
EFFECTIVE ALCOHOL TREATMENT IN DWI COURT: DOING THE RIGHT THING, IN THE RIGHT WAY

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The alcoholism and other drug addiction treatment field is in the midst of an “identity crisis”. Psychologist Erick Erikson coined this phrase when describing the years during which teenagers begin to question who they are and where they fit. It has been more than 200 years since the term “alcoholism” first appeared in print and at least 140 years since the first sanitariums to treat “inebriates” surfaced. Nonetheless, arguably, the treatment field is still in its adolescence. Thankfully, the field is no longer in its infancy as it may have been when Morality Model proponents concluded that personal choice and moral weakness were the main causes of alcohol problems. The field has grown beyond its toddler years when advocates of the Temperance Model taught that alcohol was a substance to be avoided by all, leading to 1920s-era Prohibition. And while some might argue to the contrary, the treatment field is no longer analogous to a pre-adolescent as it might have been when the American Disease Concept Model took hold and Alcoholics Anonymous took its nascent steps in the 1930s.

The progress toward a more sophisticated “grown-up” view of alcohol-related treatment notwithstanding, the contemporary addiction treatment field struggles today as stakeholders like judges, researchers, neuroscientists, pharmaceutical companies, insurers, and consumer advocacy groups question what we have assumed regarding treatment outcomes, efficacy, and effectiveness. New terms such as “best practices”, “expert consensus”, “manual-based interventions”, and of course, “evidence-based practices” are commonplace. This paradigm shift toward science-based, outcome-oriented alcohol treatment has led to an identity crisis in many addiction professionals who are astute enough to notice the shift. Under the lens of the microscope everything is questioned and much has turned out to be questionable. Some of what we thought we knew about what works in treatment, which treatments work, and even the essence of treatment itself has been called into question. Some of our long treasured approaches are falling short under the scrutiny of increasingly rigorous scientific examination.

That we no longer have to rely on knowledge that is based largely on tradition, belief, or anecdotal evidence is welcome to most in the field. However the implications for treatment systems in general and DWI Courts in particular are significant and potentially unsettling. To increase effectiveness, some programs will need to discard approaches that have not been proven effective and replace them with those that have. These are strong words that suggest the need for bold action. The evidence is becoming increasingly clear. Treatment works, but not always. Alcoholism and other drug addiction treatment is the right thing to do, but to be effective it must be done in the right way.

EVIDENCE-BASED TREATMENT APPROACHES

There are at least three major recent studies that shed light on how best to treat individuals with alcohol-related problems: Project MATCH¹, the UK Alcohol Treatment Trials (UKATT) and the COMBINE² Study. All three studies involved the use of large randomized clinical trials. A fourth study, the on-going Mesa Grande Project, represents a massive undertaking by William Miller and Paula Wilbourne that includes a meta-analysis of at least 361 clinical trials of treatment for alcohol use disorders. Considered collectively, these four studies represent what evidence shows about effective alcohol-related treatment. Here is some of what is known.

1. **COGNITIVE BEHAVIORAL** approaches are among the most effective approaches for the treatment of alcohol-related disorders.³ Proponents of these approaches postulate that substance use is a learned behavior that is both triggered and reinforced by internal and external factors, including situations and cognitions. Effective interventions within this approach include, for example, behavior contracting, social coping skills training, and relapse prevention therapy.⁴ One such approach, Moral Reconciliation Therapy (MRT®), is an evidence-based treatment with longitudinal outcome research published over 20 years in professional journals. The National Drug Court

¹ Project Matching Alcohol Treatment to Client Heterogeneity (Project MATCH)

² Combining Medications and Behavioral Interventions for Alcoholism (The COMBINE Study)

³ Taxman, F.S. (1999). Unraveling “What works” for offenders in substance abuse treatment services. *National Drug Court Institute Review*, 2(2): 93-134.

