DRUG ALCOHOL FINDINGS *Matrix cell*

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies
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Drug Treatment Matrix cell C5: Management/supervision: Safeguarding the community

One of 25 cells in the Drug Treatment Matrix

K Risk-need-responsivity model really does help (2011). Training probation officers in the risk-need-responsivity model intended to match interventions to the offender reduced recidivism among a sample of probationers among whom substance use was a common concern. For discussions click here and here and scroll down to highlighted headings.

K Motivational interviewing style clashes with criminal justice context (2001). Actual performance of US probation staff after motivational interviewing training contradicted promising written responses, and the officers were rated as less 'genuine' than before – possibly because the work context limited how far they could genuinely stay true to motivational principles. Related discussion in cell B5's bite.

K Leadership affects adoption of evidence-based practices (2008; free source at time of writing). Leadership qualities including knowledge and experience and commitment to a rehabilitation focus predicted good substance use treatment practice in US criminal justice services.

K Practical way to triage offenders to appropriate sentencing/treatment (2011). US study confirmed risks of re-offending and needs related to offending (in particular for addiction treatment) are independent dimensions which can be assessed to guide sentencing and treatment in ways which reduce reoffending. For discussion click and scroll down to highlighted heading.

K Adjust drug court sentencing/treatment to offender progress (2012). Among an impressive series of studies of US drug courts, where specialist judges negotiate the offender's treatment and supervision and regularly monitor progress. During the programme illegal drug use was reduced by triaging offenders to more or less intensive treatment/supervision and then adapting based on their response. Longer term findings (2014; free source at time of writing) on crime remained in favour of the adaptive programme, but none of the differences were statistically significant. For discussion click and scroll down to highlighted heading.

R Drug courts have the edge on usual adjudication (2012). In drug courts the judge or magistrate negotiates treatment and supervision for the offender and plays an active part in both. The most thorough and extensive review to date tentatively concludes they reduce crime compared to usual adversarial proceedings. For related discussion click and scroll down to highlighted heading.

R Female offenders particularly need holistic treatment (2008). Argues that treatment for female offenders should take into account the high prevalence of post-traumatic stress and other mental and physical health problems, and the importance of relationships and of their roles as mothers. Concludes that women respond best to holistic, integrated programmes which incorporate empowerment and peer mentoring and adopt a collaborative rather than an authoritarian approach.

R Substance use practitioners can be helped to incorporate child protection (2007). After reviewing international research, British experts on the family dimensions of substance use problems questioned the commonly reported perception of drug treatment workers that child welfare is beyond their skills and professional comfort zones. For discussion click and scroll down to highlighted heading.

R G Specific recommendations on training for treatment in a criminal justice context (Australian Government, 2005). Uniquely focuses on training staff to treat substance use problems in a criminal justice context, formulating guidance on training and its management based on a review of research specific to this context and more generic literature and principles. For discussion click and scroll down to highlighted heading.

R G Creating and maintaining 'family sensitive' treatment services ([Australian] National Centre for Education and Training on Addiction, 2010). Reviews generic and substance use-specific research as a basis for guidance on workforce development policies and practices to help ensure treatment services safeguard their clients' children. For related

discussion click and scroll down to highlighted heading.

G UK clinical guidelines stress continuity of treatment for prisoners ([UK] Department of Health, 2017). Comprehensive, practice-oriented official clinical guidelines. Chapter on treatment in criminal justice systems advises against forced withdrawal from opiate-type drugs and stresses seamless transfer to treatment on release and provision of naloxone to prevent opioid overdose deaths.

G US consensus on substance use treatment in the criminal justice system ([US] Substance Abuse and Mental Health Services Administration, 2005). Consensus guidance endorsed by US experts; includes treatment interventions, matching these to the offender, and planning programmes.

G Incorporating child protection in substance use services ([UK] Advisory Council on the Misuse of Drugs, 2003). Results of an inquiry in to the welfare of and responses to children in the UK seriously affected by parental drug use. Includes (starting p. 82) guidance on incorporating child protection measures in the work of drug and alcohol services. Update published in 2006. For discussion click and scroll down to highlighted heading.

G Scottish guidance on protecting families and children advocates whole-family recovery (Scottish Government, 2013). Guidance specific to substance use intended for all child and adult services, including drug and alcohol services. What new patients should be asked about children and the role substance use services should play in a system which (*Getting our Priorities Right* is the title) prioritises child welfare. For discussion click and scroll down to highlighted heading.

