

Federal Judicial Center
Off Paper Episode 3

Mark Sherman: From the FJC in Washington, D.C., I'm Mark Sherman and this is *Off Paper*. Today's program is all about what could treatment for substance use and mental health disorder looks like for individuals who are on pretrial or post-conviction supervision. Our guest, Dr. Peter Luongo, is executive director of IRETA - the Institute for Research, Education and Training in Addictions in Pittsburg, Pennsylvania.

Dr. Luongo has worked in the behavioral health field for many years as a social worker, researcher, and administrator. In the state of Maryland he worked for three governors as the director of the Department of Health and Mental Hygiene's Alcohol and Drug Abuse Administration, and was with the Montgomery County Maryland Department of Health and Human Services for over two decades in a variety of clinical and administrative leadership roles. For the past several years, Dr. Longo has been working with the FJC, and multiple federal district courts, and U.S. probation and pretrial offices as an educator and clinical consultant.

He received his PhD in social work from the University of Maryland and has served as a faculty associate at Johns Hopkins University. So if you want to know more about the fundamentals

of good treatment from an expert who really gets it, we've got your guy right here. Stay tuned folks.

Pete Luongo, welcome to the program.

Peter Luongo: Good morning, Mark. Thank you for having me.

Mark Sherman: So I'd like to start our conversation by asking you for some observations about the challenges of identifying and obtaining high quality treatment services for individuals under federal supervision. Over the past few years I know you've had many conversations with district courts all over the country about how they work with people who have substance use and mental health disorders so I know you've really learned a lot about how the federal courts operate in this arena. I just wanted to take a few minutes to pick your brain, so to speak, about what you've learned. So what have you learned?

Peter Luongo: Okay, Mark. Well, quite a bit over the last few years. I think the first thing is to recognize just how difficult it is for anybody to be able to judge what is good substance use or mental health disorder treatment. As it turns out, this is one of those parts of the health care system where there's virtually no consumer protection types of data that's published. In other words, there's not only no scorecard, there simply isn't any way that the public or a purchaser of services,

like a federal district court, U.S. Probation, can look to know how a good performance is discriminated from just an average performance. In other words, you have more information about the quality of refrigerators you're going to go purchase than you do the substance use disorder treatment or the mental health treatment. That is unfortunately across the country.

So number one, you're at the same disadvantage as everybody else. Number two, to its credit, I think the probation system has organized itself well around the idea of having people on staff who get a chance at learning what the local services are about - the treatment specialist or contract specialist. I think that's a really strong piece that's there. I think the piece that is really confounding as well though is the performance measurement and knowing a scorecard. It's actually knowing what you want to buy. All treatment is not equivalent. And I think one of the pieces that I've noticed is how difficult it is for the court on a pretrial or post-trial to actually know what level of service somebody needs.

What I mean is in only a few instances have I come across where there's an actually independent of a treatment program assessment to give a level care. I think that really is a hard thing for people because what happens is treatment becomes thought of as all the same and, in fact, really it isn't. If somebody is a better match to an outpatient program, that's

where they need to go. If somebody is needing a long term residential program, that's where they need to go. Those are very different situations and I think sometimes it's really hard for the court to be able to get the information independent of the treatment program that would help them make a better decision. So those are some kind of early broad brush types of things.

But the other piece is what a challenge it is between working in an urban area and a rural area. In some instances, in an urban area there are frequently many more treatment providers than there are in rural areas where in fact you may have only a couple of choices and then you really are stuck. You're stuck because there's no other place to go and you've got to use that service. So I think those are very tough challenges for a court and for probation, the differences between an urban and a rural area.

Transportation is daunting, and I think that also means you have fewer providers or you probably don't have a variety of services available to you. In an opioid epidemic that we have right now, not being able to have medications as an option to stabilize someone is a pretty tough one. But those programs and those services aren't available everywhere across the United States, and I think that handicaps what happens for the courts on both the pretrial and a post-trial basis.

Mark Sherman: So Pete, that last point regarding urban versus rural I think is one that is very confounding generally in the system. I wanted to try to drill down with you a little bit more about that because it's something that comes up fairly often in conversations that I have with folks in the courts. I know it comes up in conversations that you have with folks in the courts.

