

Counseling. In S. M. Barton-Bellessa & J. G. Golson (Eds.), *Encyclopedia of Community Corrections*, Thousand Oaks, CA: Sage Publications (2012).

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Community corrections has a long history of providing counseling and guidance to offenders released to the community. John Augustus, the “father of probation,” provided counseling and employment assistance to the misdemeanants released to his care and reported on their progress to the Courts. This followed a general cultural concern for correction, reform and rehabilitation. Early proponents of juvenile justice and diversion counseled juveniles and sought to provide them with better opportunities. A strong focus on the needs of female offenders early in the twentieth century provided a significant counseling emphasis.

In the context of community corrections, counseling has typically taken three forms: surveillance based counseling, intended to determine whether the offender has been fulfilling his commitments to the court and the community; rehabilitative counseling, aimed at the helping the offender to make positive decisions about their life choices and personal directions; and therapeutic counseling, aimed at discovering and modifying the root causes of criminal behavior. These kinds of counseling have also been provided in three contexts: as provided by the community corrections official on a one-to-one basis, as group interventions, either in-house or by contractors and as provided by contract agencies.

The early history of community corrections was marked by a powerful rehabilitative emphasis that continued until the period of civil unrest in the 1960s and 1970s. During this early period, covering about half a century from the establishment of the first probation departments in the 1920s and 1930s, probationers were typically first time offenders or minor misdemeanants more in need of assistance than surveillance. Even parolees, persons released early from prison to complete their remaining time on the streets, although viewed as more dangerous and more in need of surveillance than probationers, were provided with counseling in hope that their lifestyles could be amended.

Community Corrections Officers as Counselors

During the 1950s and early 1960s rehabilitative counseling became a mainstay of community corrections and was often based on either Rogerian or depth psychological techniques. Rogerian techniques were non-directive. They provided little or no actual direction but focused on active listening; assuring the client that they were being understood and seeking

to build a sense of positive self worth in the offender. Such techniques were centered in the clients' supposed need to be heard. Freudian or depth psychological approaches focused on allowing the offender to discover the roots of their problem behaviors through a process of self discovery. As manifested in community corrections, such efforts often resulted in clear suggestions for action. Because the providers of such counseling were often neither qualified social workers nor trained psychotherapists, the value of such interventions was often questioned.

By the mid 1960s, during a period of growing concern for the due process rights of most defendants and a rising awareness of the social and psychological consequences of arrest and imprisonment, there were further concerted efforts to remove juveniles from the criminal justice system. During this same period a large number of probation and parole officers were trained social workers and there was a recommendation from the national government that probation officers should have an MSW as an educational qualification.

Throughout the history of community corrections there echoed a controversy about the propriety of probation and parole officers providing counseling and therapy. It was often argued that most of the staff was unqualified to provide counseling, let alone therapy and that the more important duties associated with community corrections were to ensure that the offender did not reoffend, that the conditions of supervision were fulfilled and that the community was protected. It was further argued that the two roles would interfere with one another. The counseling perspective would prevent the officer from appropriately enforcing the conditions of supervision and the law enforcement approach would make a therapeutic alliance impossible. As the officer was always bound to enforce the conditions of supervision, the assumed need for confidentiality and trust was unreasonable.

During the 1980s a strong reaction against rehabilitation, often echoing the tentative findings of Robert Martinson that no rehabilitation strategy had universal efficacy--nothing works—came together with an increasing intolerance for non-punitive sanctions and the justice as fairness movement, to deemphasize counseling by community corrections officers and to focus on enforcement and surveillance. This also led to a devaluing of parole and its surveillance role in the community. As a result of this shifting emphasis, a great deal of the service provision and counseling in community corrections was shifted to contract agencies.

A middle way found by some officers was to identify the specific needs of each offender. This came to be known as the consumer-based approach which was often paraphrased: some need bread, others need Shakespeare and still others needed to be apprehended and incarcerated. It was the community corrections officer who needed to make that determination.

