A tale of two literatures: Perspectives from corrections regarding drug and alcohol treatment for offenders

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Introduction

Offenders with drug and alcohol problems are one of the most significant groups requiring rehabilitation in the correctional system and there is widespread agreement that there is a need to provide effective evidence based interventions for them.

The National Drug Strategic Framework has identified the reduction of drug related crime as one of its goals. The Recommendations of the Australian National Council on Drugs report on Supply, Demand and Harm Reduction Strategies in Australian Prisons emphasises the risks of drug use by offenders to both health and correctional outcomes and conclude that it is "therefore appropriate that this issue is addressed by the most effective strategies available."

However, what we consider to be the most effective strategies available will vary depending on our perspective of the goals of drug and alcohol interventions with offenders, our understanding of the relationship between drug use and crime and whether we address the needs of individuals as drug dependent or as drug-related offenders.

There are two different paradigms in relation to drug treatment of offenders, based in two separate bodies of literature. One paradigm is a broadly defined ‘health’ perspective and the other paradigm is an offender rehabilitation perspective, and the two are seldom brought together. As a consequence, these two bodies of literature utilise different language and concepts. We believe that there is a need to bring these two bodies of literature together to develop a comprehensive and integrated treatment framework for offenders with alcohol and drug problems, grounded in the evidence base from both health and correctional perspectives. In this brief paper, we will highlight the differences and similarities between these two paradigms rather than provide an integrated framework.

Goals of drug treatment for offenders

The overall roles of Corrections Departments are to administer sentences imposed by the courts and to maintain community safety. Within this framework the primary goal of alcohol and drug treatment of offenders is to reduce re-offending and, as a consequence, increase community safety. For those offenders in custody a further goal is to meet duty of care responsibilities to address the broad health and welfare needs of individuals and provide, as far as possible, access to health and other services equivalent to those available in the community.

The key principle underpinning the National Drug Strategy is the minimisation of harm to individuals and society resulting from the use of alcohol and other drugs through a balance between supply reduction, demand reduction and harm reduction. The definition of harm in the strategy is very broad. Harm can occur in the areas of physical and mental health, behaviour, crime and contact with the justice system, employment, education, housing, financial status, family and relationships, psychological issues, and social connectedness. Within this framework AOD treatment contributes to both demand reduction and harm reduction.
Gowing and colleagues identified a series of specific goals of AOD treatment as being to:

- reduce the use of drugs,
- reduce the risk of infectious diseases,
- improve physical and psychological health,
- improve social functioning
- reduce criminal behaviour.

The reduction of criminal behaviour is seen as one of a number of goals of drug treatment, and may be seen as a side benefit of the treatment of drug use and dependence.

This perspective is based on a particular understanding of the relationship between drug use and crime - that drug use causes crime. While this is likely to be true for a proportion of offenders with drug problems, there is growing evidence that the relationship between drug use and crime is complex and multifactorial.

**Relationship between drug use and crime**

Substance use has been identified consistently in the international literature as a major factor associated with criminal behaviour; however, the nature of the relationship is contested. There are three main interpretations of the relationship between drug use and crime in the literature:

- that drug use leads to offending;
- that offending leads to drug use; and
- that both drug use and offending is caused by a third variable.

The first interpretation, that drug use leads to offending, appears self-evidently true in relation to specific drug offences - such as drug selling - although there is a group of offenders convicted of drug trafficking offences who do not use drugs themselves. This interpretation is also frequently used in relation to acquisitive property offences committed by drug users to support their habit and violent offences committed while acutely intoxicated with alcohol, methamphetamine or cocaine. The use of drugs appears to be a predictor of recidivism and it has been found that the more times offenders have been incarcerated the more likely they are to have a drug problem. A significant proportion of offenders attribute particular offences to their use of alcohol and other drugs. Evidence from treatment outcome studies that a range of drug treatments lead to reduced involvement in crime also provides support for this interpretation.

Evidence for the second interpretation, that offending leads to drug use, receives some support from evidence that offenders are more likely to report that criminal conduct commenced prior to their first use of drugs. For males, offending typically commenced prior to the onset of illicit drug use and regular offending preceded regular illicit drug use. Females are less likely than males to report that their offending behaviour commenced prior to commencing drug use with 35% of females and 17% of males reporting that drug use commenced first and 34% of females and 54% of males reporting that offending commenced first.

