



National Institute  
on Drug Abuse

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## State Parole Policies and Procedures Regarding Drug Abuse Treatment

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ACQUISITIONS

State Parole  
Policies and Procedures  
Regarding Drug Abuse Treatment

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
Public Health Service  
Alcohol, Drug Abuse, and Mental Health Administration

National Institute on Drug Abuse  
5600 Fishers Lane  
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This report is issued by the Criminal Justice Branch, Division of Resource Development, National Institute on Drug Abuse (NIDA). It is one of a number of reports addressing the interface and processes between the nationwide drug abuse treatment system directed by the Institute and the various Federal, State, and local agencies of the criminal justice system.

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*The material herein does not necessarily reflect the opinions, official policy, or position of the National Institute on Drug Abuse of the Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, U.S. Department of Health Education, and Welfare.*

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## FOREWORD

The Division of Resource Development, National Institute on Drug Abuse, and its Criminal Justice Branch are pleased to publish this report on State Parole Policies and Procedures Regarding Drug Abuse Treatment. This is the first of a number of publications produced by the National Institute on Drug Abuse to address the important interface between NIDA's nationwide drug abuse treatment network and our Nation's criminal justice system. While some of these publications will be designed for specialized audiences within the criminal justice system, all will focus on developing greater coordination and cooperation between these two systems at the Federal, State, and local levels.

This study on State parole policies and procedures has particular significance because of NIDA's demonstration initiative to provide systematic monitoring of a sample parolee population through regular urine testing. First proposed by NIDA Director Dr. Robert L. DuPont as "Operation Trip-Wire," this current initiative is designed to reduce the enormous social costs of heroin addiction by maintaining close surveillance and prompt referral to treatment for those persons on controlled release to their communities. This document is an important first step in learning how current State parole practices impact the drug-abusing criminal offender.

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*Director*  
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REVIEW OF STATE PAROLE POLICES AND PROCEDURES  
REGARDING DRUG ABUSE TREATMENT

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I. INTRODUCTION

Of the estimated 500,000 - 700,000 narcotics users and addicts in the United States, available data suggest that the majority come in contact with the criminal justice system at one time or another, and that perhaps as many as 25 percent are ultimately processed through some State correctional institution. This would imply that the correctional system occupies a significant role in the management, treatment, and control of narcotic drug use in America.

For more than five decades, the appropriateness of incarceration in the treatment of addiction has been actively debated. Those in favor of the argument claim, first, that maximum security institutionalization prevents the addict, at least for a given period of time, from using drugs; the individual is not only removed from a source of supply, but s/he is also prevented from contaminating others. Second, proponents of incarceration for addicts indicate that imprisonment will allow the offender to assume responsibility for his/her own actions, and will simultaneously serve as a deterrent against future drug use and criminal activity. Conversely, those opposed to incarcerating the addict argue that prison is not an appropriate tool for the treatment of addiction, that rehabilitation can be more effectively implemented at the community level, and that, if a narcotics user must be temporarily confined for the protection of society, treatment should endure throughout the period of imprisonment. Current thinking in the treatment of addiction has come to agree with these latter notions, and has looked toward an offender's parole period as an effective time for the application of treatment.

Parole is a terminal form of correctional treatment. It is a variety of conditional release from the institutional setting after the offender has served a portion of his/her sentence. As such, and in theory, parole functions in the individualization of correction, and offers incentives to reform, while enabling society and its authorities to retain protective custody over the released offender. Yet parole systems are typically suffering from a lack of financial, manpower, informational, and community resources which are necessary for the successful reintegration of the paroled offender, and these directly impact on the possible community based treatment of those parolees with histories of narcotics use. This is further aggravated when parole policies discriminate against the narcotic addict, or when parole field personnel are not trained to accept and deal with this specialized population.

The Law Enforcement Assistance Administration (LEAA) initiated in 1975, through its State Planning Agencies (SPAs), a three year program to implement planning for drug abuse treatment and rehabilitation services throughout the State Correctional System. Many of the National Institute on Drug Abuse (NIDA) existing Federal Funding Criteria were incorporated in the mandatory program plans and there exists a further mandate to consult with NIDA's designees, the Single State Agencies (SSAs), regarding these plans. While both LEAA and NIDA attempted to provide a satisfactory level of advisory and technical support to both State agencies, requests for assistance in designing new community based and institutional programs continue, and have markedly increased in the last year. These and other circumstances highlight the need for additional written resource materials in this area.

The Domestic Council White Paper Report to the President (1975) designated the treatment and rehabilitation of the drug abusing criminal offender as a top priority program area and directed immediate action to begin new initiatives for this target group. There is a continuing need to provide SSAs with examples of program development, data collection and analysis, and information exchange.

Legislative and administrative obstacles were most prevalent for drug abusing criminal offenders after release from an institution (during the so called postcommitment phase). Traditionally, most State and local level correction programs have excluded narcotic offenders (drug abusers) from specialized treatment services run by corrections, such as prerelease programs, work furlough, halfway houses, and other treatment resources. There is a need to determine whether the problem pertains to restrictive policies, lack of communication, or other factors, so that appropriate technical assistance can be provided to accelerate the flow of rehabilitation services to drug abusing criminal offenders.

It was within this context that this study was commissioned.

## II. OBJECTIVES OF THE STUDY

This study addresses the following objectives as delineated by the Criminal Justice Branch, Division of Resource Development, of the National Institute on Drug Abuse:

1. Conduct a review of State policies regarding parole activities and programs to determine how current policy, procedures, or practices impact on drug abusing criminal offenders.
2. Review State release and parole practices to determine the kinds of assistance afforded addict offenders being released on parole to the community, placing emphasis on the written materials and counseling programs provided to releases and the extent to which they include NIDA treatment network capabilities.
3. Recommend appropriate strategies for the implementation of policies, procedures, and practices to increase the likelihood that parolee drug abusers are afforded the opportunity of early release to community based treatment programs. Wherever possible, a forecast of the impact of these policy changes on NIDA's community based treatment network will be included.
4. Identify and describe legislative, administrative, organizational, and other constraints that may require enabling legislation.

In order to accomplish this set of study objectives, the following operational tasks were completed:

- (1) Programs and practices regarding the addict or drug abusing parolee were identified through the State parole authority in many States. (See appendix A.)
- (2) An initial list of States was compiled for participation in the study.
- (3) Basic criteria were identified by which each State was assessed for site selection and subsequent visits.
- (4) Nine States were earmarked for inclusion in the study.
- (5) Agreement to participate in the study was secured from each of the nine parole authorities, the offices of parole services, the State drug treatment networks, and the nine Single State Agencies of drug abuse prevention.
- (6) The parole authority, parole services, and drug treatment programs were contacted to identify and describe activities and programs related to the drug abusing parolee. (See appendix B for details of the study methodology.)

(7) Site visits to each of the nine designated States were documented in individual reports.

(8) A final report for the study was prepared.

This study focused on State programs, policies, issues, and problems related to the parolee with a history of drug addiction or abuse. In some cases, the nature of the correctional organization combined probation and parole, so that it was sometimes difficult to separate the two for discussion purposes. In other cases, abuse of alcohol and other drugs were combined concerns of the SSA. In all cases, however, the site visit discussions focused primarily on the parolee and drug addiction.

### III. FINDINGS AND ISSUES

The findings of this overview and the report of the site visits to nine States were discussed in three phases as the incarcerated offender progresses to release on parole. These three phases were characterized by:

- (1) Institutional and/or prerelease drug treatment, preparation for parole readiness, and parole planning
- (2) The process of parole decisionmaking and the impact of that procedure upon postrelease drug treatment for the addict parolee
- (3) Parole supervision and simultaneous involvement of the parolee in community drug treatment.

These three phases were demarcated on the basis of their cumulative impact upon the addict parolee and on the basis of emergent issues that became apparent in each of the phases. Therefore, the findings and related issues were sequentially ordered and recorded accordingly, beginning with the prerelease phase, followed by the parole decisionmaking phase, and closing with the parole supervision and community drug treatment phase. These findings and issues were developed and summarized for the nine States site visited and are in no way meant to be generalized for the remaining forty-one States. The nine States visited were California, Georgia, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Virginia, and Wisconsin.

#### INSTITUTIONAL PROGRAMS AND PREPAROLE PLANNING FOR RELEASE OF ADDICTS

Drug treatment programs within correctional institutions were not operative in all nine States. The range of formalized program services varied from none in Wisconsin and Georgia, to a comprehensive four stage program in Ohio, to an entire institution devoted to the treatment of civilly committed addicts in California. Virginia and Rhode Island parole personnel indicated there were special programs or plans for programs in the offing. In New York at least two of 31 institutions for adult offenders reportedly operated specific programs for addicts, but time constraints prevented further documentation of these two programs.

Generally, the concepts of developing prerelease plans and establishing institutional parole representatives constituted the thrust of institutional drug treatment. These two program types were the mainspring from which much postrelease drug treatment for parolees was initiated. Therefore, institutional treatment for drug abuse was infrequently realized, but the referral process that precluded parolee involvement in drug treatment after release was begun prior to release, from within the institution. Insofar as this first effort to make referral originated while the offender was still incarcerated, the institution has been the environment in which the first of the three phases has taken place. The types of prerelease activities heretofore summarized are

described further in the following sections, closing with reports of examples of two comprehensive programs operating in Ohio and California.

