there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn may well result if the threat is actually carried out. In any event, the counselor should try to make the warning in a manner that does not identify the individual as an AOD abuser.

Duty to warn issues present an area in which staff training, as well as a staff review process, may be helpful.

Reporting Criminal Activity Of Clients

Intention to Commit Criminal Activity

What should a program do when a client tells a counselor that she intends to get her children new clothes by shoplifting (a crime the counselor knows she has committed many times in the past). Does the program have a duty to tell the police?

A program generally does not have a duty to warn another person or the police about a client's intended actions unless the client presents a serious danger of violence to an identifiable individual. Shoplifting rarely involves violence, and it is unlikely that the counselor will know which stores are to be victimized. Petty crime like shoplifting is an important issue that should be dealt with therapeutically. It is not something a program should necessarily report to the police.

Disclosure of a Previously Committed Crime

Does a program have a responsibility to call the police when a client discloses to a counselor that he participated in a serious crime some time in the past?

Suppose that a client admits during a counseling session that he killed someone during a robbery 3 months ago. Here the program is not warning anyone of a threat, but serious harm did come to another person. Does the program have a responsibility to report that?

In a situation where a program thinks it might have to report a past crime, there are generally three questions that need to be answered:

Is there a legal duty to report the past criminal activity to the police under State law. Generally, the answer to this question is no. In most States, there is no duty to report a crime committed in the past to the police. Even in those States in which failure to report a crime is considered a crime, violations of the law are rarely prosecuted.

Does State law permit a counselor to report the crime to law enforcement authorities if he or she wants to. Whether or not there is a legal obligation imposed on citizens to report past crimes to the police, State law may protect conversations between counselors of AOD programs and their clients and exempt counselors from any requirement to report past criminal activity by clients. Such laws are designed to protect the special relationship AOD counselors have with their clients.

State laws vary widely on the protection they accord communications between clients and counselors. In some States, admissions of past crimes may be considered privileged and counselors may be prohibited from reporting them; in others, admissions may not be privileged. Moreover, each State defines the kinds of relationships protected differently. Whether a communication about past criminal activity is privileged (and therefore cannot be reported) may depend upon the type of professional the counselor is and whether he or she is licensed or certified by the State.

Any program that is especially concerned about this issue should ask a local attorney for an opinion letter about whether there is a duty to report and whether any counselor-patient privilege exempts counselors from that duty.

If State law requires a report (or permits one and the program decides to make a report), how can it comply with both Federal confidentiality regulations and State law. Any program that decides to make a report to law enforcement authorities about a client's prior criminal activity must do so without violating either Federal confidentiality regulations or State laws. A program that decides to report a client's crime can comply with Federal regulations by following one of the first three methods described above in the discussion of duty to warn.

- It can make a report to the criminal justice agency that mandated the offender into treatment, if it has a criminal justice system consent form signed by the offender that is worded broadly enough to allow this sort of information to be disclosed.
- It can obtain a court order permitting it to make a report if the crime is sufficiently serious.
- It can make a report in a way that does not identify the individual as an AOD client.

Because of the complicated nature of this issue, any program considering reporting a client's admission of criminal activity should seek the advice of a lawyer familiar with local law as well as Federal regulations.

Other Exceptions to the General Rule

Reference has been made to other exceptions to Federal confidentiality rules prohibiting disclosure regarding offenders who are assessed or treated for AOD abuse. Eight additional exceptions to the general rule on confidentiality exist:

- Information that does not reveal the client is an AOD user
- Information shared with staff within the treatment program; information shared inside the agency with staff not part of the assessment or treatment unit
- Information regarding crimes on program premises or against program personnel
- Reporting child abuse or neglect
- Information disclosed to an outside agency that provides the program with services
- Information disclosed in a medical emergency

- Disclosures authorized by a special court order
- Information disclosed to researchers, auditors, and evaluators

Communications Not Disclosing Patient-Identifying Information

Federal regulations permit programs to disclose information about an offender if the program reveals no patient-identifying information. Patient-identifying information is information that identifies someone as an AOD abuser. Thus, a program may disclose information about an offender if that information does not identify him or her as an AOD abuser or support anyone else's identification of the offender as an AOD abuser.

There are two basic ways a program may make a disclosure that does not identify a client.

