S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies
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Drug Treatment Matrix cell E5: Treatment systems; Safeguarding the community

One of 25 cells in the Drug Treatment Matrix

S Proactive arrest referral works best ([UK] Home Office, 1999). Treatment entry and consequent crime reduction promoted by proactively engaging arrestees or offenders in cells and courts.

S California's experience with compulsory treatment (1977). Lessons of contemporary relevance from the California Civil Addict Program on how to integrate criminal justice procedures with voluntary and coerced treatment.

K Retention maximises treatment's crime-reduction impact ([UK] National Treatment Agency for Substance Misuse, 2012). Treatment systems which retain patients maximally protect society from crime as assessed by reconvictions.

K Characteristics of successful systems to divert from prison to treatments (2011; free source). Interviews with stakeholders in Californian localities with the most successful systems identified four clusters of success factors: fostering offender engagement, monitoring their progress, and sustaining their cooperation; cultivating buy-in among key stakeholders; capitalising on the prestige, influence and power of the court and the judge; and creating a setting which promotes high-quality treatment, use of existing resources, and broad financial and political support.

K System changes double post-release aftercare completion (2009). Promoting aftercare following release from a prison therapeutic community entailed improvements in offender involvement in pre-release planning, the aftercare funding system, staffing, cross-system training, and community support structures. See related guidance (Public Health England, 2018) for England.

K Promoting continuity of opioid use treatment after prison (2018). From the USA, a rare randomised trial found in favour of continuing methadone maintenance when patients entered prison rather than compulsory withdrawal. The potential benefits were most apparent in the near-100% continuation of protective treatment during the highly overdose-prone weeks after leaving prison, likely to have helped (2018) prevent overdose deaths. See related guidance (Public Health England, 2018) for England and related review below.

K Systemic barriers to employing problem drug users ([UK] Department for Work and Pensions, 2010). Interviews with drug service clients in Britain and with staff working in or with treatment agencies highlighted the need for greater integration between treatment services, the social security system, employment services and employers.

K Lessons from Welsh pilot of integrated support for children affected by substance use in the family (Welsh Government, 2014). Evaluation of the first three local schemes in a nationwide rollout of services based on the Option 2 (2012) crisis intervention service for families of parents with drug or alcohol problems. Documents how the schemes changed in response to experience and strategic and operational contexts.

R The more voluntary the treatment the greater the crime reductions (2008). Synthesis of 129 studies of offender treatment for problems including substance use finds treatment's crime-reducing impact increased to the degree to which the offender was free to choose treatment. Implication is that treatment systems should make it easy and attractive for problem drug users to enter treatment without legal coercion. For discussion click and scroll down to highlighted heading.

R Expert guidance on treatment and criminal justice integration (2003). Evidence-based thoughts of eminent researcher on therapeutic criminal justice interventions for problem drug use. Argues for blending treatment and criminal justice sanctions/supervision in the offender's own community ("enabling clients to maintain family and social contacts and seek or continue in gainful education or employment"), offers guidance on matching interventions to the offender, and identifies characteristics of successful programmes. See also this academic (2002) and fully referenced version. For discussion click and scroll down to highlighted heading.

R Melding disparate objectives and cultures is key to criminal justice treatment (Australian Government, 2005). Realistically acknowledges (section headed "Providing AOD treatment within the context of the criminal justice system") that criminal justice and treatment have different objectives and philosophies and don't naturally see eye to

eye, but argues that education and training can underpin collaboration to achieve shared goals. For discussion click and scroll down to highlighted heading.

R Plan for continuity of care to make most of opioid maintenance in prison (2012). Continuity of treatment from before to during and after prison is the key to gaining benefits similar to those in seen in community settings. See related guidance (Public Health England, 2018) for England and related study above.

G Commission for recovery in the community and in prisons ([UK] National Treatment Agency for Substance Misuse, 2010). Calls for commissioners to replicate "as appropriate" within prisons a balanced, recovery-focused treatment system with access to community-based and residential treatment, and ongoing mutual aid support.

