

10 Treatment for Offenders Under Community Supervision

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Overview

Substance abuse treatment for parolees and probationers differs from treatment for people in jail or prison. Although their freedom is curtailed, they have greater access to drugs and alcohol than the incarcerated population, and hence more opportunities to relapse. Moreover, securing basic needs such as food and shelter is often of paramount importance, especially for parolees attempting to reintegrate into society.

After describing the population under discussion in this chapter, the text takes up levels of supervision and treatment. Next, the discussion provides a broad look at the services needed by probationers and parolees and examines the treatment issues that are specific to offenders under community supervision. The chapter then suggests strategies that are helpful in improving collaboration between the substance abuse treatment and criminal justice systems. Finally, the chapter presents descriptions of sample programs.

The offenders discussed in this chapter also are discussed elsewhere in the TIP. Probationers, for example, are often sentenced through the drug courts described in chapter 7, *Treatment Issues in Pretrial and Diversion Settings*. Indeed, much of the material in chapter 7 is applicable to the probation population. Many probationers also have spent time in jail, as discussed in chapter 8, *Treatment Issues Specific to Jails*. Chapter 9, *Treatment Issues Specific to Prisons*, describes the prison culture that parolees left upon release. In order to acquire an understanding of the full range of issues that affect the treatment of offenders under community supervision, the reader is advised to consult these other relevant chapters.

The Population

Both parolees and probationers are under community supervision; nonetheless, they represent different ends of the criminal justice continuum. Whereas parolees and mandatory releasees are serving a term of conditional supervised release following a prison term, probationers are under community supervision instead of a prison or jail term.

Despite their differences, parolees and probationers often share a history of drug or alcohol use. Approximately two thirds of probationers can be characterized as alcohol- or drug-involved offenders (Mumola and Bonczar 1998), while almost 74 percent of State prisoners expected to be released between 2000 and 2001 were drug- or alcohol-involved (Beck 2000*c*). Parolees and probationers also are alike in that their freedom is conditional; both groups must meet certain conditions in order to avoid incarceration or reincarceration. Often, treatment for drug or alcohol dependence is one of those conditions.

The number of people under community supervision has increased over the past decade. More than 4.8 million individuals were under community supervision in 2003, compared to 3.8 million in 1995. The parole population has been the slowest growing since 1995, with an average annual rate of 1.7 percent; however between 2002 and 2003, the growth rate nearly doubled to 3.1 percent (Glaze and Palla 2004).

Despite the shared experience of individuals under community supervision, as Figure 10-1 indicates, parolees and probationers differ considerably.

Levels of Supervision

While both probationers and parolees are under community supervision, the level of supervision varies according to individual circumstances. These differences are described below.

Intensive Supervision

Intensive supervision generally involves frequent contact with supervising officers, frequent random drug testing, strict enforcement of probation or parole conditions, and community service. The level and type of supervision that are labeled intensive vary widely but usually require closer supervision and greater reporting requirements than regular probation. Contacts can range from more than five per week to fewer than four per month. Conditions usually include having a job or attending school, and participating in treatment. Intensive supervision parole has similar requirements and variations for offenders completing their sentences in the community.

Intermediate Supervision

Compared to traditional supervision, intermediate supervision can include increased drug testing, short jail stays, increased reporting to criminal justice staff, referral to day reporting centers, attending 12-Step meetings, community service requirement, curfews, work release centers, electronic monitoring, and more frequent home visits.

Treatment Levels and Treatment Components

Chapter 3, Triage and Placement in Treatment Services, provides detailed information on selecting an appropriate treatment level. This section builds on the material in chapter 3 to provide information specific to offenders under community supervision. Placement will depend on a number of factors, including the duration and severity of the offender's substance use as well as the crimes committed. The level of treatment services recommended for the offender should be individualized and based on a multidimensional, diagnostically driven assessment; clinical

Figure 10-1
Comparison of Probationers and Parolees

	Probationers	Parolees
Number (as of December 31, 2003)	4,073,987	774,588
Gender (as of December 31, 2003)	77 percent male 23 percent female	87 percent male 13 percent female
Race/Ethnicity (as of December 31, 2003)		
African American	30 percent	41 percent
Hispanic/Latino (can be of any race)	12 percent	18 percent
Caucasian	56 percent	40 percent
Crimes	24 percent for drug law violation 17 percent for driving while intoxicated	40 percent for drug offenses 24 percent for violent offenses
Drug or alcohol involved	83 percent (based on State prisoners expected to be released by the end of 1999)	74 percent (based on State prisoners expected to be released between 2000 and 2001)
Mental illness	13.8 percent	14.3 percent
Parole/probation violations led to incarceration/reincarceration in 1998	17 percent incarcerated	42 percent reincarcerated
Drug/alcohol treatment as condition of release	41 percent	N/A
Mandatory drug testing	32.5 percent	N/A
<i>Sources:</i> Beck 2000 <i>b</i> ; Ditton 1999; Glaze and Palla 2004; Hughes et al. 2001; Mumola 1998; Office of National Drug Control Policy (ONDCP) 2003.		

cal judgment; and availability of resources in a given community.

Residential

Residential treatment for those supervised in the community incorporates several approaches involving cooperative living for people receiving treatment. The most used residential model is the therapeutic community (TC), which provides a well-controlled, 24-

hour, structured treatment environment. (See chapter 9 for a discussion of prison-based TCs.)

Some programs provide services for 8 or more hours a day, 5–7 days a week, with clinical staff available days and evenings. Other residential programs are recovery homes for employed offender-clients, with evening and weekend treatment and limited onsite staff. Facilities may include hospitals or hospital-

based programs, institutional housing, sections of apartment complexes, and dormitory-like residences.

Most residential treatment programs use a group-centered approach to create an environment that duplicates certain aspects of a family and makes clients accountable to their peers. Residents collaborate on chores, laundry, and meal preparation with the aim of participation in problemsolving, goal setting, and improving cooperation and communication skills. Residential treatment should be followed by continued care in an outpatient setting.