### Prerelease Plans

All of the nine site visited States reported some process by which parole planning begins prior to the offender's release from the institution. Frequently, this planning involved the inmate, his/her assigned parole agent or an institutional parole representative, and an institutional staff person or counselor. The inmate generally developed or contributed to the development of his/her own release plan, with primary emphasis being on securing a job and a place of residence. In the case of some addict offenders, the planning process often included contact with a community drug program for future acceptance as a client. In Pennsylvania, the drug program staff frequently provided recommendations to the parole board with regard to an individual applicant's release and referral to community based treatment.

In Virginia, the development of a parole plan does not begin until after parole has been granted. The plan proposed by the inmate is then filed with a District Chief in parole services. In the case of the addict parolee, it was submitted to a screening committee for final review and recommendation to be delivered to the board for final approval. The most significant feature of this particular prerelease planning process was the composition of the screening committee, which included a variety of treatment program staff and the parole officer assigned to the case. The utilization of a comprehensive screening committee, with emphasis on participation by both treatment and parole representatives, has reportedly improved the likelihood of placing an addict parolee in the appropriate treatment modality. Most release planning processes were not this comprehensive, but the screening committee concept of Virginia was generated out of the referral process that affects the addict parolee in particular.

In Georgia, the parole board assumed responsibility for identifying the drug related problems and needs of individuals prior to their parole hearing. The administrative staff of the parole board investigated the feasibility of implementing parole plans and determined whether or not parole supervision (under the direction of the Georgia State Department of Corrections/Offender Rehabilitation) might fulfill the conditions of parole. Although the board staff carried out the investigation, they maintained coordination with the office of parole supervision. Board staff were responsible for investigating personal and social history and for recommending drug treatment as a condition of parole, if deemed necessary. After parole was granted, the office of parole supervision was notified and verified the manageability of compliance with the conditions of parole. Arrangements for carrying out the parole plan were then determined by parole supervisors.

### Institutional Parole Representatives

Pennsylvania and New Mexico placed Institutional Parole Representatives (IPRs) in some of their correctional facilities. IPR staff members are parole employees who are placed in institutions to provide prerelease information to the respective parole boards for case hearing reviews. Being institutionally



based staff, they provide an informational link between an offender's institutional history and his/her parole readiness for the parole board to review and consider. The information provided included some form of subjective assessment of the eligible parolee, a criminal history report, and other institutional documents and reports.

#### Plans to Implement Institutional Programs

Both Virginia and Rhode Island indicated they are currently planning to implement institutional programs.

- . Virginia. In Virginia, statistical summaries indicated that about 65 percent of the institutionalized population had a history of drug use. Although formal institutional programs were not known to the parole board, the screening committee concept was operative in two areas of Virginia which provided a multidisciplinary review and evaluation of inmate-devised parole plans prior to release. Both the Division of Probation and Parole Services and the parole board expressed their desire to see the eventual implementation of institution based services, and program plans are currently being developed.
- . Rhode Island. In Rhode Island's single correctional facility, the Adult Correctional Institution, program development was underway. A TASC-sponsored drug treatment program based on the therapeutic community concept and philosophy was to begin operating in early 1977. An onsite cottage, staffed with specially trained corrections counselors, supervises a small group of drug residents who are within six months of parole eligibility.

#### Other Programs

As mentioned earlier, two of the 31 institutions in New York have formalized drug treatment programs operating. Due to limitations of site visit duration, scope, and scheduling, no additional program information was obtained.

#### No Institutional Programs

Lastly, no formalized drug treatment programs appeared to be operative in any of Wisconsin's six correctional institutions for adult offenders, nor in any of Georgia's adult institutions.

#### Specific Examples of Institutional Drug Treatment Programs

- . California Rehabilitation Center (CRC). A California statute implemented a legal provision whereby addict offenders can be civilly committed for a zero to seven year term at CRC. The term usually consists of short term drug treatment, averaging less than one year in a nonpunitive, but

institutional setting. The statute delineates a systematic progression of addict offenders through inpatient and outpatient phases. The former phase occurs at CRC and the latter is contingent upon conditional release much like parole. Institutional programs at CRC include a variety of individual and group counseling activities, some of which operate similarly to a therapeutic community. A variety of vocational and educational programs are also offered at CRC and a unique tutorial program supplements the regular educational curriculum.

CRC represented the most specialized of institution based programs identified insofar as all its functions were directed toward treatment and rehabilitation of addict offenders. Staff reported that CRC currently maintains a male and female resident population of over 2,000, representing about ten percent of the incarcerated population in California. Offering a diverse array of services and programs in the context of a more or less open ended length of stay, CRC and the civil commitment provision typify the concept of treating addicts in lieu of incarceration.

Although 97 percent of all CRC referrals are convicted felons, some voluntary and self referrals do occur. Occasionally, after release to outpatient status, resumed drug use prompts the supervising parole officer to encourage voluntary return to CRC for short term treatment, known as limited placement.

Eligibility criteria for admission to CRC was limited to include only cases where there was no history of commercial narcotics sale; where there was no use of patterned violence, including the use of weapons; where previous criminality appeared to be chronic and unrelated to drug usage; and where repeated stints and failures at CRC appear not to have had personal impact on the addict.

Project KICK Drug Rehabilitation Program at Lebanon Correctional Facility. There were drug programs of some type at each of the eight Ohio correctional institutions. Within the correctional system, project KICK was considered the most sophisticated and comprehensive of the eight programs. It consisted of a four stage, developmental and incremental self improvement progression for inmates expressing interest in the program. The four stages were based upon principles of volunteerism, self determination, motivation, and contractual obligation. Program participants were closely screened by high level institutional staff prior to admission to Level I and prior to advancement to Levels II, III, and IV. Program attendance

and participation were basic evaluation criteria. As the participants progressed from level to level, they became increasingly involved in therapeutic activities, educational workshops, and presentations, and eventually facilitated group sessions as paraprofessionals. The earlier levels focused upon training activities, while the later levels became testing grounds for eventual autonomous group leadership and participation in institutional administration.

Although the program philosophy and practice was the most unique of Ohio's institutional drug programs, it was reportedly in danger of dissolving due to financial curtailment in 1977 and the limited availability of treatment slots. At the time of the site visit, there were 56 members at Level I, 59 at Level II, one at Level III, and none at Level IV. Another 54 applicants to Level I were recently rejected due to the unavailability of program slots.

#### PAROLE BOARD DECISIONS AND THE ADDICT

The process by which an offender's status changes from inmate to parolee was traditionally conducted in secret by a select group of citizens who convened on a regular basis to determine when to grant and when to deny parole. Parole boards were criticized most recently for the arbitrariness and unchecked discretion that characterized parole decisions. Few States have issued parole decisionmaking guidelines and boards were traditionally responsible only to the State Governor. Hence, the reasons for deciding whether or not to parole an individual were kept from the inmate. The site visit discussions with board members focused upon the factors that impacted on a board decision to parole or not parole an offender with a known history of drug abuse. In the nine States visited, none of the parole decisionmakers indicated a bias toward addicts with regard to parole denial. The issue of addiction or drug abusing behavior was not singularly a justifiable reason to deny parole. However, where that factor was one of a variety of other poor risk factors, parole boards indicated that parole denial was likely to follow the first hearing.

Beyond the decision to grant or deny parole, the decisionmakers have also taken a role in determining the nature of the parole supervision by delineating special conditions. For the addict parolee, the parole boards have not consistently specified participation in drug treatment as a condition of parole. Rather, the specificity of a drug treatment condition varied from case to case, as well as from board to board. In some instances treatment in general was a condition of parole, which necessitated the parolee and his/her parole officer initiating referral and placement to an appropriate treatment modality. The other extreme was evidenced by parole boards indicating that due to poor treatment program credibility, a particularly trustworthy and reliable treatment program would be named in the special condition to insure placement there.

In the nine site visited States the decision to parole or not to parole was not contingent upon an offender's past history of drug abuse or addiction. However, addiction was noted for parole board consideration insofar as special

conditions frequently addressed the drug problem by requiring some type of community based treatment. The following discussion, beginning with descriptions of the parole board organizational structure and operations in each of the nine States, will address the issues relative to parole decisionmaking more specifically.

### The Organizational Structure and Operations of Parole Boards

Among the nine States that participated in site visitation, five had parole boards which were autonomous bodies and four were under the aegis of other State agencies, including correctional or social service arms of State government. In all but two States the parole board members were appointed by the Governor for terms ranging in duration from three to seven years; in the remaining two States, Wisconsin and Ohio, board members were selected by the board chairperson for permanent service. In both States, civil service employment was a requirement of all board members. In Wisconsin, the chairperson was appointed by virtue of having been Deputy Secretary of the Department of Health and Social Services in that State; in Ohio, the chairperson was designated by the adult paroling authority in that State. Board autonomy contributed to the use of discretion among parole board members when making decisions and gubernatorial appointments frequently precluded and minimized accountability to the public as well as to the offender.

Six of the States had no specific statutory requirements regarding board membership; the two States (Ohio and Wisconsin) that recruit members from civil service rosters abided by those particular requirements; among the remaining States, Rhode Island alone specifically required members to be representative of professions such as medicine, law, corrections and/or social work. Even though specific requirements for board membership were generally not mandated, most parole board members were recruited from fields which appear to be relevant to their task, much like those required by Rhode Island statute. Experience in some area of the criminal justice system and "interest" in that field were consistently sought among board members, which was demonstrated throughout the nine States.