The third interpretation is that both drug use and crime are caused by a third variable or set of variables. These may be individual factors such as personality disorder or a general deviant lifestyle or more distal social and structural factors. Major literature reviews in the areas of crime prevention, prevention of mental health problems, and prevention of alcohol and drug problems have been conducted in Australia in recent times. These studies provide support for the view that both criminal behaviour and chronic drug use and dependence are part of a broader vulnerability to
adverse health, social, educational and mental health outcomes. Common risk factors for criminal behaviour, mental health problems, and drug problems have been identified and include individual factors such as rebelliousness and early and persistent problem behaviour, poor family functioning, lack of family support, traumatic life events including abuse and neglect, academic failure, poor social and coping skills, and alienation from society. These factors are cumulative and the likelihood of poor outcomes is related to the total number of risk factors rather than to any specific risk factors.

The Drug Using Careers of Offenders study was undertaken by the Australian Institute of Criminology to shed further light on the relationship between drug use and offending. This study found that 81% of all offenders had used cannabis, 58% amphetamines, 45% heroin, 32% cocaine and 60% had used two or more drugs. The study identified eight categories of offenders based on regularity of offending and the main types of offences committed although most offenders had committed more than one type of offence. Regular drug sellers and regular drug buyers each comprised 7% of the sample while 27% were regular property offenders, 8% regular violent offenders, 8% regular fraud offenders, 5% homicide, 15% regularly committed multiple offence types and 24% did not regularly commit any type of offence. The results of this study indicate that:

- The prevalence of drug use varies between different offending types with regular multiple offenders, regular drug sellers and regular property offenders most likely to report recent use of multiple drugs.
- Offending behaviour typically commenced 1–2 years prior to drug use and there were clear differences between crime types in whether individuals attributed their offending behaviour to drug use.

The authors concluded that illicit drug use is not directly linked to the onset of the criminal career but to the escalation of offending.

The detailed exploration of the relationship between drug use and offending which was undertaken in this study showed that the reasons why offenders engage in criminal activity vary significantly between offenders. It is likely that the relationship between drug use and offending is complex, multi factorial and bi-directional, incorporating elements of the three interpretations presented above and that different factors are influential at different stages in the criminal or drug use career and in relation to particular situations and offence cycles. This complexity needs to be taken into account in order to provide the most appropriate individualised assessment and interventions for drug-related offenders.

Two literatures

The AOD treatment field bases its practice on the large body of evidence regarding the effectiveness of alcohol and drug treatment. This body of literature covers a wide range of treatment types and includes small scale trials of particular interventions, large scale treatment outcome studies such as the Australian Treatment Outcome Study (ATOS), the National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD), the UK National Treatment Outcomes Research Study (NTORS), and the US Drug Abuse Treatment Outcome Study (DATOS) and meta analyses such as Cochrane Reviews. The primary focus of this body of literature is on reducing drug use and harm to individuals and the community. Reduction of offending behaviour is one of a number of outcomes of treatment but is not the primary focus of treatment. There is
good evidence of the effectiveness of a range of alcohol and drug treatments in reducing drug use and related harm including criminal behaviour\textsuperscript{xiii}.

Over the past decade, there has been a major shift in correctional practice internationally towards offender rehabilitation. This shift has been driven by an ‘extraordinary growth’ in knowledge in corrections regarding ‘what works?’ in effecting behaviour change. This body of evidence is collectively known as the “what works?” literature and by 1997 there were over 1500 publications including a number of influential meta-analyses. This body of literature identifies the characteristics of effective interventions to reduce re-offending (including alcohol and drug interventions) and demonstrates that offenders who attend rehabilitative programs are 10% to 36% less likely to re-offend than those who do not. In essence this literature states that effective treatment results from cognitive behavioural treatments targeting the dynamic risk factors of higher risk offenders\textsuperscript{xiv}.

AOD Treatment Literature Key Features

Gowing et al (2001)\textsuperscript{xv} and the Beckley Foundation (2006)\textsuperscript{xvi}, reviewing the evidence for effective treatment, each identified four main types of treatment.

- Low threshold services which aim to make contact and engage users,
- detoxification,
- pharmacological treatments and
- psychosocial treatments.

The major focus of many low threshold services is harm reduction, although they also encourage drug users who are not ready to enter treatment to maintain some contact with services and can promote entry to treatment and encourage a degree of behaviour change. This category can also include brief motivational interventions designed to be conducted in a range of settings by workers who may not have specialist training in alcohol and other drugs. There is good evidence of their effectiveness in reducing drug use and related harms in those with less severe problems and in encouraging those with more severe problems to enter treatment\textsuperscript{ xvii}.