Outpatient

Outpatient treatment for probationers and parolees can be provided to many more offenders for the same level of funding as residential treatment. It ranges from traditional outpatient services provided by treatment professionals in regularly scheduled sessions in a group or individual setting, to intensive outpatient treatment several hours per week. Because outpatient treatment tends to be more intense in community settings than in correctional institutions, offenders may be receiving more intense treatment than during incarceration. Intensive outpatient treatment includes day or evening programs in which clients engage in a full spectrum of services while living at home or in a special residence. For more details on this level of care, see chapters 3 and 5 of this TIP, as well as the forthcoming revised TIPs, *Substance Abuse: Clinical Issues in Intensive Outpatient*

Treatment for Alcohol and Other Drug Abuse (Center for Substance Abuse Treatment [CSAT] in development d) and *Substance Abuse: Administrative Issues in Intensive Outpatient Treatment* (CSAT in development c).

Within a treatment continuum, intensity decreases over time as the individual meets treatment goals. Offenders may initially be placed in residential settings, followed by intensive outpatient treatment and continuing care. With institution-based treatment as a foundation, outpatient services in the community can help offenders to continue working on their problems and developing social and work skills in group processes familiar to them from their earlier treatment experience.

Halfway Houses

Halfway houses are transitional facilities where clients are involved in schoolwork, work, training, and other activities that do not necessarily include any drug abuse treatment when run by the criminal justice system. The halfway house can be a step up to greater liberty (i.e., for a person released from prison) or a step down for an offender in need of greater supervision (i.e., for a person who violated probation requirements). Some clients need halfway houses that can help them stabilize or maintain recovery as they enter society. Usually these programs provide individual counseling along with group, family, or couples therapy. Offenders can leave the facility for work, school, or therapy but are otherwise restricted to the halfway house,

Dallas County Judicial Treatment Center: A Sample Community-Based Substance Abuse Treatment Program

Dallas County, Texas, established a residential substance abuse treatment program for probationers to relieve prison overcrowding. Based on a modified therapeutic community with a 12-Step component, it included basic substance abuse treatment, life-skills training, drug education, and group counseling. After 1 year, arrests for program graduates were one half of those for probationers who were expelled or transferred. Those who participated in a residential aftercare program had even lower arrest rates (Knight and Hiller 1997).

which is in the community but can be attached to a jail or other correctional institution. House responsibilities are shared and rules must be followed. The length of stay may be related to sentence length and depend on individual progress toward specific goals.

Day Reporting

Day reporting centers are facilities to which offenders must report in person or by phone from a job or treatment site as part of their larger supervision plan. The regular reporting back to probation or parole officers mandated under this intermediate sanction is aimed at monitoring offender movements or incapacitating them. Reporting must be done at specified times, often throughout the day. Day centers may include assessment for special needs and such services as anger management, drug testing, General Equivalency Exam (GED) preparation, drug and medical/mental health treatment, violence prevention, community service, and vocational training.

Some day centers primarily function as staging areas from which offenders are sent out in work crews to perform manual labor in the community: cleaning highways, painting schools, etc. Others offer chiefly educational opportunities. In many jurisdictions, day centers have become day treatment centers whose primary mission is to provide outpatient alcohol and drug abuse treatment of various intensities. Public or private treatment agencies or correctional agency staff may provide the treatment.

Treatment Components

Substance abuse is a chronic, relapsing disorder influenced by numerous interacting biological, psychological, and social factors. To provide treatment addressing these factors, the consensus panel believes that a full range of services should be available, which might include components from the following list:

- Screening and assessments—medical, psychiatric, and substance abuse (see also chapter 2, Screening and Assessment)
- Detoxification (see also the forthcoming TIP *Detoxification and Substance Abuse Treatment* [CSAT in development a])
- Medical assessment—pregnancy tests and treatment for HIV and AIDS, other sexually transmitted diseases, and tuberculosis (see also chapter 2, Screening and Assessment)
- Full-range medical treatment
- Treatment planning—medical, psychiatric, and substance abuse (see chapter 4, Substance Abuse Treatment Planning)
- Counseling—group, individual, family, couples (see chapter 5, Major Treatment Issues and Approaches)
- Residential treatment for substance abuse
- Substance abuse education—didactic lectures, interactive groups, videos, reading assignments, and journal-writing assignments
- Relapse prevention services
- Crisis intervention
- Drug testing and monitoring

Salt Lake City, Utah: A Sample Day Reporting Center

The day reporting center in Salt Lake City, Utah, has been operating since 1994. It serves high-risk/high-need offenders who abuse substances and who have had technical violations or committed new offenses while on probation or parole. Program activities are designed to reduce recidivism and enhance recovery by improving coping skills, preventing relapse, improving job and employment skills, and promoting a smooth reentry to the community. A study of offenders who attended and were discharged from the program during a 1-year period showed that these individuals had fewer property crime offenses, fewer criminal charges, and less substance use in their first year after discharge. A longer stay was associated with better positive outcomes up to 120 days, after which the effect diminished (Bureau of Justice Assistance 2000).

- Self-help education and support
- HIV/AIDS education, testing, and counseling
- Comprehensive pregnancy management—prenatal care and parenting classes and/or childbirth classes
- Mental health services—medications when indicated
- Social and other support services for the offender and family members
- Vocational and educational training
- Family services unrelated to substance abuse treatment
- Assistance in managing entitlements (e.g., food stamps, veterans benefits)
- Acupuncture and other nontraditional adjuncts
- Housing assistance

Additional services may be needed to address sexual abuse, child abuse, domestic violence, victimization, guilt and remorse, and family problems. These can be coordinated on an individual basis through case management and collaboration among system practitioners.

What Treatment Services Can Reasonably Be Provided for People Under Community Supervision?

Parolees and probationers receive similar services in community supervision. This section highlights the panel's recommended treatment options for both populations.

Basic Needs

Parolees and probationers often cannot meet their basic needs. In some situations, treatment cannot begin until such fundamental needs as housing and employment are met. In other

cases, such as when the client cannot maintain prolonged abstinence or when detoxification is needed, the client should be engaged in treatment before he or she receives assistance in locating housing or a job.