Aggregate information. A program can report aggregate data about its population (summing up information that gives an overview of the clients served in the program) or some portion of its population. Thus, for example, a program could tell the newspaper that in the last 6 months it screened 43 offenders, 10 female and 33 male.

Release of information that does not indicate or imply the AOD status of the client. A program can communicate information about an offender in a way that does not reveal the offender's status as an AOD treatment patient (§2.12(a)(i)). For example, a program that provides services to clients with other problems or illnesses as well as AOD abuse may disclose information about a particular client as long as the fact that the client has an AOD abuse problem is not revealed. An even more specific example: A program that is part of a general hospital could have a counselor call the police about a threat a client made, as long as the counselor does not disclose that the client has an AOD abuse problem or is a client of the AOD abuse treatment program.

Programs that provide only AOD services or that provide a full range of services but are identified by the general public as AOD programs cannot disclose information that identifies a client under this exception, since letting someone know a counselor is calling from the "XYZ Treatment Program" will automatically identify the offender as someone in the program. However, a freestanding program can sometimes make anonymous disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the offender's status as an AOD abuser.

Communications Among Treatment Staff

Federal regulations permit some information to be disclosed to individual staff within the same program. Restrictions on disclosure do not apply to communications of information among personnel 1) within a program or 2) between a program and an entity that has direct administrative control over that program (§2.12(c)(3)). Such communications can occur only if the personnel have a need for the information in connection with their duties in providing diagnosis, treatment, or referral for treatment of AOD abuse.

In other words, staff who have access to patient records because they work for or administratively direct the program (including full-time or part-time employees and unpaid volunteers) may consult among themselves or otherwise share information if their AOD treatment work so requires (§2.12(c)(3)). And staff may communicate patient-identifying information to a person or entity having "direct administrative control" over a program if there is a need for the information "in connection with their [AOD] duties."

Communications Among Nonclinical Staff

A question that frequently arises is whether this exception allows a program that assesses or treats offenders and that is part of a larger entity (such as a probation department) to share confidential information with others who are not part of the assessment or treatment unit itself. The answer to this question is among the most complicated in this area. In brief, there are circumstances in which the assessment unit can share information with other units, but it is essential before such a system is set up that an expert in the area be consulted for assistance.

Two crucial issues must be considered.

- The program must always keep in mind that it may communicate only information that will assist it or the supervisory entity to provide AOD services.
- Once communications are made to an entity having administrative control over the program, that entity becomes part of "the program," and it is now subject to Federal confidentiality regulations. This means that personnel in that entity must become familiar with the Federal rules and that information they gain from the AOD program cannot be redisclosed to anyone else, unless the offender consents or one of the other exceptions in the Federal regulations applies.

Crimes on Program Premises or Against Program Personnel

When an offender has committed or threatened to commit a crime on program premises or against program personnel, the regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. In such a situation, without any special authorization, the program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a patient at the program (§2.12(c)(5)).

Reporting Child Abuse and Neglect

All 50 States and the District of Columbia have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made.

Most States now require not only physicians but also educators and social service workers to report child abuse. Most States require an immediate oral (usually telephone)

report and many now have toll-free numbers to facilitate reporting. (Half the States require both oral and written reports.) All States extend immunity from prosecution to persons reporting child abuse and neglect. (In other words, a person who reports child abuse or neglect cannot be brought into court.) Most States provide for penalties for failure to report.

Federal confidentiality regulations permit programs to comply with State laws that require the reporting of child abuse and neglect. Thus, if an offender reveals to program staff that he or she has neglected or abused children, that fact may well have to be reported to State authorities. Note, however, that this exception to the general rule prohibiting disclosure of any information about a client applies only to initial reports of child abuse or neglect. Programs may not respond to followup requests for information or to subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, unless the offender consents or the appropriate court issues an order under subpart E of the regulations.

Because of the variation in State laws, programs should consult an attorney familiar with State law to ensure that their reporting practices are in compliance.

Qualified Service Organization Agreements

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into what is known as a qualified service organization agreement (QSOA). A QSOA is a written agreement between a program and a person or entity providing services to the program, in which that person or entity: 1) acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the program, he, she, or it is fully bound by [Federal confidentiality] regulations; and 2) promises that, if necessary, he, she, or it will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations (§2.11, 2.12(c)(4)). A sample QSOA is provided in Exhibit 7-4.

