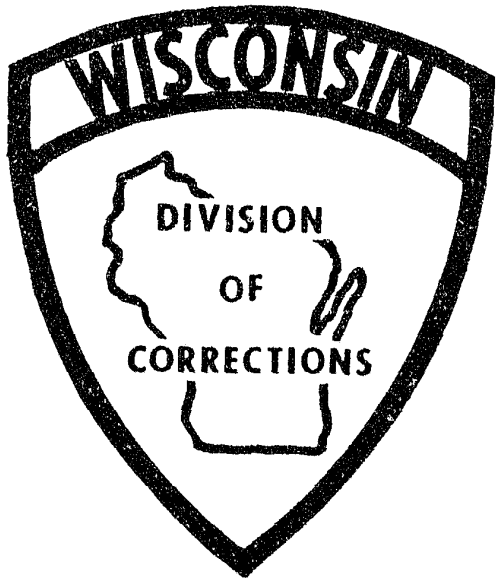
# PROJECT REPORT #10

TREATMENT GUIDELINES




## DEPARTMENT OF HEALTH AND SOCIAL SERVICES

CASE CLASSIFICATION/STAFF DEPLOYMENT PROJECT

BUREAU OF PROBATION AND PAROLE

DIVISION OF CORRECTIONS

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CASE CLASSIFICATION/STAFF DEPLOYMENT PROJECT

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## *INTRODUCTION*

*After the Assessment of Client Needs scale was developed, the Case Classification/Staff Deployment Project sought to develop treatment guidelines for each need category listed.*

*Agents and Field Supervisors were surveyed to establish lists of agents considered to have expertise in dealing with a specific type of client need. From these lists, agents were selected to serve on one of the eleven committees charged with developing guidelines.*

*Each committee dealt with one of the following need categories:*

1. *Academic/Vocational Needs*
2. *Employment*
3. *Financial Management*
4. *Marital/Family Relationships*
5. *Companions*
6. *Emotional Stability*
7. *Alcohol Usage*
8. *Other Drug Usage*
9. *Mental Ability*
10. *Health*
11. *Sexual Behavior*

*This report outlines the work of these committees.*

ACADEMIC/VOCATIONAL SKILLS

A. Identification of Problem

The absence of a high school diploma may be an indication of inadequate academic or vocational skills. (A high school diploma, however, does not automatically mean competence). While job experience without a diploma may be adequate under some circumstances, most situations call for a high school diploma to satisfy basic needs for employment, job security and/or promotional potential.

More specifically, a client exhibits a problem in the area of Academic/Vocational Skills if any of the following interfere with daily functioning:

1. General lack of reading or writing skills.
2. Poor motor skills (coordination).
3. Lack of math skills (ability to make change, keep time, read calendar, etc.).
4. Lack of specific vocational skills.
5. No regular or equivalency high school diploma.

All the resources normally contacted in doing a Pre-Sentence or Social Investigation can be helpful in determining the client's current situation and his motivation and ability to pursue an academic or vocational education. Factors in the investigation which are particularly important are school records, assessments by school personnel and current ability tests.

B. Treatment Approach

It is important to determine the client's attitude toward education, his perception of his academic ability and his actual ability. It is also important to determine from medical and social records whether the client has any particular physical or emotional deficiency which would affect his participation in an educational setting. For example, the client might have a speech, hearing, or visual problem or a particularly strong emotional reaction to testing procedures; there may also be special educational problems such as dyslexia and dysgraphia. If education is to be a planned intervention strategy, the following are prerequisites: having a private place which can be used for studying; having enough time set aside both for attending school and for doing homework; frequently there must be family support; transportation must be available; and the necessary financial arrangements must be explored and planned for.

The first phase in forming a case plan is to identify the client's short and long range academic and vocational goals. Although Probation and Parole clients have seldom experienced much success in an educational setting and seldom have concrete educational objectives, goals can be explored and developed based upon long-range vocational ambitions or aspirations. Information concerning prerequisites and available resources for satisfying the prerequisites for a particular vocational ambition can be provided by the agent or a referral source.

The second phase in case planning is to prepare step-by-step, realistic plans with the client. It is imperative that goals be realistic in relation to the client's abilities if the client is to experience any degree of success. It is

important that the individual steps of the implementation strategy can be readily accomplished in order that the client can experience successes along the way; this also provides the agent with the opportunity to congratulate the client for accomplishing his own goals. Plans should be quite explicit whether they are written or verbal arrangements with the agent; contracting in a written form which may be attached to the Probation Agreement is sometimes helpful. It is important to remember that educational intervention strategies must be primarily voluntary on the part of the client. The contract may make certain demands upon the agent as well as the client. For example, in the first stages of implementation, the agent might test the client's motivation by making him responsible for going through the time-consuming and frustrating experience of enrolling at an educational facility, with the agent assisting in whatever way possible to secure financial assistance. A form of incentive for the client might be an early discharge contingent upon completion of the ultimate academic or vocational goals.

When the case plan is implemented, it is important for the agent to monitor the client's progress through collateral and personal contacts. Since this is primarily a voluntary intervention strategy, the agent generally takes a supportive and treatment strategy, reinforcing periodic client success and putting failures into proper perspective. It is essential that the ongoing monitoring and information gathering be used in a reformulation and reevaluation of the original plan, sometimes explicitly renegotiating a new written or verbal contract with the client.

