Substance Use and Misuse among Justice-Involved Persons: Practice Guidelines for Probation Staff[1]

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What Do Probation Staff Need to Know about Substance Use and Misuse?

A substance use disorder (SUD) is a pattern of alcohol or drug use that causes significant impairment or problems. Of course, not everyone who uses substances will go on to develop a SUD. The number of people who use a substance who then develop a SUD is called "conditional dependence." On average, about 12 percent of people who use a substance at least once will develop a SUD, with some substances (e.g., alcohol, marijuana) having lower rates of conditional dependence, and other substances (e.g., cocaine, heroin) having somewhat higher rates (Lopez-Quintero et al., 2011). Heroin and cocaine also appear to have the quickest progression from initial use to a SUD (0-4 months), while cannabis and alcohol often take longer to progress to a SUD (1-6 years and 3-15 years, respectively) (Lopez-Quintero et al., 2011). Like substance use itself, SUD can range from a relatively mild SUD that can be treated with brief advice or counseling to a very severe SUD that might require intensive inpatient services. This is one reason it is important to use an evidence-based screening tool that measures recent substance use, rather than relying on criminogenic risk/need assessments that measure broader behaviors or substance use that occurred long ago.

SUDs are more frequent among males, and people who are younger, have lower incomes, are unemployed, began using substances at an earlier age, and have certain mental health conditions (Chen, O'Brien, & Anthony, 2005). In a national survey, around 20 percent of males on probation had a drug use disorder, 30 percent had an alcohol use disorder, and 40 percent had any SUD (Substance Abuse and Mental Health Services Administration, 2014). In another survey, about half of male probationers were in need of substance use treatment, but only around one quarter actually received treatment in a given year (K. E. Moore et al., 2019; Perry et al., 2015).

What Do Probation Staff Need to Know about Substance Use and Abuse in the Criminal Legal System?

People who use substances are much more likely to be justice-involved (Dellazizzo et al., 2020; Hayhurst et al., 2017; T. M. Moore et al., 2008; Yukhnenko, Blackwood, & Fazel, 2020). For example, nearly 40 percent of federal and state prisoners reported using drugs and 30 percent reporting drinking alcohol at the time of their offense (Maruschak, Bronson, & Alper, 2021), and nearly half had a substance use disorder in the 12 months prior to incarceration. Substance use is also the most important modifiable risk factor for recidivism, followed by antisocial peers, mental health needs, and employment problems (Yukhnenko et al., 2020). There are several reasons why substance use and crime tend to be so strongly connected: people are more likely to commit crimes when they are under the influence (e.g., violent crimes, intoxicated driving); people often commit crimes when they are trying to obtain substances (e.g., robbery, financial crimes); and people may buy, sell, or possess illegal substances directly (e.g., possession, distribution). While under supervision, people who are using substances might have a harder time maintaining obligations to their jobs or families, or completing other requirements.

What Role Does Substance Use Treatment Have in the Criminal Legal System?

Substance use treatment in the justice system can reduce both substance use and criminal behavior (Perry et al., 2019; Perry et al., 2013, 2014; Prendergast, Podus, Chang, & Urada, 2002). In one study, people who were mandated to substance use treatment were as satisfied with their treatment and were as likely to be abstinent after one year as those who were accessing treatment voluntarily (Kelly, Finney, & Moos, 2005). Furthermore, in another study, people who were mandated to treatment were more ready to change their substance use than people who were there voluntarily (Gregoire & Burke, 2004). People who were entering treatment because of legal coercion were three times as likely to have started positive changes in the month before beginning treatment. This suggests that a certain amount of legal pressure can increase motivation to change substance use.

Chandler et al. (2009) described some "best practices" for integrating substance use treatment into the justice system. Some of their key recommendations include: 1) use

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screening and assessment to determine the correct treatment placement; 2) make treatment long enough to ensure stability; 3) carefully monitor substance use while people are in treatment; 4) employ a mix of rewards and sanctions to keep people engaged; 5) use medication-assisted treatment where indicated; and 6) provide housing, employment assistance, and medical care to assist with recovery. Importantly, these strategies rely on coordination between justice agencies, treatment providers, mental health agencies, and healthcare providers.

