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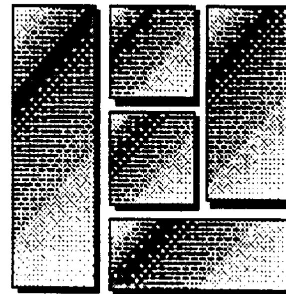
CONFRONTING RELAPSE AND RECIDIVISM: CASE MANAGEMENT AND AFTERCARE SERVICES IN THE OPTS PROGRAMS



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EXECUTIVE SUMMARY

Overview

The Opportunity to Succeed (OPTS) program was designed to reduce substance abuse relapse and criminal recidivism by providing comprehensive aftercare services to felony offenders who have alcohol and drug offense histories. Enrollment in OPTS was anticipated to improve access to, and utilization of, needed community-based services by eligible probationers/parolees. In addition to supporting sobriety and reducing criminal activity, OPTS services were expected to promote pro-social attitudes and behaviors among participants, resulting in such desirable outcomes as gainful employment and responsible family/domestic arrangements.

The Opportunity to Succeed Mission

Opportunity to Succeed programs are intended to deliver community-based services that promote sobriety, law-abiding, and other pro-social behavior in adult, substance-abusing felons. The program rationale is that such offenders are less likely to relapse and engage in future crimes if they are exposed to a comprehensive suite of aftercare services (including substance abuse treatment, counseling, and skills-building activities), as well as graduated sanctions that include incentives for positive behavior and penalties for failure to comply with program requirements. Service delivery is structured around case management, involving collaborative partnerships between a lead service agency and the local probation/parole office in each demonstration site.

OPTS programs were initiated in 1994 as three-year demonstrations in five communities -- Kansas City, MO; New York City, NY; Oakland, CA; St. Louis, MO; and Tampa, FL. The program model was developed by The National Center on Addiction and Substance Abuse (CASA); both program implementation and evaluation occurred under CASA's administrative oversight. The demonstration programs were funded by the Robert Wood Johnson Foundation (RWJ) and the Bureau of Justice Assistance at the U.S. Department of Justice. OPTS programs continued in three of the original sites beyond the demonstration phase, which concluded in Summer, 1997. The National Institute of Justice (NIJ) and RWJ funded The Urban Institute's evaluation of OPTS implementation and impact in three communities -- Kansas City, MO; St. Louis, MO; and Tampa, FL.

OPTS pairs local probation/parole departments -- offices of the Missouri Department of Corrections in Kansas City and St. Louis, and the Florida Department of Corrections in Tampa -- with lead service agencies that provide case management and other social services. The primary service providers -- The National Council on Alcoholism and Drug Dependence (Kansas City), the Drug Abuse Comprehensive Coordinating Office (Tampa), and Lutheran Family and Children's Services (St. Louis) -- directly delivered some treatment and supportive services to

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adult probationer/parolees (as well as provided limited assistance to their family or domestic networks), in addition to referring OPTS clients to other service providers with whom the sites had established MOUs or close working relations.

The research used an experimental model that randomly assigned eligible felons to either the OPTS program (treatment group) or routine supervision (control group). Program implementation was documented by researchers using a number of techniques, including field visits to directly observe program activities; one-on-one interviews and small group discussions with staff, and separately with clients; and secondary analysis of program materials (e.g., memoranda of agreement, brochures, newsletters).

This report describes the major components of the OPTS model, including aspects of case management and supervision, as well as core services offered to OPTS clients in each of the five core domains in the three selected sites (see Morley et al., 1995, 1998; and Rossman et al., 1998a, 1998b, for other OPTS documentation reports).

OPTS Core Services

- **Substance abuse treatment**, ranging from 12-step programs through intensive residential placements, is a key component of the OPTS model.
- **Employment services** that assist clients in finding and maintaining legitimate employment.
- **Housing**, including adequate, drug-free supportive living situations, such as halfway houses, group houses, and apartments to share, to assist clients in avoiding relapse.
- **Family strengthening services**, such as parenting classes, family counseling, anger management, and domestic violence counseling.
- **Health and mental health services**, ranging from regular check-ups to specialized care when needed, are envisioned since substance abusers often have a wide variety of physical and mental health problems.

Although the model calls for the provision of these core services, it does not expect that each OPTS client will require the full spectrum of support. Rather, services are to be provided on an as-needed basis. The exception to this is the substance abuse treatment, which is a mandatory requirement for all participants.

This report also assesses selected service utilization attributes and outcomes, including such considerations as: 1) the use of specific categories of services (e.g., housing, family skills training, education or training programs); 2) the variety and comprehensiveness of services supporting individuals; 3) the service intensity, i.e., the number of contacts and duration of utilization by service type; and 4) recipients' reported level of satisfaction with the services they received.

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Key Findings

There was a high degree of variation among the sites in terms of program implementation, consistent with the model's intent to allow flexibility and autonomy in local decision making and practices. For example, sites were expected to use existing community-based resources, in preference to developing their own services. Thus, it is not surprising that the suites of services and mix of providers varies dramatically across the three programs, as these reflected the extant service networks and capacities in Kansas City, St. Louis, and Tampa. Other site variations likely resulted from the visions, internal organizational structures, and decision making of the lead agencies and/or the partnering probation and parole agencies regarding the roles and responsibilities of their respective staffs. For example, St. Louis was the only one of the three sites to use a team approach that co-located case managers, POs, and core service providers from the substance abuse treatment and employment service areas.

In general, the sites were satisfied with their efforts in mounting this demonstration; however, both line staff and administrators acknowledged areas of weakness as their programs evolved. To their credit, individuals and organizations were often quite proactive in defining weak or troublesome elements and introducing refinements that could strengthen their local efforts.

Case Management

A key feature of the OPTS model is its use of case management. Although the model does not specify the form case management should take, it does imply that case management should involve service planning; service provision, either directly by lead agency staff or using brokered services; and monitoring of client progress. Case manager contact also facilitates the intensive supervision anticipated by the OPTS model (as an adjunct to probation officer oversight). Overall, OPTS clients generally appreciated their case managers, viewing them as advocates who supported and motivated them.

- OPTS clients had considerable amounts of contact with their case managers, particularly in their early stages of OPTS participation. Clients experiencing a crisis situation (e.g., having a relapse, being evicted) or those with particularly difficult problems received more focused attention until the situation was resolved. Overall, 69% of clients reported they met with their case manager at least weekly during the first three months of participation in OPTS, and 19% of this group reported daily or almost daily meetings during that time period; 25% of clients reported daily telephone contact during that timeframe. Frequency of case manager-client contact diminished over time, as planned by the sites. By the last three months of their first year in OPTS, only 35% of clients reported weekly contact with case managers.

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Similarly, OPTS clients received considerably more contact in the form of home visits from their case managers than from their probation officers. Approximately 28% of OPTS clients reported receiving more than one home visit per month from their case manager during the first year of OPTS participation, while only 10% reported that frequency of home visitation from their PO.

- Ideally, case managers should have expertise in a variety of areas, including the ability to: develop resources, make clinical assessments or at least understand them across disciplines (i.e., medical, mental health, substance abuse treatment, etc.), and deliver direct services. In practice, case managers had various professional backgrounds and levels of expertise; some were new to the local area, or new to the field, and were unfamiliar with local resources and how to access them. As a result, sites encountered several case management hurdles, including: 1) consistent and appropriate service planning as a basis for brokering or directly delivering individualized suites of services; 2) familiarity with services across multiple, key domains; and 3) balancing the intense demands of crisis management, with the responsibility to perform routine case management and service provision.

- Case management could be strengthened by involving a broader range of professionals and para-professionals in service planning -- perhaps through use of team case management, which might take a form similar to the St. Louis approach. A team approach may diffuse the burdens of decision making, and the stresses associated with high-maintenance clients, and enhance decisions by drawing on the insights and skills of other staff. Having clinicians or other skilled diagnosticians as part of the OPTS team would be useful, given some of the challenges encountered.

  In addition, a team approach creates a form of back-up system for case managers. By participating in team meetings, case managers and other involved professionals develop sufficient familiarity with each others' cases to enable a client's needs to be met by a back-up case manager, when the assigned case manager has limited availability due to crises or emergency situations with other clients.

- Sites generally did not institutionalize or formalize procedures for case management and related functions, resulting in some inconsistency of practices across case managers, particularly when staff turnover occurred. It is important to develop guidelines outlining case management responsibilities and how these are to be performed, and identifying those activities and decisions (e.g., ordering urinalysis, imposing sanctions, meeting with clients) to be performed individually

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by case managers, and those to be performed in conjunction with POs. This ensures consistency of practice across staff, facilitates training of new staff, and helps ease transitions. Similarly, establishing standard procedures/mechanisms for recording information in client case files is desirable, to enable other staff to readily understand a client's status in case of the need to "pinch hit" for the regular case manager, or to ease transitions when there is staff turnover.

- Although local programs were provided with management information systems (MIS) as part of the demonstration, these were not used as extensively as optimally desired to record client and service information, and they were *not* used as a tool for such case management purposes as updating service plans and making decisions as when to graduate or terminate clients. Use of the MIS for such purposes could facilitate decision-making and contribute to greater consistency in treatment of clients.

Supervision and Monitoring

Frequent contact with the case manager, combined with standard levels of contact with the probation/parole officer, was expected to result in the more intensive supervision envisioned by the OPTS model. Such increased supervision is intended to enable early identification of problem behaviors or service needs, facilitating rapid and appropriate responses in the form of graduated sanctions or incentives, to either reinforce positive behavior or institute corrective actions to mitigate unacceptable behavior. Frequent urinalysis testing was intended to be a key element of intensive supervision under the OPTS strategy. Another important element of the OPTS model was use of sanctions and incentives -- intended to "give teeth" to the increased supervision.

- In practice, urinalysis testing did not occur as frequently as anticipated -- in part because the programs did not follow a regular protocol or schedule that ensured frequent testing of all clients. Staff exercised discretion in ordering urinalysis, resulting in more frequent testing for new clients and those whose sobriety was suspect. During the first six months of OPTS participation, clients in the three sites combined reported receiving an average of approximately 11 drug tests, compared with approximately 8 tests during the last six months of their first year. Overall, most OPTS clients were not tested as frequently as probationers involved in drug court programs, although they were tested more frequently than the control group under routine supervision. Approximately 14% of OPTS clients reported that they were *never* tested during their first year of OPTS participation.

- Prompt receipt of test results is a key factor in their usefulness, since this enables case managers and POs to act on violations in a timely way. Time lags in obtaining test results were a problem encountered at various times. Some sites

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addressed this by using field test kits, which provide immediate results, but have the drawbacks of detecting limited numbers of substances, and with costs escalating if testing was needed for more than a single substance. Others identified laboratories that guaranteed return of results within a specified time frame (e.g., one day) -- but paid more for their services.

- Use of sanctions and incentives under OPTS was largely idiosyncratic, rather than the systemized approach envisioned by the model. Sanctions and incentives were not always spelled out in advance, and they were not always consistently applied, limiting their effectiveness. Recent research on drug courts (Harrell et al., 1999) indicates that successful programs forge an understanding with program participants of behavioral requirements and consequences -- perhaps in the form of a contract that specifies the consequences for particular infractions. Consistency in application of incentives and sanctions (underscoring the certainty of consequences), immediacy of the penalty or reward, and salience of sanctions to the offender also have been found to be key elements of successful programs.

- Despite requirements for participation in substance abuse treatment, approximately 16% of OPTS clients reported they did not participate in any treatment services -- apparently most of these without the knowledge or agreement of the case managers or POs. Implementing and adhering to procedures for monitoring client compliance is highly desirable to detect relapse or other violations at an early stage. Practices that appear most useful for this purpose include: more frequent drug testing; use of logs clients can bring to service providers (e.g., AA/NA meetings) to have their attendance recorded; and having case managers follow-up with service providers to verify receipt of services and adherence to program protocols.

Service Provision

Achievement of OPTS objectives is dependent, at least in part, on carrying out the model's objective of increasing ex-offender involvement in social service programs. The local programs tried to identify, broker, or directly deliver a wide range of services within the targeted domains. Prior to (or shortly after) program implementation, local programs implemented agreements (generally in the form of Memoranda of Understanding or Agreement) with a limited number of service agencies to furnish core services. Under optimal circumstances, the OPTS approach would not only use existing resources, but also assess the "holes" in the continuum of care, and creatively build partnerships within and across service provider networks to bridge the gaps. Despite the challenges associated with identifying and securing services for OPTS clients, a considerable range of service providers and services in the core domains was evidenced across sites. The lead agencies also functioned as service providers in all sites, providing one or more

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core services in addition to counseling or therapeutic interventions associated with case management.

- OPTS clients can be characterized as having vulnerabilities in multiple domains. In the 90 days prior to their most recent incarceration, 78% of OPTS clients acknowledged alcohol use; 44% used marijuana, and 51% used crack cocaine. Many faced severe problems, some of which had not been diagnosed or treated previously, while others had comparatively few issues to address. Some clients posed greater challenges than others -- because of special needs, such as dual diagnosis; personal characteristics; or resistance to services. In some instances, problems or failures in service provision may have been due to faulty assessment or referral to programs that were inappropriate for clients with certain types of problems. In some cases, referral decisions were based on availability of space when service was needed, rather than on the best match for a particular client's needs.

- It appears that an adequate continuum of community-based services was developed in the three sites. Substance abuse treatment represents the service component most widely and consistently implemented across sites, followed by the employment and job training component, housing, and health and mental health components. Parenting skills was the least fully implemented component. Availability of drug-free housing, transportation, health care, and dual diagnosis services represent the most frequently reported gaps in the continuum of services. One case manager in Tampa noted a lack of "innovative" treatment as a gap in substance abuse treatment services; for example, treatment featuring acupuncture or alternative, holistic techniques is limited. Gaps also were encountered in programs that meet the needs of clients with special circumstances (e.g., HIV, dual diagnosis).

- Co-location of services -- including case managers and probation officers -- is beneficial to clients, staff, and service providers. "One-stop shopping" is more convenient for clients -- it conserves time and also their limited resources (such as money for transportation to various locations). Team members liked the face-to-face interaction across agency lines, and the opportunity to share decision making, particularly when it came to trouble-shooting difficult cases.

- In addition to offering core services, it is vital for programs to provide services that mitigate situations that may be critical barriers to client success. Lead agencies went beyond the five core service areas to address a variety of client needs, such as: transportation assistance (e.g., bus passes) to permit clients to access needed services, or to facilitate job-hunting and steady employment; clothing for job interviews or employment (e.g., work boots or uniforms); emergency services, such as food and clothing; and funding to facilitate

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acquisition or retention of stable housing (e.g., rental deposits, utility costs). Similarly, they performed an advocacy role in clients' interactions with criminal justice or social service systems, or an interventive role to address various emergency situations (e.g., domestic or housing crisis).

- On-going resource development on the part of case managers was critical to adequately supplement service deficits that developed because of the dynamic nature of local service environments. Existing programs might abruptly close or change key features (such as eligibility requirements or service modalities) in response to political or fiscal factors -- affecting service options for OPTS clients. The sites expanded the network of service providers beyond those identified in the core partnerships to fill gaps in service, for redundancy, to ensure availability of service where programs had limited capacity, or to meet clients' unique needs.

- Formation of a community-wide service cabinet with regular meetings was an approach successfully used in one site. The cabinet engaged providers of commonly used services to discuss service delivery issues affecting clients, and promoted stronger collaboration and common understanding of the program. Such cabinets promote familiarity with the changing configuration of local service resources and their strengths and limitations, as well as serving as a forum to identify gaps in services, capacity issues, or other barriers to service delivery.

Systems Integration and Program Institutionalization

At its inception, the OPTS program implicitly linked two separate systems -- social services and criminal justice. The model envisions collaboration between case managers and POs to provide enhanced client supervision and service provision. Although local partnerships were developed during the OPTS planning phase, such partnerships typically engaged the lead service agency and the cognizant probation/parole department, but not other branches of the criminal justice system. Further, in some sites, the lead agency-probation office partnerships were implemented loosely, sometimes based on the goodwill and face-to-face relationships established among individuals, rather than more formally erected on systems or structural integration, backed by institutionalized policies and procedures.

- Steps should be taken early in the initiative to carefully identify and engage major stakeholders. To some extent, the potential for success of OPTS programs may have been curtailed by the relative absence of the courts (particularly judges) and correctional facility administrators during planning and implementation periods, and on advisory boards. OPTS programs were sometimes constrained in their abilities to carry out service placement and supervision, or to implement graduated sanctions, in part due to the actions of judges who court-ordered offenders to other kinds of programs or supervision outside of the OPTS network.

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- Coordination with correctional facilities is critical to enable advance service planning to help facilitate a smooth transition to community-based aftercare. In St. Louis, OPTS case managers, POs, and sometimes other core team members traveled to the correctional facility where most OPTS clients were detained to meet them, explain the program, and begin developing service plans prior to their release. In the absence of such coordination, correctional facilities often did not inform probation officers in advance of an offender's actual release, leaving it up to the offender to report to their PO within a stipulated time frame (e.g., 72 hours). Although most complied, some did not -- sometimes resulting in long time lags before individuals were linked to case-managed services, including the required substance abuse treatment. In some cases, these offenders never attached to OPTS, and were subsequently terminated from the program as absconders.

- The philosophy or attitudes of the probation/parole agency in particular can affect the success of programs such as OPTS. More conservative departments may not embrace the treatment and sanctions orientation of OPTS, and the atmosphere in such departments may not be conducive to accommodating or nurturing such a program. Thus, care should be exercised in selecting the probation "unit" in which the program is housed, to ensure that not only dedicated probation officers, but also their supervisors, are supportive of program goals (e.g., both should have a treatment-oriented approach, rather than traditional supervision approach).

- Given the pivotal roles of the lead service agency and lead probation/parole department, it is important to take steps to clearly identify and institutionalize the roles and responsibilities of these organizations and, by extension, of case managers and POs. It is crucial to develop clear understandings regarding respective roles and values, and to articulate a shared vision for the initiative. Policy boards, service cabinets, and similar structures at the policy level, and practices such as cross-training and staff meetings for line staff provide a forum for consensus building about program goals and objectives, as well as facilitate discussion among key players concerning roles, responsibilities, and values.

- The strongest collaboration was demonstrated at a site that employed various mechanisms designed to promote information sharing, joint decision making, and buy-in among staff at both the systems level (top administrators) and service delivery level (including supervisory and line staff). Practices implemented included: co-location of key staff (including core service providers), routinized report structures, regular meetings, and shared responsibility for executing program tasks (e.g., joint home visits, meetings with clients).

- Staff turnover, at both the policy and program level, threatens the stability and longevity of the initiative. The loss of key administrators can be detrimental, since individuals who replace them may lack the institutional memory, shared vision,

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and understanding of -- or commitment to -- the initiative. Likewise, staff turnover at the program level may adversely affect continuity and quality of service provision. Policies should be implemented to reduce the likelihood of staff loss (e.g., careful selection of line staff to ensure their suitability for this type of initiative, practices that mitigate burn-out) and, where that is not feasible, to ensure smooth transitions (e.g., manuals and guidelines documenting the program's evolution and operations).

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CHAPTER 1
THE OPPORTUNITY TO SUCCEED INITIATIVE

The OPTS Model

The OPTS initiative was designed to deliver aftercare services to substance-abusing felons, who are returning to the community after a period of incarceration that included treatment for alcohol or drug abuse. The program intervention is designed to: 1) reduce the prevalence and frequency of substance abuse and associated criminal behavior; 2) strengthen the positive ties of probationers and parolees to work, family, and community; 3) increase offender involvement in social service programs and primary health care; and 4) enhance the coordination and integration of parole/probation agencies and social service providers.

A key supposition underlying the OPTS intervention is that alcohol and drug abuse are disorganizing factors that increase the likelihood offenders will continue to engage in criminal activity. This is consistent with research that documents both 1) the disproportionate amount of crime perpetrated by substance-abusing individuals and 2) the linkage between frequency of substance abuse and severity of criminal behavior (Anglin and Maugh, 1992; Chaiken, 1989; Field, 1989; Innes, 1986; Leukefeld, 1985; Vito, 1989).

Since a significant amount of U.S. crime during the past three decades has been directly related to substance abuse, criminal justice officials have implemented numerous programs -- extending as far back as the 1966 Narcotic Addict Rehabilitation Act (NARA) -- designed to mitigate the problems associated with drug-abusing offenders. Such efforts, which have generated mixed results in terms of effectiveness, have included special drug courts, deferred prosecution programs, supervised pre-trial release with a treatment requirement, drug-testing programs, Treatment Alternatives to Street Crime (TASC) diversionary programs, Intensive Supervision Programs (ISPs), therapeutic communities (TCs), and halfway houses for probationers or parolees (Anglin and Maugh, 1992; Falkin and Natarajan, 1993; Field, 1989; Hayes and Schimmel, 1993; Inciardi, Lockwood, and Quinlan, 1993; Leukefeld, 1985; Minor and Hartmann, 1992; Pearson and Harper, 1990; Petersilia and Turner, 1990, 1993; Van Stelle et al., 1994).

Increasingly, researchers and practitioners have recognized that substance abuse tends to be one of a constellation of dysfunctional circumstances, rather than occurring in isolation. Many substance-abusing offenders lead disadvantaged lives, characterized by multiple problems that include inadequate job and interpersonal skills; educational deficiencies; inappropriate housing; and poor health, sometimes related to low income and lack of access to health care resources, but sometimes directly related to drug-induced illness and disease (e.g., hepatitis, tuberculosis, HIV/AIDS) (Martin and Scarpitti, 1993). Consequently, believing that holistic approaches will increase the likelihood of achieving successful resolution of clients' issues, some

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contemporary programs have incorporated multi-disciplinary sets of services to simultaneously address problems that clients experience in different domains.

The OPTS model falls within this vein. OPTS programs are built around primary partnerships of probation/parole departments and human service organizations that jointly oversee supervision and service delivery to eligible offenders. The model envisions collaboration between case managers and probation/parole officers to ensure enhanced client supervision and service provision. A strong partnership of service and supervision is anticipated based on keeping caseloads small for both case managers and probation/parole officers (POs); designating only a single PO in each demonstration site as the dedicated OPTS PO; and co-locating service and supervision staff, where feasible.

The program strategy aims to achieve reductions in substance abuse relapse and criminal recidivism, as well as increases in other pro-social behavior, through the provision of aftercare services in five core areas:

- **Substance abuse treatment aimed at relapse prevention** is a mandatory component of the OPTS model. Treatment modalities range from 12-step programs through intensive residential placement; services also include drug use monitoring and support groups.

- **Employability training and employment services** include various nterventions that assist clients in finding and maintaining legitimate employment. Gainful employment is a requirement of probation/parole supervision. For some individuals, suitability for employment may be related to educational deficits that can be mitigated by GED completion or vocational training; for others, employment services may be more limited (e.g., assistance in preparing resumes and identifying job openings).

- **Housing** is a central concern of probation/parole supervision since incarcerated offenders cannot be released without a home plan indicating that satisfactory living arrangements have been designated. Housing services include placement in drug-free, supportive environments (e.g., halfway houses, group houses, and apartments to share), as well as other related emergency services such as crisis assistance if a domestic situation suddenly deteriorates and requires immediate relocation, or provision of emergency funds to cover unexpected expenses (e.g., unusually high utility bills).

- **Family strengthening services** include parenting training, family counseling, anger management and domestic violence counseling to help clients end violent or destructive behaviors, or other family interventions that assist clients in assuming responsibility for their children and generally strengthening their family relationships.

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- **Health and mental health services**, ranging from routine examinations to specialized care when needed, since substance abusers often have a wide range of physical and mental health problems. These problems may or may not be directly related to substance abuse, but either way may have an influence on treatment outcomes. For example, some clients may be dually diagnosed or may enter the program with serious illnesses (e.g., HIV/AIDS or tuberculosis), requiring substantial medical support.

Further, the model anticipates close supervision, including 1) increased drug testing and 2) the use of graduated sanctions, developed by the lead service agency and the probation/parole office at each site, for program violations (such as "dirty" tests).

The model underscores that OPTS is not designed to supplant existing service strategies in the community. It is, however, intended to build upon and coordinate existing systems of service delivery. The primary partner agencies (probation/parole and lead service organizations) are expected to coordinate their efforts with a network of community-based service providers, leveraging existing services and filling gaps in service provision, as needed.

The OPTS Sample

The OPTS evaluation uses an experimental design: 398 eligible offenders were randomly assigned to receive either OPTS case-managed services (the treatment group) or routine probation/parole supervision (the control group). Offenders returning to targeted neighborhoods were eligible for participation in the study if they: 1) were required to serve a minimum of one year of probation/parole; 2) had a history of substance abuse; 3) had completed a substance abuse treatment program while incarcerated or in a court-ordered residential facility in lieu of jail (see Appendix A for brief descriptions of the programs from which OPTS participants were drawn); 4) had felony convictions, excluding violent crimes or sex offenses; and 5) were 18 years of age or older. The research cohort was recruited between mid-winter, 1995, and September, 1996. Treatment group participants could receive aftercare services through OPTS for a maximum of two years.

The Research Design

The national evaluation includes process, impact, and cost and benefit analyses based on multiple sources of information. Evaluation activities included cross-site documentation of program development, implementation, and operations. Such analyses were designed to describe client characteristics and program participation, as well as to: 1) examine the nature of partnerships between key organizations, 2) assess the efficacy of various program components and processes, 3) develop understanding of barriers to program implementation, and 4) identify strategies that were successful in mitigating such obstacles.

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The general causal model guiding the national evaluation is that the OPTS program facilitates substance abuse aftercare designed to strengthen offenders' pro-social bonds and reduce risks (such as unemployment, educational deficits, poverty, family instability, housing deficits, and impaired physical or mental health). Such interventions are intended to diminish the clients' use of alcohol and drugs, and hence their propensity to engage in criminal behaviors. This, in turn, should reduce costs to the criminal justice system and to society as a whole by reducing the incidence of substance relapse and criminal recidivism attributable to these clients.

Key research hypotheses posit that compared to ex-offenders under routine supervision, probationers/parolees receiving OPTS services will: 1) have better access to services, and higher rates of service utilization; 2) exhibit more pro-social attitudes and behaviors, and have greater involvement in positive social networks; 3) present fewer long-term problems with substance abuse relapse; and 4) demonstrate less criminal recidivism. In addition, OPTS programs are expected to contribute to system reforms that facilitate increased interagency information sharing; increased joint case planning; increased cross-agency referral and services utilization; improved tracking of client progress and service utilization; and an expanded array of service options for program participants.

The conceptual framework underlying the impact evaluation is presented in Exhibit 1. The antecedent factors OPTS is designed to mitigate -- involvement with illegal substances, criminal behavior, economic instability, family instability, social disorganization, and compromised health or mental health -- are shown in the first column. The key components of the OPTS model, comprised of five core service areas, together with case management and intensive supervision, are identified in the middle column. Finally, the third column identifies the outcomes expected to result from the OPTS intervention.

Data Sources

Taken together, the antecedent factors, intervention activities, and expected program outcomes guided the research plan for collecting both qualitative and quantitative data. Researchers observed program operations directly, and held a small number of focus group discussions with OPTS clients, during frequent site visits conducted throughout the three-year demonstration period. Qualitative information also was collected during in-person and telephone interviews with cognizant program staff and representatives of partner agencies; for example, research staff visited many treatment service providers during field visits to gain a general understanding of the services and how each service fit into the local OPTS network. Information also was derived from the OPTS MIS, which was designed to track services and short-term outcomes for OPTS clients, and from program reports and other relevant documents.[1]

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[1] OPTS implementation activities and the MIS also are described in earlier reports (e.g., Morley et al., 1995, 1998; Rossman et al., 1995; and Rossman et al., 1998a and 1998b).

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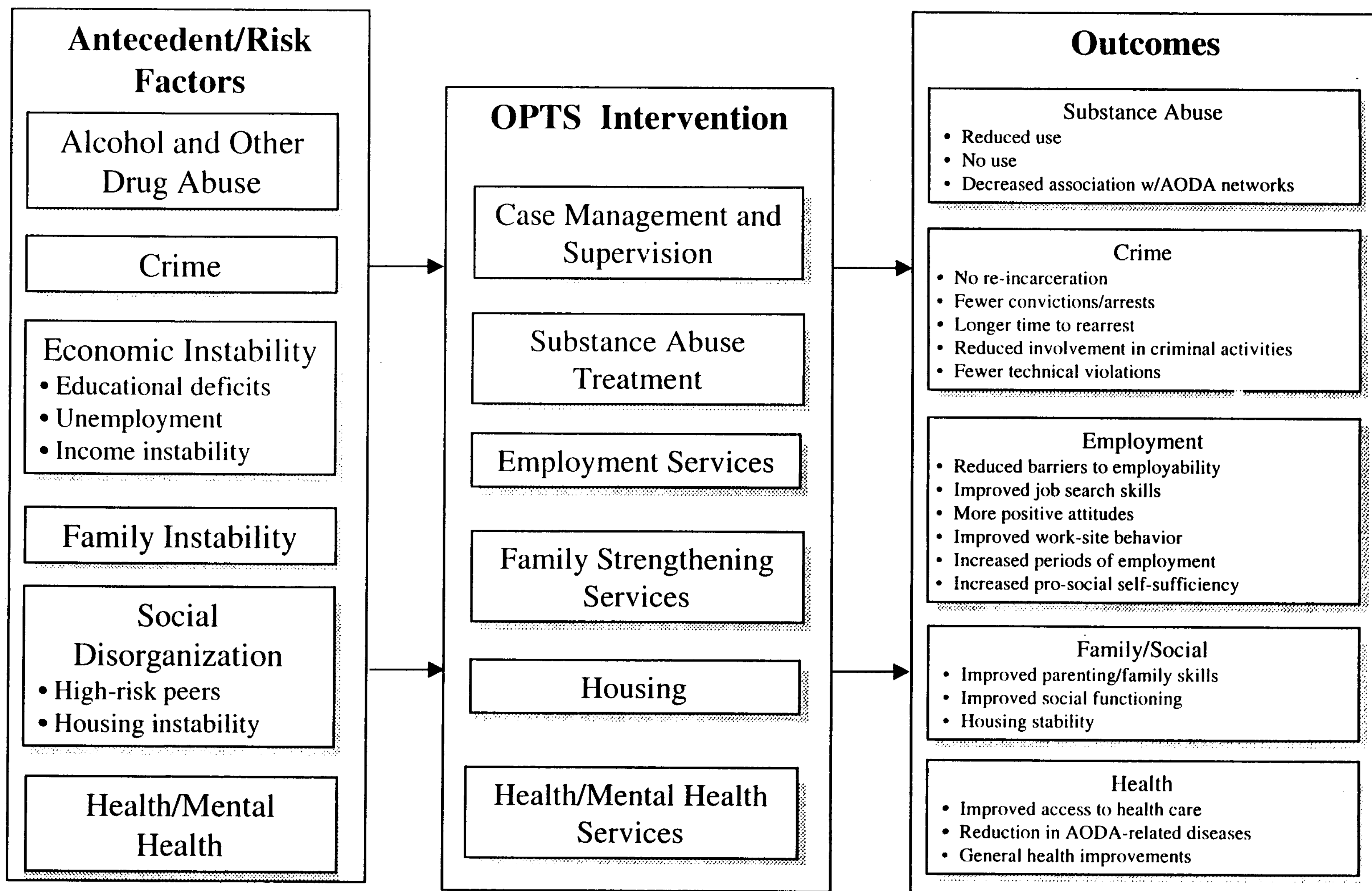
Exhibit 1-1: The OPTS Evaluation Model



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Quantitative data derived from two sources: official records extracted from criminal justice databases (e.g., histories of arrests and technical violations) and detailed baseline and follow-up surveys with OPTS clients and probationers/parolees under routine supervision. The baseline survey used a 90-minute structured interview that captured information about the respondents' demographic characteristics; employment status; general health and history of substance abuse; past involvement with the criminal justice system, as well as unreported criminal activity; and family and social networks prior to OPTS program entry or assignment to routine probation/parole supervision.

The follow-up survey duplicated most baseline elements and, in addition, included respondents' perceptions of their needs for various services, information on the duration and intensity of substance abuse services received, and self-reported improvement and satisfaction with other OPTS services or routine supervision. Embedded in both surveys are modified forms of the Drug Severity Index and other sub-scales of the Offender Profile Index (OPI) (Inciardi et al.,1993)[2] and the criminal calendar reporting system developed in the RAND Corporation's Second Inmate Survey (Chaiken and Chaiken, 1982) and later refined by a host of other studies (see, for example, Horney, undated).

The calendar reporting technique facilitates respondent recall in reporting monthly variations in life circumstances, including events such as substance abuse treatment, employment, enrollment in school, criminal activity, and incarceration or other institutional confinement, during a specified timeframe. For example, as part of the follow-up survey, respondents were asked in which months, if any, they received treatment in the form of: 1) detoxification, 2) halfway house or corrections-based treatment, 3) short-term residential treatment, 4) a therapeutic community or long-term residential treatment, 5) methadone maintenance, 6) outpatient drug counseling, 7) Alcoholics Anonymous or Narcotics Anonymous, 8) other 12-step programs or counseling programs, and 9) acupuncture. Individuals who reported participating in various treatment modalities were further probed about the nature, frequency, and duration of their involvement (e.g., whether they received individual or group counseling, how long sessions lasted, and why treatment ended). Respondents also were asked in what months, if any, they were subjected to urinalysis testing for drug use; the frequency of testing within those months; and whether they failed any tests.

Similarly, in the employment domain, respondents were asked about their job and income histories; current work status and reasons for not working, if unemployed; attitudes about working; sources of income within the designated "calendar reporting" year; and amount of income from each source within the last month of the "calendar reporting" period. The follow-up survey also asked respondents about difficulties they encountered in seeking or retaining

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[2] The surveys ask respondents about their recent, as well as lifetime, use of substances, including: alcohol, marijuana, inhalants, hallucinogens, pills ("uppers" or "downers"), amphetamines, opiates, cocaine, crack, speedball, heroin, and illegal methadone.

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gainful employment, employment services they received through OPTS or routine probation/parole supervision, and their level of satisfaction with such services.

The Scope of This Report

This report describes the major components of the OPTS model, including aspects of case management and supervision, as well as services offered OPTS clients in each of the five core domains:

- Chapter 2 identifies the primary partnerships of lead service providers and probation/parole offices, and describes the key elements of case management and supervision.
- Chapter 3 examines the spectrum of substance abuse treatment, including self-help groups, outpatient services, residential treatment, and detoxification programs, available to OPTS clients.
- Chapter 4 looks at the range of employment services.
- Chapter 5 describes transitional housing, crisis shelter, and other housing assistance used by OPTS clients.
- Chapter 6 details the various services provided to help clients become self sufficient and to strengthen pro-social family attitudes and behaviors.
- Chapter 7 focuses on medical and mental health care services.

The intent is to illustrate the diversity of services offered to OPTS clients, within and across the core domains, in each local program. Where feasible, the chapters highlight pertinent client characteristics, based on self-report data, to provide a context for viewing service delivery.

Each of the chapters covering aspects of the OPTS model concludes with a discussion of the challenges encountered in serving this clientele. The final chapter, Chapter 8, summarizes lessons learned that may be used to strengthen future efforts targeted to similar populations.

Several caveats are in order. Self-report data used in this document are derived from information provided by the 151 OPTS clients (i.e., 45 from Kansas City, 66 from St. Louis, and 36 from Tampa) who completed the follow-up survey[3]. Since OPTS was designed primarily to mitigate substance abuse and crime, questions about substance use and treatment were more

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[3] Four of these individuals did not complete baseline surveys.

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detailed than those referring to other types of problems for which participants may have received services; consequently, the report provides better estimates of substance abuse service use, than those of other services. However, even in that domain, some service use may have been under-reported. For example, at least one case manager reported referring most of his clients to detoxification services; however, only 9% of clients across the three programs reported receiving such treatment, and most were not from the site where that case manager was located.

It had been hoped that the local OPTS MISs would capture referrals and patterns of service utilization that independently validated self-report data and staff discussions. Regrettably, these databases were not as robust as anticipated. Therefore, MIS data have been used in this report largely to determine or confirm the identities of various service providers in each domain, but not to establish the extent to which clients received different types of services, the particular providers of services to specific clients, or the duration and intensity of services.

Finally, throughout these discussions, the emphasis is on lead agency and other community-based provider activities, since these organizations carried the weight of service provision. Probation and parole officers, however, were often key players in service planning and in reinforcing service or supervision requirements. The nature of their involvement is alluded to here, but more thoroughly captured in the Urban Institute's report on OPTS collaboration (see Morley et al., 1998).

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CHAPTER 2
THE PRIMARY PARTNERSHIPS
AND CASE MANAGEMENT SERVICES

The Primary Partnerships: Lead Service Agencies and Community-Based Corrections Offices

In each demonstration site, OPTS pairs the local probation and parole agency -- the Missouri Department of Corrections in Kansas City and St. Louis, and the Florida Department of Corrections in Tampa -- with a social service agency. Exhibit 2-1 shows the primary partners in each location, and the staffing structure.

Exhibit 2-1
Primary Partnerships

	Kansas City	St. Louis	Tampa
Lead Agency	National Council on Alcoholism and Drug Dependence (NCADD)	Lutheran Family and Children's Services (LFCS)	Drug Abuse Comprehensive Coordinating Office (DACCO)
Probation and Parole Agency	Missouri Department of Corrections, Kansas City Office	Missouri Department of Corrections, St. Louis Office	Florida Department of Corrections, Tampa Circuit Office
Lead Agency Staff	1 Coordinator (PT) 2 Case Managers (FT) 1 Admin. Assistant	1 Coordinator (PT) 3 Case Managers (FT)[4]* 1 Admin. Assistant (PT)	1 Coordinator (PT) 2 Case Managers (FT) 1 Admin. Assistant (PT)
Probation Officer Staff	1 Dedicated PO	2 Dedicated POs*	Initially 2 Dedicated POs; subsequently a few POs in each field office

The lead service agencies in each community are nonprofit organizations with offices located in the selected target areas. The primary agencies in Kansas City and Tampa each have long histories of providing substance abuse treatment or services to offenders. The National Council on Alcoholism and Drug Dependence (NCADD), the lead agency in Kansas City, has

[4]*A third case manager and a third PO were added when the OPTS caseload was augmented.

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provided a variety of services related to substance abuse since 1959. Historically, NCADD has provided a combination of direct services and referral (or information brokering) services. The former include provision of educational/support programs such as *How to Cope* for spouses and domestic partners of substance abusers, and *Children at Risk Encounter (CARE)* for children in families with adult substance abusers. Other services include both telephone referrals and a center that assesses individuals' substance abuse treatment needs and refers them to appropriate service providers.[5] NCADD also provides information to other professionals in the community seeking advice in making referrals for their own clients, and operates a resource center (lending library) with materials on substance abuse and related topics.

Tampa's Drug Abuse Comprehensive Coordinating Office (DACCO), founded in 1973, is one of the primary providers of substance abuse treatment services in Hillsborough County (which includes Tampa). DACCO services include client assessment and evaluation; outpatient treatment programs; residential treatment centers; transitional housing units for individuals in recovery; employee assistance programs; and educational programs for high-risk youth (including counseling and educational programs provided in schools and alternative school settings). DACCO also operates specialized programs, such as *Substance Abusing Mothers and Their Infants (SAMI)*, which includes group therapy, parenting skills, and educational/vocational training for addicted mothers, and services and day care for their infants and toddlers (DACCO, undated). Aside from OPTS, DACCO is under contract with the Department of Corrections to provide a variety of services, including nonsecure residential treatment (in the agency's Residential II treatment facility); assessment; and outpatient treatment. DACCO also is a service provider under the Treatment Alternatives to Street Crime (TASC) program, for which its community services staff monitor clients' progress and report to the court or cognizant probation officer. In addition, DACCO staff provide evaluations and case management services for offenders in the Drug Court program (DACCO, undated), and operate an Outpatient Acupuncture Treatment Component for the Drug Court.

The lead agency in St. Louis, Lutheran Family and Children's Services (LFCS), differs from those in the other sites in that the multi-service organization has a religious affiliation, and its primary focus is neither substance abuse treatment, nor services to offender populations. LFCS originated as an orphanage in 1868; and has continued to focus on children and families in providing adoption and foster care services; family, marriage, and individual counseling; family life education; and family advocacy. In recent years, the agency has expanded its community services to include transitional housing and counseling services for the homeless. Its Cooperative Congregational Outreach (CCO) program provides employment training and placement

[5] Kansas City OPTS is uniquely located in the first county (Jackson County) to institute an anti-drug sales tax whose revenues are provided to support a range of substance abuse prevention and treatment programs. NCADD provides assessment services supported by this tax to the County (NCADD, 1993).

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assistance, casework and referral, advocacy, and emergency food and utility assistance in cooperation with four St. Louis congregations.[6]

During the demonstration period, OPTS programs in each community were contracted to provide services for specified numbers of caseload slots. Initially, each site was expected to serve 40 clients at any given time; subsequently, the maximum caseload in St. Louis was increased to 55, and reduced to 30 in Tampa.

> Case managers are expected to identify clients' service needs and link them with appropriate providers. Probation officers remain officially responsible for ensuring that OPTS clients adhere to supervision requirements and behave in accordance with the law.

The program strategy assigns the role of case management to the lead service agencies, anticipating that these organizations will work collaboratively with the specified probation/parole agencies and also will negotiate agreements with other local providers of core services perceived to prevent relapse and recidivism.[7] The model anticipated that each probation/parole agency would dedicate one or two probation/parole officers to the OPTS program; i.e., all OPTS clients would be under the supervision of these POs, although these officers also might supervise other offenders, depending on departmental requirements for PO caseload size.

Each of the local programs co-located case managers and probation officers, when this was feasible. In Kansas City, case managers and probation officers were intermittently co-located at NCADD's offices. In Tampa, case managers were given office space at the central probation office, which was the office to which the original OPTS POs were assigned. St. Louis differed from the other two sites in that both case managers and OPTS probation/parole officers were co-located with the core service providers who offered substance abuse treatment and employment search services -- essentially constituting a team approach to case management and decision making. Also, St. Louis made use of the services of a volunteer, who was a retired social worker, to extend the team's ability to link clients with various social and therapeutic supports.

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[6] Although LFCS' primary clients seemingly differ from OPTS clients, agency staff feel that OPTS participants have characteristics in common with their other clientele. Many of the families the agency routinely serves, particularly those in transitional housing and the CCO program, include adults who have been incarcerated or are substance abusers. Also, LFCS' sister agency, the Lutheran Ministry, provides chaplaincy services in the city and county jail systems. Thus, OPTS is perceived as consistent with the agency's mission. Administrators reflected their approval of the program by contributing to its financial support for several funding cycles beyond the demonstration period.

[7] The sites have employed a variety of mechanisms to promote such collaboration among case managers, OPTS officers, and other service providers (e.g., co-location of offices, regularly-scheduled meetings, and joint case staffings). See Morley et al., 1998, for detailed discussion of multi-level collaboration in OPTS programs.

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Case Management

A key feature of the OPTS model is its use of case management. The model neither specifies the form case management should take (e.g., frequency or location of contact, individual or team decision making regarding service planning), nor delimits the scope of case management activities. However, it does imply that, regardless of form, case management should involve service planning; service provision, either directly by lead agency staff or using brokered services; and monitoring of client progress. The following sections highlight these features in each of the three sites. In general, program activities varied over time, within and across the sites, depending on: 1) individual case manager and PO styles of interacting with individuals on their caseload(s); 2) client profiles, which elicited customized responses from program staff; and 3) the local context which, even in the relatively short span of three years, experienced changes in departmental policies, law, and resources that impacted program delivery.

Service Planning

Although the OPTS model calls for provision of five core services, it was expected that -- aside from substance abuse treatment, which was mandatory for all participants, but would require different treatment modalities dependent on the nature and severity of the individual's addiction -- each client would have specific needs, requiring only a few of the covered services during the course of his/her program participation. Hence, one important function of the case managers is to assess client needs and develop individualized service delivery plans.

> To assist in appropriately linking clients to service providers, Tampa staff developed a listing of subcategories of need under major types of need, and classified service agencies according to the subcategories their services address (see Appendix B). For example, clients' need for housing would be further delineated as drug free, near public transportation, furnished, etc. This agency classification was based on case managers' visits to assess the services provided by various agencies and to develop agreements to serve OPTS clients, which also was done during the early months of program implementation.

OPTS case managers used the early months of program implementation, before service delivery began, to develop client intake and assessment procedures. Initial assessment and plan development were typically performed in the early weeks of contact with clients, and might be documented either formally or informally, depending on agency protocols or the individual styles of various case managers. Two sites, Tampa and St. Louis, initiated contact with offenders prior to their release from correctional or court-ordered residential facilities, beginning needs assessment and service planning in advance of the clients' return to the community. In St. Louis, this pre-release outreach had two interesting facets: 1) case managers were accompanied to the Institutional Treatment Center (ITC) by the OPTS PO (and sometimes other core team members from DART and the Employment Connection) to impress on future clients that lead agency staff and probation/parole staff were functioning as a team in supervising them; and 2) case managers

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and POs also jointly made home visits to families prior to the offenders' release, to explain the program and the services they would provide to clients and family members.

Within and across sites, procedures for updating service plans varied over time and depending upon individual case managers, as well as client profiles. Sometimes service delivery was changed to meet emergent client needs or in recognition of clients' progress, and new "plans" were not formally drawn up, although such changes might be reflected in case files or the OPTS MIS.