G Reducing drug-related crime and rehabilitating offenders (2010). In the absence of more resources, government-supported expert group recommends commissioning and coordination measures to improve outcomes from drug treatment and interventions for prisoners in England.

G Clinical governance in drug treatment ([UK] National Treatment Agency for Substance Misuse, 2009). Guidance for providers and commissioners on systems to deliver and demonstrate that the quality and safety of services are of a high standard and continually improving; includes prison- and community-based criminal justice interventions.

G The roles of substance use services in systems to safeguard children ([UK] Advisory Council on the Misuse of Drugs, 2003). Results of an inquiry in to children in the UK seriously affected by the drug use of parents or guardians. Includes (starting p. 71) guidance on how drug treatment and other services can act together in the best interests of the children. Update published in 2006 documents (from p. 44) the degree to which such systems had been established.

G Protocol for joint working between drug/alcohol services and children/family services ([UK] National Treatment Agency for Substance Misuse, 2011). Intended to help local areas develop agreements to strengthen the relationship between these services to safeguard the children of substance using parents. Includes identification of at-risk children, assessment and referral, sharing information, and staff competencies and training. For 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. What new patients should be asked about children and the role these services should play in a system which ("Getting our Priorities Right" is the document's title) prioritises child welfare. For discussion click and scroll down to highlighted heading.

G Working together to prevent domestic violence and abuse ([UK] National Institute for Health and Care Excellence, 2016). Planning and delivering multi-agency services for domestic violence and abuse. Includes but not specific to substance use.

G Implementing support systems to prevent domestic violence and abuse related to substance use (2017). From Adfam, the national UK charity specialising in drugs and the family, good-practice guidance on how commissioners and service managers can meet the needs of adults in families affected by substance use. Brings together Adfam's 30+ years of experience in family support.

MORE Search for all relevant analyses or for sub-topics go to the subject search page and hot topics on protecting children and on whether testing for and sanctioning substance use can displace treatment.

Last revised 12 October 2018. First uploaded 01 June 2013

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What is this cell about? Constructing local, regional or national systems featuring treatment for adults whose criminal or other undesirable behaviour has made them subject to legally backed sanctions or controls. In these contexts, treatment is offered or imposed not because it has been sought by the patient, but because it is thought that treating their substance use problems could reduce crime or otherwise benefit the community. Typically the targets are offenders who commit acquisitive crimes to fund drug purchases in illegal markets, to some extent driven by their dependence on those drugs. Also includes treatment systems which benefit the community by identifying and/or responding to problem drug use, such as by protecting the user's children and family. As with commissioning in general, involves organising treatment provision to meet the needs of the relevant population in the context of resource constraints and national policy.

Research on treatment systems is rarely of the 'gold-standard', randomised trial format. Whole areas and multiple coordinating agencies cannot easily be randomly assigned to implement new systems of care, while others must stand still or do the conventional thing to form a comparator; communities have their own lives, politics and event-driven diversions beyond the researcher's control. Instead, researchers usually look for patterns in what naturally happens rather than manipulating it to test the consequences; nearly all this cell's key studies used variants on this methodology. The apparent practice implications of these studies are weakened by the fact that the observed patterns may not be due to the presumed cause-and-effect mechanisms, but instead reflect influences which randomisation would have taken out of the equation by evening them up across intervention and comparison systems.

Treatment systems developed for criminal justice and allied purposes are usually derived from those centred on patient welfare and the overcoming of dependence; the impact of treatment in general on crime is the reason why it was adopted for criminal justice purposes. This means that for more research and ideas and we can refer you back to cells dealing with treatment systems generally, with medical treatments, and with psychosocial therapies.