Housing

A lack of housing for offenders under community corrections supervision is a major problem in most jurisdictions; yet stable living arrangements are crucial to treatment. Available housing often is inconvenient to jobs, public transportation routes, community social services, or other agencies and includes drug-involved family members and/or friends. Sometimes a halfway house, a “sober house,” or recovery house are better alternatives than the offender-client's home. Attention to residential resources for clients should be a critical factor in case planning by corrections supervisors. Probation and parole officers should be required to visit and evaluate client residences promptly.

Reintegration With Family Members and Social Support

The offender's home environment often is not helpful for encouraging adherence to treatment. Treatment providers should explore the family's dynamics promptly during a home visit and make alternative living arrangements if the environment threatens to undermine treatment progress. Negative family dynamics take many forms. The offender may be the scapegoat for family problems, making his or her return to the home counterproductive. Also, other family members may be actively using drugs or involved in criminal activities.

Domestic violence and child abuse situations present additional issues, including the personal safety of family members. To determine how healthy the home is, counselors need to make frequent home visits. Generally, community corrections supervisors assess levels of safety in the home when there is a question,

although there are some substance abuse treatment programs that also perform this function.

To supplement the support an offender may be receiving from family members, the treatment plan should include recreational opportunities and other outlets to build healthy social relationships.

Vocational Training and Employment

Although highly important to an offender's recovery, vocational training and employment can create problems when they are mandated by the community supervision agency before the offender has been engaged in treatment. If the client has not undergone treatment, there is a high risk that money earned will be spent on drugs or alcohol. Another common result of mandating employment before treatment is that the offender may lose his or her job because of behavior related to substance abuse. Achieving and maintaining abstinence depends on structured, phased programming. Vocational training should occur before employment to enable the offender to retain a job or obtain a better one. Wexler (2001a) suggests beginning vocational training at the start of treatment rather than introducing it at the end. Integrating vocational assessment, counseling, training, placement, and followup throughout treatment is a challenge and requires consistent collaboration within and outside of agencies. However, actuating vocational treatment goals can serve as the matrix holding all other goals of reintegration into the community. For additional information about vocational issues and offenders, see chapter 8 in TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000c).

Case Management

Case management is the process of linking the offender with appropriate resources, tracking his or her progress through required pro-

grams, reporting this information to supervising authorities, and monitoring court-imposed conditions when requested. It should provide the following functions for offender-clients:

- Assessment of the client's strengths, weaknesses, needs, and ability to remain crime- and drug-free
- Planning for treatment services and fulfillment of criminal justice obligations, such as restitution, community service, or regular contacts with probation officers or other criminal justice officials
- Brokering treatment and other services and ensuring continuity as the client moves along criminal justice and treatment continuums
- Monitoring and reporting progress
- Providing client support, such as identifying problems and advocating with legal, social service, and medical systems in response to needs
- Monitoring urinalysis, breath analysis, or other chemical testing for substance use

Case management tests the ability of the criminal justice and treatment systems to work collaboratively and is based on two types of agreement: the agreement between the client and the two systems laying out protocols and consequences of infractions, and the agreement between the two agencies, a memorandum of understanding (MOU) that defines how each will manage the caseload of offender-clients in the jurisdiction. There can be one or two case managers representing each system. If two case managers are involved, they must coordinate efforts, working to encourage a multidisciplinary response that takes advantage of a

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wide range of treatment and rehabilitation options. For more on MOUs see chapter 11, *Key Issues Related to Program Development*. For more on case management see TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998a).

Relapse Prevention

When an offender experiences relapse, it is crucial to gauge the seriousness of the “slip” to determine appropriate interventions. One positive urine test or one drink after a long abstinence should not be viewed as failure but as a signal for stepped-up treatment and closer monitoring. Because resumption of drug abuse can lead to resumption of criminal activity, graduated sanctions for relapses should be specified in the treatment plan. It is essential that personnel from both the criminal justice and treatment systems agree to the range of responses and times when certain responses are appropriate. Repeated relapses must trigger consequences based on danger to the community and the offender’s treatment progress.

The rate of relapse is high among offenders, and relapse prevention training must be provided at the beginning of and throughout treatment, and stressed prior to release. Personal relapse plans should be developed for all parolees receiving treatment. Relapse prevention skills should be part of each offender-client’s treatment plan, addressing how clients can refuse drugs and identify and manage triggers for craving. When relapse occurs, clients must be helped to understand it is part of the recovery process, rather than a personal failure, so they can rededicate themselves to success. If properly handled, relapse can lead to increased motivation for recovery, strengthening an individual’s knowledge of his or her limitations, the dangers of stressors, and awareness of what could be lost by leaving the treatment process.

In negotiating the MOUs, treatment and criminal justice officials need to collaborate and must support sanctions consistent with treat-

ment so that relapse is not simply punished as a criminal offense. Criminal justice decision-makers at all levels, including judges and court personnel, should be aware that relapse is a characteristic feature of substance use disorder that must be anticipated, prevented, and addressed. Sanction possibilities include

- House arrest
- Assignment to halfway house
- More frequent drug testing
- Electronic monitoring
- Day treatment
- Brief jail stays
- Assignment of community service hours

Treatment Issues for People Under Community Supervision

The point at which an individual acknowledges the need for drug treatment varies by personal circumstance. What is a crisis for one person is not a crisis for another.

However, at a number of junctures many offenders indicate readiness to accept substance abuse treatment. These include the point of arrest, the point of release back to the community, any point at which there is a diversion decision, sentencing, after certain periods of incarceration, on entering probation, or when there is a choice between entering a residential treatment program or a jail. Other critical choice points include changes in one’s social position in the community or personal crises such as the death of a loved one, loss of a job, or suicide attempt.

Because of the diversity of offenders under community supervision, treatment issues vary widely. A parolee recently released after a 20-year sentence will, for example, have different issues and needs than a probationer who has spent minimal time in a correctional facility and who has more immediate ties to the community. Still, there are treatment issues

that are common to both parolees and probationers. This section addresses those issues. Treatment issues unique to probationers and parolees are addressed in separate sections.

Self-Esteem and Identity

Shame and stigma are tremendous obstacles for offenders to overcome after an arrest or in making the transition between incarceration and the community. One effective approach to overcoming this stigma involves encouraging offender-clients to become active as volunteers in support of a community activity. Providing an opportunity for individuals to make a positive contribution to the community—to “give back”—may reduce feelings of alienation and build self-regard.

