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TREATING CLIENTS IN THE CRIMINAL JUSTICE SYSTEM

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ABOUT THE INSTRUCTOR

Ed Roberts, M.A., LCDC, CCJP is the Director of Treatment Operations for CEC/Civigenics, Inc. – the largest “for profit” provider of correctional treatment programs in the country. He is the former Clinical Director of the Texas Department of Criminal Justice Substance Abuse Treatment Program, has authored numerous articles, and collaborated with Dr. Stanton Samenow in the design and on-screen presentation of the video & DVD series "Commitment to Change: The Power of Consequences." This video series is produced by FMS Productions. Ed has a Master's Degree in Counseling from Sam Houston State University and received certification from the William Glasser Institute in the practice of Reality Therapy. He is a member of the American Counseling Association, the Association for Specialists in Group Work, the Association of Addiction and Offender Counselors, and the National Association of Alcohol and Drug Addiction Counselors. Ed also serves on the Board of Directors for the International Credentialing and Reciprocity Consortium (IC & RC), and has served as a trainer/consultant for the National Institute on Corrections (NIC).

The Evolving Landscape: Substance Use Treatment in Criminal Justice Settings

When TIP 44 was published in 2005, substance use treatment within the criminal justice system was an established but unevenly implemented practice. Two decades later, the landscape has shifted in response to the opioid crisis, the expansion of drug courts and diversion programs, the introduction of medication-assisted treatment in correctional settings, and growing recognition of polysubstance use as the norm rather than the exception.

A 2023 review in Current Opinion in Psychiatry examined the role of polysubstance use on criminal justice involvement. The researchers analyzed 18 recent studies and identified the "syndemic nature of polysubstance use, criminal justice involvement, and adverse outcomes," meaning these factors compound each other in ways that exceed their individual effects. The review found significant barriers preventing access to evidence-based treatment within justice settings and identified critical gaps in research on social determinants of health, racial and ethnic disparities, and reentry interventions (Jones et al., 2023).

This finding has direct implications for the triage and placement processes described in this course. Clinicians assessing justice-involved clients should expect polysubstance use as the default presentation and screen accordingly, rather than focusing narrowly on a single substance of concern.

Treatment Effectiveness: What Large-Scale Studies Show

The fundamental question for practitioners in criminal justice settings is whether treatment delivered in these contexts produces meaningful outcomes. A 2024 study published in BMC Psychiatry used nationwide registry data from 11,893 participants to evaluate treatment-based diversion as an alternative to imprisonment. The results were concrete: substance misuse decreased by 7 percentage points, adverse mental health events dropped by 5 percentage points, and participants accumulated 3 fewer criminal charges compared to standard incarceration. The researchers concluded that treatment-based intervention represents "a superior alternative to incarceration in its target group" (Virtanen et al., 2024).

These findings validate the approach central to TIP 44: providing structured substance use treatment within and alongside the criminal justice system produces better outcomes than incarceration alone. The question for practitioners is not whether to treat, but how to deliver treatment effectively within the constraints and opportunities of the justice system.

Medication-Assisted Treatment in Correctional Settings

One of the most significant developments since TIP 44 was published is the expansion of medication-assisted treatment (MAT) into correctional facilities. In 2005, few jails or prisons offered opioid agonist medications. Today, the landscape is changing, though not without controversy and implementation challenges.

A 2025 systematic review examined extended-release pharmacotherapies for substance use disorders

in incarcerated populations, analyzing 16 studies (drawn from 25 papers) covering 3,403 participants. Extended-release buprenorphine showed more promising outcomes than extended-release naltrexone, with emerging evidence supporting its role in reducing opioid use and improving treatment retention. However, the review found "no clear evidence for the effectiveness of extended release naltrexone and buprenorphine among individuals in the criminal justice system compared with shorter acting formulations," suggesting that medication access matters more than the specific formulation (Woods et al., 2025).

The clinical takeaway for practitioners working in justice settings is that medication should be part of the treatment planning conversation for clients with opioid use disorder, regardless of whether they are currently incarcerated, transitioning to the community, or on supervised release. The period immediately following release from incarceration carries the highest overdose risk, making medication continuity a safety-critical issue.

Jail-Based Medication: The Strongest Recent Evidence

If the question of whether to offer medication in correctional settings was once genuinely contested, the evidence accumulated since TIP 44 has largely settled it, and the counselor working in a justice setting should know the strength of that evidence in order to advocate effectively. The most influential single study appeared in 2025 in the New England Journal of Medicine, the most prominent medical journal in the world. In a cohort of 6,400 people with probable opioid use disorder held in Massachusetts county jails, those who received medication for opioid use disorder in jail had roughly half the risk of fatal overdose after release compared with those who did not, an adjusted hazard ratio of 0.48, along with lower all-cause mortality and a modest reduction in reincarceration. Buprenorphine was the medication most often provided, in about two-thirds of cases (Friedmann et al., 2025). A halving of overdose-death risk is not a marginal effect. It places jail-based medication among the most powerful life-saving interventions available in any correctional setting, and it directly addresses the reentry danger described above.

The foundational experimental evidence is older and equally instructive. In a randomized controlled trial published in the Lancet, people who had been receiving methadone in the community at the time of arrest were assigned either to continue methadone during incarceration or to undergo the forced tapered withdrawal that most facilities still impose. Those who continued methadone were more than twice as likely to return to community treatment within a month of release, an adjusted hazard ratio of 2.04, with 96 percent of the continued-methadone group re-engaging compared with 78 percent of the forced-withdrawal group (Rich et al., 2015). The clinical implication is one of the clearest in this literature: a client who arrives in custody already stabilized on medication should have that medication continued, not stripped away, because discontinuation predictably reduces the post-release treatment engagement that keeps people alive. The common correctional practice of routine withdrawal is not a neutral default. It is an intervention with foreseeable harm.

Initiating medication in jail, not merely continuing it, also reduces the return to custody. A study of 469 incarcerated adults with opioid use disorder across two adjacent Massachusetts jails, one that offered buprenorphine and one that did not, found that those with access to buprenorphine were less likely to recidivate after release, 48.2 percent versus 62.5 percent (Evans et al., 2022). The medication that treats the disorder simultaneously serves public safety, which reframes correctional treatment as an

intervention that benefits the individual and the community at once. The broadest synthesis of this evidence comes from a 2024 systematic review and meta-analysis in the Lancet Public Health, which pooled 126 studies of interventions for people who experience incarceration. Opioid agonist treatment provided inside prisons reduced in-prison mortality by roughly three-quarters, and agonist treatment continued during the first weeks after release reduced community mortality by a comparable margin. The same review found that therapeutic community interventions reduced both re-arrest and reincarceration across pooled samples (Macdonald et al., 2024). For the counselor, the message across these studies is consistent: medication prevents death, continuity across the custody-to-community transition is where that protection is won or lost, and the counselor who advocates for both is applying the strongest evidence the field has produced.

Peer Support in Criminal Justice Settings

TIP 44 emphasizes the importance of linkages between institutional treatment and community-based services. One approach that has gained substantial traction since 2005 is the use of peer support specialists, individuals with lived experience of recovery who serve as navigators, mentors, and advocates for justice-involved clients.

A 2022 commentary in the Journal of Addiction Medicine argued that peer support specialists represent "an underutilized resource in the criminal justice system for opioid use disorder management." The authors noted that peer specialists have demonstrated effectiveness in helping individuals "navigate the healthcare system, reintegrate within their community, and successfully adhere to their individual treatment and recovery goals." They proposed integrating peer support into interdisciplinary addiction care teams within correctional facilities (Hamilton et al., 2022).

For treatment planners working within the framework described in this course, peer support addresses a specific gap: the transition between institutional treatment and community reentry. Clinicians can establish treatment plans, connect clients with medications, and coordinate with community providers, but peer specialists provide the relational continuity and lived-experience credibility that clinical staff cannot replicate.

Harm Reduction in Justice Settings

The adoption of harm reduction practices within criminal justice-connected treatment programs represents one of the more contested developments in the field. Recent research has begun to quantify both the reach and the limitations of harm reduction approaches for justice-involved populations.

Desai et al. (2025) surveyed 108 SUD treatment programs in New Jersey to examine the prevalence of harm reduction practices. Among the programs studied, 55.6% dispensed naloxone to clients, and 50.9% did not use toxicology screens as a basis for discharge decisions, two practices considered consistent with harm reduction principles. However, the study found that "clients referred by correctional programs were significantly less likely to attend a program that used either harm reduction practice" (Desai et al., 2025). This finding highlights a structural tension: while harm reduction is gaining traction in the broader treatment system, the criminal justice pipeline tends to channel clients

toward more abstinence-oriented programs. Counselors working in justice settings should be aware of this referral pattern and its implications for treatment matching.

The relationship between specific substances and recidivism patterns also carries implications for how harm reduction strategies are designed for justice-involved populations. Karlsson and Hakansson (2022) followed 4,207 prison clients with substance use disorders and found a 68% recidivism rate. Critically, "risk factors differed substantially" by crime category: alcohol use correlated with violent recidivism, while age and heroin use elevated risks for property and drug crimes (Karlsson & Hakansson, 2022). For harm reduction programming in correctional settings, this suggests that interventions must be substance-specific rather than generic. A harm reduction approach targeting opioid overdose prevention may not address the alcohol-related violence patterns that drive a different subset of recidivism.

Timko et al. (2022) studied 341 veterans involved in the criminal justice system and identified four latent classes of risk: a normative class (53%), a high criminogenic thinking class (27%), a recurrence class (11%), and a high drug use class (9%). Among the 47% of veterans falling into the higher-risk classes, elevated depression was a common co-occurring factor (Timko et al., 2022). This classification has practical implications for treatment planning in justice settings: nearly half of justice-involved veterans presented with profiles that combined substance use with significant mental health burden, indicating that harm reduction strategies must account for psychiatric complexity to be effective with this population.

The Reentry Window: Overdose Risk and Continuity of Care

The period immediately following release from jail or prison is one of the most dangerous in a justice-involved person's life. Tolerance drops during incarceration, and the first weeks back in the community carry a sharply elevated risk of fatal overdose. The clearest recent evidence that continuity of treatment can address this danger comes from Lim and colleagues (2023), who studied 15,797 adults with opioid use disorder released from New York City jails across more than 31,000 incarceration events. In the first month after release, receiving methadone or buprenorphine while in jail was associated with an 80 percent reduction in overdose-death risk, with an adjusted hazard ratio of 0.20, and a comparable reduction in all-cause mortality. The clinical lesson for counselors is that the reentry moment is not a routine transition but a high-risk clinical event. When a client leaves a correctional setting, the counselor's task is to ensure that treatment does not stop at the jailhouse door. A warm handoff to community treatment, a scheduled first appointment, an active medication prescription, and access to naloxone are not administrative niceties. In the weeks after release, they are the difference between a client who survives to continue recovery and one who does not.

Matching Treatment to Risk, and the Limits of the Formula

The dominant framework for organizing treatment in justice settings is the Risk-Need-Responsivity model, which holds that services should be matched to the offender's level of criminogenic risk, target the needs that drive offending, and be delivered in a way responsive to the individual's learning style and circumstances. The framework has real support, but recent evidence cautions against treating it as a

formula that guarantees results. Duan and colleagues (2023) meta-analyzed 25 studies of community correction programs, which contributed 35 independent effect sizes, and found that full participation in these programs significantly reduced recidivism overall. Notably, though, interventions that fully followed all three Risk-Need-Responsivity principles achieved results similar to those that did not, leading the authors to conclude that the principles "are not golden," while also cautioning that the underlying literature was highly heterogeneous and of low quality. For the practitioner, the useful takeaway is not to abandon risk-need matching, which remains a sensible way to allocate scarce treatment resources, but to hold it with appropriate humility. Matching intensity to risk is a reasonable starting point rather than a substitute for clinical judgment about the individual client in front of you.

Treatment Courts and Judicial Supervision

Diversion into treatment courts, in which a judge supervises the client's progress and treatment substitutes for or supplements incarceration, has become a central feature of the criminal justice response to substance use. Trood, Spivak, and Ogloff (2021) conducted a systematic review and meta-analysis of judicial supervision covering 56 separate investigations, with more than 11,000 people in the treatment conditions and more than 12,000 comparison subjects. They found that problem-solving courts using judicial supervision significantly reduced both the odds and the frequency of recidivism compared with conventional court processing, with stronger effects when judicial oversight was frequent in the early phases of treatment. For counselors working within a drug court or similar diversion program, this evidence supports the model while also pointing to a practical principle. The active ingredient appears to be sustained, engaged judicial contact during the vulnerable early period, which means the counselor's coordination with the court, and the timeliness of the information the counselor provides, genuinely affects outcomes.