Where should I start? Combining and implementing the precepts of the reviews which form our two starting points would give planners a good chance of constructing successful treatment/criminal justice systems for drug-driven offenders. First starting point features the work of Professor Douglas Marlowe, the US researcher whose studies on matching criminal justice programmes to the characteristics of the offender were highlighted in cell C5. In two freely available reviews he has distilled the implications for programme planners of his own and other research and experience; one was an academic presentation, the other more practitioner-friendly.

Professor Marlowe argues that in contrast to programmes which rely on *either* criminal justice procedures or treatment, those which blend the two offer the opportunity to systematically adjust the mix according to the offender. Some do best simply by being diverted into treatment, while others require intensive monitoring by criminal justice authorities and consistent sanctions/rewards to ensure they engage with treatment. Look in the practitioner-friendly version at the panel headed "Elements of Successful Programs". It lists what Professor Marlowe judges to be "core … attributes" shared by the most demonstratively effective of these programmes: they take place in the community rather than in prison; offer the reward of avoiding a criminal record or imprisonment; have the authority to make revoking criminal justice sanctions contingent on treatment completion and abstinence; can closely supervise offenders via (among other means) tests for drug use and reports from their clinicians; and can quickly impose programmed sanctions and rewards without having to hold further formal hearings. Not all these elements will be needed for every offender, but they should be there from the start if indicated for that offender, and available to be implemented later if the offender's progress (or lack of it) suggests they are needed.

Second starting point is a review co-published by the Australian government. Its contribution is to

summarise what it will take for criminal justice and treatment systems to work together to offer the programmes described by Professor Marlowe. Turn to page 10 of the PDF file and you will see a bulleted list which distils US guidance down to nine ingredients for joint working between treatment and criminal justice systems. The following pages expand on those elements, explaining on page 12 that they come to a head in the case-management orchestration of services for the offender throughout their sentence/treatment. Doing this collaboratively "assumes that the criminal justice worker and the treatment provider view themselves as partners in a common effort to get the client-offender in recovery from [alcohol and other drug] abuse and living a crime-free life". How far that collaboration should go is explored in the next section.

Issues to consider and discuss

▸ **How far should collaboration go?** Return to that quote which ended the section above, taken from our Australian starting point review. The review says that achieving coordinated treatment in a criminal justice context "assumes that criminal justice worker and the treatment provider view themselves as partners in a common effort to get the client-offender in recovery from [alcohol and other drug] abuse and living a crime-free life". Building on this joint foundation, the two sides of this partnership "can co-operate in setting goals for the client-offender, responding to undesirable or order-violating behaviour, and adjusting the terms of probation or parole and/or the type and intensity of treatment". Elsewhere the same document says collaborative working relationships mean responses to issues such as relapse will be "based on trying to achieve common goals for the client-offender," which in turn means "the criminal justice system is much more likely to trust clinicians to make decisions and treatment personnel are more likely to base their decision on clinical grounds with full consideration of security and public safety".

"Full consideration" and "common goals" imply a collaboration so deep that what started out as the disparate goals identified in the review eventually coalesce. Given that the power in this collaboration lies mainly with the criminal justice system – which must enforce the goals of the sentence, can require reports from the treatment service, and can revoke or change treatment – do 'shared' goals become in practice those of the criminal justice system? That seems to be the view of a US expert whose manual on criminal justice supervision was listed in cell D5. Decisively tipping the balance in favour of criminal justice priorities, she saw (p. 69) a good relationship between criminal justice staff and treatment services as enabling them to "work together toward the goal of maximum recidivism reduction" – the criminal justice system's priority. In the same vein, treatment services "must address criminogenic needs," which may include substance use, but not concern themselves with "non-criminogenic factors, such as anxiety and low self-esteem" which "do not contribute to the mission of recidivism reduction".

