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This Issue in Brief

Public Policy and Sentencing Reform: The Politics of Corrections.—Author Peter J. Benekos focuses on the politicalization of corrections and presents a public policy critique of correctional reform. As fear of crime and victimization have generated retributive rhetoric and get-tough crime control policies, the consequences of these policies—high incarceration rates and prison crowding—have now become their own public policy issues with critical implications for corrections. A review of one state's legislative reform efforts suggests that sentencing policies can be proposed with the get-tough rhetoric but are ostensibly more responsive to correctional needs, i.e., overcrowding and cost, than to the issues of crime, criminals, or crime control.

The Costliest Punishment—A Corrections Administrator Contemplates the Death Penalty.—According to author Paul W. Keve, the United States—going contrary to the general trend among nations—is maintaining its death penalty, with growing numbers of prisoners on its death rows, while at the same time showing a general reluctance actually to execute. Meanwhile, the public is mostly unaware that maintenance of the death penalty is far more costly than use of life imprisonment and has no proven deterrent effect. The author cautions that the interest in expediting executions by limiting appeals must be resisted because even with all the presumed safeguards, there are still repeated instances of wrongful convictions. He adds that the death penalty as respectful of the feelings of victim families is a defective concept because it actually puts families through prolonged anguish with the years of appeals and successive execution dates.

The Refocused Probation Home Visit: A Subtle But Revolutionary Change.—Home visits have historically been used in the control/law enforcement function of probation work, as well as in the treatment/service function. However, the current state of probation—dramatically affected by burgeoning caseloads, increased numbers of "difficult" clients, and emerging issues of officer safety—has made it necessary to rethink the concept of home visits. Now, many agencies are limiting home visits to high risk cases and using such visits solely for control—an approach which may be consistent with a shift in probation practice towards a law enforcement orientation. In an article reprinted from the *Journal of Contemporary Criminal Justice*, author Charles Lindner looks at the

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Successful Drug Treatment in a Criminal Justice Setting: A Case Study

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Introduction

CONCERN ABOUT chemical dependency is a major social and political issue in the United States. The loss in human potential and the associated social, health, and criminal justice costs are staggering. An important consideration for public support of substance abuse treatment is the critical relationship between substance abuse and criminal behavior. While significant differences will remain concerning the causal effects of drug abuse and crime, ". . . it has been assumed that if drug abuse were reduced, there would be a concomitant reduction in drug-related crime" (Hubbard et al., 1987, p. 127).

Prisons are extraordinarily expensive to build and operate; thus, it is necessary for the criminal justice system to develop effective ways of dealing with criminal defendants on both a cost and social basis. The 1987 prison construction cost typically varied ". . . between $50,000 and $75,000 per cell, and the associated per prisoner maintenance cost averaged $14,000 per year" (Petersilia, 1987, p. 2). At a conference convened by the National Institute of Justice (NIJ), Charles B. DeWitt noted that the country's prison population is increasing ". . . at a thirteen percent (13%) annual rate" (Criminal Justice Newsletter, 1990, p. 1). To maintain that rate of growth, the estimated cost for new construction alone is estimated to be $100 million per week (Criminal Justice Newsletter, 1990, p. 1).

Probation is a subsystem of the criminal justice system. Its effectiveness is measured by the number of individuals who successfully complete their supervision and are mainstreamed back into society as functioning, productive people. Constructive and positive change in its clients is a tangible demonstration that the system is working effectively. As its overall goal, probation has a specific outcome, i. e., the modification or change of behavior through a structured program of community supervision. Basic to the goals of probation are deterrence, rehabilitation, and restraint. These objectives are particularly important in the supervision of chemically dependent probationers and parolees.

Within the general definition of deterrence are two meanings. According to Lampe, individual or special deterrence ". . . refers to controlling the behavior of others by means of the threat of apprehension and/or punishment" (1985, p. 23), whereas general deterrence refers ". . . to controlling the behavior of others by means of the example made of the offender who was caught" (p. 26). An adjunct to deterrence is rehabilitation which focuses on change. It not only seeks to change offender behavior, but ultimately, to effect a lifestyle change which will lead to constructive, rather than destructive, behavior. Both deterrence and rehabilitation interface with the emphasis of restraint. Restraint acts to impede the offender from the commission of further offenses. Consequently, the focus is in making continued criminal behavior impossible. As Wexler et al. have stated: "Although criminal justice sanctions alone may have uncertain value in reducing the criminality of drug-involved offenders, those sanctions can serve a powerful role by facilitating drug treatment" (1986, p. 6).

