Tools for Building Effective Community Corrections

Home Confinement and Drug and Alcohol Treatment

The Center for
Community
Corrections

Home Confinement and Drug and Alcohol Treatment

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CCC
A public-private partnership promoting an
effective system of community corrections
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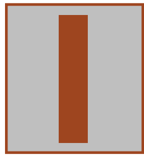
This project is dedicated to the following propositions:

- That successful community corrections depends on intergovernmental collaboration which recognizes the needs and promises of each level of government;
- That successful community corrections demands a genuine partnership with the community;
- That the optimum use of community corrections requires public officials and a public who understand its purpose and are willing to support its programs;
- That small, relatively inexpensive changes in the right places can do much to increase the likelihood of successful community corrections.

Introduction



In the United States today, there are about 6 million people under some kind of control by the criminal justice system. They are in prison and jails, on probation or parole, or released pending trial or sentencing. About two out of three are in the community—living next door, down the street, in this town or the next.

The degree of supervision experienced by offenders living in the community depends on the supervision required or mandated, and the availability and use of programs in their area. Some live in halfway houses and others check in daily at a day reporting center. Some send in report forms once a month and hear nothing from their supervising officers if there has been no change of address or employment. Others are visited at their place of work and randomly provide urine samples that are tested to assure the offender is remaining drug and alcohol free.

A variety of community corrections programs has been developed, thanks to technological advances, that provide an extra dimension of monitoring and accountability for offenders living in the community. This paper looks at two of these programs: home confinement and drug treatment. It tries to answer those questions most frequently raised about the programs, the technologies that support them, and the issues that surround them, so that policymakers can gauge how best to use home confinement and treatment to increase public safety and reduce the risk of re-offending.

In this discussion the term “offender” is used to describe someone who may be at any point in the criminal justice system: from those charged

with an offense and awaiting trial to those who have already been convicted, sentenced, and are serving all or part of their sentences in the community. Both home confinement and drug and alcohol treatment may be a condition of pre-trial release, of probation or part of a program that allows early release from jail.

Policymakers play a critical role in determining the availability, quality, and uses of these programs. Some of the decisions with which they wrestle include the following:

For whom should these programs be available?

Do present statutes allow their maximum use?

Are the technologies overly intrusive?

What is the need relative to present availability?

By whom should they be delivered? Monitored? Evaluated?

If private providers are used, should they be licensed?

These are not easy decisions to make. The following information is designed as background to these issues.

PART 1

Questions and Answers About Home Confinement

What problems does home confinement address?

State prisons and county jails are constantly overcrowded. The moneys they require risk jeopardizing funds for other public services. Because of mandatory laws, some of the more serious offenders have been released from prison early in order to make room for individuals convicted of lesser crimes. Many of those now incarcerated have been convicted of nonviolent offenses, of minor drug offenses, or of property offenses such as shoplifting or stealing to support a habit. Keeping many of the nonviolent in the community under close supervision can free up space behind bars for those who pose real risk to the public's safety.

Home confinement (HC) creates a degree of supervision impossible to provide by probation or parole officers alone. HC is a condition of release to the community where the offender is required to remain at home for at least part of the day. It is both a tool to help control inmate population and a rigorous form of punishment because it curtails individual liberty. It also can be used with new technologies to increase the regular gathering of data about individual offenders. It can spot trends toward compliance or noncompliance.

The ability to supervise these individuals particularly carefully permits increased numbers to be kept out of jail or prison. That extra supervisory capacity also increases the ability of offenders to make a safe transition back to the community following their release from prison or jail.

How does home confinement work?

Most frequently, HC is used as part of a sentence. If the offender is on probation, the sentence may specify the term of HC, which may be all or part of the term of probation. In other situations, HC is required until a certain phase of programming is completed. Similarly, HC can be a condition of early release from jail or prison, to cover all or part of an offender's remaining sentence.

When an offender is placed on HC, the supervising officer works with the offender to establish a schedule. There are several ways to define the time offenders are allowed to be unsupervised in the community. Here are three, ranging from one allowing a fair amount of "free" time, to one that allows hardly any.

- Require the offender to be home during a fixed, **curfew** period, such as 10:00 PM to 6:00 AM. At all other times the offender is free to move around the community.
- Require **house confinement,** which means the offender is expected to be at home except when he is at work or at program activities such as AA meetings or drug treatment.
- Require **home detention,** which means the offender must remain at home at all times, and is permitted to leave the house only rarely for very specific activities such as church services and/or doctors' appointments.[1]

Compliance with the home confinement condition is monitored and an alarm is sounded when the offender is in non-compliance or does not do as expected. If the offender leaves work or treatment too early, does not return home on time, or leaves during a time that he or she is expected to remain home, the equipment notifies the monitor. The monitor is also notified when the equipment loses contact because the electricity and/or the telephone is disconnected.