In the criminal justice system, behavioral treatments are widely used because of their relatively low cost and ability to address other factors that are related to substance use (e.g., social support, antisocial thinking, motivation). In fact, there are several behavioral treatments that have a strong evidence base both inside and outside the justice system, including motivational interviewing, cognitive behavioral therapy, and contingency management (all described below). In addition, there is good evidence that medication-assisted treatment can be helpful for some people, particularly those with an opioid use disorder. Some people benefit from behavioral treatment alongside medication, for instance receiving motivational or contingency-based approaches to encourage them to continue taking a medication for a SUD.

What Are the Evidence-based Treatments for Substance Use in the Criminal Legal System?

People in the criminal justice system are often asked to make changes they previously hadn't considered (e.g., stop using drugs, find employment, avoid certain people). The transtheoretical model of change (TTM; DiClemente & Prochaska, 1998) describes how people become more ready for change, whether for internal reasons or because of external pressure. In short, it says that people progress through a series of stages when considering a change. People's readiness ranges from precontemplation (no awareness or interest in change) to contemplation (some awareness, but mixed feelings about change), to preparation (having a plan for change), to action (having recently made changes), to maintenance (having maintained changes over time). Finally, relapse is a common part of the cycle; most people have setbacks when they try to change a longstanding behavior. A study of people in recovery from alcohol or drug use disorders found that people made an average of 5.35 serious attempts before finally resolving a significant substance use problem (Kelly, Greene, Bergman, White, & Hoeppner, 2019). And of course, motivation is specific to the area. People may be very ready to change their substance use, but not at all ready to change their peer group, or they may be very ready to change their substance use, but don't think they need treatment to do it.

Ideally, a person's internal reasons to change substance use (e.g., "My family will be proud of me if I stay clean") should work alongside external reasons (e.g., "If I fail my UA, I might get a weekend in jail") to move people through the stages. In reality, however, motivation is more complicated. People may be told to change their behavior immediately (quit using drugs right now) where previously there was little readiness (someday I might quit using drugs). In addition, certain legal requirements (pay fees, attend classes) might seem unfair to the person, or might even be seen as at odds with other goals (pay for childcare).

In focus groups of probationers with a history of drug use, Spohr et al. (2017) identified a range of reasons people said it was important to finish probation:

- Financial (e.g., "To have more money")
- Time (e.g., "So I can spend more time relaxing or doing what I want to do")
- Freedom (e.g., "To quit having to check in with others when I want to do something")
- Shame (e.g., "So people will quit judging me")
- Relationships (e.g., "To set an example for my children")
- Legal (e.g., "To avoid going to jail or prison")
- Getting on with life (e.g., "To make my life better")

Interestingly, the areas themselves were less predictive of probation success than the overall pattern. In general, people who had more internal, future-focused reasons (the authors called these "better life" reasons) were more likely to make changes in their substance use, compared to people who had more external, present-focused reasons (the authors called these "tangible loss" reasons). This is consistent with self-determination theory (Ryan & Deci, 2000), which says that people are more likely to make lasting changes if they believe they have some ownership over the changes (autonomy), feel confident in their ability to make the changes (competence), and believe that others will support the changes (relatedness).

Practically, this means that you should consider the full range of things that might motivate a person, and help that person appreciate the ways that completing probation would "make my life better," "help me get on with my life," "set an example for others," and "make my family proud of me." People who are thinking about and prioritizing these internal, future-focused reasons are more likely to work towards their probation goals. In fact, it might be counterproductive to keep warning a probationer about the legal consequences of staying unemployed when the probationer has said their main motivation is to find a job or support their family.

Beyond individual factors, there is evidence that the way providers deliver substance use treatment can influence client outcomes (Moyers & Miller, 2013). In a probation setting, Rodriguez et al. (2017) found that when counselors used a more pushy, suggestion-giving style, probationers were less likely to talk about change, and less likely to be abstinent two months later. In fact, a positive, balanced working relationship between probation staff and clients is an important predictor of client outcome (Skeem, Louden, Polaschek, & Camp, 2007).

