: Why did you miss these treatment sessions?
Client: I had to go to work.
Judge: Does your employer know that you’re on a program?
Client: No. I didn’t want to say.
Case Manager: You need to work out a schedule with your therapist so that you can go to work but not miss sessions.
Judge: If you still miss, either get a new job or try telling your employer. If it’s a good employer, he or she should understand. Most do.
[from fieldnotes]

The judge is rather lenient in the above case because the client is working (he showed documentation proving so) and because he has most likely not had other sanctions or is newer to the program. The judge will not be as lenient, even if the client is working, if he perceives the missed sessions to be an indicator of a larger issue, namely, irresponsibility or not taking the program seriously:

Judge: You’re crawling when you should be running by now… Don’t ever mistake kindness for weakness. Big mistake.
Client: I got a job and that’s why I missed treatment… Is there any way I can get a second chance?”
Judge: Second?! How about a third? You getting into the program was your first chance. Then, I gave you parole. That was your second chance. In baseball, it’s three strikes and you’re out…What are you gonna do if I give you another chance?

Client: Go to treatment.

Judge (reluctantly): We’ll continue the hearing. But listen to me. If I hear of one violation. Just one! You know how much time you’re looking at?

Client: 18 months.

Judge: 18 months.

Public Defender: There might be a problem getting him in treatment because he was discharged from [names treatment program].

Judge: Well, get him in. That’s one of the conditions. We’ll continue the hearing on November 8th.

[from fieldnotes]

The judge is not as tolerant in this case, even though the client also claims that work is interfering with treatment sessions. Similarly, the judge will grant harsh sanctions for missing treatment if it is an ongoing problem:

Assistant D.A.: Your Honor, the client has been AWOL from treatment and has not seen or communicated with his case manager.

Client: How long have you been in the program?

Judge: Since February of ’03.

Client: No, you’re a year off. You started in January of ’04. Yet, you haven’t learned to call your case manager and talk about your problems? You’ve only completed four months of this program even though you’ve been in it for eighteen months. You’ve spent over a year in Phase 3. The bottom line is you’ve done nothing. You’re very immature and very irresponsible. You are going to go to jail for a week. You should think about what you want… You need to stop wasting my time. You’ve been here too long with nothing to show for it.

[from fieldnotes]

Attending treatment sessions is also one of the criteria for advancing through the program to the next “phase.” The judge grants a harsh sanction for the client in the situation above – a week in jail because of the client’s lack of progress. If the client fails to return to treatment after his time in jail or fails to attend all of his sessions regularly, the Assistant
District Attorney will likely request a “show cause hearing”, which is the final hearing to determine whether a client will be dismissed from the program.

While the court emphasizes the importance of attending treatment sessions, it also monitors how the treatment program delivers services. Through weekly reports and meetings with case managers, the therapists from the treatment facility must demonstrate the extent to which the client is participating in the court-determined treatment plan. This also leads to court monitoring of the treatment facility itself, since case managers will visit the various facilities and request reports about treatment.

*Liz* (public defender): “The treatment court is very involved in holding the treatment facilities accountable for providing effective treatment. The traditional criminal justice system, again, is not usually involved. They usually assume that the treatment facility is providing adequate treatment without really knowing if they are or not. So that allows the client to in fact get effective, real treatment.” [from interview]

Monitoring of treatment programs is another way that the drug court program differentiates itself from the traditional criminal justice system, even though they also have initiatives that incorporate drug and alcohol treatment. It also further extends the court’s jurisdiction into how treatment services are delivered, presumably even to those participating in the drug/alcohol program who are not involved with the treatment court program. In the end, it also adds to the confusion about the difference between the legal components of the treatment court program and the medical ones.

*Just Say No*

Another way that the client’s drug/alcohol problem becomes a prominent focus in the court program is through the enforcement of abstinence. The importance of abstinence is initially emphasized by the assistant district attorney when the clients are in
the courtroom entering their plea of “no contest” and formally enrolling in the drug treatment court program. The assistant district attorney gives an overview of the rules of the court program and emphasizes that from that moment forward, the client cannot use drugs or alcohol:

*Assistant District Attorney* [addressing new clients]: You need to know that from the moment you enter your plea, you are in the program. You cannot use drugs. We’re going to get you treatment to help you.

[from fieldnotes]

The judge will frequently refer to this instruction by the assistant district attorney if a client claims that he/she did not realize that he/she could not use drugs before starting treatment. Also, if the judge determines that the client has used drugs or alcohol at some point, the client will have to go back to the beginning of whatever phase of the program he/she was in.

Every drug/alcohol treatment program affiliated with the court emphasizes abstinence and monitors drug use through weekly urine drug tests. Those drug test results become part of the client’s monthly report, and the therapist and case manager will let the judge know if any urine tests were positive or missing. Even after a client completes a treatment program, he/she will continue participating in weekly urine drug tests. If a drug screen is positive, the client will be sanctioned for relapsing.

Many treatment providers and researchers regard relapse as an unfortunate, but likely, component of the recovery from drugs and alcohol (see McLellan et al. 2000). The structure of the treatment court program suggested that it had the same attitude. If a client was new to the program and had positive drug test results in his monthly report, the judge
was quite lenient in sanctioning the client. He would most likely assign a 200-word essay on relapse as a sanction. Here is one example:

*Judge:* Have you used since June 3rd?
*Client:* No.
*Judge:* Because if you have, it’ll show up. We give you the opportunity to be honest with the court...Some people need time to get it in gear. You need to ask for help and we’ll help you... It’s not a shame to stumble. Everyone does.
[from fieldnotes]

Here, the judge is encouraging the client to be honest with the court about using drugs. As he says, everyone stumbles. Relapse as inevitable at the beginning of the program was frequently mentioned. However, if the client denied that he/she was still using, and the drug test results were positive, the judge expressed concern that the client was being dishonest with the court, something for which the judge would assign a more serious sanction. Tolerance for relapse, then, existed as long as the client was honest about it:

*Judge:* Have you used in the last week?
*Client:* No.
*Judge:* You looked to my right. You’re new to treatment, it’s not unusual to relapse once in a while...Why don’t you rethink your answer?
*Client:* I used on Saturday.
[from fieldnotes]

In these cases, the client will still likely get sanctioned. However, the sanction will be minimal, usually a short essay on relapse.

Clients would also be sanctioned for using alcohol, although they would not often be tested for it, unless the client was initially evaluated as having a significant alcohol problem.
Asst. Public Defender, Liz [standing next to client and holding hat and framed certificate]: The client completed Phase 1.

Judge [looking over report]: It says here that he consumed alcohol.

Asst. Public Defender [putting down items and picking up report from table] Right. That was before he started treatment.

Judge: He still needs to be sanctioned.

Asst. DA: Yes he does.

Judge: Ok. We’ll do that. You’re going to have to write an essay addressing the alcohol use. You know you can’t do that once you enter the program. Congratulations on completing Phase 1. [applause from courtroom and Public Defender gives him the items]

[from fieldnotes]

In the above example, the client admitted to having consumed alcohol at some point between entering his plea of “no contest” and his first treatment session. He is still sanctioned, however, because of the rule that the clients cannot consume alcohol or drugs once they are officially in the program.

Tolerance for relapse declined if the client was not honest about it. Here is an example of a client who, while in a residential treatment facility, apparently used somebody else’s urine instead of his own for a drug test:

Judge: There is a consequence for tampering with a urine. Do you know what that consequence is?

Client: No.

Judge: It’s an automatic one week in jail… If you had been honest, you wouldn’t be going to jail. Part of treatment is to pick you up when you fall. Very few make it through without falling. It’s the nature of the beast. Nobody said it would be easy…

[from fieldnotes]

The judge grants a sanction of one week in jail, but also mentions that if the client had been honest, then he would have received a much lighter sanction. Having the stated rule that a client will spend a week in jail for tampering with a urine also reinforces the importance of two of the central principles of the drug treatment court program – responsibility and abstinence. A tampered urine does not give the court accurate records
about the client’s drug use and indicates that the client is not taking responsibility for his/her actions.

There was also less tolerance for relapse if the client demonstrated an ongoing problem with still using drugs, or if the client missed treatment sessions or appointments in addition to using drugs:

*Assistant Public Defender:* This case has been discussed. The client missed four sessions. Two were excused. And he continues to test positive for marijuana.

*Assistant D.A.:* He also fails to meet with his case manager.

*Client:* I’m on dialysis. That’s why I missed my case manager appointment.

*Judge:* What about the marijuana use?

*Client:* I was depressed at the holidays. I found out I had bad kidneys.

*Judge:* Let’s see here. In March, you wrote an essay. In April, you were in the Jury Box. May, a day at Options. Sounds like a song. [Sings next sentence] I got sanctioned again…You’re going to spend a weekend in jail and you’ll have to go to a Recovery House.

[from fieldnotes]

In the above case, the client had to write an essay because he had a positive report for drugs in March. In the subsequent two months, he was also sanctioned for continued use and possibly missed sessions. The judge this time gives him a much harsher sanction – jail time and a recovery house (a structured living environment), showing decreasing tolerance for the client’s continued drug use and for other things the judge classifies as irresponsible (such as missing sessions).

The judge also was less tolerant if the client tested positive for drugs that were not the primary drug he/she was in treatment for. Here is a situation in which the client has a positive drug report but the case manager mentions that the exact drugs that were used are not yet known:
Judge: When was the last time you used?
Client: Sunday.
Judge: Just marijuana?
Client: Yes.
Case Manager: We want to know if he’s using Xanax.
Judge: We know you’re going to slip. But if you slip and start using new drugs, you’re not taking advantage of the program. The report will tell us what you’re using. Will the urine test come back saying you also used Xanax?
Client: No.
Judge: What made you go ahead and use on Sunday?
Client: I was with friends.
Judge: People, places, and things. You have to separate yourself…Need to get it into gear. You’ll need to write a 200 word essay.
[from fieldnotes]

Again, the judge articulates that tolerance is somewhat inevitable when a person begins treatment for alcohol/drugs. However, this case is treated more seriously because it appears that the client is using Xanax in addition to marijuana, which is the drug he is in treatment for.

Sanctions for drug use became more severe if the client continued using. The first time a client tested positive for drugs, or if he/she had a significant amount of time in the program before relapsing, then the sanction would most likely be a short essay. If the client continued to use, sanctions would include spending a day sitting in the jury box, spending a day at Options (a drug treatment program in a local prison), or having to move into a Recovery House. It was not entirely clear at what point continued drug use could lead to expulsion from the program. In all of the cases that I observed that were dismissed from the program, there were additional violations, such as missing treatment or case manager sessions, or getting arrested again, in addition to possible continued drug use. I never witnessed a client getting evicted from the program solely because of continued drug use.
Another way that addiction was considered a disease was through the encouragement and enforcement of attending Narcotics Anonymous or Alcoholics Anonymous meetings. These meetings also place abstinence as a primary goal of “recovery” from drug and alcohol abuse. The handbook that all participants received on the day that they entered their plea indicated that one of the rules of the program was to actively participate in alcohol/drug treatment, which would include attending twelve-step meetings such as Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous. Participants could log in their attendance at these twelve-step meetings in the last 15 pages of the handbook.

Attending twelve-step meetings was often encouraged or required by the drug/alcohol treatment program that the client was assigned to through the court. However, court staff might also require participation in these meetings on occasion, regardless of the treatment facility’s policy regarding twelve-step attendance. Here, the judge is asked about whether he mandates twelve-step meeting attendance:

**Caller:** “Do you implement or require participation in a 12 step program like A.A. or N.A.?”

**Judge:** “It depends. I will, if I believe a client needs a sponsor and needs N.A. or A.A. And we have Marijuana Anonymous also in Philadelphia. Yes, I will order it as a condition of participation in the program.” [from radio interview]

Other court staff might also require twelve-step meeting attendance as part of treatment.

It is the court evaluator’s job to assign the client to a particular treatment program. At the same time, he can add components to the client’s treatment plan that are in addition to what the treatment facility requires:
Patrick (evaluator): “I’m a big fan of, you know, kind of requiring 12 step meeting attendance… [If someone comes back to me for a re-evaluation because they relapsed], now I’m gonna require two or three N.A. meetings a week. On the sole fact that, look, even if you don’t really want to participate, even though you don’t have your hand up telling everybody who you are, call yourself an addict, if you sit there long enough, you are bound to build a relationship with somebody. You’re gonna leave there with one phone number. And my whole bit is that, the next time that comes on you, you really can’t rap to your girl or your mom about this. You might say to yourself, I might as well call this dude instead of going to jail.” [from interview]

For the evaluator, twelve-step meetings could serve as a protective factor against returning to drug use or criminal activity, since the client will possibly build relationships with other abstinent people. This is the primary reason he gave for requiring these kinds of meetings, rather than as some sort of therapeutic outlet for the client.

Mandating twelve-step meetings as part of drug/alcohol treatment results in the court staff becoming active participants in the organization of the client’s treatment for addiction. In this case, we see an overlap of the court’s main responsibility of monitoring treatment with actually determining treatment plans by incorporating twelve-step meetings into the program. While the court staff have this authority to determine or change the course of treatment for the client, somewhat ironically, the treatment facility would not have the same authority. The treatment plan that was determined by the court evaluator could not change without the treatment facility consulting the court staff.

In addition to requiring twelve-step meetings, the court will use twelve-step language and “slogans” throughout their interactions with clients. Use of this language spreading into the courtroom demonstrates how pervasive the twelve-step model of addiction is. It has been well-established as the primary model of addressing addiction in
drug/alcohol treatment programs. As an extension, it then becomes the primary model of understanding addiction in the courtroom as well.

For instance, the judge will refer to somebody as being in “denial” of an alcohol or drug problem if he/she is not honest with the court about using substances. Here is one scene as an illustration:

Assistant District Attorney: Your Honor, this matter was discussed in the back. The client has missed sessions and he also came to group [treatment sessions] intoxicated.  
Public Defender: …Your Honor, the client appears to still be drinking. We are very concerned about it. Otherwise, he has been doing everything he needs to do.  
Client: I haven’t been drinking.  
Case Manager: Your Honor, the client admitted to drinking before their 10am meeting. His counselor said he admitted to drinking to him.  
Judge: Did you just say that you weren’t drinking?  
Client: I don’t think I was drinking.  
Judge: There’s no in between. You either did or you didn’t. You’re obviously in denial about your alcohol problem.  
Client: I don’t have an alcohol problem.  
Public Defender: I would like to ask the court for a reassessment so that we can determine the exact nature of Mr. Johnson’s problems.  
Judge: Reassessment granted. I also order a Jury Box for his next appointment.  
[from fieldntoes]

In the above situation, the judge tells the client that he is in “denial” of his alcohol problem. What then happens also demonstrates an overlap of the clinical and the legal: through the public defender’s insistence, the client will be reassessed (that is, he will receive a clinical evaluation of his drug and alcohol problems) and by the judge’s order, the client will also be punished by having to sit in a jury box for the entire duration of court the next time he is scheduled to appear. In this case, perceived denial of a drug or alcohol problem leads to both clinical and punitive outcomes.
Other words and phrases from twelve-step ideology were commonly used. In the judge’s introductory speech to new participants, he tells them to remember three positive and three negative words. The three negative words are “people, places and things.” He cites these as three sources of trouble for the client that could lead to continued drug use, further arrest, and/or a prison sentence. The phrase “people, places, and things” is also a common maxim of twelve-step programs to illustrate the main causes of relapse of drug/alcohol use after some period of abstinence. In group treatment sessions that I observed (see Chapter 5), the phrase used just on its own, without context, produces a shared understanding of its meaning among the members. The judge’s use of the phrase expands its meaning beyond just alcohol or drug use into criminal behavior as well. Throughout the program, the judge will repeatedly emphasize “people, places and things” as a source of not just relapse into drug use but also relapse into criminal activity after some period of abstinence from both.

Case Manager: My client was positive for opiates, marijuana, and cocaine.
Judge: What do you have to say for yourself?
Client: I moved in with my mom but it’s not the right environment. There is a lot of peer pressure…
Judge: I told you when you started. People, places, and things. It’s not going to be easy.
[from fieldnotes]

The judge would often try to relate the reason for relapse back to people, places and things, even if it was not the reason, as was the case later that same day:

Judge: When did you last use marijuana?
Client: A week ago.
Judge: Why did you relapse?
Client: I don’t know.
Judge: Were you alone or with other people?
Client: I was by myself.
Judge: Well, you’re new to the program. You’ll have to do a 200 word essay on relapse.
[from fieldnotes]

The judge asks the client if he was with other people as if he wanted to demonstrate how that would lead to drug use. When the client admits that he was alone, the judge does not resort to any twelve-step lingo as the possible reason, and instead relates it to the client being “new” to treatment.

How the clients responded to the judge indicated that they also understood the importance of this phrase. Here is an example of a client who has been attending treatment sessions regularly, but had a positive urine drug screen for cocaine at some point in the prior month:

Judge: What happened there?
Client: People, places, and things. I was helping friends bag drugs…
Liz (public defender): He was helping other people stay addicted.
Judge: You’ve been in the program long enough to know…You’re using the lingo. Since May 4th have you been hanging out with that group?
Client: No.
Judge: Looks like you’ve got a lot of time on your hands. You will have to do 36 hours of community service by your next appointment.
[from fieldnotes]

The judge in the above situation is quite lenient with the client, even though he was obviously engaging in an illegal activity. When a client would recognize that “people, places, and things” led to a relapse of drug use or criminal activity, the judge would demonstrate disappointment with the situation, but as long as the client was still attending treatment sessions, did not often assign particularly harsh sanctions.

Similarly, when a client would graduate from the program, he/she would occasionally refer to that phrase as a reminder of how to stay out of trouble or as advice
for the current clients in the program. Here is one client, an African American male in his mid-20s, speaking on graduation day to the audience:

Client: …I’ll never forget the judge’s words: people, places and things. They can really get you in trouble… [from fieldnotes]

Here the client associates the phrase with the court, rather than a twelve step program. He also uses the expanded meaning of the phrase found in the court- that of causes of general “trouble” and not just relapse into drug or alcohol use.

This phrase was of utmost importance for the court. The meaning went beyond relapse of drug/alcohol use; it conveyed a sense of responsibility to the whole program. In the judge’s introductory speech to the clients he always cited those three negative words as the only negative words that the client needed to remember. He always also followed up that forewarning with a story of a former client:

Judge (addressing group of new clients): There was a 19 year-old guy here. And I was going to order a Recovery House for him because he kept using drugs and was getting into trouble, got arrested again. Even before I could order it, this guy says, “Judge, I would like a Recovery House.” I knew he needed one. I said, “why do you want to go to a Recovery House?” He said, “I can’t get clean living at home.” I said, “you live with your mom, your brother, and your sister, right?” He said, “yeah.” I said, “so what’s the problem?” He says, “they all use and they all sell.” So if this 19 year-old can leave his mother, his brother, and his sister, then you can do it. [from fieldnotes]

While “people, places and things” are often associated with continued drug use and criminal behavior, the simplicity of the phrase suggested to the client that he/she should have almost no trouble staying away from those factors. However, since most of these clients were young, African American males living in racially segregated, poverty-stricken neighborhoods, simply avoiding those “triggers” for drug use and criminal activity was hardly so simple or easy. Yet, the neighborhood context in which most of
these men/women lived was never given much consideration by the court as itself a major problem for the client.

Consistent use of the phrase “people, places and things” also suggests that rather than addiction being a problem of the individual (i.e., of the individual’s biology, genetics, or psychology), that the “disease” is in fact environmentally produced. If it is only other people, certain places, and things (such as drug paraphernalia) that will lead to relapse, then the implication is that the illness is not actually of the individual’s own control (or brain).

*Understanding Addiction: Take the Bone Away from the Dog*

The importance of addiction for the drug treatment court program was also articulated through training sessions at the annual conferences of the National Association of Drug Court Programs. The organization promotes the development of drug courts throughout the United States, lobbies for federal funding of drug court programs, and instructs groups on how to start a drug court program. While Philadelphia’s treatment court staff were not mandated to attend the conference, examining the topics discussed can offer insight into how drug courts are organizationally constructed and how they relay information about addiction and other issues to those who work in the drug court community.

The association’s website claimed that over 3000 individuals attended the 2006 conference. Most of these attendees were employees of various drug courts around the country, as well as some members of the Alumni Association (former drug court clients) and those who were attempting to begin drug court programs in their community. Descriptions of all of the sessions and copies of PowerPoint slides from several sessions
were available on the association’s website. These materials showed how information on addiction and treatment were disseminated to the attendees.

The 2006 conference offered 21 different “tracks” that each contained multiple sessions on a given topic. Only four of the tracks appeared to be exclusively about drugs or drug treatment. One of these tracks addressed the chemical properties of various drugs, and included separate sessions on marijuana, opiates, and cocaine and their effects on the individual. Another track dealt primarily with developments in pharmaceutical drugs for treating alcohol/drug abuse. Two tracks were devoted to assessing clients and issues about treatment for alcohol/drug problems. The remaining 17 tracks were devoted to program issues, such as starting a drug court, getting funding for the court program, clearing legal “hurdles” to implementing drug courts, issues with juvenile drug courts, evaluating rewards/sanctions, and the role of state government in drug court programs.

My purpose in researching this conference was to discover how the drug court programs, through this national organization, educate court staff on issues of addiction and treatment. Of course, these findings do not necessarily lead to the conclusion that the court staff in Philadelphia adhere to the same perspectives, but they do reveal how the national association of drug courts views issues of addiction and treatment and what they promote to individual programs. Because this was my focus, I only examined handouts and powerpoint slides that were posted from several sessions that dealt with issues of addiction and drug/alcohol treatment.

One session was entitled “Understanding Drug Abuse and Addiction” and discussed the effects of drugs on the individual’s neurochemistry and brain processes. This session emphasized that “addiction is a brain disease” and discussed evidence about
how prolonged drug use could change the brain in fundamental and long-lasting ways. This is also the primary perspective of addiction that is promoted by the National Institute of Drug Abuse (NIDA), a federal government agency that provides millions of dollars each year to research on issues of drug abuse/dependence and treatment. As the director of NIDA, Dr. Nora Volkow, explained in a recent interview with Terry Gross on National Public Radio’s *Fresh Air*:

“What happens is, when someone takes the drug acutely, their dopamine will go up, very high concentrations. With repeated administrations, your brain starts to adapt with undergoing a shifting on the threshold. As a result of that, you will need more and more and more dopamine in order to have the same perception. Your brain becomes tolerant to the effect, and these in turn will contribute to you wanting to take the drug because, without it, you no longer feel normal. In other words, it has changed from wanting to take the drug because you like the way it made you feel, you wanted to get high, to needing to take the drug because, otherwise, you do not feel normal.” [from radio interview]

This conference session had slides discussing the particular effects of cocaine, opiates, methamphetamines, hallucinogens, marijuana, and alcohol. The same presentation also had a slide titled “Relapse Happens” and discussed how relapse was primarily due to “poor craving management” but that it was possible to “get the train back on the tracks.” None of the slides in this session discussed treatment issues or indicated what the appropriate types of treatment would be for the “brain disease.”

Another session was entitled “Substance Abuse Treatment: What Works?” and consisted of 44 powerpoint slides for the hour and fifteen minute presentation. This session discussed that treatment was both “art and science” but that contemporary treatment tended to emphasize the science part more, largely because of research developments. One slide had a large picture of a dog with a bone in its mouth and read,
“Addiction is like…A dog with a bone.” The slide elaborated on this comparison by comparing “addiction/denial” to the dog not wanting to let go of the bone, “craving” to the dog getting excited when it thinks it’s going to get its bone, and “loss of control” to the dog always wanting more bones. The next slide had the same dog pictured, but without the bone in his mouth and proclaimed “Treatment is like…Obedience School for the Dog.” Apparently, “you teach the dog’s owner to control the dog” and “you develop a variety of tools (relapse prevention) to help the dog be obedient.” The slide also does warn that “some dogs are harder to train” but that you can “try to motivate the dog to change.” The session then goes on to explain various approaches to drug/alcohol treatment, such as counseling, specific motivational approaches, cognitive behavioral approaches, and pharmacological methods. The presentation concludes by indicating that “Research suggests that the most important issue in Drug Court is to create an environment in which participants remain engaged in treatment for significant periods of time. The design of drug court provides this structure.” Indeed, in Philadelphia’s treatment court, the client most often attends treatment several days a week for several months, and then continues with individual sessions less frequently for additional months.

Since there were so few presentations on the actual treatment of alcohol/drug addiction, this presentation carries much weight in promoting a certain perspective of addiction and treatment to the court staff. Most of the staff in attendance at this session would not be drug/alcohol counselors but instead court staff (i.e., case managers, evaluators, prosecutors, public defenders). The presentation’s stated purpose was to make them aware of treatment issues so that they could better understand the clients they are
dealing with. However, the overtly judgmental metaphor used in the presentation (the client as a dog) is troubling since that will be the only image the attendees will be left with in trying to understand addiction and treatment. At the same time, while it is not known exactly how powerful these sessions are in the daily operation of drug treatment courts across the country, the impact is probably substantial in Philadelphia’s program, especially considering that Judge Gallo served in a leadership role of this large national organization several years ago. In addition, it is the only organization to provide such a conference for drug court employees and those considering the implementation of a drug court.

The Court Staff as Legal and Medical Authorities

In the last section, I demonstrated how the court program emphasizes the importance of treatment in its daily activities and organizational structure. This section examines individual court staff members in how they address the client’s “addiction” problem in the court program. While the case managers are the only category of court employees whose explicit job description is to negotiate the treatment side of the program with the legal side, in reality, every prominent member of the court staff has an ambiguous overlap of legal and clinical roles.

By definition, the case manager is the most directly related to both parts of the treatment court program – the clinical and the legal. As the supervisor of the treatment court case managers, Ashley, indicates:

*Ashley:* “Case managers are the liaison between the court and the treatment agency. We are responsible for the client’s care and advocate on a daily basis to ensure the client’s needs are being met both clinically and
judicially. While the clinicians at the treatment site provide therapy and the Public Defender and District Attorney provide the legal interventions, the Case Manager provides the ancillary services to the client to assist them in their ongoing success in recovery.” [from interview]

Case managers meet with the counselors at the treatment programs on a regular basis to discuss the clients’ progress in treatment. Case managers also must make sure that court-imposed sanctions are followed through. While the case manager supervisor in the above explanation separates the “clinical” staff and the “legal” staff, in reality, every person involved in the court program must navigate both sides of the program.

For instance, the assistant public defender that represents the vast majority of treatment court clients, Liz, must offer legal advice to the client, including an initial opinion about whether the client should enter the program. Liz meets with each eligible client during that first court session and goes over his/her case and the various options they have. She is also legally responsible to tell them their chances of “beating the case” by going to trial. However, she does mention that it is not just whether or not the client will be found not guilty that determines if he/she decides to enter the court program:

*Liz: “It’s really a combination of factors… If he can end up with no criminal record using traditional criminal justice, generally most clients would prefer that. Now, that’s not always the case because the other thing that the treatment court offers is a very effective drug treatment, um, and intense case management, and referral to ancillary services.” [from interview]*

While the assistant public defender indicates that she would advise a client to take the treatment court program even if it seemed that he could “beat the case” by going to trial, I never witnessed a private attorney representing any of the clients suggesting the same thing. For instance, here is a situation where a client’s private attorney is talking with the assistant District Attorney about his client:
Lawyer: We need to push back the date. I haven’t seen the discovery yet.
Assistant DA: Does he want the program?
Lawyer: I don’t know. [points to paper on Assistant D.A.’s desk] See, these three guys are dealing. My client is just there.
[from fieldnotes]

In the above interaction, it appears that the lawyer will base his advice to his client on the evidence of the case, since there is no discussion about the client’s drug addiction. If it looks more likely that his client will be found not guilty of the charges, the scene suggests that the lawyer will advise him not to take the program. Of course, I never interviewed any of those attorneys, so I can only make that assessment based on observations. I am not suggesting that a private lawyer might not ever consider the client’s alcohol/drug problem in the decision-making process, but that because private lawyers have such limited interaction with the treatment court (not one lawyer seems to handle many of the cases), that his/her role is purely legal in the initial decision-making process. The assistant public defender, on the other hand, has a different role with the court, and therefore will be more likely to incorporate clinical considerations into the advice she offers her clients. Patrick, the treatment court evaluator, suggests that the public defender recommends the program to everybody that he evaluates to be clinically eligible:

Patrick: “[Liz] really encourages everybody to take the program and she has a million clients and not a lot of time, so they don’t really get the scope of the program necessary. They kinda get the like, ‘if you don’t want this on your record, take treatment court.’” [from interview]

He also suggests that while Liz may recommend the program for clinical reasons that a client often enters the program primarily for legal ones.
The assistant public defender will also advocate for increased treatment during weekly court sessions. When she refers to a client’s drug/alcohol problem, she appears to be trying to elicit empathy from the judge and assistant district attorney, especially if the client is facing dismissal from the program. For example, here is the case of a male who has not complied with the treatment court program and his previous sanctions:

*Judge* [looking over report]: You have not been in treatment since October 8th. You missed your day at Options…[sits back] What do you have to say?

*Client*: I made a mistake.

*Judge*: Yeah. A big one.

*Asst. DA*: He hasn’t done anything. I request a show cause hearing.

*Liz (Asst. PD)*: I request the court gives him another chance. He may have a dual diagnosis that needs to be addressed.

*Judge*: That’s his obligation, not our’s…All he’s done is get to Phase one…30 days clean and sober.

*Liz*: I believe he will do better. We need to know his true diagnosis and get him the treatment he needs.

*Judge*: Show cause hearing under advisement. I’ll give my answer next week.

[from fieldnotes]

In this case, the Assistant Public Defender (PD) pleads with the judge to give the client another chance. She argues that he might have a dual diagnosis, that is, a mental health condition in addition to the substance abuse problem. In these contested cases, most often the assistant public defender brings up addiction and treatment issues and asks for another chance in the program for the client. The Assistant District Attorney takes an oppositional role and will demand further legal intervention, usually in the form of dismissal from the program and a jail sentence. In none of the cases I observed did the Assistant D.A. ask the court to give a client another chance because of treatment issues. In most of these cases, the judge does not give the client another chance, even with the
assistant PD’s appeal as can be seen in this case of an individual who has been in the program for more than two years and did not appear for his last court session:

*Liz (Asst. PD)*: I would request that the court consider giving him another chance. He has a substantial addiction to heroin. He did complete treatment and he was assigned to a recovery house. He had a difficult time at the recovery house and he relapsed. We would like to request another opportunity.

*Judge*: I can’t do that. He has had multiple chances. You’ve only completed 4 months of a 12 month program and you’ve been here for over 2 years. Show cause hearing granted for 11/15.

[from fieldnotes]

The judge refuses to grant Liz’s appeal for another chance. He mentions that the client had “multiple chances” and failed. By granting a show cause hearing, the judge is basically agreeing to terminate the client, since so few show cause hearings resulted in anything except expulsion from the program.

Liz often relates the client’s problems in the program (missed sessions, positive drug screens) to addiction and mental health issues. She will also ask the court for a re-evaluation to support the claim that the client should be given another chance because his/her treatment might not be appropriate for his/her problem. The ordering of a re-evaluation also appears to be used as a stall tactic by the assistant public defender. If the judge permits the re-evaluation, then the case will get pushed back another month. Liz seems to advocate for re-evaluations most often when the judge appears undecided about what to do with a particular client, as though the extra month and more serious diagnosis will sway the judge to let the client have another chance in the program. Patrick, the evaluator, even mentions that he might get sent some clients from the court to re-evaluate if Liz is “lookin’ for an angle.”
Similarly, the assistant public defender will use addiction and treatment issues to elicit leniency from the judge in sentencing hearings. These are instances when the client has been dismissed from the program and the judge needs to determine his/her punishment. Here is a case that was scheduled for a show cause hearing but the client waived his right to the hearing and asked to proceed directly to sentencing:

*Liz (Asst. PD)*: I would like to ask the court to recognize that he did waive his right to a show cause hearing. He’s taking responsibility…I also ask the court to consider that he did complete phase 1, phase 2 and phase 3 and a residential treatment program…He also made substantial progress on his recovery… He did relapse and he didn’t come back and ask for help… He has a long way to go and he recognizes that… His wife supports him. He says he’s learned a lot from the program… Hopefully once he finishes his sentence, he can put those tools to use… Hopefully he can come out and be the person he’s learned to be through treatment – a good husband and father.