C. When to Make a Referral

Referrals should be made in cases when the agent, in conference with the supervisor, reviews the case and determines that the agent lacks time and/or the specific expertise necessary to provide effective treatment. However, when a referral is made, the agent continues to maintain primary case responsibility in close liaison with collateral contacts to insure an effective relationship with the resource. When resources are used, it is important that roles are clearly defined and proper communication and coordination exist.

D. Resources

1. Department of Vocational Rehabilitation
2. State Employment Agencies
   a. C.E.T.A.
   b. On-the-job Training Program
   c. Vocational Testing
3. Temporary Private Employment Services, such as Manpower. (This sort of resource often does skill-testing)
4. Bureau of Clinical Services
5. County Mental Health Clinic
6. Technical Schools
7. High Schools
8. C.A.P.
9. College Testing Centers
10. Local Programs

11. Medical Assistance
12. G.E.D. Programs
13. Alternative Schools
14. Free-health Clinics
15. Purchase of Services Funding
16. University Tutoring
17. Culture Minority Organizations
18. Volunteer Organizations
19. Apprenticeship (open-labor organizations)
20. Remedial Aid Groups
21. Literacy Groups
22. Goodwill Industries
23. County Homemakers Services
24. School Counselors
25. Veteran's Administration
26. Religious Organizations (Jewish Vocational Services, Lutheran Social Services)
27. Higher Educational Aid Boards
28. Private Industry
29. Civic Organizations
30. 51.42 Boards
31. Wisconsin Information Service
32. Local Library and Librarian

EMPLOYMENT

A. Identification of Problem

Probation and Parole Agents deal with a unique segment of the labor force. Although some clients possess the skills necessary to obtain and maintain gainful employment, the majority suffer from chronic unemployment, sporadic employment or under-employment. Some of the underlying factors of an employment problem are: family disorganization; emotional instability; low motivational levels; low self-esteem; lack of training, education or skills; lack of desire for change; physical or emotional handicaps; race, class and sex discrimination. Typically, with men and women under supervision a number of these handicaps and disabilities are present in varying degrees.

Identification of problem areas can be accomplished through the agent's basic problem identification instrument, the social history (Pre-Sentence Investigation, Probation Social or Admission Investigation).

B. Treatment Approach

1. Direct Approach(Advocacy): In cases where clients have manifest deficiencies in terms of lack of saleable skills, low motivation or poor attitude, agents have traditionally operated as motivators, teachers and disciplinarians working to manage and overcome the client's limitations. The Direct Approach should include practical approaches such as accompanying employment visits, encouraging early rising and structuring employment search. Advocacy by agents can be utilized to deal with prejudicial attitudes and practices of certain employers. Role-playing can assist a client in learning how to make a positive impression during job interviews.

2. Educational and Vocational Placement: In cases where clients require basic types of training to acquire saleable skills or in situations where clients possess the ability to acquire more sophisticated or complex skills, the agent functions to inform the client of opportunities, sometimes to motivate the client and to help set up funding to cover the client's financial needs. This strategy is, of course, a long-range strategy and sets economic self-sufficiency as a longer-range goal.

C. When to Make a Referral

When the client does not possess the necessary skills or training to qualify for work in the existing job market, the agent should seek the appropriate educational training resource, as discussed under the Academic/Vocational Skills Standard. However, in cases where clients have suitable skills, attitudes and behavior to seek, secure and maintain appropriate employment a referral should be made. Here, the agent extends the least amount of personal involvement, merely making the client aware of existing opportunities and referring him to responsible persons in public and private employment agencies. In these cases the client must have demonstrated an ability to "follow through" with assignments.

D. Resources

1. Job Service; Division of Vocational Rehabilitation (employment assistance and vocational training).
2. Jewish Vocational Services (Milwaukee).
3. Goodwill Industries (several locations).
4. Sheltered Workshops (several locations).
5. Short-term opportunities in federally run or subsidized programs.
6. On-going relationships with local employers (small businessmen and personnel managers of larger firms) have been proven profitable, particularly with the smaller parole offices.

FINANCIAL MANAGEMENT

A. Identification of Problem

Financial management problems are viewed as being an integral part of other behavioral problems. In our society, a person's worth is generally measured in economic terms thus supporting the view that many offenses stem from economic motivation.

The offense may be a cue to a financial management problem (worthless checks, welfare fraud, forgery, embezzlement, shoplifting, theft). An interview is necessary to establish whether the motivation for the crime was primarily economic rather than the result of some other behavioral manifestations. In addition to the client's view of his or her financial management status, the following sources may indicate the existence of a problem.

1. A verified listing of the client's assets and liabilities.
2. Present address and number of recent moves.
3. A credit card check or Credit Bureau check.
4. Prior garnishment or bankruptcy.
5. Client utilization of a checking account.
6. Information from creditors or spouses.
7. Type and length of employment, and present net income.
8. A discrepancy between stated income and standard of living (determined as the result of a home visit).
9. Personal habits such as gambling, drinking or use of drugs may indicate abnormal expenditures.

B. Treatment Approach

Agents may establish treatment in the following ways:

1. Establish a budget for the client to include a savings plan and a continuous update of assets and liabilities.
2. Control of client's money through disbursement (C-32) or wage assignment (C-148).
3. Review records from the credit bureau for monitoring purposes. (This resource can be located by contacting the local Chamber of Commerce).
4. Counsel client to agree to voluntary repossession of property by creditors.
5. In extreme cases, counsel in the direction of amortization or bankruptcy.