For example, recently I was in a meeting with several chief U.S. probation and pretrial officers and there was discussion about budget as there often is when you're working with the government as you all know. There was some discussion about, for example, when we're in challenging budget times, how group treatment is less expensive than individual treatment.

But also one of the chiefs raised the issue, a chief who comes from largely a non-metropolitan district - I would say a rural district - made the point that he basically has one treatment provider available if not in the district, which is quite large, then in a large division of the district, a large geographic area. The issue for this chief was, well, if I start cutting down on the amount that I use that treatment provider and that treatment provider is dependent on our contract, they're going to shut down and we're not going to have any treatment provider.

So that's one issue. I think the other issue is, okay, when you're stuck with really one major treatment provider for both substance use treatment and mental health treatment in your district or another division of your district, are you stuck with that treatment provider? What options might there be? And if there are very limited options, what would the approach or what should the approach be of a U.S. probation pretrial office facing that situation? I know that's a lot, so let's just take it one by one.

Peter Luongo: Well, I think you really are describing a situation that's more frequent than what any of us ever realized where you simply are in a position to only have a single provider or maybe two providers and them being dependent upon the probation contract and public patients. So when you have something like that, how would you find a way to create some incentives for that person in that program to do the job that you would like them to do?

We've been having discussions about performance incentives within a contracting mechanism. It's not unusual in a lot of public contracts. It's something that became routine when we introduced it in Maryland, that you were able to put in some easy to measure reliable valid data points that influenced somebody's income. But that seems to be a very difficult proposition.

On the other hand, putting in performance measures that allow for probation and the treatment program to be able to see how they're doing makes an enormous difference. In fact, recalling just how much performance improved just by people knowing what the performance is. So it's tracking patient outcomes but in treatment measures like, Mark, initiation and engagement. Initiation, how quickly you see someone upon a referral engagement having at least three face-to-face contacts within the first 30 days after treatment has started.

Those are very good reliable concrete measures that talk about what we have understood about engaging people in treatment. For the most part, no one knows that information. So just being able to agree in a contract what are the things that we're going to measure here and what we're going to look at together turns out to improve performance even without the incentive of additional compensation linked to those. I think that's number one.

The second thing where you have an underserved area is to let's start to take advantage of what we now have as technology. For the most part medical schools' departments of psychiatry across the country have embarked on telepsychiatry projects. Also schools of social work, as well as its schools of counseling, all have the opportunity to provide tele-counseling.

In fact, states are amending their practice regulations for professions to allow for that kind of interaction in treatment.

So what you may have is a physical location within your district of only one provider but the potential from multiple providers providing a clinical service who are remote. There has been a number of ways that that's been tested out and proven to be kind of the way to go in underserved areas.

So I think those are the types of things that I don't think have yet been explored by courts. And of course since people report to their probation office, as well as in fact they have probation officers or pretrial officers going out to them, you might be able to set up kind of nodes where there are ways that someone can sit in front of a camera and sit in front of a computer and have a provider at the other end doing the service. So we haven't explored a whole lot of that in the criminal justice system yet, but it's coming to provider networks because it's the way that we're extending services to underserved areas.

Mark Sherman: So a couple of questions. When we've got a situation where there's really only one provider in a district or in a division of a district and basically there's really no competition, does that raise any issues in terms of performance incentives?

Peter Luongo: I think it means you are going to have a really hard time, not impossible. I think that for the most

part people have no idea how they're doing as an agency, and the purchasers of services often do not know how the people that they're paying for treatment are doing. So I think just having a transparent co-viewing of agreed upon data makes a difference in improving performance. I think there isn't a program out there that doesn't want to do a good job, but even looking at your own data is an incentive to do better once you know how it is.

We've gone so far as to also show people what the average is for those measures are in their state. I'm not sure our colleagues in the criminal justice system know that every state actually is required - when they receive the federal block grant for substance use treatment and prevention - they have to report a data set on people who enter treatment and leave treatment. It's called TEDS, Treatment Episode Data Set. Within that are some measures that are reported annually that say here's what's going on across the country. You can get statewide averages, too, and you might be able to use those as a baseline to compare how it's going for our clients who are being treated here and how your program are doing.

So you try and use that as an opportunity to have a discussion what looks like it's going well, what might be done differently, what could you do differently. And I think absent any other competition for the contract or for the patients,

you're trying to - if you would - use people's professional ethics and their need to do it well as the basis. I can't think of very many other ways to do it. And when we've done that, it's been relatively successful.