The size of parole boards varied from three to 12 members in the nine States, while the average membership was about six. The small boards with three, four, and five members functioned as a single unit, hearing cases and determining outcome on the basis of majority rule. The larger boards, such as 12 members in New York, ten in Wisconsin, and seven in Ohio, divided up into smaller two and three member hearing teams to decide cases. Generally, additional members became involved when the case being heard involved long term or life sentence reduction. Seven of the nine boards functioned on a full-time basis. Only the Rhode Island Parole Board and the Narcotic Addict Evaluation Authority in California operated on part-time bases.

Parole eligibility requirements varied from State to State, ranging from having served one-fourth to one-half of the maximum of an indeterminant sentence, to having met the criteria of a detailed eligibility listing which varied from sentence to sentence.

## Conditions and Factors Contributing to Parole Decisions

The following section is divided into three parts. The first, Conditions of Parole, describes the formal and statutorily defined conditions of parole as they pertain to addict parolees. The second and third sections, Other Factors and Parole Boards' Knowledge, are more informal knowledge bases that effect parole decisionmaking. These latter two sections describe factors with less direct, but nevertheless, crucial impact.

Conditions of Parole. In seven of the nine States there were conditions of parole relative to drug use, in that the parolee was required to abstain altogether from continued drug use. In Ohio, the conditions were very general and required compliance with all State, Federal, and local laws; in California, the terms of release were altogether different, since civil commitment defines the addict parolee as an outpatient. The outpatient was under supervision of Narcotic Addict Outpatient Program parole agents, subject to somewhat different conditions of release than the typical parolee. The outpatient was subject to comply with statutes like all other parolees prohibiting use of illicit drugs. In addition, s/he was required to undergo periodic urinalysis. All of the nine States developed provisions for "Special Conditions" to be appended to the standard list, though only the Georgia and Wisconsin Parole Boards chose to make infrequent use of that provision. In Georgia, the addition of special conditions was subject to the approval of the parole officer assigned to the case in question. The other seven States made varying use of the special conditions with regard to addict parolees, adding conditions that specified one of the following:

- (1) Nonspecified (i.e., any) drug treatment program involvement such that specific program selection and referral was left up to the discretion of parole officers and their clients
- (2) Designated involvement in a specific treatment program modality, such as outpatient methadone maintenance or six months residential treatment
- (3) Conditional release to a particular, named, and board approved program
- (4) Placement in a special narcotic addict parole supervision caseload.

. Other Factors and Information that Contribute to Parole Decisions. Since parole decisions were not shown to be influenced in a direct way by the offender's history of drug use, it was in an indirect way that this factor figured into the decision to grant parole. In other words, drug use in and of itself did not precipitate decisions to deny parole. However, once parole was granted, the history of drug use was addressed as an issue to be considered when special conditions were outlined.

Obviously a history of drug use must have been transmitted to the parole board in order for it to play a role in the listing of special conditions. As was indicated earlier, this information was frequently provided to the board by an institutional source. It took the form of a staff recommendation or it was integral to the inmate's parole plan as submitted to the board for review. Since diagnostic reports seldom accompanied case histories or institutional records, the origin of the drug use information was most often the inmate himself. Most of the information regarding drug use rates in institutions was derived from offender self reports and was seldom substantiated any further. Therefore, the history of drug use came to the attention of the parole board from sources of questionable reliability and authority. Occasionally, the first time that the offender's drug use was noted was at the parole hearing itself.

. The Parole Boards' Knowledge of Drug Use and Community Drug Services. Another area of information that has contributed to the delineation of special conditions for addict parolees is that of drug use itself and drug treatment services. None of the members of the parole boards in the nine States were required to have shown any expertise in special fields such as that of substance abuse. Yet, as was mentioned earlier, many parole board members were appointed on the basis of occupational or professional interests which frequently included medical or health related professions. Once appointed, however, board members throughout the nine States were not required to undergo additional training or counseling for special topics relative to parole, such as drug abuse. Board members were selected for their respective contributions to the pool of board expertise and that rationale precluded any inservice training or skill building.

In Rhode Island, the supervisory parole staff noted with regret the obvious pitfalls of fixed special conditions for drug using parolees which made no differentiation between the drugs used. Similarly, this limited view of drug abuse by parole board members resulted in unnecessary referrals to treatment modalities through the special conditions provision. In other States, parole officers felt that occasionally an uninformed or overzealous parole board has taken upon itself a diagnostic and referral role without having a sufficient body of knowledge with which to prescribe treatment. Most parole boards suggested that there is a trend toward generalizing special conditions with regard to drug treatment, thereby transferring the



Table 1

Summary of Parole Authority Activities, Composition  
and Other Characteristics in Nine Selected States<sup>1/</sup>

Characteristics	California <sup>2/</sup>	Georgia	New Mexico	New York	Ohio	Pennsylvania	Rhode Island	Virginia	Wisconsin
Organizational Context	Antonomous	Antonomous	Antonomous	Department of Correctional Services	Department of Rehabilitation and Correction	Antonomous	Department of Social Welfare	Antonomous	Department of Health and Social Services
Board Appointment	Governor	Governor	Governor	Governor	Department of Rehabilitation and Correction Chief of Adult Parole Authority	Governor	Governor	Governor	Secretary, Department of Health and Social Services
Size of Board (Number Member Appointment)	4	5	3	12	7	5	5	5	10
Length of Board Member Appointment	4	7	3	6	Permanent	6	5	4	Permanent
Type of Board Appointment Full-time (FT), Part-time (PT)	PT	FT	FT	FT	FT	FT	PT	FT	FT
"Special" Requirements for Board Membership <sup>3/</sup>	None	None	None	None	Yes <sup>4/</sup>	None	Yes <sup>5/</sup>	None	Civil Service
Number of Cases Heard	Approx. 14,000-15,000 per year	Approx. 400-500 per month	150-200 per month	9,808 per 1975 <sup>6/</sup>	Approx. 6,223 per 1975	4,105 per FY 1974	414 per FY 1976	NA	Approx. 3,500 per Year

Table 1 continues.



Table 1 (Continued)

Characteristics	California	Georgia	New Mexico	New York	Ohio	Pennsylvania	Rhode Island	Virginia	Wisconsin
Involving Drug Usage	100%	20%	NA <sup>7/</sup>	56% based on 1974 parolees	NA	NA	NA	NA	NA
Referral to Treatment	Special Condition Only	Special Condition (Andromeda)	Occasional Board Referral	Special Condition Only	Special Condition	Special Condition Only	Special Condition Only	Special Condition Only	Special Condition but Seldom Used

<sup>1/</sup> This table is presented as a visual condensation of material in this section. Because no comparative data were obtained from States, it is not meant to infer relationships across States.

<sup>2/</sup> All information in this table for California refers to the Narcotic Addict Evaluation Authority.

<sup>3/</sup> Most States do not require special qualifications. However, all States had requirements such as board members must not have other business, hold political office, hold positions in a political party, etc.

<sup>4/</sup> Qualifications by education or experience in correctional work (law enforcement, probation, parole), in law, in social work, or in a combination of these three.

<sup>5/</sup> A physician (psychiatry, neurology), a member of Rhode Island bar, and one professionally trained in correctional work or closely related field.

<sup>6/</sup> Case heard from the New York State Correctional Institutions only.

<sup>7/</sup> No figures given but was estimated to be a "high" percent.



responsibility for referral to the supervising parole officer. Only in cases where program availability was limited or where many programs were of reputedly poor quality, did parole boards actually require explicit placement by means of adding a specific program condition to parole.

Related to the issue of spelling out special conditions was the board's knowledge of existing community drug treatment services. Parole boards appeared to have obtained most knowledge of treatment through parole agents. In a few cases, drug programs contacted the board for advertising and to solicit referrals. But most members indicated that they preferred to relinquish the task of referral to parole officers. They suggested that this approach was appropriate because the officers have the advantage of knowing more about a particular parolee and of having more contact with and knowledge of available programs and services. Therefore, although the decision to parole or not to parole the addict offender was the responsibility of the parole board, the delineation of special conditions relative to drug use was approached cautiously throughout the nine States. Board members recognized their limitations to the extent that they recommended treatment but preferred not to designate treatment programs by name. Where specific programs were cited in special conditions, the board added that its decision could be changed should a parole officer suggest a more appropriate alternative. Some parole plans submitted for board review included a request or recommendation for specific placement. In these cases, parole boards characteristically incorporated that program into special conditions, consistent with the plan outline.

With respect to the board providing information or written materials about drug treatment to parolees, it became evident that this generally took place prior to the parole hearing or soon thereafter. The offenders learned of drug programs while devising parole plans with institutional and treatment staff before release, or they became involved in the selection process after release, in conjunction with the parole officer. Most frequently, parole officers seemed to be the source of information regarding treatment availability and services for the parolee, rather than the parole board.

Finally, parole boards do not customarily become involved with parolee followup unless parole violation and revocation proceedings have been initiated by the supervising parole officer. Table 1 provides summary information related to parole authority activities, composition, organization, and conditions of parole.