C. When to Make a Referral

Referral is appropriately made in the following instances:

1. At the request of the client.
2. When the agent does not have time or expertise to deal with the problem.
3. When there is an apparent need for some type of financial assistance, such as medical assistance, food stamps or SSI.

D. Resources

1. Consumer Credit Counseling Services (non-profit agencies which are sponsored by the National Foundation for Consumer Credit, 1819 H Street NW, Washington, D.C. 20006).
2. Creditable loan companies may assist in an amortization.
3. Credit Unions could offer a consolidation loan at a reasonable interest rate.
4. The following agencies are available for providing consumer advice and for accepting consumer complaints:
   Division of Consumer Credit, Office of the Commissioner of Banking, 30 West Mifflin Street, Madison, Wisconsin 53702
   Office of Consumer Protection, Department of Justice, State Capitol, Madison, Wisconsin 53702
5. Legal Aide Society (garnishments, judgments, and bankruptcy proceedings).

MARITAL/FAMILY RELATIONSHIPS

A. Identification of Problem

Stresses within a marriage or family can negatively affect the personal and social adjustment of the client. Disorganization or stress is likely to create conditions resulting in a high probability of client failure under supervision and requires early detection and treatment. It is important to note that a positive relationship within a marriage and/or family can provide support and strong motivation for the client to successfully adjust to supervision in the field or in an institution.

To determine if a problem exists, the agent should:

1. Explore the client's social history using the Pre-Sentence Investigation and/or files from previous periods of supervision.
2. Interview the client and family members to determine their perception of problems.
3. Contact collateral resources having knowledge of the client and family (schools; public and private social service agencies; medical resources).
4. Possibly request a psychological or psychiatric evaluation.
5. Assess the client's needs based on strengths, weaknesses and overall functioning of the family unit.

B. Treatment Approach

1. Individual, marital and family counseling, divorce counseling (degree and treatment modalities depend on needs and agent's expertise). Counseling areas could include personal adjustment, employment, budgeting, intra-family relationships, sexual dysfunction and relationships outside the family.
2. Group counseling (parent groups; couple groups).
3. Special effort should be made to cooperate with institutional social services staff to coordinate and insure that services to the client and his family are provided during a period of incarceration.

C. When to Make a Referral

1. Referrals should be made when the agent, alone or in conference with the supervisor, reviews the case and determines that he lacks the time and/or expertise to provide treatment.
2. Referrals should be made if there may be a need for "diagnostic" evaluation. Evaluation can take place at any stage in the process.
3. When a referral has been made, the agent maintains primary case responsibility and contact with the resource to insure that proper communication and coordination exist.

D. Resources

1. Bureau of Clinical Services, institutional social services and other Bureau personnel.
2. Mental health clinics or counseling centers providing evaluation and/or treatment services.
3. Individual family and marital counselors; e.g., psychiatrists, psychologists, clergymen, social workers.
4. Legal Aid; e.g., separation and divorce process.

5. Planned Parenthood.
6. Private family service agencies; e.g., Lutheran, Catholic, Family Services of America.
7. County Department of Social Services; e.g., protective services, financial assistance.

COMPANIONS

A. Identification of Problem

A problem exists when a client has a lack of positive associates or when his/her companions or associations are a group that is detrimental to the client's ability to successfully complete the period of supervision. Associations can be assessed and evaluated via the routine investigatory process.

B. Treatment Approach

1. Individual or group counseling by the agent.
2. Encouragement or arrangement of positive personal relationships.
3. Restrict specific relationships on probation agreement (C-10) as a condition of probation.
4. Arrange specialized treatment program with agent follow-up to insure that treatment is progressing.
5. Environment manipulation such as group or foster homes, county jails, half-way houses, placement with friends or relatives, etc.
6. Positive approach to leisure time management - spare time activities.
7. Utilization of county jail during non-working hours.

C. When to Make Referrals

1. When negative companions are due to problems with alcohol, other drugs, mental ability, etc., refer to the appropriate treatment standard.

D. Resources

1. Volunteers in Probation.
2. Clergy.

EMOTIONAL STABILITY

A. Identification of Problem

The primary emotions causing people difficulty are anger, fear, guilt, anxiety and grief. These emotional states can be dichotomized into those which are internalized (turned inward) or those which are externalized (acted-out). The four major categories of instability with which corrections officers have to deal are: depression, anxiety, acting-out behaviors and volatile situations.

1. Characteristics of Mild and Moderate Depression

   a. Loneliness
   b. Hopelessness
   c. Isolation and withdrawal from social contact
   d. Self-recrimination and guilt
   e. Feelings of worthlessness
   f. Low self-esteem
   g. Pessimism
   h. Lack of energy
   i. Boredom
   j. Somatic complaints

2. Characteristics of Severe Depression

   The same characteristics under mild and moderate depression appear in severe depression, but in a more pronounced state with the following additional characteristics:

   a. Reality contact remarkably impaired
   b. Disturbances in thinking--delusions (false beliefs)
   c. Hallucinations - Perception of strange objects and events without any appropriate external sensory stimuli (hearing voices)
   d. Little insight into the nature of his behavior
   e. Thoughts, threats, or attempts at suicide

3. Characteristics of Anxiety

   Anxiety is a less common emotional problem than others exhibited by correctional clients. An individual suffering from anxiety may become involved in attention-seeking behaviors and "cries for help" rather than offenses based on a profit motive (shoplifting, annoying phone calls and other nuisance offenses). The agent should distinguish anxiety exhibited when a person is placed on supervision from chronic anxiety.

   a. Relatively constant state of tension.
   b. Restlessness and diffuse uneasiness.
   c. Generalized irritability.
   d. Difficulty in concentrating and making decisions.
   e. Fear of making mistakes.
   f. Occasional insomnia.
   g. Chronic state of alarm and mobilization.

