GUIDELINES FOR COMMUNITY SUPERVISION OF

DWI

OFFENDERS

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Section I
Overview of the Problem and the Need for National Guidelines for the Community Supervision of Impaired Driving Offenders

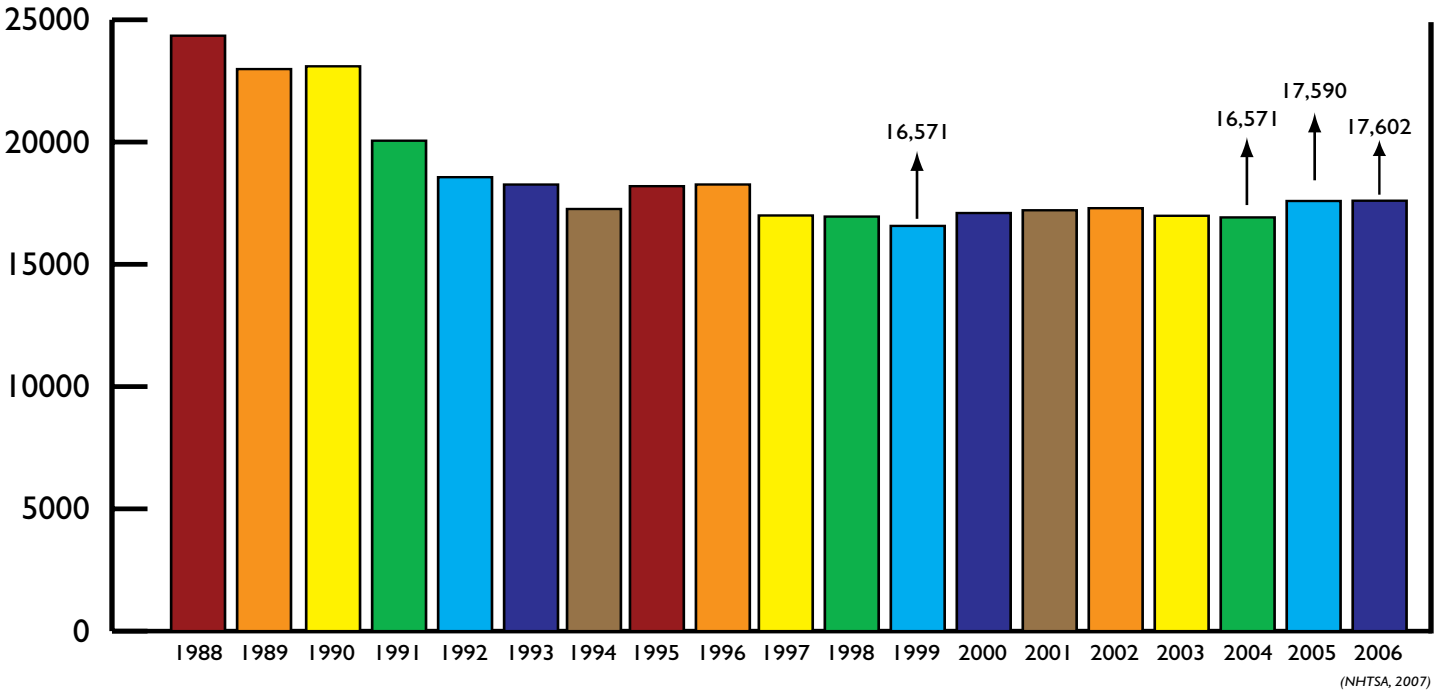
In spite of the tireless efforts of thousands of highway safety advocates over the past 25 years, impaired driving continues to be a major problem in this country. Every hour, drivers are arrested for driving under the influence or driving while intoxicated and, for many, this will not be their first offense. According to the National Highway Traffic Safety Administration, nationwide one person every 40 minutes, approximately 35 people a day, or nearly 13,000 people each year, die in traffic crashes involving a vehicle driver or a motorcycle operator with a blood alcohol concentration (BAC) of .08 grams per deciliter (g/dL) or higher (National Center for Statistics and Analysis, 2006).

All 50 States, Puerto Rico, and the District of Columbia have established the BAC of .08 g/dL as the "per se" level that is "over the limit" under their laws. In addition, some drivers are impaired by drugs and medications. A study from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2004) reports that in 2002 and 2003, 21 percent of people age 16 to 20 reported that they had driven in the past year while under the influence of alcohol and/or illicit drugs.

Various terms are used to describe impaired driving. State laws generally use the terms Driving While Impaired (DWI) and Driving Under the Influence (DUI); advocacy groups and members of the public may use the term "drunk driving." For the purposes of this document, the term "driving while impaired" (DWI) is being used as an inclusive and generic term and will include the operation of a motor vehicle following the use of alcohol, drugs, prescription and/or over-the-counter medications—separately or together.

As Figure I-1 indicates, over the past 30 years, there have been some promising reductions in the percentage of alcohol-related fatalities and injuries, including a slight reduction in fatal crashes between 2004 and 2005 (National Center for Statistics and Analysis, 2006). Several factors, including but not limited to, public education campaigns; increased public awareness of the problem; passage of laws (e.g., increasing the minimum drinking age, laws reducing the BAC per se level, increasing penalties for offenders); increased enforcement of impaired driving laws and improved safety features in cars (e.g., seat belts, air bags) are contributors to this success.

Figure 1-1: People Killed in Alcohol-Related Traffic Crashes, by Year



(NHTSA, 2007)

In addition, due to the efforts of groups like Mothers Against Drunk Driving (MADD), the penalties have increased for drinking and driving, especially for repeat offenders. A few of the legislative changes adopted by all 50 States and the District of Columbia include:

- A legal drinking age of 21 years old;
- Per se, or implied consent, laws defining it as a crime to drive with a BAC at or above a level of .08 g/dL; and
- Zero-tolerance laws which prohibit drivers under 21 from having any measurable amount of alcohol in their blood.

The bad news is that—despite these efforts—it is not enough, and the task ahead is still monumental. The Early Edition of Traffic Safety Facts 2005 (NHTSA, 2006) provides a compilation of fatal motor vehicle crash data from the Fatality Analysis Reporting System (FARS) and nonfatal crash data from the General Estimates System (GES). According to FARS data, a total of 43,443 people lost their lives in motor vehicle crashes in 2005 and the GES data reports that another 2.7 million people were injured. In 2005, 39 percent of people were killed and 9 percent of people were injured in alcohol-related crashes. The median BAC for alcohol-involved drivers and motorcycle operators continued to be .16 g/dL; which means that more than half of all alcohol-involved drivers and motorcycle operators had BACs equal to or higher than twice the illegal per se level in all States, Puerto Rico, and the District of Columbia. Financial costs of alcohol-related crashes are astronomical. According to NHTSA (2000), the costs of alcohol-related fatalities and injuries exceeded $50 billion in the year 200.

DWI offenders comprise a significant portion of the criminal justice population, according to the uniform crime reporting data; in 2005 approximately 1.4 million arrests occurred for impaired driving, which creates an enormous burden on an already overwhelmed criminal justice system. For many DWI offenders, it is not their first offense. Thirty-four percent of DWI offenders in jail and 8 percent on probation reported three or more prior arrests or convictions (Maruschak, 1999). Those with previous license suspensions and DWI convictions often have higher levels of blood alcohol concentration (by about 25 percent) when involved in fatal crashes than those without such history (Greenfeld, 1998).

Beyond that, nearly 40 percent of all offenders (not just DWI) in 1996 reported they were using alcohol at the time of the offense for which they were convicted (Greenfeld, 1998) and significant portions of the prison offender population (17 percent of State prison inmates in 1991)

report being under the influence of illegal drugs at the time they committed their crimes (Bureau of Justice Statistics, 1997). Thus, not only are significant numbers of the United States correctional population responsible for impaired driving incidents, but the high incidence of substance use among all offenders suggests these offenders could present a heightened risk of committing impaired driving crimes in the future.

The Role of Community Supervision in Working with DWI Offenders

The concept of probation began in 1841 with the innovative work of John Augustus, a Boston boot maker, who was the first to post bail for a man charged with being a common drunk (Augustus, J., 1852). Since its simple beginning, probation has become the most common form of sentencing in the United States (Bureau of Justice Statistics, 1997). According to the Bureau of Justice Statistics (BJS), in 2005 over four million offenders were supervised on probation and nearly three-quarters of a million on parole. Of the offenders placed on probation, about 50 percent were felony, 49 percent were misdemeanant and 1 percent had other infractions. Of all the offenders placed on probation in 2005, 26 percent were sentenced for a drug law violation and 15 percent had been sentenced for driving while impaired or intoxicated (Glaze, 2006).

The vast majority of convicted impaired driving offenders are supervised in the community. In 1997, almost nine in ten (89 percent) convicted DWI offenders were on probation (Maruschak, 1999). Besides probationers, offenders released on parole, pretrial release, diversion programs, and others receiving alternate types of supervision (such as through a specialized court without formal probation) increase the numbers of individuals supervised by community corrections agencies (an inclusive term that incorporates probation, parole, pretrial release programs, diversion, specialized courts, etc.) specifically for impaired driving offenses. Agencies that provide supervision for DWI offenders in the community require a continuum of disposition and supervision options to effectively achieve the concurrent goals of rehabilitation, accountability, and public safety.

The Challenges to Community Supervision of DWI Offenders

Making the necessary changes to improve community supervision outcomes with DWI offenders is complicated by a variety of factors. Among the foremost challenges faced by judges when sentencing DWI offenders is underestimating the impact of more serious offenders, including repeat DWI offenders and those with a high BAC of .15 g/dL or more, as well as incomplete or unavailable criminal history and traffic records. DWI offenders, especially those who are not being charged at a felony level, are often released on a minimal bond or without pretrial supervision due to these incomplete legal histories. In addition, diversion records are usually not documented on the individual's permanent driving record. This process often results in multiple diversion opportunities because the individual may incorrectly be considered a first-time offender. Related challenges also include the number of years during which a DWI conviction can be considered as a prior offense, and the accessibility of prior records related to pretrial, diversion, or conviction (National Association of State Judicial Educators & The Century Council, 2004.). More needs to be done to check for prior criminal history and traffic records and assess all DWI offenders for risk before decisions are made regarding the type of supervision on which the offenders should be placed.

Community corrections professionals and agencies also face challenges to the supervision of DWI offenders. For example, community corrections caseloads often are inordinately high, making it difficult for staff to provide adequate supervision to offenders (Robertson & Simpson, 2003). According to Camp and Camp (2002), in 2000, the average caseload for adult probation supervision was 133 (range from 60 to 320); for regular adult parole supervision, the average caseload was 73 (range from 25 to 253), and the average caseload for combined probation and parole was 94 offenders (range from 50 to 176). Extremely large caseloads (most of which are generalized caseloads that consist of people who have committed a variety of offenses) make it difficult for supervising officers to meet the diverse and individual needs of the variety of offenders they supervise.

Because of ever-increasing workloads, and stagnant or shrinking funding, many community corrections agencies have been forced to provide less supervision for certain groups of offenders. In some cases, agencies have elected to not provide direct supervision to misdemeanant offenders and have placed them on "banked" caseloads so that they may only report by mail or be contacted if they fail to comply with a court-ordered sanction. Many impaired driving offenders, no matter how potentially lethal, are classified as misdemeanants and, therefore, do not receive active supervision when placed on banked caseloads. See Figure I-2 for a summary of results from a report released in July 2003 by the Traffic Injury Research Foundation (TIRF) that identifies eight key problems that impede the community supervision of drunk drivers.

The offenders themselves can also bring in more complicating factors. In 1997, 37 percent of DWI offenders under community corrections supervision exhibited indicators of past alcohol dependence and more than half had received alcohol treatment or participated in a self-help program in the past. Addiction is a chronic, relapsing disorder. It requires ongoing treatment to achieve stabilization and assist individuals to improve their functioning and remain in recovery. For impaired drivers whose crimes are related to addiction or problem use of alcohol and other drugs, requiring that they obtain and participate in appropriate treatment services is an important component of their effective supervision in the community. This adds a special challenge to the supervision process. While corrections and substance abuse treatment services have many commonalities, they also may have many differences, including different missions, vocabularies, and practice methods. Community corrections professionals must develop effective working relationships with substance abuse treatment providers so that they can effectively monitor and support offenders' involvement in treatment.

Added to the complexity of all of these other issues is the occurrence of poly-drug use among some impaired driving offenders, including use of alcohol combined with any number of other (often illegal) substances. As different treatment modalities may be appropriate for different substances of abuse, it may be necessary to coordinate multiple treatment modalities for one client or to find one treatment program that can combine treatment modalities.

Finally, substance abuse may often co-occur with mental illness. Indeed, it is widely believed that some mentally ill individuals turn to substances to self-medicate their illnesses. Again, multiple treatment programs or programs that combine substance abuse and mental health treatment may be necessary, increasing the tasks and skills required to supervise these offenders.

The Purpose of the Guidelines for the Community Supervision of DWI Offenders

To protect the public and provide DWI offenders with adequate interventions to help promote behavior change, it is important for community corrections agencies to assess their practices and programs for this population. The guidelines presented in this document are intended to provide a framework for developing, implementing and operating effective programs for the community supervision of DWI offenders. These strategies are recommended to achieve the best possible outcomes and to provide a structure from which to build a solid approach and direction to ensure long-term public safety by reducing recidivism through offender behavioral change.

How the Guidelines Were Developed

Because of the dearth of evaluative literature specific to the community supervision of DWI offenders, there were several places from which information was gathered and used to serve as a foundation for the development of the guidelines. First, the American Probation and Parole Association (APPA) initiated a large scale effort to gather specific agency-based information on current community corrections policies, strategies and supervision practices for pre-trial defendants or convicted impaired driving offenders. This was accomplished through the development and administration of an online questionnaire that probation, parole and community corrections agencies across the nation were asked to complete. The questionnaire was completed by 129 agencies in 31 States and provided information related

Figure I-2: Problems Impeding Community Supervision of DWI Offenders

A report released in July 2003 by the Traffic Injury Research Foundation (TIRF) surveyed 890 probation and parole officers from 41 States and identified the following eight key problems that impede the community supervision of drunk drivers (Robertson & Simpson, 2003).

1. *Non-compliance with court orders.* Supervising officers who are charged with the day-to-day supervision lack accurate and timely information, authority to impose sanctions for non-compliance, and sufficient resources to monitor and assist offenders. Noncompliance with court orders was identified as the number one obstacle to effectively monitoring offenders.

2. *High Caseloads.* The population of offenders on community supervision has been increasing steadily for several years and there has been an even sharper increase for DWI offenders. With the increases in enforcement, prosecution, and sentencing, demands on DWI supervision have increased substantially. Cutbacks and/or stagnant funding for agencies have caused staff deficiencies, which has exacerbated the caseload burden. According to the TIRF report, "Officers … report that their average caseload consists of 112 offenders, including 55 for DWI offenses [and] some officers … reported caseloads of up to 1,300 offenders."

3. *Conflicting Goals.* Probation activities must achieve separate and often conflicting goals, including monitoring behavior and enforcing compliance on the one hand, and rehabilitation on the other.

4. *Sentencing Disparity.* A broad range of sentences and conditions of supervision imposed on offenders are common among those who have committed similar offenses. The result of these varying conditions and requirements is that supervision becomes much more complicated and offenders often perceive penalties as unfair which can detract from the goal of behavioral change.

5. *Program Design.* Poor programming often excludes offenders from beneficial programs. They are often excluded because they are unable to pay fees. Further problems include legislative incompatibilities, irregular administration and operation, inconsistent enforcement and/or the use of technologies that are not sufficiently advanced to prevent or detect circumvention.

6. *Paperwork.* Officers have reported that they spend almost one-third of their time filling out forms, documenting contacts, and writing reports. Time spent on paperwork reduces the amount of time that can be spent in supervising offenders, especially lower-level offenders. Additional frustration is felt by the officers when no action is taken on violation reports they do complete, especially for serious violations.

7. *Net Widening.* New or alternative sentences or programs are implemented in an effort to reduce jail overcrowding, but are used in a manner other than as originally planned, so they become an "add-on" rather than a true alternative. As a result, supervision caseloads are increased, which reduces the ability of officers to adequately supervise DWI offenders.

8. *Records.* Access to current and accurate criminal history and motor vehicle records in a timely manner is critical for any decision-making process involving an offender from pretrial release to sentencing and supervision. The necessary records are often maintained by different agencies and for different amounts of time, making verification difficult. Inaccurate and incomplete information often results in a more lenient sentence or disposition.

to their current practices and supervision practices. See Appendix J for a summary of some of the findings from the questionnaire and a list of participating States.

In addition, wherever possible, the recommended guidelines were based on principles of evidence-based practices for risk reduction (see Figure I-3) defined by the National Institute of Corrections, as well as key components of the DWI/Drug Court Model that have been proven to be effective (see Figure I-4).

Once a guideline was drafted, the following questions were asked to assess whether the recommended guideline would be appropriate for community-based corrections programs to implement in the supervision of DWI offenders:

- Does the guideline have a positive impact on the community supervision of DWI offenders?
- Is it reasonable and feasible to expect a community supervision program to implement the guideline? If not, why not, and how else should it be implemented?
- Is the guideline based on the principles of evidence-based practice, promising practice, or other commonly accepted standard or theory?
- Does the guideline promote behavioral change leading to recidivism reduction?
- Does the guideline give you a sense of what immediate or intermediate outcome to expect?

There may be instances where an individual agency may not be able to implement one or more of the recommended guidelines. It is more practical to view an individual agency's adherence to these guidelines in terms of a continuum. A guideline that may not be able to be implemented today may be able to be implemented in the future as the agency's circumstances, needs, or resources change. Therefore, supervising officers and probation and parole agencies should view the guidelines outlined in this document as benchmarks for success.

Conclusion

Drinking drivers and other drug impaired drivers cause death and injury to innocent men, women, and children each day. The goal of community corrections agencies providing supervision for DWI offenders is to ensure long-term public safety by reducing recidivism through behavioral change. The purpose of this document is to provide a framework to assist in planning, implementing, and enhancing services provided to offenders who are under community supervision for driving while impaired. Agencies should examine and reassess their strategies for supervising all DWI offenders, including high-risk repeat and high-BAC impaired driving offenders. In the same way that the risk principle in evidence-based practices directs community corrections agencies to focus primarily on high-risk criminal and delinquent offenders, agencies should make concerted efforts to target high-BAC and repeat alcohol and drug impaired drivers for more effective community supervision practices.

The following section of this document will provide a description of the guidelines recommended for the supervision of driving while impaired offenders. The appendices provide suggested readings, information on tools and technology, sample graduated sanctions, promising practices and strategies, and sample process and outcome measures.

Figure I-3: Principles of Evidence-based Practices

Principle 1) *Assess Actuarial Risk/Needs* – offenders are not alike, determine risk and needs that must be addressed to reduce likelihood of re-offending.

Principle 2) *Enhance Intrinsic Motivation* – Increase offender's motivation to change behavior.

Principle 3) *Target Interventions* – Provide effective interventions matched to the offender's criminogenic needs according to the principles of risk, needs, and responsivity.

Principle 4) *Skill Train With Directed Practice* – Use cognitive behavioral methods when appropriate.

Principle 5) *Increase Positive Reinforcement* – Behavioral change is increased through positive reinforcement.

Principle 6) *Engage Ongoing Support in Natural Communities* – Pro-social family networks increase the resources available and reinforce positive behavior.

Principle 7) *Measure Relevant Processes/Practices* – Collect data to determine program impact on offender behavioral change as well as staff performance.

Principle 8) *Provide Measurement Feedback* – Encourage behavior change by providing feedback.

(Bogue, 2004)

Figure I-4: Key Components of DWI/drug Court As Identified by the National Association of Drug Court Professionals

1. DWI/Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
3. Eligible participants are identified early and promptly placed in the drug court program.
4. DWI/Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participants' compliance.
7. Ongoing judicial interaction with each DWI/Drug court participant is essential.
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9. Continuing interdisciplinary education promotes effective DWI/Drug court planning, implementation, and operations.
10. Forging partnerships among DWI/Drug courts, public agencies, and community-based organizations generates local support and enhances DWI/Drug court program effectiveness.

(National Association of Drug Court Professionals, 2004)

Section II
Guidelines for the Community Supervision of Impaired Driving Offenders

This section outlines guidelines for the community supervision of DWI offenders. They focus on three primary goals: public safety, offender accountability, and behavioral change. For each guideline, there is a rationale provided that explains the reason the principles espoused in the guideline are important. Following the rationale, there are suggested implementation strategies, which include considerations from a policy and practice perspective on how to put the guideline into action. Keep in mind the suggested implementation strategies are not meant to be prescriptive and should not be confused with the guideline itself; they are merely suggestions on how community supervision agencies or supervision officers can achieve the intent of the guideline.

Guidelines for the Community Supervision of Impaired Driving Offenders

Guideline 1
Investigate, collect, and report relevant and timely information that will aid in determining appropriate interventions and treatment needs for DWI offenders during the release, sentencing, and/or supervision phases.

Guideline 2
Develop individualized case or supervision plans that outline supervision strategies and treatment services that will hold DWI offenders accountable and promote behavioral change.

Guideline 3
Implement a supervision process for DWI offenders that balances supervision strategies aimed at enforcing rules with those designed to assist offenders in changing behavior.

Guideline 4
Where possible, develop partnerships with programs, agencies, and organizations in the community that can enhance and support the supervision and treatment of DWI offenders.

Guideline 5
Supervision staff should receive training that will enhance their ability to work effectively with DWI offenders.

Guideline 6
Assess the effectiveness of supervision practices on DWI offender through both process and outcome measures.

Guideline 1

Investigate, collect, and report relevant and timely information that will aid in determining appropriate interventions and treatment needs for DWI offenders during the release, sentencing, and/or supervision phases.

Key Points

- Gather information on the offender's prior criminal history and traffic record.
- Conduct an actuarial risk and needs assessment on DWI offenders.
- Screen and/or assess DWI offenders for substance abuse issues.
- Screen and assess DWI offenders for poly-substance abuse and mental health issues.
- Whenever possible, prepare and provide a pre-release report to releasing and pre-sentence report to sentencing authorities.
- If not collected (or complete) at the pre-sentence phase, collect information prior to case or supervision planning.

Rationale

Investigate and Collect Information

Has this person been arrested or convicted of other crimes? Has this person had previous DWI arrests? What was the blood alcohol concentration at the time of arrest? Does this person need alcohol and drug treatment? Has this person been treated previously for substance abuse issues? Does this person have other psychiatric disorders that should be addressed? What is the risk that this person will re-offend? What are the criminogenic needs that should be addressed to change their behavior? The answer to these and other questions can (and should) result in different responses and interventions for DWI offenders. However, the answers to these questions are not always provided at times that will leverage the most effective results. In some cases, the answers to some of these questions may not even be sought or determined.

Without relevant and timely information, it is difficult—if not impossible—to make an informed decision about an effective problem resolution. The same holds true for decisions related to the best strategy for responding to and working with DWI offenders. Pertinent and timely information about the offender including the offender's criminal history, driving record, risk and needs, and substance abuse dependency is crucial to working effectively with DWI offenders—from the point of sentencing through the community supervision process. Community corrections professionals often are ideally situated and equipped to gather this information for releasing and sentencing authorities.

Information obtained from a risk and needs assessment yields pertinent information that can help in determining the best interventions for a DWI offender. An actuarial risk and needs assessment examines the risk (the likelihood that an offender will commit additional offenses) and criminogenic needs (factors that appear directly correlated to an individual's propensity to commit crime such as low self-control, anti-social behavior, anti-social personality, anti-social values and attitudes, criminal/deviant peer association, substance abuse, and dysfunctional family relations) of the offender. The results allow staff to develop and recommend more appropriate supervision practices and interventions for individual offenders (Andrews & Bonta, 1998).

Another primary purpose of actuarial risk and needs classification systems is to determine the levels of supervision by risk (e.g., high, medium, and low); therefore allowing

the supervision officer to focus the majority of his or her time with the higher risk offender. While the risk and needs assessment provides a means for gathering useful information on criminogenic needs of offenders that can assist in decision making about release, sentencing, and case or supervision planning, traditional risk and needs assessment instruments used in a justice setting may not accurately depict the re-offending risk of the impaired driving offender.

Most DWI offenders are misdemeanants and are rated at a lower risk level than felony offenders because of this offense level categorization. In addition, many DWI offenders score as low risk because any past criminal history is likely to be lower level offenses (e.g. worthless checks, disorderly conduct, previous DWI) and to be nonviolent. Although unstable at times, DWI offenders also are typically able to maintain some level of employment and residence, and marital relationships—if existing—are usually unstable but intact.