G Key capabilities for treatment staff to work with male perpetrators of domestic violence (2015). Published by King's College, London, and developed from UK research. Helps substance use treatment services define and clarify key staff capabilities (knowledge, attitude and values, ethical practice, skills and reflection and professional development) for working with male substance users who are violent to intimate partners. See also generic NICE quality standards ([UK] National Institute for Health and Care Excellence, 2016) for health and social care services on assessing and responding to domestic abuse.

G Good practice in responding to domestic and sexual violence involving substance use (2013). UK guidelines based on a three-year government-funded project to improve responses to victims and perpetrators of domestic and sexual violence associated with substance use and/or mental health problems. Includes minimum standards of practice and guidance on policies and procedures. See also generic NICE quality standards ([UK] National Institute for Health and Care Excellence, 2016) for health and social care services on assessing and responding to domestic abuse.

G Australian guidance on addressing family and domestic violence in addiction treatment ([Australian] National Centre for Education and Training on Addiction, 2013). Among other functions, intended to guide managers in organising policies, procedures and staff training and development to identify and address family or domestic violence among substance use patients.

G US guidance in substance use treatment and domestic violence ([US] Substance Abuse and Mental Health Services Administration, 1997). US consensus guidance on how treatment services can identify and work with both perpetrators and victims.

G UN guide to starting and managing needle and syringe programmes in prison (United Nations Office on Drugs and Crime, 2014). Companion to WHO's generic guide (World Health Organization [etc], 2007) to managing needle exchanges.

MORE Search for all relevant analyses or for subtopics go to the subject search page and hot topics on child protection and helping the families of substance users.

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What is this cell about? Therapy (cell A5) and therapists (cell B5) matter of course, but how well they can work depend on the management functions of selecting, training and supervising staff, and managing the intervention programme. In highly controlled studies, it may be possible to divorce the impact of interventions from the management of the service delivering them; in everyday practice, whether interventions get adopted and adequately implemented, and whether staff are able to develop and maintain appropriate attitudes and knowledge, depend on management and supervision.

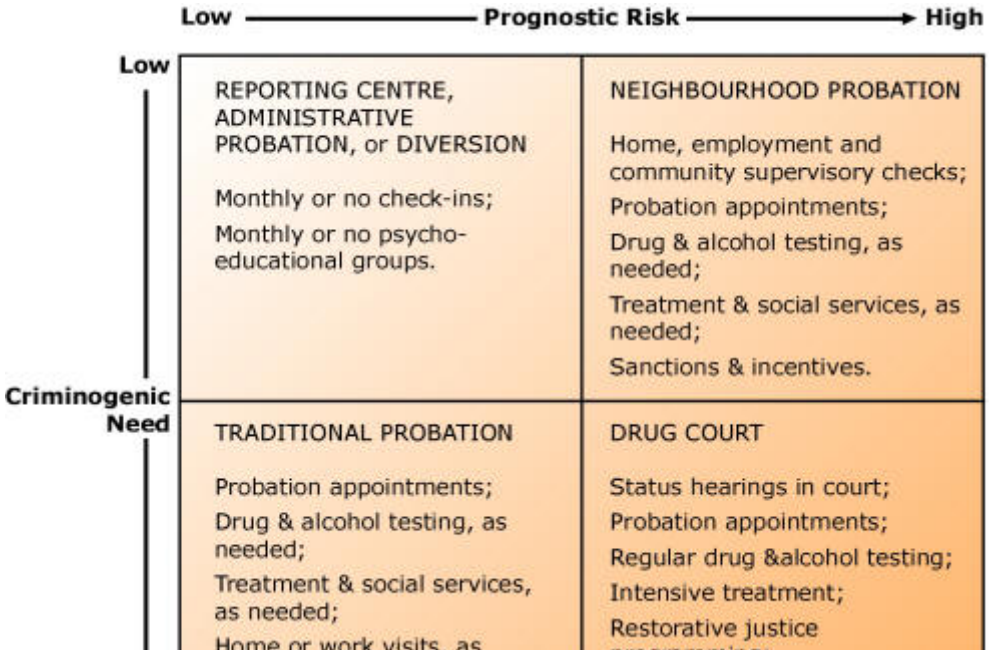
This cell is about the role played by these functions in substance use treatment instigated by criminal justice and other authorities not because it has been sought by the patient, but primarily in order reduce crime or otherwise benefit the community – not least, their partners and children. Even when not targeted at community benefit, these benefits may nevertheless emerge, so this cell may also include studies which document the community and family impacts of treatment in general.

