Response: The claims of public health and public safety

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Jennifer Mankey: The overall message of the article, I think, is most appropriate in this era of decreased funding for treatment, criminal justice, and behavioral and medical services. The purposeful, improved sorting and matching of offenders to the most appropriate treatment and supervision can help us to use our scarce resources most effectively, while maintaining community safety.

William Wendt: The message certainly rings true to folks in our system. But the issue of having offenders in treatment for 12 months to maximize outcomes is of concern to providers because of funding. There aren't enough resources to keep folks in treatment for that period of time.

Allan Cohen: The author makes a compelling argument for the integrated approach. But while he points out that highly structured cognitive-behavioral therapy [CBT] works very well for the high-risk group, these are very expensive programs to run. I don't know whether or how widely that could be adopted in community treatment programs. I don't know if there is enough money for training and paying staff for those interventions. Money aside, training people to do structured, contingency-management, cognitive-behavioral therapies is not easy.

Mankey: That's true, but I think that we need to rise to the challenge. In Colorado, some probation officers deliver CBT to their clients. I wonder whether, in communities where teaching CBT would be a particular burden to treatment providers, the probation department and treatment programs could integrate what they both are using for these patients.

Cohen: They could use manualized treatment models like the Matrix model. That would facilitate their joint role.

After reading Dr. Marlowe's work, I am more encouraged about serving these patients. My sense is that we're getting better at addressing these issues, and that there is hope for bigger strides in the future.

Wendt: It's a tough road, but we are getting there, with more collaboration between the systems and blended funding.

Mankey: I agree. And there is finally good research coming out that can help guide us in the juvenile offender field.

Cohen: I'd like to know more about what it is that really makes the difference for these patients. Dr. Marlowe's article suggests that a coercive factor is very important in the outcomes. I'd like to know a little bit more about what other specific factors do or don't relate to treatment outcomes.

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Finding common turf

Mankey: Something in the article that resonates with my experience is the need to sort out the roles of the criminal justice or juvenile justice side and the treatment side. For example, Marlowe recommends that with low-risk offenders, the criminal justice monitor/supervisor/probation/parole officer should refrain from supervision over treatment. If they are currently supervising treatment, asking about attendance and progress, Marlowe recommends that they stop doing so. Instead, they should concentrate on supervising the offender's functional behaviors, which show whether treatment is working. This is a critical point: With high-risk offenders, the recommendation is for more of a coordinated, case-management approach, with more information-sharing and more criminal justice supervisory authority.

Wendt: I can tell you, from my previous life as a director of a treatment program, that some probation officers want to dictate the terms of treatment and are overly invasive in the process, demanding to sit in on staffings and wanting to write the treatment plan. I

can certainly empathize with some of their frustrations: Some feel their clients aren't getting good treatment; the system is inadequate, they don't treat the family, they don't have the full array of services. It's easy for the officer to think, 'If I did the treatment myself, or if I controlled it, it would be better.'

Philosophical issues feed the tension between treatment providers and criminal justice. Some practitioners feel that they are therapists, not cops. If the client comes in and says, 'I've relapsed,' or produces a drug-positive urine sample, the counselor is afraid that sending that information to the parole officer pits counselor against client. Particularly if they are working from a harm-reduction model and the client is at risk for violating probation and being incarcerated. That is a very real issue for some practitioners more than others.

Cohen: In California we run across philosophical bias constantly. One is the old stigma against methadone. Both in drug courts and in Proposition 36, methadone maintenance treatment is largely excluded from the client's options, even though it's included in the language of the law. In many counties the local judges who oversee the drug courts are forcing patients who are doing well on methadone maintenance to discontinue methadone treatment as a prerequisite to participation in the drug court program. In the first year of Proposition 36, 11.5 percent of clients in that program listed heroin as their primary drug of choice, and only 0.9 percent of them are in methadone maintenance treatment. I know from speaking to colleagues in other States that they face similar biases. The situation is changing, but very, very slowly.

Wendt: I don't think that is as much of an issue in our community. Most of our methadone providers have decent working relationships with the criminal justice system. We also don't have the high volume of opiate-dependent folks that you are probably seeing.