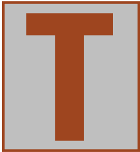
[1]Paul J. Hofer and Barbara S. Meierhoefer, *Home Confinement*. Washington, DC: Federal Judicial Center, 1987, 73 pp.

Agencies with electronic monitoring programs have policies that determine how to respond to each type of alarm. Usually they respond 24 hours a day and 7 days a week. Often an officer will go to the offender's home or call the offender to try to determine the situation.

Any penalties for non-compliance are determined and made clear by the entity imposing the program when the offender's home confinement begins.

Good quality programs require collaboration between probation, courts, law enforcement and other agencies. HC programs may be operated by public agencies or by any private agency that serves offenders in the community. HC programs are being operated by probation departments, parole authorities, and pre-trial supervision agencies. They are also offered by private, non-profit agencies such as the Salvation Army and the Volunteers of America, as well as by numerous, less well-known agencies that serve offenders in local communities or small geographical areas. They are also offered by for-profit service providers.

What technologies are used?



here are a number of types of equipment being used in a variety of ways to monitor offenders to determine whether they are in compliance with a home confinement condition.

Telephone calls may be made by the supervising officer to the monitored location during the time the offender is required to be there.

Supervising officers may periodically signal **beepers** worn by offenders.

Programmed contact equipment allows an automated system to make periodic calls to the monitored location, usually the offender's home, to verify that he or she is there.

Continuously signaling equipment has three parts:

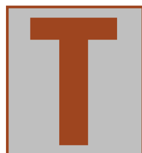
- a ***transmitter*** worn by the offender, usually on the ankle;
- a ***receiver-dialer*** attached to the telephone at the monitored location, usually the offender's home, to receive the signal from the transmitter and to dial; and
- the ***central computer*** at the monitoring center whenever the offender either enters or leaves home.

HYBRID EQUIPMENT combines the features of continuously signaling devices with the features of programmed contact devices.

TRACKING TECHNOLOGY, the latest development, shows, via equipment worn by the offender, the offender's location anywhere in the community, even when moving around.

ENHANCEMENTS exist to some of this equipment. One allows an offender to take a Breathalyzer test at home. Responding to a telephone call, the offender blows into a device attached to the telephone. Another allows two receiver-dialers to respond to one transmitter. The offender can then be monitored at home and at work, or at any other second location.

WHAT TYPES OF OFFENDERS ARE ON HOME CONFINEMENT?



There are three different groups to consider: lowest risk, moderate risk, and reintegrating offenders.

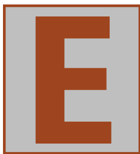
LOWEST RISK POPULATIONS: Most offenders on HC have been charged with or convicted of lower-level offenses, would likely have remained in the community in any case, and HC simply closely checks their behavior for a period of time. Some programs include only these low-risk offenders who already have a high probability of success.

MODERATE RISK POPULATIONS: At the other extreme, some programs are established to serve those "at risk of failure," as one last

chance for offenders to remain in the community and not have to go to prison. This second type of program is monitored very closely. It serves offenders who have already shown that they present some risk, would be expected to have a higher failure rate than the first group, and do.

REINTEGRATING POPULATIONS: Home confinement may also be used to facilitate the transition from prison back into the community for those who have almost completed their prison sentence and would, in any case, be returning to the community in a short time. This period of transition from institution to community has been recognized by other professions as difficult under even the best of circumstances. This might be considered analogous to the way in which mental health workers gradually reintegrate patients who have been hospitalized for several months or years through increasing home visits before final discharge. Rehab hospitals construct mock ATM machines and grocery stores in their basements to help acclimate patients to re-entering "the real world." So release on HC allows the offenders' or prisoners' behavior to be monitored, while providing help with their adjustment during this critical period.

ARE THESE OFFENDERS PUTTING A COMMUNITY AT RISK?



Experience shows that most home confinements end successfully. This means that the offender completes the required period on home confinement.

Remember, most, if not all, of the participants would be in the community anyway. By participating in HC more information is known about their activities. How wisely the information is used makes a difference to public safety and to how much an offender profits from participation in the program. Elected officials, through stipulating provisions that must be present in any HC program, regardless of who runs it, can assure that case information is being used wisely to manage offenders.

Does home confinement work?

As we have learned from medical research, the way to learn whether a treatment works for a particular condition is to find a group of people with that condition and randomly assign them to a group that receives the treatment and one that does not. A similar approach with people in the criminal justice system, however, raises many moral and ethical issues. Therefore, not surprisingly, there are few, if any, solidly conducted statistical studies of HC that might answer the question.

At the same time, we all know that change for any of us is difficult, and trying to change is very stressful. Many research studies have shown that offenders fail shortly after release from prison. Programs such as HC, which provide support during this crucial period, make sense and often provide offenders with intervention when the trouble is just beginning, before it becomes too serious. Elected officials can make sure that outcome data is reported to them and that they discuss the impact of such programs.

