

# Guidelines for Community Supervision of DWI Offenders





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Revised April, 2020

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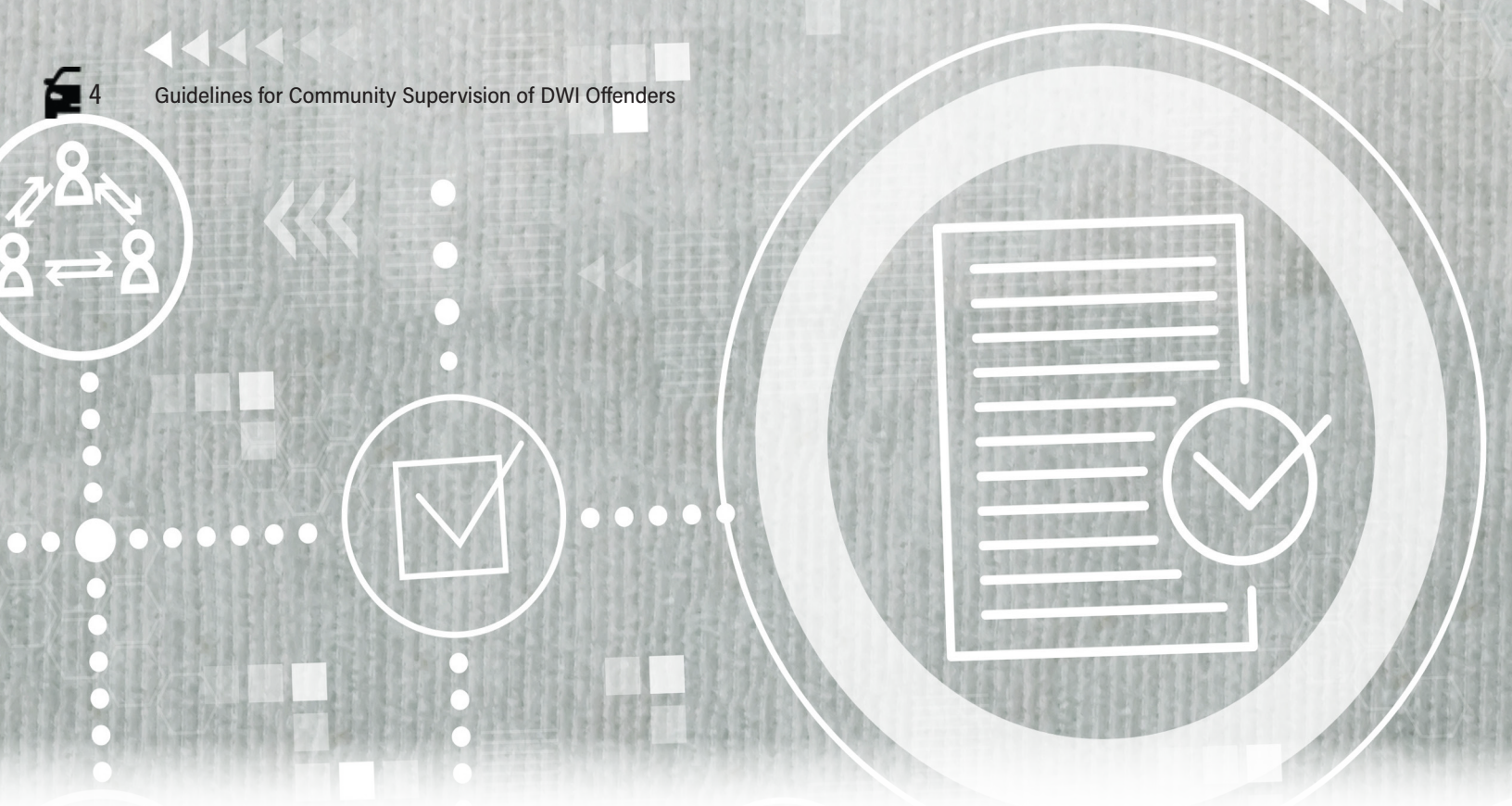
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March 2008

The research for this document was supported under Cooperative Agreement Number DTNH2215H00481 from the National Highway Traffic Safety Administration, U.S. Department of Transportation. This document was prepared by the American Probation and Parole Association, in conjunction with the Council of State Governments. Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Transportation.

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# Section I

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

Despite the tireless efforts of thousands of highway safety advocates over the past 30 years, impaired driving continues to be a major problem in the United States (US). 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 (NHTSA) Fatality Analysis Reporting System (FARS), in 2018 there were 10,511 people killed in alcohol-impaired driving crashes which is an average of 1 alcohol-impaired-driving fatality every 50 minutes (National Center for Statistics and Analysis [NCSA], 2018a). These alcohol impaired-driving fatalities accounted for 29% of all motor vehicle traffic fatalities in the United States in 2018 committed by a vehicle driver or a motorcycle operator with a Blood Alcohol Concentration (BAC) of 0.08 grams per deciliter (g/dL) or higher (NCSA, 2018c).

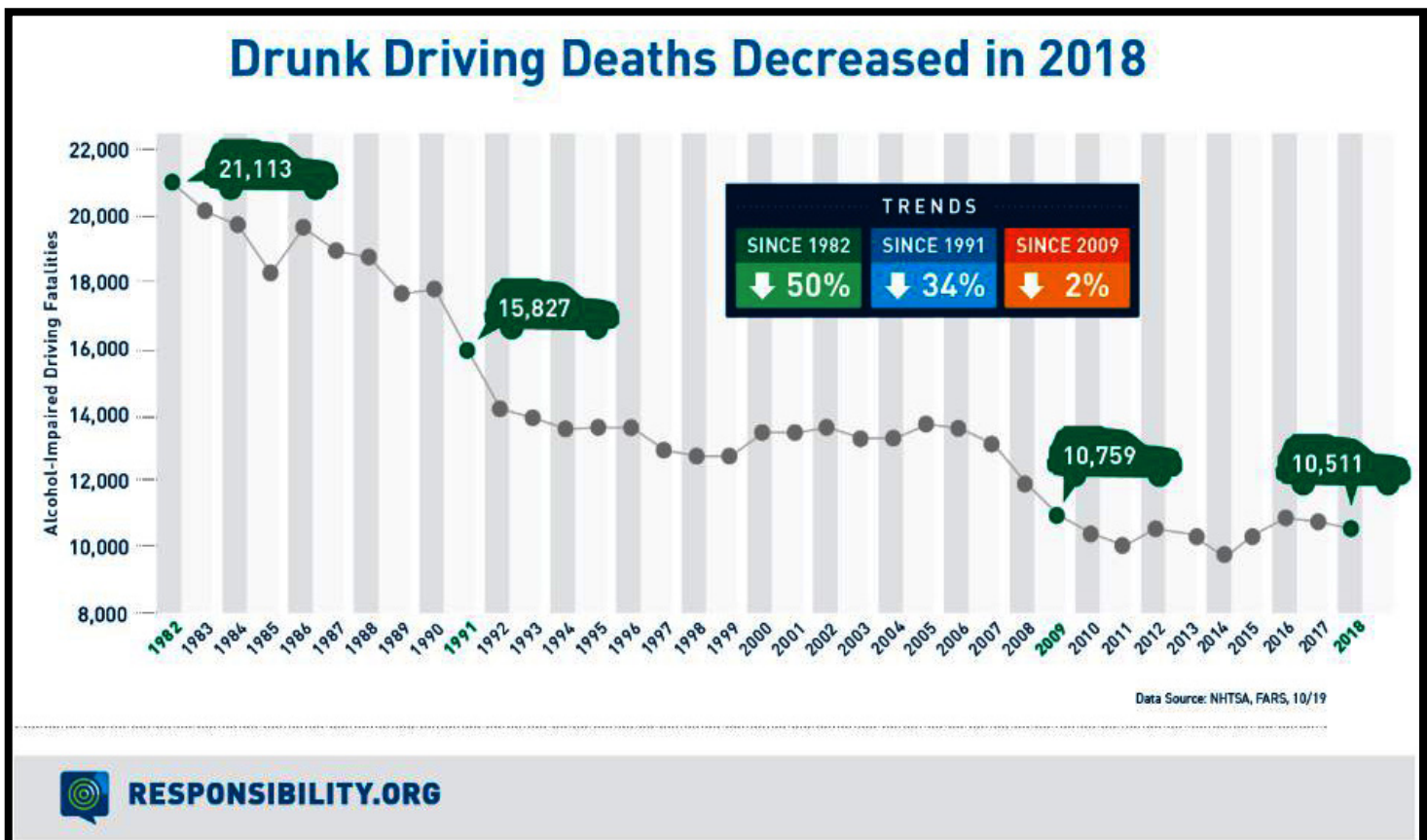
All 50 states, Puerto Rico and the District of Columbia have established the BAC of 0.08 g/dL as the “per se” level that is “over the limit” under their laws. In 2018, Utah lowered their BAC “per se” level to 0.05 g/dL and other States are considering the same change. Drivers can be impaired by substances other than alcohol including illegal drugs and prescription and over the counter medications. The 2013-2014 NHTSA Survey of Alcohol and Drug Use by Drivers showed that 22.5% of nighttime drivers tested positive for illegal, prescription or OTC medications (Kelley-Baker et al, 2017). Additionally, the presence of illegal drugs in drivers climbed from

12.4% in 2007 to 15.1% in 2013-2014. As more states legalize medical and recreational marijuana use, it is reasonable to hypothesize the number of fatally injured drivers testing positive for the presence of marijuana will increase with increased availability of the drug.

Various terms are used to describe impaired driving. State laws generally use the terms Driving While Impaired (DWI), Operating While Intoxicated (OWI), 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, unless otherwise noted, the term “driving while impaired” (DWI) is being used as an inclusive and generic term and will include the operation of a motor vehicle impaired by alcohol, illegal drugs, prescription and over-the-counter medications—separately or together.

As Figure 1-1 indicates, over the past 35 years, there have been some promising reductions in the percentage of alcohol-related motor vehicle fatalities and injuries (NCSA, 2018b). Several factors, including but not limited to: 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: Drunk Driving Deaths Decreased in 2018*





In part by the efforts of advocacy groups like Mothers Against Drunk Driving (MADD), the penalties for drinking and driving have increased, especially for repeat DWI offenders. A few of the legislative changes adopted by all 50 States and the District of Columbia that have contributed to the decline in impaired driving crashes include:

- ➔ A legal drinking age of 21 years old;
- ➔ Per se 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.

Unfortunately, despite these efforts, these enhanced alcohol policy changes are not enough, and the task ahead to reduce and eliminate impaired driving fatalities and crashes is still an ongoing priority.

In 2018, 37,133 people lost their lives in motor vehicle crashes and another 1.6 million people were injured (NCSA, 2018a). Of the 36,560 total motor vehicle fatalities, 10,511 individuals (or 29%) were killed in an alcohol-related crash. Additionally, in 2017 more than 345,000 people were injured in alcohol-related crashes.

“

*DWI offenders comprise a significant portion of the criminal justice population. In 2017, almost 1 million people were arrested for driving under the influence of alcohol or narcotics, which creates an enormous burden on an already overwhelmed criminal justice system.*

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Of the 10,874 people who died in an alcohol-impaired-driving crash in 2017, there were 6,618 drivers (61%) had BACs of .08 g/dL or higher. The remaining fatalities consisted of 3,075 motor vehicle occupants (28%) and 1,181 non-occupants (11%). To this end, the financial costs of alcohol-related crashes are astronomical, and in 2010 alcohol-related crashes cost the United States \$44 billion a year (Blincoe, Miller, Zaloshnja, & Lawrence, 2015).

DWI offenders comprise a significant portion of the criminal justice population. In 2017, almost 1 million people were arrested for driving under

the influence of alcohol or narcotics, which creates an enormous burden on an already overwhelmed criminal justice system (Federal Bureau of Investigation, 2018, Table 29). For many DWI offenders, it is not their first offense. Thirty four percent of DWI offenders in jail and 8% on probation reported three or more prior arrests

or convictions (Maruschak, 1999). Those with previous license suspensions and DWI convictions often have higher BAC levels (by about 25%) when involved in fatal crashes than those without such history (Greenfeld, 1998).

In the US, the average BAC among drivers in fatal crashes is above .15 (NCSA, 2018c). Beyond that, nearly 40% of all criminal offenders (not just DWI) in 1996 reported they were using alcohol at the time of the offense for which they were convicted (Greenfeld, 1998). In a 2004 survey of inmates in state and federal correctional facilities, 32% of state prisoners and 26% of federal prisoners said they had committed their current offense while under the influence of drugs (Mumoa & Karberg, 2006). Additionally, the 2005 National Crime Victimization Survey revealed 26% of the victims of violence reported that the offender was using drugs or alcohol (U.S. Department of Justice, 2006). Thus, not only is a large portion of the US correctional population responsible for impaired driving incidents, but the high incidence of substance use among all offenders suggests these individuals 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, 1974). Since its simple beginning, probation has become the most common form of sentencing in the United States (Bureau of Justice Statistics [BJS], 2018). In 2016, 4,357,100 individuals were supervised on probation or parole, and of the individuals placed on probation, about 59% were sentenced for a felony conviction(s) (BJS, 2018). Of all the individuals placed on probation, 24% were sentenced for a drug law violation and 14% (or almost 610,000 individuals) had been sentenced for driving while impaired or intoxicated or another traffic offense (BJS, 2018).

The majority of convicted impaired driving offenders are supervised in the community. Depending on the type of offense, jurisdiction and available resources, this might include supervised or unsupervised probation or parole, or placement on a specialized or general caseload. Besides probationers, individuals 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 number of persons 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 supervisees in the community require a continuum of disposition and supervision options to 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 can be complicated by a variety of factors. Among the foremost challenges faced by judges when sentencing these individuals is underestimating the impact of more serious offenders, including repeat DWI offenders and those with a high BAC of .15 g/dL or more. This is further complicated by incomplete or unavailable criminal history and traffic records. Additionally, many jurisdictions do not use a validated alcohol specific risk/needs assessment tool to evaluate those factors that contribute to the likelihood of the individual recidivating in the community by committing another DWI.

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 incomplete legal histories, the lack of available resources, or the absence of a validated DWI specific risk/needs assessment tool. Additionally, 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.

*It is widely believed that some mentally ill individuals turn to substances to self-medicate to minimize or alleviate their symptoms.*

Another challenge also includes the number of years during which a DWI conviction can be considered as a prior offense. This lookback period is the maximum amount of time between offenses that can legally result in an aggregate charge, and depending on the state, can range from 5 years to lifetime (American Automobile Association [AAA] DUI Justice Link, 2019). More needs to be done to check for prior criminal history and traffic records and assess all DWI defendants for risk and needs before decisions are made regarding the type of supervision on which the individuals 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 DWI supervisees (Robertson & Simpson, 2003). In 2000, the average caseload for: adult probation supervision was 133 (range from 60 to 320), regular adult parole supervision was 73

(range from 25 to 253), and combined probation and parole was 94 supervisees (range from 50 to 176) (Camp & Camp, 2002). Figure 1-2 displays recommended sizes of community supervision caseloads from Burrell (2006) that was determined through risk and needs assessments.

***Figure 1-2: Recommended community supervision caseload size based on risk<sup>1</sup>***

<b>Case Type</b>	<b>Cases to Staff Ratio</b>
Intensive	20:1
Moderate to High Risk	50:1
Low Risk	200:1
Administrative	No Limit

Extremely large and complex caseloads of offenders who have committed a variety of offenses make it difficult for supervising officers to meet the diverse and individual needs of each offender. 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 individuals. In some cases, agencies have elected to not provide direct supervision to misdemeanants and have placed them on “banked” or administrative 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 are classified as misdemeanants and, therefore, do not receive active supervision when placed on banked caseloads. In 2003, the Traffic Injury Research Foundation (TIRF) comprised a report of eight key problems that impede the community supervision of alcohol-impaired drivers and a summary of this report is in Figure 1-3 (Robertson & Simpson, 2003).

The behaviors and conditions of the offenders themselves can also complicate the supervision process. Addiction is a chronic, relapsing disorder that requires ongoing treatment to achieve stabilization and assist individuals with improving 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. Corrections and substance use disorder treatment services have many commonalities, but they also have many differences including different missions, vocabularies, and practice methods. Community corrections professionals must develop effective working relationships with treatment providers so that they can effectively monitor and support the supervisee’s involvement in treatment.

<sup>1</sup> Burrell, 2006



Another layer of complexity of community supervision is the issue of poly-drug use among some impaired drivers, including the use of alcohol combined with any number of other (often illegal) substances. As of 2019, medical marijuana is legal in 33 states and the District of Columbia, and 10 states and the District of Columbia have legalized marijuana for recreational use. It is anticipated that more states will legalize medical and/or recreational marijuana in the coming years, and this creates further challenges for law enforcement agencies

*Substance use disorders may often co-occur with mental illness. It is widely believed that some mentally ill individuals turn to substances to self-medicate to minimize or alleviate their symptoms.*

when determining impairment for DWI cases as well as probation/parole departments in managing supervision and treatment of DWI offenders. Different treatment modalities may be appropriate for different types of substance use, and it may be necessary to coordinate multiple treatment modalities for one client or to find one treatment program that can combine treatment modalities.

Substance use disorders may often co-occur with mental illness. It is widely believed that some mentally ill individuals turn to substances to

self-medicate to minimize or alleviate their symptoms. For this reason, treatment programs that combine substance use disorder and mental health treatment may be necessary for these types of clients, which will inadvertently increase the tasks and skills required to supervise these individuals.

Historically, the emphasis in state statute and community corrections has been to focus specifically on offender alcohol use in absence of those criminogenic factors that impact recidivism within this challenging population. As will be discussed in this document, these criminogenic factors play a major role in how DWI offenders are both assessed and supervised.

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

### *Supervisees*

To protect the public and provide DWI supervisees with adequate interventions to help promote behavior change, it is important for community corrections agencies to assess their practices and programs for this population.

### ***Figure 1-3: Problems Impeding Community Supervision of DWI Offenders***

A report released in July 2003 by 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. Officers can feel additional frustration 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.



The guidelines presented in this document are intended to provide a framework for developing, implementing and operating effective programs for the community supervision of individuals convicted of DWI while under the influence of alcohol, drugs, or both. 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 behavioral change of the individual.

## How the Guidelines Were Developed

Due to limited 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 drivers. 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 in 2005 by 129 agencies in 31 States and provided information related to their current 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 1-4) defined by the National Institute of Corrections, key components of the DWI/Drug Court Model that have been proven to be effective (see Figure 1-5), and the 10 guiding principles of DWI Courts (see Figure 1-6).

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 supervisees:

- ➔ Does the guideline have a positive impact on the community supervision of DWI supervisees?
- ➔ 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.

## Summary

Alcohol- and 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 supervisees 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 individuals who are under community supervision for driving while impaired. Agencies should examine and reassess their strategies for supervising all impaired drivers, including the high-risk repeat, high-BAC and polysubstance abusing DWI supervisees. 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 supervisees, agencies should make concerted efforts to screen and assess high-BAC, repeat alcohol and drug impaired drivers for more effective community supervision practices.

*Agencies should examine and reassess their strategies for supervising all impaired drivers, including the high-risk repeat, high-BAC and polysubstance abusing DWI supervisees.*

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



*Figure 1-4: Principles of Evidence-Based Practices<sup>2</sup>*

**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 and 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.

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<sup>2</sup> Bogue et al., 2004

***Figure 1-5: Key Components of DUI and Drug Court as Identified by the National Association of Drug Court Professionals<sup>3</sup>***

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.

<sup>3</sup> Bureau of Justice Assistance, 2004



*Figure I-6: The Guiding Principles of DWI Courts as Identified by the National Center for DWI Courts<sup>4</sup>*

### **GUIDING PRINCIPLE 1: Determine the Population**

Targeting is the process of identifying a subset of the DWI offender population for inclusion in the DWI Court program. This is a complex task given that DWI Courts, in comparison to traditional Drug Court programs, accept only one type of offender: the hardcore impaired driver. The DWI court target population, therefore, must be clearly defined, with eligibility criteria clearly documented.

### **GUIDING PRINCIPLE 2: Perform a Clinical Assessment**

A clinically competent and objective assessment of the impaired-driving offender must address a number of bio-psychosocial domains including alcohol use severity and drug involvement, the level of needed care, medical and mental health status, extent of social support systems, and individual motivation to change. Without clearly identifying a client's needs, strengths, and resources along each of these important bio-psychosocial domains, the clinician will have considerable difficulty in developing a clinically sound treatment plan.

### **GUIDING PRINCIPLE 3: Develop the Treatment Plan**

Substance dependence is a chronic, relapsing condition that can be effectively treated with the right type and length of treatment regimen. In addition to having a substance use disorder, a significant proportion of the DWI population also suffers from a variety of co-occurring mental health disorders. Therefore, DWI Courts must carefully select and implement treatment strategies demonstrated through research to be effective with the hardcore impaired driver to ensure long-term success.