One of the more important impacts of the consumer-based approach was a focus on case management that was imported directly from social work practice. In case management, as a counseling style, the Community Corrections professional and the offender identify specific needs and tasks and collaboratively develop plans for their realization. While viewed as a common sense implementation by those familiar with client-centered social work, the approach provided a significant set of tools for often overworked and undertrained probation and parole officers. Further because the approach is task driven, it provided a significant means of integrating needs-based counseling with the surveillance and compliance monitoring duties of the

community corrections officer. Both kinds of tasks could be integrated into the same case management scheme. One of the results of the approach was a transparent sense of the expectations and needs of the officer, the courts and the offender.

Individual counseling with offenders, sometimes within a case management structure, has also focused on various psychotherapeutic approaches. More recently, the National Institute of Corrections has promulgated a counseling strategy based on Motivational Interviewing, a style of counseling that is client centered and moves towards discovering the offenders own motivations and capacities for change. The technique and its theoretical basis have been used across multiple disciplines and have received strong empirical support.

Motivational interviewing grows directly from the Stages of Change model that came to public attention with the publication in 1994 of Prochaska, Norcross and diClementi's *Changing for Good*. The Stages of Change model outlines a series of stages through which any change or decision process must pass and identifies specific means for passing from precontemplation (roughly equivalent to denial) to completion in which the change has been completed and is relatively self-maintaining. Motivational interviewing works with the offender or client to identify goals that are meaningful to them, as well as those that are obligatory, and gently guides them in constructing a strategy to attain them. The approach is compatible with a strengths based approach that assumes that clients, including offenders, have meaningful outcomes and the resources to attain them. In this case, the counselor's main responsibility is to subtly guide the process rather than to impose direction.

Group Counseling

Among the non-contractual counseling efforts, usually provided by community corrections officers in an office context, are various modes of group counseling and therapy. These are preferred as being cost effective and relatively easy to implement, but their efficacy is questionable. In-house implementations have included drug and alcohol counseling, anger management, supervision adjustment groups, employment preparation groups and others. One of the advantages of such groups is that they cost very little and are often used to provide mandated treatment for persons who, on a clinical basis, have few problems.

A significant part of the logic of group interactions is that they rely heavily on the experience of offenders to provide support, motivation and feedback to others in the same situation. This is understood to be particularly valuable because the members of the group understand that the information comes from the personal experience of persons in situations similar to their own.

Apropos the classical duties of surveillance counseling, groups have also been established to orient offenders to community supervision, provide information about community reintegration, and work to readjust criminal attitudes. In many agencies, newly released or sentenced offenders are assigned to orientation groups to ensure their understanding of the conditions of supervision and the services available to them in the agency. Parole agencies at various governmental levels have instituted transitional programs for new releasees that include orientation to supervision and work readiness programs. Offenders who have received substance abuse counseling or treatment are also provided with links to outpatient treatment providers.

Contractual Services

Concurrently with whatever style of counseling the Community Corrections Officers provide themselves, there has always been a range of contractual services used to fulfill the conditions of supervision. Most importantly, these have been provided by substance abuse treatment agencies, community mental health centers, private mental health providers and social service organizations. A range of these services has been provided by both inpatient and outpatient providers. In some cases these agencies have included halfway houses and day reporting centers.

In the Federal system, these services are let out to bid on a contractual basis and payment for them is included in the agency's annual budget. Some states follow suit but others require the offender to pay for their own treatment or rely on state funded agencies for services.

Typically the service provider works in concert with the community corrections officer. There are generally regular contacts between the agencies and a fairly free flow of information to ensure that the offender is compliant and that appropriate services are being rendered.

With the institution of the HIPAA legislation in 1996 (The Health Insurance Portability and Accountability Act of 1996), monitoring of contract medical services, with special regard to drug and mental health treatment, were complexified by the requirement that even mandated patients, have a right to privacy and must sign release forms in order for the Community Corrections Officer and the treatment providers to communicate about the offender's progress. For most supervisees this presents little problem and is understood to be a necessary part of the supervision process.