The Weight of Trauma

Counselors working with justice-involved clients are working, in the great majority of cases, with trauma survivors. Messina (2023) conducted the first randomized controlled trial of a brief, peer-facilitated trauma-specific intervention with 221 men incarcerated for violent offenses. As the study observes, prisons are saturated with trauma survivors, yet trauma has rarely been the focal point of corrections-based treatment. The intervention produced significant improvement on 11 of the 13 trauma-related outcomes, with the largest effects on mental health functioning, trait anger, and anxiety. Two implications follow for practice. First, trauma is not a special case among justice-involved clients but closer to the norm, and treatment that ignores it is treating only part of the person. Second, trauma-specific work is feasible and effective even in a prison setting, which undercuts the assumption that meaningful trauma treatment must wait until a client returns to the community. The behaviors that bring clients into the justice system are frequently rooted in histories the client has never had a safe place to address, and the counselor may be the first person to offer one.

Women in the Justice System

Women in the criminal justice system have distinct treatment needs, and the evidence increasingly shows that programs designed with those needs in mind produce better results. Edwards and colleagues (2022) systematically reviewed post-release programs for women leaving prison with substance use disorders, covering 12 programs and nearly 3,800 women. Recidivism was significantly reduced in five of the twelve programs, about 42 percent. The programs that reduced recidivism shared a recognizable set of features, which the review identified as transitional and gender-responsive programming, individualized support, and integrated services that addressed substance use, mental health, and trauma together rather than in isolation. The review also flagged a sobering gap, noting that substance use itself was significantly reduced in only one program, a reminder that outcome measurement in this field remains weak. For the counselor, the practical message is that generic treatment ported over from male-dominated programs tends to serve women poorly, and that continuity of care from prison into the community, paired with attention to trauma and caregiving responsibilities, is where the gains appear.

The Larger Comparison: Treatment Versus Incarceration

Underlying all of these specific findings is a broader question the field has now answered with reasonable confidence. Does treating substance use work better than simply punishing it? Tomaz, Moreira, and Souza Cruz (2023) systematically reviewed 23 studies comparing treatment and punishment responses to drug-involved offenders. The review concluded that treatment functions as an effective response of the criminal justice system in reducing criminal recidivism and drug use, while addressing the criminogenic effect of imprisonment itself, and that interventions privileging treatment should therefore be chosen over punishment. For counselors, this is more than an academic finding. It is the empirical foundation for the work itself. The client sitting in a treatment session rather than a cell is, on the weight of the evidence, less likely to return to the justice system, and the counselor's work is a genuine part of the reason.

A Practical Synthesis for the Criminal Justice Counselor

Taken together, these findings translate into a set of priorities for the counselor working with justice-involved clients. The reentry window demands active planning, because the weeks after release are when the risk of death is highest and when continuity of medication and care saves lives. Risk-need matching offers a reasonable way to organize services, provided it is applied with judgment rather than as a rigid formula. Treatment courts work best when the counselor coordinates closely with an engaged judge during the early phase. Trauma is so common in this population that assessing and addressing it is not optional, and it can be done effectively even inside a correctional facility. Women require programming designed for their circumstances rather than adapted from programs built for men. Underneath all of it sits the central finding that treatment reduces reoffending in ways that incarceration does not.

None of this replaces the foundational guidance in the original course. It sharpens it. The counselor who screens for trauma, plans deliberately for reentry, coordinates with the court, tailors services to the

individual and to gender, and keeps the client connected to care across the transition from custody to community is applying the best current evidence about what reduces both substance use and return to the justice system. The work is difficult and the systems are often unhelpful, but the evidence is clear that the work matters. A client who completes treatment and stays connected to care is measurably more likely to build a life outside the justice system, and the counselor is a central reason that becomes possible.

Treating Clients in the Criminal Justice System

Introduction

Identifying offenders in need of substance abuse treatment is only the first step in providing help to these individuals. Because no single treatment has been shown to be effective for all offenders, effective matching to individual needs such as vocational or employment skills, family counseling, and mental health services improves the likelihood that the client will successfully complete treatment. Matching to specific treatment interventions also is cost-effective and improves the quality of services within existing programs. For example, offenders appropriately matched to either a high-structure, behaviorally oriented program or a low-structure counseling program consistently have significantly less severe problems and lower rates of substance abuse than those not appropriately matched to treatment programs. Finally, with only a limited number of available intensive treatment slots (e.g., residential services) in many criminal justice settings, offenders placed in these programs who do not need or desire intensive treatment may be disruptive or drop out of treatment prematurely, preventing others from benefiting from them.

This course provides detailed information on how to best use the information obtained through the screening and assessment process as identified in the course “Screening and Assessment of Criminal Justice Clients” in order to match the offender to appropriate treatment services. It begins in the first section by examining triage and placement issues. Then, we look in Section 2 at substance abuse treatment planning.

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Section 1: Triage and Placement in Treatment Services

Treatment Levels and Components

Treatment matching in the criminal justice system is most effective when there is a continuum of services – ranging from low to high intensity. This section provides a brief description of treatment levels that may be available in criminal justice settings. The continuum of treatment levels includes three major treatment categories: pretreatment services, outpatient treatment, and inpatient treatment (including residential care). Several types of program services often are available within each treatment level. As the text box below indicates, research suggests that all major treatment levels are effective. Nonetheless, it is recommended that clients should be matched not only on the intensity of services they need, but also on the particular components that are responsive to their individual needs.

Effectiveness of Treatment Levels—Results from the DATOS Study

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Results from the federally funded Drug Abuse Treatment Outcome Studies (DATOS) (Hubbard et al. 1997; Simpson et al. 2002) indicate that all major treatment levels (including long-term residential, short-term inpatient, outpatient, and outpatient methadone) are effective in reducing substance abuse and criminal activity. For example, reductions in weekly cocaine use from pretreatment to 1 year post treatment follow-up ranged from 46 percent among short-term residential clients to 20 percent among outpatient methadone clients. Reductions in criminal activity from pretreatment to 1 year post treatment follow-up ranged from 25 percent among long-term residential clients to 8 percent among outpatient clients.

Key findings and implications from the DATOS studies include the following:

- All substance abuse treatment modalities are effective in reducing substance abuse and criminal activity.
- Residential treatment programs of at least 3 months' duration are particularly cost-effective for use with criminal justice clients.
- Client readiness for and commitment to change and engagement and retention in treatment are important predictors of treatment outcomes. These factors, when routinely assessed by criminal justice programs, may be useful in targeting offenders who need more intensive services (e.g., intensive case management).

- Measures of client engagement and treatment progress are good predictors of dropout from treatment. When routinely assessed, these predictors can help identify clients who require specialized interventions (e.g., peer mentors, motivational enhancement therapies, individual counseling) to sustain their involvement in treatment.
- Involvement in post treatment peer support activities is helpful in preventing relapse. Clients are more likely to engage in ongoing peer support groups if they begin these activities during treatment.
- Among clients with prior treatment experience, outcomes are more dependent on the quality of relationships with treatment counselors than are outcomes for first-time clients (Franey and Ashton 2002).

Pretreatment Services

Pretreatment services, which are not part of primary treatment, include primary prevention, early intervention, and detoxification. Primary prevention and early intervention are not typically used in criminal justice settings.

- *Primary prevention.* These are services for people who have not used substances. Most primary prevention programs are in schools or the community.
- *Early intervention.* This includes psychoeducational programs for those who have used substances and are considered to be at high risk for substance-related problems or have a history of substance abuse. Other interventions include screening and assessment to identify substance abuse problems. Brief interventions also are appropriate for offenders who use substances but who do not meet the diagnosis of having a substance use disorder. For example, ongoing evaluation can help determine if referral to a more intensive level of care is needed. In some instances, early intervention can be used as short-term treatment for individuals with low-severity substance abuse problems.
- *Detoxification.* Medically supervised detoxification services are required for offenders whose alcohol or drug abuse has caused severe and life-threatening symptoms (e.g., acute intoxication, blackouts). Although detoxification typically is conducted prior to the onset of substance abuse treatment, it is important to provide a thorough assessment during detoxification and to provide orientation to the recovery and treatment process. For more information, see our course “Screening and Assessment of Criminal Justice Clients.”

Outpatient Treatment

Also referred to as ambulatory care, outpatient treatment provides a broad range of services without overnight accommodation and includes non-intensive and intensive outpatient treatment, methadone treatment, and day treatment or partial hospitalization. Some of these services can be provided following inpatient or residential treatment, or as follow-up care after involvement in a residential program.

- *Non-intensive outpatient treatment*. This is substance abuse treatment that includes professional assessment and treatment involving less than 9 hours per week in regularly scheduled sessions. Non-intensive outpatient treatment often addresses related psychiatric, emotional, and social issues, and offers a forum to explore issues such as the relationship between violence and mental disorders. Non-intensive outpatient treatment also can accommodate clients with job or family responsibilities, as treatment services may be offered on weekends or evenings.
- *Intensive outpatient treatment.* This is substance abuse treatment with professional assessment and treatment from 9 to 20 hours per week in a structured program. These programs can be held on evenings or weekends.
- *Methadone treatment.* This is a medically supervised outpatient treatment that provides counseling while maintaining the client on the drug methadone. This regimen is used primarily for heroin or other opioid addiction and provides a legitimate, closely monitored substitute for illicit drugs. The client must be able to document at least a 2-year history of addiction to qualify for a methadone treatment program. It is rarely used with those who are incarcerated.
- *Day treatment or partial hospitalization.* This is substance abuse treatment with professional assessment and treatment of more than 20 hours per week in a structured program. This is the most intensive of the outpatient treatment options and can be used for treating clients who demonstrate the greatest degree of dysfunction but who do not require inpatient or residential treatment. Evening and weekend programming often is included.

Inpatient Treatment and Residential Care

Inpatient treatment options include intensive medical, psychiatric, and psychosocial treatment provided on a 24-hour basis. The continuum of residential care includes psychosocial care at the most intensive end and group living with no professional supervision at the least intensive end. It is unlikely that the full range of services will be available in any one community.

- *Intensive residential treatment.* This long-term treatment can be directed by a substance abuse treatment professional or could be medically directed. Intensive residential treatment is appropriate for people with multiple problems, especially those with co-occurring mental and substance use disorders (COD). Psychosocial rehabilitation is always a goal of treatment. The duration of treatment in this setting varies considerably, from 3 months to as long as 2 years.
- *Therapeutic community (TC).* The traditional TC is a long-term (15 to 24 months) rehabilitative model that is often staffed by recovering professionals, treatment and mental health professionals, and vocational and educational counselors. Therapeutic help from the residential community paves the way for residents to recover from their substance abuse problems and to develop the vocational, educational, and social skills they need to become productive members of society. Most TC residents have been involved with the criminal justice system. The theory and practice of the TC have been detailed in the literature (De Leon 2000), and the effectiveness of these programs has been documented both in prisons and in community-based settings (Melnick et al. 2001).
- *Psychosocial residential care.* This long-term (6 to 24 months) psychosocial care model has elements similar to the therapeutic community model in that it relies heavily on peer pressure as well as formal treatment to shape behavior. It is appropriate for people with substance abuse problems and concomitant disorders that do not require acute medical or psychiatric intervention. People compliant with psychiatric and other prescription medications are appropriate for this level of care. The focus of care is on psychosocial rehabilitation.
- *Medically monitored intensive inpatient treatment.* This level of care involves around-the-clock medical monitoring, assessment, and treatment in an inpatient setting, usually by a nurse or nurse practitioner. It is used for clients who have acute and severe substance use disorders and who may also have a coexisting medical or psychiatric disorder. Such treatment generally involves a short to intermediate length of stay (7 to 45 days) and may include nonmedical or social model programs with variable lengths of stay.

- *Medically managed intensive inpatient treatment.* This level of care involves around-the-clock, medically directed evaluation and treatment in an acute-care inpatient setting, usually by a medical doctor. This level of care is appropriate for the treatment of medical and psychiatric problems that may require biomedical treatment (such as life support) or secure services (such as locked units). Such treatment generally involves a short to intermediate length of stay (7 to 45 days).
- *Short-term nonhospital intensive residential treatment.* This treatment is generally 21 to 45 days in length and is designed to teach the client how to live a substance-free life and to provide motivation for the maintenance of such a lifestyle. Follow-up care on an outpatient basis and continued participation in peer support groups is recommended to maintain the recovery process begun in the residential setting.
- *Halfway house.* Residents are expected to follow house rules and share house responsibilities in a residential setting under staff supervision. Residents generally find their own way to outside activities (e.g., work, court, counseling, vocational training, and schooling). The house sometimes offers treatment services. Length of stay is limited or unlimited depending on the attainment of specific progress goals.
- *Group home.* This refers to a residential, transitional living situation without any specific treatment plan and minimal staff supervision. It is sometimes known as a three-quarter-way house. Residents may work and receive education, training, or treatment in the community. House residents generally decide on admission of new residents. House responsibilities are shared, and the house is governed and run by its residents. The length of stay is generally unlimited as long as abstinence from substances is maintained; the Oxford House model includes complete resident self-governance and self-sufficiency. The key to success in all such models is that the living situation is substance free, which supports abstinence among residents.

