Federal Probation

DECEMBER 1992

Federal Probation

A JOURNAL OF CORRECTIONAL PHILOSOPHY AND PRACTICE

Published by the Administrative Office of the United States Courts

VOLUME LVI DECEMBER 1992 NUMBER 4

This Issue in Brief

Euphoria on the Rocks: Understanding Crack Addiction.—A certain mystique surrounds crack cocaine and makes supervision of crack addicts a real challenge for even the most seasoned probation officer. Stressing the importance of knowing the facts about this drug, author Edward M. Read focuses on helping the officer understand the drug itself, the dynamics of addiction to it, and how to assess a person's dependence on it.

The Costs and Effects of Intensive Supervision for Drug Offenders.—Authors Joan Petersilia, Susan Turner, and Elizabeth Piper Deschenes report the results of a randomized field experiment testing the effects of an intensive supervision probation/parole project for drug-involved offenders. Among the findings were that intensive supervision apparently did not affect drug use, did not reduce recidivism, and cost more than routine supervision.

A Day in the Life of a Federal Probation Officer—Revisited.—Six United States probation officers update an article published in *Federal Probation* more than 20 years ago by describing what might come up in a typical workday. The authors—E. Jane Pierson, Thomas L. Densmore, John M. Shevlin, Omar Madruga, Jay F. Meyer, and Terry D. Childers—all of whom serve in specialist positions—offer commentaries about their work that range from philosophical to highly creative.

Personality Types of Probation Officers.—Are there personality characteristics common to probation officers? Authors Richard D. Sluder and Robert A. Shearer address the question, reporting findings from a study of 202 probation officers using the Myers-Briggs Type Indicator (MBTI). The authors discuss the patterns of MBTI personality characteristics among the officers studied, reviewing the strengths and potential weaknesses of the personality types.

When Do Probation and Parole Officers Enjoy the Same Immunity as Judges?—Authors Mark Jones and Rolando V. del Carmen examine the types of defenses a probation or parole officer enjoys in civil liability suits, focusing on the concepts of absolute, quasi-judicial, and qualified immunity. The authors

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Euphoria on the Rocks: Understanding Crack Addiction

By Edward M. Read
United States Probation Officer, District of Columbia

SUPERVISION OF today's crack addict presents a daunting challenge to even the most seasoned probation officer. Crack cocaine will undeniably remain a powerful force in the 1990's. Unfortunately, this drug has also taken on an aura of enigmatic proportions. Crack is relatively new to the streets, having appeared on the scene in the mid-1980's. Research and conventional wisdom about cocaine in general has undergone tremendous shifts in recent years, only further complicating the supervision process. Richard Ashley wrote as recently as 1975 that "there appears no good reason and even less evidence to suggest that cocaine is an especially dangerous drug" (1975). But crack cocaine? Not so at all. It is powerfully addictive, reasonably cheap to buy in small quantities, and destroys lives at an alarming rate.

Probation officers are not alone in their desperation. The crack cocaine problem confounds experienced treatment professionals as well. Put simply, crack addiction *seems* to defy all logic. This is especially so to those who have unwittingly or otherwise remained ignorant of its distinct chemical properties, impact on brain functioning, and disease process. Probation officers watch their clients "hit the pipe" and smoke away their freedom. They watch rational behavior and thought patterns vanish. Suspicion lingers that crack addicts are somehow different than alcoholics or other addicts. But are they really? What is it with this drug? Officers end up confused, frustrated, and angry. Why can't they just stop? Why always "just one more rock"?

This article will unveil the shroud of mystique that surrounds crack cocaine. Unless crack addiction is understood for what it is, and unless this understanding evolves into a factual knowledge basis, probation officers working with its victims will increasingly "burn out." Frustration will lead to more and more cynicism, resulting in unnecessary negative fallout for all concerned. The focus here will be to help the supervising officer understand the drug itself, the dynamics of addiction to it, and how to better assess a person's dependency on it. A concluding section will introduce the concept of "empathic supervision," argued as the most effective way to reasonably approach both client accountability mandates *and* positive supervision outcome.

"Toot," "Base," and "Crack": Keeping Them Straight

"Toot" is cocaine hydrochloride. Known also as "snow," "snort," "blow," and "the lady," this is the white crystalline powder that so infatuated Sigmund Freud during the late 1880's (Hafen & Soulier, 1989), as well as the young and upwardly mobile during the 1970's. It is sold on the illicit market for $75 to $100 a gram with purities ranging from 10 to 75 percent. A gram is approximately the amount of substance contained in a typical artificial sweetener packet: not much. An "eighth" or an "eight ball" is an eighth of an ounce, or 3½ grams. Snorting cocaine is by far the most popular form of ingestion, mostly because of the erroneous belief that it is relatively nonaddicting and self-limiting. Dependency simply develops over a longer period of time, and as written by Washton (1989, p. 13), "While proportionately fewer intranasal users probably end up addicted as compared to IV users or freebase smokers, the majority of cocaine addicts are snorters." Most crack addicts start out snorting cocaine hydrochloride before moving on to crack. Curiously enough, snorting cocaine has often been described as a "learned experience." The high is subtle, the euphoria very discreet. It takes about 5 minutes before the user will feel the effects, and the high itself will last only about 20 to 30 minutes.