Mark Sherman: We're talking with Dr. Peter Luongo, executive director of the Institute for Research, Education and Training in Addictions. Dr. Luongo has been working for several years now with the federal courts to teach probation and pretrial officers, judges, defenders, prosecutors, and treatment professionals about evidence-based substance use and mental health treatment. We'll be back to talk some more with him after a short break. This is *Off Paper*.

Female Voice: The FJC has new videos available online from some of the best clinicians and researchers in the country that will help you deepen your knowledge about issues of substance use and mental health in the criminal justice context.

Dr. Margaret Sheridan of the University of North Carolina and Dr. Kerry Ressler of Harvard University discuss brain development and toxic stress in children and adolescents. Dr. Peter Friedman of the University of Massachusetts and Baystate Health offers an overview of the neurobiology of addiction and the neuropharmacology of opioid addiction. Dr. Eden Evins of Massachusetts General Hospital provides a lecture on the biology and treatment of addictive disorders and co-occurring

psychiatric disorders. And Dr. John Kelly of the Massachusetts General Hospital Addiction Recovery Management Service talks about that service as an example of good outpatient treatment for substance use disorders.

All of these videos and more are available on fjc.dcn's probation and pretrial services education page under video programs.

Mark Sherman: We're talking with Dr. Luongo of the Institute for Research, Education and Training in Addictions.

So Pete, I want to ask for your help in deciphering, maybe even demystifying, some of the concepts surrounding substance use and mental health treatment. I also think our audience would really benefit from having just a deeper understanding of the fundamentals of good treatment. As you know, many people in supervision have either a substance use disorder, a mental health disorder or some combination of the two. So could you walk us through the basics of how an individual should be screened, how he or she should be assessed, and how he or she should be matched with the type or types of treatment that will be most beneficial?

Peter Luongo: Well, I think the first piece is to understand the difference between screening and assessment. Screening is a short set of questions that are designed to trigger off whether somebody has an indication of a problem that

requires an assessment to determine what type of treatment and what level of treatment they need. So screenings can be as simple as a ten-question questionnaire that create a score that can be matched against a scale. So there's an empirically derived number above which someone needs to be able to go on further to assessment, below which there really isn't a need to go any further. So that's a baseline.

We have found good results in creating a process of screening for caseworkers in social services, for nurses, for doctors, for probation officers, counselors in schools - ways to employ a standardized set of questions that trigger off whether there's something you need to be concerned about. So some of these screens, Mark, are I have a smartphone and an app on my smartphone that has five different screening tools, five empirically validated reliable screening tools that can be used. So there isn't a whole lot that's easier than to do that.

There's also linked to screening the notion of a brief intervention. If somebody has problematic -- or an indication that they misuse alcohol every so often, not enough to trigger off a referral for a formal assessment, or they have indications of some potential continuing use of substances, you can do a brief intervention which is to offer some advice and some options. And so we usually talk about Screening and Brief Intervention, SBI.

Then we talk about SBIRT referral to treatment. In this particular instance, in a good system, if you have screenings being done by every probation officer just in the course of what they're doing and have it on their smartphone, they might use an AUDIT or a DAST or a CAGE. Those are some of the standardized instruments I get to use. But they screen somebody and they hit the problem threshold, now you move on to assessment.

Typically assessment is done by a licensed professional who ideally is independent of any of the places that would get a referral for treatment. In other words, a typical situation that you would want to avoid is sending somebody to a treatment program and have the assessment done there because everyone's guarantee you that about 98 percent to 99 percent of the time it's that they're eligible for their program.

But you're trying to now get an assessment that determines what kind of problem, what level of problem, and what level of care they need to be matched to. Most assessments end up as a combination of some standardized protocol. For instance, something like an addiction severity index on the addiction side which gives you a set of problem index scores that indicate what needs to be paid attention to.

Then the clinician looks at the assessment and using placement criteria - for instance the American Society of Addiction Medicine has placement criteria - that based upon your

assessment you match somebody to a level of care. That level of care is all the way from an outpatient, which is up to nine hours of face-to-face clinical time a week, or an intensive outpatient which is between 9 and 16 hours, all the way up to various types of residential programs - detoxification, relatively short-term residential programs. But the key here is this assessment is done by a licensed or certified professional who can make an independent judgment using standardized criteria.