⁴ Larimer, M.E., Palmer, R. S. & Marlatt, G. A. (1999). Relapse prevention: An overview of Marlatt’s cognitive-behavioral model. *Alcohol Research & Health*, 23, 151-160.

- Institute in 2005 cited MRT as proven to reduce recidivism in DWI Courts. In May 2008, MRT was selected for inclusion on the National Registry of Evidence-Based Programs and Practices (NREPP) sponsored by SAMHSA in mental health treatment, substance abuse treatment, and co-occurring disorders. The research has demonstrated in multiple settings the efficacy of MRT treatment in Corrections, Drug Courts, and other settings.
2. Similarly, the **COMMUNITY REINFORCEMENT APPROACH (CRA)** has consistently been rated as among the most effective interventions.⁵ Based on the tenets of Operant Conditioning, this approach systematically increases the availability and desirability of substance-free activities to provide alternatives to drinking. CRA utilizes both natural and contrived reinforcers and frequently includes “vouchers”, which are tangible rewards in response to abstinence and/or related behaviors. CRA is the most researched contingency management strategy and has demonstrated positive results for more than thirty years. Combined with the supervised administration of disulfiram (Antabuse), CRA has been found to be especially effective when used to treat those in outpatient treatment.⁶
 3. **MOTIVATIONAL INTERVIEWING (MI)** has been found to be among the more clinically and cost effective approaches.⁷ MI is an approach that utilizes reflections, empathy, resistance, change-supportive client statements, and other techniques to prepare people to change addictive and other behaviors. MI has been found to be especially beneficial for those with low to moderate alcohol dependence; those with high levels of anger at treatment entry; and young people with occasional heavy drinking patterns. For those with more severe dependence, MI was found to be effective as a prelude or adjunct to other treatment modalities, but not as a stand-alone treatment.⁸

⁵ Hunt, G. M., & Azrin, N. H. (1973). A community reinforcement approach to alcoholism. *Behaviour Research and Therapy*, 11, 91-104.

⁶ Azrin, N. H., Sisson, R. W., Meyers, R., & Godley, M. (1982). Alcoholism treatment by disulfiram and community reinforcement therapy. *Journal of Behavior Therapy and Experimental Psychiatry*, 13, 105-112.

⁷ Burke, B. L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology*, 71, 843-861.

⁸ Vasilaki, E. I. & Cox, W. M. (2006). The efficacy of motivational interviewing as a brief intervention for excessive drinking: A met-analytic review. *Alcohol*, 41 (3): 328-335.

Motivational Enhancement Therapy (MET) is a manual-guided MI application that was found to be effective in the landmark Project MATCH study.⁹

4. **BRIEF INTERVENTIONS** that included five or fewer sessions have sometimes been found to be effective when compared with much longer and more elaborate interventions. Brief interventions often include behavioral feedback, simple structured advice, and/or motivational counseling. In the Mesa Grande Project, brief interventions were rated as the most effective approach.¹⁰ These positive effects were found for up to two and perhaps as long as four years. It is noteworthy, however, that these interventions, which are often delivered in conjunction with primary medical care, were effective with those who were considered hazardous or harmful drinkers. There is little evidence that they are sufficient for individuals with more severe alcohol problems or alcohol dependence.
5. **BEHAVIORAL COUPLES THERAPY (BCT)** has been found to be effective in the Mesa Grande Project and other studies.¹¹ BCT is based on the assumption that problematic alcohol use and relationship functioning are intrinsically linked for couples. This approach seeks to engage both partners in therapy, achieve abstinence, and improve relationship functioning. These gains are sought through a limited number of structured sessions, as opposed to traditional marital therapy, which can sometimes be less structured and more open ended.
6. **PHARMACOLOGICAL TREATMENT** as an adjunct to psychosocial treatment or in conjunction with structured medical management sessions has been found to be effective.¹² The COMBINE Study found that for those with severe alcohol dependence the use of naltrexone in combination with medical management sessions delivered by health care professionals was at least as effective as typical evidence-based psychosocial interventions. Acamprosate has not

⁹ Project MATCH Research Group. (1999). Summary of Project MATCH. *Addiction*, 88, 1369-1375.