The Nature of Problems Experienced by OPTS Clients Requiring Services

An informal survey of OPTS case managers, coordinators, and probation officers during the early months of program implementation and client interaction (i.e., summer, 1995) captured their perceptions of clients' service needs across various domains. Not surprisingly, both lead agency and probation/parole staff identified substance abuse and working through emotional problems as the areas in which the largest proportion of clients had major problems. Knowing how to find a job also was identified as a major problem by both groups. Housing and health care were not widely reported to be problems for a large proportion of clients, although lead agency staff tended to report these as a greater problem than did probation/parole staff. The latter, however, more frequently reported that clients required educational assistance to complete GEDs or high school diplomas. Needs for food or clothing were not considered to be major problems for most clients. Relationships with spouse/domestic partner, other family members, and children were not widely seen as problems for a large proportion of OPTS clients, although a few staff members reported these areas as major problems for very high proportions of clients. Some problem areas that were not specifically included among the core services -- transportation, and managing time or money -- were consistently rated as being major problems for a large proportion of clients.

Similarly, during their follow-up interviews, OPTS clients were asked whether a series of issues -- including activities of daily living, housing difficulties, family dynamics, employability or employment concerns, and health care -- were problems they experienced during their first 12 months post-release from incarceration (see Appendix C for the complete set of problem items and response patterns). The top problems they reported were:

- Maintaining sobriety (52.4%)
- Remaining drug free while living in their neighborhood (45.3%)
- Avoiding hanging out with family or friends who use alcohol or drugs (41.3%)
- Needing a car for work or emergencies (39.1%)
- Controlling anger or expressing anger in non-physical or non-violent ways (38.4%)
- Getting along with spouse or domestic partner (34.0%)
- Having enough money for rent deposit (32.5%)
- Scheduling and keeping treatment and probation appointments that did not conflict with work hours (32.4%)
- Getting a driver's license (31.1%)
- Finding a place to live (28.5%)

For the most part, client assessments were accomplished informally, based on case managers' perceptions of clients' needs or as a result of services requested by either the clients or supervising POs. Contrary to program planners' expectations, Tampa was the only site to use the

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Addiction Severity Index (ASI), which determines individuals' level of addiction to alcohol/drugs, because staff in the other locations were generally not trained to use such tools. Completion of the ASI was part of the intake process, and considered a fundamental part of the battery of assessment instruments. For example, Tampa's intake also included a health history inventory with emphasis on tuberculosis and HIV items, as shown in Appendix D.

Although case managers in the other sites did not typically rely on standardized diagnostic instruments, some had clients complete self-assessment forms or tools. Such self-identified needs were used by case managers in developing service plans and also to remind clients of their own plans to deal with problem situations or achieve specified goals. For example, Kansas City assessments used a rating scale (from "no help required" to "crisis stage"), for clients to identify the degree of help needed in various services areas. Clients also were asked to complete "Change is Possible" personal plans, which require clients to identify resources or actions they can take to avoid substance abuse or criminal behavior (both forms are included in Appendix D). Kansas City subsequently introduced changes to reflect emergent interest in moving from a deficits-based model of treatment to an assets-based approach. Similarly, St. Louis had clients complete an "Ecomap," and "Ecological Network Strategy" (included in Appendix D). Using the Ecomap, clients identified the nature of the connection (e.g., strong, stressful, or tenuous) between themselves and other individuals or spheres of life, such as family, friends, work, religion, school, and health care. They then identified three spheres of life they would like to improve, and specific actions they plan to take to make those improvements.

Although case manager/PO pairs performed a variety of functions in tandem, conducting client needs assessments and developing service plans were not treated as joint functions in any of the local programs. To some extent, there was duplication of effort in this area: while service planning and referral were deemed major case management responsibilities under the OPTS model, this did not relieve POs of their routine supervisory responsibilities, which often included intake procedures that required needs assessment and service referral. In general, POs focused more on arranging services required for clients to comply with court orders (such as substance abuse treatment), which tended to limit the range of service needs they considered during their initial client contact. While the case managers and POs independently developed plans, they tried to coordinate their efforts through service team meetings or informal discussions.

> In St. Louis, OPTS POs completed brief intake questionnaires for each client, as well as monthly reports (see Appendix D). This information was used to calculate the clients' "risk scores," based on past substance abuse and social factors (e.g., mental health and family problems), which do not change over time, and their "needs scores," which change over time to reflect changes in substance abuse, educational and vocational areas, criminal activities, and probation/parole violations. As part of these procedures, POs indicate specific goals (e.g., to obtain employment and maintain sobriety) for each offender.

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Service Provision

Some services were available directly from the case manager or under the umbrella of the lead agency; some client needs necessitated referrals to other providers in the local community.

Theoretically, service provision under a case management model may include: 1) linchpin or brokering activities to coordinate referral and delivery of services offered by other providers; 2) interventive activities to keep clients out of institutions, provide crisis services under emergency conditions, or serve as advocates with courts and other entities; 3) therapeutic activities, including counseling and clinical therapies designed to help clients understand their strengths and problems, and to develop relapse prevention skills; or 4) integrative activities such as arranging or providing for transportation, teaching life-skills, and helping with employment or education problems. Each local program developed its own approach, encompassing some, but not necessarily all, of these components, as described below.

Linchpin or Brokering Activities

"A case manager should be knowledgeable of community resources, and tied to community networks. The key to effective case management is being able to readily link clients to resources and services."
A Kansas City case manager, commenting on key qualifications for case managers

As noted above, case managers assumed primary responsibility for assessing client needs and ensuring clients were linked to appropriate services. At the systems level, resource development was a critical aspect of brokering and linking clients to services. Given the breadth of services anticipated for OPTS clients, program planners recognized that lead service agencies would be able to directly provide some, but not all, needed services. Consequently, each site was encouraged to identify local providers that could assist the lead agency in supplying the five core services to OPTS clients. Thus, prior to program implementation or shortly thereafter, local programs implemented Memoranda of Understanding/Agreement (MOUs/MOAs) with a limited number of service agencies to furnish the services unavailable directly from the lead agency, as shown in Exhibit 2-2 and described in some detail in Chapters 3 through 7.

On-going resource development was critical to adequately supplementing service deficits that developed in relation to the dynamic flow of community-based resources. In their role as service brokers, case managers proactively worked to identify and leverage the services of additional providers, instead of relying solely on established partners such as those with signed MOUs (also see Exhibit 2-2 and Chapters 3-7 for information about these ancillary service providers). Political and fiscal factors often impacted the availability of services in the local context, in a way that destabilized existing service partnerships and required the forging of new networks. For example, the unexpected closure of Kansas City's foremost detox treatment program, Act One, meant case managers had to quickly identify alternative resources (in this

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Exhibit 2-2

Overview Of OPTS Collaborative Service Delivery Structure, By Site

	Kansas City	St. Louis	Tampa
Lead Agency	National Council on Alcoholism and Drug Dependence (NCADD)	Lutheran Family and Children's Services (LFCS)	Drug Abuse Comprehensive Coordinating Office (DACCO)
Probation or Parole Agencies	Missouri Department of Corrections, Kansas City Office	Missouri Department of Corrections, St. Louis Office	Florida Department of Corrections, Tampa Circuit Office
Core[1] Providers: Substance Abuse	NCADD OPTS Group Community Recovery Home (closed 7/95) NARA Program Welcome House Fellowship House	DART	DACCO Relapse Prevention DACCO Res II Aftercare
Employment	Full Employment Council	Employment Connection	Vocational Rehabilitation Florida Job Services
Housing	Community Recovery House Fellowship House	*no core providers*	DACCO Drug Free Housing
Family, Parenting & Life Skills	NCADD How to Cope, CARE Survival Skills	LFCS Counseling Services & Workshops (Man to Man, FEW)	DACCO Relapse Prevention
Health & Mental Health	Swope Parkway Health Center Samuel Rodgers Community Health Center	OPTS volunteer counselor	Psychological Management Group
Other Service Providers	<u>AODA TREATMENT:</u> Act One (detox) Comprehensive Mental Health Svcs. CSTAR Gateway Residential Johnson County Substance Abuse (closed mid 1995) Imani House Kansas City Community Center (KCCC) NA/AA groups Northland Recovery (detox) T.B. Watson Park Lane Hospital Recovery Dynamics Research Medical Center SACEK (in Kansas) Central KC Mental Health	<u>AODA TREATMENT:</u> Agape House Archway Communities Treatment Center Dismas House (halfway house) Salvation Army-Harbor Lights (halfway house) Magdela (halfway house) Mission Gate NA/AA groups <u>EMPLOYMENT:</u> Adult Learning Center LFCS CCO program Voc Rehabilitation	<u>AODA TREATMENT:</u> Agency for Community Treatment Svcs. Crossroads Daytop Goodwill Day/Night Trtmt. VA Hospital S.A. Program Operation Par Center for Women Avon Park NA/AA groups Manna House <u>EMPLOYMENT:</u> Career Diagnostics Center Center for Women

[1] Core providers constitute those service providers that were a central part of the OPTS network of services, those most often used during the course of the demonstration, or those with whom OPTS initially established MOUs.

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Exhibit 2-2 (continued)

Overview Of OPTS Collaborative Service Delivery Structure, By Site

	Kansas City	St. Louis	Tampa
Other Service Providers (cont'd)	V.A. Hospital EMPLOYMENT: Four West Employment Group MO Div. of Employment Security Project Prepare (AFL-CIO) apprenticeship program) Restart Southeast Community Center (ABE, GED) Swope Parkway Training Prgms. Voc Rehabilitation (also drug education) HOUSING: Gateway Residential Imani House KCCC Leisure Care LINC Recovery Zone Salvation Army Sheffield Place Shelter Plus Care V.A. Hospital (also gen. drug) Welcome House Wise Council House USCCA FAMILY SERVICES, ETC.: Ad Hoc Group Against Crime Alternatives for Anger Associated Addictions (domestic violence) Communiversity-UMKC Jr. League Thrift Store KC Corrective Training (domestic violence) Family Advocacy Network LINC (parenting) United Service Community Action Agency YMCA HEALTH and MH: Comprehensive Mental Health Anger Management Jackson County Health Clinic KC Health Dept. KCCC Truman Med. Center Central KC Mental Health	HOUSING: ALIVE Apartment Finders Dismas House (also drug treatment until 3/97) Family Support Services Harbor Lights (also drug treatment until 3/97) Harris House Oxford House St. Patrick Center FAMILY SERVICES, ETC.: Family Resource Center-home-based counseling LFCS Food Bank and Thrift Store RAVEN Sherman Weaver home-based counseling HEALTH and MH: Regional Hospital St. Louis University Health Ctr. Hyland Center St. Louis Metro Psychiatric Ctr. Central Intake Unit City Health Department Hopewell Clinic Life Source St. Louis Mental Health People's Clinic	HOUSING: Chrysalis House Crossroads Transitional Housing The Spring Tampa Homeless Network FAMILY SERVICES, ETC: Hillsborough Parenting Bay Area Legal Services People Licensed Under Supervision HEALTH AND MH: Commun. Health & Human Services The Spring

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case, Park Lane Hospital's medical detox unit) and create an in-road for client access. Similarly, in St. Louis, the program had to find new resources for clients' health care when a partnership with the Health Department was undermined by financial constraints and downsizing in that agency.

> St. Louis clients were referred for individual counseling if they lacked the kind of healthy, pro-social interpersonal skills necessary to function effectively in the home and work place. For example, clients who frequently changed jobs often cited an inability to get along with their co-workers or supervisor. Such clients could be referred for individualized, home-based counseling.

The network of service providers used by OPTS programs also was expanded beyond core service partnerships to fill gaps in service or for redundancy to ensure space in service areas where programs had limited capacity. Hence, multiple substance abuse treatment providers were needed, particularly for intensive or residential interventions, because many of these facilities have long waiting lists, making them virtually inaccessible to clients who have immediate needs.

In addition, network expansion occasionally occurred when it became necessary to meet one or more clients' specialized needs. For example, St. Louis recognized clients' resistance to counseling services of all types; in response, the program's volunteer located providers who would offer home-based individual and family counseling. Similarly, one Kansas City client was a habitual shoplifter, who case managers determined might benefit from assistance geared specifically to that problem. The program identified and referred this client to a local resource -- the Kansas City Corrective Training, Inc. (KCCT), a multi-service organization that offers, among other services, a rather unique anti-shoplifting education program.

Across the sites, case managers forged relationship with new providers primarily through development of professional and personal contacts. St. Louis's program coordinator facilitated resource development by hosting a networking conference for local service providers. Case managers in both Tampa and Kansas City used the early months of program implementation, when they were serving relatively few clients, to actively seek out and visit agencies that were potentially valuable additions to the planned service network. For example, one of the Tampa case managers deliberately contacted AIDS networks because she felt OPTS needed to be prepared in the event that any of their clients required HIV/AIDS-related housing or social services.

At the level of individual client services, brokering client referrals generally involved case managers in the process of contacting service providers to locate or confirm availability of services. In the instances of providers who had not previously served OPTS clients, case managers had to determine what, if any, eligibility criteria existed and make sure clients could meet these requirements. Often, in addition to referring clients to services, case managers actually made and confirmed appointments (and, in some instances, physically transported clients to their appointments), or assisted clients with any necessary paperwork associated with program enrollment or fulfilling eligibility requirements.

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Advocacy or Interventive Activities

> "Case managers function as advocates in the sense that one champions the cause of the underdog. OPTS clients are the underdog -- with two strikes against them, the first being their addiction, the second their criminal record. The case manager is an active advocate who works to secure opportunities for each client."
> *A St. Louis case manager, commenting that client advocacy was an essential ingredient of OPTS case management*

Case managers performed a variety of functions, not all of which involved delivering or linking clients to services. In this respect, case managers frequently served as client advocates in in their interactions with officials in the criminal justice or social service systems. In cases where clients had multiple minor transgressions, such as missed appointments or a series of relapses, and probation officers were inclined to take a hard line (e.g., declaring the individual an absconder, or formally reporting technical violations leading to an arrest warrant, and likely revocation), case managers often advocated for giving the individual another chance or instituting a sanction and closer supervision. Similarly, case managers sometimes championed the interests of their clients before city, county, and municipal courts. In Tampa, where the city's courts conduct frequent case reviews, case managers regularly appeared before the court to apprise the judges of clients' progress or to endorse treatment-oriented supervision recommendations proffered by the clients' probation officers. Clients in focus group discussions expressed their appreciation for this support because they recognized that the case managers had credibility with the courts, and judges were inclined to accept their recommendations.

In addition, case managers worked to improve clients' domestic situations, sometimes using advocacy and sometimes providing emergency assistance under crisis circumstances. For example, case managers in all three communities tried to informally advise clients on how to repair familial relationships that disintegrated under the weight of substance abuse, crime, or other anti-social behaviors such as poor anger management. At the same time, case managers might try to contact family members to inform them of a client's progress and to encourage re-unification. In a related example, one of the Tampa case managers was heavily involved in working with Florida's Department of Children and Families to assist a client in securing the return of her children. Similarly, the Kansas City program purchased an airline ticket that permitted a client to be reunited with his child.

OPTS clients experienced various emergency situations requiring outside assistance; for example, 20% reportedly did not have suitable clothing for different weather conditions, 14% had a problem getting food for themselves or their families, 13% needed clothes for family members, and 11% had difficulty paying for prescription medication. The OPTS programs responded by providing emergency supplies such as food or clothing, or assisted with the purchase of medications or eyeglasses for clients or their family members. For example, LFCS, the lead agency in St. Louis, kept clothes at the OPTS office in order to offer immediate service

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to clients or family members; this program also provided clients and their families with items such as car seats, baby clothes, and formula.

Across the three sites, the programs routinely assisted clients in paying rent (e.g., to provide the first month's rent or security deposit), utilities, and mortgages to stave off foreclosure, etc. In Kansas City, for example, clients who were employed could access loans, while those unemployed could receive "donations," from NCADD to help with a variety of daily needs, such as to purchase work uniforms or pay court fines or fees. Clients were expected to repay loans, although some did not honor such commitments. St. Louis offered similar assistance, and designed a client contract as a means to hold clients accountable and obtain repayment when assistance to an individual client exceeded the budgeted per client housing allocation (about $300 annually). Tampa case managers often regarded assistance of this type as both a reward for good behavior, and an opportunity to motivate clients to take greater responsibility for their own lives. For example, one client was told the program would cover the costs for telephone installation, but the client needed to make the necessary arrangements; another client was offered a budget to purchase a bicycle for transportation, but again was required to research the options.

Likewise, case managers often supplied the extra degree of security desired by employers and landlords. They frequently served as clients' spokespersons, speaking to potential employers and housing managers on behalf of their clients. Case managers across the three programs reported it was not unusual for them to place follow-up calls to employers and landlords when conflicts arose, or to check on client progress in an effort to identify and resolve potential unrest, before it could reach untenable levels.

Case managers diffused crises in other ways, as well. Over time, case managers in each site acquired beepers or cell phones that permitted them to be constantly accessible to clients (and other service providers or POs), regardless of the day or time. It was not unusual for clients to call a case manager if they felt they were on the verge of buying or using alcohol or drugs, or if they had some other immediate problem. For example, a Kansas City case manager recounted receiving a page from a client who was in the midst of a domestic quarrel that was escalating towards violence; the case manager hastened to the scene in time to mediate the situation before it moved completely out of control.

Therapeutic Services Provided Directly by the Lead Agency

Although many clients were referred to other providers for substance abuse, mental health counseling, or other clinical therapies, they also received some assistance in this regard from case managers. Most of the therapeutic services directly provided by OPTS staff consisted of informal advice and counseling that would not meet standards of clinical intervention (and clearly did not involve the administration of any prescription medication). However, in two sites (Kansas City and Tampa), client group meetings were implemented as substance abuse treatment

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components that were more formal interventions, regarded by many as therapeutic in nature. Both the NCADD OPTS group in Kansas City (which ended in the second program year) and the DACCO Relapse Prevention group in Tampa are described in the section on outpatient substance abuse treatment in Chapter 3.

> Tampa case managers and agency director had a running dialogue on whether the scope of case management should include counseling. Their views parallel the uneasiness felt by case managers and program staff in the other two sites. Namely; some case managers felt ill-equipped to act in a counseling capacity because they lacked the training and professional expertise. Others, although technically equipped, felt there was inadequate time to offer real, clinical counseling -- that is, case managers indicated that they couldn't provide clinical counseling in addition to brokering client services, monitoring client compliance and progress, outreaching to family members, and trying to comply with reporting requirements.

Across the three programs, case managers tried to provide informal counseling, which was generally oriented toward promoting greater self-awareness, self-control, and other pro-social attitudes and behavior. For example, Kansas City case managers frequently served as sounding boards for family members' frustrations or concerns over the clients' behavior. Staff consistently delivered the message that families did not have to accept the client's negative or destructive behavior, but that family members were responsible for their own enabling behavior(s). Case managers reminded family members that support was available to them; for example, the lead agency had several educational programs (e.g., CARE and COPE) designed to help adults and children develop more constructive responses that would be beneficial to both the client and other members of the family.

Other Direct Service Provision

Aside from the counseling or therapeutic interventions mentioned in the preceding section, each of the lead agencies directly provided one or more of the other core OPTS services, as well as engaged in other integrative activities, such as providing for transportation, helping with employment difficulties, or trouble-shooting clients' other problems.

Although they had not planned to do so, lead agencies directly delivered job-related services in addition to referring OPTS clients to one or two employment/job training services with which the primary partners had prior relationships or which they identified early on. For example, in Kansas City, NCADD sponsored a "Labor Market Overview" for OPTS clients in April, 1995: staff arranged to bring in representatives from a range of employment and training service providers, union representatives, etc., to introduce their programs or organizations to OPTS clients. Representatives from approximately eight organizations were present for this half-day event, which was mandatory for OPTS clients. Clients were provided with information about labor market trends, skills training, and accessing resources.

In all three communities, case managers were proactive in "job development," contacting and cultivating potential employers. In St. Louis, for example, case managers: 1) contacted

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employers who had hired some OPTS clients to inquire about possible job opportunities for others, 2) actively searched newspaper ads for appropriate openings, 3) advocated for their clients by responding to "help wanted" signs that were publicly displayed, and 4) networked with colleagues who had ties to training and placement services. At one point, LFCS seriously considered assisting OPTS clients by beginning a small business (e.g., cabinet making or cooking) that could build skills and provide revenue, although they did not pursue this because probation staff cautioned against it.[8] However, LFCS did hire at least one of the OPTS clients to do some rehab work as a temporary job on some of their agency's transitional housing units. Also, in both Tampa and St. Louis, case managers referred some clients to temporary employment agencies, which provided an opportunity for clients to update their skills in short-term work assignments that sometimes led to more permanent positions.

OPTS POs reportedly also played important roles in facilitating probationer/parolee employment. POs were instrumental in reminding clients that employment was a condition of supervision and that they needed to comply with the requirements of the services their case managers directed them to. Some POs reinforced the message by discussing clients' plans for obtaining a job during their scheduled meetings; engaged in development activities to identify job openings; or routinely verified client employment by checking pay stubs or contacting employers.

Case managers also delivered direct services by facilitating workshop seminars and client groups. For example, NCADD implemented a life skills curriculum, *Survival Skills for Men*, and LFCS tried to encourage clients' assumption of pro-social responsibilities, by introducing first an Afrocentric *Man to Man* workshop series, and when that proved untenable, the seminar series called *Family Empowerment Workshop* (FEW). These services are described in Chapter 6.

Case managers performed other integrative activities of various kinds, helping clients to balance the mundane, yet critical, duties of everyday life. For example, case managers frequently encouraged clients to further their education, and supplied them with lists of locations and course listings for enrolling in GED courses or suggested community colleges that could offer educational advancement. In Kansas City, for instance, the case manager offered to assist clients who needed to obtain school supplies, such as course materials or art supplies.

Also, although bus passes were routinely distributed to assist clients, some providers were not located near public transportation routes or emergencies arose making private transportation a necessity. Lack of transportation or insufficient transportation was an issue in all three sites, and this motivated case managers to provide "taxi service" in order to ensure clients actually arrived at services to which they had been referred or achieved other expectations, such as

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[8] POs were wary about compromising the professional nature of their relationships with clients. For example, one concern was that clients who received seed money to start a business could potentially become indebted beyond the scope appropriate for case manager/client relationships, and that this could damage the accountability or objectivity of the correctional program). Additionally, they were wary of creating a situation where one OPTS client might hire another OPTS client, placing the first in a position of authority over the second.

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arriving to work on time.[9] In St. Louis, for example, the OPTS administrative assistant took one OPTS client to an emergency room for a severe toothache, and waited with him for service (which was not provided at that time because there were many more serious cases ahead of him), so he was sent to a different provider the next day. In another case, the case manager accompanied the child of one OPTS client to school to help him register for the lunch program because the client had conflicting work responsibilities.

Monitoring Client Progress

Case managers have responsibility for monitoring client progress. Under the OPTS model, monitoring entails several activities, undertaken individually or in conjunction with cognizant POs to ensure consistency in supervising clients, including:

- Client contact to assess on-going service needs, as well as progress in achieving individual and programmatic goals.
- Communication with external service providers to verify clients' compliance with programs and services to which they have been referred, and to determine whether anticipated outcomes are being achieved.
- Urinalysis testing to independently establish that clients have not relapsed.
- Use of graduated sanctions and incentives to hold clients accountable for non-compliance or other transgressions, while motivating them to demonstrate desired behaviors.

Each of these is described below.

Client Contact

Case manager contact with clients serves multiple purposes: 1) on-going interaction between case managers and clients, as an adjunct to probation officer oversight, facilitates the intensive supervision anticipated by the OPTS model; 2) it is also a mechanism for tracking client progress and changes in service needs to provide direction for updating service plans and referral to brokered services; and 3) it affords the opportunity to directly deliver services, such as informal or therapeutic counseling, as previously described. Through frequent interaction with clients, case managers become aware of high-risk behaviors, relapse, criminal activities, or other

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[9] Probation officers in at least one community were unsympathetic to this need, and unsupportive of case managers' involvement: they reasoned that these offenders typically had not committed their crimes within their own neighborhoods, and were well able to arrange transport when they chose to do so.

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failures to adhere to probation or parole requirements. Ideally, this contact positions case managers to detect emergent problems before they reach crisis proportions and undermine individuals' abilities to remain sober and otherwise succeed at home, at work, and in the community.

Case manager contact typically occurs in several ways: telephone contact, individual office visits, and home visits (or, occasionally, visits at the client's workplace or other location). Home visits differ from other forms of contact in that they provide an opportunity for case managers to meet, and interact with, other family members or housemates of the client, and are often used as an opportunity to identify needs of other family members/domestic partners, and to refer them to services. In addition, home visits, particularly the initial visits, are used to obtain a sense of the appropriateness of the client's surroundings, which sometimes results in efforts to find other housing in cases where, for example, family members or other residents appear to be involved in drug use, or when drug trafficking appears prevalent in the immediate neighborhood.

Prior to program implementation, each of the three local programs planned to have case managers meet fairly frequently with OPTS clients, and two anticipated that a phased system would be used, with contact decreasing over time. For example, Kansas City intended to have case managers meet with clients three times per week during the first phase of client participation (the first 90 days in the program, or longer, based on client progress); then contact would decline with length of participation, to twice weekly in the second 90-day phase, and weekly contact in the third.[10] Similarly, St. Louis planned a phased reduction in contact based on longevity of participation, with twice weekly, in-person meetings; weekly home visits; and daily telephone contact during the first six months of participation. For clients whose progress was satisfactory, routine home visits and telephone contact would be eliminated after the six-month timeframe.

Based on discussions with program staff, Kansas City and St. Louis adhered fairly closely to the planned frequency of case manager-client meetings. Kansas City case managers reported urging clients to meet with them at least twice during the week (such meetings lasted about an hour). They noted that if a client was unable to keep a scheduled appointment, telephone contact typically sufficed to replace the meeting. Case managers also reported conducting frequent home visits, generally of about one half-hour in duration. Case managers in St. Louis said they typically had office meetings with their clients once or twice per week, and visited their homes or workplaces at least once per month. In

> The St. Louis program initiated an additional component to augment its case management activities. Clients are required to make daily telephone contact with the OPTS administrative assistant at the lead agency for the first six months post-incarceration. Clients may identify specific needs (e.g., clothing, health care, bus passes) during this call, to be passed on to the case manager. This contact also assists in monitoring clients, in that case managers make efforts to locate clients if they do not call in regularly.

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[10] Kansas City also had planned to have case managers meet with individuals in the neighborhood offices used by Project NeighborHOOD to facilitate client access; however, this feature was not implemented.

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addition, case managers sometimes accompanied clients to appointments with other service providers. While Tampa did not stipulate frequency of case manager contact at the outset, as the program was implemented, case managers seemingly adopted the practice of weekly meetings with new clients. Although case managers initially jointly conducted home visits with OPTS probation officers about once per month, as the program expanded to include more than one or two dedicated OPTS POs, case managers performed home visitation without them (see Morley, 1998, for detailed discussion of case manager-PO collaboration within the three sites).

Exhibits 2-3 and 2-4 present self-report data on frequency of case manager in-person meetings during the first and last three months, and home visits throughout, clients' first year in the OPTS program. Overall, 69% of clients reported they met with their case manager at least weekly during the first three months of participation; this included 19% who reported daily or almost daily meeting during that quarter. In addition to in-person contact, 25% of clients (i.e., 26% of Kansas City, 34% of St. Louis, and 10% of Tampa cohorts, respectively) reported daily telephone contact with case managers during this same timeframe. An additional 37% of clients across the three sites reported weekly telephone contact. In general, the frequency of contact diminished over time.

Across the three sites, the intensity of contact varied depending on case managers' styles of client interaction, client needs, and also other demands on case managers at any given time. Office visits might last 30 minutes to an hour, but could be more or less intensive depending on circumstances. Home visits ranged from 15 minutes to two hours in length, and it was not unusual for them to reach the upper bounds since these often included discussions with family members, as well as with clients.

Regardless of routine patterns of contact, all sites reported that case managers increased contact with specific clients on an as-needed basis. Thus, a client in a crisis situation (e.g., having a relapse, being evicted), or one with particularly difficult problems or service needs, received considerably more contact, perhaps including daily meetings or telephone contact, several home visits per week, etc., until that situation was resolved. As a result of this intensive responsiveness to such needs, however, case manager contact with some other clients during that time period may have been reduced, particularly on occasions when there were several clients needing intensive contact at the same time.

Also, it should be noted that some OPTS clients relapsed or engaged in other non-compliant behavior that resulted in their placement in an institutional setting (e.g., halfway house, short-term treatment facility, or jail). Case managers' ability to continue meeting with such clients was often determined by the procedures in place at the receiving facility. Sometimes the facility's regulations prohibited ongoing contact; however, where feasible case managers often continued to work with these clients, or with members of their family or household, to support their immediate needs, as well as to plan for their future needs upon full reinstatement in the OPTS program.

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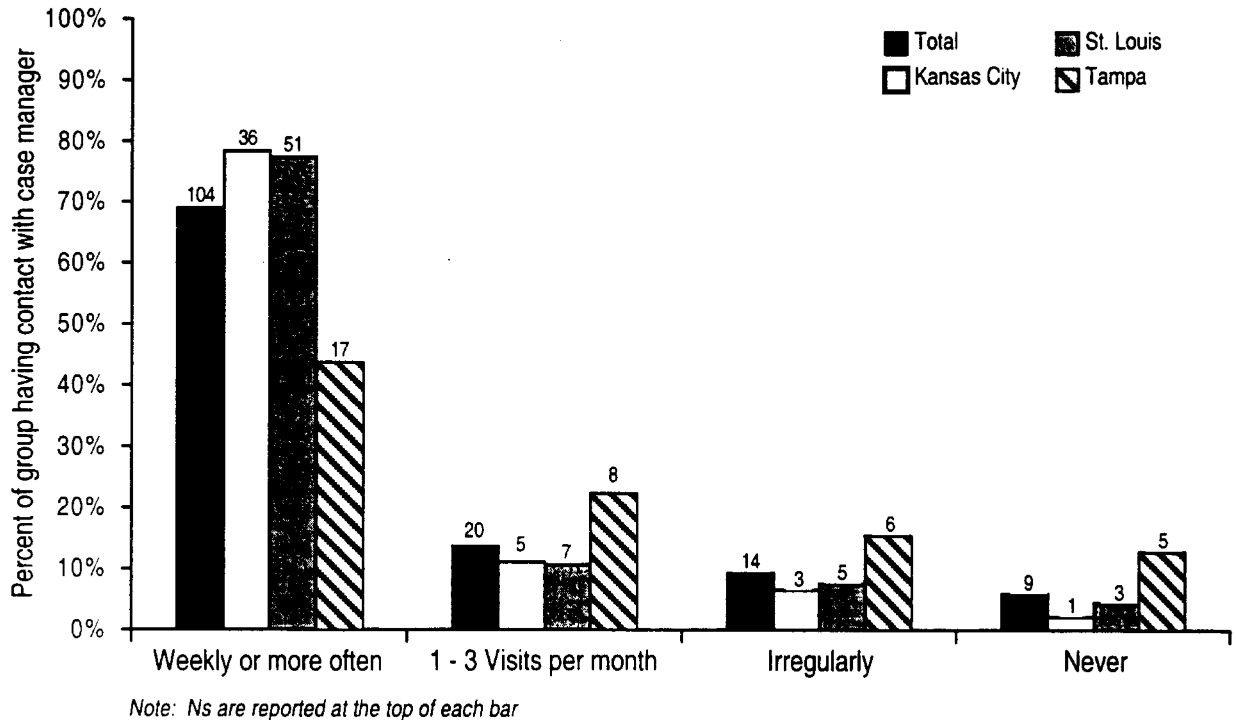
EXHIBIT 2-3.

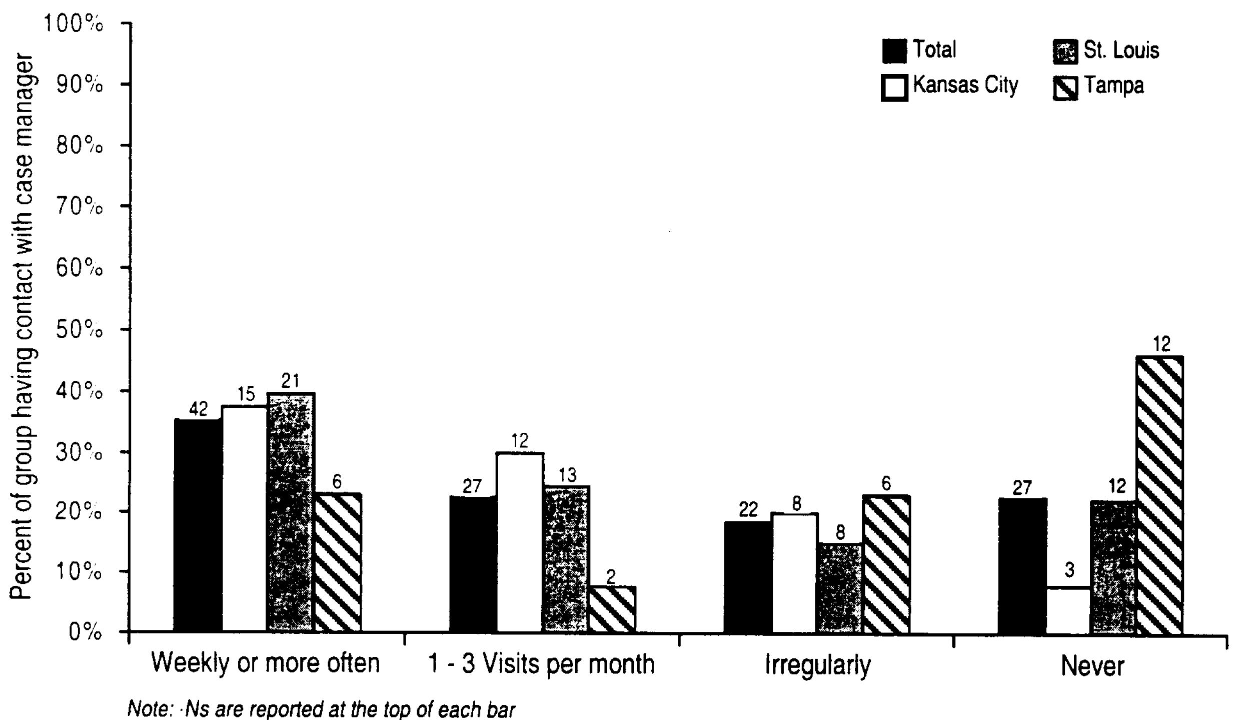
In-Person Contact with Case Manager During Clients' First Year of OPTS Participation

FIRST 3 MONTHS



Note: Ns are reported at the top of each bar

LAST 3 MONTHS *EXCLUDING THOSE INCARCERATED DURING LAST 3 MONTHS*



Note: Ns are reported at the top of each bar

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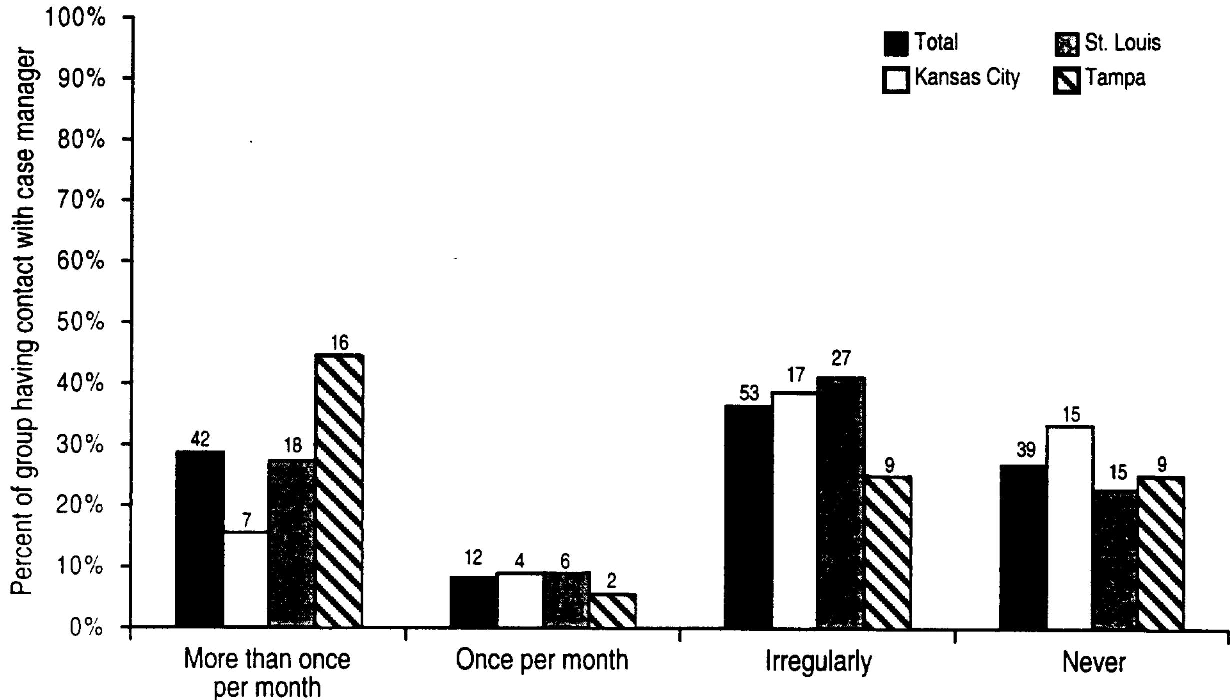
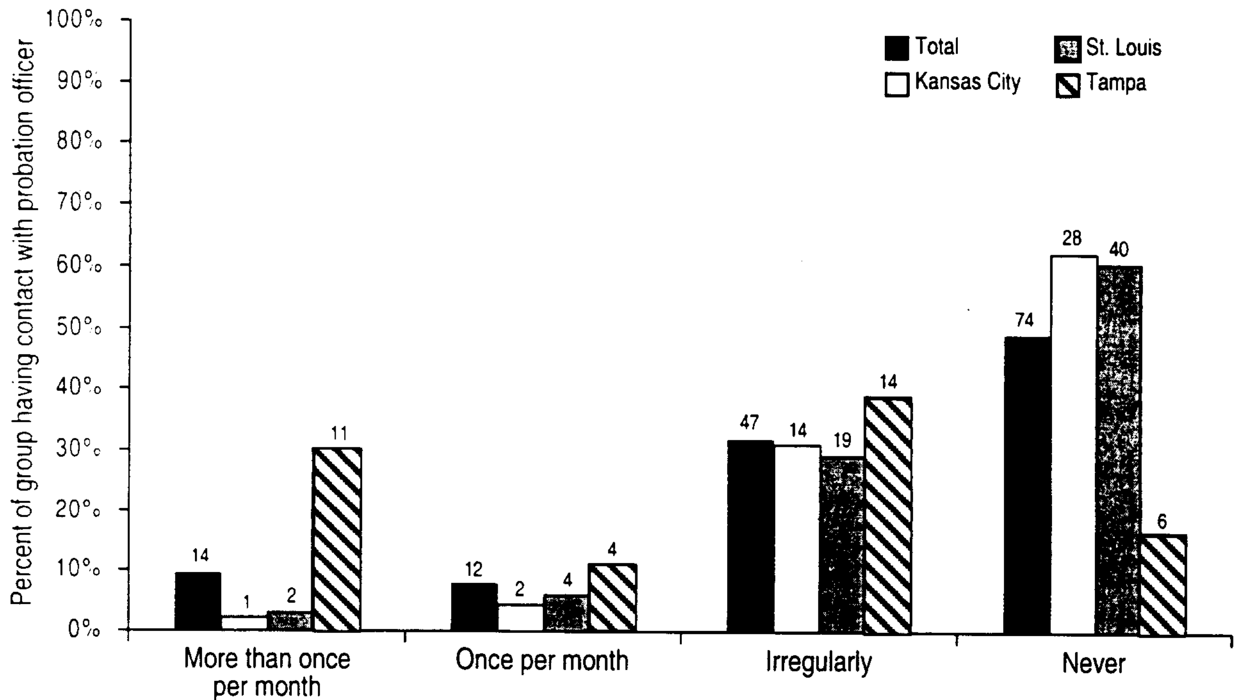
Exhibit 2-4.
Home Visits During the First Year of OPTS Participation

Case Manager Home Visits



Note: Ns are reported at the top of each bar

Probation Officer Home Visits



Note: Ns are reported at the top of each bar

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Case management is regarded as one prong of the more intensive supervision envisioned by the OPTS model; however, the full force of supervision is realized through the combined efforts of case managers and cognizant probation/parole officers. Although clients have contact with their case manager and OPTS PO, they generally see them separately (i.e., joint office visits with OPTS clients occurred in all sites, but typically these were not routinely scheduled). Exceptions to this commonly occur during the client's initial post-release visit, which often involves (or is intended to involve) both the case manager and the OPTS PO. Similarly, both case managers and POs often are present to confront clients about problem behaviors, such as dirty urine tests or failure to comply with program or probation requirements, or to notify them that sanctions are being imposed. In some cases, depending on the nature of the problem, such meetings also may include staff from other service-providing agencies.

> In general, co-location facilitated joint visits, since it enabled both the case manager and probation/parole officer to readily sit in when a client came to the office, without necessarily pre-scheduling a time when both could be present. St. Louis made deliberate efforts to schedule clients' meetings with the case manager and probation/parole officer in consecutive time slots on the same day (in essence, piggybacking the two meetings); this permitted them to either compare notes directly after the meetings or to be available for impromptu joint visits. In other sites, frequency of joint visits tended to vary across CM-PO pairs, and were affected by personal preferences and availability. One case manager in Kansas City noted that he had a joint meeting with the PO and a different client about once a month, but that such joint meetings had been more frequent with a previous PO assigned to OPTS, who apparently was more supportive of the practice. In Tampa, joint meetings were only held when the case manager and probation officer felt it was necessary; there were no regularly scheduled joint meetings.

The model does not assume that POs will have more frequent contact with OPTS clients than with other probationers/parolees. Since OPTS clients are mandated to some form of drug aftercare, they are among the groups of offenders that generally receive somewhat more frequent PO contact than lower-risk offenders. In Kansas City and St. Louis, for example, frequency of contact varies with clients' risk scores (which are based, in part, on substance abuse); most OPTS clients are seen on a weekly basis, although that may be reduced to every other week or once a month after they have been in the community for a while and are more stable. In Tampa, monthly probation officer/client contact is mandated; but actual contact with OPTS clients tends to be more frequent than that.

Although the OPTS model assumed that probation/parole officer contact with OPTS clients would follow the rules and procedures of their respective agencies, client self-report of contact with POs during their first and last three months of program participation for their first year post-incarceration portrays a different picture. As shown in Exhibit 2-5, St. Louis clients reported considerably more contact with POs than did the control group under routine supervision. Conversely, Tampa clients reported less contact with their POs than did the control group.

