Amenability to Treatment of Drug Offenders

Douglas B. Marlowe, J.D., Ph.D.
Treatment Research Institute and University of Pennsylvania
Nicholas S. Patapis, Psy.D., M.A.C.J.
Treatment Research Institute and University of Pennsylvania
David S. DeMatteo, J.D., Ph.D.
Treatment Research Institute

THE "WAR ON DRUGS" that began in the 1980s contributed to an unprecedented expansion in the U.S. inmate population. Prison and jail admissions more than tripled in the ensuing years (Harrison & Karberg, 2003), with drug violations accounting for approximately 60 percent of the increase in the federal inmate population and one-third of the increase in the state inmate population (Belenko & Peugh, 1998; Harrison & Beck, 2002). As of 2001, drug offenders comprised more than half (57 percent) of federal prison inmates and over 20 percent of state prison inmates in this country (Harrison & Beck, 2002).

Reliance on imprisonment has done little to stem the tide of crime and illicit drug use. Over two-thirds (68 percent) of offenders, including drug offenders, are arrested for a new crime within three years of their release from prison, nearly one-half (47 percent) are convicted of a new crime, and over one-half (52 percent) are re-incarcerated either for a new crime or for a technical violation (Langan & Levin, 2002). Moreover, in some studies, approximately 85 percent of drug-abusing offenders returned to drug use within one year of release from prison and 95 percent returned to drug use within three years (e.g., Marlowe, 2002; Martin, Butzin, Saum, & Inciardi, 1999).

Prison over-crowding has led to court-imposed caps on inmate populations in several states and is producing spiraling costs related to the expansion of correctional facilities. Partly as a result of this, various initiatives have been devised to provide community-based supervision and treatment to drug offenders in lieu of criminal prosecution or incarceration. These range in intensity from true diversion programs, to standard and intensive probation programs, to judicially supervised programs such as drug courts. True diversion programs – sometimes called "probation without verdict" – have traditionally permitted low-level misdemeanor or summary offenders to have their charges dropped and their arrest record expunged contingent upon completion of a prescribed regimen of supervised probation and drug treatment. Record expungement permits the individual to respond, truthfully, on an employment application or similar document that he or she has not been arrested for a drug-related offense. Pre-plea drug courts commonly include a diversionary component as well, in which graduates can have their charges dropped upon completion of the program and can have their arrest record expunged after remaining arrest-free for an additional legally-prescribed waiting period.

A few states, including Arizona, California, the District of Columbia, and Hawaii, recently enacted laws expanding eligibility for a probation-without-verdict model of diversion to all nonviolent drug-possession offenders who are not currently charged with another felony or serious misdemeanor offense and who have not previously been convicted of or incarcerated for such an offense within a specified time period. These statutes generally provide drug-possession offenders with multiple chances to succeed at diversion. Pursuant to California's Proposition 36 (California Substance Abuse and Crime Prevention Act of 2000), for example, if an offender violates a drug-related condition of probation or commits a new drug-possession offense, the State can only revoke probation if it can prove by a preponderance of the evidence that the offender is a "danger to the safety of others." For a second drug-related violation of probation, the State must prove that the offender is either a danger to the safety of others or is "unamenable to drug treatment" to accomplish a revocation (e.g., *In re Mehdizadeh*, 2003).

Implicit in any initiative that provides drug treatment in lieu of incarceration is that eligible offenders are reasonably likely to benefit from available drug treatment interventions. In the case of California's Proposition 36, this construct of "amenability to treatment" is explicitly referenced in the criminal statute. In other contexts, it is simply a logical prerequisite for the initiative. There can be no rational justification for placing drug offenders in treatment if they do not require treatment, do not want treatment, or are unable to make use of existing interventions.

On its face, amenability to treatment would seem to be a clinical issue to be determined by drug treatment providers in the course of their professional work with clients. Who better to decide whether a particular offender is amenable to treatment than a trained practitioner with expertise in assessing motivation

and prognosis for change? Many terms, however, do not retain their common-language definition when they are incorporated into a statute or interpreted by the courts. Words may lose their colloquial meaning and take on a technical legal definition that reflects a sum total of public-policy considerations. Policy concerns set the maximum limits on what types of drug offenders can be considered potentially amenable to treatment and what types of drug treatment services should reasonably be available to these individuals. Within those policy-imposed constraints, however, there is room for clinical judgment in rendering amenability-to-treatment decisions. The drug abuse treatment literature provides some guidance in making these assessments; however, further research is needed to improve upon their accuracy and reliability. This article reviews the legal and clinical factors that should be considered in making amenability-to-treatment determinations.

Criminal History

Amenability to treatment is inextricably linked in the minds of policymakers with offenders' criminal history. Virtually any program that provides drug treatment in lieu of incarceration excludes offenders with violent, serious, or recidivist criminal records. Proposition 36, for instance, excludes drug-possession offenders charged with a concurrent felony or serious misdemeanor offense, as well as those previously convicted of or incarcerated for such an offense within the previous five years. Similarly, as a condition of receiving federal funding, drug courts cannot treat violent offenders, defined as those who have been charged with or convicted of an offense involving the use of a weapon, death or serious injury to a victim, or force against another person (Violent Crime Control and Law Enforcement Act of 1994).

