

Substance Abuse Treatment and the Adult Offender on Probation or Parole

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Section 1 - Introduction

The link between substance abuse and crime is well documented.

The majority of state inmates (53 percent) and almost half of federal inmates (45 percent) were abusing substances or dependent on drugs in the year before their incarceration. Among probationers, drug trafficking and possession are among the most common offenses, and approximately ¼ of those age 44 or older are on probation for driving while intoxicated.

Fortunately, there is ample evidence that involvement in substance abuse treatment reduces recidivism. Treatment is cost effective, too. Partly as a result of the reduced burden on courts and criminal justice systems, the Kentucky Division of Substance Abuse found that every \$1 spent on treatment saved almost \$4 in future costs to taxpayers. Other states have found comparable cost and benefit ratios, too.

In response to the effectiveness of substance abuse treatment, a number of programs and initiatives have been implemented on the local, state, and federal level throughout the U.S. to help more offenders in institutional and community settings.

However, even substance abuse counselors, social workers, and case managers in community mental health centers or other settings serving the general public are likely to see offenders in their programs at some point. More than 40% of offenders on probation are ordered to enter some form of substance abuse counseling and often, there simply are not enough slots in drug courts or other community programs specifically for offenders.

This home study course, "Treating the Adult Offender on Probation or Parole," provides an overview of the screening, assessment, treatment planning, and counseling processes with adult offenders on probation or parole. Having a basic working knowledge of the criminal justice system helps when working with this population, so here are some definitions of terms related to this topic:

Classification – The process by which a criminal justice agency (jail, probation dept., etc.) assesses the security risk of an offender and his/her need for social services.

Community corrections – A form of corrections that seeks to reintegrate the offender into the community. Examples include diversion programs, house arrest, electronic monitoring, probation, and parole.

Competence - the legal ability to act on one's own behalf. This question is generally asked when the offender is also mentally ill and may not be able to understand the charges against him/her. Mental health courts must deal with this issue frequently.

Day reporting – A place where offenders on probation or parole must report to be supervised for a certain number of hours a day, usually for a pre-determined number of days. While at a day reporting center, offenders may receive social services, learn vocational skills, or perform community service.

Diversion – A process where a defendant's prosecution is deferred or dropped if certain conditions are met. This can also refer to a process where an offender is diverted from prison and into a community program.

Drug court – Specialized courts for felony drug offenders. These courts entail intensive supervision, drug testing, substance abuse treatment, and other services. They usually operate with, or within a probation department.

Electronic monitoring - A system of checking an offender's whereabouts using an electronic device. Usually, a monitor is attached to the offender (often by means of an ankle strap) which will report the offender's physical location through the use of a GPS monitor. These devices can be used to report to the court on an offender's compliance or non-compliance with court orders involving place (such as "stay away from..." or "no contact with...").

Expungement - If granted by a judge, this allows an offender's records to be sealed and removed from criminal history records. Thus, the record of an offender's arrest will no longer be found, and s/he can truthfully answer "no" to the question "have you ever been convicted of" Drug courts often dismiss the charge and expunge the record if a person successfully completes treatment, thus leaving the offender with no criminal history.

Felony - A criminal offense serious enough that the penalty will result in incarceration in a state institution.

Incompetent to stand trial - A judge finds the defendant is unable to understand the charges against him or her, due to a mental disability. Thus, the charges will not be heard until the defendant is "restored to competence". This may result in a court order placing the person in a mental health facility until competence can be restored.

Intensive Supervision Probation – A form of probation in which the probation officer closely monitors a smaller caseload of offenders.

Misdemeanor - A criminal offense, the penalty for which could result in incarceration in a local jail or community corrections facility. Generally, any law violation resulting in 6 months of incarceration or less is a misdemeanor.

Not Guilty By Reason of Insanity - A court finds that at the time of the criminal offense, the defendant was unable to understand the difference between right and wrong due to his/her mental condition. When this finding is made, the court will either return the person to a mental health facility for further inpatient treatment, or order outpatient community treatment. If the person fails to comply, he/she can be returned to a mental health facility. Community treatment for these persons will either be supervised by a mental health agency or by a probation agency, who will report to the court regarding the person's compliance.

Parole – Community supervision of an inmate who has served part of his or her sentence in an institution. The offender must abide by specific terms as a condition of remaining on parole.

Pre-sentence investigation – An investigation into the background of a defendant that helps the court determine the most appropriate sentence. This usually occurs after conviction, but before sentencing.

Probation – A sentence where the offender is allowed to remain in the community in lieu of incarceration. A probation officer ensures compliance with specific terms and conditions.

Restoration - An action that can be taken by a judge or parole representative where the offender is restored to probation or parole even though he has violated the original conditions. The judicial body may impose additional or revised conditions on the offender. For example, an offender with positive drug screens may be restored to probation but ordered into residential treatment. Generally, restoration involved a more restrictive release.

Restitution - A court-ordered condition stating that the offender must compensate his victim for his or her losses. For instance, if something has been stolen it must be paid for, or, if physical or mental damage has been done, the offender must pay the medical bill. Generally, the court will order a specific amount, and the probation or parole investigator must determine what this amount is so the court can order it.

Revocation - An action by a judge or parole board representative that rescinds an offender's release. In the same action, generally, the original sentence is imposed.

Violation - An action taken by a person on probation or parole that is contrary to the boundaries imposed by his release conditions. For example, if the court has ordered that the person remain drug-free, and they have a positive urine, this would be a violation. Usually, the probation or parole agent reports the violation to a judge or parole representative by means of a hearing. If the alleged violation involves treatment conditions, representatives of the treatment program may be required to testify.

Section 2 - Screening & Establishing A Working Relationship

The primary purpose of screening is to establish the need for an in-depth assessment. It is a formal process designed to determine whether there is enough evidence to refer the client for further evaluation.

Screening involves information-gathering and administering screening instruments which are well researched, have a known level of reliability, and often have cut-off scores. The screening process can provide the client with entry into the appropriate service, or suggest no service if appropriate.

Guidelines for Working with Offenders

When working with offenders, the entire treatment process, beginning with screening, will usually involve more than one agency and its records. Thus, a first and very important step in establishing a treatment process is to establish a communication and record-sharing process between agencies.

An important difference between criminal justice agencies and substance abuse treatment agencies is the availability of information. For instance, the disposition of a felony is automatically a matter of public record. If treatment has been made an order of the court, this information would be included in the case disposition.

Further information, however, such as what treatment would consist of, or where the individual has been referred, cannot be disclosed. Staff of both criminal justice and treatment agencies find these mandates confusing, and must have clearly established guidelines as to where the boundaries lie in these situations. Inter-agency agreements should be documented in policy and procedure, and be readily available to staff.

Agencies must agree what boundaries will be observed in the performance of specific duties. As an example, a treatment agency may find itself in the position of reporting results of urine tests to the court while being ethically uncomfortable with doing so, as a positive test may lead to the client being charged with violation of probation or parole. Should such tests be used for this purpose, a clear chain of evidence

must be established around the validity of the test, with a degree of confirmation suitable for findings before a judge.

Obtaining and Evaluating Records

Offenders may minimize and/or deny the need for treatment to a greater degree than other clients. In other cases, offenders may actually exaggerate their need for treatment if participation in it can result in decreased terms of incarceration. In many legal scenarios, criminal involvement due to addiction is felt to be a worthy of an alternative to incarceration, whereas participation in drug sales as the specific means to a profitable end is not. Thus, clients who have charges related to drug sales may try to convince others they have issues with use as well.

Information obtained from offender clients, whenever possible, needs secondary verification, which can be obtained from a variety of sources. Police reports will provide a record of the client's charge(s) and the disposition of their case. Probation and parole records will generally give a history of prior treatment efforts, if any, and may include some perspective on the client's drug history and the seriousness of his/her involvement.

Criminal justice records may provide information about the client's possible co-occurring disorders, whether the client has been medicated for such disorders in the past, and, if so, what medication was used. Criminal justice records will also provide information about the client's past history of interpersonal aggression, and may help determine whether it is general or aimed at particular individuals, such as police or corrections personnel, and whether it is racial, ethnic, or gender-based; an important factor when program groups are composed.

Many programs, especially those where men and women are together in groups, may wish to screen out persons with particular criminal behavior, such as sex offenses. Any charge involving fire-setting is often a rule-out offense for residential programs, since program insurance coverage may be discontinued if such residents are accepted.

Client Interview

An important component of the screening process is discussing the information obtained with the potential client. While the screener is not expected to have interview skills equivalent to those of a therapist, a screener who takes time to establish rapport with the client and to develop some sense of the client's truthfulness will add depth to the screening process.

Areas that can be addressed are client readiness, life management and problem-solving abilities, motivation, and truthfulness. In the screening context, these questions

can be reliably answered in a “yes/no” context by comparing the client’s responses to records already held.

As an example, if the client contends he/she has no arrest history, a comparison with police records will supply an answer to the “truthfulness” question. Thus, the screening process can be organized in such a way that the screener will not have to supply therapeutic interpretation of the client’s input. Generally, though, clients who feel comfortable in the interview are more likely to participate well; thus, to the extent possible, a relationship must be established.

Screening Instruments

Many screening instruments have known reliability and can be easily administered without extensive training for the individual screener. The most comprehensive list of these instruments can be found in Treatment Improvement Protocol (TIP) 44, which can be viewed online or obtained free of charge from the Substance Abuse and Mental Health Services Administration (www.samhsa.gov).

Of particular note, the Addiction Severity Index (ASI) can be useful for either screenings or assessments with adult offenders. The ASI is a structured interview that covers a number of areas (substance use, legal, medical status, and psychiatric, for example). Both the interviewer and the client rate the severity of each area which, in turn, affects the total score. An additional benefit is the ASI has a follow-up version that can help counselors and researchers examine clients’ progress over time. The ASI is in the public domain and is available at no charge.