Stories abound of ex-offenders who experienced a successful recovery from substance use disorders through inspirational interventions and became mentors to young people, playing key roles in steering them toward law-abiding lives. Successful programs recognize the importance of building the client’s sense of worthiness.

Program success also depends on the quality of the staff, the treatment approach, and individual client motivation. Given the critical importance of self-esteem to recovery, the panel recommends that training in developing client self-esteem be mandatory for community corrections personnel.

At the same time, self-esteem is not always a useful treatment target or goal with offenders. Feelings of shame and stigma are sometimes missing, especially in those having antisocial

Advice to the Counselor:

Recommended Treatment Services for People Under Community Supervision

- Help the client address basic needs, such as housing or employment.
- A client’s living arrangements are crucial to treatment. Counselors should be aware of residential resources and collaborate with corrections supervisors and probation and parole officers on finding appropriate housing for clients if needed.
- A client’s treatment plan should include recreational opportunities and other outlets to help them build healthy social relationships in addition to the support clients may be receiving from their family.
- Try to start vocational training for clients at the beginning of substance abuse treatment rather than at the end of treatment.
- Case management is an opportunity for the criminal justice and substance abuse treatment systems to collaborate to take advantage of a wide range of treatment and rehabilitation options for clients.
- Relapse prevention skills should be part of each offender treatment plan, and personal relapse prevention plans should be developed for all parolees receiving treatment. These plans address how clients can refuse drugs, identify triggers, and manage cravings.
- One positive urine test or one drink after a long abstinence should not be viewed as a failure but as a signal for stepped-up treatment and closer monitoring.
- Graduated sanctions for relapses should be specified in the treatment plan because resumption of drug abuse can lead to resumption of criminal activity.

traits and psychopathy. Targeting self-esteem without also increasing sense of personal responsibility and empathy for others may only result in a more confident criminal. Community service serves to reconnect the offender with the community and allows for retribution.

Financial Concerns

Many offenders have multiple financial responsibilities—child support, family obliga-

tions, job requirements, restitution, and treatment schedule—which can be major obstacles to successful treatment. A client burdened with overwhelming responsibilities sometimes gives up, saying, “I just couldn’t handle it.” Criminal justice and treatment professionals need to plan realistic require-

Establishing an offender’s motivation to change is an essential first step in substance abuse treatment.

ments for individuals under community supervision.

Some communities have recognized the obstacles and stress presented by competing assignments and schedules imposed on offenders, which often necessitate expensive and time-consuming travel between sites. On Maryland’s Eastern Shore, Tyson’s Food, a major chicken producer,

has given parole officers an office on-site at the processing plant so that employees do not need to miss work to meet reporting requirements. Drug courts impose numerous reporting responsibilities, but officials can make a reasonable attempt to accommodate the logistics of offenders’ job, treatment, and family responsibilities.

Barriers to Treatment

Probationers and parolees may live in fear of the system; their freedom is conditional, and a mistake is likely to lead to reincarceration. Among the many internal barriers that can inhibit treatment success for offender-clients are

- A history of failure
- Alienation from and cynicism about the social structures and governmental agencies that typically have had a major impact on them

- A sense of hopelessness that anything can make a difference in their lives
- A culturally supported belief that treatment is for weak people
- The perception that treatment is further punishment

Those working with probationers and parolees need training to address each of these barriers. It is important for professionals working with offenders under community supervision to learn that offenders often do not realize that the goal of community corrections is to prevent them from being reincarcerated. Another treatment component should address the realities of incarceration and the impact of being a felon. Offenders being supervised in the community need to be informed of what they stand to lose by violating supervision requirements.

Motivation for Treatment

Establishing an offender’s motivation to change is an essential first step in substance abuse treatment. It cannot be skipped. Generally, clients lack focus or goals, which must be established to permit motivation. Those working with probationers and parolees need to be familiar with techniques of motivation and how to create and/or support the offender’s desire to break a pattern of criminality. Without genuine motivation on the part of the offender-client, treatment problems can be guaranteed. Clients need to feel hope and counselors need to plan a continuum of events that can begin to generate hope. During early stages of treatment, the offender-client should be oriented toward small accomplishments.

Flexibility on the part of community corrections officials is important. Both treatment programs and corrections agencies can work together to build opportunities for success—keeping an appointment, having a clean urine test, or completing homework—small, structured steps that clients can take with relative ease and derive confidence from as they

progress. When the client completes one goal, the provider should be ready to suggest the next. Incentives can be built into the system as well. For example, the more frequent the negative drug test results, the less frequent the mandatory testing.

Those who abuse substances often are gifted manipulators with long histories of manipulative behavior in many systems. They may be able to simulate motivation but lack any real emotional investment in changing behavior. Clear, consistent, and uniform messages promote recovery and prevent the two systems from being used against one another. If the word “on the street” is that staff can be manipulated, treatment providers will face an uphill battle with many clients.

Motivational interviewing is one of the most frequently used strategies for enhancing motivation. The technique assumes the client’s ambivalence about change and produces cognitive dissonance by eliciting the negative consequences of the addictive behavior.

Motivational interviewing has been effective in the treatment of alcoholism (Bien et al. 1993; Galbraith 1989; Miller and Rollnick 1991) and methadone treatment for opioid abuse (Saunders et al. 1995; Van Bilsen and Van Emst 1986). For more on motivational interviewing, see the section on brief treatment in chapter 8 and TIP 35 *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999b).

Negative Counselor Attitudes

Treatment is impeded when counselors have a negative perception of the client’s desire to change, believe there is a poor prognosis for recovery, or are reluctant to serve offenders in general. Clients easily pick up on a provider’s negative attitude, which often confirms their own feelings about the futility of attempts to give up drugs. The cross-training of professionals helps build an understanding of offender-clients’ needs and potential, but professionals in both systems must acknowledge that the very nature of substance abuse

means that maintaining recovery is a long-term goal.

Lifestyle Changes

The kinds of changes community corrections professionals ask drug offenders to undertake are extraordinarily challenging and difficult to contemplate on a personal level. Many offenders have had limited experience with success and few opportunities to test their ability to succeed. A drug court or prison may be the first setting in which some offenders have a genuine chance to discover the capacity to change their lifestyles.

