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Treatment Retention: A Theory of Post-Release Supervision for the Substance Abusing Offender*

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WITH DWINDLING STATE budgets, and a prison population that is almost four times what it was 30 years ago (Beck, 2000), offenders are being returned to communities. Most released offenders (84 percent) are still under some form of active supervision (Glaze, 2002). Accordingly, the United States parole population has grown to three-quarters of a million persons under parole supervision (Glaze, 2002). However, the success of offenders released from prison has typically been poor. Over 67 percent of prisoners released in 1994 were rearrested within a three-year period. Of those, 46.9 percent were convicted of a new crime (Langan and Levin, 2002).

The considerably larger parole population has a different make up than those of paroled offenders just several decades ago. When offense type is examined, it has been determined that the majority of offenders released are no longer violent offenders (Travis and Petersilia, 2001). Drug offenders now make up more than a third of prisoners released. In addition, driving under the influence/driving while intoxicated offenders make up the largest percentage of public order prisoners released (Langan and Levin, 2002). And, it is estimated that when alcohol is combined with drugs, 80 to 90 percent of offender populations have a problem with one or both of them (Champion, 2002; Abadinsky, 2003). Drug-involved offenders have presented unique challenges for probation and parole agencies, as they have found themselves dealing with an offender group that may not pose an injurious threat to communities, but is still at high risk to recidivate.

In light of most states' financial situation, their current prison populations (Beck, 2002), and the poor outcomes of released offenders (Langan and Levin, 2002), a renewed focus on "reentry" has come from practitioners and scholars alike (Austin, 2001; Travis and Petersilia, 2001). Through this focus, some research has emerged on what works in treating offenders (see Andrews, 1995; Cullen, 2002; Cullen and Gendreau, 2000; Cullen and Gendreau, 2001; Gendreau, 1996; Lipsey, 1999; Losel, 1995), as well as how best to supervise them (Clear and Corbet, 1999; Cullen, Eck and Lowenkamp, 2002; Karp and Clear, 2000; Reinventing Probation Council, 2000; Taxman and Byrne, 2001; Taxman, 2002).

However, the supervision research, largely adopted from policing literature, has fallen short in that it has proposed either agency-level recommendations or general approaches to be implemented for all offenders. Additionally, these theories have yet to be empirically tested, which is possibly a result of their design. While these theories have marked an advance from previous approaches, they have provided little guidance for the individual officer working with specific types of offenders in the community. Whereas theories of police officer approaches are probably best applied generally, because they will span across line level patrol officers whose departments rarely have any control over what call for service will be assigned to them, the same does not hold for probation/parole agencies and their line level officers. Indeed, an advantage that probation/parole agencies have is the relative ease with which they can specialize and match certain offender types (i.e., substance abusers, sex offenders) with officers trained to deal with specific offender types and their individualized risks, needs, and responsivity levels.

In this paper a theory is proposed for effectively supervising the post release substance- abusing offender. This theory contains specific components that, if applied in the field, could be subject to empirical evaluation. This is accomplished by focusing on two main areas; post release treatment and supervision. This research suggests that these two entities should not be divergent, but instead need to be unified if any success is to be seen in curbing recidivism and producing long-term change. As such, an argument for the "treatment retention" theory of supervision is made.

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Treatment

Farabee and his colleagues (1999) outlined six main barriers to implementing successful substance abuse programs for offenders: client identification and referrals, recruitment and training of treatment staff, redeployment of correctional staff, over-reliance on institutional versus therapeutic sanctions, aftercare, and coercion. Here, the focus is on the last three of these barriers. However, it is important to note that the likelihood of success for the treatment retention model will be reduced if the offender does not receive effective treatment while incarcerated.

In successfully handling substance abusing offenders, the evidence supports the use of therapeutic communities (TCs) that are long-term and intensive in their delivery (Butzin, Scarpitti, Nielson, Martin, and Inciardi, 1999; Butzin, Martin and Inciardi, 2002; Griffith, Hiller, Knight, and Simpson, 1999; Harrison, 2001; Hiller, Knight, and Simpson, 1999; Inciardi, Martin, and Butzin, 2004; Pearson and Lipton, 1999). Pearson and Lipton (1999) found an overall effect size of .16 for TCs relative to various control groups and other treatments in their meta-analysis of correctional-based treatments for drug abuse. Therapeutic communities that are most effective contain a cognitive treatment component and focus on individual offenders' risks, needs, and responsivity. The evidence in support of programs adhering to these principles is perhaps even more overwhelming (see Andrews et al., 1990; Andrews, 1995; Cullen, 2002; Cullen and Gendreau, 2000; Cullen and Gendreau, 2001; Dowden and Andrews, 1999; Gendreau, 1996; Griffith et al., 1999; Lipsey, 1999; Losel, 1995).