Section 3 - Assessment

Assessment is an in-depth interview with a screened client, generally taking one to two hours or more, and is designed to determine the best possible treatment solution for the client, based in part on his/her diagnosis.

It includes as much information about the client as is available and addresses the availability, suitability, and manageability (including financial means) possessed by the client to meet the established goal of the appropriate treatment program.

Special Considerations

Clients who may fall outside the boundaries of standard treatment as a result of the assessment process are generally those with DUI first offense or other misdemeanor charges. These persons may be found to be in need of education rather than treatment, and may be encouraged to meet the goal of appropriate or modified use of alcohol rather

than abstinence. These clients may not meet diagnostic criteria for abuse, and thus program participation generally will not require alcohol abstinence.

Even with these clients, though, the counselor should recommend abstinence from illegal drugs. Particularly with the criminal justice population, any illegal activity may result in a further criminal record, or a violation of probation or parole. It is not helpful to argue with clients about their “rights” or to debate whether something should be legal – the fact that drug possession is illegal is enough to argue for abstinence.

A second client group with whom legitimacy of drug use may arise are those with questionable prescribed medications, such as opiates for pain or benzodiazepines for anxiety. The counselor may find him/herself in debate with a physician about this, which may not be resolved at the time of the assessment. In any case, the counselor should make the treatment choice that appears most legitimate, while understanding that assessment is an ongoing process.

The Assessment Process with Adult Offenders

The assessing counselor should review all the material gathered during the screening process, including criminal justice and mental health records, general health records, history of violence, aggression in general or that aimed at a particular group, intellectual capacity, and history of trauma. These records will help the counselor determine whether a particular program will be suitable for a particular client.

With criminal justice clients, it is particularly important to determine to the extent possible whether other clients, staff, and the community will be safe if a client is in a program. If a judge has ordered a client into a program, it may occasionally be necessary to advise the court that a client is not suitable.

The assessing counselor will also need to review the results of any screening instruments completed by the client, and may wish to administer tests or refer the client for further testing which, if possible, should be conducted in a forensic setting. Many court systems have forensic clinics attached to the court, and the clinicians within them are generally quite familiar with issues around psychopathic behavior, which may be a concern with criminal justice clients.

Counselors should provide an atmosphere where the client feels safe sharing personal information but does not feel he/she will be successful at manipulating the assessor. The client must understand that failing to follow the recommendations of the assessor may have consequences impacting his/her status in the criminal justice system.

The assessor must examine the same types of historic and current behavioral information they would with any client. However, with clients on probation or parole,

the counselor must pay special attention to unresolved legal issues, the client's general level of criminality, and whether functioning in non-criminal ways in the community is a viable option for this particular client.

Too often, it is assumed that clients' criminal activity is caused by substance abuse or is greatly exacerbated by their use of substances. To determine the level of criminality, it may help to:

- Ask how old the client was when he/she stole something or committed another crime, versus the client's age at the time of first substance use.
- Determine the client's presence of mind at the time of a more recent offense. For example, did the client plan the criminal activity ahead of time? How did a client get away with an offense for which he/she was never arrested?
- Look at whether the client has any history at all of functioning appropriately in the non-criminal world.

Assessors should also bear in mind the diagnostic criteria for antisocial personality disorder which, in a way, is simply a more formal term for "criminality." Diagnostic criteria include:

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
 - (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
 - (2) deceitfulness, as indicated by repeatedly lying, use of aliases, or conning others for personal profit or pleasure
 - (3) impulsivity or failure to plan ahead
 - (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
 - (5) reckless disregard for safety of self or others
 - (6) consistent irresponsibility, as indicated by repeated failures to sustain consistent work behavior or honor financial obligations
 - (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
- B. The individual is at least age 18 years
- C. There is evidence of Conduct Disorder with onset before age 15 years
- D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.

Other factors to consider when assessing the adult offender include the client's ability to obtain/maintain housing, his/her history of physical/sexual abuse as either victim or perpetrator, and his/her history of other trauma which may impact treatment. As an example, women who have a history of child sexual abuse may find awareness of this issue unbearable when they achieve sobriety. Management of such a history may be a factor in choosing a program for the person.

Treatment Choices and Considerations

There are program choices for criminal justice clients not generally available to other kinds of clients. The primary example is the drug court, with the entire treatment process taking place during the course of court supervision. Generally, those who enter drug court have pending charges held in abeyance (meaning that the court makes no finding of either guilty or not guilty) until they complete the drug court program. Upon successful completion, the client may have his/her charges dismissed; thus, the successful client will not have a conviction of record.

Many criminal justice programs include a primary residential component, intended to offer the client more than basic sobriety. Such programs take into account the need for the client to change his/her behavior in ways other than abstinence, such as finding legitimate ways to generate income.

Persons who are in a drug court are often monitored by specialized case managers or probation/parole officers, who have smaller caseloads and more frequent contact with their supervisees. This may include home visits, drug monitoring, office visits, electronic monitoring, or day reporting programs. These supervision programs are referred to in the agency as Intensive Supervision. Some drug courts also have probation officers or staff certified or licensed as substance abuse counselors. Drug court clients are more likely to be on probation (supervision in lieu of incarceration) than on parole (supervision after incarceration) due to the way in which charges are managed in these courts.

Failure to complete a court-ordered program will have a significant impact on the client's successful completion of court supervision, and may include the revocation of probation or parole.

Some intensive outpatient programs have been designed particularly for criminal justice clients. Since relapse may cost the client his/her freedom, it is often legitimate to intensify the treatment experience to decrease the likelihood of positive drug screens. Plus, many judges and probation/parole officers want intensive treatment for particular offenders, but want them to obtain employment right away so they can begin paying court costs and restitution. Intensive outpatient treatment can bridge this gap. Criminal justice clients may also attend programs not designed particularly for them. Many achieve

sobriety just by attending outpatient or inpatient counseling in conjunction with 12 Step groups such as Alcoholics Anonymous.

Completing the Assessment

The end result of the assessment will be a recommendation and referral of the client to treatment. It is helpful to have the client sign release of information documents at this point with the treatment program so the assessor can be notified of the client's admission and progress. In criminal justice cases, the assessor may be reporting to the court or the probation/parole agency about the client's progress in treatment on a regular basis. The time frame for this is generally established within the agreed-upon inter-agency guidelines.

On occasion, the client's physical or mental health status may be so severely damaged the assessor will have to forgo the in-depth interview and help the client get admitted to a general hospital detoxification program or a mental health facility. If the client is mentally or physically unstable, an effective interview cannot be done at any rate, and the assessor can consider the client's condition to constitute an emergency. Should this happen, an in-depth assessment can be done at a later date, when the client is stabilized.

Section 4 – Treatment Planning

At each step, the process for achieving client recovery becomes more individually specific. The treatment plan is the most specific step yet, and constitutes a written agreement between the client and his/her primary therapist about the sequence of activities that will be undertaken in order to maximize the client's potential for success. This requires the client's specific needs be taken into account and provided for in some component of the client's treatment.

Choosing Primary Treatment

Once again, an established treatment plan requires an in-depth interview with the client. During this interview the therapist and client will decide together what components should be completed in order for the client to have the best chance for continued success.

The first issue in treatment planning is determining what is medically necessary for the client. To establish this, it is crucial that the client reveal his/her drug/alcohol use within the last 24 to 48 hours. Heavy use of alcohol or benzodiazepines in particular will make it necessary for the client to enter a detoxification program that has physician oversight. Obtaining client cooperation for this step may be a struggle, because criminal

justice clients will not want to admit recent substance abuse. It may be necessary for the therapist to ask the client to submit to a urine test at this point.

If the client's drug of choice has been opiates, the person may be involved in an outpatient detoxification effort at the time of referral. Most states have designated primary physicians authorized to medicate and supervise the progress of persons on buprenorphine, and methadone is still widely available. Some persons may present who are on methadone maintenance, but want to successfully stop using all other drugs. Whether this is possible or ethically desirable is a question the treatment agency will have to address.

A second issue around initial choice of treatment is whether the client needs mental health intervention and possibly medication in order to meet physical problems, such as potential for harm to self or others, created by mental health disabilities. Consideration in this event needs to be given to the need for medically supervised care. Generally, when a client needs to be medically supervised for detoxification, or to meet mental health needs, it is clear an inpatient or residential primary treatment experience is necessary, primarily because removal from the environment in which the person was using substances constitutes his/her only chance for successful sobriety, and also creates the best environment for determining the ongoing need for medication.

It is possible that detoxification will be followed by outpatient treatment, or Intensive Supervision programs as the primary treatment of choice for this individual. It may be that primary treatment choices have already been made and agreed upon during the assessment process, and, if so, the program name and proposed length of stay should be stated in the treatment plan.

Additions to the Treatment Plan

With all persons coming to treatment on probation or parole, the issue of criminality will have to be addressed. Information will be needed from the client as to how his/her substance abuse is related to criminality.

If it seems clear that criminal behavior arises primarily from drug/alcohol addiction, then it is possible addressing drug/alcohol dependence will result in an end to criminal behavior upon abstinence. If criminality seems to have begun before the use of substances, or if substance use seems an adjunct to criminal behavior, then the issue will have to be addressed in a particularly direct way.

Practitioners should use concrete, specific wording in the treatment plans of criminal offenders. When criminal thinking errors are salient, many clients will go to great lengths to find "loopholes" in the treatment plan or program requirements for personal gain or manipulation purposes. In particular, the treatment plan should clearly

indicate that merely showing up is not enough to successfully complete treatment. Explain to clients what constitutes adequate group participation and what the consequences for falling asleep in group, using substances, and so forth will be.