### **GUIDING PRINCIPLE 4: Supervise the Offender**

Driving while impaired presents a significant danger to the public. Increased supervision and monitoring by the court, probation department, and treatment provider must occur as part of a coordinated strategy to intervene with hardcore DWI offenders and to protect against future impaired driving.

### **GUIDING PRINCIPLE 5: Forge Agency, Organization, and Community Partnerships**

Partnerships are an essential component of the DWI Court model as they enhance credibility, bolster support, and broaden available resources. Because the DWI Court model is built on and dependent upon a strong team approach, both within the court and beyond, the court should solicit the cooperation of other agencies, as well as community organizations to form a partnership in support of the goals of the DWI Court program.

### **GUIDING PRINCIPLE 6: Take a Judicial Leadership Role**

Judges are a vital part of the DWI Court team. As leader of this team, the judge's role is paramount to the success of the DWI Court program. The judge must be committed to the sobriety of program participants, possess exceptional knowledge and skill in behavioral science, own recognizable leadership skills as well as the capability to motivate team members and elicit buy-in from various stakeholders. The selection of the judge to lead the DWI Court team, therefore, is of utmost importance.

<sup>4</sup> National Center for DWI Courts, 2007

## **GUIDING PRINCIPLE 7: Develop Case Management Strategies**

Case management, the series of inter-related functions that provides for a coordinated team strategy and seamless collaboration across the treatment and justice systems, is essential for an integrated and effective DWI Court program.

## **GUIDING PRINCIPLE 8: Address Transportation Issues**

Though nearly every state revokes or suspends a person's driving license upon conviction for an impaired driving offense, the loss of driving privileges poses a significant issue for those individuals involved in a DWI Court program. In many cases, the participant solves the transportation problem created by the loss of their driver's license by driving anyway and taking a chance that he or she will not be caught. With this knowledge, the court must caution the participant against taking such chances in the future and to alter their attitude about driving without a license.

## **GUIDING PRINCIPLE 9: Evaluate the Program**

To convince stakeholders about the power and efficacy of DWI Court, program planners must design a DWI Court evaluation model capable of documenting behavioral change and linking that change to the program's existence. A credible evaluation is the only mechanism for mapping the road to program success or failure. To prove whether a program is efficient and effective requires the assistance of a competent evaluator, an understanding of and control over all relevant variables that can systematically contribute to behavioral change, and a commitment from the DWI Court team to rigorously abide by the rules of the evaluation design.

## **GUIDING PRINCIPLE 10: Ensure a Sustainable Program**

The foundation for sustainability is laid, to a considerable degree, by careful and strategic planning. Such planning includes considerations of structure and scale, organization and participation and, of course, funding. Becoming an integral and proven approach to the DWI problem in the community however is the ultimate key to sustainability.



## Section II

### Guidelines for the Community Supervision of Impaired Driving Offenders

This section outlines guidelines for the community supervision of DWI offenders. These guidelines focus on three primary goals: public safety, offender accountability, and behavioral change. For each guideline, there is a rationale provided that explains the reason these principles 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 defendants 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 supervisees accountable and promote behavioral change.

### **Guideline 3**

Implement a supervision process for DWI supervisees 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 supervisees.

### **Guideline 5**

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

### **Guideline 6**

Assess the effectiveness of supervision practices on DWI supervisees 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 defendants during the release, sentencing, and/or supervision phases.*

### Key Points

- ➔ Gather information on the defendant's prior criminal history and traffic record.
- ➔ Conduct an actuarial risk and needs assessment on DWI defendants.
- ➔ Screen and/or assess DWI defendants for substance use disorder issues.
- ➔ Screen and assess DWI defendants for poly-substance use disorder and mental health issues.
- ➔ Whenever possible, prepare and provide a pre-release report to releasing, and presentence report to sentencing authorities.

If not collected (or complete) at the presentence phase, collect information prior to case or supervision planning.

### Rationale

#### *Investigate and Collect Information*

To provide relevant information to the court at the pretrial or presentence phase, or to establish an effective case supervision plan after sentencing, it is important to consider the following:

- ➔ Previous arrests and convictions,
- ➔ DWI arrest history,
- ➔ Blood alcohol concentration at the time of arrest,
- ➔ Any impairing drugs in the driver's system at the time of the arrest,
- ➔ Present need for alcohol and drug treatment,
- ➔ Previous treatment history for substance use disorder issues,

- ➔ Indication(s) that the defendant may need screening and assessment for psychiatric disorders,
- ➔ Placement on a specialized DWI caseload (if available),
- ➔ Referral for screening and placement in DWI or Hybrid Drug Court,
- ➔ Assessed level of risk of the defendant reoffending, and
- ➔ Criminogenic needs that should address defendant behavior.

The response to these and other considerations can (and should) result in different responses and interventions for individuals convicted of DWI. However, the ability to obtain this information is not always provided at times that will leverage the most effective results. In some cases, this information 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 defendant including the defendant's criminal history, driving record, risk and needs, and substance use disorder 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 validated alcohol 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 (i.e., the probability of an individual convicted of one DWI being arrested for a subsequent DWI offense) 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 use disorder, and dysfunctional family relations) of the defendant. 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 supervising officer to focus the majority of his or her time and available resources with the higher risk supervisee. While the risk and needs assessment provides a means for gathering useful information on criminogenic needs of defendants that can assist in decision making about release, sentencing, and case or supervision planning, traditional more generic risk and needs assessment instruments used in a justice setting typically will not accurately depict the re-offending risk of the impaired driver.



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 and maintain an attitude that it is okay to drink or use drugs and drive. About one-quarter of all drivers arrested or convicted of driving while intoxicated or driving under the influence of alcohol are repeat offenders (Warren-Kigenyi & Coleman, 2014). Additionally,

a 2015 Gallop Poll showed that only 29% of respondents believed that driving under the influence of marijuana would be considered a serious problem (Ander & Swift, 2015). 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 driven while impaired numerous times before they were caught and arrested.

It is important, however, to recognize that not all alcohol or drug impaired drivers have the same level of addiction or the same treatment needs.

Therefore, it also is important to screen and/or

assess defendants to determine the extent of their substance use disorder 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 individual. For example, screening and assessment can help identify those individuals with the greatest treatment needs, who pose the most risk to the public, and who may require the use of specialized technology (e.g., continuous transdermal alcohol monitoring) during the supervision process (Robertson, Vanlaar, & Simpson 2007).

“

*It is important, however, to recognize that not all alcohol or drug impaired drivers have the same level of addiction or the same treatment needs.*

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## Screening and Assessment of Impaired Drivers

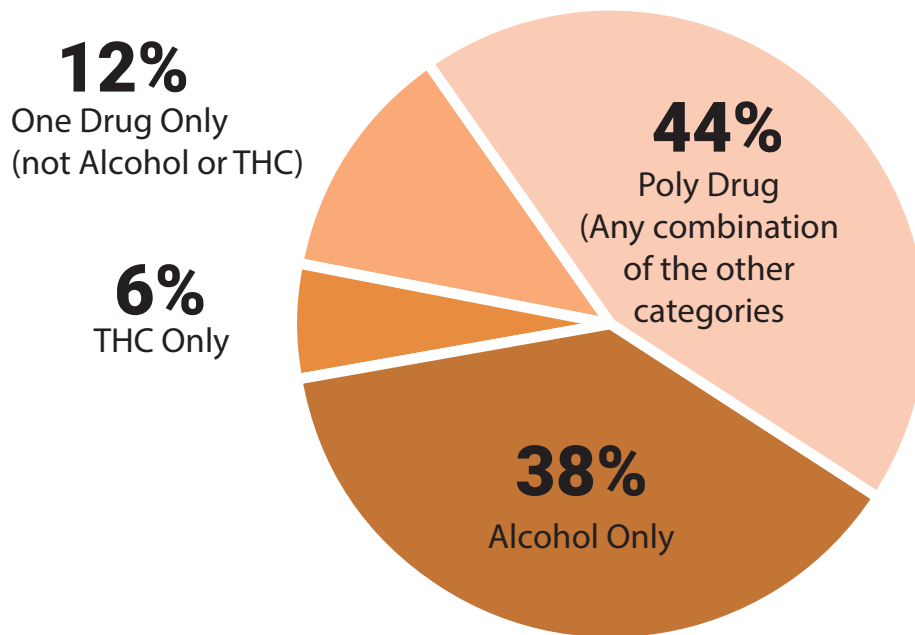
According to the Substance use disorder and Mental Health Services Administration (SAMHSA), Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment (SAMHSA, 2017). Therefore, community corrections professionals can use screening tools to triage an impaired driver to determine if he or she may have a more serious problem with alcohol and drug use 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 administered by community corrections professionals during the intake, pre-release, presentence, or at post-sentence with minimal training (see **Appendix B**). Some problem-solving courts use these screening tools as a quick efficient method to determine if defendants will be placed on a monitoring track or complete further assessment to better determine client recidivism risk and treatment/supervision needs.

Alcohol and drug assessment refers to more comprehensive evaluation of an individual's substance use issues to identify the nature and extent of the problem and how it can be best addressed (Robertson et al., 2007). Alcohol and drug assessments should be conducted by personnel certified in alcoholism, drug addiction or with extensive clinical training and expertise (NHTSA, 2006). Tools such as the Impaired Driver Assessment (IDA) are designed to be conducted by probation staff or para-professionals after receiving appropriate training. This tool does not give a diagnosis but rather provides an estimate of offenders' risk of recidivism and preliminary information on client needs. More information for the IDA can be found in **Appendix C** and **Appendix L**.

During alcohol and drug screening and assessment, community corrections professionals also need to be cognizant of poly-substance use among supervisees. Poly-substance use—which is the use of multiple substances— seems to be more the norm than the exception for many DWI offenders. The Washington State Traffic Commission (Figure 2-1) found that the majority of impaired drivers in fatal crashes in their state had multiple drugs in their system. 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 individual's drug(s) of choice and range of substances used. It is not uncommon for an arresting officer to stop his investigation when alcohol impairment has been determined. As such we may assume that alcohol is the only drug of choice. It is important to provide broad screen drug testing to determine other substances that may be used by the individual. Determining both the type of use and the level of use is important for establishing the right intervention and treatment.



**Figure 2-1: Alcohol and Poly-Drug Use in Fatal Crashes in Washington State- 2008-2016<sup>5</sup>**



Source: Washington Traffic Safety Commission (2018). *Marijuana Use, Alcohol Use, and Driving in Washington State*

## Co-occurring Mental Health Disorders

Many individuals who abuse substances also have one or more co-occurring mental disorders that can make treatment more complex. Nelson and colleagues (2015) examined the prevalence of mental health disorders by gender and found that 50% of female drunk drivers and 33% of male drunk drivers have at least one psychiatric disorder.

SAMHSA recommends screening and assessment for other mental health issues that may be co-occurring with the individual's substance use disorder so that intervention and treatment can be targeted appropriately. It may be that there will be inadequate time to do full mental health assessments prior to release or sentencing. Assessment tools such as the IDA includes a Psychosocial Scale which may reflect if the client has been experiencing some mood and psychological distress prior to intake, including stress, depression, angry responding and even using alcohol or other drugs to manage these conditions. If it is determined that further assessment is needed, it can be incorporated into the court-ordered conditions of supervision, if deemed necessary.

<sup>5</sup> Grondel, Hoff, & Doane, 2018

Overall, it is important to recognize that not all impaired drivers are alike—as such, there is not one sanctioning or treatment strategy that is effective for all DWI defendants. Matching DWI defendants 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 individual’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 defendant 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 individuals’ needs and determining if there are poly-substance use disorder issues or co-occurring mental disorders that need to be addressed.

## **Presentence Reports for DWI Cases**

The information gathered as well as screening and assessment results should be shared with those individuals who use it during the decision making and case planning process. Presentence investigation reports (PSI) are the most common way that information is provided to sentencing judges. In addition to reporting assessment information, criminal history the person preparing the PSI also can suggest recommendations for conditions of supervision or release that reflect those criminogenic factors that impact the potential for recidivism. 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 at Presentence*

If your agency does not prepare and provide presentence investigation reports on DWI defendants for releasing and sentencing authorities, talk with appropriate authorities about the utility of these types of reports and what information should be gathered to assist in their decision making. Also, discuss how adequate time would be provided to investigate, assess and collect needed information. Optimally, all presentence 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 defendant. However, if there is not adequate time to prepare a written presentence report, discuss with releasing and sentencing authorities what other strategies could be used to provide them with the needed information (e.g., verbal report or the scored results of a validated DWI risk needs assessment tool). 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, habitual and high BAC drunk drivers.



If your agency already conducts presentence 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 presentence investigations. Finally, talk with the community supervision officers who receive these reports post-sentence to determine if the content informs their decision making.

Review and enhance (if necessary) information sharing policies and practices (see *Guideline 4*) with other agencies maintaining information on DWI defendants (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 defendants. 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 defendants. Determine if there is interest and resources to establish a standardized automated record keeping system across agencies. Standardizing the record systems would

*If your agency already conducts presentence 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.*

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 DWI risk and needs assessment on all DWI defendants (including misdemeanants). Although a number of risk screening instruments are available for the general population of offenders, such as the Level of Service Inventory-Revised (LSI-R), there are no widely used risk assessment instruments specifically designed to assist probation officers or case managers in determining what, if any, level of community supervision is needed for the DWI supervisee (Lowe, 2014).

If it is not feasible to require a risk and needs assessment on all DWI defendants, consider requiring it for repeat, or habitual, drunk drivers. Preferably the risk and needs assessment would be required during the presentence or even the Pre-trial 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 defendants, research the various instruments available to determine which one will best meet your agency and defendant population's needs. Most generic assessment tools are not validated to capture risk and needs of DWI convicted defendants and place too much emphasis on alcohol use and as such may suffer from "tunnel vision" (Robertson, R., Wood, K., & Holmes, E., 2014).

Establish a policy that requires all DWI defendants to be screened for alcohol and drug abuse during the presentence 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 statutes or court rules that stipulate the type of AOD screening tool that is to be used on DWI defendants. For example, in Nebraska, the Supreme Court issued a court ruling that requires all probation agencies to follow a standardized model for substance use disorder services. The model includes the type of AOD screening tool that they must use.

Some states have statutory requirements that dictate the length of time that an individual must participate in treatment, regardless of the findings during assessment. 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.
- ➔ The cost of the tool. Some are free to the public, while others need to be purchased.
- ➔ If an AOD screening tool is being used to determine sentencing or case planning, it is imperative that Judges, prosecutors and defense attorneys be included in training and planning processes to ensure they are fully informed of its role in the court process.
- ➔ 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 individuals for more comprehensive alcohol, drug and mental health assessment by a qualified provider, if warranted by the initial screening. It also is recommended that more comprehensive alcohol and drug assessments be required on all repeat DWI offenders. Make sure that agency policies stipulate that referrals for alcohol and drug assessments be made to a qualified licensed provider using validated assessment tools and that results are provided to appropriate authorities to aid in decisions related to needed intervention strategies and treatment services.

See **Appendix A** for suggested supplemental resources on assessment tools for the DWI population.

### *Practice Considerations*

- ➔ While gathering information or interviewing during the pretrial process, officers need to be careful not to coerce defendants into waiving due process rights.
- ➔ When interviewing defendants, supervision officers should be encouraged to use motivational interviewing (MI) techniques to help illicit more helpful information. Studies have shown that these techniques are extremely effective for DWI defendants. The following are examples of ways outreach workers use the MI approach (SAMSHA, 2010):
  - Ask permission to talk with individuals instead of assuming they want to talk.
  - Create a safe and accepting space for the defendant to interact.
  - Learn what is important to the individual and address immediate needs.
  - Find out what services the defendant wants and has the motivation to pursue.
  - Refrain from pushing individuals into services they do not want.
  - Determine the person's stage of readiness to change behavior.

- Explore ambivalence using open questions and reflective statements.
- Affirm the person's strengths.
- Elicit and reinforce client change statements using MI skills.
- Help enhance the individual's commitment to change.

When collecting information on DWI defendants 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 and/or drug test results;
- ➔ prior criminal history;
- ➔ motor vehicle records;
- ➔ past participation in diversion, treatment, or other special programming including Ignition Interlock devices or electronic monitoring;
- ➔ 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,
  - potential risk to the community
  - License, driving status
  - 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 individual as well as the welfare of the community. Conditions of supervision and release that are recommended for DWI supervisees should be realistic, relevant, and evidence informed. 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, supervisee, and direct the case planning process by allowing for multivariate programming?
- ➔ Are strategies research supported, evaluated, and evidence based?
- ➔ Are sanctions for noncompliance and incentives/rewards for compliance swift and certain?
- ➔ Some offense-specific conditions of supervision that should be recommended for the supervision of DWI supervisees include (but are not limited to):
  - ➔ Abstain from the use of alcohol and illegal use, sale, possession, distribution, or transportation of controlled drugs. For those states that have legalized marijuana for medical or recreational use, consideration should also be made in addressing this within the recommendation to the court.
  - ➔ Participate in and satisfactorily complete a designated substance use disorder, mental health counseling and/or treatment program, and/or mutual help group such as Alcoholics Anonymous or Narcotics Anonymous, Rational Recovery 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, oral fluid, urine).

## Guideline 2

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

### Key Points

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

### Rationale

The use of information obtained from a presentence 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 should guide the supervision officer in the development of an individualized case or supervision plan (with assistance and input from the supervisee). The case plan will identify appropriate supervision strategies and treatment interventions that will assist the supervisee in understanding his or her behavior, learn to manage his or her behavior and comply with societal norms, and, ultimately, engage the supervisee 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 supervisee compliance and behavioral change (Taxman, Shepardson, & Byrne, 2005). More information on graduated sanctions and incentives can be found in *Guideline 3*.

For DWI supervisees, the need for substance use disorder treatment is often a reality and, when warranted, should be incorporated within the case or supervision plan along with supervision strategies aimed at addressing other criminogenic needs (National Institute on Drug Abuse, 2006). Appropriate alcohol, drug and mental health treatment for supervisees who abuse substances can improve community supervision outcomes (e.g., decrease future alcohol and drug use, improve relationships with family members, and improve employability). In addition, research indicates that people who are coerced by the criminal justice system to enter treatment are just as likely to do as well as someone who voluntarily enters alcohol and drug treatment (Urbanoski, 2010). However, it is important for community supervision officers to recognize that not all individuals who have a history of alcohol or drug use need drug or alcohol treatment. In addition, not all supervisees who are identified as substance abusers need the same type of treatment (NIDA, 2006). Therefore, screening and assessment play a major role in the establishment of case plans for DWI supervisees.

Screening and assessment (as discussed in *Guideline 1*) with a validated DWI risk need assessment tool is a crucial step in identifying who may need more in-depth treatment. Another crucial step in targeting clients for appropriate treatment services is communication and collaboration with treatment providers. Early (and sustained) involvement of treatment providers will not only help target supervisees 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 Supervisees**

### *Policy considerations*

- ➔ Consider requiring individualized case or supervision plans for all DWI supervisees. If it is not feasible to require them on all DWI defendants, require them for all repeat and habitual DWI supervisees.
- ➔ Review the typical conditions of supervision—along with supervision strategies and treatment services—available for DWI supervisees 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 supervisees 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 supervisees.

- ➔ Strengthen interagency relationships with substance use 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 supervisees that outlines specific supervision and treatment strategies. Review information outlined in *Guideline 1* to assist in making informed decisions about appropriate interventions and treatment services for DWI supervisees. If this information is not provided in advance (e.g., through a presentence 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 pre-release or presentence 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.
- ➔ 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 supervisee and the supervision officer. Establish goals, a timeline for completion and integrate alcohol, drug treatment and mental health 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 individual in the development of the case or supervision plan and in the prioritization of objectives. Motivational interviewing techniques can be helpful when working with supervisees in establishing a case or supervision plan. Miller & Rollnick (2013) define motivational interviewing as a “collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.” (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 individual's confidence.