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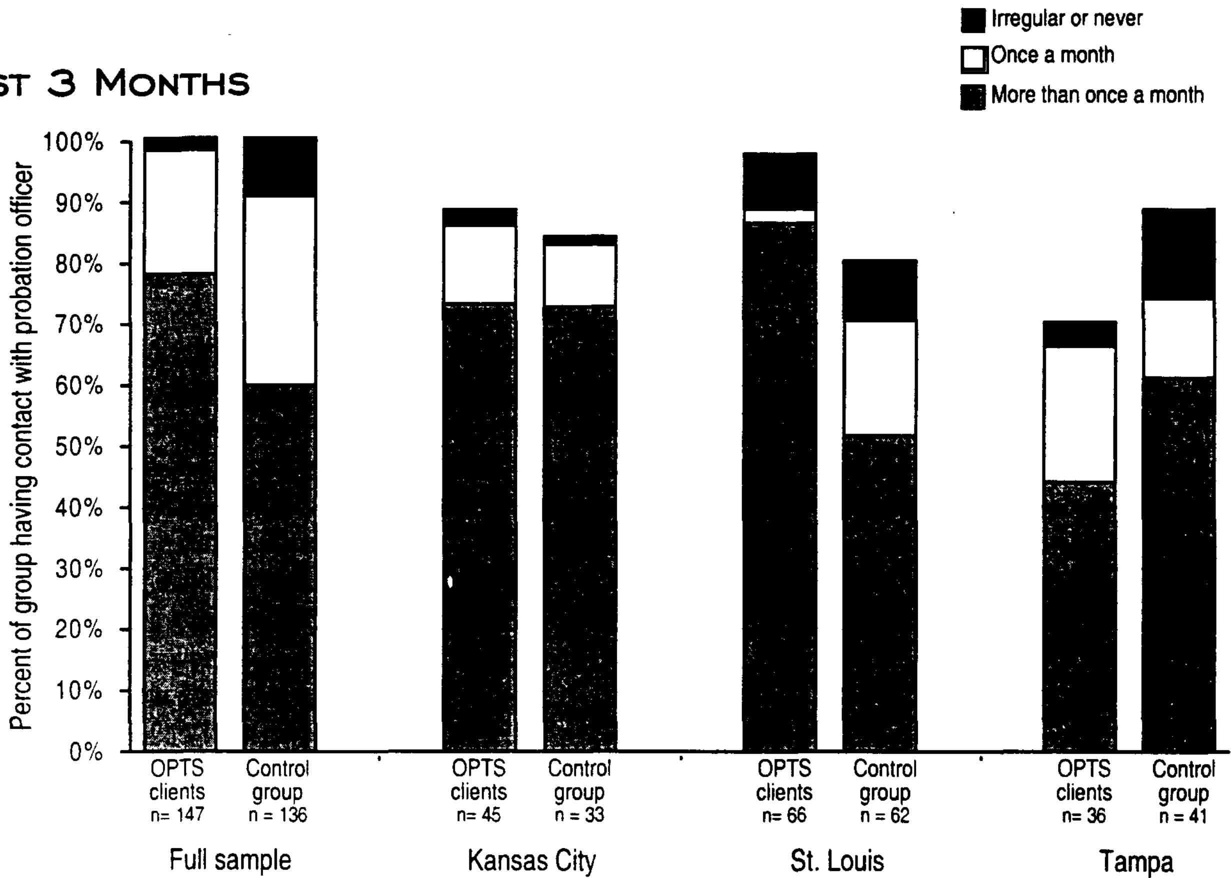
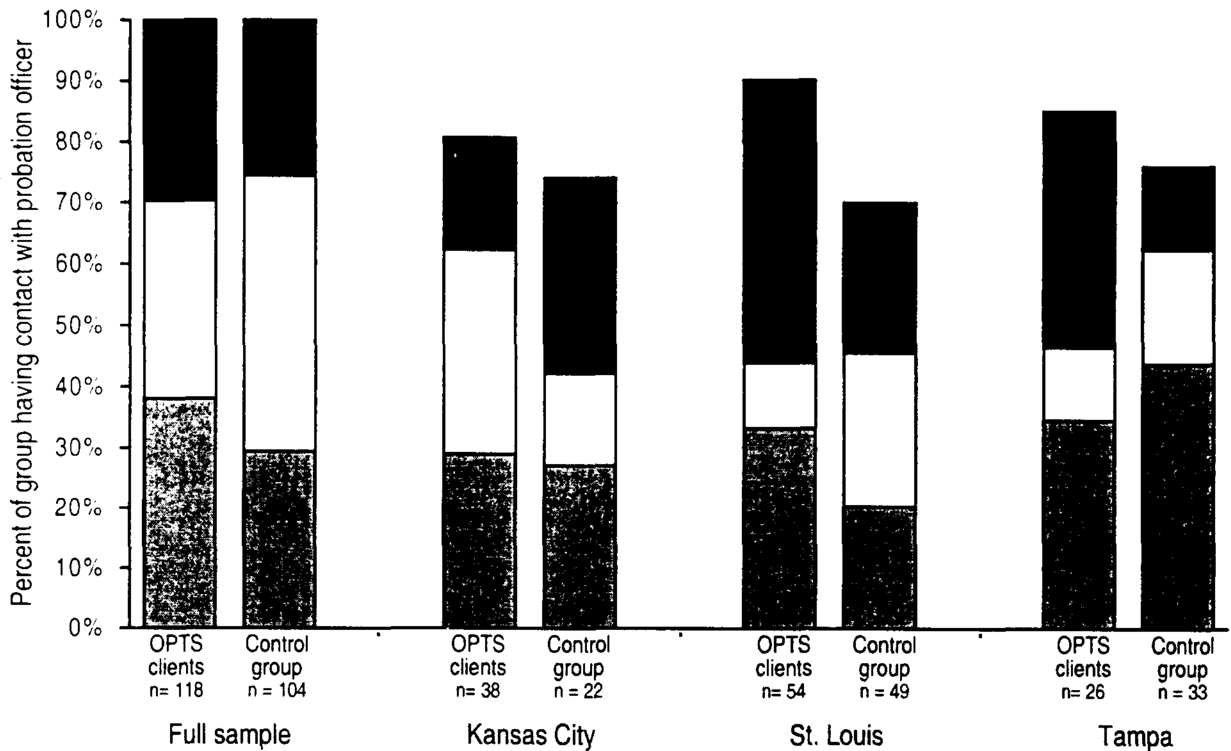
Exhibit 2-5.

PO Contact, Comparing OPTS Clients to Routine Supervision of Control Group

First 3 Months



Last 3 Months *controlling for incarceration*



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Case Managers' Contact With Service Providers and Probation Officers

Case managers are expected to monitor client progress to determine whether services are, in fact, being provided (or attended) as planned; whether they are having the desired effect in terms of client improvement; and whether goals have been reached or new service needs have developed, necessitating modifications to a client's service delivery plan. Depending on the nature of the services provided, case managers might establish weekly telephone contact with service provider staff to confirm the client's attendance and document his/her progress. In-person visits or meetings also were held. POs were kept informed of client progress, typically by telephone communication (case manager-PO pairs in Kansas City and Tampa reported daily phone contact was not unusual; St. Louis case managers and POs were co-located, which virtually eliminated the need for phone contact). Conversations with both service providers and POs covered such topics as client problems or progress, the appropriateness of a particular service or agency for OPTS clients, or the potential provider's capacity to accept a client at a particular time.

> Kansas City staff noted that in-person contact with service providers regarding OPTS clients represented a departure from the lead agency's usual pattern of communication with other agencies, namely by telephone or letter. OPTS case managers frequently went on site to meet with other service providers, which was felt to be beneficial in terms of increasing the visibility of the lead agency and the program.

OPTS sites regularly scheduled team meetings between the OPTS POs and case managers (clients were generally not present at these meetings).[11] In St. Louis, the expanded service team routinely participated in these meetings; as did a retired social worker who volunteered her services to provide counseling and referral for OPTS clients. In other sites, other service delivery staff were sometimes included (see Morley et al., 1998, for detailed discussion of collaborative structure).

Team meetings provided a forum to review client progress, and for joint decision making related to treatment and service needs, imposition of sanctions, ordering urinalysis, or changing a client's status in the program. Typically, the meetings highlighted

> Case managers were sometimes uneasy about discussing a client's illegal activities with the PO, feeling that such information sharing would be a violation of the client's confidentiality. Specific incidents of this nature triggered generic discussions. In St. Louis, for example, the core team spent a fair amount of time in team meetings clarifying and identifying situations in which confidentiality should or could be maintained, versus what information had to be shared with the PO or the rest of the team.

[11] Kansas City instituted weekly team meetings; St. Louis held service team meetings twice per month. Tampa initially planned to hold weekly meetings between OPTS POs and case managers to discuss clients, with other service providers included as needed. After target area expansion led to involvement of numerous POs, the site instituted monthly group meetings to enable the case managers and the OPTS coordinator to meet with all POs at once. In addition to the group meetings, the case managers met once or twice a month with the OPTS POs with whom they were co-located.

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particular cases, but sometimes they focused on examining possible procedural or programmatic refinements, perhaps sparked by discussions regarding a particular incident.

Case manager-probation/parole pairs across the sites regularly used formal staffings or interventions with clients in attendance to deal with individuals who had positive urinalysis tests, committed other serious violations, or experienced serious problems. In St. Louis, a typical client intervention consisted of the core service team meeting as a group with the offender to confront him/her about the problem, and obtain the individual's agreement to take steps recommended by the team to resolve the difficulties. Where appropriate, sanctions might be imposed, or changes made to the client's service or treatment plans, as part of the intervention. Tampa and Kansas City used essentially the same approach for similar circumstances; key players typically involved in the intervention included the case manager, probation/parole officer, other service agency staff (where relevant), and the client.

Urinalysis Testing

Although random drug testing is a feature of probation/parole supervision in most jurisdictions, the OPTS strategy intended that more frequent urinalysis monitoring be incorporated into the oversight of program participants. The underlying philosophy was that increasing the frequency of testing would permit staff to detect any relapses at an early stage, so that clients could receive the appropriate treatment and sanctions to avoid more serious relapse and possible re-incarceration. The model did not stipulate the frequency with which such testing should be performed.

Across the sites, staff indicated that new clients, as well as those whose sobriety was suspect, were typically tested more frequently than those who had been in the program for awhile. Some clients, particularly those who had relapsed, might be tested as frequently as weekly (but this did not appear to be the norm). As clients progressed in their recovery, and produced fewer or no positive results, testing typically decreased to a monthly basis, or even more intermittent.

> One probation officer noted that, although case managers can independently ask for a "drop," she has informed them that she needs to be present, so she has direct knowledge of the circumstances in case she later has to testify in court (e.g., if the test is dirty, and the client disputes the finding).

In general, POs took the lead with regard to drug testing, although case managers could order such tests or request that they be performed. Also, OPTS clients might be subjected to other drug testing administered by the various substance abuse treatment programs in which they were enrolled or if they resided in a halfway house. Testing took various forms over time within the three programs. POs could, and often did, use field kits. These had the advantage of returning immediate results, but staff in some sites (notably the Missouri sites) were uncomfortable with their use because the tests were limited in the

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substances they could detect, were seen as costly, and were of uncertain validity and reliability. Staff also used laboratory facilities to collect and analyze specimens.

Tampa clients were tested on a schedule determined by their PO. Most POs tested their clients on a monthly basis; however, offenders on Drug Offender Probation (DOPO) supervision were required to submit to weekly testing. Case managers could and did appeal to the POs to test clients they suspected of use. Field test kits, the Florida Department of Corrections standard operating mode for collecting and analyzing urine samples, were perceived as affording immediate and reliable results for minimal cost (about $1.75). In keeping with DOC policy and the field kits' limited detection capacity (test kits are only able to test for one drug per slide), probation officers routinely tested offenders for their drug of choice. Periodically, a multipanel urinalysis procedure (i.e., tests for seven substances) was used; costs associated with this procedure are also reasonable -- approximately $7.45 for supplies and processing. Probation officials attribute the manageable costs of urinalysis to the Department's high volume of testing (i.e., supplies are purchased in such huge quantities that the cost per test is kept reasonably low).

Kansas City clients were typically tested on a monthly basis, although new clients or unstable clients were tested more often. Typically, case managers requested the testing, a private local laboratory was used, and NCADD covered the costs using OPTS funding. The lab tested for PCP, marijuana, and cocaine, charging a flat $14 fee per test. Test results were generally received within a few days. Probation officers also did testing, using field kits or relying on services provided by DOC laboratories. Field kits ranged in cost from $3.50, to test for one substance, to $18.00 for a full range of drugs. POs also could use a DOC laboratory, which charged approximately $2.00 to test for each separate substance, but usually could not return results in under one month. When any test results indicated a client's relapse, case manager contact was increased, often including Saturday visits.

In St. Louis, client progress was assessed according to a "phase-based" model. Urinalysis testing also progressed in phases. Although there was variation over time, as the program stabilized, clients tended to have weekly testing during their early month(s); then twice monthly during the second phase; and finally, testing on a monthly basis or less. Probation/parole officers performed the "drops," but additional testing also could be ordered by case managers.

Initially, the program sent tests to a distant laboratory for analysis. Consequently, the site began using field kits, which gave immediate results, but were limited in terms of the substances they could detect and also were deemed costly. Subsequently, they negotiated an agreement with a local laboratory that would provide two-day turnaround; however, this proved costly: $17.00 per test, if the sample was negative; $30 per test if the results were positive. Therefore, the program resorted to relying on a mixture of testing approaches.

In addition to urinalysis testing both Kansas City and St. Louis initiated use of breathalyzer testing during the second program year. This was done in response to staff concerns that clients' abstention from drugs correlated with an increase in their use of alcohol. St. Louis staff reportedly began using the breathlyzer to test clients who showed up at DART's outpatient

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group sessions with alcohol on their breath. Also, in both Missouri sites, the OPTS POs conducted mass testing on a sporadic basis. That is, once or twice per year, POs would test every single client on their caseload, regardless of the client's status in the program.

Exhibit 2-6 shows the mean number of drug tests self-reported by OPTS clients during their first year of OPTS participation. The data depict frequency of testing in six-month increments, only for those who reported any testing; across the three sites, 20 clients reported never having been tested during this time frame (i.e., 4 clients each in Kansas City and St. Louis, and 12 clients in Tampa).

Sanctions and Incentives

> Relapse is part of recovery. The steps to success are little things, like keeping appointments, arriving on time....So much depends on where the client is starting from....Relapse happens at any time -- some clients are doing really well; they have a job, and they've been clean for a long time; and then suddenly, they turn up dirty....
> *St. Louis staff, commenting on the need for sanctions and incentives*

Since program planners envisioned closer oversight of OPTS clients than would ordinarily accompany routine supervision of probationers/parolees, the model called for the use of graduated sanctions to offset offenders' increased risk of detection and punishment for relatively minor infractions (e.g., failure to keep appointments, non-compliance with treatment plans) or initial instances of more serious infractions, such as "dirty" urine tests. The system of sanctions was intended to enable programs to impose consequences without unduly terminating clients. In addition to various penalties, OPTS programs also were expected to use incentives, or rewards, to recognize clients' accomplishments, and to encourage or motivate them to continue making progress in the program.

The topic of sanctions and incentives was addressed at one of the cross-site planning conferences sponsored by CASA during program development; guidelines for sanctions developed at that conference are included in Appendix E. For example, a first incidence of infraction might be met with an informal sanction, such as telephone contact with the case manager or PO; a second infraction might trigger an unscheduled meeting with the case manager or PO; while additional infractions or more serious incidences of non-compliance would elicit more severe consequences, including possible termination from the program or revocation of probation/parole.

The local programs intended to adhere fairly closely to these guidelines, with minor modifications; however, each experienced some difficulty in implementing the sanctions (and incentives) protocols as planned. In some cases, the problems were primarily logistical; while in others, there were philosophical concerns about the use of these practices that prevented their full implementation.

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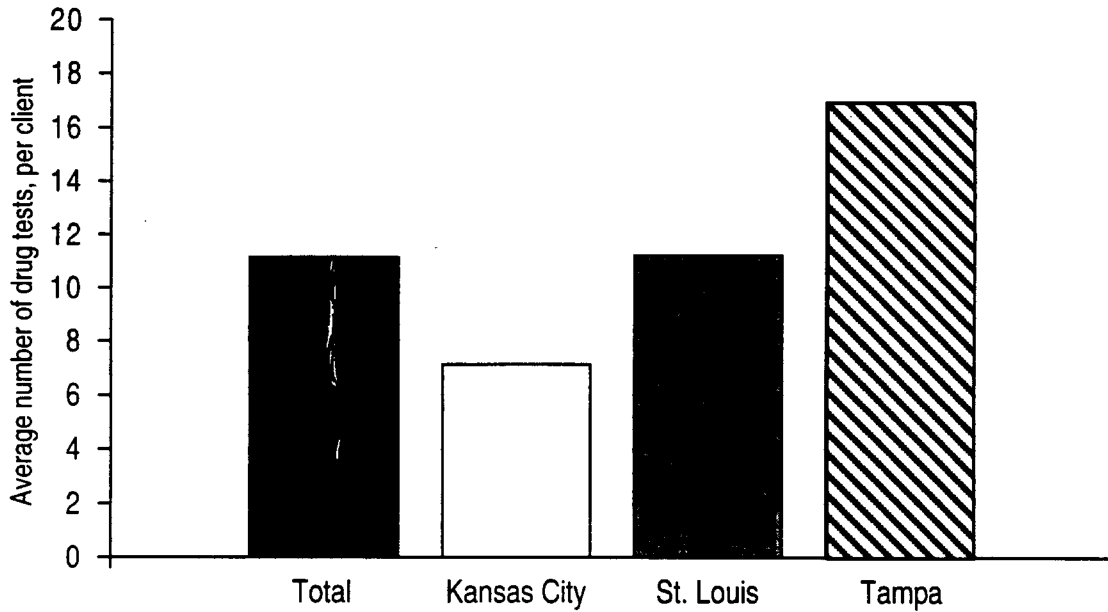
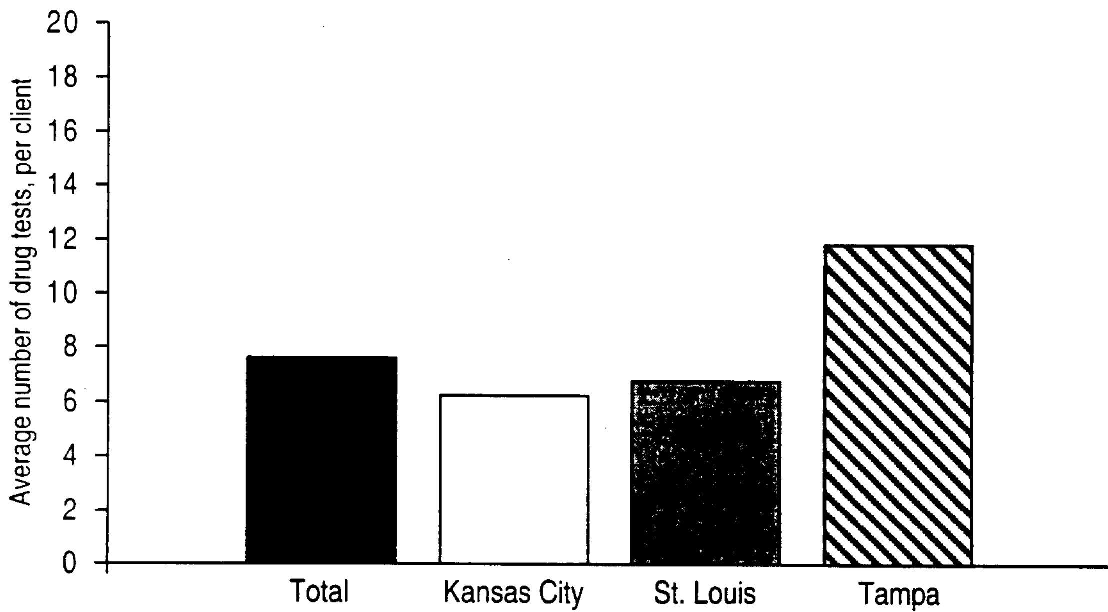
EXHIBIT 2-6.

Average Number of Drug Tests, per Client* During Their First Year of OPTS Participation

FIRST 6 MONTHS



LAST 6 MONTHS



**Months in which clients were incarcerated are not included to avoid attributing to OPTS any testing that occurred during confinement.*

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In both Kansas City and St. Louis, procedures varied over time, but typically sanctions were imposed on a case-by-case basis. This permitted staff to take individual circumstances and other factors (e.g., the client's desire to remain sober, willingness to attend treatment, and interest in remaining in the local community) into consideration when selecting an appropriate sanction. In Kansas City, the case manager often took the lead in identifying the need for sanctioning particular clients, but would confer with the cognizant PO. By contrast, St. Louis used its core team (which included the case manager, PO, and staff from the substance abuse and employment services programs) to conjointly make these decisions.

Kansas City OPTS often placed clients in detox programs or outpatient treatment in response to positive urine tests; while some regarded this as a sanction, others were decidedly uncomfortable with the notion of treatment as punishment. More typical of the sanctioning response was the insistence that clients with infractions have more frequent contact with case managers. At least one client was placed under house arrest as a sanction; and, lead agency staff also decided to use the probation department's "day report" program as an OPTS sanction for clients who failed to participate in OPTS, and who were in danger of having their probation revoked. Clients assigned to day report were required to report to the probation office daily and spend the entire day there for 12 to 16 weeks. While in day report, they participated in programs such as anger management, drug and alcohol abuse services, and survival skills (life skills). Clients were suspended from OPTS while participating in the day report program, and re-entered OPTS after successful completion of day report.

St. Louis also made some modifications to its planned sanction system. For example, community service was added as a sanction. The form of service initially imposed was providing assistance in the OPTS office (such as cleaning or painting), but other community service activities also could be required. At one point, the program instituted house arrest as a sanction, but later discontinued this practice due to its costliness and general lack of satisfaction with the results. Also, early in the first year of operations, the program added a new step intended to avert the need for sanctions: postcards were sent to clients who had failed to adhere to one or more of three basic requirements: calling to check in with the administrative assistant, meeting with the

> In general, if a client recidivates, sanctioning efforts may depend on what actions are taken by a judge. In St. Louis, staff felt that most local judges were supportive of treatment if the crime or technical violation were related to relapse. For infractions that did not result in the individual's appearance before a judge, sanctioning decisions (and also decisions about incentives) were made at service team meetings.
>
> The site followed a graduated approach, but sanctioning was more individualized than envisioned by the CASA model. The core team reviewed client compliance and progress in team meetings and reached consensus on the next steps for that person: this might require a person suspected of relapse to return to more frequent attendance at group therapy sessions and also be subjected to more frequent drug test screening; if the individual's problem persisted, s/he might be required to enter residential treatment; after two such admissions, the person might be terminated from OPTS and a warrant might be issued for her/his arrest.
>
> Program staff felt the OPTS clients were given many more chances than offenders under routine supervision. However, they regarded this as consistent with the program mandate.

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probation officer as scheduled, or attending a substance abuse treatment group meeting. The card notified clients of what they had failed to do, and instructed them to contact the probation officer and case manager to discuss their reason for the particular lapse.

Tampa case managers had less flexibility in using sanctions than the other community-based programs. This was largely due to justice system requirements that proscribe POs' authority (and by extension, case managers' ability) to impose sanctions.[12] Authority to impose sanctions, such as changes in supervision (e.g., day treatment, electronic monitoring, etc) or mandatory treatment, is reserved for judges. Thus, such measures reportedly could be required and enforced only by court order.

All three programs planned a variety of incentives to motivate or reward clients; although the extent to which plans were implemented varied over time and with different case managers. Neither Kansas City, nor Tampa, identified specific behaviors that clients needed to exhibit to obtain incentives; however, both sites used such incentives as certificates of achievement, tickets to entertainment or sporting events, meal vouchers for local restaurants, and decreased contact with case managers and POs, on an ad hoc basis. For example, Tampa used free books of bus passes as incentives that could be distributed at the joint discretion of the case manager and PO; the program also distributed some meal vouchers; and at least one client was provided with a bus ticket to visit family members living out of town. Over time, Kansas City case managers sometimes rewarded individual behavior spontaneously (e.g., taking a client out to lunch to acknowledge some progress), but also recognized progress more systematically at annual banquets where certificates of achievement were awarded.

In contrast, the St. Louis proposal identified specific behaviors that would earn positive reinforcements, such as:

- Free lunch for two for keeping all appointments for two weeks.
- Free movies for two for keeping all appointments for one month.
- Free lunch for the family, if the client had no positive urinalysis for one month.
- Free dinner and movie tickets for two for having no positive urinalysis for two months.

These were not implemented wholly as envisioned because the team was unable to solicit community donations to furnish such awards. However, the team did provide such rewards as bonus goods and services (e.g., groceries, tickets to movies or special events, vouchers for meals in local restaurants) on a case-by-case basis. Also, the program used the monthly dinner meeting that was open to clients and their families to publicly award certificates marking milestones and to hold periodic graduation ceremonies.

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[12] Clients were court ordered to participate in substance abuse aftercare as part of their supervision. However, participation in OPTS, itself, was voluntary, since offenders could be in compliance with supervision requirements by attending a variety of other aftercare programs.

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Client Satisfaction

Clients interviewed in small-group sessions during the course of site visits throughout the demonstration period reported that case managers typically served as a confidantes -- good listeners, who provided objective perspectives that helped individuals view their circumstances in a more accurate light. Clients remarked that case managers gave them the extra support they needed by calling them frequently to catch up and by drawing them out on issues and concerns; further, clients observed that they could count on their case managers to provide support when it was needed.

Similarly, at the end of one year of OPTS participation, clients were queried about their perceptions of the support they received from their case manager(s) and PO(s). As shown in Exhibit 2-7, most clients perceived case managers positively. Also, clients were more favorably disposed to the support received from case managers than from POs (see Exhibit 2-8). However, it should be noted that, compared to offenders in the control group who were under routine supervision, OPTS clients rated their POs more favorably on all ten items, and the differences were statistically significant on seven out of the ten items.

Exhibit 2-7
Clients' Perception of Case Managers

The following statements have to do with your feelings about your case manager during the 12 months .... Your case manager will not see your responses. How often would you say your case manager...	**Always %**	**Sometimes %**	**Never (%)**
a. Spoke in a way you understood	92	4	4
b. Respected you and your opinions	81	13	5
c. Understood your situation & problems	76	14	10
d. Was someone you trusted	66	17	17
e. Helped you view your problems/situations more realistically than before	70	15	15
f. Helped focus your thinking & planning	65	20	15
g. Taught you useful ways to solve your problems	64	16	20
h. Motivated and encouraged you	75	11	14
i.Helped you develop self-confidence	65	16	19

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Exhibit 2-7 Clients' Perception of Case Managers			
j. Developed a treatment plan with reasonable goals & expectations for you	68	15	17

Exhibit 2-8 Clients' Perceptions of Probation/Parole Officers			
The following statements have to do with your feelings about your PO during the 12 months.... Your PO will not see your responses. How often would you say your PO...	**Always %**	**Sometimes %**	**Never (%)**
a. Spoke in a way you understood	78	9	12
b. Respected you and your opinions	67	20	11
c. Understood your situation & problems	62	22	14
d. Was someone you trusted	44	23	31
e. Helped you view your problems/situations more realistically than before	50	23	25
f. Helped focus your thinking & planning	46	23	29
g. Taught you useful ways to solve your problems	40	24	34
h. Motivated and encouraged you	54	18	26
i.Helped you develop self-confidence	48	17	32
j. Developed a treatment plan with reasonable goals & expectations for you	50	17	31

Case Management Challenges

The local programs encountered a variety of challenges in implementing case management, performing service planning, overseeing service delivery, and monitoring client progress. The following discussion highlights key issues experienced by two or more sites.

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Service plans often were not formally recorded as "blueprints for individual actions." Case managers had reasonably small caseloads, and really went to considerable lengths to bond with their clients, so that they personally had a clear idea of the services they expected each client to receive. However, the lack of formalized plans hampered some client oversight when turnover or referral required that a different staff member or professional step in and try to carry out planned activities with transparency.

Case managers were charged with responsibility for determining client needs and matching them with appropriate services. As noted above, the first OPTS case managers used the early months of program implementation, before intake began, to develop their client intake and assessment procedures and forms, and to develop other case management procedures, such as protocols for information to be maintained in files, etc. However, the sites experienced some degree of staff turnover; and possibly because the program was so new, many of the procedures were not institutionalized as part of the organizational culture. The OPTS model did not detail specific standards for case management; and, none of the sites had policy or procedural manuals to help guide new case managers. In cases where there was an overlap of incoming and outgoing case managers, some training took place, but in general, replacement staff were left to develop their own style of case management.

Case managers across the sites came from very various backgrounds, with differing skills and experience. This variability affected service planning and delivery, as well as the brokering of services across all domains, but was specifically troublesome with respect to the delivery or brokering of substance abuse treatment and mental health services. In most cases, neither case managers, nor cognizant POs were certified addictions counselors, although some had prior experience in working with substance abusers. Often case managers lacked the requisite training or experience to make interdisciplinary -- particularly clinical -- determinations about client needs, and were also unfamiliar with standardized tools that might have permitted uniformity across staff (and clients). Additionally, staff were sometimes unfamiliar with distinctions among various treatment modalities, or requirements for client admission to different treatment milieus. Further, case managers were sometimes called upon to directly deliver intervention programs (as opposed to referring clients to other service providers); less clinically-oriented staff reportedly did not feel comfortable facilitating the in-house counseling/relapse prevention groups and therefore, the groups usually lapsed if the "more experienced" case manager was not available to lead the meeting or left the OPTS program.

In addition, some of the case management staff were new to the local area, or new to the field, and were unfamiliar with local resources and how to access them. Even seasoned case managers had difficulty connecting clients to services at times, for a variety of reasons, including: 1) demand for services outpaced the supply in some areas; 2) clients could not meet eligibility criteria for some services; 3) the local context kept changing, such that some service providers ceased to exist, while others altered their service offerings; or 4) there were true gaps in the continuum. These barriers to service are described more fully in subsequent chapters that address the key service domains.

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Across the three sites, case managers diligently worked to stay abreast of changes in the local service landscape, and to develop a reserve of services that could be accessed quickly on an as-needed basis. Case managers and supervisory staff in each of the programs actively outreached to expand the network of service providers that OPTS could call upon. In addition, each program tried to meet gaps in service or otherwise provide for client needs by developing and implementing small-scale programs within the lead agency. These efforts met with varying degrees of success. For example, despite the programs' best efforts, client participation at lead agency workshops was typically marginal at best; further, varying levels of client interest, flux in caseload composition, and resource limitations meant the continuity with which such programming could be offered was limited.

Perhaps the two components that elicited the greatest consternation on the part of program staff were urinalysis testing and graduated sanctions, as described below. Although the most significant issues associated with urinalysis testing were the costs and the length of time it took to receive results, each of the sites had to grapple with logistics in the early stages of program implementation when urinalysis monitoring did not appear to differ much from the usual probation/parole practices. In St. Louis, for example, urine tests were not performed for the initial OPTS clients because the program had not worked out "chain of custody" procedures to do so (virtually all OPTS participants in the early months of the program were male, while the OPTS PO was female; therefore, the program needed to call upon another male staff member, who was not regularly available to supervise the tests).

> Departmentwide probation and parole policies may impact the nature and intensity of drug testing in a program such as OPTS. For example, in Missouri, a probation/parole policy was implemented that required frequent testing of violent offenders, using the allotted resources that were in place. Given budgetary constraints, more frequent testing of that cohort translated into less frequent testing for other categories of offenders.

Similarly, in Kansas City, the lead agency did not complete arrangements regarding the urinalysis component (in terms of finalizing an agreement with a laboratory) until several months had passed. Ultimately, NCADD contracted with a private laboratory that could return results within 48 hours at minimal cost; however, POs noted that the lab was a short distance from NCADD, and case managers sometimes sent clients there unaccompanied, giving them the opportunity to clear their systems prior to testing. Another logistical issue regarded frequency of testing. The site's initial plan called for frequent testing, but this was re-visited because lead agency staff felt it was inconsistent with the nature of the service-driven relationship they wanted to develop with clients. Case managers wanted to develop a relationship different than what they viewed as the typical probation officer-offender supervision relationship. Consistent with that, they did not want to conduct many urine tests. Staff felt it was acceptable to use fewer tests than originally planned, combined with testing as appeared warranted based on client behavior.

While staff in Tampa and Kansas City were satisfied with the turnaround time for receiving urinalysis results, St. Louis initially sent its samples to the Cremer ITC for analysis,

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which took four to six weeks to return results (but had the advantage of being paid for by state funds through the probation/parole department). Lead agency staff were frustrated by this long lag time because it made it difficult for them to confront errant clients: by the time the results were received, clients often had regained sobriety, and case managers were conflicted about enforcing a sanction once the client was seemingly clean. In response to this situation, probation officers used field kits for non-routine tests (i.e., to test a client suspected of recent use); however, budgetary constraints within the Department of Corrections meant officers had to cut-back on the use of field kits. Ultimately, the lead agency contracted with a local laboratory that could return results in a timely fashion, but at a fairly high price for tests, particularly positive tests that required verification and therefore were billed at a higher rate. Due to cost concerns, the program limited the use of this resource to "crisis" drops (i.e., non-routine drops for the purpose of confirming and confronting suspected relapse).

As noted previously, the use of graduated sanctions and incentives was largely idiosyncratic in practice, rather than the systemized approach envisioned by the OPTS model. Tampa program staff felt constrained by the nature of the local court and correctional contexts, which greatly limited their use of these measures in any systematic fashion. Sanctions were used fairly consistently in St. Louis throughout the demonstration period; however, at least some of the core team expressed frustration about the use of sanctions, noting that negative sanctions did not appear to mean much to clients, and did not seem to influence their behavior (e.g., sanctioning did not appear to induce clients to increase their attendance at particular activities). A key actor noted that if they rigorously followed the sanctions system, they "would have no one left in the program," since a considerable proportion of clients had relapsed by using drugs or alcohol at some point after enrollment in OPTS. She felt program staff had been deliberately restrained in imposing negative sanctions, because it would "drive both clients and staff crazy" to fully enforce the system.

Kansas City staff also had a variety of concerns about the use of sanctions during the demonstration period; and in addition, they surfaced concerns about incentives. Key staff re-visited this topic at their meetings on several occasions. Since there were several conditions associated with probation and parole supervision, and sanctions associated with violating the requirements, the OPTS case managers were uncomfortable about imposing a second set of sanctions. They wanted to deal with clients from what they regarded as a more positive perspective than implied by a sanction system, and generally tried to give clients several chances (depending on the client and the circumstances) to comply with program requirements. There was also some concern about whether requiring additional treatment (or services), perhaps in response to dirty tests, should be considered a sanction.

With regard to incentives, Kansas City staff had some philosophical concerns about providing rewards for behaviors that clients should be practicing (i.e., rewarding behavior that was expected). Staff sometimes also felt that clients were not yet at a stage where their behavior was deserving of reward. Therefore, at various times during the demonstration period, incentives were not in use at this site. One notable exception, however, was related to the Survival Skills

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course: fresh fruit was available at these sessions, and site staff considered using fruit, or randomly providing other, unannounced incentives (such as tickets to the movies, sporting events, or the zoo, for those attending the focus groups on a particular day) to encourage attendance. Also, a graduation ceremony (including a dinner) was held for clients completing the Survival Skills course.

Lastly, a related issue that surfaced among staff pertained to the appropriate circumstances under which to terminate a recalcitrant client or, conversely, to graduate one who was seemingly compliant. OPTS programs were designed to give offenders more than one chance to achieve and maintain sobriety, as well as to get other areas of their lives in order. Sometimes the decision to terminate a client was made by the courts, as judges responded to technical or legal violations, but oftentimes, such decision making remained the purview of case managers or POs. As the program unfolded, CASA issued written guidelines for suspending or terminating participants; however, these were loosely enforced, and tended to focus on individuals who had never fully attached to the program or were flagrantly non-compliant.

Case managers often made multiple attempts, often spanning several weeks or months, trying to locate a non-compliant client, prior to having the individual declared an absconder. Similarly, they tried to give clients several opportunities to perform satisfactorily after an instance of relapse or other troublesome behavior. These efforts were often time and resource intensive, as well as frustrating for staff. Among other considerations, the efficient use of resources is an underlying concern of program administrators and staff: they need to balance the wise use of resources (e.g., caseload slots, staff, funds) with clinical or programmatic determinations of how to satisfy individual client needs for services/treatment. Across all sites, case managers recalled instances of clients they went to great lengths to help -- repeatedly moving an individual from one treatment program to another in an extraordinary attempt to facilitate the client's recovery process -- until finally the determination was made, after several relapses or other infractions, that continuing to offer services was tantamount to professional enabling, and that the client needed to be terminated, in part to free the resources in the hopes of benefitting someone else.

Similarly, case managers and other key staff often grappled with trying to determine client readiness to be graduated from OPTS (or phased down to fewer services, or less intensive contact with OPTS). Decision making was relatively easy, and consensus fairly high, when it involved clients who demonstrated exemplary performance -- no positive urine tests, stable employment situations for six or more months, good family and home conditions; however, the situation was more conflicted when clients with "checkered" performance (e.g., some relapses, some failure to attend meetings as required) were under consideration. For example, St. Louis team members apparently held widely divergent views on how criteria might be implemented for this: some members felt clients should not be graduated until and unless they had demonstrated total compliance with program expectations; others took a more moderate view that the program's goal was not to totally re-make participants, but rather to get them to address the root cause of their addiction and criminal involvement and demonstrate progress in moving toward

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more pro-social attitudes and behavior. Given these disparate viewpoints, the program was unable to establish formal graduation criteria throughout most of the demonstration period. As a result, many of their clients were retained in OPTS for the maximum allowable two-year period, although some of these clients probably had received as much benefit of services, and progressed as far as they were going to, months before their official graduation.

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CHAPTER 3
SUBSTANCE ABUSE TREATMENT

Substance abuse treatment services were a central focus of the OPTS initiative. As previously noted, unlike the other core services that were used on an as-needed basis, OPTS clients were mandated to participate in some form of substance abuse treatment. Consequently, substance abuse treatment was the most widely implemented service component of the five domains that comprise the OPTS model.

Clients' Presenting Profiles

OPTS programs in each demonstration site served clients with various substance abuse problems, including alcohol abusers and individuals who were eligible for the program largely because they *sold* drugs.[13] Exhibit 3-1 presents the frequency of substance use reported by clients for two distinct time periods: 1) their lifetime and 2) the 90 days prior to the most recent incarceration that qualified them for inclusion in the OPTS sample. As depicted in that exhibit, alcohol, marijuana, and crack cocaine were the three most prevalent substances reported during the 90-day period. Combining the total "N" in columns three through eight in Exhibit 3-1 shows that 78% of OPTS clients acknowledged alcohol use during the 90-day period, while 44% used marijuana, and 51% used crack cocaine. Approximately 55% of the OPTS clients who reported using crack during that time frame had used the drug *several times per day*. Among alcohol users, 37% reported drinking *several times daily* during this same period. Similarly, within the relatively small percentage of IV drug users, more than half reported daily use, typically several times per day, during that period.

Alternatively, many of the clients reported they had not used particular substances (i.e., "Not At All") during the three-month pre-OPTS reporting period, suggesting that while respondents may have experimented with, or even regularly used, a variety of substances in their past, few were actively using the full suite of substances with which they had prior involvement. Interestingly, 8% of the client sample (12 individuals) reported no use of any of the 18 substances during the 90-day period; these individuals were generally involved in drug selling, rather than using.

Exhibit 3-2 presents the most prevalent patterns of client multi-substance use pre-OPTS, for the total sample and by site. Among the 92% who reported use during the three months prior

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[13] The OPTS initiative tacitly assumed either 1) that drug sellers also were drug users or 2) that drug-selling offenders, because of their close proximity to drugs, need some form of treatment not only to recognize the harm to others (the customers) and the potential for harm to themselves, but also to modify their behavior accordingly. However, some case managers perceived that sellers were not always users, and reportedly were reluctant to require clients who sold, but did not themselves use drugs, to attend substance abuse treatment sessions.

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Exhibit 3-1: Drug Use History of OPTS Clients (N=147)

DRUG	Lifetime: Ever Used		Three Months Prior To Incarceration: Not At All		1 to 5 Times Total		1 to 3 Times Per Month		About Once per Week		Several Times Per Week		Once per Day		Several Times Per Day	
	Percent	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent	N
Alcohol	95.9	141	22.4	33	6.8	10	6.1	9	6.1	9	21.1	31	8.8	13	28.6	42
Marijuana	86.3	127	55.8	82	6.8	10	7.5	11	5.4	8	4.1	6	3.4	5	17.0	25
Inhalants	5.4	8	100.0	147	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0
Hallucinogens	32.7	48	93.9	138	1.4	2	1.4	2	1.4	2	1.4	2	0.0	0	0.7	1
Pills (downers)	20.4	34	93.2	137	1.4	2	0.7	1	0.7	1	2.0	3	0.7	1	1.4	2
Pills (uppers)	19.7	29	97.3	143	0.0	0	1.4	2	0.7	1	0.0	0	0.0	0	0.7	1
Amphetamines*	6.9	10	99.3	145	0.0	0	0.0	0	0.7	1	0.0	0	0.0	0	0.0	0
Opiates	17.7	26	91.8	135	0.0	0	0.0	0	0.0	0	0.7	1	2.0	3	5.4	8
Cocaine*	56.8	83	75.3	110	2.1	3	2.7	4	0.0	0	8.9	13	2.1	3	8.9	13
Crack	66.0	97	49.0	72	2.7	4	3.4	5	4.1	6	10.2	15	2.7	4	27.9	41
Speedball	6.1	9	97.3	143	1.4	2	0.0	0	0.7	1	0.0	0	0.0	0	0.7	1
Basuco	1.4	2	98.6	145	0.7	1	0.0	0	0.0	0	0.0	0	0.0	0	0.7	1
Heroin (IV)	15.0	22	92.5	136	1.4	2	0.7	1	0.0	0	0.7	1	0.7	1	4.1	6
Cocaine (IV)	16.3	24	93.2	137	1.4	2	2.0	3	0.0	0	0.7	1	0.7	1	2.0	3
Speedball (IV)	13.6	20	95.0	139	0.0	0	0.7	1	0.0	0	1.4	2	1.4	2	2.0	3
Speed (IV)	4.1	6	98.6	145	0.0	0	0.7	1	0.0	0	0.0	0	0.0	0	0.7	1
Other Narcotics (IV)	1.4	2	100.0	147	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0
Illegal Methadone	4.8	7	98.0	144	1.4	2	0.0	0	0.7	1	0.0	0	0.0	0	0.0	0

* N=146

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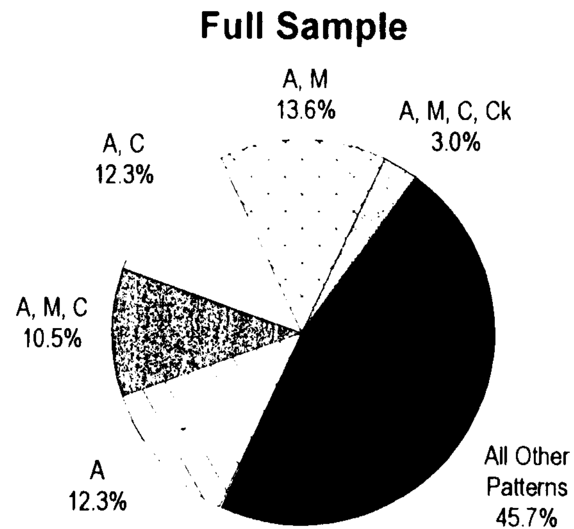
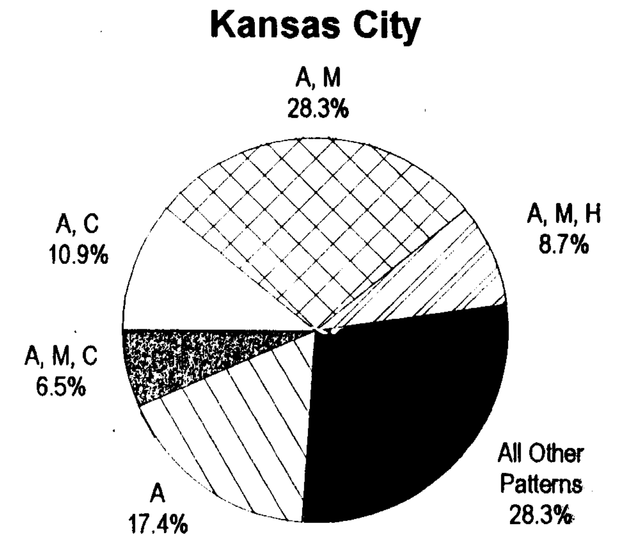
EXHIBIT 3-2.

Prevalent Patterns of Drug Use for OPTS Clients in 3 Months Prior to Incarceration

(Percentages Based on Those Who Reported Any Drug Use in this Period) N = 162





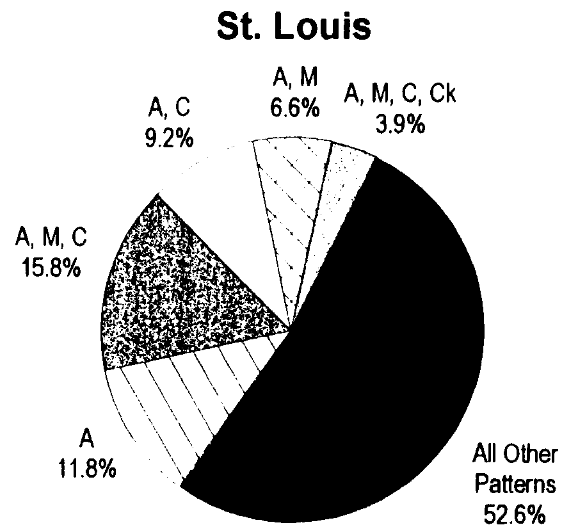
A = Alcohol

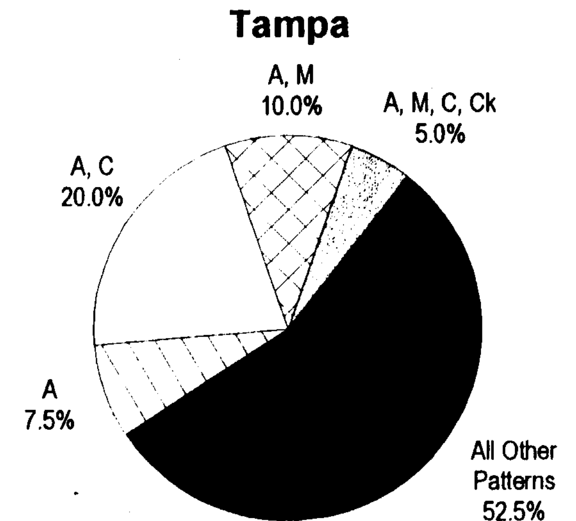
M = Marijuana

C = Crack

H = Hallucinogens

Ck = Powder Cocaine





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to their incarceration, four patterns were prevalent, specifically: 1) alcohol and marijuana, used by 13% of those who reported use during that time frame; 2) alcohol and crack (12%); 3) alcohol, crack, and marijuana (12%); and 4) alcohol only (about 11%). About 3% of OPTS clients reported a pattern of use that involved alcohol, marijuana, cocaine, and crack cocaine; these respondents are incorporated into the "All Other Patterns portion" of the "sample" pie.

Further, as part of the follow-up survey, clients were asked what their drug of choice was at the time they were arrested and incarcerated (preceding their enrollment in OPTS). Almost 50% said cocaine or crack, and 16% said marijuana (and no other drug was mentioned); almost 10% mentioned only alcohol. The percentage of clients who said heroin, methadone, or the other opiates was 10% (14 clients). Three clients reported they had no drug of choice, because they only *sold* drugs; and one client reported neither using, nor selling drugs at all.