A QSOA should be used only when an agency or official outside of the program is providing a service to the program itself. An example is when laboratory analyses or data processing is performed for the program by an outside agency.

A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so that the program can function effectively. QSOAs may not be used between programs providing AOD services.

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about [an offender] for the purpose of treating a condition which poses an immediate threat to the health" of the offender or any other individual. The

regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).

The exception permits disclosure only to medical personnel. This means that it cannot be used as the basis for a disclosure to the police or other nonmedical personnel, including family.

Whenever a disclosure is made to cope with a medical emergency, the program must document in the offender's records:

- The name and affiliation of the recipient of the information
- The name of the individual making the disclosure
- The date and time of the disclosure
- The nature of the emergency.

Court-Ordered Disclosures

A State or Federal court may issue an order that will permit a program to make a disclosure about an offender that would otherwise be forbidden. A court may issue one of these authorizing orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information[12] (§2.61).

Before a court can issue a court order authorizing a disclosure about an offender, the program and any offenders whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement to the court.13 Generally, the application and any court order must use fictitious (made-up) names for any known offender, and all court proceedings in connection with the application must remain confidential unless the offender requests otherwise (§§2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find good cause only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure will have on the patient, the doctor-patient or counselor-patient relationship, and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§2.64(d)). The judge may examine the records before making a decision (§2.64(c)).

If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a patient for a crime, the court must also find that:

- The crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury

- The records sought are likely to contain information of significance to the investigation or prosecution
- There is no other practical way to obtain the information
- The public interest in disclosure outweighs any actual or potential harm to the patient, the doctor-patient relationship, and the ability of the program to provide services to other patients.

When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel. (If the program is a governmental entity, it must be represented by counsel.) (§2.65(d).)

There are also limits on the scope of the disclosurethat a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the offender's confidentiality, including sealing court records from public scrutiny (§§2.64(e), 2.65(e)).

The court may order disclosure of "confidential communications" by an offender to the program only if the disclosure:

- Is necessary to protect against a threat to life or of serious bodily injury
- Is necessary to investigate or prosecute an extremely serious crime (including child abuse)
- Is in connection with a proceeding at which the offender has already presented evidence concerning confidential communications (for example, "I told my counselor...") (§2.63).

Research, Audit, or Evaluation

Research and evaluation of the efficacy of AOD treatment for offenders are essential if criminal justice agencies are to increase their interest in and use of AOD treatment as part of intermediate sanctions. But can AOD programs share patient-identifying information with researchers and program evaluators?

The confidentiality regulations permit programs to disclose patient-identifying information to researchers, auditors, and evaluators without patient consent, providing certain safeguards are met (§§2.52, 2.53).

Research

AOD programs can disclose patient-identifying information with persons conducting "scientific research" if the program director determines that the researcher 1) is qualified to conduct the research, 2) has a protocol under which patient-identifying information will be kept in accordance with the regulations' security provisions (see §2.16), and 3)

has provided a written statement from a group of three or more independent individuals who have reviewed the protocol and determined that it protects clients' rights.

Researchers are prohibited from identifying any individual client in any report or otherwise disclosing any client identities except back to the program.

Audit and Evaluation

Approved entities performing an audit or evaluation (for example, utilization or quality control review) may have access to client records on the program's premises. Approved entities include Federal, State, and local government agencies that fund or are authorized to regulate a program, private entities that fund or provide third-party payments to a program, and peer review entities. Any person or entity that reviews client records to perform an audit or conduct an evaluation must agree in writing that it will use the information only to carry out the audit or evaluation and that it will redisclose client information only 1) back to the program, 2) in accordance with a court order to investigate or prosecute the program (§2.66), or 3) to a government agency overseeing a Medicare or Medicaid audit or evaluation (§2.53(a), (c), (d)).

Approved entities may also copy or remove records but only if they agree in writing to maintain patient identifying-information in accordance with the regulations' security requirements (see §2.16), to destroy all patient-identifying information when the audit or evaluation is completed, and to redisclose client information only 1) back to the program, 2) in accordance with a court order to investigate or prosecute the program (§2.66), or 3) to a government agency overseeing a Medicare or Medicaid audit or evaluation (§2.53(b)).

Any other person or entity determined by the program director to be qualified to conduct an audit or evaluation, and who agrees in writing to abide by the restrictions on redisclosure, can also review client records. However, only approved entities can copy or remove records.