4. Characteristics of Acting-Out Behaviors

   a. Inadequate conscience development.
   b. Lack of anxiety or guilt.
   c. Inability to profit from mistakes.
   d. Impulsivity.
   e. Irresponsibility.
   f. Low frustration tolerance.
   g. Poor judgment.
   h. Defective social relationships.
   i. Ability to put up a good front to impress and exploit others.
   j. Authority problems.
   k. Ability to quickly rationalize and project the blame on others.

5. Characteristics of Potential Volatile Situations

   a. Drinking client.
   b. The armed client.
   c. The out-of-control client.
   d. Volatile family quarrels.
   e. Agent-induced stress (apprehensions and searches).

B. Treatment Approaches

1. Mild Depression - Attempt to mobilize individual's energy toward more positive productive and self-fulfilling or satisfying behaviors.

   a. Identify client's existing interests and attempt to create or structure opportunities for success through contracting concrete goals.
   b. Attempt to stimulate new, easily obtainable interests.
   c. Help the individual to learn new ways of perceiving himself, responding and relating to others; e.g., assertive training.

2. Severe Depression

   a. Seek and encourage in-patient treatment.
   b. Secure psychiatric evaluation for medication.
   c. Although suicidal threats or behaviors may occur under any of the three major categories, they generally are an outgrowth of severe depression.

      1. Treatment techniques for suicidal threats by telephone:

         a. Respond to all calls as serious threats.
         b. Attempt to secure information regarding individual's whereabouts (phone number and address).
         c. Attempt to get individual to ventilate.
         d. Let individual know you don't want him to make that choice.
         e. Attempt to arrange meeting as soon as possible with client.
         f. Try to persuade individual to stay with someone (relative, friend, volunteer).
         g. Attempt to persuade individual to call back within a couple of hours to determine if he is alright.
         h. If suicidal attempt seems imminent, notify police, rescue squad, etc.
         i. Plan more intensive treatment program.
         j. Recognize that the call itself implies a desire to live.

3. Anxiety

   a. Provide appropriate reassurance.
   b. Establish contracts and develop concrete goals (decision-making, adjustment of the client or his family to the consequences of decisions).
   c. Engage in reality testing to honestly evaluate fears.
   d. Be aware of the agent's own anxiety. (Keep one's cool).

4. Acting-Out Behaviors

   (These individuals tend to be the most difficult to "treat", because they do not recognize that they have a problem and if they do, they may not want to do anything about it.)

   a. Avoid traditional insightful approaches (exploring behavior's origins).
   b. Develop concretely structured programs with realistic expectations; i.e., contracts (effects of behavior). It is important that the agent follow through with both negative and positive terms of the agreement.
   c. Provide close surveillance.
   d. Assertive training is frequently helpful in teaching clients to meet needs without alienating others.

5. Potential Volatile Situations

   a. The primary consideration of all potentially volatile situations is the safety of all parties concerned. If gentle persuasion appears to be ineffective, attempt to remove yourself and others from the scene.

   b. Do not escalate the hostility.
   c. Give the individual an out and terminate the interview when it appears appropriate.
   d. Attempt to secure reenforcements such as another agent or someone else in the office or notify the police.
   e. Effective ways of dealing with hostility either in anticipation of or following the precipitating event:

      a. Allow individual to ventilate.
      b. Retain calm voice throughout interview.
      c. Avoid personal confrontation ("It's the job, not me.").
      d. Acknowledge agent mistakes.
      e. Teach individual displacement techniques and alternative physical ways of relieving anger (running, hitting a punching bag).

C. Referral for All Emotional States

1. Consultation with Clinical Services and fellow agents, as well as supervisory conferences, should be considered if the need for referral is questioned.

2. A referral should always be made whenever the agent feels he is unable to effectively deal with the problem. A referral should be made in anticipation of actual crisis situations, when severe problems present themselves.

D. Resources for All Emotional States

1. Each local unit has a manual of all community resources available, contact persons and referral procedures. This manual notes the type and range of services available for each unit as there is a great deal of variance in programs offered by different localities.

2. Resources available are totally dependent upon the community, but generally the county has one of the following available for clients with an emotional problem:

   a. Community mental health clinic.
   b. County guidance clinic.
   c. County hospitals.
   d. Private psychiatric clinics.
   e. County social service agencies.
   f. Private social service agencies such as Catholic and Lutheran Social Services.
   g. 51.42 Boards.

ALCOHOL USAGE

A. Identification of Problem

Alcohol abuse is the deliberate use of alcohol in a way that interferes with the client's physical and/or mental health, his relationships with other people or his ability to hold a job. It is both a cause and a symptom of individual disorganization.

