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This Issue in Brief

Community Service: A Review of the Basic Issues.—Triggered by the Federal Comprehensive Crime Control Act of 1984, the evolution of community service as a formal condition of probation has caused judges and probation officers to pay increased attention to the requirements of community service programs. Authors Robert M. Carter, Jack Cocks, and Daniel Glaser state that as various options are considered, basic issues must be identified, related to a system of judicial and correctional philosophy, and implemented in an atmosphere in which citizens have ambiguous feelings about community service as a sentencing option. In this article, the authors attempt to identify the basic issues and to place them in a frame of reference for practitioners.

The Alcoholic, the Probation Officer, and AA: A Viable Team Approach to Supervision.—Probation officers are encountering increasing numbers of problem drinkers and alcoholics on their caseloads. Most officers are not specifically trained to work with the alcoholic, and author Edward M. Read advances a practical treatment model for use in the probation supervision setting. The author stresses the necessity for an important re-education process which includes full acceptance of the disease model of alcoholism and an accompanying renunciation of several damaging myths still all too prevalent. Several techniques of countering the alcoholic denial system are discussed, and the author highlights the appropriate use of Alcoholics Anonymous in the supervision process.

The Perceptions and Attitudes of Judges and Attorneys Toward Intensive Probation Supervision.—In recent years the spectrum of criminal justice sanctions has widened to accommodate an intermediate sentencing alternative known as intensive probation supervision (IPS). In his study of the perceptions and attitudes of court personnel toward IPS in Cook County, Illinois, author Arthur J. Lurigio found that, overall, judges and public defenders viewed IPS favorably, whereas state's attorneys were essentially unwilling to accept IPS as a viable option to prison. According to the author, the success of IPS programs often hinges on developing effective strategies to promote the program so that it appeals to the various elements in the criminal justice system.

The Role of Defense Counsel at Sentencing.—This article establishes the duties and obligations of defense

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The Alcoholic, the Probation Officer, and AA: A Viable Team Approach to Supervision

BY EDWARD M. READ

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ALCOHOLICS ARE entering probation offices around the country with alarming frequency. Although alcoholism has always held a high correlative relationship to crime statistics (Lieberman and Haran, 1985; Cunnigham, 1980), community sentiment towards the drunk driver has become much less tolerant. Responding in kind, state and local legislative systems have beefed up enforcement, prosecution, and sentencing of the drunk driver. Consequently, and in the interests of serving our respective communities, probation officers are finding themselves at a pivotal juncture in the lives of many functioning (and not quite so functional, of course) alcoholics.

Unfortunately, practical treatment literature is scant at best, and we are all too often left without knowledgeable direction. Many alcoholics do not fall neatly into our pre-existing supervision models. They have special problems which require specially designed solutions and intervention techniques.

In view of this, we hope to advance a relatively simple treatment response model, the composition of which focuses on an honest acceptance of alcoholism as a disease, an appropriate and entirely positive (therapeutic) use of our authority as probation officers, and an effective introduction of the client to Alcoholics Anonymous (AA) with consistent and closely monitored followup.

A Problem

The problem might not only be the alcoholic and his obviously abusive drinking pattern. Some of it may lie with us as well. Our personal feelings about alcohol, our experiences with family members, and even our consumption patterns can pose a formidable barrier to successful intervention. It is a greatly misunderstood condition with a substantial variation of ideas, attitudes, and definitions. An essential re-education process is in order which includes a close examination of our own insecurities and prejudices as they may relate to our work with the alcoholic. This may be difficult for some. Alcoholism is a pervasive disease which has undoubtedly touched many of us personally. It is a disease which has absolutely no regard for class or socioeconomic distinction. Nor is it always a very visible disorder outside the family setting. In fact, the overwhelming majority of alcoholics are unwittingly masking their disease by continued employment, home ownership, and even upward career mobility.