Cocaine hydrochloride is soluble in water and can also be injected intravenously. Ingested in this way, the euphoria becomes much more pronounced and similar to the effects outlined below for both "base" and crack. A "speedball" is a common street term used to describe the mixing of heroin and cocaine within the same solution.

"Base" is short for "freebasing." Cocaine powder is next to impossible to smoke outright, although some do sprinkle powder on cigarettes or marijuana joints. In reality this is a waste; most of it decomposes before it reaches the lungs. Efficiency dictates a better preparation process. And this involves "freeing" the basic cocaine alkaloid from its hydrochloride "base" via a simple chemical conversion procedure using ether, water, and heat. Much of the cocaine is lost through the condensation process, so people must use larger quantities of cocaine to produce a dose of freebase. There is an informal status system which places freebase smokers above crack users. Freebasing is costlier, involves more of a ritual, and therefore holds more status on the street.

"Crack" is nothing more than ready-made "freebase," perhaps best described as a fast-food version. To the unfamiliar eye, it resembles ivory-colored soap shavings and has the texture of porcelain. Instead of ether, common baking soda can be used in the simple conversion process. Sometimes the rocky flakes are sprinkled

on marijuana or tobacco cigarettes. However, more commonly it is smoked in a glass water pipe. Mixing crack "rocks" with PCP is called "spacebasing," an obviously dangerous combination. Make no mistake, crack and freebase are the same drug: cocaine. There will be no distinction on a urinalysis lab report. By comparison, look at it in terms of our most beloved and legal central nervous system stimulant, caffeine. If cocaine powder is regular coffee, freebase might be espresso. And crack would be instant espresso: no expensive "process," just add water and enjoy. All of it is coffee, just three different types with increasing potency.

Wallace (1991, p. 8) described the introduction of crack to the United States as a "packaging and marketing breakthrough." Indeed it was. Crack cocaine revolutionized the availability and cost-prohibitiveness of cocaine powder. Instead of having to come up with nearly $100 for a gram of coke, obviously difficult for mainstream America to afford, not to mention inner-city youth, today a person can purchase a "rock" or two for as little as $5 to $20. This will buy several minutes of intense escape. It is the ideal "quick fix" for an America infatuated with immediate gratification and easily marketable solutions. But what is the payoff? What is it really like?

Inhaling the Ecstasy...And Paying Its Price

Just imagine..."euphoria on the rocks." Not from the bottle of cheap street wine but all within a mere 8 seconds of putting down "the pipe." The "rock" will crackle as the butane flame hits the screen, the vapors are released, and the lungs are charged. No worries, no problems, nothing but good feeling—all over. There is virtually no time lapse. The high is immediate. Users passionately describe it as the most intense high one could experience. Here is one person's rendition:

> The intensity of it was just so enormous, and I couldn't believe the rush. It was similar if not better than the rush we received from shooting it but you didn't have to put the holes in your arms. . . . The sensation starts in your head and goes down through your body. . . . It's very similar to an orgasm, the intensity of it (Waldorf, Reinarman, & Murphey, 1991, p. 115).

Keep in mind the downside. The high is *very* short-lived—less than 10 minutes in most cases. Contrast this to the results measured in hours of drugs like alcohol, marijuana, LSD, PCP, the narcotics, and the sedative-hypnotics.

Probation officers must come to believe in and, even more importantly, respect the intensity of this euphoric high. Far too often the impact of the high itself becomes overshadowed by the drug's basic illegality. Clearly officers cannot experiment personally with the drug. But they should have a deep phenomenological respect for its potential to induce euphoria. Physicians are not required to undergo personal encounters with diabetes before they treat diabetics. So it is with probation officers and crack addiction. The exceptional officer will seek to understand this phenomenon, convey as much to the addict, and avoid falling prey to the myth (or "cop-out"?) that only recovering professionals possess the knowledge and expertise to work with addicts. This is just not true (Wallace, 1991, p. 231). The officer should be prepared to respond to such a challenge by the client but should not make matters worse by believing it.

Contrary to what is often touted by the media and others less informed, crack is not always instantly addicting. That one puff inevitably leads to crack addiction is a vast oversimplification. Many abusers experiment with crack for months before getting into a pattern that could be characterized as abusive or dependent. Some recognize the lure and walk away from it. Others quit on their own before their lives are destroyed. However, and as Waldorf, Reinarman, and Murphey (1991, p. 114) write, "a clear majority of our freebasers offered compelling testimony on the extraordinary hold this form of cocaine use can have over those who indulge in it more than a few times." Nevertheless, probation officers must avoid the tendency to overreact prematurely the moment they discover their client "on crack." They should respect the client's individuality and personal circumstances and then initiate an individual assessment process. The officer should get the facts. Everyone's crack use is not the same. In fact, there are as many different types of crack users as there are non-crack users. An overreaction will only hasten the chances for a client to withdraw, detach, or otherwise distrust the probation officer's expertise.

