DRUG & ALCOHOL FINDINGS *Matrix cell*

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Drug Treatment Matrix cell D5

# Organisational functioning; Safeguarding the community

Key research on the influence of the treatment organisation on the effectiveness of drug treatment in the criminal justice system and allied settings. Asks whether the criminal justice context enhances or limits treatment (perhaps both), whether quality is better in smaller services, and whether treatment services should see themselves as family services.

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S Seminal studies K Key studies R Reviews G Guidance MORE Search for more studies

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K Inter-service networking by smaller agencies associated with evidence-based treatment (2008; free source at time of writing). Rather than large, well resourced corporations, among treatment agencies working with US criminal justice services, it was smaller organisations which networked with other organisations which were more closely associated with the adoption of evidence-based substance use treatment practices. For discussion click and scroll down to highlighted heading.

K Motivational interviewing style clashes with criminal justice context (2001). Actual performance of US probation staff after motivational interviewing training contradicted more promising written responses, and the officers were rated as less 'genuine' than before – a probable example of organisational context limiting how far a practitioner could genuinely stay true to motivational principles. Same study described in an Effectiveness Bank essay. For discussion click and scroll down to highlighted heading.

K Offenders do better in treatment if sanctions are credible and clear (2004). Offenders in New York ordered to the same residential therapeutic communities stayed longer and later committed fewer crimes if sent by criminal justice programmes which had credible sanctions and ensured offenders understand these and knew they were being monitored. For related discussion click and scroll down to highlighted heading.

K Success factors for court-supervised treatment (2011; free source at time of writing). Distilled success-promoting characteristics from interviews with stakeholders in Californian districts with high-performing (crime reduction and programme completion) court-supervised drug treatment systems. "In effect, the policies and practices that were developed were not designed to 'make' participants change but instead ... at cultivating the desire to want to change. In addition, the supportive role played by key stakeholders was perceived as ... crucial." For related discussion click and scroll down to highlighted heading.

K Offenders respond to therapeutic community environment (2008; free source at time of writing). Initial impressions of a supportive and safe residential therapeutic community predict how long residents will stay and their later substance use. Implication is that organisational changes which foster these impressions might improve outcomes.

R Supervising offenders is about the quality of the relationship (2002). Download is the whole issue of the journal; the featured article starts on page 16, numbered 14. Question addressed (page numbered 23) is how criminal justice agencies responsible for supervising offenders can overcome the "social worker vs. law enforcement" conflict to transform themselves into agents not just for monitoring offenders, but bringing about positive changes in their behaviour. Associated supervision manual below. For discussion click and scroll down to highlighted heading.

R Integrating substance use treatment and criminal justice supervision (2003; free source at time of writing). Analyses research to find the common organisational features of effective programmes.

R Drug courts have the edge on usual adjudication (2012). Drug courts seek to transform the court from an adversarial arena focused on punishment to a collaborative one focused on treatment to help the offender overcome crime-generating substance use problems. Tentatively concludes that the courts reduce crime more effectively than usual proceedings.

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 Do criminal justice settings undermine motivational interviewing? (2006). Asks whether the contradictions of at the same time helping and punishing, controlling and being client-centred ("motivational arm-twisting"), undermine motivational interviewing's ethos and effectiveness. For discussion click and scroll down to highlighted heading.

R G How treatment services can become 'family sensitive' ([Australian] National Centre for Education and Training on Addiction, 2010). Reviews generic and substance use-specific research as a basis for guidance on organisational cultures and workforce development practices to help ensure drug treatment services safeguard children. Quotes associated report (Australian National Council on Drugs, 2014) on policy and child protection systems in Australia related to implementing child and family sensitive practice in substance use services. For discussion click and scroll down to highlighted heading.

R G Prison context poses special challenges for treatment (1999). Eminent US researchers pool their research knowledge and experience to identify and propose solutions to six common barriers to developing effective treatment programmes in prison. For discussion click and scroll down to highlighted heading.

G Incorporating child protection in UK 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 related discussion click and scroll down to highlighted heading.

G Whole-family recovery advocated in Scotland (Scottish Government, 2013). Guidance specific to substance use intended for all child and adult services, including drug and alcohol services. Challenges substance use services to play their part (Ge*tti*ng our Priori*ti*es Right is the title) in prioritising child welfare. For related discussion click and scroll down to highlighted heading.