Even though they may score low-risk, on many scales, alcohol and drug impaired drivers are potentially very dangerous and pose a substantial risk to public safety. This is due in part to the fact that many people who are arrested and convicted of DWI continue to drink and drive (NHTSA, 1995) and maintain an attitude that it is okay to drink or use drugs and drive. NHTSA (1995) reported that the likelihood of arrest for DWI varies from 1 in 200 instances in some communities to 1 in 2,000 in others. When viewed from this context, it is likely most first-time DWI offenders have actually driven while impaired numerous times before they were caught and arrested.

It is important, however, to recognize that not all alcohol or drug impaired driving offenders have the same level of addiction or the same treatment needs. Therefore, it also is important to screen and/or assess offenders to determine the extent of their substance use and abuse and the level of risk he or she poses to the public. The results can also provide insight into the most appropriate level of monitoring (frequency and intensity) and supervision needed for each offender. For example, screening and assessment can help identify those offenders who are in the most need of controlling their substance abusing behavior, who pose the most risk to the public and who may require the use of specialized technology (e.g., continuous transdermal monitoring) during the supervision process (Robertson, Vanlaar, & Simpson, 2006).

According to the SAMHSA, screening is "a process for evaluating someone for the possible presence of a particular problem" (SAMHSA, 2005, p. 7). Therefore, community corrections professionals can use screening tools to triage a DWI offender to determine if he or she may have a more serious problem with alcohol and drug abuse that may warrant further and more detailed alcohol and drug assessment (Chang, Gregory, & Lapham, 2002). There are a variety of alcohol and drug screening tools that can be used easily and inexpensively that can typically be administered by community corrections professionals during the intake, pre-release, or pre-sentence report process with minimal training (see Appendix B).

Alcohol and drug assessment refers to more comprehensive evaluation of an offender's substance abuse issues to identify the nature and extent of the problem and how it can be best addressed (Robertson, Vanlaar, & Simpson, 2006). Alcohol and drug assessments should be conducted by personnel certified in alcoholism, drug addiction or with extensive clinical training and expertise (NHTSA, 2005).

During alcohol and drug screening and assessment, community corrections professionals also need to be cognizant of poly-substance use among offenders. Poly-substance use—which is the use of multiple substances—seems to be more the norm than the exception for many DWI offenders. Armed with the knowledge that multiple substance use is all too common, it is important for supervision officers and treatment providers to comprehensively determine the offender's drug(s) of choice and range of substances used. Determining both the type of use and the level of use is important for establishing the right intervention and treatment.

Many offenders who abuse substances also have one or more co-occurring mental disorders that can make treatment more complex. For example, in a recent study of DWI offenders adjudicated in the Multnomah County (Oregon) Driving Under the Influence of Intoxicants Intensive

Supervision Program, conducted by Lapham, C'de Baca, McMillan, and Lapidus (2006), approximately 54 percent of respondents were alcohol-dependant. In addition, 65 percent of men and close to 80 percent of women had at least one lifetime disorder coexisting with substance abuse. SAMHSA (Center for Substance Abuse Treatment, 2005) recommends screening and assessment for other mental health issues that may be co-occurring with the individual's substance abuse so that intervention and treatment can be targeted appropriately. It may be that there will be inadequate time to do these types of mental health screenings and assessments prior to release or sentencing; however, they can be incorporated into the court-ordered conditions of supervision, if deemed necessary.

Overall, it is important to recognize that not all DWI offenders are alike—as such, there is not one sanctioning or treatment strategy that is effective for all DWI offenders (Mayhew & Simpson, 1991, as cited in NHTSA, 2005). Matching DWI offenders with the most appropriate intervention and treatment services that will translate to a lower risk of recidivism should be the goal of any sentencing or releasing authority, as well as any community corrections agency. Optimally, the investigation process should be designed to allow time to gather information about the offender's current and prior history (including traffic record), as well as time to conduct an actuarial risk/needs assessment, and screen and/or assess the offender for alcohol and drug issues. This type of information lays the foundation for identifying repeat and habitual DWI offenders, making decisions about the types of interventions (e.g., supervision strategies and treatment) that will meet offenders' needs and determining if there are poly-substance abuse issues or co-occurring mental disorders that need to be addressed.

Report Information

Gathering information and performing screening and assessments on offenders is not enough—information must be provided to the appropriate people so it can be utilized during decision making and case planning. Pre-sentence investigation reports (PSI) are one way (and probably the most common way) that information is provided to sentencing judges. In addition to reporting offender information, the person preparing the PSI also can suggest recommendations for conditions of supervision or release (Wahl, 1994). To ensure public safety as well as to promote the desired behavioral changes Wicklund (2005) recommends conditions of supervision or release be based on the needs of the offender identified during the investigation process (including any appropriate treatment needs) and that the conditions be realistic, relevant, and/or research-supported.

Tips for Investigating, Collecting, and Reporting Relevant and Timely Information

Policy Considerations

- If your agency does not prepare and provide pre-sentence investigation reports on DWI offenders for releasing and sentencing authorities, talk with appropriate authorities about the utility of these types of reports and what information could be gathered to assist in their decision making. Also discuss how adequate time would be provided to investigate and collect needed information. Optimally, all pre-sentence investigation reports should be in writing. This will allow information gathered to be passed along to other agencies (or staff) who may become involved in the supervision of the offender. However, if there is not adequate time to prepare a written pre-sentence report, discuss with releasing and sentencing authorities what other strategies could be used to provide them with the needed information (e.g. verbal report). If it is not possible to prepare a PSI on all DWI offenders, consider adopting the policy for certain types of DWI offenders, such as repeat and habitual drunk drivers.
- If your agency already conducts pre-sentence investigations, talk with representatives from the sentencing and releasing authorities (e.g., judges) to determine if they are getting the type of information needed to make informed decisions. Also, talk with community corrections staff who are performing the investigations to determine if they are encountering any barriers that impede information gathering during pre-sentence investigations.

» Review and enhance (if necessary) information sharing policies and practices (see Guideline 4) with other agencies maintaining information on DWI offenders (e.g., law enforcement, drivers and motor vehicles departments, pre-trial services, diversion, and supervision programs) to assure that supervision staff can access the type of information they need on DWI offenders. This may require meetings with administrators from various organizations to examine the type of information needed, identify the barriers to accessing the information, and establish solutions for overcoming barriers. Make sure to inform administrators of the various organizations why information you are seeking is needed and how it will benefit your agency and the sentencing and releasing authorities, how information will be used, and how, ultimately, it will enhance public safety. When policy and procedures are developed (or revised) for information sharing, make sure to put the new policy and procedure in writing and share it with appropriate staff and partner agencies.

When reviewing information needs and working with partner agencies, keep in mind that different agencies have different recordkeeping policies and practices (e.g., type of information gathered, how long information is maintained). If a partner agency's (or your agency's) recordkeeping process sets up situations in which there is inefficient access to needed criminal histories or drivers' records, talk with partner agencies about how this may impede decisions regarding sentencing and release of DWI offenders. Determine if there is interest and resources to establish a standardized automated record keeping system across agencies. Standardizing the record systems would reduce delays in entering important data and significantly improve the ability of law enforcement and supervision officers to locate accurate and up-to-date information in a timely manner.

- Implement (or revise, if necessary) policy that will require an actuarial risk and needs assessment on all DWI offenders (including misdemeanants). If it is not feasible to require a risk and needs assessment on all DWI offenders, consider requiring it for repeat and habitual drunk drivers. Preferably the risk and needs assessment would be required during the pre-sentence investigation phase. If the risk and needs assessment is not performed prior to release or sentencing, it should be required during the case and supervision planning phase. If your agency does not already use an actuarial risk and needs assessment instrument that can be used on DWI offenders, research the various instruments available to determine which one will best meet your agency and offender population's needs. See Appendix A for suggested supplemental resources on risk and needs assessment.
- Establish a policy that requires all DWI offenders to be screened for alcohol and drug abuse during the pre-sentence investigation process. If time does not allow for screening, then require it during the case and supervision planning phase. If your agency does not already have an alcohol and other drug (AOD) screening tool, research the various instruments available to determine which one will best meet your needs. Keep in mind that some States may have legislation or court rules that stipulate the type of AOD screening tool that is to be used on DWI offenders. For example, Pennsylvania implemented legislation in 1983 that mandates use of the court reporting network that includes a computer-assisted screening tool that is administered by a trained screener. In Nebraska, the Supreme Court issued a court ruling that requires all probation agencies to follow a standardized model for substance abuse services. The model includes the type of AOD screening tool that they must use. Some additional issues to consider when choosing an AOD screening tool include:
  - » The type of information the screening tool yields (e.g., does it give the agency adequate information to determine appropriate and intermediate intervention and whether further assessment is needed?).
  - » The type of staff training required to prepare them to administer the screening tool.
  - » The time it takes during the interview to

administer the tool.
    - » Whether there is a specific screening tool that the agency is mandated to use. For example, some States have legislation or court rules that specify what screening tool is to be used.
    - » The cost of the tool. Some are free to the public, while others need to be purchased.
    - » If the screening tool determines a more comprehensive AOD assessment is necessary, then a referral should be made to a certified AOD assessor. See Appendix B for information on various AOD screening tools.

- Assure your agency has procedures in place for referring offenders for more comprehensive alcohol and drug assessment by a qualified provider, if warranted by the initial screening. It also is recommended that more comprehensive alcohol and drug assessment be required on all repeat and habitual DWI offenders. Make sure that agency policy stipulates that referrals for alcohol and drug assessments be made to a qualified provider and that results are provided to appropriate authorities to aid in decisions related to needed intervention strategies and treatment services.

Practice Considerations

- During any information gathering or interviewing during the pretrial process, officers need to be careful not to coerce defendants into waving due process rights.
- When interviewing offenders, supervision officers should be encouraged to use motivational interviewing (MI) techniques to help illicit more helpful information.
- When collecting information on DWI offenders for releasing and sentencing authorities (or for use in case and supervision planning), suggested information to gather includes (but is not limited to):
    - » information related to the blood alcohol concentration;
    - » prior criminal history;
    - » motor vehicle records;
    - » past participation in diversion, treatment, or other special programming;
    - » results from an actuarial risk and needs assessment such as
        - ✓ *levels of social and family functioning,*
        - ✓ *current living situation,*
        - ✓ *employment status or employability,*
        - ✓ *physical and mental health,*
        - ✓ *financial situation, and*
        - ✓ *collateral contacts from family members, employers, and victims (if possible); and*
    - » history of alcohol and other drug use and the results from alcohol and drug screening and/or assessments.
- When possible, recommendations also should be made to releasing and sentencing authorities for the type of supervision, intervention, and treatment services that will best meet the needs of the offender.
- Conditions of supervision and release that are recommended for DWI offenders should be realistic, relevant, and/or research supported. Some guiding questions to help determine if the conditions meet these criteria include (Wicklund, 2005):
    - » Is there an expectation of compliance and that the conditions of supervision will be completed?
    - » Are the necessary resources for a continuum of treatment available?
    - » Does the supervision staff have the tools to enforce conditions of supervision (workable caseload, technology for monitoring)?
    - » Are conditions of supervision germane to the offense, offender, and direct the case planning process by allowing for multivariate programming?
    - » Are strategies research supported, evaluated, and supported by results?
    - » Are sanctions for noncompliance and incentives/rewards for compliance immediate?
- Some offense-specific conditions of supervision that should be recommended for the supervision of DWI offenders include (but are not limited to):
    - » Abstain from the use of alcohol and illegal use, sale, possession, distribution, or transportation of controlled drugs.

» Participate in and satisfactorily complete a designated substance abuse counseling and/or treatment program, or mutual help group such as Alcoholics Anonymous or Narcotics Anonymous, to the satisfaction of the supervision officer.

» Submit to laboratory or field testing for substances of abuse at the direction of the supervision officer, (e.g., breath, blood, urine).

Guideline 2

Develop individualized case or supervision plans that outline supervision strategies and treatment services that will hold DWI offenders accountable and promote behavioral change.

Key Points

- Develop individualized case or supervision plans on DWI offenders.
- Base elements of the case plan on information collected related to the offender's history, risk and criminogenic needs, and substance abuse issues.
- Involve the offender in the development of the plan.
- Develop goals and objectives in the plan that are strength-based.
- Include graduated responses that are tied to the offender's completion or lack of completion of objectives.
- Develop a behavioral contract (signed by the offender) outlining supervision goals and strategies.
- Match the offender with appropriate treatment services based on their indicated needs.
- Identify services and support needed to help offender accomplish his or her goals and objectives.
- Reevaluate the case or supervision plan with the offender and treatment providers regularly to determine if adjustments need to be made.

Rationale

According to Patricia M. Harris (1994, p.19), professor and associate dean at the University of Texas at San Antonio, "When assessment and planning do not occur or are conducted poorly, supervision is haphazard, conducive to negative outcomes, and ultimately indefensible." Therefore, using information obtained from a pre-sentence report including, but not limited to, the prior criminal history and traffic record of the offender, the risk/needs assessment and AOD screening and/or assessment the supervision officer should develop an individualized case or supervision plan (with assistance and input from the offender). The case plan will identify appropriate supervision strategies and treatment interventions that will assist the offender in understanding his or her behavior, learn to manage his or her behavior and comply with societal norms, and, ultimately, engage the offender in a process of behavioral change (Taxman, 2002). Case or supervision plans also should outline graduated responses (sanctions and incentives) that can be used by supervision officers to motivate offender compliance and behavioral change (Taxman, Shepardson, & Byrne, 2005). More information on graduated sanctions and incentives can be found in Guideline 3.

For DWI offenders, the need for substance abuse treatment is often a reality and, when warranted, should be incorporated within the case or supervision plan (National Institute on Drug Abuse, 2006) along with supervision strategies aimed at addressing other criminogenic needs. Appropriate alcohol and drug treatment for offenders who abuse substances can improve community supervision outcomes (e.g., decrease future alcohol and drug use, improve relationships with family members, improve employability). In addition, research indicates that people who are coerced by the criminal justice system to enter into treatment are just as likely to do as well as someone who voluntarily enters alcohol and drug treatment. However, it is important for community supervision officers to recognize that not all offenders who have a history of alcohol or drug

use need treatment. In addition, not all offenders who are identified as substance abusers need the same type of treatment (NIDA, 2006).

AOD screening and assessment (as discussed in Guideline 1) is a crucial step in identifying who may need more in-depth treatment. Another crucial step in targeting offenders for appropriate treatment services is communication and collaboration with treatment providers. Early (and sustained) involvement of treatment providers will not only help target offenders for appropriate services and encourage participation in those types of services, but it also can help treatment providers incorporate other supervision requirements as treatment goals (e.g., abstinence from alcohol and drug use; housing and childcare; medical, psychiatric, and social support services; vocational and employment assistance) (NIDA, 2006).

Tips for Developing Individualized Case or Supervision Plans for DWI Offenders

Policy considerations

- Consider requiring individualized case or supervision plans for all DWI offenders. If it is not feasible to require them on all DWI offenders, require them for all repeat and habitual DWI offenders.
- Consider developing or purchasing automated case management software to streamline the process for developing and monitoring case or supervision plans. Some agencies have designed their own systems, while other agencies rely on pre-packaged systems. See Appendix A for suggested supplemental resources related to the development of automated case management systems (including the Functional Standards for Automated Case Management Systems for Probation and information on the University of Maryland's Automated Tracking Systems—HATTS).
- Review the typical conditions of supervision—along with supervision strategies and treatment services—available for DWI offenders within your agency and your community. Where possible, strive to enhance the options available to the agency and to supervision officers that will help them achieve the goals of holding offenders accountable and promoting behavioral change (including the development of graduated responses for addressing compliance). See Guideline 3 for more information on successful supervision strategies for working with DWI offenders.
- Strengthen interagency relationships with substance abuse and mental health treatment providers in the community. See Guideline 4 for more information on enhancing partnerships with outside agencies and organizations.

Practice Considerations

- Develop an individualized case or supervision plan for all DWI offenders that outlines specific supervision and treatment strategies. Review information outlined in Guideline 1 that is recommended for making informed decisions about appropriate interventions and treatment services for DWI offenders. If this information is not provided to you in advance (e.g., through a pre-sentence report) or if the information you receive is incomplete (e.g., screening indicates an AOD assessment is needed but the assessment has not been completed), then make sure to gather needed information and follow through on recommendations prior to completing the case or supervision plan.
- Remember, if a risk and needs assessment and an AOD screening were not completed as part of a prerelease or pre-sentence report, both should be completed to determine the risk level and AOD treatment needs, prior to assignment to a caseload or to the development of a case or supervision plan. The conditions of supervision may need to be amended or adjusted by the court to include the recommended AOD treatment requirements.
- Develop a case or supervision plan that contains information such as the problem to be addressed, behavioral objectives/conditions of supervision, and action plans for the offender and the supervision officer. Establish goals, a timeline for completion and integrate alcohol and other drug treatment services. See Appendix C for the components of a case plan.
- When developing goals and objectives for case and supervision plans consider the following (Monchick, Scheyett, & Pfeifer, 2006):

- » Create goals, objectives, and task-oriented strategies based on information from the risk/needs assessment and alcohol and drug history. When possible, involve the offender in the development of the case or supervision plan and in the prioritization of objectives. Motivational interviewing techniques can be helpful when working with DWI offenders in establishing a case or supervision plan. Rollnick and Miller (1995, ¶3) define motivational interviewing as a "directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence." (See Appendix A for suggested supplemental resources related to motivational interviewing).
- » Goals, objectives, and strategies should be framed in a positive and strength-based context (e.g., focus on things to achieve rather than things to avoid). They should be reasonable and attainable, behaviorally specific and measurable, include time frames, and clearly define responsibility for actions. Agreed-upon incentives and sanctions should be tied to the completion or lack of completion of each objective. Smaller, short-term goals may be useful in building the offender's confidence.

- When developing the case or supervision plan identify the offender's social network (e.g., family members, friends, community) and determine ways to enhance and tap into these informal social controls to build the offender's sense of responsibility and sense of belonging. Also be sure to include a mixture of clinical and control services (Taxman, 2002).
- Implement the agreed upon plan through a behavioral contract. The behavioral contract should clearly define supervision and treatment goals as identified in the individualized case plan. The behavioral contract should identify expected behavior including both sanctions for non-compliance and incentives for compliance. See Guideline 3 for more tips related to graduated sanctions and incentives. A sample behavioral contract is provided in Appendix D and example sanctions and incentives are provided in Appendix E.
- When making referrals for DWI offenders who need substance abuse treatment services, consider the following:
  - » Resist referring DWI offenders into a standardized treatment program. Offenders should receive treatment in a manner that is consistent with their addictions, abilities and learning styles.
  - » Treatment referrals also should match the appropriate level of care indicated in the risk/needs and the alcohol and drug assessment. For example, offenders who meet drug dependence criteria should be given higher priority for treatment than those who do not. Less intensive interventions, such as drug abuse education or self-help participation, may be appropriate for those not meeting criteria for drug dependence (NIDA, 2006). Research shows that referrals to a level of care that does not match the identified needs of the offender can be counterproductive.
  - » Treatment should target factors that are associated with criminal behavior. For example, treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to drug abuse and criminal behavior may improve outcomes (NIDA, 2006). See Appendix H for information on the Nebraska Standardized Model, which includes a form for officers to send to treatment providers indicating the risk and need factors.
  - » Consider the length of supervision ordered for offenders requiring substance abuse treatment services. Recovery from drug addiction requires effective treatment, followed by management of the problem over time. DWI offenders, who have been identified as having an addiction, whether they are repeat or first-time offenders, need to have time to recover from the addiction. Short term supervision for offenders with severe drug problems and co-occurring disorders does not allow time for the needed behavioral changes. The length of supervision needs to be a minimum of one and if possible two years to

allow for treatment and recovery. Treatment must last long enough to produce stable behavioral changes (NIDA, 2006). Therefore, if the original term of supervision is not adequate, it may be necessary, if possible, to request an extension of supervision to allow time for needed treatment.

  - » Remember that many offenders with substance abuse problems also have co-occurring mental health needs or poly-substance abuse issues. Therefore, assure that there is a process in place to identify co-occurring disorders (e.g., depression, anxiety, and other mental health problems) and poly-substance abuse. When applicable, plan an integrated approach with treatment providers in the case or supervision plan to also address these issues with offenders.
  - » Substance abuse is a disease of relapse. Therefore, consider how to address relapse when it occurs in the case or supervision plan (e.g., incentives for sobriety and graduated sanctions for continued use).

- Establish a collaborative relationship with treatment providers and communicate regularly with them regarding the offenders' treatment progress, changes in treatment or supervision plans, and incentives and sanctions. Also talk with local treatment and mental health providers about current supervision strategies and discuss how these strategies reinforce or may be counterproductive to treatment goals. Encourage treatment providers to incorporate supervision strategies into treatment goals (e.g., abstinence from alcohol and drug use; housing and childcare; medical, psychiatric, and social support services; vocational and employment assistance).
- Identify specific monitoring tools that can be utilized during the supervision phase (electronic monitoring, drug testing, reporting schedule). See Appendix F for an overview of tools and technologies that can assist in monitoring DWI offenders.
- Supervising officers should assure that offenders are aware of the conditions of their supervision, understand what they are required to do and not do while on supervision (i.e., behavioral objectives), know what services are available to help them achieve their behavioral objectives and know how to access those services, understand how the supervision officer will monitor compliance, and are aware of the types of graduated responses, sanctions, and incentives that the supervision officer and/or the releasing or sentencing authority can use to address issues of noncompliance and facilitate behavioral change.
- Consider the use of DWI Victim Impact Panels (VIP) as a way to build empathy and educate the offender about the impact that drunk driving has on its victims. VIPs should be used when it does not impose a burden on those in the community who have suffered losses due to a DWI crash.
- Assess and reassess. Case and supervision planning is a dynamic process and should occur more than once (e.g., during intake) during the supervision process. The case or supervision plan should be re-evaluated regularly with the offender and with the AOD treatment provider to be certain it continues to appropriately address the offender's needs (Monchick, Scheyett, & Pfeifer, 2006). Keep in mind when working with DWI offenders, it may be necessary to reassess and modify the case and supervision plan one or more times during the supervision process.

Guideline 3

Implement a supervision process for DWI offenders that balances supervision strategies aimed at enforcing rules with those designed to assist offenders in changing behavior.

Key Points

- Develop and implement supervision strategies based on evidence-based practices.
- Focus on supervision strategies that enforce rules and facilitate behavioral change.
- Monitor DWI offenders closely and consistently.
- Apply graduated sanctions and incentives in a swift and certain manner.
- Understand the impact of the cycle of addiction and the stages of change on the supervision process.
- Develop rapport and use good communication skills designed to increase DWI offenders' motivation to change and decrease their resistance and ambivalence to the change process.
- Assist the offender in accessing needed services and treatment.
- Take advantage of tools and technologies available to aid in the monitoring of DWI offenders.

Rationale

The ultimate goals of supervision when working with DWI offenders are to (1) enforce the conditions of supervision to hold offenders accountable for their current offense; (2) monitor offender behavior and compliance to protect public safety and to (3) assist offenders in behavioral changes to reduce/prevent the likelihood they will engage in this type of behavior in the future. This requires community supervision officers to perform dual roles as an enforcer of rules and as a facilitator of behavioral change. The conflict that supervision officers often feel between these two roles is not new; however, a results-oriented approach to supervision demands that a variety of strategies be employed to effectively reduce recidivism. Blending the enforcement role of supervision with the rehabilitation role of supervision offers opportunities for holding offenders accountable and for changing offender attitudes and behaviors—all of which ultimately leads to enhanced public safety (Taxman, Shepardson, & Byrne, 2005).

According to Robertson and Simpson (2003), some DWI offenders (particularly repeat offenders) quickly learn that weaknesses in the monitoring process means that they do not necessarily have to comply with some or all of their conditions of supervision. When offenders are able to circumvent penalties and avoid compliance, it compromises public safety and can result in more problematic behavior by the offender. Research also shows that for sanctions for noncompliance to be effective, they must be swift and certain (Taxman & Soule, 1999). Assuring that offenders comply with their conditions of supervision and that issues of noncompliance are addressed in a timely manner can only be accomplished through close and consistent monitoring practices. There are a plethora of tools and technologies available to assist in more timely and effective monitoring of DWI offenders today and that can allow the offender to remain employed or in school, live at home, and continue to be involved in pro-social activities.