The treatment plan should include specifics about participation in activities believed to encourage sobriety, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Women for Sobriety, and state the expectation clearly within the treatment plan. Statements should be clear about minimums, such as “Attend at least two AA/NA meetings weekly”, or “Attend the AA Beginner’s Meeting every Tuesday”.

The treatment plan may also include specific items aimed at addressing desirable changes in the client’s ability to manage daily life. These items can be very personally specific, and include everything from money management to getting along with relatives, and can address thought, feeling, or behavior. As a rule of thumb, treatment plan components should be stated positively instead of negatively and include standards for measurement. For example, “I will stop hating my father” is not a measurable goal, but “I will make two positive comments publicly about my father on a daily basis” can be monitored by a whole group and measured daily.

However, it may be necessary to directly identify and hopefully prevent certain negative behavior, such as agreements to avoid certain people, places, and things. These agreements may necessarily be stated negatively; for example, “No participation in card games” if gambling generally preceded drug use for a client.

Clients must understand that failure to complete a component of the treatment plan may result in failure to complete treatment satisfactorily. If completing treatment is a probation or parole condition, the client’s freedom depends upon it. All treatment plans should be written and signed, and regarded as a part of the client record. If changes are made, they should be documented and initialed or signed by the primary therapist and the client.

Progress toward treatment plan goals and objectives should be part of the documentary case record. The treatment plan could be shared with the probation or parole officer working with the client, and the client should be aware of this. If there has been a history of non-compliance with supervising criminal justice agencies, regular attendance at meetings with probation/parole may be a component of the treatment plan.

Section Five - Treatment Participation

The client’s participation in treatment is a continuous exercise in assessment and evaluation, shared by the client, his primary therapist, and any other staff or treatment persons who have access to the client during his or her stay. For criminal justice clients,

the main questions clinicians should ask are: 1) Whether he/she is now drug-free and intent upon continuing to be drug-free; and 2) Whether the client's other thoughts, feelings, and behavior are likely or unlikely to advance this outcome.

The history of treatment for substance dependence includes, in all the general literature, the theory that honesty and personal insight are essential to successful sobriety.

However, the criminal justice client may have more difficulty achieving these skills than most. Criminal justice clients often have a history of lying, manipulation, being deceitful in relationships, self-involvement without empathetic ability, and responses aimed at fulfilling wants rather than to have honest exchange with others. Thus, the criminal justice client's complete behavioral pattern often undoes the interpersonal tasks believed to be necessary to achieving a drug-free lifestyle.

Since the criminal justice client may begin with so little insight, insight-oriented therapies are not generally the most useful. Instead, methods having a reputation as useful for this population are:

- Rational Emotive/Rational Behavior Therapy,
- Reality Therapy,
- Cognitive or Cognitive Behavioral Therapy,
- And other methods having a primarily behavioral or thought approach, as opposed to a feeling, approach.

A long-standing dispute in the treatment of substance abuse from an insight-oriented perspective is that many such therapists believe the patient will stop using substances once his/her "reason" for doing so has been identified. However, in substance abuse treatment circles, this belief system is regarded as untrue and inappropriate for intervention with an addicted person and for addicted offenders in particular.

There are several reasons why this is so. For example, substance use (which, obviously, is a behavior) on the part of a criminal justice client needs to be addressed immediately. Otherwise, the client will be re-incarcerated long before any insight-oriented, "why" types of questions can be addressed.

Plus, many in both the treatment field and in the lay public see non-directive, insight-oriented approaches as inviting excuses from clients for irresponsible behavior and as setting the stage for clients to say what he/she thinks the therapist wants to hear.

Instead, the criminal justice client in treatment must be encouraged to clarify the connection between his/her substance use and criminal behavior. This connection is very individual, and the client's belief system about what is and is not actually "criminal" behavior will have to be addressed.

For example, many criminal justice clients agree that cocaine is harmful, but confuse the penalty for certain behavior with the difficulty it may cause in an effort to establish sobriety. Clients may express clear intent to stay away from cocaine, but will see no harm in smoking a joint “now and then”.

Clients may also have difficulty evaluating whether or not they can drink “moderate” amounts of alcohol and may need direction about the definition of terms in this regard. Clients will also need evaluation about what other behaviors may be addictive or compulsive, including behaviors such as gambling, sex, or spending.

The criminal justice client may present for treatment with no solid interpersonal relationships in his or her life. There may also be a host of relationships which are based on abuse, manipulation, or mutual criminal activity, with the client as either abuser, victimized party, or, sometimes, both. Especially in the case of family, it will be important to the client’s potential for progress to discern whether or not these relationships can be continued at all.

Frequently, clients will reveal in treatment that their parents and siblings are involved in use and sale of substances, and the client may need to choose either sobriety or continued involvement with his/her family. Often, with criminal justice clients, the affiliation with family or friends, whether productive or not, has become a matter of unquestioning loyalty, and the treatment process may be the first occasion when such affiliations have been questioned.

Addressing the client’s thinking errors and poor behavioral choices is a necessity for successful treatment outcomes. Along these same lines, many in this population have generally failed to master simple tasks, such as attendance, participation, accomplishing expected assignments, and dealing appropriately with authority.

The program may need to provide clear direction about these issues. For instance, a group therapist may state that appropriate participation requires talking, not just “showing up”. The client may also be required to follow a clear time schedule, and may need to be told being late or leaving early will not result in completion. The client may need to be confronted repeatedly about the meaning of requirements, and to connect the necessity to do this in treatment with the necessity for continued compliance in the world of ordinary work. Many in the criminal justice population have little or no familiarity with the work environment, and may need very specific direction in this regard.

The client’s continued sobriety is an expectation in any treatment program. As has been mentioned earlier, it is helpful to have a third party, such as a hospital laboratory, provide results of urinalysis which are medically verifiable and have chain of custody trails which can be produced for court hearings. Since the client’s freedom is at risk, treating parties must exercise caution around the use of urinalysis.

In order to be maximally helpful to clients, treatment staff must remember it is the client who is in need of change. When staff assume too much credit for positive outcomes, or feel extreme responsibility for the negative outcome of any client, the staff member will eventually experience difficulty continuing in the job. Staff will have feelings, sometimes strong feelings, about clients, but must make sure they keep an emotional safety zone available.

This is an important issue in any setting, but in the case of criminal justice clients, over-identification is related to the possibility an unsuccessful client will go to jail.

Promising Community-Based Treatment Approaches with Criminal Offenders

Motivational Interviewing: The blending of services for those with criminal justice, mental health, and chemical dependency issues has resulted in a continuing quest for the best approach to client resistance.

Generally, “resistance” is viewed as the desire of the individual to continue behaviors that are viewed as illegal, or at least harmful, by those in authority. Over time, the combined fields of criminal justice and counseling have changed in terms of the primary model proposed to have the most satisfactory effect on client change. This has gone from an unwillingness to try treatment with any individual who was not specifically asking for intervention, to an extremely confrontational approach favored in the early development of therapeutic community models for drug treatment.

However, the current thinking about the Motivational Interviewing model is that in giving the client more control, a better outcome can be expected. A demonstrated effect of the motivational interviewing approach is that while the client is left in control of planning and outcomes, the therapist or interceding party can very beneficially assist the client’s understanding of his/her own situation.

Motivational interviewing is an interventional technique developed by therapists studying what worked best to promote change with alcoholics. The initial experimentation with and writing about these techniques were first provided comprehensively by Bill Miller and Steve Rollnick, in their 1991 book about Motivational Interviewing.

The interventions developed around this method involve both particular style and particular technique, so that it is essential to success that the therapist adopt a particular attitude toward appropriate client intervention. This system suggests a confrontational style is ineffective in dealing with addictive problems, primarily because under such conditions the client will spend much of his/her time in treatment defending behavior rather than debating usefully with himself whether change needs to be made. Motivational interviewing suggests that the therapist help the client debate through his

own contemplation whether he/she needs to make changes. This also suggests that a plan established primarily by the client rather than primarily by the therapist is essential to the question of whether permanent change will be made by the client or not.

Thus, the suggested style for appropriate therapeutic intervention recalls the methods of Rogerian techniques: reflective listening, empathy and warmth, and a client-centered attitude. To be effective, the client must persuade himself or herself to initiate change, so that direct persuasion is not thought to be a useful style. The therapist should use active listening and non-confrontational restatement of client input, in order to help the client "listen" more actively to their own ambivalence. This approach basically assumes that clients who misuse or abuse chemicals are generally aware that their use may be harmful. However, contrary to the assumption that clients are typically either in denial or are outright resistant to change, the motivational interviewing approach recognizes that clients are often ambivalent instead.

The suggested style for therapists is to engage the client in an atmosphere of warmth and acceptance regardless of how the client presents the situation, to make it possible for the client to acknowledge his/her own conflict openly by using re-statement of client input, to honor the client's desire to be autonomous by maintaining a non-confrontational approach, and to present the therapeutic relationship as a function of working together toward an end involving improvement rather than to persuade the client's agreement with the therapist's point of view. In this atmosphere, the client is the person with authority and control, and the therapist should honor the client's autonomy.

Motivational interviewing is defined as being based on four principles:

- 1) Empathetic - Therapists share their understanding of the client's point of view
- 2) Points out discrepancies - Therapists help the client identify the differences between how they do live and how they want to live. They also discuss with the client any difference between their desires and their actual daily behavior.
- 3) Accepting- Therapists understand resistance to change is normal rather than pathological.
- 4) Emphasizes autonomy - Therapists respect the client's right to be in charge, and allow the client to be the decision-maker in terms of making changes. The therapist should also honor the client's right to refuse to change, but may help the client identify when or how this would interfere with the client's own desired outcomes.