In those cases where substance abuse treatment has required medically supervised detoxification or when, in the opinion of the Court or the community correctional agency, the services needed were beyond the capacities of staff, drug treatment has been provided across a range of treatment possibilities. The least restrictive drug treatment counseling may include evaluation, weekly individual and group counseling session and a not atypical demand that the offenders attend some minimal number of twelve step meetings.

While not understood as treatment or counseling per se, the twelve step protocols as provided by Alcoholics Anonymous, Narcotics Anonymous and similar organizations have been a mainstay of many community corrections efforts. These have extended beyond substance abuse to anger management, overeating, family violence and other kinds of personal problems. In general, the twelve step organizations are viewed as supportive or adjunctive treatments.

More restrictively, offenders with long term addictions and histories of relapse may be referred for inpatient drug treatment. Often preceded by medically supervised detoxification, inpatient treatment may last from 45 days to eighteen months or more. Longer treatments typically include staged re-entry with continuing counseling, job assistance and family counseling. Traditionally most such treatments have included a mandatory twelve step component.

Many correctional communities have endorsed methadone and its variants as the treatment of choice for heroin and opiate abusers. More recently, naltrexone and buprenorphine (medications that block the pleasurable effects of opiates) have also been approved for addiction

treatment. Methadone is ideally provided in a context where the medication is provided on a time-limited basis with both group and individual outpatient counseling (methadone to abstinence programs). However, in many instances it is provided as a simple replacement for the opiate with little consideration of termination.

Classical inpatient drug treatment developed out of the Synanon model that emerged in the New York during the 1960s. It emphasizes, group and individual counseling, strict conformity to community regulations and involvement in a long term restructuring of values, directions and motivations. Special emphasis is also placed on personal responsibility for past and present actions.

More recently, inpatient and outpatient counseling for substance abuse issues as well as more general anti-recidivism counseling have focused on cognitive behavioral and relapse prevention models. Cognitive behavioral models address thinking patterns, associations and patterns of behavior that lead to substance use or offending. They often rely heavily on educational materials. Relapse prevention seeks to build cognitive behavioral strategies to avoid relapse and recidivism. Both involve understanding how and when the offending behavior occurs and learning to make other choices.

Mental health treatment and counseling is often provided by community mental health centers that have psychiatrists, psychologists and therapists on staff. Under Court order the offender is referred to treatment at the center and his progress is monitored by center personnel with regular reports and conferences with the Community Corrections Officer. Increasingly these services are managed by Community Corrections Officers with specialized caseloads and specialized training.

Specific services provided in the community often include sexual offender treatment, anger management and treatment for perpetrators of family violence. Like drug treatment, these services may include both individual and group counseling. For batterers, violent and sexual offenders, empathy based treatments: treatments that are aimed at teaching the offender how to appreciate the damage that has been done to the victim is a popular, if unproven, treatment modality.

Within the community there exist a large variety of counseling agencies and service providers that are privately funded or supported by grants and charitable donations. These are often sources of educational and vocational counseling. Adult education classes and literacy programs typically operate at no charge to the offender and without the need for special contracts with the Community Corrections Agency.

Finally, there are a variety of for profit day report centers, halfway houses and private prisons that can provide a variety of services for the offender who has returned or is returning to the community.

See Also: Augustus, Addiction-Specific Support Groups, Case Management, Caseload and Workload Standards, Conditions of Community Corrections, Correctional Case Managers, Day-Treatment/ Day-Reporting Centers, Drug- and Alcohol-Abusing Offenders and Treatment, Drug Courts, Family Group Conferencing, Martinson, Robert (Nothing Works), Motivational Interviewing, Offender Needs, Offenders With Mental Illness, Parole, Parole Officers (Training

and Duties), Probation, Probation/Parole Fees, Reentry Programs/Initiatives, Sex Offenders in the Community, Specialized Caseload Models, Violent Offender Reconciliation Programs, Violent Offender Reentry Initiation

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