The Pre-Sentence or Social Investigation phase of receiving a new probationer or parolee is an ideal medium for gaining insight into the client's attitude and behavior. Parts of the Pre-Sentence or Social Investigations which are particularly relevant to an assessment of alcohol usage are:

1. Police reports indicating alcohol abuse problems.
2. Employment record.
3. Client's medical problems, especially liver, kidney and "nerve" problems.
4. The pattern of behavior of an alcoholic client when drinking (quantity, frequency and length of time of alcohol abuse).
5. Family attitudes toward alcohol abuse and toward the abusing client.

B. Treatment Approach

Treatment must involve the client's immediate family unit. The treatment goal is socially acceptable behavior that allows functioning on a daily basis and minimizes or eliminates self-destructive behavior and/or behavior detrimental to persons or property.

1. Phase 1 - CONFRONTATION

   a. The client should be confronted with the results of the study and diagnosis of his alcohol abuse. Confrontation is accomplished in a constructive manner with the final goal of this phase being a client's acceptance of the fact that he abuses alcohol.

2. Phase 2 - VOLUNTARY TREATMENT

   a. Treatment options and community resources are discussed in detail with the client.
   b. The client is guided and his decision making process is monitored, but the client makes his own decisions about treatment plan involvement.
   c. The client is required to give specific details of his treatment plans and, in the agent's presence, make a commitment to begin treatment.
   d. The agent's responsibility is surveillance of the individual, monitoring treatment progress and modifying goals based on progress.

3. Phase 3 - DIRECTIVE

   a. Forced treatment is indicated when alcohol abuse is deemed a critical factor in the individual's disorganization and the client refuses to involve himself in Phase 2 treatment or is personally unable to successfully engage in Phase 2 treatment. Forced treatment should be made a

special condition of probation, in writing, and a signed Consent to Release of Information form must be secured. The condition must be an enforceable one.

b. A treatment program of the type where progress can be measured should be used.
c. Treatment options include, but are not limited to: out-patient treatment; in-patient treatment; halfway house placement (both as treatment resources and aftercare facilities); chemical support; psychiatric and psychological counseling. These may be used in any combination, but can be augmented by casework support of the agent.

4. CRISIS INTERVENTION

a. Voluntary or forced detoxification may be necessary.
b. Detention may be indicated if the client is dangerous while drinking. Clients who display assaultive or aggressive behavior as the result of drinking are to be considered dangerous and require the immediate action of the agent.

5. MODIFICATION OF CASE PLANNING

Modification at any point should be the logical consequence of set-backs, resistance or failure. This can include a logical progression from Phase 2 to Phase 3, or between treatment options enumerated in Phase 3. Modification can be made by the agent or by the court to include confinement as a condition of probation. In the face of frequent, chronic or severe set-backs, revocation may be considered.

C. When to Make a Referral

While agents should usually take immediate action to insure early treatment involvement of alcohol abusive clients, referrals are appropriate at any phase of treatment. Familiarity with community resources and knowledge of the client's needs may narrow available treatment options that are appropriate.

D. Resources

1. Division of Vocational Rehabilitation Services for Alcoholics,
2. Division of Mental Hygiene.
3. Bureau of Alcohol and Other Drug Abuse.
4. County Hospitals.
5. Community Guidance Centers.
6. Alcohol Information Referral Services.
7. Criminal Justice Reference and Information Center.
8. Community Detoxification Centers.
9. Alcoholics Anonymous
10. Chemical Support (Antabuse).
11. Half-Way Houses.

OTHER DRUG USAGE

A. Identification of Problem

Drug abuse is the use of illicit chemicals, other than alcohol, with interferes with: health (psychological or physiological); family relationships; or vocational, educational or legal aspects of one's behavior.

An operational treatment approach assumes study of the client's background and a diagnosis of his drug abuse problem. The following sources may indicate the existence of drug abuse:

1. Client, family and/or peer group interviews.
2. Pre-Sentence Investigations; the Probation Social.
3. Testing and evaluations.
4. Information obtained from Federal, State and local law enforcement agencies.
5. Other social service agencies (assuming the agent has access to these sources).

B. Treatment Approach

1. The client should be educated as to the consequences of continued illicit drug activity.
2. Agent and client should discuss the results of identification and diagnose the extent of the problem.
3. After the severity of the problem is established, appropriate treatment modalities should be discussed. Included would be a continuum of level of structures, i.e., from low level (agent and/or outpatient counseling and urine surveillance) to high level (secured, in-patient treatment).
4. A resource listing of drug treatment agencies utilized by agents, and provided by the drug and alcohol abuse section, will facilitate the referral and agency selection process.
5. After a treatment plan is devised, the agent's responsibility should include initiation and monitoring of the referral, if appropriate. Consent to Release of Information forms should be initiated.

6. Treatment agencies' responsibilities, in addition to treating the client, should include submission of treatment plans, progress reports, staffing, mutually agreed upon dates of discharges, and other pertinent agreed upon responsibilities.
7. In cases of involuntary treatment, i.e., when the client does not agree with the treatment plan but the severity of the problem requires therapeutic intervention, the treatment should be written into the agreement as a special condition of probation and parole. This procedure is also recommended, but is left to the discretion of the agent, in cases of voluntary treatment.