In thinking about what works, the benefits to victims and community from keeping nonviolent offenders in the community should not be undervalued. Victims have been able to receive restitution when offenders have been required to get jobs to pay them for the harm caused. Communities have received significant benefits from work crews tending their parks and repairing or painting abandoned buildings.

A note of caution: equipment is sometimes sold by overzealous salespersons who have little background in or understanding of criminal justice. They present the electronic monitoring equipment as a panacea, creating false expectations of a magic bullet. It is, of course, not that. It is simply a tool to monitor offender compliance with home confinement requirements.

How costly is home confinement when used with electronic monitoring?

Officials should be careful about claims that home confinement saves money. Costs per offender per day vary from a couple of dollars to $35 or $40. The differences in costs are primarily related to the type of equipment used and

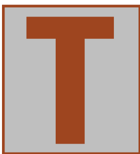
how the service is provided. The program oversight and coordination costs are also to be considered.

In addition to the equipment costs, there are costs related to the monitoring. Some agencies purchase equipment and use their staff to monitor the output. Others contract with companies who, for a fee, monitor the output of the devices and notify agency staff when there is an alarm.

Through electronic monitoring, supervising officers will of course have more information about an offender. In order to interpret and act on that increased information, officers supervising electronically monitored offenders need lower case loads than other probation or parole officers. The usually recommended load is between 20 and 25 cases. That, too, can represent an additional cost.

The costs of the program may be paid by a public agency, by the participants, or by some combination of the two. Some costs may be paid by the agency operating the program or by the agency that pays the private provider operating the program. However, the offenders/participants may also be required to pay all or part of the costs. They may pay a fixed sum, a percentage of income, an amount based on income, or some amount based on other factors. While there are potential cost savings, quality of public safety and increased offender accountability are the real reasons to pursue HC programs.

What are the issues around home confinement?



The primary issues for policymakers revolve around:

The use of home confinement. Most of the present participants in HC would probably be in the community anyway. And most probationers can typically complete their sentences without the use of this program. To make prudent use of scarce resources, HC needs to be targeted to those for whom close supervision is really needed, either for the public's safety or for the offender's successful transition back to the community.

The quality of programs. HC programs credible to both community and offenders require immediate response to information showing non-compliance with predetermined schedules. Leadership, communication networks and technologies working together are all required to make the program effective.

Therefore, in addition to pursuing the questions listed in the Introduction, policymakers may want to be sure that:

- Programs are targeted to those most in need of extra supervision;
- Programs are carefully monitored and can respond quickly on a 7-day-a-week, 24-hour basis;
- If private providers are used, contracts provide for these ingredients, and are closely monitored by the appropriate public agency;
- Reports on the outcomes of HC programs are sent to policymakers at least on an annual basis.

PART 2

Questions and Answers About Drug and Alcohol Treatment

What problems does treatment address?

Drug and alcohol treatment programs are critically important and cost-effective. Serious substance abuse problems can lead to criminal behavior. According to the White House Office of National Drug Control Policy's National Assembly: Drugs, Alcohol Abuse, and the Criminal Offender, $1 spent on drug treatment has been estimated to save $6 in further health and criminal justice costs.

Substance abuse is a part of American society, and elected officials oversee criminal justice budgets with increasing allocations dedicated to alcohol and substance abuse problems. It is estimated that drug and alcohol problems are indicated in the cases of approximately 70% of inmates in prisons and jails. Some are there for selling drugs, others for offenses committed in order to have the resources to obtain drugs, and still others are there for offenses committed while using and/or under the influence of drugs.[2] The percentage of those with drug problems under community supervision may approach the rate of persons in

[2]Maguire, Kathleen and Ann L. Pastore, editors, *Sourcebook of Criminal Justice Statistics 1998*, U.S. Department of Justice, Bureau of Justice Statistics, Washington, DC, U.S. Government Printing Office, 1999.

prisons and jails. At least 21% are convicted of a drug offense, and one-third are drug tested.[3]

A great deal has been written about the abuse of various substances, particularly alcohol and illegal drugs. Interest and concern have focused not only on the criminal justice system, but also on industries such as transportation or those involving the operation of heavy equipment. Many employers who would never have considered it 15 or 20 years ago now have included testing in union contracts: testing employees prior to hiring them, testing randomly throughout their employment, or testing after an incident has occurred, such as an accident. This broadening of interest and concern has led to refinement of the techniques that have been in use and the development of new technologies and approaches.

It has also raised questions about the intrusiveness of drug testing, privacy of such information, and the consequences that attach to those who fail drug tests. Most experts agree that: (1) testing should be used to identify persons who are in need of substance abuse treatment; and (2) for those receiving treatment to make sure they are abstaining from drugs.