Speaking to researchers in the early 2000s, a magistrate in England involved in ordering the treatment of drug-dependent offenders put it more bluntly:

> *We're not interested in your cultural values; I'm interested in you doing what we want you to do*

> *[I]t's called a 'partnership', that suggests an equal relationship, and OK that has advantages because you know you're on a level pegging; you can have a constructive dialogue. But also it overlooks the nature of the relationship. You know, we are giving you taxpayers' money on behalf of the state to do something; you will do what we want in terms of the contract, and you'll do what we want because the court – the state – have said that Joe or John has to be dealt with in this way. We're not interested in your cultural values; I'm interested in you doing what we want you to do. But that's robust talk. It doesn't sit well with the partnership culture.*

Exemplified by this quote, the researchers found that faced with treatment's differing priorities and ways of working, "courts and probation staff may increasingly find themselves reverting to a 'command and control' style of management that is at odds with contemporary notions of partnership working". Is this type of crime-centred 'collaboration' inevitable or even desirable, or will it 'kill the goose that lays the golden egg' – robbing treatment of its focus on the patient's welfare, and with that its ability to

engage them and engender crime-reducing change? In one of the US starting point reviews listed above, Professor Marlowe somewhat shifted the emphasis. While advocating integration of criminal justice and treatment efforts and acknowledging that treatment should cooperate with the authorities (for example, by providing regular progress reports and testimony at hearings), nevertheless he insisted that "responsibility for ensuring offenders' adherence to treatment and avoidance of drug use and criminal activity is not … delegated to treatment personnel who may be unprepared or disinclined to deal with such matters and who may have very limited power to intervene". It is, in other words, not the treatment service's job to stop the offender returning to crime; that degree of sharing of goals is explicitly ruled out. Presumably, primarily their job is to 'treat' their patient's substance use problems.

Where these issues come to a head is in rules about confidentiality – in particular, what the treatment service can/must disclose to criminal justice officers about the offender and what they have said or done during treatment. The Australian review deals with this on page 14 of the PDF file, the US review in the panel headed "Confidentiality Guidelines for Integrated Approaches". Can you discern any substantive differences between the two?

▸ **Is coercion a good thing?** At the level of an individual offender dependent on drugs, the answer we have learnt is that it depends on their characteristics and how they react to initial treatment and supervision. But this cell addresses the question at the level of a whole local, regional or national treatment system. At this level the issue is whether the system should be set up to maximise the degree and extent of coercion, or focus on making treatment so accessible, welcoming and non-stigmatised, that formal criminal justice coercion is the exception.

Cell D5's bite recounted what has become the conventional understanding of the role of criminal justice coercion in treatment: that it "has the tools and the authority to 'hold' problem drug users in treatment long enough and get them to 'work the programme' diligently enough to gain benefits". US authorities are definite that "Individuals under legal coercion tend to stay in treatment longer and do as well as or better than those not under legal pressure." This assertion is not without research support, but findings are inconsistent and studies methodologically weak. Sometimes things go better for legally coerced treatment entrants, sometimes worse, sometimes about the same. Few studies could locate a comparison group comparable enough to be sure their findings were due only to the absence versus presence of formal coercion, rather than (for example) differences in the types of patients who are coerced or not, or in the treatments they receive.

One way to gain an impression of the *potential* impact of coercion is to pool the results of these studies, generating an overall estimate of the *association* between coercion and crime reduction. To the degree to which the biases of the studies balance out, this might also be an estimate of the cause-and-effect impact of adding coercion to the treatment mix. Listed above, just such a synthesis was conducted of 129 studies which compared the recidivism of groups of offenders under different degrees of legal pressure to enter treatment; in nearly 4 in 10 of the studies, the treatment addressed substance use. The analysis improved on prior attempts by categorising pressure on a five-point scale from mandatory through descending degrees of coercion to voluntary, and by dividing studies into those where offenders were in custody, versus those where they were being supervised and treated outside prison.