The cultural context of crack use is also critical to understand. It is not used in a vacuum. Its intensity must be weighed against the user's socioeconomic and ethnic reality. A 22-year-old, poor and undereducated, black man from the inner city may experience a very different high (phenomenologically speaking, i.e.) than his counterpart in white suburbia. This was described eloquently by Jefferson Morley, writing in the *New Republic* (1989), when he chided the establishment for its own obsessive-compulsive addiction to materialism. How dare we vilify this drug so without actually trying it? He dared to try it and wrote:

> Crack is a pleasure both powerful and elusive. Smoke a rock and, for the next 20 minutes, you will likely appreciate sensuous phenomena ranging from MTV to neon lights to oral sex with renewed urgency. After your 20 minutes is up, you will have a chemical aftertaste in your mouth and, in all likelihood, the sneaking desire to smoke another rock—to see what that was really all about. Just one more. . . . You can be a moral tourist in the land of crack and still get a sense of how the drug can make sick sense to demoralized people. If all you have in life is bad choices, crack may not be the most unpleasant of them.

This is a provocative statement written by a presumably well-educated professional writer looking for answers to the crack problem. He writes from a firsthand, if not risky, personal perspective. Although crack use is not confined exclusively to the disenfranchised and has permeated the ranks of the middle class (Wallace, 1991, p. 5), probation officers witness its use and abuse primarily by the less fortunate and less gifted. And within this population and cultural setting, the choice to use crack could indeed become a dangerously alluring proposition—"if all you have in life is bad choices," that is. Accepting this and trying to understand it may be the most important step a probation officer can take to help his or her client recover.

Now some additional thoughts on the context of use, not cultural but social context. Crack is not as much a "social" drug as marijuana, alcohol, or powdered cocaine (ingested intranasally; also known as insufflation). In fact, it is often a selfish drug, frequently used in isolation. And if used in the context of others (e.g., a "crack house"), it is rarely passed around. The user generally wants to use it all, or it is shared among two people who inevitably end up arguing over whether or not they got equal "hits." For many it is a true "private" experience. There are numerous accounts of men becoming involved in compulsive masturbation, often to the total exclusion of real intimate relationships, due to their crack use (Washton, 1989, p. 87). Again, the isolation, the immediate rush, and the intensity of the high are key components to understanding the crack experience.

The "crash": The price paid for the 5- to 10-minute "rush" and subsequent euphoria is a serious one indeed. This facet of crack use gets to the very heart of its addictive prowess. An alcohol hangover, something many readers have undoubtedly experienced, is one thing. The body is actually undergoing a state of temporary detoxification, returning to its natural state. Only a bonafide alcoholic winds up "craving" a drink beyond the hangover. For most, it is largely confined to annoying *physical* symptomatology experienced more within the body than the brain. But the crack hangover is aptly called a "crash," "as proportionately as intense as the high" itself (Washton, 1989, p. 23). It is profound and quick, usually overcoming its victims within minutes of their putting down the pipe. But, unlike the typical alcohol hangover, this crash experience is primarily confined to the brain and its depletion of vital pleasure-producing neurotransmitters. Keep this distinction in mind as the forthcoming pharmacological principles are discussed.

Pleasure Principles: Crack on the Brain

Dopamine

Wallace (1991, p. 13) characterizes crack as a "uniquely addicting drug," based upon its neurochemical actions alone. She writes that, "Users actually experience a neurochemically based need for more cocaine, which, after chronic use, manifests itself as an all-consuming cocaine craving" (p. 13). Dr. Sidney Cohen describes this as the "pharmacologic imperative" of cocaine use (Washton, 1989, p. 22). Put crudely, crack on the brain prevents it from calming down. Unlike other drugs, crack rapidly (this speed factor is very reinforcing) zeros in on the "reward" center. It finds the specific neurotransmitters responsible for good feelings, or euphoria, and by blocking the reabsorption process, floods the surrounding neurons with a naturally produced chemical called "dopamine." But because crack also destroys the enzyme that carries any leftover dopamine back to the nerve cell that released it, it temporarily robs the brain's ability to naturally produce good feelings. This is the essence of the "crash" and why the user's brain demands "just one more rock."

Primary Disease

As Washton (1989, p. 39) puts it, "Intense cravings may be more of a factor in cocaine addiction than in other drug addictions, precisely because cocaine's action in the brain occurs in the very same area where basic drives are reinforced." Animal studies make it clear: The desire for cocaine will surpass even that of basic survival. Rats will self-administer cocaine to their death, over and above food, sex, and water. The bottom line is this: The intense cravings for crack have a physiological basis that undercuts any element of personal volition or choice. Put in yet another way, crack addicts compulsively use the drug "in the absence of personality disorders, depression, anxiety, situational stressors, or family dysfunction" (Washton, 1990, p. 55). As has been argued about alcoholism (Read, 1988), crack addiction is a primary disease, not the result of underlying sociopathy or psychological dysfunction.

Physical Dependency

Not typically associated with crack addiction, probation officers must become familiar with physical dependence and tolerance, factors usually linked more with heroin or alcohol dependency. Although detoxification from alcohol is far more dangerous, and crack produces no dramatic withdrawal syndrome, crack is physically addictive. For many years (particularly the early 1970's), powdered cocaine's street reputation was enhanced by proponents who stated repeatedly that "at least coke is not physically addictive." Researchers today do not hold this view—particularly with crack cocaine. The physical addiction is described in terms of "potent urges and cravings for the drug resulting from chronic biochemical alteration in brain chemistry" (Washton, 1989, p. 24). In other words,

crack establishes a biochemical mandate for more and more, the essence of true physical addiction.