*Client*: I accept my failure. Thank you for the opportunity. I learned a lot but unfortunately I wasn’t able to apply it. When I’m out, I’ll try to apply it.

*Judge Gallo*: This is not pleasurable for the court. It’s sad, especially since you’ve been here for more than three years. And now you’re being terminated and sent off to jail or prison. You will be released from prison at some point, and if you don’t change your ways, you’ll be right back here. Either jail or death, that’s it. I accept that you’ve learned a lot and the court recognizes that you completed Phases 1 through 3. Sentence is as follows…

[from fieldnotes]

In this case, the assistant public defender’s appeal does appear to result in leniency; while the maximum sentence for the client’s two charges was 30-60 years, the judge orders the client to jail for only 8½–24 months for both charges concurrently. While there was no case in which the judge gave the maximum sentence, both by my observation and through his own admission to clients during court sessions, the sentence he gave in the above case was particularly lenient (about 1 year) compared to the maximum sentence (60 years).
While an occasional positive drug test was not taken too seriously by the court, as indicated earlier, repeated relapse was a significant problem and resulted in more serious sanctions. The staff explained a client’s relapse in very different ways. Relapse was used by the assistant public defender as evidence that the client had a disease that required additional treatment. The assistant district attorney, however, used a client’s relapse to argue that the person was not taking advantage of the program and therefore should be sanctioned harshly or possibly terminated from the program. Here is a case of a male who had a warrant out for his arrest because he had not shown up for treatment sessions. He ended up back in the court because he was arrested for a new drug possession charge:

Assistant D.A.: Your Honor, I request a show cause hearing. The client completed phase 2 back in June of ’04 [emphasis because that was more than a year ago]. He is only here today because he was arrested for a new drug charge… He tested positive and obviously continues to use…
Assistant P.D.: He did test positive…he needs treatment. He is here because he still needs treatment. Your Honor, I ask that we give him another opportunity.
Judge: 99% of the people who are terminated need treatment. 1-2% probably conned their way, saying they needed treatment. I’m not sure yet what I’m gonna do… Bring him back in one week for my decision.
[from fieldnotes]

The assistant D.A. emphasizes the client’s continued drug use as evidence that the client is not taking the program seriously. The assistant public defender instead emphasizes that the drug use is a sign that the client needs treatment and therefore should be able to remain in the program. In this particular case, the judge does not immediately expel the individual from the program, but does eventually grant a show cause hearing because the client spent so long in the program and only advanced through the second phase.

The judge would rarely be lenient to clients who still had demonstrated substance abuse problems. This could relate to the judge’s stated perspective on substance abuse:
Interviewer: I’m interested in this underlying problem here that you talked about and you said as you sat in criminal court you were unable to address really the underlying problem. Do you see it as a mental health problem primarily?

Judge Gallo: No, it’s a substance abuse problem. But it’s like I tell them, what came first, the chicken or the egg? Did the drug abuse create these other issues they have or did these other issues lead to the drug abuse? Now some people obviously have serious mental health problems and they try and, I guess, medicate themselves through the use of drugs. But most people in the program do have other issues to deal with. And, they’re emotional: anger, very low self-esteem, they’re distrustful of everyone in the system. So again you have to break down, it’s almost like I guess in boot camp. You know, you see these movies where they really strip down these people and then they try to build them up. But the principle’s the same and we obviously don’t do it exactly that way. But we try really to break down all these barriers and then build it up from the beginning with the hope and the expectation that they really buy into this. Most people do this initially because they don’t want to go to jail. [from radio interview]

The judge admits that most people first join the treatment court program because they want to avoid jail. His courtroom actions mirror much of this assessment he makes in the interview. At the same time, it helps to explain his positive overtures in the courtroom for those who do end up “buying in” to the program. The issue, then, does not appear to be that clients with more serious drug problems are more likely to not succeed. The judge’s actions and statements suggest that he views every client rather similarly, as far as his/her substance abuse problem. His repeated use of the iceberg metaphor (the actual substance abuse problem is only the 10% on top) seemed an effort to communicate to clients that they were going to be held responsible not just for drug use and criminal behavior, but for the structural and personal limitations that were below the surface (unemployment, family problems, emotional/physical abuse, etc).

At the same time, the judge indicates that it is the court’s responsibility to provide as much treatment as the client needs to succeed. Otherwise, the person will return to
criminal activity because the substance abuse problem was not addressed. Here is his response when asked how many chances a person gets in the treatment court program:

*Judge Gallo:* “It depends on the situation… You look at the totality of circumstances and decide when is enough enough. And have we done everything, the question is *clinically,* is there anything else we can do for these people? And then secondarily, you have to maintain the integrity of the program which means unfortunately some people aren’t gonna make it.” [from radio interview]

As a result, in many cases, the judge would exercise some leniency if a client demonstrated that he/she was trying in the program, even if he/she continued to use drugs. However, the judge was not tolerant and would reprimand the client for lacking responsibility and commitment to the program. Here is an example:

*Judge:* This matter has been discussed. You’re still struggling in the program. You have missed sessions, positive urines… You say it’s because of peer pressure… I was told you are suffering from depression.  
*Client:* Yeah.  
*Judge:* You can’t use that as a crutch. Not to minimize your problems, but most people in this program suffer from depression.  
*Asst PD:* And you didn’t go to your [psychiatric evaluation].  
*Judge:* You’re like a dog chasing its tail; you’re going nowhere fast. You’re going to spend a day at Options.  
[from fieldnotes]

The judge states that almost everybody in the treatment court program suffers from mental health issues. This could be one way to demonstrate the level of responsibility he wants other clients in the courtroom to have. At the same time, it suggests a rationale for why the drug treatment court could be a successful program. Because everybody really has the same problems, if some people succeed, it must mean that everybody has the potential for success and it is the individual’s fault if he/she does not progress in the program.
The client also emphasized issues of addiction during court sessions. Most often, drug/alcohol problems were brought up as a way of demonstrating their commitment to the program. They would also be used to elicit sympathy from the judge and to ask for another chance if he/she committed some infraction. Here is a situation where the client left the treatment program and never reported to his case manager. As a result, a bench warrant was issued. He was arrested on that bench warrant and brought into court:

*Judge:* What do you have to say?
*Client:* I messed up…I was in denial; I didn’t understand what an addict was. Now I know. I have an addictive personality. I know that now.
*Asst. DA:* Your Honor, we request a show cause hearing. Mr. Ortiz has been AWOL longer than he’s been in the program.
*Judge:* Ordinarily I would agree with you. But he never gave himself an opportunity to do anything. Clinically, do we need a reassessment?
*Asst. PD:* Yes.
*Judge:* Let’s get that.
[from fieldnotes]

In this situation, the client uses the lingo of the court (he was “in denial”) and appeals to the judge for another chance. His appeal seems to work, since the judge permits him to return to treatment. Of course, it is impossible to know the judge’s thought process in these cases, and why in some instances he would be lenient but in others he was not. As the judge stated earlier in an interview, he is concerned that the court offers everything clinically possible before dismissing a client. In this case, especially since the judge orders a reassessment, it appears that he is concerned that the court might have failed the client clinically even though the client had left the treatment program where he had been and never called any of the court staff.

Here is another case where the client attempts to elicit sympathy from the judge because of his drug problem. It also appears that Liz, the assistant public defender, is
coaching the client to request a Recovery House to convey that the client is being responsible:

*Asst. Public Defender*: Failed to appear on July 20th…arrested on court’s warrant…At the time he failed to appear, he had missed several sessions and had relapsed. Court ordered Recovery House… He has no new cases.  
*Client*: [speaks for a while about family problems, including having to take care of his grandfather and then his grandfather dying]  
*Judge* (interrupts him): Let me stop you. You’re talking about the last few months. What about from January through June? What did you do during that time?  
*Client*: I messed up.  
*Judge*: You did nothing! [Reads through file and mentions four sanctions]  
*Client*: But then I went more than I had ever gone in July.  
*Asst. PD* (to client): What do you want?  
*Client*: I want to go to a Recovery House. I’m having a hard time stopping smoking. I do well for a couple of weeks but then I mess up.  
*Asst. D.A.* (says somewhat condescendingly): Do you think you’re having a hard time because you were missing treatment?  
*Client*: Yeah.  
*Judge*: There are all of these people here to help you. You could have called your case manager. You could have talked to someone here. But you chose not to do that.  
*Asst. PD*: Judge, would you consider sending him to a Recovery House with sheriff to transport?  
*Judge*: I want to hear more from him. I’m not sure if I can do that yet.  
*Asst. PD*: He wrote a letter.  
[The court clerk hands the Judge the letter. The Judge reads it.]  
*Judge*: I think this explains it. I’ll grant a Recovery House with sheriff to transport.  
*Client*: Thank you, Your Honor.  
[from fieldnotes]

While I do not know what was in the letter, it was powerful enough that the judge offers him another chance in the program pending a move into a Recovery House. Again, it appears that the judge is lenient because the client demonstrated an adequate level of responsibility.

The client and the public defender often work together in creating a picture of the client’s drug problem as the reason for other trouble in the program. Here is another
situation where the client and the public defender attempt to explain the client’s absence from treatment as a result of his drug problem. As seen in most of these cases, the assistant district attorney takes an adversarial role:

*Judge:* According to your May report, you’re not taking the methadone. You have positive urines for opiates, benzos and cocaine. What do you have to say?

*Interpreter (translating client’s response):* [something about missing treatment]

*Judge:* (loudly) Why didn’t he go?

*Interpreter:* He was caught in a vice.

*Judge:* What does that mean?

*Interpreter:* A vice - addiction. He’s not using anymore.

*Asst. PD:* He was doing well…When he relapsed, he left treatment and didn’t talk to anyone.

*Asst. D.A.:* The only reason he’s here is because of a new arrest.

*Judge:* The bench warrant will stand.

*Public Defender:* I request that the treatment court re-evaluate him, have him come in on a Wednesday.

*Judge:* Makes no difference to me.

[from fieldnotes]

The client attempts to show (with the assistance of the assistant public defender) that his relapse is an indication that he needs treatment (and therefore the drug court program). The judge, however, does not express interest in discussing the case from a clinical standpoint. While relapse itself was often sanctioned rather lightly, the client’s new arrest seems to overshadow the clinical considerations. Many of the evaluation research on drug courts uses outcome measures like re-arrest rates (both while in the program and post-graduation) to measure how “successful” the drug court program is. This client would be a negative outcome for the court. The judge, then, in an effort to reduce such negative outcomes, might be less lenient in an effort to demonstrate to the other clients in the courtroom that getting arrested again could lead to the most serious sanctions.
Overlapping Authority: Inconsistencies and Ambiguities

Problems with the Addiction Label

While the treatment court program emphasizes that its goal is to treat the problem of addiction, in reality a person’s criminal record determines eligibility for the program much more often than his/her clinical evaluation. This leads to two possible outcomes and, as a result, problems with the way the addict label is used. One is that those with substance abuse problems might not be given the “addict” label because his/her criminal offense is too “serious” to be eligible to participate in the program. For instance, violent offenses and offenses that carry mandatory minimum sentences are, for the most part, not eligible. The implication, then, is that if you sell drugs you are probably an addict and you will receive monitored treatment for it, as indicated by the “targeting” that the district attorney’s office does. However, if you carry a gun when you sell drugs (a violent offense) or you are possessing a lot of drugs when you get arrested (something that might qualify for a mandatory minimum sentence), then you do not receive the “addict” label. Instead, you will most likely go to prison39.

The second possible outcome is that somebody will be targeted as eligible for the program because of his/her offense but that he/she will not actually have a problem with drugs. One research study found that about one-third of felony drug court participants did not meet the clinical criteria for having a significant substance use disorder (Marlowe, Festinger, and Lee 2004). In Philadelphia’s program, there was much evidence to suggest that many clients received the “addict” label yet never demonstrated having a significant

39 Admittedly, there are other criminal justice initiatives that such a person might be eligible for, including treatment in prison. However, my argument is that there is a problem in assuming that those who sell drugs
problem with drugs or alcohol. For instance, most clients are evaluated as needing outpatient treatment for marijuana abuse. As a result, somebody who admits to smoking marijuana once a week would be evaluated as being addicted to marijuana and in need of outpatient treatment. Somebody who drinks alcohol once a week would be less likely to be labeled an “alcoholic” indicating that the illegality of marijuana is the reason for attaching the “addict” label, rather than the frequency of use. According to Patrick, the court evaluator, if a person says that he/she has a problem, then that is the main criteria for attaching the addict label, regardless of how infrequently that person might use the drug or the lack of evidence of any use at all:

*Patrick:* “I mean there’s a lot of word on the street about how to handle this kinda thing, you know, like some of the really common ones are if you get caught with heroin, dealing heroin, say you *use* it because you’ll be a felony, you know, delivery case. So a lot of guys come in here and tell me some, sell me this whole story about the opiates they use and then they never pop hot for it, you know. It’s never an issue, only to find out that no, they never used that, you know, and maybe we put them in in-patient a week for no reason just because he didn’t want to catch a F1, something like that. So you know, most of the job is kind of sifting through the nonsense…” [from interview]

In the above instance, the individual becomes eligible both legally and clinically for the program, yet never demonstrates heroin use. The clinical judgment is based solely on the client’s self-report. The most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) contains several categories of drug abuse and dependence and the symptoms associated with each. These criteria are not used by the court in
determining the appropriate treatment for the individual, nor in differentiating “abuse” from “dependence.”  

Several staff members of a treatment program that was affiliated with the treatment court also revealed to me in interviews that they believed the majority of clients who were sent to their treatment facility did not have significant drug problems. One of these staff members related the treatment court’s published success rate, as in the large number of clients who remain drug-free after graduating from the program, as “over-inflated” because most of the drug court clients do not have a serious drug problem at the start of the program.  

While this inconsistent labeling might seem like a serious problem for the integrity of the program, instead the whole addict label itself gets reconstructed within the treatment court. That is, “addict” becomes a loose label for persons who engage in any drug-related behavior, from occasional use to frequent use to selling. This distinction becomes most apparent during the graduation ceremonies, where the addiction label, if not used to illustrate addiction to drug use, would often be articulated instead as related to the lifestyle of drug dealing. Here a former drug court participant addresses the group of graduates:

*Former Client:* Let me start by saying that we have two kinds of addicts here – the drug user and the drug seller. One is addicted to drugs, the other addicted to money. I don’t want you to think that if you don’t use drugs that you’re not an addict…  

Similarly, in another graduation ceremony, one of the graduates indicates a similar perspective:

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40 I would not go so far as to argue that using the DSM-IV is the best way to assess actual “addiction,” only
Client: …I wasn’t addicted to the drug, I was addicted to selling the drug… I would make a lot of money right on the spot and I could buy whatever I wanted, right then. Now I’m working and I make money but it’s really different. I can’t get things right when I want them. I have to wait for my paycheck… I used to sell in my high school and now I can’t even help my son and teach him history because that was always the last period of the day in school. And I was always skipping that class so I could get rid of the rest of what I was selling. [from fieldnotes]

This perspective was never articulated during a client’s monthly court appearance. All of the clients who graduated from treatment court also completed a drug treatment program. Most often, these clients attended sessions as scheduled and would have few or no sanctions. Therefore, issues of their “addiction” were never discussed during monthly court appearances. For clients who were not sanctioned, there really was no indication of what a “successful” treatment experience was, except for negative drug tests. However, if the client never really had a problem with drugs, then further abstaining from drugs would not be a difficult task. Yet, he/she would be rewarded for that behavior through the various phases of the program. These speeches at graduation, however, indicated that the client did still attach the “addict” label to himself/herself, but not necessarily in the sense of habitual drug use. Here is another example:

Client [in graduation speech]: I want to thank Judge Gallo for every sanction…it helped me realize that I can beat this if I surrender… Drugs were just 10% of the problem. [from fieldnotes]

This perspective that actual drug use was not the biggest problem was articulated early on by the judge in his introductory speech to new drug treatment court clients, through his use of the iceberg metaphor (page 1).

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41 This issue is examined more closely in the next chapter.
There is also some evidence to suggest that there is confusion about what the “addict” label indicates:

*Patrick:* “These guys have such an aversion to the term ‘drug addict’ or ‘addiction.’ I mean, it’s unbelievable. I always ask them, ‘Do you think you have a drug problem? And you can tell me no, it’s no problem. I just want to know what you think.’ They all say ‘no.’ And then some of them will follow that by, ‘No, I don’t have a drug problem. I do have a problem with weed, but I don’t have a drug problem.’ And every time, I’m like ‘Damn!’ [laughs]” [from interview]

This confusion over what does or does not constitute a drug problem or addiction appears to happen often, according to the court evaluator. This suggests that there might be disagreement over the definition of “addiction.” Still, the client learns through the actual drug/alcohol treatment component and his/her interactions with the judge how to appropriately use the addict label. However, the definition of “addict” and what one uses the label to refer to remains ambiguous.

*Treatment Court as a Second Chance at Life*

Distinguishing between the clinical and the legal/punitive elements of the treatment court program is ultimately not necessary to the court staff, because they perceive the program in general to be more of a “second chance” and their role as almost missionary in nature. How exactly the client turns his life around, then, is really not important. This basically sums up their overview of the program and why the addict label also gets morphed into having many different meanings. They express that they want to help these clients, and that they will use whatever tools they can to accomplish that.

This perspective occurs at every level of the program. Here the evaluator emphasizes the importance of getting a job and going to school to the clients, rather than focusing on the client’s drug problem:
Patrick: “Over time I’ve learned, like instead of making the pitch like, ‘Hey, you can come in here and get clean and have more of a spiritual, emotional…’ You know, really what I’ll say is, ‘Look, if you want to be about some things, and smoking weed all day is standing in the way of that, this might be a good idea. If you want to start a little business, if you want to start a little rap game, if you want to do whatever you want to do.’ …Because that message, everybody’s interested in. We’re like, ‘Look. I can help you get a job, I can help you get a job apprenticeship, I can help you get an education.’ That, they wanna hear. But as far as, ‘I can offer you drug free living…’ [laughs], unfortunately, it just doesn’t really resonate with them.” [from interview]

From this quote it also appears that it took Patrick some time to come to that new perspective. But at the same time, the perspective is of general “help” to the individual, perhaps in the form of education and job training, and the nature of the client’s drug problem is really not all that important.

Similarly for the judge, whether addiction is a disease or not, is not an important distinction that needs to be made to meet the program’s overarching goal of “helping”:

Judge: “Most people deserve a second chance. And, and you can label drug addiction as, as a disease, as a problem, whatever you want to call it. The reality is, we have to deal with it. And, one of the ways to deal with it is through these programs. It’s not for everybody, but if we can do more of this and help more people, it’s just a snowball effect, how it affects the entire family, the children and so forth. So, to me, we just need more of it.” [from radio interview]

Helping people is really the end goal. And from the judge’s emphasis on non-clinical components later in the program, like enrolling in a school program or getting a job, it appears that these social factors are much more important outcomes than abstinence alone.

Other ways that this perspective of treatment court as a second chance at life for the client is articulated in the program is through the court staff’s emphasis on clients who initially have problems in the program but then “turn around” in some way:
Case Manager: He’s doing very well. Made a 360 degree turn.
Judge: Are you gonna start GED soon?
Client: The 29th.
Judge: Ok. Hopefully we won’t have any more problems.
[from fieldnotes]

At graduation ceremonies, the judge emphasized initial difficulties that the client had in the program and the positive outcomes that occurred after some sort of “turn around.” These are stories that are not just important to the court, possibly as evidence that the treatment court is an appropriate way to handle such cases, but these are stories that are important in American culture. What was emphasized as important in the courtroom – individual responsibility, learning from mistakes, accountability – are the same values that are emphasized in our larger culture.

Clients also would vocalize this sentiment of treatment court as a second chance, often in graduation speeches:

Client graduating [addressing crowd]: What is treatment court? A second chance at life! [from fieldnotes]

Similarly, in an interview with a former client of the program:

Larry: “So my life…and I seen the light…my life particularly made a 360. So, I thank God for prison, I thank God for Treatment Court because my life is just a 360. The negativity that I thought I wanted to be around was no longer there.” [from interview]

Graduation ceremonies in general are often emotional events. The clients were likely genuinely happy, both to be finishing the program (and having his/her record expunged) and for having accomplished something. Those speeches, as discussed earlier, seemed to be enough evidence for the court staff that the program was successful, since actual long-term follow-up with most of the clients did not occur.
Various court staff also articulated that the program is effective because of positive outcomes for the client, most of which are social markers, rather than anything associated with drug and alcohol use:

_Mario_ (Manager of Specialty Courts): “…Most of our clients, I think 70% of our clients who graduate are doing very well - have obtained proper employment, have re-engaged with family members, and, you know, have become productive members in our society…Instead of just giving them prison, a prison sentence. And if the client does have a problem, it’s a great way to get back on their feet. To just start, you know. Ok, I messed up. They’re given a second chance.” (emphasis mine) [from interview]

As the above quote from Mario suggests, whether or not the client has an addiction to drugs is not the most important consideration for evaluating “success” in the program.

Patrick, the evaluator, also has a similar perspective:

_Interviewer_: So do you think [Treatment Court] is the best way to handle these kinds of cases?

_Patrick_: I’m definitely a fan. Because taking any kind of marginalized population that doesn’t have a lot of access to resources and offering them resources, I’m a huge fan of. Which is what we do… Offering them parenting classes, offering them job training, things like that, that they really wouldn’t have access to otherwise.”

This emphasis on positive social outcomes as evidence that the treatment program is appropriate for handling these cases is found among all of the court staff. Some of the staff will also cite help with addiction as a beneficial component of the program:

_Liz_ (assistant public defender): “Well, the treatment court, first of all, tries to treat the addiction which is usually the underlying cause of the criminal behavior… I think it’s effective in dealing with addiction and all the other issues that arise when a client is drug-addicted.” [from interview]

Of all of the court staff, Liz emphasized issues of addiction and treatment the most. She also cites a definition of addiction as one very close to that proposed by the National Institute on Drug Abuse and the National Association of Drug Court Professionals:
Liz: “I mean, just in my ten years of doing this… I think it’s a combination of environmental and genetic reasons. Addiction is a brain disease, I think there is a genetic factor, and obviously if you’re around people and your whole lifestyle is drinking and using drugs that’s going to have an effect on it too, but I am just a layperson…” [from interview]

Still, all of the Treatment Court Staff that I interviewed viewed addiction as a disease:

*Interviewer:* “Do you think that alcohol or drug abuse is a disease?”
*Mario:* “Yeah.”
*Interviewer:* “In what way is it a disease, like, what makes it a disease?”
*Mario:* “It’s… They’re unable to stop on their own. They need counseling…it’s, you know…it’s for life. It’s forever. It’s like a disease, you know, they can prevent from relapsing. They can prevent that by using various tools - counseling, talking to people, staying away from people, places, and things. Not necessarily taking medication but I think they just have to follow through a criteria which allows them to stay drug free.”

How most of the staff defined the disease of addiction, however, was just as ambiguous as how the addict label was used throughout the drug court program.

*Patrick:* “I definitely buy into the disease mentality of addiction. I absolutely believe that it is incurable… The kind of idea of addiction that is laid out pretty much in twelve-step fellowships is the one that I subscribe to. That incurable, and fatal, but absolutely can be recovered from…”
*Interviewer:* “Do you think that addiction is genetic?”
*Patrick:* “… My personal opinion is no, not really…because addiction does not discriminate. You can go to any rehab and have the street-living dude who shot heroin into his neck with puddle water next to the pretty boy who bought oxies with his trust fund. There’s no discrimination whatsoever, so I would be really hard-pressed to believe that a certain anybody was more affected than the rest.”

Both of these staff members emphasize that addiction is a lifelong disease and that abstinence is the most effective method of addressing the issue. Yet, Patrick does not agree that addiction is genetic and Mario seems to be reluctant about certain medications being used to treat addiction. These differing perspectives are also likely because there is no one perspective of “addiction” that is emphasized in the treatment court program. The two characteristics that both Mario and Patrick emphasize – that addiction is lifelong and
the necessity for abstinence – are the only two characteristics that the court also repeatedly emphasizes to the clients. These perspectives are not at odds with the treatment court program because the end result is much larger than just treating the possible addiction to drugs that the client has; the end result is that the client undergoes a transformation into a “better person.”

Conclusion: Ambiguity and Institutional Legitimacy

This chapter has presented the many ways in which the clinical component of Philadelphia’s Drug Treatment Court Program (specifically, alcohol/drug treatment and counseling) overlaps with the legal proceedings and expectations of the program. From the targeting of individuals for eligibility into the program through the graduation ceremony, each stage of the program involves an ambiguous notion of “addiction” within a legal framework.

All of the court staff members have roles that overlap the clinical and legal interventions of the program, some by design (i.e., case managers) and others by the organization of the court setting (i.e., the judge or the assistant public defender). This overlap produces ambiguity about when the clinical part of the program ends. To what extent progressing in the program is determined by doing “clinically” well, or by participating in educational or vocational activities, both of which involve the court’s evaluation of what is considered “responsible” behavior, is also not clearly defined. Creating a program that determines that a judge is the most appropriate person to evaluate a client’s progress in treatment leads to further complication in defining the rewards and sanctions of the program – are they clinical interventions or punishment? This might also
lead to Judge Gallo’s perspective that coercive treatment is more successful than voluntary treatment\(^{42}\).

The history of drug and alcohol control in the United States has often involved competing views of the issue between those who advocated for a more “therapeutic” way of handling those who used drugs and alcohol and those who sought more punitive methods. The criminal justice system has successfully held onto its control over the issue, even in the context of increasing public opinion that drug addiction is a “disease,” and more “medicalized” treatment developments, like methadone. The use of the addiction label in the drug treatment court program further legitimizes the criminal justice’s role in dealing with drug problems. Drug treatment courts, because they incorporate drug and alcohol treatment might appear to be a more “therapeutic” form of justice (Nolan 2001), but at the same time are legitimizing the criminal justice system’s role in the control of issues around drug use. They are successful in doing this because they do not refute the evidence that drug addiction is a “disease” that needs to be treated. Instead, they put treatment for it under the legal supervision of a judge and promote an ambiguous definition of “addiction” into which any problem could be placed. In the end, for somebody to succeed in the program, he or she does need to admit that he or she has an addiction; but what exactly that addiction is to – whether it be marijuana, opiates or the “lifestyle” of being a drug user, is not of prime importance. Further, while the alcohol or drug treatment portion of the program may last only three to six months, to “graduate” from the program takes at least another six months or longer and requires activities in

\(^{42}\) While some studies have found coercive treatment to be as effective, and sometimes more effective, than voluntary treatment, other studies argue that this conclusion is over-stated and that once you control for
addition to drug treatment (such as getting a job). In the next chapter, I explore similar issues about the labeling and management of addiction in two outpatient drug treatment programs.

other factors, like severity of problem, then coercive treatment is not more effective than voluntary treatment (Norland et al., 2003).
CHAPTER 5: DEFINING AND MANAGING ADDICTION IN OUTPATIENT TREATMENT

As I illustrated in Chapter 3, outpatient treatment has become the most prevalent method of treatment for drug and alcohol problems in Pennsylvania, as well as the United States, today. This was the result of several factors, most significant being a decrease in state funding, as well as the reduction in insurance reimbursement, for inpatient treatment programs. Additionally, research reports of national samples concluded that there were not significant differences in outcomes between those who had completed outpatient versus those who had completed inpatient treatment (for example, Miller and Hester 1986, Cummings 1991), yet outpatient treatment was far more cost-effective (Mojtabai and Zivin 2003). Since this is the most common form of substance abuse treatment today, I examine in this chapter how one outpatient treatment facility organizes its services around addiction treatment and how it articulates the nature of substance abuse problems to its clients.\(^43\)

The findings in this chapter are from two outpatient treatment programs that operate independently as separate programs, but are at the same time affiliated with the same university and hospital system. Both are overseen by the same administrative body at the University. They are located in different parts of the same building; they operate separately as far as budgets and client management are concerned. There is some overlap in staff, however, and counselors in one program might also have responsibilities in the other. Clients might also participate in both programs in different capacities.

\(^{43}\) Staff members at the outpatient programs referred to individuals in treatment as either “patients” or “clients.” In the next chapter, I elaborate on this classification and its implication for the labeling of addiction as a disease, but for simplicity and consistency, I refer to all individuals in the treatment programs as clients throughout this chapter.
One is an outpatient methadone maintenance treatment program (Southside Clinic) that utilizes group therapy and individual counseling in addition to the prescription and distribution of methadone. The other, Westview Clinic, is an intensive outpatient program (IOP) that operates both in coordination with the methadone treatment program (by accepting individuals from that program for intensive outpatient care) and separately (by accepting individuals who are self-referred or from the criminal justice system)\(^{44}\). I completed observations at group therapy sessions at both programs and interviewed clients and staff members in each program\(^ {45}\).

This chapter will explore the organizational philosophy and treatment practices in these programs. While the treatment programs overall promote a definition of addiction as a “disease” that needs to be treated, the characteristics of the disease are ambiguous and not precisely defined. This ambiguity is found both in interviews with staff members, as well as in interactions between clients and staff members in group therapy settings. It results partly from staff members being able to choose among a number of theories related to why some people become drug addicts. It also results from the use of multiple treatment methods within one facility –methadone maintenance, 12-step philosophy, and psychotherapy. The ambiguity also results from the need for the staff to negotiate how to fit the client’s own personal responsibility into how the client “became” addicted, and in their progression through treatment. Classifying addiction as a disease poses the

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\(^{44}\) The names of the programs, as well as all of the individuals interviewed and observed in group therapy, have been changed.

\(^{45}\) All interviews were tape-recorded and transcribed verbatim. I did not use a tape-recorder during observations at the programs. The group interactions depicted in this chapter are from fieldnotes I wrote after each observation.
additional problem of having to fit the client’s initial choice to consume drugs into that model.

Overview of Southside and Westview Clinics

Southside and Westview Clinics are both state-licensed treatment programs that are affiliated with a Philadelphia university and hospital. While the clinics vary in types of treatment, they share many characteristics, such as sources of funding, general philosophical approach to treatment, and high staff turnover. The clinics operate in the same physical facility, a two-story non-descript building; the only signs indicating that it houses treatment programs are 8.5” x 11” paper printouts taped to the glass of the two outside doors. The residential neighborhood where the facility is located is almost exclusively African American (94%) with the percentage of individuals living in poverty (32%) being considerably higher than the city-wide rate (23%)\(^46\). The median household income of the neighborhood was also much lower than that of the entire city ($21,800 vs. $31,000). While I was unable to obtain the demographic characteristics of the clients in each program, my own observations, as well as conversations with the clients, led me to conclude that nearly every client in the Westview program lived in the surrounding neighborhood. The Southside clinic, however, seemed to attract clients from a wider area of the city, probably because there were fewer methadone maintenance programs in the city than ordinary intensive outpatient programs.

\(^{46}\) These figures were obtained from aggregating the 2000 Census data in the three census tracts immediately surrounding the facility.
Both clinics receive most of their reimbursement for treatment services from government funding sources, primarily through Medical Assistance (Medicaid) and a program called “Behavioral Health Special Initiative” (BHSI), which is funded by a Commonwealth grant that allocates money for substance abuse treatment to those who are low income but do not qualify for Medicaid. Southside Clinic has more clients who pay out of pocket for treatment; the program supervisor estimated that about 25% of the clients were “fee payers” who pay for services on a sliding scale. Neither clinic would authorize services to get reimbursed directly from private insurance. The program supervisors in both clinics mentioned past problems in getting reimbursed from private insurance companies. For clients who claim that their insurance covers treatment, each program would require the client to pay up front and then take the paid bill to their insurance company to apply for reimbursement themselves. This practice was not surprising, since healthcare advocates have discussed the lack of insurance coverage for substance abuse treatment, and mental health services in general, in recent years. A 1999 national survey of managed care organizations revealed that only 56% of those surveyed covered outpatient methadone treatment (“Managed Care Not Stepping Up to Cover Methadone Treatment” 2000). Still, the same study found that 94% of managed care organizations covered outpatient treatment. When I learned of that statistic, I asked an administrator at the Westview Clinic for a further explanation of their policy. She explained that their location attracts so few people with private insurance that administratively they could not handle the separate billing requirements for each plan.