8. In the case of a drug abuse client, one should anticipate treatment failures which may necessitate modification of the current treatment plan. If modification of the current treatment plan is warranted, then reassessment and development of a new treatment plan may be necessary. An amended agreement is strongly recommended.

C. When to Make a Referral

If the client does not repond to individual counseling, a referral to a specialist or to another resource may be necessary. The agent, in conference with the supervisor, should review the situation to determine if the agent has time and/or expertise necessary to provide effective treatment.

D. Resources

It is strongly recommended that agents familiarize themselves with Division of Corrections Resource personnel, and the Alcohol and Drug Abuse Resource Directory.

MENTAL ABILITY

A. Identification of Problem

A mental ability problem refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior. Impairment can include one or more of the following aspects of adaptive behavior:

1. Maturation - acquisition of early developmental skills.
2. Learning ability - facility with which knowledge is acquired as a function of experience.
3. Social adjustment - degree to which an individual is able to maintain himself independently in the community and in gainful employment; ability to meet and conform to other personal and social responsibilities and standards set by the community.

Approximately 3% of the population is considered retarded. An estimated 120,000 individuals in Wisconsin fall into the following categories:

1. Borderline ("slow learners") - IQ 68-85 - have difficulty with tasks requiring reasoning and/or verbal facility, but can meet routine uncomplicated demands.
2. Mild (educable) - IQ 57-67 - capable of independent and productive lives.
3. Moderate (trainable) - IQ 35-51 - capable of developing self-help, self-protection; have limited skills; can contribute partially to their self-support if given adequately protected, stimulating environment (e.g., sheltered workshop).
4. Severe and profound - IQ 0-35 - need constant care or supervision throughout lives.

If it is determined during the pre-sentence process that the client is so limited and unable to participate in the investigative and supervision process, the court should be informed of this fact; further diagnostic study is recommended.

If an agent suspects borderline intelligence or mild retardation, the extent of the problem should be determined by:

1. Reviewing previous Bureau contacts (case file; Central Records Unit file).
2. Determining the client's ability to comprehend the probation or parole conditions or counseling instructions by reviewing the agreement form or through verbal inquiry.
3. Contacting collateral resources having knowledge of client; i.e., educators, social service agencies, family. Consent to Disclosure of Privileged Information form (C-159) is required.
4. Observing personality attributes of client; one or more of the following may be exhibited: Extraordinary desire for recognition and acceptance; extraordinary desire to "please" others; unmet need for meaningful heterosexual experiences; low frustration tolerance; lack of communication skills; lack of academic/vocational skills.
5. Consider having a diagnostic evaluation completed by the Bureau of Clinical Services or by public or private social service agencies.

B. Treatment Approach

1. The degree and treatment modalities of individual or family counseling depend on client needs and the agent's expertise. Areas of counseling could include personal, employment, budgeting, intrafamily relationships and relationships outside the family. Expectations of the client should be realistic, i.e., based on needs and limitations.

2. Assist the client in obtaining employment if needed, by providing supportive services which could include transportation, helping to complete applications and exploring job openings. The agent should also provide follow-up services with the employer and the client.

3. If indicated, counseling the client and/or family members may be necessary regarding possible institutional placement.

4. If the client is so limited that he/she is unable to participate in the supervision process, consideration should be given for the return of the client to court for Judicial Review and a recommendation should be made for vacating or modification of the order. However, the agent should have an alternative plan; e.g., institutionalization or other agency involvement. (The present state law should be clarified so that severely limited retarded individuals (51 and below IQ) would not be placed under the criminal justice system).

C. When to Make a Referral

1. When a diagnostic evaluation is considered necessary.
2. When the client does not respond to individual counseling or the deficiencies limit independent functioning, there may be a need to utilize other resources. The agent alone, or in conference with the supervisor, should review the situation to determine if the agent has the time and/or the expertise necessary to provide effective treatment. It should be understood that regular weekly or more frequent sessions with the client could be necessary. Sessions may be required for a prolonged period until treatment goals are met.

Note: A close working relationship with resources should be maintained. Roles should be clearly defined to assure proper coordination and communication.

D. Resources

Placements

a. Mental retardation treatment and/or residential facility; e.g., Wyalusing. Limitations are understood and activities are geared to the client's abilities.

b. Halfway houses or adult group homes. If available, these placements allow the client to live in the community where he can maintain family, school and work contacts.

c. Foster home. A younger client is able to preserve normal community life opportunities. In addition, the foster home offers the experience of having close parental relationships when real parents are inadequate.

d. Psychological treatment facility; e.g., Mendota (usually designed primarily for emotionally disturbed). This can be used selectively when a retarded client shows indications of much emotional disturbance.

2. Individual and Social Service Agencies

   a. Public social service agencies (including SSI disability determination if indicated).

   b. Professionals providing diagnosis, referral, and/or treatment; e.g., physicians, psychiatrists, psychologists, Bureau of Clinical Services, attorneys; e.g., protective payee.

   c. School personnel; i.e., psychologists, educational counselors, vocational advisors, school social workers, occupational teachers, learning disability teachers.

   d. Mental health clinics or counseling centers providing evaluation and/or treatment services.

   e. Instructional, vocational services and/or job placement and counseling; i.e., Goodwill, Opportunity Center, if available, State Vocational Rehabilitation.

   f. Private family service agencies; e.g., Catholic Lutheran, Family Services of America.

   g. 51.42 Boards. Basically provide funding for treatment given through other agencies and in some areas provide specialized staff to implement the services.