Tolerance

As with alcoholism, and with repeated use (over a much shorter period of time, though), a larger and larger dose of crack is required to achieve the same initial high. This is called tolerance. Chronic users will end up administering doses that earlier on would have been lethal. Unlike other drugs, crack smoking is often a binge experience, marked by fairly regular and sometimes lengthy periods of abstinence. But during prolonged binges, continued doses will produce decreasing euphoria. A point will inevitably be reached where the drug no longer provides any pleasurable sensations at all. It becomes a futile exercise in chasing that vividly remembered "paradise lost." So why "just one more rock"? Because the intense conditioning remains strong as does the relief demanded by the escalating dysphoria and chronic depression. While one more "rock" may not bring euphoria, it will certainly prevent the "crash" and perhaps at least make the depression slightly less miserable.

Anhedonia

Repeated crack use depletes the brain's supply of naturally produced dopamine. Since dopamine is so important to maintaining a normal mood and mental state, its deficiency induces dysphoria and worse still, "anhedonia," or the inability to experience pleasure normally (Washton, 1989, p. 45). Imagine not being able to enjoy food, sex, friends, or your favorite pastime. This is classic anhedonia, commonly experienced by newly recovering addicts, sometimes for months after their last use. Keep in mind that the phenomenon of anhedonia is virtually nonexistent for most recovering alcoholics whose initial abstinence often shows rapid physical and emotional payoff. Probation officers must make this distinction for their clients, describe it as such, and assist them in working it through. As part and parcel of the postacute withdrawal process associated with early cocaine recovery, officers should remember that these are physiologically based symptoms occurring *after* one has achieved a period of abstinence, usually somewhere within the first 90 days. Throw in triggered cravings and doing "just one more rock" makes all the sense in the world.

Triggered Cravings

Triggered cravings or "conditioned-cues" (Early, 1991, p. 84) are an inescapable pitfall of crack cocaine recovery. They are produced by the repetitive and complex relationship between the euphoria associated with using and the event immediately preceding it: when, where, and why the client typically used. Deeply imprinted in the brain, they take the form of very real neurochemical changes induced by any number of seemingly innocuous events, places, or things. Examples might be a song, a particular street-corner, a certain friend, hearing the word "coke," or seeing a movie depicting drug paraphernalia. Such cravings usually commence 2 weeks after the addict's last use of the drug.

These intense cravings for crack will occasionally occur during a period of anhedonia, making them all that much more potent and dangerous. Recovering crack addicts will actually believe that their craving will escalate uncontrollably until getting high becomes the only option. They do not know their cravings are time-limited (20 to 30 minutes at the most); consequently, they are in need of repeated reassurance that the cravings will diminish over time as the brain works through postacute withdrawal. They must be taught techniques for surviving these critical time periods, such as calling a sponsor, thinking it through, or using relaxation exercises. Furthermore, they must be shown, in very basic and concrete terms, ways of distinguishing their feelings from behavior, that one does not automatically constitute the other.

Finally, and by way of summary to highlight the importance of these pharmacological principles peculiar to crack addiction, probation officers must learn to overcome their predilection for "blaming the victim." The responsibility for the addictive process rests not with the individual user's moral judgment or lack of willpower, but within the brain and the chemical prowess of crack cocaine itself. Responsibility for recovery and treatment does finally rest with the addict. But it is the probation officer who has the formidable task of educating the client about the facts of his or her addiction within a distinctly nonjudgmental and compassionate atmosphere. Myth reduction is what this is all about: cracking through the myth, from *both* sides of the probation officer's desk.

Cracking Through the Myth

It is no myth that the crack cocaine problem is still in its infancy. With ample time to grow and flourish, it will presumably worsen. Unfortunately, good and reliable research data still lag behind in painfully short supply. Such ground is fertile soil for the perpetuation of destructive myths and misconceptions. Just over 10 years ago researchers wrote, "Relatively few persons whose primary drug of abuse is reported as cocaine appear in drug treatment facilities" (Phillips & Wynne, 1980). One decade later, and due solely to the widespread introduction of crack cocaine, a statement such as this seems preposterous.

Today we are seeing headlines that read: "Reversing Course, Cocaine-Use Indicator is Rising" (*Washington Post*); "Treating Cocaine Addicts: Why It's so Tough"

(*Washington Post);* and "Experts Finding New Hope on Treating Crack Addicts" (*New York Times*). Yet despite the appearance of increased attention, the myths somehow persevere, the research not incisive enough or widespread enough to break through the barriers of time and stereotype. As mentioned above, probation officers must "crack" through the myth and get to the facts that do exist, however much in short supply they may appear to be. Here are some typical examples, some of which have been addressed above but merit re-emphasis:

Crack addiction is NOT a psychological dependency. True, it is a complex and multifaceted disease process determined by the interaction between physiological (or biological), psychological, and social factors (Wallace, 1991, p. 118). As a society it seems we are forever driven to "reductionalize," to simplify and find the easy or one-dimensional way to explain away life's anomalies. So it is today with addiction to illegal drugs such as crack cocaine which is of course also overshadowed by the "politically correct" national obsession with the "war on drugs." Over time, addiction to alcohol (a legal drug) became less and less victimized by such prejudice as the media and popular culture came to accept its disease-based etiology. Addiction to cocaine has some catching up to do, even among a handful of treatment professionals (Washton, 1989, p. 48). But the mandate is clear. Addicts cannot respond, let alone recover, if left to treatment practitioners or probation officers who view their disease from moralistic high ground.