#### TREATING THE ADDICT PAROLEE

##### Identification of the Need for Treatment and Finding Treatment Programs

The process of identifying the drug addict in the criminal justice system has not been empirically well developed. The label of "addict," although widely used throughout that system, has not been authenticated in many cases by medical diagnosis. However, the user history has been noted in presentence investigation reports; it has been reaffirmed by classification staff in correctional institutions; and it surfaces again at parole hearings. Frequently all of these reports have relied upon little more than the offender's self

report at each juncture of the system. By the time the information has reached the parole officer who is assigned to supervise the addict on parole, the question of addiction is no longer a question but has achieved the status of undisputed truth. Although this identification procedure has not necessarily been conducted in a scientific or medically professional manner, the history of drug use or addiction has characteristically been identified early in the criminal career and is frequently highlighted throughout the offender's involvement with the criminal justice system. An informal grapevine has emerged as a predominant conduit of information regarding drug use among offenders. In all but one of the nine States, the criminal justice system grapevine and its attendant records, reports, and files provided the chief source of drug use information relied upon by parole officers. Another source, the primary source for all drug history, was the offender himself. In California, the identification procedure occurs with greater sophistication and authenticity. This was attributed to the civil commitment procedure which applies only to addicts or abusers who have been diagnosed by one or two medical doctors.

Among the most significant findings regarding the involvement of addict parolees in community based drug treatment programs were that:

- (1) Referrals to treatment occurred through various and sundry channels
- (2) They were obtained through an equally varied array of sources.

Parole boards assumed the most passive role of all the relevant parties in terms of their referral activity. Most often when parole boards recommended treatment they left the task of actual referral and placement up to the supervising parole officer and the parolee.

The parolee and the parole agent became familiar with the available drug treatment resources in a given community in a number of ways. Without exception, parole officers have transmitted information about programs to each other, maintaining a fairly healthy internal grapevine. In addition, community health agencies, and/or Single State Agencies, have compiled and distributed drug treatment program directories to all agencies of the criminal justice system, including parole offices. In some instances inmates were responsible chiefly for developing their own parole plans. Institutional staff also provided a viable source of program information. In some cases, inmates actually established the initial contact with programs to which they hoped to be referred. Other sources of program information were transmitted to parole officers through the news media, through deliberate outreach and client seeking efforts by newly established programs, through formalized parole officer staff meetings, and, although infrequently, through parole board recommendations.

A screening committee currently operates in conjunction with Virginia parole officers and includes representatives from the local programs. This committee functions as a resource for parole plan review and for recommendations regarding placement in treatment programs. Two other unique sources of

program information are:

- (1) The Community Resource Fair held four times annually at the California Rehabilitation Center, whereby community agencies seek out future clients from within the institution, enabling inpatient initiated program contacts.
- (2) A recently created Resource Staff Position in the Los Angeles office of the Narcotic Addict Outpatient Program, where parole officers can find detailed, up to date, and objective assessments of the available community drug treatment resources, designed to free officers of the overwhelming task of constant program evaluation.

In only one of the nine States, New Mexico, was there a stated shortage of treatment slots. Although this situation was changing, the parole board and parole officers were hesitant to refer parolee clients to programs with less structure and supervision than that inherent in a residential program or therapeutic community. Since those particular programs were extremely limited, addict offenders were sometimes denied parole, not on the basis of their institutional behavior, but because, by the board's admission, there were no adequate halfway house type facilities to release them to. In some cases, these parolees were placed in long term programs in neighboring States.

#### Parole Supervision and Treatment

##### Parole Officers' Assessment

- Overview. Parole officers throughout the nine States seemed confident of their knowledge of drug abuse, of recognizing the symptoms of drug use, and of the stressful life situations that were likely to precipitate resumed drug usage. In most cases, the parole officers underwent some form of special training regarding drug use and addiction. The training usually focused upon the pharmacological and epidemiological aspects of drug use. In only a few cases do parole officers undergo extensive or ongoing training in drug abuse that includes special counseling strategies and techniques, such as crisis intervention.

Most parole officers have learned about the local drug programs from having parolees referred to them. New programs have traditionally introduced themselves to parole officers by means of literature distribution and personal contact. Occasionally, programs have come to the attention of the parole officer through the parolees who are familiar with programs in their communities. In any case, the programs relied upon most heavily have demonstrated to the parole officer that the services offered are adequate, that the personnel are trustworthy

and qualified and that some measure of client success has been realized. It was especially important to parole officers to have developed a good rapport and open communication with treatment staff in drug programs, a relationship which seemed to evolve as programs matured and stabilized.

- Special Caseloads. Of the nine States site visited, five of them (California, New York, Ohio, Pennsylvania, and Virginia) operated formalized and separate parole supervision units for the addict parolee. New Mexico has attempted to conduct addict supervision in a special manner, with little success, but the program was reported to have been premature and shortsighted. Georgia and Wisconsin have developed informal special assignment procedures whereby addict parolees are more or less clustered in caseloads. Parolees were deliberately assigned to particular parole officers based on their demonstrated ability and expertise in supervising addicts and referring them to drug treatment programs. The remaining State, Rhode Island, due to the size of its parole supervision unit (five officers throughout the entire State) neither formally nor informally assigns addict parolees to special caseloads.

The primary distinctive characteristics of "special" addict parolee supervision are listed below:

- (1) Caseloads are comprised entirely or almost entirely of parolees identified as having a history of problematic drug use or addiction.
- (2) Special caseloads are usually smaller than the regular assignment, restricted by statutorily defined upper limits, for closer and more intensive supervision.
- (3) Parole officers of special units have usually undergone some degree of specialized training in addition to the regular orientation, varying from extremely limited to fairly sophisticated training programs.
- (4) Parole officers take on the increased supervisory task of collecting urine samples and/or conducting urine testing for addict parolee cases.

With regard to caseload sizes, the prevailing mark of distinction for special caseloads, the five States with formalized special supervision units for addict parolees ranged from a low of 30 cases per officer to a high of 50 cases, with ceilings prescribed for those units. As a result of this limitation, designed to enhance closer supervision, some sort of case selection process must ensue. In most situations a large group of addict parolees were not able to be added to existing special caseloads but spilled over into so-called "regular" caseloads. It has been observed that as many as 50-60 percent of all parolees in a given jurisdiction could benefit from placement in a special caseload for addicts, whereby as few as ten percent of those identified as "at risk" were ultimately placed under special supervision.

Regular caseloads, on the other hand, were larger and officers were not necessarily trained to deal with addicts. These caseloads ranged from 40 to 120 parolees per officer, with an average of 65 per officer. In some instances, this was about twice as large a caseload as the special caseloads of addicts. Urinalysis was usually used at the discretion of the supervising officer rather than as a standard tactic for closely supervising the addict. Parolee involvement with community drug treatment programs was also largely a matter of officer discretion. But even regular parole officers suggested that more supervision was advisable for the addict, and drug programs frequently provided that additional coverage if only through urine testing. Table 2 summarizes the information regarding parole supervision in the nine selected States.

Table 2

Summary of Information Related to ParoleSupervision in Nine Selected States<sup>1,2/</sup>

Characteristics	California	Georgia	New Mexico	New York	Ohio	Pennsylvania	Rhode Island	Virginia	Wisconsin
Organization	Department of Corrections	Department of Corrections Offender Rehabilitation	Department of Corrections Probation and Parole Supervision Division	Department of Corrections Services	Adult Parole Authority, Department of Rehabilitation and Corrections	Pennsylvania Board of Probation and Parole	Department of Social Welfare	Virginia Department of Corrections	Department of Health and Social Services
Specialized Drug Units Operated	Narcotic Addict Outpatient	Not Formalized <sup>3/</sup>	No	Narcotic Treatment Unit (NYC)	Specialized Drug Treatment Officer	Drug Unit	No	Drug Specialists	Not Formalized <sup>3/</sup>
Caseload Size of Special Units	32	--	--	35-40 (NYC)	30-40	40-50	--	50	--
Special Training for Specialized Units	Yes	--	--	Yes, some	Limited	Some	--	Yes	--
Urinalysis in Specialized Units	Yes	--	--	Yes, limited	N.A.	Yes	--	Yes	--
Caseload Size of Nonspecialized Units	--	118-120	60-70	--	Average about 65	Average about 65	60	60-70	40-60
Approximate Percent of Regular Caseload with Drug History	--	12-15	50		--	--	75	--	10

<sup>1/</sup> Same as footnote in Table 3.<sup>2/</sup> Parole supervision visits were made in the following cities only: Los Angeles, San Francisco, Atlanta, Albuquerque, New York City, Cincinnati, Columbus, Philadelphia, Providence, Richmond, Madison, and Milwaukee.<sup>3/</sup> Assignments are made to special officers.





#### IV. ASSESSMENT AND IMPLICATIONS

##### INTRODUCTION

The major issues and problem areas were introduced in the preceding section. The following discussion addresses those issues in the context of a limited assessment and briefly considers the implications for NIDA and the SSAs.

Based only upon the information obtained from the nine site States, five major issues were identified. These included:

- (1) Problems over the interpretation and application of client confidentiality regulations
- (2) The quality of drug treatment programs
- (3) The need for programs for incarcerated addicts
- (4) The need for better statistics and historical information about incarcerated addicts and addicts on parole
- (5) The limitations of special parole caseloads for addicts.

Additional minor issues were identified by some of the site contacts, although they were not as predominant as the first five listed here. The closing section contains a description of the remaining issues and their implications.