The Southside and Westview programs also operated on a similar level in terms of philosophical approach to addiction treatment. The structure of group therapy was
similar in the two programs, although the IOP group therapy focused more heavily on the amount of time an individual had been abstaining from drugs. At the beginning of every group IOP meeting at Westview, clients had to report their drug(s) of choice and how much “clean time” they had. This practice occurred occasionally in the “pre-IOP” group in Southside Clinic, but was not consistent. Both programs emphasized abstinence from drugs and alcohol as a primary goal of treatment and utilized twelve-step practices and ideology. There was some fluidity of staff roles between the two programs that likely contributed to (or was perhaps the result of) this similar focus. For instance, two of the counselors that I interviewed from Westview Clinic (the IOP program) had previously worked as counselors in the Southside Clinic. In addition, one of the facilitators of the group I observed at Southside, Wendy, was a counselor who worked primarily with court-mandated clients in the Westview program.

Both Southside and Westview also appeared to have high counselor turnover rates. This is consistent with studies that have shown substance abuse counselors to have a high rate of voluntary turnover (McLellan, Carise, and Kleber 2003, McNulty, Oser, Johnson, Knudsen and Roman 2007). One study estimated that the average annual turnover rate was 18.5%, a much higher rate than other occupations considered to have high turnover, like teaching and nursing, which average around 12% each year (McNulty et al. 2007). While I did not obtain official employment statistics at either treatment program, it is worth noting that among the six staff members that I interviewed at both clinics, only the program supervisor at each program was still working there in September 2007. The four counselors who had the most direct contact with clients had all quit by then. All of the staff I interviewed (even the two who were still working there)
mentioned being dissatisfied with their salary; most also mentioned feeling emotionally
exhausted by the job and the large caseload. For instance, here is a statement from my
interview with Wendy, a counselor whose job description included counseling most of
the court-mandated clients in Westview, as well as running the pre-IOP group at
Southside one day a week:

Wendy: “I have definitely been burnt out by this job. I…I can still do it, it
hasn’t affected the way I treat my clients, but I know that it’s rapidly
approaching, and I can’t spend the rest of my life doing this.” [from
interview]

Wendy indicated that she was working on a nursing degree and planned on quitting once
she found a job in that field. Two of the other counselors also mentioned working on
additional degrees or certifications. Emotional exhaustion has been found to be associated
with greater intent to leave the job, even when controlling for counselor salary (Knudsen,
Ducharme and Roman 2006).

While the staff members that I interviewed expressed dissatisfaction with
elements of the job, all of them also mentioned positive things about the work. They all
mentioned enjoying aspects of counseling, and many had positive things to say about the
clients in the programs:

Kevin (Westview program supervisor): “What I particularly enjoy about
substance abuse treatment, and also the eating disorder treatment, was
when people make that change, stop using drugs, stop doing the
compulsive activities, you see dramatic change. And there’s the window
for dramatic change that you see much less of in most of the fields of
psychiatry.” [from interview]

Despite reporting positive aspects of working in the program, almost all of the
counselors, regardless of which program they worked in, indicated that they were only
“somewhat satisfied” with their job.
The staff that I encountered in both programs were very different from the clients in terms of race and class. All of the counseling staff that I observed and interviewed were middle-class whites who lived in predominantly white, middle-class neighborhoods. All of them had college degrees; all but one additionally had a Master’s Degree. These demographic differences led to a social distance that I perceived between the clients and the staff. Wendy mentioned that she would experience that social distance at times:

_Wendy (Southside/Westview counselor):_ “At first they do, they give me that attitude like, “you don’t know, you don’t know what I’m talking about, you don’t know what I’m going through,” and then we get past that because, really, what does that have to do with your addiction? And sooner or later if I keep re-directing them, they get over it. But, um, one woman I did have a lot of trouble with because she kept going, “do you have any kids? You ever smoke crack?” I’m like, ”No. What does that have to do with…?” “You can’t relate to me, I’m not talking to you.” And it got to the point where we weren’t making any progress. She would sit in my office for an hour and not say a word… I’m like, “Well, you’re required to be here for an hour a week and you will sit here for an hour.” She’d say, ”That is fucked up, I’m not sitting here.” I’m like, “Well, then you’re in violation.” And, we did eventually change her counselor because there is no sense in pulling teeth. That’s not constructive. And it’s not helpful to anyone, so we did eventually transfer her, but...but other than that, most of them, they get over it quickly.” [from interview]

Wendy indicated that some clients felt that she, as an educated, middle-class, young, white, single woman, was unable to understand their problems. This social distance may have contributed to the negative aspects counselors reported about their job. It also related, as I will discuss later in this chapter, to the counseling staff’s perception that neighborhood and economic factors, such as living in poverty, were related to drug abuse. This social distance also resulted in a general distrust that occurred between the counselors and the clients, a topic that I revisit in Chapter 6.
Southside Clinic

Southside Clinic is primarily a Methadone Maintenance Treatment Program (MMTP) that offers outpatient group and individual therapy in addition to the prescription and distribution of methadone. Most clients in the Southside clinic reported heroin as their main drug of use, although a substantial number reported using prescription medication (i.e., Oxycontin or Percoset). The program supervisor, Linda, estimated that about 90% of the Southside clients were self-referred, with the remaining 10% being referred from a variety of sources, such as the criminal justice system, a doctor, or a member of the clergy.

All clients, regardless of referral source, are mandated to meet with a designated counselor at least once a week when they first start treatment. They must also complete a federally-mandated one-hour course in education about HIV/AIDS. As they continue through the program, the amount of time that they have to spend with their counselor decreases. Those who had been in the program for several years might only see their counselor for a half-hour each month. New clients were also mandated to attend a group therapy meeting twice a week for an hour each time. This group was called the “pre-IOP” group, and was a recent implementation of the program for those clients who were also evaluated to need intensive outpatient treatment, which they were scheduled to receive at the Westview Clinic. New clients would spend about two weeks, on average, in the pre-IOP group before being transferred into an IOP group in the Westview Clinic. Wendy, one of the counselors who moderated the pre-IOP group, but who primarily worked in

47 “Maintenance” refers to the practice of prescribing methadone to a client for an extended period of time, rather than just for detoxification purposes. Methadone is supposed to suppress withdrawal symptoms associated with discontinued opiate use and block the euphoric effects of opiates.
Westview Clinic, created the pre-IOP group for methadone clients. The purpose of the

group, as articulated by her and the rest of the staff that I interviewed, was to give the
new clients a chance to “stabilize” on their methadone and learn some of the expectations
of the intensive group sessions before they started. All of the staff mentioned past
problems with methadone clients “nodding off” in the IOP group as a result of not being
completely adjusted to their methadone dosage. After the client finished the IOP
program, he or she would continue individual counseling at Southside Clinic along with
taking daily doses of methadone.

To be a state-licensed program that administers methadone, the program must
follow strict federal regulations, as well as any additional state-level regulations that have
been imposed. The federal regulations were first established in 1972 by the Federal Food
and Drug Administration (FDA) and are also managed by the Drug Enforcement
Administration (DEA), since methadone is classified as a narcotic drug with some
potential for abuse (Rettig and Yarmolinsky 1995). In 2001, the regulations were updated
and enforcement of them was shifted from the FDA to the Substance Abuse and Mental
Health Services Administration (SAMHSA). These regulations are very specific
regarding how physicians may use methadone to treat opiate addiction. They also require
practitioners who dispense methadone (or any other narcotic drug for purposes of
maintenance) to register with the DEA annually; the DEA then determines if the
physician would be likely to comply with the security and record-keeping requirements
(Rettig and Yarmolinsky 1995). A 1995 report from the Institute of Medicine
summarized these regulations by stating, “No other medication is so highly regulated” (Rettig and Yarmolinsky 1995, 28)\textsuperscript{48}.

The federal regulations also require a person to demonstrate that he/she has been addicted to opiates for at least one year. Southside Clinic would usually verify this by making sure the client tested positive for opiates and he/she exhibited physical signs of addiction (such as track marks from using needles to inject drugs intravenously) or had a history of prior treatment episodes. If the individual reported using the opiate orally and did not have previous treatment, then the clinic would require him/her to bring in a letter from a family member or friend demonstrating that the person had been using the substance for over a year. Southside Clinic only accepts individuals who are 18 years or older.

The federal regulations also restrict the distribution of methadone to hospital pharmacies and treatment programs, with additional regulations regarding “take home” doses. Most clients, especially those newer to the program, must visit the clinic daily to receive their methadone dose, which is administered in liquid form by nurses. The client must drink their prescribed dose in front of the nurses. Clients could eventually receive take-home doses of methadone, after meeting additional requirements set up by Southside, including being on the program for at least three months. While methadone clinics nationwide, and the public, often cite cases of diversion as evidence that methadone should not be given to clients in take home bottles, research suggests that the amount of diversion that occurs does not justify the extremely tight regulations around

\textsuperscript{48} It was this same report by the Institute of Medicine that led to regulation changes in 2001 that were designed to allow for more flexibility and medical judgment in treatment, as reported in a 2001 issue of Alcoholism and Drug Abuse Weekly (“CSAT Issues Landmark Methadone Regulations”).
the dispersion of methadone (Rettig and Yarmolinsky 1995)\(^{49}\). While the federal regulations were changed in 2001 to permit more flexibility around take-home bottles, Southside Clinic’s own rules around them have actually become stricter.

Demand for methadone treatment nationwide often exceeds the supply. In the summer of 2005, when I conducted most of my observations at Southside, there was a waiting list for the program that meant an individual would have to wait about three weeks before starting treatment. The program also emphasized methadone maintenance treatment as something of a “last resort” for individuals who wanted to stop using opiates. As the brochure from Southside states:

> If you’ve been addicted to heroin or other opiates for many years, have tried a number of detoxes/reehabs and find yourself addicted again, or can’t go into a hospital, methadone maintenance is probably right for you.

Such a statement implies that a person should try other forms of treatment before enrolling in a methadone maintenance program, further suggesting that methadone maintenance is reserved for the most “severe” cases of opiate addiction (those who have been addicted “for many years” with multiple failed attempts at other forms of treatment). This perspective was further reinforced by counselors at both Southside and Westview Clinics. For instance, from an interview with Kevin, Westview’s program supervisor:

> **Interviewer:** “Do you think that methadone maintenance is the best way to treat opiate abusers?”
> **Kevin:** “I think methadone maintenance is the best last resort for treating opiate users. I do not think it’s the first choice for first-time treatment, because if you don’t have to go on methadone, you’re better off not.”

\(^{49}\) “Diversion” refers to the theft (and subsequent selling) of methadone from legally authorized dispensing locations.
Kevin reiterates the idea in the program’s brochure that methadone should be a “last resort” for treating opiate addiction. Many of the counselors I interviewed had reservations about methadone maintenance treatment, suggesting that they thought it was not always the best way to deal with drug addiction.

Westview Clinic

Westview is an Intensive Outpatient Program (IOP) that lasts 12-16 weeks and entails six hours of group therapy each week in addition to one hour of individual counseling. In order to “graduate” from the program, a client must complete 36 sessions and test negative for all illicit drugs for at least one month. Westview also offers outpatient counseling services for those who complete the IOP program or who are mandated to continue treatment after the IOP program (for instance, many court-mandated clients). Kevin, the program supervisor, indicated that the designated amount of time (12 weeks) for treatment was based on a “research model” of what is deemed to be successful. He likely was referring to a number of research studies that show that the longer somebody remains in treatment, the more positive outcomes he/she has both at the end of treatment and at follow-up. The National Institute on Drug Abuse (NIDA), a government agency affiliated with the National Institutes of Health, reports that three months is the minimum amount of time required to demonstrate significant improvement (“Principles of Drug Addiction Treatment: A Research-Based Guide” 1999). Kevin also indicates that most funding sources will not pay for treatment after 16 weeks.

There were many more clients at Westview Clinic who were court-mandated to treatment, compared to Southside Clinic. This likely occurred because most of the court-mandated clients were evaluated as needing treatment for marijuana abuse (and cocaine
abuse to a lesser extent). Peter, one of the counselors, estimated that at any given time about one-third to one-half of the clients in his group session were court-mandated to treatment. The associate director of the Substance Abuse Division of the university indicated that as of 2006, about 50% of the clients in Westview Clinic were there because of involvement with the criminal justice system. He also indicated that this proportion had increased in recent years; he related that in 1997 only about 20-25% had been court-mandated. He also indicated that the overall number of criminal justice-related clients had not increased, but that the number of self-referrals had decreased, therefore changing the ratio.

Wendy, the same counselor who ran one of the pre-IOP groups at Southside (the methadone maintenance program) each week, was primarily responsible for individual therapy for Westview’s clients who were referred from the criminal justice system. She also acted as the liaison to the various criminal justice initiatives, having frequent contact with the clients’ parole officers and case managers. She would also appear in treatment court to give a monthly report for any of her clients in that program.

Westview Clinic ended its relationship with Philadelphia’s Treatment Court by the Fall of 2007. Kevin, Westview’s program supervisor, indicated that the number of people being referred to Westview from Treatment Court had been consistently declining over the past two years, that it got to the point where it was too much work on their end (i.e., going to court once a month) for the small number of clients that were being referred to them. When I asked him why he thought that Treatment Court was referring fewer people to Westview, knowing that in recent years the actual number of people in the Treatment Court Program had increased, he indicated that he thought some of the other treatment programs in the same area of the city were better connected politically to the Treatment Court Program, and were therefore receiving more referrals. Westview continues to accept clients from the other criminal justice initiatives, like
Progression through Treatment

When a client begins treatment in either program, he or she completes a series of questionnaires and has a face-to-face interview with a counselor. Based on the information gathered, the counselor would place the client in a designated “level of care” and determine if the client was appropriate for methadone treatment (if an opiate user). There were no “medical” criteria that had to be met for methadone treatment; the client’s self-report of continued use and some documentation of that (either track marks or a letter from a friend) was considered evidence of addiction.

If the client was evaluated as appropriate for IOP treatment, then the counselor would assign him/her to a specific group, usually based on the time that the client wanted and how large the groups already were. When possible, counselors might try to determine which group would be the best “fit” for the client:

Kevin (talking about a new client from the criminal justice system): “…if that drug-free group is functioning well and so on, and we have some more senior people in there that are from the criminal justice system and so on, that can kind of be a role model and so on. That’s the one of choice in my mind. What the…you don’t want is a group where it’s got no, no peer leadership and criminal justice and that can be a mess. It could feel like you’re a substitute teacher in a high school in the inner city.” [from interview]

Westview Program had four different IOP groups scheduled during my observations. The groups were divided into one group of those receiving methadone (all of whom were from the Southside clinic), one group of those not receiving methadone (named the “drug free” group), and two “mixed” groups that consisted of both people from the Southside clinic and those not receiving methadone as part of treatment. The program seemed to go

Forensic Intensive Recovery (FIR) and Intermediate Punishment (IPP), because those cases did not require 171
back and forth about whether or not to have “mixed” groups, based on feedback from both the clients and the counselors, but ultimately had to use them because other factors (like clients’ schedules) became more important determinants of the structure of the group. The classification of the non-methadone-using group as “drug free” implied that those taking methadone were still using an illicit substance. There were many clients in the “drug free” group taking prescription anti-depressants and other medication, but were not labeled as drug users in the same way, suggesting that the methadone clients were not as “clean” as the other group members.

The designation of a “pre-IOP” group in the Southside clinic was rather arbitrary. The intent, as communicated by the staff, was that clients new to the Southside clinic who were evaluated as needing IOP treatment would go to the pre-IOP group first in order to “stabilize” on their medication and get acquainted with the “group process.” There were no strict criteria on how long a client had to remain in pre-IOP before moving into an IOP group at Westview. Those who consistently attended the pre-IOP group sessions and participated seemed to move quite quickly into the IOP program (usually within 2-3 weeks). There was one client, Karl, while I was observing, however, who returned to the pre-IOP group after finishing the IOP treatment program because he wanted to continue some form of group therapy. This seemed to be due to the fact that there were no other groups in the program for those who were still experiencing problems with using drugs but had completed their allotted time in another group. That the counselors thought that a group of individuals very new to methadone treatment and

as much additional work for the counselor.
often still using drugs themselves was the best environment for somebody who had been at Southside’s program for over two years seemed injudicious to me.

Being assigned to IOP treatment is supposed to reflect needing a higher level of care than ordinary outpatient care. However, the most critical factor used to decide whether a Southside client should attend IOP treatment in order to still be enrolled in the methadone maintenance program was whether or not the client was working:

_Interviewer:_ “So when someone comes in depending on whether they are CBH or BHSI [public insurance programs], or fee-paying, do they get evaluated differently?”

_Linda:_ “No. But their treatment is different. If you’re a fee payer, you are probably working therefore you don’t go to IOP because it would interfere with work. If you are not, that means you don’t have anything to do with your day so we make sure you do. And CBH will pay for it and pay extra and pay much more for IOP. But it’s a flat fee if you’re a fee payer and you’re probably working, either day or night, but you certainly don’t need so many hours to be tied up when you’re already tied up. Your life is already partially structured.”

If a client was working full-time then he/she was most often a “fee-paying” client and was not mandated to attend IOP treatment. This policy was enacted around the year 2000, according to the program’s director. The rationale was that IOP treatment might help to engage the methadone clients in treatment with the expectation that they would then have better outcomes. Linda’s response, however, suggests that there was also a financial benefit to the program since the costs of the treatment would be reimbursed by public insurance programs. She also eventually revealed some contradictions with this policy, since the intent seemed to be to give the client more “structured” time:

_Interviewer:_ “Say payment weren’t an issue or there were enough slots, do you think it would be beneficial for a lot of those people [fee payers] to go to IOP?”

_Linda:_ “Oh sure. I believe in it whole heartedly. But I’m not allowed to because no one will pay for it… So let’s say that I’m disabled because I
got Hepatitis C, so bad from using, which I never stopped, that I can’t work in the plant where I used to work. I’m no different from the guy who isn’t working. Except that I get a pension so I don’t qualify for Medical Assistance and I’m on Social Security Disability. So between the two, I maybe get 1,200 dollars a month, but my life is still sheer hell. I’m still using as much as the next guy, why shouldn’t I get it?”

Kevin also talked about this policy and defended it by arguing that those who were not working were actually “worse off”:

Kevin: “In general, people that are not working are worse off on many levels. Because, you can’t be that bad off and still work. You can be pretty bad off and still work, but there are limits. And more often some of the problems are less chronic among the people who are still working. The other thing is, early recovery, a very important component at least in my mind is you need something constructive to do with your time. If you’re working, that takes up a fair amount of time. If you’re not working, well, being in 9 hours of group and an hour of individual a week takes up at least some more of your time. So there’s a good argument from that respect.” [from interview]

This rationale suggests that a person’s employment status becomes a symptom of their drug problem. There is no distinction made for those who might be actively looking for a job but have not yet found one. These clients would also be mandated to attend IOP treatment.

Clients had a mixed reaction to this policy. There was some indication that many would merely “go through the motions” of the IOP program so that they could continue at the Southside clinic, but were not very interested in participating in that treatment program. Other clients seemed to like the addition of group meetings:

Christine [Southside group, white, age probably mid 30s]: I was on this program like 12 years ago. But it wasn’t anything like this. I mean, you just came and got your meds and that was it. There was no group like this or anything. This is a lot better. [from fieldnotes]
Other Southside clients expressed frustration with the policy of having to attend the Westview program, especially if they began working after starting treatment:

Brian [Southside group, white age probably late 20s]: So now I have a job and I want to keep it, but I don’t know if I can because I have to come here.
Wendy: Well, this place is a lot better than jail. I mean, in jail they tell you what to do. Here, you get to dictate what you’re going to do. The only thing we mandate is that you go to IOP, but the rest is on you and what you want to get out of it.
Brian: Yeah, but that could make me lose my job.
Wendy: Well, what you could do is get a letter from your employer and show Linda. She’ll then excuse you from IOP and you’ll become a fee payer. It’s like $75 a week, but I think there’s a sliding scale. Because otherwise we think you’re committing insurance fraud by working but having welfare pay for you to be here.
Barbara: Wow. They won’t let you get away with anything. They won’t even let you work here.
Wendy: You can work; you just then have to become a fee payer. Look, if you’re working and you’re still using, you’re going to end up spending like half of what you make on drugs. This way, you just give us 3 months. That’s all IOP is, 3 months…and in the long run it’s more profitable, because you will be clean, then you can get a job and actually keep the money. So it’s more profitable for you in the long run.
[from fieldnotes]

Wendy likely refers to jail because Brian previously indicated that he had recently been released from jail where he had spent ten months. In this exchange, we see the distinction made between those who are perceived to be “legitimately” working and those, like Brian, who are likely working under the table. There is no discussion, however, about how difficult it likely is for Brian, a convicted criminal, to get a decent-paying job. Instead, Wendy suggests that those in Brian’s situation are trying to commit insurance fraud and want to avoid going to IOP. The policy, then, does not advocate for clients to work, especially if they are already receiving public insurance coverage for treatment.

Another situation in group illustrates this policy:
George (Southside clinic, white, probably early 20s): I feel like I’ve started making some changes.

Wendy: Like working, right? You got a job.

George: Yeah.

Wendy: How many days do you work right now?

George: 7.

Wendy: What about when you go to IOP? How are you going to do that with your work schedule?

George: Well, I guess I won’t be able to work as much then. I’m just trying to work a lot now cuz I need to get some money together, take care of things. But once I go to IOP, I won’t work for that month I guess.

Wendy: Month?! Try three months.

George: Three?! Whew. I didn’t know it was that long. I mean, I guess I’ll just work now so I can take care of some things. But then I won’t work.

[from fieldnotes]

Wendy initially seems to be supportive of George getting a job and his positive outlook on “making some changes.” However, because he is already in the pre-IOP group, she does not give him the opportunity to opt out of the IOP program, even though he is working.

Just as the evaluation for IOP treatment relies on external circumstances and funding issues, other stages of the treatment programs are dictated more so by funding than clinical considerations. When a person completes treatment is often determined by their funding source. IOP treatment is supposed to last 12-16 weeks, although some funding programs will extend that time based on a clinical evaluation. For those who cannot continue being funded, however, they will have to leave the treatment program, despite not actually being “better” by the clinic’s standards. This is illustrated by the difference between somebody completing treatment and somebody graduating from treatment.

Kevin: “Finished is, hey, we ran out of time! And maybe it’s time to try something different. Graduation is, ok, you have completed this successfully and you got at least a month of not using, clean urines.
You’re making progress, and compliant, and you’ve done 36 sessions, yeah. You get a cake.” [from interview]

The document “Basic IOP Treatment Expectations,” which clients had to sign at the beginning of the program, lists Westview’s specific graduation requirements. Kevin indicated that those who are “finished” but not graduated might be referred to residential treatment, or in the case of the Southside clients, returned to ordinary outpatient, methadone maintenance treatment (which will often be funded indefinitely). These requirements for graduation, while explicitly guided by funding considerations, do not appear to be equally based on clinical research:

*Interviewer:* “As far as the requirements for graduation, like the one month of being drug-free. Where did those requirements come from?”

*Kevin:* “They seemed like a good idea. [chuckles] We made them up, of course!”

Kevin seemed to read a lot about addiction and treatment issues; he referred to these in our interview and in the group sessions he led. The graduation requirements may be based on evaluation of the research, but he does not offer a specific study or body of work that suggests that these requirements would lead to more successful outcomes at follow-up.

The clinic’s concern over funding was also evident by their creation of an IOP “make up” group:

*Wendy:* And you need to go to group, because for those who are on CBH [public funding program], they will cut you off if you attend less than two sessions per week. And if that happens, you then either need to become a fee payer or get on BHSI [another public funding program]. That’s why we started having a make-up group once a week so people won’t get kicked off by CBH. [from fieldnotes]
Wendy also suggested in her interview that some of the motivation of accepting court-mandated clients was because of funding considerations:

*Wendy:* “Because it’s so hard to keep this program afloat, we’ve taken in the FIR and IPP, Treatment Court, federal clients, taking in these people to help generate money. And, these guys definitely need treatment, but I think it’s a different type of treatment than what is typically provided here…” [from interview]

These policies indicate that funding sources drive the treatment process much more than clinical research or a client’s own progress.

**Addiction: A Disease Just Like Any Other**

Both Southside and Westview programs referred to treating drug addiction as a disease. However, the exact nature of the “disease” of addiction was not easily defined by the staff, and was also not clearly communicated to the clients during group sessions. As this section illustrates, the “disease” of addiction was rather ambiguous in definition and resulted in treatment practices that often treated the client as a criminal, or at least untrustworthy, rather than as a “patient” in need of medical treatment. The use of twelve-step methods in the treatment programs also contributed to a confused notion of what exactly addiction is.

Westview Clinic introduces the concept of addiction as disease to its clients through its patient manual, entitled a “Brief Guide to Westview Substance Abuse Treatment Program”:

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51 I do not view twelve-step methods as antithetical to a “medicalized” view of addiction, since they refer to addiction as a “disease.” However, those who adhere to a twelve-step philosophy for treating addiction will often be resistant toward more medicalized treatments, like pharmaceutical methods.
We believe addiction is a complex disease that affects the addict mentally, physically, socially, emotionally and spiritually. Because an addict’s whole life is affected, basic lifestyle changes are necessary for successful recovery.

Treatment goals include overcoming denial and ambivalence, establishing and maintaining abstinence, building a support system, identifying basic patterns and issues, developing relapse prevention skills and identifying and addressing other problems as needed...

The program emphasizes, through this manual, that addiction is a “complex disease.” While they never explain the cause of that disease (biological/genetic predisposition, psychological issues, social forces, etc), they do elaborate on the consequences of addiction, which are said to affect every aspect of the client’s life. The treatment goals and twelve-step ideology are articulated as the methods by which the client is supposed to achieve those “lifestyle changes.”

Staff members mostly agreed with the notion that addiction was a disease, but had very different ways to conceptualize the components of the disease.

Interviewer: “So do you think drug abuse is a disease?”
Linda (Southside Program Supervisor): “I know I’m supposed to, so I guess I do.”
Interviewer: “What do you mean you’re supposed to?”
Linda: “I believe it’s a disease, part physical and part mental… Yes, I believe it’s a disease.”
Interviewer: “Can you explain that a little bit? What’s the physical part, what’s the mental part?”
Linda: “Well, I don’t separate the physical and mental. Because it leads to stress, stress results in Cortisol and other neurotransmitters being produced too much or too little, which leads to emotional reactions to those drugs. I believe that in some sense, genetics makes a difference. I believe that you make THIQ with heroin and alcohol. THIQ, tetrahydroisoquinilone, is a byproduct which certain people do and certain people don’t… It’s been found in the brain of alcoholics when you dissect them and do an autopsy that they have THIQ, which is a byproduct of metabolization of either alcohol or heroin. The fact that they make it and I don’t leads me to believe for sure that it’s a disease. That they have an endorphin-like substance that they get addicted to, that I don’t. I don’t make enough
thyroxin. I take pills. I have a disease. They make too much of something else. They got a disease too.”

In this interaction, Linda, Southside’s Program Supervisor, explains that she thinks addiction is a disease, largely because of biological and genetic factors. She goes on to explain one of the genetic theories of alcoholism, the “THIQ Hypothesis,” that was presented in David Ohlms’s 1993 book, *The Disease Concept of Alcoholism*. While this theory has been controversial, it has also found much support in the addiction treatment community. Linda’s use of it implies that she would also attribute this characteristic to drug addicts, and not just alcoholics, since she never clearly differentiates drug addiction from alcoholism. Kevin, Westview’s Program Supervisor, also explains addiction as a biological disease:

*Interviewer*: “Would you say then that alcohol or drug abuse is a disease?”

*Kevin*: “Oh, sure, however one defines it.”

*Interviewer*: “And how would you define it as a disease?”

*Kevin*: “Ah (pretends to scream)! Probably that it is a…definable syndrome where you can specify the course and, um, predisposing factors and so on. The usual one they compare it to is diabetes. It’s not a bad analogy.”

*Interviewer*: “Why do you think that’s a good analogy?”

*Kevin*: “Cuz they are both affected by lifestyle behaviors. Exercise, ingestion and diet can determine diabetes in the majority of people. Most people on a bad enough diet, lack of exercise and so on, you’re going to become diabetic. Likewise for drugs and alcohol. There’s an old A.A. [Alcoholics Anonymous] saying, once you become a pickle you can’t go back to being a cucumber. And…there’s good evidence that that is probably true. There are brain changes, and physiological changes that come with long term use of a substance that the body’s adaptation to that… It never goes back to being like it was before… I don’t go with the idea that…no alcoholic, that nobody who drank alcoholically can ever go back to drinking socially. There are instances. I think it’s a bad bet. But certainly some people can do it. And I’ve seen some people appear to do it. And who’s to say? …So you do undergo changes in the substance abuse. So that means that you’re susceptible for the rest of your life, to some degree.”
While Kevin uses biological evidence to discuss how addiction is a disease, his definition of addiction is different from Linda’s. Kevin employs a definition of addiction that is promoted by the National Institute on Drug Abuse (NIDA), which states that addiction is a “brain disease.” On their website, NIDA’s Director, Nora Volkow, offers the following “Message to Medical and Health Professionals”:

“Recognizing drug addiction as a chronic, relapsing disease characterized by compulsive drug seeking and use is critical to being able to identify and help those who have it. Drugs of abuse affect the brain by mimicking neurotransmitters (e.g., heroin or marijuana) or by altering their regulation and release (e.g., cocaine and amphetamine). In this way, they disrupt normal brain communication. Repeated disruptions in the brain’s normal signaling processes can eventually lead to addiction - affecting the very circuits needed to exert good judgment and inhibitory control over actions. With these abilities "seized," the drug-addicted person will compulsively choose drugs, even in the face of devastating life consequences” (www.nida.nih.gov).

Both Linda and Kevin articulate a definition of addiction that relates to brain processes, although Kevin seems to promote NIDA’s definition of drug addiction. He also discusses addiction as something that is chronic and, in an earlier statement in the interview, defines addiction in terms of compulsive drug seeking, again promoting NIDA’s definition. Kevin’s conceptualization of addiction, and his comparison of drug addiction with diabetes, is also similar to a view that has been proposed by researchers at Philadelphia’s Treatment Research Institute, and most notably published in the Journal of the American Medical Association in a 2000 article entitled “Drug Dependence, A Chronic Medical Illness” (McLellan, Lewis, O’Brien and Kleber 2000). In this article, the authors suggest that drug addiction should be conceptualized as a chronic medical disorder rather than as an acute disease. They offer comparisons of addiction treatment outcomes with those from treatment for diabetes, hypertension and asthma and conclude
that adherence to medication and relapse rates are similar across all of those “chronic diseases” (McLellan et al. 2000). Kevin was more articulate about using this more recent definition of addiction as a brain disease that is similar to other chronic diseases, while Linda cited a genetic theory that was developed in the early 1990s. However, these two ideas are not mutually exclusive, as NIDA also promotes genetic factors as one of the reasons that some people become addicted to drugs and alcohol. Neither Linda nor Kevin appeared to have been instructed as part of their job to adhere to one definition over another, so I could only conclude that each one prefers the definition that he/she gave.

The other counselors that I interviewed who ran the various group therapy sessions in either Southside or Westview Clinics also had different notions of whether they considered addiction to be a disease, although all cited some biological/genetic explanation as one of the factors involved.