As the degree of voluntariness increased, so too did the treatment programme's crime-reduction impact relative to the comparator. While recognising its limitations, the authors said their analysis "challenges a number of studies that concluded mandated treatment is effective and superior to nonmandated or voluntary treatment in outcome and retention". Since "It appears that some element of coercion may adversely affect the outcome of voluntary treatment," they called for "Further research … on methods of motivating offenders to attend treatment on their own and/or increasing choice and reward for attending treatment."

These findings and conclusions argue (as in respect of alcohol treatment, did Project MATCH researchers) for there to be easily accessible and appealing doors to treatment of as many different kinds as are needed to attract different kinds of drug-driven offenders to enter without formal coercion.

But before accepting these implications, check the caveats in our commentary. Among the most concerning is that offenders who seek and enter treatment voluntarily may simply be more motivated to overcome their substance use problems and end their criminal careers. Perhaps equally motivated offenders formally coerced into treatment would do just as well, but are fewer in number – otherwise they would already have sought treatment on their own initiatives. In this scenario, coercion is not counterproductive, but may seem that way because on average it is applied to less motivated offenders.

However, talking of treatment systems and (un)motivated substance users and as if they were independent factors is almost certainly misguided. Motivation is not necessarily a fixed feature of the individual, but may itself be affected by treatment options. Availability of non-stigmatised, easy-access and attractive treatment might generate motivation to overcome your substance use problems because they offer the prospect of an attainably better life. On the other hand, feeling forced into treatment, the nature of which you cannot choose, could undermine whatever motivation was there in the first place. Prospective patients may be motivated to choose a *particular* approach rather than one imposed on them, and being able to choose it might improve their outcomes.

Whatever your views on these issues, the research synthesis throws into question what have become conventional assumptions about the equality or superiority of legally coerced treatment, tending to support common-sense understandings that what one freely chooses to commit to is more likely to engage one and have the desired effects. The caveats mean, however, that the question is not yet answered either way, and cannot be until we have studies which have randomly allocated offenders to different degrees of coercion while equalising every other element which might affect outcomes.

▸ **Balancing client confidentiality and child protection** As in criminal justice treatment, confidentiality is a critical issue in the treatment of parents whose children may be at risk – an issue too big and too important for local service plans to fail to address. In England in 2014/15 an estimated 47,989 children were living with opiate-dependent women and 93,024 with opiate-dependent men.

In 2013 a report from Australia's National Centre for Education and Training on Addiction investigated how alcohol and drug services can develop child and family sensitive practice. According to some treatment staff, a barrier to developing such practice was the requirements placed on them by local administrations to notify child protection services if they believed a client's children were at imminent risk. Concerns included loss of trust if child protection services approached the client, but also frustration when children who had been notified were not investigated and no feedback was provided. There was also the issue of when to notify – only when a serious event had happened or was looming, or in response to a developing pattern of less serious but perhaps cumulatively damaging behaviour?

Arrangements for treatment services to pass information to child protection services were addressed on page 4 of guidelines from England's National Treatment Agency for Substance Misuse and in chapter 3 of similar Scottish guidance. Both focused on explaining that overlapping legal considerations not only allow but in some circumstances require disclosure of risk, even if the patient withholds consent, and sometimes even without seeking consent if broaching the issue might aggravate risk or prejudice subsequent investigations. Both also acknowledged that local protocols may build on this foundation. Similar issues arise in relation to disclosure of domestic violence between adults (1 2 3).

What more would you like to see in your local arrangements, how would this help safeguard at-risk children – and would not assuring confidentiality risk failing to safeguard children because parents react by not coming forward for treatment or withholding information? You might also consider what difference (if any) it makes if, as in Scotland, the child welfare system initiates legal proceedings only for the most serious cases. Scotland instead relies primarily on social work support and if warranted, (self-)referral to a Children's Hearing, where a panel of three elected and trained local volunteers coordinates support for the family and monitors progress, with the ultimate possibility of turning the case over to the enforcement system if progress is insufficient. It contrasts with the more legalistic systems in the rest of the UK and may facilitate joint working with families, but also enables some to disregard the panel's findings.


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