Motivational Interviewing

Motivational interviewing (MI) is a treatment approach that focuses on developing discrepancy between a person's goals and behavior (Miller & Rollnick, 2012). MI is a sort of "cousin" to the TTM because it suggests ways of talking with people to move them from one stage to the next. While MI suggests certain conversational skills such as open questions, affirmations, reflections, and summaries, the mindset or "spirit" of MI is also important. MI emphasizes *collaboration* (clients are seen as a source of expertise that can be drawn from), *evocation* (the client's background and experience is a source of strength), and *acceptance* (clients have the right to make decisions about their own lives).

MI has a substantial track record in substance use counseling, both as a stand-alone intervention as well as integrated with other counseling approaches (Frost et al., 2018). MI was originally designed to provide a motivational "booster" before starting treatment. However, many research studies have found that a single MI session is often helpful on its own to initiate behavior change. Once people become motivated to change, they often seek out other services on their own. Interestingly, there is evidence that MI may

be more beneficial for severe substance users, compared to other treatment approaches. For instance, one study of pregnant drinkers found that MI was most beneficial for the heaviest drinkers (Handmaker, Miller, & Manicke, 1999), while another study of cannabis users found that MI was most effective for heavy users (Mason, Sabo, & Zaharakis, 2017). In addition to substance use, MI can be used to help people make changes in other behaviors that affect probation success (Walters, Clarke, Gingerich, & Meltzer, 2007). You might use MI techniques to encourage people to talk about the benefits of completing treatment, what they are learning in treatment, and how they will avoid situations that put them at risk of relapse. MI emphasizes careful listening, a good working relationship, respect for the person's autonomy, and eliciting ideas and solutions from the person.

Here's an example of a conversation between a probation officer and client that might happen early in the probation process. The officer uses the conversation to help the person think about the person's commitment to finishing a treatment program, despite some reluctance. The officer avoids the temptation to lecture or nag the client about what he *should* do, but rather focuses on the person's internal reasons for completing treatment.

Officer: *I wanted to talk next about your substance treatment condition. As you know, you've been assigned to IOP. That's three sessions per week for eight weeks.*

Client: *I don't really think I need that much treatment. My drinking's not that big a deal. It's never been a problem for me to quit, and I wasn't even drinking the night I was arrested.*

Officer: *So it feels like a heavy lift right now. I'm curious about your level of commitment to completing IOP, all things considered. If 1 is "not at all" committed, and 10 is "very" committed, how committed are you to successfully completing IOP?*

Client: *Well, it's a 10. I know I have to finish, but I don't know how I'm supposed to go to treatment and look for a job at the same time.*

Officer: *A 10 is a pretty high level of commitment. What are some of the reasons you're so committed?*

Client: *Well, just getting on with my life is the main thing. Finishing probation.*

Officer: *So, moving on with your life. And what else makes it a 10 and not a lower number?*

Client: *I guess my family is another reason. I have a daughter and want to be there for her. Right now, probation is like this dark cloud that follows me around. I want to be able to get a job and contribute for once in my life.*

Officer: *Sounds like those are two pretty big motivators. One is just getting through probation, and the second is making a better life for your family. So let's talk about your plan for the next couple weeks, both staying clean and signing up for treatment.*

Notice how the officer ignores the client's more resistant talk, and instead follows the more productive talk—in this instance, reasons the person is committed to finishing treatment, despite his ambivalence. From an MI standpoint, it's a good investment to spend a few minutes talking about motivation before entering the planning phase. A manual developed by the National Institute on Corrections gives more extensive instructions for using MI in community corrections settings (https://nicic.gov/motivating-offenders-change-guide-probation-and-parole).

