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3 Triage and Placement in Treatment Services

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 chapter provides detailed information on how to best use the information obtained through screening and assessment in order to match the offender to appropriate treatment services. It begins by discussing three major treatment categories and outlines barriers to placement. A detailed discussion of triage and placement follows.

Overview

Treatment Levels and Components

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- Inadequate Screening and Assessment
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- Offender Motivation and Readiness for Change
- Examples of Triage and Placement Approaches

Conclusions and Recommendations

Treatment Levels and Components

The consensus panel believes that 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, the consensus panel believes 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

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 posttreatment followup 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 posttreatment followup 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 posttreatment 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 chapter 2 of this TIP and the forthcoming TIP *Detoxification and Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] in development *a*).

Outpatient Treatment

Also referred to as ambulatory care, outpatient treatment provides a broad range of services without overnight accommodation and includes nonintensive 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 followup care after involvement in a residential program.

- *Nonintensive outpatient treatment*. This is substance abuse treatment that includes professional assessment and treatment involving less than 9 hours per week in regularly scheduled sessions. Nonintensive 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. Nonintensive 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. (For more information see the forthcoming TIPs *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* [CSAT in development *d*] and *Substance Abuse: Administrative Issues in Intensive Outpatient Treatment* [CSAT in development *c*].)
- *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. (For more information see TIP 43, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* [CSAT 2005*a*]).
- *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). A 2-day training course offered by the Mid-America Addiction Technology Transfer Center in Kansas City, Missouri, is available. This course consists of lectures, small groups, and instructional materials on the TC model and how it works. For more information go to www.mattc.org/index.html.
- *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 nonoffender 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

The consensus panel believes that 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.

Based on the experiences of consensus panel members, 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 the consensus panel believes 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 (for more information on confidentiality, go towww.hipaa.samhsa.gov and seeCSAT 2004)
- 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. The consensus panel recommends that 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 3-1). 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 are discussed comprehensively in chapter 2. This section outlines how to use information derived from screening and assessment to make triage and placement decisions.

As described in Figure 3-1, 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. For more information on the instruments listed, see chapter 2 and appendix C.

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.” (See chapter 2 for information on identifying 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 3-1) (Falkin et al. 1999).

Information needed for triage and placement

- 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

Use of some of these instruments is described in chapter 2.

- 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

Use of these instruments is described in chapter 2.

- 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).

Information needed for triage and placement

- 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, problemsolving 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

Instruments used to compile this information

Use of these instruments is described in chapter 2.

- 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, the consensus panel cautions that 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 chapter 5 regarding matching treatment services to the offender's stage of recovery. For more information, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).

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 consensus panel thought that 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

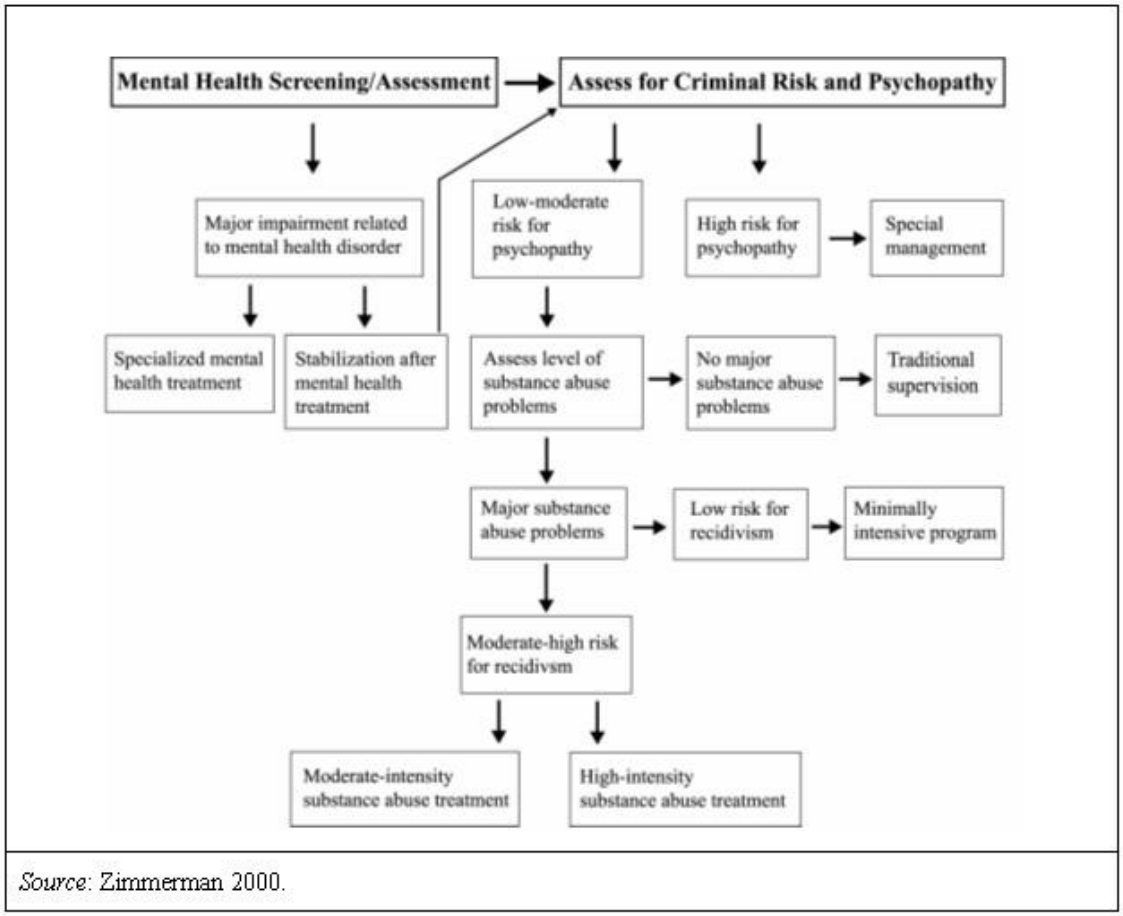
The ASAM approach, or similar dimensional matching strategies, may be useful for substance abuse treatment staff within criminal justice settings. Although the ASAM criteria have not yet been formally adapted for offender populations, the PPC-2R could prove helpful in providing a structured vehicle for 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).

Conclusions and Recommendations

The consensus panel recommends that several key points 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.

Figures



Source: Zimmerman 2000.

Figure 3-1 Placement and Triage Strategies