G Manual for research-based offender supervision (2005). What research-based 'tools of the trade' (in the words of the title) does a criminal justice supervision agency need to transform it into a force for positive/therapeutic change in substance using and other offenders. Associated review above from the same author.

G US consensus on treatment in the criminal justice system ([US] Substance Abuse and Mental Health Services Administration, 2005). Guidance endorsed by US experts includes the kinds of services feasible and desirable in the criminal justice/prison context.

G Addressing family and domestic violence problems in alcohol and other drug treatment ([Australian] National Centre for Education and Training on Addiction, 2012). Includes ("Part C: What can alcohol & other drug services do?") principles to follow and actions to take to respond to the high levels of domestic violence associated with problem substance use, with recommendations for organisations from generic front-line services to those specialising in substance use treatment. Written for the Australian context but will be more widely applicable. For related discussion click and scroll down to highlighted heading.

MORE Retrieve all relevant Effectiveness Bank analyses or search more specifically at the more effective than others and on child protection.

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Last revised 13 September 2018. First uploaded 08 June 2013

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## What is this cell about?

As well as concrete things like staff, management committees, resources, and an institutional structure, organisations have histories, values, priorities, an ethos, and links with other organisations. Together these features affect whether they offer an environment in which staff and patients/clients can maximise their potential. Among the mechanisms expected to link organisational features to performance is how keenly and effectively agencies seek and incorporate evidence-based practices. Lying at the intersection between column D on organisational-level influences and row 5 on safeguarding the community, this cell is specifically about the role organisational features play in treatment organised and/or funded by criminal justice and other authorities which offer or impose treatment – not because it has been sought by the patient – but because it could reduce crime or otherwise benefit the community.

Compared to research on interventions, organisational-level research is scarce and rarely of the gold-standard, randomised controlled trial format. Instead, researchers usually look for patterns in what naturally happens rather than changing what happens in order to test the consequences. Those patterns may be due the presumed cause and effect mechanisms, but may instead be due to other influences which the analysis cannot take into account and is unable to equalise between the focal intervention and the comparator against which it is benchmarked. Randomisation is intended to ensure any such influences are equalised, preventing both known and unknown influences obscuring the effect of the intervention. In the absence of randomisation or an equivalent procedure, these influences remain in play, making it difficult to draw conclusions from the findings of a study.

From the relatively few studies listed in this cell, you will see that organisational research is particularly lacking on treatment intended to safeguard the community. In the expectation that organisational influences in these settings may not differ too much from those elsewhere, we can also refer you back to cells dealing with these influences in harm reduction, generically across treatment, in medical treatments, and in psychosocial therapies.

## Issues to consider and discuss

▸ **Does the criminal justice context limit treatment?** In theory the great advantage of treatment ordered and supervised by the criminal justice system is that it can (analysis listed above) 'hold' patients in treatment and get them to comply with the programme sufficiently to gain benefits, preventing the early drop-out and patchy attendance which undermine work with 'voluntary' clients. In so far as this can be assessed, formally coerced versus other routes into treatment have been found (free source at time of writing) equally effective. But what does the coercion which keeps patients in treatment do to the quality of the contacts it enforces, and does the criminal justice context cramp treatment's therapeutic scope?

In respect of practitioner skills and relationship style, in cell B5 we appreciated the extra challenges involved in maintaining a therapeutic, client-centred stance in a criminal justice context, yet also the importance of doing so. As a US expert put it in a review listed above, "agencies have tried to achieve two purposes – enforcer and social worker – and have found the polar nature of the two tasks often conflicting". This same conflict was highlighted by the title (Motivational arm twisting: contradiction in terms?) of a review by Drug and Alcohol Findings listed above of motivational interviewing for clients coerced into treatment. It concluded that "the approach can work – given that substance use is an appropriate focus, that the patients have the resources to make positive changes, the therapist can remain true to motivational principles, and the patients feel safe to open up to their therapist". In a criminal justice context, elements are often missing from this constellation, especially the ability for treatment staff genuinely to adopt a client-centred stance. Inevitably, the business of treatment and of relationship-forging differ when the 'client' is not there because they want to be, when for them you may represent an oppressive authority, and when in reality you and/or your employers do have a control as well as a therapeutic role.

The consequence of this clash between organisational context and therapeutic principles seemed apparent in a study listed above of the performance of US probation staff trained in motivational interviewing. Under the heading, "It just isn't natural," its implications were explored in a Findings essay. They emerged from an evaluation of a two-day motivational interviewing workshop for probation staff in Oregon, who gave glowing accounts of improvements in their understanding of and proficiency in

motivational interviewing, views they sustained over the subsequent four months, and which had been corroborated by a post-workshop pen-and-paper assessment.