HEALTH

A. Identification of Problem

Because physical and emotional health are closely associated with behavior and self-concept, it is important to explore this need area at the time of a Pre-Sentence or during an intake Social Investigation. Questions, such as the eight that follow, can be used during an interview to determine health needs.

1. Do you have any health problems which worry you?

2. Have you ever missed work/school or been unable to care for yourself or your family for several days at a time because of serious illness or accident?

3. Have you ever been hospitalized for a physical or emotional problem? If affirmative, ask client to sign a medical release form.

4. When was the last time you saw a doctor. If client is a woman who has not had a Pap exam during the past year, the agent should explain the importance of this simple exam.

5. Have you ever seen a psychiatrist, psychologist or counselor?

6. When was the last time you saw a dentist?

7. Are you presently taking any medication or receiving treatment for any health problems?

8. Do you have health insurance or are you now receiving medical assistance?

There are other health concerns which can be probed and discussed during the collection of data for the PSI or Social Investigation, or at a later time during the supervision period. Examples of such topics would include the following:

a. Family planning and birth control.

b. VD and personal hygiene.

c. Nutritional practices.

B. Treatment Approach

Since the agent does not do any actual treatment of physical problems, the agent should counsel client by educating and informing the client of the existing problem considering client perspective, prior attempts to deal with the situation and alternative solutions available. Then the appropriate referral should be made.

C. When to Make a Referral

1. At the request of the client.

2. When the agent perceives a situation as serious and demanding immediate attention such as contagious or fatal diseases, conditions which result in inability to keep a job or produce extreme social ostracism, or a degenerative

condition. In these extreme situations, the agent may use persuasion, or if necessary, the coercion of special conditions on the Supervision Agreement or request that the Court impose a special condition.

3. When non-urgent health concerns which improve well-being and life-style are expressed by the client, the agent could give information to the client about resources or make appointments with the agreement of the client. (Examples of these concerns would be immunization, relaxation and exercise, weight control and general health education programs.)

Whenever an agent makes a referral or a client reports hospitalization or treatment, the agent should seek follow-up reports through the use of a signed information release form.

D. Resources

1. References

a. Medical Dictionary

b. Merk Manual

c. Physician's Desk Reference

d. Telephone Book Yellow Pages under Health or Social Service Organizations.

2. Services

a. County Guidance Clinics (counseling).

b. Treatment Centers for drug and alcohol abusers (counseling).

c. Public Health Departments (physical health care and health education).

d. Visiting Nurse Service (physical health care in the home).

e. State Schools/Bureaus for the Blind and Deaf (self-care, social skills and employment training).

f. Private physicians; dentists; therapists; local hospitals and clinics.

3. Maintenance

a. Local 51.42 Boards (financial aid and counseling for mental health and addiction problems).

b. County Social Services (medical assistance, food stamps).

c. Social Security Disability (financial).

d. V.A. Assistance (financial).

e. State Division of Vocational Rehabilitation (financial assistance and job/personal counseling for the physically and mentally handicapped).

f. Division Purchase of Services (limited financial aid).

SEXUAL BEHAVIOR

A. Identification of Problem

Sexual behavior causes problems when that behavior is considered illegal or adversely affects the individual's social functioning and emotional adjustment.

Unlike other treatment areas, sexual problems, because many manifestations are illegal, can be identified through the current offense or previous criminal history of the client. However, it is possible for the individual to exhibit sexual problems which have not as yet led to a confrontation with the legal system. When the sexual problem is not the current offense, it is important for the agent to scrutinize the client's file to determine if there were any other previous offenses or problems documented. Problems may also be uncovered through the course of supervision and experience with the client. Illegal sexual behavior includes the following:

1. Exhibitionism
2. Voyeurism
3. Pedophilia
4. Incest
5. Rape
6. Prostitution
7. Homosexuality

B. Treatment Approach

(It is important to treat not only the sexual problem exhibited but also the underlying social and emotional problems).

1. Treatment Approach for Exhibitionism and Voyeurism

   a. Attempt to develop a non-threatening relationship by moving slowly. Avoid rushing before the individual has admitted the need for change.

   b. Attempt to reduce or eliminate stress factors. Most behavior occurs immediately after a frustrating experience or disappointment.

   c. Attempt to develop feelings of accomplishment or self-worth.

   d. Help the client work through guilt feelings.

   e. Reduce passivity through assertive training.

   f. Encourage independence, initiative and channel aggression to acceptable behavior.

   g. Encourage more social contacts with both sexes.

h. Include family members in treatment in an effort to overcome any attitude of rejection or ridicule directed toward the client.

i. If the behavior pattern persists, an immediate referral to Clinical Services is warranted.

2. Treatment Approach for Child Molesting

a. Formalize conditions in the probation agreement prohibiting association with juveniles and requiring participation in a treatment program.

b. Use supportive techniques aimed at reducing feelings of inadequacy.

c. Assertive training may be required.

d. Use family members in counseling to overcome attitudes of rejection or ridicule directed toward the client.

e. Encourage more frequent contacts and social exposures with adults of both sexes.

f. Make an immediate referral to Clinical Services.

3. Treatment Approach for Incestual Behavior

a. Remove the offender from the home where the offense occurred.

b. Contact protective services for the protection of the victim.

c. Make an immediate referral to Clinical Services, since this behavior is usually associated with serious mental illness, senile deterioration and/or alcoholism.