*Interviewer: “Do you think that alcohol or drug abuse is a disease?”*
*Wendy: “That’s like the million-dollar question. I…for some people I do believe it, and others I don’t. So, it varies. There’s no cookie-cutter format that I can actually put each client into or, each drug addict, alcoholic, cause they all have different backgrounds, they have different reasons for drinking, um, I think that there are a lot of chemical imbalances, what you would be calling disease, that drive people to use, or drink, or whatever the case may be, but in general, I think that, again, everyone has choices, and people who are not being treated properly for whatever their symptoms are, are self-medicating for it, and trying to make up for it.”*
*Interviewer: “So, it sounds like maybe they have some other kind of mental illness, but this drug use, the drug abuse itself, is not a mental illness, is that what you’re saying?”*
*Wendy: “Right.”*
*Interviewer: “Like they’re using that to medicate this other illness that they have.”*
*Wendy: “Right. And because of their lack of education or coping skills, they, they don’t know what else is out there for them… So, I don’t believe that it’s actually just one set thing. It goes back and forth. Cuz you meet people, who you think, it’s got to be a disease, it’s got to be something like
that, but once you get to the base of the problem, and you realize where they’re coming from, it’s a whole different story.”

Interviewer: “What do you mean, like at first you would think, this has got to be..?”

Wendy: “I’m again going back to the methadone clinic. Like sometimes you think, no one would actually say, ‘let me stick this needle in my arm, that’s a good idea’... So you think that it is some type of disease, but then when you work with them, and you find out the abuse that goes on in their families, the drug addiction in their families, the environment that they live in, it’s of no surprise. A lot of the women, I’d say...I’d say at least fifty percent of them, have been abused- verbally, physically, sexually... their histories reflect why they’re self-medicating. If you come from a broken home and mom and dad beat you or hated you or disowned you, you’d have a lot to forget about, you’d have a lot to want to cover up, and a lot of them are very successful with using benzos [Benzodiazepine], for example. Benzos make these people into zombies, like you have no feelings left. Then when they finally come to and we start talking about feelings, and they’re crying for a couple hours straight, like oh, you forgot what it feels like to have those, and they get really upset... But I definitely think that there is some type of genetic exchange of addiction. A trait, I guess. A characteristic or a weakness. That’s my best guess.”

Wendy explains addiction multiple ways in this interaction, but focuses heavily on external circumstances that might lead one to abuse drugs (specifically, different types of abuse or the social environment). She still also relates a possible genetic component to addiction, however, indicating that it is perhaps some combination of these external factors, along with a genetic “weakness” that leads to addiction. She does not cite any research studies, however, like Linda or Kevin do, to explain her perspective. Her initial reaction to the question (“that’s like the million dollar question”) indicates that she believes the disease concept is something that can be debated, is controversial, and is a question with no easy answer.

Tom, another counselor at Westview, disagrees with the idea that addiction is a disease:
Interviewer: “Do you think drug abuse or alcohol abuse is a disease?”
Tom: “No. [laughs somewhat nervously]”
Interviewer: “So some people think that’s it’s a disease, do you think they have it wrong?”
Tom: “Yeah.”
Interviewer: “Could you elaborate a little bit?”
Tom: “Um…well…a couple reasons. One, this idea that it’s a brain disease and that once somebody uses a substance that they’re going to…that their brain is going to continue to need the substance, I just know that that’s not true given the amount of people who use, have used, and experimented with drugs and never end up having drug use problems. We can actually see a significant decline after, after [age] 24, 25 which is right about the end of college, of the people who are using at significant levels and then it kinda drops off. So there is that and then there is the whole gateway theory which is…you can’t switch causality where the actual, the majority of marijuana users, even though the majority of cocaine and heroin users may have started with marijuana, alcohol, the majority of alcohol users and marijuana users never used harder drugs, so it’s not this kind of progressive disease…”

Here, Tom is arguing against the “brain disease” notion that Kevin discusses. Tom also argues against the “gateway theory” of drug use that assumes that those who start off using drugs like alcohol or marijuana will eventually escalate into using “harder” drugs like cocaine and heroin. This theory is often linked to the notion that drug addiction is a “progressive disease” that becomes more serious over time, leading to the use of what some consider as “harder” drugs. While Tom quite clearly articulates evidence against these two theories of addiction as disease, his own notion of addiction is not as straightforward:

Interviewer: “Why do you think some people become alcoholics or drug addicts?”
Tom: “Um…multi-factorial. I think for the large part it’s a learned behavior, that it’s very much a skill they developed to give them either positive experiences or take away negative experiences that they learned….either through, you know, modeling from parents or close friends or just their own experimentation and they find this just works for this and this works for that… But each person it’s gonna be different. I mean, you have the one person that, they’re an alcoholic, but they only
While Tom initially articulates strong opposition to the idea that addiction is a disease, in
the above interaction he promotes a notion for the etiology of drug abuse that is very
similar to Wendy’s. Wendy also expressed some hesitation in labeling all of her clients as
“diseased,” but still did convey the opinion that some addiction was like a disease. Tom
uses much of the same reasoning Wendy does, citing addiction as a learned behavior that
is often the result of poor coping skills and environmental influences. Similar to Wendy,
he also indicates that there is not one definition that fits everybody, that there are multiple
reasons, including genetic/biological factors, that influence whether somebody becomes
addicted to drugs. Still, it is interesting that Tom dismisses the idea that addiction is a
disease after stating that there could be a genetic or biological component in some
individuals that “bring out” the addiction.

Indeed, one thing that all of the staff had in common was a belief that drug
addiction could be produced by multiple factors, one of which was genetic.

*Interviewer:* “Why do you think some people become alcoholics or drug
addicts?”

*Kevin:* “I think there’s a definite genetic component… And the research
suggests as well that there is a significant genetic component. On the other
hand, it’s clearly related to social influences… There’s a book by Stanton
Peele, *Love and Addiction*, if I remember it… from years ago. And one of
the studies he cites is the Vietnam, where there were a fair number of
people who used heroin while in Vietnam and the greatest proportion of
them came back to the United States, stopped using, went on with their
lives. They were physically dependent on it there, but hey, didn’t carry it over. Substance abuse, like almost any compulsive activity, I think serves to be an escape from self. And that can be a powerful thing... The determinant is how it’s affecting your life. And certainly anybody using a physically addicting drug at sufficient quantities and for long enough is going to be quote, hooked, and may well have a hard time getting off. And if you throw in other factors, socio-economic, emotional, psychiatric and so on, complicates the picture and makes it less likely that they will be successful in doing that. So sure, it’s a lot of things.”

Kevin, in this exchange above and in earlier ones cited, adheres to the concept that addiction is a chronic disease. It is particularly interesting here, then, that he cites Stanton Peele and the Vietnam study, to illustrate possible social forces involved (i.e., the stress of fighting in a war). Peele is a very outspoken critic of the biological disease concept of addiction and explicitly states that he uses a “distinctly nonmedical approach” to understanding and treating addiction (www.peele.net)52.

All of the other counselors also related some combination of genetics, individual psychological problems, and environmental factors as the primary causes of addiction:

Peter: “On a very basic level, doing drugs is a resistance. In other words, it’s a defense. In other words, needing to take a substance so I don’t have to feel x, y and z emotion, it’s a defense against feeling that... It’s like, I’m living in this poverty-stricken area, I have basically no options, I dropped out of school in the ninth grade, I don’t have much. So there’s a lot of hopelessness, especially with the socio-economic level that we deal with here. And so they got to take a break, got to get away from that hopelessness and powerlessness for a while...” [from interview]

Jerry: “I think part of it is genetic, I think part of it is the whole nature/nurture thing... Searching for something that will make them feel better... I know in my case...alcoholism in my family, the generation

52 Stanton Peele is a psychologist who has written at least six books on the topic of addiction. He concludes that addiction is “a pattern of behavior and experience which is best understood by examining an individual's relationship with his/her world” (www.peele.net). His books are critical of the treatment industry using biological models of addiction and 12-step practices, with little empirical evidence to prove their effectiveness. His use of the term “addiction” indicates that he does view it as something that needs treatment, but insists that the most effective way is a “nondisease approach” (www.peele.net).
before. So I think there’s a genetic component. I think the genetic component could be overcome if the person is free from the stress that make people want to self-medicate…” [from interview]

The idea that addiction was largely the result of an individual “self-medicating” was another widespread notion articulated by the staff at both Southside and Westview Clinics. It relates to both the internal psychological problems (i.e., a mental disorder, like depression) and the external forces (i.e., living in a poverty-stricken area) that were also cited as factors that could produce addiction. Peter and Jerry were the two counselors that I interviewed who also discussed having had their own problem with drugs and alcohol. Still, their definitions of addiction are quite similar to Wendy and Tom’s, even though they have a different personal experience with drugs and alcohol. This could be the result of the overarching philosophy of the clinic – considering addiction to be a disease, while also utilizing twelve-step practices – being promoted by all of the staff. The frequent reference to environmental/social factors that were applicable to the neighborhood surrounding this treatment facility (i.e., high rates of poverty and drug use) also suggests that the counselors were focusing on patterns of circumstances that they observed in their clients’ surroundings. Unfortunately, I cannot say if this perspective would be different if the counselors worked in a treatment facility that attracted mostly middle-class clients. It does seem difficult, however, to attach such characteristics to addiction in general, if the counselors were in a different social environment, or there was less social distance between them and the clients.

The apparent widespread acceptance by the staff that addiction is a disease did not interfere with a concurrent notion that the client had to take responsibility for getting “well.” This idea is central to many different medical conditions, and is one of the
characteristics of illness that Talcott Parsons described in his theory of the “sick role” (Parsons 1975). Parsons contended that to be “sick” was to take on a new social role. One of the legitimizing criteria for being able to take on the “sick role” was a general notion by the population that it was not the person’s fault that he/she was sick. However, to sustain that legitimacy, the person must also demonstrate that he/she was trying to get better, such as by visiting a doctor, taking medication, or seeking some other socially approved treatment method. If the person was perceived to be taking responsibility for his/her illness, then he/she would be granted the sick role status and would not generally receive any moral condemnation for contracting the illness (Parsons 1975). Addiction however, even when considered to be a disease, still carries with it a characteristic that makes it difficult for staff to differentiate what the client was responsible for, since to “contract” the disease of addiction, one must choose to initially ingest drugs. Similarly, the “disease” only continues if the person continues using drugs. The treatment staff were more hesitant to extend the “sick role” status onto the clients at Southside and Westview because of a perception that the client was in some way at fault for contracting the “illness” of addiction. For instance, Linda, Southside’s program supervisor, here discusses her view that clients do not often take enough responsibility for their “disease”:

_Linda:_ “I think too many professionals make excuses and enable. We don’t set enough structure and enough expectations… You know, I have high cholesterol. They expect me to avoid cheese, they _expect_ me to-and if I don’t then I get badly yelled at. But we say, oh you poor thing, you’ve got a disease.”

_Interviewer:_ “So there is some responsibility that comes along with it?”

_Linda:_ “I think so much of it, they say ‘we’re throwing it up to God’ and I say, ‘you’re just throwing it up, God’s too busy for you. You gotta help out here.’ I really don’t like that throwing it up to God. Not turning it over, throwing it up.”
While Linda refers to clients not taking enough responsibility in seeking out and adhering to treatment, other staff would fault the client for initially engaging in a behavior that could lead to drug addiction.

*Interviewer:* “To what extent is a person’s alcohol or drug problem their own fault?”

*Wendy:* “I’d say, 98 percent their fault. Because everyone has choices, no one stuck a needle in your arm; no one shoved the booze down your throat. Everything that they do is a choice in life. Um, once they’re actually addicted in the physically addicting drugs, that, that could be different. Um, such as the opiates. Some people claim getting on pain killers, and becoming addicted to the pain killers that were prescribed by a doctor. I believe that that happens, and I know that people have chronic pain, and before you know it, you can’t stop taking them. So that, that I think is realistic. But, um, I’d say that majority of it is their choice.”

Here, Wendy differentiates between those who become addicted unknowingly, by becoming physically addicted to medications prescribed by a doctor, and those who take a drug initially just for pleasure. She ascribes different levels of responsibility to the two groups.

Most counselors agreed that drug addiction was not primarily the fault of the client, indicating that they were somewhat willing to extend the sick role status to their clients. Mostly this seemed to be related to the counselors’ general acceptance of addiction as a disease, even if they had difficulty articulating the specifics of that disease.

*Linda:* “I don’t think anything is anybody’s fault…I don’t believe that disease is fault…” [from interview]

*Interviewer:* “To what extent would you say a person’s alcohol or drug problem is their own fault?”

*Peter:* “I would say not too much…Well, if it’s a disease, then would you say somebody is at fault for having tuberculosis, or is somebody at fault for having cancer?... Now, at certain points, a person assumes responsibility for dealing with the problems... And obviously part of the addiction characteristic is denial, not wanting to deal with it. So I would say it’s probably nobody’s fault for becoming an addict or an alcoholic,
but...being ready to stop or wanting to stop... In other words, wanting to deal with it is their responsibility.”

By defining addiction as a disease, the staff must concede some of the blame they might extend to the client. Still, the counselors emphasized the need for the client to take responsibility for his/her addiction, which usually meant staying engaged in treatment and not using drugs anymore.

*Kevin:* “It’s not their own fault, it’s their own responsibility. .. Fault I think is a bad way of looking at it. Responsibility, I think, is a good way of looking at it because... It doesn’t matter how you got lost in the forest, it’s up to you to find your way out. Blaming other people is pointless, blaming yourself is pointless. It’s the old Jim Brown approach to addiction. It’s this story where Jim Brown was sitting with, what was his name?...Richard Prior! And Richard Prior was telling him all these things and making excuses all over the place. And Jim Brown, big burly guy, just sat there and said, “so what are you gonna do about it?” That’s the Jim Brown approach. It comes down to that. It’s up to you to make the changes. Treatment, et cetera, are all there to try and assist you. And encourage you and...as an old client did a poem about pushing hope. That’s what, when she goes to therapy, that’s what they do, they push *hope* instead of drugs. It’s still up to you.” [from interview]

Therefore, the counselors did not equate responsibility and blame. At the same time, there was an implied view that clients did not often accept that responsibility, as in Peter’s assertion that many clients were in “denial” of having a problem. Denial is articulated as a characteristic of addiction but is not often associated with other diseases.

This notion of responsibility related to the counselors articulating to the clients in group sessions that they had control over their “illness.” Here is an interaction between one of the counselors and a new Southside client, Cathy, during a pre-IOP group meeting. Wendy had just read over a handout that described the need to give up some control of every detail in one’s life:
In this interaction, Wendy is quick to tell Cathy that she has control over using drugs, even though Cathy seems to think otherwise. With the notion of responsibility came this insistence to clients that while treatment could give them the tools to battle their addiction, it was ultimately their task to use them effectively.

Treating the “Disease”

These counselors were the primary educators about addiction for the clients in the treatment program. Both programs’ group meetings had specific educational components (handouts, workbooks, videos, etc); at other times throughout the group meeting, discussion of how addiction was a disease would emerge. Just as each counselor emphasized different components of what addiction was, counselors would communicate the idea that addiction was a disease to their clients in different ways. At the same time, because of the programs’ structure and overarching treatment philosophy, all of the counselors emphasized certain components of treatment to the clients that related to the acceptance of addiction as a disease. Those communicated as the most important were the goal of abstinence, using 12-step programs as part of and in addition to treatment at the facility, and using medication (methadone) effectively for the Southside clients. In both programs, clients and staff would also use an ambiguous notion of addiction that could
extend to other behaviors besides using drugs, such as buying and selling drugs that they considered diseases in and of themselves.

Promoting Abstinence

Abstinence from drugs and alcohol is often an explicit goal of treatment programs in the United States. Many research studies that have attempted to determine whether or not a treatment program was “successful” will ask clients about drug use at some point post-treatment; complete abstinence at follow-up is often constructed to be the most positive outcome (see for example, Acharyya and Zhang 2003, Tiet et.al. 2007). Both Southside and Westview programs emphasized abstinence as a goal but also a requirement of treatment. One of the forms that clients must sign when beginning Westview is entitled “Basic IOP Treatment Expectations.” The fourth of ten points reads “I am expected to identify significant problems, set goals and actively work on significant personal change including complete abstinence from all psychoactive substances, including alcohol and marijuana” [emphasis mine]. Abstinence was monitored in both programs by weekly urine tests. However, while the programs explicitly included alcohol as one of the drugs one must abstain from, I never witnessed anybody being tested for alcohol use (i.e., through a breathalyzer test).

The Westview Program (outpatient group therapy) emphasized abstinence by requiring group members to introduce themselves at the beginning of each group session, list what drug(s) they were in treatment for, and how much “clean time” they had (that is, how many days that they had not used drugs). Abstinence from drugs for at least four weeks at the end of treatment was also a requirement for “graduating” from the Westview Program; those who had not achieved abstinence by the end of the allotted treatment time
were said to have “completed” the treatment program, but were distinguished from those who graduated.

While the Southside program (methadone maintenance) also emphasized abstinence, they did so differently. The pre-IOP group in the Southside Clinic did not focus in a similar way on counting the days that the client had not used, although the program itself did monitor client drug use. In the Southside program, whether or not the client used drugs was attached to various privileges and sanctions in the program. There appeared to be an expectation in the Southside Clinic that a new client would take several days or weeks to accomplish abstinence, while his/her methadone dose was stabilizing. There was also confusion articulated by those in the Southside program about whether they could consume other drugs, besides opiates, and alcohol:

Joe [Southside clinic, white, age 23] (raises his hand): I have a question. Do you think it’s like a relapse if you go out and have a couple of beers, just in a social situation? I mean, not to get drunk, but like if I was out and just wanted to feel not so anxious, so I have a couple of beers to relax?

Vince [white, age probably mid 30s]: Yeah, that’s a relapse!

Joe: I mean, it’s not hard liquor or anything. It’s just a couple of beers, drinking socially.

Al [white, age probably mid 50s]: Yeah, I think that’s all right. Like I have older kids, I got kids in their 30s. And my one son, he’ll come over to watch the game. And he’ll bring a pizza and he’s 26, so he’ll bring a six pack. And I’ll have a beer and watch the game with him. I don’t see what the problem with that is.

Joe: I mean, there’s drinking wine at events, like Hanukkah or Passover. Is that bad, taking a drink of wine then?

Vince: Well, that’s a religious ceremony, so that’s ok.

Kevin [counselor]: As long as Hanukkah is not every day, right?

Joe: But even just having like 2 beers? I mean, it’s not to get drunk, just to be more comfortable socially. And it’s only like twice a month.

Vince: So you’re saying you can’t relax without drinking a couple of beers?

Joe: No, just that it helps. Like if I don’t know the person, it helps me to be more social. I don’t need it to hang out with people I know. It doesn’t make me want to go get high or anything.
Kevin: Ok, well is alcohol a drug?
Vince: Yep. Alcohol is a drug.
Joe: I think alcohol is a drug. But not beer, cause it’s not hard liquor.
(Kevin looks half-amused, half-astonished.)
Kevin: Karl, do you think alcohol is a drug?
Karl [African American, age 35]: Yes. Alcohol is a drug.
Kevin: Alcohol is a drug.
Karl: It’s a gateway drug!
Kevin: That’s true... Alcohol is an inhibitor, right? So it lowers your inhibitions. And some people, a lot of people, have found alcohol to be their downfall. Like they start drinking, and then maybe find themselves using again. Or maybe they try replacing alcohol or some other drug for their drug of choice. But eventually, just think, hey, I’m doing this, why not just do what I really want to do? But, you’re an adult. And that doesn’t happen to everybody. But you should be careful. Why take the chance?
Al: That’s true. Why take the chance, right? Next time my son comes over I’m gonna tell him, no six-pack, bring a six-pack of Pepsi! Or I’m not letting you up the stairs! (laughs)
Joe: Yeah, I guess I see what you’re saying.
Kevin: And if you use alcohol to feel less anxious, then you’re never learning how to act in those situations. Like some addicts have used for so long and they never learned how to act in certain situations. But it does also lower your inhibitions, so you might find yourself wanting to use. But, hey, you’re an adult so you need to make that decision.
[from fieldnotes]

In this pre-IOP group session at Southside, the methadone maintenance program, clients debate whether or not alcohol is a drug and whether or not it is acceptable to use it if he/she is attempting to stop opiate use. Kevin, Westview’s program coordinator, was substituting for Jerry and Wendy during this group meeting because both of them were out of the office. Interestingly, Kevin does not explicitly tell them that using alcohol would be a violation of the rules of the clinic. Instead, he lets them come to their own conclusion about whether or not they should use alcohol. The confusion itself could be due to the clinic not testing explicitly for alcohol, although I did not witness similar discussions in the group meetings of Westview, which also did not test for alcohol. It appears, then, that this confusion might be related to the clients in Southside taking
methadone (an illicit drug) as part of their treatment. This might lead them to question whether all drugs are “bad” to use, since they are using an illicit substance as part of treatment.

Southside clients who were outwardly concerned with abstinence tended to be those who also attended twelve-step meetings, like Alcoholics Anonymous and Narcotics Anonymous. Here is an interaction between two Southside clients in a pre-IOP group session discussing the goal of life-long abstinence:

Billy [Southside clinic, white, age probably early 20s]: Does it get any easier?
John [white, age probably early 30s]: I’ve met people at meetings who have 10, 20 years clean. And they still think about it!
Billy: Yeah, but does it get easier?
John: Yeah, it gets easier. But it’s forever. It doesn’t go away.
[from fieldnotes]

Abstinence was tied to the idea that there was no cure for addiction, but that abstinence could help put the disease into a form of “remission.” This notion was very much tied to a twelve-step view of addiction. Related to this idea, clients and staff also conceptualized addiction as a life-long disease. As Wendy here communicates to her pre-IOP group:

Wendy (explaining the “five stages” of treatment that she writes on a chalkboard): …Then there’s maintenance, followed by strategies for long-term maintenance…Because this is a life-long process. Dealing with your drug dependence is a lifetime thing. It doesn’t go away. You may get to the point where you don’t have to think about it everyday, but it still never goes away. It’s like the gift that keeps on giving. Cause you’ll always have the drug dependence. It’s like, you won the steak knives, but you got the juicer along with it. [from fieldnotes]

Wendy here discusses the idea that even after treatment, a person will still be dependent on drugs. While Wendy’s analogy implies that addiction is a prize of some sort, I did not observe other counselors using such flip remarks. Addiction as a lifelong disease was
communicated consistently to group members, and abstinence was similarly a lifelong goal.

When the Southside client did transfer to the IOP group in Westview, he/she would then follow the IOP rule of maintaining abstinence and begin counting days.

*Kevin* [substituting for Wendy in the pre-IOP group]: Ok. Let’s start with check in. Say your name, what your drug of choice is, and how much clean time you have. Who wants to start?

*Joe* [white, age 23]: What if you don’t count?

*Kevin*: We’ll figure it out when we get to you.

*Joe*: Can I just say “question mark?”

*Kevin*: No. We’ll get to that. Who wants to start?

[from fieldnotes]

As this example illustrates, even if the client did not want to keep track, he or she was mandated to do so. This resulted in some clients giving a vague notion of time, such as “a couple of weeks” or “since the middle of July” when it was their turn to announce their abstinence record.

While this expression of “clean time” was a central component to the group meeting at Westview, there were no major repercussions during the group session for those who recently used drugs or who did not achieve long-term abstinence even after being in treatment for several weeks. Clients were given the option of “sharing” something that was bothering them with the rest of the group, but were never required to talk about their recent drug use. During the group sessions I observed, no counselor ever reprimanded a client for relapsing or not maintaining abstinence. I also did not witness extensive verbal praise for those who did abstain for an extended amount of time except in several group sessions where other group members would begin clapping for those who reported “clean time” of any duration. The program’s rules did state that three
consecutive positive urines would result in being placed on a “contract” which implied that continued use would lead to termination from the program.

Most counselors agreed with the policy that clients should abstain from drugs and alcohol and used sobriety as a marker of whether or not a client was doing well after leaving treatment. Only Tom, a counselor at Westview, explicitly stated that he did not agree with abstinence being a requirement for treatment or as the best measure of success:

Interviewer: “Do you think that abstinence is a requirement for someone to get better?”
Tom: “No. Um…again, kinda on a case by case basis, there might be certain individuals I think, you know, in order for you…to not have any other problems again, you can’t go back because…you go crazy, go above and beyond. But there is those people that smoke marijuana once a month or two or three times a year they use cocaine and then, of course, there is the whole moderation drinking…two drinks a day or when they go out, two or three drinks and then they stop. So abstinence isn’t really a requirement… And I would never say it would be a requirement even if I thought they should remain abstinent, but I would keep that in mind as working with them, pushing them towards that.”

Tom does not say that abstinence is the ultimate goal for all of his clients. He mentions considering the issue on a case by case basis and that controlled drug use might be possible for some. Still, he does articulate that he would “push” somebody towards abstinence if he thought it was an appropriate goal for that particular client.

While most clients were able to abstain from drug use long enough to graduate from the Westview program, all of the counselors had a rather pessimistic view of the eventual outcome of those who left treatment. Wendy estimated that only 25% of her clients that graduated would meet her criteria of “doing well” in the future: not using any drugs, no criminal justice system involvement, and positive engagement in employment.
and/or school. Other counselors also gave low estimates for the number of clients they expected to still be abstaining from drugs after finishing treatment, using similar criteria to determine “success.” Wendy also mentioned that “most” of her court-mandated clients would go back to using drugs (most often smoking marijuana), immediately after completing treatment. She does relate the statistic that only two out of her 30 clients in the past year had been re-arrested after leaving treatment, however she does not ultimately consider this to be a marker of treatment success, since they might be still using drugs or engaged in selling drugs. Counselors related this low success rate back to the original factors that led to the client’s drug addiction, namely neighborhood, family, or other environmental problems:

Wendy: “I think that what’s available outside of here for them is limited. And they…try to find an ex-criminal a job today, it’s insane, like it is so hard to find them employment that… And how can I talk to, how can I talk these kids into working at McDonalds, when there’s bling-bling that you get from selling drugs quicker and easier?” [from interview]

Ultimately, failing to abstain from drugs while in treatment was seen as evidence that a client was not adequately progressing through the program. In the Westview clinic, these clients would often be referred to a higher level of care, such as inpatient treatment. Southside clients, however, would remain in the methadone program even if they continued to use other drugs, as long as the counselor perceived them as trying to abstain.

In the pre-IOP group I observed, there was one client, Karl, who had been in the methadone program continuously for about two years despite Wendy’s claim that he had never tested negative for drug use.
Using Twelve-step Methods

As I described in Chapter 2, the use of twelve-step methods in state-licensed drug treatment programs is pervasive. Both Southside and Westview programs explicitly and implicitly used twelve-step philosophy and methods in their treatment programs. They did so in three ways: by integrating 12-step practices and philosophy into group meetings, by encouraging or mandating that clients attend 12-step meetings in addition to treatment, and by using 12-step methods individually during counseling sessions. While the use of 12-step methods as part of treatment is common, it also adds to the ambiguous definition of addiction that gets promoted by both treatment programs, since 12-step philosophy includes the idea that addiction is a disease, but more so as a metaphor without reference to specific research on the causes of addiction. The twelve-step view of addiction has really not changed at all since its inception in 1935.

Group meetings in both Southside and Westview would often incorporate twelve-step practices. Westview’s client manual explicitly states the program’s relationship with twelve-step methods:

*Twelve-step ideology is incorporated into treatment. Twelve-step meetings are available on-site and participation is strongly encouraged as an invaluable source of support and path to a new way of living.*

One of the ways that the ideology was incorporated into treatment was that at the conclusion of every group meeting in Westview’s IOP program, clients would stand up, put their arms around each other, and recite the serenity prayer\(^{53}\). While Alcoholics Anonymous does not take credit for authoring the prayer, it is common practice to recite

\(^{53}\) The serenity prayer is attributed to theologian Reinhold Neiburh. The first part, which is recited at most 12-step meetings, reads: “God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference.”
the prayer at A.A. meetings and events. Counselors in both Southside and Westview programs would also use handouts from books and publications that used 12-step language and practices. For example, counselors used “Just for Today,” a book considered to be a resource for those in Alcoholics/Narcotics Anonymous that includes daily topics for meditation. Wendy and Jerry repeatedly used the “Surviving Addiction Workbook” in the pre-IOP group at Southside Clinic. This workbook included lessons on the components of addiction as well as questions the client had to answer about his/her problem. Wendy and Jerry would often use the group meeting to go over pages in this workbook and have clients discuss its content. The workbook was overtly 12-step oriented. In the beginning of the workbook, it recommends using the 12-step program of AA/NA: “Twelve step programs can help you gain or maintain sobriety, and regain your self-esteem.” Throughout the book, it refers to specific steps of AA/NA, such as “making amends” to family members and friends.

Two of the counselors, Jerry and Peter, were open about their own past addictions to drugs and alcohol. Both were also proponents of AA/NA’s treatment philosophy and would relate that material in their group meetings. For example:

Joe [Southside clinic, white, age 23]: So, I’m still having a problem with the idea of Higher Power. But what I think, I think it means unity…Like I ran into a friend of mine. A guy I used to run with, and now he’s clean. Which was really cool. And he’s like a devout atheist, but he told me he thinks of like the group consciousness as his Higher Power. And that makes sense to me…
Jerry [counselor]: Joe, I want you to do something. Get an NA book. One that has the Traditions in it. And you tell me what the Traditions say about unity. Ok?
[from fieldnotes]
Joe is expressing some difficulty with one of the central concepts of 12-step programs: the acceptance of a higher power that has ultimate control over the individual’s addiction. Jerry then encourages him to read the central text of NA book, implying that he would find an appropriate answer there.

Tom was the only counselor who expressed resistance to using 12-step methods during the group meetings. In one group session I observed, he announced that the group was no longer going to close with the serenity prayer, but that they were going to instead try something different, such as each person going around and articulating what he/she found most useful about group that day. His request was met with vociferous resistance from the group members. One member said that she liked using the serenity prayer because it reminded her of an NA meeting. Ultimately, Tom backed down and let the group continue using the prayer. In an interview I asked him about that group meeting:

*Interviewer:* “Why did you want to change that?”
*Tom:* “Umm… two reasons, one, um… because of the mention of God in there and being respectful to other people that might not believe or feel that is a necessary part of their treatment for drug and alcohol dependence and then two, just to try and move treatment programs away from, from the twelve-step model which hasn’t been shown to be any more effective than running laps around the track.

*Interviewer:* Has there been anything else you tried to change as far as the content to kinda go along with this idea that, you know, that you might want to push the group away from more twelve step type stuff?
*Tom:* Right, um… Although I do incorporate some of the stuff, like some of the sayings because I think it goes along with my…I mean I come from a CDT [Cognitive Development Therapy] approach so some of the stuff kinda, you know, I’ll work that in if it fits in… But yeah, I do more behavioral and skills-type stuff during the activities and looking at how people think about their drug use. As opposed to talking about powerlessness and getting a sponsor.”

Tom says that his reasoning for eliminating the prayer during the group session had to do with the general ineffectiveness of 12-step methods. While it has been difficult to
research AA/NA’s effectiveness because of the group’s insistence on protecting the anonymity of its members by not keeping records, and its loose organizational structure, many conclude that its “success rate” is probably quite low (for example, Bufe 1998). While Tom goes on to mention how he focuses the group away from 12-step components, he does admit that he will use some of the “sayings” if they fit in with what he is trying to accomplish therapeutically. He also did mention that if he were creating his “ideal treatment program,” that he would include 12-step meetings as an option, but also include meetings that did not use 12-step methods or philosophy for those who did not want it. Additionally, during group meetings, I never witnessed Tom discourage any of the group members from discussing the benefits of 12-step meetings, because he did see some value to them, mostly for group support.