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Aftercare

An important component of TC programs is relapse prevention and aftercare. In this part of treatment the offender creates a plan to assist him or her in not returning to a drug-involved lifestyle after release. Here, the principles of risk, need, and responsivity are again important, as offenders usually return to the same area they resided in when they committed their offense. The initial assessment that addressed the offender's various risks, needs, and responsivity levels will help in drawing up the relapse prevention plan.

It is also important for the treatment staff and probation/parole officer to share the assessment of the offender's risk factors. In doing so, the two can work in unison to assist the offender in reducing his or her likelihood for relapse and re-offense. In addition, the assessment process

should be continuous throughout the treatment process, in order for the level of care and supervision to be modified accordingly.

Establishing a support system, whether family or peer based, is critical in this stage of treatment. Slaught (1999) found family influences to be a dominant factor in whether a released offender returns to drug use or not. A clarification of family roles by the treatment provider or supervising officer, directed towards assisting the offender in maintaining sobriety, is an integral part of treatment (Slaught, 1999). On the other hand, in some cases the family will merely be a "trigger" for use and cannot be a support.

One way of contending with the non-supportive family is by developing additional supports in the community. If the offender is involved in a therapeutic community treatment program, it will be largely peer-based and it may be important to carry this over into the community. However, the offender will likely be required to find new peer supports, as terms of supervision are not inclined to allow for continued association with fellow parolees. Weekly or more frequent 12-step participation has been found to be an effective tool in maintaining an offender's long-term abstinence from substance use (Read, 1995; Florentine, 1999). In addition, the use of transitional living arrangements such as Oxford House have been effective in keeping offenders away from family triggers at home (Read, 1995).

The evidence is rapidly mounting that in-prison TCs with follow-up aftercare treatment that is cognitive based are effective in reducing recidivism. This is especially true for those offenders who complete aftercare treatment (e.g., Hiller et al., 1999; Knight, Simpson, and Hiller, 1999; Larimer and Palmer, 1999; Martin et al., 1999; Chanhatasilpa, MacKenzie, and Hickman, 2000; Dowden, Antonowicz, and Andrews, 2003; Inciardi et al., 2004). Dowden and his colleagues' (2003) meta-analysis revealed an average reduction in recidivism of 15 percent for relapse prevention programs compared to other treatment programs and control groups. Additionally, they found programs that adhere to the principles of risk, need, and responsivity typically yielded the better outcomes (Dowden et al., 2003.). Furthermore, Larimer and Palmer (1999) found cognitive-behavioral relapseprevention-based approaches effective for reducing the frequency of relapse episodes as well as the intensity of lapse and/or relapse episodes among offenders who resumed use after treatment.

Important to note is that a "relapse episode" does not only mean substance use, but also a return to an event which could trigger use. Recall that central to the relapse prevention model is the detailed classification of factors or situations that can precipitate relapse episodes (Larimer and Palmer, 1999). Larimer and Palmer's (1999) finding is important because it examined drug use, as opposed to solely focusing on recidivism. It suggests that relapse is a likely experience for an offender in recovery. How the relapse is handled is where the treatment retention model turns to the joint effort of treatment personnel working with the client and the probation/parole officer supervising the offender.

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Coercion

In the past, there has been much conflict between treatment personnel and correctional officials over the issue of voluntary or coerced treatment. Some of the driving forces for therapists include achieving sobriety, preventing relapse, and maintaining confidentiality about the aspects of a substance abuse disorder (Reddick, 2000). Lowering recidivism rates, on the other hand, typically drives probation departments. For the most part, drug and alcohol therapists tend to subscribe to the medical model of treatment. However, non-compliance is often the norm with offender populations. Consequently, it is unlikely the previous medical model of treatment alone will be effective in treating an offender who abuses substances. In view of this, the cognitive approach has emerged, the notion that an offender's pattern of thinking must be changed. The task of educating treatment providers about offender therapy often falls to probation and parole departments, as the treatment community is still theoretically grounded in the medical approach (Reddick, 2000).