While it is sometimes easier to devote more time and energy to the enforcement aspect of monitoring, it is important that the rehabilitative side (i.e., behavioral change) not be ignored in the process (Robertson & Simpson, 2003). This concept is reinforced by Petersilia (1999) who examined research on intensive supervision programming and concluded that control-oriented supervision has little impact on recidivism unless it is coupled with a therapeutic approach. In a 14-site study of intensive supervision programs, it was found that offenders who had some counseling services (e.g., substance abuse, employment)

tended to have better outcomes than those who were only subjected to surveillance (Petersilia & Turner, 1993).

It is well established that alcohol and drug addiction is a brain disease that affects behavior and that DWI offenders who have alcohol and drug addiction issues may experience relapses or return to alcohol and drug use (NIDA, 2006). In addition, most offenders begin the supervision process denying their wrongdoing and resisting the idea that they must change their behavior. The rehabilitative or behavior side of supervision recognizes that learning and sustaining new behaviors is part of enhancing public safety. As such, supervision officers should incorporate strategies during the supervision process that will help facilitate offenders' movement through the change process. Likewise, offenders must proactively participate in the change process or face the consequences (Taxman, Shepardson, & Byrne, 2005).

A powerful tool that community corrections agencies can provide supervision officers to aid in the supervision process is a series of graduated (less to more severe or intense as the action indicates) responses that they can use to encourage compliance and behavioral change. These responses should encompass a balance of sanctions (e.g., disciplinary action aimed at noncompliant behavior) and incentives (e.g., motivational response designed to reinforce positive behavior) (NIDA, 2006). The use of graduated sanctions and incentives is a key component of drug courts and a contributor to their success (Lindquist, Krebs, & Lattimore, 2006). Yet, these are strategies that also can be applied administratively in the community supervision process outside the bounds of a courtroom.

Taxman and Soule (1999) indicate that graduated responses provide supervision officers with a mechanism for working with offenders with chronic relapsing conditions (such as substance abuse) and changing offender behavior by dealing with the addiction disorder. Substance abusers tend to discount future consequences (Murphy, Vuchinich, & Simpson, 2001), therefore, the use of graduated sanctions and incentives are more likely to have the desired effect with DWI offenders when they are perceived as fair and when they occur soon after the behavior at which they are aimed (NIDA, 2006). In addition, the Massachusetts Supreme Judicial Court's Standards on Substance Abuse indicate the appropriate response to a relapse must be fashioned based on each offender's individual needs, history of substance abuse, and previously used treatment modalities (Massachusetts Supreme Judicial Court Standing Committee on Substance Abuse, 1998). Further recommendations by Monchick, Scheyett, and Pheifer (2006) indicate that responses should be treatment-relevant, strength-based, and consistent with program or agency philosophy.

Tips for Implementing a Supervision Process That Enforces Rules and Facilitates Behavioral Change

Policy Considerations

- Review the literature on evidence-based practices related to changing offender behavior. See Appendix A for suggested supplemental resources on evidence-based practices and behavioral change.
- It is recommended that the community corrections agencies implement policy and practices that reflect the dual purpose of community supervision—enforcement of rules and facilitation of offender behavioral change for the purpose of enhancing public safety. The agency's vision and mission statement also should reflect these values and staff should be educated and provided resources to assist them in putting the mission into practice.
- Examine workload, caseload, and resource issues within the agency and how this affects the quality of supervision of DWI offenders. Appendix G provides summaries of promising programs/strategies that some community corrections agencies have adopted to increase the effectiveness of supervision of DWI offenders.
- Review the policy and procedures related to monitoring DWI offenders. Assure that procedures are established that will result in timely and certain responses for addressing offender behavior. This includes review or development of policy standards and procedures for the flow of accurate and timely information between service and treatment providers and supervising officers regarding offender progress and noncompliance.
- Review supervision strategies and treatment services available for working with DWI offenders to assure there

is a balance of strategies that will help supervision officers enforce rules and facilitate behavioral change.

- Talk with supervision officers to determine which of the current supervision strategies, tools and technologies are working well and which may not be producing the desired results for DWI offenders. Make adjustments to policy and procedure, if needed, or develop new policy and procedure that supports effective and efficient use of these strategies, tools, or technologies.
- Consider the use of additional strategies (e.g., generalized caseloads, special DWI caseloads, intensive supervision, drug court, DWI court, alcohol and drug education and treatment) and tools and technologies (e.g., alcohol screening instruments, alcohol and drug assessment tools, electronic monitoring, transdermal alcohol monitoring, ignition interlock, drug testing, laptops, personal digital assistants) to aid in supervision of DWI offenders. See Appendix F for descriptions of some of the tools and technologies that can be used to monitor and supervise DWI offenders. Determine which ones the agency should research more thoroughly and consider implementing as part of its supervision practices. Discuss new strategies, tools, and technologies being considered with supervision staff to get their input. When examining new strategies, tools, and technologies, some issues to consider include (but are not limited to) how the strategy, tool, or technology will aid in the supervision process; who the target population(s) will be; eligibility criteria or program requirements; who (or what agency) has the authority to impose the strategy, tool, or technology; potential obstacles or barriers to effective implementation and utilization (e.g., cost to offender, cost to agency, outdated or inconsistent access to technology, legislative incompatibilities); and how the effectiveness of the strategy, tool, or technology will be assessed.
- If the cost of new tools and technologies to offenders is an identified barrier, consider developing a fund to help offset these costs so offenders will not be excluded from programs because of their inability to pay fees.
- Review policy and practice related to using breath, blood and urinalysis testing for monitoring compliance. Supervision officers should be allowed to randomly test for the use of alcohol and drugs, using field testing, in-house testing or a laboratory. Officers should also be able to increase or decrease the testing as a sanction or incentive. Standards should be developed to add the use of continuous transdermal alcohol monitoring and/or ignition interlock devices if needed. This may require authorization by a supervisor or the court.
- Review the types of AOD and mental health treatment available to meet the needs of the DWI offender. A continuum of AOD services should include, but is not limited to, AOD education, out-patient treatment, in-patient treatment, day reporting centers, residential treatment, half-way houses, and mutual help groups such as Alcoholics Anonymous and Narcotics Anonymous. If a need is identified work with local treatment providers to implement services. See Guideline 4 for more information on developing effective interagency partnerships.
- Create standard forms for various actions such as pre-sentence reports, progress and violation reports. Consider automation and the use of technology to reduce the duplication of information and to simplify the sharing of pertinent information during the supervision process.
- Review policy and practice for admission of DWI offenders to alternative or high risk programs. Ensure that net-widening does not occur and that only appropriate offenders (those with certain characteristics or sufficiently severe offense histories) are sentenced to alternative programs. Offenders should not be assigned to higher levels of supervision than required.
- If your agency does not already have a formal system for using graduated responses (sanctions and incentives) to respond to negative and positive offender behavior, consider developing one and incorporate it into the agency's polices and procedures. Taxman and Soule (1999) identify three general models of graduate responses: (1) a program model in which responses are part of a new intervention strategy (e.g., drug court); (2) a judicially ordered sanction schedule that is attached to the court order for probation in which the judge defines circumstances in which responses will be used and

empowers the community supervision agency or officer to administer those responses, and (3) an administrative model in which the community corrections agency outlines a system for supervision and monitoring in which graduated responses are used in the standard supervision practice. Taxman and Soule recommend adopting the administrative approach, when possible, in part because it helps redefine the nature of basic supervision into a proactive model. The graduated responses become part of the agency policy and supervision officers are responsible for using the model to respond in a more consistent and timely manner to different types of offender behavior. For an administrative model for graduated responses to be successful, it requires a good relationship and communication between the community corrections agency and the judiciary. Therefore, if community corrections agencies want to adopt an administrative model for graduated responses, they should involve the judiciary in the development of the model to gain their approval and support for giving more latitude in using sanctions and incentives as part of the overall supervision strategy.

- Additional issues to consider when developing a system of graduated responses include (Taxman & Soule, 1999):
    - » Developing a list of sanctions that are not more intrusive or restrictive than necessary (Tonry, 1996).
    - » Outlining sanctions in a manner that is commensurate with the severity of the behavior (von Hirsch, 1993).
    - » Increasing the severity of the sanctions as negative behavior continues (Altschuler & Armstrong, 1994).
    - » Including options for reinforcing positive behavior.
    - » Developing a process for the progression and utilization of sanctions and incentives in a manner in which offenders will view them as impartial and consistent with rules, ethics and logic (Burke, 1997).
    - » A system for applying graduated responses needs to build in procedures that will allow for swift (Rhine, 1993) and certain response. If responses are delayed it can increase the offender's perception that the response is questionable or unfair. Likewise, increased perception of certainty of punishment can deter future deviant behavior (Grasmack & Bryjak 1980; Paternoster 1989; Nichols & Ross 1990). Therefore, regardless of which graduated response model you choose (i.e., program, judicially ordered, or administrative) when developing a system for graduated responses, determine which responses can be applied administratively by supervision officers, which require approval from a supervision officer's supervisor, and which require involvement from the court.
- See Appendix E for a chart that provides examples of graduated responses for working with DWI offenders.
- Where possible, develop policy delineating the supervision officers authority to impose meaningful sanctions and encouraging the use of incentives. For responses that require approval of supervisory staff or the court, work to decrease the amount of time and procedure involved in seeking remedies through these channels. For example, talk with the court about establishing special dockets (e.g., weekly or daily sanctions docket) or processes for responding to due process concerns or applying sanctions that involve incarceration (Taxman & Soule, 1999).
- Another factor that can affect the ability to provide swift intervention is the ability to acquire accurate and timely information from treatment and service providers (e.g., ignition interlock, electronic monitoring, transdermal alcohol monitors, attendance at treatment sessions) regarding violations and noncompliant behavior (Robertson & Simpson, 2003). Therefore, develop good information sharing protocols with treatment and service providers to assure the receipt of timely information. More detailed information on developing methods for sharing information among agencies is discussed in Guideline 4.

- If your agency already has a formal system for graduated responses in place, review your current system with supervision officers, treatment providers and the court to assure that the system is working effectively and that the responses are generating the desired results. If deemed necessary, address any obstacles or barriers to the current system and make needed adjustments.
- To assure that agency policy and procedures regarding the use of graduated responses are being implemented and used appropriately, incorporate the use of the graduated responses into supervision officers' performance reviews. Assure they are aware they will be assessed on their use of the graduated response.
- Provide training to supervision officers on the appropriate and proportional use of graduated sanctions and incentives as part of case management.

Practice Considerations

- Become familiar with literature regarding the stages of change (see Appendix A for supplemental resources).
- Get to know the offender. Review all case materials including the pre-sentence report, prior criminal history, sentencing information, conditions of supervision, risk/need assessment results, and AOD screening and/or assessment results. Assure that all DWI offenders have been screened or assessed for AOD needs (see Guideline 1 for more information).
- Engage the offender in the change process by preparing them for dealing with issues that affect criminal behavior and contribute to their legal troubles (Taxman, 2002). Use motivational interviewing skills to increase motivation in the offender and reduce resistance and ambivalence. See Appendix A for information on supplemental resources related to Motivational Interviewing.
- Refer to and use the case or supervision plan and behavioral contract developed with the offender as a guide while monitoring compliance. Assure that the offender is following through with recommended treatment services and that other conditions of his or her sentence are being monitored. When changes are made to the plan, make sure the offender is aware of those changes.
- Initiate drug and alcohol testing early and continue on a random, unannounced basis.
- Assure that offenders are receiving services (mental health, substance abuse) based on the intensity of treatment they need (education or treatment). Establish regular lines of communication between the supervision officer and the treatment and/or service providers to ensure increased accountability, information sharing and compliance to case plans. The supervising officer should have knowledge of the type of treatment being provided. During the referral process, the supervising officer should communicate the prior record of the offender, BAC at time of arrest, and the criminogenic risk factors. If at all possible, the supervising officer and treatment provider should develop the treatment plan together. Two-way communication should be established regarding progress in treatment, compliance with conditions of supervision, results of drug tests, information from collateral contacts (e.g., family, employer, law enforcement, etc.) and any additional information related to progress in treatment or supervision. Reports should be received immediately if the offender leaves the treatment program without authorization, uses alcohol or drugs while in treatment, becomes suicidal, or requires additional medical or mental health treatment.
- Obtain a signed release of information by the offender that will allow the supervision agency and the treatment provider to share pertinent information regarding the DWI offender.
- When working with offenders with substance abuse problems, be able to identify triggers for relapse (Taxman, et al., 2005) including, positive drug tests, association with drug or alcohol using peers, changes in housing or employment and failure to live up to the basic supervision requirements such as reporting.
- Understand the stages of change and consider how graduated responses can be applied when relapse occurs, rather than automatic revocation.
- Document all activities, findings and problems. Include information gathered from face-to-face, telephone, or other first person contact. Record the offender's progress

through the stages of change and how incentives and sanctions have been applied.

- Conduct periodic supervision face-to-face contacts, in the office and in the home of the offender to review the case plan, encourage compliance, build self-esteem, and reward progress (Monchick, Scheyett, & Pheifer, 2006).
- Conduct announced and unannounced home contacts and other collateral contacts to evaluate the offender's living environment, ensure program compliance, and maintain contact and gather relevant information from family members or other involved parties (Monchick, Scheyett, & Pheifer, 2006).
- Whether in the home, field, or collateral, contacts are the core function of the supervision process. The process of interviews between the supervising officer and the offender helps to assess, through conversation and observation, how well the offender is adhering to the conditions of supervision and how well they are meeting other objectives outlined in their case or supervision plan.
- The purpose and tone of contacts with the offender also are a key component to encouraging successful behavioral change; therefore, work on establishing a good rapport with clients. Contacts should not focus merely on the exchange of information. They should be more of an engagement process designed to achieve desired results (Taxman, 2002).
- Extend community supervision, if necessary and possible, for a period of time sufficient to complete the level and type of treatment deemed appropriate for the offender.
- If available, use technological tools and devices (see Appendix F) to assist in monitoring compliance, however, be sure that:
    - » The tool is appropriate for the offender.
    - » You have been trained in the use of the tool.
    - » You will receive reports on compliance.

- Periodically remind the offender of the provisions in the behavioral contract including (Taxman & Soule, 1999):
    - » The types of infractions that will lead to revocation.
    - » The types of infractions that will require court intervention.
    - » The types of infractions for which the supervision officer has authority to impose sanctions.
- Act immediately, when there is a violation of the conditions of supervision or the behavioral contract.
- Utilize incentives to encourage and reinforce positive behavior. Apply incentives in a timely manner and let offenders know when they are receiving a reward. For example, sometimes a supervision officer may decide to decrease the frequency of drug tests required; however, if this is done without informing the offender it will not have the same type of impact on their behavior. In other words, they have to know they are being rewarded and for what reason they are receiving the reward to make the connection to their behavior.
- Use praise as a reward for positive behavior—this can be a powerful motivator (Lindquist et al., 2006).
- Make sure you document the allocation of sanctions, incentives and interventions to ensure the proportionality and progression of subsequent sanctions, incentives, and interventions.
- If required, notify appropriate authorities or entities (e.g., court, supervisors, and treatment providers) of offender's sanctions and incentives.
- When working with DWI offenders, any occurrence of driving on a suspended license should be considered a violation of supervision and require a sanction.

Guideline 4

Where possible, develop partnerships with programs, agencies, and organizations in the community that can enhance and support the supervision and treatment of DWI offenders.

Key Points

- Identify and develop partnerships with service and treatment providers that will enhance supervision services and meet the needs of DWI offenders.
- Develop written agreements that support and outline how the partnership will function.
- Develop written policies and procedures regarding interagency partnerships.
- Understand how information flows intra-agency and interagency and identify the impact on privacy.
- Discuss information sharing needs with partner agencies and strive to overcome barriers related to information exchange.

Rationale

It is important for community corrections agencies and supervision officers to know what resources are available in their communities that will assist them in supervising and meeting the treatment needs of DWI offenders. Community corrections agencies and supervision officers often are under considerable programmatic, time, and budgetary constraints. Communities also have limited financial and human resources. This lack of sufficient resources poses a serious impediment to enforcing and reinforcing compliance (Robertson & Simpson, 2005). Effective collaboration can expand the range of supervision strategies and services that community correction agencies can offer to offenders. The purposeful and improved ability to sort and match resources to offenders needs helps community corrections agencies use scarce resources more effectively, while enhancing public safety (Cohen, Mankey, & Wendt, 2003). In addition, effective partnerships with community agencies also help build support and ties with the community and decrease role confusion and duplication of services among service providers.

When forming partnerships with other agencies, there needs to be a shared vision and understanding about how services will be delivered; otherwise, the partnership may produce unsatisfactory results. Misunderstanding, misconceptions, and miscommunication weaken partnerships. Formulating an understanding of what and how services will be delivered gives both sides opportunities to avoid and resolve issues that can make the exchange of services more effective and efficient. It also presents an opportunity to discuss how each program, agency, or organization will conduct future evaluation efforts and how and what type of information can be shared (Godwin, Heward, & Spina, 2000).

A key element in the development of effective interagency partnerships is the ability to share pertinent information. NIDA (2006) indicates the coordination of alcohol and drug abuse treatment with community supervision planning can encourage participation in alcohol and drug abuse treatment and can help treatment providers incorporate community supervision requirements as treatment goals. In a study conducted by Robertson and Simpson (2005), the majority (88%) of probation officers agree that improved information sharing and communication with treatment providers would greatly improve their ability to supervise offenders and encourage compliance with court-ordered sanctions.

Often there are long-standing and substantial barriers

that must be addressed when developing a plan for more effective and efficient information sharing among agencies. One obstacle to information sharing encountered by many community supervision agencies and treatment providers can be attributed to tension about how cases should be managed that sometimes results from the philosophical differences between the two disciplines. For example, some treatment providers feel that community corrections officers are overly invasive and want to dictate the terms of treatment. Additionally, some treatment providers feel the "enforcement" aspect of working with offenders gets in the way of the therapeutic process. If a client comes to a session and admits they have relapsed or produces a positive urine sample, the drug counselor may recognize that relapse is part of the recovery process but may be apprehensive about sending that information to the community corrections officer because they feel the officer may use it to revoke their client's probation or parole (Cohen, Mankey, & Wendt, 2003).

Other barriers to information sharing may include, but are not limited to, agency policies regarding privacy and confidentiality, misunderstandings about provisions outlined in the Health Insurance Portability and Accountability Act (HIPPA), lack of understanding and agreement on the type of information that should be shared, and mistrust of how information will be used. Regardless of the barriers that need to be overcome, the benefits (e.g., increased public safety, more effective services and interventions for offenders, decreased recidivism) to information sharing outweigh the disadvantages. The development of privacy and information sharing policies also ensures "that issues and concerns are addressed before individual harm occurs or practices become a matter of agency or administrator embarrassment, criticism, or liability" (U.S. Department of Justice Global Advisory Committee, 2005, p. 7). Ultimately, solid privacy and information sharing policies help protect agencies and make it easier to share information (U.S. Department of Justice Global Advisory Committee, 2005).

Implementation Strategies for Guideline for Developing More Effective Partnerships

Policy Considerations

- Conduct a needs and resources assessment regarding the supervision and treatment services for DWI offenders. Identify where adequate resources exist and where gaps may need to be filled. Examples of services needed for DWI offenders may include (but are not limited to):
    - » Drug and alcohol assessment
    - » Drug and alcohol treatment (outpatient, inpatient, residential)
    - » Cognitive behavioral treatment programs
    - » Substance abuse education programs
    - » Mutual-help and recovery groups
    - » Mental health counseling
    - » Detoxification
    - » Victim impact panels
    - » Drug testing, on site and lab
    - » Ignition interlock
    - » Continuous transdermal alcohol testing
    - » Electronic monitoring with alcohol sensor
    - » Electronic monitoring
    - » Gender specific
    - » Culturally specific

- When assessing needs and resources, it may be helpful to talk with supervision staff and to network with other agencies in the community that serve DWI offenders (misdemeanor courts, municipal courts, drug courts or other problem-solving courts, parole, reentry programs, treatment providers, etc.). Also, when networking with these types of entities new gaps in services may be identified that need to be addressed, new insights may be gleaned on the types of services and treatment that need to be provided, and new ways to partner and share resources may be discovered.
- When potential new partners are identified obtain detailed information on the types of services being provided by the agencies. Information it may be helpful to gather includes the population the program or agency serves, whether the service or treatment providers have any

applicable certifications, the types of services provided, an estimate of the flow and source of clients served by the program or agency, methods of referral to the program or agency, methods of evaluation of client needs, methods for providing services that address the client needs and the rationale for the chosen methods of service delivery, methods used for monitoring clients and providing feedback to referral sources, criteria for successful or unsuccessful termination from the program or agency, and costs associated with services (DeHoog, 1984; Lieber, 1987).

- Before contracting for services, know who the agency's contact person is, have an established method for communication, and be sufficiently satisfied with the agency's capacity for delivering effective and efficient services, the entity's corporate status (e.g., individual, partnership, corporation, nonprofit, or for profit), and the agency's delineation of daily responsibility for services delivered (Lieber, 1987). Also, be aware of the type of treatment modality (e.g., therapeutic option) that treatment providers use and whether they use treatment strategies that have been shown to reduce re-offending. Discuss ways in which supervision staff and treatment providers can work together to assure offenders are targeted for appropriate services. Be cognizant of the agency's vision and philosophy for the provision of services and treatment. Meet with local treatment and mental health providers to review current supervision strategies and discuss how these strategies reinforce or may be counterproductive to treatment goals. Encourage treatment providers to incorporate supervision strategies into treatment goals (e.g., abstinence from alcohol and drug use; housing and childcare; medical, psychiatric, and social support services; vocational and employment assistance).
- Contact individuals or organizations who use or have used the services of the prospective partner agency to ascertain their satisfaction with the services received (Beto, 1987).
- Determine if the agency or service is regulated (e.g., State license, status of the license, are they compliant).
- Respect partnering agency's needs and constraints. Inform them of your agency's needs and constraints. Develop strategies that will allow the partnership to accommodate each agency's needs and constraints, whenever possible.
- Whenever possible, develop a written agreement with service and treatment providers. Some programs or agencies may want the understandings to be a legal document. In those cases, involve an attorney in reviewing and implementing the contract (Scherman, 1987). However, agreements do not have to be that formal. The agreement can simply be a letter that outlines each agency's expectations and is signed by the ranking administrator of each organization. Make sure the person who is negotiating the elements of the agreement has decision-making authority. Some elements to address in agreements between agencies include:
    - » The type of treatment or services that will be provided
    - » Cost for services to the respondent, if any
    - » Treatment and referral criteria
    - » The process for referring cases or clients
    - » Frequency and type of client contact
    - » The process for successful and unsuccessful termination of clients or cases
    - » Frequency and type of communication among the respective agencies and programs
    - » Expectations for sharing information (see Guideline 8 for more details on information sharing)
    - » Confidentiality issues
    - » Outcome measures

- Many agencies already have policy and procedures related to sharing information, confidentiality and or privacy. If your agency has these types of policy and procedures, review them to assure they are able to address and respond to current needs, issues, and laws. Also evaluate the policies to determine if they are relevant to 21st century technology.
- If no policy exists in these areas or if they are outdated, consider developing or revising appropriate policy and procedures.

- Talk with supervision staff to identify current obstacles and barriers to information sharing both within the organization and among its various partners related to the supervision of DWI offenders. Also talk with appropriate personnel from partner agencies to identify obstacles and barriers they may be encountering related to information sharing with your organization.
- Appoint a project team to work on the development of the new information sharing, privacy and confidentiality policies. Recommended team members should include policymakers; line staff; legal representatives; technical staff; and others who have a role in collecting, maintaining, using, disseminating, and retaining information (U.S. Department of Justice Global Advisory Committee, 2005). When examining issues related to sharing information across agencies, it may also be helpful to involve key representatives from those agencies on the team.
- Chart or map the flow of information and information processes both within the agency and between partner agencies to identify decision points related to information collection, use and dissemination. You can map information flows through focus groups, interviews with stakeholders, or with the use of templates or other mapping tools. See Appendix A for some suggested readings on building partnerships and enhancing information sharing protocols that include resources that provide more detailed information on mapping information flow.
- When mapping the information flow, also conduct a privacy impact assessment (PIA) that describes the personal information flows in a project and analyzes the possible privacy impacts of the information exchanges. The purpose for doing a PIA is to identify and recommend options for managing and minimizing privacy impacts (Office of the Privacy Commissioner, 2006).
- There is no universal privacy and information policy that an agency can adopt as is. Therefore, it is imperative that agencies examine applicable State, local and federal laws and develop policy that is consistent with those laws. When doing so, conduct an analysis of applicable laws to provide guidance to the agency about what information may be collected, what information may not be collected, how the information can or cannot be collected, and with whom it may be shared. Be on the look out for gaps where there is no law to guide the policy or where there are conflicts in laws and practices that need to be reconciled before drafting policy (Global Privacy and Information Quality Working Group, 2006).
- When developing the information sharing policy and examining issues related to confidentiality and privacy, ascertain what you need to know versus what you want to know. In other words, consider how to share only that information that is necessary to move the case forward. Review the "Fair Information Practices" that were developed and formalized in the 1980s to address issues related to the commercial use and sharing of personally identifiable information. Evaluate and consider the applicability and appropriateness of these principles within your agency (U.S. Department of Justice Global Advisory Committee, 2005). See Appendix A for supplemental resources related to building partnerships and enhancing information sharing.
- Consider the possible impact of technology (including existing technology and/or new technology the agency and its partner agencies may be considering) on privacy and information sharing policies and procedures. Review information developed by the U.S. Department's Global Justice Information Sharing Initiative at www.it.ojp.gov/global.
- Educate yourself about the provisions outlined in the Health Insurance Portability and Accountability Act (HIPPA) and how these may or may not relate to your agency. There are often misunderstandings about how HIPPA is applied within justice agencies. There is an informative bulletin published by the CMHS National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness in February 2007 titled Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems that examines this issue in more detail. The bulletin is available

for download at www.gainscenter.samhsa.gov/pdfs/integrating/Dispelling_Myths.pdf.