Potential Barriers to Triage and Placement

Inadequate Screening and Assessment

Accurate screening and assessment are necessary for effective placement. However, resources, adequate time to conduct comprehensive assessments, and trained staff are not always available in criminal justice settings. As a result, substance abuse treatment in criminal justice settings often is based on sparse and inadequate information (Knight et al. 2002).

Competing Demands in Institutional Settings

A challenge for substance abuse treatment programs in institutional settings is the competing demands on offenders' time. For example, a prison's need for labor to fulfill its contracts and maintain itself can compete with an offender's needs for treatment. Or, inmates could be assigned to institutional education programs. In addition, there are also competing demands for treatment. Treatment service options often are limited and waiting lists exist for most services in community-based programs. The community-based system of care across the country largely is funded to provide services to a non-offender population. In some cases, prioritization of community treatment services for offenders has placed a strain on the limited number of available treatment slots.

Information Flow

Issues regarding the transfer of information across different settings in the criminal justice system present a major barrier to effective placement in offender treatment services. For example, this might include a need for a centralized database that can be accessed by various providers as offenders move through the system.

Creating a Triage and Placement System

To ensure appropriate treatment for offenders who abuse substances, the offender's needs and available resources must be balanced. Coordination of treatment matching within the criminal justice system can reduce the long-term costs of incarceration and other criminal justice functions only if adequate personnel and funding are available for case management. Ongoing planning and coordination among criminal justice staff, substance abuse treatment staff, and policymakers and other stakeholders is important to establish an effective treatment matching system.

The optimal approach would be to assemble a team consisting of correctional/supervision and clinical staff to develop a triage and placement system and to assume responsibility for compiling and processing treatment matching information. Once the triage and placement system has been developed, the team can review cases referred to treatment, transfers, and placement in high intensity or specialized treatment programs (e.g., co-occurring disorders services).

This coordinated approach also can ensure that ongoing troubleshooting occurs to adjust eligibility criteria, to check admission and transfer procedures, and to monitor reentry to the community. Although triage and placement teams do not necessarily meet on a daily basis, they are regularly involved in reviewing offenders' placement status and decisions to place or transfer offenders to different program settings. Scoring criteria for assigning offenders to different levels of treatment often are developed by clinical staff with significant involvement and review by criminal justice staff (e.g., classification officers). Use of scoring criteria and development of a triage and placement database are useful for document standardization and treatment provision across different groups of offenders.

Following are key triage and placement activities that can be jointly undertaken by a team of correctional and clinical staff:

- Developing a treatment placement database of treatment resources available in the community or correctional facility
- Defining key characteristics of existing treatment programs and the types of offenders and associated levels of treatment needs with whom the programs are most successful
- Documenting the referral process with appropriate timeframes and communication requirements for each system
- Outlining the information to be shared between agencies and developing procedures for transfer of key information without breaching confidentiality
- Describing offender treatment and supervision/management responsibilities for each organization to avoid duplication of efforts, interagency conflict, and lapses in monitoring offenders
- Evaluating the effectiveness of treatment matching practices and placement criteria on an ongoing basis
- Determining offenders' eligibility for and access to health, mental health, and social services in the community

Triage and Placement Strategies

Triage and placement strategies for offender treatment programs depend on the range and type of services available, specific eligibility requirements attached to various programs, and the resources available to manage this process. In some criminal justice settings (e.g., jails) only limited types of services are available, such as 12-Step groups or a more intensive treatment program. In these settings, elaborate triage and referral systems are unnecessary, and placement decisions are often based on a brief substance abuse screening and a brief risk screening (e.g., for violence, acute mental health symptoms) to determine eligibility for the program. This often is accomplished by a single staff member and through a combination of self-administered tests, brief interview, and records review.

In settings that feature a range of treatment services, triage and placement are usually lengthier, often involving multiple staff and compilation of multiple sources of information. These settings often use a scoring system or "algorithm" to determine which offenders should receive priority for available treatment slots. In general, the sophistication of a treatment matching system should reflect the

- Range of different levels of treatment intensity available
- Scope of information needed to determine eligibility for admission to the various levels of treatment
- Consequences for "mismatching" offenders to the different levels of treatment

Under most conditions, triage and placement decisions are guided by the need to reserve program slots for offenders with more severe substance abuse problems and who present at least moderate risk for criminal recidivism (see Figure 1). Research indicates that treatment programs targeting offenders with moderate to high risk for recidivism produce the greatest posttreatment reductions in recidivism and are more cost-effective (Andrews et al. 1990; Bonta 1997; Gendreau 1996). However, research does not support placement of moderate- to high-risk offenders in minimally intensive treatment services (e.g., educational groups, 12-Step groups) unless additional, more intensive services are also provided. In summary, offenders with more severe addiction problems and more significant risks for criminal recidivism do not experience positive treatment outcomes unless they are placed in highly structured and intensive treatment programs. Conversely, assigning low-severity offenders to these high-intensity programs often is inefficient and counterproductive for people who use drugs casually, who are then exposed to the corrosive effects of more seasoned offenders with pronounced criminal attitudes, beliefs, and lifestyles.

Advice to the Counselor: **Triage and Placement**

- Measurements of client readiness for change, commitment to change, and engagement in treatment are important predictors of treatment outcomes.
- In settings with limited services available, elaborate triage systems are unnecessary and placement often can be determined with a brief interview of the offender, some self-administered tests, and a records review.
- Accurate screening and assessment are necessary for effective triage and placement in the face of competing demands for resources.

Compiling Information to Guide Triage and Placement Decisions

Screening and assessment issues in the criminal justice field are discussed comprehensively in the course “Screening and Assessment of Criminal Justice Clients”. This section outlines how to use information derived from the screening and assessment process to make triage and placement decisions.

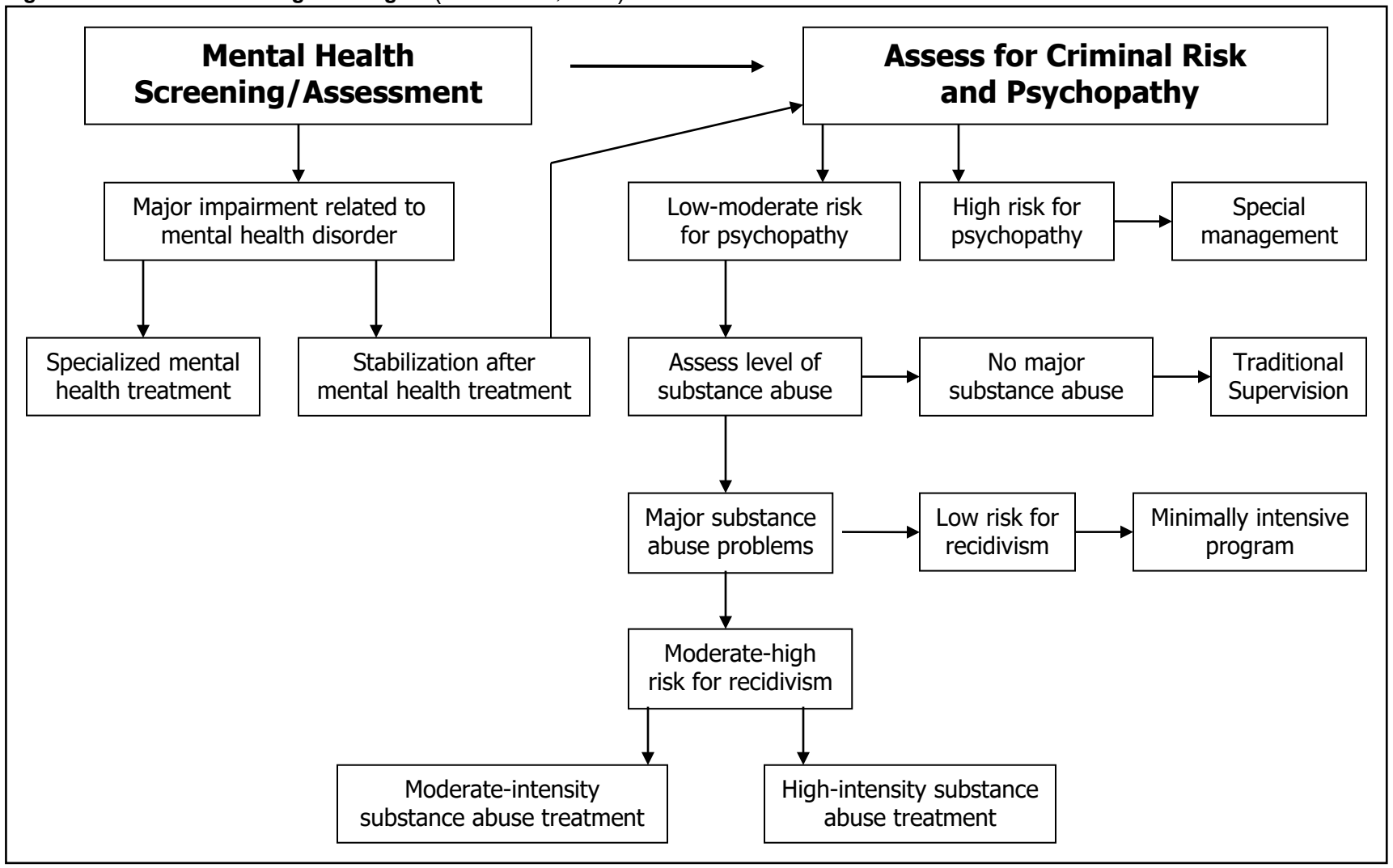
As described in Figure 1, placement and triage strategies in criminal justice settings often use a tiered approach. In the first stage of this process (screening and assessment), attempts are made to identify major mental health problems or psychopathy that would interfere with involvement in substance abuse treatment. If one of these problems is identified, the offender can be directly routed to a specialized treatment or management unit/program. This tiered approach enables criminal justice staff to quickly identify offenders who are not good candidates for substance abuse treatment and prevents unnecessary substance abuse screening and assessment for offenders who would perform poorly in existing substance abuse programs.

If a range of offender treatment options is available, placement in services usually is determined by the following factors:

- Risk for criminal recidivism
- Level of offender needs for substance abuse, mental health and other psychosocial or medical services, and employment
- Offender motivation and readiness for treatment
- Other offender characteristics including cognitive and intellectual abilities, abilities to read and write, and related abilities to communicate in individual and group settings and to withstand stress in highly intensive therapeutic communities

Research indicates that treatment programs that place individuals in services according to these areas are likely to enhance outcomes for offenders (Andrews et al. 1990; Gendreau 1996). The following sections discuss each of these areas in relation to triage and placement services, identify information sources necessary for placement, and list instruments that can be used to compile the information.

Figure 1 Placement and Triage Strategies (*Zimmerman, 2000*)



Risk for Criminal Recidivism

Assessment of the risk for future criminal and/or violent behavior is of vital importance in the process of assigning offenders to treatment programs within the criminal justice system. Offender characteristics and environmental factors used to estimate the likelihood of future criminal behavior are termed "risk factors."

Once criminal risk factors are identified, research indicates that structured and intensive cognitive-behavioral approaches can address offenders' "criminogenic needs" related to their dynamic risk factors (those that are likely to change over time) (Andrews and Bonta 1998; Wanberg and Milkman 1998). Andrews and Bonta (1998) have identified several promising targets for treatment intervention based on dynamic risk factors:

- Developing and improving life management, problemsolving, and self-control skills
- Developing associations or relationships and bonding with prosocial and anticriminal peers and with prosocial and anticriminal role models
- Enhancing closer family feelings and communication
- Improving positive family structures to promote monitoring
- Managing and changing antisocial thoughts, attitudes, and feelings

In general, offenders who are at high risk for criminal recidivism require more structured and intensive treatment interventions such as intensive outpatient treatment, day treatment, residential treatment, or TCs, while low-risk offenders are better suited for low-intensity interventions such as outpatient treatment, drug education, and peer support or 12-Step programs (see Figure 1) (Falkin et al. 1999).

<u>Information needed for triage and placement</u>

- Criminal history, including age at first arrest, number and type of prior arrests, history of violence and aggressive behavior, history of incarceration, probation and/or parole revocations
- Age, education, marital status, employment history
- Characteristics of psychopathy, including entitlement, impulsivity, superficial interpersonal relationships, lack of empathy, sensation seeking, poorly controlled anger
- Nature of offender's family and social network (prosocial versus procriminal)
- Other personality disorders, including paranoia

Instruments used to compile this information

- Psychopathy Checklist—Revised (PCL-R) and the Psychopathy Checklist-Screening Version (PCL-SV)
- Psychopathic Personality Inventory (PPI)
- Level of Services Inventory—Revised (LSI-R)
- Millon Clinical Multiaxial Inventory—III (MCMI-III), Correctional Form
- Personality Assessment Instrument (PAI)
- Novaco Anger Inventory
- Jesness Inventory
- Paulus Deception Scale
- Inventory of Sensation Seeking

Level of Substance Abuse Problems

Offenders with current alcohol or drug dependence and a history of chronic substance use generally require more structured and intensive levels of treatment (Knight et al. 1999*b* ; Simpson et al. 1999*a*). There is some evidence that highly structured treatment approaches that use a cognitive-behavioral orientation are more effective for offenders with pronounced substance abuse problems, in comparison to less structured client-centered approaches that use nondirective, supportive counseling strategies (Thornton et al. 1998). Offenders who have less serious substance abuse problems are likely to benefit from a variety of treatment options across a range of modalities and levels of intensity (Knight et al. 1999*b* ; Simpson et al. 1999*b*).