Cognitive Behavioral Therapy

Cognitive behavior therapy (CBT) focuses on changing thought patterns that lead to problem behaviors (Beck, 2020). A CBT approach might teach people different ways of thinking or coping, and help them come up with new skills to avoid substances (Milkman & Wanberg, 2007). A related approach, relapse prevention, teaches people how to anticipate and cope with relapses, for instance using strategies to keep a slip from becoming a full-blown relapse.

There is good evidence that CBT can reduce substance use and related problems (Magill et al., 2019). CBT has been integrated into many different programs such as *Moral Reconation Therapy*, *Reasoning and Rehabilitation*, and *Thinking for a Change* that address broader areas of thinking and behavior. A CBT-based program might teach people how to recognize and evaluate thoughts that lead to trouble, how to identify new ways of thinking, how to prepare for stressful situations, and how to effectively communicate their needs (Bush, Glick, & Taymans, 1997). A probation officer might use CBT strategies to help someone identify antecedents to substance use (e.g., moods, locations, or people that tempt them to use) and to develop alternative ways of coping with stressors (e.g., move to a different area, distract yourself, wait a few minutes before deciding).

Here's an example of a conversation between a probation officer and client to identify high-risk situations that might increase the risk of alcohol use. A "situation" might include people and locations, as well as what the probationer is thinking or feeling at that moment. Ideally, the person would actually practice the skills during the office visit, rather than just talking hypothetically about what they would do.

Officer: *Last month we talked about some of the reasons it was important to finish IOP. Notably, you said you wanted to make things better for your family and just move on with your life without having probation hanging over your head.*

Client: *Yes, those are my main reasons.*

Officer: *Of course, staying clean is going to be a big part of the process. In what kinds of situations are you more likely to drink?*

Client: *Typically with friends, but I'm not drinking any more.*

Officer: *That's great. I can definitely see your commitment. So when you were drinking, how did it usually get started?*

Client: *Normally, someone would text me when I'm about to get off work and we would meet at a bar or a friend's house.*

Officer: *So what kind of strategies are you using now to avoid drinking? How are you managing?*

Client: *Spending more time with family I guess. I'm still hanging out with some of the same people, just not at the bars.*

Officer: *What are you telling people when they invite you out to drink?*

Client: *I just say I can't hang out with them.*

Officer: *So you're comfortable telling them it's not an option because you're on probation. How about if you were at someone's house and there were other people drinking. What strategies would you use to make sure you don't start drinking?*

Client*: I guess I could move to a different area. There's usually a group of people that aren't drinking. Or I could leave.*

Officer: *Yeah, so physically moving to a different area so you're not being tempted by it. That's a good idea too.*

CBT requires active participation by clients to brainstorm and learn new skills. For this reason, you might use motivational techniques early in an office visit (or early in the probation process) to build motivation and readiness, and then shift to a CBT approach to help develop practical skills in the area. From a stages-of-change perspective, MI can be more helpful early in the process (precontemplation, contemplation), while CBT is helpful later in the process (preparation, action, maintenance, relapse).

Contingency Management

Contingency management (CM) uses structured incentives to shape behaviors (Dallery, Meredith, & Budney, 2012). CM points out that people are more likely to engage in behaviors that are rewarded, even if the reward is relatively small (e.g., positive recognition, bus pass, entry in gift card raffle). A structured CM system might establish a point system for certain behaviors (e.g., being on time for appointment, attending treatment, having a negative UA), develop a clear way for people to see their progress, provide early incentives so people can experience a reward for their progress, and include point escalation or bonuses for sustained positive behavior (Rudes et al., 2012). Although some may object that CM is just "paying people to be good," there is good evidence that CM is a cost-effective way to change behavior (Ginley, Pfund, Rash, & Zajac, 2021; Olmstead, Sindelar, Easton, & Carroll, 2007; Rash, Alessi, & Petry, 2017). Notably, CM has a good track record among people who use stimulants such as cocaine or amphetamines (De Crescenzo et al., 2018), for which there are not good treatment medications available (as there are for opioid use disorders).