Courts invariably uphold these exclusionary criteria on the ground that the legislature could reasonably have concluded that serious or recidivist offenders are un-amenable to treatment *as a matter of law*. For instance, California appellate courts have routinely upheld Proposition 36's stringent requirement that eligible offenders be free of felony or serious misdemeanor charges for the immediately preceding consecutive five years on the ground that excluded offenders could reasonably be considered, as a matter of public policy, to be un-amenable to treatment (*People v. Lee*, 2002; *People v. Superior Court of San Bernardino County*, 2002; *People v. Superior Court of Santa Clara County*, 2002). California courts have upheld on similar grounds the exclusion of offenders with concurrent misdemeanor charges, even if the disqualifying charges were closely related to the principal charge of drug possession or drug intoxication—for example, driving under the influence *(People v. Campbell, 2003)* or cultivating marijuana for personal use *(People v. Phelps, 2003)*. Because criminal offenders have no implicit right to be diverted from incarceration, the public and policymakers are free to draw bright-line rules based upon an intuitive sense of what they perceive as fair and in the best interests of public safety *(e.g., People v. Superior Court of Napa County, 2002)*.

The Supreme Court of the United States weighed in several decades ago in favor of such hard-line exclusions. The Narcotic Addict Rehabilitation Act (NARA, 1966)—which has since been repealed—once provided for civil commitment to drug treatment in lieu of incarceration for nonviolent drug-addicted individuals convicted of certain federal offenses, provided they were "likely to be rehabilitated through treatment" and had fewer than two prior felony convictions. The Supreme Court upheld the exclusion of offenders with two or more prior convictions on the ground that Congress could rationally have concluded that such persons would be less amenable to rehabilitation *(Marshall v. United States, 1974)*. According to the Supreme Court, excluding recidivist offenders was justified because such individuals might expose the program to exploitation, might present unacceptable risks to society, or might hinder the successful treatment of others.

A number of commentators have criticized treatment-amenability determinations as being mere pretexts for withholding treatment from more culpable offenders (Frase, 1991; Melton, Petrila, Poythress, & Slobogin, 1997; Slobogin, 1999). According to this argument, the real question is not which offenders are amenable to treatment, but rather which offenders the public and policymakers are amenable to giving a second chance at redemption. As the previous cases illustrate, policy issues do set outer bounds on which offenders may be considered amenable to treatment. And it is true that such across-the-board exclusionary criteria run the risk of being both over-inclusive and under-inclusive. Individuals whose criminal histories were fueled largely by drug use, and who are motivated for treatment, may be denied access to programs because they committed exclusionary offenses. On the other hand, unmotivated offenders may be diverted to treatment based upon the nature of their charges, regardless of their actual prognosis for change. Given that prosecutors' charging practices are often influenced by factors having little to do with a defendant's actual degree of culpability (e.g., the strength of the evidence, or the effectiveness of defense counsel), offenders may be excluded from diversion programs based upon factors that are wholly unrelated to clinical outcomes.

It is overstated, however, to characterize amenability-to-treatment determinations as pretextual. The fact is that past behavior is the best predictor of future conduct (e.g., Melton et al., 1997; Monahan et al., 2001). Past criminal history is among the best and most robust predictors of future prognosis in correctional programs generally (e.g., Cottle, Lee, & Heilbrun, 2001; Gendreau, Little, & Goggin, 1996; Morgan, 1993; Roundtree, Edwards, & Parker, 1984) and among drug-involved offenders in particular (e.g., Hepburn & Albonetti, 1994). For the most part, psychometric risk-assessment instruments perform little better in predicting criminal recidivism than actuarial projections based predominantly on offenders' past antisocial behavior (e.g., Bonta, 2002). It is defensible, therefore, to consider past criminal conduct in determining whether an offender is likely to be amenable to future rehabilitative efforts.

The problem is that criminal history is an inexact variable. Studies have typically relied on global or summative indexes of criminal history in rendering predictions of recidivism, such as offenders' number of prior arrests, age at first arrest, or age of onset of criminal activity regardless of detection. This does not permit predictions of which specific types of offenses bode the best for drug treatment outcomes. Although it is clear that violent offenders have the poorest prognosis in rehabilitation (Monahan et al., 2001), the evidence is scant in terms of comparing outcomes for drug-abusing individuals charged with drug-possession offenses to, for example, those charged with property offenses, drug-dealing offenses, or vehicular offenses. Data do suggest that the prognosis for future recidivism and for involvement in predatory offenses may be worse if drug abuse and crime emerged together in the offender's history, as opposed to instances in which criminal activity ensued from the need to obtain money for drugs or from the resulting dysfunction of chronic drug use (Farabee, Joshi, & Anglin, 2001). These data do not, however, address offenders' amenability to drug treatment, and they do not focus on specific types of offense categories. Until research uncovers specific criminal-history risk factors for failure in rehabilitation programs, policymakers will continue to rely on their intuitions and on the preferences of their constituencies in selecting exclusionary offenses for criminal-diversion programs.