Information needed for triage and placement

- Substance dependence symptoms
- Substance abuse-related arrests (e.g., driving under the influence [DUI]/driving while intoxicated [DWI], drug possession and sales)
- History of substance abuse (frequency, quantity, type of substances, route of administration)
- Drug test results or other pre- or postsentence information related to substance abuse
- History of involvement in substance abuse treatment services

Instruments used to compile this information

- Addiction Severity Index (ASI)
- Simple Screening Instrument for Substance Abuse (SSI-SA)
- Texas Christian University Drug Screen (TCUDS)
- Alcohol Dependency Scale (ADS)

Level of Mental Health Problems

Offenders with co-occurring mental disorders have participated successfully in many substance abuse treatment programs in criminal justice settings, although they generally have more pronounced difficulties in employment, family relationships, and physical health (Peters et al. 1992) and sometimes have cognitive deficits related to their mental disorders. Although offenders with co-occurring substance use and mental disorders present unique challenges, their ability to participate in treatment programs varies according to their functioning level in several key areas, including the ability to sustain attention and to participate in individual and group interactions, their vulnerability to emotional conflict, and the presence of acute symptoms (e.g., paranoia, delusions). As a result, triage should include a mental health assessment to examine the potential effects of mental health problems on their participation in available treatment programs. Even moderate to high levels of mental disorders can be accommodated in many criminal justice treatment programs, particularly those with mental health and other health services staff available, and that feature specialized treatment services for people with co-occurring disorders (Edens et al. 1997).

<u>Information needed for triage and placement</u>

- Acute mental disorder symptoms that can influence the offender's ability to participate in individual or group treatment settings
- Suicidal or other violent behaviors
- Cognitive and interpersonal or social impairment caused by current mental disorder symptoms, specifically related to attention and concentration, problem solving skills, interpersonal skills, and frustration tolerance
- Effects of stress and other environmental influences on mental disorder symptoms and related behavioral problems
- Likelihood of recurrence of mental disorder symptoms and behavioral problems given environmental conditions in available treatment programs
- Accommodations available in existing treatment programs to address mental disorder symptoms and behavioral problems

<u>Instruments used to compile this information</u>

- Minnesota Multiphasic Personality Inventory (MMPI)
- Millon Clinical Multiaxial Inventory—III (MCMI-III)
- Symptom Checklist 90-Revised (SCL90-R)
- Brief Symptom Inventory (BSI)

Offender Motivation and Readiness for Change

The offender's motivation and readiness for treatment is another key factor in triage for placement in substance abuse treatment. Motivation and readiness for change are important predictors of treatment compliance, dropout, and outcome, and this information is vital (Ries and Ellingson 1990). Treatment is likely to be ineffective until individuals accept the need for treatment of their substance abuse as well as other related problems.

An offender's motivation to participate in treatment is influenced by justice system sanctions and incentives, including court orders to complete treatment, probation revocation, more intensive mandatory treatment, "good time" credit for involvement in correctional treatment, and incarceration in jail or prison. Offenders also may be motivated by negative consequences outside the justice system, including threats to stable housing, employment, family, and marriage (Ziedonis and Fisher 1994).

However, assessments of motivation and readiness for change that occur outside clinical settings can misidentify significant numbers of offenders who could benefit from involvement in substance abuse treatment. Many offenders who initially appear unmotivated can quickly become engaged in treatment through peers who are committed to recovery and who are actively involved in treatment. Involvement in group counseling and contact with program participants and staff can stimulate motivation for change in the previously unmotivated offender.

Motivation for treatment changes over time, and offenders often cycle through several predictable stages of change during the treatment and recovery process. The stages of change model has been developed to describe recovery from various types of addictive disorders (Prochaska et al. 1992), and includes the following stages:

- Precontemplation (unawareness of substance abuse problems)
- Contemplation (awareness of substance abuse problems)
- Preparation (decision point)
- Action (active behavior change)
- Maintenance (ongoing preventive behaviors)

Offenders who are in the precontemplation stage of change have little awareness of substance abuse (or other) problems and have few intentions of changing their behavior. Awareness of problems increases in later stages, as the individual begins to consider the goal of abstinence. However, due to the chronic relapsing nature of substance use disorders, movement through stages of change is not a linear process, and offenders often return to earlier stages of change before achieving sustained abstinence.

Assessments of offenders' motivation for treatment and their current stage of change are useful in matching to different types of treatment and to developing treatment plans. For example, matching offenders to treatment services that are appropriate to the current stage of change is likely to enhance treatment compliance and outcomes. Conversely, for offenders who are in the early stages of change, placement in treatment that is too advanced and that does not address ambivalence regarding behavior change may lead to unsuccessful termination from treatment. For individuals in the later stages of change, placement in services that focus primarily on early recovery issues also may lead to unsuccessful termination from treatment. Several considerations are provided in the course “Treatment Issues and Approaches in the Criminal Justice System” regarding matching treatment services to the offender's stage of recovery.

Information needed for triage and placement

- Perceived severity of drug and alcohol problems
- Interest in making changes in drug and alcohol use
- Steps that have been taken by the offender toward abstinence from alcohol or drugs
- Perceived importance of receiving substance abuse treatment

Instruments used to compile this information

- Circumstances, Motivation, Readiness, and Suitability Scale (CMRS) (De Leon and Jainchill 1986; DeLeon et al. 1994)
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)
- University of Rhode Island Change Assessment Scale (URICA) (DiClemente and Hughes 1990)

Examples of Triage and Placement Approaches

The following three examples demonstrated effective use of triage and placement strategies.

Florida Department of Corrections

The Florida Department of Corrections has operationalized a multilevel triage process to refer inmates to substance abuse treatment programs. This process involves the following steps:

- Review by classification staff to examine sentence structure, prior arrests, and correctional history.
- Brief screening for substance abuse problems and dependence symptoms using a modified version of the SSI-SA.

- Personal interview.
- Determination of the need for treatment based on the substance abuse screening, the history of drug or alcohol offenses, prior history in correctional treatment, recommendations by drug courts or other sentencing courts, and staff or self-reported referral for treatment.
- Assignment of a "priority score" for substance abuse treatment, based on the substance abuse screening score, the number of prior substance abuse offenses, number of prior correctional treatment episodes, positive drug test results, and counselor interview results.
- Routine identification of inmates prioritized for substance abuse treatment through "flags" initiated within the computerized database.

Several of the components contributing to the priority score are weighted, including recommendations for treatment from drug courts or other sentencing courts, DUI manslaughter convictions, and unsuccessful termination from community corrections residential treatment programs. The inmate priority score is entered on a computerized database. Inmates with high priority scores are then transferred to facilities with substance abuse treatment programs, where an additional substance abuse screening and interview is conducted. Priority placement in intensive treatment services is provided for inmates with at least 12 to 18 months remaining on their sentence.

Megargee and Case Management Classification Systems

Correctional systems have long used a variety of typologies to match clients to treatment and supervision approaches in institutional and community settings. These typologies usually are based on a combination of criminal history variables and psychosocial characteristics. One example of a multidimensional treatment matching system is the Megargee System, which is based on an extensive analysis of Minnesota Multiphasic Personality Inventory (MMPI) responses given by a large sample of Federal prison inmates. Ten distinctive profile types have been identified, each with varying treatment implications that range from recommended placement in the least restrictive setting to placement in specialized mental health facilities (Vigdal and Stadler 1996).

The Case Management Classification (CMC) system was developed by the Wisconsin Department of Corrections. Based on an offender's responses to a 45-minute semistructured interview, four categories are used to determine treatment assignment within the correctional system:

1. Selective intervention for offenders who have led relatively stable, prosocial lives. The current offense resulted from an isolated stressful event and represents a temporary lapse.

2. Environmental structure for offenders lacking social and vocational skills who are typically led by others into criminal activity.
3. Casework control for offenders with very unstable lives who are actively involved with drugs or alcohol and have a number of prior arrests.
4. Limited setting for offenders with long-term criminal involvement and who are comfortable with their criminal lifestyle and strive for success through criminal activity.

ASAM Patient Placement Criteria

One approach that has been developed to assist in triage and placement decisions for substance abuse treatment services is the revised version of the American Society of Addiction Medicine (ASAM) *Patient Placement Criteria* (PPC-2R) *for the Treatment of Substance-Related Disorders*, Second Edition, Revised (ASAM 2001). These criteria provide guidance for substance abuse counselors and other treatment staff in determining the best "match" between client characteristics and several levels of treatment services. An interview format of the ASAM PPC-2R is under development for use in clinical settings. Within the ASAM approach, treatment matching is facilitated for several different levels of treatment, including the following:

- Level 0.5 Early intervention
- Level 1 Outpatient treatment
- Level 2 Intensive outpatient treatment/partial hospitalization
- Level 3 Residential/inpatient treatment
- Level 4 Medically managed intensive inpatient treatment

Client characteristics are described across six dimensions for each level of treatment. Within each of these dimensions, the client characteristics described are intended to reflect a good "match" between client needs and the treatment setting. Dimensions of client characteristics in the ASAM-PPC-2R system are

1. Alcohol intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery environment

The ASAM approach, or similar dimensional matching strategies, may be useful for substance abuse treatment staff within criminal justice settings. Although the ASAM criteria have not yet been formally adapted for offender populations, the PPC-2R could prove helpful in providing a structured vehicle for determining which offenders would benefit from different levels of treatment intensity, structure, and supervision. One additional dimension that could be useful to

incorporate in criminal justice adaptations of the ASAM PPC-2R is the risk for criminal recidivism. Levels of treatment services specified within the ASAM criteria would also need to be tailored to specific types of criminal justice settings (e.g., drug courts, restitution or day treatment centers, in-jail and in-prison settings), with additional client-offender dimensional criteria developed for each of these new settings. Although this adaptation process would require some attention, there is likely to be significant overlap between client-offender dimensional criteria for these new settings (e.g., drug courts), and existing ASAM criteria for various settings (e.g., intensive outpatient treatment, therapeutic communities).

Section 2: Substance Abuse Treatment Planning

> *The good treatment plan is a comprehensive set of tools and strategies that address the client's identifiable strengths as well as her or his problems and deficits. It presents an approach for sequencing resources and activities, and identifies benchmarks of progress to guide evaluation.*
>
> Center for Substance Abuse Treatment (CSAT) 1994*d* , p. 21

While screening and assessment identify the offender's need for substance abuse and other treatment services, and triage and placement services match the offender to the proper treatment, the treatment plan is where the information gathered is used to put treatment into practice. A treatment plan is a map specifying where clients are in recovery from substance use and criminality, where they need to be, and how they can best use available resources (personal, program-based, or criminal justice) to get there. At a minimum, the treatment plan serves as a basis of shared understanding between the client and treatment providers. Clients learn what is expected of them in program commitments and attendance.

There are many approaches to treatment planning, but they possess some basic commonalities; this section discusses each in further detail. The severity of substance abuse-related problems must be determined, since this is the basis for appropriate placement in a treatment program. In addition, the presence of co-occurring mental disorders must be assessed because these may limit the type of treatment approach and identify the need for psychiatric care. Also important is assessing factors such as procriminal attitudes and psychopathy that may suggest persistent criminality unrelated to substance abuse. The degree to which the individual is motivated to change behavior and lifestyle is another critical factor that has a bearing on whether motivational enhancement interventions, sanctions, or more self-directed treatments are appropriate. Finally, offender-clients should be involved in developing their treatment plan so that they can be referred to appropriate services in the community.

Assessing the Severity of Substance Use Disorders

Treatment planning within the criminal justice system requires a comprehensive assessment of an offender's substance abuse history and patterns of use, including drug(s) of abuse, chronological patterns of use, specific reasons for use, consequences of use, and family history of drug and alcohol abuse. Often treatment involvement within the criminal justice system is based primarily on a conviction or plea to a drug-related offense. Although the number and type of

substance-related charges is sometimes a fairly good indicator of substance abuse and related problems, the offense category alone is not a foolproof indicator of treatment need or of appropriateness of referral to a specific program. The presence of intoxicants in blood or urine at the time of arrest is a better, albeit imperfect, indicator.

Using multiple indicators for assessing the severity of a substance use disorder is important because individuals with few substance-related problems typically do not respond favorably to intensive treatment and fail to identify with the process of recovery. Close association with more severely affected offenders can result in the less-severe offender becoming socialized into a criminal and drug-oriented lifestyle through contagion of attitudes and introduction to a criminal social network. Minimally, an assessment of severity should focus on determining the impact of use on the individual's community adjustment. Usually this also entails taking a drug history that inquires about the frequency, dosage, and types of drugs used. A drug history may also inquire about the times at which, or settings in which, an offender uses.