That's the first pieces that you want to see in a system. You want to be able to have screening done by, in this particular instance and probably the capacity I've seen, probation officers who do wonderful interviews across this country. Doing a brief screen is absolutely within their skillset and within their mission, and the assessment piece then being done by some independent party. Sometimes those are separate contracts and most of the time they are part of a treatment program. In the ideal, you want the determination of type of problem, level of care made by someone outside of the treatment program.

I think the next thing, Mark, is you want to be able to know the quality of a treatment. I think if you have a way to assess how good the treatment is, you're really going to be in better shape. There are five things we tell people to look for,

that this is from work that's been done by the National Institute on Drug Abuse. I think the first thing, Mark, is you want to look at does the program use treatment that's backed by scientific evidence? As things turn out, we actually have some interventions that have passed what the FDA requires for bringing a drug to market in at least two randomized controlled blind studies.

So you're going to want to know what are the interventions, what's the treatment that are provided in that treatment program. If you get something like, well, we use just 12 steps, that's probably not good enough. Or, we believe addiction is a disease. That's probably not good enough. What you really want to look for, are they using things like cognitive behavioral therapy? You know, a way to help individuals recognize and avoid or cope with situations where they're still likely to use. It's an active very problem-focused engaging kind of a treatment.

We also know that if they use something like motivational incentives, a learning theory, contingency management, that's an empirically-based approach. It's something like motivational interviewing. So the first thing you want to find out is are they using empirically-based treatments? The other thing, are they tailoring the treatment to the individual or is it really program-focused care?

One of the really upsetting pieces about the current specialty addiction system is you go in as a patient and you get what they do. It's not that they do what you need. So if you're going into a residential program for instance on a Wednesday, and Wednesdays are occasional days. You happen to be somebody who's a professional engineer but you've been drinking alcoholically. You go in and everybody is finding out how to take the GED. You go, well, gee, I have a bachelor's degree in electrical engineering. They said, well, this is what we're doing right now, please sit down.

Then they start to talk about how you would look on the Internet for a job, and then how you would get a job interview. You go up again and say, gee, I really have a job that's waiting for me back home. Then they say sit down, you're disrupting us. Basically by the end of the day you're not only really unhappy as a patient in a program like that, your chart probably says something like is resistant to change. That is an example, a not fictitious example of what happens when it's program-focused care and not care that's tailored to the individual.

I think there's also the need to make sure that as somebody moves along in treatment, that they change the treatment to match where somebody is at. So that if something is working fine, great. If something's not working, maybe there's been a relapse. Or if it's a person with severe mental illness and

they're not showing up, you don't discharge them because they're showing the symptoms of their disorder. What you do is change your approach. So you really want to find a program that adapts the treatment to where somebody is at.

The fourth thing, Mark, is you want to make sure that treatment is long enough. A relatively short-term treatment doesn't really yield the benefits that you want to see. Now that doesn't in any way say that having somebody go to detox and maybe a short stay of residential treatment is wrong. It's wrong if the short-term residential treatment isn't followed on by a step down to intensive outpatient or a step down to outpatient.

What we know is that an outpatient treatment for substance use or for halfway houses, the length of stay that's a best determinant of success is at least 90 days. If they're there fully engaged in 90 days on either an outpatient treatment or in residential or a series of residential with halfway house, they're going to complete. And the gains that they make seem to last. In fact, that's so reliable a finding you're not funding that kind of research anymore.

So length of stay is related to good outcome, but don't be fooled by length of stay has to be in one particular place. That's not true. Referring back to adapting treatment to where people are at, if you need to be detoxed, that's great. A

short-term residential, that's great. But you need them to continue care in whatever is the next appropriate setting for the right length of time. And I would tell you that, at a minimum, it's 90 days of active care.

The last thing you want to look at in a treatment program, a system really is what we're talking about, is how do they introduce the idea of self-care and self-help. There are a number of fellowships out there. And the reason is professional treatment can only go so far. At some point someone has to take over and be surrounded and be part of a supportive recovery environment. If that piece of it is not introduced through the formal treatment, I think we found that that's a really severe shortcoming.

You want to have a brief recap it would be - are they using evidence-based treatments? Is it tailoring your treatment to the person? Does the program adapt treatment as it moves along? Is the duration of care long and is it sufficient enough? Are they introducing people to self-care and self-help in some of the fellowships? So that would be kind of a systems viewpoint from screening all the way into treatment.