A counselor who is a role model of courage or compassion can often be very effective in persuading clients to reevaluate their lifestyles. On the other hand, counselors should also be prepared for setbacks, lapses, and slow progress, as offenders come to terms with the extent of lifestyle change that is being asked of them.

Self-Help Groups

Self-help groups frequently are a crucial component in recovery; they can provide peer support and nurture positive change. As bridges between incarceration and community, they can help with crises and personal growth. Probation and parole officers often advise clients to attend well-known programs like Alcoholics Anonymous or Narcotics Anonymous, saying, “Don’t take my word. I’m not the expert. Listen to the folks who’ve been there.” Other self-help groups may be appropriate depending on a client’s beliefs, needs, and interests, such as Survivors of Incest Anonymous, Secular Organizations for Sobriety, church or feminist groups, or veteran organizations. Practitioners need to remember, however, that although self-help groups are not a substitute for counseling, they can be an important adjunct to it.

Adherence to Supervision Conditions

Both parole and probation officers need to be attuned to treatment needs, the dynamics of substance use disorders, and the changes required to maximize an offender-client's chance to succeed. Training needs to be provided to them on how to craft requirements that support a client's potential for success. Flexibility must be built into the requirements, given the complex pressures on most offenders in the community. Cross-training is necessary to facilitate information sharing among the entire range of professionals involved from presentence to probation or parole. While public safety is always a priority, training for probation and parole officers should emphasize that the offender's long-term treatment will bring sustained improvements in public safety.

Revocations because of technical violations of probation or parole requirements are a major barrier to completion of successful treatment. Required expectations for offender behavior need to be realistic. Cross-training can be helpful in fostering a shared vision of success. Such training should have specific goals. For example, the consensus panel suggests that training for probation officers working with drug offenders could include education on what treatment is and is not. Generic models of treatment should be presented. Similarly, treatment professionals working with drug offenders should be trained on the role of parole and probation in the criminal justice system. Probation and parole are frequently the most misunderstood element of the system, considered to be "law enforcement" by treatment professionals and "social work" by law enforcement. Often the breakdowns in communication between probation, parole, and treatment professionals are the result of a lack of understanding of each other's roles.

Vulnerability to Relapse

Both parole and probation officers, who may have a supportive role before the client enters treatment, are likely to move into supervisory mode once treatment is underway to reduce public safety and liability risks. Zero tolerance and "three strikes" policies make it difficult for officers to overlook drug lapses and contradict knowledge that substance use disorder is a chronic disease. Relapse is not necessarily a failure. The common belief that treatment does not work is often based on the fact that most people recovering from substance use disorders relapse from time to time.

Roles as Workers and Taxpayers

Not only have arrests and imprisonment removed many young men and increasing numbers of young women from their communities and families, the majority have no financial resources to cushion their return. Their length of time away from the job world and lack of skills or experience to enter the marketplace leave many offenders low on the job ladder and further unable to support families or meet social expectations. Simply having a job, and particularly paying taxes, can be a completely foreign experience for many offenders. If parole or probation reporting and other multiple requirements are inflexible, they can prevent clients from being able to earn a living and contribute as tax-paying citizens.

Increasingly, vocational training, GED programs, and job readiness training are being added to treatment. If programs do not offer these services, they can link to community agencies that can provide them. Offenders need specific preparation for responding to a prospective employer's questions about their past. Lying is often a first choice, given the prospect that admitting to a criminal history will likely bar them from the job. A felon may

be legally obligated to disclose a criminal past.

Treatment for Specific Populations

Both probationers and parolees with substance use disorders are likely to have additional treatment needs. Model programs described at the end of this chapter include comprehensive services to address a range of issues. This section briefly highlights the treatment issues of specific populations. For more detailed information, see chapter 5, *Major Treatment Issues and Approaches*.

People with co-occurring disorders

Of the 74 percent of probationers and parolees identified as having drug and/or alcohol problems, 11.4 percent were also identified as having mental illness (Beck 2000c). The prevalence of co-occurring disorders among these populations means that many offenders will need assistance with their mental illness as well as their drug or alcohol problems. Treatment for co-occurring mental disorders should be tailored to the particular treatment plan, and revised according to ongoing assessment. Coordinated (integrated when possible) services are especially important for offenders with mental illness. An example of one model for treating offenders with mental illness is highlighted on the next page.

The National GAINS Center for People with Co-occurring Disorders in the Justice System

Advice to the Counselor: **Treatment Issues for People Under Community Supervision**

- Counselors can help offenders overcome the stigma of past incarceration by encouraging them to become active as volunteers in support of a community activity.
- For some clients financial stresses can be an obstacle to successful treatment. Counselors can work with criminal justice personnel to help plan realistic financial requirements for clients.
- Counselors need to help clients address any internal barriers clients may be experiencing, such as a history of failure, sense of hopelessness, or the perception that treatment is further punishment. Counselors can help offenders understand that the goal of community corrections is to prevent them from being reincarcerated.
- An essential first step for treatment is to establish a client's motivation to change. Counselors should be familiar with motivational techniques (such as motivational interviewing) and how to create or enhance a client's desire to break a pattern of criminality.
- Counselors should be careful not to project negative attitudes, which might be picked up by clients and reinforce their feelings of futility about substance abuse treatment.
- Being a role model of courage or compassion can be effective in persuading clients to reevaluate their lifestyles and make positive changes.
- Self-help groups can be a crucial component in a client's recovery by providing peer support and nurturing positive feelings.
- Counselors can help clients applying for employment prepare for responding to a prospective employer's questions about their past.

provides an online information source of value to those who work with offenders. The GAINS Center collects and analyzes information, and develops materials specifically for people who work with offenders with mental illness, and provides technical assistance to help localities plan, implement, and operate appropriate, cost-effective programs. For further information go to <http://gainscenter.samhsa.gov>.