##### INTERPRETATION AND APPLICATION OF CLIENT CONFIDENTIALITY REGULATIONS

The most consistently raised issue with respect to parole and drug treatment participation by addict parolees revolved around conflicts and confusion over client confidentiality regulations. Without exception, the task of supervising parolees has been confounded by parolee participation in drug treatment programs in all nine States. In some cases the problems have been overcome and minimized over time, but confidentiality issues remain in the limelight, exemplifying both a potential and an actual conflict of interests.

The common denominator of confidentiality problems has been determined by both parole officers and treatment staff to be largely attributable to miscommunication and confusion over interpretation of the regulations. Treatment program staff adhered to the regulations so strictly that they simultaneously interloped with parole officer functions. The manifestation of the confidentiality dispute has developed around the traditional differences that exist between the law enforcement/custodial and treatment/rehabilitation models of offender supervision. Most clearly identified in the institutional setting, this philosophical and practical distinction was also apparent in the supervision of parolees who were involved in drug treatment outside the institution. Not only were parole officers perceived by parolees and treatment staff alike as representatives of law

enforcement, but parole officers perceived treatment staff in the role of client protector. They frequently blamed treatment staff for undermining parole supervision in the name of confidentiality. The parolee was consequently subject to two distinct sets of rules, both of which were identified as a source of the parole and treatment conflict and confusion.

A corollary of the confidentiality issue was that many drug treatment programs were initially established and staffed by exaddicts and/or exoffenders. The "in group" nature of this kind of staffing pattern contributed to the strained relations with parole officers, who had experienced the application of confidentiality regulations as a tool for keeping the clients out of their reach. Instances of unreported runaways and irregular reporting of urinalysis results increased the level of distrust that existed between the two systems. The guise of confidentiality gave credence and legitimacy to the old inmate code of behavior that prescribed internal secrecy and negatively sanctioned "ratting."

The relationship with the parole community in most of the nine States has improved substantially now that many drug treatment programs have become more mature and more professionalized. In addition, programs have developed staffs comprised of both paraprofessionals and professionals. They have also relaxed the stringency with which they apply confidentiality protections in order to attract more criminal justice referrals. In addition, parole officers have undergone an image change, posing less of a legal threat to programs and their parolee clients. Officers have demonstrated their encouragement of parolee participation in drug treatment by exercising greater tolerance and laxity when positive urine tests are reported, by participating with their parolees in some treatment program activities, and in at least one locale, by serving as treatment program board members.

In sum, although the confidentiality regulations have highlighted a traditional difference in philosophy between parole supervision and drug treatment, in some cases a new level of trust and cooperation has begun to emerge. A more realistic and less literal application of confidentiality regulations has been instituted, sometimes aided by formalized release of information forms. Most often, the informal development of individual relationships between parole officers and treatment staff personnel has superseded the conflict of interest over confidentiality.

Implicit in this resolution are possible solutions for other States that are experiencing similar difficulties. It should be encouraging that the dispute over confidentiality seems to have been endured by most of the nine site States, even though related problems continue to surface.

#### QUALITY OF DRUG TREATMENT PROGRAMS

Although confidentiality obstacles may have lessened to a large extent, parole officers and parole board members in all nine States were universally interested in improving the quality of programs, even to the extent of having licensing and staff credentialing procedures.

In one locale, the parole division recently created a staff position for the purpose of providing parole officers with program information. A single individual collects and updates information on quality assessment, program personnel turnover, program philosophy and reputation, and general program evaluation of the local service providers. As staffing patterns have become more mixed, with concomitant movement toward professionalization and program maturation, concern over quality has centered more upon improving overall aspects of service delivery. The SSAs and NIDA might best promote criminal justice utilization of treatment programs and services by acting to insure that programs provide quality care.

Residential programs modeled after the therapeutic community concept were identified by parole agents in the selected States, since they offer the most comprehensive type of addict supervision. Admittedly, residential programs were not perceived to be appropriate for all clients. But where treatment program shortages or referral limitations were noted, it was largely attributable to too few or no residential slots. Parole agents frequently cited specific residential programs among those they preferred for their parolee clients based on their personal experience and/or the experiences of their clients.

#### THE NEED FOR INSTITUTIONAL TREATMENT PROGRAMS

In the nine site States there were few formalized drug treatment programs functioning inside correctional institutions. With few exceptions, prisons that are currently operating in the nine site States were not providing formalized comprehensive drug treatment rehabilitative services while the addict was incarcerated. The few exceptions were described in the preceding section of this report (pp.7-8). Most criminal justice personnel contacted during this study, as well as the drug treatment service providers, were not only aware of this problem but also suggested that institutional program development was high among priority needs. According to the institutional, parole, and treatment staffs, the lack of institutional programs has impacted on the parolee by disrupting any semblance of continuity of care for addict offenders. Many parolees have been involved in treatment as juveniles or probationers prior to incarceration and become reinvolved subsequent to release from the institution. The fact that many institutions do not have drug treatment programs has been highlighted, because this disrupts pre- and postinstitutionalization treatment efforts.

The philosophy and operation of the California civil commitment process represented one of the exceptional State's responses to the problem of discontinuity of care. As indicated earlier, this process has incorporated inpatient and outpatient phases of treatment through institutional supervision at CRC and parole supervision through the NAOP (pp.7-8). Continuity of drug treatment programming and care has apparently been achieved through the application of this model.

The implications of this gap in providing continuous care are twofold. First, the corrections component of the criminal justice system has been very reluctant to introduce treatment programs to the incarcerated offender.

Federal encouragement from LEAA, perhaps in the form of appropriate funding priorities, might provide the incentive to develop more emphasis on implementing institutional treatment. Secondly, the SSAs have sensed much frustration over this issue and could eventually take a lead role in a program or providing technical assistance, with the joint endorsement of LEAA and NIDA. Philosophy and funding have provided the greatest obstacles to developing treatment programs in the institution, and both State and Federal agencies could conceivably alleviate some of these problems by setting administrative level examples and precedents.

Other consequences of there being limited institutional drug treatment programs are:

- (1) That some type of selection procedure has been enacted to determine which of the many addicts will be eligible for the few treatment slots.
- (2) That the nine parole boards frankly admitted they favor offender involvement in institutional programs, or they would if many were available; their decisions are often influenced by institutional program involvement. The nine parole boards did not indicate any discriminatory bias with regard to subjecting addicts to more stringent parole readiness criteria than that used for other nonaddict cases. However, it became apparent that those offenders who were not able to avail themselves to one of a limited number of institutional treatment slots may in fact have not been reviewed as positively as the handful of offenders who gained entry to such programs. It was indirectly suggested by some board members that noninvolvement in programs did not enhance favorable parole review in the same way that program participation did. By default, those addict offenders who could not (or refused to) participate in an institutional drug treatment program were at least indirectly subjected to parole case review without the added advantage of having been involved in an institutional treatment program. Increasing the availability of treatment throughout the institutional setting, perhaps with NIDA and/or LEAA support, would diminish the possibility of inadvertent parole board bias.

#### THE NEED FOR INFORMATION ABOUT THE INCARCERATED ADDICT AND THE ADDICT ON PAROLE

A major obstacle to thoughtful planning is that there are few accurate and well documented incidence and prevalence reports in the nine States, reflecting the extent to which prison inmates have been involved with drugs. A consistently and frequently reported complaint was that:

- (1) Not only were such data largely unavailable, but

- (2) In the few instances where institutions provided such data, it was of negligible quality due to cursory diagnostic and classification procedures and the reliance upon inmate self report.

Consequences of not having access to accurate incidence and prevalence data has limited the planning process, because:

- (1) Institutional staff did not have adequate means for assessing offender program needs, much less the means for meeting those needs
- (2) The parole community was not able to develop insightful planning procedures for involving parolees in community based drug treatment programs
- (3) Neither the parole community nor the drug treatment programs were able to commit themselves and their services to the population at risk, because that population is estimated to range from 20-90 percent of those institutionalized.

Parole board members frequently found themselves in the position of having to make parole release decisions on the basis of a limited amount of information. Although all nine State boards utilized a variety of reports and historical summaries about the offender coming before them to make a parole determination, information about drug problems or past drug involvement was reported to be highly subjective. The information was oftentimes derived from sources who were not qualified to make such assessments and the reports seldom included frank accounts of the extent to which an inmate had continued to use drugs while incarcerated. Since drug use was only one of many factors considered by parole boards at eligibility hearings, it may have been that accurate drug-related information was not singularly crucial to parole decisionmaking. However, this issue also reemphasized the overall lack of drug use incidence and prevalence data which continues to frustrate those professionals who are ultimately responsible for addict parolee clients. Board members did, in fact, express a need for more reliable institutional information, if for no other reason than to reduce the margin of error that is possible when making uninformed decisions. Furthermore, parole boards were also well aware of an undocumented but reputedly high level of drug involvement by incarcerated offenders, and they wanted indicators that would enable them to better define that usage pattern. Again, the implication was for NIDA and LEAA to endorse projects, perhaps through joint funding or other administrative activity, designed to provide this data for planning and informational purposes.

#### LIMITATIONS OF SPECIAL CASELOADS

Special caseloads, in the five States where they are operative, were lauded by boards for the utility of the specialized service they provide for addict parolees. There were, however, a limited number of special slots available to which addicts could be assigned. The intentional and necessarily restrictive

limits placed on caseload sizes have resulted in a selecting out process, since there are not enough spaces for all addicts. Rough estimates have been made, suggesting that probably only about 10 to 20 percent of all drug abusing or addicted parolees are currently under special supervision. The SSAs and NIDA could be reaching more addicts who are involved in the criminal justice system as parolees, by endorsing special caseloads and by interfacing with the appropriate criminal justice agencies.