Hiller et al. (1999) found the level of offender commitment to be a risk worth noting in the assessment of an offender's likelihood for success in treatment. However, strong motivation is not necessary to facilitate the treatment process. Sanctions or enticements, either in the personal life or the criminal justice system, can significantly increase treatment entry and retention rates, as well as the success of drug treatment interventions (Martin and Lurigio, 1994; Martin and Inciardi, 1997; Hanlon, Nurco, Bateman, and O'Grady, 1999; Peterson, 2003). In addition, Torres (1997) found that coerced treatment produced more long-term change when compared to voluntary treatment. Given this knowledge, effective supervision becomes important, as offenders often are unwilling participants in the treatment process.

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Supervision

In the past, frequent drug testing and intensive supervision was the response to substance abusing offenders. Traditionally, intensive supervision programs (ISP) have been characterized by close monitoring and surveillance as well as swift punishment-oriented responses to any violations (Cullen, Wright, and Applegate, 1996; Petersilia, 1998; Petersilia and Turner, 1992; Petersilia and Turner, 1993; Martin and Lurigio, 1994). However, intensive supervision programs have been found to have equal to or higher rates of recidivism than regular probation or prison sentences (Cullen et al., 1996; Gendreau et al., 2000; Petersilia, 1998; Petersilia and Turner, 1992; Petersilia and Turner, 1993; Martin and Lurigio, 1994). One reason for this is the high amount of technical violations associated with these programs (Fulton, Latessa, Stichman, and Travis, 1997; Martin and Lurigio, 1994; Petersilia, 1993; Petersilia, 1998). On the other hand, proponents of these practices argue that these offenders are then incapacitated, eliminating their ability to perpetrate further criminal acts. However, Petersilia and Turner (1992 and 1993) found technical violations to be a weak predictor of future criminality.

With respect to the substance abusing offender, Agopian (1990) found that new crimes committed by ISP drug involved offenders were extremely rare (under 20 percent), but that the clients did exhibit a high failure rate due to technical violations. Petersilia, Turner, and Deschenes (1992) found no significant differences in recidivism rates for drug offenders monitored intensively versus those who were supervised routinely. However, they did find that ISP clients had higher rates of technical violations. Ryan (1997) found new crimes to be the reason for nearly six percent of revocations in the Vermont ISP program. However, substance abuse accounted for the highest amount of technical infractions, 33.3 percent respectively. And, a history of drug and alcohol use was highly correlated with revocation. Accordingly, the practice of incapacitating revoked ISP offenders may not really be targeting those offenders recidivating by committing a new crime.

Despite the less than encouraging outcomes of intensive supervision programs, some positive findings have also emerged. Although it is a preliminary finding, much of the research shows some evidence to support intensive supervision and treatment (Bonta, Wallace-Capretta, and Rooney, 2000; Cullen et al., 1996; Gendreau, Goggin, Cullen, and Andrews, 2000; Fulton et al., 1997; Petersilia, 1998; Petersilia and Turner, 1992; Petersilia and Turner, 1993). Indeed, Petersilia and Turner (1993) found reductions in recidivism of 10-20 percent where treatment was combined with intensive supervision. Bonta and his colleagues (2000) found significantly lower recidivism rates for high-risk offenders who received treatment and intensive supervision compared to those who did not.

Hanlon, Nurco, Bateman, and O'Grady (1998) found employment and continued involvement in a social support style of treatment to be positively correlated with offender success on parole. Here, the intensive supervision program did not mandate immediate revocation for infractions, but instead allowed officers to use discretion and other sanctions if appropriate. It was also determined that those offenders who completed the social support treatment program were more likely to be successful in the long-term, despite early troubles after release (Hanlon et al., 1998). Similarly, Martin and Inciardi (1997) found that intensive aftercare in conjunction with case management produced better retention in treatment. They concluded that more long-term change

would be likely, despite the lack of success in the short-term, as it appeared offenders were gaining self-esteem and a desire to change (Martin and Inciardi, 1997). Accordingly, the evidence suggests intensive supervision, if applied correctly, may be effective for offenders in conjunction with effective treatment. In addition, retention of clients in treatment may be the gateway to long-term change and lower recidivism rates.

Despite the evidence that retention in treatment may be an effective way of producing change, probation authorities are still limited in their ability to compel offenders to remain in treatment. Revocation, which is still the norm, often leads to reincarceration, which would remove the offender from treatment. Yet, failure to sanction offenders for a violation of court conditions and treatment could lead to re-offense or full-blown relapse, the latter from which recovery is less likely. Consequently, it is important for departments to have a wide array of intermediate sanctions at their disposal to hold offenders accountable, while retaining them in treatment.