Mark Sherman: The next to the last point that you made about is the duration of treatment sufficient I think is worth just emphasizing. Obviously, these are all very important points. I love the way that you kind of encapsulated them into

sort of five questions or five areas of inquiry for courts to be aware of or probation and pretrial to be aware of, basically anybody who's involved with the supervision of individuals in the community. But this idea of is the duration of treatment sufficient I think is very valuable because it's not just about sort of being in one place for X period of time. It's really about putting together perhaps the treatment specialist and the probation and pretrial office working with treatment providers and folks in the community about how do we provide sufficient care over a period of time for this individual. It can be sort of a continuum. It doesn't have to be just sort of in the one place.

Peter Luongo: Absolutely, Mark, you hit it right on the head. You want to be able to have continuous care of the appropriate intensity to not just duration. Sadly a lot of what we see in the specialty addiction system is kind of treatment light. You're not seeing people enough times. In fact, dropout rates are frightening particularly in outpatient care. You end up seeing within 45 days the majority of people not showing up, just stopping. I think even in the criminal justice system where there is a fairly compelling reason for somebody to continue, they drop out. That's pretty disturbing.

That's why sometimes, Mark, we look at what happens upfront initiation and engagement. But it is really better thought of

as a continuum. So you want to see people enough but for a duration of time that's sufficient. In the very least we know at least 90 days on the outpatient side and the halfway house side makes sense. It depends on the severity of a problem, but intensity and duration, very huge.

Mark Sherman: That's an excellent segue into, before we head to a break, I wanted to ask you about treatment matching. Sort of not looking at treatment as just sort of this generic approach to dealing with this problem or these problems that an individual is presenting with, but that it's a very nuanced, as we've been discovering throughout this conversation, substance use treatment and mental health treatment like any area of health care, very nuanced. It needs to be assessed, screened, diagnosed very carefully. Then the type of treatment needs to be matched to what's coming out of that screening assessment and diagnosis. We're dealing with folks again in our system, as you know, who present with one or the other or both, often both types of disorders. Then there are variations within those.

Peter Luongo: Oh yeah.

Mark Sherman: So could you talk a little bit, before we head to a break, about this concept of treatment matching and just what are your observations about it?

Peter Luongo: Okay. Just the whole concept of matching, which is the preferential assignment to a condition that's

likely to maximize benefit for the patient. So you're assigning with some criteria in mind to a situation that is likely to maximize the benefits the patient or the individual is going to get. So that concept is operationalized in different ways.

In substance use treatment, for the most part everyone now is using the American Society of Addiction Medicine criteria which ask you to look at six dimensions and look at a defined level of care all the way from early intervention, to outpatient, to long-term residential, and stops in between. By the way, for adolescents, there is a set of criteria of the same nature. After your assessment, you're essentially clinically evaluating where your patient, where this individual fits based on these criteria and these dimensions. And you'll get a level of care that this is a person who would be best suited to an intensive outpatient program where they get 9 to 16 hours of care in a week.

We have some similar criteria that are used to match people with co-occurring psychiatric and substance use disorders. In a broad speak, there's kind of a four-quadrant scheme that we use where we look for a program that can treat patients who have a low severity of mental health and a low severity of alcohol and drugs or a high severity of mental health and a low severity of alcohol and drugs. Low severity mental health, high-severity AOD, all the way up to a very special placement for someone with

high severity on the mental health side and high severity on the substance use side. What you try and do is rate the program's ability or the practitioner's ability to provide within each one of those matches.

So you have something we call co-occurring capable where they'll be able to see somebody who has low severity mental health and high severity AOD, or high severity mental health, low severity AOD all the way to co-occurring enhanced where they could take the most difficult patients on both the psychiatric morbidity and the substance use morbidity.

So it's not that every program can do everything. They're not designed that way. Being able to classify what programs can do makes the match happen, and having a standardized assessment and using standardized placement criteria make for the chances of an optimal match for that person. There's no guarantees. Things change. That's why you do constant assessments of how patients are doing as a clinician, because you have to change, so one of those five points. You adapt to where your patient or your client is at.