The re-education process must begin at home by putting to rest certain widespread myths about alcoholism. Gone should be the days of probation officers casually describing their alcoholic clients as weak-willed or morally insufficient. Alcoholism is an insidious disease, and we should be discussing an alcoholic's denial process, his powerlessness over drinking, and even perhaps his physiological predisposition to the drug. We must also try and move beyond our pessimism. Incorporating an honest respect for the possibility of recovery is an essential beginning for us all.

The Alcoholic

The alcoholic suffers from a progressive disease, the primary symptom of which is denial. Therein lies our challenge. What should be recognized and accepted as much is that this facet of the disease is not something for which the alcoholic is initially responsible. It is not his fault, in other words. The alcoholic drinks because he has to, not just because he wants to; this is especially so during the middle to late stages of the disease. As Phelps and Nourse (1986) so aptly point out, "It is a baffling, powerful, cunning disease that hides its presence so skillfully that it is not even recognized by the vast majority of its victims or their doctors." This is an area deserving of extreme caution in our day-to-day work with alcoholics. If not fully cognizant of this process, and especially when coupled with possible personal resistance or "enabling" tendencies, we can easily fall prey to the alcoholic's clever but manipulative excuse-making (Cunningham, 1980). The result will be a dangerous delay in the delivery of services or treatment.

How often we listen to our clients confidently relate to us their recent experiences with alcohol, the theme of which centers on their "control" or recent "cutback" triumphs. Sometimes convincing indeed, we may begin to doubt our abstinence directives. But if allowed to persist unbridled, or if overlooked and minimized, our clients will only languish longer in the midst of their denial. And meanwhile, the disease worsens. Most social drinkers would have little difficulty putting down

the bottle at the slightest hint of adverse action. Not so with the alcoholic, and this needs to be addressed openly with him. As widely respected authors Milam and Ketcham (1981) write, "Alcoholics can never safely return to drinking because drinking in any amount will sooner or later reactivate their addiction." Alcoholics are physiologically incapable of processing alcohol the way normal drinkers do. And this means any amount. Once again, we have a commonly held misconception which assumes that what characterizes an alcoholic is solely the massive quantity he consumes. Not so. There are, indeed, a few "heavy" drinkers who do not have the disease of alcoholism, they do not drink against their will, and controlled consumption remains intact. It is the effect the alcohol has on the individual over time and what it does to him which emerges as a key factor (Phelps and Nourse, 1986). Some alcoholics may drink what appears to be only a moderate amount to many of us and yet still encounter "problems" (change of personality, marital discord, irresponsible behavior). However, unlike nonalcoholics, they persist in their drinking despite these obvious negative consequences. The primary supervision goal should be abstinence, and we must learn to resist the alcoholic's natural inclination to divert, distract, and minimize his personal consumption habits.

Alcoholism is a progressive illness with strikingly predictable stages of advancement (Milam and Ketcham, 1981). The early, adaptive stage of the disease (for most alcoholics, that is) has as its hallmark one's ability to increase alcohol intake and still function normally—thus the importance of high blood alcohol content levels absent visible signs of intoxication. The middle stage of the disease is characterized by physical dependence, craving, and loss of control. The disastrous final stage of the illness will be marked by severe physiological deterioration, social isolation, and eventually death. There is no need here to concentrate on an in-depth analysis, description, or validation of alcoholism as a progressively fatal disease. As AA literature states so simply, there are but three alternatives facing the drinking alcoholic: jail, mental hospital, or death (*Alcoholics Anonymous,* 1984). Think about personal friends, relatives, or acquaintances touched by alcoholism. What was the end result for them, short of complete abstinence? As probation officers we must face this glaring reality. Why? Because our job will be to help translate this concept for the alcoholic so that he may be able to accept the inevitable destiny of his own disease. Otherwise, why stop drinking?