Assessment of the severity of a substance use disorder may lead to an actual diagnosis of a substance use or dependence disorder. However, most offender treatment programs consider routine use of illicit drugs without a diagnosable disorder to be a legitimate focus for treatment, since any use is illegal and may result in arrest or violations of community supervision guidelines. Also, most settings lack the qualified staff and time required to make formal diagnoses, and clients are sometimes in the setting for too short a time to delay treatment while awaiting formal diagnosis of a substance use disorder. In these settings, clinical impressions are more feasible than are formal diagnoses, and common sense, assisted where possible by standardized assessment instruments, should prevail in deciding whether and how to provide treatment services. Fortunately, several standardized instruments with good psychometric properties are available in the public domain, or at low cost, for the purpose of screening and assessment of substance use severity.

Assessing the Severity of Co-Occurring Disorders

Another important area to assess in developing a treatment plan is the presence and impact of psychological and emotional problems, particularly those that are not the direct result of substance abuse. Offenders with severe substance use disorders have relatively high rates of affective disorders, anxiety disorders, and personality disorders. These disorders can contribute to the development of substance use problems, or the emotional disorders may develop as a consequence of the physiological effects of long-standing drug use and the stressful or traumatic life events that are often experienced as part of a lifestyle in

which drug use plays a central role. Some individuals have mental health problems prior to intake; others develop them during adjudication, incarceration, or community supervision. Commonly encountered disorders include anxiety, depression, and posttraumatic stress disorder (PTSD) (Teplin et al. 1996).

Developing programs to assist those with co-occurring mental and substance use disorders requires integrating treatments and modifying commonly used interventions to take into account possible cognitive disabilities and increased need for support among these individuals. In addition, system-level barriers in funding, staffing, and training must be overcome (Drake et al. 2001).

Although the treatment of co-occurring severe mental disorders and substance use disorders sometimes is provided in specialized, more intensive programs, less severe mental disorders that do not cause major functional impairment can be treated and managed effectively within mainstream programs. Moreover, not addressing these underlying problems can increase the likelihood of relapse. It is important to note, however, that the early stages of recovery often are marked by increases in depression and anxiety, due, in part, to residual effects of substance withdrawal and also to the individual's recognition of consequences related to his substance abuse, including incarceration or other restrictions to his liberty. Likewise, substance abuse may mask an underlying mental disorder that may not become apparent until the offender is no longer using drugs or alcohol. Thus, assessments should be repeated regularly during the treatment process.

Advice to the Counselor: Mental Health Issues

- After a few months of abstinence, most clients will show a decrease in negative mood related to their substance use. However, abstinence may reveal the presence of other, more serious mental disorders (such as posttraumatic stress disorder, depression, schizophrenia, intermittent explosive disorder, or borderline personality disorder) that will require collaboration with a mental health professional. Some individuals will achieve a level of adjustment that will allow them to continue in mainstream substance abuse treatment, but others will require more intensive intervention for their co-occurring disorders.

Posttraumatic Stress Disorder and Depression

Problematic early life experiences, physical and sexual abuse, witnessing violence among family and friends, and other traumatic life events often emerge as key issues in substance abuse treatment. Whether identified initially or after a period of treatment, it is important that these issues be reflected in the treatment plan, matched with interventions likely to be effective, and tracked with regard to progress. For example, while most clients will find that negative mood will decrease over the first few months of abstinence and treatment, an individual's depression, nightmares, and other trauma-related symptoms might persist after several months. If symptoms do not require transfer to a mental health services program, this individual should be referred to mental health professionals for further assessment and treatment. The referral could result in recommendations for antidepressants and/or antianxiety medications and/or involvement in cognitive-behavioral therapy related to trauma and substance abuse issues. These interventions may be instrumental in preventing substance abuse relapse and allowing the client to continue making progress within her substance abuse treatment program.

Serious Mental Disorders

Although they occur less frequently than PTSD and mild anxiety or depression, serious mental disorders (including schizophrenia, delusional disorder, bipolar disorder, and major depression) can adversely affect the ability of treatment programs to manage an offender's behavior. Behavioral disorders that involve self-harm (e.g., cutting or burning oneself, suicidal threats or attempts), and impulsive and uncontrollable aggression are particularly problematic to manage in a treatment setting. These more severe behaviors require involvement of mental health professionals for diagnostic workup and treatment interventions.

In the case of serious mental disorders and threatening behavioral disorders, an assertive, psychiatrically based treatment approach is needed during the most intensive phases of the disorder. After the more severe symptoms have abated (usually through medication and behavioral management on a specialized unit or in a hospital), collaboration between mental health and substance abuse professionals is needed to determine the best approach to manage and treat the individual. Some individuals will achieve a level of adjustment that will allow mainstreaming within substance abuse programs, with medication monitoring in collaboration with medical staff. Other individuals will require more intensively integrated care and intervention for their co-occurring disorders.

Intermittent Explosive Disorder

Treatment planning for individuals who present with an intermittent threatening behavioral disorder is complex. If these behaviors are fairly frequent, it will be impractical to manage the individual in a mainstream program. If these behaviors occur infrequently, the individual may be manageable in the mainstream setting, but only with additional assessment as to the causal antecedents (immediate situation and circumstances) of the outbursts or self-harm behaviors and an analysis of the incentives and perpetuating factors that fuel the behavior. With this assessment in hand, the treatment plan can be used to alert and guide the individual and staff regarding triggers for the unwanted behaviors and ways to defuse their appearance, or ways to limit the threat they present to the client and others.

The treatment plan in such cases will often involve the client's committing to a behavior contract that requires reporting strong temptations or urges to the staff, specifies self-control strategies, and clarifies the consequences of the behavior, which may include sanctions for misconduct, intensification of treatment, or removal from the mainstream program with referral to a specialized behavioral unit. In many cases psychiatric consultations and medication management can be helpful.

Borderline Personality Disorder

Individuals diagnosed with borderline personality disorder (BPD) sometimes engage in severely disruptive behaviors. Individuals with this disorder typically experience many specific negative emotions (vulnerability, hostility, sadness, anxiety, etc.) or a nonspecific but intense sense of distress or "feeling bad." This is combined with an inability to monitor and control emotions, alternating chaotic or contradictory ways of relating to self and others, and self-harm or dramatically self-destructive behaviors.

Dialectical Behavior Therapy (DBT) (Linehan 1993) has been developed specifically for treatment of BPD. This treatment requires specialized training, and manualized interventions are available to guide group treatment sessions. DBT approaches can be successfully integrated with substance abuse treatment in much the same way that the treatment of severe mental disorders is coordinated with mainstream substance abuse treatment. Clients participating in DBT do so on a voluntary basis, and agree to attend skills training sessions and to work on reducing suicidal or self-injurious behavior and other behaviors that interfere with treatment. Core DBT interventions involve careful examination of clients' problems and emotional difficulties, as well as a recognition that these problems make sense within the context of current life situations. Problem solving skills are used throughout DBT, as are contingency management,

cognitive-behavioral treatment approaches, supervised "exposure" to past trauma events, and use of psychotropic medication.

The DBT approach typically consists of at least 1 year of treatment, comprising weekly individual psychotherapy and group therapy sessions. Individual sessions explore problematic behaviors and chains of events leading up to the behaviors, while therapy sessions focus on interpersonal effectiveness skills, tolerance of distress, emotional regulation, and self-awareness or "mindfulness" skills. The pretreatment phase of DBT is dedicated to assessment, orientation, and developing commitment to the treatment process.

Three subsequent stages of treatment emphasize self-examination and development of skills. Stage 1 of DBT involves examination of suicidal and other problem behaviors that interfere with treatment and the client's quality of life, and development of related skills to address these issues. Stage 2 of DBT addresses problems related to PTSD, and Stage 3 is focused on developing self-esteem and addressing individual treatment goals.

Advice to the Counselor: Borderline Personality Disorder

- Severely disruptive clients may have borderline personality disorder. Dialectical Behavior Therapy has been developed specifically for treatment of this disorder and can be successfully integrated with substance abuse treatment programs.

Criminality and Psychopathy

In developing treatment plans for substance-involved offenders, it is important to assess whether criminal attitudes and behaviors predated drug and alcohol abuse and whether criminogenic personality features will impede involvement in treatment. This assessment is useful in constructing a balance between risk containment and rehabilitative activities prescribed for the offender, and, along with substance use disorder severity and presence of psychopathology, is one of the most important predictors of treatment outcome. Although substance abuse treatment has become increasingly integral to the criminal justice system, it should not be assumed that crimes committed by drug-involved offenders are solely the result of drug-acquiring behavior or are attributable to intoxication and

impaired brain functioning. The majority of drug-involved offenders show a dramatically reduced pattern of criminal activity while they are abstinent and involved in treatment, as compared with periods of active substance abuse (De Leon et al. 1982; Deschenes et al. 1991). Nonetheless, some offenders persist in committing a high frequency of property and violent crimes, even in the absence of substance abuse.

Sources of Criminality

Many offenders begin their criminal careers before the onset of substance use, with drugs and alcohol being more symptomatic of a broader pattern of delinquency, acting-out, and social deviance. Three sources of criminal behavior that are closely associated with drug use can be identified: procriminal values, procriminal associates, and psychopathy.

Procriminal values

Procriminal values in adults are most often the result of the combination of early involvement with delinquent peers, the experience of parental neglect or abuse, the absence of prosocial resources and strengths (such as literacy, employability, and social skills), and exposure to an overly permissive or procriminal environment, such as an unsafe school or crime-ridden neighborhood. Examples of procriminal values include intolerance for personal distress and unwillingness to accept responsibility for behaviors that adversely affect others. Procriminal values and attitudes, coupled with a longstanding pattern of antisocial and criminal behaviors, are the key elements of psychopathy.

Procriminal associates

Procriminal associates can develop from life in proximity to high-frequency crime areas, but more often the choice of criminal associates is the logical result of "criminal thinking" and procriminal values. Procriminal associations are also formed during incarceration or involvement in criminal justice programming. Often these are not balanced by prosocial friendships because of the person's inability to overcome the stigma of having a criminal record or attract and maintain relationships with individuals who are socially less "marginal."

Procriminal values and thinking, as well as criminal associates, are rooted in normal cognitive, emotional, and social processes, such as the need for belonging and approval, the need to feel that one has gotten a "fair deal" in life, and the need to feel a sense of self-efficacy and security. Because the origin and perpetuation of these factors are based primarily in normal psychosocial aspects of the person - that is, they are based on thoughts, emotions, and ways of relating that are within normal limits - they are fairly susceptible to being modified using the psychosocial methods common to the major substance abuse treatment modalities. Individuals whose criminality results primarily from these two factors can learn new ways of thinking and valuing, as well as new ways of

feeling and how to manage their feelings, especially in the context of developing new prosocial and prorecovery relationships.

Psychopathy

Psychopathy is distinguished from both procriminal values and procriminal associates in that it is most often conceptualized as a personality trait with primarily biological underpinnings. When this trait becomes extreme it can be described as a personality disorder. Personality disorders are distinctive, longstanding, pervasive patterns of behavior, which usually begin early in life. Personality disorders tend to affect almost every aspect of a person, such as thinking, feeling, perceiving, and relating to others, with worsening cycles of self-defeating and maladaptive behavior. Most theorists and researchers view psychopathy as the result of interactions between biological differences - primarily located in the brain (Anderson et al. 1999; Laakso et al. 2001) - and the most early and basic experiences that shape the personality, such as the experience of bonding, attachment, and concern for others (Hare 1996). Psychopathy is expressed in ways of thinking (impulsive, irresponsible, and grandiose) and feeling (without empathy and shallow) that typically result in behaviors that seriously infringe on the rights of others.

In contrast to the BPD, the most notable characteristic of individuals with severe psychopathy (other than persistent criminality and exploitation of others) is the lack of normal attachment to and value for other people. Although they can be glib and charming, people with psychopathy have a shallow and fleeting ability to experience, express, and understand social emotions such as embarrassment, self-consciousness, shame, guilt, pity, and remorse. This affective-interpersonal deficit often is expressed in the form of cold and callous use of other people without regard for their feelings or well-being. This lack of empathy is usually the basis for a lack of remorse for criminal behavior and is supported by the belief that society and the victim are at fault, rather than the perpetrator, or that the damage done by one's crimes is of little consequence (Hare 1998*a*).

The Psychopathy Checklist-Screening Version (PCL-SV) can provide an important screening mechanism for identifying those offenders who may require a more extensive evaluation. All other things being equal, individuals who are low in psychopathy can be expected to respond favorably to substance abuse treatment in the criminal justice system and to significantly reduce their criminal behavior as the result of this treatment. Individuals who are in the moderate range of psychopathy will benefit from treatment but will require more intensive monitoring, an emphasis on consequences and potential sanctions versus personal aspirations and goals, and vigilance for deception and manipulation of treatment and criminal justice supervisors.