Of what does drug treatment consist?

Drug and alcohol treatment are particularly important to changing criminal behavior. According to an in-depth survey of probationers in 1995, drug trafficking and possession of drugs were the prevailing felony charges; driving while intoxicated and assault were the two top misdemeanant charges. Yet only 41% of probationers that year were given treatment as a condition of probation, 37% actually received treatment, and drug testing was required of only 32%. Access to treatment for offenders is also essential after release because there is so little treatment behind bars and sustained treatment and aftercare can cut re-arrest rates by at least half.

[3]Bureau of Justice Statistics, Characteristics of Adults on Probation, 1995, U.S. Department of Justice, Washington D.C. 1997.

The National Institute of Drug Abuse has developed a list of principles for drug addiction treatment. The list includes the following items:

- No single treatment is appropriate for all individuals.
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavior therapies.
- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
- Treatment does not need to be voluntary to be effective. However, individual motivation to engage in treatment sustains long-term abstinence.
- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.[4]

These are elements elected officials will want to know are present in treatment programs funded with public moneys.

[4] *Ibid.*

For the individual drug addict, the addiction can permeate many aspects of life and functioning, affecting, and often interfering with, employment and relations with family, friends and the larger community. Given the complexity of the disorder, it is not surprising that there is no magic bullet and no treatment approach that is effective with everyone. No matter what approach is taken, the principles enumerated by the National Institute of Drug Abuse (NIDA) apply.[5]

Nor is it surprising that an addict may relapse after the first try, and even after many subsequent treatment approaches, since addiction has so many life-style components. Many feel that recovery from addiction to alcohol or drugs is a life-long process and therefore relapsing behavior should not mean that a person should go to jail without further evidence of a pattern of criminal behavior.

Contrary to what many think, drug treatment does not have to be voluntary to be effective. The findings of studies related to this have been summarized as follows:

- Addicts need not be internally motivated at the outset of treatment to benefit from it. However, motivation is thought to be important in preventing dropouts from drug treatment and retaining offenders in treatment long enough for them to establish drug-free living habits.

- Legal involvement or coerced treatment may in fact motivate some clients who would not otherwise participate in treatment. Indeed, addicts who are legally pressured into treatment may outperform voluntary patients, because they are likely to stay in treatment longer and are more likely to graduate from their treatment programs.

- Without formal coercive mechanisms, the treatment system would not attract many of the most dysfunctional addicts, and surely could not retain them.[6]

[5]National Institute of Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide,* National Institutes of Health Publication Number 99-4180, Printed October 1999, 54 pages.
[6]Satel, Sally L., M.D., *Drug Treatment: The Case for Coercion*, Washington, DC, The AEI Press, 1999, pg 45.

Treatment can be seen as in three phases: detoxification, active treatment, and aftercare or relapse prevention.[7]

Detoxification

Detoxification is the process of ridding the body of the drugs or alcohol and safely managing the physical symptoms of withdrawal. It is not always necessary, depending on whether the last drug used is still in the system, how much was used, and the type of drug used. If this stage is required, it may need to be medically supervised because of the danger of convulsions, to alleviate to the extent possible the agony of withdrawal, and because the addict may have other medical problems such as malnutrition, liver dysfunction, AIDS or hepatitis. While it is sometimes thought of as treatment, detoxification is more appropriately thought of as a prelude to treatment.

Active treatments

Active treatments may be all or partially inpatient or may be entirely outpatient. If they are inpatient, they may be in a hospital, a group home or other facility. Treatment may involve the use of drugs or be drug-free. A few of the major types of treatment include the following:

> THERAPEUTIC COMMUNITIES focus on the re-socialization of the addict, using the entire community as the treatment agent. The planned length of stay in these programs is usually at least 6 to 12 months. Synanon, Phoenix House, and Second Genesis are among the best known of the long-term residential treatment programs.
>
> SHORTER-TERM RESIDENTIAL TREATMENT MODELS last 3 to 6 weeks and were originally started as treatment for alcoholics. They have now been expanded to include drug addicts, and generally are

[7]The materials for this section are drawn primarily from the National Institute of Drug Abuse publication *ibid*. and Ray Oakley and Charles Ksir, *Drugs, Society and Human Behavior* 7th Edition, St. Louis, MO, Mosley Press, 1996, pgs. 49–50. The section on relapse prevention is drawn from these sources and Terence T. Gorski and John M. Kelley, *Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders, Technical Assistance Publication Series 19*, Rockville, MD, U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, 1996.

expected to be followed by long-term outpatient treatment. There are also a number of therapeutic approaches to the treatment of drug addiction that may be behavioral and/or require medications, such as methadone. It is noted that an adjunct to treatment, auricular acupuncture, has been recognized by NIDA as effective in reducing cocaine addiction.