Followup Research

Research that follows clients for any period of time after they leave treatment presents a special challenge under the Federal regulations. The AOD program, researcher, or evaluator seeking to contact former clients to gain information about their status after leaving treatment has to do so without disclosing to others any information about the clients' connection to the AOD program.

If followup contact is to be attempted over the phone, the program or research entity has to be sure it is talking to the client before it reveals who it is or that there is a connection to AOD abuse treatment. For example, asking for Sally Jones when her husband or child answers the phone and announcing that the caller is from the XYZ AOD Program (or the Drug Research Corporation) violates the regulations. Another approach is for the program (or research agency) to form another entity, without a hint of AOD treatment in

its name (for example, Health Research, Inc.) that can contact clients without worrying about disclosing information via the contact. However, when persons from this entity call clients, they still have to be careful about what they say over the phone and be sure that they are speaking to the client before revealing any connection to AOD abuse treatment.

If followup is to be done by mail, the return address should not disclose any information that could lead someone seeing the envelope to conclude that the former client was in treatment.

Endnotes

[1.] This chapter was written for the consensus panel by Margaret K. Brooks, Esq.

[2.] Citations in the form "§2..." refer to specific sections of 42 C.F.R. Part 2.

[3.] The results of urine tests performed by AOD programs are protected by the Federal regulations. However, urine testing conducted by criminal justice authorities for the purposes of uncovering illegal drug use or monitoring offenders' compliance with rules against illegal drug use are not protected under the Federal regulations.

[4.] Only offenders who have "applied for or received" services from a program are protected. If an offender has not yet been assessed or counseled by a program and has not him- or herself sought help from the program, the program is free to discuss the offender's drug or alcohol problems with others. But, from the time the offender applies for services or the program first conducts an assessment or begins to counsel the offender, the Federal regulations govern.

[5.] If the offender is a minor, parental consent must also be obtained in some States.

[6.] Note, however, that no information that is obtained from a program (even if the client consents) may be used in a criminal investigation or prosecution of a client unless a court order has been issued under the special circumstances set forth in §2.65. 42 U.S.C. §§290dd-3(c), ee-3(c); 42 C.F.R. §2.12(a),(d).

[7.] Once the criminal justice system consent has expired, no further information can be disclosed, unless the offender signs another (noncriminal justice system) consent to release the information (or another of the regulations' exceptions applies). For a discussion of how an AOD assessment or treatment program operating as part of an intermediate sanction can obtain the AOD treatment records that were compiled by an AOD treatment program the offender previously attended, see below.

[8.] Suppose the offender had already been sentenced when he or she was assessed by Program A, but is being treated by Program B. Would §2.35(d) permit the probation department to release the assessment to Program B without a separate consent from the offender. It would, since the offender's criminal justice status would not have changed

and it would be doing so "to carry out [its] official duties with regard to ... [the criminal justice status] action in connection with which the consent was given."

[9.] When a client enters treatment because of involvement with the criminal justice system, program staff should maintain an open mind about whether communications with an employer would be beneficial to the client. A client who tells program staff that his or her employer will not be sympathetic about the decision to enter treatment may well have an accurate picture of the employer's attitude. Insistence by program staff on communicating with the employer may cost a client his or her job. If such communication takes place without the client's consent, the program may find itself facing an unpleasant lawsuit.

[10.] Moreover, the Federal AOD regulations make it clear that Federal law overrides any State law that conflicts with the regulations (§2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hasenie v. United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.

[11.] Note that the Federal statutes and regulations strictly prohibit any investigation or prosecution of a client based on information obtained from records unless the court order exception is used. 42 U.S.C. §§290 dd-3(c) and ee-3(c) and 42 C.F.R. §2.12(d)(1).

[12.] For an explanation about how to deal with subpoenas and search and arrest warrants, *see Confidentiality: A Guide to the Federal Laws and Regulation*s, published in 1991 by the Legal Action Center, 153 Waverly Place, New York, 10014.

[13.] However, if the information is being sought to investigate or prosecute a patient for a crime, only the program need be notified (§2.65). If the information is sought to investigate or prosecute the program, no prior notice at all is required (§2.66).