> *After motivational interviewing training probation officers seemed less 'genuine' than before*

The disappointment came when these assessments were checked against ratings of audiotapes of how the therapists actually behaved at three stages: before the workshop with an offender-client; at the end with someone acting as a client; and with a real offender-client four months later. When the raters were assessing overall adherence to motivational principles rather than specific techniques, though there were improvements, these were modest and left trainees far short of expert practice standards, largely because they were unable to suppress their previous interactional styles. On one dimension which attempted to reflect how "genuine" the probation officers were, things had even got worse. Four months later, even the post-workshop boost in the use of specific techniques had eroded. Clinching this negative picture was the fact that, compared to pre-workshop tapes, their clients had also not improved in terms of evidencing greater commitment to change versus resistance during the sessions.

How can we interpret these findings? It seems likely that the natural way a probation officer relates to offenders is far removed from motivational interviewing, and reversion to type was the dominant trend. In the end, training officers to go against this grain made little progress, and meant that after the workshops they seemed less genuine in their interactions with clients than before. Told about this finding, the trainees explained that "they had simply felt less comfortable and natural in trying out this new clinical style". It is easy to imagine that within the explicitly unequal and coercive context of the criminal justice system, adopting motivational interviewing's 'It's up to you' stance might feel false to probation officers, and also to observers and the offenders being counselled. To the extent that this happens, one of the 'common factors' seen as underpinning successful therapy will be missing from the encounter.

Such difficulties were expertly described and evaluated (review listed above) by leading US researchers, who pooled their knowledge and experience to explain why real-world programmes sometimes fail to live up to expectations derived from more 'ideal-world' trials. Though focused on prison, much is relevant also to community sentences. Give yourself just the ten minutes or so it will take to read the Effectiveness Bank's account of the review, and as you do, consider whether these barriers and proposed solutions apply to the British context, whether the barriers truly are the main ones facing treatment in criminal justice settings, and whether the proposed solutions are workable and optimal.

▸ Is small beautiful? In 2014 Sara McGrail, a well-informed commentator on substance use treatment systems in England, had described (see article starting page 14 of the linked PDF) the transformation of a patchwork of local services into national conglomerates, as retendering exercises driven by austerity-era cost-cutting forced smaller 'Third Sector' charitable and/or independent agencies to merge with larger ones or face extinction. From the point of view of a leader of one such conglomerate whose service were well represented in the criminal justice sector, in 2013 the picture had looked similar: "This drive to grow, to get bigger and to demonstrate significant increases in year-on-year turnover is a very evident driving force in the decisions that Third Sector leaders make ... success in the substance abuse treatment marketplace has usually been defined principally in terms of growth." Ironically, his service was later to be swallowed up by and further expand a yet larger conglomerate: click to unfold the story.

> *This drive to grow is a driving force in the decisions Third Sector leaders make*

> Supplementary text. Click to close
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> The writer was Ian Wardle, the chief executive of the Lifeline Project, which itself had been rapidly expanding from its Manchester base to run services "spread across Yorkshire, the North East, the North West, London and the Midlands, working within diverse towns, cities and villages", with a workforce of 1473 staff and over 1000 volunteers. Large and well established as they were, in 2017 Lifeline itself was forced to close and its services further expanded the portfolio of what was already the largest 'Third Sector' drug and alcohol treatment provider in the UK, Change Grow Live, at the time reported to have an annual income of £158 million and employing 2800 people. Whatever the other reasons for Lifeline's collapse, the financial squeeze which has driven other mergers was apparent to the administrators appointed to manage the closure: "with further cuts to public expenditure budgets and some poorly funded projects, Lifeline had seen turnover drop and made a significant loss from its trading activities".
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> Close supplementary text

For Sara McGrail, this agglomeration process "reduces innovation, increases costs and limits choice for commissioners and service users". That it might also detract from the adoption of evidence-based practices was the message of a US study listed above of services working at the junction of substance use treatment and the criminal justice system. Researchers expected large, well-resourced organisations to be among those leading the quality field. Instead, indicators of resourcing and size were negatively related to evidence-based practices and other indicators of high quality treatment provision; smaller was, it seemed, better. Instead of greater size, by far the factor most closely related to quality was the degree to which services networked and carried out joint activities with other services, especially other treatment services. Also related were training opportunities and the degree to which management prioritised quality. Intriguingly, the results suggest that the most fertile ground for quality-improving innovation at the substance use/criminal justice interface is an active network of not very large treatment providers and criminal justice agencies. How did this surprising implication come about?