Some agencies have developed systems of "progressive incentives" for positive behavior alongside "progressive sanctions" for negative behaviors. The assumption is that a system's response should be dynamic—stepping up or down—based on how a person is behaving. (Of course, many probation agencies already use sanctions this way—sanctions might range from a behavioral contact or warning for small offenses, to house arrest or jail confinement for larger offenses.) Notably, incentives do not need to involve money—non-monetary incentives might include a reduction in reporting frequency, waiver of fees, adjustment of curfew restrictions, travel permission, or positive affirmation from a supervisor.

In developing a system of progressive incentives, the first step is to develop a list of behaviors you want to reinforce. For instance, Table 1 is simplified from a model used in El Paso County, TX (the full report can be found at https://www.epcounty.com/epcs/documents/ProgressiveSanctionsIncentivesManual.pdf). The left column gives a list of positive behaviors, while the right column shows incentives for meeting that milestone.

Progressive sanctions and rewards programs are transparent so that clients are aware of what behaviors will be sanctioned and which will be rewarded. Some plans contain detailed point systems that add and subtract points toward certain actions. Many plans include worksheets to increase clarity, transparency, and fairness between different probationers. A comprehensive plan for progressive sanctions and incentives often involves larger system changes. However, you can still use the principles of CM by looking for ways to reinforce positive progress.

Medication-Assisted Treatment

In addition to behavioral treatments, there is good evidence that medication-assisted treatment (MAT) can improve substance use outcomes, particularly for clients with opioid use disorder (Substance Abuse and Mental Health Services Administration, 2019). Common medications include:

1. Methadone is a long-lasting opioid agonist medication that can lessen the "lows" caused by long-term opioid use and improve people's overall functioning. By law, methadone can only be administered in certified opioid treatment programs (OTPs) where most people are required to attend every day. However, some people can receive take-home doses after meeting requirements for treatment compliance.
2. Buprenorphine is a partial opioid agonist that activates some opioid receptors while also blocking others. Buprenorphine is most commonly provided as a medication given by prescription and filled at a regular pharmacy. The most widely used forms of buprenorphine also contain naloxone to discourage people from abusing the medication. Buprenorphine can be provided as a daily tablet or film dissolved under the tongue, as a monthly injection, or as a subdermal implant every 6 months.
3. Naltrexone is an opioid antagonist that blocks the rewarding effects of opioids. Naltrexone does not produce any intoxicating effects on its own, but rather blocks the rewarding effects if someone tries to use opioids while they are taking naltrexone. Naltrexone is typically provided monthly as an intramuscular injection.

Methadone and buprenorphine, in particular, tend to improve retention in treatment during incarceration and after release into the community (K. E. Moore et al., 2019). While there is less evidence that these medications reduce recidivism directly, people who receive MAT tend to be more engaged in treatment, and thus at lower risk of criminal behavior, compared to people who do not receive MAT (Substance Abuse and Mental Health Services Administration, 2019). Notably, behavioral and medication-assisted treatments are often used alongside each other. For instance, MI might encourage a person to continue taking medication, while CBT might help teach broader coping skills to help avoid relapse.

While some people might view medication

TABLE 1.
Levels of Compliance Behaviors and Incentives

Behavior	Incentive
Level 1: Client compliant with terms of supervision for 1/3 of original term	
Current with probation fees Completion of community service hours Compliance with AA/NA attendance	Positive affirmation from officer or supervisor Reduction in community service hours Reduction in reporting
Level 2: Client compliant with terms for supervision for 2/3 of original term	
Completing residential treatment program Clients on specialized caseload who show consistent reporting for ≥ 2 years Low-risk clients who have no technical violations for ≥ 1 year	Reclassification to less intensive level of supervision Less frequent reporting Reduction in substance abuse testing
Level 3: Client compliant with terms of entire supervision	
Completion of specialized program Completion of residential program Completion of specialty court program	Acknowledged for good behavior by court Recommend full-term discharge Positive affirmation from court

as substituting "one drug for another," the evidence is clear that medication tends to produce better treatment outcomes, compared to behavioral treatments alone. For instance, there is good evidence that starting people on MAT during a high-risk window, such as during jail discharge or after being seen in the emergency department for an overdose, can help them stay in treatment and avoid future substance use (D'Onofrio et al., 2015). According to the U.S. Surgeon General, long-term medication maintenance is important; people who received MAT for less than 3 years were more likely to relapse, compared to people who were maintained on MAT for more than 3 years (Substance Abuse and Mental Health Services Administration & Office of the Surgeon General, 2018).