Linda had a more laissez-faire attitude toward twelve-step methods. Here she discusses that twelve step methods have become more widely incorporated into methadone maintenance treatment:

_Interviewer:_ “How do you feel about that? Do you feel that that’s a good thing?”
_Linda:_ “Sure, though it’s not my cup of tea. But sure, the more different options you have for patients, the more patients you can reach. I’m in favor of anything if it’ll work…”

Linda sees twelve-step components as offering more options for the clients. Similarly, Kevin articulates the utility of twelve-step meetings, but also distinguishes between a twelve-step meeting and the group therapy sessions at Westview:

_Amanda [Westview clinic, African American, age probably early 30s]:_ I don’t know how to share at meetings. But I feel like I need to talk all the time…
_Kevin_ (running the IOP group because Tom is out of the office): You don’t need to tell everyone everything. You should tell certain things to
your counselor, some things to your sponsor, share some things in this
group, share things in a meeting…
[from fieldnotes]

Jerry also mentioned a similar idea, that NA meetings were one of the many tools that a
client had in trying to achieve abstinence.

In addition to promoting twelve-step philosophy during group meetings,
counselors would encourage clients to attend AA/NA meetings outside of treatment.

Most of the time, this encouragement was explicit:

Wendy: OK. If being bored and not having anything to do can be a trigger,
what can you? What do you do instead?
Joe: I go to NA meetings with my brother.
Wendy: Meetings. That’s a good one. Karl, there’s a meeting right on the
corner from your house. When was the last time you went to a meeting?
Karl (thinking): I went…yesterday! I go to meetings four times a week!
Wendy (seems surprised): Really?
Karl: Yeah. After I did my 90 in 90…I think I did like 120 straight.
Wendy: Did you get a sponsor?
Karl: No, not yet. I’m working on that.
[from fieldnotes]

In this exchange, Wendy offers the possibility of going to AA/NA meetings as an option
for clients who report boredom as a trigger for drug use. Karl’s response that he did “90
in 90” (90 meetings in 90 days) suggests that somebody at the program may have told
him to follow that schedule, especially since he indicates not having a sponsor.

Counselors also promoted meetings for other reasons, such as a place to find
positive role models:

Jerry [Southside counselor]: Ok. So where do we get the positive role
models we need to stay clean?
Lee [white, age probably early 20s]: Meetings.
Jerry: Bingo!
Cathy [white, age probably mid 30s]: Yeah, I’m going to start going to the
Thursday meeting here.
Jerry: Steven, do you know what he means by meetings?
Steven [African American, age probably mid 30s]: Yeah. N.A., Alcoholics Anonymous, Drug Addicts meetings.  
Jerry: Right.  
[from fieldnotes]

Here, Jerry encourages the client to discuss meetings with each other. Jerry also informed the group that he had a book in his office that listed all of the daily AA/NA meetings in the city.

Peter, the other counselor (in addition to Jerry) who mentioned using Alcoholics Anonymous for his own substance abuse problem, saw A.A. as central to his own ability to remain abstinent from drugs and alcohol. In our interview, he uses phrases and concepts from A.A. to illustrate why some people will not overcome their “disease”:

Peter: “In A.A. there’s a slogan that says, ‘Some don’t make it.’ You know, some people die of their addiction. Part of their self or their will is so strong that it doesn’t want to surrender to some sort of treatment or higher power or whatever.” [from interview]

Peter uses this rationale in discussing why some people will not get “better” even if they complete the treatment program. His use of the A.A. slogan could also help him cope with the emotional difficulties of his job and the high relapse rate that does occur for those who go through treatment.

Wendy, in her role as the primary counselor for the court-mandated clients, mentioned that she would advise clients to attend AA/NA meetings after leaving treatment:

Wendy: “A lot of them get involved with NA or AA before they leave here…the Treatment Court guys less than the [other court-mandated] guys. Those guys are more likely to go to AA or NA. So we implement things that will give them at least some structure when they get out of here. Because, I mean they get out of here and they’re let go completely. Some of them, if they have other cases, may have another probation officer, but for the most part they’re done.” [from interview]
Wendy here is referring to problems that could occur once the client leaves treatment that might lead the client back to using drugs and engaging in criminal behavior. The main rationale that other counselors also gave for the importance of attending 12-step meetings was that they provide a support system for the clients who by living in high-poverty, drug-infested neighborhoods might be surrounded by “triggers” to return to their old lifestyle.

In addition to the staff encouraging clients to attend 12-step meetings, clients often had experience with 12-step meetings before beginning formal treatment. Most expressed positive feelings about these meetings during group sessions and would attempt to persuade other members to also attend:

*Charlotte* [Westview clinic, African American, age probably late 30s]: What do you mean you don’t have support? Do you go to meetings?  
*Ray* [African American, age probably mid 30s]: Yeah, I go.  
*Charlotte*: Do you have a sponsor?  
*Ray*: No. I can’t find anyone that I would want to…that I could ask to be my sponsor.  
*Charlotte*: You should go more.  
[from fieldnotes]

When discussing the meetings during group sessions, both Westview and Southside clients often referred to the different kinds of twelve-step meetings (A.A., N.A.) as being “all the same” and would compare where they thought the “best meetings” in the city were. They would also share their 12-step knowledge with others in the group who were less familiar:

*Patricia* [court-mandated, Westview clinic, African American, age probably mid 40s]: I was told to get a sponsor. I went and asked this woman and she said no. [she seems to be asking Tom, the counselor leading the group] What’s a sponsor for anyway?
Barry [African American, age probably late 30s]: A sponsor is there to guide you through the steps. You call that person if you want to use and they talk to you. [from fieldnotes]

Group members frequently discussed 12-step meetings and philosophy during group meetings. Counselors were typically supportive of these conversations and would offer additional information about AA/NA at times. Counselors often related twelve-step philosophy to their overall conception of addiction as a disease:

Peter: “Like, if people are just sort of having a discussion about things then all of a sudden there’s an aspect of addiction that is brought up. Then…then it’s my job or whatever at that point to bring up well, this is an illustration of denial and you know denial is one of the main characteristics of addiction… A big part of addiction is denial.” [from interview]

While I did not observe any individual counseling sessions, there were some indications that at least some of the counselors would work on the “steps” of AA or NA with clients individually during sessions, or at least talk about 12-step philosophy during individual meetings.

Wendy (talking to the Southside group): And I have a client who’s very much anti-NA. I mean, he said, there is no way I’m going to those meetings. So, I do the steps with him as part of treatment. I mean, I’m not a sponsor, so I don’t know all the things, but he works on the steps as part of treatment. And he’s really getting something out of it. [from fieldnotes]

Working on the steps and then discussing them with a counselor was also recommended by the “surviving addiction workbook” that was used in the pre-IOP meetings. The manual explicitly stated, “Spiritual recovery issues can be addressed by working the 12-Step program of recovery, and discussing these issues with a counselor or therapist.” In Wendy’s example it is not clear whether she offered her client such assistance or whether the client approached her.
A substantial number of clients, especially those taking methadone, expressed reservations about attending 12-step meetings.

_Loretta [Southside clinic, African American, age 43]:_ Oh, I hate those NA meetings! I won’t go to those anymore.  
_Drew [African American, age 25]:_ Yeah, I can’t stand…like there was this one guy who was always speaking and leading meetings and all that. And then, you know, I see him copping on the street. I see him buy a big bag of dope! And then he gets up there in that meeting and is talking about not using and…that just really got me mad. And, you know, I didn’t say anything. But one time, he was talking and then he saw me sitting there. And he was then like, ‘oh shit, is this guy gonna say something?’ But I don’t say anything. I figure, God knows you’re full of shit. You know you’re full of shit. I don’t have to tell all these people.  
_Victoria [white, age probably mid 30s]:_ And a lot of them probably know he’s full of shit.  
_Drew:_ Right.  
_Loretta:_ Yeah, I couldn’t stand those NA meetings anymore. Everyone’s getting high outside of the meetings. Getting together and getting high. Or all the guys will be checking out the ladies. I mean, it’s all about getting high and having sex.  
_Matt [white, age probably late 20s]:_ And don’t dare tell them you’re on methadone!  
_Loretta:_ Oh, yeah.  
[from fieldnotes]

One of the reasons group members gave for not wanting to attend 12-step meetings was that they perceived many of the people in the meeting to be inauthentic in some way, most often because they continued to use drugs despite declaring their abstinence to others in the meeting. Most criticisms of 12-step meetings by those in Southside, however, had to do with the hostility they reported feeling from others at the meetings:

_Joe [Southside group, white, age 23]:_ I don’t like some meetings, like people look at you ‘cause you’re on methadone. My brother says something, I can’t remember what it is, but something so people know he’s on methadone and at this one meeting they just started barreling him!  
_Wendy [counselor]:_ Does he say that he’s on life-saving medication?  
_Joe:_ No, not that. But something so people know what he means. But then they just get all on people about that.
Karl [African American, age 35]: It sounds like there’s nothing good going on at that meeting!

Wendy: Right. I mean, what would they say to someone on insulin? That you shouldn’t be taking insulin?

Joe: Yeah, like I’ve met people who don’t think you should take an aspirin!

Cathy [white, age probably mid 30s]: Some of them are really against any medications whatsoever. Like I’m on anti-depressants and there are people who would look down on that. So I don’t tell them.

[from fieldnotes]

Here, the group members discuss how judgmental they perceive many people at N.A. and A.A. meetings. This exchange also illustrates a paradox about 12-step meetings in general: they advocate for the acceptance by the public that addiction is a “disease,” yet members tend to be resistant toward any medications that could help with treatment of the disease. Some Westview group members who were not taking methadone would also mention that they perceived methadone to be substituting one drug for another. Wendy’s comparison of methadone to insulin is one common response by those who advocate for the benefits of methadone treatment. It also relates to the comparison made between addiction and diabetes as both chronic diseases requiring daily medication.

Joe: I go to NA meetings. And at meetings, you know, I’ll say I’m in a methadone program, just to weed the people out. Like most people will give me looks and stay away from me, but there will be one or two who’ll come up and say ‘yeah, I know what you’re going through.’ So I say it at the meetings, to weed those other people out, even if I just find one or 2 people I can talk to. [from fieldnotes]

Joe discusses the hostility he received at meetings in several group sessions. However, he still values the 12-step philosophy, so he continues going, and has developed a strategy that then also puts him into contact with others who might be taking methadone but were hesitant to let the group know.
Westview Clinic would hold N.A. meetings every week. On the several occasions that I was observing on that day, it was rare to witness any of the group members staying after group to go to that meeting. At some point around the time I began my observations, they also started holding “Methadone Anonymous” meetings once a week. Methadone Anonymous began in 1991 by Gary Sweeney, an Education Coordinator at a methadone maintenance program in Baltimore (www.methadone-anonymous.org). Methadone Anonymous is modeled after the 12-step program of Alcoholics Anonymous, but tailored for opiate addicts who are also using physician-prescribed medication as part of treatment. Their initial formation was in direct response to the hostility that many reported receiving from other attendees at Narcotics Anonymous meetings. The organization’s website also explains that medication issues should not be discussed at meetings: “there is no need at meetings for patients to discuss their medications, including methadone or other prescribed drugs” (www.methadone-anonymous.org). Rather, the primary goal of the meeting is to discuss the twelve steps and how to achieve abstinence from alcohol and drugs, just as A.A. or N.A. meetings. Southside clients expressed interest and enthusiasm when they were told that these meetings existed in the facility, however, no member ever mentioned his/her experience attending these meetings in any of the groups I observed.

The use of twelve-step ideology in the programs contributed to the general ambiguity that surrounded the disease concept of addiction. The main focus of using

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54 I personally found it somewhat strange that the group was named “methadone anonymous” since the many 12-step groups that exist (i.e., alcoholics anonymous, cocaine anonymous, gamblers anonymous, debtors anonymous, etc.) tend to name the main “problem” or addiction that the group focuses on before the word “anonymous.” I wonder how using that phrase might impact the stigma of methadone that the
twelve-step methods appeared to be as a way to communicate to the clients at both Southside and Westview that their problem was a life-long one that would require consistent monitoring. It also seemed to be advocated as a resource for meeting other people from their neighborhoods with drug problems who might offer support. Because AA/NA promotes the notion that addiction is a “disease,” incorporating these methods into the treatment programs did not contradict other messages about addiction that the counselors were trying to convey. At the same time, however, promoting twelve-step philosophy did not help the client understand what exactly addiction is. The fact that many Southside clients felt resistance from those at twelve-step meetings who thought that using methadone was a violation of the abstinence requirement, as well as the need for a “methadone anonymous” group, indicated that the twelve-step philosophy is in general still resistant toward a “medical model” of addiction that addresses it solely as a biological problem. In the end, rather than clearly articulating how addiction should be considered a disease and what the appropriate treatment for it is, the two overarching concepts of promoting abstinence and individual responsibility prevailed as the central concerns that were communicated to clients.

Monitoring the Medication

Group sessions also tended to focus on individual-level problems that a client was having, from finding a job to trying to regain custody of his/her children. In the Southside clinic, many of the group members and much of the group’s time focused on the medication of methadone itself and whether the person was receiving the correct dose to
prevent withdrawal symptoms. This was likely due to the Southside clients in the pre-IOP group being new to the treatment program and often very new to taking methadone. Newness to methadone treatment was one of the reasons stated for the creation of the pre-IOP group, so that clients could become “stabilized” on their dose before going into Intensive Outpatient (IOP) treatment. What was not typically discussed, however, was the science behind methadone and the psychopharmacology of the substance. The chief complaint among clients was that they were not on a large enough dose, and mentioned still craving and using heroin to avoid withdrawal symptoms, such as nausea:

Mike [Southside clinic, white, age probably early 30s]: Well, if I had enough, then it would last and I wouldn’t get sick at night.
Wendy [counselor]: You’re getting sick at night?
Mike: Yeah, like around midnight. I get the sweats, I start shaking. Get sick, shittin’. So like last night, I went out at 2:30 and copped.
Wendy: So you’re high right now?
Mike (says defensively): No. I mean I used, but I’m not high.
[from fieldnotes]

Wendy would often tell these clients to make an appointment to see the medical director at Southside. Other group members would share their knowledge and/or personal experience with achieving the correct dose of methadone:

[same group meeting]
Wendy (talking to Mike): Well, then you need to see the doctor.
Jackie [Southside group, white, probably age mid-30s]: Maybe he needs a split dose.
Mike: They keep raising it by 10 milligrams, but it doesn’t seem to do anything.
Wendy: You should talk to the doctor. He can raise it more than that. See, we’re only allowed to raise it 10 milligrams, but the doctor can see you and raise it more in just one time\(^{55}\). Mike, how long have you been on methadone?
Mike: About a month.

\(^{55}\) Wendy is referring to the practice where counselors can fill out a request form for an increase in methadone for a particular client. The doctor would review these request forms on a near-daily basis and approve the request with his/her signature, without examining the patient.
Wendy: And it’s never held you all day and night?
Mike: No.
Wendy: Well, then you need to see the doctor and tell him.
Jackie: Maybe it’s not working because of his metabolism.
Wendy: Well, that happens sometimes but…(says as if trying not to offend Mike)…usually the person is really thin.

Jackie, another group member, offers the knowledge that she has of methadone and “split doses,” where a client will take half of his/her typical dose every 12 hours. She also relays her knowledge about the effects that one’s metabolism has on the processing of methadone. Rarely did I observe any of the counselors in the Southside Clinic discussing such details about methadone with the clients in the group meetings. The “educational” component of the group never focused specifically on methadone on any day that I observed. Counselors would occasionally offer advice to group members expressing problems with their methadone dose, but most often just referred them to the doctor at the clinic.

Joe [Southside group, white, age 23]: Jerry, I think my medication is too strong. I don’t feel right.
Jerry [counselor]: How much are you taking?
Joe: 30 milligrams.
Jerry: And you’re feeling like it was too much?
Joe: Yeah, not all the time. Just today for some reason. Like I sort of feel stoned, but not really. And I just feel kind of weird, like my stomach.
Jerry: Tell me how you feel.
Joe: Like a kind of knottiness.
Jerry: How was your sleep last night?
Joe: I slept fine. As normal as normal can be.
Jerry: Did you eat anything this morning?
Joe: No. I’m not really a breakfast eater. I mean, I like breakfast food. I’ll eat breakfast food, but usually it will be in the afternoon.
Jerry: You should try eating something before you come. Then maybe you wouldn’t feel that way.
Joe: Yeah, I just never really ate breakfast.
Jerry: Well, try it.
[from fieldnotes]
Clients in group seemed to have a general understanding of how methadone worked, and were acutely aware of how much they were taking, but did not often seem to know about some of the side effects of methadone, such as possibly feeling nauseous when taking it.

A similar situation occurred in the pre-IOP group several weeks later:

_George [Southside group, white, age probably early 20s]:_ Well, I missed a few days of coming here ‘cause that stuff makes me sick. Like I would take it and it would upset my stomach.

_Wendy:_ You get sick from the medication? Maybe you’re on too much.

_George:_ Yeah, I would just feel so sick… But when I didn’t come, I didn’t get sick or anything.

[from fieldnotes]

Again, this lack of knowledge about methadone’s effects often led to the more-experienced group members educating the lesser-experienced ones about how to negotiate medication issues within the program:

_[Southside group, several weeks after the group meeting above where Mike complains of not having a high enough dose. This interaction takes place as clients are coming into the group room before group starts]:_

_Karl (to Mike):_ How you doin?

_Mike:_ I’m ok. It’s still not holding me though. I’m still getting sick in the morning.

_Karl:_ Really? Did you talk to the doctor?

_Mike:_ Yeah, but I need to get more. They only increased me 10 milligrams. That’s not enough.

_Karl:_ You just gotta keep going and making a big deal about it.

_Mike:_ Yeah, I’m going to try to make another appointment.

[from fieldnotes]

Clients often relied on one another for information about the effects of methadone and how to achieve the “correct” dose.

While every counselor that I interviewed believed that addiction could have biological or genetic foundations, most of the counselors expressed some dissatisfaction with methadone as a form of drug treatment. In many ways this is counter-intuitive
because methadone treatment is arguably the most “medicalized” way of dealing with addiction. That treatment providers who themselves adhered to a disease concept of addiction were often critical of methadone treatment could be the result of the continuing stigma that surrounds methadone treatment. It might also be due to their education and training being largely in the area of counseling, so they might be resistant to using medications when talk therapy could also work. Peter did suggest that this could be the source of some of his resistance to methadone:

Peter: “I sometimes get…a sense and it’s hard to put my finger on it. But a sense more of…the methadone, it’s a more primitive level of give me food, give me food. And you’re like a food dispenser or a food regulator, rather than, I’m here to work on problems.” [from interview]

While Peter did reveal that he thought methadone could sometimes be an effective treatment approach, his response above illustrates his general attitude toward methadone, and how he feels like a “food dispenser” in his job at times. This feeling was tied to his overall perspective on the medicalization of mental health problems:

Peter: “And that’s part of the medicalization thing, I think that…I think that sometimes the medical community uses things for a mechanically, a mechanistic view of the body and the self and healing and it’s like, there’s more. I’ve been to some conferences for trainings on methadone and also on psychopharmacology and nobody said a word about alternative methods. I’ve been trained in some energy healing stuff and I’ve experienced a lot of work with acupuncture. None of this is even given a thought. I mean, I shouldn’t say that. There are some people that, there’s been some research. I think the basic orientation is let’s deal with this chemically. And while it’s successful and it’s successful in the short-term, I don’t know whether it does a person a service to just be limited to that. I’ll put it that way, just to be limited to that. To make that your only thing in your toolbox that you go to, I don’t think that’s fair to people maybe, or doing them a service.” [from interview]

Peter did indicate that he thought medicalization could sometimes be a good thing, in that it could reduce the stigma associated with substance abuse and other mental health
disorders. His general outlook, however, is much more critical about using medications to treat these conditions. While some of his resistance could be due to his relationship with Alcoholics Anonymous, much of it appears to be that he takes a personal affront to his role in the clinic (as a counselor) being compromised in some way when methadone is involved. Other counselors expressed a similar sentiment about how methadone could be a good tool, but that it should only be used in conjunction with other treatment methods, rather than just on its own. This could also relate to the counselors’ perspective that drug abuse and addiction was often caused by other factors, not just biological and genetic ones. They may agree that methadone could be effective at helping to alleviate some of the physiological symptoms of opiate withdrawal, but that there were other factors that contributed to the problem that would not be addressed by medication alone.

Those who were critical of methadone often gave reasons that appeared to have more to do with the strict federal regulations over the distribution of methadone than the effects of the medication. One of these regulations requires clients to visit the treatment facility daily to receive his/her dose. Take-home doses can be “earned” throughout the program, but nobody is given a very large supply, even those who have been on the program for years. Many of the counselors saw this as an unappealing aspect of methadone, in that clients are restricted in their daily activities because they have to go to the clinic. Here Kevin discusses some of his reservations about methadone treatment:

Kevin: “...Having to get medicated early in the morning before they can do anything else, and so on. And, ok…it throws in an extra step of getting beyond that. But again, if other things aren’t working, it’s effective. That’s maybe where the Suboxin [buprenorphine] and so on is a good choice because it’s less confining. And less, kind of…what’s the word? The word that came into mind is enslaving. [laughs]” [from interview]
Kevin offers buprenorphine as a possible alternative to methadone, since buprenorphine involves a prescription for the substance that a person uses completely at their own discretion. It moves treatment for opiate abuse solely into a doctor-patient relationship. What Kevin does not mention, however, is that buprenorphine is very expensive and is not yet covered by public or private insurance plans. Peter also used the same idea, that methadone is “enslaving,” when describing the regulations of methadone treatment:

Peter: “Some people are able to live pretty functional and worthwhile lives, and work and do everything. But the fact is, they still have to come here like once a day for the rest of their life for like a chunk. Everyday it’s given to getting the substance. It says to me, there’s never a full freedom. They’re always enslaved to the substance at some level. That’s a strong word to use, but…I’m just saying…” [from interview]

Along this same idea, most of the staff were critical of the idea that clients would take methadone for “life” or for a very long time, even though some, as Wendy did in a group session, referred to it as a “life-saving” medicine, and compared it to treatments such as insulin. While all of the counselors were critical to some extent, most of them did indicate that they thought it was beneficial for some clients or for a limited time:

Interviewer: “How do you feel about methadone maintenance…as far as treatment for a drug problem?”
Tom: “I think it’s a great idea if you use it for what it’s used for. It’s very… has a high effectiveness rate and its better than people still using heroin and committing crimes and doing all those things. So, it’s a step up from where they were.”

Tom discusses some of the findings from research on the use of methadone, that overall there are reductions in criminal activity, drug use and increased productivity among those who engage in the treatment. His comment about it being great if it is used “for what it’s used for,” however, also indicates that he thinks the substance is not always used in the
right capacity. Similarly, Linda, Southside’s program coordinator, here discusses a client who eventually left treatment:

*Linda:* “One of my clients said to me, and I love it. He was about my age, and I’m sixty and it was about two or three years ago. He was approaching sixty, he worked for the school district and he said, “Look, I’m getting married, and I’m going to retire soon... And she’ll be done in like a year or two, she’s a teacher. We want to travel. I want to get off. I’m done. I found my wife, and a new wife, the old one didn’t work. And I’ve been on for thirty years. Enough.”... He’s fine.” [from interview]

Linda is an advocate for methadone maintenance. In an interview, she indicated that her “ideal treatment program” would include methadone maintenance for those under the age of 18. At the same time, as this interview segment shows, she does not seem to approve of its indefinite use. She speaks proudly of this client who decided after thirty years that he did not want to take methadone anymore. She seems to point to him as the program’s ultimate “success story.” The staff’s impressions of whether methadone was an appropriate treatment modality could partly be a result of the general ambiguity expressed about how addiction is a disease, but could also perpetuate that ambiguity within the treatment program, since overall they are critical of a pharmacological approach to treating addiction while at the same time advising clients about medication issues.

*Equalizing Addictions*

The disease concept promotes ambiguity, because of its impreciseness and multiple theories of causation surrounding it. Still, both treatment programs promoted the idea that addiction should be thought of, and to some extent, treated like a disease, despite difficulty articulating what exactly caused the disease. As part of that notion, all “addictions” were discussed as equally devastating; that is, those who injected heroin
were labeled an addict in the same way that someone who frequently smoked marijuana was. This label of “addiction” also extended to other behaviors related to drugs and was not restricted to only drug use.

Substances were not generally distinguished from one another, with the exception that methadone was only used to treat those using opiates. In the IOP program, groups tended to be mixed as far as what substances people reported having problems with. Additionally, in both program’s group therapy sessions, strategies about how to avoid using “drugs” were often discussed. The strategies were discussed as if they universally applied to any mind-altering substance; they were never drug-specific.

Jerry [counselor, pre-IOP group at Southside]: That’s what this group is about. I should really just be sitting here and you are all here to help each other. ‘Cuz we all have the same disease, so we can really help each other. [from fieldnotes]

Jerry refers to them all having the “same disease” of addiction, no matter what the actual drug is. Similarly, during another pre-IOP group session at Southside, where predominantly clients were in treatment for heroin use, Wendy handed out a worksheet entitled “Cravings to Use Cocaine or Other Drugs.”

One of the reasons that the general use of “addiction” did not apply differently to different drugs could be that clients reported using multiple types of drugs. Most favored one drug over another (i.e., heroin vs. crack cocaine), and at times seemed confused when they would use a drug other than their main drug of choice.

Vanessa [Southside group, African American, age probably early 30s]: I really want to get clean. I don’t even want to use. But I find myself using. Like, I leave the house and I don’t plan on getting high, but I see the dealers, and I’m like ‘whattya got?’ And I’m using! Like, my drug of choice was always heroin. I would sniff it. Now, I’m trying to get clean from that, and I find myself smoking crack! And I was never into that!
That was not my choice drug. But, it’s like, I just find myself doin it. [from fieldnotes]

Many of the clients taking methadone reported using drugs other than heroin. Since methadone is designed to block the effects of heroin, the Southside clients would often turn to using other drugs, rather than attempt to overcome that block with a large amount of heroin. The clients often discussed their drug-related problems in universal language, as if everybody had the same problem. Here, one of the Southside group members, extends that notion to twelve-step meetings:

_Drew [Southside clinic, African American, age 25]:_ It’s the truth. I mean, I used to go to meetings and I didn’t get anything from it because I just thought I was so different. Like, these other 89 people got the same thing, but I’m so different, right?

_Josh [white, age probably late 20s]:_ We all got the same disease.

_Drew:_ Right. And I don’t think that anymore. But I used to. And then you’d hear some people, like looking down on heroin users.

_Josh:_ Right. Like, ‘I only did oxycontin, so I’m not as bad as you who did heroin.’ That’s crazy. They’re all opiates.

_Drew:_ Right. Or looking down on those who smoke. Like, I’m a snorter, so that’s not as bad as you ‘cause you’re there smoking…

_Charlotte [African American, age probably early 30s]:_ Yeah. That shit don’t make no sense. [from fieldnotes]

Here, the clients discuss the hierarchy that is sometimes created among drugs users, by differentiating the types of drugs used and the main route of administration. While twelve-step meetings will often seem to be drug-specific (toward alcohol, cocaine, or marijuana for example), clients would discuss going to meetings that were not necessarily named for their main drug of choice. For example, many of the opiate users would discuss going to Alcoholics Anonymous meetings because they liked them better.

Indeed, the “disease” was not really about the substance itself, but more about the person who used the substance. This logic followed from those who discussed genetic
predispositions as a major factor in developing an addiction, to those who focused on neighborhood or family factors. While counselors discussed drugs as having chemical properties that promoted addiction, nobody relied on a theory that addiction was solely the result of using too much of a substance. All of the counselors included other factors as likely contributors to the “disease.” Similarly, clients would discuss other aspects of the drug-using subculture, not just the actual use of a substance, as being related to their own addiction:

Billy [Southside clinic, white, age probably early 20s]: Yeah, I've been clean from dope since October 27th of last year. That’s the last time I used, right before I got locked up. But I think I’m like addicted to the lifestyle. Like the whole copping, and going to cop and figuring out how you’re gonna get the money… [from fieldnotes]

Clients spent a lot of time discussing this notion, of being addicted to the process of obtaining drugs, often summed up as “the thrill of the chase”:

Annie [Southside clinic, white, age probably mid-30s]: I used to get up early. I would be out the door, by like 6, 6:30. I used to take the bus from South Philly to North Philly. I just loved it. I mean, I loved the routine. I loved going to get it.

Karl [African American, age 35]: The thrill of the chase!

Annie: Yeah, I mean, I just loved it. I loved doing it too, but I even just loved the routine. Getting up early and going up there. [The group laughs a bit that she used to get up so early to go cop]

Karl: (chuckles) You were getting there and people were still there from the late shift!
[from fieldnotes]

Similarly, at another group meeting several weeks later, a client refers to the same issue:

Cathy [Southside group, white, age probably mid 30s]: And that running around to get it. Like they say, the thrill of the chase. That was fun. And I mean, at least for me, I didn’t even enjoy the high part. That didn’t feel good anymore. But the getting it felt good. [from fieldnotes]
Cathy describes the joy she would experience obtaining the drug, even when she says she was not enjoying actually using the drug anymore. Others described being “addicted” to other parts of the ritual of using drugs that they missed now that they were in treatment:

*Lee [Southside group, white, age probably early 20s]*: I think I was addicted to the needle. I just loved that feeling, that needle going in.

*Joe [white, age 23]*: Oh, me too. It got to the point where I would shoot water, just to have that feeling.

*Karl*: I never heard that!

*Lee*: I was the same way. I would shoot anything. The first time I was on methadone, I would take it and then shoot anything I could find in the kitchen. I would shoot baking soda… I shot crack.

*Paul [white, age probably mid 20s]*: Would you mix it with vinegar?

*Lee*: Yeah, or I would just mix it with lemon juice. Then you can shoot it.

[from fieldnotes]

Because the clients would discuss these other behaviors as part of their drug addiction, the counselors would often try to turn these conversations toward discussions of what to do with the time they used to use to obtain drugs:

*Jerry [Southside counselor, looking at the clock]*: Now look at how much time we just spent talking about this. Because that’s what we’re used to, right? Copping, getting money, getting drugs, using… I mean, this was all we knew! Steven, maybe you kept using cause there was nothing else you knew how to do. So let’s think about that. What else are we good at? What can we replace the lifestyle with? Steven, what else are you good at?

*Steven [African American, age probably mid 30s]*: Chess. I play chess.

*Jerry*: That’s great. How about you Cathy?...

[from fieldnotes]

Since addiction was related to the *behavior* that the person engaged in, rather than the specific drug, other drug-related behaviors were identified, labeled, and “treated” as addictions. Most commonly, this occurred with the clients who were involved with the criminal justice system and had been court-appointed to treatment. These clients, who overwhelmingly were arrested for selling drugs, were sent to treatment as part of an initiative (such as drug treatment court) aimed at reducing future criminal involvement.
While they had been evaluated as having a substance abuse problem, the staff perceived most of these clients to not actually have the “disease” of drug addiction:

_Wendy [Westview/Southside counselor]: “I would say that the majority of my [court-mandated] clients are not drug addicts. They have drug use histories, but not necessarily drug addicts.”_

_Interviewer: “So if you don’t think that they’re really addicts, why do they get referred to this program?”_

_Wendy: “…Marijuana will stay in your system for up to thirty days, so that kind of indicates that they have been using for over thirty days each time, so anybody who has a drug history and a drug background, is presumed to have an addiction problem. And I do think that there is a type of addiction, but not necessarily to the drug. To the lifestyle, maybe. To the people, the places, the things that they deal with. Um, they’re addicted to the lifestyle of selling drugs and making that money, that quick money. The girls, the money, the cars, that’s what they all tell me. So, it’s the bling-bling.”_

_Peter (talking about members of his group): “Some of them are court-mandated and don’t have a lot of true interest in making any changes in their life; they’re doing this, uh…um, some of them found that they could get a reduced sentence, reduced time, by saying, ‘Oh, I’m an addict, and I’ll go into treatment.’ When the fact is they actually had no addictive problem whatsoever…They were in jail, possibly for a substance-related crime, such as, you know, possession, or possession with intent to sell. And some of them have actually been much more involved in selling drugs than using drugs. And some of them actually had no interest in using drugs, but they still have to come here, so…So the focus, sometimes is to help people see how even involvement with drugs led to criminality for them and how that impacted their life…And then the other part of that is, even though they weren’t involved or addicted to using the drugs, some of them were…almost addicted to the drug world, or the excitement. You can get a rush of excitement when you close a profitable deal. And so that kind of rush is something that they were addicted to or found they were very drawn to repeatedly, despite the consequences, which definitely is a sign of addiction.” [from interview]_

Despite the general agreement that these clients were not addicted to using drugs, these clients would still take part in the IOP group therapy sessions and identify their drugs of choice and “clean time” just like the self-referred clients. They did not often speak during group about having a drug problem, yet the clinic still labeled them as “addicts,” although
their disease was not using drugs, but was instead the act of selling drugs or some other behavior. As Wendy indicates, some of the clients might be labeled addicts simply because marijuana metabolizes more slowly in the body and can be detected for a longer time after use than most other substances, including cocaine or heroin.