PACT (Programs for Assertive Community Treatment)

The PACT model targets individuals with severe and persistent mental illness (which may include schizophrenia and other psychotic disorders, bipolar disorder and severe and recurrent depressive disorders, and occasionally severe personality disorders or severe anxiety disorders). Many if not most PACT clients have co-occurring addictive disorders, medical problems, and more than one psychiatric illness. The hallmark of PACT is low caseload size (15 clients per staff person) and an integrated team approach that includes people with medical, psychiatric, nursing, social work, psychology, case management, addictions, and other expertise who view the clients as a shared responsibility. Typically these programs will follow the client across locations. They do outreach into homeless shelters and street locations, they work with other providers when the client is hospitalized, and they will work with jails to advocate for good treatment.

Research indicates that PACT is effective in reducing hospital recidivism and, less consistently, in improving other client outcomes (Drake et al. 1998a; Wingerson and Ries 1999). Another study compared a PACT with a standard case management approach at 3-year followup. The results indicated that the PACT adapted for clients with co-occurring disorders produced greater improvements on measures of quality of life and clinician ratings of alcohol use and substance abuse (McHugo et al. 1999).

Female clients and children

Nearly a million women were on probation in 2003, and nearly 100,000 were on parole (Glaze and Palla 2004). Women under community supervision accounted for 85 percent of females in the criminal justice system in 1998. About 45 percent of women whose parole ended in 1996 were back in prison or had absconded. Women who successfully finished parole were incarcerated for an average of 15 months and on parole for an additional 20 months (Greenfeld and Snell 1999).

Mothers who are to be incarcerated often lose custody of their children because of neglect and/or abuse, but the loss of children is extremely difficult for them to accept. If children are removed, criminal justice and treatment providers need to consider providing assistance for dealing with grief and loss. A client who has demonstrated a sustained period of sobriety during treatment should be considered for a phased return of her children. Mothers reentering the community from correctional institutions are likely to have a difficult time reuniting with their children. They and their children should work with family service agencies on reunification issues, when appropriate.

Clients with HIV/AIDS or other illnesses

Offenders face additional challenges when they are unable to work because of illness. Access to medical help is essential. The consensus panel believes that comprehensive assistance to offenders should include prevention education, medical and social service support, grief counseling, and other psychological services. Services should include infectious disease risk assessment and screening, medical interventions such as primary care, and family counseling. Continuing care should include followup and hospice care. Case managers can assist in coordinating care for such infectious diseases as HIV, hepatitis C, tuberculosis, and sexually transmitted diseases. For more on infectious diseases in criminal justice clients, see chapters 2 and 6.

Treatment Issues Specific to People on Parole

Prisoners released into the community face a sometimes bewildering transition. Nearly 80 percent of prisoners returning to the commu-

nity are released on parole under conditional release (Petersilia 2000). A successful transition from offender to citizen often depends on successful treatment. Successful treatment helps individuals to be more realistic about their strengths and weaknesses, more skilled and willing to endure obstacles encountered in maintaining a job or obtaining an education, and more confident about meeting family and work responsibilities.

Continuum of Care

Because substance use disorders are long-term, relapsing illnesses, a crucial aspect for reentry is to develop and sustain an integrated continuum of care between substance abuse treatment providers, the parole officer, and social service agencies that can assist the inmate's reintegration into the community. Ideally, cross-system integration for offender transitional services contributes to cost benefits as a result of reduced recidivism (Inciardi 1996; National Institute of Justice 1995; Swartz et al. 1996). However, the parolee does not exist in a discrete, well-coordinated system, but rather in a cluster of independent agencies and entities with separate justice responsibilities. Some entities collaborate closely; others do not. Most operate under separate funding streams, with differing organizational missions that may or may not share philosophical orientations toward public safety and offender rehabilitation. Boundary spanners and case managers can sometimes help maintain continuity. TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998b), discusses this topic in depth.

Aftercare and Continuing Care

Several studies have supported the long-term efficacy of postprison aftercare and treatment services in the reduction of recidivism and relapse. For example, Wexler (1995) found that those who participated in prison- and community-based therapeutic community treatment committed fewer crimes than their

counterparts who did not receive aftercare services. Inciardi (1996) reported similar findings: lower rates of drug use and recidivism than those enrolled only in institutional treatment programs.

Residential aftercare contributes to improved postprison outcomes. For optimal results, the offender should remain in treatment in the community. Studies show, for example, that the most effective treatment lasts a minimum of 3–6 months, and outcomes improve with additional time in treatment. This is true for all treatment modalities and particularly for treatment of offenders (Hubbard et al. 1988; Simpson 1984; Wexler 1988).

Case Management

Case management is the crucial function that links the offender with appropriate resources, tracks progress, reports information to supervisors, and monitors conditions imposed by the supervising agency. These activities take place within the context of an ongoing relationship with the client. The goal of case management is continuity of treatment, which, for the offender in transition, can be defined as the ongoing assessment and identification of needs and the provision of treatment without gaps in services or supervision. Accountability is an important element of a transition plan, and case management includes coordinating the use of sanctions and incentives among the criminal justice, substance abuse treatment, and possibly other systems.

Ideally, case management activities should begin in the institution before release and continue without interruption throughout the transition period and into the community. Reassessments should be conducted at various stages throughout the incarceration and community release process. These periodic assessments should form the basis for ongoing case management and service delivery.

Ancillary services are needed before and after release to prepare the offender for the return to family, employment, and the community.

Studies (Knight et al. 1999a; Martin et al. 1999; Wexler et al. 1999b) have revealed the importance of aftercare for the maintenance of treatment effects. Foremost among needs for ancillary services are drug-free housing or other living arrangements, employment, family support, transportation, education, and primary health care. Others include literacy training, HIV/AIDS education, and prosocial support networks (Belenko and Peugh 1998; Hiller et al. 1999b). Offenders may need help learning basic life skills such as budgeting, using public transportation, and parenting. Improving clients' likelihood of obtaining a job through GED preparation, enrollment in an educational program, vocational training, or job-seeking skills classes increases their chances of success after release.

This array of services reflects the multiple psychosocial needs of offenders and takes into account the likelihood that they may experience periods of relapse, requiring more intensive levels of treatment and supervision. Other needs are training to improve interpersonal skills within families and among peers and training in anger management to learn

new methods for resolving conflicts. Family members should be involved whenever possible, and participation in self-help groups should be encouraged.