A bleak picture has been painted, but alcoholism is not a hopeless condition. Far from it, in fact. Most of us, either consciously or unconsciously at one time or another, have subscribed to the misguided notion that unless the alcoholic sincerely wants help, he will be doomed to become alcoholism's sure victim. There is absolutely no evidence to support such thinking. Even recovering alcoholics in AA admit, of their first encounter with the "program," that the last thing on their mind at the time was an honest desire to stop drinking. Furthermore, and as Milam and Ketcham (1981) write, "the alcoholic may lie, steal, and cheat to protect his right to drink. But his deceptions and refusals are no indication that treatment will fail. No matter how fiercely the alcoholic fights those who want to help him stop drinking, he can be helped more often than not." Our cynicism must be dispelled. Alcoholics are generally quite sensitive individuals who are skilled in identifying loopholes, inconsistencies, and convictionless stances on the part of professionals. Probation officers have enough barriers to the recovery process as it is, and this is one facet of our work over which we do have control.

Four areas crucial to the understanding of the alcoholic have been discussed in this section. First, we must both respect and understand an alcoholic's powerful denial system. Second, we must stand with conviction behind our expectations for complete abstinence. Third, we must be convinced ourselves of the progressive nature of the illness. And fourth, we must honestly believe in the potential for individual recovery.

The Probation Officer

For the purposes of this article, we are assuming the alcoholic has already been identified as such (either by the probation officer himself, the court, or an outside professional). Hopefully, and this unfortunately does not seem to occur with near enough frequency, the court will have already imposed a special condition banning alcohol consumption while on supervision. But even if there exists no such formal court support, an individual probation officer is certainly not precluded from insisting upon his own directive to that extent. The key here stands with the probation officer's skill in justifying (to the client) the no drinking requirement.

So, an initial supervision priority should be placed upon an education process through which the alcoholic will begin to see the disturbing relationship between his continued compulsion to drink and the existence of very real adverse consequences. This assumes, and rightfully so, that the probation officer possesses a good working knowledge of the illness, its etiology, and its progression. Educating our clients will only work to the extent we have accepted a similar responsibility.

But education alone will usually not suffice. As written in *Alcoholics Anonymous* (1984), the AA bible

(commonly known as "The Big Book"), "the actual or potential alcoholic, with hardly an exception, will be absolutely unable to stop drinking on the basis of self-knowledge." For years it was mistakenly held that alcoholics would be unable to initiate recovery unless a meaningfully low "bottom" had been reached, one which required family loss, job loss, and consequent complete personal devastation. Fortunately, even the experts in AA have changed their thinking in this regard. They write, "alcoholics who still had their health, their families, their jobs, and even two cars in the garage, began to recognize their alcoholism (*Twelve Steps and Twelve Traditions,* 1984). In their day-to-day contact with newcomers, AA's began to espouse the necessity of raising their "bottoms" to the point it might effect or "hit" others. By reaching back in their own drinking histories they could show that even years before they lost full control, alcohol had been no mere habit.

Most probation officers cannot necessarily do this for their clients. Perhaps then the probation officer should endeavor to hasten the delivery of a "bottom" to the alcoholic in spite of himself and his powerful denial system. As Cunningham (1980) alluded, we should strive through forced enlightenment, if you will, to create an artificial "bottom" around which the alcoholic may have difficulty maneuvering. This is the therapeutic use of our authority taken in close association with our knowledge of the disease itself. Specifically, it means lowering pain thresholds, creating discomfort by insisting upon complete abstinence, nonacceptance of "controlled" drinking behavior, possible returns to court for violations, and even jail. The result just may be that crucial connection between an alcoholic's continued drinking, his tenuous court status, and ultimately his powerlessness over the drug.

Those of us uncomfortable with the therapeutic use of confrontation as a supervision tool will be put to the test. But in most cases, and to varying degrees in all, it will behoove us to try and accept the possibility of long-term benefits the assumption of such a posture may have, no matter how distasteful it is initially perceived.

Of course, we must not ignore the relapse nature of this disease (Whitfield, 1985). And although this facet of alcoholism is worthy of a separate article all to its own, it should be acknowledged as an important example of an alcoholic's struggle with his addiction. Suffice it to say that you will know when a relapse is a relapse and not simply an alcoholic's refusal to try to stop.