The Spectrum of Substance Abuse Treatment

Ideally, a full complement of services related to alcohol and drug treatment encompasses a range of care that permits substance abusers to access those services that specifically match their individual needs. Since the programs were not limited to recruiting a particular type of drug user or addict (e.g., heroin addict or chronic cocaine abuser), the local OPTS networks of treatment services had to be diverse to adequately address client needs.

Research conducted by the U.S. Department of Health and Human Services' Center for Substance Abuse Treatment (1994) suggests that such a continuum includes at least three components: 1) pretreatment services[14], 2) various outpatient programs, and 3) short- and long-term inpatient treatment. Two other components also are desirable: detoxification regimens and support groups that offer relapse prevention assistance.

The three sites varied with respect to the nature and extent of services available to OPTS clients. In general, the range of substance abuse interventions was based on availability of the different types of services within each community. Each encompassed a wide variety of program types from support groups that met once or twice weekly to residential treatment facilities designed to offer inpatient care for more serious addictions. Some of the substance abuse services were provided directly by the lead service agencies or under MOUs with core partner organizations, others were accessed on a case-by-case basis. Exhibit 3-3 provides a summary of the providers who treated OPTS clients in each site, categorized by type of service. Exhibit 3-4

[14] Pretreatment services generally consist of substance abuse education, and monitoring, screening, and possible referral at the early intervention level. Such services typically are not considered primary treatment, but are used as a tool in prevention and possibly early intervention. For OPTS clients, prevention services were not used, because nearly all clients had histories of alcohol or drug abuse. The few who reported no problems ever with substance abuse were either in denial (or possibly fabricating the truth) or were eligible for OPTS because of their conviction for the delivery or sale of drugs.

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Exhibit 3-3
Substance Abuse Treatment Providers, by Treatment Type and Site

Treatment	Kansas City	St. Louis	Tampa
Self Help	NA/AA	NA/AA	NA/AA
Outpatient Non-Intensive	NCADD OPTS group* Recovery Dynamics Comprehensive Mental Health Services VA Hospital	DART	DACCO RES II aftercare at DACCO, and at RES II* DACCO Relapse Prevention (outgrowth of DACCO group)* VA Hospital
Methadone Maintenance		DART	DACCO*
Intensive	NARA* Johnson County Substance Abuse	DART* Archway Communities	Goodwill Industries Agency for Community Treatment Services (ACTS) Center for Women
Residential Halfway Houses	Kansas City Community Center (KCCC) Community Recovery House * Fellowship House* Gateway (under CMHS umbrella) Welcome House*	Dismas House Salvation Army-Harbor Lights Magdela	Crossroads
Short and Long-Term Treatment	KCCC Imani Johnson County Substance Abuse VA Hospital	DART Residential* Archway Communities Treatment Center Agape House Mission Gate	DACCO Res I and Res II* Operation PAR ACTS Daytop Avon Park Manna House VA Hospital Substance Abuse Program
Crisis/Emergency Care	Park Lane Hospital ACT One KCCC Johnson County Substance Abuse Northland Recovery Fellowship House	DART Residential* Archway Communities Treatment Center	ACTS

*Core providers

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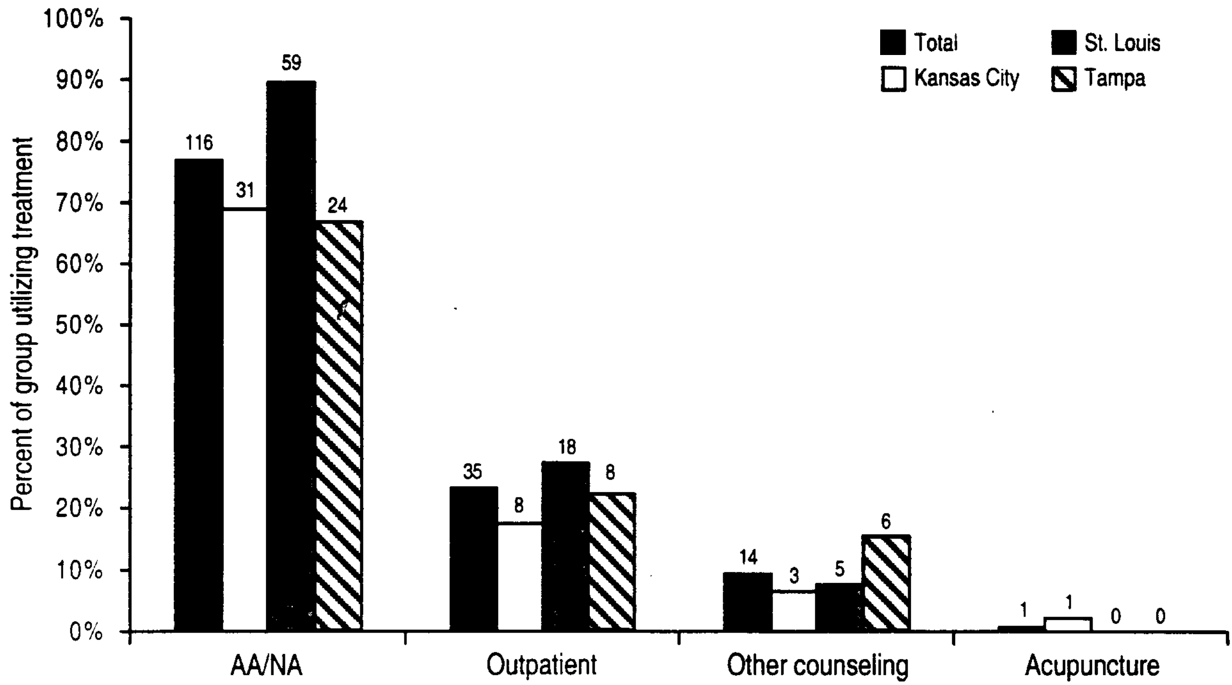
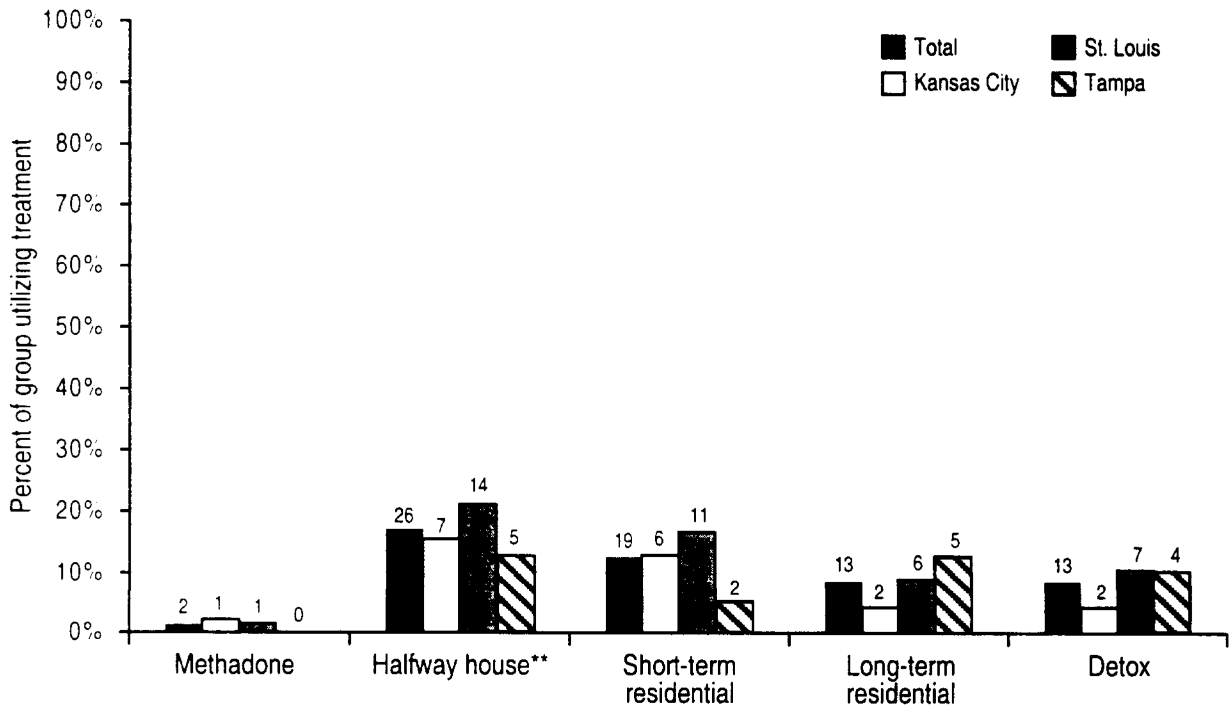
EXHIBIT 3-4.

Substance Abuse Services* Used by Clients During Their First Year of OPTS Participation



Note: Ns are reported at the top of each bar



Note: Ns are reported at the top of each bar

* *Individuals may receive multiple substance abuse services*

***Includes 7 clients who may not have received substance abuse treatment while in residence.*

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details the number and percentage of OPTS clients who reportedly used the different types of drug treatment services.[15] There were 23 clients across all sites (i.e., 11 in Kansas City, 4 in St. Louis, and 8 in Tampa) that reported they did not attend *any* of the treatment services they were asked about. In addition, these 23 clients did not use any medication as part of a treatment to help them reduce or stop their drug use.

The discussion in the following sections highlights the services frequently used by OPTS clients.

Self-Help Groups

Across the demonstration sites, the OPTS programs regarded self-help groups -- particularly those based on the 12-step recovery model -- as key parts of their local continua of services available to help prevent substance abuse relapse. Well-known and well-respected, these groups are often used as an important adjunct to treatment; although some substance abuse interventions do not consider self-help groups as falling within the continuum of treatment services because meetings are facilitated by lay leaders (who are in recovery), and are not intended to provide therapy or counseling. Nevertheless, many treatment programs, including some residential programs, mandate that their clients attend self-help groups; and probation/parole officers historically have encouraged or required substance abusers on their caseloads to attend self-help group meetings.

The best known groups are Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA). These three programs are based on the 12-step model of recovery that has a largely spiritual base, focuses on abstinence, and encourages active participation in self-help meetings and related activities. As individuals become members, they may be linked to a sponsor, who is a person in recovery. A sponsor's relationship to the newer member is similar to that of a mentor.

Individuals who do not like the spiritual aspect of these services frequently can attend other 12-step groups; communities often offer various options, such as groups based on ethnicity, gender (e.g., Women for Sobriety), veteran status, or age (e.g., meetings for elderly alcoholics or addicts). There are no fees or dues for these programs. Transportation is frequently arranged by participants to help out other members who would have difficulty getting to the program location.

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[15] These data derive from the self-report follow-up questionnaire, which asked respondents about intensity, duration, and frequency of use for nine different types of treatment services (not counting medication), including: detoxification programs, halfway houses, short-term residential programs (up to 30 days), long-term residential or therapeutic community programs, methadone maintenance programs, AA and NA support groups, outpatient drug treatment, other counseling programs or support groups/aftercare programs, and acupuncture treatments.

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Based on self-report data from the follow-up survey, the treatment services most utilized by clients during the 12 months after their enrollment in OPTS were Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Approximately 77% (116) of all OPTS clients (i.e., 70% in Kansas City, 88% in St. Louis, and 67% in Tampa) attended AA or NA at some time during the 12 months. Of the clients who attended AA or NA, nearly half were required to attend as part of their supervision requirements or as part of the requirements of a residential program in which they were participating. The latter was often the case for individuals in the halfway houses in St. Louis. One-third of those required to attend self-help meetings reported they also entered the programs for other reasons, such as they were tired of their lifestyle or their addiction.

Principles of the AA's 12-Step Model

The steps for Alcoholics Anonymous are virtually identical to other 12-step programs. They are as follows:

1) We admitted we were powerless over alcohol -- that our lives had become unmanageable.
2) Came to believe that a Power greater than ourselves could restore us to sanity.
3) Made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4) Made a searching and fearless moral inventory of ourselves.
5) Admitted to God, to ourselves, and to another human beings, the exact nature of our wrongs.
6) Were entirely ready to have God remove all these defects of character.
7) Humbly asked Him to remove our shortcomings.
8) Made of list of persons we had harmed, and became willing to make amends to them all.
9) Made direct amends to such people wherever possible, except when to do so would injure them or others.
10) Continued to take personal inventory, and when we were wrong promptly admitted it.
11) Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for the knowledge of His will for us and the power to carry that out.
12) Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

Case managers and probation officers in all sites were aware of the support groups in their communities, and often encouraged their clients to attend. Almost 20% of OPTS clients reported that one of their main reasons for entering AA/NA was that their probation officers encouraged their attendance; similarly, 14% reported that one of the main reasons they entered the program was that their case managers encouraged treatment. St. Louis clients were specifically asked by the OPTS core service team (which includes case managers, probation officers, and DART counselors) to bring in a log showing that they attended AA/NA or other self-help group meetings. The case managers in Kansas City routinely gave all clients a list of local meetings, but they were not mandated to attend, unless required as part of their court-ordered aftercare.

The average duration of attendance was just under eight months, as shown in Exhibit 3-5. The majority of clients (55%) across all sites who attended AA or NA went a few times each week, and another 22% attended sessions once weekly; a small number of clients (at least four in each site) attended AA/NA sessions daily. There were some differences in attendance patterns by site: 67% of OPTS clients who went to self-help meetings in St. Louis reportedly attended a few times each week, in comparison to 34% in Kansas City and 52% in Tampa who said they attended a few times a week. This may be because case managers and DART counselors "required" regular or consistent attendance, and followed up by monitoring client logs.

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Exhibit 3-5
Duration, Intensity, and Short-Term Outcomes of Substance Abuse Treatment Reported by OPTS Clients

Treatment	N	Number Entering a Program More than Once in 12 Months	Average Duration	Mean Hours of Individual Counseling per Week[a]	Mean Hours of Group Counseling per Week	% Saying Treatment Helped Them Stop Using, Cut Down, or Maintain Sobriety for at Least 3 Months
Residential						
Short-Term	19	4	28.5 days	2.9 (N=14)	12 (n=19)	74%
Long-Term	13	0	4.5 mos	1.8 (n=11)	10.5 (n=13)	84.6%
Halfway House[b]	19	4	2.1 mos	1.5 (n=14)	16.5 (n=17)	52.6%
Non-Residential						
Intensive Outpatient	6	1	6.6 mos	4.6	12.8	75%
Non-Intensive Outpatient	29	4	7 mos	1.1 (n=19)	3.1 (n=28)	79.3%
Other Counseling	14	n.a.	6 mos	0.8 (n=4)[c]	5.8 (n=11)[c]	85%
AA/NA	116	n.a.	7.9 mos	n.a.	n.a.	82%

[a]Because some programs did not have individual counseling, mean is only calculated for those who received individual counseling.
[b]Excludes clients who did not enter the halfway house for drug treatment, and therefore did not receive counseling in the halfway house. Overall, 26 clients reported entering a halfway house, but 7 of those went primarily for housing.
[c]N's are small because respondents did not report much "counseling" within the "other" programs listed, such as anger management and relapse prevention.

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Outpatient Treatment

Outpatient treatment can include highly professional psychotherapy or simply informal, facilitated peer group discussions. All types of counseling can be found in the variety of programs that abound. Individual and group therapies are usually the most popular types of counseling, but counseling can include peer group support, marital counseling, anger management, vocational therapy, and cognitive therapy.

Outpatient programs comprise a broad range of community-based services that fall along a continuum from intensive (9 or more hours per week in a structured setting) to non-intensive interventions (less than 9 hours per week). Non-intensive programs often address emotional and social issues that impact a client's potential for relapse. The majority of these programs focus on relapse prevention. Aftercare programs (i.e., programs designed to follow through after a more serious and structured drug treatment intervention has been completed) that require attendance once or twice per week also may be considered non-intensive outpatient programs. Similarly, treatment-related services such as the anger management programs, family counseling, and other life skills-type programs designed to assist OPTS clients with issues that are related to substance use and abuse may be considered within the purview of outpatient treatment.

Another type of outpatient program offers support groups modeled on 12-step programs; these are based on the principle of total abstinence (consistent with AA/NA), but use certified counselors who are often recovering addicts to conduct group and individual counseling. There may be additional program staff providing consulting and resource backup. Counseling is mostly directed to issues surrounding family and interpersonal relationships. During the support group meetings, clients focus on the first four steps of AA, and then can progress to the remaining steps through involvement with AA and NA.

In addition, outpatient treatment may include methadone maintenance.[16] Methadone maintenance outpatient programs may be either short or long term, but frequently last 12 months or longer (although when methadone is used to detox from opiates, this usually takes anywhere from three weeks to six months).[17] Eventually, the dosage is tapered off, until the individual is fully weaned from methadone.

After self-help groups, the next most utilized treatment service was outpatient counseling. Approximately 23% (i.e., 35) of OPTS clients across the sites reported receiving outpatient drug

[16] Methadone, a narcotic analgesic used as a substitute for heroin, morphine, codeine, and other opiate derivatives, suppresses withdrawal symptoms and does not produce euphoria or sedation. Also, it renders concurrent use of opiates ineffective in producing the characteristic euphoric high.

[17] While it is classified here as an outpatient treatment, methadone maintenance can be part of inpatient residential programs, and some jails and prisons have methadone maintenance programs. Also, some detox programs use methadone, with or without other stabilization medications.

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treatment during the 12-month follow-up period.[18] Of these, four clients reported just receiving outpatient drug treatment services and nothing else during the 12-month follow up, and 17 clients (11.3%) reported attending only outpatient services and Alcoholics Anonymous or Narcotics Anonymous. The overwhelming majority of these 17 clients were concurrently attending both outpatient and AA/NA during the same months. The remainder received outpatient treatment and a mix of other substance abuse treatments.

Fourteen clients (9.3%), including the three just mentioned, reported attendance at other types of counseling programs that could include anger management, family counseling, life skills training, or support groups other than AA/NA.[19] All fourteen reported attending AA and NA in addition to their other counseling. Only one client (from St. Louis) out of 14 reported attending family counseling (in other words, listed family counseling as "other").

Only a small number of clients (6) across the three sites attended outpatient services with nine or more hours of counseling each week (see Exhibit 3-5). These six clients attended an average of 13 hours of group counseling each week, and more than four hours of individual counseling each week. The reason most frequently given as to why clients entered outpatient programs (both intensive and non-intensive) was that the programs were a supervision requirement. However, when the distinction is made between those who received nine or more hours of counseling and those who received less, the second most frequent reason for entering the program differs. Those attending the more intensive outpatient programs reported more often that their PO encouraged treatment and those attending the less intensive programs reported more often that their case managers encouraged treatment. Clients attended outpatient drug treatment programs -- both intensive and less intensive -- for an average of approximately seven months.

Only one OPTS client (in St. Louis) self-reported participation in a methadone maintenance program. He reportedly entered the program because he was becoming a parent and wanted to become drug free. A second client in Kansas City also received methadone briefly as part of an in-patient hospital detox program. The low numbers involved with methadone maintenance programs were not entirely unexpected since the overwhelming majority of OPTS clients were not addicted to heroin.

In Kansas City, NCADD case managers operated the aftercare component most commonly recommended for OPTS clients: the weekly OPTS focus group, which provided substance abuse education and counseling. The foundation for this OPTS aftercare component derived from the National Institute of Health's *Recovery Training and Self-Help: Relapse Prevention and Aftercare for Drug Addicts* manual. In the group meetings, OPTS clients and case managers explored 24 topics associated with substance abuse education and relapse

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[18] Use of outpatient services by OPTS clients may well be under-reported, as some clients may not have included treatment sessions offered by the lead agency in their self reports.

[19] Respondents were queried separately about their participation in "outpatient drug treatment counseling" and "other counseling programs or support groups (outside of AA/NA)." However, it is possible that some respondents included drug aftercare and relapse prevention type programs in the first category.

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intervention/prevention. Course materials (video tapes, books, etc.) focused on relapse intervention and prevention, and were used to facilitate discussion among participants. Clients entered the group shortly after completion of the intake process. Although regular group attendance was required, only a few clients met this expectation, and therefore, the group was discontinued in the early part of the second program year, as it was supplanted by Recovery Dynamics.

Program staff in Kansas City believed that their focus group sessions needed to have more structure. The approach offered by Recovery Dynamics was seen as promising in this regard.[20] This model presents the steps to recovery in a goal-oriented format designed to help clients develop an accurate understanding of addiction and identify solutions that lead to recovery. The program materials include both video and audio components to address the needs of clients with poor literacy skills or physical impairments. NCADD underwrote costs associated with providing the books and supplies needed for the group, which was initially facilitated by an individual in recovery.[21] Ten OPTS clients were referrred to the program, which took place at NCADD one night each week for 28 weeks. The clients also were expected to attend a Cocaine Anonymous group weekly and another 12-step group meeting of their choice each week.

Although Kansas City OPTS did not routinely refer clients to outpatient substance abuse programs other than AA and NA, case managers did refer clients to a variety of other outpatient treatment providers on an as-needed basis. Referral to a particular program was largely based on where the client lived and availability (no waiting list). Both case managers indicated that many outpatient programs have waiting lists. For more intensive outpatient treatment, Kansas City OPTS referred clients to such agencies as Resource Development Institute's Narcotics Addicts Rehabilitation Act (NARA) program; Johnson County Substance Abuse Services, Inc.; and Imani House. Comprehensive Mental Health Services and Central Kansas City Mental Health were occasionally used as referrals for less intensive outpatient services.

Clients attending outpatient programs most frequently went to NARA, a comprehensive, intensive outpatient day treatment program that provides assessment, drug education, individual and group counseling, and aftercare. NARA was one of the few providers mentioned in the original proposal, and with which NCADD had an MOU. Johnson County Substance Abuse offered outpatient services, as well as a three- to five-day detoxification program, and a 30-day intensive short-term treatment program. It used a variety of counseling groups to facilitate the client's re-entry and re-socialization into the community. However, the program was closed in

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[20] NCADD was introduced to Recovery Dynamics by one of the OPTS volunteers, who had been certified at the Kelly Foundation, Inc., in Little Rock, AK. Recovery Dynamics reportedly has been incorporated into the curriculum of more than 300 substance abuse treatment programs worldwide, with chapters operating in 31 states and 7 countries (Australia, Canada, England, Ireland, Sweden, Switzerland, and the U.S.).

[21] Subsequently, when the group leader relapsed, one of the OPTS case managers attended Recovery Dynamics training, so that he could continue to conduct the classes.

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the summer of 1995. Imani House, located within a few miles of NCADD, offers a range of evaluation services and both outpatient and inpatient treatment.

In contrast to Kansas City, all St. Louis OPTS clients were initially sent to the substance abuse service provider, DART, whose outpatient services are located in the same facility as the OPTS office, as previously noted. OPTS clients participated in mandatory group counseling sessions focused on substance abuse treatment, education (including HIV prevention), and relapse prevention. The expectation was that clients would attend group meetings twice weekly for a four-month period; meet intermittently in individual sessions with the group leader; and subsequently reduce their involvement as they demonstrate progress in maintaining sobriety. When the program first began, OPTS clients participated in a group with other DART clients; as the number of OPTS clients increased, a group was formed solely for them. DART also initiated a daytime group for OPTS clients, in addition to the usual evening group, to accommodate those whose jobs required them to work in the evening. The thrust of the groups changed in the Fall of 1995, in conjunction with a grant DART received to develop a "state of the art" aftercare approach (which affects other DART clients, not just those in OPTS). DART counselors received training in the Gorski model, that advocates a 15-step paradigm through which addicts learn to: 1) identify warning signs that could lead to relapse and 2) implement plans to interrupt or prevent relapse.[22]

The majority of St. Louis OPTS clients who received outpatient services were receiving them through DART. However, clients in need of more intensive outpatient services could be referred to a new day treatment program at Archway Communities Treatment Center. Clients can attend the day treatment program six hours daily, two to five days per week. Archway Communities also operates a 21- to 30-day inpatient treatment program and a five-day social detoxification program.

In Tampa, clients were able to receive outpatient substance abuse treatment from both the lead agency and alternate service providers. Many of the OPTS clients returned to the community after completing court-ordered treatment in a DACCO or other residential facility; for clients leaving DACCO's residential facilities, DACCO aftercare was mandatory for at least one month, (for some, it was longer). Because the Tampa program served relatively few clients during the first year of the demonstration, the diversity of outpatient treatment options was limited. Some OPTS clients attended group meetings for DACCO outpatients, which were facilitated by one of the OPTS case managers (this began as coincidence; the case manager had an independent contract to provide counseling services for DACCO clients). These meetings focused on continuing treatment and relapse issues (e.g., identifying relapse triggers, how to remain clean

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[22] In contrast to traditional relapse prevention models that emphasize avoidance (i.e., addicts are directed to avoid certain places, people, or things), the Gorski model reportedly equips addicts to both address the root cause of their addiction, and to anticipate and handle relapse-triggering situations. Addicts are taught how to devise and implement a relapse prevention plan; how to recognize relapse triggers; and how to preserve their recovery by objectively evaluating situations and selecting appropriate, pro-social responses (see Gorski et al., 1993).

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and sober). A group solely for OPTS clients -- DACCO Relapse Prevention -- was formed in late 1995, as more OPTS clients were released to the community. The primary focus of this group was relapse prevention, and it included family issues. A few of the clients regularly brought their spouses or significant others.

Clients who needed more intensive outpatient services than the OPTS group or DACCO aftercare could provide received outpatient treatment through referral to Goodwill Industries' day/night treatment program. This is a more intensive intervention than that provided by DACCO. As part of a very structured, eight-week outpatient program, clients participate in services for four hours per day (during the day or night).The Goodwill Industries program features full assessment and psychosocial profiles of clients, in addition to three-phase treatment and counseling components. Each client works closely with a case manager who tracks the client's progress. The Goodwill case manager also can refer OPTS clients to other services. For clients who can afford payment, there is a small copayment. The Goodwill program is designed to serve state probation/parole clients; in the summer of 1995, it expanded to serve county probation and parole clients. The program is unique in that it cannot have a waiting list. Goodwill is often used if a client fails traditional, less structured outpatient treatment. If a client also is unsuccessful in the Goodwill program, s/he is usually referred to a residential program via a court order from the judge. The director of Goodwill indicated that for more than 90% of the cases they referred to residential treatment, judges have supported the decision with a court order.

Other agencies that became part of the Tampa OPTS network of outpatient services included the Center For Women and the Agency for Community Treatment Services (ACTS). The Center provides intensive outpatient substance abuse treatment for up to six months, under its Project Recovery division. ACTS is a comprehensive substance abuse agency that provides intensive outpatient treatment, as well as short- and long-term residential treatment; the agency also houses the only non-profit detoxification facility in Hillsborough County.

Also, OPTS programs in both Tampa and St. Louis referred some clients to local Veterans Administration (VA) hospitals. Typically, VA hospitals provide outpatient and some inpatient substance abuse services. For example, the Chemical Dependency Division in Tampa offers a 21-day outpatient program; a six- to eight-week outpatient counseling evening program that operates three days per week for two hours per session; a DUI court intervention program; and a partnership program with the Salvation Army designed to outreach to women.

Residential Treatment

Residential programs range from non-intensive, community-based treatment to more intensive inpatient therapies that include medical, psychiatric, and psychosocial treatment provided on a 24-hour basis. Programs differ in the intensity of the intervention(s), particularly substance abuse services, and the time frame required to successfully complete on-site treatment. Some residential programs are simply halfway houses, to which clients self refer or are referred

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by POs or case managers. Clients can usually stay in these programs up to six months, hopefully remaining until the lead counselor deems the individual ready to be released to the community. Ideally, halfway houses offer supportive living environments that facilitate pro-social skills building and a range of other services, including various activities aimed at reducing the risk of substance abuse relapse. By contrast, other types of inpatient residential programs emphasize the substance abuse treatment aspect: intensive residential programs generally use a specific treatment modality or type of therapy such as therapeutic communities or reality therapy. Short-term programs typically offer 30 or fewer days of service (although some patients may remain slightly longer if supervisors believe the client can successfully complete the program with a moderate extension of treatment days). Longer-term programs span several months, and may require one year or more of institutional care, with community-based aftercare services available once the residential portion has been successfully completed.

Across all sites, 17% (26) of OPTS clients entered a halfway house during the 12-month follow-up period. Almost a quarter of those clients entered the halfway house directly from a Missouri Institutional Treatment Center (ITC) because they did not have a satisfactory home plan upon exiting the ITC. Not counting the clients who entered directly from the ITC, the reason most frequently reported for entering a halfway house was because the client's probation officer encouraged treatment. The average stay in the halfway house was 2.1 months.

Fewer clients attended residential treatment programs than resided in halfway houses: 13% of all clients (19) entered a short-term residential facility, and 9% (13) were placed in long-term residential treatment. Among the sites, St. Louis had the highest percentage of clients (17%) reporting that they entered a short-term facility at some time during the 12 month follow-up, as compared to 13% in Kansas City and 5% in Tampa. By contrast, Tampa OPTS used long-term residential services for 13% of its clients (5), whereas St. Louis used such services for 9% (6 clients) and Kansas City for 4% (2 clients).

In the three sites, halfway houses for substance abusers generally consist of two types:

- Social model recovery homes or sober living houses, such as the Oxford house model, which historically have their roots in housing for recovering alcoholics who want to live together in a supportive environment that is drug- and alcohol-free. Many of these houses are democratically run and self-supporting.

- Transitional housing that offers treatment beds or just community placement beds for those who need housing. These halfway houses are primarily funded by the state's Department of Corrections. Staff usually include counselors who use case management techniques.

Both Kansas City and St. Louis had a number of Department of Corrections-funded halfway houses that could easily admit OPTS clients by referral from their case manager when clients needed a very structured living environment (e.g., their living arrangements at home posed

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problems).[23] Tampa clients also were referred to halfway houses when their living environment posed a great threat to a drug-free life. However, unlike the referral process in the Missouri sites, clients in Tampa were usually mandated to the halfway houses by judges at sentencing for a crime, or during case review (which happened monthly for the handful of OPTS clients who also had drug offender probation status in Tampa).

In Kansas City, the Kansas City Community Center (KCCC), Community Recovery House, and Gateway are halfway house programs that offered OPTS clients substance-free housing with a treatment component. KCCC provides 30- to 90-day aftercare programs in a residential facility, as well as temporary drug-free housing and weekend placements. KCCC essentially is two separate programs: 1) the DOC-contracted 90-day residential treatment program and 90-day work release, and 2) a Department of Mental Health-funded 30-day comprehensive inpatient program. However, the treatment component of the DOC-contracted halfway houses ended in March, 1997, when the Department of Corrections decided that its halfway houses should focus more exclusively on housing and general counseling issues. From then on, clients in need of substance abuse treatment have to be referred to outside treatment during their stay in the halfway house.

Community Recovery House offers a drug-free, structured living environment for men and women, as well as life skills training; substance abuse treatment and counseling; relapse education and prevention; and an aftercare component. Mandatory group and individual counseling, and completion of daily chores are designed to add structure to clients' lives and to facilitate a sense of responsibility. Length of treatment varies from six weeks to six months.

Gateway is a privately funded 30-day program in Independence, Missouri (a suburb east of Kansas City) that is part of Comprehensive Mental Health Services, Inc. As with KCCC, halfway house clients attend treatment counseling offsite -- in this case, at a nearby hospital during the day, Monday through Friday. Clients can remain in the program longer than 30 days, if they are unable to return to any other drug-free living environment. The program is funded by the Community Backed Anti-Drug Tax (COMBAT), and clients do not have a copayment.

In addition to these programs, NCADD also had MOUs with two other halfway houses: Fellowship House and Welcome House. Neither of these facilities were used by many OPTS clients. The Fellowship House program, which provides 30 days of housing and has an on-site treatment component, was particularly problematic as some residents reported it was not a drug-free environment, thereby complicating their recovery.

In St. Louis, Dismas House and Harbor Lights operate as DOC-funded halfway houses. Dismas House has 60 beds for state DOC clients, ten of which are for women. Most of the remaining beds are for federal clients. Of the state DOC-beds at Dismas House, only 29 slots are

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[23] However, in the Spring of 1997, contractual changes resulted in removing drug treatment services from halfway houses.

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for treatment, the remaining are community placement beds. Dismas is the only house that accepts women. The Salvation Army's Harbor Lights program only houses state-DOC clients, and has a capacity of 50 treatment beds. Clients are generally assigned to the halfway house for 90 days, but can progress through the program in as few as six weeks or remain up to six months.

OPTS case managers cannot control to which halfway house a client is admitted. All DOC-contracted halfway houses have waiting lists; for example, Dismas House's waiting list can be as long as three months. The general success rate is reportedly 60% for the state clients. If a client fails a halfway house program, they will usually be referred to another DOC-funded halfway house; it is rare that a house permits an unsuccessful client to return to its program. Clients must obtain a job within three weeks. Clients give 50% of their pay to the halfway house, and half of that goes to the state; the remaining 50% is put into a savings account for the client.

OPTS clients in Tampa were sometimes referred to one of the Crossroads programs, which focus on life skills and also offer substance abuse treatment. The programs are based on a therapeutic community model that allows members of the community (residents and staff) to work together to address and solve problems. When a resident is ready to leave, s/he may enter the aftercare program that serves individuals who have successfully completed a Crossroads residential program.

The Crossroads program for women consists of two components: a primary residential program and a transitional housing program. The primary residential program serves approximately 50 women annually in the 16-bed facility (half of the 16 beds are for DOC-supervised clients). The transitional program can accommodate up to six women at a time in its three-bedroom facility. The average stay is approximately six months. The program focuses on issues specific to female offenders. In addition to substance abuse prevention, relapse prevention counseling, and education, Crossroads offers counseling in the areas of self-esteem, education, budgeting, employability, parenting, and family reunification.

The men's residential program is similar to that for women. Seventeen beds are available, serving approximately 85 male offenders annually. Residents enter the program directly from jail or prison; or have past criminal records, are living on the streets, and ready to make a fresh start. Crossroads also offers a 15-bed forensic program, which is one of two community-based residential programs available statewide to serve mentally ill individuals who have experienced legal problems related to their psychiatric conditions. During the course of a treatment year, the program focuses on mental health issues, adult daily living skills, communication and resocialization, substance abuse and recovery, leisure skills, and medication management.

Although halfway house programs are available in all the sites, inpatient programs for serious drug abusers are scarce, there are generally long waiting lists, and costs can be prohibitive for some private programs that operate in, or are accessible to, the sites. Additionally, some inpatient programs are designed specifically for clients who abuse one particular substance --

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such as heroin or cocaine -- and, therefore, are not be geared to deal with multi-substance abusers. Specialization of this type is not unusual in therapeutic community programs.

As noted above, Kansas City used KCCC and the now-defunct Johnson County Substance Abuse Services to provide some residential treatment in addition to that provided by halfway houses. The program also relied on services provided by Imani House. Imani House offers a 90-day treatment program, specifically targeting HIV clients and African American males. Clients attend 30 days of intensive inpatient treatment, followed by 60 days of outpatient aftercare.

In addition to the halfway houses, some St. Louis OPTS clients were referred to DART's 30-day residential treatment program, Archway Communities Treatment Center, Agape House, or Mission Gate. Archway, mentioned earlier in the discussion of outpatient programs, provides a 65-bed, 30-day residential treatment center funded by the Department of Mental Health. Agape House offers a privately-funded 30-day residential treatment program with three months of housing aftercare, if needed.

For more extended treatment, St. Louis's clients -- both male and female -- can enter Mission Gate, where they can receive inpatient services for up to two years. Mission Gate is a privately funded long-term program that operates ten homes, with a total capacity of 70 individuals, including some units for women and their children, and others for males. The program targets offenders (both prior to and after release from jail or prison), although it is not DOC-funded. Clients pay a fee of $40 to $50 dollars per week. The services include individual and group counseling, 12-step groups, parenting classes, and mandatory Bible study. Individuals must apply to enter Mission Gate. Once admitted, clients are expected to stay clean (drug-free), attend program activities, and adhere to applicable curfews (i.e., a 9:00 p.m. curfew applies during the first 30 days; the curfew lengthens to 11:00 pm after that; the program progresses in quarterly increments with graduation possible at 12 months; during the clients' last three months, s he must be engaged in a home group and curfew lengthens to 12:00 p.m.). Although clients must be drug free to enter the program, the program does not always terminate clients for non-compliance. The director of Mission Gate specifically stated that OPTS clients are a good match for Mission Gate because the OPTS case managers and probation officers have been very willing to work with the program's counselors to conduct urine drops, and make and follow-up on service referrals.

Within Tampa, there are two main residential facilities in addition to halfway houses from which offenders can receive substance abuse treatment: DACCO's Residential I and Residential II. While OPTS client reside in any of these facilities, they are supervised by the probation officer assigned to the residential facility, not by their OPTS PO. However, the OPTS case manager can remain in contact with clients while these individuals reside in the facility.

Residential I is a four- to six-month, 60-bed modified therapeutic community that serves both men and women who enter the program voluntarily. Approximately 20 beds are reserved for

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women. The program also uses 12-step techniques that employ recognition/acceptance of drug use as a disease, learning to deal with obsessive/compulsive thinking patterns, and dependence upon other recovering addicts for support and guidance. Residents have a comprehensive therapeutic mileau that includes a curriculum of lectures, intensive individual and group therapy, and adult education classes. The program operates in four phases, each dealing with a specific aspect of rehabilitation and treatment: the first is restrictive, with no phone calls, mail, or passes to leave the facility, progressing to the fourth phase where the resident is eligible for up to 48-hour passes. After successful completion of four phases, the residents may begin their job search.

The Residential II facility follows the same therapeutic approach as Residential I, but houses only male probationers who have been court-ordered to treatment. Violent offenders and sex offenders are excluded. The facility has 65 beds, but recently has been providing drug treatment services to approximately 70 clients. Clients are evaluated in court, before they arrive at the facility. Residential II treatment typically spans six months, although more extended treatment is possible. Like Residential I, clients follow a comprehensively structured routine, receive health care, vocational training, and individual and group counseling; additionally, family and couples counseling are provided. Residential II also includes a mandatory employment component: residents are required to work following approximately the third month of treatment (upon completion of the third of the required six treatment phases). When the residential program is completed, offenders attend mandatory weekly aftercare group sessions provided by DACCO. A client can go through Residential II only twice. If a client fails twice, he will most likely be referred to a more intensive long-term treatment facility.

In addition to the DACCO facilities, Tampa OPTS' service network for residential treatment also includes the Agency for Community Treatment Services (ACTS), mentioned earlier under outpatient services, and the Daytop program. ACTS is a private, non-profit agency that offers two options for residential services in Hillsborough County: a 28-bed short-term residential facility and a 75-bed transitional housing program for the dually diagnosed. In addition, ACTS operates a 56-bed, long-term treatment facility in Pinellas County for court-ordered "nuisance" offenders (mostly chronic, long-term users).

The Daytop therapeutic treatment facility is located two hours north of Tampa in Ocala, Florida. Daytop is a 198-bed facility, serving individuals from all over the state who need long-term treatment; 175 beds are for offenders under supervision by the State Department of Corrections; the remaining beds are privately funded. The program generally covers 18 months of treatment, including an aftercare component where clients are assisted with their re-entry into the community. A large percentage of Daytop's clients are dually diagnosed.

Other residential programs, such as Manna House and Avon Park, were used for a few clients. Manna House, which is part of Metropolitan Ministries, offers family-oriented 90-day residential treatment with a heavy counseling focus. Avon House, which is about two hours east of Tampa, serves dually diagnosed individuals; the program has staff who are certified to oversee pharmacologic treatment regimens, making it possible to care for individuals who require daily

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medication. The facility has a long waiting list, and gives priority to court-ordered clients. Similarly, Operation PAR, a well-respected and well-known program located outside of Tampa, offers a 12-month program for serious drug users. Although the facility has 10 beds funded by the Department of Corrections, it always had a lengthy waiting list, making it largely inaccessible for OPTS clients.

Detoxification Programs

In addition to the treatment programs described above, each of the cities had programs where individuals such as OPTS clients could detoxify from drugs. Detoxification -- or medically supervised withdrawal from a substance -- is often the necessary first step for many patients. This is usually provided as an inpatient service in a hospital or medical setting, but persons needing detoxification can be treated in outpatient settings as well. Detoxification can take any number of days, although such treatment generally does not exceed one week. It is often used prior to admission to an inpatient or outpatient treatment program since the client needs to withdraw from the substance s/he has been abusing before beginning to cope or deal with the addiction. Not all programs offer medical detoxification; some provide only social detoxification, which has become more popular in recent years, where no medication is used to assist the withdrawal from drugs.

Nearly 9% of OPTS clients across the three sites (i.e., seven clients in St. Louis, four in Tampa, and two in Kansas City) reported using detox programs at some point in their 12 months on the street after they were released from prison or jail. The majority of these clients went through a medical detoxification where they were given medication to block, prevent, or reduce their drug craving.

Kansas City OPTS used a few options for medical detoxification because the case managers established contact with several private hospitals that offered these services. One in particular, Park Lane Hospital, provides comprehensive services while a person is in the detox program. Park Lane receives funding from COMBAT dollars, and can accept indigent clients, as well as clients on Medicaid (and Medicare). After the client has completed detox (three to seven days), s/he can be referred to a halfway house for aftercare detox services. ACT One, which was not a private hospital, provided social detox. However, in February of 1997, funding ended and ACT One closed, at least temporarily. ACT One's closing created an influx of patients at other social detoxification programs in the city, such as KCCC (described earlier). Fellowship House trained its staff to perform emergency detox services, and granted OPTS clients immediate ("no waiting") access. Also, since regular residents were offsite on passes, OPTS participants were permitted to spend weekends at the House for virtually any reason (e.g., too much weekend drinking around them; family and friends were using drugs).

In St. Louis, DART has a medical detox program, which was the only such program outside of a private hospital. DART's detox, however, is a methadone detox, as is the program at

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DACCO, in Tampa. DART's methadone maintenance program is connected with their 30-day residential program. Tampa's methadone detox, which apparently was not used by any OPTS clients during the demonstration period, is part of a longer 21- to 180-day outpatient program. Because the majority of St. Louis OPTS clients have little need for a methadone detox, case managers have referred clients to Archway Communities' detox program. However, Archway often has a two-week waiting list. Similarly, in Tampa, some OPTS clients were referred to ACTS, which offers a social detox program that was seen as appropriate to meet client needs.

Challenges to Providing Substance Abuse Treatment

So long as clients had not already relapsed or otherwise violated supervision requirements, initial referrals and subsequent substance abuse treatment decisions were typically made by case managers, often with input from the client, and sometimes in consultation with the PO. In St. Louis, such decisions were jointly discussed by the core team, which included a substance abuse treatment provider. However, when clients had serious technical violations or new criminal offenses, court processes would intervene; and it was possible that the courts might order a client to specific treatment not associated with OPTS, as part of the terms of supervision or in lieu of incarceration.

Depending on the site and the individuals involved, judges were not always familiar with the objectives and services subsumed by the OPTS program, nor were they necessarily predisposed to seek treatment solutions to offenders' transgressions. However, Tampa case managers made concerted efforts to outreach to judges, and this frequently resulted in court orders that were consonant with service planning. Similarly, OPTS staff in Missouri noted that their courts are treatment-oriented; POs typically would request judges to stipulate a particular provider, and these requests were generally granted. Occasionally, with or without approval from the OPTS program, judicial decision making resulted in the individual's termination from the program, either due to re-incarceration or court-ordered treatment to a long-term residential facility.

Efforts to merge OPTS service delivery to other existing systems presented a different set of challenges with respect to clients placed in halfway houses. One issue was related to the fact that DOC-funded halfway houses typically have POs assigned to supervise residents. For each affected client, OPTS programs needed to work out lines of authority and communication among the case manager, the dedicated OPTS PO (in those sites where this feature remained intact), and the PO overseeing probationers/parolees in the halfway house. A related problem was that OPTS clients were sometimes referred to halfway houses as a sanction for substance abuse relapse, in part reflecting the hope that this would impose greater oversight of their behavior (reducing the opportunities for continued drug use). However, the halfway houses are non-secure environments, and many clients simply walked away. Not only did this render the sanction ineffective, but also frequently placed case managers at a disadvantage because they were not notified of the problem until substantial time had elapsed.

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Barriers to substance abuse treatment were encountered at the individual, as well as the system level. At the individual level, some clients were unwilling or unable to successfully complete programs to which they were referred. In some cases, this was likely due to personal characteristics of the client; but in other instances, such failures may have been associated with faulty assessment or linkage to programs whose strengths (or conversely, limitations) made them an inappropriate choice for clients with certain types of problems.

> "Some clients are so needy that it is unrealistic to think that OPTS can do anything for them, especially those clients with severe drug habits -- often revocation to the ITC is the most viable option."
> *A Missouri PO, commenting on treatment failures*

Although substance abuse treatment was the only one of the core services that was mandated for all OPTS clients, 16% reported never having participated in self-help groups or other kinds of treatment. A few clients may not have been referred to treatment because their case manager perceived them as drug dealers who did not have a substance use problem and would not benefit from treatment designed to eliminate drug use.

The vast majority of clients, however, were expected to attend some form of substance abuse intervention. A few clients gave plausible explanations for their failure to participate in the services to which they had been referred; for example, some clients suggested that arrangements had been made for them to live in a halfway house, but they opposed this intervention because the facility was not drug free and therefore, not conducive to their recovery, or they feared for their personal safety (or the security of their possessions). Most, however, were simply non-compliant; and this was either not detected by case managers and POs, or was permitted to continue so long as the individual appeared reasonably stable in terms of shouldering other responsibilities, and did not have other technical or criminal violations.