Previous Failures in Treatment

It is popular among drug-treatment providers and drug abuse researchers to characterize addiction as being a "chronic relapsing condition." In fact, drug dependence does share many similar characteristics with chronic medical illnesses such as diabetes and hypertension in terms of its genetic heritability, treatment non-compliance rates, and relapse rates (McLellan, Lewis, O'Brien, & Kleber, 2000). A corollary of this position is that multiple treatment episodes are not only acceptable for drug abusers, but expected. Following a chronic-care model, each successive treatment episode is believed to build upon previous efforts in contributing to and maintaining longer-term successful outcomes. This argument has the convenient advantage of making drug treatment impenetrable to criticism. Treatment can never be said to fail; rather, it simply lays the groundwork for future gains that will ultimately be detected.

Correctional authorities and policymakers are, not surprisingly, impatient with this point of view. They are charged with diverting offenders from a criminal career path immediately, and cannot await hypothetical gains that might or might not emerge at some contingent future date. Courts, in particular, have generally not bought the chronic-care argument with regard to drug offenders. If the past is, indeed, prologue to the future, then several courts have reasoned that past negative reactions to treatment are apt to foreshadow future treatment failures (e.g., *Gronquist v. Walter, 2001*). As one court asserted: "It is difficult to conceive of more reliable objective evidence of lack of amenability to treatment and future dangerousness than the fact that, despite being in treatment, the defendant continues to engage in the very criminal behavior for which he or she is being treated" (*State v. McNallie*, 1994, p. 298).

The research evidence is contradictory about whether multiple treatment episodes do, in fact, contribute to longer-term improvements, or whether the lion's share of improvement should be expected to occur early in a client's contact with treatment. Some data indicate that multiple past treatment episodes are associated with better outcomes during an index treatment episode in terms of longer lengths of stay in treatment and less post-treatment drug use (Hser, Grella, Chou, & Anglin, 1998; Maddux, Prihoda, & Desmond, 1994; Simpson & Joe, 1993). However, other studies—some conducted by the same investigators—have reported better outcomes for treatment-naïve clients and poorer outcomes for those with extensive treatment histories (Brewer, Catalano, Haggerty, Gainey, & Fleming, 1998; Hser, Grella, Hsieh, Anglin, & Brown, 1999; Hser, Joshi, Anglin, & Fletcher, 1999; Simpson, Savage, & Joe, 1980). Notably, two studies examining virtually the same data-set came to contradictory conclusions about whether multiple methadone maintenance treatment episodes were associated with reduced criminal recidivism (Merrill, Alterman, Cacciola, & Rutherford, 1999) or with no change in recidivism (Rothbard et al., 1999).

These inconsistencies are not unexpected because virtually all of the studies used single-group, pre/post research designs that analyzed correlates of symptom improvement among subjects. Because many of the studies involved no experimental control and had no suitable comparison conditions, they do not permit scientifically defensible causative inferences to be drawn about the effects of drug treatment services (National Academy of Sciences, 2001). Another problem with the aforementioned research is that it cannot effectively control for the "graying out phenomenon" that commonly occurs among drug abusers and offenders (Blumstein & Cohen, 1987; Moffitt, 1993). Drug use and crime tend to wane naturally as offenders get older. Without an appropriate control condition, improvements resulting from age-effects may be falsely attributed to treatment, because older individuals are more likely to have had multiple treatment episodes by virtue of having had more opportunities for treatment over time.

A recent program of experimentally controlled research lent scientific support to the hypothesis that past treatment failures may be a negative risk factor for future outcomes among drug offenders. More importantly, the results of that research provide guidance about how to potentially manage such offenders more effectively and counteract the negative influences of prior treatment failures. In the first study, misdemeanor drug court clients were randomly assigned either to an intensive level of judicial supervision involving bi-weekly status hearings in drug court, or to a low level of supervision in which they were monitored by treatment personnel and only had status hearings as needed in response to serious infractions. The results revealed that participants who had prior failed experiences in drug abuse treatment provided significantly more drug-positive urine samples and were significantly more likely to be terminated from the drug court program when they were assigned to as-needed hearings; however, such clients performed equivalently or better than most other clients when they were required to attend bi-weekly court hearings (Festinger et al., 2002). This same interaction effect was replicated in two new jurisdictions in rural and urban communities (Marlowe, Festinger, & Lee, 2003; Marlowe, Festinger, & Lee, in press). These results do suggest that prior treatment failures may be a negative risk factor for the treatment of drug offenders, but more importantly, they point to promising approaches for managing or negating this risk. Rather than excluding offenders with a prior treatment history from diversionary programs, it might be preferable to assign them to a more intensive and closely supervised program such as drug court.

