4 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) 1994d, 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 chapter 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.

Overview

Assessing the Severity of Substance Use Disorders

Assessing the Severity of Co-Occurring Disorders

Posttraumatic Stress Disorder (PTSD) and Depression
Severe Mental Disorders
Intermittent Explosive Disorder
Borderline Personality Disorder

Criminality and Psychopathy

Sources of Criminality
Psychopathy

Client Motivation and Readiness for Change

Focus on Personal Strengths

Implementing an Effective Treatment Planning Process

Offender Involvement in the Development of the Treatment Plan
Coordination of Treatment Planning and Sharing of Treatment Information
Linkages With Community Treatment
Conclusions and Recommendations

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 (see chapter 2).

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). (See also TIP 42, Substance Abuse Treatment for Persons With Co-Occurring Disorders[CSAT 2005b]. )

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. Problemsolving 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 prorerecovery relationships. Treatment approaches that address criminal thinking are discussed in chapter 5.

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 1998a ).

The Psychopathy Checklist-Screening Version (PCL-SV) can provide an important screening mechanism for identifying those offenders who may require a more extensive evaluation. The PCL-SV and other instruments for examining psychopathy are discussed in more detail in chapter 2. 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. (See chapter 3 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. Several techniques for screening and assessment of readiness for change are discussed in chapter 3.

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. (For more information, see TIP 35, Enhancing Motivation for Change in Substance Abuse Treatment[CSAT 1999b ].)

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

The consensus panel believes that 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 4-1). 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 4-1 Client's Recovery Plan (CRP)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>WH #</th>
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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
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. The consensus panel recommends that treatment plans 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. (See TIP 30, Continuity of Offender Treatment for Substance Use Disorders From Institution to Community[CSAT 1998b].)

Conclusions and Recommendations

The consensus panel recommends that several 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.

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