4. Treatment Approach for the Rapist

a. Help the client recognize the aggressive and hostile qualities of the action.

b. Structure a situation to help the client ventilate hostility and discover more appropriate ways of expressing hostility.

c. Encourage activities which enhance self-confidence and reduce the need for control.

d. Since forcible rape is frequently associated with antipersonalities who have displayed aggressive tendencies in the past, consider treatment techniques utilized in dealing with other acting-out behaviors.

e. Always make a clinical referral.

5. Treatment Approach for the Prostitute

a. Attempt to establish the source of motivation (psychological, monetary or both).

b. Consider clinical referral.

c. Provide supportive techniques to improve self-confidence.

d. Consider confrontation and reality orientation regarding the undesireable and detrimental aspects of the behavior.

e. Provide vocational or employment counseling.

6. Treatment Approach for Homosexuality

a. This form of sexual behavior is extremely difficult to change, especially if the individual has no desire to become heterosexual. If there is no motivation to change, efforts should be directed as follows:

1. Ensure that the client has relations only with consenting adults.

2. Counsel the client to become more discrete and to avoid public display.

3. Assist the client in resolving guilt and anxieties associated with homosexuality and concomitant social pressures.

4. Counsel the client to avoid potential problem areas such as triangle relationships.

b. If there is motivation for change, efforts should be directed as follows:

1. Evaluate for clinical referral.

2. Attempt to help the individual overcome his fears in relating to the opposite sex; provide opportunities for this experience through the the use of an agent of the opposite sex.

3. Help to improve the individual's overall functioning in all areas (family, job peer relationships, etc.).

4. Consider group therapy which is generally very effective with this type of problem.

C. When to Make a Referral

In addition to specific situations where a referral is mandatory, referrals should be made in cases where the agent lacks the time or the expertise necessary to provide effective treatment.

Wis. Dept. of Health and Social Services
Division of Corrections
Form CC/SD 02 (8/76)

# ASSESSMENT OF CLIENT NEEDS

Client Name _____ (Last) _____ (First) _____ (MI) Client Number _____

Probation Control Date or
Institution Release Date _____ (Month, Day, Year) Agent Last Name _____ Number _____

Date of Evaluation _____

Select the appropriate answer and enter the associated weight in the score column. Higher numbers indicate more severe problems. Total all scores.

| | | | | SCORE |
|---|---|---|---|---|
| **ACADEMIC/VOCATIONAL SKILLS** | | | | |
| -1 High school or above skill level | 0 Adequate skills; able to handle everyday requirements | 2 Low skill level causing minor adjustment problems | 4 Minimal skill level causing serious adjustment problems | |
| **EMPLOYMENT** | | | | |
| -1 Satisfactory employment for one year or longer | 0 Secure employment; no difficulties reported; or homemaker, student or retired | 3 Unsatisfactory employment; or unemployed but has adequate job skills | 6 Unemployed and virtually unemployable; needs training | |
| **FINANCIAL MANAGEMENT** | | | | |
| -1 Long-standing pattern of self-sufficiency; e.g., good credit rating | 0 No current difficulties | 3 Situational or minor difficulties | 5 Severe difficulties; may include garnishment, bad checks or bankruptcy | |
| **MARITAL/FAMILY RELATIONSHIPS** | | | | |
| -1 Relationships and support exceptionally strong | 0 Relatively stable relationships | 3 Some disorganization or stress but potential for improvement | 5 Major disorganization or stress | |
| **COMPANIONS** | | | | |
| -1 Good support and influence | 0 No adverse relationships | 2 Associations with occasional negative results | 4 Associations almost completely negative | |
| **EMOTIONAL STABILITY** | | | | |
| -2 Exceptionally well adjusted; accepts responsibility for actions | 0 No symptoms of emotional instability; appropriate emotional responses | 4 Symptoms limit but do not prohibit adequate functioning; e.g., excessive anxiety | 7 Symptoms prohibit adequate functioning; e.g., lashes out or retreats into self | |
| **ALCOHOL USAGE** | | | | |
| | 0 No interference with functioning | 3 Occasional abuse; some disruption of functioning | 6 Frequent abuse; serious disruption; needs treatment | |
| **OTHER DRUG USAGE** | | | | |
| | 0 No interference with functioning | 3 Occasional substance abuse; some disruption of functioning | 5 Frequent substance abuse; serious disruption; needs treatment | |
| **MENTAL ABILITY** | | | | |
| | 0 Able to function independently | 3 Some need for assistance; potential for adequate adjustment | 6 Deficiencies severely limit independent functioning | |
| **HEALTH** | | | | |
| | 0 Sound physical health; seldom ill | 1 Handicap or illness interferes with functioning on a recurring basis | 2 Serious handicap or chronic illness; needs frequent medical care | |
| **SEXUAL BEHAVIOR** | | | | |
| | 0 No apparent dysfunction | 3 Real or perceived situational or minor problems | 5 Real or perceived chronic or severe problems | |
| **AGENT'S IMPRESSION OF CLIENT'S NEEDS** | | | | |
| -1 Minimum | 0 Low | 3 Medium | 5 Maximum | |

Use the reverse side to list any special circumstances which should influence the level of supervision.

**TOTAL** _____

END