How Can Probation Staff Support and Enhance Evidence-based Treatment for Substance Use?

Probation staff play an important role in the recovery process. Your actions help determine whether people will engage in treatment and make positive changes that affect them, their families, and the community. Substance use involves aspects of motivation and cognition, but it is also a brain disorder. Over time, substance use can alter the chemistry of the brain, changing decision-making capacity, and making it more difficult for people to avoid future substance use. Looking at substance use this way can help people understand someone would continue to use a substance despite harmful effects ("Why don't they just stop?"). It can also help people appreciate the logic of using a medication to reset the brain's chemistry, perhaps over a long period of time.

First, ensure that your agency is properly screening for substance use. Substance use and misuse are on a continuum, with some people needing a relatively small amount of treatment and others needing a great deal more treatment. As mentioned earlier, typical risk/needs assessments are not good tools for gauging the kind of treatment a person needs, because they often ask about things that happened a long time ago, and may focus on larger factors that are only tangentially related to substance use.

Second, use your interactions to support evidence-based treatment concepts. Treatments that use cognitive and motivational concepts tend to be more effective, while those that rely on more general education or "processing" tend to be less effective. Consider browsing through the manuals used by treatment providers and ask clients about what they are learning in treatment that has been helpful. Also realize that people may be more ready to make changes during "teachable moments," when some important life event has occurred or they have experienced a setback.

Finally, appreciate that how you talk to people can make a difference in how they behave. A good working relationship can set the stage for change. Clients should understand that you want them to succeed, are interested in their wellbeing, respect their right to make decisions, and will fairly dispense the actions of the court. Part of this process involves avoiding stigmatizing language like "addict," "user" or "abuser" that may discourage people from engaging in treatment. When speaking about people, one rule of thumb is to use "people first" language that emphasizes the person rather than the behavior. So "substance abuser" or "addict" becomes "person with a substance use disorder" or "person in recovery." This makes it clear that the behavior is not an essential characteristic of the person. People don't need to be defined by their past actions. They have the capacity right now to make their own lives better, as they contribute to their families and the community.

Key Terms

Substance Use: Any use of alcohol or drugs, including illegal drugs, prescription drugs, and inhalants (tobacco/vaping might also be included in some definitions).

Substance Abuse: A pattern of alcohol or drug use that results in significant problems with work, family, health, risky behaviors or legal issues.

Substance Dependence (or Substance Use Disorder): A medical term to describe a pattern of drug or alcohol use that has resulted in changes such as physical tolerance, withdrawal, and continued use of the substance despite significant problems.

Co-Occurring Disorders: A combination of two or more substance use disorders and mental disorders (e.g., opioid use disorder and anxiety disorder).

Motivational Interviewing: A collaborative conversational style to strengthen a person's motivation and commitment to change.

Cognitive Behavioral Therapy: A counseling approach to help people identify and change thought patterns that lead to negative behaviors.

Contingency Management: The systematic application of rewards to influence behaviors such as reaching treatment goals.

Medication-Assisted Treatment (or Medication for Addition Treatment): Medications used (with or without counseling or behavioral therapy) to treat a substance use disorder.

Key Takeaways

1. Substance use is common in the criminal justice system, and closely connected with crime and recidivism.
2. Your agency should properly screen for substance use and refer to appropriate treatment.
3. Evidence-based treatments include motivational interviewing, cognitive behavioral treatment, contingency management, and medication-assisted treatment where indicated.
4. You should focus on people's internal, future-focused reasons for completing probation to help facilitate long-term change.
5. You should use motivational and cognitive behavioral strategies to support evidence-based treatment concepts.
6. Your interactions with a probationer set the stage for a good working relationship and positive change.

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