Calling upon other available community resources should not be resisted. The experts in the field all stress the need for a multifaceted approach to treatment which focuses equally on group counseling (not to be confused with AA), AA, and other self-help groups available for the nonalcoholic family member. The client should not have the option of choosing his own treatment plan. And more often than not, the probation officer will find himself compelled to insist upon regular attendance. Verification procedures should be employed and noncompliance should not be viewed lightly.

The use of portable breathalyzers (especially during initial sessions) as means of assuring a client's commitment to sobriety should be welcomed. It is not uncommon for an alcoholic to be sitting quietly in our office, seemingly unintoxicated, and yet possess a blood alcohol content of .20 or above. This individual did not simply have a few beers before bed last night. The breathalyzer must be accepted as an additional therapeutic tool, not an intrusive violation of a probably nonexistent mutual trust. Use it frequently. If your client is alcohol-free on a consistent basis it just may be a measure of progress. If not, it shows where more work is required.

Our work with clients should not be confined to the office. We need to be in the field on a consistent basis talking with family members and others who have effect on the client. Nonalcoholic family members require education as well. And they can provide excellent insight into what our client may actually be doing about his problem. Community agencies to which our client has been referred should also be visited regularly. It should be no surprise to those of us in the field that often our client's description of his activities bears a marked dissimilarity to that of our collateral sources. Once again, the forces of denial become disturbingly evident.

We have begun to outline some of the potentially constructive supervision tools required for treatment of the alcoholic client by the probation officer. But self-knowledge, education of the client, and therapeutic confrontation as means of hastening or raising a "bottom" for the client must not end here. Most alcoholics require introduction to the experts in personal recovery which should include a closely monitored and educated exposure process.

Alcoholics Anonymous

One can hardly fail to take notice, within almost all books, articles, or papers devoted to the study of alcoholism, of AA's reputation as a profound winner. Granted, it may not be suitable for all. However, the plain truth shows a surprising percentage of those few who do recover seem to find solace within the fellowship of Alcoholics Anonymous (Wholey, 1984).

Dr. Charles Whitfield, a prominent practitioner in the field and author of *Alcoholism and Spirituality* (1985), has gone so far as to model his entire therapeutic approach (and philosophy of recovery) along the lines of AA's steps. He writes at one point in his book, "Alcoholics Anonymous may be the most important phenomenon of the 20th century. The Twelve Steps of AA—the heart of the program—are the result of the wisdom of many recovering alcoholics who were struggling to stay sober and to improve their lives, and who did so."

So, we hardly lack the evidence supporting our endeavors to introduce the alcoholic to AA. However, a simple directive or instruction by a probation officer to his client to attend a certain amount of meetings per week will simply not suffice. For as Milam and Ketcham (1984) state, "most recovering alcoholics... have the same reservations about AA that nonalcoholics have, envisioning AA members as a group of losers and scruffy fanatics speaking a mumbo-jumbo of love, spiritual renewal and brotherhood." It seems to be as widely misunderstood as the disease itself, and if the probation officer is to be successful in making his referral, he must be qualified to sell his product. Now this is not to suggest the probation officer requires the capacity to explain in specific detail how the program functions (even AA's will shun such queries—"it just works"). What it does imply is some basic knowledge of what AA is and is not. AA is not a religious program but it can be a spiritual one. AA might ruin one's drinking but there will be no coercion to stop. It is a program of attraction and not one of promotion. AA is an ongoing process and personal transformation to accept life on its own terms without alcohol and not an event designed to "cure." AA's only requirement for membership (and indeed its primary purpose, i.e., to help the alcoholic stay sober) is a simple desire to stop drinking. It does not insist upon an "honest" desire to do so. AA members are your neighbors, your coworkers, and your leaders, not skid row losers. These are but a few of the distinctions with which a probation officer should feel comfortable.