While there are a number of compelling reasons which act to persuade the drug user to engage in treatment, perhaps the most compelling is that of legal sanction and the potential for incarceration. "The leverage created by this threat, and by the sanction itself, permits treatment to be considered as a viable option by the serious abuser" (Wexler et al., 1986, p. 6). While it is conceded that there are offenders for whom nothing works, there are others, the vast majority for whom a structured program of mandated treatment intervention will reduce both the use and abuse of drugs. This article describes such a program, designed and implemented by the United States Probation Office in the Northern District of California.

Establishing the Program

The authority for a Federal probation and parole drug aftercare program was initially established by the Narcotic Rehabilitation Act of 1966 (NARA) (Federal Judicial Center Study, 1984, p. 1). With the enactment of the ". . . contract services for Drug Dependent Federal Offenders Act of 1978, responsibility for operating the program was transferred from the Attorney General of the United States and the Director of the Bureau of Prisons, to the Director of the Administrative Office of the United States Courts" (Federal Judicial Center Study, 1984, p. 1). The Probation Division, Administrative Office of the United States Courts,

was delegated the responsibility for the program, and specific authority to contract for aftercare services was deferred to the chief probation officers or their designees in each judicial district.

The basic policies and procedures of the aftercare program are set forth in Volume X of the *Guide to Judiciary Policies and Procedures*. Aftercare, as described in this volume, ". . . is the treatment and urine surveillance provided addicted or drug-dependent Federal offenders after their release from institutions or placement on Probation." Therefore, the aftercare program is not a post-corrections support effort but, rather, a supervision program. Treatment and urine surveillance are provided by the direct order of the district court or Parole Commission. The treatment and urine surveillance tasks can be accomplished by contracting for the required services and/or by probation officers directly or some combination thereof.

The Northern District of California is composed of the 15 coastal counties along the California coast between Monterey and the Oregon border. The probation office is headquartered in San Francisco, with branches in Oakland, San Jose, Santa Rosa, San Mateo, Santa Cruz, and Monterey. The district's probation officers are responsible for supervising the community activities of both probationers and parolees. A significant number, 40 percent, of the total client population have either experienced or have ongoing problems with drugs and/or alcohol. Predicated on positive urine tests results, client self-admissions, and treatment provider reports, the most commonly abused drugs are crack cocaine, cocaine, methamphetamine, heroin, alcohol, and marijuana. Additionally, many drug aftercare (DAC) clients use combinations of drugs, i.e., cocaine or heroin and alcohol or marijuana; heroin and alcohol; and crack cocaine and alcohol or marijuana are just a few of these lethal drug combinations. Consequently, a small, yet significant percentage of the total DAC population is heavily addicted and requires immediate and often costly residential treatment, while the others are attempting to control their addiction or on the verge of becoming addicted but can be deterred with appropriate treatment intervention.

In January 1984, the chief probation officer for the Northern District of California directed two senior probation officers (drug aftercare specialists) to design and implement a district-wide DAC program. It was agreed that the aftercare program should be proactive. The officers wanted to identify problem clients for the purpose of structuring a community supervision plan aimed at neutralizing drug dependency. In the past, probation officers had been content to allow problems to occur and then attempt to address them. The drug aftercare specialists proposed that once a client was identified as a DAC case, intervention should begin immediately. Why wait for the problem to evolve? Initiate a strategy of education, prevention, and deterrence, thus providing the client with the opportunity to successfully complete supervision while simultaneously dealing with his or her drug problem. For that matter, when an individual is placed on probation or parole, with a drug aftercare condition of supervision, it is the expectation of the court, Parole Commission, and the public that ". . . placing a person under a 'drug aftercare' condition, mandated special supervision . . ." (Anthony, 1988, p. 7). Consequently, the essence of treatment in a probation setting is the creation of an environment in which intervention can occur. "Whether a client's use of drugs or alcohol is considered circumstantial, recreational, medicinal, compulsive, intensive or experimental, the person under a drug aftercare stipulation must be assisted in accepting the need for specialized handling" (Anthony, 1988, p. 7).

Treatment Modalities

Although there are numerous theories concerning the cause of drug abuse, over the past several decades, three principal treatment strategies have emerged: methadone maintenance, residential treatment, and out-patient drug-free programs.

A treatment protocol which gained prominence during the 1960's for the treatment of heroin addiction is methadone maintenance. Methadone is a legally controlled synthetic medication. It is relatively cheap and allows the serious drug abuser to enjoy a relatively normal lifestyle. The actual treatment consists of dispensing to the user, initially daily and later less frequently, carefully measured doses of methadone which, when orally ingested, occupy the opiate receptors in the brain and eliminate the craving for opiates.

Residential programs, more commonly referred to as therapeutic communities, feature a highly controlled 24-hour-per-day drug-free environment. The user lives at the program, depending on the program, anywhere from 6 months to 2 years. During this time, the individual participates in a structured social model treatment process aimed at facilitating a complete lifestyle change.