Mark Sherman: My guest is Dr. Peter Luongo, executive director of the Institute for Research, Education and Training in Addictions in Pittsburgh, Pennsylvania. After a short break we'll talk more with Pete about treatment modalities for individuals with substance use and mental health disorders and

the challenges that criminal justice professionals and courts face when they are working with individuals who have both, also known as co-occurring disorders.

We'll also talk about what behaviors should be expected from individuals on federal supervision who have serious substance use and mental health disorders, and strategies that court professionals can use to achieve the best possible outcomes. I'm Mark Sherman and this is *Off Paper*.

Male Voice: Probation and pretrial services officers know that successfully transitioning clients back into the community means staying on top of the latest research on substance use, mental health disorders, treatment services, and the development of job-related skills. To help officers do that, FJC probation and pretrial services education has developed Treatment Services: Negotiating Pathways and Supporting Successful Transitions - an online course that includes documents, videos, and links to other kinds of resources. All of these address topics like the science of behavioral health, treatment modalities, evidence-based behavioral responses tools and medicated-assisted treatment.

After taking the course, an officer or anyone else in the judiciary interested in learning about these topics should be able to better understand treatment modalities, match individuals to appropriate treatment services, collaboratively

plan and implement a continuum of care for a client and act as an agent of change. You can find the course on fjc.dcn's probation and pretrial services education page under e-learning programs.

Mark Sherman: Dr. Peter Luongo of the Institute for Research, Education and Training in Addictions is our guest. In the last segment, Pete, we talked about a number of things. So I wanted to take a few minutes here to focus specifically on treatment modalities. For example, there's been a lot of information lately in the media about medication-assisted treatment for individuals who are addicted to opioids. There's also a fair amount of misunderstanding about MAT. So I wanted to ask you, what is MAT? Who can most benefit from it? And what are some of the challenges MAT presents for people on supervision and those responsible for supervising them?

Peter Luongo: Sure. It's a terrible misnomer when we are still saying medication-assisted treatment. There isn't any other place in health care where a term like that could even surface or survive as long as it has. You don't talk about medication-assisted hypertension treatment. You don't talk about medication-assisted diabetes treatment. You simply talk about treatment for hypertension and diabetes which probably includes the use of medication - a variety of medications,

different classes - as well as diet and exercise, all those types of things. So we're stuck with this term.

What happened over the years is we have developed a set of medications that are effective for particular addictive disorders. Those include opioid dependence, as well as alcohol. And they are woefully underutilized. The early days of heroin was matched with the use of a substitute called methadone which was designed amply and well for stabilizing somebody's cravings. Then you have the opportunity to look to deliver clinical counseling services. Over the time, unfortunately, methadone has been not simply evolving to the medication but it's also become a level of care where it's dispensed daily at a clinic.

They also say that the medication is used also in the treatment of pain and pain management. So methadone used for pain management can be prescribed by any physician. That physician cannot prescribe it as part of treatment for opioid dependence. It's a very odd set of circumstances that we've come to accept over the years. So most of what people see as medication-assisted treatment is actually a methadone maintenance treatment. The problem is it's become a level of care. Most of the treatment that happens is only about two hours of clinical time a month for patients who have some of the more difficult and intractable types of social problems that co-exist with an addiction.

There are other medications that are useful. Buprenorphine, which can be prescribed by a physician in an office setting, doesn't have to be dispensed at a specialized clinic. The physician and now nurse practitioners and physician assistants have to do a training and get a waiver from DEA. Oddly enough they can dispense, they can prescribe but there's no requirement for any kind of clinical counseling. This also makes, as you imagine, a sort of a profit center for physicians who want to treat patients.

But there have also been a very difficult set of circumstances where people get buprenorphine prescriptions and never engage in any of the clinical services. And there are also some medications that are very effective for use in tamping down the issue of heavy drinking and getting somebody to the point where they're able to move on to abstinence.

So medications are effective. They are only effective if they are joined with the clinical counseling services. So right now across the United States, there's a project that actually we're involved in. It is a demonstration of severing medication from the level of care. So what that means is that patients would get a medication and the program would be reimbursed for the medication. But then that whole systemic assessment gets done and patients are then at the right clinical level of care. So you may be prescribed and dispensed methadone, but you're in

an intensive outpatient program where you're getting between 9 and 16 hours of clinical services in a week. This is a departure from what's been happening in the past.