Performance During Treatment

As discussed previously, Proposition 36 provides drug-possession offenders with multiple opportunities to succeed on probation. It essentially erects an irrebuttable presumption that eligible drug offenders are amenable to treatment until they fail three times, at which point they are irrebuttably presumed to be un-amenable to treatment. As characterized by one California appellate court, under Proposition 36 "[a] first time offender is conclusively presumed to be amenable to treatment. A second time offender also is presumed to be amenable to treatment, but that presumption may be rebutted. A third time offender is conclusively presumed to be unamenable to treatment and ineligible for probation" (*People v. Williams*, 2003, p. 702).

It is a simple case to conclude that an offender is un-amenable to treatment if he or she repetitively engages in serious rule violations during treatment, inhibits the participation of other clients, or continually fails to show up for sessions (e.g., *In re Dasinger*, 2002). It is a more difficult matter to interpret a compliant offender's non-responsiveness to the interventions. As reviewed in the previous section on past treatment failures, the research evidence is ambiguous, at best, about whether non-responsiveness to treatment portends future non-responsiveness. The data suggest that changing an offender's treatment plan—by, for example, increasing the schedule of court hearings—could counteract the effects of past treatment failures. Proposition 36 and other programs for drug offenders do provide substantial discretion to judges and other criminal justice professionals to increase or alter an offender's treatment requirements in response to poor performance in treatment. In principle, then, offenders under Proposition 36 should only be determined to be un-amenable to drug treatment after failing to respond to three different treatment regimens.

In reality, however, there is insufficient variability in the types of drug treatment services that are available in this country to permit a meaningful adjustment of many offenders' treatment plans. Approximately 75 percent to

80 percent of drug treatment programs are outpatient, abstinence-oriented, 12-Step-based programs that deliver services in a group as opposed to individual format (Mulvey, in press; SAMHSA, 2001). In practice, therefore, offenders are typically sent back repeatedly for the same—or more of the same—services that did not work for them before. Waiting for the same treatment regimen to fail three times and then declaring the offender un-amenable to treatment does not comport with logic. If 12-Step groups do not work for an opiate-addicted individual, for example, it is quite conceivable that the same individual could be amenable to methadone maintenance.

Treatment-amenability determinations do not ordinarily consider what services should be available to offenders in an ideal world. The issue is not what services are hypothetically available, but rather what services are immediately and realistically available to this offender at a reasonable cost (e.g., *United States v. Atkins*, 1997). Again, policy considerations set the outer limits on amenability assessments. Clinical issues are relevant, but not dispositive, and are trumped by practical and economic exigencies. As a result, the majority of drug offenders may not be amenable to drug treatment as it is currently conceptualized and delivered. In essence, programs such as drug courts and Proposition 36 give eligible offenders a few chances to respond to a narrow class of readily available services. If they do not respond to those services, they are processed through other criminal justice channels.

Characteristics of the Offender

Certain demographic characteristics have been associated with poorer outcomes in offender rehabilitation programs. These include being younger, male, poor, less intelligent, less educated, having first-degree relatives with drug abuse problems or criminal histories, and being a member of certain racial sub-groups (although the direction of race-effects has been inconsistent across studies) (e.g., Andrews & Bonta, 1998; Gendreau et al., 1996). Not surprisingly, statutes and court opinions steer clear of these demographic variables when considering the relevant risk factors for determining amenability to treatment. It would almost certainly run afoul of due process and equal protection requirements to exclude individuals from correctional rehabilitation programs based upon their immutable demographic characteristics.

Oddly enough, it is unclear in many instances whether offenders must have a serious or diagnosable substance use disorder in order to be eligible for various diversionary initiatives. For example, the introduction to Proposition 36 declares California's intent to provide treatment in lieu of incarceration to "drug-dependent" criminal offenders; however, the substantive provisions of the statute apply to individuals charged with drug-possession offenses, and do not indicate whether those individuals must also have a demonstrable drug-use problem. Similarly, drug courts are intended to treat offenders "with substance abuse problems" (Violent Crime Control and Law Enforcement Act of 1994, § 2201(1)); however, no guidance is provided to indicate how severe the "problem" must be.

Notably, in some studies, nearly one-half of misdemeanor drug court clients (Marlowe, Festinger, Lee, et al., 2003; Marlowe, Festinger, & Lee, 2003), one-third of felony drug court clients (Marlowe et al., in press), and two-thirds of drug-involved felony pre-trial defendants (Lee et al., 2001) produced "sub-threshold" drug abuse composite scores on the Addiction Severity Index (ASI), similar to a community sample of non-substance abusers. This raises the question whether some individuals who are just beginning to experiment with drugs, or who may be non-drug-using dealers, are perhaps being diverted into these programs unnecessarily.

From a prevention perspective, one could argue that it is appropriate to place drug-experimenters into these types of programs as a means of staving off a serious drug problem before it develops. The programs typically involve regular urinalysis monitoring of drug use, consistent sanctions for positive test results, and psycho-education on the negative effects of drugs. This could have the beneficial effect of stopping a developing drug-use habit in its tracks.