In the group, those who were court-mandated to treatment would occasionally mention being in the treatment program because of their criminal justice status:

Michelle [Westview clinic, African American, probably age mid 30s]: (to Karen) You were a dealer? That’s why you are here?
Karen [African American, age probably mid 30s]: Yeah. Well, I also sniffed heroin. I didn’t mess with crack, though. Didn’t want the paranoia. [imitates crack users getting paranoid and the group laughs a lot].
[from fieldnotes]

Michelle associates Karen’s drug-selling status as a reason she would be in the IOP treatment program. Karen agrees that that is the primary reason why she is there, although she mentions also having a problem with using drugs.

The counselors generally still perceived that a drug treatment program was the appropriate place for these individuals, despite agreeing that they did not have a significant drug use problem. Instead, they felt they were treating other serious problems that these individuals faced which likely led to their criminal status:

Kevin [Westview program coordinator]: “When you’re working with a client like that, you’re main focus is not on abstinence from substance abuse, because that’s easily done. It’s on, ok, what the hell are you gonna do with your life? Do you like being in jail? Assuming you don’t, ok, how you gonna get out of this stupid system so you don’t have to put up with that crap?” [from interview]

Wendy (referring to the court-mandated clients): “I do like working with them… I like getting back to what started this. And I like working on that type of issue. Rather than going on and on about the drug addiction, I break it down to them in the beginning – like, you’re really not a drug addict, are you? And we talk about what has happened prior to them
From Kevin and Wendy’s responses, there is some indication that they find working with the court-mandated clients rewarding because they are able to focus on issues outside of substance abuse. Similarly, Tom indicated that these clients likely belong in some kind of program and that putting them into treatment is better than incarcerating them:

Tom: “If it was legal to use the substance they probably wouldn’t have any problems with it… So it’s kind of hard to say what you would want to do with them. Um, I guess putting them in treatment as opposed to jail would be the best option, but then there are those that get arrested that do have real problems… You want treatment for them or some type of service, but um….honestly the system’s not perfect, but I think a better assessment done when they get arrested, so that they get to a program or service. I mean it could just be they’re just having financial problems, they don’t need to come here for that.” [from interview]

Tom refers to these clients possibly having “financial problems” and relates their selling of drugs as one option among a limited list of jobs that they could obtain.

One of the consequences of labeling these clients as “diseased” in this other way is that many of the clients will openly discuss their intention of using drugs in the future, once it is not monitored by a treatment program or parole officer. While they never revealed this during any of the group sessions I observed, several clients would tell me individually that court-mandated clients would talk to them about using drugs in the future. Here, Barry, a self-referred Westview program client discusses having a disease with those who would not label themselves as drug addicts:
Barry [African American, age probably late 30s]: Other people are here because of court… Sometimes I feel like I don’t fit in. I’m outside and other people be asking me, “you really have a problem?” Other people are like, “I don’t have a problem.” Well, I have a problem! I have an allergic reaction to certain substances. I’m not here because I’m made to come because of court or whatever, I’m here because I have a problem… A lot of people here are not educated about the disease of addiction. [from fieldnotes]

Barry was one of the only clients who openly expressed dissatisfaction with the group being largely composed of court-mandated clients. He suggested in several group sessions that he was not getting what he personally needed from the treatment program because of its inclusion of clients who did not think they had a substance abuse problem.

The court-mandated clients tended to stay in treatment longer than the self-referred clients and also had longer periods of abstinence. They also faced severe consequences, like prison, if they failed to attend treatment or tested positive for drug use. In the groups I observed, the court-mandated clients would often discuss how many days they had left in the program with each other. It was a common occurrence for them to pass around the sign-in book and count back to see how many sessions they had attended and how many more they were required to complete. They would express excitement when they were close to graduating. As Kevin stated above, if the substance problem is not severe, then achieving abstinence will not be difficult. This related to his perception that the “success rates” touted by programs like treatment court were somewhat embellished:

Kevin: “Treatment court, FIR, IPP, and so on, I think, have an inflated success level. It’s inflated because a significant proportion of clients never really had an addiction. Many of them do, but many of them don’t. So, hey, if the guy doesn’t really have an addiction the fact that he stays clean isn’t all that impressive. I mean, ok. Does that mean it’s a good reason not to do it? No, I don’t think so. Because I think it serves other purposes, they
learn other skills. They get out of the life of selling and so on. But, in terms of treatment of *addiction*, it’s inflated.” [from interview]

At the same time, even though she recognizes drug use not to be the main problem, Wendy expresses concern that clients will return to drug use after leaving treatment:

*Wendy:* “And they’ll stay clean while they’re here, but after they leave here, I don’t know what they do. And, some of them have admitted to me that they’re going to graduate and smoke pot that week, or the same day. And I’m like, are you really? ‘Ah, no Miss Wendy, I’m not gonna do that.’ I’m like, oh, I get sad because I think that they will. So, that’s what leads me to believe that it’s more lifestyle than necessarily addicted to marijuana.” [from interview]

The last part of her statement illustrates how she classifies the clients referred from the criminal justice system as different from the other clients in the program. While she earlier discussed social and environmental factors as related to the disease of addiction, the court-mandated clients exhibit those same factors but do not have the same “disease” according to Wendy.

**Conclusion**

The ambiguity of the disease concept of addiction is present in the organization and philosophy of these treatment programs. While the two programs differ most significantly on the treatment methods used (methadone maintenance vs. ordinary outpatient), they use similar therapeutic techniques and rely heavily on a 12-step approach to addiction treatment. Thus, in the more “medicalized” program (Southside), there is no clear evidence that their approach to treatment is based on a more medicalized notion of addiction as a disease that is best treated with medications like methadone. Instead, both programs use the “disease” concept for a similar purpose: as a way to
minimize the differences between individual clients (such as drug seller vs. drug user) and in an attempt to convince the clients that they need the programs to “heal” them. Despite the different methods used (methadone vs group therapy), the staff in each program have very similar conceptualizations of addiction and the “best” way to handle it. The differences in race and class between the staff and the clients also appears to be related to how the staff conceptualize addiction, since they often name social/environmental factors as possible explanations. In the next chapter, I discuss the consequences of this ambiguity found both in the Drug Treatment Court program and in these treatment programs and how it results in the use of both therapeutic and punitive methods for managing individuals labeled as addicts.
CHAPTER 6: FURTHER AMBIGUITIES AND THE ISSUE OF THERAPEUTIC PUNISHMENT

The previous two chapters illustrated the ambiguous use of “addiction” in both the Drug Treatment Court and in two outpatient substance abuse programs. In both settings, drug addiction was characterized as a disease, although individual staff members had difficulty articulating the exact components of the disease and the most appropriate treatment modality. While they also recognized addiction as a social problem, stemming from poverty, childhood abuse, and joblessness, both seemed to promote an increase in individual responsibility as the best way to deal with it. The “addict” label also was reconstructed in both the drug treatment court and in the treatment programs to include a broad set of behaviors associated with a “lifestyle” of using and selling drugs. This chapter will elaborate further on the ambiguities within the settings previously described and discuss possible consequences of those ambiguities. In particular, I will illustrate how this ambiguity around the addiction label contributes to the persistence of the stigma associated with substance abuse and leads to mutual distrust between those in treatment and the staff. This ambiguity also results in the use of what I term “therapeutic punishment,” a technique used in all of the settings that results from the hybrid notion of addiction as both a disease that needs to be treated, as well as a symbol of irresponsibility and criminality. Therapeutic punishment, as I use the concept, relates to the intent in all settings to punish clients who do not follow the established rules of each program in a way that is viewed as an extension of the clinical “treatment” offered in each setting. Thus, those working in these programs perceive what I (and the clients) often view as punitive methods to be therapeutic in their execution and goal.
Labeling Disease and the Diseased

In this section, I will elaborate on further ambiguities and inconsistencies of the addiction label in both the drug treatment court and the Southside and Westview treatment programs. While all of the settings used the “disease” concept of addiction to frame the organization of their respective programs, there were further ambiguities around this concept that suggested that there was either conflict around the use of the disease concept, or at least a lack of agreement on how exactly addiction should be characterized as a disease.

Drug Treatment Court – What Is “Clinical?”

The court proceedings and the examination of the roles of individual court staff members illustrated the complex overlap of the “medical” and the “legal” realms in the drug treatment court program. Rather than the clinical side of the program being distinct from the legal proceedings and monitoring (since it operates in a separate location), there is instead an ambiguity of who is the authority for clinical interventions and who is the authority of legal ones.

This ambiguity of how the disease of addiction is articulated is found in the judge’s differentiation between the “clinical” part of a client’s monthly report and the rest of it. While he makes a point of emphasizing whether or not the client is doing “clinically” well, at the same time, what is clinical and what is not is never clearly articulated. Here is one case of a young African American male client, who appears to be in his late twenties. During his monthly appearance, the court staff report that he was recently arrested at a concert in Philadelphia:
Judge Gallo: You’re a mixed bag. Clinically, you’re doing well. You have all negative urines, you attend your sessions, go to NA meetings. The downside is you were arrested again… You did an essay for today. What did you learn?
Client: I learned that addiction is a disease and recovery is the cure. As long as I stick with my recovery, I’ll be fine.
Asst. Public Defender: Your Honor, the client completed Phase 1 as of July 15th.
Judge: Congratulations. [Applause from the courtroom]
[from fieldnotes]

During this interaction, the client admitted that he was at a concert with his friends who were smoking marijuana. Still, the judge emphasizes that “clinically” he is doing well (despite obviously interacting with people using drugs). Additionally, the judge does not give him a sanction (he was sentenced to community service through Community Court) and ends up rewarding him for completing Phase 1. This case presents a rather confusing message to this client and the others in the courtroom. While the client tested negative for drug use, he is still engaging in behaviors that in other situations the court views itself as symptoms of a “disease” (selling drugs). Perhaps because his friends were using drugs, and not selling them, that the client is deemed to still be following the rules of the program. Here is another similar case where a client was arrested in the previous month for drug possession:

Judge Gallo: Let’s start with the good stuff. You’re going to sessions, you have clean urines. But now you picked up a new arrest… Clinically, you’re doing well… Are you still working with your grandfather?
Client: Yes.
Judge: Fulltime or part-time?
Client: Fulltime.
[from fieldnotes]

Again, the judge determines the client to be doing “clinically” well, even though he was arrested for possession of drugs. From these two instances, doing well “clinically” seems
to mean that the client attends treatment sessions and has negative urine drug screens. At the same time, engaging in further illegal behavior involving drugs does not seem to impact the judge’s perception of how the client is progressing clinically through the program.

Not doing well “clinically” appears to mean that the client has missed treatment sessions and/or is continuing to use drugs. For example:

*Counselor:* He has positive urines. He missed one session and made it up.
*Judge Gallo:* You relapsed... This is a mixed report because you continue to use.
*Client:* I just started the program. It’s hard for me.
*Judge:* You’ll have to write a 200 word essay on relapse.

[from fieldnotes]

The judge refers to it being a “mixed report” indicating that the client is not meeting expectations clinically yet is doing well in other areas of the program that are not clearly defined. Implied in this example is that the client would not have a mixed report if he discontinued using drugs. It can also be determined from other interactions that missing meetings with the client’s case manager is not part of the “clinical” monitoring:

*Judge Gallo:* Clinically, this is an excellent report. The only negative thing is that you haven’t been staying in touch with your case manager.
*Client:* My grandfather passed. I’ve been goin’ down South a lot.
*Judge:* Like I said, clinically, you’re doing excellent. You’re working. Doing everything right. But you need to stay in touch with your case manager.
[from fieldnotes]

That the judge mentions working as one of the reasons the client is doing “clinically” well adds to the ambiguity of what the judge exactly means by clinical or non-clinical parts of the treatment court program.
Also, as the client progresses in the program, the drug treatment part of the report becomes less important, as if at some point the client moves beyond the “clinical” portion of the program. Once the client has completed the specific alcohol/drug treatment program that he/she was assigned to, he/she will only meet with the counselor at the facility every week or so. When the client is this far in the program, the judge focuses almost completely on “non-clinical” issues during the client’s monthly court appearance. Issues of education and employment are much more important in determining if the client is “doing well.” Here is one case where the client has recently finished the drug treatment portion of the program:

_Counselor_: The client successfully completed IOP [Intensive Outpatient Treatment]. Urines are all negative.
_Judge Gallo [to client]_: Take your hands out of your pocket. This is a good report. Make sure you stay in touch with your case manager. Now you’re in outpatient… Why haven’t you started GED classes?
_Case Manager_: We’ll follow up on that.
_Judge_: Ok.
[from fieldnotes]

The judge recognizes that the client is progressing through the program by finishing the treatment program and stepping down to individual sessions with a therapist. He also takes the opportunity to remind the client that he is now responsible for completing a GED. The judge will also emphasize the importance of a client working once he has finished the drug treatment program:

_Counselor_: Client attended all sessions and all urines were negative.
_Judge Gallo_: This is a very good report. How you doing? Now the only thing you need is to get you some work.
_Case Manager_: He completed Phase 3 as of May 21st.
_Judge_: Congratulations [people in courtroom applaud]
The judge emphasizes that the client needs to get a job. At the same time, he congratulates the client on having a good report. Most of the time, the judge does not specify whether the client needs to complete an education program or whether he/she needs to get a job; either one seems to provide enough evidence that the client is progressing through the court program. The transfer of focus from drug treatment issues (most often referred to as “clinical” by the judge) to issues of working and education adds to the ambiguity of what exactly the court is “treating.” While these social issues (like under-education and unemployment) might be viewed as related to the causes of addiction (both to using drugs and the “lifestyle” of drug selling), they are not explicitly linked to the client’s drug problem during the court sessions.

If a client does not pursue further education or employment, and is physically capable of doing so, he/she is reprimanded for halting progress in the program. It was never clearly articulated exactly at what point the client had to be enrolled in an education program or working, but it was implied that if the client was not pursuing either of those things that he/she risked negative repercussions. Still, I never witnessed a client getting sanctioned for completing treatment and testing negative for drug use, but not yet working or pursuing further education. For instance, here is the judge’s interaction with a client who has just completed the first two phases of the program:

*Judge*: How come you haven’t started GED classes?
*Client*: I’m going to as soon as possible.
*Judge*: What’s holding you back?
*Client*: I slacked off.
*Judge*: You don’t want to slack off. Go get your GED and/or get a job. Congratulations on completing phases 1 and 2 [applause].
[from fieldnotes]
The judge tells the client that he can choose which program to do: get a job or get a GED. The emphasis is on doing one of those things, but the repercussion for not following through with either is unclear.

This movement in the program’s focus from treatment to education/employment occurs once the client has finished the drug treatment portion of the program. The evaluator explains one possible reason why this change occurs:

*Patrick*: “If they’re in [outpatient treatment] and are unemployed, I mean, they absolutely need to be enrolled in a GED program or community college or something, you know. Instead of just idle time, which we’ve found over and over again in this program to really be a killer.”

There is a perception that the client’s life is not structured enough, most likely because he no longer has near-daily treatment sessions to attend. The reasoning is that the client might revert back to drug use or other criminal behavior if work or school does not take over the time that treatment used to. In this sense, then, any activity is beneficial to the client; the problem is having a lack of “responsible” things to do during the day.

This ambiguity over what exactly is “clinical” in the drug treatment program also relates to the construction of a drug-selling lifestyle as itself an illness that needs to be treated. Since drug use is not necessarily the chief problem for these clients, the court insists on the completion of requirements that are extraneous to drug treatment, like getting a job or further education. The treatment court program is designed to take a year to complete, although most take longer to get through the various phases. The intense drug treatment component, however, usually ends long before the client completes the court program. Thus, the client will often spend just as much time being monitored by the
court while he/she is supposed to complete GED classes or get a job, as he/she was while attending drug treatment sessions.

_Southside and Westview – Are you a Patient or a Client?_

The terminology used to refer to a person in the treatment programs varied. Overall, most counselors referred to the individuals in treatment as “clients,” suggesting a general lack of medicalization in the programs, at least according to the counselors. One tends to use such a label in professional situations where a service is being rendered, such as in a lawyer-client relationship. However, in the mental health field, the term client is often used to describe somebody who is in therapy with a counselor or psychologist, and Pennsylvania law uses both “psychiatrist-patient” and “psychiatrist-client” when describing the confidentiality privilege of such a relationship (for instance, PA State Law 6544). There were some differences between the two programs, though, suggesting that the individuals in treatment at Southside (the methadone maintenance program) were more “diseased” than the individuals in Westview (the outpatient program).

At the program-level, Southside attempted to label the individuals in treatment as “patients.” The “Patient Handbook” that individuals would receive at the start of treatment consistently used the term “patient” to describe the individuals in treatment. One of the Southside counselors who organized the pre-IOP group meetings, Jerry, also only ever referred to individuals in Southside as patients, either in speaking with me or during group sessions.

In Westview, the label “client” was more consistently applied to the individuals in treatment. Westview’s handbook never referred to those in treatment as “patients,” but
only as clients. Similarly, Kevin, Westview’s counseling supervisor, always referred to those in either treatment program as clients, suggesting a more traditional perspective as far as the kind of treatment that was being offered there (group and individual counseling).

These labels were not consistently applied in each program, however. Some counselors referred to individuals in treatment as “clients” or “patients” almost interchangeably, with no apparent distinction between the two labels. While the use of “patient” more often in Southside suggests some program-level effort to “medicalize” those taking methadone as part of treatment, the lack of agreement among the counselors in each program seemed to just confuse the issue. For instance, Linda, Southside’s program coordinator, used both terms interchangeably, despite only working in the Southside program. This reluctance to consistently extend a medical term for the individual receiving treatment could be a form of resistance by the staff to fully extend the “sick role” to those in substance abuse treatment.

**Consequences of Ambiguity**

*The Persistence of Stigma*

Erving Goffman (1963) defined stigma as “an attribute that is deeply discrediting” in that it prevents an individual from being fully accepted by the rest of society (p. 3). He elaborated on three different types of stigma. The one that relates to the individuals described in this dissertation is the type of stigma associated with a perception that certain individuals are “weak-willed” (4). In this category, Goffman included, among

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56 Individuals in the Drug Treatment Court program were always referred to as “clients” by the court staff.
other categories, alcoholics, addicts, and criminals. All of the individuals in the settings that I have investigated in this dissertation belong in those categories. Even those in treatment who were not court-mandated (those who were self-referrals) were in some ways treated as “criminals” since they had been engaging in an illegal behavior (drug use). This was most evident when the staff had difficulty conceptualizing addiction as a disease and their tendency to ascribe some blame to the individual for “choosing” to use drugs in the first place. Both the drug treatment court and the outpatient drug treatment programs use the disease concept of addiction in an attempt to shed the stigma associated with substance abuse. However, neither is successful, and their organization instead actually promotes further stigma.

Substance abuse itself carries an additional stigma that has not disappeared despite its partial medicalization. If anything, the Southside clients, who receive the most “medicalized” treatment, methadone maintenance, were more stigmatized for their drug problem, based on the interactions they had with individuals at twelve-step meetings and even others in the same treatment facility (at the Westview program), as I described in Chapter 5.

The organization of dispensing methadone promoted stigma. For instance, clients had to wait outside of the clinic for their daily dose of methadone:

Joe: I mean, the stigma of methadone. Like, standing out on the corner waiting for the clinic to let you in to get medicated. Where’s the anonymity in that? When I was working at Wawa, up at 9th and Chestnut, my manager drove by and saw me standing outside of a methadone clinic. So, now he knows about my problem! [from fieldnotes]

Here, a methadone maintenance client recognizes that there is a stigma associated with substance abuse treatment. He expresses concern about his employer knowing that he is
taking methadone, suggesting that he might be treated negatively (or at least differently) because of it. The facility could adopt new strategies to help alleviate that stigma, such as creating a waiting area inside or by staggering medication times for a longer period throughout the day; however, no staff member I interviewed described problems with this system, so it seemed unlikely to change.

The organization of the drug treatment court also promoted further stigma. It appeared that by conceptualizing addiction (including selling drugs) as a disease that could be treated, they were attempting to offer a more therapeutic method of dealing with these offenders, instead of putting them through the typical criminal court proceedings. However, by attaching the “disease” label, since it is a “disease” that itself still carries a heavy stigma, they were in effect doubling the stigma that these clients already had as criminals. Thus, they were stigmatized twice: first, in the courtroom, where they were labeled a criminal, because they had to plead guilty to the charges against them in order to enter the court program, and then again in the drug treatment program, where they were labeled as diseased, either because they were addicted to using drugs, or addicted to the lifestyle of selling drugs.

*Therapeutic Punishment*

I use the concept “therapeutic punishment” to describe the response by the staff in both the Drug Treatment Court program and in the Southside and Westview treatment programs when the client does not follow some set rule. This technique results because of the belief that addiction is a “treatable” disease but at the same time carries with it an
unusual level of responsibility compared to other named diseases\textsuperscript{57}. In this section I will demonstrate how therapeutic punishment is employed in both settings. The concept refers to the staff’s own conception of the purpose of the technique, that it is punitive but at the same time something that the client “needs” in order to get better. In both settings, staff members describe how this practice is necessary if the client is going to succeed. I want to emphasize, however, that I am not using the term to suggest that I believe that the forms of punishment that they use are in any way beneficial to the clients.

While I did not coin the phrase therapeutic punishment, I am using it in a different capacity than how other researchers have. The only published studies I could locate that use the phrase “therapeutic punishment” refer to a behavior-modification technique that has been used with individuals with severe mental deficiencies, such as autism or retardation (Simmons and Reed 1969, Rolider, Cummings and Van Houten 1991). In this method, pain and punishment are used as treatment modalities in an attempt to change undesired behavior that is usually violent and/or self-destructive in nature. It is a punishment of the body, in that it involves the restricting of movement, contingent exercise, and in earlier forms, the administration of electric shocks. While it is a controversial method, many researchers conclude that it can be effective.

My use of the concept “therapeutic punishment” refers to a broader set of practices that both the Drug Treatment Court and the outpatient treatment programs used in an effort to extinguish the undesirable behavior of the clients, usually after they had violated an established rule. The punishment in these settings is most often of the mind,

\textsuperscript{57} I recognize that treatment for other stigmatized diseases, like AIDS, could also involve elements of therapeutic punishment. This is a possible area of further research, but for the purposes of this dissertation, will only be considered in the contexts I observed.
although in the Southside program (the methadone maintenance program), therapeutic punishment techniques revolve around the prescription of medication, and therefore can be punitive to the body as well as the mind.

While nobody in either program would refer to their techniques as therapeutic punishment (or perhaps even any form of punishment), I use the term because it conveys what the staff appear to believe is the benefit of such a practice. That is, they often view the drug-using population as irresponsible when it comes to doing what they need to do in treatment. These techniques, then, become a way to punish what they view as irresponsibility, while at the same time preserve their role as therapists and treatment providers by rationalizing that the punishment is really just another form of therapy. The best metaphor that was used in both settings that summarizes the main components of therapeutic punishment was that of “the carrot and the stick” which refers to the rewards and punishment system that exists because of the various rules in each setting.

*Therapeutic Punishment in Drug Court*

In Chapter 4, I described the types of sanctions that the treatment court used. A number of sanctions that were given in the program seemed purely punitive – such as short-term jail sentences, writing an essay, or spending a day watching the court proceedings from the jury box. However, it is quite ambiguous whether they are enforced for punitive or clinical reasons.

Ordering a client to write an essay, usually of about 200 words, was most often used as a sanction for relapse. The judge would almost always emphasize that the topic of the essay would be relapse itself. Thus, since relapse was considered a likely “symptom” of addiction, this sanction had “clinical” overtones to it. There was a suggestion that
writing this essay could be therapeutic for the client and perhaps help him/her think more deeply about his/her drug problem. The court took such a sanction seriously; the judge would ask the client during the next session for the essay and read it to himself while the client stood in front of his bench. He would then usually comment on the content of the essay, most often a short approval, such as “good essay” and occasionally ask the client a clarifying question about what he/she wrote. While the clients who were given the sanction of writing an essay did not object to the harshness of the punishment in the same way they did for other sanctions, such as being sent to a Recovery House, many of them lacked a high school diploma, so it was likely still an arduous task for them to complete. At the same time, writing an essay would be used as punishment for violating other components of the program. Occasionally, I witnessed the essay being used as a sanction for missing sessions and the client being instructed to write an essay about “responsibility.” Whether this sanction was punitive or clinical, then, was ambiguous and appeared to be used for both ends.

The most ambiguous sanction as determining whether it gets used for clinical or punitive purposes was the ordering of a recovery house. A recovery house, also known as a “halfway house,” is a structured living environment where clients live with other individuals who have problems with drugs or alcohol. There is often an initial “blackout” period where the individual cannot leave the house for any reason, including work. Throughout his/her time in the recovery house, he/she’s whereabouts are heavily monitored and controlled. Typically, a person would reside in a recovery house for three months to a year. When the judge ordered a recovery house, it was usually after repeated
problems, such as missed treatment sessions and positive urine tests. Here is one example:

*Asst. D.A.*: This case was discussed in the back. He missed 3 more sessions and continues to be positive for marijuana.

*Client*: I missed because I moved. I called them and told them.

*Asst. D.A.*: He has more missed sessions and he continues to use.

*Asst. Public Defender, Liz*: He admits he was using again. Says urines should be negative as of now. He was told about this previously and that the court would order a Recovery House.

*Judge Gallo*: He’s going to a Recovery House.

*Client*: Can the court please give me another chance? I’m working. I need to go to work.

*Judge*: There’s no reason you can’t work while you live in a Recovery House.

*Asst. Public Defender*: Well, there will be a 30-day blackout.

*Judge*: [holds up a mirror and gets angry] Don’t blame me, blame you! If you lose your job it’s not my problem.

*Client*: Please just give me another week…

*Case Manager*: A Recovery House is recommended.

*Judge*: That’s where you’re going.

[from fieldnotes]

The judge here appears angry and the client expresses that he does not want to live in a recovery house. Whether the client loses his job because of the initial blackout does not appear to be the judge’s primary concern. While the sanction is punitive on one hand, the judge seems to think that it is also an attempt to give the client more assistance clinically.

At times, however, sanctioning a client to live in a recovery house was not a direct response to his/her continued drug use and seemed to be used as punishment for other violations of the program. For instance:

*Asst. Public Defender*: The client missed five treatment sessions… [Judge Gallo] sentenced him to community service and he has not done any of it. He was even given tokens to get there.

*Judge Malloy*: Where are the tokens?

*Client*: I live in Southwest. I used one to do some of my business.

*Judge*: So all of this prevented you from doing your community service?

*Client*: I live far away.
Asst. Public Defender: You should put it on the calendar.
Judge: I order another Recovery House. I’m not pleased with the reasons you give. When you’re in front of a court and the Judge tells you to do something, it’s not a request. You need to do it… Judges are a cranky bunch when they order something and it doesn’t get done. I will order a Recovery House and order you spend five days in jail. If you made an effort and fell short, I would have taken it into consideration. But you didn’t even make an effort.
[from fieldnotes]

In this example, Judge Malloy (substituting for Judge Gallo58) orders a recovery house as punishment for not completing a different sanction. There is never any mention of drug use in the above case, suggesting that a recovery house could also be used purely as punishment for violations of the program. Similarly, Patrick, the evaluator, here discusses that a recovery house could be ordered in response to the client not attending sessions, but not necessarily because he/she cannot stop using drugs:

Patrick: “If it’s really just bad attendance, not so much hot urines, but really just poor attendance, then a case manager can, will just put ‘em in, because that’s just a lack of structure… It’s not so much a concern about heavy use or something like that.” [from interview]

He suggests that a case manager could also place the client in a recovery house for missing sessions; ordering a recovery house is not just used for “clinical” purposes.

The assistant public defender, Liz, would often suggest a recovery house because she saw it as a necessary part of treatment, rather than as a punishment. Here is the case of a young male client who tested positive for drugs in the past month but will not admit he is using drugs. He also has missed appointments with his case manager and the case manager reports that he has not given a good address or phone number:

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58 This was the only day when I observed court that Judge Gallo was not the presiding judge.
Liz: Will the court reorder the Recovery House?
Client: Why do I need that?
Judge: Because the court ordered it.
[from fieldnotes]

The assistant public defender requests a recovery house because she thinks it will help the client clinically. Interestingly, the judge does not explain the purpose and emphasizes that his instruction is all the client needs to understand.

Those working in the treatment court program would emphasize the clinical necessity of sending somebody to a recovery house. Here, Mario, the Manager of Specialty Courts, emphasizes that recovery houses are sometimes necessary for clients who have more serious drug problems. He talks about conditions that might make the evaluator recommend a recovery house at the start of the treatment court program:

Mario: “The Recovery house is…we don’t just refer clients to a Recovery House because we want to send them to a Recovery House. Recovery House is a serious, you know, it’s a Recovery House. People reside, have drug problems. And if a client doesn’t have a stable home environment, then we’ll recommend… If the client is residing with a friend who is using, we’ll also recommend. There’s certain flag, red flags that will click with case managers, to refer clients to a recovery house. We don’t just refer clients because, like, we don’t like them.” [from interview]

Mario emphasizes that the evaluators would recommend a recovery house to a client because he says they are genuinely concerned about the likelihood of the client succeeding in the program considering his/her current living situation. He probably emphasizes this because the clients most often perceive a recovery house as a very harsh form of punishment. Patrick, the clinical evaluator for the treatment court program, also echoes that recovery houses are not a form of punishment, even if the client thinks that they are:
Patrick: “A Recovery House is not a sanction; it’s a clinical intervention. Like, you can’t stop using, so we’re gonna put you in a more disciplined structure where you can. But the client sees it as a sanction… Being told when to sit, when to eat, this, that and the other. And a lot of times that’s the turning point. Because it’s worse, to some effect it’s worse than jail because you can be in a Recovery House for two or three months.” [from interview]

He explains it as a clinical intervention, not a sanction, despite previously mentioning that a case manager could order a recovery house for missed sessions. In the court setting, it was used as both a clinical intervention and a sanction. If the evaluator recommended a recovery house at the initial evaluation, he described it as solely a clinical intervention. This added to the ambiguity of whether the purpose of ordering a recovery house was clinical or punitive.

Recovery houses fit into the program’s assertion that all sanctions are clinical tools to help the client. Those working in the treatment court program emphasized the use of recovery houses and other sanctions as a “wake up call” for the client:

*Patrick (evaluator)*: “Sometimes those sanctions or the Recovery House or whatever is the necessary wake up call. I know a lot of people in recovery and a lot of people got clean in jail, period. Being in jail was the bottom they needed to hit to realize that I don’t want to live like this anymore… Sometimes I advocate for the two-week long jail sanction. Let him wake up! Let him see, let him really get a taste of this. ‘Cause right now he thinks this is glamorous. And jail will certainly take the glamour out of the game for most guys. But, you know, just letting people rot in jail is another thing entirely.” [from interview]

Here, the evaluator distinguishes between jail as a sanction for treatment court and putting somebody in jail for the original offense. Similarly, the judge emphasizes jail not as punishment, but a “wake up call” in the following court interaction:

*Asst. DA*: This matter was discussed. The client has positive urines, he was discharged from two recovery houses, he has missed sessions…

*Judge*: What do you have to say for yourself?
Client: [talks for a while about getting into a fight at one of the Recovery Houses]

Judge: You’re going to have to spend five days in jail. This is too serious to give you a non-jail sentence. Don’t think of it as punishment, think of it as a wake up call. You have three cases with us. You can possibly go to prison for a long time… We can’t tolerate people who get thrown out of two recovery houses. If you relapse, we’re not happy about it, but we can tolerate it.