Resistance to treatment also was an on-going theme for clients who participated in the various treatment options. All OPTS clients entered the program from a residential/incarceration treatment program, and some did not feel they required any additional treatment; others disliked or mistrusted counselors or facilities, felt the recommended treatment was too intrusive, were distressed that the selected facility was a distance from home, or believed it would not help them to achieve or maintain sobriety. Program staff tried to accommodate individual preferences for referral to treatment, when this was not seen as incompatible with their perceptions of what specific clients needed to avoid relapse or regain sobriety. However, for some kinds of treatment, program staff and clients, alike, confronted limited choices.

> Many of the Tampa clients were enrolled in OPTS as they returned to the community upon completion of the six-month DACCO residential treatment program; from their perspective, they already had completed an extensive treatment program, gotten jobs, and were ready to resume a normal life.

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In an effort to be more responsive to client needs, OPTS programs in each of the sites established outpatient groups just for OPTS clients. The programs experimented with holding the meetings at different times (daytime, nighttime), days of the week, and at different locations to make them more convenient. Despite these efforts, the groups generally were not well attended.

Aside from treatment issues surrounding individual clients, program staff identified other issues that primarily were external to OPTS. Although each site had a continuum of treatment services available, the network of providers and treatment offerings kept changing as some programs were discontinued (e.g., due to loss of funding) and others were newly introduced. For example, a number of Kansas City substance abuse programs closed in 1995. Similarly, in 1997, substance abuse treatment was no longer offered in DOC-funded halfway houses in Missouri. Across all sites, case managers proactively tried to develop an expanded network of service providers to whom they could refer clients; such outreach was needed to fill service gaps and meet the specialized needs of clients with unique or rare problems, as well as to identify replacement services for defunct providers.

Local programs sometimes targeted a particular population for their services (e.g., some programs use Afro-centric curricula or focus on serving female abusers) or specialized in a specific drug problem, and client characteristics did not always meet such criteria. For example, some inpatient programs are designed specifically for clients that abuse one particular substance, such as heroin or cocaine; this is the case with some therapeutic community programs. Many OPTS clients were poly-drug abusers, and some programs were not geared to deal with this.

> "In general, substance abuse treatment programs aren't in short supply in Kansas City, although high-quality treatment is limited... particularly need good inpatient treatment.
> *Local staff, commenting on gaps in service*

Programs that met the needs of clients with special circumstances (e.g., HIV, dual diagnosis) were in short supply. And, some services were difficult to access because of waiting lists or high fees. In all three sites, inpatient programs were scarce; tended to offer short-, rather than long-term care; and generally were characterized by long waiting lists. Long-term residential treatment was often available only at a distance from the local community, and clients were inclined to avoid being so far from home because it deprived them of contact with family and friends.

Funding also was a problem under various circumstances. Treatment costs were prohibitive for some private programs that operate in the sites. Similarly, some services were available, but became essentially "off-limits" to OPTS clients due to changes in eligibility or funding requirements; for example, providers who had served OPTS clients stopped accepting Medicaid or switched the insurance plans with which they affiliated. Staff reported that in some cases there were more treatment options for those with no insurance, for whom they could arrange pro bono care, than for those with insurance, which often limited the nature or duration of covered care.

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Finally, case managers sometimes encountered difficulty finding suitable placements for clients who had relapsed or had failed to complete a program for any number of reasons. Clients often could not be re-admitted to a program once terminated or if they successfully completed it, but subsequently relapsed. Thus, after each "false start," a client had fewer treatment options available to him/her. Often, the treatment programs selected first were those that were most accessible; once those were ruled out, individuals might be left with increasingly less desirable choices (e.g., programs that were more costly, more restrictive in their requirements, or at a farther distance from home). In some cases, there were no alternatives except to place the client at the end of a long waiting list -- not only delaying treatment, but increasing the likelihood of escalating problems.

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CHAPTER 4
EMPLOYMENT SERVICES

OPTS clients were not required to participate in employment services, although they were expected to be fully employed as a condition of their probation or parole supervision.[24] Some individuals were able to return to positions they held prior to their pre-OPTS incarceration; others felt able to secure a new job or resolve other work-related difficulties without the assistance of an employment service.[25] Based on their self-report, nearly 49% of OPTS clients had some employment during the month they returned to their respective community; 45.5% had either full- or part-time employment, while 3.4% reported working at both full- and part-time jobs. Only 12% of this cohort (i.e., 4 Kansas City clients, 6 in St. Louis, and 8 in Tampa) reported no employment throughout the follow-up period. Exhibit 4-1 identifies the percentage of OPTS clients who reportedly experienced employment-related problems during their first year of OPTs supervision, while Exhibit 4-2 depicts the percentage of OPTS clients who reported that they were referred for various employment-supportive services.

Employment Service Providers

As was the case with substance abuse treatment services, each site established MOUs or close working relations with organizations that could provide employment services. As previously presented in Exhibit 2-2, Kansas City OPTS aligned with the Full Employment Council and also used the services of the Missouri Division of Employment Security. St. Louis primarily relied on the services provided by the Employment Connection, which was co-located with the DART substance abuse treatment program, and OPTS case managers and PO staff. Tampa OPTS most often used the services of the Florida Job Service. Both St. Louis and Tampa used Vocational Rehabilitation services for eligible clients. Most of these collaborating agencies have experience serving low-income populations and offer program components developed for populations with characteristics similar to OPTS clients. For example, in addition to OPTS, the Full Employment Council receives referrals from the Kansas City drug court program, while St. Louis' Employment Connection also administers contracts with city and county boot camp programs, and the city's intensive supervision probation program.

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[24] While clients were not required to participate in OPTS employment programs/services, CASA's contracts with each of the sites did include special conditions that specified site-specific employment targets (i.e., the percentage of participants who were expected to be employed).

[25] At the time of their baseline interviews, 13.6% of Kansas City clients, 42.4% of St. Louis clients, and 27.8% of Tampa clients reported they had been unemployed prior to the incarceration that qualified them for inclusion in the OPTS aftercare program.

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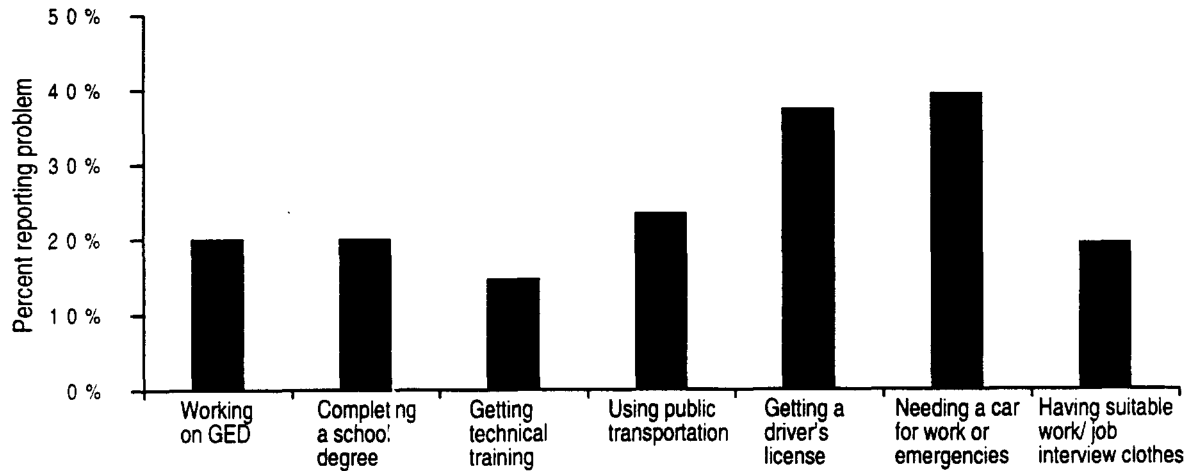
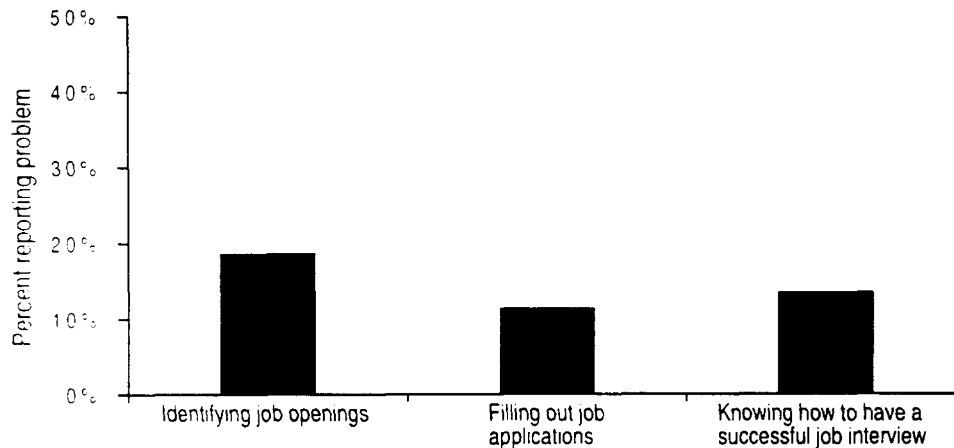
EXHIBIT 4-1.

Employment-Related Problems Reported by OPTS Clients (N = 147)

BARRIERS TO EMPLOYABILITY



PROBLEMS WITH JOB SEARCH SKILLS



WORKSITE PROBLEMS

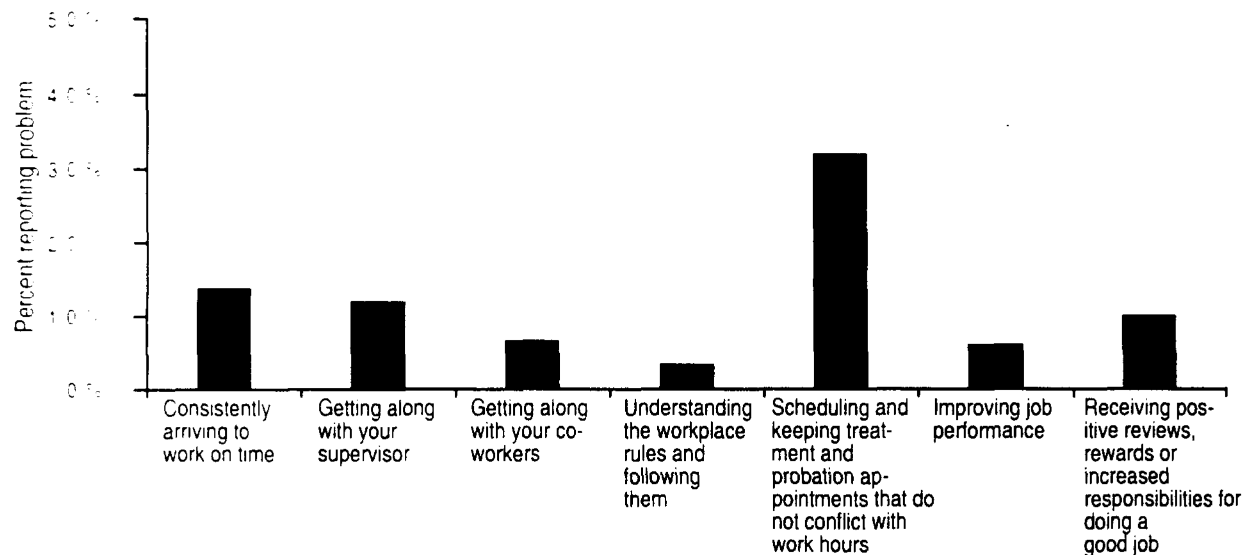


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EXHIBIT 4-2.

Referrals for Employment Assistance, by Site (N = 147)

REFERRALS FOR ASSISTANCE TO RESOLVE EMPLOYABILITY BARRIERS

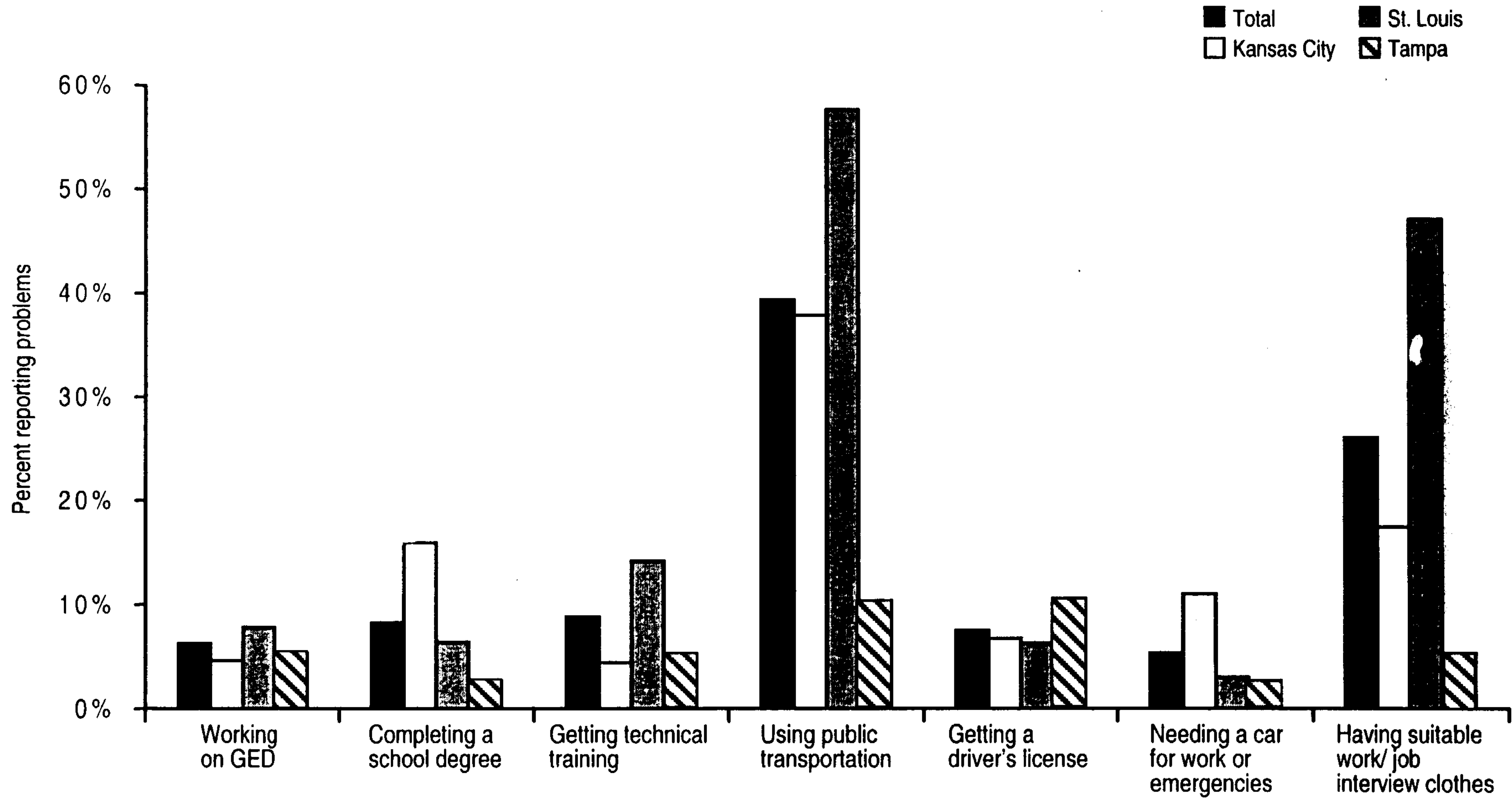

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EXHIBIT 4-2. (CONTINUED)

Referrals for Employment Assistance, by Site (N = 147)

REFERRALS FOR ASSISTANCE WITH JOB SEARCH

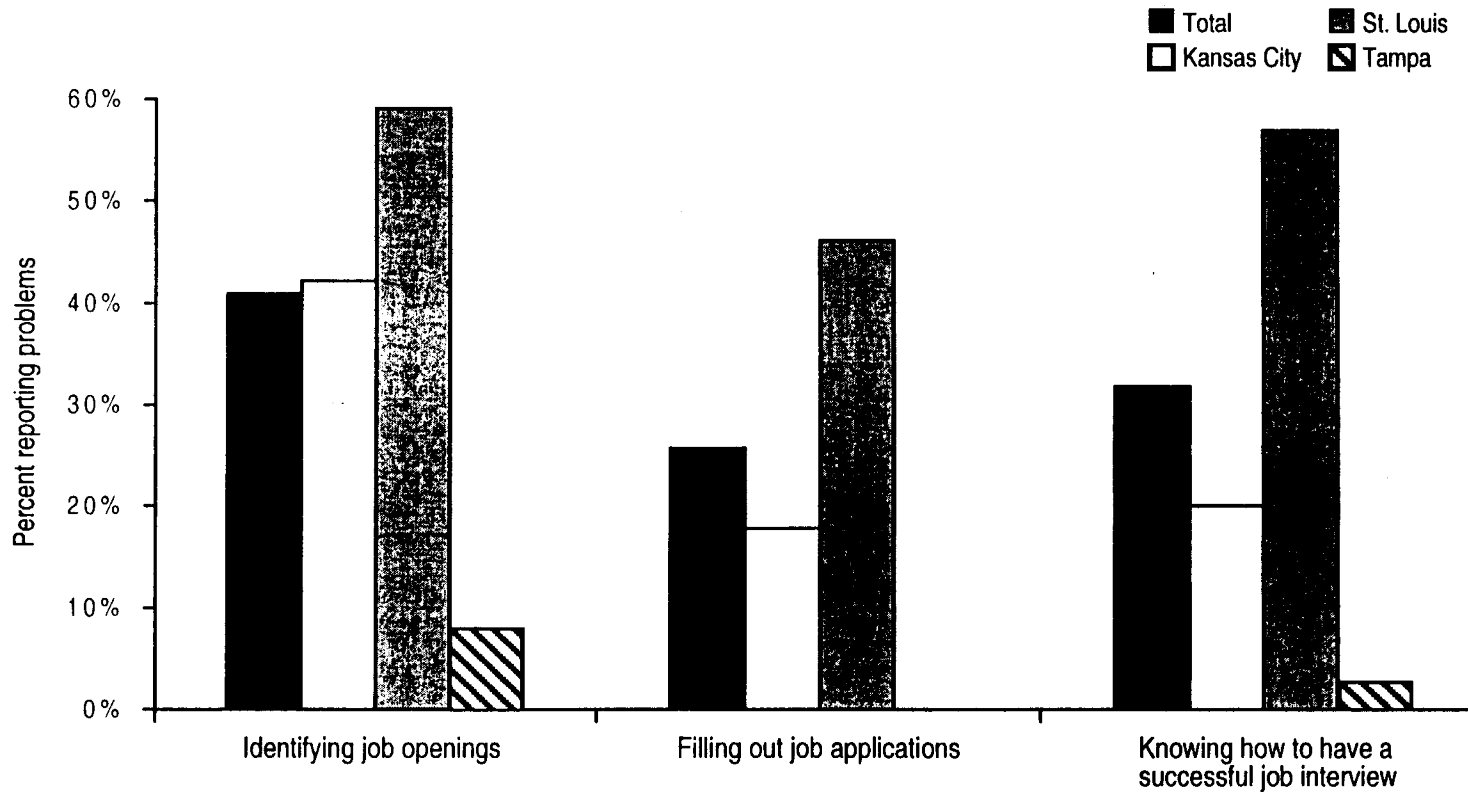

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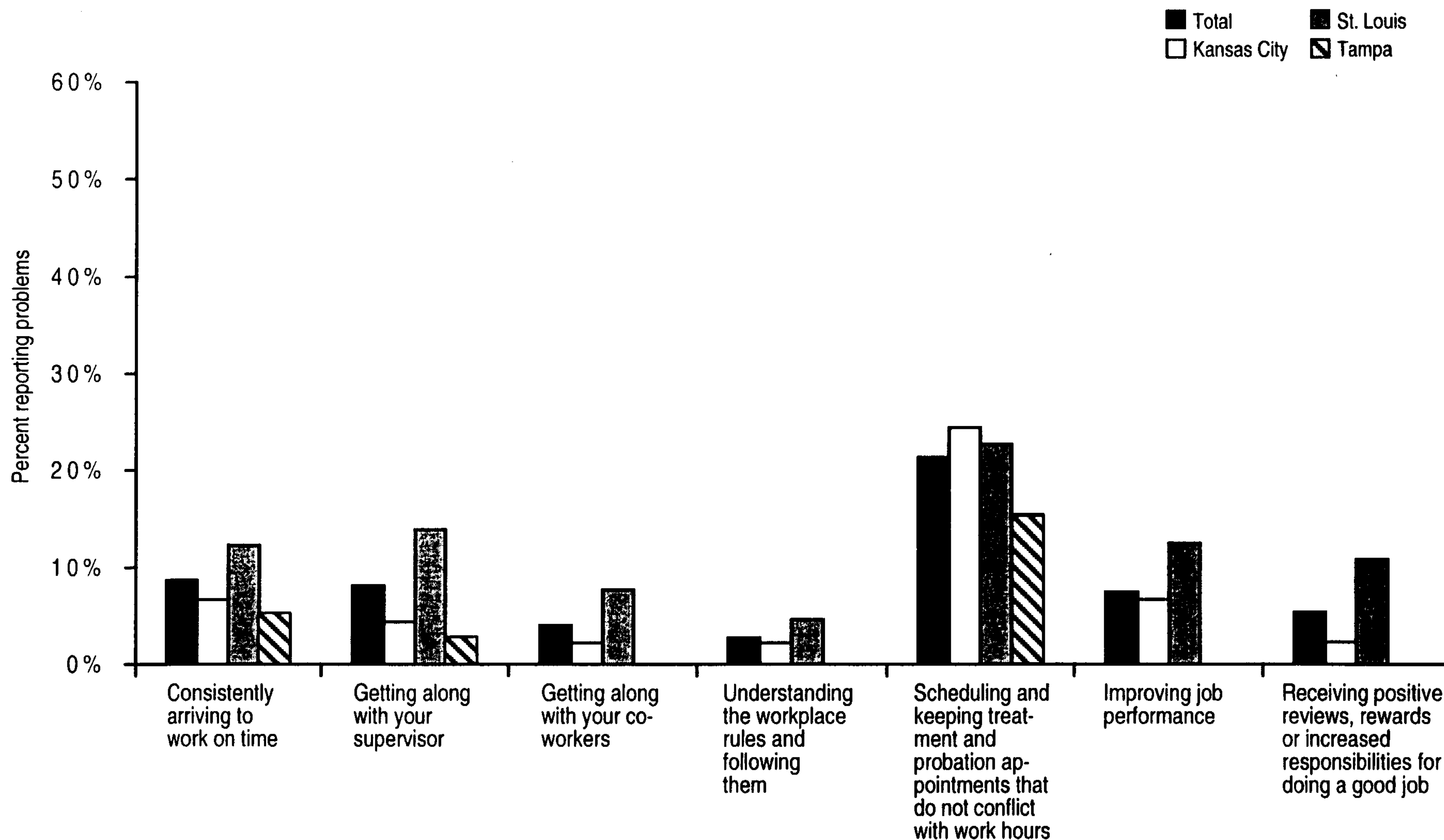
Exhibit 4-2. (continued)

Referrals for Employment Assistance, by Site (N = 147)

Referrals for Assistance with Worksite Problem Behavior



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Across the sites, the various employment organizations provided a range of services, differing in intensity and duration. Core elements included:

- Assessment of clients' skills and career interests.
- Basic job search skills training, largely focused on how to: develop a resume, fill out applications, identify job openings, and conduct themselves in job interviews.
- Job referral and placement services.

A few agencies offered more extensive services, such as adult basic education or GED courses, vocational skills training, apprenticeship programs or other opportunities for on-the-job training, or support services for work-related needs.

In Kansas City, NCADD referred the majority of OPTS clients in need of employment services to the Full Employment Council (FEC), which typically serves economically disadvantaged youth and adults or those with some tangible barrier to employment such as limited marketable skills, physical or mental disabilities, substance abuse, or criminal records. FEC offers a wide range of services including individualized career counseling to identify skills, interests, and career goals; classroom training at community colleges or vocational schools to acquire new skills; access to GED study; job search and placement assistance; apprenticeship programs; and support services such as providing school books, limited child care, or clothing/uniforms needed for work (e.g., work boots for those entering construction jobs).

Typically, client intake entails three steps: completion of the FEC application, an interview, and needs assessment. Although FEC offers a large number of program services, the majority are based on income guidelines and require detailed assessments to accurately establish client eligibility. Once the appropriate level of eligibility is established, clients can receive job training, labor market information, and pre-certification for employment. Clients are then introduced to FEC job consultants and complete another skills assessment that focuses on career interests and opportunity. At this point, clients either progress to vocational training, school, or a GED program. FEC provides clients with the opportunity to pursue a GED, while simultaneously searching for a job. Length of training typically ranges from 4 to 12 weeks; clients tend to average 6 weeks before entering the job market. Clients enrolled in FEC's apprenticeship programs -- like the AFL-CIO's Project Prepare -- obtain immediate employment.

In addition to the FEC, some Kansas City clients were directed to employment services available through a relatively recent partnership of the Department of Probation and Parole and the Missouri Division of Employment Security (DES). Under this program, a DES employment counselor was re-positioned to one probation and parole office (4 West) to serve probationers/parolees from the entire region. The program offers week-long workshops that include basic training on how to: develop a resume, fill out job applications, and prepare for job interviews. Individuals can use the program services as long as necessary until they find

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employment or until their probation/parole officer determines they are not benefitting from these resources.

In St. Louis, one employment service provider, Employment Connection (EC), has been a major partner in the OPTS collaboration since the program's planning phase, although other resources (e.g., the Cooperative Congregational Outreach (CCO) services and Vocational Rehabilitation, which offers services much like those described in Tampa, below) also have been used on a more limited basis. All OPTS clients are referred to the EC program, and many are served by it. All EC clients receive the same basic services: skill assessment, consultation with an employment counselor, job search skills training, referrals, placement, and, when possible, clothing is provided to needy clients. EC also organizes job fairs that draw a range of employers from the service and manufacturing industries (e.g., hotels, security firms, clerical, custodial services). GED training had been offered by the agency, but was discontinued in Spring, 1995, due to insufficient funding. The agency emphasizes placing clients in full-time jobs, but occasionally individuals are referred to part-time positions, if they have special circumstances (e.g., if the individual is enrolled in school or receiving disability benefits, and the OPTS team determined that a part-time job would be acceptable).

Clients initially attend a two-day World of Work (WOW) training program that includes a pre- and post-assessment. This focuses on how to get and keep a job, and how to resolve conflicts on the job. Then they return to work with a counselor, who can provide additional assistance on job search activities -- how to find a job, use networks, and dress correctly. Clients participate in videotaped, simulated interviews before and after attending WOW, to build self-esteem by enabling them to see their own improvement. WOW training and individual counseling also deal with work-related attitudes, including conflict resolution, working with supervisors, and how to leave a job appropriately. The program also teaches clients how to address their incarceration history in job applications and interviews.

Felony offenders receive additional assistance: the directed job search component, which provides more structured programming through daily classes that meet from 9 a.m. to 1 p.m., Monday through Thursday. Clients are expected to clock in while job searching. The employment counselor interacts directly with the clients, focusing on skill assessment, interest identification, interview preparation (coaching), skill cultivation, and referrals. In the morning, clients go through the job search classroom course, and then are encouraged to use classified ads that list job openings. EC is equipped with telephone stations to facilitate job searches, and provides scripts next to each phone to guide this process. Clients are encouraged to use the scripts to cultivate their skills when calling about a job; the script contains prompts that clients should follow (e.g., to say, "I will call back in a few days to check on the status of this opening"). The EC employment specialist dedicated to OPTS reported that OPTS clients tended to receive more individualized attention than other adults using the agency's services; for example, significant time was spent structuring OPTS client resumes and identifying referrals.

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The agency's goal is for clients to secure a job within three weeks -- staff estimate that it takes approximately 40 applications to schedule four interviews that yield an offer of employment. Wages ranged generally from $4.25 per hour for dish washing to $6.50 for production jobs (during the OPTS demonstration time frame).

Although EC was used as the major source of employment services, LFCS also used employment services available through its CCO program (a community outreach initiative that operates in cooperation with four local congregations). CCO services include employment training and placement assistance, emergency food and utility assistance, resettlement and restabilization of homeless persons, and other social supports such as advocacy. LFCS has contact with employers through this network. OPTS staff used these contacts as a backup to find placements for a few OPTS clients. For example, LFCS was able to coordinate some temporary employment with a clothing manufacturer for five OPTS clients. To facilitate these arrangements, a case manager was sent onsite to supervise OPTS clients during the short-term assignment. These clients were paid $6 per hour, in addition to receiving several free items of clothing and the opportunity to purchase other clothing at a discount.

In Tampa, many of the clients entered the OPTS program directly from court-ordered residential treatment programs. These programs mandate as part of the treatment regimen that offenders be gainfully employed before they can return to the community. Since probationers/parolees exiting these facilities were already employed, the Tampa OPTS program experienced less demand for employment services than the other two sites. Nevertheless, OPTS staff worked in conjunction with three employment/job training organizations -- Florida Job Services, Vocational Rehabilitation, and the Career Diagnostics Center -- on an as-needed basis.

Florida Job Services is a state-funded, 401 K program that offers "one-stop shop" job services and training specifically designed for convicted felons. The office employs two staff: one primarily serves as an employment counselor, while the other is responsible for developing jobs by contacting potential employers. Through this program, felons receive individualized attention and other services, such as bus passes. The counselor has access to a computer database that lists jobs, with salary and requirements; this information is retrieved in the client's presence and used to discuss options, transportation, and related issues. In addition, counselors are able to post a bond of up to $25,000 on behalf of the client; thus encouraging employer participation. A 30-day follow-up and reporting period follows placement, during which time clients are required to check-in with the employment counselor.

Vocational Rehabilitation Services, a division of the Florida Department of Labor and Employment Security, serves clients with physical or mental handicaps that interfere with, or preclude, their ability to work. OPTS case managers determined that their clients might be eligible for these services since substance abuse problems may be considered as disabilities. Program components include: 1) referral and intake; 2) vocational and medical evaluations performed by a panel of doctors, psychologists, and hospital staff; 3) rehabilitation planning; 4) treatment (e.g., short-term medical, surgical or psychiatric/psychological care to reduce or

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remove a disability; artificial limbs, hearing aids, wheelchairs, or glasses may be provided); 5) work adjustment training to assist clients in adapting to work conditions, and vocational training for competitive employment; and 6) job placement. In addition, residential services (e.g., attendant services, homemaker services, modifications to a client's home, architectural accessibility and services to other members of the client's family) can be provided if these are deemed necessary to help clients accomplish their objectives.

The Vocational Rehabilitation counselors estimate that it takes a minimum of six months to a maximum or four years for clients to become employed through their program. The different types of training programs take various amounts of time. Also, the agency does not routinely work with the same employers over and over, because their clientele's disabilities require job solutions that are individualized.

The Career Diagnostics Center (CDC) is part of the Hillsborough County Public Schools. It provides occupational assessments and career planning services, at no charge, for adults who do not have clear career or vocational/technical direction. CDC's focus is on linking clients to training; they do not provide any job placement services. CDC conducts a variety of assessments to evaluate the individual's educational level (i.e., grade equivalent) and to determine whether the client's basic level of educational attainment qualifies him/her for vocational training. The Test for Adult Basic Education TABE) is used to measure the client's eligibility for entry into a vocational training program; if an individual fails to qualify s/he will be referred to CDC's Intensive Learning Lab to improve educational skills. Depending on interests and ability, individuals may be referred for training as a paralegal secretary, massage therapist, medical technician, or other office support function. Most clients are referred to training available through the public schools, although some are referred to private-sector programs. Also, CDC assists clients in finding the funding to cover training costs (e.g., through scholarships or JTPA monies), if needed.

In addition to these services, a few female clients were referred to Displaced Homemakers, a program offered by the Center For Women. The Displaced Homemakers programming provides women with education, job skills workshops, loans, and business suits to encourage their efforts to be self supporting. As part of their training, program participants are involved in volunteering with senior citizens.

Challenges to Providing Employment Services

As noted above, not all OPTS clients required employment services or availed themselves of the services that were offered. Some individuals returned to jobs they had occupied prior to their incarceration; others were returning to the community from court-ordered, residential treatment facilities or halfway houses that required offenders to be employed for a period of time pre-release. In addition, some clients independently found employment using their own resources or networks. However, each of the OPTS programs encountered challenges in providing services

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for the majority of their caseloads who were unemployed. Commonly cited difficulties included: clients' resistance to services; lack of high-quality jobs; limited services to accommodate clients with special needs; organizational factors that mitigate against serving some types of clients; and client characteristics that undermined success.

Staff and service providers in all three communities reported some client unwillingness to use employment services provided or brokered by OPTS. Most of the non-compliance was fairly benign; for example, staff noted that they periodically had to remind clients about the importance of attending scheduled meetings and shouldering personal responsibilities for locating employment, but that they rarely had to exert pressure to have clients follow through on job leads. However, some clients actively refused to participate in the employment programs to which they were referred. Clients offered a range of explanations for this behavior, including: they did not need help and preferred to find a job on their own; the program was too intrusive in its time demands (i.e., they did not perceive that they needed to attend daily sessions); the curricula was designed with a different population in mind and did not suit their needs; they had already been through this exact training component or a similar job search skills program and didn't want to do it again; or they had little confidence in the agency's ability to help them find a job that was not low-paying or dead-end.

Non-compliance was handled on a case-by-case basis. Generally, case managers resolved these problems by identifying the individual's concerns and exploring alternative arrangements. Occasionally, sterner measures were needed, and OPTS POs reinforced the message that probationers/parolees needed to comply with the demands of services they were directed to by case managers, particularly in this area, because employment is a mandatory requirement of supervision.

It should be noted that case managers and POs were often sympathetic to the clients' complaints because they perceived many of these objections as valid. Indeed many of the key OPTS staff regarded employment services offered under the program as not as strong as some of their other service components.

Among the weaknesses noted was the fact that many of the employment service providers had limited capacity and were ill-prepared to place clients in diverse and good quality jobs. With respect to capacity, employment agencies may not be able to respond efficiently in providing intensive services to so many needy clients simultaneously. Some agencies acknowledged waiting periods of two to three weeks. While this may not seem like a long time, many clients were frustrated by having to wait before their assisted job hunt could begin in earnest; some felt pressured by economic problems, while others were concerned because their PO was pressuring them to comply with the employment requirements of supervision.

Many of the employment agencies had structured their services to serve the "lowest common denominator" -- the most unskilled, uneducated job seeker. Some employment services repeatedly dealt with only a handful of employers, who represent high turnover industries that

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have a steady need for new labor; many of these type of positions pay minimum wage or less. Apparently few of the collaborating employment services have a policy such as the one espoused by the Florida Job Services; namely, the lowest wage they deemed acceptable in identifying suitable job openings for client placement was $5.00/hour (which exceeded the existing minimum wage requirement of $4.25/hour).

Most of the service providers networked with a limited number of market sectors that offered predominately low-paying, entry-level positions (e.g., fast food operations; unskilled factory jobs) and were unable to adequately serve clients with para-professional or professional skills and experience. Despite the stereotype that offenders are hard to place because of deficient skills and lack of legitimate work experience, St. Louis, for example, struggled to place experienced, educated clients in positions of responsibility paralleling those they had held prior to incarceration.

Case managers in each site responded to deficits in employment service capacity or breadth of scope by cultivating relationships with other service providers, or by becoming more directly involved in identifying suitable job openings for their clients. In both Tampa and St. Louis, case managers referred some clients to temporary employment agencies. This provided clients with opportunities to update their skills in short-term work assignments that sometimes culminated in offers of more permanent employment.

> Discussions with staff and clients identified several relevant anecdotes regarding the need for employment at all skill levels. For example:
>
> One client had 15 years of experience running his own business; however, the employment counselor seemingly didn't know where to refer him. In this instance, case managers were instrumental in linking the client to other supportive services. Ultimately, the client opened his own business and did sufficiently well to start hiring employees, including a few OPTS clients, to work a couple of days per week.
>
> Two other individuals who reportedly encountered similarly limited services did not fare as well, both ended up re-incarcerated though not necessarily due to their job woes. The first was an OPTS client, who reported she had previous experience performing data entry, but was only referred for factory jobs. The other was a control group member, who had a four-year college degree, but couldn't obtain gainful employment. He was referred for fast food positions, which he claimed provided insufficient pay to cover his student loans. He resorted to operating a black market furniture and electronic goods trade; ultimately receiving a five-year sentence for fraud/forgery.

Other barriers were introduced by requirements internal to specific employment service providers. For example, some agencies limit the number of times a client can be served or the time frame within which clients can return for repeat services. St. Louis' EC requires people to wait one year after job placement before returning to request assistance in finding another job. However, the agency made an exception for OPTS clients by permitting them to return for assistance more frequently because they were experiencing high job turnover.

A different kind of problem was encountered in Kansas City. FEC requires that its clients have a fixed address in order to receive its employment services. However, some OPTS clients

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were homeless -- they were living in short-term transitional housing, or moving from one relative's or friend's home to another -- and had difficulty meeting this requirement. Because lack of a stable or permanent address complicated service delivery, program staff tried to resolve the impasse by referring such clients to the Salvation Army. However, this was not always a workable solution since the Salvation Army charges a modest fee, which some individuals were not able to meet in the absence of a job.

Aside from barriers represented by external factors, some difficulties were encountered due to characteristics of the client -- and his or her suitability for employment. Employment counselors typically expressed the view that if a client wanted to work, s/he could be placed in a job. Realistically, however, some clients are harder to place than others. Clients who cannot read or write are difficult to place, although they apparently can be helped through the Vocational Rehabilitation service that assists individuals with disabilities. Also apparently, women are somewhat harder to place than men because many have young children. As a result, women may require more flexibility in working arrangements or additional services, such as assistance in securing suitable child care.

Staff reported that clients were relatively easy to place in jobs, even with their histories of substance abuse and criminal activity. Potential employers often had had earlier contact with OPTS or its service providing agencies, and therefore were familiar with the backgrounds of the population being referred for employment. In general, clients were encouraged to acknowledge their criminal history on job applications or in interviews when dealing with employers who were unfamiliar with their background (the criminal history will show up, in any event, if the employer performs a records check). Employment counselors often suggested that clients put their "best foot forward" by emphasizing positive aspects such as education, training, or experience first and then briefly listing their prison record.

Apparently, many employers are willing to hire recovering addicts. However, relapse is always a thornier issue. Some employers remained supportive through a client's relapse. Other employers not only rejected the employee, but also refused to accept future placements from the service agency after a client relapsed -- as one counselor reported, employers may feel it is just not cost effective, especially if they invested time and money on training the new hire.

> "Detox, drug-free housing, and relapse prevention are key precursors to success -- employment takes a back seat because it provides clients with the means to get high, if and when they are not in treatment or recovery. The key to success is staying clean."
> *Kansas City Case Manager*

OPTS clients demonstrated fairly high job turnover: one counselor estimated that clients stayed in their first job approximately one month, and that some clients didn't settle into employment until after their second or third placement. According to counselors, some clients repeatedly displayed poor work habits or attitudes, while others just quit or walked off the job with little or no warning. In some cases, this was due to substance abuse relapse. Some of the

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employment counselors reported that they will work with a client to negotiate time off for relapse treatment or to secure new employment -- although they find it harder to place a client in a second job if the person has been dismissed from a prior position.

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CHAPTER 5
HOUSING

Individuals may require housing assistance for a variety of reasons, such as homelessness, unsuitable living arrangements, or high-risk and drug-infested accommodations that make it more difficult for them to remain in recovery. OPTS clients reportedly experienced a variety of housing problems during their first year of program participation.

Release requirements of correctional institutions typically regard the transfer of offenders to community-based supervision as contingent on home plans that demonstrate designated living arrangements in the community are satisfactory. However, some OPTS clients were unable to establish suitable home plans, necessitating housing assistance as part of their return to the local area. Other clients encountered difficulties once in the community that required drug-free, transitional housing; these included such crises as family or domestic relations that deteriorated after the individual returned home, client relapse or concerns about increasing risk of relapse, or drug use in the home or surrounding neighborhood that threatened or compromised the individual's ability to maintain sobriety.

All told, nearly a third of OPTS (29%) clients reported having problems finding a place to live during the twelve months following their return to the community. Many of their difficulties were related to financial constraints associated with low or unstable incomes; for example, 33% reported they did not have sufficient money to make a rental deposit, 22% had difficulty paying rent, and 22% had difficulty paying their utility bills. But, other housing-related problems also surfaced: 45% reported problems remaining drug-free while living in their neighborhood, and 15% had concerns about keeping their existing housing.

Under the OPTS model, clients could access a variety of housing assistance, including: 1) placement in supportive, drug-free housing such as halfway houses, group houses, and apartments to share; 2) crisis shelter when domestic situations deteriorated, necessitating immediate relocation; and 3) provision of emergency funds to cover unexpected expenses. Sometimes clients expressly requested assistance; other times, case managers assessed living arrangements as unhealthy or not conducive to recovery, and initiated a change in housing. Various housing placements had the added advantage of offering residents a range of on-site amenities in addition to shelter; these included such services as counseling, support groups, life skills training, or employment placement.

As with substance abuse treatment and employment services, lead agencies directly delivered some services to clients, while also referring individuals who needed assistance to other community-based providers who could help resolve their housing difficulties. Exhibit 5-1 shows the percentage of OPTS clients who said they were referred for help in solving various housing-related problems.

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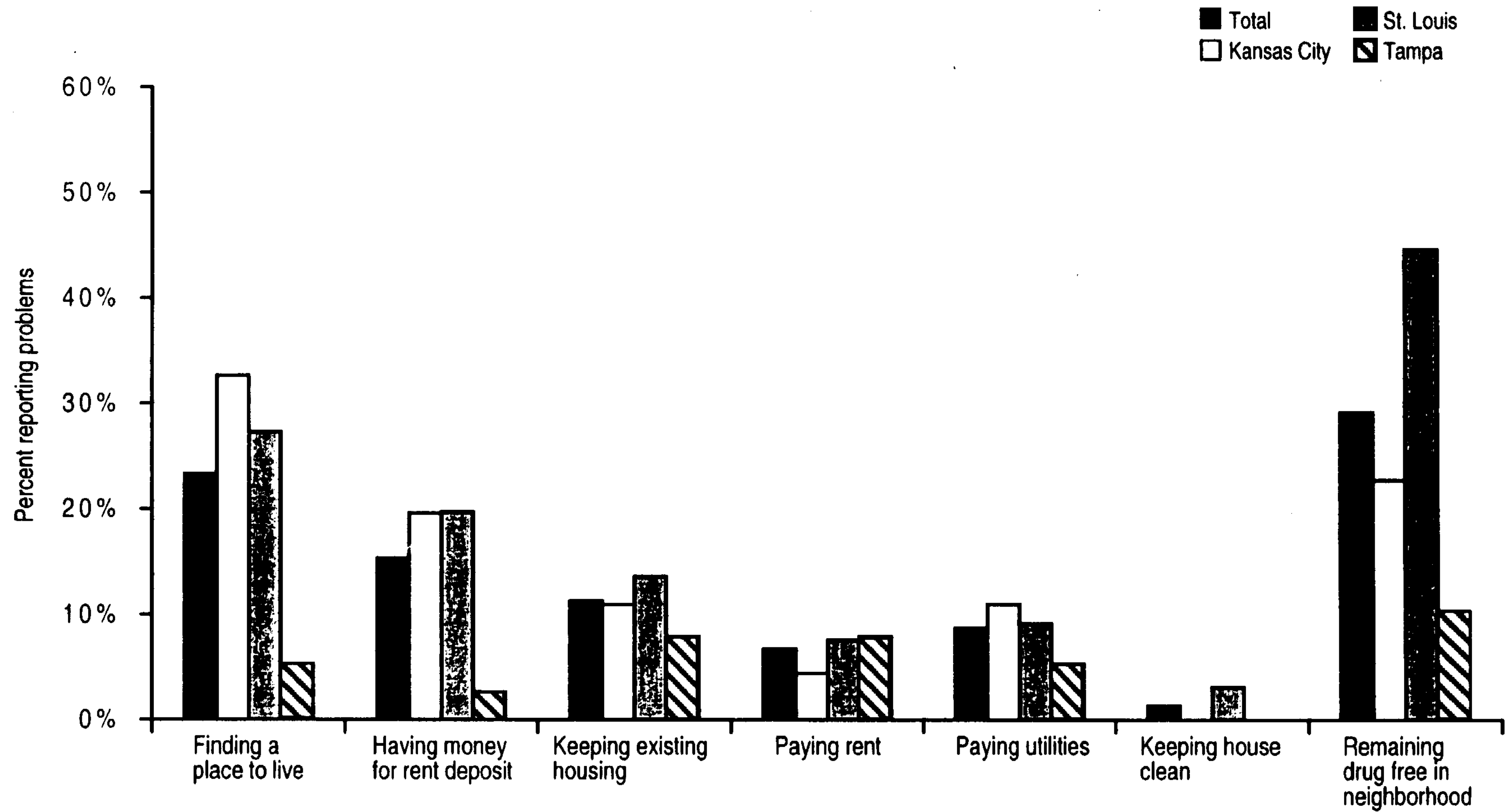
EXHIBIT 5-1

Referrals for Housing Services, by Site (N = 147)



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Transitional Housing

Since a client crisis of some type (e.g., an untenable domestic situation, drug relapse, or eviction) typically motivated a housing placement, availability of space served as the primary determining factor for referral to some providers, rather than others. Halfway houses were routinely used to meet client housing needs because most of these providers 1) offer a number of DOC-contracted community placement beds, 2) are generally able to accommodate clients for varying lengths of time, and 3) pose few eligibility criteria. Another attractive feature of many halfway house programs is the substance abuse treatment provided, as previously described in Chapter 3. However, over time -- because the demand for suitable transitional housing seemingly outpaced the supply -- sites tried to develop and use a cadre of other comunity-based housing providers, including homeless shelters and private companies to address client's needs for services in this domain.