Appendix A -- Bibliography

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Appendix B -- Costing Issues

Calculating the cost of providing alcohol and other drug (AOD) abuse treatment services for offenders in intermediate sanctions programs is an important part of overall program planning and implementation. Data are necessary to determine the costs of various services, so that cost benefits may be analyzed and programs judged in an economic context.

Unfortunately, only a limited amount of data about costing were available in preparing this report, and the data showed a wide range of costs. Individual jurisdictions may find it beneficial to analyze in detail their own current costs in providing AOD abuse treatment services for criminal offenders, so that they can build a database that can be used for future decisionmaking about treatment options and planning treatment programming.

The data include costs for:

- Residential programs
- Outpatient programs
- Day reporting programs
- Detoxification
- Monitoring and drug testing (usually urinalysis).

In one large metropolitan area in the Midwest, residential services provided to 271 offenders over a 1-year period cost $1,400,149 or $5,167 per person. These ranged from $3,564 per person in a transition program to $7,302 per person in a halfway house.

In a second jurisdiction, a county in the Southwest, the estimated operating costs for community-based residential services for offenders were $55 to $95 per client per day, or an annual range of $20,075 to $34,675 per client. In this county, costs for residential detoxification were substantially higher, ranging from $115 to $130 per day.

Outpatient treatment programs cost considerably less. In the Midwestern metropolitan area, the cost for outpatient services for 61 clients totaled $31,602, or $518 per client annually. Day reporting programs cost $716,130 annually for 359 clients, or $1,995 per client. A community service program in this jurisdiction cost $66,667 for 186 clients, or $358 per client annually. In the county in the Southwest, outpatients costs were provided only for detoxification programs. These were $32 per day, at least one-third less than the cost of residential detoxification. However, even in the outpatient setting, detoxification services seem to be significantly more expensive than other types of outpatient services.

A study by Treatment Alternatives to Street Crime (TASC) in another large Midwestern city calculated a per diem client cost of $5.02 for outpatient services. For the purposes of comparison to the above statistics, this would total $1,832 per client per year, if services were provided every day of the year. TASC statistics were based on treatment of released offenders who were living in a facility similar to a halfway house and required

assessment and case management services. Clients had an average length of stay of 111 days. The cost analysis did not include the costs of urinalysis.

The TASC cost analysis computed that labor costs -- i.e., the cost of the salary of the case manager, plus supervisory costs -- accounted for 65 percent of the total cost of the direct services provided. The remaining 35 percent included direct program expenses such as staff travel, supplies, equipment rental and maintenance, telephone, postage, and facility rental. In addition, 25 percent of the direct service total was budgeted for indirect costs. Thus, based on an average annual case manager salary of $20,000, plus $5,400 for fringe benefits, costs were:

- Labor: $25,400
- Supervision: $2,540
- Nonlabor costs: $9,779
- Indirect costs: $9,430.

TASC based its per client, per diem costs on a 40-client caseload, and 235 days of service in 1 year.

TASC also calculated per diem per client costs in other cities around the country. The lowest cost, $5, found was in a large Northeastern city. In a Southern city the per diem per client cost was $5.50. It was $7.50 in a Southwestern city, and it ranged from $5 to $10 in a State in the Northwest.

Appendix C -- Cultural Competence

The definitional material below was adapted from *Towards a Culturally Competent System of Care,* by T.L. Cross, B.J. Bazron, K.W. Dennis, and M.R. Isaacs, 1989 (available from the Georgetown University Child Development Center, Washington, D.C.). The Cultural Competence Checklist is adapted from a questionnaire by Drs. George Simons and Bob Abramms entitled Managing the Dominant Culture, which appears in *The Questions of Diversity, 5th Edition,* copyright 1992, ODT, Inc., Amherst, Massachusetts (all rights reserved; reproduced with permission). It is available from ODT.

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to work effectively in cross-cultural situations. Cultural competence acknowledges and incorporates, at all levels, the importance of culture, the assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. It is born of commitment to provide quality services to all and a willingness to risk.

Continuum of Competence

Cultural destructiveness -- Attitudes, policies, and practices that are destructive to cultures and individuals within cultures. (Disenfranchisement, control, exploitation, destruction of cultural systems.)

Cultural incapacity -- The systems or agencies do not intentionally seek to be culturally destructive, but rather lack the capacity to help. (Discriminatory hiring, subtle messages regarding what values should be, lower expectations for minority clients.)