Because of the high level of relapse after detoxification, it is not seen as a stand alone drug treatment. Nevertheless, detoxification is an important stepping stone to other drug free treatments or may represent the end point of a period of substitution maintenance treatment.

Pharmacological treatments for dependence include medications for symptom management, substitution therapy and blocking and aversive agents.

There is a wide range of psychosocial treatments which may be delivered individually, or in groups, on an outpatient basis or in residential settings. These types of treatment may include case management and assistance with a wide range of welfare services – eg housing, employment, education, child and family assistance, finances and legal services as well as intensive therapeutic services.

There is now a strong consensus that ‘treatment works’ and this has been demonstrated in a wide range of studies including major outcome studies investigating treatment in existing services under ordinary day to day conditions and there is a growing consensus about which types of treatment are effective. There is strong evidence from multiple sources that opioid maintenance treatments- methadone and buprenorphine - are effective in the treatment of opioid dependence and that they promote:

- retention in treatment,
• reductions in illicit drug use and injecting,
• reductions in mortality,
• improvement of health status, and
• reduction in criminal behaviour.

Effectiveness is enhanced when adequate doses are provided and when combined with treatment addressing the psychological and social issues that accompany dependence xviii.

Psychosocial treatments also have good evidence of effectiveness and a recent report by the Beckley Institute (2006) xix identified 6 types of effective intervention including:
• manualised drug free counselling,
• motivational interviewing when used in combination with other approaches,
• cognitive behavioural therapy,
• contingency management approaches,
• therapeutic communities
• 12 step facilitation in formal treatment programs.

The effectiveness of cognitive behavioural therapy is enhanced when it is combined with other approaches such as pharmacotherapies and contingency management. Contingency management is most effective during treatment and with positive incentives rather than negative sanctions. The evidence for 12 step groups is not as strong but 12 step residential services are as effective as other approaches xx.

For those who remain in treatment, therapeutic communities and other residential services are as effective as other forms of treatment in spite of the fact that their client group are likely to have more severe problems than clients of other treatment services. However, dropout from residential services is much higher than for other treatment types xxi.

While relatively few studies include recidivism as an outcome there is evidence that for those who complete treatment, treatment is effective in reducing drug-related offending. Marsch (1998) in a meta analysis on the impact of methadone maintenance therapy on offending found that there was a significant effect on drug and property offences xxi. A systematic review by Holloway and colleagues for the UK Home Office in 2005 found that methadone treatment, heroin prescription treatment, therapeutic communities and psychosocial programs are all effective in reducing drug related crime xiii. The National Treatment Outcomes study, also in the UK, found that criminal convictions reduced after admission to treatment, with further progressive reductions in criminal convictions across the 5 year follow-up with the effect strongest for acquisitive offences xxiv.

A number of factors have been found to increase the effectiveness of treatment. For pharmacotherapies the importance of adequate doses has been well demonstrated. For all treatments, retention in treatment and stability of treatment- having fewer episodes of treatment- are important as are dealing with a range of needs including housing, employment etc, responsiveness to individual needs, the development of trusting therapeutic relationships, combining different forms of treatment and linking treatment to ongoing care and support xxv.

“What Works?” Literature Key Features

Underpinning the ‘what works?’ model for offender rehabilitation is the Psychology of Criminal Conduct, a social-psychological theory of offending behaviour, described as the Risk-Need-Responsivity Model. The RNR model claims to have the capacity to predict, influence and explain offending behaviour xxvi.
The model identifies three key principles regarding Risk, Need and Responsivity\textsuperscript{xxvii}.

The Risk principle is concerned with the risk of re-offending and identifies who should be treated through the use of structured empirical assessment of risk factors which have been shown to be predictive of future offending. The risk principle determines that the higher risk offender receives intensive services and the lower risk offender receives minimal or no services. Intervention with low risk offenders may increase risk through association with other offenders and/or acquisition of pro-criminal beliefs and attitudes. Intervention with the very high risk egocentric offender may also increase risk (for example psychopaths developing additional social skills for anti social purposes). A number of empirically designed assessment tools are available to assess level of risk of re-offending and individualised assessments are applied to determine particular patterns of high risk situations and to build an understanding of the offender’s criminality.

The Need principle determines what should be targeted for treatment. Risk factors may be classified as either ‘static’ which refers to risk factors which exist in the past and cannot be changed- for example the number of prior offences- and ‘dynamic’ which refers to risk factors which are capable of change such as substance use. Criminogenic needs are dynamic risk factors which empirically predict re-offending. Re-offending can be reduced by addressing dynamic risk factors and/or enhancing protective or strength factors. However, treatment is provided to target the identified criminogenic needs, rather than non-criminogenic needs more distantly related or unrelated to offending such as depression or low self esteem.