Referral to special caseloads was initiated by the parole board in most cases, and it became apparent that some exercise of discretion was used to determine which parolees ultimately get referred to special caseloads. Where special caseloads existed, they were nevertheless only partially successful in addressing the needs of addict parolees simply because they were severely constrained by insufficient staffing. Additional subjectivity was used by the decisionmaking board members who had to determine and project which parolees were most likely to benefit from special supervision or were least likely to fail parole without it.

In a related manner, the nine States varied to a great extent in the degree to which they resorted to using the special conditions option for requiring parolee participation in drug treatment. In a few cases, boards indicated that they would rarely add special conditions; in others, conditions took on the character of a program referral; and in still other cases, parole officers were left with an open ended "treatment" condition, to be acted upon according to their assessment of the case. Parole agents seemingly preferred the greater latitude afforded them by this last option, and parole boards also preferred to exercise flexibility rather than specificity in the referral process. Occasionally, board members indicated that they could make a specific treatment recommendation in the form of a parole condition, but generally they appreciated and respected the parole officer's capacity to better assess and adapt a parolee's treatment needs to appropriate placement.

Drug treatment programs, SSAs, and NIDA might best direct their energies toward enabling parole officers to increase their knowledge about existing treatment resources. On the other hand, LEAA or other appropriate criminal justice agencies might endorse programs designed to enlighten parole boards with respect to the availability of community based treatment.

With special addict caseloads in some parole divisions, the process for referring addicts to treatment has become more centralized and professionalized. However, at least two problem areas have become apparent. First, the earliest of special addict caseloads (created in the early to mid-1960s) began with adequate numbers of officers, extensive special training programs and recruitment procedures, and were frequently afforded supplemental services such as part-time psychiatric and toxicologic staff expertise. At this point, most of the caseloads are filled to capacity, the number of training programs have diminished, officer recruitment practices have become less competitive and supervisory tasks are increasingly co-opted for paperwork and investigatory duties. In short, the concept of special caseloads is still intact and operative, but the units reportedly have not been able to maintain the initial level of qualified personnel and services. Budgetary constraints were most

often blamed for the deterioration of services and the reduced amount of training. Parole officers in the selected States indicated they must rely upon cursory inhouse training programs or invest their own time and resources into seeking out pertinent coursework and training workshops.

Second, subsequent to filling special caseloads, a large group of addict parolees have been assigned to regular caseloads where officers are less attuned to drug problems and are sometimes altogether opposed to drug treatment for parolees. The spillover to regular caseloads is the result of some sort of arbitrary selection process and is used to determine which addicts should be specially supervised. Another effect of having addicts in nonspecialized caseloads (where special caseloads are operative) is that the potential for discouraging parolee involvement in drug treatment programs is increased. Furthermore, nonspecialized officers are not as well acquainted with community resources available to the addict nor have they actively developed good rapport with local program staff.

### OTHER ISSUES

The major problem areas and implications have been briefly discussed. In closing there are several other issues, not as universally expressed in the nine States visited as those cited up to this point, but nevertheless important.

#### Unemployment

Unemployment is a pervasive problem for all parolees, and is an additional one for the addict parolee. Parole agents report high unemployment rates for their addict clients and feel that the chances for successful completion of parole are greatly diminished by this burden. Even enrollment in vocational rehabilitation programs provides negligible encouragement, because it merely postpones the eventual frustration that most addict parolees sense when confronted with dim job prospects. Finally, addicts are generally not highly skilled in either occupational or social conduct, unfamiliar with job application procedures and inhibited by low self esteem and uncertainty about their employability. The development of job application skills in conjunction with formalized vocational training was an identifiable program need area. However, the parole officer also realizes that job security is no panacea for solving all problems faced by addict parolees.

Unemployment among addicts is a problem area that SSAs and NIDA should specifically address. It would seem appropriate for them to consider encouraging policy and program development with other Federal and State agencies and programs, such as the CETA and Manpower Development projects under the auspices of the Department of Labor. The problem of unemployed addicts could be addressed by NIDA and the appropriate labor agency, much like the interfaced planning and programming that has been developing with LEAA for addict offenders.

#### Short Term Detention

A second problem area identified was the dilemma faced by parole officers who know by sight or by urinalysis that a parolee has been using narcotics,



but who do not feel it is necessary or even advisable to initiate revocation proceedings by reporting the violation. Parole officers in this study generally tolerated a few technical deviations, particularly with respect to drug usage, before they resorted to reporting the violation. One of the reasons for this approach might be attributed to the severity of the outcome of revocation. Many officers felt it was not always in the parolee's best interest to be returned to prison for what may well have been a singular incident or what may have represented a response to the culmination of problems faced by the parolee. They felt the parolee should at least be given the chance to "clean up" on his/her own initiative. Parole officers preferred short term detention for drug-related violations, regarding this as a less drastic alternative to reimprisonment, but a necessary stopgap measure. Crisis intervention, short term detention and detox, and other programs similar in concept to California's Short Term Stress Units were recommended as possible alternatives to the more formalized revocation and return to prison syndrome. These suggestions might provide NIDA and the SSAs with ideas for further program development for addicts on parole based upon the short term detention model.

#### Limitations of Program Referrals

In a few of the site States, program referrals are limited by the lack of fiscal resources allocated for subcontracting drug treatment services for clients referred from the criminal justice system. In other States, programs are concentrated in few or distant metropolitan areas. Parolees were subsequently placed in the metropolitan areas for treatment, rather than in their home community. Trading off drug treatment for return to home and family concerns many parole officers, because it defeats part of the very purpose of parole.

In at least one State with this problem, the Single State Agency responsible for drug programming recently became part of the State mental health network, which enables statewide service delivery through the existing regional mental health centers. It has been observed that inappropriate, distant, or remote placement in treatment oftentimes results in addict parolees absconding. This obviously jeopardizes both drug treatment and parole. NIDA and the SSAs could address this problem by developing a wide array of program alternatives in areas with limited options, by expanding program reach to rural service areas, and/or by developing placement alternatives based on compromise with corrections and parole authorities.

#### Program Versus Jail

The length of treatment program residency has created a problem in areas where the duration of the treatment plan competes with the length of jail time for some sentences. Currently, when a parolee violates parole, the "choice" between drug treatment and jail time is no choice at all because some program commitments exceed jail sentences. Especially in cases where a parolee has resumed drug usage, parole officers sometimes suggest or insist upon drug treatment program participation in lieu of the inevitable return to the institution. However, when the treatment alternative requires an 18 month to 2 year residency commitment and the term of reincarceration is far shorter, the parolee typically chooses to spend the time in jail. The duration of

commitment to treatment program participation should be comparable to the sentence under consideration. Perhaps NIDA could assume the role of lead agency in an effort to ascertain sentence lengths or the average duration of return to prison stays for parolees who technically violate conditions of parole. This would seem to be especially important for cases where the technical violation is drug-related, since a treatment program alternative would be an appropriate recourse to returning the parolee to the institution. If the discrepancies between long term treatment programs and sentence lengths could be identified and empirically documented, SSAs and/or drug treatment programs could devise a more suitable range of programs or they could incorporate more flexibility among existing programs.

### Changes In Program Clientele

Marihuana law changes and the increasing use of diversion programs have impacted on both correctional institutions and parole. The current group of offenders are increasingly being committed for more violent offenses than was the case prior to these changes. Parole officers and treatment programs alike have reported that the clientele they are supervising and treating have generally been "tougher" clients. Therefore, parole officers have become more concerned with the intensity of treatment programs insofar as they provide a surrogate level of parole supervision. For program personnel, this change in clientele has implicitly effected normal operation of programs in that some have developed client eligibility criteria that exclude exoffenders who have committed violent crimes. In addition, an almost custodial function has been added to the routine treatment activities. To some extent the resultant changeover of clientele, from middle class and student marihuana smokers to more hard core narcotic addicts, has necessitated the creation and expansion of longer residential or therapeutic programs to dually treat and supervise criminal justice system referrals.

### Urinalysis

Many questions have been raised regarding the accuracy of urinalysis and, hence, its utility as a monitoring technique. Parole agents have experienced varying degrees of success with urine testing labs, occasionally detecting false positive or false negative results by virtue of "loading" the sample submitted for testing. The margin of error is usually small, but it causes concern among those officers who have had experiences with error. An additional concern is the tightening of parole budgets that preclude or curtail extensive urine testing. Lastly, some officers question the utility of testing simply because they feel that nothing short of constant testing ensures close monitoring of drug usage.

Parole officers and treatment personnel alike have become skeptical about relying on test results, and, therefore, they also rely on personal contacts with addict parolees to determine resumed dysfunctional drug usage. NIDA should consider initiating an empirical assessment of quality and cost benefit analysis of urine testing programs that are supported with Federal funds.

## V. RECOMMENDATIONS

Based on the assessment and implications of the results of this research, recommendations for further research or implementation have been generated for each of the previously mentioned issues: interpretation and application of client confidentiality regulations, quality of drug treatment programs, the need for institutional treatment programs, the need for information about the incarcerated addict and the addict on parole, and limitations of special caseloads.