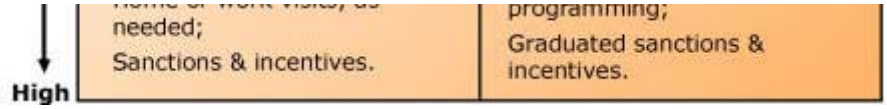
Where should I start? It is rare to find reviews focused on workforce development in such a narrow sector as substance use treatment in criminal justice contexts, but the Australian state of Victoria commissioned just such a review to inform its training programme. Published jointly with the Australian government, it benefits from an unusually well resourced national focus on workforce development in substance use treatment. Among other things, it thoughtfully explores the role of management, training and supervision in the melding of disparate objectives and philosophies. On the basis of the review, the same document also offers management guidance.

Among its messages on training are that: it must focus on offending as well as substance use; along with educational programmes, it can underpin collaboration between criminal justice and treatment systems despite their "very different operating principles, values and procedures"; managers and supervisors play a key role in ensuring the sustainability of skills learnt in training; and staff competence is critical to implementing rehabilitation in the forensic setting – an argument also made by a report on the first trial of training probation officers in the 'risk-need-responsivity' model, of which more below.

Highlighted study In an impressive series of studies, US researcher Douglas Marlowe persistently and systematically sought ways to manage criminal justice drug treatment and supervision to match the characteristics of the offender. The objective is to avoid costly, onerous and sometimes counterproductive over-intervention, while safeguarding the community from crime by ensuring that offenders likely to respond well only to intensive programmes get them.

This cell features two of his studies. The first (listed above) tested a system for triaging drug using offenders to different intensities of supervision and treatment based on characteristics associated with recidivism and poorer outcomes in standard programmes. The system allocated offenders to a quadrant of a 2x2 table depending on their





'criminogenic need' (assessed by factors including substance dependence, serious mental illness, and chronic drug-related ill-health) and their 'prognostic risk' (assessed by factors including age, onset of substance misuse and delinquency, criminal and treatment histories, antisocial associates, and employment and living stability) ▸ figure.

One trial and sentencing option was allocation to a drug court. Specialising in drug using offenders, how these courts work is described more fully in our analysis of a review listed above and in cell B5's bite. Distinctive features are that the judge or magistrate negotiates treatment and supervision regimens for the offender instead of a more severe punishment, and plays an active part in both through regular face-to-face reviews of how the offender is doing, during which discussion, negotiation, praise and encouragement replace adversarial proceedings.

The intention was to reserve the intense supervision and treatment of the drug court for high-risk and high-need offenders. At the opposite poles, low-risk and low-need offenders would be subject to minimal monitoring and intervention requirements. In between were offenders at high risk but low need, for whom intensive probation supervision was indicated, and those with high needs but a low risk of failing usual sentencing options, who were to be assigned to traditional probation.

Hampered in particular by restricted access to more intensive supervision, offenders often could not be allocated as intended, providing an opportunity to assess the impact of the intended disposal. The key finding was that high risk/need property offenders of the kind drug policy has focused on in Britain were less likely (41% v. 56%) to be re-arrested when (as intended) assigned to a drug court rather than to usual probation, a finding replicated in respect of convictions. It contributed to the overall finding that offenders assigned their matched options were non-significantly less likely to be re-arrested (35%) than those assigned to a less intensive alternative (41%), though this finding was not statistically significant.

The second of Professor Marlowe's studies (listed above) focused on how to deal with defendants assigned to drug courts. His earlier work (1 2) had established that high-risk offenders were more likely to test free of drugs and to complete their court orders when assigned to fortnightly rather than less frequent, 'as needed' reviews. The study built on this foundation, testing whether as well as matching the initial programme to the offender, it also helped later to adjust it (based on criteria derived from research) according to how well they had actually responded. Our analysis explains the system used and its impact – most notably, that during their roughly four-month court orders offenders whose supervision and treatment were systematically adapted to their progress were over twice as likely as other drug court probationers to test negative for illegal drugs. Crime-reduction impacts were also apparent over the 18 months after adjudication, but not to a statistically significant degree, suggesting a need for continuing reinforcement.