A more serious concern is that non-addicted drug dealers could be placed in these programs by virtue of the fact that they were only charged with or convicted of a drug-possession offense, and they may feign a drug-use problem in order to avoid a more serious criminal disposition. It is difficult to detect such instances of faking on self-report instruments like the ASI because the items are self-evident in their focus. The questions ask directly about instances of drug use and can be manipulated convincingly. Some assessment instruments have been developed to detect subtle signs of addiction using questions that are not obvious in their intent. However, those instruments were designed to detect drug-use problems among individuals who are in "denial" or are under-reporting their drug use. They were not designed to detect over-reporting of drug use.

For these reasons, some programs rely on admission urine drug-screens to ensure that subjects have a drug-use problem. Individuals who test negative for drugs over the first few weeks of the program may subsequently be deemed ineligible. This could have the unintended consequence of inducing subjects to use drugs when they first enter the program in order to avoid being excluded and assigned to a more severe criminal disposition. Anecdotally, some drug court participants in the authors' studies have reported in confidential research interviews that they took drugs prior to intake to ensure they would be accepted into the program. Unfortunately, there are no easy solutions to these problems and practitioners must rely on their clinical judgment and experience to detect individuals who were possibly diverted into treatment inappropriately.

A related concern is whether offenders need be desirous of treatment or motivated to stop using drugs in order to benefit from drug treatment. Evidence does suggest that intrinsic motivation for change predicts post-treatment improvements (e.g., Prochaska, DiClemente, & Norcross, 1992). However, evidence also suggests that subjects who are legally coerced into treatment perform as well or better than those who ostensibly enter treatment voluntarily (e.g., Farabee, Prendergast, & Anglin, 1998; Marlowe et al., 2001). It appears that length of tenure in treatment is most predictive of outcomes, regardless of whether that tenure is influenced by internal motivation, external legal pressures, or some combination of the two.

This suggests that motivation for change may be a welcome positive prognostic indicator at baseline, but perhaps need not be a prerequisite for entry into a diversionary program. This is fortunate, because it is difficult to reliably and validly measure intrinsic motivation for change. Similar to measures of drug-use severity, instruments that measure motivation for change can be easily faked because the items are transparent in content. The most commonly used instruments, for example, inquire whether the subject believes he or she has a problem worth changing, and call for a yes/no or true/false response. Offenders who wish to enter a diversionary program can easily gather which is the "correct" answer. Thus, rather than focusing on internal motivational states that cannot be observed or validated, it appears more justifiable to improve the programmatic elements of various initiatives to ensure that subjects' behaviors are reliably monitored and responded to.

On a final note, many research studies have reported that certain personality disorders are associated with poorer drug treatment response. In particular, a diagnosis of Antisocial Personality Disorder (APD)—characterized by chronic and persistent antisocial behavior, irresponsibility,

and selfishness (American Psychiatric Association, 1994)—is associated with lower retention rates in substance abuse treatment (Goldstein et al., 1999; Leal, Ziedonis, & Kosten, 1994; Marlowe, Kirby, Festinger, Husband, & Platt, 1997), higher rates of program non-completion (Alterman, Rutherford, Cacciola, McKay, & Boardman, 1998), and shorter time to first relapse following graduation from treatment (Goldstein et al., 2001). A few studies, however, have reported that substance abusers with APD generally performed equivalently to other clients (e.g., Brooner, Kidorf, King, & Steller, 1998; Cacciola, Alterman, Rutherford, & Snider, 1995; Longabaugh et al., 1994; McKay, Alterman, Cacciola, Mulvaney, & O,Brien, 2000; Messina, Wish, & Nemes, 1999). The discrepancies across studies may be attributable to at least two factors. First, subjects with APD may respond poorly to typical drug treatment programs, but may respond well to highly structured and closely monitored interventions. Second, there may be excessive heterogeneity within the diagnosis of APD, such that only the more seriously antisocial individuals may perform poorly in drug treatment.

As was described previously, studies in drug courts found an interaction effect between the schedule of court hearings and subjects' prior history of drug treatment failures. In those same studies, a comparable interaction effect was also found for APD. Specifically, misdemeanor and felony drug court clients with APD provided significantly more drug-positive urine samples, reported significantly more days of alcohol intoxication, and were significantly more likely to be terminated from the drug court program when they were assigned to as-needed court hearings; however, subjects with APD generally performed equivalently to other clients when they were scheduled to attend bi-weekly court hearings (Festinger et al., 2002; Marlowe et al., in press). This lends support to the hypothesis that outcomes for APD clients may be improved by providing them with more intensive structure and monitoring.