Mankey: We have spent the last 12 years building relationships and providing policies and processes for our juvenile offender populations to be appropriately treated. In general, the treatment providers who serve kids referred through our juvenile probation and other agencies are very open and provide good services for the juvenile offender population. It took a lot of work to build that relationship. In Colorado now, any adolescent treatment provider who receives State funds is required to accept the juvenile offender population in addition to the general adolescent population. That has really helped us move toward cross-training our juvenile justice agencies and adolescent treatment providers to implement the best practices of the day. Obviously, we are still working on it.

Wendt: I think that blended-funding models are important. My contract with the State has a line item to fund treatment for offenders. As soon as we received this money, I met with every TASC [Treatment Accountability for Safer Communities] director in our 35-county area, and said, 'Listen, we have funds to support this program. Let's work together. You can refer your clients to us. Let's look at some blended-funding models and increased collaboration.' Some TASC programs have taken it a step further. They will pay a portion of the client's copayment if it seems to be a barrier to treatment. I think this kind of modification to the system is what's going to be required.

Mankey: The case calls for some solid, coordinated case-management approaches between criminal justice and treatment. In Denver, juvenile TASC has played this role. Communities that don't have TASC programs are going to have to ratchet up their criminal justice supervision and institute cross-training between the criminal justice and treatment communities.

Dueling assessments

Cohen: In California there doesn't seem to be any consistency across the State with respect to what treatment should be. Often the judge is the one who determines how intensive the drug court experience will be for an offender. In Proposition 36, each of our 52 counties implements the program in its own way. Someone who is referred for level 1 treatment in Los Angeles County will not necessarily get the same intensity of treatment as a level 1 patient in Ventura County. In many cases, there are few tie-ins between the treatment prescription and any logical, evidence-based clinical guidelines. I would like to see treatment tied to ASAM [American Society of Addiction Medicine] patient placement criteria. While this is the standard in some counties, it is, for the most part, the exception rather than the rule. Treatment should always be evidence-based and conform to good clinical practice

standards rather than personal bias, irrespective of the patient's motivation for seeking or entering treatment. I believe that this author's work is a step in that direction.

Wendt: I disagree about the ASAM criteria, because they don't assess risk factors for criminal recidivism. From the criminal justice system's point of view, they are not helpful.

When we started improving our collaboration between criminal justice and providers here in Colorado, we found we were speaking different languages. We were using different instruments, different placement criteria. We developed a kind of creative crosswalk between what the standardized offender assessment was essentially saying and the ASAM world that providers live in. I think it has been fairly successful.

Mankey: Your comment on crosswalking the ASAM and the criminal justice assessments is critical, Bill, because the risk assessment is administered within the criminal justice system. That's where they determine a low-level versus a high-level offender, which in turn is determining the level of treatment as well as criminal justice supervision. So coordination really is crucial.

Cohen: The idea of mapping something from criminal justice onto a clinical tool is absolutely necessary. The Community Assessment Centers that assess offenders referred through Prop 36 use the ASI [Addiction Severity Index], which does address the patient's legal situation to some degree. The ASI seems to be the instrument most of California is relying on for assessment and placement.

Trying to match patients with treatment has always been a challenge. I intend to take this article to the decisionmakers—the judges, the probation and parole departments that we deal with—to help convince them that more thought does need to go into these decisions, and that not everybody fits into one category of risk.

Mankey: We have had some measure of success in matching offenders to treatment. Our juvenile drug courts focus on the medium- and high-risk offenders, but the entry criteria probably do the best job of sorting out these groups. We might have a couple of low-risk offenders in the courts, too. As this article points out, an increased level of supervision for low-risk patients isn't a good use of resources.

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Dr. Marlowe suggests that with a little tweaking of the treatment protocol, lower risk offenders can participate with the general population. To my mind, there are different dynamics that happen if, say, an offender gets put into a group setting. He or she may have some issues that are distinct from the general population.

Cohen: There are arguments on both sides with regard to mixing offenders and nonoffenders. There are benefits to not having to set up two tracks in your program. You can run it more cost-efficiently, you can deliver it to more people, and you are not stigmatizing the offenders any more than they already are stigmatized. &