¹⁰ Kaner, E., Beyer, F., Dickinson, H., Pienaar, E. Campbell, F., Schlesinger, C., et al. (2007). Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews*, Issue 2.

¹¹ Powers, M. B., Vedel, E., & Emmelkamp, P. M. G. (2008). Behavioral couples therapy (BCT) for alcohol and drug use disorders: A meta-analysis. *Clinical Psychology Review*, 28, 952-962.

¹² Omalley, S. S., & Carroll, K. M. (1996). Psychotherapeutic considerations in pharmacological trials. *Alcoholism: Clinical and Experimental Research*, 20(7 Suppl), 17A-22A.

been found to be effective in major U.S. studies, including the COMBINE study.¹³ However it has been found to be effective in European studies.^{14 15} The reasons for the differences in U.S. versus European study results are not clear.

COMMUNITY SUPPORT OPTIONS

Notably absent from the list of evidence based practices is Alcoholics Anonymous (AA) participation. Because AA is not professional treatment it was not included in many of the clinical trials referenced. However the Mesa Grande Project analyzed the seven studies that sought to determine the effectiveness of AA for those in treatment. These studies did not find AA to be effective for those in treatment when compared to other interventions. (There are other studies that demonstrate improved results with the inclusion of AA or other mutual-help groups. However most of these studies are limited and generally involve less rigorous research designs). If there is a single instance where scientific findings appear to fly squarely in the face of conventional wisdom, this is it. Regarding the effectiveness of Alcoholics Anonymous for those in treatment, the evidence suggests the following:

1. AA appears to be effective for those who are most suited for it, but not all find this approach useful or acceptable.¹⁶
2. Those who attend meetings regularly have better outcomes.
3. The inclusion of the evidence-based approach, Twelve Step Facilitation (TSF), appears to increase the usefulness of AA for those in treatment. TSF was found to be as effective as CBT and MET in the Project MATCH study.

¹³ Anton, R. F., O'Malley, S. S., Ciraulo, D. A., Cisler, R. A., Couper, D., Donovan, D. M., et al. (2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: The COMBINE study: A randomized controlled trial. *JAMA*, 295. 2003-2017.

¹⁴ UKATT Research Team 2005a, Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). *BMJ* 331: 331-541.

¹⁵ Bouza, C., Magro, A., Munoz, A. *et al.* (2004) Efficacy and safety of naltrexone and acamprosate in the treatment of alcohol dependence: a systematic review. *Addiction* 99, 811-828.

¹⁶ Kaskuta, P. H. (2009). Alcoholics anonymous effectiveness: Faith meets science. *Journal of Addictive Disorders*, 28 (2): 145-157.

(TSF is a manual-guided program for introducing participants to the first four of the twelve steps and the twelve step fellowships.)

4. Coerced AA attendance has not demonstrated effectiveness. In fact, the few studies that have examined coerced participation have found it to be ineffective. Most of the AA-related studies analyzed in the Mesa Grande Project included primarily individuals who were mandated to attend AA by court order.¹⁷ (These are the studies where AA participation fared especially poorly.) While coerced *treatment* has been found effective in other studies, evidence does not yet indicate the same for mandated Alcoholics Anonymous attendance.¹⁸

In addition to the findings regarding mandated Alcoholics Anonymous participation, other common practices that have not been found to be effective in treating alcohol problems include, but are not limited to: generic counseling, alcohol and other drug education, confrontational interventions (intended to shatter denial), and psychodynamic therapy (e.g. focusing on the family of origin and subconscious drives). Even some of the approaches that have demonstrated some success in other populations are not yet supported by a strong evidence base, particularly in the field of alcohol treatment. These approaches include, for instance, solution focused therapy, guided meditation¹⁹, and acupuncture.

NEXT STEPS

The implications for DWI courts are significant.