Some of the methods recommended to achieve such outcomes are talked about as "**OARS**":

- 1) Asking **open-ended questions** - those that cannot be answered with a simple "yes" or "no".

2) Using **affirmations** about client strengths. This includes pointing out to clients occasions when they were successful but hadn't given themselves credit ("You stayed sober for a month - how'd you do that?")

3) Using **reflective listening** - reflect to the client what s/he is telling you, focusing on their talk about successful change (even when the success is small)

4) Using **summaries** - Reflective listening that includes all the client just told you. Announce this is what you intend to do, then tell the client what they have just said. This includes both positive and negative statements they have made, but with primary attention to the positive. Attention can be re-shifted at this point to setting a positive direction for continuing talk.

The therapists who developed these techniques suggest Motivational Interviewing is more than just a set of techniques, but is a counseling style demonstrating a particular way of being with the client. SAMHSA's Treatment Improvement Protocol (TIP) #35 includes a list of counseling behaviors that are **suggested against** in the Motivational Interviewing style. These include:

- 1) Ordering or directing in an authoritarian manner
- 2) Warning or threatening
- 3) Giving advice or unsolicited suggestions
- 4) Persuading, arguing, or lecturing
- 5) Moralizing, preaching, or telling clients their duty
- 6) Judging, criticizing, disagreeing, or blaming
- 7) Agreeing, approving, or praising
- 8) Shaming, ridiculing, labeling, or name-calling
- 9) Interpreting or analyzing
- 10) Reassuring, sympathizing, or consoling
- 11) Questioning or probing
- 12) Withdrawing, distracting, humoring, or changing the subject.

Clients, it is suggested, cope with these behaviors on the part of the therapist by using their own techniques for resistance, including most commonly **arguing, interrupting, denying, and ignoring**. In other words, the therapist's behavior will likely result in the client using resistance techniques. This may set the stage for a power struggle between the client and therapist. While this may result in compliance, or even short-term change on the part of the client, it is not likely to result in permanent change, since any self-direction engaged in is aimed at the power of the therapist rather than at the behavior in need of change. According to the principles of Motivational Interviewing, change must be self-directed in order for change to be permanent.

Motivational Interviewing involves not just a set of techniques, but a therapeutic style and philosophic stance. This may seem counter to set principles, particularly for those whose experience and client population have been primarily in the corrections field.

Corrections and criminal justice, including many therapeutic environments derived from these populations, have been traditionally based on directive rather than non-directive interventional techniques. Significant reassessment and re-direction may be necessary for counselors with this primary experience to adopt such change. There is a significant body of literature and educational opportunity available for those in need, and a good starting point is Treatment Improvement Protocol #35, available through SAMHSA.

Stages of Change Model: To help therapists choose the most appropriate intervention, the motivational interviewing approach incorporates the Stages of Change model developed by Prochaska and DiClemente. This behavioral view was first developed through the study of people who were ending their use of cigarettes, and became applicable in general to those who were attempting to change behavior around drug abuse or addiction. It has become applicable to other behavior change areas, including other health concerns.

The Stages of Change purports that people tend to approach change in stages, and, in general, most persons travel through the identified stages before the behavior change is integrated into the person's life. This model clarifies why a visit to the de-tox center is not enough to ensure a person's reliability in regard to abstinence from drug or alcohol use. The changes in thought required to establish a clear change in behavior develop slowly, and must allow the client to travel through an intellectual process that is very individual. It is not enough, the theory suggests, to have new information (such as the reasons why drugs are dangerous) from an intervening party, such as a counselor.

Research on this model suggested that each stage must be completed successfully before the next can be approached. It was also established that the movement from one stage to another must be left in the hands of the client, and that the therapist's role in this development was to mirror the client's feelings, and thus help the client clarify their own mental processes. Thus, this model supports the basic ideas of Motivational Interviewing - that the therapist's primary role should be supportive reflection rather than directing action toward the client.

The stages of change proposed in the model are as follows:

1) **Precontemplation:** Persons in this stage are not ready to embrace change. They have no desire to make the change suggested, and are not persuaded by someone pointing out the negative consequences of their behavior.

Professionals who intervene often have much less influence than they think they do, and as a result, the changes believed to be shown by clients are often simply a way of getting the professional to leave them alone, rather than an intention to really change behavior. It is not useful to engage a person in this stage in treatment, because there will be no real result. Programs that in general try to point out the harmful result of behavior

(such as drug/alcohol use) will not be useful to this group, because they will automatically screen the negative data from their thinking.

For this group, it is often more useful to allow them to talk about the positive versus negative aspects of their behavior, and clearly state not just the risks, but the positive results of their drug or alcohol use. People use substances because they perceive some kind of a positive result. Allowing a client to clarify this will give the counselor a clearer picture of why they might be willing to endure any negative consequences in order to continue use of the substance.

2) **Contemplation:** In this stage, the client will be open to the idea of change. However, the person is willing to admit the negative effects of the behavior, but is also weighing the losses that will be experienced when the behavior is stopped. At this point, the person is undecided. However, given that the treatment goal is to intervene in negative behavior, an undecided client has made an advance. This is a stage in which behavioral action will not take place, since the decision to change or stop use has not been made by the client.

3) **Preparation:** At this point, the client has decided upon action. The client will have identified the goal as quitting use, and will be thinking about and constructing a plan of action that will bring this about. This is the point at which intervention and suggested methods of treatment will be accepted. In this stage, the client is ready to consider the opinions of professionals as to what kind of treatment might be the most beneficial.

4) **Action:** During this phase, the primary behavior change is made, and all other action involves solidifying that change. This may involve steps like entering and completing treatment, making and beginning to carry out a recovery plan, choosing and working with a counselor, selecting and establishing relationships with other people who can assist in the behavior change, and other such steps that require not just thinking about but putting new behavior into action. The client wishes to, and believes he/she can implement new behavior. A goal and course of action have been selected, and the individual's intention is to act in accordance with this plan.

5) **Maintenance:** This stage involves maintaining the change successfully. In addiction treatment, this generally means preparing a catalogue of techniques that can be used to prevent relapse and sustain abstinence from one's drug(s) of choice. This includes habits in both their personal and professional life that contribute to the abstinence choice - for example, most people who intend to stay sober must find alcohol-free places in which to have fun. The necessity for certain changes is completely dependent upon the individual - some people find they must not socialize in bars at all; others find it is possible on a limited basis. For the person to be successful requires an appropriate utilization of "people, place, and things" that prohibit relapse, and this is highly

individual, although participation in 12-step programs provides numerous ideas for how this process is best accomplished.

Relapse is considered a part of the Stages of Change model, a problem that can be expected once a reliable behavior change has been achieved. Relapse should not be seen, it is stressed, as failure, but as a normal part of a sustained behavior change, particularly when the change involves an addictive behavior. Relapse is looked upon as an opportunity to learn more about one's patterns, to see how the relapse occurred, and to put in place techniques in both thought and behavior that will prevent the situation from happening again. Relapse is thought to be a normal consequence of any addictive process, and those who experience this are emphatically instructed not to feel they have failed. Here it is suggested people examine their coping strategies, evaluate what might have failed, and put new options in place.

The developers of this model have suggested that the implementation of it does not happen in one series of events, consistently moving forward. It is suggested that a person involved in this series of changes will move back and forth along the model, sometimes reversing course and having to re-evaluate a part of the process.

Thus, some people take far longer than others to achieve the result of behavior change, and some people never do. Nevertheless, it is felt that helping the person along a model based primarily on individual decision will have far more likelihood of success than a model based on change attempted due to the desire of someone else. Change is far more likely to occur when the client has a "buy-in". The imposition of negative consequences (such as a jail sentence) may temporarily result in the client verbalizing a desire for change, but the likelihood that this will have a permanent effect is felt to be small. This is why the imposition of undesirable circumstance, such as a jail sentence, do so little to change behavior on a permanent basis.

Drug Court: As described in previous chapters, drug courts are specialized courts where felony drug offenders undergo intensive court supervision in tandem with long-term residential or outpatient treatment. Perhaps the most unique aspect of drug courts is the presiding judge takes a much more active role in monitoring clients progress than he or she would in a court of law. Drug court participants usually undergo treatment with a community-based provider.

With drug courts, it is helpful to understand the context in which they came to be. For decades, substance abuse and addiction increasingly became the country's most significant criminal justice problem, and the criminal justice system expanded greatly in order to deal with this population, which is at a high risk for recidivism. The American prison system also expanded greatly in response to this trend. Although many states since the 1970's have tried to build enough additional correctional facilities to house all these offenders, incarceration alone did nothing to significantly reduce this population.

Obviously, the main reason why incarceration alone had not worked well was many of the crimes, such as burglaries, were committed in order to get drugs or items which could be sold for drugs. Other criminal behavior involved drugs directly, such as the sale of illegal substances or the sale of pills obtained through prescription.

Questions began to arise as to whether police or medicine should have control of the availability of some substances, and what circumstances were legitimate for obtaining prescriptions. While much more law enforcement effort was put into the control of, or elimination of, substance availability, the number of persons who reported criminal behavior related to abuse or addiction increased.

It became clear that standard responses to crime, particularly the use of personal restrictions (probation, incarceration, and parole) were not enough to noticeably change behavior in the case of drug abuse or addiction. What was needed was the right combination of treatment and criminal justice supervision where, to some degree at least, the treatment was forced.

Drug Courts were initiated as a potential solution, in which criminal justice goals and treatment goals were to be combined. While sanctions were imposed on the offender, the person also had an arena in which specific rehabilitation could occur. At the same time, incarceration loomed as a consequence for failure to comply or as a consequence for relapse.