First, we should acknowledge that this study shares the limitations noted above; the links it found may not have arisen from any causal connection between evidence-based practice and smaller size and greater networking, but from other processes. Nevertheless, taking the implications for the moment at face value prompts questions worth pursuing. Perhaps large service-provider conglomerates tend to be worlds unto themselves, with their own central workforce development and information hubs, their own data-collection and evaluation procedures, and their own ways of working replicated across constituent sub-services – the cost-saving structure which may have enabled them to grow by out-competing smaller providers. Smaller organisations may in contrast be more mission-driven – perhaps newly emerging from the problems they are addressing – and need to look outside themselves for support and ideas. If they find or forge an active network, they rub up against other independent services with different ways of doing things; opportunities for learning and anti-stagnation experiences are maximised.

Here we have taken a considerable leap from the small and shaky platform provided by the study to describe a scenario compatible with, but by no means proven by, its findings. Does this scenario make sense to you, and even if it does, might any plusses of smaller organisations be counteracted by the resources larger organisations can dedicate to management, research, training and supervision?

▸ Should treatment services become family services? At the level of the clinician and service manager, this issue was explored in cell C5, where we noted that the temptation is to see the substance user as your sole legitimate focus and to sideline the uncomfortable but important obligation to protect the children in their lives. In contrast, national policies in the UK and elsewhere insist that when children are in the picture, their needs are primary. Here we briefly revisit the same issue, but at the level of the treatment organisation, which has a responsibility to be clear to its managers and staff about its priorities and responsibilities and who it is there to benefit. Since these issues are taken here as a given, before continuing you may wish to familiarise yourself with the conundrum of prioritising children when their parent is the patient by turning back to cell C5's discussion.

On those issues Australian research and guidance has been prominent, and is highly relevant to the similar situation in the UK. Sharing authors and perspectives, the two key reports were published respectively in 2010 (listed above) and 2014 (listed above).

> *Consideration [should] be given to redefining the 'client' to include children and family members*

After reviewing research, analysing Australian policy and intervention strategies, and consulting stakeholders, among the findings of the 2014 report was that "lack of clarity over who was the client – the adult or the child" posed a barrier to child and family sensitive practice. It led to perhaps the reports' most challenging recommendation: that "Consideration be given to redefining the concept of 'client' in alcohol and other drugs treatment to include children and family members." A foreword in the 2010 report had made the same point: "Family Sensitive Policy and Practice becomes a process whereby the unit of intervention becomes the family – a mother, a father, a child, an aunty – however family needs to be defined – and thus shift[s] the focus of the intervention from individual case management to working out how the family can function better."

Put in these terms, the depth and breadth of the change required becomes clear, and clear too is that a new awareness of child welfare among clinicians and managers is not enough; nothing short of a reorientation of the entire organisation (and beyond that of service funders, planners and commissioners) will meet the reports' requirements. The researcher who wrote the foreword quoted in the paragraph above had also led a review of research on how to improve outcomes for children living in families with parental substance misuse. Nowhere was its conclusions more emphatic than at the level of the

organisation: “the importance of having an organisational commitment to the development of family-focused interventions cannot be understated”.

The two Australian documents detail what that “organisational commitment” means in practice. On the agenda are reconsidering assessment procedures, interventions, staff training, who is involved in treatment and who in designing services, and above all, treatment goals. Read these two freely available reports and ask yourself, is such a reorientation possible in the services you know of, and what would it take to achieve it? Remember that problem users of illegal drugs who enter treatment are often divorced from their families, and most problem opiate users (the major part of the drug treatment caseload) do not have day-to-day responsibility for children; in England in 2014/15 an estimated 29% were living with children (1 2), leaving nearly three-quarters who were not. The UK’s own major report (listed above) on substance users and children seems to advocate less of a root-and-branch reorientation: “all drug agencies should contribute to assessing and meeting the needs of their clients’ children ... Services should thus aim to become family friendly with an emphasis on meeting the needs of women and children” (emphasis added). Even this, they foresaw, “will not be easy [and] will have major resource, staffing and training implications”. Should the UK aim instead for the thoroughgoing service reform advocated in Australia?

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