Sanctions

Petersilia (1998) illustrates that over the past decade much has been learned about the effectiveness of intermediate sanctions. She contends that intermediate sanctions have shifted from getting tougher to combining graduated sanctions and treatment. In addition, the use of community-based sanctions has become more prevalent and yielded some promising findings with respect to recidivism (Petersilia, 1998).

Torres (1998) contends that an effective supervision strategy for substance abusing offenders contains a wide array of sanctions to hold offenders accountable for violations. Examples of sanctions could be admonishments by the probation officer, the court, parole commission, or even community. In addition, the use of community service or inmate labor detail, increasing supervision length or frequency of interactions, upping the level of treatment, home confinement, discretionary jail time, or residential treatment are all sanctions that could be used in a graduated format to retain an offender in treatment as opposed to revocation and returning them to prison. However, to adhere to this graduated sanction approach, departments will typically have to alter the style in which their officers supervise substance-abusing offenders.

Supervision Style

Klockars (1972) revealed four basic roles or styles of probation officers: law enforcer or control-oriented, timeserver, therapeutic or social service, and the synthetic or combined approach. More recently, research on supervision style has dichotomized probation/ parole officers as either law enforcers or social service officers (Anderson and Spanier, 1980; Burton, Latessa, and Barker, 1992; Clear and Latessa, 1993; Ellsworth, 1990; Fulton et al., 1997; Glaser, 1969; Lawrence, 1984; McCleary, 1978; Purkiss, Kifer, and Hemmens, 2003; Seiter and West, 2003; Steiner, Purkiss, Roberts, Kifer, and Hemmens, 2004 Studt, 1978). However, Clear and Latessa (1993) did find that the two dominant roles, law enforcer and caseworker, are not incompatible. Sigler (1988) found similar results in his research, provided the department supported the two dichotomous styles. And, others have found that officers see themselves more as service brokers than law enforcers or social service officers when measuring supervision style outside the dichotomy (Sluder, Shearer, and Potts, 1991; Sluder and Reddington, 1993; Shearer, 2002). Consequently, it is possible that the synthetic officer described by Klockars (1972) can be achieved. This is the officer that can hold offenders accountable for their behavior, yet also work with the offender to solve problems and reduce their risk to re-offend.

On the other hand, it has been noted that often the law enforcer style of officer is selected to supervise intensive supervision caseloads (Petersilia et al., 1992; Ryan, 1997). Ryan (1997) discussed how this may be a flaw in the design of such programs, as the offenders selected for these programs are high-risk for violations. With this in mind, as well as the research supporting the effects of retaining offenders in treatment (Chanhatasilpa et al., 2000; Hanlon et al., 1998 Hiller et al., 1999; Inciardi et al., 2004; Knight et al., 1999; Martin et al., 1999; Martin and Inciardi, 1997), it is important for officers to alter their prior revocation oriented approach to supervision, what one senior Utah officer called "hook 'em and book 'em," to an alternative

model where the goal becomes treatment retention. Treatment retention is not a social service approach. Instead, it falls somewhere between the law enforcement and social service dichotomy, more in line with service brokerage. Accordingly, an important component of this model is the brokerage of sanctions designed to coerce the often resistant offender to remain in treatment.

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Conclusion: Supervising the Post-Release Substance Abuser

It has been determined that a large portion of the offenders returning to communities have problems with substance abuse (Harrison, 2001; Langan and Levin, 2002). These offenders present unique challenges to community corrections personnel. In this paper, the barriers to implementing successful substance abuse programs for offenders after release (Farabee et al., 1999) were addressed by synthesizing the research-based best practices for supervising reentry of the substance abuse offender. Accordingly, an empirically testable model for the individual officer supervising the substance abusing offender on parole entitled "treatment retention" was conceived (see Table 1).

In terms of treatment, the research seems to support the use of therapeutic communities that contain a cognitive component, within facilities coupled with aftercare treatment upon release (Chanhatasilpa et al., 2000; Hiller et al., 1999; Inciardi et al., 2004; Knight et al., 1999; Martin et al., 1999). With respect to the aftercare treatment, the relapse prevention model should guide the treatment personnel as they work with the offender to identify relapse-triggering situations and develop cognitive-based problem-solving strategies to work through them.