RELAPSE PREVENTION is an approach to both treatment and aftercare, which teaches the patient to identify and correct dysfunctional behaviors, enhance self-control and provide self-monitoring techniques. It can be used as a treatment during the active treatment phase and provide techniques for use during aftercare. Relapse prevention provides specific tasks and skills to the patient in the recovery process, shows the patient how to recognize when he or she is beginning to relapse, and how to change before starting to use again.

Relapse prevention is not the only means of aftercare for addicts. Other common and well-known approaches are the 12-Step Program of Alcoholics Anonymous (AA), and the similarly structured programs of Narcotics Anonymous (NA) and Cocaine Anonymous (CA). These may be used by themselves or in conjunction with relapse prevention.

Education is also an important element of drug programs. It focuses on drugs, what they are, their effects on the body, and why they are dangerous. These courses can range from simplified, cursory overviews to longer examinations. Any criminal justice offender may be provided with the opportunity to take such a course whether or not he or she has tested positive for drugs, and whether he or she has a drug history. It is felt that providing information will allow a person to make an informed decision about whether he or she wishes to try drugs, continue experimentation with drugs or risk becoming addicted.

FOR WHAT DRUGS DOES THE CRIMINAL JUSTICE SYSTEM TEST?

Testing in the context of criminal justice is usually done to prevent, deter, or detect use if it has occurred. While prescription drugs can be abused, and there are a variety of "designer drugs" made in clandestine laboratories, the drugs for which tests are conducted in the criminal justice system are alcohol, heroin, cocaine, marijuana, amphetamines, and PCP.

Heroin

Heroin is made from morphine, a naturally occurring substance extracted from the poppy plant. Pure heroin is not usually available on the street. Rather, it is cut and its purity is reduced with sugar, starch, powdered milk and/or other white powders, sometimes including poisons. Heroin is usually injected, although it can be sniffed, snorted or smoked. The addict does not know the purity and so is at risk of an overdose on the one hand, or a very weak product, on the other hand.[8]

Cocaine

Cocaine comes from the leaf of the coca plant found in the Andes Mountains of South America, and is the most potent stimulant of natural origin, providing a euphoric high followed by a crash. Cocaine basically comes in two forms:

1) A fine white crystalline powder that has been cut or diluted with cornstarch, talcum powder and/or sugar, or with other stimulants such as amphetamines. It may be injected in powder form, in which case the effect will be felt in 15 to 30 seconds. When inhaled or snorted, the effect will be felt in 3 to 5 minutes.

2) Crack, the form of cocaine that is processed from the powdered cocaine with ammonia or baking soda and water into a crystalline structure. Smoked, its effect is felt within 10 seconds and the high lasts 20 to 30 minutes.[9]

Amphetamines

Amphetamines are a group of manufactured or man-made drugs that are generally taken orally or injected. They may also be put in a crystalline form and smoked. Their effects are similar to cocaine but the onset is slower and the duration longer. They may be mixed with

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[8] Taken from the DEA website page on heroin and the National Institute of Drug Abuse, Research Report Series, Heroin: Abuse and Addiction. Both were printed 3/27/00.

[9] *Ibid.*

cocaine to extend the cocaine high. When smoked, the high lasts 8 to 24 hours.

Marijuana

Marijuana comes from the leaf of the cannabis plant. It is both grown in the United States and imported. A tobacco-like substance is produced by drying the leaves and the flowering top. This substance is usually smoked, often rolled into a hand-rolled cigarette. It may also be smoked by replacing some of the original contents of a commercially made cigar or cigarette with marijuana.[10]

PCP

PCP used to be made commercially, but now, virtually all available PCP is the product of illegal laboratories so it varies greatly in appearance and effect. Possible effects may include detachment from surroundings, numbness, lack of coordination, and feelings of invulnerability. Some users may experience feelings of acute anxiety and impending doom, while others may become hostile and violent. PCP can also produce a psychosis that is indistinguishable from schizophrenia.[11]

A drug testing program in a criminal justice setting has to be carefully done in order to assure that it is effective and legally defensible. Therefore, some of the elements needed to insure those points include:

- clear and comprehensive policies;
- secure collections of samples;
- maintenance of the chain of custody of the sample;
- use of an initial screening test and a more sophisticated confirmatory test for samples that test positive;
- quality controls in the testing laboratory;
- retention of positive samples; and
- re-testing of positive samples in disputed cases.

A complete list of NIDA's principles can be found in the Appendix at the end of this paper.

[10] *Ibid.*
[11] *Ibid.*

Why and how is testing conducted?

For drugs.

There are many reasons to test criminal justice clients for drugs. The government's National Institute of Drug Abuse points out that one of the most important reasons for drug testing is that it's a necessary part of drug treatment and a necessary component of the supervision of offenders, particularly since abstinence from drugs is usually a condition of release.