- ➔ When developing the case or supervision plan, identify the supervisee's social network (e.g., family members, friends, community) and determine ways to enhance and tap into these informal social controls to build the individual'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 supervisees who need substance use disorder treatment services, consider the following:

- ➔ Resist referring individuals into a standardized treatment program. Referrals should be based on assessment and the individual needs of the supervisee.
- ➔ Treatment referrals also should match the appropriate level of care indicated in the risk/needs and the alcohol and drug assessment. For example, individuals who meet drug dependence criteria should be given higher priority for treatment than those who do not. Less intensive interventions, such as drug 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 individual can be counterproductive.
- ➔ Treatment should target factors that are associated with criminogenic risk factors. 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 individuals requiring substance use treatment services. Recovery from drug addiction requires effective treatment, followed by management of the problem over time. DWI supervisees, 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 individuals with severe drug problems and co-occurring disorders does not allow time for the needed behavioral changes. The length of supervision for high need individuals 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, 2014). 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 individuals with substance use disorder problems also have co-occurring mental health needs or poly-substance use disorder 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 use disorder. When applicable, plan an integrated approach with treatment providers in the case or supervision plan to also address these issues with individuals.
- ➔ Substance use disorder 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 individuals' 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 (e.g., electronic monitoring, drug testing, reporting schedule). See **Appendix F** for an overview of tools and technologies that can assist in monitoring DWI supervisees.
- ➔ Supervising officers should assure that supervisees are aware of the conditions of their supervision, understand what they are required to do and not do while on community 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) to build empathy and educate the individual 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/ 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 supervisee and with treatment provider to be certain it continues to appropriately address the individual's needs (Monchick, Scheyett, & Pfeifer, 2006). The supervision process is ever evolving. The information we have on a defendant at the time of sentencing may look much different six months later. Keep in mind when working with DWI supervisees, it may be necessary to reassess and modify the case and supervision plan multiple times during the supervision process.

## Guideline 3

*Implement a supervision process for DWI supervisees that balances supervision strategies aimed at enforcing rules with those designed to assist individuals 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 supervisees 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 supervisees' motivation to change and decrease their resistance and ambivalence to the change process.
- ➔ Assist the supervisees in accessing needed services and treatment.
- ➔ Take advantage of tools and technologies available to aid in the monitoring of DWI supervisees.

### Rationale

The ultimate goals of supervision when working with DWI supervisees are to: (1) enforce the conditions of supervision to hold supervisees accountable for their current offense; (2) monitor supervisee behavior and compliance to protect public safety, and to (3) assist supervisees 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, an outcome-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 individuals accountable and for changing supervisee attitudes and behaviors—all of which ultimately leads to enhanced public safety (Taxman, Shepardson, & Byrne, 2005).



Per Robertson & 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 individuals can circumvent penalties and avoid compliance, it compromises public safety and can result in more problematic behavior by the supervisee. Research also shows that for sanctions for noncompliance to be effective, they must be swift and certain (National Institute of Justice, 2012). Assuring that supervisees 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 supervisees today and that can allow the individual 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 and the supervisees level of risk, needs and responsivity be addressed as part of the supervision process. Developed in the 1980s and first formalized in 1990, the risk-need-responsivity model has been used with increasing success to assess and rehabilitate criminals around the world. As suggested by its name, it is based on three principles:

1. the risk principle asserts that criminal behavior can be reliably predicted and that treatment should focus on the higher risk offenders;
2. the need principle highlights the importance of criminogenic needs in the design and delivery of treatment;
3. the responsivity principle describes how the treatment should be provided (Bonta & Andrews, 2007).

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 individuals 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 their 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 problem-solving courts and a contributor to their success (Lindquist, Krebs, & Lattimore, 2006). A rule of thumb is to have at least equivalent amounts of positive reinforcement and punishment available for participants. If participants may be punished for missing a counseling session, then they should also be able to earn a reward for attending a counseling session. In this way, participants have a roughly equal opportunity to earn a reward or to incur a sanction (Marlowe, 2012). These are strategies that should also be applied administratively in the community supervision process outside the bounds of a courtroom.

Relapse is common in addiction treatment, with relapse rates being between 40 and 60 percent. This rate is very similar to rates of relapse with other chronic diseases like hypertension, asthma, or type I diabetes (NIDA, 2018). Most relapse occurs within the first year of recovery with two thirds occurring in the first 90 days (Walton, 2011). Taxman & Soule (1999) indicate that graduated responses provide supervision officers with a mechanism for working with supervisees with chronic relapsing conditions (such as substance use disorder) and changing supervisee behavior by dealing with the addiction disorder. Individuals with substance use disorders 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 supervisees when they are perceived as fair and when they occur soon after the behavior at which they are aimed (NIDA, 2006).

Additionally, when addressing relapse, clients may have challenges in several areas. Examples include family difficulties, limited social skills, educational and employment problems, mental health disorders, infectious diseases, and other medical issues. Treatment should take

these problems into account, because they can increase the risk of drug relapse and criminal recidivism if left unaddressed (NIDA, 2018). Further recommendations by Monchick, Scheyett, & Pheifer (2006) indicate that responses should be treatment-relevant, strength-based, and consistent with program or agency philosophy.

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*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*

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## 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 supervisees. **Appendix G** provides summaries of promising programs/strategies that some community corrections agencies have adopted to increase the effectiveness of supervision of DWI supervisees.
- ➔ Review the policy and procedures related to monitoring DWI supervisees. Assure that procedures are established that will result in swift and certain responses for addressing supervisee 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 individual progress and noncompliance.
- ➔ Review supervision strategies and treatment services available for working with DWI supervisees 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 supervisees. Adjust policies and procedures, if needed, or develop a new policy and procedure that supports effective and efficient use of these strategies, tools, or technologies.
  - Consider the use of additional strategies (e.g., special DWI caseloads, intensive supervision, drug court, DWI court etc.) as well as tools and technologies (e.g., alcohol screening instruments, alcohol and drug assessment tools etc.) to aid in supervision of DWI supervisees. See **Appendix F** for descriptions of some of the tools and technologies that can be used to monitor and supervise DWI supervisees. Determine which strategies the agency should research and consider

implementing as part of its supervision practices. 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 supervisee, 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 supervisees is an identified barrier, consider developing an indigence fund to help offset these costs so supervisees will not be excluded from programs because of their inability to pay fees. When possible, consider staggering start dates for the payment of Court fines and fees to allow the likelihood that the defendant will be compliant with both court orders and treatment obligations. The cost of fines, probation fees, treatment, technology (e.g., ignition interlock, etc.) coupled with possible challenges related to transportation and employment may impede the individual's success on community supervision.
- ➔ Review policy and practice related to using breath, blood, saliva 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 in addition to other promising technologies. Depending on community risk and needs, multiple technologies may be used on a single defendant. This may require authorization by a supervisor or the court.

- ➔ Review the types of drug and mental health treatment available to meet the needs of the DWI supervisee. A continuum of alcohol and other drug (AOD) services should include, but is not limited to: AOD education, intensive out-patient treatment, in-patient treatment, day reporting centers, residential treatment, half-way houses, and mutual help groups such as Alcoholics Anonymous, Narcotics Anonymous or Rational Recovery. 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 presentence 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 supervisees to alternative or high-risk programs. Ensure that net-widening does not occur and that only appropriate individuals (e.g., those assessed with certain characteristics or sufficiently severe offense histories) are sentenced to alternative programs. Individuals 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 supervisee behavior, consider developing one and incorporate it into the agency's policies and procedures. To be most effective, responses should be a part of a larger, evidence-based supervision approach that takes into account the risk and needs profiles of the individuals being supervised. 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 supervisee behavior. For an administrative model of 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:

- ➔ 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).

Options for reinforcing positive behavior.

- ➔ Developing a process for the progression and utilization of sanctions and incentives in a way that supervisees will view them as impartial and consistent with rules, ethics and logic (Burke, 1997).
- ➔ Where possible, develop policy delineating the supervision officer's 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. Responses by justice system agents to problematic behaviors among supervisees must be prompt. Supervisees must clearly know the process for handling infractions from the outset, and this process must promote accountability and responsibility to achieve ideal outcomes (APPA, 2012).

- ➔ Another factor that can affect the ability to provide swift intervention is 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.

The American Probation and Parole Association published a report called *Effective Responses to Offender Behavior* (APPA, 2012). This report highlights key lessons learned around planning and implementation of sanctions and incentives, with attention to ways in which states and local jurisdictions can improve effective responses in probation and parole supervision. See **Appendix E** for a chart that provides examples of graduated responses for working with DWI supervisees.

### *Practice Considerations*

- ➔ Become familiar with the literature regarding the stages of change (see **Appendix A** for supplemental resources).
- ➔ Get to know the individual. Review all case materials including the presentence report, prior criminal history, sentencing information, conditions of supervision, risk/need assessment results, and AOD screening and/or assessment results. Assure that all DWI supervisees have been screened or assessed for risk and needs as well as criminogenic factors that contribute to recidivism (see *Guideline 1* for more information).
- ➔ Engage the supervisee 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 individual 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 supervisee as a guide while monitoring compliance. Assure that the supervisee 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 individual is aware of those changes. Initiate drug and alcohol testing early and on a random, unannounced basis.
- ➔ Assure that supervisees are receiving services (mental health, substance use disorder) based on the intensity of treatment they need (education or treatment) based on their risk needs assessment. 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 be knowledgeable on the type of treatment being provided as well as the evidence-based treatment modality being used. During the referral process, the supervising officer should communicate the prior record of the supervisee, BAC/drug testing results at time of arrest, and the criminogenic risk factors. If 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 supervisee 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 supervisee that will allow the supervision agency and the treatment provider to share pertinent information regarding the individual.
- ➔ When working with supervisees with substance use disorders, supervising officers should be able to identify triggers for relapse 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 (Taxman et al., 2005).
- ➔ 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 supervisee's progress through the stages of change and how incentives and sanctions have been applied.

- ➔ Based on the supervisee's risk to reoffend, conduct periodic supervision face-to-face contacts, in the office and in the home 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 individual'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 supervisee helps to assess, through conversation and observation, how well the individual 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 supervisee 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 individual.

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 supervisee.
- ➔ You have been trained in the use of the tool.
- ➔ You/your department will receive reports on compliance and have established protocols in place to respond to this information.
- ➔ 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 supervisees 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 supervisee it will not have the same type of impact on their behavior. In other words, they should 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, Krebs, & Lattimore, 2006).
- ➔ As an ongoing incentive, reinforce the types of behaviors that may result in reduced supervision or early termination of probation.
- ➔ 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 supervisee's sanctions and incentives.
- ➔ When working with DWI supervisees, 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 supervisees.*

### Key Points

- ➔ Identify and develop partnerships with service and treatment providers that will enhance supervision services and meet the needs of DWI supervisees.
- ➔ 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.

### 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 supervisees. 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, 2003). Effective collaboration can expand the range of supervision strategies and services that community correction agencies can offer to supervisees. The purposeful and improved ability to sort and match resources to individual needs helps community corrections agencies use scarce resources more effectively, while enhancing public safety (NIDA, 2006). 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 as well as their role in meeting case plan objectives; otherwise, the partnership may produce unsatisfactory results. Misunderstanding, misconceptions, and miscommunication weaken



partnerships. Formulating an understanding of what and how services will be delivered and where barriers can be identified 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. A key element in the development of effective interagency partnerships is the ability to share pertinent information (Engelhardt et al., 2016).

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 & Simpson (2003), 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 due to tensions about how cases should be managed that may result 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 supervisees gets in the way of the therapeutic process. For example, 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 (HIPAA), 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 supervisees, 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 and Guidelines for Developing More Effective Partnerships

### *Policy Considerations*

Conduct a needs and resources assessment regarding the supervision and treatment services for DWI supervisees. Identify where adequate resources exist and where gaps may need to be filled. Examples of services needed for DWI supervisees may include (but are not limited to):

- ➔ Drug and alcohol screening and assessment
- ➔ Drug and alcohol treatment (outpatient, inpatient, residential)
- ➔ Mental health treatment
- ➔ Alcohol monitoring (ignition interlock, transdermal and mobile alcohol monitoring devices as well as other technologies focused on alcohol and drug impaired driving)
- ➔ Cognitive behavioral treatment programs
- ➔ Substance use disorder education programs
- ➔ Mutual-help and recovery groups
- ➔ Reentry programs
- ➔ Mental health counseling
- ➔ Transitional living facilities
- ➔ Detoxification
- ➔ Transportation to employment and treatment
- ➔ Employment assistance
- ➔ Drug testing, on site and lab
- ➔ Electronic monitoring for home arrest with alcohol sensor
- ➔ Trauma informed treatment



- ➔ Gender specific treatment
- ➔ Culturally specific treatment.

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 supervisees (e.g., 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 that 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.

Ask treatment providers about their program curriculum and whether it is built on evidence-based practices.

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. If contracting decisions are made outside of the probation department, be sure to offer input (whether requested or not) on specific needs related to supervision and compliance. It is important to remember that the most knowledgeable resource in determining the most appropriate evidence-based intervention maybe you and your department.

Be aware of the type of modality (e.g., therapeutic option) that treatment providers use and whether they use treatment strategies that are consistent with evidence-based practices. Discuss ways in which supervision staff and providers can work together to assure supervisees are targeted for appropriate services and be cognizant of the agency's vision and philosophy for the provision of services and treatment. Meet with local 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). Some additional items to consider are:

- ➔ Contact individuals or organizations who use or have used the services of the prospective partner agency to ascertain their satisfaction with the services received
- ➔ 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. However, agreements do not have to be that formal. The agreement can simply be a letter or a Memorandum of Understanding (MOU) 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 supervisee, if any
- ➔ Time from referral/assessment to treatment (wait lists)
- ➔ 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 policies 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 supervisees. 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.

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, parameters for confidentiality and with who(m) this information may be shared. Agencies should provide information on their data storage protocols and practices to determine if they are in concert with existing department requirements. Be on the lookout 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 drawing policy (U.S. Department's Global Justice Information Sharing Initiative, 2017).

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. 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 (2017).

*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*

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. The American Probation and Parole Association provides a brief that addresses the misperceptions around information sharing between health service providers and criminal justice agencies, particularly surrounding federal laws, the Health Insurance Portability and Accountability Act (Matz, 2014).



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. Additionally, determine what types of releases or other legal documents should be created and under what circumstances they should be used. There should be a plan in place for 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, 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 or state DWI task force (through your state highway safety office) that consists of agencies and individuals who work and/or have common interests in areas related to serving and supervising DWI supervisees.

*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.*

Provide training to all staff on the types of strategies and services available to aid in the supervision of DWI supervisees. 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*

#### Determining and using Appropriate Treatment Services

- ➔ Identify and monitor each individual'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. Community supervision agencies and treatment providers should share test results with each other.
- ➔ Educate yourself on the types of strategies and services available to aid in the supervision of DWI supervisees. 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 supervisees for services or treatment.
- ➔ Seek references for substance use, mental health and other treatment, providers assuring they are using evidence-based modalities, communicating information in a timely fashion etc.
- ➔ It is important that the probation department and treatment provider have a shared definition and understanding of treatment to be provided to DWI supervisees. The American Society of Addiction Medicine (ASAM) describes Intensive Outpatient Treatment as providing nine or more hours per week of skilled treatment, 3-5 times per week in groups of no fewer than three and no more than twelve clients. Departments are encouraged to work with treatment providers that adhere to these standards (ASAM, 2015).
- ➔ 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 supervisee 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 alcohol monitoring companies, ignition interlock manufacturers, drug testing companies) as well. Ask questions related to the expectations and



limitations of the equipment and determine if there are ways for the supervisee to remove or sabotage the equipment. Ask if drug testing labs are equipped to test for all relevant substances and enquire as to their turnaround time in providing results, testing sites hours of operation and expert court testimony, if needed.

### *Effective Communication and Information Sharing Between Agencies*

- ➔ Strive for open communication with service and treatment providers.
- ➔ Work with treatment/service providers to develop and revise supervision and treatment goals that include the coordination of sanctions and incentives.
- ➔ Establish the procedure for verifying information, how often reports will be received, the types of violations that will be reported and the training that will be offered to probation staff.
- ➔ 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 supervisee, make modifications to the treatment plan, and/or develop appropriate graduated sanctions and incentives for the supervisees.
- ➔ 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 policies 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 extremely helpful to provide treatment providers with information on the supervisee'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 supervisees.*

### Key Points

Provide training to staff on evidence-based practices that support the effective supervision of DWI supervisees. Assure staff receives training on substance use disorder, 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 supervisees, it compromises the effectiveness of community supervision as a sentence and jeopardizes public safety. Supervising and monitoring DWI supervisees 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 individuals 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 defendants, standardized ways of supervising, monitoring, and encouraging compliance may not be as effective. Staff training on addiction issues and other needs of DWI defendants (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 can use (Robertson & Simpson, 2003), can equip community corrections professionals to establish more effective case and supervision plans and help them employ more effective case monitoring practices.

### Implementation Strategies for Training Staff on Effective Supervision of DWI Supervisees

#### *Policy Considerations*

Provide training to supervision officers on evidence-based practices that support effective supervision of DWI supervisees. General training in substance use disorder and chemical addiction should be provided as part of any initial officer orientation and/or ongoing professional development. Smaller probation departments may not have the volume of cases to support specialized caseloads. As such, it can be unrealistic to expect

that officers develop an expertise to work with DWI cases when faced with all the other unique populations under supervision. To this end, consider appointing staff members to serve as a DWI subject matter experts. These individuals would receive available DWI specific training and serve as the department point person for issues surrounding alcohol technologies, specialized assessments, treatment, etc. Additional training topics to consider include:

- ➔ Motivational interviewing and stages of change
- ➔ The use of validated DUI risk/needs assessment tools
- ➔ Signs of relapse and relapse prevention
- ➔ How to develop case or supervision plans that promote behavioral change and match treatment services with the needs of the individual.
- ➔ 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 supervisees through both process and outcome measures.*

### Key Points

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

### Rationale

Monitoring performance and outcomes in the supervision of DWI supervisees 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 the process, programs better account for 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.

Drug and DWI Courts have been at the forefront of developing performance measures to measure the performance of their programs. The drug court logic model provides a good example of considerations in evaluating and measuring a program (National Institute of Justice, 2014).

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 Supervisees

### *Policy Considerations*

A key to successful evaluation that assesses how effectively an agency is working with DWI supervisees is to develop policies and procedures related to working with these individuals 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.

Do not 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 supervisees.

When determining what to evaluate, in addition to what your agency considers success, give consideration as to how other stakeholders (e.g., supervisees, 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

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*To minimize the risk of bias, when possible and resources allow, use an objective evaluator.*

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problem solving with the agency involved to see if adjustments to protocols can be made to address and resolve the identified problem. Therefore, align program evaluation efforts with performance evaluations and ensure that staff are aware of 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 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.

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). These data are used in research involving detailed, verbal descriptions of characteristics, cases, and settings. Qualitative research typically uses observation, interviewing, and document review to collect data. 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 use disorder 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 several 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.
- ➔ When considering the development of a case management system, other considerations should include the following:
  - Does the Case Management System (CMS) embed a validated assessment?
  - Do the assessments link to case plans?
  - Can you measure if the supervising officer/case manager is focusing on the identified needs?
  - Are the CMS objectives (and dosages) appropriate to the client's needs? (Risk, Needs, Responsivity)
    - » Do these data roll up to measurable outcomes?
    - » To measure the client progress?
    - » To measure the CM performance?
    - » To meet agency deliverables to match their mission/vision
    - » Justify budgets to their funding sources?

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:

## Unique Issues in the Supervision of Drug Impaired Drivers

### Key Points

- ➔ Polysubstance abuse is prevalent within the DWI population
- ➔ Communicate with treatment providers and drug testing labs to understand drug trends within the community
- ➔ The risk factors of impaired driving are much the same regardless of alcohol or drug usage
- ➔ Screen and assess DWI defendants for substance/poly-substance use disorders and mental health issues.
- ➔ Consider the use of alcohol technologies for drug impaired driving cases.

## Rationale

With the advent of legalization of medical and recreational marijuana, there has been increased attention placed on drug impaired driving. As of 2019, 33 states have legalized medical marijuana, and 10 of these states and the District of Columbia have also legalized recreational marijuana. While the laws pertaining to marijuana are continuing to change and evolve throughout the US, driving under the influence of drugs (DUID) remains illegal in every state.

The legalization of marijuana has prompted a myriad of studies on the impact of driving under the influence of delta 9-tetrahydrocannabinol (THC), the psychoactive component of cannabis, as well as other drugs. The result of these studies is sobering. Results from the NHTSA roadside survey in 2013-2014 by Berning and colleagues (2015) showed that:

- ➔ 22.5% of weekend night-time drivers tested positive for illegal, prescription or over the counter medications. This is a 6.2% increase over the same population in 2007.
- ➔ The proportion of nighttime weekend drivers with illegal drugs in their systems was 15.2% while the proportion with prescription or over-the-counter medications that could affect driving was 7.3%.
- ➔ The proportion of total drug-positive nighttime weekend drivers increased from 16.3% in 2007 to 20.0% in 2013-2014.
- ➔ The drug showing the greatest increase from 2007 to 2013-2014 was marijuana (THC) where THC-positive drivers increased from 8.6% in 2007 to 12.6% in 2013-2014.