¹⁷ Miller, W. R., & Wilbourne, P. L. (2002). Mesa grande: A methodological analysis of clinical trials for alcohol use disorders. *Addiction*, 97(3), 265-277.

¹⁸ Speiglmán, R. (2006) Mandated AA attendance for recidivist drinking drivers: policy issues. *Addiction* 92 (9), 1133-1136.

¹⁹ Mindfulness Based Relapse Prevention (MBRP), which incorporates Vipassana (or “insight”) meditation, was found to be effective in reducing substance use rates among an incarcerated population. [Bowen, et al. (2006). Mindfulness meditation and substance use in an incarcerated population. *Psychology of Addictive Behaviors*, 20, 343-347.] Further research showing success will be required before MBRP can be considered “evidence-based”.

1. Programs are encouraged to identify evidence based practices and adopt these practices as the foundation of their treatment interventions. No single approach is effective for all programs or participants. Fortunately, there are a range of evidence based practices from which to choose. The federal government’s National Registry of Evidence-based Programs and Practices is a recommended resource for identifying these practices. This registry can be accessed at: www.nrepp.samhsa.gov.
2. DWI courts that service alcohol dependent individuals should seek to incorporate medication-assisted treatment—primarily naltrexone and perhaps acamprosate. Monitored administration of disulfiram (Antabuse) may also be considered especially when delivered as a component of the Community Reinforcement Approach.
3. Programs that incorporate Alcoholics Anonymous or other mutual aid groups, as most DWI courts do, should consider incorporating Twelve Step Facilitation (TSF) into their treatment component. Programs are encouraged to review the evidence involving the ineffectiveness of mandating AA. Alternatives to mandating AA attendance may need to be adopted, such as providing incentives for participation in AA, as opposed to mandating it; determining which participants are most amenable to and/or suitable for AA; and offering choices that include other types of mutual support programming in addition to AA or other 12-step groups. Finally, there is solid legal precedent establishing that programs must not penalize or deny participation to individuals who refuse to attend 12-step groups because of religious content (e.g. prayers, references to “God” in 12 steps). For such individuals, comparable secular alternatives must be offered.
4. For most DWI courts participants, abstinence is the desired outcome. An alcohol abstinence treatment goal is appropriate for participants whose alcohol dependence, age, and/or criminal misconduct justify it. DWI courts are most appropriate for drinking drivers who are alcohol dependent.²⁰ However, if a particular program includes individuals who are not dependent or others for whom a goal of moderate drinking may be appropriate, then incorporating evidence-based controlled drinking approaches such as Behavioral Self-Control Training (BSCT) is recommended.

²⁰ *The Ten Guiding Principles of DWI Courts*. National Center for DWI Courts.
http://www.dwicourts.org/sites/default/files/nadcp/Guiding_Principles_of_DWI_Court.pdf

5. In all likelihood abstinence will remain the desired goal for those participating in most DWI courts, rendering BSCT inappropriate. However, if a program chooses to include participants who are not alcoholics, evidence says that abstinence is often achievable through evidence-based *brief* interventions, as opposed to more extensive and costly ones.

Admittedly, not finding an approach effective isn't the same as proving that approach ineffective. Poor documentation of interventions and the lack of consistent implementation may explain why some treasured approaches have failed to withstand the scrutiny of research. However, under repeated examination, some treatment approaches are found to be effective consistently, while others are not. Practitioners and programs that persist in using those approaches that haven't been found to be effective, especially in the absence of those that have, are engaging in questionable practices at best.

Some of what has been discovered and discussed in this article may have challenged personal beliefs and long-standing professional practices. Some who, like this writer, are staunch advocates for Alcoholics Anonymous and other mutual support groups are especially taken aback by the finding regarding mandated AA participation. However, this and other findings are best viewed not as an indictment of past practices, but as an opportunity to adjust current practices to match current knowledge. In many respects, this is precisely what we expect from our participants. We should expect no less from ourselves.