Cocaine addiction DOES differ from alcohol and other drug dependencies in several important ways. There is a difference. As Washton states, "... the cocaine addict is not simply an alcoholic who just happened to choose a different drug" (1990, p. 65). Alcohol and cocaine are pharmacologic opposites; one a central nervous system depressant, the other a central nervous system stimulant. Try to understand the particular "fit" between the person and the drug. Understand the narcissism peculiar to this disease and that many cocaine addicts feel they are a cut above the common "junkie" or "drunk." Cocaine or crack addiction develops and progresses much more rapidly than alcoholism, sometimes making it difficult for both user and family to identify or accept the presence of a problem. The user is more likely to see the problem as "the drug" itself and resist any suggestion to accept the "disease within." Cocaine addicts identify best with other cocaine addicts, especially during the early stages of treatment. Subsequent reintegration with alcoholics, and others, is possible and recommended but only after a reasonable period of abstinence.

Recovery does NOT mean abstinence from crack cocaine only. Absolutely. This is one of the single most neglected facets of the typical probation officer encounter with a crack addict. Treatment and recovery demand that the addict abstain from all mood-altering substances, including alcohol. Alcohol and other drugs such as marijuana and sleeping pills have the potential to trigger strong cravings for cocaine. Through a process of "associative conditioning" (Washton, 1989, p. 70), they become strong reminders and promote unexpected disinhibition even for clients who have no known history of prior alcohol or other drug abuse. Other drugs may also prevent the biochemical recovery of brain functioning disrupted by the cocaine. This means that probation officers must continually ask about drinking habits, insist upon total abstinence, and educate their clients throughout. Overlooking this important component only fosters another dangerous myth, held by both addict and probation officer, that recovery is abstinence (i.e., from the particular drug of choice) alone. It is not. Recovery involves active change on all fronts, including emotional, lifestyle, and spiritual risk-taking. Otherwise, and as they say in Alcoholics Anonymous, "the same person will drink again."

Relapse is NOT a sign of poor motivation or treatment failure. Yes, and Washton (1989, p. 115) puts it succinctly when he writes, "Relapse means that there is something wrong with the patient's recovery plan—not the patient." Relapse also assumes that recovery has begun, that a period of abstinence has been achieved beyond superficial compliance. This being the case, there are several relapse myths that must be challenged. Perhaps most damaging of all is the false assumption that relapse is a sign of poor motivation or treatment failure. Why so damaging? Because it reveals a certain naivete about the very nature of addictive disease that will surely undercut any helping or monitoring effort. Change is very risky, and while some may indeed be ambivalent about getting clean, "even the most highly motivated and sincere patients [clients] can have relapses" (Washton, 1989, p. 115). Treatment and recovery are all about learning from relapse mistakes, developing better plans, recognizing relapse triggers, and applying relapse prevention methods. On the other hand, relapses are not unavoidable. There is always a beginning, usually a change in attitude or a stressful event that occurs well before an addict "picks up," followed by a progression of addictive thinking, poor choices, and finally a snowballing of negativity that results in the decision to use again—sometimes months after the relapse actually began. Returning to crack is the endpoint, not the beginning of the relapse. There are always early warning signs (failure to attend Narcotics Anonymous/Cocaine Anonymous meetings, hanging out with old friends, missing appointments, drinking alcohol, etc.) that telescope this

progression. Experienced probation officers will learn to recognize the signs and intervene as early as possible.

Clean urines are NOT a reliable predictor of recovery. Definitely true. This is yet another way of emphasizing the point that abstinence alone is not recovery. Probation officers are frequently lulled into a false sense of security once they have their clients on a drug testing regimen. Make no mistake about it, urinalysis is critical to the supervision and treatment process (Earley, p. 1991, p. 146). Most crack addicts sincere in their recovery actually want it. But there is no better substitute for gauging one's commitment to recovery than by "meeting" attendance (Narcotics Anonymous/Cocaine Anonymous, etc.), working the "12 steps," sponsorship, participating in group and/or individual counseling, developing a relapse prevention plan, and working on lifestyle changes (acquiring work, enhancing education, etc.). Besides, clients frequently "beat" probation officers on urines. Many drug testing schedules involve twice weekly urine drops on the *same* days. Some may consider this a waste of resources, since cocaine has such a short half-life and is metabolized out of the body within as little as 48 hours, sometimes less if "flushed." Unless a truly random and unexpected schedule is implemented, involving consistent "call in's" and/or surprise home visits, the officer cannot afford to make assumptions.