It is possible that drug offenders with a more severe subtype of APD may be at greatest risk for failure in rehabilitation programs. Psychopathy is a subtype of APD that is characterized by severe narcissism and emotional detachment in addition to chronic antisocial behavior. Psychopathy has consistently emerged in research studies as one of the strongest predictors of violence and other criminal activity in offender and forensic-psychiatric populations (Harris, Rice, & Cormier, 1991; Hart, Kropp, & Hare, 1988; Hemphill, Hare, & Wong, 1998; Serin, 1996; Serin & Amos, 1995). Among prison inmates, psychopaths are approximately three times more likely to recidivate than non-psychopaths (Hemphill et al., 1998). In one study of over 1000 recently released civilly committed psychiatric patients, psychopathy emerged as the strongest predictor of violence out of 134 risk factors that were studied (Monahan et al., 2001). Few studies have specifically addressed outcomes for psychopaths in drug treatment and further research is needed to determine whether these individuals may be least amenable to drug treatment services.

Unfortunately, research on APD and psychopathy may be of greater theoretical value than practical value because of the high assessment burden. The most commonly used and better-validated instruments for APD and psychopathy require professional interviewing skills, clinical judgment, and access to fairly extensive background records and historical data to render an accurate diagnosis. It is questionable whether typical offender rehabilitation programs have sufficient resources and expertise to complete these assessments. Without such resources, it may be necessary to rely on more easily collected data elements such as offenders' past treatment history, past criminal history, and current response to treatment in making treatment-amenability determinations.

Conclusion

In many respects, the construct of amenability to treatment reflects a tentative conclusion rather than a prediction. The fact is that relatively little is known about what types of drug offenders are apt to succeed in rehabilitative programs. In the absence of such evidence, reasonable approximations or extrapolations must be made from existing data and from commonsensical notions about the harbingers of success. Consistent with the belief that the past is prologue to the future, it is generally presumed that prior criminal history, prior treatment history, and current performance in treatment are among the most robust predictors of future treatment response. As such, offenders are conclusively deemed to be unamenable to treatment if they committed serious or violent prior offenses, failed in previous rehabilitative programs, or recidivated during the current treatment episode. At this stage in our knowledge, these are not unreasonable assumptions and there are some data to support them; however, in the future, it is hoped that social science research will contribute more sensitive and robust predictors of treatment response.

References

Alterman, A. I., Rutherford, M. J., Cacciola, J. S., McKay, J. R., & Boardman, C. R. (1998). Prediction of 7 months methadone maintenance treatment response by four measures of antisociality. *Drug and Alcohol Dependence*, 49, 217-223.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Press.

Andrews, D. A., & Bonta, J. (1998). *The psychology of criminal conduct* (2nd ed.). Cincinnati, OH: Anderson.

Belenko, S., & Peugh, J. (1998). *Behind bars: Substance abuse and America's prison population*. New York: National Center on Addiction and Substance Abuse at Columbia University.

Blumstein, A., & Cohen, J. (1987). Characterizing criminal careers. *Science, 237*, 985-991.

Bonta, J. (2002). Offender risk assessment: Guidelines for selection and use. *Criminal Justice and Behavior, 29*, 355-379.

Brewer, D. D., Catalano, R. F., Haggerty, K., Gainey, R. R., & Fleming, C. B. (1998). A meta-analysis of predictors of continued drug use during and after treatment for opiate addiction. *Addiction, 93*, 73-92.

Brooner, R. K., Kidorf, M., King, V., & Steller, K. (1998). Preliminary evidence of good treatment response in antisocial drug abusers. *Drug and Alcohol Dependence, 49*, 249-260.

Cacciola, J. S., Alterman, A. I., Rutherford, M. J., & Snider, E. C. (1995). Treatment response and problem severity of antisocial personality substance abusers. *Journal of Nervous and Mental Disease, 183*, 166-171.

California Substance Abuse and Crime Prevention Act of 2000, Cal. Penal Code §§ 1210 *et seq.* (Deering 2003).

Cottle, C. C., Lee, R. J., & Heilbrun, K. (2001). The prediction of criminal recidivism in juveniles: A meta-analysis. *Criminal Justice and Behavior, 28*, 367-394.

Farabee, D., Joshi, V., & Anglin, M. D. (2001). Addiction careers and criminal specialization. *Crime and Delinquency, 47*, 196-220.

Farabee, D., Prendergast, M., & Anglin, M. D. (1998). The effectiveness of coerced treatment for drug-abusing offenders. *Federal Probation, 62*, 3-10.

Festinger, D. S., Marlowe, D. B., Lee, P. A., Kirby, K. C., Bovasso, G., & McLellan, A. T. (2002). Status hearings in drug court: When more is less and less is more. *Drug and Alcohol Dependence, 68*, 151-157.

Frase, R. S. (1991). Defendant amenability to treatment or probation as a basis for departure under the Minnesota and Federal sentencing guidelines. *Federal Sentencing Reporter, (May/June)*, 328-333.

Gendreau, P., Little, T., & Goggin, C. (1996). A meta-analysis of the predictors of adult offender recidivism: What works! *Criminology, 34*, 575-596.