There are four body products that presently may be tested to determine whether an offender has been abusing drugs: blood, urine, hair, and sweat. There are also new methods currently under development to test saliva and fingernails. The cost of drug testing depends on the method used, the number of drugs being tested, and the volume of tests conducted.

For alcohol.

Criminal justice officials rely on alcohol testing to verify sobriety. It can provide a warning of non-compliance with conditions of parole and probation. In agencies with "zero tolerance" policies regarding alcohol and/or drugs, the first positive test triggers the beginning of a revocation process. With respect to zero tolerance, elected officials face difficult choices about methods for handling relapse.

The usual ways to test for alcohol are blood, urine and breath testing. It should be noted that while any sample collected to test for drugs could be tested for alcohol as well, in a criminal justice setting it is rarely done and certainly not part of the testing routine of most laboratories.

While breath testing is frequent and common, it is not without its problems. The most common is that the equipment can show the use of alcohol when none has been consumed. The use of mouthwashes and other legal products that contain alcohol can cause the equipment to report alcohol. Another problem is that the consumption of certain ethnic and spicy foods can cause the equipment to show that alcohol has been consumed when it has not.

Alcohol stays in the body a short time and so tests must be conducted shortly after consumption. How fast a person's body processes the alcohol depends in part on body weight. According to one source, 2 drinks would cause a person of 100 pounds to have a blood alcohol content, or BAC percentage, of .08, while someone weighing 220 pounds would have a BAC of only .03. The same source also noted that .01 should be subtracted for every hour of drinking as the body metabolizes the alcohol.[12]

While equipment to analyze the breath alcohol level has been around for quite a while, recently all kinds of new testing devices have been developed, driven in large measure by concern over drunk driving. Not only are devices now available for law enforcement use, they are also available for use at home and by employers.

Two new breath testing approaches have criminal justice applications, particularly related to the sanctioning of drunk drivers.

> ***First,*** an alcohol tester can be built into an electronic monitoring device. The offender receives telephone calls at random times of the day asking him to blow into the device attached to the monitoring equipment.
>
> ***Second,*** an alcohol sensor can be tied into the ignition system of a car. Before the car can be started, the person must blow into the device with breath that does not indicate the consumption of alcohol.

Does treatment work?

Treatment is effective for many offenders provided they are motivated to engage in sustained treatment, and they have access to a range of services that are geared to the individual and regularly assess his or her progress. Offenders can be coerced into treatment, and coercion may be important in getting their participation in treatment programs.

[12]Laminated card provided by Roche Laboratories, *op. cit.*.

According to a Rand study, for every dollar devoted to treatment, seven dollars will be saved in costs related to imprisonment, lost income, health care and other social services. So whether it is the White House Office's National Assembly Conference Proceedings' reference to $6 in savings already mentioned, or the $7 of the Rand study for broader costs, the investment in treatment clearly would have a big payoff.

Most researchers agree that for treatment to be effective it must engage the person, provide incentives, develop contingencies for sanctions for non-compliant behaviors, and regularly assess the status of the individual's progress. Continuity of access to treatment is important in providing treatment that works. Drug courts, TASC programs, halfway houses, therapeutic communities and other structured programs can be linked to community out-patient and self-help groups like Alcoholics Anonymous. Individual and group counseling also are important, and can often reach out to families to help offenders sustain their recovery.

Although there are varying evaluations of different programs, what seems clear is that treatment works well if it is coordinated, carefully done, and the client stays in the program. For those who stay in treatment, the longer they participate in treatment, the greater their chances of staying drug free. So the key to treatment success is linked to duration of retention for individuals in programs. According to many researchers, programs that engage participants in motivational and behavioral reinforcements are the most likely to reduce relapse by those who have dropped out of the program. The challenge for community corrections is to provide a continuum of treatment options for offenders to prevent relapse and maximize gains over a period of a year or more.

How can one be assured of the quality of the programs?

Drug and alcohol testing and treatment are absolutely critical ingredients of any program for offenders with a history of abuse. But to be effective, the programs need to reflect the elements embodied in NIDA's principles, particularly the need for different types of treatments to respond to the differences among the individuals involved.

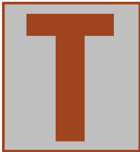
The treatment of addicts requires a motivated therapist or leader who has received specialized training. While it is sometimes tempting to award a contract for treatment to the lowest bidder, it is important to assure that the treatment provider is professionally competent and aware of the latest techniques.

Certification of testing.

There are two federal agencies that are concerned with the accuracy and certification of tests. They are the National Institute of Drug Abuse (NIDA) and the National Transportation Safety Board (NTSB). When laboratories and equipment are certified by either or both of these two agencies, the accuracy of the test results is assured. Therefore, criminal justice agencies that contract with certified laboratories or for certified equipment can be sure they can believe the results.