Individuals high in psychopathy require the most intensive in-prison and community supervision and monitoring. Intensive treatments that engage the client in deep emotional processing, that require "working through" life experiences to develop insight, or that stress the development of social skills for their own sake should be avoided for this group. Treatments should be limited to practical relapse prevention activities, including relapse to illegal or seriously self-defeating forms of manipulation and exploitation of others, with increased monitoring for drug use. All self-reported aspects of community adjustment must be carefully corroborated by first-hand observation or reported by an independent third party, including, for example, attendance at required programming, status of living conditions, type and hours of work, criminal background of close associates, and use of leisure time.

Offenders with severe psychopathy tend to do poorly in treatments of all types, when compared to those without severe psychopathy. Of great importance is the surprising and paradoxical finding (now replicated) that offenders with severe psychopathy who are given intensive treatment re-offend more frequently and more seriously than offenders with psychopathy who go untreated (Hobson et al. 2000; Reiss et al. 1999, 2000). In other words, treatment may be contraindicated for offenders with severe psychopathy.

Advice to the Counselor: Psychopathy

- Individuals high in psychopathy require the most intensive in-prison and community supervision and monitoring. Treatment should be limited to practical relapse prevention activities, including relapse to illegal or seriously self-defeating forms of manipulation and exploitation of others, with increased monitoring for drug use.
- All self-reported aspects of community adjustment must be carefully corroborated by first-hand observation or an independent third party.

Client Motivation and Readiness for Change

The successful implementation of a treatment plan depends, to a great extent, on the client's motivation and readiness for change. Motivation level has been found to be an important predictor of treatment compliance, dropout, and outcome, and is useful in making referrals to treatment services and in determining prognosis (Ries and Ellingson 1990). Motivation is sometimes thought of as an emotional commitment to voluntary engagement in treatment. However, this view is overly

simplistic, since motivation can be influenced by many factors including the threat of sanctions or the promise of rewards for treatment engagement (such as reduced jail time, access to needed services, or transfer to a desired correctional facility where the treatment will take place). Motivation and readiness for treatment are expected to change over time, and individuals often cycle through several predictable "stages of change" during the treatment and recovery process. Due to the chronic relapsing nature of substance abuse problems, offenders frequently return to previous stages of change before achieving recovery goals and sustained periods of abstinence. (Refer back to Section 1 for a discussion of the stages.)

A number of attempts have been made to link the readiness to change approach to a substance abuse-specific model that involves "phases" of recovery. Each phase of recovery is typified by a characteristic level of motivation, often reflected in engagement with treatment and with specific recovery-related activities. These models have considerable value for both treatment planning and research as ways of describing and communicating about where a client is in regard to readiness (McHugo et al. 1995).

Assessment of treatment readiness and stage of change is useful in treatment planning and in matching the offender to different types of treatment. For example, matching offenders to treatment that is appropriate to their current stage of change is likely to enhance treatment compliance and outcomes. For individuals in the early stages of change, placement in treatment that is too advanced and that does not address ambivalence regarding behavior change may lead to early termination from the program. For offenders who are in later stages of change, placement in services that focus primarily on early recovery issues may also lead to premature termination from treatment. Staff involved in treatment planning should be careful to assess the offender's stage of change and readiness for substance abuse treatment and to consider this information when developing treatment plan goals. Ongoing review of readiness for treatment can be provided through use of self-report instruments, focused discussion with the client, observation of the client within a treatment program, and review of collateral reports from treatment staff, criminal justice staff, and family members.

Motivation for change is so often an issue for criminal justice clients that perhaps most treatment plans should contain a section addressing motivation and readiness for change. Surprisingly, individuals who verbalize the greatest desire for treatment may not have more than a vague sense of their own motivation to escape the negative consequences they are currently experiencing, such as incarceration, debt, or ill health. However, staying focused on the positive consequences and rewards of recovery is an essential aspect of the recovery process. From the first point of intake to the final community supervision session, promoting and utilizing motivation should be an upfront aspect of criminal justice

management of substance abuse treatment. Motivational interviewing methods, providing feedback to clients on key aspects of assessment findings and progress toward treatment plan goals and intimate involvement of the client in the construction and revision of the treatment plan are important ways of enhancing client engagement in treatment.

Advice to the Counselor: Motivation for Change

- Treatment plans should contain a section addressing motivation for change. Clients may have only a vague sense of their own motivation for treatment. However, staying focused on the positive consequences of recovery is an essential aspect of the recovery process.
- From the first point of intake to the final community supervision session, promoting and utilizing motivation should be an upfront aspect of substance abuse treatment.

Focus on Personal Strengths

The strengths-based approach to treatment planning in juvenile justice and adult criminal justice settings has been received with enthusiasm in many quarters. This contrasts with the traditional deficit-based approach to treatment planning for adults involved in the criminal justice system. Strengths can be recognized and used in treatment planning without neglecting deficits or decreasing the necessary emphasis on accountability and responsibility. Offenders tend to exaggerate or minimize their strengths. Assisting clients in identifying and getting an accurate estimate of their personal strengths should emphasize, but not be limited to, those that are relevant to recovery.

Strengths assessment often begins by determining what interests or inspires the client or by identifying those things in which the client has a sense of pride. Therapeutic community settings often identify specific roles within the treatment environment that clients can take on as their strengths and work to develop them further. Other modes of intervention perhaps need to create roles or activities for clients that use their strengths or identify opportunities outside of the program itself. Women's programs often emphasize the strengths that enabled survival during periods of abuse or neglect. Identifying and working with strengths in the treatment planning process allows the client to be less defensive about the identified deficits and problem areas in the same plan. It is important, however,

that the perception of the strengths as legitimate and of value be shared among the members of the planning team and with the client.

Implementing an Effective Treatment Planning Process

Offender Involvement in the Development of the Treatment Plan

It is essential for clients to be involved in setting case management goals that are in their own best interests. Success of the treatment plan can be greatly aided by the client's involvement in the development of specific objectives and interventions. An example of this process is the Client's Recovery Plan (CRP), in use at the Walden House program in San Francisco (see Figure 2). The client documents his perception of his circumstances, needs, and tendencies, and these are incorporated into the program treatment plan. The CRP opens the dialog between the client and the staff on a more equal footing.

Figure 2 Client's Recovery Plan (CRP)

Name _____

Date _____ *WH #* _____

Note to client

This form is provided to you, as a Walden House client, in order to obtain **your** input into your treatment plan. Your counselors will be evaluating you and your treatment needs based on the Psycho-Social History and Assessment that you provided them. This form is your opportunity to do your own self-evaluations on the same categories.

Instructions

Please describe your own preferences or ideas of what you feel you need in the following categories (if the category does not apply, please put "N/A").

Drug and Alcohol

_____

_____

__

Childhood/Family

_____

_____

__

Relationship/Marital/Sexual

_____

_____

__

Friendship/Recreation and Leisure/Religious/Spiritual

_____

_____

__

Parenting/Child Protective Services (CPS)

_____

_____

__

Criminal Justice

_____

_____

__

Education

_____

_____

Employment

_____

_____

Housing

_____

_____

Mental Health

_____

_____

Overall, is there anything else you feel you need that is not covered in the above areas that is related to your substance abuse recovery?

_____

In your opinion, how much treatment time do you feel you need? Be specific.

_____

_____

Your signature:

_____

Thank you. Your input is appreciated and will be taken into consideration in the development of your treatment plan. You are to bring this completed form with you to your clinical assessment meeting.

Coordination of Treatment Planning and Sharing of Treatment Information

Treatment planning activities in criminal justice settings should include the full range of professionals involved in supervising, monitoring, and providing therapeutic services. In noncustody settings, it is useful to have probation or parole officers involved in this process, in addition to staff from halfway houses, employment/vocational services, and family members. In custody settings, treatment planning could involve case management or transition staff who may be responsible for coordinating prerelease plans and making arrangements for treatment appointments following release from custody. Treatment plans need to be updated at different transition points in the criminal justice system (e.g.,

following release from custody, transfer to less intensive supervision status, or departure from a halfway house setting), as the offender's motivation, response to environmental stressors, and level of involvement in treatment may significantly change. Signed releases of confidential information and interagency memorandums of agreement can help to ensure that treatment plans and other key information are transferred to appropriate staff during these transition points.

Relapse prevention plans often are used within community-based treatment programs in the criminal justice system to develop a coordinated approach to supervision, treatment, and judicial supervision that recognizes the importance of substance abuse relapse. Relapse prevention plans often describe high-risk situations for the offender which increase the likelihood of relapse, relapse "triggers" or cues (e.g., interpersonal conflict, negative or positive emotions, drug paraphernalia, old drinking or drug associates), skills to be developed to address

problems related to relapse, and specific strategies to deal with relapse urges, "triggers," and high-risk situations. Relapse prevention plans are used in a number of drug courts, and help develop consensus among court, supervision, and treatment staff about an offender's current "risk" level for relapse and in organizing responses to critical incidents and problem behaviors.

Linkages With Community Treatment

For criminal justice clients who will not remain long in a jail setting, linkages to the appropriate community services are an essential part the treatment plan. The shorter the jail detention, the more important these links become, especially if a client needs a range of services, including educational, vocational, legal, medical, and mental health. For these links to work most effectively, the treatment plan must include all relevant information about the client that may be needed by the community providers involved. This will allow all the different parties to agree on their own responsibilities to the client as well as the conditions for reporting back to the case manager as needed for the client's welfare. In some cases an interagency audit, however informal, can be useful to identify gaps in the treatment plan and barriers to the client's progress, as well as the strengths present in the client's situation.

Successful links with community agencies require careful planning and considerable resources to develop. Treatment planning and case management as a whole will be easier for treatment professionals if these relationships already exist and can be called upon quickly. Case managers can cultivate these relationships by being involved whenever possible in activities of the agencies they work with, such as by attending committee or planning meetings, in helping staff members of these organizations to develop offender programs and policies, and by contributing to resource materials and manuals.

Conclusions and Recommendations

Key points that need to be considered when developing a triage and placement system for substance abuse treatment in the criminal justice system:

- An effective triage and placement system should be developed to ensure adequate training and availability of staff to conduct assessments.
- In general, offenders who have significant risk for substance abuse and criminal recidivism should be prioritized for initial placement in substance abuse treatment services, rather than in other institutional programs (e.g., educational or vocational/employment services). These offenders should be referred to intensive treatment programs (e.g., day treatment, intensive outpatient, residential services).

- Mental disorder symptoms and impairment should be carefully considered in determining placement in substance abuse treatment services. The functional ability of inmates should be the central concern in triage and placement decisions, rather than mental disorder diagnoses.
- A centralized substance abuse treatment database should be created to organize results from screening and assessment, to help coordinate the triage and placement process, and to track offender progress in treatment.
- In addition to key information regarding substance abuse problems, risk for criminal recidivism, and mental health problems, triage and placement decisions also should consider the offender's motivation and readiness for treatment, the length of sentence/incarceration, prior history in treatment, violence potential, and other related security and management issues.
- A centralized database that provides timely information on offenders as well as the availability of services should be developed to improve triage and placement.

Key points be considered when developing a substance abuse treatment plan for clients in the criminal justice system:

- Sufficient resources are needed for comprehensive assessment and treatment planning, including adequate staffing, clerical support, and access to computers and management information systems.
- When sharing information is not feasible (e.g., routinely providing detailed information to a drug court judge regarding offender disclosures in treatment), consultation, training, and written agreements are needed to define the types of information that will be shared, with whom, and under what circumstances.
- Procedures should be developed to control the flow of relevant information to the various staff involved in an offender's treatment and supervision. These procedures are required to protect the privacy and confidentiality rights of offenders. (For more information on confidentiality, consult www.hipaa.samhsa.gov and see CSAT 2004.)
- The offender should be involved in all major aspects of the treatment planning process.
- Procedures should be adopted for in-prison treatment programs regarding information sharing and flow of treatment records from one institution to another. Such procedures should control access to treatment providers and provide protection against rerelease of information related to self-disclosures of previous unreported criminal behavior or the intent to commit future crimes and psychiatric and medical histories, except when required by law. (For more information on confidentiality, consult www.hipaa.samhsa.gov and see CSAT 2004.)
- Treatment plans should assess the severity of the substance use disorder as well as any COD in order to place the offender in an appropriate treatment setting.

- Treatment plans should address motivation and readiness for change.
- Treatment plans should incorporate a strengths-based approach.
- Offenders possessing some degree of psychopathy may respond less well to traditional substance abuse treatment but benefit from intensive in-prison and community supervision that emphasizes consequences and sanctions for relapses.
- Correctional therapeutic community (TC) programs should consider use of instruments to measure client progress in treatment, as defined by the TC's goals for social and psychological change.

Appendix B: Glossary of Terms

Acquittal: Judicial deliverance from a criminal charge on a verdict or finding of not guilty.

ADAM: Arrestee Drug Abuse Monitoring Program; a program sponsored by the National Institute of Justice that periodically administers drug tests and short research interviews to samples of new arrestees in selected cities.

Addiction: Drug craving accompanied by physical dependence that motivates continuing use, resulting in a tolerance to the drug's effects and a syndrome of identifiable symptoms.