Prior to program implementation, Kansas City negotiated MOU's with two housing providers -- Community Recovery House and Fellowship House (each described in the section on residential substance abuse treatment) -- but worked proactively throughout the demonstration to develop a range of additional housing providers, including Recovery Zone, Wise Counsel House, Salvation Army Rehabilitative Center, and Leisure Care, a home for the developmentally disabled. One of the particularly comprehensive resources identified was Living in a New Community (LINC), a nonprofit program that offers transitional housing to homeless and at-risk families (i.e., mostly single parents and their children; no housing is available for single individuals).

Through LINC, eligible applicants may receive 90 to 120 days of shelter at no-cost; families are placed in individual units in contrast to the communal accomodations offered by many homeless programs. In keeping with LINC's objectives to empower individuals to achieve self-sufficiency, clients also receive structured counseling services, including: employment and job training, budgeting and financial management, homemaking and nutrition, and parenting and family counseling, including one-on-one counseling for children. Program participants are subjected to random drug tests, and are required to save 50% of all earnings in order to reduce debt and secure new housing; LINC educates participants on how to secure subsidized housing and the range of resources available. These services are offered only to individuals in the transitional housing program. LINC can serve nine families simulanteously; typically, about 30 families are served annually.

The St. Louis OPTS program used a range of communty resources to address client housing needs, including private halfway houses and church-related housing. Although the lead agency operated a housing program for homeless individuals, most OPTS clients did not match that program's target population or its eligibility criteria. Also, the housing offered by this program bordered high crime, high drug areas of the city; therefore, case managers were hestitant to access that resource even for the clients who met the criteria.

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Lacking MOUs with housing providers, the St. Louis program relied heavily on its partnership with the probation department to place clients in drug-free housing. DOC-contracted community placement beds (each halfway house set aside a number of beds for displaced probationers/parolees, including those without an acceptable home plan) often represented the most accessible resource for OPTS clients in need of short-term, drug-free housing. As noted under residential substance abuse treatment, St. Louis clients were commonly refered to Dismas House and the Salvation Army's Harbor Lights halfway house programs.

St. Louis also referred its homeless clients to the St. Patrick Center. Services provided by the St. Patrick Center include shelter and job training. St. Patrick's has both a career counselor ("work specialist") and financial counselor on staff to teach money management skills and provide career counseling. Additionally, the Center operates a restaurant in which homeless clients can work. OPTS case managers referred several clients to the shelter, but reported there was little follow through on the clients' end.

In Tampa, clients were able to access housing through DACCO, the lead agency. DACCO operates two drug-free apartment complexes; rent ranges from $225 per month, per person, for single adults in one- and two-bedroom apartments, to $400 per month for a family; availability of units varies from month to month. Eligibility criteria include: full-time employment, or part-time employment and full-time school attendance; a history of substance abuse; and currently in recovery. Tampa Crossroads, Inc., offers both a transitional housing component and a residential treatment program (as described earlier). The transitional housing component provides life skills education and employment development.

In addition, female addicts in Tampa could be referred to Chrysalis House, although few OPTS clients required housing at this site. Chrysalis House is a halfway house for women who are recovering from drug or alcohol dependency. The facility actually does not offer any substance abuse treatment to its clients, but residents are expected to pursue involvement in a 12-step program, and the home's rules and policies embrace the 12-step philosophy advocated by Alcoholics Anonymous. Potential residents must satisfy several admission criteria, including: 1) abstinence from any mood altering substances for the five days prior to admission; 2) demonstrated "clean bill of health" as determined by a health professional; 3) commitment to reside in the house for a period of 90 days; and 4) desire to remain drug free. Individuals also must demonstrate an ability to pay rent; prior to admission, potential clients are required to pay a minimum of $225 or the equivalent of the first three weeks of rent. All residents are required to pay a minimum of $85 per week in rent. Residents are restricted to the house for their first week. Additionally, all residents are required to obtain full-time, day time employment. Individuals who do not obtain full-time employment within three weeks after being admitted to the house are discharged.

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Crisis Shelter

Provision of crisis shelter related to domestic violence appeared to be minimal. Self-report data indicate that 15% of OPTS clients had been involved in physical fights with their spouse or partner during the 12 month follow-up period. In response to separate questions, 24% of female clients reported they had been beaten or threatened by their partners; and, 10% of male clients disclosed they had beaten or threatened to beat their spouse or partner during the 12-month reporting period.[26]

Spouses or domestic partners of Kansas City clients (and their children) could be referred to Sheffield Place, a transitional residence for homeless women and children. In addition to housing, Sheffield Place provides education programs structured to cultivate long-term survival skills; topics include problem solving, budgeting/financial management, and parenting and relationship skills. The agency is relatively new (opened in 1991) and small: HUD grants and private donations support operating costs and salaries for the three full-time staff members. The facility is limited to serving a maximum of 14 families. Although available, the facility apparently did not serve any OPTS clients: one case manager referred the girlfriend and child of an OPTS client to Sheffield Place, but the woman declined to use the service.

In St. Louis, case managers relied heavily on their volunteer social worker to assist them in placing clients in domestic violence shelters. The program not only offered services to OPTS clients, but also made the effort to extend housing services to other family members who found themselves in crisis situations; for example, one client's relapse necessitated moving his domestic partner and their children out of the home. Unable to secure emergency shelter for the woman and children, the PO ultimately rented a hotel room for the family's weekend use until more suitable housing arrangements could be established.

Female clients and the spouses or domestic partners of male clients in St. Louis were referred to Alternatives to Living In Violent Environments (ALIVE), a non-profit organization that offers victims short-term emergency shelter and support services, including individual and group counseling, court advocacy (i.e., assistance in securing restraining orders, etc.), transportation services, and referral assistance in obtaining more permanent, secure shelter. Additionally, ALIVE operates several outreach and community education seminars on family violence.

Tampa clients in need of emergency shelter due to deteriorating domestic relations were referred to The Spring, a 65-bed "safe house," operating since 1977 through United Way funding and a variety of grants. The facility has 52 full-time counselors and staff, 52 part-time employees, and additional volunteers, who facilitate substance abuse treatment, parenting skills

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[26] Direct comparisions do not exist for these specific items, which were part of a series of sensitive gender-specific questions: the query used to measure domestic violence for female respondents assumes victimization, while the companion question for men assumes they were the batterers.

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programming, and other support services such as counseling. The Spring provides a six-month family violence intervention program for domestic violence offenders, most of whom are court-ordered to attend. Additionally, if a client is using drugs, referrals are made to rehabilitation programs such as Project Recovery, which offers outpatient treatment. The Spring also operates a children's program in the shelter, where youth go to school and pre-school, grouped according to ages.

Permanent Housing and Housing Assistance

OPTS-related housing assistance came in various forms. In addition to direct service delivery (such as the financial assistance described earlier), OPTS case managers researched resources that clients could navigate on their own. For example, St. Louis clients reportedly received assistance from the Housing Authority. Tampa clients with emergency assistance needs were referred to Tampa Homeless Network, which paid the first month of rent (up to $300) for qualified candidates. Kansas City case managers encouraged clients to use a HUD directory, which listed low-income, one- to four-bedroom apartments, to identify and research housing options. This directory provided the location and contact information for apartment complexes in the Kansas City metropolitan area. The case managers also encouraged clients to apply for housing under HUD's "236 Program," which provides basic rent assistance. To qualify, an applicant's adjusted income had to fall within the agency's income limit; income criteria apparently varied by apartment complex. Qualifying applicants had to pay the "basic rent" amount delineated by HUD -- usually 30% of earnings. However, long waiting lists for subsidized housing precluded most clients from securing housing under that program.

Kansas City case managers also referred clients to the United Services Community Action Agency (USCCA); to facilitate client self-sufficiency, case managers provided the referral and clients were expected to follow through. USCCA is a private, non-profit organization incorporated since 1978 to meet the needs of low-income persons. Among its many services are family resource assistance that includes emergency food, utility assistance, emergency rent assistance, a thrift store, and holiday programs. USCCA also offers employment services and home management workshops.

As clients who required transitional housing progressed in their recovery, becoming more stable, some began to need secure permanent housing. At least one Kansas City client was referred to Shelter Plus Care, which provides housing to mentally ill, homeless individuals through a partnership with the Missouri Department of Mental Health. The majority of applicants are referred to the program by case managers, and Shelter Plus Care expects these case managers to play a significant role in assisting qualified individuals to find appropriate housing. Program eligibility guidelines require prospective clients to be: homeless, disabled (drug addicts or individuals with a known substance abuse problem are eligible), under the supervision of a case manager, and the recipient of at least one year's worth of a full complement of services that have been documented. For qualifying individuals, Shelter Plus Care provides housing vouchers that

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enable clients to rent modest apartments at substantially reduced prices (about $300 below the regular rent). Clients must use vouchers within 60 days after receiving them, which requires concerted effort on the part of the case manager to locate suitable housing within a constrained time frame; the other down side for the case manager is the amount of paper work that must be done in conjunction with using the vouchers.

St. Louis case managers used Apartment Finders to identify housing options for clients. Apartment Finders searches for apartments and other housing based on selected criteria. Although the service was frequently used, OPTS clients reported limited success in terms of results because they often could not afford the housing options identified by the service.

Challenges to Providing Housing Services

For reasons noted earlier, Tampa experienced fewer challenges in linking clients to housing services than its Missouri counterparts; the self-report data reflect this difference: only 17% of Tampa clients reported having problems finding housing compared to 36 percent of Kansas City and St. Louis clients. Nevertheless, limited local resources, eligibility issues, and legal constraints posed key challenges to staff across the sites. Additionally, poor client follow-through on housing referrals and resistance to housing options that did not meet their personal preferences also inhibited housing placements.

In Missouri, long waiting lists for HUD-sponsored subsidized housing (i.e., Section 8 housing), for which most OPTS clients were readily qualified, precluded access to this affordable housing resource. Halfway houses provided the most viable housing alternative for clients in these sites; since most halfway houses operated DOC-contracted community placement beds, case managers could typically secure a slot for a client with minimal effort and delay.

> While halfway houses afford ready placement, clients complained that most facilities did not provide totally drug- or alcohol-free living environments.

The lack of drug-free transitional housing in the Missouri sites remained an issue throughout the demonstration period. Case managers and POs in St. Louis and Kansas City routinely cited the lack of drug-free transitional housing for offenders, especially those re-entering the community, as a major impediment to client recovery.

Across the three sites, eligibility criteria also limited the reserve of housing resources open to OPTS clients. For example, some housing was suitable for families, but would not accept OPTS clients who were single and in need of shelter; conversely, some clients needed a placement that would permit them to remain with their family, at a time when the only available units were those that accomodated single individuals. Case managers in both Tampa and St. Louis struggled to supply OPTS clients with adequate drug-free housing despite the fact that each lead agency operated housing units. St. Louis clients neither met the criteria for LFCS housing,

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nor fit within the purview of that program's target population. Tampa clients were often denied access to DACCO's apartments because applicants were required to have six months of sobriety and full-time employment to qualify for these housing units.

Also, Florida state law presented another obstacle that frequently was a barrier for Tampa clients who needed housing. Under a provision of the Florida state code, rental agents and private landlords have the right to refuse to rent property to convicted felony offenders. At least one OPTS client was unable to secure permanent housing for this reason; ultimately, he moved in with an acquaintance.

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CHAPTER 6
FAMILY STRENGTHENING AND LIFE SKILLS SERVICES

Family services were incorporated in the OPTS model to address risk factors associated with family instability. The model allowed for some autonomy in determining the nature of services under this component. The model originally focused on the need for parenting training, but this subsequently was broadened to comprise a range of activities that were compatible with reducing anti-social family and peer pressures in offenders' lives, as well as enhancing clients'general self-sufficiency. Thus, services offered included: basic life skills, anger management and domestic violence counseling, family or marital counseling, and other activities designed to end violent or destructive domestic behaviors and help clients assume responsibility for their children/families and themselves.

In terms of marital status or domestic partnerships:

- More than half (57%) of OPTS clients across the three sites were single and not living with a domestic partner. Similarly, nearly 2% of the treatment group were widowed, and not living in partnered relationships.

- 11% (i.e., 16 clients) were married, and two of these marriages had taken place during the clients' first year of OPTS supervision.

- 20% (i.e., 30 clients) were separated or divorced, including five relationships that had ended in separation or divorce during the one-year follow-up period.

- 11% were living in partnered relationships, including three individuals (of the 16 living in non-marital relationships) who began living with domestic partners during their first year of OPTS participation.

With respect to parental status, 67% of OPTS clients reported they had children who were younger than 18 years old: 42% of all clients had one or two children, 21% had three or four children, and 3% had 5 or more children. In many cases, these children were the product of multiple relationships, so that the nature of parent-child contact varied with each dyad. Nearly 25% of OPTS clients had all of their children (younger than18 years old) living with them; another 18% had at least daily visits with some of their children, while others of their children lived with them. Also, virtually 16% of clients saw their children on a weekly basis, while a similar portion (approximately 17%) had infrequent visits (i.e., only once or twice per year) or had no contact with any of their children. An additional 9% had some of their children living with them, but had infrequent or no contact with other offspring.

In terms of assuming parental responsibility for the financial support of their children, 24% of clients reported they fully supported all of their children; 41% said they provided partial

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support for all of their children; and 12% said they supported at least some of their children fully, while they provided partial support for the others. By comparison, 9% reported they did not provide financial support for any of their children; and 15% indicated that they did not provide any support for some of their children, although they contributed fully or partially to the support of the remainder.

OPTS clients reportedly experienced a variety of problems related to family and life skills: as noted in Chapter 2, 41% had problems avoiding family or friends who use alcohol or drugs; 38% had difficulty controlling anger or expressing it in non-physical or non-violent ways; and 34% said they problems getting along with their spouse or domestic partner. Approximately 21% of the client sample reported they had been unfaithful to their partner during the one-year follow-up period; and 15% reported physical fighting or assaultive encounters with their spouse or partner. In addition, 20% reported they had difficulty getting along with family members, other than their spouse or domestic partner; and, outside of the family, 14% had been involved in more than one fight that came to blows. Further, nearly one-quarter of clients reported problems re-establishing contact with adult family members (22%) or with their children (21%). In terms of self-sufficiency, clients had a range of difficulties, many of which have been identified throughout this report; these include: financial constraints that threatened their abilities to provide food, clothing, and suitable housing for themselves and their dependents; problems finding pro-social recreational and leisure activities (15%), and difficulty keeping their houses clean (12%).

Among the critical services provided to OPTS clients were family advocacy and emergency assistance (as described in Chapter 2 and elsewhere throughout this report). Educational programming, counseling services, and family support services, as described below, were provided to varying degrees, within and across the three sites during the three-year demonstration period. Exhibit 6-1 portrays the percentage of OPTS clients who self-reported that they were referred for family or life skills services. Exhibit 6-2 shows the percentage of clients who reported participating in training programs, workshops, or counseling that focused on parenting issues.

> In Kansas City, efforts to stregthen offenders' relationship with family included providing one client with the funds necessary to fly his daugther from California back to Missouri: the OPTS client expressed the desire to resume his role as primary caregiver when his daughter reported an abusive relationship with her mother (she also had asthma and felt living in Missouri would be better for her condition).

Skills Building Services

Offender attitudes about family and social responsibilities were addressed through workshops, seminars, and one-on-one time with program staff. For example, NCADD implemented a workshop series, *Survival Skills for Men*, which both the project coordinator and a case manager were trained to conduct. The *Survival Skills for Men* curriculum addressed basic life skills issues, such as financial management and problem-solving skills, as well as employment, health, and nutrition; two of the program's ten sessions focused on parenting skills

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EXHIBIT 6-1

Referrals for Family Strengthening, Life Skills, and Self Sufficiency, by Site
(N = 147)

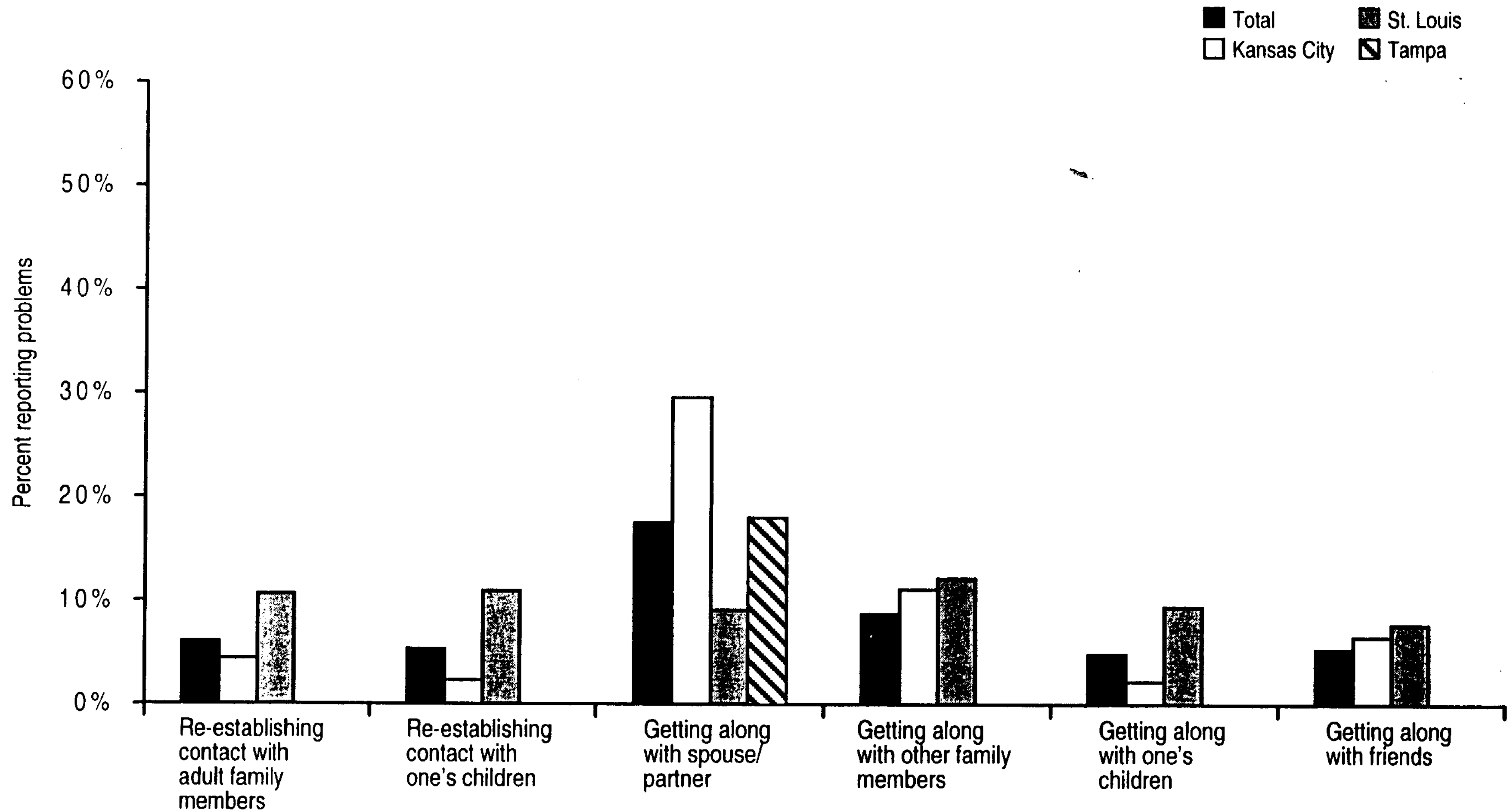

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EXHIBIT 6-1. (CONTINUED)

Referrals for Family Strengthening, Life Skills, and Self Sufficiency, by Site
(N = 147)

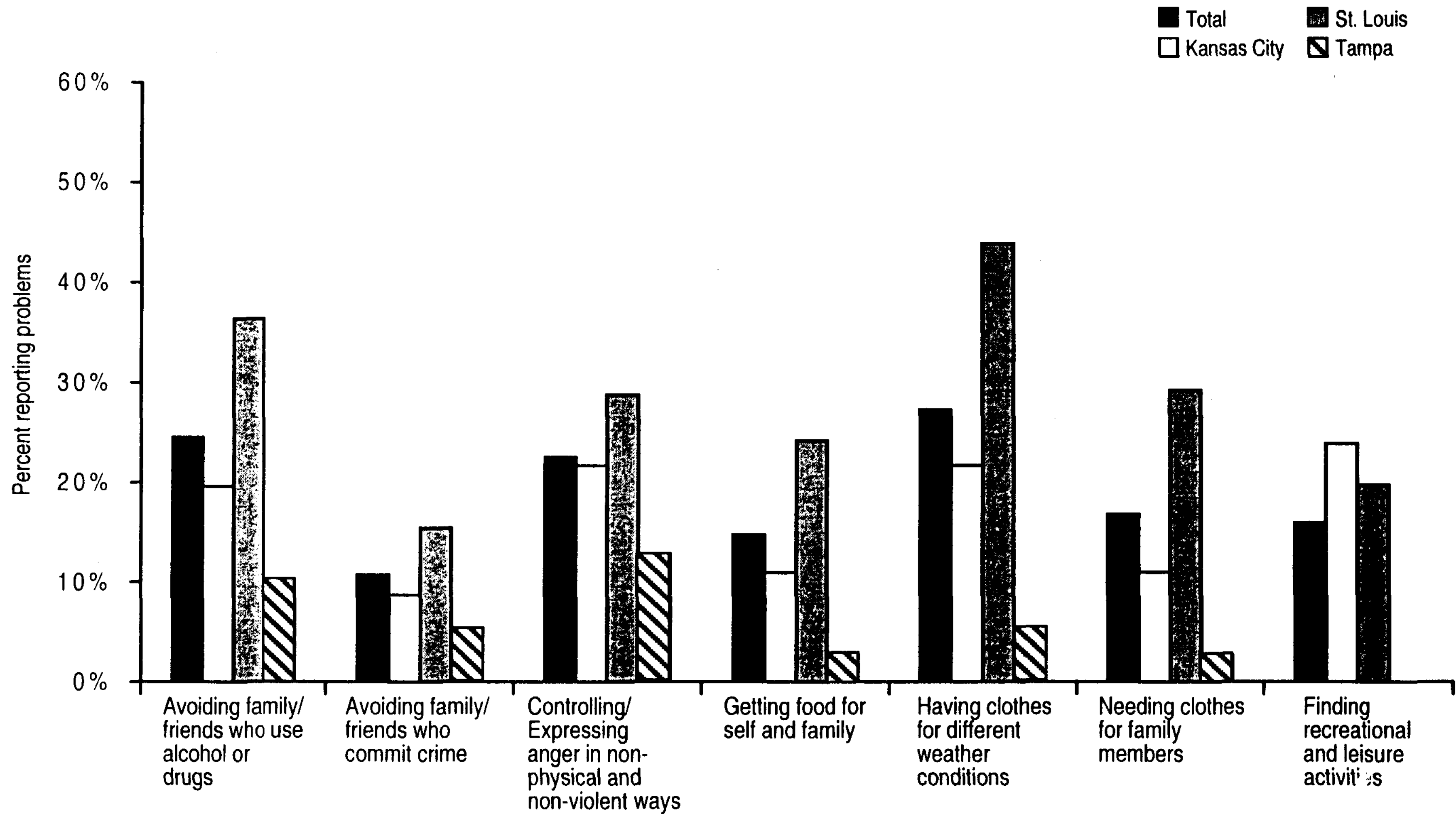

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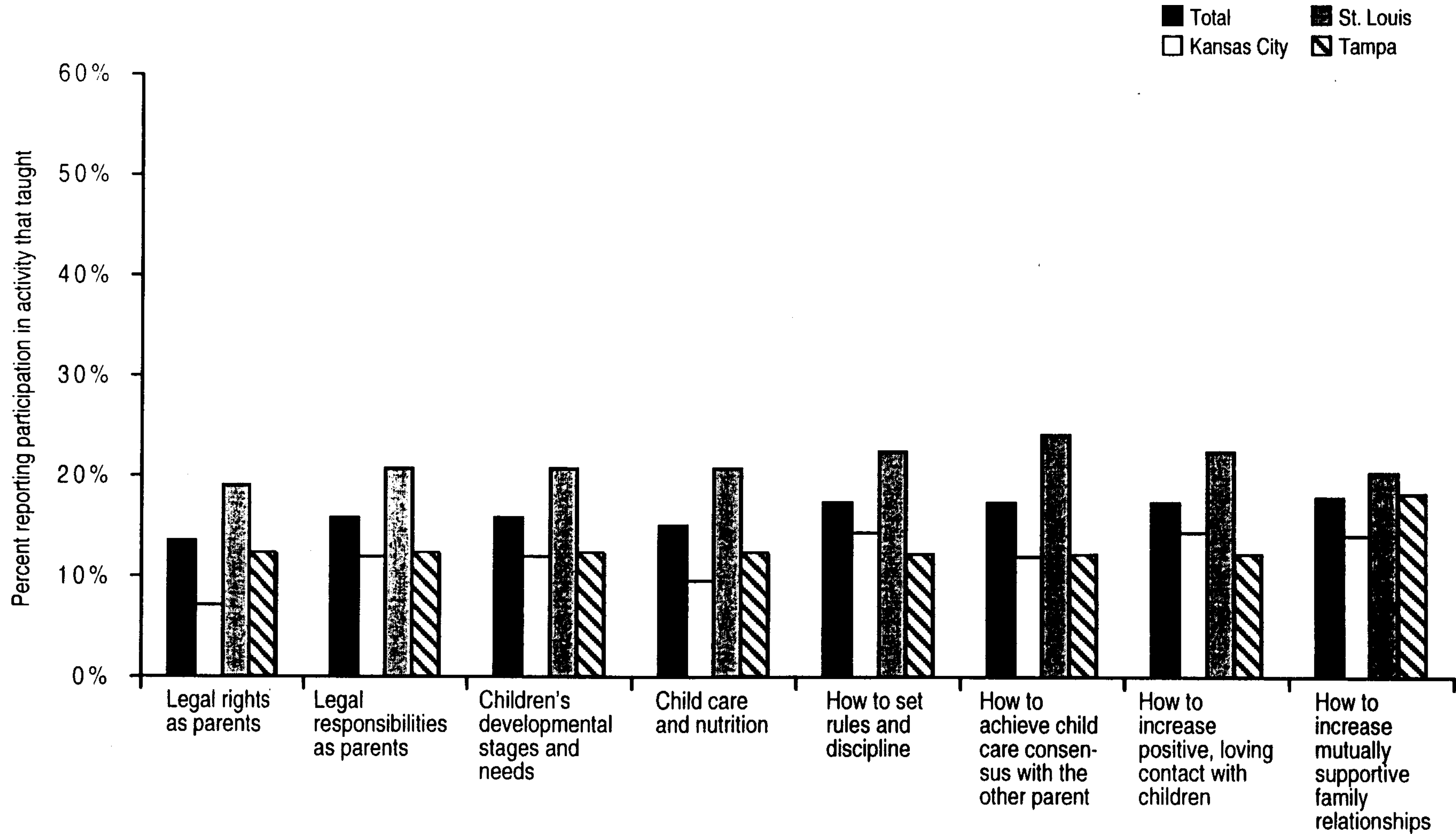
Exhibit 6-2.

Client Participation in Parenting Skills, by Site (N = 147)



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(fatherhood development) and family roles. The series was held at the lead agency, where OPTS clients attended sessions twice weekly for five weeks. Saturday "lab" sessions, including a field trip to the library to acquire library cards and do research on family and local history, also were held. Clients graduated from the program if they attended eight of the ten sessions. Initiated in June 1995, the Survival Skills groups for OPTS clients continued into the second program year, but ceased by August 1996 as client interest and participation subsided. Although started specifically for OPTS clients, the program also was incorporated into the local probation office's Day Report program -- a community-based sanction for probationers.

To address clients' concerns about how to succeed in the community after incarceration, the Kansas City program also referred clients to the *Felon-to-Felon* workshops. These were conducted by an ex-offender with the Ad Hoc Group Against Crime, one of the city's oldest grass-roots crime prevention and community mobilization efforts. *Felon-to-Felon* provided a comfortable forum for clients to discuss the challenges associated with re-entry into the community. In addition, the workshop introduced clients to a positive role model to whom they could relate; namely, a former offender who successfully transitioned to the community and was leading a pro-social life. The Ad Hoc Group Against Crime also offered a lecture series, *Building a Successful Life After Prison*, that addressed the issue of successful re-entry into the community. The series was led by the uncle of an OPTS client, also an ex-offender, who had written a book on the subject.

Some clients were referred to Kansas City Corrective Training, Inc. (KCCT) if they needed to improve specific skills. KCCT provides a range of educational services to court-ordered defendants, including: shoplifting prevention, check writing, a drug-free program that involves drug testing for entry-level, municipal drug offenders, and the Substance Abuse Traffic Offenders Program (SATOP).

In addition, Kansas City OPTS formed a relationship with the YMCA from the start of the program to address clients' needs for constructive recreational activities. In addition to sports and games, the YMCA offers workshops that focus on a wide variety of life issues, such as basic nutrition and health maintenance. The objective was to provide recovering addicts and alcoholics with an alternative to drugs and crime. OPTS purchased memberships for clients to use YMCA facilities, including attending any programs offered by the organization.

In St. Louis, case managers briefly facilitated an Afrocentric *Man to Man* workshop series, which was introduced after arrangements with a parenting skills provider fell through. Sessions met on a weekly basis from August through September, 1995. Designed to enhance clients' self-esteem, self-reliance, and respect for self and others, the *Man to Man* curriculum taught participants about their history, culture, and identity as African-American males; acceptable roles, such as appropriate behavior for husbands and fathers; and basic life skills, including budgeting and time management.

Family Empowerment Workshop (FEW) seminars were introduced following the conclusion of the *Man to Man* group. Developed and implemented by St. Louis case managers as a mechanism to address a host of relationship and parenting-related issues, the FEW seminars

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focused on such diverse topics as: the history of Black America, domestic violence, anger and stress management, interpersonal abuse (physical, sexual, and verbal), dimensions of a healthy self-concept, and child development. In deference to the changing demographic composition of the program's caseload (i.e., the program was aggressively recruiting women by this point), several workshops were devoted to female clients; and the domestic partners of male clients were encouraged to attend these sessions. This special series, *Women Let's Rap*, focused predominantly on educating women about healthy relationships -- distinguishing between healthy and unhealthy relationships, and how to facilitate healthy, mutually supportive relationships. Issues pertaining to female sexuality, parenting, and recovery also were addressed. Responsibility for coordinating the workshops rotated among the site's three case managers; materials, including information on available services, were provided to clients at the end of these sessions. The format generally consisted of a guest speaker followed by a question-and-answer period; for example, a representative from RAVEN, a St. Louis domestic violence counseling and education program, facilitated the seminar on domestic violence.

St. Louis also used the services of its social worker volunteer to arrange family, as well as individual counseling. In general, clients were referred to family counseling if they had issues with domestic and familial relationships, such as problems relating to their children, or conversely, if they had issues relating to their own parents. Services were provided by both a Family Resource Counseling Center and an independent therapist. Both providers served clients as long as deemed necessary to work out the issues associated with their respective presenting problems.

Tampa OPTS primarily used its *Relapse Prevention* group to address family and life skills issues. Case managers encouraged the clients to attend with their domestic partners. This outpatient counseling program -- primarily focused on substance abuse avoidance, as described in Chapter 3 --was developed as an alternative to the lead agency's outpatient aftercare group, in part to accomodate family members who were prohibited from attending the existing group sessions.

In addition, case managers linked clients to several ancillary services, such as The Parenting Center at Hillsborough Community College, Bay Area Legal Services, and the People Licensed Under Supervision (PLUS) program. The Parenting Center conducts parenting education classes designed to prevent child abuse. Classes cover a broad range of topics such as effective training and discipline techniques; how parents can build the self-esteem of their children; appropriate pre-natal care; home management, etc.

Bay Area Legal Services (BALS) provides free civil legal services to the poor and elderly of Hillsborough and Pasco counties. Clients may receive legal advice and services on a wide variety of legal matters, including: family law (custody, domestic abuse), housing, public benefits (social security, SSDI, general assistance), senior advocacy (health care, consumer issues, housing), probate/wills, and consumer law. BALS also operates a Ryan White program to assist people with AIDS. To qualify for BALS services, individuals must fall under the federal poverty line.

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In Florida, conviction for a drug felony results in automatic suspension of the offender's driver's license, which can introduce transportation problems into the mix of daily living issues that OPTS clients must resolve. PLUS is a non-profit program, operated in collaboration with the courts that is able to issue valid Florida drivers' licenses to offenders enrolled in the program once they have fulfilled any court-ordered terms. The PLUS program educates, informs, assists, and directs participants in preventive behavior and meeting responsibilities with the end objective focused on obtaining a driver's license. To participate in PLUS, offenders must be able to pay small amounts toward outstanding traffic-related court charges; PLUS monitors participants for as long as it takes them to fulfill court requirements and receive their license.

Domestic Violence Services

Other services available to clients and their families included anger management and domestic violence classes. Analysis of the baseline self-report data indicates that approximately 14% of male OPTS clients identified themselves as perpetrators of domestic violence at some point during their adult life, while 26% of female clients reported having been beaten or threatened by a spouse or partner at some point since turning 18; additionally, as noted in the preceding chapter, follow-up data suggest that 10% of OPTS men admitted engaging in abusive behavior during their first year of OPTS supervision, while 24% of female clients reported they were the vicitims of domestic violence during this timeframe.

Kansas City initally referred clients and families to anger management classes, as a partial solution to troubled domestic relationships. However, during the second program year, case managers made a conscious shift in service provision, choosing to refer clients and their families to domestic violence education services, rather than anger management programs. Two key resources were leveraged: Associated Addictions and Family Advocacy Network, Inc. (FAN). Associated Addictions offers anger management programming, as well as more specific and intensive domestic violence education and counseling services. OPTS clients also received services through two FAN programs: the Domestic Violence Intervention (DVI) program, and the Solicitation Intervention program geared to individuals arrested for prostitution. The domestic violence program, designed for batterers, runs for 12 weeks (their victims do not attend these sessions, but may attend separate sessions). Masters-level counselors and social workers lead the DVI sessions. There is a fee ($250) to attend the DVI, and reduced rates ($145) are available for individuals on public assistance; participants are required to pay a portion of the fee at entry, but may opt for weekly payments on the remaining balance. The curriculum focuses on a variety of topics including: communication, manipulation, boundaries, family, addictions, wellness, roles and attitudes, belief systems, behaviors, emotions, and self-esteem.

The program also tried to refer clients in relationships characterized by domestic violence to a psychologist that the Department of Corrections used. The psychologist provided couples counseling, which initially the program used as a negative sanction. However, staff found that the couples counseling just wasn't working as they'd hoped: clients resisted this service for several reasons, including interpersonal issues associated with the therapist.

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St. Louis case managers referred male clients to RAVEN for domestic violence intervention services: RAVEN's 12-month domestic violence education component consists of weekly educational classes, together with 40 weeks of group counseling; many clients are referred to RAVEN by the state's Department of Family Services, although a portion of clients are probationers and parolees referred by the courts. A psycho-educational approach based largely on the Deluth Intervention Project's domestic violence education model, RAVEN's educational component cultivates the offenders' sense of personal responsibility for abusive behaviors, discusses the typology of interpersonal abuse (i.e., sexual, physical, and emotional abuse) and its impact, as well as assists clients in identifying domestic violence triggers and constructive methods for diffusing such situations. Issue areas addressed in class include: gender differences, respect and oppression, definitions of abuse and abusive behaviors, aggressive versus assertive behavior, and effective parenting skills. Clients are required to pay a sliding-scale fee; further, clients with three unexcused absences must repeat the class from the beginning. Classes are led solely by volunteers, who represent a diverse group of facilitators, including social workers, ministers, and attorneys.

> In one circumstance, a case manager, who realized that one of her clients was involved in a domestic violence situation, conducted a home visit to mitigate the problem. Working with the client and his partner, she developed a contract -- for which both partners were accountable -- specifying what each would and would not do.

Family Outreach Efforts

Case managers and POs, alike, recognized that family members, including the clients' domestic partner, represent rich sources of information, often providing a sense of context through which staff gain a better understanding of the clients and their circumstances. Additionally, the attitudes and behavior of family members often play a pivotal role in facilitating or undermining clients' recoveries. Family members sometimes need education to facilitate recovery efforts on the part of OPTS clients, and to avoid behaviors that may sidetrack these efforts.

> One OPTS coordinator illustrated how family members can subtlely undermine recovery, even when they are attempting to be supportive. He recounted how on one occasion a case manager picked up a client at his home to bring him to an appointment. As the client got into her car, his mother offered him a cup of gin to quench his thirst on the ride. Although she was trying to be helpful to her son, she apparently did not equate drinking alcohol with the substance (drug) use she knew was forbidden under the terms of supervision, and did not regard this as threatening his recovery.

For these reasons, program staff employed a variety of tactics to engage clients' families in OPTS activities and in the clients' recoveries. As noted in Chapter 2, case managers (and POs) made home visits not only to monitor client compliance, but also to assess family or household situations, and offer services that might be beneficial. Across the three sites, case managers informally advised and counseled clients and members of their families as issues arose. They also provided other types of one-on-one support as needed by clients or family members. For

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example, case managers in Tampa played particularly pro-active roles in assisting clients to retain or regain custody of their children. In addition, a female OPTS client and the domestic partner of a male OPTS client were referred to an agency that provides services for addicted mothers and their children. The case manager also arranged for housing for the latter individual (who left the housing after a very short time, however).

St. Louis staff, for example, referred a number of clients' children to CALL, which is the lead agency's mentoring program. Similarly, in Kansas City, case managers presented a packet of information to the clients' families detailing the services available to them through NCADD. The agency historically has provided educational and support groups targeted to family members of substance abusers; these include the How to Cope program designed to educate spouses and domestic partners so that they will not enable their mates' addictions, and Children At Risk Encounter (CARE), which targets children and focuses on safety issues related to drug and alcohol use.

Aside from these offerings, case managers invited OPTS participants and their domestic partners, as well as other NCADDclients, to attend *Effective Black Parenting* sessions, which were lead by an OPTS case manager trained to facilitate this curriculum. Designed by black scholars using survey research information and other data collected from black parents, the *Effective Black Parenting* program, addressed parenting issues through a series of workshops. Other services available to family members in Kansas City included classes in Growing Up Black and Proud.

Both Missouri programs initiated regular family-focused activities such as holiday dinners and recreational outings; these activities were designed, in part, to facilitate more pro-social, positive interaction between clients and their families, especially for those with children. St. Louis held monthly dinners for clients and their families; these dinners provided the opportunity for family and staff to interact in a relaxed social atmosphere. Dinners commonly had a theme; for example, the theme for one dinner -- back to school -- specifically addressed the needs of the children of OPTS clients. Kansas City staff held dinners and picnics in conjunction with events to recognize clients' achievements. Also, all three sites provided clients who had made gains in recovery with gift certificates to local restaurants and tickets to local sporting and arts events as incentives or rewards -- these were typically designed to provide pro-social activities for clients that could be shared with their families.

Challenges to Providing Family Strengthening and Life Skills Services

Despite the services described above, the underlying reality was that the programs struggled to implement this component. Only NCADD implemented the type of formal parenting skills training curriculum that was originally envisioned as a primary feature of the program, although clients in all three sites were occasionally referred to programs offered by the lead agency or other services. To satisfy or comply with the model, the programs instead offered a spectrum of informal services and broader-based skills programming designed to promote or

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cultivate pro-social family functioning both on the part of clients and members of their families or households.

The programs perceived that costs for services might limit clients' or families' abilities to accept such assistence when it was offered. Consequently, case managers worked to identify providers who operated on sliding-scale fees or who would agree to other flexible payment arrangements. Thus, for example, to encourage family members' participation, NCADD waived the usual fee for its CARE and COPE programs for OPTS clients. Nevertheless, although case managers frequently referred family members to these programs, participation was minimal.

Clients tended to resist many of the services offered under this component, though their resistence to family strengthening and skills building was not as vigorous as it was to mental health services. While some individuals and their family members professed to have objectives that were consonant with those of the OPTS program, and were grateful for services that could help them achieve such goals, others were resentful of what they regarded as their involuntary participation and the unwelcome attention it brought to their private lives:

- As noted above, at least half of the clients were single and not living in a domestic relationship. While some, regardless of current marital or relationship status, had children they saw infrequently or not at all, and at least one-quarter had one or more children they were not supporting financially, often these were not regarded as "family" commitments that clients wanted to handle more responsibly (e.g., the adult relationships that had resulted in the co-parenting were so tenuous or dysfunctional that clients preferred not to re-visit them, or the offspring that resulted, in any fashion).

- Some families or domestic partners saw OPTS as a threat to their economic livelihood, particularly when the client or other close family/household members were engaged in drug dealing or had other sources of illicit income.

- Others viewed OPTS as an intrusion, just another arm of the social services or legal system trying to regulate their lives.

- Some were mistrustful of the system or suspicious of service providers in general, while others had difficulty engaging in specific services for a range of reasons (e.g., they did not perceive they had a problem requiring intervention of this nature, or they did not like or trust the counselor).

Further, case managers attributed clients' resistance to family services, particularly those that emphasize a counseling approach, as a cultural response. For example, case managers reported that the African-American community does not encourage individuals to discuss personal issues with outsiders. From the client's perspective the airing of intimate details of one's personal life or that of one's family may be regarded as a sign of weakness or disloyalty. The aversion to counseling was seen not only in the wariness regarding family services, but also in the strong resistence to mental health services, as described in the next chapter.

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St. Louis tried to overcome client resistence by identifying culturally appropriate resources. For example, a black, female psychologist was asked to facilitate at least some of the women's workshop sessions. The program's female case manager had hoped the psychologist's presence at the workshops would lessen her clients' reluctance to therapy; however, resistance to these services remained high.

Similarly, because the clients were generally resistant to counseling interventions, the program's social worker volunteer tried a creative approach. She located and referred clients for home-based counseling, which she hoped they would find more palatable than having to access services in more public locations. This, too, met with only limited success.

Family and client resistance to family intervention services and parenting skills training also inhibited service provision in Kansas City. There, case managers were concerned about what they regarded as the heavy enabling behaviors exhibited by the clients' families, and the program struggled to involve family members in family counseling and other services. Attempts by the Kansas City lead agency to provide family-oriented services to family members included sending invitations to the families of all clients, requesting them to attend the How to Cope series. Efforts such as these drew limited response, which case managers attributed largely to their belief that most family members were in denial or were enabling the clients' behavior.

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CHAPTER 7
HEALTH CARE

Most OPTS clients did not report health problems during their first year in the program. For example, 73% rated their health during the last six months of that period as excellent or good. A few clients reported such health problems as pneumonia (6%), hepatitis (2%), and various sexually transmitted diseases (i.e., herpes, gonorrhea, syphillis, and chlamydia were each reported by one or two clients). Also, 17% reported they had been hospitalized during the year for illnesses or injuries not related to their substance use, and 12% reportedly were hospitalized for health problems associated with their substance abuse. And, while 56% reported being tested for HIV, less than 5% of all OPTS clients estimated having a "high" or "sure" chance of developing AIDS.

More clients reported suffering mental health problems. For example, both serious depression and anxiety were reported by 27% of clients, and approximately 5% said they had considered or attempted suicide during the year following their release from prison or jail (in addition, one client committed suicide during this period, despite receiving treatment that service providers had thought was helping to reduce the individual's illness).

Provision of health care was a challenge in each site. Across the three sites, clients reported some difficulty in accessing or using health care services. For example, 24% encountered problems getting dental care; nearly 20% said they had a problem getting medical care; 13% reportedly had trouble getting eyecare or obtaining eyeglasses; 11% had problems paying for prescription medication; and 8% had problems getting mental health treatment. Exhibit 7-1 shows the percentage of clients who said they were referred for various health care services under the auspices of OPTS.

Medical and Mental Health Services

Of the three sites, only Kansas City negotiated MOU's with local health care providers as a mechanism to ensure client access to medical and mental health services. Core Kansas City providers included two of the city's comprehensive health care clinics: Swope Parkway and the Samuel Rogers Community Health Center. When appropriate, case managers also relied on the Veterans Administration Hospital as a resource for more comprehensive psychiatric treatment.