[from fieldnotes]

That the client was evicted from a recovery house is treated like a bigger problem than continued drug use.

Short-term jail sentences were often a sanction for major violations or repeated problems. Even though these seem like purely punitive sanctions, the court staff views them as having clinical benefits. Here is a case where a young male client had missed several treatment sessions. He claimed that he had to go to work, although he did not provide any proof of employment. There is also some discrepancy about sessions that he attended and signed in for, that the counselor is claiming he missed:

Judge Gallo: All these things start to add up…You tell us you’re doing one thing, you do another. We now have the book. We’re going to check the signatures. You’re going to do a day at Options, because of all of this unnecessary work we had to put into this case. [from fieldnotes]

Options is a drug treatment program in a Philadelphia prison. In this case, there is no clinical reason for him to go to Options; he does not test positive for drug use. It appears to be used as a punishment for missed sessions and general signs of irresponsibility. Still, he is ordered to go to this jail-based substance abuse program for a day. This program in particular has also been referred to as a possible “wake up call” to the client, because he/she will spend time in a prison environment.
The court staff never expressed concern that this simultaneous use of sanctions as both clinical interventions and punishment might be problematic, in that it sends a confusing message to clients about the nature of their “disease.” The court staff referred to the use of sanctions as an effort to always “help” the client. As an extension of that, they often see their individual job as helping clients in various ways:

*Judge Gallo:* “I cannot be effective if I don’t communicate to [the clients], to let them know that this program is only here to help them.” [from radio interview]

Still, the judge also refers to himself as an enforcer of some sort, when describing the program itself as “the carrot and the stick”:

*Interviewer:* But do you think of yourself as the stick?

*Judge Gallo:* Sure.

*Interviewer:* Because, you’re the judge, you make the final determination.

*Judge Gallo:* Absolutely. The final call is always mine.

Similarly, the assistant public defender talks about sanctions as helping a client in a clinical sense:

*Interviewer:* “So when a person is having trouble, on the report they’re missing sessions or they have a positive urine result for using drugs…How does the team decide what the appropriate sanction should be?”

*Liz:* “Basically we decide on a sanction by figuring out what will advance the client’s treatment, what will help the client’s treatment.”

Sanctions, according to the assistant public defender, are always used as clinical interventions. The judge also implies that everything about the program, including the sanctions, is an effort to help the client. The reality of when and how sanctions are imposed, however, results in a much more ambiguous overlap of clinical and punitive responses to clients’ behavior.
Therapeutic Punishment in Treatment

Just as there were incentives and sanctions in the treatment court setting, Southside and Westview programs had similar components as part of the treatment program’s daily operations. Again, I use the term “therapeutic punishment” to describe these incentives and sanctions, not to legitimize the practice, but to illustrate what I perceive the program’s philosophy to be around the use of incentives and sanctions. In the treatment programs, therapeutic punishment operated in conjunction with the rules set up by each program. Violating these rules could result in serious sanctions.

At the treatment programs, the rules of the IOP program would often be communicated to the clients, in written and oral forms. Wendy, a counselor for Westview’s program as well as one of the group counselors at Southside, educated the clients in Southside’s pre-IOP group about these rules before the client started IOP. Every so often, she would hand out a four-page document that described the various rules, including one page describing the attendance and make-up policy that clients had to sign before beginning IOP treatment. Of all of the rules, attendance was taken the most seriously, even above abstinence. As Wendy described to the pre-IOP group one day:

Wendy (describing the rules of IOP treatment at Westview): And they want to start like a three strikes and you’re out policy up there. Like if you’re late to group 3 times, then you’re kicked out. Because if you’re going to just blow it off, why should we hold your spot? Why can’t someone else from here take it? [from fieldnotes]

Westview includes tardiness in its rule of attendance, not permitting those arriving past a certain time (usually 15 minutes past the start time) to join the group. As Wendy states, arriving late three times could even result in somebody being forced out of treatment. I never actually witnessed this rule enforced; it appeared that there was some negotiation
that would occur between the counselor and the individual client who was having attendance issues. While one could view the attendance policy cynically as the treatment program’s insurance of getting reimbursed for services, that lateness was also enforced suggests that the policy is at least related to requiring a determined level of responsibility from the clients.

Attendance was heavily monitored for clients who were in treatment through the criminal justice system. In many ways, the threat of returning to court or to jail was the “stick” that the treatment program used to make the clients follow the established rules. Abstinence was also enforced with this same threat. Counselors would refer to using the clients’ legal status in an attempt to exert their own authority:

_Wendy_: And I also have different leverage, like here you have the court system as leverage, [in the Southside clinic] you just have their methadone as leverage. [from interview]

Counselors who worked with the clients from the criminal justice system would frequently meet with the client’s parole officer or case manager, depending on the program. This led to multiple facets of supervision over the clients. Counselors would report any attendance or drug use issues to the parole officer or case manager, and that person might then exercise some sort of punishment in return.

_Peter_: And obviously there’s the pressure of their parole officer, saying you gotta do this or otherwise we’re going to put you back to prison. [from interview]

In general, the counselors referred to this set-up positively; they seemed to enjoy having more power because of the possible punishment that clients would face if they did not follow the program’s rules, as Wendy’s comment about the types of leverage she has suggests.
As I described in chapter 5, clients from the various criminal justice initiatives (FIR, IPP, Treatment Court) would often publicly act in group as if they were “doing time” by attending treatment. They frequently looked at the sign-in book to count the number of days of treatment they had remaining, and reminded others in the group that they were forced to be there.

*Michelle [Westview group, African American, age probably early 40s]:* We have consequences if we don’t show up. You don’t.

*Barry [Westview group, African American, age probably mid 30s]:* I have consequences.

*Sean [Westview group, African American, age 20]:* Yeah, but they’re not as serious.

*Barry:* They are consequences for myself!

[from fieldnotes]

Here, Barry appears resentful to two of the court-mandated group members for suggesting that they face more serious consequences if they do not attend. The different referral source (criminal justice versus self) led to some minor conflicts between these group members, although not all court-mandated clients would blatantly resist group therapy. There seemed to be a sort of tipping point where if there were a large number of clients referred from the criminal justice system in the IOP group (or several outspoken ones), then the group tended to focus on criminal justice-related issues and clients felt more comfortable openly challenging the idea that they needed group therapy or other forms of treatment, like twelve-step meetings.

In the Southside clinic, methadone was often both the “carrot” and the “stick” used to control clients. As Wendy mentioned above, methadone could be used as “leverage” in the counselor-client relationship. Wendy had worked solely as a counselor
in the Southside program before moving into her joint position at Westview, so she could be speaking from her experiences there.

There are a number of rules set up by the Southside clinic around the dispersion of methadone and the sanctions that occur as a result of clients not following rules which verify Wendy’s comment. First, clients are instructed to receive their medication at a scheduled time (there are three different medication times daily), and they must visit the clinic every day to receive the medication. An incentive (or “carrot”) used by the Southside clinic was earning the ability to take home bottles of methadone, so that clients would not have to visit the clinic daily. While federal regulations were relaxed in 2001 to allow methadone clinics to distribute a month’s supply for clients, the Southside clinic’s own policy was more restrictive around the number of take-home bottles permitted. When I inquired about Southside’s policy on take-home bottles of methadone, the facility’s “Coordinator of Treatment” indicated to me that they would never permit a client to take home as much as a month’s supply because of the possibility that the client would sell the substance or use it not as directed. Southside’s procedure manual for counselors indicated that it was possible for client’s to earn 6 take home bottles at a time (permitting them to visit just once each week), but this was only after three years of near-perfect attendance and complete abstinence. It was much more common for clients to receive one take home bottle, but to qualify for that, the client had to meet very strict criteria. The patient manual states that “permanent THBs [take home bottles] are a privilege and not a right.” To earn one take home bottle (usually used for Sunday), the client had to complete at least three months of treatment, have had no alcohol or drug use during that time, attended counseling sessions as scheduled, and have not engaged in
known criminal activity or behavioral problems at the clinic. Furthermore, the patient manual indicates that “the treatment team must be able to justify that the benefits to your recovery of earning THBs outweigh the risks of diversion of the methadone.” While other prescription drugs have far greater psychoactive effects than methadone (like oxycontin, for instance), none of them are regulated to the extent of methadone. Southside’s intense regulation (more strict than the federal requirements) implies that the clinic does not fully trust their own clients with the medication they prescribe.

While these are the program’s written criteria around THB privileges, there were indications that the previous medical director did not necessarily follow them:

*Linda:* I like the *new* medical director. I liked the old one, I just didn’t like the way he ran the place…
*Interviewer:* What didn’t you like about the way the old medical director ran things? What did he do?
*Linda:* ‘Benzo-Bill’ gave everybody take home [bottles]…Even when they didn’t deserve them. He made excuses for them and enabled them… He put into place a set of principles which he quickly ignored. The principles were good. His ignoring them just taught people to try harder, beg harder and reinforced everything wrong… I like the man; I just didn’t like what he did. He was trying to be too kind and too kind is not good. It doesn’t help the people to change. If it doesn’t hurt, don’t change it. So they did whatever they wanted… He tried to please everybody, but that wasn’t right. You don’t please them. [imitating client] ‘well, I feel better when I take drugs.’ [imitating doctor] ‘Ok, take drugs.’

After further probing, and speaking to other counselors, I learned that this nickname for the previous doctor, “Benzo Bill,” was rather widespread through the clinic. The name was a reference to clients continuing to use benzodiazepines (such as Xanax) while taking methadone. Linda suggests that the doctor was too lenient with THBs and that led to the clients abusing other drugs, like benzodiazepines, with no real consequences. Other counselors have mentioned to me that benzodiazepine use by their clients is quite
common, even if they do not earn THBs, because the mixture of benzodiazepine and methadone produces a feeling very similar to that of heroin. Jerry estimated that as many as 40% of Southside’s clients used Benzodiazepines, either by prescription or purchasing them illegally:

Jerry: You know, we have like this tiny window of opportunity to try to talk to them before the street just pulls them right back. And, I told you, like with the benzos [benzodiazepine]. I mean, I would say 40% of our patients are using benzos with the methadone. But I’m glad to see [the new medical director] is trying to take it out of here. Like, there was a guy who was going to the program at the VA. And they kicked him out cause he was on benzos. So he came here. We let him in here. But he had to be a fee payer here. He didn’t have to pay at the VA cuz he was a war veteran. So then he tapered off of them. And now he’s going back to the VA. But he was telling me he worked at the airport! And I was just thinking, my God! If you’re working at the airport high on benzos, we’re all in trouble!
[from interview]

There were additional rules set up around the return of empty take home containers. If clients failed to return an empty container at their next visit, they would lose THB privileges for one week and be placed on a late-day medication time for one to two weeks. The bottle would also be inspected to make sure that the label had not been removed or tampered with, in order to continue receiving THB privileges. One encounter during the pre-IOP group I observed suggested that clients might also be refused medication all together for not bringing back a THB:

[Leonard comes into pre-IOP group one day saying that he could not get medicated that day because he did not bring back his take-home bottle]
Leonard [Southside clinic, white, age probably late 20s]: I’m not feeling too good today because I didn’t get medicated.
Kevin: Why not?
Leonard: I forgot my take-home bottle. So they won’t medicate me.
Karl: Can you get it and bring it back?
Leonard: Yeah, they said if I bring it back I have to wait until 5.
Karl: Five?! Why not when you bring it back?
Leonard: I don’t know. I guess I’m being punished. I don’t want to wait around all afternoon. I mean, if I don’t get medicated, then I want to get high. And I got this money in my pocket now. And I’m thinking of leaving here and getting high!
[from fieldnotes]

Leonard describes that he would have to wait until late in the day to receive the medication, even if he does bring it back that day. While the program’s manual describes the purpose of the restrictions around take-home bottles as an attempt to “inspire more self-reliance and responsibility,” the client instead characterizes them as punishment.

Another way that methadone distribution was used as “leverage” was in changing medication times. Most clients expressed the desire to be medicated as early as possible. Many cited reasons related to working or other kinds of responsibilities that took up their daytime hours. If a client missed a counseling session, a group meeting, tested positive for drugs, or did not return a take home bottle on time, then he or she could face a medication time change as a punishment. Changing the client’s medication time was a common sanction at Southside. While it was perceived as strictly punitive by the clients (including the possibility that they would experience withdrawal symptoms in the morning), it was perceived as a “therapeutic” response by the program, an attempt to instill more responsibility in the client.

While this sanction was commonly used, one counselor expressed some reservations about the kind of message that it sent and what it said about the role of therapy in the program:

Jerry: The medication is the whip that we crack…It doesn’t jive with my concept of therapy. I’d like to see the patient be in therapy. They have all sorts of paranoia about earning take-home bottles and medication times and all kinds of rules and regulations that they have to conform to... I’d like to see therapy take the front seat. [from interview]
In the group sessions I observed, Jerry often treated the clients with a lot of respect and empathy. This might be due to his having worked previously at an outpatient treatment program for working professionals. That is, his perspective on addiction might be more broad, since he has seen its impact on both middle and lower-class individuals, and therefore might not approve of using such stigmatizing methods.

The most threatening sanction was a forced detox from the program, where clients would receive dramatic reductions in their daily methadone dose over a few days, until they would not receive any more at all and be released from the program. This most often occurred for disciplinary reasons, but could also be a result of the client not following the clinic’s rules around attendance and abstinence:

*Sam* [Southside group, white, age probably mid 20s]: I don’t know if I’m going to IOP, though, cause I might be getting detoxed.

*Wendy*: Why?

*Sam*: Cause I missed yesterday.

*Cathy* [white, age probably mid 30s]: You missed an appointment with your counselor?

*Sam*: Yeah. So she said if I missed it, I’d be detoxed.

*Wendy* (looking a bit shocked, although not really genuinely): So what are you going to do? Will you get sick?

*Sam*: I don’t know. I haven’t stopped getting high, so... I’m going to pay what I owe and then get on another program.

*Wendy*: What about going inpatient?

*Sam*: Yeah, I’m gonna try to go away.

[Wendy tells Sam to go speak with his counselor, Linda, about getting another chance. He comes back to group a little while later and tells Wendy that he was given another chance.]

In this case, Sam was threatened with detox as punishment for not attending a counseling session. However, after speaking again with his counselor, he is given another chance. While the medical director would likely have to approve such a measure, the client is led to believe that it is completely at the counselor’s discretion whether or not he/she will
continue on the program. This gives counselors an enormous amount of power over the client.

While counselors suggested that most often this would be a “last straw” as a result of continued problems with the client’s behavior, there was some indication that it might be used as punishment even for one-time breaches of expected behavior. For instance, at one point while I was observing, several neighbors had complained to the clinic (and their state representative’s legislative aide who lived nearby) about clients from Southside standing on their sidewalks and being noisy in the morning. While this was a direct result of the clinic not having a waiting room for clients about to receive their medication, and not permitting them to stand directly in front of the clinic before it opened, the clinic instead addressed the neighbors’ concerns by demanding that the clients also not loiter anywhere in the vicinity of the facility. Here, Jerry relates that new rule to the pre-IOP group:

Jerry: So, this is serious. And something like this, they might try to get a sacrificial lamb. Or maybe a couple of people. Throw them off the program to show they’re serious. So don’t be that sacrificial lamb. [from fieldnotes]

Jerry warns the group to take the new rule seriously, or face expulsion from the program. His statement also indicates that ordinarily such a violation would probably not entail being forceably detoxed from Southside, but the clinic was taking this situation very seriously, likely because of one of the neighbor’s relationship with a powerful political figure.

This rule of no loitering in front of the facility before it opened for the first medication time created further problems for clients. Because many clients would arrive
before the clinic unlocked its doors, they would create their own rules around who would be medicated first, which eventually led to conflict between clinic participants:

_Jerry_ (talking about a client who had been expelled from the program): He was ecstatic because he and his girlfriend were going to move into their first apartment. They were going to look at it that morning. So he drove up at 8 o’clock in the morning, got out of his car. Stood by the door, thought he was first in line. Guards got here and opened the door. Others got out of their cars. “Number one? You’re number 12! That’s not how it works. You’re supposed to check when you get here and see who’s number 1, 2.” But they arrived early. He reached in his back pocket and pulled out his knife. Told the guard about it when he got inside. And whether the knife was ever seen or not, I don’t know. I asked the patient and he said he just reached in his back pocket to make him think he had something. [from interview]

While the clinic might argue that their not having a waiting room for clients receiving medication had to do with space restrictions, there was never any indication that they were trying to accommodate the clients at these established medication times to avoid potential conflict or issues with neighbors. It was this waiting outside the clinic that some clients also expressed as a further sign of the stigma associated with receiving methadone and how methadone programs are often dissociated from more “medical” treatment facilities. Clients once discussed during group an incident where someone spray-painted “methadone clinic” on the side of the plain gray building and clients were forced to still stand in front of it waiting for their medication, until the clinic removed the graffiti several days later.

The program used this system of incentives and sanctions because they viewed it as therapeutic for the client, in that it would ultimately encourage the client to become more responsible. Here, Peter discusses his perspective on how this method is often associated with methadone maintenance treatment in general:
Peter: The whole methadone system is not where I would personally go. Part of that seems a little bit mechanical and it’s a little bit more behaviorist than my orientation is. In other words, not behaviorist, but more reward-punish oriented.

Interviewer: Do you think that about methadone maintenance treatment in general?

Peter: Somewhat. Because it’s like, ok. You’re not doing this, we’re going to withhold your medicine until a certain time. And that will change your behavior. So...It’s more carrot and stick oriented. But also, it’s like, that’s what works, too [chuckles].

Peter disagrees with the tactic, but at the same time, mentions that it is a tactic that works.

There was some indication that this was the case from the groups I observed:

Jerry: George, what did you learn from group today?

George [Southside clinic, white, age probably mid20s]: Well, I guess I learned from [the other group members’] experiences. Like, I learned not to mess up, because, like, his dose got cut.

[from fieldnotes]

The use of a “carrot and stick” model is probably not restricted to just this methadone maintenance program. Other researchers, through interviews with methadone clients, have suggested that methadone treatment programs exert power and control over the individual by changing aspects of the medication (such as the dosage level) as punishment (for instance, Bourgois 2000). Such research suggests that therapeutic punishment exists in other methadone treatment programs across the United States, although I did not explore this issue in other methadone treatment programs in Philadelphia, so I do not know exactly how widespread this practice is.

The use of therapeutic punishment in both the drug court and the treatment programs was a further extension of the ambiguity of addiction as a disease. It could also be thought of as an extension of the stigma associated with being a drug addict, or a drug-using criminal. It is important to note, however, that there were some organizational
differences between the two settings in how they used therapeutic punishment. On one hand, it appeared that the “therapy” part of the court program was used as punishment, whereas punishment in the treatment programs restricted the clients’ access to therapy.

*Mutual Distrust*

The ambiguity around the definition of “addiction” used in the programs, as well as the use of therapeutic punishment, led to a general sense of distrust between the clients and the staff in the treatment programs and in the drug treatment court. While this distrust was likely produced initially by the social distance between the staff and the clients, and the stigma associated with substance abuse, it was further exacerbated by the use of therapeutic punishment and the reluctance to fully treat the clients as “diseased” patients.

The rules in the Southside and Westview programs, and the use of therapeutic punishment, imply that at some level the treatment programs do not fully trust the clients. They do not allow them to wait inside the clinic before being medicated or after group therapy; there are signs placed throughout the facility reminding the client that the clinic is not somewhere for them to “hang out.” Counselors would define the distrust they had toward clients often in terms of manipulation; they often perceived their clients as not telling the truth or trying to get something that they wanted without being completely honest:

*Wendy:* [The criminal justice clients] manipulate a lot, but it’s a lot different manipulation than the methadone clinic clients. These guys are a lot more…they’re a lot more clever. They have a lot more stories, a lot more excuses. [from interview]
Some of this distrust was institutionalized by the program:

George: And then I was buying methadone on the street. Like 80 milligrams a day. And I was like, this is nuts, cause I can go get on a program and get this stuff for free… And when I started, they were like, you’ve got methadone in your system. They thought I was trying to get a double dose, like I was on another clinic somewhere else. They called around and found out I wasn’t. But that’s what they thought at first.

Jerry: They do that with everyone who comes in with methadone in their system.

[from fieldnotes]

Jerry indicates that any client who had methadone in their system would receive extra scrutiny because they were suspected of lying to the clinic in order to be prescribed more of the medication.

In addition, counselors would report that the methadone clients were more difficult to work with than the Westview clients. They often labeled them as “whiny” or “childlike”:

Tom (talking about working with Southside versus Westview clients): .There are differences. But of course that’s my own, my own biases and schemas coming out with that because I definitely see the heroin addicts as more needy, more whiny, less functional. Um, they’re in constant need, in need of something or complaining about something that I think the other clients just are able to do and take care of and things like that. [from interview]

While the counselors revealed most of these feelings during our private interview, there were times during group sessions that counselors would communicate that distrust of the clients:

Jerry: Let me ask you this, Josh. If you could hack into the computer system and see when you were going to be tested, would you use when you knew you wouldn’t get caught?

Josh: No.

[from fieldnotes]
In this exchange, Jerry is implying that Josh would continue to use drugs if he knew that he would not get caught.

The staff in the drug court program also revealed a sense of distrust of the clients. Patrick, the court evaluator, mentioned that he perceived some of the clients to be less than completely honest about their drug problem, in order to get into the program. During court sessions, the judge also would communicate his suspicions that the clients might be lying about their drug-related activities.

Patrick also related the activities of the drug court clients to the high homicide rate in Philadelphia:

*Patrick:* I mean, if you’re dealing drugs, you are part of the problem, my friend. You are toxic on the streets of Philadelphia right now. These kids, these 15, 16-year old kids that are being gunned down are absolutely tied into drug wars and gang wars and nonsense like that. [from interview]

Distrust was a two-way street in these settings, with the clients also openly expressing distrust toward the program or specific staff. In this pre-IOP group meeting, the clients discuss their lack of confidence that the facility is giving them the correct methadone dose:

*Jackie [Southside group, white, age probably early 30s]:* Yeah, well, you know what could be goin on? I notice, and it’s only with certain nurses back there, that sometimes it just tastes like water. And it’s only with certain nurses. Like sometimes it tastes normal, but then sometimes it tastes like water and then I’m feeling sick by the end of the day. I’m just saying…it’s certain people. It’s not like it would be that hard to dump out half the bottle and fill it with water. Like I heard there was a nurse who was doing that and they got fired. And then like a week later they got hired back again.

*Wendy:* That wouldn’t happen (shaking her head). I can say that that’s definitely not true.

*Jackie:* Well, that’s what I heard.
Karl [African American, age ]: You know what, I can agree with what she’s sayin’. Cause I notice the same thing sometime. And they have the cups piled up and you can’t even see what they’re pouring out.

Jackie: Yeah, and sometimes they already have the cup there, even before you get up to the window.

Karl: Yeah!

Wendy: All of the medicine comes out of the same machine.

Jackie: But, you know it wouldn’t be that hard to take some. I think you should put up one of those cameras in there to watch them. You have them in the bathrooms watching us, so why not watch them?

Karl nods in agreement.

Wendy: Ok. I’ll bring it up at the next staff meeting. But I can’t guarantee anything. I can tell them what you’re telling me, but I don’t know what they’ll do.

Jackie: They won’t do anything.

[from fieldnotes]

I doubt that Wendy brought this concern up at the next staff meeting and it never came up in group again while I observed. While it is a rather far-fetched claim, it does demonstrate the level of distrust that the clients had of the facility in general. Other clients would question the counselors about information they were given:

Steven [Southside clinic, African American, age probably late 30s]: I need an increase [in methadone dosage]. But they said you didn’t put it in for me, Jerry.

Jerry: I did put it in.

Steven: Well, they said they didn’t get it. So they said you must not have put it in.

Jerry: The way it works is I put it in, I put the increase request in your chart. Then the doctor looks at it. Signs off on it and then it gets put into the system up front. So if it’s not up there, maybe the doctor hasn’t looked at it yet. Cause you were with me when I wrote it up. Then I put it in the chart. So, I’ll have to see if the doctor got it.

[from fieldnotes]

In this situation, Steven is concerned that Jerry did not put in a request for an increase in methadone, despite witnessing Jerry fill out the form during their individual session.

Again, this suggests a rather intense level of distrust between the client and his counselor.
Wendy also reported that she felt as though her court-mandated clients were “oppositional” to her:

*Wendy:* I’m just trying to work with these clients where they are right now. I…I don’t set the standards too high, don’t set them too low. I, I pretty much am very satisfied considering how frustrating it does get. I do have a lot of clients who are just oppositional. It doesn’t matter what I say, they just disagree. And, that is frustrating, but my expectations of where they are, I understand that that’s how they’re going to behave. [from interview]

Similarly, Jerry referred to the client’s distrust:

*Jerry:* And there’s always, in this program, I see that us versus them mentality, counselors versus patients. [from interview]

Wendy’s and Jerry’s comments suggest that this level of distrust hinders the actual treatment that should occur but also suggests that they do not view themselves as part of the problem.

The staff of the treatment court also intimated that the clients did not fully trust the court staff.

*Judge Gallo:* Many of these clients, and we do call them clients, by the way, are lacking in everyday living skills. They don’t understand being on time, they don’t understand picking up a phone and calling someone when you can’t be there, they don’t, they’re somewhat distrustful of the system, you kind of have to earn their respect. [from radio interview]

Much of this distrust seemed to be attached to a general distrust of public institutions, like the criminal justice system or the Department of Human Services. Research shows that African Americans have a higher level of distrust of institutions like the police, the legal system, and the medical profession than whites (Marschall and Shah 2007; Kennedy, Mathis and Woods 2007). Since the clients in these programs fit a similar demographic
profile to those in such studies, it is not surprising that they would also express distrust and resentment at these kinds of institutions.

In Westview, many of the clients who had been arrested for drug-related offenses would express resentment toward the police and the criminal justice system. One member claimed that he was framed by a police officer, while two group members recounted stories that the police tried to set up a situation to make it seem like they were snitching on their dealers when they were arrested for drug possession. Others would talk about the prison system specifically. For example:

_Steven_: Right. I’ve seen them, guys I know, go in and get tested. And if they had methadone in their system, they’d get sent right back. Right back to Graterford! That’s because it’s all about the money.

_George_: That’s right. It’s a big money maker up there. They just want to get you back in. That’s all they care about, is the money.

[from fieldnotes]

In addition to the criminal justice system, clients would often express distrust of the Department of Human Services (DHS); many had children removed from their custody by this institution:

[Amanda, a new group member, talks about just getting out of prison and how she wants to get custody back of her 7 year old son, who is living with Amanda’s older daughter. She is having trouble, however, because her daughter will not give up custody.]

_Amanda_: I just want to go get him.

_Karen_: No, don’t do that! That’s kidnapping. You’ll go right back to jail.

_Mark_: Go to 11th and Market [I can’t remember what is there that several group members offered as a possible resource for Amanda’s issue].

_Amanda_: Yeah, maybe I should go to DHS.

_Karen [expressing excited concern]_: No! You don’t want to go there! DHS… They’ll take him away from you _and_ her.

_Ruby_: And then they’ll go and take the grandson while they’re at it! [this is the only time I recall Ruby saying anything in group unless she was directly asked a question].

[from fieldnotes]
While it is not surprising, then, that these clients were also distrustful of the treatment programs, it is unfortunate that they draw such comparisons between the police force, for instance, and the counseling staff.

This mutual sense of distrust, then, is not likely a product of participating in these treatment programs, but rather an extension of clients’ distrust with public institutions in general and the court staff and counselors’ stereotypical expectations of behavior from drug-using individuals. The program staff were likely reacting to the pre-existing stigma associated with substance abuse, and the stereotypes around those living in poverty-stricken, largely African American neighborhoods. Counselors would admit that they often did not fully “understand” clients because of their different class backgrounds. One result of these perceptions was that the staff would make moral judgments about the client’s “choice” to use drugs in the first place. This implies that they initially view clients as somewhat irresponsible, even if they are a “product” of their environment. One counselor, Wendy, described this moral judgment that the treatment programs would make:

Wendy: We don’t teach them about addiction. We say, “good,” “bad,” “no,” “yes,” and we treat them like they’re in kindergarten instead of educating them about the consequences of it and the damage that it does.
[from interview]

Certainly, there were group sessions where the materials implied that there was something “bad” about those who used drugs. For instance, a worksheet in the “Surviving Addiction Workbook” used in Southside’s pre-IOP group asked clients to “Describe how alcohol/drugs affected your personality, and any of your character defects that could interfere with your recovery” [emphasis in original]. Similarly, the constant
reference to the client’s “lifestyle” as a problem in itself, in both the court setting as well as the treatment programs, was a moral judgment that the client was not living up to some objective standard.

Conclusion

Substance abuse treatment is often seen by liberal-minded individuals as the answer to America’s “drug problem.” In addition, support for the expansion of drug treatment courts nationwide often crosses party lines, because of the possible cost-saving benefits. Many justify this position by saying that addiction is a disease that needs to be treated just like any other. Recent polls also indicate that the public thinks we should place drug users in treatment, rather than in prisons. While those in the treatment community likely agree with that response, since they often stated that treatment programs are beneficial for drug-using individuals (even those they do not consider to be addicted to drugs), this chapter reveals that drug treatment programs do not necessarily have many of the characteristics we would typically associate with “medical” treatment. Instead, the stigma associated with using drugs is often present within, and perpetuated by, treatment programs. Interestingly, methadone maintenance, which is arguably the most “medicalized” way to deal with substance abuse, seems to have the worse stigma, since it carries an additional stigma from those within the treatment community. Before we advocate for more funding for treatment programs and the diversion of individuals from prison to treatment, we need to be confident that the treatment programs themselves are not simply replacing the harsh punishment of prison life with judgmental policies thinly disguised as “treatment.” My study only examines one treatment facility in a poor,
African American neighborhood, so I recognize that such infantilizing language and punishments might not be used elsewhere, and might become institutionalized because of the race and class of the clients there.
CHAPTER 7: 
CONCLUSION

This dissertation illustrates how the label of “addiction” in both treatment and criminal justice settings was ambiguously defined and also applied to not only drug use but a wider range of behaviors (such as selling drugs). This ambiguity, which often centered around the role that individual responsibility played in the development of the “disease,” led to the use of therapeutic punishment in both settings. This finding is perhaps not all that surprising, since the history of drug policy in the United States, especially since the beginning of the “war on drugs” in 1971, reveals an overlap of treatment and punishment in focus and funding in an attempt to fight this ongoing war. In this conclusion, I return to my original research questions and summarize my main research findings. I then reflect on how those findings relate to the medicalization of deviance thesis and the social construction of disease more broadly. I also discuss the limitations of this study.

Responding to My Research Questions

In the introduction to the dissertation (Chapter 1), I offered evidence that suggested that the general public views drug and alcohol addiction as a “disease” or “illness,” as shown in national polls from the past 20 years. On the surface, drug addiction has been medicalized to an extent, especially during the latter half of the 20th century, although it still carries with it a criminal status and often the moral condemnation of society. What is less known, however, is how this medical-legal-moral hybrid conceptualization of addiction plays out on a day-to-day basis in the institutions
that label and manage drug problems. I used a qualitative research methodology to examine how drug problems are characterized and managed in institutions that label individuals as drug “addicts.” I now turn to my primary research questions and summarize the main findings in each area.

How is Drug Addiction Conceptualized and Managed in a Criminal Justice Setting?

To answer this question, I observed the public sessions of Philadelphia’s drug treatment court program for six months, conducted interviews with several of its staff and clients, and examined related documents, including training materials from the annual meeting of the National Association of Drug Court Professionals. The drug treatment court provided a rich setting to explore this question because it is a criminal justice initiative that evaluates, recommends and directly supervises the client’s drug treatment during the course of the program, which often lasted longer than one year.