This is also important in thinking about how to use other medications. If there is a need for a court or probation to have some effective responses or more effective responses for people with a heroin addiction, you can contract for a physician to provide medication services. And you can then have your probationary or pretrial client go into your contracted system of treatment where they can get placed in either outpatient, intensive outpatient, residential, or halfway house. So, there's a lot more flexibility that's available right now than there's been in the past.

At the same time, in some parts of the United States, you don't have any of this available. Sadly, only 5 percent to 7 percent of the people that have an alcohol use disorder ever are treated with medication as part of it. And about 20 percent to 25 percent of the people who are opioid dependents ever get evaluated for the potential use of medication. That is very difficult to understand. The arguments in the past are based on ideology that medication, you know, you're substituting one drug for another and one hide for another. Actually that is blatantly inaccurate.

The medications, when used as directed and were properly monitored and matched with the clinical services, are simply part of a package to bring somebody to a recovery position. So you're using this to support a recovery. There's been plenty written about a medication-assisted recovery orientation. And there's plenty of empirical evidence on the effectiveness of these medications in conjunction with the clinical services. As a standalone, no, it won't work very well.

But only 20 percent to 25 percent of the people are ever even evaluated for the use of these medications. Mark, what I'd like to say is right now a standard of care that is really *the* standard of care is I am a nonmedical practitioner, I am capable of diagnosing and treating mental disorders. If I diagnosed someone with a bipolar disorder or major depressive disorder and I don't get a medication evaluation, I would be violating the standard of care. I should be brought up on charges by my licensing board. That is the standard of care. At some point, we will get to that with addictive disorders. That if we have effective medications that can be useful for a patient and we do not provide access to that, that is a violation and will be a violation of the standard of care.

Mark Sherman: I know that lately you've been doing a lot of thinking, Pete, about how criminal justice professionals and

courts can improve the way they work with individuals who have co-occurring disorders.

Peter Luongo: Yes.

Mark Sherman: One of the things that I've noticed in my work across the system, for example, in the federal courts, is that when an individual has a co-occurring disorder or co-occurring disorders, there's a tendency in the court to focus on the substance use disorder and not as much on the mental health disorder, or in some cases, to miss the mental health disorder entirely. I don't know why that is. It may just be the orientation of the court. It could be a whole multitude of factors. But I wanted to get your thoughts about this and what advice you have for court professionals.

Peter Luongo: Sure. These are difficult situations for everybody. But I also think that in all fairness our courts and probation, they're not getting all the information right away that would lend them to pay close attention to the mental health side. You can have somebody who has been incarcerated for a long period of time or even in the community for a while and there's simply not access to any mental health records that have been done or any mental health assessments.

It's also true that substance use disorders tend to be easier to spot in part because of some of the nature of activities that bring individuals to the attention of the U.S.

court system. There might be arrests of possession, possession with attempt to distribute evidence of their own use, not overly subtle. So it might be more information is available on the substance use side.

The other thing is the subtlety of some of the conditions that people have. They've been able to manage themselves for a while. In the probation supervision or the pretrial supervision, these things sort of reveal themselves. So I think the first thing that you want to take a look at from your treatment system is are we able to get an assessment. Nowadays we would call them a behavioral health assessment. This again is an independent assessment. Independent meaning you don't send them to a substance use treatment agency and say we want them treated. Or you don't send them to a mental health agency. Get if possible, and if you can design it in, somebody to make an independent assessment. It doesn't have to be long. You know, 40 to 60 minutes.

There are standardized protocols, Mark, that are readily available and a licensed independent practitioner under states' board of health occupations. Like a licensed clinical social worker or a licensed professional counselor can actually make those diagnoses. You're trained to do it. So if you have somebody who has a comorbid psychiatric and substance use disorder, you want to then find a treatment program.

But first of all, you want to figure out is this a high severity mental health case or low severity mental health case, a high severity substance use or low severity substance use? Again this is the way that a trained, skilled clinician thinks. Anyone can find a program that you could match the severity levels to which means you've got to have programs out there that you looked at and can then know, you could know ahead of time what they can match to. Can they match to high severity mental health, low severity substance use? So you've got to be able to know that right up front. Critically important.

The other piece is you do not want to get in the situation where you send someone to two different places, the joke about two dentists working in the same mouth. You don't want two practitioners. You're treating a person here, not an administrative label. Yes we administratively label things with diagnoses, but our emphasis is on treating a person. You really want to have an agency or a treatment provider that can do the entire package for you. In other words, don't administratively split up this person.