Resistant crack addicts CAN get clean even if they are not overtly motivated. Yes, they can. This widely held misconception sets up a groundswell of negative expectations. The erroneous thinking is that unless clients are miraculously motivated to seek help for themselves, they are destined for failure, regardless of outside effort or intervention. This attitude kills. No one ever walks into a Narcotics Anonymous or Alcoholics Anonymous meeting without a footprint firmly embedded on his or her back, whether it be his or her spouse's, his or her employer's, or his or her probation officer's. The motivation for recovery begins *in* treatment, not before. Addiction is about denial, and it is the probation officer's responsibility to "raise the bottom" and hold an addict accountable to the positive expectations of recovery (Read, 1987). Keep in mind that ". . . a crack smoker's arrogance, aloofness, and grandiosity represent a defense against painfully low self-esteem, shame, and guilt over crack-related deterioration and behavior" (Wallace, 1989, p. 203). Avoid getting caught up in negative expectations. Look beyond the outward personality manifestations of the disease process. Recognize it for what it is but move on.

Most crack addicts do NOT require inpatient medical detoxification. True. Unlike alcohol withdrawal, crack cocaine detoxification is not a life-threatening process. It is painful and it is very real, but not fatal. Early (1991, p. 53) captures it well when he writes:

> Drug craving, depression, agitation, and the cocaine-induced distortions about life are the complications of acute and chronic cocaine consumption. How an addict thinks and feels in the early stages of coming off cocaine *is* cocaine withdrawal. Cocaine withdrawal is severe; it affects addicts in the most complex and least understood part of the body—the brain.

Formal medical detoxification may not be necessary in most cases. Remember also that detoxification is just that; *it is not treatment.* Related to this misconception is one that stipulates crack addiction is so powerful that it demands inpatient treatment in all but few of the cases. Washton et al. (1991) and others make a strong case for the advantages offered by intensive outpatient programs. Inpatient treatment isolates addicts too much from the "street" where they will encounter real-life triggers to use again. By remaining outpatient, and carrying on with their day-to-day lives, they have ample time to practice "drug-free coping skills." After detoxification, and for those assessed as chemically dependent, crack addicts seem to benefit the most from a combination of individual and group therapy (Washton, 1989, p. 145). Groups are a must, particularly if membership includes one or more actively recovering addicts. And all the better if they happen to possess personality strength and charisma.

The anonymity of 12 step recovery groups (such as Narcotics Anonymous and Cocaine Anonymous) does NOT preclude mandated attendance of clients by probation officers. True, once again. Strictly enforced and closely monitored attendance at Narcotics Anonymous/Cocaine Anonymous and other 12 step group meetings should form the core of every probation officer's supervision plan (Read, 1990). This is so regardless of whether or not the client already has a full plate of individual and/or group counseling. In some cases, depending on the assessment (see below) of the addict's dependency level, this may be all that is needed. Most groups are accustomed to and welcome probation officer referrals. Unfortunately, many officers either neglect to make this a mainstay of their supervision effort or are mislead by the "anonymity" tradition. Officers should become familiar with program jargon, learn the steps, and have directories and literature on hand to lend. At the very least, officers should obtain a copy of the "Blue Book" or *Narcotics Anonymous* (1990). Officers should try to hook up already recovering (legitimately, i.e.) addicts who have "clean time" with others less so; they should communicate with fellow officers and supervise introductions. After all, this is the basis of healthy recovery: "passing it on."

Two final comments on 12 step or mutual self-help groups: First, going to "meetings" does *not* constitute treatment. Treatment is the responsibility of trained professionals, not peers helping one another stay clean. Officers should try not to confuse the two. Sec-

ond, there is nothing wrong with being "pro-choice" when it comes to the client who stands strongly (and genuinely, you assess) against attending a traditional 12 step group on grounds that it is a religious program. Although Narcotics Anonymous, Alcoholics Anonymous, and others are "spiritual" programs and not religious in nature, officers should know when to be flexible and take advantage of emerging alternative groups such as Rational Recovery.

Assessment: Use It or Lose It

Taking a good drug history is critical to the intervention process. Not fully using the assessment process results in significant losses to both officer and client. Probation officers frequently have insufficient hard data with which to make their treatment recommendations. By not taking the time to accurately assess their clients' addiction, they also miss out on the valuable clinical interaction between officer and client in gathering the information itself. It is simply not sufficient to extract an admission of use and proceed to make referrals. Officers need facts. Where have the clients been (vis-a-vis their drug use) and where are they right now? They need a detailed drug use history capable of making those fine distinctions between less severe "drug abuse" and out of control drug "dependency." Officers are not clinicians, but they must learn to assess. Without an assessment, there is no starting point for referral, no chart for the course of treatment, and no content with which to confront the addict's denial system (Washton, 1989, p. 79).