Recidivism

Parole failures now account for 35 percent of all prison admissions. Two-thirds of all parolees are rearrested within 3 years (Petersilia 2000), many on technical revocations, but most rearrests occur in the first 6 months. Offenders with mental illness are especially likely to be rearrested.

Given the importance of aftercare in the reduction of recidivism, several Federal and State Initiatives have sought to provide integrative treatment. One such program, the Serious and Violent Offender Reentry Initiative, is highlighted below.

Serious and Violent Offender Reentry Initiative

In conjunction with several Federal partners, the U.S. Department of Justice, Office of Justice Programs, created a comprehensive program to reduce violent crime by helping high-risk offenders prepare for reentry to society. The Initiative provides funding for the development, implementation, and enhancement of reentry programs. Programs funded under the Initiative will be tailored to address the three phases of reentry:

- *Phase 1—Protect and Prepare.* Institution-based programs will provide services to prepare the offender for reentry, including education, mental health and substance abuse treatment, job training mentoring, and diagnostic and risk assessment.
- *Phase 2—Control and Restore.* These community-based transition programs will assist offenders prior to and immediately following their release by providing education, monitoring, mentoring, life skills training, assessment, job skills development, and mental health and substance abuse treatment.
- *Phase 3—Sustain and Support.* In this phase, community-based, long-term support programs help offenders who have successfully completed their criminal justice supervision to connect with social services agencies and community-based organizations that provide ongoing services.

Further information on the Serious and Violent Offender Reentry Initiative is available at the Office of Justice Programs Web site: <http://www.crimesolutions.gov/ProgramDetails.aspx?ID=167>

Treatment Issues Specific to Probationers

Compared to parolees, probationers are less likely to have spent extended time in a correctional facility, and their ties to the community are relatively intact. The latter is both a benefit and a detriment in terms of substance abuse. On the one hand, offenders on probation may have the support of their families and their communities.

They may be able to maintain some consistency in their employment, their residence, and their family lives. On the other hand, probationers face a more immediate return to the surroundings and influences associated with their drug or alcohol use. For example, the offender with alcohol dependence is likely to return to the same neighborhood with the same bars, liquor stores, and friends.

As with parolees, in order to be effective treatment must necessarily focus on changing ingrained patterns of behavior and thinking and avoiding the people, places, and things that the offender associates with drug or alcohol use. Unlike people on parole, however, the issue is not so much to reintegrate into society, but rather to learn new ways to live in that society. Much of the information presented in chapter 7 is also applicable to probationers, since many probationers have been sentenced through drug courts.

Strategies for Improving System Collaboration

Initiatives such as cross-training, coordinated and comprehensive planning, and followup interdisciplinary meetings can help justice and treatment system partners to develop a shared, client-centered mission and a coordi-

Advice to the Counselor: **Treatment Issues for People on Parole**

- Counselors can collaborate with parole officers and social service agencies to assist a client's reintegration into the community and help maintain the continuity of services.
- Counselors can help clients with securing postprison aftercare and treatment services, which have been shown to reduce recidivism and relapse.
- Ancillary services (e.g., drug-free housing, employment, family support, transportation, education, health care) are needed before and after release from prison to prepare the client for return to the community.

nated response. Figure 10-2 (next page) provides an example of how the goals of the treatment and criminal justice systems can be viewed as similar, although on the surface they appear disparate.

Memorandum of Understanding

When a substance abuse treatment program and a criminal justice agency collaborate, an MOU will outline the objectives of each partner, the expectations each partner has about the obligations of the other, and communications between the program and the criminal justice agency. For programs treating offenders, it is crucial to identify who will make certain decisions and what kinds of information will be reported. For example, will the program or the criminal justice agency decide when an offender's relapse into alcohol or drug use will be handled as a violation of the conditions of probation? How detailed are the program's reports to the criminal justice agency? Matters such as these can be resolved upfront between the program and criminal justice agency. An MOU or letter of agreement makes explicit the responsibilities agreed upon by each system.

Figure 10-2
Paradigm of Collaboration

Goals of Treatment System	Goals of Supervision System	Shared Goals
<ul style="list-style-type: none"> • Reduce recidivism/criminal behavior. • Provide evaluation and treatment services. • Practice social skills. • Develop working alliance. • Prevent secondary pathology. • Collaborate/consult with other providers. • Honor confidentiality. 	<ul style="list-style-type: none"> • Reduce recidivism/criminal behavior. • Maximize the use of databases on the offender. • Enhance supervision. • Rely on third party expertise. • Focus on public safety. • Respond to court mandates. 	<ul style="list-style-type: none"> • Minimize risk to public. • Obtain adherence to treatment plan and abstinence from substance use. • Alleviate symptoms of illness. • Promote successful community reintegration with the goal of abstinence. • Encourage family/social support. • Support employment efforts.

Information-Sharing and Confidentiality Issues

To develop effective treatment plans that respond to individual needs and problems, community-based organizations need information from the paroling institution about the offender's previous substance abuse treatment. Obtaining such information often is problematic because of ethical considerations about client privacy and Federal laws guaranteeing strict confidentiality of information about all people receiving substance abuse prevention, assessment, and treatment services. For more detailed information on confidentiality and privacy, see chapter 7. (Additional information on confidentiality can be found in CSAT 2004.)

Program Violations

Ideally, program violations should be addressed in the context of treatment needs before legal sanctions are considered, depending on the severity of the violation. However, this is realistic only if the supervising agent and the provider of care agree on how to make it work; it is not realistic if there is not a solid agreement between the two systems. When possible, this understanding can

be established by an initial agreement between the offender-client's probation or parole officer and treatment provider.

Personnel and Training

While some States do not require licensing for treatment providers, it is undesirable to have unaccredited, unlicensed people providing treatment. The consensus panel feels strongly that individuals providing treatment to offender populations should meet minimum standards of recognized accrediting authorities in addition to receiving specialized training in substance use disorders and relapse prevention. Special attention needs to be paid to the training of recovering staff who are essential counseling resources for therapeutic communities and other programming. Their credibility with clients and role modeling potential cannot be underestimated. Programs that include opportunities for clients to begin counselor training while in custody enrich programs and offer increased hope for participants. However, careful guidelines are needed concerning crime-free and sober years, in addition to other standard professional counselor requirements.