> *The trial was a rare example of a study building on predecessors to step-by-step improve outcomes*

The trial was a relatively rare example of a study building on its predecessors to step-by-step improve outcomes, in this case for offenders and for the community, a series culminating in a coherent, easy-to-understand system which could widely be implemented – if the programmes it indicated offenders needed were funded and available.

Issues to consider and discuss

▸ **Is cognitive-behavioural the way to go?** Published in 2005, our starting point review was upbeat about the interventions available for managers and trainers to build on, declaring that "Recent evaluations … reflect a promising deviation from previous perceptions of 'nothing works' to an era of

practice that is driven by rigorous program evaluation and evidence-based service delivery". Adhering to the 'risk-need-responsivity' model for matching intervention to offender (of which more below) and stressing cognitive-behavioural approaches, the authors might have been even more optimistic had they seen the findings of the later Canadian study listed above.

That study was concerned with training probation officers to implement supervision based on the risk-need-responsivity model and cognitive-behavioural counselling – an influential family of approaches which aim to teach new, relapse-preventing ways of acting and thinking. Typically the focus is on coping with the triggers, situations or emotional states likely to precipitate relapse. Rather than a set programme, the training was about principles and techniques. There seems less cause for optimism when those principles and techniques are packaged into 'programmes'. The major British study to date found that the main cognitive-behavioural programme (ASRO) for problem substance users on probation could not be shown to have reduced reconviction rates, and convincing evidence for any such programmes is generally lacking. The story is the same in relation to programmes for drink-related offending, leading us in the Alcohol Treatment Matrix to ask, "Why is the record so poor?" – in particular for cognitive-behavioural programmes.

> *There seems less cause for optimism when those principles and techniques are packaged into 'programmes'*

For substance use treatment in general, research findings do not warrant 'nothing works' pessimism about psychosocial approaches, but do suggest that 'nothing works better' than any other similarly extensive and coherent approach, including cognitive-behavioural programmes. Rather than the specific programme, the key thing may be that training in *any* convincing new approach instils optimism, can re-moralise a jaded workforce, and offers a coherent treatment rationale they can communicate to the offender – the 'common factors' discussed in cell A4's bite. Training in these approaches also offers trainees specific activities and objectives via which offender and therapist can collaborate, communicate and develop their relationship – and that has been thought critical since at least Carl Rogers' seminal work, highlighted in cell B4.

What is the essential performance-promoting core of training? Transmission of specific understandings and skills, or are these mainly a vehicle for bolstering non-specific common factors? Can the latter be done without the former? Why the stress on cognitive-behavioural approaches, when these have not yet been proven to be the most effective way to treat substance use problems among offenders?

▸**How can you prioritise the child when your patient is the parent?** Cell B5 argued that of all the 'tricky' situations treatment practitioners face, "Perhaps trickiest of all is therapy of parents whose substance use and other behaviours might seriously threaten their children's welfare." The temptation is to sideline this uncomfortable but crucial work, placing the onus on drug service managers to counter this through training, support, monitoring and supervision. To managers devolves the task of putting into day-to-day practice the insistence in guidance that child welfare is paramount, despite the fact that their service's client/patient is not the child, but their parent. *Getting our Priorities Right* was how the title of Scottish guidance formulated the task, and that means envisioning and organising the service as one prong of a multi-agency approach focused not on the parent-patient, but on the family. According to the guidance, it starts (p. 25) with incorporating family-focused questions in the assessment of new patients, and continues with an alertness to how changes in their drug use and treatment (such as being detoxified or being prescribed methadone) might affect associated children.

So alien was this to the substance use services of the time that in their 2003 *Hidden Harm* report, UK government drug policy advisers envisaged (p. 83) only a modest direct role for drug services in the "medium to longer term". Even that, they foresaw, "will not be easy [and] will have major resource, staffing and training implications". How far Britain had to go had been revealed by a survey of drug agencies which found "only a handful" made deliberate attempts to assess and meet the needs of their clients' children. Three years later things had improved, but in respect of joint working around drug using parents or their children, only for around 45% of the services which responded to a further survey.