- Make sure that clients are aware of what type of information may be shared, who the information may be shared with and how the information may be used.
- Determine what types of releases or other legal documents should be created and under what circumstances they should be used.
- Determine how information should be shared between agencies (e.g., in writing by letter, verbally, email, etc) and what other internal controls are necessary when information is shared (e.g., co-signature by supervisor). Outline provisions for how information sharing will be documented and recorded by the various agencies.
- Discuss with partner agencies how information will be used and how improved information sharing can meet the needs of both agencies and improve outcomes for the client. When disagreements occur regarding the result of certain types of information being shared (e.g., an automatic technical violation filed when a treatment provider informs the probation officer that a client has relapsed), work toward reaching a consensus of how to alleviate these types of barriers (e.g., agree on a graduated response—as opposed to automatic violation—to reported relapses).
- Have written agreements approved and signed by the appropriate authority.
- Agreement should be flexible and allow for modifications or changes when necessary.
- Periodically review and evaluate how partnerships with the various agencies are working.
- Develop strategies for maintaining effective interagency partnerships such as meetings, telephone communication, mutual training workshops, joint staff or meetings. Also, encourage agency staff to get to know staff from these agencies and develop positive working relationships with them. Often the personal professional relationships built and maintained among staff can facilitate the most effective partnerships.
- Consider joining and/or forming a coalition that consists of agencies and individuals who work and/or have common interests in areas related to serving and supervising DWI offenders.
- Provide training to all staff on the types of strategies and services available to aid in the supervision of DWI offenders. Consider cross-training with partners.
- Assure that all staff members receive training on the agency's information sharing, privacy and confidentiality policies and procedures. When developing a training plan, it should take into consideration the role and duties of those being trained and include information on how staff will be held accountable for adhering to the policies. Provide periodic refresher courses on these policies.

Practice Considerations

- Identify and monitor each offender's unique needs for support and rehabilitation services, coordinate access to appropriate services, and ensure linkages and coordination among treatment and service providers.
- Initiate drug and alcohol testing early and continue on a random, unannounced basis.
- Work with treatment/service providers to develop and revise supervision and treatment goals that include the coordination of sanctions and incentives.
- Educate yourself on the types of strategies and services available to aid in the supervision of DWI offenders. Review the tips provided above for community corrections agencies for insight into the type of information you should know about the agencies or individuals to which you refer offenders for services or treatment.
- Seek references for treatment providers.
- Get to know treatment providers to which you refer clients to facilitate a more collaborative working relationship. Develop a two-way communication process. Provide treatment providers with information related to the criminogenic risk and needs of the offender to assist in treatment planning and develop a treatment plan with the provider. Request verification on compliance and notification of noncompliant behaviors.
- Get to know service providers (e.g., electronic monitoring companies, ignition interlock companies, drug testing companies) as well. Ask questions related to the

expectations and limitations of the equipment and determine if there are ways for the offender to remove or sabotage the equipment. Establish the procedure for verification of information, how often reports will be received, and the types of violations that will be reported.

- Strive for open communication with service and treatment providers.
- Develop rapid, easy communication devices and formats for information and progress reports between service and treatment providers.
- Establish a collaborative relationship with treatment and service providers that allows for problem-solving, accountability, reciprocity, and a shared vision.
- Educate yourself about your agency's information sharing, privacy and confidentiality policies and procedures.
- Inform supervisors or managerial staff of any problems, obstacles, or barriers that you encounter when sharing information with partner agencies.
- Get to know staff of partner agencies with whom you will be sharing information. Develop a good rapport with these individuals and approach your work with reciprocal clients from a team perspective that will enable you to keep track of the progress of the offender, make modifications to the treatment plan, and/or develop appropriate graduated sanctions and incentives for the offender.
- When necessary, inform staff of partner agencies about your agency's policies with regards to privacy and information sharing. Be aware of their agency's polices and procedures as well.
- Make sure that clients are aware of what type of information may be shared, who the information may be shared with, and how the information may be used.
- Be aware of the types of releases or other legal documents that should be signed by clients regarding information sharing and privacy.
- Review agency policies and procedures and be cognizant of the type of information you can share with outside agencies, when information can be shared, and how you share the information. Limit the passage and receipt of information to only that which is necessary to move the case forward (i.e., what you need to know versus what you want to know). For example, when making the referral for treatment, it may be helpful to provide treatment providers with information on the offender's risk to re-offend and his or her criminogenic needs.
- Discuss with partner agencies how information will be used and how improved information sharing can meet the needs of both agencies and improve outcomes for the client. When disagreements occur regarding the result of certain types of information being shared (e.g., an automatic technical violation filed when a treatment provider informs the probation officer that a client has relapsed), work toward reaching a consensus of how to alleviate these types of barriers (e.g., agree on a graduated response—as opposed to automatic violation—to reported relapses).

Guideline 5

Supervision staff should receive training that will enhance their ability to work effectively with DWI offenders.

Key Points

- Provide training to staff on evidence-based practices that support the effective supervision of DWI offenders.
- Assure staff receives training on substance abuse, cycle of addiction, and the stages of change.
- If your agency does not provide formal training, educate yourself.

Rationale

When community corrections staff do not receive adequate training and resources to aid in their supervision of DWI offenders, it compromises the effectiveness of community supervision as a sentence and jeopardizes public safety. Supervising and monitoring DWI offenders can be complex, involving a broad range of conditions with varying levels of supervision that rely on considerable cooperation and coordination with a variety of other justice and community agencies (including treatment providers) [Robertson & Simpson, 2003]. Alcohol and drug addiction has well-recognized cognitive, behavioral, and physiological characteristics that compel many offenders to continue to use substances, despite the harmful consequences to themselves and others (NIDA, 2006). Due to the addiction aspect of working with substance abusing DWI offenders, standardized ways of supervising, monitoring, and encouraging compliance may not be as effective. Staff training on addiction issues and other needs of DWI offenders (e.g., poly-substance use, co-occurring mental disorders), as well as on the operation and effectiveness of various sentences and programs they are required to monitor and technologies they are able to use (Robertson & Simpson, 2003), can equip community corrections professionals to establish more effective case and supervision plans, as well as help them employ more effective case monitoring practices.

Implementation Strategies for Training Staff on Effective Supervision of DWI Offenders

Policy Considerations

Provide training to supervision officers on evidence-based practices that support effective supervision of DWI offenders. General training in substance abuse and chemical addiction should be provided as part of any initial officer orientation and/or ongoing professional development. Additional training topics to consider include:

- Motivational interviewing and stages of change
- Signs of relapse and relapse prevention
- How to develop case or supervision plans that promote behavioral change and match treatment services with individual offender's needs.
- The cycle of addiction and its implication for its predictive use for future violations.
- The appropriate and proportional use of graduated sanctions and incentives as part of case management.

Practice Considerations

In absence of formal training, conduct research on the topics identified above. See Appendix A for suggested supplemental resources on a variety of topics.

Guideline 6

Assess the effectiveness of supervision practices on DWI offender through both process and outcome measures.

Key Points

- Evaluate your agency's effectiveness in supervision of DWI offenders.
- Assess process and outcome measures.
- Learn from and share evaluation results.

Rationale

Monitoring performance and outcomes in the supervision of DWI offenders is a basic ingredient to agency and program accountability. While often feared and avoided, evaluation creates a learning environment that allows agencies to improve policy, procedures, and practices. Evaluation highlights positive outcomes, uncovers ineffective practices, guides agencies to explore alternative methods for achieving stated goals, and positions agencies to demonstrate results and compete for limited funds.

Results-oriented approach to evaluation examines two types of measures—process measures and outcome measures. Process measures help programs obtain fundamental feedback on whether the program or practice is being implemented or operated according to specifications (i.e., What did the program or practice do?). Examining process measures helps to explain why particular effects were produced and identify how processes can be modified to produce desired outcomes (Blalock, 1990). By controlling process, programs can control outcomes. Outcome measures are needed to assess a program's immediate, intermediate, and ultimate effects (i.e., What effect did the program or practice have?). By measuring outcomes, community supervision agencies can better assess the effectiveness of various activities and program components, learn from successes, and fine tune the program's practices (Boone, Fulton, Crowe, & Markley, 1995).

Evaluation efforts need to be ongoing because program evaluations only provide outcomes for a specified period of time. To use evaluation as a framework for continual program improvements, periodic evaluations are necessary. More frequent evaluations when new policies or practices are being implemented can be especially helpful as they transition from a conceptual framework into actual program practice. Intermediate results can be used to make mid-course corrections in practices or procedures that may be necessary to address unexpected challenges.

Implementation Strategies for Assessing Effectiveness of Supervision of DWI Offenders

Policy Considerations

- A key to successful evaluation that assesses how effectively an agency is working with DWI offenders is to develop policies and procedures related to working with DWI offenders that have clear, measurable, and realistic objectives. If objectives are unrealistically optimistic, an agency may not be able to demonstrate that it has been successful with its DWI programming—even if it has done a good job.
- Don't try to measure so much that it compromises the evaluation process. Limit the scope of the evaluation to no more than four to six well defined research questions. Questions should encompass a reasonable balance between process and outcome measures.
- Process measures are those that help programs obtain fundamental feedback on whether the program or practice is being implemented or operated according to the way it was designed (e.g., do staff and agency practice matching the established standards, policy, and procedures). Outcome measures are those that help agency

administrators determine if desired results (e.g., is the agency meeting the established benchmarks or measures of success) are being achieved. Generally, the public is more concerned with an agency's outcome measures. They want to know the overall effect of an agency or program. However, outcomes alone do not tell us what an agency (or its staff) is doing. The way agencies can improve their outcomes is by making sure its processes are working the way they are designed. In other words, by controlling processes, agencies can control and improve outcomes (Connolly, 2003). Therefore, it is imperative that agencies not overlook the importance of assessing process measures when conducting evaluations. Appendix I contains examples of process and outcome measures related to the supervision of DWI offenders.

- When determining what to evaluate, in addition to what your agency considers success, give consideration as to how other stakeholders (e.g., offenders, victims, treatment providers, the judiciary, community) may define success. Understand that stakeholders' definitions of success may include measures beyond the staffs' interests. By including measures that are important to stakeholders, community corrections agencies demonstrate their commitment to the community and sustain community interest and involvement.
- One way to prioritize research questions when making a final selection of what the evaluation will cover is to ask, "I need to know _____, because I need to decide_____ _____."
- Share evaluation results, good or bad, with stakeholders.
- For outcomes that do not meet the agency's expectations, give careful consideration to what modifications to program policy, procedure or practice may need to occur to achieve more positive results in the future. Some modifications can be made exclusively within the agency; however, some negative outcomes may be attributed, in part, to other stakeholders' roles in the process. For example, it may be determined that supervising officers are not able to respond timely to violations of conditions of probation because of inefficient information sharing between treatment providers and the supervising officers. This will necessitate problem solving with the agency involved to see if adjustments to protocols can be made to address and resolve the identified problem.
- Remember, what gets measured gets done (Osborne & Gaebler, 1993, as cited in Boone, Fulton, Crowe, & Markley, 1995). Therefore, align program evaluation efforts with performance evaluations and ensure that staff are aware of the what is being measured.
- Create a step-by-step work plan for conducting the evaluation. The work plan should include information on the research questions being examined, data elements needed to address the research questions, methodology or techniques needed to answer the question, how data will be collected and analyzed, who is responsible for performing specific evaluation tasks and for collecting and analyzing data, and target dates for milestones in the evaluation plan.
- To minimize the risk of bias, when possible and resources allow, use an objective evaluator. However, an outside evaluator is not essential and should not deter agencies from conducting their own evaluation. Local colleges and universities are potential sources for outside evaluators.
- Rather than arranging for an outside evaluator at the last minute or when an urgent need arises, try to anticipate the need for future evaluations and develop ties with potential evaluators and researchers in the local area. Faculty members at local and regional universities are excellent resources for evaluation and research expertise and may welcome the opportunity to design and conduct a program evaluation for little or no cost.
- When an outside evaluator is used, view the community corrections agency as a customer with certain needs and expectations. Recognize that outside evaluators may also have specific needs and expectations related to the evaluation process. Communicate and work together to specify what information is hoped to be gained from the evaluation, identify resources available for the evaluation, and address potential barriers or obstacles to evaluation efforts.
- Ask for outside evaluators to design the evaluation that will ensure the integrity of the information within the

agency's time and resource constraints.

- Determine what data needs to be collected to answer research questions related to agency objectives.
- Develop case management practices that will make data collection easier. Data collection can be streamlined and simplified if forms and methods of program documentation (including automated systems) are designed with evaluation in mind. Only collect data that will be analyzed, used to modify and improve program operations, or reported. In other words, don't collect data that you do not need or do not plan to use in some way.
- Gather both qualitative and quantitative data. Qualitative data is information that is difficult to measure, count, or express in numerical terms (e.g., whether supervision officers are effectively using motivational interviewing techniques). This type of data is used in research involving detailed, verbal descriptions of characteristics, cases, and settings. Qualitative research typically uses observation, interviewing, and document review to collect data (Connect Wyoming, n.d.). Quantitative data is information that can be quantified in the form of numbers (e.g., the number of DWI cases that were sent for evaluation for substance abuse treatment).
- Develop concise policies and procedures for data collection and analysis and update them as the agency's needs and responsibilities change. Incorporate these policies and procedures into the agency's case management and monitoring policies.
- Include outcome measures in contracts with outside service and treatment providers.
- Examples of data sources include conditions of supervision forms, case or supervision plans, results of drug and alcohol screening and assessment instruments, and court dockets.
- Form partnerships and collaborative relationships with agencies that have access to data needed for evaluation efforts (e.g., courts, law enforcement agencies, treatment providers, service providers).
- States may have laws that regulate the collection, maintenance, and use of data. Also, some States have laws that regulate the sharing of data between collaborating agencies. Research and comply with these laws.
- Automated information systems can make conducting evaluations more efficient by reducing paperwork, maintaining data in an organized fashion, and providing quick access to information and results. When developing an automated management information system:
    - » consider establishing a committee to guide its implementation;
    - » consult a computer systems expert to examine agency needs, assist with preparation of a request for proposals, and review vendor bids;
    - » carefully evaluate a number of management information system hardware and software options;
    - » if finances and expertise allow, develop a program- or agency-specific management information system; and
    - » evaluate management information system capabilities periodically to ascertain if new hardware or software purchases can make the system more effective and efficient.
- An ideal management information system allows for collaborating agencies to share information. However, if a multi-user information system is used, make decisions about ownership of records, confidentiality of information, and responsibilities for updating and maintaining records.

Practice Considerations

- Document, document, document. Regardless of the type of evaluation system implemented by a community corrections agency, or the varied ways that the data can be collected, the data collected only provides a clear picture of the program if the correct data is entered.
- Incorporate outcome measures in all case or supervision plans.
- Ask questions; if you are unclear about how an established policy is to be implemented then the policy or procedure is unclear and the analysis of what is to be accomplished is also unclear.
- Encourage evaluation of your supervision practices, this will let you know if the work you are doing is making a difference.

Section III
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Section IV
Appendices

Appendix A: Supplemental Readings and Resources

- Substance Abuse and Addiction (Cycle of Addiction, Relapse Prevention)
- Risk and Needs Assessment
- Screening and Alcohol and Drug Assessment
- Automated Case Management Systems
- Motivational Interviewing and Stages of Change
- Graduated Responses—Sanctions and Incentives
- Evidence-Based Practices and Behavioral Change
- Building Partnerships and Enhancing Information Sharing Protocols

Appendix B: Alcohol and Drug Screening Instruments for DWI Offenders

Appendix C: Components of a Case or Supervision Plan

Appendix D: Sample Behavioral Contract

Appendix E: Sample Graduated Sanctions and Incentives

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Appendix H: Nebraska Standardized Model—Policy, Procedures, and Forms

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Appendix J: Overview of Findings of the APPA Questionnaire on the Supervision of DWI Offenders

Appendix A
Supplemental Readings and Resources

Substance Abuse and Addiction (cycle of addiction, relapse prevention, stages of change)

Suggested readings

Cavaiola, A.A., & Wuth, C. (2002). *Assessment and treatment of the DWI offender.* Binghamton, NY: Haworth Press, Inc.

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www.nida.nih.gov

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samsha.gov

MedlinePlus
www.nlm.nih.gov/medlineplus/drugabuse.html

SAMHSA's Center for Substance Abuse Prevention
http://prevention.samhsa.gov

SAMHSA's Center for Substance Abuse Treatment
http://csat.samhsa.gov

National Association of Alcohol and Drug Abuse Counselors
http://naadac.org

Center for Substance Abuse Research
www.cesar.umd.edu

National Institutes of Health
http://health.nih.gov/search.asp/21

National Institute on Alcohol Abuse and Alcoholism
www.niaaa.nih.gov

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www.niaaa.nih.gov/Publications/AlcoholResearch

Risk and Need Assessment

Suggested readings

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Web Sites

Substance Abuse and Mental Health Services Administration (SAMHSA).
www.samhsa.gov

Alcohol and Drug Abuse Institute
http://depts.washington.edu/adai

Substance Use Screening & Assessment Instruments Database
http://lib.adai.washington.edu/instruments

Automated Case Management Systems

Suggested readings

Taxman, F.S., & Sherman S. (1998). Seamless systems of care: Using automation to improve service delivery and outcomes of offenders in treatment. In L.J. Moriarty & D.L. Carter (Eds.), *Criminal Justice Technology in the 21st Century.* Springfield, IL: Thomas. Available online at www.bgr.umd.edu/pdf/tech_case_mgnt.pdf.

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U.S. Department of Justice Global Justice Information Sharing Initiative
www.it.ojp.gov/topic.jsp?topic_id=8

University of Maryland's Automated Tracking System (HATS)
www.bgr.umd.edu/hats.html

Motivational Interviewing

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Center for Strength-Based Strategies
www.buildmotivation.com

Motivational Interviewing Network Trainers (MINT)
www.motivationalinterview.org

Graduated Responses—Sanctions and Incentives

Suggested Readings

Lindquist, C., Krebs, C., & Lattimore, P. (2006). Sanctions and rewards in drug court programs: Implementation, perceived efficacy, and decision making. *Journal of Drug Issues, 36*(1) 119-144.

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Web sites

University of Maryland: Bureau of Government Research
www.bgr.umd.edu

Evidence-Based Practices and Behavioral Change

Suggested readings

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National Institute of Corrections Information Center
www.nicic.org

Building Partnerships and Enhancing Information-sharing Protocols

Suggested Readings

Fulton, B.A. (1996). *Restoring hope through community partnerships: The real deal in crime control.* Lexington, KY: American Probation and Parole Association.

Global Privacy and Information Quality Work Group. (2007, January). *Information quality: The foundation for justice decision making.* Washington, DC: Global Privacy and Information Quality Work Group.. Retrieved April 30, 2007, from http://it.ojp.gov/documents/IQ_Fact_Sheet_Final.pdf.

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Global Justice Information Sharing Initiative (U.S. Department of Justice)
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Other Related Topics

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Appendix B

Alcohol and Drug Screening Instruments for DWI Offenders

Instrument	Administered by	Testing Time	Primary Domain	Considerations
Alcohol Severity Index (ASI)	Structured interview administered by a trained technician	50 – 60 minutes, Computerized and pencil/paper administration	Assesses substance-use disorders only, guides treatment planning	Yields two sets of scores: severity ratings (need for treatment) and composite scores (severity during the past 30 days).
Alcohol Use Inventory (AUI)	Training is required	35 – 60 minutes, Computerized and pencil/paper administration	Perceptions, benefits, styles of drinking	More for treatment planning thatn screening. Best predictive value for DWI recidivism
CAGE	No minimum training requirement	1 minute, Computerized and pencil/paper administration	Alcoholism	Convenient, non-threatening Limited use for DWI screening
Driver Risk Inventory (DRI) (Newer Version DRI-11)	Computerized and commercialized	30 – 35 minutes, Computerized and pencil/paper administration	Alcohol, drugs, driver risk, stress/coping	Truthfulness correction, Designed for DWI Screening
Life Activities Inventory (LAI)	Self report	60 minutes, pencil/paper administration	Life situation and personality scales	Designed for DWI Offenders to assess treatment induced changes in life circumstances over time
MacAndrew Alcoholism Scale ((Revised) of the Minnesota Multiphasic Personality Inventory-2 (MAC-R)	Restricted to psychologist who trained in administering and scoring	Clinical Interview	Alcoholism scale derived from the MMPE	Subscale of MMPI and single best predictor of recidivism
Minnesota Assessment of Chemical Health (MACH)	Computerized program	30 minutes, Computerized	Severity, stressors, obstacles, referral	Integrates questions from MAST, MF, and the DSM-IV criteria for alcohol abuse and dependence
Mortimer-Filkins Questionnaire (MF)	No minimum training requirement	45 – 90 minutes, pencil/paper administration	Developed specific for DWI population	Widely used since 1971, Identifyes problem drinkers, potential problem drinkers, social drinkers
Michigan Alcoholism Screening Test (MAST)	No minimum training requirement	10 min, pencil/paper administration	Alcohol Screening	Probably the most widely used since 1971. All studies done on males, does not distinguish between past and present drinking.
Research Institute on Addictions Self-Inventory Instrument (RIASI)	No minimum training requirement	20 minutes, pencil/paper administration	Developed for screening DWI population	Predictive of recidivism, easy to administer, no cost
Substance Abuse Life Circumstances Evaluation (SALCE)	Computerized test	20 minutes, pencil/paper administration	Designed for DWI screening to determine need to alter use of alcohol or other drugs	Computerized test report contains treatment recommendations
Substance Abuse Subtle Screening Inventory (SASSI)	Structured interview administered by a trained technician	10 – 15 minutes, Computerized and pencil/paper administration	Chemical dependence, related psychosocial domains	Designed for screening of a variety of clinical populations

Sources: (Chang, Gregory, & Lapham, 2002; Cavaiola & Wuth, 2002)

Appendix C

Components of a Case or Supervision Plan

The court has sentenced the individual to probation. Now what do you do? The supervision officer uses various tools and techniques to obtain the information necessary to write a case plan. Although the pre-sentence report and risk and needs assessment are good resources, interviews with the offender are the best source of information for developing the case plan.

Pertinent Interview Information

- Date/circumstance of problem
- Probationer recognition of problem
- Recurrence
- Triggers
- Solutions
- Complaints
- Negative consequences
- What could be different?
- What would probationer like to do?

Considerations for Developing a Case Plan – Be SMART

SMART is an acronym for five considerations when developing a case plan.

Simple – Keep the problem statement, behavioral objective, and action plan simple and to the point.

Measurable - The outcomes of the case plan have to be measured in some way.

Attainable - Having a realistic goal allows success and gives the offender the incentive to invest time and energy into the plan.

Realistic - No effort will be put forth by the offender if he/she is required to do too much too quickly. More effort is then needed by the supervision officer.

Time-framed - Actions cannot be open-ended; they must have a beginning and an end.

Using a Case Plan

- Use the case plan to monitor compliance.
- The case plan should be the driving force behind every offender contact.
- The case plan is a dynamic instrument that may need to be changed during the management of a case.
- Restitution, fines and fees, and monetary penalties are court-ordered sanctions and should be enforced as any other term or conditions of supervision.