### INTERPRETATION AND APPLICATION OF CLIENT CONFIDENTIALITY REGULATIONS

Regarding client confidentiality regulations the following recommendations are suggested by this research:

- . Determine the purpose of confidentiality rules and regulations as they apply to the parolee and his/her participation in drug treatment.
- . Examine the problems concerning miscommunication and confusion by parole officers and treatment staff over interpretation of the regulations and design strategies for reducing such problems.
- . Examine the attitudes, perceptions, and problems of parole officers regarding treatment programs staffed by ex-addicts and/or ex-offenders.
- . Determine the optimal mix of professional and paraprofessional staffing of treatment programs and the impact on anticipated treatment outcomes.
- . Encourage the treatment and parole staff to act jointly in the interest of treatment for the client through greater communication and interaction (both formal and informal).

### QUALITY OF DRUG TREATMENT PROGRAMS

Recommendations concerning the quality of drug treatment programs include the following:

- . Identifying the quality dimensions of drug treatment for monitoring purposes and for selection by parole supervision.
- . Considering the costs and benefits of licensing and credentialing procedures.

- . Providing a centralized source regarding program information including location, sponsor, program philosophy, client characteristics, and treatment methodology.
- . Considering the development of quality standards that can be easily interpreted by parole supervision in guiding choice of program and providing overall criminal justice utilization.
- . Determining the types of treatment programs currently utilized or preferred by criminal justice personnel.

#### THE NEED FOR INSTITUTIONAL TREATMENT PROGRAMS

Recommendations addressing the need for drug treatment facilities within the correctional setting include:

- . Provision of needs and guidelines for the development and implementation of drug treatment programs in the institutional setting.
- . Determining the impact of the institutional based program (or lack of program) on the pre- and postinstitutional treatment efforts.
- . Combining efforts from NIDA and LEAA through Federal funding to induce more emphasis on implementation of institutional based treatment.
- . Considering a lead role taken by the SSAs to encourage program development and/or provide technical assistance and extend the purpose of such programming to parole boards and parole officers.
- . Determining the optimal number of institutional based programs, their locations, and eligibility requirements.

#### THE NEED FOR INFORMATION ABOUT THE INCARCERATED ADDICT AND THE ADDICT ON PAROLE

Information on the incarcerated addict and the addict on parole is an essential element of successful program planning and evaluation. Recommendations concerning addict data include:

- . Developing plans for the collection of incidence and prevalence data reflecting drug involvement among prison inmates.
- . Developing plans for use of such data to assist in planning and for informational purposes.
- . Developing means for making such information available for planning types of program needs both within and without the institution including SSA, treatment programs, and parole boards.

## LIMITATIONS OF SPECIAL CASELOADS

Special caseloads provide specialized services to addict parolees. Future directions concerning caseload specialization include the following:

- . Evaluating the special caseload relative to the nonspecialized caseloads for purposes of endorsing and promoting the growth of such programs.
- . Promoting specialized caseloads.
- . Promoting information to nonspecialized caseloads to keep them equally informed.
- . Directing the efforts of treatment programs, SSAs, and NIDA to the distribution of information to parole officers to increase knowledge concerning the availability of treatment.
- . Determining the criteria used for referral to special caseloads.

## OTHER ISSUES

Additional recommendations for research in areas of concern not previously addressed include:

- . Encouraging policy and program development with other Federal and State agencies and programs, such as CETA and Manpower Development projects, under the Department of Labor, addressing the employability of the (parole) addict offender.
- . Considering further development of the short term detention model as a means for crisis intervention in the case of "minor" drug-related parole violations prior to the more drastic return to prison.
- . Ascertaining average duration of stay for parolees returned to prison who technically violate parole (particularly where the violation is drug-related) and suggest treatment participation of comparable time as opposed to prison sentences.

## APPENDIX A

### PRELIMINARY FINDINGS OF THE 33 STATES REVIEWED

#### FOR SITE SELECTION

##### INSTITUTIONAL LEVEL

Of the 33 States who responded with documentation, eleven (California, Colorado, Connecticut, Illinois, Kansas, Louisiana, Massachusetts, Nebraska, New York, Virginia, and Wisconsin) indicated that they identify the drug addict within the institution. The estimated percentages of drug users in institutions varied from 5-60 percent, based upon inmate self reports or drug-related offenses. The Massachusetts system identified only the drug law violator and New York identified both the users and the offenders in its institutions.

Only five States (California, Connecticut, Nebraska, New York, and Wisconsin) indicated the existence of specialized institutional programs for the offender with a history of drug use.

Sixteen of the 33 States reported some type of prerelease programs, including work release. However, few appeared to operate drug-specific programs. Those who cited prerelease programs made no special reference to the eligibility criteria nor the policy toward the inclusion or exclusion of the narcotic involved offender.

##### PAROLING AUTHORITY LEVEL

Information was obtained for all 50 States regarding: (1) the organization of the paroling authority in the State governmental structure; (2) the membership qualifications of the board members and the selection procedures for assigning board members; and (3) parole statutes dealing with parole eligibility criteria, parole hearings, and parole conditions. For the majority of the 33 responding States, parole authorities were Governor-appointed autonomous agencies responsible only to the Governor. In only four States (Michigan, Missouri, Ohio, and Wisconsin) did the paroling authorities operate differently.

Parole statutes for the most part made no special mention of the drug involved or the addicted offender. In thirteen States, there were provisions for "Special Conditions" or a general condition requiring the parolee to uphold all State and Federal laws, which includes drug laws. These conditions enabled the paroling authorities to: (1) enforce existing drug laws; and (2) recommend treatment and/or special surveillance for the known addict parolee. (The thirteen States with these provisions were Arizona, Delaware, Hawaii, Illinois, Michigan, Missouri, New Jersey, New York, Oregon, Tennessee, Virginia, Wisconsin, and Wyoming). Another thirteen States (California, Delaware, Florida, Georgia, Maryland, Missouri, Nevada, New York, Ohio, Oregon, South Carolina, Tennessee, and

Virginia) listed a condition specifically prohibiting nonprescribed drug use. Only four States (California, Louisiana, Maryland, and Massachusetts) made specific mention of treatment program conditions for addict parolees, and Ohio alone declared the addict ineligible for its unique "Shock Parole" program for early release.

In all the States, the violation of any parole condition was sufficient justification for revocation proceedings to be initiated, but technical violations (e.g., not showing up for weekly urinalysis) were usually handled unofficially at the discretion of the parolee's supervising parole officer. Legal violations (i.e., a drug arrest) can result in return to prison, beyond the jurisdiction of the paroling authority.

Eleven States (California, Colorado, Connecticut, Florida, Louisiana, Maryland, Missouri, New York, Pennsylvania, Virginia, and Wisconsin) indicated that they attempt to identify the parolee who has a history of drug abuse or addiction, although the means of identification varied from State to State. Of the 33 States, 12 (Arkansas, California, Connecticut, Georgia, Iowa, Maryland, Massachusetts, Michigan, New Jersey, Oregon, Pennsylvania, and Virginia) specifically mentioned parole programs that address the special needs of the addict parolee. These programs ranged from weekly urinalysis and other special surveillance techniques to intensive and special counseling sessions.

With the available information, it was not possible to determine exactly how paroling authorities became informed of treatment options, nor was it possible to tell how frequently the parole authorities returned parolees to treatment programs. The nondrug-specific programs listed did not reflect admissions policies, nor did they indicate the likelihood of addict parolees being referred to their programs.

#### COMMUNITY LEVEL

A few States statistically identified the number of addicts or drug involved parolees released to the community. Those States (California, Colorado, Connecticut, Florida, Maryland, Massachusetts, Michigan, New York, Pennsylvania, and Virginia) estimated that approximately 40 percent of those released on parole were known to have had some prior involvement with drugs. Parole divisions in only a few States appeared to provide special parole supervision and services for the addict parolee. Referrals seemed to be initiated by the parole officer in conjunction with the parolee. Some programs were sponsored and run by a statewide division of probation and/or parole services.

Differential rates of parole violation, revocation, return to prison, and caseload sizes for addict and nonaddict parolees were largely unavailable in the reports collected. Specific classes of violators, such as drug addicts, were virtually nonexistent.

## APPENDIX B

### STUDY METHODOLOGY

#### INTRODUCTION

The purpose of this study was to identify and describe the parole activities and programs related to addict parolees in each of the selected States. Both the issues of addiction and involvement in the criminal justice system were addressed as a two-pronged problem for the addict parolee. The study, however, focused upon the criminal justice system's response to the problem of drug addiction or abuse as it impacted on criminal justice agencies and personnel. The specific agencies and personnel involved were State paroling authorities, parole officers, and, to a limited extent, institutional staff in their roles and functions relative to the addict parolee. Site visits with personnel of the appropriate State parole authorities, parole services offices, and drug treatment programs were conducted to better understand the issues, activities and problems related to the addict parolee. This section presents the specific methodology employed by the Research Triangle Institute (RTI) to meet the study objectives outlined previously.

#### CONTACTS WITH STATE PAROLING AUTHORITY

Nine States were selected for site visit contacts to further identify and document programs and practices relating to the addict parolee. In order to gather as much information as possible before selecting States for site visits, the following activities were conducted:

- (1) Information was obtained from the American Correctional Association (ACA) and two ACA directories of nationwide corrections agencies and parole statutes
- (2) Telephone calls were placed to each of the 50 State paroling authorities or parole service agencies to request documentary materials
- (3) Permission was sought from States who do not publish annual reports, or who do not make special references to drug involved populations, to amass State-specific statistics reported to the National Council on Crime and Delinquency (NCCD).