Some agencies set up their own laboratories. In this case, they have to hire staff who are qualified to conduct the tests and can testify about the results in court.

How much does drug treatment cost?



he establishment of a program to test for drugs and alcohol requires care and has costs attached.

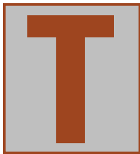
- Alcohol testing requires the purchase of a Breathalyzer and then continuing purchase of the replacement mouth pieces.
- Agencies that contract for urine testing usually find that the costs are related to the volume of drug tests expected. Each test can cost $8.00 or more.
- The costs of blood testing would also be determined by the laboratory charges.
- The sweat patch tests for drug residue in perspiration, and is a proprietary product of the company that makes and tests it. The patches run about $25.00 each, with reductions in costs for significant volumes.

- Other approaches to testing are new and proprietary and may be costly.

There are few agencies supervising offenders in the community that do not have some kind of a testing program for substance abuse. Some get grants from the state agency that distributes federal crime control money. Others receive some support by participating in research projects. Most agencies support all or part of the program as part of their ongoing operating budget.

And a reminder that the potential savings mentioned earlier represent an offset worth calculating.

What are the issues around treatment?



The primary issues around drug and alcohol treatment revolve around the following:

The level of abuse. Zero tolerance, discussed earlier, has implications for jails and prisons. So does the level of alcohol for DUI.

Availability of treatment. If treatment is to be made a condition of probation, both residential and out-patient treatment programs need to be available without displacing those in need who are NOT under court jurisdiction. Managed care, health insurance coverage, state, federal, and local Medicaid coverage for treatment are issues related to access to treatment.

Quality of programs. Perhaps the state already requires certification of its drug testing laboratories, or perhaps that might be required. State licensing might also be considered. And if private providers are used, then the demands and monitoring of contracts become useful tools to ensure quality.

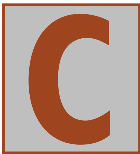
Therefore, in addition to pursuing the questions in the Introduction, policymakers will want to know:

- The effect on different elements of the criminal justice system of a zero tolerance policy;

- The availability of drug and alcohol treatment programs compared to the needs of the "regular" population, of the jail and prison population, of those under community supervision;
- The degree to which NIDA principles are incorporated into government programs and required of private providers; and
- The evaluations conducted of state-funded treatment programs.

PART 3

Linking Treatment With Home Confinement



hanging behavior is never easy. By providing careful monitoring and quality treatment, the likelihood of effecting that change increases dramatically.

Criminal justice leaders ascertain that home confinement is used along with other programs and resources to increase sobriety and constructive behavior. Home confinement linked with treatment programs can create powerful control and support for the offender living in the community.

There is a long list of programs that those on home confinement might be required to attend. Most of the programs are established to address the issues that caused the offender to become involved in crime in the first place. The most frequent are probably drug treatment, Narcotics Anonymous and Alcoholics Anonymous. Offenders may also receive victim awareness programming, anger management or conflict resolution, depending on his or her needs.

Drug addicts and alcoholics usually reveal that they did not want to be addicts and that they didn't like it. Yet the ability to stop is easier said than done, and slips can be an inevitable part of the recovery process. One approach to substance abuse treatment that is used with home confinement and in many other contexts is called "relapse prevention." This approach helps the offender recognize and manage relapse warnings or triggers that can lead to the use of drugs or alcohol after a period of abstinence.

Some programs combine home confinement with a program such as a day reporting center. During the day, offenders gather at a facility to

participate in activities such as those mentioned above, as well as job training, job readiness or training in particular skills. At night, the offenders then are on home confinement with electronic monitoring. Elected and other officials can determine how these program requirements are met in their communities.

The most promising practices are the linking of home confinement participation with treatment programs. For instance, the continuing or renewed use of drugs by an offender puts a community at risk. Therefore intervention by a drug treatment program reduces the risk to the community, holds the offender accountable, and provides him or her with tools that he or she can use to change behavior. Drug treatment is only one of numerous examples of the "win-win" situation that occurs when programs are provided in the community. But oversight, program coordination and quality of services are key to program success.

Appendix

National Institute of Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide,* NIH Publication Number 99-4180, October, 1999, pages 3 through 5.

The summary of the document presents principles of effective treatment:

1. **No single treatment is appropriate for all individuals.** Matching treatment setting, interventions and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace and society.

2. **Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available and readily accessible.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational and legal problems.

4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychother-

apy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached after about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Counseling (individual and group) and other behavioral therapies are critical components of effective treatment of addiction.** In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding non-drug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and the community.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatment and medications can be critically important.

8. **Addicted or drug-abusing individuals with co-existing mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the

same individual, patients presenting both conditions should be assessed and treated for the co-occurrence of both types of disorder.

9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

10. **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment intervention.