Why it is so difficult to truly forefront children's needs – and the risky gaps that open up without energetic management – was explored by a study in Finland, whose findings will resonate with many in the UK. "Dedication solely to helping the substance abuser" led to a myopia about their children in the beliefs and practices of clinical staff. Not sufficiently countered by organisational policies and management, the natural tendency to focus on the face-to-face client meant few questions were asked about children, and then sometimes only as background information on the focal client.

After reviewing international research, in a freely available article listed above British experts on the family dimensions of substance use problems questioned the commonly reported perception of drug treatment workers that addressing child welfare is beyond their skills and professional comfort zones. Though acknowledging differences, their view was that whether focusing on the drug user or on their children, "the same basic skills of forming a therapeutic relationship and counselling" are required.

Substance use problems do not have to be overcome in order to help the child

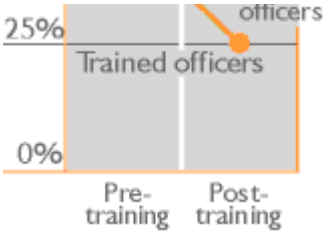
Reading this review will take you a long way towards appreciating what those skills are, and what supplemental skills and knowledge are needed to better protect children. Once you have read it, take the stance of a manager with substance use-related targets and expectations and staff who joined a substance use service to tackle addiction. Arguably the key message in the review is that substance use problems do not have to be overcome in order to help the child. Instead the focus should be on family disharmony and abuse, parental conflict, separation and loss, and inconsistent, neglectful and ambivalent parenting: "The key points here are that as practitioners we can intervene to help these children; and that the focus does not have to be on the parental substance misuse problem, but on promoting necessary beneficial factors in children's lives." How far can you go down this road, would it detract from substance-focused work, or would your service risk condemnation and perhaps even closure if you failed to protect children? What would the review's perspectives mean for staff recruitment and training? Were the UK government's drug policy advisers right when they warned that taking on board child protection "will not be easy [and] will have major resource, staffing and training implications"?

▸ Is 'risk-need-responsivity' the key to matching interventions to offenders? Despite the prominence of the 'risk-need-responsivity' model (▸ panel) in criminal justice treatment interventions, training offender supervisors to implement this model has rarely been evaluated. Canada hosted the first trial (listed above). It evaluated the training of probation officers to match intensity of services to risk of reoffending, to target the factors which underlie criminal behaviour, and to match intervention style and content to the offender using risk-need-responsivity principles. The offender sample was not exclusively problem drinkers or drug users, but generally their substance use seemed a major issue in their offending. Both the model the officers were trained in, and the training itself, stressed targeting problematic attitudes and thoughts using cognitive-behavioural principles, but without formalising these into a manualised programme. This randomised trial showed such training can not only improve officers' skills and sharpen their practice, but also reduce the recidivism of the offenders ▸ chart.

The risk-need-responsivity model

The 'risk-need-responsivity' model has been highly influential in guiding treatment interventions with offenders. Its three core principles are:
Risk Providing intensive services to clients at higher risk of reoffending and minimal services to lower risk clients.
Need Target criminogenic needs or the dynamic risk factors which underlie or drive criminal behaviour such as pro-criminal attitudes and substance use.
Responsivity Match the style and mode of intervention to the abilities, motivation, and learning style of the offender.

Note from our analysis that the training seems to have embodied effective interactive methods. Perhaps crucially, these included feedback on actual performance and continued post-training support 'pushed' to the officers



rather than left for them to access (or not) on their own. However, a study of this kind can only make a stab at identifying the active ingredients stimulated by the training which led to the recidivism reductions. Analysis of recordings of supervision sessions suggested that the sole factor which accounted for these reductions was the use of cognitive techniques to alter pro-criminal attitudes – a suggestion difficult to substantiate, as use of these techniques were bound up with the training and with how well the probation officers had responded to this training.

Why this study was so important can be appreciated by turning to cell B5, where we learn that adjustments to the number and frequency of supervision contacts and caseload size (considered proxies for the officer's ability to exert control over the offender) have generally made no difference to reoffending. Instead, the *quality* of the work undertaken between supervisor and offender seems the active ingredient. The study's importance is that it seems to have found a way to improve quality and in turn reduce offending. But before you accept these implications, carefully read through our commentary on the study, and ask yourself if you can rely on its findings to guide the training of offender supervisors and how they conduct their supervision.

Thanks for their comments on this entry in draft to Douglas Marlowe of the US National Association of Drug Court Professionals. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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