The researchers involved in the development of the APPA Impaired Driving Assessment (IDA) determined that one of the five major risk factors for DWI recidivism was prior alcohol and other drug (AOD) use and involvement, including prior AOD treatment (Lowe, 2014). The impact of drugs combined with alcohol exponentially increases crash risk on our roadways.



In a study on the association of drug use and crash risk in European studies (Figure 3-1), all drugs increase crash risk to some extent and amphetamines, multiple drugs, and drugs together with alcohol increase crash risk substantially (Shulze et al., 2012; Griffiths, 2014 as cited in GHSA, 2017).

**Figure 3-1 Crash Risk Associated with Drug Use in European Studies<sup>6</sup>**

<i>Risk Level</i>	<i>Relative Risk</i>	<i>Drug Category</i>
Slightly Increased risk	1-3	Marijuana
Medium increased risk	2-10	Benzodiazepines Cocaine opioids
Highly increased risk	5-30	Amphetamines Multiple drugs
Extremely increased risk	20-200	Alcohol together with drugs

### *DUID Challenges*

DWI investigations are unique in law enforcement in that once the arresting officer has determined that the driver is above the legal limit for blood alcohol concentration, there may be no attempt to determine if drugs may also be present in the driver's system. The procedures for making an arrest, obtaining a BAC from a breath or blood sample, prosecuting a DWI alcohol charge, and obtaining a conviction are far easier, quicker, and cheaper to process than for DUID. Thus, if an officer observes impairment and detects, or suspects, that alcohol is a cause of the driver's impairment, often only alcohol DWI evidence and charges will be pursued. Officers may consider drug impairment if roadside testing rules out alcohol or if the observed behavior and impairment does not reflect the driver's BAC level (GHSA, 2015; GHSA, 2018b).

In states where medical/recreational marijuana use is illegal, officers who determine the driver's impairment is a result of marijuana usage often will pursue a charge of possession rather than DUID (GHSA, 2018a; NHTSA et al., 2017). Additionally, many prosecutors and judges may not be as familiar with the technical aspects of drug-impaired driving cases as they are with alcohol-impaired driving cases. If a case involves both drugs and alcohol, prosecutors usually will bring only the DWI charge because it is easier to explain to the judge and jury and is less expensive to prosecute (NHTSA et al., 2017; Thomka, 2014). As such, it is not safe to assume that supervisees convicted of DWI's have only consumed alcohol while behind the wheel. In a Dane County

<sup>6</sup> Shulze et al., 2012; Griffiths, 2014 as cited in GHSA, 2017

Wisconsin study, nearly 40% of the subjects with BACs exceeding .10 screened positive for one or more drug categories in both oral fluid and blood (Edwards, Smith, & Savage, 2017). These were individuals who most likely would have just been prosecuted for alcohol-impaired driving.

While the effects of alcohol on driving are well understood, the impact of the myriad of other drugs on driving are much more complex. Most psychoactive drugs are chemically complex molecules whose absorption, action, and elimination from the body are difficult to predict. Furthermore, there are considerable differences between individuals regarding the rates with which these processes occur. Alcohol, in comparison, is a more predictable substance. Drug presence alone does not imply impairment and there is no established relation between drug presence, as measured by a drug test, and impairment, for any drug (NHTSA et al., 2017). Moreover, some drugs reported in drug tests are non-impairing metabolites, and this is especially true for marijuana. Heavy marijuana users may test positive even though it may have been several days or weeks since they last used the drug.

At present, marijuana cannot be measured accurately in breath but can be measured in blood, urine, or saliva. The blood concentration of its active component, THC, rises very quickly after consumption but then drops rapidly, as does marijuana impairment. Thus, THC measured in blood or urine does not imply that someone is impaired. To this end, the impairing effects of marijuana can vary substantially across individuals (Compton, 2017).

Findings from existing studies on the impact of marijuana and driving vary widely, but from the standpoint of community supervision, this is typically a mute issue. Individuals under community supervision are prohibited from the use of any illegal drugs and anyone with a charge or history of a substance abuse disorder (regardless of the drug of choice) is typically court ordered to abstain from alcohol and marijuana in addition to illegal drugs.

As stated by GHSA (2018a), the basic components of, and strategies for, addressing impaired driving are the same for alcohol and drugs: convincing drivers not to drive while impaired, detecting an impaired driver, observing and recording behavioral evidence of impairment consistent with alcohol or a drug, obtaining chemical evidence of alcohol or drugs, prosecuting the individual with the court determining the appropriate sanction at sentencing. The strategies for community supervision for DUID cases also mirror those convicted of DWI for alcohol with the assessment of risk and needs, developing supervision strategies and treatment plans.

Approximately 4.6 million individuals under community supervision in the United States, and at least two thirds of these individuals have a drug and/or alcohol offense (Kaeble, 2018). A significant portion of this



population could be a potential threat to our roadways, regardless of whether they have ever received an impaired driving conviction. Because of the prevalence of polysubstance use in impaired drivers, supervising officers need to be mindful that individuals convicted of alcohol-impaired driving may have also been under the influence of other substances or drugs. Consideration should be given to the use of broad field urinalysis testing to screen for polysubstance use and to promote client accountability. While these tests can be expensive, the alternative can be continued undetected drug use while under supervision and the likelihood of “the word” being spread to other supervisees that certain drugs are not being tested. The Treatment Assessment Screening Center (TASC) (2018) recommends that a broad screen urinalysis test include:

- ➔ Alcohol
- ➔ Amphetamine
- ➔ Barbiturates
- ➔ Benzodiazepines
- ➔ MDMA
- ➔ Methadone
- ➔ Opiates
- ➔ Oxycodone
- ➔ Phencyclidine
- ➔ Propoxyphene
- ➔ THC
- ➔ Tramadol

And ideally:

- ➔ Ketamine
- ➔ Synthetic Cannabinoids (Spice/ K2)
- ➔ Synthetic Cathinones (Bath Salts)

It should be noted that with the emergence of synthetic drugs, testing of new substances is ever-changing and dynamic. Consistent communication with drug laboratories can better determine local and regional drug trends as well as their ability to detect new substances. Additionally, the proliferation of drugs can be unique to specific regions of a county or state. For example, heroin may be epidemic in one region while methamphetamine may be on the rise in another.

## Policy Considerations

### *DUID cases and Problem-Solving Courts*

Despite their drug(s) of choice, the behaviors of individuals convicted of DUID are quite similar to those convicted of alcohol-impaired driving. The National Center for DWI Courts recommend that those individuals that meet all other entry criteria, and are arrest for DUID, be placed in DWI Court. However, treatment should reflect the needs of the individual, and as such, their treatment may not involve alcohol use. This should be determined through assessments provided by treatment providers.

### *DUID cases and Alcohol Technologies*

Just as we cannot assume that individuals convicted for a DWI will not use marijuana and/or other illegal drugs, we cannot assume that those convicted of DUID will not drink and drive. Prior studies have shown that polysubstance abuse is common with individuals convicted of DUID. In a Miami-Dade study, 39% of drivers who were found to have a BAC above .08 also tested positive for the presence of drugs (Logan, Mohr, & Talpins, 2014). In the Dane County, Wisconsin study, nearly 40% of the subjects with BACs exceeding .10 screened positive for one or more drug categories in both oral fluid and blood (Edwards, et al., 2017).

Ignition interlock devices or other alcohol detection technologies are useful countermeasures to deter and prevent alcohol impaired driving, but this technology is not intended to detect drugs. Some states require the use of ignition interlock regardless of the type of impairment. When a supervising probation officer has the discretion to mandate interlock, consideration should be given to the individual's substance abuse history, drug and alcohol testing results, and their compliance on community supervision.

### *DWI risk assessment tools and DUID cases*

Previous chapters of this document support the need to use alcohol/DWI specific risk assessment tools for DWI cases. The Impaired Driver Assessment can capture risk for both alcohol and drug-impaired driving cases. To ensure fidelity, it is recommended that probation departments investigate the applicability of their DWI risk assessment tools for DUID populations.



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# Section V: 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: The Impaired Driver Assessment Tool

## Appendix D: Components of a Case or Supervision Plan

## Appendix E: Sample Behavioral Contract

## Appendix F: Sample Graduated Sanctions and Incentives

## Appendix G: Tools and Technologies to Assist in the Supervision of DWI Offenders

## Appendix H: Promising Practices and Strategies for the Supervision of DWI Offenders

## Appendix I: Nebraska Standardized Model—Policy, Procedures, and Forms

## Appendix J: Examples of Process and Outcome Measures for the Supervision of DWI Offenders

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

## Appendix L: Screening for Risk and Needs Using the Impaired Driving Assessment



# Appendix A: Supplemental Readings and Resources

## *Substance Use Disorder and Addiction*

### Suggested readings

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## Web Sites

- ➔ Alcohol Research & Health—National Institute on Alcohol Abuse and Alcoholism: [www.niaaa.nih.gov/Publications/AlcoholResearch](http://www.niaaa.nih.gov/Publications/AlcoholResearch)
- ➔ The Association for Addiction Professionals/ National Association of Alcohol and Drug Abuse Counselors: <http://naadac.org>
- ➔ Center for Substance Use Disorder Research: [www.cesar.umd.edu](http://www.cesar.umd.edu)
- ➔ Foundation for the Advancement of Alcohol Responsibility: <http://responsibility.org/drun-driving/drun-driving-research>
- ➔ MedlinePlus: [www.nlm.nih.gov/medlineplus/drugabuse.html](http://www.nlm.nih.gov/medlineplus/drugabuse.html)
- ➔ National Center for DWI Courts: <http://www.dwicourts.org/>
- ➔ National Institute on Alcohol Abuse and Alcoholism: <http://www.niaaa.nih.gov/>
- ➔ National Institute on Drug Abuse: [www.nida.nih.gov](http://www.nida.nih.gov)
- ➔ National Institutes of Health: <http://health.nih.gov/search.asp/21>
- ➔ Substance Abuse and Mental Health Services Administration (SAMHSA): [www.samsha.gov](http://www.samsha.gov)
- ➔ SAMHSA's Center for Substance Abuse Prevention: <http://prevention.samhsa.gov>
- ➔ SAMHSA's Center for Substance Abuse Treatment: <http://csat.samhsa.gov>
- ➔ Traffic Injury Research Foundation: <http://www.tirf.ca/index.php>



## *Screening for Risk and Need/ Screening and Assessment for Drug and Alcohol*

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## Web Sites

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- ➔ Foundation for Advancing Alcohol Responsibility: [www.Responsibility.org](http://www.Responsibility.org)
- ➔ IDA Recource Center: <https://www.appa-net.org/IDARC/>
- ➔ Substance use disorder and Mental Health Services Administration (SAMHSA): [www.samhsa.gov](http://www.samhsa.gov)
- ➔ Substance Use Screening &Assessment Instruments Database: <http://lib.adai.washington.edu/instruments>
- ➔ Traffic Injury Research Foundation: <http://www.tirf.ca/index.php>

## Drug-Impaired Driving

### Suggested Readings

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## Websites

- ➔ AAA Foundation for Traffic Safety: <https://aaafoundation.org/>
- ➔ Alcohol and Drug Abuse Institute: <http://depts.washington.edu/adai>
- ➔ Drug Impaired Driving learning Centre: <http://druggeddriving.tirf.ca/>
- ➔ Foundation for Advancing Alcohol Responsibility: [www.Responsibility.org](http://www.Responsibility.org)
- ➔ Governors Highway Safety Association: [www.ghsa.org](http://www.ghsa.org)
- ➔ National Highway Traffic Safety Administration: <http://www.nhtsa.gov/>
- ➔ Substance use disorder and Mental Health Services Administration (SAMHSA): [www.samhsa.gov](http://www.samhsa.gov)
- ➔ Traffic Injury Research Foundation: <http://www.tirf.ca/index.php>

## Automated Case Management Systems

### Suggested readings

- American Probation and Parole Association Template Request for Proposal for Technological Solution for Requesting Entity [http://www.appa-net.org/eweb/docs/APPA/pubs/RFPTemplate\\_Specifications.docx](http://www.appa-net.org/eweb/docs/APPA/pubs/RFPTemplate_Specifications.docx)
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### Web sites

- ➔ National Association for Court Management: <https://nacmnet.org/>
- ➔ National Center for State Courts: <http://www.ncsc.org/>
- ➔ Statewide Maryland Automated Record Tracking (SMART): <https://www.igsr.umd.edu/SMART/>
- ➔ U.S. Department of Justice Global Justice Information Sharing Initiative: <https://it.ojp.gov/global>



## *Motivational Interviewing and Stages of Change*

### **Suggested readings**

Bogue, B., & Nandi, A. (2012). *Motivational interviewing in corrections: A comprehensive guide to implementing MI in corrections*. Washington, DC: U.S. Department of Justice, National Institute of Corrections. Retrieved from <https://s3.amazonaws.com/static.nicic.gov/Library/025556.pdf>.

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### **Web sites**

➔ Center for Strength-Based Strategies: <http://buildmotivation.com>

➔ Motivational Interviewing Network Trainers (MINT): <https://motivationalinterviewing.org/>

## *Graduated Responses—Sanctions and Incentives*

### **Suggested Readings**

Nagy, G. (2007, March). Risk-based incentives and sanctions in Travis County. Retrieved from <http://doc.ks.gov/community-corrections/resources/Travis%20County%20sanctions%20and%20incentives%20by%20Geraldine%20Nagy.pdf/>.

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## Web sites

- ➔ National Center for DWI Courts: <http://www.dwicourts.org/>
- ➔ National Association of Drug Court Professionals: <http://www.NADCP.org>
- ➔ National Drug Court Institute: <https://www.ndci.org/>

## *Evidence Based Practices and Behavioral Change*

### Suggested readings

- Bogue, B., Campbell, N., Carey, M., Clawson, E., Faust, D., Florio, K., Joplin, L., Keiser, G., Wasson, B., & Woodward, W. (2005). *Implementing evidence-based practice in community corrections: The principles of effective interventions*. Washington, DC: National Institute of Corrections. Retrieved from <https://nicic.gov/implementing-evidence-based-practice-community-corrections-principles-effective-intervention>.
- Foundation for Advancing Alcohol Responsibility, American Probation and Parole Association. (2015). *Hardcore Drunk Driving Community Supervision Guide* [https://www.responsibility.org/wp-content/uploads/2015/02/Hardcore-Drunk-Driving\\_Community\\_Supervision\\_Guide.pdf](https://www.responsibility.org/wp-content/uploads/2015/02/Hardcore-Drunk-Driving_Community_Supervision_Guide.pdf)
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## Web sites

➔ National Institute of Corrections Information Center: <https://nicic.gov/>

## *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. (2010, January). *Information quality: The foundation for justice decision making*. Washington, DC: Global Privacy and Information Quality Work Group. Retrieved from <https://it.ojp.gov/GIST/50/Information-Quality--The-Foundation-for-Justice-Decision-Making>.

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Global Privacy and Information Quality Working Group. (2006, September). *Privacy technology focus group: Final report and recommendations*. Washington, DC: U.S. Department of Justice, Global Justice Information Sharing Initiative. Retrieved from [https://it.ojp.gov/documents/privacy\\_technology\\_focus\\_group\\_full\\_report.pdf](https://it.ojp.gov/documents/privacy_technology_focus_group_full_report.pdf).

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## Web sites

➔ Global Justice Information Sharing Initiative (U.S. Department of Justice): <https://it.ojp.gov/global>

## Other Related Topics

## Suggested Readings

Coleman, H., & Mizenko, K. (2018, May). *Impaired-driving leadership model: Findings based on three state case studies* (Report No. DOT HS 812 516). Washington, DC: National Highway Traffic Safety Administration. Retrieved from <https://rosap.nhtl.bts.gov/view/dot/36877>.

Dehn, J. (Spring, 2007). Mechanics of Minnesota's staggered sentencing. *Impaired Driving Update*, XI(2), 31-44.

Foundation for Advancing Alcohol Responsibility. (n.d.). *Hard core drunk driving judicial guide: A resource outlining judicial challenges, effective strategies and model programs (2nd ed.)*. Washington, DC: National Association of State Judicial Educators. Retrieved from [https://www.responsibility.org/wp-content/uploads/HCCDD\\_JudicialGuide\\_550c679742098.pdf](https://www.responsibility.org/wp-content/uploads/HCCDD_JudicialGuide_550c679742098.pdf).

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- National Highway Traffic Safety Administration. (2005). *A guide to sentencing DWI offenders*. Washington, DC: National Highway Traffic Safety Administration. Retrieved from [https://pubs.niaaa.nih.gov/publications/SentencingDWI/A\\_Guide2.pdf](https://pubs.niaaa.nih.gov/publications/SentencingDWI/A_Guide2.pdf).
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- Robertson, R., Vanlaar, W., & Simpson, H. (2007). *10 Steps to a strategic review of the DWI system: A guidebook for policymakers*. Ottawa, ON: Traffic Injury Research Foundation. Retrieved from [http://tirf.ca/wp-content/uploads/2017/01/TIRF\\_Booklet.pdf](http://tirf.ca/wp-content/uploads/2017/01/TIRF_Booklet.pdf).



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## Appendix B: Alcohol and Drug Screening and Assessment Instruments for DWI Offenders<sup>7</sup>

<i>Instrument</i>	<i>Administered by</i>	<i>Testing Time</i>	<i>Primary Domain</i>	<i>Considerations</i>
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 than screening. Best predictive value for DWI recidivism
Impaired Driver Assessment (IDA)	Training is required	45 minutes, computerized or pencil/paper administration	DWI screening to assess for risk to recidivate, service needs, and response to interventions	Designed for use at frontend of justice system, supplements more comprehensive substance use disorder or mental health assessments
CAGE	No minimum training requirement	1 minute, Computerized and pencil/paper administration	Alcoholism	Convenient, non-threatening Limited use for DWI screening
Computerized Assessment and Referral System (CARS)	Online training at Resonsibility.org	10 minutes-2 hours depending on test	Diagnostic report generator for immediate diagnostic information for up to 20 DSM-IV Axis I disorders (onset, recency, persistence)	CARS is divided into modules representing various mental disorders and psychosocial factors. The individual administering can determine any subset of modules
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

<sup>7</sup> Chang, Gregory, & Lapham, 2002; Cavaola & Wuth, 2002; Lowe, 2014



<i>Instrument</i>	<i>Administered by</i>	<i>Testing Time</i>	<i>Primary Domain</i>	<i>Considerations</i>
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, Identifies 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 use disorder 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



# Appendix C: The Impaired Driving Assessment Tool

## 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. The presentence report and DWI specific risk and needs assessment tools are the best starting point in the development of case management plans and should be used in concert with interviews and feedback with the probationer.

## 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 probationer the incentive to invest time and energy into the plan.
- Realistic -** No effort will be put forth by the probationer if he or 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 probationer 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 individual into the justice system. Describe any other factors that contribute to the existing situation and impact the behavior of the probationer. 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 identify. Internal behavior<sup>1</sup> is also important because attitudes and beliefs drive thoughts and thinking drives behavior. However, supervision officers cannot change the individual's attitude, the individual must 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 individual's responsibility, since her/she fails or succeeds by their own effort. Giving the probationer a voice in the behavioral objectives assures objectives are desired by the individual.

### *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 use disorder 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.

# Appendix D: Sample Behavioral Contract

## BEHAVIORAL CONTRACT FOR SUPERVISION<sup>8</sup>

NAME: \_\_\_\_\_

Case Number: \_\_\_\_\_

Supervision Officer \_\_\_\_\_

PROBATION: ☐ PAROLE: ☐ Supervision Start Date: \_\_\_\_\_ Supervision End Date: \_\_\_\_\_

COMPAS Total Score: \_\_\_\_\_ Last COMPAS Date: \_\_\_\_\_ Next COMPAS Due: \_\_\_\_\_

SPECIAL CONDITIONS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### 1. Criminogenic Need

COMPAS Subscale Score: \_\_\_\_\_

History: \_\_\_\_\_

Triggers \_\_\_\_\_

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

### 2. Criminogenic Need

COMPAS Subscale Score: \_\_\_\_\_

History: \_\_\_\_\_

Triggers: \_\_\_\_\_

Long Term Goal: \_\_\_\_\_

<sup>8</sup> 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.			