Case Plan Components

Problem Statement

Describe the existing situation that brings the offender into the justice system. Describe any other factors that contribute to the existing situation and impact the behavior of the offender. Describe how this situation is affecting his/her life and what changes and consequences have resulted from this situation. Add details; be specific with the situation and behaviors associated with the situation.

Behavioral Objectives

State a positive behavioral outcome to the problem statement, and do not focus on the attitude. Behaviors are observable and easy to identity. Internal behavior[1] is also important because attitudes and beliefs drive thoughts, and thinking drives behavior. However, supervision officers cannot change the offender's attitude, the offender has to change.

Be as positive as possible by stating what will and should happen, not what cannot or should not happen. If objectives are stated positively, change becomes less of a negative.

The objectives need to be phrased in terms of the offender's responsibility, since her/she fails or succeeds by their own effort. Giving the offender a voice in the behavioral objectives assures objectives are desired by the offender.

Behavioral Objectives

My goal is to stop drinking and driving and learn techniques to help me reach my goal.

Probationer Action Plan

I will enroll, participate, and complete the ABC substance abuse program. Enrollment in the ABC program will occur by MM/DD/YY and the program will be completed by MM/DD/YY.

- I will attend AA once a week.
- I not drive a vehicle while my driver's license is suspended.
- I will not use alcohol while I am on probation.
- I will meet my supervision officer, after work, on the first and third Wednesdays at 6:00 pm either at my home or at the probation office.

Source: Probation Officer Certification Academy, Arizona Supreme Court Reaccreditation Application submitted 2007 to American Probation and Parole Association

1 Internal behavior may be a misnomer; one should consider cognition or cognitive activities, which are thoughts, attitudes and beliefs. Behavior is outward, measurable and observable, but not always easy to identify.

Appendix D

Sample Behavioral Contract

BEHAVIORAL CONTRACT FOR SUPERVISION[2]

NAME: _____

Case Number: _____

Supervision Officer: _____

PROBATION: ❒ PAROLE: ❒ Supervision Start Date: _____ Supervision End Date: _____

COMPAS Total Score: Last COMPAS Date: Next COMPAS Due:_____

SPECIAL CONDITIONS: _____

_____

_____

I. Criminogenic Need

COMPAS Subscale Score: _____

History: _____

Triggers: _____

Long Term Goal: _____

Short Term Steps Offender Responsibilities	Officer Responsibilities	Date to be Completed	Date Completed
1.			
2.			
3.			
4.			
5.			

II. Criminogenic Need

COMPAS Subscale Score: _____

History: _____

Triggers: _____

Long Term Goal: _____

2 Sample provided by Faye S. Taxman, College Park, Maryland: University of Maryland

Short Term Steps Offender Responsibilities	Officer Responsibilities	Date to be Completed	Date Completed
1.			
2.			
3.			
4.			
5.			

III. Criminogenic Need

COMPAS Subscale Score: _____

History: _____

Triggers: _____

Long Term Goal: _____

Short Term Steps Offender Responsibilities	Officer Responsibilities	Date to be Completed	Date Completed
1.			
2.			
3.			
4.			
5.			

Additional Needs to be Addressed: _____

_____

Offender Interests

1. _____

2. _____

3. _____

4. _____

Compliance: Sanctions and Incentives Matrix

CLIENT SIGNATURE: _____DATE: _____

PO SIGNATURE: _____DATE: _____

CPO/DCPO/SRPO: APPROVE: ❒ DISAPPROVED: ❒

COMMENTS: _____

_____

Appendix E

Sample Graduated Sanctions and Incentives

A Model of Graduated Sanctions	
Behavior	**Sanction** * May require administrative approval ** May require Court Order
Positive UA	
1st Positive breath, blood or urine drug test	• Increased drug testing • Increased reporting
2nd Positive breath, blood or urine drug test	• Random drug testing includes weekly home contacts • Increase in reporting schedule
3rd Positive breath, blood or urine drug test	• Electronic Monitoring with Alcohol Monitor* • Increase Self-Help Group • Increased Level of Treatment
4th Positive breath, blood or urine drug test	• Continuous Remote Alcohol Monitoring* • 2-5 days in jail**
Technical Violations	
Failure to report as directed, curfew violations, failure to maintain employment, changing residence without notify supervision officer, Leaving State without authorization or other violations of travel restrictions.	• Increased drug testing • Increased level of reporting
2nd or subsequent violations	• Electronic monitoring* • Increased level of supervision • Increased level of reporting • Day reporting center • Increase community service
Failure to Comply with Treatment Recommendations	
Leaving residential treatment without authorization, not attending outpatient treatment, using alcohol or drugs while in treatment, not attending self-help group as required	• Electronic monitoring* • Increased level of supervision • Increased level of reporting • Day reporting center* • Increase community service
2nd or subsequent violations	• Electronic monitoring with alcohol monitor* • Continuous remote alcohol monitor* • Weekend in jail** • Increased level of treatment • Increased level of supervision

A Model of Graduated Sanctions	
Behavior	**Sanction** * May require administrative approval ** May require Court Order
New Arrest	
New misdemeanor arrest, other than DWI	• Review policy on sanction prior to determination of guilt • If found guilty, determine if supervision will be revoked or extended • Electronic monitoring* • Increased level of supervision • Increased level of reporting • Day reporting center*
New felony arrest, other than DWI	• Review policy on sanction prior to determination of guilt • If found guilty, determine if supervision will be revoked or extended • Electronic monitoring* • Increased level of supervision • Increased level of reporting • Day reporting center*
Driving on a suspended license	• Electronic monitoring* • Increased level of supervision • Increased level of reporting • Day reporting center* • 2-5 days in jail**
New DWI arrest, felony or misdemeanor	• Review policy on sanction prior to determination of guilt • If found guilty, determine if supervision will be revoked or extended • Electronic monitoring* • Increased level of supervision • Increased level of reporting • Day reporting center* • Ignition Interlock** • Inpatient treatment • Revocation of probation**

A Model of Graduated Sanctions	
Behavior	**Incentive**
Positive UA	
1st Negative breath, blood or urine drug test	• Positive words from supervision officer
2nd Negative breath, blood or urine drug test	• Positive words from supervision officer
3rd Negative breath, blood or urine drug test	• Positive words from supervision officer and decrease in random drug testing
4th Negative breath, blood or urine drug test	• Positive words from supervision officer and decrease in random drug testing • Non-monetary positive reward, if allowed by agency policy (coupons for movies or food, bus passes).
Compliance with Supervision Requirements	
Offender has report as directed, complied with curfew violations, maintained employment and residence, or notified supervision officer of changes and requested authorization to leave the State or other violations of travel restrictions. No new arrests.	• More flexible reporting schedule • Decrease in reporting requirements • After half of supervision is completed consider non-monetary positive reward, if allowed by agency policy (coupons for movies or food, bus passes). • After three-fourths of supervision, or earlier, consider early discharge.
Compliance with Treatment Requirements	
Offender has been compliant with treatment requirements and actively participates in program. Has completed treatment and continues to attend self-help groups, discusses triggers with supervision officer and has a relapse plan.	• Decrease supervision reporting requirements, but do not eliminate. • Decrease drug testing requirements, but do not eliminate. • Acknowledge completion of treatment; if possible give a certificate to purchase AA Big Book or other AA publications.

Appendix F

Tools and Technologies to Assist in the Supervision of DWI Offenders

Electronic Monitoring

An electronic monitor is a device that is placed on an individual and used to monitor his or her location and activities. It is typically used as an alternative to incarceration or as a condition of community supervision.

How it can aid in supervision of DWI offenders:

- Provides structure and close supervision, enables offenders to obtain or maintain employment, and supports and reinforces rehabilitation and treatment.
- EM devices can also have alcohol sensors attached to determine the use of alcohol. Offenders on sentencing alternatives, such as staggered sentencing, are often required to use EM devices with alcohol sensors as a supervision strategy. See Appendix G for more information on how staggered sentencing is being used as a strategy for sentencing repeat DWI offenders.
- EM tends to be less expensive than incarceration and assists in reducing jail overcrowding.
- EM devices can be added as a sanction for noncompliant behavior or removed as an incentive for compliance. In most cases, the cost associated with EM is assessed to the offender and not having to pay is an incentive for compliant behavior.
- Officers can use hand-held devices to conduct "drive-by" verifications.
- EM devices may actively or passively report data to an officer or central monitoring agency.

Suggested Resource

With funding from the National Institute of Justice, the American Probation and Parole Association has developed Offender Supervision with Electronic Technology to help community corrections agencies understand and appreciate the process needed to incorporate and implement new or enhance existing electronic supervision strategies. This document can be accessed online at www.appa-net.org/resources/pubs/docs/OSET.pdf.

Ignition Interlock Devices

An ignition interlock is a device that is installed on motor vehicles to prohibit individuals under the influence of alcohol from operating the vehicle. Individuals are required to blow into the device before starting the vehicle. If the device detects alcohol, it will prevent the vehicle from starting. In addition, at random times during the operation of the vehicle, the driver will be prompted to blow into the device to ensure they are not under the influence. When used as a condition of supervision in conjunction with a monitoring and reporting the ignition interlock system provides DWI offenders with an alternative to full license suspension. Use of the system for repeat or high BAC offenders is often required by legislation and/or mandated by the motor vehicle department or other administrative authority. For example, 37 States have enacted legislation providing for its integration into the DWI adjudication and sentencing process. Cost for the ignition interlock is usually charged to the offender which often denies indigent offenders access. Indigent funds should be established allowing access for those who are unable to pay.

How it can aid in supervision of DWI offenders:

- Installation of an Ignition Interlock device allows the DWI offender to remain employed, in school, and involved in other pro-social activities when a driver's license has been suspended.

- Ignition interlock devices prevent the vehicle from being started if the breath sample provided by the driver contains more than a predetermined blood alcohol concentration.
- A report of the BAC level at the time of every ignition start-up is maintained in the unit.
- Data obtained through the recording devices show patterns of abuse that can lead to DWIs and the information offers insight into offender behaviors and triggers for relapse.
- Interlocks have been found to be beneficial for both first-time and repeat alcohol impaired offenders. "The interlock is very effective while it is on the vehicle, and the net benefit (accumulated during time on and off the interlock) in terms of reduced recidivism is substantial." (Robertson, R.D., Vanlaar, W.G.M., & Simpson, H. M. (2006). *Ignition interlocks from research to practice: A primer for judges.* Ottawa, Ontario, Canada: Traffic Injury Research Foundation, p. 8).

Suggested Resource

The Traffic Injury Research Foundation has published a document tilted A Criminal Justice Perspective on Ignition Interlock. This document is available online at www.trafficinjuryresearch.com/publications/pub_details.cfm?intPubID=226.

Breath, Blood, and Urinalysis Testing

DWI offenders are usually required to abstain from the use of alcohol or drugs during the term of supervision. The chemical analysis of breath, blood, or urine testing can be used to monitor court-mandated compliance and detect the specific amount of alcohol and/or drugs in the offenders system. Breath and urinalysis (UA) testing allows the supervision officers to randomly test for the use of alcohol and other drugs during office or home contacts. The offender also can be referred to a hospital or a lab for urinalysis or blood testing.

How it can aid in supervision of DWI offenders:

- With the proper equipment, or with equipment used by law enforcement officers, supervision officers can give quick on-the-spot breath tests to determine a specific BAC.
- Supervision officers can request that an offender submit to urinalysis testing, for the detection of drugs other than alcohol, during office or home contacts.
- Because breath and UA testing can be required on a random basis varying schedules can be developed.
- Testing can also be increased (sanction) or decreased (incentive) as needed to reward compliant behaviors or sanction noncompliant behavior.

Continuous Transdermal Alcohol Testing

Continuous transdermal alcohol testing is a valid way to determine whether an offender has consumed a small, moderate, or large amount of alcohol. It is designed to be used as a screening device to determine alcohol use and not to produce a specific BAC reading. The monitoring device is a passive, non-invasive tool that monitors alcohol consumption 24 hours a day 7 days a week for an extended time. The tamper-and water-resistant bracelet captures transdermal alcohol reading from continuous samples of vaporous or insensible perspiration collected from the air above the skin. (Robertson, Vanlaar, & Simpson, 2006). Cost for the continuous transdermal alcohol testing device is usually charged to the offender which often denies indigent offenders access. Indigent funds should be established allowing access for those who are unable to pay.

How it can aid in supervision of DWI offenders:

- Random breath tests are only able to show if the offender has alcohol in their system at the time the test is given. Continuous transdermal alcohol monitoring monitors alcohol consumption 24 hours a day, seven days a week.
- Continuous transdermal alcohol testing will ensure compliance with court-ordered terms of abstinence.
- Officers are provided with access to Web-based reports to obtain a variety of progress reports specific to their caseload and receive customized notification of events and alerts.
- The device can be recommended at the beginning of supervision for any repeat or high-BAC offender. It can then be removed as an incentive for compliant behavior or added back as a sanction for noncompliant behavior.
- Continuous transdermal alcohol testing can be used in a variety of programs including pretrial, probation, specialty courts, treatment, and re-entry and parole.

Suggested Resource

The Traffic Injury Research Foundation in Ottawa, Ontario, has published a resource titled *Continuous Transdermal Alcohol Monitoring: A Primer for Criminal Justice Professionals.* The document is available online at: www.trafficinjuryresearch.com/publications/PDF_publications/CTAM_Primer_Booklet.pdf.

Appendix G

Promising Practices and Strategies for the Supervision of DWI Offenders

New York – Statewide STOP – DWI

New York State's Special Traffic Options Program for Driving While Intoxicated (STOP-DWI) is a fine-supported local options program enacted through legislation in 1981. The legislation allowed each county to establish a STOP-DWI program. Counties were given a large degree of latitude to develop programs that meet their specific local needs. A comprehensive plan was developed and a STOP-DWI coordinator appointed to oversee the program. The counties, In turn, received all fines collected for alcohol and other drug-related traffic offenses within their jurisdictions.

An example of a STOP-DWI involving probation services is the DWI Alternative Project in Suffolk County. The program initiated in 1986 provides a cost-effective alternative sentencing option for the jail bound multiple DWI offenders. If sentenced under this option, offenders are placed in a jail-like facility consisting entirely of DWI offenders, and are provided with both correction and treatment services for the duration of the mandated confinement time. Oversight of the facility is provided by the county's sheriff's department and long-term aftercare and supervision is provided by probation's Alcohol Treatment Unit. Since the onset of this program, the recidivism rate for Suffolk County has remained between 12 to 15 percent.

In Westchester County, Operation Night Watch is supported by the Westchester County STOP-DWI coordinator and serves as the centerpiece for an effective probationer management program. Probation officers conduct unannounced resident checks day and night to test for alcohol/drug use, to confiscate alcohol/drugs in their possession, and to intervene early in the relapse cycle to facilitate inpatient and/or outpatient treatment. Since drinking is most often done at night and depending on manpower availability, Operation Night Watch is performed at some levels throughout the week. During a typical Thursday, Friday, and Saturday night, the program mobilizes the entire DWI Enforcement Unit to conduct targeted surveillance and enforcement of the court-ordered conditions on probationers. Unannounced, officers seek out probationers in their homes, place of business, in bars, or wherever they may be, checking on their individual court-ordered conditions.

The success of this statewide comprehensive program is based on effective legislation that allows for the local programming option, establishing self-sustaining local programs that are funded through DWI fines, developing a strong statewide association of county programs, and committing to community partnerships. In 2002, New York's STOP-DWI program was designated a "Model of Excellence" by the National Highway Traffic Safety Administration. Information about individual county STOP-DWI programs can be found on the State association Web site at www.stopdwi.org.

New York - Westchester County, White Plains, NY – Department of Probation DWI Enforcement Unit[3]

Westchester County (White Plains, NY) Department of Probation DWI Enforcement Unit, has established an offense specific surveillance and enforcement system to ensure that repeat DWI offenders comply with the court-ordered restrictions on alcohol/drug consumption and driving while impaired. Department policy and supervision strategies with clear relevance to the DWI offenders have been established. Fourteen probation officers are assigned to the Probation Departments DWI Enforcement Unit and supervise and conduct surveillance over the approximately 1,300 DWI offenders.

Following are some of the DWI Offender Enforcement Unit's policies and practices.

Department of Probation Policy

- A monthly fee of $30 is assessed on all probationers.
- Probation officers conduct warrantless searches.

3 National Highway Traffic Safety Administration Eastern Region. (2005, April). Westchester County Department of Probation DWI Enforcement Program: A Best Practice. Info 2 Share, 05(01).

- Probation officers assigned to the DWI Unit are authorized to issue traffic tickets for DWI offenses.
- All offenders convicted of DWI/Drugs are referred to the DWI Unit for supervision. All cases are referred to an approved treatment agency/facility for services by the unit.
- People sentenced to probation supervision by a court or conditional release commission with a specific condition to submit to a recognized drug test is tested randomly or on an as needed basis.
- Probation Electronic Home Monitoring is made available for eligible offenders as an alternative to incarceration or detention.
- Probationers with revoked licenses may be eligible for restricted driving privileges contingent on the installation of a court-ordered ignition interlock system. Costs associated with the interlock are the responsibility of the probationer.
- A completed report containing information on adherence to the order and conditions of probation are submitted to the court that has the sole discretion for re-licensing.

Practices

- In-person supervision contacts with offenders are conducted randomly depending on the offenders' involvement in treatment, results of alcohol/drug screens, and overall supervision progress.
- All probationers are required to enroll in and successfully complete a State-approved treatment program. Probation officers insure compliance with treatment conditions through coordination with treatment agencies.
- Probation officers arrest probationers for DWI.
- DWI offenders may be fitted with ignition interlock for limited driving privileges. All DWI felony probationers must participate in the interlock program when they become eligible to drive.
- DOP is piloting in-vehicle cameras to ensure the probationer is the person providing the breath sample in order to start the vehicle, and global positioning system to monitor the exact location of the probationer.
- Probation officers take immediate appropriate action with probationers who are found consuming alcohol and/or illicit substances in violation of their court order and conditions of probation. The probation officers conduct unannounced resident checks day and night (Operation Night Watch) to test for alcohol/drug use, to confiscate alcohol/drugs in their possession, and to intervene early in the relapse cycle to facilitate inpatient and/or outpatient treatment.
- Victim Impact Panels for DWI offenders are conducted bi-monthly in partnership with Mothers Against Drunk Driving (MADD).

On May 9, 2006, NHTSA recognized the Westchester County (White Plains, NY) Department of Probation DWI Enforcement Unit for its excellent performance in keeping probationers convicted of DWI from repeating offenses.

For more information on the Westchester County Department of Probation DWI Enforcement Unit contact:
Westchester County Department of Probation:
Rocco A. Pozzi, Commissioner
Robert Watson, Supervisor, DWI Enforcement Unit
Telephone: 914-995-3505
E-mail: rww1@westchestgov.com

Pennsylvania – Legislated Court-Reporting Network Evaluation[4]

Legislation enacted in Pennsylvania in 1984, and rewritten in 2002, authorized a systems approach to responding to the problem of driving under the influence. The components of the DUI legislation include a mandatory 12.5-hour DUI school, victim impact panels, and the use of a 106-question screening tool called the Court Reporting Network Evaluation (CRN) for all DWI offenders. The evaluation is conducted by specially trained and certified CRN evaluators. The CRN evaluation is mandated by the DWI legislation. It is the first step in matching the treatment needs of the offender with the most appropriate level of care. Completing treatment is legislatively mandated as well. The legislation further requires that driving privileges are restored only after the appropriate AOD treatment has been completed.

The CRN, which is Web-based, houses information related to the offender's quantity and frequency of use of alcohol and other licit and illicit substances. The offenders' responses are scored and the results are printed into a one-page summary. The summary includes evaluation results along with driving record and prior offense information. The DWI legislation requires that this one-page summary be provided to the judge prior to sentencing.

For more information on the Pennsylvania Court Reporting Network Evaluation (CRN) see the Web site for the Pennsylvania DUI Association at www.padui.org.

Pennsylvania DUI Association

Few States have professional associations with a mission to take action in support of the initiatives being undertaken to encourage and facilitate the growth of safety programs. The Pennsylvania DUI Association was established in 1979 to take action in support of the initiatives being undertaken to encourage and facilitate the growth of safety programs in Pennsylvania. The association is a nonprofit, professional association which provides technical assistance and support to alcohol-highway safety professionals and other safety professionals representing the fields of highway safety.

Included in the association's responsibilities are DUI instructor certification workshops, CRN evaluator certification workshops, Advanced workshops in CRN evaluation and DUI instruction, county DUI coordinator training, management and technical assistance for county alcohol-highway safety programs, compilation and maintenance of the directory of county alcohol-highway safety programs, and essentially any other activities directly related to alcohol-highway safety programs for professionals in Pennsylvania. For more information on the Pennsylvania DUI Association see its Web site at www.padui.org.

Virginia Alcohol Safety Action Program[5]

Twenty-four local alcohol safety action programs (ASAP) make up the Virginia alcohol safety action program (VASAP). A commission, comprised of 12 members with a broad range of knowledge and experience, formulates and maintains standards to be observed by local ASAPs, periodically evaluating them to ensure they are servicing their communities in an effective and efficient manner. VASAP provides a network of probationary, administrative, case management, and client services that is readily adaptable and expandable to meet local and State needs. It works with local employee assistance programs in combating the problems of substance abuse, provides funds for local law enforcement training and assistance in grant funding requests, and offers attorneys and judges knowledge and a wider variety of intervention programs to dispose of DWI cases in a manner appropriate to both community and offender needs.

VASAP is the only statewide court-related DWI intervention program in the Nation, diverting thousands of offenders annually from costly incarceration in local jails, thus realizing substantial savings to the commonwealth. Offenders placed on

4 Scoles, P. (2004). The program management and evaluation procedures manual for the Commonwealth of Pennsylvania's court reporting network (CRN). PA Department of Transportation, Bureau of Highway Safety and Traffic Engineering, Alcohol Safety Action Program.

5 1 800 DUI Laws. (n.d). Virginia: Alcohol Safety Action Program. Retrieved May 9, 2007, from www.1800duilaws.com/dui_schools/va_duischools.asp.

probation by the court are given a restricted license and ordered to report to their local ASAP within 15 days. There, a case manager classifies the offender to determine the appropriate education and/or treatment services. The offender pays a fee determined by program assignment. The case manager supervises each case to ensure that probation requirements are fulfilled.

VASAP is completely funded by offender fees and government grants. Many studies on a national basis have found that the ASAP program is extremely cost-effective as well as extremely successful. For more information on the Virginia Alcohol Safety Action Program see its Web site at www.1800duilaws.com/dui_schools/va_duischools.asp.

Staggered Sentencing[6]

Staggered sentencing (also referred to split sentencing, structured sentencing or sentencing by thirds) is a new way to sentence repeat drunk driving offenders. Essentially, this type of sentencing approach divides a standard jail sentence into thirds or segments that the court stretches out over an offender's probation period. Offenders immediately serve the first segment of jail time. On the day of sentencing, the offender is instructed by the judge that the offender can return to court and request the judge to stay the second and third segments of jail. Offenders must, at the review hearing, satisfy the judge that they are and intend to stay sober, they have the support of their probation officer (if one is available), and they have not committed a new alcohol-related offense. If the offenders re-offend by getting a new DUI at any time during their probationary period all non-executed jail time is executed by the court. Staggered sentencing works best for repeat offenders where the jail segments are 10 days or greater—where the incentive to stay sober is greater.

For more information, *Controlling Repeat DWI Offenders with Staggered Sentencing, A Legislative Brief* can be found online at: http://www.house.leg.state.mn.us/hrd/pubs/stagsent.pdf. Also see *Strategies for Addressing the DWI Offender: 10 Promising Sentencing Practices* published by the National Highway Traffic Safety Administration at www.nhtsa.gov/people/injury/enforce/Promising Sentence/images/10promising.pdf.

6 Dehn, J. (n.d.). DUI staggered sentencing—How it works. Unpublished document.

Appendix H

Nebraska Standardized Model for Substance Abuse Services—Policy, Procedures and Forms[7]

The State of Nebraska, through a justice and provider collaboration over a 10-year process, designed the Standardized Model for Substance Abuse Services. The model is based on the premise that in order to reduce offender risk and potential recidivism, providers need an understanding of criminogenic factors and justice needs a better understanding of substance abuse. The model provides for a uniform understanding, definitions and process by which offenders will be assessed, evaluated, and treated. Effective, January 1, 2006, the Nebraska Supreme Court adopted as a court rule the use of the standardized model for all other offenders in Nebraska courts when substance abuse evaluations and treatment referrals are ordered.