11. **Possible drug use must be monitored continuously.** Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, through urinalysis or other tests, can help the individual withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

12. **Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behavior that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapse to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve prolonged abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

Resources and Contacts

More detailed information on any of these or related topics can be obtained from the following:

From the Federal Government:

Center for Substance Abuse Prevention

Substance Abuse and Mental Health Services Administration
U.S. Dept. Of Health and Human Services
5600 Fishers Lane, Rockwall II
Rockville, MD 20857
301-443-0365

Center for Substance Abuse Research

University of Maryland, College Park
4321 Hartwick Road, Suite 501
College Park, MD 20740
301-443-8329
301-403-8342

Federal Judicial Center

1 Columbus Circle NE, 6-432
Washington, DC 20002-8003
202-273-4072

National Institute on Alcohol Abuse and Alcoholism

National Institutes of Health
U.S. Department of Health and Human Services
Willco Bldg., Suite 400-msc7003
6000 Executive Blvd.
Bethesda, MD 20892
301-443-3851

National Institute of Corrections

Community Corrections Division
320 First Street, NW, Room 200
Washington, DC 20534
202-307-3995

National Criminal Justice Reference Service

301-738-8895
email: look@NCJRS.aspen

Office of Justice Programs
Bureau of Justice Assistance
Clearinghouse
800-688-4252

Office of Justice Programs
Drug Court Program
810 7th Street, NW
Washington, DC 22151
202-616-5001

Office of Justice Programs
OJP Corrections Program
810 7th Street, NW
Washington, DC 22151

Office of National Drug Control Policy
Executive Office of the President
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20502-0002
202-395-6700

National Organizations Focusing on Community Corrections, Elected Officials and Substance Abuse Treatment:

American Bar Association
Criminal Justice Section
740 15th Street, NW
Washington, DC 20005-1009
202-662-1500
202-662-1501

American Correctional Association
4380 Forbes Blvd.
Lanham, MD 20706
301-918-1800

American Jail Association
2053 Day Road, Suite 100
Hagerstown, MD 21740-9795
301-790-3930

American Judges Association
National Center for State Courts
300 Newport Ave., P.O. Box 8798
Williamsburg, VA 23187-8798
804-259-1841

American Probation and Parole Association
Council of State Governments
P.O. Box 2167
Lexington, KY 40595-2167
606-244-8207

Drug Strategies, Inc.
1575 Eye Street, NW, Suite 210
Washington, DC 20005
202-289-9070

International Community Corrections Association
P.O. Box 1987
LaCrosse, WI 54602
608-785-0200

Justice Fellowship
P.O. Box 16069
Washington, DC 20041-6069
703-904-7312

National Acupuncture Detoxification Association
P.O. Box 1927
Vancouver, WA 98668-1927
360-260-8620

National Association of Counties
440 First Street, NW, Eighth Floor
Washington, DC 20001
202-393-6226

National Association of Drug Court Professionals
901 North Pitt St., Suite 370
Alexandria, VA 22314
703-706-0576
703-706-0577

National Center on Addiction and Substance Abuse
152 West 57th Street, 12th Floor
New York, NY 10019-3310
212-841-5200
212-956-8020

National Center on Institutions and Alternatives
3125 Mount Vernon Avenue
Alexandria, VA 22314
703-684-0373

National Conference of State Legislatures
444 North Capitol Street, NW, Suite 500
Washington, D.C. 20001
202-624-5400

National Criminal Justice Association
444 North Capitol Street, NW, Suite 608
Washington, DC 20001

National Governors Association
444 North Capitol Street, NW
Suite 250
Washington, DC 20001
202-624-5360

Therapeutic Communities of America
1611 Connecticut Ave., Suite 4-B
Washington, DC 20009
202-296-3503
202-518-5475

Websites:

American Bar Association
http://www.abanet.org

American Correctional Association
http://www.corrections.com/aca

American Methadone Treatment Association, Inc.
http://www.assnmethworks.org

American Probation and Parole Association
http://www.appa@csg.org

American Society of Addiction Medicine, Inc.
http://www.asam.org

Drug Strategies, Inc
http://www.drugstrategies.org

International Community Corrections Association
http://www.iccaweb.org

National Institute on Alcohol Abuse and Alcoholism
http://www.nida.nih.gov

Office of Justice Programs
http: www.ojp.usdoj.gov

Office of National Drug Control Policy
http://www.
whitehousedrugpolicy.org

Therapeutic Communities of America
http://www.tcanet.org

Substance Abuse and Mental Health Services Administration
http:samshsa.gov

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Capitol Corrections Group

About the Center for Community Corrections

The Center for Community Corrections is a broad coalition of former public officials, researchers and correctional professionals representing local, state, and federal concerns. The Center was created in 1987 to promote the overall concept of community-based sanctions as well as specific program options.

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