Swope Parkway provides a range of medical and mental health care services (as well as as other supportive services such as employability training) to indigent individuals and the "working poor." Functioning as a one-stop shop, Swope Parkway offers clients such services as: outpatient medical care; dental and eye care (clients can be fitted for contacts or glasses on the premises); obstetrics and gynological services; HIV screenings and testing for sexually transmitted diseases; substance abuse treatment and mental health services, including psychological evaluations; and intensive therapy, as well as individual and group counseling provided by several therapists on

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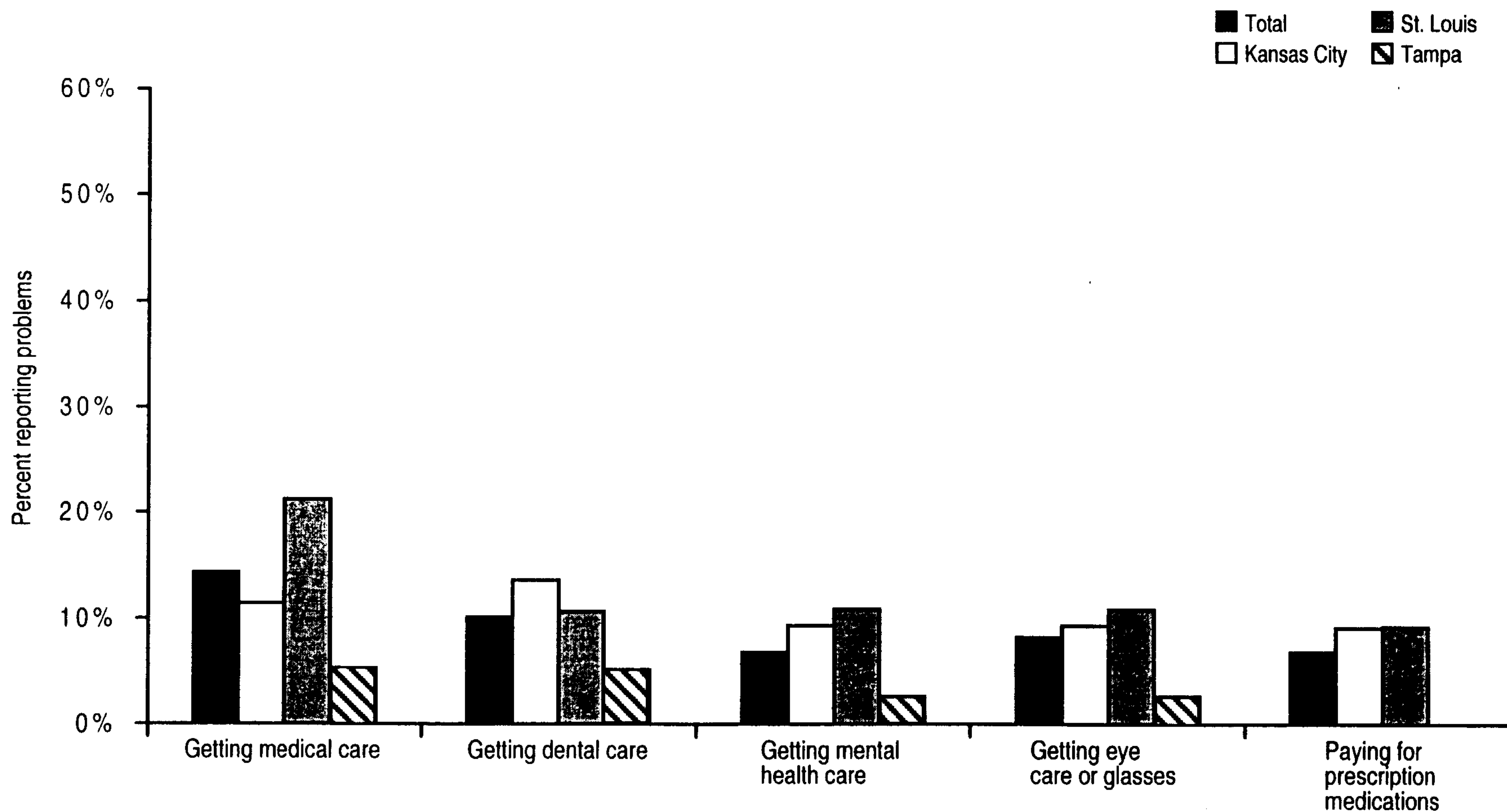
EXHIBIT 7-1.
Referrals for Health Care, by Site (N = 147)



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staff. Additionally, Swope Parkway operates a pharmacy on its premises, as well as a homeless program (that provides clothing and food, and links homeless clients to Kansas City shelters); a residential program for the mentally ill (designed to facilitate more independent living by teaching basic life skills); and a short-term residential substance abuse program that includes an aftercare component. The clinic operates seven days per week. Qualifying clients may pay for services on a sliding scale.

Eligibility workers at the clinic helped OPTS clients apply for various forms of public assistance such as Medicaid, Food Stamps, General Relief (public aid that provides restricted Medicaid benefits up to three months), and benefits through Women, Infants and Children (WIC) program. Services routinely received by OPTS clients included dental care, eye glasses, prescription medicines, and psychiatric evaluations.

Samuel Rogers Community Health Center also offers multiple services to the Kansas City community, including: a comprehensive, primary care medical clinic; mental health and substance abuse treatment; and an adult day care program. These service components operate in various locations throughout the city. Obstetrics, gynocological, pediatric, and adult medical services, including eye care, are available through the Center's health clinic; a pharmacy also operates within the clinic. A surgeon and opthomologist, working at the clinic one to two days per week, address clients' more specialized needs. The Center primarily serves the city's low-income population. Medicaid, Medicare, and most other forms of insurance are accepted, and services also may be paid on a sliding scale. Counseling costs and pharmaceutical services for uninsured or indigent individuals are covered through the Center's "grant program" -- that is, through monies received from the United Way, the city's COMBAT tax, and funds provided by the county.

The Center's mental health component provides outpatient substance abuse counseling, including HIV counseling, family therapy and marital counseling, anger management classes, and counseling services for compulsive gamblers. Substance abuse treament groups and anger management groups are held four times per week, and participants receive individual counseling on a weekly basis. Two psychiatrists (one specializing in child psychology), a psychologist, three certified substance abuse counselors, and three mental health couselors comprise the Center's mental health services staff.

In St. Louis, the program unexpectantly had to rely on referring clients to Regional Hospital and its various satellite clinics to provide medical and dental services. Clients also were referred to several of the city's university-affiliated medical clinics, including the St. Louis University Health Center. Another resource to which clients were referred was the People's Clinic, which became available toward the end of the demonstration. Serving poor individuals with little or no coverage, the People's Clinic offers medical and dental care to clients based on a sliding-fee scale.

Community-based clinics and university medical centers also provided primary mental health services to St. Louis clients. Clients were referred to Metro St. Louis Psychiatric Center, Life Sauree Consultants, St. Louis City's Health Department, Hopewell Clinic, and Highland

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Center for psychological evaluations and referrals for therapy. LFCS (the lead agency) provided individual and couples' counseling to OPTS clients on a sliding-fee scale through one of its in-house programs; although OPTS participants were generally disinclined to use this resource. Through OPTS, clients could also access a private therapist who would conduct counseling sessions in the client's home; the program's volunteer cultivated this service in response to client's resistance to mental health services.

Tampa reportedly did not pursue MOUs with local health care providers partially due to the lead agency's substance abuse treatment provider status, which presumably included protocols for accessing medical care needed by clients, and also because the local area offers numerous clinics designed to serve the city's indigent population. As expected, clients reportedly received health care from community clinics, the majority of which were designed to serve low-income individuals, and used a sliding-scale scheme for fees for services. The greatest obstacle to delivering such services was transportation. The geographic spread of the city meant clients often had to travel relatively long distances to access health care. Since Florida law requires the immediate revocation of driver's licenses for an individual convicted of a felony offense, OPTS clients had to depend on public transportation, which in Tampa, operates only for a limited number of hours each day.

For mental health services, Tampa clients were typically referred to Psychological Management Group (PMG); however, OPTS clients were occasionally treated by two other providers, The Spring and Apple Services (see discussion under crisis housing services), as well. PMG is a private practice group -- comprised of psychologists, clinicians, licensed mental health/ licensed social workers, and an Advanced Registered Nurse/Practitioner -- that treats offender and non-offender populations with psychological or substance abuse problems. Further, the group is one of Tampa's two major mental health providers treating sex offenders. PMG offers consultations, evaluation services (mental health or psychological evaluations), and a variety of treatments, including both group and individual counseling. Treatment is largely group-oriented, and premised on the cognitive behavior approach -- an approach focused on skills development as opposed to gaining behavioral insights. Treatment targets many problems, and includes groups on: conflict and negotiation; relapse prevention; anger management; domestic violence; assertiveness training; impulse control disorders; and mood disorders. All groups are bilingual, open-ended, and follow a module form (i.e., circular format of sorts); the module format facilitates free entry of new clients at any time, so clients can be integrated immediately into treatment. Cyclical curricula for group counseling ranges in length from 8- to 26-week sessions. Most clients pay for services on a sliding scale.

Challenges to Serving OPTS Clients

Despite the fact that OPTS clients reported generally good health, some did suffer acute illnesses requiring treatment, a limited number had chronic debilitating diseases (e.g., HIV/AIDS), and numerous clients required routine health care (such as annual physical examinations, dental treatment, or eyecare). Further, clients needed various types of mental health treatment; some for relatively transient difficulties, but others for more severe clinical

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conditions. Among the challenges encountered within and across the three programs were a variety of difficulties associated with limited access (e.g., scarce community resources, unusally lengthy waiting lists, eligibility criteria, lack of insurance, transportation, or other logistical barriers). In addition, OPTS staff contended with other issues, such as the special needs of particular subsets of their caseloads (e.g., individuals who would qualify as dually diagnosed), client resistence to mental health treatment, and concerns about the quality of services available within OPTS and the larger community.

Staff in the St. Louis OPTS program reported the most difficulty with accessing medical services for their clients, but all three sites experienced problems related to mental health treatment. Various factors at play within the local context accounted for much of the struggle St. Louis encountered in linking clients to medical care. Although the site initially secured the involvement of the city's Health Department in the collaborative, departmental budget cuts eliminated that agency's participation in the partnership. The lead agency continued attempts to re-involve the Health Department in the demonstration at both the policy and service level, but remained unsuccessful. Health Department staff turnover, on-going budget issues, and local politics worked against the envisioned partnership becoming viable.

Unable to re-constitute the partnership with the Health Department, the St. Louis program grappled with how to access and navigate the public health system. The fact that OPTS clients in this site straddled two service sectors, the county and the city -- each of which operates separate social service systems with disparate eligibility criteria -- further complicated service provision. Despite these difficulties, the St. Louis program apparently linked more of its clients to health services than was the case in Kansas City or Tampa (as shown in Exhibit 7-1).

The addition of a part-time volunteer to the St. Louis OPTS service team dramatically improved the picture. The volunteer, a retired social worker with more than 25 years of experience in the local social services system and a doctorate in social work, brought practical knowledge needed to navigate the beaucracy and more readily access local medical and mental health service systems.

To some extent, in St. Louis, access to medical care was inhibited by the clients' lack of health insurance coverage. Although the majority of clients were eligible for MEDICAID benefits, few had applied. Unlike Kansas City, St. Louis case managers did not have an eligibility worker at their disposal; therefore, program staff were left to grapple with the red tape. The program coordinator spent a significant amount of time early in the demonstration communicating with contacts in the public health system in order to better understand procedures and policies, and to guide clients regarding which clinics to go to and what forms needed to be filled out for particular clinics. In many instances, particularly for male participants, the OPTS program covered the costs of clients' medical care, prescriptions, or other needed health items (e.g., shoulder braces, humidifiers). Case managers encouraged female clients (roughly 10% of the caseload) -- who presented multiple health care needs, but were also more likely to resist such services -- to access free services such as the wellness clinics provided by Regional Hospital, which offered free STD/ HIV screenings, or breast exams offered by the Department of Health's wellness clinics.

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St. Louis employed numerous strategies both to increase client access to health care, and to induce clients to use available services. For example:

- Staff invited a representative from an area dental clinic to address clients at an OPTS-sponsored luncheon.

- LFCS (the lead agency) also held a health fair. Designed in part to forge relationships with new providers, the health fair provided services to community residents (i.e., blood pressure clinics and lead screenings); OPTS participants were invited to attend, although only one client did.

- Case managers leveraged the expertise of their team partners to identify new providers and increase client access to services; for example, DART, this site's core substance abuse treatment provider, applied its knowledge of the local mental health service network to link clients to psychiatric evaluation services. Likewise, the employment services partner on the OPTS service team worked to place clients in jobs with health care benefits.

- Case managers offered to drive reluctant clients to health care appointments.

As noted, all three sites encountered challenges in serving the mental health needs of their constituent caseloads. As with medical care, accessibility was often an issue. For example, most of Tampa's mental health centers reportedly operate with eight-month waiting lists; as a result, only individuals with serious mental disorders are likely to access treatment in a timely manner.

To some extent, program staff reported feeling ill-equipped and unprepared to properly address the magnitude and diversity of mental health needs presented by clients. Case managers did not necessarily have the expertise to diagnose such problems, were unprepared to administer standard diagnostic tools, and often were unfamiliar with community resources that could assist them in pinpointing clients' conditions and determining suitable interventions.

> Relying primarily on information provided by the client during OPTS program intake, case managers learned piecemeal the true nature and complexity of issues -- such as childhood sexual and physical abuse, or sexual orientation -- that clients wrestled with. This process of piecemeal disclosure may have enhanced the staff's sense of inadequacy; and the news of one client's suicide certainly exacerbated it. Reflecting on lessons learned, staff reported that the addition of a therapist to the service team would have been a tremendous asset.

Many clients had never been clinically evaluated, so case managers had no historical information to guide them in determining which clients needed services, or to which services specific individuals should be referred. Missouri case managers, for instance, lamented the lack of mental health assessment data available from the criminal justice system. They had incorrectly assumed that psychological evaluations were performed as part of routine Department of Corrections intake or home planning procedures, but found that probation files yielded few

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details about medical/mental health histories.[27] As a result, program staff were often surprised by the level of mental health needs exhibited by clients.

Interestingly enough, it appears that the OPTS clients, themselves, posed a formidable obstacle to mental health service delivery. Frequently, clients either ignored case managers' referrals for psychiatric evaluations or completed the evaluation, but refusedthe recommended course of action (e.g., individual or group therapy, or medication).

> One St. Louis team member observed that once the mental health issue was raised, some clients went so far as to try and separate from the program. Others became passive aggressive; and many clients lied about following up on referrals for assessment or treatment -- i.e., they claimed to have received services, but case manager monitoring of service utilization revealed that the clients never went to the appointment. In some instances, program sanctions were imposed on these clients in an effort to induce them to cooperate with recommended therapies.

Clients' active resistence resulted in generally under-utilized mental health services, as well as erratic or incomplete treatment regimens for those who made cursory efforts to comply with program requirements. For example, clients in St. Louis would reportedly attend the initial sessions of family or couples' counseling, but would not pursue additional meetings. In response, as noted in the preceding chapter, the program's volunteer arranged for a therapist to make home visits to counsel clients who otherwise refused to attend counseling services.

Delivering services to subsets of the program population, primarily those with certain health conditions or female clients, presented a separate set of challenges for case managers. For example:

- Tampa case managers noted that confidentiality concerns and legal safeguards in place to protect individuals' privacy made provision and monitoring of compliance more difficult when treatment involved HIV-positive clients.

- Similarly, case managers in St. Louis, the site serving the largest number of female clients, observed that women present a host of service issues that male clients do not: health problems related to prostitution, mental health issues associated with histories of sexual abuse or partner violence, and the need to access health care for their children. Case managers reported that female clients resisted their referrals to a private therapist, as well as other mental health services, despite concerted efforts to use a professionals who were female and

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[27] Clients in Missouri entered the OPTS program upon completion of the substance abuse program provided by DOC's network of Institutional Treatment Centers (ITCs), see Appendix A. As explained by DOC representatives, mental health assessments are not conducted as part of the ITC intake process. Further, ITCs do not treat dually-diagnosed offenders because staff cannot regulate their medications (although some ITC inmates presumably have conditions that would qualify them for dual diagnosis). At least one ITC (Farmington) was exploring the feasibility of implementing a program for the dually diagnosed, but recognized that, at minimum, this would require changes in staffing requirements.

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black. As previously mentioned, reluctance to use mental health services and family counseling was seen as a cultural issue: male clients also avoided these services, and case managers recognized that the African-American community does not easily divulge personal issues to outsiders.

Each of the sites struggled, for several reasons, to serve the mental health needs of dually-diagnosed clients (i.e., those who have both a clinically-diagnosed psychological disorder and drug dependence) or those exhibiting behaviors consistent with dual diagnosis. Such clients are reportedly among the most challenging to serve, and are time and resource intensive for line staff. For example, some clients were on prescription medications (e.g., Lithium or Prozac) for psychiatric conditions, but often did not take them regularly, giving the case managers and POs a "wild roller coaster ride." Others, who needed psychotropic medications, used drugs or alcohol to self-medicate, further exacerbating their cycle of addiction, inhibiting recovery, and increasing the risk of revocation.

Another factor that inhibited the provision of services to this subset of the OPTS population was client resistance to psychological evaluations. According to both case managers and probation officers, clients' frequently ignored referrals for psychological evaluations. In the absence of a clinical assessment, staff could not confirm their professional hunches of dual diagnosis.

> One St. Louis probation officer estimated that at least seven clients on her roster were dual-diagnosis cases; however, only two had been clinically diagnosed and were receiving treatment as such. Getting clients to complete the psychiatric evaluation was only half the battle as "most resist[ed] the medication and ongoing counseling." In a few instances, sanctions were imposed on clients who failed to comply with the terms of their treatment: at least one client was determined non-compliant and sent to a halfway house for failing to take the Prozac prescribed as the result of his psychiatric evaluation.

Further, communities often lack adequate treatment programs for these kinds of patients. In Tampa, mental health professionals noted that the local area has insufficient structured residential programs for individuals with serious mental disorders; similarly, there are limited medication management resources. This meant that individuals, who were diagnosed with disorders managable by medication, were unable to access psychiatrists who could prescribe and monitor appropriate pharmacologic remedies.

In St. Louis, by contrast, at least one OPTS service team member expressed concern that local mental health professionals were quick to medicate clients, almost to the exclusion of other modes of mental health intervention, but provided little follow-up care. They cited the experience of one client as not unusual: the client -- who did not have insurance (a consistent barrier to services) -- was referred to a local treatment center, which held her overnight in an observation unit, gave her a prescription for Prozac, and then released her without any plans for follow-up treatment.

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CHAPTER 8
LESSONS LEARNED

This chapter synthesizes some of the key factors that affected the OPTS programs throughout the three-year demonstration, as addressed throughout this report. In so doing, the discussion highlights strengths of the model and its application by the local sites, as well as challenges encountered and actions taken to mitigate or resolve such difficulties.

OPTS clients were all substance-abusing felony offenders who had recently completed incarceration or court-ordered treatment programs. As a group, they can be characterized as having vulnerabilities in multiple domains. Many faced severe problems, some of which had not been diagnosed or treated previously, while others had comparatively few issues to address. As in other areas of human services, OPTS clients represented a heterogeneous population: some were highly resistant to supervision, suspicious of both social service and corrections systems, and undesirous of social services that were optional under the model; while others were more or less committed to reforming, some of whom pro-actively sought and accepted a wide variety of services for themselves and their families.

Based on clients' self-reported problems and the observations of OPTS case managers and probation/parole officers, programs of this nature should be prepared not only to offer the core services laid out in the model (e.g., standard substance abuse treatment, job placement, drug-free housing, family strengthening, and health services), but also other services that mitigate situations that may be critical barriers to client success. These include such services as:

- Transportation assistance to permit clients to access needed services, or to facilitate job-hunting and steady employment.
- Emergency services, such as food, clothing, and funding to facilitate acquisition or retention of permanent housing (e.g., rental deposits, utility costs).

Further, programs need to consider that specific segments of this clientele may have more extensive problems, and may require services that are costly or in limited supply. In particular, the OPTS demonstration programs found that dually diagnosed clients, and those who exhibited characteristics consistent with this diagnosis, fit this description. Similarly, female clients often were in need of a wider spectrum of services (e.g., related to child care issues, domestic abuse, ramifications of sexual abuse or prostitution) and more resistant to complying with recommended interventions.

One of the striking observations about the OPTS demonstration is that there was a high degree of variation among the sites in terms of program implementation. To some extent, the model developed by program planners allowed for flexibility and autonomy in local decision making and practices. For example, sites were expected to use existing community-based resources, in preference to developing their own services. Thus, it is not surprising that the suites

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of services and mix of providers would vary dramatically across the three programs, as they reflected the extant service networks and capacities in Kansas City, St. Louis, and Tampa.

However, there were other site variations that likely resulted from the visions, internal organizational structures, and decision making of the lead agencies or the partnering probation and parole agencies regarding the roles and responsibilities of their respective staffs. For example, St. Louis was the only one of the three sites to co-locate case managers, POs, and core service providers from the substance abuse treatment and employment service areas. And, unlike the other sites, Tampa really struggled to adhere to the model's expectation of a few dedicated POs, who would work closely with case managers and oversee OPTS clients. Aside from these examples, field visitation and the follow-up survey data pointed to numerous other examples of site differentiation in implementation of the model; these included considerable differences in case manager and PO contact among the three sites, as well as in policies for conducting drug testing.

In general, the sites were satisfied with their efforts in mounting this demonstration; however, both line staff and administrators acknowledged areas of weakness as their programs evolved. To their credit, individuals and organizations were often quite proactive in defining weak or troublesome elements and introducing refinements that could strengthen their local efforts.

For conceptual clarity, although there is overlap among the topics subsumed, the following discussion has been grouped into three categories around issues associated with: 1) performance of case management; 2) supervision and monitoring, as well as systems integration of OPTS primary partners with the larger criminal justice system; and 3) local service networks. The recommendations suggested reflect the sites' experiences, together with conclusions drawn by the research team based on analysis of qualitative and quantitative data.

Case Management

Models of case management have been implemented for a variety of purposes (e.g., as part of mental health system reforms or to address the needs of the elderly in securing coordinated medical and social services). Some are quite limited in defining the scope of case management duties; for example, case managers may be used only to make referrals, schedule appointments, and confirm client receipt of recommended services. By contrast, OPTS envisioned a considerably more expansive role for its case managers. To some extent, case management was used to counteract the fragmentation and limited availability of services in the existing social service systems in the demonstration communities.

> An important feature and strength of the OPTS program was that OPTS case managers played a central role in directly delivering and brokering services, as well as serving as advocates for their clients.

Case managers were committed to this program, appeared genuinely concerned about clients and sensitive to their needs. As envisioned by the model, the local programs

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kept caseloads small (typically, fewer than 20 active clients per case manager, at any given time), and case managers focused on trying to maintain a high level of contact with their particular clients. The case management role permitted a flexibility that often does not exist in the offender/PO relationship. For example, case managers:

- Engaged in frequent client contact under a variety of circumstances -- in their own or other providers' offices, by telephone, home visits, at the client's workplace, or as they facilitated access to services by transporting clients to treatment or other important appointments.

- Extended services beyond the client, reaching out to meet the needs of spouses, domestic partners, and other family or household members.

- Served as sentries, identifying gaps in service, problems with capacity of certain services, or issues related to the quality of service provision in the local community.

Despite the fact that clients generally appreciated case managers, as evidenced by client satisfaction ratings, they often avoided services for a variety of reasons, including: resistance to supervision in general, perception that they did not need certain services, aversion to some types of services such as family or mental health counseling, belief that particular services or providers would not personally benefit them, or difficulty with the logistics (transportation, scheduling, or financing) of using certain services. Case managers, separately and with PO support, tried various approaches to increase clients access to, and use of, services. These included:

- Provision of bus passes.

- Trying to find providers whose personal characteristics would set clients at ease (cultural sensitivity or gender matching).

- Bringing providers into OPTS offices to provide introductory presentations on their programs (to increase client understanding and comfort level).

- Using providers who made house calls (offered to a very limited extent in St. Louis by a volunteer counselor affiliated with OPTS).

- Imposition of sanctions, although this element of program implementation was weaker than envisioned by the model.

In addition to making referrals and monitoring service use, the OPTS model implicitly expected case managers to have expertise in a variety of areas, including the ability to: develop resources, make clinical assessments or at least understand them across disciplines (i.e., medical, mental health, substance abuse treatment, etc.), and deliver direct services. In practice, these

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aspects of case management can be viewed as a weakness in implementation of the model, for various reasons. Alternatively, one could argue that the weakness resided in the model, for establishing expectations that were unrealistic in the real world setting of the demonstration sites.

Case managers had various professional backgrounds and levels of expertise; not surprisingly, some were more proficient than others in performing these disparate functions. Lead agencies in different sites sought somewhat different qualifications in filling this position. In general, the salary for the OPTS case managers was relatively low (a common problem for social service providers), which affected the mix of qualifications that could be obtained for this position. It also reportedly contributed to the turnover in this position experienced to varying degrees by the three sites. A key staffing consideration for case manager positions in all sites appeared to be hiring individuals who were comfortable working with the OPTS population and the vision of the OPTS model. To varying degrees, the sites also sought to hire case managers with some similar characteristics to the OPTS clients (e.g., ethnicity, gender, past substance abuse), to facilitate client bonding with case managers. Such considerations may have outweighed technical qualifications in making staff selections in some instances.

As a result of the varying proficiencies in case manager skills, within and across the local programs throughout the demonstration period, several case management hurdles were encountered, as identified earlier. These include such issues as:

- Consistent and appropriate service planning as a basis for brokering or directly delivering individualized suites of services.
- Familiarity with services across multiple, key domains.
- Balancing the intense demands of crisis management, with the responsibility to perform routine case management and service provision.

Service Planning

The OPTS model implicitly assigns the role of diagnosis (needs assessment) and service planning to case managers. Case managers brought varying strengths and backgrounds to this function. Some case managers were very experienced in working with substance abusers, were familiar with appropriate instruments for assessing various levels of treatment needs, and were able to distinguish services that should (or could) be called into play at different points in a client's addiction, relapse, or recovery. Others had strengths in having worked with an offender clientele, or with other populations who were high-risk or high-need for social services. However, the whole gamut of knowledge and skill did not typically reside within single individuals.

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Case managers sometimes had limited experience with performing formal client assessments and using diagnostic tools to consistently match individual characteristics and presenting problems with available services in each of the covered domains. Also, within and across sites (over time, and dependent upon different personnel occupying the case manager role), service planning varied in the extent to which individual plans were customized and matched to client characteristics, and the degree to which plans were comprehensive in identifying service needs and responses across multiple domains. For example, self-help support groups and generic outpatient programs were heavily relied on as treatment modalities for OPTS clients. However, at least some clients had underlying problems (e.g., dual diagnosis, histories of child or sexual abuse) that complicated their recovery. While case managers generally became aware of such issues and referred clients to appropriate services, or to entities that could perform more sophisticated forms of diagnosis, this did not uniformly occur at an early stage in the client's OPTS participation. It is possible that more structured and comprehensive intake, including diagnostic screening of a more clinical nature, would have detected the need for other types of intervention in addition to, or in place of, the services that were offered. However, the latter clinical assessments were beyond the capabilities of OPTS case managers, and routine provision of such diagnoses required some arrangement with a provider of clinical services.

Service planning also differed with respect to case management techniques (e.g., whether formal plans were drawn up; reviewed with clients and service providers; and updated to reflect progress or, conversely, to address new problems or needs that emerged). Procedures were not necessarily institutionalized within the various case management organizations. Although OPTS clients typically were not shifted from one case manager to another within the lead agency to balance case loads or for other administrative purposes, it was possible that a new case management assignment might occur (e.g., due to staff turnover), and the absence of case management protocols, as well as limited documentation in client case files, could introduce discontinuity in client care.

Familiarity With Core Services

Familiarity with local services is critical to success in meeting clients' needs in a number of ways. At the client level, such knowledge is central to identifying suitable placements that: 1) are consistent with individuals' treatment/service needs, 2) match clients' socio-demographic characteristics with program/service eligibility requirements, and 3) avoid or minimize logistical barriers to service accessibility and use.

Also, as noted in Chapter 1, the OPTS model envisions that local programs will not supplant existing systems of service, but will augment such resources. Thus, at the systems level, staff familiarity with local service networks is crucial in positioning OPTS programs to determine where service gaps or shortages exist that they may have to cover with their own resources, either by directly offering the missing supports or by negotiating with existing providers to expand or enhance their current services.

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Case managers were generally knowledgeable about community resources; able to find placements for clients once determinations had been made regarding the services to which individuals should be referred; and often instrumental in calling administrators' attention to service limitations or gaps that required remediation. However, these were not easy functions to perform, largely for two reasons:

- The number and intricacy of the various service domains covered by OPTS made familiarity with all possible services and providers within these sectors very difficult.

- Local service environments are dynamic (which, of course, is beyond the control of any OPTS program). Thus, adequacy of information and ability to negotiate arrangements for any particular placement can vary within very short time frames (e.g., as programs with limited capacity reach their maximum level and can no longer accommodate a new referral; or where providers change their eligibility requirements or service offerings, or go out of business altogether).

Crisis Management

In addition to differences with respect to their attitudinal response to OPTS, as noted in the preceding section, clients also differ considerably in the nature and intensity of their addictions, criminal histories, and other elements of personal or social dysfunctionality. Such distinctions translate into the kinds of demands they make on service systems, in general, and case managers, in particular.

Some clients are so needy and crisis-laden that they consistently require high-level attention from their case manager; others experience emergencies (e.g., a drug use relapse, a domestic incident that culminates in an immediate need for new housing arrangements) that require relatively short-term, but virtually all-consuming attention from the case manager. Under either of these types of scenarios, despite the relatively small caseload sizes, case managers can find themselves unable to provide sufficient support and supervision to other, less resource-intensive clients. This probably does not pose a major threat if crisis management of one or two clients diverts case manager attention from the remainder of the caseload for relatively brief periods of time (i.e., a couple of days at the most). However, some case managers experienced long periods where they were intensively caught up in the seemingly intransigent problems associated with one or another of their clients, and essentially could not fully attend to the majority of their clientele.

A number of problems may be associated with crisis or emergency management; oddly enough, the adverse effects that occurred seemed to impact staff more than clients. One potential consequence is that case manager's focus on the immediate needs of some clients could result in relative inattention to, and failure to detect emerging problems with others. Thus, problems or

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service needs which might have been ameliorated before they reached crisis proportions or otherwise hampered clients' progress, might go unattended and undermine success. Although this theoretically is a possibility that programs replicating OPTS should be concerned about, no such instances of this type were actually identified by staff or the research team throughout the OPTS demonstration.

Instead, the ramifications of client crises and emergencies that surfaced were those that affected staff: namely, staff frustration and burnout. Staff were not always expert in the discrete substantive domains that correlated with clients' problems; thus, linking clients to services, even under routine conditions, could be an exercise in frustration as case managers struggled with uncertainty about which services to call into play, and also bumped up against the changing nature of local services, eligibility criteria, and space/slot limitations that made it difficult to actually connect an individual with the optimal placement. Not surprisingly, such frustrations were exacerbated when working with highly resistant clients, or under emergency conditions where life-altering or life-threatening situations were unraveling, and time was of the essence.

> Despite the best efforts of case managers and POs, some clients did not respond to OPTS intervention. Programs need to be prepared to offer support to staff who are committed to clients' success, and are hard hit by client failures.
>
> Kansas City arranged *pro bono* consultations with a psychologist, who held quarterly meetings with case managers, POs, and the program coordinator. Staff were able to discuss difficult cases, or present cases where case managers and POs held conflicting views about appropriate actions to take. The psychologist played an important therapeutic role in helping case managers, as well as probation officers, manage stress and reduce occupational burnout often associated with high-maintenance clients.

Closely related to such frustration was case managers' stress and their potential to suffer burnout. To some degree, staff discomfort was an outgrowth of their recognition of some of the dire circumstances in which their clients found themselves, together with acknowledgment of the part they are expected to play in resolving clients' problems. In general, case managers are responsible for connecting clients to services, or directly delivering services, to reduce individuals' problems. However, under some circumstances, some case managers were so caught up in the human element of their clients' crises that they were unable to maintain sufficient professional distance. In a few instances, case managers became so enmeshed in clients difficulties that they found themselves enabling some individuals in a futile effort to have them succeed despite the clients' unwillingness (or inabilities) to assume responsibility for their own actions. Understandably, the burden of holding themselves accountable for situations beyond their control sometimes became overwhelming for case managers.

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Recommendations for Strengthening Case Management

- Carefully select staff who are substantively knowledgeable, familiar with the local service environment, and open to forging new kinds of working relationships with POs and other service providers.

> OPTS line staff recommended the following criteria be considered when choosing staff, particularly to work with substance-abusing offender populations. Select staff who:
> - Believe the impossible is possible.
> - Understand the population.
> - Are able to interact with different disciplines and agencies.
> - Have had prior experience with other institutional domains, possibly as an employee or volunteer
> - Have an ability and willingness to educate clients and other team members in areas where they possess expertise.
> - Have the stamina to accept clients' relapse, which can be very demoralizing.

- Involve a broader range of professionals and para-professionals in service planning and oversight to leverage expertise; this might be accomplished within the context of team case management, which might take a form similar to the St. Louis approach.

Given some of the challenges encountered, it appears that it would have been useful to have clinicians or other (para-)professionals who are skilled diagnosticians as part of an OPTS team. Also, programs and clients could benefit from having access to eligibility workers or others familiar with means-tested programs, public and private insurance, and related matters that may facilitate service placement and utilization.

A team approach might also be used to establish a form of back-up system for case managers. Requiring all case managers to participate in team meetings would establish sufficient familiarity with each others' cases to enable a client's needs to be met by a back-up case manager, when the lead case manager was trouble-shooting crises or emergency situations. A team approach also might diffuse the burdens of decision making, and the stresses associated with high-maintenance clients, as well as enhancing decisions by drawing on the insights and skills of other staff.

- Develop written guidance outlining case management responsibilities and how these are to be performed. For example, state criteria and guidelines for: performing intake interviews and administering client assessments; requesting drug testing; imposing sanctions or providing incentives; or suspending, terminating, or "graduating" clients. Such guidelines can be used to train new staff, to help ease transitions, and also can serve as reference materials for current staff.

State expectations about which activities and decisions (e.g., ordering urinalysis, imposing sanctions, meeting with clients) are to be performed individually by case managers, and which should be performed in conjunction with POs. Such materials

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would be useful in shaping case managers-PO collaboration, and promoting common understanding of expectations.

Also, develop written guidelines for interacting with other service providers. These might entail developing MOUs or MOAs for providers whose services are anticipated to be used frequently over the long term; or, might simply be guidance for case managers to use in ensuring that service providers who are dealing with one or two OPTS clients will be willing and able to share information on client use of services and progress.

- Document the evolution of the program and the history or rationale associated with decisions, particularly those associated with changes in program operations or practices related to clients. This information should be formally compiled into a manual that is readily available to supervisors and staff. This will facilitate program continuity in times of staff turnover, and may reduce future confusion or time spent revisiting prior decisions.

- Enhance the flexibility of all staff by providing cross-training on such topics as what information is needed for a comprehensive client intake, how to detect emergent problems and when to take action, and what services are specifically useful in mitigating or resolving particular needs or problems. Cross-training offers another potential advantage if it includes staff from other agencies -- it can promote interdisciplinary understanding of the roles played by other professionals who are also interacting with OPTS clients, and it can identify the resources that such agencies can bring to the table.

- Augment staff training with resource materials that are developed, and updated as needed, to reflect the service offerings and eligibility or other requirements of the local network.

- Encourage case managers to participate in professional meetings and conferences that would promote familiarity with local resources. If a community-wide service cabinet is formed (discussed below), case managers should be included in its meetings.

- Implement procedures for monitoring client compliance, including use of more frequent drug testing; logs clients can bring to service providers (e.g., AA/NA meetings) to have their attendance recorded; and follow-up contact with service providers to verify receipt of services and adherence to program protocols.

- Use standard procedures/mechanisms for recording information in client case files to enable other staff to readily understand a client's status in case of the need to "pinch hit" for the regular case manager, or to ease transition when there is staff turnover.

- Develop a management information system (MIS) to record service plans, chronologies of drug and alcohol treatment, involvement with the criminal justice system, case management contact, drug testing outcomes, service referrals and service use, violations

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and sanctions. Require case managers to *use* the MIS to periodically update service plans, and as input in making such decisions as when to graduate or terminate clients.

- Develop approaches to alleviate staff stress and burnout. Aside from adopting a case management team model, as discussed above, this might entail assigning a counselor to act as a sounding board or advisor, or arranging for staff to attend training or workshops designed to address stress-related issues.

Systems Integration: The OPTS Lead Agency and the Criminal Justice System

The OPTS program, unlike some other case management models, implicitly linked two separate systems at its inception -- namely, social services and criminal justice. Program designers used a planning phase during which interested communities were encouraged to forge local partnerships in keeping with the model. However, such partnerships typically engaged the lead service agency and the cognizant probation/parole department, but not other arms of the criminal justice system, such as the courts or corrections agencies. Further, the lead agency-probation office partnerships were often implemented loosely, sometimes based on the goodwill and face-to-face relationships established among individuals, rather than more formally erected on systems or structural integration, backed by institutionalized policies and procedures.

During the three-year demonstration, three issues that emerged in this regard were the need to:

- Implement more rigorous supervision protocols, including frequent drug testing and effective sanctioning practices;
- Ensure that OPTS is anchored within the larger criminal justice system; and
- Institutionalize the roles and responsibilities of the lead agency and the probation/parole department and, by extension, of the case manager and PO.

Establishing OPTS Within the Criminal Justice System

OPTS programs were sometimes constrained in their abilities to carry out service placement and supervision or implement graduated sanctions, in part due to the actions of judges who court-ordered offenders to other kinds of programs or supervision outside of the OPTS network. For example, Tampa clients could, and often did, ask the court to change their supervision requirements. If a judge approved a new supervision status, the individual could be

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assigned to a PO who was unfamiliar with OPTS and who did not actively support the case manager's service recommendations.

Similarly, OPTS case managers occasionally were constrained with some clients in their abilities to carry out intended sanctions, which sometimes included more intensive services (e.g., from outpatient to short-term residential treatment). For example, where technical violations resulted in the client's return to court, the presiding judge might be unfamiliar with the program and disinclined to solicit (or act upon) recommendations proffered by the case manager or PO. In a number of cases, clients were revoked, sent to jail or a DOC- treatment facility for a period of a few months, and then released without any requirement for further supervision. However, they *could* have been retained in program under the conditions that graduated sanctions were brought to bear, or under a suspended status, pending the release from court-ordered sanctions, at which point they could have been reinstated in OPTS and resumed its aftercare services and supervision.

An additional difficulty encountered by OPTS programs was that correctional facilities often did not inform probation officers in advance of an offender's actual release. Instead, offenders were told to report to their PO within a stipulated time frame (e.g., 72 hours). Most complied, but some did not, and even a relatively brief time "on the street" without supervision or supports can be sufficient for some individuals to lapse into substance abusing or criminal behavior, or to abscond. The lack of advance notice and, possibly more importantly, the lack of collaborative relations with correctional facilities, meant that there was little advance service planning to help facilitate a smooth transition to community-based aftercare. St. Louis and Tampa took steps to address these issues. In St. Louis, OPTS case managers, POs, and sometimes other core team members traveled to the correctional facility where most OPTS clients were detained to meet them, explain the program, and begin developing service plans prior to their release. Tampa staff also had close ties with the local jail and residential treatment facility from which OPTS clients were drawn, since each was located relatively close to the lead agency's offices, enabling case managers to readily connect with clients before their release.

Institutionalizing Roles and Responsibilities

OPTS programs are intended to use an integrated approach that involves joint supervision of OPTS participants by case managers and probation/parole officers. The model envisions collaboration between the case manager and the PO to provide enhanced client supervision and service provision. The primary partner agencies also are expected to coordinate their efforts toward achieving this end, and to coordinate with a network of community-based service providers to ensure provision of services to OPTS clients, and to identify gaps in the service system and recommend ways to address them.

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> A key administrator in St. Louis noted that collaboration in the planning and execution of the program was strong and beneficial, enabling development of trust and respect among all levels of the collaborative. The investment in collaboration in this site was felt to "reap rewards."

Given the pivotal roles of the lead service agency and lead probation/parole department, it is important to take steps to clearly identify and institutionalize the roles and responsibilities of these organizations and, by extension, of case managers and POs. The way in which OPTS was planned in the demonstration communities laid the foundation for this by involving key players from lead partner agencies from the beginning in developing understanding of their respective roles and of program procedures. As noted above, these partnerships were often loosely structured, and some were based more on interpersonal relationships established among individuals than on institutionalized policies and procedures. However, the latter is preferable to ensure program continuity over time, as well as consistent practice across participants.

Turnover of high-level administrators can have detrimental effects on cross-agency relationships, since their replacements may lack the institutional memory, shared vision, and understanding of the initiative of the original participants. New leaders may have a different agenda, and may not have the same degree of commitment to the initiative as those who helped nurture and shape it in its early stages. In probation/parole departments in particular, the new administration may adopt different philosophies or approaches to offenders that filter down to affect individual PO's collaborative practices or behavior.[28] Some turnover among lead service or probation agency administrators who had been instrumental in developing the OPTS initiative occurred throughout the demonstration period, with varying degrees of impact on the programs in their sites.

The philosophy or attitudes of the probation/parole agency in particular can effect the success of programs such as OPTS. More conservative departments may not embrace the treatment and sanctions orientation of OPTS, and the atmosphere in such departments may not be conducive to accommodating or nurturing such a program. In addition, the OPTS model requires probation departments and individual officers to relinquish some of their traditional decision-making authority or control to an entity outside the system, such as a community-based service providing organization. Turf issues may undermine working relationships among staff, and also may skew the way services are delivered to clients. For example, POs may insist that all OPTS clients participate in a given service(s) (e.g., anger management classes), even though case managers or others feel that service is not suited to an individuals' circumstances.

Even agencies that *are* supportive of the model may not be willing or able to carry out all steps desirable for optimal functioning. For example, all of the sites' POs carried caseloads in addition to OPTS clients, apparently because probation agencies were unwilling to assign

[28] Changes in agency philosophy or practice also may occur due to pressures from the external environment (including turnover in elected officials or attitudes toward crime or offenders), even in the absence of staff turnover.

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officers to caseloads as small as those associated with OPTS. In a few cases, the additional caseload was fairly substantial, at least during specific time periods. This made it difficult for POs to allocate much time to collaborating with case managers, participating in team meetings or home visits, etc., and reduced their flexibility to meet with clients or case managers on short notice (e.g., in a crisis situation). In addition, one probation agency was not able to maintain its original commitment to provide a small number of dedicated POs for OPTS in the face of a greatly expanded target area and changes in laws regarding release to supervision. As a result, case managers were required to interact with many POs, undoubtedly limiting the degree to which close collaborative relationships developed.

The OPTS model envisions a strong partnership of service and supervision, where: 1) caseloads are deliberately kept small for both case managers and probation/parole officers (POs); 2) a single probation/parole officer in each site is assigned to work with the case manager(s); and 3) co-locating service and supervision staff, where feasible. Under OPTS, supervision of offenders is a collaborative effort characterized by joint decision making and shared accountability for clients. Case managers and PO s retain their respective roles, but characteristics of each role complement the other.

> Case managers and POs have the opportunity to mutually reinforce and extend each other's roles through symbiotic relationships that emphasize the strengths of each.

For example, although it might be assumed that probation/parole officers routinely provide close supervision of offenders, in reality, high caseloads lead to relatively infrequent or superficial contact, allowing early warning signs of relapse or recidivism to go undetected. Case managers, however, frequently interact with clients to broker or deliver services, and monitor progress. Additionally, they may be regarded as a buffer between offenders and POs -- offender clients are reportedly more willing to share some types of information (e.g., about relapse or other behavioral lapses) with case managers than with their POs. Thus, case managers can enhance not only the amount of supervision provided by the probation officer, but also serve as an early sensor of the need to buttress services with sanctions.

Similarly, probation officers may refer offenders to some services, but rarely have the time to link them to a full spectrum of services, or monitor their participation to ensure initial or continued receipt of services. Case managers generally are predisposed to treat clients holistically, linking them to a multiple services. Ideally, they also track receipt of services and client progress to identify additional or changed service needs. However, case managers lack legal authority to mandate participation in services or to impose penalties for non-participation or other inappropriate behaviors. The PO's legal and supervisory capacity can be called on to "give teeth" to the case manager's recommendations and referrals, as well as to ensure appropriate actions are taken for non-compliance with program requirements.

One challenge associated with case manager-probation/parole officer collaboration in supervision of offenders is that their respective job and organizational requirements or

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expectations place different demands on the individuals occupying these positions, which affects their interaction with one another, as well as their approach to clients. The case manager role emphasizes helping *clients*, primarily through referral to services and encouraging use of those services, as well as providing counseling (formal or informal) and overall encouragement and support. The PO role traditionally emphasizes *probationer or parolee supervision* (ensuring *offender compliance* with court-ordered or other law enforcement requirements) and concern with public safety. One OPTS PO noted that "most POs are suspicious by nature; it's needed, it's part of the job." In some cases, POs felt case managers did not fully appreciate the legal considerations associated with serving offender populations. At times, differences in perception or understanding emerged only after a problem arose, such as cases where a case manager did not share information about a client's illegal activities with the PO.

In addition to differences in perceptions or values, case manager-PO pairs were not always clear about what was expected in terms of performing functions jointly, or making decisions collaboratively. Availability of written guidelines, which the sites generally appeared to lack, would likely help reduce some problems encountered.

Turnover at the case manager or PO level occurred with some frequency in some sites. Probation agencies in some sites seemed to be characterized by frequent staff changes, some due to promotions, others to movement of POs among various offices. Case manager turnover was more extensive in some sites than others; some turnover was for personal reasons, including career advancement. In a few cases, case managers left due, at least in part, to relatively low wages and benefits associated with their positions. Turnover at the case managers or PO level disrupts existing collaborative relationships, in which partners have developed understandings of each other's approach to work, established patterns of communication and, more importantly, developed common understandings or agreements about how particular types of client issues or problems will be addressed. When turnover occurs, some time usually passes before the "new team" forges similar relationships and understandings, which may affect services to clients, as well as the quality of the collaboration.