Addiction Severity Index (ASI): A standardized assessment tool used to conduct a comprehensive drug evaluation and to match offenders' drug problems with treatment approaches. (See also **Offender Profile Index**.)

Adjudication (for adults): The process of resolving a criminal case through the determination of guilt or innocence and determining a sentence if the person is convicted of the crime.

Adult offender: In most States people 18 or older are considered adult offenders and processed through the adult criminal justice system, but in three States people 16 or older are processed as adults and in some other States it is 17 or older.

Aftercare: Treatment that occurs after completion of inpatient or residential treatment.

Alcoholics Anonymous: The best known of self-help support groups, which serves as an important adjunct to treatment.

Ancillary treatment services: These include education about substance abuse, self-help groups (Alcoholics Anonymous, Narcotics Anonymous), and skills training.

Arrest: The physical taking of a person into custody on the grounds that there is probable cause to believe he or she has committed a criminal offense. An arrest may follow an investigation by law enforcement and is authorized by a warrant issued by a court.

Assessment: Evaluation or appraisal of a candidate's suitability for substance abuse treatment and placement in a specific treatment modality/setting. This evaluation includes information on current and past use/abuse of drugs; justice system involvement; medical, familial, social, educational, military, employment, and treatment histories; and risk for infectious diseases (e.g., sexually transmitted diseases, tuberculosis, HIV/AIDS, and hepatitis). (See also **Screening**.)

Bail: Security (usually financial) provided as a guarantee that an arrested person will appear for trial; release from imprisonment based on that security. (See also **Financial bail** and **Nonfinancial conditions**.)

Behavior contracts: An agreement between counselor and client about the sanctions and incentives that are to be applied when specified when the client performs specified behaviors.

Bond hearing: Proceeding before a judge to determine what (if any) conditions to set for a detainee's release pending trial.

Booking facility: A secure lockup usually operated by the local police or sheriff's department. New arrestees are taken to and held in booking facilities for paper processing, fingerprinting, criminal records, and warrant checks, pending the initial appearance before a judge.

Boot camp: Typically, a sentence to a boot camp (also called shock incarceration) is for a relatively short time (3–6 months). These camps are characterized by intense regimentation, physical conditioning, manual labor, drill and ceremony, and military-style obedience.

Boundary-spanner: An individual with knowledge of both substance abuse treatment and criminal justice systems who can facilitate the interaction of the two for the purpose of obtaining substance abuse treatment for offenders under criminal justice supervision.

Center for Substance Abuse Treatment: CSAT is a Federal agency within the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is part of the Public Health Service, under the Cabinet-level Department of Health and Human Services.

Classification: The process by which a jail, prison, probation office, parole, or other criminal justice agency assesses the security risk of an individual offender and the individual's need for social services.

Clinical formulation: The process of integrating information obtained through assessment into larger patterns or processes.

Clinicians: (See Counselors and clinicians.)

Coercion: The use of incentives and sanctions to encourage participation in substance abuse treatment.

Cognitive-behavioral therapy: Treatment that focuses on learning and practicing coping skills, some of which are cognitive in nature.

Community corrections: A model of corrections that has a primary goal of reintegrating the offender into the community. Typically will consist of judicial dispositions that involve alternatives to incarceration, such as diversion program, house arrest, electronic monitoring, probation, and parole.

Community notification laws: Laws that allow law enforcement to inform the public of the whereabouts (in some jurisdictions the specific home address) of offenders. The laws generally apply to sex offenders and typically include the "risk" level of the offender. Community notification laws are in effect in 50 States and the District of Columbia.

Community reintegration planning: Preparation and strategy for each prisoner's release from custody. The plan prepares for the prisoner's return to the community in a law-abiding role after release.

Community supervision or Community-supervised activities: These are outside the formal criminal justice system. Such activities include, for example, drug testing, programs to promote sobriety and prevent relapses, and day reporting centers.

Community treatment: This is a program outside the formal criminal justice setting. It may be run by public or private organizations (nonprofit or profit-making). Treatment may take place in a residential group (e.g., a halfway house) or a nonresidential activity (e.g., required attendance at Alcoholics Anonymous meetings). Treatment methods may vary. Both community treatment and community supervision are usually mandated by a court. An active partnership between these two should be built into planning activities for both.

Conditional release: Release from custody under specified conditions.

Confidentiality: The right of privacy for a client's/offender's personal information, except in certain law-enforcement situations.

Continual interagency communication: The ongoing cooperative effort among treatment/criminal justice/public health personnel needed to successfully treat and supervise offenders involved with drugs. Communication among these systems facilitates a united approach.

Co-occurring disorders: The co-occurrence of a mental disorder and a substance use disorder. Other uses of the term include substance abuse accompanied by one or more physical or psychological conditions. Sometimes referred to as dual disorders.

Corrections system: Includes jails and detention centers, prisons, and community supervised settings.

Counselors and clinicians: Treatment professionals serving clients who abuse substances and are involved in the criminal justice system.

Court-mandated treatment: A court order to participate in treatment as part of a sentence or in lieu of some aspect of the judicial process.

Cultural competence: A set of academic and interpersonal skills that helps individuals increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. It requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable people from the community in developing focused interventions, communication, and support.

Curfew: In the criminal justice context, a rule or condition applied to individuals on probation or parole, requiring them to be in their residence and remain there by a specific time. An individual sentenced to house arrest will have a curfew.

Day reporting center: An intermediate sanction, this is a place where offenders on probation or parole must report to receive supervision for a certain number of hours each day. These centers may include educational services, vocational or skills training, and other service delivery. Offenders may also report by phone from a job or treatment site during the day.

Denial breaking: An intervention strategy designed to confront thought processes that prevent the individual from acknowledging problems related to his or her use of alcohol or illicit substances.

Detention: Holding a defendant in jail or other facility pending trial or determination of guilt.

Detention center: For adults, a holding facility such as a jail.

Determinate sentence: A sentence in which the length of incarceration is fixed by the court.

Deterrence: Being deterred from criminal activity because of fear of involvement in the criminal justice system or other punishment.

Detoxification: A structured medical or social milieu in which an individual is monitored for withdrawal from the acute physical and psychological effects of addiction.

Developmental interagency coordination: Collaboration among personnel from criminal justice, treatment, and public health to form expert justice/treatment/public health systems. For example, developmental interagency coordination is essential in the assessment of the drug-involved offender and in the development of referral procedures and reporting policies, as well as in understanding each system's definition of success and failure.

Disposition: The final resolution of a criminal case (e.g., in a case in which an individual is found not guilty, the disposition is an acquittal and release).

Diversion: The process whereby a defendant's prosecution is deferred or dropped if certain conditions are met. Diversion also is the judicial option to refer prison-bound cases to a review board, which in turn may recommend that the original sentence be modified or suspended and that the offender be placed in a residential or nonresidential program.

Drug courts/Drug treatment courts: Specialized courts commonly designed to handle only felony drug cases, usually involving adult nonviolent offenders. Drug courts can involve intensive monitoring, drug testing, outpatient treatment, and support services. They often operate with probation supervision and services.

Drug testing: Technical examination of urine samples to determine the presence or absence of specified drugs or their metabolized traces.

Drug use forecasting: Arrestee urinalysis data based on studies conducted under the Drug Use Forecasting (DUF) System of the National Institute of Justice.

DSM-IV: *Diagnostic and Statistical Manual, 4th edition,* published by the American Psychiatric Association, a standard manual used to categorize psychological or psychiatric conditions.

Due Process (of Law): Legal proceedings established to protect individual rights and liberties.

DUI, DWI: Driving under the influence or driving while intoxicated.

Duty to warn: A treatment professional's duty to report a patient's threat to harm another or to commit a crime (does not apply to knowledge of a client's past offenses).

Electronic monitoring: A sanction in which an electronic device is worn by an offender that can alert corrections officials to the unauthorized absence from the house of a person under curfew/house arrest. (See also **House arrest**.)

Financial bail: An amount of money, set by a judge, that is used to ensure the defendant's appearance at court. (See also **Bail** and **Nonfinancial conditions**.)

Habilitation: Training in social problemsolving skills for people with mental illness requiring the client to**:** (1) define the problem; (2) generate alternative solutions; (3) choose the best solution, (4) make a plan, and execute it; and (5) evaluate the outcome.

Halfway house: A transitional facility where a client is involved in school, work, training, etc. The client lives onsite while either stabilizing or reentering society drug free. The client usually receives individual counseling, as well as group/family/marital therapy. He or she may leave the site only for work, school, or treatment. This facility can be in the community or attached to a jail or similar institution. (See also **Work release** .)

House arrest: The restriction of offenders to their homes for various periods of time. (See also **Electronic monitoring** .)

Incarceration: Holding a person in a detention center, jail, or prison (State or Federal) because of suspected or actual involvement in criminal activity.

Indeterminate sentence: A prison sentence in which the amount of time to be served is indeterminate and is usually determined by a Parole Board after a minimum period of incarceration. Judges generally impose a minimum and maximum incarceration term in indeterminate sentences.

Infectious diseases risk assessment: Evaluation of a person's risk for sexually transmitted diseases, tuberculosis, HIV/AIDS, and other infectious diseases, including information regarding current and past history, screening, and treatment of such diseases. Testing and referral for treatment are recommended for those with substance use disorders who are assessed as at high risk for such diseases. Those with substance use disorders who are assessed as at low risk should be reassessed intermittently. Thus, collaboration between criminal justice personnel, treatment personnel, and public health personnel must be developed in order to ensure interagency coordination in the assessment and treatment of the drug-involved offender at various stages throughout the criminal justice continuum and in the development of referral procedures and reporting policies, as well as in understanding each system's definitions of success and failure.

Intermediate sanctions: Community-based programs providing increased surveillance, tighter controls on movement, more intense treatment for a wider assortment of maladies or deficiencies, increased offender accountability, and greater emphasis on payments to victims and/or corrections authorities. Intermediate sanctions are less punitive than incarceration but more punitive than simple probation. (See also **Sanctions**.)

Interpersonal issues: Those between the client and counselor in the therapeutic relationship. Includes boundaries, training, the need for peer role models and cultural sensitivity, respect for confidentiality and privacy, and the counselor's duty to report certain client crimes.

Intrapersonal issues: Those stemming from an individual's psychological makeup and/or physical conditions (including co-occurring disorders), as well as one's social skills, educational status, and personal support system.

Jail: A place for holding a person in lawful custody, usually while he or she is awaiting trial. In some jurisdictions, jails are used punitively for offenders serving short-term sentences or those involving work release or weekends in incarceration. Jails range in size from small rural ones with a dozen or so cells to urban settings with thousands of cells. Jails usually are operated by cities or counties.

Linkages: The provider establishes working relationships with various agencies and facilities in order to refer clients with multiple life problems to accessible, appropriate vocational training, medical, assisted living, and legal assistance services.

Management Information System (MIS): A computer system that assists in organizing information for the purposes of planning and maintaining a business or other organization.

Mandatory release: Required release of an inmate from incarceration upon the expiration of a certain period, as stipulated by a determinate sentencing law or by parole guidelines.

Memorandum of understanding (MOU): A written but noncontractual agreement between two or more agencies or other parties to take a certain course of action.

Methadone treatment: Medically supervised outpatient treatment that provides counseling while maintaining a client on the drug methadone (used mainly for heroin or other opioid addiction).

Monitoring for compliance: Surveillance of an offender to ensure that the conditions imposed on an individual are being adhered to.

Narcotics Anonymous: A self-help and support group similar to Alcoholics Anonymous.

National Treatment Plan Initiative: Developed by CSAT, this initiative is a blueprint for improving substance abuse treatment.

Negative predictive value: The proportion of offenders identified by a screening or assessment instrument as not having substance abuse problems, compared to the total number not having substance abuse problems.

Nonfinancial conditions: Release requirements set by a judge that do not include monetary payment (e.g., required participation in supporting services, such as substance abuse treatment). (See also **Bail** and **Financial bail**.)

Nonresidential treatment of incarcerated people: In this form of treatment, prisoners receive treatment either through day care programs, regularly scheduled therapeutic groups, or other nonresidential programs.

"No Wrong Door": This key component of CSAT's National Treatment Initiative indicates that no matter where they enter the health or social service system, people should be able to get treatment for substance abuse, either directly or through appropriate referral.

Offender Profile Index: A standardized assessment tool used to conduct a comprehensive drug evaluation and to match offenders' drug problems with treatment approaches. (See also **Addiction Severity Index**.)

On recognizance: Release on one's own responsibility (e.g., with an obligation to appear in court, but the release is not secured by financial bail).

Overall accuracy: The extent to which a screening or assessment instrument classifies respondents correctly.

Parole: The conditional release of an inmate from prison under supervision after part of a sentence has been served. The inmate is subject to specific terms and conditions which are monitored by an officer/agent.

Peer staff: Individuals in recovery from substance abuse disorders who have been trained for work in the treatment or criminal justice areas.