Cultural blindness -- Color or culture make no difference. All people are the same. Approaches are universal. Services are so ethnocentric as to be useless

to all but the most assimilated people of color. (Ignore cultural strengths, encourages assimilation, blames the victims, eligibility for services equals assimilation.)

Cultural precompetence -- Implies movement. Realizes weaknesses and makes attempts to improve. False sense of movement and accomplishment. One goal equals enough. Tokenism.

Cultural competence -- Acceptance, respect for differences. Attention to dynamics of differences. Continuous expansion of cultural knowledge. Groups are different with diverse subgroups. Seeks consultation from people of color. Hires those committed to their community. Provides support to staff to become comfortable working in cross-cultural situations. Understands interplay between policy and practice. Committed to policies that enhance diverse clientele and services.

Cultural proficiency -- Holds cultures in high esteem. Conducts research, develops new therapeutic approaches based on cultures. Publishes and distributes information. Hires staff who are specialists in culturally competent practice. Advocates for culturally competent practice. Advocates for cultural competence throughout the system and society.

Cultural Competence and Proficiency

- Attitudes are less ethnocentric and biased.
- Policies are more flexible and culturally impartial.
- Practices are more congruent with the culture of client from initial contact to assessment.
- The system:

  -Values diversity and respects its worth.
  -Culturally assesses itself.
  -Understands the dynamics of difference
  -Institutionalizes the value of both cultural competence and cultural proficiency.
  -Adapts to diversity.
  -Has a value base for both.
  -Incorporates valid research into the care process.

Cultural Competence Checklist

Check the items which are true of you.
Hint: The more true, the better! However, don't kid yourself about how well you see yourself perform in these areas. Get feedback from others as well as rating yourself.

When I belong to the dominant culture:

- I am aware that I am part of a dominant culture, and know how its dynamics work. I listen to people of other cultures when they tell me how my culture affects them.
- I have a philosophy of fairness and I let others in my culture know about my commitment.
- I realize that people of other cultures have fresh ideas and different perspectives to bring to my life and my organization.
- I work to make sure that members of other cultures are heard and are respected for their differences.
- I coach others on how to succeed in my culture. I tell them the unwritten rules and show them what they need to do in order to function better.
- I ensure that my subordinates and colleagues from other cultures are prepared for what they have to do to meet the demands of my culture.
- When I train or coach others, I do not put them down or undermine the value of their differences.
- I give others my personal support and loyalty even if they are rejected or

criticized by members of my culture.
- I am aware that outsiders to my culture recognize my cultural peculiarities better than I do and I go to them for information about the effect of things that I do and say.
- I recognize how stress causes individuals to revert to older and narrower beliefs and the desire to make onself and one's culture right and others wrong.
- I apologize when I have done something inappropriate that offends someone of a different background.
- When answerable to or reporting to someone of a different culture, I deal directly with that person and avoid the tendency to "go over his or her head" to a person of my own culture.
- I make others aware of unfair traditions, rules, and ways of behaving in my culture or organization that keep them out.
- I acknowledge people for what they have accomplished in terms that make them feel recognized in their own right, not just because they have been useful to me.
- I resist the temptation to make another group the scapegoat when something goes wrong.
- I give others honest yet sensitive feedback about how they perform on the job. I have learned to give feedback to people of other cultures in a way that is sensitive yet clear and useful.
- I distribute information, copies, results, etc., to whomever should get them regardless of cultural differences.
- I go out of my way to recruit, select, train, and promote people from outside the dominant culture. Despite the fact that I may naturally feel less comfortable with them, I see this as one of my responsibilities as a manager.

When I don't belong to the dominant culture:

- I realize that, because of my background, I have something distinctive to contribute to the place or organization in which I find myself.
- Even when rejected, I take pride in my culture. I take steps to build by self-esteem and the self-esteem of others who, like me, do not belong to the dominant culture.
- While I know that I do not have to lose my cultural distinctiveness to fit in, I realize that I may have to learn new information and skills that will enable me to succeed in the dominate culture.
- I look for and cultivate relationships with members of the dominant culture who help me "read between the lines" to understand the unwritten rules about "how the system works."
- When I succeed in the dominant culture, I am careful not to make myself an exception or separate myself from others of my background.
- I share what I learn about the dominant culture with others like myself.
- I recognize that when under pressure, I tend to revert to older and narrower beliefs and want to make myself and my culture right and others wrong.
- I sympathize and collaborate with other nondominant groups to achieve common objectives in the dominant culture.