### 3. Criminogenic Need

COMPAS Subscale Score: \_\_\_\_\_

History: \_\_\_\_\_

Triggers: \_\_\_\_\_

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. \_\_\_\_\_

### 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 <i>* May require administrative approval</i> <i>** May require Court Order</i>
<b>Positive UA</b>	
1st Positive breath, blood or urine drug test	<ul style="list-style-type: none"> <li>→ Increased drug testing</li> <li>→ Increased reporting</li> </ul>
2nd Positive breath, blood or urine drug test	<ul style="list-style-type: none"> <li>→ Random drug testing includes weekly home contacts</li> <li>→ Increase in reporting schedule</li> </ul>
3rd Positive breath, blood or urine drug test	<ul style="list-style-type: none"> <li>→ Electronic Monitoring with Alcohol Monitor*</li> <li>→ Increase Self-Help Group</li> <li>→ Increased Level of Treatment</li> </ul>
4th Positive breath, blood or urine drug test	<ul style="list-style-type: none"> <li>→ Continuous Remote Alcohol Monitoring*</li> <li>→ 2-5 days in jail**</li> </ul>
<b>Technical Violations</b>	
<p>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.</p> <p>2nd or subsequent violations</p>	<ul style="list-style-type: none"> <li>→ Increased drug testing</li> <li>→ Increased level of reporting</li> <li>→ Electronic monitoring*</li> <li>→ Increased level of supervision</li> <li>→ Increased level of reporting</li> <li>→ Day reporting center</li> <li>→ Increase community service</li> </ul>
<b>Failure to Comply with Treatment Recommendations</b>	
<p>Leaving residential treatment without authorization, not attending outpatient treatment, using alcohol or drugs while in treatment, not attending self-help group as required</p> <p>2nd or subsequent violations</p>	<ul style="list-style-type: none"> <li>→ Electronic monitoring*</li> <li>→ Increased level of supervision</li> <li>→ Increased level of reporting</li> <li>→ Day reporting center*</li> <li>→ Increase community service</li> <li>→ Electronic monitoring with alcohol monitor*</li> <li>→ Continuous remote alcohol monitor*</li> <li>→ Weekend in jail**</li> <li>→ Increased level of treatment</li> <li>→ Increased level of supervision</li> </ul>



### *A Model of Graduated Sanctions*

Behavior	Sanction
	<i>* May require administrative approval</i> <i>** May require Court Order</i>
New Arrest	
New misdemeanor arrest, other than DWI	<ul style="list-style-type: none"><li>→ Review policy on sanction prior to determination of guilt</li><li>→ If found guilty, determine if supervision will be revoked or extended</li><li>→ Electronic monitoring*</li><li>→ Increased level of supervision</li><li>→ Increased level of reporting</li><li>→ Day reporting center*</li></ul>
New felony arrest, other than DWI	<ul style="list-style-type: none"><li>→ Review policy on sanction prior to determination of guilt</li><li>→ If found guilty, determine if supervision will be revoked or extended</li><li>→ Electronic monitoring*</li><li>→ Increased level of supervision</li><li>→ Increased level of reporting</li><li>→ Day reporting center*</li></ul>
Driving on a suspended license	<ul style="list-style-type: none"><li>→ Electronic monitoring*</li><li>→ Increased level of supervision</li><li>→ Increased level of reporting</li><li>→ Day reporting center*</li><li>→ 2-5 days in jail**</li></ul>
New DWI arrest, felony or misdemeanor	<ul style="list-style-type: none"><li>→ Review policy on sanction prior to determination of guilt</li><li>→ If found guilty, determine if supervision will be revoked or extended</li><li>→ Electronic monitoring*</li><li>→ Increased level of supervision</li><li>→ Increased level of reporting</li><li>→ Day reporting center*</li><li>→ Ignition Interlock**</li><li>→ Inpatient treatment</li><li>→ Revocation of probation**</li></ul>

### *A Model of Graduated Sanctions*

Behavior	Incentive
<b>Positive UA</b>	
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
	➔ Positive words from supervision officer and decrease in random drug testing
4th Negative breath, blood or urine drug test	➔ Non-monetary positive reward, if allowed by agency policy (coupons for movies or food, bus passes).
<b>Compliance with Supervision Requirements</b>	
Probationer 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.	<ul style="list-style-type: none"> <li>➔ More flexible reporting schedule</li> <li>➔ Decrease in reporting requirements</li> <li>➔ After half of supervision is completed consider non-monetary positive reward, if allowed by agency policy (coupons for movies or food, bus passes).</li> <li>➔ After three-fourths of supervision, or earlier, consider early discharge.</li> </ul>
<b>Compliance with Treatment Requirements</b>	
Probationer 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.	<ul style="list-style-type: none"> <li>➔ Decrease supervision reporting requirements, but do not eliminate.</li> <li>➔ Decrease drug testing requirements, but do not eliminate.</li> <li>➔ Acknowledge completion of treatment; if possible give a certificate to purchase AA Big Book or other AA publications.</li> </ul>



## Appendix F: Tools and Technologies to Assist in the Supervision of DWI Supervisees

### Electronic Monitoring (EM)

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 supervisees:*

- ➔ Provides structure and close supervision, enables supervisees 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. Supervisees 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 supervisees.
- ➔ 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 supervisee 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](http://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 above the alcohol set point (determined by the state, usually approximately .02), it will prevent the vehicle from being operated. In addition, at random intervals 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 probationers with an alternative to full license suspension. Use of the system for repeat or high BAC probationers is often required by legislation and/or mandated by the motor vehicle department or other administrative authority. For example, all 50 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 probationer which often deters indigent probationer access. Indigent funds should be established allowing access for those who are unable to pay.

*How it can aid in supervision of DWI probationers:*

- ➔ Installation of an Ignition Interlock device allows the DWI probationer 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 operated if the breath sample provided by the driver contains more than a predetermined breath alcohol concentration (BrAC).
- ➔ A report of the BrAC level at the time of every ignition start-up is maintained in the control unit of the device.
- ➔ Data obtained through the control unit shows 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, Vanlaar, & Simpson, 2006).
- ➔ Research has shown that when ignition interlock devices are used in concert with treatment and supervision, it can reduce recidivism by up to 35%. (CDC, 2016).



## Suggested Resources

- ➔ The Association of Ignition Interlock Program Administrators
  - Established in 2011 and is comprised of researchers, criminalists, forensic scientists, regulatory inspectors, manufacturing representatives, probation and parole officers, and law enforcement personnel among others. Their mission is to bring leadership to the ignition interlock device community by promoting best practices, enhancing program management, and providing technical assistance to improve traffic safety by reducing impaired driving.
  - Their website is: <http://aiipaonline.org/>
- ➔ NHTSA has published a document titled Ignition Interlocks-What You Need to Know: A Toolkit for Policymakers, Highway Safety Professionals and Advocates.
- ➔ The Traffic Injury Research Foundation has published a document titled A Criminal Justice Perspective on Ignition Interlock.
- ➔ NHTSA has published a document titled Case Studies of Ignition Interlock Programs.

## Breath, Blood, Oral Fluid and Urinalysis Testing

DWI probationers 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 individual's 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 probationer also can be referred to a hospital or a lab for urinalysis or blood testing.

*How it can aid in supervision of DWI probationers:*

- ➔ 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 a probationer submit to urinalysis testing. EtG/EtS is a laboratory based urine test that will detect the presence of alcohol up to 80 hours after consumption. This is sometimes referred to as "The 80 Hour Alcohol Test" or "Alcohol Urine Test" and tests for Ethyl Glucuronide and Ethyl Sulfate. This is the Ethyl Glucuronide urine test or EtG testing of alcohol in urine.

- ➔ 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 individual 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 probationer which often denies indigent probationers access. Indigent funds should be established allowing access for those who are unable to pay.

*How it can aid in supervision of DWI probationers:*

- ➔ 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 probationer. 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.



## Mobile Alcohol Monitoring

Mobile alcohol devices are commonly court-ordered as an alternative to the ignition interlock for offenders who do not drive or own vehicles. Similar to most alcohol monitoring devices in vehicles, the in-home device and the hand-held device have cameras attached. The device reports the subject's picture and makes it available to the monitoring authority for photo-matching.

Both devices are portable and relatively simple to use. The In-Home device must be plugged into an outlet; no phone service or internet service is necessary. The unit is calibrated at a service location and all test results are uploaded and sent to the monitoring authority.

The hand-held unit requires cell phone service to upload results instantly after testing. The number of tests required per day is determined by the monitoring authority. Monitoring authorities can change the number of tests or the time of the tests at any time. Both devices use fuel-cell technology to test breath samples for alcohol. The fuel cell within the device has two platinum electrodes with a porous acid-electrolyte material between them. As a breath sample runs through the device and passes one side of the fuel cell, the platinum oxidizes any present alcohol in the air and produces acetic acid, protons, and electrons.

## Appendix G: Promising Practices and Strategies for the Supervision of DWI Probationers

### South Dakota-The 24 / 7 Sobriety Project

In counties implementing the program, first-time DUI offenders with a BAC of at least 0.17% and repeat DUI offenders must participate in the 24/7 Sobriety Program to obtain a conditional driver's license. The 24/7 Sobriety Program is being used by the courts as a condition of bond, sentence/probation, and family courts. The program stresses separating the offender from alcohol as a method to rehabilitate drunk drivers and change. The program uses several tools to make sure that the participants are following the program guidelines. The tools include: twice-a-day breath tests (PBTx2), transdermal monitoring systems, drug patches and urine tests. Additionally, participants may be required by the court to use more than one testing/monitoring method.

Of the tools available, PBTx2 is the most common monitoring tool used. If participants don't show up for a scheduled test, or a test shows he has consumed alcohol, then his probation, parole or bond may be instantly revoked and he may be immediately jailed. Sanctions are swift, certain and measured. Sanctions most often afford a reinstatement into the program. The program allows for a considerable amount of freedom for the offender. For example, participants can still drive, work and stay with their families. This reduces jail populations and allows participants to continue to be part of their community.

#### *Program Effectiveness:*

Twenty thousand DUI offenders have been placed on the program's twice-per-day testing regimen. Of those, 99.4% have shown up on time for compliance (breath) tests and tested negative for alcohol use; 0.6% failed to show up or failed their breath tests. Compared to DUI offenders not in the program, participants with two DUI arrests who were in the program for 30 consecutive days had a 74% reduction in recidivism when studied three years after their second DUI arrests. Those with three DUI arrests had a 44% reduction in recidivism, and those with four DUI arrests had a 31% reduction in recidivism.

#### *Program Cost Effectiveness:*

The program has evolved into a participant pay model with formal adopted rules and procedures. The web-based 24/7 management software coordinates data, testing sites, and communicates information to all agencies that are involved with the system and administer the project. No taxpayer dollars are necessary to operate. Flexibility is built into the business model and allows the testing agency to utilize existing or new resources to maximize efficiencies. Price points for testing have been kept low to eliminate the need for indigency considerations by the court.



### *Source of Funding:*

Program is funded entirely by participant fees.

### *Factors to Consider When Replicating the Program:*

Criminal justice authorities need to be convinced of the benefits of the program and that it is not “soft on crime.” The 24 / 7 Sobriety Program allows law enforcement and other agencies that are involved with the criminal justice system to be proactive in the fight against drunk driving.

## **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 [here](#).

## **Pennsylvania DUI Association**

Few States have professional associations with a mission to act 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 act 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. More information on the Pennsylvania DUI Association can be found [here](#).

## **Virginia Alcohol Safety Action Program<sup>5</sup>**

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 use disorder, 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 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.

## Staggered Sentencing<sup>6</sup>

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 please utilize the Controlling Repeat DWI Offenders with Staggered Sentencing, A Legislative Brief and NHTSA's Strategies for Addressing the DWI Offender: 10 Promising Sentencing Practices documents.

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.  
1 800 DUI Laws. (n.d). Virginia: Alcohol Safety Action Program. Retrieved from <http://www.vasap.state.va.us/index.html>  
Dehn, J. (2007). DUI staggered sentencing: How it works. Criminal Justice, Winter. [https://heinonline.org/HOL/Page?handle=hein.journals/cjust21&div=66&g\\_sent=1&casa\\_token=&collection=journals](https://heinonline.org/HOL/Page?handle=hein.journals/cjust21&div=66&g_sent=1&casa_token=&collection=journals)

# Appendix H: Nebraska Standardized Model for Substance Abuse Services—Policy, Procedures and Forms<sup>9</sup>

## CHAPTER 6 TRIAL COURTS ARTICLE 13 SUBSTANCE USE SERVICES

### Section.

- 6-1301. Compliance with Standardized Model for Delivery of Substance Use Services required.
- 6-1302. Definitions.

### **§ 6-1301. Compliance with Standardized Model for Delivery of Substance Use Services required.**

Substance use evaluations and treatment services for juveniles and adults 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 as set forth in the Standardized Model for Delivery of Substance Use Services, as promulgated by the Nebraska Supreme Court Administrative Office of Probation. Substance use evaluations and treatment must be obtained by a registered service provider. Substance use evaluations and treatment services that do not conform to the requirements of the Standardized Model for the Delivery of Substance Use Services shall not be accepted by the courts. Nothing in this rule shall preclude an individual from obtaining, at his or her own expense, additional substance use evaluations or treatment referrals which may or may not comply with the minimum standards referred to within the Standardized Model for the Delivery of Substance Use Services.

### **§ 6-1302. Definitions.**

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 the Administrative Office of Probation. Adopted November 30, 2005, effective January 1, 2006. Renumbered and codified as §§ 6-1301 – 6-1303, effective July 18, 2008. § 6-1301 amended July 2, 2014.

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<sup>9</sup> Updated in 2016



## Standardized Model for the Delivery of Substance Use Services

### I. Policy:

The Standardized Model for Delivery of Substance Use Disorder Services for juvenile and adult probationers/problem-solving court participants (hereinafter referred to as “clients”) is used to recognize the connection between substance use and crime/delinquency and effectively address it through treatment. Reliable data indicates that treatment works. Research also shows that mandated treatment can be more effective than voluntary treatment. It is the intent of the Administrative Office of Probation (hereinafter referred to as “Probation Administration”) to provide a meaningful opportunity for client 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 Problem-Solving Court Coordinator, to ensure that communication between probation and problem-solving court officers and providers be consistent, open, and focused on criminogenic risk and need factors that, when reduced, will improve the client’s ability to live a productive, engaged and crime-free/delinquency-free life.

### II. Definitions:

For purposes of the Standardized Model for Delivery of Substance Use Disorder Services (hereinafter referred to as “Standardized Model”), the following definitions shall apply:

**Case Monitor** — 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** — An 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.

**Problem-Solving 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, or a county employee who is authorized, though a combination of county and state funding, to administratively oversee operation of a local problem-solving court and its employees.

**Problem-Solving Court Probation 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 Problem-Solving Court Coordinator of the Probation District.

**Problem-Solving Court Supervision Officer** — A county-based employee who is charged with the responsibility of case management for adult and juvenile clients involved in non-probation-based programs and services as authorized by Neb. Rev. Stat. § 29-2246(12) and reports directly to the program Problem-Solving Court Coordinator.

**Specialized Probation Officer** — This position has the same statutory responsibilities and authority as a traditional probation officer and is primarily responsible for the case management of clients classified as high-risk or placed on Intensive Supervision Probation. The CBI Officer reports directly to the Chief Probation Officer or designee.

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

**Registered Substance Use Service Provider** (hereinafter referred to as “Registered Service Provider”) — An individual or agency with a clear understanding of the Standardized Model that (1) agrees to adhere to all elements of the Standardized Model; (2) holds a valid license, which includes within its scope of practice the ability to administer substance use disorder evaluations and/or treatment; (3) meets the basic educational requirements set forth in Section III. A, and/or C and H of this Model; and (4) registers its services with and is approved by Probation Administration.

**Registered Substance Use Service Providers List** — An up-to-date list of Registered Substance Use Disorder Service Providers maintained by Probation Administration.

### III. Procedures:

#### A. Special Considerations for Working with Justice Clients<sup>10</sup>

This section highlights considerations for Officers and Providers that must be made when working with justice clients.

4. **Criminogenic Risk and Needs.** Registered Service Providers need to be cognizant that justice clients present with unique factors that need to be considered in both the evaluation and treatment process. Effective services must consider and address criminogenic risk and need throughout the process, if long term behavioral change and a reduction of recidivism are to be achieved.

<sup>10</sup> Section A: Special Considerations for Working with Justice Clients and Section I: Substance Use Treatment Best Practice Standards were developed either in whole or in part from the Adult Drug Court Best Practice Standards, Volume1. Alexandria, VA: National Association of Drug Court Professionals, 2013. Print.



- 5. Enhanced Family Engagement.** Concerted effort is made to involve and engage the client's significant others / family members in the assessment, treatment, and discharge planning processes, when indicated and appropriate.<sup>2</sup>
- 6. Historically Disadvantaged Groups (Cultural Competence).** Citizens, including justice clients, who have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status receive the same opportunities as other citizens to engage in substance use disorder services.
- 7. Professional Demeanor.** Responses to client non-compliance are delivered without expressing anger or ridicule. Participants are not shamed or subjected to foul or abusive language. Modeling appropriate behavior is essential in ensuring client success.
- 8. Trauma Informed Care.**
  - a. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both clients and providers, and helps survivors rebuild a sense of control and empowerment. Becoming "trauma-informed" means recognizing that people often have many different types of trauma in their lives.
  - b. People who have been traumatized need support and understanding from those around them. Often, trauma survivors can be re-traumatized by well-meaning caregivers and community service providers. Although exact prevalence estimates vary, there is a consensus in the field that most persons in justice services are trauma survivors and that their trauma experiences help shape their responses to outreach and services. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert. Trauma impacts one's relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection.

<sup>2</sup> As found in the Criminal Justice Substance Use Disorder Standards of Practice. Approved by the Nebraska Justice Behavioral Health Committee (JBHC) on March 11, 2009. Revised on September 11, 2013.

## B. Registered Service Provider Requirements

Probation Administration shall consider for registration only those individuals or agencies who have a clear understanding of the connection between substance use and criminal/delinquent behavior and meet the following criteria.

**1. Nebraska License.** Providers hold a current Nebraska Behavioral Health License or Provisional Behavioral Health License where the scope of practice includes the ability to administer substance use or co-occurring evaluations and/or substance use disorder services.

**2. Required Knowledge and Training for Substance Use and Justice.** Substance Use Providers must complete the following training.

- a. Complete an approved, 6-hour basic education course regarding substance use and criminogenic factors which contribute to a client's law violating/delinquency behavior.
- b. Registered Service Providers must participate in twelve (12) criminogenic, 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 Website.

3. Registered Service Providers, who wish to provide both substance use evaluation and treatment services, will not need to duplicate completion of requirements 2(a) and 2(b).

- c. Providers must obtain education/skill training on the following within 6 months of being approved as a Registered Service Provider:

4. Proficiency in the Standardized Model;
5. Criminal Justice processes and procedures (Probation, Parole, Problem-Solving Courts); and
6. ASAM criteria and Stages of Change (Transtheoretical Model by Prochaska and Diclemente)

- d. Registered Providers must have an understanding of the model process and agree to the requirements of the **Standardized Model** for probation and problem-solving court clients to include:

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

- e. It is recommended that Registered Service Providers seek additional education, skills and knowledge regarding working with justice clients. The *Addiction and Criminal Justice Performance Assessment Rubrics*, developed by the Nebraska Justice Behavioral Health Committee (JBHC) provides a model for such development (Attachment 1).



3. **Fee for Service and Payment.** Registered Service Providers may be entitled to a direct payment for delivery of a substance use service depending on the eligibility of the client referred for service. The criteria for client eligibility are determined by Probation Administration and payment for services is coordinated through the Fee for Service Delivery Program and the Fee for Service Rules.
3. **Registered Service Provider Services.** Providers may register their services, at no cost, with Probation Administration's office. The application process and a complete listing of Registered Service Providers are found on the Judicial Branch Web site. Providers must have computer access and a secure email address.

## C. Compliance with Standardized Model

Probation Administration utilizes a quality assurance process to ensure providers are complying with the requirements of the Standardized Model.

1. **On-Site Review.** On-Site review of client information will be conducted to ensure compliance with the Standardized Model and will include a checklist derived from the Registered Service Provider's program plan.
2. **Technical Assistance.** Technical assistance can be requested by providers or agencies that would like additional assistance with staff development and training opportunities. It is designed to be a proactive approach to ensure service delivery is in compliance with the Standardized Model.
3. **Program Improvement Plan.** Within its discretion, Probation Administration may require the use of a program improvement plan in order to rectify issues of noncompliance with the Standardized Model for an agency or individual providers. This plan will be created by the provider and approved by Probation Administration to address the concern noted and will be result driven and time oriented.

## D. Complaint Investigation Process

**1. Grounds for Imposition of Sanctions.** Any of the following may be grounds for imposition of sanctions or removal as a registered provider:

- a. Unprofessional or unethical conduct that violates the code of ethics for behavioral health treatment providers;
- b. Conviction of a criminal charge, either misdemeanor or felony, which is deemed by the Nebraska Supreme Court to evidence moral turpitude, dishonesty, fraud, deceit, or misrepresentation. Dispositions of criminal charges other than by acquittal or dismissal (e.g., pretrial diversion) may also constitute grounds for removal;
- c. Failure to maintain licensure in good standing within the behavioral health scope of practice. A licensing investigation may be grounds for temporary removal until such investigation and disposition has concluded; and
- d. Failure to comply with the Standardized Model or incompetence as a provider.