Crack "Dependency"

Perhaps the most versatile tool available to guide the probation officer's interview for a good drug history assessment is the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders*, otherwise known as the "DSM-III-R" (APA, 1987). Drug treatment experts throughout the country favor this diagnostic measure (Wallace, 1991, p. 15). And by using its common language, the overall continuity of care is strengthened. To put it loosely, everybody will be reading off the same page. An entire article could be devoted to assessment alone, so just the basics will be introduced here. The DSM III-R makes a clear distinction between "abuse" and "dependency." Assessing a person for crack dependency involves the presence of three of the following nine symptoms, some of which "have persisted for at least one month, or have occurred repeatedly over a longer period of time":

1) **Client uses in larger amounts or over a longer period of time than intended.** This focuses on the key aspect of "loss of control." The client intends to spend $30 but ends up blowing his entire paycheck, perhaps for the last four paydays in a row. Or, he or she admits to getting high for a few hours Friday night but winds up not returning home until Saturday morning. The officer should get specific. Asking questions along this line also helps determine the user's pattern. Perhaps an eventual drug testing regimen could be altered accordingly as means of providing tighter control.

2) **Client admits to a persistent desire to get high or one or more unsuccessful attempts to cut down or control his or her use.** The probation officer could gain valuable relapse trigger information by soliciting specific details. What was it that pulled the client over the edge after making a decision to cut back or stop altogether? Was it a user-friend, a song, boredom, a street corner, or the sight of drug paraphernalia? A good beginning would be to ask questions designed to throw light on why a user made a decision to try to stop in the first place. This cuts to the core of recognizable adverse consequences, an obvious first step toward recovery.

3) **Client spends a great deal of time involved in activities necessary to acquire the drug, getting high on it, or recovering from its effects.** This is yet another twist on determining how disruptive a person's use of crack has been. What kind of time and effort was required to obtain the crack? Was theft or other criminal activity involved? Did the person smoke "for hours on end" once he or she obtained it? The officer should not confuse the user who is occasionally offered crack by friends with the addict who must devote increasing amounts of time and energy to design "schemes" of procuring it.

4) **Client experiences frequent intoxication or withdrawal symptoms that prevent the fulfillment of major role obligations such as work, school, or home.** Does the user call in sick to work or not look for work because of getting high or "crashing"? Does the user smoke while he or she should be caring for his or her children? How does the user's spouse or "significant other" feel about the user's getting high? Is it affecting the user's relationships? Persistence with this line of questioning only further enhances the possibility of breaking through the barriers of denial. This is compassionate confrontation, an absolute necessity with this population.

5) **Client discontinues or cuts back on important social, occupational, or recreational activities in favor of getting high.** Possibly due to anhedonia and other physiological symptoms of compulsive use, many addicts find themselves losing interest in everything but "chasing the pipe." Questions that help determine the "pre-crack" using state of the individual will help deepen respect for the progressive nature of the disease. What did the user do for fun before getting into crack? How responsible was the user before? And what is the user like now?

6) **Client continues to get high despite the knowledge of having a persistent or recurrent social, psychological, or physical problem caused or exacerbated by his or her use.** The typical probationer or parolee whose current offense relates to crack use but who persists in getting high again would conform to this criterion. As would the wife who loses her children but continues to smoke, or the husband whose wife leaves because of his smoking. Again, specificity is important. The officer should demand that the client think, feel, and thoroughly respond to the questions. An addict must have help in coming to terms with the insanity of his or her addiction; this is one way of getting to it.

7) **Client begins to show marked tolerance to the drug.** Usually this means reporting at least a 50 percent increase in the amount of crack required to achieve the desired effect. Or that there has been a pronounced diminution of effect after smoking the same amount of crack. Some will report not being able to get high at all. Here it is important to get specific about dosage levels and amount of money spent. The officer should not be surprised if the addict reports astronomical escalation over the course of his or her usage.

8) **Client experiences withdrawal symptoms.** These usually include dysphoric mood, depression, insomnia, irritability, and anxiety that follow cessation of use but do not include the immediate results of a "crash." This is to say that they persist for more than 24 hours after the person's last dose, thereby extending beyond the simple unpleasant rebound effects that even the casual user would feel.

9) **Client uses drug to avoid or relieve withdrawal symptoms.** This speaks for itself. Is the addict using compulsively to avoid withdrawal, to avoid the "crash," or—perhaps more to the point—to simply lessen the misery of living without?

Crack "Abuse"

The criterion for "abuse" is much simpler. First, it must involve at least one of the following: continued use despite adverse consequences (#6 above) and recurrent use in situations that are physically hazardous (operating an automobile, working with heavy machinery, etc.). Second, some of these symptoms need to have persisted for at least a month or have recurred repeatedly over a longer period of time. And, finally, the "abuse" category is suitable for a person who does not meet the criteria for "dependence" outlined above.

The impact of following these guidelines in conducting a drug history interview should be obvious. By patiently walking the client through these questions and exchanging information in this way, probation officers will be naturally induced to start the formation of a working "relationship," one that extends beyond the "do as I say" paradigm. Just as importantly, the officer will be laying the foundation for breaking through the denial system. The goal is to match the addict's current level of dependency with an appropriate treatment option. By determining specific patterns of use, relapse triggers, and losses associated with crack use, the officer can tailor a supervision plan to the individualized needs of the addict. Put even more simply, starting "where the client is" becomes the focus. The ultimate beneficiary is not solely the client. Valuable treatment resources and time wasted on guesswork are also unavoidable outcomes. Everyone becomes a winner.