Whenever possible, training should be carried out across criminal justice and substance

abuse treatment systems and should integrate personnel from both. The curriculum should cover needs and approaches to specific populations in the jurisdiction, such as women, minorities, those with co-occurring mental disorders, and clients with special needs, and incorporate input from each of these groups to ensure the training's relevance, accuracy, and sensitivity. General topics to consider include

- A broad overview of how each system works
- Common ground shared by substance abuse treatment and criminal justice systems
- Education on the language and jargon of the systems so that providers understand each other's language
- Clarification of system roles and personnel roles within each system
- Ways in which the two systems can communicate, work together, and manage conflicts
- Cultural competence issues
- Confidentiality requirements
- Effective case management for the offender-client
- Rationales for intermediate sanctions programs for drug offenders
- Eligibility requirements for intermediate sanctions programs and how they can be applied to individual cases
- Reporting requirements and agreements
- Pharmacotherapy

Participants in training for this type of community supervision program should include

- Judges
- Prosecutors
- Probation and parole officers
- Treatment program administrators
- Counselors
- Public treatment-funding agencies
- Defense attorneys
- Ancillary program staff

Special presentations can be made to policy-makers (e.g., State and local legislators or advisors to the State or county) that focus more on systems and legislative issues. For more on training on screening and assessment, see chapter 2. For general information on treating offenders, see chapter 5.

Sample Programs

Treatment Accountability for Safer Communities

For a description of TASC, see chapter 7.

The Amity Project

The Amity Project was a collaboration between Amity, Inc., and the Pima County, Arizona, Department of Probation and funded by The Center for Substance Abuse Treatment, U.S. Department of Health and Human Services, in 1990. The program targeted offenders who were at high risk of having their probation revoked because of their substance abuse. By incorporating the key elements of a therapeutic community into a day and evening program, the unique structure escalated sanctions, including urine screens and varying supervision levels, case management, educational and vocational training, family support and counseling, coordination of medical services, and intensive aftercare. After 2 years, drug use relapses among probationers declined, positive urine screens decreased by more than 50 percent in the first year, and job placement increased. Because of the success of the employment component, the project had to extend its activities to nights and weekends to accommodate the employed offenders. The program ended when funding was not renewed, despite its promising start (Healey 1999).

Breaking the Cycle

A joint project of the ONDCP and the National Institute of Justice, U.S.

Department of Justice, Breaking the Cycle is designed to interrupt the downward spiral of drug use, crime, imprisonment, and recidivism and is currently being tested by three adult justice systems nationwide. The goal of the program is to reduce drug use and crime through increased collaboration between justice system practitioners and treatment providers. The Breaking the Cycle model encourages a change in the way both systems respond to offenders who use drugs and includes the following initiatives:

- Drug testing of all arrestees before the initial court hearing
- Placement of people who use drugs in appropriate treatment and monitoring programs
- Intensive pretrial and post-sentence case management
- Appropriate, graduated sanctions and incentives to address offender behavior
- Judicial oversight of offender compliance (National Institute of Justice 2001)

Probationers in Recovery

An intensive probation program in San Diego County, California, Probationers in Recovery requires offenders to participate in intensive drug treatment and drug testing. The program has made a strong effort to combine substance abuse treatment with the heightened surveillance of intensive supervision. The program targets high-risk offenders and excludes people with psychotic disorders and excessive criminal or violent histories. The requirements for program completion are comparatively high, including self-help, group and individual therapy, job club, drug education, social skills development, and life skills components lasting a minimum of 6 months (Curtis et al. 1994).

KEY-CREST

Located in Wilmington, Delaware, KEY-CREST has an in-prison therapeutic community, and a 6-month residential, community-based TC with a work release program for inmates with histories of substance abuse. The program includes an aftercare stage, where clients are under community supervision. Data from a 3-year followup indicate that the group in aftercare shows the most powerful effects of the earlier treatment (Martin et al. 1999). For additional information, see chapter 9.

Special Offender Services Program

One model program for the treatment of offenders who have developmental disabilities or at least three deficits in essential adaptive skills or behaviors was developed in the mid-1980s by Lancaster County, Pennsylvania. This program, known as Special Offenders Services (SOS), helps qualified offenders who have been placed on probation or parole. SOS works in a number of areas to help this group by educating criminal justice personnel, facilitating the use of social services (through case management), building client self-esteem (which it does by rewarding small successes and not placing unreasonable demands on its clients), educating clients about their rights and responsibilities, and providing skills training in areas such as recreational activities (since many offenders who are cognitively challenged may not know how to spend their free time). The program's success is demonstrated by the extremely low recidivism rate of its clients, which, as of 1992, was only 5 percent (Wood and White 1992).

Conclusions and Recommendations

Based on their knowledge and experience, consensus panel members offer the following conclusions and recommendations regarding treatment for probationers and parolees:

- Offenders can be effectively controlled and managed by a combination of treatment and surveillance while on probation at a far lower cost than if they are in jail or prison.
- Offenders under community supervision who have substance use disorders need services from multiple systems. Services should be accessible on an as-needed basis to ensure positive outcomes and smooth transitions.
- Cross-training of probation and parole officers, case managers, and substance abuse counselors is vital for the delivery of coordinated services.
- Community supervision should be based on the recognition that relapses are unavoidable and not necessarily indicative of failure. Intensification in the level of supervision should be matched by an intensification of the level of treatment. Likewise, the intensity of supervision should decrease over time as the individual meets treatment goals.
- Probationers who have avoided incarceration should receive education on the realities of incarceration and the impact of being a felon on the offenders' lives.
- Ideally, case management activities for parolees should begin in the institution before release and continue throughout the transition period for a minimum of 3 months of treatment after release.
- Reassessment should be conducted throughout the period of community supervision.
- All residential treatment should be followed by continued care in an outpatient setting.
- Optimally, probation and parole officers should visit and assess the client's residence and place of employment periodically in the course of community supervision.
- Vocational programming should be ongoing and integrated with substance abuse treatment.
- Community supervision staff should be involved in treatment planning and treatment team activities whenever possible, particularly when issues of sanctions and placement in community treatment are reviewed.