- I resist the inclination to cluster *exclusively* with my own kind of people or *exclusively* with people from the dominant culture when I am in mixed company.
- I resist blaming the dominant group for everything that goes wrong.
- I know how to present distinctive features of my culture and its points of view in ways that others can hear and understand.
- I can respect individuals of other cultures and treat them fairly even though I may be fiercely committed to conflicting political goals.
- I know how to refresh myself from the wellsprings of my own culture when I am exhausted by trying to understand and work in the dominant culture.
- I resist the temptation to make another group the scapegoat when something goes wrong.

Appendix D -- Federal Resource Panel

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[Exhibits]

Exhibit 1-1: Forms of Intermediate Sanctions

- **Means-based fines (also called "day" fines).** The total amount of these fines is calibrated to both the severity of the crime and the discretionary income of the offender, with the calibration and calculation established by the court as a whole for all cases in which this type of fine is to be imposed. (This is in contrast to traditional fines that are imposed at the discretion of the judge according to ranges set by the legislature for particular offenses.) Defendants with more income (and/or fewer familial obligations) pay a higher overall fine than those with lower incomes (and/or more obligations) for the same crime. This approach to setting the fine amount is typically coupled with expanded payment options and tighter collection procedures.

- **Community service.** This is the performance by offenders of services or manual labor for government or private, nonprofit organizations for a set number of hours, with no payment. Community service can be arranged for individuals, case by case, or organized by corrections agencies as programs. For example, a group of offenders can serve as a work crew to clean highways or paint buildings.

- **Restitution.** Restitution is the payment by the offender of the costs of the victim's losses or injuries and/or damages to the victim. In some cases, payment is made to a general victim compensation fund; in others, especially where there is no identifiable victim, payment is made to the community as a whole (with the payment going to the municipal or State treasury).

- **Special needs probation programs or caseloads.** In these approaches to intermediate sanctions, officers with special training carry a restricted caseload. Typically, these approaches are used with offenders who have committed some categories of domestic violence, sex offenses, and driving under the influence, and with mentally ill, developmentally disabled, or substance-abusing offenders. Supervision in a specialized caseload may mean more intensive or more intrusive supervision than in routine caseloads, the provision of enhanced social and psychological services, and/or specific training or group activities, such as anger management classes or victim impact meetings.

- **Outpatient or residential AOD abuse treatment centers.** Both public and private treatment centers may be contracted to provide treatment to offenders, as described in this TIP.

- **Day centers or residential centers for other types of treatment or training.** These centers are established to provide services other than AOD abuse treatment. For example, a center may provide skills training to enhance offenders' employability.

- **Intensive supervision probation.** The level and types of supervision that are labelled intensive vary widely, but usually involve closer supervision and greater reporting requirements than regular probation for offenders. This can range from more than five contacts a week to fewer than four per month. It usually entails other obligations (to attend school, have a job, participate in treatment, or the like). *Intensive supervision parole* has similar requirements -- and variations -- but is provided usually by parole agents to offenders who have completed a prison term and who are serving the balance of their sentence in the community.

- **Day reporting centers.** Under the terms of this intermediate sanction, offenders must report to the center for a certain number of hours each day, and/or report by phone throughout the day from a job or treatment site, as a means of monitoring and incapacitating them.

- **Curfews or house arrest (with or without electronic monitoring).** Offenders are restricted to their homes for various durations of time, ranging from all the time to all times except for work or treatment hours, with a few hours for recreation. Frequently the curfew or house arrest is enforced by means of an electronic device worn by the offender which can alert corrections officials to his or her unauthorized absence from the house.

- **Halfway houses or work release centers.** Offenders in these centers can leave for work, school, or treatment, but are otherwise restricted to the facility. The facility can be in the community or attached to a jail or similar institution.

- **Boot camps.** Typically, a sentence to a boot camp (also called shock incarceration) is for a relatively short time (3 to 6 months). As the name implies, boot camps are characterized by intense regimentation, physical conditioning, manual labor, drill and ceremony, and military-style obedience. (Because boot camps are a form of incarceration, some in the criminal justice field reject their inclusion in the category of intermediate sanctions. Others include boot camps because placement in them is intended to take the place of a longer, traditional prison term.)