A derivation of the long-term residential treatment is the short-term (28-to 30-day) treatment or detoxification program. Usually operated by hospitals or private agencies, short-term treatment provides the drug user with an opportunity to stabilize and prepare for continued treatment on an outpatient basis.

Finally, outpatient drug-free programs emphasize counseling, both individual and group, and urine testing, while also stressing the philosophy and twelve-step principles advanced by Alcoholics/Narcotics Anonymous. Outpatient treatment, like methadone

maintenance, allows the client to remain in the community.

Drug Aftercare

Effective intervention is possible only when it is guided by clear theoretical constraints concerning both the cause of and treatment of drug abuse. ". . . A sound set of practical therapeutic recipes with parallel tracks and options based on the best available data, may be what is needed to guide treatment of drug abuse in many of the settings in which it is practiced" (Grabowski, 1986, p. 36). Therefore, until a single dominant theory for drug abuse and causation and treatment emerges, the safest and most practical approach to both its etiology and treatment intervention is to use a multi-dimensional system which draws the best from each theory. This is precisely what has occurred in the Northern District of California. The district does not subscribe to any particular theory of drug addiction and utilizes all three of the major treatment protocols with clients. It discourages, and rarely uses, methadone maintenance; nevertheless, the district subscribes to the proposition that "all types of drug treatment have shown progress in reducing drug use and criminality" (Visher, 1990, p. 4).

In the Northern District of California, it is assumed that every case which has been designated drug aftercare (DAC), if not already addicted, has the potential to become addicted and requires a treatment strategy aimed at deterring addiction. The district's premise is that the recreational user will be discouraged from using drugs because the risks are too great, whereas the serious abuser will have two choices: either accept the responsibility to combat addiction or suffer the consequences. To give structure to its philosophy, the district designed a 1-year phase/sanction DAC supervision protocol. The purpose of the phase/sanction system is twofold: 1) to foster the reputation that drug use would not be tolerated in the Northern District of California and 2) to offer support and the very best drug treatment to any client who wishes to remain drug-free. Incorporated into the phase/sanction system are the following program priorities:

Referrals

All new supervision cases with a substance abuse condition are subject to a 1-year drug aftercare program, unless there is: a) no documented, supported evidence of drug abuse; and b) the offender denies a history of drug abuse; or c) drug abuse was several years prior to the instant offense. In the event that any combination of exclusionary criteria exists, the offender is referred for 90 days of phase I urine testing *only*. After 90 days, if there are no positive tests for drugs and full compliance with the urine testing schedule, the probation officer initiates a formal request with the court or Parole Commission for suspension of the DAC condition. However, should the offender test positive for drugs or fail to adhere to the testing regimen, the client is immediately referred for a complete menu of aftercare services.

Identification of Substance Abuse Clients

Gone are the days when drug abuse indicators are readily discernable; therefore, the cornerstone of any substance abuse program must be a sophisticated system of urine collection/analysis. To be effective, collection should be totally randomized, observed, and potentially occur 7 days a week. Thus, all clients are required to participate in a code-a-phone urinalysis program.

The code-a-phone urine testing protocol mandates that each client be assigned a code number. Thereafter, on a daily basis, the offender calls a message unit and listens for pre-recorded instructions. The recording details which code numbers will be required to test. If the client's code number is indicated, then he or she *must* report for a urine test the following day.

The purpose of random testing is to instill in the offender the knowledge that if he or she uses drugs, there is the distinct possibility the use will be detected. Of equal importance is the fact that the potential success of any substance abuse intervention program is significantly enhanced if use is detected before it evolves into relapse and renewed addiction.

Treatment Providers

Because of individual client differences and the complexity of addiction and treatment, it is important that contracts be established with service providers capable of providing a broad range of treatment services. All contract treatment providers are expected to be experts in relapse prevention, recovery, and the addictive process. Moreover, a thorough knowledge and understanding of twelve-step principles and associated self-help support and intervention groups is required. Finally, it is critical that providers be familiar with the criminal justice system, comfortable with DAC clients, and endorse the philosophy of the phase/sanction system.

Phase/Sanction System

The DAC program is a 1-year-long, three-phase program. Each phase is divided into 120-day treatment components. At a minimum, each DAC client is expected to participate in the following:

Phase I—Four Months

I. Client will submit a minimum of *six (6)* random or *eight (8)* scheduled urine tests per month;

AND weekly Narcotics Anonymous meetings; *OR ten (10)* random or *twelve (12)* scheduled urine tests per month.

II. Treatment evaluation performed by the contractor.

III. Counseling, as directed.

Phase II—Four Months

I. Client will submit at least *four (4)* random or scheduled tests per month *AND* weekly Narcotics Anonymous meetings; *OR eight (8)* urine tests per month, either on a scheduled or code-a-phone basis.