Policy

The Standardized Model for Substance Abuse Services for juvenile and adult probation clients is used to recognize the connection between substance abuse and crime and address it effectively through treatment. Reliable data indicates that treatment, even coerced, works. It is probation's intent to provide a meaningful opportunity for offender rehabilitation in an effort to reduce recidivism, promote good citizenship, and enhance public safety. It is the chief probation officer's responsibility, as well as that of the ISP coordinator and the drug court coordinator, to ensure that communication between probation officers and providers be consistent, open, and focused on criminogenic risk and need factors that, when reduced, will improve the offender's ability to live a productive and crime-free life.

Procedures and forms

Nebraska Standardized Model for Substance Abuse Services provides for the following:

Simple Screening Instrument (SSI) is an assessment tool used to determine the presence of a current substance abuse problem and identify the need for further evaluation. The SSI is effective for adults and juveniles; is highly sensitive and detects all substances; and requires 10 to 15 minutes. SSI is in the public domain

Standardized Risk Assessment Reporting Format for Substance Abusing Offenders is a risk instrument used by probation officers to communicate risk indicators to treatment providers. The standardized risk assessment reporting format was created by the developing committee under the guidance of the University of Nebraska, Lincoln. It is used to communicate risk indicators to the provider.

The Offender Selection Worksheet referenced in the policy is another instrument used specifically in the probation pre-sentence investigation and intended to be considered in conjunction with all other information gathered such as a SSI. It is not provided as it is not in the public domain.

Registered Providers: To ensure consistent and accurate diagnoses and recommendations for treatment and to formalize information-sharing between the justice system and substance abuse providers, all referrals for substance abuse evaluations shall be made to a registered treatment provider.

For additional information on the Nebraska Standardized Model for Substance Abuse Services contact:
Nebraska Supreme Court
Administrative Office of the Courts & Probation
P. O. Box 98910, Lincoln, NE 68509
Phone: 402-471-3730

7 Information on the Nebraska Standardized Model for Substance Abuse Services was provided by the Nebraska Probation System, Office of Probation Administration.

Office of Probation Administration

Ellen Brokofsky, Probation Administrator

OVERVIEW OF STANDARDIZED MODEL FOR SUBSTANCE ABUSE SERVICES

Policy Summary –
It is Probation's intent to provide a meaningful opportunity for offender rehabilitation in an effort to reduce recidivism, promote good citizenship, and enhance public safety. The Model is designed to ensure that communication between probation officers and providers is consistent, open and focused on criminogenic risk and need factors that, when reduced, will improve the offender's ability to live a productive and crime-free life.

Required Use –
Nebraska Supreme Court rule (copy attached) requires compliance with all elements of the Model for substance abuse evaluations and treatment referrals ordered for adult felony drug offenders by the courts of the State of Nebraska, including drug courts or other similar specialized programs operating pursuant to an inter-local agreement, if some or all of the cost for such evaluation or treatment referral is reimbursed by funds provided pursuant to Neb. Rev. Stat. § 29-2262.07 or Community Corrections Council funds made available by the Council to Probation Administration. Use of the Model is recommended by the Supreme Court for all other offenders in Nebraska courts where evaluations and treatment referrals are ordered.

Elements of the Standardized Model:

Screening
Probation officers use a standard Simple Screening Instrument (SSI), alone or in combination with Probation's computerized assessment instruments, to determine the presence of a current substance abuse problem and identify the need for further evaluation.

Risk Assessment
Probation officers use a Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF) to communicate to treatment providers an indication of the offender's risk of re-arrest.

Registered Providers
Probation shall consider for registration only those individuals or agencies who have a clear understanding of the connection between substance abuse and criminal offending and meet the following criteria:

1. Registered Providers must hold a valid license that includes in its scope of practice the ability to administer substance abuse evaluations and/or treatment.

2. Registered Providers must have completed an approved basic education course regarding criminogenic factors contributing to an offender's law violating behavior and participate in 12 continuing education hours every 2 years following. A curriculum list and further information regarding the basic education course requirements shall be available through Probation Administration and the Judicial Branch Web site.
3. Registered Providers must have an understanding of the model process and agree to the requirements of the **Standardized Model for Substance Abuse Services** for probation clients to include:
    - The Simple Screening Instrument (SSI)
    - The Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF)
    - The Nebraska Standardized Reporting Format for Substance Abuse Evaluations for all Justice Referrals
    - Substance Abuse Services for Adult Criminal Justice Clients Continuum of Care
    - Use The Addiction Severity Index (ASI) for adult offenders or the Comprehensive Adolescent Severity Inventory (CASI) for juvenile offenders to assist in appropriate data collection and objective placement level of treatment recommendations
    - Use a validated assessment tool developed and approved for assisting in the diagnosis of addiction
    - Use the Nebraska Standardized Reporting Format for Substance Abuse Evaluation
    - Register their services prior to delivery in a database and provide data from those services in accordance with all confidentiality requirements
    - Provide services in accordance with defined levels of care and minimum standards
4. Registered Providers may be entitled to a direct payment for delivery of a substance abuse service depending on the eligibility of the offender referred for service. The criteria for offender eligibility are determined by Probation Administration and payment for services is coordinated through the Fee for Service Voucher Program.
5. Providers may register their services, at no cost, with Probation Administration's office. Application forms and a complete listing of Registered Providers will be posted on the Judicial Branch website in the near future.

Evaluations

Providers agree to use the Addiction Severity Index (ASI) for adult offenders or the Comprehensive Adolescent Severity Inventory (CASI) for juvenile offenders to assist in appropriate data collection and objective placement levels of care recommendations.

Treatment Programs

Providers agree to standardized levels of care ensuring offenders will receive appropriate treatment.

Nebraska Supreme Court Rule Regarding Use of Standardized Model for Delivery of Substance Abuse Services

Substance abuse evaluations and treatment referrals for adult felony drug offenders ordered by the courts of the State of Nebraska, or by judges presiding over non-probation-based programs or services such as a drug court or other similar specialized programs as defined herein, shall comply with the minimum standards established by the Standardized Model for Delivery of Substance Abuse Services as promulgated by the Nebraska Supreme Court Office of Probation Administration, set forth in Appendix A of this rule, if all or any portion of the cost for such evaluation or treatment referral is reimbursed by funds provided pursuant to Neb. Rev. Stat. § 29-2262.07 or state funds appropriated to the Community Corrections Council for substance abuse treatment which is made available by the Council to Probation Administration. Nothing in this rule shall preclude an offender from obtaining, at his or her own expense, additional substance abuse evaluations or treatment referrals which may or may not comply with the minimum standards referred to herein.

For purposes of this rule, non-probation-based programs and services shall mean those programs and services defined and authorized by Neb. Rev. Stat. §§ 29-2246(12) and 29-2252(16) which are operating pursuant to an interlocal agreement with state probation.

The Supreme Court recommends the use of the Standardized Model for all other offenders in Nebraska courts when substance abuse evaluations and treatment referrals are ordered.

Adopted by the Nebraska Supreme Court November 30, 2005, to be effective January 1, 2006.

Standardized Model for Delivery of Substance Abuse Services
Appendix A

I. Policy:

The Standardized Model for Delivery of Substance Abuse Services for juvenile and adult probation clients is used to recognize the connection between substance abuse and crime and address it effectively through treatment. Reliable data indicates that treatment, even coerced treatment, works. It is the intent of the Administrative Office of Probation (hereinafter Probation Administration) to provide a meaningful opportunity for offender rehabilitation in an effort to reduce recidivism, promote good citizenship, and enhance public safety. It is the Chief Probation Officer's responsibility, as well as that of the Intensive Supervision Probation (hereinafter ISP) Coordinator and the Drug Court Coordinator, to ensure that communication between probation officers and providers be consistent, open, and focused on criminogenic risk and need factors that, when reduced, will improve the offender's ability to live a productive and crime-free life.

Each probation district officer, under the direction of the Chief Probation Officer; each ISP Officer, under the direction of the ISP Coordinator; and each Drug Court Officer, under the direction of the Drug Court Coordinator, shall maintain an updated Registered Substance Abuse Providers List which shall be provided by and maintained in the office of Probation Administration.

II. Definitions:

For purposes of the Standardized Model for Delivery of Substance Abuse Services, the following definitions shall apply:

Case Manager — Working under the general supervision of the Chief Probation Officer, this is a highly responsible support staff position. The work involves managing and coordinating activities associated with the supervision of administrative and low-risk probation cases.

Chief Probation Officer — A Probation Administration administrative and supervisory employee appointed by the Probation Administrator pursuant to Neb. Rev. Stat. § 29-2253(3) and (4) who is charged with the management of a probation district or assigned ISP region.

Drug Court Coordinator — A Probation Administration employee appointed via an interlocal agreement as authorized by Neb. Rev. Stat. § 29-2252(16) and who reports directly to the Chief Probation Officer of the district.

Drug Court Officer — A Probation Administration employee appointed via an interlocal agreement as authorized by Neb. Rev. Stat. § 29-2252(16). This person is charged with the responsibility of case management for adult and juvenile offenders and reports directly to the Drug Court Coordinator of the district.

ISP Coordinator — A supervising probation officer employed by Probation Administration who is responsible for the daily operation of the ISP unit within the respective ISP region. The ISP Coordinator reports directly to the ISP Chief Probation Officer of the region.

ISP Officer — This position has the same statutory responsibilities and authority as a traditional probation officer and is primarily responsible for the case management of high-risk offenders placed on Intensive Supervision Probation. The ISP Officer reports directly to the ISP Coordinator.

Probation Officer — This position routinely engages in performing a wide variety of investigatory and supervisory responsibilities involving offenders. Probation Officers have the authority to arrest and detain offenders as provided by Neb. Rev. Stat. § 29-2266 (2) and (3).

Registered Substance Abuse Provider (Registered Provider) — An individual or agency with a clear understanding of the Standardized Model which (1) agrees to adhere to all elements of this Model; (2) holds a valid license, which includes within its scope of practice the ability to administer substance abuse evaluations and/or treatment; (3) meets the basic educational requirements set forth at Section III. F(2) of this Model; and (4) registers its services with and is approved by Probation Administration.

Registered Substance Abuse Providers List — An up-to-date list of Registered Substance Abuse Providers maintained by Probation Administration.

III. Procedures:

A. Screening Assessment

The **Simple Screening Instrument (SSI)** (Attachment 1) is an assessment tool used to determine the presence of a current substance abuse problem and identify the need for further evaluation. The SSI is effective for adults and juveniles; is highly sensitive and detects all substances; and requires 10 to 15 minutes for completion.

The SSI shall be utilized by probation officers or designated staff to screen offenders for alcohol and other drug abuse (AOD) as a stand-alone assessment or in combination with Probation's computerized assessment screening.

1. The SSI shall be administered face-to-face by a trained probation officer or case manager.
2. The SSI shall be completed in conjunction with the presentence investigation (PSI) or predisposition investigation (PDI) as part of the body of the investigation. It shall be incorporated into the "Drugs and Alcohol" section of the investigation. A copy of the SSI shall be attached to the investigation.
3. If a chemical dependency issue is suspected and no PDI or PSI is ordered, the probation officer/case manager shall administer the SSI and use the results as a screen for further evaluation, referral, or modified order of probation.
4. The SSI shall be utilized as a tool of case management guiding the probation officer/case manager regarding the need for referral for a substance abuse service.
5. If the court orders a substance abuse evaluation prior to a **Simple Screening Instrument (SSI)** (Attachment 1) and **Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF)** (Attachment 2) being completed, these instruments shall be administered for data purposes in conjunction with a referral for an evaluation. In the event the court has already ordered and received a completed substance abuse evaluation, a SSI shall still be completed for case management purposes.
6. Administration of the SSI:
   Explain purpose to client.
   - Ask questions in a straightforward manner.
   - Probe, listen, and empathize.
   - Pause between questions; allow time to discuss when appropriate.
   - Generally, adhere to the exact wording.

- Feedback responses to offender when appropriate.
- Don't "lead" offender into answers.

7. Scoring the SSI:
   - DO NOT score questions #1 and #15 - too general.
   - DO NOT score questions #17 and #18 - gambling. *
   - DO NOT score observational items.
   - Persons with AOD problems will usually score 4 or higher -- refer for substance abuse evaluation.
   - Score of less than 4 does not rule out an AOD problem; use observations to assist with decision to refer for substance abuse evaluation.

* If either #17 or #18 on the SSI is answered "Yes," refer for gambling evaluation.

B. Risk Assessment

The **Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF)** is used to give treatment providers an indication of the offender's risk of re-arrest.

The probation officer/case manager will use his or her professional judgment and information gleaned from other Probation risk assessment tools (OSW, Risk/Needs) to complete the SRARF.

1. The probation officer/case manager shall record on the SRARF the relative level of risk of re-arrest posed by the offender as either low, medium, or high.
2. Special concerns, comments, or complicating factors important to the provider's understanding the offender's current risk shall be documented, for example, sexual assault on a 3-year-old, 2nd offense DUI but really is the 3rd, family member's death.

C. Evaluation Referral and Confidentiality

To ensure consistent and accurate diagnoses and recommendations for treatment and to formalize information-sharing between the justice system and substance abuse providers, all referrals for substance abuse evaluations shall be made to a Registered Provider who is chosen by the offender from the Registered Substance Abuse Providers List.

1. When referring an offender for a substance abuse evaluation, a **Referral for Substance Abuse Evaluation Form** (Attachment 3) shall be completed and signed by the offender. This affords a preliminary release to the Registered Provider concerning the need for collateral information from the Probation office. A copy of this form shall be retained in the offender's probation file.
2. The probation officer shall provide upon request of the offender's agency of choice (Registered Substance Abuse Providers List) collateral information concerning the results of the SSI, the SRARF, the prior offense record, and BAC (Blood Alcohol Content) if applicable.
3. After a Registered Provider has been selected by the offender, probation officers shall ensure a release of information has been signed and remains on file during the period an offender is under presentence investigation, is on probation, is involved in non-probation-based services/programs and being supervised by a probation officer, or remains in treatment.

D. Evaluations

Only substance abuse evaluations in compliance with the Standardized Model shall be received by the Probation office. Pursuant to the Standardized Model, each substance abuse evaluation received shall be completed and signed by a Registered Provider, who, within his or her scope of practice, is permitted to conduct substance abuse evaluations and has agreed to adhere to all elements of Nebraska's Standardized Model. All Registered Providers shall use the **Nebraska Standardized Reporting Format for Substance Abuse Evaluations for all Justice Referrals** (Attachment 4).

1. Substance abuse evaluations not adhering to this format shall be reported to your direct supervisor, Chief Probation Officer, ISP Coordinator, or Drug Court Coordinator to determine whether referral to Probation Administration is necessary.
2. A **Registered Substance Abuse Providers List** shall be provided by and maintained in the office of Probation Administration. It is the responsibility of the district to obtain and maintain up-to-date copies. Chief Probation Officers, ISP Coordinators, and Drug Court Coordinators are expected to provide input to Probation Administration concerning the addition and/or deletion of local providers to the Registered Substance Abuse Providers List.
3. As determined by Probation Administration, certain offenders may be eligible for payment of their evaluations via the Fee for Service Voucher Program as long as the referring probation officer receives supervisory approval and a Registered Provider is utilized for this service.

E. Treatment

To ensure that programs serving substance abusing offenders are meeting minimum standardized levels of care, probation officers/case managers shall refer such offenders to Registered Providers who have agreed to adhere to these levels of care. It is critical that levels of care are consistent with and linked to criminogenic risk and need factors.

1. Probation officers/case managers shall refer offenders for substance abuse services pursuant to either the **Substance Abuse Services for Adult Criminal Justice Clients Continuum of Care** (see Attachment 5) or the **Substance Abuse Services for Juvenile Justice Clients Continuum of Care** (Attachment 6).
2. When referring an offender for substance abuse treatment, a **Referral for Substance Abuse Evaluation Form** shall be completed by the probation officer and signed by the offender. This affords a preliminary release (if necessary) for the Registered Provider to obtain collateral information from the Probation office. A copy of the form shall be retained in the offender's probation file.
3. The probation officer shall provide upon request of the offender's agency of choice (Registered Substance Abuse Providers List) collateral information concerning the results of the SSI, the SRARF, the prior offense record and BAC (Blood Alcohol Content) if applicable.
4. After a Registered Provider has been selected by the offender, probation officers shall ensure a release of information has been signed and remains on file during the period of time an offender is under a presentence investigation or under supervision.
5. A Registered Substance Abuse Providers List shall be provided by Probation Administration. It is the responsibility of the district/region to obtain and maintain up-to-date copies. Chief Probation Officers are expected to provide input to Probation Administration concerning the addition and/or deletion of local providers to the Registered Provider list.

6. As determined by Probation Administration, certain offenders may be eligible for payment of their treatment via the Fee for Service Voucher Program as long as the referring probation officer receives supervisory approval and a Registered Provider is utilized for this service.

F. Registered Providers

Probation shall consider for registration only those individuals or agencies who have a clear understanding of the connection between substance abuse and criminal offending and meet the following criteria:

1. Registered Providers must hold a valid license that includes in its scope of practice the ability to administer substance abuse evaluations and/or treatment.
2. Registered Providers must have completed an approved basic education course regarding criminogenic factors contributing to an offender's law violating behavior and participate in 12 continuing education hours every 2 years following. A curriculum list and further information regarding the basic education course requirements shall be available through Probation Administration and the Judicial Branch Web site.
3. Registered Providers must have an understanding of the model process and agree to the requirements of the **Standardized Model for Substance Abuse Services** for probation clients to include:
    - The Simple Screening Instrument (SSI)
    - The Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF)
    - The Nebraska Standardized Reporting Format for Substance Abuse Evaluations for all Justice Referrals
    - Substance Abuse Services for Adult Criminal Justice Clients Continuum of Care
    - Use The Addiction Severity Index (ASI) for adult offenders or the Comprehensive Adolescent Severity Inventory (CASI) for juvenile offenders to assist in appropriate data collection and objective placement level of treatment recommendations
    - Use a validated assessment tool developed and approved for assisting in the diagnosis of addiction
    - Use the Nebraska Standardized Reporting Format for Substance Abuse Evaluation
    - Register their services prior to delivery in a database and provide data from those services in accordance with all confidentiality requirements
    - Provide services in accordance with defined levels of care and minimum standards
4. Registered Providers may be entitled to a direct payment for delivery of a substance abuse service depending on the eligibility of the offender referred for service. The criteria for offender eligibility are determined by Probation Administration and payment for services is coordinated through the Fee for Service Voucher Program.
5. Providers may register their services, at no cost, with Probation Administration's office. Application forms and a complete listing of Registered Providers will be posted on the Judicial Branch Web site.

G. Special Considerations

When a probation officer/case manager receives and finds an evaluation or recommendation to be inconsistent or lacking information (criminal history, prior evaluation or treatment, drug testing self-report, other collateral, etc.) and/or fails to address other criminogenic risk factors, he or she shall:

1. Call the Registered Provider to discuss missing or conflicting information.
2. Inquire of the Registered Provider whether the new or missing information changes the evaluation/recommendation.
3. Bring any unresolved discrepancies to the court's attention with a recommendation for a subsequent evaluation.

H. Data Collection

Data collected through the SSI and SRARF provides an understanding of Nebraska's substance abusing population. Probation staff will enter SSI and SRARF data into the Nebraska Criminal Justice Information System (NCJIS) and the Nebraska Probation Management Information System (NPMIS). NCJIS and NPMIS are currently not integrated data systems, and therefore, data entry is necessary in both systems.

1. Probation officers/case managers or designated staff shall enter online SSI and SRARF data directly into NCJIS.
2. Probation officers/case managers or designated staff shall capture SSI scores and SRARF risk levels and submit to a support staff person designated by the Chief Probation Officer, ISP Coordinator, or Drug Court Coordinator for data collection or entered directly by a probation officer into NPMIS.
3. Upon the completion of a substance abuse evaluation, the following information shall be entered into NPMIS (under the "Model" tab) by probation officers/case managers or designated staff:
    - the date completed
    - ideal level of care
    - available level of care

I. Training

Through the Administrative Office of Courts/Probation, training for probation officers/case managers is required concerning basic and continuing education pertaining to substance abuse, the Standardized Model, and instruments utilized, in order to properly assess and supervise offenders under Probation's authority. All probation officers/case managers shall:

- Understand the policies and procedures associated with the Standardized Model.
- Be trained on the principles of criminogenic risk and need factors (to include but not limited to criminal thinking and motivational interviewing).
- Be trained on the nature of substance abuse addiction in adults and juveniles during the first year of employment (35 hours required). Subsequent yearly training (8 hours) to include, but not limited to, relapse prevention, strength-based treatment principles, and American Society for Addiction Medicine (ASAM) criteria.
- Understand the operation of the Nebraska Substance Abuse Service Delivery System.
- Be trained on the Standardized Model, the process and tools utilized, to include:
    - Administration of the Simple Screening Instrument (SSI)
    - Administration of the Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF)
    - Nebraska Standardized Reporting Format for Substance Abuse Evaluations for all Justice Referrals
    - Understanding the Addiction Severity Index (ASI) and Comprehensive Adolescent Severity Inventory (CASI)

  - Standardized Levels of Care Continuum for Substance Abuse Services for Juvenile and Adult Criminal Justice Clients
- Understand the incorporation of the Standardized Model into the presentence investigation and case management.
- Understand the proper use of NCJIS and NPMIS concerning data collection associated with the Standardized Model.

Attachments:

Attachment 1 — Simple Screening Instrument (SSI)
Attachment 2 — Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF)
Attachment 3 — Referral for Substance Abuse Evaluation Form - General Letter to Providers
Attachment 4 — Nebraska Standardized Reporting Format for Substance Abuse Evaluations for all Justice Referrals
Attachment 5 — Substance Abuse Services for Adult Criminal Justice Clients Continuum of Care
Attachment 6 — Substance Abuse Services for Juvenile Justice Clients Continuum of Care

NEBRASKA PROBATION SYSTEM
POLICIES AND PROCEDURES
(Chapter 5, Supervision)

Approval Date: _____

Standardized Model for
Substance Abuse Services

I. POLICY:

The Standardized Model for Substance Abuse Services for juvenile and adult probation clients is used to recognize the connection between substance abuse and crime and address it effectively through treatment. Reliable data indicates that treatment, even coerced treatment, works. It is Probation's intent to provide a meaningful opportunity for offender rehabilitation in an effort to reduce recidivism, promote good citizenship, and enhance public safety. It is the Chief Probation Officer's responsibility, as well as that of the ISP Coordinator and the Drug Court Coordinator, to ensure that communication between probation officers and providers be consistent, open, and focused on criminogenic risk and need factors that, when reduced, will improve the offender's ability to live a productive and crime-free life.

Each probation district officer, under the direction of the Chief Probation Officer, each ISP Officer under the direction of the ISP Coordinator, and each Drug Court Officer under the direction of the Drug Court Coordinator, shall maintain an updated listing of registered substance abuse providers which shall be provided by and maintained in the office of State Probation Administration.

II. PROCEDURES:

A. Screening Assessment

The Simple Screening Instrument (SSI) (Attachment 1) is an assessment tool used to determine the presence of a current substance abuse problem and identify the need for further evaluation. The SSI is effective for adults and juveniles; is highly sensitive and detects all substances; and requires 10 to 15 minutes.

The SSI shall be utilized by probation officers or designated staff to screen offenders for alcohol and other drug abuse (AOD) as a stand-alone assessment or in combination with Probation's computerized assessment screening.

1. The SSI shall be administered face-to-face by a trained probation officer or case manager.

2. The SSI shall be completed in conjunction with the presentence investigation (PSI) or predisposition investigation (PDI) as part of the body of the investigation. It shall be incorporated into the "Drugs and Alcohol" section of the investigation. A copy of the SSI shall be attached to the investigation.

3. If a chemical dependency issue is suspected and no PDI or PSI is ordered, the probation officer/case manager shall administer the SSI and use the results as a screen for further evaluation, referral, or modified order of probation.

4. The SSI shall be utilized as a tool of case management guiding the probation officer/case manager regarding the need for referral for a substance abuse service.
5. If the court orders a substance abuse evaluation prior to a Simple Screening Instrument (SSI) (Attachment 1) and Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF) (Attachment 2) being completed, these instruments shall be administered for data purposes in conjunction with a referral for an evaluation. In the event the court has already ordered and received a completed substance abuse evaluation, a SSI shall still be completed for case management purposes.