**2. Investigation and Notification of Grounds for Removal.** Complaints against a registered provider shall be investigated to determine if the complaint warrants formal action. Investigation shall commence when the Deputy Probation Administrator receives a written complaint against a registered service provider from the Department of Health and Human Services Division of Public Health, or upon the initiation of Probation Administration.

- a. Where formal action is deemed necessary, written notice of the complaint shall be delivered by certified mail to the registered service provider.
- b. The registered service provider shall have 15 days to file a written response with the Administrative Office of Probation, Community-Based Programs and Field Service Division.
- c. Upon receipt and review of any such written response, the Deputy Probation Administrator may take any of the following actions:
  1. Immediately remove the registered service provider and schedule a hearing,
  2. Dismiss the complaint, or
  3. Schedule a hearing to consider the complaint formally.



- 3. Formal Hearing.** If the Deputy Probation Administrator elects to schedule a formal hearing, such hearing shall be held within 30 days of the receipt by the Deputy Probation Administrator of the written response. If requested, any individual whose attendance is sought at the formal hearing shall be permitted to appear telephonically and/or through video conferencing. Notice of the time and place of the formal hearing shall be given by certified mail to the provider under investigation of a complaint, at least 15 days prior thereto. A hearing panel of three individuals shall be responsible for the conduct of the formal hearing. Panel membership shall include the following:

  - a. One member of the Fee for Service Delivery Committee;
  - b. The Probation Administrator, who shall preside over the hearing; and
  - c. One provider who serves as a Registered Provider, to be appointed by the Probation Administrator.
- 4. Conduct of Hearing.** The hearing panel shall receive such information and/or documentation as it sees fit, including if deemed appropriate by the panel, the taking of testimony. At the conclusion of the hearing, the panel may take any such action as it determines appropriate, including the immediate removal of the provider under investigation of a complaint, the dismissal of the complaint, or the imposition of any of the other sanctions as listed under [Sub-section 5 - Sanctions](#). The rules of evidence do not apply to these hearings.
- 5. Sanctions.** If sufficient cause exists, the Deputy Probation Administrator, in consultation with the panel, may impose one or more of the following sanctions:

  - a. Issue a written reprimand;
  - b. Specify corrective action with which the provider must comply in order to remain on the statewide register of providers, including the completion of educational courses;
  - c. Suspend the provider from serving as a registered service provider in the Nebraska courts for a specified period of time, or until corrective action is completed; and/or
  - d. Remove and permanently prohibit the provider from serving as a Registered Service Provider for Standardized Model for the Delivery of Substance Use Services in Nebraska courts.
- 6. Consequences of Sanctions.** No provider who has been suspended or removed from the Registered Substance Use Service Provider List shall be utilized for services by the Nebraska Probation and Judicial System, nor shall such provider be entitled to any compensation from Probation Administration, during his or her suspension or removal.

## E. Evaluations

### 1. Substance Use and Co-occurring Evaluations

- a. Only substance use and co-occurring evaluations in compliance with the Standardized Model shall be received by the probation or problem-solving court office. Pursuant to the Standardized Model, each substance use or co-occurring evaluation received shall be completed and signed by a Registered Service Provider, who, within his or her scope of practice, is permitted to conduct substance use or co-occurring evaluations and has agreed to adhere to all elements of Nebraska's Standardized Model. All Registered Service Providers shall use the **Nebraska Standardized Reporting Format for Substance Use and Co-occurring Evaluations for all Justice Referrals** (Attachment 4).
- b. As per Probation Administration policies and procedures, officers shall insure that all elements of the substance use or co-occurring evaluation are found within the evaluation. Substance use and co-occurring evaluations not adhering to this format shall be reported to the officer's direct supervisor, Chief Probation Officer, or Problem-Solving Court Coordinator to determine local engagement with the Registered Service Provider and whether subsequent referral to Probation Administration is necessary.
- c. As determined by Probation Administration, certain clients may be eligible for payment of their evaluations via the Fee for Service Delivery Program, as long as a Registered Service Provider is utilized for this service.

### 2. Registered Service Providers that Provide Evaluation Services

In addition to the Registered Service Provider Requirements found in Procedures III, Section B, Registered Service Providers conducting substance use or co-occurring evaluations for justice clients must have an understanding of the model process and agree to the specific requirements of the Standardized Model to include:

- a. The authorized Substance Use Screening instrument.
- b. The authorized Risk Screening instrument.
- c. Substance Abuse Services for Adult Criminal Justice Clients Continuum of Care.



- d. Become certified to administer and utilize the Addiction Severity Index (ASI) for adult clients or the Comprehensive Adolescent Severity Inventory (CASI) for juvenile clients to assist in appropriate data collection and objective placement level of treatment recommendations.
- e. As identified in the Registered Service Provider Application Process, use of a minimum of two validated assessment tools developed and approved for assisting in the diagnosis of substance use and substance use disorders.
- f. Use of the Nebraska Standardized Reporting Format for Substance Use and Co-Occurring Evaluations for all Justice Referrals.

### 3. Substance Use Screening Instrument

A **validated screening** tool is used to determine the presence of a current substance use problem and identify the need for further evaluation.

- a. The **authorized** screening instrument (Attachment 2) shall be utilized by probation and problem-solving court officers, or designated staff, to screen clients for substance use disorders as a stand-alone screening or in combination with additional authorized screening tools.
- b. If the findings of the screening instrument indicate that further evaluation is needed; the officer shall include recommendations for a substance use or co-occurring evaluation in the investigation or, as per district policy, refer the adult or juvenile for a substance use or co-occurring evaluation and include the screening findings as part of the investigation. If placed on direct probation or conducted during supervision, a modified order may need to be obtained a referral of a substance use or co-occurring evaluation.

### 4. Risk Screening Instrument

- a. The **authorized** risk screening tool (Attachment 3) is completed by the probation or problem-solving court officer or designated staff to provide Registered Service Providers an indication of the client's risk of re-arrest.
- b. The probation or problem-solving court officer, or designated staff, will use professional judgment in conjunction with information gleaned from other authorized risk screening tools to complete the risk screening.

## 5. Referrals

To ensure consistent and accurate diagnoses and recommendations for treatment services and to formalize information-sharing between the justice system and substance use providers, all referrals for substance use and co-occurring evaluations shall be made to a Registered Service Provider, who is chosen by the client from the Registered Substance Use Service Providers List.

- a. Referral for a substance use or co-occurring evaluation will be conducted through an automated process, utilizing both the Registered Service Provider and Nebraska Probation Administration web-based management information systems.
- b. The probation or problem-solving court officer shall provide upon request of the client's Registered Service Provider of choice (Registered Substance Use Service Providers List) collateral information concerning the results of the screening and risk tools, the current offence, the prior adult criminal record, and BAC (Blood Alcohol Content), if applicable. This information will be provided electronically through the Registered Service Provider and Nebraska Probation Administration web-based management information systems.

## 6. Release of Information

After a Registered Service Provider has been selected by the client, officers shall ensure a release of information has been signed and remains on file during the period the adult/juvenile is under presentence or predisposition investigation, pre-adjudication or predisposition supervision, is on probation, is involved in problem-solving court, or remains in treatment.

## 7. Registered Service Providers List

- a. A **Registered Substance Use Service Providers List** shall be provided by and maintained by Probation Administration. It is the responsibility of the probation district and/or problem-solving court to maintain an up-to-date listing.
- b. Chief Probation Officers and Problem-Solving Court Coordinators are expected to provide input to Probation Administration concerning the addition and/or potential removal of local providers to the Registered Substance Use Disorder Service Providers List.



## F. Treatment Services

### 1. Treatment Standards of Practice

In utilizing research-based, best practices, substance use treatment standards are established to create a foundation of quality for substance use disorder treatment services as defined by the Standardized Model.

- a. **Continuum of Care.** A comprehensive continuum of care for substance use treatment is found within the Standardized Model. The Standardized Model governs the level of care that is provided. The availability to access services within the continuum of care will vary based on geographical location; however, a referral to the appropriate service should be made based on the evaluation recommendations, ideal level of care, and/or the client's individual response to treatment. A client should not receive punitive sanctions if they fail to respond to a level of care that is substantially below or above their assessed ideal level of care for their treatment needs.
- b. **Program Plan.** The **Nebraska Registered Service Provider's Program Plan for the Delivery of Treatment Services** is a required management document to assist with organization and to ensure clients accomplish desired outcomes. Program Plans are used in determining whether a potential vendor/contractor has the capacity to serve clients, achieve outcomes for a purchased service, and has policies, procedures and processes in place to begin service. The Program Plan should be written as if the target audience was staff, clients, and members of the public. (Attachment 5)
- c. **In-Custody Treatment.** Clients should not be incarcerated for the sole purpose of completing treatment, obtaining access to detoxification services and/or sober living quarters.
- d. **Team Response.** Officers and treatment providers are expected to work together to create a team dynamic that is supportive of both the client's supervision and therapeutic risks and needs. The level of engagement between the officer and treatment provider may vary based on the intensity of the client's risk and needs. Clear communication protocols are established between the officer and treatment provider to ensure accurate and timely information about each client's progress in treatment.
- e. **Treatment Dosage and Duration.** Clients with active substance addictions<sup>11</sup> should receive a sufficient dosage and duration of substance abuse treatment to achieve long-term sobriety and recovery. Research has found that for high risk and need clients approximately 200 hours of counseling over a minimum nine to twelve months is the most effective. However, treatment dosage and duration must allow for flexibility to accommodate individual differences in each participant's response to treatment.

<sup>11</sup> Diagnostic terminology is in flux in light of recent changes to the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). The terms *addiction* and *dependence* are defined herein in accordance with the American Society of Addiction Medicine (ASAM), which focuses on a compulsion to use or inability to abstain from alcohol or other drugs: "Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response." Available at <http://www.asam.org/for-the-public/definition-of-addiction>.

- f. Treatment Modalities.** As part of the screening process, clients should be screened for their suitability for group interventions. Group membership is guided by evidence-based selection criteria including participants' gender, trauma histories and co-occurring psychiatric symptoms. Treatment groups ordinarily should have no more than twelve participants, and a minimum of four participants, to create a supportive, effective group dynamic. For groups that are treating externalizing or acting-out behaviors, such as illegal activity and substance use, two facilitators are often needed to monitor and control group interactions.
- g. Evidence-Based Treatments.** Treatment providers are expected to administer behavioral or cognitive-behavioral treatments that are documented in manuals and have been demonstrated to improve outcomes for addicted persons involved in the justice system. Treatment providers are proficient at delivering the interventions and are supervised regularly to ensure continuous fidelity to the treatment models. The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an Internet directory of evidence-based treatments called the *National Registry of Evidence-Based Programs and Practices* (NREPP). Treatment providers can search the NREPP web site, free of charge, to review and study substance use treatments that have been demonstrated to improve outcomes for addicted adults and juveniles in the justice system. Simply being listed on the NREPP does not guarantee that an intervention is effective with the justice population.
- h. Medications.** Medically assisted treatment (MAT) can significantly improve outcomes for addicted justice clients. Clients prescribed psychotropic or addiction medications should be done so based on medical necessity as determined by a treating physician with expertise in addiction psychiatry, addiction medicine, or a closely related field.
- i. Provider Training and Credentials.** Treatment providers are to be licensed to deliver substance abuse treatment, have substantial experience working with justice populations, are culturally competent in relation to historically disadvantaged groups and are supervised regularly to ensure continuous fidelity to evidence-based practices.
- j. Peer Support Groups.** In addition to professional counseling, justice clients are expected to regularly attend self-help or peer support groups. The peer support groups follow a structured model or curriculum such as the 12-step or Smart Recovery models. Before clients enter the peer support groups, treatment providers are expected to use an evidence-based preparatory intervention, to prepare the clients for what to expect in the groups and assist them to gain the most benefits from the groups (i.e. 12-step facilitation therapy).



- k. Continuing Care.** As clients begin to establish a foundation of sobriety, treatment focuses on relapse prevention and continuing care. The client, with their counselor, should prepare a continuing-care plan to ensure they continue to engage in prosocial activities and remain connected with a peer support group after their discharge from treatment and ultimately, discharge from supervision.
- l. Therapeutic Adjustments.** Clients should not receive punitive sanctions if they are otherwise compliant with their treatment and supervision requirements but are not responding to the treatment interventions. Under such circumstances, the appropriate course of action may be to reassess the individual and adjust the treatment plan accordingly, including the ideal level of care. Adjustments to treatment plans are based on the recommendations of Registered Service Providers, within their scope of practice.

## 2. Registered Service Providers that Provide Treatment Services

In addition to the Registered Service Provider Requirements found in Procedures III, Section B, Probation Administration shall consider for registration only those individuals or agencies who have a clear understanding of the connection between substance use and criminal/delinquent behavior and meet the following criteria specific to the delineation of treatment services:

- a. Provide knowledge in group counseling through previous training or complete an approved course in group therapy and dynamics;
- b. Provide a description of his or her experience treating clients with substance use disorder. This is to be provided within 6 months of being approved as a Registered Service Provider to conduct treatment services and consist of at least 100 documented hours of treatment with a substance use disorder population. If working with a group modality, 50 of the 100 hours must be facilitated group experience with clients diagnosed with a substance use disorder.
  - 1. Fully licensed clinicians need to provide a description of how they acquired their experience. This could be provided through narrative, professional vitae, or other format as approved by Probation Administration.
  - 2. Provisionally licensed clinicians need to provide documentation from a clinical supervisor of the attained hours. This may follow the format utilized for state licensure requirements within the clinician's scope of practice.

- c. Submit the authorized Program Plan, according the approved guidelines, which integrates client satisfaction and treatment outcome measure(s) (Attachment 5)
- d. Register their services prior to delivery in a database and provide data from those services in accordance with all confidentiality requirements.
- e. Provide services in accordance with defined levels of care and best practice treatment standards as found within the Standardized Model.
- f. As determined by Probation Administration, certain clients may be eligible for payment of their treatment services via the Fee for Service Delivery Program as long as a Registered Service Provider is utilized for this service.

### 3. Referrals

To ensure that programs serving substance use and substance use disorder clients are meeting standardized levels of care, probation and problem-solving court officers/case monitors shall refer such clients to Registered Service 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.

- a. Probation and problem-solving court officers/case monitors shall refer clients for substance use and substance use disorder services pursuant to either the **Substance Use Services for Adult Criminal Justice Clients Continuum of Care** (Attachment 6) or the **Substance Use Services for Juvenile Justice Clients Continuum of Care** (Attachment 7).
- b. Referral for substance use and substance use disorder services will be conducted through an automated process, utilizing both the Registered Service Provider and Nebraska Supreme Court web-based management information systems.
- c. The probation and problem-solving court officer shall provide, upon request of the client's Registered Service Provider of choice (Registered Substance Use Service Providers List), collateral information that shall include the individual's high and very high criminogenic risk factors. This information will be provided electronically through the Registered Service Provider and Probation Administration web-based management information systems.



#### 4. Release of Information

After a Registered Service Provider has been selected by the client, probation and problem-solving court officers shall ensure a release of information has been signed and remains on file during the period of time a client is under presentence or predisposition investigation, pre-adjudication or predisposition supervision, is on probation, is involved in problem-solving court, or remains in treatment.

#### 5. Registered Service Providers List

- a. A **Registered Substance Use Service Providers List** shall be provided by Probation Administration. It is the responsibility of the probation district and/or problem-solving court to maintain an up-to-date listing.
- b. Chief Probation Officers and Problem-Solving Court Coordinators are expected to provide input to Probation Administration concerning the addition and/or potential removal of local providers to the Registered Substance Use Disorder Service Provider list.

### G. Justice Education and Training

Through the Administrative Office of Courts/Probation, training for probation and problem-solving court officers, case monitors and designated staff is required concerning basic and continuing education pertaining to substance use disorders, the Standardized Model, and instruments utilized, in order to properly screen, assess, investigate and supervise clients under probation and problem-solving court's authority. All designated staff shall:

1. Understand **Probation Administration Policies and Procedures** associated with the Standardized Model.
2. Be trained on the **Principles of Criminogenic Risk and Need Factors** (to include but not limited to criminal/delinquent thinking and motivational interviewing).
3. Be trained on the **nature of Substance Use and Substance Use Disorders in Adults and Juveniles** during the first year of employment (35 hours required). Subsequent yearly training (8 hours) will include, but not limited to, relapse prevention, strength-based treatment principles, and American Society for Addiction Medicine (ASAM) criteria.

4. Understand the operation of the Nebraska Behavioral Health Service Delivery System.
5. Be trained on the Standardized Model, the process and tools utilized, to include:
  - a. Administration of the authorized screening instrument.
  - b. Administration of the authorized risk assessment.
  - c. Nebraska Standardized Reporting Format for Substance Use Evaluations for all Justice Referrals.
  - d. Understanding the Addiction Severity Index (ASI) and Comprehensive Adolescent Severity Inventory (CASI).
  - e. Standardized Levels of Care Continuum for Substance Use Disorder Services for Juvenile and Adult Justice Clients.
  - f. Understand how the Standardized Model is incorporated into the investigation and case management of justice clients.
6. Probation Administration will utilize the *Addiction and Criminal Justice Performance Assessment Rubrics*, developed by the Nebraska Justice Behavioral Health Committee (JBHC) as a guidance tool for continued development for probation and problem-solving court staff (Attachment 1).

**Attachments:**

**Attachment 1 – Justice Behavioral Health Committee’s Addiction and Criminal Justice Performance Assessment Rubrics**

**Attachment 2 – Authorized Substance Use Screening Instrument**

**Attachment 3 – Authorized Risk Screening Instrument**

**Attachment 4 – Nebraska Standardized Reporting Format for Substance Use and Co-Occurring Evaluations for all Justice Referrals**

**Attachment 5 – Nebraska Registered Service Provider’s Program Plan for the Delivery of Treatment Services**

**Attachment 6 – Substance Use Services for Adult Criminal Justice Clients Continuum of Care**



## Attachment 1: Addiction and Criminal/Juvenile Justice Performance Assessment Rubrics

*“Recognizing the connection between substance use and crime and addressing it effectively through treatment is imperative to ensure public safety and public health for Nebraska citizens.” (Substance Abuse Treatment Task Force Final Report, January 1, 2000)*

**Preface:** The addictions and justice systems, as well as licensed providers, are covered by distinct and separate regulations and guidelines which are encouraged to be complementary and supportive of the elements recommended in this document. Licensed and non-licensed professionals will each be dealt with in separate sections of this document.

### Performance Assessment Rubrics for Licensed Addiction Professionals Working in the Addictions Field (PLADC, LADC, PLMHP, LMHP, LIMHP, LCSW, Psychologist Ph.D., MD)

#### Licensed Professionals who work in the Addictions Field

Licensed professionals typically have an array of strengths and skills that range from newly developing to exemplary as they enter the addictions service delivery field and gain experience in working with individuals with substance use disorders and who are involved in the justice system. In addition, the level of training across varied disciplines providing addictions service is diverse and difficult to quantify. It is acknowledged that a variety of skills and knowledge are needed and it has become important for professionals to adapt to integrating elements specific to the criminal justice population. It is important to note that the skills and knowledge reviewed here are intended for the development of addictions professionals to better work with the justice population.