Supervision of Substance-Abusing Offenders

Substance abusers often struggle to achieve and maintain sobriety, and they often require multiple services from different service sectors -- which can be wearing on individuals even if they are pre-disposed to seek help, and may also drain limited system resources unless efforts are coordinated and delivered at appropriate points in the clients' recovery. However, *clients* for OPTS case management and aftercare were not just voluntary candidates for improved services, they *were offenders* required to participate in treatment and other services, although they often had to be cajoled and coerced against their will, despite their status.

Essentially, frequent contact with the case manager, combined with standard levels of contact with the probation/parole officer, is expected to result in the more intensive supervision

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envisioned by the OPTS model. Such increased supervision is intended to enable early identification of problem behaviors or service needs, and rapid and appropriate responses, in the form of graduated sanctions or incentives, to either reinforce positive behavior or institute corrective actions to mitigate unacceptable behavior.

> Urinalysis can be a powerful supervision tool for detecting non-compliance and relapses at an early stage, so that clients can receive the appropriate treatment. It also enables immediate enforcement of expectations through graduated sanctions.

Urinalysis testing under the OPTS strategy was intended to be a key element of intensive supervision. Testing of OPTS clients was anticipated to occur more frequently than the random drug testing commonly used for those under probation/parole supervision. In practice, OPTS clients were tested more often than probationers under routine supervision, but less frequently than offenders under drug offender supervision or drug court programs. In effect, testing did not occur as frequently as anticipated -- in part because the programs did not follow a regular protocol or schedule that ensured frequent testing of all clients. OPTS staff were able to use their discretion in ordering urinalysis tests, resulting in more frequent testing (perhaps weekly, or sometimes more frequent) of new clients and those whose sobriety was suspect. As clients progressed, testing typically decreased to a monthly basis, or one that was intermittent. Overall, however, most OPTS clients were not tested as frequently as probationers involved in drug court programs. In fact, approximately 14% of OPTS clients reported that they were *never* tested during their first year of OPTS participation.

Prompt receipt of urinalysis test results is a key factor in their usefulness, since this enables case managers and POs to act on violations in a timely way. However, time lags in obtaining test results was a problem encountered in some OPTS sites at various times. Use of particular laboratories for analysis was associated with longer turn-around times in some sites, but those laboratories were often less costly than those that provided results more quickly. Some sites were able to use field test kits, which provide immediate results, but detect limited numbers of substances, and also were considered relatively costly.

Another important element of the OPTS model was intended use of sanctions and incentives to "give teeth" to the increased supervision, including urinalysis testing. Recent research on drug courts (Harrell et al., 1998) indicates that a critical aspect of successful programs is forging an understanding of behavioral requirements and consequences -- which may be in the form of a contract that makes clear the consequences of particular behaviors. Consistency in application of incentives and sanctions (which underscores the certainty of consequences), immediacy of the penalty or reward, and salience of sanctions to the offender also have been found to be key elements of successful programs. OPTS sanctions and incentives, for the most part, did not meet these criteria. Sanctions were not always spelled out in advance, and they were not always consistently applied, limiting their effectiveness as deterrents.

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Recommendations for Strengthening Supervision and Criminal Justice Systems Integration

- Establish schedules and protocols for urinalysis testing, to ensure that clients are tested considerably more frequently than those on routine probation/parole (e.g., at least weekly). Schedules should be designed so there is flexibility to test as circumstances warrant. Make arrangements to enable prompt receipt of test results, so sanctions or treatment can be initiated in a timely way. This may involve identifying and using laboratories that guarantee return of analysis within a specified time frame (e.g., one day) -- and possibly paying more for their services. Provide field test kits for use when in cases where immediate confirmation of substance use is needed, and breathalyzers to enable testing for alcohol use.

- Establish contracts with clients, or otherwise provide clear information about the sanctions (consequences) or incentives associated with various behaviors. To enhance the deterrent effect of sanctions and incentives, be sure that the penalties and rewards selected are meaningful to the offenders, and that they are administered consistently and without delay.
- As recommended previously, develop written guidance (i.e., criteria and guidelines) related to such functions as urinalysis testing, applying sanctions and incentives, suspending, terminating and graduating clients.

- Steps should be taken to carefully identify and engage major stakeholders. To some extent, the potential for success of OPTS programs may have been curtailed by the relative absence of the courts (particularly judges) and correctional facility administrators during planning and implementation periods, and on advisory boards.

- Exercise care in selecting the probation "unit" in which the program is housed, to ensure that not only dedicated probation officers, but also their supervisors, are supportive of program goals (e.g., both should have a treatment-oriented approach, rather than traditional supervision approach). Obtain agreement from probation and lead service agencies that more than one high-level administrator will be involved with the initiative (e.g., attending regular meetings, being kept apprised of program status, and key decisions) to enhance the "institutional memory" of the project and to help ensure smoother transitions in case of high-level turnover.

- Enter agreements with corrections facilities to ensure that case managers and POs obtain not only advance notice of client's anticipated date of release to the community, but also of their actual release date. Develop guidelines and protocols to ensure that case managers meet with clients prior to their release (or have telephone contact, it they are located in distant facilities) to introduce the program and obtain basic information to initiate service planning.

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- Facilitate case managers' and POs' abilities to operate as a team by implementing policies and procedures supportive of such arrangements, including:

Co-location of services is beneficial to clients and to staff and service providers. "One-stop shopping" is more convenient for clients -- it conserves time and also their limited resources (such as money for transportation to various locations). Team members liked the face-to-face interaction across agency lines, and the opportunity to share decision making, particularly when it came to trouble-shooting difficult cases.

1) Co-locate case managers and probation officers at least part of the time -- preferably for half, or more than half, of the work week. St. Louis pointed out the benefits of co-located services, but also noted that this may involve additional costs for renting "satellite space" to accommodate staff who are being re-positioned to one-stop service locations.

2) Provide case managers and probation officers with pagers and cellular phones to facilitate telephone communication when staff are in the field.

3) Encourage or require that the case manager-PO team see clients jointly (for at least some regular meetings), and conduct some joint home visits (where applicable), to strengthen their collaboration, and reinforce the message to clients that they are expected to comply with recommended aftercare treatment and service plans.

4) Include supervisors of case managers and POs in team meetings to help ensure that: CM-PO teams stay on track in terms of their respective roles; differing perspectives and responsibilities are respected; and that team interaction is collaborative in nature.

- Provide cross-training to probation officers and case managers to help them better understand each others' functions and perspectives. It is particularly important to provide training -- and written guidance -- to case managers regarding legal obligations and safety issues associated with probation officers' responsibilities, and in the nuances of supervision regulations that can cause clients to be violated. Expanding cross- training to include other service providers also is desirable.

- Where possible, allow probation officers to self-select for the dedicated PO position, with the understanding that developing and working in a collaborative relationship is a key aspect of the position. Select officers who are treatment oriented, have good communication skills, and the flexibility to work collaboratively with case managers.

  Obtain agreement -- perhaps in the form of a MOU -- that dedicated probation officers will not be assigned caseloads other than OPTS clients, or that the size of any other caseload will be limited (the maximum size of any non-OPTS caseload should be stipulated).

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- Obtain probation department agreement to supersede, wherever feasible, probation agency practices that result in clients being transferred to supervision of a different probation officer (e.g., due to change in probation status, such as placement on electronic monitoring, or transfer to a halfway house or other residential facility). Obtain agreements that the dedicated PO will remain the cognizant PO for program clients, wherever feasible, in cases where transfer cannot be avoided.

- Recognize that staff turnover at the program level may adversely affect continuity and quality of service provision. Policies should be implemented to reduce the likelihood of staff loss (e.g., careful selection of line staff to ensure their suitability for this type of initiative, practices that mitigate burn-out) and, where that is not feasible, to ensure smooth transitions (e.g., manuals and guidelines documenting the program's evolution and operations).

- Joint hiring of staff (or interagency agreement on which existent staff will be assigned to OPTS) also may promote staff retention. Such a staffing approach requires partner organizations to achieve consensus on the desirable characteristics of employees, as well as to clarify the specific requirements of the job and how it relates to other functions. Joint consideration of such details may result in more careful selection of individuals who are well-suited to these roles. Joint staffing decisions also may reduce the likelihood that the respective organizations will impose inconsistent demands that lead to staff frustration.

Service Network

Achievement of OPTS objectives, such as reducing the prevalence and frequency of substance abuse and associated criminal behavior, and strengthening positive ties of ex-offenders to work, family and community, is dependant, at least in part, on the model's objective of increasing ex-offender involvement in social service programs. As noted previously, OPTS initiatives are intended to build on and coordinate existing systems of service delivery, not supplant them. The program model requires that sites arrange for provision of aftercare services in five core areas (substance abuse treatment, employability training and employment services, housing, family strengthening and support services, and health and mental health), although it was not anticipated that each OPTS client would need all of these services. Prior to program implementation (or shortly thereafter), local programs implemented agreements (generally in the form of Memoranda of Understanding or Agreement) with a limited number of service agencies to furnish core services. Under optimal circumstances, the OPTS approach would not only use existing resources, but also assess the "holes" in the continuum of care, and creatively build partnerships within and across service provider networks to bridge the gaps.

Clients exhibited diverse problems and needs; in response, the local programs tried to identify, broker, or directly deliver a wide range of services within the targeted domains. At least

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some services also were extended to spouses, domestic partners, family and household members. Some clients posed greater challenges than others -- because of special needs, such as dual diagnosis; personal characteristics of the client; or resistance to services. In some instances, problems or failures in service provision may have been due to faulty assessment or referral to programs that were inappropriate for clients with certain types of problems. In some cases, referral decisions were based on availability of space when service was needed, rather than on the best match for a particular client's needs.

> On-going resource development on the part of case managers was critical to adequately supplement service deficits that developed in relation to the dynamic flow of community-based resources.

Gaps in the service delivery system, particularly in programs that meet the needs of clients with special circumstances (e.g., HIV, dual diagnosis) were frequently encountered. Waiting lists and shorter periods of service provision than optimal were relatively common for some services (e.g., inpatient drug treatment, long-term residential treatment), and funding or other eligibility requirements (e.g., drug treatment programs' acceptance of Medicaid or particular types of insurance) further limited service options. Some programs limited potential clientele due to their focus on a particular population (e.g., female or youthful abusers, or abusers of a specific substance, such as heroin or cocaine), or use of a specific approach (e.g., use of an Afro-centric model). The changing landscape of local service provision, where existing programs might abruptly close or change key features (such as eligibility requirements or service modalities) in response to political or fiscal factors also affected service options for OPTS clients. The sites expanded the network of service providers beyond those identified in the core partnerships to fill gaps in service for redundancy, to ensure availability of service where programs had limited capacity, or to meet clients' unique needs.

Despite the challenges associated with identifying and securing services for OPTS clients, a considerable range of service providers and services in the core domains was evidenced across sites. The services varied in the degree to which they offered formal or standardized interventions, the duration or length of service delivery per client, and the intensity (e.g., the frequency of contact). Not surprisingly, the widest range of services appears to have been provided in the core service area of substance abuse treatment. Services in this domain ranged from self-help (e.g., 12-step model) and support groups, various types of outpatient treatment, and short- and long-term residential (in-patient) treatment programs, including halfway houses.

The lead agencies functioned as service providers in all sites, providing one or more core services in addition to counseling or therapeutic interventions associated with case management. In some cases, the original OPTS design called for the lead agency to provide services in its typical sphere of activity (e.g., in Tampa, DACCO routinely provides residential and outpatient substance abuse treatment, and operates a number of drug-free housing facilities). Over time, the lead agencies took on provision of a variety of services that, in effect, addressed some of the service gaps identified. For example, the St. Louis OPTS program established a small-scale clothing closet and food pantry at the OPTS office. This was initiated to readily provide clothing

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when a job interview or job opportunity became available on short notice, or to address emergency needs for food or clothing that could not be delayed until access to the regular food or clothing banks could be arranged. Similarly, most lead agencies adopted the practice of providing loans to OPTS clients, primarily to enable them to obtain, or retain, housing. Lack of funds for the deposit on an apartment, or to pay rent or utility bills to avoid loss of an existing housing arrangement, was a commonly encountered problem that jeopardized OPTS clients' ability to secure stable housing.

Lead agencies also acted to modify the scope of one of the core services. The OPTS model initially called for parenting skills training as one of the core components. Over time, the lead agencies broadened their interpretation of this service to include more generalized family interventions, such as family support or family strengthening activities. This modification was due, in part, to the recognized need for services to support and address problems in the family/domestic structure that often threatened to undermine recovery. Thus, services such as anger management, domestic violence counseling, and other family support services were added to this component. This component also encompassed broader skills building services, addressing such issues as life skills (financial management and problem-solving skills), self-esteem and self-reliance development, and successful re-integration in the community after incarceration. Parenting and family strengthening skills were often included in more generic skills building programs. The lead agencies often provided services associated with this component, although referrals also were made to existing service providers.

It became clear during the course of the demonstration that client needs that were not directly related to a particular service often acted as barriers to receipt of that service. For example, lack of personal transportation, or absence of public transportation that links particular areas in the community relatively directly during both day and evening hours, could effectively block clients from participating in services of a specific agency. This was particularly detrimental in cases where clients had special needs that were addressed by relatively few agencies. Similarly, lack of transportation often served as a barrier to fulfilling the employment conditions of supervision, or limited the potential employment opportunities available. The need for appropriate clothing for participation in job interviews, or for working once hired, was an issue lead agencies also had to address on occasion.

Recommendations for Strengthening Service Networks

- Cultivate relationships with more than one service provider in each service domain. Forming collaborative relationships with multiple providers services should result in such benefits as: 1) increased capacity to simultaneously serve high-need clients in a timely fashion and 2) more depth in the service suite, since providers can be selected to respond to different service needs. It is important to include providers who have experience working with offender clienteles, but who also are prepared to offer services that meet the needs of a diverse population.

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- Retain some flexibility in selection of service partners. When partnerships are established prior to, or shortly after, program initiation, service providers may be included (or conversely, overlooked) based on who was at the table during the planning phase. Although advanced planning is desirable, decision making often takes place before staff have realistic exposure to actual clients and their needs. It may be that some of the originally selected providers are unprepared to serve the range of clients that subsequently enter the program or they may be unable or unwilling to introduce new approaches into their pre-existing service configuration.

- Encourage case managers and POs to forge relationships with new providers through development of professional and personal contacts. This might be done by attending regular professional meetings of cognizant service sectors, or by the lead agency periodically hosting workshops or conferences that enable networking. Case managers should be encouraged to view resource development as part of their jobs, and to periodically seek out potential service providers to expand the network. This activity could be performed when caseloads are lighter than usual, or when there are periods of "down time" for some reason.

- Obtain MOUs with all service providers. These should require information sharing with case the case manager, PO, or other cognizant program staff (e.g., program coordinators or staff assigned to data collection), as well as provision of service to clients.

- Form a community-wide service cabinet with regular (e.g., quarterly) meetings to engage service delivery staff of agencies commonly used in discussing service delivery issues affecting clients, and to promote stronger collaboration and common understanding of the program. Such cabinets promote familiarity with the changing configuration of local service resources and their strengths and limitations, as well as serving as a forum to identify gaps in services, capacity issues, or other barriers to service delivery.

- Encourage case managers or POs to participate in, or even initiate, local task forces or study groups seeking to address gaps in services for populations such as OPTS clients.

- Where feasible, expand the "team" participating in regular case-manager-PO meetings to include key service providers (those who serve substantial numbers of program clients).

- Anticipate, and make arrangements to address, ancillary client needs that serve as barriers to receipt of services or fulfillment of supervision requirements, such as transportation to service providers or employment sites, work clothing or tools, etc.

- Use the media to develop a positive image of the program among the general public and key decision makers -- including leadership of service providing agencies that might otherwise be reluctant to accept substance abusing offenders. Similarly, the media can

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serve as a forum to publicize the need for specialized or scarce services for this population.

Individualized public relations or networking efforts may also be useful to address some service-related issues. OPTS case managers have outreached to employers to inform them about the OPTS program and to educate employers about the "potential benefits of hiring an ex-offender." Such advance efforts may help shape employers' expectations and willingness to deal with offenders who are returning to the workforce in a more realistic and, possibly, tolerant fashion. At the least, improved communication between employers and program staff or service providers may alert case managers or employment counselors to emerging workplace problems that can be resolved before they undermine a client's success. This approach may be useful in cases where particular service providers -- e.g., housing or substance abuse treatment services -- are reluctant to accept OPTS clients because of their backgrounds.

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APPENDICES

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APPENDIX A

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APPENDIX A

The Missouri ITCs evolved as the state's response to a substantial increase in the need for alcohol and drug treatment for offenders, combined with increases in the institutional population. The state experimented with use of a private residential program in Kansas City to provide treatment specifically targeted to parole violators in 1987, and found it was cost effective and did not represent a threat to the public. Consequently, the Department began establishing its own treatment centers on the grounds of secure correctional facilities in January, 1991. ITCs serve: 1) probationers sentenced under a special statute that allows the court to retain jurisdiction through the 120-day treatment program (which can be for a new arrest or technical violation); 2) parolees receiving treatment per order of the Parole Board; and 3) newly-convicted offenders identified for treatment (Missouri Department of Corrections, undated-b).

The Missouri treatment programs provide a highly structured and confrontive approach, emphasizing a 12-step program, group therapy, drug education, relapse prevention, life skills straining, and aftercare planning. Offenders also are provided the opportunity to enroll in GED courses while in treatment.

Inmates were expected to successfully complete the treatment regimen in order to be eligible for the OPTS research. A number of OPTS participants actually did not receive the full 12 weeks of treatment, because they entered the program one week or more into the treatment cycle. However, if they were considered "successful" in the ITC, regardless of the number of weeks spent in the program, they were permitted to enter the OPTS demonstration program.

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and combining elements of lifestyle change, cognitive interventions, and behavioral skills training designed to maintain reduced substance abuse after release. Inmates attend classes five days per week for two hours daily for 27 sessions, and must attend a minimum of five AA/NA meetings during that time. They also receive AIDS classroom training. Inmates who do not have a high school diploma or GED also must attend scheduled GED sessions. Inmates remaining in jail for more than six weeks are enrolled in an advanced skills group, and continue in the program until their release (Hillsborough County Sheriff's Office, undated).

Hillsborough County Jail Substance Abuse Program

As part of the relapse prevention approach, participants are asked to identify risky situations that commonly trigger their own substance abuse. Inmates are taught to assess how these situations prompt rationalizations that support the use of the substance in that particular situation, and how to replace this with more adaptive thought patterns.

Participants are taught coping skills -- such as drug refusal skills, stress management, and ways to handle emotional states, including depression, frustration, anger, or disappointment -- to help them deal with high-risk situations. They also are taught how to cope with a slip, or single incident of breaking abstinence, to enable them to get "back on track" with a minimum of guilt and self-blame, since such negative emotions may contribute to a full-blown relapse. In addition, the program teaches inmates about building a drug-free social network, developing a balanced lifestyle, developing alternative sources of enjoyment, and building a long-term plan for recovery (Hillsborough County Sheriff's Office, undated).

Tampa's three residential programs included DACCO's Residential I and II facilities, and the Crossroads facility that serves only female offenders:

- **Residential I** is a four- to six-month, 60-bed modified therapeutic community that serves both men and women. Approximately 20 beds are reserved for women. The program also uses Alcoholics Anonymous/Narcotics Anonymous techniques that employ recognition/acceptance of drug use as a disease, learning to deal with obsessive/compulsive thinking patterns, and dependence upon other recovering addicts for support and guidance. Residents have a comprehensive therapeutic mileau that includes a curriculum of lectures, intensive individual and group therapy, and adult education classes. The program operates in four phases: the first is restrictive, with no phone calls, mail, or passes to leave the facility, progressing to the fourth phase where the resident is eligible for up to 48-hour passes. After successful completion of the four phases, residents may begin their job search.

- **Residential II** follows the same therapeutic approach as Residential I, but houses only male probationers who have been court ordered to treatment (violent or sex offenders are excluded). The facility has 65 beds, but recently it occasionally has provided drug treatment services to as many as 70 clients. Clients are evaluated in

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APPENDIX B

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Areas of Client's Needs

I. Housing:

1. Drug Free
2. Reasonable Cost
3. Access to Food/Cooking
4. Near Bus Line / Transportation
5. With Companionship
6. Some Basic Furnishings
7. Some Treatment Involvement Required
8. Will Accept HIV+
9. Co-Ed
10. Emergency Family Housing

Resources:

Salvation Army Transitional - Kathleen Avery	1 thru 6
DACCO Apartments - Jay Saltares	1 thru 4, 9
Willingness House - Chuck Bevitt	1 thru 8
Raisins - Fred Bell	1 thru 9
Homeless Recovery/Metropolitan - James Joyce	1 thru 10

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III. Drug Education and Counseling:

1. Regular Weekly Sessions
2. Reasonable Cost / Sliding Scale
3. Existing Department of Corrections Contract
4. Day Time Groups
5. Evening Groups
6. Family Counseling
7. Relapse Planning

Resources:

DACCO D.C. Outpatient Group Counseling	1 thru 5, 7
DACCO Residential	1, 2, 3, 7
Goodwill Intensive Day/Night Treatment	1 thru 5, 7
Psychological Management Group	1 thru 5, 7
Lee Davis Center	1, 2, 5, 6
Local AA / NA Groups	1, 4, 5, 7
Mental Health Care, Inc.	1, 2, 4, 5, 6, 7

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V. Daily Living Skills:

1. Transportation
2. Clothing
3. Budgeting (Money Management)
4. Religious Affiliation
5. Legal Services
6. Nutrition and Food Preparation
7. Physical Health & Hygiene
8. Household Items (dishes, etc.)

Resources:

HART Busline	1
K-Mart; Salvation Army; Walmart	2, 8
Consumer Credit Counseling - Diane Trithart	3
Share-A-Van - Kit McElvey	1
Sun Coast Aids Network (SCAN)	5
Bay Area AIDS Consortium	6

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APPENDIX C

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How much of a problem was this at any time during 12 months of post-release supervision?

Percentage Reporting Some Problem

	Treatment	Control	Total
Finding a place to live	28.5	25.0	26.8
Having enough money for rent deposit	32.5	28.7	30.7
Keeping existing housing	15.2	16.8	16.0
Paying rent	21.9	25.6	23.6
Paying utilities	21.2	27.0	24.0
Keeping house clean	11.9	8.8	10.4
Getting food for self and family	13.9	11.0	12.5
Having a way to cook meals	6.0	6.6	6.3
Shopping for groceries	13.9	13.9	13.9
Using public transportation*	27.3	17.5	22.7
Getting a driver's license	31.1	40.2	35.4
Needing a car for work or emergencies	39.1	32.9	36.1
Having to make costly car repairs	16.6	17.5	17.0
Having clothes for different weather conditions	19.9	16.8	18.4
Having suitable work/job interview clothes	20.5	18.3	19.4
Needing clothes for family members	13.3	10.2	11.8
Finding recreational and leisure activities	14.6	16.8	15.6
Re-establishing contact with adult family members	21.9	22.6	22.2
Re-establishing contact with children	20.5	27.0	23.6

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Getting dental care	24.2	21.9	23.1
Getting mental health care	8.0	10.2	9.1
Getting eyecare or glasses	13.3	8.8	11.2
Paying for prescription medication	10.7	14.6	12.5
Maintaining sobriety	52.4	59.6	55.8
Attending scheduled drug treatment programs	27.3	24.8	26.1
Getting adequate nutrition, sleep, exercise	24.2	26.3	25.2
Resolving health problems	14.7	12.4	13.6
Remaining drug free while living in your neighborhood	45.3	47.5	46.3

* significant at 0.05

*** significant at 0.10

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APPENDIX D

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Tampa Materials

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SISAR Number ____________

CASA

"Opportunity To Succeed"

PERSONAL HEALTH HISTORY

● ____________ Date ____________ Occupation ____________

Birthplace ____________ Age _____ Single ___ Married ___ Divorced ___ Widowed ___

NOTE: This is a confidential record of your medical history. Information contained here will not be released to any person except when you have authorize us to do so.

Family History	IF LIVING Age	Health	IF DECEASED Age	Cause
Father				
Mother				
Brother or Sister				
2.				
3.				
4.				
Husband or Wife				
Son or Daughter				
2.				
3.				
4.				

Has any blood relative ever had:	Please Circle	Who
Cancer	No Yes	
Tuberculosis	No Yes	
Heart Trouble	No Yes	
High Blood Pressure	No Yes	
Bleeding Tendency	No Yes	
Stroke	No Yes	
Diabetes	No Yes	

General:
Unusual fatigue
Unusual weakness
Abnormal thirst
Unable to sleep
Anemia
Swollen glands

Neck:
Goiter
Lump or swelling
Pain or stiffness

PERSONAL HISTORY ILLNESSES:

Have you ever had any of the following: Please Circle

Measles
German Measles
Mumps
Chicken Pox
Whooping Cough
Scarlet Fever or Scarlatina
Diphtheria
Smallpox
Pneumonia
Influenza
Pleurisy
Rheumatic Fever or Heart Disease
Arthritis or Rheumatism
Any Bone or Joint Disease
Neuritis or Neuralgia
Bursitis, Sciatica or Lumbago
Polio or Meningitis
Gonorrhea or Syphilis
Anemia
Jaundice
Epilepsy
Migraine headaches
Tuberculosis
Diabetes
Cancer
High or low blood pressure
rs
. .patitis
Food, chemical/drug poisoning
Hay Fever or Asthma
Hives or Eczema
Frequent infections or boils
Frequent cold or sore throat

ALLERGIES: Are you allergic to:
Penicillin or Sulfa
Aspirin, Codeine or Morphine
Mycins or other antibiotics
Tetanus, antitoxin or serums

INJURIES: Have you had any:
Broken or Cracked bones
Concussion or head injury

WEIGHT: Now: One Year Ago:
Maximum: When:

TRANSFUSIONS: Have you ever had:
Blood or Plasma Date:

Surgery: have you ever had:
Appendectomy
Any other operation Year:

Have you ever been advised to any surgical operation which has not been done ____________

Have you been treated or hospitalized for any other illness not previously mentioned
____

EKG: Ever had an electrocardiogram?
Date:

Are you an organ donor? YES NO

X-RAYS: Have you ever had X-rays of:
Chest
Stomach or Colon
Gall Bladder
Extremities
Back
Mammogram (female)

Immunizations: Have you had:
Tetanus Shots
Date of last Tetanus Shot:

SYSTEMS REVIEW: Do you have trouble with the following:

EYES:
Eye strain
Seeing double
Seeing halo about lights

EARS:
Hearing loss
Infections
Ringing in ears
Earache or discharge

THROAT AND MOUTH:
Frequent cold sores
Hoarseness
Bleeding gums
Dental problems

BREASTS:
Lump
Discharge
Pain

EXTREMITIES:
Arthritis
Varicose veins
Cramps in legs

HEART & LUNGS:
Chronic cough
Coughing up blood
Shortness of breath
Night sweats
Chest pain or pressure
Palpitation or fluttering
Swollen ankles

KIDNEY, BLADDER AND GENITALS:
Albumin or sugar in urine
Blood or pus in urine
Kidney or bladder infection
Getting up nights to urinate
(________ times)
Trouble starting urine stream

NEUROLOGICAL:
Frequent headaches
Fainting spells
Convulsions
Paralysis or weakness
Dizzy spells

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"OPPORTUNITY TO SUCCEED"

CASA

HIV Risk Assessment Questionnaire

Please circle the appropriate answer:

YES NO Have you ever been tested for HIV (the virus that causes AIDS)?

SINCE 1978

YES NO Have you injected drugs?

YES NO Are you a male who has had sex with another male?

YES NO Have you had sex while using non-injecting drugs, including alcohol?

YES NO Have you traded sex for drugs or money?

YES NO Have you had a sexually transmitted disease?

YES NO Are you a child of a woman with HIV/AIDS?

YES NO Are you a hemophiliac?

YES NO Have you had a blood transfusion?

YES NO Are you a health care worker who has been exposed to contaminated blood or body fluids?

YES NO Have you had intercourse with the opposite sex without using a condom?

YES NO Have you been sexually assaulted?

YES NO Have you had sexual intercourse with a man who has had sex with a man?

YES NO Have you had sexual intercourse with a person at risk for HIV/AIDS?

(PRINT) **Name of Client:** ______________________________

Signature of Counselor: ______________________ **Date:** __________

Referred to Treatment at DACCO? ____ Yes ____ No **Program:** ______________

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Kansas City Materials

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OPTS JOB READINESS SCALE
CURRENT

Name:______________________________ Date:____________

OPTS CASE MANAGER____________________ Date:____________

	STRENGTHS						WEAKNESSES			
PHYSICAL	10	9	8	7	6	5	4	3	2	1
Stamina	__	__	__	__	__	__	__	__	__	__
Stable home	__	__	__	__	__	__	__	__	__	__
Child care	__	__	__	__	__	__	__	__	__	__
Transportation:______	__	__	__	__	__	__	__	__	__	__
OCCUPATIONAL										
Job goal:___________	__	__	__	__	__	__	__	__	__	__
Aptitude	__	__	__	__	__	__	__	__	__	__
Skill level	__	__	__	__	__	__	__	__	__	__
Work Experience	__	__	__	__	__	__	__	__	__	__
Relevant training	__	__	__	__	__	__	__	__	__	__
PSYCHOLOGICAL										
Emotionally stable	__	__	__	__	__	__	__	__	__	__
Good coping skills	__	__	__	__	__	__	__	__	__	__
Good Self-esteem	__	__	__	__	__	__	__	__	__	__
Handles frustrations	__	__	__	__	__	__	__	__	__	__
Handles criticism	__	__	__	__	__	__	__	__	__	__
PLACEMENT										
Application	__	__	__	__	__	__	__	__	__	__
Resume	__	__	__	__	__	__	__	__	__	__
Positive Attitude	__	__	__	__	__	__	__	__	__	__
Interview	__	__	__	__	__	__	__	__	__	__
Cover stories	__	__	__	__	__	__	__	__	__	__
SOCIAL										
Communication	__	__	__	__	__	__	__	__	__	__
Dress	__	__	__	__	__	__	__	__	__	__
Hygiene	__	__	__	__	__	__	__	__	__	__
	10	9	8	7	6	5	4	3	2	1

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Where, how and with whom did you spend your first night following release? ______________________________

____

____

What are some of the things you want to accomplish during your first year out? ______________________________

____

____

What's likely to happen in reality? ______________________

____

____

What resources do you have that could help you achieve your goals? ______________________________________

____

____

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How do you plan to deal with these people? ______________

____

____

Using the four elements of self-destructive behavior listed below, write a paragraph describing your self destructive behavior.

1. Seeing something that you want but have no right to have.
2. Believing that nobody has a right to tell you to control your urges.
3. Abusing your power.
4. Earning the penalty connected to your self-destructive actions.

____

____

____

____

____

____

X______________________________ X______________________
OPTS CLIENT SIGNATURE DATE

X______________________________ X______________________
OPTS CASE MANAGER DATE

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4. How have you tried to control your consumption of chemicals or alcohol?

1.

2.

3.

5. Give 5 examples of how powerlessness (loss of control) has revealed itself in your own personal experience.

1.

2.

3.

4.

5.

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UNMANAGEABILITY

1. What does unmanageability mean to you?

2. What could you identify as your "social" unmangeability?

   1.

   2.

   3.

3. Give examples of your sober personal unmanageability.

   1.

   2.

   3.

   4.

4. What goals have you set for your life?

   1.

   2.

   3.

   4.

5. Prior to treatment, how did you try to achieve these goals?

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OPPORTUNITY TO SUCCEED (OPTS)
SERVICE/TREATMENT CONTRACT

NAME: **DOB: / /** **SSN: - -**

ADDRESS: **PHONE: ( ) -** **STATUS:**

EMPLOYMENT	**1**	**2**	**3**	**4**	**5**	**Please circle the number that best describes your current situation.**
TRAINING	**1**	**2**	**3**	**4**	**5**	
HOUSING	**1**	**2**	**3**	**4**	**5**	
FAMILY	**1**	**2**	**3**	**4**	**5**	**1=no help reqd.** **2=stable** **3=help needed** **4=difficulties** **5=crisis stage**
12-STEP MTGS.	**1**	**2**	**3**	**4**	**5**	
HEALTH CARE	**1**	**2**	**3**	**4**	**5**	
TREATMENT	**1**	**2**	**3**	**4**	**5**	
TRANSPORTATION	**1**	**2**	**3**	**4**	**5**	

I agree to participate fully in my contract which will include asking for and accepting help form my OPTS Case Manager. I will accept responsibility for my survival by committing to a path of positive growth; which will include living a crime and drug free lifestyle.

X______________________________ X____________________
OPTS CLIENT SIGNATURE DATE

X______________________________ X____________________
OPTS CASE MANAGER DATE

OPPORTUNITY TO SUCCEED (OPTS)
SERVICE/TREATMENT CONTRACT

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St. Louis Materials

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STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
BOARD OF PROBATION AND PAROLE

MONTHLY SUPERVISION REPORT

OFFICE USE ONLY

- ☐ INITIAL SCALE
- ☐ ENTER

OFFICER NAME AND NUMBER

SUPERVISION NUMBER

NAME | PHONE NUMBER

ADDRESS | CITY | STATE | ZIP CODE

WITH WHOM DO YOU LIVE? (NAME AND RELATIONSHIP) | YOUR SOCIAL SECURITY NUMBER

NAME OF PRESENT EMPLOYER, ADDRESS, CITY, ZIP CODE | EMPLOYER'S PHONE NUMBER

NAME OF SUPERVISOR | IS EMPLOYER AWARE OF PROBATION/PAROLE? ☐ YES ☐ NO | TOTAL INCOME FOR PAST 30 DAYS

DO YOU OWN A VEHICLE? ☐ YES ☐ NO | MODEL | YEAR | MAKE

DESCRIPTION/COLOR | LICENSE NUMBER

HAVE YOU BEEN ARRESTED DURING PAST 30 DAYS? ☐ YES ☐ NO IF YES, DATE OF ARREST ____________

ARRESTING DEPARTMENT | CHARGE

SIGNATURE | ACCEPTED BY | DATE | TIME ☐ A M ☐ P M

DO NOT WRITE BELOW THIS LINE

____ **EDUCATIONAL/VOCATIONAL**
0 - FULL-TIME FOR 4 MONTHS
1 - PART-TIME, FULL-TIME LESS THAN 4 MONTHS, SCHOOL, TRAINING, OR UNEMPLOYMENT COMPENSATION
2 - UNEMPLOYED

____ **LEGAL** (EXCLUDING PRESENT OFFENSE)
1 - NO ARREST IN THE PAST 8 MONTHS
2 - NO CONVICTIONS, 1 ARREST IN THE PAST 8 MONTHS
3 - 2 OR MORE ARRESTS, PENDING CHARGE OR CONVICTION IN THE PAST 8 MONTHS.
DATE OF ARREST ____________

____ **SUBSTANCE ABUSE**
1 - NO DRUG USAGE/ALCOHOL PROBLEM IN LAST 8 MONTHS
2 - DRUG USAGE/ALCOHOL PROBLEM IN LAST 8 MONTHS
3 - ACTIVE ABUSE IN LAST 4 MONTHS
DATE OF LAST USAGE/PROBLEM ____________

____ **CLIENT RESPONSIBILITY**
1 - NO TECHNICAL VIOLATION IN LAST 8 MONTHS
2 - TECHNICAL VIOLATION IN LAST 8 MONTHS
3 - TECHNICAL VIOLATION IN LAST 4 MONTHS OR PENDING REVOCATION
DATE OF LAST TECHNICAL VIOLATION ____________
CONDITIONS CITED ____________

____ **SOCIAL** (IN LAST 4 MONTHS)
0 - NO PROBLEM
1 - PROBLEM NOT REQUIRING INTERVENTION
2 - PROBLEM REQUIRING INTERVENTION

SUBSTANCE ABUSE
____ ALCOHOL
____ MARIJUANA/HASHISH
____ OPIATES
____ STIMULANTS/COCAINE
____ DEPRESSANTS
____ INHALENTS/SOLVENTS
____ HALLUCINOGENS

SOCIAL
____ MENTAL PROBLEMS
____ FAMILY PROBLEMS
____ FINANCIAL
____ ASSOCIATES
____ ASSAULT/AGGRESSIVE
____ PHYSICAL
____ OTHER

9-UT, ABOVE

RISK SCORE ____ | NEED SCORE ____ | LEVEL

MONTHLY ACTIVITIES

MO 931-3698 (6-93)

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EMPLOYMENT (PREVIOUS)

NAME OF COMPANY

ADDRESS

POSITION	SALARY
DATES OF EMPLOYMENT	REASON FOR LEAVING

NAME OF COMPANY

ADDRESS

POSITION	SALARY
DATES OF EMPLOYMENT	REASON FOR LEAVING

NAME OF COMPANY

ADDRESS

POSITION	SALARY
DATES OF EMPLOYMENT	REASON FOR LEAVING

MILITARY

BRANCH OF SERVICE	SERIAL NUMBER
INDUCTION DATE	TERMINATION DATE
TYPE OF DISCHARGE	RANK WHEN DISCHARGED

OCCUPATIONAL DUTIES

IF DISCHARGED OTHER THAN HONORABLE, EXPLAIN WHY

FINANCES

TO WHOM DO YOU OWE MONEY AND HOW MUCH

DO YOU HAVE A SAVINGS ACCOUNT?	CHECKING ACOUNT

WHERE

DO YOU OWN OR ARE YOU BUYING YOUR OWN CAR?	YEAR

MODEL	DESCRIPTION	LICENSE NUMBER

TYPE OF INSURANCE

HOME

OWN OR BUYING	RENTING	MONTHLY PAYMENTS
VALUE	BALANCE OWED	NUMBER OF ROOMS
CONDITION OF HOME GOOD	AVERAGE	POOR

NAME AND RELATION OF PERSONS RESIDING IN THE HOME

RESIDENCE ☐ HOUSE ☐ APARTMENT ☐ DUPLEX ☐ TRAILER

HEALTH

HAVE YOU EVER BEEN HOSPITALIZED ☐ YES ☐ NO IF YES, STATE WHY, WHEN AND WHERE

ML 931-1907 (8-91)

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Psychosocial Assessment

Family Environment and Marital History:

1. Describe your living situation prior to incarceration ______________________

   ____

   With whom were you living prior to incarceration? (spouse, children, parents) ______________________

   ____

   Can you return there to live? Yes No If no, what are your plans? ______________________

   ____

2. Information on spouse/significant other:

   Name: ______________________ Age: ______ Relationship: ______________________

   Educational level: ______________________ Occupation: ______________________

   Describe your current relationship: _____Very Close _____Close _____Somewhat Distant _____Distant

3. Describe spouse's/significant other's alcohol/drug use (including medication):

What kind of alcohol/drug is used?	How often	How much

4. How many times have you been married? ______ Have you been in a live-in relationship? Yes No

   Describe your past and current live-in or marital relationships:

Name	Date Together Or Married	Date Apart Or Divorced	Reason for Break-Up	Relationship Good-Fair-Poor

   Have you ever been separated? Yes No If yes, how many times? ______________________

   What was the longest separation? ______________________ Are you separated now? Yes No

   Is there a divorce pending? Yes No Is this separation alcohol or drug related? Yes No

5. Have you ever been physically abused by a spouse/significant other? Yes No

   If yes, explain: ______________________

   ____

6. List all children and step-children:

Name	Age	Other Parent	Relationship Good-Fair-Poor

   How much contact do you have with each of your children? ______________________

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Have you ever been . ...ally ...usive toward anyone? Yes ? If ye.. .oward whom and when?__

____

Were you under the influence of drugs/alcohol at the time?________________

EDUCATIONAL HISTORY:

13.Formal Education (indicate highest level completed in all areas that apply)

_______ Elementary School

_______ High School

_______ GED

_______ College

_______ Vocational or Technical Specify:________________________

____

Have you had difficulty with, or received special education services for:

a._____learning disability b._____reading c._____writing d._____hearing e._____speech

Describe your general academic performance: ____below average ____average ____above average

EMPLOYMENT HISTORY:

14.Employment status immediately prior to incarceration:

a._____full-time c._____temporary e._____retired g._____unemployed

b._____part-time d._____disabled f._____student

How long had you been at your most recent job?________________

How did you feel about your job?________________

Describe your relationship with your supervisor:________________

____

Describe your relationship with your co-workers:________________

____

15.Do you believe that drinking/drug use has affected your job performance? Yes No

If yes, in what ways?________________

____

16.Describe your employment history:

1. Employer________________ Length of time:________________

Responsibilities:________________

Reason for leaving:________________

Might they be interested in hiring you again?________________

2. Employer________________ Length of time:________________

Responsibilities:________________

Reason for leaving:________________

Might they be interested in hiring you again?________________

3. Employer________________ Length of time:________________

Responsibilities:________________

Reason for leaving:________________

Might they be interested in hiring you again?________________

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Of those mentioned a... e, wh..h social relationships are not (; or a...hol-centered? (specify)

____

____

Indicate clubs, organizations or groups which you participate in on a regular basis:______________

____

What group activities have you previously been involved in, but no longer pursue?______________

____

MILITARY HISTORY:

25.Were you ever in the armed forces? Yes No Were you ever in active combat? Yes No

Type of discharge:____

Describe military experience:____

Did you have any problems with alcohol/drugs while in the military? If so, describe:______________

____

LEGAL STATUS:

26.Have you ever been stopped for driving while intoxicated or under the influence? Yes No

If so, how many times?_____When?____

____

____

27.Do you presently have a valid driver's license? Yes No If no, please explain:______________

____

____

ACTIVITY PATTERNS:

28.Describe your daily activities before incarceration (hobbies, recreational activities, other interests):

____

____

What are your special skills, talents, interests?____

____

____

29.Describe any activities that you associate with your alcohol/drug use:______________________

____

____

Describe any former activities that you no longer pursue due to your alcohol/drug use:______________

____

____

Describe any activities that could be pursued in place of alcohol/drug use:______________________

____

____

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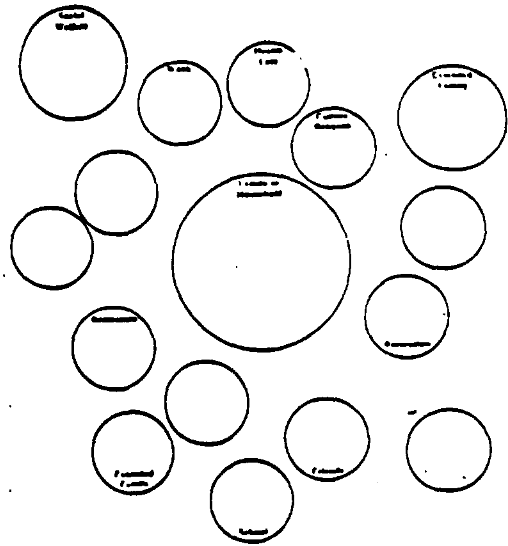
ECOMAP

_____ strong connection
_____ stressful connection
---- tenous connection

Draw arrows to signify flow of energy



What will make you happy with yourself/your life? ______________________

____

____

ECOLOGICAL NETWORK STRATEGY

List Three (3) Spheres of Life you want to make your life happier:	List Actions you want to take to improve to make the improvement that will make you life happier:
	a. ______________
1) ______________	b. ______________
	c. ______________
	a. ______________
2. ______________	b. ______________
	c. ______________
	a. ______________
3. ______________	b. ______________
	c. ______________

____
CLIENT'S SIGNATURE

____
CASE MANAGER SIGNATURE

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APPENDIX E

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Graduated Sanctions

The community organization and the parole or probation department must work together to develop a system of graduated sanctions for program violations. For example, since relapse is strongly associated with addiction, we can anticipate that participants in treatment may have episodes of relapse. Similarly, participants may miss scheduled appointments or fail to participate in certain activities.

We do not anticipate that such violations should automatically result in program termination or re-incarceration. The program should devise a series of graduated, intermediate sanctions for program violations that allow the case manager and parole or probation officer programmatic flexibility, while still maintaining close control over the participant's behavior.

During the development stage of the demonstration, sites were asked to develop guidelines for defining and imposing sanctions. These guidelines were discussed and approved by all participating agencies as part of a cross-site conference held in St. Louis in February 1993 and are presented below:

Offender Demonstrated Lack of Responsibility By:	1st	2nd	3rd	4th
Failure to Attend Appointment (i.e., Employment, Case Manager Substance Abuse Tx, Counseling)	Informal	Level 1	Level 2	Level 3
Inability to Gain Employment	Informal	Level 1	Level 2	Level 2
Failure to Obtain/Maintain	Informal	Level 1	Level 2	Level 3
Positive Urinalysis	Level 2	Level 2	Level 3	Level 3
Arrest for New Charges				
City Ordinance	Level 2/3	Level 2/3	Level 2/3	Level 2/3
Misdemeanor	Level 2/3	Level 2/3	Level 2/3	Level 2/3
Felony	Level 2/3	Level 2/3	Level 2/3	Level 2/3
Conviction for New Charges				
City Ordinance	Level 1/2	Level 1/2	Level 2/3	Level 2/3
Misdemeanor	Level 1/2	Level 2/3	Level 2/3	Level 4
Felony	Level 4	________	________	________

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