6. Administration of the SSI: Explain purpose to client.
   - » Ask questions in a straightforward manner.
   - » Probe, listen, and empathize.
   - » Pause between questions; allow time to discuss when appropriate.
   - » Generally, adhere to the exact wording.
   - » Feedback responses to offender when appropriate.
   - » Don't "lead" offender into answers.

7. Scoring the SSI:
   - » DO NOT score questions #1 and #15 - too general.
   - » DO NOT score questions #17 and #18 - gambling.*
   - » DO NOT score observational items.
   - » Persons with AOD problems will usually score 4 or higher -- refer for substance abuse evaluation.
   - » Score of less than 4 does not rule out an AOD problem; use observations to assist with decision to refer for substance abuse evaluation.

B. Risk Assessment

The Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF) is used to give treatment providers an indication of the offender's risk of re-arrest.

The probation officer/case manager will use his or her professional judgment and information gleaned from other Probation risk assessment tools (OSW, Risk/Needs) to complete the SRARF.

1. The probation officer/case manager shall record on the SRARF the relative level of risk of re-arrest posed by the offender as either low, medium, or high.

2. Special concerns, comments, or complicating factors important to the provider's understanding the offender's current risk shall be documented, for example, sexual assault on a 3-year-old, 2nd offense DUI but really is the 3rd, family member's death.

C. Evaluation Referral and Confidentiality

To ensure consistent and accurate diagnoses and recommendations for treatment and to formalize information-sharing between the justice system and substance abuse providers, all referrals for substance abuse evaluations shall be made to a registered provider.

* If either #17 or #18 on the SSI is answered "Yes," refer for gambling evaluation.

1. When referring an offender for a substance abuse evaluation, a Referral for Substance Abuse Evaluation Form (Attachment 3) shall be completed and signed by the offender. This affords a preliminary release to the registered provider concerning the need for collateral information from the Probation office. A copy of this form shall be retained in the offender's file.
2. The probation officer shall provide upon request of the offender's agency of choice (registered provider list) collateral information concerning the results of the SSI, the SRARF, prior offense record, and BAC (Blood Alcohol Content) if applicable.

3. After a registered provider has been selected, probation officers shall ensure a release of information has been signed and remains on file during the period an offender is under presentence investigation, is on probation, is involved in non-probation-based services/programs and being supervised by a probation officer, or remains in treatment.

D. Evaluations

Only substance abuse evaluations in compliance with the Standardized Model shall be received by the Probation office. Pursuant to the Standardized Model, each substance abuse evaluation received shall be signed off by a Licensed Drug Abuse Counselor (LDAC), licensed psychologist, licensed physician, or licensed mental health professional, who, within his or her scope of practice, is permitted to conduct substance abuse evaluations and has agreed to adhere to all elements of Nebraska's Standardized Model. All registered substance abuse providers shall use the Nebraska Standardized Reporting Format for Substance Abuse Evaluations for all Justice Referrals (Attachment 4).

1. Substance abuse evaluations not adhering to this format shall be reported to your direct supervisor, Chief Probation Officer, ISP Coordinator, or Drug Court Coordinator to determine whether referral to Probation Administration is necessary.
2. A registered provider list shall be provided by Probation Administration. It is the responsibility of the district to obtain and maintain up-to-date copies. Chief Probation Officers, ISP Coordinators, and Drug Court Coordinators are expected to provide input to Probation Administration concerning the addition and/or deletion of local providers to the registered provider list.
3. As determined by Probation Administration, certain offenders may be eligible for payment of their evaluations via the Fee for Service Voucher Program as long as the referring probation officer receives supervisory approval and a registered provider is utilized for this service.

E. Treatment

To ensure that programs serving substance abusing offenders are meeting minimum standardized levels of care, probation officers/case managers shall refer such offenders to registered providers who have agreed to adhere to these levels of care. It is critical that levels of care are consistent with and linked to criminogenic risk and need factors.

1. Probation officers/case managers shall refer offenders for substance abuse services pursuant to either the Substance Abuse Services for Adult Criminal Justice Clients Continuum of Care (see Attachment 5) or the Substance Abuse Services for Juvenile Justice Clients Continuum of Care (Attachment 6).

2. When referring an offender for substance abuse treatment, a Referral for Substance Abuse Evaluation Form shall be completed by the probation officer and signed by the offender. This affords a preliminary release (if necessary) for the registered provider to obtain collateral information from the Probation office. A copy of the form shall be retained in the offender's file.

3. The probation officer shall provide upon request of the offender's agency of choice (registered provider list) collateral information concerning the results of the SSI, the SRARF, the prior offense record and BAC (Blood Alcohol Content) if applicable.

4. After a registered provider has been selected, probation officers shall ensure a release of information has been signed and remains on file during the period of time an offender is under a presentence investigation or under supervision.

5. A registered provider list shall be provided by Probation Administration. It is the responsibility of the district/region to obtain and maintain up-to-date copies. Chief Probation Officers are expected to provide input to Probation Administration concerning the addition and/or deletion of local providers to the registered provider list.

6. As determined by Probation Administration, certain offenders may be eligible for payment of their treatment via the Fee for Service Voucher Program as long as the referring probation officer receives supervisory approval and a registered provider is utilized for this service.

F. Registered Providers

Probation shall consider for registration only those individuals or agencies who have a clear understanding of the connection between substance abuse and criminal offending and meet the following criteria:

1. Providers must hold a valid license that includes in its scope of practice the ability to administer substance abuse evaluations and/or treatment.
2. The provider must have completed an approved basic education course regarding criminogenic factors contributing to an offender's law violating behavior and participate in 12 continuing education hours every 2 years following.
3. The provider must have an understanding of the model process and agree to the requirements of the Standardized Model for Substance Abuse Services for probation clients to include:
   - » The Simple Screening Instrument (SSI)
   - » The Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF)
   - » The Nebraska Standardized Reporting Format for Substance Abuse Evaluations for all Justice Referrals
   - » Substance Abuse Services for Adult Criminal Justice Clients Continuum of Care
   - » Use The Addiction Severity Index (ASI) for adult offenders or the Comprehensive Adolescent Severity Inventory (CASI) for juvenile offenders to assist in appropriate data collection and objective placement level of treatment recommendations
   - » Use a validated assessment tool developed and approved for assisting in the diagnosis of addiction
   - » Use the Nebraska Standardized Reporting Format for Substance Abuse Evaluation

» Register their services prior to delivery in a database and provide data from those services in accordance with all confidentiality requirements
» Provide services in accordance with defined levels of care and minimum standards

4. Providers may be entitled to a direct payment for delivery of a substance abuse service depending on the eligibility of the offender referred for service. The criteria for offender eligibility are determined by Probation Administration and payment for services is coordinated through the Fee for Service Voucher Program.
5. Providers may register their services, at no cost, with the Nebraska Supreme Court Office of Probation Administration. Application forms and a complete listing of registered providers will be posted on the Judicial Branch Web site.

G. Special Considerations

1. When a probation officer/case manager receives and finds an evaluation or recommendation to be inconsistent or lacking information (criminal history, prior evaluation or treatment, drug testing self-report, other collateral, etc.) and/or fails to address other criminogenic risk factors, he or she shall:
   » Call the provider to discuss missing or conflicting information.
   » Inquire of the provider whether the new or missing information changes the evaluation/ recommendation.
   » Bring any unresolved discrepancies to the court's attention with a recommendation for a subsequent evaluation.
2. In the event a court orders a specific level of care without the benefit of a standardized evaluation, a probation officer shall submit to the court a Request for Modification requesting an order for a substance abuse evaluation.
3. If prior to court adjudication an evaluation or level of care is created without the benefit of a registered provider adhering to the standardized model, an updated evaluation shall be required to include the necessary elements of the Standardized Model (at no additional cost to the offender).

H. Data Collection

Data collected through the SSI and SRARF provides an understanding of Nebraska's substance abusing population. Probation staff will enter SSI and SRARF data into the Nebraska Criminal Justice Information System (NCJIS) and the Nebraska Probation Management Information System (NPMIS). NCJIS and NPMIS are currently not integrated data systems, and therefore, data entry is necessary in both systems.

1. Probation officers/case managers or designated staff shall enter online SSI and SRARF data directly into NCJIS.
2. Probation officers/case managers or designated staff shall capture SSI scores and SRARF risk levels and submit to a support staff person designated by the Chief Probation Officer, ISP Coordinator, or Drug Court Coordinator for data collection or entered directly by a probation officer into NPMIS.
3. Upon the completion of a substance abuse evaluation, the following information shall be entered into NPMIS (under the "Model" tab) by probation officers/case managers or designated staff:
   » the date completed
   » ideal level of care
   » available level of care

I. **Training**

Through the Administrative Office of Courts/Probation training is required concerning basic and continuing education pertaining to substance abuse, the Standardized Model, and instruments utilized, in order to properly assess and supervise offenders under Probation's authority. All probation officers/case managers shall:

- » Understand the policies and procedures associated with the Standardized Model.
- » Be trained on the principles of criminogenic risk and need factors (to include but not limited to criminal thinking and motivational interviewing).
- » Be trained on the nature of substance abuse addiction in adults and juveniles during the first year of employment (35 hours required). Subsequent yearly training (8 hours) to include, but not limited to, relapse prevention, strength-based treatment principles, and American Society for Addiction Medicine (ASAM) criteria.
- » Understand the operation of the Nebraska Substance Abuse Service Delivery System.
- » Be trained on the Standardized Model, the process and tools utilized, to include:
- » Administration of the Simple Screening Instrument (SSI)
- » Administration of the Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF)
- » Nebraska Standardized Reporting Format for Substance Abuse Evaluations for all Justice Referrals
- » Understanding the Addiction Severity Index (ASI) and Comprehensive Adolescent Severity Inventory (CASI)
- » Standardized Levels of Care Continuum for Substance Abuse Services for Juvenile and Adult Criminal Justice Clients
- » Understand the incorporation of the Standardized Model into the presentence investigation and case management.
- » Understand the proper use of NCJIS and NPMIS concerning data collection associated with the Standardized Model.

Attachments:

Attachment 1 -- Simple Screening Instrument (SSI)
Attachment 2 -- Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF)
Attachment 3 -- Referral for Substance Abuse Evaluation Form - General Letter to Providers
Attachment 4 -- Nebraska Standardized Reporting Format for Substance Abuse Evaluations for all Justice Referrals
Attachment 5 -- Substance Abuse Services for Adult Criminal Justice Clients Continuum of Care

Attachment 1

SIMPLE SCREENING INSTRUMENT

Interviewer reads the following to the client: "The questions that follow are about your use of alcohol and other drugs. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months."	
In the past 6 months,	
1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin, or other opiates, uppers, downers, hallucinogens, or inhalants.)	Yes No
a. When did you first use alcohol or other drugs (excluding tobacco)?	___/___/___
b. When did you last use alcohol or other drugs (excluding tobacco)?	___/___/___
2. Have you felt that you use too much alcohol or other drugs?	Yes No
3. Have you tried to cut down or quit using alcohol or other drugs?	Yes No
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)	Yes No
5. Have you had any of the following?	
a. Have you ever had blackouts or other periods of memory loss?	Yes No
b. Have you ever injured your head after drinking or using drugs?	Yes No
c. Have you ever had convulsions, delirium tremens ("DT's")?	Yes No
d. Have you ever had hepatitis or other liver problems?	Yes No
e. Have you ever felt sick, shaky, or depressed when you stopped drinking or using?	Yes No
f. Have you ever experienced a crawling feeling under the skin after you stopped using drugs?	Yes No
g. Have you ever been injured after drinking or using?	Yes No
h. Have you ever used needles to shoot drugs?	Yes No
i. Have you ever been depressed or suicidal?	Yes No
6. Has drinking or drug use caused problems between you and your family or friends?	Yes No
7. Has drinking or drug use caused problems at school or at work? (Including attendance.)	Yes No
8. Have you been arrested or had other legal problems (such as bouncing bad checks, driving while intoxicated, theft, or drug possession)?	
9. Have you lost your temper or gotten into arguments or fights while using alcohol or drugs?	Yes No
10. Have you needed to drink or use drugs more and more to get the effect you want?	Yes No
11. Have you spent a lot of time thinking about or trying to get alcohol or drugs?	Yes No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?	Yes No
13. Have you felt bad or guilty about your alcohol or drug use?	Yes No
The next questions are about your lifetime experiences.	
14. Have you ever had a drinking or drug problem?	Yes No
15. Have any of your family members ever had a drinking or drug problem?	Yes No
16. Do you feel that you have a drinking or drug problem now?	Yes No
The next questions are about your experience with gambling.	
17. Have you ever had to lie to people important to you about how much you gambled?	Yes No
18. Have you ever felt the need to bet more and more money?	Yes No

Scoring for SSI (For official use only)

Individual ID:_____ Date:_____

Location: _____

Items 1, 15, 17 & 18 are **NOT** scored. The following items are scored as a 1 (yes) and 0 (no):

Total Score: _____ **Score Range: 0-14**

Preliminary interpretation of responses:

Score	**Degree of Risk for AOD Abuse**
0-1	None to low
2-3	Minimal
>/=4	Moderate to high: Refer for further substance abuse evaluation

Observation Checklist for Interviewer: Did you observe any of the following while screening this individual?

a. Needle track marks	Yes	No
b. Skin abscesses, cigarette burns, or nicotine stains	Yes	No
c. Tremors (shaking and twitching of hands and eyelids)	Yes	No
d. Unclear speech: slurred, incoherent, or too rapid	Yes	No
e. Unsteady gait: staggering or off balance	Yes	No
f. Dilated (enlarged or constricted (pinpoint) pupils)	Yes	No
g. Scratching	Yes	No
h. Swollen hands or feet	Yes	No
i. Smell of alcohol or marijuana on breath	Yes	No
j. Drug paraphernalia such as pipes, paper, needles, or roach clips	Yes	No
k. "Nodding out" (dozing or falling asleep)	Yes	No
l. Agitation	Yes	No
m. Inability to focus	Yes	No
n. Burns on the inside of the lips	Yes	No

Interviewer Comments: _____

_____

The SIMPLE SCREENING INSTRUMENT is a component of the NEBRASKA STANDARDIZED MODEL FOR ASSESSING SUBSTANCE ABUSING OFFENDERS A Partnership Initiative Between the Nebraska Justice and Substance Abuse Systems

Attachment 2

Client's Name _____ Today's Date _____

Rater's Name _____ Date of Birth _____

RISK ASSESSMENT REPORTING FORMAT

Instructions: This instrument is used to give treatment providers an indication of the offender's risk of rearrest. Justice system personnel should indicate whether, in your professional judgement, the offender's circumstances in each of the following areas indicate an increased likelihood of rearrest.

	Yes	No
1. AGE	❒	❒
Examples: The offender was relatively young at the time of first arrest/conviction. The offender is currently 12 or younger.		
2. PRIOR RECORD	❒	❒
Examples: The offender's arrest record causes concern. The offender has had prior terms of probation/parole. The offender has absconded or been revoked.		
3. OFFENSE TYPES	❒	❒
Examples: The offender has prior arrests for theft/auto theft/burglary/robbery. The offender has an arrest for assault, sexual assault, or weapons.		
4. ATTITUDE	❒	❒
Examples: The offender does not accept responsibility/rationalizes behavior. The offender is unwilling to change.		
5. PERSONAL RELATIONS	❒	❒
Examples: The offender's personal relationships are unstable or disorganized. The offender has gang associations.		
6. **SUBSTANCE USE**	❒	❒
Examples: The offender is involved in occasional or frequent use of alcohol/drugs. The use of alcohol/drugs causes any disruption of functioning.		

FOR JUVENILES ONLY

	Yes	No
7. **SCHOOL/EMPLOYMENT**	❒	❒

(Check "Yes" if offender has dropped out and is not employed.)
Examples: The offender has behavior or attendance problems at school or work. The offender is placed below expected grade.

FOR ADULTS ONLY

	Yes	No
7. **EMPLOYMENT**	❒	❒

(Check "No" if full-time student.)
Examples: The offender has unsatisfactory employment or is unemployed. The offender has not been regularly employed or in school for the last year.

8. MALTREATMENT	❒	❒

Examples: The offender has been reported to be the victim of either neglect or abuse (emotional, physical, or sexual).

OVERALL IMPRESSION

In your professional judgement, indicate the relative level of risk of rearrest posed by this offender.

Low ❒ Medium ❒ High ❒

Comments/Concerns/Complicating Factors (e.g., trauma, victim, mental health, other identified needs):_____

_____

_____

The SIMPLE SCREENING INSTRUMENT is a component of the NEBRASKA STANDARDIZED MODEL FOR ASSESSING SUBSTANCE ABUSING OFFENDERS A Partnership Initiative Between the Nebraska Justice and Substance Abuse Systems

Attachment 3

STANDARDIZED MODEL COMMUNICATION BETWEEN
PROBATION AND PROVIDER OF SUBSTANCE ABUSE SERVICES

To: Registered provider (refer to provider list)

FROM: Probation Officer/Case Manager

RE: Referral for Substance Abuse Evaluation/Treatment Form

Name of Offender: _____

Docket: _____ Page: _____

Current Charge(s):_____

_____

_____

The undersigned individual named above is being referred to you/your agency for the substance abuse service listed above. Please forward a signed authorization to the probation officer/case manager listed above and the individual's Simple Screening Instrument (SSI), Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF), prior criminal record, and BAC (Blood Alcohol Content) (if applicable), will be forwarded to you. Thank you.

Date: _____ Date: _____

_____ _____

Probationer/Defendant Probation Officer/Case Manager

Adopted by the Nebraska Supreme Court on November 30, 2005 to be effective January 1, 2006.

NEBRASKA STANDARD REPORTING FORMAT FOR SUBSTANCE ABUSE EVALUATIONS FOR ALL JUSTICE REFERRALS

A. DEMOGRAPHICS

B. PRESENTING PROBLEM / PRIMARY COMPLAINT
   1. External leverage to seek evaluation
   2. When was client first recommended to obtain an evaluation
   3. Synopsis of what led client to schedule this evaluation

C. MEDICAL HISTORY

D. WORK / SCHOOL / MILITARY HISTORY

E. ALCOHOL / DRUG HISTORY SUMMARY
   1. Frequency and amount
   2. Drug and/or alcohol of choice
   3. History of all substance use / misuse / abuse
   4. Use patterns
   5. Consequences of use (physiological, legal, interpersonal, familial, vocational, etc.)
   6. Periods of abstinence / when and why
   7. Tolerance level
   8. Withdrawal history and potential
   9. Influence of living situation on use
   10. Other addictive behaviors (e.g., gambling)
   11. IV drug use
   12. Prior SA evaluations and findings
   13. Prior SA treatment

F. LEGAL HISTORY (Information from Criminal Justice System)
   1. Criminal History and other information
   2. Drug testing results
   3. Simple Screening Instrument (SSI) results
4. Risk Assessment Reporting Format for Substance Abusing Offenders SRARF) results

G. FAMILY / SOCIAL PEER HISTORY

H. PSYCHIATRIC / BEHAVIORAL HISTORY
   1. Previous mental health diagnosis
   2. Prior mental health treatment

I. COLLATERAL INFORMATION (Information from Family/Friends/Criminal Justice/Other)

Report any information about the client's use history, pattern, and/or consequences learned from other sources.

J. OTHER DIAGNOSTIC / SCREENING TOOLS – SCORE AND RESULTS

Report the results and score from any other substance abuse assessment tool used that is not the ASI or CASI.

K. CLINICAL IMPRESSION

1. Summary of evaluation
   a. Behavior during evaluation (agitated, mood, cooperative)
   b. Motivation to change
   c. Level of denial or defensiveness
   d. Personal agenda
   e. Discrepancies of information provided

2. Substance abuse diagnostic impression (including justification)
   a. Identify the substance abuse diagnostic impression
   b. May include Axis I-V (include information gained from other sources on psychiatric or medical diagnosis, if known)

3. Strengths identified (for the client and the family)
4. Problems identified

L. RECOMMENDATIONS

1. Primary / ideal level of care recommendation
   • Identify the substance abuse level of care and service(s) that would best meet the need of the client.

2. Available level of care / barriers to ideal recommendation
   • If the substance abuse level of care and service(s) are not available or there is some other reason the client cannot receive that service, identify those reasons. Include the next best substance abuse level of care and service that the client will be referred to.

3. Client / family response to recommendation
   a. Document the client's response to the level of care and service recommendation.
   b. Include the family's response to the level of care and service recommendation.

Adopted by the Nebraska Supreme Court on November 30, 2005 to be effective January 1, 2006.

PERTINENT BIOPSYCHOSOCIAL INFORMATION

	YES	NO	NOTES
1. MEDICAL / HEALTH STATUS			
a. Eating disorders issues			
b. Infectious diseases present			
c. Head trauma history			
d. Organ disease (liver, heart, other)			
e. Pregnancy			
f. Medication status and history			
g. Other pertinent medical problems			
h. Nutritional			
2. EMPLOYMENT / SCHOOL / MILITARY	YES	NO	
a. Employment history			
b. Financial responsibility problems			
c. Work ethic / goal setting problems			
d. Military history			
e. Attendance issues			
f. Performance / goal setting problems			
g. Learning disabilities present			
h. Cognitive functioning difficulties			
3. FAMILY / SOCIAL DESCRIPTION	YES	NO	
a. History of use / treatment			
b. Family communication issues			
c. Family conflict evident (domestic, sexual, physical, neglect, etc.)			
4. DEVELOPMENTAL	YES	NO	
a. Abandonment issues			
b. Significant childhood experiences			
5. SOCIAL COMPENTENCY / PEER RELATIONSHIPS			
a. Authority issues present			
b. Assertiveness issues present			
c. Submissiveness issues present			
d. Social support network			
e. Substance-using peers prominent			
f. Isolation issues			
g. Use of free time / hobbies			
h. Group v. individual activities			
i. Gang membership / affiliation			
6. PSYCHIATRIC / BEHAVIORAL	YES	NO	
a. Need for mental health treatment evident			
b. Danger to self or others present			
c. Legal issues past or present			
d. Violence by history			
e. Impulsivity by history			
f. High risk behaviors by history			
7. INDIVIDUALIZED NEEDS	YES	NO	
a. Spirituality			
b. Cultural issues impacting AOD use			
c. Anti-social values / beliefs			

Attachment 5

SUBSTANCE ABUSE SERVICES

FOR ADULT CRIMINAL JUSTICE CLIENTS

The terms listed are for use by all substance abuse providers and criminal justice entities in referring criminal justice system clients to substance abuse services provided in Nebraska.

LEVEL OF CARE (LOC): General category that includes several similar types of services.
Substance Abuse Services: The specific service name that more specifically identifies the type of actual substance abuse service a client will receive.
Adult: Age 19 and above.

NOTE: Not all of these services are available in Nebraska; some services may be available in some areas but not in others. This service array is intended to be a balanced array of substance abuse services that could meet various needs at different levels of severity.

LOC: EMERGENCY SERVICES

(very short term, unscheduled service availability in time of crisis in a variety of settings)

Crisis Phone Line	Clinician on-call for early intervention/screening/referral; available 24/7.
Mobile Crisis / Crisis Response Teams	Teams of professional and/or paraprofessionals that offer on-site screening usually in the home; brief interventions to stabilize the crisis and refer for SA Crisis/Crisis Respite or other appropriate service, and a thorough SA evaluation; available 24/7; includes access to a LADC.
SA Emergency Shelter or SA Respite	Residential- or home-based service for a short-term placement of an individual in a substance abuse crisis; most clients are not intoxicated but program has capability to supervise alcohol/drug social setting detoxification (non-medical); length of stay varies by legal status, but emphasis is very short term (less than 7 days); 24/7 availability of on-site clinically managed and monitored services as needed; client is medically stable; very limited nursing coverage/can be on-call.
Emergency Community Support	Support service for persons once a MH or SA crisis has been stabilized; 1:1 staff to client work to ensure client focuses on relapse and recovery management, and skill teaching, assistance with housing, ensure attendance at medical appointments or SA non-residential treatment services; coordination of a care plan; coordinating services, transportation; 24/7 on call; service is very short term; often provided concurrently with another SA service to ensure client stays connected with services; LoS varies but not longer than 30-90 days.
Emergency Stabilization and Treatment	Service to stabilize acute withdrawal and/or intoxication symptoms and return person to independent living in the community or engage and refer the person to a recovery program; supportive services therapy, brief SA assessment, primary clinical treatment for substance abuse disorder implemented, and coordination of services to help the client aleviate a substance abuse crisis; LoS varies but not longer than 14 days; on-site clinically managed and monitored; medically stable; limited nursing coverage.
Social Detox	Residential service for the short-term placement for an adult needing alcohol/drug detoxification (non-medical); length of stay varies but usually not more than 5-7 days depending on the drugs involved; 24/7 on-site availability of clinically managed and monitored; medically stable; limited nursing coverage.
Medical Detox	24-hour medically supervised alcohol/drug detoxification where severe medical issues are involved; 24/7; medical staff coverage.
Emergency Protective Custody (EPC)	Crisis Center services provided in a medical facility to stabilize a person in psychiatric and/or substance abuse crisis; clinically managed detox with legal hold; 24/7; admission on involuntary basis by EPC legal hold because of alleged dangerousness to self or others; generally 7 day or less stay to stabilize, begin emergency treatment and referral to most appropriate service to meet client's need; LoS not longer than 7 days, or if the client is on an EPC hold may continue to a commitment hearing.
Civil Protective Custody (CPC)	Residential services; 24-hour legal hold to keep someone involuntarily in a social detox service.