Andrews and Dowden (2006)\textsuperscript{xxviii} list “the big eight” dynamic risk factors or criminogenic needs for offending in general:

- History of anti social behaviour
- Antisocial personality pattern
- Antisocial cognition (criminal thinking)
- Antisocial associates
- Family and marital relationships
- School and work history (poor academic and work achievement)
- Leisure/recreational skills
- Substance use.

These factors have been empirically demonstrated to be correlated with future offending.

McMurran and Priestley (2004)\textsuperscript{xxix} have identified the dynamic risk factors which specifically relate to drug-related offending.

- Substance use – with evidence that combined alcohol and drug problems are most predictive of re-offending
- Poor impulse control
- Financial problems
- Poor academic achievement
- Hostile beliefs,
- Antisocial rationalisations
- Criminal lifestyle and peers.

Treatment interventions for drug-related offenders need to target these factors.

The Responsivity principle determines how treatment should be delivered. The style and mode of treatment services should be closely matched to the preferred learning styles and abilities of offenders, the characteristics of the offender should be matched with that of the facilitator and the skills of the facilitator should be matched to the program delivered. Interventions should be based on cognitive behavioural therapy and include problem solving, social interaction and coping skills rather than didactic...
information provision, experiential non directive counselling, or psychodynamic approaches. Responsivity is further divided into internal responsivity and external responsivity. Internal responsivity considers competencies (e.g., cognitive skills, literacy), interests, and motivation to engage in treatment, age, learning style, culture, demographic variables and various barriers to treatment. External responsivity refers to facilitator characteristics and setting characteristics. In practice, responsivity has been poorly addressed in correctional programs.

The RNR differs from the AOD literature in that its primary goal is risk management through reduced re-offending, achieved through targeting treatment to those at highest risk of reoffending and addressing dynamic risk factors alone. The health and well-being of the offender are not of concern in the RNR except as they influence responsivity.

The characteristics of effective interventions to reduce re-offending have been identified and include programs:

- which are well supported by theory or research,
- that target factors which are amenable to change and are related to offending,
- use cognitive behavioural methods,
- match the length and intensity of the program to the risk of re-offending,
- target multiple needs
- are responsive to individual characteristics.

Effectiveness is further enhanced if these programs are linked to ongoing maintenance programs to support behaviour change and prevent relapse.

Common features
The two perspectives of AOD workers and correctional staff have many common features although they are in different settings. Motivation and readiness to change are important offender characteristics influencing the effectiveness of treatment. The work of Prochaska and DiClemente on the cycle of change and the work of Miller and Rollnick on Motivational Interviewing have had a significant influence on correctional practice as they have on AOD treatment practice. Of particular importance has been the understanding that motivation and readiness to change are dynamic and are influenced by the relationship between the client and therapist as well as the attitudes and responses of others in the environment. Recent work on the importance of the therapeutic alliance suggests that up to 40% of the variance in treatment effectiveness may be related to the relationship between the client and the therapist.

Reviews of the effectiveness of correctional drug and alcohol treatments demonstrate that correctional based therapeutic communities, cognitive behavioural programs, and methadone maintenance are all effective in reducing re-offending.

The AOD and the offender rehabilitation literature both rely upon evidence for the effectiveness of cognitive behavioural therapy, contingency management, relapse prevention and therapeutic communities, although they may be couched in different terms. Both recognise the importance of motivational interviewing and the stages of change, goal setting and the development of trusting relationships with the therapist to the effectiveness of treatment. Evidence for the effectiveness of cognitive behavioural therapy, contingency management, relapse prevention and therapeutic communities comes from both fields.
Conclusions

The duty of care for offenders in custody means that correctional jurisdictions have a responsibility to provide evidence-based drug treatment interventions which address both health and well-being concerns and offending behaviour issues, that is, to manage risk and meet need.

All offenders with drug problems need access to appropriate evidence based treatment for the management of drug related health problems, intoxication and withdrawal and to address both the physical and psychosocial dimensions of drug use and dependence.

Those offenders at moderate to high risk of re-offending for whom substance use is an identified criminogenic need also require programs, based on evidence of what works in reducing re-offending, which address substance use and offending and are based on individualised assessment of the relationship between drug use and offending.

This treatment system needs to be embedded in an overall drug strategy that addresses supply reduction, demand reduction and harm reduction and a broad rehabilitation framework which addresses therapeutic needs as well as housing, education, employment, family issues and assists with successful reintegration into the community on release.

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