#### Basic elements recommended to work with the criminal/juvenile justice population:

- ***Knowledge of the Nebraska Justice System (Adult and Juvenile)***
  - » Criminal and Juvenile Justice System Points
  - » Necessity for collaboration and case management for criminal offenders
  - » Evidenced-based interventions to address criminality
  - » Understanding the state service delivery system and maintaining competency in accessing this system.
- ***Knowledge of Criminogenic Factors in Addictions Treatment***
  - » Knowledge of the impact of criminogenic factors on thinking
  - » Knowledge of how criminal thinking impacts substance use disorder treatment and outcomes
  - » Knowledge of the difference between criminal behavior and criminogenic need
  - » Knowledge of risk for re-offending on the treatment, management and intervention planning processes
  - » Knowledge of the Stages of Change for readiness to change
  - » Knowledge of Motivational Interviewing and its use in treating criminal offenders

- » Knowledge of American Society of Addiction Medicine (ASAM) criteria, Level of Care placement criteria
- » Basic knowledge of the difference between criminal thinking behaviors and potential psychopathology.
- ***Instrument Training Needs***
  - » Standardized Model Components
  - » Familiarity with instruments evidenced-based and strength-based in design that integrate family systems into the assessment process
  - » Addiction Severity Index and/or Comprehensive Adolescent Severity Inventory
- ***Standardized Reporting Format for Assessments***
- ***Risk Assessment domains***

How risk for re-offending impacts assessment, treatment, management and intervention strategies

- ***Simple Screening Instrument***
  - » Overview of Tools utilized by the Criminal Justice System
- ***Corrections and Probation: LS/CMI (Adult)***
- ***OJS and Probation: YLS/CMI (Youth)***



<b>Rubrics – Skill / Knowledge Levels for Licensed Addictions Professionals</b> <b>Suggested LEVELS of Knowledge and Skills</b>	<b>Level I</b> <b>Basic Knowledge; 1-3 years of Experience; Provisional Levels</b>	<b>Level II</b> <b>Full Licensure; 2-6 years of Experience; Training in Criminogenic elements</b>	<b>Level III</b> <b>5 plus years of Experience, Capable of fulfilling a supervisory role with staff</b>
<p>Note: These “levels” are intended to assist in training, evaluation, and supervision. They are not intended to be a gauge of competency or ethical practice.</p>	<ul style="list-style-type: none"> <li>Identifies a variety of models and theories of addiction and other substance-related problems (e.g., trauma, mental health, domestic violence, etc.); has minimal understanding and application of their specific relationship to client treatment.</li> <li>Is minimally aware of how criminogenic need impacts substance abuse treatment (Demonstrates basic awareness of)</li> <li>Minimally understands the CJ system and the need for collaboration in case management (Demonstrates basic understanding of)</li> <li>Aware of the substance use context for individual clients but does not integrate treatment strategies, and interactions with the client, with understanding of the context.</li> <li>Identifies the behavioral, psychological and physical health, and social effects of various psychoactive drugs, but does not readily recognize how their effects are demonstrated by clients</li> <li>Basic awareness/ knowledge and integration of medical and psychological disorders in treatment.</li> <li>Basic knowledge of ASAM criteria and the levels of care appropriate for consumers with a variety of needs.</li> <li>Drug Testing Basics &amp; beyond (con games etc.)</li> <li>Understands, values &amp; applies cultural competency</li> </ul>	<p><b><i>In addition to Level I:</i></b></p> <ul style="list-style-type: none"> <li>Understands a variety of models and theories of addiction and other substance-related problems (e.g., trauma, mental health, domestic violence, etc.); in order to contribute to the review and planning of intervention strategies with the supervisor or treatment team.</li> <li>Is aware of how criminogenic need impacts substance abuse treatment and demonstrate knowledge of the difference between criminal behavior and criminogenic need</li> <li>Collaborates well with CJ professionals for case management including the addition of the Risk Assessment and information in screening and assessment</li> <li>Uses specific treatment planning strategies to address criminogenic need</li> <li>Demonstrates sensitivity to the context within which individual clients live.</li> <li>Identifies behaviors, psychological and physical health needs, and social effects of psychoactive drug use on clients and family members.</li> </ul> <p>Identifies and relates medical and psychological disorders to co-existing substance use disorders.</p>	<p><b><i>In addition to Level II:</i></b></p> <ul style="list-style-type: none"> <li>Uses knowledge of a variety of models and theories of addiction and other substance related problems (e.g., trauma, mental health, domestic violence, etc.); to understand and plan intervention strategies for a variety of clients.</li> <li>Takes individual client’s context into consideration when planning and delivering addiction services.</li> <li>Identifies behavioral, psychological, physical health, and social effects of substance use on clients and family members and uses the information to plan comprehensive treatment with the individual and significant others.</li> <li>Incorporates appropriate referral and/or treatment of medical and psychological disorders, which co-exist with substance use disorders.</li> </ul> <p>Utilizes the principles of Recovery Management in working with the criminal justice population</p>

**Optional Rating Scale: Check those boxes above that best describe the proficiency.**

☐ Level 1    ☐ 1.5    ☐ Level 2    ☐ 2.5    ☐ Level 3

**Comments:**

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## Performance Assessment Rubrics for Justice Professionals

Practicing Criminal Justice professionals typically have an array of strengths and skills that range from newly developing to exemplary as they enter the addictions service delivery field and gain experience in working with individuals with substance use disorders and who are involved in the justice system. It must be clear though that they are not licensed clinicians. There are certain services that are outside of their scope. The table below delineates what types of skills and knowledge may be seen in individuals as they advance in their careers as Criminal Justice professionals.

<b>Rubrics – Skill / Knowledge Levels for Criminal Justice Personnel: Suggested</b>  <b>LEVELS of Knowledge and Skills</b>	<b>Level I</b> <b>Entry Level</b>	<b>Level II</b> <b>Intermediate Level</b>	<b>Level III</b> <b>Advanced Level</b>
<p>Note: These “levels” are intended to assist in training, evaluation, and supervision. They are not intended to be a gauge of competency or ethical practice.</p>	<ul style="list-style-type: none"> <li>• Understands and uses the basics of Rapport Building</li> <li>• Introduction to Psychological First Aid</li> <li>• Understands and uses the basics of De-escalation</li> <li>• Understands and uses 1st response basics</li> <li>• Understands the basics of addiction (A &amp; D 101)</li> <li>• Understands Suicide Assessment</li> <li>• Minimal/basic awareness of Mental Health &amp; screen for referral</li> <li>• Understands the basics of ASAM dimensions and Levels of Care</li> <li>• Drug Testing Basics &amp; Beyond (con games etc)</li> <li>• Introduction to Standardized Model</li> <li>• Introduction to cognitive groups.</li> <li>• Introduction to criminogenic risk factors.</li> <li>• Understands treatment system and basics of recovery</li> <li>• Understands, values &amp; applies cultural competency</li> </ul>	<p><b><i>In addition to Level I:</i></b></p> <ul style="list-style-type: none"> <li>• Understands and utilize Psychological First Aid</li> <li>• Introduction to cognitive intervention strategies</li> <li>• Crisis Intervention</li> <li>• Uses Rapport Building skills</li> <li>• Understands and effectively utilizes Motivational Interviewing skills</li> <li>• Understands risk factors for criminal thinking and impact on behavior and addictions treatment outcomes</li> <li>• Knowledge of ASAM criteria and the levels of care appropriate for consumers with a variety of needs and for collaboration with addictions professionals</li> </ul>	<p><b><i>In addition to Level II:</i></b></p> <ul style="list-style-type: none"> <li>• Understands assessments in Standardized Model (SSI &amp; Risk Assessment information)</li> <li>• Understands Cognitive Intervention Strategies</li> <li>• Completes and uses advanced Motivational Interviewing</li> <li>• Supervision and management of persons at risk</li> <li>• Integrates information and provides Case management &amp; referral</li> <li>• Education skills</li> <li>• Understands and incorporates cognitive based education groups as part of supervision</li> <li>• Understands &amp; implements the Standardized Model</li> <li>• Understands and uses knowledge of criminogenic risk factors</li> <li>• Incorporates ASAM – unique characteristics of Level of Care choices in referrals and communication</li> </ul>



The rubrics encompass Criminal Justice personnel at varying levels. Accurately and appropriately addressing offenders with substance abuse problems is a critical element at all levels. The varied criminal justice positions where this may apply includes, but is not limited to, the following:

Position	Level I Entry Level	Level II Intermediate Level	Level III Advanced Level
Booking Officers (6-24 hrs working with clients)	X	X	
Correctional Officers	X	X	
Unit Staff	X	X	X
Corrections Supervisors	X	X	X
Case Managers	X	X	X
Probation Officers	X	X	X
Treatment Probation Officers	X	X	X
SASS Officers	X	X	X
Probation Supervisors	X	X	X
Administration	X	X	X
Parole Officers	X	X	X
Parole District Supervisors	X	X	X
DOC – Social Workers	X	X	X
Youth Security Specialists	X	X	X
Youth Security Supervisors	X	X	X
Youth Counselors	X	X	X
Programming Professionals (Juvenile Correctional Facility)	X	X	X
Family Permanency Specialists	X	X	X
Family Permanency Supervisors	X	X	X
Children & Family Outcome Monitors	X	X	X
Children & Family Services Specialists	X	X	X
Children & Family Services Specialist Supervisors	X	X	X

**Optional Rating Scale: Check those boxes above that best describe the proficiency.**

☐ Level 1    ☐ 1.5    ☐ Level 2    ☐ 2.5    ☐ Level 3

**Comments:**

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## **Additional recommendations for curriculum for justice professionals:**

### Suicide and Mental Health

- ***Truths and Myths about Suicide and Self Abuse***
- ***Statistical data including demographics, method and location***
- ***How mental illness impacts suicide and self-abuse***
- ***How incarceration impacts suicide and self-abuse***
- ***Signs and symptoms of persons at risk***
- ***Emergency response***

### Substance abuse

- ***Categories of substances of abuse and examples of each***
- ***Methods of ingesting***
- ***Signs and symptoms of use, abuse and dependence***
- ***Emergency response***
- ***How and when to ask about use***
- ***Impact on society***
- ***Recovery***
- ***Treatment***
  - » How and why it works
  - » Treatment system

### Organizational goals

- ***Identification, screening and referral***
- ***Supervision, liabilities and litigation***
- ***Management methods***
- ***Staff safety***
- ***Reporting procedures and documentation***



## Attachment 2: Instructions for Administration of the Simple Screening Instrument

The SSI is effective for adults and juveniles; is highly sensitive and detects all substances; and requires 10 to 15 minutes for completion.

1. The SSI shall be administered face-to-face by a trained probation officer or case monitor.
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 identified substance use section of the investigation. A copy of the SSI shall be attached to the investigation.
3. If a substance use is suspected and no PDI or PSI is ordered, the probation officer/case monitor 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 monitor regarding the need for referral for a substance use evaluation.
5. If the court orders a substance use evaluation prior to a **Simple Screening Instrument (SSI)** (Attachment 2) being completed, this instrument 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 use 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" the individual 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 substance use concerns will usually score 4 or higher -- refer for substance use evaluation.
    - Score of less than 4 does not rule out a substance use problem; use observations to assist with a decision to refer for a substance use evaluation.

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

## Attachment 2, Continued - Simple Screening Instrument

<p><b>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.”</b></p>		
<p><b>In the past 6 months,</b></p>		
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.)	Yes	No
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
<p><b>The next questions are about your lifetime experiences.</b></p>		
14. Have you <u>ever</u> had a drinking or drug problem?	Yes	No
15. Have any of your family members <u>ever</u> had a drinking or drug problem?	Yes	No
16. Do you feel that you have a drinking or drug problem <u>now</u> ?	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):

___ 2	___ 7	___ 12
___ 3	___ 8	___ 13
___ 4	___ 9	___ 14
___ 5 (any items listed)	___ 10	___ 16
___ 6	___ 11	

**Total Score:** \_\_\_\_\_ **Score Range:** 0-14Preliminary 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:** \_\_\_\_\_

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**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 Use Systems**

***Attachment 3: Standardized Risk Assessment Reporting Format for Substance Using Justice Clients (Risk Inventory)<sup>12</sup>***

Client's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Rater's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. The probation officer shall record on the SRARF the relative level of risk of re-arrest posed by the individual as either low, medium, or high.
2. Special concerns, comments, or complicating factors important to the provider's understanding the individual's current risk shall be documented, for example, sexual assault on a 3-year-old, 2<sup>nd</sup> offense DUI but really is the 3<sup>rd</sup>, family member's death.
3. If the court orders a substance use evaluation prior to a **Standardized Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF)** being completed, this instrument shall be administered for data purposes in conjunction with a referral for an evaluation.

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<sup>12</sup> Adopted by the Nebraska Supreme Court on November 30, 2005, modified in January 2014.

**RISK ASSESSMENT REPORTING FORMAT**

Instructions: This instrument is used to give treatment providers an indication of the individual's risk of re-arrest. 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 re-arrest.

	<b>Yes</b>	<b>No</b>
<b>1. Age</b>		
Examples: The individual was relatively young at the time of first arrest/conviction. The juvenile is currently 12 or younger.	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Prior Record</b>		
Examples: The individual's arrest record causes concern. The individual has had prior terms of probation/parole. The individual has absconded or been revoked.	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Offense Types</b>		
Examples: The individual has prior arrests for theft/auto theft/burglary/robbery. The individual has an arrest for assault, sexual assault, or weapons.	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Attitude</b>		
Examples: The individual does not accept responsibility/rationalizes behavior. The individual is unwilling to change.	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Personal Relations</b>		
Examples: The individual's personal relationships are unstable or disorganized. The individual has gang associations.	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. Substance Use</b>		
Examples: The individual is involved in occasional or frequent use of alcohol/drugs. The use of alcohol/drugs causes any disruption of functioning.	<input type="checkbox"/>	<input type="checkbox"/>

For Juveniles Only:

	<b>Yes</b>	<b>No</b>
<b>7. School/Employment</b> <input type="checkbox"/> <input type="checkbox"/>		
(Check "Yes" if juvenile has dropped out and is not employed.) attendance problems at school or work. The juvenile is placed below expected grade.		
<b>8. Maltreatment</b> <input type="checkbox"/> <input type="checkbox"/>		
Examples: The juvenile has been reported to be the victim of either neglect or abuse (emotional, physical, or sexual).		

For Adults Only:

	<b>Yes</b>	<b>No</b>
<b>7. Employment</b> <input type="checkbox"/> <input type="checkbox"/>		
(Check "No" if full-time student.) Examples: The individual has unsatisfactory employment or is unemployed. The individual has not been regularly employed or in school for the last year.		

**Overall Impression**

In your professional judgement, indicate the relative level of risk of re-arrest posed by this individual.

Low ☐ Medium ☐ High ☐

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

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## Attachment 4:

### NEBRASKA STANDARD REPORTING FORMAT FOR SUBSTANCE USE AND CO-OCCURRING 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
  - 1. Drug and/or alcohol of choice
  - 1. History of substance-induced/use/disorder
  - 1. Use patterns
  - 1. Consequences of use (physiological, legal, interpersonal, familial, vocational, etc.)
  - 1. Periods of abstinence / when and why
  - 1. Tolerance level
  - 1. Withdrawal history and potential
  - 1. Influence of living situation on use
  - 1. Other addictive behaviors (e.g., gambling)
  - 1. IV drug use
  - 1. Prior substance use evaluations and findings
  - 1. Prior substance use disorder treatment
- F. LEGAL HISTORY (Information from Criminal Justice System)
  - 1. Criminal History and other information
  - 1. Substance testing results
  - 1. Simple Screening Instrument (SSI) results
  - 1. Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF) results
- G. FAMILY / SOCIAL PEER HISTORY
- H. BEHAVIORAL HEALTH HISTORY
  - 1. Previous mental health diagnosis
  - 1. Prior mental health treatment



- I. COLLATERAL INFORMATION (Information from Family/Friends/Criminal Justice/Other)
  - 1. 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
  - 1. Report the results and score from any other substance abuse assessment tool used that is not the ASI or CASI.
- K. ASAM Multidimensional Assessment
  - 1. Dimension 1: Acute Intoxication and/or Withdrawal Potential
    - a. Intensity:
    - b. Justification:
  - 2. Dimension 2: Biomedical Conditions and Complications
    - a. Intensity:
    - b. Justification
  - 3. Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
    - a. Intensity
    - b. Justification
  - 4. Dimension 4: Readiness to Change
    - a. Intensity
    - b. Justification
  - 5. Dimension 5: Relapse, Continued Use, or Continued Problem Potential
    - a. Intensity
    - b. Justification
  - 6. Dimension Recovery/Living Environment
    - a. Intensity
    - b. Justification
- L. CLINICAL IMPRESSION
  - 1. Summary of evaluation
    - a. Behavior during evaluation (agitated, mood, level of cooperation)
    - b. Motivation to change
    - c. Level of denial or defensiveness
    - d. Personal agenda
    - e. Discrepancies of information provided
  - 2. Substance use or substance use disorder diagnostic impression (including justification)
    - a. Identify the substance use and substance use disorder diagnostic impression

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

## M. RECOMMENDATIONS

1. Primary / ideal level of care recommendation
  - a. Identify the substance use or substance use disorder level of care and service(s) that would best meet the need of the client.
2. Available level of care / barriers to ideal recommendation
  - a. If the substance use or substance use disorder 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 use level of care and service that the client can 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.

### PERTINENT BIOPSYCHOSOCIAL INFORMATION

## 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

[illegible]

## Notes

## 2. EMPLOYMENT / SCHOOL / MILITARY

- 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

[illegible]

**3. FAMILY / SOCIAL DESCRIPTION**

- a. History of use / treatment
- b. Family communication issues
- c. Family conflict evident  
(domestic, sexual, physical, neglect, etc.)

YES	NO

Notes

**4. DEVELOPMENTAL**

- a. Abandonment issues
- b. Significant childhood experiences

YES	NO

**5. SOCIAL COMPETENCY / 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. BEHAVIORAL HEALTH**

- 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

YES	NO

**7. INDIVIDUALIZED NEEDS**

- a. Spirituality
- b. Cultural issues impacting AOD use
- c. Anti-social values / beliefs

YES	NO

## Co-Occurring Evaluations

The co-occurring evaluation will contain all the elements found within the substance use evaluation, with the exception of Section M Recommendations, which will be implemented into Section O- Recommendations of the Co-Occurring Evaluation.

### M. MENTAL STATUS EXAMINATION

1. Appearance
  - a. Age
  - b. Gender, Race, Ethnicity
  - c. Body build
  - d. Position
  - e. Posture
  - f. Eye contact
  - g. Dress
  - h. Grooming
  - i. Manner
  - j. Attentiveness to examiner
  - k. Distinguishing features
  - l. Prominent physical abnormalities
  - m. Emotional facial expression
  - n. Alertness
2. Motor
  - a. Agitation
  - b. Abnormal movements
3. Speech
  - a. Rate
  - b. Volume
4. Affect
  - a. Appropriateness
  - b. Observation
  - c. Mood
5. Thought Content
  - a. Suicidal Ideation
  - b. Homicidal ideation
  - c. Paranoid ideation
  - d. Delusions
  - e. Other major themes discussed by client



## 6. Thought Process

- a. Associations
- b. Coherence
- c. Logic
- d. Stream
- e. Attention

## 7. Perception

- a. Hallucinations
- b. Illusions

## 8. Global Evaluation of Intellect

## 9. Insight

## 10. Mini-Mental State Exam

# N. DIAGNOSIS

# O. CO-OCCURRING RECOMMENDATIONS

## 1. Primary/Ideal level of care (what would best meet client needs)

- a. Identify the level of care and service(s) that would best meet the need of the client.

## 2. Available level of care/barriers to ideal recommendation

- a. If the 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 level of care and service that the client can be referred to.

## 3. Client/Family response to recommendations

- 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

## 4. Identification of who needs to be involved in the client's treatment

## 5. Treatment plan including transitioning to lower levels of care and discharge planning

## 6. A means to evaluate the client's progress throughout their treatment and outcome measures at discharge

## 7. Recommended linkages with community resources

## **Attachment 5: Nebraska Registered Service Provider's Program Plan for the Delivery of Treatment Services**

### **Nebraska Registered Service Provider's Program Plan for the Delivery of Treatment Services**

#### **Purpose of a Program Plan**

A Program Plan is a management document to assist with organization and to ensure consumers accomplish desired outcomes. Program Plans are used in determining whether a potential vendor/contractor has the capacity to serve consumers, achieve outcomes for a purchased service, and has policies, procedures and processes in place to begin service. The Program Plan should be written as if the target audience was staff, consumers, and members of the public.

#### **Consumer Participation**

There should be a mechanism for meaningful participation of consumers in the development, evaluation, and ongoing updates of a Program Plan.