II. Counseling, as directed.

Phase III—Four Months

I. Client will submit to at least *two (2)* random tests *AND* weekly Narcotics Anonymous meetings; *OR six (6)* urine tests per month.

II. Counseling, as directed.

Generally, the client should be encouraged to attend Narcotics Anonymous meetings, rather than to increase his or her urine submissions. (Regular attendance may be a mitigating factor in a subsequent DAC violation; refusal/failure to attend may be an aggravating factor.)

A critical component of the phase system is the graduated set of sanctions. In the event that a client tests positive for drugs, or fails to adhere to program requirements, a sanction defines those treatment options available to the probation officer. The purpose of the sanction is to deter further drug-seeking and/or drug-using behavior.

Program sanctions are triggered by an episode. An episode is defined as:

1. A positive urine test;
2. Submitting a diluted or otherwise fraudulent urine sample;
3. Any three missed counseling appointments, urine tests, or failure to submit a testable amount of urine, or combination thereof; or
4. Except as noted above, failure to comply with or complete any sanction.

Altogether, three levels of sanctions were developed. Beginning with the least intrusive form of treatment (increased urine tests), sanction protocols may be quickly ratcheted upward to more intense and restrictive treatment options (residential treatment), requiring both the notification and concurrence of the court and Parole Commission. The goal is to ensure continuity of officer response, make the client responsible for his or her behavior, and manage offender community risk, while at the same time allowing for maximization of individualized treatment. The concept emphasizes treatment within a context of authority. Accordingly, the client fully understands that:

1. Failure to complete any phase is the basis for a return to phase I and a re-start of the year-long treatment cycle; and
2. To remain on probation or parole, it is necessary to be clean and sober.

The client is confronted with clearly defined and unavoidable consequences (sanctions) for program noncompliance and/or drug use. However, the offender is also introduced to a program of drug treatment which will allow him or her to assume a clean and sober lifestyle.

Results

Recent research disclosed "... that urine monitoring initiated by the criminal justice system is a necessary component of a sanctioning strategy for offenders who abuse drugs, but, alone, is not sufficient to reduce drug use and criminal activity of drug-involved offenders" (Grabowski, 1986). While drug testing, alone, is not enough, "some form of rehabilitative drug treatment program can lessen recurrence of drug abuse and may substantially reduce or eliminate future criminal behavior" (Grabowski, 1986).

To this end, the substance abuse specialists for the Northern District of California have worked diligently to provide a comprehensive and meaningful program of intervention and treatment. If there is to be failure, let it be the client's, for the probation office will have provided both the environment and opportunity for intervention to occur. Each DAC client is referred to a professional substance abuse therapist for an assessment and evaluation. A written report is completed and submitted to the probation officer, with a recommended course of treatment. Intervention options include: drug-free counseling, psychotherapy, group counseling, family counseling, recovery groups, transition groups, substance abuse education groups, intensive outpatient treatment, psychological evaluations, psychiatric evaluations, monitoring and payment for psychotropic medication, short-term residential treatment (28 to 180 days), and long-term residential treatment (6 to 18 months).

Based on data accumulated by aftercare specialists, since its inception, the DAC program has continued to expand in both scope and dimension. For example, in 1983, 139 cases were identified as DAC, and 24 (or 17

percent) were receiving contract intervention services. As of November 1990, almost 700 cases were identified as DAC, and 366 (or 55 percent) were participating in contract treatment intervention services. Of even more significance has been the reduction of overall drug use in the district.

In 1984, a total of 217 cases were identified as DAC. From that population, 3,050 urine scheduled tests were taken throughout 1984. Between 18 and 21 percent of the tests were returned as positive for illicit drugs. During fiscal year 1990, which ended in October, 666 cases were identified as DAC. This population provided 15,514 randomly taken urine tests during the year. Of all urine tests taken, 6.6 percent were returned positive for drugs. This amounted to an an average reduction of 14.4 percent in the district's urine positive drug test rate.

"Between 1983 and 1990, the total number of cases supervised in the District increased by 152%; however, during that same period, the number of drug tests increased not 152%, but, rather, 3,500%. Thus, the figures point out that although there was an increase in supervision cases between 1983 and 1990, even factoring in that increase, there remained a dramatic increase in the number of tests administered to substance abuse cases" (Buddress et al., 1990, p. 18).

Predicated on these results, it can be safely assumed that the drug aftercare program in the Northern District of California has contributed both to the reduction of drug use and abuse by its clients, while also preventing renewed criminal behavior. It is a multiple-modality approach to a multi-dimensional problem.

Most criminal justice officials agree that options other than traditional incarceration or probation are needed. The Northern District's drug aftercare program is an example of a highly structured successful program of drug intervention and treatment, in combination with probation or parole supervision.

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