Debate continues, and has been exacerbated to some degree, about whether forced treatment results in dependable change. An interesting result of this has been that organizations such as Drug Courts have embraced therapeutic methods that focus on the client as the instrument of change rather than the therapist or program. Motivational interviewing techniques, and concepts such as the Stages of Change have been embraced by Drug Courts as the most currently useful methods for ensuring that lasting change occurs. Thus, the idea that court-ordered treatment can result in self-motivated clients has expanded considerably.

Drug Courts also grew out of the need to expedite the movement of drug cases through the criminal justice system. The concept was first used in the federal system, and shortened the time between arrest and disposition in many cases. However, this did little to reduce the offender population and provided no treatment alternatives to incarceration. As it became increasingly apparent that incarceration alone would do little to change behavior around drug abuse and addiction, more courts became willing to assume a different kind of change agent role.

The first Drug Court began in Dade County, Florida, in 1989. It was established in response to the growing community problem with crack cocaine. The originating belief,

which was validated, was that criminal behavior could be reduced by providing treatment for addiction.

Since then, drug courts have evolved in all 50 states, and research indicates the recidivism rate for drug court offenders is lower than that for offenders with drug issues whose cases proceed through other courts. Thus, the drug court model is seen as successful in both the judicial and the treatment systems.

The drug court model has led to the creation of other kinds of courts. Family courts have emerged as a model, in which child custody issues have been settled with the agreement of parents to attend treatment, and community treatment programs have become far more involved with the court system. DUI courts have been established in various communities to deal with traffic offenses involving drugs or alcohol.

Drug courts and their related spin-offs have basically become a way for the community as a whole to become more involved in rehabilitation, and for the offender to be able to rehabilitate himself or herself within the community. The hope is that the offender and the offender's family will be reintegrated into the community as productive citizens, rather than removing the offender from the community while leaving the family with feelings of trauma and shame.

The rehabilitative model also has defenders in the police community, with one of the most currently vocal (at the time of this writing) the National Director of Drug Court Policy, Gil Kerlikowski, who was previously the Chief of Police in Seattle, Washington. Mr. Kerlikowski is quite vocal in his contention that incarceration alone does not work to change the behavior of drug offenders, and that this approach alone does nothing to reduce the offender population.

Although drug courts in all states establish their own policies and procedures, in general, they are similar: the drug courts are meant to serve non-violent offenders whose legal violations resulted primarily from drug abuse or addiction. In many jurisdictions, offenders are required to enter a guilty plea to the charges held against them. The plea is then held in abeyance (without further legal action) until the treatment outcome is established.

If the client successfully completes treatment, in many jurisdictions, the client's case is dismissed and may even be expunged (meaning no record of the case will be preserved. If this is the outcome, then the client can legitimately say "no" in any situation where the question "have you ever been convicted of a felony?" is asked. This is an outcome very attractive to most offenders, since establishing a conviction record, especially of a felony, is disastrous for most efforts to gain satisfactory employment, particularly under current economic conditions. Thus, the most harmful outcome of a

criminal conviction might be avoided. If, however, the client is unable to complete their program, a conviction might still be obtained.

Most drug courts rely heavily on drug testing. This may be done by court or treatment personnel, or an outside agency may be hired for the express purpose of drug testing. An ongoing point of contention is whether any positive, or "dirty" drug test should result in a client's expulsion from the programs. Some drug court judges have responded to this by incarcerating clients for short periods of time, but the legal community has not always responded well to such behavior. This give judges arbitrary power, according to the legal community, rather than imposing a proscribed response for a particular offense. In addition, most drug testing by urinalysis has a percentage of false positive tests, so the "dirty" test is not 100% trustworthy.

Courts have responded to this problem in a variety of ways. Some send "dirty" drug tests to a hospital lab for verification, some test again, some do not impose severe sanctions after one positive test. However, given that the primary purpose of the program as a whole for the offender to emerge from treatment abstinent, it is of particular importance to find some way to verify that the client is indeed drug-free. Demonstrating abstinence is the way for drug court clients to show they should be released from criminal justice supervision and should have fewer consequences due to their criminal involvement than they otherwise would have.

Many other court models have arisen as a result of the origin of drug courts. Those most closely related to drug courts are as follows:

1) DWI/DUI Courts - Courts that focus on Driving While Intoxicated or Driving Under the Influence (of alcohol or drugs). Generally, these are post-conviction courts that focus on providing treatment or education for offenders whose crimes are alcohol-related. Since most DUI/DWI offenses are misdemeanors, the long-term consequences of such offenses are less than those of many criminal charges involving drugs. Many states are now considering new methods for police to make arrests based on drug use rather than alcohol use, so this group of courts may expand.

2) Family Courts/Family Dependency Courts - These courts focus on custody issues involving parents whose addiction affects their ability to care for their children. Generally, successful completion of programs provided by this model will result in family reunification. It is intended to make it less likely for children to be removed from the family home when there is parental abuse or addiction involved.

3) Federal District Drug Court/ Federal Re-entry Court - These are drug courts under the jurisdiction of the federal system. They are primarily intended to provide incarcerated individuals with treatment prior to community re-entry. In these courts, the offender has been convicted and has served part of a sentence, but may be discharged

early from imprisonment so that treatment can be completed. The focus with these courts is on community re-entry, and is a post-conviction option.

4) Juvenile Drug Court - These models provide offenders who are not adults with services similar to those provided to adults. The youth may have charges dismissed if s/he successfully completes a treatment program and demonstrates the intention to remain drug-free. Programs provided to this population are designed in particular for young people, and the recipients are not mixed with adult offenders in treatment.

5) Re-entry Drug Court - This model is also for convicted offenders who obtain treatment during the last part of their period of incarceration in order to facilitate abstention from drugs after release, and prior to the end of supervision by parole authorities. These courts function on the drug court model, in which the focus of all court personnel is on facilitating the client's abstinence.

6) Tribal Healing to Wellness Courts - these courts are particular to the Native American legal system, and are used by tribes for Native American offenders. Included are native views of healing and tribal traditions and healers. This is combined with the treatment processes used by non-tribal courts.

Two models based on the Drug Court which will be discussed more thoroughly are the Mental Health Court, which has expanded greatly in recent years, and the Veterans Court, a relatively new project for a very needy population - the returned military person in need of special services to deal with involvement in the criminal justice system.

Mental Health Courts: The history of mental health treatment in America has been primarily a series of social and legal changes, excluding and re-including the mentally ill in the community.

Initially, mental disorders were thought of as a spiritual malfunction, probably caused by devil possession, so those believed to be disordered were removed from the community, and generally either shunned or mistreated. Since the disorders were believed to stem from some source other than medical problems, not much was provided in the way of medical care.

This view changed, and medicine was included in proper treatment of mental illness. Facilities built specifically to care for mentally ill people, called "asylums", were initially attractive enough that the homeless purposely invented mental illnesses for use during bad weather, in order to stay there, and people were willing to place the elderly in custodial care because the care was sufficient. As these institutions became more popular, the populations within them grew to a point where care became inadequate. Thus, the institutions once again grew to have a negative reputation, deservedly so. Before the

development of psychotropic drugs, particularly offensive interventions were used as treatment, including electroshock therapy and extreme confinement.

During the 1960's, mental health professionals began to see institutionalization as negative, and felt there were a number of hospitalized people who could function on their own in the community if provided with appropriate resources. The development of psychotropic drugs was helpful in this regard, since they often provided stability adequate for decent functioning if the individual was cooperative in taking their medication. Around this time, a huge move toward deinstitutionalization took place, and many mental hospitals were closed.

The intention was to treat this population of persons adequately in the community, but this effort failed at least in part, and a fairly large portion of these persons were next found in community correctional institutions. At this point, the criminal justice community found itself having to make provisions for people with identified mental disorders, with the possibility of inadequate care leading to further arrest and incarceration. The police community found itself in difficulty in terms of its treatment of those whose behavior was primarily due to mental illness. There were nation-wide instances where mentally ill persons were shot by police, resulting in widespread negative reaction.

At this point, the criminal justice system found itself more involved with a population of mental health clients that had to have special intervention designed for them. Judges began to order such things as attending treatment or taking medication as probation or parole conditions, and the interaction between corrections and treatment personnel expanded. Special conditions relating to treatment became commonplace with court supervision, and interrelationship between treatment and corrections became standard. Court began to designate some community programs as capable of serving court clients, while avoiding other programs as lacking adequate supervision levels for court clients. Thus, mental health programs began to look toward cooperation with court systems and funding from criminal justice sources for their financial stability.

The new situation provided many good opportunities for criminal justice, mental health, and substance abuse programs to work toward common goals. Cooperation led to continuous discussion around problems that had not been open up to that point. Examples included what might constitute appropriate treatment, including whether or not court-ordered treatment might result in change.

Mental health personnel tended to find incarceration an objectionable alternative, so this led to discussions about other alternatives, such as long-term residential treatment. The issue of dangerousness, particularly the dangerousness of clients to treatment personnel, resulted from instances in which residents of treatment programs became violent, and outcomes had to be discussed and included in policy. Court systems began

using law designed primarily for persons with mental health issues, including graduated levels of court supervision for those persons found Not Guilty By Reason of Insanity. Some probation departments supervise caseloads of these persons, who can be moved to more restrictive levels of care if they fail to conform in the community. This is generally due to psychotic episodes caused by failure to take medication.

The most problematic result of having a melding of criminal justice and mental health populations is that a large number of persons continue to be incarcerated primarily due to mental health problems. Mental health clients began to be seen as another special population, like substance abuse clients, who needed to be served differently by the court system. Thus, the mental health population involved in the court system constituted a group for whom special courts have been developed, using the model provided by drug courts in order to serve this population.