Probation/parole officers should begin by partnering with their treatment providers in an attempt to educate one another on what works best to reduce relapse and recidivism. In this model, the probation/parole officer and the treatment provider become a team with the common goal of treatment retention. As the focus is shifted to supervision, it is important to note that coerced treatment can yield as effective, if not more favorable results than voluntary treatment (Hanlon et al., 1999; Martin and Lurigio, 1994; Martin and Inciardi, 1997; Peterson, 2003; Torres, 1997). It has been discovered that the traditional intensive supervision approach was not effective in producing long-term change (Cullen et al., 1996; Gendreau et al., 2000; Martin and Lurigio, 1994; Petersilia, 1998; Petersilia and Turner, 1992; Petersilia and Turner, 1993). However, a more promising approach seems to be intensive supervision that employs a phase system that includes graduated sanctions designed to retain offenders in treatment while not compromising public safety (Torres, 1997).

As a component of supervision, Torres (1997) endorses reliable drug detection devices. This is important because early detection is critical in order for the supervising officer to respond swiftly before the offender retreats to full-blown relapse. Violations should be handled on an individual basis, but it is important to communicate with the offender up front that each violation will receive some form of sanction (Hanlon et al., 1999; Torres, 1997). Here, the psychological literature in support of immediate short-term punishments tailored to the offender's individual risks, needs, and responsivity level is relied upon (see Andrews et al., 1990; Andrews, 1995; Cullen and Gendreau, 2000; Dowden and Andrews, 1999; Gendreau, 1996). Torres (1997), as well as Hanlon et al. (1999), advocate for a continuum of sanctions that is graduated leading up to returning the offender to prison. However, prior to reincarceration, graduated sanctions can be an effective way of coercing an offender into compliance with treatment (Hanlon et al., 1998; Petersilia, 1998; Torres, 1997). And, retaining the offender in treatment until he or she completes aftercare has yielded promising results in achieving abstinence, the goal of treatment providers, and reductions in recidivism, the goal of probation and parole agencies (Chanhatasilpa et al., 2000; Hiller et al., 1999; Inciardi et al., 2004; Knight et al., 1999; Martin et al., 1999).

In addition to monitoring the offender's progress in treatment, the officer should be working with the offender to better other domains of his or her life. Part of the relapse prevention model is the focus on how treatment and sobriety relate to other areas of the offender's life. The old adage of "I just supervise the court order" (Klockars 1972:550) is not applicable if an officer wants to

effect any meaningful change and is serious about achieving long-term public safety. Taxman (2002) and Cullen et al. (2002) argue that a probation or parole officer should act as a problem solver. Klockars (1972) describes a synthetic officer that uses tools from the law enforcer style of supervision as well as the social service approach to achieve offender compliance. The problem solver theory of supervision appears to expand on this idea. In the treatment retention model, problem solving is tailored to the individual offender through the use of the relapse prevention plan to identify and prevent the individual offender's opportunities for relapse. This is achieved by working with the offender's family, the neighborhood the offender lives in, as well as through the use of service brokerage to assist the offender in obtaining employment and pro-social peers.

Probation departments that choose to have their officers implement this approach to supervision need to be careful about what their policies and procedures allow officers to do. Role conflict brought about by departmental bureaucracy or legislative mandate can lead to poor work performance (Clear and Latessa, 1993) and officer burnout (Whitehead and Lindquist, 1984). Probation agencies should create specialized, manageable caseloads to allow officers time to work with treatment providers and communities as well as utilize their discretion in handing out individualized sanctions for non-compliance. In addition, agencies should provide training on treatment and effective supervision if they expect their officers to adopt this philosophy. Training has been found to be an effective way of guiding officers' attitudes and clarifying roles (Fulton, Stichman, Latessa, and Travis, 1997). In addition, supervising officers should be cautious in their expectations, as offenders can often take long periods of time to accept treatment and begin to change. Often, there will be many bumps in the road (relapses). However, through the use of the promptly applied graduated sanctions and by exercising a problem-solving approach tailored to the individual offender's risks, needs, and responsivity level, officers should begin to see some success with this challenging population.

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Table 1: Treatment Retention
Reducing Agency Goals to the Officer Level

	Traditional ISP Model	Broken Windows Model	Treatment Retention Model
Goal	Surveillance and Control	Promote public safety	Retain Offender in Treatment
Offenders Targeted	All	All	Post release substance abusers
Post-Release Treatment	None/medical model	Research based	Cognitive behavioral aftercare/ relapse prevention model
Supervision Style	Law enforcer	Problem solver	Substance abuse specialist/service and sanction brokerage
Partnership Building	None	Law enforcement and crime prevention entities	Treatment providers, offender's individual support system
Response to Violation	Revocation	Swift and sure, graduated sanction	Graduated sanction tailored to individual treatment plan
Effect	Offender returned to prison	Unknown	Offender coerced into treatment

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