Exhibit 5-1: Components of an Agreement Between the Treatment Agency and the Criminal Justice Agency

A. A description of the range of intermediate sanctions that will be used and the level of treatment that will accompany the sanctions:
    1. Information about the duration of the various criminal justice sanctions and the duration of treatment;
    2. A description of the content of treatment: what the treatment will entail.
B. A description of information that will be shared by the treatment program and the criminal justice agencies:
    1. A specific description of circumstances (such as absconding) when it will be the treatment program's responsibility to notify the criminal justice agency;
    2. Definition of a regular period of reevaluation and identification of the system that will conduct and document the reevaluation.
C. Identification of which agency will supply ancillary services to the client group.
D. A description of responses to compliance with treatment and/or sanctions and identification of which agency will decide the consequences of each noncompliant behavior:
    1. A description of the consequences of noncompliant behavior such as:
        i. Unwillingness to commit to treatment and/or participate in the treatment program
        ii. Drug-positive results
        iii. Absconding
        iv. Other issues: violence, sex, etc.;
    2. Identification of the agency that will decide the consequences of each noncompliant behavior.

Exhibit 5-2: Items in the Client Agreement

- A description of the treatment program:
    - Duration of treatment
    - Intensity or level of treatment
    - -Components and stages of treatment.
- Categories and consequences of misconduct:
    - Rules of the treatment program and consequences of violating the rules
    - Consequences of AOD relapse
    - Consequences of absconding
    - Consequences of violations of probation or parole conditions.
- Information to be disclosed by the treatment program to the criminal justice system:
    - The types of information disclosed

  - When the disclosures are made
  - The client's signature permitting the disclosures as provided for by Federal confidentiality laws and regulations.
- Discharge criteria.

Exhibit 5-3: Positive Incentives for Treatment and Consequences of Negative Behavior

Positive Incentives:

- Exposure to models of success
- Small successes to counteract clients' experience of failure, including ceremonial acknowledgments of clients' accomplishments
- Favorable criminal justice outcomes: the promise of some reduction or modification in the duration or intensity of the overall sanction
- Positive program elements that respond to clients' specific needs, including referrals for ancillary services such as:
  - Housing
  - Vocational/educational training
  - Primary health care
  - Employment.

Consequences of Negative Behavior:

- Clear consequences for infractions
- Consistent enforcement of rules and application of consequences.

Exhibit 7-1: Consent for the Release of Confidential Information: Criminal Justice System Referral

I, _____, hereby consent to

Name of defendant)

communication between _____and

Treatment program)

_____

Court, probation, parole, and/or other referring agency)

the following information:
_____

Nature of the information, as limited as possible)

The purpose of and need for the disclosure is to inform the criminal justice agenc(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

_____

_____

I understand that this consent will remain in effect and cannot be revoked by me until:

_____There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

_____

Other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records and that recipients of this information may redisclose it only in connection with their official duties.

_____

Date(Signature of defendant/patient)

_____

Signature of parent, guardian, or

authorized representative if required)

Exhibit 7-2: Consent for the Release of Confidential Information

I, _____,
authorize

Name of patient)

_____

(Name or general designation of program making disclosure)

to disclose to _____

(Name of person or organization to which disclosure is to be made)

the following information:
_____

Nature of the information, as limited as possible)

_____

_____

The purpose of the disclosure authorized herein is to: _____

_____

(Purpose of disclosure, as specific as possible)

_____

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(Specification of the date, event, or condition upon which this consent expires)

Dated: _____

Signature of participant)

_____

Signature of parent, guardian, or

authorized representative when required

Exhibit 7-3: Prohibition on Redisclosing Information Concerning AOD Abuse Treatment Patients

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Exhibit 7-4: Qualified Service Organization Agreement

XYZ Service Center ("the Center") and the _____

_____

(Name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide the following services:

_____

(Nature of services to be provided)

_____

_____

Furthermore, the Center:

1.Acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the patients in the Program, it is fully bound by the provisions of the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and

2.Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the Federal confidentiality regulations, 42 CFR Part 2.

Executed this _____ day of _____, 199__.

_____
President
XYZ Service Center
(Address)

_____
Program Director
(Name of Program)
(Address)