There are agencies that can develop this capability or already have this capability. So if you're specifically looking for effective treatment for people with comorbid psychiatric and substance use disorders, you're going to have to put in your procurement exactly that. There's a language that indicates

that you are going to be able to treat in an integrated way - there are certain phrases and words - in an integrated way, the person who has both disorders. You should be able to handle this level of severity. You should have psychiatry so that medications, if necessary, can be prescribed and monitored. You will have urinalysis available for people who have substance use disorders. If somebody needs to be seen multiple times a week, you have that capability. So those are the things that you have to know you need for this population, and then purchase them through your procurement services.

Now managing somebody who has both disorders. In this high-tech age, this is absolutely a low-tech labor intensive activity. I think that these individuals are the people who are most at risk for having adverse things happen to them and for them doing adverse things simply because it's difficult to be able to manage both disorders. So that's one reason why you need one agency and one treater.

So the low-tech piece of this, these are the cases that you have less time available. These are the ones you want to spend more time available. These are the ones you want to have periodic face-to-face sit-downs with the treatment provider and go over specifically where things are.

So if I am a treatment specialist and I'm managing on behalf of the court a supervision that includes multiple people

with co-occurring disorders, I make sure that we have a sit-down every quarter and go over where things are and where things need to be. There's simply no way around that. And in spite of doing that, you still have the potential for some disruptive types of things. But keeping close tabs on having a unified front that probation or pretrial knows what's going on in treatment and treatment knows what's going on in probation, it's probably the best way, Mark, to manage those situations effectively.

Mark Sherman: Pete, we've been talking about very complex matters. You did say just a minute or so ago we are dealing with people and people are complex entities, as you know.

Peter Luongo: Indeed.

Mark Sherman: So to wrap up, what should probation and pretrial officers, judges and other professionals who are involved with the supervision of individuals who have these types of disorders expect from them in terms of behavior, behavior change, responsivity to treatment, that kind of thing? What are the implications for officers and others in terms of how they can best work with clients and treatment providers to achieve the best possible outcomes? You've sort of answered that last question already, but I wonder whether you have any sort of parting advice as we wrap things up here for folks who

are involved in the supervision of individuals with these types of disorders.

Peter Luongo: Well, Mark, this is definitely parting advice from a clinical social worker. There's little value in placing a heavy emphasis on the, if you would, hammer that the court has with this group. This is a group that will not well respond to some of the normal constraints that we typically use to control somebody's behavior. This is a group that will respond well to relationship. I have seen probation interviews that were so masterful at connecting with people and helping them through crisis things in some site visits over the years that I made that I wish I could have taped them and used them for first and second year students, graduate students who are just learning everything. They were so well done.

So the relationship piece is very important, but also not holding entirely to the most stringent constraints on their behavior. What I mean is work more from the positive reinforcement side, the shaping the behavior side, and having the court as well as the supervising officer understand that there might need to be a few more tolerances here.

Now clearly there are deal breakers that we may have in the community who are getting rearrested. There are things that simply can't be ignored. But this is a group that's not going to respond in a normal, always rational way. You've got

somebody who is pathologically disturbed, the conduct disorder kind of kid - the conduct disorder and the oppositional defiant, that kind of thing. They're going to respond to constraints and the power sort of a dynamic. This is not a group by definition that will do well with that. So I think the relationship building, the keeping close tabs on communication, and as much as possible work on the positive reinforcement and the strengths-based approach works really well. And also, by the way, it helps you as the person trying to be the helper not get so frustrated.

Mark Sherman: Pete, I want to thank you very much for talking with us.

Peter Luongo: You're very welcome. Thanks for having me, Mark.

Mark Sherman: Pete Luongo is executive director of the Institute for Research, Education and Training in Addictions. His work as a clinician, researcher, educator, and consultant to the federal courts on issues of substance use and mental health disorders and treatment is having an important impact on how probation and pretrial officers, judges, defenders, prosecutors and treatment professionals approach their work with individuals on federal supervision. If you have a chance, check out IRETA.org. It has some great free resources available to help you learn more.

Our producer is Paul Vamvas. The program is directed by
Craig Batten [phonetic]. I'm Mark Sherman. Thanks for
listening. See you next time.

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