### **I. Program Plan Content**

#### **A. Program Overview**

*This section should contain all of the following:*

1. The program's mission
2. The program's philosophy
3. Goals, objectives and specific outcomes
4. Description of the treatment modalities to be provided to achieve the program objectives and meet client needs
5. Population served, to include information about:
  - a. Age (children, adolescents, older adults; specify age ranges)
  - b. Sex
  - c. Gender (specifically women's issues)



6. Special populations served
  - a. for example: physical or cognitive disabilities, co-occurring substance use and mental disorders, rural populations, HIV positive, homeless, veterans, race and ethnicity, sexual orientation, criminal justice population.
7. Settings (i.e., description, addresses, phone and fax numbers)
8. Days of operation
9. Hours of operation
10. Frequency of services
11. Payer sources
12. Fees
13. Estimated length of stay for a consumer to successfully complete the program
14. Description of how the program includes evidence-based practices
15. Describe how program activities are designed to the specific needs of the program's consumers
16. Procedures for documentation, such as:
  - a. Progress notes and other relevant records include:
    - 1) Progress towards identified goals and objectives
    - 2) Significant events in the person's life
    - 3) Changes in frequency of services and levels of care
  - b. All documents generated by the organization include original (or electronic signatures), are signed, and are dated

## ***B. Client Rights and Responsibilities, Grievance and Complaints***

*This section should contain all of the following:*

1. Consumer Rights document with an all-inclusive list of rights
  - a. Rights should be written in language understandable to consumers and families.
  - b. The consumer should receive a copy of the Consumer Rights document
  - c. Date and duration of session/service and modality.
2. Procedures for informing consumers of rights
3. Addresses therapeutic consumer/staff relationships
4. System for reporting, investigating, and resolving allegations of abuse, neglect and exploitation
5. Complaint and Grievance procedure and documentation of actions taken toward resolution

### **C. Screening and Admission Criteria**

*This section should contain all of the following:*

1. Screening process; implementation of procedures for:
  - a. If/How screening is conducted and by whom
    - 1) Screening should include (and be documented):
      - a) Presenting problem
      - b) Referral source
      - c) Urgent and immediate needs
      - d) Legal status
      - e) Funding source
      - f) Whether the organization can provide the needed services based on appropriateness and eligibility criteria
2. Admission criteria
  - a. Appropriateness and eligibility criteria
    - 1) Must not exclude persons solely on the basis of previous admission record, marital status, race, sexual orientation, color, national origin, religion, or disability without adequate referral to appropriate services
    - 2) Restrictions (such as age, gender, etc.) must be clearly stated and justified in the program plan.
  - b. Level of treatment recommended
3. Description of specific admission processes with policies and procedures, to include:
  - a. How admissions are conducted
  - b. Who is responsible for making admission decisions

### **D. Assessment**

*This section should contain all of the following:*

1. Procedures that describe the assessment and information gathering process, including:
  - a. A description of how consumers, families, and others with collateral information are involved in the assessment
  - b. Identification of who is qualified and responsible to perform assessments
  - c. List of all screenings, tools, and evidenced base practices
  - d. A description of the system of referral to alternative services for those clients who do not meet admission criteria. (Referrals must be documented.)



2. Assessments should be strength-based and include the following (at a minimum), in accordance with the Standardized Model format:
  - a. Demographics
    - 1) includes age, sex, sexual orientation, gender, gender expression, marital status, spirituality, culture, housing, transportation, insurance
  - b. Presenting Problem / Primary Complaint
  - c. Medical History
  - d. Work / School / Military History
  - e. Alcohol / Drug History Summary
  - f. Legal History
  - g. Family / Social Peer History
  - h. Psychiatric / Behavioral History
    - 1) Trauma History
      - a) i.e., abuse/neglect, witnessing violence, natural disasters
      - b) When assessing trauma, the provider will provide appropriate intervention if needed and within the provider's scope of practice. (Referrals will be provided as necessary.)
  - i. Collateral Information
  - j. Other Diagnostic / Screening Tools – Score and Results
  - k. Clinical Impression
  - l. Recommendations
  - m. Attachment A: Pertinent Biopsychosocial Information
3. Referral mechanism and coordination with external providers when needs are identified
4. Specific time frames for assessments, reassessments/evaluations

## **E. Orientation**

*This section should describe the following:*

1. Time frame for orientation
2. How the consumer/family are oriented to the program following admission
3. Describe the systematic approach for keeping consumers involved and providing opportunities for feedback throughout all phases of the program
4. Documentation of an orientation that is understandable to the client and includes (at a minimum):
  - a. Explanation of rights and responsibilities
  - b. Notice of privacy practices (includes confidentiality)

- c. Complaint and appeal procedures
- d. How input can be given
- e. Consent to treat
- f. Intervention regarding danger to self, others, and abuse (i.e., mandatory reporting)
- g. Access to afterhours services and crisis intervention services
- h. Financial obligations
- i. Program policy regarding alcohol, drugs, prescription medication, weapons, violence
- j. Program policy regarding alcohol and drug use while participating in treatment services
- k. Conditions for administrative discharge
- l. Assessment process
- m. Transition and discharge criteria
- n. How the service (i.e., treatment) plan will be developed
- o. Explanation of provider collaboration with partnering agencies (e.g., behavioral health, criminal justice, medical, child welfare)

## **F. Treatment Plan**

*This section of the program plan should describe how the treatment plans in this organization contain the following key elements:*

1. Description of the treatment planning process and written procedures
  - a. Treatment planning is based on the client's strengths, and problems, abilities, identified in the assessment process
    - 1) For the criminal justice client, incorporates the elements of the Standardized Model, screening, and assessment tools
  - b. Identification of the person(s) responsible for service/treatment planning
  - c. Time frames for development and revision of the service/treatment plan
  - d. Consumer and family participation
  - e. Coordination of care to include (at minimum) staff, consumers and/or families, and criminal justice professionals as appropriate
2. Each treatment plan should include:
  - a. Identified problem statement(s), goals, objectives, and interventions specifically related to criminogenic risks (including substance use), identified needs, and strengths.
    - 1) Objectives are measurable, achievable, and have established time frames (i.e., a specific date)
    - 2) Interventions related to the accomplishment of the goal/objective which include a frequency



- b. Crisis/Relapse/Safety plans are developed and included, as applicable and within the provider's scope of practice. (Referrals will be provided as appropriate.)
- c. Treatment objectives for special populations served

## **G. Transition and Discharge Planning**

*This section should contain all of the following:*

1. Transition and discharge criteria:
  - a. Criteria should indicate when and how transition and discharge will be determined
  - b. Observable criteria, consistent with the program's purpose
2. Policies and procedures describing specific transition and discharge processes that include:
  - a. Specific time frames for transition and discharge planning and discharge summaries
  - b. Transition planning should begin upon admission
  - c. Identification of who is qualified and responsible for transition discharge planning and summaries
  - d. Referral mechanism and coordination with other programs in transition and discharge planning
  - e. Description of how consumers, families, and others are involved in transition and discharge planning
  - f. How the transition and discharge plans are incorporated into a consumer's treatment plan
  - g. Authorization to release and exchange information
3. Transition and discharge plans should include:
  - a. Crisis/relapse plan including triggers and interventions
  - b. Plan for follow-up, continuing care, services
  - c. Consumer's plan to further his/her recovery
4. Discharge summary description should include:
  - a. Admission and discharge dates
  - b. Reason for discharge
  - c. Describes the services provided
  - d. Diagnosis
  - e. Consumer progress in relation to the treatment plan (i.e., identified goals and objectives)
  - f. Medications prescribed upon discharge (if applicable)
    - 1) Indicate how medications will be obtained following discharge (if applicable) and the identified provider
  - g. Referrals and recommendations
  - h. Time frame for completion of discharge summary

## **H. Outcomes**

*This section should include all of the following:*

1. How the organization is collecting outcome measures.
2. Implementation of a performance improvement plan based on the outcome measure.
  - a. This could include client satisfaction survey, agency satisfaction survey, discharge planning satisfaction survey, outcomes measures.

## **II. Annual Review of the Program Plan**

Review of the plan should be conducted at least annually and as necessary to accurately reflect the services provided and dated.



## Attachment 6: 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 use disorder 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)

<b>Crisis Phone Line</b>	Clinician on-call for early intervention/screening/referral; available 24/7.
<b>Mobile Crisis / Crisis Response Teams</b>	Teams of professional and/or paraprofessionals that offer on-site screening usually in the home; brief interventions to stabilize the crisis and refer for
<b>SA Emergency Shelter or SA Respite</b>	SA Crisis/Crisis Respite or other appropriate service, and a thorough SA evaluation; available 24/7; includes access to a LADC.
<b>Emergency Community</b>	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.
<b>Support and Treatment</b>	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.

<b>Emergency Stabilization</b>	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 use disorder implemented, and coordination of services to help the client alleviate a substance abuse crisis; LoS varies but not longer than 14 days; on-site clinically managed and monitored; medically stable; limited nursing coverage.
<b>Medical Detox</b>	24-hour medically supervised alcohol/drug detoxification where severe medical issues are involved; 24/7; medical staff coverage.
<b>Social Detox</b>	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.
<b>Emergency Protective Custody (EPC)</b>	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.
<b>Civil Protective Custody (CPC)</b>	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)

<b>Screening</b>	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.
<b>Emergency SA Evaluation</b>	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 clinician 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.
<b>SA Evaluation</b>	All SA evaluations completed for justice clients must be completed by a clinician 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 intoxication 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 use disorder, 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 <b>Community Support</b>	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
LV 2 <b>Intensive Outpatient Counseling</b>	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 <b>Partial Care</b>	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 intoxication or withdrawal and few biomedical complications; 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.



<p>Lv 3</p> <p><b>Halfway House</b></p>	<p>CLINICALLY MANAGED, LOW INTENSITY: Non-medical transitional residential program for persons who as with chemical dependency or substance use 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.</p>
<p>Lv 2</p> <p><b>Therapeutic Community</b></p>	<p>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.</p>
<p>Lv 2</p> <p><b>Dual Residential (MH/ SA)</b></p>	<p>CLINICALLY MANAGED, MEDIUM-HIGH INTENSITY: Non-medical, simultaneous, integrated substance abuse and mental health residential. Residential treatment for persons with co-occurring primary chemical dependence <b>AND</b> 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.</p>
<p>Lv 2</p> <p><b>Extended Residential</b></p>	<p>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</p>
<p>Lv 1</p> <p><b>Short Term Residential</b></p>	<p>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.</p>

# Appendix I: Examples of Process and Outcome Measures for the Supervision of DWI Probationers

## 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 probationers, or the extent to which probationers 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 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 probationers include, but are not limited to:

- the percent of DWI probationers screened for AOD history;
- the percent of AOD screenings that required a further substance use disorder evaluation or assessment;
- the percent of DWI probationers 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;
- the percent of incentives used for each probationer during a six-month period;
- the percent of revocation proceedings resulting from technical violations;
- the percent of probationers with case plans;
- the percent of probationers involved with supervision officers in developing behavioral contracts;
- the percent of probationers referred to community substance use disorder treatment;
- the number of treatment providers receiving information from the supervision officer relating to criminogenic risk/needs of the probationer;
- 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 probationers reassessed according to agency policy;
- the percent of probationers attending outpatient and/or inpatient treatment;
- the percent of case plans implemented by agency standard;
- the percent of DWI of probationers accepted by various AOD treatment agencies;
- the percent of supervision officers trained in motivational interviewing.

## COMMUNITY SUPERVISION OF DWI DEFENDANTS PROCESS MEASURE EXAMPLE

<b>Program:</b>	<b>AOD Screening</b>
<b>Standard/Objective:</b>	<b>All DWI defendants must receive an AOD screening before being sentenced by the court.</b>
<b>Process Measure:</b>	<b>Percent of DWI defendants receiving an AOD screening</b>
<b>Data Elements:</b>	<b>Number of DWI defendants being sentenced, number of AOD screenings</b>
<b>Formula:</b>	$\frac{\text{Number of DWI Defendants receiving AOD screening within timeframe}}{\text{Number of DWI Defendants sentenced within the timeframe}}$
<b>Example:</b>	<p><b>There were 100 DWI defendants sentenced during a six-month period.</b></p> <p><b>100 offenders received an AOD screening.</b></p>

100 received an AOD screening

100 DWI offenders sentenced within a six-months period x 100 = 100%

THE COMPLIANCE RATE FOR RECEIVING AN AOD SCREENING IS 100%.

STANDARD/OBJECTIVE WAS ACHIEVED.

**COMMUNITY SUPERVISION OF DWI DEFENDANTS PROCESS MEASURE EXAMPLE**

<b>Program:</b>	<b>Presentence reports</b>
<b>Standard/Objective:</b>	<b>The court will receive a presentence report on all DWI defendants prior to sentencing.</b>
<b>Process Measure:</b>	<b>Percent of presentence reports received by the court prior to sentencing within timeframe</b>
<b>Data Elements:</b>	<b>Number of DWI defendants being sentenced, number of presentence reports prepared within timeframe</b>
<b>Formula:</b>	<b><u>Number of presentence reports prepared for DWI Defendants within timeframe</u> Number of DWI Defendants sentenced within timeframe</b>
<b>Example:</b>	<b>There were 100 DWI defendants sentenced during a six-month period. 95 presentence reports were prepared during the six-month period.</b>

95 presentence reports were prepared during a six-months period  
100 DWI defendants were sentenced in a six-months period x 100 = 95%  
THE COMPLIANCE RATE FOR PREPARING PRESENTENCE REPORTS IS 95%.  
STANDARD/OBJECTIVE WAS NOT ACHIEVED.

## COMMUNITY SUPERVISION OF DWI DEFENDANTS PROCESS MEASURE EXAMPLE

<b>Program:</b>	<b>Individualized Case Plans</b>
<b>Standard/Objective:</b>	<b>All DWI defendants will have an individualized case plan developed within six weeks of being placed on community supervision.</b>
<b>Process Measure:</b>	<b>Percent of DWI defendants with an individualized case plan developed within six weeks of being placed on community supervision.</b>
<b>Data Elements:</b>	<b>Number of individualized case plans completed within the timeframe. Number of DWI defendants sentenced during timeframe.</b>
<b>Formula:</b>	<b><u>Number of individualized case plans completed within timeframe</u> Number of DWI Defendants sentenced within timeframe</b>
<b>Example:</b>	<b>There were 100 DWI defendants sentenced during a six-month period. Individualized case plans were completed for 50 DWI defendants within six weeks.</b>

**50 individualized case plans completed within six weeks**  
**100 DWI defendants were sentenced in a six-months period x 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 PROBATIONERS OUTCOME MEASURE EXAMPLE

<b>Program:</b>	<b>Number of Positive Urine Tests for Drug Use</b>
<b>Standard/Objective:</b>	Track the percent of DWI probationers with a positive urine test for the use of drugs.
<b>Process Measure:</b>	Percent of DWI probationers given a urine test who test positive for drugs during a specific timeframe.
<b>Data Elements:</b>	Number of DWI probationers on supervision who test positive for drugs during a specific timeframe. Number of DWI probationers tested during the timeframe.
<b>Formula:</b>	$\frac{\text{Number of confirmed positive tests}}{\text{The number of offenders tested}}$
<b>Example:</b>	<p>During a three-month timeframe, there were 78 positive drug tests among the 409 DWI offenders who were tested.</p> $\frac{78 \text{ positive tests}}{409 \text{ DWI Probationers tested}} \times 100 = 19\%$

### THE RATE OF POSITIVE DRUG USE FOR DWI PROBATIONERS 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 PROBATIONERS OUTCOME MEASURE EXAMPLE**

<b>Program:</b>	<b>Substance use disorder Treatment</b>
<b>Standard/Objective:</b>	<b>All DWI probationers will participate in substance use disorder treatment as a condition of supervision.</b>
<b>Outcome Measure:</b>	<b>The percent of DWI probationers participating in substance use disorder treatment</b>
<b>Data Elements:</b>	<b>Number of DWI probationers in AOD treatment during the timeframe, number of DWI offenders during the timeframe.</b>
<b>Formula:</b>	<b><math display="block">\frac{\text{Number of DWI probationers in AOD treatment}}{\text{Number of DWI Offenders}}</math></b>
<b>Example:</b>	<b>During a three-month timeframe, there were 78 positive drug tests among the 409 DWI offenders who were tested.</b> <b><math display="block">\frac{78 \text{ positive tests}}{409 \text{ DWI Probationers tested}} \times 100 = 19\%</math></b>

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

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

## COMMUNITY SUPERVISION OF DWI PROBATIONERS OUTCOME MEASURE EXAMPLE

<b>Program:</b>	<b>Discharges from Supervision</b>
<b>Standard/Objective:</b>	Track all DWI probationers terminated from community supervision by type, (e.g., revoked, early termination, and expired full term) during timeframe.
<b>Process Measure:</b>	Percent of DWI probationers discharged that that supervision expired full term during timeframe. Probationers expired full term during timeframe, total number of DWI probationers terminated during timeframe.
<b>Formula:</b>	<u>Number of DWI probationers expired full term during timeframe</u> Total number of DWI Probationers terminated within timeframe
<b>Example:</b>	236 DWI probationers were discharged with an expired full term during 2008. 350 DWI probationers were discharged from supervision during 2008.

236 discharge – expired full term

350 DWI probationers 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 from 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 misdemeanor offenders as felony offenders are being supervised.
- The number of new cases exceeds the number discharged cases in both felony and misdemeanor cases.
- Three-fourth of respondents indicated alcohol was the substance used by offenders at the time of their arrest.

### *Reports*

- 27 percent require presentence reports in all cases/42 percent require alcohol evaluation.
- 38 percent require presentence reports on some offense levels/36 percent require alcohol evaluation.
- 72 percent of the programs not requiring presentence 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 another 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 use disorder or repeat DWI offenders (e.g., entry level academy, State and local training, general substance use disorder 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 use disorder 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.
- Driver 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 use disorder education is required in 54 percent of the programs.



- 60 percent of programs require victim impact panels.
- Driver 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 is 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 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 programs 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 use disorder treatment.
- 74 percent of programs will not collect data on the number leaving substance use disorder treatment without completing.
- 53 percent of programs will not collect data on the results from random drug testing.

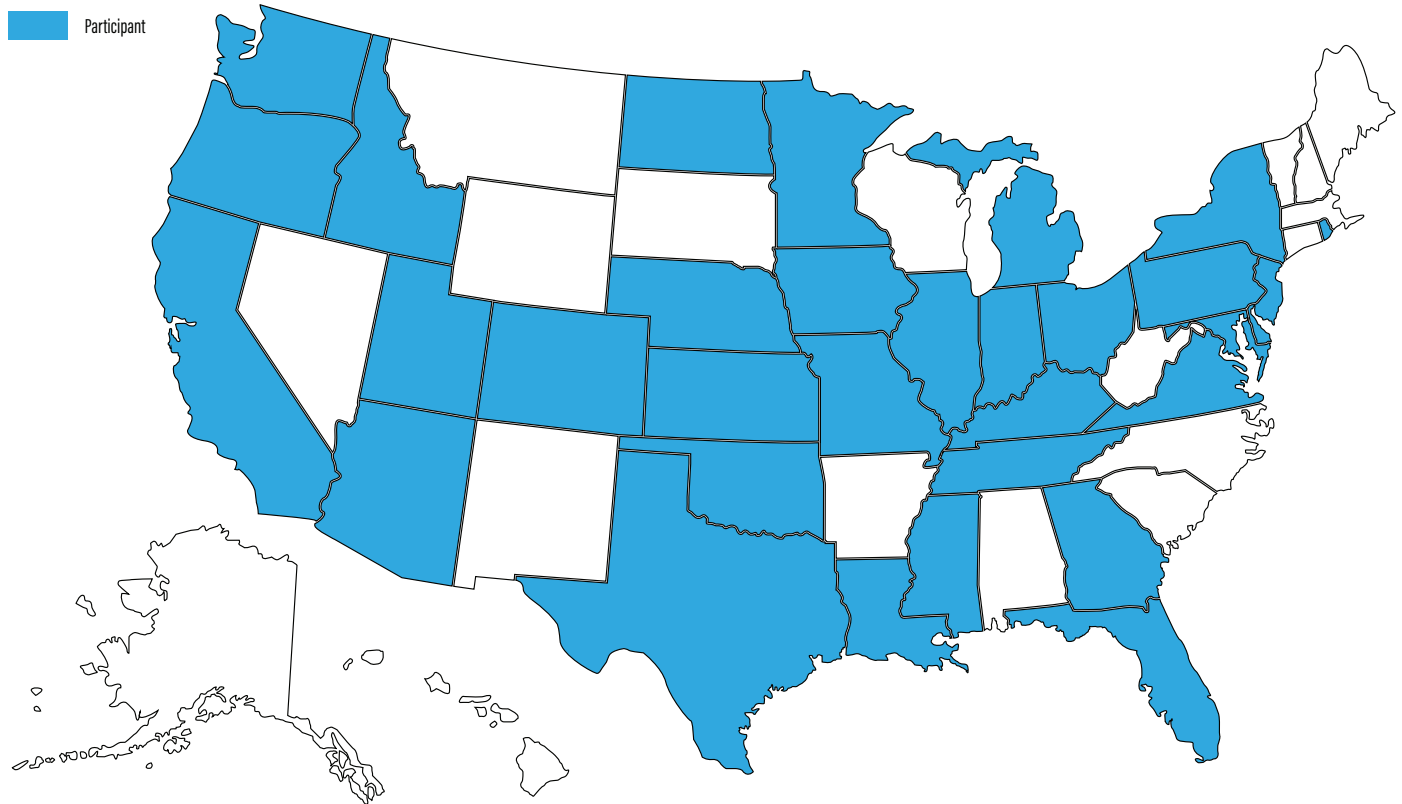
## Evaluation

- 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 presentence 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

## Appendix J: States that Participated in APPA Questionnaire



## Appendix L: Screening for Risk and Needs Using the Impaired Driving Assessment

### SCREENING FOR RISK AND NEEDS USING THE IMPAIRED DRIVING ASSESSMENT



U.S. Department of Transportation  
National Highway Traffic Safety  
Administration