#### PREPARATION OF A CHECKLIST OF INFORMATION

Based on the data gathered, a checklist of information was developed covering the issues and problems to be discussed with the paroling authorities, parole officers, and drug treatment authorities at the site visits (see exhibit B.1). The checklist was designed to facilitate and assist study personnel in conducting site visits within each State. The list was not developed for, nor was it intended to be, a formal interview schedule. It did serve, however, as a standard guideline to collect information relevant to the study during the site visits.



## SELECTION OF NINE REPRESENTATIVE STATES

The information gathered during the preliminary review of State parole practices was summarized and reviewed by RTI and NIDA staff prior to the selection of States to be site visited. The materials were summarized with reference to the issues, activities, and drug treatment programs at the institutional level, the paroling authority level, and the community level. These preliminary findings have been included as appendix A. Nine States were recommended to and approved by NIDA for site visitation. The nine States were California, Georgia, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Virginia, and Wisconsin. Contact was then made with each of the nine State paroling authorities to solicit their cooperation and to verify scheduling of each prospective visit. In addition, letters of endorsement were sent by the American Correctional Association and NIDA to the paroling authorities and SSAs, respectively.

## SITE VISITS TO NINE STATES

Site visits were conducted with the nine selected States between November 1976 and February 1977. Exhibit B.2 provides a review of selected information regarding each State visited. A variety of personnel from each of the States participated in the site visits, including parole board members, parole board staff, parole officers, other parole services staff and administrators, treatment program personnel, Single State Agency personnel, corrections staff, and parolees. The site visits involved a total of 25 visit days and contacts with a total of 102 persons.

The methodology employed by RTI in conducting the site visits was to first meet with paroling authority personnel for 2-3 hours. Participation from parole authorities ranged from full board representation in California and Pennsylvania to a single representative of the board in New Mexico.

Next, the site visit team contacted the parole supervision staff. In all nine cases those contacted included parole officers and their supervisors. Finally, as a result of discussions with the paroling authorities and/or supervision staff, contacts were made with other personnel such as corrections staff, treatment program staff and/or SSA staff and administrators. Lengths of discussions varied considerably from 30-40 minutes to prolonged periods of 2-3 hours, depending on whether meetings were held with a sole individual or a group of individuals.

The RTI site visit staff used the checklist of information as a guideline for the site visit discussions, since it provided a standard listing of the minimum issues to be addressed. The discussions ultimately focused upon parole officer communication with treatment programs, confidentiality of parolee treatment records, and parole authority responsibility in referring for treatment. Discussions reflected the items on the checklist of information.

The site visit staff of one or two persons recorded all information through note taking. Upon completing each site visit, a report was prepared to facilitate future report preparation and to have materials organized and documented soon after the site visit was conducted.

EXHIBIT B.1

PAROLE QUESTIONS  
(Adult Parole Only)

A. Institutional Level

1. Size of institutionalized population (sex, age).
2. Location and types of institutions (population size, sex, age).
3. Size of institutionalized population who were narcotic addicts prior to incarceration (age, sex):
  - a. Proportion of institutionalized population
  - b. Proportion by type and location of incarceration.
4. What drug programs exist within the State institutions for incarcerated offenders?
  - a. What types of programs are they?
  - b. How many narcotic addicts are admitted per year to each program?
  - c. What are the program objectives?
  - d. What are the criteria for admission into these programs?
  - e. What types of personnel (background and experience) are responsible for these programs?
  - f. Is there interface between these institutional programs and community based treatment programs?
5. Is there a prerelease (conditional or unconditional) program designed specifically for the incarcerated narcotics offender?
  - a. What are the program objectives?
  - b. Who is eligible for admission into the program (program eligibility criteria)?
  - c. What types of personnel are involved in the administration of the program (background and experience)?
  - d. How many addicts go through this program per year? How many are paroled? How many are released unconditionally?
  - e. How does the program work? Is there an "agenda" listing the requirements of the program?
  - f. Is there interface with community based drug treatment programs? Who and how?

6. Are there any other institutionalized programs and services designed specifically for the narcotic addict?
7. Is there a prerelease program for all prisoners who are coming up for release (conditional or unconditional)?
  - a. What are criteria for admissions?
  - b. Program purpose and objectives?
  - c. How many prisoners go through the program per year?
  - d. How many narcotic addicts go through the program per year?

B. Paroling Authority Level

1. How is the paroling authority organized?
2. What is the purpose and function of the parole authority? What are the statute qualifications for the members of the parole authority?
3. How do State statutes address parole issues, including parole eligibility, parole hearings, conditions of parole, and revocation of parole?
4. To what extent do State parole statutes single out the narcotic offender or the use of narcotics?
5. Size of parolee population (sex, age).
6. Proportion of parolee population who were narcotic addicts prior to incarceration:
  - a. Proportion of parolee narcotic addicts incarcerated for narcotic offenses
  - b. Proportion of parolee narcotic addicts incarcerated for nonnarcotic offenses.
7. What are the parole options open to the paroling authority (e.g., halfway houses, community based correction, work furlough, traditional parolee-parole officer relationship, etc.)?
  - a. How many are placed in these programs or parole arrangements?
  - b. How many were narcotic addicts?
  - c. How many were eligible for parole per year?
  - d. Of those who were eligible for parole, how many were narcotic addicts?
  - e. Are there special conditions in any of these programs that relate specifically to the narcotic addict and this decision to parole? What are they and why are they used?

8. What consideration is given by the parole authority to availability of and access to drug treatment programs during the decision to parole?
  - a. What information does the parole authority have regarding treatment programs?
  - b. How do they get this information?
  - c. How is this information transmitted to the parolee narcotic offender, pre- and postrelease?
9. What responsibility or power does the parole authority have to assign narcotic offender parolees to drug treatment programs once the offender is paroled?
10. What is the policy (explicit or implied) of the parole authority toward the paroling (releasing) of narcotic addicts?
  - a. Does this differ between men and women?
  - b. Does this differ by type of release program (e.g., halfway house, work furlough, etc.)?
  - c. Does this differ according to reason for incarceration (drug offense only versus other offenses)?

C. Community Level

1. What is the size of the paroled population and what proportion were/are narcotic addicts?
2. Are there special units or specially trained parole officers for the supervision of addict parolees?
  - a. What proportion of the addict parolees receive this special drug-related supervision?
  - b. What are the criteria for selection?
3. What community resources are available for treatment of addicts?
  - a. How do these programs interface with the addict parolee population?
  - b. How do these programs interface with parole officers and those responsible for addict parolee supervision?
  - c. How do these programs interface with the parole authority?
4. How are the community resources made available to the addict-parolee?
  - a. What are the selection criteria?
  - b. Conditions of remaining in the program?
  - c. Caseload?

5. What is the violation rate of addicts versus nonaddicts?
6. Among these cited for violation of parole, what is the "return-to-prison" rate for addicts versus nonaddicts?
7. What community resources are available for the treatment of addicts? (And what resources are there that the parole people are not aware of?)
8. What are the parole officers' caseload sizes for those who supervise addicts versus nonaddicts?



EXHIBIT B.2.

Summary of Site Visit Activities and Contact with State Parole Authority  
Parole Supervision and Drug Treatment Personnel, November 1976 to February 1977

State	Site Visit Dates (1976,1977)	Number of RTI Personnel Involved	Parole Board Involvement		Other Parole Authority Staff	Parole Supervision Personnel	Drug Treatment Personnel	Other	Length of Site Visits (days)
			Total Board	Board Member Representative					
California	1/12- 1/14 1/17- 1/18	2	-- <sup>1</sup>	1 <sup>2</sup>	1	6	4	1 <sup>3</sup>	5
Georgia	12/13-12/15	2	no	2	1	3	2	2 <sup>4</sup>	2
New Mexico	1/5 - 1/7	2	no	1	1	4	5	--	3
New York	12/6 -12/8	2	no	2	--	6	3	--	3
Ohio	12/27-12/29	1	no	1	--	2	3	4 <sup>5</sup>	3
Pennsylvania	11/30-12/2	3	yes	5	2	5	1	1 <sup>6</sup>	3
Rhode Island	12/13-12/14	2	no	4	1	1	1	--	2
Virginia	12/6 -12/7	1	no	1	1	3	2	--	2
Wisconsin	1/31- 2/1	2	no	8	1	5	2	3 <sup>7</sup>	2
Total	--	--	--	25	8	35	23	11	25

<sup>1/</sup> Met with all members of the California Narcotic Addict Evaluation Authority (NAEA) briefly.

<sup>2/</sup> Met with Mr. Edward Walker, Chairman of California NAEA, for more intensive discussions.

<sup>3/</sup> Superintendent of the California Rehabilitation Center.

(Exhibit B.2 continues.)

EXHIBIT B.2. (Continued)

4/ Personnel of Georgia Department of Corrections/Offender Rehabilitation.

5/ Includes Director of Social Sciences, Lebanon Correctional Institution, Ohio Department of Rehabilitation and Correction, two patients under treatment at Project CURE; and parolees under supervision, Ohio Division of Parole.

6/ Anonymous addict parolees under supervision.

7/ Includes Supervision, Drug and Alcohol Abuse Section of the Wisconsin Division of Corrections; Drug Abuse specialist and Director of the Bureau of Planning and Research, Wisconsin Division of Corrections.





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