The Bureau of Justice Assistance, in the U.S. Dept. of Justice, coordinates with SAMHSA to organize and fund mental health courts. Thus, at the federal level, cooperation between criminal justice and mental health personnel is required for the concept to appropriately function. BJA suggests two primary criteria for the modeling of mental health courts:

- 1) Judicial supervision, with periodic review, of offenders with mental illness, mental retardation, or mental illness/substance abuse. These offenders are either misdemeanants or have committed non-violent crimes.

- 2) Coordinated delivery of services, including case management, specialized training of criminal justice personnel, provided treatment in the least restrictive setting possible, the possibility of dismissing charges upon completion of treatment, and court supervision for the period of time that would not exceed the maximum allowable sentence for the committed offense. The offender must agree to treatment in order to be eligible for this court.

At the time of this writing, the number of courts federally funded under Dept. of Justice grants is about 36. The total number of mental health courts in the United States is around 175. Many of these are locally or state-funded, and are operated generally under the principles established for federal courts. The primary goal is to provide specialized treatment and a specific model of court supervision for offenders who are diagnosed with treatable conditions, when these conditions have been responsible for their involvement in the criminal justice system.

There are also mental health courts attached to the Juvenile section of some court systems. Similar objectives are followed for both adult and juvenile courts - to provide defendants, regardless of age, with appropriate court-monitored treatment, and to

dispose of the individual's criminal case in the least restrictive but most treatment-oriented way.

Outcome studies have been primarily done on "problem-solving" courts, including both drug courts and mental health courts. The Dept. of Justice outcome information concludes that these courts improve mental health and reduce substance abuse. They also indicate having such options available saves public money because the problem-solving courts cost less (primarily due to the reduced cost of community treatment versus incarceration) and the likelihood that future crime will be reduced for those who participate in such services. Funding for such court systems is believed to be cost-effective, although funding for such services has been reduced due to the recent recession. However, funding for prisons and community correctional facilities has been significantly reduced as well, so less money is available for criminal rehabilitation through any means.

Courts with specialized populations now include courts with a population of defendants who are military veterans. These courts include workers who are veterans or are particularly familiar with special problems which may be experienced by veterans, including medical or psychological problems resulting from trauma, and special familiarity with Post-Traumatic Stress Disorder. Although this has become a popular idea, funding for new programs has diminished, and this model may expand less readily than the drug court model has.

Thinking Errors Approaches: Criminal "thinking errors" have become a significant focus in the last several years, partly due to books such as *Inside the Criminal Mind* by Stanton Samenow. In his book, Dr. Samenow argued that any form of treatment failing to address the offender's world view results, quite simply, in a sober criminal. Subsequent books, treatment curricula and videos have addressed the same topic in a variety of ways, but all basically utilize a cognitive-behavioral approach to changing how offenders think and how they should interact with others in a more constructive, positive manner.

The exact terminology varies from one source to the next, but generally the various approaches focus on the following types of thinking patterns commonly seen in offenders:

Closed Thinking - This refers to the tendency to strongly resist any alternatives to their own views of the world. This is certainly a common tendency of many non-offenders in treatment for substance abuse. However, the forms of closed thinking demonstrated by many offenders keeps them mired in patterns of behaviors and thoughts that place them at a high risk for recidivism.

Disregard for Others & Self-Centeredness – This is a more specific type of closed thinking where the views, needs, and rights of others are disregarded, or even violated if

it suits the offender's needs. This is not to say all offenders demonstrate self-centered thoughts and behavior all the time. But if they believe a particular situation requires them to choose between what they want versus considering the rights or needs of others, many offenders will place their own whims first.

Blaming Others – This is another type of closed thinking where offenders avoid responsibility for their actions by insistently blaming others for their legal predicament or for their general life situation. Authority figures are typically the first to be blamed, but many will also blame friends, acquaintances, partners in crime, and even family members.

Manipulation – As mentioned before, many offenders look for “loopholes” in program rules, or uses what one staff person says to manipulate another staff person into granting their wishes.

Manipulation Through Anger – Many offenders have survived by intimidating others or displaying verbal or physical aggression in order to get their way. Admittedly, it can be difficult to tell whether a client has genuinely lost his temper, or if he is using it as a tool to get his way or simply to keep anyone from getting close to him. Sometimes, it may be a combination of the above.

Manipulation By Honesty – This will often manifest itself in one of two ways: 1) The client is completely honest about a situation that has happened (for example, admitting to substance use while in the treatment program). However, the client may be revealing such information because he knows program staff will eventually find out anyway, and he is angling for a lesser consequence or no consequence at all for being forthcoming. 2) “Selective honesty,” where the client reveals only the facts that suit him well in that particular situation, while omitting any mention of facts that cast him in an unfavorable light or will result in a consequence for him.

Assuming the Worst – This refers to the tendency of many offenders to assume the worst about others and their motives. Obviously, this stance may have served offenders well on the streets, but causes problems for them in other situations.

Going It Alone – Many offenders simply do not trust others and, as a result, believe they're better off “going it alone” rather than confiding in others or asking for help. While this stance has certainly helped many offenders survive on the streets, it often causes problems in a treatment program where self-disclosure is the norm.

Making Exceptions – This is basically “selective morality,” where offenders are quick to criticize others (especially authority figures) who appear to be dishonest or inconsistent in some aspect of their behavior, while excusing their own unscrupulous behavior.

Expects Immediate Rewards – The offender expects quick rewards or gratification after spending a nominal amount of time complying with the program, with probation or parole requirements, or with the expectations of others in general.

Low Frustration Tolerance – Here, the client talks as though they will give up, or actually do give up when they experience a setback. For example, a client wants to quit a job they just started because it's physically demanding and pays little.

Adherence to the "Criminal Code:" Many offenders will view treatment staff as authority figures, and resistance to treatment is often resistance to the counselor's real or perceived authority. Furthermore, many offenders fear being seen as weak by their peers because they participate in treatment and disclose problems. Some will purposely appear to be "good" clients in front of staff while bullying their peers behind the scenes.

Although in general, it appears that structured, cognitive-based group interventions have a positive impact on substance abusing clients, the evidence supporting specific approaches or curricula is variable. Plus, an ongoing concern in the substance abuse treatment field is the potential for various "thinking errors" approaches to stigmatize clients unnecessarily.

Forced Treatment and the Criminal Justice Client

The issue of forcing offenders into treatment through legal coercion (defined as a client entering treatment due to the order of a judge or a supervising correctional authority and facing consequences if non-compliant) has been debated in the substance abuse treatment field, corrections, and even society at large for decades.

The Harrison Act of 1914, which attempted to regulate through criminal law the use of opiates in the United States, resulted in the establishment of the first facility offering treatment with methadone in Lexington, Kentucky. This facility, described by Dr. Thomas Kosten as a prison-like hospital, or hospital-like prison," was built specifically "for the confinement and treatment of persons addicted to the use of habit-forming narcotics. And, of course, the Harrison Act was soon followed by Prohibition. In more recent times, a larger part of the substance abuse treatment population has come from the criminal justice system and, with the emergence of drug courts, there is now an entire court system centered around what some regard as forced treatment.

Although it is widely believed in the field and in the lay public that clients must want treatment for it to succeed, the National Institute of Drug Abuse (NIDA) reports treatment outcomes for those under legal pressure are as good or better than those for people who enter treatment voluntarily. In a study comparing mandated clients to voluntary groups, the Veterans Administration (VA) found that rates of abstinence,

employment, and re-arrest were about the same for both groups at one-year and five-year follow-ups.

The conclusion reached by NIDA, and many others who work with offenders, is that neither punishment alone, or forced abstinence alone teaches people to change, primarily due to the influence of drugs on the brain. However, one of the authors of the VA study cautioned that more research is needed before their conclusions result in more imposed treatment on more offenders.

Cultural Considerations

In most jurisdictions, the ethnic and cultural background of the offenders is substantially different from the general population of that jurisdiction. In comparison to the general population, African Americans are disproportionately incarcerated or subject to community supervision, and this is also true to a degree with Hispanics/Latinos.

Unfortunately, there are relatively few culturally specific treatment programs available in programs for offenders, and few institutions or community based treatment programs have the space or funds to implement such programs.

Nevertheless, the degree to which a counselor establishes an effective relationship with a client depends partly on the counselor's cultural competence. As such, counselors are ethically obligated to engage in the appropriate training needed to establish familiarity with particular client populations. A helpful guide for establishing cultural competence, originally developed by Cross et al (1989), is outlined in the Treatment Improvement Protocol 46 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Here, six stages of cultural competence are described, which are as follows:

Stage 1: Cultural Destructiveness. People in this stage demand that others assimilate to a certain culture and fit the pattern of that culture.

Stage 2: Cultural Incapacity. Those in this stage lack the capacity or will to help minority clients in the community. This person applies resources unfairly and may even see segregation as desirable.

Stage 3: Cultural Blindness. Here, professionals believe that race and culture make no difference because all people are the same. Not surprisingly, people in this stage tend to favor assimilation while ignoring the strengths of various cultures.

Stage 4: Cultural Precompetence. A counselor in this stage may lack information or may be unsure how to proceed, but generally realizes his/her weaknesses and desires to deliver quality services to minority populations.

Stage 5: Cultural Competence. The counselor shows acceptance of and respect for differences and actively expands his/her knowledge of other cultures.

Stage 6: Cultural Proficiency. Persons in this stage hold all cultures in high esteem while continuing to add to their base of knowledge.

Although this model was designed as tools for administrators to assess their organizations, counselors can, and should use it to examine their own competencies with particular populations. This continuum can also be used as a guide for suggesting training topics for individuals or whole organizations.

In addition, counselors working with offenders need to assess the degree to which the client identifies with some type of offender culture, be it “prison culture,” “street culture,” or with the “criminal code” referenced earlier in this section. Counselors should not assume the client necessarily does identify with it. Both authors have worked with a fair number of offenders who were gainfully employed for several years, but at some point chose to supplement their income by selling drugs because of the easy money.