Personal bond: Release from court on one's own promise to appear in court, without financial conditions. Similar to release **on recognizance**.

Pharmacotherapies: Treatment of disease with drugs. In substance abuse treatment, these include methadone, naltrexone, and buprenorphine.

Placement: Assigning substance abuse treatment program participants with appropriate community substance abuse treatment facilities when such individuals leave the correctional facility at the end of a sentence or on parole.

Plea bargain: An agreement by a defendant to plead guilty to a criminal charge with the expectation of receiving some consideration from the prosecution for doing so. Typically the consideration is a reduction of the charge. The defendant's goal is a penalty lighter than the one warranted by the charged offense.

Positive predictive value: The proportion of offenders identified by a screening or assessment instrument as having substance abuse problems, compared to the total number having substance abuse problems.

Preliminary hearing: A court hearing in which initial information about the case is presented. This hearing usually is used to determine if there is sufficient evidence of guilt to continue the case, resolve evidentiary issues, or make initial case decisions.

Prerelease assessment: This information on an individual's situation/condition, as provided by treatment professionals, should be available to the judge, prosecutor, and other participants at the time of a presentence hearing or trial/sentencing. If an individual is paroled, the information should be conveyed to the parole officer for follow-up and evaluation. Recommendations for referral for treatment can be made at this time.

Presentence hearing: An event at which the prosecutor, defense attorney, and judge meet before a trial to establish parameters for that trial. A plea bargain is often negotiated at this point.

Presentence investigation: An investigation into the background and character of a defendant that assists the court in determining the most appropriate sentence in a case. Typically occurs after the person has been convicted, but prior to sentencing.

Pretrial hearing: Appearance in court before a magistrate, at which time bond is set or a determination is made to retain a person in jail or release him or her.

Pretrial stage: Activities in the criminal justice process that occur between arrest and trial.

Prison: A secured institution (Federal or State) in which convicted felons are confined after sentencing for crimes. Prisons are classified as minimum-, medium-, or maximum-security facilities, based on the need for internal institutional fortification. Inmates are similarly classified, according to severity of offense and/or other behavior and are usually assigned to prisons having a corresponding level of security.

Probation: A sentence in which the offender is allowed to remain in the community in lieu of incarceration. The individual is supervised and is ordered to comply with specific terms and conditions.

Problem-solving courts: These specialized court settings include drug courts, family courts, jail courts, and mental health courts.

Process evaluation: Determination of whether individuals actually received the treatment as it was intended to be delivered; examines implementation and operation of a program in comparison with the stated intent.

Protocol: Consists of guidelines and procedures for dealing with a particular issue or activity.

Psychopharmacology: The science dealing with the effect of medications in treating psychiatric conditions.

Recidivism: The commission of crime after an offender has been sentenced and/or released.

Re-entry formulation: The process of providing counseling and community-based supports to ex-offenders who abused substances and who are returning to society.

Relapse prevention: Strategy to train people with substance use disorders to cope more effectively and to overcome the stressors/triggers in their environments that may lead them back into drug use and dependency.

Reparation: (See Restoration.)

Residential treatment: Inpatient treatment, in which the client spends 24 hours a day in the treatment environment.

Restoration: Sometimes referred to as reparation, its aim is to restore the community to its state before a crime was committed. It does this in part by preventing the offender from reoffending through rehabilitation, incapacitation, or deterrence.

Restitution: Payment by an offender of the costs of a victim's losses or injuries and/or damages to the victim. Payment can be made to a general victim compensation fund or to the community as a whole (with the payment going to the municipal or State treasury).

Risk/needs assessment: A comprehensive report that includes a client's social, criminal, and other history. The report usually includes a recommendation for sentencing if the client is found guilty.

Sanctions: Legally binding orders of a court or paroling authority that deprive or restrict offender liberty or property. An **intermediate sanction** (see above) is more rigorous than traditional probation but less so than total incarceration.

Screening: Gathering and sorting of information used to determine if an individual has a problem with substance abuse and, if so, whether a detailed clinical assessment is appropriate. (See also **Assessment**.)

Security classification (in criminal justice): The process of assigning an inmate to a category based on the perceived likelihood of an offender's attempt at escape, propensity for violence, or management concerns.

Sensitivity: The extent to which a screening or assessment instrument accurately identifies those with substance use disorders (true positives).

Sentencing: The disposition of a case where penalties are imposed.

Skills training: This includes job and vocational skills, life skills (budgeting, leisure, etc.), literacy and GED classes, anger management, general coping skills, communication skills, parenting classes, building families and relationships, and social skills.

Sobering station: A 24-hour facility where individuals can be housed and monitored while under the influence of mood-altering substances.

Sobriety maintenance: The last step in recovery when the client has achieved stable sobriety and efforts are directed toward maintaining that stability.

Special-needs probation programs or caseloads: In these approaches to intermediate sanctions, officers with special training carry a restricted caseload. Typically, these approaches are used with offenders who have committed certain categories of domestic violence, sex offenses, and DUI, and with offenders who are mentally ill, developmentally disabled, or abuse substances. This situation can mean more intensive or intrusive supervision than in routine caseloads; enhanced social and psychological services; and/or specific training or group activities, such as anger management classes.

Specific populations: These include a wide range of people facing a wide range of issues—for example, racial/ethnic/sexual minorities and women, people with disabilities, older people, and those who are underserved or underrepresented in treatment. This term can also include violent offenders, sexual offenders, victims or perpetrators of domestic abuse, psychopaths, and offenders with life sentences.

Specificity: The extent to which a screening or assessment instrument accurately identifies those without substance use disorders (true negatives).

Split sentence: A sentence involving a short period of incarceration followed by probation or some other form of community supervision.

Stakeholders: Those who have a key interest/investment in an issue or activity—includes clients, treatment and criminal justice personnel, and policymakers.

Test-retest reliability: This quality of a screening or assessment instrument, expressed as a coefficient, is "obtained by administering the same test a second time to the same group after a time interval and correlating the two sets of scores" (American Educational Research Association 1999, p. 183).

Therapeutic community: Traditionally, this is a long-term (up to 24 months) rehabilitative model that relies mainly on peer staff and on work as education and therapy. Other staff include treatment and mental health professionals and vocational and educational counselors. The aim here is a global change in a person's lifestyle, focused on developing vocational, educational, and social skills. Most residents have been involved with the criminal justice system.

Treatment: Refers to the broad range of primary and supportive services - including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychological services, and follow-up - provided for people with alcohol and illicit drug problems. The overall goal of treatment is to eliminate the use of alcohol and illicit drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse progress of associated problems.

Treatment matching: Pairing clients with treatments and services that reflect their particular traits and needs in order to enhance the potential for better outcomes.

Treatment planning: The process of planning a client's total course of treatment, based on the findings of assessment procedures.

Treatment progress assessment: A process that determines the value of the chosen course of treatment, its suitability for the client, and how it should be extended or adjusted if necessary.

Triage: A process for sorting injured people into groups based on their need for medical treatment—in short, immediate attention and first-stage treatment for people with substance abuse disorders and others.

Trial: A court hearing at which a prosecutor presents a case against a defendant to show that he or she is guilty of a crime. The defendant presents information to support the plea that he or she is not guilty. The judge or jury decides the verdict.

Unbroken contact: Early, thorough, and substantial substance abuse treatment delivered in an unbroken manner throughout the entire criminal case-handling process, from arrest through the completion of the sentence. The components of the system must transfer not only the offender but also the cumulative record of what the system has learned and what it has done.

Urinalysis: The testing of a urine sample for the presence of drugs.

Waiver: A court action in which the defendant agrees to forgo certain legal rights, such as the right to a grand jury hearing or the right to a speedy trial. The term is also used to indicate the transfer of a juvenile offender to the adult criminal justice system when he or she has been accused of committing certain serious crimes.

Work release: An alternative to total incarceration, whereby inmates are permitted to work for pay in the free community but must return to a secure facility during their nonworking hours. (See also **Halfway House**.)

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Appendix C: Post Test and Evaluation for Treating Clients in the Criminal Justice System

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

NOTE: QUESTIONS ON THE ONLINE EXAM MAY BE IN A DIFFERENT ORDER THEN THE PRINTED EXAM.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. Specialized treatment interventions include:

    a. Individual counseling
    b. Motivational enhancement
    c. Peer mentors
    d. All of the above

2. A long-term (15-24 month) rehabilitative residential model often staffed by recovering professionals and other counselors, including vocational and educational components, is called:

    a. A Therapeutic Community
    b. Psychosocial residential care
    c. A Halfway House
    d. A Group Home

3. The community-based system of care across the country is primarily designed to provide services to a non-offender population.

    a. True
    b. False

4. An optimal treatment matching system should reflect:

    a. The range of different levels of treatment intensity available
    b. Admission eligibility information needed for each level of treatment
    c. Consequences of “mismatching” offenders to treatment levels
    d. All of the above
    e. None of the above

5. Offenders with more severe addiction problems and more significant risks for criminal recidivism experience the most positive treatment outcomes when placed in highly structured and intensive treatment programs.

    a. True
    b. False

6. Referral to a more specialized treatment or management program is necessary for persons with any of the following except:

    a. High criminogenic/recidivism risk
    b. Major mental health disorder
    c. Low cognitive functioning
    d. Psychopathy

7. Offender characteristics and environmental factors used to estimate the likelihood of future criminal behavior are termed “recidivism correlates.”

    a. True
    b. False

8. Entitlement, lack of empathy, sensation seeking, and superficial interpersonal relationships are primarily characteristic of:

    a. Sociopathy
    b. Narcissistic personality disorder
    c. Psychopathy
    d. None of the above

9. Which of the following is useful information in triage and placement?

    a. Offender’s family and social network characteristics
    b. Offender’s criminal history
    c. Existence of personality disorders, including psychopathy
    d. Offender’s age, education, marital status, employment history
    e. All of the above

10. All but which of the following are listed as instruments to gauge the level of substance abuse problems?

    a. SASSI (Substance Abuse Severity Screening Index)
    b. ASI (Addiction Severity Index)
    c. Alcohol Dependency Scale (ADS)
    d. Texas Christian University Drug Screen (TCUDS)
    e. Simple Screening Instrument for Substance Abuse (SSI-SA)

11. The ability of offenders with co-occurring disorders to participate in treatment depends on all of the following except:

    a. Ability to sustain attention
    b. Physical functioning
    c. Cognitive functioning
    d. Ability to participate in individual and group interactions
    e. Vulnerability to emotional conflict

12. Justice system sanctions and incentives, including mandatory treatment, do not significantly influence towards an offender's motivation to participate in treatment.

    a. True
    b. False

13. Involvement in group counseling and contact with program participants and staff can stimulate motivation for change in the previously unmotivated offender.

    a. True
    b. False

14. In the Prochaska stages of change model, the decision to do something about the substance abuse problem happens in the _____ stage.

    a. Pre-contemplation
    b. Contemplation
    c. Preparation
    d. Action
    e. Maintenance

15. The Magargee Classification System is based on an extensive analysis of federal inmates' responses to the:

    a. ASI
    b. MMPI
    c. URICA
    d. SOCRATES
    e. None of the above

16. The American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC-2R) for the Treatment of Substance-Related Disorders has not yet been formally adapted for offender populations.

    a. True
    b. False

17. Severely disruptive behavior, intense sense of distress, self-destructive behaviors, and an inability to monitor and control emotions are characteristic of:

    a. Post-traumatic Stress Disorder (PTSD)
    b. Intermittent Explosive Disorder
    c. Bi-polar Disorder
    d. Borderline Personality Disorder

18. Because procriminal values and thinking are rooted in *normal* cognitive, emotional and social process, they may be modified by the psychosocial methods used in substance abuse treatment.

    a. True
    b. False

19. "Psychopathy" differs from "pro-criminal values" and "pro-criminal associates" in its:

    a. Emergence later in life
    b. Lesser degree of criminal involvement
    c. Biological underpinnings
    d. Greater likelihood to improve with treatment
    e. All of the above

20. _____ is an approach that has been developed specifically for treatment of borderline personality disorder, and can be successfully integrated with substance abuse treatment programs.

    a. Dialectical Behavior Therapy
    b. Cognitive Behavioral Therapy
    c. Community Reinforcement Approach
    d. Personality Restructuring Approach

21. It can be safely assumed that crimes committed by drug-involved offenders are attributable to intoxication and impaired brain functioning.

    a. True
    b. False

22. From the first point of intake to the final community supervision session, promoting and utilizing _____ should be an upfront aspect of substance abuse treatment.

    a. Abstinence techniques
    b. Peer support
    c. The client's motivation
    d. A treatment plan

23. The offender should be involved in all major aspects of the treatment planning process and should address motivation and readiness for change.

    a. True
    b. False

24. Incarcerated individuals are exempt from privacy and confidentiality protections of HIPAA.

    a. True
    b. False

25. "Triggers" that may provoke a relapse include:

    a. Old drinking or drug associates
    b. Being around drug paraphernalia
    c. Interpersonal conflict
    d. Negative or positive emotions
    e. All of the above