Goldstein, R. B., Bigelow, C., McCusker, J., Lewis, B. F., Mundt, K. A., & Powers, S. I. (2001). Antisocial behavioral syndromes and return to drug use following residential relapse prevention/health education treatment. *American Journal of Drug and Alcohol Abuse, 27*, 453-482.

Goldstein, R. B., Powers, S. I., McCusker, J., Lewis, B. F., Bigelow, C., & Mundt, K. A. (1999). Antisocial behavioral syndromes among residential drug abuse treatment clients. *Drug and Alcohol Dependence, 53*, 171-187.

Gronquist v. Walter, 2001 U.S. App. LEXIS 18667 (9th Cir. 2001).

Harris, G. T., Rice, M. E., & Cormier, C. A. (1991). Psychopathy and violent recidivism. *Law and Human Behavior, 15*, 625-637.

Harrison, P. M., & Beck, A. J. (2002). *Prisoners in 2001* [No. NCJ-195189]. Washington, DC: Bureau of Justice Statistics, U.S. Dept. of Justice.

Harrison, P. M., & Karberg, J. C. (2003). *Prison and jail inmates at midyear 2002* [No. NCJ-198877]. Washington, DC: Bureau of Justice Statistics, U.S. Dept. of Justice.

Hart, S. D., Kropp, P. R., & Hare, R. D. (1988). Performance of male psychopaths following conditional release from prison. *Journal of Consulting and Clinical Psychology, 56*, 227-232.

Hemphill, J. R., Hare, R. D., & Wong, S. (1998). Psychopathy and recidivism: A review. *Legal and Criminological Psychology, 3*, 139-170.

Hepburn, J. R., & Albonetti, C. A. (1994). Recidivism among drug offenders: A survival analysis of the effects of offender characteristics, type of offense, and two types of intervention. *Journal of Quantitative Criminology, 10*, 159-179.

Hser, Y. I., Grella, C. E., Chou, C. P., & Anglin, M. D. (1998). Relationships between drug treatment careers and outcomes: Findings from the National Drug Abuse Treatment Outcome Study. *Evaluation Review, 22*, 496-519.

Hser, Y. I., Grella, C. E., Hsieh, S. C., Anglin, M. D., & Brown, B. S. (1999). Prior treatment experience related to process and outcomes in DATOS. *Drug and Alcohol Dependence, 5*, 137-150.

Hser, Y. I., Joshi, V., Anglin, M. D., & Fletcher, B. (1999). Predicting post-treatment cocaine abstinence for first-time admissions and treatment repeaters. *American Journal of Public Health, 89*, 666-671.

In re Dasinger, 2002 Cal. App. LEXIS 6713 (2002).

In re Mehdizadeh, 105 Cal. App. 4th 995 (2003).

Langan, P. A., & Levin, D. J. (2002). *Recidivism of prisoners released in 1994* [No. NCJ-193427]. Washington, DC: Bureau of Justice Statistics, U.S. Dept. of Justice.

Leal, J., Ziedonis, D., & Kosten, T. (1994). Antisocial personality disorder as a prognostic factor for pharmacotherapy of cocaine dependence. *Drug and Alcohol Dependence, 35*, 31-35.

Lee, P. A., Marlowe, D. B., Festinger, D. S., Cacciola, J. S., McNellis, J., Schepise, M. M., Merrill, J. C., Harrell, A. V., & McLellan, A. T. (2001). Did "Breaking the Cycle" (BTC) clients receive appropriate services? [abstract]. *Drug and Alcohol Dependence, 63 (Supp. 1)*, S89. Presentation at the 63rd Annual Scientific Meeting, College on Problems of Drug Dependence, Scottsdale, AZ.

Longabaugh, R., Rubin, A., Malloy, P., Beattie, M., Clifford, P. R., & Noel, N. (1994). Drinking outcomes of alcohol abusers diagnosed as antisocial personality disorder. *Alcoholism: Clinical and Experimental Research, 18*, 778-785.

Maddux, J. F., Prihoda, T. J., & Desmond, D. P. (1994). Treatment fees and retention on methadone maintenance. *Journal of Drug Issues, 24*, 429-443.

Marlowe, D. B. (2002). Effective strategies for intervening with drug abusing offenders. *Villanova Law Review, 47*, 989-1025.

Marlowe, D. B., Festinger, D. S., & Lee, P. A. (2003). The role of judicial status hearings in drug court. *Offender Substance Abuse Report, 3*, 33-46.

Marlowe, D. B., Festinger, D. S., & Lee, P. A. (in press). The judge is a key component of drug court. *National Drug Court Institute Review.*

Marlowe, D. B., Festinger, D. S., Lee, P. A., Schepise, M. M., Hazzard, J. E. R., Merrill, J. C., Mulvaney, F. D., & McLellan, A. T. (2003). Are judicial status hearings a "key component" of drug court? During-treatment data from a randomized trial. *Criminal Justice and Behavior, 30*, 141-162.