Obviously, the counselor does not want to reinforce the client’s identification with any variant of an offender culture. But it is nevertheless a culture that exists, and it behooves the therapist to have a basic understanding of it and how the client sees himself/herself in that context.

Section Six - Aftercare and Relapse Prevention

Although each client is unique, the need for aftercare treatment, particularly when followed by residential treatment, is believed to be universal. This belief is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and by ample research showing that client outcomes improve significantly when they are involved in some level of treatment for at least a year.

Aftercare As An After-Thought

Even so, aftercare often does not get the funding or attention it needs. In many instances, counselors in the residential program must cover aftercare group sessions on top of their residential responsibilities, and meet individually with aftercare clients mainly when a crisis occurs.

Occasionally, probation and parole officers inadvertently reinforce “aftercare as an afterthought” when they believe an offender has fulfilled the program’s requirements by

completing the residential component, and they subsequently treat aftercare noncompliance as a less serious violation.

Making The Most of Aftercare

Here are some ways to strengthen aftercare services for offenders:

Additional staff: If funding permits, hiring even one staff person to work primarily with aftercare clients can strengthen your aftercare services considerably.

One of the authors was once involved with an enhanced aftercare counseling program for men, most of who were on probation or parole. The program had a counselor who conducted groups and individual sessions, and the agency collaborated with another nonprofit that provided employment related assistance. The enhanced program had a higher completion rate than the agency's aftercare programs that were covered by residential counselors.

On-site housing: Some facilities have long-term housing on site, intended for those in aftercare, who can live at the facility, hold jobs in the community, to serve as role models for newer clients struggling in the earliest phase of recovery.

12 Step group participation: Research indicates that participation in 12 Step groups such as Alcoholics Anonymous and Narcotics Anonymous is beneficial. Programs often require clients to submit proof of attendance at a pre-determined number of 12 Step group meetings a week.

Collaboration with probation and parole officers: To avoid the types of problems mentioned earlier, program staff need to address expectations and requirements regarding the offender's participation in aftercare treatment. Often, the probation/parole officer will simply agree the offender needs to stay in treatment for as long the treatment program deems necessary. Other times, the parties may agree on a specific amount of time the offender will spend in aftercare.

Involve community resources: For many years, the chemical dependency treatment profession has specialized in providing time-limited acute care where families, faith leaders, and other potential community allies have not been invited into the recovery process to the extent they should have been.

As a result, a growing number of experts are calling for a paradigm shift where the addiction treatment field:

- Supplements acute care with a long-term focus where families, persons in recovery, and many other sectors of the community are integrated into the process better than they currently are; and
- Builds on the personal responsibility and strengths of individual, families, and communities.

This shift is even more important in regard to offenders, given the stigma attached to the label of “ex-offender,” the barriers to employment faced by people with criminal records, and the need for role models who can support the offender in the context of his or her environment.

Relapse prevention: The aftercare period in treatment is used to design and implement a relapse prevention plan specifically created for the individual client. That plan will generally include the following components:

- A list of daily activities, including people, places, and behaviors, that will be supportive of drug-free living
- A list of daily activities, including people, places, and behaviors that will be detrimental to drug-free living and should thus be avoided
- A list of supportive activities which should be engaged in on a regular basis, such as attendance at AA meetings, supportive therapy, or good self-care such as exercise or nutritious eating.
- A list of activities that could be problematic or could replace the use of drugs/alcohol as addictive behaviors, such as gambling or making poor sexual choices. These activities should be monitored carefully or avoided altogether.
- A list of activities which will help stabilize basic living for the client, such as job-seeking or school plans, and procedures for attending to these needs.

Relapse prevention plans are unique to the individual. For example, it may be perfectly possible for one person to play cards for “fun”, while, for another person, this same game may border on or become an addictive behavior. Current thinking in the field suggests it is common for a person with one addiction to develop another; thus, switching from one behavior to another problem behavior is a concern for all individuals with addictive or compulsive behavior patterns.

The issue of relapse prevention extends the need for an accurate and complete client assessment, with an appropriate treatment plan. Engaging in one’s treatment plan is simply extended by aftercare, with the client acting on his/her relapse prevention plan.

As would be expected with the criminal justice population, a determination to be made is whether the criminal activity engaged in by the client is a part of their drug/alcohol use, or would exist separate from it. In some areas, particularly the sale of drugs, it is unlikely a person can engage in such activity for any length of time without drug use. Though this may seem obvious to the counselor, it is nevertheless helpful to point out to the client that engaging in criminal activity of any sort is more than likely to have negative results, including incarceration, which will not help the client's potential for an improved sober lifestyle.

Clients may have to try behaviors they think will prove workable and report back to a counselor or group on their results. The counselor or group may wish to point out parts of this proposed behavior that are risky or likely to portend relapse, and help the client find a way to escape the impending danger. For example, many clients will have relatives or friends who are users and will have to design a way to deal with these people without drug use. Generally, counselors and others in recovery will support the view that very limited or no contact is the approach most safe for continued drug-free living.

If the client admits to a "lapse" or "slip", hopefully intervention from counselors and other recovering people will prevent a full-blown relapse, meaning the resumption of drug use at a level as severe or more severe than that prior to treatment.

Section Seven – Employment

Many offenders with histories of substance abuse also have a history of unstable employment, or even no employment in some cases. As described before, the way in which many offenders view the world has certainly contributed to their past or present employment problems.

However, offenders face a number of legitimate obstacles to obtaining and maintaining employment, and it is incumbent on counselors to ensure that offenders get the assistance they need in relation to obtaining and maintaining employment. Counselors should develop and maintain collaborative relationships with organizations that are suited to helping offenders with their employment needs.

"Going to Work with a Criminal Record: Lessons from the Fathers at Work Initiative" is a publication about the lessons learned from this initiative, which was funded by the Charles Stewart Mott Foundation and managed and evaluated by Public/Private Ventures. It provides a good summary of issues to consider when addressing offenders' employment needs. Here are some of the issues:

Do no harm: First, you must know whether your clients have been convicted of a crime and, if so, of what crime(s) they have been convicted. More than a few clients with

criminal records have been referred to job training programs by well-intentioned professionals, only to train for a job they may not legally hold because of their criminal record, or because of the specific convictions on their record.

We emphasize the word “specific” because, for example, there is a big difference between “theft” and “grand theft” legally, and such distinctions can be a deciding factor in whether or not an offender is eligible to hold certain kinds of jobs in your jurisdiction. The counselor needs to know the exact charges a client has been convicted of, or has pending against him/her so a referral can be made accordingly.

The “conviction question.” Offenders usually need to be coached about how to properly address the issue of a criminal record with prospective employers. Many offenders may be inclined to lie about this on applications or in interviews. However, the counselor should encourage the offender to consider the possible consequences of doing so (the employer eventually learns about it, getting fired leads to problems with probation officer, etc.). Conversely, clients should also be advised to avoid the other extreme, in terms of disclosing excessive details about their history of criminal activity or drug use. The Fathers at Work Initiative publication provides a good overview of this topic.

Compliance with probation and parole: Sometimes, the obstacles to offenders getting and keeping a job may inadvertently result from their probation and parole requirements. Court hearings are usually scheduled at the convenience of the court, not the client. Or the intensive outpatient treatment program which the client is required to attend has hours that conflict with the client’s job or related transportation difficulties. As a counselor, you may have to collaborate with both the client and the probation/parole officer to find a solution that helps the offender comply with both job and community supervision requirements.

Finding employers who are willing to hire people with criminal records: Even in better economic times, programs serving offenders may have to spend time locating scrupulous employers who are willing to hire offenders, or who can at least be convinced to do so if they are lukewarm to the idea. Professionals should refrain from feeling critical toward businesses that are reluctant to hire offenders. Some companies may face certain legal liabilities if they do, while other businesses may feel better about hiring offenders if you collaborate with them to address problems with clients as they arise.

Encourage clients to be realistic: Many offenders, especially if they have an unstable or no employment history, will initially need to obtain low-skill, low-paying jobs, both for survival reasons and to remain in compliance with probation or parole. Clients still need to manage their expectations even if they get a job that pays substantially more than minimum wage. As an employment specialist was quoted in the Fathers at Work Initiative publication, “A \$14 per hour job sounds really great, and participants without transportation will say they are willing to walk back and forth.

Reality sets in when they get the second shift, work 8 or 9 hours, and it's pitch dark when they get off work and need to start walking."

Remember, in addition to having thinking errors that skew their vision of the world, many offenders have below average interpersonal skills and advance planning skills. When offenders are looking for a job or struggling to retain one, counselors can help clients develop these skills to be applied in a real-time situation.

Section Eight – Female Offenders

Offender Statistics by Gender

According to the Bureau of Justice Statistics (BJS), women comprise 14% of violent offenders, 22% of all arrestees, 16% of convicted felons, and 10% of the corrections populations. Although women still comprise a small portion of the criminal justice population, the number of women convicted of felonies in state courts since 1990 has grown at more than twice the increase in the male population. This brings the total of convicted women to one for every 109 adult women.

One-half of women in state prisons were using both alcohol and drugs at the time of offense, with 25% being daily drinkers. They are also more likely than men to enter correctional facilities at a more advanced stage of drug abuse than men. Adult male offenders are twice as likely as women to have juvenile records, but women were far more likely to have been crime victims as juveniles. According the BJS, 44% of women incarcerated, on probation, or on parole had a history of physical or sexual assault as victims sometime during their lives. Seven out of 10 of these women have minor children.

And, according to a study by the National Institute on Drug Abuse, women offenders, in comparison to men, are more likely to be mentally ill and to have employment and child-rearing issues while in custody or under supervision.

