to 33 percent of untreated inmates.

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Classification, Assessment, and Treatment Planning for Alcohol and Drug-Involved Offenders

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The history of criminal justice decision making in the United States has often been described as a chronicle of missed opportunities, failed experiments, and arbitrary and misguided judgments. Laws have been passed without consideration of their long-term or even short-term consequences; programs have been implemented in the absence of appropriate need, resources, or basic cognizance of the issues they were intended to address; and experiments have been tried, and either continued or abandoned, typically with limited knowledge of their effectiveness. The reasons for the many miscalculations have been numerous—ignorance and bias, political expediency, frustration, faulty intuition, and even the fear of crime and criminals.

None of this should suggest, however, that **all** decisions made by, and programs established in, criminal justice organizations have been faulty. There is much that has been positive. Of special interest here are **classification** and **assessment**—aspects of criminal justice decision making that have an interesting past and an important future.

The terms "classification" and "assessment" are often used interchangeably, but in the criminal justice field the two have alternative histories and applications. "Classification" comes primarily from the correctional field, and every prison experience begins with classification.

In its broadest sense, classification is the process used to determine the educational, vocational, treatment, and custodial needs of the offender. At least theoretically, it is a system by which a correctional agency reckons differential handling and care, and fits the treatment and security programs of the institution to the requirements of the individual.

"Classification" in the correctional field

The most rudimentary forms of correctional classification were seen when the practice developed of imprisoning people after conviction. Separating the guilty from the not-guilty was itself a process of classifying those accused of criminal behavior. The separation of debtors from criminals was a type of classification by legal status.

Classification is now based on diagnostic evaluation and treatment planning, followed by placement of the offender into the recommended institutional program or into one type of correctional facility as opposed to another.

Early forms of classification included the segregation of men from women, youths from adults, and first offenders from habitual criminals. Examples of rudimentary classification schemes include the reformatory movements of the late 19th century, the differentiation between maximum- versus medium- and minimum-security prisons, and the designation of Alcatraz as a superpenitentiary for the most incorrigible felons.

As correctional systems continued to evolve, the principle of classification was used as the basis for separating the feeble-minded, the tubercular, the venereally-diseased, the sexually deviant, the drug addicted, and the aged and physically disabled from the general prison population or for placing them in special institutions.

Currently, classification goes beyond the mere separation of offenders on the basis of age, gender, custodial risk, or some other factor. It is now based on diagnostic evaluation and treatment planning, followed by placement of the offender into the recommended institutional program or into one type of correctional facility as opposed to another. The extent to which classification schemes are used tends to vary, however, not only from State to State but also among institutions within the same jurisdiction.

"Assessment" in criminal justice

"Assessment" in criminal justice has typically been a suborder of classification. Historically, custodial decisions, and eventually bail, sentencing, and parole decisions, were being made on assessments of risk—risk of escape, risk of absconding, risk to the community, and risk of recidivism.

Early in the 20th century, however, **clinical** assessments began to play a role in criminal justice decision making. In 1925, for example, a medical committee of the American Prison Association initiated assessment strategies for determining appropriate treatments for "normal" versus "feeble minded" offenders, and for "psychotic" versus "neuropathic" offenders (which included epileptics, alcoholics, and drug addicts).

Clinical assessments of drug-involved offenders began in the

1960s under the Narcotic Addict Rehabilitation Act (NARA) programs at the Federal level, the Civil Addict Program (CAP) in California, and the Narcotic Addiction Control Commission (NACC) in New York. Procedures were refined and expanded with the establishment of the Treatment Alternatives to Street Crime (TASC) programs and other court diversion initiatives funded by the Law Enforcement Assistance Administration (LEAA) during the 1970s.

From the close of the 1970s through the 1980s, clinical treatment assessments became more common in criminal justice decision making. This period coincided with the emergence of cocaine as a drug of choice at the close of the 1970s and the "war on drugs" in the 1980s, the combination of which resulted in overwhelming numbers of drug-involved offenders coming to the attention of police, court, and correctional systems across the Nation.

Benefits of AOD assessments

Assessments for alcohol and drug-involved offenders should be operative at a variety of levels, and for numerous reasons. An overview of the evaluation literature on the treatment of alcohol and other drug abuse suggests that everything is working and that everything is failing.

What this means is that all drug programs seem to be working for some clients. Whether the approaches are therapeutic communities, methadone maintenance programs, outpatient and day treatment initiatives, long-term and short-term in-patient psychotherapeutic regimens—all seem to be working for many clients. Yet the same programs are also failing for even greater numbers of clients.

The role of assessment is to determine what approach is best for whom; that is, how best to screen clients into treatment. Going further,

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it would appear that in any given program or modality, some clients receive the maximum benefits potentially available to them while others do not. As such, clinical assessments help to focus program resources upon those who might benefit the most.

And finally, many clinicians in the drug and alcohol fields are often faced with the problem of determining when a client has been in treatment long enough or when clients have received the maximum benefits that a program has to offer. Clinical assessments, if properly structured, suggest when clients should be phased out of treatment or into alternative levels of intervention.

Assessment as an aid to treatment planning

Within this context, assessments of alcohol- and drug-involved offenders should be of several types:

1. Treatment "needs" assessments should be in place to determine what type of programmatic intervention is appropriate—long-term or short-term residential treatment, intensive or moderate outpatient treatment, chemical detoxification, or perhaps some other modality. As such, treatment needs assessment serves as a broad sorting mechanism.

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TIP on Screening and Assessment

Dr. Inciardi is the chair for a CSAT Treatment Improvement Protocol (TIP) now being developed on Screening and Assessment for Alcohol and Other Drug (AOD) Abuse Among Adults in the Criminal Justice System. A consensus development panel, made up of experts from the fields of criminal justice and AOD treatment, will share, review, and assess the current state of knowledge regarding AOD assessment and screening in both fields. The consensus panel will:

- Recommend AOD screening and assessment services that need to be provided to offenders at various entry points within the system, depending on the level of the offenders' AOD problems and their need for correctional supervision
- Identify the particular screening and assessment tools that appear to be most successful with offenders
- Provide guidelines to assist criminal justice agencies in using the screening/assessment tools and in increasing the linkages between screening and treatment

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2. "Readiness for treatment" assessments should be implemented to better understand the extent to which clients are motivated for treatment, and whether they are likely to benefit from the services offered to them.

3. Comprehensive treatment "planning" assessments should occur once a client reaches a given program to determine how intensive the treatment should be and on which areas it should focus.

4. Treatment "progress" assessments should be undertaken periodically to determine whether clients are responding to treatment and whether changes in the intervention should be considered.

5. Treatment "outcome" assessments are also critical to determine the extent of behavioral change, success, and failure.

Available clinical instruments

Clinical instruments are already available for conducting assessments. Such items as the Addiction Severity Index, the Minnesota Multiphasic Personality Inventory (MMPI-2), the Michigan Alcoholism Screening Test, and the Offender Profile Index are but a few of the scales available, and new instruments are developed and tested regularly.

Assessments for drug-involved offenders are of value to criminal justice agencies in helping them to better manage clients and utilize resources. Treatment is a more cost-effective intervention than imprisonment, if treatment is indeed the appropriate intervention. But the full benefits of classification and assessment can only be realized by means of comprehensive assessment and treatment planning.