One of the most effective ways of expanding our knowledge base is by actually attending a few AA meetings. Most metropolitan areas have a virtual potpourri of meeting formats and styles. Some are open "speaker's" meetings and available to anyone interested. Customarily, two recovering alcoholics will tell their stories (both pre-AA and post). To those in the audience who are recovering this is often a helpful reminder of from whence they came and of their continuing progress. For others, perhaps the doubters, it can provide a potential life-saving identification process. There are open (i.e., to nonalcoholics as well) discussion meetings and closed (alcoholics or those who think they have a problem) discussion groups. AA's will be talking about their recovery on a variety of different levels. Finally, and in most areas, you will find "closed step meetings" where members will usually be discussing their personal experience with a particular "step" of the program.

A probation officer should become aware of these different meeting types and be capable of specifically pointing them out to the prospective newcomer in the local directory of meetings. A notation will usually be made distinguishing one from the other in the directory. Having helpful AA literature on hand in the office (and certainly the directory itself) should be the rule and not the exception. It goes without saying that the probation officer should eventually become somewhat conversant on the 12 steps themselves. A widely used guide published by AA is entitled *Twelve Steps and Twelve Traditions* and is available for purchase at many meetings or through the local AA service organization found in most telephone books.

Most of us are accustomed, to some degree at least, in the making of an AA referral. Our verification slips are being discovered in many local meetings, and we are occasionally experiencing pockets of AA community resentment at the influx of "slip signers." The thing to be remembered here is that AA as a whole has little regard for how the newcomer arrives. On the other hand, and because each individual AA group is self-governing (they prefer to use the term autonomous), some meetings may resist the signing of court slips. This is particularly true in more rural settings. In metropolitan areas, the client can simply be encouraged to pick another meeting and attend elsewhere.

Now is the time for discussion of several supervision hints and monitoring practices which could enhance an individual client's experience with AA. Do not be shy about insisting upon five to six AA meetings per week. This is *not* excessive. Most newcomers arriving at AA on their own are encouraged by others in the program to attend 90 meetings during their first 90 days of sobriety. Length of time between the last drink, at least initially, can be very important to the newly sober alcoholic. Stress regular attendance at the same meetings each week. The client will begin to see others recover and might find himself more prone to opening up as he begins to feel comfortable. Suggest a good mixture of speaker's meetings, discussion groups, and closed step meetings. One could easily be lost to the corner of a large speaker's meeting and never risk talking to anyone. Step meetings tend to be the smallest, and their members very serious about recovery. Firmly encourage the acquisition of a sponsor, someone in the fellowship with a few years of

sobriety, willing to offer an insider's view of AA to the newcomer. Sponsors are usually eager to accept such a role as it offers them an opportunity to give back some of what they have received. Do not be reluctant to telephone the sponsor and inquire as to a person's progress. Engage your clients in discussions about AA and what transpires. If he is attending a few step meetings (and he probably should be), ask him to talk about a particular step. Not only will your expression of interest be therapeutic for the client, but you will also quickly learn to tell whether or not he is actually going to meetings. During your office visits and when collecting verification slips for your file,do not dismiss the slips lightly. Are they naming meetings which actually exist in the directory? Do you notice glaring discrepancies with some of the signatures found in different places (potential forgery) or a preponderance of full names (AA's will generally write their first name and the first letter of their last, but this is by no means a steadfast rule)? Finally, remember a person's sobriety date (his last drink) if at all possible. Congratulations and support are in order at significant time intervals such as 3 months, 6 months, and 1 year.

With steady attendance, sponsorship, and probation officer support and monitoring, more than one highly resistant client has been seen capitulating to the influence of AA.

Conclusion

Probation officers, many not professionally trained alcohol counselors or therapists, are encountering growing caseloads of problem drinkers and alcoholics. A significant challenge is posed here and a professional response required of us by the community and the court for whom we work. We have tried, on the basis of currently accepted definitions, treatment practice, and etiology, to advance a therapeutic framework for use within the probation supervision setting. In our view, it is possible to formulate an important alliance comprised of the alcoholic, the educated probation officer, and AA which stands a good chance of success. But at times, our greatest measure of success may remain totally unobserved—the probation failure returning to AA at a later date, knowing of no other place to turn for help (but at least he *now* knows).

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