Conclusion: "Empathic Supervision" and Accountability Revisited

The American criminal justice system has recently experienced a growing preoccupation with supervision accountability and offender compliance. Some call it the "new penology" (Shichor, 1992). Community protection and "zero tolerance" mandates occasionally assume precedence over traditional counseling and rehabilitative ideals. Within this atmosphere it is not unusual for the results of a urinalysis report to render all that is necessary to "dispose" of a case. A "positive for cocaine" automatically initiates the standard referral to outpatient treatment and additional drug testing. Or perhaps an immediate referral to the "drug unit." Or in less tolerant offices, a return to court or even jail. Some may feel that when their client is "safely" referred for treatment, the officer role suddenly diminishes to that of program monitor, and little else. Report the positive urines. Report missed appointments. And send them back to jail when they are deemed uncooperative.

This knee-jerk reaction and subsequent detachment has several pitfalls, not the least of which is a complete disregard for individual clients, the prognosis of their particular drug problem, and an appropriate individualized treatment plan. Probation officers owe it to themselves as professionals, as well as to their clients, to move beyond this simplistic reactionary response. Supervision accountability, individual assessment, and a deepening positive relationship with the client are not mutually exclusive facets of the probation officer's role. In fact, a firm but consistently applied "empathic supervision" style that focuses on assessment and relationship formation will *assure* much tighter accountability standards. Research need not substantiate this point. It is common sense, albeit paradoxical.

Empathic supervision demands that the probation officer seek development of a relationship with his or her client that results in trust and respect. Officers need not trust their clients; this is not a two-way street. But unless

clients trust and respect their supervising officers, the game is over. Although this is a general principle that holds true for all interactions with clients, it is particularly crucial to the relationship between officer and drug user where denial, distrust, and resistance are natural precursors (Wallace, 1991, p. 202). Empathizing with the addict, not to be confused with sympathizing or pitying, comes across as the single most important task in getting through and effecting positive change. Skillfully communicating this understanding of "where the client is" becomes the next most important task (Washton et al, 1991, p. 1425).

Empathy is not a term casually embraced by probation officers today. Somehow it sounds like "social work" or "treatment," words that presumably diminish the coveted law enforcement philosophy. However, in reality they need not be such strange bedfellows. Empathic supervision simply means placing emphasis on getting to know the clients and understanding their predicaments, from their perspectives. In more concrete terms, it means playing an active role in their recovery, both before and after referral. It means spending time really listening, asking the right questions, conveying respect, reinforcing achievement, and continually assessing the person's commitment to recovery. It means conducting three-way interviews with treatment program staff, visiting with family members, and educating, advocating, or confronting when necessary. The end result will be more information, enhanced accountability (or law enforcement), and certainly more effective supervision. Officers should try it and test it out. Crack addiction may suddenly lose its enigmatic aura and become less formidable, an addict more workable, and the officer's professional life much more fulfilling.

REFERENCES

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders (3rd ed. rev.).* Washington, DC: Author, pp. 165-169.

Ashley, R. (1975). *Cocaine: Its history, uses and effects.* New York: Warner Books, p. 188.

Boodman, S. (1989, November 28). Treating cocaine addicts: Why it's so tough. *Washington Post.*

Early, P.H. (1991). *The cocaine recovery book.* California: Sage Publications, Inc., pp. 84-146.

Hafen, B.Q., & Soulier, D. (1989). *Cocaine and crack.* Minnesota: Hazelden Educational Materials, Inc., p. 1.

Isikoff, M. (1991, November 17). Reversing course, cocaine-use indicator is rising. *Washington Post.*

Kolata, G. (1989, August 24). Experts finding new hope on treating crack addicts. *New York Times.*

Morley, J. (1989, October 2). What crack is like. *The New Republic.*

Narcotics Anonymous. (1987). Van Nuys, CA: World Service Office, Inc.

Phillips, J.L., & Wynne, R.D. (1980). *Cocaine: The mystique and the reality.* New York: The Hearst Corporation, p. xxvi.

Read, E.M. (1990). Twelve steps to sobriety: Probation officers working the program. *Federal Probation, 54*(4).

Read, E.M. (1988). Identifying the alcoholic: A practical guide for the probation officer. *Federal Probation, 52*(3).

Read, E.M. (1987). The alcoholic, the probation officer, and AA: A viable team approach to supervision. *Federal Probation, 51*(1).

Shichor, D. (1992). Following the penological pendulum: The survival of rehabilitation. *Federal Probation, 56*(2).

Waldorf, D., Reinarman, C., & Murphey, S. (1991). *Cocaine changes: The experience of using and quitting.* Philadelphia: Temple University Press, p. 115.

Wallace, B.C. (1991). *Crack cocaine: A practical treatment approach for the chemically dependent.* New York: Brunner/Mazel, Inc.

Washton, A.M. (1989). *Cocaine addiction: Treatment, recovery, and relapse prevention.* New York: W.W. Norton and Company, Inc.

Washton, A.M., & Stone-Washton, N. (1991). Outpatient treatment of cocaine addiction: Suggestions to increase its effectiveness. *The International Journal of the Addictions, 25*(12A), pp. 1421-1429.