Implications for Treatment Providers

These statistics clearly indicate treatment programs must address issues for female offenders that may, or may not be so pertinent in programs for men.

For example, one reason why many women offenders hesitate to disclose, or fully acknowledge their substance abuse is they fear losing custody of their minor children, or of losing the chance to regain custody if the children have already been removed from the home. And once they are sober and undergoing the earliest stage of treatment, many women offenders may focus on their children to the detriment of the treatment process and the earliest stage of recovery.

Plus, much of the current literature indicates women differ from males in terms of the reasons (emotional problems and relationship issues, for example) for beginning drug use. A Cook County jail study indicated one-third of the women incarcerated there had diagnostic levels of post-traumatic stress disorder (PTSD).

Granted, there is debate about whether males suffer to a relatively equal degree from physical and sexual abuse in childhood, which is under-reported by males. However, evidence currently available indicates abuse history is a major component of the assessment, diagnosis, and treatment-planning picture for female clients, and is a necessary component of successful recovery to a greater degree than with males.

Adapting Programs for Female Offenders

Although there is still debate in some quarters, the current literature suggests gender-specific treatment works best for female offenders. Reasons for this include our strong cultural history of gender discrimination and harassment, as well as female offenders' low self-esteem, unhealthy interpersonal relationships, and history of violent victimization. The two most familiar treatment models for criminal justice clients have been the 12-Step model and the therapeutic community (TC), both originally devised for males who need to recant a narcissistic world-view.

Conversely, it is believed women need an empowerment model based on recanting the control of abusive others and becoming more independently functional. Researcher & writer Stephanie Covington suggests a "relational model," in which she sees the primary developmental motivation as not separation (often viewed as primary in adult male development), but establishing a strong sense of connection with others. She further sees emotional and sexual abuse, whether current or past, as a primary relapse trigger. Treatment programs for women should focus on establishing a strong sense of self and a strong sense of relationship with others. A necessary component of treatment, therefore, is a physical and emotional sense of safety. In the lives of many female offenders, such a place has never before been established.

As a result, aftercare is a critical component of treatment for women offenders, since many have unstable or no work histories and/or difficulties balancing work and child care responsibilities, especially if transportation is an issue. Many offenders may have histories of being sexually harassed on the job or working in sexually oriented businesses. Plus, women must also deal with factors related to appearance, which figures largely in self-esteem, and thus may need more input around nutrition and health, including education and treatment for eating disorders.

So for all these reasons plus additional ones like family reunification if child welfare agencies are involved, treatment for women may need to be longer-term and include more residential, childcare, and transportation components than that of males.

Non-traditional components of treatment, if made available, such as acupuncture, meditation, or yoga, would doubtless benefit both men and women. However, women offenders may have less experience with choice-making and tend to make choices for the benefits of others at their own expense. Thus, choosing treatment components when possible would give women more experience in the area of future decision-making. Plus, it could benefit clients to find they can influence their health and appearance through exercise and cognitive intervention rather than substances. In short, effective treatment for women offenders should be focused more on empowerment and on building and including a positive support system in the process.

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Substance Abuse Treatment and the Adult Offender on Probation or Parole

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Substance Abuse Treatment and the Adult Offender on Probation or Parole

POST TEST QUESTIONNAIRE

1. Drug trafficking and possession are among the most common offenses committed by probationers.

True _____ False _____

2. _____ is a place where offenders on probation or parole must report to be supervised for a certain number of hours a day, usually for a pre-determined number of days.

- a. Drug court
- b. Day reporting
- c. Parole
- d. Non-medical detoxification

3. Offenders almost never exaggerate the need for treatment

True _____ False _____

4. Many programs can screen out clients with certain types of offenses, such as sex offenses and arson.

True _____ False _____

5. In the Addiction Severity Index, both the interviewer and the client rate the severity of each life area which, in turn, affects the total score.

True _____ False _____

6. Practitioners should use _____ wording in the treatment plans of criminal offenders.

- a. concrete & specific
- b. general
- c. vague
- d. none of the above

7. "I will stop hating my father" is a good example of a measurable goal.

True _____ False _____

8. Which of the following is not one of the stages of change proposed by Prochaska and DiClemente?

- a. precontemplation
- b. contemplation
- c. anticipation
- d. maintenance

9. Which of the following is an ongoing concern in the substance abuse treatment field about the various “thinking errors” approaches?

- a. There is no evidence at all to support the efficacy of such approaches.
- b. There are simply too many approaches to keep them all straight.
- c. They may stigmatize clients unnecessarily
- d. None of the above

10. Which of the following are diagnostic criteria for antisocial personality disorder?

- a. There is evidence of conduct disorder with onset before age 15.
- b. There is a pattern of disregard for and violation of the rights of others occurring since age 15
- c. The individual is at least 18 years of age
- d. All of the above

11. Which of the following is not generally considered to be a useful treatment approach with offenders?

- a. Rational-Emotive Therapy
- b. Insight-oriented approaches
- c. Reality Therapy
- d. Cognitive Behavioral Therapy

12. The number of women convicted of felonies in state courts since 1990 has grown at more than twice the increase in the male population.

True _____ False _____

13. Which of the following statements best describes motivational interviewing?

- a. Clients on community supervision must be monitored and controlled as much as possible.
- b. Motivation is a relatively fixed state that can be changed only through external pressure.
- c. Resistance and “denial” usually indicates the therapist (not the client) needs to try a new strategy.

14. The current literature suggests gender-based treatment approaches for female offenders work no better than approaches typically used in programs for men.

True _____ False _____

15. According to the Stages of Change model, an offender who thinks there may be cause for concern but is still ambivalent about change is in the _____ stage.

- a. Precontemplation
- b. Contemplation
- c. Action
- d. Maintenance

16. For working with women offenders, researcher & writer Stephanie Covington suggests a _____, in which she sees the primary developmental motivation as establishing a strong sense of connection with others.

- a. connectedness approach
- b. interconnection model
- c. triangulation approach
- d. relational model

17. A pre-sentence investigation normally occurs after an offender's conviction, but before his/her sentencing.

True _____ False _____

18. Compared to male offenders, women offenders are less likely to enter correctional facilities at an advanced stage of substance abuse.

True _____ False _____

19. Aftercare treatment is an especially critical component for women offenders because:

- a. Often, they have unstable or no work histories
- b. Many female offenders must juggle work, child care, and transportation issues at the same time.
- c. All of the above

20. Studies appear to confirm that, when properly implemented, drug courts are an effective treatment option for offenders.

True _____ False _____

21. The Harrison Act of 1914 attempted to regulate through criminal law the use of opiates in the United States.

True _____ False _____

22. Almost without exception, research has shown that offenders coerced into treatment have worse outcomes than clients who voluntarily undergo treatment.

True _____ False _____

23. The process where a defendant's prosecution is deferred or dropped if certain conditions are met is called _____.

- a. probation
- b. acquittal
- c. diversion
- d. "soft on crime"

24. Client outcomes improve significantly when they are involved in some level of treatment for at least a year.

True _____ False _____

25. Competence is the legal ability to act on one's own behalf during the judicial process.

True _____ False _____

26. In terms of thinking errors, _____ refers to the tendency to strongly resist alternatives to one's own view of the world.

- a. closed thinking
- b. blaming others
- c. assuming the worst
- d. manipulation

27. In terms of thinking errors, _____ involves being quick to criticize others (especially authority figures) who appear dishonest or inconsistent in some way, while excusing your own unscrupulous behavior.

- a. closed thinking
- b. assuming the worst
- c. making exceptions
- d. none of the above

28. The first drug court was founded in _____.

- a. New York City
- b. Dade County, Florida (correct answer)
- c. Ann Arbor, Michigan
- d. Muskingum County, Ohio

29. Restoration involves compensating the victim of the offender's crime.

True _____ False _____

30. According to the Stages of Change model, how should relapse be viewed?

- a. As the worst possible outcome for the client
- b. As a learning opportunity and as a normal part of changing addictive behavior
- c. As something that shouldn't happen more than once.
- d. None of the above

31. The motivational interviewing approach advises against which of the following techniques?

- a. Moralizing
- b. Advice-giving
- c. Reassuring
- d. All of the above

32. The most unique aspect of drug court is the judge takes a much more active role in monitoring clients' progress than he or she would in a court of law.

True _____ False _____

33. Why should offenders disclose their criminal record to prospective employers?

- a. Because offenders cannot legally work in certain occupations
- b. Because offenders with specific criminal convictions cannot legally work in certain occupations.
- c. Because of the likelihood an employer will eventually find out about it.
- d. All of the above

34. Sometimes, probation and parole requirements can make it difficult for an offender to get or keep a job.

True _____ False _____

35. Motivational interviewing is based on four principles. Which of the following is not one of those principles?

- a. Empathic
- b. Accepting
- c. Emphasizes autonomy
- d. Directive

36. In the Stages of Change model, each stage must be completed successfully in order to go to the next stage

True _____ False _____

37. _____ involves a judge allowing an offender's criminal record to be sealed and removed from criminal history records.

- a. Diversion
- b. Expungement
- c. Shock probation
- d. Early release

38. Motivational interviewing recommends the use of reflective listening, open-ended questions, and affirmations.

True _____ False _____

39. Counselors who hold all cultures in high esteem while continuing to add to their base of knowledge are in the stage of:

- a. Cultural competence
- b. Cultural blindness
- c. Cultural proficiency
- d. None of the above

40. What is the most advanced stage in the Stages of Change model?

- a. Maintenance
- b. Action
- c. Permanence
- d. None of the above

I, _____ (name of participant) affirm that I am the person who completed this home study and am responsible for this post test.

Signature: _____