Marlowe, D. B., Glass, D. J., Merikle, E. P., Festinger, D. S., DeMatteo, D. S., Marczyk, G. R., & Platt, J. J. (2001). Efficacy of coercion in substance abuse treatment. In F. M. Tims, C. G. Leukefeld, & J. J. Platt (Eds.), *Relapse and recovery in addictions* (pp. 208-227). New Haven, CT: Yale University Press.

Marlowe, D. B., Kirby, K. C., Festinger, D. S., Husband, S. D., & Platt, J. J. (1997). Impact of comorbid personality disorders and personality disorder symptoms on outcomes of behavioral treatment for cocaine dependence. *Journal of Nervous and Mental Disease, 185*, 483-490.

Marshall v. United States, 414 U.S. 417 (1974).

Martin, S. S., Butzin, C. A., Saum, S. A., & Inciardi, J. A. (1999). Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware. *Prison Journal, 79*, 294-320.

McKay, J. R., Alterman, A. I., Cacciola, J. S., Mulvaney, F. D., & O'Brien, C. P. (2000). Prognostic significance of antisocial personality disorder in cocaine-dependent patients entering continuing care. *Journal of Nervous and Mental Disease, 188*, 287-296.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA, 284*, 1689-1695.

Melton, G., Petrila, J., Poythress, N., & Slobogin, C. (1997). *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers* (2nd ed.). New York: Guilford.

Merrill, J., Alterman, A., Cacciola, J., & Rutherford, M. (1999). Prior treatment history and its impact on criminal recidivism. *Journal of Substance Abuse Treatment, 17*, 313-319.

Messina, N. P., Wish, E. D., & Nemes, A. (1999). Therapeutic community treatment for substance abusers with antisocial personality disorder. *Journal of Substance Abuse Treatment, 17*, 121-128.

Moffitt, T. E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: A developmental taxonomy. *Psychological Review, 100*, 674-701.

Monahan, J., Steadman, H. J., Silver, E., Appelbaum, P. S., Robbins, P. C., Mulvey, E. P., Roth, L. H., Grisso, T., & Banks, S. (2001). Rethinking risk assessment: The *MacArthur study of mental disorder and violence*. New York: Oxford University Press.

Morgan, K. D. (1993). Factors influencing probation outcome: A review of the literature. *Federal Probation, 57*, 23-29.

Mulvey, K. (in press). Substance abuse counselor characteristics. *Journal of Substance Abuse Treatment.*

Narcotic Addict Rehabilitation Act of 1966, Pub. L. No. 89-793, 80 Stat. 1438, 18 USC §§ 4251-4255 (repealed 1984).

National Academy of Sciences. (2001). *Informing America's policy on illegal drugs: What we don't know keeps hurting us.* Washington, DC: National Academy Press.

People v. Campbell, 106 Cal. App. 4th 808 (2003).

People v. Lee, 2002 Cal. App. Unpub. LEXIS 6828 (2002).

People v. Phelps, 2003 Cal. App. Unpub. LEXIS 2480 (2003).

People v. Superior Court of Napa County, 98 Cal. App. 4th 78 (2002).

People v. Superior Court of San Bernardino County, 97 Cal. App. 4th 530 (2002).

People v. Superior Court of Santa Clara County, 104 Cal. App. 4th 692 (2002).

People v. Williams, 106 Cal. App. 4th 694 (2003)

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102-1114.

Roundtree, G., Edwards, D., & Parker, J. (1984). A study of personal characteristics related to recidivism. *Journal of Offender Counseling Services and Rehabilitation, 8*, 53-61.

Rothbard, A., Alterman, A., Rutherford, M., Liu, F., Zelinski, S., & McKay, J. (1999). Revisiting the effectiveness of methadone treatment on crime reductions in the 1990s. *Journal of Substance Abuse Treatment, 16*, 329-335.

Serin, R. C. (1996). Violent recidivism in criminal psychopaths. *Law and Human Behavior, 20*, 207-217.

Serin, R., & Amos, N. (1995). The role of psychopathy in the assessment of dangerousness. *International Journal of Law and Psychiatry, 18*, 231-238.

Simpson, D. D., & Joe, G. W. (1993). Motivation as a predictor of early dropout from drug abuse treatment. *Psychotherapy: Theory, Research, Practice, Training, 30*, 357-368.

Simpson, D. D., Savage, L. J., & Joe, G. W. (1980). Treatment histories of clients treated for drug abuse. *American Journal of Drug and Alcohol Abuse, 7*, 127-140.

Slobogin, C. (1999). Treating kids right: Deconstructing and reconstructing the amenability to treatment concept. *Journal of Contemporary Legal Issues, 10*, 299-333.

State v. McNallie, 870 P.2d 295 (Wash. 1994).

Substance Abuse and Mental Health Services Administration (SAMHSA). (2001). *National Survey of Substance Abuse Treatment Services* (N-SSATS). Rockville, MD: Author.

United States v. Atkins, 116 F.3d 1566 (D.C. Cir. 1997).

Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322, 108 Stat. 1796, 42 USC §§ 13701 *et seq.* (2003).