LOC: ASSESSMENT SERVICES

(screening and evaluation tools used to determine the level of a SA problem and make appropriate service)

Screening	General screening by provider to identify a substance abuse problem and refer for a complete SA assessment, early intervention or treatment; includes screen for mental health and gambling issues. Criminal Justice referrals will have had an SSI screen done by criminal justice system staff.
Emergency SA Evaluation	SA evaluation needed on an unscheduled basis and completed within 24 hours of request; ***all evaluations completed for justice clients must be completed by a clincian licensed by the State of Nebraska to assess and treat substance abuse problems and who has completed the Standardized Model requirements and state-approved ASI and criminal justice behaviors/thinking training; available from any state-licensed SA service provider;*** Evaluation/Assessment Tool Required: Addiction Severity Index (ASI); Approved State Reporting Format: SA Evaluation/ Assessment results are required to be provided in the state-approved reporting format only.
SA Evaluation	***All SA evaluations completed for justice clients must be completed by a clincian licensed by the State of Nebraska to assess and treat substance abuse problems and who has completed the Standardized Model requirements and state-approved ASI and criminal justice behaviors/thinking training; available from any state-licensed SA service provider;*** Evaluation/Assessment Tool Required: Addiction Severity Index (ASI); Approved State Reporting Format: SA Evaluation/Assessment results are required to be provided in the state-approved reporting format only.

LOC: NON-RESIDENTIAL SERVICES

(least intensive services based on clinical need offered in a variety of community settings; client lives independently)

NOTE: Persons MUST be psychiatrically and medically stable to be admitted to the non-residential services.

NON-RESIDENTIAL SERVICES: A range of services for persons at risk of developing, or who have substance abuse problems, specific functional deficits, problems with intoxification or withdrawal, but few biomedical complications. Clients may have significant deficits in the areas of readiness to change, relapse, continued use or continued problem potential or recovery environment and, thus, are in need of interventions directed by licensed addiction specialists rather than medical or psychiatric personnel in a variety of non-residential settings. Level 1 is the most intensive and Level 5 is the least intensive service in this level of care.

Lv 5	**Prevention and Education**	Education and other activities designed to prevent abusing substances.
Lv 5	**Intervention**	Intervention counseling and education for persons experimenting or currently using substances but who are NOT abusing or dependent; staff supervised EDUCATION programs are very structured with a specific outcome for the client; LoS varies (i.e., minimally one staff supervised 6- or 8-hour class; other options might include eight 1-hour sessions, three to four 4-hour sessions, or other); includes support group or self-help referrals.
Lv 5	**Methadone Maintenance**	Administration of methadone medication to enable an opiate-addicted person to be free of heroin; methadone replacement for heroin is a lifetime maintenance program; counseling therapy interventions are included in the service.
Lv 5	**Care Monitoring SA/MH**	Monitoring service designed for persons eligible under the definition for Community Support Mental Health or Substance Abuse, who have made significant progress in recovery and stable community living, or for those clients unwilling to accept the more intensive and rehabilitative community support service; this service monitors a client's progress in community living, provides crisis/relapse intervention/prevention as needed, provides oversight and follow-up functions as identified in the client's monitoring plan (i.e., services, appointments, reminders), and intervenes to protect current gains and prevent losses or decompensation/relapse; contact with client as needed.
Lv 4	**Outpatient Counseling**	Individual and/or group counseling/therapy by a clinician licensed in Nebraska to treat substance-use disorders that disrupt a client's life; treatment focus is on changing behaviors, modifying thought patterns, coping with problems, improving functioning, and other services to achieve successful outcomes and prevent relapse. LoS varies depending on individual illness and response to treatment (i.e., may average 10-12 sessions at 1-4 hours per week but treatment frequencies and duration will vary); includes brief therapy model (3-5 sessions); group therapy sessions include approx 3-8 persons; family counseling is included.
Lv 3	**Community Support**	Support for persons with chemical dependency and functional deficits; 1:1 staff-to-client support (face to face) in residence or other non-office location to ensure client focus on rehabilitating his/her social and relationship skills; aiding client in use of appropriate coping skills; active relapse and recovery management and skill teaching; provides client advocacy; assistance with housing, accessing transportation, and a variety of other case management activities; ensure attendance at medical appointments or SA non-residential treatment; coordination of a care plan and services; 24/7 on-call availability of community support worker; often provided concurrently with another non-residential SA non-residential service.

Lv 2	**Intensive Outpatient Counseling**	Intensive group and individual counseling for persons with substance abuse disorders or chemical dependence; counseling provided by a clinician licensed in Nebraska to treat substance abuse disorders; offered in day or evening, before or after work; more intensive than Outpatient Therapy and less intensive than Partial Care; service includes a combination of group sessions 3-5 times/week plus individual sessions 1-3 hours/week; total services to the client averages 10-15 hours per week; hours per week are tapered to a prescribed schedule or client need as the client transitions to the less intensive Outpatient Therapy or other service; LoS varies with individual response to treatment but the intensity of the service averages 5-6 weeks in duration.
Lv 1	**Partial Care**	Very intensive day treatment program by clinician licensed in Nebraska to treat substance abuse disorders for clients with substance abuse or dependence problems; medical backup; includes individual and group counseling and medication monitoring services; services are provided 5 days per week at 6-8 hours of daily including a minimum of 4 hours daily of primary SA treatment; LoS varies but average is 5-6 weeks; highest intensity, non-residential service.

LOC: RESIDENTIAL SERVICES

(treatment services provided in a 24 hour community based residential setting)

NOTE: Persons MUST be psychiatrically and medically stable to be admitted to the residential services.

CLINICALLY MANAGED RESIDENTIAL SERVICES: An array of residential services for persons who need a structured, safe living environment to develop recovery skills; have specific functional deficits; minimal problems with intoxification or withdrawal and few biomedical coomplications; client may have significant deficits in the areas of readiness to change, relapse, continued use or continued problem potential or recovery environment, and thus is in need of interventions directed by addiction specialists rather than medical or psychiatric personnel. Level 1 is the most intensive and Level 3 is the least intensive service in this level of care.

Lv 3	**Halfway House**	CLINICALLY MANAGED, LOW INTENSITY: Non-medical transitional residential program for persons who as with chemical dependency or substance abuse disorder who are successfully moving from more intensive treatment to independent living and seeking to re-integrate into the community; structured living environment and semi-structured activities designed to develop recovery living and relapse prevention skills; assistance in maintaining or accessing employment and developing the skills necessary for an independent life free from substance abuse outside of residential treatment; service has capacity to address mental health issues; counseling is provided by a clinician licensed in Nebraska to treat substance abuse disorders; LoS varies but is usually not longer than 3-6 months.
Lv 2	**Therapeutic Community**	CLINICALLY MANAGED, MEDIUM INTENSITY: Non-medical transitional residential treatment for persons with chemical dependency; treatment includes psychosocial skill building through a longer term, highly structured set of peer-oriented activities incorporating defined phases of progress; services include individual and group counseling/therapy, relapse prevention, education, vocational and skill building; service has the capacity to address mental health issues; counseling is provided by a clinician licensed in Nebraska to treat substance abuse disorders; program is staff secure; LoS varies but is usually not longer than 10-18 months.
Lv 2	**Dual Residential (MH/ SA)**	CLINICALLY MANAGED, MEDIUM-HIGH INTENSITY: Non-medical, simultaneous, integrated substance abuse and mental health residential treatment for persons with co-occurring primary chemical dependence **AND** primary major mental illness (schizophrenia, bi-polar, major depression, major psychosis); structured, supervised service includes addiction recovery counseling and activities, medication management and education, and psychosocial rehabilitation services; focus on mental functioning, not psychiatric care; staff include dually credentialed clinicians (LADC/LMHP) and/or both LMHPs and LADCs; LoS varies but is usually not longer than 4-8 months.
Lv 2	**Extended Residential**	CLINICALLY MANAGED, MEDIUM-HIGH INTENSITY: Non-medical longer term, medium intensity residential service for chronic chemically dependent persons who are at a high risk for relapse and/or potential harm to self or others; clients have significant deficits in ability to perform activities of daily living and/or cognitive deficits; counseling is provided by a clinician licensed in Nebraska to treat substance abuse disorders; program is staff secure; LoS ranges from 8-24 months; service has capability to address mental health issues.
Lv 1	**Short Term Residential**	CLINICALLY MANAGED, HIGH INTENSITY: Non-medical residential community treatment for persons with a primary chemical dependency, an entrenched dependency pattern of usage and an inability to remain drug-free outside of a 24-hour care; highly structured, intensive, shorter term comprehensive addiction recovery service including individual, group counseling/therapy, and relapse prevention; medication monitoring; service has the capacity to address mental health issues; counseling is provided by a clinician licensed in Nebraska to treat substance abuse disorders; program is staff secure; LoS varies but is usually not longer than 14-30 days.

Appendix I

Examples of Process and Outcome Measures for the Supervision of DWI Offenders

Process Measures

Process measures determine if a program was implemented as designed and are linked to staff activities. Process measures should be based on written policies, procedures, standards, rules and/or regulations. They may include the number and type of contacts, the number of referrals for treatment, the style of interaction between officers and offenders, or the extent to which offenders were appropriately classified. Process measures can be examined through observation of program activities, interviews and case audits and are needed to determine if a program was implemented as designed. Specifically they provide a mechanism to (Boone, Fulton, Crowe, & Markley, 1995):

- Identify program goals
- Consider causal linkages to criminal behavior
- Specify the program's target population
- Describe what services are actually being delivered
- Investigate unanticipated consequences, and
- Search for explanations of success, failure and change

How to Develop a Process Measures

1. Establish a standard or requirement for performance.
2. Monitor staff performance against the standards.
3. Assess level of compliance with standards
4. If there is noncompliance with the standard, either modify the standard or train staff to comply.

Example process measures related to the community supervision of DWI offenders include, but are not limited to:

- the percent of DWI offenders screened for AOD history;
- the percent of AOD screenings that required a further substance abuse evaluation or assessment;
- the percent of DWI offenders receiving a risk/needs assessment;
- the percent of presentence reports, (pretrial, presentence, prerelease) completed and submitted to the court prior to sentencing;
- the percent of accurate and complete presentence reports;
- the numbers of days between the violation and the imposition of sanctions;
- the percent of times incentives are used in each case during a six month period of time;
- the percent of incentives used for each offender during a six month period of time;
- the percent of revocation proceedings resulting from technical violations;
- the percent of offenders with case plans;
- the percent of offenders involved with supervision officers in developing behavioral contracts;
- the percent of offenders referred to community substance abuse treatment;
- the number of treatment providers receiving information from the supervision officer relating to criminogenic risk/needs of the offender;
- the percent of treatment providers involved in case planning with the supervision officer;
- the percent of treatment providers regularly providing progress reports to the supervision officer;
- the percent of DWI offenders reassessed according to agency policy;
- the percent of offenders attending outpatient and/or inpatient treatment;
- the percent of case plans implemented by agency standard;
- the percent of DWI offenders accepted by various AOD treatment agencies;
- the percent of supervision officers trained in motivational interviewing.

COMMUNITY SUPERVISION OF DWI OFFENDERS PROCESS MEASURE EXAMPLE

Program: AOD Screening

Standard/Objective: All DWI offenders must receive an AOD screening before being sentenced by the court.

Process Measure: Percent of DWI offenders receiving an AOD screening

Data Elements: Number of DWI offenders being sentenced, number of AOD screenings

Formula:

$$\frac{\text{Number of DWI Offenders receiving AOD screening within timeframe}}{\text{Number of DWI Offenders sentenced within the timeframe}}$$

Example: There were 100 DWI offenders sentenced during a six month period. 100 offenders received an AOD screening.

$$\frac{\text{100 received an AOD screening}}{\text{100 DWI offenders sentenced within a six months period}} \times 100 = 100\%$$

THE COMPLIANCE RATE FOR RECEIVING AN AOD SCREENING IS 100%. STANDARD/OBJECTIVE WAS ACHIEVED.

COMMUNITY SUPERVISION OF DWI OFFENDERS PROCESS MEASURE EXAMPLE

Program: Presentence reports

Standard/Objective: The court will receive a presentence report on all DWI offenders prior to sentencing.

Process Measure: Percent of presentence reports received by the court prior to sentencing within timeframe

Data Elements: Number of DWI offenders being sentenced, number of presentence reports prepared within timeframe

Formula:

$$\frac{\text{Number of presentence reports prepared for DWI Offenders within timeframe}}{\text{Number of DWI Offenders sentenced within timeframe}}$$

Example: There were 100 DWI offenders sentenced during a six month period.
95 presentence reports were prepared during the six month period.

$$\frac{\text{95 presentence reports were prepared during a six months period}}{\text{100 DWI offenders were sentenced in a six months period}} \times 100 = 95\%$$

THE COMPLIANCE RATE FOR PREPARING PRESENTENCE REPORTS IS 95%. STANDARD/OBJECTIVE WAS NOT ACHIEVED.

COMMUNITY SUPERVISION OF DWI OFFENDERS
PROCESS MEASURE EXAMPLE

Program: Individualized Case Plans

Standard/Objective: All DWI offenders will have an individualized case plan developed within six weeks of being placed on community supervision.

Process Measure: Percent of DWI offenders with an individualized case plan developed within six weeks of being placed on community supervision.

Data Elements: Number of individualized case plans completed within the timeframe. Number of DWI offenders sentenced during timeframe.

Formula: Number of individualized case plans completed within timeframe / Number of DWI Offenders sentenced within timeframe

Example: There were 100 DWI offenders sentenced during a six month period. Individualized case plans were completed for 50 DWI offenders within six weeks.

$$\frac{\text{50 individualized case plans completed within six weeks}}{\text{100 DWI offenders were sentenced in a six months period}} \times 100 = 50\%$$

THE COMPLIANCE RATE FOR DEVELOPING INDIVIDUALIZED CASE PLANS IS 50%. STANDARD/OBJECTIVE WAS NOT ACHIEVED.

Developing Outcome Measures

Outcome measures are needed to assess a program's impact. Outcome measures are linked to offender change and assess the effectiveness of various activities and program components, allowing agencies to learn from successes, and fine tune the program's practices (Boone, Fulton, Crowe, & Markley, 1995):

- Multiple outcome measures should be used
- Include both intermediate and long-term measures
- Must be measurable and trackable
- Must be objective rather than subjective
- If only outcomes are examined, little direction is available for program policy making
- By controlling process, programs can control outcome.

Example outcome measures may include, but are not limited to, the percent of DWI offenders (Boone, Fulton, Crowe, & Markley, 1995):

- receiving the recommended sentence
- recommended for and successfully completing supervision
- with a reduction in drug use violations
- with early discharges
- with revocations
- with a reduction in risk/need within six months
  - with positive urinalyses
  - completing ordered AOD treatment
  - absconding rates
  - rate of employment
  - revocations due to technical violations
  - showing improvement in attitude
  - number of drug free days

COMMUNITY SUPERVISION OF DWI OFFENDERS OUTCOME MEASURE EXAMPLE

Program: Number of Positive Urine Tests for Drug Use

Standard/Objective: Track the percent of DWI offenders with a positive urine test for the use of drugs.

Process Measure: Percent of DWI offenders given a urine test who test positive for drugs during a specific time frame.

Data Elements: Number of DWI offenders on supervision who test positive for drugs during a specific timeframe.
Number of DWI offenders tested during the timeframe.

Formula: $\frac{\text{Number of confirmed positive tests}}{\text{The number of offenders tested}}$

Example: During a three month timeframe, there were 78 positive drug tests among the 409 DWI offenders who were tested.

$$\frac{78 \text{ positive tests}}{409 \text{ DWI Offenders tested}} \times 100 = 19\%$$

THE RATE OF POSITIVE DRUG USE FOR DWI OFFENDERS 19%.*

*Benchmarking – If the objective is to reduce the percent of positive drug tests, urine tests would be tracked for one year to establish a baseline. Following the second year of tracking if the percentage goes down, then a benchmark is established as a reduction in the percent of positive drug tests for an objective.

COMMUNITY SUPERVISION OF DWI OFFENDERS
OUTCOME MEASURE EXAMPLE

Program: Substance Abuse Treatment

Standard/Objective: All DWI offenders will participate in substance abuse treatment as a condition of supervision.

Outcome Measure: The percent of DWI offenders participating in substance abuse treatment

Data Elements: Number of DWI offenders in AOD treatment during the timeframe, number of DWI offenders during the timeframe.

Formula: Number of DWI offenders in AOD treatment
Number of DWI Offenders

Example: During 2008, 365 DWI offenders participated in AOD treatment. There were 475 DWI offenders on community supervision during the timeframe.

365 offenders participated in AOD treatment
There are 475 DWI offenders under supervision x 100 = 76%

THE COMPLIANCE RATE FOR DWI OFFENDERS PARTICIPATING IN AOD TREATMENT IS 76%. STANDARD/OBJECTIVE WAS NOT ACHIEVED.

COMMUNITY SUPERVISION OF DWI OFFENDERS
OUTCOME MEASURE EXAMPLE

Program: Discharges from Supervision

Standard: Track all DWI offenders terminated from community supervision by type, (e.g., revoked, early termination, and expiredfull term) during timeframe.

Process Measure: Percent of DWI offenders discharged that that supervision expired full term during timeframe.

Data Elements: Number of DWI offenders expired full term during timeframe, total number of DWI offenders terminated during timeframe.

Formula: Number of DWI offenders expired full term during timeframe
Total number of DWI Offenders terminated within timeframe

Example: 236 DWI offenders were discharged with an expired full term during 2008. 350 DWI offenders were discharged from supervision during 2008.

236 discharge – expired full term
350 DWI offenders were terminated in 2008 x 100 = 67%

67% WERE DISCHARGED COMPLETING FULL TERM SUPERVISION.
Benchmark not established for objective, need to track for at least two years and determine objective.

Appendix J

Overview of Findings of the APPA Questionnaire on the Supervision of DWI Offenders

Overview of Findings

In January 2005, a questionnaire was developed by the American Probation and Parole Association to assist in documenting current supervision practices and identifying programs and practices that are effective, innovative, and demonstrate reduction in recidivism of DWI offenders.

The questionnaire was to be completed by an agency administrator, program supervisor, or the individual most knowledgeable about the community supervision of DWI offenders. The following is an overview of some of the results form the questionnaire.

The term driving while impaired (DWI) is being used as an inclusive and generic term because several terms (e.g., driving under the influence [DUI] and driving while intoxicated [DWI] are frequently used interchangeably). Impaired drivers include those affected by any psychoactive substance including alcohol and other drugs, including prescription drugs.

Initial data from programs responding

- 139 programs responded to the questionnaire.
- 129 of those responding provide supervision for DWI offenders. The following data pertains to the 129 respondents providing DWI supervision.
- 82 percent were local programs and 18 percent were State programs.
- 95 percent provide probation services.
- 74 percent do not provide diversion.
- Twice as many misdemeanant offenders as felony offenders are being supervised.
- The number of new cases exceeds the number discharged cases in both felony and misdemeanant cases.
- Three-fourth of respondents indicated alcohol was the substance used by offenders at the time of their arrest.

Reports

- 27 percent require pre-sentence reports in all cases/42 percent require alcohol evaluation.
- 38 percent require pre-sentence reports on some offense levels/36 percent require alcohol evaluation.
- 72 percent of the programs not requiring pre-sentence reports also do not require an alcohol evaluation.

Diversion from the traditional court system

- 50 percent of State statutes permit DWI offenders to be diverted from the traditional court system (e.g., diversion or other pre-trial program).
- 57 percent maintained records for 2 to 5 years after the diversion ended.
- 55 percent of responding programs did not return the offender to court if diversion was not completed because due to violations of conditions.

Caseload size

- Of the programs providing intensive supervision, 64 percent have caseloads of 25 or less.
- Of the programs providing exclusive DWI supervision, 42 percent have caseloads of 151 or more.

Training

- 54 percent of programs provide specialized training for officers working with substance abuse or repeat DWI offenders (e.g., entry level academy, State and local training, general substance abuse training).

Conditions of supervision mandated by statute and/or court/program

First-Time DWI Offenders

- 58 percent of programs have court/program mandates requiring probation/parole or court-ordered supervision.
- Electronic monitoring is allowed by statute in 58 percent of programs.
- Fines are allowed by statute in 75 percent of programs.
- 80 percent of programs require random alcohol/drug testing by court/program order.
- Substance abuse education is required by statute in 52 percent of the programs and by court/program in 51 percent of the programs.
- 60 percent of programs require victim impact panels.
- Drivers license restrictions are required by statute in 79 percent of programs.

Repeat DWI Offenders

- 65 percent of programs have court/program mandates requiring probation/parole or court-ordered supervision.
- 55 percent of court/programs require electronic monitoring.
- Fines are required by statute in 74 percent of programs.
- Random alcohol/drug testing is by statute and/or court/program order in 88 percent of the programs.
- Substance abuse education is required in 54 percent of the programs.
- 60 percent of programs require victim impact panels.
- Driver's license restrictions are required by statute in 79 percent of programs.
- Statutes require a jail sentence in 60 percent of the programs.
- Driver's education or training schools are required by statute in 87 percent of programs.
- Driver's license restriction, suspension, or revocation in required by statute in 81 percent of the programs.
- 54 percent of programs allow ignition interlock by State statute.
- Attendance at a 12-step program is a required in 57 percent of the programs.

Sanctions for technical violation

- A warning or reprimand is a sanction for a technical violation in 88 percent of the programs.
- 90 percent of programs increase supervision contacts for a technical violation.
- 90 percent of programs refer to drug/alcohol treatment program for a technical violation.
- 55 percent of programs refer to mental health treatment program.
- 88 percent of program increase drug and alcohol testing procedures.
- 60 percent increase the use of electronic monitoring.
- 60 percent increase the level of supervision to intensive supervision.
- 60 percent of programs consider residential placement.
- 60 percent of programs extend the length of supervision.
- 87 percent of programs will request a court hearing for a technical violation.
- 79 percent of programs will consider revocation of pre-trial release/probation/parole.

Victims Services

- Victim impact statements will be requested in 66 percent of responding programs.
- 84 percent of programs will request restitution as a condition of supervision.
- 53 percent will require offender to attend a victim impact panel as a supervision requirement.

Data Collection

- 76 percent of programs will collect data on the number of new cases assigned to supervision.
- 74 percent of programs will collect data on the number of cases discharged from supervision.
- 67 percent of programs will collect data on the number of revocations of supervision.
- 52 percent of programs will not collect data on the number of new convictions while under supervision.
- 95 percent of programs will not collect data on the number of new driving convictions within 6 months of release from supervision.
- 94 percent of programs will not record collect data on the number of new driving convictions within 12 months of release from supervision.
- 53 percent of programs will not collect data on the number successfully completing substance abuse treatment.
- 74 percent of programs will not collect data on the number leaving substance abuse treatment without completing.
- 53 percent of programs will not collect data on the results from random drug testing.

Evaluation

- 71 percent of programs do not have an evaluation component to measure effectiveness.

According to responding programs the following would improve programs or make the program more effective in reducing the recidivism of DWI offenders:

- Increased staff
- Assessments/triage services
- Reduced caseloads
- Required pre-sentence reports/alcohol assessments
- Funds for treatment
- Consistency in sentencing
- Staff development/training
- Immediate court response for violations
- Longer period of supervision
- Specialized caseloads
- Drug Court/DWI Court
- Standardized statistical data collection
- Less plea bargaining – no reduction of charges
- Special programming for the chronic DWI offender
- Tools - Ignition interlock, alcohol/drug testing equipment, electronic monitoring

States that Participated in APPA Questionnaire

Arizona
California
Colorado
Florida
Georgia
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maryland
Michigan
Minnesota
Mississippi
Missouri
Nebraska
New Jersey
New York
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
Tennessee
Texas
Utah
Virginia
Washington

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