Any Drug Use is Drug Abuse

Cases deemed eligible for treatment court were most commonly those arrested for non-violent drug sales (possession with intent to deliver). The treatment court was responsible for evaluating the client’s addiction problem. The client’s diagnosis was largely based on self-reports and the client’s own admission that he/she needed and wanted drug treatment (and, by extension, the drug treatment court program). The frequency of use, or the negative consequences that would occur because of use, were recorded and perhaps used to frame the extent of the client’s addiction problem, but were not requirements for demonstrating that he/she had a problem or that he/she was eligible for the court program. Thus, any drug use could be conceptualized as “abuse” because of the illegal status of the substance. A client who reported smoking marijuana several times
a week would be sent to treatment for “marijuana abuse,” although a similar client who reported having several alcoholic drinks each week would likely not be labeled as having “alcohol abuse” unless he/she demonstrated other “symptoms.” The chief reasons that somebody entered treatment court, then, appeared to be the nature of his/her offense and that he/she reported any use of illegal substances. This tendency to conflate use and abuse helps to maintain the punitive/deviant aspects of using drugs, because the person who uses any amount of illegal drugs is labeled “deviant” in two ways - as a drug user and as having the illness of addiction.

*The Overlap of Legal and Medical Authority*

While each of the court staff (such as the judge, the public defender, the assistant district attorney, and the client’s case manager) had specific duties associated with his/her role in the court, all of the staff’s roles involved some sort of ambiguous overlap of legal and clinical elements. The structure of the case manager’s job was the most blatant overlap of legal and clinical roles, since he/she was responsible both for following up with the client’s treatment plan and whatever sanctions the court imposed. The other staff, however, also exhibited some overlapping roles. The judge could increase the “treatment” portion of the program, by ordering the client to move into a Recovery House or to attend a designated number of twelve-step meetings. Similarly, the court evaluator might recommend certain structured activities as part of the “treatment plan” if he viewed the client as having too much idle time. The public defender admitted that she would take the client’s clinical report into consideration when advising him/her on the legal options available in the case. Rather than the court dealing solely with the legal aspects of the case, including enforcing the client to be compliant with the required number of treatment
sessions and remaining drug-free, the court’s authority would extend into the clinical components, since it was ultimately the judge who decided if the client was “doing well” or not.

The ambiguity of these roles would occasionally lead to conflict in the court. Conflict mostly occurred when a client was facing expulsion from the program, either because of repeated non-compliance with the requirements of the program, for leaving treatment unannounced (going “AWOL”), or for being arrested for a new crime. In these instances, the public defender would cite the client’s addiction problem as the primary reason for the infraction and would most often ask the judge to give the client another chance, which could involve a more intense drug treatment program. She would raise the possibility of the client having undiagnosed mental health issues or a more severe addiction problem than previously thought. The assistant district attorney in these cases would focus on the client’s irresponsibility and seek termination. The judge struck some balance between these two positions, although at this stage would most likely concur with the assistant district attorney’s more punitive position. Thus, while the public defender minimized the client’s own responsibility because of his/her “illness,” the assistant district attorney (and often the judge) did not allow the client’s addiction problem to overshadow what they articulated as the client’s responsibility in the situation.

*Addiction is More than Just Using Drugs*

While any drug use could be defined as addiction (as long as the client professed that he/she had a problem and the court evaluator agreed), “addiction” was extended to a broader range of behaviors than just drug use. Addiction was openly discussed in the courtroom as a problem of the drug “lifestyle,” most often that of selling drugs. One
possible reason for this is that many of the clients might not actually be addicted to using
drugs, at least from a clinical perspective, and therefore the court needed to label some
other aspect of the client as “diseased” in order to legitimize the program. While clients
did not openly admit that they were not in fact addicted to using drugs during their
monthly court appearances, they would do so at graduation ceremonies (when there were
no real consequences for their “honesty”). However, through the initial speech he gave to
new clients entering the court program, the judge implied that addiction means something
more than just using drugs. In that speech he maintains that clients must admit that they
have a “problem” with drugs and/or alcohol, but he does not specify that the problem has
to be using drugs.

This extension of addiction to other behaviors is also related to the court’s focus
on what it sees as other treatable problems, like unemployment and under-education.
Once the treatment episode is over, the client continues his/her monthly appearances
before the judge, and the focus turns to the client becoming “responsible” in other areas
of his/her life. Of course, drug use is still paramount in the client progressing through the
program; a relapse at a later phase of the court program would result in the client having
to go back to the beginning of that phase. Still, once the client appeared to get his/her
drug “problem” under control and completed treatment, the judge would rarely bring up
issues of drug addiction. He would instead ask the client about employment, school, or
family issues. While it seemed as though the client was supposed to make some
designated progress in these areas, sanctions were not very common as long as the client
continued to test negative for drugs and to meet with his/her case manager as scheduled.
This reconstruction of addiction to mean other problems (what a sociologist might even consider to be “social problems”) also allowed the court staff to view the drug treatment court program as helping an underserved population access services that they needed to improve their life situation. In interviews, the court staff minimized the actual drug “problem” that the client might have; they framed the court program as a “second chance” at life. Clients also used similar language in describing the program at the graduation ceremony. Job-training programs, assistance with getting further education, parenting classes, and individual counseling are certainly much-needed services for those arrested (and for those in prison) if we want to reduce our recidivism rate. However, I find it problematic that these programs are only available to individuals who agree to go through what is described as a “drug treatment program” and to be continually monitored by the criminal justice system. Such a program furthers the notion that the underlying problems that led to the initial arrest (such as lack of decent jobs, access to education programs, family problems) are individual problems with individual, not structural, solutions. Furthermore, the criminal justice system’s success in creating a program that incorporates the widely held view that drug addiction is a “disease” that needs treatment, solidifies its position as the prime authority over those who use drugs and commit drug-related crime. They have convinced us that we do not need to change our drug laws; instead we can change how to deal with those who are arrested. The end result is that drug treatment courts, and similar criminal justice initiatives, become hegemonic means for dealing with drug users in the United States, and effectively silence the debate around other alternatives to dealing with drugs, such as harm reduction techniques or drug legalization. This position is also tied to the fact that we are the only nation that has
declared a “war” on drugs, and as long as we consider any use of drugs to be “abuse” of some sort, then our drug “problem” will always be significant.

*How is Drug Addiction Conceptualized and Managed in a Treatment Setting?*

To answer this question, I conducted observations and interviews at two outpatient drug treatment programs that operated within the same facility. One program was a methadone maintenance treatment program and the other was an intensive outpatient treatment program. I consider the methadone maintenance program as more “medicalized” because it uses what the treatment community refers to as the “medical model” of addiction and a pharmaceutical as the primary method of treating opiate addiction. The intensive outpatient program did not use pharmaceutical methods, but relied more heavily on group therapy sessions as part of treatment.

*The Ambiguity of Addiction*

Similar to Philadelphia’s drug treatment court, the definition of addiction that was articulated and promoted by the treatment programs was rather ambiguous. It included behaviors associated with drug use, such as selling drugs and the “thrill of the chase” of buying drugs, and also tied the causes of addiction to the social context of where the facility was located (in a poor neighborhood known for high levels of drug use and crime). Therefore, just as social problems became medicalized to an extent in the drug treatment court, these same issues (unemployment, lack of education, family problems) were often cited by the treatment staff as the causes of an individual’s addiction, and not the consequences of it. If a person had more problems in one of these areas (for instance, was unemployed), then they were also evaluated as needing additional treatment (such as intensive outpatient, level 1B, rather than ordinary outpatient, level 1A).
The treatment staff had rather different conceptualizations of drug addiction, although only one counselor openly dismissed the idea that addiction was a disease. All of the staff cited multiple possible reasons why a person would become an addict, often emphasizing genetics, mental health problems, and the individual’s social environment. The staff also did not convey a clear definition of addiction to the clients during group therapy sessions. Defining the causes of addiction did not seem to be related to treating addiction.

Abstinence as Both Requirement and Goal

Similar to the treatment court program, drug use was monitored by the treatment programs and abstinence was promoted. In order to “graduate” from the intensive outpatient program (IOP), a client would have to abstain from drug use for the last month of treatment. The methadone maintenance program did not have a structured time-frame and many clients would continue on the program indefinitely (sometimes for years). Abstinence was used as a reward mechanism in the methadone program for gaining additional privileges, like take-home doses of methadone. Unlike the treatment court program, however, relapse was not usually harshly sanctioned in either treatment program. Continued drug use at the beginning of treatment, or relapse after some time of abstinence, was considered quite normal in the treatment programs. While the lack of abstinence of other drugs led to further restrictions on taking home doses of methadone, continued drug use by itself did not lead to expulsion from the program. The judge was much more confrontational about continued drug use to clients in the treatment court program than any of the counselors I observed in the treatment programs.
Still, abstinence could be considered an indication that treatment was “working” for the client. On the other hand, if the client was unable to remain abstinent for an extended period of time, his/her continued drug use became a “symptom” of the disease of addiction and could lead to more intense treatment (such as inpatient care). In the treatment court setting, continued drug use could also be constructed (as it often was by the assistant district attorney) as evidence of the client’s irresponsibility and not as evidence of a more serious disease.

*Multiple Methods – Whatever Works*

The ambiguous definition of addiction that was articulated throughout the treatment programs could be related to the multiple treatment methods that are offered and encouraged in this setting. Group therapy, individual therapy, twelve-step methods, and methadone maintenance were all prevalent within these two treatment programs. At the same time, different methods could be used to support different conceptions of addiction. For instance, if a staff member subscribed to the brain disease theory, then I would expect him/her to promote the use of pharmaceuticals as part of treatment. Yet, even the staff that recognized some of the benefits of methadone maintenance treatment were very reluctant to it being used long-term and on its own. The program itself referred to methadone maintenance as a “last resort” for treatment, suggesting that there is something dangerous or, perhaps, even immoral about using it.

One method did not appear to be favored over another, either. Each one was mentioned as having properties that could help the addict. Even the counselor who was resistant to twelve-step methods was supportive of clients who found them useful. Some of the methods, when used together, resulted in conflict (such as the backlash from
twelve-step meeting attendees that many in the methadone program discussed). In an attempt to reconcile those differences, the clinic hosted a weekly meeting of “Methadone Anonymous,” although the strategy did not appear to be immediately successful, since many of the clients in the methadone program still expressed concerns about the stigma associated with methadone use, some of which was directly related to the program’s own policies about dispensing the medication.

**Consequences of Ambiguity: Stigma and Therapeutic Punishment**

The ambiguity surrounding the addiction label in both the treatment court and the treatment programs led to the persistence of the stigma associated with drug addiction and the use of therapeutic punishment in both settings. The clients in the more medicalized treatment modality, methadone maintenance, were actually more stigmatized than those in other forms of treatment, a finding that challenges those who contend that medicalization results in decreasing stigma. The treatment program was somewhat responsible for the persistence of that stigma due to its structuring of how medication was dispensed and take-home bottles were earned. I first considered that such stigmatization was related to our American cultural “ethic” of hard work, that is, taking methadone requires one not to work very hard at getting better. However, since American society has largely accepted pharmaceutical medication as the primary method of treating illnesses (and just about any other behavior that we consider to be deviant in some way), the way that methadone is stigmatized within the treatment community suggests evidence of a different phenomenon. One possible reason I came to believe is that since those most resistant to such medications are often the twelve-step community (medications like methadone violate their notion of abstinence), that the prevalence of twelve-step methods
and philosophy within treatment programs means that such resistance would already be institutionalized. Combining the criminal justice system with treatment also led to additional stigma, since those referred to treatment from the criminal justice system were in effect stigmatized twice – first as a criminal and then as “sick.”

Therapeutic punishment refers to the ways in which the addicts were sanctioned in both the treatment court and the treatment programs. While the programs viewed their responses as “helping” the clients become more responsible, the tactics were rather punitive in nature. Often, they used therapy itself as a form of punishment. For instance, in the court, a Recovery House was often used in response to rather severe violations, like continued drug use or missed treatment sessions. While the court viewed it as an additional form of therapy that the client needed, the client’s outward resistance suggested that he/she instead viewed it as something not much different from prison itself (because of its extremely strict structure and living arrangements)⁵⁹. In the methadone maintenance program, the medication became a tool for “leverage” that the program staff used to maintain control over the clients’ behavior. Violations of program rules resulted in changes in medication times or doses. Such methods led to clients often being distrustful of the staff in both programs, while the methods themselves seemed to be related to the staff members’ initial distrust of the clients, because of their “deviant” status as criminals, addicts, or both. This was also revealed in the images and language used to discuss clients by the court and the treatment programs (clients as dogs and child-

⁵⁹ As I mentioned in Chapter 3, I did complete interviews with a number of individuals in both treatment programs to understand the individual in treatment’s perspective on what I observed and his/her conception of addiction. I chose to not include a discussion of those interviews because the fieldnotes and other interviews I cite provide evidence to support my findings and these additional interviews did not contradict
like). Thus, just because we might label something as a “disease” and manage it in a clinical setting does not mean that we do not continue to also incorporate punishment into its treatment.

Evaluating the Medicalization of Deviance Thesis

The overwhelming public support that addiction should be viewed as a “disease,” and the development of clinical and pharmaceutical methods to treat it, are evidence that drug addiction has been medicalized over time. Still, this study challenges some of the key notions that Conrad and Schneider make about that medicalization process and its consequences. Specifically, my study challenges their notion that medicalization is a straight-forward process (either forward or backward), that medicalization leads toward a movement away from punitive methods of handling the issue, and that an individual is not found to be responsible if he/she is suffering from a “disease.” I will address each of these issues separately and then consider what this means for the social construction of disease categories in general.

One of the problems with Conrad’s medicalization thesis is that he often uses examples to illustrate a process of medicalization or demedicalization that suggests that these are the two opposite sides of a continuum, and that even if something was partially medicalized, that it was moving in one direction or the other. My research instead reveals that this medical-legal-moral hybrid way of defining and managing drug addiction could be a rather stagnant designation and is not necessarily moving in either

any of my findings or analysis. I did present a paper on these individual perspectives at the 2006 meetings of the American Sociological Association and plan on returning to them for future analysis.
direction of becoming more or less medicalized. Having this hybrid definition does not seem to produce much conflict at the institutional level, even though it produces a very ambiguous notion of what the causes of addiction are and who has the authority to manage it.

In addition, there are clear benefits to both institutions (the criminal justice system and the treatment establishment) of keeping this hybrid designation. Drug courts allow the criminal justice system to decrease its crowded caseload and prison population and at the same time successfully convince the public (and politicians of both political parties) that it is a beneficial program because it reduces recidivism and drug use of the arrestees, and therefore also saves the taxpayer money. As a result, treatment programs have a steady influx of clients referred from the criminal justice system, ensuring that they have a steady stream of income. Recent statistics show that those referred from the criminal justice system are the largest category of people in drug treatment programs, so it would seem that programs are reliant on those clients to keep themselves financially stable. This cooperation then suggests that even though it is labeled a “disease,” that the management of drug addiction can involve both the criminal justice system and the treatment establishment. While I do think that these benefits help prolong the relationship between the criminal justice system and treatment, I do not think that every individual involved in these institutions is actively trying to protect the hybrid designation because of these benefits. I do think that those working in both settings strongly believe that drug addiction requires treatment because it is a “disease” and that this is a more compassionate way to handle it. Still, it is quite remarkable how the criminal justice
system has managed to retain its control over an issue (drug use) in the context of increasing medicalization.

The third criticism of Conrad’s analysis that this dissertation offers involves the issue of responsibility when someone is labeled as having a “disease.” Conrad (and Parsons for that matter) contend that once a behavior is medicalized, that the person is not viewed as responsible anymore for having the disease (or punished for it). In both the court and the treatment programs, however, I illustrated the use of what I termed therapeutic punishment, which was very much tied to the idea of responsibility. Both the court and the treatment programs viewed individuals as responsible for being addicts: they chose to consume a substance that they knew could have negative consequences. This tied issues of self-control to responsibility and accountability for the drug problem. The client was instructed to simply stay away from “people, places and things” as part of treatment. While a temporary relapse to using drugs was considered quite normal, prolonged use instead was characterized as a marker of irresponsibility and perhaps not “trying” hard enough. This criticism is illuminated by a 2006 USA Today/HBO poll of family members of drug/alcohol addicts. In this survey, 76% of respondents indicated that “addiction is a disease.” Still, 82% of respondents indicated that “lacking willpower” was either a major or minor factor in their family member’s addiction, which had far greater support than the 60% indicating that genetics was a major or minor factor (USA Today 2006). So, even those who consider addiction to be a “disease” do not release the individual from being responsible for contracting the illness and for getting “better.”

This notion of responsibility for acquiring a disease, in addition to being responsible for treating it, is surely not limited to drug/alcohol addiction. Those with
diabetes, heart disease, and HIV/AIDS are all viewed as being somewhat responsible for their diseased state, except in rare instances (such as contracting HIV from a blood transfusion). Similarly, they are expected to follow a certain regimen of proper diet, exercise and medication to keep the illness under control. Still, drug addiction often carries with it an additional stigma because drugs are illegal and viewed as immoral in our society. If one looks at the plethora of anti-drug public service announcements from the last 70 years, you can find similar themes throughout, such as people who use drugs are “bad,” those who use drugs fund our foreign enemies, and drugs make people do things that “normal” people would not do. Such themes surrounding drugs in American culture are ingrained in movies, books, and television programs that include any reference to a drug user. In the same way that the court and the treatment programs conflate any drug use with abuse/addiction, our cultural messages about drug use tell us that any drug use is “bad” or “immoral.” These are designations that have not changed over time, nor do I expect that they will change in the near future, even if more people accept the idea that addiction is a brain disease. That people have to choose to consume drugs in the first place will always make them have a level of responsibility for their “disease” that the medicalization of deviance thesis minimizes.

Limitations

The major limitations of this dissertation are those that are common for qualitative research in general. While I demonstrated in Chapter 3 that the types of programs where I did research were the most common forms of treatment in both Pennsylvania and the United States, and that state licensing requirements standardize services to a large extent
across the state, I cannot generalize my findings to other outpatient treatment programs. The same is true for the drug treatment court. While there are a number of characteristics that all drug courts have in common, Philadelphia’s treatment court is likely to have some differences at the organizational level from other courts nationwide. Still, as a sociologist, I have to believe that human behavior is determined in large part by the social context in which we exist. For that reason, although my research methods do not permit me to generalize to larger populations, I would expect at least some of my analysis to apply to other treatment programs and drug treatment courts (especially those in urban areas), and by extension, to deepen our understanding of how addiction is labeled and managed by similar institutions.

There are several other limitations in this study that are not solely related to the type of research that I conducted. Two major court players, specifically Judge Gallo and the assistant district attorney, who were both present at every court session, declined to be interviewed for this project. While I do believe that the interview transcript I secured from an hour-long radio interview with the judge added significantly to my data, I recognize that I was not able to ask questions (and follow-up questions) specific to my project. The transient nature of some of the clients in the drug treatment programs also meant that my interviews with those in treatment were limited by only being able to speak with those who attended at least a couple of group sessions. These clients might have a different perspective on addiction and the treatment program than those who left very soon after beginning treatment.

My observations were also limited to group sessions in the treatment programs and the public sessions of the court. I was never permitted to observe in the “back stage”
of the courtroom, where the court team discussed “problem” clients before court started. In addition, I did not observe individual sessions between counselors and clients in the treatment program or in case management sessions. I do not consider this a major limitation, however, since the focus of my analysis is on the negotiation of addiction issues within the group and public court settings in order to understand the organizational set-up of the programs.

One important limitation to note is that I cannot be certain if I would have observed the same persistence of stigma and use of therapeutic punishment in treatment programs that cater to wealthier populations. There certainly seemed to be a mutual sense of distrust between the clients and the staff in both the court and the treatment programs because of obvious differences of race and class. The treatment staff also seemed to relate drug problems to characteristics of the surrounding neighborhood of the treatment facility, so I am not sure what would replace that conceptualization in a treatment facility located in a middle-class, white neighborhood (although treatment programs rarely exist in those locations).

While I should cite a similar limitation as far as the treatment court I observed, I do believe that the criminal status of the individuals involved would largely dictate how the court staff treated them. In addition, arrest statistics show that those arrested (and imprisoned) for the types of drug-related offenses that drug courts target are disproportionately of the lower class and racial minorities. Therefore, while I recognize I do not have data to support this, I think that there would be more similarities than differences among courts, even considering different locations (urban vs suburban vs rural).
One of the benefits of qualitative research is that the researcher is able to investigate deeply into the meanings of concepts and how those meanings are negotiated and shared in certain settings. Because that sort of investigation is laborious and takes a long time, the researcher often does not have the time, money or energy to include many sites in a research project. This study is also limited in scope because of the selection of only three sites for investigation. While the drug treatment court is the criminal justice initiative that has the most direct overlap of the criminal justice and treatment institutions, it would be presumptive to attempt to generalize my findings to the “criminal justice system” in general. Similarly, by only looking at outpatient drug treatment programs, even if they were similar to other programs in the city or the state, I cannot generalize to the “treatment establishment” in general. These were known limitations when I designed the research project. Since my focus was on understanding how “addiction” was defined and managed in specific settings, the method was the most appropriate for exploring the meanings of that concept.
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APPENDIX A. SAMPLE INTERVIEW GUIDE – TREATMENT COURT STAFF

[I would add/delete questions as they pertained to the person’s specific role in the court or treatment program. This is a sample questionnaire that I used with the public defender. All of the interviews I did were semi-structured, so the interview would often lead to questions that were not anticipated by the guide.]

1. What are your general job responsibilities? What does a typical day look like for you?

2. When did you start working in this position?

3. Did you ever work in any other jobs related to drug/alcohol treatment? For how long were you in each position? Why did you leave?

4. Can you go through the process for me of how somebody ends up in the treatment court program?
   a. At what stage do you meet with them initially?
   b. What is the evaluation process?
   c. What happens when “Commonwealth rejects”? [why would a person be there?]
   d. What happens if person does not want to enter tx court program? About what percentage of people that you encounter opt not to do the program?
   e. On Tuesdays, court coordinator often says “possible plea.” Does that mean they want the program? What do they have to do next?
   f. Court coordinator also says “No discovery.” What does that mean?
   g. What percentage do you think have private counsel?

5. When people are evaluated and sent to treatment, how do you determine which treatment program you are going to send them to? [any contracts with some? Location? Etc]

6. Do you have any kind of follow-up with the treatment program?

7. Do you meet with the clients outside of the day they appear in court?

8. Do you meet with treatment staff? How do you get updates about how the client is doing in treatment? How about updates about client meeting with case manager?
9. When a person is not doing what they are supposed to do (missing tx sessions, testing positive for drugs, etc), how do you decide what the appropriate sanction should be? [Group decision, who has the ultimate say? What happens when there are conflicting opinions?]

10. Do you meet with clients after they graduate from the program?

11. If you were designing a Drug/Alcohol treatment program and you had unlimited funds, what would that program look like? What kinds of things would you include?

12. Do you think the treatment court program is a good idea? Why? Is it the best way to handle these types of cases or could you think of an even better way?

13. Why do you think some people become alcoholics or drug addicts?

14. To what extent is a person’s alcohol or drug problem their own fault?

15. Do you think that alcohol or drug abuse is a disease or an illness?
   If yes: What makes it a disease? Can you compare it to any other diseases? Is it a genetic disease?
   If no: Some people think that it is a disease, do you think that they have it wrong?

16. Is there anything else that you would like to add, something that I didn’t ask about that you think I should have?

Thank you so much for talking to me today. [End of interview]
APPENDIX B. SAMPLE INTERVIEW GUIDE – TREATMENT PROGRAM STAFF

1. First, tell me the exact title of your position.

2. And what does that entail in a very general sense? What are your general job responsibilities? What would a typical day look like for you?

3. When did you start working in this position?

4. Did you ever work in any other jobs related to drug/alcohol treatment? For how long were you in each position? Why did you leave?

5. What kind of training have you had in terms of the work you do in this facility? [Probes: Any formal certification programs? Are there ongoing education/training sessions? Are these mandatory or voluntary?]

6. What is your educational background? Did you graduate from college? If so, what was your major?

7. (If went to college) Did you start working in the field of Alcohol/Drug treatment right after you graduated college? 
   If yes: So, about how long do you think you’ve been working in this field, in total?
   If no: What kinds of jobs did you have before starting to work in this field?

8. What was the first job that you had in the field of drug/alcohol treatment? 
   (If not current job) Where was that? What did you do? How long did you work there? Why did you leave?

9. Why did you start working in the field of alcohol/drug treatment? (If interested in “helping people,” why in this field rather than some other field where you could help people?)

10. How satisfied are you in your current job? Would you say that you are very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

11. (If very or somewhat satisfied) That’s great. It’s nice to like your job. What in particular do you like about your job?

12. (If very or somewhat dissatisfied) Why would you say that you are very/somewhat dissatisfied with your job? What don’t you like about it?

   [Probes: Is it something about the treatment facility? Is it something about the field of A/D treatment? What kind of job would the person like? Does the person plan on looking for a new job?]
13. Can you go through the process for me of how somebody ends up in the treatment program or the FIR program, or the IPP program?

14. If you were designing a Drug/Alcohol treatment program and you had unlimited funds, what would that program look like? What kinds of things would you include?

15. Why do you think some people become alcoholics or drug addicts?

16. To what extent is a person’s alcohol or drug problem their own fault?

17. For people who are arrested for drug-related offenses. What is the best way to handle those cases, in your opinion? Should the person go to jail? Go to treatment? Some combination of the two (i.e., treatment in prison)?

18. Are there any drugs that you think should be decriminalized? Do you think there are any drugs that are legal now that should actually be illegal?

19. Do you think that alcohol or drug abuse is a disease or an illness?
   \[\textbf{If yes:}\] What makes it a disease? Can you compare it to any other diseases? Is it a genetic disease?
   \[\textbf{If no:}\] Some people think that it is a disease, do you think that they have it wrong?

20. Is there anything else that you would like to add, something that I didn’t ask about that you think I should have?

Thank you so much for talking to me today. [End of interview]
APPENDIX C. SAMPLE INTERVIEW GUIDE – TREATMENT PROGRAM CLIENT

Thank you for agreeing to talk with me today. I’d like to ask you some questions about your experiences in this treatment facility and other types of treatment you may have had in the past. Just as a reminder, your responses are completely confidential. There will be no record of your name with your responses and this information will not be released to this treatment center or anywhere else.

1. When did you begin treatment at this facility?

2. Can you tell me about the events that led up to you coming into treatment here.

   [Probe: What was the process of entering treatment? (Encouragement from family, friends, criminal justice system, social worker, etc)]

3. What drug or drugs are you in treatment for?
   How long have you been using these substances?

4. When you started treatment here, did you undergo some sort of initial evaluation?

   [Probe: If says “not sure,” did you fill out any sort of questionnaires, were you interviewed by someone who worked here about your past medical and drug use history?]

   **If yes**: What did that evaluation involve?
   **If no**: Did you receive any kind of evaluation elsewhere before coming here (maybe from another treatment center or from the courts)?

5. Did you receive a diagnosis concerning your alcohol/drug problem during this evaluation or at the beginning of your treatment here?

   [Probe: If person is unaware what this means, explain how some people might have their alcohol or drug problems diagnosed by a doctor or clinician as “abuse” or “dependence.”]

6. And why did you come to this facility, rather than some other facility?

   [Probe: Whose decision was it ultimately (insurance company, family member, judge, etc)?]
   [Probe: What were the features of the facility that attracted you (location, been here before, recommended by family member/friend, etc)?]
7. (If not answered in above question), why did you choose this type of treatment or level of care (Inpatient, Intensive Outpatient, Outpatient, Methadone Maintenance, etc.), rather than some other type?

8. Are you currently receiving any medications as part of alcohol/drug treatment?
   
   **If yes**, what medications specifically are you being prescribed and/or taking? What are these meds for?

   **If no**, did you ever receive medication as part of alcohol/drug treatment?

9. Have you ever had any other formal treatment in a facility before?
   
   [Probes: How many times? When? For how long? Where? What type of program was it?]

   (If multiple treatment experiences, go through each one separately and find out the type of program, the duration of the program, when that experience occurred, whether or not the person completed the program, general opinion of program)

10. How about Alcoholics Anonymous or Cocaine Anonymous or Narcotics Anonymous? Did you ever attend those types of meetings in the past?

11. Do you currently attend any of these types of meetings?
   
   [Probes: Why or why not? Are you encouraged to do so? If so, by whom? Are you resistant to those types of meetings? If so, why?]

12. How about other 12-step meetings, like Al-Anon or Gamblers Anonymous or Codependents Anonymous or Debtors Anonymous? Did you ever attend any of these types of meetings?

13. What about any other type of public group meeting for alcohol or drug problems? Did you ever attend any meeting of that nature? (Not 12-step but still have A/D tx as focus: i.e., Rational Recovery, Secular Sobriety meetings, etc.)

14. Tell me about your experiences in treatment here. How are you finding this treatment facility? What do you like about this treatment facility?

15. What don’t you like about this treatment facility or what would you change if you could?

16. What do you hope to get out of your experience in treatment here? Are there “goals” that you have set for yourself or that you’ve set with the help of a counselor/therapist?
17. Ok, let’s go through your activities at this facility. How often do you come here? For how long each time? What do you do here (groups, individual sessions, meetings with doctors, etc)?

18. Do you ever do any 12-step related things in treatment here at this facility?

[Probe: If group therapy, do you ever say the serenity prayer during group? Do you work on “steps” as part of treatment?]

Now I want to go back and ask you some more specific questions about your alcohol/drug use.

19. I am going to list some people and I want you to tell me whether or not you ever discussed your alcohol/drug use with any of them.

   a. Did you ever discuss your alcohol/drug problem with a doctor?
      If so, what did he/she say about it? What advice did he/she give?

   b. …with a family member?
      If so, what did he/she say?

   c. …with a close friend?
      If so, what did he/she say?

   d. …with a co-worker?
      If so, what did he/she say?

   e. …with a psychologist or psychiatrist?
      If so, what did he/she say?

20. (If not revealed in responses to any of previous questions) Are you in treatment because you feel that your drug/alcohol use had gotten out of control?

   Did you feel like you might have a drug/alcohol problem? (If no, skip to question 24)

21. (If patient feels that he/she has a problem) How did you know you had a problem?

   [Probe: Did somebody tell you that you had a problem or did you think so on your own?]

22. When does alcohol use become a problem? When does drug use become a problem?

   Is this for anybody, or just you?
23. (If patient feels that he/she has a problem) Why do you think that you developed a drug/alcohol problem?

[Probe: Do you think your problem is different from other people’s drug or alcohol problems? If yes, how is it different? If no, why is it not different?]

24. (If patient feels that he/she has a problem) Do any of your family members have problems with alcohol or drugs?

If yes, do you think this might have something to do with your own problem?

25. (If patient does not think that he/she has a problem) Do you think that your alcohol or drug use could ever escalate into you having a drug/alcohol problem?

If yes: At what point could that happen? Did that ever happen in the past?
If no: Why not? Why are alcohol and drugs not a problem for you? Do you think that they are a problem for some people? Why might they be a problem for some people but not for you?

26. Do you have any family members or close friends who think that using alcohol or drugs is bad?

27. Would you say that you are or ever have been an alcoholic or a drug addict?

28. What does it mean to be an alcoholic or an addict?

29. Why do you think that some people become drug addicts or alcoholics?

30. If somebody is an alcoholic or a drug addict, do you think that it is probably their own fault?

[Probe: Is it always their fault? Sometimes? When is it their own fault? When might it not be their own fault?]

31. Would you say that alcoholism or drug addiction is a disease or an illness?

If yes: Why? What makes it a disease? Can you compare it to any other diseases?
If no: Why not? There are a lot of people that think it is a disease, do you think that they have it wrong?

Well, that’s all the questions I have. Thank you so much. I’ve really enjoyed talking to you today. If I think of any other questions that I would like to ask you, would you mind talking to me again for a little bit?  [End of Interview]